

North Dakota Department of Justice Settlement Agreement

Implementation Plan

December 14, 2020 – December 14, 2022



North Dakota Department of Human Services

Aging Services Division

September 21, 2021

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List of Acronyms

ADA – Americans with Disabilities Act
ACL – Administration for Community Living
ADRL – North Dakota Aging and Disability Resource Link
APRA – American Rescue Plan Act
CMS – Centers for Medicare and Medicaid Services
CIL – Center for Independent Living
CQL – Council on Quality and Leadership
DHS – North Dakota Department of Human Services
DOJ – Department of Justice
DSW/FC Resource and Training Center - Direct Service Workforce/Family Caregiver
Resource and Training Center
FTE – Full-Time Equivalent
HCBS – Home and Community-Based Services IP - Implementation Plan
MFP – Money Follows the Person
MFP-TI – Money Follows the Person-Tribal Initiative
NAHRO – National Association of Housing and Redevelopment Officials
NCAPPS - National Center on Advancing Person-Centered Practices and Systems
NCI-AD – National Core Indicators – Aging and Disabilities
ND – North Dakota
NDC3 – North Dakota Community Clinic Collaborative
NDHFA – North Dakota Housing Finance Authority
NDHIN – North Dakota Health Information Network
NF – Nursing Facility
NF LoC – Nursing Facility Level of Care
PCP – Person Centered Plan
PCPs – Person Centered Plans
PSH – Permanent Supported Housing
PPE – Personal Protective Equipment
QI – Quality Improvement
QSP – Qualified Service Providers
RD – Rural Differential
SA - Settlement Agreement
SME – Subject Matter Expert
SNF – Skilled Nursing Facility
SPED – North Dakota Service Payments for the Elderly and Disabled Program
TA – Technical Assistance
TPM - Target Population Member
TPMs – Target Population Members
USDOJ – United States Department of Justice

Introduction

About the Settlement Agreement (SA)

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

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

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

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

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

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

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

The SA requires the development of an Implementation Plan (IP) (defined in Section VI). The IP identifies benchmarks, timelines, and initial performance metrics for meeting the SA requirements, assigns agency and division responsibility for achieving those benchmarks, and establishes strategies to address challenges to implementation.

To operationalize this requirement, the State will develop the IP and a series of IP Updates over the life of the SA. The first covers a period of 24 months. Updates will occur annually thereafter.

Our Vision: Re-aligning Systems of Care

North Dakota (ND) is actively working to transform the home and community-based services (HCBS) experience for TPMs, making sure it is streamlined, effective, culturally-informed, and a viable alternative to institutional living.

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

Today, many TPMs' experience suggests that their only option for receiving supportive services is in an institutional setting, and that no meaningful option for services delivered in a home setting exists.

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

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

The strategies contained in the IP focus on the need to:

- Increase access to community-based service options through policy, process, resources, tools, and capacity building efforts.
- Increase individual awareness about community-based service options and create opportunities for informed choice.
- Widen the array of services available, including more robust housing supports.
- Strengthen interdisciplinary connections between professionals who work in behavioral health, 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.

The North Dakota IP

Over the eight years of the SA, the State will define and implement initiatives that will help effectuate system transformation.

The IP outlines actions to be taken in the first two years of the SA, with annual updates to follow that will outline both new initiatives and operational challenges and successes. The 2020-2022 IP describes initiatives in four key areas of work.

Policy and Process

- Establish workgroups to evaluate and make recommendations on policy and practice in all key areas of system transformation:
 - Case Management Assignment
 - Environmental Modifications
 - Health Care Accommodations
 - Housing Services
 - Informed Choice
 - Service Delivery
 - Skilled Nursing Facility Level of Care
 - Quality Improvement (QI)
- Streamline and accelerate provider enrollment processes.
- Establish processes that can be operationalized.
 - Annual Nursing Facility Level of Care (NF LoC) screening determinations,
 - Access to informed choice referrals and person-centered planning processes,
 - Consistent engagement with TPMs through in-reach and outreach, and
 - Transition and diversion support teams.
- Review and improve policies around:
 - Transition coordination,
 - Rate structures for difficult-to-access services,
 - Risk management / incident prevention, and
 - Effective integration of reasonable modifications into Person Centered Plans (PCPs).

Case Management and Expanded Services

- Broaden access to HCBS case management and informed choice referral and person-centered planning processes.

- Expand transition and housing supports, with a focus on building connections between TPMs and professionals involved in both supportive services and housing services.
- Strengthen interdisciplinary connections between professionals who work in behavioral health, home health, housing, and HCBS.
- Expand access to permanent supported housing by offering rental assistance and new support service connections.
- Provide incentives to service providers who are willing to expand the HCBS services they offer.

Training and Capacity Building

- Develop recruitment and retention strategies to help individuals and businesses to develop the capacity needed to expand their offerings of HCBS.
- Increase the efficiency with which Qualified Service Providers (QSPs) are enrolled and available to provide services.
- Create resource and training centers for consumers, direct workforce, peer specialists, and for HCBS providers.
- 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.
- Obtain approval to move forward with the HCBS capacity building initiatives outlined in the American Rescue Plan Act (ARPA) of 2021, Section 9817 funding plan, including increased competency related to behavioral health.
- Build capacity across disciplines to foster greater understanding of housing strategies, including rental assistance policies and environmental modifications.

Data and System Tools

- Implement a new case management platform to better connect all parties involved in serving TPMs, with connections established between related data systems (such as the Aging & Disability Resource Link (ADRL) and rental assistance).
- Create resources that support improved practice, including a QSP match portal, housing inventory, environmental modification resources, and referral networks.
- Clearly define elements to be included in the informed choice process related to housing barriers and preferences.
- Implement quality measures, including National Core Indicators, to inform policy and practice.

A Review of IP Themes

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

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

1. **Case management** is a core service that helps connect TPMs to the information and resources they need at a moment of a critical life decision. The availability of competent, person-centered case management that is built on a foundation of thorough and timely assessment is a critical component of any high-functioning HCBS system. *[Section VII of SA]*
2. **Person Centered Plans (PCPs)** need to be at the heart of the State’s HCBS system. The strategies in the IP are intended to solidify the principles and practices of PCP development as a foundational element of the State’s delivery of HCBS, both through training and the establishment of new processes that support in-reach as a critical element of connection. *[Section VIII of SA]*
3. To make non-institutional housing options possible, TPMs must have access to **community-based services** when and where they need them. The IP establishes workgroups tasked with identifying opportunities to improve service delivery and reasonable modification processes, develop, and deliver targeted training, and access to capacity building resources and supports for service providers. *[Section IX of SA]*
4. Having access to information at the right time requires both the State and its private healthcare partners to modify processes and practices related to screenings and Level of Care assessments. The IP focuses on evaluating and modifying policy as needed, and on establishing a functioning **Informed Choice** referral process that can effectively identify TPMs and provide them with both information and a PCP to facilitate their informed choice. *[Section X of SA]*
5. Facilitating **transitions** from a skilled nursing facility (SNF) to permanent supported housing (PSH) requires coordination of resources and access to both housing and services in the community where a person is going to live. The IP builds capacity across systems to expand the number of successful transitions that occur across ND. *[Section XI of SA]*
6. Permanent supported **housing** (PSH) is the broad term used to describe community-based housing alternatives to an institutional setting. PSH must be

integrated, affordable, and accessible as per a TPMs needs. Additionally, the TPM must be able to access the long-term services and supports they need to maintain independence in the community setting. The State will work with partners to broaden access to supports that create PSH in communities across ND, including rental assistance, transition supports, resources to help modify living environments, and general facilitation of a TPMs' needs related to identifying suitable housing. *[Section XII of SA]*

7. In ND, HCBS are delivered primarily by private sector **providers**, both non-profit and for-profit. Building private sector **capacity** to deliver services will require policy changes, incentives, coaching and support. *[Section XIII of SA]*
8. Making connections at the right time and with the right resources is essential to enabling informed choice. Conducting effective **In-reach** and **Outreach**, building capacity to serve TPMs, empower peer and **natural supports**, and aligning screening and referral processes to support an individual PCP requires policy modifications, changes in process and practice, and training. *[Section XIV of SA]*
9. The State must be able to measure the impact of the changes it is making across systems by understanding the impact of work that happens within and between systems. The intentional development of cross-system approaches to **data collection** and analysis that are outlined in the IP will help assure continued attention to benchmarks and performance measures. *[Section XV of SA]*
10. Defining and understanding indicators of **quality** in how services are delivered and how systems operate will require the State to examine performance measures that allow for direct assessment. *[Section XVI of SA]*

IP Timeline and Process

The IP was developed with input from stakeholders and feedback from both the USDOJ and the subject matter expert (SME) and his team. Expectations for the IP are outlined in Section VI of the SA.

The State's focus in this first 24-month IP is to set the foundation for our work by addressing elements from each of the requirements outlined in Sections VI – XVI of the SA. The State's IPs are designed to follow the same "section" format as used in the SA.

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

The strategies under each section of the IP provide the details on how the State intends

to start meeting the requirements of the SA during the first two years of implementation. The IP and strategies within the plan may be revised as necessary to meet the SA requirements.

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

Plan	Submitted By	Approved By*	Time Period Covered
		SA Effective Date	Dec 14, 2020
IP	May 25 2021	Sept 1 2021	Dec 14, 2020 – Dec 14, 2022
IPr1**	June 14 2022	Aug 15 2022	Dec 15, 2022 – Dec 14, 2023
IPr2	June 14 2023	Aug 15 2023	Dec 15, 2023 – Dec 14, 2024
IPr3	June 14 2024	Aug 15 2024	Dec 15, 2024 – Dec 14, 2025
IPr4	June 14 2025	Aug 15 2025	Dec 15, 2025 – Dec 14, 2026
IPr5	June 14 2026	Aug 15 2026	Dec 15, 2026 – Dec 14, 2027
IPr6	June 14 2027	Aug 15 2027	Dec 15, 2027 – Dec 14, 2028
		Period of Substantial Compliance	Dec 15, 2028 – Dec 14, 2029
		Termination of SA if Substantial Compliance is achieved	Dec 14, 2029

**The noted approval date is an estimate based on timelines suggested by the processes that are described in the SA. **Implementation Plan Revision (IPr)*

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

The IP and all related reports will be made available to the public via the State’s DOJ website: <https://www.nd.gov/dhs/info/pubs/doj-settlement.html>.

IP Performance Measures and Benchmarks

The timelines listed under the strategies are estimated internal target completion dates unless otherwise noted. The dates were developed internally by the State and are not governed by the SA and may be modified as necessary and without consequence to the State's compliance with the SA.

The following is a summary of **Benchmarks** identified in the SA, through December 14, 2022.

By June 14, 2021

- The SME is required to produce a **Safety Assurance Plan** that includes a plan to train community providers about incident reporting, review procedures to mitigate harm, and require Agency QSPs employing non-family to have a QI plan. The State is also required to submit critical incident reports to the USDOJ and the SME within 7 days of the reported incident. SA, *Section XVI, B*
- State will provide **technical assistance** to SNFs and community providers who make a commitment to provide HCBS. SA, *Section XIII, D*

By September 14, 2021

- State will provide for the role specialization and training of HCBS Case Managers SA, *Section VI, F*.
- **Expand** the HCBS Medicaid **waiver** service array to include residential habilitation, community support services and companionship, and amend the ND Service Payments for the Elderly and Disabled Program (SPED) functional and financial eligibility criteria to expand access to community-based services. SA, *Section IX, D and H (2)*
- State will conduct individual or group **in-reach to each SNF** to inform residents about community-based services and SA requirements. SA, *Section XIV, A (1)*
- Demonstrate that State **provided the required information** and ask the TPM to indicate in writing they received such information. SA, *Section X, A & B*

By December 14, 2021

- Complete **person-centered planning** with 290 TPMs; at least 50% must be completed with TPMs who reside in a SNF. SA, *Section XIII, I (3a)*
- State will **enable TPMs who self-direct their care** to receive sufficient support to do so including information and assistance to help them identify, select, supervise, and resolve conflicts and challenges with their community providers. SA, *Section IX, D and H (1)*
- Provide *permanent supported housing* to at least 20 TPMs with an identified need for these services. SA, *Section XII, B(1a)*

By June 14, 2022

- **Provide required information** to all TPMs and guardians and update the NF LoC approval process to ensure TPMs who are referred for a particular SNF service are offered the same service in the community if a community-based version exists or can be provided through a reasonable modification to existing programs or services. *SA, Section X, A & B*
- Ensure **transitions** occur no later than 120 days after the member chooses to pursue transition to the community. *SA, Section XI, E (2a)*
- Enhance the current **data collection** process to collect data as required in the SA. *SA, Section XV, A*

By December 14, 2022

- Complete **person-centered planning** with total of 580 TPMs (years 1 and 2); at least 50% must be completed with TPMs who reside in a SNF. *SA, Section XIII, I (3b)*
- Require an **annual NF LoC determination screening** for all TPMs who reside in a SNF and assure necessary services are incorporated into the PCP. *SA, Section X, A & B*
- **Transition** at least 100 TPMs from a skilled nursing facility to the most integrated setting appropriate and **divert** at least 100 at risk TPMs from SNFs. *SA, Section XI, E (2a)*
- Provide **permanent supported housing** to at least 30 additional TPMs with an identified need for these services. *SA, Section XII, B (1b)*

SA Section VI. Implementation Plan

Responsible Division(s)

ND Governor's Office and ND Department of Human Services (DHS) Aging Services Division

Agreement Coordinator ([Section VI, Subsection A, page 8](#))

Implementation Strategy

Appoint Agreement Coordinator. The Agreement Coordinator is responsible for leading the State team tasked with ensuring access to community-based services that allow TPMs to live in the most integrated setting appropriate.

Challenges to Implementation

As the Aging Services Division Director, Ms. Nancy-Nikolas-Maier, has been appointed the Agreement Coordinator; sufficient staff time to complete duties of both Division Director and Agreement Coordinator.

Remediation

To assist with administrative and reporting duties required in the SA, the DHS received an additional full-time employee. **(Target hire date October 1, 2021)**

Draft IP (Section VI, Subsections B and C, page 9)

Implementation Strategy

Conduct a series of project planning sessions to develop and draft strategies to meet requirements. The SME team worked with the State to review the plan prior to submission and alignment of the plan with four required plans developed by the SME. **(Submitted May 28, 2021)**

Challenges to Implementation

The State encountered unavoidable delays in finalizing the contract with the SME as required in the SA.

Remediation

The State requested and received a 45-day extension to draft the IP to accommodate a delay in finalizing the SME contract.

Service Review ([Section VI, Subsection D, page 9](#))

Implementation Strategy

Strategy 1. Conduct internal listening sessions that include a review of relevant services with staff from the ND DHS Aging Services, Medical Services, and Developmental Disability Divisions. 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. **(Complete April 1, 2021)**

[Appendix A](#) lists potential barriers that will be addressed during this IP period.

Performance Measure(s)

Increase number of SPED recipients.

Number of providers enrolled to provide services.

Number of consumers served.

Strategy 2. Update the SPED client cost share/fee schedule to increase access to services for individuals who needed services but could not afford the SPED client cost share. This will allow additional TPMs who are eligible for SPED to access services in the most integrated setting appropriate. **(Complete July 1, 2019)**

Strategy 3. Increase access to SPED for less impaired individuals who need services to live in the most integrated setting appropriate, thus diverting them from a higher level of care. **(Complete January 1, 2020)**

Performance Measure

Number and percent increase in TPMs enrolled in SPED.

Strategy 4. Add residential habilitation, community-support services, and companionship to the HCBS 1915 (c) Medicaid waiver. **(Complete January 1, 2020)**

Challenges to Implementation

Residential habilitation and community-support services were approved January 1, 2020. Webinars were held in early 2020 to recruit QSPs, but due to the COVID-19 pandemic provider enrollment was delayed. The first TPMs were served with these new services in November 2020.

Remediation

The State has 10 agency QSPs currently enrolled to provide these new services and is actively working with more for qualification. The State held additional

webinars to recruit QSPs and offer enrollment assistance beginning in June 2021.

Performance Measure

Number and percent increase in number of providers offering these new services.

Strategy 5. Implement rate increases for supervision, non-medical transportation, non-medical transportation escort, and family personal care. The services were chosen because the current rates were previously identified as too low to attract enough QSPs. A waiver amendment will be submitted to the Centers for Medicare and Medicaid Services (CMS). **(Target completion date January 1, 2022)**

Stakeholder Engagement ([Section VI, Subsection E, page 9](#))

Implementation Strategy

The State will create ongoing stakeholder engagement opportunities including quarterly USDOJ SA stakeholder meetings the first two (2) years 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. **(Quarterly Listening Sessions begin June 15, 2021)**

The State will work with community partners to hold HCBS Community Conversations in all nine (9) case management territories and Native American reservation areas in ND. The meetings will provide information about HCBS and provider enrollment and will include an opportunity to receive valuable feedback from local community stakeholders about the provision of HCBS in rural and Native American communities. State will post meeting minutes, stakeholder requests, and the State's response after each meeting. State will also create a calendar of events section on the DOJ portion of the DHS website. **(Target completion date December 31, 2021)**

Challenges to Implementation

It can be difficult to recruit and sustain stakeholders willing to provide ongoing input, especially from individuals who receive services.

Remediation

The State worked with the National Center on Advancing Person-Centered Practices and Systems (NCAPPS) to create an asset map of existing stakeholders in ND. Strategies and proven practices were identified to directly involve individuals who receive services. These strategies will be used to allow TPMs an opportunity to meaningfully engage in the process.

Performance Measures

Number of stakeholder engagement opportunities provided.

Number of attendees.

SME Consultation (Section VI, Subsection F, page 9)

Implementation Strategy

Agreement Coordinator will meet weekly with SME and team to consult on IP. Agreement Coordinator will provide required updates to USDOJ, submit draft, and incorporate updates as required. **(Complete May 28, 2021)**

SME and IP ([Section VI, Subsection G, page 9](#))

Implementation Strategy

Strategy 1. The State will meet no less than weekly with SME to revise the IP as required by the SA. **(IP updated June 14, 2022)**

Strategy2. Each revision to the IP will include a review of data collected and outcomes achieved, and how that informs revised strategies. **(IP updated 6.14.22)**

Website ([Section VI, Subsection H, page 10](#))

Implementation Strategy

Establish a webpage for all materials relevant to ND and USDOJ SA on the DHS website. The plan and other materials will also be made available in writing upon request. A statement indicating how to request written materials is included on the established webpage found here <https://www.nd.gov/dhs/info/pubs/doj-settlement.html>. **(Complete June 14, 2020)**

SA Section VII. Case Management

Responsible Division(s)

DHS Aging Services Division

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

Implementation Strategy

Strategy 1. Specialize role of the HCBS case manager. The State will employ HCBS case managers who will provide HCBS case management full time. To streamline supervision, training, and the implementation of HCBS consistently across the State, 64 full-time equivalent (FTE) positions were moved from County Social Services to State employment. Specialization will include clarifying roles and responsibilities as it relates to the provision of services to all TPMs, including those living in the community and those residing in a SNF. **(Complete January 1, 2020)**

Challenges to Implementation

Finding qualified case management staff in rural or frontier areas of ND.

Remediation

Hire and closely supervise social workers with less than one year experience and allow staff to telecommute from surrounding areas.

Strategy 2. The State will create and require a comprehensive standardized training curriculum be completed by all HCBS case managers. The State will provide ongoing training and professional development opportunities to include cultural sensitivity training to ensure a high-quality trained case management workforce. The State has contracted with a local expert in Native American cultural competency to develop training for HCBS case managers. Post-training evaluation tools to ensure understanding of training objectives will be developed. **(Target completion date December 31, 2021)**

Performance Measure(s)

Percent of HCBS case managers trained in the standard curriculum by December 31, 2021.

Percent of HCBS case managers trained to cultural sensitivity.

Percent of HCBS case managers found to be competent in key learning objectives after receiving cultural sensitivity training.

Strategy 3. The State expanded the ADRL to include a centralized intake process to assist TPMs in learning about and applying for HCBS. **(Implemented January 1, 2021)**

Referrals can be made over the phone or submitted via the internet. The DHS Aging Services Division employs six (6) staff who provide information and assistance in completing the centralized intake process. If a TPM or their legal decision maker wants to apply for HCBS, the intake assessment is sent to an HCBS supervisor who assigns a HCBS case manager to complete an assessment and verify eligibility. Person-centered planning is undertaken and completed with each TPM.

Challenges to Implementation

The State has two different information technology systems, one for the ADRL intake system and another for case management. To streamline processes and create efficiencies, it will be necessary to integrate the two systems.

Remediation

The State has contracted for development of the interface. **(Target completion date September 15, 2021)**

Performance Measure(s)

Number of referrals received by case management territory through the updated ARDL centralized intake process.

Average number of days to assign an HCBS case manager following referral. **(Tracking began May 1, 2021)**

Percent of case management referrals responded to within 5 business days.

Number and percent of HCBS case management staff trained on new system.

Strategy 4. Implement an informed choice referral process to identify TPMs who screen at a NF LoC and inform them about HCBS, person-centered planning, and transition services available under Medicaid to help TPMs receive services in the most integrated setting appropriate.

Informed choice referral visits are being conducted by HCBS case managers, and due to staff capacity, are currently targeting individuals who express interest in HCBS or because their care needs are best served in the community. The ND NF LoC tool has been updated to include questions to identify these TPMs. The provision of information about HCBS is available to everyone, including people with higher needs. The State will develop strategies to revise this tool and process and build staff capacity to assure that it meets the provisions of the SA. **(Informed choice visits implemented January 1,**

2021)

Challenges to Implementation

Adequate staff capacity to conduct informed choice visits and HCBS case management and the development of protocols to continue to try and reach TPMs who initially decline an informed choice visit.

Remediation

The State submitted a request and received approval from CMS to use Money Follows the Person (MFP) capacity building funds to employ staff to conduct informed choice referral visits. The additional staff will be primarily responsible to conduct informed choice visits with TPMs. They will also be responsible to conduct facility in-reach to Medicaid consumers who are currently residing in the (SNF) and inform them about HCBS options. **(Target completion date October 1, 2021)**

Performance Measure(s)

Number of informed choice referrals.

Number of TPMs referred through informed choice to transition services through MFP.

Number of long-term stay NF LoC determinations provided to TPMs by case management territory.

Strategy 5. Create a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. Campaign will include marketing on social media, and providing public education to the public, professionals, stakeholders, and TPMs at serious risk of entering nursing facilities. Campaign will also include providing education to those parties that recommend SNF care to TPMs. **(Target Completion Date December 14, 2022)**

Performance Measure(s)

Number of ADRL contacts per month.

Strategy 6. 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 assess need and request additional resources, if necessary, in the next biennium executive budget request. **(Complete July 1, 2022)**

In addition, the State will provide technical assistance, training, and ongoing support to encourage State and tribal providers to enroll to provide HCBS case management to

TPMs. This includes using MFP Tribal Initiative funds to help tribal entities hire licensed social workers to provide culturally competent HCBS case management services in Native American communities.

Performance Measure(s)

Number of HCBS case managers hired by Tribal nations.

Strategy 7. Implement a new case management system to simplify the case management processes and reduce time required to complete administrative responsibilities of the position. Reducing administrative burden will free up staff time to conduct person-centered planning and other TPM-facing case management functions. **(Target completion date December 1, 2021)**

Performance Measure(s)

Percent reduction in case manager time spent on administrative functions after the case management system is fully implemented.

Assignment ([Section VII, Subsection B, page 10](#))

Implementation Strategy

Strategy 1. Ensure a HCBS case manager is assigned within two business days to all TPMs. **(Target completion July 1, 2022)**

Challenges to Implementation

The State needs to address additional strategies to assign a HCBS case manager to all TPMs in accordance with the SA. This requirement may be difficult to operationalize and sustain. Consideration needs to be made for TPMs who refuse case management or who are otherwise unable to participate in the process.

Remediation

The State will convene a Case Management Assignment workgroup to develop strategies and recommendations to meet the requirements of the SA.

The State will invite TPMs, family, guardians, State staff, tribal representatives, internal and external HCBS case management providers, MFP transition coordinators, hospital and nursing home discharge planners, and other interested stakeholders to participate.

The group's primary purpose is to provide recommendations for the State to consider the development of a tiered case management approach that is

respectful of the TPM's wishes and abilities, while also meeting the State's obligation to offer, through a HCBS case manager, individualized, community-based services to all TPMs who qualify and accept services.

In addition, the State is exploring ways to better utilize all case management resources in the State to build capacity across the (DHS). This includes utilizing new federal funding opportunities to more quickly build the capacity to assign a HCBS case manager to all TPMs as required. **(Workgroup established November 1, 2021, Recommendations complete March 1, 2022)**

Performance Measure(s)

Number and percent of in-reach visits made to Medicaid consumers residing in SNFs.

Number of TPMs assigned to a HCBS case manager.

Average number of contacts by HCBS case managers, for those TPMs that initially refuse case management services.

Strategy 2. If a TPM in a SNF indicates they are interested in HCBS between NF LoC reviews, they are referred to the ADRL and assigned a HCBS case manager.

The State will increase SNF in-reach activities by working with the MFP / Centers for Independent Living (CIL) staff to contact current TPMs residing in a SNF and inform them about HCBS. In addition, State staff will conduct follow up visits to build relationships and continued education about HCBS with TPMs who initially refused an informed choice visit. **(Target implementation date January 1, 2022)**

Challenges to Implementation

Case management and MFP administrative functions are not completed or accessible within the same IT system.

Remediation

To facilitate effective communication and robust person-centered planning for TPMs transitioning from a SNF, the State will work with its vendor to integrate the MFP process into its new case management Information Technology system. This will allow all relevant individuals to have access to information necessary to provide case management and transition coordination services as efficiently as possible. **(Target completion date August 15, 2021)**

Performance Measure(s)

Average number of days from assignment of a HCBS case manager to first contact.

Capacity (Section VII, Subsection C, page 10)

Implementation Strategy

Strategy 1. Simplify the HCBS case management process to ensure a sufficient number of HCBS case managers are available to serve TPMs. The HCBS case managers are required to keep track of the number of hours they work, and the type of work being performed. Reports can be run to calculate the amount of time spent conducting client-facing case management services versus administrative tasks. This information will be used to determine staff capacity and number of FTEs needed. **(Six-month reporting begins June 14, 2021)**

Performance Measure(s)

Average weighted caseload per Case Manager.

Percent reduction in administrative tasks after case management system is fully implemented.

Strategy 2. 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. **(Complete May 1, 2021)**

Challenges to Implementation

The volume of ADRL referrals, informed choice visits requests, and interest in HCBS in general has been much higher than anticipated because of COVID-19. COVID-19 visitor restrictions in SNFs and other congregate settings have increased awareness and need for HCBS. Additional staff are needed to complete case management functions.

Remediation

The State submitted a request and received approval to use MFP capacity building funds to hire five (5) staff to conduct informed choice referral visits so that the HCBS case managers have capacity to provide case management to additional TPMs in the most integrated setting appropriate. Staff will be hired in areas of the State with the highest number of referrals and/or in rural areas where the most travel is required. **(Target completion date October 1, 2021)**

In addition, the State will review its current weighted caseload assignment process to ensure the appropriate amount of case management services are being provided to TPMs residing in a SNF, and to those who are referred for

admission to a SNF.

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. The DHS promulgated an administrative rule that describes the powers and duties of public and private entities as it relates to the informed choice referral process. ND Admin. Code 75-02-02.4-04 (4) requires these entities to afford HCBS case managers full access to TPMs who are residing in or currently admitted to their facility. **(Complete January 2, 2021)**

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 DHS Medical Services Program Integrity unit which may result in the termination of provider enrollment status.

Performance Measure(s)

Number and percent of SNFs providing less than full access to TPMs.

Number of referrals for denial of full access made to Program Integrity.

Number of investigations initiated due to denial of access.

Strategy 2. Conduct training with hospital and SNF staff to discuss the HCBS informed choice referral process and subsequent changes to the ND NF LoC tool effective January 1, 2021. The training will be adjusted over time to reflect further changes to the NF LoC and Informed Choice process that will be made during the time this IP in effect. **(Initial training complete December 17, 2021)**

Challenges to Implementation

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

Remediation

Training will be held at least annually for the first two years of the SA. **(Target completion date December 14, 2022)**

Performance Measure(s)

Number of SNF and hospital staffed trained on informed choice

Strategy 3. Inform facilities in writing that they must afford HCBS case managers access to TPMs per State and Federal regulations and the SA. **(Complete March 26, 2021)**

Challenges to Implementation

The health and visitor restrictions put into place because of the COVID-19 pandemic have limited face-to-face access to hospital and facilities.

Remediation

The State will ensure that all State employees follow required safety procedures, including the appropriate use of personal protective equipment, when entering facilities. The State provides PPE for all State employees.

The State purchased telecommunication equipment for 100 SNFs and basic care facilities in ND. Facilities that requested the equipment signed an agreement ensuring that the equipment be made available to all residents to facilitate virtual visitation, including visits with HCBS case managers.

Performance Measure(s)

Number and percent of informed choice visits conducted in-person.

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

Implementation Strategy

Provide HCBS case managers and relevant State agencies access to all case management tools including the HCBS assessment and PCP. **(Target completion date July 1, 2021)**

Performance Measure(s)

Number of case management entities that have logins and access to the new case management system.

Quality ([Section VII, Subsection F, page 11](#))

Implementation Strategy

Strategy 1. Specialize role of the HCBS case manager. The State will employ HCBS case managers who will provide HCBS case management full time. **(Complete January 1, 2020)**

Strategy 2. To ensure a quality HCBS case management experience for all TPMs the State will update the current annual case management reviews to ensure sampling of all components of the process (assessment/person-centered planning/authorization/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. **(Target completion date January 1, 2022)**

Performance Measure(s)

State produces an individual audit summary report and will compile the data into an annual report. Report will measure the error rate by territory and type.

ADRL ([Section VII, Subsection G, page 11](#))

Implementation Strategy

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

SA Section VIII. Person-Centered Plans

Responsible Division(s)

DHS Aging Services Division

“Charting the LifeCourse” Training ([Section VIII, Subsection A, page 11](#))

Implementation Strategy

Implement new case management system for State staff, public, private, and tribal HCBS case managers and QSPs that includes “Charting the LifeCourse” person-centered planning framework tools. HCBS case managers will create, with the TPM, the PCP that will be maintained and updated in the new system. **(Target completion date December 1, 2021)**

Challenges to Implementation

HCBS case managers must be trained on new person-centered planning framework tools and post-training evaluation needs to occur to ensure staff competency.

Remediation

The State will procure a foundational skill building educational series that will be virtually facilitated by the LifeCourse Nexus Team with the HCBS case managers and other DHS Aging Services Division staff. This series will be expanded to include a session on conflict resolution. **(Target completion date December 1, 2021)**

Select Aging Services Program Administrators and the HCBS case management supervisors will also complete the train-the-trainer “Charting the LifeCourse” Ambassador series. The series provides a more comprehensive overview of person-centered planning principles and decision making. It will be used to develop a training curriculum for current and future HCBS case managers. The State will also work with LifeCourse Nexus University of Missouri Kansas City Institute for Human Development and stakeholders to adopt performance measures, core competencies, and identify the corresponding skills and abilities necessary to demonstrate proficiency in person-centered planning principles. **(Target completion date March 1, 2022)**

Performance Measure(s)

Number of HCBS case managers fully trained in “Charting the LifeCourse” and

other person-centered planning tools as of December 31, 2021.

Number and percent of TPMs that have a completed individualized PCP.

Number of HCBS case managers who meet core person-centered competencies.

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

Implementation Strategy

Strategy 1. Ensure that the HCBS functional assessment and individualized PCP contained in the new case management system meets all requirements of subparts 1-8. The PCP will be updated when an TPM goes to the hospital or SNF and remains available and accessible in the new system when the TPM returns to the community. **(Target completion date December 31, 2021)**

Challenges to Implementation

MFP transition coordinators do not currently use the new case management system to track and develop transition plans for TPMs.

Remediation

The State will work with case management vendor to incorporate the MFP transition coordination process and tools into the case management system. **(Target completion date August 15, 2021)**

Performance Measure(s)

Number of new PCP meetings completed by the HCBS case manager per month.

Number of PCP updated every 6 months as required.

Strategy 2. Update current policy that states if the TPM enters a SNF and services are not used for at least thirty (30) days, the case should close unless prior approval is received. After discharge, a TPM must submit another application and re-apply for services once they are ready to resume care in the community. HCBS case managers are also required to complete a new functional and financial assessment.

Policy will be updated to clarify that a TPM does not have to reapply for services if they were an eligible recipient before they entered the SNF, and they are there on a short-term NF LoC stay. HCBS case managers will update the assessment and PCP to reflect any change in need or preference but will not need to complete a new financial assessment unless there has been a substantial change, or they are due for a required annual reassessment. **(Complete July 1, 2021)**

Performance Measure(s)

Number and percent of HCBS case managers trained on new policy.

Strategy 3. To facilitate the exchange of information across settings, an interface will be created between the new case management system and the ND Health Information Network (NDHIN) to make a PCP part of the patient health record that is available to qualified clinicians. **(Target completion date January 1, 2022)**

Challenges to Implementation

Time required to build an interface between the two systems and education to the provider community about HCBS care plans that may be viewed as part of the patient record.

Remediation

The case management/NDHIN interface is part of the new case management system contract. The project has an assigned project manager who is responsible for coordinating meetings and facilitating the timely completion of the project.

Strategy 4. The SA states that TPMs will not be required to rely on natural supports if they choose not to do so, or if the proposed person(s) is unable to or unwilling to provide natural supports.

The DHS will add the above statement to the HCBS policy and procedure manual and will also implement the following to meet this requirement:

- Live alone eligibility requirements for residential habilitation and community-supports are too restrictive and will be removed to allow more TPMs to access services. A waiver amendment will be submitted, and administrative code will be updated accordingly. **(Target completion date January 1, 2022)**
- Currently, TPMs who live with family are not eligible to receive supervision. This requirement will be removed. A waiver amendment will be submitted, and administrative code will be updated accordingly. **(Target completion date January 1, 2022)**

Strategy 5. Every PCP will incorporate all the required components as outlined in Section VIII.C.1-8 and these are apparent in PCP documentation. The person-centered planning tool in the new case management system will allow all required information to be captured and included in the plan.

The State will update the annual case management review process to include sample PCPs from each HCBS case manager to ensure they are individualized, effective in identifying, arranging, and maintaining necessary supports and services for TPMs, and

include strategies for resolving conflict or disagreement that arises in the planning process **(Target implementation date January 1, 2022)**

Performance Measure(s)

Number of PCPs completed per month.

Number and percent of PCPs reviewed by State that meet all requirements.

Strategy 6 The person-centered planning tool has been updated to adequately capture information on housing needs and is specific to each TPM housing barriers. Necessary supported housing services are also identified on the PCP. **(Complete December 31, 2021)**

Policy Manual Update ([Section VIII, Subsection D, page 12](#))

Implementation Strategy

Current policy requires that when a TPM applies for long-term services, the HCBS case manager initiates the person-centered planning process.

Challenges to Implementation

Policy is included in the approved 1915 (c) HCBS Medicaid waiver and current case management training but is not included in the HCBS policy manual.

Remediation

The DHS will add the person-centered planning requirements from the waiver into the case management section of HCBS policy and procedure manual 525-05. **(Target completion date November 1, 2021)**

Performance Measure(s)

Number of PCPs completed per month.

Percent of PCPs completed within required timeframe.

Number and percent of PCPs reviewed by the State that meet all requirements.

Conflict Resolution TA ([Section VIII, Subsection E, page 13](#))

Implementation Strategy

To resolve conflicts that arise during development of the PCP, the State will request technical assistance from NCAPPS to provide training to assist the HCBS case managers in developing the skills necessary to help resolve conflicts that emerge during development of the PCP, including the option for a TPM to obtain a second opinion from a neutral healthcare profession. Conflict resolution will become a core competency used to measure case management understanding of person-centered planning principles. **(Target completion date April 1, 2022)**

Performance Measure(s)

Number and percent of TPMs that request a second opinion.

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

Implementation Strategy

Strategy 1. 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 DHS Legal Advisory Unit and other agencies or boards to determine if a request for reasonable modification can be accommodated as required in the SA. HCBS policy will be updated to determine how requests for reasonable modification may submitted for review and reconsidered. **(Target completion date October 1, 2021)**

Challenges to Implementation

TPMs, HCBS case managers, and other stakeholders may not understand reasonable modification as required under Title II of the ADA.

Remediation

The State will develop materials (which are reviewed by the SME and USDOJ) that explain the reasonable modification requirements under the ADA. These will be available on the USDOJ settlement page of the DHS website and available in writing as requested. Information on how to request such information in writing will also be listed on the webpage. The State will conduct 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 track all requests for reasonable modification to identify trends in service gaps, location, utilization, or provider capacity.

Performance Measure(s)

Number and percentage of HCBS case managers trained on reasonable modification.

Number of HCBS case managers after receiving training who showed increased understanding of reasonable modification requirements under the ADA.

Number of stakeholders provided education about reasonable modification.

Number of requests received and outcome of those requests per month.

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

Implementation Strategy

Strategy 1. The State will develop a process to submit all transition plans that identify a setting other than the TPM's home, a family home, or an apartment as the TPM's most integrated setting appropriate to the SME for the first two years of the SA. **(Reporting begins June 1, 2021)**

Performance Measure(s)

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

Person-centered planning TA ([Section VIII, Subsection H, page 13](#))

Implementation Strategy

Strategy 1. To ensure annual ongoing training, the State will utilize 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 DHS Aging Services Division staff. The entity will also be required to assist the State in developing person-centered planning policy and procedures, performance measures and core competencies that will assist the TPM in receiving services in the most integrated setting appropriate. **(Target completion date October 1, 2021)**

Performance Measure(s)

Number and percent of HCBS case managers trained on person-centered planning practices.

Number of HCBS case managers who after receiving training showed increased understanding of person-centered planning principles.

Number of HCBS case managers who meet core person-centered planning competencies.

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

Implementation Strategy

During the IP period, the State must develop PCPs with at least 290 unduplicated TPMs within one year of the effective date and an additional 290 TPMs within two years of the effective date. At least half of the TPMs who receive person-centered planning each year will be SNF TPMs.

Through facility in-reach, community outreach, and increased public awareness of the ADRL and HCBS options, the State currently seeks to identify TPMs who are interested in receiving services in the most integrated setting appropriate. Based on current case management capacity, TPMs who indicate a preference to receive services in the community are assigned an HCBS case manager who will complete a PCP. The State will develop additional strategies so that before the end of the SA, all TPMs will be provided a PCP so they can make an informed choice.

Strategy 1. Ongoing person-centered planning technical assistance is being provided to the State as part of an Administration for Community Living (ACL)/CMS technical assistance opportunity administered by the (NCAPPS).

The State will ensure ongoing technical assistance after September 30, 2021, by using MFP capacity building funds to procure person-centered planning technical assistance from a qualified entity from October 1, 2021 – September 30, 2025. **(Provider procured October 1, 2021)**

Strategy 2. Ensure that a PCP is completed with every TPM who requests HCBS, beginning in the initial 24 months, with those expressing interest in HCBS. **(Complete December 14, 2021)**

Performance Measure(s)

Number of PCPs for TPMs not residing in the SNF that are completed by December 14, 2021, and December 14, 2022.

Number of PCPs for TPM residing in SNF that are completed by December 14, 2021, and December 14, 2022.

Number of targeted in-reach visits conducted.

Number of completed PCPs for at risk and TPMs in SNF.

Strategy 3. Conduct targeted in-reach to TPMs. To help identify TPMs residing in a SNF, the MFP transition coordinators and DHS Aging Services Division staff who complete informed choice visits will also conduct targeted in-reach to TPMs residing in SNFs to discuss HCBS and the potential benefits of community living. For the first 24 months, if a TPM indicates a preference for community living they will be assigned an HCBS case manager and MFP transition coordinator who will complete a PCP. A housing facilitator will also be assigned if the plan identifies housing as a barrier to community living. **(Target start date October 1, 2021)**

Challenges to Implementation

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

Remediation

Utilize additional staff positions that have been authorized.

Performance Measure(s)

Number of targeted in-reach visits conducted.

Number of TPMs in SNF referred to MFP.

Number of HCBS case managers assigned to TPM in SNF.

Percent of housing facilitators assigned when housing is an identified barrier on the PCP.

Strategy 4. To help ensure that HCBS case managers conduct person-centered planning in a culturally responsive way, the State will implement the following recommendations from the August 2020 “Partnering Equitably with Communities to Promote Person-Centered Thinking, Planning and Practice” brief.

(See Appendix B). [Partnering Equitably with Communities \(nd.gov\)](#) (Target completion date March 1, 2022, and ongoing)

- Ensure that the Peer Support Resource Center referenced in this document provides opportunity for culturally specific peer supports to the greatest extent possible.

- Holding HCBS Community Conversations in all Native American reservation communities in ND.
- Including representation from Native American and New American communities on all workgroups described in this IP.
- Providing cultural sensitivity training created by local subject matter experts to all HCBS case managers.
- Ensuring access to interpretive services and translating informational materials into other languages.
- Providing funds through the MFP tribal initiative for Tribal nations to hire HCBS case managers to provide culturally competent case management services to tribal members.

SA Section IX. Access to Community-Based Services

Responsible Division(s)

DHS Aging Services Division

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

Implementation Strategy

Strategy 1. HCBS policy will be updated, by service, to clarify that HCBS will be delivered in the most integrated setting appropriate, including at a TPMs home, workplace, and other community settings. **(Target completion date October 1, 2021)**

Strategy 2. A Service Delivery stakeholder workgroup will be established to identify ways to improve flexibility in the service delivery system. The State will invite TPMs, family members, guardians, State administrative staff, tribal representatives, HCBS case managers, QSPs, and other interested stakeholders to participate. The group's primary purpose is to make recommendations for the State to consider regarding ways to improve the authorization and service delivery process and create contingency/emergency back-up plans that do not rely on the TPM to identify informal supports.

The State will use the recommendations to develop contingency/emergency back-up-plan training for HCBS case managers, update policy and develop provider recruitment strategies to increase access to other QSPs in the event of an emergency, improve the authorization of services, and updates to the PCP.

State staff will be responsible for taking any regulatory action necessary to implement the agreed upon recommendations from the workgroup. **(Workgroup established November 1, 2021, Recommendations developed and reported March 1, 2022)**

Performance Measure(s)

Number of contingency plans incorporated into the PCPs that have been audited.

DSW/FC Resource and Training Center (Section IX, Subsection D, page 14)

Implementation Strategy

Strategy 1. The State requested and received approval to use MFP capacity building funds to establish a Direct Service Workforce/Family Caregiver Resource and Training Center (DSW/FC Resource and Training Center) to assist TPMs who choose their own

individual QSPs to successfully recruit, manage, supervise, and retain QSPs. The DSW/FC Resource and Training Center will also help TPMs to understanding the full scope of available services and the varying requirements for enrollment, service authorization, and interaction with HCBS case management. **(Agency procured December 31, 2021)**

Performance Measure(s)

Number of TPMs who self-direct or who express interest in self-direction supported by the DSW/FC Resource and Training Center.

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

Implementation Strategy

Strategy 1. Educate HCBS applicants on the right to appeal any decision to deny/terminate/reduce services by adding information to the Application for Services form. HCBS case managers will be required to inform TPMs that they can help them file an appeal during the person-centered planning meetings. **(Target completion date October 1, 2021)**

Strategy 2. Educate TPMs who are already receiving services on their right to appeal any decision to deny/terminate/reduce HCBS by adding information to the “HCBS Rights and Responsibilities” brochure. HCBS case managers will be required to inform TPMs that they can help them file an appeal during the person-centered planning meetings. **(Target completion date October 1, 2021)**

All TPMs receiving HCBS must be made aware and provided a copy of the required information. HCBS case managers are required to explain the information, which is signed by the recipient and/or their legal decision maker, if applicable.

Performance Measure(s)

Number of TPMs provided written information on the right to appeal.

Strategy 3. TPMs cannot be categorically or informally denied services. Policy will be updated to require 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. **(Target completion Date October 1, 2021)**

Strategy 4. Conduct an analysis of the number of units being authorized and utilized, by case management territory, to determine if there are significant discrepancies in the amount of services available to TPMs across the State. **(Target completion Date April 1, 2022)**

Performance Measure(s)

Number of service units authorized and utilized by territory.

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

Implementation Strategy

Strategy 1. The State will work with the DHS Legal Advisory Unit and other agencies or boards to determine if a request for reasonable modification, including the delegation of nursing tasks, can be accommodated as required in the SA. HCBS policy will be updated to determine how requests for reasonable modification may submitted for review and reconsidered. **(Target completion date October 1, 2021)**

Performance Measure(s)

Number and percent of HCBS case managers trained on reasonable modification.

Number of stakeholders provided education about reasonable modification.

Number of reasonable modification requests received and outcome.

Strategy 2. Some requests for reasonable modification may conflict with the ND Nurse Practices Act, N.D. Cent. Code § 43-12.1. The State will meet with the ND Board of Nursing and will request to convene a Healthcare Accommodations workgroup with members of the Board of Nursing. The purpose of the workgroup is to further explore ways to support TPMs in receiving necessary medical care so they can remain in the most integrated setting appropriate and develop recommendations for the State to consider. If necessary, the State will consider options associated with its oversight responsibilities to resolve any disputes regarding practice differences between nurses and non-nurses to assure that TPM requests for accommodation can be met in the most efficient and effective manner. Recommendations will be shared with stakeholders and their feedback incorporated into any policy or regulatory change resulting from recommendations made by the workgroup. **(Workgroup established November 1, 2021, recommendations complete April 1, 2022)**

Strategy 3. The State will use existing extended personal care services or the nurse assessment program to pay a registered nurse to administer training to the QSP to ensure that the QSP can perform needed nursing-related services for the TPM in the community. **(Complete December 14, 2021)**

Performance Measure(s)

Number of TPMs receiving extended personal care.

Strategy 4. Policy will be updated to require the HCBS case manager to assist TPMs in making a request for reasonable modification to the State when services are necessary but unavailable are identified during the person-centered planning process. **(Target completion Date October 1, 2021)**

Performance Measure(s)

Number of requests for reasonable modification and outcome.

Strategy 5. The State will track all requests for reasonable modification to identify trends in service gaps, location, utilization, or provider capacity. Reports will be reviewed at a quarterly meeting attended by all DHS Divisions that administer HCBS. Strategies to address identified issues will be established and included in future revisions of the IP. **(Target completion date October 1, 2021)**

Performance Measure(s)

Number of requests for reasonable modification and outcome.

Denial Decisions ([Section IX, Subsection G, page 15](#))

Implementation Strategy

All decisions to deny a TPM requesting HCBS is based on an individualized assessment. TPMs will not be categorically denied services and are provided the legal citation for the denial and their appeal rights as required.

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](#))

Implementation Strategy

Strategy 1. Add residential habilitation, community-support services, and companionship to 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. **(Complete January 1, 2020)**

Challenges to Implementation

Residential habilitation and community-support services were approved January 1, 2020. Webinars were held in early 2020 to recruit QSPs, but due to the COVID-19 pandemic, provider enrollment was delayed. The first TPMs were served with these new services in November 2020.

Remediation

The State has ten QSPs currently enrolled to provide these new services and is actively working to enroll other interested providers. The State will hold additional webinars to recruit QSPs and offer enrollment assistance beginning in October 2021. Individualized enrollment assistance will be available through the DSW/FC Resource and Training Center. The entity operating the Resource Center will be responsible to outline the strategies they will use to advertise and provide the assistance necessary to ensure that the assistance is available to everyone who needs it.

Performance Measure(s)

Number of QSPs who received enrollment assistance.

Number of QSPs successfully enrolled to provide services.

Strategy 2. Update SPED financial and functional eligibility criteria to increase access to SPED. **(Complete July 1, 2019, and January 1, 2020)**

Performance Measure(s)

Number of TPMs served in the SPED program.

Percent increase in SPED recipients.

Number of individuals who apply for SPED and are denied.

SA Section X. Information Screening and Diversion

Responsible Division(s)

DHS Aging Services & Medical Services Divisions

Informed Choice Referral Process ([Section X, Subsection A, page 15](#))

Implementation Strategy

Strategy 1. Implement an informed referral choice process to identify TPMs and provide information about community-based services, person-centered planning, and transition services to all TPMs and guardians, if applicable, who formally request or are referred for placement in a SNF and who are screened for a continued stay in a SNF.

Because of staff capacity the State currently provides this information to TPMs and guardians who express interest in HCBS or who, because of their care needs, are best served in the community. On June 14, 2022, the State will begin providing the required information to all TPMs as required in the SA.

Strategy 2. To identify TPMs when they are screened at a NF LoC and ensure that they receive information about community-based services, person-centered planning, and transition services, and therefore have an opportunity to make an informed decision about where to receive services, the ND NF LoC tool has been updated to include questions to identify TPMs who are interested in learning about community-based options or who, because of their level of need, might be best served in the community.

State staff are required to conduct the visits within five (5) business days of the referral. If a TPM chooses HCBS, a HCBS case manager is assigned and a referral is made to MFP, if applicable. TPMs are currently asked to indicate in writing whether they received such information. **(Complete January 1, 2021)**

See [Appendix C - Informed Choice Referrals ND Admin Code 75-02-02.4](#)

See [Appendix D - Informed Choice Educational Materials](#)

Challenges to Implementation

Staff capacity to conduct informed choice visits and HCBS case management.

Remediation

The State requested and received approval to use MFP capacity building funds to hire staff to conduct informed choice referral visits to free up case management capacity to serve additional HCBS recipients. Staff will be hired in areas of the State with the highest referrals and/or in rural areas where the most

travel is required. **(Target completion date October 1, 2021)**

Challenges to Implementation

Because TPMs residing in a SNF are not currently required to have an updated NF LoC determination, they are not being asked if they want to discuss community-based service options outside of the Minimum Data Set (MDS) Section Q assessment.

Remediation

Informed choice referral staff will be required to conduct on-going group in-reach visits to each SNF at least twice per year until December 14, 2022, when all TPMs are screened annually.

Challenges to Implementation

The informed choice referral process currently targets TPMs who are interested in learning about community-based options or who, because of the level of need, might be best served in the community. The State will develop strategies to provide informed choice visits to each TPM residing in a skilled facility by June 14, 2022, as required.

Remediation

The State will develop an Informed Choice workgroup and invite TPMs, family, guardians, State staff, tribal representatives, HCBS case managers, hospital, and nursing home discharge planners, and other interested stakeholders to participate. The group's primary purpose is to develop a list of recommendations for the State to consider on how to best provide the required information to ensure the TPMs and guardians have a true understanding of the availability of HCBS that will allow them to live in the most integrated setting appropriate.

The group will also address how a TPM who, after being provided all required information, may decline community services in favor of SNF placement, if that is their preferred setting. The workgroup will review the current process, forms, and educational materials to ensure they are reflective of cultural and geographic norms, respect the wishes of TPMs who may initially oppose participation in an informed choice visit while considering the State's continued duty to ensure that the TPM understands the specific community-based services that are available to them so they can make an informed decision. **(Workgroup developed October 1, 2021, Recommendations complete April 1, 2022)**

Performance Measure(s)

Number of TPMs who received informed choice visits.

Number of informed choice visits that resulted in TPM transitioning to a community setting.

Number of informed choice visits that resulted in diversion of TPM from an institutional setting.

Number and percent of TPMs in SNF reached through group or individualized in-reach.

Number and percentage of informed choice visits where the TPM requested follow up and the follow-up visit occurred.

Strategy 3. The current informed choice referral process requires staff to complete the SFN 892 – Informed Choice Referral for Long-Term Care form during each visit. The form requires a signature from the TPM or their legal decision maker to confirm they received and understand the required information. Educational materials to help TPMs understand their options have been developed and are required to be used during each visit.

Challenges to Implementation

Some TPMs who are discharging from the hospital or who have recently been admitted to a SNF have refused visits because they state they prefer the SNF or feel it is not the right time to discuss their care needs and preferred setting. TPMs have a right to decline a service, opportunity, or benefit in accordance with the SA.

Remediation

If a TPM refuses an informed choice visit, State staff are required to ask if the TPM would like to schedule a follow up visit or be contacted later. State staff shall leave a copy of the educational materials and ADRL contact information. The Informed Choice workgroup will develop recommendations to identify strategies to address these issues. **(Workgroup developed October 1, 2021, Recommendations complete April 1, 2022)**

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 the informed choice 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 will be updated to require 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. **(Complete January 1, 2021)**

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 DHS including Aging Services, Medical Services, Developmental Disabilities, Behavioral Health, Vocational Rehabilitation, or the Human Service Centers.

Remediation

The State has implemented a bi-weekly interdisciplinary team meeting to staff necessary but unavailable service requests with staff from Aging Services, Behavioral Health, 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 concept will be replicated with other DHS divisions to staff reasonable modification requests or to staff situations where it is unclear which HCBS waiver or State plan benefit would best meet the needs and wishes of the TPM. **(Target completion date October 1, 2021)**

Performance Measure(s)

Number of cases staffed per interdisciplinary team meetings and outcome.

Number of requests for reasonable modification and outcome.

Strategy 2. The State will establish a NF LoC workgroup. The State will invite State staff, hospital, and nursing home discharge planners, HCBS case managers, TPMs, family members, guardians, and other interested stakeholders to participate. The primary purpose of the workgroup is to develop recommendations for the State to consider that will help determine what incremental changes need to be made to the initial and continued stay NF LoC eligibility criteria to remove any inherent barrier in the functional eligibility criteria that prevent TPMs from receiving the types of supports necessary to live in the most integrated setting.

The group will also provide recommendations to ensure that TPMs who no longer screen at a NF LoC will be allowed sufficient time to safely transition to the community and find necessary supports. The State will be responsible to complete any regulatory process that will be required to incorporate the agreed upon recommendations.

(Workgroup established December 1, 2021, Recommendations complete May 1, 2022)

Strategy 4. Conduct an annual NF LoC screening for all Medicaid recipients living in a SNF. The State will update the contract with the NF LoC determination vendor to allow for annual determinations and require them to assist with educating SNF staff. **(Target completion date December 1, 2022)**

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 thirty (30) days. This could negatively impact TPMs who need sufficient time to transition back to the community.

Remediation

The State will convene the NF LoC workgroup described above to identify a plan to ensure that TPMs who no longer screen at a NF LoC will be allowed sufficient time to safely transition to the community and find necessary supports.

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

Implementation Strategy

The SME has drafted a Diversion Plan with input and agreement from the State. The plan outlines a range of recommendations that are intended to inform and support the State's actions related to improving diversions, both during the timeframe of this version of the IP, as well as throughout the duration of the SA.

(See [Appendix E](#) - Diversion Plan)

The State is currently implementing or has incorporated the following recommendations included in the Diversion plan into the IP. The State will consider implementing other recommendations included in the plan in future IP updates.

- Identifying and providing outreach to TPMs at serious risk of entering a SNF through the informed choice referral process.
- Establishing a workgroup to develop recommendations to improve the informed choice process to ensure all required information is provided in a meaningful, culturally competent way. This will include developing protocols that will allow HCBS case managers to continue to engage TPMs who initially decline their informed choice visits or did not express interest in HCBS.
- Developing a formal peer support program through the proposed Peer Support

Resource Center that will allow individuals an opportunity to meet other individuals living, working, and receiving services in an integrated setting before deciding where to receive services.

- Creating a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. Campaign will include marketing on social media and providing education to the public, professionals, stakeholders and TPMs at serious risk of entering nursing facilities. Campaign will also provide education to those parties that recommend SNF care to TPMs.
- Assuring that the State contractor for Medicaid NF LoC determinations promptly notifies the Aging Services Division when it receives a NF LoC referral for review and assessment and enters the data into the State system. State contractor currently notifies Aging Services within one (1) business day of the name and contact information of every TPM that was successfully screened the previous business day. This information is tracked in a database and provided to the HCBS Case Managers daily. State staff ensure that the individuals being referred are actual TPMs and all SNFs in ND are enrolled Medicaid providers.
- Promptly assigning an HCBS case manager to all TPMs who contact the ADRL by assigning the referral within three business days of the completion of the intake assessment, to an HCBS case manager who begins the person-centered planning process.
- Working with the national person-centered planning contractors to create a companion guide to the “Charting the LifeCourse” person-centered planning vision tool to reflect the interests and situations of older adults and persons with physical disability and improve the person-centered planning process.

SA Section XI. Transition Services

Responsible Division(s)

DHS Aging Services Division

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

Implementation Strategy

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

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

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

- Use MFP funds to hire three (3) additional MFP transition coordinators in Bismarck, Grand Forks, and Minot. Two additional FTEs were hired in the Fargo office with Centers for Independent Living (CIL) funds. **(Staff hired and trained November 1, 2021)**
- Recruit and retain additional community transition providers willing to enroll with ND Medicaid to provide services under the HCBS waiver by reviewing the adequacy of current reimbursement rates, providing incentive grants to encourage providers to enroll and providing technical assistance to the CILs who are interested in expanding

their capacity to provide these services. **(Target completion date December 1, 2021)**

- Conduct a policy review to further define the functions, responsibility, and reporting requirements for MFP and HCBS waiver community transition support services. The policies will be available online. This process will include a review of other high performing state MFP programs to learn about and potentially adopt successful transition strategies to best serve TPMs. **(Target completion date November 1, 2021)**

Challenges to Implementation

Identifying providers willing to enroll with ND Medicaid to provide community transition services under the HCBS waiver.

Remediation

The State requested and received approval to use MFP capacity building funds on May 7, 2021, to offer incentive grants to support start up and enrollment activity costs for new or existing QSPs to establish or expand their business to provide HCBS. Grants will be awarded in amounts up to \$30,000 based on the priority of need of the services the agency will provide. **(Grants awarded by November 15, 2021)**

Performance Measure(s)

Number of MFP transition coordinators hired November 1, 2021.

Number and total dollar amount of incentive grants awarded.

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

Implementation Strategy

Strategy 1. The State will include the requirement to report transitions that have been pending for more than 100 days in the MFP policy and procedure manual. The Agreement Coordinator will be responsible for securely forwarding a list of the names of TPMs whose transition has been pending more than 100 days. The report will include a description of the circumstance surrounding the length of the transition. The State currently tracks the days from referral to transition. **(Required completion date June 14, 2022)**

Performance Measure(s)

Number of transitions taking longer than 100 days reported to SME.

Number and percent of transitions occurring within the 120-day timeframe.

Strategy 2. The State will include the requirement to report transitions that have been pending for more than 90 days to the MFP program administrator in the MFP policy and procedure manual. The MFP program administrator will facilitate a team meeting to staff the situation and provide more intensive attention to the situation to remediate identified barriers preventing timely transition. **(Target completion date October 1, 2021)**

Strategy 3. The State will 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. This information will be used to develop training and future strategies to improve the transition process. Review team will include State staff, HCBS case managers, MFP transition coordinators and housing facilitators.

Performance Measure(s)

Number of transitions supports team members trained on successful strategies. **(Target completion date January 1, 2022)**

Transition Team (Section XI, Subsections C & D, pages 16-17)

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 informed choice 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 two (2) business days of the original referral an HCBS case manager is assigned, and the team must meet within ten (10) business days to begin to develop a PCP. The MFP 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 one (1) year post discharge. The HCBS case manager also provides ongoing case management assistance.

Performance Measure(s)

Track number of transition referrals and timelines for case management assignment. **(Tracking began May 1, 2021)**

Number of successful transitions.

Number of PCPs completed with TPMs in SNF.

Number of in-reach activities conducted.

Transition goals ([Section XI, Subsection E, page 17](#))

Implementation Strategy

Strategy 1. Effective January 1, 2021, the MFP grant was authorized for three additional years. The State will continue to use the funds and resources from this grant to provide transition supports. **(Complete)**

Strategy 2. 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 100 SNF TPMs to transition to the most integrated setting appropriate. The State will divert at least 100 TPMs from SNF to community-based services. **(Required completion date December 14, 2022)**

To meet these requirements, the State needs to develop additional capacity to inform TPMs about HCBS, person-centered planning, and transition supports. The State intends to build capacity by hiring additional staff to conduct informed choice referral visits and conduct facility in-reach to TPMs living in a SNF. **(Target completion date October 1, 2021)**

In addition, the State will request funds in the 2022 MFP budget request to hire additional MFP transition coordinators and transition assistants. The assistants would coordinate the logistics of the actual move and help conduct post discharge follow up. **(Target completion date January 1, 2022)**

Challenges to Implementation

The most significant challenge is recruiting and retaining providers who can employ enough direct care staff to provide 24-hour supports when that level of care is necessary to support the TPM in the community.

Remediation

The primary remediation effort is to address the workforce issue through the MFP capacity building funding proposal. These funds will be used to offer incentive grants to recruit new QSPs, develop a DSW/FC Resource and Training Center to address enrollment, retention, and training of providers, and improve the ability of TPMs to find QSPs that match their service needs through the *ConnectToCareJobs* system.

This system connects individuals to a platform for providers to market their skills

and be matched with a TPM. The State will work with the DSW/FC Resource and Training Center to develop a QSP capacity survey to determine the ability of current providers to staff their currently authorized hours, ability to staff increased hours, and capacity to serve additional clients.

Performance Measure(s)

100 unduplicated SNF TPMs successfully transitioned.

100 unduplicated at risk TPMs successfully diverted.

Strategy 3. The State tracks TPMs using a unique identifier and will report unduplicated transition and diversion data. **(Complete December 14, 2021)**

Challenges to Implementation

Case management and MFP administrative functions are not completed or accessible within the same IT system.

Remediation

The State will work with the new case management system vendor to integrate the MFP process into the case management system. The system can create unique TPM records that show the progression of service delivery from initial referral through service provision and case completion. **(Target completion date August 15, 2021)**

SA Section XII. Housing Services

Responsible Division(s)

DHS

DHSSME Housing Access Plan ([Section XII, Subsection A, page 18](#))

Implementation Strategy

The SME has drafted a Housing Access Plan with input and agreement from State. The SME Housing Access Plan outlines a range of recommendations that are intended to inform and support the State's actions related to improving housing access, both during the timeframe of this version of the IP, as well as throughout the duration of the SA. (See [Appendix F](#)- Housing Access Plan)

The State is currently implementing or has incorporated the following recommendations included in the Housing Access Plan into the IP. The State will consider implementing other recommendations included in the plan in future IP updates.

- Establishment, integration, and maintenance of a housing inventory resource.
- Additional policy conversation and partnership with public housing authorities and affordable housing providers across ND related to policies, preferences, and practices that would support TPMs.
- Efforts to establish State-funded rental assistance as well as partnerships that help assure maximum utilization of existing federal rental assistance programs.

Implementation Strategy

Development of housing needs and preferences tools that will be incorporated into informed choice and case management processes.

Strategy 1. Convene State Housing Services workgroup to review current State context and provide housing strategies to be incorporated into the IP. **(Workgroup established April 1, 2021, recommendations complete August 2021)**

Challenges to Implementation

Time and resources to effectively coordinate ongoing housing planning efforts across State systems.

Remediation

Assemble interagency USDOJ Housing Support workgroup to develop solutions

collaboratively.

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

Implementation Strategy

Strategy 1. Connect TPMs whose PCP identify a need for PSH or housing that SME agrees otherwise meets requirements of 28 C.F.R. § 35.130(d) (Milestone dates December 14, 2021 / December 14, 2022 / December 14, 2023 / December 14, 2024)

Challenges to Implementation

Matching available housing stock with TPM needs, including integration of support services, environmental modifications, and rental assistance to effectively create (to the greatest extent possible) a PSH solution in the community/setting of the TPM's choice.

Remediation

Implementation of a housing locator/housing inventory that can be integrated into ADRL system.

Performance Measure(s)

Utilization of housing inventory/locator resource by housing support professionals

Number of TPMs who indicated housing as a barrier who were provided PSH. Targets include Year 1 – 20, Year 2 – +30, Year 3 – +60, Year 4+ - number based on need for PSH identified in PCPs.

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

Housing costs as percent of household income

Strategy 2. Develop housing inventory, integrated with the ADRL system, that identifies availability of housing options that may be suitable to meet the needs of TPMs who have an identified housing barrier. The inventory should include, to the greatest extent possible, information related to accessibility, affordability, availability, and tenant selection criteria as well as information related to a property's status as PSH as per the SA. **(Target completion date October 1, 2022)**

Challenges to Implementation

No existing mechanism to ensure timely updates to databases, particularly occupancy (availability), complexity of identifying information related to access to

services that are likely to be available at any location.

Remediation

Build on housing inventory developed and maintained by MFP transition team and consider opportunities to integrate into ADRL-based search capabilities.

Performance Measures

Utilization rate of housing inventory by diversion and transition teams.

The number of times the inventory is successful in helping secure housing.

Strategy 3. Convene State Housing Services workgroup 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. **(Target completion date March 1, 2022)**

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

Implementation Strategy

Strategy 1. Increase the network of housing facilitators and transition coordinators actively working in the State. **(Target completion date November 1, 2021)**

Challenges to Implementation

Need for additional providers who are willing to apply the range of resources related to Housing Access in the IP.

Remediation

Partner with provider recruitment efforts currently underway (ex. MFP, ND Rent Help) to establish Communities of Practice that will build and solidify connections between parties engaged in this work.

Strategy 2. Create network and contact information for housing support professionals to know how they can work together and provide clear guidance on how to effectively divert TPMs from institutional settings. Connect HCBS case management and informed choice referral process to new housing support resources that are available in the State to enable actions outlined in each TPMs PCP. **(Target completion date November 1, 2021)**

Challenges to Implementation

Identifying collaboration tools that can help assure effective connections between teams.

Remediation

As the new system gets established, utilize the MFP transitions team as a resource hub. The housing facilitators that are part of the MFP transition effort are already working to develop and function on a statewide basis. Their experience can help bridge knowledge gaps as more people are integrated into a broader housing referral network.

Challenges to Implementation

Clearly identifying the interconnectivity between professionals working with TPMs (ex. transition coordinator, housing facilitator, property managers, care coordinators, case aids, and intake/informed choice resources).

Remediation

Process mapping exercise including workflow analysis.

Performance Measure(s)

Number of referrals made and resulting services accessed.

Strategy 3. Define a process to guide appropriate identification of professionals who will work together to help overcome barriers that are identified in TPM 's PCPs. Professionals from housing facilitation, HCBS case management, transition coordination, rental assistance, and environmental modification will be represented on the Housing Services workgroup to build stronger interconnectivity between disciplines.

The ND Housing Services workgroup will work together to help assure that both diversion and transition-oriented teams have what they need to develop practical housing action plans for each TPM who has housing barriers identified in their PCP.

Diversion teams will focus on working with TPMs who are still in a community setting and need additional supports to avoid a move to a SNF. A typical diversion team will include an HCBS case manager, housing facilitator, and the TPM and will consult with a property manager or vulnerable adult protective services worker as appropriate.

Transition teams will focus on working with TPMs who are in a SNF and desire a transition to community. A typical transition team will include an HCBS case manager, a transition coordinator, a housing facilitator, and the TPM and will consult with a discharge planner or property manager as appropriate. **(Target completion date December 1, 2021)**

Strategy 4. Staff diversion or transition teams to meet benchmarks required by dates noted in the SA as appropriate, for each TPM who has an identified housing need. **(Target completion date for establishing metric and process to report on performance measures December 1, 2021)**

Challenges to Implementation

Making the connection between ad hoc community-based teams and specific TPMs with housing needs.

Remediation

Communities of Practice to facilitate region-specific knowledge.

Performance Measure(s)

Establish timeliness metric for connecting diversion or transition team to TPM

Number and percent of team connections made by timeliness metric.

Strategy 5. Assure that there are meaningful connections between housing and case management tracking systems utilized to support the PCP for each TPM. **(Target completion date December 1, 2021)**

Challenges to Implementation

Both State-level data systems (housing and case management) are new; integration practices need to be explored, built, and trained.

Remediation

Identify liaisons working within each system to ensure connections happen at key implementation points, in addition to any automated integrations that may be possible.

Strategy 6. Incorporate information on system updates in trainings for HCBS workers, including how data collected related to housing will be used in reporting. **(Target completion date November 1, 2021)**

Challenges to Implementation

Coordinating supplemental training into regular system training schedule.

Strategy 7. Define housing barriers that may face ND renters and ensure those variables are reflected and addressed in informed choice and case management process. **(Target completion date July 1, 2021)**

Challenges to Implementation

Modifying field variables in case management/ADRL system to appropriately reflect barriers experienced by TPM (with multi selection enabled).

Remediation

Connect with technology system vendor to ensure that the system is capturing the barriers.

Performance Measure(s)

Number of informed choice referrals that collect information related to housing barriers.

Number of PCPs that show evidence that individual-level barriers are referred to and addressed by the Diversion and Transition teams who are working with the TPM.

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

Implementation Strategy

Strategy 1. Develop a matrix that identifies the full range of home and environmental modification resources available in ND. **(Target completion date October 1, 2021)**

Challenges to Implementation

Absence of coherent approach, administration, or definition of environmental modifications in ND systems.

Remediation

Assemble interagency Environmental Modifications workgroup to develop solutions to issues that are identified as barriers to TPM's ability to secure environmental modifications. Workgroup to include representation from DHS Medical Services, DHS Economic Assistance, DHS Executive Office, DHS Life Skills Transition Center, DHS Developmental Disabilities division, DHS Aging Services division, Department of Commerce Division of Community Services, ND Housing Finance Agency.

Strategy 2. Identify needed program adjustments to broaden access to home and environmental modification resources. **(Target completion date April 1, 2022)**

Challenges to Implementation

Multiple Federal and State funding sources to align.

Remediation

Work with interagency Environmental Modifications workgroup to develop solutions to identified challenges.

Strategy 3. Work with Interagency Environmental Modifications workgroup to identify and implement amendments to existing 1915c waivers. **(Target completion date July 1, 2022)**

Challenges to Implementation

Timeframe required for waiver amendments.

Remediation

Include staff with experience developing amendments.

Strategy 4. Develop training for housing support providers 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 ongoing training opportunities for housing professionals/teams regarding integration of reasonable modification ideas into the PCP. **(Target completion date January 1, 2022)**

Challenges to Implementation

Lack of expertise in this area by existing staff and organizations.

Remediation

Involve local government staff with experience in housing rehabilitation.

Strategy 5. Identify training 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. **(Target completion date November 1, 2021)**

Challenges to Implementation

Lack of expertise in this area by existing staff and organizations.

Remediation

Involve organizations with occupational therapy, housing rehabilitation and

adaptive technologies/equipment experience in this initiative.

Strategy 6. As per SA Section XII(D)(3)(a)-(c), examine policies of housing providers and Medicaid policy (specifically SNF) to create guidance regarding "intent to return home", resulting in a usable resource for eligibility workers and housing support team professionals.

"Intent to Return Home" is identified in individual service plans that involve a person's "intent" following a change in status. This may preclude a TPM from being able to maintain their housing while temporarily in an institutional setting because of housing provider or Medicaid-related policies and requirements related to time away from a housing unit. Add information about intent to return home to informed choice document as needed, including information that needs to be communicated to SNF to facilitate continued TPM access to monthly payments which further enable a return home.
(Target completion date October 1, 2021)

Challenges to Implementation

Complexity of underlying systems.

Remediation

Involve people with expertise in federal housing and Medicaid in this initiative.

Performance Measure(s)

Utilization of intent to return home element of informed choice process.

Strategy 7. Develop recommended practice guidelines that housing providers can choose to adopt if they want to better align with "intent to return home" goals established in the TPM's service plan or informed choice document. Include clear communication expectations as part of the TPM diversion and transition teams.
(Target completion date November 1, 2021)

Challenges to Implementation

Decentralized nature of Federal housing delivery in ND.

Remediation

Partnership with ND National Association and Housing Rehabilitation (ND-NAHRO) Organizations and ND Housing Finance Agency (NDHFA).

Strategy 8. Offer guidance to professionals involved in service teams regarding subsidy rules related to filing change of income forms with housing subsidy providers. Include guidance on how to access resources that can bridge TPM housing costs during out-of-

home stays. **(Target completion date November 1, 2021)**

Challenges to Implementation

Decentralized nature of Federal housing delivery in ND.

Remediation

Partnership with ND-NAHRO and NDHFA to develop materials.

Strategy 9. Develop a benefits management resource as a parallel to the process MFP uses to help ensure people maintain housing even during time in SNF. This includes training on specific practices that help ensure access to housing even during temporary out-of-home stays (ex. SNF, hospital, rehabilitation center). **(Target completion date February 1, 2022)**

Challenges to Implementation

Difficulty in incorporating new resource type into referral networks.

Remediation

Partner with the DHS Vocational Rehabilitation Division to explore opportunities to collaborate and expand access to benefits planners.

Performance Measure(s)

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

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

Implementation Strategy

Strategy 1. Broaden access to fair housing training to all housing facilitators and make available to all professionals involved in transitions and diversions. **(Target completion date October 1, 2021)**

Performance Measure(s)

Number and percentage of staff trained (include all disciplines represented by Housing Services workgroup).

Rental Assistance ([Section XII, Subsection F, page 20](#))

Implementation Strategy

Strategy 1. Outline State strategy for access to rental assistance, including all resources available (ex. HUD Housing Choice voucher, Mainstream voucher; Veterans Administration Supportive Housing voucher; Rural Development rental subsidy; State rental assistance (new); emergency rent assistance (State or federal)). Include processes for accessing rental assistance (eligibility, referral, documentation, and determination). Develop State rental assistance brief that outlines State resources and strategy. **(Target completion date October 1, 2021)**

Performance Measure(s)

Number of TPMs who are accessing various forms of rental assistance.

Strategy 2. Expand permanent supported housing capacity by funding and providing rental subsidies for use as permanent supported housing. **(Target completion January 1, 2022)**

Challenges to Implementation

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

Performance Measures(s)

Number of TPMs who receive rental assistance.

Number of TPMs who do not experience housing cost burden (i.e., pay more than 30% of their monthly adjusted income for housing) by receipt of rental assistance.

Strategy 3. Enhance the existing ND Housing 101 training course that has been designed to introduce helping professionals to housing concepts, terminology, and market information. Identify additional modules to include in the training curriculum to allow for deeper knowledge on specific topics, and determine which modules need to be localized to be effective. Include modules for transition and diversion teams regarding applying for rental assistance, and for housing facilitators regarding “Opening Door” as a resource to mitigate housing barriers. **(Target completion date December 1, 2021)**

Challenges to Implementation

Maintaining appropriate brevity given breadth of topics to include.

Remediation

NDHFA and MFP partnership to update.

SA Section XIII. Community Provider Capacity and Training

Responsible Division(s)

DHS Aging Services and Medical Services Divisions

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

Implementation Strategy

Strategy 1. Use MFP capacity building funds to establish (DSW/FC Resource and Training Center) to assist and support Individual and Agency QSPs and family caregivers providing natural supports to the citizens of North Dakota. **(Agency procured December 31, 2021)**

The primary goals of the DSW/FC Resource and Training Center are to:

- Provide one on one individualized support via email, phone, and/or video conferencing to assist with enrollment and reenrollment, electronic visit verification, billing, and business operations to recruit and retain a sufficient number of QSPs. This will include the development of technical assistance tools such as user guides that will be available in multiple languages.
- 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.
- Facilitate the development of a workgroup of experts to provide guidance on the project.
- 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 DSW/FC Resource and Training Center. A needs assessment which includes a survey of individual QSPs and QSP agencies will be conducted to determine the current capacity and unmet needs of this direct care workforce across the State, including provider capacity to serve rural and Native American communities.
- Establish and implement a QSP agency recruitment process. This will include working with small business development organizations to increase the number of QSP agencies available to meet the needs of all eligible individuals.

Performance Measure(s)

Number of QSPs assisted by the DSW/FC Resource and Training Center.

Number of QSP agencies receiving Council on Quality and Leadership (CQL) accreditation.

Number of new agencies enrolled as providers.

Number of new independent QSPs enrolled as providers.

Number of agencies that expand array of services.

Number of such agencies serving tribal and other under-served and rural communities.

Strategy 2. Implement an inflationary rate increase for all HCBS services that was approved in the 21-23 DHS budget. Providers will receive a 2% increase in year one of the biennium and a 0.25% increase in year two. **(Required implementation date July 1, 2021 & July 1, 2022)**

Performance Measure(s)

Rate increases published on July 1, 2021.

Strategy 3. Implement an additional rate increase, as approved in the 21-23 DHS budget, for supervision, non-medical transportation, non-medical transportation escort, and family personal care. A waiver amendment will be submitted. **(Target implementation date January 1, 2022)**

Performance Measure(s)

Rate increases published on January 1, 2022.

Number of new providers enrolled to provide these services.

Strategy 4. Conduct a QSP survey with the goal of completing a provider inventory, by case management territory, to analyze gaps in services and assess current and available capacity that is not being fully utilized. The survey will seek to determine the number of active agency providers (including which services each provider offers) and the number of active individual QSPs including which services each offers, how many TPMs each QSP currently serves, and how many additional TPMs or service hours they could provide. Results from the survey will also be used to identify barriers to service expansion and strategies to overcome such barriers. **(Survey distributed January 1, 2022, results trended and published March 1, 2022)**

Challenges to Implementation

Sufficient survey participation to glean quality data.

Remediation

The State will work with staff from the DSW/FC Resource and Training Center to create strategies to encourage participation and make the survey available to be completed in multiple ways.

Strategy 5. Create a centralized QSP matching portal in cooperation with ADvancing States to replace the current QSP searchable database.

The new system will be implemented with State specific modifications to a national website called *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 will have the capacity to create reports, be routinely updated, and available to HCBS case managers and others online. It will allow QSPs to include information about the type of services they provide, hours of work availability, schedule availability, and languages spoken. **(Target implementation date June 1, 2022)**

Performance Measure(s)

Number of QSPs and individuals trained to *ConnectToCareJobs* by August 1, 2022.

Number of users of portal on monthly basis.

Strategy 6. Pay the CQL accreditation fees for up to ten agencies who are willing to develop residential habilitation and community-support services for the HCBS Waiver serving adults with a physical disability or adults 65 years of age and older. Deferring costs for accreditation will increase capacity to provide the 24-hour a day services needed to support TPMs with more complex needs in the community. **(Target implementation date October 15, 2021)**

Strategy 7. The State will streamline the agency and individual QSP enrollment process and revise the current enrollment packet. **(Target implementation date January 1, 2022)** The redesign will address the following.

- Identify internal and external barriers to enrollment and how those will be reformed.
- Identify staff responsible to complete each activity and outline procedures.
- Create strategies to make it easier during initial enrollment to include all services

a QSP is qualified to provide.

- Consider additional training modalities and training that reflects and respects cultural beliefs and practices.
- Inform HCBS case managers and others on revisions in the provider enrollment process. Notify current providers when the revised certification process is complete and train to the revised processes.
- Address competency-based training such that non-medical tasks like money management will not require medical review.

Challenges to Implementation

Provider enrollment changes may need to be amended in Administrative Code, which requires legislative approval.

Remediation

The State will submit request to amend administrative code if required.

Performance Measure(s)

Number of QSPs trained to the revised processes.

Strategy 8. The State will create a Communication and Recruitment Plan to engage other agencies as potential community providers for the target population. The plan will include the development of a series of educational webinars that focus specifically on a particular community-based service and the qualifications that are needed for enrollment. Webinars will be marketed through DHS website, social media page, direct mail, email, and through stakeholder list serves. **(Target completion date November 1, 2021)**

Performance Measure(s)

Number of webinars offered by topic and number of attendees.

Number of applications received for the QSP incentive grants.

Strategy 9. Support start-up and enrollment activity costs for new or existing QSPs to establish or expand their business to provide HCBS. Grants will be awarded in amounts up to \$30,000 based on the priority of need of the services the agency will provide. **(Grants awarded by October 15, 2021)** (See [Appendix G](#) - MFP Capacity Building Funding Request)

Performance Measure(s)

Number of grants awarded by date.

Number of new providers offering services, including number serving tribal and frontier areas.

Number of existing providers expanding to provide HCBS.

Number of agencies that expand array of services.

Strategy 10. To reduce the responsibility of individual QSPs and improve the recruitment and retention of providers statewide, the State will consider other provider models including the Agency with Choice/Co-employer model. The State will evaluate the benefit of adding formal self-direction to the HCBS waiver and Medicaid State Plan – Personal care. **(Target completion date July 1, 2022)**

Strategy 11. To ensure timely enrollment and revalidation of QSPs, the State has amended its contract with the vendor to include provider enrollment services for QSPs. The vendor will follow State requirements and provide sufficient staff to complete all new enrollment applications within fourteen (14) calendar days of receipt of a complete application. The vendor will also be required to process provider revalidations prior to the revalidation due date. **(Target start date January 1, 2022)**

Performance Measure(s)

Number and percent of new QSP applications processed within fourteen (14) calendar days.

Number of QSP revalidations completed before revalidation due date.

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

Implementation Strategy

Strategy 1. The State will create critical incident reporting training opportunities for QSPs. Training will be provided through online modules and virtual training events. The State will update QSP handbook to include current reporting requirements. The State will also work with staff from the DSW/FC Resource and Training Center to develop ongoing training that will assist QSPs in understanding and complying with safety and incident reporting procedures. **(First critical incident reporting training complete August 1, 2021)**

Performance Measure(s)

Number of QSPs trained on reporting procedures.

Strategy 2. Implement training suggestions included in the Safety Assurance Plan – [Appendix J](#).

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

Implementation Strategy

The SME has drafted a Capacity Plan with input and agreement from the State. The plan outlines a range of recommendations that are intended to inform and support the State's actions related to improving capacity, both during the timeframe of this version of the IP, as well as throughout the duration of the SA. (See [Appendix H](#)- Capacity Plan.)

The State is currently implementing or has incorporated the following recommendations included in the Capacity plan into the IP. The State will consider implementing other recommendations included in the plan in future IP updates.

- Reviewing the weighting system for caseload assignment with a focus on the care coordination needs of TPMs, the provision of the appropriate level of case management services to each TPM residing in a SNF, and those who seek or are referred for admission to a SNF.
- State will consider implementing a tiered case management system to more efficiently build the capacity to assign a HCBS case manager to all TPMs as required in the SA.
- Implementing a new case management system that serves as a centralized data reporting system where information is stored, identifying available capacity for each HCBS case manager. This system operates in real-time and is available to the ADRL staff to use in the screening and referral process to optimize the matching of TPMs and available HCBS case managers.
- As part of the case management implementation and design, the State conducted a review of required case management documentation and designed the new process with the intent to eliminate unnecessary and duplicative documentation, to reduce the amount of time spent on administrative tasks and enhance HCBS case manager capacity.
- HCBS case managers, SMEs from the national person-centered planning technical assistance group, and the MFP Tribal Initiative team were consulted and made recommendations to improve the new process. These efforts are ongoing, and the State is committed to continuously improving the case management system.
- Using caseload and referral data to determine where case management

shortages exist and developing a plan to request additional resources to address capacity shortages, if necessary, in the next Executive budget request.

- The State specialized the role of the HCBS case manager when they became State employees in January 2020. The State is currently updating policy and procedures for HCBS case managers, MFP Transition Coordinators, housing facilitators, and others to define roles and responsibilities of each. The State will produce a process map to clearly delineate the responsibilities of each team member. This information will be shared with facility staff, TPMs, and stakeholders.
- The HCBS case managers and Aging Services staff are currently being trained in person-centered planning principles with the assistance of nationally recognized subject matter experts.
- The State will work with the DSW/FC Resource and Training Center to identify and address shortages in agency providers, by case management territory, and identify ways to incentivize current providers to build capacity and recruit additional agency providers and individual QSPs.
- The State will conduct a QSP capacity survey with the DSW/FC Resource and Training Center to assess current and future capacity to serve TPMs. They will also be responsible to create strategies for QSPs to support one another including a QSP list serve.
- The State will be replacing the current QSP searchable database with the assistance of ADvancing States and implement the *ConnectToCareJobs* system to help to identify available providers in all areas of the State. The system will allow QSPs to better market themselves and share their availability with others.
- The State is currently conducting a review of the provider enrollment process to streamline and improve the enrollment experience for providers. Once complete, this information will be shared with all providers.
- The State is evaluating the capacity to find backup service providers in the event of an emergency and has secured another Lifespan respite grant to provide additional respite opportunities for TPMs and their families.
- Consider adopting a new provider model to reduce the administrative burden on individual QSPs including the Co-Employer/Agency with Choice Model.
- Conduct a rate analysis to determine discrepancies in rates paid to in-home providers and SNF staff.
- Make changes to the HCBS Medicaid waiver to allow the rural differential (RD) rate to apply to additional services thus increasing access in rural communities.

- Conducting an analysis of the number of units being authorized and utilized by case management territory to determine if there are discrepancies in the amount of services available to TPMs across the State.
- Using the resources that can be made available through the ND Spending Plan for implementation of 10% temporary FMAP increase for HCBS/Section 9817/American Rescue Plan Act of 2021, to provide incentives to providers that will serve TPMs with high level of need or in rural and Native American communities.
- Provide meaningful statewide training opportunities for all QSPs to ensure understanding of the SA, HCBS, person-centered-planning, and the authorization and claims reimbursement system
- Consider revising the QSP training requirements to improve the provider experience and ensure a quality provider workforce.
- Creating the DSW/FC Resource and Training Center to improve the support provided to agency and individual QSPs.
- Offer incentive grants to encourage large and small agencies to expand their capacity to serve additional TPMs and expand their service array.

Capacity Building ([Section XIII, Subsection D, page 21](#))

Implementation Strategy

Strategy 1. Provide incentive grants to organizations (including SNFs) that enroll and provide HCBS. Grants may also be used for current QSP agencies that are willing to expand their current service array or expand their service territory to assist TPMs in rural areas, including tribal communities. **(Grants awarded November 15, 2021)**

Strategy 2. The State will provide ongoing group and individualized training and technical assistance to SNFs that express interest in learning about HCBS. The State will develop a HCBS orientation presentation and materials that will be shared with SNFs. State staff will present at the LTC Conference. **(Six-month technical guidance complete June 14, 2021, Additional outreach efforts December 1, 2021)**

Performance Measure(s)

Number of SNFs requesting individual technical assistance.

Number of SNFs that have enrolled to provide HCBS.

Strategy 3. 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 (CB-LTSS) 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, 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.

Performance Measure(s)

Number of Tribal entities enrolled to provide HCBS.

Number of individuals receiving HCBS per month by tribal owned QSP agencies.

Strategy 4. The State submitted a proposal to CMS and will seek legislative authority if approved to use the temporary 10% increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS to enhance, expand and strengthen the HCBS system for TPMs. (See [Appendix I](#) - Draft Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817) [Rebalancing Toolkit \(nd.gov\)](#).

The plan includes the following strategies that directly impact TPMs covered in the SA:

- Developing a pilot program that supports both the recruitment and retention of direct care workforce in the HCBS industry. Engage workforce partners to identify financial incentives that would be meaningful to members of the workforce and impactful in terms of overall workforce availability. Consider targeted incentives for specified service types (ex. respite), enhanced training/endorsements, duration of service, and complexity of care.
- Additional funding beyond that provided under the MFP Capacity Building Grant to develop new community services and supports offered through a series of tiered start-up grants, incentives, and supports to providers who increase their capacity to provide HCBS. Incentives may be used for skilled nursing facilities or health systems who open a HCBS service line, for new providers of high priority services (ex. respite, round-the-clock services, personal care, and nursing), for existing providers who expand into new service geographies, and providers who develop capacity for complex care cases. Awards will incentivize both establishment of new service lines as well as enhancement of established delivery of service.

- Contract with a consultant to overhaul the training system that is currently in place to serve both QSP and direct service providers in HCBS service lines. Ensure that the training platform is culturally responsive and infuses person-centered practices, is available in multiple languages, and is delivered in using modern approaches to effective adult learning. Revise the training catalog available to direct care workforce and establish career pathways and progressive endorsements and certifications that allow for implementation of additional initiatives within the ARPA North Dakota State Spending Plan, including behavioral health, crisis intervention, and de-escalation competencies.
- Increasing transitions and diversions through flexible transition supports from institutions to HCBS settings, and to more appropriate community-based settings, depending on circumstance. An example is establishing a transition fund to supplement available resources for people who are transitioning from institutions to the community. Funds are meant to be flexible and utilized by Transition and Diversion teams to address unexpected needs that arise in the move to a less restrictive setting. Eligible uses include, but are not limited to, environmental modifications, assistive technology, security deposit, furnishings, moving costs, and utility hook-up fees.

Included as eligible beneficiaries, people who are not currently eligible for transition supports from other Medicaid sources, for example people moving from one community setting to another (i.e., parents' home to independent living or non-accessible home to accessible home).

- Consider providing rental assistance to individuals who identify housing costs as a barrier to independent living in the least restrictive setting of their choice. Rental assistance could be first month's rent, deposits for utilities, or supports delivered by housing providers.

Work to enhance access to the full range of environmental modifications that would help people live successfully in home or community settings. Work with a consultant to identify program adjustments that will broaden access to home modification resources, including examining requirements that define who can provide construction-related services and program definitions that consider assistive technologies, equipment. Consider incentives for builders who are willing to engage as a home modification provider. Develop training for HCBS case managers and housing facilitators to appropriately access various environmental modification resources.

- Conduct a QSP Rate Innovations and Gap Analysis. This strategy would aim to identify innovative ways to adjust QSP rates so that services with potential high impact on access to HCBS for older adults and people with disabilities are better incentivized. Examples include a shift differential for QSPs who provide care at night, on weekends, and on holidays; respite care; system of "backup" or

emergency care providers-of-last-resort to address high need cases or staff emergency situations; and rates adjusted for intensity.

- Provide behavior intervention consultation and supports to direct service providers. The State is aware that oftentimes it is difficult to find HCBS providers who can, and will, serve clients with behavioral health needs. Strategies to increase these services could include establishing resources for QSPs and other HCBS providers to access, that would create behavior intervention plans, helping staff high need/high complexity cases, and offering consultation to in-home providers as needed.
- Enhancing the HCBS delivery system requires the support of effective infrastructure. This includes technological and human resources; quality, outcomes, and other measures of success; and a relentless focus on usability of systems. Infrastructure investments should keep the person at the center of design in every system component. Support the development of a Care Connect platform that facilitates connections between QSPs, consumers, and families.
- Invest in ADRL platform to incorporate affordable housing database, and other modifications to support user experience. Enhance availability of resources to support informed choice and HCBS case management. Equip Developmental Disability and HCBS case managers with resources to facilitate efficient work from HCBS settings.
- Establish a framework for routine, repeatable, timely access to information identified as core indicators/measures to improve quality, outcomes, and positive impact for TPMs. Define quality in each realm of the system, incorporating National Core Indicators and National Core Measures with State defined priorities.

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

Responsible Division(s)

DHS Aging Services Division

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

Implementation Strategy

Strategy 1. State staff will conduct group in-reach presentations at every SNF in North Dakota. Ensure a consistent message is being used throughout the State. **(Complete September 14, 2021)**

Challenges to Implementation

The health and visitor restrictions put into place because of the COVID-19 pandemic have limited face to face access to SNFs.

Remediation

In-reach visits must be conducted in person unless there is a valid documented reason why a face-face visit is not possible. When necessary, for example when COVID-19 visitation restrictions are in place, in-reach visits may be completed virtually. Staff can request to use State owned telecommunication equipment purchased for facilities with COVID-19 relief funds to facilitate virtual communication. The State will ensure that all State employees will follow required safety procedures including the appropriate use of State provided PPE when entering facilities. The forms used to document the details of the informed choice visits require the case manager to indicate if the visit was held virtually or in-person. State staff review all the completed informed choice forms and will address any issues if TPM meetings are being conducted virtually without a valid reason.

Performance Measure(s)

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

Number of individual in-reach/informed choice visits conducted with TPMs residing in SNFs per year.

Strategy 2. Identify TPMs when they are screened at a NF LoC and ensure that they have an opportunity to make an informed decision about where to receive services. The

newly created informed choice referral process provides for virtual or face-to-face person-centered planning and information about the benefits of integrated settings, which may include facilitated visits or other experiences in such settings and offers opportunities to meet with other individuals with disabilities who are living, working, and receiving services in integrated settings, with their families, and with community providers. It requires making reasonable efforts to identify and address any concerns or objections raised by the TPM or another relevant decision maker. **(Implemented January 1, 2021)**

Challenges to Implementation

Staff capacity to conduct informed choice visits and HCBS case management.

Remediation

The State has requested and received approval to use MFP capacity building funds to hire staff to conduct informed choice referral visits to free up case management capacity to serve additional HCBS recipients. Staff will be hired in areas of the State with the highest referrals and/or in rural areas where the most travel is required. **(Target Completion Date October 1, 2021)**

Performance Measure(s)

Conduct 250 individual in-reach/informed choice visits with TPM residing in SNFs per year.

Number of informed choice visits completed every six (6) months.

Strategy 3. Procure an entity that can serve as a Peer Resource Center in ND. The Peer Resource Center will serve as a centralized place for referral. It will establish a process and requirements for peer support training and reimbursement. It will facilitate appropriate and timely connections between peer support specialists, individuals, and families who would benefit from this type of service.

Resource Center staff will develop specific expertise that gives TPMs across the lifespan who are interested in transitioning to the most integrated setting appropriate, and those who want to remain in their current home environment but also need available services and supports to do so. It will create the opportunity to connect with a peer who has lived experience navigating and utilizing HCBS. **(Target completion date March 1, 2022)**

Challenges to Implementation

MFP capacity building funds will cover costs related to staffing, training, and travel for a two-year period.

Remediation

The State will include a request for appropriation to continue peer supports in the DHS budget request in the Executive budget for the 23-25 biennium.

Challenges to Implementation

The State needs to accommodate requests for peer support prior to the Peer Support Resource Center being established.

Remediation

The CILs have agreed to take referrals for peer support and match TPMs with individuals living and receiving services in the community who can share their lived experience.

Performance Measure(s)

Number of referrals for peer support and outcome.

Number of individuals receiving information or support from new center.

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 will update the informed choice referral process to include similar questions. If accommodations are needed the State, hospital, or SNF will provide the necessary accommodation as required. Individual accommodations may include auxiliary aides such as interpreters, large print and Braille materials, sign language for the hearing impaired, and other effective methods to deliver appropriate information to TPMs. The State will update the ADRL and DHS website to include information on how to request accommodations. **(Target completion date October 1, 2021)**

Performance Measure(s)

Number of TPMs who requested and received communication accommodation.

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

Implementation Strategy

Strategy 1. The DHS communications team will develop a communication plan to ensure frequent outreach and training is available to at risk TPMs and their families about HCBS and the SA requirements. The communication plan will include ways to use the marketing tools developed to promote the ADRL and increase awareness of HCBS. The plan will be revised based on stakeholder input provided during the USDOJ SA stakeholder meetings. **(Target completion date November 1, 2021)**

Strategy 2. Create a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. Campaign will include marketing on social media and providing public education to the public, professionals, stakeholders, and TPMs at serious risk of entering nursing facilities. Campaign will also include providing education to those parties that recommend SNF care to TPMs. This includes health care professionals/staff who are most likely to be in regular contact with TPMs and potential TPMs prior to requests or applications for NF admissions, such as geriatricians, primary care physicians serving a significant number of elders, and rehabilitation facility staff. **(Target Completion date December 14, 2022)**

Performance Measure(s)

Number of ADRL contacts.

Strategy 3. Work with staff from Medical Services and the ND Department of Health to identify common precursor events to subsequent requests for SNF placement (such as hospital admissions for elders for a broken hip, admission to SNF for short-term rehabilitation, etc.).

Use available data to identify individuals utilizing such services and provide those individuals information about long-term community-based services.

Respite Services ([Section XIV, Subsection E, page 22](#))

Implementation Strategy

Strategy 1. The State will educate providers and stakeholders during the respite services webinar and stakeholder meetings that HCBS policy currently allows the RD rate to apply to the 24-hour cap on overnight respite. **(Policy updated July 1, 2021)**

Performance Measure(s)

Number of TPMs utilizing respite care with the RD rate.

Number of hours of respite services provided.

Strategy 2. The State will enhance, expand, improve, and provide supplemental respite services and education to family caregivers in North Dakota with resources provided through a Lifespan Respite Care Program: State Program Enhancement Grant. The State will use the grant to continue to provide and develop new virtual and group training opportunities led by individuals who provide natural support to TPMs. **(Grant submitted May 18, 2021)**

Performance Measure(s)

Number of trainings on this topic conducted by natural support providers.

Strategy 3. The State will continue to provide education and respite services to individuals providing natural supports. The following in person/virtual training for informal supports is currently available. **(Complete December 14, 2020)**

- Dementia Care Services and Older Americans Act Family Caregiver Support Program training for caregivers of TPMs with dementia.
- Powerful Tools for Caregivers evidence-based training.
- Powerful Tools for Native American Caregiver training.
- Tai Ji Quan: Moving for Better Balance
- Stepping On: Falls prevention program.

The State will use additional funding provided by the American Rescue Plan to expand evidence-based training programs for TPMs and their natural supports. The State contracts with North Dakota State University Extension and will provide funds to expand the service array to include programs that promote self-advocacy services to increase mobility, functionality, and capacity to age in the community for older adults and adults with physical disabilities. **(Target completion date November 1, 2021)**

Performance Measure(s)

Number of individuals who attended training by service.

Strategy 4. The State will conduct training for HCBS case managers and stakeholders to increase awareness of the North Dakota Community Clinic Collaborative (NDC3) available at NDC3.org. NDC3.org is a one-stop, virtual infrastructure for NDC3 partner organizations, supporting the development, delivery, management, and monitoring of evidence-based programs that promote self-management of chronic health conditions and foster well-being. Professionals can use the system to find evidence-based programs in their community and assist TPMs to enroll. Fact sheets will be created for HCBS case managers to provide to TPMs and their natural supports to inform them of

the availability and benefits of these programs. **(Target completion date December 1, 2021)**

Performance Measure(s)

Number of individuals who attended training by service.

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

Implementation Strategy

Strategy 1. The State will work with the DHS Civil Rights Officer and the ND Department of Information Technology to review all printed documents and all online information available on the USDOJ Settlement page of the DHS website to ensure compliance with this SA. **(Target completion date December 1, 2021)**

Performance Measure(s)

Number of documents converted.

Strategy 2. The DHS will build capacity by training the staff member hired to assist with the implementation and reporting requirements of the SA to review and update documents to ensure compliance with ADA. **(Target completion date January 1, 2021)**

Challenges to Implementation

Limited number of staff trained to review all documents in a timely manner.

Remediation

The DHS will work to build additional internal capacity and reach out to other State agencies and external subject matter experts to collaborate in building a comprehensive team trained to address ADA compliance in documentation and online publications.

SA Section XV. Data Collection and Reporting

Responsible Division(s)

DHS Aging Services Division

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.

Strategy 1. Contract with a new vendor to implement a case management system. This new system will allow the State to collect and report the aggregate data as required. **(Target completion date December 1, 2021)**

Challenges to Implementation

The State currently collects complaint information in a system that is different than the new case management system.

Remediation

The new case management system will be customized to include aggregate complaint data.

Performance Measure(s)

Number of complaints received through the General Complaint Process.

Strategy 2. Determine staff capacity and number of FTEs needed to provide a sufficient number of HCBS case managers to serve TPMs. HCBS case managers are required to keep track of the amount of hours they work as well as the type of work being performed. Reports can be run to calculate the amount of time spent conducting case management versus administrative tasks. **(Six-month reporting begins June 14, 2021) (Target completion date December 14, 2021, and ongoing)**

Performance Measure(s)

Percent of staff time expended on administrative tasks after the new case management system is fully implemented.

Percent of staff time expended on direct service case management tasks after

the new case management system is fully implemented.

SA Section XVI. Quality Assurance and Risk Management

Responsible Division(s)

DHS Aging Services and Medical Services Divisions

Implementation Strategy

The SME has drafted a Safety Assurance Plan with input and agreement from the State. The plan outlines a range of recommendations that are intended to inform and support the State's actions related to ensuring the safety of and the quality of services for TPMs, both during the timeframe of this version of the IP, as well as throughout the duration of the SA. (See [Appendix J](#)- Safety Assurance Plan)

The State is currently implementing or has incorporated the following recommendations included in the Safety Assurance Plan into the IP. The State will consider implementing other recommendations included in the plan in future IP updates.

- The State has established a consistent incident reporting and response process to be used for all critical incidents. The system captures all data recommended in the plan. The process has been documented in the policy and procedure manual. This includes how and when the critical incident report will be reported to the USDOJ and the SME.
- The State will implement a workflow process map to identify all steps in the reporting and remediation of critical incidents. The map will be used in future training to ensure understanding of the process and requirements.
- The State has held and will continue to provide critical incident report training to all providers. Training materials and video recordings are available online.
- The State will utilize a workgroup to develop a QI policy and procedures that can be adapted by Agency providers who employ non-family as required in the SA. The State will require the QI plans to include an individual safety plan created as part of the PCP and must be submitted to the State for approval.
- The updated HCBS functional assessment includes a safety assessment of the home to ensure adequate equipment or environmental modification services are offered to ensure the home is accessible and functional for the TPM. It also assesses the need for supervision.
- The State holds a quarterly critical incident report meeting where all reports are reviewed. The State will develop a process to include a mortality review of all deaths, except for death by natural causes, to determine whether the quality, scope, or amount of services provided to the TPM were implicated in the death. Information gleaned will be used to identify and improve gaps in the service

array.

- The State has a process for the public to file complaints and has updated the DHS website to include information on how to report. This information is shared at stakeholder meetings and other public events involving TPMs.

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

Implementation Strategy

Strategy 1. The State will create critical incident reporting training opportunities for QSPs. Training will be provided through online modules and virtual training events. The training will focus on the State's data system and the State's processes for reporting, investigating, and remediating incidents involving the TPM.

The State will update the QSP handbook to include current reporting requirements. The State will also work with staff from the DSW/FC Resource and Training Center to develop ongoing training that will assist QSPs in understanding and complying with safety and incident reporting procedures. **(First critical incident reporting training complete August 1, 2021)**

Performance Measure(s)

Number of QSPs trained on reporting procedures.

Number of training modules created.

Number of virtual training events conducted.

Number of critical incident reports that were reported on time.

Strategy 2. Agency QSP enrollment standards will be updated to require licensed agencies or entities employing non-family community providers to have a QI program that identifies, addresses, and mitigates harm to TPMs they serve. This would include the development of an individualized safety plan for each TPM. 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. **(QI program required January 1, 2022)**

Challenges to Implementation

Changes in provider enrollment requirements require an amendment to ND Administrative code 75-03-23.

Remediation

The State will submit request to amend ND administrative code for legislative approval.

Performance Measure(s)

Number of Agency QSPs and entities with QI program in place.

Strategy 3. Implement the National Core Indicators – Aging and Disabilities (NCI-AD). The State will collaborate with ADVancing States and the Human Services Research Institute (HSRI) to support implementation. NCI-AD is a process that measures and tracks the State's performance and outcomes of HCBS provided to TPMs. Quality performance reports will be made available on the DHS website and shared at USDOJ stakeholder meetings. **(Target completion date July 1, 2022)**

Challenges to Implementation

Funds to continue to implement NCI-AD beyond 2024.

Remediation

The State will include an appropriation request to continue to implement the NCI-AD process in the DHS budget request to the Governor's office for the 23-25 biennium.

Strategy 4. The State will convene a QI workgroup. The State will invite State staff, including the Medical Services QI coordinator, QSP agencies, TPMs, family members, guardians, and other interested stakeholders to be part of the group. The group's primary purpose will be to participate in the development of resources and tools to help agencies create a QI program that identifies, addresses, and mitigates harm to TPMs they serve. This will include the development of a process for the State to determine whether providers identify and report critical incidents as required. Resources will be made available to all QSPs. **(Workgroup established October 1, 2021, Recommendations complete December 1, 2021)**

Strategy 5. The State developed a process to submit critical incident reports to the USDOJ and SME within seven (7) days of the incident as required in the SA. **(Reporting begins June 12, 2021)**

Performance Measure(s)

Percent of critical incident reports submitted within seven (7) days of incident as required.

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

Implementation Strategy

Policy will be updated to require a remediation plan to be developed and implemented for each incident, except for death by natural causes. The State will be responsible to monitor and follow up as necessary to assure the remediation plan was implemented. **(Policy updated July 1, 2021)**

Challenges to Implementation

QSPs do not always follow critical incident reporting requirements or fail to report critical incidents in a timely manner.

Remediation

The DHS Aging Services Division will create critical incident reporting required trainings for QSPs. Training will be provided through online modules and virtual training events. The State will update QSP handbook to include current reporting requirements. **(First training complete August 1, 2021)**

Performance Measure(s)

Percent of required remediation plans completed.

Number of training events conducted.

Number of online modules created.

Number of critical incident reports that were reported on time.

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

Implementation Strategy

The State will use the new 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 likelihood of future incidents.

To assure the necessary safeguards are in place to protect the health, safety, 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.

Strategy 1. The new case management system will be used to receive and review all critical incidents. Critical incident reports must be submitted and reviewed within one (1) business day. **(Target completion date August 1, 2021)**

Challenges to Implementation

QSPs are not required to use the new case management system. If a QSP does not have access to the system, they need another way to submit a critical incident report.

Remediation

Therap developed a form that is currently available to all QSPs to submit a critical incident report. All reports are routed to Nurse Administrators for review and follow up within one (1) business day. Once the report is finalized, all critical incident report information (regardless of how it is submitted) is available in the new case management system to ensure accurate data reporting.

Challenges to Implementation

Critical incident report information is not currently available to all State employees authorized to investigate and/or remediate such incidents.

Remediation

The critical incident report information in the new case management system will be made available to all ADRL, Informed Choice, MFP, Options Counseling, and Vulnerable Adult Protective Services staff. **(Target completion date July 1, 2021)**

Performance Measure(s)

Percent of critical incidents reviewed within one (1) business day of receipt.

Strategy 2. The DHS Aging Services Division 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 DHS Aging Services Division Director, HCBS program administrator(s), HCBS nurse administrators, Vulnerable Adult Protective Services (VAPS) staff, LTC Ombudsmen, and the DHS risk manager. **(Complete December 14, 2020)**

Performance Measure(s)

Percent of critical incident reports reviewed by State staff.

Strategy 3. Identify workflow processes for the investigation and remediation of

reported or otherwise suspected incidents referenced in this section of the SA. The processes will be documented in policy and/or provider contracts and manuals. Processes to include:

- Completion of any missing data elements from the initial report to be completed by the lead investigator for the State,
- Timelines and guidelines for the investigation of incidents,
- Development of a remediation plan for each confirmed incident, except for death by natural causes, (the remediation plan to include who is responsible for implementing as well as monitoring and a timeline for both), and
- A method for tracking when an incident has an associated complaint.
(Timeline for completion February 1, 2022)

Strategy 4. The State will develop a process to include a mortality review of all deaths, except for death by natural causes, of TPMs to determine whether the quality, scope, or amount of services provided to the TPM were implicated in the death. The review will be conducted by the quarterly critical incident report committee. Information gleaned from the review will be used to identify and address gaps in the service array and inform future strategies for remediation. **(Timeline for completion January 1, 2022)**

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. **(Reporting begins June 1, 2021)**

Performance Measure(s)

Number of amendments reported.

Complaint Process ([Section XVI, Subsection F, page 25](#))

Implementation Strategy

Strategy 1. Implement a process to receive and timely address complaints by TPMs

about the provision of community-based services. 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 fourteen (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. **(Reporting begins June 14, 2021)**

Performance Measure(s)

Number of TPM complaints.

Number of TPM complaints that were responded to within required timeframe.

Strategy 2. The State will publicize its oversight of the provision of community-based services for TPMs and provide mechanisms for TPMs to file complaints by disseminating information through various means including adding information to the DHS website, HCBS application form, “HCBS Rights and Responsibilities” brochure, presentation materials, and public notices. **(Target completion date November 1, 2021)**

Strategy 3. The Agreement Coordinator will submit a Complaint Report that includes a summary of all complaints received as part of the biannual data reporting requirements. **(Reporting begins June 14, 2021)**

Appendix A: Barriers to HCBS that will be addressed during the initial IP timeframe

Based on stakeholder input and a review of relevant services from the USDOJ listening sessions the following potential barriers to current State and Federal (HCBS) will be addressed during the initial implementation planning period.

Proposed Implementation date: July 1, 2021

- Chore services do not allow lawn care which can create housing problems for TPM. HCBS policy will be updated to include lawn care under chore services.
- The definition of an individual who is obligated to provide care is unclear and needs to be further defined as a legal spouse. HCBS policy will be updated.
- The 24-hour cap on overnight respite services does not allow for the rural differential (RD) rate. HCBS policy will be updated to allow the RD rate to apply to the 24-hour cap on overnight respite.
- The unit cap for homemaker services provided by an agency is too low and will be increased. HCBS policy will be updated.

Proposed Implementation date: January 1, 2022.

- Rates for supervision, non-medical transportation, non-medical transportation escort, and family personal care are too low. To build provider capacity a rate increase was approved in the 21-23 DHS budget. A waiver amendment will be submitted.
- Definition of family for family personal care is too restrictive and will be expanded to build family provider capacity. A waiver amendment will be submitted, and administrative code will be updated.
- Live alone eligibility requirements for residential habilitation and community-support services are too restrictive and will be removed to allow more TPMs to access services. A waiver amendment will be submitted, and administrative code will be updated accordingly.
- TPMs who live with family are not eligible to receive supervision; this requirement will be removed. A waiver amendment will be submitted, and administrative code will be updated accordingly.
- The rule that Environmental Modification can only be provided when a TPM owns the home is too restrictive and will be expanded to allow modifications of rental

property. A waiver will be submitted, and administrative code will be updated accordingly.

- The RD rate cannot be authorized for transition support services, supervision, and companionship which restricts access for TPMs residing in rural areas. A waiver amendment requiring CMS approval will be submitted to allow the RD rate for these services.

Appendix B: Partnering Equitably with Communities to Promote Person-Centered Thinking, Planning and Practice

Partnering Equitably with Communities to Promote Person-Centered Thinking, Planning and Practice”, ND Department of Human Services and NCAPPS, August 2020.

[Partnering Equitably with Communities \(nd.gov\)](#)

Appendix C: Informed Choice Referrals in ND Admin Code

[Informed Choice Referrals ND Admin Code 75-02-02.4](#)

Appendix D: Informed Choice Educational Materials

[Informed Choice Educational Materials](#)

Appendix E: Diversion Plan



Human Services

MAS Solutions, LLC
Subject Matter Expert

North Dakota Diversion Plan

On December 14, 2020, the State of North Dakota entered into a Settlement Agreement with the United States Department of Justice. The agreement is designed to serve adults with physical disabilities that are capable of living in integrated community settings with sufficient services and supports, to receive the necessary care in that setting. Those individuals, considered members of the target population for purposes of the settlement agreement, are “individuals with a physical disability over the age of 21 who are eligible or likely to become eligible to receive Medicaid long-term services and supports and are likely to require such services for 90 days.” As a result of the Settlement Agreement, North Dakota has created an implementation plan to address the areas that are currently barriers to allowing Target Population Members (TPMs) to remain in or return to the community.

The Diversion Plan describes the activities needed to facilitate and incentivize the provision of appropriate long term supports and services in home and community-based settings for at risk TPMs as an alternative to admission to a nursing facility. Pursuant to the provisions of Section X and XI of the Settlement Agreement, the Diversion Plan provides for the identification of those seeking or those who have been referred for admission to a nursing facility, State intervention prior to such admission. This includes the provision of person-centered planning with the individuals involved and the offering and provision of appropriate services capable of meeting the individuals’ needs for long term services and supports in the most integrated setting for all TPMs whose Person - Centered Plan (PCP) indicates that diversion is appropriate and unopposed.

The components of the Diversion Plan align with the strategies and activities provided for in multiple sections of the Settlement Agreement and Implementation Plan including, in particular, outreach, Home and Community-Based Services (HCBS) capacity-building, case management, and person-centered planning. Successful implementation of these strategies will reinforce the success of the Diversion Plan.

The SME is aware that North Dakota may have already acted and developed strategies related to some or all of these recommendations, but also thought it important to include in this plan for cross reference. Actions that have already been initiated may be included in the Implementation Plan.

Goal #1: Identify at risk TPMs including those who are considering or seeking admission to nursing facilities, who are hospitalized and at risk of being discharged to nursing facilities, and provide education about HCBS to potential

TPMs and others who may recommend nursing facility care.

Action: Target outreach to maximize identification of at risk TPMs and optimize opportunities to provide information on HCBS options”

Strategies

1. The SME urges the State to identify and outreach to those TPMs who are at serious risk of entering nursing facilities.
 - a. Provide outreach about HCBS to the public, senior citizen centers, and stakeholders.
 - b. Review existing data and other information from partners that could identify TPMs and provide them with information on HCBS.
 - i. Update and use the Aging and Disability Resource Link (ADRL) database to identify TPMs.
 - ii. Use Medicaid claims data to identify TPMs admitted to hospitals, short-term rehabilitation facilities, or using similar services that may reflect a higher likelihood of being a TPM, and provide such TPMs with information about HCBS.
2. The SME suggests that the State conduct outreach to offer education to those parties that may recommend nursing facility care to a potential TPM.
 - a. Provide outreach and information about HCBS that could meet the needs of TPMs requiring long term services and supports as an alternative to nursing facilities and to those who typically make Nursing Facility Level of Care (NF LoC) assessments and nursing home placements, with a particular focus on:
 - i. hospital discharge planners,
 - ii. rehabilitation facilities,
 - iii. tribal agencies, and
 - iv. primary care physicians serving Medicaid patients.
 - b. Develop and enter into written agreements or memoranda of understanding that establishes a protocol for hospitals and other facilities to contact the Aging Services Division as part of the facility’s discharge planning process or to refer the TPM to the Aging Services Division or both.

Goal #2: Divert TPMs from unnecessary admission to nursing facilities by offering appropriate Home and Community-Based Services, thereby mitigating and preventing unnecessary segregation.

Action: Develop and implement a plan to quickly identify and reach TPMs who have been hospitalized or referred for nursing facility services.

Strategies

1. The SME recommends that the State investigate options for prompt determination of Medicaid eligibility for HCBS, such as presumptive eligibility for the Medicaid-expansion adult population under the age of 65, in order to

minimize delays involved in the authorization of HCBS.

2. The SME urges the State to change current policies and procedures affecting admission to nursing facilities to require State intervention and consideration of HCBS for TPMs prior to admission.
 - a. Assure that the State contractor for Medicaid eligibility determinations promptly notifies the Aging Services Division when it receives a NF LoC referral for review and assessment and whenever it determines that NF LoC criteria have been met for a TPM.
 - i. Assure that upon receipt of such determination that the State assigns a case manager who promptly engages the TPM in the processes of informed choice. Discussions between the parties and the SME are ongoing relative to the provision of case management services.
 - ii. Assure that the assigned case manager's name, the date of the assignment, and the subsequent steps in the person-centered planning process are entered into the State data system.
 - iii. Consider using (if this does not already occur) short-term NF LoC certifications for TPMs so that if a nursing facility placement occurs when the person-centered planning process is underway, the offer of HCBS can still be made to the TPM and the PCP can include a transition plan.
 - b. The SME recommends that the State revise its informed choice process and documentation as follows:
 - i. Consider a revised process for TPMs that do not express an initial interest in HCBS.
 - ii. Revise the question about whether or not the TPM would like to "explore" home and community alternatives so that it provides more opportunity to converse.
 - c. The SME recommends that the State process and confirm that the TPM is eligible to receive Medicaid-funded nursing facility care and that such facility is authorized to bill Medicaid for that TPM before an assignment is made, if that is the most integrated setting selected by the TPM.
 - i. The SME feels that it is important (if it has not already done so) that State policies and procedures applicable to nursing facility admission require the nursing facility to document that a newly admitted TPM was referred to the Aging Services Division for assignment of a case manager prior to admission and that informed choice was discussed and a decision made based on that discussion.
3. The SME recommends that the State consider assigning a case manager to each identified at risk TPM as provided for in the Settlement Agreement. Discussions between the parties and the SME are ongoing relative to the provision of case management services
 - a. When it is determined or confirmed through the ADRL intake process that an individual is an at risk TPM with an interest in HCBS, this information should be immediately transmitted to an HCBS supervisor who should assign a case manager. The case manager should then contact the TPM to conduct an

- assessment and begin the person-centered planning process.
- b. The State should review this process and develop necessary revisions so that as the term of the eight-year Settlement Agreement progresses, case managers are able to be timely assigned (or a viable alternative is approved) to all identified TPMs. This could include a particular focus on those TPMs that do not express an initial interest in HCBS.
4. The SME recommends that the State further develop strategies that ensure progress toward meeting the provisions of Section VIII (Person Centered Planning) of the Settlement Agreement and ensuring that a Person Centered Plan is developed for at risk TPMs. Discussions between the parties and the SME are ongoing relative to the provision of person centered plans.
 - a. Complete the functional assessment and person centered planning process prior to or as soon as possible after a decision by the TPM as to where they would like to live.
 - b. Provide information about the benefit of integrated settings.
 - c. Offer TPMs opportunities to meet with other individuals living, working, and receiving services in integrated settings, preferably in the same geographic area, before making a decision as to where the TPM would like to receive services.
 - d. Offer an appropriate and individualized set of HCBS to be provided in the most integrated setting available.
 - e. Triage the services and supports necessary to meet the immediate needs of the TPM.
 - f. Presume that TPMs who go through the person centered planning process accept the community-based services designed to meet their needs unless they object and opt out of HCBS.
 - g. Provide TPMs with the option to self-direct their services.
 - h. Take into account the TPMs ethnic, cultural, and spiritual interests and practices.
 - i. To the greatest extent possible, TPMs will not be unduly influenced or subjected to bias of any sort during the person centered planning process.
 5. The SME recommends that the State develop a data system that tracks HCBS services and setting offered and whether they were accepted or refused and the reasons why to assist in identifying gaps or limitations in HCBS that could be addressed.
 6. The SME recommends that the State consider including as part of the person centered planning process discussions about and planning for what the TPM would like to have happen if they are hospitalized, including who will notify the case manager in the event of a hospitalization.
 7. The SME suggests that the State work with national person centered planning contractors to design an accelerated process person centered planning process and plan for those TPMs in hospitals that includes informed choice.
 8. The SME suggests that the State modify the person centered planning process

curriculum to reflect the interests and situations of seniors and persons with physical disabilities.

9. The SME recommends that the State consider waiving training components for a family member who is identified as capable of providing services to the TPM to avoid a nursing home placement for three (3) months. The family member will be expected to complete training within 90 days.

Appendix F: Housing Access Plan



Human Services

MAS Solutions, LLC
Subject Matter Expert

Housing Access Plan

On December 14, 2020, the state of North Dakota entered into a settlement agreement with the United States Department of Justice (USDOJ). The agreement is designed to serve adults with physical disabilities that are capable of living in integrated community settings with sufficient services and supports and to receive the necessary care in that setting. As part of this agreement, the state committed to providing, at minimum, the following number of Permanent Supported Housing (PSH) options for class members whose Person Centered Plans identify a need for PSH:

- 20 members within one year,
- Additional 30 members within two years,
- Additional 60 members within three years, and
- Additional Permanent Supported Housing based on aggregate need.

Across the country, the lack of affordable and accessible housing options is one factor leading to institutionalization, homelessness, and housing instability. This challenge is often exacerbated in rural areas where there is less housing inventory and, what housing inventory is available, may be older (and therefore less likely to be accessible), of poor quality, and not meet federal, state, and/or local housing standards.

Individuals living with disabilities residing in institutions considering transition come to this difficult housing landscape with their own set of challenges including discrimination in the rental market, incomes often at or below 20 percent of Area Median Income (AMI), those whose sole source of income is Supplemental Security Income (SSI), and difficulties navigating the housing search process while residing in an institutional setting.

Individuals living with disabilities in North Dakota institutions face a myriad of challenges. The recommendations below seek to provide strategies to address these challenges by providing housing supports to Target Population Members (TPMs), enhancing access to existing affordable and accessible rental inventory, creation of new affordable accessible rental inventory, and increasing access to other housing options and opportunities through implementation of a housing locator system.

The SME is aware that North Dakota may have already taken action and developed plans related to some or all of these recommendations, but felt they should be included in this plan for cross reference. Actions that have already begun may be included in the

Implementation Plan in Section XII.

Goal #1: The Subject Matter Expert (SME) compels the state to ensure that Target Population Members (TPMs) receive housing supports identified in Person Centered Plans (PCPs) that are designed to support a transition to and success living in the community.

Action: It is of critical importance that the state identify the types of housing support services that will be available to the TPM and develop strategies to deliver those services to the TPM.

Strategies

It is recommended that the state:

1. Convene a workgroup to identify the types of housing supports that should be available to TPMs. For reference, it is of strategic importance for the state to review the Informational Bulletin published by CMS in June 2015 on [Coverage of Housing-Related Activities and Services for Individuals with Disabilities](#) that describe a range of housing transition and tenancy sustaining services.
2. Conduct a crosswalk of housing transition and tenancy sustaining services that are already covered in existing Medicaid authorities or other state funded programs.
3. Identify mechanisms to pay for housing support services, such as through changes to Medicaid waivers, Money Follows the Person grants, or state funds.
4. Identify the types of positions that will have a responsibility in providing housing supports (e.g. case managers, housing facilitators, and others identified by the state), and specify the types of housing support services that these positions will offer.
5. Establish a mechanism to assess housing support needs in the person centered planning process.

Goal #2: The SME urges the state to increase access to existing affordable and affordable accessible rental units through policy change and relationship development.

Action 1: It is of critical importance that the state update the current housing inventory to ensure a complete inventory of affordable rental housing opportunities across the state.

Strategies

1. The inventory should identify properties by funding source and location.
2. Where available, the inventory should identify properties by accessibility, target population, unit size, property management company and contact number for property management company.
3. It is important that this inventory is kept current through a database available

through those seeking to locate rental housing.

Action 2: The SME recommends that the state identify opportunities for waiting list preferences and/or dedication of turnover units for TPMs in existing affordable rental housing.

Strategies

It is recommended that the state:

1. Develop a waiting list preference marketing “pitch” for property management companies about the Settlement Agreement, the need for affordable rental housing for TPMs, and how dedicating a small amount of turnover can have a significant impact.
2. Using an updated inventory, identify five (5)-10 property management companies that manage the largest number of affordable rental properties. It is recommended that the state select one of these large property management companies known to be “friendly” to the target or similar population and test the “pitch” with this agency.
3. Work with the United States Department of Housing and Urban Development (HUD), using United States Department of Justice (USDOJ) support as needed, to develop a standardized process for securing waiting list preference for TPMs at these properties.
4. Based on the meeting with the first property management company, refine marketing efforts and continue to meet with the targeted property management companies to secure preference for turnover units.
5. Meet with the North Dakota Apartment Association and share the opportunities to meet preferences/dedicated turnover in affordable and market rate units.

Action 3: The SME recommends that the state identify properties with high turnover and higher than average vacancy rates as potential housing options for TPMs.

Strategies

It is recommended that the state:

1. Conduct a review of occupancy data for properties funded through the Low Income Housing Tax Credit (LIHTC) program.
2. Conduct a review of occupancy data for HUD Assisted Housing properties or request USDOJ assistance securing such data from HUD.
3. Request USDOJ assistance securing current occupancy data from the United States Department of Agriculture (USDA) Rural Housing Service.
4. Meet with property management companies at properties with higher than average vacancy rates to secure waiting list preferences or come to other referral agreements.

Action 4: It is important for the state to secure set-aside units in existing (4% and 9%) Low Income Housing Tax Credit (LIHTC) units through incentives in upcoming Qualified Allocation Plans (QAPs).

Strategies

It is recommended that the state:

1. Review the language in the Texas Department of Housing and Community Affairs (TDHCA) Qualified Allocation Plan that secures units in existing housing through incentives in the current QAP. (The QAP is a document that states must develop in order to distribute federal (LIHTCs), which can be awarded only to a building that fits the QAP's priorities and criteria.)
2. Consider modifying the QAP, similar to the TDHCA plan, in order to secure units more quickly. The state housing and services agencies should work together to determine how to target QAP incentives, e.g. target incentives to secure one-bedroom fully accessible units.

Action 5: Maximize use of affordable accessible rental units.

Strategies

It is recommended that the state:

1. Conduct a survey – using a relatively simple tool for design such as Survey Monkey – to determine the number of affordable, accessible units that are leased to households that do not require the design features.
2. Work with property managers and service providers through interviews, meetings, or focus groups to understand barriers to leasing accessible units (both affordable and market rate) to persons needing the design features.
3. Develop and implement a series of recommendations based on the focus groups with managers to maximize use of accessible units including use of lease addendum, tenant and/or project-based vouchers for market rate units, and other strategies.

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

Action 1: Produce new integrated Permanent Supported Housing units utilizing federal and state capital resources.

Strategies

It is recommended that the state:

1. Review the current incentive structure within the state's QAP to determine areas for refinement to further promote development of set-aside units that meet the

needs of TPMs.

2. Consider modifying the QAP to ensure incentives are structured in a way that produce units that are integrated, accessible, affordable, and provide access to necessary services. The current state QAP contains a number of incentives, however, these are not structured to result in the combined features needed by the TPM. For example, the QAP includes incentive points for universal design, but not necessarily for those units to target to those whose incomes are at 30% of Area Median Income.
3. Consider reviewing priorities set in other capital funding administered by the state (Housing Incentive Fund, Housing Trust Fund, etc.) to best leverage these resources in combination with LIHTC incentives to create affordable, accessible PSH.
4. Consider whether additional state-funded operating resources are necessary to finance the development of PSH units at rent levels affordable to TPMs.
5. Outline specific criteria for the marketing of accessible units in properties developed with state financing including notification of available accessible units to appropriate referral networks and preferences established for households who need accessible features.

Action 2: The SME urges the state to maximize opportunities for use of federally-funded tenant-based vouchers.

Strategies

It is recommended that the state:

1. Review the [Housing Choice Voucher Data Dashboard](#) and identify Public Housing Agencies (PHAs) with low utilization rates. Particular attention should be paid to the utilization rates of Mainstream Vouchers and Non-Elderly Disabled Vouchers (NED).
2. Where vouchers are not being fully utilized, conduct outreach to PHAs to promote a waiting list preference for TPMs.
3. In addition to a waiting list preference, explore whether PHAs have the ability and capacity to project-base some of their voucher portfolio. Increasing the availability of project-based vouchers will provide additional resources for developers to finance PSH units incentivized in the QAP.
4. Work with the local National Association of Housing and Redevelopment Officials (NAHRO) chapter to set-up a committee focused on producing recommendations to increase landlord engagement and participation in the Housing Choice Voucher Program. The committee should consider possible resources to fund landlord incentives and/or mitigation funds as well as strategies for retention (e.g. landlord forums, appreciation events).

Action 3: The SME compels the state to identify state funding to be used for tenant-based vouchers for TPMs to meet Settlement Agreement requirements in Section XII.B.1 (a-d) when an alternate source of rental assistance is not available

to a TPM.

Strategies

The state is urged to:

1. Identify state resources that can be used to support state funded rental assistance for TPMs.
2. Establish a policy that includes the purpose and intended use of vouchers (e.g. for TPMs, bridge to federal source), how the vouchers will be administered, eligibility criteria, TPM cost-sharing requirements (e.g. up to 30% of income), and types of housing that the voucher may be used for (e.g. lease-based permanent supported housing). The state's policy should articulate the timeframe when a TPM will be referred for a state funded voucher, the referral process that will be used, and the housing inspection process.
3. Collect data on the use of state funded vouchers. Data should include, at a minimum, tenant demographic data, tenure in housing, length of time on state voucher, and reasons for termination or eviction.
4. Consult with the Subject Matter Expert on development of the policy for state funded rental assistance vouchers.

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

Action: Implement an updated housing locator system.

Strategies

It is of critical importance that the state:

1. Continue review of housing locator technology options and select a model to use going forward. It is recommended that the state not develop its own model unless it can demonstrate that it can develop the technology successfully and in a timely manner and that "off the shelf" products cannot meet the state's needs.
2. Select or develop a housing locator that can implemented as rapidly as possible to support the Settlement Agreement's housing benchmarks and that can provide up-to-date housing availability.
3. Secure funding for housing locator technology purchase or development and designate or hire staff to implement and/or work with contracted locator system staff.
4. Provide training in and access to the housing locator technology for all housing and/or transition specialists and case managers working to transition TPMs.

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

Action: The SME recommends that the state develop a housing needs and

preferences tool that can be used to identify the housing needs and preferences as identified by TPMs and staff during the person centered planning process.

Strategies:

It is recommended that the state:

1. Review housing needs and preferences approaches used by other states to inform their work.
2. Develop a housing needs and preferences tool that can be incorporated into the person centered planning process. This may be added as a section to the Person Centered Plan (PCP) or an additional document added to the PCP.
3. Establish a protocol to notify the Subject Matter Expert when a community placement other than Permanent Supported Housing is recommended or preferred by the TPM.

Goal #6: The Subject Matter Expert shall be notified prior to transition of any recommended placements to settings other than Permanent Supported Housing for review of the transition plan.

Action: A protocol for notifying the Subject Matter Expert (SME) will be developed by the state for when a community placement other than Permanent Supported Housing (PSH) is recommended or preferred by the TPM, providing as much advance notice as possible prior to transition.

Strategies:

It is recommended that the state:

1. Develop a form to share with the SME that addresses the reasons for a referral to a community placement that is not PSH. The form should identify:
 - a. All housing options that were considered and recommended;
 - b. Target Population Member preferences;
 - c. the types of services that would be needed to support the TPM in a PSH setting;
 - d. How the housing placement meets the most integrated setting as defined in the Settlement Agreement. Examples of integrated settings can be found in the [Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.](#) and the [Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services \(HCBS\) Settings Final Rule.](#)
2. Establish a process for the SME to review and discuss the pending placement with the state and whether the placement will reflect the state's requirements of an appropriate setting in the Settlement Agreement.

Appendix G: MFP Capacity Building Grant Opportunity Project Narrative

Summary/Abstract

The North Dakota Money Follows the Person (MFP) demonstration project has provided important opportunities to advance the State's institutional transition of individuals from nursing facilities/hospitals to a less restrictive setting, preferably home. Capacity-building and system transformation, continues and is now required through a Settlement Agreement with the United States Department of Justice. There are six components to this proposal that involve multiple divisions within the North Dakota Department of Human Services including Aging Services Division, Medical Services (Medicaid), Developmental Disabilities, Behavioral Health Services, and Children and Family Services. Here is a summary of the components to this proposal:

1. Home and Community-Based Workforce/Provider Retention and Expansion: Access to community-based services and provider capacity development and training, have been identified as the primary barriers that need to be addressed to make community-based services readily available across the State. North Dakota has identified projects to increase provider capacity and quality to include the development of a Direct Service Workforce/Family Caregiver Resource and Training Center. The State agency will also offer provider training and development incentive grants or loans, and assist with required accreditation costs. The Resource Center will be implementing Qualified Services Provider (QSP) agency recruitment strategies, QSP recruitment, training and support, and technical assistance to increase the amount of and retain service providers.
2. Institutional Diversion and Transitions: The projects identified to safely transition individuals from SNF/hospitals home include the enhancement of transition support services, an informed choice process, in-reach, and outreach activities to increase knowledge of services and advancing the utilization of assistive technology.
3. Person-Centered Practice: The MFP Grant, the Settlement Agreement, and the technical assistance recommendations from the National Center on Advancing Person-Centered Practices and Systems outline opportunities and requirements for the State to improve training and provision of Person-Centered Practices (PCP). The projects identified include securing ongoing technical assistance on PCP for Aging Services, provision of annual training, development of a train the trainer model, and development of PCP tools for family and individuals receiving services that are culturally sensitive.

4. Children’s Service System Capacity Assessment: The State agency will complete a comprehensive needs assessment of child and related family services across the State, to identify short-term, intermediate, and long-term recommendations focused on development of 1915(c) or 1915(i) Medicaid funded services and other system change outcomes that lead to child and family success with minimal barriers to access services. The project would involve a system wide assessment and facilitated implementation of system change recommendations.

5. Quality Monitoring and Data Collection: The State agency will successfully coordinate, communicate, track and report implementation progress of the required activities of the Settlement Agreement and MFP Capacity Building Grant and to assess HCBS service customer satisfaction and quality of services. The projects would include one staff member to coordinate the implementation of the Settlement Agreement and funding for implementation of the National Core Indicators (NCI) and the NCI for the Aging and Disability Populations.

6. Peer and Family Supports: The State agency will develop an in-person and virtual peer and family support referral and support process that will allow individuals from across the lifespan interested in transitioning to an integrated setting the opportunity to connect with a peer who has lived experience navigating and receiving community-based services. Family supports may also include system navigation and benefits counseling to ensure understanding and access to home and community-based services and supports. This service will be coordinated by one entity who could enroll or subcontract with community providers with expertise in services targeted to various groups.

Goals, Objectives, and Outcomes

The goals and actions listed below will ensure that the State agency achieves the objectives of the MFP Capacity Building Grant, the requirements of the Settlement Agreement and technical assistance recommendations from the National Center on Advancing Person-Centered Practices and Systems.

1. Home and Community-Based Workforce/Provider Retention and Expansion

GOAL: To increase the number and capacity of QSPs and family caregivers that are actively serving clients to support individuals transitioning from SNFs or other institutions by: 1/1/2022.

a. Direct Service Workforce/Family Caregiver Resource and Training

Center: The Resource and Training Center will support the increased number of active QSPs and Family Providers by assisting with enrollment as a provider, providing skill building “ECHO Training”, and offering technical assistance with billing, EVV, Therap, business development, marketing,

service authorization, billing, etc. Participation in training and ongoing support will be documented beginning 10/1/2021. Qualified Services Provider (QSP) agency recruitment capacity will also be developed in cooperation with other State entities with the goal of increasing the number of QSP agencies and expanding services offered by existing agencies.

- b. Incentive grants and loans** -Approximately four hundred thousand dollars will be awarded as grants or loans to up to twenty-five agencies. These will be used to incentivize agency providers to expand services or for new agency providers. These grants are also available to tribes who want to certify as an agency. Awards will begin by 10/15/2021 and be completed by 9/30/2025.
- c. Accreditation cost funding** will be provided to new Aging Services providers who are willing to provide services that will meet the more complex needs of individuals who are returning to an integrated setting or who want to remain in the community. Ten agencies will be assisted with CQL or other agency accreditation costs which qualifies them to provide services to individuals with complex medical needs. Awards will begin by 10/15/2021 and be completed by 9/30/2025.
- d. QSP matching portal** will be implemented and modified in cooperation with the ADvancing States organization to significantly improve the capacity of individuals in need of community services to evaluate and select Independent QSPs and QSP agencies with the skills that best match their support needs by June 1, 2022.
- e. Development of case management remote work capacity:** To provide remote Wi-Fi Hotspots and document signature/print capacity for all HCBS case managers/Informed Choice staff to work remotely or closer to the communities in which transitioning individuals live by 12/1/2021.

2. Institutional Diversion and Transitions

The five new transition/informed choice services staff will inform 200 individuals monthly of the community service options available to those who receive Medicaid and who meet level of care screening requirements and provide transition services by 8 /1/2021. Frequency of informed choice will increase to those individualize who stabilize medically.

3. Person-Centered Practice

North Dakota will enhance PCP initial and annual training to all HCBS case managers to include Charting the Life Course Model to HCBS case managers by 10/1/2022. A train the trainer model will be developed by 10/1/2022.and up to five staff will be trained as trainers. PCP tools for families and individuals receiving services will also be developed that may include training videos, handouts, guidebooks, and posters, and made available or given to approximately 2,100 individuals to encourage their

participation in the care planning process.

4. Children's Service System Capacity Assessment

The goal of this project is to complete a comprehensive needs assessment of child and related family services across ND and to identify short-term, intermediate, and long-term recommendations focused on development of 1915(c) or 1915(i) Medicaid funded services that lead to child and family success with minimal barriers to service access. The comprehensive **assessment of the children's service system** will identify and facilitate the implementation of system change recommendations to meet the community support needs of children that are either not served by any waiver or other service system or are underserved by the current State Medicaid waiver system of supports. The intent of this project is to identify service changes to the children HCBS services system necessary to the support and services needs of children that are not being served by any kind of waiver or service at this time. An example of this would be children with a physical disability do not qualify for any HCBS services other than Medicaid State Plan-Person Care program. The project would identify wavier services or system changes needed that more comprehensively meet the HCBS needs of children with any type of disability.

5. Quality and Data Collection:

Successfully develop a reporting and data collection process to implement the required activities of the Settlement Agreement and assess HCBS service quality and outcomes through NCI and NCI-AD by hiring one dedicated staff person to address the collection of valid and reliable data in all services, meaningful reporting, service quality which will be analyzed and trended and used to improve health outcomes.

6. Peer and Family Supports

To develop and implement a **system navigation and benefits counseling system** by peers to ensure understanding of and access to home and community-based services and supports for those who have transitioned from SNFs. This support system will be coordinated by one entity, yet to be identified, who will hire peer supports by 12/1/2021 for up to five peers and will reach out to 25 people. Evaluate program data and based on utilization the goal will remain the same or increase in years two and three based on utilization of the service.

Proposed Projects

The proposed projects identified in the goals and objectives are described in more detail below:

Home and Community-Based Workforce/Provider Retention and Expansion

A. Establishing a Direct Service Workforce/Family Caregiver Resource and Training Center (DSWRC)

The DSWRC will provide continuous technical assistance/training, and guidance to Qualified Services Providers and family care providers. The DSWRC will support both the development of new providers and support their retention long term by providing the following services:

- Provide access to different training methods and topics created or made available from a variety of vendors to increase skills, competencies and confidence of a workforce that often works in isolation.
- Support development of new providers and increase retention and decrease turnover of caregivers who struggle to maintain enrollment due to challenges with provider enrollment, Electronic Visit Verification (EVV), billing, skill building, and other administrative requirements.
- Produce material/information and provide technical assistance on authorizations, enrollment, billing, and EVV to improve the successful delivery of services.
- Make Information and technical assistance training available in a variety of formats (in person, internet, social media, mobile phones, printed materials)
- Provide stress management and coping skills training, caregiver support blog or group support to reduce the stress and burden of being a caregiver.
- Provide module-based training materials on personal care activities, information on a variety of medical diagnosis, strategies for working with people with intellectual disability, brain injury, dementia, behavioral health issues and substance abuse, how to teach skills (habilitation), and effective support strategies for the participants.
- Provide training to individuals on how to select, train and manage QSPs. Communication skills and conflict resolutions training will be offered. This will help increase utilization of QSPs and their retention.
- Establish a Qualified Services Provider (QSP) agency recruitment: Establish a QSP agency recruiting and development process in cooperation with other State agencies or a vendor to be selected working with small business development to increase the number of QSP agencies needed to meet the needs of all individuals identified by the Settlement Agreement.

B. Provision of Provider Development Incentive Grants

Offer Provider agency Incentive grants to assist with the startup costs that pose significant barriers to new providers considering offering services to individuals with complex medical needs. Grants would be targeted for the services that will meet the needs of individuals with the most complex medical needs needed to be successful living in community. These would be competitively awarded to agencies that will provide

waiver services, Medicaid State Plan-Personal Care, and 1915(i) services.

C. Accreditation Cost Assistance

Provide payment assistance for the required Council on Quality Leadership (CQL) accreditation fees to assist with the development of agencies that provide the Medicaid waiver services of residential habilitation and community-support services that will allow up to 24-hour a day services in the community.

D. Services Matching Portal

Provide the modification costs for the QSP Agency matching portal that will be implemented in cooperation with ADvancing States to significantly improve the capacity of individuals in need of community services to evaluate and select QSP agencies.

E. Remote Work Technology Capacity

To provide remote Wi-Fi Hotspots and document signature/print capacity for all HCBS case managers/Informed Choice staff to work remotely.

Institutional Diversion and Transitions:

The proposed projects, identified in the goals and objectives section are described in detail below:

A. Informed Choice and Transition Staff

This project will establish funding for five full-time positions to complete the informed choice process and to provide transition assistance services for individuals discharging from SNFs or hospitals back to a community setting. Staff will determine the frequency in which they meet with individuals in the SNFs to ensure choice of service setting and increase awareness about community services available. The Department will submit a request to the Governor to include these positions in the Executive budget request for the 23-25 biennium.

B. Assistive Technology Utilization

This project will establish funding for the State assistive technology agency to provide information and training to community providers and caregivers to foster independence so individuals can live more safely and securely in their home. The increased utilization of assistive devices will support increased utilization of home and community-based services.

Person-Centered Practice

The State will improve training and provision of Person-Centered Practices to all new and existing HCBS case managers as part of a statewide initiative. The project will secure payment for ongoing technical assistance on PCP for the Aging Services

Division staff, provide annual PCP training, implement a PCP train the trainer process, and develop PCP tools for families and individuals receiving services. Training on cultural competency and sensitivity will also be integrated.

Children's Service System Capacity Assessment:

This project will complete a comprehensive needs assessment of child and related family HCBS and other services to identify short-term, intermediate, and long-term recommendations for development of Medicaid Funded Home and Community-Based Services for children with the focus on outcomes that lead to child and family success with minimal barriers to service access. The project will involve a system wide assessment and facilitated implementation of HCBS services and system change recommendations.

Quality and Data Collection:

The project will provide funding to employ a fulltime staff member to help coordinate, communicate, and report implementation progress on the required activities of the Settlement Agreement with the United States Department of Justice. Funding will also support the implementation of the National Core Indicators (NCI) and the NCI for the aging and disability populations. Data that will be gathered includes admissions to nursing homes, number of placement days, outreach activities to nursing homes, informed choice visits, days in transition, services individuals receive and utilization, cost of services in quarter increments, satisfaction with services, critical incidences, readmissions, etc.

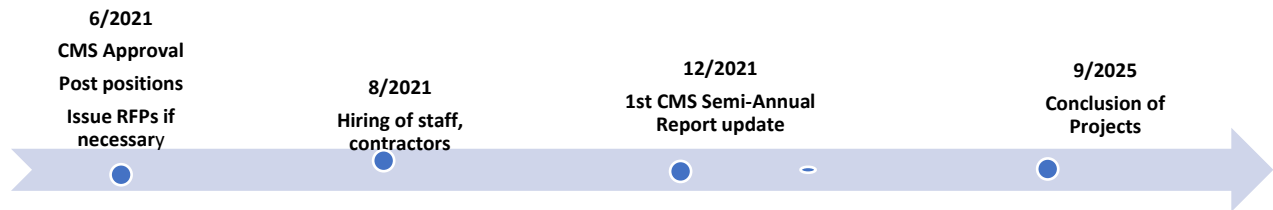
Peer and Family Supports:

The project will provide funding for the development of a system of Peer and Family Supports. In-person and a virtual peer and family support referral and service delivery structure will be developed. This will include identifying the State positions or contracted agency responsible that would hire, train, and manage individuals from across the lifespan interested in transitioning to an integrated setting the opportunity to connect with a peer who has lived experience navigating and receiving community-based services. Family supports will include the provision of system navigation and benefits counseling to ensure understanding and access to home and community-based services and supports. This system will be coordinated by one entity who will enroll or subcontract with community providers with expertise in services targeted to various groups.

Project Management

All progress on the programs and initiatives outlined in this proposal will be reported in writing on a semi-annual (twice yearly) basis to the MFP Project Director, with highlights to be included in the CMS semi-annual report and discussed with the CMS Project

Officer during ongoing regularly scheduled meetings. Here is a high-level timeline of activity milestones:



Below we have outlined the reporting structure for each of our project's components:

1. Home and Community-Based Workforce/Provider Retention and Expansion
The Program Administrators from Aging and Medical Services will coordinate with the Aging Services Director and will coordinate implementation and reporting efforts with the MFP Grant Program Administrator for semi-annual progress.
2. Institutional Diversion and Transitions
The Program Administrator for the Informed Choice process reports to the Aging Services Director and will coordinate implementation and reporting with the MFP Grant Program Administrator for semi-annual progress reports.
3. Person-Centered Practice
The Program Administrator for the PCP projects report to the Aging Services Director and will coordinate implementation and reporting with the MFP Grant Program Administrator for semi-annual progress reports.
4. Children's Service System Capacity Assessment
The Developmental Disabilities, Medical Services, and Children and Family Services Program Administrators will work with the vender contracted for the project with the MFP Grant Program Administrator for semi-annual progress reports.
5. Quality and Data Collection
The Data Coordinator for the Settlement Agreement reports to the Aging Services Director and will coordinate implementation and reporting with the MFP Grant Program Administrator for semi-annual progress reports.
6. Peer and Family Support
The Program Administrators responsible report to the Aging Services Director and will coordinate implementation and reporting with the MFP Grant Program Administrator for semi-annual progress reports.

Appendix H: Capacity Plan



MAS Solutions, LLC
Subject Matter Expert

North Dakota Capacity Plan

On December 14, 2020, the state of North Dakota entered into a settlement agreement with the United States Department of Justice (USDOJ). The agreement is designed to serve adults with physical disabilities that are capable of living in integrated community settings with sufficient services and supports and to receive the necessary care in that setting. Those individuals, considered members of the target population for purposes of the Settlement Agreement, are “individuals with a physical disability over the age of 21 who are eligible or likely to become eligible to receive Medicaid long-term services and supports and are likely to require such services for 90 days.” As a result of the Settlement Agreement, North Dakota has created an implementation plan to address the issues that are currently barriers to allowing target population members to remain in or return to the community. Currently, there are more eligible members of the target population on Medicaid residing in nursing facilities than are receiving home and community-based services.

Barriers exist in the capacity of North Dakota’s case management and community providers, both agencies and individual Qualified Service Providers (QSPs) that present challenges in meeting service needs for individuals transitioning from and being diverted from nursing facilities. Included in the agreement is the requirement for the development of a Capacity Plan to provide technical assistance from the Subject Matter Expert (SME) to assist the state with accomplishing the goals of the Settlement Agreement. The Capacity Plan is designed to address these barriers and assist in streamlining and building systems to allow more target population members to remain in or return to the community, with all necessary services and supports to achieve self-determination by living life as they choose to live. Strategies and actions in the Capacity Plan are designed to address short-term needs and build processes and procedures that North Dakota can maintain and sustain into the future.

The SME is aware that North Dakota may have already taken action and developed plans related to some or all of these recommendations, but thought it important to include in this plan for cross reference. Actions that have already begun may be included in the Implementation Plan in Sections VII, VII, and XIII.

Goal #1: The SME recommends that the state identify shortages in case managers and community providers (agencies and individual QSPs), address those shortages, and increase capacity to most effectively serve Target Population members (TPMs).

Action: Identify and address potential shortages in case managers, by case management territory, through implementation of internal efficiencies and building additional case management capacity to serve and support the target population.

Strategies

1. The SME recommends that the state develop a methodology to determine the actual and projected shortage rates for case managers (CM) by case management territory, including rural areas and Native American populations.
 - a. Identify gaps in case manager availability to serve Target Population Members (TPMs) in rural areas and in Native American populations by conducting a capacity gap analysis.
 - b. Review the weighting system for caseload assignment with a focus on the care coordination needs of TPMs, the provision of the appropriate level of case management services to each TPM residing in a nursing facility, and those who seek or are referred for admission to a nursing facility (per the provisions of the Settlement Agreement.) Discussions between the parties and the SME are ongoing relative to the provision of case management services. Strategies that move the state forward in providing for case management services could be included in the Implementation Plan.
 - c. Consider a graduation in the level of engagement of the CM for TPMs in nursing facilities, those who are not initially seeking to return to the community, and those who are preparing to transition. Frequency of contact and level of engagement should increase as the TPM moves closer to returning to the community. Additional strategies could be considered, throughout the term of the Settlement Agreement, for how to provide an adequate and appropriate level of informed choice and person centered planning for those that are not initially interested in transitioning to the community.
 - d. Develop a backup plan in the event of a sudden case manager vacancy to ensure that TPMs are adequately served.
 - e. Create a centralized data reporting system where information is stored, identifying available capacity for each case manager. This system must be updated routinely and be available to the Aging and Disability Resource Link (ADRL) staff to use in the screening and referral process to optimize the matching of TPMs and available case managers.
2. The SME recommends that the state develop and implement recruitment strategies for additional case managers if it is determined that shortages exist or are projected to exist. This may include outreach, (particularly in geographic areas lacking capacity), incentive payments, clear procedures, and parties responsible for expediting the recruitment and hiring of additional case managers.
 - a. Using data that identifies where actual and projected shortages exist, prepare the justification for the next executive budget request to the ND legislature.

3. The SME urges a complete review of required case management documentation and eliminate unnecessary or duplicative documentation, or both, to reduce the amount of time spent on administrative tasks and enhance case manager capacity.
 - a. All required documentation for intake, assessment, and ongoing contacts and updates with the TPM is gathered.
 - b. Case manager supervisors may make recommendations on what changes can be made efficiently to reduce time spent on administrative duties. Technical assistance is available for independent reviews and recommendations from the SME for this work.
 - c. Develop a strategy for determining what forms and processes are codified in administrative code or regulation that require amendments to streamline processes.
4. The SME recommends that the state address case management role clarification and specialization to enhance capacity to meet the needs of TPMs.
 - a. Clarify responsibilities of case managers regarding required outreach and frequency of contacts to a TPM.
 - b. Adjust existing CM responsibilities to include working with nursing facility discharge planners to assure that TPMs in nursing facilities routinely receive information regarding HCBS and the capacity of a case manager to be assigned.
 - c. Consider recruiting, hiring, and training (or engage a contractor) TPM case managers to a medical care coordination model of case management or contracting for this service. This could include hiring individuals with a master of social work degree well versed in addressing individuals with complex medical needs and focused on community transition. Assign these case managers to TPMs discharging from nursing facilities or presenting at hospitals qualifying at a nursing facility level of care and maintain that assignment for the first year. One option for consideration would be that subsequent to year one, other ND-licensed case managers without that specialized experience could assume case management responsibilities for the TPM.
 - d. Develop policy and procedures for case managers, housing specialists, natural and family supports, hospitals, and nursing facilities (including discharge planners) to provide support for TPMs, including communication protocols, single points of contact, and documentation requirements.
 - i. Implement a process mapping project to clearly delineate which positions are responsible for doing what and when.
 - e. Train all case managers in the revised person centered planning process to ensure that the individual or assigned guardian is included in the planning process and cultural needs and preferences are addressed.

Action: Identify and address shortages in agency providers, by case management territory, and identify ways to incentivize current providers to build capacity and recruit additional agency providers and individual QSPs.

Strategies

1. The SME urges the state to inventory/survey, by case management territory, the number of agency providers (including which services each provider offers) and the number of individual QSPs (including which services each offers, how many clients each QSP currently serves, and how many additional clients or service hours they could provide) to identify gaps in services and capacity for services.
 - a. Inventory/Survey current agency providers, analyzing where gaps in services or current and available capacity that is not being fully utilized exist.
 - b. Create strategies to eliminate gaps through the expansion of services offered by current agency providers and individual QSPs.
 - c. Identify barriers to service expansion and strategies to overcome such barriers.
 - d. Implement goals, action steps, and timelines included in the Money Follows the Person (MFP) Capacity Building Grant to increase capacity.
 - e. Create a centralized data reporting system where this information is stored, identifies capacity, can be updated routinely, and is available to case managers and others.
2. The SME encourages the state to streamline the agency provider enrollment system.
 - a. Identify internal and external barriers to enrollment and how those may be reformed.
 - b. Identify staff responsible to complete each activity and outline procedures. Technical assistance is available for independent reviews and recommendations from the SME for this work.
 - c. Implement goals, action steps, and timelines included in the MFP Capacity Building Grant to increase capacity.
 - d. Inform case managers and others on revisions in the provider enrollment process.
 - e. Notify current providers when the revised certification process is complete.
 - f. Provide ongoing support during the certification and credentialing process.
 - g. Create a communication and recruitment plan to engage other agencies as potential community providers for the target population.
3. Implement the requested MFP Capacity Building Grant goal of increasing access to assistive devices.
4. The SME recommends that the state streamline the individual QSP enrollment process.
 - a. Inventory current individual QSPs, identifying where gaps exist or current capacity is not being fully utilized.
 - b. Create strategies to eliminate gaps through the expansion of services offered by individual QSPs including simplifying the process by which QSPs add to their service arrays if they are meeting the standards to provide these additional services.
 - c. Assure that case managers are aware of the availability of individual QSPs who wish to serve non-family members and are encouraged to develop

- awareness about individual QSPs and the services they provide to expand the list of providers to TPMs seeking services.
- d. Identify and list barriers to service expansion and strategies to overcome barriers.
 - e. Revise the current enrollment packet, simplify to eighth (8th) grade reading level, revise competency checklist to include only medical tasks, and expand training modalities.
 - f. Implement the Centers for Medicare and Medicaid Services (CMS) approved (when final) MFP Capacity Building Grant with measurable goals and objectives to support the individual QSP enrollment process.
 - g. Explore the co-employer model* (described at the end of this goal) to engage existing agencies to assist in enrollment, management, billing, and payroll of individual QSPs.
5. The SME encourages the state to address health and safety needs of TPMs and QSPs by:
- a. Insisting that all TPMs have a back-up caregiver to provide services when the normally scheduled QSP is unavailable (this QSP can also provide regularly scheduled respite);
 - b. Marketing respite services to increase use of such services; and
 - c. Offering support groups or a “QSP blog” to improve health outcomes, decrease feelings of loneliness, and extend caregiving.
6. The SME recommends that the state evaluate the effectiveness of the individual QSP referral/finder system for TPMs.
- a. Create a centralized database where information about training, geographic area, hours of work availability, schedule of availability, languages spoken, special considerations (i.e., allergies), and consider adding a simple biography of the QSP.
 - b. Simplify the “search” ability of the database so the QSP “finder” list is more user friendly for TPM and case managers to locate providers, including a printable version.
 - c. Train case managers and individuals on use of the QSP “finder” list.

****Co-Employer/Agency with Choice Model***

This is an approved CMS self-directed model where a provider agency and the individual (in this instance a TPM) share employer responsibilities. The agency is the employer of record and their Federal Employer Identification Number (FEIN) and National Provider Identifier (NPI) is used. The individual recruits, selects, schedules, manages, assists with training, and can dismiss the individual QSP. The agency sets the employee wage (it can be a pay range) and maintains hiring and firing responsibilities, that the individual QSP is eligible to work, and protects against fraud and abuse and neglect. The agency manages the authorization for services, bills for services, and pays the employer and employee taxes.

Goal #2: The SME recommends that the state seek to better align authorization processes and reimbursement systems and rates, and reduce disparities in

nursing facility and HCBS provider staff compensation for the same or similar services regardless of location or setting.

Action 1: Streamline and make consistent the authorization process for community-based services regardless of where the services are provided

Strategy

The SME recommends that the state develops and implements a plan to eliminate discrepancies in authorization processes and reimbursement rates across case management territories to promote equal access to HCBS services regardless of geographic location.

- a. The plan to decrease discrepancies in authorization and reimbursement of services could use existing differential reimbursement rates, where those differences are based on incentives for providers to recruit and retain staff and to offer services in underserved areas pursuant to the implementation plan.
- b. The plan should include periodic monitoring and review of authorization requests and decisions to assure that discrepancies do not remain or recur.
- c. Train individual QSPs and agency providers on the authorization and billing/reimbursement process and the process for doing so should be included.

Action 2: Reduce any significant disparities between the average reimbursement rates for nursing facilities and the average reimbursement rates for a comprehensive package of home and community-based services for comparable TPMs.

Strategies

1. The SME recommends that the state compare daily average nursing home rates to the overall daily average cost of providing an appropriate package of services for a TPM in a community setting, determine the extent of the disparity, and determine potential rate adjustments or other steps that could reduce the disparity without jeopardizing home and community-based services (HCBS) cost effectiveness or cost neutrality.
 - a. Address, with the Centers for Medicare and Medicaid Services (CMS), options to eliminate the incremental “time-for-task” approach to reimbursement for HCBS, as this is a significant barrier for HCBS service delivery, and transition to a bundled package of services delivered in a “block” of hours.
 - b. Utilize its databases, including Medicaid claims data, to track services authorized, hours or other amount of services actually provided, and the cost of such services for each TPM. This data should be used to compare the cost of average utilization of HCBS services compared to nursing facility services for a TPM with comparable needs. The data could also be used to track diagnoses, services authorized, utilization, and gaps in services that lead to

- hospitalization or nursing facility admission.
- c. Train individual QSPs and agency providers on the importance of tracking utilization of authorized services, why services are not being utilized, adjust schedules to increase utilization, and monitor the data to ensure services are delivered consistent to the authorization.
 - d. The SME recommends that the State implement rebalancing strategies and demonstrate progress in rebalancing it long term services and supports.

Action 3: Align reimbursement rates for nursing facilities and QSPs (agencies and individuals) sufficiently to encourage reduction or elimination of disparities in wages paid to staff providing the same or similar services in different settings, taking into account factors such as overtime, commuting times, benefits offered, etc.

Strategy

- a. The SME suggests that the state arrange for a compensation study to determine the levels of compensation (wages and benefits) paid to nursing facility staff and agency and individual QSPs who provide the same or similar services. A primary goal of this study would be to determine what, if any, disparities exist between total compensation packages (wages and benefits) in these different settings.
- b. It is recommended that the study use a tool (to be developed by the state or a contracted vendor) that allows for a comparison of compensation for nursing facility and agency and individual QSPs based on the service provided and/or job duties, regardless of the particular job titles of the comparable staff.
- c. This study would take into account the number of hours' agency and individual QSPs and nursing facility staff work, including overtime hours and commute times to deliver necessary services.
- d. The study would take into account any training, certification, or licensure requirements for the services provided to assure comparability.

Goal #3: The SME recommends that the state develop additional incentives for community providers and individual QSPs who serve members with significant medical or supervision needs, or both, (including overnight needs and/or the need for intermittent on-call services), Native American populations, and members in rural areas.

Action: The state is encouraged to develop and implement a plan and procedures that offer higher payment rates and additional incentives to serve the subpopulation members noted above.

Strategy

The SME recommends that the state establish criteria defining “members with significant medical or supervision needs, or both,” and for “rural areas,” for consideration of additional incentives for purposes of this goal and request funding for

additional incentives if those are warranted.

- a. Include in the Executive Budget a request to the ND Legislature for funding for additional incentives.
- b. Adopt and publicize definitions.
- c. Provide incentives to agency providers and individual QSPs who complete training for nurse delegated tasks and behavioral support strategies.
- d. Codify and communicate information to agency providers and individual QSPs.
- e. The implemented plan and action steps should outline the additional incentives available to agency providers and individual QSPs able to serve these subpopulations. The information about how to communicate, apply for, and secure incentives from the state is made readily accessible.
- f. The number of agency providers and individual QSPs who accept additional incentives, the number of TPMs served as a result of those incentives, and the additional cost of providing such incentives to be reported to the SME through a data dashboard on a quarterly basis.
- g. Continue to implement the rural differential rate that is established and submit to the SME for review and feedback.
- h. Implement the MFP Capacity Building Grant, once approved, to pay for certification costs for Tribes to become their own agency providers or for agencies that primarily serve Tribal members.

Goal #4: The SME recommends that the state assure that community providers are trained with sufficient frequency, intensity, and in all areas of North Dakota on:

- **the Settlement Agreement,**
- **Home and Community-Based Services (HCBS),**
- **person centered planning, and**
- **the authorization and reimbursement system.**

Action: Revise statewide training for individual QSPs and agency providers to improve timeliness of service delivery and increase capacity to optimally serve Target Population members.

Strategies

1. It is recommended that the state revise the training process for individual and family QSPs by:
 - a. Simplifying readability of forms to an eighth (8th) grade reading level, with a particular focus on provider agreements.
 - b. Consider revising the competency training checklist to remove non-medical tasks, such as money management, that currently require medical review.
 - c. Amending ND Administrative Code 75-03-23, if needed, to incorporate changes in the enrollment and training requirements of agency providers and individual QSPs (forms, training modules, competency tests, renewal, etc.).

- d. Giving consideration to using personal care topics training modules with a competency test rather than skill demonstration for non-medical tasks to increase access to training (an example is available from Arizona).
 - e. Involving the recipient of services in the training process to individualize training to needs and preferences.
 - f. Working with Native American leaders to revise training to reflect and respect cultural and spiritual beliefs and practices.
 - g. Giving consideration to using an “update” process when recertifying agency providers and individual QSPs every two years rather than the current process where the entire enrollment packet must be completed again on a yearly basis.
 - h. Enhancing the Abuse, Neglect, and Exploitation; Blood Borne Pathogen; and HIPAA trainings agency providers and individual QSPs receive.
 - i. Providing a written module for Medicaid Fraud and Abuse to use for those who do not have computer access to view the current training video.
 - j. Giving consideration to using provider agencies to assist with training and managing individual QSPs through a co-employer model.
 - k. Clarifying the incident reporting process to include how changes in health conditions are identified and communicated. Train individual QSPs in the process to include reporting to case managers and to the appropriate department.
 - l. Revising the individual QSP finder list process to make it easier for a TPM to select an individual QSP.
 - m. Identifying activities necessary in order to provide ongoing support to individual QSPs that:
 - i. Identifies a point of contact and determines an adequate level (frequency) of contact with the individual QSP. The state should consider the resource training center and agency providers for this role.
 - ii. Makes training and support tools available in other (than English) common languages – suggest using a 5-10% of population calculation in order to determine the number of translations necessary.
 - iii. Reaches out to individual QSPs annually that are identified as having not billed in the previous quarter to attempt to match such persons with an individual or agency to provide service rather than the current process of not recertifying the individual QSP.
2. The SME recommends that the state improve support to agencies by expanding certifications to increase service availability and capacity by:
- a. Designing an outreach plan for agency providers with less than 15 employees to encourage other provision of other services, particularly Residential Habilitation and Support services, essential for the target population. The state may need to dedicate another staff person to assist with this task.
 - b. Assisting the agency provider with improving compliance to policy and procedures for different state services.
 - c. Designing or using existing materials to help new and smaller agencies establish a business.

- d. Revising the agency certification process to include cultural, ethnic, and spiritual considerations when training Tribes to be a provider agency.
 - e. Reviewing and suggesting changes to ND Administrative Code 75-03-23, if needed, to incorporate changes in the enrollment and training requirements of agency providers (forms, training modules, competency tests, renewal, etc.).
 - f. Revising the Competency Training Checklist to remove non-medical tasks, such as money management, from medical performance review and allow the agency to approve competency.
 - g. Giving consideration to allowing agency providers to use state modules or design their own module for approval by the state, to develop a proctored competency test for non-medical tasks that will simplify training processes.
 - h. Allowing agency provider staff to be trained to assess competencies exempt from nurse delegated tasks, such as transfer and handwashing.
 - i. Giving consideration to having agency providers train and track family members who provide services to one family member, differently than individual QSPs providing services to other individuals.
 - j. Encouraging agencies to involve the recipient of services in the training process to individualize training to needs and preferences.
 - k. Clarifying the incident reporting process to include how changes in health conditions are identified and communicated. Train staff to the process to include reporting to case managers and the appropriate state agency.
 - l. Simplifying the two-year re-certification process to an “update” rather than complete the entire certification packet.
3. The SME recommends that the state could develop a database to register all agency providers and individual QSPs and categorize if provider is a family QSP or Tribal affiliated.
 4. The SME recommends that the state further assess the practicality of developing a training center given the rural and frontier nature of North Dakota.
 - a. Determine if the training curriculum can be provided in virtual formats for greater accessibility.
 - b. Consider making training available for groups in person or virtually with a live trainer as well as making training options available that are pre-recorded which individuals can access at different times.
 - c. Consider a cost-benefit analysis to aid in decision making.
 - d. Consider using provider agencies to perform tasks associated with resource training center goals.
 5. The SME recommends that the State revise person centered planning training for case managers and train 100 percent of case managers to the revised model.
 - a. Schedule and train case managers statewide to revised person centered planning processes.
 - b. Train case managers on the revised planning process and tool to use with older persons (+65).
 - c. Train case managers to the person centered planning process to use with individuals in the hospital or nursing facility (“informed choice interview”) until they begin their transition, when the full planning process and developed plan

- will be used.
- d. Ensure that case managers receive cultural sensitivity training.
 - e. Train select case managers (or pursue a contractor to do the same) to a medical model or care coordination model of case management to use with TPMs returning to the community from nursing facilities or hospitalization.

Appendix I: Draft Spending Plan for Implementation of ARPA Section 9817

Draft Spending Plan for Implementation of the American Rescue Plan Act of 2021,
Section 9817. [Rebalancing Toolkit \(nd.gov\)](#)

Appendix J: Safety Assurance Plan



MAS Solutions, LLC
Subject Matter Expert

North Dakota Safety Assurance Plan

On December 14, 2020, the state of North Dakota entered into a settlement agreement with the United States Department of Justice (USDOJ). The agreement is designed to serve adults with physical disabilities that are capable of living in integrated community settings with sufficient services and supports, to receive the necessary care in that setting. Those individuals, considered members of the target population for purposes of the Settlement Agreement, are “individuals with a physical disability over the age of 21 who are eligible or likely to become eligible to receive Medicaid long-term services and supports and are likely to require such services for 90 days.” As a result of the Settlement Agreement, North Dakota has developed an implementation plan to address the areas that are currently barriers to allowing Target Population Members (TPMs) to remain in or return to the community.

Developing this Safety Assurance Plan is also a requirement of the Settlement Agreement to assure that the an incident reporting and review process is established and agency providers employing non-family members to serve TPMs are trained in the system and that such agency providers have a quality improvement program in place that identifies, addresses, and mitigates harm to the TPM. Actions and strategies in the Safety Assurance Plan are designed to address immediate needs and build processes and procedures that North Dakota can maintain moving forward to meet the requirements of the agreement.

Goal #1: The SME recommends that the state train community providers on incident reporting and review procedures designed to identify, address, and mitigate harm to Target Population members they serve.

Action #1: The SME urges the state to establish a consistent incident reporting and response process to be used for all incidents listed under Strategy 1.g (below). The SME also recommends the development and use of a single data system accessible to and used by state employees authorized to investigate and/or remediate such incidents. This process should be in place no later than 18 months from the effective date of the agreement.

Strategies

1. The data elements for reporting incidents should include:
 - a. report date/time;
 - b. reporter name;
 - c. reporter contact info (e.g. email address, phone number,);

- d. reporter agency (if any);
 - e. recipient Last Name, First Name, Medicaid ID, Address, Phone Number, Date of Birth (DOB);
 - f. general information about the incident; and
 - g. incident type classifications:
 - i. Deaths;
 - ii. Life-threatening illnesses or injuries;
 - iii. Alleged instances of abuse, neglect, or exploitation;
 - iv. Changes in health or behavior that may jeopardize continued services;
 - v. Serious medication errors;
 - vi. Illnesses or injuries that resulted from unsafe or unsanitary conditions; and
 - vii. Any other incident currently required to be reported pursuant to state law or policy or which was required as of the effective date of the Settlement Agreement (December 14, 2020.)
2. The SME recommends that the process for responding to reported incidents include a data system that provides entry fields for:
 - a. investigator and/or case manager progress notes,
 - b. conclusions with respect to the incident or situation,
 - c. the outcome of the review including whether substantiated or unsubstantiated, and
 - d. an incident remediation plan, if applicable.
 3. The SME recommends that the state identify workflow processes (mapping the steps in the process) for the investigation and remediation of reported or otherwise suspected incidents described above. The processes will be documented in policy and/or provider contracts and manuals. Processes should include:
 - a. completion of any missing data elements from the initial report to be completed by the lead investigator for the state,
 - b. timelines and guidelines for the investigation of incidents,
 - c. development of a remediation plan for each confirmed incident with the exception of death by natural causes, (the remediation plan to include who is responsible for implementing as well as monitoring and a timeline for both), and
 - d. A method for tracking when an incident has an associated complaint.
 4. The data system and workflow processes will assure the issuance of a report to the Settlement Agreement Coordinator, the United States Department of Justice, and the Subject Matter Expert within seven (7) days for the types of Incidents listed above and a remediation plan for such incidents (with the exception of death by natural causes) as called for in the Settlement Agreement.

Action #2: The SME recommends that the state train community providers on the state's data system and processes for reporting, investigating, and remediating incidents.

Strategies

It is recommended that the state:

- a. Develop training materials and curriculum to include a specific focus on the state's data system and the state's processes for reporting, investigating, and remediating incidents to the Target Population Member;
- b. Provide this training to agency providers pursuant to a schedule developed by the state;
- c. Make the materials and curriculum available to agency providers so that staff can access these online; and
- d. Develop materials in the form of videos, virtual and in person group training and self-study modules methods, and alternative communication methods to ensure training is available to all agency providers.

Goal #2: The SME urges the state to ensure that all licensed agencies or entities employing non-family community providers have a quality improvement program that identifies, addresses, and mitigates harm to Target Population Members (TPMs) they serve.

Action: The SME urges the state to require agencies who employ individuals who are not family members of the TPM to have a quality improvement program (process and plan) and provide the plan to the state. The required quality improvement program will identify, address, and mitigate harm to TPMs.

Strategies

1. The SME recommends that the quality improvement process and plan include a review to assure that the TPM has an individualized safety plan that was developed as a component of their person centered plan. The safety plan need not be developed by the provider unless it was not included in the person centered plan developed by the case manager and the TPM. This safety plan will include:
 - a. Identifying health issues, behavioral issues, and the individual's access to health care providers;
 - b. Safety assessment of the home or other place the individual is living for items such as;
 - i. Grab bars in bathrooms,
 - ii. Slip and fall hazards such as loose throw rugs,
 - iii. Clear pathways between rooms, and
 - iv. Documented need for home and environmental modifications and
 - c. The determination of level of supervision needed.
2. With the consent of the TPM or his/her legal guardian if applicable, or if otherwise authorized by law; identification of relevant family members, friends, or neighbors who interact with the individual on a regular basis; and the provision of information to those persons on how and to whom to report if significant problems or incidents arise, the SME recommends that the State provide for review of every agency provider's quality improvement program and individual

- safety plans, if such plans were developed by the provider.
3. It is suggested that the state work with all agency providers to develop performance improvement targets aimed at improving health outcomes for TPMs. The SME recommends that the state develop a clear set of guidelines for incident response, review, investigation, and remediation. The state should outline the specific steps in the process including defining the roles and responsibilities of the state, agency providers, and other relevant parties. The guidelines could make clear, for example, in the case of alleged abuse of a TPM by an agency employee, whether witnesses should be interviewed first by the provider, by state agency staff, law enforcement personnel, or others.

Goal #3: The SME recommends that the state improve the availability, accessibility, and quality of community based services provided to TPMs and ensure the continued health and safety of those members.

Action: The SME recommends that the state take additional actions to ensure the health and safety of TPMs who receive Home and Community Based Services (HCBS) in accordance with the member's person-centered plan. It is recommended that the state develop and publicize its oversight of the provision of HCBS and provide mechanisms for TPMs to file complaints.

Strategies

It is recommended that the state:

1. Provide for a mortality review for every death of a TPM (with the exception of death by natural causes). At least one individual involved in such a review should have relevant health care credentials. The purpose of the review would be to determine whether the quality, scope or amount of services provided to the TPM were implicated in the death. Information from mortality reviews should be used to promote service improvements at the agency provider or across the service system as appropriate.
2. Conduct an audit of the data system periodically (at a minimum of twice annually) to identify if there are agency providers that are over- or under-reporting. This audit would include review of a random sampling of client files and records to determine if there are incidents documented that should have been reported that were not reported or were reported subsequent to the deadline for reporting.
3. Review, on no less than a quarterly basis, incident reporting data to identify common or critical issues being reported, trends in reporting, and what can be done to mitigate harm.
4. Conduct outreach and education to the public and mandated reporters on new processes and data system requirements in order clarify and provide updates on reporting requirements.
5. Develop, per the Settlement Agreement, a mechanism for the public to file complaints relative to the provision of HCBS. The SME recommends that the mechanism include complaints regarding the availability, accessibility, or quality

- of services as well as the health and safety of TPMs.
6. Consider development and use of an adult abuse registry that would enable the state to identify individuals who have been confirmed to have committed significant abuse or neglect of vulnerable individuals and include procedures governing the employment or supervision of such individuals in the HCBS system.