Implementation Plan

June 14, 2026 – December 13, 2027

North Dakota Department of Health and Human Services

Aging Services

Draft submitted August 1, 2026

Contents

List of Acronyms

ADA – Americans with Disabilities Act
ADRL – Aging and Disability Resource Link
CCBHC - Certified Community Behavioral Health Clinic
CMS – Centers for Medicare and Medicaid Services
CIL – Center for Independent Living
CIR- Critical Incident Report
DD – Developmental Disabilities
DDPM – Developmental Disabilities Program Manager
DHHS – Department of Health and Human Services
DME – Durable Medical Equipment
EVV – Electronic Visit Verification
Ex-SPED – Expanded Service Payments to the Elderly and Disabled
FTE – Full Time Equivalent
FMAP – Federal Medical Assistance Percentage
HCBS – Home and Community Based Services
HCBS waiver – HCBS Medicaid waiver
HUD – Housing and Urban Development
IP – Implementation Plan
LMS – Learning Management System
LTSS OC – Long Term Services and Supports Options Counseling
LTC TCM - Long Term Care Targeted Case Management
MFP – Money Follows the Person
MFP-TI – Money Follows the Person-Tribal Initiative
MMIS – Medicaid Management Information System
MOU - Memorandum of Understanding
ND – North Dakota
NF LoC – Nursing Facility Level of Care
PCP – Person Centered Plan
PSH – Permanent Supported Housing
QSP – Qualified Service Provider
QSP Hub – Qualified Service Provider Resource Hub
SA – Settlement Agreement
SFN – State Form Number
SME – Subject Matter Expert
SNF – Skilled Nursing Facility
SPED – Service Payments to the Elderly and Disabled
TBI - Traumatic Brain Injury
TDPP – Transition and Diversion Services Pilot Program
TPM – Target Population Member
UND – University of North Dakota
USDOJ – United States Department of Justice
VAPS – Vulnerable Adult Protective Services

Introduction

About the Settlement Agreement (SA)

On December 14, 2020, the State of North Dakota (State) entered into an eight (8)-year Settlement Agreement (SA) with the United States Department of Justice (USDOJ). The SA is designed to ensure that the State will meet the requirements of Title II of the Americans with Disabilities Act (ADA).

The SA addresses a variety of concerns that were brought forward by Target Population Members (TPMs). The concerns included the following:

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

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

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

Updates to the Settlement Agreement

Over the past few months, representatives from the State, the USDOJ, and the Subject Matter Expert (SME) team have worked together to discuss and draft a narrowed SA. The parties have agreed that the State has achieved substantial and durable compliance in several areas of the original SA. As a result, the sections related to Person-Centered Planning and Information, Screening, and Diversion have been removed, and the requirements in several other areas have been significantly reduced. Although the narrowed SA has not yet been finalized, the strategies included in this Implementation Plan (IP) and the corresponding performance indicators in each section reflect the proposed narrowed requirements.

The strategies developed to meet the requirements of the SA will provide long-lasting benefits for current and future Target Population Members (TPMs) who want to live and

receive services in their homes and communities rather than in institutional settings. The primary focus areas reflected in this IP include case management capacity, transition services, and housing. DME, capacity and guardian education are also a focus of some of the Year six (6) and seven (7) IP strategies.

Implementation Plan Timeline and Process

This updated Implementation Plan (IP) includes the strategies that will continue to be implemented in Year 6 and 7 of the SA, as well as a few new strategies that were designed based on lessons learned and data from the first 5.5 years of SA implementation.

Previous strategies that are complete, were not effective, or are not included in the updated Settlement Agreement requirements were removed.

The Implementation Plan covers the period from June 14, 2026, through December 13, 2027, of the Settlement Agreement. It is of note that the narrowed version of the Settlement Agreement reduces the term of the Agreement from eight (8) years to seven (7). Year 7 concludes on December 13, 2027. Some of the strategies and initiatives in this proposal are contingent on legislative appropriation to fully implement. The State included ongoing initiatives and services for inclusion in the Department of Health and Human Services (DHHS) Aging Services base budget request. The Legislature will next be convened in January 2027.

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

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

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

Our Vision: Realigning Systems of Care

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

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

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

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

The following goals and issues are driving system change efforts in ND:

- Increase access to community-based service options through policy, process, planning, resources, tools, and capacity building efforts.

- Increase individual awareness about community-based service options and create opportunities for informed choice.

- Provide robust housing support while navigating federal changes that have made accessing federal rental assistance more difficult.

- Strengthen interdisciplinary connections between professionals who work in behavioral health, developmental disability, home health, housing, Long Term Care and HCBS.

- Implement broad access to training and professional development for providers and transition team members to support improved quality of services. For example, providers have been offered behavioral health and motivational interviewing training. The Behavioral Health Division is partnering with the QSP Hub to provide additional training on specific behavioral health diagnoses.

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

- Navigate the ever-changing federal requirements to administer HCBS including implementing the Medicaid Access Rule, and revalidating provider enrollment for every QSP over the next 2 (two) years.

- Preventing fraud, waste, and abuse while strengthening program integrity and addressing the misconception that all HCBS programs lack adequate oversight.

- Developing comprehensive, individualized person-centered plans for every TPM.

- Increasing access to quality in-home and community- based care statewide in rural and urban areas.

Outcome of System Change Efforts

Evidence of real system change is clear when looking at the number of individuals in North Dakota who have been diverted or transitioned from more costly and restrictive levels of care. The State has also expanded awareness of and access to HCBS, as

shown by the increased contacts with the Aging and Disability Resource Link (ADRL) and LTSS Options Counseling (LTSS OC). The data below reflects the impact of the first 5.5 years of the Settlement Agreement.

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

- 1,770 new TPMs diverted from a SNF by providing necessary services and support so they can remain at home with their family and friends.

- Provided State or Federally funded HCBS to 3,143 unduplicated adults in 2021; 3,189 in 2022; 3,368 in 2023; 3,391 in 2024, and 3,364 in 2025. In 2020, the total unduplicated number of individuals receiving HCBS was 2,731.

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

    - ADRL staff answered 80,699 calls for information and assistance about HCBS and responded to 6,781 web referrals for HCBS.

- Providing in-reach to TPMs in hospitals and SNFs who were referred for a long-term stay at a SNF and providing them with information about HCBS, person-centered planning, and transition supports significantly increased the number of referrals to the MFP program.

    - LTSS OC staff provided information about HCBS options during 5,487 visits to TPMs referred for a long-term stay in SNF.

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

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

    - Forty (40) Agency QSPs were successfully enrolled as residential habilitation and community support providers.

- HCBS case managers responded to 9,738 referrals for HCBS and opened 5,167 cases since December 13, 2020.

- The State has also increased the number of enrolled QSPs, especially agency

QSPs. There are 1,257 individual and 247 agencies currently enrolled to provide care.

IP Performance Measures and Benchmarks Final 16 Months of the SA

The following is a summary of the major Year 6 and Year 7 benchmarks identified in the Settlement Agreement (SA):

- By December 13, 2026, transition 70% of Target Population Members (TPMs) who have signed consent and are requesting transition from Skilled Nursing Facilities.
- By the end of the Settlement Agreement, transition at least 75% of TPMs who have signed consent to transition, including individuals on the State's pending list.
- Provide permanent supported housing to TPMs by allocating $300,000 in the Aging Services base budget to support permanent supported housing.
- Submit biannual data reports and data dashboards to the USDOJ and the SME on July 15, 2026; February 1, 2027; and July 1, 2027.

Year 6 and 7 Priorities

During Year 6 and 7 of SA implementation, key strategies will continue to be implemented or finalized to ensure the upcoming Settlement Agreement benchmarks are met and system change efforts are successful. They include:

- Increasing the direct care workforce and improving the QSP experience by continuing to improve the systems implemented to help QSPs with provider enrollment, revalidation, claims submission, and documentation of services provided. This will include:
    - Finalizing the Connect to Care marketing features.
    - Collaborating with the QSP Hub to expand their role and responsibilities to help enroll QSPs.
    - Collaborating with stakeholders and industry leaders to find ways to identify and recruit traditional and non-traditional providers willing to expand their business model to include the provision of HCBS.
    - Improve the quality of HCBS by changing the competency requirements to require direct care providers to successfully complete the HCBS Core Competencies that were designed by the University of Wisconsin-Green Bay.

- Continue to monitor the capacity of case management, transition coordination, and housing facilitation to meet the continued demand for HCBS.

- Continue to improve and develop the reporting and data collection process to implement the required activities of the SA and effectively use data to assess HCBS service quality and outcomes.

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

    - Focus on ensuring TPMs have continued access to rental assistance, environmental modification, and assistive technology assessments.

- Continue to provide behavioral health support such as access to mental health services at the community behavioral health clinics and crisis support, to TPMs and behavioral health training for QSPs.

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

- Continue to prioritize timely, efficient, and safe transitions for TPMs.

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

- Continue discussions on ways to improve access to DME so TPMs have the equipment they need to receive safe and necessary care in their home.

- Work with the Guardianship and Conservatorship Office to educate individuals with guardians about their rights to community-based care and having their preferences considered.

SA Section VI. Implementation Plan

Responsible Division(s)

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

Agreement Coordinator (Section VI, Subsection A, B, C)

The State has assigned an Agreement Coordinator and Settlement Agreement Support Specialist. The State holds regularly scheduled internal meetings to review progress toward implementing the strategies included in the IP and collaborates with the State's Olmstead Coordinator.

SME Consultation and IP

Implementation Strategy

The State will continue to work with the SME. The Agreement Coordinator will meet weekly with the SME and team to consult on the IP. Agreement Coordinator will provide required updates to USDOJ, submit drafts, and incorporate updates as required. The revisions to the IP will focus on implementation through the end of the agreement, challenges encountered by the State to date, and strategies to navigate barriers with plans to address noncompliance if required. (Ongoing strategy)

Service Review (Section VI, Subsection D)

Implementation Strategy

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

Stakeholder Engagement (Section VI, Subsection E)

Implementation Strategy

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

2026-2027 Meeting Schedule:

- September 23, 2026
- December 15, 2026
- March 17, 2027
- June 16, 2027
- September 15, 2027
- December 15, 2027

Updated Strategy 2. The State will host eight (8) in-person meetings in rural, frontier, and Native American reservation areas of North Dakota to discuss Home and Community-Based Services (HCBS). These sessions, distinct from DOJ stakeholder

meetings, aim to assess existing services and address unmet HCBS needs, especially in underserved areas. Meetings will offer information on HCBS, provider enrollment, and gather local feedback to guide improvements. Event dates will be posted on the DHHS website, and a year-end feedback summary will inform future service enhancements. Invitations will be extended to local hospitals, Skilled Nursing Facilities, social services, community leaders, and advocates. (Target completion date June 14, 2027)

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

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

Website (Section VI, Subsection G)

Implementation Strategy

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

Section VI. Performance Measure(s)

Number of unduplicated individuals served in HCBS by funding source.

SA Section VII. Case Management

Responsible Division(s)

DHHS Aging Services

TPM Education and Case Management Capacity (Section VII, Subsection A & B)

Implementation Strategy

Strategy 1. The State employs HCBS case managers who provide HCBS case management full time and assist TPMs in learning about, applying for, accessing, and maintaining HCBS. The State requires all newly hired HCBS case managers to complete a comprehensive standardized training curriculum that has been developed within the first three (3) months of employment. The State also provides ongoing training and professional development opportunities to include cultural awareness training for special populations to ensure a high-quality trained case management workforce. The State continues to work with Tribal stakeholders to identify local experts in Native American cultural competency to develop and deliver training for HCBS case managers. Post-training evaluation tools to ensure understanding of training objectives have been developed. (Ongoing strategy)

Updated Strategy 2. To ensure that all Medicaid-eligible individuals, including those applying for Developmental Disability (DD) services through the DD intake system, have access to information about all HCBS options for which they may qualify. The DD Section will continue to inform eligible individuals about the State's HCBS coverage during the initial DD intake. Information will also be provided annually thereafter. The DD intake process includes new materials outlining the full range of HCBS programs administered by the DD Section, the 1915(i) waiver, Aging Services, Medicaid State Plan, and other DHHS services. If a TPM seeks more information about the services administered by Adult and Aging Services, the DDPM conducting the intake will connect that individual to the ADRL team, who will provide additional details and start the intake process. Additionally, the DD Section updated the case management system to integrate this information into the intake process. A section was also added to the DD individual service plan for individuals and guardians to sign, confirming receipt of this information.

The DD section will conduct statewide case file reviews quarterly based on a statistical sample of cases to ensure that individuals are receiving information about the State's full range of HCBS programs and Medicaid State Plan services as measured by the presence of a signed individual service plan indicating the receipt of this information. (Ongoing Strategy)

Updated Strategy 3. The volume of ADRL referrals, visit requests, and interest in HCBS in general remains high. The State has twice increased the number of case managers available to serve this population and is requesting to hire ten (10) additional case managers in the first year of the 2027-2029 biennium. Additional staff are needed as caseloads continue to increase and individuals have more complex needs. HCBS Case Managers increasingly have weekly contact with individuals who require a higher level of case management due to complex physical and behavioral health needs.

The goal is to have a weighted caseload of no more than 100 cases per case manager and continue to ensure a sufficient number of HCBS case managers are available to serve TPMs. The State assigns caseloads to individual HCBS case managers based on a point system that calculates caseload by considering the complexity of case and travel time necessary to conduct home visits. The State completes a monthly review of

statewide caseloads to determine capacity and ensure enough HCBS case managers are available to serve TPMs. (Ongoing strategy)

Strategy 4. The State has two (2) FTE that serve as provider navigators who will assist all HCBS case managers statewide in finding QSPs to serve eligible HCBS recipients. Assistance from the provider navigators frees up time for the case managers and assists them in keeping up with the increased demand for HCBS. (Ongoing strategy)

Updated Strategy 5. The State has established a workgroup consisting of HCBS Case Management Supervisors, HCBS Case Managers, and Aging Services Program Administrators to analyze the business processes and workflows related to the case management system. The workgroup continues to identify tasks within the case management process that can be delegated to administrative support staff, allowing HCBS Case Managers to spend more time on client-facing responsibilities.

The DHHS mailroom is currently providing administrative support for three (3) of the eight (8) case management territories. The Department plans to determine the additional staffing needed to expand this support to the remaining territories. (Target completion date March 31, 2027)

New Strategy 6. To further reduce case management workloads, the State is considering updating the HCBS intake process to require individuals interested in services to provide proof of income during intake when it is not clear that they are likely to qualify for state or federally funded programs or they refuse to provide information about their finances. Once documentation is received indicating the individual is likely to meet the financial eligibility requirements, an HCBS Case Manager would be assigned to complete a home visit. Individuals who are already enrolled in Medicaid, receive Supplemental Security Income, or have other verified financial eligibility would not be required to submit additional documentation.

The intent of this strategy is to prevent unnecessary travel for home visits when individuals ultimately do not meet the financial eligibility requirements for services. (Target completion date December 31, 2026, and ongoing)

New Strategy 7. The State is taking the necessary regulatory steps to allow Aging Services to complete six (6)-month reassessments virtually when only emergency response services, homemaker services, home-delivered meals, companionship, and/or non-medical transportation under the SPED and Ex-SPED programs are authorized. This flexibility would apply whether these services are authorized individually or in combination. This change will help reduce case managers' travel time while continuing to ensure regular contact with the individuals receiving services. In-person visits will continue to be conducted for the initial assessment, the annual reassessment, and whenever the individual requests one or experiences a change in condition that requires an update to their PCP. The State also plans to request this same flexibility as part of the upcoming HCBS waiver renewal submitted to CMS. (Target completion date April 1, 2027, and ongoing)

Strategy 8. The State has requested Federal Medical Assistance Percentage funds (FMAP) from CMS to cover the cost of providing case management to Medicaid-eligible individuals receiving Medicaid HCBS. A Medicaid waiver amendment to make this change was approved. This shift is expected to increase federal funding, which may be used to hire additional case managers and potentially support staff to meet the growing demand for these services. (Waiting for final CMS approval, will be an ongoing strategy)

Full Access (Section VII, Subsection C)

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

Updated Strategy 2. Conduct training with hospital and SNF staff to discuss HCBS, LTSS OC, facilitate case management for TPMs, and the required annual level of care screening. The training will be adjusted over time to reflect further changes to the Nursing Facility Level of Care (NF LoC) process and to address any emergent issues and may be provided virtually. The continued focus will be to help these entities understand the need to make referrals as soon as possible to facilitate safe discharge and access HCBS the first day they return home. Training will be held at least biannually until the end of the Settlement Agreement. One (1) of the training courses will be held virtually. (Target completion date June 14, 2027)

Section VII. Performance Measure(s)

Total number of HCBS case managers serving Tribal nations.

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

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

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

SA Section VIII. Person-Centered Plans – Deleted

Responsible Division(s)

DHHS Aging Services

Responsible Division(s)

DHHS Adults and Aging Services

QSP Hub (Section IX, Subsection A)

Implementation Strategy

Updated Strategy 1. Continued access requires an adequate number of providers willing to provide care across the State**.** The State will continue to use MFP capacity building funds to maintain the work of the QSP Hub operated by the Center for Rural Health at UND. The QSP Hub assists TPMs who choose their own individual QSPs to successfully recruit, manage, supervise, and retain QSPs. The QSP Hub will also help TPMs to understand the full scope of available services and the varying requirements for enrollment, service authorization, and interaction with HCBS case management.

The majority of newly enrolled QSPs received technical assistance through the QSP Hub to support the enrollment process. The QSP Hub also fields hundreds of calls from QSPs, reducing the number of provider inquiries previously handled by HCBS Case Managers and QSP Enrollment staff.

The QSP Hub's workplan will be updated to include additional responsibilities related to provider enrollment. QSP Hub staff will have the authority and access to the systems needed to assist providers in not only understanding but completing enrollment requirements. Once the QSP Hub determines that a provider’s application is complete, they will notify enrollment staff, who will complete the remaining steps required to meet State and Federal provider standards and issue a QSP number.

After a QSP number is assigned, QSP Hub staff will contact the provider to conduct an orientation and provide ongoing technical assistance as needed. (Target implementation date October 1, 2026, and ongoing)

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

staff to ensure the providers' safety. MFP Rebalancing funds are now used for this fund. (Ongoing strategy)

Updated Strategy 3. Provide behavior intervention consultation and support to direct service providers. The State is aware that oftentimes it is difficult to find HCBS providers who can, and will, serve clients with behavioral health needs. Strategies to increase these services could include establishing resources for QSPs and other HCBS providers to access that would create behavior intervention plans, helping staff with high need/high complexity cases and offering consultation to in-home providers as needed. The State worked with the Behavioral Health Division to identify providers in ND who already provide this service. Two provider agreements have been established with qualified entities and training was conducted with the HCBS Case Managers, Transition Coordinators, so they know how to access these services. HCBS Case Managers make QSPs aware of this service during PCP (Ongoing Strategy)

Updated Strategy 4. Aging Services staff are working with the Behavioral Health Division and the State Hospital to streamline transitions and improve working relationships and expectations of the role that the behavioral health community has in ensuring the health and welfare of transitions involving TPMs with co-occurring behavioral health and substance use disorders. After many years of collaboration, the group decided that the behavioral health or state hospital staff will follow the regular process of contacting the ADRL if they have a referral for transition. Interdisciplinary staffing occurs every week and the team uses these meetings to discuss transition cases. (Ongoing Strategy to collaborate with behavioral health community)

Updated Strategy 5. The State worked with behavioral health subject matter experts to create a process for community support and residential habilitation agency QSPs to earn a behavioral health endorsement as part of QSP enrollment. The endorsement is earned after agency leadership, i.e. owners, registered nurses, field staff supervisors complete specialized training that will provide them with additional skills to help support TPMs with behavioral health needs. Training has been provided and includes de-escalation, positive behavioral support, trauma, and trauma informed care, crisis support, and personal protection skills. The State offered grant opportunities to pay the costs of sending agency staff to attend the training. This educational opportunity is based on a trainer model, so the leaders of these organizations have the capacity to train their field staff. Recertification training has also been held to ensure providers can maintain the skills they learned during the training. (Ongoing strategy)

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

Mobile crisis services are available statewide, and they are available 24 hours 7 days a week. The mobile crisis unit acts as an intake system to determine if an in-person assessment is necessary to help resolve a behavioral health crisis. Response could include one or more overnight stays at the local crisis unit or admission to the State

hospital. Services include withdrawal management, supportive therapy, and referrals to needed services.

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

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

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

Updated Strategy 7. The State intends to convert every Regional Human Service Center to become a Certified Community Behavioral Health Clinic (CCBHC). Four are actively working to become certified. This model is designed to ensure access to comprehensive behavioral health care. CCBHCs are required to serve anyone who requests mental health or substance use treatment, regardless of their ability to pay, where they reside, or age. CCBHCs are required to get people into care quickly and must provide: 24/7 crisis services, comprehensive services that reduce the need for multiple providers, and care coordination to help people navigate health care, social services, and other systems. The Behavioral Health Division will be requesting legislative authority to achieve state certification for the four (4) remaining clinics. (Ongoing Strategy)

Right to Appeal (Section IX, Subsection B)

Updated Implementation Strategy

Strategy 1. TPMs cannot be categorically or informally denied services. Policy requires HCBS case managers to make formal requests for services or reasonable modification requests when there are unmet service needs necessary to support a TPM in the most integrated setting appropriate. All such requests and appeals must be documented in the PCP. TPM and HCBS applicants are made aware of the right to appeal any decision to deny/terminate/reduce services by maintaining information in the Application for Services form, and the "HCBS Rights and Responsibilities" brochure. (Ongoing strategy)

Strategy 2. HCBS policy includes the process of requesting reasonable modification for review and consideration. Some requests for reasonable modification may conflict with the ND Nurse Practices Act, N.D. Cent. Code § 43-12.1. The State will continue to meet with the Board of Nursing to review all medically related reasonable accommodations to review trends and make recommendations for policy or legislative changes that will allow more TPMs to live at home and receive necessary healthcare. (Ongoing strategy)

Strategy 3. The State will track all requests for reasonable modification to identify trends in service gaps, location, utilization, or provider capacity. Reports are reviewed at a quarterly meeting attended by all DHHS Divisions that administer HCBS. Strategies to address identified issues will be established and included in future revisions of the IP. (Ongoing Strategy)

Section IX. Performance Measure(s)

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

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

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

SA Section X. Information Screening and Diversion – Deleted

SA Section XI. Transition Services

Responsible Division(s)

DHHS Aging Services

MFP and Transitions (Section XI, Subsection A)

Implementation Strategy

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

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

and learn how to access community resources. TPMs also have access to nurse assessments and back-up nursing services.

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

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

- Continue to evaluate the current capacity of the MFP transition coordinators in Bismarck, Grand Forks, Minot, and Fargo to determine if additional FTEs are needed. If the State determines there is a need, the State will request funds in future MFP budgets which requires approval from CMS.

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

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

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

Transition Teams (Section XI, Subsection B)

Updated Implementation Strategy

Strategy 1. To ensure TPMs have the support necessary to safely return to an integrated setting, the HCBS case manager, MFP transition coordinator, and housing facilitator (if applicable) will work as a team to develop a PCP that addresses the needs of the TPM including a risk assessment.

Once a TPM is identified through the LTSS OC referral process or other in-reach strategy, the MFP transition coordinator will meet with the TPM to explain MFP and the transition planning process. Within five (5) business days of the original referral an HCBS case manager is assigned, and the team must meet within 14 business days to begin to develop a PCP. The MFP transition coordinator is responsible for continuing to provide transition support and identify the discharge date. Once the TPM is successfully discharged, the MFP transition coordinator continues to follow the TPM for up to one (1) year post discharge. The HCBS case manager also provides ongoing case management assistance.

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

Strategy 2. The State will continue to require that transitions that have been pending (pending means from date of signed consent) for more than 90 days are reported to the MFP program administrator. The MFP State staff will facilitate a team meeting to staff the situation with the transition coordinator, HCBS case manager, and housing facilitator and provide more intensive attention to the situation to remediate identified barriers preventing timely transition. Transitions that have been pending for more than 90 days are also reported to the DOJ and SME. The Agreement Coordinator will be responsible for securely forwarding a list of the names of TPMs whose transition has been pending for more than 90 days. The report will include a description of the circumstance surrounding the length of the transition. The State currently tracks the days from signed consent to transition. (Ongoing strategy)

Updated Strategy 3. The State will continue to conduct a quarterly review of all transitions to identify effective strategies that led to successful and timely transitions, trends that slowed transitions, and gaps in services necessary to successfully support TPMs in the community. The State identified the following issues to be the top 10 barriers to TPMs accessing community living. TPMs may have barriers in multiple areas. TPMs may have other barriers like behavioral health needs but this list includes the need that is causing the barrier. (Ongoing strategy)

Jan – Jun 2026 Top 10 Barriers to Transition	**Number of**
TPMs on 90+ day Active Transition List	**TPMs**
Needs Housing Voucher	11
Accessible Unit	8
Specialized Equipment	8
Housing Modifications	7
Provider Needed	7
Credit Issues	5
Eviction	2
Lacks Identifying Documents	3
24/7 Provider Needed	3
Needs Traditional Medicaid	3
Lacks Income	2

Transition Services (Section XI, Subsection C)

Implementation Strategy

Updated Strategy 1. Recent changes to HUD rules and other challenges have made accessing federal housing assistance increasingly difficult, highlighting the growing importance of State-funded housing resources. To maximize the use of federal rental assistance, the State requested to use MFP supplemental services funding to cover rent for TPMs for up to six (6) months. If further support is needed beyond this period, State-funded rental assistance will cover the remaining costs. This strategy, approved by CMS, requires the development of an individualized housing plan. Additionally, a TPM rental payment agreement must be signed to ensure TPMs understand their responsibility for paying their portion of the rent. This agreement clarifies program expectations and helps TPMs better understand the MFP benefits they receive. The State tracks the number of TPMs who receive State or Federally funded rental assistance. The goal of this strategy is to reduce the number of TPMs waiting for affordable and accessible housing and to decrease the number of days it takes to transition. (Completed April 22, 2026, and ongoing)

Updated Strategy 2. To address the barrier of TPMs not receiving the correct durable medical equipment (DME) upon discharge from a SNF, the State is collaborating with facilities to implement a targeted solution. Certain aspects of discharge planning are best managed by facility staff, including securing the necessary doctor’s orders for DME to ensure the TPM’s safety after discharge. However, delays often occur when facilities do not promptly order the equipment or fail to submit insurance claims in a timely manner.

To improve MFP staff's understanding of the DME process and strengthen their ability to advocate for needed equipment, the Medical Services Program Administrator for DME will continue providing training to transition team members and SNF staff. MFP staff have received guidance on DME eligibility and authorization requirements and have been encouraged to contact the Program Administrator directly if they encounter issues with DME approvals.

The MFP team will also develop a tip sheet and checklist for Transition Coordinators to share with physicians and therapists when ordering equipment for individuals transitioning to the community. This document will help ensure the appropriate equipment is ordered in a timely manner, reduce delays in discharge, and ensure Medicaid funding is explored as the primary payment source whenever appropriate. (Target completion date December 31, 2026, and ongoing strategy)

Updated Strategy 3. Transition teams sometimes have questions about whether a TPM has the capacity to consent to receiving MFP transition support. When this situation occurs the transition team contacts facility staff to discuss the case and sends a letter to the SNF as required to determine whether any advance directives are in place and to understand how the TPM consented to care upon admission to the facility.

In some cases, the TPM has a legal decision-maker who does not support the individual's transition plan. The transition team uses a person-centered approach to mediate conflicts. When a guardian has legal authority to make decisions regarding the individual's healthcare and residence, the guardian's consent is required for the transition to occur. If necessary, a neutral third party may be involved to help facilitate resolution.

In other cases, a question of capacity exists but the TPM does not have a legal decision-maker and is legally able to consent to transition. However, barriers may still exist. For example, securing housing can be difficult if landlords are reluctant to rent to an individual they believe may not understand the legal obligations of signing a lease. In addition, a transition may be delayed while the TPM is awaiting formal capacity determination.

To address these issues, the State plans to collaborate with the Office of Guardianship and Conservatorship, Legal Services of ND, Protection and Advocacy, and other stakeholders to explore potential solutions. These may include identifying neutral mediators, training peer supporters to serve as supported decision-making resources, and developing educational materials to help TPMs understand their rights to make their own decisions and the steps they can take if they believe their guardian is not respecting their needs and preferences.

The State will track stakeholder meetings and document recommendations to inform future implementation strategies that will be incorporated into the IP. The State will also develop educational materials and track the number of TPMs who receive assistance advocating for their right to live in the community, as well as the outcomes of mediation or peer support efforts that result in successful transitions. (Workgroup established target completion date December 31, 2026)

Strategy 4. To address credit and personal finance barriers due to not paying bills, bad debt, and difficulty budgeting money. TPMs who have this issue listed as a barrier and have the capacity to participate in a training course will be referred to take the SmartwithMyMoney.nd.gov program. This free website allows individuals to create an account, take a research-based financial personality assessment, and learn how their personality affects their money decisions. The program also seeks to improve financial knowledge by providing information on key topics designed to help people make sound financial decisions. The site offers personalized learning resources to improve financial literacy. The State will track the number of TPMs who complete the training and then become eligible to get assistance with paying their previous debt to remove the barrier. (Ongoing strategy)

Updated Strategy 5. To address the barrier of missing essential documents such as a State identifying document (ID) or birth certificate required for federal housing and other assistance, the Housing Facilitation Referral assessment will now ask if they have a valid ID, birth certificate, and proof of citizenship status at the outset of involvement. If any documents are missing, Housing Facilitators and Transition Coordinators will immediately begin assisting them in obtaining these, reducing the chance of transition

delays. It is interesting to note that documentation is not required to enter SNF but is required to access housing supports and HCBS. Therefore, SNF have no need to gather these types of documents upon admission. (Ongoing strategy)

Updated Strategy 6. Deciding to move from a SNF and back into the community is a significant decision. Some TPMs have not lived independently, managed a household, or been responsible for tasks like paying bills, buying groceries, or maintaining utilities for a very long time. Additionally, TPMs might worry about accessing necessary care and living without 24-hour in-person support, even if they no longer require that level of care. These concerns can lead to hesitation or uncertainty about transitioning, and it may take time for them to fully consent to a move.

Some TPMs may struggle to identify exactly what's holding them back from setting a transition date and may benefit from talking to individuals with lived experience who can guide them through the process. All TPMs are offered peer support but not many TPMs take advantage of this service. To address this issue, the State started a pilot program in the Northwest quadrant where peer supports are assigned to the team from the start of the transition process. Individuals in that area can opt out of peer support, if desired, otherwise the peer support specialist will attend team meetings and engage and follow the individual through the transition process as well as post-transition. The State will track the number of TPMs who are using peer support and if the service helped them come to a decision about transition. (Ongoing Strategy)

Transition Goal (Section XI, Subsection D)

Updated Implementation Strategy

Updated Strategy 1. By December 13, 2026, through increased awareness, including in-reach and outreach efforts, person-centered planning, risk planning and ongoing monitoring and assistance, the State will use local, State, and Federally funded HCBS and supports to assist at least 70% of the TPMs who sign informed consent forms to transition to the most integrated setting appropriate for their needs. In addition, the State will review those who have consented to transition on the final day of each Settlement Agreement year. The total number of signed informed consent forms will be noted with the number of people who have transitioned and those still waiting as of that date each year.

By March 13, 2027, the State will review its IP to see if it needs updates to transition 75% of TPMs who have signed consent as of December 13, 2026.

By June 13, 2027, 75% of all TPMs who between the effective date of the SA and December 14, 2026, have signed informed consent. This includes TPMs on both the active and pending 90+day reports. (Ongoing Strategy)

Strategy 2: A barrier to community living for some TPMs is the difficulty of securing enough direct support staff, particularly when their physical needs require more than two (2) caregivers to ensure safety during intermittent care that is needed throughout

the day. To address this issue, the State will authorize assistive technology assessments to determine if equipment could reduce the need for human assistance. Additionally, the State is exploring remote monitoring solutions to potentially decrease reliance on multiple caregivers, offering TPMs more care options and greater independence. (Ongoing strategy)

Updated Strategy 3. The QSP Hub will complete a provider survey annually. The State will work with the QSP Hub and the lead UND researcher to develop a QSP capacity survey. The survey will try to determine the ability of current providers to staff their currently authorized hours, ability to staff increased hours, and capacity to serve additional clients. The State will continue to use the information from the study to develop recruitment and retention strategies that appeal to what QSPs said they like about providing direct care, i.e. ability to help others and job flexibility. (Target completion date December 13, 2026)

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

Section XI. Performance Measure(s)

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

Transition 70% of those requesting transition, who have consented, and are eligible by the end of Year six (6).

Number of referrals for peer support, outcome(s), and satisfaction survey information.

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

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

SA Section XII. Housing Services

Responsible Division(s)

DHHS

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

Implementation Strategy

Strategy 1. Connect TPMs to integrated community housing with community supports whose PCP identifies a need for PSH or housing that SME agrees otherwise meets requirements of 28 C.F.R. § 35.130(d). If the State wishes to count a transition to an Agency Adult Foster Care or other disability-specific residential setting toward its transition benchmarks, it will submit documentation supporting the request to the SME for review and approval. (Ongoing strategy)

Challenges to Implementation

In the first half of 2026, accessible and affordable housing is the number one (1) barrier for TPMs awaiting transition in some areas of the state. Consistent gathering of data from multiple points of system entry has helped the State to better understand the barriers to accessing integrated community housing.

Remediation

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

Strategy 2. When landlords notify Housing Facilitators about an available accessible apartment for rent, the facilitators will begin tracking this information to match available housing with TPMs waiting to transition. The total number of accessible units will be reported in both the MFP and USDOJ semiannual reports. This tracking helps pinpoint unit locations, fosters stronger relationships with landlords, and enables Housing Facilitators to efficiently connect TPMs and MFP recipients with suitable housing options. (Ongoing strategy)

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

Permanent Supported Housing (Section XII, Subsection C & D)

Implementation Strategy

Expand permanent supported housing capacity by funding and providing rental subsidies for use as permanent supported housing. The State will provide rental assistance with $300,000 appropriated during the 2025-2027 Legislative session. The $300,000 will be included in the 2027-2029 Aging Services base budget. TPMs will pay no more than 30% of their monthly adjusted income. (Ongoing Strategy)

Housing Support Resources (Section XII, Subsection E)

Implementation Strategy

Updated Strategy 1. Individuals who enter a nursing home for a short-term stay and intend to return to the community must take certain steps to prevent their home from being counted as an asset when determining Medicaid eligibility.

To help with this process, the State developed a brochure for use by the LTSS options counselors, eligibility workers, landlords, discharge planners, and housing support professionals. The brochure explains the HUD and Medicaid requirements related to temporarily leaving a housing unit and provides guidance on how TPMs can maintain their housing while they are in a nursing facility.

State staff are also trained to ask TPMs or their legal decision-makers whether they have the necessary documentation to maintain their housing assistance and Medicaid eligibility during their temporary institutional stay. (Ongoing Strategy)

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

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

When an environmental modification project is approved for an eligible individual and no provider is available, the State's designated assistive technology provider, a local non-profit organization and Agency QSP, will act as the intermediary. They will subcontract the work and pay contractors in installments using this fund. The non-profit will oversee project completion, manage payments through the Medicaid Management Information System (MMIS) and receive an overhead fee for managing the project. Once the overhead fee is deducted, the remaining funds will be returned to the pool for future use. If the eligible individual passes away or the project is not completed, the fund will bear the cost. The MFP Program Administrator will oversee this contract to ensure the proper use of funds and that they are returned upon project completion. The goal of this initiative is to help more TPMs remain in their homes by making them safe and accessible for necessary care. (Ongoing Strategy)

Strategy 3. The State has developed a Supported Housing Services Collaborative made up of housing and community service providers, DHHS staff, and the State Housing Finance agency. The Collaborative established the following goals and is creating action steps to mitigate barriers to effective housing supports that allow eligible populations to access community integrated housing. This process will include defining challenges to implementation. (Ongoing Strategy)

Goal #1: Ensure that Target Population Members receive housing supports identified in Person Centered Plans that are designed to support a transition to and success living in the community.

Goal #2: Increase access to existing affordable and accessible rental units through policy change and relationship development.

Goal #3: Increase Permanent Supported Housing opportunities for TPMs by expanding capacity through rental housing development and rental subsidies.

Goal #4: Ensure housing specialists have access to updated housing availability options.

Goal #5: Placements to housing should be consistent with settings as defined as Permanent Supported Housing in the Settlement Agreement.

Goal #6: Notify the SME prior to transition of any recommended placements to settings other than Permanent Supported Housing for review of the transition plan.

Updated Strategy 4. The rules governing HUD Mainstream Vouchers have changed. It is now possible for anyone with a disability under age 62 years in America to request a housing voucher from the ND Housing Authorities. To ensure that Mainstream Vouchers remain available for TPMs in North Dakota, the State is working with seven (7) of the state's eight (8) housing authorities to update their policies and establish MOUs. These agreements create a priority process for eligible residents and establish a separate waiting list for Mainstream Vouchers.

MOUs have been finalized with the Great Plains, Grand Forks, Minot, Williston, Burleigh, and Cass County Housing Authority (which also serves Stark County). The Fargo Housing Authority has not signed a MOU because they do not have any available vouchers. The waitlist in that area is very long. (MOUs in effect until December 31, 2027)

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

Housing Specialist Training (Section XII, Subsection F)

Implementation Strategy

Housing Specialists will receive in-person training on federal laws that prohibit housing discrimination against individuals with disabilities, with a particular emphasis on the Fair Housing Act and Title II of the ADA, and the Agreement's requirements. Training is done annually with Fair Housing of ND and the ND Department of Labor. All Housing Coordinators are required to attend. (Ongoing strategy)

Housing Specialists (Section XII, Subsection G)

Implementation Strategy

The strategies included in the Housing Services Section Subsection B-E also apply to Subsection G.

Section XII Performance Measure(s)

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

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

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

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

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

Number of environmental modifications completed using rebalancing funds.

Increase in the total number of environmental modification projects.

Decrease in the number of days it takes to complete environmental modification projects.

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

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

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

SA Section XIII. Community Provider Capacity and Training

Responsible Division(s)

DHHS Aging Services and Medical Services

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

Adequate Supply of QSPs (Section XIII, Subsection A)

Implementation Strategy

Updated Strategy 1. Continue to use MFP capacity building funds and rebalancing funds for the QSP Hub. The QSP Hub assists and supports Individual and Agency QSPs and family caregivers providing paid and natural supports to the citizens of ND. Expand QSP Hub's employees' access to the QSP Portal so they can provide technical assistance and assist applicants to enroll as a QSP. (Ongoing strategy funded through December 2027)

The primary goals of the QSP Hub are to:

- Provide one-on-one individualized support via email, phone, and/or video conferencing to assist with enrollment and reenrollment, EVV, billing, and business operations to recruit and retain a sufficient number of QSPs. This includes the development of technical assistance tools such as user guides that will be available in multiple languages. All technical assistance tools have been updated to reflect the new QSP application portal enrollment process. This also includes the ability to make updates to the applicant and providers records in the QSP Portal to support ever changing federal regulations.

- Create and maintain accessible, dynamic, education and training opportunities based on the needs of the individual QSPs, QSP agencies, Native American communities, and family caregivers providing natural support services. This may include training to improve the business acumen of providers.

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

- Develop an informational support network for QSPs including developing a website, listserv, and avenues for QSPs to support one another.

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

- Establish and implement QSP agency recruitment initiatives.

- Through an increased role in the QSP enrollment and revalidation process use access to the QSP Portal to assist applicants to submit a complete application and send it to the provider enrolment team to finalize and issue a QSP number.

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

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

Strategy 2. QSP agencies requesting training need support in business acumen, particularly in managing the claims process, followed by marketing services and staff management. To meet these needs, the State will collaborate with the QSP Hub to provide the requested training. The QSP Hub has produced service-specific claims videos that guide users through each step of service authorization and claims submission, aimed at helping new users get started after enrollment. Additionally, the State will continue to involve Medical Services claims staff and the billing system vendor to offer comprehensive claims training. (Ongoing strategy funded through December 2027)

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

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

Updated Strategy 3. Continue operating the online provider enrollment portal for agency and individual QSPs. The system is used for initial QSP enrollment, provider revalidation, and maintenance of provider and service array information.

Effective September 1, 2026, Aging Services will assume responsibility for enrolling and revalidating QSPs. To support this transition, the current enrollment staff housed within Medical Services will become Aging Services employees. Effective October 1, 2026, the QSP Hub's responsibilities will expand to include increased access to the QSP Portal functionality so they can better help the agency and individual QSPs that call the Hub to complete and submit a valid application. The QSP Hub team will have the ability to upload documents, adjust service territories, and make changes to the providers' service area. This will eliminate the need to get the enrollment team involved and many issues can be resolved quickly over the phone. (Ongoing strategy)

Intended Outcome: Complete enrollment and revalidation of completed individual and agency QSP applications within an average of 14 days after submission of a complete application.

Data: The State will use enrollment data to track the average enrollment and revalidation dates from the QSP Enrollment Portal to assure timeliness in processing.

Strategy 4. Continue to maintain the centralized QSP matching portal in cooperation with ADvancing States. The new system was designed with State-specific modifications to a national website called Connect to Care formally referred to as ConnecttoCareJobs to significantly improve the capacity of TPMs in need of community services to evaluate and select individual and agency QSPs with the skills that best match their support needs.

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

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

Intended Outcome: QSPs will be able to effectively use the system to market their services to HCBS recipients and the public thus increasing access to HCBS and reducing the number of providers requesting referral and marketing assistance from the QSP Hub.

Data: The State will track the number of QSPs using the system that choose to update their provider profile as a way of marketing their services. The QSP Hub will track the number of calls they receive regarding a lack of referrals and marketing experience.

Strategy 5. To facilitate timely transitions for TPMs who live in areas where QSPs are hard to find, the State will support TPMs or their chosen QSP agency in using targeted marketing strategies to recruit staff. Funding will be made available to create job descriptions and post advertisements on social media and other platforms, highlighting specific individuals' needs. TPMs can choose to include details about the type of care required or the specific qualities they are seeking in a provider. This personalized approach aims to attract applicants motivated by a desire to help others and support individuals with disabilities in community living. (Ongoing strategy)

Intended Outcome: Recruit individuals willing to enroll as a QSP and provide care to TPMs waiting to transition due to a lack of available providers or staff in their chosen community. Reduce the number of TPMs waiting for a provider to facilitate their transition from a SNF to the community, and decrease the total time required to complete TPM transitions.

Data: The State will track the number of providers recruited the number of TPMs who ultimately transitioned home, and the number of days to transition in

situations where this marketing strategy was used.

Updated Strategy 6. To continue to ensure timely enrollment and revalidation of QSPs, the State will transition the responsibility for QSP enrollment duties from Medical Services to Aging Services. Three (3) temporary QSP enrollment staff and one full-time QSP Enrollment Coordinator will become Aging employees on September 1, 2026. These staff use the QSP portal to complete the federally required enrollment functions and the QSP Hub will be responsible for assisting applicants and providers to gather the necessary information and documentation to submit a complete application. QSP enrollment staff are still responsible for managing the Connect to Care QSP registry, which interfaces with the QSP portal to ensure provider's information is accurate and up to date. The QSP enrollment staff will also use the system to process provider revalidations and manage provider data. (Transition completion date October 1, 2026, and ongoing strategy)

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

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

Updated Strategy 7. Finalize the project to implement the new HCBS Core Curriculum training modules that will be required for direct care staff serving individuals in Aging Services, Developmental Disabilities Services, and Autism Services. The vision of the project is to establish innovative workforce training strategies that meet provider needs and improve the quality of life for North Dakotans with disabilities.

The goals of the project are to:

- Identify and address the needs of providers and caregivers.
- Improve the quality of training by establishing standardized training protocols that remain with individual direct care providers as they change employers or serve different populations.
- Establish consistent training policies and procedures across Aging Services, Developmental Disabilities Services, and Autism Services.
- Identify and maintain core HCBS competencies required of all direct care providers.
- Improve collaboration and coordination among state agencies and stakeholders.

The State has adopted the HCBS Core Curriculum developed by the University of Wisconsin–Green Bay. Direct care staff serving any of the populations listed above are required to complete the core curriculum upon enrollment and every three (3) years thereafter. Providers with substantiated complaints or critical incidents may also be required to complete specific training modules as part of a remediation plan. (DD and

Medical Services implemented training requirements August 1, 2026, Aging Services target implementation date is January 1, 2027)

> Intended Outcome: Increase access to HCBS by simplifying the training requirements needed to enroll as a provider serving multiple populations.
>
> Data: Track the number of providers trained and enrolled to provide care across various populations, including Aging Services, Developmental Disabilities, and Behavioral Health.

Strategy 8. Increase the capacity for providers to serve TPMs on Native American reservation communities by continuing to partner with Tribal nations and to request funds for the Money Follows the Person-Tribal Initiative (MFP-TI).

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

The State will continue to support the development and success of Tribal entities who enroll as QSPs to provide HCBS in reservation communities by gathering feedback to improve processes, providing technical assistance and training, and staffing cases to ensure TPMs have the services they need to live in the most integrated settings appropriate. Three (3) of the five (5) tribal nations in ND are participating in this initiative. Spirit Lake does not participate in the grant but has already created their own QSP agency. Mandan, Hidatsa, Arikara Nation; Standing Rock Sioux Tribe; and Turtle Mountain Band of Chippewa Indians are currently participating in the grant.

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

Updated Strategy 9. The State was granted an extension by CMS to continue to use the temporary 10% increase to the FMAP fund for certain Medicaid expenditures for HCBS to enhance, expand and strengthen the HCBS system for TPMs. (Ongoing strategy through December 2026)

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

- Peer Support project for TPMs
- ConnecttoCareND Learning Management System (LMS) implementation
- QSP Enrollment Portal
- Marketing the ADRL
- Workforce training and LMS integration

- Behavioral health training for HCBS case managers and QSPs

Critical Incident Reporting (Section XIII, Subsection B)

Updated Implementation Strategy

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

Limited Grants (Section XIII, Subsection C)

Updated Implementation Strategy

If resources allow, the State will consider offering additional grants to nursing homes and other community-based providers that are willing to establish a QSP agency or expand their service area to provide care in rural and other underserved counties of ND. (Ongoing strategy)

Section XIII. Performance Measure(s)

Number of QSPs assisted by the QSP Hub.

Number of new agencies enrolled as providers.

Number of agencies that stopped providing services.

Number of new individual QSPs enrolled as providers.

Number of individual QSPs that stopped providing services.

Number of QSPs trained to Connect to Care system formally referred to as ConnecttoCareJobs by February 29, 2027.

Number of SNFs that have enrolled to provide HCBS.

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

Responsible Division(s)

DHHS Aging Services

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

Updated Strategy 1. State staff will conduct annual group in-reach presentations at every SNF in ND and ensure a consistent message is being used throughout the State. State staff will schedule and advertise a follow-up visit at the facility to give TPMs additional time to process the information and ask any additional questions. (Target complete date December 13, 2026, and ongoing)

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

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

If a TPM chooses HCBS, the LTSS Options Counselors complete an SFN 584 form, and then the ADRL staff will send the referral to the MFP transition coordinator who assembles the transition services team to begin person-centered planning. The transition team consists of the MFP transition coordinator, HCBS case manager, and a housing support specialist.

If a TPM is not initially interested in HCBS they are asked if they want to receive a follow-up visit. If they decline a follow-up visit, they are provided written information and the contact information of the case manager and are informed that Aging Services staff will make a visit on an annual basis to complete the person-centered planning process. TPMs are currently asked to indicate in writing whether they received information on HCBS.

TPMs will be seen by the facility case manager/ LTSS Options Counselor when initially referred for a long-term stay in a SNF. Current TPMs living in a SNF will be seen annually in the month in which they were originally admitted to the SNF. (Ongoing strategy)

Stakeholder Outreach (Section XIV, Subsection B)

Implementation Strategy

Continue to implement a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. The campaign will include marketing on social media at least three (3) times in Year Six (6) and Year Seven (7) of the SA and will provide public education to the public, professionals, stakeholders, and TPMs at serious risk of entering nursing facilities. The campaign will also include providing education to those parties that recommend SNF care to TPMs. This includes health care

professionals/staff who are most likely to be in regular contact with TPMs and potential TPMs prior to requests or applications for SNF admissions, such as geriatricians and primary care physicians serving a significant number of elders. State staff will also staff information booths at community events and will make themselves available for media requests and to present information about HCBS at stakeholder meetings and virtual and in-person conferences across the State. (Ongoing strategy through December 13, 2027)

Please see Section VI, Subsection E, for additional stakeholder outreach strategies.

Accessible Documents (Section XIV, Subsection C)

Updated Implementation Strategy

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

The State has made considerable progress in this area and has removed non-accessible publications from its website. (Ongoing strategy)

Section XIV. Performance Measure(s)

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

SA Section XV. Data Collection and Reporting

Responsible Division(s)

DHHS Aging Services

Methods for Collecting Data (Section XV, Subsections A, B, & C)

Implementation strategy

Strategy 1. Provide the USDOJ and SME biannual reports containing data according to the SA that addresses the status of the State's compliance. The State will also provide final data dashboards as required in the SA. The State will retain all data collected pursuant to this SA and make it available to the USDOJ and SME upon request. The State will retrieve summary and aggregate data from a variety of sources including the case management system, MMIS data warehouse, and provider enrollment.

Updated Strategy 2. The State will continue to improve and revise its data collection efforts and will maintain a set of Key Performance Indicators on the Department's

website to illustrate the State's progress and challenges implementing the ND USDOJ SA. Key Performance Indicators are reported quarterly. (Ongoing strategy)

Key performance indicators include:

1. Referrals to HCBS
2. Average weighted HCBS case management caseloads.
3. Number of TPMs served in a Skilled Nursing Facility (SNF).
4. Number of TPMs served in the community.
5. Number of TPMs diverted from a SNF.
6. Number of TPMs transitioned from a SNF.
7. Average annual cost of HCBS and SNF care.
8. Average length of time from QSP completed application submission to enrollment.
9. Number of QSP agencies enrolled as providers.
10. Number of individual QSPs enrolled as providers.
11. Number of QSPs retained.
12. Number of TPMs who are receiving 24/7 care and the number of QSPs authorized to support 24/7 care.
13. Number of unduplicated individuals receiving HCBS.
14. Number of QSPs by county; indicate tribal, rural and frontier.

Section XV. Performance Measure(s)

Number of individuals served under HCBS.

SA Section XVI. Quality Assurance and Risk Management

Responsible Division(s)

DHHS Aging Services and Medical Services

Updated Implementation Strategy

Critical Incidents (Section XVI, Subsections A & B, page 24)

Implementation Strategy

Updated Strategy 1. The State will submit quarterly summary data to the USDOJ and SME as required in the SA. The following incidents will be included in the report: (Ongoing strategy)

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

Strategy 2. The State will continue to provide quarterly critical incident reporting training opportunities for QSPs. The trainings are advertised by sending emails to agencies and individual QSPs and posting training dates on the QSP Hub website. The State will also utilize the help of the ND LTC Association to remind their members about reporting requirements and will provide individual training if certain QSPs show a pattern of submitting late reports.

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

Strategy 3. The DHHS Adult and Aging Services will continue to utilize a Critical Incident Reporting Team to review all critical incidents on a quarterly basis. The team reviews data to look for trends, need for increased training and education, additional services, and to ensure proper protocol has been followed. The team consists of the DHHS Aging Services Director, HCBS program administrator(s), HCBS nurse administrators, VAPS staff, LTC Ombudsmen, and the DHHS risk manager. (Ongoing strategy)

Strategy 4. The State conducts a mortality review of all deaths, except for death by natural causes, of TPMs to determine whether the quality, scope, or number of services provided to the TPM were implicated in the death. The review is conducted by the quarterly critical incident report committee. The committee review consists of a review of the reason for the death, if there was an obituary/notice of death posted, if law

enforcement was involved, and if there was an autopsy completed. Information gleaned from the review is used to identify and address gaps in the service array and inform future strategies for remediation. (Ongoing strategy)

Notice of Amendments to USDOJ and SME (Section XVI, Subsection C)

Implementation Strategy

The State will submit written notice to the USDOJ and the SME when it intends to submit an amendment to its State-funded services, Medicaid State Plan, or Medicaid waiver programs that are relevant to this SA, and provide assurances that the amendments, if adopted, will not hinder the State's compliance with this SA. (Ongoing strategy)

Section XVI Performance Measure(s)

Number and percent of Critical Incident Reports that were reported by agency and facility providers, on time.

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

Number of critical incident reports that have an associated complaint.

Number of amendments reported.