North Dakota – Department of Justice Settlement Agreement

Biannual Report
June 14, 2025 – December 13, 2025

ND Department of Human Services
Aging Services Division

Submitted

January 31, 2026

List of Acronyms

ADA – Americans with Disabilities Act
ADRL – Aging and Disability Resource Link
ARPA – American Rescue Plan Act of 2021
CAPABLE - Community Aging in Place, Advancing Better Living for Elders
CCBHC - Certified Community Behavioral Health Clinic
CM – Case Manager
CMS – Centers for Medicare and Medicaid Services
CIL – Center for Independent Living
CIR – Critical Incident Report
CQL – Council on Quality and Leadership
DD – Developmental Disabilities
DDPM – Developmental Disabilities Program Manager
DHHS – Department of Health and Human Services
DME – Durable Medical Equipment
EPCS – Extended Personal Care Services
EVV – Electronic Visit Verification
Ex-SPED – Expanded Service Payments to the Elderly and Disabled
FTE – Full Time Equivalent
FMAP – Federal Medical Assistance Percentage
HCBS – Home and Community Based Services
HCBS waiver – HCBS Medicaid waiver
HSC – Human Service Center
HSRI – Human Services Research Institute
HUD – Housing and Urban Development
ISP – Individual Service Plan
IP – Implementation Plan
LTSS OC – Long Term Services and Supports Options Counseling
LTC TCM - Long Term Care Targeted Case Management
MFCU – Medicaid Fraud Control Unit
MFP – Money Follows the Person
MFP-TI – Money Follows the Person-Tribal Initiative
MMIS – Medicaid Management Information System
MOU - Memorandum of Understanding
MSP-PC – Medicaid State Plan-Personal Care Services
NCAPPS – National Center on Advancing Person-Centered Practices and Systems
NCI – National Core Indicators
NCI-AD – National Core Indicators – Aging and Disability
ND – North Dakota
NDAC – North Dakota Administrative Code
NF LoC – Nursing Facility Level of Care
OAA – Older Americans Act
PCP – Person Centered Plan
PSH – Permanent Supported Housing
POA – Power of Attorney

QSP – Qualified Service Provider
QSP Resource Hub – Qualified Service Provider Resource Hub
SA – Settlement Agreement
SME – Subject Matter Expert
SNF – Skilled Nursing Facility
SPED – Service Payments to the Elderly and Disabled
TBI – Traumatic Brain Injury
TDP – Transition and Diversion Program
TPM – Target Population Member
UND – University of North Dakota
USDOJ – United States Department of Justice
VAPS – Vulnerable Adult Protective Services

Introduction

On December 14, 2020, the State of North Dakota (ND) entered into an eight (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 requires the State to submit biannual reports to the USDOJ and the Subject Matter Expert (SME) containing data according to the Implementation Plan (IP). The initial IP was approved on September 28, 2021, as required in the SA.

This report describes progress toward the requirements listed in Sections VI–XVI for June 14, 2025, through December 13, 2025. The report is based on the approved SA IP. All the requirements and associated strategies toward compliance that were due or are being worked on in this reporting period are included. New information is provided under the progress report heading highlighted in yellow and target dates were modified when necessary.

A reporting dashboard of the activities conducted in this reporting period are included as Appendix A – 2025 Aging Services DOJ SA Dashboard to this report. They provide statistical data and additional information about the progress that has been made toward the required benchmarks of the SA regarding Long Term Services and Supports (LTSS) Option Counseling home and community-based services (HCBS), Aging and Disability Resource Link (ADRL), transition support services, and housing to assist target population members (TPMs).

The State also posts an annual comparison dashboard (Link will be added when dashboard is finalized) that highlights the progress and data trends since the SA was signed on December 14, 2020.

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

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

- **Increase access** to community-based service options through policy, process, resources, tools, and **capacity building** efforts.
- Increase **individual awareness** about community-based service options and create **opportunities** for LTSS Options Counseling.
- Widen the **array of services** available, including more **robust housing-related supports**.

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

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

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

What We're Proud of

Major accomplishments during the second six (6) months of Year 5 (**June 14, 2025 – December 13, 2025)** of the USDOJ SA: Annual data for Year 5 is available in Appendix A.

- **Transitioned 44 TPMs** from a Skilled Nursing Facility (SNF) to integrated community housing where they can receive necessary support while enjoying the freedom and benefits of community living.

- **Diverted 147** new individuals from a SNF by providing necessary services and support so they can remain at home with their family and friends.

- Provided **information about HCBS** options through **1,019** unduplicated LTSS Options Counseling referral visits to **685** unduplicated TPMs referred for a long-term stay in a SNF.

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

    - Provided **7,982 callers** with information and assistance about HCBS and assisted another **971** through the **web intake** process**.**

    - Referred **765 individuals** from these contacts for **HCBS**, which is an average of **128** per month.

- HCBS Case Managers responded to **1,881 HCBS referrals** from all sources (ADRL intake, direct referral, MFP, LTC Eligibility Unit, and LTSS Options Counseling visits).

- Provided State or federally funded HCBS to **3,364 unduplicated** adults in this reporting period.

- Provided **permanent supported housing** assistance to **18 (MFP Rental and/or TPM Rental Assistance) TPMs** who transitioned out of a SNF.

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

conferences, and training events.

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

A Year 5 perspective

In Year 5 of the SA, demand for HCBS remained consistent. Many TPMs have significant care needs, which continues to increase workloads for case managers and State staff. A total of 3,364 individuals received HCBS during the year, including 944 TPMs, representing 28% of those served. Of these TPMs, 112 (12%) are receiving 24-hour community support or residential habilitation services.

Although this group is relatively small, it accounts for a significant portion of Medicaid waiver spending and has contributed to rising service costs. Over the past five (5) years the State has expanded access to services for individuals with lower levels of need by investing in programs that do not require a nursing facility level of care to become eligible. These services help people receive support earlier, maintain independence, and potentially avoid more intensive and costly care. As a result of these factors, the total number of TPMs, diversions, and transitions was lower this year.

Despite a small reduction in the numbers served, the weighted caseload for HCBS Case Managers was at an all-time high of 121 during this reporting period. HCBS Case Managers responded to 1,881 referrals to assess individuals requesting HCBS. On average, 157 new referrals and 79 new cases opened for HCBS each month during this reporting period. Not every individual referred is found eligible, but the case managers are required to complete an in-home assessment with everyone who requests it. The total number of referrals that resulted in an open case also declined this year, as many individuals who need assistance do not meet financial eligibility requirements or do not have a sufficient level of impairment to qualify for help paying for their care.

To build additional case management capacity, Adult and Aging Services recently hired four (4) HCBS case managers, including three (3) nurse case managers, and one (1) Basic Care case manager. Once trained, these staff will take cases from existing case managers and help reduce overall workloads.

The State also hired an additional Complaint and Grievance Administrator, added another Ombudsman, and approved the expansion of a part-time administrative position to full-time.

Despite a small decline this year the preference for in-home care remains strong and is expected to grow as the baby boomer generation ages. According to the ND State Data Center, North Dakota's 65+ population, currently about 18% of the total population, will increase by approximately 3,000 people by 2035. While a slight decline is projected between 2035 and 2045, growth in the 85+ population is expected to resume thereafter. We are serving a high number of people under HCBS while the growth in Medicaid members receiving care in SNFs is trending down. In 2021 the State reported that 2,376

Medicaid eligible individuals were receiving care in a nursing home; in 2025 that number is 2,168, a 9% decrease.

The Administration for Community Living estimates that seven (7) in 10 individuals will require long-term services and support for at least five (5) years. A primary challenge for all states is ensuring adequate funding, case management, provider capacity, program administration, and accessible, affordable housing to meet this demand. While serving individuals in the least restrictive setting (typically a private or family home) remains a top priority, it is increasingly complex due to the rising number of current and future TPMs. Because of medical complexity or a need for protective oversight, some TPMs integrated settings may be a shared living model, specifically Agency Adult Foster Care, where the services of community support and residential habilitation are provided to Medicaid eligible individuals. This setting may be most appropriate for individuals with complex medical needs.

We are still seeing a trend in serving TPMs that require care for not only physical disabilities but also complex medical and behavioral health needs. Over the past year, the State has provided free Therapeutic Options training for residential habilitation and community support providers. Participants who complete four (4) days of training earn a behavioral health certificate, enabling them to train their direct care staff and access ongoing behavioral health consultation services from Therapeutic Options. Many, but not all, agency providers completed the training; therefore, the State plans to offer it again in the first quarter of 2026.

Capacity issues continue to be a barrier for some individuals seeking to transition from a SNF. In some cases, individuals have guardians who may not support their desire to live and receive services in the community. In other situations, the transition team may question whether a person fully understands the support needed to live safely in the community. However, unless a court has determined the individual to be incompetent, the person retains the right to consent to services.

These situations can create challenges as teams work to balance an individual’s right to self-determination with their responsibility to ensure the health and safety of TPMs receiving HCBS.

The State recently hired an Executive Director for the new Guardianship and Conservatorship Office. Adult and Aging Services will collaborate with this office and other stakeholders to develop training for TPMs about their rights, particularly when they believe their guardian is not honoring their preferences. Additional training on issues related to decision-making capacity, guardian authority, supported decision making and promoting the possibility of successful community living will continue and strategies will be added in the next IP.

Final efforts are underway to fully implement all projects funded by the MFP Capacity Fund and the ARPA of 2021 Section 9817 10% enhanced FMAP proposal, as approved by CMS. These additional funds have been instrumental in the progress made toward meeting the SA requirements. The State received another extension from CMS to continue to expend

the funds until June 30, 2026. The State is working within a limited timeframe to complete as many projects as possible.

The State was also given CMS approval to spend the remaining MFP Capacity funds until September 30, 2027. The State was recently made aware that there will be a cap on Money Follows the Person funds in 2026 and is working to adjust the 2026 budget to match the lower amount that will be awarded.

The chart below shows what was included in the 2025-2027 DHHS budget to assist in the administration of HCBS. The Legislators approved every executive budget request that was made for the purpose of enhancing HCBS for the target population. Continued Executive Leadership and Legislative support for services provided by Adult and Aging Services have made it possible to bring about meaningful change in the HCBS system. Adult and Aging Services staff have completed all the required regulatory work, updated policy, and implemented rate increases as necessary to implement these budget requests.

2025-2027 DHHS Approved Budget Requests	**General Fund Increase**
Transition and Diversion Project	$2,733,934
TPM Housing Assistance	$300,000
Adult Protective Services	$390,829
Senior Nutrition & Health	$2,933,343
Family Caregiver Support Program	$991,256
Marketing ADRL	$42,000
QSP Targeted Rate Increase	$3,595,104
Private Duty Nursing & Home Health Rate Increase	$1,235,768
Total	**$12,222,234**

The focus of several Year 5 initiatives outlined in the approved IP were designed to improve the quality of HCBS for individuals, especially those with complex needs. The State plans to transition from the current documentation-based competency process to a module-based training system, where direct care staff must complete training and pass a competency exam. Additionally, the State is considering a requirement that agencies have at least two (2) years of experience providing direct care before enrolling to deliver residential habilitation or community support services. Experience is essential, as these services support individuals with significant medical needs who often also face functional limitations, mental health concerns, and substance use issues.

The State has chosen a curriculum developed by the University of Wisconsin and has begun working on customizing the training for North Dakota providers which will be completed by the end of April. The Developmental Disability and the Medical Services children's waiver providers will also be using this core curriculum. The State will hold stakeholder meetings to discuss new competency requirements. Other states who have made similar changes report that they were met with resistance from members of the

provider community who may not agree with the need for additional qualifications. However, the complexity of the care, and the fact that the State is now paying very competitive rates for all services, warrants the need to change the competency requirements.

Another increasingly discussed concern is the potential for fraud and waste within the HCBS delivery system. The State collaborates closely with the Medical Services Program Integrity Unit, which is responsible for enrolling and auditing QSPs, as well as with the Medicaid Fraud Control Unit (MFCU), to take swift action against providers who engage in improper billing or deliver substandard care. Over the past year, the State has terminated the provider status of 10 agency QSPs who did not meet provider requirements, inappropriately billed, lacked documentation, or were not providing an acceptable standard of care. The State recognizes that the federal regulations that must be followed to provide these services to eligible individuals are complicated. Since the start of the SA the State has supported providers by investing in systems that, if used correctly, allow providers to meet the requirements for using electronic visit verification, claims submission, and service documentation. In addition, agency providers will soon have access to a verification system that is built into the QSP portal to conduct required background screenings for employees who will provide direct care to Medicaid recipients in late April, 2026. Providers committed to meeting state and federal payment requirements can use these tools at no cost to help them stay compliant.

Adult and Aging Services and staff from Medical Services provider enrollment held two (2) in-person agency and individual QSP Program Integrity workshops this fall, in Fargo and Bismarck, along with a virtual option. The goal was to help providers better understand documentation and record-keeping requirements and to showcase new tools available through our case management and claims submission system to help them be compliant. Staff from the MFCU participated in and explained their role and provided examples of fraud and waste by providers (including QSPs) that have led to criminal convictions in ND. The QSP Hub also presented their services, and the events were well attended and will likely be repeated in the future.

Ongoing workforce challenges continue to place strain on the service system in some areas of the State. While a significant number of individual and agency providers have been recruited, gaps remain, particularly in rural communities where some TPMs are unable to find providers who meet their needs. In contrast, the eastern region of the State has a higher concentration of providers, which has resulted in increased competition for referrals. Many agency QSPs prefer cases that require more intensive services, as longer shifts make it easier to recruit staff, making it more difficult to find providers for individuals who need smaller amounts of care provided throughout the day.

Despite these challenges, the State believes we have achieved significant successes. As a result of the State's response to the SA, thousands of individuals are now living and receiving care in their preferred, integrated community settings. The State believes it has met, and in many areas exceeded, the benchmarks outlined in the SA. The State remains committed to providing high-quality home and community-based services (HCBS) to eligible individuals across North Dakota so TPMs can receive the care they need at home and experience the benefits of community living.

Looking Ahead

A Year 6 - 7 (an 18-month plan that runs through 9/30/27) IP is due March 31, 2026. These are some key themes that will drive the strategies going forward.

Support QSPs

- Finalize the Connect to Care marketing features.
- Offer personal resilience and ethics training to QSPs.
- Recruit providers who are willing to serve individuals with complex needs and lower-level needs that are provided intermittently throughout the day.
- Finalize the employee verification screening tool in the QSP Enrollment Portal.
- Finalize the customization of the QSP training modules and learning management system.

Divert TPMs from Institutional Stays

- Assess the need for additional case managers and program staff to support the consistent and increasing demand for Home and Community Based Services (HCBS).
- Complete the implementation of projects funded by the Federal ARPA 9817 plan to strengthen the HCBS infrastructure.

Facilitate TPM Transitions to Integrated Settings

- Analyze the benefits of integrating peer support into the transition team model through the peer support pilot being conducted by Independence Center for Independent Living (CIL).
- Focus on independent living skills to help TPMs adapt to community living.
- Collaborate with the newly formed Guardianship & Conservatorship Office to develop education on guardianship, advance planning documents, and the rights of TPMs to have their preferences considered when choosing to live and receive care in the community.

Expand Permanent Supported Housing

- Maximize state and federal resources to provide rental assistance for TPMs.
- Continue to work with the housing providers and landlords to help TPMs access affordable and accessible housing.

Increase Quality and Integrity in HCBS

- Update QSP provider qualifications to incorporate competency-based learning and establish experience requirements for delivering higher-level services.
- Continue to work with MFCU and Medical Services Program Integrity Unit to increase provider compliance with State and federal regulations and combat fraud, waste, and abuse.

Year 6 Settlement Agreement Requirements (12/14/25-12/13/26)

The chart below lists the requirements from the SA that are due during Year 6 of the SA.

SA Section #	Requirement	Due Date
VI.F	Develop an Implementation Plan for Year 6 and 7 (An 18-month plan that runs through 9/30/27).	03/31/2026
XIII.D	Provide technical guidance to SNFs that commit to provide HCBS and rural community providers who commit to expand	Ongoing requirement
XIV.A 1.	Conduct individual or group in-reach to each nursing facility	Completed annually
VIII.I 2.	Person-centered planning training for Case Managers	Completed annually
X.B.2.	Implement incremental changes to the NF LoC process and community-based services eligibility	06/14/2022 and ongoing
X.B.3.	Require annual NF LoC determination screening for all	12/14/2022 and ongoing

	continued stays in a nursing facility for TPMs.	
XI.B	Transitions occur no later than 120 days after TPM chooses	06/14/2022 and ongoing
XV.D	Submit year 6-7 IP	3/31/2026 – The date was pushed back so the biannual report is submitted before the IP.
XV.D	State Biannual Data Report	01/31/2026 & 07/31/2026
VIII.I	Provide PCPs to an additional 670 TPMs within six (6) years of the effective date	12/13/2026
XI.E	Transition at least 70% of TPMs from SNFs	12/13/2026
XI.E	Divert at least 150 TPMs from SNFs so that at least 400 TPMs have been diverted since the effective date	12/13/2026

SA Section VI. Implementation Plan

Responsible Division(s)

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

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

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

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

Implementation Strategy

Continue to conduct internal and external listening sessions that include a review of relevant services with stakeholders and staff from the ND DHHS Aging Services, Medical

Services, Developmental Disability, and the Behavioral Health Division. One priority is identification of administrative or regulatory changes that need to be made to reduce identified barriers to receiving services in the most integrated setting appropriate. **(Ongoing strategy)**

A listening session is conducted during every ND USDOJ SA stakeholder meeting. Feedback is used to modify policy and waiver amendments. The State will continue to hold listening-sessions in future years of the agreement. 2025 Listening Session Summary

Progress Report:

Based on feedback received during the 2025 events, the State took the following actions during this reporting period:

QSP training. To address training needs for Qualified Service Providers (QSPs), the Department is adopting the University of Wisconsin–Green Bay HCBS training modules as the baseline training required for QSP enrollment. The State is also reviewing additional training options to determine requirements for behavioral health, traumatic brain injury (TBI), and dementia care credentials. Stakeholders emphasized that credentials should be voluntary and that providers should have choice and input regarding training requirements. This belief may be widespread amongst QSPs. The QSP survey included a question about how many QSP believed there are skills trainings that could help improve or expand the services they provide. Fifty-six percent of the QSPs who answered this question responded no. Of those who said yes, most wanted to learn ways to best provide care to the individuals they serve. The State believes requiring new training and provider requirements is warranted because of the increasingly complex needs of TPMs.

Rates for medically complex individuals. In response to feedback regarding individuals with complex medical needs, the State will discuss the potential addition of medical tiers to residential habilitation and community support rates as part of the 2027–2029 executive budget request.

Housing barriers. To address housing as a major barrier to community living, the State received an ongoing appropriation of $300,000 in the Adult and Aging Services budget to provide rental assistance to Target Population Members (TPMs).

Guardianship needs. To respond to the growing demand for guardians, the State received $423,000 in the Adult and Aging Services budget to support the Guardianship Establishment Fund. There is currently a waitlist for these services. The State has created an Office of Guardianship to oversee all guardianship functions, including management of the Guardianship Establishment Fund for both Aging and Developmental Disabilities. The State will also develop educational materials to help individuals with guardians better understand their rights and available options when their preferences related to community living are not being considered. Issues related to capacity and consent for community transition will also be addressed.

Disease-specific training. In response to interest from QSPs in disease- and diagnosis-specific training commonly associated with HCBS recipients, the State is partnering with the QSP Hub to develop a series of webinars. A training schedule has been created (see below), and the QSP Hub will promote these opportunities across the stakeholder network.

- January 2026
    a. Topic: Working with Traumatic Brain Injury (TBI)
    b. Presenter: NDBIN
- February 2026
    a. Topic: Supporting Nutritious Outcomes/ Diabetes Management
    b. Presenter: Dr Eric L. Johnson: UND
- March 2026
    a. Topic Communicating Effectively: "*This class teaches how dementia affects communication, including tips for communicating well with family, friends and health care professionals."*
    b. Presenter: Alzheimer's Association
- April 2026
    a. Topic: Physical Well Being
    b. Presenter TBD (UND PT Department)
- May 2026
    a. Topic: Meet First Link
    b. Presenter: First Link Staff

Session 2: Fall 2026

- August 2026
    a. Topic: Strok
    b. Presenter TBD
- September 2026
    a. Topic: Chronic Heart Disease
    b. Presenter: TBD
- October 2026
    a. Topic: Addiction and Substance Use Disorder
    b. Presenter TBD NAADAC
- November 2026
    a. Topic Creating a Safe Home Environment
    b. Presenter UND Occupational Therapy Department
- December 2026
    a. Topic: Nutritional Well Being
    b. Presenter: Brooke Fredrickson: brooke@brookefredrickson.com Intuitive Eating, Mindful Eating, Weight Science, Weight-Neutral Nutrition, Diabetes, Childhood Weight & Feeding Issues, Body Image, Psychology of Eating

Two-person assist needs. In response to questions about the need for two-person assistance in home settings, the State has a rate augmentation fund that can cover the cost of a second worker when assistance with transfers is required. This fund is set to expire on June 30, 2026. Because this need is expected to continue, the State is exploring requesting CMS approval to extend the fund using Money Follows the Person (MFP) rebalancing funds.

Medical housing. To address the need for medical housing for TPMs with extraordinary medical needs, the State received $200,000 to support development of a medical housing prototype. The prototype will incorporate design features recommended by disability advocates. A request for qualifications has been issued to identify a qualified provider to design the prototype and estimate construction costs and rental cash flow.

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

Implementation Strategy

Strategy 1. The State will continue to create ongoing stakeholder engagement opportunities including quarterly ND USDOJ stakeholder meetings through Year 5 of the SA. The State will educate stakeholders on the HCBS array, receive input on ways to improve the service delivery system, and receive feedback about the implementation of the SA. The State asks for feedback on a variety of topics, shares data, and allows time for attendees to share any issues they feel need to be addressed at each meeting. A Stakeholder feedback summary will be completed at the end of the year. **(Ongoing strategy)**

2026 Meeting Schedule:

- March 23, 2026
- June 3, 2026
- September 23, 2026
- December 15, 2026

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. **(Completed December 13, 2025)**

Progress Report:

In-person meetings were held in the following locations - Bismarck, Minot, Casselton, Valley City, Oakes, Wahpeton, Belfield, and Dickinson. There was a mixture of attendance from community people, health professionals, and individuals receiving some services. The biggest concern was lack of awareness about the programs and lack of workforce, especially in the rural areas. Adult and Aging Services staff will attend the next tribal consultation meeting to provide an update about the upcoming HCBS Medicaid waiver renewal. We will offer the opportunity to hold a public input meeting with any tribal nation that is interested.

The ND State Plan on Aging is also due so we will host additional meetings for input. There will be virtual and in-person sessions to be completed by April 1, 2026.

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

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

Progress Report:

Monthly meetings have continued with the Native American Stakeholder group on HCBS Initiatives. This group continues to work through details of the HCBS Care Coordination service and through changes to the North Dakota Medicaid State Plan, and Targeted Case Management Services that would improve access to tribal run entities that enroll to provide Targeted Case Management.

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

Implementation Strategy

Agreement Coordinator will meet weekly with the SME and team to consult on the IP. The Agreement Coordinator will provide the required updates to USDOJ, submit drafts, and incorporate updates as required. The revisions to the IP will focus on implementation for the upcoming year, challenges encountered by the State to date, and strategies to resolve them with plans to address noncompliance if required. **(Ongoing strategy)**

Progress Report:

The Agreement Coordinator and the SME continue to meet weekly.

Website (Section VI, Subsection H, page 10)

Implementation Strategy

Maintain a webpage for all materials relevant to ND and USDOJ SA on the DHHS website. The plan and other materials are made available in writing upon request. A statement indicating how to request written materials is included on the established webpage found here U.S. Department of Justice Settlement Agreement | Health and Human Services North Dakota. **(Ongoing strategy)**

Section VI. Performance Measure(s)

Number of unduplicated individuals served in HCBS by funding source.

- 3,364 unduplicated individuals are being served under all HCBS funding sources. (839 HCBS Medicaid waiver, 715 MSP-PC, 1,742 SPED, and 68 Ex-SPED).

SA Section VII. Case Management

Responsible Division(s)

DHHS Aging Services

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

Implementation Strategy

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

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

Updated Strategy 2. The State has two (2) Full Time Equivalent (FTE) that serve as provider navigators who will assist all HCBS case managers statewide in finding QSPs to serve eligible HCBS recipients. The State is considering the feasibility of using the new Connect to Care system, formally referred to as ConnecttoCareJobs platform, to share referrals for HCBS to QSPs. Assistance from the provider navigators frees up time for the

case managers and assists them in keeping up with the increased demand for HCBS. **(Ongoing strategy)**

Progress Report:

Two (2) provider navigators continue to assist TPMs with identifying available QSPs. The navigators are very knowledgeable and have created good connection with the provider community. The provider navigators have received 758 referrals during this reporting period. The State has determined that it will not be using ConnecttoCareJobs platform to share referrals for HCBS to QSPs as the current process is working well.

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

Progress Report:

The provider navigators continue to track all the referrals not only for Fargo but also Grand Forks, Bismarck, and Minot to ensure there is equal distribution since there are more service providers in the bigger communities. The referral tracker includes if a referral went out to a provider and if they ultimately received and acknowledged the referral.

Updated Strategy 4. To ensure a sufficient number of HCBS case managers are available to assist TPMs in learning about, applying for, accessing, and maintaining community-based services for the duration of the SA, the State will continue to monitor weighted caseloads of the 74 licensed social workers currently hired as HCBS case managers. The State has plans to add four (4) additional case managers in 2025 and to add one (1) additional Basic Care Case Manager. **(Hiring completed and ongoing strategy)**

Progress Report:

The State has hired four (4) new HCBS Case Managers and one (1) Basic Care Case Manager. The State administratively claims Medicaid funds to cover the cost of case management services provided to Medicaid-eligible individuals. This additional revenue will support the continued provision of these services and help fund the hiring of additional case managers as needed.

New Strategy 5. The State has established a workgroup consisting of HCBS Case Management Supervisors and Aging Services Program Administrators to analyze the business process of entering all required information into the State's case management system. The goal of this review is to identify steps that may be delegated to administrative support staff thus freeing up time for the HCBS Case Managers to focus on client-facing

duties. If enough administrative tasks are identified, the state will consider the feasibility of hiring administrative support for the HCBS Case Managers. **(Ongoing Strategy)**

Progress Report:

The areas that administrative staff could help case managers to free up their time to do their main social work duties have been identified. The State is discussing the process of creating a centralized electronic mail room that would process all the HCBS Case Managers' mail, including sending PCPs to eligible individuals, providers, etc. This type of support would greatly reduce their workload. Funds are available to hire two staff, but we need approval for two new FTE. The agreement coordinator will work with the executive leadership team on this request.

Several changes and updates have been made. We are continuing to review processes and make changes as we are able.

Assignment (Section VII, Subsection B, page 10)

Implementation Strategy

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

Progress Report:

Cases are assigned to case managers within an average of two (2) days.

Capacity (Section VII, Subsection C, page 10)

Implementation Strategy

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

Challenges to Implementation

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

Remediation

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

Progress Report:

Caseloads are reviewed monthly, and the goal is to have an overall weighted caseload of 110 per case manager. Caseloads continue to increase and are the highest ever since the start of the SA with the most recent months being at an overall average weighted caseload of 124 across the state. In December 2025, the weighted caseload average increased to 125. The State will monitor what impact the addition of four (4) new HCBS Case Managers has on the weighted caseload average and include information in future reports.

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

Progress Report:

See response in Section VII, Subsection A. Updated Strategy 4.

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

Implementation Strategy

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

Progress Report:

There were no incidents in which a SNF refused full access to a TPM residing or being admitted to a SNF.

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

Challenges to Implementation

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

Remediation

Training will be held at least biannually in Year 5 of the SA. One (1) of the training courses will be held virtually. **(Completed December 13, 2025)**

Progress Report:

See Section VII Performance Measure(s)

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

Progress Report:

The LTSS Options Counselors continue to utilize educational materials daily.

New Strategy 4. To ensure that all Medicaid-eligible individuals, including those applying for Developmental Disability (DD) services through the DD intake system, have access to information about all HCBS options for which they may qualify. The DD Section will establish a process to inform eligible individuals about the State's HCBS coverage during the initial DD intake. Information will also be provided annually thereafter. The DD intake process will include new materials outlining the full range of HCBS programs administered by the DD Section, the 1915(i) waiver, and Aging Services. If a TPM seeks more information about the services administered by Adult and Aging Services, the Developmental Disability Program Manager (DDPM) conducting the intake will transfer the call to the ADRL team, who will provide additional details and start the intake process. Additionally, the DD Section will work with the vendor to update the case management system to integrate this information into the intake process. A section will also be added to the DD individual service plan for individuals and guardians to sign, confirming receipt of this information.

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

The DD section will also conduct quarterly quality checks of up to 20 cases to ensure that eligible individuals receive information about the state's HCBS coverage, both initially and annually thereafter. The number was selected after reviewing the individuals who meet the TPM definition and requested intake through the DD system. At the time, 19 individuals in the DD system met the TPM criteria. This process will begin in October 2025, using data

from July 1, 2025 - September 30, 2025. **(Target implementation date February 11, 2026)**

Progress Report:

The DD Section worked with a marketing firm to produce written educational materials that have been printed and shipped to DD staff across the State. The DD Section will hold another statewide training on February 10, 2026, to discuss how the materials will be used during intake to help individuals and their legal decision makers to understand what type of services they may be eligible to receive. After this training, staff will be expected to use the new materials and provide options counseling.

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

Updated Implementation Strategy

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

Progress Report:

The State is required to update the PCP and the HCBS assessment to comply with the Ensuring Access to Medicaid Services (Access Rule). The most notable changes will require HCBS Case Managers to ask questions about a TPMs alcohol and drug use, conduct a Brief Interview for Mental Status assessment, and a Patient Health Questionnaire. The State is working with the case management system vendor to implement this change. **(Target updated completion date March 31, 2026**)

Quality (Section VII, Subsection F, page 11)

Updated Implementation Strategy

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

Progress Report:

See Section VII Performance Measure(s)

ADRL (Section VII, Subsection G, page 11)

Implementation Strategy

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

Section VII. Performance Measure(s)

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

- The annual report for 2025 was completed by January 31, 2026. All case manager audits were completed within the required timeframe. Error rates are not measured by territory as each case manager helps in multiple territories. Each of the 75 case managers working in this reporting period are reviewed through in-depth audits annually and twice per year for an overall audit of their cases.

Total number of HCBS case managers serving Tribal nations.

- There are 15 HCBS Case Managers (CMs) who work in reservation communities.

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

- A total of 163 non-state staff attended the training for hospital and SNF staff. Nine (9) trainings were held in 2025, eight (8) in-person and one (1) webinar style training was held across the State.

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

- DD Options Counseling will officially start after February 10, 2026 staff training.

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

- We have had 36 inquiries/referrals/staffing from DD to Aging Services. Eleven individuals switched to Adult and Aging Services. Not all cases were opened because education was provided to the DD Case Managers during the staffing about offering Medicaid State Plan or other DD services to eligible individuals that would best meet their needs.

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

- An evaluation of the February 10, 2026, training to kick off the DD Options Counseling process will include a pretest and posttest survey to measure what was learned about the new process.

SA Section VIII. Person-Centered Plans

Responsible Division(s)

DHHS Aging Services

Training (Section VIII, Subsection A, page 11)

Updated Implementation Strategy

- See Section VIII, Subsection H (Ongoing strategy)

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

Updated Implementation Strategy

Every PCP will incorporate all the required components as outlined in Section VIII.C.1-8 of the SA and these are apparent in PCP documentation. The PCP tool in the case management system will allow all required information to be captured and included in the plan. The PCP will be updated every six (6) months, annually, and when a TPM goes to the hospital or SNF and remains available and accessible in the system when the TPM returns to the community.

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

The new federal HCBS Quality Measures will require the State to modify parts of the PCP. The State will review any proposed changes to the PCP with the SME before changes are implemented. **(Completed July 2025 and ongoing date March 31, 2026 and ongoing)**

Progress Report:

See Section VII. Subsection E

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

Implementation Strategy

The new federal HCBS Quality Measures will require the State to modify parts of the PCP. The State will review any proposed changes to the PCP with the SME before changes are implemented. **(Ongoing strategy)** Section XI, Subsection B, new strategy 6 for additional information.

Progress Report:

Draft documents were submitted to the USDOJ team and the SME on July 19, 2025. The State continues to work with the case management vendor to finalize the updated PCP in the system.

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

Implementation Strategy

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

Progress Report:

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

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

Implementation Strategy

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

Progress Report:

See Section VIII Performance Measure(s)

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

Updated Implementation Strategy

To ensure annual ongoing training, the State will use MFP capacity building funds to procure an entity to provide ongoing technical assistance and annual person-centered planning training through September 30, 2025. Training will be required for all HCBS case managers and DHHS Aging Services staff. The full development of the PCP competency training learning modules, hands on learning, train the trainer, and evaluation of competency components is complete. This curriculum will be completed by most of Aging Services staff by December 13, 2024. New hires will be required to complete the training in the first 12 months of employment with Aging Services.

In 2025, the State will implement the “Train the Trainer” portion of the curriculum throughout Aging Services. The State is considering using federal ARPA 9817 10% funds to hire a temporary staff person with an education degree and experience in adult learning to teach the train the trainer curriculum to Aging Services staff.

In 2025, the workgroup that was responsible for developing the PCP training competencies will meet again to determine the best way to roll this out. Aging Services supervisors and mentors will be trained in the Indicators of Competency and Evaluating Competency in Person-Centered Planning. **(Updated target completion date May 31, 2026)**

Progress Report:

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

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

The entity and State have developed and conducted the train-the-trainer program for person-centered competencies, learning modules, and hands on learning. Supervisors of

State staff will learn how to determine staff competency and will learn ways to remediate any gaps in knowledge identified through the process. The trainer program is complete and the training of supervisors to determine competency will roll out in the first few months of 2026.

The state continues to offer the Adult and Aging Services Person-Centered Competency Training Series to ensure new hires can complete the training in the first 12 months of employment with Aging Services.

In 2025, the State implemented the “Train the Trainer” portion of the curriculum throughout Aging Services. Nine (9) trainers were trained and facilitated the training series in 2025. All HCBS Case Managers have been trained in the competencies within the required timeframe.

The State used federal ARPA 9817 10% funds to hire a temporary staff person with an education degree and experience in adult learning to complete the implementation of evaluation of Person-Centered Competencies and data collection that will be used to inform professional development and quality management practices. The data collected can be used by supervisors, trainers, mentors, and quality assurance teams to observe, rate, and document demonstration of competency attainment and provide recommendations to staff for improvement and/or additional skill development. Aging Services supervisors, mentors and staff will be trained in the Indicators of Competency and Evaluating Competency in Person-Centered Planning. The evaluation of competency is based on self-reflection, supervisor/observation, service experience, and quality audit/review. Project completion date is May 31, 2026.

Person-Centered Planning Process and Practice (Section VIII, Subsection I, page 13)

Implementation Strategy

Updated Strategy 1. Through facility in-reach, community outreach, and increased public awareness of the ADRL and HCBS options, the State seeks to reach TPMs and assist them in receiving services in the most integrated setting appropriate. The State continues to complete person-centered planning with TPMs as required. There is no specific PCP benchmark for Year 5. By the end of Year 6 of the SA the State must conduct person-centered planning with an additional 670 TPMs.

Progress Report:

The State continues to engage with TPMs through person centered planning about care options in the most integrated setting. Long Term Services and Support Options Counselors (LTSS OC) complete person-centered planning with TPMs who first enter the SNF and then again annually. The state has already surpassed the number of PCPs required for Year 6. If a TPM wishes to have person-centered planning occur more frequently, the LTSS OC accommodates this request.

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

Progress Report:

See Section VIII Performance Measure(s)

Strategy 3. The State has assigned a case manager to every SNF and hospital in the State. The case managers assigned to the facility are required to visit TPMs in that facility and provide person-centered planning at least annually. **(Ongoing strategy)**

Challenges to Implementation

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

Remediation

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

Progress Report:

See Section VIII Performance Measure(s)

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

HCBS Care Coordination services will include:

- Identifying needs and locating necessary resources to establish or maintain a stable and safe living arrangement,
- Coordinating, educating, and linking individuals to resources,
- Providing and establishing networks of support,

- Assisting with necessary paperwork and documentation to help gain access to services to ensure a stable and safe living environment, and,

- Assisting with the development of the PCP.

Progress Report:

HCBS Care Coordination was approved in the HCBS waiver. No providers have yet enrolled to do HCBS Care Coordination. The State continues to collaborate with Tribal QSP agencies who are interested in enrolling to provide this service.

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

Progress Report:

Due to restrictions on sharing PHI across units the idea of creating a report will no longer be pursued. The LTC Medical eligibility unit has agreed to tell us when or if an individual has applied for ND Medicaid on an individual need to know basis. This process is currently working well.

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

Progress Report:

See Section VIII Performance Measure(s)

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

The QSP enrollment portal will include tool tips in Spanish, French, Nepali, Arabic, and Bosnian. Applicants who need an interpreter to assist them in enrolling as a QSP can call the QSP Hub who will utilize an interpreter service when providing enrollment support**.** **(Completed January 1, 2025)**

Progress Report:

The QSP Hub uses a translation service to support providers with the application process. During this reporting period, the following languages were supported: Bosnian, Arabic, and Spanish.

Section VIII. Performance Measure(s)

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

- No TPM transitions involved moving to a setting other than a private home, family home or apartment.

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

- All HCBS case managers met person-centered planning competencies within the required timeframes. All case managers attend annual training and newly hired case managers take the training as part of the onboarding process.

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

- A total of 80 PCPs were reviewed and 100% met the SA requirements.

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

- Denials are not tracked by TPM status. The following denial data is based on all denials for HCBS recipients. The count is not unduplicated.
    - One (1) functional eligibility denial was originally appealed in July, but the individual decided to rescind the appeal.
    - One (1) functional eligibility denial was appealed in July, but the individual did not show to hearing and it was determined abandoned.
    - One (1) case was terminated in November and is currently under appeal. The individual for this appeal case is not classified as a TPM.

Denial Reason	Denial Reason Definition
Did not cooperate w/Assessment	The individual or their legal decision-maker refused to answer assessment questions, or provide additional information that is necessary to determine functional eligibility
Financial eligibility	Individuals have income/assets that exceed program caps.
Functional Eligibility	Individuals are not impaired in enough ADLs/IADLs to meet eligibility requirements.
Health/Welfare/Safety Concerns	Individuals' needs cannot be met. The need exceeds service limits, or the individual is placing them themselves or their providers at risk.

No Services	The individual did not use any of the services that were authorized for more than 30 days.
Not in Agreement/Assessment	The individual or their legal decision-maker does not agree with the results of the assessment. Individuals may lack insight into why they are impaired in certain ADLs/IADLs.
Not in Agreement w/PCP	The individual or their legal decision-maker did not agree with the recommendations the case manager made regarding the type and amount of services that were needed.

Month/Year Request	Denial Reason	# of Denials
June 14, 2025 – June 30, 2025	Functional Eligibility	5
	Financial Eligibility	2
	No Services	1
	Did Not Cooperate w/ Assessment	3
July 2025	Financial Eligibility	1
	Functional Eligibility	21
	No Services	1
	Not in Agreement w/Care Plan	1
	Did Not Cooperate w/ Assessment	3
August 2025	Functional Eligibility	16
	Financial Eligibility	3
	Did Not Cooperate w/ Assessment	1
	Wants to Remain on PACE	1
September 2025	Functional Eligibility	13
	Financial Eligibility	1
	Did Not Cooperate w/ Assessment	1
	No Services	1
October 2025	Functional Eligibility	14
	Financial Eligibility	2
	Did Not Cooperate w/ Assessment	10
	No Services	1
November 2025	Functional Eligibility	14
	Financial Eligibility	4
	Did Not Cooperate w/ Assessment	5
December 1, 2025 - December 13, 2025	Functional Eligibility	6
	Financial Eligibility	2
	No Service	1
	Did Not Cooperate w/Assessment	4
Totals		**138**

Number of unduplicated PCPs completed for TPMs in the community.

- 1,012 unduplicated PCPs were completed for TPMs living in the community during this reporting period.

Number of unduplicated annual PCP visits to TPMs in SNF.

- 2,093 unduplicated PCP visits were completed with TPMs residing in a SNF from December 14, 2024 – December 13, 2025.

Number and percentage of PCPs produced by transition coordinators and reviewed by the State that meet all SA requirements.

- The Transition Coordinators completed 46 MFP and six (6) TDP PCPs and the DDPMs completed seven (7) for a total of 59 PCPs. Of the 59 PCPs, 51 (86%) were reviewed.

SA Section IX. Access to Community-Based Services

Responsible Division(s)

DHHS Adults and Aging Services

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

Implementation Strategy

Updated Strategy 1. The State compiled a list of potential services that will enhance the current service array and fill gaps in the service delivery system for potential inclusion in the 2025-2027 DHHS Executive Budget request. Services may be added to one or more of the state or Medicaid HCBS funding sources. The State will implement any of the new services and projects included in the Executive Budget Request if they are approved during the 2025-2027 Legislative session. **(Completed July 1, 2025)**

Progress Report:

The services below were approved during the 25-27 Legislative session.

- State Rental Assistance funds – $300,000
- Transition and Diversion Support Services - $5,289,397

Updated Strategy 2. The State is still considering using presumptive eligibility to assist Medicaid applicants in accessing HCBS. The Agreement Coordinator has had ongoing conversations with the Medical Services Director, other states, and CMS. Recently, CMS issued new guidance on the use of presumptive person-centered plans of care, which could help TPMs access HCBS more quickly. The new guidance may have a similar effect of

helping eligible TPMs to gain access to HCBS quickly. The State will continue discussions with stakeholders on how to best implement this in ND. **(Decision made January 1, 2026)**

Progress Report:

The State worked with Medicaid eligibility staff to develop a process for using interim care plans for presumptive eligibility. During that process it was determined that using presumptive eligibility would not be as helpful as using Medically Frail services for many TPMs. Under Medically Frail TPMs are eligible for up to 1,200 units of Medicaid State Plan personal care and state funded HCBS. These services can be used to meet their needs while they are applying for eligibility under traditional Medicaid which will allow them to access the HCBS waiver. The LTC Eligibility unit advised that the only entity that can determine presumptive eligibility is the hospital but the number of people who ultimately meet Medicaid eligibility is low and providers are reluctant to serve TPMs for fear of not having a funding source. Providers are willing to help those on Medically frail so we will use this process when appropriate to assist TPMs.

Implementation Strategy

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

The State worked with the QSP Hub to develop a performance measure to evaluate the success of the support provided by the QSP Hub to TPMs who request assistance with self-direction. **(Ongoing strategy funded through December 2026)**

Progress Report:

See Section IX Performance Measure(s)

Updated Strategy 2. To reduce the responsibility of individual QSPs and improve the recruitment and retention of providers statewide, the State will determine the feasibility of implementing any changes to the provider model or include formal self-direction policies in the HCBS waiver and Medicaid State Plan – Personal Care programs. If a decision is made to adopt this model, we would request Legislative appropriation during the 2027-2029 legislative session.

Challenges to Implementation

Formal self-directed service options are part of most Medicaid funded HCBS. States can collect Federal Medical Assistance Percentage (FMAP) for self-directed services if approved by CMS. However, because most of the in-home services provided to eligible individuals in ND are funded under the State's Service Payments to the Elderly and Disabled (SPED) program, additional state general fund appropriations

would be required to pay for the fiscal intermediary services required under formal self-direction.

Remediation

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

The State will also consider the significant investment in creating systems to improve the QSP enrollment experience completed over the past few years to make the final decision. System investments include the QSP Enrollment Portal, QSP registry ConnecttoCare, free access to Electronic Visit Verification (EVV) and the documentation and billing submission system. These investments have shifted much of the administrative burden off the providers. **(Updated Target completion date for decision May 31, 2026)**

Progress Report:

Adult and Aging Services staff continue to discuss the feasibility of adding formal self-directed services in the HCBS waiver and Medicaid state plan personal care.

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

Updated Implementation Strategy

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

Progress Report:

See Section IX Performance Measure(s)

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

Implementation Strategy

Strategy 1. HCBS policy includes the process to request a reasonable modification for review and consideration. Some requests for reasonable modification may conflict with the ND Nurse Practices Act, N.D. Cent. Code § 43-12.1. The State will continue to meet with

the Board of Nursing to review all medically related reasonable accommodations to review trends and make recommendations for policy or legislative changes that will allow more TPMs to live at home and receive necessary healthcare. **(Ongoing strategy)**

Progress Report:

Regular biannual meetings are held with the North Dakota Board of Nursing to review accommodations and provide updates. The most recent meeting took place on November 17, 2025, during which we reviewed trends, and discussed current cases and the ongoing approach to accommodation. It was affirmed with the Nursing Board that the Department will continue to process all nursing accommodations as special approvals, even when they involve common medical tasks, to ensure proper training and oversight in the provision of care.

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

The most common modification requests in 2024 include requests to:

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

Because of the number of requests received to modify extended personal care services in this way, the State submitted a waiver amendment to CMS to make escort an allowable task. If approved, case managers will no longer need to request a modification of policy for this purpose because it will become a permanent part of the service. **(Completed January 1, 2025, and ongoing)**

Progress Report:

See Section IX Performance Measures(s)

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

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

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

Updated Strategy 1. Continue to recruit and retain residential habilitation and community-support services funded under the HCBS 1915(c) Medicaid waiver to provide up to 24-hour support and community integration opportunities for TPMs who require these types of supports to live in the most integrated setting by assisting up to five (5) additional eligible

agency QSPs in US DOJ SA Year 5 with paying for their CQL accreditation. **(Funds are still available to serve providers who agree to serve rural and gap areas)**

Progress Report:

See Section IX Performance Measure(s)

Currently, assistance with funding for CQL accreditation is only available to those agencies who serve an area of need (e.g. rural or gap area) in the state. This update to policy was on July 1, 2025. The state enrolled three (3) new providers from during this reporting period for a total of 33 agencies enrolled in these services.

Updated Strategy 2. Continue to use the rate augmentation fund to reimburse providers for additional expenses incurred while delivering authorized services to HCBS recipients. These additional funds can cover costs such as employee travel, training, and employee wait time between serving clients. The fund may also offer incentives for Agency QSPs to pursue additional staff training in caring for individuals with dementia, TBI, or behavioral health issues. Additionally, the funds can be used to contract professionals to develop individualized program plans that mitigate known risk while supporting clients in the most integrated environment. The primary requests that have been made to this fund are requests to pay for supplies to complete chore services, and requests to pay a second provider to assist with physically demanding care like transfers, or for two (2) staff to be in the home to ensure the providers' safety. **(Ongoing through May 31, 2026)**

Progress Report:

This program continues and is ongoing through the end of the ARPA funding. The Rate Augmentation Pilot will end on May 31, 2026. The State is considering the feasibility of requesting approval from CMS to use MFP rebalancing funds to continue operating the rate augmentation fund.

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

The State has appropriated $351,000 in the 25-27 biennial budget to enhance the quality of HCBS, to reimburse QSP agencies enrolled in providing personal care to maintain on-call staff. However, with 168 agencies enrolled in providing personal care, there are not enough funds to cover on-call staff for every agency. To address this, the State will establish a competitive grant process. This will allow agencies currently serving HCBS recipients to apply for funds, either to provide stipends for on-call staff or to hire "floater" positions. The floaters will be available on demand to address urgent needs, such as when a scheduled staff member is unable to complete their shift or in other unexpected situations**. This project has been delayed because of competing priorities. A progress report will be included in the next report. (Target completion date July 31, 2026, and on-going)**

Updated Strategy 4. Provide behavior intervention consultation and support direct service providers. The State is aware that oftentimes it is difficult to find HCBS providers who can, and will, serve clients with behavioral health needs. Strategies to increase these services

could include establishing resources for QSPs and other HCBS providers to access, that would create behavior intervention plans, helping staff with high need/high complexity cases, and offering consultation to in-home providers as needed. The State is working with the Behavioral Health Division to identify providers in ND who already provide this service. Provider agreements will be established with qualified entities and training will be conducted with the HCBS Case Managers, so they know how to access these services. **(Target completion date January 1, 2025, and ongoing)**

Progress Report:

The State has a provider agreement with behavioral analysts to help support individuals who have both behavioral health and physical health needs. The goal with this service is to follow the TPMs through the transition and diversion process to support their behavioral health needs while in the facility and post transition. Two (2) referrals were made to this vendor, but the meetings never happened because of the timing or requests and other issues that arose during the transition process.

Updated Strategy 5. Aging Services staff are working with the Behavioral Health Division and the State Hospital to streamline transitions and improve working relationships and expectations of the role that the behavioral health community has in ensuring the health and welfare of transitions involving TPMs with co-occurring mental health and substance use disorders. Representatives from each of these areas are participating in person-centered planning team meetings and developed a set of goals and training expectations for providers.

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

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

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

The group is also recommending there be ongoing consultation and crisis intervention support for providers working with someone who is in crisis because of a mental health or substance use issue. The IP contains additional strategies to implement these goals during Year 5. **(Ongoing Strategy to collaborate with behavioral health community)**

Progress Report:

In June and July of 2025, Therapeutic Options conducted a train-the-trainer model training in Bismarck and Fargo for QSPs who provide Residential Habilitation and Community Supports. Adult and Aging program administrators then presented this information to Adult and Aging Services staff in two (2) monthly meetings. The State is offering additional

training to the QSP agencies that did not participate in the first round of training, and we are disusing the feasibility of offering the training to other types of QSPs.

Updated Strategy 6. The State will work with behavioral health subject matter experts to create a process for Community Support and Residential Habilitation agency QSPs to earn a behavioral health endorsement as part of QSP enrollment. The endorsement would be earned after agency leadership (i.e. owners, registered nurses, field staff supervisors) complete specialized training that will provide them with additional skills to help support TPMs with behavioral health needs. The State, with the help of the State Hospital, has identified the type of training that will be provided. Training will include de-escalation, positive behavioral support, trauma and trauma informed care, crisis support, and personal protection skills. The State will offer grant opportunities to pay the costs of sending agency staff to attend the training. This educational opportunity is based on a train the trainer model, so the leaders of these organizations have the capacity to train their field staff. In the future, the State will also consider the feasibility of paying a higher rate to QSPs that have this endorsement when working with TPMs who need this level of specialized training to ensure successful community living. **(Target completion date May 31, 2026, and ongoing)**

Progress Report:
The State of Oregon uses a standardized curriculum for provider training and relies on subject matter experts for specific components of its certification program. A clinical director from a behavioral health clinic is reviewing the certification modules provided by Oregon and will make a final recommendation on whether the State should adopt them.

New Strategy 7. The State will work to procure a vendor that could teach motivational interviewing to Aging Services staff and the management staff of QSP agencies that are enrolled to provide Residential Habilitation and Community Supports. **(Target completion date June 30, 2026)**

Progress Report:

Motivational Interviewing is scheduled to occur in Fargo and Bismarck as well and will be offered to all Adult and Aging Services field staff and contracted staff. This training is not a train-the-trainer model, but a two (2) day course to enhance those skills in working with co-occurring disorders.

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

Progress Report:

Although there have been no recent meetings with the State Administrator for Behavioral Health, Adult and Aging staff collaborate with Behavioral Health Clinics to staff cases when needed.

Updated Strategy 9. Continue to educate QSPs about the existence and availability of crisis services that can assist when a TPM being supported in the community has a mental health crisis. The services include the mobile crisis team and crisis facilities.

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

What the mobile crisis team offers:

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

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

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

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

Another resource QSPs can use is the 988 Suicide and Crisis Lifeline funded by the Substance Abuse and Mental Health Services Administration. This service is available across the United States and offers 24/7 call, text, and chat access to trained crisis counselors who can help people who are experiencing suicidal, substance use, or other mental health crises 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)**

Progress Report:

Qualified Service Providers (QSPs) can contact the Human Service Center (HSC) crisis line and may go out to an individual's home if needed. Although the State does not specifically track when crisis services are used by QSPs, a review of CIRs shows that providers are utilizing this service, most recently in a situation where an HCBS recipient was threatening suicide.

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

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

Progress Report:

See response in Section IX.H. New Strategy 8

Section IX. Performance Measure(s)

Number of QSPs offering on-call services.

- Request for a competitive grant proposal will be completed by ~~September 1, 2025,~~ July 31, 2026.

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

- The QSP Hub provided technical assistance 47 times for self-directing support to 17 unduplicated people. Two (2) individuals that identified themselves as TPM's. The others were family members, community members, medical providers, and QSP's helping communicate a need and advocate for the TPM.

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

- The QSP Hub completed 10 community outreach events to promote awareness of the QSP profession. This included high school events and career events in areas in need of providers.

Number of TPMs receiving extended personal care.

- There are a total of 308 total consumers receiving extended personal care.

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

- A total of 33 agencies are enrolled in both Residential Habilitation & Community Support services. Three (3) new agencies enrolled during this reporting period.

- There are 85 individuals who received 24-hour care in this reporting period. Eighty (80) receive Community Support Services and five (5) receive Residential Habilitation Services.

- There are 27 individuals in Agency Adult Foster care homes who have shared rates (not 24-hour care rate), 21 receive Community Supports and six (6) receive Residential Habilitation.

- A total of 112 individuals received 24-hour support under these programs, 101 received Community Supports and 11 received Residential Habilitation.

- A total of 23 QSPs provided 24-hour support during this reporting period.

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

    - There were no appeals for any reasonable modification denials during this reporting period.

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

    - There were 68 approved requests for reasonable modifications during this reporting period.

Month/Year Request	Service	# of Approvals
June 14, 2025 – June 30, 2025	Nursing Tasks	6
July 2025	Nursing Tasks	13
August 2025	Nursing Tasks	11
September 2025	Nursing Tasks	8
October 2025	Combined Unique Services	1

	Nursing Tasks	6
November 2025	Services Over Cap	2
	Nursing Tasks	12
December 1, 2025 – December 13, 2025	Nursing Tasks	9
Totals		**68**

SA Section X. Information Screening and Diversion

Responsible Division(s)

DHHS Aging Services & Medical Services

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

Implementation Strategy

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

Progress Report:

See Section X Performance Measure(s)

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

Implementation Strategy

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

Challenges to Implementation

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

Remediation

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

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

Progress Report:

See Section X Performance Measure(s)

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

Progress Report:

This is an ongoing process.

Challenges to Implementation

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

Remediation

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

Progress Report:

There were no individuals whose NF LoC required the State to complete an administrative hold to assist in forming a safe discharge plan during this reporting period.

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

Implementation Strategy

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

November 2025 SME Report

Section X. Performance Measure(s)

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

- 927 Individuals attended the in-reach presentations held in 75 SNFs.

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

- There were 989 unduplicated visits from December 14, 2024 – December 13, 2025.
    - SFN – 685 (69%)
    - Hospital – 254 (26%)
    - Home/Community – 14 (1%)
    - Swing bed – 36 (4%)

Number of unduplicated annual PCP visits to TPMs in SNFs.

- 2,093 unduplicated PCP visits were completed with TPMs residing in SNFs from December 14, 2024 – December 13, 2025.

Number of cases staffed per interdisciplinary team meetings and outcomes.

- There were 50 interdisciplinary staffing that involved 40 unduplicated individual cases during this reporting period. Note: some individuals have been staffed more than once.
    - June 14, 2025 – June 30, 2025 – 8

- July 2025 – 8
- August 2025 – 8
- September 2025 – 8
- October 2025 – 7
- November 2025 – 10
- December 1, 2025 – December 13, 2025 – 1

- The outcomes of the staffing's include:
  - Providing case managers with directions on how to effectively mitigate risks and develop a thorough risk assessment.
  - Guidance on how to interact with individuals who struggle with behavioral health symptoms.
  - Collaboration between the staff within behavioral health, developmental disabilities, vulnerable adult protective services, MFP/ADRL transitions, and other community agencies to provide comprehensive services.
  - Providing overall technical assistance and education as to how services may be authorized to fit the needs of consumers.

SA Section XI. Transition Services

Responsible Division(s)

DHHS Aging Services

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

Implementation Strategy

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

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

TPMs transitioning from an institutional setting will be assigned 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 responsible for 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.

Progress Report:

The State continues to complete contract monitoring and technical assistance is provided on a routine basis. Training is provided monthly, and the state hosted a Transition/Housing Collaboration for two half days in November 2025. The group learned about a North Dakota Association for the Disabled, Workforce Technology Project through Protection & Advocacy, and conducted role playing through the transition process, and some other engaging activities to focus on program allowances and definitions. The CILs and Housing Facilitators also participated in the Hospital and Nursing Facility presentations held across the state to provide feedback and build partnerships with the facilities. The take-home messages shared were the need for a timely referral from the SNF and transparent communication so that the providers in the community can be better equipped to meet the individual's needs.

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)**

Progress Report:

The state has requested federally funded short-term rental assistance for six (6) months, so that we can leverage our state funds and provide more assistance to all, by utilizing this funding option if approved by CMS. The timing of a decision from CMS is unknown.

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

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

Updated Challenges to Implementation:

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

Progress Report:

Of the 78 completed transitions in Year 5 of the SA, 51 (65%) of TPMs were transitioned within 120 days. Thirty-five percent (35%) took longer than that. Eleven (11) of the twelve (12) TPMs who transitioned using the Transition and Diversion Services Project (TDP) were transitioned home in 60 or less days. One transition took over 150 days. This program does not require a TPM to have resided in the nursing home for 60 or more days. This is a requirement of MFP. The State believes that this can be attributed to a shorter length of stay, helping to make transitions more successful. If people have recently entered the nursing home and indicate a desire to return to the community, steps can be taken to help them keep their housing and secure their income, facilitating a smoother transition.

This is currently being reported regularly through an active list which shows anyone who has not transitioned within 90 days of consent. In addition to this list is also a closed list. This list includes anyone who was open over 90 days from consent who then had their case closed for various reasons prior to transitioning. There is also a list included for

anyone who transitioned and a separate list for individuals who may eventually transition but may have chosen to have a visit from the Options Counselors quarterly, semiannually, or annual versus a monthly visit by the transition team.

Updated Strategy 2. The State will continue to conduct a quarterly review of all transitions to identify effective strategies that led to successful and timely transitions, trends that slowed transitions, and gaps in services necessary to successfully support TPMs in the community. In 2024, 36 unduplicated TPMs had a quarterly review because they were waiting for transitions for 90 or more days. The State identified the following issues to be the top 10 barriers to TPMs accessing community living. TPMs may have barriers in multiple areas. An update to the SA requires the State to design and implement two (2) new strategies to mitigate barriers TPMs face when trying to transition to the community. The strategies are contained throughout this section.

Progress Report:

Top 10 Barriers to Transition 12/14/2024-12/13/2025	N=45
TPMs on 90+ day Active Transition List	n/a
Accessible unit needed	5
Voucher needed	4
Lack of Documents	3
Credit issues	2
Eviction history	2
Behavioral Issues	1
Needs to gain strength	1
Provider needed	1
Income needed	1
Not Medicaid eligible	1

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

Progress Report:

See Section XI Performance Measure(s)

Updated Strategy 4. Addressing the issue of finding a provider, especially one available 24/7, ranks high on the list of the most common transition barriers. However, these numbers can be misleading because in most cases, the transition coordinators don't start searching for a provider until the housing issues are resolved. The State will change the way we track future data and will not include finding a provider as a barrier unless providers are actively being sought. Many TPMs needs can be met through Residential Habilitation and Community Support Providers and there are 31 providers currently enrolled to provide these services. However, many of them are limited to serving people in the Fargo area. The State will continue to offer assistance for obtaining initial CQL accreditation for up to five (5) additional agencies who want to enroll to be Residential Habilitation and Community Support Providers**.** The State will track the actual number of TPMs who are waiting to transition because they can't find a provider and the number of Agency providers who have been assisted to enroll. **(The State has funding available to assist with CQL accreditation for providers willing to serve in rural or gap areas.)**

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

Progress Report:

The State assisted four (4) agencies with CQL accreditation during this reporting period. One (1) is a new agency, not currently enrolled and is working on the requirements, one (1) is an agency who is now enrolled, and two (2) are previous agencies who were already enrolled.

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

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

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

Progress Report:

A dedicated Durable Medical Equipment (DME) Training was completed on October 16, 2024, by the Program Administrator in Medical Services who oversees the DME program. The State invited the DME program administrator to the training with the nursing facilities so she can hear the concerns and provide responses. The State also discovered and shared an additional resource option for DME provided by ND Association for the Disabled. The State will provide additional training opportunities for the CILs and on-going technical assistance.

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

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

To address these issues, the State plans to collaborate with Legal Services of ND, Protection and Advocacy, and other stakeholders to explore solutions. These may include identifying mediators, training peer supports as supportive decision-makers, and developing resources to educate TPMs about their rights to make their own decisions and what steps to take if they feel their guardian is not respecting their needs and preferences. The State will track meeting dates and suggested recommendations for the development of future strategies that will be added to the IP. The State will draft educational materials and track the number of TPMs who were assisted in advocating for their right to live in the community and the outcomes of any third party or peer support attempts to mediate these situations that led to successful transition. **(Target completion date to draft recommendations, educational materials, and assignment of third neutral third party/peer support July 1, 2026)**

Progress Report:

Capacity has been documented as a barrier/concern in some monthly 90+ day reviews.

The State has drafted a FAQ document regarding guardianship and informed consent law in ND. The document will be shared with the SME and DOJ team for their review and input. Once complete, the Legal Advisory Division will conduct training with all Adult and Aging Services staff.

A workgroup meeting will be held with the stakeholders mentioned in the above strategy later this year. During the last Legislative session, a bill to require the development of a Statewide Guardianship agency was passed. During a recent US DOJ SA stakeholder meeting there was feedback that suggested we may need to wait to have these types of discussions with a broader stakeholder group until that agency is up and running. The agency will start in April 2026. The State has had multiple meetings with the new Director to discuss concerns we have seen as it relates to TPM transition and diversions including a meeting with DOJ staff and members of the SME team. The State will continue to involve the director and agency staff in future discussions involving TPM capacity and healthcare consent issues.

MFP has implemented a new process to check and see if new referrals have a guardian prior to their first meeting with the participants. The 90+ day list now includes a section that clearly indicates which TPMs have a guardian or a DPOA for healthcare.

MFP is also documenting who is not in agreement with the transition plan; family, guardian, client, and are more inclusive regarding who is impacting the decision along with who has authority in that regard.

New Strategy 7. 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 will be referred to take the SmartwithMyMoney.nd.gov program. Learn more here. 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. **(Implemented August 2024 and ongoing)**

Progress Report:

- **Dakota CIL**: Two (2) TPMs completed the voluntary course; both individuals required payment of back rent, one (1) has transitioned and the other transition is still pending. The training is available to all CILs to use as a tool in developing strong transition plans

  The Transition Coordinators and Housing Facilitators met with the *Smart with My Money* trainer on June 18, 2025, to learn more about the platform. Currently, users must create an account and log in to access the courses. Aging staff inquired about the possibility of printing training materials for individuals to use as a reference while taking the course and are awaiting a response from the platform. An Aging Services team member will follow up on this request.

New Strategy 8. To address the barrier of missing essential documents such as a State identifying document (ID) or birth certificate required for federal housing and other assistance, the Housing Facilitation Referral assessment will now ask if they have a valid

ID, birth certificate, and proof of citizenship status. If any documents are missing, Housing Facilitators and Transition Coordinators will immediately begin assisting them in obtaining these, reducing the chance of transition delays. **(Implementation date January 1, 2025)**

Progress Report:

Transition Coordinators and Housing Facilitators are required to identify and document this information at the time of referral to ensure it is obtained from the outset. Housing Facilitators have made coordinated efforts to implement updates to this process.

Updated Strategy 9. The State contracted with Legal Services of ND to hold scheduled "futures planning" events and to distribute tool kits to educate HCBS recipients about the need to take steps now to ensure their health care and other wishes are known in the event they become incapacitated. The goal of the in-person events was to provide education and have a completed durable power of attorney for health care or other legal documents that are ready to be shared with their family and healthcare providers by the end of each event. Legal Services also held monthly educational webinars from November 2024 – March 2025. HCBS recipients who want to create advance directives can also schedule a virtual appointment with attorneys from Legal Services. The State tracked the number of HCBS recipients who attended the events and completed advanced directives to include in future reports. **(Completed April 1, 2025)**

Progress Report:

Twenty-six (26) webinars or in-person events were held throughout the state in 2025 at various locations. Seventy-one (71) directives/POAs were completed at these events. The State is exploring the possibility of continuing to offer futures planning to HCBS recipients now that the ARPA 9817 funds are ending and will provide updates in future reports.

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

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

that all of the CILs have trained peer support professionals that can serve an TPM who is interested in receiving this service. **(Contract is complete and staff have been hired January 1, 2026)**

Progress Report:

See Section XI Performance Measure(s)

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

Updated Implementation Strategy

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

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

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

Progress Report:

The discharge form has been updated to include the discharge date. In addition, a letter was drafted to send to SNFs that have sent past MFP referrals with less than a two (2) week discharge plan. The letter was sent to 25 SNFs on February 20, 2026. The State will continue to document and track referral timeliness to see if the additional education had any impact.

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

Updated Implementation Strategy

Strategy 1. By December 13, 2026, through increased awareness, including in-reach and outreach efforts, person-centered planning and ongoing monitoring and assistance, the State will use local, State, and Federally funded HCBS and supports to assist at least ~~60~~ 70% of the TPMs who request transition to the most integrated setting appropriate. Referrals are the number of TPMs who have signed consent to participate in MFP or ADRL

transitions and are actively waiting to transition. The State will also divert at least 150 TPMs from SNF to community-based services. **(Ongoing Strategy through December 13, ~~2025~~ 2026)**

Progress Report:

See Section XI Performance Measure(s)

New Strategy 2: A barrier to community living for some TPMs is the difficulty of securing enough direct support staff, particularly when their physical needs require more than two (2) caregivers to ensure safety during intermittent care that is needed throughout the day. To address this issue, the State will authorize assistive technology assessments to determine if equipment could reduce the need for human assistance. Additionally, the State is exploring remote monitoring solutions to potentially decrease reliance on multiple caregivers, offering TPMs more care options and greater independence. **(Ongoing strategy, target completion date for a decision about remote monitoring solutions March 31, 2026)**

Progress Report:

Through person-centered planning, the state works with individuals to identify barriers to community living. When it is identified that there is a barrier such as difficulty of securing enough direct support staff, particularly when their physical needs require more than two (2) caregivers, the case manager works with the individual and providers to offer options that may help to alleviate the identified barrier. The State may authorize an assessment to evaluate if there are options for environmental modification, specialized equipment or assistive technology that could reduce the need for human assistance. Additional staff have been authorized to serve TPMs who need a two (2) person assist using the Rate Augmentation fund. Remote monitoring is a tool that could be used with the written consent of the TPM and their legal decision-maker and will require that any restrictions are based on an assessed need and justified in the PCP as required by the HCBS settings federal rule.

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., the ability to help others and job flexibility. **(Completed December 13, 2025**)

Progress Report:

QSP Hub 2025 Annual Survey Results

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

Progress Report:

A total of 44 individuals transitioned during this reporting period. There were five (5) MFP participants who also have transitioned as a TPM in a prior reporting period. These five (5) individuals were not included in this reporting period transition numbers.

Section XI. Performance Measure(s)

Number and total dollar amount of incentive grants awarded.

- There were 16 applications received from QSPs, two (2) Transportation Grants, for $75,000 and $73,000, were awarded on June 13, 2025, for the purchase of four (4) ADA accessible vehicles to provide transportation services to TPMs. The grants were awarded to Blossom Services in Fargo and All-Embracing Home Care that operates in Fargo and Grand Forks. Both grants were successfully completed. The State is determining the feasibility of awarding more grants with any carryover from the 9817 10% Plan Funds.

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

- There were nine (9) individuals re-institutionalized for more than 30 days during this reporting period.
    - Four (4) individuals decided not to go back to the community.
    - Two (2) of these events ended upon death of the individual.
    - Two (2) individuals are still working to return to the community.
    - One (1) individual was closed by HCBS due to health, welfare, and safety.
- Reasons for re-institutionalization:
    - Deterioration of health.
    - Fall,
    - Broken hip,
    - Choking,
    - Swelling,
    - Flu,

        - Dizziness and confusion.

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

- During discussions on June 30, 2025, it was decided the State would report anyone who signed consent based on the referrals who are actively working towards transition and divide that number by anyone who transitioned.
- 55% of the TPMs who requested transition by signing the consent form transitioned to the community.
    - 120 referrals were received.
    - Eighty (80) individuals (71 MFP and 9 TPD) signed consent.
    - Forty-four (44) individuals transitioned.

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

- There were no peer support referrals to the pilot project being administered by the Independence CIL during this reporting period because the project is just getting started.

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

- Thirteen (13) individuals received a combination of a voucher, Project Based, MFP Rental and/or TPM Rental Assistance.

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

- There were 40 TPMs who used alternative rental assistance and 29 are still living in the community one (1) year later. Of those 40 TPMs:
    - Two (2) individuals are deceased.
    - Nine (9) individuals moved back to a SNF.
        - Two (2) of these nine (9) are going through the MFP transition process a second time.

SA Section XII. Housing Services

Responsible Division(s)

DHHS

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

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

November 2025 SME Report

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

Implementation Strategy

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

Challenges to Implementation

In 2024, accessible and affordable housing is the number one (1) barrier for TPMs awaiting transition in many 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.

Progress Report:

See Section XII Performance Measure(s)

New Strategy 2. During the first few years of the SA 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 or return to their homes by making them safe and accessible for necessary care. The State will continue to educate the CILs that this service is available statewide. **(Completed August 1, 2025)**

Progress Report:

See Section XII Performance Measure(s)

New Strategy 3. When landlords notify Housing Facilitators about an available accessible apartment for rent, the facilitators will begin tracking this information to match available housing with TPMs waiting to transition. The total number of accessible units will be reported in both the MFP and 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. **(Implemented October 2024 and ongoing)**

Progress Report:

See Section XII Performance Measure(s)

Updated Strategy 4. Convene quarterly State Housing Services Collaborative to review and offer feedback on the Low-Income Housing Tax Credit Qualified Application Plan annually, particularly as related to the incorporation of plan elements that would increase TPMs' access to affordable, appropriate housing options. **(Ongoing strategy)**

Progress Report:

The State continues to have a strong relationship with our housing partners like the North Dakota Housing and Finance Agency. The goals for the collaborative remain the same and the group will reconvene to welcome any new members and align with the Governor's Housing Initiative.

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

Implementation Strategy

Updated Strategy 1. Complete and maintain a housing coordinator crosswalk to identify the entities that offer housing facilitation and what type of support they offer to ensure everyone is aware of the parameters of each program. The intent is to avoid duplication and understand the eligibility of each program to facilitate appropriate referrals. **(Ongoing Strategy)**

Progress Report:

The crosswalk was completed, and a summary was drafted in December 2024.

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

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

Progress Report:

See Section XII Performance Measure(s)

New Strategy 3. The rules governing HUD Mainstream Vouchers have recently changed. It is now possible for anyone with a disability under age 62 years in America to request a housing voucher from the ND Housing Authorities. To ensure that HUD Mainstream Vouchers are available for TPMs living in ND, the State is working with the eight (8) ND

Housing Authorities to update their policies and create MOUs to establish a priority list for local citizens and develop a separate waiting list for Mainstream Vouchers. **(Completed December 31, 2025)**

Progress Report:

Five (5) of the eight (8) Housing Authorities have signed a MOU. Cass County, Stark County and Fargo Housing Authorities have not completed MOUs at this time but continue to be strong partners and supports for transitions and diversions. Both Public Housing Authorities have been willing to process and accept ported vouchers from other areas of the state and have called upon for assistance with two project-based rental units whose contracts were dissolving.

New Strategy 4 To increase access to resources to provide environmental modification to TPMs already living in the community, the Rehab Accessibility Program (RAP) administered by the ND Housing Finance Agency will update the amount of funds available to pay for renovations from $5,000 to $7,000 per person. The $300,000 fund allows unspent dollars to carry over each year through Federal Fiscal Year 2029. The fund offers grant dollars for the renovation of properties occupied by lower-income North Dakotans with physical disabilities. Examples of qualifying renovations include the installation of ramps, door levers, walk-in/roll-in showers, grab bars and widening of doorways. Mainstream vouchers are only available to disabled people under the age of 62. **(Estimated completion date June 1, 2026)**

Progress Report:

See Section XII Performance Measure(s)

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

Implementation Strategy

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

Progress Report:

Housing facilitators are equipped in this area and have looked to North Dakota Association for the Disabled which is a local nonprofit and other partners to assist in providing funding

for deposits and other costs. Housing Facilitators worked with ND Assistive to formalize training for case managers and other entities to access the Home Modification Capital Fund.

All 11 Housing Facilitators, through Minot State University, have begun the ADA Coordinator Training Certificate Program and one of the Housing Facilitators is fully certified. Individuals must pass a test after completion of the required number of credits.

Updated Strategy 2. Individuals who enter a nursing home on a short term stay who have the intent to return to the community must take steps to protect their housing from being counted as an asset when determining Medicaid eligibility. Guidance in the form of a brochure has been created for use by the LTSS OC, eligibility workers, landlords, discharge planners, and housing support team professionals. The brochure is used to educate TPMs on how to maintain their housing while temporarily in an institutional setting because of HUD and Medicaid-related policies and requirements related to the allowable time away from a housing unit. The State will work on a process to help TPMs maintain their community housing by flagging the individual as someone who has an "intent to return home" and is in the facility on a short-term stay. State staff will be trained to ask the TPM or their legal decision maker if they have the required documents to ensure that they can receive housing assistance and maintain their Medicaid.

Challenges to Implementation

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

Remediation

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

Progress Report:

See Section XII Performance Measure(s)

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

Progress Report:

Twice a year, the Housing Facilitators hold a series of 12-week training courses to ensure the team has the most up-to-date housing-related information. During this reporting period, there were 580 attendees. This number is not unduplicated.

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

Implementation Strategy

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

Progress Report:

Each year the Housing Facilitators attend the Fair Housing training to stay current, and all incoming staff are required to attend this training as well.

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

Implementation Strategy

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

Challenges to Implementation

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

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

Progress Report:

See Section XII Performance Measure(s)

Section XII Performance Measure(s)

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

- Twenty-six of 44 TPMs who transitioned in this 6-month reporting period received either a voucher, project based, and/or MFP rental assistance. Some individuals received more than one resource.

- 8 Voucher
- 14 Project Based
- 14 MFP Rental Assistance
- 4 TPM Rental Assistance

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

- There were 40 TPM's who transitioned a year ago who were utilizing State funded rental assistance.
    - Twenty-nine individuals are still living in the community.
    - Two (2) of these individuals are deceased.
    - Nine (9) have moved back to a SNF.
    - Two (2) who moved back to a SNF are now back in the transition process.

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

- There were 33 individuals out of 44 who transitioned and received housing facilitation.

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

- There were no requests to maintain housing in the community during a SNF stay.

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

- Thirty-four TPMs who transitioned received rental assistance during this reporting period.

Number of environmental modifications completed using rebalancing funds.

- There were no modifications completed during this reporting period using rebalancing funds. The project started on August 1, 2025.

Increase in the total number of environmental modification projects.

- There were nine (9) modifications completed for eight (8) individuals during this reporting period. There were five (5) modifications completed from December 14, 2024 – June 13, 2025. That is an increase of four (4)

modifications.

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

- Eight (8) of the modifications were completed in an average of 39 days. The average during the last reporting period was 54 days, therefore there was a decrease of 15 days.

- One (1) of the modifications was extensive and took 302 days to complete.

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

- $300,000 remains in the fund at this time.

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

- There were six (6) landlords reporting to MFP that they had various accessible units open for MFP participants during this reporting period. In these six (6) unique contacts there are a minimum of 23 separate accessible units identified.

    - Optima – Grand Forks – 1 unit
    - Accessible Space – Minot – 1 unit
    - Accessible Space – Jamestown – 12 units
    - Accessible Space – Dickinson - 7 units
    - Scott Kramer – Rugby – several mobile homes
    - Metro Plains – Fargo – 1 unit
    - LCD – Fargo – new building, unknown amount of units
    - Beyond Shelter, Inc. – Fargo – 1 unit

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

- Five (5) TPMs were matched with accessible housing during this reporting period. Five (5) TPMS were matched to apartments in Minot, Jamestown and Fargo.

SA Section XIII. Community Provider Capacity and Training

Responsible Division(s)

DHHS Aging Services and Medical Services

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

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

Implementation Strategy

Updated Strategy 1. Continue to use MFP capacity building funds for the QSP Hub. The QSP Hub assists and supports Individual and Agency QSPs and family caregivers providing paid and natural supports to the citizens of ND. **(Ongoing strategy funded through December 31, 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 new technical assistance tools such as user guides available in multiple languages. All technical assistance tools were to reflect the new QSP application portal enrollment process.

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

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

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

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

- Establish and implement QSP agency recruitment initiatives.

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

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

Progress Report:

See Section XIII Performance Measure(s)

New Strategy 2. The 2024 QSP Annual Survey revealed that 30% of individual QSPs who expressed interest in additional training specifically requested education on various diseases and medical conditions. In response, the State will collaborate with the QSP Hub and other qualified entities to find training tools and live events to enhance QSP knowledge in this area. Potential topics include schizophrenia, bipolar disorder, dementia, traumatic brain injury (TBI), stroke, multiple sclerosis, and Parkinson's disease. **(Ongoing strategy funded through December 31, 2027)**

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

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

Progress Report:

A drafted outline of disease specific and behavior related training has been sent to DHHS for review and approval. Once approved the QSP Hub will work to complete a variety of training specific to various medical conditions and behaviors. The QSP hub has also drafted a live training schedule that will allow professionals to educate our QSP's on specific diseases and medical conditions. With approval, these training opportunities will begin in March 2026.

New Strategy 3. The 2024 QSP Annual Survey indicated that most QSP agencies requesting training need support in business acumen, particularly in managing the claims process, followed by marketing services and staff management. To meet these needs, the State will collaborate with the QSP Hub to provide targeted training. The QSP Hub will produce service-specific claims videos that guide users through each step of service authorization and claims submission, aimed at helping new users get started after enrollment. Additionally, the State will involve Medical Services claims staff and the billing system vendor to offer comprehensive claims training. The QSP Hub will also create specialized training focused on marketing strategies for small businesses. **Ongoing strategy funded through December 31, 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. Responses to this question will also be tracked in the 2025 QSP Annual Survey. The QSP Hub will be asked to track and trend the number of calls to the Hub related to these topics after training is provided.

Progress Report:

The QSP Hub team meets with MMIS monthly. The MMIS education team is working on claims related resources and the QSP Hub will share these resources when they are available. The QSP Hub has training around business acumen topics included in the monthly training series (Section XIII. Strategy 2). The series will take place during 2026-2027.

Updated Strategy 4. The updated QSP Hub work plan will focus on developing partnerships with ND high school and college student career counseling services to discuss the possibility of placing individuals working on a Certified Nursing Assistant certification or those studying to be an RN, OT, PT etc., with QSP agencies to gain experience and coursework credits while providing HCBS. Students could complete a placement in the community and could be hired as employees or work toward credit hours on their degree. **(Ongoing Strategy)**

Intended Outcome: Healthcare students will complete internships in QSP agencies, gaining HCBS experience that can lead to employment opportunities and increased access to HCBS.

Data: The QSP Hub will track the number of internships established and the number of students who were retained by the agency or indicated interest in pursuing future work in the in-home and community-based services field.

Progress Report:

The QSP Hub has worked to reach out and meet with various school districts. There are plans to guest speak with the Grand Forks Career Impact Academy. The QSP Hub has participated in a variety of ‘scrubs’ events that take place in our rural school systems. The locations during this time frame included: Devils Lake, Grand Forks, Cavalier/Pembina, and Harvey. The QSP Hub will continue to evolve this strategy as opportunities allow but it is difficult to track if any students went on to become a QSP because the QSP Hub does not track which students they speak to at these events.

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

Intended Outcome: Services with a rate increase may attract additional providers, thereby expanding access to HCBS.

Data: The State will track the number of QSPs enrolled to provide the service before the rate increases and monitor changes in enrollment after the increase to assess impact.

Progress Report:

The Legislators approved a two (2) percent inflationary increase for all QSPs effective July 1, 2025. The increase has been implemented, and all providers have been made aware of the new rates. The State will track enrollment trends and report the data in the next report. From July 1 - December 31, 2025, 34 new agencies and 203 individual QSPs have been enrolled.

In addition, a targeted rate increase for the following services and unit rates was approved January 1, 2026, and it has been implemented. The State submitted an HCBS waiver amendment and it was approved effective January 1, 2026.

Service	Proposed Agency Rate (15 min)	Percent Increase	Proposed Individual Rate (15 min)	Percent Increase
Personal Care	$9.40	16%	$6.84	16%
Chore	$9.40	16%	$6.84	16%
Homemaker	$9.40	16%	$6.84	16%
Respite	$9.40	16%	$6.84	16%
Supported Employment	$9.40	16%	$6.84	16%
Transitional Living	$9.40	16%	$6.84	16%
Companion Care	$9.10	25%	$6.63	25%
Supervision	$9.10	25%	$6.63	25%

Non-Medical Transportation	$9.10	25%	$6.63	25%
Nursing Care	$19.71	25%	$15.64	25%

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

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

Progress Report:

Provider enrollment statistics are tracked separately for agency and individual QSPs. In 2025, the average processing time for QSP application approval was 10 days for individual providers and 33 days for agency providers. Processing times were longer in the last two (2) quarters of 2025 due to an increased volume of applications, higher number of providers applying for services with more complex enrollment requirements and working with providers who do not upload all the required documents when they first submit their application. The numbers are also reflective of a change in procedure. In the past applications that were inactive for more than 15 days were closed and the applicant had to start the process over. Based on provider's feedback the practice has now changed, and providers are provided with technical assistance, and applications are left open if the provider is still actively working on enrollment.

Medical Services currently has three (3) full-time staff dedicated to provider enrollment.

Updated Strategy 7. Continue to refine and fully implement a centralized QSP matching portal in cooperation with ADvancing States. The system is currently in place and replaced the former QSP online searchable database. The new system was designed with State-specific modifications to a national website called Connect to Care formally referred to as ConnecttoCareJobs to significantly improve the capacity of TPMs in need of community services to evaluate and select individual and agency QSPs with the skills that best match their support needs.

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

updates of new QSPs and changes to current QSP information so information in both systems is always current.

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

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

Progress Report:

See Section XIII Performance Measure(s)

Updated Strategy 8. The State will create a Communication and Recruitment Plan to engage other agencies as potential community providers for the target population in "service desert" areas like Jamestown and Dickinson, ND. The plan may include meeting directly with the leadership of specific healthcare agencies like hospitals and SNFs and their provider associations to directly ask for their assistance in providing HCBS to TPMs that live in their service area. The Aging Services Section Director will work with the Public Information officers to design an outreach letter that can be used to communicate with SNFs or health systems who may be interested in becoming a QSP. In addition, the State will continue to provide ongoing group and individualized training and technical assistance to SNFs that express interest in learning about HCBS. **(Updated Target completion date ~~August 1~~, ~~October 1, 2025~~ ongoing strategy)**

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

Progress Report:

The State has not sent letters but has chosen to hold meetings with agencies who already provide care in the "service desert" communities. A meeting was held on January 21, 2026, with a local DD provider in Jamestown to discuss the possibility of providing in-home care to a TPM who has been waiting a long time to transition. The provider declined to assist, stating they do not have adequate staff to take on more clients.

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

> **Intended Outcome:** Recruit individuals willing to provide care to TPMs waiting to transition due to a lack of available providers or staff in their chosen community. Reduce the number of TPMs waiting for a provider to facilitate their transition from a SNF to the community, and decrease the total time required to complete TPM transitions.
>
> **Data:** The State will track the number of providers recruited the number of TPMs who ultimately transitioned home, and the number of days to transition in situations where this marketing strategy was used.

Progress Report:

Transition teams have explored the possibility of doing this with TPMs who have been waiting to find a provider so they can transition. The TPMs have declined and do not want their information shared in this way. Transition teams will continue to offer this option for TPMs in the future.

New Strategy 10. Support start-up and enrollment activity costs for existing QSPs to establish or expand their ability to provide non-emergency medical transportation, non-emergency medical transportation escort, and community integration activities for HCBS recipients by providing grants to purchase new or used accessible vehicles. These grants will be available to HCBS providers in good standing, who have been enrolled for a minimum of two (2) years and those who are currently providing services to an HCBS recipient. The State is currently determining the amount of funds available and number of grants that will be awarded. **(Grants awarded by May 01, 2025)**

> **Intended Outcome:** Increase access to transportation and community integration services by providing grants to QSP agencies for purchasing accessible vehicles.
>
> **Data:** Increase the percentage of HCBS recipients who report that transportation is not a barrier to accessing the community, as measured in the 2025 National Core Indicators for Aging and Disability (NCI-AD) survey.

Progress Report:

See Section XI Performance Measure(s)

Updated Strategy 11. To ensure timely enrollment and revalidation of QSPs, the State will continue to keep QSP enrollment duties in-house. The State hired five (5) temporary QSP

enrollment staff that work under the supervision of the Medical Services QSP Enrollment Coordinator. Staff use the QSP portal to complete all aspects of QSP enrollment. QSP enrollment staff are also responsible for managing the Connect to Care QSP registry, which interfaces with the QSP portal to ensure the 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. **(Implemented January 03, 2024, 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.

Progress Report:

See Section XIII Performance Measure(s)

Updated Strategy 12. Continue to work with a vendor to complete a project to assess the current training requirements and structure for HCBS providers working in Aging Services, Developmental Disabilities Services, Autism Services, and Behavioral Health Services. The vision for the project is to identify and establish innovative workforce training strategies to meet provider needs and improve the quality of life for North Dakotans with disabilities.

The expected goals of the project are to:

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

DHHS partnered with an independent consulting firm to perform the assessment and develop recommendations to implement pathways for an innovative workforce training strategy. As part of their assessment, they asked key stakeholders to complete a web survey and to participate in discovery sessions to provide perspective and inform our understanding of both the current workforce training structure, as well as the needs and desires for the future. The State is currently drafting a Request for Purchase (RFP) to revise the current training for HCBS providers across the lifespan. Future drafts of the IP will contain strategies to implement the training recommendations including the possibility of offering scholarships to providers to encourage participation. **(Target completion date June 30, 2026)**

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

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

Progress Report:

The State has agreed to use a curriculum that was created by the University of Wisconsin. Staff will begin working with the vendor to customize the curriculum by the end of January and a kickoff meeting was held on January 23, 2026, to configure the LMS that will host the new training.

Updated Strategy 13. Each year many individual QSPs enroll to provide care to one person who may be a relative or a friend who needs assistance. When the individual they serve passes away, moves to a SNF etc., they often stop being an individual QSP. Some of these former QSPs, if asked, may have enjoyed the caregiving role and would be willing to serve other individuals in need of care. Retaining these QSPs would increase the State's capacity to serve TPMs. Now that the new QSP enrollment portal is complete, State staff will work with the QSP Hub staff to design an effective outreach campaign to attempt to retain QSPs who originally enrolled to serve a family member or friend. QSPs in areas of the State that lack sufficient QSPs will be targeted. The State will target QSPs that were disenrolled in the past six (6) to nine (9) months and were in good standing with the DHHS will be targeted for this project. The State will track the number of individuals we reached and if any of them enrolled to provide care. We will also add language to the QSP handbooks to make sure people are aware of the ongoing opportunity to be a QSP after their family caregiver journey ends. **(Target Completion Date March 1, 2026)**

Intended Outcome: Increase access to HCBS by recruiting former QSPs in good standing to become providers again.

Data: Track the number of providers who re-enroll and the number of HCBS recipients they subsequently serve.

Progress Report:

See Section XIII Performance Measure(s)

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

Updated Implementation Strategy

The State will provide ongoing critical incident reporting training opportunities for QSPs. Training will be provided through online modules and virtual training events. The State QSP handbook includes current reporting requirements. The State will also work with staff from the QSP Hub to develop marketing of ongoing training that will assist QSPs in

understanding and complying with safety and incident reporting procedures. The QSP Hub assists in making QSPs aware of training opportunities, but the training content is developed and delivered by an Aging Services nurse administrator. **(Ongoing strategy)**

Progress Report:

Critical incident reporting training was completed on September 30, 2025, with 21 QSPs in attendance. In addition to these sessions, QSPs have access to an online training module, various Therap resources, 1:1 education, and a recorded live training for additional learning.

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

Implementation Strategy

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

November 2025 SME Report

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

Implementation Strategy

Updated Strategy 1. Increase the capacity for providers to serve TPMs on Native American reservation communities by continuing to partner with Tribal nations and to request funds for the Money Follows the Person-Tribal Initiative (MFP-TI).

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

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

The State holds monthly meetings with a group of subject matter experts with representation from each Tribal nation in ND to address the outstanding in-home and community-based service needs of Tribal members. The group is currently implementing 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)**

Progress Report:

The State continues to hold monthly meetings with a group of subject matter experts with representation from each Tribal nation in North Dakota 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 state is currently working with the group to simplify and align the assessment and documentation to ease access to home and community-based services.

Updated Strategy 2. Increase the capacity for providers to consult accessibility experts when implementing HCBS such as environmental modification by providing funding to the CILs or other organizations to allow more of their staff to be trained as accessibility experts. Grants will be awarded to allow approved agency staff to complete the ADA Coordinator Training Certificate Program or other similar training. **(Training is being scheduled target completion date of May 31, 2026.**

Progress Report:

See Section XII, Subsection D Updated Strategy 1.

Updated Strategy 3. The State submitted a proposal and continuously updates the plan approved by CMS and has secured the legislative authority to use the temporary 10% increase to the FMAP for certain Medicaid expenditures for HCBS to enhance, expand and strengthen the HCBS system for TPMs. **(Ongoing strategy through June 30, 2026)**

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

Progress Report:

- QSP Rate Augmentation Fund
    - Peer Support project for TPMs started August 1, 2025. Independence CILis implementing this pilot program and has recently hired staff to manage this effort.
- Hospice and Home Care Grant
    - The grant has ended but the hospice organization continues to provide home and community-based services including nursing services as a QSP in the expanded service area. They will also continue to provide hospice services statewide and have a house calls program where doctors and nurse practitioners provide care in the individuals' home.
- ConnecttoCareND implementation

- The State is still waiting to complete full integration of the 4L system into the QSP enrollment portal before asking Agency QSPs to claim their accounts. Integration should happen by February 28, 2026. The 4L system is an automated tool that allows agency providers to screen employees to ensure they meet the necessary requirements to provide services funded by state and federal programs. It checks for criminal convictions, sex offender status, debarment from government contracts, and other disqualifying factors.

- Once this feature is fully operational, Agency QSPs will be asked to claim their enrollment portal accounts and enter all employees who serve publicly funded clients into the system for validation through the 4L system. This information will be transmitted through a nightly interface, enabling agencies to create an account and a social media-style profile in ConnecttoCareND to help market their services.

- The final step in implementing the ConnecttoCareND system is to begin using its learning management platform to host provider training modules. These modules will replace the current method used to demonstrate a QSPs competency to provide care. The State is working with Advancing States to procure standardized training that will be used by all HCBS providers in North Dakota. Additional training modules such as those focused on dementia care, traumatic brain injury (TBI), and other specialized topics, will also be hosted on the platform, allowing providers to earn credentials in these areas. The type of training a provider has completed will be visible to individuals using the registry to help them find a qualified HCBS provider. **(Target implementation date May 31, 2026)**

- Companionship services

    - The State contracted with Lutheran Social Services of MN to start a volunteer senior companion program for individuals who do not qualify for companionship services paid for under State or federally funded HCBS services. **(Completed August 1, 2025, funded through July 31, 2026)**

- QSP Enrollment Portal

    - The portal is operational, and the State is continuing to enhance the features based on user feedback.

- Marketing the ADRL

    - The State has secured funding to advertise the ADRL through social media 4 times per year.

- Workforce training and learning management system integration
    - See explanation under ConnecttoCareND implementation
- Behavioral health training for HCBS case managers and QSPs
    - See explanation in Section IX, Subsection H Updated Strategy 5.
- Capacity incentive grants
    - See explanation in Section XI. Performance Measure(s) - Number and total dollar amount of incentive grants awarded.

Section XIII. Performance Measure(s)

Number of QSPs assisted by the QSP Hub.

- The ND QSP hub provided technical assistance a total of 4,144 times during this reporting period. There were 1,020 unduplicated activities.

Number of QSP agencies receiving CQL accreditation.

- A total of 33 QSP agencies are CQL accredited. The State assisted four (4) agencies to maintain or obtain new accreditation during this reporting period.

Number of new agencies enrolled as providers.

- 36 new agencies enrolled as providers during this reporting period.

Number of agencies that stopped providing services.

- 10 agencies stopped providing services during this reporting period.

Number of new individual QSPs enrolled as providers.

- 211 new individuals enrolled as providers during this reporting period.

Number of individual QSPs that stopped providing services.

- 116 individuals stopped providing services during this period.

Rate increases effective January 1, 2026.

- Targeted rate increases were implemented effective January 1, 2026.

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

- There is not yet formal training for this platform as it is still in the process of being configured with the new training modules

Number of SNFs that have enrolled to provide HCBS.

- No new SNF have enrolled as QSPs. There are two (2) SNF who are currently enrolled to provide HCBS.

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

Responsible Division(s)

DHHS Aging Services

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

Strategy 1. State staff will conduct annual group in-reach presentations at every SNF in ND and ensure a consistent message is being used throughout the State. State staff will schedule and advertise a follow-up visit at the facility to give TPMs additional time to process the information and ask any follow-up questions. (**Complete December 13, 2025, and ongoing)**

Progress Report:

See Section XIV Performance Measure(s)

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

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

If a TPM chooses HCBS, they ask the nursing home to complete a State Form Number (SFN) 584 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. Because it will take time to see all TPMs in a SNF there may be individuals who would benefit from knowing about HCBS options prior to their scheduled visit.

LTSS OCs will continue to provide written information and their contact information during their initial and annual visits and will be required to document in the care plan that the individual was provided with this information. **(Ongoing strategy)**

Progress Report:

This is an ongoing process.

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

Implementation Strategy

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

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

Progress Report:

See Section XIV Performance Measure(s)

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

Updated Implementation Strategy

Continue to implement a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. Campaign will include marketing on social media at least four (4) times in Year 5 of the SA and will provide public education to the public, professionals, stakeholders, and TPMs at serious risk of entering nursing facilities. 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, 2025, and ongoing)**

Progress Report:

Adult & Aging Services are currently contracted with KAT Communications until 9/30/2026 to continue to run the ADRL PSA to create awareness about the services. Every month there is either social media or a digital campaign being run on their Good Health TV platform that is played in Indian Health Services clinics across the State. Adult & Aging Services has had booths or presented at 17 different events across the state to keep raising awareness about the services that the state has to offer.

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

The State will continue to use an additional $250,000 of supplemental grant funds that were recently awarded to enhance, expand, improve, and provide supplemental respite services and education to family caregivers in ND with resources provided through the Lifespan Respite Care Program: State Program Enhancement Grant, and other State and Federal funds. Grant received June 2021. **(Ongoing strategy)**

Progress Report:

See Section XIV Performance Measure(s)

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

Updated Implementation Strategy

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

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

Progress Report:

A workgroup has been developed within DHHS to collaborate with other divisions about website document accessibility. The deadline for all website documents to be fully accessible is April 24, 2026, except for those that have been archived in the past.

Section XIV. Performance Measure(s)

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

- A total of 927 individuals attended presentations at 75 SNFs.

Number of TPMs who requested and received a communication accommodation.

- 272 TPMs receiving HCBS received a language accommodation for interpreter services from December 14, 2024 – December 13, 2025.
- Twenty-six individuals received language accommodation for LTSS OC.
- 246 individuals received language accommodation for HCBS.

Number of TPMs who access respite, and the hours provided.

- Seventy-eight (78) TPMs are authorized to receive respite care. On average about 38 hours of respite care is authorized every month to assist caregivers in getting a short break from the caregiving duties.
- A total of 2,552 respite service hours were provided through the Lifespan Respite Care Voucher Program to 65 caregivers who provided care for individuals over the age of 21 from July 1, 2025 - December 31, 2025.

SA Section XV. Data Collection and Reporting

Responsible Division(s)

DHHS Aging Services

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

Implementation strategy

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

Updated Strategy 1. Continue to contract with a vendor to maintain and enhance the case management system that was fully implemented August 1, 2022. **(Target completion date December 13, 2025, and ongoing strategy)**

Progress Report:

The system was recently updated to accept interfaces from Wellsky when a SNF submits a 584-referral form in that system. This interface replaced a cumbersome manual process.

Updated Strategy 2. With the assistance of the Senior Research Analyst for the ND HealthCare Workforce Group at UND the State designed a method to analyze the number of units being authorized and utilized, by case management territory, to determine if there are significant discrepancies in the number of services available to TPMs across the State for the study period of State Fiscal Years 2022-2023 (July 1, 2021 – June 30, 2023). The study included Medicaid beneficiaries with 24 months of continuous coverage, or the duration of the two (2) state fiscal years. Anyone who died during the study period or who did not have continuous enrollment was removed from the study group.

Beneficiaries who met the study group criteria were screened for the presence of one (1) or more of the procedure codes. Beneficiaries who met enrollment and procedure code criteria were matched to the authorization file. The claim units from the service file were totaled and compared to the authorized services used.

Included services:

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

The State received preliminary data and determined that further refinement is necessary to ensure accurate calculations. The issue arises with group authorizations, where multiple QSPs are authorized to provide the same services to a TPM within the same period. Sharing units among multiple QSPs is common practice, as it allows two (2) or more providers to share caregiving responsibilities, ensuring continuous coverage and a backup plan if one QSP cannot cover a shift.

In the State's case management system, when multiple QSPs are authorized to serve the same TPM for the same dates, a group service authorization is created to represent the shared overall units. Technically, each provider has their own authorization showing access to the full authorized units in case they really need to provide all the care because the other two (2) QSPs are unavailable. However, the case management system groups these authorizations to indicate that only the total authorized units—not multiple sets of the full amount—are available. For example, if a TPM is authorized for 70 units of homemaker services per month, these units may be shared among three (3) providers. Each provider receives an individual authorization for 70 units in the case management system, but they are grouped to limit the providers collectively to the 70-unit maximum.

The challenge arises when these authorizations transfer to MMIS, which does not recognize group authorizations. As a result, MMIS reflects that the TPM has access to 210

units instead of the intended 70. Consequently, the MMIS data used to calculate the units authorized versus units used inaccurately shows that the TPM only utilized 70 of 210 units, significantly impacting the overall total of units used. The chart below illustrates draft homemaker data that shows that only 55% of the units authorized were used. This number seems very low considering the number of individuals who request homemaking services highlighting the need for further refinement to ensure accurate data elements and reporting.

Draft Homemaker Data

Procedure	Authorization Class	Number (all authorizations)	Percent
S5130 Homemaker	Authorizations	4,325	n/a
S5130 Homemaker	Authorized Services	723,670.50	n/a
S5130 Homemaker	Services Used	398,844.00	55.1%
S5130 Homemaker	Services Remaining	324,826.50	44.9%

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

Challenges to Implementation

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

Remediation

The State will work with the case management system vendor and the USDOJ, SME, and other experts to create a report that will produce reliable results that may assist the State in creating additional strategies to successfully implement the requirements of the SA. **(Completed July 31, 2025).**

Progress Report:

The State worked with UND Rural Health to complete an analysis of utilization data for Home and Community-Based Services (HCBS) authorized under various procedure codes for State Fiscal Years 22 & 23 (July 1, 2021 – June 30, 2023). The purpose was to evaluate service usage trends, identify areas of over- or under-utilization, and inform potential policy, funding, and operational improvements. Analysis of the data was included in the report submitted July 31, 2025.

A similar analysis will be required by CMS under the Medicaid Access Rule. This rule is intended to improve access to care, strengthen health outcomes, and advance health equity for Medicaid beneficiaries, particularly those receiving home and community-based services (HCBS). States must report the number of service units authorized and utilized for personal care, home health aide, homemaker, and habilitation services. The State is collaborating with the case management vendor to develop a report that will capture these data elements by May 1, 2026.

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

Progress Report:

This strategy was successfully implemented with VAPS reports now being entered electronically through an automated process. This advancement has enhanced coordination between HCBS and VAPS, improving efficiency and streamlining data management.

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

Key performance indicators include:

1. Referrals to HCBS
2. Average weighted HCBS case management caseloads.
3. Number of TPMs served in a skilled nursing facility (SNF).
4. Number of TPMs served in the community.
5. Number of TPMs diverted from a SNF.
6. Number of TPMs transitioned from a SNF.
7. Average annual cost of HCBS and SNF care.
8. Average length of time from QSP application submission to enrollment.
9. Number of QSP agencies enrolled as providers.
10. Number of individual QSPs enrolled as providers.

11. Number of 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 QSPs by county; indicate tribal, rural, and frontier.

Progress Report:

The KPI report is submitted to the SME every quarter and the most recent version is posted on the ND US DOJ SA website. 2025 Q4 KPI Report

Section XV. Performance Measure(s)

Number of service units authorized and utilized by county.

See Section XV Subsection A. Updated strategy 2 and Appendix C

SA Section XVI. Quality Assurance and Risk Management

Responsible Division(s)

DHHS Aging Services and Medical Services

Updated Implementation Strategy

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

November 2025 SME Report

Updated Strategy 1. ND will use a portion of the Vulnerable Adult Protective Services Coronavirus Response and Relief Supplemental Appropriations Act of 2021 funds to implement a unified critical incident reporting process. The unified system will meet the requirements of the HCBS quality framework that must be adapted by states with an MFP grant. All VAPS staff will have access to the critical incident reporting form in the web-based data collection system. Reports will be collected and automatically shared electronically with the case management system to be included in the critical incident reports. This will create a unified system for collection and sharing of critical incident reporting throughout Aging Services. This should allow for better coordination of services and data tracking. ND will continue to fund these efforts through the American Rescue Plan Act (ARPA) funding for VAPS. **(Completed February 1, 2025)**

Progress Report:

This has been implemented. An automated process has been developed where a "BOT" enters the APS report into the General Event Report (GER) module within the Therap Case Management system.

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

Implementation Strategy

Strategy 1. The State will continue to provide quarterly critical incident reporting training opportunities for QSPs. The trainings are advertised by sending emails to agencies and individual QSPs and posting training dates on the QSP Hub website. The State will also utilize the help of the ND Long Term Care 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 focuses on the State's data system and the State's processes for reporting, investigating, and remediating incidents involving the TPM. **(Ongoing strategy)**

Progress Report:

See Progress Report for Section XIII.B.Implementation.

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

Updated Challenges to Implementation

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

Remediation

The State has assigned one of the nurse administrators to be responsible for providing technical assistance to QSP Agencies to help them implement robust QI programs. State staff have reviewed all current QSP QI programs

for compliance. When a QI program does not meet standards, the State provides technical assistance and may recommend additional training or resources the QSP agency can use to reach compliance. Agency QSPs may also contact the QSP Hub for additional training and support.

Progress Report:

See Section XVI Performance Measures(s)

Updated Strategy 3. National Core Indicators – Aging and Disabilities (NCI-AD) is a process that measures and tracks the State's performance and outcomes of HCBS provided to TPMs. The NCI-AD survey was completed by over 400 HCBS recipients in 2023 and the survey will be completed again starting January 2025. The State reviewed the results of the study and collaborated with ADvancing States and the Human Services Research Institute (HSRI) to interpret the results. The State will include strategies to mitigate any identified quality issues, gaps in the service array, etc. in future versions of the IP. Quality performance reports are made available on the DHHS website and shared at USDOJ stakeholder meetings. The State intends to complete the NCI-AD survey every two (2) years. **(Ongoing Strategy)**

Progress Report:

The National Core Indicators – Aging and Disabilities (NCI-AD) survey was completed between December 2024 and March 2025. The State will review the results of the study and collaborate with ADvancing States and the Human Services Research Institute (HSRI) to interpret the results. The State will include strategies to mitigate any identified quality issues, gaps in the service array, etc. in future versions of the IP. Quality performance reports are made available on the DHHS website and shared at USDOJ stakeholder meetings.

Follow up on January 6, 2026 with ADvancing States and the Human Services Research Institute (HSRI) confirmed we can expect to receive the full report in March 2026 from the survey.

New Strategy 4. The 2023 NCI – AD report shows that 25% of TPMs on the HCBS waiver have had a history of at least two (2) falls in a six-month period and another 10% did not know or were unsure of their fall history. Aging Services CIR data shows that there were 54 falls reported in 2024 involving TPMs. Many of the falls happened in memory care facilities resulting in emergency room visits via ambulance. To reduce falls amongst TPMs, Aging Services staff will work with the memory care facilities to implement one of the evidence-based falls prevention programs offered under the Older Adult Administration (OAA) Title III-D Preventive Health program. Staff at participating memory care facilities will be trained to offer the fall prevention classes for free and will incorporate the classes into their resident activity programs with the goal of reducing fall related CIRs from this population. **(Target implementation date July 1, 2025. Did not implement the strategy due to no participants)**

Progress Report:

Aging Services reached out to memory care facilities to implement one of the evidence-based falls prevention programs offered under the OAA Title III-D Preventive Health program. Memory care facilities were offered free training and travel reimbursement. None of the memory care facilities chose to participate in the program because they would be required to keep data to measure program effectiveness.

New Strategy 5. The 2023 NCI – AD report shows that 15% of survey participants stated that they lack transportation to get to medical appointments, and 6% of the Medicaid State Plan - Personal Care participants stated they do not have transportation to get to medical appointments. Sometimes TPMs use the emergency room even when medical need is not really an emergency. One reason for this may be because it can be difficult to find a non-emergency medical transportation provider and the authorization process is not efficient. The State has already modified the QSP enrollment portal to allow individual and agency QSPs to enroll as a non-emergency medical transportation provider making getting access to a provider easier. The next step is for Aging Services staff to work with the Medical Services Division to improve the authorization process to make it easier for TPMs to access this important service. **(Estimated completion date July 31, 2026)**

Progress Report:

Further information will be provided in the next reporting period. Delays have occurred because of competing priorities in both Adult and Aging Services and the Medical Services Division.

Updated Strategy 6. The State will continue to submit critical incident reports to the USDOJ and SME within seven (7) days of the incident as required in the SA. The SA was updated on August 29, 2024, to streamline the types of incidents that must be sent to the USDOJ. Based on this modified agreement the State now submits data within seven (7) days of the incident for: (**Ongoing strategy)**

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

Progress Report:

There was a total of 191 CIRs during this reporting period. All 191 (100%) were reported within the seven (7) day timeframe.

Strategy 7. An Aging Services nurse administrator is responsible to work with State staff to implement the HCBS Quality Measure Set as identified in State Medicaid Director letter SMD# 22-003 RE: Home and Community-Based Services Quality Measure Set (Measuring and Improving Quality in Home and Community Based-Services/Medicaid). The

HCBS Quality Measure Set is designed to assess quality and outcomes across a broad range of key areas for HCBS. The HCBS Quality Measure Set is also intended to promote more common and consistent use, within and across states, of nationally standardized quality measures in HCBS programs, and to create opportunities for CMS and states to have comparative quality data on HCBS programs. CMS plans to incorporate use of the measure set into the reporting requirements for specific authorities and programs, including the MFP program. Initial data collection needs to start in 2025 to be reported in 2026. The State has begun the process of implementing these measures and regularly attends training provided by CMS. Aging Services staff will be responsible for training state staff and QSPs on the details of the measures and their intended use. **(Ongoing Strategy)**

Progress Report:

The implementation of the CMS Quality Measure Set remains an active and evolving initiative. Since the hiring of the Quality Nurse Administrator in October 2023, a comprehensive crosswalk and review have been completed to evaluate existing processes in comparison to the federal requirements. This analysis informed the development of an implementation plan outlining necessary change.

Draft revisions to HCBS case management assessments and documentation—specifically targeting Measures 1 and 2—have been developed through multiple collaborative workgroup sessions. These updates include changes to the case management assessment, care plan, and risk assessment to ensure compliance with the measure requirements. The revised components have been integrated into the Therap system and are currently pending final approval for implementation.

In collaboration with various departments across Health and Human Services, work is underway to establish processes for Measures 6, 7, and 8. These meetings are ongoing and focused on developing a consistent, coordinated approach to reporting.
Currently, we continue to await further federal guidance regarding implementation timelines and additional reporting expectations.

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

Updated Implementation Strategy

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

To ensure timely reporting, DHHS Adult and Aging Services conducts critical incident reporting required training for QSPs. Training is provided quarterly through online modules and virtual training events. The QSP handbook includes current reporting requirements and critical incident reporting requirements are included in the QSP orientation that is required to enroll or revalidate as a QSP. In addition, the State reminds providers of the reporting timeframes each time a CIR is not submitted on time. **(Ongoing strategy)**

Progress Report:

See Section XVI Performance Measure(s)

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

Implementation Strategy

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

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

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

Progress Report:

See Section XVI Performance Measure(s)

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

Progress Report:

Quarterly CIR team meetings continue to occur in January, April, July, and October of each year.

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

Progress Report:

The Department continues to conduct mortality reviews at the quarterly CIR Team Meetings which includes 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. Deaths are classified as "natural/expected, other, sudden unexpected, and unknown."

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

Implementation Strategy

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

Progress Report:

See Section XVI Performance Measure(s)

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

Implementation Strategy

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

Progress Report:

See Section XVI Performance Measure(s)

Strategy 2. The State publicizes its oversight of the provision of community-based services for TPMs and provides mechanisms for TPMs to file complaints by disseminating information through various means including adding information to the DHHS website, HCBS application form, “HCBS Rights and Responsibilities” brochure, presentation materials, and public notices. **(Ongoing strategy)**

Progress Report:

This is an ongoing process.

Updated Strategy 3. The State has seen an increase in the number of complaints that have been filed about the care provided by QSPs. This trend in reporting is indicative of the increased number of individuals receiving HCBS each year, the complexity of the care needed by TPMs, and awareness of the right to file a complaint. The State is monitoring the capacity of the Complaint Administrator to manage the increased reports and has made a request and is considering options to fund an additional FTE to be allocated to Adult and Aging Services. The State is also looking at systems that will assist the Complaint Administrator to audit billing more efficiently in situations where the complaint alleges poor care or inappropriate billing. **(Target completion date March 1, 2025)**

Progress Report:

- Appendix D for a list of complaints filed during this reporting period.
- An additional complaint administrator was hired in December 2025.
- The State continues to collaborate with the MFCU and other key partners to promote the integrity and quality of HCBS services provided by QSPs. Adult and Aging Services worked with stakeholders to organize a provider integrity event focused on key compliance topics such as documentation, billing practices, and use of EVV. The event also highlighted recent system improvements designed to give QSPs the tools they need to meet state and federal requirements.
- Agency and individual in-person events were held in Fargo and Bismarck in October 2025. Nineteen (19) individual providers, and 47 Agency QSPs attended in-person. A virtual option was also offered and attended by 80 Individual QSPs and 89 QSP agency staff. **(Completed November 1, 2025)**

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

to take advantage of the HCBS system for personal gain. The orientation was implemented in January 2024 and will be periodically reviewed and updated. **(Ongoing Strategy)**

Progress Report:

The enrollment orientation is complete and will be updated as changes arise. The QSP Hub offers a monthly Getting Started Session to recently approved QSPs. This training helps with a variety of onboarding tasks in setting the providers up with knowledge and resources to be more successful as a provider.

The QSP Hub also participated in the DHHS Quality and Compliance training to QSP providers across the state. The training was recorded and posted for review on the QSP Hub website.

New Strategy 5. To build relationships and improve quality, Aging Services Program and Nurse Administrators are meeting with the leadership of all Residential Habilitation and Community Support Agencies to discuss program requirements, roles, and responsibilities of HCBS Case Managers and QSP Agency staff, and expectations for providing quality care and incident management. These meetings have been well received, and the Nurse Administrators will soon begin meeting with Extended Personal Care Nurses to improve communication and consistency of this important program. **(Ongoing strategy~~)~~**

Progress Report:

Program Administrators continue to meet with Residential Habilitation and Community Support provider agencies. Nurse Administrators meet with each new agency prior to and after enrollment to review program requirements and meet one-on-one with QSPs enrolled to provide NE/Expc services. Nurse Administrators hosted a Provider Update on October 17, 2025, for all Residential Habilitation and Community Support providers, with 35 in attendance, and conduct one-on-one meetings with Extended Personal Care Service providers as needed to educate them on service requirements and expectations. The Quality Nurse conducts audits of all agency QSP policies.

A video was recorded with overview of the programs and requirements, which has been posted on both the Adult and Aging and QSP Hub websites. In collaboration with the QSP Hub, Nurse Administrators also helped to develop a webinar for QSPs on April 16, 2025.

Section XVI Performance Measure(s)

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

- This information is not currently tracked by agency and facility providers. The data below includes both agency and individual QSPs. The data will be tracked by agency and facility for future reports.

- June 14, 2025 – June 30, 2025: 12/15 – 80%

- July 2025: 23/31 – 74%
- August 2025: 34/43 – 79%
- September 2025: 40/47 – 85%
- October 2025: 24/28 – 86%
- November 2025: 19/23 – 83%
- December 1- December 13, 2025: 3/4 – 75%
- Avg total for reporting period: 155/191 – 81%

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

- 71% of Agency QSPs have a QI program in place that are required to have one.
- 6% of Agency QSPs are considered non-compliant with the QI program.
- 9 agencies were found to be non-compliant and did not meet the QI program requirements; these agencies have all been terminated.

Audits will continue to be an ongoing process as new agencies are continually enrolled to provide HCBS services.

Number of critical incident reports that have an associated complaint.

- 21 incidents out of 191 reported to the DOJ had an associated complaint.

Number of amendments reported.

- One waiver amendment effective January 1, 2026 was reported to the DOJ

Number of TPM complaints and outcomes.

- Appendix D

APPENDIX A

This version of the dashboard was created for the purpose of ADA accessibility

2025 Aging Services DOJ SA Dashboard (December 14, 2024 – December 13, 2025)

LTSS OC Dashboard

Territory LTSS OC Referrals Summary

Total referrals sent to territories for LTSS OC visit	**1,372**	
Seen for a LTSS OC Visit	1,019	74%
Contacted but does not meet LTSS OC criteria	280	20%
Unable to locate	15	1%
Referred deceased	57	4%
Referral outcome pending	1	0%

Notes: 1,372 referrals were sent to the HCBS CM territories. Individuals that do not meet the LTSS OC criteria or that cannot be reached after two attempts, are sent written information about HCBS. Referral outcome pending reflects a lag in data submission. All referrals are reviewed by an HCBS Program Administrator.

Unduplicated Territory LTSS OC Referrals Visit Summary

Total unduplicated individuals receiving referral contact	**989**	
Visit Location	**Total**	**Percent**
Nursing Facility	685	69%
Hospital	254	26%
Home/Community	14	1%
Swing Bed	36	4%

Notes: Out of the total 1,372 referrals sent to the HCBS territories, 989 total unduplicated contacts were made. On June 14 of 2022, the State began seeing all TPMs who are referred for a long term stay in a skilled nursing facility (SNF) as required in the SA.

Territory LTSS OC Transition Referrals Summary

Total LTSS OC Referrals visited that were referred to MFP	**234**	**23%**
Transition Outcome	**Total**	**Percent**
Completed Transition	77	33%
Pending Transition	39	17%
Closed Before Transition	118	50%
Number of completed LTSS OC referral transitions receiving HCBS	19	25%

Notes: Referrals to MFP and HCBS indicate preference to receive care in the community. Not all those referred will transition due to individual choice, eligibility, or death. Individuals not interested in pursuing transition, will be seen annually by the LTSS Options Counselor.

HCBS Dashboard

HCBS Monthly Case Totals

	DEC 14-31	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC 1-13
MSP PC	692	706	700	707	707	711	712	721	739	744	743	732	718
Med Wav	677	686	694	688	696	710	705	726	731	735	746	748	729
SPED	1,796	1,819	1,821	1,850	1,854	1,865	1,864	1,886	1,905	1,920	1,909	1,908	1,871
Ex-SPED	104	105	104	105	106	104	100	101	100	97	99	100	100

Notes: This information reflects all open cases across HCBS programs, not just TPMs and may count individuals more than once if they receive services from multiple programs. While overall numbers may appear stable, the next section highlights how many cases open and close due to the complex medical needs of the population.

HCBS Worked Summary

Total opened MSP cases	270	Total opened MW cases	271	Total opened SPED cases	871	Total opened Ex-SPED cases	29
Total closed MSP cases	295	Total closed MW cases	199	Total closed SPED cases	705	Total closed Ex-SPED cases	28

Notes: These are the number of cases that are worked each month for all HCBS recipients, not just TPMs. The number of cases opened remains high at 1,441 during this reporting period. More individuals are utilizing SPED services. HCBS Case Managers are required to manage opening referrals, pending, and closing cases. This contributes to the complexity of providing case management services to older adults and adults with physical disability. HCBS Case Managers are no longer responsible to provide case management in Basic Care facilities.

HCBS Case Management Referrals

Total HCBS Referrals	1,881
Average HCBS referrals per month	157
Total opened HCBS cases	950
Average opened HCBS cases per month	79
Annual percentage of total opened cases per referral	51%
Total running unduplicated pending HCBS cases	208

HCBS Cases Opened Per Month

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
66	96	93	61	83	96	77	72	84	84	53	85

Monthly Percentage of Opened Cases Per Referral

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
45%	62%	52%	40%	51%	57%	51%	49%	52%	52%	37%	57%

HCBS Referrals Received Per Month

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
148	155	179	153	164	169	150	146	163	162	142	150

Referral Summary

Case Totals	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Pending Case Total	68	54	58	63	77	81	75	48	70	62	62	66
Opened Case Total	66	96	93	61	83	96	77	72	84	84	53	85

Pending Referral Reason Summary

QSP Enrollment	137
Waiting to hear back from applicant (client unresponsive or assessment not yet completed)	1,106
Waiting on Medicaid eligibility	168
Waiting on financial verification	240
Waiting on Medical/OT documents	137
Transition from facility	685

Unduplicated Pending Referral Case Summary

Month	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Pending Case Total	186	193	207	220	224	209	198	202	202	202	222	208

Notes: HCBS referrals are tracked by calendar year (January - December). 1,881 referrals for HCBS were sent to the HCBS CM territories from all referral sources (ADRL intake, direct referral, MFP, LTC Eligibility Unit and LTSS OC visits). The annual average of open cases is 51%. This is down from previous years due to more people inquiring about support in the home, who do not meet the eligibility for these services. As the older adult population grows, there will be individuals who need care but do not qualify for State or federally funded HCBS.

Pending cases are active HCBS referrals that are still being worked and do not yet have a formal outcome. The pending referral reason summary totals are unduplicated. Waiting to hear back from applicant totals result from client unresponsiveness, also including cases recently assigned where an assessment has not yet been completed.

HCBS Long Term Care (LTC) Diversions

Unduplicated total number of TPMs diverted from a SNF	312
Total MSP Level B & C TPM diversions	48
Total HCBS Med waiver TPM diversions	273
Total SPED TPM diversions	73

Notes: A Target Population Member (TPM) is an individual receiving HCBS as an appropriate alternative to a skilled nursing facility (SNF), at least 21 years of age, has below $25K in assets and meets a nursing facility level of care (NFLoC). TPMs may receive services from multiple programs at the same time and terminate/re-enroll in

programs. The SA requires the State to divert an additional 150 at risk TPMs by 12/13/2026. The State has exceeded this benchmark.

ADRL Dashboard

Aging & Disability Resource Link (ADRL) Contacts

Total unique ADRL Information & Assistance (I & A) inquiries	45,172
ADRL I & A calls	15,815
ADRL website hits	34,067
ADRL unique website hits	29,357

Average ADRL I & A wait time (in minutes)	1
Web referrals	1,926

Notes: The ADRL is a centralized intake system for applying for State or Federally funded HCBS. TPMs, family, and other interested parties can make HCBS referrals via the phone, email or online. Due to a system change, we are currently unable to track website hit data for the last half of the year. For the fourth year in a row, the call wait time is one minute. A social media ad campaign is run quarterly. Whenever an ad runs, the number of contacts to the ADRL increases.

Transition Dashboard

TPM Transition Referrals Summary

Total TPM transition referrals	**216**	
Referrals	**Total**	**Percent**
MFP	201	93%
Transition & Diversion Program	15	7%
HCBS MW Community Transition	0	0%
Transitions without Community Supports	0	0%

By Grant Population

DD	ELDER	PD
11	122	68
1	6	8
0	0	0
0	0	0

Note: 216 TPMs have been referred for transition. Not all referrals go on to sign a consent to participate in the transition process. 148 (69%) individuals signed consent.
Transition services help TPMs move from an institutional setting to their own home and community. The majority of referrals involve older adults. The State currently provides transition support services through the following programs: MFP grant, Transition and Diversion Program, and the HCBS Medicaid waiver.
The HCBS Medicaid waiver also pays for community transition support services to eligible individuals.

TPM Transition Referrals Completed Summary

Total TPM transition referrals that completed transition	78	n/a
Transitions	Total	Percent

MFP	66	85%
Transitions & Diversion Program	12	15%
HCBS MW Community Transition	0	0%
Transitions without community supports	0	0%

By Grant Population

DD	ELDER	PD
1	45	20
1	3	8
0	0	0
0	0	0

Notes: Of the 148 individuals who requested to transition by signing a consent, 38 closed prior to transitioning, 68 transitioned, leaving 42 individuals active in the transition process. Cases close for various reasons, often due to death or the individual decides they are not ready for transition at this time.
There were 78 successful transitions from an institutional setting to the community during this reporting period, 10 of which signed consent in a prior period. The SA requires the State to transition 70% of the TPMs that were referred for transition support by 12/13/2026. The State transitioned 55%. Ten additional TPMs transitioned but they also transitioned within the last four years of the SA so they were not counted here.

TPM Transitions Completed Setting & Longevity Summary

Transition Setting	Home	Family	Apartment	Adult Foster Care	Other
MFP	15	6	44	0	1
Transition & Diversion Program	2	1	9	0	0
Med W Community Transition	0	0	0	0	0
Transition without support	0	0	0	0	0

Transition Longevity	Within 30 Days	31-60 Days	61-90 Days	91-120 Days	121-150 Days	Over 150 Days
MFP	12	7	8	13	7	19
Transition & Div Prog	10	1	0	0	0	1
MW Comm Trans	0	0	0	0	0	0
Trans without support	0	0	0	0	0	0

Notes: 78 TPMs transitioned from a nursing facility to an integrated setting.
1 TPM transitioned to an agency adult foster care, indicated as other, because this was the most integrated setting appropriate to meet their needs.
65% of transitions occurred within 120 days of referral. 20 individuals who have been waiting to transition for over 150 days, were successfully transitioned to the community during this reporting period.

Housing Dashboard

TPM Home Modification Summary

Total TPMs who received modification assistance	15
HCBS Medicaid waiver home modifications	6
MFP transitions with home modifications	9

Notes: Nine (9) TPMs who were successfully transitioned to the community received assistance with home modifications. Six (6) individuals living in the community, diverted from a SNF, also received home modification services through the HCBS Medicaid waiver. TPMs are offered home modification services to ensure a safe living environment.

TPM Permanent Supported Housing (PSH) Summary

Total unduplicated TPMs who received permanent supported housing	**48**
TPM rental assistance	7
MFP rental assistance	30
Project based	24
Voucher	14

Note: Forty-eight TPMs who were successfully transitioned to the community received PSH. The PSH summary totals are not unduplicated because a TPM can utilize more than one type of service.

TPM Housing Facilitation Assistance Summary

Total unduplicated TPMs who received housing facilitation assistance	**53**
Addressing barrier to housing	17
Securing accessibility features	11
Securing home modifications	11
Securing accommodations in housing unit	5
Provided education on rights and responsibilities of tenant	37
Securing needed documents for housing	23
Completion of housing assistance application	23
Completion of housing application	30
Housing search	28

Notes: All TPMs are offered housing facilitation. 53 utilized it during this reporting period. The housing facilitation summary totals are not unduplicated because a TPM can utilize more than one type of assistance. Housing facilitators work with the MFP transition team to assist TPMs in locating and securing integrated housing in the community.

HCBS TPM Receiving Housing Support Summary

Reporting Period	6/14/25 – 12/13/25	12/14/24 – 6/13/25
Unduplicated HCBS TPMs receiving housing supports	358	344

HCBS TPM Housing Services Received Summary

Reporting Period	6/14/25 – 12/13/25	12/14/24 – 6/13/25
Other	23	15
Housing Facilitator	63	46
Rental Assistance	305	297

Notes: This section identifies TPMs receiving HCBS who also received some type of housing support. Rental assistance may include subsidized/income-based housing, voucher, HUD, etc.

Potential Housing Supports Identified for HCBS TPM Summary

Reporting Period	6/14/25 – 12/13/25	12/14/24 – 6/13/25
Unduplicated HCBS TPM care plans searched to determine necessary housing services identified summary	1,011	1,017

Necessary Housing Services Identified Summary

Reporting Period	6/14/25 – 12/13/25	12/14/24 – 6/13/25
No housing concerns/requests	854	876
Other	20	22
Rental Assistance	64	61
Assistance w/ rental mods or accommodations	20	13
Education on rights & responsibilities of being a good tenant	15	11
Assistance with housing mods	29	20
Assistance locating required documents	27	21
Assistance with housing assistance application	47	35
Assistance with housing search	52	38

Notes: This section identifies housing services necessary for individuals who receive HCBS to successfully live in the most integrated setting, reflecting data from all TPM person-center plans. Most TPMs don't have housing needs identified on their person-centered plan because they may already be living in the community. The other category encompasses a wide variety of supports unique to each case. For example, the individual may be on a waiting list for a ground floor, may need help with a more accessible apartment in the future, or looking for alternative housing but doing so independently. Assistance with the completion of applications for housing assistance may also include assistance with rental assistance or vouchers of any kind.

Appendix C

North Dakota HCBS Authorized Services (2025)

Adams 18 Members 24,270 Units 13 Providers	**Barnes** 35 Members 23,968 Units 24 Providers	**Benson** 59 Members 17,509 Units 45 Providers	**Billings** 0 Members 0 Units 0 Providers	**Bottineau** 34 Members 11,163 Units 22 Providers	**Bowman** 16 Members 6,533 Units 10 Providers	**Burke** 8 Members 2,156 Units 12 Providers	**Burleigh** 432 Members 228,873 Units 158 Providers
Cass 704 Members 529,970 Units 235 Providers	**Cavalier** 5 Members 583 Units 6 Providers	**Dickey** 25 Members 3,500 Units 14 Providers	**Divide** 14 Members 7,609Units 13 Providers	**Dunn** 8 Members 1,681 Units 4 Providers	**Eddy** 7 Members 1,156 Units 7 Providers	**Emmons** 14 Members 6,481 Units 11 Providers	**Foster** 12 Members 3,037 Units 9 Providers
Golden Valley 9 Members 916 Units 7 Providers	**Grand Forks** 312 Members 194,183 Units 122 Providers	**Grant** 12 Members 2,782 Units 12 Providers	**Griggs** 2 Members 170 Units 170 Providers	**Hettinger** 7 Members 3,068 Units 7 Providers	**Kidder** 9 Members 10,564 Units 9 Providers	**LaMoure** 15 Members 2,383 Units 7 Providers	**Logan** 1 Members 170 Units 1 Providers
McHenry 16 Members 4,857 Units 16 Providers	**McIntosh** 15 Members 3, 169Units 11 Providers	**McKenzie** 9 Members 3,727 Units 8 Providers	**McLean** 19 Members 6949 Units 23 Providers	**Mercer** 32 Members 7,556 Units 12 Providers	**Morton** 165 Members 94,293 Units 96 Providers	**Mountrail** 6 Members 656 Units 4 Providers	**Nelson** 11 Members 3,202 Units 11 Providers
Oliver 3 Members 820 Units 5 Providers	**Pembina** 28 Members 11,011 Units 21 Providers	**Pierce** 25 Members 11,591 Units 13 Providers	**Ramsey** 90 Members 48,393 Units 45 Providers	**Ransom** 34 Members 7,698 Units 12 Providers	**Renville** 12 Members 3,048 Units 9 Provider	**Richland** 66 Members 44,080 Units 42 Providers	**Rolette** 151 Members 68,713 Units 98 Providers
Sargent 13 Members 3,405 Units 11 Providers	**Sheridan** 8 Members 4,077 Units 11 Providers	**Sioux** 58 Members 90,201 Units 5 Providers	**Slope** 0 Members 0 Units 0 Providers	**Stark** 129 Members 80,504 Units 61 Providers	**Steele** 4 Members 743 Units 5 Providers	**Stutsman** 83 Members 21,153 Units 23 Providers	**Towner** 8 Members 3,193 Units 9 Providers
Traill 27 Members 9, 153 Units 19 Providers	**Walsh** 37 Members 11,330 Units 30 Providers	**Ward** 283 Members 154,855 Units 110 Providers	**Wells** 22 Members 7,768 Units 11 Providers	**Williams** 71 Members 28,572Units 38 Providers	**Out of State** 91 Members 25,223 Units 76 Providers	n/a	n/a

APPENDIX D

Complaint Type	Number of Complaints	Unsubstantiated	Substantiated	In Progress	Notes
Abuse/Neglect/Exploitation	5	2	3	0	Three allegations of abuse were substantiated. In response to one substantiated allegation, the agency took immediate action and terminated the employee who was the subject of the complaint. The second agency involved in substantiated abuse allegations was terminated as a QSP due to systemic issues that were resulting in poor care and violations of the program agreements.
Illness and Injury that resulted from unsafe or unsanitary conditions	0	0	0	0	
Serious Medication Errors	0	0	0	0	
Care Unacceptable to Department	77	14	19	44	Nineteen allegations of poor care were substantiated. Four providers, associated with nine of these complaints, were terminated after the allegations were determined to be pervasive or indicative of systemic issues. Seven providers addressed the identified concerns with a remediation plan. Two additional providers completed a formal remediation plan as required by the Department.
Criminal Behavior	0	0	0	0	
Criminal History	0	0	0	0	
Theft	5	5	0	0	
Under the influence of Drugs	0	0	0	0	
Absenteeism	6	3	0	3	
Criminal Activity	0	0	0	0	
Inappropriate Billing	12	1	1	10	One provider was terminated due to billing inappropriately.
Property Damage	0	0	0	0	
Breach of Confidentiality	5	0	5	0	Five complaints alleging breaches of confidentiality were substantiated. Three of these complaints involved two agencies that successfully completed remediation through re-education and retraining of their employees. One individual QSP was provided with technical assistance to address the identified issues.

					One QSP was terminated after the assessment determined that, in addition to the breach of confidentiality, significant care-related deficiencies were also identified.
Disrespectful	3	1	1	1	One complaint alleging disrespect toward an HCBS participant was substantiated. The agency addressed the issue through remediation and terminated the employee whose conduct was determined to be inappropriate.
Self-Neglect	0	0	0	0	
Other-Not entering general event reports (GER) as required	3	0	3	0	Three providers were given technical assistance to ensure GERs are entered as required.
Totals	116	26	32	58	