North Dakota Settlement Agreement with the US Department of Justice

Report of the Subject Matter Expert

March 2022

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EXECUTIVE SUMMARY

The State of North Dakota (ND) entered into a Settlement Agreement with the United States Department of Justice (USDOJ) in December 2020, resolving complaints alleging that the State fails to administer long-term services and supports to people with physical disabilities in the Most Integrated Setting appropriate, in violation of the Americans with Disabilities Act. The Settlement Agreement requires the development of an Implementation Plan to identify benchmarks and timelines for meeting requirements, biannual data and progress reports by the State, and biannual reports from the Subject Matter Expert (SME). This is the SME's second report on progress being made by North Dakota.

The draft Implementation Plan was submitted by the State on May 28, 2021. Following that time, the SME and USDOJ reviewed and commented on the plan regarding changes that the State could make to improve the draft. The Implementation Plan was finalized by the State on September 21, 2021. While the initial plan is a two-year plan, in accordance with Section VI.G of the Settlement Agreement, the State is required to revise the plan after 18 months and then annually thereafter. This first revision is expected in June 2022 and will focus on implementation for the third year of the Agreement, challenges encountered to date and strategies to resolve them, and, if necessary, plans to address any issues of noncompliance that may have arisen during the initial two years of the Settlement Agreement.

Frequent and robust communications take place on a regular schedule between the State and the SME, the State and USDOJ, and the SME and USDOJ. Meetings focus on technical assistance and clarification regarding requirements of the Settlement Agreement, and compliance in achieving benchmarks and addressing barriers to progress.

PROGRESS TOWARD MEETING REQUIREMENTS

The State has worked diligently on multiple components of the Settlement Agreement through Implementation Plan strategies. The State has achieved most of the first year requirements established as noted below.

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SA Section #	First Year Requirements Achieved
VI.A	Appoint an Agreement Coordinator
VI.F	Develop an Implementation Plan for Years 1 & 2
XIII.D	Provide technical guidance to nursing homes that commit to provide HCBS and rural community providers who commit to expand
XV.D	Complete and submit State Biannual Data Report #1
IX.H.1	Seek approval for residential habilitation, community support services, and companionship services from the Centers for Medicare & Medicaid Services (CMS)
IX.H.2	Amend financial and functional eligibility of the SPED program
XIV.A.1	Conduct individual or group in-reach to each nursing facility
VIII.H	Provide Person-Centered Planning training to case managers
XII.B.1. a	Provide permanent supported housing to 20 Target Population Members
XV.D	Complete and submit State Biannual Data Report #2

Of the requirements from the first year, one was not achieved, and the SME believes that two others would benefit from further development.

Person Centered Planning

The Settlement Agreement, in Section VIII.I.3.a, requires the State to complete person-centered planning with at least 290 Target Population Members (TPMs) by December 14, 2021. Planning must result in a comprehensive Person-Centered Plan (PCP) that meets all listed requirements in Section VIII.C. At least half of those completed (145) must be for TPMs in Skilled Nursing Facilities (SNFs) and at least half (145) for at risk TPMs. This benchmark was not met in year one. The State is developing a proposed schedule for the completion of fully compliant PCPs to reach the benchmarks established for both year one (290) and year two (an additional 290) by the end of year two, or December 14, 2022. The State has shared with the SME and the US Department of Justice that person centered planning is occurring but acknowledges that the plans they have completed do not yet meet the requirements of the Settlement Agreement. The delay in developing PCPs was created in part by a vendor delay in fully developing the electronic case management record that the State will use to meet the requirements of the Settlement Agreement. The electronic record is a Software as a Service (SaaS) model used across 20 states. The requirements of the Settlement Agreement resulted in the State needing to request customization to applications in this record. Customization was scheduled for completion by December 31, 2021. The State, in communications with the vendor, now anticipates this completion date to be July 2022. To address the vendor delay, the State has created, with input from the SME and USDOJ, a streamlined set of Person Centered Plan forms that meets all the requirements (Section VIII.C.1-8) that case managers will use these forms going forward to comprehensively document the work being done until the electronic record is implemented.

Role Specialization and Training of Case Managers
Section VII.F requires the State to provide for role specialization and training of case managers for TPMs who receive community-based services to support the State's compliance with Sections VII.A and VII.C. Section VII.A requires that case managers assist TPMs in learning about, applying for, accessing, and maintaining community-based services. The State indicates that role specialization and training of case managers is complete based on the transition of the State's case managers from county employment to State employment. This is a significant step in establishing role specialization and sets the stage for further and more focused specialization. This may include specializations to focus on complex medical situations and those involving multiple/dual diagnoses. The SME has recommended to the State that it consider a tiered case management system to address further specialization. In the State's second Biannual Report submitted in January 2022, it indicated that 88% of case managers have completed the standard, core training and the remainder will do so by March 2022. The SME believes this core curriculum meets the requirement of assisting TPMs to learn about, apply for, access, and maintain community-based services. It will be necessary to complete additional training in person centered planning and Person Centered Plans with the new set of streamlined State forms that has been developed and again when the electronic record is complete.

Self-Direction
In its January 2022 Biannual Report, the State indicates that it has taken the necessary steps to allow TPMs to self-direct (e.g. selecting, hiring, and supervising their own providers; determining what services they want), but also indicates that it does not have a "formal process" or use a Centers for Medicare & Medicaid Services (CMS) model for self-direction. A CMS model would provide TPMs with more information on self-direction including the control and choice they have in self-directing services and provide for fiscal agent services. Further discussions with the State and the SME on this issue will take place in the coming months. It is noted that the Settlement Agreement in Section IX.D does not define self-direction nor require a formal program. It does require, however, that the State take necessary steps to enable TPMs who self-direct their care to receive sufficient support to do so. The State has implemented elements of self-direction and indicates that all TPMs are able to select their own providers, pick services that work best for them, determine the service schedule, etc. However, the SME suggests that for a strong and sustainable program of self-direction the State choose a CMS model and make regulatory changes necessary to implement it. This includes additional support for those self-directing and developing materials to educate the public about the model. Being able to self-direct services in North Dakota also ties to other areas noted in this report, including the capacity of Qualified Service Providers, training, the availability of housing stock, and the ability to access information.

REPORT STRUCTURE

The State is working to address all the requirements of the Settlement Agreement and has developed a multitude of strategies to do so. Progress toward achievement of those requirements is noted both in the State's January 2022 Biannual Report and this document. The

SME has noted areas of concern and what is happening to address those areas here, making recommendations for the next reporting period. This report is not a comprehensive “list” of the actions that the State has completed or is working toward finalizing. It instead focuses on those areas the SME believes, at this juncture, require the highest level of continued and focused attention.

The report is divided into the following five sections:

- Capacity
  - Qualified Service Providers
  - Case Management
  - Informed Choice
  - Person Centered Planning
- Transitions
- Diversions
- Housing, and
- Data Collection & Reporting.

The SME chose to combine four significant areas under the “Capacity” umbrella. As is noted in greater detail in this report, the SME is concerned about:

- The number of Qualified Service Providers (QSPs) available to serve Target Population Members. It has been reported to be even more difficult to find providers in the past two years due to the pandemic.
- The capacity of case managers, as increasing referrals for Home and Community-Based Services (HCBS) has led to an average caseload for each case manager of 54 individuals.
- The increasing number of requests for informed choice visits to learn more about HCBS, the ability to employ enough people to make those visits, and, as demand grows as a result of these visits, how that will further drive capacity issues for case managers and QSPs.
- The need to complete 580 Person Centered Plans that meet all the Settlement Agreement requirements by the end of the second year of the Agreement and how the State will manage staffing patterns to assure that is accomplished.

The report discusses the number of transitions that have occurred from Skilled Nursing Facilities. The State has indicated verbally to the SME that this is the greatest number of transitions that have occurred during a year and has further shared with the SME the number of transitions that are currently underway to allow people to return to the community with necessary services and supports to live successfully. The SME is encouraged by this work, the additional planning happening to ensure that even more transitions occur in the coming year, and the resourcefulness of the State in securing additional funding and personnel to allow that to occur.

In the January 2022 Biannual Report from the State, North Dakota indicated that 268 individuals were diverted from entering a Skilled Nursing Facility in the past year through the

provision of HCBS, allowing them to remain at home and in the community. The SME is encouraged by the work being done by the State in this area to provide information and options before a Target Population Member seeks to enter a SNF.

In the area of Housing, this document reflects the number of persons the State has reported who have received Permanent Supported Housing, those that have had the assistance of a housing facilitator, environmental accommodations that have been completed, and changes to policy and regulation that will increase those efforts in year two of the Settlement Agreement. There is also discussion in this report of the work being done by two State housing workgroups to further assist TPMs in identifying and accessing necessary and appropriate housing to return to or remain in the community.

The State has worked to align four (4) data systems that allow it to report on what has/is happening for Target Population Members. The complicated nature of aligning multiple systems has resulted in the State manually completing many data reporting processes which increases the possibility for error with a target population that numbers in the thousands. While strides have been made in understanding how this work is achieved, the SME has included recommendations for continued improvement to move the State from the manual reporting of data to that which is system-generated, can be gathered more accurately, and is less prone to human error, further confirming that data being reported is reliable, verifiable, and valid.

RECOMMENDATIONS

The Subject Matter Expert recommends that the State place priority focus on the following items during the next reporting period (six [6] months) to continue to address needs of TPMs:

- Complete development of the new enrollment/reenrollment process for QSPs.
- Review training requirements for those providing all services and determine if they are necessary for service provision.
- Assure completion of the application so that providers can apply for funds to offer recruitment and retention bonuses.
- Complete and distribute another round of incentive grants to enhance QSP capacity.
- Move the tracking of caseloads from a manual process to one that can be directly inputted into data systems where reports can be more easily generated.
- Address the administrative burden on case managers of tracking “pending cases” for HCBS enrollment (e.g. Medicaid determining eligibility, awaiting action from the client, individuals enrolling as QSPs) and how that can be more efficiently managed.
- Assure completion of training for case managers on person centered planning, effective documentation, and addressing cultural needs and preferences.
- Assure training for all case managers on the new streamlined set of State Person Centered Plan forms and subsequent electronic record for PCPs.
- Establish a plan, including timelines, that indicates how the State will reach or largely reach the benchmark of completed Person Centered Plans that meet all requirements of

the Settlement Agreement by December 2022. Submit a sufficient number of plans to demonstrate progress toward that goal.
- Assure that housing facilitators/case managers/transition coordinators have the most currently available information on housing stock so assistance can be provided timely.
- Continually work to develop and maintain a comprehensive housing inventory accessible to professionals and TPMs.
- Work with the electronic case management record vendor to map the requirements of the Settlement Agreement to the data system to ensure the ability to report on all required elements.
- Complete training with the system vendor, Therap, around reporting elements of the system.
- Design any necessary custom reports in the electronic record to ensure that all reporting requirements in the Settlement Agreement are achieved.

CAPACITY

The greatest need in North Dakota is to grow capacity to serve Target Population Members. The volume of increased interest in Home and Community-Based Services has been much higher than anticipated by the State. Capacity deficits take multiple forms impacting both internal operations and external needs. There are issues of capacity in the number and location of Qualified Service Providers available, the number of case managers available to coordinate services for a greatly increased caseload, the number of community outreach specialists available to facilitate informed choice, and the amount of person centered planning that can be completed. The most pressing capacity issue lies in building a greater community-based workforce. Streamlining other processes is important but will also have a limited impact on improving service delivery if provider capacity to deliver services is not enhanced.

QUALIFIED SERVICE PROVIDERS (QSPs)

Workforce Capacity

Section XIII.A of the Settlement Agreement requires that the State take necessary steps to ensure an adequate supply of qualified, trained community providers to enable Target Population Members to transition to and live in the Most Integrated Setting.

The number of providers available to deliver authorized services for TPMs is limited. The chart below shows the distribution of Qualified Service Providers. “Private” QSPs in the graph are those persons who work only with their family member. Some family providers may also be enrolled to provide services to others under personal care such as homemaker services. The State has indicated that the number of QSPs changes frequently, rising and falling. The State notes that the capacity of QSPs has become an even greater concern during the pandemic. This is a nationwide concern that affects many different industries – “the great resignation” – but especially the service and hospitality industries. This nationwide concern has a direct effect on recruiting and maintaining caregivers. The chart (see next page) detailing the number of QSPs in each county was provided by the State Department of Human Services. It should be noted that

some QSPs provide services across multiple counties, particularly in the rural and frontier areas of the state.

Some barriers to workforce capacity in North Dakota, including a challenging enrollment process and extensive training requirements, may be more easily addressed than others through alterations by the State. These will be described in more detail below.

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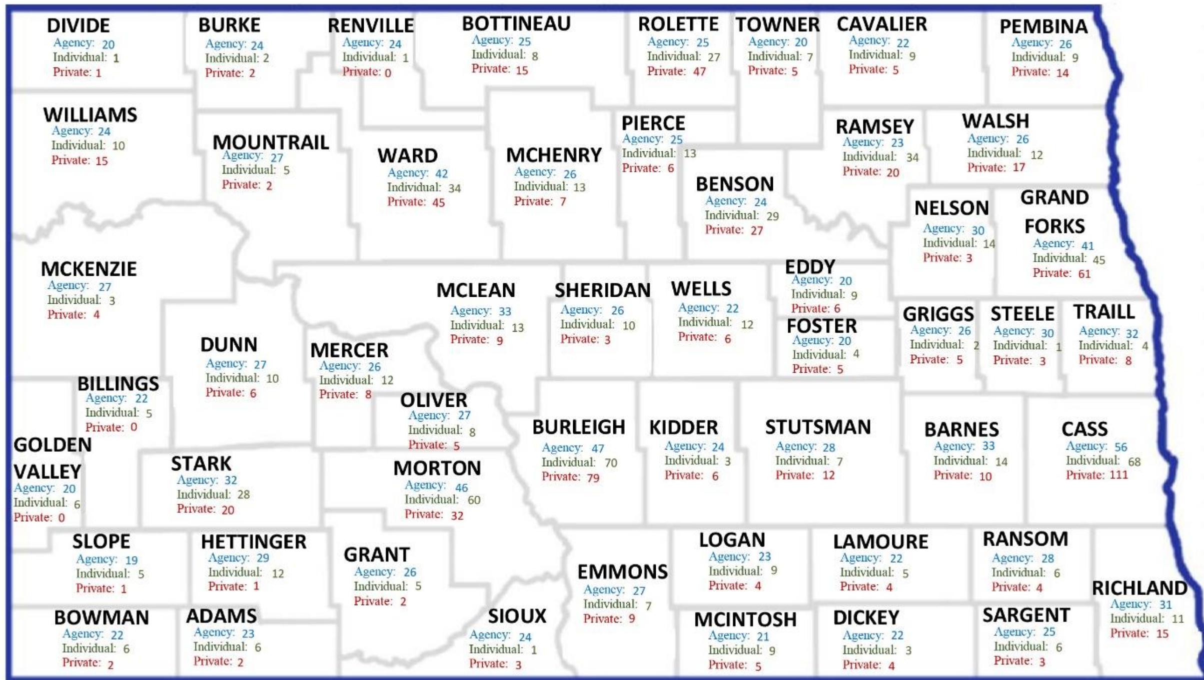
NORTH DAKOTA QSP TOTALS PER COUNTY



County	Agency QSPs	Individual QSPs	*Private QSPs	**Total
Adams	23	6	2	31
Barnes	33	14	10	57
Benson	24	29	27	80
Billings	22	5	0	27
Bottineau	25	8	15	48
Bowman	22	6	2	30
Burke	24	2	2	28
Burleigh	47	70	79	196
Cass	56	68	111	235
Cavalier	22	9	5	36
Dickey	22	3	4	29
Divide	20	1	1	22
Dunn	27	10	6	43
Eddy	20	9	6	35
Emmons	27	7	9	43
Foster	20	4	5	29
Golden Valley	20	6	0	26
Grand Forks	41	45	61	147
Grant	26	5	2	33
Griggs	26	2	5	33
Hettinger	29	12	1	42
Kidder	24	3	6	33
Lamoure	22	5	4	31
Logan	23	9	4	36
McHenry	26	13	7	46
McIntosh	21	9	5	35
McKenzie	27	3	4	34

*Private QSPs only work with their individual family member(s) or identified they don't want to be listed on public site

**Individual county totals are not unduplicated because some providers work in multiple counties

County	Agency QSPs	Individual QSPs	*Private QSPs	**Total
McLean	33	13	9	55
Mercer	26	12	8	46
Morton	46	60	32	138
Mountrail	27	5	2	34
Nelson	30	14	3	47
Oliver	27	8	5	40
Pembina	26	9	14	49
Pierce	25	13	6	44
Ramsey	23	34	20	77
Ransom	28	6	4	38
Renville	25	1	0	26
Richland	31	11	15	57
Rolette	25	27	47	99
Sargent	25	6	3	34
Sheridan	26	10	3	39
Sioux	24	1	3	28
Slope	19	5	1	25
Stark	32	28	20	80
Steele	30	1	3	34
Stutsman	28	7	12	47
Towner	20	7	5	32
Traill	32	4	8	44
Walsh	26	12	17	55
Ward	42	34	45	121
Wells	22	12	6	40
Williams	24	10	15	49
TOTAL UNDUPLICATED QSPs IN THE STATE				*1,091*

Find a QSP at https://apps.nd.gov/dhs/qsp/qspsearch.aspx

Last Updated 02/02/2022

Relative to those being served in the community, the State can identify the number of open cases in each county, but that number is not exclusive to the target population. Case managers, like QSPs, work across county lines and also serve individuals who receive assistance through the Service Payments to the Elderly (SPED) program who may not qualify as a TPM and assist Basic Care clients.

The State is taking steps to address issues to increase workforce capacity, perhaps the most significant being the creation of the Direct Service Workforce/Family Caregiver Resource and Training Center (DSW/FC RC). This "resource hub" will be operated through an initial three-year contract with the University of North Dakota School of Medicine & Health Sciences Center for Rural Health. Included in the scope of work for the DSW/FC RC is:

- Conduct a needs assessment with individual and agency QSPs to determine current capacity and service gaps
- Assist QSPs with the enrollment and reenrollment process
- Provide QSP orientation
- Create and maintain accessible, dynamic education and training opportunities based on the needs of individual QSPs, QSP agencies, family providers, and individuals self-directing services
- Provide training support and technical assistance for Electronic Visit Verification (EVV) and billing
- Create communication tools for QSPs (a listserv and website) to provide relevant and accurate information in a continuous fashion to increase retention efforts
- Create mentoring and networking opportunities for QSPs, and
- Create recruitment strategies for QSPs.

The new center began operation in January 2022. As outlined in the scope of work, a strategic plan, including a project plan, is to be complete within 60 days to outline how center staff will accomplish the required responsibilities.

The State is providing spotlights on different services via twice-monthly webinars that began in November 2021. These webinars explain in-home and community-based services the ND Department of Human Services funds that give adults with physical disabilities and older adults options beyond nursing facility care. Individuals who could benefit from services, their family members, and community entities that work with older adults and adults with physical disabilities are encouraged to participate. By sharing more about available services, the State hopes to increase interest in Home and Community-Based Services and find individuals who may be interested in becoming a service provider. The State notes in its January 2022 Biannual Report that an additional 13 webinars are scheduled from January – July 2022. Recordings of the webinars are also available on the Aging Services website.

The State is also beginning to explore what it would take to engage others who are not traditional candidates to enhance the QSP workforce. For example, to increase the availability of homemaking services, the State would like to determine what would be necessary for groups

such as private home care entities (e.g. Merry Maids) to engage. The State will need to modify requirements to engage groups of this nature, determining how to simplify the QSP enrollment process and streamline training/certification requirements. The State is also seeking to identify how individuals with different credentials (e.g. Direct Service Providers in the developmental disability community) could be recruited to serve the target population.

As the State continues to roll out its new electronic case management record, significant progress has been made on tools for QSPs. Within the system, the provider can easily see if they have new authorizations and complete EVVs. Through a direct interface between this system and the Medicaid Management Information System (MMIS), QSPs can seamlessly complete their billing. This has allowed QSPs to bill with more frequency, improving their ability to manage their own resources.

Enrollment & Training

The current enrollment process with the State is challenging for individual QSPs. There are numerous forms to be completed and instructions for them are not as clearly outlined as they could be. It has been reported by the State to the Subject Matter Expert that almost 50% of individuals seeking to enroll as a QSP submit incomplete forms, hoping that the State will contact them and provide a higher level of assistance to complete the necessary steps. This further slows the enrollment process due to staffing limitations at the State. It has been reported to the Subject Matter Expert that it can take many months to complete the enrollment process because enrollment packets are not complete on submission and the support to correct submission errors and omissions is not adequate. Additionally, the current reenrollment process happens every two (2) years and QSPs must re-submit all the documentation that was required at enrollment to maintain the ability to provide services.

The State is taking several steps to address enrollment issues. The ND Department of Human Services has convened a group to review the process and enrollment forms to streamline it. Responsibility for specific tasks to complete this project have been assigned and an individual designated to oversee it. When this internal group has streamlined the forms required to enroll as a QSP in North Dakota, the consolidated enrollment packet will be sent to a new vendor – Veridian Fiscal Services – who will then oversee the enrollment process for the State. The State has indicated that six (6) employees will be assigned to manage the QSP enrollment process, and the vendor has indicated a benchmark of two weeks (14 days) from submittal of a complete enrollment packet to completion of approval. In the Biannual Report from January 2022 (Pg. 62) the State indicates a target completion date of April 1, 2022, to streamline the agency and individual QSP enrollment process and revise the current enrollment paperwork.

A primary responsibility of the Direct Service Workforce/Family Caregiver Resource and Training Center is to assist individuals in enrollment and reenrollment as a QSP. This may include assisting the individual in obtaining a National Provider Identifier (NPI) number, completing the application form, and identifying the necessary technology for EVV and billing.

Obtaining an NPI requires multiple steps and involves two different websites, creating a barrier for those individuals who have less experience interfacing with government processes.

A Home and Community-Based Services case manager working in one of the tribal areas indicates that she carries enrollment applications with her to encourage family and friends to become QSPs to provide a level of service delivery. This could improve the delivery of HCBS to TPMs in tribal areas, as other members of their tribe will know their culture and be responsive to it. She further noted that she sometimes stays to help complete the application as it is complicated. This is a strategy that could be mirrored by other case managers to increase capacity across the state.

The State requires that every QSP delivering services through Medicaid complete training to demonstrate competency in 21 areas, and complete training in Medicaid fraud and abuse before they can begin delivering care and billing for services. This is true for both the caregiver offering services only to a family member when Medicaid is the payor and individuals delivering services to multiple people. This can be a barrier to finding more people to offer services. Not every TPM requires assistance in every domain in which a QSP must demonstrate competency. The need for all QSPs to demonstrate competency in each area when they may be delivering a single service (e.g., homemaking, chore) also presents a barrier to enrollment.

Recommendations

There are several recommendations from the SME's Capacity Plan that would further enhance the work that is underway or being planned to address QSP capacity:

1. Create strategies to eliminate gaps through the expansion of services offered by individual QSPs, including simplifying the process by which QSPs add to their service arrays.
2. Assure that case managers are aware of the availability of individual QSPs who wish to serve non-family members and are encouraged to develop awareness about individual QSPs and the services they provide to expand the list of providers for TPMs.
3. Choose a CMS recognized self-directed program that allows the individual receiving services to train QSPs to their specific care needs.
4. Engage provider agencies in the training and support of QSPs.

Recruitment & Retention

There are longstanding recruitment and retention issues for providers serving Target Population Members in North Dakota and nationally. These were heightened during the pandemic when more than 57% of nursing facilities in the State suspended admissions for a period in the final quarter of 2021 due to their own staff recruitment and retention issues, increasing requests for HCBS. The State also reports that the desire to not go to a nursing facility is increasing as more information about available services is shared. In addition to its work on streamlining enrollment processes and creating the DSW/FC RC, the State has two other ways in which it is supporting recruitment and retention efforts.

The first is a competitive grant process to support the development or expansion of QSP agencies. These grants are being made available for the purpose of providing the funds necessary to either start a new QSP agency or expand the services of a current QSP agency. The State has selected 14 recipients out of 32 applications for its first round of grants, including 5-7 in rural areas and a few serving indigenous populations. Each grant is funded up to $30,000. A second round of incentive grants is planned in 2022 targeting services where the need is greatest for additional providers.

The second effort is the distribution of funds that can be used as bonuses to recruit or retain QSPs. These funds are being made available through the *North Dakota Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817*. It is anticipated that providers will be able to apply for these funds beginning in March 2022. Agency providers will be eligible to apply for both recruitment and retention bonus funds. Individual providers will be eligible to apply for retention bonus funds.

Recommendations

1. Complete development of the new enrollment/reenrollment process.
2. As the State is considering how to engage non-traditional candidates (such as Merry Maids) and altering training requirements, it is also suggested that the State review training requirements for everyone providing services and determining if some of those can be changed based on what service is being offered.
3. Assure completion of the provider application for bonus funds so those monies can be distributed.
4. Complete and distribute another round of incentive grants to enhance provider expansion of services.

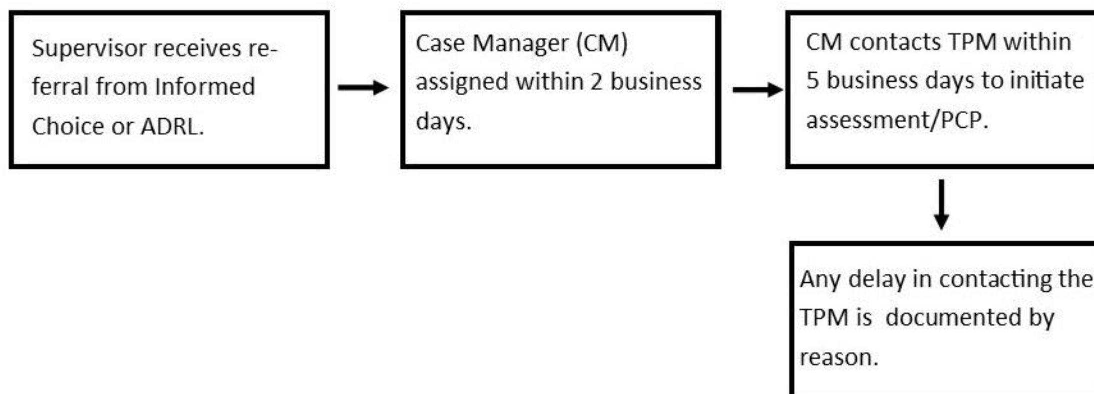
CASE MANAGEMENT

In the Settlement Agreement, Section VII.C requires the State to provide a sufficient number of case managers to enable them to provide all necessary services listed in a TPM's Person Centered Plan, discuss community-based service options, meet regularly face-to-face, and complete person centered planning. Over the course of the past year, HCBS caseloads have increased significantly as interest in and referrals for HCBS have risen. Since the beginning of the Settlement Agreement, the State has reported 1,744 referrals (ND Biannual Report, Jan. 2022, "2021 Aging Services HCBS USDOJ SA Dashboard") that have resulted in 832 new cases opened and 877 cases pending. Pending cases are active HCBS referrals that are still being addressed and do not yet have a formal outcome. Although funding was made available from the Legislature to hire three (3) new case managers in the current biennium, there is concern that there will, in the future, be an insufficient number of case managers to effectively address the needs of clients as referrals to HCBS continue to increase and the requirement for annual level of care screenings for all TPMs goes into effect. The State has 67 case management positions and as of the writing of this report, 65 positions are filled and two are vacant, both on the eastern side of North Dakota. The State is currently able to serve all persons interested in HCBS and does not have a waiting list for case management.

According to the January 2022 Biannual Report (Pg. 13), one (1) independent case manager has been hired by the Standing Rock Sioux Tribe. The State has provided technical assistance and training to this individual and is also supporting the development of HCBS services by tribal entities.

Tracking Caseloads
In January 2022, the State reported that 55 full-time case managers have an average caseload of 54 individuals (ND Biannual Report, Jan. 2022, Pg. 15). The State also noted that some case managers in rural areas have caseloads of up to 70 individuals. Three (3) part-time case managers have an average caseload size of 45 and nine (9) case management supervisors carry an average caseload of 15. In addition to serving Target Population Members, case managers are responsible for an additional 700 Basic Care clients. The State uses a weighting system when assigning new clients to a case manager. The weighting system considers the complexity of client needs and distance for travel and assigns a score based on those needs. Efforts are made to equalize weighted caseloads among case managers.

North Dakota Target Population Member Referral Process



The process of tracking clients from the date a referral is received by the case management supervisor, the date assignment of a case manager was made, the date contact with the client is made, and the date the assessment has been completed are currently tracked manually using an Excel spreadsheet. This information is then aggregated monthly and included in data dashboards prepared by the State for reporting. The State has indicated that when the new electronic record is complete, this data will be able to be gathered through that system for streamlined reporting. The current process and data have been shared visually with the SME. While still manual, the information in the State report on length of time from referral to assignment to a case manager of one (1) day and the percent of case management referrals responded to within five (5) days – 96% – is verifiable. (ND Biannual Report, Jan. 2022, Pg. 11).

Administrative Burden

Case managers are responsible for much of the documentation required for TPMs. The burden is particularly high when a TPM is just beginning services and when the case is closed. It is noted that most of the State's new electronic record is being implemented. The completion of the Person Centered Plan and the complaint module are not yet finalized. Although this will gather all the information for a new client in one place, it can still require additional time to navigate and locate all the necessary modules that need completion. The State has been training case managers on the new system, though there have been delays in reaching the internal benchmark for completion of that training. The State indicated that with the increasing number of referrals and the fact that the electronic record is not complete, it was more important that case managers spend their time in direct contact with TPMs, returning to completion of training when changes to the system are finished. It was reported by the State that in the first year of transition to the new system the amount of time spent on administrative activities has been consistent with previous years.

The case managers, in addition to working with active clients, are also responsible for tracking those individuals for whom HCBS are still pending. There can be numerous reasons for a case to be pending such as difficulty in reaching the TPM, awaiting Medicaid approval, transition delays, securing housing, etc. The January 2022 State Biannual Report shows that 50.8% percent of cases are pending ("2021 Aging Services HCBS USDOJ SA Dashboard.") Every case manager has pending cases. It also takes a great deal of time to make phone calls to providers and inquire about their availability, creating additional delays. The State is considering the hiring of a staff member who could act as a service/provider navigator to help case managers and consumers find QSPs. The State has indicated that this would initially be a pilot project to try and prove the concept works. The use of navigators has shown benefits in other jurisdictions such as Santa Fe County, New Mexico.

The State, as part of its performance metrics, has shared information on the amount of time spent in billable case management activities and administrative tasks, using time tracked in the State's workforce system. The graph below represents the division of time by activity (Pg. 14 and Pg. 77 of the ND Biannual Report, Jan. 2022).

CM Workforce Data	**Reporting Period**	**12.20-11.21**
Project	**Sum Of Hours**	**% Of Hours**
HCBS Admin	34,228.92	29.62%
HCBS CM	81,317.67	70.38%
Grand Total	**115,546.59**	**100.00%**

The SME has made additional recommendations in the Capacity Plan regarding documentation to further address the administrative burden of case managers.

1. The SME urges a complete review of required case management documentation to eliminate unnecessary or duplicative documentation, or both, to reduce the amount of time spent on administrative tasks and enhance case manager capacity.
2. Develop a strategy for determining what forms and processes are codified in administrative code or regulation that require amendments to streamline processes.

Complex Needs

The State has shared with USDOJ and the SME that Target Population Members now enrolling in HCBS have more complex needs. They may have underlying behavioral health issues (including such things as untreated schizophrenia), suffered a Traumatic Brain Injury, or require around-the-clock care. It is difficult to find QSPs who will serve these individuals due to the extent of their needs, and those that can are at or near capacity. In the past, HCBS case managers could work jointly with Human Service Center field staff for a long period to gain assistance in addressing the TPM's needs on an ongoing basis. The State has shared that this is no longer the case as behavioral health case management is now more short-term. The Human Service Center field staff has moved from providing services to individuals long-term to working toward recovery and moving them out of the behavioral health system. The more complex needs presented and lack of necessary support to meet the challenges of these cases increases the administrative burden for the case manager to assure that multiple authorizations have been completed and numerous providers have been selected to deliver services.

Beginning in June 2022, the State must assign a case manager to every Target Population Member, which increases the concern regarding case management capacity. As noted in the Capacity Plan, the SME has recommended that the State continue to address case management role specialization to enhance capacity to meet the needs of TPMs.

The SME recommends that the State consider a graduation in the level of engagement of the case manager for TPMs in nursing facilities, for those who are not initially seeking to return to the community, and those who are preparing to transition. Frequency of contact and level of engagement should increase as the TPM moves closer to returning to the community. In addition to this tiered case management structure, additional strategies could be considered throughout the term of the Settlement Agreement for how to provide an adequate and appropriate level of informed choice facilitation and person centered planning for those that are not initially interested in transitioning to the community.

A second recommendation from the SME in the Capacity Plan is to consider recruiting, hiring, and training TPM case managers in using a medical care coordination model of case management (or contracting for this service). This could include hiring individuals with a Master of Social Work degree well versed in addressing individuals with complex medical needs and focused on community transition.

Training
There are extensive training requirements for case managers that could be streamlined. In addition to internal requirements of the State, licensed social workers must also complete 30 hours of continuing education over every two-year period. While licensure requirements can't be changed, the State could address its internal training requirements.

The State reports (ND Biannual Report, Jan. 2022, Pg. 10) that 88% of HCBS case managers have completed the standard curriculum for their work. The State indicates that 121 Aging Services staff are participating in the Charting the Life Course and person centered planning training, which is in addition to the standard curriculum. The initial series of this training was completed in January 2022. Any new staff that are hired and staff who missed sessions will be attending make up sessions and/or receive their training as part of the onboarding process. Additional training will be held as new tools are developed for person centered planning – both a streamlined set of State forms that has been created now for interim use and when the person centered planning tools are complete in the electronic record. There is variance among employees about how elements of the PCP are documented and how efficiently they can be accessed. The SME has delivered technical assistance in this area to case managers, Centers for Independent Living (CIL) staff, and community outreach specialists through three (3) sessions to aid in more comprehensive and consistent documentation and is prepared to offer more training during the next reporting period.

Serving the Native American Community
Individuals from Standing Rock and Grand Forks have indicated an interest in becoming independent case managers to provide more assistance to tribal communities. There is one individual from Standing Rock enrolled as a case manager and attending training with State staff, but, as of the writing of this report, is not yet ready to accept referrals. The State has indicated they will work with independent case managers on training and getting them enrolled. This will assist in addressing current capacity issues.

Cultural competency is key when working with Native American communities. Stakeholders have indicated to USDOJ and the SME that case managers need to be more culturally sensitive when working with members of tribes and that the person centered planning process needs to better address cultural issues. In October 2021 training to cultural sensitivity was offered by the State for case managers. All 65 case managers have completed the training. Following that training case managers reflected on the knowledge they believe they have gained from this training (Pg.10, ND Biannual Report, Jan. 2022).

Question 1: I am knowledgeable of Native American populations in North Dakota.				
	Very	Somewhat	Neutral	Very Little
Pre	10%	65%	12%	11.7%
Post	83%	16.1%	1.1%	
Increase				
Question 2: I understand the barriers that Native Americans face accessing services.				
	Very	Somewhat	Neutral	Very Little
Pre	13.8%	64.9%	14.9%	6.4%
Post	82.8%	21.5%		
Increase				
Question 3: I am conscious of my own biases.				
	Very	Somewhat	Neutral	Very Little
Pre	25.5%	62.8%	11.7%	
Post	45.2%	39.8%	15.1%	
Increase				
Question 4: I understand the benefits and importance of cultural competence in my practice.				
	Very	Somewhat	Neutral	Very Little
Pre	72.3%	23.4%	4.3%	
Post	87%	10.9%	2.2%	
Increase				
Question 5: I am confident working across cultures.				
	Very	Somewhat	Neutral	Very Little
Pre	21.3%	57.4%	16%	5.3%
Post	60.2%	35.5%	4.3	
Increase				

Recommendations

1. Move the tracking of caseloads from a manual process to one that can be inputted directly into the electronic case management record where required reports can be easily generated.
2. Address the administrative burden of tracking those "pending" HCBS enrollment and how that will be managed going forward.
3. Assure completion of training around person centered planning, effective documentation, and addressing cultural needs and preferences.
4. Consider contracting with more providers to offer case management, including agency providers that do not provide other HCBS services to the individual to avoid a conflict.

INFORMED CHOICE

Informed choice is facilitated through interviews conducted with Target Population Members who are in a Skilled Nursing Facility. Maximus, the State vendor that verifies Nursing Facility Level of Care (NFLoC) screens, provides a daily list of individuals who have screened and have

transitioned to the SNF. The State then deploys community outreach specialists to contact those individuals. The State reports they contacted 936 individuals in year one ("2021 Aging Services Informed Choice DOJ SA Dashboard," ND Biannual Report, Jan. 2022). Twenty-two (22) percent of those visits have been completed in person and 78% were completed through virtual or telephonic contacts. Many of the SNFs have had visitor restrictions during the pandemic, causing the greater percentage of visits to be conducted virtually. An additional 309 individuals have initially declined an informed choice visit. The State has verbally reported to the SME that processes are in place so that the follow-up occurs with the Target Population Member approximately one (1) month later.

During those visits/interviews the community outreach specialist provides information about available Home and Community-Based Services, seeks to build a relationship with the TPM, learn about what services they may have had prior to entering the SNF, barriers encountered in finding/keeping care, specific needs of the person (including housing), and if the TPM is interested in returning to community-based living. The State has modified the structure of the interview to gain more information than it had originally to better support a care plan for every TPM. If the TPM indicates interest in returning to the community, the person centered planning process formally begins. At times the referral is made to case management and at other times, based on capacity concerns, the community outreach specialist completes the person centered planning process with the TPM. The State reports it received 1,009 referrals expressing interest in HCBS during the first year of the Settlement Agreement. If the TPM refuses the interview or indicates that they are not interested in HCBS, information about services is left for them in the event they change their mind, and the community outreach specialist follows-up with them on a routine basis.

The State has identified funding for and increased, by 10 full-time equivalents (FTEs), community outreach specialist positions to help meet the need of TPMs' requests for information about HCBS. Of those new positions eight (8) have been filled and outreach continues to recruit and hire the remaining two (2) positions. As part of the Implementation Plan, the State has also convened an Informed Choice Workgroup to make recommendations to improve the outreach process. In addition to informed choice interviews, the State also conducts in-reach to persons in all SNFs. The State reports reaching 443 TPMs through group in-reach visits in every SNF and completing 718 individual in-reach visits in the SNFs through the informed choice facilitation process (ND Biannual Report, Jan. 2022, Pg. 37).

PERSON CENTERED PLANNING

Person centered planning is at the core of determining what services are needed and desired by the TPM to return to or remain in the Most Integrated Setting. Requirements for planning are reflected in Section VIII.A.,B.,C., and D. of the Settlement Agreement. The State has been working to streamline the person centered planning process while ensuring that the resulting Person Centered Plan meets all the requirements noted in the Settlement Agreement.

The State uses the Life Domain Vision Tool crafted by LifeCourse Nexus to capture information from the TPM and family members about eight (8) life domains. This tool gathers information about the TPM's desires and needs, reflects discussions had with the TPM and case manager, and is the building block for creating a responsive PCP. In 2021, in addition to the Vision Tool, there were multiple State forms (dependent on funding streams) and independent living plans used in person centered planning. The State had anticipated that the vendor would be able to complete the build out of the required PCP documentation in the electronic record by the end of 2021. This did not occur, and the State anticipates it may not be complete for several months.

To continue efforts to deliver and capture in documentation an effective person centered planning process and resulting plan, the State has created two new forms – an HCBS Person Centered Plan and a Transition Plan. These forms have been shared with the SME and USDOJ for feedback and suggestions were incorporated. These new forms, the Life Domain Vision Tool, the risk assessment/health and safety plan, and other required assessments (e.g. financial) will document a complete Person Centered Plan that meets the requirements of the Settlement Agreement. They replace numerous other State forms, care plans, and independent living plans that have been used previously. The new forms will be uploaded to the client record and, when the build out of this portion of the electronic record is complete, data from forms that have been completed will be uploaded directly into the system. In introducing these new forms, the State must administer additional person centered planning training to case managers and transition coordinators on how to complete these plans in compliance with Section VIII.H of the Settlement Agreement.

The Settlement Agreement, in Section VIII.I.3.a, required the State to complete person centered planning (resulting in a comprehensive PCP that meets all the requirements listed) with 290 Target Population Members by the end of the first year (December 14, 2021), based on the effective date of the agreement. At least half of those required to be completed (145) were with TPMs in Skilled Nursing Facilities and at least another half with those at risk of going to a SNF. The Settlement Agreement further indicates, in Section VIII.3.h that "…the State will have satisfied each interim benchmark if it has either (1) met the benchmark or (2) largely met the benchmark and demonstrated significant efforts to reach the actual benchmark and important reasons why the benchmark was not met." Although the State did not meet this benchmark in year one, a proposed schedule for the completion of fully compliant PCPs is being developed by the State, to achieve or largely achieve the benchmarks established for both year one (290) and year two (an additional 290).

In discussions with the SME and the US Department of Justice, the State acknowledges that the care plans they have completed do not yet meet all the requirements of the Settlement Agreement. The State has indicated, however, that a significant level of person centered planning is occurring. From review of a sample of case files, it is evident that care planning is occurring. However, improvements in plan structure, efficient access to information, and documentation/plan comprehensiveness and consistency are needed. These improvements are

in the process of being implemented. The SME will continue to provide training and technical assistance to support the State's efforts to complete the year one and year two benchmarks for person centered planning and PCPs that meet the requirements of the Settlement Agreement and establish the groundwork for meeting PCP benchmarks for the remaining term of the Agreement.

Person centered planning can be a lengthy process, particularly if the Target Population Member has high needs that require securing multiple services to either divert them from admission to the SNF or help them to transition home. As was noted earlier in this section, case managers are carrying high caseloads (averaging 54 clients per case manager) as more TPMs are seeking home and community-based services. Higher caseloads decrease capacity to complete person centered planning as established by the benchmark. Streamlining and effectively training about required documentation is essential to help the State meet the requirement as the number of case managers will not increase in the coming year.

When TPMs have a complete Person Centered Plan it is necessary to track in an aggregate fashion what services were requested, what services were authorized, and what services are being delivered. That information helps to inform QSP capacity and improves understanding of the level of effort required by the case manager to ensure that the TPM has the necessary services to remain in or return to the community. When the electronic case management record is complete this reporting is expected to be robust and more easily captured and accessed. This data is not currently being collected.

Recommendations

1. Assure training for all case managers on the new State forms for Person Centered Plans.
2. Ensure that the documentation gathered in the new PCP forms is included (by attachment) in the electronic record until the PCP section of that record has been finished.
3. Assure completion of the PCP module in the electronic record.
4. Determine how existing reports in the electronic record can track the necessary aggregate data or assure creation of a customized report to compile this information.

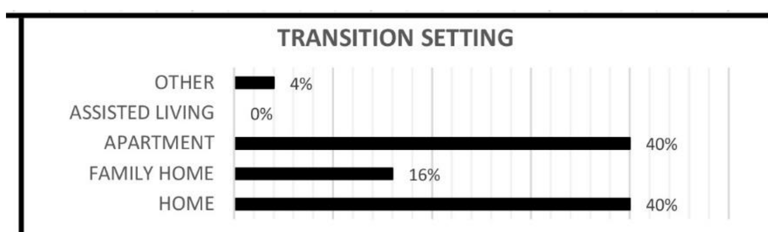
TRANSITIONS

The Settlement Agreement in Section XI outlines requirements for the State to assist Target Population Members in transitioning home from the Skilled Nursing Facility, consistent with the TPM's ability to make an informed choice and the Most Integrated Setting identified in the Person Centered Plan. Within two (2) years of the Effective Date (which will be December 14, 2022) the State is required to transition at least 100 TPMs from Skilled Nursing Facilities to community-based services.

In its January 2022 Biannual Report ("2021 Aging Transition Services USDOJ SA Dashboard") the State reports 88 transitions since the effective date of the agreement, December 14, 2020.

Most of those TPMs who have transitioned to community-based services (61) are assisted through the State's Money Follows the Person (MFP) program. These individuals tend to have high needs, requiring more focused attention from the care team comprised of the case manager, transition coordinator, and housing specialist to assure that all service needs can be met, and the transition is successful. The Money Follows the Person program remains involved with the TPM for 365 days post-transition. TPMs that transitioned to the community through the MFP program in 2021 selected the following locations to live ("Other" references Adult Foster Care):

Other transitions that have occurred to date have been supported through the Aging & Disability Resource Link (ADRL) grant (25 transitions), the Medicaid HCBS waiver (1 transition), and one (1 transition) occurred without transition supports, although that TPM is now receiving HCBS. While the care planning process remains the same as those transitioning through MFP, Target Population Members funded through the ADRL grant and waiver resources tend to have lower service needs than those who transition through MFP. Using ADRL grant and HCBS waiver resources, the State can also more quickly assist the person to transition to the Most Integrated Setting as there is not the requirement that the individual must be in an institutional setting for longer than 60 days (as is the case with MFP supported transitions). There is also the flexibility for using these resources to transition individuals out of different types of congregate care settings. The 25 TPMs that have been transitioned through ADRL resources in 2021 selected the following locations for their residence:



Transition Coordinators

As the State has worked to meet the requirements of Section XI of the Settlement Agreement, a significant amount of work has begun to assure that required documentation is appropriately completed. The Subject Matter Expert, working in concert with the MFP director, has provided training opportunities to North Dakota staff (case managers, transition coordinators, Centers for Independent Living staff) to assist in ensuring that documentation is complete, consistent,

and reflects requirements of the Settlement Agreement in Section VIII regarding person centered planning. In addition, the State has reported to the SME that regular meetings are held with CIL staff to address documentation issues and additional training is being provided by the State. As the State moves to new PCP forms and eventual tool in the electronic record, transition coordinators who form part of the care team will also be trained in the new Person Centered Plan.

The State's transition coordinators are employed by and housed within the four (4) Centers for Independent Living, though funding for these positions comes from the State MFP grant. The CIL directors supervise the transition coordinators. The scope of work for the CILs was updated by the State to further ensure that requirements of the Settlement Agreement are met and to better coordinate all the functions of the CILs from advocacy to transition coordination to documentation.

To assist with the number of people requesting transition, in 2021 the State used MFP funds to hire three (3) additional transition coordinators. Two (2) additional full-time equivalent staff were hired with Centers for Independent Living Funds (ND Biannual Report, Jan. 2022, Pg. 41). To further address ongoing and increasing requests for transition services, the State has included an additional eight (8) transition coordinators and two (2) assistant transition coordinator positions in its 2022 MFP budget request to the Centers for Medicare and Medicaid Services.

Transition Timeframes

By June 14, 2022, Section XI.B of the Settlement Agreement requires the State to assure that transitions occur no later than 120 days after the TPM chooses to pursue transition. The State has already made significant progress toward achieving this benchmark. The State reported that 25 transitions through the ADRL (ND Biannual Report "2021 Aging Transition Services USDOJ SA Dashboard," Jan. 2022) were completed in no more than 90 days, with 84% reported as complete within 30 days. All ADRL transitions occurred well within the benchmark during 2021. Of the 61 MFP transitions that have occurred since the effective date of the Settlement Agreement, the State reports that 82% of those transitions have occurred within 120 days, 38% of those within 30 days as significant progress toward this benchmark. There are and will continue to be times that transitions are delayed for specific reasons, such as waiting for home modifications to be completed or securing providers to offer the authorized HCBS for the Target Population Member.

More specifically the State reports the following information regarding length of transition during 2021:

TRANSITION TIME FRAME SUMMARY		
DAYS FROM REFERRAL TO TRANSITION	**TOTAL**	**PERCENTAGE**
WITHIN 30 DAYS	23	38%
31 - 60 DAYS	14	23%
61 - 90 DAYS	5	8%
91 -120 DAYS	8	13%
121 - 150 DAYS	2	3%
151 - 180 DAYS	2	3%
181 - 210 DAYS	1	2%
211 - 240 DAYS	2	3%
241 - 270 DAYS	3	5%
271 - 300 DAYS	0	0%
301 - 330 DAYS	0	0%
331 - 360 DAYS	0	0%
OVER 360 DAYS	1	2%
TOTAL	61	100%

Looking Forward

By December 14, 2022, the State is required per Section X.B.3 of the Settlement Agreement to complete at least an annual level of care determination screening for continued stay in a nursing facility for all Target Population Members. There are many individuals who have not had a level of care determination screening for several years and may no longer qualify for a nursing facility level of care. The State believes that this annual screening will significantly increase the number of TPMs who will need to transition to the community. This requirement increases already pressing concerns regarding QSP and case management capacity.

There were 191 referrals to the MFP program in 2021 (ND Biannual Report "2021 Aging Transition Services USDOJ SA Dashboard," Jan. 2022). The greatest number of requests came in the third quarter of 2021 (62 requests). During this quarter it was verbally reported by the State that more referrals started to be received from Skilled Nursing Facilities after the State had completed outreach to the SNFs regarding available community-based services.

Due to the increase in referrals to the MFP program in 2021, the State requested an additional $1.2 million from CMS in its recurring annual budget to assist with MFP staffing needs, which was approved. Based on that request and the typical annual expansion of funding for the MFP program, the State anticipates an additional $2.2 million in the approved MFP budget for 2022. With this additional funding the State intends to hire an additional eight (8) transition coordinators and two (2) transition coordinator assistants as noted earlier (ND Biannual Report,

Jan. 2022, Pg. 42). Transition coordinator assistants will be available to aid transition coordinators with tasks such as securing necessary items for an apartment to allow a person to return to the community, freeing up more time for the transition coordinator to work with a greater number of TPMs.

It has been reported to the SME and USDOJ that there are occasions when discharges and transitions from the SNF to the community have occurred absent adequate notice to put all necessary services and supports in place. There have been times when these rapid discharges have required the State to scramble to ensure transitions are properly supported and safety risks are mitigated. Some TPMs choose to leave the SNFs without notice to either the facility or the State. It has been reported that in other instances TPMs are discharged from facilities without sufficient notice to State and CIL staff for necessary services and supports to be put in place. Discharge planning and coordination is crucial to successful transitions. Formal protocols for notification of discharges to the State for TPMs that might need HCBS following discharge are not in place. The State will continue to focus on building relationships with the SNFs to improve the ability to help North Dakotans transition safely. The SME recommends that the State consider establishing policy or regulation to help alleviate this concern. The SME further recommends that that State track all instances of inadequate discharge planning and lack of sufficient notice to transition staff to support the need for such policy/regulation.

In 2021 the State also received a one-time $5 million MFP Capacity Building Grant. Funds from this grant allowed for the creation of the Direct Service Worker/Family Caregiver Resource and Training Center (noted in greater detail in the “Capacity” section of this report) to be developed and allowed for the hiring of more community outreach specialists; those staff are responsible for completing informed choice interviews.

Recommendations

1. Assure training on the use of the new PCP Transition form.
2. Document information provided to the CILs regarding consistency and completeness of PCP planning and documentation.
3. Evaluate timelines for transitions, identify trends that delay transitions and those that contribute to their success.
4. Consider policy or regulation to ensure adequate notice of discharges from SNFs so that appropriate home and community-based services and supports can be established.

DIVERSIONS

In keeping with Section XI of the Settlement Agreement, the State is also required to divert at least 100 Target Population Members from Skilled Nursing Facilities by December 14, 2022, the first interim benchmark for the diversion requirement. The criteria used by the State to reach that benchmark is to count all TPMs who had not received HCBS for at least one (1) year who are now being served in the community and not moving to a SNF. The State reports that it

diverted 268 unduplicated TPMs in the first year of the Settlement Agreement (ND Biannual Report, Jan. 2022, Pg. 46), already surpassing the benchmark for the first two years combined.

The SME – as part of the State's Implementation Plan – completed a Diversion Plan with a plethora of recommendations for how the State could address diverting individuals from a SNF. On Pgs. 39-40 of the January 2022 Biannual Report, the State has included the recommendations they are currently pursuing from the Diversion Plan. Some of the strategies noted by the SME to target outreach to maximize identification of at risk TPMs and optimize opportunities to provide information on HCBS options are:

1. Identify and outreach to those TPMs who are at serious risk of entering nursing facilities.
    a. Provide outreach about HCBS to the public, senior citizen centers, and stakeholders.
    b. Review existing data and other information from partners that could identify TPMs and provide them with information on HCBS.
        i. Use Medicaid claims data to identify TPMs admitted to hospitals, short-term rehabilitation facilities, or using similar services that may reflect a higher likelihood of being a TPM and provide such TPMs with information about HCBS.
2. Conduct outreach to offer education to those parties that may recommend nursing facility care to a potential TPM.
    a. Provide outreach and information about HCBS that could meet the needs of TPMs requiring long term services and supports as an alternative to nursing facilities and to those who typically make Nursing Facility Level of Care assessments and nursing home placements, with a particular focus on:
        i. hospital discharge planners,
        ii. rehabilitation facilities,
        iii. tribal agencies, and
        iv. primary care physicians serving Medicaid patients.
    b. Develop and enter into written agreements or memoranda of understanding that establishes a protocol for hospitals and other facilities to contact the Aging Services Division as part of the facility's discharge planning process, or to refer the TPM to the Aging Services Division, or both.

The SME and the US Department of Justice have had the opportunity to review "diversion case files" submitted by the State. Suggestions on how they could be improved were offered and have been incorporated into training with case managers. Of those that have been reviewed, there are TPMs presenting with significant needs, e.g. requiring 24-hour care and involving multiple family members and providers to assure their ability to remain at home and in the community. More than 230 family caregivers help support their loved ones. The State has made provisions to be able to pay family members as QSPs to help keep their loved one at home. A variety of funding sources assist with this. In addition to Medicaid, funds can be received through the Service Payments for the Elderly and Disabled (SPED) program and Expanded Service Payments for the Elderly and Disabled (EXSPED) program. Some of these funding

sources require the TPM to have a copay. It was shared by the State in conversation with the SME that there are individuals who do not wish to participate in home and community-based services because of those copay requirements and elect instead to move to a SNF.

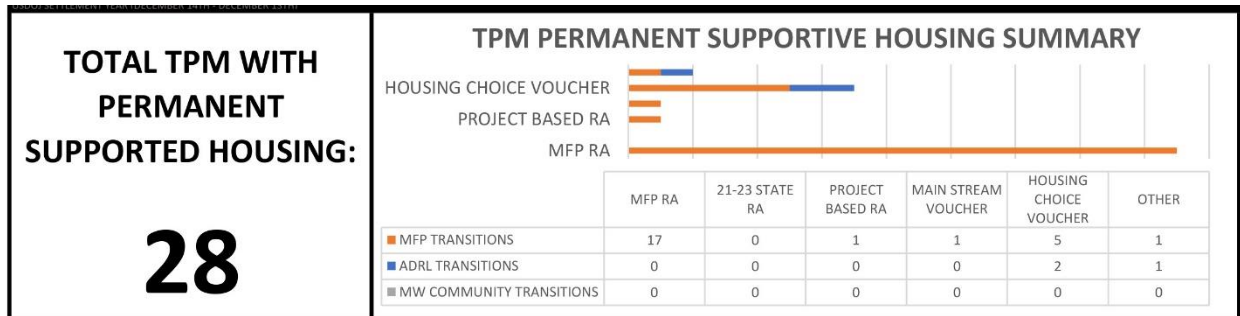
The SME will review PCPs that will be submitted on the new State forms and provide additional technical assistance. That review will include plans from multiple case managers to get a sample of consistency and comprehensiveness.

HOUSING

Section XII of the Settlement Agreement addresses Housing Services. To address the needs of Target Population Members for housing facilitation and Permanent Supported Housing (PSH), the State has created two workgroups – one focused on Housing Services and the second on Environmental Modifications. The Housing Services Workgroup gathered first in the Spring of 2021. It is a "long-term" group that will be focused on guiding and creating policies related to housing concerns for TPMs. The Environmental Modification Workgroup is more tactical; they are attempting to learn from other states about what solutions have worked to increase the ability to offer housing modifications in an efficient manner.

Permanent Supported Housing

Secure housing is a significant issue for persons transitioning to the community from a Skilled Nursing Facility. The Settlement Agreement, in Section XII.B.1.a, identifies the requirement that the State provide Permanent Supported Housing to at least 20 TPMs within one year of the effective date. The State reported (ND Biannual Report "2021 Aging Services Housing USDOJ SA Dashboard," Jan. 2022) that Permanent Supported Housing was provided to 28 TPMs in year one of the Settlement Agreement.



	MFP RA	21-23 STATE RA	PROJECT BASED RA	MAIN STREAM VOUCHER	HOUSING CHOICE VOUCHER	OTHER
MFP TRANSITIONS	17	0	1	1	5	1
ADRL TRANSITIONS	0	0	0	0	2	1
MW COMMUNITY TRANSITIONS	0	0	0	0	0	0

Permanent Supported Housing can be funded through a variety of programs including Housing Choice, rental assistance, and the Opening Doors Landlord Risk Mitigation Fund. The Money Follows the Person program, through which most transitions occur, also provides "bridge" funding for housing assistance for the first year of transition during which time other funding sources can be secured.

Environmental Modifications
Environmental modifications have been identified by the State as one of the significant gaps in the provision of housing and TPMs returning to community settings. Section XII.D.2 of the Settlement Agreement calls for the State to provide assistance to the TPM to access housing modifications (in addition to the delivery of HCBS) so the individual can remain in or return to the community.

The Environmental Modifications Workgroup has gathered information from several existing programs in other states. As a first step, the State submitted comments to the Centers for Medicare and Medicaid Services during the public comment period for the 1915c Medicaid Waiver. The State intends to continue to gather and provide recommendations in coming months to enhance access to these supports. Specific items have been noted by the State in its efforts to increase access to home modifications (ND Biannual Report, Jan. 2022, Pg. 54-55) that have been submitted as part of the HCBS 1915c Medicaid waiver renewal application:

1. Adding assistive technology professionals to the list of those that can supply a written recommendation for environmental modification and specialized equipment
2. Allow installation costs to be added to the coverage of specialized equipment
3. Increase the threshold of spending on specialized equipment from $250 to $500 without prior approval
4. Expand qualifications for QSPs for environmental modification and specialized equipment to allow a handyman/contractor/tradesman in good standing to enroll as a QSP for environmental modification and specialized equipment, and
5. Allow a handyman to provide installs and modifications to the home not exceeding $4,000 (licensed contractors would not be limited at this same dollar threshold).

State personnel have indicated that it is easier to complete home modifications through the Money Follows the Person program. The program can directly reimburse contractors for work that needs to be done and is completed. Currently the State, because Medicaid requires those delivering such services to be providers so they can bill and be paid through the Medicaid Management Information System (MMIS), is less able to do so. The State reports that contractors are interested in entering into long-term agreements for this type of work rather than billing by the job as is necessary through MMIS. The changes noted above that have been requested to the Medicaid waiver may alleviate some of those concerns.

The State reports completing 11 home modifications for TPMs in 2021 through the MFP program (ND Biannual Report "2021 Aging Services Housing USDOJ SA Dashboard," January 2022).

Housing Services
Every individual who seeks to transition from a SNF to the community is assigned a housing facilitator through Money Follows the Person or the ADRL grant in accordance with Settlement Agreement Section XII.D, to assure that housing presents no barrier to the return to the community. Housing facilitators work with case managers and transition coordinators as a team

to best meet the needs of the TPM. Of the 88 individuals who transitioned back to the community in year one of the Settlement Agreement, 56 have been identified by the State as using the services of a housing facilitator.

The State has other housing facilitators (through ND Rent Help [NDRH]) that do not currently provide support to TPMs. Much of their work has been focused on supporting individuals and families experiencing homelessness. The MFP/ADRL and NDRH teams will work to evaluate housing facilitator reach and impact in the coming months to identify opportunities for coordination and further expand available resources for residents of the State.

Housing Needs Assessment & Inventory

In efforts to improve the ability of housing facilitators and case managers to assist TPMs to secure appropriate housing to return to the community, the State is planning a housing needs assessment and inventory. The State is seeking to develop an inventory tool (target completion date October 1, 2022) that can be built into a database so that all staff and TPMs can easily access accurate information. The tool must be designed so that it is easily and continuously updated. The Money Follows the Person program has a housing locator tool that the State wants to build upon and make more robust. The intent is to build from that tool and focus more heavily on data elements that are of the most interest to housing facilitators working with TPMs who experience barriers. The SME noted in the Housing Access Plan that the inventory should identify properties by funding source and location, accessibility, unit size, and the property management company with contact information. Money has been allocated in the approved ND American Rescue Plan Act spending plan to complete this activity.

Additionally, the State is looking to procure a more updated housing needs assessment for all North Dakotans than what it currently has, which relies on five (5)-year-old census data. The State is partnering with state universities to accomplish this and is looking to reimagine the entire assessment to build a new model for the future. The target date for when and how this comes together across multiple departments is 2023.

The State has noted several challenges to addressing housing issues for TPMs and all their citizens:

1. The need for a comprehensive workflow analysis that outlines the role of those involved in addressing housing needs, particularly for TPMs.
2. Aligning and moving forward in the same direction with the multitude of departments and partners involved in housing services across the Housing Finance Agency and the Department of Human Services.
3. Human resource limitations.

Recommendations

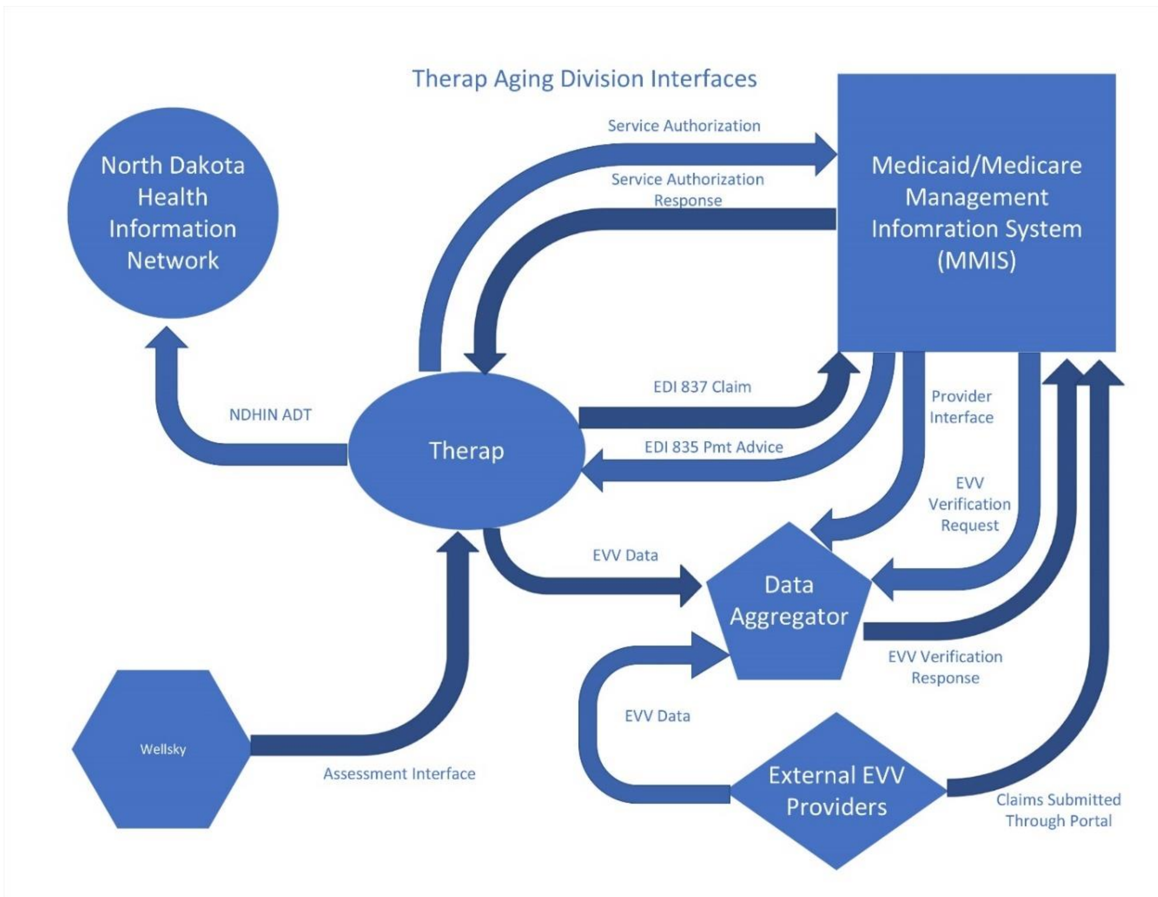
1. Assure that housing facilitators/case managers/transition coordinators have the most current information available on housing stock so that assistance can be provided timely.

2. Continually work to develop and maintain a comprehensive housing inventory accessible to professionals and TPMs. The SME noted in the Housing Access Plan that a review of housing locator technology options needs to occur to select a model that can be used moving forward. The SME recommended that the State not develop its own model unless it can demonstrate that it can develop the technology successfully and in a timely manner and that "off the shelf" products cannot meet the State's needs.

DATA COLLECTION & REPORTING

Data Systems

The Settlement Agreement, in Section XV, discusses requirements for the State to enhance its data collection system for Target Population Members in Section XV.A and generate summary/aggregate data (Section XV.B) about the number of at risk TPMs, Skilled Nursing Facility TPMs, and those that have transitioned to the community. The interfaces for this information are complex as it involves four data systems – Therap, Wellsky, the North Dakota Health Information Network, and the Medicaid Management Information System that involve assessment data, clinical data, service authorizations, electronic visit verification information, and claims data. To better help understanding, the State created a flow chart that outlines the interfaces of those systems (see below).



These data systems remain separate, and much of the data provided in the most recent Biannual Report by the State continues to be tracked manually outside of these interfaces, particularly as it relates to the assignment of case managers. There has been some streamlining between Therap (where authorizations reside) and MMIS (where actual reports of services utilized are reported). The State has shown to the SME, in demonstrations of the electronic record, the linkages between the two systems for QSP billing. More work is required relative to building reports and determining reporting capacity for this combined information. This includes matching reporting requirements with Settlement Agreement requirements to, in part, determine the reports that will be readily available and those that might require customization and involve production cycle delays. The State reports that its data warehouse for MMIS is approximately six (6) weeks delayed in reporting actual service delivery data (claims data) due to volume, completion of billing by providers, processing of this information, and the provision that providers can adjust billing for a period of time.

The new electronic record, when completed, should be able to capture and report on all data related to Section XV.A.1, XV.A.2, and XVI.D. It should also be able to capture the required information in Section XVI.B of the Settlement Agreement surrounding quality assurance, risk management, and reporting of critical incidents, including the timeliness of those reports.

Related to Section XV.B, the system will be able to report (in summary/aggregate form) the number of TPMs who are in the at risk population, the number of SNF Target Population Members, and the total number that have transitioned to the community. The State can report on the number of at risk TPMs known to them in the community. This number is ascertained by tallying those persons receiving services through HCBS, Medicaid State Plan B&C, and SPED that screen at the nursing facility level of care and have assets under $25,000. The State can also report the number of TPMs who reside in nursing facilities and those that have transitioned.

It is essential that the State continue to work with their vendor to include all data fields related to Section XV and Section XVI in the case management system. The State also needs to further integrate their data systems to mitigate the possibility for error from the manual collection and data entry that is currently underway.

Critical Incident Reports

In July 2021 the State began reporting critical incidents through its electronic record. In its January 2022 Biannual Report (Pg. 80) the State indicates that only 14% (69 of 494) of those incidents were reported in a timely manner. Not all these incidents pertain to TPMs. The SME has reviewed 133 critical incident reports during the first year that are estimated to pertain to TPMs. The State indicates it will continue to educate providers on what types of incidents that need to be reported and the importance and need to improve timely reporting of incidents.

Five (5) reports were not reviewed by the State within one (1) business day, therefore 99% of the reports were reviewed timely after they were received. The State has provided the SME and

USDOJ with reviewed critical incident reports including remediations within required timeframes. The State is working with The Council on Quality and Leadership and agency QSPs to create a standard that will require providers to identify how they will report critical incidents in a timely fashion.

Complaints

The State is manually monitoring complaints received regarding Target Population Members and includes that data in its January 2022 Biannual Report (Pg. 85). In the most recent reporting period, the State identified 24 complaints and the remediation taken to resolve those.

TPM Complaints 6/14/2021-12/13/2021					
Complaint Type	**# by Type**	***Pending Outcome**	**# Unsubstantiated**	**# Substantiated**	**Remediation**
Absenteeism	3	0	0	3	Provided T&A
Abuse/Neglect/Exploitation	6	2	0	4	Provided T&A to the Agency employer
Breach of Confidentiality	1	1	0	0	Provided T&A
Poor Case Management	0	0	0	0	N/A
Criminal History/Activity	4	2	1	1	Provided T&A
Theft	2	0	2	0	N/A
QSP Disrespectful	0	0	0	0	N/A
Inappropriate Billing	1	0	0	1	Terminated
Poor Care	4	2	0	2	Provided T&A
QSP Damaged Recipient Property	0	0	0	0	N/A
QSP under the Influence of Drugs/Alcohol	1	0	0	1	Employee terminated
Self-Neglect	1	0	0	1	Provided T&A
Other- Not Wearing PPE	1	0	0	1	Provided T&A
Total Complaints associated with TPM	**24**	**7**	**3**	**14**	

Recommendations

1. Map the requirements of the Settlement Agreement to the new case management data system to ensure the ability to report on all required elements.
2. Complete discussions and training with the vendor related to reporting elements of the system.
3. Design any necessary custom reports to ensure that all reporting requirements in the Settlement Agreement can be achieved.

CONCLUSION

The State has demonstrated progress in the implementation of the requirements of the Settlement Agreement. The State works collaboratively with the SME and USDOJ and readily integrates feedback offered. Outreach and in-reach regarding the availability of Home and Community-Based Services has been strong. Infrastructure continues to be developed and every area of the Settlement Agreement is being addressed or beginning to be addressed in some manner. The State increased the number of transitions from Skilled Nursing Facilities over previous years and case managers are assisting more individuals in the community, diverting them from the need to seek institutional care. Housing facilitation and supports are being provided and requests for environmental modifications addressed.

The next six (6) months is a critical time for the State as it continues to implement all the requirements of the Settlement Agreement. This includes focused attention on progress toward meeting year one and year two benchmarks of 580 Person Centered Plans and addressing other critical capacity issues of Qualified Service Providers, informed choice referrals, and case management. The State also needs to ensure completion of the new electronic case management record. Processes continue to be developed and refined in many areas as the State operationalizes implementation strategies aimed at meeting Settlement Agreement requirements.