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North Dakota - Department of Justice Settlement Agreement

Biannual Report
June 14, 2022 – December 13, 2022

ND Department of Human Services
Aging Services Division

Submitted January 31, 2023

Final draft March 04, 2023

List of Acronyms

ADA – Americans with Disabilities Act
ACL – Administration for Community Living
ADRL – Aging and Disability Resource Link
CMS – Centers for Medicare and Medicaid Services
CIL – Center for Independent Living
CIR- Critical Incident Report
CQL – Council on Quality and Leadership
DD - Developmental Disabilities
DHHS – Department of Health and Human Services
Ex-SPED – Expanded Service Payments to the Elderly and Disabled
FTE – Full Time Equivalent
HCBS – Home and Community Based Services
HCBS waiver - HCBS Medicaid waiver
HSRI - Human Services Research Institute
IC- Informed Choice – References changed to Long Term Services and Supports Options Counseling
IP - Implementation Plan
LTSS Options Counseling – Long Term Services and Supports Options Counseling
MFP – Money Follows the Person
MSP-PC - Medicaid State Plan Personal Care Services
NCAPPS - National Center on Advancing Person-Centered Practices and Systems
ND – North Dakota
NF LoC – Nursing Facility Level of Care
PCP – Person-Centered Plan
PSH – Permanent Supported Housing
QSP – Qualified Service Providers
QSP Resource Hub – Qualified Service Provider Resource Hub
RA – Rental Assistance
SA – Settlement Agreement
SME – Subject Matter Expert
SFN – State Form Number
SNF – Skilled Nursing Facilities
SPED – Service Payments to the Elderly and Disabled
TPM - Target Population Member
UND – University of North Dakota
USDOJ – United States Department of Justice
VAPS – Vulnerable Adult Protective Services

Introduction

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

The SA requires the State to submit biannual reports to the USDOJ and the Subject Matter Expert (SME) containing data according to the Implementation Plan (IP). The initial IP was approved on September 28, 2021, as required in the SA.

This report describes progress made toward the requirements listed in Sections VI–XVI for the period of June 14, 2022, through December 13, 2022. The report builds on the approved SA IP. All the requirements and associated strategies toward compliance that were due or are being worked on in this reporting period are included. New information is provided under the progress report heading highlighted in yellow and target dates were modified when necessary.

Reporting dashboards are included as Link to Appendix A to this report. They provide statistical data and additional information about the progress that has been made toward the required benchmarks of the SA regarding LTSS Options Counseling (informed choice), home and community-based services (HCBS), Aging and Disability Resource Link (ADRL), transition support services, and housing to assist target population members (TPM).

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

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

- **Increase access** to community-based service options through policy, process, resources, tools, and **capacity building** efforts.
- Increase **individual awareness** about community-based service options and create **opportunities** for LTSS Options Counseling (informed choice).
- Widen the **array of services** available, including more **robust housing-related supports**.
- Strengthen **interdisciplinary connections** between professionals who work in behavioral health, home health, housing, and home and community-based services (HCBS).
- Implement broad access to **training and professional development** that can support improved **quality** of service, highlighting practices that are **culturally**

informed, streamlined, and rooted in **person-centered** planning.

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

What We're Proud of

Major accomplishments during the second 6 months of Year 2 - (June 14, 2022 – December 13, 2022) of the USDOJ SA

- **Transitioned 64 TPMs** from a Skilled Nursing Facility (SNF) to integrated community housing where they can receive necessary support while enjoying the freedom and benefits of community living.

- **Diverted 168** individuals from a SNF by providing necessary services and supports so they can remain at home with their family and friends.

- Received **559** unduplicated TPMs referrals for individuals who have been approved for a long term stay in a SNF and provided **information about HCBS** options through **541** LTSS Options Counseling visits. Eighteen TPMs were not seen due to death or were unable to locate.

- **2,367** TPMs currently reside in a SNF, the State completed **726** Person Centered Plans (PCPs) and risk assessments for these individuals which was 31% of this population.

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

  - Provided **8,009 callers** with information and assistance about HCBS and assisted another **664** through the **web intake** process**.**

  - Referred **864 individuals** from these contacts for **HCBS**, which is an average of **144** per month.

- HCBS Case Managers responded to **967 HCBS referrals** from all sources (ADRL intake, direct referral, MFP, LTC Eligibility Unit, and LTSS Options Counseling visits).

- Provided State or federally funded HCBS to **2,438 unduplicated** adults in this reporting period. Please note, these numbers include participants who have been receiving services for many years and they do not all meet the definition of a TPM.

- Provided **permanent supported housing** assistance to **41 (rental assistance) TPMs** who transitioned out of a SNF.

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

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

Lessons Learned

After two years of implementing the Settlement Agreement (SA) the following initiatives stand out as being key to the successful implementation of the USDOJ SA thus far.

- The State created a Year 1 and Year 2 comparison dashboard that highlights the progress and data trends since the SA was signed on December 14, 2020. Link to Appendix A.

- Streamlining the supervision and training of the HCBS case managers to enhance consistency. All staff have the same understanding of how to authorize services, interpret policy, and complete and document robust person-centered planning.

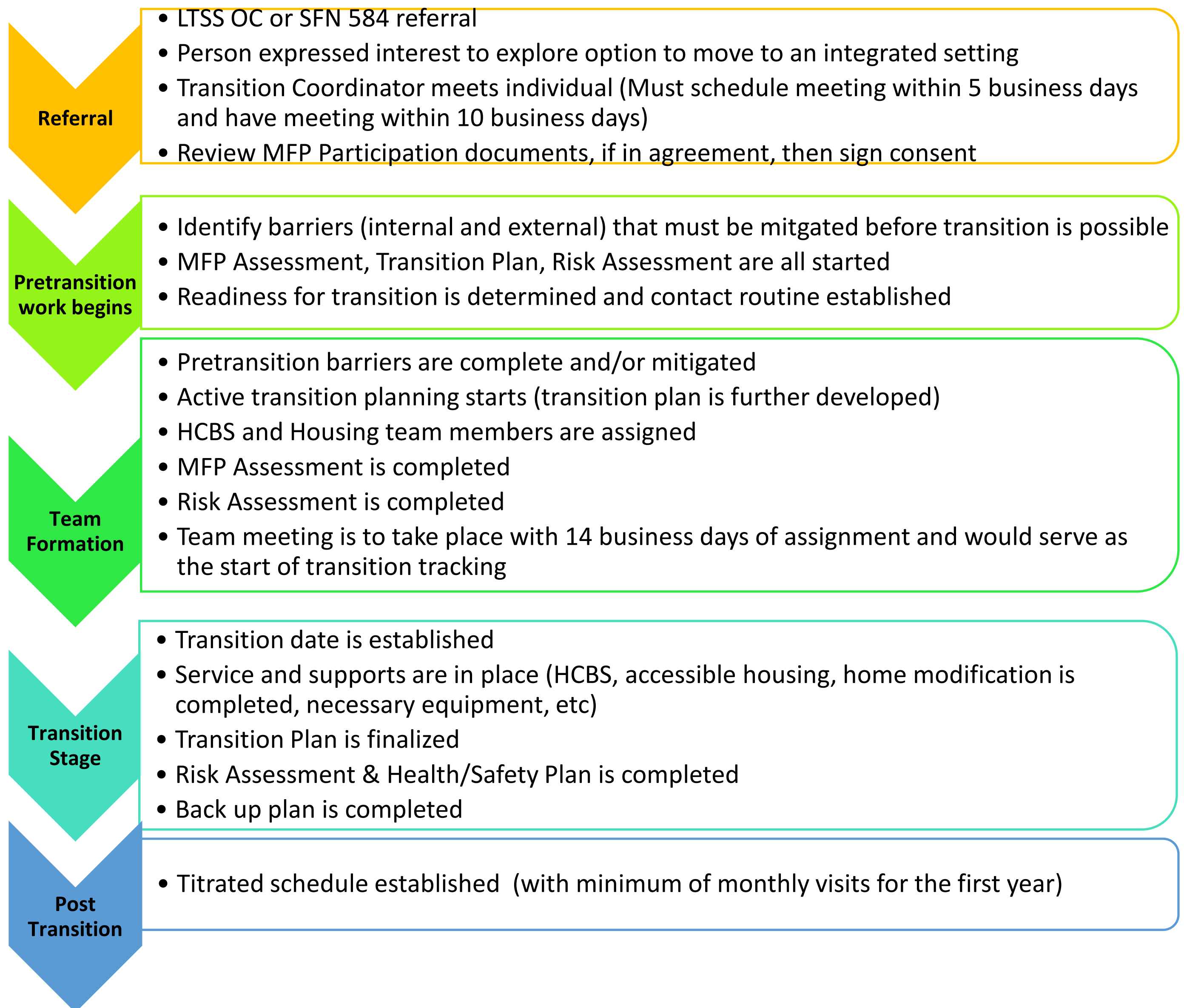
- Creating the ADRL centralized intake system to streamline the intake process and make timely and appropriate referrals to the HCBS case managers.

- Finalizing the implementation of an electronic case management system that is used by all Aging Services HCBS and contract staff. The system has led to more consistent data collection and reporting.

- Implementing the LTSS Options Counseling process with all TPMs who are referred to or residing in a SNF for a long-term stay. This process has created a tremendous amount of awareness in the SNF, and for the first time since Money Follows the Person (MFP) was implemented in ND, we have seen an overall increase in the number of transition referrals that come directly from the SNFs.

- Creating transition teams consisting of a Transition Coordinator, HCBS Case Manager and a Housing Facilitator that are assigned to every transition case. The team approach has improved communication between staff and helped ensure that barriers such as housing, community services, transition supports, and assistive technology are addressed and included in the planning process prior to transition.

- The State documented the stages of transition and the overall transition process in the chart below. The State will continue to refine this and other processes to strengthen the service delivery system and ensure more individuals with disability can live in an integrated setting and enjoy the benefits of community living.



Looking Ahead

During Year 3 of the US DOJ SA the State intends to focus on improving the provider experience related to provider enrollment and the providers ability to market their services to TPMs. The State has currently launched two (2) IT projects. One will create an electronic process for completing and submitting QSP enrollment documents online. In addition, the State has officially initiated implementation of the *ConnectToCareJobs* platform. This platform will be designed to replace the current QSP list. The platform will allow QSPs to better market their services by creating a more detailed provider profile that will be available to TPMs looking for a QSP. Providers can upload a resume, picture, references, hours of operation and much more.

The State has also included several requests to improve the overall HCBS system in the 2023-2025 Executive Budget request for inclusion in Senate Bill 2012 which is the DHHS appropriation bill. All the HCBS related requests in the Executive Budget Recommendations were designed to further improve and strengthen the HCBS system.

The State is committed to continuing to work with internal and external stakeholders to successfully implement the US DOJ SA. The successful implementation of all the initiatives in this important project will help to improve the lives of older adults and adults with disability in North Dakota.

Year 2 Settlement Agreement Requirements (12/14/21-12/13/22)

The chart below lists the requirements from the Settlement Agreement (SA) that are due during Year 2. The State believes that all but one of the Year 2-year requirements have been met or are on track to be substantially met by December 13, 2022, as required.

SA Section #	Requirement	Due Date
VI.F	Develop an Implementation Plan for Years 3	Submitted 6/14/2022
XIII.D	Provide technical guidance to nursing homes that commit to provide HCBS and rural community providers who commit to expand	Ongoing requirement
XV.D	Submit State Biannual Data Report	7/15/2022
XIV.A 1.	Conduct individual or group in-reach to each nursing facility	Completed annually
VIII.I 2.	Person-centered planning training of Case Managers	Completed annually
VIII.I 3.	Additional 290 TPMs receive person-centered planning	12/13/2022
X.A.1.	Provide information about community-based services to all TPMs who formally request or are referred for placement in a SNF	06/14/2022
X.A.2.	Demonstrate information shared with all TPMs regarding HCBS	09/14/2022
X.B.1.	All screenings and evaluations for nursing facility services included in the PCP	12/13/2022
X.B.2.	Implement incremental changes to the NF LoC process and community-based services eligibility	06/14/2022 and ongoing
X.B.3.	Require annual NF LoC determination screening for all continued stay in a nursing facility for TPMs.	12/14/2022

XI.B	Transitions occur no later than 120 days after TPM chooses	*06/14/2022 and ongoing
XI.E2. a	Transition 100 TPMs from SNF in the first 2 years of the SA	12/13/2022
Xi.E2. a	Divert 100 at-risk TPMs from SNFs in the first 2 years of the SA	12/13/2022
XII.B1. b	Permanent supported housing to an additional 30 TPMs	12/13/2022
XV.A	Enhance data collection to meet all reporting requirements	06/14/2022
XV.D	State Biannual Data Report	1/31/2023
* The State has not fully met this requirement due to the complex needs of some TPMs, including health and safety factors. The majority (72%) of transitions in Year two (2) of the SA were completed within 120 days. The State will strive to meet this benchmark, but some transitions will take longer because of the complex needs of TPMs. Please see additional explanation on page 57.		

SA Section VI. Implementation Plan

Responsible Division(s)

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

Progress Report:

- Nancy Nikolas Maier, Director, ND DHHS Aging Services Division, was appointed Agreement Coordinator on February 10, 2021.

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

Implementation Strategy

Conduct a series of project planning sessions to develop and draft strategies to meet requirements.

Progress Report:

- A draft of the revised Implementation Plan was submitted on June 14, 2022.

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 DHHS 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. **(Ongoing strategy)**

Progress Report:

A listening session is conducted during every ND USDOJ SA stakeholder meeting. Feedback is used to modify policy and waiver amendments. The State continued to hold listening-sessions in the second year of the agreement.

Increase number of SPED recipients.

- During this reporting period there were 452 new individuals enrolled in SPED, 52 of them are TPMs.

Number of providers enrolled to provide services.

- There are 954 individual QSPs and 139 agencies currently enrolled to provide HCBS.

Number of consumers served.

- There were 2,438 unduplicated individuals served under all state and federally funded HCBS during this reporting period.

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. **(Completed 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. **(Completed January 1, 2020)**

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

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). **(Completed February 1, 2022)**

Progress Report:

Waiver amendment approved by CMS January 1, 2022. Rate increase became effective February 1, 2022.

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

Implementation Strategy

The State will create ongoing stakeholder engagement opportunities including quarterly ND USDOJ SA stakeholder meetings the first two 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.

Progress Report:

Stakeholder meetings/quarterly listening sessions were held March 7, 2022, June 9, 2022, September 15, 2022, and December 8, 2022.

Link to 2022 Listening Session and Stakeholder Meetings Summary

https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/2022%20Listening%20Sessioins%20and%20ND%20DOJ%20Stakeholder%20Meetings%20Input%20Summary.pdf

The State will work with community partners to hold HCBS Community Conversations in all eight 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 DHHS website.

Progress Report:

Number of stakeholder engagement opportunities provided.

- Two ND DOJ Stakeholder meetings/listening sessions were conducted during this reporting period.
- One in-person Community Conversation was held in Fargo on September 20, 2022.

Number of attendees.

- ND DOJ Stakeholder meetings/quarterly listening sessions were held on September 15, 2022, with 57 people in attendance and December 8, 2022, with 40 people in attendance.

- Forty (40) individuals attended the Community Conversation event.

The State will schedule additional community conversation meetings in the case management territories and the four reservations in 2023. The meetings will be locally advertised as well as listed on the on the Department's website. Feedback is used to make changes in the service delivery system etc. and the changes are shared at ND USDOJ stakeholder SA meetings.

- See above Section VI.E for link to 2022 Listening Session and Stakeholder Meeting Summary.

The State is working with the Department of Health, Office of Heath Equity tribal liaisons to schedule community conversations in conjunction with other events being held on the reservation. The State developed a one-page written brief that explains the purpose of the community conversations and discussed the need to better engage with tribal communities at the Medicaid tribal consultation meeting. Stakeholders at that meeting suggested that we work with the UND Native American Resource Center staff to design meaningful public input meeting on each reservation. **(Target Completion Date November 2023)**

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.

Progress Report:

- Weekly meetings are conducted between the Agreement Coordinator and the SME.

- Meetings are conducted between the Agreement Coordinator and the DOJ bi-weekly or as needed.

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 revision submitted June 14, 2022)**

Strategy 2. Each revision to the IP will include a review of data collected and outcomes achieved, and how that informs revised strategies. **(IP revision submitted June 14, 2022)**

Website (Section VI, Subsection H, page 10)

Implementation Strategy

Establish a webpage for all materials relevant to ND and USDOJ SA on the DHHS 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.hhs.nd.gov/us-department-justice-settlement-agreement **(Completed June 14, 2020)**

SA Section VII. Case Management

Responsible Division(s)

DHHS 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. (**Completed January 1, 2020)**

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. **(Completed December 31, 2021 and ongoing)**

Progress Report:

Performance Measure(s)

Percent of HCBS Case Managers trained in the standard curriculum.

- One hundred percent (100%) of HCBS case managers completed the standard curriculum as required. New case management staff have three (3) months from the hire date to finish the training.

Percent of HCBS Case Managers trained to cultural sensitivity.

- Sixty-two (62) of the sixty-six (66) HCBS Case Managers (94%) completed the most recent training on November 28, 2022. The remaining four (6%) Case Managers need to complete the training and the modules will be assigned. Three additional trainings on cultural sensitivity have been previously provided to Aging Services staff,

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

- Aging and Adult Services has partnered with NCAPPS, HSRI, and Charting the LifeCourse and developed the key competencies for person centered planning including cultural awareness. The development of the curriculum and evaluations are in development.

Environmental Racism with Dr. Warne November 28, 2022				
Question 1: I am knowledgeable about the impact US land policy has on American Indian health disparities.				
	Very Knowledgeable	Somewhat Knowledgeable	Neutral	Very Little Knowledge
Pre	4%	54%	24%	18%
Post	85%	14%	0%	1%
Question 2: I can describe environmental justice or environmental racism.				
	Very Knowledgeable	Somewhat Knowledgeable	Neutral	Very Little Knowledge
Pre	4%	48%	30%	18%
Post	64%	35%	0%	1%
Question 3: I can specify at least two examples of how U.S. historical naming of lands and sport mascots illustrates cultural incompetence.				

	Very Knowledgeable	Somewhat Knowledgeable	Neutral	Very Little Knowledge
Pre	11%	52%	25%	12%
Post	85%	14%	0%	1%

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 DHHS 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.

Progress Report:

Performance Measure(s)

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

- The number of intake referrals received by case management from the ADRL is 864.

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

- The average number of days to assign a case manager to a referral from June – November 2022 is 1.5 days.

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

- The percent of case management referrals responded to within five days from June – November 2022 is 100%.

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

- There are 66 HCBS Case Managers and 100% have been trained on the new case management system.

Strategy 4. The State implemented an LTSS Options Counseling (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. The name of the

visits has been changed to LTSS Options Counseling as it is a better way to describe the intent of the visits.

LTSS Option Counseling (informed choice) visits are being conducted by 10 LTSS Options Counselors. The ND NF LoC tool has been updated to include questions to identify TPMs. The provision of information about HCBS should be available to everyone. Starting June 14, 2022, the State is conducting LTSS Options Counseling (informed choice) visits with all TPMs to assure that the State meets the provisions of the SA. **(Completed June 14, 2022 and ongoing)**

Progress Report:

Performance Measure(s)

Number of LTSS Options Counseling (informed choice) referrals.

- 1,313 LTSS Options Counseling (informed choice) referrals were sent to the HCBS case management territories from June 14, 2022 – December 13, 2022. 1,170 TPMs accepted visits, 90 individuals referred did not meet the TPM criteria, nine (9) TPMs were unable to be located, 44 were deceased.

Number of TPMs referred through LTSS Options Counseling to transition services through MFP.

- Seventy-six (76) TPMs were referred through the LTSS Options Counseling (informed choice) process to MFP transition services. To date, eighteen 18 of the 76 referrals have successfully transitioned to the community. Five (5) are no longer in the transition process because of personal choice or death. The other 53 are still actively participating in the transition process.

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

CM Territory #	# NF LoC
Territory 1	135
Territory 2	155
Territory 3	50
Territory 4	190
Territory 5	275
Territory 6	120
Territory 7	264
Territory 8	124
Total	**1, 313**

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. Education was provided in November 2022 and was targeted at hospital, nursing home staff who work with discharge planning. **(Completed December 14, 2022 and ongoing)**

Progress Report:

The ADRL social media campaign was run again in August of 2022. The digital campaign view through rate was 74.25%, substantially higher than the typical 15% view through rate of similar advertising campaigns. The social media campaign resulted in 2,315 viewers taking action and following the link to learn more. In addition, Aging Services staff presented information and had booths at various community events to raise awareness about HCBS.

Performance Measure(s)

Number of ADRL contacts per month.

- A total of 23,101 ADRL contacts (calls 8,009, 664 web intake, unique web hits 14,428) were made between June 14, 2022 – December 13, 2022, for an average of 3,850 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. **(Completed January 1, 2023)**

Progress Report:

The Governor's 2023-2025 Executive Budget Request includes a request for 10 additional HCBS Case Managers, one Aging generalist and two service navigators

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.

Progress Report:

Performance Measure(s)

Number of HCBS Case Managers hired by Tribal nations.

- Standing Rock Sioux Tribe has a position which is currently vacant. There is no contract at this time, however MFP- Tribal Initiative funds remain available to enter into a contract.

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. **(Completed August 1, 2022)**

Progress Report:

Case Managers began using Therap in January of 2021 to create provider service authorizations necessary for claims billing and electronic visit verification (EVV). The Therap case management system is currently used to receive referrals from the ADRL, store client demographics, complete HCBS participant assessments, caregiver assessment, SPED financial assessment, the vision tool and case notes. The risk assessment and LTSS Options Counseling (informed choice) referral forms for long-term care were recently added. The system is also used for critical incident reporting and for complaints. The full implementation of the case management system was complete when the person-centered plan was added to the system on August 1, 2022.

Case Managers keep track of their time in the State's workforce system. They track billable case management time and administrative tasks like training etc. Nearly 78% of the Case Managers' time is spent on actual case management tasks. Less than 23% of case management time is spent on administrative tasks. The case management system was not fully implemented until August 1, 2022 therefore, the information below reflects case management time based on the case management process at that time.

Performance Measure(s)

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

- There has been a 2% reduction in the amount of time spent on administrative tasks.

CM Workforce Data	Reporting Period	6.22-12.22
Project	**Sum Of Hours**	**% Of Hours**
HCBS Admin	11,624.84	22.26%
HCBS CM	40,604.78	77.74%
Grand Total	**52,229.62**	**100.00%**

CM Workforce Data	Reporting period	12.21 – 06.22
Project	**Sum of Hours**	**% Of Hours**
HCBS Admin	12,927.30	24.28%
HCBS CM	40,306.93	75.72%
Grand Total	**53,234.23**	**100.00%**

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. **(Completed July 1, 2022)**

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 DHHS. This includes utilizing new federal funding opportunities to more quickly build the capacity to assign a HCBS Case Manager to all TPMs as required. **(Recommendations completed July 2022**)

Progress Report:

Performance Measure(s)

Number and percent of LTSS Options Counseling visits made to Medicaid consumers residing in SNFs.

- There are 2,367 current Medicaid recipients residing in SNFs. There were

469 **unduplicated** initial individual in-reach visits, and 726 LTSS Options Counseling visits were completed. In addition, 38 annual in reach visits conducted by Developmental Disabilities Program Managers (DDPMs), were completed during this reporting period. Through this process 48% of all Medicaid recipients residing in SNFs have received an individual in-reach visit. The State will continue to provide these visits as they are an effective way to educate TPMs on their right to learn about and apply for HCBS.

Number of TPMs assigned to a HCBS Case Manager.

- There is a total of 740 TPMs living in the community that are receiving HCBS that were assigned to an HCBS Case Manager during this period.

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

- No TPMs have refused case management services. HCBS recipients must have a Case Manager as part of the PCP process. TPMs who reside in a SNF receive case management from an LTSS Options Counselor who has been assigned to the facility to provide case management.

  If a TPM chooses not to participate in a conversation and complete LTSS options counseling questionnaire, they are still provided information and contact information for the LTSS Options Counselor. All TPMs will be seen at least annually around the time of their annual NF LoC redetermination.

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-re ach 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 LTSS Options Counseling (informed choice) visit. **(As of June 14, 2022, the state no longer targets which TPMs to visit. All TPMs residing in the SNF are seen by a LTSS Options Counselor.)**

Progress Report:

The LTSS Options Counselors provide information and case management to TPMs currently residing in the SNF. Staff were assigned to be the Case Manager by facility, rather than by individual, so they can spend enough time in each facility to build trust and relationships with residents, facility staff and families. Positive working relationships between the SNFs and HCBS will result in better discharge planning and transition outcomes for TPMs.

If a TPM in a SNF indicates they are interested in learning more about HCBS LTSS they

are referred to MFP and are assigned a Transition Coordinator. The Transition Coordinator meets with the individual and discusses the transition process and options for LTSS. If the individual is interested in receiving services, they are moved through the transition process according to their needs.

Performance Measure(s)

Average number of days from assignment of a HCBS Case Manager to first contact.

- The average number of days from assignment of a HCBS Case Manager to first contact is 2.5 business days for TPMs living in the community. Referrals for HCBS have stayed consistently high throughout the first two (2) years of the settlement agreement. The average number of actual cases per HCBS case Manager is 58 with a weighted score of 117.The State is requesting additional FTE to address in the Executive budget request to address this issue.

- A process has been set up to produce a monthly list of SNF TPMs by their annual NF LOC determination month. The LTSS Options Counselors use this list to organize and plan the visit to each facility.

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 began June 14, 2021)**

Progress Report:

There are several strategies throughout the implementation plan that describe the States effort to increase case management capacity. A request for 10 additional case management FTEs was included in the Aging Services proposal for the Department's 2023-2025 Executive budget request.

HCBS Case Managers can currently provide all necessary case management services listed in a member's Person Centered Plan (PCP). This includes meeting face-to-face with TPMs (if current public health restrictions allow) to discuss community-based service options, as dictated by individual needs, and completing Person Centered Planning when the person is identified as a TPM.

Performance Measure(s)

Average weighted caseload per Case Manager (June 2022).

- The average caseload of an HCBS case manager is 58 with an average weighted caseload of 117. The goal is to increase HCBS case management capacity to lower the average weighted caseload per case manager to 100.

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

- See CM workforce data chart in Section VII.A.7.

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. **(Completed May 1, 2021)**

Remediation

The State submitted a request and received approval to use MFP capacity building funds to hire five (5) staff to conduct LTSS Options Counseling (informed choice) referral visits so that the HCBS Case Managers have increased 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**. (Completed October 1, 2021)**

In addition, the State reviewed 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.

Progress Report:

There are currently 10 staff employed to provide LTSS Options Counseling at all SFNs and hospitals. These staff were moved from temporary staff to permanent FTE positions on October 31, 2022.

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 DHHS promulgated an administrative rule that describes the powers and duties of public and private entities as it relates to the LTSS Options Counseling (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. **(Completed 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 DHHS Medical Services Program Integrity unit which may result in the termination of provider enrollment status.

Progress Report:

No SNFs denied access to the facility during this reporting period. Some facilities, families and guardians have asked questions about the State's right to discuss community-based options with their relatives. In response the State continues to provide a 'Frequently Asked Questions' document to assist the LTSS Options Counselors and the MFP Transition Coordinators in explaining an individual's right to visitors, right to participate in care planning and to understand their treatment options. This document was shared with the SNF and Aging Services staff. In addition, with the permission of the TPM the State has included facility staff in the LTSS Option Counseling visits so they can see the process first-hand. This practice has proven to be an effective way to overcome any misconceptions or inaccurate assumptions about the LTSS-OC process on the part of facility staff.

Performance Measure(s)

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

- None

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

- None

Number of investigations initiated due to denial of access.

- None

Strategy 2. Conduct training with hospital and SNF staff to discuss the LTSS Options Counseling (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 LTSS Options Counseling (informed choice) process that will be made during the time this IP in effect.

Remediation

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

Progress Report:

Performance Measure(s)

Number of SNF and hospital staff trained on LTSS Options Counseling (informed choice) process.

- There were two (2) virtual meetings conducted:
  - November 18, 2022. There were 87 people in attendance.
  - November 30, 2022. There were 92 people in attendance.
  - The meetings were targeted toward hospital and nursing home discharge planners.

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

Progress Report:

Performance Measure(s)

Number and percent of LTSS Options Counseling (informed choice) visits conducted in-person.

- A total of 578 visits were conducted during this 6-month reporting period.
- There 557 visits were conducted in-person.
- There were 21 conducted virtually or via telephone

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. **(Completed date August 1, 2022)**

Progress Report:

Performance Measure(s)

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

- 134 state or contracted staff have access to Therap. This includes Aging Services case management, ADRL intake, Community Service Coordinators, LTSS Options Counseling, VAPS investigators, Housing Facilitators and Transition Coordinators. On August 1, 2022, the approved PCP was made available in Therap to all Aging field staff and the CIL Transition Coordinators.

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. **(Completed January 1, 2020)**

Progress Report:

The State is continuously looking for ways to simplify and improve the case management process to best serve TPMs. The State is working with the case management vendor to create better workflows in the system. The State is considering several options to increase capacity to serve TPMs which include finding an alternate way to provide basic care case management, designating specific staff to determine eligibility, and manage pending cases. **(Ongoing strategy)**

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/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. **(Completed January 1, 2022. Reviews are done annually)**

Progress Report:

Performance Measure(s)

State produces an individual audit summary report and will compile the data into an annual report.

- All audits are completed by December 31st of each year. The current auditing process includes the review of the information listed in Strategy 2. The 2022 audit report was completed January 31, 2023. The report indicates the type of errors, and each Case Manager is trained individually. Twice per year, State staff meet with each case

management territory to review all errors.

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)

DHHS 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. **(Completed date August 1, 2022)**

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 DHHS Aging Services Division staff. This series will be expanded to include a session on conflict resolution. **(Completed January 31, 2022 training on-going)**

Progress Report:

The new case management system was completed when the person-centered planning tool that meets all Settlement Agreement requirements was added to Therap on August 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, and January 31, 2022.

- All Case Managers hired before August 2022 have completed the

Charting the LifeCourse series. The series is offered every six (6) months for those individuals hired after August 2022. Case Managers have 12-months to finish the series. Accommodations are made if a new staff person starts right after a new training cycle begins. The modules require completing the coursework and participating in a required facilitated discussion. The online learning training management system tracks course progress for each team member.

- Aging and Adult Services has partnered with NCAPPS, HSRI, and Charting the LifeCourse and developed the key competencies for person centered planning including cultural awareness. The development of the curriculum and evaluations are in development. **(Target completion date August 2023)**

- Training was provided to Aging Services staff on December 7, 2022 for the Business Intelligence tools that are available in the new case management system.

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

- There is a total of 740 unduplicated TPMs receiving HCBS in the most integrated setting. This number includes new and open TPMs during this reporting period. The approved PCP was implemented effective March 1, 2022. On that date all Case Managers were required to use the new form at their next PCP meeting scheduled with each TPM.

    - Seven hundred sixteen (716) of the 740 TPMs (97%) have an approved SFN 1265 PCP and SFN 1267 Risk Assessment Health and Safety Plan.
    - The other 24 have a plan but it is not the approved PCP that meets all DOJ SA requirements. They were in the TPM's cases that were closed before the new care plan was required so the do not have a new plan, but they were open during the reporting period.

Number of HCBS Case Managers who meet core person-centered competencies.

- A group was assembled in September 2022 through a partnership with Aging and Adult Services has partnered with NCAPPS, HSRI, and Charting the LifeCourse and developed the key competencies for person centered planning including cultural awareness. The development of the curriculum and evaluations are in development. **(Target completion date August 2023)**

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 a TPM goes to the hospital or SNF and remains available and accessible in the new system when the TPM returns to the community. **(Completed date August 1, 2022)**

Progress Report:

The benchmark to complete 290 PCPs was not met for Year 1 of the SA. The State has agreed to "make up" the required 290 PCPs during the second year of the SA in addition to producing an additional 290 PCPs with TPMs. The State has met this benchmark. State and contracted staff have completed 1,463 PCPs with TPMs using the approved planning tools and 764 (726 LTSS Options Counseling and 38 DDPM) of them were completed with TPMs currently residing in a nursing home

The electronic PCP that meets all the SA PCP requirements has been created in the case management system. State staff were trained and began using the electronic version of the PCP August 1, 2022.

Performance Measure(s)

Number of new PCPs completed by the HCBS Case Manager per month.

- There were 132 total PCPs developed for new TPMs.
    - June 14 – 30, 2022 – 7
    - July – 22
    - August – 25
    - September – 28
    - October – 22
    - November – 18
    - December 1 – 13, 2022 - 10

Number of PCP updated every six months as required.

- The State does not have the ability to differentiate between six month or annual assessments in the case management system. Therefore, twice per year the State will complete a review of all case files in the case management system to ensure that all required paperwork is complete. This includes making sure the PCPs are up to date. The State will have data to report once the first semiannual review is complete.

Strategy 2. Update current policy that states if the TPM enters a SNF and services are not used for at least 30 days, the case should close unless prior approval is received. After discharge, a TPM must submit another application and reapply 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 **(Completed July 1, 2021)**

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. **(Completed September 23, 2021)**

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 DHHS 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. **(Completed 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. **(Completed January 1, 2022)**

Progress Report:

A Medicaid Waiver amendment was approved effective January 1, 2022. The administrative code update is also complete. Policy has been updated to ensure that natural supports are not required to provide services to HCBS individuals. Training on the Waiver amendment was held on January 24, 2022, and the policy became effective February 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. **(Completed July 1, 2022)**

Progress Report:

Performance Measure(s)

Number of PCPs completed per month.

- Fully compliant PCPs per month for all HCBS individuals (TPMs and all other HCBS recipients):
    - PCP are considered complaint if they contain required information and were created using the approved PCP form or the PCP in the Case Management system.

    - June 14 – June 30 – 57
    - July – 480
    - August – 456
    - September – 472
    - October – 441
    - November – 472
    - December 1 – December 13 – 364

- Fully compliant PCPs by month for TPMs only:
    - June 14 – June 30 – 14
    - July – 136
    - August – 108
    - September – 124
    - October – 130
    - November – 221
    - December 1 – December 13 – 99

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

- 100% of the current PCPs are reviewed and approved by the State. The State has determined that after March 1, 2022, all plans meet the current State and federal requirements for a PCP and the requirements in the SA Section VIII. C. (1-8)

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. **(Completed March 1, 2022)**

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.

Progress Report:

Performance Measure(s)

Number of PCPs completed per month.

- See response under Section VIII.B & C.5.

Percent of PCPs completed within required timeframe

- There is not a current measurement for data regarding the number of PCPs for TPMs completed within the required timeframe. Starting in March 2023 a semi-annal audit of all HABS recipients will include a requirement to review whether PCPs were completed during the required timeframe.
- The State is also working with the case management vendor to add a TPM indicator field to the PCP. This will allow the State to better track data specific to TPMs **(Target Completion Date October 1, 2023)**

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

- See response under Section VIII.B&C.5.

Conflict Resolution (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. **(Completed April 1, 2022, ongoing**)

Progress Report:

Staff from the Charting the LifeCourse provided training on conflict resolution on January 10 and 20, 2022. As part of the onboarding process, every six (6) months we will offer and require all new workers to participate in conflict resolution training. New

workers have 12 months to complete the ten (10) hour training services that includes the required HCBS case manager conflict resolution training. In addition, team members engage in inter- and intra-agency discussions to help resolve areas of conflict and work with family members, guardians, facility staff, and the TPM to resolve conflicts around identified barriers to living in the most integrated setting.

New HCBS Case Managers are also provided training on how to complete the risk assessment shortly after their start date. This training includes also includes information on how to address conflict when creating a plan to address risk.

Performance Measure(s)

Number and percent of TPMs that request a second opinion.

- No TPMs have requested 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 DHHS Legal Advisory Unit and other agencies or boards to determine if a request for reasonable modification can be accommodated as required in the SA. HCBS policy will be updated to determine how requests for reasonable modification may submitted for review and reconsidered. **(Completed February 1, 2022)**

Progress Report:

Performance Measure(s)

Number and percentage of HCBS Case Managers trained on reasonable modification.

- Sixty-four (64) of the 66 (98%) current Case Managers attended the training provided by the Legal Advisory Unit on September 19 and 29, 2022 or watched the recorded version.
- The training was made available as an online course in December 2022 and the two remaining staff are enrolled to complete the course.

Number of HCBS Case Managers after receiving training who showed increased

understanding of reasonable modification requirements under the ADA.

- At the beginning of the live training, 60% of the group were accurate in understanding basic reasonable modification requests. At completion of the live training 80% of the group had an accurate understanding of more complex reasonable modification requests. The State will continue to provide education on this subject to ensure all staff understand the reasonable modification requirements.

Number of stakeholders provided education about reasonable modification.

- Reasonable modifications were discussed at the ND DOJ Stakeholder meeting held on June 9, 2022, with 55 stakeholders in attendance. **(Completed June 9, 2022**.)

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

- A total of 29 requests were received, 24 were approved and five (5) were denied.

Reasonable Modifications			
Month/Year Request	**Accommodation Type**	**Approved**	**Denied**
June 14, 2022 – June 30, 2022	Requested chore for pet care. Not a covered service and would not reduce risk of institutional placement		1
	Request not an available service		1
	Permitted overnight staff for supervision to sleep because of individual’s intermittent need.	1	
July 2022	Request would not reduce risk of institutional placement/exceeds cap of services		1
	Service combination	3	
	Nursing tasks	2	
August 2022	Environmental Mod over 20% value of the home		1
	Requested chore for pet care. Not a covered service and would not reduce risk of institutional placement		1
	Nursing tasks	2	
	Service combination	1	
September 2022	Service Provider Accommodation	2	
	Nursing	4	
October 2022	Nursing tasks	5	

November 2022	Nursing tasks	2	
	Service combination	1	
	Exceed the monthly cap	1	
Dec 1, 2022 – Dec 13, 2022		0	
Totals		**24**	**5**

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 began June 1, 2021)**

Progress Report:

Performance Measure(s)

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

- No transition plans identified a setting other than the TPM's home, family home, apartment, or foster home.

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 DHHS Aging Services Division staff. The entity will also be also 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.

Moving toward developing a sustainable training and staff development program that combines instructional and experiential learning as a part of initial onboarding, ongoing professional development, and performance management practices to support the core competencies of all Adult and Aging Services division staff and providers.
(Updated target completion date ~~December 31, 2022~~ December 31, 2023 and ongoing)

Progress Report:

Performance Measure(s)

Number and percent of HCBS Case Managers trained on person-centered planning practices.

- All 66 Case Managers (100%) have completed the series of trainings to include the five person-centered planning domains of:

  - strengths-based, culturally informed, whole person focused;
  - cultivating connections inside the system and out;
  - rights, choice, and control;
  - partnership, teamwork, communication, and facilitation;
  - documentation, implementation, and monitoring.

  The series includes training on and working within the Charting the LifeCourse framework, training on cultural diversity, training on services and programs within DHHS along with training on LTSS that are offered through other stakeholders.

  Any new staff who onboarded after August 2022 will be required to complete the Charting the Lifecourse foundational series within their first 12 months of employment. The course is offered every 6 months to accommodate new hires.

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

- The State is currently working with the Administration for Community Living (ACL)/CMS technical assistance opportunity administered by the **National Center on Advancing Person-Centered Practices and Systems** (NCAPPS) to develop core competencies for staff. The team is working on developing a skill building training process and standard performance measures.

- Adult and Aging Services has selected state specific questions for the National Core Indicators – Aging and Disability (NCI-AD) survey that are reflective of person-centered competencies that have been established for Aging Services staff. This will allow for TPMs to report their experience with person-centered planning.

Number of HCBS Case Managers who meet core person-centered planning competencies.

- See response above.

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 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.

The State experienced unanticipated delays in the vendor's development and finalization of a Person-Centered Plan form that is fully compliant with the requirements of the Settlement Agreement within the web-based case management system. The State has responded to this challenge with the creation of State forms, to be used in the interim, to meet these requirements. The forms were developed and finalized in February 2022.

The State has provided a sample of new PCPs to the USDOJ and the SME for their review to ensure this benchmark is met for SA Year 1 and Year 2 by December 14, 2022. An electronic version of the approved PCP was created in the State's case management system and finalized on August 1, 2022.

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)**

Progress Report:

> ND was notified on September 16, 2021, that ND DHHS has been selected to receive an additional two years of NCAPPS technical assistance. This extends the assistance through September 30, 2023. ND has modified the contract with HSRI in August of 2021 to add the MFP Capacity Building Funds needed to fund the ongoing person-centered planning technical assistance for Aging Services from October 1, 2021 – September 30, 2025.

In September 2022, an in-person group comprised of staff from every area of Aging Services met and developed competencies that were based on the five (5) person-centered competencies that were created by NCAAPS.

The State's goal is to develop a sustainable training and staff development program that combines instructional and experiential learning as a part of initial onboarding, and ongoing professional development and performance management practices to support the core competencies of case managers (and similar roles) for all Aging Services Division programs **(Target completion date August 31, 2023)**

The MFP Capacity Fund will continue to fund this project.

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. **(Completed December 14, 2021)**

Progress Report:

Performance Measure(s)

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

- A total of 346 approved PCPs were completed with TPMs living in the community during the previous reporting period (December 14, 2021 – June 13, 2022) and 718 approved PCPs have been completed with TPMs living in the community during this reporting period (June 14, 2022 – December 13, 2022. That is a total of 1,064 approved PCPs completed to TPMs living in the community in Year 2 (December 14, 2021 – December 13, 2022). The TPMs referenced here may have already been receiving services or were newly enrolled in HCBS.

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

- A total of 64 transition PCPs have been completed with individuals in SNF.
- LTSS Options Counselors completed 726 PCPs and risk assessments with TPMs residing in an SNF between June 14, 2022 – December 13, 2022.
- Developmental Disabilities Program Managers completed 38 PCPs and risk assessments with TPMs residing in an SNF between June 14, 2022 – December 13, 2022.

Number of targeted in-reach visits conducted.

- In-reach presentations were conducted in all 74 facilities between June and December 2022. The group informational sessions were attended by 952 residents, staff, family members, and the public.

Strategy 3. Conduct targeted in-reach to TPMs. To help identify TPMs residing in a SNF, the MFP transition coordinators and DHHS Aging Services Division staff who complete LTSS Options Counseling (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.

Progress Report:

See information reported under Strategy 2 above.

Performance Measure(s)

Number of targeted in-reach visits conducted.

- In-reach presentations were conducted in all 74 facilities between June and December 2022. The group informational sessions were attended by 952 residents, staff, family members, and the public.

Number of TPMs in SNF referred to MFP.

- A total of 111 TPMs in SNFs were referred to MFP during the reporting period.

Number of HCBS Case Managers assigned to TPMs in SNF.

- Ten (10) LTSS Options Counselors have been assigned as Case Managers to each SNF. They are responsible for providing required information to TPMs.

- A MFP Transition Coordinator and HCBS Case Manager were assigned to 77 TPMs that living in the SNF that and referred to MFP during this reporting period.

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

- 100% of individuals with a housing barrier were assigned to Housing Staff, 27 individuals were assisted during this reporting period.

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. **(Ongoing strategy)**

Progress Report:

- Ensure that the Peer Support Resource Center referenced in the Partnering Equitably with Communities to Promote Person-Centered Thinking, Planning, and Practice document provides opportunity for culturally specific peer supports to the greatest extent possible.

    - The Peer Support Center has not yet been developed. Internal meetings have been held to identify the requirements of a potential request for proposal to secure a provider of this service.

- Holding HCBS Community Conversations in all Native American reservation communities in ND.

    - The State is working with the Department of Health, Office of Heath Equity tribal liaisons to schedule community conversations in conjunction with other events being held on the reservation. The State developed a one page written document that explains the purpose of the community conversations and discussed the need to better engage with tribal communities at the Medicaid tribal consultation meeting. Stakeholders at that meeting suggested that we work with the UND Native American Resource Center staff to design meaningful public input meeting on each reservation. **(Target Completion date November 1, 2023)**

- Including representation from Native American and New American communities on all workgroups described in the IP.

    - Each of the tribal nations are sent an invite to all stakeholder meetings. The State has reached out to Health Equity staff assigned to each tribal nation to brainstorm ways to engage this stakeholder group.

- Providing cultural sensitivity training created by local subject matter experts to all HCBS Case Managers. The State is committed to continuing to provide cultural sensitivity training to all staff.

    - Sixty-two (62) of the 66 HCBS Case Managers (94%) completed the cultural awareness training on November 28, 2022. The remaining four need to complete the training and the modules will be assigned. See response under Section VII.A.2.

- Ensuring access to interpretive services and translating informational materials into other languages.

    - The QSP Hub and the University of North Dakota are currently in the middle of entering into a contract with a translation and interpretation

service to help provide more meaningful technical assistance to non-English speaking QSPs. This should be effective shortly after the new year and will be promoted.

- 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.

    - Standing Rock Sioux Tribe has MFP tribal initiative funds available to hire a Case Manager for HCBS, the position is currently vacant. No contract is in place at this time however, funding remains available should a contract emerge.

    - Turtle Mountain's new hire is training with Adult and Aging Services staff on Case Management.

    - MFP funds remain available for any Tribal Nation that is interested in pursuing HCBS services through MFP-Tribal Initiative

SA Section IX. Access to Community-Based Services

Responsible Division(s)

DHHS 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. **(Completed November 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 updated date ~~September 30, 2022~~ May 2023, Recommendations developed and reported ~~December 31, 2022~~ June 30,2023)**

Progress Report:

Performance Measure(s)

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

- 100% of the contingency plans incorporated into the current PCPs have been audited by State staff. HCBS Program Administrators review and approve all PCPs.

QSP Resource Hub (Section IX, Subsections D, page 14)

Implementation Strategy

Strategy 1. The State requested and received approval to use MFP capacity building funds to establish a QSP Resource Hub to assist TPMs who choose their own individual QSPs to successfully recruit, manage, supervise, and retain QSPs. The QSP Resource Hub 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)**

Progress Report:

On December 1, 2021, the State contracted with the Center for Rural Health at UND School of Medicine to develop the resource and training center which will be commonly known as the QSP Resource Hub. The State and UND staff meet bi-weekly to discuss progress on the contract requirements and emerging issues. The QSP Resource Hub staff completed an agency and individual QSP survey and are in the process of developing a QSP orientation curriculum that can be used for individuals considering becoming a QSP or for those newly enrolled as a QSP. The QSP Hub is also responsible for developing a strategic plan and recruitment and retention strategies for QSPs.

Performance Measure(s)

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

- The QSP Hub provides resources, contact information, and direct help finding answers for individuals who self-direct regarding problems their providers may be having with enrollment and billing. During this reporting period, three (3) contacts to the QSP Hub have been from individuals who self-direct. Data indicated that these individuals, have

called to advocate on behalf of the QSP that supports them. Specific areas included concerns about why their QSP had not been paid and application status inquiry. All calls and emails that come into the QSP Hub are tracked using the Center for Rural Health's data tracking system. Information about the call, program & goals, length of call, as well as other content areas are tracked.

- The State will work with the QSP Hub to develop strategies to inform individuals that self-direct their care about the services offered by the QSP Hub. **(Targeted Completion date June 30, 2023)**

Number of QSPs who received enrollment assistance.

- During this reporting period, of the 322 individual QSPs that contacted the QSP Hub for assistance, 137 needed support with enrollment. Enrollment support included:
    - providing an overview of the enrollment process
    - emailing and mailing QSP handbooks/packets
    - answering questions on errors
    - fixing forms that were not submitted correctly, and
    - completing the entire application process together with the QSP. Support with the NPI registration, Fraud Waste and Abuse training, and the SFN 583 are frequently supported.
- There were 54 agency contacts, 31 required enrollment support.

These are unduplicated numbers and indicated only initial contacts regarding enrollment, not ongoing enrollment support.

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. **(Completed February 1, 2022)**

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. **(Completed February 1, 2022)**

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.

Progress Report:

Performance Measure(s)

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

- All 740 TPM's have been educated on their right to appeal initially and annually with the Rights and Responsibilities Brochure. Case Managers discuss the Rights & Responsibility Brochure with the TPM and the TPM signs an acknowledgement of receiving ad discussing the rights to appeal. Additionally, the TPM signs an Application for HCBS services initially and the PCP initially, annually and every six (6) months which all outline the individual's 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. **(Completed February 1, 2022)**

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. **(Completed May 31, 2022)** The State will work with the MFP data analyst to better define these numbers and draw meaningful conclusions from the available data.

Progress Report:

Performance Measure(s)

Number of service units authorized and utilized by territory.

- Link to Appendix E

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

Implementation Strategy

Strategy 1. The State will work with the DHHS 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 be submitted for review and reconsidered. **(Completed February 1, 2022)**

Progress Report:

Performance Measure(s)

- The State created a template for the Case Managers to use to submit reasonable modification requests. The template includes all the information that is necessary to make a timely determination.

Number of stakeholders provided education about reasonable modification.

- Reasonable modifications were discussed at the ND DOJ Stakeholder meeting held on June 9, 2022, with 55 stakeholders in attendance. Case Managers talk with the HCBS recipients about their right to request a reasonable modification of policy. Case Managers are also required to ask for modification on the individual's behalf.

Number of reasonable modification requests received and outcome.

- See reasonable modification chart in Section VIII.F.1.

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. **(Recommendations completed December 2022**)

Progress Report:

A meeting was held on January 6, 2023, with staff from the Board of Nursing, to review the most recent nursing related accommodations that have been approved. No changes to policy are necessary. Recommendations were discussed regarding an on-call nursing agency to assist as a resource to QSPs and QSP agencies. The ND Board of Nursing recommended that agency QSPs have a nurse or RN contracted or employed to assist with any health care accommodations being made.

The State included a request for funds in the Executive Budget Request to pay QSP agencies to have staff on call after normal business hours. If the funds are received, we will work with QSP agencies that employ nurses to offer this service to TPMs.

TPMs who are receive MFP transition services already have access to an on-call

nurse 24-hours per day. The contracted nursing agency is also required to periodically call TPMs who have successfully transitioned to the community to see if they have any questions or concerns and to ensure their medical needs being met.

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. **(Completed December 14, 2021)**

Progress Report:

Performance Measure(s)

Number of TPMs receiving extended personal care.

- Currently there are 64 TPMs using Extended Personal Care Services, 19 receiving SPED, and 42 on HCBS Medicaid 1915(c) waiver.

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. **(Completed February 1, 2022)**

Progress Report:

Performance Measure(s)

Number of requests for reasonable modification and outcome.

- See reasonable modification chart in Section VIII.F.1.

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 DHHS Divisions that administer HCBS. Strategies to address identified issues will be established and included in future revisions of the IP. **(Completed February 1, 2022)**

Progress Report:

Reasonable modification requests are being tracked and the State will be setting up a separate meeting to provide adequate time to discuss this topic.

Performance Measure(s)

Number of requests for reasonable modification and outcome.

- See reasonable modification chart in Section VIII.F.1.

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.

Updated Strategy 1. Continue to 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 are required to inform TPMs that they can help them file an appeal during the person-centered planning meetings. **(Ongoing strategy)**

- This information is provided in the Person-Centered Plan, the application, and the Rights and Responsibilities form.

Strategy 2. Continue to educate TPMs who are already receiving services on their right to appeal any decision to deny/terminate/reduce HCBS using the updated “HCBS Rights and Responsibilities” brochure. HCBS Case Managers are required to inform TPMs that they can help them file an appeal during the person-centered planning meetings. **(Ongoing strategy)**

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.

- See update under Section IX.E.2.

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. **(Completed January 1, 2020)**

Progress Report:

Performance Measure(s)

Number of QSPs successfully enrolled to provide services.

- Fifteen (15) QSPs are successfully enrolled to provide residential

habilitation and/or community support services since the service was added to the HCBS waiver.

- Since companionship was added to the HCBS waiver we have also seen an increase in the number of QSPs who have enrolled to provide this service. One-hundred and sixty-seven (167) QSPs are enrolled to provide companionship services.

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

Progress Report:

Performance Measure(s)

Number of TPMs served in the SPED program.

- A total of 123 TPMs are served through SPED during this reporting period.

Percent increase in SPED recipients.

- A total of 96 TPMs were served under SPED in the last reporting period, (December 14, 2021 – June 13, 2022). The number of TPMs reported during the last reporting period was incorrectly reported at 125 due to a lag in data. This is a 28% increase in TPMs being served under SPED during this reporting period.

Number of individuals who apply for SPED and are denied.

- A total of 66 SPED applications were denied based on applicable State law or administrative code. These numbers reflect all SPED individuals as there is no way to differentiate if individuals are potentially TPMs or not. The denial/termination reasons are as follows:
    - 26 - Functional eligibility
    - 10 - Financial eligibility (100% fee)
    - 9 – Unable to assess/did not cooperate
    - 8 - No action/services pursued
    - 6 - Unable to determine financial eligibility (did not cooperate with financial assessment)
    - 4 - Financial eligibility (over assets)
    - 1 - Health, welfare, safety
    - 1 – One functional eligibility impairment due to DD/MI
    - 1 – Functional eligibility for under 18 population

SA Section X. Information Screening and Diversion

Responsible Division(s)

DHHS Aging Services & Medical Services Divisions

Long Term Services & Supports (LTSS) Options (Informed Choice) Referral Process (Section X, Subsection A, page 15)

Implementation Strategy

Strategy 1. Implement an informed choice referral 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 only provided 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 process changed, and the State began providing the required information to all TPMs as required in the SA.

Progress Report:

MFP funds were used to hire five (5) LTSS Options Counselors (informed choice) staff. Older American Act funding was utilized to hire five (5) additional LTSS Options Counseling staff.

They are responsible for visiting all TPMs in nursing homes and hospitals who are referred for a long term stay in the nursing home as required by the Settlement Agreement.

The 10 LTSS Options Counselors were initially hired as temporary employees and were converted to full-time employees on October 31, 2022.

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.

State staff conduct the visits with all TPMs within 10 business days of the referral. If a TPM chooses to learn more about HCBS options a referral is made to MFP to explore transition options. MFP works with the individual to develop a person-centered team to support the transition process. TPMs are currently asked to indicate in writing whether they received such information.

Progress Report:

Performance Measure(s)

Number of TPMs who received LTSS Options Counseling (informed choice) visits.

- A virtual or in person LTSS Options Counseling (informed choice) visit was conducted with 1,104 unduplicated TPMs.

Number of LTSS Options Counseling (informed choice) visits that resulted in TPM transitioning to a community setting.

- Eighteen (18) LTSS Options Counseling (informed choice) visits resulted in a transition to the most integrated setting during this reporting period.

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

- There were 2,367 Medicaid recipients residing in SNFs and 469 **unduplicated** initial individual in-reach visits, 726 annual in reach visits conducted by LTSS OC, and 38 annual in reach visits conducted by Development Disabilities Program Managers (DDPMs) during this reporting period. Therefore, 48% of all Medicaid recipients residing in SNFs have received an individual in-reach visit.

Number and percentage of LTSS Options Counseling (informed choice) visits where the TPM requested follow up and the follow-up visit occurred.

- There were 23 requests for follow up visits.
    - 14 follow up visits were completed
    - 2 individuals passed away before follow-up was completed
    - 7 TPMs requested a follow-up visit sometime after this reporting period

Remediation

The State partnered with staff from National Center on Advancing Person-centered Practices and Systems to hold an LTSS Options Counseling (informed choice) workgroup meeting and invited TPMs, families, guardians, State staff, tribal representatives, HCBS Case Managers, hospital, and nursing home discharge planners, and other interested stakeholders to participate. The group discussed the current state of this process and developed 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 also addressed 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 reviewed 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 LTSS Options Counseling (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. An attendance poll was taken and a breakdown of who attended is included in Appendix be below. **(Workgroup developed October 1, 2021, Recommendations completed April 1, 2022)**

Progress Report:

- **Completed March 23, 2022.** Link to Appendix B.

The following recommendations were implemented from the workgroup feedback.

- The State made changes to the SFN 892 questionnaire used during LTSS Options Counseling visits (informed choice) that addressed any concerns related to meeting their financial needs in the community.

- The State changed the amount of time allowed for State staff to visit a TPM in the hospital or nursing home from 5 days to 10 days. This will allow for the TPM to adjust to their surroundings before having this important conversation.

- Implemented a two week follow up visit after each SNF group in reach presentation. This will allow a TPM and their family members time to consider the information presented and ask any follow up questions they may have.

- Streamlined the internal communication process to funnel all requests for transition supports to the MFP team. And the State designated the MFP Transition Coordinator as the lead, so the TPM has a primary contact through the transition process.

Performance Measure(s)

Number of TPMs who received LTSS Options Counseling (informed choice) visits.

  - See Strategy 2 in this section.

Number of LTSS Options Counseling (informed choice) visits that resulted in TPM transitioning to a community setting.

  - See Strategy 2 in this section.

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

reach.

- See Strategy 2 in this section.

Number and percentage of LTSS Options Counseling (informed choice) visits where the TPM requested follow up and the follow-up visit occurred.

- See Strategy 2 in this section.

Strategy 3. The current LTSS Options Counseling (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.

Remediation

If a TPM refuses an LTSS Options Counseling (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 LTSS Options Counseling (informed choice) workgroup will develop recommendations to identify strategies to address these issues. **(Workgroup developed October 1, 2021, Recommendations completed April 1, 2022)**

Progress Report:

All TPMs living in SNF receive a visit from the LTSS Options Counselor (informed choice) staff. The worker will provide required information and their contact information. If the individual chooses not to participate in the person-centered planning discussion the worker documents that on the plan and lets them know they can contact the LTSS Options Counselor (informed choice) any time. TPMs are also informed they can expect an annual visit around the time of their annual NF LoC redetermination.

Based on workgroup recommendations the State developed an updated LTSS Options Counseling (informed choice) brochure that helps TPMs, family, guardians and facility staff understand the new annual NF LoC redetermination requirement that began on December 14, 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 LTSS Options Counseling (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 that are identified but are not available in the community, policy was updated to require the HCBS Case Manager to formally request services or submit a reasonable modification request to the State for consideration. This information is incorporated into the PCP. **(Completed January 1, 2021)**

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 DHHS 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. **(Meetings started April 28, 2021)**

Progress Report:

The meetings are now held weekly and allow for cross-divisional interdisciplinary team meetings. Behavioral health, Aging Services, Developmental Disabilities (DD), MFP, and the Human Service centers have been notified of the time slotted for the meetings. If the time slot does not work, arrangements are made to accommodate other interdisciplinary team meetings.

Performance Measure(s)

Number of cases staffed per interdisciplinary team meetings and outcome.

- There were 106 cases staffed from December 14, 2021 – December 13, 2022.

Number of requests for reasonable modification and outcome.

- See reasonable modification chart in Section VIII.F.1.

Strategy 2. The State established a NF LoC workgroup and invited 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 was 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 completed by September 1, 2022)**

Progress Report:

The workgroup recommended that policy be adopted that will allow nursing homes an opportunity to request an extension of a residents current NF LoC screening date if they suspect that an individual (who is due for their annual NF LoC redetermination) will no longer meet the screening criteria. Nursing homes can request an extension of up to 120 days from the MFP Program Administrator to provide sufficient time for a discharge plan to be put in place. If the nursing home is actively working with the transition team, they may request an additional 120-day extension.

No recommendations were made to change the NF LoC criteria. The group felt the current process is working well.

Annual NF LoC redeterminations started December 14, 2022, which was the deadline in the SA for all TPMs. The State held two stakeholder meetings on November 18, (87 people attended) and 30 (92 people attended) 2022 that provided training and gathered input from the broader group. Attendance included staff from hospitals, nursing home and State employees.

There is no Strategy 3 in this section it was omitted in error.

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. **(Completed December 14, 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 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.

Progress Report:

- See Progress Report in Strategy 2 above.
- There were 158 NF LoC screenings completed in December 2022 and 216 completed in January 2023. Two requests to extend the NF LoC date were granted for residents who were suspected to no longer screen. All other screenings were approved.

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.

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 revisions.

Progress Report:

- Developing a formal peer support program through the proposed Peer Support Resource Hub 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.
    - State is working with a Project Manager to draft a scope of work and request for proposal to procure a peer support agency through a competitive procurement process. (**Updated Target Completion date ~~December 1, 2022~~ September 1, 2023)**
- 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.
    - The ADRL social media campaign was run again in August of 2022. The digital campaign view through rate was 74.25%, substantially higher than the typical 15% view through rate of similar advertising campaigns. The social media campaign resulted in 2,315 viewers taking action and following the link to learn more.
    - Aging Services community service coordinators participated in fifty-one

outreach (51) events that were held across the State during this reporting period. During the events Aging staff provided information via presentations and information booths about HCBS and the mission of Aging Services. It is estimated that over 800 people attended these events.

  - The success of the social media campaigns speaks to the need and interest around HCBS designed for older adults and adults with physical disability. Everyone who lives long enough, may eventually have a need for care themselves or will know someone who will. This fact increases the challenge of having sufficient services and providers ready to meet the needs of this growing population.

- 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 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.

  - The State and the vendor worked to develop a process that is working well. A monthly NF LoC annual redetermination report has been created and is sent to the SNF and the LTSS Options Counseling (informed choice) staff. State provided trainings with hospital and SNF staff in November 2022.

- 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.

  - The average number of days from assignment of an HCBS Case Manager to first contact is 2.5 business days.

- 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.

  - Since the development of the approved SFN 1265 PCP and SFN 1267 Risk Assessment Health and Safety Plan there is no longer a need for the companion guide. This strategy was removed in the June 2022 IP revision.

SA Section XI. Transition Services

Responsible Division(s)

DHHS 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 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 by February 28, 2022.

Progress Report:

- Dakota CIL (Bismarck) has four full-time MFP Transition Coordinators and one part time assistant coordinator.
- Independence (Minot) has three fulltime and one half-time MFP Transition Coordinators.

- Freedom CIL (Fargo) has two full-time MFP Transition Coordinators and has funds to hire one more.
- Options CIL (East Grand Forks) has two full-time Transition Coordinators and funds to hire two more.

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. **(Completed February 1, 2022)**

Progress Report:

The State issued a request for proposals to provide a second round of QSP incentive grants. Applicants could receive bonus points for agreeing to provide services in high demand like transition supports. Thirty-nine (39) applications were reviewed. Twenty-three (23) grants were awarded in December 2022.

- The QSP Incentive Grants were awarded on December 7, 2022. Grants ranging from $33,910 to $50,000 were awarded to 23 entities. The awards totaled $1,119,883. ARPA 10% Savings funds were used for this project.
- Link to QSP Grant Award Summary

  https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/qsp-grant-award-summary.pdf

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 upon issuing of CMS guidance)**

- The MFP operational protocol has been updated specific to the DOJ SA but not submitted for review. The MFP operational protocol format is being updated by CMS at this time and they are requesting that no operational protocol amendments be submitted until the new requirements are finalized and communicated to MFP Grantees.

Performance Measure(s)

Number of MFP transition coordinators hired to date.

- A total of 12 full-time and part-time transition coordinators have been hired. MFP has budgeted for 14 full-time and one part-time transition coordinators.

Number and total dollar amount of incentive grants awarded.

Twenty-three (23) of the 39 incentive grant applications received were awarded on December 7, 2022. Award amounts varied between $33,910 and $50,000 for a total of $1,119,883. ARPA 10% Savings funds were used for this project.

Link to QSP Grant Award Summary.

The State is meeting with staff from other state MFP programs to discuss best practices and explore ways to improve our current MFP program. Meetings have been held with New Jersey, West Virginia, and Washington. Meetings were also held with staff from Connecticut, Ohio, Texas, and South Dakota.

Progress Report:

The takeaway from these meetings is that most of the states had significantly more administrative staff to assist in with the implementation of the MFP grant. This was true even for states that did not have transition numbers as high as ND. The State also found that our policies and procedures were consistent or more comprehensive than what other states are doing.

As a result, the following staff has been hired to address the capacity necessary to effectively administer MFP.

- Transition Service Specialist
- Referral Specialist
- MFP Data Analyst
- ADRL Referral Specialist
- ADRL Program Administrator

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, to the SME and DOJ, a list of the names of TPMs whose transition has been pending more than 100 days. The report will include a description of the circumstances surrounding the length of the transition. The State currently tracks the days from referral to transition. **(Completed June 14, 2022 and on-going)**

Progress Report:

Performance Measure(s)

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

- There were 63 transitions that have taken longer than 100 days during this reporting period. All were reported to the SME.

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

- Forty-five (45) individuals moved within 120 days or 75% of transitions during this reporting period.

- Fifteen (15) individuals transitioned in over 121 days or 25% of transitions during this reporting period.

- The SA requires that transitions take no more than 120 days after the member chooses to pursue transition to the most integrated setting to avoid unnecessary nursing facility stays. Although the State agrees that this is an appropriate goal for most transitions, some transitions take longer than the 120 days due to the complex needs of the TPM, including health and safety. Rushing transitions can result in unsafe discharge. In some cases, significant and long-standing barriers to transition need to be adequately addressed before a plan is made to move back to the community. For example, TPMs may have an upcoming surgery, or need to learn to use prosthetics before they are ready to transition. If transitions are going to be successful, it is necessary to take the time to develop a solid transition plan that ensures that necessary services and supports are available to ensure the health and safety of the TPM. The State will work with the SME to further address this issue.

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. **(Report submitted by July 31, 2022 and on-going)**

Progress Report:

During the month of May 2022, Aging Services Program Administrators and MFP Staff began meeting monthly to review all pending transitions near, at, or past 90+ days. Information about the transitions and reason for the delay are tracked in a spreadsheet during these meetings, all of which are attended by the MFP Coordinator. This report will be sent to the SME quarterly and discussed at the weekly SME update meetings.

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.

Progress Report:

Performance Measure(s)

Number of transitions supports team members trained on successful strategies. **(Updated Target completion date ~~August 1, 2022~~ March 1, 2023)**

- The formal quarterly meeting to review successful transitions will begin in February 2023. Monthly reviews of all transitions are conducted by regional territory staff and the CIL Transition Coordinators.
- New Transition Coordinators have been provided training two times per month every month. Group training on MFP transition services was also provided.
- The State has a quality assurance process where State staff review all transitions and provides individualized training with team member who may have specific questions or need to work on a skill.

Transition Team (Section XI, Subsection C & D, page 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 LTSS Options Counseling (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 five business days of the original referral an HCBS Case Manager is assigned, and the team must meet within 14 business days to begin to develop a PCP. The MFP 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 year post discharge. The HCBS Case Manager also provides ongoing case management assistance.

Progress Report:

Performance Measure(s)

Track number of transition referrals and timelines for case management

assignment.

- A total of 120 transition referrals were received, and transition coordinators were assigned within five business days for each referral.

Number of successful transitions.

- There were 64 transitions successfully completed with TPMs during this reporting period. There was a total of 121 successful transitions in Year 2. The corrected number of transitions for the first half of Year 2 is 57 and not 62 as previously reported.

- Number of PCPs completed with TPMs in SNF.

  - There were 64 transition plans for TPMs who transitioned during this reporting period.

  - There were 726 PCPs completed by LTSS OC for TPMs residing in a SNF during this reporting period.

  - There were 38 PCPs completed by DDPMs for TPMs residing in a SFN.

Number of in-reach activities conducted.

- The second round of group in-reach presentations began in June 2022.

  - In-reach presentations were conducted in all 74 facilities between June and December 2022. The group informational sessions were attended by 952 residents, staff, family members, and the public.

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. **(Completed January 1, 2021)**

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 LTSS Options Counseling (informed choice) referral visits and conduct facility in-reach to TPMs living in a SNF. **(Ten staff hired by May 2022)**

Progress Report:

There are currently 10 staff employed to provide LTSS Options Counseling at all SFNs and hospitals.

Funds were approved in the 2022 MFP budget to hire additional MFP transition coordinators and transition assistants. One assistant has been hired and coordinates the logistics of the actual move and helps conduct post discharge follow up. **(Completed February 1, 2022)**

Progress Report:

The MFP budget requesting additional funding to hire staff was submitted on February 1, 2022. All the positions were approved in the budget

- The 2022 MFP budget includes the following funds for the following positions:
    - Dakota CIL (Bismarck): 4 Transition Coordinators.
    - Freedom CIL (Fargo): 3 Transition Coordinators.
    - Options CIL (East Grand Forks): 2 Transition Coordinators.
    - Independence (Minot): 2 full-time and 2 (1.5 FTE) part-time Transition Coordinators.

MFP also pays for transition coordination on a fee for service basis for other CIL staff to assist with MFP transition work when necessary. If additional capacity is needed the CILs engage their other independent living specialists to provide MFP or ADRL transition coordination.

Performance Measure(s)

100 unduplicated SNF TPMs successfully transitioned.

- Sixty-four (64) individuals successfully transitioned out of SNFs during this reporting period. There was a total of 121 successful transitions in Year 2. The corrected number of transitions for the first half of Year 2 is 57 and not 62 as previously reported.

100 unduplicated at risk TPMs successfully diverted.

- One hinders sixty-eight (168) individuals were diverted from nursing facility placement during this reporting period. Diversion happens when an individual who screens at a NF LoC and is on Medicaid or at risk of

Medicaid receives the necessary HCBS to prevent their institutional placement.

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

Progress Report:

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. **(Completed August 1, 2022)**

- All aspects of the case management system including the PCP were available in Therap by August 1, 2022.
- The MFP Transition Plan, MFP Assessment and the Risk Assessment/Health and Safety Plan were all in Therap by September 1, 2022.
- By January 31, 2023, all individuals currently in the transition process will have updated documents in Therap.

SA Section XII. Housing Services

Responsible Division(s)

DHHS

Progress Report:

Many of the strategies outlined in Section XII focus on how the State would identify new ways of working together, to assure connections were made between housing and home and community-based service resources. The strategies identified opportunities to gather data that could provide meaningful insight into housing barriers (XII-C-7, XII-D-1); build awareness amongst professionals who work in either housing or HCBS about the “other side of the HCBS” equation (XII-B-1, XII-C-2, XII-D-4, XII-D-7, XII-E-1, XII-F-3); and build real capacity in our state service and support infrastructure to make transitions and diversions much more possible than they were before (XII-B-2, XII-C-1, XII-C-4, XII-D-2, XII-F-2).

Section XII of the Year 1 IP outlines the beginning stages of several related and ongoing efforts that together will strengthen housing resources available to TPMs in North Dakota. To ensure that housing is not a barrier to transition or diversion, we will continue building our collaboration muscle - enhancing communication, building on

partnerships that have been established, and improving training and resources available to people who are working to support TPMs diversions and transitions.

SME 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.

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.

- Progress toward establishing an enhanced 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 and ongoing)**

Progress Report:

Workgroup members come together to discuss cross-agency initiatives that arise throughout the year; work is task-focused and involves individuals from both the public and private sector as necessary. The two state agencies with primary responsibility for housing policy in ND include DHHS MFP and Economic Assistance Section and the ND Housing Finance Agency (NDHFA).

Staff from these agencies lead the workgroup and are responsible for moving housing-related policy forward for a broad range of housing needs, including how to best use resources to support diversion and transitions of TPMs more effectively.

As an example, workgroup members noticed that people who were receiving

transition services were not accessing the State's Opening Doors landlord risk mitigation fund, even when their situation was a good fit for Opening Doors.

Opening Doors is a statewide landlord mitigation fund to assist individuals facing significant rental barriers with access to rental property. The program started from a collaboration between the MFP and the NDHFA who administers the program.

Opening Doors provides households with a rental barrier the opportunity to access housing. The housing barrier could be poor credit, poor prior rental history, or a criminal conviction. The program also encourages landlords to lease units to households that may not meet all their rental criteria by providing coverage if there is excessive damage or lost revenue during the rental. This service provides landlords with up to 18 months of coverage and up to $2,000 damages from the fund if a tenant violates the lease by abandoning the unit, does not pay rent, or causes damage above and beyond the security deposit.

To qualify an individual must be enrolled or eligible to enroll in Medicaid or Medicaid Expansion, have an intellectual, developmental, physical, aging-related, or behavioral health condition or be a youth exiting the foster care system. They also must have a housing barrier that would disqualify them under ordinary rental selection criteria and be willing to accept care coordination and supportive services

The ND Housing Finance Agency worked with the DHHS MFP team to modify how this program is administered and essentially open the door for more people to use this tool. DHHS' MFP housing facilitators are now tasked with completing the initial enrollment in Opening Doors; the NDHFA required follow-up is handled by transition coordinators, who were already documenting contact with individuals as required by the NDHFA program as part of their transition support work.

Three (3) of the CILs are currently providing the care coordination services to individuals who apply for the program. The CIL in Minot and Bismarck have been long-standing providers. The Fargo CIL completed the training and started proving services on February 13, 2023. MFP housing staff hope to recruit additional providers across the State,

The next in-person Statewide Housing Service meeting will be held on April 13, 2023.

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

Implementation Strategy

Strategy 1. Connect TPMs to housing facilitators whose PCP identifies 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)

Progress Report:

Housing facilitators work with the TPM's team to identify suitable housing options when housing has been deemed a barrier by the TPM. The housing facilitators consider a person's decision about where they want to live, and then work on addressing needs related to accessibility of living unit, affordability, and issues of access related to a TPM's criminal background and the background check policies in place by local housing providers.

Performance Measure(s)

Utilization of housing inventory/locator resource by housing support professionals

- All housing facilitators have access and utilize the housing locator tool as part of their daily job assignment.

- The state currently uses an MFP housing database which is available to every housing facilitator. The State does not track the number of times the database is used. The link is also assessable through the ADRL, so the public has access.

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.

- Of the 64 individuals who transitioned from a nursing home to the community during this reporting period, 41 received rental assistance. Eleven (11) received home modification, and 27 individuals received some type of housing assistance from a housing facilitator. Housing assistance may include filling out housing applications, finding required documentation, finding accessible affordable housing, requesting a reasonable accommodation from landlord, assist with porting a voucher to the required community.

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

- Housing outcomes for each TPM are not yet in place in a way that can be tracked. A Data Analyst position has been created to gather data and design a method to track this information and it will be available in future reports. (**Target Completion date June 1, 2023)**

Housing costs as percent of household income

- Tracking began on October 1, 2022. Housing costs range from 9% to

30% 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 Permanent Supported Housing (PSH) as per the SA.

Progress Report:

The housing services workgroup discussed housing inventories that are currently being used in ND to identify the feasibility of strengthening the data by updating property information when a home modification or other accessibility feature is added to the dwelling. This would allow everyone to have the most up to date information when helping TPMs finding. .

The Therap case note Referral and Transition Questionnaires have been updated to gather more comprehensive data on housing stability and inventory on PSH. Additional information will be available in future reports**. (Completed October 1, 2022)**

Strategy 3. Convene State Housing Services workgroup to review and offer feedback on the Low Income Housing Tax Credit Qualified Application Plan (LIHTC QAP) annually, particularly as related to the incorporation of plan elements that would increase TPMs' access to affordable, appropriate housing options. **(Completed March 2, 2022)**

Progress Report:

MFP Housing Facilitation Staff and other members of the Housing Services work group continue to provide comment and recommendations annually to the Low Income Housing Tax Credit Qualified Application Plan

Feedback for development of next housing allocation plans including the LIHTC QAP will be requested in February 2023 in connection with the public comment period.

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. **(Complete June 2022)**

Progress Report:

The availability of workforce dedicated to providing housing and transition support grew significantly in Year 1 and Year Two of the IP. MFP added both housing facilitator and transition coordinator capacity, as did ND Rent Help. Both efforts grew capacity by contracting with community-based organizations.

ND Rent Help is the North Dakota emergency housing assistance program that provides funding to increase housing stability and prevent eviction. Funding from the Consolidated Appropriations Act of 2021 and funds from the American Rescue serves as a primary resource for this program.

ND Rent Help replaces North Dakota's Emergency Rent Bridge program. The program supports households in keeping their existing housing or identifying a new housing arrangement. This includes payment of past rent, current rent, and past due utilities.

	MFP		ND Rent Help (NDRH)	
	Start of Year 1	End of Year 2	Start of Year 1	End of Year
Housing Facilitator	3 (via MFP contract with Minot State)	7 (via MFP contract with Minot State) Adding 1 in Fargo area and 4 across the state for ADRL in 1/23-3/25	0	44 (via contracts with 78 agencies, located in all ND regions) *Note: NDRH housing facilitators' work extends beyond work with TPMs.
Transition Coordinator	6.5 via MFP (contract with 4 CILS)	12.5 via MFP (contract with 4 CILS) Adding 4 across the state for ADRL	0	0 *Note: While not true "transition coordinators", ND Rent Help added follow-up support to all existing housing facilitator contracts for individuals who needed additional assistance maintaining housing stability.

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 TPM's PCP. **(Ongoing Strategy)**

Progress Report:

The network of housing support professionals has established strong practices related to diversion, primarily through the leadership of the MFP team (see more detailed description in Strategy 3 below). Because of the enhanced processes that are now in place, there has been an increase in the frequency of conversations that recognize housing and services as connected concepts. HCBS case managers talk about housing in the regular course of their work; housing facilitators talk about home and community-based services in the regular course of their work; landlords talk about the need for services and service

providers talk about the need for housing.

While this type of "organic" conversation can be hard to track, the impact is unmistakable. The work that occurred throughout Year 1 of the IP has established the connection between housing and services in people's minds. It has helped TPMs, and the people involved in supporting them, to be more curious about and interested in what's possible. Our ongoing work is to continue to add clarity to these conversations, but the real success to date is that the essential and foundational connections have been established for many.

Continued partnership between Housing Facilitators, HCBS Case Managers, and Transition Coordinators has allowed 270 TPMs to find the permanent supported housing they need to successfully transition to the community during the first two (2) years of the SA.

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.

Progress Report:

There is a team of State staff and community providers who are brainstorming ways to make environmental modification services more available to TPMs. The State is exploring ways to create a sustainable environmental modification funding stream that will reduce financial risk of providing these services to TPMs. The State is working through the State procurement process to identify a vendor who would manage a pool of funds that would allow them to enroll as a Medicaid provider and subcontract with a handyman or contractor to complete environmental modifications. The idea is to expand the number of willing contractors by making the process simpler for billing and reimbursement while still being able to access Medicaid funds that can be used to pay for these services to all eligible HCBS recipients. The State will ultimately need to get approval from CMS to use the MFP State rebalancing funds.

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. **(Completed April 1, 2022 and ongoing)**

Progress Report:

Performance Measure(s)

Establish timeliness metric for connecting diversion or transition team to TPM

- Housing facilitators provide access to housing supports that help TPMs find affordable and accessible housing. They help TPMs complete

rental assistance applications, apply for rent help, and communicate with potential landlords.

- Housing facilitators are required to meet the following timeliness metric. Once a transition referral is received the case is assigned to a housing facilitator within two (2) business days. The MFP Transition Coordinator will contact housing facilitator and the HCBS Case Manager within five (5) business days of referral to schedule the first Transition Team meeting. The Transition meeting will be held within 14 business days of the referral. The housing facilitator will then meet with the TPM based on the needs identified during the first meeting.

- The State will continue to refine how it tracks and reports on various degrees and types of housing facilitator engagement needed by a particular TPM.

Number and percent of team connections made by timeliness metric.

- Data collection began October 1, 2022, and 100% of the 16 TPMs referred for housing after this date were seen within the timeliness metric. **(Ongoing Strategy)**

Strategy 5. Assure that there are meaningful connections between housing and case management tracking systems utilized to support the PCP for each TPM. **(Ongoing Strategy)**

Progress Report:

Transition Coordinators, Housing Facilitators, and HCBS Case Managers all utilize Therap and the teams meet at least monthly to review individuals, barriers, and needed supports and services.

Strategy 6. Incorporate information on system updates in trainings for HCBS workers, including how data collected related to housing will be used in reporting. **(Training complete June 14, 2022 and ongoing)**

Progress Report:

Information on housing data elements was included in staff training on forms that support informed choice and person centered planning.

Strategy 7. Define housing barriers that may face ND renters and ensure those variables are reflected and addressed in the LTSS options counseling and case management process. **(Completed April 1, 2022)**

Progress Report:

The Housing Services work group identified the most common housing barriers faced by ND renters for inclusion in the LTSS options counseling referral

process. Informed choice forms were updated in September 2021 (starting point for paper-based collection of information related to housing barriers)

Performance Measure(s)

Number of LTSS options counseling referrals that collect information related to housing barriers.

- 559 LTSS OC referrals were conducted using the updated form that assesses housing needs.

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.

- Since August 15, 2021, all MFP/ADRL transition TPMs have had housing barriers identified and a plan developed to address the identified barriers. The case management system was updated on October 1, 2022 to include a way to report on housing related needs of TPMs. Additional data will be included in future reports.

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. **(Updated Target completion date ~~December 14, 2022~~ April 1, 2023)**

Progress Report:

Gathered information from Medicaid-oriented programs to better understand North Dakota's current model in context of other states. Reviewed non-Medicaid environmental modification program options in parallel with Medicaid funded options. Work informed several of the changes that were made to ND Administrative Code and updates to the HCBS Medicaid waiver that enable greater access to environmental modifications. Changes described in Strategy 2.

The State will compile their information and make it available in the next semiannual report.

Strategies 2. Identify needed program adjustments to broaden access to home and environmental modification resources**. (Completed April 1, 2022)**

In response to public comment the HCBS Medicaid waiver was updated to add Assistive Technology Professionals to the list of professionals that can supply a

written recommendation for Environmental Modification and Specialized Equipment services. Installation costs were also added to the coverage of Specialized Equipment as this service is also used to support TPMs to live in an integrated setting.

The qualifications for a QSP for environment modification and specialized equipment were modified to allow a handyman/contractor/tradesman in good standing who is willing to provide a professional reference relevant to their ability to complete the necessary work to meet the qualifications to enroll as a QSP.

The North Dakota Century Code (NDCC 43-07-02) allows for a handyman to complete jobs not exceeding $4,000 without a contractor's license. If the handyman does not have a contractor's license, they must provide a letter of reference showing they meet the qualifications to do minor installs and modifications to the home. The handyman would be allowed to provide installs and modifications to the home not exceeding $4,000 in time and materials. A licensed contractor would qualify as a QSP with their contractor's license and would not be limited to the $4,000 threshold.

Specialized equipment was also updated to include covering the cost of generic technical devices (tablets, computers, etc.) when they are needed for the functionality of other assistive technology such as smart home devices. **(Completed April 1, 2022)**

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

Progress Report:

Combined Year 1 Strategies 2 and 3 as both are related to implementation of changes that will be needed to make environmental modifications more readily available in North Dakota.

Workgroup members submitted public comments during administrative rule making process and HCBS waiver update based on early findings from evaluation of environmental modifications programs in North Dakota. The public comments changes resulted in the updates described in Strategy 2 above.

Updated 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**. (Updated target completion date ~~December 14, 2022~~ June 13, 2023)**

- Training on fair housing and home modifications was conducted on January 27, 2023. This training is also included in the new hire onboarding process.

Updated Strategy 5. Identify training resources that help professionals/teams better understand flexibilities that may be possible with reasonable modification of housing that help TPMs and their families and/or caregivers better understand options available to them.

Progress Report:

Content of Year 1 Strategy 4 was combined with Year 1 Strategy 5.

State staff will conduct training with housing facilitators, HCBS case managers and LTSS Options Counseling staff to help them understand how reasonable modification works, what type of modifications can be requested and how requests are made. The process to request a reasonable modification can come from HCBS Case Management, Transition Coordinators. The State created a template that is completed and submitted to State staff for approval or a, modification to HCBS. Housing Facilitators make request directly to the landlord for accommodation and modification of housing needs. **(Completed February 1, 2022)**

Currently there is a HCBS Medicaid Waiver amendment to further define environmental modification services in the Waiver that should be approved on April 1, 2023. The State will provide an update to State and contracted staff to explain the impact on these services after we receive approval.

The State is exploring third party agencies who have experience in this area to host more trainings.

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 a process that helps to identify in the individual service plan that a person’s “intent” is to return home after SNF placements. The SNF is responsible to complete a SFN 132 Physicians statement for Medicaid temporary stay review for individuals entering a long term care facility form and submit it to the State’s Medicaid eligibility unit. This informs the eligibility staff of the TPMs intent and allows the TPM to keep their income to pay for their housing expenses and Medicaid still covers the SNF stay. The LTSS options counseling staff will be trained about the “intent to return home” process. When a TPM communicates their desire to transition back to the community the worker will be prompted to check with the SNF and ensure that the form has been completed. The State will work to develop a protocol that Aging Staff would use to make sure that a person who wants to return home maintains their housing. **(Updated target completion date ~~December 14, 2022~~ June 30, 2023)**

Progress Report:

Began building awareness of the issue with professionals involved in Medicaid

eligibility, case management and housing supports. The State is ready to start having this discussion and put practices in place that define when and how to contact a TPMs housing provider to help maintain housing during a temporary displacement. State will present at the 2023 statewide housing authority conference and the 2023 NDHFA Multifamily Housing Forum to discuss the topic and begin exploring policy modifications with individual housing authorities. **(Target completion date ~~December 14, 2022~~ June 30, 2023)**

Performance Measure(s)

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

- Five (5) individuals maintained their housing in the community during a SNF stay during this reporting period. No one from the MFP program lost their housing during this reporting period. Maintaining housing or finding new or accessible housing is a part of the current transition 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. **(Updated target completion date December 14, 2023**

Progress Report:

Please reference progress reported in Strategy 6.

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. **(Updated target completion date December 14, 2022)**

Progress Report:

Please reference progress reported in Strategy 6.

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). **(Updated target completion date December 14, 2022)**

Progress Report:

Performance Measure(s)

Number of TPMs who successfully maintain their housing in the community

during a SNF stay.

- Please reference progress reported in Strategy 6.

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. **(Updated target completion date December 14, 2022)**

Progress Report:

Performance Measure(s)

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

- Seven (7) staff (100%) Housing Facilitators received training.
- Fair Housing Training with the Department of Labor was held on January 27, 2023. Six (6) Aging Services MFP staff, ten (10) transition coordinators and CIL staff, and all seven (7) Housing facilitator staff.

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. **(Updated target completion date December 14, 2022)**

Progress Report:

Performance Measure(s)

Number of TPMs who transitioned and are receiving various forms of rental assistance.

- Forty-one (41) out of the 64 TPMs who transitioned received rental assistance during this reporting period.

Strategy 2. Expand Permanent Supported Housing (PSH) capacity by funding and providing rental subsidies for use as permanent supported housing. **(Services are available ongoing strategy)**

Progress Report:

Delivered rental assistance to TPMs both with MFP funds and assistance from ND Rent Help. Built a streamlined connection for housing facilitators working with TPMs to be able to quickly access rental assistance for TPMs via the ND Rent Help portal (available for up to 12 months, including assistance with utilities). The temporary assistance provided by ND Rent Help allows time to establish a more permanent source of assistance for a TPM should it be necessary for their situation (ex. connection to housing authority-administered resources).

Performance Measures(s)

Number of TPMs who receive rental assistance.

- See response in Strategy 1 above.

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

- None of the 64 TPMs who transitioned are experiencing housing cost burden.

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. **(Updated target completion date June 14, 2023)**

Progress Report:

The State is working to update content of Housing 101 course online module. Simplified information regarding Opening Door program.

SA Section XIII. Community Provider Capacity and Training

Responsible Division(s)

DHHS 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 QSP Resource Hub to assist and support Individual and Agency QSPs and family caregivers providing natural supports to the citizens of North Dakota.

Progress Report:

Performance Measure(s)

Number of QSPs assisted by the QSP Resource Hub.

- Three hundred seventy-six (376) unduplicated individual and agency QSPs were assisted during this reporting period.

Number of individuals assisted (unduplicated)

- Three hundred twenty-two (322) individual QSPs were assisted during this reporting period.

Number of individuals assisted (multiple contacts)

- Out of the 322 individual QSPs assisted 137 called back for additional assistance.

Number of agencies

- Fifty-four (54) agency QSPs were assisted during this reporting period.

Number of QSP agencies receiving Council on Quality and Leadership (CQL) accreditation reimbursed by the State.

- The State has currently paid for the initial CQL accreditation for seven (7) currently enrolled providers. The State will pay for one agency that will receive accreditation in March 2023, and four (4) agencies paid for Systems Accreditation and the State will be paying for the next level of accreditation when it becomes due pending the availability of funding.

Number of new agencies enrolled as providers.

- Five (5) new agency QSPs were enrolled this reporting period. Two (2) providers enrolled to provide care in rural counties.

Number of new independent QSPs enrolled as providers.

- One hundred seventy-eight (178) individual QSPs enrolled during this reporting period. Seventy-four (74) individual QSPs signed up to serve in communities with a population of less than 15,000 people. Twenty-four (24) individual QSPs signed up to working in communities on a

reservation.

- One-hundred seventeen (117) individual QSPs and three (3) agency QSPs were closed during this reporting period.

Number of agencies that expand array of services.

- If a QSP wants to expand their service array they send a letter or email to the enrollment staff who update the change in the QSP access database. Because this is a manual process the data cannot be easily calculated using the current data collection system. The State is working to change the way QSPs enroll and is creating a QSP web portal where providers can securely apply to become a provider, add services, or expand their service territory. Once this system is complete, reports can be run that will provide this information. **(Updated target completion date for the web portal ~~December 31, 2022~~ August 31, 2023)**

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

- There are three (3) Tribal QSP Agencies
    - Spirit Lake Okiciyapi – 28 clients
    - Standing Rock Sioux Tribe (N/A)
    - Turtle Mountain Tribal Aging Agency – 25 clients
    - North Segment Home Services – No current HCBS clients
    - South Segment of the MHA nation – Data not currently available
- MFP-TI is funding both a Tribal Nations QSP Agency in Turtle Mountain and we are aware that Spirit Lake Nation has one QSP agency. Home Instead is also working with MHA Nation for QSP supports with this funding.

Strategy 2. Implement an inflationary rate increase for all HCBS services that was approved in the 21-23 DHHS budget. Providers will receive a 2% increase in Year 1 of the biennium and a 0.25% increase in Year 2.

Progress Report:

Performance Measure(s)

Rate increases published on July 1, 2022.

- Inflationary rate increases for July 1, 2022, were granted and new

rates posted on the DHHS website.

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

Progress Report:

Performance Measure(s)

- The following rate increases were approved on January 01, 2022 and became effective February 01, 2022.
    - Non-Medical Transportation from $3.27 to $8.74 per 15-minute unit.
    - Non-Medical Transportation (Escort) from $3.53 to $6.71 (agency) & $4.89 (individual).
    - Family Personal Care from $76.67 to $150 per day.
    - Supervision from $2.49 to $6.71 (agency) & $4.89 (individual).

Number of new providers enrolled to provide these services during this reporting period.

- Thirty-seven (37) individual or agency QSP enrolled to provide Non-Medical Transportation.
- Seventy-three (73) individual or agency QSPs signed up to provide Non-Medical Transportation-Escort.
- Thirty-eight (38) individual QSPs signed up to provide Family Personal Care.
- Forty-three (43) individual or agency QSPs enrolled to provide supervision.

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)**

Progress Report:

The QSP Resource Hub completed an agency and individual QSP survey. A link to a presentation, which serves as the formal report, summarizing the results is found here. The survey results will be used to inform decisions about training, recruitment strategies and provider rates. QSP Resource Hub staff developed a formal report for the State that was presented at the December 8, 2022 ND DOJ Stakeholder meeting. Staff will also explore how to project the number of QSPs that may be needed to meet the growing demand for HCBS.

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. **(Updated target implementation date June 1, 2023)**

Progress Report:

Performance Measure(s)

Number of QSPs and individuals trained to *ConnectToCareJobs* (**Updated target implementation date October 1, 2023)**

Number of users of portal on monthly basis.

- The *ConnectToCareJobs* portal has not been implemented. The State fully executed a contract with Advancing States to complete this project on January 24, 2023. A project kick-off meeting was held and initial configuration data has been submitted to the development vendor**. (Soft launched is scheduled for October 2023.)**

Strategy 6. Pay the CQL accreditation fees for up to 10 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. **(Completed October 15, 2021)**

Progress Report:

Number of QSP agencies receiving Council on Quality and Leadership (CQL) accreditation reimbursed by the State.

        - The State has paid for the initial CQL accreditation for seven currently enrolled.

        - The State will pay for one agency that will receive accreditation in March 2023.

        - Four agencies paid for Systems Accreditation and state will be paying for the next level of accreditation when it becomes due as long as funds are available.

Strategy 7. The State will streamline the agency and individual QSP enrollment process and revise the current enrollment packet. **(Updated target implementation date ~~December 1, 2022~~ August 31, 2023)**

Progress Report:

<u>Performance Measure(s)</u>

Number of QSPs trained to the revised processes.

- The initiative to streamline and improve the Agency and individual QSP enrollment process is ongoing. Staff from the Medical Services Division are spearheading the project to update the QSP enrollment handbooks. The person who was responsible for this project retired and the position was vacant until January 2023. This delayed progress on this effort. The new QSP enrollment administrator has already finished updating the Agency QSP handbook and the application forms and will be finishing the individual handbook and application revisions soon.

    - Both QSP handbooks and enrollment forms are being revised to:

        - Make enrollment requirements clearer.

          Incorporate separate forms into one document to eliminate missing information from applications.

        - Make it easier for QSPs to know which services to choose upon enrollment.

            - Providers will be able to enroll for all the services they are eligible to provide if they meet the basic QSP enrollment requirements. QSPs will choose to opt out of enrolling for a service instead of opting in.

- Update training documents for the enrollment vendor with clear guidance on what QSPs need to submit for initial enrollment and at renewal. The State is also working on creating a provider enrollment web portal that will allow interested individuals the ability to submit their application online and is holding weekly calls

with the enrollment vendor to troubleshoot frequent pitfalls and suggestions to improve 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 DHHS website, social media page, direct mail, email, and through stakeholder list serves. **(Plan created and strategy ongoing)**

Progress Report:

Performance Measure(s)

Number of webinars offered by topic and number of attendees.

- ND DHHS Adult & Aging Services is embarking on a Multigenerational Plan on Aging (MPA) effort which will result in a 10-year living strategic plan. The MPA will bring together a diverse group of stakeholders and new non-traditional partners. To share information and promote continued partnerships, the State will hold Lunch and Learn sessions to share information from existing and new partners. These will serve to broaden awareness of services in the state that can help older adults and individuals with disabilities remain active and engaged in their homes and communities.

- North Dakota's MPA overall strategic goals for this plan were featured on a national webinar and State staff have been invited to present on this subject at a national conference later in the year.

  - Four (4) broad goals have been developed and the State is working toward holding a facilitated kick off meeting to further refine actions steps.

    - Services Closer to Home – North Dakotans will be able to live in the setting of their choice with the support they need to thrive as they age.

    - Futures Planning – North Dakotans receive widespread outreach and learning opportunities for legal, financial and healthcare planning.

    - Social Engagement and Accessibility – North Dakotans experience lifelong opportunities for meaningful engagement with their families, communities, and workplaces.

    - Workforce- North Dakotans enjoy ready access to quality

services through targeted efforts to attract and retain a qualified workforce.

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 February 1, 2022)**

Progress Report:

Performance Measure(s)

Number of grants awarded by date.

- Twenty-three (23) incentive grants were awarded on December 7, 2022.
- Fourteen (14) incentive grants were awarded on January 14, 2022.

Number of applications received for the QSP incentive grants.

- There were 39 applications received for the QSP incentive grants.

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

- See information below.

Number of existing providers expanding to provide HCBS.

- Nine (9) QSP will expand services to tribal and rural/frontier areas.
- Five (5) QSPs enrolled to become new agency providers.
- Three (3) current QSPs will purchase handicapped accessible vehicles to better serve clients.
- Two (2) QSPs expanded to serve underserved groups.
- Two (2) QSPs expanded to serve in urban areas.

Number of agencies that expand or enhance capacity to provide HCBS.

- Twenty-three (23) of the 39 incentive grant applications received were awarded on December 7, 2022. Award amounts varied between $33,910 and $50,000 for a total of $1,119,883. ARPA 10% Savings funds were used for this project.
  Link to QSP Grant Award Summary.

Strategy 10. To reduce the responsibility of individual QSPs and improve the recruitment and retention of providers statewide, the State continues to consider and evaluate other provider models including the Agency with Choice/Co-employer model. The State continues to evaluate the benefit of adding formal self-direction to the HCBS waiver and Medicaid State Plan – Personal care. **(Updated target completion date December 01, 2022 and ongoing)**

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 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.

The State continues to work with the vendor to meet the enrollment deliverables described above. The State has hired an individual to oversee QSP enrollment and provide contract management and technical assistance to the vendor. **(Updated start date June 1, 2022 and ongoing)**

Progress Report:

Noridian took over the processing of individual and agency QSP enrollment April 5, 2022. There have been some challenges identified in the roll out and the State is working closely with the vendor to resolve the issues.

Performance Measure(s)

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

- From June 1, 2022 through December 31, 2022 the enrollment vendor reported that 152 QSP applications were received. Seventy-five (75) or 49% of the applications were completed within 14 days.

Number of QSP revalidations completed before revalidation due date.

- The vendor is continuing to build capacity to meet these contract requirements. The vendor has four (4) full-time employees and one supervisor working on QSP enrollment. The State has the ability to request expedited enrollment when necessary and continues to work with the vendor to improve the QSP enrollment experience.

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

Progress Report:

Performance Measure(s)

Number of QSPs trained on reporting procedures.

- A total of 85 individuals attended three (3) learning sessions during this period. These training sessions are conducted quarterly.
  - Seven (7) QSPs – June 17, 2022
  - Fifty (50) QSPs – September 14, 2022
  - Twenty-eight (28) QSPs – September 28, 2022

An e-learning module has been created and is posted to the Adult and Aging Services website.

The QSP Hub orientation includes critical incident reporting information based on the existing information from the handbook. The first QSP orientation was held in January 2023.

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.

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.

Progress Report:

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.

- The Bismarck territory is experimenting with having one (1) Case Manager complete all the intake for new referrals. This has created some efficiencies, but also may not be sustainable for one Case Manager to manage all of the referrals. The Department has requested 10 FTE in the 2023-2025 Executive Budget Request. In addition, we have requested one (1) Aging Generalist position that would provide half time HCBS case management services. The Department also requested two (2) Service Navigators to help the HCBS Case Managers find qualified providers for TPMs. If the FTEs are approved, the State will designate three (3) FTE to provide Basic Care case management which will free up additional time for the HCBS Case Managers because they will no longer be required to support a Basic Care caseload.

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.

- See above.

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.

- The State and vendor have worked to incorporate all aspects of the case management process into the new system. The system will act as a centralized data reporting system. The system operates in real-time and is available to ADRL staff, MFP staff, and the Housing Coordinators. An additional referral interface is being considered to further streamline HCBS referrals from SNFs. The system has been updated to include a complaint component and all agency QSPs are required to have a Therap account to report Critical Incident Reports. The full implementation of the case management system is complete. The person-centered plan and complaint system were implemented August 1, 2022. **(Target completion date July 31, 2022)**

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.

- In the past six (6) months approximately 78% of the Case Manager's time was spent on billable case management tasks and approximately 22% was spent on administrative duties. That is a 2% reduction in administrative time since the last biannual report. The State will continue to monitor these numbers with the goal of further simplifying

and streamlining the case management process.

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.

- A contract has been established with Knowledge Services to conduct the NCI-AD survey beginning January 23, 2023 to be completed by May 31, 2023. Delay in target completion date is due to the time it took to secure a vendor.

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.

- This work is ongoing. Request for additional staff capacity was included in the 2023-2025 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.

- Aging Services worked with the State IT Division to create process maps for all major functions of the HCBS. The State developed visuals for TPMs and other professionals to help understand the role of each member of the transition teams and the ADRL referral process. The State continues to evaluate our processes and make changes that will improve the transition experience for TPMs. **(Process Maps Completed May 1, 2022)**

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.

- See related response above.

The State will work with the QSP Resource Hub 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 contracted with The Center for Rural Health, located at the

University of North Dakota School of Medicine & Health Sciences to operate the QSP Resource Hub. One of their first major initiatives completed is a QSP survey. Link to Independent QSP Survey Results. QSP Resource Hub staff are continuing to work on a strategic plan to determine what type of strategies will build provider capacity and retention.

- The State offered QSP Agencies funds for recruitment and retention bonuses that can be used to help recruit and retain qualified individuals to provide direct support to TPMs. To date 33 agency and 398 individual QSPs have participated, and $415,800 has been allocated. **(Completed March 1, 2022)**

The State will conduct a QSP capacity survey with the QSP Resource Hub 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 QSP hub will conduct a QSP capacity survey annually. The QSP hub will start a building connections group to create a platform for QSP's to build connections with each other in effort to strengthen the workforce. In discussion of a QSP list serve with aging services, it has been determined that the QSP hub will not create this. Based on the current set up and logistics of how the QSP information is stored within aging services, it will not be feasible to provide this to the QSP Hub. Instead, Aging services will send out all information to the existing QSP's when the QSP hub provides resources and materials. **(Target completion date May 31, 2023)**

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 *ConnectToCareJobs* portal has not been implemented. The State fully executed a contract with ADvancing States to complete this project on January 24, 2023. A project kick-off meeting was held and initial configuration data has been submitted to the development vendor. (**Soft launched scheduled for October 2023).**

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.

- This work is ongoing. **(Updated Target completion date ~~December 1, 2022~~ August 31, 2023)**

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.

- This work is ongoing. Information from the QSP Survey and funding from the 10% FMAP fund will be used to help develop capacity for agencies to provide backup services to TPMs. The State included funds in the Executive budget request to pay QSPs to provide on-call staff that would be available in case of emergency, if the regularly scheduled is provider unable to complete their shift, etc.

Consider adopting a new provider model to reduce the administrative burden on individual QSPs including the Co-Employer/Agency with Choice Model.

- This work is ongoing and additional models are being explored for potential inclusion in the 2025-2027 Executive budget request.

Conduct a rate analysis to determine discrepancies in rates paid to in-home providers and SNF staff.

- Funds from the ND Spending Plan for implementation of 10% temporary FMAP increase for HCBS/Section 9817/American Rescue Plan Act of 2021 used to procure a vendor to complete a rate study. The rate study began on July 1, 2022 and results were provided in November 2022. The primary goal of the study was to determine the best way to attract and retain quality providers to support HCBS across populations.

  The study focus included a summary of the current rate methodology, review of the direct support professional compensation by setting a description of current process flows and the authorization process, and the alignment of policy goals and rate methodologies. The results showed that tiered rates base on acuity may be beneficial in recruiting and retaining QSPs willing to serve individuals with complex medical and behavioral health needs. **(Target completion date ~~October 1, 2022~~ May 1, 2023 and ongoing)**

  Link to Qualified Service Provider (QSP) Rate Study

  https://www.hhs.nd.gov/us-department-justice-settlement-agreement

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.

- Effective January 1, 2022, the RD rate may be used for supervision, companionship, and transition support services.

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.

- See response in Section IX.E.4.

The Department is working with the case management vendor to create a custom report that would compare the number of services authorized to the number of services billed. **(Target completion date ~~July 1, 2022~~ April 1, 2023)**

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.

- There are several initiatives that seek to remedy this issue. The rate study is complete and will help the State consider pricing strategies that will create an incentive to serve TPMs with complex needs, especially in rural areas of the State. The following items were included in the Executive budget request:

    - Increase the daily rate max paid for individual Adult Foster Care from $96.18 to $100 a day.

    - Increase the daily rate max paid for Family Home Care providers from $48.12 a day to $80 a day.

    - Requesting up to 30 bed hold days per participant for Residential Habilitation and Community Support services to help ensure they don't lose their community provider when they have a short-term hospital or rehabilitation stay.

    - Requesting to add a base rate for the first hour for Personal Care Services to help ensure provider access for TPMs who only need a few hours of care.

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

- This will be a major function of the Resource Hub which started December 1, 2021. The work is ongoing. The QSP Resource Hub completed an agency and individual QSP study and developed and started holding QSP orientation in January 2023. QSP orientation will be available once per month. The QSP Hub also provides individualized technical assistance to agency QSPs who want to enroll or expand their service array. The work is ongoing, the next major initiative will be to start providing and designing training to increase the quality and capacity of QSPs.

Consider revising the QSP training requirements to improve the provider experience and ensure a quality provider workforce.

- The work is ongoing, the next major initiative will be to start providing and designing training to increase the quality and capacity of QSPs. In addition, the State is using ND Spending Plan for implementation of 10% temporary FMAP increase for HCBS/Section 9817/American Rescue Plan Act of 2021 to procure a vendor who will study and provide recommendations to streamline the training requirements and processes for QSPs and other direct service providers. **(Target completion date October 31, 2023)**

Creating the QSP Hub to improve the support provided to agency and individual QSPs.

- The State entered into a contract with the Center for Rural Health, located at the University of North Dakota School of Medicine & Health Sciences effective December 1, 2021. The QSP Resource Hub started providing a monthly enrollment orientation for QSPs and is designing a training plan to increase the quality of the QSP workforce. They began a process to provide individual technical assistance to agencies who are interest in becoming Qualified Service Providers.

Offer incentive grants to encourage large and small agencies to expand and enhance their capacity to serve additional TPMs and expand their service array.

- Twenty-three (23) of the 39 incentive grant applications received were awarded on December 7, 2022. Award amounts varied between $33,910 and $50,000 for a total of $1,119,883. ARPA 10% Savings funds were used for this project.
  Link to QSP Grant Award Summary

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.

Progress Report:

- See response above in Section XIII.C. Implementation Strategy
- No nursing facilities applied to be a QSP agency during the most recent round of incentive grants.

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.

Progress Report:

Performance Measure(s)

Number of SNFs requesting individual technical assistance.

- One (1) SNF has requested technical assistance in the last six months and is enrolling as a QSP.

- The State provided training to long-term care facilities about the LTSS Option Counseling process on November 18 and 30, 2022.

Number of SNFs that have enrolled to provide HCBS.

- The State continues to remind SNFs of the opportunity to provide HCBS. We are aware of one (1) SNF that submitted an application to become a QSP.

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.

Progress Report:

Performance Measure(s)

Number of Tribal entities enrolled to provide HCBS.

- The MFP Tribal Initiative has assisted in the development of a QSP agency on the Turtle Mountain Band of Chippewa Indians Nation.
- MFP is working with the South Segment of the Three Affiliated Tribes on a pilot project to offer QSP Services by a member of the tribe that owns and operates the QSP agency.
- The Spirit Lake Nation and the North Segment of the Three Affiliated

Tribes are also a QSP Agency that were started without funding from MFP.

- Standing Rock is an approved QSP agency, they do not provide services at this time.

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

- TM Tribal Aging Agency (Currently serving 25 HCBS recipients)
- Standing Rock Sioux Tribe (N/A)
- North Segment Home Services (N/A)
- Spirit Lake Okiciyapi (Currently serving 28 HCBS recipients)
- South Segment of the MHA nation – Data not currently available

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.

Progress Report:

On December 21, 2021, the State received Legislative spending authority to implement the 10% FMAP increase fund. Future progress reports will include additional information on the implementation of the plan.

- Developed a pilot program that supports both the recruitment and retention of direct care workforce in the HCBS industry. The State offered QSP funds for recruitment and retention bonuses that can be used to help recruit and retain qualified individuals to provide direct support to TPMs. To date 33 agencies and 398 individual QSPs have participated, and $415,800 has been allocated. **(Completed March 1, 2022)**

- Additional funding beyond that provided under the MFP Capacity Building Grant to develop new community services and supports was 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.

    - A second round of incentive grants was made available to individuals and other entities interested in providing HCBS to adults with physical disability. There were 39 grant applications received, 23 were awarded. Award amounts varied between $33,910 and $50,000 for a total of $1,119,883. **(Target completion date December 2022.)**

- The initial purchase of service agreement for these projects is in effect for 6-months. The State is hoping that a shorter implementation period will help QSPs begin to start providing new services in new territories quickly giving a boost to the service delivery system,
- The State will complete an impact report once the projects are complete to quantify how effective these grants were in increasing access for TPMs and other who are choosing to receive necessary care in the least restrictive environment.

- 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 using modern approaches to effective adult learning. Revise the training catalog available to the 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. **(Target completion date December 31, 2023)**.

- 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 fr
- om 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 are 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).

  - The flexible transition program that was used to start the ADRL COVID grant has been expended. The State is currently using ND Spending Plan for implementation of 10% temporary FMAP increase for HCBS/Section 9817/American Rescue Plan Act of 2021 to continue to fund this program. During this reporting period nine TPMs were transitioned to the community using these funds. Forty-four (44) other individuals have been transitioned out of other congregate settings i.e., basic care, assisted living, domestic violence shelters.

- 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.

- Assist with a deposit that includes first month rent.
- Assist with utility deposit.
- Assist TPMs with past due rent with State General Funds.
- TPMs are assigned a Housing Facilitator.
- TPMs are assisted with ongoing rent with State General Funds.

- 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 and 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. **(Target completion date December 31, 2023)**

- Completed a QSP Rate Innovations and Gap Analysis. This strategy aimed 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 system of "backup" or emergency care providers-of-last-resort to address high need cases or staff emergency situations; and rates adjusted for equity and intensity.

    - Rate study was started July 1, 2022. Recommendations provided November 2022.
      Link to Qualified Service Provider (QSP) Rate Study

- 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. **(Target completion date June 30, 2023)**

    - A draft request for proposal has been completed and the State will work through the procurement process to secure a vendor.

- 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 the *ConnectToCareJobs* platform that facilitates connections between QSPs, consumers, and families.

  - The State has entered into a contract to develop the *ConnectToCareJobs* platform. Work is ongoing, soft launch target date is October 1, 2023.

- Invest in the ADRL platform to incorporate affordable housing database, and other modifications to support the user experience. Enhance availability of resources to support LTSS Options Counseling (informed choice) and HCBS case management. Equip Developmental Disability (DD) and HCBS Case Managers with resources to facilitate efficient work from HCBS settings.

    - The State created an interface between the ADRL and Case Management systems to gather the required information to make sure the HCBS referral is appropriate and includes all required information to increase efficiencies for the Case Managers.
    - We are working to create an additional interface between the ADRL and Case Management system to create a similar process that will improve the efficiencies of referrals to transition services for TPMs residing in a SNF.

- 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.

  - The State has secured a vendor to implement National Core Indicators Aged and Disabled (NCI-AD) in ND. In-person surveys will begin in January 2023.
  - The State is requesting in the Executive budget request, one additional FTE to act as quality manager for Aging Services to help implement the HCBS quality measures.

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

Responsible Division(s)

DHHS 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. **(Completed September 14, 2021, and repeated annually)**

Progress Report:

Performance Measure(s)

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

- In-reach presentations were conducted in all 74 facilities between June and December 2022. The group informational sessions were attended by 952 residents, staff, family members, and the public. The State has exceeded this requirement.

Number of individual in-reach/LTSS Options Counseling (informed choice) visits conducted with TPMs residing in SNFs per year.

- A virtual or in person LTSS Option Counseling (informed choice) visit was conducted with 726 unduplicated TPMs residing in SNFs during this reporting period.

- A virtual or in person Developmental Disabilities Program Manager (DDPM) visit was conducted with 38 unduplicated TPMs residing in SNFs during this reporting period.

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 LTSS Options Counseling (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)**

Progress Report:

Performance Measure(s)

Conduct 250 individual in-reach/LTSS Options Counseling (informed choice) visits with TPM residing in SNFs per year.

- A total of 726 unduplicated TPMs residing in an SNF received an LTSS Options Counseling (informed choice) visit during this reporting period.

- A total of 38 unduplicated TPMs residing in an SNF received an options counseling visit by their assigned Developmental Disabilities Program Manager (DDPM)

Number of LTSS Options Counseling (informed choice) visits completed every six months.

- A total of 594 LTSS Options Counseling visits were conducted with TPMs listed on the Daily Referral List during this reporting period. Individuals on this list have all been recently referred for a long-term stay in SNF.

- A total of 726 LTSS Options Counseling visits were conducted with TPMs listed on the Annual Referral List during this reporting period. Individuals on this list are individuals who are currently residing in the SNF whose NF LoC annual redetermination is due.

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**. (Updated target completion date ~~December 1, 2022~~ December 31, 2023)**

Progress Report:

Performance Measure(s)

Number of referrals for peer support and outcome.

The CILs provide peer support services to TPMs statewide. There were no new referrals for Peer Support by the CILs in this reporting period.

Number of individuals receiving information or support from new center.

- The new Peer Support Center has not yet been developed. The Planning team continues to discuss the desired structure and outcomes for the Peer Support 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 LTSS Options Counseling (informed choice) process to include similar questions. If accommodations are needed the State, hospital, or SNF will provide the necessary accommodation as required. Individual accommodations may include auxiliary aides such as interpreters, large print and Braille materials, sign language for the hearing impaired, and other effective methods to deliver appropriate information to TPMs. The State will update the ADRL and DHHS website to include information on how to request accommodations. **(Target completion date October 1, 2021)**

Progress Report:

Performance Measure(s)

Number of TPMs who requested and received communication accommodation.

- Twelve (12) requests were made by TPMs in facilities, all were accommodated. No requests were made by TPMs in the community.

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

Implementation Strategy

Strategy 1. The DHHS 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. **(Completed November 1, 2021)**

Progress Report:

- The Communication Plan was completed on November 1, 2021. The Plan was reviewed at the March 17, 2022, stakeholder meeting and is available on the Aging Services website. Efforts are ongoing. Another social media campaign was conducted in March 2022. See response in Section VII.A.5. See note on Pg. 15.

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)**

Progress Report:

See response above under Strategy 1.

Performance Measure(s)

Number of ADRL contacts.

- Calls – 8,009
- Web Intake – 664
- Unique Website Hits –14,428

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.

Progress Report:

The State developed a report of the most common medical diagnosis of TPMs who are residing in SNF. This information will be used as part of a broader conversation around what contributes to the need for long-term placement in a SNF. This information will be used to inform future strategies that will be included in the Year three (3) IP.

- Hypertension – 594
- Dementia – 405
- Diabetes – 661
- Heart – 211
- Arthritis – 376
- Kidney – 329
- Depression – 232
- Covid – 177
- COPD – 252
- Cancer – 62

- Stroke – 44

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)**

Progress Report:

Performance Measure(s)

Number of TPMs utilizing respite care with the RD rate.

- A total of 17 TPMs received respite paid at the RD rate during this reporting period.

Number of hours of respite services provided.

- State and federally funded HCBS provided 1026.5 hours of respite care to eligible individuals and their family caregivers under the HCBS waiver during this reporting period.

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 received completed June 1, 2022)**

Progress Report:

Performance Measure(s)

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

- A total of seven (7) Powerful Tools for Caregivers classes were conducted from June 2022 through December 2022 with a total of 43 attendees.
- Twenty-seven (27) caregivers accessed respite through the Lifespan Respite Care Grant from June 2022 through December 2022.

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. **(Completed 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 development of the Community Aging in Place – Advancing Better Living for Elders (CAPBLE) program. CAPABLE is a person-centered home-based program that integrates services from an occupational therapist, registered nurse, and a handy man who work together with older adults to set goals to improve function and safety in the home. The first two Capable participants were enrolled in February 2023. **(Completed January 1, 2023)**

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. **(Completed February 7, 2022)**

Progress Report:

Performance Measure(s)

Number of individuals who attended training by service.

- A training was held February 7, 2022, to present on evidence-based practices to all 101 Aging Services staff that were employed at that time as well as the Transition Coordinators
- Professionals that work with the NDC3.org website will provide a webinar for a broad group of stakeholders as part of the MPA Lunch and Learn series this summer.

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

Implementation Strategy

Strategy 1. The State will work with the DHHS Civil Rights Officer and the ND Department of Information Technology to review all printed documents and all online information available on the USDOJ Settlement page of the DHHS website to ensure compliance with this SA. **(Updated target completion date May 31, 2022, and ongoing)**

Progress Report:

Performance Measure(s)

Number of documents converted.

- The Department migrated to a new Department of Health and Human Services website and instead of brochures and booklets the new website will include content rather than linked documents. This will improve the ability of people with disabilities to utilize communication aids, like readers, when using DHHS website.
- The DOJ Settlement Support Specialist will compile a list of the documents on the DOJ Settlement Agreement website to determine what can be included as content and what has to remain a document. She will work with Public Information and Multi-Media Specialists to improve the accessibility of the information on the DOJ Settlement Agreement website.

Strategy 2. The DHHS 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. **(Completed October 26, 2021)**

SA Section XV. Data Collection and Reporting

Responsible Division(s)

DHHS 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.

Progress Report:

- The State case management system will be used to track individual demographics, assessment data, PCP, case notes, provider authorizations, provider electronic visit verification data, claims submission data, complaints and CIRs. The system also tracks case management referrals. **(Completed August 1, 2022)**

- The State is working with Aging Services business analyst and the case management vendor to design specific reports that will help the State report data required in SA, IP, and related performance measures. **(Targeted completion date ~~December 31, 2022~~ June 30, 2023)**

- The Aging Services business analyst is working with the vendor and is using the Basecamp system to track the progress of the reports listed. All but the last three (3) reports have been completed.

Case Management System Reports
Medicaid Waiver Quality Assurance Report
Medicaid Waiver Recipients with Narratives
Medicaid Waiver Goals and Assurance
Monthly Cost by Funding Source
Rural Differential SFN 212 and Rate
Count of Care Plans Completed with TPM
HCBS Cases Worked Summary
HCBS Care Plans by Service Support
HCBS Care Plans by Funding Source
Aging NCI-AD Report
I&R Module Report
Housing Facilitator Transition Plan Report
Housing Services Referral Assessment Report
MFP Referrals
MFP Transitions
Financial Assessment
Informed Choice LTSS Option Counseling
Risk Assessment and Safety Plan
Participant Assessment
DOJ Complaints Assessment Report

- The case management system vendor provided training to Aging Services staff to learn about the business intelligence tools that are currently available in the case management system. **(Completed December 7, 2022)**

- The State will streamline the current dashboard report and will make the following key measures available on the Department's website.

  - Number of unduplicated TPMs served in the state or federally funded HCBS.

  - Number of TPMs being served in a SNF.

  - Total number of contacts to the ADRL.

  - Total number of individuals referred to HCBS case management.

  - Total number of TPMs who transitioned to an integrated setting.

  - Total number of LTSS Option Counseling visits that resulted in a TPM transitioning to the community.

  - Total number of TPMs receiving home modifications.

  - Total number of TPMs who were diverted from an SNF because they are receiving HCBS in the community.

  - Total number of TPMs receiving permanent supported housing.

  - Total number of TPMs receiving rental assistance.

  - Total number of TPMs who maintained their housing in the community during a SNF stay.

  - Average annual individual cost comparison by HCBS funding source and average annual cost of SNF care.

  - Total number of new QSPs enrolled per calendar year.

  - Total number of new QSP applications processed within 14 calendar days.

  - Total number of QSPs who received enrollment assistance from the QSP Hub.

  - Total number of new QSP Agencies serving tribal and other underserved/rural communities per year.

    - Total number of QSPs by county.
    - Total number of TPM complaints responded to within the required timeframe.
    - Total number of PCPs created with TPMs in the community and with TPMs in a SNF.
    - Average monthly weighted caseload per Case Manager.
    - Percent of provider CIRs reported within the required timeframe.
    - Percent of remediation plans completed by quarter.
- The State worked with the Case Management vendor to implement the complaint system, which was completed on June 14, 2022. In the interim the State continued to utilize an Access database to capture and report on complaints. Complaints are received through the ADRL and are assigned to the complaint investigator and complaint reports are run out of Therap.
- All State staff that investigate complaints now have access to the complaint database. In addition, all providers are required to have an account in Therap so they can enter the Critical Incident Report (CIR) directly into the system where they are reviewed by an Aging Services Nurse Administrator.
- The State worked with the vendor and determined that a VAPS interface to the CIRs and the case management system is not feasible.

Performance Measure(s)

Number of complaints received through the General Complaint Process.

- Sixty-one (61) QSP complaints were received during this reporting period. Link to Appendix C.

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 in the State's time and attendance system to calculate the amount of time spent conducting case management versus administrative tasks.

Progress Report:

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.

See response in Section VII.A.7

- The State's Executive budget request includes funding for 10 additional FTEs to provide case HCBS management services. The LTSS Options Counselors were moved to classified FTE positions on October 1, 2022.

SA Section XVI. Quality Assurance and Risk Management

Responsible Division(s)

DHHS 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.

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 reports will be reported to the USDOJ and the SME.

  Progress Report:

  - This initiative is complete, but the work is ongoing. Quarterly webinar training will be provided to agency and individual QSPs. An e-training module is available online. Link to Critical Incident Reporting (nd.gov). A recorded webinar is also available online.

- 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.

  Progress Report:

- The mapping process is complete. State staff are working on creating a visual aid for providers and staff. **(Updated target completion date October 1, 2022)**

- The Critical Incident training which includes a 'How to Report A Critical Incident for Qualified Service Providers' document is available on the Adult and Aging Services website. https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/qsp-critical-incident-reporting.pdf

- The State has held and will continue to provide critical incident report training to all providers. Training materials and video recordings are available online.

  Progress Report:

  - See related response above.

- The State will utilize a workgroup to develop Quality Improvement (QI) policies 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.

  Progress Report:

  - The State contracted with the Council on Quality and Leadership (CQL) to manage the QI workgroups and create standards for the program. Current providers must have a compliant QI program by December 31, 2022. **(QI standards completed February 23, 2022)**

  - Aging Services staff are working on a process to ensure QSP agencies are complying with the new quality standards. The required provider QI standards are included in the updated Agency QSP handbook. Current agencies had until December 31, 2022, to fully develop their program. Audit work began in January 2023.

- 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 updated assessment includes questions about safety, need for environmental modification and supervision. The HCBS waiver allows for a formal assistive technology assessment to be completed as part of specialized equipment and supplies.

- 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 developed this process and the first mortality review was conducted in January 2022. The CIR Team holds quarterly meetings where all deaths are reviewed for trends one week prior to the meeting. The team then discusses these deaths and any trends found at the committee meeting. Information discussed is included in the Team meeting minutes. Staff from the Medicaid Fraud Control Unit. (MFCU) have joined the CIR Team.

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

  - The State and the Case Management vendor have finalized the implementation of the complaint system. In the interim the State continued to utilize an Access database to capture and report on complaints.

  - The complaint process has been updated to include the ADRL intake as the entry point of the QSP complaints. Training has been provided to Case Managers. Information has been added to the website and is reviewed at all ND USDOJ SA stakeholder meetings to ensure ongoing awareness.

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 QSP Resource Hub to develop ongoing training that will assist QSPs in understanding and complying with safety and incident reporting procedures. **(First critical incident reporting training completed August 1, 2021)**

Progress Report:

QSP Quality Improvement (QI) Program training sessions were conducted on June 22, 2022, and June 28, 2022, with a total of 60 QSPs in attendance.

Performance Measure(s)

Number of QSPs trained on reporting procedures.

- Seven (7) QSPs – June 17, 2022
- Fifty (50) QSPs – September 14, 2022
- Twenty-eight (28) QSPs – September 28, 2022

Number of virtual training events conducted.

- Two (2) CIR virtual training events were held during the reporting period. A total of 35 individuals attended between the two events. Virtual training is held every quarter.

Number of training modules created.

- One (1) training module for online learning has been developed and is posted to the Aging Services website. Link to Critical Incident Reporting (nd.gov)

  Education on use of and where to find this module is completed at each quarterly virtual training. It is also emailed to all QSPs when each virtual training event is completed.

The QSP Hub developed a new QSP orientation that briefly covers the critical incident reporting information based on the existing information from the handbook.

- Virtual Training Events-
  - Fifteen (15) live application support sessions
- The QSP hub has the follow learning opportunities available online. These sessions are available to anyone at any time and are located on our website under training, quick video guides. North Dakota Qualified Service Provider Hub Training - Quick Video Guides (ndqsphub.org)
  - How to fill out SFN 1603, SFN 583, SFN 433, SFN 615, W-9,
  - Intro Session: What is the QSP Hub?
  - Session 1: What is a QSP?,
- Session 2: How do I become a QSP? The following trainings are drafted and in editing for web.
  - New QSP orientation,
  - Session 3: I have been approved as a QSP, now what?,
  - Session 4: EVV Documentation,

    - Session 5: EVV/Billing,
    - Types of services: An overview of the services a QSP can provide,
    - Helpful things to know and understand about AFC before applying,
    - What is the difference between and individual QSP and a QSP Agency?
- The following are sessions that have not been drafted but are outlined to be done in 2023:
    - Session 6: What it means to be self Employed,
    - Session 7: QSP Renewal Process,
    - Session 8 - What it means to be a mandated reporter,
    - Session 9: HCBS,
    - Session 10: What to do if... (QSP Audits, State Exclusions, OIG Referrals, and QSP Complaints).

Live application support was offered weekly from August-December. There were 0-13 individuals at each session. The QSP hub will be offering Building Connection groups time a month starting in January in effort to strengthen relationships within the QSP community.

Number of critical incident reports that were reported on time.

- Out of the 322 incidents involving TPMs, 200 (62%) were reported on a timely basis by providers.

    - June 14 – June 30, 2022 – 15 out of 36
    - July 2022 – 33 out of 49
    - August 2022 – 36 out of 59
    - September 2022 – 27 out of 45
    - October 2022 – 30 out of 51
    - November 2022 – 34 out of 47
    - December 1 - 13, 2022 – 25 out of 35

- The CIR team provides individual technical assistance to providers and facilities who are not reporting timely. Virtual training is completed every quarter and a recorded training is available online.

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, 2023)**

Progress Report:

Performance Measure(s)

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

- Fifteen (15) QSP agencies that provide Residential Habilitation and Community Supports had the QI program in place by December 31, 2022. Four (4) additional developmental disability providers are CQL accredited and would also meet the QI program requirements.

- Training was provided to the QSP agencies on the QI program standards on June 22, 2022 and June 28, 2022. We will begin auditing each QSP agency to ensure they have a QI program in place beginning January 2023. Agencies with CQL accreditation or another type of accreditation, approved and reviewed by the State, will meet the QI standards.

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 DHHS website and shared at USDOJ stakeholder meetings. **(Updated target completion date ~~July 1, 2023~~ December 31, 2023)**

Progress Report:

- A contract has been established with Knowledge Services to conduct the NCI-AD survey beginning January 23, 2023 to be completed by May 31, 2023. Delay in target completion date is due to the time it took to secure a vendor.

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. **(Completed February 23, 2022)**

Progress Report:

- See progress report under Strategy 2 above.

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

Progress Report:

Performance Measure(s)

Percent of critical incident reports submitted within seven days of incident being reported as required.

- All of the 322 incidents were reported in a timely manner by the State to the SME, which is a 100% compliance rate.

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)**

Progress Report:

Performance Measure(s)

Percent of required remediation plans completed.

- There were 268 incidents with remediation/follow-up sent to the DOJ.
- Twenty-five (25) involved QSP complaints.
- Forty (40) involved Vulnerable Adult Protective Services (VAPS)

Remediation includes incidents that are reviewed with the ND Dept of Health, Ombudsman, QSP complaints program administrator, and the Medicaid Frauds Compliance Unit (MFCU). This does not include deaths by natural cause. A mortality review is conducted at each quarterly CIR team meeting.

Number of training events conducted.

- Three (3) virtual training events were conducted.

- Seven (7) QSPs – June 17, 2022
- Fifty (50) QSPs – September 14, 2022
- Twenty-eight (28) QSPs – September 28, 2022

Number of online modules created.

- One (1) training module for online learning has been developed and was posted to Adult and Aging Services website in January 2022.
  - This module is discussed with QSPs at the quarterly critical incident virtual training events and a link to the training is also shared.
  - The link to this module is also shared when providing one on one education to QSPs.

    https://www.hhs.nd.gov/human-services/providers/adults-and-aging/qualified-service

The QSP Hub developed a new QSP orientation that covers the critical incident reporting information based on the existing information from the handbook. The first QSP orientation was held virtually in January 2023.

- Two (2) CIR virtual training events were held, and one in-person presentation was done at the LTC Conference. Virtual training is done quarterly.
- Fifteen (15) live application support sessions were completed by the QSP Hub.

See Section VXI.A&B.Strategy 1

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, and welfare of all TPMs receiving HCBS, all critical incidents as described in the SA must be reported and reviewed by the State. Any QSP who is with a TPM, involved, witnessed, or responded to an event that is defined as a reportable incident is required to report the critical incident.

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 business day. **(Completed July 1, 2021)**

Progress Report:

Performance Measure(s)

Percent of critical incidents reviewed within one business day of receipt.

- Out of the 322 incidents involving TPMs, 306 (95%) were reviewed within required timeframes.

  - June 14 – June 30, 2022 – 34 out of 36
  - July 2022 – 46 out of 49
  - August 2022 – 56 out of 59
  - September 2022 – 45 out of 45
  - October 2022 – 48 out of 51
  - November 2022 – 44 out of 47
  - December 1 - 13, 2022 – 33 out of 35

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

Progress Report:

Performance Measure(s)

Percent of critical incident reports reviewed by State staff.

- 100% of critical incident reports received were 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.

Progress Report:

Processes to include:

- Completion of any missing data elements from the initial report to be completed by the lead investigator for the State,

  - The Critical Incident Reporting protocol defines additional investigators who may be involved in the critical incidents including: the Ombudsman, the ND DOH, and VAPs investigators.

- Timelines and guidelines for the investigation of incidents,

- Program Administrators meet as needed to review these incidents and as needed to ensure there is follow-up if the incident involves a QSP complaint. As of June 14, 2022, the QSP complaints are now in the case management system, and it can be documented as a task that it also involves Critical Incident report.

- 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).

  - Remediation plans are documented in the corrective action/plan of future corrective action section within the incident report. The type of remediation plan/timeline is dependent on the type of incident. Each critical incident that is forwarded to the DOJ/SME for review has a remediation plan included for review.

- A method for tracking when an incident has an associated complaint. **(Completed June 14, 2022)**

  - Incidents that have an associated complaint are marked by the QSP complaint Program Administrator in the complaint documentation and noted in the Critical Incident report (GER in Therap).

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. **(Completed January 1, 2022)**

Progress Report:

A list of all deaths will be sent out one week prior to quarterly incident reporting meeting to all Critical Incident Report team members and will be documented in meeting minutes. Each death is reviewed by HCBS Case Manager and Nurse Administrator. Unexplained deaths are also forwarded to Aging Services Director to review. The Medicaid Fraud Control Unit (MFCU) has joined the CIR team.

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 began June 1, 2021)**

Progress Report:

Performance Measure(s)

Number of amendments reported.

- Since December 14, 2020, three amendments to the HCBS waiver and a 5-year waiver renewal application were submitted to the USDOJ, and the SME as required.
- The Medical Services 1915(c) HCBS waiver was approved for a 5-year renewal effective April 1, 2022.
- The State is requesting a Waiver amendment that would be effective April 1, 2023. The purpose of the amendment is to incorporate administrative language changes that were approved under the North Dakota Administrative Code (NDAC) effective October 1, 2022, further defining waiver language under the services of Environmental Modification, Non-Medical Transportation, Supervision, Residential Habilitation, Community Supports, and Adult Residential Services. The amendment would also update internal processes for person-centered planning, client choices, handling reasonable modifications requests, and Long-Term Services and Supports Options Counseling.
- 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 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 began June 14, 2021)**

Progress Report:

Performance Measure(s) Number of TPM complaints

Number of TPM complaints

- There were 61 complaints involving TPMs during this reporting period.

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

- All 61 complaints were responded to within the required timeframe. Link to Appendix C.

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 DHHS website, HCBS application form, “HCBS Rights and Responsibilities” brochure, presentation materials, and public notices. **(Completed February 1, 2022)**

Progress Report:

The Rights and Responsibilities Brochure has been updated and posted to the DHHS Aging Services publications website and distributed to the HCBS Case Mangers. Additional training on the updates was held on January 24, 2022, during the HCBS Update meeting. The application for services has also been updated and was manualized on February 1, 2022.

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 began June 14, 2021)**

Progress Report:

Performance Measure(s) Number of TPM complaints

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

- There were 61 complaints associated with a TPM from June 14, 2022-December 13, 2022. All complaints were responded to within the required timeframe. Link to Appendix C.

Appendix A

Appendix A is the Dashboard reports.

Appendix B

ND Stakeholder Engagement Meeting: Long-Term Care Options Counseling in North Dakota

Meeting Date: March 23, 2022

Agenda

9:00 – 9:15	**Welcome + Introductions + Meeting Goals** *Bevin Croft*
9:15 – 9:30	**Long-Term Care Options Counseling: What it is and why it matters** *Nancy Nikolas-Maier*
9:30 – 9:45	**Review Current Process and Updated Referral Form** *Sandi Erber*
9:45 – 9:50	**Common Themes from Stakeholder Interviews** *Pat Rivard*
9:50 – 9:55	**Break**
9:55 – 10:25	**Conversations about Community Options** *Sandi Erber and Pat Rivard*
10:25 – 10:55	**Follow-Up Strategies** *Sandi Erber and Pat Rivard*
10:55 – 11:00	**Closing + Next Steps** *Bevin Croft*

Meeting Polls

A total of 34 participants joined the meeting and 18 participated in the meeting polls.

In what roles do you self-identify?

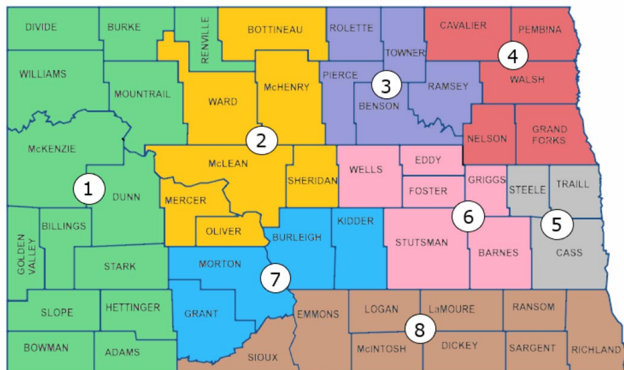
- Person with a disability/person who uses long term services and supports: 4% (1)
- Family member/natural supporter: 4% (1)

In what roles do you self-identify?

- Person with a disability/person who uses long term services and supports: 4% (1)
- Family member/natural supporter: 4% (1)

- Hospital Staff (discharge planner, social worker, administration): 0% (0)
- Nursing Facility Staff (discharge planner, social worker, administration): 8% (2)
- Ombudsman: 0% (0)
- Qualified Service Provider: 0% (0)
- Community Case Manager or Social Worker: 24% (6)
- Tribal Member or Tribal Representative: 4% (1)
- Advocate or Self-Advocate: 12% (3)
- Government Employee (federal, state, tribal, or municipal): 44% (11)

What region do you live or work in?



- 1: 4% (1)
- 2: 14% (3)
- 3: 9% (2)
- 4: 0% (0)
- 5: 23% (5)
- 6: 4% (1)

- 7: 28% (6)
- 8: 14% (3)

Engagement Questions

Should a question be added to the screening form to learn if an individual has concerns about having the financial resources needed to move back into the community?

- *When you were in the community, you said you lived in your home, did you have any concerns about financially meeting your needs?*
  - I think anyone in a facility on Medicaid will have financial concerns.
    - Is this something we need them to talk to us about before they know us though?
  - Financial question should be asked upfront. Most people are willing to discuss finances if they know it will help the ultimate decision they are making.
  - Consider hanging posters around facilities.
    - During COVID, families wouldn't have even been able to see posters – not sure families would see posters because visitation has been restricted.

How can we improve the group meetings?

- The forms for the meetings are helpful and it's obvious there's more effort being put into this because the forms are more complete.

What kind of follow-up should we do with individuals after the group meetings to determine if they are interested in learning more or pursuing community options?

- Offer to come back the following week to meet with residents individually who are interested in pursuing.
- Post-presentation survey.

How should we ensure that families/natural supports are informed of community options and services?

- Advertise in local papers in rural areas or do letters to invite family members.
- Offer to contact families directly if they have an interest.
- Social media outreach.
- Peer visiting training.

What is a good timeframe for follow-up on information on community services? Aging Services currently reaches out 2-5 days after referral. If this should be expanded, how long?

- With hospitalizations specifically, the 5-day window tends to be a little short because the individual has been through so much and are still healing and families might be overwhelmed. One more voice that comes in gets a little overwhelming and lost in translation sometimes. From a team perspective, an extended period would be helpful, either 7 or 10 days so that information is more easily received.
    - Agreement with waiting a few days. The nursing home has so many assessments and therapies to do right away as well as adjusting to the environment and routine of the facility.
- From a Center for Independent Living perspective, sometimes get a referral two weeks after the meeting, so timely communication is critical.

What kind of follow-up should there be for individuals referred via the process but decline to meet with a Case Manager?

- Brochures are nice.
- Having the case worker and nursing home social worker working together more often will be helpful, especially when the resident later chooses to get more information. Then, the conversation can be held at another time.

What recommendations do you have for the follow-up process (frequency of checking in, discussion topics, materials to provide, etc.)?

- Facilities ask for the brochures to include in their admission packet because it's a great way to get the word out.

What kind of follow-up should there be for individuals referred via the process, meet with the Case Manager, and decline to pursue community options?

- When the case worker is in the facility at another time, it would be fine to stop in and visit again in case they have further questions, or just to say hello.
- Provide some testimonies of success.
  - When we hear of dreams and hopes, it can help others think about their options and what's possible for them.
- Casual conversation follow-up.
- Case Manager lets individual know they will be back in the building and ask if it's ok to pop back in – maybe less about LTSS Options Counseling (informed choice) visit and more about relationship building.
- Talking with the nursing facility social worker three to six months after the meeting to see if there's any change with the individual and reconnect with the individual/family.
- Provide the nursing facility with brochures to give to residents/families during annual care conferences and/or upon admission, along with LTSS Options Counseling (informed choice) workers contact information.
  - The process on who to contact is still confusing.
    - Each facility will get a worker assigned to that facility. Do have the ADRL and the information is on all programs – no wrong-door approach to contacting. If anyone calls that number, they will get information on home and community based services and LTSS Options Counseling (informed choice) or community outreach specialists can go out and do a visit.
      - Like the phrase "no wrong door."
    - Having a specific worker in the facility will be great.
- Worker leaves a business card and a brochure after every visit and likes to make special mention to the ADRL line, too.

Are there other suggestions on how to help people in a hospital or nursing facility make informed decisions about where they live and receive services and supports?

- Is there already hospital and nursing home staff training provided or offered to staff so questions can be asked during admission and discharge planning?
- Some social workers are not happy about LTSS Options Counseling (informed choice) coming in to do visits.
  - Example of needing to get the word out to families: Wondered where MFP was in 2018 when mom had a stroke, and nursing home didn't share that with the individual.

    - Having the social worker part of the LTSS Options Counseling (informed choice) visit has been beneficial and reiterating that LTSS Options Counseling (informed choice) is another resource for the individual and the social worker.
    - Social workers often have administration pressuring them to keep long-term care facility beds full.
- Workers in Dickey County have been great but struggle to understand who does what part for discharge planning.
    - The Role Matrix does outline responsibilities.
    - The LTSS Options Counseling (informed choice) workers start the person-centered planning.
    - Consider enhancing the roles and responsibilities process.
- Lack of physician support has been a barrier with nursing facilities as well, so education to the physicians is huge.
- There's more accountability for Centers for Independent Living and less on nursing facility for discharge planning, will there be anything in place imposed for them by the state? Sometimes nursing facilities make the process harder for the CILs but have no accountability.
    - There is administrative code about who governs what, and Aging Services needs to know if a facility blocks someone from coming. People have a right to visitors. This isn't a substitute for discharge planning and there's still an obligation for people to go home.

Other Questions and Comments

- Who are the community outreach specialists?
    - They are State staff who work for Aging Services that go out and visit individuals in the community to do LTSS Options Counseling (informed choice) visit.
- Always looking to meet CEU's, will this be submitted as such?
    - Stakeholder engagement don't count, but there are other trainings that CEUs are offered for.
- Appreciation for the meeting, including, "Thank you all for the hard work, it's a process, but it's clear ND is definitely moving in the right direction!"

Appendix C

Complaint Type	# by Type	Pending Outcome	Unsubstantiated	Substantiated	Remediation provided
Absenteeism	16	3	6	7	4 resulted in a remediation plan and 3 resulted in technical assistance
Abuse/Neglect/Exploitation	4	0	4	0	Technical Assistance- employee was terminated, AFC Corrective Action
Breach of Confidentiality	1	0	0	1	remediation plan
Poor Case Management	0	0	0	0	
Criminal History/Activity	3	0	2	1	Provided Technical Assistance and recoupment of payments
Theft	0	0	0	0	
QSP Disrespectful	4	2	1	1	provider completed remediation
Inappropriate Billing	6	1	0	5	3 resulted in technical assistance and recoupment of payments. 1 resulted in termination, 1 was referred to program integrity
Poor Care	24	9	5	10	1 termination, 1 technical assistance a recoupment of payments, 8 resulted in a remediation plan
QSP Damage Recipient Property	2	0	1	1	remediation plan
QSP under the influence of Drugs/Alcohol	1	0	0	1	1 remediation was complete, employee was terminated
Self-Neglect	0	0	0	0	
Other	0	0	0	0	
Total complaints associated with TPM	61	15	19	27	

Appendix D

Appendix D is the Comparison Dashboard reports.

Appendix E