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North Dakota Settlement Agreement to Resolve the US Department of Justice Investigation

Report of the Subject Matter Expert

August 2021

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EXECUTIVE SUMMARY

In December 2020 the State of North Dakota entered into a Settlement Agreement with the United States Department of Justice, resolving complaints alleging that the State fails to administer long-term services and supports to adults with physical disabilities in the most integrated setting appropriate, as required by the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131-12134, and its implementing regulation, 28 C.F.R. §§ 35.101-35.190. As part of the Settlement Agreement, the State retained a Subject Matter Expert to provide technical assistance, independent reviews of compliance with the provisions of the Settlement Agreement, and offer recommendations to the State to support compliance. This is the first report of the Subject Matter Expert (SME).

The State is required by the Settlement Agreement to create and keep updated an Implementation Plan that outlines the strategies it will use to meet the requirements of the Settlement Agreement. As part of that Implementation Plan, the Subject Matter Expert created four plans to enhance those strategies in the areas of Capacity, Housing Access, Diversion, and Safety Assurance. Information included in the plans provide goals, strategies, and action steps for the State to consider to enable it to move efficiently and effectively in achieving compliance with the Settlement Agreement.

The areas outlined in the Settlement Agreement that require the focus of the State in order to make the improvements necessary to achieve compliance include the following:

- case management,
- person centered planning,
- informed choice,
- access to information about home and community-based services,
- the diversion of Target Population Members (TPMs) from Skilled Nursing Facilities,
- transition services,
- housing services,
- building community provider capacity, and
- improving data collection and reporting.

While early in the process of demonstrating and evaluating compliance to the Settlement Agreement, the State has begun making changes to address requirements. Some of the key actions that have been undertaken by the State are included in the following table. This is not a comprehensive list of the actions that the State reports to have taken in support of its progress in meeting the requirements of the Settlement Agreement. Additional references are included in the body of this report.

Initial Key Actions Undertaken By the State
The movement of case managers from county employment to State employment for improved consistency and oversight.
Funding, hiring, and training of additional staff, including case management positions.
The selection and initial implementation of a new case management system to track and provide valid, reliable, and aggregate data.
Training in and deployment of person centered planning.
Increasing provider capacity and service array.
Acquired Money Follows the Person Capacity Building Grant funds to support additional staff dedicated to informed choice and the development of a Resource Center.
Initiated stakeholder engagement.

The SME has worked, and will continue to work, extensively with the State to provide technical assistance to support the State's efforts to achieve compliance with the requirements of the Settlement Agreement. The further development and implementation of key performance measures and compliance instruments will inform future reports, addressing strategies put forth by the State in the Implementation Plan. The Subject Matter Expert, in this report, has provided recommendations (beginning in detail on Page 22) that he suggests can contribute to the State's progress in meeting the requirements of the Settlement Agreement.

The Subject Matter Expert recommends that the State focus on these recommendations during the next six (6) to 12 months. These recommended actions are detailed in this report. The State reports implementation of some of these recommendations are underway. For others, the State has indicated it is developing strategies, as an aspect of its Implementation Plan, to initiate recommended actions. Highlights of these recommendations include the following:

- Conducting a workflow/business analysis;
- Considering a tiered case management system;
- Enhancing alignment of informed choice facilitation, person-centered planning, and Nursing Facility Level of Care (NFLoC) assessment processes;
- Providing for more efficient identification of at-risk Target Population Members;
- Reviewing training curricula and consider revisions;
- Assurance of Native American and rural population representation on all new workgroups being convened as part of Implementation Plan strategies and that each workgroup has a clear, outcome-oriented charter;
- Completing a QSP survey to ascertain available services;
- Reviewing and revising case management documentation requirements to ease administrative time and increase capacity for direct service provision;
- Reviewing and revising the enrollment process for Qualified Service Providers (QSPs) and agency providers;
- Considering other provider models to assist TPMs and QSPs; and
- Establishing or improving tracking and reporting mechanisms for data.

INTRODUCTION

The Settlement Agreement

In December 2020 the State of North Dakota (ND) entered into a Settlement Agreement with the United States Department of Justice (USDOJ), resolving complaints alleging that the State fails to administer long-term services and supports to adults with physical disabilities in the most integrated setting appropriate, as required by Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131-12134, and its implementing regulation, 28 C.F.R. §§ 35.101-35.190. The USDOJ notified North Dakota that it was opening an investigation in December 2015, after the USDOJ received complaints alleging that complainant adults with physical disabilities were capable of, and did not oppose, living in integrated community settings with the types of community-based services that already exist in the State's long-term care service system. Complainant adults further alleged that they and others like them could not access and maintain necessary community-based services and were forced to enter, or were at serious risk of entering, nursing facilities to receive care.

Both parties (USDOJ and the State of ND) recognize that providing adequate community-based services is the most effective way to enable individuals with disabilities to remain in or return to home and community settings and are committed to full compliance with the ADA. To achieve the goal of long-term services being provided in the most integrated setting, the State has committed to developing and implementing effective measures to prevent unnecessary admissions to nursing facilities and to successfully transitioning nursing facility residents to the community where appropriate and unopposed.

For the purposes of the Settlement Agreement, a Target Population Member (TPM) is "an individual with a Physical Disability over the age of 21 who is eligible or likely to become eligible to receive Medicaid long term services and supports and is likely to require such services for at least 90 days. The target population is comprised of:

1. Individuals with physical disabilities who are at serious risk of entering nursing facilities to access Medicaid-funded long-term care composed of individuals with physical disabilities who (1) have been referred for a level of care determination screening to access nursing facility services and are likely to require long-term services and supports; or (2) need services to continue living in the community, have impairments that make them likely to screen at a Nursing Facility Level of Care (NFLoC), and have been determined eligible for the Service Payments for the Elderly and Disabled (SPED) program with less than $25,000 in assets; or (3) need community-based services to continue living in the community and currently have a case management provider or have contacted the State's Aging and Disability Resource Link; and
2. Individuals with physical disabilities who (1) are receiving Medicaid-funded nursing facility services and are likely to require long-term services and supports; or (2) are receiving nursing facility services, are likely to become eligible for Medicaid within 90 days, have submitted a Medicaid application, and have approval for a long-term nursing facility stay."

The Subject Matter Expert

The Settlement Agreement, in Section V, calls for a Subject Matter Expert (SME) to be retained by the State to provide technical assistance, independent reviews of the work taking place, monitoring compliance with the Settlement Agreement, and making recommendations that the SME suggests will assist the State in meeting compliance requirements. The SME for this agreement is Mr. Michael Spanier. Mr. Spanier has also engaged a team of individuals (the "SME Team") to assist him in this work. The team members (Dr. Kris Ericson, Mr. Jim Jackson, Ms. Heidi Davis, and Ms. Patricia Barton) and Mr. Spanier delved into many important subject areas key to compliance with the Settlement Agreement including:

- case management,
- person centered planning,
- informed choice,
- Nursing Facility Level of Care,
- diversion strategies,
- project management and workflow processes,
- safety assurance,
- provider capacity,
- training for case managers and providers, and
- information technology structures, processes, and reporting.

Additionally, Mr. Spanier has engaged the Technical Assistance Collaborative (TAC) to provide further expertise in the area of housing. In particular, TAC has provided assistance to the SME in making recommendations for addressing the gaps in housing and home modifications that are essential to the State being able to assure success in meeting the goals of the Settlement Agreement.

The SME and SME Team drafted four plans that are incorporated into the State's Implementation Plan in the areas of Housing Access, Capacity, Safety Assurance, and Diversion. These plans were crafted in such a way as to provide technical assistance to the State on resources, strategies, action steps, and performance and compliance measures to offer the State informed recommendations about how to effectively and efficiently reach the core goals of the Settlement Agreement. The information contained in these plans is intended for use by the State as it implements additional strategies throughout the eight (8) year term of the Settlement Agreement.

Technical assistance, to be most constructive, requires a collaborative and problem solving approach between the SME and the State to be effective in addressing the needs and wishes of Target Population Members and, ultimately, achieving compliance with the Settlement Agreement. The US Department of Justice and the SME expect this technical assistance to continue throughout the length of the Settlement Agreement and be of a collegial and transparent nature. In addition to the Agreement Coordinator, Ms. Nancy Nikolas-Maier, SME Team members have met and will continue to work with other staff in the ND Department of Human Services as well as other entities to achieve the core goals of the Settlement

Agreement. The SME Team extends our gratitude to the dedicated staff of the Aging Services Division who responded to our inquiries and provided information on the nuances of the North Dakota service delivery systems. The SME and his team will continue to work in partnership with the State to achieve success.

Purpose of this Report

Every six months, the SME will draft and submit to the parties a comprehensive and public report on the State's progress with Implementation Plan strategies and performance measures, compliance with the Settlement Agreement, recommendations to reach compliance, and suggestions for the focus of the next six (6) months. This is the Subject Matter Expert's initial report.

During the next six (6) to 12 months, the Subject Matter Expert Team will transition further into its role of monitoring and measuring compliance. Compliance instruments are being developed that will provide the State with the opportunity to demonstrate compliance with the provisions of the Settlement Agreement and the SME with the tools necessary to evaluate compliance. Future reports will focus on selected core compliance topics. Included in the State's Implementation Plan are numerous performance measures that, when reported on, will provide data to allow for further assessment of the State's progress toward compliance. Specifically, the SME Team will focus on:

- Monitoring overall progress on the Implementation Plan;
- Analyzing and verifying data and compliance tasks to measure performance and progress;
- Reviewing transition plans, especially for those discharged from Skilled Nursing Facilities (SNFs);
- Providing technical assistance in support of the State's efforts; and
- Reviewing critical incidents, including those that lead to readmission to a SNF or hospital.

Notable Progress by North Dakota

The State has made progress in several areas both prior to and subsequent to the execution of the Settlement Agreement. The SME acknowledges the significant work that the State has undertaken and continues to take on in improving its service system and improving and enhancing the lives of TPMs. For example:

1. Previously, case managers were in the direct employ of county social services agencies. On January 1, 2020, 64 case managers were moved to State employment. This change provided the ability for the State to better manage the work of those case managers assigned to address the needs of Target Population Members and better lends itself to a consistent statewide approach to the provision of case management services.
2. The State has begun training all case managers on the person centered planning process. The State has drafted a Home and Community-Based Services (HCBS) Companion Guide to the *Charting the LifeCourse* person centered planning tool to assist

case managers in understanding the requirements of person centered planning and development of a person centered plan.

3. The State has initiated implementation of a new information technology platform that will incorporate, over time, a complete person centered planning and informed choice process and the ability to track such information in real time. In the course of this work, those TPMs who receive services through the Money Follows the Person (MFP) program will also have transition plans built into the same comprehensive case management record.
4. The State has received a MFP Capacity Building Grant from the Centers for Medicare and Medicaid Services (CMS). The State will use this grant, in part, to build a robust training and resource center for Qualified Service Providers (QSPs) to improve enrollment processes, training, and ongoing support to assure that QSPs and TPMs can be connected and receive services in an appropriate and timely fashion. Qualified Service Providers are those persons and agencies the State designates as authorized to provide long-term services and supports. The State will also use funds from the MFP Capacity Building Grant to hire five (5) additional staff to assist with the facilitation of informed choice decision-making.
5. From the date of the Settlement Agreement through June 14, 2021 the State reports that 29 TPMs residing in Skilled Nursing Facilities (SNFs) have successfully transitioned to the most integrated setting and 117 TPMs have successfully been diverted from placement in a SNF and are receiving home and community-based services (HCBS).
6. On January 1, 2021, the State added residential habilitation, community support services, and companionship services to its Centers for Medicare and Medicaid Services 1915(c) waiver. These services will increase access to 24 hour supports for TPMs living in the most integrated setting, medication administration, care coordination, and supervision. As of this report, the State indicates it has enrolled 10 Qualified Service Provider agencies to provide residential habilitation and community support services and an additional two (2) are actively working toward qualification. Fifty-eight (58) QSPs (agencies and individuals) are enrolled to provide companionship services.
7. The ND Department of Human Services, in conjunction with the needs of its Aging Services Division, received funding and position authorization from the 67th Assembly of the North Dakota Legislature, which meets biennially. The Legislature provided funding for a new position subordinate to the Settlement Agreement Coordinator to help manage the Settlement Agreement and its requirements, along with three (3) additional full-time equivalent (FTE) case manager positions to address the needs of TPMs.

Recommended Actions

The Subject Matter Expert suggests that the State focus on the recommendations noted in the Executive Summary during the next six (6) to 12 months. The State reports implementation of a number of these actions are underway and the SME suggests that further development is required. For others, the State has indicated it is developing strategies, as an aspect of its Implementation Plan, to initiate recommended actions. Detailed information about these recommendations begins on Page 22.

THE IMPLEMENTATION PLAN

The Settlement Agreement requires the State to develop and revise an Implementation Plan to demonstrate how it will ensure that all the requirements in the agreement are addressed and successfully met over the term of the Settlement Agreement. Meeting the requirements as set forth will require enhancing systems and services for vulnerable populations such that individuals will always be able to choose where they want to live, despite any presenting disability.

As required in Section VI of the Settlement Agreement, the plan must:

1. Identify benchmarks and timelines for meeting the Settlement Agreement's requirements,
2. Assign agency and division responsibility for achieving those benchmarks, and
3. Establish a method to address challenges to implementation.

Additionally, Section VI of the Settlement Agreement requires that the State engage with stakeholders early to identify concerns, goals, and recommendations regarding implementation of the Settlement Agreement. To that end, the State led six (6) initial listening sessions, concluding the last of these on March 31, 2021, and reported that more than 100 people attended. The State has reported that feedback from these listening sessions was used by the State as it drafted Implementation Plan strategies.

On May 28, 2021, the State submitted its draft Implementation Plan to the Subject Matter Expert and the US Department of Justice (USDOJ). The State's approach to its plan is in alignment with the requirements of the Settlement Agreement and included the development of strategies to achieve each requirement, noted challenges to individual strategies, and indicated plans for remediation. As requested by the State, the SME review of the draft plan included a focus on recommendations for building a more fully functional service system that can be operationalized now and into the future.

The four plans, drafted by the Subject Matter Expert, provide a breadth and depth of information to the State to achieve the goals of the Settlement Agreement. These plans – Capacity, Housing Access, Diversion and Safety Assurance – include specific strategies and action steps designed for incorporation into the current and future iterations of the Implementation Plan. The steps outlined in these plans can help the State operationalize the envisioned system changes from today through the middle years of the Settlement Agreement timeframe and on to the end, at which point the Settlement Agreement requires that significant changes will have been made and codified to better serve the people of North Dakota. Incorporation of additional action steps and strategies from these plans into the "body" of the Implementation Plan would further strengthen it. The SME looks forward to further discourse with the State on implementing additional strategies and taking necessary action steps to drive the necessary system and culture changes. Per Section VI of the Settlement

Agreement, 18 months following the completion of the Implementation Plan and every year thereafter the State – in consultation with USDOJ and the SME – will revise its Implementation Plan.

As of this writing the draft Implementation Plan has been reviewed and commented on by USDOJ and the SME and returned to the State for their consideration. Included in this review was a high level document provided by the Subject Matter Expert outlining 11 issues for the State's attention. A revised plan is anticipated in August 2021. Reviewers will look for the State to incorporate some of the comments to the draft in the final plan.

The final plan will provide a road map for the State through December 2022 to continue to build the necessary foundation and infrastructure to reach substantial compliance with the Settlement Agreement. The plan has dozens of specific tasks or activities that State staff will need to complete within the next 18 months. In most instances, staff that are responsible for implementation activities are also performing other activities that are not related to the Settlement Agreement. Therefore, it is essential that leadership pays particularly close attention to staff bandwidth as critical milestones loom.

In addition, stakeholder interest and participation will increase as changes are made. As key deliverables are developed, the SME encourages the State to seek ongoing input from the SME, USDOJ, and stakeholders. This will allow the State to be transparent and improve the buy-in and quality of these deliverables. The State, following the requirements of Section VI of the Settlement Agreement, will review the Implementation Plan with future revisions to the plan occurring in conjunction with the review.

AREAS OF PRIMARY FOCUS

There are several areas that require more immediate focus by the State for the next reporting period. These are areas that have demanded significant attention during this initial phase of the Settlement Agreement and the drafting of the Implementation Plan. Continued attention and refinement in these areas is essential for the State to achieve success in meeting the requirements of the Settlement Agreement.

Housing Availability and Home Modifications

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

North Dakotans living with disabilities residing in Skilled Nursing Facilities (SNFs) who are considering transition to the community, come to this difficult housing landscape with additional challenges, including discrimination in the rental market, incomes often below the

Area Median Income, the need for home modifications to be able to return to the community, and difficulties navigating the housing search process while residing in an institutional setting.

The State is aware of the amount of work that needs to be done to address housing options for TPMs. As outlined in the Implementation Plan, the State intends to convene a Joint Housing Support Workgroup that will include individuals from the ND Department of Human Services (DHS) Aging Services Division, ND DHS Economic Assistance Division, and ND Housing Finance Agency. Additionally, the State indicates that individuals from HCBS case management, transition coordination, rental assistance, and environmental modification will be represented in the workgroup to build stronger interconnectivity between disciplines. The State has indicated that this workgroup will create recommendations and a plan to assist the State in addressing housing requirements outlined in Section XII of the Settlement Agreement.

The SME recommends that the State bring this workgroup together as soon as possible and establish concrete outcomes and expectations for completing its work. According to the Implementation Plan, the State will rely on the workgroup to provide recommendations and strategies that will allow the State to meet the requirements in Section XI of the Settlement Agreement. This includes transitioning at least 100 TPMs from Skilled Nursing Facilities to the most integrated setting by December 14, 2022 and being able to effectively manage housing needs for Target Population Members in the future.

A significant barrier that the workgroup and State will be challenged to address is the closing of Lutheran Social Services (LSS, which included LSS Housing, Inc.), a large provider of multiple services in North Dakota. In January 2021, LSS announced that they were closing the organization due to financial struggles. LSS Housing, Inc., launched in 2008, worked to address the need for affordable housing amid escalating rents and housing shortages across the State. A property management arm of LSS Housing, Inc. also ensured that tenants and buildings were maintained on a permanent basis. At the time of its closing, LSS Housing owned or managed 34 properties in 22 towns across the State that provided housing to about 1,400 residents (https://www.inforum.com/community/nonprofits/7032693-Lutheran-Social-Services-of-North-Dakota-files-bankruptcy-to-pay-off-creditors). Professionals in the State have noted that it will take time for others to step in and manage those existing properties to retain a significant level of housing stock. This presents additional challenges for TPMs who need to maintain or secure affordable and accessible housing to live in the community.

In April 2021, funds from the Money Follows the Person (MFP) Grant were approved by CMS and received by the State. These funds will support the hiring of four (4) additional housing facilitators and a housing initiatives coordinator, central actors in assisting Target Population Members to return to community-based settings. The State reports that three (3) of those positions have been filled and it is actively recruiting to fill the final housing facilitator position. Increased capacity in staff is only part of the solution to improve the effectiveness of housing services for TPMs. It is recommended that the State offer and implement clear guidance to create linkages, common goals and understanding between housing facilitators, transition

coordinators, and case managers. An effective data collection system, which is currently being developed and requires additional refinement, is essential to achieve this goal.

Section XII.B of the Settlement Agreement requires providing Permanent Supported Housing (PSH) to 20 Target Population Members whose Person Centered Plan identifies that need within one year of the effective date. In its first semi-annual report regarding requirements of the Settlement Agreement (dated June 14, 2021), the State reports that since December 14, 2020, 29 Skilled Nursing Facility TPMs have successfully transitioned to the least restrictive setting. Seven (7) TPMs who indicated housing was a barrier for HCBS in their Person Centered Plan (PCP) were provided Permanent Supported Housing.

A second area of immediate focus in the housing arena is the capacity of the State to assist TPMs with necessary home modifications to remain in or return to the community. In its current §1915(c) Centers for Medicare and Medicaid Services Home and Community Based Waiver, the State limits funding for disability related home modifications to "a recipient living in their own home or the home of a family member." The home must be owned by the recipient or the recipient's family member.

This restriction prevents Target Population Members from remaining in or returning to the community. To qualify as a TPM, the individual must receive or be eligible for Medicaid. As such, their income is unlikely to support them owning their own home and, under the terms of the Settlement Agreement, natural supports are not required to be available to the individual. The State is aware that this restriction creates potential difficulties and has taken steps to initiate a change to this requirement by submitting revised language to the Centers for Medicare and Medicaid Services to remove this restriction with a target effective date of January 1, 2022.

The State has incorporated in its Implementation Plan several strategies and recommendations to address housing barriers that were also noted in the Housing Access Plan. The SME recommends that the State consider incorporating additional strategies and actions steps detailed in the Housing Access Plan in future iterations of its Implementation Plan.

Identification of Target Population Members

The Settlement Agreement, in Section IV.A, clearly outlines who is a member of the Target Population – all individuals over the age of 21 with physical disabilities at serious risk of entering Skilled Nursing Facilities or those individuals meeting the criteria who are already residing in such facilities to receive necessary services and supports, and who receive Medicaid or are eligible to receive Medicaid. During the initial period of the agreement, the State has focused on person centered planning for those TPMs who express an interest in accessing home and community-based services (HCBS) and living in the community. The SME recommends that the State develop additional strategies to facilitate the provision of case managers, the development of Person Centered Plans (PCPs), and the fully informed choice of each Target Population Member in keeping with Section VII and Section VIII of the Settlement

Agreement. All TPMs include those ready now to be served in the community, those who initially expressed opposition to home and community-based services, those not yet ready for transition, and those that do not possess the capacity to decide at this time. Early identification of TPMs will continue to be a challenge for the State as the population is large and fluid.

Developing and implementing additional strategies to better meet the needs of each member of the Target Population to focus on case management, person centered planning, and the State's current informed choice process are needed to meet Settlement Agreement requirements. At this early juncture, it is difficult for the SME to fully ascertain how the State plans to address the needs of every TPM and the structures that will be created to assure that fully informed choice, person centered planning, and case management assignment to facilitate the process are provided to all. The State has indicated that it is planning revisions to the current informed choice documentation as an additional step toward providing for fully informed choice.

Case Managers and Case Management

A current challenge is the ability of the State to provide a case manager for every member of the Target Population. The draft Implementation Plan indicates that the State will provide a case manager for any Target Population Member who indicates an interest in HCBS and a desire to remain in or return to the community. This may be a good starting point, however, the Settlement Agreement, in Section VII.B, requires that a case manager is provided to every TPM upon identification. As such, the State, in order to comply with this provision of the Settlement Agreement, needs to develop a system that addresses this requirement and assures that TPMs receive necessary supports. The SME is recommending that the State develop a tiered case management system that outlines how case managers are allocated and the activities in which they need to engage depending on the current status of the TPM (e.g. ready for HCBS, initially does not express interest in HCBS, not yet ready for transition, unable to make a decision.)

1. Assignment – Related to the identification of the Target Population Member is the issue of who receives a case manager and when that happens. The State, as noted, moved 64 HCBS case managers from county social services to State employment. Additionally, the 2021-23 approved budget contains funding to add three (3) additional full-time equivalent case manager positions. Those individuals have been hired and will begin training and work in August and September 2021.
2. Administrative Tasks – Case Managers (CMs), in conversations with the SME Team, have shared that approximately 50 percent of their time is taken up by administrative activities, lessening the time they have available to meet with TPMs and manage increasing caseloads. Some of these activities are required to deliver appropriate services, including creating authorizations and developing PCPs. The State is moving to a new data system that is being designed to simplify and streamline the amount of time required for these activities.

The transition to a new case management system presents an additional challenge to the State as there is a learning curve and the system is being modified as it is being created to synchronize the many components of Settlement Agreement requirements, in addition to others essential to effective case management (e.g. MFP transition services, housing specialists). An essential part of this new data system implementation is more efficient tracking of Target Population Members assigned to case managers. In the development of this new data system, the State indicates that the desire is to streamline how caseloads are tracked, along with the tracking of Person Centered Plans and renewal dates for updating such plans. The SME recommends that the State place a priority focus on expediting the full development of the new system to integrate that information. As part of the development of its new data system, the State will need to ensure that they are able to collect and report, among other items listed in Section XV of the Settlement Agreement, reliable, valid, and aggregate data from case managers on the number, type, and frequency of contacts with Target Population Members.

An additional issue is that the State has, in the past, approached the provision of case management as a benefit or service that the Target Population Member has the right to decline. It is the SME's position that case management is not a benefit or service that can be declined, but rather it is the point where assessment and eligibility are determined. The State has indicated an intention to modify the current process and develop protocols based on recent discussions with USDOJ.

Pursuant to Section VII and Section VIII of the Settlement Agreement, the State is required to provide a case manager and complete person centered planning with every TPM, regardless of the outcome of where they choose to live. The Settlement Agreement requires that a case manager be assigned to each TPM when they are identified. The TPM, per Section XV.O of the Settlement Agreement, does not have to accept offered services, but it remains an obligation of the State to ensure that information has been shared and received so that the individual is able to make a fully informed choice.

Person Centered Planning/Plans and Informed Choice

The assignment of a case manager begins the process of person centered planning. According to Section VIII of the Settlement Agreement, the developed plan must be comprehensive in scope and must reflect the desires of the Target Population Member and/or their legal guardian regarding identified needs and desired services to meet these needs in the most integrated setting. Only when this is complete can the TPM make an informed choice about where they want to live and receive services.

The State has recently secured a new tool to aid in person centered planning – *Charting the LifeCourse* – a strategy outlined in the Implementation Plan. This tool, and training in its effective use, will allow the State to meet the requirements of Section VIII.C of the Settlement Agreement, regarding all of the elements that must be included in the Person Centered Plan. As recommended by the SME, the State is indicating that the tool is being adapted to individuals

who are elderly and/or not able to adequately participate in person centered planning at this time.

Pursuant to Section VIII.I of the Settlement Agreement, the State must meet the requirement of completing 290 Person Centered Plans (PCPs) within the first year of the effective date of the Settlement Agreement (December 14, 2021) and an additional 290 within two years of the effective date (December 14, 2022.) Half of those plans (145 per year) need to be completed with Target Population Members currently residing in Skilled Nursing Facilities. The State indicates that ongoing technical assistance for person centered planning is being provided to the State as part of an Administration for Community Living CMS technical assistance opportunity administered by the National Center for Advancing Person-Centered Practices and Systems (NCAPPS). The State notes in the Implementation Plan that to ensure annual ongoing training they will utilize MFP Capacity Building Grant 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 ND DHS Aging Services Division staff. The entity will also be required to assist the State in developing person-centered planning policy and procedures that will assist the TPM in receiving services in the most integrated setting.

Currently, the State assigns a home and community-based service case manager after the individual has expressed interest in receiving services. The Settlement Agreement requires that the State conduct person centered planning to determine which services and supports would allow TPMs to live in a community setting. The person centered planning process, including an assessment of needs and an identification of available services, is necessary for TPMs to make an informed choice about where to live and receive services. Also currently, the State uses an informed choice interview process that, rather than operating as a necessary part of person centered planning, is separate from and happens before person centered planning occurs.

Further, to date, the State indicates that the individual can decline an informed choice interview so that they are not provided the necessary opportunity to receive information about home and community-based services. The Settlement Agreement requires that a case manager be assigned and that person centered planning happens prior to making an informed choice decision. The State has indicated that it is beginning the work of better aligning these processes and will alter the sequencing of its informed choice process and form as a further step toward addressing these issues.

Nursing Facility Level of Care (NFLoC)

The NFLoC process is used to determine whether an individual's impairments are extensive enough or due to specific conditions that would qualify the individual for Medicaid-funded long-term care services. The Settlement Agreement, pursuant to Section X.B, requires the State to integrate the NFLoC form and assessment process with person centered planning and informed choice processes within two (2) years. When this integration is achieved, the NFLoC screening can serve as a gateway that determines whether an individual meets this eligibility

requirement without presupposing or initially establishing where the person's long-term services are provided. The SME suggests that, moving forward, the State develop and implement strategies that ensure that the TPM's informed choice as to the setting for long-term services comes subsequent to the completion of the person centered planning process. It is important that the TPM has an appropriate opportunity to learn about services that could be provided in the community that are able to meet their needs as effectively as the Skilled Nursing Facility.

While the State has until December 14, 2022 to complete this integration, strategies need to be developed to ensure that this requirement is met. The current NFLoC form and process, does allow TPMs to express an interest in community placement. Currently, those who screen at the NFLoC and do not express an interest are not taken through the person centered planning process that would put them in position to make an informed choice. The Settlement Agreement, in Section X.B.2, requires the State to begin to make incremental changes to the NFLoC process within 18 months. This will help ensure that the State is able to meet the requirement noted above. A significant first step in the integration of these processes has been completed by the State. Previously, case managers did not have access to the NFLoC assessment. That has changed and every case manager can access the NFLoC for TPMs on their caseloads which allows for a better understanding of the TPM's functional needs.

The current NFLoC form begins with a required choice and designation as to whether the screen is being initiated for the purpose of SNF placement, HCBS, or various other options. While information about the initial setting, length of stay, or scope of long-term services is needed for billing purposes, a more thorough discussion about the most integrated setting needs to occur as early in the process as possible and subsequent to the person centered planning process being completed. The SME suggests that the form be altered so that the designation of why the screen is being requested falls at the end of the document instead of the beginning. A significant barrier to further integration noted by the State is the role of independent discharge planners and the speed at which discharge may occur, depending on the setting. It is reported that most rehabilitation in North Dakota occurs in SNFs. The SME recommends that the State work on strategies to further integrate the discharge planning process including improving connections with discharge planners and ensuring that all discharge planners have sufficient information about HCBS.

In its comments on the draft version of this report, the State indicated that under its current system, the health care professional who completes the NFLoC form is expected to work with the TPM to make a determination as to the initial setting for long-term services. The SME recommends that the State develop strategies to further integrate this initial placement process with the person centered planning and informed choice processes required by the Settlement Agreement. The integration of the NFLoC form and process with case management and person centered planning will better enable the State to ensure that qualifying TPMs are afforded the opportunity to make an informed choice to remain in or return to the most integrated setting in the community or to receive services in a nursing facility.

The SME recommends that as the State better aligns the NFLoC assessment process with other requirements of the Settlement Agreement, particularly in Sections VII and VIII, that the State develop strategies to offer specific training to health care professionals about home and community-based services – what exists, how they are accessed, and how they might speak with Target Population Members about considering living in the most integrated setting. The State indicates that it plans to develop additional in reach strategies to meet with people living in SNFs and inform them about HCBS.

Service Capacity to Address TPM Needs in the Community

Section XIII.A of the Settlement Agreement requires the State to take necessary steps to ensure an adequate supply of qualified, trained providers to enable TPMs to transition to and live in the most integrated setting consistent with their informed choice and needs. A challenge in assisting Target Population Members to be able to live in the most integrated setting is the need for greater capacity of individual and agency Qualified Service Providers (QSPs). This is particularly true in rural areas of the state and in effectively assisting Native American populations. Many QSPs offer services only to a single family member. Agency providers and other QSPs willing to serve Target Population Members are not always able to meet the requests for services, noting insufficient staff. Additionally, it has been stated that the case manager may not be fully aware of the availability of some providers (and the services they are able to deliver) and may not leverage them as well as possible to meet the needs of more TPMs.

QSP Database – Although the State does maintain a database of QSPs on its website, and this database is searchable by geographic parameters and specific services, there seems to be limited awareness of this resource. The SME's experience is that the QSP database is difficult to use for selecting QSPs available based on the TPMs service needs. In the State, the case manager is required to assist the TPM to find a QSP by searching the database. The Settlement Agreement requires that TPMs can direct the services they want to have and choose their providers. Navigating this process is complicated and requires simplification. The SME encourages the State to simplify this process so TPMs can secure services more readily. The State has indicated, in its Implementation Plan, that it is working with Advancing States to create a "more robust" QSP list to aid in the process.

Qualified Service Provider Enrollment

There are both internal and external barriers to the QSP enrollment process. To enroll, the State requires a multitude of forms to be completed along with proving certification of completed training in fraud, waste, and abuse. The applicant is also required by the federal government to obtain a National Provider Identification number to submit with their application. There are additional form completion requirements for eight (8) specific services that, if the QSP wants to offer those, must be submitted along with the completed enrollment application.

Individuals who enroll as QSPs are self-employed contractors. If this is the first time that an individual is engaging in self-employment there are many tasks that must be learned to assure that they are in keeping with tax laws and any unemployment insurance and workers compensation insurance requirements that may exist. The State does not withhold taxes and insurance payments which can be complicated to navigate. Additionally, the QSP must achieve a competency certification to be a provider of services.

Once the enrollment application has been completed and sent to the North Dakota Medical Services Division (Medicaid), the applicant must receive approval to be enrolled. This process can take many weeks to complete. This further constrains capacity and the ability of the State to meet HCBS requests from TPMs. A further barrier is that the enrollment process must be completed every two years. The SME recommends that the State consider a streamlined update to replace the need for re-enrollment that can be completed by the QSP to maintain registration with the State to provide services.

As mentioned, there is a significant amount of training required for newly enrolling QSPs, some of which involves lengthy waits for a competency trainer to be available. The training is also a general training to ensure meeting the health needs of many TPMs or for a family caregiver who is only serving one TPM. To ensure that the competency of the QSP can be verified by a medical professional, all of the required components of training are included in that review, even those tasks that may not be medical in nature. The SME recommends further review and determination of mandatory training requirements, identifying training requirements specific to what individual QSPs need in order to provide services, including the TPM in training (particularly for indigenous populations), and how competency to tasks is ensured.

There are additional models that the State can consider regarding how providers are employed that could assist in streamlining the enrollment, training, and certification of QSPs. Other models might also make it easier for Target Population Members to self-direct their care, including managing a budget for their services and hiring their own providers. One such model that the SME recommends for consideration by the State, among other options, is the Co-employer/Agency with Choice model, used in multiple rural states. The State has indicated that the planned resource center, once developed, will help with enrollment and support of QSPs. The State plans to collect feedback and data on use of the center once developed.

While an *Informational Packet for New QSPs* is available on the website, it does not seem to meet the needs of newly enrolled Qualified Service Providers. North Dakota case managers indicate that they are often called by the QSP for assistance on billing, Electronic Visit Verification (EVV), and other matters. This further reduces capacity of both QSPs and case managers as they must spend additional time managing what is described as a complex system instead of providing face-to-face services with the client. Another option the State might consider is designating fiscal agents to assist QSPs in order to reduce the number of these tasks that the case manager is called on to address.

To conclude, there is a lack of qualified providers in the State for TPMs. Under the Settlement Agreement (Section XIII.A), the State is required to take necessary steps to ensure an adequate supply of trained and qualified providers. Through the MFP Grant, the State is reimbursing providers to achieve accreditation to become a provider for residential habilitation and community support services in an effort to increase provider capacity. As those actions continue and providers are accredited for these services, the SME will work with the State to determine if there are further actions that could be considered to address the lack of providers.

Culturally Appropriate Services for Native Americans

The SME and USDOJ have recommended that the State adopt strategies aimed to improve access and increase provider capacity in Native American communities. The SME recommends that the State include provider recruitment and outreach strategies specific to Native American communities in the Implementation Plan. To do so effectively, the SME encourages the State to engage with tribal leaders and liaisons to ensure that provider and case manager trainings reflect and respect cultural and spiritual beliefs, practices and sovereignty.

In the fall of 2019, the State engaged with several stakeholders around the topic of "Partnering Equitably with Communities to Promote Person-Centered Thinking, Planning, and Practice." (Report distributed August 2020.) Among those they engaged in this process were:

- Native American Development Center, Bismarck, ND
- Turtle Mountain Band of Chippewa Indians Elders, Turtle Mountain Retirement Home
- Standing Rock Elders, Standing Rock Visitor Center
- Phyllis Howard, Mandan, Hidatsa, and Arikara (MHA) Nation Tribal Elder, and
- Theresa Grant, Turtle Mountain Band of Chippewa Indians.

The State asked people what person centered "looks like" in North Dakota and received a wealth of responses about the culture of Native Americans and how that must weave into principles that govern services. They also spoke of the challenges of creating a person centered system, challenges both historical and current. Those participating also offered numerous suggestions on engagement within their communities that are essential to case managers working with these individuals and developing Person Centered Plans that effectively honor their culture and traditions in the provision of services. The State indicates that it has worked with tribal stakeholders to review and make changes to new assessment and planning documents and will be adding additional strategies to the Implementation Plan that reflect its current work in this area.

Additionally, the State has shared that the Standing Rock Tribe has hired their first case manager. The SME applauds these efforts, anticipates further discourse about specifics, and encourages their continuation to assure that the Native American communities and leaders believe that the needs of these particular TPMs are being met.

Addressing Needs of Target Population Members in Rural Communities
Similar to the work necessary to appropriately address Native American populations, the SME encourages the State to further address the needs of Target Population Members who live in rural communities, of which there are many. There are fewer Qualified Service Providers in those areas and those that do exist often travel longer distances to provide necessary services. Because some of these rural areas are geographically large, case managers – like providers – located in these areas must spend additional time in travel to provide required services and planning for TPMs.

The State has implemented a rural differential rate for services to enable providers to be reimbursed at a higher rate based on how far they must travel to provide necessary services. This is a good step in the direction of increasing provider capacity in rural areas. As an aspect of addressing the provisions of Section XIII of the Settlement Agreement, the SME recommends that the State create specific strategies in the Implementation Plan that target potential QSPs in rural areas, which include communication about the skills needed to serve the Target Population, how to become a Qualified Service Provider, assistance in enrolling as a provider, and making connections with TPMs seeking such services.

Training
As required by the Settlement Agreement in Section XIII, the State must assure an adequate supply of qualified community providers to enable TPMs to transition to and live in the most integrated setting. The State needs to assure that case managers, housing staff, transition coordinators, and providers have the necessary training to perform their duties. This includes training in administrative responsibilities and requirements across home and community-based services and Money Follows the Person-funded transitions, documentation requirements, assessment and evaluation of eligibility for services, a new and robust person centered planning process, the new case management system that will manage all Person Centered Plans and other required documentation for TPMs, the HCBS service array, critical incident reporting, competency to services being delivered, addressing changes to service plans, the rights of Target Population Members to appeal decisions made for services, home modifications, billing, Electronic Visit Verification, and housing supports and linkages.

The breadth of this training curricula is extensive and has different components based on the role of the individual (e.g. case manager, QSP.) The State must ensure that training requirements are met, but it must also make sure that trainings are truly effective in building and testing competency of staff and providers. In the Capacity Plan, Goal #4, the SME has recommended several strategies that may assist the State in delivering all of the required training in a more efficient fashion. Some examples include:

a. Simplifying readability of forms to an eighth (8th) grade reading level, with a particular focus on provider agreements.
b. Consider revising the competency training checklist to remove non-medical tasks, such as money management, that currently require medical review.

c. Giving consideration to using personal care topics training modules with a competency test rather than skill demonstration for non-medical tasks to increase access to training.
d. Involving the recipient of services in the training process to individualize training to needs and preferences (particularly for Native American populations.)
e. Giving consideration to using provider agencies to assist with training.

The SME recommends that the State look to this goal in the Capacity Plan for additional ideas to enhance its current training structures and platforms to make training more streamlined and accessible to all individuals.

Capacity and Role Specialization of Staff

The State currently employs 64 HCBS case managers and has received authorization and funding for an additional three (3) full-time equivalent case managers. The State reports that those additional staff will begin in August and September 2021. Additionally, the State has developed a weighted system for the assignment of case managers. The weighted system takes into account factors such as case complexity and travel requirements. Based on the level of need of the Target Population Member and, at times, where they are located, case managers may have fewer or more individuals on their caseload, attempting to balance the amount of time and effort that each case manager must undertake to assure all necessary services are delivered to TPMs.

The State notes in the Implementation Plan that role specialization has been completed for case managers, indicating that all of them have received training as HCBS case managers. The SME is working with the State to gain additional clarity regarding the responsibility of case managers related to outreach and the frequency of contacts with a Target Population Member. The State has also indicated that they plan to assign specific case managers to different nursing facilities to develop strong relationships with discharge planners and, in keeping with Section X.A of the Settlement Agreement, to assure that information is routinely received by facility staff and TPMs about the availability of HCBS. This is an additional task that will become part of the specialization of the case manager and his/her role.

The Settlement Agreement, in Section VIII, calls for case managers, transition planners, and housing specialists to be available to any TPM as defined in the Person Centered Plan. It is recommended that the State more clearly define the "who, what, and when" to describe how those different players engage with the Target Population Member and how the interactions and decisions made from different parts of the system are captured effectively in the Person Centered Plan. A key component in meeting this challenge is the further need for role clarification.

Data/Information Technology (IT) System Conversion and Reporting

The State is in the process of migrating to a new data system for case managers and Qualified Service Providers to better meet the requirements in Section XV of the Settlement Agreement.

In addition, the State plans to include other areas of focus in the new system, including the addition of Target Population Members involved through the Money Follows the Person Grant so that the individual record is complete and housed in one location.

The State uses a different IT system for the Aging and Disability Resource Link (ADRL), which is the primary connection point for individuals seeking aging services. An interface between the ADRL database and the case management database has been developed that the State indicates will go live in September 2021. The State reports that the ADRL intake that is uploaded daily to the new system is a building block for development of the TPM case management record that will include person centered planning, services delivered, transition plans, and ongoing service eligibility.

The State continues to work on the transition to its new data system – Therap – to manage the needs of Target Population Members. The State indicates that the HCBS assessment, *Charting the LifeCourse* person centered planning tool, and critical incident reporting would be live on July 1, 2021. The Implementation Plan further indicates that the system should be in full operation by December 2021. The State uses claims data to provide information on utilization of services delivered to TPMs. In the future, the Therap system will be able to provide rates of authorization of specific services. Aggregate utilization of specific services will continue to be reported through claims data. The SME and the State are engaged in further discourse to more fully understand how all of the data required to be reported in the Settlement Agreement is managed and whether there are opportunities to further refine data collection and reporting processes.

RECOMMENDATIONS

The role of the Subject Matter Expert, as outlined in Section V.C of the Settlement Agreement, includes offering recommendations that the SME believes could facilitate or sustain compliance with the Settlement Agreement. The State is not obligated to adopt these recommendations, however, the State is obligated to meet the requirements of the Settlement Agreement. The SME recommends due consideration of the following recommendations in order to facilitate compliance with the Settlement Agreement.

Conduct a Workflow/Business Analysis

There are multiple processes in the workflow of the State that the SME is concerned may overlap, may be missing, or require reordering. How case managers, housing specialists, and transition specialists are assigned, as required in the Settlement Agreement, requires further clarification. A workflow map requires development to provide a visual representation of the actions, decisions, or tasks performed to clarify processes to achieve results and would be of benefit to the State and the SME to ensure that requirements are being met. A workflow map provides an easy and quick way to visualize common processes from beginning to end. Required steps, when mapped, create a standard workflow and gaps and barriers to the workflow are identified and addressed. The workflow map should include role clarifications for

different positions and when and what triggers certain actions. The SME recommends that the State consider all departments, divisions, and programs that affect the TPM.

Consider a Tiered Case Management System

Target Population Members fall into several different "groups." There are those TPMs who are ready now to transition from the Skilled Nursing Facility or receive services to remain in the community, those who have stated they initially are not interested in HCBS, those not yet ready to transition, and those for whom significant medical or capacity issues make them unlikely to transition to the community any time soon.

With the limitations that exist on the number of case managers available to address the needs of all Target Population Members, the SME, as it noted in detail in the Capacity Plan, recommends that the State consider deploying a tiered case management system. In designing such a system, case management services increase as an individual is ready to transition to the community or needs assistance to be diverted from Skilled Nursing Facility placement. When services are in place and functioning successfully, the case manager can reduce the amount of time with the TPM, still assuring that needs are met and renewals of services occur, but also allowing them to shift attention to assisting others TPMs who may then exhibit greater need for a case manager's time. The SME recommends that such a plan include strategies for continued outreach to those TPMs who initially do not express interest in HCBS.

Enhance Alignment of Informed Choice Facilitation, Person Centered Planning, and Nursing Facility Level of Care (NFLoC) Assessment Processes

Recommendations and strategies related this topic are found in the *Areas of Primary Focus* Section of this report.

Provide More Efficient Identification of At-Risk TPMs

Earlier identification of TPMs in the community is essential. For too many, once they apply or are referred for admission to a Skilled Nursing Facility (SNF) and the need is urgent, it is easier and faster to get admitted to a SNF than to assess needs and plan for an appropriate set of HCBS. The State system identifies at-risk Target Population Members when they contact the ADRL, apply for Medicaid, or are assessed at a nursing facility level of care. The Diversion Plan outlines strategies for the State to consider, including how it might triage immediate needs of a TPM to maintain them in the community while additional services are being secured.

In the Diversion Plan crafted by the SME and appended to the Implementation Plan, specific recommendations and action steps are suggested for how the State could address the need for earlier identification of at-risk TPMS to mitigate the urgency of the contact. These suggestions include (1) providing outreach about HCBS to the public, senior citizen centers, and stakeholders; (2) reviewing existing data and other information from partners that could identify Target Population Members and provide them with information on HCBS; and (3) conducting outreach to offer education to those parties that may recommend Skilled Nursing Facility care to a potential TPM.

Review Training Curricula and Consider Revisions
There is extensive training required of case managers and Qualified Service Providers across a variety of topics – administrative, clinical, and service oriented in nature. It is recommended that the State review these curricula in their entirety, determining what might be streamlined, what could be offered in different formats (e.g. classroom or on demand), and how to most effectively ensure that case managers and QSPs are sufficiently trained in the least amount of time required.

As noted earlier, the Capacity Plan includes multiple strategies and action steps for the due consideration of the State as it reviews training processes for QSPs and case managers. The SME recommends that the State review action steps and strategies in order to strengthen the Implementation Plan and facilitate compliance with the Settlement Agreement.

Assure Native American and Rural Representation
It is essential that the State ensure that Native Americans and Target Population Members and QSPs who live and work in rural areas are involved in all aspects of planning, how issues are addressed, and how changes are made moving forward. One important step is to ensure that representation of Native Americans and individuals from rural areas of the State exists on each of the nine (9) new workgroups identified in the Implementation Plan. The State might further consider that some workgroups have a "sub-workgroup" exclusively focused on assuring that the needs of Native Americans and rural populations are adequately addressed, as they will differ dramatically from more populous areas of the state. It is often easy to lose focus in an identified area workgroup on how needs differ based on culture and/or geography. As the State deploys these workgroups it is recommended that it also ensure that there is a specific outcome-oriented charter for each group to provide the recommendations and strategies that will enhance the Implementation Plan and assist in meeting requirements of the Settlement Agreement.

Complete a QSP Survey
The State needs to know where Qualified Service Providers (QSPs) are located, where they are willing to work, what services they are able to offer, and their capacity for each service. Without this information, the State will be challenged to assist Target Population Members to connect with providers to offer the services needed to remain in their homes and communities. Additionally, without this comprehensive information, the State will not know where specific gaps truly exist – and they have identified that provider capacity is a significant gap – and be able to develop further plans to eliminate those gaps and develop recruitment strategies to build the provider workforce. The State has indicated that plans are in place to complete this survey with the assistance of the University of North Dakota through the QSP Resource Center that is being developed.

Review and Revise Case Management Documentation Requirements
Recommendations and strategies related this topic are found in the *Areas of Primary Focus* Section of this report.

Review and Revise the Enrollment Process for QSPs
Recommendations and strategies related this topic are found in the *Areas of Primary Focus* Section of this report.

Consider Other Provider Models to Assist QSPs
The State has indicated an intent to consider multiple provider models that address how providers are employed that could assist in streamlining the enrollment and authorization of QSPs. Other models might also make it easier for Target Population Members to self-direct their care.

A model that the SME suggests is worthy of due consideration by the State is the Co-employer/Agency with Choice model. This model engages existing agencies to assist in enrollment, training, management, billing, and payroll of individual Qualified Service Providers. The Co-Employer model is an approved CMS self-directed model where a provider agency and the Target Population Member share employer responsibilities. The agency is the employer of record. The TPM recruits, selects, schedules, manages, assists with training, and can dismiss the individual QSP. The agency sets the employee wage and maintains hiring and firing responsibilities, that the individual QSP is eligible to work, and protects against fraud and abuse and neglect. The agency manages the authorization for services, bills for services, and pays the employer and employee taxes.

Establish or Improve Tracking and Reporting Mechanisms
The State uses a variety of tools to track and report data regarding Target Population Members and services delivered. As the new data system for case management is deployed and then enhanced through the addition of MFP transition information and housing information, the SME recommends that the State ensure that they can deliver reports from the system that adequately reflect the information needed by the SME and USDOJ to provide a comprehensive view of the State's activities toward compliance with the Settlement Agreement. There needs to be a way to certify that everything from an initial inquiry or referral through discharge from a Skilled Nursing Facility and a return to home and community can be tracked and reported on an individual and/or aggregate basis. The Settlement Agreement requires that the State be able to track and report on TPMs no matter where they are in the system. The State has been actively working on this process.

CONCLUSION

Even prior to the effective date of the Settlement Agreement on December 14, 2020, the State had been taking actions to address some of the needs identified during the course of the investigation leading to the Settlement Agreement. The State has made progress through its good faith efforts to create an infrastructure and develop initial plans for the major areas set forth in the Settlement Agreement.

In addition, the State has held internal cross agency team meetings to help inform the Implementation Plan. During the next six (6) months, in addition to the foci noted above, the SME suggests that the State look to its experiences in its Money Follows the Person Grant and make efforts to take valuable lessons learned from previous transitions to enhance those for more members of the Target Population. The State will need to be nimble in its efforts to take these early lessons and pivot to create the necessary changes in policies, protocols, and processes to ensure that as they move forward all the requirements of the Settlement Agreement are being addressed.

The next six (6) months will be a critical time for the State regarding implementation of Settlement Agreement requirements, especially on critical processes (e.g. case manager assignment, informed choice, and person centered planning). Many processes and deliverables need to be developed or refined and operationalized to meet timeframes that have been set forth. Data presented by the State must be verified by the SME to evaluate progress toward meeting the requirements of the Settlement Agreement. There are several areas that will require the State to focus their resources to develop these processes and deliverables. Of critical importance are facilitating informed choice by providing person centered planning, continued transition efforts for TPMs, developing strategies for diverting individuals from Skilled Nursing Facilities, provider capacity, training, and continued and meaningful ongoing engagement of stakeholders.