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SECTION A – PROJECT GOALS AND BENCHMARKS

Introduction / Goals

Project Introduction

In 2007 the Centers for Medicare and Medicaid Services awarded North Dakota(ND) a grant through the Money Follows the Person (MFP) Rebalancing Demonstration Program established by the Deficit Reduction Act of 2005. The State intends to use MFP funding to develop processes that will assist individuals with moving out of Intermediate Care Facilities for persons with an intellectual disability and Nursing Facilities (institutions) and to assure that the necessary Home and Community Based Services are available to support community living. The design and development of a system that can serve all individuals in need of support services in the community will be the benchmark of success for the North Dakota MFP grant process.

North Dakota will provide transition assistance to those persons that would not have naturally moved out of nursing facilities by offering a Nursing Facility Transition Coordination demonstration/supplemental service. ND has 80 nursing facilities with the capacity to serve 6080 persons. The current total population of our nursing facilities is at about 92% occupancy. The State will continue to support the efforts of North Dakota nursing facilities as approximately 40% of all residents who are discharged per year are discharged to their home or to a more independent level of care.

A Nursing Facility Transition Coordination service has been developed to facilitate transitions from nursing facilities across the state. The four ND Centers for Independent Living have been contracted to provide these services. Supplemental services are offered to pay for onetime transition costs to additionally support transitions from nursing facilities into community settings. A Nursing Call Service has been developed to offer 24 hour backup assistance to all participants of the grant.

To promote long term and sustainable system changes the Stakeholder Committee identifies and documents barriers to services and unmet support needs. Services considered necessary are identified and communicated to the appropriate State legislative and governmental agencies, advocacy groups, and provider groups. The Stakeholder group advocates for the funding and/or policy changes required to “fill the gaps” in the service delivery system. The MFP Stakeholders Committee and workgroups has been tasked with the overarching responsibility of collaboration for system change to increase the capacity of the community support services.

A Pilot Resource Link was established in the Bismarck Region of ND in 2009. It served as a single-point-of-entry for long term care and support services for adults with disabilities in the designated pilot region. The Resource Link also provides a Web-based (and telephone/TTY disability accessible) Aging and Disability Resource Center that can be accessed by seniors and adults with disabilities, their family members, providers, and others to obtain information and assistance accessing long term support services. The Aging Services Division of the ND Department of Human Services has expanded the services of Options Counseling statewide. ND MFP Services will continue to cooperate with the Aging Services Division to promote increased use of community supports through this new service as it implemented across ND.

The MFP grant process also has been utilized to promote state wide education processes to increase public awareness and utilization of the Long Term Care services available in the community. The Resource Link supports this goal. Education will promote a better understanding of the support needs of persons with a disability and for persons that are aging, help to communicate the services currently available, and the most effective ways to access services. The Resource Link plays a key role in this process.

The Resource Link supports the efforts of the Centers for Independent Living in transitioning individuals from nursing facilities by referring potential consumers and providing information about the local resources available to support persons transitioning to the community. The Resource Link also assists consumers currently living in the community connect with resources and services that may assist them to delay admission to an institution.

For the past 20 years North Dakota has been working to ensure that persons with intellectual and developmental disabilities are being cared for in the least restrictive environment possible. In the 1960s, the Life Skills and Transition Center (Center) had over 1,200 residents between its two facilities in Grafton and Dunseith. The Dunseith facility has closed and the resident census at the Center has declined to the current level of about 83 people. This decrease was a direct result of the availability of improved training and treatment, increased community-based supports including the establishment of eight regional human service centers, and growth in the number of private providers.

North Dakota also has 67 community Intermediate Care Facilities for Persons with an intellectual disability (ICF/ID). The ICF/ID facilities are currently serving 471 persons. Many of the individuals that reside in an ICF/ID facility previously were residents of the ND Life Skills and Transition Center. The ND MFP grant assists individuals now residing in a community ICF/ID with transition to a more integrated setting in the community as services are available to meet their needs.

During the 1990s a number of programs were initiated that were aimed at further reducing the number of admissions to the Center while enhancing available community services. For instance, the Evaluation, Respite, Intake, and Consultation unit was established to allow a more rapid response to regions referring for admissions and to provide informal intervention to prevent admissions. This was later replaced with the comprehensive Clinical Assistance, Resources, and Evaluation Services program, which was established to ensure high-quality and systematic assistance to private providers and human service centers. Today, the Center continues to provide needed services and supports to consumers living in the community and to their support services providers enabling consumers to be more successful participants in their communities.

In 2005 The North Dakota Legislature directed the Department of Human Services, with input from developmental disabilities service providers, to develop a plan to transfer individuals from the Life Skills and Transition Center to community placements with transfers beginning in the 2005-2007 biennium. The Department convened the Life Skills and Transition Center Transition to the Community task force made up of providers, advocates, consumer family members, and various divisions within the Department. The Task Force has been working to build the care infrastructure in the community and to determine the long-term viability and role of the Life Skills and Transition Center.

The Task Force has developed a draft plan for building community services capacity and an enhanced state wide crisis intervention system. The three subcommittees of this task force are currently working to develop specific strategies to transition individuals from the Life Skills and Transition Center into the community and divert new admissions to the institution. The MFP Grant Program Administrator is now a member of the task force to support the long term sustainable system changes being recommended to serve persons transitioning from the Life Skills and Transition Center or community ICF/ID facilities. MFP participants transitioning from the Life Skills and Transition Center or a community ICF/ID will be supported by the Money Follows the Person Grant for the first year after transition and with supplemental services funds for onetime moving related costs.

Demonstration Objectives

1. Rebalancing: Increasing use of HCBS

The demonstration service of Nursing Facility Transition Coordination will work cooperatively with nursing facility discharge planning teams to facilitate transitions for qualified consumers who have spent a minimum of three months in a nursing home and/or another institution, meet level of care requirements for nursing facility care, and have been determined to be Medicaid eligible for the at least one day prior to transition. The Transition

Coordinators along with the discharge planning team will rely on a variety of home and community-based services and supports to make these transitions viable. The Transition Coordinator will provide support for the 365 days following transition to optimize adjustment. Once the transition period has concluded, transitioned consumers will be able to maintain themselves in a community setting through services available under the State's 1915(c) Waivers, the Medicaid State Plan, the Service Payments to the Elderly and Disabled Program, the Expanded Services Payment to the Elderly and Disabled Program, the Older Americans Act, and other community-funded programs.

The grant will financially support additional persons transitioning from the Life Skills and Transition Center or a Community ICF/ID for the duration of the grant. This financial support will be provided during the first year of transition from the institution with the enhanced rates provided by the grant. The additional Federal funding provided by the grant will be utilized to increase the capacity of the community service system. The Life Skills and Transition Center Community Transitions Task Force will work with the MFP Grant Administrator to determine the most effective ways to utilize the MFP Grant funds to increase the use of services in the community.

2. Money Follows the Person: Eliminate barriers that prevent/restrict flexible use of Medicaid funds to receive LTC in HCBS.

In addition to services already offered under North Dakota's 1915 c Waivers, Transition Assistance will be made available to ease the transition back into community living for all population groups being served by the grant. These service payments will be for one-time occurrences, such as security deposits, home furnishings, assistive technology, and home modifications. The availability of flexible funding has been shown to make a significant difference in enabling a former nursing facility or ICF/ID resident achieve his or her goal of living in the community.

The Money Follows the Person Stakeholder Committee and workgroups that have been established are considered vital to the success of the Money Follows the Person Rebalancing demonstration initiatives and in creating long term sustainable system change. The general responsibilities of the committee will be to provide ongoing oversight and/or advice on State policy changes to achieve rebalancing, monitor grant implementation progress, monitor achievement of grant benchmarks, and to suggest ways to improve program design or implementation. The Committee includes consumers and/or their family members, advocacy groups, provider association representatives, State agency staff, and housing agency representatives in a collaborative planning process that can uniquely facilitate change.

The Stakeholder Committee and workgroups have identified barriers to service, gaps in the service delivery system, funding concerns, and policy changes that would eliminate barriers to flexible use of Medicaid funds for the provision of Long Term Care in community settings. The Committee and the workgroups will continue the collaborative efforts that have been established to promote and create sustainable changes to North Dakota's care delivery systems. In addition the Life Skills and Transition Center Transition to the Community Task Force has established specific strategies to improve services to individuals with a developmental disability and will continue to work with the MFP Grant Manager to implement those strategies.

The Stakeholder Committee has identified the shortage of qualified providers and the limited services available in the community as the primary barriers to achieving the capacity to provide support services at levels needed in the community. These issues encompass the need for training of service providers, recruitment of additional persons to provide services, and the development of additional services to support persons with more challenging needs. The barriers cross services for all population groups and at all levels of service. The intent is long term development of the professionals needed to support persons transitioning during and after the demonstration period. The Direct Service Worker Resource Center (<http://www.dswresourcecenter.org/>) will be used as a resource to accomplish this goal. North Dakota will address these issues with Money Follows the Person rebalancing funds, maintained in a separate fund, over the life of the grant in the following ways:

Develop recruitment processes to attract new providers for all population groups. This will be accomplished through activities such as:

- Provide informational sessions around the state that would outline the process for becoming a Qualified Service Provider (QSP), define the role of a QSP, and, describe the opportunities available in the state. This process will involve Medical Services Program Administrators establishing a series of informational sessions around the state each year. The sessions will be advertised using public service announcements. The process and informational modules will be developed for long term use in the state's QSP recruitment efforts.
- MFP has funded the Direct Service Professional (DSP) recruitment efforts of state DD service providers. This involved contracting with a consultant or other services to develop sustainable recruitment strategies. This included such activities such as TV advertising and provision of informational sessions at high schools and colleges, and other locations. The North Dakota Association of Community Facilities continues to work with the Governor and the Lieutenant Governor about the importance of professionalizing DSP's.

- Continue to implement public education strategies to communicate / market the HCBS services available to support continued community residence. This involves the development and implementation of a marketing plan and/or process that can be utilized around the state.
- Fund a small demonstration grant to a nursing facility to provide personal care in the community or incentive program. In many of the small ND cities the local nursing facility is the only resource for services of any kind. Current reimbursement rules for nursing facilities create disincentives for nursing facilities to provide community based services such as personal care or other Home and Community Based Services. In addition to the limited population in these communities most qualified care givers are employed by the local nursing facility. To address the reimbursement structure issues that these facilities face a grant would be offered that would allow a nursing facility to offer community based services without compromising their financial situation. This would also provide them with the opportunity to expand their scope of practice and support efforts of the policy changes necessary to make the provision of personal care or other related service a viable means to support persons in the community.

Grants would be structured to address the administrative and care requirements of expanding services while at the same time utilizing the current rules and regulations, and funding related to the provision of QSP services.

- Training processes for service providers of all population groups are accomplished by: a) providing training opportunities to service providers in relation to positive behavior interventions to meet the needs of higher need individuals transitioning to the community. To support the efforts of service providers to develop the skills necessary to serve persons with the most significant disabilities specialized training opportunities are developed and provided. This training has been added to the current training curriculum offered to DD provider staff at this time.
- Web based and face to face training is provided for individuals to become or to continue as a qualified service provider as defined by N.D.C.C. 50-06.2-02(6) and to provide training to nurses who will provide the training to individuals to become or continue to as a qualified service provider. The QSP recruitment efforts planned are designed to increase the number of providers. This increase in providers will necessitate the demand for training resources and opportunities.

3. Continuity of Service: Assure continued provision of HCBS after 1-year transition period.

The State will assure the continuity of services to all Money Follows the Person (MFP) Grant participants following their one-year transition period to community living. Participants will continue to receive home and community based services and supports through the State's 1915 c Waivers, the State Plan, and other programs for which they may qualify. Participants who have successfully transitioned to community living and continue to be eligible for HCBS services will be assigned a case manager who will be responsible for coordinating all aspects of a participant's care plan, as well as monitoring the provision of services provided under that plan. The types of case management services available include: Home and Community Based Services Case Manager, Developmental Disabilities Program Managers, and Case Managers for persons with a serious mental illness.

North Dakota will continue to work to rebalance long term care funding resources to support consumer preferences for home and community based care with the goal of preventing unnecessary or premature institutionalizations and to allow consumers a wider range of options. Additional customized services under a 1915c Waiver or other funding sources will be assessed and developed based on service needs identified during the MFP grant period and contingent on legislative approval.

The use of a person-centered service planning and delivery model will help to eliminate barriers to the flexible use of services funded by Medicaid. The model is a critical first step in departing from the previous rigidity of service plans that were based on where consumers live, not necessarily on what they need. North Dakota wants to assess support needs first and work to develop a system that can meet those needs with home and community based services.

4. QA/QI: Ensure at least same level of QA for MFP participants as available to other HCBS beneficiaries.

Quality assurance protocols have been developed for the Nursing Facility Transition Coordination Service, Transition Assistance payments, and the 24 hour on call nursing service to be offered during the grant period. In addition an incident management, risk mitigation, and 24-hour backup services quality protocols have been developed to assure that the health and welfare needs of all MFP participants are addressed in a responsive manner. Processes for these are outlined in the Operational Protocol in more detail. The quality assurance strategies in place for the 1915(c) Waiver services that MFP participants will be receiving are generally outlined as well in the Operational Protocol.

SECTION A.2 – BENCHMARKS

The following are the five benchmarks that will be measured for the North Dakota’s Money Follows the Person Demonstration.

Benchmark #1: Projected number of eligible individuals to be assisted in transitioning

The following table represents the projected number of eligible individuals in each target group to be assisted in transitioning from an inpatient facility to a qualified residence during each year of the demonstration beginning June 1, 2008. Individuals included in the “other” category are children that are expected to transition into the Medically Fragile Children’s Waiver, Children’s Hospice Waiver or other Home and Community Based Services waivers or the Medicaid State Plan services.

Proposed Transition Benchmarks for MFP Grant 2011-2018

Grant Year	Aged	Physically Disabled	Individuals with ID/DD	Dual Diagnosis: ID / DD and MI	Other	TOTAL
2007	0	0	0	0	0	0
2008	1	1	3	0	0	5
2009	4	7	4	0	0	15
2010	6	6	8	0	0	20
2011	15	15	8	0	1	39
2012	15	15	8	0	1	39
2013	15	19	12	0	1	47
2014	15	19	12	0	1	47
2015	15	19	12	0	1	47
2016	15	19	12	0	1	47
2017	15	19	12	0	1	47
2018	15	19	12	0	1	47
TOTALS	131	158	103	0	8	400

Benchmark #2: Qualified expenditures for HCBS during each year of the demonstration program

Institutional vs. HCBS Expenditures Total				
	CY 2013	CY 2014	CY 2015	CY 2016
Total NF Expenditures	264,333,000	274,906,320	285,901,580	297,343,600
DD/ID Expenditures	111,549,605	109,546,359	104,035,151	94,728,802
	375,882,605	384,452,679	389,936,731	392,072,402
Decrease in NF Expenditures	2,643,330	2,749,063	2,859,016	2,973,436
Decrease in DD/ID Expenditures	3,169,237	3,295,994	3,427,832	3,574,693
	5,812,567	6,045,057	6,286,848	6,548,129
% Decrease to Institutional	1.55%	1.57%	1.61%	1.67%
HCBS Expenditures	19,707,149	20,495,435	21,315,252	22,167,862
ID/DD Expenditures	164,169,259	172,303,385	182,391,134	194,573,968
	183,876,408	192,798,820	203,706,386	216,741,830
NF MFP Expenditures	3,752,990	3,897,984	4,048,798	4,205,679
ID/DD MFP Expenditures	1,567,356	1,628,258	1,691,574	1,756,921
	5,320,346	5,526,242	5,740,373	5,962,600
% Increase to HCBS	2.89%	2.87%	2.82%	2.75%

Benchmark #3:

Benchmark # 3 MFP Housing Program Initiative:

Program Goal: Develop and maintain an effective, consumer accessible comprehensive housing resource system of safe, affordable, accessible, quality, permanent housing options for consumers wishing to transition to the community from an institutional level of care and for consumers at risk of institutionalization.

Measurable Objective #1: Develop a comprehensive database/ registry of available safe, affordable, accessible, quality, permanent housing options by June 1, 2012.

Measurable Objectives #2: ND Housing Staff will assist a targeted number of consumers each year transitioning from an institutional level of care or at risk of institutionalization to find suitable, affordable, and/or accessible housing in the community.

Housing Target Goals

Year	Units Located
2012	30
2013	40
2014	40
2015	50
2016	50
2017	50
2018	50
2019	50

Measurable Objective #3: The MFP Housing Initiative staff will deliver at least six outreach housing presentations each year between 2011 and 2019 to community housing partners for purpose of enlisting their participation in addressing the housing needs.

These presentations will be for purpose of educating traditional and non-traditional community partners, including, but not limited to, group home operators, social service providers, landlords, apartment complex owners and housing developers in the state with the overall goal of enlisting their participation in addressing the housing needs of consumers transitioning from institutional to community settings or for consumers at risk for institutionalization.

Benchmark #4: Home and Community Based Services Marketing Services

Program Goal: Develop and maintain an effective public education process to promote the awareness and utilization of home and community based services for consumers wishing to transition to the community from an institutional level of care and for consumers at risk of institutionalization.

Campaign #1

Measurable Objective #1: Develop vendor booth materials and collateral marketing materials for utilization by the ND Department of Human Services staff in the ongoing attempts to educate eligible individuals about Home and Community Based Services (HCBS).

Measurable Objective #2: Develop a HCBS Tool Kit which includes brochures and pamphlets, booklets, flyers, fact sheets, posters, bookmarks, comparison charts, postcards, instruction sheets, and questionnaires that can be utilized by county case managers and ND Department of Human Services staff for ongoing outreach.

Measurable Objective #3: Develop and implement marketing strategies to inform individuals of the opportunity to become a Qualified Service Provider (QSP).

Measurable Objective #4: Create tools for the MFP Transition Coordinators to educate nursing facilities and residents of the MFP transition process.

Measurable Objective #5: Develop and implement outreach strategies for medical professionals including hospital discharge planners, clinics, physicians, pharmacists, to educate concerning available HCBS and referral processes.

Measurable Objective #6: Agency MABU will develop and implement mass media and internet-based marketing strategies to inform eligible individuals about HCBS options.

Measurable Objective #7: Create tools for the MFP Transition Coordinators (TC) to educate nursing facilities and residents of the MFP transition process and develop and implement outreach strategies for medical professionals including hospital discharge planners, clinics, physicians, pharmacists, to educate concerning available HCBS and referral processes.

Measurable Objective # 8: Agency MABU will develop and implement mass media strategies to inform eligible individuals about HCBS options.

Measurable Objective #10: Develop and implement marketing strategies to inform individuals of the opportunity to become a Qualified Service Provider (QSP).

Benchmark #5 Nurse Quality Assurance Services

Program Goal: Develop and maintain an effective nursing quality assurance process to assure safe and successful transitions for consumers returning to community from a nursing facility or hospital setting. This initiative is also designed to increase the number of successful transitions to community placements.

Measurable Objective #1: Provide all MFP participants transitioning from a nursing facility with an on-site assessment prior to transition to identify their health related support needs in the community.

Measurable Objective #2: Provide all MFP participants that have transitioned from a nursing facility with a follow-up nursing quality visit within 14 days of transition to determine if the recommended health related supports are in place, if the services are sufficiently meeting the needs of the individual, and to determine if additional health related supports may be needed.

Measurable Objective #3: Provide all MFP participants that have transitioned from a nursing facility with a follow-up nursing quality visit within 90 days of transition to determine if the recommended health related supports are in place, if the services are sufficiently meeting the needs of the individual, and to determine if additional health related supports may be needed.

SECTION B – DEMONSTRATION IMPLEMENTATION POLICIES AND PROCEDURES

B.1 Participant Recruitment and Enrollment

The ND Outreach/Marketing/Education Operational Protocol will outline the general and population specific efforts that have been or will be utilized to educate potential participants/family members, agency professionals, and the community about the MFP demonstration. Reference is invited to this section B. 3 Outreach/Education/Marketing of the operational protocol for a review of these strategies.

Target Populations

Nursing Facilities:

The ND MFP Demonstration will specifically target persons for transition who are elderly or persons that have a physical disability and have expressed that they expect to be discharged to the community or as indicated in Minimum Data Set MDS section Q.

The Medical Services Division will additionally identify nursing facility residents either in an active or pending Medicaid status. The name of those identified will be forwarded to both the nursing facility social worker and the regional MFP transition coordination staff for review. The MFP transition coordinator will schedule an appointment with each social worker to review the needs of each individual to determine how to communicate the availability of MFP services. The review will involve discussion of the recipient's medical and cognitive status to determine the need for involvement of family and/or a legal decision maker. Once a decision is reached by the social worker and transition coordinator, the transition coordinator will communicate in person with the individual recipient, their family and/or the legal representative to provide information about the MFP Grant services.

Persons with a developmental disability with a section Q preference to return to the community will also be offered transition assistance from a nursing facility. In addition these persons will need to have been residing in an institutional setting for at least three months, meet level of care requirements, and have been determined to be Medicaid eligible for one day immediately prior to transition.

The Minimum Data Set (MDS) is a tool used by nursing facilities to assess the needs of their current residents/consumers. ND will utilize this assessment to help determine eligibility for MFP participation.

Section Q of the MDS assessment evaluates the residents "Participation in Assessment and Goal Setting".

- The document specifically asks (Q0300) what the Resident's Overall Expectation of their nursing facility admission.

The nursing facility professionals responsible for completing the assessment communicate with the individual/consumer in the communication method preferred by the individual to ascertain the individual's preference.

Level of Care Review

Individuals completing an application for the North Dakota MFP Grant Program will be required to meet institutional level of care at time of admission to the respective institutional setting. This level of care eligibility will be tracked by the MFP Program Administrator utilizing the agency responsible for the screening process of each designated setting. Level of Care screening will be completed at time of discharge to the community or within eleven months of transition to the community based on the community service program eligibility supporting the consumer's transition.

Nursing Facility Level of Care Screening Criteria

Minimum criteria for nursing facility Level of Care as specified in the North Dakota Administrative Code 75-02-02-09.

In determining level of care, the individual must require or meet a minimum of one of the criteria listed in "Section A" **or** two criteria included in "Section B" **or** criteria in "Section C" **or** all the criteria in "Section D".

Section A:

1. Nursing Facility (NF) stay is, or is anticipated to be, temporary for receipt of Medicare Part A benefits. Nursing facility stay may be based on this criterion for no more than fourteen (14) days beyond termination of Medicare Part A benefits;
2. The individual is in a comatose state; Date of onset: _____
3. The individual requires use of a ventilator for at least six (6) hours a day;
4. The individual has respiratory problems that require regular treatment, observation or monitoring that can only be provided by or under the direction of a registered nurse (or in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse) and she/he is incapable of self-care;
 - a. Problem
 - b. Treatment

5. The individual requires constant help at least 60% of the time with at least two (2) of the following Activities of Daily Living (ADL's):
 - a. Toileting (process of using toileting equipment and cleansing self)
 - b. Eating (process of getting food from receptacle into the body)
 - c. Transferring (process of moving to and from bed, chair, toilet)
 - d. Locomotion (process of navigating home environment with or without adaptive devices, as appropriate)
 - e. Constant help is required if the individual requires a caregiver's continual presence or help, without which the activity would not be completed.
 - i. Identify and describe:
6. The individual requires aspiration for maintenance of a clear airway;
 - a. Describe Frequency:
7. The individual has dementia, physician diagnosed or supported with corroborative evidence for at least 6 months, and as a result of that dementia, the individual's condition has deteriorated to the point that a structured, professionally staffed environment is needed to monitor, evaluate and accommodate the individual's changing needs.
 - a. Describe needs and provide date of onset/initial diagnosis:
 - b. Date of Diagnosis:
 - c. Needs:

Section B: (If no criteria in section A are met, an applicant or resident is medically eligible for NF level of care if at least two of the following criteria apply):

1. The individual requires administration of a prescribed:
 - a. Injectable medication; **or**
 - b. Intravenous medication and solutions on a daily basis; **or**
 - c. Routine oral medications, eye drops or ointments on a daily basis
 - d. List relevant medications:
 - i. Medication Dosage:
 - ii. Route:
 - iii. Date started:
2. The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse (or, in the case of a

facility which has secured a waiver the requirements of 42 CFR 483.30 (b), a licensed practical nurse). Identify diagnosis and describe services needed:

- a. Unstable Medical Diagnosis:
 - b. Date of instability:
 - c. Services Required:
3. The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatments. (e.g., gait training, bowel and bladder training) which are provided at least five (5) days per week. Identify restorative procedures required:
- a. Restorative Services
 - b. Frequency Provided
4. The individual needs administration of feedings by:
- a. Nasogastric tube
 - b. Jejunostomy
 - c. Gastrostomy parenteral route
 - d. Other (specify):
5. The individual requires care of:
- a. Decubitus ulcers
 - b. Stasis ulcers
 - c. Other widespread skin disorders (specify):
 - d. Treatment required:
6. The individual requires constant help at least 60% of the time with one (1) of the following:
- a. Toileting (using toileting equipment and cleansing self)
 - b. Transferring (moving to/from bed, chair, toilet etc.)
 - c. Locomotion (navigating home environment with/without adaptive devices)
 - d. Eating (getting food from receptacle into the body)
 - e. Describe Assistance Needed:

Section C: If **no** criteria in Section A and/or insufficient criteria in Section B was met, an applicant/resident who applies to or resides in a nursing facility for non-geriatric individuals with physical disabilities may demonstrate that nursing facility level of care is necessary if:

1. The individual is determined to have restorative potential. Describe:

Section D: If no criteria in Section A, Section B or Section C are met, the individual who applies for care in a nursing facility may demonstrate that a nursing level of care is medically necessary if:

1. The individual has an acquired brain injury which includes:
 - a. Date
 - b. Anoxia
 - c. Cerebral vascular accident
 - d. Brain tumor
 - e. Infection
 - f. Traumatic Brain Injury;

2. As a result of the brain injury, the individual requires direct supervision at least eight (8) hours a day.
 - a. Describe Supervision
 - b. Who Provides

Level of Care Appeal Process

The individual or legal representative may appeal the Level of Care eligibility decision within 30 days of the date of this notification. If the request for a hearing is received by the appeals supervisor within 10 days from the date of this notice, the funding for services may continue until an appeal decision is reached. However, all costs for services received must be paid back if the appeal is upheld. The individual may represent him/herself in an appeal hearing or may use a legal counsel, relative, friend, or other spokesperson. The reason for the appeal must be submitted in writing to:

Appeals Supervisor
North Dakota Department of Human Services
600 East Boulevard Avenue
Bismarck, North Dakota 58505-0250

75-01-03-08.2 – Notice of preadmission screening and resident review determinations.

1. An individual dissatisfied with an adverse determination made with regard to the preadmission screening and resident review requirements of 42 U.S.C. 1396r(e)(7)(A) or (B) may request a fair hearing in review of that determination.

2. The right to request a fair hearing under subsection 1 arises upon receipt of a notice under subsection 3.

3. If the department's action in administering preadmission screening and resident review is adverse to an individual, the department shall provide to the individual a written notice which conforms to section 75-01-03-07 and which includes:
 - a. A statement of the adverse determination;
 - b. The reason for the adverse determination;
 - c. The date of the adverse determination; and
 - d. A statement that 42 U.S.C. 1396r(e)(7) requires the Department to make such determinations.

4. For purposes of this section and sections 75-01-03-07 and 75-01-03-09.2:
 - a. "Adverse determination" means a determination made in accordance with 42 U.S.C. 1396r(b)(3)(F) or 42 U.S.C. 1396r(e)(7)(B), through the application of section 75-02-02-09, that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services, but does not mean a determination, made under 42 CFR 483.128, that an individual is not suspected of having mental illness or mental retardation; and

 - b. "Significant change" means:
 - i. A Significant physical status improvement experienced by a nursing facility resident, such that the resident is more likely to respond to special treatment for that condition or might be considered appropriate for a less restrictive alternative setting;
 - ii. The presence of a nursing facility resident's mental illness, mental retardation, or condition related to mental retardation, not identified prior to admission, when it later emerges or is discovered;
 - iii. Exhibition of increased symptoms of mental illness or behavioral problems by a nursing facility resident; or
 - iv. A circumstance arising if a review resulted in a determination requiring inpatient psychiatric treatment for a nursing facility resident, and an update to that determination is needed to support that individual's admission or readmission to a nursing facility following delivery of psychiatric services.
 - v. Preadmission screening and resident review, including determinations of significant change, is undertaken applying professional judgment and standards approved by the department that are consistent with the requirements of 42 CFR part 483, subpart C, and 42 U.S.C. 1396r(f)(8).

Nursing Facility Transition Recruitment and Enrollment Process:

All persons who are eligible for home and community based services and reside in a nursing facility and have expressed that they expect to be discharged to the community or as indicated in MDS section Q, will be eligible to participate in the ND MFP demonstration. This includes persons eligible for the North Dakota HCBS Waiver for HCBS Services, North Dakota Technology Dependent Waiver, Medically Fragile Children Waiver, Children's Hospice Waiver, ID/DD Waiver, other waivers as developed, MFP demonstration services, state funded services or informational community support services. All current waiver services are listed to allow for MFP eligibility and services to persons that are elderly, persons with a developmental disability, or persons with a physical disability. Services received from any one of these programs during participant grant eligibility would be considered a MFP demonstration service and not a waived service.

The Transition Coordinator staff from the ND Independent Living Centers will be the professionals involved with enrolling MFP participants that reside in a nursing facility. The four centers include the Dakota Center for Independent Living of Bismarck and Dickinson; Independence Inc. of Minot and Williston; Options Resource Center for Independent Living of East Grand Forks and Cavalier; and Freedom Resource Center of Fargo and Jamestown. Each of these Centers will be responsible for serving the nursing facilities in their designated service area. All transition coordinators will be responsible for outreach and transition activities.

The Transition Coordinators will be providing MFP brochures and information to nursing facility social services staff to use to make other residents aware of the grant and will be available for presentation to NF Resident Counsels or facility staff. An MFP sign will be displayed in all nursing facilities.

The demonstration project as originally planned was designed to focus nursing facility transition services only in the Fargo and Grand Forks regions of State for the first year of the grant. The MFP nursing facility transition services demonstration services are now provided Statewide from the beginning of grant implementation. In addition, there are eight full time nursing facility transition coordinators employed by the Centers for Independent Living CILs dedicated solely to outreach and MFP transition activities.

The ND Department of Human Services, Medical Services Division maintains a Minimum Data Set (MDS) database and this will be used to help identify potential grant participants. ND nursing facilities complete a comprehensive MDS assessment quarterly and this information is submitted to the ND Department of Human Services.

In addition, the lower Resource Utilization Groups RUG will be considered for possible transitions to the community. Transition coordinators will be required to visit all nursing facilities in their designated quadrants on a quarterly basis to do outreach activities which may include visiting resident councils, family councils, individual residents, and facility staff.

The Money Follows the Person(MFP) Program Administrator will access the information contained in the Minimum Data Set (MDS), which is an instrument used in nursing facilities to assess residents. All certified Medicare or Medicaid nursing facilities must complete, record, encode and transmit to CMS the MDS for all residents in the facility. While the MDS was developed to provide consumers with an additional source of information about the quality of nursing home care and to help providers improve quality of care, it is also a tool that could be used to identify and locate nursing facility residents who would like to be served in an alternative setting. The MFP Program Administrator will use the MDS information to identify nursing facility residents who wish to be served in a more home-like setting and to assess which residents are most likely to be successful in transitioning to the community.

The most recent Minimum Data Set (MDS) on file in the ND Department's database will be used to first identify Medicaid individuals who meet the minimum three-month institutional requirement and expects to be discharged to the community. Once identified, information on all individuals will be forwarded through the mail by the MFP Grant Program Administrator to both the local Center for Independent Living Nursing Facility Transition Coordinator (TC) and the individual's nursing facility Social Services Director. Once the referral information has been received the Transition Coordinator and the NF Social Services staff will interview the nursing facility consumer/resident together to determine if transitioning is desired by the individual and to assess the potential for transitioning the individual to his or her desired community based on available informal and formal resources and supports available in the community.

In addition, any Medicaid eligible individual can self-refer to a TC if they meet the level of care at the time of admission to the institution, meet minimum 3 -month occupancy criteria, and intend to move to a qualified residence. If a Local Contact Agency (LCA) is already providing information to a resident, the Nursing Facility Transition Coordinator would not become involved until after the initial information is given to the resident and transition is desired.

The TC is responsible to initiate contact with the NF Social Services representative and to conduct a face-to-face interview with the potential participant, family/legal decision maker and the NF Social Services representative to determine the individual's desire to participate in the MFP Grant services. The TC will enlist the nursing facility discharge planning team, appropriate health care professionals, and consumer-identified informal supports to gain additional information to support the viability of a transition to the community.

The TC will be responsible to address the concerns/questions that may be identified by the consumer, a family member/legal guardian, or NF staff member related to the MFP participant's interest in transitioning to the community.

If a nursing facility resident has a developmental disability and is in need of assistance with a transition to the community, a referral will be initiated to the regional human service center for Developmental Disabilities (DD) Program Management services. The

TC will work with the DD Program Manager to determine the most appropriate transition assistance delivery system to be employed.

After implementation individuals who are admitted to nursing facilities will be recruited for the MFP demonstration project through a variety of agency groups including:

- Nursing Facility Social Services staff,
- Long Term Care Ombudsman Program staff,
- ND Protection and Advocacy Project Representatives,
- County Social Services Staff and,
- Center for Independent Living Center Transition Coordinators.
- Local Contact Agencies (LCAs)

The Nursing Facility Social Services staff, Center for Independent Living Transition Coordinators, Long Term Care Ombudsman, ND Protection and Advocacy staff, County Social Services staff and Local Contact Agencies will be provided with MFP specific training related to eligibility, demonstration and supplemental services, consent, rights, and processes by the MFP Program Administrator. (Attachment B.1-E (MFP Power Point and Person Centered Training Information) A Referral Packet Information List and Process Directions (B.1-F) will be prepared for use by Transition Coordinators and NF Social Services staff when meeting with potential MFP demonstration participants to review service options for transition to the community and to assure that all necessary consent and rights information is reviewed and needed documents are signed. This packet will include the following documents: B.2-A Informed Consent Document; B.1 Money Follows the Person Brochure and Rights Document B.2-C Guardianship Expectation Document; B.1-B MFP Role Matrix ; B.1-C MFP Fact Sheet; B.5-A Transition Assistance Request Form, and an Assistive Technology Assessment form from the IPAT agency.

1) Local Contact Agency Overview

The ND Department of Human Services (DHS), which includes the State Unit on Aging, the State Medicaid agency, and home and community-based long term care services was awarded \$398,692 for a two-year period ending September 30, 2012 to enhance the provision of long term care options counseling for older adults and adults with physical disabilities and their families through the Aging and Disability Resource Center (Resource Link) and Money Follows the Person (MFP) projects. This effort now continues under the MFP Grant through MFP Administrative funding. It will transition to state general funds on 1/1/2015 The options counseling staff focuses on preventing pre-mature admissions to institutions and helping nursing facility residents understand their options if they desire to move to a community setting.

Options counseling services are currently available statewide in ND. Our goals are to build capacity in providing options counseling, and to strengthen coordination between

the eight regional Local Contact Agencies (LCAs) and the MFP project by increasing education and training efforts. Objectives include:

- A) The deployment of eight LCA options counseling agencies to increase opportunities for person-centered planning with residents who are interested in transitioning from skilled facilities;
- B) Providing training and education on service and support options for nursing facility staff and the public; and
- C) Increasing resident transitions to of the facility residents referred to the LCAs.

2) Current Status of MFP- Resource Link-Partnership

ND was awarded a three-year grant in October 2009 to develop a pilot Resource Link in one region of the state. Legislators authorized DHS to accept the federal grant in December 2009. The state's first Resource Link was implemented in Bismarck and Burleigh County (Pop 69,416). It was expanded to serve three additional counties in year two and the remaining six counties in Region VII in year three. The Resource Link serves older individuals and adults with physical disabilities.

The Resource Link pilot was co-located and integrated into the Older Adults Services Unit (Aging Unit) at the department's West Central Human Service Center (West Central HSC). This unit is a part of ND's designation as a Single Planning and Service Area and serves the 10-county central region. The Resource Link is now available statewide in each region of the state.

Coordination with MFP: DHS administers the MFP grant through its Medicaid Division, which also administers home and community-based long term care services. The MFP program administrator is the lead person for MDS 3.0 Section Q. The Aging Services Division supervises the Options Counseling agencies and is a member of the MDS 3.0 Section Q workgroup. The MFP program has contracted with the CILs to provide transition assistance to nursing facility residents.

CIL transition coordinators meet with facility residents to assure eligibility and secure consent to participate in MFP services. An assessment is completed to identify community support needs followed by collaborative person-centered transition planning with the resident, their family, nursing facility staff, and community support agency personnel. A transition occurs when all identified needs, risks, and backup planning is complete.

3) Goals, Objectives and Outcomes

ND has two primary goals to 1) enhance ND's capacity to provide options counseling to support transitions from institutions and to prevent premature institutionalization, and to

2) strengthen coordination between the Resource Link, Options Counselors/LCAs and MFP project. MFP transition project objectives now include:

1) Continuation of one contracted LCA options counselor positions to increase opportunities for person-centered planning with residents who are interested in transitioning from skilled facilities; 2) provide training and education on service and support options for nursing facility staff and the public; and 3) increase community placements of the facility residents referred to the LCAs.

ND's MFP project focuses on increasing available home and community-based service options and helping people transition from institutions to the community. ND's MFP currently contracts with the four CILs to provide transition coordination services. Due to resource limits, they use existing staff who have other duties. They are based in Bismarck, Cavalier, Devils Lake, Dickinson, Fargo, Grand Forks, Jamestown, and Minot. No coordinators provide full-time transition assistance.

There is a lack of awareness of long term care options. The general public lacks awareness of service and support options available in the community to address long term needs. Available resources vary across communities, and this may also present barriers to some residents who want to return or remain in their preferred community. This will be addressed by close collaboration between nursing facilities, the Resource Link, LCAs, and MFP transition coordination services to evaluate individual's needs, finances and available community transition support resources.

Our initiative continues to develop and implement professional training through the Resource Link to new LCA/Options Counseling Agencies options counselors, long term care ombudsman program staff, and MFP partners so they have a shared understanding of person-centered planning, options counseling, and their respective roles and coordination in supporting MFP transition work. They will be involved in awareness building activities. To support that, ND will create educational tools including manuals, fact sheets, posters, multi-media, brochures, and public presentations.

4) Nursing Home Transition and Diversion Program

This program will serve older adults and adults with physical disabilities who reside in institutions and desire to move to a community setting and their families. As the program matures, ND will begin diversion activities by partnering with health systems and other providers to help people remain in the community and delay or prevent institutional placement.

ND desires to create infrastructure to support the LCA functions and MFP implementation.

Options counseling services have expanded statewide as of January 1, 2013.

Formal and Informal Referral Process:

The goal of the North Dakota MDS 3.0 Section Q referral process is to initiate and maintain collaboration between the nursing facility and the local contact agency and/or a

transition agency to support the resident's expressed interest in being transitioned to community living.

The LCA educational brochure titled "Your Right to get Information about Returning to the Community" will be distributed and utilized by North Dakota Nursing Facilities and Local Contact Agency staff to educate individuals about available community services and supports. See Appendix B.1.I.

Nursing Facility Role

Referral to Local Contact Agency

- **Q0500**-When a resident (or family or significant other or guardian/legally authorized representative, if the resident is unable to respond) answers yes to the question; "Do you want to talk to someone about the possibility of returning to the community?" a Local Contact Agency (LCA) Referral Form will be completed and faxed or mailed to the designated contact agency within 10 business days of the completion date of the MDS. This will typically be completed by the facility social services staff or other designated discharge planner. See Appendix B.1.G
- **Q0600**- A Local Contact Agency (LCA) Referral Form will be completed and sent to the designated contact agency within 10 business days when the assessment process identifies a resident's desire to speak with someone about returning to community living. See Appendix B.1.G (LCA referral)

Release of Information:

Nursing facilities will manage the release of information to the Local Contact Agency per their facility HIPPA Policy and Procedure.

Care Planning

- Follow-up care planning will need to be initiated by the interdisciplinary care team to assess the resident's preferences and needs for possible transition to the community. Facilities are encouraged to utilize the "Discharge Plan of Care" developed by the MDS 3.0 Section Q Planning Committee to assure that all minimum planning requirements are addressed by the Care Team. See Appendix B.1.H (Service Activity Visit Summary)
- The Local Contact Agency will be responsible to respond to all LCA referrals received from the nursing facility within 3 business days by phone and will complete an in person visit within 15 business days.

- If the Local Contact Agency does not contact the facility discharge planner by telephone or in person within 3 business days, the nursing facility is encouraged to make a follow-up call to the designated Local Contact Agency.

Local Contact Agency

- Once a Local Contact Agency Referral Form has been received, the LCA staff member will follow-up within 3 business days with a phone call to the designated discharge planner to review the referral. This may include establishing an in person visit date.
- Within 15 business days the LCA will meet in person with the resident and anyone else that the resident would like to have present. The purpose of this meeting is to gather information about the goals of the resident, identification of their support needs, and to provide information about community living options that may or may not be available in the community.
- The LCA will prepare and present an LCA Service Activity Summary in cooperation with the individual nursing facility resident. The LCA Service Visit Activity Summary will outline the community living options, the long-term care supports and services that may or may not be available in the community, and will identify agencies available to assist with transition if the resident's support needs can be met in the community. This information will include contact information. The LCA will provide a copy of the completed LCA Referral Document to the resident and facility discharge planner at the time of the in person visit. See Appendix B.1.G and Appendix B.1.H

A final copy of the LCA Service Visit Activity Summary will be provided to the discharge planner within 3 business days. The Discharge Planner will provide a copy to the resident upon receipt. The LCA will also provide a copy of the Summary to the MFP Program Administrator for all MFP eligible residents. See Appendix B.1.H.

Transition Agency and/or Nursing Facility Discharge Responsibilities:

- The nursing facility, the LCA and/or a transition agency including MFP transition coordination services will jointly explore community care options/supports and conduct appropriate care planning to determine if transition back to the community is possible.
- If the resident wishes to move forward with discharge/transition, the facility interdisciplinary care team will assist with the discharge care planning process which will be reflected on the nursing facility Discharge Plan of Care. This

assistance could include a referral to MFP or one of the other agencies available to assist with the resident's transition planning needs.

- If the resident wishes, the facility social services staff member/discharge planner will assist the resident with referral to a transition agency/MFP to work toward the resident's goal of returning to the community.
- The nursing facility and the transition agency/MFP will work collaboratively to support the resident's expressed interest in being transitioned to community living.
- The resident, interdisciplinary team and the transition agency (when a referral has been made to a transition agency /MFP) will determine the services and assistance that the resident will need post discharge (e.g., homemaker, meal preparation, ADL assistance, transportation, prescription assistance, etc.) and make appropriate referrals.

A MFP participant who is re-institutionalized for a period of time greater than 30 days is deemed disenrolled from the MFP program. However, a disenrolled individual may re-enroll in the program without re-establishing the 3-month institutional residency requirement.

A former participant may re-enroll in the MFP program after first undergoing re-evaluation (Attachment B.8-A Transition Assessment) by their Transition Coordinator/discharge planning team and after development of a current Independent Living Plan (ILP). (Attachments B.8-B Independent Living Plan which includes Risk Mitigation Plan/24 hour Backup; B.8-H Risk Assessment and Mitigation Policy and NF plan form; B.8- I 24-backup Planning Policy and Back-up Plan).

Once the individual is found appropriate for waiver or other community support services, the consumer and planning team will develop and/or update their Independent Living Plan so that it addresses the change in the status of the MFP participant and any necessary support service needs in the community. This planning process will involve the review and update of the risk mitigation and 24 hour backup plans to assure that they continue to address the participant's current need for support. As long as a former MFP participant meets Medicaid waiver eligibility criteria, the participant continues to be eligible for MFP services at the enhanced Federal Medical Assistance Percentage (FMAP) match.

See Attachments:

B.1-A MFP Referral; B.1-B MFP Role Matrix; B.1-C MFP Fact Sheet; B.1-D MFP Brochure and Rights Document; B.1-E: Education PowerPoint/Person Centered Planning Information; B.1.F: Referral Packet Information B.2-A Informed Consent Document; B.2-C Guardianship Expectation Document; B.8-A Transition

Assessment; B.8-B Independent Living Plan which includes Risk Mitigation Plan/24 hour Backup; B.8-H Risk Assessment and Mitigation Policy and NF plan form; B.8- I 24-backup Planning Policy and Back-up Plan

North Dakota Life Skills and Transition Center and Community Intermediate Care Facilities for Persons with Intellectual Disabilities:

The MFP Demonstration will specifically target persons for transition that reside at the ND Life Skills and Transition Center or a community ICF/ID, have a diagnosis of a intellectual disability and desire to return to the community. In addition these persons will need to have been residing in an institutional setting for at least three months, meet ICFID level of care requirements, and have been determined to be Medicaid eligible for at least one day immediately prior to transition. MFP participants will be involved with MFP demonstration services in the community. These will be the same services the participant would normally have received through one of the developmental disabilities waived services.

ICF/ID Level of Care (LOC) requirements are as follows:

The Progress Assessment Review (PAR) (Attachment B.8-D) is the comprehensive assessment used to evaluate an individual's support and service needs. There are two PAR formats: one for children birth to three and one for individuals three and older. The PAR is also the evaluation used to determine whether an individual meets the basic requirements for ICF/ID level of care.

The Progress Assessment Review (PAR) is an individual assessment that describes the level of supports needed by an individual 3 years of age and older in the following areas: residential, day services, motor skills, independent living, social, cognitive, communications, adaptive skills, behavior, medical, psychiatric and legal. The PAR also includes a section that lists the individual's diagnoses on Axis I regarding chronic or recurrent clinical disorders, Axis II regarding chronic or recurrent personality disorder or mental retardation and Axis III regarding chronic or recurrent medical conditions from the DSM IV. The DD Program Manager completes the PAR with input from the consumer and/or family and provider support staff.

The D.D. Program Manager completes the PAR either at the time of intake or shortly thereafter, prior to the eligibility determination for developmental disabilities Program management services. Certain areas derived from the PAR will provide the MFP Regional Eligibility Team with information regarding limitations in the seven major life activities during the process of the eligibility determination.

- Self care
- Learning

- Receptive and Expressive Language
- Mobility
- Self Direction
- Capacity for Independent Living
- Economic Self Sufficiency

The Child PAR (for children birth to three years of age) addresses: Engagement/Persistence, Reasoning/Problem Solving, Listening/Understanding, Speaking/Communicating, Phonological Awareness, Print Awareness, Fine Motor, Gross Motor, Hygiene/Nutrition, Cooperation/Self Control, Social Relationships, Arts/Movement/Music, numbers/Operations, Patterns/Measurement, Matter/ Force/Energy, and Family Roles/Relationships.

Once the PAR is completed, an indicator is derived from the scores in the assessment that determines whether an individual meets the basic criteria for the ICF/ID level of care. The indicator is referred to as the “HCBS indicator”. If the HCBS is “Y” (Yes), the individual meets the basic criteria; “N” (No), the basic criteria is not met and the individual cannot be screened; “P” (Professional Judgment), the case manager must apply the criterion outlined in State policy DDD-PI-090 to determine if the individual can be screened.

If the individual is eligible for DD Program Management Services, the Program Manager will assist the individual and/or their legal decision-maker to identify desired outcomes and the services that can assist them in achieving the outcomes. If the individual chooses to receive a waiver service within the next 30 days, and meets the ICF/ID level of care, the Program Manager will complete the ICF/ID level of Care screening document.

The **Case Action Form** documents an individual’s need for an ICF/ID level of care. The information contained in the Case Action Form is entered into the MMIS (Medicaid Management Information System) payment system. The Case Action form, in conjunction with the Individual Service Plan, authorizes reimbursement for Title XIX Medicaid funds for ICF/ID and DD Waiver Home and Community Based waiver services.

The Progress Assessment Review (PAR) and ICF/ID level of care screening (Case Action Form) must be updated at least annually. System generated alerts within (Therap) inform the case manager of when the annual PAR and LOC are due. The individual’s screening status/LOC should also be reviewed, and updated if necessary; each time an individual starts or terminates a DD service to ensure the screening status LOC is correct. If the Case Action Form is not current and accurate, the Medicaid payment is suspended.

Review of ICF/ID Level of Care Decisions

The PAR (which is the assessment for Level of Care) is completed annually. Based on a formula the results indicate screening categories. A sample of all PARs and ICF/ID level of care screenings are reviewed and compared during the human service center licensure process. If errors are discovered the regional human service center must develop a plan of correction and a follow up sample will be examined.

If an individual was incorrectly screened, the program manager will work with the individual to find alternative funding sources to meet their support needs

North Dakota Life Skills and Transition Center and Community Based Intermediate Care Facilities for Individuals with an Intellectual Disability Transition Recruitment and Enrollment Process:

All persons who are eligible for home and community based services and reside at the ND Life Skills and Transition Center (NDLSTC) or who reside in a community based ICF/ID in ND and meets MFP eligibility requirements will be eligible to participate in the ND MFP demonstration. This includes persons eligible for the ID/DD Waiver, Developmental Disabilities Self Directed Supports Waiver and the Medically Fragile Children Waiver.

The waivers require that the participant meet ICF/ID level of care requirements as well as waiver specific functional eligibility requirements. Once it is determined that an individual meets MFP specific criteria an assessment is completed by the DD Program Manager to determine waiver specific eligibility based on the individual service needs of the participant. (Attachment B.8-D Developmental Disabilities Progress Assessment Review (PAR))

The ND MFP demonstration will be implemented statewide for this population group as the community service delivery infrastructure is generally well established.

North Dakota has developed a discharge-planning model to identify eligible consumers at the state operated institution (North Dakota Life Skills and Transition Center – a.k.a. NDLSTC) for persons with developmental disabilities. The discharge-planning model, named the Residential Decision Profile (RDP) (Attachment B.8-E), is based upon principles from the U. S. Supreme Court Olmstead Decision. In general, no person is under commitment to the Life Skills and Transition Center, as residence is a voluntary decision of the person and/or legal decision-maker (such as guardian, which includes annual judicial oversight). The preferences of the person and recommendations of state professionals (Developmental Disabilities Program Manager (DDPM) and NDLSTC Staff) are measured by the RDP with discharge planning emphasized for those with most agreement. Although the preferences are updated every year, each person is assured the RDP can be modified at any time during the year if there is a change.

For Medicaid eligible individuals, residing in Life Skills and Transition Center ICF/IDs, the service and community preferences of the person, and/or their authorized

representative, DDPM and NDDC Staff help guide the priority for discharge planning from the Life Skills and Transition Center (DC) and are recorded in the Residential Decision Profile as:

A) The Individual:

- 1) The RDP is finalized he/she clearly wants to leave NDLSTC
- 2) Generally appears to want to leave NDLSTC, but the decision may not be firm because it varies, is not completely clear, or there are some reservations
- 3) Unclear which way the person prefers
- 4) Generally appears to want to stay at NDLSTC but the decision may not be firm because it varies, is not completely clear, or there are some reservations
- 5) Clearly wants to stay at NDLSTC

B) Guardian, Court, or other legal decision-making authority

- 1) Clearly wants the individual to leave NDLSTC
- 2) Generally wants the individual to leave NDLSTC, but the decision may not be firm because it varies, is not completely clear, or there are reservations
- 3) Unclear which way the legal decision-maker prefers, or NOT Applicable
- 4) Generally wants the individual to stay at NDLSTC, but the decision may not be firm because it varies, is not completely clear, or there are reservations
- 5) Clearly wants the individual to stay at NDLSTC

C) NDLSTC Staff (note: SP Team NDLSTC staff perspective) on services unique to NDLSTC

- 1) Clearly believes the individual does NOT need NDLSTC services
- 2) Generally appears NOT to need NDLSTC services, but the decision may not be firm because it varies or there are some reservations
- 3) Unclear to the NDLSTC staff
- 4) Generally appears to NEED NDLSTC services, but the decision may not be firm because it varies or there are some reservations
- 5) Clearly NEEDS the NDLSTC services

D) DD Regional Program Administrator/Program Management perspective on services known to be available in the region or elsewhere in the state (not based upon openings):

- 1) Clearly able to meet individual's needs
- 2) Generally appears that the services are able to meet individual's needs, but the decision may not be firm because it varies or there are some reservations
- 3) Unclear to regional staff as to the availability of such services

- 4) Generally appears that the services are NOT able to meet individual's needs, but the decision may not be firm because it varies or there are some reservations
- 5) Clearly unable to meet the individual's need

The statements listed above are selected by each party before or during the Support Plan meeting, or on their behalf by the team based upon the best understanding the team has of each person (group) perspective. The decision reflects the current opinion, based upon the most current information available to them, and relate to the person now and in the foreseeable future. Each perspective may only choose from the answers available, and may only choose one – however, each person (group) may add to the comments.

From a “scoring” perspective, the number of each selected answer is the “weight” given that answer and a total score may be calculated for the individual. To provide agency planning, the scores would range from 4 (all 1’s) (clearly awaiting a place to move to) to 20 (all 5’s) (clearly exceeding the services of the region and state providers to meet the individual’s needs) and anywhere in between. This provides a ranking of people planning to leave NDDC for private provider opportunities in the communities of choice. This process also highlights areas of disagreement, confusion, and focus planning.

A RDP total score of 12 or less has sufficient agreement that formal discharge planning will be initiated by the NDDC Support Team. At that time consumers and/or their legal decision maker will be made aware of the MFP demonstration services available and will be provided with the opportunity to make an informed decision about participation in the demonstration. The ND Life Skills and Transition Center Social Worker and/or Program Coordinator will be responsible for reviewing the MFP informed consent document (Attachment B.2-A), MFP Brochure, (Attachment B.1-D), Role Matrix (Attachment B.1-B), the MFP Fact Sheet (Attachment B.1-C) documents with the consumer and/or their legal decision maker at that time.

The ND Life Skills and Transition Center Social Worker and Program Coordination staff will be provided with MFP specific training related to eligibility, services, consent, rights, and processes (Attachment B.1-E) by the MFP Program Administrator. An information packet will be prepared for use by each Support Team Program Coordinator/social worker when offering MFP demonstration services for transition to the community to assure that all necessary consent and rights information is reviewed and needed documents are signed (Attachment B.1-F).

For individuals residing in small, community-based intermediate care facilities for the mentally retarded, North Dakota utilizes a referral process whereby consumers and families, working with their DD Program Manager, have an opportunity to make informed decisions regarding the provision of services and supports, choice of service providers, and choice of intermediate care facility for individuals with an intellectual disability (ICF/ID) or home and community-based (HCBS) waiver services. This may include providing the consumer and/or family with questions they may wish to ask

potential providers, and furnish provider/agency brochures describing available services and supports. The DD Program Manager will offer to arrange tours and visits to provider agencies and will accompany the consumer and family on these visits. It may also involve formal referral or case management networking to link consumers with community resources that are not providers of traditional DD services. This process is also utilized with individuals residing at the Life Skills and Transition Center that are considering community placement.

North Dakota will use existing information technology systems to identify MFP participant demographic, financial and case plan information. This information includes Medical Assistance Eligibility, Level of Care determination, and length of time in each level of service including at the ICF/ID level of care. The existing technology system, Therap addresses supports coordinated through developmental disabilities program management. The objective of Therap is to be a consumer driven, outcome oriented, accountable, and integrated business solution.

Through Therap's case management processes, case plans are developed and managed that stress outcomes, goals, and objectives to meet consumer and family needs to work toward providing the most efficient and effective developmental disability services for North Dakota citizens.

Individual ICF/ID planning teams, including the DDPM will review the service needs of all consumers during their annual or other planning meetings based on the community provider specific assessments completed in preparation for those meetings. If the consumer and/or their legal decision maker, the DDPM, and the community provider recommend transition to an alternative setting in the community the consumer will be informed of alternatives available under the demonstration grant and that the individual is given choices of services and community residences which must be agreed to by the individual in the individual's transition plan which identifies the demonstration services to be furnished, the individual's choice of providers, informal supports, and residence. If the consumer wishes to participate in the MFP demonstration the DDPM will specifically review and have the consumer/legal decision maker sign the MFP consent document (Attachment B.2-A) and will provide and explain the MFP Brochure (Attachment B.1-D) and the MFP rights documents(Attachment B.2-B), Role Matrix (Attachment B.1-B) MFP Fact Sheet (B.1-C), Guardianship Expectations (Attachment B.2-C), and assist in the development of the transition plan(Attachments B.8-H Risk Assessment and Mitigation Policy and DD plan form; B.8-I 24-hour Backup Planning Policy and Back-up Plan)

The North Dakota Life Skills and Transition Center Staff, DD Program Managers, and community provider program coordination staff will be provided with MFP specific training related to eligibility, services, consent, rights, and processes by the MFP Program Administrator. (Attachment B.1-E) An information packet (Attachment B.1-F) will be prepared for use by DD Program Manager when meeting with potential MFP

demonstration participants to review service options for transition to the community and to assure that all necessary consent and rights information is reviewed and needed documents are signed.

An MFP participant who is re-institutionalized for a period of time greater than 30 days is deemed disenrolled from the MFP program. However, a disenrolled individual may re-enroll in the program without re-establishing the 3-month institutional residency requirement.

A former participant may re-enroll in the MFP program after first undergoing re-evaluation by their support/planning team and after development of a new and current Transition/Individual Service Plan (ISP) (Attachment B.8- C. Once the individual is found appropriate for waiver services, the planning team and DD Program Manager will develop a transition plan (Attachments B.8-H Risk Assessment and Mitigation Policy and DD plan form; B.8- I 24-Backup Planning Policy and Back-up Plan and ISP that addresses the change in the status of the MFP participant and necessary supports in the community. This planning process will involve the review and update of the risk mitigation and 24 hour backup plans to assure that they continue to address the participant's current need for support. As long as a former MFP participant meets Medicaid waiver eligibility criteria, the participant continues to be eligible for MFP services at the enhanced Federal Medical Assistance Percentage (FMAP) match.

See Attachments:

B.1-B MFP Role Matrix; B.1-C MFP Fact Sheet; B.1-D MFP Brochure and Rights Document ; B.2-A Informed Consent Document;; B.2-C Guardianship Expectation Document; B.8- C Developmental Disabilities Individual Service Plan; B.8-D Developmental Disabilities Progress Assessment Review (PAR); B.8-E Resident Decision Profile; B.8-H Risk Assessment and Mitigation Policy and NF and DD form; B.8- I 24-Backup Planning Policy and Back-up Plan; B.1-E Education PowerPoint and B.1-F Referral Packet Information List

Re-enrolling into ND MFP Program

Participants who have not completed 365 days in the MFP Program

When an MFP demonstration participant is readmitted into an inpatient facility for a period of time less than 30 days, the participant remains enrolled in the program.

When an MFP demonstration participant is readmitted into an inpatient facility for a period of time greater than 30 days, the participant will be considered as disenrolled from the MFP demonstration program. However a former MFP participant that was disenrolled prior to the completion of 365 days in the demonstration may re-enroll back into the MFP demonstration without re-establishing the 90 day institutional residency requirement. That participant is eligible to continue to receive MFP services for any

remaining days up to the maximum 365 days of demonstration participation. Enhanced FMAP will be claimed for MFP services during that period.

Participants who have completed 365 days in the MFP Program

ND will allow individuals who have been re-institutionalized after completing their initial 365 days of participation to enroll for a second time in ND MFP Grant Services if they are “qualified individuals” who have been in a “qualified institution” for at least 90 consecutive days less any short term rehabilitative days as per the MFP Policy guidance on “Qualified Individual” dated 5-17-10. The qualified participant must transition into MFP “qualified housing.”

When a former MFP participant requests to be re-enrolled into ND MFP Grant Services, the Transition Coordination Agency will re-evaluate the former MFP participant’s post MFP Program Plan of Care to determine causes for re-institutionalization.

The re-evaluation process will include the following:

1. The Transition Coordination Agency will complete the ND MFP Re-enrollment Evaluation to determine the basis for re-institutionalization and submit to the ND MFP Project Director for Review.

The Re-enrollment Evaluation will determine if the Plan of Care could not be carried out as a result of:

- (a) Medical and/or behavioral changes resulting in the necessity of readmission into the inpatient facility.
 - (b) The lack of community services that adequately supported the participant that were originally identified in the original plan of care.
 - (c) The plan of care was not supported by the delivery of quality services.
 - (d) Changes that will be necessary to Plan of Care taking into consideration the causes of re- institutionalization.
2. The MFP Program Administrator will review the Re-enrollment Evaluation including recommendations for Plan of Care changes made by the Transition Coordination for the purpose of approving re-enrollment into MFP Grant Services.
 3. The MFP Program Administrator will provide written notification of the final decision on re-enrollment to the Transition Coordination Agency after which time the normal transition process will be followed. If re-enrollment is not approved the individual may appeal a denial per the MFP appeals process.

Attachment B.1 Out of State Transition Request

Consumers that wish to participate in the ND MFP Grant for purposes of transitioning to another state will need to meet the standard MFP eligibility requirements for enrollment and for transition to community services including the following:

MFP Eligibility Requirement at time of enrollment:

1. 90 days institutional residence
2. Medicaid Payment for services for at least the last day of services
3. Meets Institutional LOC at enrollment

Transitions/Discharge Out of State:

1. Moves to MFP qualified housing environment (Non-institutional Setting)
2. Community Based Services arranged to meet needs post transition
3. Post discharge case management
4. Post discharge plan in place that includes backup planning in new location

Transition Coordination Services will be provided by either the DD Program Manager or the Center for Independent Living Center Transition Coordination staff. MFP Program Administrator will facilitate transition with other state MFP projects.

Tribal Initiative

Money Follows the Person Tribal Initiative

North Dakota State University (NDSU) will work in collaboration with the Department of Human Services (DHS) and North Dakota's eligible tribes and tribal organizations (T/TO) partners to promote tribal leadership in 1) the design of an effective and culturally sensitive package of Medicaid community-based long term services and supports (LTSS), 2) the operation of delegated administrative responsibilities on behalf of state Medicaid agencies, 3) the elimination of barriers that prevent the use of Medicaid funds to support tribal members with LTSS needs, and 4) strengthening the ability of state Medicaid programs to respond to the unique needs of tribal communities.

The Money Follows the Person Tribal Initiative (MFP-TI) has four distinct phases as follows:

Phase 1: Concept Paper

Phase 2: Operational Protocol: Detailed Timeline and Activities

Phase 3: Execution of Operational Protocol and Program Submittal

Phase 4: Program Implementation

NDSU will facilitate the involvement and the development of the MFP-TI deliverables with the participating tribes for each of the four phases of the MFP-TI. The required

deliverables for each Phase must be submitted to and approved by the CMS Project Officer before a DHS and NDSU may advance to work on a subsequent phase of the MFP TI project.

NDSU will assist the ND DHS with the preparation and submission of reports on the MFP TI deliverables that contain sufficient information so the CMS Project Officer, other federal officials, and external stakeholders may use the reports to clearly understand the phases of the state's program implementation.

NDSU will follow the required MFP Tribal Initiative Program Terms & Conditions as noted in the Program Announcement or RFA/RFP. These terms and conditions apply to states that have been approved for Money Follows the Person Tribal Initiative (MFP TI). They serve as an addendum to the terms and conditions already in place as part of the state's existing MFP grant award.

Following are the deliverables for the MFP-TI:

Phase One: Concept Paper - \$285,567 of which \$279,167 is obligated to NDSU

Phase One of the grant activity is considered complete when the state and T/TO receive approval from CMS on 1) a partnership/collaboration agreement between the state and tribe(s), 2) a summary of participating tribal population details, including a needs assessment, and 3) a proposal and budget for Phase Two.

Activities the state will take in developing the state-tribal partnership/collaboration agreement:

ND will use MFP TI administrative resources to assist T/TOs to transition tribal members with disabling and chronic conditions out of institutions or inpatient facilities and into a program of community-based LTSS tailored to meet the needs of American Indians (AIs) in a culturally appropriate manner. Additional MFP resources will also be used to increase the availability of LTSS in T/TOs, to expand the tribal role in state Medicaid programs, and to improve community integration of AIs in need of LTSS.

NDSU's American Indian Master of Public Health (NDSU AI MPH) team will coordinate outreach, engagement, tribal needs-assessment, and development activities using existing communications mechanisms and direct tribal community engagement. This will include locating one full-time staff member with each T/TO to locally coordinate communication and needs assessment.

The outcome of Phase One will be a Concept Paper that will consist of three major components: 1) Partnership/collaboration commitment, 2) Relevant tribal population characteristics, and 3) a signed commitment agreement between the state and Tribes. The Community Transformation Grant (CTG) funded by CDC will produce a Statewide Health Needs Assessment (HNA). The NDSU AI MPH Team is currently working with DOH on the Tribal component of CTG and the HNA. Year 2 of 5 has been completed for CTG, and the HNA is already under development. These outcomes will help to inform the work of the MFP TI.

PHASE TWO: Operational Protocol: Detailed Timeline and Activities \$100,000 to \$300,000

Phase Two of the grant activity is considered complete when the state and T/TO receive approval from CMS for 1) a detailed operational protocol, timeline, and budget that includes processes and activities related to the goals and parameters of the desired program, 2) details related to respective roles, 3) the development of tribal administrative structures to address delegated functions, and 4) mechanisms to assure and oversee quality.

PHASE THREE: Execution of Operational Protocol and Program Submittal \$400,000 to \$1,000,000

Phase Three is considered complete when the state and T/TOs have 1) implemented partnership agreements, 2) engaged in necessary program development activities, 3) created, as needed, tribal administrative structures to implement delegated functions on behalf of the State Medicaid Agency, 4) developed a proposal including a rate structure, for community based LTSS tailored to the needs of AI and consistent with the terms of the CMS-IHS MOU relative to federal match rate 1 and 5) submitted and received approval for a program proposal for community based LTSS under a Medicaid authority.

PHASE FOUR: Program Implementation \$ 250,000 to \$600,000

In this phase, MFP resources may be used for the following:

- Administrative costs: Continued administrative functions related to transition, operations, and development of a sustainability plan, and
- Service costs: States may accept an MFP enhanced federal match rate for transitioned individuals for the first 365 days. Additionally, the qualified residence requirement applies to any services for which the enhanced federal match is claimed.

Phase Four activities are considered complete upon the implementation of a sustainable

Medicaid community based LTSS program authority serving as an alternative to institutional care for tribal members, the transition of AI from institutions, the associated activities that support AI to move from institutions to their communities, and the termination of the MFP grant.

Medicaid services delivered by tribal programs are eligible for 100 percent federal match if:

- 1) The services are provided by a tribal facility, tribal facility employees, or contractual agency of the tribal facility, even if not on the premises of the facility,
- 2) The service is considered a “facility service,” - that is, one within the proper scope of services which can be claimed by that facility under IHS authorities; and
- 3) The service is claimed by the IHS facility as a service of that facility - that is, included in the funding agreement with the IHS under the Indian Self-Determination and Education Assistance Act, P.L.93-638.

The amount of award is \$285,567 and the project period and budget are 05/01/2007 to 03/31/2016.

- This award is authorized by Title VI, Chapter 6, Subchapter B Section 6071 of the Deficit Reduction Act of 2005 as amended by Section 2403 of the Affordable Care Act of 2010.
- This award is also subject to the HHS Grants Policy Statements (HHS GPS). Any applicable statutory or regulatory requirements, including 45 CFR Part 74 or 92, directly apply to this award apart from any coverage in the HHS GPS.

NDSU will assist DHS is fulfilling its MFP-TI reporting obligations. This grant is subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (P.L. 109-282), as amended by Section 6202 of P.L. 110-252 and implemented by 2 CFR Part 170.

- NDSU will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflicts of interest or personal gain.
- All Travel by NDSU staff must be documented with the following information: Traveler, destination and starting point, purpose of travel (why it is necessary for implementation of the award), date of travel, total mileage, flight costs, lodging and per diem. Documentation must be submitted the DHS for submission to Grants Management specialist and Program Officer with Financial Status Reports.

B.2 Informed Consent and Guardianship

Procedures for Providing Informed Consent

As a first step in ensuring that participants have informed consent, participants and/or their legal representatives will be provided with ample information concerning the MFP project and ongoing opportunity for questions. North Dakota will require that all individuals participating in the MFP Demonstration or their Legally Authorized Representative (LAR) -- i.e., parent, guardian, or managing conservator of a minor individual, or a guardian of an adult -- be informed of all their rights (Appendix B.2-B) and options for long-term services and supports and that participation is voluntary. This includes acceptance of services and the consent to participate in the evaluation component of the grant. The Informed Consent Form (Appendix B.2-A) will be signed only by the individual being transitioned or those who have legal authorization to act in the individual's behalf.

The Transition Coordinator or DD Program Manager will determine if the participant has a guardian or an active Durable Power of Attorney (DPOA). The Coordinator or Program Manager will obtain a copy of the legal document(s), review it/them and have an understanding of the extent of the surrogate decision-making power that exists. This

information will be garnered from a review of the facility records once consumer consent is obtained. For participants with a guardian or other legal representative, both the participant and the legal guardian will be involved in providing information and in the transition planning process.

Transition Coordination, Developmental Disabilities Program Management, or the -Life Skills and Transition Center Social Work staff will secure the appropriate signatures on the Informed Consent form (Appendix B.2-A) which indicates that the participant has been informed and is voluntarily choosing to participate in the MFP Demonstration without coercion.

Awareness of Transition Process/Knowledge of the Services and Supports

Section B.1 Participant Recruitment and Enrollment of the MFP Operational Protocol identifies the transition process and information provided to the consumer and/or their Legally Authorized Representative for nursing facility and ICFs/ ID and Life Skills and Transition Center transitions.

Consumers will be identified for grant participation in several ways including but not limited to MDS assessments, nursing facility referral, referral from an advocacy representative, family referral, community provider referral, case manager referral, and self-referral. In most cases, the initial contact for a nursing facility transition will be through the Transition Coordinator and the nursing facility social worker who will provide information on the transition process. The Transition Coordinator would then conduct an assessment of the individual's transition needs and work with the nursing facility discharge team to assist with transition.

Individuals living in an ICF/ID facility or at the -Life Skills and Transition Center are not likely to identify themselves for grant participation due to the nature of their disability. Life Skills and Transition Center staff or DD Program Management staff will be the most likely to make the initial referral for services. At the Life Skills and Transition Center the individual support plan team using the Residential Decision Making Process (RDMP) and RDP (Attachment B.8-E Resident Decision Profile) is the typical first step in assessing the desire to move into a community setting and the increasing awareness of the transition process. At a community ICF/ID the DD Program Manager and the consumers planning team will communicate MFP information when community transitioning is being planned. It is during this process that the individual's desires and choices for their preferred living arrangement are determined and information is gathered to effect a successful transition. The Life Skills and Transition Center Social Worker and/or the DD Program Manager in cooperation with the community provider team will further discuss the transition process, assist in locating the preferred living arrangement, and develop a transition plan that takes into consideration the individual's need and choice for services and supports.

Information about Rights and Responsibilities

Informed consent under this MFP Demonstration will include two components: 1) the acceptance of services and; 2) the consent to participate in the evaluation component of the project.

The consent for waiver services will follow current 1915(c) waiver practices (as dictated by CMS) and will be obtained during the support planning phase of the transition but prior to the delivery of home and community-based services. Risks of receiving certain services, the range of services that are available, and any restrictions on amount, duration and scope because of cost caps will be included in the informed consent process. Additional supports necessary to carry out the service plan will be fully explained to the prospective MFP Demonstration participant or representative, particularly with regard to self-directed services and supports.

The Informed Consent form (Attachment B.2-A Informed Consent Document) will include the provision that participation in the MFP Demonstration is voluntary and protects project-related information that identifies individuals. The document will state that the information is confidential and may not be disclosed directly or indirectly, except for purposes directly related with the conduct of the project. The document will also indicate that the state will obtain written consent of the individual prior to disclosure of individual level information.

Finally, the Informed Consent form advises the individual that they can withdraw from the project at any time, that the 24-hour nurse call service will only be available while they are an active MFP participant, that the MFP Demonstration services are available for one year, and that their support services will continue after the MFP Demonstration period through an existing Medicaid 1915c waiver as long as they continue to meet the eligibility requirements for the program.

Waiver Appeal Process

The waiver appeal process is outlined Section B.6 Consumer Supports:

Guardianship Alternatives

Guardianship is considered the least favorable alternative to independent decision making by a consumer. The least restrictive alternative for decision making support is most preferred. Alternatives that are most commonly considered include payee/fiduciary services to manage finances, Health Care Directives, Power of Attorney arrangements for the management of finance or property, Durable Power of Attorney arrangements to manage finances, property, or medical decisions, and/or conservatorship to manage finances. Limited guardianship is also considered more favorable than full guardianship when that is deemed appropriate by the court.

Guardian Relationships

North Dakota Century Code chapter 30.1-28 allows a court to establish a guardianship of a person lacking decision making capacity. After court order, guardianship continues until the death of the guardian or the ward, or the guardian resigns. The court may terminate the guardianship before then, and can appoint a replacement (successor) guardian. Sometimes when the ward is a spouse or child, the guardian can name a successor guardian in the guardian's will. The guardian must file an annual report with the court. The guardian is responsible for the ward's care, comfort, and maintenance, and any training, education, or habilitative services that are appropriate. The guardian must care for the ward's property. The court may give the guardian partial or complete decision making authority in the areas of residential, educational, medical, legal, vocational, and financial decision-making. No matter what powers the court grants the guardian, the guardian must maximize the ward's involvement in decision making. The guardian may only intervene in the ward's life to the extent necessary to protect the ward. If possible, the guardian should act as they believe the ward would act if the ward had full knowledge and decision-making capacity. A guardian always needs a court order for the ward's psychosurgery, abortion, sterilization, or experimental treatment. Unless the court orders otherwise, the ward retains the rights to vote, marry, divorce, apply for a driver's license, or testify in legal proceedings.

MFP Participant Welfare

A review of a MFP participant's contact with their guardian six months prior to MFP participation will be completed by the Transition Coordinator or DD Program Manager/Life Skills and Transition Center Social Worker. The nature of this contact will be reviewed based on the guardian's response to the need of the ward. Nursing facilities, community-ICF/ID facilities, and the Life Skills and Transition Center professionals all document guardian contact with potential MFP participants and have firsthand knowledge of this contact. It will be expected that guardians have demonstrated active involvement related to the health and welfare needs of the MFP participants.

North Dakota guardianship laws and guidelines do not identify a specific frequency of visits that a guardian or legal representative must abide by in order to meet the responsibilities owed to their ward. For the MFP project, however, the frequency of guardianship interaction is ensured, through the care planning requirements that are established in the HCBC waivers. The ND MR/DD Waiver requires the development of an Individual Service Plan (Plan of Care) Attachment B.8- C Developmental Disabilities One Service Plan) with the involvement of the Service Coordinator (DD Program Manager), with input from the individual, his/her guardian, family and friends. The services outlined in the Individual Service Plan are tailored specifically to the interests,

needs, and competencies of each individual. The Service Plan reflects the choices made by the individual and or guardian and becomes effective only after receiving individual or legal guardian approval. The service agreement is monitored and assessed and any change or additional service needs again require participant and legal guardian involvement and agreement.

The HCBS waiver provides similar safeguards and guidelines for ongoing participant and guardian involvement for development of Care Plans. This includes the development of a Plan of Care prior to receipt of Home and Community Based Services and ongoing review of care after transition that will involve the participant and their legal guardian.

MFP Guardianship Requirements and Interactions

If a public guardian has been appointed for a prospective MFP Demonstration participant, DD Program Manager, Life Skills and Transition Center Social Worker, or the Transition Coordinator must make contact with that guardian to explain the choices of the prospective MFP participant, key features of the MFP Demonstration program, and various long-term services and support options that are available to the individual.

Guardians of MFP participants will be provided MFP guardian expectations document (B.2-C) outlining the standards that they will be expected to follow in their interaction with the MFP participants. As a project requirement, the Transition Coordinators or DD Program Manager/Life Skills and Transition Center Social Worker will engage in a minimum of one contact with the participant and their ward prior to any transition being implemented. A contact will serve to maximize the information sharing and assessment. The Transition Coordinator or DD Program Manager will also follow up with both the participant and their legal guardian post-transition to ensure that the individual has successfully transitioned to community living. The Transition Coordinator or the DD Program Manager/Life Skills and Transition Center Social Worker will document these contacts and share information with the MFP Grant Program Administrator wherever appropriate.

See Attachments:

B.1 Money Follows the Person Brochure and Rights Document; B.2-C Guardianship Expectation Document; B.8- C Developmental Disabilities Individual Service Plan

B.3 Outreach, Marketing and Education

The primary types of media to be used for MFP outreach, marketing, and education will be brochures, electronic media, MFP Grant Program Administrator presentations, Local Contact Agency outreach efforts, newsletter communication, and other written training materials.

In order to educate and inform the public of available community services, ND MFP realizes that there needs to be an increased effort on communicating with all ND citizens in regard to the MFP transition process. A concerted marketing effort would strengthen the educational process, therefore increasing the likelihood that more transitions will occur. Some of the activities that this marketing effort have-included are creative development services (Marketing Agency), tool kit development, educational materials, development and print expenses, website development, booth materials, postage, public and media relations and promotional giveaways.

MFP Brochure

The State of North Dakota will utilize the MFP brochure as one method to market MFP Demonstration Grant Services and to provide outreach and education to prospective consumers, family members, professionals, and the general public. The MFP Stakeholder Committee has developed the MFP brochure in English and large print

versions. The MFP brochure will be available in Spanish and translated into other alternative languages as the need is identified. The Brochure will include information on the purpose/mission of the MFP grant; grant eligibility criteria; four primary objects of the grant; contact numbers; and website information.

The MFP informational brochure is targeted to:

- Potential Enrollees (Consumers)
- Family Members/ Decision Makers/Legal Decision Makers
- Service Providers
 - Families of children appropriate for HCBC services
 - Hospital Discharge Planners
 - Outreach Workers
 - Home and Community Based Case Managers
 - Public Health Offices
 - Parish Nurses
 - Human Services Center Personal
 - Home Health Agencies
 - Senior Centers
 - DME Venders
 - Senior Centers
 - Hospitals and Clinics
 - Nursing Facilities

A Money Follows the Person Fact Sheet have been prepared for Center for Independent Living staff, Stakeholder Committee Members, DD Program Managers, HCBS Case Managers, LTC Social Services Staff, the MFP Grant Program Administrator, LTC Ombudsman Staff, Protection and Advocacy Staff and other professionals to use in conjunction with the MFP Brochure to educate consumers, family members, and other professionals about MFP services, eligibility, and related referral process.

See Attachments B.1-C and B.1-D

Electronic Media

The fully accessible ND MFP Website provides an overview of the demonstration services and supplemental services available during the demonstration period outlines MFP eligibility criteria, lists referral contact information, and Stakeholder Committee and workgroup minutes and meeting schedules. The Website will be listed on the MFP brochure to encourage a more in-depth review of MFP Grant referral and contact information. <http://www.nd.gov/dhs/info/pubs/mfp.html>

The ND Aging and Disabilities Link is maintained by the North Dakota Department of Human Services' Aging Services Division. The link is a one-stop connection to information about services that enhance independence, assure quality of life, and meet the unique needs of seniors and people with disabilities living in North Dakota and other states. The link will include information about MFP Demonstration Services, referral processes, and contacts. The Link will be used by the Aging and Disabilities Resource Center staff to provide MFP specific information.

<http://www.nd.gov/dhs/onlineserv/ndseniornfoline/index.aspx>

Newsletters

Quarterly MFP information will be provided for the quarterly Home and Community Based Services newsletter that is targeted to HCBS case managers and other County Social Services professionals.

Quarterly MFP information will be provided for the Regional Aging Services Newsletter. This newsletter audience includes county Social Services Directors and HCBS Case Managers, Options Counselors, Senior Centers, and Regional Aging Council members.

MFP information will be provided for the Long Term Care Social Workers of ND Association Newsletter.

MFP information will be provided to the ND Association of Community Providers for their newsletter.

MFP information will be provided to the Protection and Advocacy Project and Ombudsman programs for inclusion in their newsletter.

Outreach/Education

MFP training and educational forums and other types of outreach will be scheduled and provided to HCBS Case Managers, Aging and Disabilities Resource Link staff, LTC Ombudsman staff, hospital discharge planners, Nursing Facility Social Services Staff, Nursing Facility Administrators, Protection and Advocacy staff, etc. including the strategic methods outlined below:

- MFP information booth at Long Term Care Conventions
- Provide written MFP information to Nursing Facility Administrators
- Provide training to HCBS Case Managers at regional meetings and annual training.
- Provide informational packets for use by DD Program Manager when enrolling MFP participants

- Provide informational packets for use by Long Term Care Social Services staff when discussing MFP with potential participants and their family members
- Provide training to Long Term Care Social Services staff during association membership meeting or annual training
- Provide MFP information to Regional Councils on Aging , Governors' Commission on Aging, Forum on Aging, and other senior groups like the Senior Sensation and Graying of North Dakota
- Life Skills and Transition Center program staff will be provided with an overview of the MFP grant, transition services available, supplemental services options, eligibility requirements, and referral processes
- Provide MFP information to Senior Center staff/ outreach workers
- Provide MFP information to Long Term Care Ombudsman and Volunteer Ombudsman at annual training session
- Provide MFP information to members of the ND Association of Community Facilities serving persons with developmental disabilities
- Provide MFP information to ND Advocacy Groups including ND Association of Disabilities, ND Disabilities Advocates Consortium, ND Protection and Advocacy, AARP, IPAT, Center for Persons with Disabilities
- Provide Information to Staff of Centers for Independent Living
- Review MFP services and referral processes with Aging and Disabilities, Resource Link staff and Resource Link staff when developed
- Continue MFP grant education with ND Housing providers and initiate contact with all public housing authorities directors related to the needs of MFP participants
- Provide Regional Aging Service Program Administrators with information related to MFP services and referral process options.
- Stakeholder Committee Member verbal communication to their organization
- Provide an MFP Grant poster to nursing facilities and ICF/IDs to make consumers aware of the grant.
- Provide ongoing outreach to the ND Indian Reservation and Tribal communities with the assistance and support of the DHS Tribal Liaison. This will include continued invitations to participate on the MFP Stakeholder Committee, continued DHS involvement with Tribal planning groups, and MFP participant specific outreach by Transition Coordinators or DD Program Manager on a case by case basis.
- Provide Local Contact Agency with information and education on MFP grant referral process.

Local Contact Agency

MDS 3.0 Section Q is designed to engage nursing facility residents in their discharge planning goals by directly asking the resident if they want information about long-term care community options. The primary goal is to support the nursing facility resident's ability to achieve his or her highest level of functioning.

Section Q is also intended to promote information exchange between nursing homes, local contact agencies, and community-based long-term care providers as well as to promote discharge planning collaboration between nursing homes and local contact agencies for residents who may require medical and supportive services to return to the community.

Enriched transition resources are now available and will grow over time. Resource availability varies across local communities and may present barriers to allowing some resident's return to their community. Close collaboration between the nursing facility and the local contact agency is needed to evaluate the resident's medical needs, finances and available community transition resources.

The Local Contact Agencies will be responsible to respond to nursing facility staff referrals and requests for information by providing information about community-based long-term care supports and services to residents and/or to nursing facility staff through a process called "Options Counseling". This "Options Counseling" will involve one or more visits with the resident and those persons the resident would like to be involved with the process and the provision of an "Options Plan" outlining what services and supports may be available in the community. The Options Plan will also provide information about the agency choices that may be able to assist with discharge or transition activities including MFP transition coordination services.

Once the community services options plan has been outlined by the Local Contact Agency, nursing facility staff will work jointly with community agencies that can assist with discharge/transition to the community for nursing facility residents that wish to pursue transition.

The community agencies available to assist with transition include but are not limited to the Centers for Independent Living; Money Follows the Person Grant Transition Coordination Services; County Home and Community Based Services Case Management; and private home health services. The nursing facility and the community transition agencies are jointly responsible to meaningfully engage the resident in their discharge and transition planning process and collaboratively work to arrange for all of the necessary community-based long-term care service

North Dakota has designated the 8 Regional Options Counseling Agencies as the Local Contact Agencies. The Regional Options Counseling Agencies serve designated counties in their region. Nursing facilities will be served by the Regional Options Counseling Agency designated to provide services in the county where the nursing facility is physically located. See Attachment (F) for specific designation and Local Contact Agency information

MFP Marketing Plan:

North Dakota has worked with Marketing consultant agency to assist in developing statewide marketing plans and strategies. A concerted marketing effort does strengthen the educational process, therefore increasing the likelihood that more transitions will occur. Some of the activities that this marketing effort include and are currently utilized are creative development services (Marketing Agency), tool kit development, educational materials, development and print expenses, website development, booth materials, postage, public and media relations and promotional giveaways.

Pre-implementation Outreach /Marketing/ Education Activity

- Long Term Care Association Administrators, Nurses, and Social Service Staff were provided with MFP training at six separate regional meetings. Training included a review of the Transition Coordination demonstration service and supplemental services, eligibility requirements, and referral process.
- Adult HCBS Committee was provided with MFP training related to the Transition Coordination demonstration service and supplemental services, eligibility requirements, and referral process.
- Region V and Region VIII Councils on Aging were provided with training related to the MFP demonstration services, supplemental services, eligibility requirements, and referral processes.
- ND Disabilities Advocates Consortium
- ND Protection and Advocacy agency state advocates were provided with a full review of the MFP grant including service options, eligibility, and referral processes.
- The ND Community Facility Providers Board members were provided with a full review of the grant services as they pertain to services for persons with a developmental disability.
- The IPAT consortium was provided with a review of the MFP grant, demonstration services, eligibility requirements, and referral processes.
- County Social Services Directors were provided with an overview of the MFP grant services, eligibility requirements, and referral processes.
- Grand Forks County Vulnerable Adults Committee including housing providers, DD providers, and HCBS providers were provided with information about the MFP grant demonstration and supplemental services, eligibility requirements, and referral processes.

B.4 Stakeholder Involvement

The North Dakota Money Follows the Person Stakeholder Committee was established on November 20, 2007 for the purpose of providing ongoing oversight and/or advice on State policy changes to achieve rebalancing, monitoring grant implementation progress, monitoring achievement of grant benchmarks, recommending ways to improve program design or implementation, participating in the design of the operational protocol (OP), and monitoring its implementation throughout the demonstration period. Active stakeholder involvement is considered vital to the success of the implementation of the Money Follows the Person Rebalancing Demonstration Grant.

The Stakeholders Committee is focused on identifying and implementing strategies that will assist North Dakota to achieve the four primary objectives of the MFP Demonstration Grant with respect to institutional and home and community-based long-term care services under State Medicaid programs to include:

1. Rebalancing

Increase the use of home and community based, rather than institutional, long-term care services

2. Money Follows the Person

Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

3. Continuity of Service

Increase the ability of the State Medicaid program to assure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institutional to a community setting.

4. Quality Assurance and Quality Improvement

Ensure that procedures are in place (at least comparable to those required under the qualified HCB program) to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services, and to provide for continuous quality improvement in such services.

Consumer participation in the MFP Stakeholder Committee is critical to supporting long term successful system changes. ND has worked with the ND Protection and Advocacy and the Centers for Independent Living to support consumer involvement. Consumers have taken an active role in both the workgroups and the Stakeholder Committee offering significant insight and active participation in decision making and program design

suggestions. Additional Consumers will be invited to participate in the workgroups and the Stakeholder Committee as they volunteer or are identified throughout the term of the Demonstration.

To encourage stakeholder involvement arrangements have been made to support participation in the stakeholder meeting through payment of travel expenses for attending members. Members are provided with a travel voucher to complete after each meeting for payment of the expenses that are related to participation. In addition consumers that participate in meetings are reimbursed for travel, lodging, meals, and personal care assistance expenses. The use of interactive technology is being employed to allow distant stakeholders to participate in workgroups.

Membership

The Stakeholder Committee includes direct consumers and/or their family members, Advocacy Groups, Providers and provider association representatives, State agency staff, housing agency representatives, and a representative of Governor's office. The Committee specifically includes the following members:

Consumers and/or their family members and Advocacy Groups:

Four Consumers/ one family member, ND Protection and Advocacy, ND Long Term Care Ombudsman, The ARC of ND, Interagency Program for Assistive Technology (IPAT), AARP, NDAD, ND Centers for Independent Living, NDDAC, and a member of the ND Committee on Minority of Health Disparities.

Provider Associations:

ND Long Term Care Association, ND Community Facilities Association, Home Nursing Association. Long Term Care Social Workers of ND, Public Health Association

Providers:

County Social Service Case Management, County Social Services Board

Housing:

ND Community Action Association, County Housing Authority, NDHFA, ND Dept of Commerce-Division of Community Service, Medicaid Infrastructure Grant Housing Task Force Representative

Governmental Representatives:

Olmstead Commission Rep, Office of the Governor

Department of Human Services:

Executive office, Fiscal, Aging Services, Developmental Disabilities, ND Life Skills and Transition Center, Regional Human Service Center Administration, Vocational Rehabilitation, Tribal Liaison, Medical Services-Long Term Care

Continuum, HCBS Services, Administration, Money Follows the Person Grant Program Administrator, Program Operations

Workgroups:

In addition the MFP Stakeholder Committee established five workgroups for the purpose of developing the operational protocol. These include the groups of Goals and Benchmarks, Nursing Facility Transitions, DC/ ICF/ID Transitions, Housing, and Quality Assurance. The Stakeholder Committee reviews and gives final approval for all the work submitted by the workgroups. The workgroups include additional stakeholders not part of the larger MFP Stakeholder Committee. These workgroups include:

- **Goals and Benchmarks:** This workgroup is responsible for addressing the four primary objectives of the MFP Grant, grant benchmark design and review, case study development, and preparation of the operational protocol related to goal development.

Membership includes representatives from the following groups/agencies:

County Social Services Administration and Case Management, AARP Representative, ND Protection and Advocacy, Consumers, ND Long Term Care Association, ND Dept of Human Services, Aging Services Division, Center for Independent Living Representatives, Dept of Humans Services, Medical Services, Dept of Human Services, Developmental Disabilities, DHS, Money Follows the Person Grant Program Administrator, Older Americans Act Provider, The ARC of ND, Ann Carlson Center representative, a consumer, and a family member.

- **Nursing Facility Transitions:** This workgroup is responsible for the design of the new Transition Coordination demonstration service to be provided to consumers that wish to return to the community. This includes development of the processes, assessments, referral procedures, transition plans, forms, and policies necessary for successful transitioning to occur. Operational protocol related demonstration policy and procedures that address transitions from a nursing facility are the responsibly of this workgroup.

Membership includes representatives of the following groups/agencies:

HCBS Case Managers, Long Term Care Social Workers, Long Term Ombudsmen, Regional Aging Services Program Administration, ND Protection and Advocacy, IPAT, three consumers, Representatives of the Four Centers for Independent Living, Outreach Worker, Burleigh County Senior Adults Program, ND Public Health, and two consumers.

- **Life Skills and Transition Center/Community ICF/ID Transitions:** This workgroup is responsible for the MFP operational protocol related implementation policies and procedures for all transitions from the Life Skills and Transition Center and Community ICF/ID facilities.

Membership includes representatives of the following groups/agencies:

Developmental Disabilities State Office personal, ND Association of Community Facilities representative, DD Case Management, ND Life Skills and Transition Center representatives, MFP Program Administrator, The ARC of ND, Protection and Advocacy of ND and the Life Skills and Transition Center Transition Team and Committees, and one family member.

- **Housing:** The MFP Housing workgroup is functioning as part of the Housing Alliance of North Dakota (HAND). This workgroup is responsible for the development of the strategies to assure that MFP participants have available, affordable, and accessible housing options. In addition the development of the operational protocol related to housing is the responsibility of this workgroup. Implementation of the housing strategies will also be addressed.

The North Dakota MFP State Housing Facilitator and the MFP Regional Consumer Housing Resource Specialists will work collaboratively with the Housing Alliance of North Dakota and MFP Housing workgroup members.

Membership includes representatives of the following groups/agencies: ND Protection and Advocacy, ND Community Action Association, County Housing Authorities, ND Housing Finance Agency (NDHFA), ND Dept of Commerce-Division of Community Service, Long Care Association-Assisted Living Facility Representative, IPAT Coordinator, Center for Independent Living representative, MFP Program Administrator, Community Works Housing Coordinator, Medicaid Infrastructure Grant Housing Task Force Representative

- **Quality Assurance:** This workgroup is responsible for the development of the operational protocol related to quality for transitions from nursing facilities and the Life Skills and Transition Center/Community ICF/ID facilities. This includes addressing the required waiver quality assurance requirements and the three additional quality requirements of Incident management, 24 hour backup, and risk mitigation. This committee is responsible for the implementation of the demonstration service of 24 hour on call nursing services for all MFP participants.
- **Membership includes representatives of the following groups/agencies:** ND Protection and Advocacy, Department of Human Services, Medical Services

Division-HCBS Waiver, Long Term Care Association-Nursing Facility Quality Assurance Representative, HCBS Case Management, County Social Services Administration, ND Association of Community Facilities, Department of Human Services, Developmental Disabilities, Life Skills and Transition Center, ND Association for Home Care, Vocational Rehabilitation, MFP Grant Program Administration, and the ND Department of Health (State Survey Organization)

Life Skills and Transition Center – Transition to the Community Task Force

The Department convened a task force of stakeholders in 2005 to prepare a plan in response to the mandate from North Dakota House Bill 1012 – Section 16, to transfer appropriate Life Skills and Transition Center residents to communities. The Superintendent of the Life Skills and Transition Center chairs the task force and task force members include Department staff, community providers, advocates and family members. As a result of input from task force members, a statewide needs survey, and onsite stakeholder input sessions conducted in each of the eight state regional service areas, the task force determined community capacity needs to be built and resources need to be expanded in order to meet the current and projected needs of individuals in the community.

Recommended action steps developed by the task force to accomplish the transitioning of people to the community include: a community placement plan for each individual residing at the Life Skills and Transition Center; a statewide crisis prevention and response system that is based on a “zero reject” model; increased need for crisis intervention services including crisis beds, out-of-home crisis residential services, in-home technical assistance, follow-along services after out-of-home crisis residential services placement, and enhanced training for community professional and direct care staff; increased consultation consisting of behavioral planning and oversight, sexual health, psychiatric and psychological issues. The Transition Task Force is acting in conjunction with the MFP demonstration grant to accomplish these goals. The MFP Grant Program Administrator is now a member of this task force and the recommendation for service system improvements to meet the support needs of persons with a developmental disability will be addressed to the extent possible within the operational protocol of the MFP Demonstration Grant.

Other Stakeholder Involvement

The ND Association Community Facilities conducted a Developmental Disabilities stakeholder meetings in January of 2008 using grant money provide by the ND Council on Developmental Disabilities for the purpose of identifying system improvements. The information from these meetings will be addressed by the MFP Stakeholder Committee and the Transitions to the Community Task Force.

Legislative Partnership Committee

This committee has also been established by stakeholders involved in the provision of services to persons with a developmental disability. The Committee includes state legislative representatives, Life Skills and Transition Center personal, Parent representatives, Consumer representatives, Guardianship provider representatives, Direct support professionals, ND Association of Community Facility representative, ARC of ND representatives, Developmental Disabilities Division Central Office representatives, ND Protection and Advocacy, ND Disabilities Advocacy Consortium representative, ND State Council on Developmental Disabilities, and the MFP Grant Program Administrator. The purpose of this committee is to assist state leadership to plan and respond to the support service needs of people who have a developmental disability. The group shares information directly with the Director of the Department of Human Services and the Governor's Office of ND. The findings of this committee will be addressed by the MFP Stakeholder Committee and the Life Skills and Transition Center/ICF/ID Transitions workgroup.

Long Term Care Association

Six LTC Association regional meetings afforded the opportunity for significant input from nursing facility administrators, NF Directors of Nursing, and Social Service Staff related to the implementation of the grant. This information resulted in changes to the referral and notification process. The Long Term Care Social Workers of ND provided input during MFP training and representation on the MFP Stakeholder Committee.

Home and Community Based Services

The ND Adult Services Committee, the County Social Services Directors Association, and two Regional Councils on Aging met with the MFP Program Administrator and have provided direction and insight into the needs of persons that are elderly or that have a physical disability and are in need of HCBS in the community. Representatives of all of these groups agreed to participate in the MFP Stakeholder Committee.

MFP Benchmark-Stakeholder Group

To assist in rebalancing the state's long term care system, we will create a stakeholder committee led by the project manager for MFP in 2008. The committee will be comprised of individuals representing Governor's Olmstead Commission, Home Health, Housing Finance Agency, CIL's, Public Health, Senior Centers, Older American Act Providers, County Social Service Board Directors, Long Term Care Association, North Dakota Center for Persons with Disabilities, licensed DD community providers, and other interested parties.

The committee's purpose will be to educate consumers of rebalancing efforts, provide information to the Resource Link on available resources, and identify activities and services lacking in communities. Additionally, the committee will develop a plan of action to enhance services in underserved areas of the state. Ongoing activities and accomplishments of the committee, educational resources made available to the public, as well as, rebalancing efforts enhanced, improved or implemented based on recommendations by the committee will be reported annually or as requested by the grantor. The ND MFP Stakeholder Committee was created to meet this Benchmark. The Committee also will collaborate with the Aging and Disabilities Resource Center staff to meet the goals of this benchmark

Prior Stakeholder Contributions:

Information for development of the MFP demonstration was obtained from the Department's Systems Transformation work group consisting of consumers, Older Americans Act (OAA) service providers, county social service boards, AARP, Protection & Advocacy, Independent Living Centers, North Dakota Long Term Care Association, North Dakota Disabilities Consortium, local housing authorities, waiver service providers, and Department staff. Additional information was obtained through statewide Department stakeholder meetings and Aging Services/HCBS state input hearings. Other state agencies and divisions that have contributed in identifying service needs or providing information are Indian Affairs Commission, Health Department, Minot State University, Division of Mental Health & Substance Abuse, Disabilities Services Division, Aging Services Division, Vocational Rehabilitation, Civil Rights Office, and Legal Services Division. Input from advocates will be made through continued efforts of the Systems Transformation work group, as well as from stakeholder meetings held at least annually to obtain input on waived services.

B.5 Benefits and Services

Target Population

The target population consists of North Dakotans who are currently residing in a nursing facility, a qualified hospital setting, the ND Life Skills and Transition Center, or in a community based ICF/ID for a period of 3 months or more, are receiving Medicaid, meet institutional level of care screening requirements at time of admission to the institution, have been determined to be Medicaid eligible for one day immediately prior to transition, and are from one of the following populations:

1. Developmental Disabilities
2. Physically Disabled
3. Elderly

Institutions

Institutions covered in the ND Demonstration project include all skilled nursing facilities, qualified hospitals, community ICF/ID facilities, the ND State Hospital, and the ND State Life Skills and Transition Center.

Transition Process from the State Hospital to an approved Money Follows the Person (MFP) Community Living Situation

- North Dakota selected individuals with a Developmental Disability (DD) as a target population to serve through the MFP grant program. Individuals with a DD that reside at the North Dakota State Hospital (NDSH) would otherwise be eligible for MFP services if not at the SH.
- Many of these individuals are no longer being served for acute mental health related needs at the NDSH and are in need of community placement.
- Their placement at an Institution for Mental Disease (IMD) prevents them from reimbursement through MFP because Medicaid isn't paying for their institutional care at the NDSH.
- These are individuals that have otherwise been served at the Life Skills and Transition Center, an ICF, but have been transferred to the NDSH due to primarily behavioral/mental health issues.
- The NDSH meets the 90 day institutional requirement of MFP. However, MFP requires at least one day of Medicaid eligibility and payment for institutional care to qualify for the one time moving costs and one year of enhanced FMAP.
- In order to access the MFP services consumers will need to participate in a one or more day qualifying stay in an intermediate care facility or other Medicaid eligible institutional setting. This stay will be utilized for assessment, behavior care

planning, community orientation, purchase of community living necessities etc. to assist the individual in establishing a successful residence in the community.

- When an individual is being considered for discharge from the NDSH, the discharge planner from the NDSH, the Regional Human Service Center Program Manager, and the Life Skills and Transition Center QMRP should collaborate to determine if participation in the MFP program is critical for a successful return to the community.
- This process will not be considered valuable for every DD transition from the NDSH; however, it could be beneficial to individuals that need one time moving costs reimbursed. Each case should be evaluated individually for weighing the benefits to the specific individual's needs.
- If it is determined that MFP participation would be vital to the success of the community transition, the team would need to evaluate the appropriate institutional care location for the individual to establish MFP eligibility. The team should utilize the brief intermediate care placement to enhance the transition process for the individual by exploring necessary behavioral care planning, staff orientation, assisting in purchasing necessary personal items etc.

MFP Rebalancing Fund Transition Assistance Services

Payment for One Time moving costs for Non-MFP Qualified consumer transitioning to the community from the ND State Hospital.

The MFP Grant Services onetime moving costs payments have been demonstrated to be a crucial factor in successful transitions to a community setting. Multiple requests have been made for this assistance for consumers of the ND State Hospital that do not meet the MFP criteria for assistance. In all situations the consumers have been persons with an intellectual or developmental disability not able to participate in an ICF stay to establish the one day of Medicaid funded institutional service. The lack of funds to pay for a return to the community creates a barrier for transitioning back to the community.

The MFP Rebalancing Fund Transition Assistance Services will be funded using MFP rebalancing dollars that will be utilized for payment of the onetime moving costs for individuals that do not meet the MFP eligibility criteria and are transitioning from the NDSH or from the ND Life Skills and Transition Center back to the community.

Individuals are not eligible for this service if they are receiving services from either the James River Correctional Center (JRCC) or the Special Assistance Unit which are both part of the North Dakota Department of Corrections and Rehabilitation.

Assistance will be requested by the DD Program Manager or the community provider in amounts up to a total payment limit of \$2,500 using the MFP Transition Assistance

Request Document. Payments will be made to the community provider to reimburse for costs incurred for the MFP participant.

Qualified Residences to Which Persons Will Be Transitioned

- A home owned or leased by the individual or the individual's family member;
- An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and
- A residence, in a community-based residential setting, to include Adult Family Foster Care or a Community Group Home

Individuals targeted will be those with a desire to transition from an institutional care setting to a home or community based services setting. Services will be provided by the various human service program including but limited to 1915(c) Waiver programs , Medicaid State Plan-Personal Care, mental health services through regional human service centers provided at this time.

Money Follows the Person Demonstration Services for Persons with a Physical Disability or an Elder

Waiver for HCB Services assists individuals to return or remain in their own homes or communities. Individuals must be Medicaid eligible, meet NF LOC criteria, voluntarily choose to participate in the programs, and must be age 16 or over.

Home and Community Based Services Waiver Services

This waiver helps eligible individuals who would otherwise require nursing home services to return or remain in their homes or communities. It gives eligible people options, if their needs can be met in their homes.

Eligibility Requirements:

- To qualify for services under the HCBS Waiver program, an individual must be:
- A [Medicaid](#) recipient (meets Medicaid income and other eligibility requirements), and
- Screened at nursing facility level-of-care, and

- At least 18 years of age OR disabled by Social Security Disability criteria, and
- Living in his or her own home or apartment (not in dormitory or other group housing), and
- Able to have his or her service/care need(s) met within the scope of this waiver

Covered Services:

- Adult Day Care - Provides at least three hours per day of attended care in a group setting
- Adult Family Foster Care - Provides a safe, supervised family living environment, 24-hour per day in a state licensed setting
- Case Management - Assesses needs; helps with care planning, provider selection, referrals and service monitoring
- Chore Service - Includes snow removal and heavy cleaning
- Emergency Response System (Lifeline) - Provides telephone emergency response
- Environmental Modification - (Limited) Modifies the home to enhance the client's independence
- Homemaker Service - Provides house cleaning, laundry, and/or meal preparation services
- Non-Medical Transportation - Transports or escorts client for essential needs such as grocery shopping, social security office visit, etc.
- Residential Care - Services provided in a facility in which at least five (5) unrelated adults reside, and in which personal care, therapeutic, social, and recreational programming are provided in conjunction with shelter. This service includes 24-hour on-site response staff to meet scheduled and unpredictable needs and to provide supervision, safety, and security
- Respite Care - Provides temporary relief to full-time caregivers
- Specialized Equipment - Provides special equipment reducing the need for human help
- Home Delivered Meals-(7) days per week – The purpose of home delivered meals is to provide a well-balanced meal to individuals who live alone and are unable to prepare an adequate meal for themselves, or who live with an individual who is unable to not available to prepare an adequate meal for the recipient. At a minimum, each meal must meet the most current meal pattern established by the United States Department of Agriculture’s (USDA) Dietary Guidelines for Older Americans.
 - Services Eligibility Criteria – The individual receiving the home delivered mail will meet the following criteria:
 - Must be eligible for the Medicaid Waiver for Home and Community Based Services
 - Must not be eligible to receive home delivered meals under the Older Americans Act

- Lives alone and is unable to prepare an adequate meal of lives with someone who is unable to or unavailable to prepare an adequate meal.
 - Service Limits – Recipients cannot receive more than (7) hot or frozen home delivered meals per week.
 - The individual will continue to receive home delivered meals under the waiver post demonstration period contingent on waiver eligibility.
- Extended Personal Care-Assistance with Medication
- Supported Employment Services - Provision of intensive, ongoing support to individuals to perform in a work setting with adaptations, supervision, and training relating to the person's disability. This would not include supervisory or training activities provided in a typical business setting. This service is conducted in a work setting, mainly in a work site in which persons without disabilities are employed
- Transitional Living Service - Services that train people to live with greater independence in their own homes. This includes training, supervision, or assistance to the individual with self-care, communication skills, socialization, sensory/motor development, reduction/elimination of maladaptive behavior, community living, and mobility.

MANAGED CARE

Program of All-inclusive Care for the Elderly (PACE)

PACE programs provide a comprehensive service delivery system which includes all needed preventive, primary, acute and long term care services so that individuals can continue living in the community. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees. For most participants, the comprehensive service package permits them to continue living at home while receiving services. Providers assume full financial risk for participants' care without limits on amount, duration, or scope of service

What is PACE

PACE programs provide a comprehensive service delivery system. This system includes:

- All Health and Preventive Benefits
- Hospital and Physician Services
- Home-Health Care and Personal Care
- Dental and Optical Care
- Pharmaceuticals
- Meals and Nutritional Counseling
- and Health Related Transportation

This comprehensive package permits elderly individuals and other persons with disabilities who qualify for nursing home level of care the ability to continue living at home.

PACE services are primarily provided in an adult health center, supplemented by in-home and referral services in accordance with a participant's needs.

Eligibility Requirements:

In order to qualify for PACE participants must:

- Be a Medicare or Medicaid enrollee who is age 55 or older
- Be eligible for nursing home level of care,
- Be able to live safely in the community when you join with the help of PACE services
- Live in a PACE service area

PACE programs receive a fixed amount of money per person, per month from a participant's state Medicaid and/or Medicare program. (Medicare funds come through a risk adjusted formula in which the program receives more for sicker enrollees).

Once enrolled, the PACE program becomes the participant's insurer and care provider and is obliged to pay for all of the participant's medical care from the point of enrollment forward.

Once enrolled into PACE, a team of health care professionals from different disciplines assesses each participant's needs and develops a care plan with the involvement of the participant and family members. This care-plan is continually monitored for changes in the needs of the participant. PACE is a voluntary program and a participant can disenroll at any time.

PACE provides another option for those individuals who are able to remain in the home with assistance. PACE also focuses on preventive care, promoting independence and health (through therapies, activities, nutrition, and on-going care-coordination), and for those established PACE sites, working toward a reduction in hospital inpatient utilization, maintaining participants in the home setting and out of nursing homes.

Covered Services:

The emphasis of the PACE program is on enabling participants to remain in their community and enhancing their quality of life. A team of health care professionals from different disciplines assesses each participant's needs, develops a care plan, and delivers all services (including acute care and nursing facility services if necessary). Minimum services that must be provided in the PACE center include primary care services, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals. The services are provided primarily in an adult health center, supplemented by in-home and referral services in accordance with a participant's needs. PACE is a voluntary program.

Location:

The Northland Healthcare Alliance has developed two PACE organizations in North Dakota. They are located in Bismarck and Dickinson. The Bismarck PACE program is able to serve 150 enrollees and Dickinson is able to serve 25 enrollees.

- North Dakota Technology Dependent Waiver assists individuals to remain in their own homes or communities. Individuals must be Medicaid eligible, meet NF LOC criteria, voluntarily choose to participate in the programs, dependent on a ventilator for a minimum of 20 hrs per day, medically stable and must be age 18 or over. Fee For Service. (Capacity of three slots)
- Medically Fragile Children Waiver serves children ages 3-18 who would otherwise require nursing home services. Self-Directed. (Capacity of 15 slots)
- Medicaid State Plan-Personal Care (MSP-PC) provides personal care services to assist individuals to remain in their own homes or communities. Individuals must be Medicaid eligible, meet Level A criteria which included impairment in one ADL or impairment in 3 of the following 4 IADLs including meal preparation, laundry, taking medications and housework or Level B criteria which includes meeting Level A criteria and meeting NF LOC criteria or Level C criteria which includes impairment in 5 ADLs. Fee For Service.
- PACE programs provide a comprehensive service delivery system which includes all needed preventive, primary, acute and long term care services so that individuals can continue living in the community. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees. For most participants, the comprehensive service package permits them to continue living at home while receiving services. Providers assume full financial risk for participants' care without limits on amount, duration, or scope of service Managed Care/Fee for Service

Additional Services Available for the Elderly and Disabled paid for by other state funding sources

Service Payments for the Elderly and Disabled (SPED) new services

<http://www.nd.gov/dhs/services/adultsaging/homecare1.html>

The SPED program provides services for people who are older or physically disabled and who have difficulty completing tasks that enable them to live independently at home.

Eligibility Requirements:

- Liquid assets less than \$50,000
- Impaired in four Activities of Daily Living (ADL's) (bathing, dressing, toileting, eating, transferring, mobility inside) OR in five Instrumental Activities of daily Living (IADL's (meal preparation, housework, laundry, shopping, taking medication, mobility outside the home, transportation, money management, telephone)
- Impairments must have lasted or be expected to last three months or longer OR
- If an individual is younger than age 18, is screened for nursing facility level of care,
- Is not living in an institution, dormitory, or congregate housing
- The need for service is not due to mental illness or mental retardation, and the individual is capable of directing his or her own care or has legally responsible party, and has needs within the scope of covered services

Covered Services Include:

- Adult Family Foster Care - Provides a safe, supervised family living environment, 24-hours per day in a state licensed setting
- Case Management - Assesses needs, helps with care planning, provider selection, referrals, and service monitoring
- Chore Service - Includes snow removal and heavy cleaning
- Emergency Response System (Lifeline) - Provides telephone emergency response
- Environmental Modifications- (Limited) Modifies the home to enhance client independence (e.g. install safety rails)
- Family Home Care - Reimburses a family caregiver who meets the relationship requirements defined by state law and resides in a client's home 24-hours per day
- Homemaker - Provides house cleaning, laundry, and/or meal preparation services
- Personal Care - Helps with bathing, dressing, transferring, toileting, and supervision
- Home Delivered Meals-(7)days per week – The purpose of home delivered meals is to provide a well-balanced meal to individuals who live alone and are unable to prepare an adequate meal for themselves, or who live with an individual who is unable to not available to prepare an adequate meal for the recipient. At a minimum, each meal must meet the most current meal pattern established by the United States Department of Agriculture's (USDA) Dietary Guidelines for Older Americans.
 - Services Eligibility Criteria – The individual receiving the home delivered mail will meet the following criteria:
 - Must be eligible for the Medicaid Waiver for Home and Community Based Services

- Must not be eligible to receive home delivered meals under the Older Americans Act
- Extended Personal Care-Assistance with Medication

Expanded Service Payments for the Elderly and Disabled (EX SPED).

<http://www.nd.gov/dhs/services/adultsaging/homecare2.html>

The Expanded-SPED program pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility.

Eligibility Requirements:

- [Medicaid](#) eligible, and
- Receives or is eligible for Social Security Income (SSI), and
- Is not severely impaired in the Activities of Daily Living of toileting, transferring, eating, and
- Is impaired in three of four Instrumental Activities of daily Living: meal preparation, housework, laundry, or taking medications OR
- Has health, welfare, or safety needs, including supervision or structured environment, otherwise requiring care in a basic care facility, and
- Is not living in an institution or dormitory, and has needs within the scope of covered service

Covered Services Include:

- Adult Family Foster Care - Provides a safe, supervised family living environment, 24 -hours per day in a state-licensed setting
- Case Management - Assesses needs, helps with care planning, provider selection, referrals, and service monitoring
- Chore Service - Includes snow removal and heavy cleaning
- Emergency Response System (Lifeline) - Provides telephone emergency response
- Environmental Modifications (Limited) - Modifies the home to enhance client independence (e.g. install safety rails)
- Family Home Care - Reimburses a family caregiver who meets the relationship requirements defined by state law and resides in a client's home 24-hours per day
- Homemaker - Provides house cleaning, laundry, and/or meal preparation services
- Respite Care - Provides temporary relief to the full-time caregiver
- Home Delivered Meals-(7) days per week – The purpose of home delivered meals is to provide a well-balanced meal to individuals who live alone and are

unable to prepare an adequate meal for themselves, or who live with an individual who is unable to not available to prepare an adequate meal for the recipient. At a minimum, each meal must meet the most current meal pattern established by the United States Department of Agriculture's (USDA) Dietary Guidelines for Older Americans.

- Services Eligibility Criteria – The individual receiving the home delivered mail will meet the following criteria:
 - Must be eligible for the Medicaid Waiver for Home and Community Based Services
 - Must not be eligible to receive home delivered meals under the Older Americans Act

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Money Follows the Person Demonstration Services for Persons with a Developmental Disability

ND will be utilizing the current Developmental Disabilities service system to facilitate transitions from the Life Skills and Transition Center and community ICF/ID facilities. During the MFP demonstration period the consumer's DD Program Manager will continue in their role as service broker however, they will additionally manage the MFP specific transition responsibilities. These responsibilities will include the provision of MFP program and rights related information to consumers/family/legal decision makers, securing MFP consent to participate documents, facilitating completion of transition plans that include risk mitigation and 24 hour backup planning, assuring transitions to qualified residences, facilitating applications for Transition Assistance and supplemental Transition Assistance services for one time transition costs, and ongoing case management follow-up after transition.

In addition the Life Skills and Transition Center Social Worker will act as the primary contact person at the Center. The social worker will provide information to consumers or their family/legal decision maker about MFP demonstration services and supplemental services. The worker will also assure the provision or rights information, eligibility requirements are met, support planning is completed, and consent documentation is in place prior to a participant's transition to a community provider.

Qualified Home and Community-Based Services Available to Individuals with a Developmental Disability through the Demonstration Program

Residential Habilitation-Residential Habilitation consists of an integrated array of individually designed training activities, assistance and supervision. Residential Habilitation is provided in licensed/unlicensed community residential settings that include Adult Family Foster Care or Family Foster Care licensed homes, group homes and homes leased, owned or controlled by individuals.

- Residential Habilitation includes:
 - (1) Habilitation Services aimed at assisting the participant to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization and other adaptive areas. Training outcomes focus on allowing the participant to improve his/her ability to reside as independently as possible in the community.
 - (2) Assistance in activities of daily living when the participant is dependent on others to ensure health and safety.
 - (3) Assistance, support, supervision and monitoring that allow the individual to participate in home life or community activities.

Residential Habilitation is provided in the following settings:

"Congregate care" means a specialized program to serve elderly individuals with developmental disabilities whose health and medical conditions are stable and do not require continued nursing and medical care, and are served within a community group-living arrangement.

"Minimally supervised living arrangements" means either:

- a. A group home with an available client adviser; or
- b. A community complex that provides self-contained rented units with an available client adviser.

"Transitional Community Living Facility" means a residence for clients with individualized programs consisting of social, community integration, and daily living skills development preliminary to entry into less restrictive settings.

"Supported Living Arrangement" means a program providing a variety of types of living arrangements that enable individuals with disabilities to have choice and options comparable to those available to the general population. Clients entering this service shall have the effects of any skill deficits subject to mitigation by the provision of individualized training and follow-along services.

"Individualized Supported Living Arrangements" means a residential support services option in which services are contracted for a client based on individualized needs resulting in an individualized rate setting process and are provided to a client in a residence rented or owned by the client.

"Family Care Option III" is an individual support provided in an apartment for adolescents or young adults who are unable to live in a family home setting. In

exceptional circumstances this service may support younger children in order to maintain them in their home community. This service also focuses on close communication and coordination with families and the school system during the transition period.

- (1) Residential Habilitation may include professional services not available as a state plan service, as needed to meet health and welfare needs of recipients. This may include behavior management, nursing, or dietetics. Behavior management services do not duplicate state plan services as services include ongoing development, application, and monitoring of behavior management plans for individuals and training of direct service staff. Psychology services reimbursable under the Medicaid state plan include only evaluation and psychotherapy by a licensed clinical psychologist. Behavior management under Behavior Consultation services in the waiver is not available to Residential Habilitation recipients as that service is limited to individuals living in a family home. Dietician services are not state plan services. Staff employed or contracted by provider agencies must meet licensure or certification appropriate to their scope of practice according to North Dakota Century Code Title 43. Professional services included as part of a rate are not billable as a discrete service

Day Habilitation/Supports – Day Supports provide assistance to the participant with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day Supports are furnished in a non-residential setting, separate from the home or facility where the participant resides, but may be furnished in the individual's home during traditional Day Supports schedules if the individual(s)' needs preclude traveling from the home on a regular basis. Day Supports focus on enabling the individual to attain or maintain his or her maximum functional level and are coordinated with any physical, occupational, or speech therapies listed in the Person Centered Support Plan. Participants may receive Day Supports outside the facility as long as the outcomes are consistent with the habilitation described in the Person Centered Support Plan and the service originates from the licensed day program. This service is limited to individuals who have exhausted eligibility for services under the Individuals with Disabilities Education Act unless enrolled in a school district pursuant to an interdepartmental plan of transition. This service may not duplicate services provided under Extended Services, Adult Day Health, or Residential Habilitation.

Supported Employment/ Extended Services – Extended Services is ongoing support for an individual in supported employment upon completion of training and stabilization in employment; providing on or off the job employment-related support for individuals needing intervention to assist them in maintaining employment. This may include job development, replacement in the event of job loss, and, must include a minimum of two onsite job skills training contacts per month and other support services as needed to maintain employment. It may also mean providing other support services at or away from the worksite. If offsite monitoring is appropriate, it must, at a minimum, consist of two meetings with the individual and one contact with the employer each month.

Supported employment/ Extended Services does not include training and services available to an individual through the Rehabilitation Act of 1973 or IDEA. Supports provided for individuals employed in the community.

Homemaker – Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is unable to manage the home and care for him or herself. Homemakers shall meet such standards of education and training as established by the State for the provision of these activities..

Adult Family Foster Care – Adult Family Foster Care is a licensed home where residential support services are provided in a family home atmosphere with not more than 4 people. Services include preparation of meals, general housekeeping, medication assistance, personal care assistance, and assistance to access the community and social and leisure activities.

Adult Day Health

Services furnished 3 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting of a health care facility or community-based setting, encompassing either health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the Person Centered Plan may be furnished as a component of this service if the provider is licensed according to NDCC 43-26.1, 43-40, and/or 43-37 as applicable to the therapies provided.

The cost of transportation from the individual's residence to the Adult Day Health program is included in the rate paid to providers of Adult Day Health services if the provider elects to include transportation in the rate.

This service is limited to individuals who have exhausted eligibility for services under the Individuals with Disabilities Education Act unless enrolled in a school district pursuant to an interdepartmental plan of transition.

This service shall not be furnished/billed at the same time of day as Extended Services, or Family Support Services

Self-Directed Supports – the opportunity to direct a fixed amount of public resources in a flexible manner that is meaningful and helpful in achieving personally defined goals so the individual may remain in the family residence or in their own home.

Personal Care Services – allow the individual to live as independently as possible while delaying or preventing the need for institutionalization.

Extended Home Health Care-Home Health Care is an Extended State Plan Service which is available when an eligible participant living with a primary caregiver has maximized the amount of service available under the State Plan. The Person Centered Plan must address health and safety issues and support Home Health Care as a service necessary in order for the eligible participant to remain in a family home setting in their community. This service is not available to participants receiving Residential Habilitation.

Behavioral Consultation-Behavior Consultation Services provide expertise, training and technical assistance to assist primary caregivers, in-home support staff and other natural supports. Activities covered are: (1) Observing the participant to determine needs; (2) Assessing any current interventions for effectiveness; (3) Developing a written intervention plan; (4) Intervention plan will clearly delineate the interventions, activities and expected outcomes to be carried out by family members, support staff and natural supports; (5) Training of relevant persons to implement the specific interventions/support techniques delineated in the intervention plan and to observe, record data and monitor implementation of therapeutic interventions/support strategies; (6) Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan with revision of that plan as needed to assure progress toward achievement of outcomes; (7) Training and technical assistance to relevant persons to instruct them on the implementation of the participant's intervention plan; and/or (8) Participating in team meetings. Behavior Consultation excludes services provided through the Medicaid State Plan or the IEP. This service is only available for individuals living in a family home. Environmental

Environmental Supports/Modifications-Home Modifications are physical modifications to a private residence that are necessary to ensure the health, welfare, and safety of the participant or to enhance the participant's level of independence. A private residence is a home owned or rented by the participant or their family (natural, adoptive, or foster family). Only items that are portable may be purchased for use by a participant who lives in a residence rented by the participant or his/her family. This service covers purchases, installation, maintenance, and as necessary, the repair of home modifications required to enable participants to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the participant. Items that are not of direct or remedial benefit to the participant are excluded from this service. Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The waiver participant or his/her family must own any equipment that is repaired.

Covered Modifications are:

1. Ramps and Portable Ramps

2. Grab Bars
3. Handrails
4. Lifts, elevators, manual, or other electronic lifts, including portable lifts or lift systems that are used inside a participant's home
5. Porch stair lifts
6. Modifications and/or additions to bathroom facilities
 - a. Roll in shower
 - b. Sink modifications
 - c. Bathtub modifications/grab bars
 - d. Toilet modifications
 - e. Water faucet controls
7. Widening of doorways/hallways, turnaround space modifications for improved access and ease of mobility, excluding locks
8. Specialized accessibility/safety adaptations/additions
 - a. Electrical wiring
 - b. Fire/safety adaptations, including alarms
 - c. Shatterproof windows
 - d. Floor coverings for ease of ambulation
 - e. Modifications to meet egress regulations
 - f. Automatic door openers/doorbells
 - g. Voice activated, light activated, motor activated electronic devices to control the participant's home environment
 - h. Medically necessary portable heating and/or cooling adaptation to be limited to one unit per participant
 - i. Stationary built-in therapeutic tables

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Central air conditioning; plumbing; swimming pools; service and maintenance contracts and extended warranties are not covered. Equipment or supplies purchased for exclusive use at the school/home school are not covered. Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained.

For individuals living in a private residence who are supported by a licensed residential provider, environmental modifications/supports will be authorized only if resulting in a cost effective reduction of staff support.

Vehicle Modifications are devices, service or controls that enable participants to increase their independence or physical safety by enabling their safe transport in and around the community. The installation, repair, and maintenance of these items are included. The waiver participant or his/her family must own or lease the vehicle. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the adaptation in the event of an accident. Modifications do not

include the cost of the vehicle or lease itself. There must be a written recommendation by an appropriate professional that the modification will meet the needs of the participant. All items must meet applicable standards of manufacture, design, and installation. Installation must be performed by the adaptive equipment manufacturer's authorized dealer according to the manufacturer's installation instructions, National Mobility Equipment Dealer's Association, Society of Automotive Engineers, National Highway and/or Traffic Safety Administration guidelines.

Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment.

Covered Modifications are:

1. Door modifications
2. Installation of raised roof or related alterations to existing raised roof system to increase head clearance
3. Lifting devices
4. Devices for securing wheelchairs or scooters
5. Handrails and grab bars
6. Seating modifications
7. Lowering of the floor of the vehicle
8. Safety/security modification

The cost of renting/leasing a vehicle with adaptations; service and maintenance contracts and extended warranties; and adaptations purchased for exclusive use at the school/home school are not covered.

To receive this service you must be living in a family home.

Equipment and Supplies-Funds may be accessed to meet the excess disability related expenses associated with maintaining an eligible consumer in their primary caregiver's home. Equipment and Supplies enable an individual living with a primary caregiver, to remain in and be supported in their family home (i.e. the home of their primary caregiver), preventing or delaying unwanted out of home placement. Individual needs identified through the person centered planning process in the following areas could be addressed through the individual budget process if the service is not covered in the Medicaid State Plan:

Examples of Equipment and Supplies not included in the Medicaid State Plan include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to

the proper functioning of such items; (d) Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: 1) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; 2) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; 3) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; 4) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan; 5) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and 6) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants; and (e) Personal Emergency Response System is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. Installation, upkeep and maintenance of devices/systems are provided.

Items reimbursed with waiver funds are in addition to any equipment and supplies furnished under the State plan and exclude those items that are not of direct benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

To receive this service, eligible consumers must be living in a family home.

In-Home Supports-Services-In-Home Supports (IHS) enable an individual with a disability, who so desires, to remain in and be supported in their family home and community. IHS is intended to support both the family member with a disability and to permit the rest of the family to live as much like other families as possible with the intent of preventing or delaying unwanted out of home placement. The eligible client must be living with their primary caregiver. IHS benefits the eligible client by supporting their primary caregiver in meeting the needs of the eligible client within their daily and community routines. Support is provided as physical or verbal assistance or prompts to: complete activities such as eating, drinking, toileting and physical functioning; improve and maintain mobility and physical functioning; maintain health and personal safety; carry out household chores and preparation of snacks and meals; communicate,

including use of assistive technology; make choices, show preference, and have opportunities for satisfying those interests; develop and maintain personal relationships; pursue interests and enhance competencies in play, pastimes and avocation; and aid involvement in family routines and participation in community experiences and activities.

IHS is available while the primary care is present or absent due to work or school. IHS is also available to provide the primary caregiver temporary relief from the demands of supporting their family member with a disability (Respite). The eligible client will be supported in the home in which they live or in the home of the relief care provider if the home is approved by the legal decision maker. IHS may also be provided on a part time or full time basis in the home of a relief care provider if the home meets the standards of a licensed foster care home.

Participants not eligible for Day Supports as they are receiving IEP services and not eligible for day care due to age (12 years of age or older) may receive enhanced non-facility based IHS with not more than two other participants. Enhanced In-Home support is designed to provide individualized after school and school break activities that support the participant's natural learning opportunities within their daily family home routines and opportunities for integration in their community with persons who are not disabled. This service does not take place in licensed facilities. The service is designed to offer the participant the opportunity to develop meaningful skills and community relationships with non-disabled individuals. Services are designed to promote maximum participation in community life while developing natural supports within integrated settings. This service enables the participant to increase or maintain their capacity for independence and develop social roles valued by non-disabled members of the community.

In Home Support also includes Family Care Option which is provided on a part time (was FCO I) or full time basis (was FCO II) in a family home that meets the standards of a licensed family or adult family foster care home. This service also focuses on close communication and coordination with families and the school system during the transition period.

Individuals providing IHS may not live in the same home as the eligible individual.

IHS supports will not be delivered in group residential settings.

Infant Development-Infant Development is a home-based, family focused service that provides information, support and training to assist families in maximizing their child's development. Early intervention professionals work with primary caregivers to identify and adapt natural learning opportunities that occur during daily family and community routines. Infant Development serves children birth to 3 years of age as they are not eligible for special education services available for children eligible for Part B-619 of IDEA offered through the North Dakota Department of Public Instruction.

- The Infant Development service delivery model is based on research showing that infants and toddlers do not learn in massed trials, but through natural learning opportunities that occur throughout the day.

Parenting Support-Parenting Support assists eligible consumers who are or will be parents in developing appropriate parenting skills. Individual and group training and support will be available. Parents will receive training that is individualized and focused on the health and welfare and developmental needs of their child. Close coordination will be maintained with informal supports and other formal supports. This service is not available if Residential Habilitation is authorized. If the eligible consumer (parent) does not have physical custody or visitation rights, they will not receive individualized child-focused training, but group training and support activities will be provided.

Transportation Costs for Financially Responsible Caregiver- Funds may be accessed to meet the excess transportation costs related to the participant's disability.

Transportation Costs for Financially Responsible Caregivers enable a family member with a disability, to remain in and be supported in their family home (i.e. the home of their primary caregiver), preventing or delaying unwanted out of home placement. Individual needs identified through the person centered planning process in the following areas could be addressed through the individual budget process if the service is not covered in the Medicaid State Plan: transportation expenses such as mileage, lodging, etc. incurred by family members related to accessing supports identified in the Person Centered Plan, lodging for the eligible client and/or accompanying caregiver will only be allowed when medically necessary or cost effective, the reimbursed amount will not exceed allowed state rates which for out of state travel are based on Federal Guidelines. In addition, lodging will not be reimbursed without a receipt.

Self-Directed Supports – the opportunity to direct a fixed amount of public resources in a flexible manner that is meaningful and helpful in achieving personally defined goals so the individual may remain in the family residence or in their own home including the following services.

Extended Services-Extended Services is ongoing on the job support and intervention necessary for an individual with a disability to maintain employment and for whom competitive employment at or above minimum wage is unlikely without the support and intervention. Support and intervention do not include normal employee orientation and training normally provided to all employees. Support and interventions include assuring health and safety, integration into the workplace, assistance with on the job interpersonal relations, and training and supervision beyond that normally provided by the employer. Transportation is not included as part of this support. The ongoing job support and intervention in this service does not include services available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142.

Current Programs Serving Persons with a Developmental Disability

Behavior Consultation -Behavior Consultation Services provide expertise, training and technical assistance to assist primary caregivers, in-home support staff and other

natural supports. Activities covered are: (1) Observing the participant to determine needs; (2) Assessing any current interventions for effectiveness; (3) Developing a written intervention plan; (4) Intervention plan will clearly delineate the interventions, activities and expected outcomes to be carried out by family members, support staff and natural supports; (5) Training of relevant persons to implement the specific interventions/support techniques delineated in the intervention plan and to observe, record data and monitor implementation of therapeutic interventions/support strategies; (6) Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan with revision of that plan as needed to assure progress toward achievement of outcomes; (7) Training and technical assistance to relevant persons to instruct them on the implementation of the participant's intervention plan; and/or (8) Participating in team meetings. Behavior Consultation excludes services provided through the Medicaid State Plan or the IEP.

Home Modifications- Home Modifications are physical modifications to a private residence that are necessary to ensure the health, welfare, and safety of the participant or to enhance the participant's level of independence. A private residence is a home owned by the participant or their family (natural, adoptive, or foster family). Items that are portable may be purchased for use by a participant who lives in a residence rented by the participant or his/her family. This service covers purchases, installation, maintenance, and as necessary, the inspection of installation activities and the repair of home modifications required to enable participants to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the participant.

Items that are not of direct or remedial benefit to the participant are excluded from this service. Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The waiver participant or his/her family must own any equipment that is repaired.

Covered Modifications are:

1. Ramps and Portable Ramps
2. Grab Bars
3. Handrails
4. Lifts, elevators, manual, or other electronic lifts, including portable lifts or lift systems that are used inside a participant's home
5. Porch stair lifts
6. Modifications and/or additions to bathroom facilities
 - a. Roll in shower
 - b. Sink modifications
 - c. Bathtub modifications/grab bars
 - d. Toilet modifications
 - e. Water faucet controls

7. Widening of doorways/hallways, turnaround space modifications for improved access and ease of mobility, excluding locks
8. Specialized accessibility/safety adaptations/additions
 - a. Electrical wiring
 - b. Fire/safety adaptations, including alarms
 - c. Shatterproof windows
 - d. Floor coverings for ease of ambulation
 - e. Modifications to meet egress regulations
 - f. Automatic door openers/doorbells
 - g. Voice activated, light activated, motor activated electronic devices to control the participants home environment
 - h. Medically necessary portable heating and/or cooling adaptation to be limited to one unit per participant
 - i. Stationary built in therapeutic tables

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Central air conditioning; plumbing; swimming pools; service and maintenance contracts and extended warranties are not covered. Equipment or supplies purchased for exclusive use at the school/home school are not covered. Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained.

Vehicle Modifications are devices, service or controls that enable participants to increase their independence or physical safety by enabling their safe transport in and around the community. The installation, repair, maintenance, of these items are included. The waiver participant or his/her family must own or lease the vehicle. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the adaptation in the event of an accident. Modifications do not include the cost of the vehicle or lease itself. There must be a written recommendation by an appropriate professional that the modification will meet the needs of the participant. All items must meet applicable standards of manufacture, design, and installation. Installation must be performed by the adaptive equipment manufacturer's authorized dealer according to the manufacturer's installation instructions, National Mobility Equipment Dealer's Association, Society of Automotive Engineers, National Highway and/or Traffic Safety Administration guidelines.

Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment.

Covered Modifications are:

1. Door modifications

2. Installation of raised roof or related alterations to existing raised roof system to increase head clearance
3. Lifting devices
4. Devices for securing wheelchairs or scooters
5. Handrails and grab bars
6. Seating modifications
7. Lowering of the floor of the vehicle
8. Safety/security modification

The cost of renting/leasing a vehicle with adaptations; service and maintenance contracts and extended warranties; and adaptations purchased for exclusive use at the school/home school are not covered.

Relatives constructing or installing items covered through this waiver service may not be living in the same home of the individual.

Equipment and Supplies -Funds may be accessed to meet the excess disability related expenses associated with maintaining an eligible consumer in their home. Equipment and Supplies enable an individual living with a primary caregiver, to remain in and be supported in their family home (i.e. the home of their primary caregiver), preventing or delaying unwanted out of home placement. Individual needs identified through the person centered planning process in the following areas could be addressed through the individual budget process if the service is not covered in the Medicaid State Plan: Examples of Equipment and Supplies not included in the Medicaid State Plan include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: 1) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant; 2) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants; 3) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; 4) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan; 5) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and 6) training or technical assistance for professionals or other

individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants; and (e) Personal Emergency Response System is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. Installation, upkeep and maintenance of devices/systems are provided.

Items reimbursed with waiver funds are in addition to any equipment and supplies furnished under the State plan and exclude those items that are not of direct benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

In-Home Supports- In-Home Supports (IHS) enable an individual with a disability, who so desires, to remain in and be supported in their family home and community. IHS is intended to support both the family member with a disability and to permit the rest of the family to live as much like other families as possible with the intent of preventing or delaying unwanted out of home placement. The eligible client must be living with their primary caregiver. IHS benefits the eligible client by supporting their primary caregiver in meeting the needs of the eligible client within their daily and community routines. Support is provided as physical or verbal assistance or prompts to: complete activities such as eating, drinking, toileting and physical functioning; improve and maintain mobility and physical functioning; maintain health and personal safety; carry out household chores and preparation of snacks and meals; communicate, including use of assistive technology; make choices, show preference, and have opportunities for satisfying those interests; develop and maintain personal relationships; pursue interests and enhance competencies in play, pastimes and avocation; and aid involvement in family routines and participation in community experiences and activities.

Indian Health Services is available while the primary care is present or absent due to work or school. IHS is also available to provide the primary caregiver temporary relief from the demands of supporting their family member with a disability (Respite). The eligible client will be supported in the home in which they live or in the home of the relief care provider if the home is approved by the legal decision maker.

Participants not eligible for Day Supports as they are receiving IEP services and not eligible for day care due to age (12 years of age or older) may receive enhanced non-facility based IHS with not more than two other participants. Enhanced In-Home support is designed to provide individualized after school and school break activities that support the participant's natural learning opportunities within their daily family home routines and opportunities for integration in their community with persons who are not disabled. This service does not take place in licensed facilities. The service is designed to offer the participant the opportunity to develop meaningful skills and community relationships with non-disabled individuals. Services are designed to promote maximum participation in community life while developing natural supports within integrated

settings. This service enables the participant to increase or maintain their capacity for independence and develop social roles valued by non-disabled members of the community.

Individuals providing IHS may not live in the same home as the eligible individual. IHS supports will not be delivered in group residential settings.

Transportation Costs for Financially Responsible Caregiver -Funds may be accessed to meet the excess transportation costs related to the participant's disability.

Transportation Costs for Financially Responsible Caregivers enable a family member with a disability, to remain in and be supported in their family home (i.e. the home of their primary caregiver), preventing or delaying unwanted out of home placement. Individual needs identified through the person centered planning process in the following areas could be addressed through the individual budget process if the service is not covered in the Medicaid State Plan: transportation expenses such as mileage, lodging, etc. incurred by family members related to accessing supports identified in the Person Centered Plan, Lodging for the eligible client and/or accompanying caregiver will only be allowed when medically necessary or cost effective, the reimbursed amount will not exceed allowed state rates, which for out of state travel are based on Federal Guidelines. In addition, lodging will not be reimbursed without a receipt.

Program Title and Summary:

- MR/DD Waiver which covers individuals of any age with mental retardation and/or developmental disabilities that would otherwise require the level of care provided in an intermediate care facility for mental retardation (ICF/ID), and meet ICF/ID Level of Care screening requirements. Fee For Service and Self Directed (ND Combined the traditional and self-directed waivers into one waiver).
- Medicaid State Plan-Personal Care (MSP-PC) provides personal care services to assists individuals to remain in their own homes or communities. Individuals must be Medicaid eligible, meet Level A criteria which included impairment in one ADL or impairment in 3 of the following 4 IADLs including meal preparation, laundry, taking medications and housework or Level B criteria which includes meeting Level A criteria and meeting NF LOC criteria. Fee For Service.

B.6 Money Follows the Person Services

Home and Community Based (Demonstration Services / Supplemental Services for Persons Transitioning from a Nursing Facility)

Nursing Facility Transition Coordination (Serving all population groups)

ND will provide the demonstration service of Nursing Facility Transition Coordination to individuals who reside in skilled nursing facilities. This service will provide needed supports to assist consumers with transition to a qualified residence of their choice prior to discharge and provide support services for one year following transition. This service will be offered statewide. Transition Coordination will be provided for up to 180 days prior to discharge as a demonstration service and all additional days as a supplemental service through discharge. Transition Coordination will be provided as a demonstration services for the term of eligibility post discharge.

The Transition Coordinator will educate potential MFP participants about the demonstration services available to assist with transition, secure consent for participation in services, provide MFP rights, appeal, and grant information, complete transition assessments, assist consumers to identify support service needs, communicate transition planning needs/issues during the discharge planning team process, assist consumers with the development of an Independent Living Plan, facilitate consumer preparation for transition, assure risk mitigation and 24 hour backup plans have been developed, and assure that all necessary arrangements have been made for successful transition.

The Transition Coordinator will provide consumer support for 365 days following transition to the community. The Independent Living Plan will be reviewed with the consumer within 45 days of transition to address any changing support needs of the consumer. The review of the Independent Living plan will include a review of the risk mitigation and 24 hour backup plans. Service delivery will be coordinated with the HCBS Case Manager involved with service delivery. Transition Coordinators will take the lead case management role during the 365 demonstration period. Visits will occur at a minimum of one time monthly for the first six months and every other month the second six months or more frequently as consumer need dictates.

Transition Coordination services will be provided by the four Centers for Independent Living serving ND including the Dakota Center for Independent Living of Bismarck; Independence Inc of Minot; Options Resource Center for Independent Living of East Grand Forks; and Freedom Resource Center of Fargo. A contract will be developed individually with each of the four Centers that will delineate the specific demonstration services to be provided for each MFP participant. The services will include outreach to all nursing facilities in their quadrant on a quarterly basis. Outreach services will include visiting resident councils, family councils, individual residents, and facility staff.

Alternative Post Transition Service Options

For MFP Participants that have needs that do not meet the comprehensive service package requirements in a 1915(c) waiver and their planning team has determined that their needs could be easily met through other similar state or county funded services or state plan services, MFP Transition Coordination Services will be offered as the primary qualifying MFP Service post transition. Transition Coordination would be provided for the entire 365 days of MFP Eligibility. The MFP participant would additionally qualify for onetime moving costs offered by the ND Transition Assistance Services that include (rent/utility deposits, furniture, household items, assistive technology, and home modifications).

The Transition Coordinator and the MFP participant would continue ongoing review of support needs and consider additional services through a waiver service if needed. A LOC determination would be conducted as needed to access waiver service if they were determined needed or would be completed around the 11th or 12th month after transition if waiver services were not needed. If the MFP participant's needs would increase during the demonstration period a waiver slot would be available.

The Transition Coordinator would work in cooperation with the Home and Community Based Waiver Case Managers located in each county to assist the MFP participant in arranging the necessary supports throughout the 365 days of MFP eligibility and with services post MFP eligible to assure continued successful community living and continuity of care to prevent re-institutionalization.

24 Hour on Call Nursing Service (Demonstration Service for all Money Follows the Person Participants)

To assure 24 hour backup to address health and welfare related needs of all MFP participants, ND will contract for a Nurse Call service. Consumers will be able to access the on-call Nursing Telephone Service 24 hours a day. The on-call Nurse will be able to assist the consumer by assessing crisis situations, contacting available service providers, and if needed will arrange for someone to go to the consumer's home to assess their situation and provide needed services.

The on-call Nursing Service Agency will initiate between 1 to 4 calls per month to do a health, welfare, and safety status review for each MFP consumer. Issues identified during these monthly calls will be determined by the consumer and their transition planning team. The Nurse Agency will contact the appropriate entity to address any identified issue for follow-up.

The consumer's Transition Coordinator or DD Program Manager will discuss this arrangement with the consumer during initial program application and again when the 24 hour back-up plan is developed. The consumer and their team will identify services in the community that will be able to address critical health and welfare needs on a 24

hour basis and provide this information to the on call nursing agency. The nursing agency will utilize this information during any call for services from the consumer. The consumer's primary mode of communication will be considered when developing the backup plan to assure access to the on call nursing service. The on call nursing service will not continue after the 365 days of MFP eligibility.

Transition Assistance: (MFP Demonstration Service for all MFP participants)

Transition assistance (previously titled Supplemental Services) is the one-time payment of community set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community. This service includes payments for the following:

- Health and safety technology (not otherwise covered by a HCBS Waiver service before transition)
- Security and utility deposits
- Home modifications(not otherwise covered by a HCBS Waiver service before transition)
- Adaptive equipment (not otherwise covered by a HCBS Waiver service before transition)
- Home/Apartment furnishings-linens, dishes, small appliances, furniture
- Assistive technology devices (not otherwise covered by a HCBS Waiver service before transition)
- One time modifications for a vehicle owned by the individual(not otherwise covered by a HCBS Waiver service before transition)
- Transition Coordination Services between Consent and 180 days pre-transition and for the term of MFP eligibility post discharge

Supplemental Transition Assistance: Supplemental Transition assistance is the one-time payment of community set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community not otherwise covered by North Dakota's MFP Demonstration Services or one of North Dakota's waiver services. Such services include but are not limited to moving expenses (costs related to moving personal belongs and transport of the consumer), payment of past due utility bills, etc.

Supplemental Transition Assistance will be provided to all MFP participants. These items or activities may include but are not limited to the following:

- Health and safety technology (not otherwise covered by a demonstration service)
- Security and utility deposits
- Home modifications (not otherwise covered by a demonstration service)
- Adaptive equipment (not otherwise covered by a demonstration service)
- Home/Apartment furnishings-linens, dishes, small appliances, furniture
- Assistive technology devices (not otherwise covered by a demonstration service)
- One time modifications for a vehicle owned by the individual(not otherwise covered by a demonstration service)
- Transition Coordination services provided pre-transition from day 181 to date of discharge.

Application Process for Transition Assistance or Supplemental Transition Assistance Services

The Transition Coordinator, DD Program Manager, or a support service provider will assist the consumer in making a request for payment of these items by submitting the Transition Assistance or Supplemental Transition Assistance Services Request Form (Attachment B.5-A) to the MFP Program Administrator for approval. Each MFP participant will have up to \$3,000 available to them to assist with transition costs. Requests for funds beyond the \$3,000 allotment will be handled on a case by case basis by the MFP Grant Program Administrator. Alternative funding sources, consumer need, and grant money availability will all be considered when additional Transition Assistance or Supplemental Transition Assistance Service funds request decision are made. An additional \$200 per MFP participant will be available for the Supplemental Transition Assistance Program with more available on a case by case basis as approved by the MFP Program Administrator.

The MFP Program Administrator will review and approve Transition Assistance and Supplemental Transition Assistance Services requests and return them to the person or agency that submitted the request. Once approved items can be purchased by the agency assisting the consumer. The agency will need to retain receipts for all items purchased and submit a MFP itemized Excel spreadsheet request for reimbursement to the MFP Program Administrator for payment approval. Centers for Independent Living will submit the request on the SFN along with their other expenses and copies of their

receipts. DD Providers will submit a MFP itemized Excel spreadsheet request for reimbursement detailing the amounts spent for each Service Category and all receipts.

Purchase limitations:

- The MFP Grant will not approve or reimburse for any type of gift cards or similar pre-purchased items. The Supplemental Funds must be used for specific items or activities so that the item purchased can be clearly identified.
- MFP will not approve more than \$300 for the purchase of a television unless medical documentation is provided that demonstrates the need for a larger amount.
- Transition Assistance or Supplemental Transition Services Items purchased for individuals that do not transition will need to be returned when that is possible.
- If the return of an item is not possible it can be retained and used for another MFP consumer. The agency should only request reimbursement for the purchase of that item when the new consumer transitions. In cases where an item cannot be returned or used by another consumer please submit as part of your normal reimbursement request and note that the item could not be returned and could not be used for another consumer.
- Transition Assistance or Supplemental Transition Assistance Service items purchased for an MFP Participant becomes the property of the MFP Participant upon their successful MFP Transition. The MFP participant is free to manage this property any way they see fit once the transition occurs.

Transition Adjustment Support-Demonstration Service

Transition Adjustment Support would be provided as a demonstration service. The services is to provide educational/supervisory assistance to individuals transitioning from nursing facilities to the community beyond the times that they receive either HCBS wavier or MSP-Personal Care services. The individual would receive assistance in relearning how to live on their own again. The Individual could receive this support service for all or part of the remainder of the 24 hours per day for a period not to exceed four months. The service would be targeted for individuals identified by their transition planning team as needing this level of support to successfully adjust to the demands of independent living. The service would be designed to decrease over time until terminated by the end of the four month period.

The service would be designed to meet the specific needs of the individual consumer including addressing need for behavioral health issues, supervision, need for staff at night etc.

A plan of decreasing adjustment assistance would need to be established and submitted to the MFP Program Administrator. The number of hours of service provided to any one individual would need to be negotiated with the MFP Grant Program Administrator on a case by case basis and approved by the Assistant Director of the Long Term Care Continuum.

Maximum Hours Available:

Days 1- 30: 14 Hours per Day
Days 31-60: 10 Hours per Day
Days 61-90: 6 Hours per Day
Days 91-120: 2 Hours per Day

Transition Coordinators will submit to the MFP Program Administrator an “Authorization to Provide MFP Transition Adjustment Support Services” outlining the services needed and the plan to decrease hours over the 120 day service period.

The Transition Coordinator will review the authorization with the consumer and the Qualified Service Provider and secure their signature. Copies of the signed authorization and the Transition Adjustment Support Billing worksheet will be provided to the Qualified Service Provider. Services will start only after the authorization has been signed by the Qualified Service Provider.

The Qualified Services Provider will record the number of hours that they have provided services and the tasks that they assisted the consumer with on the Billing Worksheet and submit these to the MFP Program Administrator on a monthly basis.

Rates/Billing

The service would be provided by a Qualified Services Provider (individual or agency) at the rate established for QSP services by the state of ND. It would be billed to the MFP Grant by the individual or agency provider that has been selected by the consumer to provide services.

Sample Request

Joe Johnson is requesting use of the MFP Transitional Adjustment Support Program. Jake would like some help from a QSP with: transportation; getting used to doing thing independently; cooking; housekeeping; transitioning back home; and a variety of other

tasks. Mr. Johnson would like help Monday, Wednesday, and Fridays. He is requesting 4 hours on each of those days for the first month, 3 hours per day for the second month, 2 hours per day for the third month, and 1 hour per day for the 4 month. These QSP hours should help Mr. Johnson transition back to independent living more safely and easily.

Services Requested:

- Assistance with getting involved with activities in the community.
- Assistance with learning the safest ways to load the dishwasher, laundry, cooking, and other housekeeping tasks.
- Assistance with learning the transit and bus system
- Assistance with unpacking items from her move
- Learning how to develop good shopping habits
- Learn skills on remembering appointments
- Assist in developing safest walking routes.
- Assist with learning how to develop safe bathing skills

Number of persons to be served:

Up to six persons are expected to need this level of support each year depending on the total number of nursing facility transitions.

Rates/Billing

The service would be provided by a Qualified Services Provider (individual or agency) at the rate established for QSP services by the state of ND. It would be billed to the MFP Grant by the individual or agency provider that has been selected by the consumer to provide services.

Costs:

This would be a MFP demonstration service and eligible for the increased FMAP. This would require state matching funds as other MFP demonstration services now require.

Money Follows the Person Eligibility

Participants will be eligible for demonstration services for a total of 365 days following transition from a qualified institution. Waiver services, State Plan Services, Service Payments for the Elderly and Disabled, and Expanded Service Payments for the Elderly and Disabled will be available on an ongoing basis following the demonstration contingent on the consumer meeting program eligibility requirements.

Qualified Home and Community Based Services to be Paid at the Enhanced FMAP Match Rate

HCBS Waiver

- Adult Day Care
- Adult Family Foster Care
- Case Management
- Chore Service
- Emergency Response System (Lifeline)
- Adult Residential
- Environmental Modification
- Homemaker Service -
- Non-Medical Transportation
- Respite Care
- Specialized Equipment
- Supported Employment Services
- Transitional Living
- Home Delivered Meals
- Extended Personal Care

Technology Dependent Waiver

- Attendant Care Service
- Case Management

Program of All-inclusive Care for the Elderly (PACE)

Medically Fragile Children Waiver

- In-Home Supports
- Institutional Respite
- Transportation
- Equipment and Supplies
- Individual and Family Counseling
- Nutrition Supplements
- Environmental Modifications

Childrens Hospice Waiver

- Case Management
- Skilled Nursing
- Hospice
- Palliative Care

- Respite
- Expressive Therapy
- Grief Counseling
- Equipment & Supplies

[North Dakota Traditional MRDD HCBS Waiver](#) April 01, 2009

<http://www.nd.gov/dhs/services/disabilities/docs/nd-traditional-mrdd-hcbs-waiver-apr01-2009.htm>

- Homemaker Services
- Adult Day Health Services
- Adult Family Foster Care
- Day Habilitation
- Residential Habilitation
- Extended Home Health Care
- In-Home Supports
- Equipment and Supplies
- Infant Development
- Behavior Consultation
- Parenting Support
- Extended Services
- Environmental Supports/Modifications
- Transportation Costs for Financially Responsible Caregiver

Medicaid State Plan Services that will be paid at the enhanced FMAP rate

- Personal Care Services (All Money Follows the Person participants)

HCBC demonstration services that will be paid at the enhanced FMAP match rate

- Nursing Facility Transition Coordination (Nursing Facility Transitions Only)

All Money Follows the Person Participants

- 24 Nurse Call Services (All Money Follows the Person participants)
- All services normally provided under one of the state's 1915c waiver programs
- Health and safety technology (not otherwise covered by a HCBS Waiver service before transition)
- Security and utility deposits

- Home modifications(not otherwise covered by a HCBS Waiver service before transition)
- Adaptive equipment (not otherwise covered by a HCBS Waiver service before transition)
- Home/Apartment furnishings-linens, dishes, small appliances, furniture
- Assistive technology devices (not otherwise covered by a HCBS Waiver service before transition)
- One time modifications for a vehicle owned by the individual(not otherwise covered by a HCBS Waiver service before transition)
- Transition Coordination Services between Consent and 180 days per-transition and for the term of MFP eligibility post discharge

Supplemental Demonstration services (for all Money Follows the Person Participants) include but are not limited to the following and will be paid at the regular FMAP rate

- Transition Coordination services provided pre-transition from day 181 to date of discharge
- Supplemental Transition Assistance: Other transition assistance is the one-time payment of community set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community not otherwise covered by North Dakota's MFP Transition Assistance Demonstration Services or one of North Dakota's waiver services. Such services include but are not limited to moving expenses (costs related to moving personal belongs and transport of the consumer), payment of past due utility bills, etc .

Money Follows the Person Demonstration (Waiver) Services Available by Money Follows the Person Population Group

Service	MR/DD	Elderly	Physical Disability
HCBS Waiver			
Adult Day Care		x	x
Adult Family Foster Care		x	x
Chore Service		x	x
Emergency Response System (Lifeline)		x	x
Adult Residential		x	x
Environmental Modification		x	x
Homemaker Service		x	x
Non-Medical Transportation		x	x
Respite Care		x	x
Specialized Equipment		x	x
Supported Employment Services		x	x
Transitional Care		x	x
Technology Dependent Waiver			
Attendant Care Service		x	x
Program of All-inclusive Care for the Elderly (PACE)		X	X
MR/DD Waiver			
Adult Day Health Services	x		
Day Habilitation Services	x		
Extended Services/Supported Employment	X		
Homemaker	X		
Residential Habilitation	X		
Extended Home Health Care	X		
Behavior Consultation	X		
Environmental Supports/Modifications	X		
Equipment and Supplies	X		
Infant Development	X		
Parenting Support	X		
Transpiration Costs for Financially Responsible Caregiver	X		
In-Home Supports	x		
Adult Family Foster Care	x		
Hospice Waiver			
Case Management	x		
Skilled Nursing			
Hospice			
Palliative Care			
Respite			
Expressive Therapy			
Grief Counseling			
Equipment & Supplies			
Medically Fragile Children Waiver			
In-Home Supports	x		X
Institutional Respite			
Transportation			
Equipment and Supplies			
Pediatric Specialty Service			
Individual and Family Counseling			
Nutrition Supplement			
Environmental Modifications			

North Dakota MFP and ND Medicaid Infrastructure Grant Integration

Assist MFP eligible individuals to consider employment during transition planning process.

Assist individuals of working age people who are transitioning through MFP with the development of an employment plan and/or a benefits planning analysis through the Work Incentive Planning and Assistance Program (WIPA). MFP will support the person through the transition process and for a year following transition to help them develop and implement the employment plan and /or access to benefits planning analysis as the individuals are interested.

MIG will support this effort by offering the following support:

This change would be supported through access to employment follow up services and trainings for people with disabilities and family members, transition coordinators, community rehabilitation service providers and vocational rehabilitation.

Rationale:

There is a need to make better connections to employment services--this project provides the resources/opportunity to tighten the weave of employment services through appropriate referral and subsequent follow along. Also, people need to understand the financial impact of employment on their benefits---work incentives information, provided through skilled benefits planners, can help share positive messages about employment and ensure people are able to make informed choices about work. Other states implementing the MFP have found that once people have transitioned to the community, they need something to do. Employment addresses this need by both 1) providing a meaningful way to occupy time and 2) offering an opportunity to connect with the community 3) Map out the transition process and find out where employment best fits into the transition. Some states who are successfully implementing this: Idaho. Share information about what goes into an employment plan and benefits planning analysis and how those processes can help a person progress toward working.

Educate Consumers about Employment Related Services

Incorporate educating consumers about work and work supports as part of MFP Public Education process.

MIG will support this effort as follows:

Implement educating people with disabilities and families regarding the importance of employment as part of the transition process. Provide training to working age adults who are transitioned or who are in the process of transitioning. Engage them in training to include: developing an employment plan, home and community based services in the work place, benefits planning and work incentives, Medicaid Buy-In (Workers with Disabilities Coverage), self-directed care, and employment supports. In addition, work could be done to help connect interested individuals with volunteer and mentoring opportunities. MIG can assist with finding ways to facilitate the connections between entities that already work to do these connections.

Rationale:

These efforts will help address the reality that transition means that you now have to think about WHAT THAT PERSON IS GOING TO DO ALL DAY. Developing work experience, soft skills, benefits planning training and services available, and making networking connections through volunteer/mentoring can help with this. In addition, educating the transition workers about the employment supports so that they can educate consumers will be a key component of this work.

Support for Home and Community Based Services (HCBS):

Capacity building for the direct care workforce including Qualified Service Providers (QSPs)

How MIG can support this effort:

MIG efforts can be utilized to support capacity building especially in rural areas, education, and training. This can help support the growth of the QSP Association of ND (QSPAND) and the use of the association to build QSP capacity in the state. The ND MIG can continue to maintain and expand the QSPAND and build its membership, hold state wide and regional meetings provide ongoing trainings for QSPs including: how to run your own business, QSP paperwork and billing, providing HCBS in the workplace, self-directed care, and provide access to other continuing education. Support for current QSPs and capacity building is vital to support the transitions into the community with available and quality HCBS. In addition, work could also be done to expand the use of the PAS Registry, the QSPAND website and the Realistic Job Preview for the QSPs.

Rationale:

The strength of the independent contractor QSP system is that consumers are able to hire a specific QSP to provide services, if they choose, rather than working with a group of providers from an agency. This provides a more self-directed atmosphere. In addition, in rural communities where agency outreach is limited, an independently contracted QSP living in the community can provide the needed services.

Transition at Termination of Money Follows the Person Eligibility

Participants will be eligible for demonstration services for a total of 365 days following transition from a qualified institution. 1915(c) Waiver services, State Plan Services, and other state services including Service Payments for the Elderly and Disabled and Expanded Service Payments for the Elderly and Disabled will be available on an ongoing basis following the demonstration contingent on the consumer meeting program eligibility requirements.

North Dakota has adequate waiver slot availability to serve all Money Follows the Person participants at the end of their 365 day Money Follows the Person eligibility period. There are no waiting lists for waiver slots at this time and no waiting list is anticipated at any time during the Money Follows the Person demonstration period.

Prior to discharge from Money Follows the Person demonstration services a level of care screening will be completed to assure waiver eligibility. The screening will be completed by the waiver service broker prior to Money Follows the Person eligibility termination. If a Money Follows the Person participant no longer meets nursing facility/ICF/ID level of care screening requirements other service programs will be offered to meet their needs based on eligibility. For persons that are elderly or with a physical disability these services will include the ND Service Payments to the Elderly and Disabled and Expanded Service Payments to the Elderly and Disabled, Older Americans Act Services, or Basic Care Services. For persons with a developmental disability these services will include Supported Living Arrangement services, ND Service Payments to the Elderly and Disabled and Expanded Service Payments to the Elderly and Disabled, and other generic community services.

Money Follows the Person participants will be issued a Notice of Denial or Termination notice by the Money Follows the Person Grant Program Administrator prior to the end of their demonstration participation period or if they are found not to meet the established Money Follows the Person eligibility criteria (See Attachment B.5-B)

Appeals

Level of Care Appeals Process

The individual or legal representative may appeal the Level of Care eligibility decision within 30 days of the date of this notification. If the request for a hearing is received by the appeals supervisor within 10 days from the date of this notice, the funding for services may continue until an appeal decision is reached. However, all costs for services received must be paid back if the appeal is upheld. The individual may represent him/herself in an appeal hearing or may use a legal counsel, relative, friend, or other spokesperson. The reason for the appeal must be submitted in writing to:

Appeals Supervisor
North Dakota Department of Human Services
600 East Boulevard Avenue
Bismarck, North Dakota 58505-0250

The Appeals Supervisor processes administrative appeals. North Dakotans who have been denied public assistance benefits or whose benefits are reduced, terminated, discontinued, or suspended may appeal a decision in certain circumstances. The office also processes other kinds of appeals including foster care and daycare licensing, child abuse and neglect assessments, nursing home transfers and discharges, and rate setting.

An individual dissatisfied with a decision made regarding services may appeal that decision to the Department of Human Services under the fair hearing rules set forth in N.D.A.C. [75-01-03-03](#). An individual must be informed of the right to appeal any actions by the case manager or the department that result in denial, suspension, reduction, discontinuance, or termination care services.

Closures, Denials, Terminations, and Reductions in Services Policy (HCBS Waiver or State Medicaid State Plan Services)

1. Closures

If a client (either new or current client) does not utilize the services authorized in the care plan within a 30-day period of time, the case should close and an [SFN 474](#), Closure/Transfer form, should be forwarded to HCBS Program Administration.

- If services were to be implemented within a few days after the 30th day, contact the HCBS Program Administrator for written approval.

County social service boards must notify HCBS Program Administration of HCBS closures using the [SFN 474](#), Closure/Transfer form, this includes all HCBS programs. The Notification is to be submitted within 3 days of closing the case.

10-day Notice Not Required

Either because the client has taken action that results in the termination of services or it is a change in benefits that is not appealable, a 10-day notice is not required. The county is required to inform the client of the action taken to close their case. The notice may be a letter stating the effective date of the closure and the specific reason.

Note: If the case closure is due to death and the County has factual information confirming the client's death, a letter is not required to be forwarded to the client's estate. The source of the information should be documented in the case file.

Any of the reasons below do not require a 10-day notice:

- a. County has factual information confirming the death of the client.
- b. The county has received in writing the client's decision to terminate services
- c. Client has been admitted to a basic care facility or nursing facility.
- d. Client's whereabouts are unknown.
- e. Special allowance granted for a specific period is terminated.
- f. State or federal government initiates a mass change which uniformly and similarly affects all similarly situated applicants, recipients, and households.
- g. Determined the client has moved from the area.

2. Denial/Termination Notice

The applicant/client must be informed in writing of the reason(s) for the denial/termination/Reduction. Complete [SFN 1647](#) or send a letter with all applicable information to the client or applicant.

The Notice of Denial/Termination/Reduction is dated the date of mailing. contact the HCBS Program Administrator to obtain the legal reference required at "as set forth . . ." The legal reference must be based on federal law, state law and/or administrative code; reliance on policy and procedures manual reference is not sufficient.

When the client is no longer eligible for the HCBS funding, the County must terminate services under this funding source. Even if services continue under another funding source, the client must be informed in writing of the reasons s/he is no longer eligible under this Service Chapter.

The client must be notified in writing at least 10 days (it may be more) prior to the date of terminating services **UNLESS** it is for one of the reasons stated in this section. The date entered on the line, the effective date field, is 10 calendar days from the date of mailing the Notice or the next working day if it is a Saturday, Sunday, or legal holiday.

The county may send a cover letter with the Notice identifying other public and/or private service providers or agencies that may be able to meet the denied/terminated applicant/client's needs.

3. Former SPED or Ex-SPED Clients

A former SPED or Expanded SPED Program recipient can be reinstated without going through the SPED or Expanded SPED Program Pool if services are re-established within two calendar months from the month of closure. However, the HCBS Case Manager must determine that the former client is still eligible and what the current service needs are.

For the SPED program, forward the SPED Program Pool Data form and the MMIS form [SFN 676](#) to HCBS Program Administration. The MMIS form should indicate the date the individual returned to services in the field “Medical Appr. Date”.

For the Ex-SPED program, forward the Ex-SPED Program Pool Data form and the MMIS form [SFN 677](#) to the HCBS Program Administration. The MMIS form should indicate the date the individual returned to services in the field “Medical Appr. Date”.

The Transfer to Another County section of [SFN 474](#) is to be used when an open case is transferred to another county. This section of the form is used when the client remains eligible for services but will not continue to reside in this county. Case information should be forwarded to the new county of physical residence.

For the Medicaid Waiver programs, in addition to submitting the [SFN 474](#), the case manager must also submit the [SFN 1288](#). In lieu of a closing date for Medicaid Waiver cases, the HCBS case manager must submit to Medical Services an end date for the level-of-care screening on the [SFN 1288](#) when services will no longer be provided to the client. Whether the case is closed due to death or by issuance of a termination notice, submit an “end date” for the level-of-care to Medical Services and a copy to HCBS Program Administration.

Submitting an “end date” is required in order for the Department to have accurate data when submitting federal reports. A change will automatically be made in the screening information when a client enters a nursing facility or swing-bed unit.

The Money Follows the Person Grant Program, within the ND Department of Human Services, shall deny or terminate MFP program services when such services to the client presents an immediate threat to the health or safety of the client, the provider of services, or others or when services that are available are not adequate to prevent a threat to the health or safety of the client, the provider of services, or others. Examples of health and safety threats include physical abuse of the provider by the client, client self-neglect, an unsafe living environment for the client, or contraindicated practices, like smoking while using oxygen.

The MFP Risk Mitigation and Risk Planning process is designed to address health or safety concerns prior to and after a transition from an institutional

setting. If during the risk mitigation and planning process the health and safety issues cannot be mitigated to the extent necessary to assure health and safety of the client, the provider of services, or others in the community or when services that are available are not adequate to prevent a threat to the health or safety of the client, the provider of services, or others

See Attachments:

Attachment B.5-A –Transition Assistance Request Form

Attachment B.5-B – Notice of Denial or Termination of Demonstration Services

B.6 Consumer Supports

MFP participants will have access to assistance and supports, including back-up systems and supports, and supplemental supports in addition to usual HCBC service package.

Access

Participants will have access to assistance and supports in a variety of ways. The means of access will vary depending upon whether the individual seeks and receives assistance and support for a transition from a nursing facility or from the Life Skills and Transition Center or a community ICF/ID facility. Individuals will primarily receive access and assistance through these four resources:

- Nursing Facility Transition Coordinators
- Home and Community Based Services Case Managers
- Developmental Disabilities Program Managers
- Life Skills and Transition Center Social Worker

Nursing Facility Transitions

Pre-Transition/Transition Services

The ND Department of Human Services will contract with the four Centers for Independent Living serving ND to provide Nursing Facility Transition Coordination. Transition Coordination services include the provision of both pre-transition and transition services. The Transition Coordinator will provide the supports needed to assist nursing facility consumers with their transition to the community. The Transition Coordinator will also assist consumers with application for Transition Adjustment services available for one time transition related costs. Transition Coordination services will also involve supporting consumer transitions for 365 days after their move from the nursing facility.

The four centers include the Dakota Center for Independent Living of Bismarck; Independence Inc of Minot; Options Resource Center for Independent Living of East Grand Forks; and Freedom Resource Center of Fargo. A contract has been developed individually with each of the four Centers that will delineate the specific demonstration services to be provided by the Center for each MFP participant.

Nurse Quality Assurance Services provides nursing input and review to the Centers for Independent Living as they transition individuals from the nursing facilities or other designated institutional settings to assure all health related aspects of services that will be needed in the community are addressed.

This is accomplished by a nurse quality assurance position visiting the individual planning to transition while still in the nursing facility to gather information concerning health related needs. The position also does a follow up visit in the home immediately after transition and a 3 month follow-up to assure all recommendations have been implemented in the individual's home following transition. This helps identify any additional needs that may have arisen.

Transition Coordinator Qualifications

Center for Independent Living staff (non-MFP funded positions.)

- Completion of a bachelor's degree in sociology, social services, social work, or field related to programmatic needs from an accredited university, plus at least one year of progressively responsible experience in programs related to assignment; or,
- High school graduation, or its equivalent, plus at least four years of progressively responsible experience in programs or services related to assignment; or,
- High school graduation, or its equivalent, plus any equivalent combination and training and experience that provides the required knowledge, skills, and abilities

Knowledge, Skills, and, Abilities Requirements

1. Must have good organizational, planning, communication, and interpersonal skills, and work well as the member of a team. Individuals must be able to exercise diplomacy, tact and good judgment.
2. Ability to perform assessments with each consumer and to interpret information and certify eligibility for programs and services available in the community and those being offered under the Money Follows the Person Grant (MFP).
3. Ability to use SAMS and other computer programs, as relevant to successful completion of MFP activities.
4. Exercise the consumer's right to privacy and adherence to HIPAA guidelines.
5. Observes and documents details relative to an individual's needs and preferences for services and service providers.
6. Demonstrates knowledge of and working experience with long-term care programs, policies and financing in North Dakota.

7. Demonstrates knowledge of and working experience with services for seniors and persons with disabilities.
8. Demonstrates skills sufficient to market services and community supports to interested individuals.
9. Have access to reliable transportation and be able to travel in assigned regional service area on frequent basis.
10. To support the objectives of the MFP Grant.

MFP Funded Nursing Facility Transition Coordinators Qualifications

Nursing Facility Transition Coordinator (ND Money Follows the Person) – Social Worker II (4212). Minimum qualifications require licensure as a Licensed Social Worker (LSW) by the ND Board of Social Work Examiners; and one year of professional human services work experience as a social worker, human relations counselor, developmental disabilities case manager, mental illness case manager, vocational rehabilitation counselor, activity therapist, addiction counselor, registered nurse, employment counselor, or a similar professional level position in the public or private sector.

Expectation, Duties, and Responsibilities

1. Must have good organizational, planning, communication, and interpersonal skills, and work well as the member of a team. Individuals must be able to exercise diplomacy, tact and good judgment.
2. Ability to perform assessments with each consumer and to interpret information and certify eligibility for programs and services available in the community and those being offered under the Money Follows the Person Grant (MFP).
3. Ability to use Social Assistance Management System (SAMS) and other computer programs, as relevant to successful completion of MFP activities.
4. Exercise the consumer's right to privacy and adherence to HIPAA guidelines.
5. Observes and documents details relative to an individual's needs and preferences for services and service providers.
6. Demonstrates knowledge of and working experience with long-term care programs, policies and financing in North Dakota.
7. Demonstrates knowledge of and working experience with services for seniors and persons with disabilities.
8. Demonstrates skills sufficient to market services and community supports to interested individuals.
9. Have access to reliable transportation and be able to travel in assigned regional service area on frequent basis.
10. To support the objectives of the MFP Grant.

Duties/Responsibilities

1. Establish and maintain cooperative working relationships with nursing facility staff, Home and Community Based Case Managers, Long-Term Care Ombudsmen, Protection and Advocacy Staff, other community health and social services agency staff, county Medicaid eligibility staff, and providers of medical and social supports and act as a liaison to these entities for MFP Grant participants.
2. Outcome measure: Respond to the MFP eligibility referral listing by providing MFP information to eligible consumers within one month of receipt. The listing will be sent by the MFP Program Administrator. Results of the contacts made must be entered on the MFP MDS referral reporting document (SFN 301) or a similar electronic version and returned to the MFP program Administrator within 2 months of the receipt of the eligibility referral listing.
3. Conduct initial interviews and secure consent for services with consumers and document in the consumer's SAMS file.
4. Must assure a Quality of Life Survey (QOL) is scheduled with the QOL vendor prior to transition and assist as needed with scheduling the eleven month QOL survey as needed by the vendor.
5. Provide MFP information to consumers as required in MFP Operational Protocol and Transition Process guidelines and document in the consumer's SAMS file.
6. Assess involvement of consumer's guardian, provide Guardianship Expectations information, and document activities in the consumer SAMS file.
7. Conduct MFP Transition assessment of consumer needs, resources, and supports and document in the SAMS system.
8. Assists the consumer and nursing facility discharge planning team to identify support needs and services
9. Assist consumer with the development of an Independent Living Plan (ILP) utilizing MFP ILP documents and retain in consumer file. Copy must be provided to the MFP Program Administrator.
10. Coordinate the development of a Risk Assessment and Risk Mitigation Plan. Copy must be provided to the MFP Program Administrator.
11. Coordinate the development of a 24 Hour Backup Plan. Copy must be provided to the MFP Program Administrator
12. Coordinate and make referrals to appropriate community resources.
13. Ensure resources the consumer will need (housing, transportation, personal assistance, etc.) are in place prior to transition from the nursing facility to the community.
14. Submit Supplemental Services Requests to MFP Grant Administrator for one time transition costs. Ensure that proper back-up documentation for expenditures is in place.
15. Coordinate the date of discharge from nursing facilities with the various programs and services in the community setting i.e. doctor, pharmacy, utilities etc.

16. Empower consumers to become his or her own advocate, and advocate on consumer's behalf when requested or necessary.
17. Assist consumer with paperwork, deadlines and record keeping.
18. Update ILP after transition to address ongoing supports needs in the community.
19. Update Risk Assessment/Mitigation Plan and 24 hour Back-up plan following all critical incident reports or similar significant changes.
20. Provide follow-up to consumer in their home on a monthly basis and as needed for first six months after transition and at least every two months the second six months after transition.
21. Assist consumers that have been re-institutionalized and/or disenrolled with a return to the community including updating transition assessment, Risk Assessment/Mitigation, 24 hour Back-up Plan and ILP as needed.
22. Coordinate termination of MFP Transition Coordination services with county HCBS Case Manager at the end of 365 days of eligibility.
23. Maintain accurate, comprehensive, and confidential case records in adherence with HIPAA guidelines.
24. Attend all in-services, trainings and meetings as requested by MFP Grant Program Administrator.
25. Maintain up-to-date knowledge of local, state, and federal guidelines and regulations relating to access services for persons with disabilities.
26. Conduct outreach or education as needed to nursing facilities or other agencies or organizations in service area.
27. Outcome Measure: Work in collaboration with the Nurse Quality Service entity to assure all recommendations made in regard to needed health care supports are obtained in a timely manner. Communication with the Nurse Quality Service will be essential and should be started prior to transition and continued on an ongoing basis for 3 months following transition.
28. Outcome Measure: Must do on-site outreach visits to all nursing facilities within the designated service quadrant on a quarterly basis. A quarterly report following the visits will be submitted to the MFP Program Administrator within 30 days of the end of the quarter. The report will include facilities contacted, activities included in the visits, and number of consumer visits within each facility. This outreach service which is done by current CIL staff will be reimbursed on a fifteen minute unit basis which will include travel time and time spent at the facility. The outreach activities assigned to the new CIL staff will be part of their monthly salary and will not be reimbursed by the unit rate.
29. The MFP grant emphasizes the health, welfare and safety quality assurance activities related to all MFP transitions including incident reporting, risk mitigation, and 24 hour back-up services. Transition coordinators will assure the completion of these activities and the other MFP quality assurance responsibilities as outlined in the MFP Operational Protocol and per contract scope of work expectations.
30. Outcome measures will be submitted to the MFP Program Administrator on a quarterly basis and also an annual report to assure all outcome measures have been met.

The provision of the above outlined services will be provided in accordance with the current Nursing Facility Transition Process Guidelines established by the MFP Nursing Facility Transitions Workgroup. These Process Guidelines may be adjusted and modified as needed by the Transition Workgroup.

Nurse Quality Assurance Service

Expectations, Duties, and Responsibilities

The expectation of the nurse quality assurance service is to work in conjunction with the transition coordination agency to identify the individual's health related service and support needs that will need to be addressed for successful transition to the community.

A nurse quality assurance provider:

- Works in collaboration with the transition coordinator
- Meets with the resident, complete an on-site review of the resident's medical records and consult with the nursing facility staff to gain insight concerning his/her health related support needs.
- Submits a report to the MFP Program Administrator and to the transition coordination agency which identifies the health related support needs of the individual and recommendations on how the needs will be met in the community. This should be accomplished at least 2 weeks, but no later than 7 days prior to transition.
- Within 14 days following transition, a follow-up visit is made to the individual's community home to determine if the recommended health related supports are in place and are they sufficiently meeting the needs of the individual. Are their additional health related supports which may be needed? Provide a summary of the visit to the MFP Program Administrator and to the transition coordination agency with any additional recommendations.
- Within 3 months, a second follow-up visit occurs to assure all health related supports are still in place and determine if any additional supports are needed.
- Will provide services to all individuals served by the transition coordinators service area.
- Will retain documentation of all initial visits to the nursing facilities and follow up home visits. A quarterly summary report of all quality assurance activities will be provided to the MFP Program Administrator.

Transition Coordinator to Participant Ratio

It is expected that the Transition Coordinator to Consumer Ratio will be ten to one during the demonstration period. The Coordinator will work in cooperation with nursing

facility discharge planning teams to complete the tasks necessary for successful transitions.

Home and Community Based Services Case Management

Home and Community Based Services Case Management Services are being provided by county social services agencies and approved agency and individual providers of case management.

HCBS Case Managers perform case management for the aged or disabled. Case managers specifically provide information and referral services as needed; intake and need assessment; develop and implement individualized care plans for consumers; develop comprehensive service plans. During the MFP demonstration period the HCBS Case Manager will work with nursing facility discharge planning teams and the Transition Coordinator to assure needed services for consumers transitioning into the community and post transition supports are continued. They will provide referral information to potential MFP candidates and facilitate contact with the Center for Independent Living in their area that provides Transition Coordination services.

Home and Community Based Services Case Manager Qualifications

The HCBS Case Manager Position requires licensure as a Licensed Social Worker (LSW) or LCSW by the North Dakota Board of Social Work Examiners (NDCC 43-41).

Home and Community Based Services Case Manager to Participant Ratio

It is expected that the HCBS Case Manager to participant ratio will be 60-70 to one for the demonstration period. HCBS Case Managers will work in cooperation with the NF Transition Coordinator and the nursing facility discharge planning teams to complete the tasks necessary for successful transitions.

Life Skills and Transition Center and Community ICF/ID Transitions

Pre-transition Services/Transition services

Developmental Disabilities Program Managers are employees of the ND Department of Human Services and operate from Human Service Centers located throughout the State of ND. These locations include Williston, Minot, Devils Lake, Grand Forks, Fargo, Jamestown, Bismarck, and Dickinson. Each region has a Developmental Disabilities Unit serving their designated area of the state. Program Managers are supervised

regionally by a DD Program Administrator with all services for persons with a developmental disability supported by Disability Services Division of the Program and Policy Office of the Department of Human Services.

Developmental Disabilities Program Managers in general are responsible for collecting data, assessing, organizing, coordinating, and evaluating professional services provided to persons with developmental disabilities and assisting them in gaining access to needed residential and day training, social, medical, educational, financial, protective and related services. Tasks included initial and on-going appraisal and assessment of consumer needs and their potential to achieve reasonable goals; collecting and maintaining pertinent data files on medical, psychological, social, and related program information. Organizes a team of concerned professionals and presents individual cases to the team and facilitates a service plan based on the needs of each consumer.

The DD Program Manager coordinates services to be provided to each consumer through continuous communication between consumer and service provider. This includes the tasks of negotiating reimbursement contracts with providers and evaluating client progress and services provided to insure satisfactory progress of service plan.

During the MFP demonstration period the DD Program Manager will continue in their role as service broker however will additionally manage the MFP specific transition responsibilities. These responsibilities will include the provision of MFP program and rights related information to consumers/family/legal decision makers, securing MFP consent to participate documents, facilitating completion of transition plans that include risk mitigation and 24 hour backup planning, assuring transitions to qualified residences, facilitating applications for supplemental support services for one time transition costs, and ongoing case management follow-up after transition.

DD Program Manager Qualifications

The DD Program Manager II position requires one year of experience as a Developmental Disabilities Program Manager I in the North Dakota Department of Human Services or meets the following North Dakota Department of Human Services definition of a Qualified Mental Retardation Professional (QMRP) is a person who has at least one year of direct care experience working with persons with a mental illness or developmental disability; is a doctor of medicine or has a bachelor's or master's degree in one of the following fields: social work, psychology, counseling, nursing, occupational therapy, physical therapy, child development and family science, communication disorders (includes audiology or speech pathology), severely multiply handicapped, special education, vocational, rehabilitation, sociology, elementary education, recreation therapy, or human resources administration and management (human service track). (Certification or licensure in one of the above fields is not required for a QMRP designation)."

Program Manager to Participant Ratio

The average caseload of the mental retardation-developmental disabilities case management unit must be no more than sixty clients per Program manager. DD Program Managers will work in cooperation with Life Skills and Transition Center discharge planning teams or with community ICF/ID discharge planning teams to complete the tasks necessary for successful transitions.

<http://www.legis.nd.gov/information/acdata/pdf/75-05-05.pdf>

Life Skills and Transition Center Social Worker

The ND Life Skills and Transition Center is a State owned and operated institution under the umbrella of the Department of Human Services. The Center provides services to persons with a developmental disability whose needs are beyond the scope of support services provided by community services providers.

General duties of the Life Skills and Transition Center Social Work are to work with the eight Regional Human Service Centers within North Dakota in the admission and discharge of individuals to and from the Life Skills and Transition Center. Also coordinate the Life Skills and Transition Center's outreach services to support people in maintaining their homes in their community. Serves as the contact person for guardians/families, teams and people served regarding information about community placement options, services provided at the Life Skills and Transition Center, and surrogate decision making (guardianship) support and/or options.

The Center social worker will be the primary access or contact person for MFP demonstration services, support services, general information, eligibility, support planning, and consent documentation prior to a participants transition to a community provider.

Social Worker Qualifications

This position requires a Bachelors of Social Work and licensure as a Licensed Social Worker (LSW) by the North Dakota Board of Social Work Examiners (NDCC 43-41).

Social Worker to Participant Ratio

It is expected that the Social Worker to participant ratio will be 30 to one for the demonstration period. The Center Social Worker will work in cooperation with DD Case managers, Center discharge planning teams, and with community provider teams to complete the tasks necessary for successful transitions.

Additional Access

In addition to the four primary means of access, consumers may receive access through the MFP Grant Program Administrator, nursing facility social services professionals, ND Protection and Advocacy Staff, Long Term Care Ombudsmen, and the Aging and Disabilities Resource Link.

Access may arise also through identification or referral from a variety of existing providers and resources including institutions and facilities such as hospitals, acute rehabilitation facilities, nursing facilities, assisted living facilities as well as through a variety of medical, DD, behavioral health, mental health and elderly care providers. These include Human Service Centers, medical providers, public and private agencies, private providers, home health care agencies, Qualified Service Providers, and Adult Day Programs.

24-Hour Emergency Back-Up Supports

The North Dakota Money Follows the Person Grant provides participant protection through the use of the statewide emergency backup system. This system will provide emergency response and backup in the event the consumer's own critical backup plans fail to ensure services and supports necessary to the consumer's health and safety. The primary emergencies likely to be faced by consumers are the failure of care providers to report for work, falls with injury, significant health changes, and extreme weather related situations. To maximize consumer choice and the principles of self-determination, consumers will select the providers of their choice for the emergency backup plan.

The levels of emergency backup provisions presented below, while providing necessary services, still reflect the philosophy of consumer choice. While adding additional layers of protection for the participants, it allows the consumer to select the plans that best fit his/her needs.

Hierarchy of Emergency Backup

The Money Follows the Person program will address the consumer's health and safety in the event of an emergency by the following hierarchy of backup protections. The levels vary by degree of emergency need. Generally a consumer will access these levels of backup in order, starting with Level 1. In case of extreme emergency, they may need to go directly to Level 3.

Level 1: Consumer Developed Emergency Backup Plans

Consumer's emergency backups for critical services will be incorporated into the Independent Living Plan/Individual Service Plan. The plan may include an informal network of family and friends, enrolled Medicaid provider agencies, Emergency Response Systems, alternative Qualified Services Providers, Center for Independent Living Staff, County Case Managers, Community Providers of services to persons with a developmental disability, or other area service providers.

Level 1: Consumer Developed Emergency Backup Plans

The Money Follows the Person Grant program requires each consumer to include an emergency backup plan within his or her Independent Living Plan/Individual Service Plan. The emergency backup plan must identify specific arrangements necessary to provide critical services, transportation, or repair or replacement of equipment, and to maintain the health and safety of the consumer in the event of a breakdown in the routine plan of care. For the consumer, a critical service is one without which the participant would suffer an immediate risk to their health, safety, or well-being.

The plan provides a section devoted to the emergency backup planning. This page will include a description of each critical service. The plan must be detailed, realistic, and updated to keep pace with changes in the individual's Independent Living/Service plan. Transition Coordinators/ Developmental Disabilities Case Managers/ Life Skills and Transition Center Staff will work with consumers, their families, and area services provides to develop this plan. The plan may include an informal network of family, friends and neighbors, enrolled Medicaid provider agencies such as a home health, Emergency Response Systems, alternative Qualified Services Providers, Center for Independent Living Staff, County Case Managers, Community Providers of services to persons with a developmental disability, or other area service providers. The backup plan will be reviewed and/or updated after transition by the Transition Coordinator/DD Case Manager and/or consumer planning team after all critical incidents, during all team meetings, and no less than one time every six months. Changes to the plan will be communicated to the nursing call agency.

The consumer and planning team will prepare the contact information needed by the 24 hour nurse call service staff to provide necessary back up services.

Consumers may reach out to their network of family, friends, and neighbors to provide interim supports. Most consumers already rely on family and friends to provide some care giving and personal care services, and in the event of an emergency, these individuals may be able to provide additional care in the absence of the paid caregivers.

Level 2: 24 Hour Nurse Call Service

Consumers may access the Money Follows the Person Grant 24 hour on-call Nursing Telephone Service. The on-call Nurse will be able to assist the consumer by assessing crisis situation, contacting available service providers, and if needed will arrange for someone to go to the consumer's home to assess the situation and provide needed services. The consumer's Transition Coordinator or DD Case Manager will discuss this arrangement with the consumer during initial program application and again when the 24 hour back-up plan is developed

Level 2: 24 Hour Nurse Call Service

Consumers may access the Money Follows the Person Grant 24 hour on-call Nursing Telephone Service. The on-call Nurse will be able to assist the consumer by assessing crisis situation, contacting available service providers, and if needed will arrange for someone to go to the consumer's home to assess the situation and provide needed services. The consumer's Transition Coordinator or DD Case Manager will discuss this arrangement with the consumer during initial program application and again when the 24 hour back-up plan is developed. The consumer and their team will identify services in the community that will be able to address critical health and welfare needs on a 24 hour basis and provide this information to the on call nursing agency. The nursing agency will utilize this information during any call for services from the consumer.

Level 3: Extreme emergency

These levels are described in greater detail below:

Level 3: Extreme Emergency Backup

Beyond the above-required emergency backup plans, and in the event of an extreme emergency, the following services can be utilized.

Adult and Child Protective Services

In an emergency situation where there is possible abuse, neglect, and/or exploitation, or criminal activity the local police will be called. The case will be referred to Adult or Child Protective Services for an investigation until a safe resolution for the consumer is made. In cases where a consumer is in immediate jeopardy, Protective Services investigators and caseworkers will work to arrange for providers that can provide safe

placement for consumers. These services may include providers such as nursing facilities, foster care homes, alternative DD Provider Agencies.

The Transition Coordinator or the DD case manager will provide information and telephone numbers to consumers and their families for Adult Protective Services, ND Protection and Advocacy, and Child Protective Services upon enrollment. In addition, Protective Services will investigate reports by any citizen that suspects abuse or neglect.

Division of Emergency Management

In the event of natural or man-made disasters, the North Dakota Division of Emergency Management coordinates disaster relief through North Dakota County Emergency Management Agencies. These regional offices in turn coordinate with community-wide organizations in the event of a disaster. Each state agency has in place contingency plans for their particular constituency in the event of fire, tornado, flooding, or terrorism. These plans include assisting individuals with disabilities with evacuation and/or continuity of critical services.

Emergency 911 Services

All Money Follows the Person consumers are advised to call the emergency telephone number 911 in the event of a crisis where health or safety is in immediate jeopardy.

24 Hour Nurse Call Service Oversight

ND-contracts with a 24 hour Nurse Call service to provide the backup services for MFP participants during their demonstration period. A contract has been developed that outlines the requirement to track number and types of calls received for services, call response times, and consumer outcomes. Daily, weekly, quarterly, and yearly reporting of utilization will also be expected of the call service. Consumers will be provided with the back-up nursing service agency name, phone numbers, and contact names in MFP participant/ consumer information materials.

The MFP Grant Program Administrator will monitor call response frequency, quality of response, and viability of consumer backup plans as part of the MFP quality assurance process. This will include review of the call system quality with the MFP Quality workgroup, and the Stakeholder Committee. Concerns identified related to the 24 hour backup plans will be communicated to the Transition Coordinator or DD Case Manager for review and follow-up.

Access to Appeals and Protective Services

If a participant in the MFP demonstration services has a complaint or concern about services received every effort will be made to deal with the issue on an informal basis or with a referral to an advocacy group such as the ND Protection and Advocacy Office or Ombudsman's Office. If however the complaint cannot be resolved the MFP participant will be referred to the ND Department of Human Services Appeals Supervisor to address the complaint through the administrative appeals process.

The Appeals Supervisor processes administrative appeals. North Dakotans who have been denied public assistance benefits or whose benefits are reduced, terminated, discontinued, or suspended may appeal a decision in certain circumstances. The office also processes other kinds of appeals including foster care and daycare licensing, child abuse and neglect assessments, nursing home transfers and discharges, and rate setting. Contact Information:

Appeals Supervisor, Legal Advisory Unit, N.D. Department of Human Services, 600 E Boulevard Avenue, Dept. 325, Bismarck, ND 58505-0250; Phone: (701) 328-2311, Toll Free: (800) 472-2622 TTY: (701) 328-3480, dhs1au@nd.gov

An individual dissatisfied with a decision made regarding services may appeal that decision to the Department of Human Services under the fair hearing rules set forth in N.D.A.C. [75-01-03-03](#). An individual must be informed of the right to appeal any actions by the case manager or the department that result in denial, suspension, reduction, discontinuance, or termination of care services.

75-01-03-03. Fair hearing - Who may receive.

1. An opportunity for a fair hearing is available to any applicant for or recipient of food stamps; aid to families with dependent children; job opportunities and basic skills training program; employment, education, or training-related child care; transitional child care; Medicaid; children's health insurance program; or low income home energy assistance program benefits who requests a hearing in the manner set forth in this chapter and who is dissatisfied
 - a. Because an application was denied or not acted upon with reasonable promptness; or
 - b. Because county agency or department action has resulted in the suspension, reduction, discontinuance, or termination of benefits
2. An opportunity for a fair hearing is available to any resident who believes a facility has erroneously determined that the resident must be transferred or discharged.
3. An opportunity for a fair hearing is available to any individual who requests it because the individual believes the department has made an erroneous

determination with regard to the preadmission and annual review requirements of 42 U.S.C. 1396r(e)(7).

4. The department may, on its own motion, review individual cases and make determinations binding upon a county agency. An applicant or recipient aggrieved by such determination shall upon request be afforded the opportunity for a fair hearing. All references in this chapter to appeals from decisions of county agencies must be understood to include appeals taken from determinations made by the department.
5. A fair hearing request may be denied or dismissed when the sole issue is one of state or federal law requiring automatic benefit adjustments for classes of recipients unless the reason for an individual appeal is incorrect benefit computation.
6. The claimant may first seek corrective action from the department or claimant's county agency before filing a request for a fair hearing.
7. If a claimant dies after a request for a fair hearing has been filed by the claimant, and before the decision of the department has been rendered in the case, the proceedings may be continued on behalf of the claimant's estate, or any successor, as that term is defined in North Dakota Century Code section 30.1-01-06, of the claimant if a representative of the estate has been appointed.
8. If a dissatisfied claimant dies before the claimant can file a request for a fair hearing, the duly appointed representative of the claimant's estate, or any successor, as that term is defined in North Dakota Century Code section 30.1-01-06, of the claimant if no representative of the estate has been appointed, may file such request when the claimant was dissatisfied with the denial of the claimant's application for assistance, or was dissatisfied with the benefits the claimant was receiving prior to the claimant's death.
9. A fair hearing under this section is available only if:
 - a. Federal law or regulation requires that a fair hearing be provided; and
 - b. The dissatisfied claimant timely perfects an appeal.

The ND MFP Rights document (Attachment B.2-B) has contact information for all of the agencies that will assist participants with appeals or protective service interventions. The contacts are listed below to provide an overview of all of the agencies and services available to meet the needs of MFP participants. The following sections outline the services available and the populations that they serve.

Client Assistance Program

The North Dakota Client Assistance Program (CAP) works with people who have applied for or are receiving services under the Rehabilitation Act. Its mission is to resolve issues or concerns individuals may have as they work with the agencies or programs that provide these services. In North Dakota the agencies and programs include:

- Centers for Independent Living
- Vocational Rehabilitation
- Tribal Vocational Rehabilitation

The Centers for Independent Living offer the Client Assistance Program to address complaints related to the services that are provided by their agencies other than MFP Transition Coordination services

The CAP also provides information about the employment regulations pertaining to the Americans with Disabilities Act (ADA). <http://www.nd.gov/cap/>

The Protection & Advocacy Project

The Protection & Advocacy Project (P&A) is a state agency whose purpose is to advocate for, and protect the legal rights of people with disabilities.

<http://ndpanda.org/>

P&A has seven different advocacy programs that serve individuals with disabilities:

1. Developmental Disabilities Advocacy Program;
2. Mental Health Advocacy Program;
3. Protection and Advocacy Project for Individual Rights;
4. Protection and Advocacy for Beneficiaries of Social Security;
5. Assistive Technology Advocacy Program.
6. Help America to Vote Program(HAVA)
7. Protection and Advocacy for Individuals with Traumatic Brain Injury

Protection & Advocacy Project Office address:

Wells Fargo Bank Building, 400 East Broadway, Suite 409
Bismarck, ND 58501-4071; Phone: 701-239-7222, Fax: 701-239-7224
panda@nd.us

Vulnerable Adult Protective Services

A vulnerable adult is any person older than age 18, or emancipated by marriage that has a substantial mental or functional impairment.

Reporting

N.D. Century Code (ND State Law) states that any person who reasonably believes that a vulnerable adult has been subjected to abuse or neglect or observes conditions or circumstances that reasonably would result in abuse or neglect may report the information to the department or to an appropriate law enforcement agency. In addition a consumer has the ability to self-report any abuse that they have experienced from a care giver at any time. The Transition Coordinator will provide education to all persons transitioned about the need to report abuse or neglect by a caregiver. The Transition Coordinator will continue to monitor service delivery including how the consumer is being treated by their caregivers.

Under the law, the N.D. Department of Human Service has the right to assess and to provide or arrange the provision of adult protective services, if the vulnerable adult consents and accepts the services. May pursue administrative, legal, or other remedies authorized by law, which are necessary and appropriate to protect a vulnerable adult who cannot give consent, and to prevent further abuse or neglect.

Seeking Services or Reporting Suspected Abuse or Neglect

To contact a vulnerable adult protective service worker in your area please contact your [Regional Human Service Center](#).

Human Service Center Contact Information:

Bismarck – 701-328-8888 or 888-328-2662
Devils Lake – 701-665-2200 or 888-607-8610
Dickinson – 701-227-7500 or 888-227-7525
Fargo – 701-298-4500 or 888-342-4900
Grand Forks – 701-795-3000 or 888-256-6742
Jamestown – 701-253-6300 or 800-260-1310
Minot – 701-857-8500 or 888-470-6968
Williston – 701-774-4600 or 800-231-7724

Another Resource:

Aging and Disabilities Resource Link
<https://carechoice.nd.assistguide.net/>

N.D. Department of Human Services

Aging Services Division
600 E Boulevard, Department 325
Bismarck N.D. 58505-0250
Phone: 701-328-4601 TTY: 701-328-3480
www.nd.gov/humanservices

Reporting Suspected Child Abuse or Neglect

A person mandated to report, or any person wanting to report suspected child abuse or neglect, should contact the [County Social Service Office](#) in the county where the child is. Each of the 53 County Social Service Offices serve as the N.D. Department of Human Services' designee for child protection services.

- Reports of suspected child abuse or neglect may be made verbally or in writing;
- If requested by the county social service office, a verbal report must be followed by a written report;

The state's reporting form, [SFN 960](#), is available at county social service office or online.

Institutional Child Protection Services

Institutional child abuse and neglect is defined by North Dakota Century Code [50-25.1-02](#) as, "situations of known or suspected child abuse or neglect where the person responsible for the child's welfare is an employee of a residential child care facility, a treatment or care center for mentally retarded, a public or private residential educational facility, a maternity home, or any residential facility owned or managed by the state or a political subdivision of the state."

When a child is suspected of being abused under circumstances that fit within this definition, the suspicion of possible child abuse or neglect can be reported to the regional supervisor of child protection services at the [Regional Human Service Center](#) in the region where the facility is located. Certain professionals are required by law to make reports whenever child abuse or neglect is suspected. ([State Form Number 960](#) may be used to make a report of suspected institutional child abuse or neglect).

Long Term Care Ombudsman Program

- Receives, investigates, and works to resolve concerns affecting residents
- Answers questions and provides information and referral services
- Promotes resident, family, and community involvement in long-term care facilities
- Promotes community education about long-term care issues

- Coordinates efforts with other agencies and organizations
- Identifies issues and problem areas, and recommends needed changes

The Ombudsman Program Serves:

- Residents of nursing facilities, assisted living facilities, basic care homes, and hospital swing bed, transitional and sub-acute settings
- Families and friends of residents
- The general public
- Employees and administrators of long-term care facilities
- Various regulatory, certification, and other agencies

Services are provided by long term care ombudsmen at the [Regional Human Service Centers](#) and by volunteer community ombudsmen who are trained by the department and who volunteer their time to serve residents of long-term care facilities. See [Fact Sheet](#) (52kb pdf).

Volunteer Community Ombudsmen

- Are recruited and trained by the Department of Human Services and are assigned to serve at long-term care facilities in their local communities
- Listen to residents' concerns, help protect resident's rights, and assure that residents receive fair treatment
- Provide long-term care residents with information about their rights and community resources

B.7 Self-Direction

Nursing Facility Transitions

Individuals included in the demonstration will be provided services primarily through an approved Section 1915(c) Home and Community Based Services waiver system and providers. During the time a consumer participates in the MFP grant process these will be MFP demonstration services paid for with MFP grant dollars and not waiver services. An assurance within this system is that consumers are provided with a choice of MFP Demonstration services or institutional services. By electing to receive HCBS waiver services, the individual is provided a choice of available providers. In most situations, individuals will receive MFP Demonstration HCBS services while residing in a leased apartment setting. The state assures that participants will have a choice in selecting their community residence, since the consumer/family member or legal decision maker

is the lessee, they cannot reside in that setting unless willingly entering into a legal lease arrangement.

The state assures that all Medicaid eligible individuals and/or their authorized representatives that reside in a nursing facility and have expressed a preference to return to the community will be informed of the demonstration project and will be given the opportunity to communicate their choice to participate in the MFP Demonstration.

North Dakota has an established system whereby an individual is assisted by a case manager in identifying service needs and then allowing the individual to choose or recruit a Qualified Service Provider (QSP), to provide for those identified needs. QSPs are individuals or agencies enrolled by the state as independent contractors to provide a myriad of services that individuals need. Individuals have the opportunity to self-direct care by selecting QSPs already enrolled or encouraging caregivers to enroll. County Social Service agencies are provided with a list of QSPs by the Department of Human Services on a monthly basis. The county case managers provide consumers with a list of available QSPs in their area. The consumer can select the QSPs that they wish to work with and/or recruit additional persons to serve as a QSP.

North Dakota has an established system that allows both individual persons and agencies to enroll with the Department of Human Services as Qualified Service Providers (QSPs) to provide home and community based services. The process is competency based with the competency verified by a health care professional, or the individual or agency can provide evidence or documentation of the ability to provide a specific service. The ability to enroll providers, based on competency to provide a service, allows an individual to recruit a person or agency of their choice and encourage that person or agency to seek enrollment as a QSP.

Person Centered Planning

The development of Independent Living Plans for all transitions from a nursing facility will be based on the guiding principles of consumer and family involvement and consumer choice and control. Independent Living Planning will be a personalized, interactive and ongoing process to plan, develop, review, and evaluate the services in accordance with the preferences and desired outcomes of the consumer. A written Independent Living Plan will be developed for each consumer utilizing a person-centered planning process that reflects the needs and preferences of the consumer.

This is a process that is designed to empower the consumer to the extent possible within the current service delivery system. Consumers will be assisted in learning how to choose QSPs and schedule them in the ways that best meet the consumer's schedule and needs. While budget choice currently is not offered, the consumer is made aware of the services approved and the time allotted by the case manager to meet those needs so that they can develop their own plan for care delivery.

North Dakota Life Skills and Transition Center and Community Based Intermediate Care Facilities for Individuals with a an Intellectual Disability Transitions

For Medicaid eligible individuals residing in ICF/IDs, the service and community preferences of the person, and/or their authorized representative, help guide the priority for discharge planning from the Life Skills and Transition Center (DC) and are recorded in the Residential Decision Profile as: 1) clearly wants to leave DC to live elsewhere now/soon; 2) generally appears to want to leave DC, but the decision may not be firm because it varies, is not completely clear, or there are some reservations; 3) unclear which way the person prefers; 4) generally appears to want to stay at DC, but the decision may not be firm because it varies, is not completely clear, or there are some reservations; or 5) clearly wants to stay at DC.

The state assures an individual will be informed of alternatives services available through the demonstration project and that each individual is offered choices of services and community residences. These choices must be agreed to by the individual in the individual's transition plan which identifies the demonstration services to be furnished, the individual's choice of providers, informal supports, and type of residence.

All individuals receiving services in community ICF/IDs are assigned a case manager from the regional Human Service Center to authorize and monitor services. This function includes ensuring individuals have choice between ICF/ID and MFP demonstration services and of the least restrictive service setting that will meet their needs.

North Dakota's Developmental Disabilities Waiver provides service options for individuals living with primary caregivers. The goal of the waiver is to provide a consumer-centered service delivery system assuring health and welfare, participant rights and safeguards and financial accountability for In-Home Support, Environmental Supports/Modifications, Material and Supplies, Extended Services, Behavior Consultation and support for Transportation Costs for Financially Responsible Caregivers in order to maintain individuals in their community.

Person Centered Planning

The development of individual plans of care/Service/Support Plans will be based on the guiding principles of individual and family involvement and consumer choice and control. Service planning/Support Planning will be a personalized, interactive and ongoing process to plan, develop, review and evaluate the services in accordance with the preferences and desired outcomes of the individual/family.

A written plan of care will be developed for each individual utilizing a family or person-centered planning process that reflects the needs and preferences of the individual and their family.

Family or person-centered planning is a process, directed by the family or the individual with long-term care needs, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual. The family or individual directs the family or person-centered planning process. The process includes participants freely chosen by the family or individual who are able to serve as important contributors. The family or person-centered planning process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve personally-defined outcomes in the most inclusive community setting. The individual identifies planning goals to achieve these personal outcomes in collaboration with those that the individual has identified, including medical and professional staff.

All services will be furnished pursuant to a written plan of care. This plan of care will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and the type of provider who will furnish each. The plan of care will address how potential emergency needs of the individual will be met. The plan of care is subject to the approval of the Medicaid Agency.

Self Direction

North Dakota's Developmental Disabilities Waiver provides service options for a individuals living with primary caregivers. The goal of the waiver is to provide a consumer-centered service delivery system assuring health and welfare, participant rights and safeguards and financial accountability for In-Home Support, Environmental Supports/Modifications, Material and Supplies, Extended Services, Behavior Consultation and support for Transportation Costs for Financially Responsible Caregivers in order to maintain individuals in their community.

<http://www.nd.gov/dhs/services/disabilities/docs/nd-self-directed-supports-waiver-apr01-2009.htm>

<http://www.nd.gov/dhs/services/disabilities/docs/nd-sds-for-families-i-w-application-2006-01.pdf>

<http://www.nd.gov/dhs/services/disabilities/docs/nd-sds-for-adults-i-w-application-2006-01.pdf>

Fiscal Agent

The Fiscal agent, ACUMEN, assists the family or individual to manage and distribute funds contained in the individual budget including, but not limited to, the facilitation of the employment of service workers by the family or individual, including Federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports.

Self Directed In-Home Support

The hourly rate used to determine the individual budget amount for Self Directed In-Home Supports cannot exceed a maximum hourly rate established by the Department of Human Services. Although a standard hourly rate will be used to determine the budget amount for Self Directed In-Home Supports, the consumer will have the flexibility to negotiate the rate at which they will compensate their selected providers. The individual budget dollar amounts for Disability Related Supports will be calculated based on excess expense estimates agreed upon by the family and Support Broker, but the family will also have the flexibility to negotiate the rate at which they will compensate their selected providers.

If the individuals documented needs exceed service utilization limits, the DD Program Manager/Support Broker may request an exception from the Disabilities Services Division (DD Unit) of the ND Department of Human Services.

To ensure consistency, Individual budgets are entered in a Lotus Notes Database. Through a workflow and approval process, the database tracks the individual budgets from the DD Program Manager/Support Broker, through the Regional DD Program Administrator, to the state level central office administrator. Edits are built into the database to prevent errors. The database also calculates total funds authorized and tracks areas in which funds are allocated. At the end of a budget period the database is updated to reflect actual funds expended.

Self Directed Support Authorizations/Individual Budgets will contain information regarding the consumer/legal guardian's rights if supports are suspended, terminated or reduced.

B.8 Quality

North Dakota Home and Community Based Services Quality Assurance Overview

The state has a quality assurance system that identifies key components, practices, and utilizes the quality framework methodology. Within this working document the following assurances will be addressed, Level of Care Determination, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability.

The State's quality management system is the framework for North Dakota's Home and Community Based Waivers. North Dakota HCBS Waiver for HCBC Services ND .0273, North Dakota Technology Dependent Waiver ND 02.00.00, and Medically Fragile Children Waiver ND 0568, Children's Hospice Waiver 0834, have an approved Appendix H: Quality Management Strategy.

ND also has one waiver that serves individuals with an intellectual or related disability.

The Money Follows the Person core team includes DD Division state office staff, the Medical Services HCBS Program Administrators, DHS fiscal staff, and the MFP Grant Program Administrator. The MFP Program Administrator has overall responsibility for Quality assurance planning for individuals transitioning to the community from Nursing Facilities and ICF/ID and utilizing services through the MFP grant.

The HCBS Quality Management team for Medicaid Waiver HCBS, Technology Dependent Waiver, Service Payments for the Elderly and Disabled (SPED), Expanded SPED, and Medicaid State Plan Personal Care include the Assistant Medical Services Director responsible for the Long Term Care Continuum, who has overall responsibility for the team, five Human Service Program Administrators. One program administrator is responsible to administrate policy and procedure for SPED EXSPED and the Waiver. One program administrator is responsible for the Qualified Service Provider (QSP) enrollment and review process, and QSP audits. Two Program Administrators are responsible for Medicaid Stat Plan personal care, case management audit and complaint resolution. One Program Administrator is responsible for waiver administration and eligibility, state funded program eligibility, and QSP rate setting.

The Quality improvement strategy is outlined in the approved Medicaid Waiver for Home and Community Based Services and the approved Technology Dependent Waiver. The same plan extends to consumers receiving services through state funds and through the Medicaid State Plan Option. The programs included are, Service Payments for the Elderly and Disabled (SPED), Expanded Service Payments for the Elderly and Disabled (EX SPED), and Medicaid State Plan Personal Care (MSP-PC).

The above programs are similar in some respects but vary in specific guidelines including functional eligibility and financial eligibility guidelines. In addition client's maybe receiving services from more than one of these programs during a concurrent

period of time. The HCBS Case Managers develop care plans for clients receiving services through the HCBS Waiver, Tech Dependent Waiver, SPED, EX- SPED, and Medicaid state plan personal care services. DD Program Managers develop care plans for Medicaid State plan personal care services.

Children' Medical Fragile and Children's Hospice Wavier Quality Teams include the Program Administration for these two children's waivers and the Assistant Director of the LTC Continuum. The Quality improvement strategy is outlined in the approved section H of each of the two children's Waivers. The above programs are similar in some respects but vary in specific guidelines functional eligibility. Both programs require nursing facility level of care however Children medical fragile also require level of need completion. Children Hospice requires a letter of 12 months life expectance. The Children's hospice waiver works in conjunction with the Medicaid state plan children's hospice services.

DD Division Quality Team for the Traditional DD Waiver includes the Director of Medical Services, the Director of the DD Division, Assistant DD Division Director, Six HSPAs, and two support staff. One HSPA is responsible for children and family support programs, early intervention services and Part C coordination, one HSPA is responsible for Adult Day and Residential Services, Licensing of DD Providers, ISLA contracts, and a HSPA is responsible for overall quality assurance, PASRR, Institutional Liaison, and Program. The Assistant DD Division Director coordinates the corporate guardianship, the DD Training Module contracts, and conducts training and monitoring of providers relative to abuse and neglect in conjunction with the ND Protection and Advocacy project. A HSPA is responsible for onsite survey of DD licensed providers of waiver services, DD Division support staff, review provider-employee background checks. A HSPA does rate setting and completes the waiver financial reports. A HSPA is responsible for the overall administration of the waiver and reviews care plans for Medicaid State Plan-Personal Care prior to service authorization and DD waiver services provided by Qualified Service Providers.

North Dakota's overall quality improvement strategy for persons with intellectual disabilities encompasses: Medicaid certification and inspection of care for intermediate care facilities for individuals with intellectual disabilities ; licensing of program and services by the Department; provider accreditation by The Council on Quality and Leadership; policies addressing provider responsibilities to report and investigate alleged incidents of abuse, neglect or exploitation involving service participants; the North Dakota Community Staff Training Program; monitoring by Program; coordination with North Dakota's Protection and Advocacy Project; and coordination and involvement of Catholic Charities North Dakota, the corporate guardian for over 370 persons with and intellectual disabilities.

The CMS Quality Framework describes quality outcomes for HCBS under six focus areas: individuals have access to home and community-based services in their communities; services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decision

concerning his/her life in the community; there are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants; participants are safe and secure in their homes and communities, taking into account their informed and expressed choices; participants receive support to exercise their rights and in accepting personal responsibilities; participants are satisfied with their services and achieve desired outcomes; and the system supports participants efficiently and effectively, and constantly strives to improve quality. Taken together, these outcomes define quality for an HCBS program. Embedded within each of these outcomes are processes that, when implemented carefully, will yield the desired effect or quality.

Quality Overview and Monitoring Position

To assure that quality review and monitoring of policy and services is completed for all MFP related services a quality review position has been established. This position will be part-time position up to forty hours per month. The position will be responsible to do chart and process review on a regular basis of MFP services as they relate to overall quality assurance/improvement. This will include assistance with development and monitoring of performance measure, remediation strategies, trending and analysis efforts to identify areas of improvement, and assistance with all quality improvement initiatives and evaluate their effectiveness.

Qualifications:

The position requires a bachelor's degree in social work or related human services field and one year of experience in a human service administration or quality review position. Strong communication skills and analytical skills are required. Individual must be a self-starter with strong initiation skills. Preference will be given to applicants with exposure to working with Quality Assurance/Improvement and experience in data collection and coordination.

The new services available under the MFP Grant:

Nursing Facility Transition Coordination demonstration/supplemental service, Supplemental Services for the payment for one time transition costs, and a 24 hour nursing call service are the three new services to be offered through the Grant. This document will describe the quality assurance process for these services.

Quality Assurance Roles of Stakeholder Committee

The Money Follows the Person Grant has established a stakeholder committee and five subcommittees that include consumers and/or their family members, advocacy groups, provider association representatives, State agency staff, and housing agency representatives. Stakeholder participation is considered vital to the success of the implementation of the Money Follows the Person Rebalancing demonstration Grant. The general responsibilities of the committee include:

- Provide ongoing oversight and/or advice on State policy changes to achieve rebalancing.
- Monitor grants implementation progress.
- Monitor achievement of grant benchmarks.
- Suggest ways to improve program design or implementation.
- Participate in the design of the operational protocol (OP).
- The OP will serve as the grant implementation policy.
- Monitor OP implementation throughout the grant period.
- Educate consumers of rebalancing efforts.
- Provide information to the Resource Link on available resources.
- Identify activities and services lacking in communities.
- Develop a plan of action to enhance services in underserved areas of the state.

The Stakeholder committee will meet formally four times per year to monitor grant implementation. The workgroups meet as needed or as directed by the stakeholder committee to address implementation strategy, suggested policy changes, or other concerns as identified. The MFP Quality Workgroup will meet two to four times per year to address quality related issues identified during the service delivery process. The workgroup will focus on 24 hour backup plan services, incident management, and risk mitigation quality issues. The workgroup will additionally review overall MFP service delivery quality throughout the grant period.

Quality Assurance Goals

The goals established by the MFP Grant Stakeholders Committee include:

1. Implement the newly designed standardized web based assessment for nursing facility consumers to evaluate their eligibility and needs.
2. Implement the MFP incident/risk management plan for all persons transitioning.
3. Implement 24-hour back-up services for persons transitioning.
4. Implement the newly developed person centered planning process that addresses risk factors that have been identified in the assessment process and outlines mitigation strategies for persons transitioning from a nursing facility. This plan will be a comprehensive plan that will also outline the client specific 24 hr backup system, service needs, referrals, and consumer choices.
5. Implement newly designed planning process for Life Skills and Transition Center and ICF/ID transitions that addresses risk factors that have been

identified in the assessment process and outlines mitigation strategies and outlines the client specific 24 hr backup plans.

Targeting Process

North Dakota a nursing facility transition coordinator (TC) service to act as a single access point for development and coordination of an individual's transition plan from the nursing facility to the community. ND has identified the Centers for Independent Living (CIL) as the single access point for transitioning from a nursing facility to a qualified residence.

Medicaid eligible individuals with physical disabilities or who are elderly, or who have a developmental disability , that have resided in a nursing facility for a minimum of three months, and are Medicaid eligible for the last day prior to transition will be targeted for transition to the community.

The most recent MDS on file in the Department's database will be used to first identify Medicaid individuals who meet the minimum three month institutional requirement, have expressed a desire to return to the community. Once identified, information on all individuals will be forwarded to the TC and to the Nursing Facility Social Services Department. A TC and the Nursing Facility Social Worker/designee will then interview individuals to determine if transitioning is desired by an individual and to assess the potential for transitioning the individual to his or her desired community based on available informal and formal resources and supports available in the community. In addition, any Medicaid eligible individual can self-refer to a TC if they meet the level of care and minimum 3-month occupancy criteria and intend to move to a qualified residence. Referrals will also be encouraged from family members, other agencies, and nursing facility professionals.

North Dakota has developed a discharge-planning model to identify eligible consumers at the state operated institution (Life Skills and Transition Center) for persons with developmental disabilities. In general, no person is under commitment to the Life Skills and Transition Center, as residence is a voluntary decision of the person and/or legal decision-maker (such as guardian, which includes annual judicial oversight). The preferences of the person and recommendations of state professionals are used to guide priorities for discharge planning.

For individuals residing in small, community-based intermediate care facilities for individuals with a an intellectual disability, North Dakota utilizes a referral process whereby consumers and families, working with their DD case Program Manager, have an opportunity to make informed decisions regarding the provision of services and supports.

Waiver Assurances

Enhanced strategies for Money Follows the Person Grant:

- A data base has been developed to maintain the number of referrals made to the grant, time span between referral and transition
- Records will be maintained documenting transitions, length of transition, re-institutionalizations
- Records will be maintained of payment history review of approved supplemental services and transitional care services. If findings are identified a resolution plan will be identified.
- Records of contacts made to the Crisis intervention team and outcomes of the results of the team's process will be recorded and evaluated.
- Nursing Facility Independent Living plans will be reviewed by the MFP Grant Manager. Checklist (transition review checklist) has been developed that outlines the essential requirements of the plan which need to be met prior to transition. See attachment B.8-K

Level of Care Determination

The state has a contract with the agency DDM-Ascend to approve nursing facility level of care determinations based on the information submitted to them by a case manager or other professional. This contract is monitored by a Medical Services Program Administrator. The level of care instrument used by the state to evaluate and reevaluate whether an individual needs services through the MFP demonstration grant or a waiver is entitled the Level of Care Determination form. The completed document must be approved by DDM-Ascend to verify that the individual meets nursing facility level of care, as defined in ND Administrative Code (N.D. A.C. 75-02-02-09). The Level of Care requirements must be met by the individual at time of admission to the nursing facility, when entering the HCBS waiver, or completed at eleven months post-discharge.

Level of Care Appeals Process

The individual or legal representative may appeal the Level of Care eligibility decision within 30 days of the date of this notification. If the request for a hearing is received by the appeals supervisor within 10 days from the date of this notice, the funding for services may continue until an appeal decision is reached. However, all costs for services received must be paid back if the appeal is upheld. The individual may represent him/herself in an appeal hearing or may use a legal counsel, relative, friend, or other spokesperson. The reason for the appeal must be submitted in writing to:

Appeals Supervisor
North Dakota Department of Human Services
600 East Boulevard Avenue
Bismarck, North Dakota 58505-0250

75-01-03-08.2. Notice of preadmission screening and resident review determinations

1. An individual dissatisfied with an adverse determination made with regard to the preadmission screening and resident review requirements of 42 U.S.C. 1396r(e)(7)(A) or (B) may request a fair hearing in review of that determination.
2. The right to request a fair hearing under subsection 1 arises upon receipt of a notice under subsection 3.
3. If the department's action in administering preadmission screening and resident review is adverse to an individual, the department shall provide to the individual a written notice which conforms to section 75-01-03-07 and which includes:
 - a. A statement of the adverse determination;
 - b. The reason for the adverse determination;
 - c. The date of the adverse determination; and
 - d. A statement that 42 U.S.C. 1396r(e)(7) requires the department to make such determinations.
 - e. For purposes of this section and sections 75-01-03-07 and 75-01-03-09.2:
 - i. "Adverse determination" means a determination made in accordance with 42 U.S.C. 1396r(b)(3)(F) or 42 U.S.C. 1396r(e)(7)(B), through the application of section 75-02-02-09, that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services, but does not mean a determination, made under 42 CFR 483.128, that an individual is not suspected of having mental illness or mental retardation; and
 - ii. "Significant change" means:
 1. A significant physical status improvement experienced by a nursing facility resident, such that the resident is more likely to respond to special treatment for that condition or might be considered appropriate for a less restrictive alternative setting;

2. The presence of a nursing facility resident's mental illness, mental retardation, or condition related to mental retardation, not identified prior to admission, when it later emerges or is discovered;
3. Exhibition of increased symptoms of mental illness or behavioral problems by a nursing facility resident; or
4. A circumstance arising if a review resulted in a determination requiring inpatient psychiatric treatment for a nursing facility resident, and an update to that determination is needed to support that individual's admission or readmission to a nursing facility following delivery of psychiatric services.
5. Preadmission screening and resident review, including determinations of significant change, is undertaken applying professional judgment and standards approved by the department that are consistent with the requirements of 42 CFR part 483, subpart C, and 42 U.S.C. 1396r(f)(8).

Money Follow the Person

Money Follows the Person Nursing Facility Independent Living Plans are required to be reviewed by the Grant Manager. An approved level of care is one of the criteria that will need to be in place prior transition for all persons participating in a waiver service post-transitions. It will be required that Level of Care screening be completed approximately two weeks prior to the transition to allow for both the completion of the plan and to assure the consumer will continue to meet the level of care following discharge from the nursing facility.

Home and Community Based Services

Level of Care is evaluated as outlined in an approved waiver. One of the primary methods is, on a quarterly basis a report is developed and reviewed to assure annual level of care determinations have been completed on the clients listed in the report.

Medically Fragile and Children's Hospice Waiver

Level of Care is evaluated as outlined in section H of the approved waivers. The Program Administrator upon admission and annual there after completes NF level of care to determine eligibility.

Developmental Disabilities

The Progress Assessment Review (PAR) is completed for all applicants. It is completed prior to determination of DD Program Management eligibility to assess individual need and supports and also determines whether the individual meets the basic ICF/ID Level of Care criteria. The regional DD Program management is responsible to complete the Level of Care determination/Case Action Form to document the ICF/ID level of care screening. System generated alerts in the individual electronic file remind the program manager when the annual level of care determination is due. There is an edit in the ND Medicaid payment system that will not allow payment for waiver services unless a current ICF/ID level of care screening is in the payment system. A query is used to examine 100 percent of waiver participants to determine if the levels of care determinations are current.

ICF/ID Screening Level Review Process

The PAR (which is the assessment for Level of Care) is completed annually. Based on a formula the results indicate screening categories. A sample of all PARs and ICF/ID level of care screenings are reviewed on an ongoing basis.

Service Plan

Money Follow the Person

MFP Grant Administrator will review each Nursing Facility Independent Living plan prior to transition and will assure that risks have been identified and mitigation plans have been addressed, that a backup plan has been developed, and consumer needs have been addressed.

Home and Community Based Services

HCBS evaluates all county case management entities on an annual basis as outlined in section H of the approved waiver and methods include but are not limited to the evaluation of service plans (percentage of plans reviewed depends on the county case load) to assure goals and contingency plans are documented, assure assessments, reassessments, and contacts are completed by policy, care plan lists services applicable to client needs. Files are also reviewed to assure that client has signed an explanation of client choice SFN 1597 which makes the client aware of their right to choose between HCBS and institutional care. If a corrective action is noted in the review process the provider is made aware and must respond.

A summary of the care plans which outline client service needs are documented by the case manager on the SFN 1467 (Individual Care Plan for all HCBS service waiver, sped and ex sped services) and SFN662 (Personal Care Services Plan) are required to be submitted to the DHS within three days of completion. All of these plans are reviewed by an HCBS Program Administrator.

Medically Fragile and Children's Hospice Waiver

Service plans for Medically Fragile are completed by DDPM annually and must address all participants assessed needs including health and safety risk factors and personal goals either by waiver services or through other means. Program managers receive a system generated alert to notify them when annual service plans are due. A query can be run at any time to review 100% of service plans to assure plans are completed within the required timelines. The DD Program Manager must inform the individual and/or the legal representative of the following assurances prior to the development and signing of each ISP. The assurances include; the right to select institutional care over waiver service, right to choose the service receiving, right to freely select a provider of services, right to request change of providers, and right to receive notification if service is denied, reduced or terminated. The rights are listed on the top of each ISP form and the individual and/or legal representative signature on the ISP is acknowledgment of rights

Service plans for Children's Hospice Waiver are completed by Hospice case managers and reviewed by both the hospice physician and the Program Administrator. These are updated or changed quarterly or at time of need. Legal representatives and team members signatures are required on plan.

Developmental Disabilities

Service plans are completed annually and must address all participants assessed needs including health and safety risk factors and personal goals and preferences. Program managers receive a system generated alert to notify them when annual service plans are due.

The following rights and assurances are included at the top of the Service Plan that is signed by the individual/legal decision maker, provider of waiver services and DD Program Manager :

I understand I have the following rights and can request a Fair Hearing if I am dissatisfied by sending a written request to the Appeals Supervisor at the North Dakota Department of Human Services, 600 East Boulevard Avenue, Bismarck, ND 58505-0250 within 30 days. I can also request an informal conference with the Regional Human Service Center Director within 10 days. A request for an informal conference will not delay my request for a Fair Hearing.

- Right to select institutional services or waiver services if it has been determined that I meet the ICF/ID level of care.
- Right to choose the services I receive, if I have elected to participate in the waiver.
- Right to freely select from and among any willing and qualified provider(s) of services and the right to request a change of service provider at any time.

- Right to receive advance notification if services are denied, reduced or terminated. If your request for a hearing is postmarked or received within ten (10) days of the date of the notice, the action will not be taken until a hearing decision is made on your appeal and you may continue to receive the current services unless you withdraw the request for hearing, you fail to appear at a hearing, or it is decided that the only issue in the appeal is one of federal or state law/policy. You are advised however, that you may be required to pay any costs for services received if your appeal is not successful.
- I have been informed of Protection and Advocacy Services.
- I have been informed of reporting procedures for abuse, neglect and exploitation.
- I understand that I must sign, date and return the ISP to the DD Program Manager. I understand that I will be visited, or if I am a legal decision maker, I will be contacted by the DD Program Manager on a periodic basis to review the plan and to determine satisfaction with services.
- I understand that for services requiring Title XIX funding I must maintain medicaid eligibility or I must private pay for those services.

Qualified Providers

Money Follow the Person

Money Follows the Person will develop a contract that will outline the responsibilities and qualifications for Transition Coordination Services. For transition assistance prior approval will be required before purchase/payment of one time transition costs-Supplemental Services Request Form B.5-A

For the 24-Hour Nursing Call Service a contract has been developed that will outline the responsibilities and qualifications.

QSP for Transition Adjustment Support: Individuals providing the MFP demonstration service of Transition Adjustment Support are required to meet qualification to be either an agency or independent Qualified Service Provider.

Home and Community Based Services

HCBS evaluates Qualified Service Providers as outlined in section H of the approved waivers. Providers are targeted based on irregularities on payment history. Provider records are evaluated to assure that they maintain accurate records, and to assure that providers complete the tasks that have been authorized. All providers are required to reenroll every two years. If a corrective action is noted in the review process the provider is made aware and must respond.

When each county is audited during their annual review, a payment history which includes payments paid to all HCBS clients, a three month payment history is reviewed for payment irregularities. Based on the results of this review purposive selection of providers to be reviewed in detail is determined.

In addition data probes are completed to capture payment histories of an entire service category and to identify irregularities.

Medically Fragile and Children's Hospice Waiver

Medically Fragile is a self-directed waiver. The fiscal manager is Acumen; Acumen completes the background checks for proposed individual in home support providers and provides payment management. Institutional and agency providers must be enrolled and approved with Acumen as a North Dakota vendor. Children's Hospice Waiver providers are licensed hospice agencies by the both the ND Department of Health and Medical Services. Services provided outside of hospice agency must be approved Medicaid providers.

Developmental Disabilities

The Department of Human Services reviews provider licensure applications according to NDAC 75-04-01. Licensure is reviewed annually. State law prohibits purchase of service from providers subject to licensure who are not currently licensed. Required providers must provide evidence of continuing accreditation by The Council. Annually all facility based programs must include current sanitation and fire inspections. Providers must obtain criminal background checks for employees. The North Dakota Community Staff Training Program was initiated in 1983 to meet the training needs of employees who provide supports to individuals with developmental disabilities served by community-based providers. The North Dakota Center for Persons with Disabilities, through a contract with the Disability Services Division, coordinates the training, develops and revises the curriculum, maintains training records, and conducts workshops and conferences. Through a network of 25 regional staff trainers, the curriculum is delivered on-site and tailored to meet agency and consumer specific needs. The services of Adult Day Health/Adult Day Care, Homemaker, Adult Family Foster Care are provided by enrolled Qualified Service Providers according to NDAC 75-03-23-07, verified by the ND Medical Services Division per respective administrative codes.

Health and Welfare

Money Follow the Person

Risk Assessment and Mitigation Plan

For Persons with a Physical Disability or an Elder:

Money Follows the Person has developed nursing facility transition assessment and risk mitigation plan that documents mitigation process for all nursing facility transitions. This plan needs to be reviewed before transition. Following transition, the plan will be reviewed by the Transition Coordinator after all critical incidents, during all planning meetings, and as needed.

The Transition assessment completed by the Transition Coordinator identifies areas of risk that need to be addressed by the consumer's planning team prior to transition. The team will include the consumer, family as appropriate, Transition Coordinator, and the nursing facility discharge planning team. The consumer and the Independent Living Plan Team will review the identified areas of risk and develop risk mitigation strategies to address those risks. The plan will be completed prior to discharge from the institution. The mitigation plan will become a part of the Independent Living Plan. The plan will be developed before transition and will be reviewed by the Transition Coordinator/DD Program Manager and/or the DD provider team following transition after all critical incidents, during all planning meetings, and as needed.

(See Attachment B.8-H)

For Persons with a Developmental Disability

For all transitions from an ICF/ID facility a needs assessment will be completed and a risk mitigation plan developed prior to transition to the community. One Services Plans and Mitigation Plans will be reviewed by Human Services staff. After transition the plan will be reviewed by planning team and/or the DD Program Manager after all critical incidents, during all planning meetings, and at least once every six months.

The Risk Assessment and Mitigation Plan will be completed by the consumer, parent or legal decision maker if applicable; DD Program Manager, team members from the "sending" agency (community ICF/ID or Life Skills and Transition Center) currently providing services and team members from the "receiving" agency (home and community based service provider) who will be providing future services under the MFP grant. The Plan should be completed approximately 7 days prior to the consumer's move to home and community based services and provided to the receiving Support Coordinator who is responsible to develop the individual person centered plan upon admission to services.

Participants should identify all risk issues that are known or believe to apply to them, briefly describe why the issue currently presents a particular risk to this person or how the issue has presented significant risk in the past. Include a

recommended strategy for managing the risk. A full analysis, decisions and plans if needed, will be made around each risk identified at the individual plan meeting held upon admission and reviewed at the 30 day person centered plan following admission to HCBS services. Participants in the 30 day person centered plan will include DDPM, representatives from sending agency team and receiving agency team responsible for plan development and implementation.

The Risk Assessment and Mitigation Plan will be a part of the consumers overall support plan upon transition from the institution. The plan will be developed before transition and will be reviewed by the Transition Coordinator/DD Program Manager and/or the DD provider team following transition after all critical incidents, during all planning meetings, and at least once every six months

(See Attachment B.8-H)

Consent (Rights/Incidents/Appeals Information)

When the Consumer/legal representative has agreed to participate in the MFP grant they will sign consent to participate, will be provided with a copy of the MFP consumer rights brochure, critical incident reporting information, and will be made aware of the appeals process.

Back Up Planning

Consumers and/or their legal representatives will participate in the development of an individualized back-up plan during the transition planning process. All back up plans will include contact information for the 24 hour on call nursing service available to all MFP participants. Information will be specifically provided to the consumer that will include back-up agency phone numbers and contact names.

Individualized back up plan development will be reviewed to assure they address the three levels of back up needed for each consumer as outlined in MFP grant policy. Backup plans will be reviewed after all critical incidents, during all planning meetings, and as needed.

Calls to the 24 hour nursing call service will generate a report that outlines the nature and outcome of each call. The MFP Grant Administrator will track all calls and document the number and type of requests for critical back-up, monitor responsiveness and timeliness of local agencies to consumer calls, and the effectiveness of individual backup plans. The MFP Grant Program Administrator will follow-up with service providers, Transition Coordinators, and Case Managers to address any needed remediation or improvements warranted.

Critical Incidents

Reportable Critical Incidents Defined

1. Abuse
2. Neglect
3. Exploitation
4. Rights Violations
5. Serious Injury
6. Missing Person
7. Death
8. Medical Emergency
9. Restraints
10. Medical Errors
11. Law Enforcement Contact
12. Suicide Attempt

General Definition

A “Critical Incident” is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well being of a Money Follows the Person Grant Participant.

Who is supposed to report a critical incident?

Any person who becomes aware of a critical incident including a consumer is to report a critical incident.

Qualified Service Providers that are enrolled with the Department of Humans Services, Transition Coordinators, and Case Managers, DD providers, DD Case Managers are required to report incidents.

Critical incident reporting for persons transitioning from a nursing facility

Individuals wishing to report an incident can contact any of the following persons:

- Transition Coordinator Name _____
Address _____
Phone _____
- Case Manager Name _____
Agency _____
Address _____
Phone Number _____
- Money Follows the Person Grant Manager: Jake Reuter, Department of Humans Services, Medical Services, Department 325, 600 East Boulevard Ave, Bismarck, ND 58505, Phone: 1-800-755-2604

Reporting Process

The critical incidents report form will be completed by the Transitional Coordinator, Case Manager, QSP or the Money Follows the Persons Grant Program Manager. Reports will be forwarded to the MFP Program Administrator within three days of the incident. The MFP Program Administrator will respond to the Incident within 10 days of the initial report. Action will be taken to resolve the concerns and a follow-up plan will be developed by the MFP Program Administrator. Incidents should

also be reported to other agencies or entities as policy, law, regulation, or the situation requires- See HCBS Abuse reporting process guidelines listed below.

Review

Critical Incident reports will be completed by the Transition Coordinator, QSP, or the HCBS Case Manager and forwarded to the MFP Grant Program Administrator for processing. MFP Administrator will respond to each incident based on need and significance within 10 days of each report. Copies of all incident reports will be maintained in the MFP participants file and tracked within a quality data base as part of the MFP Quality Assurance process.

Developmental Disabilities Community providers use an agency specific incident reporting document and management process that addresses each of the ten critical incidents defined above. Critical incidents are reviewed and tracked by the Developmental Disabilities Division. Attachment: B.8-L Protection and Advocacy Reporting Guidelines B.8-M and DDD-006 Response to Reports of Alleged Incidents of Abuse, Neglect, or Exploitation outline the processes within the Developmental Disabilities System.

HCBS Abuse Reporting Process

- A. Monitoring for Abuse, Neglect, or Exploitation: When completing monitoring tasks if the case manager suspects a Qualified Service Provider or other individual is abusing, neglecting, or exploiting a recipient of HCBS the following protocol is to be followed by the HCBS Case Manager.
- B. In all situations:
 - a. Notify the Program Administrator responsible for complaint resolution in writing of all actions taken to follow up on a suspected case of abuse, neglect, or exploitation of an HCBS recipient.
 - Identify and document in writing the name of the recipient.
 - Identify and document in writing the name of the qualified service provider or other individual.
 - Document in writing a complete description of the problem or complaint.
 - Immediately report suspected physical abuse or criminal activity to law enforcement.

- If you have reasonable grounds to believe the recipient's health or safety is at immediate risk of harm, make a home visit to further assess the situation and take whatever action is appropriate to protect the recipient.
- If you can document that no immediate risk exists, but a problem requires further action, work with the recipient and other interested parties to resolve the matter as soon as possible.
- If the HCBS Case Manager and Nurse Manager/Trainer determine that an incident is indicative of abuse, neglect, or exploitation, the HCBS Case Manager must immediately report the incident to the Department.
- Comply with North Dakota State law Chapter [50-25.1](#), CHILD ABUSE AND NEGLECT.

C. Monitoring for Abuse, Neglect, or Exploitation specific to the client's living arrangements, individuals implicated, or the Provider type.

D. Notify the Program Administrator responsible for complaint resolution in writing of all actions taken to follow up on a suspected case of abuse, neglect, or exploitation of a HCBS recipient.

- If Client lives in his or her own home and the qualified service provider is an Individual or Agency enrolled QSP:
- If you can document that no immediate risk exists, but a problem requires further action, work with the recipient and other interested parties to resolve the matter as soon as possible.
- If the qualified service provider is an Assisted Living Facility:
 - Notify the Aging Services Division Ombudsman Program Administrator and the DHS Program Administrator responsible for Assisted Living Licensing.
- If the complaint involves the provision of home delivered meals, contact the HCBS Program Administrator.
- Client lives in his or her own home and is being abused, exploited, or neglected by an individual other than the QSP:
 - File a report with law enforcement and/or Adult Protective Services as indicated by the seriousness of the allegation.
- If the client is living in a AFFC Home:
 - Contact the CSSB responsible for AFFC licensing, the appropriate human service center staff responsible for compliance of licensing regulations for AFFC and the Medical Services Division Adult Family Foster Care Service

Program Administrator, and the Aging Services Division Adult Family Foster Care Licensing Program Administrator.

- If the case involves a Licensed Child Foster Care Home, the regional representative responsible for the children's foster care licensing must be contacted.
- If the client is receiving services through the DD/MR Waiver, see Section within HCBS Case management-Service to DD/MR Population.
- When the service is provided on Reservation Lands, the Tribal Laws that govern abuse and neglect on that reservation must be followed.

E. The Department of Human Services may remove a Qualified Service Provider from the list of approved providers if the seriousness and nature of the complaint warrants such action. The Department will terminate the provider agreement with a Qualified Service Provider who performs substandard care, fraudulent billing practices, abuse, neglect, or exploitation of a recipient. North Dakota Administrative Code section [75-03-23-08](#) lists reasons why the Department may terminate a Qualified Service Provider.

Critical Incidents Definitions

1. Abuse

- a. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish of any person with developmental disabilities;
- b. Knowing, reckless, or intentional acts or failures to act which cause injury or death to a developmentally disabled or mentally ill person or which placed that person at risk of injury or death;
- c. Rape or sexual assault of a developmentally disabled or mentally ill person;
- d. Corporal punishment or striking of a developmentally disabled or mentally ill person;
- e. Unauthorized use or the use of excessive force in the placement of bodily restraints on a developmentally disabled or mentally ill person; and
- f. Use of bodily or chemical restraints on a developmentally disabled or mentally ill person which is not in compliance with federal or state laws and administrative regulations.

2. Exploitation

An act committed by a caretaker or relative of, or any person in a fiduciary relationship with, a person with a disability, means:

- a. The taking or misuse of property or resources of a person with developmental disabilities or mental illness by means of undue influence, breach of fiduciary relationship, deception, harassment, criminal coercion, theft, or other unlawful or improper means;
- b. The use of the services of a person with developmental disabilities or mental illness without just compensation; or
- c. The use of a person with developmental disabilities or mental illness for the entertainment or sexual gratification of others under circumstances that cause degradation, humiliation, or mental anguish to the person with developmental disabilities or mental illness.

3. Neglect

- a. Inability of a person with disabilities to provide food, shelter, clothing, health care, or services necessary to maintain the mental and physical health of that person;
- b. Failure by any caretaker of a person with developmental disabilities or mental illness to meet, either by commission or omission, any statutory obligation, court order, administrative rule or regulation, policy, procedure, or minimally accepted standard for care of persons with developmental disabilities or mental illnesses;
- c. Negligent act or omission by any caretaker which causes injury or death to a person with developmental disabilities or mental illness or which places that person at risk of injury or death;
- d. Failure by any caretaker, who is required by law or administrative rule, to establish or carry out an appropriate individual program or treatment plan for a person with developmental disabilities or mental illness;
- e. Failure by any caretaker to provide adequate nutrition, clothing, or health care to a person with developmental disabilities or mental illness;
- f. Failure by any caretaker to provide a safe environment for a person with developmental disabilities or mental illness; and
- g. Failure by any caretaker to provide adequate numbers of appropriately trained staff in its provision of care and services for persons with developmental disabilities or mental illnesses.

4. Rights Violations

Through omission or commission, the failure to comply with the rights to which an individual with a disability is entitled as established by law, rule, regulation, or policy.

5. Serious Injury

Reported, regardless of the cause or setting in which it occurred, when an individual sustains:

- A fracture
- A dislocation of any joint
- An internal injury
- A contusion larger than 2.5 inches in diameter
- Any other injury determined to be serious by a physician, physician assistant, registered nurse, licensed vocational nurse/licensed practical nurse.

6. Missing Person

Whenever there is police contact regarding a missing person regardless of the amount of time the person was missing

- During a period of time in which a program provider is responsible for supervision of program participant/consumer.
- Not During a period of time in which a program provider is responsible for supervision of program participant/consumer.

7. Death

The death of an individual is reported, regardless of the cause or setting in which it occurred.

- During a period of time in which a program provider is responsible for supervision of program participant/consumer.
- Not During a period of time in which a program provider is responsible for supervision of program participant/consumer.

8. Medical & Psychiatric Emergency

Admission of an individual to a hospital or psychiatric facility or the provision of emergency medical services (treatment by EMS) that results in medical care which is unanticipated and/or unscheduled for the individual and which would not routinely be provided by a primary care provider.

Use Of:

- Emergency Medical Services (example*: emergency room care)
- Emergency Psychiatric Services (example*: mental health facility admission)
- Life Saving Intervention (example*: Heimlich, CPR) – * Example is just one of several possible scenarios

9. Restraints

Every time an individual is restrained

- Personal (the application of pressure, except physical guidance or prompting of brief duration, that restricts the free movement of part or all of an individual's body)
- Mechanical (the use of a device that restricts the free movement of part or all of an individual's body. Such device includes an anklet, a wristlet, a camisole, a helmet with fasteners, a muff with fasteners, a mitt with fasteners, a posey, a waist strap, a head strap, and restraining sheet. Such a device does not include one used to provide support for functional body position or proper balance, such as a wheelchair belt or one used for medical treatment, such as a helmet used to prevent injury during a seizure.) It also means to cause a device that allows for free movement to be useable. Such as locking a wheelchair or not allowing an individual access to technology.
- Chemical (the use of a chemical, including a pharmaceutical, through topical application, oral administration, injection, or other means to control an individual's activity and which is not a standard treatment for the individual's medical or psychiatric condition).
- Included In A Written And Approved Behavior Plan
- Not Included In a Written and Approved Behavior Plan
- Seclusion: involuntary confinement in a room that the person is physically prevented from leaving.
- Isolation: forced separation or failure to include the person in the social surroundings of the setting or community.

10. Medication Discrepancy

When there is a discrepancy between what a physician prescribes and what an individual actually takes and the individual self-administers medication under supervision of the Program Provider or has medication administered by the Program Provider. A medication discrepancy is when one or more of the following occurs:

- a. Wrong medication: an individual takes medication that is not prescribed for that individual. This includes taking medication after it has been discontinued or taking the incorrect medication because it was improperly labeled.
- b. Wrong dose: An individual takes a dose of medication other than the dose that was prescribed.
- c. Omitted dose: An individual does not take a prescribed dose of medication within the 24-hour period of a calendar day. An omitted dose does not include an individual's refusal to take medication.
- d. Dose Refused: An individual's refusal to take medication resulting in a medical emergency or use of restraint

11. Law Enforcement Contact

A person receiving services is charged with a crime or is the subject of a police investigation, which may lead to criminal charges; an individual is a victim of a crime against the person; crisis intervention involving police or law enforcement personnel.

12. Suicide Attempt

Definition: the intentional attempt to take one's own life. A suicide attempt is limited to the actual occurrence of an act and does not include verbal suicidal threats by a person receiving services.

Home and Community Based Services

During onsite case management audits face to face client interviews are completed. Clients receiving services under the Medicaid waiver are targeted. Some of the questions included in the interview include was the client offered a choice of providers, is the client aware that they can change providers, does the provider complete all tasks approved, meets their needs, meets their expectations, is the provider considerate and

conscientious. If a finding is noted in the interview the case manager or appropriate contact is made to resolve the finding. HCBS policy outlines abuse/neglect/exploitation policy and maintains a data base documenting reported cases of abuse/neglect/exploitation or complaints and there resolution. Response timeline is outlined in the approved HCBS Section H. Quality Assurance Surveys are completed by HCBS Case Manager with Clients annually to assess satisfaction with services received/provided.

Medically Fragile and Children's Hospice Waiver

All participate safeguards are covered under section G of the approved waivers. This section outlines in detail process for reporting, identifying, and remediation of critical incidents and reporting, restraints and restriction, medication administration and errors. Time lines and staff responsibility is also addressed.

Developmental Disabilities

- DD Program Managers visit waiver recipients on a face to face basis each quarter to review appropriate services, consumer satisfaction, identify barriers to service, address abuse or neglect concerns, and follow-up on previously identified issues.
- During the initial licensure process, provider policies and procedures are reviewed by DD Division staff to assure they address the requirements to report and investigate all incidents of abuse, neglect and exploitation. DD Division staff and the Protection and Advocacy Project conduct a historical review of incident reports and monitor implementation of abuse, neglect and exploitation policies and conduct refresher training and follow up with all licensed DD providers every two years. Policy PI-10-16 is the Department of Human Services Policy and Procedure that addresses responses to significant events and reports of alleged incidents of abuse, neglect, or exploitation of individuals receiving developmental disabilities services from licensed DD providers. (See Attachment B.8-M)
- The DD Division maintains a data base of protective service reports.

A. Administrative Authority

Money Follow the Person

The Department of Human Services, Medical Services Division will develop a contract with the On call nursing services agency and the four Centers for Independent Living to include clearly defined roles and responsibilities, standardized policies, procedures, system performance standards, and practice guidelines. The grant manager will be responsible to monitor the contract and quality of service provider by the contractor.

Home and Community Based Services

HCBS evaluates all county case management entities on an annual basis as outlined in section H of the approved waiver. The Department of Human Services has a signed Memorandum of Understanding that outlines responsibilities with all County Social Service Boards.

Medically Fragile and Children's Hospice Waiver

The North Dakota Department of Human Services is the single state Medicaid agency which includes the DD Division and Medical Services. Waiver coordination meetings are held quarterly between Medical Services and units administering waivers. The DD Division is responsible for licensure of the eight regional DD Program Management units and all DD providers.

Developmental Disabilities

The North Dakota Department of Human Services is the single state Medicaid agency which includes the DD Division and Medical Services. Waiver coordination meetings are held quarterly between Medical Services and units administering waivers. The DD Division is responsible for licensure of the eight regional DD Program Management units and all DD providers. Medical Services enrolls qualified service providers.

B. Financial Accountability

Money Follow the Person

The MFP Grant Administrator will prior approve all transition assistance requests. The grant manager and DHS Fiscal Representative will reconcile approved services with payment histories.

On Call Nursing Service costs will be monitored by the MFP Grant Program Administrator and DHS Fiscal Representative based on the contract agreement for service payments. Numbers of call reports and

billing history will be monitored to assure proper billing processes are being followed.

Home and Community Based Services

HCBS evaluates all Qualified Service Providers as outlined in section H of the approved waivers. Providers are targeted based on irregularities on payment history. The providers documentation is reviewed to assure that provider documentation correlates with payment history, provider bills at the agreed upon rate, that they use the correct procedure code, and bill within the approved amount authorized by the case management entity. If a corrective action is noted in the review process the provider is made aware and must respond. If the provider does not respond or a pattern of inaccurate billing is noted, it could result in repayment of funds or the provider's enrollment status being terminated.

When each county is audited during their annual review, a payment history which includes payments paid for all HCBS clients, a three month payment history is reviewed for payment irregularities. Based on the results of this review purposive selection of providers to be reviewed in detail is determined.

Medically Fragile and Children's Hospice Waiver

Program Administrator for both waivers submits Level of Care to Ascend for approval as a prerequisite for waiver services. Services for Medically Fragile are authorized by the DDPM, Regional DDPA, and Program Administrator and sent to Acumen for monitoring and payment. All Children's Hospice Waiver billing is reviewed by Medical Services claims staff and audited one year after case closure. Payments for both waivers are reported quarterly by service to CMS by the DHS Fiscal office.

Developmental Disabilities

DD program managers determine Level of Care as a prerequisite for waiver services. Case managers then authorize services on the individual service plan in the web based application. Edits are built into the system to prevent payment for services not authorized. The DD claims reviewer receives weekly queries of the web based application data for individual changes to level of care and start or termination of waiver services which is entered in the Medicaid payment system.

Attachments

Appendix B.8 Quality

- B.8-A Transition Assessment
- B.8-B Independent Living Plan which includes risk mitigation plan/24 hour backup
- B.8- C Developmental Disabilities Individual Service Plan
- B.8-D Developmental Disabilities Progress Assessment Review (PAR)
- B.8-E Resident Decision Profile
- B. 8-F Notification of Denial, Termination, or Reduction in Service Form
- B.8-H Risk assessment and Mitigation Policy and NF and DD forms
- B.8- I 24-backup Planning Policy and Back-up Plan
- B.8-J Critical Incident Reporting and Management Policy
- B.8-K Checklist for the Independent Living Plan
- B.8-L Protection and Advocacy Reporting Guidelines
- B.8-M PI-10-16 -Response to Reports of Alleged Incidents of Abuse, Neglect, or Exploitation of Individuals Receiving Developmental Disabilities Services from Licensed DD Providers

B.9 Housing

The Money Follows the Persons housing goal is to implement strategies that will address the need to develop affordable, accessible, and available housing in North Dakota for MFP recipients as well as for other individuals with a disability. These strategies will be the basis for the actions of the Housing Workgroup and the Stakeholder Committee during the grant period.

Securing safe, assessable, affordable, quality, and permanent housing has been identified as one of the primary barriers to the successful achievement of this goal. The limited housing options have resulted in transitions being delayed or impossible for MFP eligible individuals

In order to fulfill the Housing Strategies, North Dakota will enlist the skills of a State Housing Facilitator and four Consumer Housing Resource Specialists to identify and research creative solutions to alleviate the housing shortage to make transitions possible.

The MFP State Housing Facilitator position would act as the primary liaison with the MFP Program Administrator and ND housing agencies and Consumer Housing Resource Specialists.

Qualifications for the position are:

- **DHS State Housing Facilitator (ND Money Follows The Person) -** Requires a bachelor's degree with a major in business or public administration, finance, accounting, or related business field, or in social work or related behavioral science field; and two years of professional level work experience in affordable housing development, city planning, multifamily property management, single family real estate development, commercial real estate, or banking/lending. Specific work experience as described above may substitute for the education requirement on a year-for-year basis.

The need for the development of local housing options, relationships with housing providers, and effective strategies to address systemic barriers in cooperation with transition coordination services is not currently being adequately addressed with the housing systems in place at this time. Transitions are being delayed or are not possible due to limited housing resources and inadequate collaborative interaction with housing providers. North Dakota believes that developing a Regional Housing Resource Specialists to serve each of the four quadrants of the State now being served by the Centers for Independent Living Centers/Transition Coordinators would provide the local contact necessary with private property owners and Public Housing Authorities to increase the number of transitions.

To successfully meet the number of transitions outlined in North Dakota's amended Operational Protocol the four proposed Regional Housing Resource

Specialists, Region 1 through 4, would work in cooperation with the proposed MFP State Housing Facilitator, local housing providers, and the North Dakota's Housing Agencies to identify and address the unmet housing needs of MFP participants.

Qualifications for the four positions are:

- **DHS Consumer Housing Resource Specialist (ND Money Follows The Person)** - Requires a bachelor's degree with a major in business or public administration, finance, accounting, or related business field, or in social work or related behavioral science field; and one year of related experience. Specific work experience as described above may substitute for the education requirement on a year-for-year basis.

Preference will be given to applicants with experience in affordable housing development, city planning, multifamily property management, single family real estate development, commercial real estate, or banking/lending.

The funding for all the Housing positions will be 100% MFP Administrative Funds. These positions will be contracted positions and will be secured through a Request for Proposal process.

Rental Gap Assistance Program

Money Follows the Person Rental Gap Assistance Program Proposal

Securing safe, accessible, affordable, quality, and permanent housing has been identified as one of the primary barriers to the successful transition of MFP eligible clients to community living. The majority of MFP transitions are occurring in the urban communities versus the rural communities. Long waiting lists exist for housing choice vouchers in these urban areas which limits housing choice and opportunity for persons attempting to transition to the community. The number of people on the waiting list for Housing Choice Vouchers (HCV) is 2,811 in the cities of Bismarck, Minot, Grand Forks, and Fargo where the majority of the MFP transitions are occurring. Wait periods for receipt of a HCV now range from 10 to 18 months.

North Dakota DHS is working to assist Public Housing Authorities (PHA) in establishing a local priority for individuals transitioning from institutional care which would decrease the length of wait time to receive a voucher. The Fargo and Grand Forks PHAs have established an MFP priority and efforts are being made with the other PHA offices around the state. This effort will be led by the new MFP Housing Project staff. The MFP Housing Project staff will also be working with the PHAs to share HCV with other offices around the state.

These efforts will not completely address the need for timely rental assistance. A Rental Gap Assistance Program is to be established utilizing ND MFP Rebalancing funds to assist MFP participants with rental payment until a HCV become available from the local PHA.

North Dakota has budgeted \$2,100 per month to provide rental assistance for up to six MFP participants per month. The number of persons served will vary dependent on the amount of assistance needed by each participant. The ND MFP Rental Gap Assistance Program will mirror the local PHA/HUD rules for maximum rent (Fair Market Value) and 30% of monthly income for rental share. Approved payments are based on the prevailing United States Department of Housing and Urban Development (HUD) Fair Market Rent guidelines of the applicable low-rent housing program in the area where the person's residence is located.

The fair market rent used shall be that for:

- A one-bedroom unit, or
- A proportionate share of rental costs in living units containing more than one bedroom.
- Assistance for rent is equal to the rent paid or the maximum allowable rent (if less), minus 30 percent of the gross income of the individual consumer.

The ND MFP Rental Gap Assistance Program will request an estimate for the amount of rent the program participant would be required to pay based on their income from the local Public Housing Authority. The ND MFP Rental Gap Assistance Program would utilize this as the participant's portion of rent. The MFP Rental Gap Assistance Program would pay the portion of rent that would otherwise be paid for by the Local Public Housing Authority.

Eligibility: In order to be considered for assistance, applicants must meet all of the following minimum criteria:

- The applicant shall be an active participant of the ND MFP Grant program.
- The applicant will meet the financial eligibility criteria of the local Public Housing Authority for a HCV or other rental assistance agency programs in the community that they plan to transition. Income and Income Exclusions for Housing Assistance will mirror the local PHA or rental assistance program guidelines.
- The applicant shall have applied for and be on the waiting list for a Housing Choice Voucher through their local Public Housing Authority or other rent subsidy programs under the U.S. Department of Housing and Urban Development or any other available rent subsidy programs.

- The applicant will provide written evidence from sources of local rental assistance available in the applicant's community that the applicant has applied for that rental assistance and that the applicant has been placed on a waiting list.
- The applicants living arrangement must meet the housing standards established by the local rental assistance agency/Public Housing Authority/HUD regulations.
- The applicant shall be financially responsible for rent or housing costs.
- The applicant shall have been discharged from a MFP grant program qualified institution into a MFP qualified housing arrangement and continued participation in the MFP Grant Program.

If you have access to the Internet, you can find out more about HUD Fair Market Rent at: <http://www.huduser.org/datasets/fmr.html>.

Application Process:

- Requests for the MFP Rental Gap Assistance program will be made by the participant's MFP Transition Coordinators and submitted for approval to the MFP Program Administrator.
- The Transition Coordinator will complete the MFP Rental Gap Assistance Program application document which is currently being developed and provide written evidence from sources of local rental assistance available in the applicant's community that the applicant has applied for that rental assistance and that the applicant has been placed on a waiting list.
- The MFP Program Administrator will establish a wait list if needed; based on time of application and time of transition to the community.

Housing Inspection:

The MFP Rental Gap Assistance Program will have all housing inspections completed by the local Public Housing Authority. The Cost of these inspections will range from \$30 to \$40 and will be paid to the local housing authority completing the inspection. These costs will be funded through the participants One Time Moving Costs and/or the MFP rebalancing fund dependent on the need of the individual participant.

Rent Payment Process:

Rental Assistance applicants are responsible for finding their own qualified unit. The property owner and/or landlord will establish the lease, enforce its provisions and collect the MFP participant's monthly rent. The ND MFP Rental

Gap Assistance Program pays the Transition Coordination or HCBS Provider Agency the difference between the market rent price and the amount of rent paid by the tenant. The Transition Coordinator/HCBS Waiver provider will make the MFP Rental Gap Assistance Program payment to the property owner/landlord on behalf of the MFP participant. The property owner and/or landlord are responsible for the maintenance and upkeep of the facility. Properties eligible for Rental Assistance must be located within the state of North Dakota.

Definition of qualified residences for MFP participants

A home owned or leased by the individual or the individual's family member;
An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and
A residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside i.e. Adult Family Foster Care or Community Group Home

Description of the State Regulations for Each Type of Housing

Adult Family Foster Care (AFFC)

An occupied private residence in which adult family foster care is regularly provided by the owner or lessee thereof to four or fewer adults who are not related by blood or marriage to the owner or lessee, for hire or compensation.

Adult Family Foster Care must meet State regulation as outlined in the “Qualified Service Provider Handbook”- Adult Family Foster Care Provider, Individual Qualified Service Provider, and AFFC Respite Provider including standards for practice and enrollment procedures as issued 5/2007 by:

Aging Services Division; N.D. Department of Human Services; 600 E Boulevard Ave, Dept 325; Bismarck, ND 58505-025; at the following website:

<http://www.nd.gov/dhs/info/pubs/docs/aging/handbook-for-qsp.pdf>

and in the State Adult Foster Care Policy Manual at:

<http://www.state.nd.us/robo/projects/66005/66005.htm>

Developmental Disabilities Residential Options

All ND community providers must be licensed to provide services. This specifically means authorization by the Department of Human Services to provide a service to individuals with developmental disabilities, pursuant to North

Dakota Century Code chapter 25-16 and as outlined in ND Administrative Code found at <http://www.legis.nd.gov/information/acdata/pdf/75-04-01.pdf>

The department also adopted and made a part of its administrative rules for all licensees the current standards used for accreditation by the council on quality and leadership in supports for people with disabilities. If a licensee fails to meet an accreditation standard, the department may analyze the licensee's failure using the appropriate 1990 standards of the council on quality and leadership in support for people with disabilities.

The following developmental disabilities services will generally be used as a qualified MFP Residence or to support and MFP participant in the community:

1. **Individualized supported living arrangements** – means residential support services options in which services are contracted for a client based on individualized needs resulting in an individualized rate setting process and are provided to a client in a residence rented or owned by the client.
2. **Family support services** – means a family-centered support service contracted for a client based on the primary caregiver's need for support in meeting the health, developmental, and safety needs of the client in order for the client to remain in an appropriate home environment.
3. **Minimally supervised living arrangements** means either – a group home with an available client adviser; or a community complex that provides self-contained rented units with an available client adviser.
4. **Transitional community living facility** – means a residence for clients with individualized programs consisting of social, community integration, and daily living skills development preliminary to entry into less restrictive settings.
5. **Home or Apartment** – The regulations relevant to an apartment/home would be the Housing Quality Standards (HQS). The HQS are Housing and Urban Development (HUD) standards. The HQS are used by the public housing authorities when they evaluate homes or apartments that are going to be rented by an individual with a housing voucher. Every residence is assessed and the results are documented and retained in the persons housing file.

Apartments/homes are reassessed on a regular basis to assure that it continues to meet standards. Only residences that meet these standards are eligible for use with a voucher.

Housing offices utilize a checklist for the assessment process. The HQS assessment checklist could be used to assure that a residence that is not subject to HUD regulation is evaluated by the professional involved with the transition. Training for this process could be provided by a housing office staff member if this situation would develop. The HQS checklist comes with instructions. This would come into play when someone moves to a private home that they own or is owned by a family member and no housing program is assisting with the housing costs.

The HQS would be applied in a reasonable fashion if used to assess a privately owned family home. The intent would not be to prevent the move but to address any real life safety issues. The need to negotiate for the welfare needs of the individual would assure that the home meets minimal standards and reasonable accommodations are made for the person moving to the home. If a concern had no impact on the person with a disability it would not be appropriate to make this a road block for the move. Example: No vent or window in older home's bathroom.

All buildings need to meet minimal building code requirements such as sewer, water, electrical codes. The additional HQS could be applied to privately owned homes beyond those standards to assure an appropriate and safe living environment. The ultimate goal is to assure a good quality of life for each person.

Housing Quality Standards address the Americans with Disabilities Act (ADA) reasonable accommodations requirements. Fair housing laws require that landlords allow renters to make their own reasonable accommodations as long as they return the apartment to its prior condition.

Document Requirements for all Residences into which Money Follows the Person Participants are placed to assure they meet Money Follows the Person Statutory Definitions for "Qualified Residences"

The Transition Coordinator will document in a computerized assessment the type of qualifying residence that the nursing facility MFP participant transitions to after discharge from the institution. The system will require the Transition Coordinator to record the type of qualifying residence that will be utilized. The Transition Coordinator will be provided with the necessary training to determine if the residence meets MFP specifications. The system is a nationally recognized software program entitled "SAMS" and will be monitored by the MFP Grant Program Manager as part of the MFP quality assurance strategy.

The Developmental Disabilities Program Manager will document on the MFP Form the type of qualifying residence that the Life Skills and Transition Center or community ICF/ID MFP participant transitions to after discharge from the institution. The DD Program Manager will be required to record the type of

qualifying residence that will be utilized. The DD Program Manager will be provided with the training necessary to determine if the residence meets MFP specifications as a qualified residence.

Project Based Housing Resources

North Dakota has 130 HUD Section 8 properties with a total of 3,398 units. There are 26 HUD Moderate Rehabilitation Properties with 378 total units in the State. Currently, there are 126 Low Income Housing Tax Credit Properties with 3,678 total units. The HOME Investment Partnership Program has 58 properties with 1,214 units. North Dakota also has 188 United States Department of Agriculture Rural Development Projects funded for a total of 2,700 units.

All Transition Coordinator providers have been provided with a listing of the project have been provided with a listing of the project based housing resources in North Dakota including contact information for specific sites. This information will assist the Transition Coordinators in locating the available housing options for the consumers that they are assisting consumers with transition.

The Money Follows the Person Stakeholder Housing Workgroup will request that the State's Low Income Housing Tax Credit (LIHTC) Program Qualified Allocation Plan (QAP) provide additional incentive for multi-family development and rehabilitation projects with set asides for the elderly and/or disabled. The State's plan, which is administered by the NDHFA, currently provides points in its scoring system for units targeted for the elderly and disabled. We will ask NDHFA to add points for this population group starting in the Fall of 2008 for inclusion in the 2009 Qualified Allocation Plan. This strategy will continue to be pursued each Fall for the following year's QAP.

The Money Follows the Person Housing Workgroup is supporting and participating in the development of a North Dakota Housing Trust Fund. This has been identified as a long-term strategy to support the development of statewide affordable, accessible, and available housing. The Housing Workgroup is working in cooperation with other groups around the State for the purpose of introducing legislation to establish a trust fund during the 2009 Legislative Session.

Tenant Based Housing Resources

North Dakota has established 32 Public Housing Authority (PHA) offices around the state to serve persons in need of assistance with their housing needs. North Dakota has 7,479 tenant based vouchers at this time. In 2007, these PHA offices issued 6,900 Housing Choice Vouchers resulting in approximately \$25.1 million in Housing Assistance Payments (HAP). The Public Housing Authority Offices hope to avoid any federal decrease in the number of housing vouchers provided at this time. If the North Dakota Housing Trust Fund is approved, efforts will be

made to develop gap services to address the waiting lists for housing vouchers in the metropolitan areas of the State.

The Money Follows the Person Housing Workgroup is supporting the development of local preferences for persons transitioning with each of the individual Public Housing Authority offices in the State. North Dakota Housing Authorities have been asked to consider Money Follows the Person participants as a local priority to the extent possible. A letter and Money Follows the Person brochure has been sent to each of the PHA Executive Directors explaining the Money Follows the Person Grant, and the needs of the consumers participating in grant services. A meeting has been requested with the Executive Directors to review and discuss the request for the establishment of the prioritizing Money Follows the Person participants. Currently, each PHA office is considering the MFP priority on an individual basis.

Strategies to assure a sufficient supply of qualified residences and to assure Money Follows the Person participants have a choice among them.

1. The MFP Stakeholder Committee has established a Housing Workgroup that includes representatives from the North Dakota Housing Finance Agency (NDHFA), the Department of Commerce, Division of Community Services; ND Community Action agencies; Public Housing Authorities (PHA); the Housing Program Director of Community Works of North Dakota; Protection and Advocacy of ND; Center of Independent Living Staff; a provider of Assisted Living services; IPAT representative; the MFP Grant Program Manager; and a member of the Medicaid Infrastructure Grant (MIG) Housing Task Force. This group is representative of all the primary housing agencies in North Dakota and will continue to meet throughout the grant period to facilitate cooperative efforts to provide integrated, affordable, and accessible community housing options.
2. The MFP Housing Workgroup will work to develop local preferences for persons transitioning with each of the individual PHA offices in the State. This will involve communicating the goals of MFP and making the request that PHAs address the issue of establishing a local MFP priority.

The directive from the HUD Secretary will be used as part of the communication with the PHAs as he has specifically encouraged PHAs to set local preferences, and to use public housing units, Housing Choice Vouchers, and Mainstream Vouchers to support people with disabilities in their transition to the community.

3. The primary provider of housing in North Dakota will be either section 8 project based or voucher based assistance. Once again this strategy will involve facilitating communication and collaboration with the ND Public

Housing Authorities (PHAs), the NDHFA, USDA Rural Development, and the Dept of Commerce to assure an adequate supply of housing. The MFP Housing Workgroup will collaborate with the Medicaid Infrastructure Grant Housing Task Force to accomplish this strategy.

4. A comprehensive list of project based housing available in ND has been developed.
5. NDHFA, USDA Rural Development, and Dept. of Commerce project based housing have been identified around the State. A list of these projects that provide restricted access to individuals with some form of a disability has been prepared for use by the professionals assisting with transitions.
6. The list of project based housing would best be managed by the local housing authorities but will be provided to the transitional staff for all population groups to be served by the grant. This process would be effective for all populations in need of housing. The intent is to assure that all local public housing authorities can provide information about all the housing options in their specific area not just voucher related information. The MFP housing workgroup will approach the PHA administrators about accepting this responsibility.

Address increased use of Section 8 Housing Choice Voucher Homeownership Program assistance.

7. At this time only two agencies are utilizing this option including Grand Forks and Fargo. This strategy is a good long term goal to pursue but it will have to be addressed individually with each local housing agency to determine if they have the capacity to manage the large amount of paperwork that goes with each case.
8. Contact the ND Builders Association to discuss incentives that would encourage voluntary development of more accessible housing.

Provide education so that builders construct projects that allow individuals to "Age in Place".

9. Request that the State's Low Income Housing Tax Credit (LIHTC) Program Qualified Allocation Plan provide additional incentive for multifamily development and rehabilitation projects with set asides for the elderly and/or disabled.
10. The state's plan, which is administered by the NDHFA, currently provides points in its scoring system for units targeted for the elderly and disabled. We will ask that they add additional points for this targeting.

11. Assisted living was also noted as a housing option that has been identified. LIHTC have been of question as it has been difficult to separate the housing and services components. Services must be optional. NDHFA will be encouraged to create LIHTC scoring incentives for the development of assisted living facilities.
12. Several funding sources exist for housing rehabilitation current housing. There are programs provided by NDHFA, USDA Rural Development, and through HUD's HOME program. Programs include Helping HANDS, RAP, 504 Rural Development Loans and Grants, HOME and CDBG programs, to name a few. Each program has funding limitations and eligibility issues.

The workgroup will contact the seven Community Action Program (CAP) regional offices to see if they would act as the primary contact for housing rehab needs. If they could not help with the programs they administer, they could refer to others. This would require some education for the CAP caseworkers if this were to work well.

13. The need to be flexible in determining what is going to work was emphasized as strategies that may work in the larger cities may not work in the more rural areas of the state.
14. The MIG housing taskforce is pressing for legislation that would require new construction to meet visit-ability standard at both the national and state level. The MFP workgroup has discussed this issue and the cultural issues around this being "required by law" for private housing projects. It is noted that providing incentives and working on long term culture change to encourage this action is of great value and the approach recommended by the MFP housing workgroup.
15. The development of a ND Housing Trust Fund has been identified as a long-term strategy to support the development of affordable, accessible, and available housing. The Housing Workgroup will work to support the development of the fund in cooperation with other groups around the state.
16. Other Potential strategies or housing related issues:
 - a. First time homebuyer's loans could be utilized for MFP and other individuals
 - b. Concerns about high taxes for the elderly in their home could be addressed with reverse equity mortgages, Homestead and disabled tax credits (state would reimburse the county for this credit).

17. Private apartment units can be identified through local MLS or apartment association but many would likely not be affordable without a Section 8 housing voucher.
18. Many nursing facilities have independent living units/apartments as part of their building. We will develop a list with assistance from the LTC Association
19. Assisted Living continues to be an appropriate MFP housing option but cost remains the primary issue. Efforts will be made to evaluate what other states are doing to utilize assisted living facilities.

Resources

North Dakota Department of Commerce

The Department of Commerce administers the Home Investment Partnerships (HOME) Program through various sub recipients including the seven Regional Community Action Agencies, two Community Housing Development Organizations (CHDOs), and the cities of Grand Forks and Bismarck. All HOME funds are restricted to benefiting low-income persons.

The Community Action Agencies utilize HOME funds to perform single-family home rehabilitation work for low-income homeowners. In addition, the agencies also receive LIHEAP funds through the ND Department of Human Services and from the US Department of Energy (DOE) for its weatherization program for low-income homeowners.

The two CHDOs, Affordable Housing Developers Inc., which covers the western half of the state, and the Eastern Dakota Housing Alliance, covering the eastern half of the state, utilize HOME funds to participate in the development and rehabilitation of multi-family apartment structures. The CHDOs are also eligible to provide homeownership assistance.

As entitlement cities, Grand Forks and Bismarck receive HOME allocations annually. They are eligible to participate in any HOME-eligible activities as long as the activity is consistent with their city's Consolidated Plan and the state HOME Program. The cities have recently been involved in the development of multi-family properties for the general population, as well as special needs populations such as transitional housing and housing for the developmentally disabled.

NDHFA can target some first time home buyer money-do not have to be 1st time buyer and can use 40 year mortgage

Home of Your Own

These funds have not been utilized at any significant level at this time

Home Choice-Non-Conventional Loan options for purchase of housing (CommunityWorks)

Utilize Habitat for Humanity housing options

Utilize Veterans Loans and related service

“Funding Sources Successfully Used by States to Support Development of Integrated, Affordable, and Accessible Community Housing” – this publication was issued in November of 2007 and will be utilized as a tool by the MFP Housing Workgroup to develop new housing strategies throughout the grant period. All workgroup members have been provided a copy for their review.

The ND MIG Housing Task Force has also created an informational housing manual that provides all persons with information on public assistance for housing, a review of the Homeownership programs, a review of property tax exemptions, a discussion of assistive technology and home modifications, a review of how to finance home modifications, an outline of housing rights and accessibility laws, and a listing of community resources. The manual is titled *“The Perfect Home: Resources and Options for People with Disabilities”* and will be provided to the Transition Coordinators for use in finding housing in their specific area of the State.

Definitions

The need to define what the group views as housing was discussed without a formal definition being finalized. Some of the concept definitions offered in the new housing document were provided for increased understanding and clarification.

Universal Design – ‘The design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.’ (Center for Universal Design, North Carolina State University at:

http://www.design.ncsu.edu/cud/about_ud/about_ud.htm

Accessible - Accessible design generally refers to houses or other dwellings that meet specific requirements for accessibility. For example: building codes, housing regulations, and guidelines.

Adaptable – Adaptable design allows some features of a building or dwelling to be changed to address the needs of an individual with a disability or a person encountering mobility limitations as he/she ages. Such design features allow the change to be made quickly...without the use of skilled labor and without changing the inherent structure of the materials.

Visit-able – Visit-able refers to homes that are not only accessible to guests with disabilities visiting the homes of non-disabled hosts, but to the future needs of the non-disabled residents as well. Access features include zero-step entrances, accessible hallways, and accessible bathroom

B. 10 Continuity of Care Post Demonstration

Nursing Facility Transitions

With the exception of demonstration/supplemental services for the transition and supplemental demonstration services for deposits, furnishings, and vehicle modifications, all home and community-based waived services and all state plan services provided as MFP demonstration services that were available to an individual in the first year following transition from the nursing facility will be available in subsequent years of the demonstration program contingent upon program eligibility requirements. The ND Home and Community Based Services waiver has the slot capacity to accept the increased number of applicants anticipated through this project, with the assumption that each new program participant will continue to be served by the respective waiver after the end of the first year of community based service provision.

The county case manager will complete a level of care screening within the last 7 days for all MFP participant's prior to the end their 365 days of eligibility to determine waiver eligibility at time of MFP discharge. If a MFP participant no longer meets nursing facility level of care screening requirements other service programs will be offered to meet their needs including the ND Service Payments to the Elderly and Disabled and Expanded Service Payments to the Elderly and Disabled, and Older Americans Act Services.

Home and Community Based Services Waiver Services available to persons with a physical disability or an elder after MFP discharge

- HCBS Waiver

This waiver helps eligible individuals who would otherwise require nursing home services to remain in their homes or communities. It gives eligible people options, if their needs can be met in their homes.

- Technology Dependent Waiver

This waiver provides attendant care service and case management

- Medically Fragile Children Waiver

This waiver provides In-Home Supports, Institutional Respite, Transportation, Equipment and Supplies, Individual and Family Counseling, Nutrition Supplements, Environmental Modifications

- Medicaid State Plan-Personal Care (MSP-PC)

Service Payments for the Elderly and Disabled (SPED)

The SPED program provides services for people who are older or physically disabled and who have difficulty completing tasks that enable them to live independently at home.

Expanded Services Payments for the Elderly and Disabled (Ex-SPED)

The Expanded-SPED program pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility.

Older Americans Act Services

The Older Americans Act of 1965 (OAA) was enacted to improve the lives of America's older individuals in relation to income, health, housing, employment, long-term care, retirement, and community service. The underlying purpose is to enhance the ability of older individuals to maintain as much independence as possible and to remain in their own homes and communities. Federal funds are allocated to states on an annual basis to provide services to older individuals.

Eligibility Requirements

- Older Americans Act Services are available to individuals who are age 60 and older. There is no means test. Individuals must be given the opportunity to contribute to the cost of the service; however, no one can be denied service due to inability or unwillingness to contribute.

Services Available

- Congregate Meals, Provides nutritional meals in a group setting
- Escort Shopping Assistance, Provides personally assistance to help people with physical or cognitive difficulties to obtain services outside the home environment
- Family Caregiver Support Program, Provides support services to informal caregivers and older adults caring for children 18 and younger
- Health Maintenance, Provides monitoring and screening services for early detection of health issues, and also provides health education, referral and follow-up
- Home Delivered Meals, Provides homebound individuals who are unable to prepare an adequate meal with a nutritious meal

- Legal Assistance, Provides legal advice and representation by an attorney to older individuals with economic or social needs
- Outreach - Includes interventions by an agency or organization for the purpose of identifying potential clients and encouraging their use of existing services and benefits
- Transportation, Provides a method of travel from one specific location to another specific location to access essential community services
- Senior Companion Services, A service that offers periodic companionship and non-medical support by volunteers (who may receive a stipend) to adults with special needs

Services for Persons with a Developmental Disability

North Dakota Life Skills and Transition Center and Community Intermediate Care Facilities for Individuals with an Intellectual Disability Transitions

All home and community-based waived services and all state plan services provided as MFP demonstration services that were available to an individual with a developmental disability in the first year following transition from the Life Skills and Transition Center or a community ICF/ID will be available in subsequent years of the demonstration program contingent upon program eligibility requirements.

The MR/DD Waiver have the slot capacity to accept the increased number of applicants anticipated through this project, with the assumption that each new program participant will continue to be served by the respective waiver after the end of the first year of community based service provision.

Within sixty days prior to discharge from the MFP demonstration services an updated level of care screening will be completed by the Developmental Disabilities Case Manager to assure waiver eligibility following MFP demonstration services. Section 11 funded services may be available to MFP participants who no longer meet the ICF level of care. DD program management services will be continued and if appropriate a referral to alternative Human Service Center services will be initiated.

Qualified home and community-based waived services available to individuals with a developmental disability following the year they receive services through the demonstration program are:

- MR/DD Waiver
- DD Self Directed Supports Waiver
- And Medicaid State Plan-Personal Care (MSP-PC)

Services that will be available include the following:

- Adult Day Health
- Day Habilitation
- Extended Services
- Homemaker
- Residential Habilitation
- Extended Home Health Care
- Adult Family Foster Care
- Behavioral Consultation
- Environmental Supports/Modifications
- Equipment and Supplies
- In-Home Supports
- Infant Development
- Parenting Support
- Transportation Costs for Financially Responsible Caregiver
- Personal Care Services – allow the individual to live as independently as possible while delaying or preventing the need for institutionalization.
- Home Health Care – intermittent nursing care provided in home to prevent institutionalization.

Self-Direction – North Dakota's Developmental Disabilities Waiver provides service options for individuals living with primary caregivers. The goal of the waiver is to provide a consumer-centered service delivery system assuring health and welfare, participant rights and safeguards and financial accountability for In-Home Support, Environmental Supports/Modifications, Material and Supplies, Extended Services, Behavior Consultation and support for Transportation Costs for Financially Responsible Caregivers in order to maintain individuals in their community.

- Equipment and Supplies
- Transportation Costs for Financially Responsible Caregiver
- Environmental Supports/Modifications
- Extended Services
- Behavioral Consultation

In-Home Supports Direct Service Workforce Development

One of the primary barriers to rebalancing the North Dakota Long Term Care Services and Supports system is the shortage of direct service workforce personnel. This shortage is statewide but is most pronounced in all rural counties and in the western half of North Dakota where our oil development industry is so

strong. The primary effect this shortage has on both institutional transitions and institutional diversions is that workers are not available to provide the levels of support available through our HCBS programs to meet the needs of consumers.

Workforce development technical assistance has been requested and provided to the North Dakota MFP project since 2009. This assistance has resulted in:

- The development of two realistic job preview videos to assist with both recruiting and retention of direct workforce personnel.
- The TA providers have provided education to Developmental Disabilities provider agencies addressing recruitment and retention strategies.
- Data collection tools have been developed to assist in tracking turnover and for legislative funding requests, a talent pipeline mapping process was developed and implemented, and a direct service workforce planning committee has been established.
- The technical assistance process has also resulted in the recommendation that North Dakota seek MFP administrative dollars to fund a position that would be responsible to coordinate all direct service workforce development in a more comprehensive manner.

Direct Service Workforce Development Coordinator

Requires one of the following:

- Bachelor's degree with a major in business, management, marketing, education or public administration with four years professional sales or marketing experience; OR
- Master's degree in business or public administration with two years professional sales or marketing experience; OR
- Associates degree in business, management, marketing or public administration with six years of professional sales or marketing experience; OR
- Eight years of professional sales or marketing experience; OR
- Any combination of experience and education as listed above, totaling eight years.

The Ideal Candidate will Possess:

The ability to develop effective and productive relationships with targeted corporations and businesses through the delivery of a consistent and positive message about working with the ND Division of Vocational Rehabilitation (DVR), position DVR as the primary point of contact for hiring qualified applicants with disabilities, assist DVR regional staff to respond effectively in building partnerships between DVR and businesses, improve field unit capacity to build local business relationships and work with DVR consumers to build job skills and work experience in preparation for obtaining and maintaining meaningful employment.

Critical Skills Include:

- Communicating effectively, both orally and in writing.
- Performing work under limited supervision and operating with high professional and ethical standards.
- Problem solving.
- Managing multiple and competing priorities.
- Basic computer usage including: Microsoft Word, Access, Outlook, Publisher and PowerPoint.

The Direct Service Workforce Development Coordinator's overarching role is to coordinate the implementation of the Money Follows the Person and other state agency related efforts to promote the professionalization of the direct service workforce and to improve recruitment and retention of direct service professionals who assist people with disabilities and older adults to live independently and with dignity in the community. This includes direct support professionals supporting persons with an intellectual or developmental disability, Qualified Service Providers serving older adults and persons with disabilities, private personal care attendants, family care givers, extended personal care providers, case aides serving persons with a serious mental illness, adult foster families, home health aides, and others.

Definition: Direct Services Workforce personnel are individuals that provide supports and services for persons with disabilities and for older adults in various community settings. These community settings include both in the consumers home and in their work environment.

Job Duties:

- Coordinate the MFP Direct Services Workforce Development Committee including member/agency recruitment, meeting scheduling and facilitation, data collection efforts, current and long term workforce recruitment and retention strategy development, and strategy communication and implementation. This includes ensuring that workforce initiatives are based on input from different sectors of the four populations being supported including aging, behavioral health, intellectual development disability, and physical disability populations. The committee will need to include a broad base of stakeholders including consumers, workers, employer agencies, and state agencies.
- Collaborate with public and private agencies, associations, and individuals to develop long term strategies to enhance the infrastructure needed to support and coordinate workforce development. This will need to include public schools, higher education institutions, job training programs, vocational rehabilitation, job service, Department of Commerce, trade associations, and the various divisions of the ND Department of Human Services
- Participate in the MFP marketing planning and implementation process as it relates to direct services workforce recruitment. This will include assisting with development and distribution of introductory QSP packet information, distribution of QSP and DSP realistic job previews, identification of consumer stories for use in marketing, and other activities developed by the marketing plan.
- Develop, schedule, and provide informational sessions routinely across the state for potential and current Qualified Services Providers in cooperation with Medical Services Division HCBS Waiver Program Administrators. This would include but is not limited to sessions that provide information on the QSP enrollment and provider responsibilities, QSP training options, resources available to fulfill their independent provider business responsibilities, QSP billing processes, and QSP documentation requirements.
- Provide individual and group technical assistance to individuals and agencies in their completion of enrollment and reenrollment forms, billing documents, documentation materials, and with understanding the responsibilities of an independent provider
- Develop, schedule, and provide informational sessions routinely across the state to promote and increase the number of Extended Personal Care Program/Nurse Educator Service providers.

- Act as liaison with the Qualified Service Provider Association including facilitating the development of informational sessions and communication sessions with association members and other QSPs.
- Provide consultation to agencies and provider associations to assist with efforts related to identification of workforce needs and development of long-term strategic plans to strengthen the direct service workforce. These strategies can include marketing, outreach, recruitment, hiring and selection strategies that are effective at attracting more qualified applicants, and lowering turnover.
- Facilitate contact between employers, state or national agencies and/or with technical assistance agencies to provide information.
- Assist state agencies and employer/provider agencies or associations with the review of their training programs, credentialing programs, apprenticeships, and talent pipe line mapping efforts as that maybe needed or requested.
- Assist state agencies and employer/provider agencies and associations with the identification of performance measures and measuring outcomes of workforce improvement efforts, including the evaluation methodologies and survey instrument design. This will include facilitation of technical assistance from agencies such as the National Direct Service Workforce Resource Center and the MFP Grant technical assistance agencies.
- Assist Aging Services Division, Family Caregiver Program staff with raising awareness about the demands of caregiving, the needs of all family caregivers, and building capacity and support for family caregivers.
- Assist the ND Department of Human Services, Division of Mental Health and Substance Abuse Services, Developmental Disabilities Division, and related community service providers with population specific and/or division specific workforce development. This could include assisting the One Center (Development Center and the ND State Hospital), Human Service Centers, Division Program Administrators, or their community partners.

Direct Service Workforce Marketing

The ND MFP Grant will work with a marketing agency contracted to develop and implement a marketing plan to promote public awareness, strengthen the image, and create more interest in the career of Direct Service workers.

The contracted marketing agency will target an audience of Women 25-54 primarily through broadcast and cable television, Television is more efficient in reaching this audience statewide than any other medium. They will develop a compelling thirty-second (:30) TV commercial and complementary radio and newspaper ads highlighting the benefits of becoming a direct service worker.

The company will use radio stations that best reach our target audience throughout the state and will also use weekly and daily newspapers to reach those living in rural communities who may be interested in working where they live.

Awareness created through mass media must be followed up with a call to action that makes it easy for interested candidates to learn more about this career opportunity. The marketing agency will work with the State to develop and launch a recruitment website for interested individuals to learn more about the requirements and qualities needed to become successful in direct service work.

The website will allow individuals to apply for positions, as well as view videos about becoming a QSP or DSP. The website will also feature a chat function where individuals can ask more questions. All statewide marketing will refer prospective candidates to visit the website. Social media also plays a significant role in recruitment of college and high school students. The marketing agency will enhance the program's internet presence through social media channels such as Facebook.

The marketing agency will work directly with healthcare educators in high schools and colleges by providing tool kits for students, informing them about occupations in the Direct Service Workforce and how it will enhance their career. These tool kits will be similar to HCBS's tool kit. The folder will include fact sheets and inserts regarding Direct Service Workforce occupations. Also included will be testimonials, along with a description and responsibilities of services. Posters, flyers, and electronic bulletin boards will be prepared for use on campuses throughout the state.

SECTION C – ORGANIZATION AND ADMINISTRATION

C.1 Organizational Structure

Medical Services, (see Medical Services Organizational Chart below) the ND Medicaid agency, is a division of the Department of Human Services (see Department of Human Services Organizational Chart below) and will manage the demonstration grant. The Medical Services division is responsible for Medicaid eligibility regulations and policies; state plan service regulations, policies, and payment; payment for all waived services; and policies and regulations for the provision of waived services to the elderly and disabled. The ND MFP Grant Program Administrator is an employee of the Medical Services Division.

The Developmental Disabilities Division within the Department is responsible for policies and regulations for the provision of waived services to the individuals who will transition from ICF/ID facilities including the Life Skills and Transition Center.

Transition services for nursing facility residents will be coordinated between Medical Services and the four Centers for Independent Living (CIL) located throughout the state. In addition, to the transition services to be provided by the CILs, all individuals receiving HCB qualified services will be assigned a case manager from the county social services office, where the individual will be living, and who will authorize and monitor HCB services. The staff from the nursing facility will also be engaged with the assessment and discharge planning efforts.

Transition Coordination Services

Center for Independent Living-Transition Coordination: ND will contract with the four Centers for Independent Living serving ND to provide Transition Coordination Services. The four Centers include the following:

- **Dakota Center For Independent Living**
3111 East Broadway Avenue
Bismarck and Dickinson
- **Options Resource Center For Independent Living**
318 3rd Street NW
East Grand Forks, MN and Cavalier ND
- **Freedom Resource Center For Independent Living**
2701 9th Avenue SW, Fargo and Jamestown

- **Independence, Inc. Center For Independent Living**
300 3rd Avenue SW, Suite F, Minot

The Director of each Center will provide direct supervision to the Transition Coordinators working for their agency. The Center Directors will manage and supervise the day to day activities of all staff providing MFP related services and assure required documents, reports, and participant interactions occur as outlined in the contract negotiated with the Department of Human Services.

The MFP Program Administrator will evaluate the performance of each individual Center and the performance of the Transition Coordination service based on the scope of practice outlined in the contract.

Transition services for ICF/ID residents involve four entities with the Department (DHS) that all are accountable to the Executive Director of the Department:

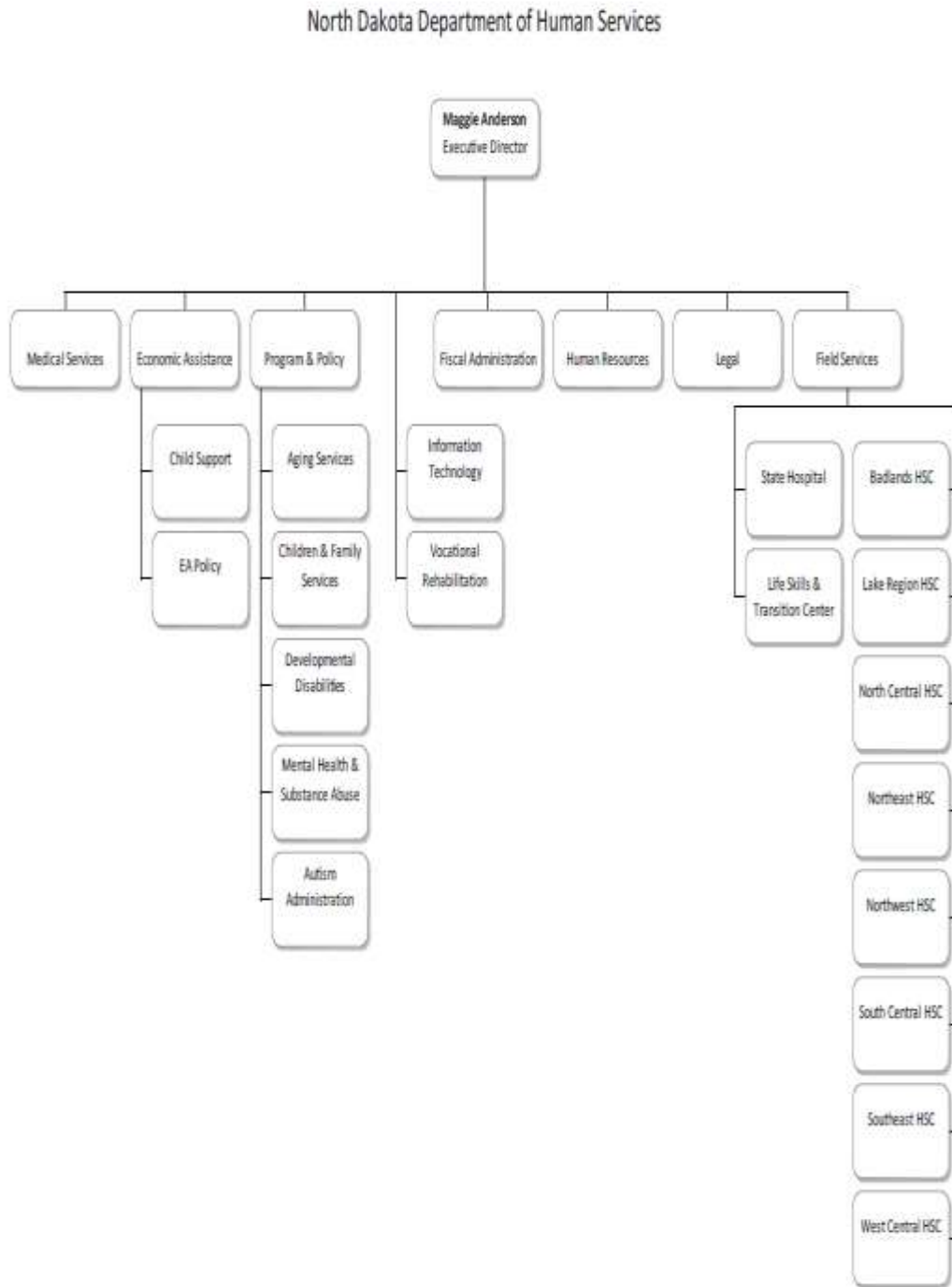
- **Medical Services Division** –Medical Services have designated personnel that work directly with the Disability Services Division (DSD) to provide support in development and administration of -ID/DD waiver and ICF/ID services.
- **Disability Services Division (DSD)** – Provides statewide policy and program development and support and oversight of ID/DD waiver and ICF/ID field operations. DSD administrators also participate in ongoing HCBS system planning and development with the Medical Services Division.
- **Developmental Disabilities program Management (DDPM)** Consists of DD program managers and Regional Developmental Disabilities Program administrators that supervise case managers within the regional Human Service Centers (HSCs) and manage and monitor the service system at the regional level.
- **North Dakota Life Skills and Transition Center**– Operates institutional ICF/ID services.

All individuals receiving services in community ICF/IDs are assigned a case manager from the regional Human Service Center to authorize and monitor services. This function includes ensuring individuals have choice between ICF/ID and waiver services and of the least restrictive service setting that will meet their needs. Responsibilities of DDPMs include referral and planning for transition of individuals from ICF/ID to ID-DD waiver/HCB services.

All NDLSTC residents are associated with a regional HSC representing their region of origin. A case manager is assigned to each individual at NDLSTC and is a member of that individual's Individual Support Plan team. This provides an ongoing and direct link for planning transition to the community service system.

DDPM communicates closely with the DSD in service planning and delivery. This includes at least monthly joint planning sessions between DSD, DDPM and NDLSTC for evaluation and consideration for referral and transition to HCB services for NDLSTC residents. DDPM then works with designated NDLSTC personnel to facilitate referral to community HCB providers to effect transition to the community.

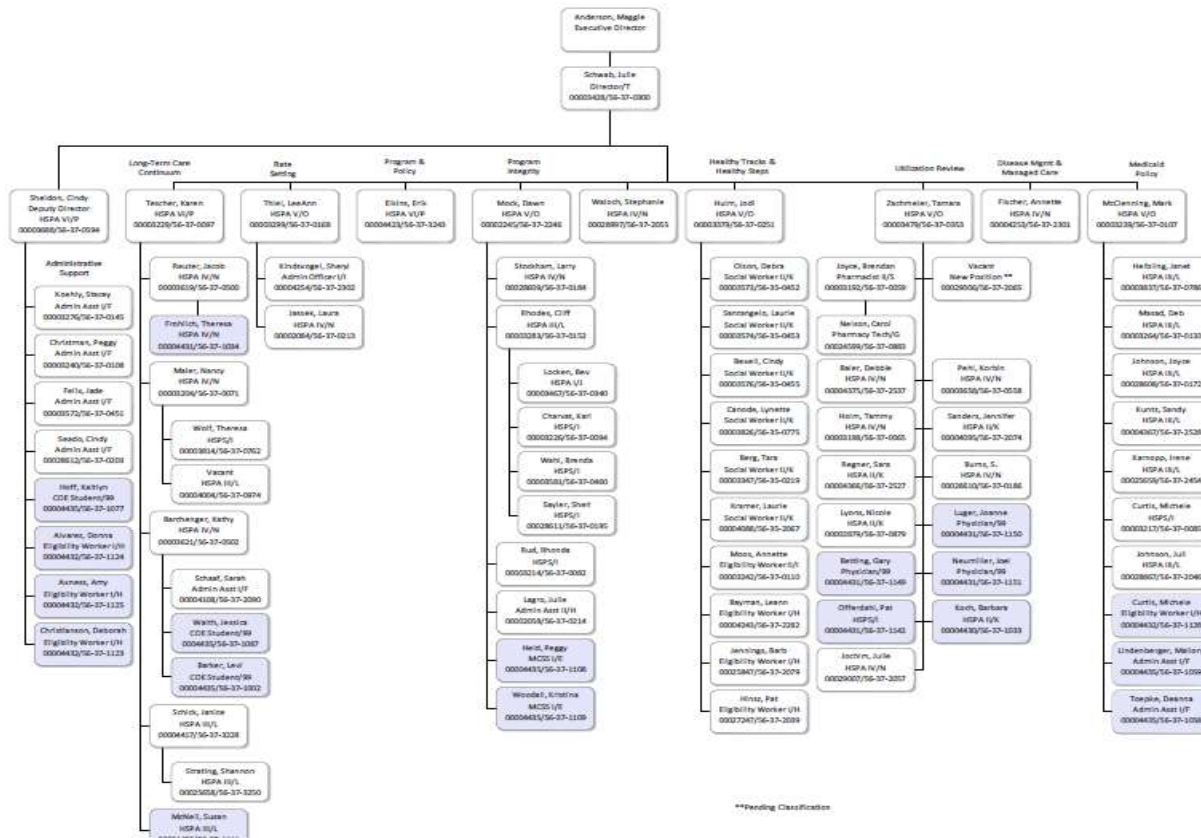
North Dakota Department of Human Services Organizational Chart



Revised 9/6/13

Division of Medical Services Organizational Chart

ND Department of Human Services
Medical Services



Revised 10/2014

C. 2 Staffing Plan

Medical Services has identified Jake Reuter as the full-time Program Administrator for the Money Follows the Person Demonstration (See Attachment G for Resume).

The Life Skills and Transition Center (DC) will have the following staff commitments to the demonstration:

- Life Skills and Transition Center, Social Worker – ½ Full-Time Equivalent (FTE)
- Eight Unit Program Coordinators each at .05 FTE.

Regional Human Service Center staff will also be involved. This will include:

- DD Program Managers
- Regional Program Administrators

These professionals will assist individuals in the ICF/ID target population with referral, pre-placement, and follow-up services, it is estimated that each individual will require 83 hours of Case Management and six hours of assistance from the Regional Program administrators.

Developmental Disabilities Division

DD Division, Adult Service Program administrator, dedicated at .05 FTE. Administrator will provide oversight to the DD transition efforts and will assist staff at the DC and the HSCs.

Center for Independent Living-Transition Coordination

ND will contract with the four Centers for Independent Living serving ND to provide Transition Coordination Services. The four Centers include the following:

Dakota Center For Independent Living

3111 East Broadway Avenue
Bismarck and Dickinson

Options Resource Center For Independent Living

318 3rd Street NW
East Grand Forks, MN and Cavalier ND

Freedom Resource Center For Independent Living
2701 9th Avenue SW, Fargo and Jamestown

Independence, Inc. Center For Independent Living
300 3rd Avenue SW, Suite F, Minot

Each of the four Centers will provide a minimum of two staff members to function in the role of Transition Coordinator. Time allotted for this service will be based on number of referrals. The Coordinators will provide the supports needed to assist nursing facility consumers with their transition to the community. The Transition Coordinator will also assist consumers with application for supplemental support services available for one time transition related costs. Coordination services will also involve supporting consumer transitions for 365 days after their move from the nursing facility.

The Director of each of the four Centers will provide direct supervision to the transition coordination staff. This will include monitoring employee performance, report completion, compliance with privacy requirements, and conduct with consumers based on the scope of practice expectation outlined in the contract for services with the ND Department of Human Services.

The contract established by the Department of Human Services with each of the Centers outlines Transition Coordination service expectations. The MFP Program Administrator will evaluate the performance of the Transition Coordination services based on the scope of practice outlined in the contract.

Nursing Call Service Agency

ND has contracted with a nursing service agency to provide 24 hour phone backup services for MFP participants. The nursing agency is providing staff 24 hours a day to manage these calls.

C. 3 Billing and Reimbursement

MFP participants that have been transitioned will be assigned a unique living arrangement code in the claims payment system (MMIS) which will allow for payment, reporting, and tracking of qualified HCB services. The code will also allow for collection of specific data on individuals transitioned ensuring individuals meet the eligibility criteria and will provide data to be used in the analysis of the success of the transition process. Specific data will include length of time institutionalized, length of time in community living, and costs of the transition plan.

Transition Coordination services will be a contracted service. Each of the four providers of this service will be required to submit monthly reimbursement requests on the required contract reimbursement form. Providers will track services provided in fifteen minute increments and will submit a request for payment of all services provided on a monthly basis. The provider will maintain an accurate accounting of services provided to individual MFP participants for program audit purposes. ND will randomly audit MFP service contracts and will initiate audits if questionable billing practice is identified.

Requests for Supplemental Services will be reviewed and authorized individually by the MFP Grant Program Administrator. A history of all payments for Supplemental Services will be maintained in the state's financial accounting system. The Grant Administrator will maintain individual files on all MFP participants for quality assurance review purposes.

Billing and payment to Qualified Service Providers is monitored routinely by the HCBS Staff of the Medical Services Division of the Department of Human Services to track billing accuracy and consistency with authorized services.

Medicaid Fraud and Abuse Unit Condensed Manual and Policies as they Relate to MFP Participants

In North Dakota the fraud unit is located within the Medicaid Program Agency. North Dakota requested a waiver and was granted the waiver do to a low volume of cases, making it not cost effective to have a separate unit from the Medicaid Agency.

Currently the unit has an administrator who is the chief auditor and investigator. The administrator is also the S/UR and TPL administrator. The Medicaid S/UR staff support the administrator in gathering Medicaid eligibility and medical payment information. There are one and one half staff members in the S/UR Unit.

The S/UR Unit in most cases conducts desk audits from referrals and exception review processing. As cases develop into potential recovery and/or criminal cases the auditor/investigator conducts a more thorough investigation, which may include an onsite announced or unannounced audit. Once the auditor/investigator has compiled a

criminal report or audit report (depending on the type of case) the merits of the case are discussed with the Medicaid Director to determine the course of action. The administrator makes recommendations to the Medicaid Director on what options may be pursued in each case.

If it is determined that the case should be referred to the Office of Inspector General (OIG) or the US Attorney's Office, the administrator prepares the report and evidence to be forwarded to the proper entity. The administrator then takes the role as technical advisor to that entity and may appear at a legal hearing as a witness to the findings.

If the matter is determined to be an administrative action to correct and recoup erroneous billings the administrator will start the procedures to notice the provider/recipient, inform the provider/recipient of the findings, the overpayment and the right of appeal. If the findings are not contested, the administrator will negotiate or dictate the terms for payment and/or other sanctions.

If the case is referred to the US Attorney or OIG for further development and processing, it is that entities responsibility to report any sanctions to the Office of Integrity for the national register. If the state takes action to sanction a provider the administrator will report the action to the OIG for the national register. It is also noted that in some cases, the case may be referred to the Attorney General's Office or State's Attorney for prosecution in the state court. Most recipient cases are handled in this manner.

The North Dakota Medicaid Program also has full and part time professional staff that conducts peer reviews, authorizes out of state services based on necessity, and determine necessity in services being provided to Medicaid recipients by Medicaid Providers. The staff consists of a medical physician, nurses, dentist, full time pharmacist and optometrist. They are also available to assist in the desk audits and on site reviews where warranted.

The fraud unit when conducting audits and investigations adhere to all confidentiality rules and follow the due process for suspected individuals and entities.

SECTION D – EVALUATION

Evaluation is not a required component of the MFP Operational Protocol. North Dakota has opted not to include its own evaluation component in its MFP demonstration design. The State will utilize data collected by the national evaluator for the MFP evaluation as indicators of the project's effectiveness. We believe the national evaluator data will provide a clear picture of the status of each individual that has transitioned, thus allowing more time for the State to focus on the actual transition activities.

SECTION E – FINAL PROJECT BUDGET

Budget Narrative

Transition Coordinator services provided before and after the transition of an individual are estimated to be a total of 60 hours at a cost of \$60 per hour, increasing 4% per year. This service will be offered as both a demonstration and a supplemental service.

Qualified Home and Community Based Services expenditures for individual transitioned from ICF/ID facilities are estimated to be the average community adult ICF/ID daily cost plus residential and day support direct care staff enhancements for additional client needs to ensure the consumer's health and safety. Estimated costs are increased 4% per year.

Expenditures for one-time services such as deposits, home furnishings, vehicle modifications, and assistive devices, are estimated at \$3,000 per individual transitioned from either a nursing facility or an ICF/ID facility.

Expenditures for 24-hour Backup Nursing Services are based on an average of two calls per month for each individual transitioned from either a nursing facility or an ICF/ID facility.

See Annual Budget Forms and Documents