Acronym List	
ADLs	Activities of Daily Living
AI/AN	American Indian/Alaska Native
AIPHRC	American Indian Public Health Resource Center
CHR	Community Health Representative
EXSPED	Expanded Service Payments for the Elderly and Disabled
IHS	Indian Health Services
LTC	Long term care
LTSS	Long term services and supports
MDS	Minimum Data Set Version 3.0 Resident Assessment and Care Screening
MFPTI	Money Follows the Person Tribal Initiative
NEMT	Non-emergent Medical Transportation
NDDHS	North Dakota Department of Human Services
NDLTCA	North Dakota Long Term Care Association
NDSU DPH	North Dakota State University Department of Public Health
QSP	Qualified Service Provider
SPED	Service Payments for the Elderly and Disabled
TCM	Targeted Case Management

North Dakota's MFPTI Program - Background

NDSU DPH is coordinating North Dakota's MFPTI project under contract with the NDDHS. NDSU DPH is home to the AIPHRC. The AIPHRC is dedicated to partnering with American Indian tribal nations to improve the delivery of culturally appropriate public health services. NDSU DPH and AIPHRC are working with the four federally recognized tribes who have tribal headquarters located in North Dakota: Mandan, Hidatsa and Arikara Nation; Spirit Lake Nation; Standing Rock Sioux Nation; and Turtle Mountain Band of Chippewa Indians. Please note that while the Sisseton-Wahpeton Oyate tribal nation has land and tribal members living in North Dakota, their tribal headquarters are located in South Dakota. Therefore, formal MFPTI efforts have not been pursued with their tribal leadership.

Phase 1 MFPTI assessments for each tribal nation included: disability rates, age demographics, current LTSS delivery capacity and individual tribal histories. To date, the Turtle Mountain Band of Chippewa Indians and the Mandan, Hidatsa, Arikara Nation have passed tribal resolutions supporting the collaborative work of MFPTI. Additionally, Standing Rock Sioux Nation's CHR Director and tribal elder has asked the MFPTI project manager for assistance assessing their current LTSS infrastructure.

Section I: Data on Institutional Population

Tribal health leaders and MFPTI staff reviewed the following information to help guide Phase 2 MFPTI planning: MDS data, home reservation information, disability status and QSP service delivery mapping. The MDS is an evaluation of people who have been admitted to nursing homes. The data collected on the MDS is required as part of federal reporting in all states. While MDS contains a variety of categorical information about in-residence patients, there is no present feature to capture tribal affiliations for those people who self-identify as being AI/AN. Race and

ethnicity is largely self-reported, though it may be arbitrarily determined by long-term care staff in instances where a resident is not able to effectively communicate and there is no other guardian or representative present. Per the information available in North Dakota's MDS reporting of residents in nursing homes.134 people self-identified as AI/AN. The following graphic depicts average characteristics of that population.

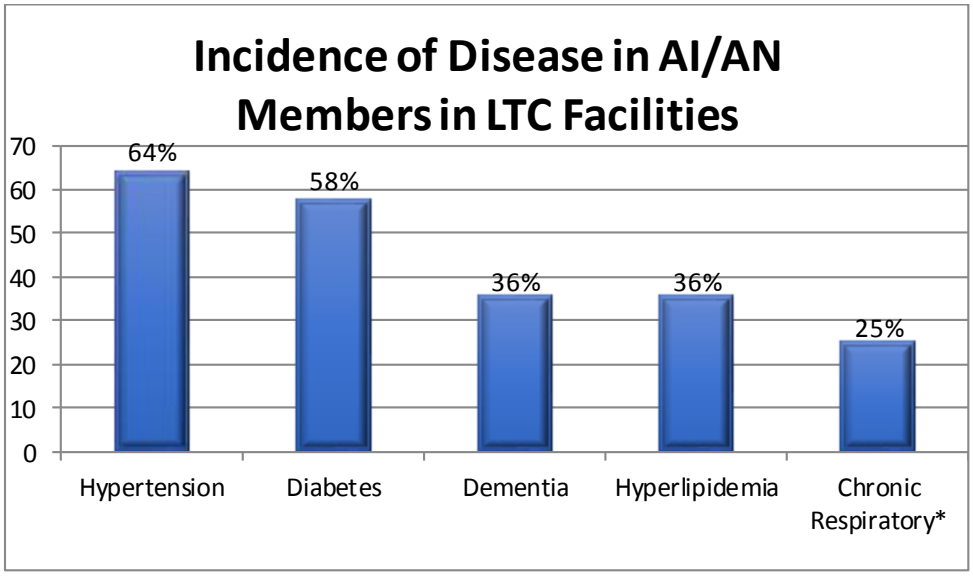
Overall Characteristics of Gender, Age and Relationship Status

Gender		Age 46-85 Years	Relationship Status
Male 47%	Female 53%	77%	32% Never Married 27% Widowed 24% Divorced 12% Married

Reported Incidence of Illness and Disease

Nursing homes perform evaluations at various points in a patient's stay in order to: assess health status; anticipate potential care needs for tasks of daily living such as feeding and dressing; and document admission and discharge reports. Following is information detailing:

- Top Incidence of Disease
- Most Common Co-Morbidities
- Results of activities of daily living evaluations for 2016



**Chronic Respiratory Disease category includes incidence of Asthma, COPD and other Chronic Lung Disease*

Patients suffering from continued illness and disability often experience higher rates of behavioral/mental health concerns. This additional pathology can be correlated to case outcomes in all disease categories.

Mental Health Co-Morbidities	Totals
Depression	50%
Anxiety Disorder	31%

The next series of charts identify the outcomes of Assessments of Daily Living tasks. Some percentages may vary over the calendar year as a patient's physical status improves or declines. The percentages calculated are totals for the entirety of 2016 assessments. These statistics have been separated into the following categories:

- Mobility & Balance (including transfers types, turning, walking and positioning)
- Bathing & Toileting (includes movement and transfer)
- Dressing & Eating

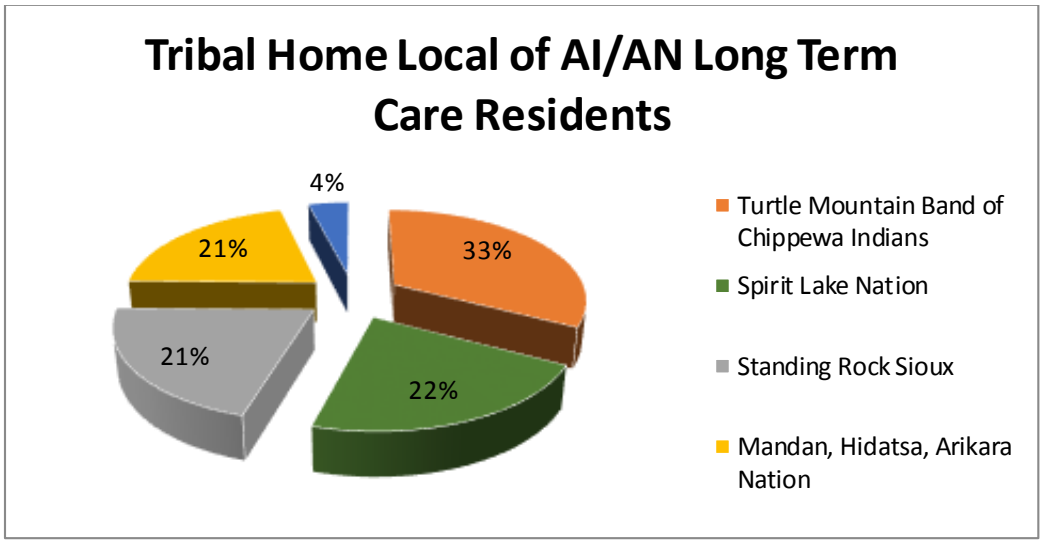
Mobility & Balance	Patient Percentage
Wheelchair	72%
Walker	28%
Balance: Unsteady in need of constant Staff Assistance	55%
Balance: Unsteady but able with minimal Staff Assistance	22%
Balance: Steady in no need of assistance	15%
Walking: No Assessment Available	50%
Walking: Unsteady in need of constant Staff Assistance	12%
Walking: Unsteady but able with minimal Staff Assistance	16%
Walking: Steady in no need of assistance	15%
Standing from Seated Position: No Assessment Available	27%
Standing from Seated Position: Unsteady in need of constant Staff Assistance	32%
Standing from Seated Position: Unsteady but able with minimal Staff Assistance	12%
Standing from Seated Position: Steady in no need of assistance	13%

Bathing & Toileting	Patient Percentage
Bathing: In need of single-support Staff Assistance	64%
Bathing: In need of two or more Staff Assistance	31%
Bathing: Completely Independent	8%
Toileting: No Assessment Available	22%
Toileting: Unsteady in need of constant Staff Assistance	34%
Toileting: Unsteady but able with minimal Staff Assistance	19%
Toileting: Steady in no need of assistance	17%

Dressing & Eating	Patient Percentage
Dressing: Unsteady in need of two or more Staff Assistance	25%
Dressing: Unsteady but able with single Staff Assistance	54%
Dressing: Steady in no need of assistance	10%
Eating: Unsteady in need of constant Staff Assistance	8%
Eating: Unsteady but able with single Staff Assistance	35%
Eating: Steady in no need of assistance	5%

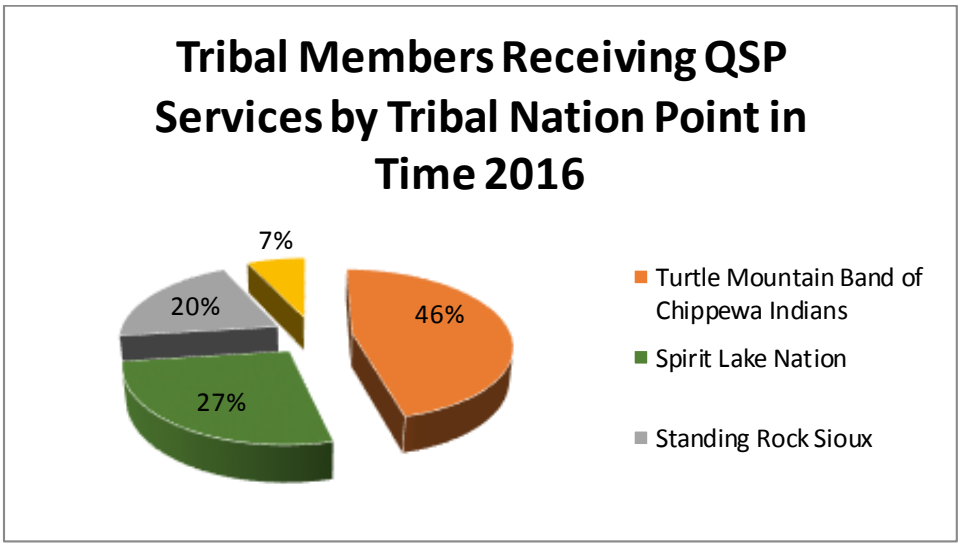
Home Reservation Identification

As noted, the MDS does not capture tribal affiliation and as a result, there is no known data for what a resident might consider "home" in regards to tribal lands or reservations. In order to ascertain this important information, North Dakota's MFPTI team collaborated with the NDLTCA to survey nursing home directors of social services to learn which reservations AI/AN members considered "home". The survey was conducted from February through May of 2016 and the response rate was high – 85% of the of the nursing homes participated, representing 110 of the 134 AI/AN people residing in long-term care facilities. Due to the small population size and the potential for identifiable information from data reported, the information is represented as percentages in compliance with HIPAA regulations for protecting PHI.



QSP Service Delivery Areas

QSPs provide a variety of home and community-based services to clients such as bathing, dressing, housekeeping, snow removal and non-medical transportation. Currently individual independent contractors are providing the home and community-based services offered by QSPs. The number of these independent contractors is very limited and is not adequate to meet the needs of tribal members at this time, or in the future as transition from institutional care is being considered. The MFPTI will assist tribal entities to become QSPs to grow the capacity of this resource and for the service to be more culturally responsive. A February 2016 point-in-time assessment showed a total of 323 AI/AN people received QSP services on or near tribal reservations within North Dakota as shown here:



In addition to bringing tribal members back to their homes and communities, establishing LTSS within the tribal nations would likely prevent admission into nursing homes or other institutions, as well as allow tribal elders to age in place within their own home. Following is data illustrating the impact of aging and disabilities within the tribal nations of North Dakota.

Tribal Community	Ages 18 to 64	Ages 65 and older
Mandan, Hidatsa, Arikara Nation	14.6%	56.3%
Spirit Lake Sioux Nation	7.8%	43.1%
Standing Rock Sioux Tribe	14.3%	46.5%
Turtle Mountain Band of Chippewa (including Trenton)	15.8%	51.0%

2000 and 2013 (ACS 5 Year Estimates

In comparison to statewide averages, rates of disability and disease are higher in AI/AN communities. In North Dakota, there is limited access to healthcare services for the American Indian population; there are two I.H.S. hospitals, one I.H.S. clinic, one 638 clinic and there are no Urban Indian Health Centers. With over 50% of the American Indian population in North Dakota eligible for Medicaid-funded services, this lack of access to health services places additional strain on tribal communities to provide for the long-term care needs of their elders and people with disabilities. Given the high number of American Indians who are eligible for Medicaid services and the high rates of disability, we expect the need for LTSS to increase within the tribal nations in the coming years. Phase 2 efforts are focused on establishing the LTSS infrastructure and increasing enrollment of eligible American Indians into Medicaid and Medicaid Expansion.

Other LTSS Service Options

Currently none of the tribal nations within North Dakota own or operate a long term care institution. Health care delivery capacity among the tribal nations within North Dakota includes:

Healthcare Service Type	Mandan, Hidatsa, Arikara Nation	Spirit Lake Sioux Nation	Standing Rock Sioux Nation	Turtle Mountain Band of Chippewa Indians
Self-determination contract (638) for CHR services	x	x	x	x
Self-determination contract (638) for tribal health clinic	x			
IHS Clinic		x		
IHS Hospital			x	x
LTSS Agency				
LTC Facility				

During tribal health leaders planning meetings facilitated by North Dakota's MFPTI team in the spring of 2016, it was learned that each of the tribal nations within North Dakota were providing LTSS services in some capacity. However, they were not billing ND Medicaid for any LTSS-related services. The services were paid by a very limited I.H.S budget line for CHRs. CHRs are important because they are members of the communities they serve and understand the dialects, social norms and cultural aspects of their patients' lives. The CHR program creates opportunities for innovation and coordination, not duplication of efforts.

It is important to note that while the CHR program has been in existence for decades in Indian Country, the CHR budget has not been increased in almost 20 **years**. Therefore, the funding and amount budgeted are not adequate to support the level of need. Many of the CHRs provide services (mostly transportation) for no payment once the IHS money runs out. They do this because they care about their elders and know that if they do not provide transportation, the elders do not have another option.

Section II: Program Description

A. For MFPTI financial and cultural sustainability, tribal nations could establish tribal home and community-based services agencies. This would link current MFPTI-specific NDDHS provider opportunities with other tribal-specific home and community-based services such as patient navigation, Medicaid or Marketplace enrollment, home visitation programs, oral health screenings, mental health screenings, substance abuse programs and many others. The tribal nations are going to follow the model White Earth Nation implemented: establish one LTSS option at a time and as capacity increases and the LTSS programs become sustainable, expand to different services. There are three NDDHS provider opportunities that can be pursued to provide LTSS and once established, integrated into tribal-specific LTSS systems to help sustain MFPTI:

- QSPs. QSPs can provide a variety of services including personal care services, chore services, respite care and transportation. There are two QSP enrollment options: individual QSP and QSP agency. Providers can also enroll to provide only QSP-related transportation services.
- TCM. A 2011 North Dakota Medicaid State Plan Amendment allows CHRs who are certified or who are working towards certification to provide TCM to tribal members under the supervision of a licensed health professional. TCM links clients to services and can bill at the all-inclusive rate per encounter.
- NEMT. While QSPs can be reimbursed for non-medical transportation, there is need for transportation to medical appointments and related pharmacy visits. The tribal nations can enroll as NEMT through the NDDHS and be reimbursed for this service.

After reviewing the assessment data, the Turtle Mountain Band of Chippewa Indians determined their Phase 2 priority as building LTSS infrastructure capacity utilizing the CHR network and current provider options through the NDDHS including QSP transportation and NEMT. The Mandan, Hidatsa, Arikara Nation determined their Phase 2 priority as building LTSS infrastructure capacity utilizing the QSP Agency provider option through the NDDHS. The Mandan, Hidatsa, Arikara Nation is also pursuing certification to become a home health agency during Phase 2.

MFPTI Infrastructure Element	Mandan, Hidatsa, Arikara Nation		Turtle Mountain Band of Chippewa Indians	
	Currently Pursuing? yes or no	If yes, date implemented	Currently Pursuing? yes or no	If yes, date implemented
Hire tribal nation MFPTI Coordinator	Yes		Yes	
QSP Agency	Yes			
QSP Transportation	Yes		Yes	
NEMT			Yes	
TCM				
Home Health Agency	Yes			

Throughout the remaining phases of MFPTI, the tribal nations will establish MFPTI-related infrastructure including:

- marketing and communication
    - tribal nation-specific communication and marketing materials need to be utilized and/or developed
    - will explore partnering with In Good HealthTV team
- transition coordination services aligned with the six quality procedures
- one-time moving costs
- transportation
- housing
    - home modifications
- 24-hour back up services
- Medicaid and Medicare certification for home health agencies
- on-going assessment for culturally-specific demonstration services.

As sovereign nations, each tribal nation will determine which options best fit their LTSS needs as well as when they pursue them.

B. The proposed service programs of TCM, QSP Agency and NEMT do not currently exist within the tribal communities, so they will not duplicate existing Medicaid statutory program authorities or state plan services. Rather, the proposed programs will operate within the existing Medicaid statutory program authorities and state plan services:

EXPED	SPED	MSP Personal Care 4, 8, 10 hours	HCBS Waiver	Technology Dependent Waiver
Adult Day Care	Adult Day Care		Adult Day Care	Attendant Care Service
Adult Foster Care	Adult Foster Care		Adult Foster Care	HCBS Case Management
Chore	Chore		Adult Residential	
Emergency Response	Emergency Response		Chore & ERS Systems	
Environmental Modification	Environmental Modification		Environmental Modification	
Family Home Care	Family Home Care		HCBS Case Management	
HCBS Case Management	HCBS Case Management		Homemaker	
Homemaker	Homemaker		Non-Medical Transportation	
Non-Medical Transportation	Non-Medical Transportation		Respite	
Respite	Respite		Specialized Equipment Supplies	
	Personal Care Services: ADLs	Personal Care Services: ADLs	Supported Employment	
			Transitional Care	
			Extended Personal Care	
			Home-Delivered Meals	
			Family Personal Care	
			Supervision	

C. Quality assurance process for all HCBS waiver and state plan personal care services will be implemented in accordance with NDDHS and CMS guidelines. The North Dakota State Plan Personal Care Program and Aging and Disabilities currently have a robust quality assurance process in place that will be followed as the MFPTI will primarily utilize these services to support individuals that either return to the community from institutional care, or have the potential for institutional care. The tribal organizations that participate in the MFPTI will be provided with technical assistance around the quality requirements so that each tribal entity has a good understanding of the quality requirements and will be able to add additional internal measures specific to the services that they offer. Additionally any new demonstration

or administrative services that may be developed will include the development of quality assurance measures that will follow the NDDHS and CMS guidelines and be culturally responsive. These will be developed in cooperation with the tribal entity that will be providing the services.

D. Following is the proposed timeline for North Dakota's MFPTI OP:

2017 **MFPTI Capacity Building**	**2018** **Implement Tribal MFPTI Transition Strategies**	**2019** **Monitor Transition Strategies**	**2020** **MFPTI Administrative Wrap-up**
Hire and train tribal MFPTI coordinator (one per tribal nation) for marketing and communication; Medicaid enrollment; meet with NDDHS MFP staff applicable to MFPTI (housing, workforce, transportation), etc. Tribal Health programs enroll as QSP, NEMT and/or TCM providers • Prioritized by the tribal nations • Add one provider option at a time Evaluate housing, transportation and other transition needs Develop transition strategies • Quality assurance • Services • Housing • Transportation • Administration and billing • Other? If needed, hire & train MFPTI transition staff	Ongoing: review current services and assess readiness for transferring Medicaid authorities to the tribal nations • Need for any cultural-specific services? If needed, hire & train MFPTI transition staff MFPTI clients receive services to bridge them to sustainable, supportive services for 365 days after their transition These "bridging" services may include moving costs, home necessities, home modifications, rental assistance, etc. December 31, 2018 – last transition day	Ongoing: review current services and assess readiness for transferring Medicaid authorities to the tribal nations • Need for any cultural-specific services? If needed, hire & train MFPTI transition staff MFPTI clients are utilizing sustainable LTSS Ongoing quality assurance for successful transitions	Quality assurance, evaluation & reporting MFPTI funding ends September 30

Section III: Roles and Responsibilities

A. 1. The state via the NDDHS, tribal nations and NDSU DPH will continue to collaborate on the planning, design and operations of MFPTI OP 2. The NDDHS contracts with the NDSU DPH for the MFPTI work. In this role, NDSU DPH provides technical assistance to both the state and tribal nations; serves as a liaison between the state and tribal nations and identifies system opportunities to improve implementation at subsequent tribal nations.

The NDDHS administers the Medicaid enrollment process for individuals. The NDDHS contracts with the Sanford Health Plan to administer the Medicaid Expansion program for individuals. Eligibility for both Medicaid and Medicaid Expansion is determined by the county social service offices. The NDDHS also administers LTSS provider enrollment processes of NEMT, QSP and TCM. Following is a more detailed summary of North Dakota's plan for enrollment, including recommendations identified during the September 2016 site visit with CMS:

- Provider enrollment. The MFPTI coordinator is providing individual enrollment assistance to tribal provider entities for both the Qualified Service Provider and Medicaid programs. In addition enrollment assistance for targeted case management will be provided. This assistance will continue throughout the grant period as new providers express and interest in enrolling as a provider.
- Medicaid enrollment. NDDHS and partnering T/TOs will work together to develop and provide training tools for tribal and IHS staff on benefits, enrollment, and services offered through Medicaid. NDDHS will work with the CMS Region 8 NAC can assist with this effort.
- NDDHS is aware that there are a number of enrollment strategies that states may elect to provide expedited pathways to coverage and/or reduce administrative burdens. The NDDHS will utilize the CMS website: https://www.medicaid.gov/medicaid-chip-program-information/bytopics/outreach-and-enrollment/enrollment-strategies.html and other contracted resource to develop enrollment strategies.
- NDDHS will partner with tribal nations to develop arrangements with other providers to expand access to home and community based services. NDDHS will establish partnerships with T/TOs to work with the CMS RO and CMS NAC to leverage federal opportunities and incentives to broaden the scope of services and providers for Medicaid-eligible tribal members in North Dakota.

2. Thus far, some challenges have emerged coordinating the provider enrollment processes because we are working across three sectors of government: NDDHS (state), IHS (federal) and tribal. However, through respectful facilitation that honors tribal sovereignty, we are overcoming intergovernmental challenges in establishing LTSS on tribal lands.

As challenges or barriers have arisen, the NDSU DPH has facilitated meetings between members of the tribal nations and the staff at NDDHS. These meetings have occurred in person, over the phone and via e-mail. These additional communication opportunities have been very beneficial as the state staff learn about the specific issues facing the tribal nations and have worked hand in hand in with us to identify solutions. This process emerged organically during Phase 1 and since it has been effective thus far, it will be continued for subsequent MFPTI phases.

B. Since North Dakota's MFPTI Phase 2 OP is focusing on existing LTSS service options, we will not be proposing changes in the state's or tribal nations' roles in administering Medicaid

services in Phase 2. The role of the tribal nations is to become enrolled Medicaid providers and the state's role is to administer the Medicaid program. The tribal nations will also work to increase enrollment of Medicaid and Medicaid Expansion-eligible individuals. Additionally, North Dakota's MFPTI team will closely follow possible changes in Medicaid and Medicaid Expansion at the federal and state levels to determine any impact on eligibility of tribal members for these programs.

1. The state will not be delegating administrative responsibilities to the tribal nations in Phase 2.
2. Again, the tribal nations within North Dakota will be building their own capacity to provide LTSS services to their citizens utilizing existing state plan provider options of QSP Agency, NEMT and TCM. As each tribal nation's capacity to provide and be reimbursed for LTSS increases, each tribal nation will assess additional LTSS options to pursue. This planning will address any potential conflict of interest policies.

C. The tribal nations are not proposing any new Medicaid authorities during Phase 2 OP. Rather, they will be utilizing the current opportunities available for LTSS through NDDHS. As the LTSS systems are up and running and are sustainable, the tribal nations will assess the need for either state plan amendments or demonstration services to allow for more culturally-specific services. Additionally, the tribal nations will continue to work with the NDDHS to monitor opportunities for 100% FMAP when patients are referred to the private sector for healthcare services.

Section IV: Detailed Timeline and Activities

(Points 1 and 2 from Section IV of the OP 2 Outline). The North Dakota MFPTI team recognizes that the MFPTI Phase 2 OP Outline requests detailed descriptions of agreements between state and tribal nations relative to roles, as well as agreements among and between tribal nations. Since North Dakota's MFPTI Phase 2 OP is focusing on infrastructure development, agreements between the state and tribal nations and potentially between and among tribal nations are not applicable at this time. However, NDSU DPH will sub-contract with Mandan, Hidatsa, Arikara Nation and Turtle Mountain Band of Chippewa Indians to hire a tribal MFPTI program coordinator for each tribal nation during Phase 2 OP. This need was identified by each tribal nation during their planning meetings.

As we move further into LTSS infrastructure development, there may be tribal resolutions passed supporting specific MFPTI work. This will be determined by new tribal councils for both Mandan, Hidatsa, Arikara Nation and Turtle Mountain Band of Chippewa Indians. Please note that tribal resolutions are the highest laws in Indian Country and are equivalent to a law passed by Congress and signed by the President of the United States.

(Point 3 from Section IV of the OP 2 Outline). Following is a detailed summary describing goals and parameters of the desired program and steps to achieve them through the length of the

project. Note that the process and steps will not change but timelines may be modified based on each tribal nation's specific MFPTI implementation timeline. Also note strategies that will assure culturally specificity and respect tribal sovereignty are designated with an asterisk.

MFPTI Capacity Building (March 2017 – December 31, 2017)

Objective 1: By December 31, 2017, establish MFPTI program infrastructure needed to support the development phase of MFPTI.

Strategy 1.1*: Identify, contract with and provide training to a tribal member in each participating tribal nation to serve as MFPTI tribal coordinator.

Strategy 1.2: Establish IT and billing systems needed to support MFPTI and provide training.

Strategy 1.3*: Identify and provide culturally appropriate MFPTI training to tribal, county and state MFPTI partners.

Strategy 1.4*: Identify unique LTSS needs of Medicaid-eligible tribal members who are interested in being discharged to their home communities.

Strategy 1.5: Enroll as QSP, NEMT and/or TCM providers with NDDHS.

Implement MFPTI Transition Strategies (January 1, 2018 – December 31, 2018)

Objective 2: By December 31, 2018, implement MFPTI transition strategies.

Strategy 2.1: Identify which health outcomes, quality and ROI metrics will be evaluated.

Strategy 2.2: As appropriate based on interest, needed/available services, transition tribal nation members from LTCF to their home reservations.

Strategy 2.3.*: Identify unique T/TO provider education and training needs.

Objective 3: By December 31, 2018, assess readiness for transitioning Medicaid authorities or state plan services (i.e. waivers or state plan amendments) to address the identified tribal needs.

Strategy 3.1: If ready, identify delegated administrative responsibilities that allow T/TOs significant leadership roles in the design and operations of a Medicaid LTSS program for tribal members.

Strategy 3.2: If ready, identify state and tribal roles in Medicaid administration as well as interest and capacity to fulfill those roles over the life of the project and after its conclusion.

Monitor MFPTI Transitions (January 1, 2019 – December 31, 2019)

Objective 4: By December 31, 2019, monitor the MFPTI transition systems.

Strategy 4.1: monitor identified health outcomes, quality and ROI metrics.

Strategy 4.2*: If needed, establish training and workforce development tracks to build provider capacity needed to sustain MFPTI services

Objective 5: By December 31, 2019, if ready, implement partnership agreements between T/TO and other MFPTI partners which clearly define administrative authority and delegated administrative responsibilities.

MFPTI Administrative Wrap-up (January 1, 2020 – September 30, 2020)

Objective 6: By September 30, 2020, evaluate quality of life improvements, clinical outcomes and assess cost savings for people who transition home through MFPTI.

Objective 7: By September 30, 2020, if ready, implement partnership agreements between T/TO and other MFPTI partners which clearly define administrative authority and delegated administrative responsibilities.

(Point 4 from Section IV of the OP 2 Outline): At this time, ND's MFPTI team doesn't anticipate delegating NDDHS functions during the timeframe of the MFPTI grant. If this changes based on implementation progress, a description of proposed tribal administrative structures to address delegated functions and mechanism to assure and oversee quality will be developed by the tribal nation with collaborative input from the NDDHS and CMS.