

Money Follows the Person Operational Protocol

North Dakota

# Money Follows the Person Operational Protocol Template

OPERATIONAL PROTOCOL VERSION 1.0

GRANT 1LICMS030171

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## HOW TO USE THE MONEY FOLLOWS THE PERSON OPERATIONAL PROTOCOL TEMPLATE

### Purpose

The Operational Protocol (OP) is the operational guide that outlines the Demonstration and addresses how the state or territory will meet the objectives of the Money Follows the Person (MFP) Demonstration. The OP describes how the state or territory will operationalize processes to ensure that the state or territory's Demonstration is equipped with the tools, infrastructure, systems, and policies to make MFP Demonstration goals and initiatives successful.

The state or territory must review and amend the OP every three years, or more frequently as needed, in response to changes in (1) federal, state, or territory law, regulation, or policy impacting MFP eligibility, enrollment, or program operations; and (2) MFP operations, inclusive of changes to any of the required MFP OP elements. Refer to MFP Program Terms and Conditions (PTC) 36 for specific requirements around amending the OP.

While the OP describes “how” the state or territory operates the MFP program, “what” the state or territory plans to do to advance MFP and Medicaid home and community-based services (HCBS) is included in the state or territory's unique MFP Work Plan. Reporting on progress is included in the state or territory's Semi-Annual Progress Report (SAR).

### Instructions

The OP template consists of 13 sections. Section A is an overview of the state or territory's MFP Demonstration; sections B through M are the required operational elements of the state or territory's MFP Demonstration. Each section contains prompts for information that are labeled by section and prompt number order (for example, section A.1, prompt A.1.1). The state or territory is required to respond to prompts in each section. Each prompt provides:

- Guidance on how to insert information
- Displays and tools for formatting and inserting information:
  - **Text response boxes.** Information may be entered in multiple lines of text and, where applicable, an external document may be uploaded into a text box.
  - **Table shells.** Table shells display the layout of tables without the information or data. Some table shells contain example entries in red text. Table shell rows may be added if needed. Table shells titled “Example Table” can be modified.

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- Checkboxes. Checkboxes are displayed as a checklist in which to place a checkmark to make a selection.

The yellow line at left indicates instructional text and is followed either by a text response box, checkbox, or a table shell.

### **A few tips for entering information**

- Text insertions must be clear, concise, and consistent.
- Directly address each prompt.
- Use the “Other Information” text box when additional information is necessary to further support, explain, or justify a response to a prompt.
- Limit text responses to no more than three pages.
- Use bullet points, tables, flow charts, and diagrams to help break up long sections of text and to briefly summarize information.
- Use preferred terms and spell out first use of acronyms.
- Do not leave prompts blank. Enter “Not Applicable” for OP prompts that are not relevant to the state or territory’s MFP program.

### **Using hyperlinks and embedding documents**

- Use hyperlinks to link to external documents that are relevant to the MFP program, including MFP marketing and educational materials, service-related documents such as assessments and program checklists, and information contained on external websites.
- Hyperlinks must be documented in Appendix A.1 of the OP.
- If you are embedding external documents within the template, follow [these instructions](#) and select “Display as icon.” This Word feature allows documents to be embedded as clickable icons and may be a preferable alternative to pasting long documents in the appendix or hyperlinking to a document.
- Accessibility features can be maintained by assigning [alt text](#) to the icons representing embedded objects.

### **Before submitting the OP, complete the following three steps:**

1. Ensure that all hyperlinks work.
2. Update the contents of the MFP OP template above by right-clicking anywhere within the field and selecting “Update field.” This will automatically update the page numbers in the contents list.
3. If amending or updating the OP, complete the change log.

## Change log

If amending or updating the OP, complete the change log by inserting entries into Table 1. The first two lines of the table provide examples of how to populate the change log.

**Table 1. Change log**

<b>Section</b>	<b>Prompt</b>	<b>Date of OP submission</b>	<b>Changes made since last revision of OP</b>
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## SECTION A. MFP PROGRAM OVERVIEW

This section briefly describes how the state or territory's MFP Demonstration is designed to meet unique state or territory long-term services and supports (LTSS) system reform efforts to increase the use of HCBS, rather than institutional LTSS. Use the prompts in this section to report on the state or territory's LTSS system assessment and gap analysis and to identify the state or territory's MFP Demonstration target population and geographic area(s) of service.

### A.1. State or territory system and gap analysis

#### A.1.1. Summary of state or territory LTSS system and gap analysis

The summary must address these components:

- **Identify LTSS population needs**
  - Developing programs to live at home longer with home and community-based services and support for older adults and individuals with physical disabilities.
  - Developmental Disabilities provides support and training to individuals and families to maximize community and family inclusion, independence, and self-sufficiency; to prevent institutionalization; and to enable institutionalized individuals to return to the community.
  - Parents with the help of their team (family, professionals, and others important to them), will determine which waiver services will assist the family the most in keeping their child home.
  
- **Identify geographic area(s) of need**
  - The MFP program service areas consist of eight state regional service areas. The Transition Coordinator staff from the North Dakota Independent Living Centers serve as the professionals involved with enrolling MFP participants that reside in a nursing facility. The four centers include the Dakota Center for Independent Living of Bismarck and Dickinson; Independence Inc. of Minot and Williston; Options Resource Center for Independent Living of Grand Forks and Devils Lake; and Freedom Resource Center of Fargo and Jamestown. Each of these Centers are responsible for serving the nursing facilities in their designated service area. All transition coordinators are responsible for outreach and transition activities. The eight service areas (territories) are as follows. Appendix A-1: Territory Coverage
  
- **Identify ways the state can test new approaches and flexibilities in its Medicaid programs to strengthen HCBS through the MFP demonstration**

In addition to services already offered under North Dakota's 1915 c Waivers, Transition Assistance has been made available to ease the

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transition back into community living for all population groups being served by the grant. These service payments have been for one-time occurrences, such as security and utility deposits, home furnishings, assistive technology, and home modifications. The availability of flexible funding has been shown to make a significant difference in enabling a former nursing facility or ICF/IDD resident achieve his or her goal of living in the community.

Another service for Money Follows the Person Recipients can receive is transition adjustment supports through their service provider. This would allow individuals extra support for a temporary period to adjust to community living. Examples could be but are not limited to the following: learning the public transportation system, engaging in community activities or integration, etc. This service follows the same unit rate and structure as the waiver or state funded service would allow.

Transition team support from date of referral. Transition team support does not stop unless someone elects to no longer participate in transition or has a change in MFP eligibility status. This means that team members are supporting the participants regardless of transition timeline.

Money Follows the Person participants begin their transition process upon consenting to the transition process. The consent serves to involve the transition team members to collaborate and mitigate barriers each participant needs to overcome for a safe and healthy transition to community living. This includes a person-centered assessment, transition plan, risk assessment, and emergency backup plan.

The emergency backup plan is used for two purposes. First, it serves as a follow-up nursing call to the participant on a cadence of up to weekly. The emergency backup plan also contains contact information for the supportive people in the participants' lives. Secondly, a 24/7 hotline that is answered by a nurse is posted on the bottom of the plan. It also includes the diagnosis or health conditions that the participant and nurse may discuss.

- **Identify ways to provide opportunities to furnish MFP demonstration services in a more equitable manner**

We have secured and budgeted funding for MFP transition coordinators as well as Housing Facilitators across the state, to include supervisory staff. These staff are contracted to work and support the MFP Demonstration grant through both pre- and post-transition support.

The state has funded 10 Long Term Services and Supports Options Counselors assigned to different facilities and a process for in-reach

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visits for individuals on Medicaid or likely to be eligible for Medicaid. These individuals meet the Nursing Facility level of care and screen for at least 90 days. The facilities included are nursing facilities, swing beds, and hospitals.

The Money Program Administrator meets with the Developmental Disabilities section each month to discuss cases, updates and any suggestions or questions that they may have with the clients they are working with. Individual units have also reached out to have more in-depth meetings or educational opportunities, especially when new staff may be joining the team.

- **Identify and determine measurable, attainable, and timely MFP Demonstration goals and outcomes**

North Dakota is working hard to make Home and Community Based Services the first option, by increasing services in our waivers and adding additional slots for Medicaid recipients. We also would like to serve more individuals utilizing Medicaid in their home or community-based setting versus an institutional setting.

The Long-Term Services and Supports Options Counselors are presenting to each facility on an annual basis, as an outreach opportunity to inform people of their options in choosing the most appropriate setting to meet their needs.

We are learning from re-institutionalization, by hosting quarterly meetings to talk about the cases that have experienced a setback, to mitigate barriers sooner or develop strategies for individuals. We are also debriefing transitions each quarter to also look at areas for improvement or trends that transitions are experienced and what training or education could be developed to learn from any concerns throughout the process.

### **A.2. Service areas and target groups of the MFP program**

#### **A.2.1. Service areas**

Specify the service area(s) in which the MFP Demonstration operates.

State or territory-wide

If not state or territory-wide, indicate specific jurisdictions:

#### **A.2.2. Target groups**

Complete Table A.2.2 to indicate the MFP target population(s) included in the state or territory's Demonstration and indicate the corresponding state or territory operating

agency administering Medicaid HCBS. Please note that target groups falling into the “Other” category must be defined here and throughout the OP.

**Table A.2.2. MFP target population groups**

Select all that apply	Target group of eligible individuals	State or territory operating agency
<input checked="" type="checkbox"/>	Older adults	DHHS: Adult and Aging Services
<input checked="" type="checkbox"/>	Individuals with physical disabilities (PD)	DHHS: Adult and Aging Services
<input checked="" type="checkbox"/>	Individuals with intellectual and developmental disabilities (I/DD)	DHHS: Developmental Disability Services
<input checked="" type="checkbox"/>	Individuals with mental health and substance use disorders (MH/SUD)	DHHS: Developmental Disability Services or DHHS: Medical Services
<input checked="" type="checkbox"/>	Other, please specify (e.g., HIV/AIDS, brain injury) Children (60 days of age through 18 years of age)	DHHS: Developmental Disability Services or DHHS: Medical Services

Describe reasons for targeting certain MFP populations. Include geographic strategies, considerations specific to rural areas, provider network considerations, and alignment with state or territory Olmstead plans and rebalancing strategies.

**Describe reasons for targeting certain MFP populations. Include geographic strategies, considerations specific to rural areas, provider network considerations, and alignment with state Olmstead plans and state rebalancing strategies.**

Our target groups of eligible individuals were developed in response to being awarded the Money Follows the Person Grant from the Centers for Medicare and Medicaid Services in 2007. The State has utilized MFP funding to develop processes that assist individuals with moving out of Intermediate Care Facilities for people with an intellectual disability (ICF/ID) and Nursing Facilities (institutions) and to assure that the necessary Home and Community Based Services (HCBS) are available to support community living. North Dakota has utilized all five of the state’s 1915(c) waivers and the Medicaid State Plan-Person Care Program to support all people transitioning to the community and plans to utilize the state’s 1915 (i).

The target population consists of North Dakotan’s who are currently residing in a nursing facility, a qualified hospital setting, the North Dakota Life Skills and Transition Center, Psychiatric Residential Treatment Facility or in a community based ICF/IDD for a period of 60 consecutive days or more, are receiving Medicaid, meet institutional

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level of care screening requirements at time of admission to the institution, have been determined to be Medicaid eligible for one day immediately prior to transition.

Attached are the level of care screening tools used throughout the state for the different waivers. The Autism waiver does utilize the Vineland © tool.

Appendix A-2: Nursing Facility Level of Care Screening

Appendix A-3: Progress Assessment Review

Appendix A-4: Psychiatric Residential Treatment Facility Level of Care

Money Follows the Person is available for all eligible participants, and we have dedicated team members who cover each area of the state, so targeting rural or urban areas is not utilized or necessary.

### **A.3. Other information**

If needed, provide other information regarding the state or territory's service area(s), target populations, or reporting that is not addressed elsewhere in the template.

MFP reports to the Center's for Medicare and Medicaid, the State of North Dakota, as well as the Department of Justice for our Settlement Agreement. Our reports vary on time frame from monthly to annually.

Appendix A-5: Department of Justice Settlement Agreement

## SECTION B. PROJECT ADMINISTRATION

### B.1. Administrative structure

#### B.1.1. Organizational chart

Provide an organizational chart that shows the entity responsible for the management of the MFP cooperative agreement and the Authorized Organizational Representative;<sup>1</sup> how the management entity relates to all other departments, agencies, and service systems providing HCBS to MFP participants; and the relationship of the organizational structure to the state or territory Medicaid agency and state or territory Medicaid director (SMD).

Upload the organizational chart into either the appendix or text box or provide an external link.

Appendix B-1: Department of Health and Human Services Organizational Chart

Appendix B-2: DHHS: Adult and Aging Services Section

#### B.1.2. Administrative structure

Describe how the state or territory will structure the administration of the MFP program, including how roles and responsibilities will be coordinated across state or territory operating agencies and managed care plans (MCP) (if applicable). Clearly indicate how the organizational and structural administration will function to implement, operate, and monitor the OP elements of the Demonstration.

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<sup>1</sup> The Authorized Organizational Representative is defined in the MFP Demonstration Program Terms and Conditions (PTC 25).

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**Example Table B.1.2. Administrative structure**

<b>Administrative entity (state/territory, other government entity, MCP or contractor/consultant)</b>	<b>OP element(s)</b>	<b>MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)</b>	<b>Formal commitments (for example, Memorandum of Understanding)</b>
DHHS: Adult and Aging Services	All	The Authorized Organization Representative along with the MFP Project Director will work in conjunction and management of the oversight and function of each element within the OP.  The Authorized Organization Representative is the Director of Adult and Aging services.	MFP Demonstration All five 1915c waiver authorities 1915i State Plan Amendment

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<b>Administrative entity (state/territory, other government entity, MCP or contractor/consultant)</b>	<b>OP element(s)</b>	<b>MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)</b>	<b>Formal commitments (for example, Memorandum of Understanding)</b>
DHHS: Medical Services	C, E, F, I, L, M	<p>C. Outreach efforts will be in conjunction with medical services and their providers of the children’s waivers.</p> <p>E. Benefits and services will provide pre- and post-transition support to individuals eligible within this population group</p> <p>F. Eligible individuals will be assigned a transition team to assist in any transition or housing-related services.</p> <p>I. Quality measurement reporting will align with their reporting structure and obtained whenever necessary</p> <p>L. Tribal members will be served under this population group and there will be no difference in services.</p> <p>M. If a public health emergency arises, this population group would follow the direction from the governor and leadership accordingly.</p>	<p>1915c Children’s hospice waiver</p> <p>1915c Autism waiver</p> <p>1915c Medically fragile waiver</p>

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<b>Administrative entity (state/territory, other government entity, MCP or contractor/consultant)</b>	<b>OP element(s)</b>	<b>MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)</b>	<b>Formal commitments (for example, Memorandum of Understanding)</b>
<p>DHHS: Developmental Disability services</p>	<p>C, E, F, I, J, L, M</p>	<p>C. Outreach efforts will be in conjunction with medical services and their providers of the children’s waivers.                      E. Benefits and services will provide pre and post transition supports to individuals eligible within this population group                      F. Eligible individuals will be assigned a transition team to assist in any transition or housing-related services.                      I. Quality measurement reporting will align with their reporting structure and obtained whenever necessary                      L. Tribal members will be served under this population group and there will be no difference in services.                      M. If a public health emergency arises, this population group would follow the direction from the governor and leadership accordingly.</p>	<p>1915c Developmental Disability waiver</p>

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<b>Administrative entity (state/territory, other government entity, MCP or contractor/consultant)</b>	<b>OP element(s)</b>	<b>MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)</b>	<b>Formal commitments (for example, Memorandum of Understanding)</b>
<p>Dakota Center for Independent Living</p>	<p>C, D, E, F, H, J, M</p>	<p>C. Outreach and engagement efforts will be in conjunction with contracted provider.</p> <p>D. CIL staff will attend and participate in Stakeholder meetings.</p> <p>E. Benefits and services will provide pre- and post-transition supports to individuals eligible for transition services.</p> <p>F. Eligible individuals will be assigned a transition team to assist in any transition or housing-related services.</p> <p>H. Transition team members will be required to complete the necessary documents to ensure quality along with a person-centered plan.</p> <p>J. Post transition follow-up will be provided and documented for the individuals with their region.</p> <p>M. If a public health emergency arises, this population group would follow the direction from the governor and leadership accordingly.</p>	<p>Contracted provider</p>

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<b>Administrative entity (state/territory, other government entity, MCP or contractor/consultant)</b>	<b>OP element(s)</b>	<b>MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)</b>	<b>Formal commitments (for example, Memorandum of Understanding)</b>
<p>Freedom Resource Center</p>	<p>C, D, E, F, H, J, M</p>	<p>C. Outreach and engagement efforts will be in conjunction with contracted provider.</p> <p>D. CIL staff will attend and participate in Stakeholder meetings.</p> <p>E. Benefits and services will provide pre- and post-transition supports to individuals eligible for transition services.</p> <p>F. Eligible individuals will be assigned a transition team to assist in any transition or housing-related services.</p> <p>H. Transition team members will be required to complete the necessary documents to ensure quality along with a person-centered plan.</p> <p>J. Post transition follow-up will be provided and documented for the individuals with their region.</p> <p>M. If a public health emergency arises, this population group would follow the direction from the governor and leadership accordingly.</p>	<p>Contracted provider</p>

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Administrative entity (state/territory, other government entity, MCP or contractor/consultant)	OP element(s)	MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)	Formal commitments (for example, Memorandum of Understanding)
Independence Inc	C, D, E, F, H, J, M	<p>C. Outreach and engagement efforts will be in conjunction with contracted provider.</p> <p>D. CIL staff will attend and participate in Stakeholder meetings.</p> <p>E. Benefits and services will provide pre- and post-transition supports to individuals eligible for transition services.</p> <p>F. Eligible individuals will be assigned a transition team to assist in any transition or housing-related services.</p> <p>H. Transition team members will be required to complete the necessary documents to ensure quality along with a person-centered plan.</p> <p>J. Post transition follow-up will be provided and documented for the individuals with their region.</p> <p>M. If a public health emergency arises, this population group would follow the direction from the governor and leadership accordingly.</p>	Contracted Provider

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<b>Administrative entity (state/territory, other government entity, MCP or contractor/consultant)</b>	<b>OP element(s)</b>	<b>MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)</b>	<b>Formal commitments (for example, Memorandum of Understanding)</b>
<p>Options Resource Center</p>	<p>C, D, E, F, H, J, M</p>	<p>C. Outreach and engagement efforts will be in conjunction with contracted provider.  D. CIL staff will attend and participate in Stakeholder meetings.  E. Benefits and services will provide pre- and post-transition supports to individuals eligible for transition services.  F. Eligible individuals will be assigned a transition team to assist in any transition or housing-related services.  H. Transition team members will be required to complete the necessary documents to ensure quality along with a person-centered plan.  J. Post transition follow-up will be provided and documented for the individuals with their region.  M. If a public health emergency arises, this population group would follow the direction from the governor and leadership accordingly.</p>	<p>Contracted Provider</p>

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<b>Administrative entity (state/territory, other government entity, MCP or contractor/consultant)</b>	<b>OP element(s)</b>	<b>MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)</b>	<b>Formal commitments (for example, Memorandum of Understanding)</b>
Minot State University	C, D, E, F, H, J, M	<p>C. Outreach and engagement efforts will be in conjunction with contracted provider.</p> <p>D. CIL staff will attend and participate in Stakeholder meetings.</p> <p>E. Benefits and services will provide pre- and post-transition supports to individuals eligible for transition services.</p> <p>F. Eligible individuals will be assigned a transition team to assist in any transition or housing-related services.</p> <p>H. Transition team members will be required to complete the necessary documents to ensure quality along with a person-centered plan.</p> <p>J. Post transition follow-up will be provided and documented for the individuals with their region.</p> <p>M. If a public health emergency arises, this population group would follow the direction from the governor and leadership accordingly.</p>	Contracted Provider

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<b>Administrative entity (state/territory, other government entity, MCP or contractor/consultant)</b>	<b>OP element(s)</b>	<b>MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)</b>	<b>Formal commitments (for example, Memorandum of Understanding)</b>
North Dakota State University	L	L. Tribal members will be served under this population group and there will be no difference in services.	Contracted Provider
Turtle Mountain Band of Chippewa Indians	L	L. Tribal members will be served under this population group and there will be no difference in services.	Contracted Provider
Home Instead	L	L. Tribal members will be served under this population group and there will be no difference in services.	Contracted Provider
US Preventive Medicine	H, I, J	<p>H. Provider will work on reporting contacts for those individuals needing follow-up nursing support.</p> <p>I. Quality will be assessed should the nurse providing support have any additional concerns or notice any trends that may be encountered.</p> <p>J. Participants will be offered this two-fold service through their demonstration eligibility period.</p>	Contracted Provider

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<b>Administrative entity (state/territory, other government entity, MCP or contractor/consultant)</b>	<b>OP element(s)</b>	<b>MFP role and key responsibilities (how the entity will implement, operate, or monitor the OP element)</b>	<b>Formal commitments (for example, Memorandum of Understanding)</b>
North Dakota Housing and Finance Agency	F	F. This entity assists in collaboration with a few projects that we are working on in conjunction with, such as the Statewide Housing Needs Assessment. We also partner in the Opening Doors Program (Landlord Risk Mitigation) and the Rehab Accessibility Program.	Partner, no formal agreement currently
Great Plains Housing Authority	F	F. This entity is willing to assist in obtaining Mainstream vouchers for transition planning.	Memorandum of Understanding
Burleigh County Housing Authority	F	F. This entity is willing to assist in obtaining Mainstream vouchers for transition planning.	Memorandum of Understanding
Grand Forks Housing Authority	F	F. This entity is willing to assist in obtaining Mainstream vouchers for transition planning.	Memorandum of Understanding
Minot Housing Authority	F	F. This entity is willing to assist in obtaining Mainstream vouchers for transition planning.	Memorandum of Understanding

## B.2. Staffing

### B.2.1. Project director and data and quality analyst

Upload the job description and performance evaluation criteria for these positions into the appendix or provide an external link.

Appendix B-3 Project Director Job Description

Appendix B-4 Data and Quality Analyst Job Description

**B.2.2. Other project staff**

Complete Example Table B.2.2 for all non-contract positions. Describe the MFP role, responsibilities, and relevant OP element(s) for each position in the last column on the table. Responses for the last column may be provided as table text, embedded documents, external links, or text indicating where the response has been added in the appendix. The relevant OP element(s) for each role are the MFP program components (as defined by the major section headers of this document; for instance, D. Community Engagement, E. Benefits and Services, and H. Reporting) on which the staff person in that position will work.

**Example Table B.2.2. MFP Demonstration staff**

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
1-MFP Transition Services Specialist	100	Administrative	Non-contractual	<p><b>Roles and Responsibilities:</b></p> <p><b>Technical Assistance and Oversight</b> Provide ongoing technical assistance to contracted staff, including:</p> <p><b>Transition Coordinators</b> – responsible for assessment, person-centered transition planning, and service coordination.</p> <p><b>Housing Facilitators</b> – responsible for identifying, securing, and coordinating appropriate community housing options.</p> <p><b>Technical assistance includes:</b> Guidance on completing comprehensive</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				<p>transition assessments. Support in developing and implementing person-centered transition plans. Interpretation of federal and state MFP policies and requirements. Problem-solving assistance related to complex participant needs. Best practices in community integration, housing stabilization, and risk mitigation. Training and onboarding support for new contracted staff. Case consultation for high-risk or complex transitions.</p> <p><b>Review and Quality Assurance</b> Review transition assessments and transition plans for</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				<p>completeness, accuracy, and compliance with program requirements. Ensure documentation meets federal MFP guidelines and state Medicaid standards. Monitor timeliness of transition milestones and required documentation. Identify deficiencies and provide corrective feedback. Track and report trends, barriers, and performance concerns.</p> <p><b>Coordination and Communication</b>            Serve as liaison between contracted providers and internal MFP program leadership.</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				<p>Facilitate case review meetings as needed.            Coordinate with housing, waiver, and Medicaid stakeholders to resolve systemic barriers.            Provide clarification on policy updates and procedural changes.</p> <p><b>Compliance and Reporting</b>            Maintain documentation of technical assistance activities.            Support audit preparation and monitoring reviews.            Assist in data tracking and reporting requirements related to transition outcomes.</p> <p><b>Relevant OP Sections: B</b>            (Program</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				Administration), F (Person-Centered Planning), I (Quality Management), J (Transition Process)
1-MFP Referral Specialist	100	Administrative	Non-contractual	<p><b>Roles and Responsibilities: Eligibility Determination (Primary Responsibility)</b></p> <p>This position primarily focuses on MFP eligibility determination but also includes intake coordination and initial case setup. Responsibilities include:</p> <p>Receive and process MFP referrals from nursing facilities, managed care organizations, waiver programs, hospitals, family members, or other referral sources.</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				<p>Conduct preliminary screening to determine basic program eligibility. Verify eligibility criteria, including:</p> <ul style="list-style-type: none"> <li>Length of institutional stay (minimum required days per MFP guidelines).</li> <li>Medicaid eligibility status.</li> <li>Qualified institutional setting.</li> <li>Interest in community transition.</li> <li>Coordinate with Medicaid eligibility staff to confirm financial eligibility when necessary.</li> <li>Document eligibility determinations in the appropriate data system.</li> <li>Issue approval or denial notifications in accordance with policy.</li> </ul> <p><b>Intake and Case Initiation</b></p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				<p>Provide information to potential participants and families about the MFP program.</p> <p>Obtain required consent forms and releases of information.</p> <p>Enter referral and participant data into tracking systems.</p> <p>Ensure all required intake documentation is complete prior to assignment.</p> <p><b>Formulate the Team Members (Defined)</b></p> <p>“Formulate the team members” means identifying, assigning, and initiating involvement of the appropriate interdisciplinary transition team based on the participant’s needs.</p> <p>This includes:</p>

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				<p>Assigning a <b>Transition Coordinator</b> responsible for person-centered planning and service coordination.</p> <p>Initiating referral to a <b>Housing Facilitator</b> when housing search or stabilization is required.</p> <p>Notifying waiver case managers or managed care representatives as applicable.</p> <p>Coordinating with discharge planners or facility staff.</p> <p>Identifying additional support when needed (e.g., behavioral health providers, peer support guardians, family representatives).</p> <p>The Referral Specialist ensures:</p>

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				<p>The appropriate team members are identified early.                      Roles are clearly communicated.                      The case is formally transferred to the transition team after eligibility approval.</p> <p><b>Communication and Coordination</b>                      Serve as liaison between referral sources and the MFP transition team.                      Clarify program requirements for referring entities.                      Track referral status and respond to inquiries.                      Participate in internal case staffing meetings when needed.</p> <p><b>Compliance and Reporting</b>                      Maintain accurate and timely documentation of referrals and eligibility decisions.</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				Track referral trends and outcomes. Ensure adherence to federal and state MFP eligibility requirements. <b>Relevant OP Sections:</b> B (Program Administration), C (Participant Eligibility), E (Outreach and Referral)
1 Program Accountant	25	Administrative	Non-contractual	<b>Roles and Responsibilities:</b> Provides fiscal oversight of the MFP program, including budgeting, expenditure tracking, and financial reporting. Ensures accurate claiming of demonstration and supplemental service expenditures in accordance with federal requirements.

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				<p>Supports preparation and submission of required fiscal reports, including CMS financial reporting. Ensures compliance with state and federal financial management standards.</p> <p><b>Relevant OP Sections:</b> B (Program Administration), E (Outreach and Referral – fiscal support), H (Budget and Financial Reporting)</p>
21- Transition Coordinators	100	<p>Service position: supplemental and Demonstration Service</p> <p><b>Position Summary</b> The Transition Coordinator provides comprehensive, person-centered transition</p>	<p>Contracted Justification for 21 Transition Coordinator Positions based on 2024 Data: Approximately 145 Annual Transitions must account for:</p> <p><b>Full Transition Lifecycle (Not Just Completed Moves)</b></p>	<p><b>Roles and Responsibilities: Person-Centered Assessment and Planning</b></p> <p>Conduct comprehensive transition readiness assessments. Identify participant strengths,</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
		<p>coordination services to eligible participants enrolled in the Money Follows the Person (MFP) Demonstration. Services are delivered statewide and are focused exclusively on supporting individuals transitioning from qualified institutional settings to community-based living arrangements. These positions provide <b>MFP-only services</b> and do not perform non-MFP waiver case management or other Medicaid administrative functions</p>	<p>Each participant typically requires:                      3–6 months of pre-transition coordination                      Day-of-transition support                      12 months of required post-transition monitoring                      This means coordinators manage:                      Active pre-transition cases                      Newly transitioned individuals                      Participants in ongoing 12-month follow-up periods                      At any given time, caseloads include multiple cohorts.</p> <p><b>Average Active Caseload Calculation Assumptions:</b>                      12-month post-transition monitoring requirement</p>	<p>preferences, needs, and risk factors.                      Develop and document individualized, person-centered transition plans.                      Establish measurable goals and transition timelines.  <b>Transition Coordination and Service Arrangement</b>                      Coordinate pre- and post-transition services required for safe community placement.                      Facilitate access to:                      Home and community-based waiver services                      Durable medical equipment                      Behavioral health supports                      Personal assistance services                      Transportation</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
		outside the Demonstration.	<p>Ongoing pipeline of pre-transition cases</p> <p>Estimated active caseload statewide at any time:</p> <p>~145 participants in post-transition year</p> <p>~40–60 in pre-transition planning phase</p> <p>Total active caseload: ~185–205 participants</p> <p>Divided across 21 coordinators:</p> <p>Approximately 9–10 active participants per coordinator at any given time</p> <p>This caseload size is appropriate given:</p> <p>High-acuity populations</p> <p>Complex medical and behavioral health needs</p> <p>Housing instability barriers</p> <p>Required face-to-face institutional visits statewide</p>	<p>Collaborate with housing facilitators to align service and housing plans.</p> <p>Participate in discharge planning meetings with institutional staff.</p> <p><b>Pre-Transition Activities</b></p> <p>Conduct regular face-to-face visits in institutional settings.</p> <p>Assist with housing applications and documentation.</p> <p>Ensure Medicaid eligibility and waiver enrollment are active at discharge.</p> <p>Develop contingency and risk mitigation plans.</p> <p><b>Day-of-Transition and Immediate Follow-Up</b></p> <p>Coordinate logistics of move-in.</p> <p>Confirm services are initiated upon discharge.</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
			<p>Intensive documentation requirements</p> <p><b>Geographic Coverage</b>                      Statewide service delivery requires regional coverage. Travel time to rural and institutional settings significantly reduces daily case capacity. Coordinators must maintain manageable caseloads to ensure timely visits and compliance.</p> <p><b>Participant Acuity and Risk Level</b>                      MFP participants often:                      Have multiple chronic conditions                      Require complex service coordination                      Face housing barriers</p>	<p>Ensure medications, equipment, and supports are in place.</p> <p><b>Post-Transition Monitoring</b>                      Provide required post-transition follow-up contacts by MFP guidelines. Monitor health, safety, and community integration outcomes. Address service gaps or emerging risks. Revise transition plans as necessary.</p> <p><b>Documentation and Compliance</b>                      Maintain detailed case documentation in state-approved systems. Meet all CMS MFP documentation and reporting standards.</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
			<p>Experience behavioral health or cognitive challenges                      Lower caseloads are necessary:                      Ensure safe transitions                      Preventing re-institutionalization                      Meet CMS quality and health/safety standards</p> <p><b>Program Growth and Pipeline Stability</b></p> <p>The 21 positions:                      Maintain referral pipeline capacity.                      Preventing service delays.                      Support program growth targets.                      Ensure continuity during staff turnover or leave.</p> <p>The allocation of 21 contracted Transition Coordinators is justified based on:</p>	<p>Participate in quality reviews and audits.</p> <p><b>Relevant OP Sections:</b> C (Participant Eligibility), E (Outreach and Referral), F (Person-Centered Planning), G (Demonstration Services), J (Transition Process)</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
			<p>Full lifecycle case management requirements (pre- and 12-month post-transition)</p> <p>Approximately 185–205 active cases at any given time</p> <p>Statewide geographic coverage demands</p> <p>High-acuity participant needs</p> <p>CMS documentation and monitoring requirements</p>	
11-Housing Facilitators	100	Service position: Supplemental and Demonstration Service	<p>Contracted</p> <p>Justification for 11 Positions (2024 Transition Volume: ~145 Annual Transitions)</p> <p>In 2024, approximately 145 individuals transitioned through MFP. Housing location and stabilization represent the most time-intensive and barrier-prone components of</p>	<p><b>Roles and Responsibilities:</b></p> <p><b>Role and Responsibilities</b></p> <p>Housing Facilitators provide specialized, MFP-only housing transition services to support individuals transitioning from institutional settings to qualified community-based residences across the state. These positions are fully</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
			<p>successful transitions, particularly given:</p> <ul style="list-style-type: none"> <li>Limited affordable housing inventory statewide.</li> <li>Increased landlord screening requirements.</li> <li>Accessibility modification needs.</li> <li>Rural housing shortages.</li> <li>Complex participant needs (behavioral health, accessibility, rental history barriers).</li> </ul> <p>On average, each transition requires intensive housing navigation over 60–120 days, including landlord outreach, application submissions, coordination with housing authorities,</p>	<p>dedicated to Money Follows the Person (MFP) activities and do not provide services outside of MFP participation. Housing Facilitators are responsible for:</p> <ul style="list-style-type: none"> <li>Conducting individualized housing needs assessments for MFP participants.</li> <li>Developing housing transition plans in coordination with case managers and interdisciplinary teams.</li> <li>Identifying and securing safe, affordable, and accessible housing options.</li> <li>Assisting participants with housing applications, documentation, landlord</li> </ul>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
			<p>inspections, and problem resolution. With 145 annual transitions:</p> <p style="padding-left: 40px;">This equates to approximately 12–14 transitions per Housing Facilitator annually. Each facilitator manages a rolling caseload of active housing searches, tenancy coordination, and stabilization activities. Geographic distribution across the state necessitates regional coverage to prevent transition delays. Without dedicated housing staff, discharge timelines would increase, institutional lengths of stay</p>	<p>negotiations, and lease arrangements. Coordinating reasonable accommodation and accessibility modifications when needed. Facilitating access to utility setup, deposits, and essential household items in coordination with approved MFP transition support. Providing tenancy-sustaining support during the transition period. Maintaining relationships with landlords, public housing authorities, and community housing providers statewide.</p>

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Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
			<p>would extend, and transition targets would not be met.</p> <p>The requested 11 FTE positions reflect:</p> <ul style="list-style-type: none"> <li>Caseload intensity</li> <li>Geographic coverage requirements</li> <li>Administrative coordination demands</li> <li>Time-limited but high-intensity housing search activities</li> <li>The need to prevent transition backlogs</li> </ul> <p>Housing Facilitators are critical to achieving annual transition targets and maintaining compliance with MFP benchmarks.</p>	<p>Tracking housing barriers and system gaps to inform statewide housing development strategies.</p> <p>Documenting all activities in accordance with MFP reporting and federal requirements.</p> <p>These services are distinct from state plan services and waiver case management and are delivered exclusively to individuals enrolled in MFP during the qualified transition period.</p> <p><b>Relevant OP Sections:</b> C (Participant Eligibility), E (Outreach and Referral), F (Person-Centered Planning), G</p>

Number and position title	Percent of full-time equivalent	Administrative or service position (if service position, indicate whether Demonstration or supplemental)	Indicate if non-contract or contract/consultant position	MFP role, responsibilities, and relevant OP element(s)
				(Demonstration Services), J (Transition Process)

### B.2.3. In-kind support

Describe positions providing in-kind support (that is, support from non-MFP staff) to the MFP Demonstration. Indicate the percentage of time each individual or position is dedicated to the grant and the roles and responsibilities of each position. Indicate the OP element(s) the positions will support. If a large number of staff provide in-kind support to the MFP Demonstration, describe the staff in general or aggregate terms, such as contracting specialists, fiscal staff, etc.

There are no in-kind support positions currently.

### B.2.4. Staffing and contract execution timeline

Provide a hiring timeline (start and end date) for non-contract staff. For contract, consultant, or subrecipient positions, provide the contract execution date and expected expiration/end date.

All positions are occupied currently and have been in a timely fashion. We do have our contracted staff, both Transition Coordinators and Housing Facilitators completing a request to fill if a position becomes vacant.

## B.3. Billing and reimbursement

### B.3.1. Billing and reimbursement procedures

Describe how the state or territory will establish billing and reimbursement procedures to link Medicaid claims to MFP individuals. Include the following:

- Description of MFP identifier codes in the Medicaid Management Information System (MMIS) and if applicable in the state or territory accounting system
- Upon transition, administrative staff enter the transition into our reporting program and notify the claims specialist within the appropriate department,

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such as Adult and Aging or Developmental Disability. The identifier code input into the MMIS system consists of an entry entitled “Money Follows the Person Grant” for anyone transitioning to community living with the Home and Community Based Services (HCBS) waiver. Each month IBM staff queries the SQL database where MFP staff documents transition and re-institutionalization events and also queries the MMIS system where records are identified with a “Money Follows the Person Grant” entry and sends the required information to CMS.

- If a re-institutionalization event takes place, this code has an end-date input into the MMIS system, so the MFP program does not get billed for any expenses incurred during the hospital or skilled nursing facility stay. This forces Medicaid to again become the payer of any claims that come through. When the participant goes back to the community the MMIS system is again updated to update the payer information to the “Money Follows the Person Grant” identifier code and MFP is again billed.
- Description of procedures for ensuring against duplication of payment for the Demonstration and Medicaid programs
  - There are policies in place and many checks and balances to make sure that we verify payments, such as proof of purchase, along with a prior authorization or request for the item. We also get verification that this item is not approvable by Medicaid and the rationale why the item is not approved through working with the administrative team in Medical Services, who oversee Medicaid.
- If the state or territory operates a managed long-term service and supports (MLTSS) program, description of your state or territory’s managed care claiming methodology to determine the portion of the capitation rate that is attributable to qualified HCBS listed in Attachment A of the MFP PTC

North Dakota does not have managed Care throughout the state. The only managed care plan that would be an option in North Dakota is the Program of All-Inclusive Care for the Elderly ([PACE](#)). This service is utilized in the urban areas of Minot, Fargo, Bismarck and Jamestown. It is not available in the rest of the State of North Dakota, thus a very small percentage of MFP participants use this service.

1. Pre-transition: Transition Coordinator would still be responsible for the MFP Assessment, MFP Transition Plan and the Risk Assessment/Health and Safety Plan. Housing Facilitator would also be assigned to address any housing barriers and work to obtain a qualified residence.
2. Transition Phase: The Transition Coordinator and Housing Facilitator would request approvable items for the individual based on their transition plan. The

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Transition Coordinator and Housing Facilitator would connect with PACE to complete what would be possible for the transition phase and assessment piece for PACE.

3. Enrollment Period: Transition Coordinator and Housing Facilitator would ask for the treatment plan that PACE utilizes for their plan of care. They would also make routine contacts throughout the enrollment period, with Transition Coordination contact at minimum monthly and with the Housing Facilitator contact no less than quarterly.
- Procedures for fraud control and monitoring
    - All MFP staff are required to take the Medicaid: Fraud, Waste and Abuse training initially and on an annual basis. Providers and contracted staff are also required to take on this training. We work in conjunction with the Medicaid Fraud Waste and Abuse Unit.

### B.4. Budget process

#### B.4.1. Budget development process

Describe how the state or territory will prepare the MFP budget. Include the following:

The state prepares the MFP (Money Follows the Person) budget using the MFP Budget Workbook, a tool that breaks down the budget into key expenditure categories for a comprehensive analysis of funding needs. The workbook consists of several sections, each addressing different components of the budget. The process involves collaboration across the department and culminates in approval from leadership and submission into Grant Solution for funding authorization.

Process for projecting annual expenditures

- Personnel: The budget begins with an analysis of current positions funded under MFP, including position status (filled or vacant), annual salary, level of effort, and associated costs. Projections for staffing are updated to reflect any anticipated changes in personnel or salary adjustments.
- Fringe Benefits: Projections for fringe benefits are calculated based on the benefits associated with each position. This includes costs for health insurance, retirement contributions, Social Security & Medicare, FICA, Group Life Insurance, unemployment, Employee Assistance Program and Worker's Compensation, ensuring that all positions are accounted for in the overall budget.
- Travel: Travel expenses are projected based on expected conferences, meetings, and regular state travel for budgeted positions. The estimation process considers factors such as the location of conferences, number of attendees,

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travel duration, and associated costs (airfare, hotel, per diem, registration fees, etc.). Regular in-state or out-of-state travel is also factored in.

- Equipment: Currently, there are no projected expenses for equipment.
- Subrecipients: For any contracts involving subrecipients or vendors, the budget includes a review of each contract for the fiscal year. This involves identifying the subrecipient/vendor, reviewing the statement of work (SOW), and determining the total annual contract amount. This ensures all external funding obligations are accurately represented in the budget.
- Other: This category includes the costs of qualifying Home and Community-Based Services (HCBS), demonstration HCBS services, and supplemental services. The projected costs are based on actual expenditure from previous years, adjusted for anticipated inflation. This approach ensures that funding estimates reflect historical data while accounting for inflationary trends.
- Indirect Charges: No indirect charges are projected for the current budget period.

### Cross-agency roles and responsibilities for developing, reviewing, and approving the budget

- Program Staff: Program staff are responsible for providing the necessary data and estimates for their respective budget categories. This includes working closely with the finance and accounting teams to ensure the accuracy of projections.
- Accounting Team: The accountant is responsible for compiling the various projections into the MFP Budget Workbook. The accountant collaborates with program staff, attends meetings, and gathers the necessary data to ensure that all budget categories are adequately addressed and documented.
- Program Director: Once the budget workbook is completed and all sections have been reviewed and finalized, the Program Director gives final approval. The Program Director plays a key role in ensuring that the budget aligns with the program's goals and objectives.

### Procedures for adjusting or reconciling the budget

- Adjustments: Should there be any changes during the budget development process, whether due to unforeseen changes in staffing, unanticipated travel costs, or fluctuations in subrecipient contracts, the MFP Budget will be updated accordingly. Adjustments will be reviewed by the relevant stakeholders to ensure they are necessary and feasible within the overall budget constraints.
- Reconciliation: After the initial budget is completed, a reconciliation process is undertaken to verify that all expenditure projections are accurate and aligned with the historical data and anticipated costs. Discrepancies are resolved by reviewing prior-year expenditures, consulting with program staff, and making necessary adjustments.

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- Final Review and Approval: Once all adjustments and reconciliations have been completed, the final budget is reviewed by the Program Director for approval. The finalized budget is then submitted into Grant Solutions to the Centers for Medicare & Medicaid Services for final review, approval, and funding authorization.

### Submission for Funding Authorization

- After the budget is approved by the Program Director, it is submitted through Grant Solutions. The submission triggers a formal review, where the application will either be approved or revisions requested. Upon approval, the budget will be authorized for funding, allowing the program to proceed with implementation of the upcoming fiscal year.

### **B.5. Other information**

If needed, provide other information regarding the state or territory's MFP Demonstration administration that is not addressed elsewhere in the template.

The state currently utilizes the Access Database to track authorizations and expenditures for the grant for both supplemental and demonstration services. This helps us better track utilization and provide projections, however, with the rise in service costs within our state, our projections have been a little unpredictable based on the growth seen within our home and community-based services.

## **SECTION C. RECRUITMENT, ENROLLMENT, OUTREACH, AND EDUCATION**

### **C.1. MFP-qualified inpatient facility recruitment**

#### **C.1.1. MFP-qualified inpatient facility types**

In Table C.1.1, describe how the state or territory will collect and verify that MFP participants are transitioning to the community from an MFP-qualified inpatient facility. Describe the process for each target population and inpatient facility type. If there are multiple “other” populations to note, illustrate the type(s) of inpatient facilities separately for each “other” population with a new row.

**Table C.1.1. MFP-qualified inpatient facility type by target group**

<b>Target population(s)</b>	<b>MFP-qualified inpatient facility types from which the target population will transition</b>	<b>Description of data collection and verification procedures</b>
Older adults	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Nursing facility</li> <li><input checked="" type="checkbox"/> ICF/IID</li> <li><input checked="" type="checkbox"/> Hospital</li> <li><input checked="" type="checkbox"/> IMD</li> </ul>	<p>The state utilizes a standardized referral, data collection, and verification process for all MFP participants. Referrals are submitted by qualified entities, including inpatient facility staff, case managers, discharge planners, and Centers for Independent Living (CIL) transition coordinators, using state-approved referral forms. State MFP staff enter referral information into the state’s case management system and MFP tracking database.</p> <p>The state verifies that the individual is transitioning from an MFP-qualified inpatient facility by reviewing facility admission and discharge documentation, level of care determinations, and provider certification. Medicaid eligibility, institutional claims, and encounter data are reviewed through the Medicaid Management Information System (MMIS) to confirm Medicaid eligibility, qualifying institutional residence, and length of stay. The state verifies that the facility meets the federal definition of a qualified inpatient facility.</p> <p>Transition progress is monitored through ongoing case management and regular coordination with CIL transition coordinators. Upon discharge, the state verifies transition to a qualified community residence through discharge documentation, case management records, and Medicaid eligibility and claims data. Participants are monitored through the MFP participation period to ensure continued program compliance.</p>

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<b>Target population(s)</b>	<b>MFP-qualified inpatient facility types from which the target population will transition</b>	<b>Description of data collection and verification procedures</b>
Individuals with PD	<input checked="" type="checkbox"/> Nursing facility <input checked="" type="checkbox"/> ICF/IID <input checked="" type="checkbox"/> Hospital <input type="checkbox"/> IMD	The state follows the same standardized referral, data collection, and verification process described above. State staff verify qualifying inpatient residence through facility documentation, level of care determinations, provider certification, and Medicaid eligibility and claims data in MMIS. Transition and discharge to a qualified community residence are verified through case management documentation and Medicaid data systems. Participants are monitored throughout the MFP participation period.
Individuals with I/DD	<input checked="" type="checkbox"/> Nursing facility <input checked="" type="checkbox"/> ICF/IID <input checked="" type="checkbox"/> Hospital <input checked="" type="checkbox"/> IMD	The state follows the same standardized referral, data collection, and verification process described above. State staff verify qualifying inpatient residence, including residence in an IMD when applicable, through review of facility documentation, level of care determinations, provider certification, and Medicaid eligibility and claims data in MMIS. Transition and discharge to a qualified community residence are verified through case management documentation and Medicaid data systems. Participants are monitored throughout the MFP participation period.
Individuals with MH/SUD	<input type="checkbox"/> Nursing facility <input type="checkbox"/> ICF/IID <input type="checkbox"/> Hospital <input type="checkbox"/> IMD	This is not a population group that North Dakota utilizes.

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Target population(s)	MFP-qualified inpatient facility types from which the target population will transition	Description of data collection and verification procedures
Other, please specify in text box below (e.g., HIV/AIDS, brain injury) Child (60 days-17 yrs old)	<input checked="" type="checkbox"/> Nursing facility <input checked="" type="checkbox"/> ICF/IID <input checked="" type="checkbox"/> Hospital <input checked="" type="checkbox"/> IMD	The state follows the same standardized referral, data collection, and verification process described above. State staff verify qualifying inpatient residence through facility documentation, level of care determinations, provider certification, and Medicaid eligibility and claims data in MMIS. Transition and discharge to a qualified community residence are verified through case management documentation and Medicaid data systems. Participants are monitored throughout the MFP participation period.

Note: MFP programs transitioning MFP participants from an IMD (see PTC 14) must provide a description in section C.1.2 of the OP of how the state or territory will verify certain requirements, such as that the individual meets MFP individual eligibility criteria. ICF/IID = Intermediate Care Facility for Individuals with Intellectual Disabilities; IMD = Institution for Mental Diseases.

### C.1.2. Institution for mental diseases (IMD) exclusion

For MFP programs transitioning MFP participants from an IMD (see PTC 14), provide a description of how the state or territory will verify that the:

- Individual meets the MFP individual eligibility criteria
- Individuals are receiving one of these benefits:
  - Services for individuals ages 65 and older in an IMD, referred to as “IMD over 65”
  - Inpatient psychiatric services for individuals younger than 21, referred to as “psych under 21”
  - Medicaid beneficiaries ages 21 through 64 residing in an IMD who are receiving services that are covered under a substance use disorder or Serious Mental Illness section 1115 demonstration

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North Dakota does not currently serve a standalone Mental Health/Substance Use Disorder target population under the MFP program. Children institutionalized in a Psychiatric Residential Treatment Facility (PRTF) are served under the children target population and receive services authorized under the 1915(c) Developmental Disabilities Waiver or 1915(i) State Plan services, as applicable.

For individuals transitioning from an IMD, the State verifies that the individual meets MFP eligibility criteria and is receiving a qualifying IMD benefit through review of Medicaid eligibility records, provider documentation, and Medicaid claims and encounter data in the Medicaid Management Information System (MMIS).

The State confirms that the individual is receiving one of the following qualifying IMD benefits:

**IMD Over 65:** The State verifies that the individual is age 65 or older and receiving Medicaid-covered services in an IMD through Medicaid eligibility records, provider enrollment records, and claims data. This includes verification that the IMD, including the North Dakota State Hospital, is enrolled as a Medicaid provider and billing Medicaid for covered services.

**Psych Under 21:** The State verifies that the individual is under age 21 and receiving inpatient psychiatric services in an IMD through review of Medicaid eligibility records, provider type, service authorization, and claims and encounter data.

Documentation supporting eligibility, qualifying IMD services, and institutional residence is maintained in the participant's MFP case record. The State verifies institutional discharge and transition to a qualified community residence through facility discharge documentation, case management records, and Medicaid eligibility and claims data.

### **C.1.3. Strategies for recruiting MFP-qualified inpatient facilities**

Describe strategies for recruiting MFP-qualified inpatient facilities to engage in the development and implementation of person-centered transition programs that offer residents the choice of leaving the facility to return to the community. Include geographic strategies, considerations specific to rural areas, alignment with state or territory Olmstead plans and rebalancing strategies, and facility access and engagement approaches.

North Dakota has Long Term Services and Supports Options Counseling. The primary role of these 10 full-time state employees is to meet with individuals who screen at a Nursing Facility level of care to 90 days or more, are eligible for Medicaid or have applied for Medicaid to explore options. This process has 3 different referral types: initial screening visit, annual person-centered planning visit, or from the Nursing Facility Presentation.

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The four Centers for Independent Living also provide outreach services to the facilities in their area to inform them about Money Follows the Person and get to know the referral source.

In addition, each year the Project Director and additional state staff, invite facilities to an in-person meeting to talk about Minimum Data Set (MDS) section Q, and other transition resources as our Home and Community Based Services continue to evolve in North Dakota and our implementation of the Settlement Agreement helps the state create additional resources and try new strategies to help us better serve North Dakotans.

The project director also meets with the Developmental Disabilities regions and providers to provide training and resources to the community, especially when individuals maybe working in a different capacity and they may have new staff who are not familiar with the Money Follows the Person Program.

Appendix C-1 Long Term Services and Supports Options Counseling Coverage

Appendix C-2 Long Term Services and Supports Options Counseling Brochure

Appendix C-3 Long Term Services and Supports Options Counseling Referral

## C.2. MFP participant recruitment and enrollment

### C.2.1. Eligibility criteria for participation in MFP

Describe any state or territory-specific MFP eligibility criteria. For example, describe your state or territory's requirements for individuals' length of stay in an MFP-qualified inpatient facility if more than 60 consecutive days. See section IV of the MFP PTC for a description of MFP eligibility criteria.

Our eligibility criteria is consistent across the state, Medicaid eligibility, 60 consecutive days, meets level of care criteria, moving out of a qualified institution to a qualified residence.

North Dakota eligibility criteria is the same across the State for anyone listed in section C.1.1 who also meets the criteria listed in the MFP Program Terms and Conditions section IV. All MFP participants are receiving Medicaid, reside in an MFP-qualified inpatient facility, have been there for 60 consecutive days, meet nursing facility level of care upon transition, and are moving to a qualified residence.

### C.2.2. Participant recruitment and enrollment process

Describe the MFP participant recruitment and enrollment process, indicating differences as applicable for each target group and inpatient facility type identified in C.1.1. Include the following:

- Describe the process to identify eligible individuals interested in transitioning from an inpatient facility to a qualified residence.

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- The individual can complete a referral in many ways, including the facility working with the individual to complete a referral. The referral is then sent to the Aging and Disability Resource Link or a shared email inbox for MFP administrative staff. The staff verify eligibility requirements are met and reach out to the referral source for additional information. The referral source is also then notified of the approval, and the referral is sent on to the contracted partners to begin the transition process. The referral serves as informed consent until formal consent for the program can be obtained.
- Describe the role of No Wrong Door (NWD) systems to recruit and enroll MFP participants.
  - The Aging and Disability Resource Link is the intake method for the State of North Dakota, there are 6 dedicated intake staff who man the phone lines, process the web inquiries and who call participants back to complete the intake to then connect the referral or participant to services.
- Describe how the state or territory will verify MFP individual eligibility criteria.
  - This work is done primarily by the MFP Referral Specialist or another administrative staff if coverage is needed that day. The process is to first verify the information on the referral with other resources, such as our level of care vendor, and our state Medicaid management system. Both systems help us verify the length of stay and the Medicaid eligibility. The individual themselves and/or guardian are contacted to discuss the desired location to transition to along with all information to best develop a person-centered transition plan.
- Describe the provider(s) rendering services to recruit and enroll individuals into MFP.
  - The Transition Coordinator staff from the ND Independent Living Centers serve as the professionals involved with enrolling MFP participants that reside in a nursing facility. The four centers include the Dakota Center for Independent Living of Bismarck and Dickinson; Independence Inc. of Minot and Williston; Options Resource Center for Independent Living of East Grand Forks and Cavalier; and Freedom Resource Center of Fargo and Jamestown. Each of these Centers are responsible for serving the nursing facilities in their designated service area. All transition coordinators are responsible for outreach and transition activities.
  - The Transition Coordinators provide MFP brochures and information to nursing facility social services staff to use to make other residents aware of the grant and are available for presentation to NF Resident Counsels or facility staff. An MFP sign will be displayed in all nursing facilities.
- Describe how the state or territory will ensure a person-centered planning process during the MFP recruitment and enrollment process. The person-

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centered planning process must include a person-centered service plan that identifies the individual's needs and individualized strategies and interventions for meeting those needs and be led by the individual and the individual's legally authorized representative if applicable.

- The person-centered planning process starts upon receipt of the referral, and the Transition Coordinator is sent out to obtain more information along with consent to enter in the MFP Program. The consent serves as a written document so that the individual is willing to work with the transition team to create a plan.
- The individuals who consent to working through the transition process are assigned a Transition Coordinator, Housing Facilitator, Home and Community Based Services Case manager/Developmental Disabilities Program Manager. During this transition process, the completion of an MFP Assessment, MFP Transition Plan and Risk Assessment/Health and Safety Plan are developed. All these documents are approved and signed by the individual and/or guardian.
- The individual also has the right to stop services at any time throughout the process.

### **C.2.3. Data sources for recruiting MFP participants**

Describe how the state or territory will process and organize data sources to identify and recruit MFP participants. The description must include the use of the Minimum Data Set (MDS) Section Q and must describe any variability among MFP target populations, MFP-qualified inpatient facilities, and state or territory operating agencies.

The North Dakota Department of Health and Human Services, Medical Services Section maintains a Minimum Data Set (MDS) database, and this has been used to help identify potential grant participants. North Dakota nursing facilities complete a comprehensive MDS assessment, and this information is submitted to the North Dakota Department of Health and Human Services through the Aging and Disability Resource Link.

In addition, the Options Counselors are reaching individuals in three different capacities through their daily list, annual person-centered plan or an annual presentation provided to the residents of Nursing Facilities. The Center's for Independent Living are also providing outreach for possible transitions to the community. Transition coordinators are required to visit all nursing facilities in their designated quadrants on a quarterly basis to do outreach activities which include visiting resident councils, family councils, individual residents, and facility staff.

Appendix C-4 Local Contact Agency Referral

Appendix C-5 Developmental Disabilities Referral

### C.3. Outreach and marketing to participants, providers, and the community

#### C.3.1. Marketing plan

Describe how the state or territory will develop and implement a marketing plan to recruit and enroll MFP participants. Include a description of the following:

Upload printed marketing materials or provide an external link to the materials in the appendix, as appropriate.

- Strategy or strategies to provide cultural, linguistic, and disability competency in the production and dissemination of marketing materials

The Project Director will work with the communication section to make sure that the information released to the public is accessible and meets the standards set forth by the department, such as color schemes, content and branding.

- Types of marketing materials and tools

The Project Director and Data and Quality Analyst will actively work to have an updated webpage, forms and documents to meet the needs of the individuals' receiving services and others who may want additional information about the program as well. Marketing tools will also be utilized for vendor booths and for publications at qualified institutions.

- Types of media approaches (print, radio, television, direct mail, social media, search engine, and so on)

The Money Follows the Person program will work closely to align with the marketing strategies for the Aging and Disability Resource Link as their advertising occurs throughout social media. MFP will continue to highlight the client testimonies that were recently released. Attached are the links to the webpage and those client testimonies and additional information within the Appendices.

[MFP Webpage](#)

[Mark's Testimony](#)

[Esther's Testimony](#)

[Kenna's Testimony](#)

Appendix C-6 MFP Booklet

Appendix C-7 MFP Case Study

Appendix C-8 MFP Fact Sheet

#### C.3.2. Outreach and education plan

Describe how the state or territory will develop and implement an outreach and education plan to recruit MFP-inpatient facility providers, service providers, affordable and accessible housing providers, community-based organizations, and other relevant entities. Include a description of the following:

Upload outreach and education materials into the appendix or provide an external link.

- **Methods and tools**

The Long-Term Services and Supports Options Counselors provide in-person outreach to the Medicaid eligible individuals who have recently been referred to for a stay of at least 90 days in a skilled nursing facility. They also complete person-centered plans with individuals on an annual basis and present annually to the broader population of those residing in a nursing facility. We also attend vendor booths as a state agency as well as in collaboration with other contract partners. We track each referral through our access database, so we can further narrow which facilities and areas of the state would need any targeted marketing strategies implemented.

- **Collaboration opportunities**

Annually each facility is formally invited to participate in a two-hour presentation across 8 different regions with partners within the Department of Health and Human Services to talk about the referral process and transition process, along with any additional information they may have asked about or have questions on. This opportunity is also followed up with the same presentation in a webinar format so that individuals unable to attend the onsite presentation can receive the information.

- **Types of events and training**

Each facility gets at least one presentation a year onsite. There is a two-hour presentation throughout the state over a couple-week span, followed up by a webinar format. Adult and Aging Services to include MFP attempt to be present for vendor booths and other annual events such as the Long-Term Care Association Conference and the North Dakota Association of Community Providers. The MFP Director also hosts regional meetings with the Development Disabilities Section and has met and attended other partnership opportunities such as Stakeholder Meetings with the DD Council and the Olmstead Committee.

### **C.3.3. Stevens Amendment and accessibility requirements**

Select the boxes below to confirm the state or territory adheres to the requirements regarding the Stevens Amendment and complies with accessibility laws.

- The state or territory affirms that it has established procedures for complying with the requirements in Section 26.G and 26.H of the CMS Standard Terms and Conditions (STC) regarding the Stevens Amendment, which describes actions federal award recipients must take when engaging in public reporting and acknowledgement of sponsors.

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- ☒ The state or territory acknowledges responsibility for complying with federal laws regarding accessibility (Attachment B of CMS STC).

### C.4. Informed consent

#### C.4.1. Informed consent criteria

Describe how the state or territory will implement procedures for obtaining informed consent. Include the following:

- Process for ensuring that each eligible individual or the individual's legally authorized representative will be provided with the opportunity to make an informed choice regarding whether to participate in the MFP Demonstration
- Process for ensuring that each eligible individual or the individual's legally authorized representative will have input into, and approve the selection of, the qualified residence in which the individual will reside and the setting in which the individual will receive HCBS
- Process for ensuring individuals are informed about all aspects of the transition process; have full knowledge of the services and support that will be provided both during and after the program year; and are informed of their rights and responsibilities as a participant, including the right to file reports or complaints regarding violation of their rights or other critical incidents
- Method(s) for obtaining informed consent (written, verbal, digital, and so on)

Provide an external link to informed consent forms and informational material. Alternatively, paste or embed those materials into the appendix or the text box below. If using the appendix, use the text box to indicate where in the appendix these materials can be found.

As a first step in ensuring that participants have informed consent, participants and/or their legal representatives are provided with ample information concerning the MFP project and ongoing opportunity for questions. North Dakota requires that all individuals participating in the MFP Demonstration or their Legally Authorized Representative (LAR) -- i.e., parent, guardian, or managing conservator of a minor individual, or a guardian of an adult -- be informed of all their rights and options for long-term services and supports and that participation is voluntary. This includes acceptance of services and the consent to participate in the evaluation component of the grant. The Informed Consent Form is to be signed only by the individual being transitioned or those who have legal authorization to act in the individual's behalf.

The Transition Coordinator or DD Program Manager determines if the participant has a guardian or an active Durable Power of Attorney (DPOA) for health care. The Coordinator or Program Manager will obtain a copy of the legal document(s), review it/them and understand the extent of the surrogate decision-making power that exists.

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This information is gathered from a review of the facility records once consumer consent is obtained. For participants with a guardian or other legal representative, both the participant and the legal guardian are involved in providing information and in the transition planning process.

Transition Coordination, Developmental Disabilities Program Management, or the Life Skills and Transition Center Social Work staff secure the appropriate signatures on the Informed Consent form which indicates that the participant has been informed and is voluntarily choosing to participate in the MFP Demonstration without coercion.

### Appendix C-9 Informed Consent

## C.5. Legally authorized representative

### C.5.1. Procedures for MFP engagement with a legally authorized representative

Describe how the MFP Demonstration will engage with a legally authorized representative and how the process aligns with state or territory policy. Include the following:

- Procedures for engaging with a legally authorized representative as part of an individual's person-centered planning process during the transition period and the 365-day MFP enrollment period
- Specific strategies and approaches when working with inpatient facility administrators who are serving as a legally authorized representative, particularly around identifying and eliminating conflict of interest concerns
- Process for verifying that an MFP participant's legally authorized representative has (1) a known relationship with the individual; (2) ongoing interaction with the individual; and (3) recent knowledge of the individual's welfare

North Dakota has made it a practice to find out at the referral process if there is a legal decision maker. The referral specialist will request the legal documentation and store it for reference with the referral documentation. Steps are taken to ensure the health care directives and guardianships are in place when an individual is claiming decision making powers. North Dakota has made it a practice to actively involve the legal decision maker in all areas of the transition from the individual's person-centered planning process through the 365-day MFP enrollment period. During the initial referral and assessment period, the relationship and interaction between the participant and legal decision maker is evaluated to ensure the welfare and goals of the participant are being met.

North Dakota has the following legal authorities to allow a legal decision maker to provide financial and/or health care help to an individual.

Advanced Directives. This authority consists of two separate documents.

Durable Power of Attorney (For Financial Matters) – N.D.C.C. Section 30.1-30

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- Principal is the individual signing the document and giving financial decision powers to another person (attorney-in-fact, also known as “agent”).
- Attorney-in-fact (agent) is the person accepting the powers.
- Only durable if it contains the words “This power of attorney is not affected by subsequent disability or incapacity of the principal or by lapse of time”. (N.D.C.C Section 30.1-30-01(5-501))
- Can be designated to start when principal signs document, or upon incapacity.
  - "Incapacitated person" means any adult person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, or chemical dependency to the extent that the person lacks capacity to make or communicate responsible decisions concerning that person's matters of residence, education, medical treatment, legal affairs, vocation, finance, or other matters, or which incapacity endangers the person's health or safety. (N.D.C.C. 30-1-26-01(2))
- Granted for financial purposes only does not include authority to make health care decisions.
- Needs to be signed and dated by principal (person with capacity granting powers to someone else).
- Ends upon death or revocation (in writing).
- Does not take the right to make decisions away from the principal (person granting the powers).
- A simple legal document, not a court order.

## Durable Power of Attorney for Healthcare (also known as Health Care Directive) – N.D.C.C Section 23-06-.5

- Principal is the person who gives health care decision powers to the agent.
- Agent is the person accepting the appointment of agent of health care directive.
- To enable adults to retain control over their own health care during periods of incapacity through health directives and the designation of an individual to make health care decisions on their behalf.
  - “Capacity to make health care decisions” is defined as the ability to understand and appreciate the nature and consequences of a health care decision, including the significant benefits and harms of and reasonable alternatives to any proposed health care, and the ability to communicate a health care decision. (N.D.C.C section 23-06.5-02)
  - The individual is said to lack capacity to make health care decisions, as certified in writing by the individual’s attending physician and filed in the individual’s medical record and ceases to be effective upon a determination that the individual has recovered capacity. (N.D.C.C. 23-06.5-03(3))
- Document gives instructions about their health care to the agent named in the document.

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- Document needs to be signed by individual giving powers, verified by a notary public or witnessed by at least two or more individuals who are at least 18 years of age (none of which can be family).
- Document can be written to start at the time of signature or can be written to start at incapacity (see above).
- Does not remove the ability to make health care decisions on their own unless deemed incapacitated (see above).
- Can be revoked in writing or by executing a new Health Care Directive
- A simple legal document, not a court order.

## Informed Consent for Health Care

In North Dakota, a written Health Care Directive or guardian is not required when helping an incapacitated person with their healthcare needs. Consent to health care, when deemed incapacitated as defined in N.D.C.C. section 30.1-26-01 as shown above, can be given to the following people:

- Spouse who has maintained significant contact with the incapacitated person
- Children of the incapacitated person as long as they are at least 18 years of age
- Parents of the incapacitated person, including stepparents.
- Adult brothers and sisters
- Grandparents
- Grandchildren
- A close relative or friend who has maintained significant contact with the incapacitated person

## Guardianship

There are three types of guardianship: Emergency, Full and Limited.

- This is an expensive court process where the judge makes the determination the individual (ward) cannot make their own financial and health care decisions.
- This process takes rights away from the individual and gives them to another person.
- If the individual has a health care directive in place, the health care directive trumps the guardianship for health care needs unless a court of competent jurisdiction determines otherwise. (N.D.C.C 23-06.1-13(1))
- Letters of Guardianship is the official document naming the guardian and the date they were appointed.

### **C.5.2. Re-enrollment**

Describe the state or territory's MFP re-enrollment policy (1) for individuals who have been re-institutionalized or hospitalized prior to completing their 365-day MFP enrollment period, and (2) for individuals who have been re-institutionalized after completing their 365-day MFP enrollment period. Include actions that occur at 30- and 60-day intervals during an individual's institutional or hospital stay.

North Dakota has adopted the following process for those individuals who have been re-institutionalized either in a hospital or skilled nursing facility (SNF) prior to completing their 365-day MFP enrollment period.

MFP administrative staff will be notified by the transition coordinators or HCBS case managers when an MFP participant has been re-institutionalized during the demonstration period. MFP administrative staff will document disenrollment from MFP when the participant has been re-institutionalized for a minimum of 30 days. MFP administrative staff will monitor the participant's length of stay utilizing an in-house case management system and its reporting features. The action of disenrollment due to re-institutionalization, re-enrollment, and subsequent discharge will recalculate the 365-day demonstration period so participants receive the remainder of enrollment days.

The MFP transition plan is updated after working with the MFP transition team to address barriers to ensure a safe and timely discharge back to community living.

On month six (180 days) of the re-institutionalization event, MFP will end services. If the MFP participant again requests MFP transition services and it has been more than 60 days after the previous MFP segment has ended as described in the deficit Reduction Act of 2005 extended by the Consolidated Appropriations Act of 2021 Section 204 Extension of Money Follows the Person Rebalancing Demonstration (b)(1)(A), then a new MFP segment can be started.

North Dakota also has a quarterly meeting to review the re-institutionalizations to provide technical assistance and search for any trends that might be leading to these events and if those events are localized or spread through the state.

Appendix C-10 Re-institutionalization Note  
Appendix C-11 Return to Community

### **C.6. Other information**

If needed, provide other information regarding the state or territory's approach to recruitment, enrollment, outreach, and education that is not addressed elsewhere in the template.

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Linked is the [Department of Justice Settlement Agreement webpage](#), for the most update information and some of the marketing strategies that Adult and Aging Services are working on as a whole.

## SECTION D. COMMUNITY ENGAGEMENT

Describe how the state or territory will engage the broad community, including but not limited to, Medicaid agency leadership, participants in HCBS programs, residents in long-term care facilities, long-term care facility staff, family members and other caregivers, HCBS providers, the aging and disability network, MCPs, housing providers, and the direct care workforce, to inform the state or territory's approach to the design of the MFP Demonstration and how the state or territory can leverage the MFP Demonstration to expand and enhance the HCBS system. Include a description of the state or territory's strategy(s), structure of the engagement process, engagement tools, communication process, and how the process will be strengthened throughout the MFP program period of performance.

North Dakota hosts an MFP Stakeholder meeting on a quarterly basis and public notice goes out from our public information office to notify the public where and when the meeting is taking place. Our contracted transition coordinators and housing facilitators also participate in this meeting and invite consumers to attend. An email list of committee members is sent off to the re-occurring meeting. The internal MFP team develop an agenda and PowerPoint to share with the group along with bringing speakers to present different changes within home and community-based services. Our committee members also include our Tribal Liaison, HCBS Program Administrators, Developmental Disabilities, Providers and Housing Collaboration members, and any other member who attend based on the public notice.

We continue to expand our stakeholder engagement by utilizing our educational sessions with Nursing Facilities and other institutions to help build on the team transition model. One of the strategies that we implement in 2024 and are going to continue for 2025 is to host regional in-person meetings (selecting four regions throughout the state) and virtually, to build connections for a more personable approach. Our plan is to send a notice to consumers within the regional area to gather their essential feedback and input.

### D.1. Community engagement process

States or territories may use Example Table D.1 to list those engaged in the design and implementation of the MFP Demonstration; to indicate the related OP element(s); and a brief description of the engagement structure, including the type and frequency of engagement and role(s) in the engagement process.

**Example Table D.1. Description and frequency of community engagement**

<b>Entities (examples)</b>	<b>OP elements</b>	<b>Description of the engagement process</b>
<b>MFP participants</b>	E, F, J	MFP participants are mailed an invitation to attend the in-person meeting within their perspective region.
<b>Family members and caregivers</b>	E, F, J	Individuals, family members and caregivers are all invited to attend.
<b>Centers for Independent Living</b>	B, C, D, E, F, J	The Centers for Independent Living not only have this service as a core service, but also are the contract entity for Transition Coordination.
<b>Long-term care facilities</b>	C, F	Our main goal is to assist in building collaboration and providing the most up to date information to the facilities, especially where turnover in the social services department is a concern.
<b>HCBS providers</b>	F, G, I, J	All HCBS providers, program administration, case managers, DD program managers, including our partners in the provider enrollment process are all invited to attend and share their updates and suggestions.
<b>Housing partners</b>	F, J	The North Dakota Housing and Finance Agency are typically present at our stakeholder meeting, along with local Housing Authorities, and our Housing Facilitator.
<b>Aging and disability networks</b>	C, D, I, J	DD Council, Protection and Advocacy and additional community partners all participate and provide comments to the Stakeholders, additional partners include some of our contracted agencies through other channels of the department.
<b>Direct care workforce</b>	G, J	The Qualified Service Provider Hub is in attendance and providers updates to the busy work as it relates to the provider network and how homecare is one of the fastest growing industries in the Nation.

## **D.2. Other information**

If needed, provide other information regarding the state or territory's approach to engagement that is not addressed elsewhere in the template.

Minutes and attendance are taken and recorded. Individuals are given the opportunity for a pre- and post-survey along with a copy of the information shared at the meeting. Following the virtual and in-person meeting is a time for open discussion for the in-person participants as some ideas might be specific to the region.

## SECTION E. BENEFITS AND SERVICES

Describe how the MFP Demonstration will provide opportunities for MFP participants to receive high-quality services in their own homes or community rather than institutions. The state or territory must describe qualified HCBS (PTC 16 and Attachment A in the PTC), Demonstration services (PTC 17), and supplemental services (PTC 24) that it will provide under the MFP Demonstration.

### E.1. Qualified HCBS

The qualified HCBS program is the Medicaid service package(s) that the state or territory will make available to an MFP participant when they move to a community-based residence. This program can be comprised of any Medicaid home and community-based state plan services and HCBS waiver program services. MFP-qualified HCBS are listed and described in Attachment A to the MFP PTC.

The state or territory must describe:

- Qualified HCBS available to MFP participants
- Target population
- Any proposed Medicaid coverage strategy to amend and implement changes to the state plan or HCBS waiver program(s) to carry out the Demonstration; these descriptions must indicate:
  - The specific HCBS program that will be changed or amended
  - Which authority the HCBS program operates under
  - When the change or amendment will occur

The state or territory may insert information using (1) Example Table E.1, (2) a description in the text response box below, or (3) a combination of both a table and a separate text description.

**Example Table E.1. MFP-qualified HCBS**

MFP-qualified HCBS	Qualified HCBS description	MFP target population(s)
HCBS under section 1905(a) state plan services	<a href="#">Medicaid State Plan Personal Care</a>	Older Adults Individuals with Physical Disabilities Individuals with Intellectual/Developmental Disabilities Children

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<p>HCBS under sections 1915(c), 1915(i), 1915(j) and 1915(k)</p>	<p><a href="#">1915(c)-Adult and Aging Waiver</a>  <a href="#">1915(c)-Developmental Disability Waiver</a>  <a href="#">1915(c)-Children’s Medically Fragile Waiver</a>  <a href="#">1915(c)-Children’s Hospice Waiver</a>  <a href="#">1915(c)-Autism Waiver</a></p>	<p>Older Adults  Individuals with Physical Disabilities  Individuals with Intellectual/Developmental Disabilities  Children</p>
<p>Other HCBS options (describe)</p>	<p><a href="#">1915(i) State Plan Amendment</a></p>	<p>Older Adults  Individuals with Physical Disabilities  Individuals with Intellectual/Developmental Disabilities  Children</p>

The only waiver that was discontinued in North Dakota since the MFP grant started, would be the Technology Dependent Waiver along with the addition of the 1915(i) State Plan Amendment.

### E.2. MFP Demonstration services

#### E.2.1. Demonstration service description

MFP Demonstration services are qualified HCBS that could be provided, but are not currently provided, under the state or territory’s Medicaid program. Demonstration services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the participant’s service plan. The state or territory is expected to test and evaluate Demonstration services. Demonstration services are not required to continue after the conclusion of the MFP Demonstration or for the participant at the end of the 365-day enrollment period. Demonstration service descriptions must include:

- The qualified HCBS Medicaid authority under which the service could be covered
- The target population(s) receiving the service
- For a new Demonstration service not currently covered under the state or territory’s HCBS program, a description of the scope of the service including a definition of the discrete service; a complete list and description of any goods and services that will be provided; any conditions that apply to the provision of the service; and eligibility criteria

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- For a Demonstration service currently authorized under the state or territory's Medicaid program, a description of how the service complements or supplements the authorized HCBS in an amount, frequency, scope, or duration greater than allowed under the state or territory's Medicaid program
- A description of how the state or territory will test and evaluate the service to determine whether the service contributes to the successful transition and community functioning of an MFP participant

The state or territory may insert information using (1) Example Table E.2.1, (2) a description in the text response box, or (3) a combination of both a table and a separate text description.

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**Example Table E.2.1. Demonstration services**

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<b>Demonstration service title</b>	<b>HCBS Medicaid authority</b>	<b>MFP target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Service testing and evaluation</b>
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<p>Transition Coordination</p>	<p>1915(c) HCBS Waivers-Community Transition Services and 1915(i) Community Transition Services</p>	<p>All</p>	<p><b>Amount, Duration, Scope:</b>                  Under the 1915(c) waiver, case management/support coordination is provided to waiver participants to develop and monitor the person-centered service plan. However, neither the 1915(c) waivers nor 1915(i) follow the participant beyond 90 days post transition and only 300 units of assistance, which does not include travel to the participant. This would negatively impact on our rural participants who would under the waiver model would not receive the same level of support and service.                  Under MFP, Transition Coordination differs in scope and intensity. It is provided from referral through 365 days post-transition and not based on unit authorization includes:                  Institutional discharge planning prior to waiver enrollment                  Cross-system coordination (housing, benefits, utilities, landlord engagement)</p>	<p>Through contract monitoring, documentation audits, transition timeliness tracking, and re-institutionalization data review.</p>
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			<p>Increased face-to-face contact during transition period</p> <p>Post-transition stabilization monitoring beyond standard waiver frequency</p> <p>Services are reimbursed fee-for-service from referral date through transition date, including limited required post-transition follow-up.</p>	
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<p>Housing Facilitation</p>	<p>There is no waiver authority for this service.</p>	<p>All</p>	<p>Service Definition:  Housing Facilitation is a transition-focused HCBS service that assists MFP participants in identifying, securing, and sustaining safe, affordable, and accessible housing in the community.  This service includes:  Conducting individualized housing needs assessments  Developing a housing-focused transition plan  Identifying available rental units statewide  Coordinating with Public Housing Authorities and private landlords  Assisting with housing applications and required documentation  Supporting reasonable accommodation requests  Coordinating inspections and lease execution  Assisting with utility set-up  Providing tenancy education and early tenancy stabilization support</p>	<p>Service Testing &amp; Evaluation:  Tracking average time from referral to housing secured  Monitoring transition success rates  Re-institutionalization rates within 365 days  Contract monitoring and documentation audits  Participant satisfaction and housing stability outcomes</p>
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			<p>Addressing barriers such as poor credit, rental history issues, or accessibility needs</p> <p>Housing Facilitation does not include payment for rent or housing costs.</p> <p>Amount, Duration, Scope:</p> <p>MFP Housing Facilitation provide:</p> <ul style="list-style-type: none"> <li>Increased intensity and frequency of contact during the pre-transition phase</li> <li>Statewide housing search capacity dedicated solely to institutional transitions</li> <li>Time-limited but high-intensity housing navigation from referral through lease-up</li> <li>Tenancy stabilization support during the 365-day MFP demonstration period</li> <li>Activities that extend beyond standard waiver case management scope</li> </ul> <p>Services are provided from referral through successful lease execution and initial stabilization, typically 60–180 days depending on housing market barriers. Housing Facilitators also follow to</p>	
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			ensure the transition over to the permanent supportive housing subsidy if the individual is utilizing temporary assistance until a voucher can be obtained.	
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<p>Moving, Deposits, Housing Set-Up, and Essential Household Items</p>	<p>1915(c) HCBS Waivers-Community Transition Services and 1915(i) Community Transition Services</p>	<p>All</p>	<p><b>Service Description:</b> MFP Transition Services are time-limited set of essentials necessary to enable an individual to establish a basic household and safely transition to a community-based living arrangement. These services are intended to support successful community integration and ensure the individual's health, safety, and welfare.</p> <p><b>Allowable Expenses:</b> Allowable expenses may include, but are not limited to:</p> <ul style="list-style-type: none"> <li>Moving costs, including transportation of personal belongings</li> <li>Security deposits required to obtain housing</li> <li>Utility deposits and necessary utility set-up fees</li> <li>Essential home furnishings, including basic furniture, household items, and other necessities required to establish a safe and functional living environment</li> </ul> <p>All items and services must be necessary, reasonable, and directly related to the individual's</p>	<p>Service utilization and effectiveness are monitored through utilization reviews, person-centered planning processes, and consumer feedback to ensure services support successful transition and sustain community living.</p>
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			<p>transition to the community.</p> <p><b>Approval Process:</b> The community transition service is a one-time up to \$3,000 request and must be approved through the administrative review process. Requests must be submitted after housing has been identified and secured, and the individual has entered into or is expected to enter into a lease agreement. Supporting documentation, such as moving company estimates, lease agreements, or itemized lists of essential household furnishings, is recommended to support the request.</p> <p><b>Service Limitations:</b> Community Transition Services are limited to one-time, non-recurring expenses up to \$3,000/transition. Whereas MFP allows for cleaning supplies and household essentials that focus on stabilization and additional post-transition support and often exceeds the \$3,000 cap in the community transition supports.</p>	
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<p>Transition Adjustment Supports</p>	<p>1915(c) HCBS Waivers-Community Transition Services</p>	<p>All</p>	<p>Transition Adjustment Supports are time-limited, transitional HCBS provided to individuals experiencing short-term stabilization needs during the transition period.                      Examples include:                      Temporary enhanced personal assistance hours to train on individualized care needs and allow providers to be trained at the same time.                      Skill-building for independent living                      Short-term behavioral stabilization supports                      Pre-tenancy independent living training  <b>Amount, Duration, Scope:</b>                      Time-limited (not to exceed 90–180 days unless justified)                      Designed to decrease as natural/community supports are established                      Provided only during MFP demonstration period</p>	<p>Utilization review, reduction in crisis events, re-institutionalization tracking, and person-centered planning documentation.</p>
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### E.3. MFP supplemental services

#### E.3.1. Supplemental service descriptions

Supplemental services are one-time services to support an MFP participant's transition that are otherwise not allowable under the Medicaid program. Supplemental services must be reasonable and necessary, not available to the participant through other means, and clearly specified in the participant's service plan. Supplemental services are not required to continue after the conclusion of the MFP Demonstration or for the participant at the end of the 365-day enrollment period. The state or territory is expected to test and evaluate supplemental services. Supplemental service descriptions must include:

- The target population(s) receiving the service
- The category of the supplemental service (short-term housing assistance, food security, payment for activities prior to transitioning from an MFP-qualified inpatient facility, payment for securing a community-based home)
- The scope of the service, including a definition of the discrete service (for example, providing payment for activities prior to transitioning from an MFP-qualified inpatient facility, describe each discrete activity under this category, such as home accessibility modifications, vehicle adaptations, and home cleaning)
- An assurance that services are responsive to a person's needs and wants described in a person-centered plan
- A complete list and description of any goods and services that will be provided
- Any conditions that apply to the provision of the service
- How the state or territory will test and evaluate the service to determine whether the service contributes to the successful transition and community functioning of an MFP participant
- Under the payment for activities prior to transitioning from an MFP-qualified inpatient facility, please include the following information for each discrete activity:
  - Specify the time period for when payment to a provider for rendering the supplemental service will occur (e.g., up to 15 days prior to discharge/transition to the community date)
  - Specify the time period for when the service will be rendered (e.g., up to 15 days prior to discharge/transition date)

The state or territory must insert information using Example Table E.3.1 and may provide additional information in the text response box below.

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**Example Table E.3.1. Description of supplemental services**

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
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<p>Short-term housing assistance Housing Plan-Short term Rental Assistance (Appendix E-1 Housing Plan)</p>	<p>All</p>	<p><b>Amount, Duration, and Scope:</b> Up to 6 months rental assistance capped at \$1,000 per month. Rental arrears may be included; however, total combined rental arrears and prospective rental assistance may not exceed 6 months of rental assistance. Participants must sign the MFP Rental Agreement prior to approval. Participant must have a documented housing need verified through assessment and person-centered plan. <b>Provider Requirements and Payment:</b> Payments are made directly to the landlord. Payment must be made prior to or concurrently with the rental period and not as an accrued or invoiced expense.</p>	<p>Rental assistance payments made directly to landlord. Housing facilitation, transition coordination, and landlord communication support included.</p>	<p>Service is authorized based on documented housing need in the person-centered plan and supports transition to permanent housing through a voucher or other sustainable housing resource. The Housing Facilitator will assist with housing identification, landlord coordination, and housing stability planning.</p>
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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
<p>Short Term Rental Assistance Unpaid rent and eviction fees</p>	<p>All</p>	<p><b>Amount, Duration, and Scope:</b> up to \$6,000 for eligible unpaid rent and eviction-related costs. The combined total of rental arrears and rent assistance must not exceed 6 months. <b>Time Period Service Rendered:</b> Prior to transition. <b>Payment Timing:</b> Fees are paid directly to landlords or providers after documentation is received and no later than the business prior to transition.</p>	<p>Housing Facilitation, Transition Coordinator and ability to communicate with the landlord.</p>	<p>1. Request and approval for the fees prior to transition 2. In addition, to the MFP Rental Agreement, the individual may be asked to complete the Smart with my Money course, if unpaid rent is requested.</p>

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
Food Security Ancillary Food	All	<p><b>Amount, Duration, and Scope:</b> Participants may receive up to \$250 per occurrence following institutional stays of 30 days or more.</p> <p><b>Provider Requirements and Payment:</b> Payment for pantry items must be completed on a cash basis. Services are rendered and paid within 30 days following the re-institutionalization.</p>	Shopping for pantry stocking and/or restocking of pantry items.	This service would be documented within person-centered plan as need.

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
<p>Payment for activities prior to transitioning from an MFP-qualified inpatient facility.</p> <p>Residential Modifications</p>	<p>All</p>	<p><b>Amount, Duration, and Scope:</b>                      Services may be provided up to 60 days prior to transition.                      Maximum allowable amount is \$15,000 per modification.</p> <p><b>Provider Requirements and Payment:</b>                      Services must be completed and paid on a cash basis no later than five (5) business days prior to transition.</p>	<p>Modification could include but are not limited to: ramp into the home, widening of doorways, grab bars through the home, bathroom modification, and features to accommodate specialized equipment.</p>	<p>Identified in the transition plan, home would need to be leased or owned by individual and if leased landlord would be agreeable to modification and aware that the modification would remain should the individual vacate the property.</p>

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
<p>Payment for activities prior to transitioning from an MFP-qualified inpatient facility.</p> <p>Personal Technology</p>	<p>All</p>	<p>Services are rendered and payment is issued prior to the participant's transition date. Payment is made only after services are completed or goods delivered, invoices submitted and reviewed and approved by the State.</p> <p><b>Amount, Duration, and Scope:</b> Up to \$350.</p> <p><b>Time Period Service Rendered:</b> Up to 60 days prior to transition.</p> <p><b>Payment Timing:</b> Vendor is paid after purchase and delivery confirmation, and prior to transition.</p>	<p>To alleviate social isolation and increase community connections through technology.</p>	<p>The intent for community and social integration should be outlined within the person-centered transition plan.</p>

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
<p>Payment for activities prior to transitioning from an MFP-qualified inpatient facility.</p> <p>Companion Animal Support</p>	<p>All</p>	<p>Services are rendered and payment is issued prior to the participant's transition date. Payment is made only after services are completed or goods delivered, invoices submitted and reviewed and approved by the State.</p> <p><b>Amount, Duration, and Scope:</b> Up to \$300.</p> <p><b>Time Period Service Rendered:</b> Prior to transition.</p> <p><b>Payment Timing:</b> Vendor is paid after purchase and delivery and prior to transition.</p>	<p>To support the individual who may no longer be able to physically support their pet and need a little bit of technology to assist them in caring for their pet.</p>	<p>The intent would be for the individual to see what resources would support and assist in continuing to care for the pet.</p>

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
<p>Payment for activities prior to transitioning from an MFP-qualified inpatient facility.</p> <p>Home Repairs/Deep Clean</p>	<p>All</p>	<p>Services are rendered and payment is issued prior to the participant's transition date. Payment is made only after services are completed or goods delivered, invoices submitted and reviewed and approved by the State.</p> <p><b>Amount, Duration, and Scope:</b> Up to \$2,500 for repairs and \$1,500 for cleaning.</p> <p><b>Time Period Service Rendered:</b> Up to 60 days prior to transition.</p> <p><b>Payment Timing:</b> Provider is paid after services are completed and invoice approved, and no later than the business day prior to transition.</p>	<p>Repairs could include flooring, roofing, and resealing a window. Cleaning could include removing garbage, sweeping, vacuuming, mopping and potential extermination services.</p>	<p>This need would be assessed and documented in the individual's plan and to ensure that the home is safe for the individual to transition to.</p>

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
<p>Payment for activities prior to transitioning from an MFP-qualified inpatient facility. Apartment Set-up</p>	<p>All</p>	<p>Services are rendered and payment is issued prior to the participant's transition date. Payment is made only after services are completed or goods delivered, invoices submitted and reviewed and approved by the State. <b>Amount, Duration, and Scope:</b> Up to \$500. <b>Time Period Service Rendered:</b> Up to 30 days prior to transition. <b>Payment Timing:</b> Provider or vendor is paid after delivery and setup, and no later than the business day prior to transition.</p>	<p>Furniture and items to be delivered and put together, prior to transition.</p>	<p>The service would be documented in the person-centered plan and would be evaluated to contribute to a successful transition by report from the transition coordinator.</p>

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
<p>Payment for activities prior to transitioning from an MFP-qualified inpatient facility.</p> <p>Assistive Technology or Specialized Equipment</p>	<p>All</p>	<p>Services are rendered and payment is issued prior to the participant's transition date. Payment is made only after services are completed or goods delivered, invoices submitted and reviewed and approved by the State.</p> <p><b>Amount, Duration, and Scope:</b> Up to \$25,000 for equipment and \$1,500 for assessment.</p> <p><b>Time Period Service Rendered:</b> Up to 60 days prior to transition.</p> <p><b>Payment Timing:</b> Provider is paid after assessment and equipment delivery, and no later than the business day prior to transition.</p>	<p>Items could include specialized positioning device, powered lift equipment to safely transfer individuals, and/or ceiling track lift.</p>	<p>The assessment would be documented in the person-centered plan and the evaluation for success would be measured by increasing the individual's independence.</p>

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
<p>Payment for activities prior to transitioning from an MFP-qualified inpatient facility.</p> <p>Transition Services 181-Discharge</p>	<p>All</p>	<p>Services are rendered and payment is issued prior to the participant's transition date. Payment is made only after services are completed or goods delivered, invoices submitted and reviewed and approved by the State.</p> <p>Transition services rendered from day 181 until the discharge day. This would be up to \$1,000 per individual and on a fee-for-service basis, billed monthly.</p>	<p>This is necessary for our complex transitions that require additional time and barrier reduction for a successful transition.</p>	<p>The need for this service would be documented in the person-centered plan and it is ideal to continue to engage with MFP individuals who may be ambivalent about transitioning.</p>

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
<p>Payment for activities prior to transitioning from an MFP-qualified inpatient facility.</p> <p>Pre-transition non-medical transportation</p>	<p>All</p>	<p>Services are rendered and payment is issued prior to the participant's transition date. Payment is made only after services are completed or goods delivered, invoices submitted and reviewed and approved by the State.</p> <p><b>Amount, Duration, and Scope:</b> Up to \$350.</p> <p><b>Time Period</b></p> <p><b>Service Rendered:</b> Up to 45 days prior to transition.</p> <p><b>Payment Timing:</b> Provider is paid after services are rendered and no later than the business day prior to transition.</p>	<p>Transportation would be non-medical and supported through their plan, such as shopping, viewing of apartment, planning for assessments, etc.</p>	<p>The need for this service would be documented in the person-centered plan and evaluated regarding a successful transition.</p>

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
Clothing allotment/Winter Clothing allotment	All	<p><b>Amount, Duration, and Scope:</b> Up to \$250 for a one-time clothing allotment. An additional \$250 for appropriate winter clothing.</p> <p><b>Time Period Service Rendered:</b> Up to 45 days prior to transition for clothing while winter clothing would be available during the MFP eligibility span. <b>Payment Timing:</b> Provider or vendor is paid after invoice within 30 days of the invoice.</p>	Clothing for individuals to have a week supply of the necessary clothes and shoes for community living. An additional \$250 could include winter gear such as hats and gloves, boots and a heavier coat.	The need for this service would be documented in the person-centered plan and evaluated regarding a successful transition.

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
<p>Payment for activities prior to transitioning from an MFP-qualified inpatient facility.</p> <p>Washer and Dryer</p>	<p>All</p>	<p>Services are rendered and payment is issued prior to the participant's transition date. Payment is made only after services are completed or goods delivered, invoices submitted and reviewed and approved by the State.</p> <p><b>Amount, Duration, and Scope:</b> Up to \$1500 for the appliances, delivery, connection fees and up to one-year warranty.</p> <p><b>Time Period Service Rendered:</b> Up to 30 days prior to transition.</p> <p><b>Payment Timing:</b> Provider is paid after services are rendered and no later than the business day prior to transition.</p>	<p>Purchase of a washer and dryer, delivery and connection fees, and up to a one-year warranty for the washer and dryer.</p>	<p>The need for this service would be documented in the person-centered plan. The state will evaluate how the washer and dryer are utilized in successful transitions by monitoring this resource based on person-centered documentation. This purchase would not be for general utility of a household but an individualized need.</p>

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<b>Supplemental service</b>	<b>Target population(s)</b>	<b>Amount, duration, and scope of service</b>	<b>Goods and services provided</b>	<b>Responsiveness to person-centered plan</b>
Payment for securing a community-based home 1. Application and Administrative fees	All	<b>Amount, Duration, and Scope:</b> Up to \$100 for application fees <b>Time Period</b> <b>Service</b> <b>Rendered:</b> Prior to transition. <b>Payment Timing:</b> Fees are paid directly to landlords or providers after documentation is received and no later than the business prior to transition.	Housing Facilitation, Transition Coordinator and ability to communicate with the landlord.	Request and approval for the fees prior to transition
Other activities: One-time health supplies	All	<b>Amount, Duration, and Scope:</b> Up to \$500. <b>Time Period</b> <b>Service</b> <b>Rendered:</b> Up to 60 days prior to transition. <b>Payment Timing:</b> Vendor is paid after delivery and no later than the business day prior to transition.	Supplies could include but are not limited to incontinence supplies, diabetic syringes, catheter supplies, feeding tube supplies, and protective personal equipment.	The need for this service would be documented in the person-centered plan. The state will evaluate how these aids are utilized in successful transitions by monitoring their use in relation to our re-institutionalization number.

Please see our attached Appendix E-5 Supplemental Services further outlining all supplemental services.

### **E.3.2. Supplemental services housing plan and food security plan**

If providing short-term housing assistance or food pantry stocking, upload the required housing plan or food security plan that describes how these services will be administered and sustained. See the March 31, 2022 [Note to MFP Recipients: Announcement of Certain Changes to Supplemental Services under the MFP Demonstration](#) for specific requirements for the housing and food security plans.

Appendix E-1 Housing Plan

Appendix E-2 Food Security Plan

Appendix E-3 Pantry List

Appendix E-4 Clothing Allotment

Appendix E-5 Supplemental Services

### **E.4. Managed long-term services and supports**

Select the box below to indicate whether your state or territory operates an MLTSS program.

- Yes, the state or territory operates an MLTSS program that includes providing HCBS to these populations: (select all that apply).
  - Older adults
  - Adults with PD
  - Individuals with I/DD
  - Individuals with MH/SUD
  - Other, please specify (e.g., HIV/AIDS, brain injury)

For states or territories that selected “Yes”, describe how the state or territory implements the MFP Demonstration under managed care programs. Clearly indicate the qualified HCBS, Demonstration, and supplemental services that are delivered under managed care. Additionally, describe how the MFP Demonstration supports or complements the state or territory’s MLTSS strategy for expanding HCBS, promoting community integration, ensuring quality, and increasing efficiency.

North Dakota does not have managed long-term services and supports.

### **E.5. Service providers**

#### **E.5.1. Qualified HCBS, MFP Demonstration, and supplemental service providers**

For each qualified HCBS, MFP Demonstration, and supplemental service, include the following:

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- Describe how the state or territory will ensure that providers have sufficient experience and training in the provision of their applicable supplemental services.

North Dakota utilizes an enrollment portal for individuals to become either an individual provider or an agency provider. Should an entity have difficulty enrolling to provide services, the QSP Hub linked here would troubleshoot and provide guidance to the provider.

Developmental Disabilities have licensing among their providers overseen through state administration. To provide higher level of services, those providers do need to become accredited. Current accreditation is through the council on quality and leadership (CQL). Legislature is currently looking at other methods of accreditation.

- Describe how the state or territory provides access to needed services or manages a waiting list when provider shortages or other barriers prevent timely provision of HCBS, MFP Demonstration, and supplemental services.

North Dakota does not currently have a waitlist for our programming and attached is the provider map which changes as providers increase or decrease depending on their individual provider's situation. The Home and Community Case Managers also submit a provider navigation request to seek out providers within the region to see if those providers are equipped to accept the referral. This means that they are qualified to provide services, and the provider is also enrolled and can accept clients. North Dakota also has a provider complaint process and program administrators are involved in this process. Should the individual have a family member who may enroll as their provider, the team can assist in this application process as well. Should a provider be hesitant to take a new individual a meet and greet opportunity is offered to help discuss the training and support that the provider may need to assist in a successful transition.

- Describe how the MFP program will ensure that MFP participants are offered the choice of a Medicaid-qualified provider under a person-centered planning process or the Medicaid authority limiting participants' choice of provider.

North Dakota offers a choice in the provider through the provider navigator process, or the individual identifying their desire for a particular provider, by word of mouth or provider advertising. The individual may also identify a family member wanting to care for or support the individual. North Dakota's list of enrolled providers is available for public use, individuals' caring for family members can choose to be on the public viewing list or opt out of this listing.

### **E.6. Other information**

If needed, provide other information regarding the state or territory's benefits and services that is not addressed elsewhere in the template.

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North Dakota is always adjusting our services to best meet the needs of the eligible individual and where we see an opportunity of growth or a gap from institutional care to community-based care.

## SECTION F. TRANSITION AND HOUSING SERVICES

### F.1. Transition services

#### F.1.1. Comprehensive transition coordination services

Describe how the state or territory's MFP Demonstration will implement comprehensive transition coordination services during these three phases: (1) pre-transition, (2) transition, and (3) during an MFP participant's 365-day enrollment period. Include the following:

- Description of transition coordination activities
- Description of person-centered planning in the transition coordination process, including:
  - How the state or territory's MFP Demonstration will ensure that each MFP participant's service plan is individualized to provide the services and supports needed to live in the community
  - How MFP participants and their legally authorized representative (if applicable) will lead the development of their service plan
- Steps in the transition coordination process
- Communication process between MFP transition coordination and Medicaid HCBS programs
- How transition coordination services advance health for all people served
- How transition coordination services promote community integration

Use discrete descriptions for each target population.

Transition Coordination services are provided by the four Centers for Independent Living serving ND including the Dakota Center for Independent Living of Bismarck; Independence Inc of Minot; Options Resource Center for Independent Living of East Grand Forks; and Freedom Resource Center of Fargo. A contract was developed individually with each of the four Centers that delineates the specific demonstration services to be provided for each MFP participant. The services include outreach to all nursing facilities in their quadrant on a quarterly basis. Outreach services include visiting resident councils, family councils, individual residents, and facility staff.

Qualified individuals requesting assistance with transition from an institutional setting will be assigned to a transition team. The Transition Team will include the MFP Transition Coordinator, the Home and Community Based Services (HCBS) Case Manager/Developmental Disabilities Program Manager (DDPM), and a Housing Facilitator.

The Transition Coordinator is responsible for taking the lead role in coordinating the transition planning process with the individual/family and all team members. This lead

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role will include assuring ongoing communication and coordination with everyone involved throughout the process from the day of referral until the end of the individual's MFP eligibility.

All populations receive transition coordination in the same manner. No population is treated differently.

### Team meeting/planning process to support the role as transition team lead

- Prepare an agenda for each meeting.
- Send to the team prior to meeting
- Manage meetings using the agenda
- Utilize the Transition Plan at meeting-List Action steps and identify who is responsible for addressing each action step/task in the plan.

The legally authorized representative (if applicable) will take part in each team meeting and will play an integral role in making sure the MFP participant is informed and understanding of the process and steps being followed to create the transition plan and meet the transition goal. The representative will also help with supportive decision making and/or make the final decisions where the participants cannot make their own decisions.

### Prior to meeting:

- Meet with the individual in transition and have them assist with preparing the meeting agenda so that their voice is the one heard by the team.
- If two CIL offices are involved, it would be important for the two-transition coordinator involved to have a pre-meeting planning session to prepare for the meeting/agenda preparation etc.

### After meeting is completed

- Provide a follow-up email to the team members to communicate assigned tasks etc.

### Transition Team Meeting:

Meeting must be within 14 business days of referral.

The MFP Transition Coordinator will coordinate the initial Transition Team meeting with the individual/family, the HCBS Case Manager, the Housing Facilitator, and nursing facility social services staff to begin the planning for transition to the community.

### Purpose:

- Understands the transition goals, services, and support needed for the individual.
- Each team member will provide a brief review of their role and services.
- MFP/HCBS/Housing will jointly complete needed documentation.
- Person Centered Plan process will begin.

### MFP Transition Coordinator Role:

- Complete required MFP documentation as the individual is able.

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- Obtain Nursing Facility Care-Plan/MAR/Face Sheet/Doctors Orders/LOC if not already received. (Optional)
- Explain process of Person-Centered/Independent Living Planning.
- Offer a Peer Visiting opportunity.
- Start MFP Transition Assessment/Person Centered Planning process in Therap
- Discuss with the Nursing Facility staff any discharge planning to be done by the Nursing Facility.
- Set first Discharge Plan meeting with Nursing Facility Social Worker, HCBS Case Manager, MFP Housing Facilitator, and family.
- Ask Nursing Facility staff to start thinking about steps for discharge planning.

### MFP Transition Coordinator Reminders:

- Any report of neglect or abuse, follow-up with appropriate referral sources (DD, Protection & Advocacy, and Ombudsman) along with Nursing Facility.
- Discuss importance of frequent Transition Team and Nursing Facility Social Services Worker communication.
- Prepare for transition/discharge planning meeting with Nursing Facility Team.
- MFP Transition Coordinator will review Medicaid eligibility after transitioning with eligibility workers after the meeting for affirmation of continued Medicaid eligibility.

### Transition/Discharge Planning Meeting

#### MFP Pre-Meeting Tasks:

- MFP Transition Coordinator schedules first discharge planning meeting after the completion of the Transition Team Meeting and assessments are conducted by the transition team members.
- MFP Transition Coordinator invites individual/family/legal representative, pertinent nursing facility staff, HCBS Case Manager and MFP Housing Facilitator to the discharge planning meeting as appropriate based on when the transition is anticipated.

#### Transition/Discharge Planning Meeting Tasks:

- Nursing Facility Social Worker/MFP Transition Coordinator jointly facilitates transition/discharge planning meetings.
- Offer a peer visiting opportunity.
- Transition Team members review their role in the process of transition/discharge planning with the individual, family members, legal representative, and Nursing Facility staff.
- Team discusses strengths, abilities, and wishes/goals of the individual through person centered focus.
- Each team member should address area of need at transition/discharge planning meeting and define appropriate referrals.
- Team reviews assessments and identified risks (MFP Risk Assessment Areas) to factors that may need to be mitigated upon transition.
- Team will identify potential barriers to transition and potential ways to address each barrier if possible.

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- Team recommends additional assessments/screening/action necessary to minimize risk factors.
- Input from transition/discharge planning meeting will be utilized to develop a person-centered plan and Nursing Facility transitional care-plan.

Appendix F-1 Transition Role Matrix

Appendix F-2 MFP Assessment

Appendix F-3 MFP Transition Plan

### F.1.2. Transitions under managed care plans

If MFP participants are required to enroll in a managed long-term care or comprehensive managed care plan, clearly describe how the MFP Demonstration will coordinate the delivery of comprehensive transition coordination services with the MCP. Include the following:

- Describe the roles and responsibilities for the MCP during each transition phase: (1) pre-transition, (2) transition phase, and (3) during an MFP participant's 365-day enrollment period
- Describe how the MFP program will ensure that MCPs provide all data and related documentation necessary to monitor and evaluate MFP transition coordination services, including identifying MFP managed care encounters through the Transformed Medicaid Statistical Information System (T-MSIS).

North Dakota does not have managed Care throughout the state. The only managed care plan that would be an option in North Dakota is Program of All-Inclusive Care for the Elderly ([PACE](#)). This service is utilized in the urban areas of Minot, Fargo, Bismarck and Jamestown. It is not available in the rest of the State of North Dakota, thus a very small percentage of MFP participants use this service as it is only offered in Minot, Fargo, Bismarck or Jamestown.

4. Pre-transition: Transition Coordinator would still be responsible for the MFP Assessment, MFP Transition Plan and the Risk Assessment/Health and Safety Plan. Housing Facilitator would also be assigned to address any housing barriers and work to obtain a qualified residence.
5. Transition Phase: The Transition Coordinator and Housing Facilitator would request approvable items for the individual based on their transition plan. The Transition Coordinator and Housing Facilitator would connect with PACE to complete what would be possible for the transition phase and assessment piece for PACE.
6. Enrollment Period: Transition Coordinator and Housing Facilitator would ask for the treatment plan that PACE utilizes for their plan of care. They would also make routine contacts throughout the enrollment period, with Transition

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Coordination contact at minimum monthly and with the Housing Facilitator contact no less than quarterly.

### **F.1.3. Housing-related services and supports**

Describe how the state or territory will structure, organize, and implement housing-related supports and services to increase affordable and accessible housing opportunities for MFP participants. Account for any differences between target population groups and geographic service areas, specifically in rural service areas.

The Money Follows the Person housing goal is to implement strategies that address the need to develop affordable, accessible, and available housing in North Dakota for MFP recipients as well as for other individuals with a disability. These strategies are the basis for the actions of the Housing Workgroup and the Stakeholder Committee during the grant period.

Securing safe, assessable, affordable, quality, and permanent housing has been identified as one of the primary barriers to the successful achievement of this goal. The limited housing options have resulted in transitions being delayed or impossible for MFP eligible individuals.

To fulfill the Housing Strategies, North Dakota has contracted for the skills of a State Housing Facilitator (SHF) and Regional Housing facilitators (RHF) to identify and research creative solutions to alleviate the housing shortage to make transitions possible.

The MFP State Housing Facilitator position acts as the primary liaison with the MFP Program Administrator and ND housing agencies and Consumer Housing Resource Specialists.

- The MFP Housing staff will coordinate statewide efforts in representing the interests of consumers in institutions and those at risk of institutionalization. This group will consist of the SHF along with the RHF's. This will ensure all stakeholders' perspectives are considered in finding solutions to the housing problems in different areas of the state. The SHF will coordinate the Housing staff and provide quarterly reports updating the MFP administrator detailing the progress made in the MFP Housing program.
- Collaborate with the ND Housing Finance Agency, the ND Department of Commerce Community Development Division, Rural Development, the Housing and Urban Development representatives, Tribal Housing entities, private Housing Developers, Public Housing Authorities, and other housing agencies to increase and enhance the housing options in ND to meet the needs of the target population and other consumers at risk of institutionalization.
- Work with local property managers and local housing authorities to address and combat housing discrimination for persons with disabilities and older citizens,

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often referred to as “Not in My Back Yard” (NIMBY), regarding issues that threaten the fair housing rights of persons with disabilities or older citizens residing in North Dakota neighborhoods.

- The SHF will educate local and statewide developers, community leaders, the public and consumers on the need for accessible, affordable, safe, quality housing options for people with disabilities and older citizens.
- The SHF will work to create a list of landlords that provide safe, accessible and affordable housing. This will be accomplished by meeting with landlords through phone calls, zoom meetings or in person to discuss the program and how we can work together to assist people with housing to meet their needs.

### Regional Housing Facilitator (RHF)-

NDCPD will hire Regional Housing Facilitators, one located in each of the four quadrants of the state.

#### Job Duties-

- RHF will assist target population individuals in their housing search, this will include.
- Participate in Fair Housing, Discrimination and the ADA training each year through the Department of Labor or another identified expert in the field.
- Filling out applications for housing subsidies and for potential rental units.
- Assisting in locating the documents needed for applications.
- Attend viewing of rental units including the walk-thru before signing of the lease.
- Assuring the client understands the terms of the lease.
- Connecting clients to agencies that will be providing services.
- Assuring modifications and accommodations are in place when moving in and appropriate as needs change.
- Participate in the development of person-centered case plans, representing the housing wishes of the target population member.
- Document activities in the Therap Case Management system per Department of Human Services, MFP Grant requirements.

Select the following housing-related services and supports available to MFP participants. See the State Health Official letter [#21-001 RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health \(SDOH\)](#) for a description of housing-related services and supports.

- Home accessibility modifications (provide a dollar amount available per participant)

These are approved as both a supplemental service (pre-transition), as part of the MFP demonstration and under the waiver if the individual qualifies. North Dakota also has the [Rehab Accessibility Program](#) which offers an option to braid funding along with confirming some other items such as taxes owed on the property and

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some of those items, so the transition team doesn't have to complete those items. Funding is listed at up to \$25,000 for a home modification to include but not limited to widening of doors and walls, installation of a ramp, bathroom modifications, and/or other items that would make a participant's home more accessible and easier for them to access or receive cares. Modifications costing more than \$25,000 may be approved on a case-by-case basis.

- ☒ One-time community transition costs (provide a dollar amount available per participant)

One-time community transition costs are listed at up to \$5,000 per participant for home furnishings, deposit and first month's rent, assistive technology, and moving costs. Transition costs exceeding \$5,000 may be approved on a case-by-case basis.

- ☒ Pre-tenancy supports

All participants are referred to and evaluated for this support, some participants may need this more than others and some may have already signed a lease and obtained a voucher. Others need support and are offered that upon the initial meeting.

Appendix F-4 MFP Housing Referral Assessment

- ☒ Tenancy supports

All participants are offered and referred to this post-transition follow-up as well. Individuals transitioning with MFP are connected to their Regional Housing Facilitator on at least a quarterly basis. Because of some state funding to support transitions until the voucher is obtained, individuals may receive housing support beyond that first year, so that contact is maintained for a smooth transition to the voucher program.

Appendix F-5 MFP Housing Transition Plan

### **F.2. Partnerships with state or territory and local housing entities**

Describe how the state or territory will develop and sustain partnerships with state or territory and local housing agencies to increase access to affordable and accessible housing for MFP participants. Include the following:

- How the state or territory will put in place partnership arrangements with state or territory and local housing entities
- How the state or territory will work with those entities to assist MFP participants to obtain affordable and accessible housing
- Description of the proposed infrastructure expenditures to support housing partnerships; examples of infrastructure expenditures include:
  - Housing specialist position(s) responsible for developing/maintaining system-level partnerships with state or territory and local housing entities

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- Technology, for example, electronic referral systems, shared data platforms, screening tool, case management systems, databases/data warehouses, housing registry
- Workforce development—for example, training, housing coordination certification, cultural competency training
- Outreach, education, and convenings—for example, design and production of outreach and education materials, translation, investments in community convenings
- North Dakota has built several partnerships within state; our contracted partners have built several long-lasting relationships and continue to do so. The MFP Housing workgroup is responsible for the development of strategies to assure that MFP participants have available, affordable, and accessible housing options. In addition, the operational protocol related to housing is the responsibility of this workgroup. Implementation of the housing strategies are also addressed.

The North Dakota MFP State Housing Facilitator and the MFP Regional Housing Facilitators work collaboratively with the Housing Agencies in North Dakota and MFP Housing workgroup members.

Membership includes representatives of the following groups/agencies: ND Protection and Advocacy, ND Community Action Association, County Housing Authorities, ND Housing Finance Agency (NDHFA), ND Dept of Commerce-Division of Community Service, Center for Independent Living representative, and MFP Program Administrator.

The MFP State Housing Facilitator position acts as the primary liaison with the MFP Program Administrator and ND housing agencies and Consumer Housing Resource Specialists.

- The MFP Housing staff will coordinate statewide efforts in representing the interests of consumers in institutions and those at risk of institutionalization. This group will consist of the SHF along with the RHF's. This will ensure all stakeholders' perspectives are considered in finding solutions to the housing problems in different areas of the state. The SHF will coordinate the Housing staff and provide quarterly reports updating the MFP administrator detailing the progress made in the MFP Housing program.
- Collaborate with the ND Housing Finance Agency, the ND Department of Commerce Community Development Division, Rural Development, the Housing and Urban Development representatives, Tribal Housing entities, private Housing Developers, Public Housing Authorities, and other housing agencies to increase and enhance the housing options in ND to meet the needs of the target population and other consumers at risk of institutionalization.
- Work with local property managers and local housing authorities to address and combat housing discrimination for persons with disabilities and older citizens, often referred to as "Not In My Back Yard" (NIMBY), regarding issues that

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threaten the fair housing rights of persons with disabilities or older citizens residing in North Dakota neighborhoods.

- The SHF will educate local and statewide developers, community leaders, the public and consumers on the need for accessible, affordable, safe, quality housing options for people with disabilities and older citizens.
- The SHF will work to create a list of landlords that provide safe, accessible, and affordable housing. This will be accomplished by meeting with landlords through phone calls, zoom meetings or in person to discuss the program and how we can work together to assist people with housing to meet their needs.

### F.3. MFP-qualified residence

Describe how the state or territory will verify and document the type of MFP-qualified residence (see PTC 15) an MFP participant resides in during the 365-day enrollment period. Use discrete descriptions for each target population if applicable. Include the following:

- Description of the process for identifying MFP-qualified residences
- Description of the provider(s) responsible for verifying and documenting the type of MFP-qualified residence
- Assessments or tools for screening MFP-qualified residences, including:
  - Name and description of the assessments of tools
  - Embed any assessments or tools below or in the appendix, or provide a link to the source

#### Definition of qualified residences for MFP participants

- A home owned or leased by the individual or the individual's family member.
- An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control
- A residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside i.e. Adult Foster Care or Agency Adult Foster Care.
- The transition address is also verified against other licensed provider group homes and other congregated living situations. If the address is questionable, the settings rule compliance officer is brought in to make that determination. In these cases, no transition funding is available until a determination from the settings rule compliance team is verified.
- Documentation of the type of MFP qualified residence an MFP participant resides in is documented on initial assessment completed upon referral. The residence is then updated and documented on the MFP transition plan and MFP transition

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case note and then transferred to the T-MSIS system when documentation of the transition is completed.

- MFP administrative staff is responsible for verifying and documenting the type of MFP-qualified residences. The residence type is obtained from initial assessment and referral and then documented in the in-house case management system. Approval and/or denial is done by MFP administrative staff using the current approved operational protocol and program terms and conditions. All approvals and denials are documented in the in-house case management system. All written materials pertaining to the approvals and denials, including the initial referral and assessment are uploaded and stored in the electronic system (Therap).

### Description of the State Regulations for Each Type of Housing

#### Adult Foster Care (AFC)

An occupied private residence in which Adult Foster Care is regularly provided by the owner or lessee thereof to four or fewer adults who are not related by blood or marriage to the owner or lessee, for hire or compensation.

Adult Foster Care must meet State regulation as outlined in the - Adult Foster Care Provider, Individual Qualified Service Provider, and Adult Foster Care Respite Provider including standards for practice and enrollment procedures listed on the [website](#).

Appendix F-6: Individual Qualified Service Provider (QSP) Handbook

Appendix F-7: Agency Qualified Service Provider (QSP) Handbook

Appendix F-8: Adult Foster Care Provider Handbook

Appendix F-9: Agency Foster Home for Adults Provider Handbook

Appendix F-10: Individual QSP Enrollment Road Map

#### Agency Adult Foster Care (AAFC)/ Agency Foster Home for Adults (AFHA)

An Agency Foster Home for Adults (AFHA) is the setting where an individual who has Medicaid can receive Home and Community Based Services (HCBS): Residential Habilitation and Community Supports. It is a licensed, home-like setting, where Residential Habilitation and Community Supports services can be provided to up to 4 adults, and up to 24 hours per day by a Qualified Service Provider (QSP) Agency.

#### Developmental Disabilities Residential Options

All ND community providers must be licensed to provide services. This specifically means authorization by the Department of Human Services to provide a service to individuals with developmental disabilities, pursuant to North Dakota Century Code chapter 25-16 and as outlined in ND Administrative Code found at [Developmental Disability Residential Options](#).

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The department also adopted and made a part of its administrative rules for all licensees the current standards used for accreditation by the council on quality and leadership in support for people with disabilities. If a licensee fails to meet an accreditation standard, the department may analyze the licensee's failure using the appropriate 1990 standards of the council on quality and leadership in support for people with disabilities.

The following developmental disabilities services will generally be used as a qualified MFP Residence or to support MFP participant in the community:

- Residential Habilitation

Residential Habilitation 525-05-30-50 Definition Residential Habilitation is formalized training and supports provided to eligible individuals who require some level of ongoing daily support. This service is designed to assist with and develop self-help, socialization, and adaptive skills that improve the participant's ability to independently reside and participate in an integrated community. Residential Habilitation may be provided in community residential settings leased, owned, or controlled by the provider agency, or in a private residence owned or leased by a participant. The participant must be able to benefit from skills training in order to assist individuals to independently complete tasks, restoration or maintenance and could also benefit from one or more of the following care coordination, community integration/inclusion, adaptive skill development, assistance with activities of daily living, instrumental activities of daily living, social and leisure skill development, medication administration, homemaking, protective oversight supervision, and transportation. Eligible participants must live alone or with an individual who is not capable or obligated to provide care i.e. able-bodied spouse. This service may be most beneficial to individuals with cognitive impairments, brain injury, stroke etc.

- Independent Habilitation

Regular, but not daily support for fewer than 24 hours per day that assists with self-help, socialization, and skills that improve the individual's ability to live independently and participate in the community.

Home or Apartment – The regulations relevant to an apartment/home would be the Housing Quality Standards (HQS). The HQS are Housing and Urban Development (HUD) standards. The HQS are used by the public housing authorities when they evaluate homes or apartments that are going to be rented by an individual with a housing voucher. Every residence is assessed, and the results are documented and retained in the person's housing file.

Apartments/homes are reassessed on a regular basis to ensure that it continues to meet standards. Only residences that meet these standards are eligible for use with a voucher.

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Housing offices utilize a checklist for the assessment process. The HQS assessment checklist could be used to assure that a residence that is not subject to HUD regulation is evaluated by the professional involved with the transition. Training for this process could be provided by a housing office staff member if this situation develops. The HQS checklist comes with instructions. This would come into play when someone moves to a private home that they own or is owned by a family member and no housing program assists with the housing costs.

The HQS would be applied in a reasonable fashion if used to assess a privately-owned family home. The intent would not be to prevent the move but to address any real-life safety issues. The need to negotiate for the welfare needs of the individual would ensure that the home meets minimal standards, and reasonable accommodation is made for the person moving to the home. If a concern had no impact on the person with a disability it would not be appropriate to make this roadblock for the move. Example: No vent or window in older home's bathroom.

All buildings need to meet minimal building code requirements such as sewer, water, and electrical codes. The additional HQS could be applied to privately owned homes beyond those standards to ensure an appropriate and safe living environment. The goal is to assure a good quality of life for each person.

Housing Quality Standards address the Americans with Disabilities Act (ADA) reasonable accommodations requirements. Fair housing laws require that landlords allow renters to make their own reasonable accommodations if they return the apartment to its prior condition.

Document Requirements for all Residences into which Money Follows the Person Participants are placed to assure they meet Money Follows the Person Statutory Definitions for "Qualified Residences"

### **F.4. Other information**

If needed, provide other information regarding the state or territory's transition coordination and housing processes and services that is not addressed elsewhere in the template.

As part of our work with [Minot State University NDCPD](#) they also host two different sections of educational and professional development opportunities known as the Tuesday Trainings. These trainings are widely attended and bring a variety of topics and resources to the surface so that the professionals working within this field can connect and gain additional resources to help support our shared individuals.

## SECTION G. SELF-DIRECTION AND INFORMAL CAREGIVING

### G.1. Self-direction

Describe any opportunities for MFP participants to receive HCBS as self-directed services.

North Dakota has some self-directed services within the DD waiver, medically fragile waiver and the Autism waiver. Participants of the Developmental Disabilities waiver can self-direct the following services: In-Home Supports, Respite, Behavior Consultation, Environmental Modification, and Equipment and Supplies. If a participant chooses to voluntarily terminate self-direction, they could receive In-Home Supports (IHS) or Respite through provider manages. Behavior Consultation, Environmental Modification, and Equipment and Supplies are only available through self-direction. The medically fragile waiver is all self-directed. For the Autism waiver respite services are offered through self-direction.

#### G.1.1. Termination of self-direction

Describe how the state or territory accommodates a participant who voluntarily terminates self-direction to receive services through an alternate service delivery method, including how the state or territory assures continuity of services and participant health and welfare during the transition from self-direction to the alternative service delivery method. Describe the circumstances under which the state or territory will involuntarily terminate the use of self-direction and thus require the participant to receive provider-managed services instead. Specify procedures for switches from self-direction to provider-managed or other service delivery systems.

Services are authorized on a quarterly basis, and the Developmental Disabilities Program Manager completes a visit with both the individual and legal decision maker (if applicable) to continue to talk about needs and services being met. Should the self-directed services not be working for the individual, the individual would be able to submit a referral to a provider for coverage. Depending on the area of the state, there may be more providers in some areas versus others. Self-directed services due not only have state oversight but they also have a fiscal agent responsible for having an on-line budget balance sheet that indicates total budget, percentage of expenditures and remaining funds. The fiscal agent also provides the participant and legal decision maker with a monthly statement of utilization.

The assessment and updated person-centered plan would occur anytime there is a change in services. If the individual is re-institutionalized the DDPM will assess and authorize services again pending the discharge date. Since the service is self-directed, the guardian or individual is working closely with the DDPM for authorization and updating the person-centered plan to ensure that the services meet the individuals' needs.

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Involuntary termination from self-direction may be necessary when the individual does not carry out his/her responsibilities under participant direction. Termination may also be necessary to assure the individual's health and welfare. In these situations, the State can terminate self-direction and require the individual to receive provider-managed services instead. When self-directed IHS is terminated, the individual should be transitioned to provider managed IHS and/or other appropriate services by revising the plan and quickly linking the person to alternate waiver providers.

### **G.2. Other information**

If needed, provide other information regarding self-direction and informal caregiving that is not addressed elsewhere in the template.

For waiver specific information the waivers are all linked below within section I.

## SECTION H. REPORTING

### H.1. Reporting plans and procedures

Describe how the state or territory will develop and implement a reporting plan and procedure for data collection, reporting, and participation in the MFP evaluation effort. The reporting plan must include data collection plans and procedures that demonstrate the state or territory's capacity to collect and share data for reporting the required program, expenditure, and financial information. States or territories must include a description of their T-MSIS data submission status and must address how identified T-MSIS data quality issues are being addressed.

Describe the reporting procedures for ensuring timely and complete data submissions to CMS, including quarterly, semi-annual, and annual reporting requirements; performance indicators and program outcome metrics; and continuous quality improvement and quality measures reporting.

Describe the strategies for ensuring that all partners and participants—including all affiliated departments, agencies, and providers—will participate in the project's evaluation.

In February 2023, a Structured Query Language (SQL) server database was designed which holds most of the data used to report on a quarterly, semi-annual, and annual basis. Using Microsoft Access integrated with the SQL server database, the Money Follows the Person program administration staff has a powerful tool to gather, track and report which allows us to comply with the granting source requirements. The system and the data itself is also used to analyze and pinpoint regions or areas where education is needed. The database is only accessible by administrative staff and individuals who have access to the remote server, for an extra layer of protection.

Therap, a Statewide data system, is also used but is not flexible to allow for query design and does not contain the reports to easily gather some of the required information needed to comply with the requirements of the grants. As the system is utilized for a variety of services within North Dakota and difficult to stratify the MFP participants within this system. Therap does allow for the contracted partners and our provider network to document within the system so that administration can view the field work being completed.

A database management manual has been created with step-by-step instructions allowing the Program administration staff to gather and input the information needed simultaneously and consistently, providing for more accurate data input, tracking and reporting. The system is backed up nightly with redundancy ensuring no data loss. Restore capabilities are also available ranging from 45 days up to the past two hours.

The database manual is utilized as a training mechanism and ensures there is a backup for each task required to be fulfilled by the grant.

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Monthly error checking utilizing the query mechanisms in the database has been designed to provide data validation and can be performed by any of the program administration staff.

Processes have been put in place for specific time frames in the month to analyze data from the Therap system in comparison with the information held in the MFP database to help ensure the accuracy of the data and the goal of accurate, consistent reporting. Using these processes and reports allows program administration staff to report accurately in the monthly reports going directly to the Centers for Medicare and Medicaid Project Manager.

A very antiquated system is also utilized to gather information which is pushed into the CMS T-MSIS system. This system does not currently match with the accurate information produced by the system used and verified daily.

Currently MFP is meeting with staff at IBM who currently provides the T-MSIS data, and with the State of ND Medicaid Data Analyst manager who provides the MMIS data to compare and verify the data being sent to CMS. Currently the only transitions being reported to CMS through T-MSIS are the transitions where they have had an identifier code input as "Money Follows the Person Grant" in MMIS. These cases are transitions where the MFP participant has transitioned and are receiving Home and Community Base Services (HCBS) under the Medicaid waiver or Medicaid State Plan personal care B or C.

The process in place provides accurate data supplied to the various Dashboards for the Department itself. The reports and the Dashboards are used to provide information to the public, different stakeholders, Centers for Medicare and Medicaid, and to the Department of Justice for the settlement agreement.

Most recently, an expense tracking tool has been designed and implemented in the system. This tool will be used to gather, analyze, and report on the various expenses requested in relation to individuals utilizing the MFP program. Currently there isn't enough data in this system to analyze the types of expenses or the regions they come from. In the future this will be used to ensure contracts with the Centers for Independence Living are sufficient, and to ensure supplemental services are sufficient to overcome barriers stopping a safe and efficient transition.

Each quarter MFP has a stakeholder meeting where all partners and participants meet to discuss the Money Follows the Person program. Prior to this meeting an agenda is created, and all agenda items are discussed. Benchmarks are created and any new issues, ideas, and suggestions are taken and discussed. MFP allows for an hour of discussion after the meeting for anyone requiring or needing unscripted time.

In addition to the stakeholder meetings, affiliated department program managers meet weekly to discuss the MFP program and all other relevant projects and services that

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make up the transition process. All issues, idea and suggestions are heard and discussed.

Appendix H-1: North Dakota MFP Monthly Report

## SECTION I. QUALITY MEASUREMENT, ASSURANCE, AND MONITORING

### I.1. Quality assurance and improvement

#### I.1.1. Quality management strategy

Provide as an appendix a comprehensive and integrated quality management strategy. Describe how the state or territory assures quality and continuously improves the quality of HCBS under the state or territory Medicaid program and assures the health and welfare of individuals participating in the MFP Demonstration. In the Work Plan, include state or territory initiatives to improve the quality of services received by individuals receiving HCBS through the MFP Demonstration and the systems that serve them. Include how the state or territory monitors and evaluates the quality of services provided to MFP participants (including supplemental services), the roles and responsibilities of all agencies involved, and remediation and improvement processes.

Describe the program's targeted system performance requirements, including that (1) the state conducts level-of-care need determinations consistent with the need for institutionalization, (2) plans of care are responsive to participants' needs, (3) qualified providers serve participants, (4) health and welfare of participants is protected, (5) state or territory Medicaid agency retains administrative authority over the program, and (6) the state or territory provides financial accountability of the program.

If the state or territory plans to integrate the MFP program into a new or existing section 1915(c) HCBS waiver program, section 1915(i) state plan HCBS, section 1915(j) self-directed personal care services, section 1915(k) Community First Choice, or a section 1115 demonstration, provide a link to the approved quality improvement system (QIS), for example as found in:

Describe how the HCBS state plan, section 1115 demonstration, or waiver program's existing QIS is or will be modified to ensure adequate oversight and monitoring of the MFP program.

- Appendix H of the section 1915(c) HCBS waiver application

[Appendix H of the 1915\(c\) Developmental Disabilities waiver](#)

[Appendix H of the 1915\(c\) HCBS Waiver](#)

[Appendix H of the 1915\(c\) Children's Hospice Waiver](#)

[Appendix H of the 1915\(c\) Children's Medically Fragile Waiver](#)

[Appendix H of the 1915\(c\) Autism Waiver](#)

- QIS information provided in the section 1915(i) state plan application

[QIS Information in 1915\(i\) state plan amendment](#)

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- The quality assurance and improvement plan used to monitor and evaluate the section 1915(j) self-directed option

This is not applicable to North Dakota.

- The quality assurance and improvement strategy used to monitor the section 1915(k) Community First Choice State Plan option

This is not applicable to North Dakota.

- Section IV of the section 1115 demonstration application, describing how delivery system reforms will impact quality, access, cost of care, and health status of the covered populations

This is not applicable to North Dakota.

### I.1.2. Quality assurance attestation

- Select this box to indicate the state or territory will cooperate in carrying out activities to develop and implement continuous quality assurance and quality improvement systems for HCBS and LTSS.

### I.1.3. HCBS quality measures

Describe how your state or territory plans to select an experience of care survey or surveys for each of the major population groups included in the state or territory's HCBS program from the [HCBS Quality Measures](#) and report on the survey data.

North Dakota plans to utilize the experienced care surveys [National Core Indicators-Intellectual and Developmental Disabilities](#) (NCI-IDD) and the [National Core Indicators-Aging and Disabilities](#) (NCI-AD). Due to North Dakota relatively small sample size, we will cycle every other year for each population group and stratified within the services available during the cycle.

Describe any limitations in the data sources, sampling strategy, or calculations used to report the HCBS Quality Measure Set, as well as any other anticipated challenges for reporting.

At this time, North Dakota does not anticipate any concerns, but as the 1915i sub-population may grow, we may need to stratify the population differently if recommended, along with building reports so that the background information will be easily gathered from the case management system.

Describe how HCBS Quality Measure Set data will be used to support MFP program monitoring and improvement.

Since North Dakota is a relatively newer member of the surveys our hope is to establish a baseline and learn some of this information and pilot some on a small scale to learn before moving forward on a full state level.

Please list the responsible party and any key partners for reporting on the HCBS Quality Measure Set and driving improvement.

Our Quality Measure Set Administrator will work with each section individually as well as bringing the sections together and verifying the data is accurate prior to reporting out. This position is responsible for making sure that our state is prepared to report, knows the requirement, timeline and develops meetings with our partners include: adult and aging services, developmental disabilities, and the medical services sections.

## I.2. Additional MFP quality assurance requirements

Describe how the state or territory will address the three additional MFP quality assurance requirements for (1) 24-hour backup systems for crucial services, (2) risk assessment and mitigation, and (3) incident management. For each requirement, describe how the state or territory will monitor its use and effectiveness and explain any variations by target population, geography, or any other factor. Describe the protocol for the reporting of incidents to the state or territory’s critical incident systems for the state or territory’s HCBS program(s).

### I.2.1. 24-hour backup systems for critical services

Using the table shell below, describe any 24-hour backup systems accessible by Demonstration participants, as well as how participants can access the systems (for example, toll-free telephone number or website). The state or territory should describe, at a minimum, the backup systems related to (1) critical services, (2) transportation, (3) direct care workers, (4) repair and replacement for durable medical equipment (DME) and other equipment (including provision of loaning equipment while repairs are being made), and (5) access to medical care (including how participants are assisted with initial appointments, how to make appointments, and how to deal with appointment or care issues). Add as many rows as needed to capture all backup systems available to Demonstration participants.

**Table I.2.1. 24-hour backup systems**

<b>Backup system</b>	<b>Description of system</b>	<b>Participant access</b>
Critical services	Critical services are available as listed on their individualized care plan (family member or a paid provider)	Individuals have a copy of their assessments and person-centered plans. They are also given their backup plan.
Transportation	Public, non-medical transportation, provider transportation, family transportation or independent transportation	Individuals have a copy of their assessments and person-centered plans. They are also given their backup plan.

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<b>Backup system</b>	<b>Description of system</b>	<b>Participant access</b>
Direct care workers	Listed on the backup plan and reported as necessary to the administrator who oversees provider complaints	Individuals have a copy of their assessments and person-centered plans. They are also given their backup plan.
Repair and replacement for DME and other equipment	Listed within the emergency backup plan or on the item of equipment	Individuals have a copy of their assessments and person-centered plans. They are also given their backup plan.
Access to medical care	Listed on the top portion of the emergency backup plan, along with the access Emergency Response System (ERS) if needed	Individuals have a copy of their assessments and person-centered plans. They are also given their backup plan. Individuals also are given information should they utilize ERS.
Other (describe):		

Describe the organization of 24-hour backup systems. Explain which state, territory, or local agencies are responsible for providing 24-hour, seven day per week emergency backup in all geographical areas in which the MFP Demonstration will operate and for each target group if it varies.

The state is in contract with US Preventive Medicine (USPM) who serves as the entity to call the participants and accept calls from the participants. This toll-free number is answered by a nurse who also has the backup plan to follow along to best support the individual making the phone call. This list is updated at least monthly or as transitions occur so that USPM can add the participants to their tickler and connect with the participant on at least a weekly basis.

Appendix I-1: Emergency Backup Plan

Appendix I-2: US Preventive Medicine Brochure

Describe the process for receiving and resolving participant complaints when the backup systems and supports do not work.

We have not seen any of these complaints but a reoccurring visit with the vendor to alleviate these concerns as they arise.

### **I.2.2. Risk assessment and mitigation**

Describe the organization of risk assessment and mitigation processes for all program participants, including monitoring.

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Attached is the Risk Assessment that is completed throughout the referral, assessment and transition process, to mitigate those risks prior to transition.

### Appendix I-3: Risk Assessment

#### **I.2.3. Incident management system**

Assure that MFP critical incidents are reported through the state or territory's incident management systems for Medicaid HCBS. Describe the organization of the incident management system used to monitor the health and welfare of MFP participants. Identify the state or territory entity responsible for receiving, reviewing, and responding to MFP critical incident reports and investigating consumer complaints regarding violation of their rights. If applicable, clearly describe how the policy differs by situation (for instance, by participant population group, qualified institutional setting, or operating division).

Participants receiving HCBS utilize Therap as the incident management system through the general event report (GER). These reports are reviewed by the transition team members or involved staff depending on the section e.g. (Adult and Aging, Development Disabilities). The Adult and Aging reports are reviewed by a nurse as the state oversight and sent on to our provider complaint process if necessary or escalate to other sections as needed.

If an individual is concerned that abuse, exploitation or neglect is occurring the process would be to complete an Adult Protective Services (APS) report so the intake worker can review the information and assign to an investigator if the intake meets the criteria for an investigation. We have three different methods of reporting as viewed on the website above. We also have a policy regarding the provider complaints outlined in the appendix below.

Appendix I-4: General Event Report

Appendix I-5: Report of Vulnerable Adult Abuse, Neglect or Exploitation

Appendix I-6: QSP Complaint Policy

#### **I.3. Other information**

If needed, provide other information regarding the state or territory's approach to quality that is not addressed elsewhere in the template.

No additional information on quality currently.

## SECTION J. CONTINUITY OF CARE POST-DEMONSTRATION

In accordance with section [6071\(c\)\(2\) of the Deficit Reduction Act of 2005](#), the MFP Demonstration must operate in connection with a qualified HCBS program to assure continuity of services for eligible individuals.

Select this box.

- The state or territory affirms that it has established procedures and processes for ensuring that the provision of HCBS will continue for an MFP participant at the conclusion of the 365-day enrollment period for as long as an individual remains eligible for medical assistance.

**SECTION K. PAGE INTENTIONALLY LEFT BLANK**

## SECTION L. TRIBAL INITIATIVE

If your state or territory has or is planning a Tribal Initiative, please describe the Tribal Initiative.

### L.1. Tribal Initiative project director

Name the project director of the Tribal Initiative, describe the percentage of time the project director spends on this initiative, and offer a brief description of the roles and responsibilities of the position.

Melissa Reardon serves as the Tribal Initiative Liaison and is a contracted staff member through North Dakota State University (NDSU) in their Department of Public Health. Melissa is a full-time tribal liaison, so her time is spent 100% working on the project's implementation.

Tribal Initiative Project Director will travel to the tribal nations (Mandan, Hidatsa, and Arikara Nation; Spirit Lake Nation; Standing Rock Sioux Tribe; and Turtle Mountain Band of Chippewa) to meet with tribal stakeholders, conduct trainings and provide technical assistance related to MFPTI operational protocol development. Staff will also travel to Bismarck to meet with North Dakota Department of Health and Human Services leadership and staff, as well as to facilitate MFPTI stakeholder meetings and strategy sessions among members of the tribal nations. MFPTI program manager will also attend quarterly Tribal Nation/North Dakota Department of Health and Human Services Consultation meetings.

Our tribal initiative project director also regularly participates in CMS-sponsored calls and the MFPTI State Peer to Peer calls and planning activities.

Tribal Initiative Project Director roles and responsibilities also include providing additional MFPTI technical assistance including:

- Coordinate, facilitate and support strategies and activities of the MFP Tribal Nations Partners group and the MFPTI 5-State Work Group. Projects include researching the different aspects of financial eligibility for American Indian HCBS; identifying and presenting/coordinating presenting at national conferences to expand our MFPTI network; developing inventory of LTSS resources in Indian Country; and developing an MFPTI guide that includes program implementation indicators for evaluation.
- Coordinate and support meaningful engagement with the NDDHHS Aging Services Director for tribal nation-related HCBS.
- Provide public health expertise where appropriate and asked by MFPTI tribal nation partners, including workforce development leadership sessions.
- Assure connectivity and coordination between the CHR programs and new state CHW program.

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- Work with American Indian Health policy expert(s) who can help advance our work.

Explore connectivity with Sisseton, Wahpeton Oyate Nation for MFPTI-related work.

Through MFPTI, tribal nations are establishing tribal home and community-based services (HCBS) that are culturally and financially sustainable. This is being accomplished through respectful facilitation by the MFPTI project director in collaboration with tribal leadership, tribal health directors, tribal CHR directors, other tribal program managers, NDDHHS staff and CMS staff. The Tribal Initiative project director has established strong partnerships with the tribal health directors, and it is through their direction and guidance that the TI PD meets directly with other tribal nation programs, or provides the information needed for the tribal health directors to meet with the different partners.

This work includes providing and/or coordinating training and technical assistance for infrastructure development, including evaluation components, which are unique to each sovereign tribal nation as described below.

### L.2. Capacity building and planning

#### L.2.1. Federally recognized Tribal nations

Name each of the federally recognized Tribal nations within the state or territory.

Mandan, Hidatsa, & Arikara (MHA) Nation (Three Affiliated Tribes)

Spirit Lake Nation

Standing Rock Sioux Tribe

Turtle Mountain Band of Chippewa Indians

Sisseton-Wahpeton Oyate Nation (this nation has headquarters in South Dakota)

#### L.2.2. Engagement with Tribal nations

Describe which tribes are MFP Tribal partners and how the state or territory engages with these partners. Describe how the state or territory engages with tribes that are not MFP Tribal partners. Include strategies and efforts to date and any anticipated or planned engagement efforts.

**Mandan, Hidatsa, Arikara Nation:** Establish MFPTI program infrastructure elements needed to support HCBS transition services.

- Continue implementation of pilot project with Home Instead serving the South Segment.
- Recruit and hire enrolled tribal members to serve as qualified service providers (QSPs).
  - Market eligibility of home and community-based services to elders and tribal nation members with disabilities.

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- Assist interested tribal nation members with the enrollment processes i.e. Medicaid, HCBS intake and assessment.
- Explore feasibility of expanding the pilot to another segment of MHA N.
- If appropriate, identify new contact/MFPTI champion at MHAN and with their guidance, determine next steps for engagement. Past strategies may be considered for this work including:
  - Recruit, hire, and train part-time MFPTI local coordinator
  - Enroll as applicable HCBS Medicaid provider i.e. QSP, Non-Emergent Medical Transportation (NEMT), Targeted Care Management (TCM)
  - Identify HCBS training needs and coordinate appropriate trainings
  - Develop and implement MFPTI marketing and communication plan
  - Recruit and hire necessary staff positions for sustainability i.e. agency director, tribal nation-specific ongoing case manager, TCM supervisor, QSP providers
  - Develop evaluation components to monitor implementation.

### **Turtle Mountain Band of Chippewa Indians**

Establish MFPTI program infrastructure elements needed to support HCBS transition services.

- Continue implementing and expanding HCBS services on Turtle Mountain Indian Reservation.
  - Enroll as applicable HCBS Medicaid provider i.e. TCM, case management, home health
  - Identify HCBS training needs and coordinate appropriate training
  - Develop and implement MFPTI marketing and communication plan
  - Recruit and hire necessary staff positions for sustainability i.e. RN/LPN, LSW, biller, QSPs, TCM supervisor, on-going case manager, etc.
  - Develop evaluation components to monitor implementation

### **Standing Rock Sioux Tribal Nation** (Not currently in contract with this Tribal Nation)

Establish MFPTI program infrastructure elements needed to support HCBS transition services.

- Support the Title VI Director in exploring feasible options to provide HCBS services. Strategies may include
- Partnering with another QSP agency i.e. Home Instead to provide the services
- Developing a new or partnering with an existing Standing Rock Sioux Tribe Tribal entity
- Partnering with the University of North Dakota Center for Rural Health National Resource Center on Native American Aging (UNDCRHNRCNAA) to hire an onsite QSP agency coordinator
- Once a viable option is identified, develop a budget and scope of work for the StandingRock Sioux Tribal Nation and NDDHHS. Implementation strategies may include:

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- Enrolling as applicable HCBS Medicaid provider i.e. QSP, NEMT, TCM, Home Health
- Identifying HCBS training needs and coordinate appropriate training
- Recruiting and hiring/contracting with necessary staff positions for sustainability i.e. TCM supervisor, LSW, biller, executive assistant, QSP providers, tribal nation-specific ongoing case manager, home health subject matter expert.
- Developing and implementing MFPTI marketing and communication plan
- Develop evaluation components to monitor implementation

### L.3. Operations

Describe the operating details of your state or territory's Tribal Initiative. Describe any operational activities that differ from the state or territory's MFP Demonstration in terms of benefits and services available to participants through the Tribal Initiative, quality assurance, self-direction options, housing options for participants, and how continuity of care is maintained after the end of the 365-day Demonstration period.

Include in the MFP Work Plan specific Tribal Initiative objectives including transition benchmarks, outreach to Tribes and Tribal providers, recruitment and enrollment efforts, and workforce development objectives including the amount of services delivered Tribally.

In North Dakota, this population is not stratified, served or qualified any differently. All services remain the same whether an individual participant is part of a tribe. We are working on building capacity and access to home and community-based services across the tribal nations with the partnership of our tribal liaison to bridge the gap on the government-to-government relationship.

### L.4. Other information

If needed, provide other information regarding the state or territory's approach to Tribal Initiatives that is not addressed elsewhere in the template.

Spirit Lake Nation has been operating its own provider agency for quite some time and has voiced not needing support from MFP to sustain their efforts.

## SECTION M. PUBLIC HEALTH EMERGENCIES

### M.1. Program adaptations in response to Public Health Emergencies

#### M.1.1. Program adaptations

Describe adaptations your state or territory's MFP Demonstration made in response to a Public Health Emergency (PHE), such as the COVID-19 PHE, declared at either the state, territory, or federal level. For instance, these could include protocols for MFP participants living in the community who test positive for COVID-19, plans to prevent COVID-19 spread among participants, modifying recommendations related to infection control or immunizations (such as the COVID-19, flu, and shingles vaccines), or ways the MFP Demonstration has expanded access to or incorporated services delivered through telehealth technology. Identify adaptations that have ended and those that are ongoing. Describe how any MFP Demonstration adaptations in response to PHEs align with and use policies and procedures from the state or territory's HCBS program(s).

North Dakota would work with regional areas to make sure that enough personal protective equipment was available to the staff members and contracted partners to ensure that the client's individual needs would still be able to be met safely. The state would follow the direction from the federal government and look to the governor as well for the updated information as it relates to the emergency. North Dakota would likely revert to some flexibilities within the waiver and services, such as telehealth services or other options as it relates to the emergency.

#### M.2. Future PHEs

Describe if and how your state or territory is planning for future PHEs in its HCBS systems and MFP Demonstration. For instance, this may include permanent adoption of measures implemented for the COVID-19 PHE.

North Dakota did adopt some items in the waiver through Appendix K of the HCBS waiver amendments and public comment period, and ultimately CMS approval for the changes to the waiver.

#### M.3. Other information

If needed, provide other information regarding the state or territory's approach to PHEs that is not addressed elsewhere in the template.

Our state again, would rely on information from the federal government and the state government to implement the necessary measures for the safety of all.

## APPENDIX A. HYPERLINKS AND GLOSSARY

States or territories may include additional information and documents that do not fit in the other template sections in the Appendix. The template provides default appendix section and subsection headings that states or territories may rename, delete, or otherwise modify as needed. States or territories may also modify the appendix section titles to meet their needs. States or territories that include hyperlinks in the OP must collect all links in the reference table below.

### App A.1. Summary of Hyperlinks

Copy all hyperlinks used in the OP into the table below, by OP section. For each link, provide a brief description (for example, “educational materials provided to participants”).

**Appendix Table A.1. Summary of Hyperlinks**

OP section	Link	Brief description
How to use	<a href="#">Embed or link to a file in Word</a>  <a href="#">Make your Word documents accessible to people with disabilities</a>	Instructions for embedding a file in a Word document  Accessibility instructions for Word documents
A. MFP program overview	No Links	
B. Project administration	No Links	
C. Recruitment, enrollment, outreach, and education	C.3.1 Outreach and marketing to participants <a href="#">MFP Webpage</a> , <a href="#">Mark’s Testimony</a> , <a href="#">Esther’s Testimony</a> , <a href="#">Kenna’s Testimony</a>  C.6 Other information <a href="#">Department of Justice Settlement Agreement webpage</a>	C.3.1-Marketing that has been distributed and published on the website.  C.6-Dept of Justice has a dedicated webpage for the reporting and implementation plans to contain all the information on one webpage.
D. Community engagement	No Links	

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OP section	Link	Brief description
E. Benefits and services	<p><a href="#">March 31, 2022 Note to MFP Recipients</a></p> <p>E.1 Qualified HCBS</p> <p><a href="#">Medicaid State Plan Personal Care, 1915(c)-Adult and Aging Waiver, 1915(c)-Developmental Disability Waiver, 1915(c)-Children’s Medically Fragile Waiver, 1915(c)-Children’s Hospice Waiver, 1915(c)-Autism Waiver</a></p> <p>and <a href="#">1915(i) State Plan Amendment</a></p> <p>E.3.1 Description of supplemental services</p> <p><a href="#">MFP Rental Agreement</a></p>	<p>Note to MFP Recipients: Announcement of Certain Changes to Supplemental Services under the MFP Demonstration</p> <p>E.1 contains numerous links to the webpages and waivers that MFP works in conjunction with for home and community-based services.</p> <p>E.3.1 MFP Rental Assistance is bridging the gap for the public voucher program. This is state funded and a pathway towards a permanent rental subsidy.</p>

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OP section	Link	Brief description
<p>F. Transition and housing services</p>	<p><a href="https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf">https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf</a></p> <p>F.1.2 Transitions under managed care plans <a href="#">PACE</a></p> <p>F.1.3 Housing-related services and supports <a href="#">Rehab Accessibility Program</a></p> <p>F.3 MFP-qualified residence Agency Foster Home for Adults <a href="#">website</a>, <a href="#">Developmental Disability Residential Options</a></p> <p>F.4 Other information <a href="#">Minot State University NDCPD</a></p>	<p>State Health Official letter #21-001 RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)</p> <p>F.1.2: PACE is the only type of managed care offered in North Dakota, and this is not a state-wide service and only available in select areas of the state.</p> <p>F.1.3: North Dakota has partnered with NDHFA to help with an additional funding resource for homes/residences that needed an increase in accessibility.</p> <p>F.3: North Dakota has Agency Foster Home for Adults and information about that setting is included in this webpage as well as a residential setting for those with Developmental Disabilities.</p> <p>F.4: This is the webpage for our work with the Minot State University housing facilitation service. There are many resources within this webpage that we collaborate with as they are our contracted partner.</p>
<p>G. Self-direction and informal caregiving</p>	<p>No Links</p>	
<p>H. Reporting</p>	<p>No Links</p>	

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OP section	Link	Brief description
I. Quality measurement, assurance, and monitoring	<p>I.1.1 Quality management strategy  <a href="#">Appendix H of the 1915(c) Developmental Disabilities waiver</a>,  <a href="#">Appendix H of the 1915(c) HCBS Waiver</a>, <a href="#">Appendix H of the 1915(c) Children’s Hospice Waiver</a>,  <a href="#">Appendix H of the 1915(c) Children’s Medically Fragile Waiver</a>, <a href="#">Appendix H of the 1915(c) Autism Waiver</a>, <a href="#">QIS Information in 1915(i) state plan amendment</a></p> <p>I.1.3 HCBS quality measures  <a href="#">HCBS Quality Measure Set</a>,  <a href="#">National Core Indicators-Intellectual and Developmental Disabilities</a>, and <a href="#">National Core Indicators-Aging and Disabilities</a></p>	<p>I.1.1: These links are attached to the waivers within North Dakota and the 1915i State Plan Amendment.</p> <p>I.1.3 Information about the HCBS Quality Measure Set to include the experience of care surveys that North Dakota is participating in.</p>
J. Continuity of care post-Demonstration	<a href="#">Section 6071(c)(2) of the Deficit Reduction Act</a>	Requirement that the MFP project must operate in conjunction with a qualified and operational HCBS program
K. Intentionally left blank	Intentionally left blank	Intentionally left blank
L. Tribal Initiative	No links	
M. Public health emergencies	No links	
Appendix A	A-4: PRTF LoC <a href="#">Chapter 75-03-17, Code of Federal Regulations (CFR), Title 42, CFR 441 Subpart D, CFR 438 Subpart G</a>	Administrative code in the Level of Care process for the Psychiatric Residential Treatment Facility.
Appendix B	No attachments	

### App A.2. Glossary

Use the glossary section of the appendix to provide a comprehensive list of acronyms used by the state or territory in responses throughout the OP. Commonly used acronyms are already defined in the glossary table. As demonstrated in the example

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table shell below (Appendix Table A.2), the glossary can also be used to provide additional context for certain acronyms through brief descriptions.

**Appendix Table A.2. Glossary**

<b>Acronym</b>	<b>Meaning</b>	<b>Brief description (optional)</b>
ADA	Americans with Disabilities Act	
ADRL	Aging and Disability Resource Link	North Dakota's No Wrong Door system
AFC	Adult Foster Care	
AFHA	Agency Foster Home for Adults	
APS	Adult Protective Services	
CANS	Child and Adolescent Needs and Strengths	
CFR	Code of Federal Regulations	
CIL	Center for Independent Living	
CM	Case Management	
CMS	Centers for Medicare & Medicaid Services	
CN	Case Note	
CQL	Council on Quality and Leadership	
DD	Developmental Disabilities	
DDPA	Developmental Disabilities Program Administrator	
DDPM	Developmental Disabilities Program Manager	
DHHS	Department of Health and Human Services	
DPOA	Durable Power of Attorney	
DOJ	Department of Justice	
DQA	Data and Quality Analyst	
ERS	Emergency Response System	
FICA	Federal Insurance Contributions Act	
GER	General Event Report	

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<b>Acronym</b>	<b>Meaning</b>	<b>Brief description (optional)</b>
HCBS	Home- and community-based services	
HF	Housing Facilitator	Interchangeable with Regional Housing Facilitator
HQS	Housing Quality Standards	
HUD	Housing and Urban Development	
I/DD	Intellectual and developmental disabilities	
IMD	Institution for Mental Diseases	
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities	
IHS	In-Home Supports	
LAR	Legally Authorized Representative	
LoC	Level of Care	
LSW	Licensed Social Worker	
LTSS	Long-term services and supports	
MAR	Medication Administration Record	
MCP	Managed care plan	
MFP	Money Follows the Person	
MFPTI	Money Follows the Person Tribal Initiative	
MHA	Mandan, Hidatsa, and Arikara	
MMIS	Medicaid Management Information System	
MLTSS	Medicaid managed long-term services and supports	
MH/SUD	Mental health and substance use disorders	
MDS	Minimum Data Set	
MFP	Money Follows the Person	

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<b>Acronym</b>	<b>Meaning</b>	<b>Brief description (optional)</b>
NCI-AD	National Core Indicators-Aging and Disabilities	
NCI-IDD	National Core Indicators-Intellectual and Developmental Disabilities	
ND	North Dakota	
NDCPD	North Dakota Center for Persons with Disabilities	
NDHFA	North Dakota Housing and Finance Agency	
NDSU	North Dakota State University	
NEMT	Non-Emergent Medical Transportation	
NIMBY	Not in My Back Yard	
OP	MFP Operational Protocol	
PACE	Program of All-Inclusive Care for the Elderly	
PD	Physical disabilities	
PTC	MFP Program Terms and Conditions	
PHE	Public health emergency	
QIS	Quality improvement system	
QRTP	Qualified Residential Treatment Program	
QSP	Quality Service Provider	
RAP	Rehab Accessibility Program	
RHF	Regional Housing Facilitator	
RN	Registered Nurse	
SA	Settlement Agreement	
SAR	MFP Semi-Annual Progress Report	
SDOH	Social determinants of health	
SHF	State Housing Facilitator	
SMD	State Medicaid director	
SNF	Skilled Nursing Facility	

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<b>Acronym</b>	<b>Meaning</b>	<b>Brief description (optional)</b>
SOW	Statement of Work	
SPA	State Plan Amendment	
SQL	Structured Query Language	
STC	Standard Terms and Conditions	CMS's standard grant/cooperative agreement terms and conditions, which can be used as a reference for definitions for key terms.
TCM	Targeted Case Management	
TFC	Treatment Foster Care	
TI	Tribal Initiative	
T-MSIS	Transformed Medicaid Statistical Information System	
UNDCRHNRCNAA	University of North Dakota Center for Rural Health National Resource Center on Native American Aging	
USPM	US Preventive Medicine	

### **App A.3. Appendix Section**

#### **App A.3.1. Appendix subsection**

Appendix A-1: Territory Coverage

Appendix A-2: Nursing Facility Level of Care Screening

Appendix A-3: Progress Assessment Review

Appendix A-4: Psychiatric Residential Treatment Facility Level of Care

Appendix A-5: Department of Justice Settlement Agreement

Appendix B-1: Department of Health and Human Services Organizational Chart

Appendix B-2: DHHS: Adult and Aging Services Section

Appendix B-3 Project Director Job Description

Appendix B-4 Data and Quality Analyst Job Description

Appendix C-1 Long Term Services and Supports Options Counseling Coverage

Appendix C-2 Long Term Services and Supports Options Counseling Brochure

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Appendix C-3 Long Term Services and Supports Options Counseling Referral

Appendix C-4 Local Contact Agency Referral

Appendix C-5 Developmental Disabilities Referral

Appendix C-6 MFP Booklet

Appendix C-7 MFP Case Study

Appendix C-8 MFP Fact Sheet

Appendix C-9 Informed Consent

Appendix C-10 Re-institutionalization Note

Appendix C-11 Return to Community

Appendix E-1 Housing Plan

Appendix E-2 Food Security Plan

Appendix E-3 Pantry List

Appendix E-4 Clothing Allotment

Appendix E-5 Supplemental Services

Appendix F-1 Transition Role Matrix

Appendix F-2 MFP Assessment

Appendix F-3 MFP Transition Plan

Appendix F-4 MFP Housing Referral Assessment

Appendix F-5 MFP Housing Transition Plan

Appendix F-6: Individual Qualified Service Provider (QSP) Handbook

Appendix F-7: Agency Qualified Service Provider (QSP) Handbook

Appendix F-8: Adult Foster Care Provider Handbook

Appendix F-9: Agency Foster Home for Adults Provider Handbook

Appendix F-10: Individual QSP Enrollment Road Map

Appendix H-1: North Dakota MFP Monthly Report

Appendix I-1: Emergency Backup Plan

Appendix I-2: US Preventive Medicine Brochure

Appendix I-3: Risk Assessment

Appendix I-4: General Event Report

Appendix I-5: Report of Vulnerable Adult Abuse, Neglect or Exploitation

Appendix I-6: QSP Complaint Policy

### **App A.4. Appendix Section**

#### **App A.4.1. Appendix subsection**

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### **App A.5. Appendix Section**

#### **App A.5.1. Appendix subsection**

##### App A.5.1.1. Appendix sub-subsection

## **APPENDIX B. OPTIONAL SECOND APPENDIX**

### **App B.1. Appendix Section**

**App B.1.1. Appendix subsection**

### **App B.2. Appendix Section**

**App B.2.1. Appendix subsection**

### **App B.3. Appendix Section**

**App B.3.1. Appendix subsection**

### **App B.4. Appendix Section**

**App B.4.1. Appendix subsection**

### **App B.5. Appendix Section**

**App B.5.1. Appendix subsection**

App B.5.1.1. Appendix sub-subsection