North Dakota – Department of Justice Settlement Agreement

Biannual Report
December 14, 2025 – June 13, 2026

ND Department of Human Services
Aging Services Division

Submitted

7/15/2026

List of Acronyms

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

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

Introduction

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

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

This report describes progress toward the requirements listed in Sections VI–XVI for December 14, 2025, through December 13, 2026. The report is based on the approved SA IP. All the requirements and associated strategies toward compliance that were due or are being worked on in this reporting period are included. New information is provided under the progress report heading highlighted in yellow and target dates were modified when necessary.

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

The State also posts an annual comparison dashboard that highlights the progress and data trends since the SA was signed on December 14, 2020.

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

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

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

behavioral health, home health, housing, and HCBS.

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

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

What We're Proud of

Major accomplishments during the first six (6) months of Year 6 (**December 14, 2025 – June 13, 2026)** of the USDOJ SA:

- **Transitioned 56 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 149** new individuals from a SNF by providing necessary services and support so they can remain at home with their family and friends.

- Provided **information about HCBS** options through **467** unduplicated LTSS Options Counseling referral visits to **456** unduplicated TPMs referred for a long-term stay in a SNF.

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

    - Provided **7,694 callers** with information and assistance about HCBS and assisted another **991** through the **web intake** process**.**

    - Referred **718 individuals** from these contacts for **HCBS**, which is an average of **144** per month.

- HCBS Case Managers responded to **868 HCBS referrals** from all sources (ADRL intake, direct referral, MFP, LTC Eligibility Unit, and LTSS Options Counseling visits).

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

- Provided **permanent supported housing** assistance to **38 (MFP Rental and/or TPM Rental Assistance) TPMs** who transitioned out of a SNF.

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

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

A 6-month perspective of Year Six

Halfway through Year 6 of the SA, demand for HCBS remained consistent. A total of 3,364 individuals are receiving HCBS, including 944 TPMs, representing 28% of those served. Although the number of TPMs is significant, over the past five (5) years the State has expanded access to services both for individuals with significant impairments and for those with lower levels of need by investing in up to 24/7 support and in programs that do not require a NFLoC care to become eligible. The lower-level services help people receive support earlier and maintain independence and housing in the community which helps them avoid more intensive and costly care. Part of the State's Long-Term Care reform strategy is to offer services and supports that help people stay independent at the first signs of functional decline. Diverting individuals with relatively low levels of need away from higher, more costly levels of care including state and federally-funded HCBS helps reserve resources for TPMs who need a higher level of care to live in the most integrated setting. The costs of serving TPMs with complex medical, physical, and behavioral health needs is continuing to rise and State's faced with budget cuts or a decrease in funding will be challenged to serve this growing population.

As previously reported, the number of individuals in need of HCBS will significantly increase as the baby boom population ages and more people will be looking for long-term care options. According to the ND State Data Center, North Dakota's 65+ population, currently about 18% of the total population, will increase by approximately 3,000 people by 2035. While a slight decline is projected between 2035 and 2045, growth in the 85+ population is expected to resume thereafter.

The number of referrals remains high, but the number that results in an open HCBS case continues to decline. Many individuals do not meet the financial or functional eligibility requirements necessary to qualify, despite having legitimate care needs and limited ability to pay for services privately.

In the past six (6) months, HCBS Case Managers have responded to 718 referrals to assess individuals requesting HCBS. On average, 144 new referrals and 67 new cases opened for HCBS each month during this reporting period. All individuals who are referred to for state or federally-funded HCBS are eligible for a home visit, which impacts case management workloads. Case Managers may travel long distances to see individuals who will ultimately not qualify for care.

To improve efficiency, the State is exploring virtual financial assessments or electronic submission of financial documentation before scheduling a home visit for individuals whose financial eligibility is uncertain. For example, this may include individuals who are not enrolled in Medicaid or are unable to accurately report their income and assets during the initial ADRL screening. If financial eligibility is confirmed, a face-to-face visit would then be conducted to complete the functional assessment. The State believes in-person visits

remain essential to accurately assess functional eligibility, identify service needs, and provide person-centered care.

To build additional case management capacity, Adult and Aging Services recently finished hiring four (4) HCBS Case Managers, and one (1) Basic Care Case Manager. The new hires appear to have some impact on the average weighted caseloads. At the end of Year 5, the average weighted caseload per HCBS Case Manager was 121. At the end of the first quarter of year six (6), the average is 118. Although the weighted caseloads are still high the trend is moving in the right direction. The State estimates we will need ten (10) new HCBS Case Managers over the next biennium to bring the caseload numbers down to an ideal 100-110 cases.

The State recently received an additional extension from the Centers for Medicare and Medicaid Services (CMS) to expend the American Rescue Plan Act (ARPA) of 2021, Section 9817, enhanced federal funding through December 31, 2026. This extension provides additional time to complete the remaining projects included in the State's approved spending plan, including finalizing the HCBS Core Curriculum developed by the University of Wisconsin – Green Bay and implementing the new learning management system (LMS).

The LMS will allow Qualified Service Providers (QSPs) to complete the training required to demonstrate competency before enrolling as providers. The HCBS Core Curriculum consists of approximately 18 to 20 hours of training, depending on the services a provider intends to deliver. Learners must successfully complete a series of quizzes to demonstrate competency before completing the curriculum. Training topics include person-centered practices, community inclusion, activities of daily living, proactive support strategies, health and safety, health and wellness, evaluation and observation, cultural humility, intimacy and respect, healthy caregiving, professionalism, and recognizing abuse, neglect, and exploitation.

The State is currently drafting administrative rules to include these new provider training requirements. In addition, the State is proposing to require agency providers to have at least two (2) years of direct care experience before enrolling to provide Residential Habilitation or Community Support Services. These services support individuals with significant physical and medical needs who often also experience behavioral health conditions and substance use disorders. Ensuring providers have appropriate experience is an important step toward maintaining high-quality, person-centered services.

Nationally, there has been increased attention on fraud, waste, and abuse (FWA) within HCBS. CMS recently directed all state Medicaid agencies to revalidate providers identified as higher risk for FWA within the next two (2) years. In North Dakota, the provider groups subject to this requirement include non-emergency medical transportation providers, 1915(i) Behavioral Health providers, and QSPs. QSPs were identified because they provide personal care services in unsupervised community settings, which may present unique program integrity challenges.

Historically, some QSPs have struggled to comply with federal and state program requirements. The State has made significant investments to strengthen provider compliance, including developing the QSP Hub and implementing an Electronic Visit Verification (EVV) system that also serves as a documentation and billing platform. While these initiatives have improved oversight, there are still compliance issues. As a result, State staff have developed a comprehensive FWA strategy designed to strengthen program integrity while maintaining access to high-quality HCBS.

Key initiatives include:

- Requiring agency QSPs to affiliate with each individual employee providing direct care services.
- Requiring each direct care employee of an agency QSP to enroll as an individual QSP and obtain a National Provider Identifier (NPI).
- Strengthening enrollment requirements for agency owners who seek to operate multiple provider agencies.
- Increasing qualification standards for Residential Habilitation and Community Support providers by requiring additional training and direct care experience.
- Strengthening EVV compliance through increased monitoring and targeted program integrity audits.
- Expanding provider education and technical assistance through quarterly compliance training and the implementation of the new LMS, including competency-based training.

Implementing these initiatives will require modifications to existing enrollment and information technology systems. The State is currently evaluating the most efficient approach to meeting the new QSP enrollment revalidation requirements. In addition, Adult and Aging Services will hire an additional Quality and Compliance Program Administrator to support provider oversight and program integrity activities.

These efforts come at a time when demand for in-home services continues to grow. All states face increasing challenges in ensuring providers understand and comply with ever evolving rules and regulations. In ND, the average QSP agency employs fewer than 10 staff, and many individual QSPs operate as independent providers. Previous provider surveys indicate that many enter this profession because they have cared for a family member or have a strong desire to help others. While most providers are committed to delivering quality care, the consequences of noncompliance are significant. The State remains committed to supporting providers through education, training, and technical assistance while strengthening oversight to identify and address inappropriate activity and concerns about poor care.

The majority of QSPs provide quality care and are committed to doing the right thing. The State is committed to helping providers succeed, which will ultimately improve access to care and increase opportunities for individuals with disabilities to live full, meaningful lives in their communities. At the same time, providers are expected to comply with program requirements to ensure public funds are used appropriately and individuals receive the high-quality services they deserve.

Looking Ahead

A Year 6 - 7 (an 18-month plan that runs through 9/30/2027) Implementation Plan (IP) is due August 01, 2026. These are some key themes that will drive the strategies going forward.

Support QSPs

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

Divert TPMs from Institutional Stays

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

Facilitate TPM Transitions to Integrated Settings

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

Expand Permanent Supported Housing

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

Increase Quality and Integrity in HCBS

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

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

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

SA Section #	Requirement	Due Date
VI.F	Develop an Implementation Plan for Year 6 and 7 (An 18-month plan that runs through 6/13/28).	08/01/2026
XIII.D	Provide technical guidance to SNFs that commit to provide HCBS and rural community providers who commit to expand	Ongoing requirement
XIV.A 1.	Conduct individual or group in-reach to each nursing facility	Completed annually
VIII.I 2.	Person-centered planning training for Case Managers	Completed annually
X.B.2.	Implement incremental changes to the NF LoC process and community-based services eligibility	06/14/2022 and ongoing
X.B.3.	Require annual NF LoC determination screening for all continued stays in a nursing facility for TPMs.	12/14/2022 and ongoing

XI.B	Transitions occur no later than 120 days after TPM chooses	06/14/2022 and ongoing
XV.D	Submit year 6-7 IP	08/01/2026 – The date was pushed back so the biannual report is submitted before the IP.
XV.D	State Biannual Data Report	01/31/2026 & 07/31/2026
VIII.I	Provide PCPs to an additional 670 TPMs within six (6) years of the effective date	12/13/2026
XI.E	Transition at least 70% of TPMs requesting transition from SNFs	12/13/2026
XI.E	Divert at least 150 TPMs from SNFs so that at least 400 TPMs have been diverted since the effective date	12/13/2026

SA Section VI. Implementation Plan

Responsible Division(s)

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

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

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

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

Implementation Strategy

Continue to conduct internal and external listening sessions that include a review of relevant services with stakeholders and staff from the ND DHHS Aging Services, Medical Services, Developmental Disability, and the Behavioral Health Division. One priority is identification of administrative or regulatory changes that need to be made to reduce

identified barriers to receiving services in the most integrated setting appropriate. **(Ongoing strategy)**

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

Progress Report:

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

An updated feedback summary will be drafted in January 2027.

QSP training. To address training needs for Qualified Service Providers (QSPs), the Department has adopted the University of Wisconsin–Green Bay HCBS training modules as the baseline training required for QSP enrollment and is finalizing the LMS. The State is still reviewing additional training options to determine requirements for behavioral health, traumatic brain injury (TBI), and dementia care credentials. The state is also updating administrative code to gain authority to require individuals and agency QSPs to meet the new training standards.

As previously reported, stakeholders emphasized that credentials should be voluntary and that providers should have choice and input regarding training requirements. This belief may be widespread amongst QSPs, and the State has already received feedback from QSP agencies that do not want their staff to take the core curriculum because they have their own training. This may be true, but 56% of the QSPs answered that they did not believe their teams need any additional training even though we continue to have complaints about untrained caregivers and poor care. The State believes requiring new training and provider requirements is warranted because of the increasingly complex needs of TPMs and the competitive rates that are reimbursed for these services.

Rates for medically complex individuals. In response to feedback regarding individuals with complex medical needs, the State will continue to monitor provider rates. A three (3) percent rate increase was given to all QSPs for dates of service July 1, 2026, and after.

Housing barriers. To address housing as a major barrier to community living, the State received an ongoing appropriation of $300,000 in the Adult and Aging Services budget to provide rental assistance to Target Population Members (TPMs). Since the start of the biennium the State has obligated $124,824 of these funds.

Guardianship needs. To respond to the growing demand for guardians, the State received $423,000 in the Adult and Aging Services budget to support the Guardianship Establishment Fund. There is still a waitlist for these services. The State has created an Office of Guardianship & Conservatorship to oversee all guardianship functions, including management of the Guardianship Establishment Fund for both Aging and Developmental

Disabilities. The State will also develop educational materials to help individuals with guardians better understand their rights and available options when their preferences related to community living are not being considered. Issues related to capacity and consent for community transition will also be addressed. Four (4) meetings have been scheduled that will bring a workgroup together to develop these materials. The work groups will consist of staff from the Office of Guardianship & Conservatorship, Adult and Aging Services, Legal Services, and Protection and Advocacy. The first meeting is August 10, 2026.

Disease-specific training. In response to interest from QSPs in disease- and diagnosis-specific training commonly associated with HCBS recipients, the State is partnering with the QSP Hub to develop a series of webinars. A training schedule has been created (see below), and the QSP Hub promoted these opportunities across the stakeholder network. Some of the training sessions were live and were not well attended. The largest webinar had 31 people in attendance. The rest of the series was pre-recorded so the providers can listen to them at their convenience.

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

Session 2: Fall 2026

- August 2026
    a. Topic: Stroke
    b. Presenter TBD
- September 2026
    a. Topic: Chronic Heart Disease
    b. Presenter: TBD
- October 2026

a. Topic: Addiction and Substance Use Disorder
b. Presenter: NAADAC

- November 2026
  a. Topic: Creating a Safe Home Environment
  b. Presenter UND Occupational Therapy Department
- December 2026
  a. Topic: Nutritional Well Being
  b. Presenter: Brooke Fredrickson: brooke@brookefredrickson.com Intuitive Eating, Mindful Eating, Weight Science, Weight-Neutral Nutrition, Diabetes, Childhood Weight & Feeding Issues, Body Image, Psychology of Eating

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

Medical housing. To address the need for medical housing for TPMs with extraordinary medical needs, the State received $200,000 to support development of a medical housing prototype. The prototype will incorporate design features recommended by disability advocates. A request for qualifications has been issued to identify a qualified provider to design the prototype and estimate construction costs and rental cash flow. The contract was awarded to Stone Group architects. A series of stakeholder input meetings are being held, and they will produce prototypes and estimated construction costs by September 2026.

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

Implementation Strategy

Strategy 1. The State will continue to create ongoing stakeholder engagement opportunities including quarterly ND USDOJ stakeholder meetings through Year 6 of the SA. The State will educate stakeholders on the HCBS array, receive input on ways to improve the service delivery system, and receive feedback about the implementation of the SA. The State asks for feedback on a variety of topics, shares data, and allows time for attendees to share any issues they feel need to be addressed at each meeting. A Stakeholder feedback summary will be completed at the end of the year. **(Ongoing strategy)**

2026 Meeting Schedule:

- March 23, 2026

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

Updated Strategy 2. The State will host eight (8) in-person meetings in rural, frontier, and Native American reservation areas of North Dakota to discuss Home and Community-Based Services (HCBS). These sessions, distinct from USDOJ stakeholder meetings, aim to assess existing services and address unmet HCBS needs, especially in underserved areas. Meetings will offer information on HCBS, provider enrollment, and gather local feedback to guide improvements. Event dates will be posted on the DHHS website, and a year-end feedback summary will inform future service enhancements. Invitations will be extended to local hospitals, Skilled Nursing Facilities, social services, community leaders, and advocates. **(Completed December 13, 2025)**

Progress Report:

In-person meetings were held in Minot, Grand Forks, Jamestown, Valley City, Bismarck, Fargo, and Wahpeton. No meetings have been held on reservations but there have been email and telephone communications with all four (4) tribes. In addition, an Adult and Aging Services team member provides onsite technical assistance for all the reservations once a month.

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

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

Progress Report:

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

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

Implementation Strategy

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

Progress Report:

The Agreement Coordinator and the SME continue to meet weekly.

Website (Section VI, Subsection H, page 10)

Implementation Strategy

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

Section VI. Performance Measure(s)

Number of unduplicated individuals served in HCBS by funding source.

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

SA Section VII. Case Management

Responsible Division(s)

DHHS Aging Services

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

Implementation Strategy

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

develop and deliver training for HCBS case managers. Post-training evaluation tools to ensure understanding of training objectives have been developed. **(Ongoing strategy)**

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

Updated Strategy 2. The State has two (2) Full Time Equivalent (FTE) that serve as provider navigators who will assist all HCBS case managers statewide in finding QSPs to serve eligible HCBS recipients. The State is considering the feasibility of using the new Connect to Care system, formally referred to as ConnecttoCareJobs platform, to share referrals for HCBS to QSPs. Assistance from the provider navigators frees up time for the case managers and assists them in keeping up with the increased demand for HCBS. **(~~Target completion date August 1, 2025, and~~ Ongoing strategy)**

Progress Report:

Two (2) provider navigators continue to assist TPMs with identifying available QSPs. The navigators are very knowledgeable and have created good connections with the provider community. The provider navigators have received 573 referrals during this reporting period.

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

Updated Strategy 4. To ensure a sufficient number of HCBS case managers are available to assist TPMs in learning about, applying for, accessing, and maintaining community-based services for the duration of the SA, the State will continue to monitor weighted caseloads of the 74 licensed social workers currently hired as HCBS case managers. The State has plans to add four (4) additional case managers in 2025 and to add one (1) additional Basic Care Case Manager. (**Hiring complete June 30, 2026)**

Progress Report:

The State has hired four (4) new HCBS Case Managers and one (1) Basic Care Case Manager. The State administratively claims Medicaid funds to cover the cost of case management services provided to Medicaid-eligible individuals. This additional revenue will support the continued provision of these services and help fund the hiring of additional case managers as needed. The State believes that it will need ten (10) additional HCBS Case Managers in the next biennium to meet the growing demand for care.

New Strategy 5. The State has established a workgroup consisting of HCBS Case Management Supervisors and Aging Services Program Administrators to analyze the

business process of entering all required information into the State's case management system. The goal of this review is to identify steps that may be delegated to administrative support staff thus freeing up time for the HCBS Case Managers to focus on client-facing duties. If enough administrative tasks are identified, the state will consider the feasibility of hiring administrative support for the HCBS Case Managers. **(Ongoing Strategy)**

Progress Report:

This meeting continues to occur and recently eight (8) case managers were added to this group. Most of the reasons why we cannot remove some tasks from the case managers not necessarily tied to serving consumers is that we do not have any administrative support staff to do those tasks. Also, the increase in data entry that case managers have is due to administration needing to be able to report items for the USDOJ and CMS and this has created more inputting of data. We have a pilot project in place in two (2) case management areas to see if the DHHS mailroom staff can help with mailing to see how many administrative support staff we will need in the future.

Assignment (Section VII, Subsection B, page 10)

Implementation Strategy

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

Progress Report:

Cases are assigned to case managers within an average of one and one-half (1.5) days.

Capacity (Section VII, Subsection C, page 10)

Implementation Strategy

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

Challenges to Implementation

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

Remediation

The State continues to monitor the need for additional HCBS case managers. The

goal is to have a weighted caseload of no more than 100 cases per case manager **(Ongoing strategy)**

Progress Report:

Caseloads are reviewed monthly by the Program Administrator and territory supervisors. This helps us determine where caseloads are high and where we need to hire or have other Territories help. The State estimates we will need an additional ten (10) HCBS Case Managers over the next biennium to keep caseloads manageable.

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

Progress Report:

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

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

Implementation Strategy

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

Progress Report:

There were no incidents in which a SNF refused full access to a TPM residing in or being admitted to the facility. One (1) facility questioned why LTC Options Counselors are required to provide information to all TPMs residing in the facility, even those with cognitive issues. The MFP Project Director and the CIL staff are continuing discussions with this provider to strengthen the relationship and address any concerns internally.

Updated Strategy 2. Conduct training with hospital and SNF staff to discuss HCBS, LTSS OC, facilitate case management for TPMs, and the required annual level of care screening. The training will be adjusted over time to reflect further changes to the Nursing Facility

Level of Care (NF LoC) process and to address any emergent issues and may be provided virtually. The Year 5 focus will be to help these entities understand the need to make referrals as soon as possible to facilitate safe discharge and access HCBS the first day they return home. **(Ongoing strategy)**

Challenges to Implementation

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

Remediation

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

Progress Report:

See Section VII Performance Measure(s)

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

Progress Report:

The LTSS Options Counselors continue to utilize educational materials daily.

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

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

The DD section will also conduct quarterly quality checks of up to 20 cases to ensure that eligible individuals receive information about the state's HCBS coverage, both initially and

annually thereafter. The number was selected after reviewing the individuals who meet the TPM definition and requested intake through the DD system. At the time, 19 individuals in the DD system met the TPM criteria. This process will begin in October 2025, using data from July 1, 2025 - September 30, 2025. **(Complete ~~July 1, 2025,~~ February 11, 2026)**

Progress Report:

A training session for DD staff members was held on 2/10/26 to review the new DD Intake Folders and Road Map. We completed pre-and post-training surveys as part of this training. The training information was also sent out to all DD staff members on 2/12/26. The new documents will help ensure that all individuals in DD, including those applying for DD services through the DD intake system, have access to information about all DHHS HCBS and Medicaid State Plan options they may qualify for.

The new folders have been in use in all eight (8) regions since the training. The Road Map document will be reviewed annually with individuals in services, and the Individual Service Plan (ISP) was updated to include language of being informed about HCBS and Medicaid State Plan services. We also updated our OSP instructions outlining the new process which includes documenting the discussion about all available services in the DDPM section as well as documenting that discussion in an Admin Note for those in DD Program Management only.

Feeback received from those in the field has been very positive, with the only negative comment that the size of the Road Map is too large to fit into work bags.

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

Updated Implementation Strategy

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

Progress Report:

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

Quality (Section VII, Subsection F, page 11)

Updated Implementation Strategy

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

Progress Report:

See Section VII Performance Measure(s)

ADRL (Section VII, Subsection G, page 11)

Implementation Strategy

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

Section VII. Performance Measure(s)

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

- The annual report for 2026 will be completed by January 31, 2027.

Total number of HCBS case managers serving Tribal nations.

- There are 15 HCBS Case Managers (CMs) who work in reservation communities. All case managers travel to other areas and serve people who are tribal members but live all over the state.

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

- Training will be completed in the fall of 2026.

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

- DD Options Counseling will officially start after February 10, 2026, staff training. Sixty-nine (69) individuals received options counseling during this reporting period.

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

- Four (4) individuals have asked for a referral for Aging from 2/11/26-7/1/26, with three (3) individuals completing the intake. One (1) individual ultimately decided not to complete the Aging intake process.

DDPM's understanding of HCBS options after February 2026 training.

- An evaluation of February 10, 2026, training to kick off the DD Options Counseling process was held and included a pretest and posttest survey to measure what was learned about the new process. The results are included in the chart below.

Question	Pre Survey %	Post Survey %
I understand what we are trying to accomplish in DD related to the USDOJ agreement.	Strongly Agree - 9.8 Agree - 37.8 Neutral - 36.6 Disagree - 12.2 Strongly Disagree - 3.7	Strongly Agree - 32.4 Agree - 54.9 Neutral - 7.0 Disagree - 4.2 Strongly Disagree - 1.4
I am familiar with the components of the new DD intake folders and how to use them.	Strongly Agree -10.8 Agree - 30.1 Neutral - 31.3 Disagree - 22.9 Strongly Disagree - 4.8	Strongly Agree - 38.0 Agree - 50.7 Neutral - 4.2 Disagree - 5.6 Strongly Disagree - 1.4
I know how and when to use the new Road Map document to inform individuals of all available services.	Strongly Agree - 3.7 Agree - 22.2 Neutral - 40.7 Disagree - 28.4 Strongly Disagree - 4.9	Strongly Agree - 32.4 Agree - 49.3 Neutral - 14.1 Disagree - 2.8. Strongly Disagree - 1.4

SA Section VIII. Person-Centered Plans

Responsible Division(s)

DHHS Aging Services

Training (Section VIII, Subsection A, page 11)

Updated Implementation Strategy

- See Section VIII, Subsection H (Ongoing strategy)

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

Updated Implementation Strategy

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

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

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

Progress Report:

See Section VII. Subsection E

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

Implementation Strategy

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

Progress Report:

The State is working with the case management vendor to finalize the updated PCP in the system. We are very close to finalizing the documents and all training will be completed in December 2026.

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

Implementation Strategy

To comply with Title II of the ADA which states that a public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination based on disability, unless the public entity can demonstrate that

making the modifications would fundamentally alter the nature of the service, program, or activity. The State will work with the DHHS Legal Advisory Unit and other agencies or boards to determine if a request for reasonable modification can be accommodated as required in the SA. **(Ongoing strategy)**

Progress Report:

The State will continue to conduct annual training with HCBS case managers and stakeholders to increase knowledge and awareness of how to identify and notify the Department that an individual has an anticipated or unmet community service need so that the State can determine whether, with a reasonable modification, the need can be met. The State will continue to track all requests for reasonable modification to identify trends in service gaps, location, utilization, or provider capacity. Training was completed June 30, 2026.

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

Implementation Strategy

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

Progress Report:

See Section VIII Performance Measure(s)

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

Updated Implementation Strategy

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

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

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

Progress Report:

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

The North Dakota Adult and Aging Services Section Person-Centered Competency Training Series was developed in collaboration with the University of Missouri-Kansas City training, as sub-contracted by the Human Services Research Institute and National Center on Advancing Person-Centered Practices and Systems (NCAPPS) and North Dakota DHHS, Adult and Aging Services. Five modules have been developed in alignment with the National Center for Advancing Person-Centered Practices and Systems' competency domains for person-centered planning facilitation. The state continues to offer the Person-Centered Competency Training Series to ensure new hires are able to complete the training in the first 12 months of employment with Aging Services. The state will continue to train new Adult and Aging Services staff as they onboard using the trained trainers.

The entity and State developed a train-the-trainer program for person-centered competencies, learning modules, and hands on learning. The train the trainer program was completed in 2025.

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

The State used federal ARPA 9817 10% funds to hire a temporary staff person with an education degree and experience in adult learning to complete the implementation and evaluation of Person-Centered Competencies and data collection that will be used to inform professional development and quality management practices. The data collected will be used by supervisors, trainers, mentors, and quality assurance teams to observe, rate, and document demonstrations of competency attainment and provide recommendations to staff for improvement and/or additional skill development. Aging Services supervisors, mentors, and staff have been trained in the Indicators of Competency and Evaluating Competency in Person-Centered Planning. The evaluation of competency is based on self-reflection, supervisor/observation, service experience, and quality audit/review. Project completion date was 5/31/2026.

Adult and Aging Services will learn ways to remediate any gaps in knowledge identified through the process. State administration will use the aggregate data from the evaluations to offer training targeted at areas of growth highlighted by patterns in the data. The entity and the State will review the collected data and offer ongoing professional development for areas identified for opportunities for growth.

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

Implementation Strategy

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

Progress Report:

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

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

Progress Report:

See Section VIII Performance Measure(s)

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

Challenges to Implementation

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

Remediation

With the assistance of the NF LoC vendor the State has developed a monthly report that lists TPMs by facility and by their original NF LoC determination date. The information in the report will assist the case manager in knowing who needs to be

seen each month in each facility. Having the information will create efficiencies by allowing staff to schedule multiple visits at the same facility on the same day. The report will help the State keep track of the TPMs and ensure all TPMs are seen as required.

Progress Report:

See Section VIII Performance Measure(s)

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

HCBS Care Coordination services will include:

- Identifying needs and locating necessary resources to establish or maintain a stable and safe living arrangement,
- Coordinating, educating, and linking individuals to resources,
- Providing and establishing networks of support,
- Assisting with necessary paperwork and documentation to help gain access to services to ensure a stable and safe living environment, and,
- Assisting with the development of the PCP.

Progress Report:

HCBS Care Coordination was approved in the HCBS waiver. No providers have yet enrolled to do HCBS Care Coordination.

New Strategy 5. The State is collaborating with Economic Assistance and the integrated eligibility system named SPACES vendor to generate a report. The report will help identify people who have submitted pending Medicaid applications, ensuring that the State is aware that they are TPMs who need Options Counseling. Aging Services staff do not have direct access to this information due to the confidentiality rules, and the report will bridge the gap connecting Medicaid data with the daily list of individuals with approved NF LoCs. **(Estimated completion date ~~January 31~~ ~~November 30, 2025~~.) This strategy will not be implemented because of competing priorities and a lack of vendor resources.**

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

Progress Report:

See Section VIII Performance Measure(s)

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

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

Progress Report:

During this reporting period 155 clients had language accommodation. The State has translated the application forms and the rights and responsibilities that TPMs receive into the top five languages listed above which may help with better understanding of the program and associated regulations.

Section VIII. Performance Measure(s)

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

- There were three (3) individuals from the Developmental Disabilities population who moved to a non-integrated setting i.e. an intermediate care facility or a group home after discharge from the skilled nursing facility. One (1) individual opted to move to basic care and is no longer a TPM.

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

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

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

- 81 PCPs were reviewed, and 100% met all SA requirements.

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

- Denials are not tracked by TPM status. The following denial data is based on all denials for HCBS recipients. The count is not unduplicated.

- Appeals this review period were not the results of denials but were instead results of terminations of already existing services. Terminations of already existing services:

    - January 2026 – terminated due to not cooperating with assessment but then agreed to cooperate so state rescinded termination and individual withdrew appeal.
    - February 2026 – terminated due to functional eligibility, individual appealed and state decision was upheld; terminated due to no services accepted but then agreed to accept so state rescinded termination and individual withdrew appeal.
    - March 2026 – terminated due to health/welfare/safety concerns, individual failed to appear at hearing, so case was deemed abandoned and dismissed.
    - April 2026 – terminated due to health/welfare/safety, individual appealed and court date is set.
    - May 2026 - terminated due to health/welfare/safety, individual appealed and court date is yet to be set.

Denial Chart Definitions	
Denial Reason	Denial Reason Definition
Did not cooperate w/Assessment	The individual or their legal decision-maker refused to answer assessment questions, or provide additional information that is necessary to determine functional eligibility
Financial eligibility	Individuals have income/assets that exceed program caps.
Functional Eligibility	Individuals are not impaired in enough ADLs/IADLs to meet eligibility requirements.
Health/Welfare/Safety Concerns	Individuals' needs cannot be met. The need exceeds service limits, or the individual is placing them themselves or their providers at risk.
No Services	The individual did not use any of the services that were authorized for more than 30 days.
Not in Agreement/Assessment	The individual or their legal decision-maker does not agree with the results of the assessment. Individuals may lack insight into why they are impaired in certain ADLs/IADLs.
Not in Agreement w/PCP	The individual or their legal decision-maker did not agree with the recommendations the case manager made regarding the type and amount of services that were needed.

Month/Year Request	Denial Reason	# of Denials
December 14, 2025 – December 31, 2025	Functional Eligibility	6
	Financial Eligibility	2
	Health/Welfare/Safety Concerns	1
	Did Not Cooperate w/ Assessment	6
January 2026	Financial Eligibility	3
	Functional Eligibility	14
	No Services	1
	Not in Agreement w/Care Plan	1
	Did Not Cooperate w/ Assessment	8
February 2026	Functional Eligibility	23
	Financial Eligibility	1
	Did Not Cooperate w/ Assessment	2
March 2026	Functional Eligibility	30
	Financial Eligibility	4
	Did Not Cooperate w/ Assessment	5
	No Services	1
	Health/Welfare/Safety Concerns	1
	Deny Services Over Cap	3
April 2026	Functional Eligibility	19
	Financial Eligibility	6
	Did Not Cooperate w/ Assessment	2
	Health/Welfare/Safety Concerns	1
May 2026	Functional Eligibility	7
	Financial Eligibility	2
	Did Not Cooperate w/ Assessment	5
	No Services	2
June 1, 2026 - June 13, 2026	Functional Eligibility	1
	Financial Eligibility	1
	Services Over Cap	1
	Did Not Cooperate w/Assessment	3
Totals		**162**

Number of unduplicated PCPs completed for TPMs in the community.

- 1,030 unduplicated PCPs were completed for TPMs living in the community during this reporting period.

Number of unduplicated annual PCP visits to TPMs in SNF.

- 1,058 unduplicated PCP visits were completed with TPMs residing in a SNF from December 14, 2025 – June 13, 2026.

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

- There were 99 individuals referred during this reporting period and 65 of those individuals have signed consent (63 MFP and 2 TPD).
    - A total of 62 (94% of the referrals) PCPs were completed,
        - 58 by the transition coordinators (56 MFP and 2 TPD)
        - Four (4) by the DDPM's.
- Of the 62 PCPs, MFP has reviewed all plans where the participant transitioned and where the participant was referred during this period, has not transitioned, and had a 90-day review. This resulted in 100% of plans meeting the SA requirements.

SA Section IX. Access to Community-Based Services

Responsible Division(s)

DHHS Adults and Aging Services

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

Implementation Strategy

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

Progress Report:

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

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

Updated Strategy 2. The State is still considering using presumptive eligibility to assist Medicaid applicants in accessing HCBS. The Agreement Coordinator has had ongoing

conversations with the Medical Services Director, other states, and CMS. Recently, CMS issued new guidance on the use of presumptive person-centered plans of care, which could help TPMs access HCBS more quickly. The new guidance may have a similar effect of helping eligible TPMs to gain access to HCBS quickly. The State will continue discussions with stakeholders on how to best implement this in ND. **(Target completion date ~~June 30~~, decision made January 1, 2026)**

Progress Report:

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

Implementation Strategy

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

The State worked with the QSP Hub to develop a performance measure to evaluate the success of the support provided by the QSP Hub to TPMs who request assistance with self-direction. **(Ongoing strategy funded through ~~September 2025~~ December 2026)**

Progress Report:

See Section IX Performance Measure(s)

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

Challenges to Implementation

Formal self-directed service options are part of most Medicaid funded HCBS. States

can collect Federal Medical Assistance Percentage (FMAP) for self-directed services if approved by CMS. However, because most of the in-home services provided to eligible individuals in ND are funded under the State's Service Payments to the Elderly and Disabled (SPED) program, additional state general fund appropriations would be required to pay for the fiscal intermediary services required under formal self-direction.

Remediation

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

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

Progress Report:

Adult and Aging Services has determined that implementing formal self-directed services within the HCBS Waiver and Medicaid State Plan Personal Care programs is not currently feasible. The cost of contracting with a fiscal management service provider would be significant, and current budget projections do not provide sufficient resources to support the implementation of a self-directed service model.

QSP Hub/Provider Models (Section IX, Subsection D, page 14)

Implementation Strategy

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

The State worked with the QSP Hub to develop a performance measure to evaluate the success of the support provided by the QSP Hub to TPMs who request assistance with self-direction. The State will track the number of agencies and individual QSPs that were given technical assistance by the Hub and the number who were successfully enrolled as a provider.

(Ongoing strategy funded through December 2026)

Progress Report:

The QSP Hub works to provide community outreach events to promote awareness of the QSP profession. This included high school events and career events in areas that need providers. During this reporting period, the QSP hub did not complete any outreach events. Due to significantly high call volume, and other demands, there were not enough staff to participate in events during this period.

The QSP Hub provided technical assistance 96 times regarding self-directing support. Of the 96 technical assistance activities, 49 were unduplicated. There were only nine (9) individuals that identified themselves as TPMs. These individuals were looking for care and support and had not been in contact with the ADRL at that point. The others were family members, medical providers, and others advocating for TPMs.

During this reporting period, there were 157 total approved new QSPs/QSP Agencies. There were 137 Individual QSP's and 20 QSP Agency's approved. The QSP Hub supported 83 of the individuals (61%) and 20 Agencies (100%). The QSP Hub supported 103 (75%) providers to become approved during this reporting period.

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

Challenges to Implementation

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

Remediation

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

The State will also consider the significant investment in creating systems to improve the QSP enrollment experience completed over the past few years to make the final

decision. System investments include the QSP Enrollment Portal, QSP registry ConnecttoCare, free access to Electronic Visit Verification (EVV) and the documentation and billing submission system. These investments have shifted much of the administrative burden off the providers. **(Decision made not to implement self-direction May 31, 2026)**

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

Updated Implementation Strategy

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

Progress Report:

See Section IX Performance Measure(s)

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

Implementation Strategy

Strategy 1. HCBS policy includes the process to request a reasonable modification for review and consideration. Some requests for reasonable modification may conflict with the ND Nurse Practices Act, N.D. Cent. Code § 43-12.1. The State will continue to meet with the Board of Nursing to review all medically related reasonable accommodations to review trends and make recommendations for policy or legislative changes that will allow more TPMs to live at home and receive necessary healthcare. **(Ongoing strategy)**

Progress Report:

The State continues to meet with the ND Board of Nursing every six (6) months to review requests for accommodation involving medical tasks. The next meeting is scheduled for July 7, 2026, to review accommodation allowed in the previous six (6) months.

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

The most common modification requests in 2024 include requests to:

1. Modify extended personal care services to allow individuals to receive a ride and

escort to medical appointments because of communication or other impairments.

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

Progress Report:

See Section IX Performance Measures(s)

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

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

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

Updated Strategy 1. Continue to recruit and retain residential habilitation and community-support services funded under the HCBS 1915(c) Medicaid waiver to provide up to 24-hour support and community integration opportunities for TPMs who require these types of supports to live in the most integrated setting by assisting up to five (5) additional eligible agency QSPs in US DOJ SA Year 5 with paying for their CQL accreditation. **(Funds are still available to serve providers who agree to serve rural and gap areas)**

Progress Report:

See Section IX Performance Measure(s)

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

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

the home to ensure the providers' safety. **(Ongoing through ~~October 31, 2025,~~ May 31, 2026)**

Progress Report:

The rate augmentation fund ended May 31, 2026. A similar fund was approved by CMS using rebalancing dollars to continue this type of service.

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

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

This project has been delayed due to competing priorities and a lack of consensus on the most effective approach to implement it for providers and TPMs. One option under consideration is limiting the grant to providers that are willing to hire and retain staff after the grant period ends. However, monitoring ongoing staff retention would require significant oversight by the State staff responsible for administering the grant. **(Target completion date ~~February September 1, 2025,~~ July 31, 2026, and ongoing)**

Updated Strategy 4. Provide behavior intervention consultation and support direct service providers. The State is aware that oftentimes it is difficult to find HCBS providers who can, and will, serve clients with behavioral health needs. Strategies to increase these services could include establishing resources for QSPs and other HCBS providers to access, that would create behavior intervention plans, helping staff with high need/high complexity cases, and offering consultation to in-home providers as needed. The State is working with the Behavioral Health Division to identify providers in ND who already provide this service. Provider agreements will be established with qualified entities, and training will be conducted with the HCBS Case Managers, so they know how to access these services. **(Target completion date January 1, 2025, and ongoing)**

Progress Report:

The State has a provider agreement with behavioral analysts to help support individuals who have both behavioral health and physical health needs. The goal with this service is to follow the TPMs through the transition and diversion process to support their behavioral health needs while in the facility and post transition. Two (2) TPMs were referred to the behavior analyst, and behavioral intervention plans were developed. Providers are currently working with the TPMs to implement the identified strategies.

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

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

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

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

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

Progress Report:

Providers were offered the four (4)-day Therapeutic Options Train-the-Trainer courses in both the Fargo and Bismarck areas. These providers will complete the recertification requirements this summer, and additional providers will have the opportunity to participate in future four (4) day training sessions.

Ten (10) Motivational Interviewing training sessions were held at four (4) locations across the state. Thirty-one (31) providers and 135 State and contracted staff attended one of the ten (10) trainings. The training provided participants with additional tools to better understand what is important to the individuals we serve and to enhance services for those experiencing mental health-related challenges. These sessions were offered to both state staff and providers to align language, approaches, and tools used to support individuals with co-occurring behavioral health diagnoses.

Updated Strategy 6. The State will work with behavioral health subject matter experts to create a process for Community Support and Residential Habilitation agency QSPs to earn a behavioral health endorsement as part of QSP enrollment. The endorsement would be earned after agency leadership (i.e. owners, registered nurses, field staff supervisors) complete specialized training that will provide them with additional skills to help support TPMs with behavioral health needs. The State, with the help of the State Hospital, has identified the type of training that will be provided. Training will include de-escalation,

positive behavioral support, trauma and trauma informed care, crisis support, and personal protection skills. The State will offer grant opportunities to pay the costs of sending agency staff to attend the training. This educational opportunity is based on a train the trainer model, so the leaders of these organizations have the capacity to train their field staff. In the future, the State will also consider the feasibility of paying a higher rate to QSPs that have this endorsement when working with TPMs who need this level of specialized training to ensure successful community living. **(Initial training completed July 2025)**

Progress Report:
Currently certified providers will receive recertification training this summer. We are also offering two (2) additional training sessions for providers who are not yet certified. Residential Habilitation, Community Support, and Extended Personal Care providers will be invited to participate.

This training uses the same curriculum as the North Dakota State Hospital and Behavioral Health Clinics, helping ensure a consistent continuum of care for individuals with complex needs across service settings.

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

Progress Report:

Motivational Interviewing occurred in Fargo and Bismarck and was offered to all Adult and Aging Services field staff and contracted staff. This training is not a train-the-trainer model, but a two (2) day course to enhance those skills in working with co-occurring disorders. Thirty-one (31) providers and 135 State and contracted staff attended one of the ten (10) trainings.

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

Progress Report:

The formal meetings described above are no longer being held due to staff capacity constraints. However, the HCBS team regularly meets with the Minot Behavioral Health Clinic team and the Fargo Behavioral Health team to collaborate and provide education. The HCBS team also meets periodically with the 1915(i) Program Administrator in Medical Services to identify opportunities for collaboration in serving shared consumers.

When a referral is received from the Human Service Center (HSC), the HCBS team often convenes case staffing with the skills trainer and the behavioral health clinic case manager to determine the most appropriate course of action.

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

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

What the mobile crisis team offers:

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

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

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

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

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

Progress Report:

When an accommodation is needed, HCBS works with the Human Service Centers (HSCs) to coordinate appropriate supports. The State will also host a future webinar for Qualified Service Providers (QSPs) to explain the behavioral health resources available to help them support individuals receiving care in the community.

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

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

Progress Report:

See response in Section IX.H. New Strategy 8

Section IX. Performance Measure(s)

Number of QSPs offering on-call services.

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

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

- See Section IX.D. Updated Strategy 1 Progress Report.

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

- See Section IX.D. Updated Strategy 1 Progress Report.

Number of TPMs receiving extended personal care.

- There are a total of 143 (34 SPED, 109 MW) consumers receiving extended

personal care.

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

- There are 40 agencies enrolled to provide Residential Habilitation & Community Support Services. The State has continued to provide funding assistance for CQL accreditation for agencies that were previously approved for assistance, and for agencies who are established and supporting individuals in a "gap" area.

- During this reporting period, the State has assisted four (4) agencies with CQL accreditation costs; three (3) of these agencies are enrolled QSP agencies providing these services and one (1) agency is currently working on the requirements for enrollment.

- A total of 120 individuals have received Community Support Services or Residential Habilitation 24 hours per day under 1:1 service in the community. A total of 27 individuals have received 24-hour support in the shared/group living environment of an agency foster home setting.

- A total of 147 individuals have received 24-hour support combined in the community and in an agency foster home under residential habilitation and community support services during this reporting period.

- Seventeen (17) individuals have been or currently are under the Residential Habilitation program, and 130 individuals have been or currently are under Community Support Services.

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

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

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

- There were 93 approved requests for reasonable modifications during this reporting period.

Month/Year Request	Service	# of Approvals
December 14, 2025 – December 31, 2025	Nursing Tasks	11
January 2026	Nursing Tasks	9
February 2026	Nursing Tasks	10
March 2026	Nursing Tasks	13

April 2026	Combined Unique Services	1
	Nursing Tasks	20
May 2026	Combined Unique Services	1
	Nursing Tasks	23
June 1, 2026 – June 13, 2026	Nursing Tasks	5
Totals		**93**

SA Section X. Information Screening and Diversion

Responsible Division(s)

DHHS Aging Services & Medical Services

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

Implementation Strategy

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

Progress Report:

See Section X Performance Measure(s)

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

Implementation Strategy

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

Challenges to Implementation

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

Remediation

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

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

Progress Report:

See Section X Performance Measure(s)

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

Progress Report:

This is an ongoing process.

Challenges to Implementation

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

Remediation

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

Progress Report:

There was one (1) individual whose NF LoC required the State to complete an administrative hold to assist in forming a safe discharge plan during this reporting period.

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

Implementation Strategy – Complete

Section X. Performance Measure(s)

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

- Presentations for 2026 have started and will be completed by 12/13/2026.

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

- There were 456 unduplicated visits from December 14, 2024 – December 13, 2025.
    - SFN – 304 (67%)
    - Hospital – 132 (29%)
    - Home/Community – 1 (0%)
    - Swing bed – 19 (4%)

Number of unduplicated annual PCP visits to TPMs in SNFs.

- 1,058 unduplicated PCP visits were completed with TPMs residing in SNFs during this reporting period.

Number of cases staffed per interdisciplinary team meetings and outcomes.

- There were 49 interdisciplinary staffing during this reporting period. Note: some individuals have been staffed more than once.
    - December 14, 2025 – December 31, 2025 – 4
    - January 2026 – 8
    - February 2026 – 4
    - March 2026 – 22
    - April 2026 – 5
    - May 2026 – 4
    - June 1, 2026 – June 13, 2026 – 2
- The outcomes of the staffing's include:

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

SA Section XI. Transition Services

Responsible Division(s)

DHHS Aging Services

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

Implementation Strategy

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

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

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

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

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

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

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

Progress Report:

Capacity for the transition coordinators within the MFP program is not a concern currently. Due to budget constraints and concerns we have added that the State would like to review any vacant positions if the State needs to reallocate resources. The State continues to provide technical assistance training and contract monitoring. The state currently has 21 dedicated MFP Transition Coordinators throughout the state.

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

Progress Report:

MFP Supplemental Services was approved with the Operational Protocol on April 22, 2026. This will allow the State to utilize another funding stream through the MFP program for up to six (6) months of short-term rental assistance until either a voucher is obtained or we would transition to a State funded resource.

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

Updated Strategy 1. The State will continue to require that transitions that have been pending (pending means from date of signed consent) for more than 90 days are reported to the MFP program administrator. The MFP State staff will facilitate a team meeting to staff the situation with the transition coordinator, HCBS case manager, and housing facilitator and provide more intensive attention to the situation to remediate identified barriers preventing timely transition. Transitions that have been pending for more than 100 days are

also reported to the SME. The Agreement Coordinator will be responsible for securely forwarding a list of the names of TPMs whose transition has been pending for more than 100 days. The report will include a description of the circumstance surrounding the length of the transition. The State currently tracks the days from signed consent to transition. **(Ongoing strategy)**

Updated Challenges to Implementation:

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

Progress Report:

These meetings and review continue to take place throughout the state and territories. We have also added the pending list to the review cycle and work closely with the Options Counseling staff regarding those individuals.

Updated Strategy 2. The State will continue to conduct a quarterly review of all transitions to identify effective strategies that led to successful and timely transitions, trends that slowed transitions, and gaps in services necessary to successfully support TPMs in the community. During this reporting period, 26 unduplicated TPMs had a quarterly review because they were waiting for transitions for 90 or more days. The State identified the following issues to be the top 10 barriers to TPMs accessing community living. TPMs may have barriers in multiple areas. An update to the SA requires the State to design and implement two (2) new strategies to mitigate barriers TPMs face when trying to transition to the community. The strategies are contained throughout this section.

Progress Report:

Top 10 Barriers to Transition 12/14/2024-12/13/2025	N=45
TPMs on 90+ day Active Transition List	n/a
Voucher needed	11
Accessible unit	8
Special equipment	8
Housing modifications	7
Provider needed	6
Credit issues	5
Eviction history	2
Identifying documents	3

24/7 provider needed	3
Lacks income	2
Traditional Medicaid	3

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

Progress Report:

See Section XI Performance Measure(s)

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

- Section IX Subsection H Updated Strategy 1 also applies to this section.

Progress Report:

The State assisted four (4) agencies with CQL accreditation during this reporting period. Three (3) of these agencies are enrolled QSP agencies providing these services and one (1) agency is currently working on the requirements for enrollment.

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

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

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

Progress Report:

We continue to have a close connection with the DME Program Administrator within Medical Services to make sure we can help facilities and transition team members identify the equipment needs early in the transition process. We have updated the discharge checklist and have been working to make this piece of the puzzle known early on during the transition process. State Program Administrators also meet with ND Assistive once a month to try to move the cases in need of transition and to ask for expedited assessments if possible.

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

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

To address these issues, the State plans to collaborate with Legal Services of ND, Protection and Advocacy, and other stakeholders to explore solutions. These may include identifying mediators, training peer supports as supportive decision-makers, and developing resources to educate TPMs about their rights to make their own decisions and

what steps to take if they feel their guardian is not respecting their needs and preferences. The State will track meeting dates and suggest recommendations for the development of future strategies that will be added to the IP. The State will draft educational materials and track the number of TPMs who were assisted in advocating for their right to live in the community and the outcomes of any third party or peer support attempts to mediate these situations that led to successful transition. There has been a delay in drafting the education because the State was waiting for the Office of Guardianship and Conservatorship to be operational so they can assist in drafting these documents **(Target completion date to draft recommendations, educational materials, and assignment of third neutral third party/peer support ~~August 1~~ ~~November 1, 2025~~ July 1, 2026)**

Progress Report:

We continue to staff these unique cases and work with all team members to help support the concerns related to capacity. Each case is unique and has different levels of capacity along with different informal support to work with these individuals sooner. Once the educational tools related to guardianship and consent are complete, they will be shared with transition team members, guardians, and TPMs.

New Strategy 7. To address credit and personal finance barriers due to not paying bills, bad debt, and difficulty budgeting money, TPMs who have this issue listed as a barrier will be referred to take the SmartwithMyMoney program. This free website allows individuals to create an account, take a research-based financial personality assessment, and learn how their personality affects their money decisions. The program also seeks to improve financial knowledge by providing information on key topics designed to help people make sound financial decisions. The site offers personalized learning resources to improve financial literacy. The State will track the number of TPMs who complete the training and then become eligible to get assistance with paying their previous debt to remove the barrier. **(Implemented August 2024 and ongoing)**

Progress Report:

There were three (3) individuals who received payment of back due or unpaid rent or eviction fees to remove this barrier to transition, for this reporting period. One individual transitioned successfully, two individuals are still working towards transition.

New Strategy 8. To address the barrier of missing essential documents such as a State identifying document (ID) or birth certificate required for federal housing and other assistance, the Housing Facilitation Referral assessment will now ask if they have a valid ID, birth certificate, and proof of citizenship status. If any documents are missing, Housing Facilitators and Transition Coordinators will immediately begin assisting them in obtaining these, reducing the chance of transition delays. **(Implementation date January 1, 2025)**

Progress Report:

This continues to be identified early in the assessment and listed as an initial barrier to work on gathering this information during the beginning stages of transition.

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

Progress Report:

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

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

Some TPMs may struggle to identify exactly what's holding them back from setting a transition date and may benefit from talking to individuals with lived experience who can guide them through the process. To support this, the State will pilot a peer support program using individuals already trained to provide peer support in ND. TPMs who have been waiting to transition for six (6) months or longer will be offered an opportunity to work with a peer support provider. This will give them a chance to explore their thoughts, address their concerns and make a more informed and timely decision about community living. The State will track the number of TPMs who are using peer support and if the service helped them come to a decision about transition. The pilot will require that a peer support professional is included as a member of the transition team in every transition case. It is important to note that all of the CILs have trained peer support professionals that can serve a TPM who is interested in receiving this service. **(Contract is complete and staff have been hired January 1, 2026)**

Progress Report:

See Section XI Performance Measure(s)

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

Updated Implementation Strategy

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

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

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

Progress Report:

Both the Skilled Nursing Facility and the Options Counseling referral contain the tentative referral date, with the plan to form the entire team if less than two (2) weeks to the discharge date. For TPMs who no longer screen at NF LOC post transition, the team will work to follow through the Transition and Diversion Program (TDP) or through the Center for Independent Living as a direct service.

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

Updated Implementation Strategy

Strategy 1. By December 13, 2026, through increased awareness, including in-reach and outreach efforts, person-centered planning and ongoing monitoring and assistance, the State will use local, State, and Federally funded HCBS and supports to assist at least 70% of the TPMs who request transition to the most integrated setting appropriate. Referrals are the number of TPMs who have signed consent to participate in MFP or ADRL transitions and are actively waiting to transition. The State will also divert at least 150 TPMs from SNF to community-based services. **(Ongoing Strategy through December 13, ~~2025,~~ 2026)**

Progress Report:

See Section XI Performance Measure(s)

New Strategy 2: A barrier to community living for some TPMs is the difficulty of securing enough direct support staff, particularly when their physical needs require more than two

(2) caregivers to ensure safety during intermittent care that is needed throughout the day. To address this issue, the State will authorize assistive technology assessments to determine if equipment could reduce the need for human assistance. Additionally, the State is exploring remote monitoring solutions to potentially decrease reliance on multiple caregivers, offering TPMs more care options and greater independence. **(Ongoing strategy, target completion date for a decision about remote monitoring solutions ~~August 1, 2025~~, March 31, 2026)**

Progress Report:

Through person-centered planning, the state works with individuals to identify barriers to community living. When it is identified that there is a barrier such as difficulty of securing enough direct support staff, particularly when their physical needs require more than two (2) caregivers, the case manager works with the individual and providers to offer options that may help to alleviate the identified barrier. The State may authorize an assessment to evaluate if there are options for environmental modification, specialized equipment or assistive technology that could reduce the need for human assistance.

HCBS funded two (2) specialized equipment purchases, a bed with specialized mattress/pressure pump on February 3, 2026, as well as a Go Lift 400 and Carry Bar 4 Hook on April 29, 2026.

Updated Strategy 3. The QSP Hub will complete a provider survey annually. The State will work with the QSP Hub and the lead UND researcher to develop a QSP capacity survey. The survey will try to determine the ability of current providers to staff their currently authorized hours, ability to staff increased hours, and capacity to serve additional clients. The State will continue to use the information from the study to develop recruitment and retention strategies that appeal to what QSPs said they like about providing direct care, i.e., the ability to help others and job flexibility. **(Completed December 13, 2025**)

Progress Report:

The QSP Hub has drafted the annual survey for 2026 and has Institutional Review Board (IRB) approval for this survey and supporting documents. This survey was shared with providers in July 2026. The final report will be completed by November 2026.

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

Progress Report:

A total of 56 individuals transitioned during this reporting period.

Section XI. Performance Measure(s)

Number and total dollar amount of incentive grants awarded.

- There have been no new grants awarded since June 13, 2025.

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

- There were seven (7) unique individuals re-institutionalized for 30 or more days during this reporting period. Three (3) individuals decided they would not return to the community and four (4) are still working on going back to the community.

- Reasons for re-institutionalization:

    - High blood pressure;
    - Bladder infection, MRSA;
    - Acute respiratory failure;
    - Pneumonia;
    - Low blood sugar;
    - Fall and injury;
    - APS substantiated neglect (Note: Perpetrator was not the QSP)

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

- During discussions on June 30, 2025, it was decided we would report anyone who signed consent based on the referrals and who are actively working towards transition, divided by anyone who transitioned. During discussions we didn't want to count consents that were already reported the reporting period prior. These are all new consent numbers.

- 86% (56/65) of the TPMs who requested transition by signing the consent form transitioned to the community.

    - 99 referrals were received.

    - Sixty-five (65) individuals (63 MFP and 2 TPD) signed consent.

    - Fifty-six (56) individuals transitioned (51 MFP and 5 TDP).

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

- There is one (1) individual who was referred during this reporting period who is also receiving Peer Support. It should be noted that we are working with the Independence CIL in the Minot area where an individual who has experience of a physical disability is serving others interested in this model of support. She has worked with 16 individuals (some are possibly TPMs) and the main services provided were

    - Independence and Skill Development – 14
    - Housing Stability – 2

- Service Navigation – 3
- Social and Community Engagement – 1
- Institutional Readmission Prevention – 1

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

- Thirty-eight of the fifty-six TPMs who transitioned, utilized one or a combination of the following benefits:

    - Voucher – 21
    - Project Based Housing – 6
    - MFP Rental Assistance – 17
    - TPM Rental Assistance – 20
    - Supplemental Services Short Term Rental Assistance – 9

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

- There were 51 TPMs who used alternative rental assistance between December 14, 2024 – December 13, 2025:

    - Three (3) individuals are deceased.

    - Nine (9) individuals moved back to a SNF.

        - None of these nine (9) are currently going through the MFP transition process a second time.

    - Two (2) are no longer in contact with MFP

    - Two (2) have moved out of state

    - Two (2) are no longer receiving Medicaid

SA Section XII. Housing Services

Responsible Division(s)

DHHS

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

Implementation Strategy - Complete

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

Implementation Strategy

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

Challenges to Implementation

In 2024, accessible and affordable housing is the number one (1) barrier for TPMs awaiting transition in many areas of the State. Consistent gathering of data from multiple points of system entry has helped the State to better understand the barriers to accessing integrated community housing.

Remediation

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

Progress Report:

See Section XII Performance Measure(s)

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

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

When an environmental modification project is approved for an eligible individual and no provider is available, the State's designated assistive technology provider, a local non-profit organization and Agency QSP, will act as the intermediary. They will subcontract the work and pay contractors in installments using this fund. The non-profit will oversee project completion, manage payments through the Medicaid Management Information System (MMIS), and receive an overhead fee for managing the project. Once the overhead fee is deducted, the remaining funds will be returned to the pool for future use. If the eligible individual passes away or the project is not completed, the fund will bear the cost. The MFP

Program Administrator will oversee this contract to ensure the proper use of funds and that they are returned upon project completion. The goal of this initiative is to help more TPMs remain in or return to their homes by making them safe and accessible for necessary care. The State will continue to educate the CILs that this service is available statewide. **(Completed August 1, 2025)**

Progress Report:

See Section XII Performance Measure(s)

New Strategy 3. When landlords notify Housing Facilitators about an available accessible apartment for rent, the facilitators will begin tracking this information to match available housing with TPMs waiting to transition. The total number of accessible units will be reported in both the MFP and USDOJ semiannual reports. This tracking helps pinpoint unit locations, fosters stronger relationships with landlords, and enables Housing Facilitators to efficiently connect TPMs and MFP recipients with suitable housing options. **(Implemented October 2024 and ongoing)**

Progress Report:

See Section XII Performance Measure(s)

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

Progress Report:

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

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

Implementation Strategy

Updated Strategy 1. Complete and maintain a housing coordinator crosswalk to identify the entities that offer housing facilitation and what type of support they offer to ensure everyone is aware of the parameters of each program. The intent is to avoid duplication and understand the eligibility of each program to facilitate appropriate referrals. **(Completed December 2024 and ongoing)**

Progress Report:

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

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

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

Progress Report:

See Section XII Performance Measure(s)

New Strategy 3. The rules governing HUD Mainstream Vouchers have recently changed. It is now possible for anyone with a disability under age 62 years in America to request a housing voucher from the ND Housing Authorities. To ensure that HUD Mainstream Vouchers are available for TPMs living in ND, the State is working with the eight (8) ND Housing Authorities to update their policies and create MOUs to establish a priority list for local citizens and develop a separate waiting list for Mainstream Vouchers. **(Completed December 31, 2025)**

Progress Report:

We still do not have MOUs with Fargo Housing Authority or Cass County Housing Authority although we have solid partnerships will these entities. Therefore, we continue to have six (6) MOUs operating throughout our state.

New Strategy 4 To increase access to resources to provide environmental modification to TPMs already living in the community, the Rehab Accessibility Program (RAP) administered by the ND Housing Finance Agency will update the amount of funds available to pay for renovations from $5,000 to $7,000 per person. The $300,000 fund allows

unspent dollars to carry over each year through Federal Fiscal Year 2029. The fund offers grant dollars for the renovation of properties occupied by lower-income North Dakotans with physical disabilities. Examples of qualifying renovations include the installation of ramps, door levers, walk-in/roll-in showers, grab bars and widening of doorways. Mainstream vouchers are only available to disabled people under the age of 62. **(Estimated completion date June 1, 2026)**

Progress Report:

See Section XII Performance Measure(s)

Environmental modification funded under HCBS:

- Stairlift/bathroom modifications approved 12/17/26, completed 2/26/26;
- Assessment for modification suggestions approved 12/31/25, completed 1/27/26;
- Ramp and door widening approved 1/14/26, completed 1/30/26;
- Bathroom grab bars approved 2/17/26, completed 4/10/26;
- Ramp approved 3/14/26, completed 4/15/26;
- Tub cutout and grab bars approved 4/16/26, completed 6/1/26;
- Handrail and stair accessibility adaptations approved 5/21/26, completed 6/8/26;
- Ramp approved 5/15/26, completed 6/23/26
- Grab bar installation/toilet riser/frames approved 5/6/26, completed 6/24/26
- Auto open door approved 5/4/26, pending due to scheduling;
- Tub cutout approved 5/20/26, pending due to scheduling;
- Bathroom remodel approved pending due to scheduling.

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

Implementation Strategy

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

Progress Report:

A training on the Rehab Accessibility Program was held during this reporting period and numerous transition coordinators, housing facilitators, and MFP Administrative staff attended that training on April 17, 2026. The training was hosted by ND Housing and

Finance Agency as they administer this program. We also have eight (8) Housing Facilitators who are now also ADA Coordinator Trained.

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

Challenges to Implementation

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

Remediation

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

Progress Report:

See Section XII Performance Measure(s)

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

Progress Report:

The following training was conducted during this reporting period:

All the Things with Medicaid – April 14, 2026 – 72 attendees
Fair Housing – April 21, 2026 – 92 attendees

Guardianship/Conservatorships – April 28, 2026 – 55 attendees
Service/ESA Animals – May 5, 2026 – attendees not recorded
HUD-VASH – May 19, 2026 – 54 attendees
Refugee Resettlement & Welcoming New Neighbors – May 26, 2026 – 56 attendees
Families Flourish ND – June 2, 2026 – 42 attendees
Active Shooter/Personal Safety – June 9, 2026 – 68 attendees

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

Implementation Strategy

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

Progress Report:

The recent Fair Housing training had 92 attendees, demonstrating strong interest among professionals who work alongside housing services. The training helped participants better understand housing-related issues and identify opportunities to collaborate in supporting home and community-based services.

In addition, Housing 101, presented by Jennifer Henderson, was offered at the Adult and Aging Symposium in two (2) sessions with 30 participants each. Due to the high demand and interest generated during the symposium, an additional webinar was held and attended by 112 individuals.

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

Implementation Strategy

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

Challenges to Implementation

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

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

Progress Report:

See Section XII Performance Measure(s)

Section XII Performance Measure(s)

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

- Thirty-eight (38) TPMs who transitioned during this reporting period received either a voucher, project based, and/or MFP rental assistance. Some individuals received more than one resource.
    - Voucher – 21
    - Project Based – 6
    - MFP Rental Assistance – 17
    - TPM Rental Assistance – 20
    - Supplemental Services Short Term Rental Assistance – 9

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

- There were 51 TPM's who transitioned a year ago who were utilizing State funded rental assistance.
    - Thirty-five individuals are still living in the community.
    - Three (3) of these individuals are deceased.
    - Nine (9) have moved back to a SNF.
    - Two (2) lost Medicaid, status unknown
    - Two (2) moved out of state, status unknown

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

- Forty- four (44) individuals who transitioned and 45 individuals who were diverted received housing facilitation.

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

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

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

- Thirty-eight (38) TPMs who transitioned during this reporting period received either a voucher, project based, and/or MFP rental assistance. Some individuals received more than one resource.

    - Voucher – 21
    - Project Based – 6
    - MFP Rental Assistance – 17
    - TPM Rental Assistance – 20
    - Supplemental Services Short Term Rental Assistance – 9

Number of environmental modifications completed using rebalancing funds.

- There were 14 modifications completed for 13 individuals during this reporting period using rebalancing funds. Some of these individuals may have transitioned during a previous period but still utilized MFP to fund the modification.

Increase in the total number of environmental modification projects.

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

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

- The average number of days to complete environmental modifications in the previous reporting period was 68 days. The average number of days to complete environmental modifications during this reporting period was 60 days. That is an average decrease of eight (8) days.

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

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

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

- There were 15 landlords reporting to MFP that they had various accessible units open for MFP participants during this reporting period. In these 15 unique contacts there are a minimum of 53 separate accessible units identified.

    - Prairie Ridge, Fargo – 2

    - Affordable Housing Developers, Inc, Rugby – 7

- Riverside Cottages, Jamestown – 1
- Valley Rental, Fargo – 1
- Goldmark, Fargo – 1
- Burlington Apartments, Burlington – 1
- AHDI Courtyard Apartments, Rugby – 4
- Prairie Ridge Lewis and Clark Development, Fargo – 6
- Valley Rental Seth, Fargo – 2
- Crossroads, Fargo – 2
- Prairie Ridge LCD March Notification, Fargo – 5
- Riverside Cottages LCD – 3
- Accessible Space Devin, Minot – 2
- Parkview Manor LCD Kelly, Washburn – 2
- North Sky, Fargo – 1
- Sunrise North, Fargo – 1
- Accessible Space Dewey Apartments – 2
- Valley Rental Wheatland Apartment, Fargo – 1
- Northland Apartments Accessible Space, Fargo – 1
- Valley Rental Summer at Osgood, Fargo – 2
- Plaza Apartments, Fargo - 1

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

- Sixteen (16) individuals were matched with accessible housing during this reporting period.

SA Section XIII. Community Provider Capacity and Training

Responsible Division(s)

DHHS Aging Services and Medical Services

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

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

Implementation Strategy

Updated Strategy 1. Continue to use MFP capacity building funds for the QSP Hub. The QSP Hub assists and supports Individual and Agency QSPs and family caregivers providing paid and natural supports to the citizens of ND. **(Ongoing strategy funded through ~~September 2025~~ December 31, 2027)**

The primary goals of the QSP Hub are to:

- Provide one-on-one individualized support via email, phone, and/or video conferencing to assist with enrollment and reenrollment, EVV, billing, and business operations to recruit and retain a sufficient number of QSPs. This includes the development of new technical assistance tools such as user guides available in multiple languages. All technical assistance tools were to reflect the new QSP application portal enrollment process.

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

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

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

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

- Establish and implement QSP agency recruitment initiatives.

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

Data: The State will use data from the QSP Enrollment Portal to monitor and analyze trends in QSP enrollment and retention. Additionally, the State will track the

number of agency and individual QSPs who received technical assistance from the QSP Hub who successfully enrolled as providers.

Progress Report:

See Section XIII Performance Measure(s)

New Strategy 2. The 2024 QSP Annual Survey revealed that 30% of individual QSPs who expressed interest in additional training specifically requested education on various diseases and medical conditions. In response, the State will collaborate with the QSP Hub and other qualified entities to fund training tools and live events to enhance QSP knowledge in this area. Potential topics include schizophrenia, bipolar disorder, dementia, traumatic brain injury (TBI), stroke, multiple sclerosis, and Parkinson's disease. **(Ongoing strategy funded through ~~September 2025~~ December 31, 2027)**

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

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

Progress Report:

The QSP Hub began a training series called Care in Practice. These training courses are designed to provide QSPs with tangible skills and knowledge to better support individuals. Guest presenters are brought in to speak on disease specific and behavior related topics. Additionally, the team has worked to prepare shortened training on disease specific areas and behavior related topics that can be viewed at any time. The intent was to build a live training course with guest presenters in each of those areas as well.

The QSP Hub held five (5) live presentations on the following topics: Home Safety and Fall Protection, Traumatic Brain Injury, Diabetes Management, What is Behavior, and ABC's of Behavior. The QSP Hub has also completed five (5) short videos on the following: Parkinson's Disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis, and Music Therapy.

New Strategy 3. The 2024 QSP Annual Survey indicated that most QSP agencies requesting training need support in business acumen, particularly in managing the claims process, followed by marketing services and staff management. To meet these needs, the State will collaborate with the QSP Hub to provide targeted training. The QSP Hub will produce service-specific claims videos that guide users through each step of service authorization and claims submission, aimed at helping new users get started after enrollment. Additionally, the State will involve Medical Services claims staff and the billing system vendor to offer comprehensive claims training. The QSP Hub will also create specialized training focused on marketing strategies for small businesses. **Ongoing strategy funded through ~~September 2025~~ December 31, 2027**)

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

Data: The State will collect training data, including attendance numbers and pre- and post-test results to assess learning outcomes. Responses to this question will also be tracked in the 2025 QSP Annual Survey. The QSP Hub will be asked to track and trend the number of calls to the Hub related to these topics after training is provided.

Progress Report:

The QSP has collaborated with Therap to host and record Therap specific training. During this reporting period the QSP Hub hosted four (4) meetings, and shared two (2) training recordings around the FHC/FPC transition, including ISP data, attendance, and how to bill in Therap.

The QSP hub did collaborate with the Medical Services staff to create training, however, Medical Services indicated that they had MMIS educators that manage this process and they should refer providers as needed to that unit.

Updated Strategy 4. The updated QSP Hub work plan will focus on developing partnerships with ND high school and college student career counseling services to discuss the possibility of placing individuals working on a Certified Nursing Assistant certification or those studying to be an RN, OT, PT etc., with QSP agencies to gain experience and coursework credits while providing HCBS. Students could complete a placement in the community and could be hired as employees or work toward credit hours on their degree. **(~~Estimated implementation date September 1, 2025~~ Ongoing Strategy)**

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

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

Progress Report:

The QSP Hub has not had the capacity to work on this goal.

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

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

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

impact.

Progress Report:

The Legislators approved a two (2) percent inflationary increase for all QSPs effective July 1, 2025. The increase has been implemented, and all providers have been made aware of the new rates. The State will track enrollment trends and report the data in the next report. From July 1 - December 31, 2025, 34 new agencies and 152 individual QSPs have been enrolled.

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

Service	Approved Agency Rate (15 min)	Percent Increase	Approved Individual Rate (15 min)	Percent Increase
Personal Care	$9.59	3%	$6.98	3%
Chore	$9.59	3%	$6.98	3%
Homemaker	$9.59	3%	$6.98	3%
Respite	$9.59	3%	$6.98	3%
Supported Employment	$9.59	3%	N/A	N/A
Transitional Living	$9.59	3%	N/A	N/A
Companion Care	$9.28	3%	$6.76	3%
Supervision	$9.28	3%	$6.76	3%
Non-Medical Transportation	$9.28	3%	$6.76	3%

Nursing Care	$20.10	3%	$15.95	3%

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

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

Progress Report:

Provider enrollment statistics are tracked separately for agency and individual QSPs. During the first quarter of 2026, the average processing time for QSP application approval was 15 days for individual providers and 65 days for agency providers.

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

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

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

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

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

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

Progress Report:

See Section XIII Performance Measure(s)

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

Intended Outcome: Increase the number of traditional healthcare providers and SNFs enrolling as QSPs, thereby enhancing access to HCBS, especially in hard-to-serve areas of the State.

Data: The State will track the number of healthcare providers and SNFs that inquire about providing HCBS after the letter is sent, as well as monitoring data to determine how many ultimately enroll and begin providing services.

Progress Report:

Outreach letters have been sent to see if any facilities are interested in providing in-home care.

Updated Strategy 9. To facilitate timely transitions for TPMs who live in areas where QSPs are hard to find, the State will support TPMs or their chosen QSP agency in using targeted marketing strategies to recruit staff. Funding will be made available to create job descriptions and post advertisements on social media and other platforms, highlighting specific individuals' needs. TPMs can choose to include details about the type of care required or the specific qualities they are seeking in a provider. This personalized approach aims to attract applicants motivated by a desire to help others and support individuals with disabilities in community living. **(~~Target implementation date November 1, 2024, and~~ Ongoing)**

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

Data: The State will track the number of providers recruited, the number of TPMs who ultimately transitioned home, and the number of days to transition in situations where this marketing strategy was used.

Progress Report:

This was not an idea that was well received by the individuals who are awaiting transition. However, the individuals were also offered a brainstorming session to talk about what it might take to transition and what barriers might need to be mitigated. One (1) individual decided to open the MFP case back up for transitioning in lieu of a brainstorming session and the transition team is working through those steps.

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

Intended Outcome: Increase access to transportation and community integration services by providing grants to QSP agencies for purchasing accessible vehicles.

Data: Increase the percentage of HCBS recipients who report that transportation is not a barrier to accessing the community, as measured in the 2025 National Core Indicators for Aging and Disability (NCI-AD) survey.

Progress Report:

There have been no new grants awarded since June 13, 2025.

Updated Strategy 11. To ensure timely enrollment and revalidation of QSPs, the State will continue to keep QSP enrollment duties in-house. The State hired five (5) temporary QSP enrollment staff that work under the supervision of the Medical Services QSP Enrollment Coordinator. Staff use the QSP portal to complete all aspects of QSP enrollment. QSP enrollment staff are also responsible for managing the Connect to Care QSP registry, which interfaces with the QSP portal to ensure the provider's information is accurate and up to date. The QSP enrollment staff will also use the system to process provider revalidations and manage provider data. **(Implemented January 03, 2024, and ongoing strategy)**

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

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

Progress Report:

See Section XIII Performance Measure(s)

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

The expected goals of the project are to:

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

DHHS partnered with an independent consulting firm to perform the assessment and develop recommendations to implement pathways for an innovative workforce training strategy. As part of their assessment, they asked key stakeholders to complete a web survey and to participate in discovery sessions to provide perspective and inform our understanding of both the current workforce training structure, as well as the needs and desires for the future. The State is currently drafting a Request for Purchase (RFP) to revise the current training for HCBS providers across the lifespan. Future drafts of the IP will contain strategies to implement the training recommendations including the possibility of offering scholarships to providers to encourage participation. **(Target completion date ~~September 01, 2025,~~ June 30, 2026)**

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

Progress Report:

The State has agreed to use a curriculum that was created by the University of Wisconsin – Green Bay. This training will be used by all QSPs, DD providers and individuals who provide care under the Children's medically fragile waiver to meet the competency requirements to be enrolled with ND Medicaid. The HCBS Core Curriculum has been updated to make it specific to the needs of providers in North Dakota. The DD Section went

live with the training on August 1, 2026. Adult and Aging Services is in the process of updating the administrative code that governs QSP requirements. If approved, the rule will take effect January 1, 2026.

Updated Strategy 13. Each year many individual QSPs enroll to provide care to one person who may be a relative or a friend who needs assistance. When the individual they serve passes away, moves to a SNF etc., they often stop being an individual QSP. Some of these former QSPs, if asked, may have enjoyed the caregiving role and would be willing to serve other individuals in need of care. Retaining these QSPs would increase the State's capacity to serve TPMs. Now that the new QSP enrollment portal is complete, State staff will work with the QSP Hub staff to design an effective outreach campaign to attempt to retain QSPs who originally enrolled to serve a family member or friend. QSPs in areas of the State that lack sufficient QSPs will be targeted. The State will target QSPs that were disenrolled in the past six (6) to nine (9) months and were in good standing with the DHHS will be targeted for this project. The State will track the number of individuals we reached and if any of them enrolled to provide care. We will also add language to the QSP handbooks to make sure people are aware of the ongoing opportunity to be a QSP after their family caregiver journey ends. **(Target Completion Date ~~March 1~~ ~~November 1, 2025,~~ March 1, 2026)**

> **Intended Outcome:** Increase access to HCBS by recruiting former QSPs in good standing to become providers again.
>
> **Data:** Track the number of providers who re-enroll and the number of HCBS recipients they subsequently serve.

Progress Report:

See Section XIII Performance Measure(s)

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

Updated Implementation Strategy

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

Progress Report:

Critical incident reporting training was completed December 22, 2025, with 39 in attendance and March 30, 2026, with 48 in attendance.

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

Implementation Strategy - Complete

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

Implementation Strategy

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

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

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

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

Progress Report:

The State continues to hold monthly meetings with a group of subject matter experts with representation from each Tribal nation in ND to address the outstanding home and community-based service needs of Tribal members. The group is currently implementing a plan to improve access to care coordination and culturally informed Long-Term Care Targeted Case Management (LTC TCM) services. The state is currently working with the group to simplify and align the assessment and documentation to ease access to home and community-based services.

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

Progress Report:

Minot State currently has eight (8) out of their 11 Housing Facilitators certified as ADA Coordinators. The other three (3) transition Housing Facilitators are working to complete this training.

Updated Strategy 3. The State submitted a proposal and continuously updates the plan approved by CMS and has secured the legislative authority to use the temporary 10% increase to the FMAP for certain Medicaid expenditures for HCBS to enhance, expand and strengthen the HCBS system for TPMs. **(Ongoing strategy through ~~December 2025 June 30, 2026,~~ December 31, 2026)**

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

Progress Report:

- QSP Rate Augmentation Fund
    - The funds allocated in the 10% plan fund are no longer available. CMS approved a similar rate augmentation program funded with MFP rebalancing funds that can be used instead.
- Hospice and Home Care Grant
    - Although the grant has ended, the hospice organization continues to provide home and community-based services, including nursing services as a QSP, in the expanded service area. The organization also continues to provide hospice services statewide and operates a house calls program in which physicians and nurse practitioners deliver care in individuals' homes. The organization recently presented at the Committee on Aging meeting and reported that it remains interested in and is accepting referrals to provide HCBS.
- ConnecttoCareND implementation
- The State has decided not to integrate a provider-based database look up feature into the QSP Portal. The recently required Fraud, Waste, and Abuse plan will require all individual providers and agency employees to obtain a National Provider Identifier (NPI). Beginning January 1, 2027, agencies will enter all direct care staff into the QSP Portal. The portal will interface with the case management system and potentially MMIS, allowing staff to be affiliated with their employer in the State's billing system. Once individuals are enrolled in MMIS, the system will conduct the necessary screenings, eliminating the need for a separate database screening tool.
- Agency QSPs that have never enrolled or revalidated their enrollment in the QSP Portal can now claim their enrollment portal accounts. The final step in implementing the ConnectToCareND system is to begin using its learning management platform to host provider training modules. These modules will replace the current process used to demonstrate a QSP's competency to provide care.

The State worked with ADvancing States to procure standardized training that will be used by all HCBS providers in North Dakota. Additional modules focused on dementia care, traumatic brain injury (TBI), and other specialized topics will also be available on the platform, allowing providers to earn credentials in these areas. Information about completed training and credentials will be visible to individuals using the registry to help them identify qualified HCBS providers. The State has completed the necessary updates to the training modules and the Developmental Disabilities Division will launch the training in July 2026. Administrative code updates are still needed before the State can require QSPs to complete the training; however, providers have been informed of these plans to support a smooth transition. **(Modules completed ~~May 31~~ June 30, 2026)**

- Companionship services
    - The State contracted with Lutheran Social Services of MN to start a volunteer senior companion program for individuals who do not qualify for companionship services paid for under State or federally funded HCBS services. The contract has been extended. **(Completed August 1, 2025, funded through July 31, ~~2026,~~ 2027)**
- QSP Enrollment Portal
    - The portal is operational and the State continues to enhance its features based on user feedback. The State is developing an interface that will send the names and email addresses of enrolled individual providers and agency employees to the Learning Management System (LMS). Users will then be able to create an account, complete the required training, and have their completion status automatically updated in the QSP Portal.
- Marketing the ADRL
    - The State has secured funding to continue to advertise the ADRL through social media four (4) times per year.
- Workforce training and Learning Management System integration
    - See explanation under ConnecttoCareND implementation
- Behavioral health training for HCBS case managers and QSPs
    - See explanation in Section IX, Subsection H Updated Strategy 5.
- Capacity incentive grants
    - See explanation in Section XI. Performance Measure(s) - Number and total dollar amount of incentive grants awarded.

Section XIII. Performance Measure(s)

Number of QSPs assisted by the QSP Hub.

- The ND QSP Hub provided technical assistance a total of 4,934 times during this reporting period. These activities accounted for over 700 hours of direct support to providers. There were 1,191 unduplicated activities. Analysis of this data shows that many providers come back to the QSP Hub for support as other issues arise. Analysis of this data also reflects the number of technical assistance activities that require additional troubleshooting to resolve. This includes reaching out to other stakeholders to troubleshoot prior to resolution. This results in multiple points of communication with providers.

Number of QSP agencies receiving CQL accreditation.

- A total of 40 QSP agencies are CQL accredited. The State assisted four (4) agencies to maintain or obtain new accreditation during this reporting period.

Number of new agencies enrolled as providers.

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

Number of agencies that stopped providing services.

- 19 agencies stopped providing services during this reporting period.

Number of new individual QSPs enrolled as providers.

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

Number of individual QSPs that stopped providing services.

- 160 individuals stopped providing services during this period.

Rate increases effective January 1, 2026.

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

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

- Providers have not yet been trained on ConnectToCareND. The Learning Management System (LMS) is currently being developed within ConnectToCareND, and, once the rollout is complete, all components of the system will be introduced to providers and training will be provided.

Number of SNFs that have enrolled to provide HCBS.

- No new SNFs have enrolled as QSPs. There are two (2) SNFs who are

currently enrolled to provide HCBS.

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

Responsible Division(s)

DHHS Aging Services

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

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

Progress Report:

See Section XIV Performance Measure(s)

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

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

If a TPM chooses HCBS, they ask the nursing home to complete a State Form Number (SFN) 584 and then the ADRL staff will send the referral to the MFP transition coordinator who assembles the transition services team to begin person-centered planning. The transition team consists of the MFP transition coordinator, HCBS case manager, and a housing support specialist.

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

TPMs will be seen by the facility case manager/ LTSS Options Counselor when initially referred for a long-term stay in a SNF. Current TPMs living in a SNF will be seen annually

in the month in which they were originally admitted to the SNF. Because it will take time to see all TPMs in a SNF there may be individuals who would benefit from knowing about HCBS options prior to their scheduled visit.

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

Progress Report:

This is an ongoing process.

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

Implementation Strategy

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

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

Progress Report:

See Section XIV Performance Measure(s)

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

Updated Implementation Strategy

Continue to implement a sustainable public awareness campaign to increase awareness of HCBS and the ADRL. Campaign will include marketing on social media at least four (4) times in Year 5 of the SA and will provide public education to the public, professionals, stakeholders, and TPMs at serious risk of entering nursing facilities. The campaign will also include providing education to those parties that recommend SNF care to TPMs. This includes health care professionals/staff who are most likely to be in regular contact with TPMs and potential TPMs prior to requests or applications for SNF admissions, such as geriatricians and primary care physicians serving a significant number of elders. State staff will also staff information booths at community events and will make themselves available for media requests and to present information about HCBS at stakeholder meetings and virtual and in-person conferences across the State. **(Ongoing strategy through December 13, 2025, and ongoing)**

Progress Report:

Completed 27 in-person events, reaching 2,030 individuals from diverse backgrounds and increasing awareness of available services. In addition, the ADRL campaign is promoted across all social media platforms quarterly through KAT Communications.

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

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

Progress Report:

See Section XIV Performance Measure(s)

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

Updated Implementation Strategy

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

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

Progress Report:

All documents on the Adult and Aging websites that have not been made accessible are marked as exclusion or archived as directed by the DHHS ADA Officer. The federal deadline for all website documents to be fully accessible has been extended to April 2027.

Section XIV. Performance Measure(s)

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

- A total of 197 individuals attended presentations at 75 SNFs have been completed so far. All presentations will be completed by December 31, 2026.

Number of TPMs who requested and received a communication accommodation.

- 155 TPMs receiving HCBS received language accommodation for

interpreters.

- 18 individuals received language accommodation for LTSS OC.
- 137 individuals received language accommodation for HCBS.

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

- A total of 1,931 respite service hours were provided through the Lifespan Respite Care Voucher Program to 40 caregivers who provided care for individuals over the age of 21 from January 1, 2026 – May 30, 2026. Medicaid eligibility information is not gathered for this program; therefore, it is not possible to determine if individuals are TPMs. However, there were 62 HCBS Medicaid waiver recipients who received respite care during this reporting period.

SA Section XV. Data Collection and Reporting

Responsible Division(s)

DHHS Aging Services

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

Implementation strategy

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

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

Progress Report:

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

Updated Strategy 2. With the assistance of the Senior Research Analyst for the ND HealthCare Workforce Group at UND the State designed a method to analyze the number of units being authorized and utilized, by case management territory, to determine if there are significant discrepancies in the number of services available to TPMs across the State for the study period of State Fiscal Years 2022-2023 (July 1, 2021 – June 30, 2023). The

study included Medicaid beneficiaries with 24 months of continuous coverage, or the duration of the two (2) state fiscal years. Anyone who died during the study period or who did not have continuous enrollment was removed from the study group.

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

Included services:

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

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

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

The challenge arises when these authorizations transfer to MMIS, which does not recognize group authorizations. As a result, MMIS reflects that the TPM has access to 210 units instead of the intended 70. Consequently, the MMIS data used to calculate the units authorized versus units used inaccurately shows that the TPM only utilized 70 of 210 units, significantly impacting the overall total of units used. The chart below illustrates draft homemaker data that shows that only 55% of the units authorized were used. This number seems very low considering the number of individuals who request homemaking services highlighting the need for further refinement to ensure accurate data elements and reporting.

Draft Homemaker Data

Procedure	Authorization Class	All Authorizations	
		Number	%
S5130 Homemaker	Authorizations	4,325	
	Authorized Services	723,670.50	
	Services Used	398,844.00	55.1%
	Services Remaining	324,826.50	44.9%

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

Challenges to Implementation

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

Remediation

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

Progress Report:

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

A similar analysis will be required by CMS under the Medicaid Access Rule. This rule is intended to improve access to care, strengthen health outcomes, and advance health equity for Medicaid beneficiaries, particularly those receiving home and community-based services (HCBS). States must report the number of service units authorized and utilized for personal care, home health aide, homemaker, and habilitation services. The State is

collaborating with the case management vendor to develop a report that will capture these data elements by ~~May 1,~~ August 31,2026.

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

Progress Report:

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

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

Key performance indicators include:

1. Referrals to HCBS
2. Average weighted HCBS case management caseloads.
3. Number of TPMs served in a skilled nursing facility (SNF).
4. Number of TPMs served in the community.
5. Number of TPMs diverted from a SNF.
6. Number of TPMs transitioned from a SNF.
7. Average annual cost of HCBS and SNF care.
8. Average length of time from QSP application submission to enrollment.
9. Number of QSP agencies enrolled as providers.
10. Number of individual QSPs enrolled as providers.
11. Number of QSPs retained.
12. Number of TPMs who are receiving 24/7 care and the number of QSPs authorized to support 24/7 care.

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

Progress Report:

The KPI report is submitted to the SME every quarter and the most recent version is posted on the ND US DOJ SA website. 2026 Q1 KPI Report

Section XV. Performance Measure(s)

Number of service units authorized and utilized by county.

See Section XV Subsection A. Updated strategy 2 and Link to Appendix B - Appendix B indicates the number of services authorized by county and the number of members and providers in those counties.

SA Section XVI. Quality Assurance and Risk Management

Responsible Division(s)

DHHS Aging Services and Medical Services

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

Progress Report:

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

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

Implementation Strategy

Strategy 1. The State will continue to provide quarterly critical incident reporting training opportunities for QSPs. The trainings are advertised by sending emails to agencies and

individual QSPs and posting training dates on the QSP Hub website. The State will also utilize the help of the ND Long Term Care Association to remind their members about reporting requirements and will provide individual training if certain QSPs show a pattern of submitting late reports.

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

Progress Report:

See Progress Report for Section XIII.B. Implementation.

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

Updated Challenges to Implementation

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

Remediation

The State has assigned one of the nurse administrators to be responsible for providing technical assistance to QSP Agencies to help them implement robust QI programs. State staff have reviewed all current QSP QI programs for compliance. When a QI program does not meet standards, the State provides technical assistance and may recommend additional training or resources the QSP agency can use to reach compliance. Agency QSPs may also contact the QSP Hub for additional training and support.

Progress Report:

See Section XVI Performance Measures(s)

Updated Strategy 3. National Core Indicators – Aging and Disabilities (NCI-AD) is a process that measures and tracks the State's performance and outcomes of HCBS provided to TPMs. The NCI-AD survey was completed by over 400 HCBS recipients in 2023 and the survey will be completed again starting January 2025. The State reviewed the results of the study and collaborated with ADvancing States and the Human Services

Research Institute (HSRI) to interpret the results. The State will include strategies to mitigate any identified quality issues, gaps in the service array, etc. in future versions of the IP. Quality performance reports are made available on the DHHS website and shared at USDOJ stakeholder meetings. The State intends to complete the NCI-AD survey every two (2) years. **(Ongoing Strategy)**

Progress Report:

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

The full report was received in March 2026 from the survey with the final report published on the ADvancing States, NCI-AD website.

The state has compared data from the past two (2) survey cycles and is in the process of analyzing the results. The survey results will be shared at the DOJ stakeholder meeting. The state will take the feedback and data results to target areas identified for growth.

The next survey cycle will start in July 2026 with a completion date of June 2027. The state can expect the finalized report for the survey in March 2028.

New Strategy 4. The 2023 NCI – AD report shows that 25% of TPMs on the HCBS waiver have had a history of at least two (2) falls in a six (6)-month period and another 10% did not know or were unsure of their fall history. Aging Services CIR data shows that there were 54 falls reported in 2024 involving TPMs. Many of the falls happened in memory care facilities resulting in emergency room visits via ambulance. To reduce falls amongst TPMs, Aging Services staff will work with the memory care facilities to implement one of the evidence-based falls prevention programs offered under the Older Adult Administration (OAA) Title III-D Preventive Health program. Staff at participating memory care facilities will be trained to offer the fall prevention classes for free and will incorporate the classes into their resident activity programs with the goal of reducing fall-related CIRs from this population. **(Target implementation date July 1, 2025. Did not implement the strategy due to no providers willing to participate)**

Progress Report:

Adult and Aging Services CIR data shows that there were 54 falls reported in 2024 involving TPMs. Many of the falls happened in memory care facilities resulting in emergency room visits via ambulance. To reduce falls amongst TPMs, Aging Services attempted to work with the memory care facilities to implement one of the evidence-based falls prevention programs offered under the OAA Title III-D Preventive Health program. Memory care facilities were offered free training and travel reimbursement. None of the memory care facilities chose to participate in the program.

NCI-AD Adult Consumer Survey 2024 – 2025 National Results

New Strategy 5. The 2023 NCI – AD report shows that 15% of survey participants stated that they lack transportation to get to medical appointments, and six (6) percent of the Medicaid State Plan - Personal Care participants stated they do not have transportation to get to medical appointments. Sometimes TPMs use the emergency room even when medical need is not really an emergency. One reason for this may be because it can be difficult to find a non-emergency medical transportation provider and the authorization process is not efficient. The State has already modified the QSP enrollment portal to allow individual and agency QSPs to enroll as a non-emergency medical transportation provider making getting access to a provider easier. The next step is for Aging Services staff to work with the Medical Services Division to improve the authorization process to make it easier for TPMs to access this important service. **(Estimated completion date ~~September 1, 2025,~~ July 31, 2026)**

Progress Report:

Further information will be provided in the next reporting period. Delays have occurred due to competing priorities within both Adult and Aging Services and the Medical Services Division. The project has also been impacted by new requirements for Non-Emergency Medical Transportation agency staff to enroll as individual providers, obtain an NPI, and affiliate with their employer, as well as revalidate their enrollment status.

Once the project resumes, Adult and Aging Services has a staff member who has the capacity to review the authorization and service delivery system to identify potential system improvements.

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

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

policy.

Progress Report:

There was a total of 149 CIRs during this reporting period. All 149 (100%) were reported within the seven (7) day timeframe.

Strategy 7. An Aging Services nurse administrator is responsible to work with State staff to implement the HCBS Quality Measure Set as identified in State Medicaid Director letter SMD# 22-003 RE: Home and Community-Based Services Quality Measure Set (Link to Measuring and Improving Quality in Home and Community Based-Services/Medicaid). The HCBS Quality Measure Set is designed to assess quality and outcomes across a broad range of key areas for HCBS. The HCBS Quality Measure Set is also intended to promote more common and consistent use, within and across states, of nationally standardized quality measures in HCBS programs, and to create opportunities for CMS and states to have comparative quality data on HCBS programs. CMS plans to incorporate use of the measure set into the reporting requirements for specific authorities and programs, including the MFP program. Initial data collection needs to start in 2025 to be reported in 2026. The State has begun the process of implementing these measures and regularly attends training provided by CMS. Aging Services staff will be responsible for training state staff and QSPs on the details of the measures and their intended use. **(Ongoing Strategy)**

Progress Report:

The implementation of the HCBS Quality Measure Set remains an active and evolving initiative. With continued guidance and updated compliance dates from CMS we have continued to work on the development of implementing system processes.

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

In collaboration with various departments across Health and Human Services, work is underway to establish processes for Measures 6, 7, and 8. These meetings are ongoing and focused on developing a consistent, coordinated approach to reporting.

We have identified options for the required quality improvement strategies and plan to submit them to CMS for review. Currently, we continue to await further federal guidance regarding implementation timelines and additional reporting expectations.

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

Updated Implementation Strategy

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

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

Progress Report:

See Section XVI Performance Measure(s)

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

Implementation Strategy

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

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

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

Progress Report:

See Section XVI Performance Measure(s)

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

Progress Report:

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

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

Progress Report:

The Department continues to conduct mortality reviews at the quarterly CIR Team Meetings which includes review of the reason for the death, if there was an obituary/notice of death posted, if law enforcement was involved, and if there was an autopsy completed. Deaths are classified as "natural/expected, other, sudden unexpected, and unknown."

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

Implementation Strategy

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

Progress Report:

See Section XVI Performance Measure(s)

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

Implementation Strategy

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

Progress Report:

See Section XVI Performance Measure(s)

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

Progress Report:

This is an ongoing process.

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

Progress Report:

- An additional complaint administrator was hired in December 2025.

- The State continues to collaborate with the MFCU and other key partners to promote the integrity and quality of HCBS services provided by QSPs. Adult and Aging Services worked with stakeholders to organize a provider integrity event focused on key compliance topics such as documentation, billing practices, and use of EVV. The event also highlighted recent system improvements designed to give QSPs the tools they need to meet state and federal requirements.

- Agency and individual in-person events were held in Fargo and Bismarck in October 2025. Nineteen (19) individual providers, and 47 Agency QSPs attended in-person. A virtual option was also offered and attended by 80 Individual QSPs and 89 QSP agency staff. **(Completed November 1, 2025)**

Strategy 4. Include information in the required QSP enrollment orientation that describes the state and federal documentation and record keeping requirements for HCBS and the penalties for noncompliance. Information from the Medicaid Fraud Control Unit (MFCU) about their authority to investigate and prosecute Medicaid provider fraud as well as abuse or neglect of residents in health care facilities, board and care facilities, and of Medicaid beneficiaries in noninstitutional or other settings is also included. The purpose of the enrollment orientation is to help ensure that QSPs understand the responsibilities of providing state and federally funded services to TPMs and to deter individuals who may try to take advantage of the HCBS system for personal gain. The orientation was implemented in January 2024 and will be periodically reviewed and updated. **(Ongoing Strategy)**

Progress Report:

The QSP Hub completed six (6) “Getting Started” sessions for new providers, which are held monthly and provide an overview of the QSP handbook, documentation requirements, best practices, and other key components. In addition, the QSP Hub hosted two (2) quarterly update meetings and two Quality and Compliance training courses, which are now also held quarterly. The QSP handbooks are being revised to incorporate plain language and an improved structure to support ease of understanding.

New Strategy 5. To build relationships and improve quality, Aging Services Program and Nurse Administrators are meeting with the leadership of all Residential Habilitation and Community Support Agencies to discuss program requirements, roles, and responsibilities of HCBS Case Managers and QSP Agency staff, and expectations for providing quality care and incident management. These meetings have been well received, and the Nurse Administrators will soon begin meeting with Extended Personal Care Nurses to improve communication and consistency of this important program. ~~**(Estimated completion date December 13, 2025,**~~ **Ongoing strategy**~~**)**~~

Progress Report:

Adult and Aging Program Administrators have met with Residential Habilitation and Community Support provider agencies and continue to meet with each new agency prior to enrollment and again after enrollment to review program requirements. The Adult and Aging Services Quality Nurse has been included in these meetings to review the QI Program requirements, and she conducts audits of all agency QSP policies. A provider update was held on June 25, 2026, for all Residential Habilitation and Community Support providers. QSPs enrolled to provide nursing services will continue to be met with one-on-one as needed. In collaboration with the QSP Hub, Adult and Aging Services staff also helped to develop a webinar for QSPs on April 16, 2025. A video overview of the programs and requirements was recorded, which has been posted on both the Adult and Aging Services webpage and the QSP Hub webpage.

Section XVI Performance Measure(s)

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

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

- December 14, 2025 – December 31, 2025: 6/8 – 75%
- January 2026: 15/18 – 83%
- February 2026: 11/13 – 85%
- March 2026: 16/17 – 94%
- April 2026: 24/27 – 89%

- May 2026: 20/22 – 100%
- June 1, 2026 – June 13, 2026: 9/10 – 90%
- Avg total for reporting period: 59/65 – 91%

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

Agency QSPs are to follow the quality improvement standards outlined in the QSP handbook. Standards are to be met through the implementation of policies and procedures that identify, address, and mitigate harm to individuals being served under HCBS. Audits are conducted and a thorough review of agency policies and procedures are completed.

There are currently 291 QSP agencies with 256 agencies requiring a QI program subject to auditing and 43 agencies considered to have met requirements based upon accreditation. Total number of agencies compliant currently is 162.

The number of agencies with CQL accreditation is 26 and the number of ARC facilities is 17. Audits will continue to be an ongoing process as new agencies are continually enrolled to provide HCBS services.

- 63.28% of Agency QSPs have a QI program in place that are required to have one.
- 3.9% or ten (10) agencies are considered non-compliant with the QI program. All these providers have been terminated.

Audits will continue to be an ongoing process as new agencies continue to enroll to provide HCBS services. There is currently a six (6) month moratorium on any new agency providers enrolling who have a business address in Cass or Burleigh County. This should drastically reduce the number of agencies QSPs enrolling over the next six (6) months.

Number of critical incident reports that have an associated complaint.

- 16 incidents reported to the USDOJ had an associated complaint.

Number of amendments reported.

- One (1) waiver amendment effective January 1, 2026, was reported to the USDOJ

Number of TPM complaints and outcomes.

- Link to Appendix C

APPENDIX A

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

Aging Services DOJ SA Dashboard (December 14, 2025 – June 13, 2026)

LTSS OC Dashboard

Territory LTSS OC Referrals Summary

Total referrals sent to territories for LTSS OC visit	**685**	
Seen for a LTSS OC Visit	467	68%
Contacted but does not meet LTSS OC criteria	161	24%
Unable to locate	1	0%
Referred deceased	18	3%
Referral outcome pending	38	6%

Notes: 685 referrals were sent to the HCBS CM territories. Individuals that do not meet the LTSS OC criteria or that cannot be reached after two attempts, are sent written information about HCBS. Referral outcome pending reflects a lag in data submission. All referrals are reviewed by an HCBS Program Administrator.

Unduplicated Territory LTSS OC Referrals Visit Summary

Total unduplicated individuals receiving referral contact	**456**	
Visit Location	**Total**	**Percent**
Nursing Facility	304	67%
Hospital	132	29%
Home/Community	1	0%
Swing Bed	19	4%

Notes: Out of the total 685 referrals sent to the HCBS territories, 456 total unduplicated contacts were made. On June 14 of 2022, the State began seeing all TPMs who are referred for a long term stay in a skilled nursing facility (SNF) as required in the Settlement Agreement (SA).

Territory LTSS OC Transition Referrals Summary

Total LTSS OC Referrals visited that were referred to MFP	**115**	**25%**
Transition Outcome	**Total**	**Percent**
Completed Transition	24	21%
Pending Transition	38	33%
Closed Before Transition	53	46%
Number of completed LTSS OC referral transitions receiving HCBS	12	50%

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

HCBS Dashboard

HCBS Monthly Case Totals

	DEC 14-31	JAN	FEB	MAR	APR	MAY	JUN 1-13
MSP PC	722	725	730	742	739	749	706
Med Wav	740	754	759	764	762	765	769
SPED	1,873	1,909	1,904	1,917	1,888	1,891	1,868
Ex-SPED	101	100	99	96	96	97	98

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

HCBS Worked Summary

Total opened MSP cases	136	Total opened MW cases	131	Total opened SPED cases	377	Total opened Ex-SPED cases	12
Total closed MSP cases	145	Total closed MW cases	86	Total closed SPED cases	349	Total closed Ex-SPED cases	16

Notes: These are the number of cases that are worked each month for all HCBS recipients, not just TPMs. The number of cases opened remains high at 656 during this reporting period. More individuals are utilizing SPED services. HCBS Case Managers are required to manage opening referrals, pending, and closing cases. This contributes to the complexity of providing case management services to older adults and adults with physical disability. HCBS Case Managers are no longer responsible to provide case management in Basic Care facilities.

HCBS Case Management Referrals

Total HCBS Referrals	718
Average HCBS referrals per month	144
Total opened HCBS cases	336
Average opened HCBS cases per month	67
Annual percentage of total opened cases per referral	47%
Total running unduplicated pending HCBS cases	217

HCBS Cases Opened Per Month

Jan	Feb	Mar	Apr	May
77	52	70	61	76

Monthly Percentage of Opened Cases Per Referral

Jan	Feb	Mar	Apr	May
53%	39%	45%	41%	56%

HCBS CM Referrals Received Per Month

Jan	Feb	Mar	Apr	May
145	132	156	150	135

Referral Case Summary

Case Totals	Jan	Feb	Mar	Apr	May
Pending Case Total	78	58	75	62	83
Opened Case Total	77	52	70	61	76

Pending Case Reason Monthly Average Summary

QSP Enrollment	9
Waiting to hear back from applicant (client unresponsive or assessment not yet completed)	88
Waiting on Medicaid eligibility	18
Waiting on financial verification	15
Waiting on Medical/OT documents	16
Transition from facility	60

Unduplicated Pending Referral Case Summary

Month	Jan	Feb	Mar	Apr	May
Pending Case Total	185	195	203	228	217

Notes: HCBS referrals are tracked by calendar year (January - December). 718 referrals for HCBS were sent to the HCBS CM territories from all referral sources (ADRL intake, direct referral, MFP, LTC Eligibility Unit and LTSS OC visits). The annual average of open cases is 47%. This is down from previous years due to more people inquiring about support in the home, who do not meet the eligibility for these services. As the older adult population grows, there will be individuals who need care but do not qualify for State or federally funded HCBS.

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

HCBS Long Term Care (LTC) Diversions

Unduplicated total number of TPMs diverted from a SNF	149
Total MSP Level B & C TPM diversions	33
Total HCBS Med waiver TPM diversions	129
Total SPED TPM diversions	42

Notes: A Target Population Member (TPM) is an individual receiving HCBS as an appropriate alternative to a skilled nursing facility (SNF), at least 21 years of age, has below $25K in assets and meets a nursing facility level of care (NFLoC). TPMs may receive services from multiple programs at the same time and terminate/re-enroll in programs. The SA requires the State to divert an additional 150 at risk TPMs by 12/13/2026.

ADRL Dashboard

Aging & Disability Resource Link (ADRL) Contacts

Total unique ADRL Information & Assistance (I & A) inquiries	7,694
ADRL I & A calls	7,694
ADRL website hits	0
ADRL unique website hits	0

Average ADRL I & A wait time (in minutes)	1
Web referrals	991

Notes: The ADRL is a centralized intake system for applying for State or Federally funded HCBS. TPMs, family and other interested parties can make HCBS referrals via the phone, email or online. The number of ADRL inquiries has grown each year of the Settlement Agreement (SA). However, due to a systems change, we were unable to track website hits for the first part of the year. The State hopes to report website hits in the next semi-annual report. Web referral numbers are available because they are tracked in a different system. For the fifth year in a row, the call wait time is one minute. A social media ad campaign is run quarterly. Whenever an ad runs, the number of contacts to the ADRL increases.

Transition Dashboard

TPM Transition Referrals Summary

Total TPM transition referrals	**99**	
Referrals	**Total**	**Percent**
MFP	97	98%
Transition & Diversion Program	2	2%
HCBS MW Community Transition	0	0%
Transitions without Community Supports	0	0%

By Grant Population

DD	ELDER	PD
4	53	40
0	2	0
0	0	0
0	0	0

Note: 99 TPMs have been referred for transition. Not all referrals go on to sign a consent to participate in the transition process. 73 individuals (74%) signed consent.
Transition services help TPMs move from an institutional setting to their own home and community. The majority of referrals involve older adults. The State currently provides transition support services through the following programs: MFP grant, Transition and Diversion Program, and the HCBS Medicaid waiver. The HCBS Medicaid waiver also pays for community transition support services to eligible individuals.

TPM Transition Referrals Completed Summary

Total TPM transition referrals that completed transition	**56**	
Transitions	Total	Percent

MFP	51	91%
Transition & Diversion Program	5	9%
HCBS MW Community Transition	0	0%
Transitions without community Supports	0	0%

By Grant Population

DD	ELDER	PD
7	25	19
0	4	1
0	0	0
0	0	0

Notes: Of the 73 individuals who requested to transition by signing a consent, 10 closed prior to transitioning, 23 transitioned, leaving 40 individuals active in the transition process. Cases close for various reasons, often due to death or the individual decides they are not ready for transition at this time.
There were 56 successful transitions from an institutional setting to the community during this reporting period, 33 of which signed consent in a prior period. The SA requires the State to transition 70% of the TPMs that were referred for transition support by 12/13/2026. The State transitioned 86%.

TPM Transitions Completed Setting & Longevity Summary

Transition Setting	Home	Family	Apartment	Adult Foster Care	Other
MFP	8	2	41	0	0
Transition & Diversion Program	2	1	2	0	0
Med W Community Transition	0	0	0	0	0
Transition without support	0	0	0	0	0

Transition Longevity	Within 30 Days	31-60 Days	61-90 Days	91-120 Days	121-150 Days	Over 150 Days
MFP	9	5	8	6	2	21
Transition & Div Prog	4	1	0	0	0	0
MW Comm Trans	0	0	0	0	0	0
Trans without support	0	0	0	0	0	0

Notes: 56 TPMs transitioned from a nursing facility to an integrated setting. 59% of transitions occurred within 120 days of referral. 21 individuals who have been waiting to transition for over 150 days, were successfully transitioned to the community during this reporting period.

Housing Dashboard

TPM Home Modification Summary

Total TPMs who received modification assistance	**21**
HCBS Medicaid waiver home modifications	7
MFP transitions with home modifications	14

Notes: 14 TPMs who were successfully transitioned to the community received assistance with home modifications. 7 individuals living in the community, diverted from a SNF, also received home modification services through the HCBS Medicaid waiver. TPMs are offered home modification services to ensure a safe living environment.

TPM Permanent Supported Housing (PSH) Summary

Total unduplicated TPMs who received permanent supported housing	**38**
TPM rental assistance	20
MFP rental assistance	17
Project based	6
Voucher	21

Note: 38 TPMs who were successfully transitioned to the community received PSH. The PSH summary totals are not unduplicated because a TPM can utilize more than one type of service.

TPM Housing Facilitation Assistance Summary

Total unduplicated TPMs who received housing facilitation assistance	**56**
Addressing barrier to housing	16
Securing accessibility features	16
Securing home modifications	14
Securing accommodations in housing unit	13
Provided education on rights and responsibilities of tenant	29
Securing needed documents for housing	25
Completion of housing assistance application	27
Completion of housing application	28
Housing search	29

Notes: All TPMs are offered housing facilitation. 56 utilized it during this reporting period. The housing facilitation summary totals are not unduplicated because a TPM can utilize more than one type of assistance. Housing facilitators work with the MFP transition team to assist TPMs in locating and securing integrated housing in the community.

HCBS TPM Receiving Housing Support Summary

Reporting Period	12/14/25 – 6/13/26
Unduplicated HCBS TPMs receiving housing supports	332

HCBS TPM Housing Services Received Summary

Reporting Period	12/14/25 – 6/13/26
Other	50
Housing Facilitator	45
Rental Assistance	295

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

Potential Housing Supports Identified for HCBS TPM Summary

Reporting Period	12/14/25 – 6/13/26
Unduplicated HCBS TPM care plans searched to determine necessary housing services identified summary	1,006

Necessary Housing Services Identified Summary

Reporting Period	12/14/25 – 6/13/26
No housing concerns/requests	860
Other	22
Rental Assistance	53
Assistance w/ rental mods or accommodations	19
Education on rights & responsibilities of being a good tenant	12
Assistance with housing mods	19
Assistance locating required documents	24
Assistance with housing assistance application	37
Assistance with housing search	33

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

Appendix B

North Dakota HCBS Authorized Services (December 2025 – May 2026)

Adams 20 Members 8,909 Units 15 Providers	**Barnes** 38 Members 14,912 Units 22 Providers	**Benson** 49 Members 12,506 Units 41 Providers	**Billings** 2 Members 310 Units 3 Providers	**Bottineau** 34 Members 11,606 Units 22 Providers	**Bowman** 16 Members 5,798 Units 9 Providers	**Burke** 8 Members 2,160 Units 11 Providers	**Burleigh** 431 Members 194,101 Units 158 Providers
Cass 702 Members 461,103 Units 248 Providers	**Cavalier** 5 Members 589 Units 4 Providers	**Dickey** 23 Members 2,481 Units 13 Providers	**Divide** 12 Members 5,605 Units 10 Providers	**Dunn** 8 Members 1,507 Units 5 Providers	**Eddy** 6 Members 810 Units 7 Providers	**Emmons** 14 Members 4,758 Units 13 Providers	**Foster** 9 Members 2,119 Units 8 Providers
Golden Valley 7 Members 747 Units 6 Providers	**Grand Forks** 298 Members 162,892 Units 125 Providers	**Grant** 12 Members 2,421 Units 11 Providers	**Griggs** 2 Members 160 Units 2 Providers	**Hettinger** 6 Members 1,796 Units 8 Providers	**Kidder** 10 Members 9,407 Units 12 Providers	**LaMoure** 13 Members 1,935 Units 9 Providers	**Logan** 1 Members 120 Units 1 Providers
McHenry 16 Members 5,236 Units 16 Providers	**McIntosh** 17 Members 2,745 Units 11 Providers	**McKenzie** 12 Members 3,694 Units 9 Providers	**McLean** 19 Members 5,215 Units 18 Providers	**Mercer** 35 Members 5,047 Units 16 Providers	**Morton** 175 Members 64,983 Units 101 Providers	**Mountrail** 9 Members 410 Units 6 Providers	**Nelson** 12 Members 2,689 Units 12 Providers
Oliver 3 Members 632 Units 5 Providers	**Pembina** 28 Members 8,822 Units 24 Providers	**Pierce** 20 Members 8,346 Units 11 Providers	**Ramsey** 92 Members 40,632 Units 47 Providers	**Ransom** 34 Members 5,675 Units 14 Providers	**Renville** 8 Members 3,299 Units 7 Provider	**Richland** 56 Members 18,010 Units 37 Providers	**Rolette** 162 Members 63,260 Units 99 Providers
Sargent 12 Members 2,621 Units 10 Providers	**Sheridan** 10 Members 3,333 Units 12 Providers	**Sioux** 56 Members 64,159 Units 6 Providers	**Slope** 0 Members 0 Units 0 Providers	**Stark** 125 Members 62,615 Units 59 Providers	**Steele** 1 Members 138 Units 1 Providers	**Stutsman** 75 Members 15,688 Units 25 Providers	**Towner** 6 Members 3,353 Units 9 Providers
Traill 30 Members 6,213 Units 20 Providers	**Walsh** 31 Members 8,992 Units 23 Providers	**Ward** 259 Members 118,792 Units 108 Providers	**Wells** 21 Members 6,212 Units 12 Providers	**Williams** 71 Members 25,743 Units 38 Providers	**Out of State** 40 Members 12,624 Units 39 Providers	n/a	n/a

APPENDIX C

Complaint Type	Number of Complaints	Unsubstantiated	Substantiated	In Progress	Notes
Abuse/Neglect/Exploitation	0	0	0	0	n/a
Illness and Injury that resulted from unsafe or unsanitary conditions	0	0	0	0	n/a
Serious Medication Errors	0	0	0	0	n/a
Care Unacceptable to Department	75	10	22	43	1-Sanctioned from accepting new participants until remediation complete; 7-Substantiated with remediation and recoupment of claims; 11-Substantiated with a remediation plan; 3-Terminated and placed on state exclusion list.
Criminal Behavior	0	0	0	0	n/a
Criminal History	0	0	0	0	n/a
Theft	1	1	0	0	n/a
Under the influence of Drugs	2	0	0	2	n/a
Absenteeism	8	1	0	7	n/a
Criminal Activity	0	0	0	0	n/a
Inappropriate Billing	5	1	1	3	1-Substantiated with claims recouped
Property Damage	0	0	0	0	n/a
Breach of Confidentiality	0	0	0	0	n/a
Disrespectful	2	0	1	1	1-Substantiated with claims recouped
Self-Neglect	0	0	0	0	n/a
Other-Not entering general event reports (GER) as required	0	0	0	0	n/a
Totals	93	13	24	56	n/a