North Dakota Settlement Agreement with the US Department of Justice

Report of the Subject Matter Expert

April 2023

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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 required 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 fourth report on progress being made by North Dakota, coming at the conclusion of two (2) full years of the Settlement Agreement.

PROGRESS TOWARD MEETING REQUIREMENTS

The State has worked in good faith and with diligence on multiple components of the Settlement Agreement through strategies laid out in the Implementation Plan to assist them in meeting identified benchmarks. The following table (see pg. 3) provides a snapshot of important benchmarks for Year 2 and the State's progress.

Most of the data reported in the "Achieved" column, is data reported by the State. Examples include the number of diversions, transitions, and TPMs provided Permanent Supported Housing. The State has indicated that this data is verifiable and will be able to produce supporting documentation. The SME will be conducting data verification activities throughout 2023.

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SA Section	Benchmark	Benchmark Date	Achieved	Additional Information
VI.F	Develop an Implementation Plan for Year 3	6/14/2022	Yes	
XIV.A.1.	1,000 in reach visits	12/14/2022	1,104	
VIII.I.3.a	Initial 290 TPMs receive person-centered planning	12/14/2021	NA	Year 1 benchmark carried into Year 2.
VIII.I 3.b	Additional 290 TPMs receive person-centered planning	12/14/2022	Significant progress – based on extrapolation of sample.	Year 2 benchmark combines Years 1 and 2 for a total requirement of 580, 50% of which are for the at-risk population. Submitted last 6 months: 716 = At-risk TPM PCPs 764 = SNF TPM PCPs Further analysis will be conducted during the next reporting period.
X.B.3.	Require annual NF LoC for all continued stay in a nursing facility.	12/14/2022	Initiated and in Process	*See Pg. 29 for additional information.
XI.E2. a	Transition 100 TPMs from SNFs in the first 2 years of the SA	12/14/2022	212	*See Pg. 17 for additional information.
XI.B	Transitions occur no later than 120 days after TPM chooses	6/14/2022	Partial Compliance	75% compliance over last 6 months. *See Pg. 17 for additional information.
XI.E2. a	Divert 100 at-risk TPMs from SNFs in the first 2 years of the SA	12/14/2022	581	*See Pg. 20 for additional information.
XII.B1. b	Permanent Supported Housing to an additional 30 TPMs	12/14/2022	99	*See Pg. 23 for additional information.

IMPLEMENTATION PLAN

The State was required, per Section XI.G of the Settlement Agreement in consultation with the Subject Matter Expert and the United State Department of Justice, to revise the original Implementation Plan at specified intervals. Plan revisions include information about challenges encountered by the State and strategies to resolve them.

There are a lot of moving parts in this work…
- Key Informant

The plan was last revised in June 2022 and submitted to the SME and USDOJ as required. Included in the plan are strategies and action steps that will guide the State's work during Year Three (3) of the Settlement Agreement (December 14, 2022 – December 13, 2023). These include new strategies in the areas of:

- Qualified Service Providers,
- Provider Models,
- Environmental Modifications,
- Housing, and addressing the needs of every Target Population Member (TPM) through case management assignment and ongoing work.

The State and SME agree that the most significant area of growth must be in Qualified Service Provider capacity. Without a sufficient provider base, TPMs will have less opportunity to transition home from Skilled Nursing Facilities (SNFs) or to remain in the community with sufficient services to prevent institutionalization. The SME has thoroughly reviewed the revised plan and offered suggestions for its improvement. The revised plan is available from the State of North Dakota website at https://www.hhs.nd.gov/sites/www/files/documents/DHS%20Legacy/ND-updated-DOJ-SA-Year-3-implementation-plan.pdf.

REPORT STRUCTURE

The State is working to address all requirements of the Settlement Agreement and has developed a multitude of strategies to do so. Progress toward achievement of those requirements is noted in both the December 2022 Biannual Report of the State and in this document. The SME used methodologies that, for this reporting period, included stakeholder meetings, weekly meetings with the Agreement Coordinator and additional Aging Services staff, quarterly meetings regarding housing, data analysis, and review of documents such as Person Centered Plans (PCPs) and the State's Biannual Report and dashboards. In the report, the SME notes areas of concern, what is being done to address those concerns and makes recommendations for further progress. This report does not address every strategy or action the State is taking. It instead discusses those areas the SME believes require the highest level of continued and focused attention.

This report includes the following sections:

- Qualified Service Provider Capacity
- Staffing
- Transitions & Diversions
- Person Centered Plans
- Housing, and
- Quality Assurance/Data Management and Reporting

This report discusses the number of transitions and diversions that have occurred, progress on person-centered planning and Person Centered Plans, changes and additions in staffing levels to improve the ability to serve Target Population Members, and reflects on the steps that have been taken by the State to improve reporting on all required elements of the Settlement Agreement.

RECOMMENDATIONS

The Subject Matter Expert recommends that the State place or consider placing priority focus on the following items during the next reporting period (December 14, 2022 – June 13, 2023) to continue to assure that the State is in compliance or to assist with the State's compliance with the Settlement Agreement. The recommendations are also included in the body of the document in appropriate sections.

- Work with the Resource Hub to determine if there are ways to retain family member QSPs to serve other Target Population Members when their loved one no longer requires their care.
- Simplify the enrollment process and the renewal of applications for QSPs to continue services.
- Find additional opportunities to provide behavioral health training to case managers and QSPs.
- Reach out to individual QSPs annually that are identified as having not billed in the previous quarter to attempt to match such persons with an individual or agency to provide service.
- Show progress in the development of communications with Native American communities.
- As the State continues to refine and expand its data collection, it should prioritize an analysis of services authorized and services delivered by category of care. This will assist in measuring the impact of efforts to expand QSP capacity.
- The upward trend from Year 1 to Year 2 in both the number and percentage of transitions exceeding 120 days is a trend that requires the State's ongoing and priority focus.
- The SME recommends that the State continue making progress in navigating the sometimes long-standing and significant barriers impeding more efficient transitions.

- Identify all risks in the risks assessment, even those currently mitigated, so that if something should occur, such as a medication issue, an appropriate response is in place.
- Addressing, with enhanced consistency, all eight (8) life domains in the PCP is recommended.
- Continue progress in enhancing PCPs, with a particular focus on risk identification and mitigation, contingency planning, and further development of individualized goals and action steps.
- Expand efforts to provide home modification assistance.
- Implement minor alterations to the structure of the Critical Incident Report to more consistently include recommendations and timelines for resolution.
- Consider implementing more stringent corrective action plans for those agencies, facilities, and individuals that are repeatedly tardy in reporting critical incidents.
- Consider creating a "Biannual Report in Brief" as well as an "Implementation Plan in Brief" that highlights the primary strategies, points of progress including challenges met, challenges that remain, and direct action steps being taken to address those challenges.

QUALIFIED SERVICE PROVIDER (QSP) 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 (TPMs) to transition to and live in the Most Integrated Setting. Growing the capacity of Qualified Service Providers (QSPs) is the most significant need in North Dakota as the State works to meet this requirement. The number of individuals who want to be served through Home and Community Based Services (HCBS) continues to increase, creating greater demand for QSPs.

QSP AVAILABILITY

Given the high number of individual QSPs, the total number is subject to frequent fluctuations. The December 2022 Biannual Report (pg. 9) indicated that there were 954 individual QSPs and 139 agencies currently enrolled to provide HCBS. This is a slight decrease in the number of individual QSPs from the previous reporting period. As noted in the December 2022 Biannual Report (pg. 76), of those 178 were new individual QSPs and 117 individual QSPs left service provision. There was an addition of five (5) new agency QSPs and three (3) QSP agencies stopped providing services.

Part of the fluctuation in numbers comes from those QSPs who are serving a family member. When that person dies or needs to seek a higher level of care (the Skilled Nursing Facility) the family member that had been providing QSP services stops doing so. The State has begun internal discussions to determine what they might be able to do to keep some of those individuals enrolled to provide similar services to other TPMs. The Subject Matter Expert (SME) has suggested that conversations also be held with the QSP Resource Hub to determine if there are ways they can help make connections and retain these individuals.

The State, issued a request for proposals through a competitive grant process to increase QSP services. The provision of incentive grants were designed to expand where a provider offers services, increase the services they offer, or start new services. Applicants could receive bonus points for agreeing to provide services in high demand such as transition supports. Twenty-three (23) grants were awarded in December 2022. These are in addition to the 14 incentive grants that had been approved in the previous reporting period. The State reported that funding for 12 of the 14 first grants approved was used. The funds not used have been retained by the State for additional grants. Following the implementation of the second round of incentive grants, the State will conduct an evaluation of those grants and their effectiveness. The 23 additional grants are funding requests between $30,000 - $50,000. The awards total $1,119,883. *American Rescue Plan Act* (ARPA) 10% savings funds are being used to support this initiative.

The lack of providers in communities delays transitions and extends Skilled Nursing Facility stays. Two communities where this is noted as a very significant problem are Jamestown and Dickinson. Of the new incentive grants, three (3) providers speak specifically to increasing services in Stutsman County where Jamestown is located and one (1) in Stark County where Dickinson is located. The State continues to offer a rural differential rate for QSPs who may not live in those areas but are willing to travel to do so. We look forward to learning how much impact these grants have on increasing capacity.

FUNDING ACTIONS/BUDGET REQUESTS

During 2022, the State offered QSPs funds for recruitment and retention bonuses that can be used to help recruit and retain qualified individuals who provide direct support to TPMs. To date, 33 agencies and 398 individual QSPs have participated, and $415,800 has been allocated (December 2022 Biannual Report, pg. 86.) We look forward to learning from the State how these bonuses have – or have not – impacted the number of QSPs available to serve Target Population Members.

The 2023 – 2025 Executive Budget Request for the State Department of Health and Human Services includes funding to:

- Increase the daily rate maximum paid for individual Adult Foster Care from $96.18 to $100 a day.
- Increase the daily rate maximum paid for Family Home Care providers from $48.12 a day to $80 a day.
- Add a base rate for the first hour of Personal Care Services to help ensure provider access for those TPMs who only need a few hours of care (December 2022 Biannual Report, pgs. 88-89).
- Provider a higher acuity rate for services with TPMs who present with significantly greater needs.

Executive budget requests are currently being addressed by the North Dakota Legislature. The Senate has completed its work and has sent the proposed Appropriations Act to the House of Representatives for their consideration.

MEDICAID ENROLLMENT

QSPs are required to enroll as Medicaid providers and, as such, the efficient processing of applications is paramount to building the available workforce. The simplification of the enrollment process and the renewal of applications for QSPs to continue services has been subject to delays. The State is taking the following actions to improve these processes. The SME recommends that this be a high priority for the State.

1. In 2022 the State's Medical Services Division entered into a contract with Noridian Healthcare Solutions to manage QSP applications for Aging Services. The contract is designed to work through the backlog of renewal applications that had developed during the pandemic and to address new applications. New applications, when submitted complete, are to be processed within 14 days. To date, Noridian has not processed any applications within the required/contracted timeframe.

   A new training is being developed in effort to help Noridian better understand the services that QSPs are enrolling to provide to improve its ability to assure that provider applications can be completed in a timely fashion so that services can begin for TPMs. The Aging Services Director/Agreement Coordinator also can expedite reviews when requested to enhance the ability for a QSP to be qualified and put in place so that an individual can leave the institutional setting and return to the community safely.

2. Aging Services has revised the SFN 1603 and the SFN 1606 which are the enrollment applications for QSPs (individuals and agencies). The new enrollment forms will streamline the way providers can select all the services they wish to offer. The first selection is "Basic Provider Services" and includes Personal Care, Homemaker, and Non-Medical Transportation Escort. The second selection is Cognitive Global Endorsement Specialties and includes Companionship, Supervision, and Respite Care. Further options include Residential Habilitation and Community Supports. Previously the provider had to individually check each service they wished to provide. Providers can opt out of any of the services they do not wish to offer in each category by indicating so on the enrollment form. The revised forms are also designed to be a single document for QSP enrollment rather than the many forms that are currently required. The forms are with the Medical Services Divison, who is working on updating handbooks so that instructions for the new processes are in place.

   The State is also proposing different processes and timelines for application renewals. Currently, all providers wishing to continue as QSPs must renew their certification every two (2) years. In the new plan the re-enrollment period will change from every two (2) years to every five (5) years. Making these adjustments requires changes to North Dakota's regulatory code, the Medicaid Waiver, and the State Plan Amendment, which

are in process. As well, as part of this new plan, individual QSPs will have to provide a certification update at 30 months, though they will not have to complete the entire application.

The QSP Resource Hub is also assisting with enrollment activities. In the December 2022 Biannual Report (pgs. 40-41) the State reports that during this reporting period, of the 322 individual QSPs that contacted the QSP Hub for assistance, 137 needed support with enrollment. Enrollment support included providing an overview of the enrollment process, emailing and mailing QSP handbooks/packets, answering questions on errors, fixing forms that were not submitted correctly, and completing the entire application process together with the QSP. Additionally, support with National Provider Identifier (NPI) registration, Fraud Waste and Abuse training, and the SFN 583 (electronic remittance advice) are frequently provided.

There were 54 contacts with agency QSPs, 31 of which were for enrollment support. The QSP Resource Hub notes that these are initial contact numbers and do not include ongoing enrollment support which is offered.

Additionally, on Pg. 40 of the December 2022 Biannual Report, the State notes that during this reporting period, three (3) contacts to the QSP Hub have been individuals who are self-directing services. Data indicate that these individuals have called to advocate for a need for the QSP that supports them. Specific areas included concerns about why their QSP had not been paid and application status inquiry. All calls and emails that come into the QSP Hub are tracked using the University of North Dakota Center for Rural Health's data tracking system. Information about the call, program and goals, length of call, and other content areas are tracked.

QSP TRAINING OPPORTUNITIES

The State has worked with the QSP Resource Hub in the development of a QSP orientation. Each month the State provides to the Hub a list of all new QSPs that have enrolled. The Hub then contacts those individuals and invites them to orientation. Orientation consists of assisting providers with assuring access to all necessary applications for recording services delivered and billing, discusses the need for documentation of visits and how that should be accomplished, reviews critical incident reporting, and offers tools for self-employment.

The QSP Resource Hub will be developing additional training for QSPs that will focus on clinical needs, be specific to the type of QSP – agency or individual, review of current competencies, and assist with the development of tribal targeted case management requirements. The QSP Resource Hub will also develop a partnership with Train ND. These trainings could be initial trainings or continuing education based on the desire of the provider. Providing more opportunities for group training may encourage more participation.

Train ND is the agency that provides competency training on a one-on-one basis with QSPs. QSPs work at their own pace to complete the training and achieve sign-off on their ability to demonstrate all competencies so they can begin work. The State pays for most of the cost, with the individual only required to pay $10 to complete the training. There is no requirement that

QSPs use Train ND for assistance. If they believe they have the skill set to demonstrate all competencies when they enroll, they can seek out a medical professional eligible to certify the demonstration of competencies and submit that to the State.

In the previous report of the Subject Matter Expert (September 2022) it was noted that an additional opportunity had presented itself through Centers for Medicare and Medicaid Services (CMS) Money Follows the Person grants. The State has been considering the use of some of these funds to provide individualized training for QSPs while the TPM remains in the Skilled Nursing Facility, better assisting the successful transition of the individual to the community with necessary and specialized services in place. It was also noted that the State is planning to use *American Rescue Plan Act* funding to increase opportunities for behavioral health training. The potential to create these opportunities should be a continued focus by the State.

SERVING THE NATIVE AMERICAN COMMUNITY

The State continues efforts to engage with tribal communities to provide case management, QSP services, and determine what needs are being noted. As part of this, the State is working with tribal liaisons in the Department of Health and Human Services Office of Healthy and Safe Communities to schedule and engage in community conversations in conjunction with other activities on the reservations. The State has created a one-page information sheet that can be shared with elders of each tribe to explain what the community conversations with Aging Services will entail. Relationship building is essential to better understand the barriers which exist that prevent more services from being available and used. The State plans to use these community conversations as listening sessions to better ascertain what areas of assistance are desired by the individual tribes. The SME suggests that the State consider allowing tribal elders to set the agenda for these listening sessions so that the information that the tribes feel is of utmost importance to be heard can be shared.

The State has funds available to assist every tribal nation to develop case management services. At one time the Standing Rock Sioux Tribe employed a case manager. That individual left to assume new work and the position is currently vacant. The Turtle Mountain tribe has hired a new individual who is currently training with Adult and Aging Services staff regarding case management.

Pgs. 76-77 of the December 2022 Biannual Report Indicates that there are three Tribal QSP agencies.

- Spirit Lake Okiciyapi – 28 clients
- Standing Rock Sioux Tribe – approved QSP, not providing services
- Turtle Mountain Tribal Aging Agency – 25 clients
- North Segment Home Service of the MHA Nations – no current clients
- South Segment MHA Nation – data not available

The MFP-Tribal Initiative is funding a Tribal Nations QSP Agency at Turtle Mountain. Home Instead is working with the MHA Nation for QSP support with this funding. Of the incentive

grants noted earlier, nine (9) of those grants indicate that the QSP agency is planning on a focus with tribal and/or rural communities.

The SME is supportive of the work the State has been doing to enhance relationships and increase services with Tribal nations. It is important for the State to show progress in understanding the unique barriers that are being encountered.

INCREASING CAPACITY

A Capacity Plan, included In the State's initial Implementation Plan, offered many recommendations for ways to increase QSP capacity to enhance the number of individuals requesting HCBS. The State has made inroads on many of those suggestions. As has already been noted, the State offered two (2) rounds of capacity grants to increase services, offered bonuses to incentivize recruitment and retention, and has made requests to enhance funding for some of the services offered.

The State is also engaged with ADvancing States in the creation of the *ConnectToCare Jobs* platform. While not yet live, this new platform is designed to replace the static list of provider names and phone numbers with an interactive platform that enables the QSP to offer more information about themselves such as services provided and available hours and days of operation, making it easier for navigators, case managers, and TPMs to locate and engage with services. It is currently reported that some willing providers never receive calls to work because people don't know who they are or what they offer – they are just a name on a list.

The State will assure when the platform is ready (anticipated August 2023) that all active QSPs are initially loaded into the system and then will provide training on how QSPs can enhance their profile. The new system will also allow the State to gather better data on where services are available, assisting in determining shortage areas that may exist. This initiative is in alignment with a recommendation made by the SME in 2021.

Discussions between the SME and the State relative to creating different incentives to increase capacity are ongoing. Discussion points include:

- Creating a career trajectory for QSPs – developing ways that QSPs can obtain greater reimbursement based on skills/education obtained.
- Increasing incentives for QSPs that work with TPMs with significant medical or supervision needs, or both, and
- Offer incentives to agency and individual QSPs who complete training for nurse delegated tasks and behavioral support strategies.

The SME has also recommended in the Capacity Plan that the State reaches out to individual QSPs annually that are identified as having not billed in the previous quarter to attempt to match such persons with an individual or agency to provide service rather than the current process of not recertifying the individual QSP if they have not billed in the previous year. The work of the State's two (2) navigators as well as the implementation of the *ConnectToCare Jobs* platform provides an opportunity to improve engagement of QSPs to serve TPMs.

The SME believes that central to increasing capacity is an understanding of how many providers are needed at any point to ensure that all TPMs are receiving necessary services to help them remain at home and in the community. Appendix E of the December 2022 Biannual Report does reflect the number of TPMs receiving services in each county, the number of providers delivering those services, and the number of units of service that are delivered. However, data is not currently tracked for what those specific services are and, as service units are not based on a uniform length of time (e.g., some are based on a daily unit, others on 15-minute or one-hour units), necessary analysis on specific service needs cannot be conducted.

To truly understand what is needed will require analysis of services authorized and services delivered by category of care and will involve not only information from the case management system where authorizations are included but also data derived from the claims system. As the State continues to refine and expand its data collection under the Settlement Agreement, it should focus on this area and create strategies to address this need. As of this writing, the State is not able to provide data to allow for this level of analysis. However, plans are in place to address this issue, including additional staff, so that the necessary data can be collected and reported.

STAFFING

There are a variety of personnel who serve TPMs and QSPs. They consist of Case Managers, Long Term Services and Supports (LTSS) Options Counselors, Transition Coordinators through the Centers for Independent Living (CILs), Aging Generalists, Navigators, Medical Services, and Money Follows the Person (MFP) staff.

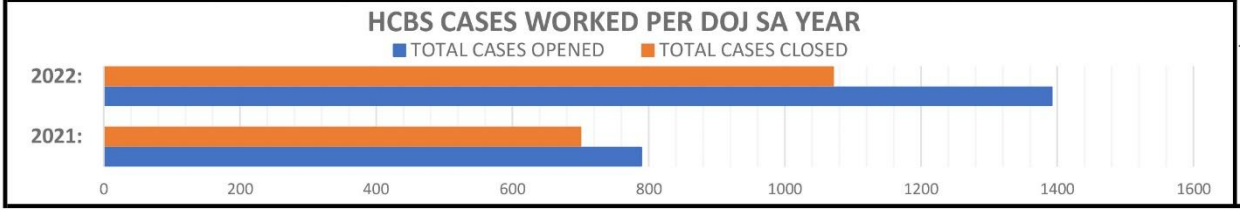
CASE MANAGERS

There are 66 case managers in the Adult and Aging Services Section of the Department of Health and Human Services. The December 2022 Biannual Report (pg. 4) indicates that 967 referrals were received for HCBS in the last reporting period and a total of 2,438 adults were served. There is a great deal of fluidity in the opening and closing of HCBS cases. The State reports in the Aging Services HCBS DOJ SA Annual Comparison Dashboard the number of cases opened and closed for all persons receiving HCBS, not just TPMs.

HCBS CASES WORKED SUMMARY

USDOJ SETTLEMENT YEAR (DECEMBER 14TH – DECEMBER 13TH)

DOJ YEAR	TOTAL OPENED CASES	TOTAL CLOSED CASES	TOTALS BY PROGRAM							
			MSP		MW		SPED		Ex-SPED	
			OPENED	CLOSED	OPENED	CLOSED	OPENED	CLOSED	OPENED	CLOSED
2021:	789	700	N/A	N/A	N/A	N/A	752	648	37	52
2022:	1,392	1,071	283	281	236	122	830	624	43	44
TOTAL:	2,181	1,771	283	281	236	122	1,582	1,272	80	96



The State indicated that there are several reasons for the high number of closures each year. Most notable, many people have unstable medical conditions or are at the end of life. As the State continues to improve its' work and reach TPMs more quickly, it is hoped that many of the individuals seen will not be as close to the end of life as the State is currently experiencing. What can be seen from the grid above is the expansive growth in the number of people that are being served at home and in the community year over year.

While addressing this significant growth, case managers have also continued to reduce the amount of time spent on administrative tasks following full implementation of the case management data system. In the last reporting period, 24.28% of the case managers time was spent on administrative tasks and in this reporting period that number dropped to 22.26% (December 2022 Biannual Report).

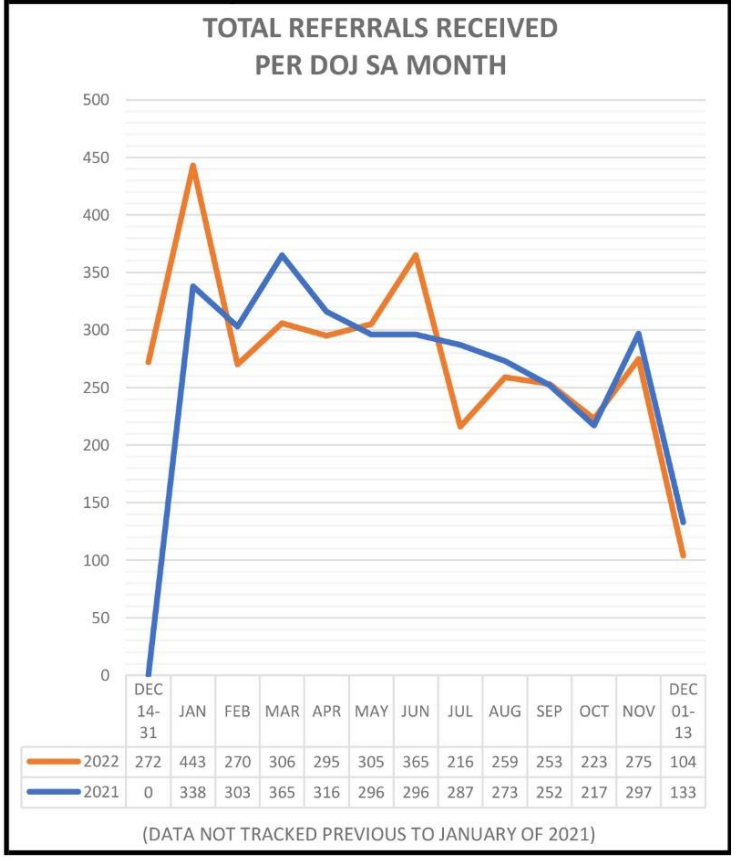
Caseloads, as can be expected from the rise in clients, have continued to grow. Currently the State reports that the average caseload is 58, with the average *weighted* caseload being 117. Cases are assigned a weight based on things such as distance required to travel to provide services and complexity of the case (e.g. multiple medical needs, behavioral health issues). The State has indicated that they would like this weighted number to be around 105. To address what is a growing need for case management services, the State in its Executive Budget Request asked for funding to hire an additional 10 case managers. While appropriations are still being considered by the North Dakota Legislature for the 2023 – 2025 biennium, the Senate is recommending a phased in approach through approval of seven (7) new case managers, four (4) in Year One of the budget, and three (3) in Year Two. Even with an increase in the number of case managers there is concern that caseloads will remain higher than desired by the growing number of people who are seeking HCBS instead of Skilled Nursing Facility care.

LTSS OPTIONS COUNSELORS

There are 10 LTSS Options Counselors who provide service in North Dakota. The status of these positions was upgraded from temporary to permanent on October 31, 2022. Options counselors serve people in the SNF or while they are in the hospital. It is the responsibility of the options counselor to assure that individuals are aware of community-based services. The State indicates that in the last reporting period options counselors saw 559 TPMs for individual visits (December 2022 Biannual Report, pg. 4).

Referrals to LTSS Options Counseling are made for every Target Population Member who is referred for a long-term stay in the Skilled Nursing Facility. As is noted in the Aging Services HCBS DOJ SA Annual Comparison Dashboard, the number of referrals has increased by six (6) percent from 2021 to 2022.

DOJ YEAR	TOTAL LTSS OC REFERRALS RECEIVED
2021:	3,373
2022:	3,586
TOTAL:	6,959



In addition to providing information about community-based services, LTSS Options Counselors are also responsible for completing Person Centered Plans (PCPs) with those individuals who choose to remain in the SNF. The process of doing this began in June 2022. The December 2022 Biannual Report (pg. 4) indicates that 2,367 TPMs reside in skilled nursing facilities and 726 of those individuals have a PCP and risk assessment completed and in place. This is 31% of the population.

AGING SERVICES GENERALIST

There is currently one (1) Aging Services generalist employed. This individual is aware of all services within the Department to provide assistance to clients. This can include things such as transportation, home delivered meals, and senior activities. This individual serves as a half-time case manager for TPMs. A request has been made to the ND State Legislature to change the status of the Aging Services generalist position from temporary to permanent.

NAVIGATORS

Two (2) positions exist within Aging Services. Navigators work with Qualified Service Providers to help connect QSPs with TPMs who are seeking care. Until the *ConnectToCare Jobs* platform is completed, the navigators do most of their work by telephone – getting to know individual QSPs and QSP agencies, determining availability, and matching them with clients. The role of the navigator has assisted the case manager who, prior to these positions being hired, was conducting the time consuming task of coordinating QSPs and availability themselves.

TRANSITION COORDINATORS – CIL STAFF

Transition coordinators are employed through contracts with the Centers for Independent Living (CIL). Transition coordinators work with those individuals living in the Skilled Nursing Facility who desire to return to the community. Their work begins in the facility, continues through the move into the community, and remains in place for one (1) year following the transition. Transition coordination is essential to meeting Settlement Agreement requirements to serve people in the Most Integrated Setting. The State has made funds available to increase the number of transition coordinators to serve the increasing number of people who wish to access HCBS. Not all the positions have been filled by the CILs (December 2022 Biannual Report pgs. 52-53).

- Dakota CIL (Bismarck) – four (4) full-time transition coordinators and one (1) part-time assistant coordinator
- Independence CIL (Minot) – three (3) full-time transition coordinators and one (1) half-time coordinator
- Freedom CIL (Fargo) – two (2) full-time transition coordinators and funds to hire one (1) additional person
- Options CIL (Grand Forks) – two (2) full-time transition coordinators and funds to hire two (2) more

The State reports receiving 479 referrals for transition from the SNFs (Aging Services HCBS DOJ SA Annual Comparison Dashboard, pg. 7) during the first two years of the Settlement Agreement. It is imperative that the CILs hire all the transition coordinators available to them to better serve the needs of TPMs. The State has hired a Transition Service Specialist to assist with strengthening how transitions are managed by the CILs. This work includes individual training with CIL staff on documentation and managing the requests that come in through their catchment area to better assure that TPMs are served in a timely manner and can return home.

ADDITIONAL STAFF

In addition to the staff previously noted, the State has been able to enlist a number of other positions within its purview to better serve TPMs and to be able to report on the work of Aging Services as it seeks to assist citizens of North Dakota to live in the most integrated setting. These positions include:

- Referral Specialists – two (2), one in the MFP program and one through the Aging and Disability Resource Link (ADRL)
- Data Analyst
- ADRL Program Administrator.

The State has worked continually to expand staffing in ways that provide, most importantly, services to TPMs and, secondly, to assure that the citizens of North Dakota are aware of options to them if they are seeking assistance. The ADRL has been a significant presence in this work. ADRL staff, as noted in the Aging Services HCBS DOJ SA Annual Comparison Dashboard (pg. 7 and below), have managed tens of thousands of contacts about services, both through the website and telephone calls. In doing so they have also reduced the wait time for individuals contacting the ADRL by telephone and more than doubled the number of web intake referrals they have received. The State should be commended for this work and outreach.

DOJ YEAR	TOTAL UNIQUE I & A INQUIRIES	I & A INQUIRIES BY SOURCE			AVERAGE CALL WAIT TIME (IN MINUTES)	TOTAL WEB INTAKE REFERRALS
		ADRL I & A CALLS	ADRL I & A WEBSITE HITS	ADRL I & A UNIQUE WEBSITE HITS		
2021:	34,487	11,207	28,092	23,280	7	576
2022:	43,475	14,255	33,691	29,220	1	1,198
TOTAL:	77,962	25,462	61,783	52,500	N/A	1,774

MEDICAL SERVICES

The final area of staffing that must be noted in this report is that of Medical Services, a Division in the ND Department of Health and Human Services that also addresses needs for TPMs. Medical Services is responsible for the approval and reapproval of individual and agency QSPs who provide necessary services to TPMs. There has been a significant turnover in staff in the Medical Services Division in the last two (2) years, some of which contributes to the delay in processing QSP applications and, in turn, providing authorized services to TPMs. There is an interim director currently in place at Medical Services. Determinations about who should

complete which activities within the section have been made and the director of Aging Services and the interim director of Medical Services are in regular contact.

An individual has been assigned to manage and improve the contract with Noridian Healthcare Services – the entity responsible to assure that QSP applications are received, processed timely, and renewed as necessary. Another individual is responsible to assure that the policy and procedure handbooks that reflect the new work requirements regarding enrollment are complete and can be put into place as soon as possible. The State has reported and shared with the SME new forms (noted earlier – SFN 1603 and SFN 1606) that will assist in streamlining these processes to more quickly allow TPMs seeking to remain in or return to home and community to have access to necessary care.

TRANSITIONS & DIVERSIONS

TRANSITIONS

Section XI.E.2.a of the Settlement Agreement requires that within two (2) years of the effective date of the Settlement Agreement, the State, "…consistent with the member's choice, as appropriate to the member's needs, transition at least 100 Nursing Facility Target Population members."

During the first two (2) years of the Settlement Agreement, the State has far exceeded this requirement by completing 212 transitions (Aging Services Transitions DOJ SA Annual Comparison Dashboard). This includes 91 transitions in 2021 and 121 in 2022. During the recently completed reporting period, 120 transition referrals were received and 64 transitions completed with TPMs (December 2022 Biannual Report, pg. 4).

TPM COMPLETED TRANSITIONS SUMMARY

USDOJ SETTLEMENT YEAR (DECEMBER 14TH - DECEMBER 13TH)

DOJ YEAR	PROGRAM	TOTAL COMPLETED TRANSITIONS	TRANSITION LONGEVITY SUMMARY					
			WITHIN 30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	121-150 DAYS	OVER 150 DAYS
2021:	MFP	64	24	14	5	8	2	11
	ADRL	26	22	2	2	0	0	0
	HCBS MW	1	0	1	0	0	0	0
	TOTAL:	91	46	17	7	8	2	11
2022:	MFP	105	19	29	12	11	5	29
	ADRL	16	16	0	0	0	0	0
	TOTAL:	121	35	29	12	11	5	29

Section XI.B of the Settlement Agreement indicates, in part, that, "…transitions will occur no later than 120 days after the member chooses to pursue transition…" As reported by the State (Aging Services Transitions DOJ SA Annual Comparison Dashboard) there are multiple factors that impact the length of transitions. These include increasing case complexity including significant behavioral health challenges, changes in health conditions, and the need to address significant and long-standing barriers. Significant barriers include provider capacity to ensure

that necessary services are in place and the logistics of arranging for environmental modifications prior to effecting a transition. Additional barriers include securing accessible housing and the member's "readiness" to transition.

During the most recent reporting period, 45 individuals moved within 120 days after the member chose to pursue transition or 75% of transitions that occurred. Fifteen (15) individuals transitioned in more than 121 days or 25% of transitions. Annual data indicates that for 2021, 14% (13/91) of transitions exceeded 120 days and in 2022, 28% (34/121) of transitions exceeded 120 days (see above chart). It is encouraging that 75% of transitions occurred within 120 days. The upward trend from Year 1 to Year 2 in both the number and percentage of transitions exceeding 120 days is a trend that requires the State's on-going and priority focus.

Subsection B further requires, in part, that, "…The State will identify any member whose transition has been pending more than 100 days to the SME and US…" The State submits this report to the SME on a quarterly basis. Additionally, the State has developed a transition team model wherein transitions taking 90 or more days are staffed regionally to identify action steps that can be taken to successfully navigate longstanding and complex barriers. Transition teams include, at a minimum, the HCBS Case Manager, MFP transition coordinator and housing facilitator.

Section XI.A of the Settlement Agreement indicates, in part, that, "…The transition will occur as soon as practicable after the member chooses to pursue transition." It appears to the SME in numerous discussions with the State and through review of what delays transitions for specific Target Population Members, that there will always be a number of transitions that cannot, in practicable terms, be safely effectuated with the necessary services and supports in place within 120 days. Knowing this, the SME recommends to the State that they continue making progress in navigating the sometimes long-standing and significant barriers impeding more efficient transitions.

The State has created transition teams and has developed and implemented the following five-step transition process (see pg. 19):

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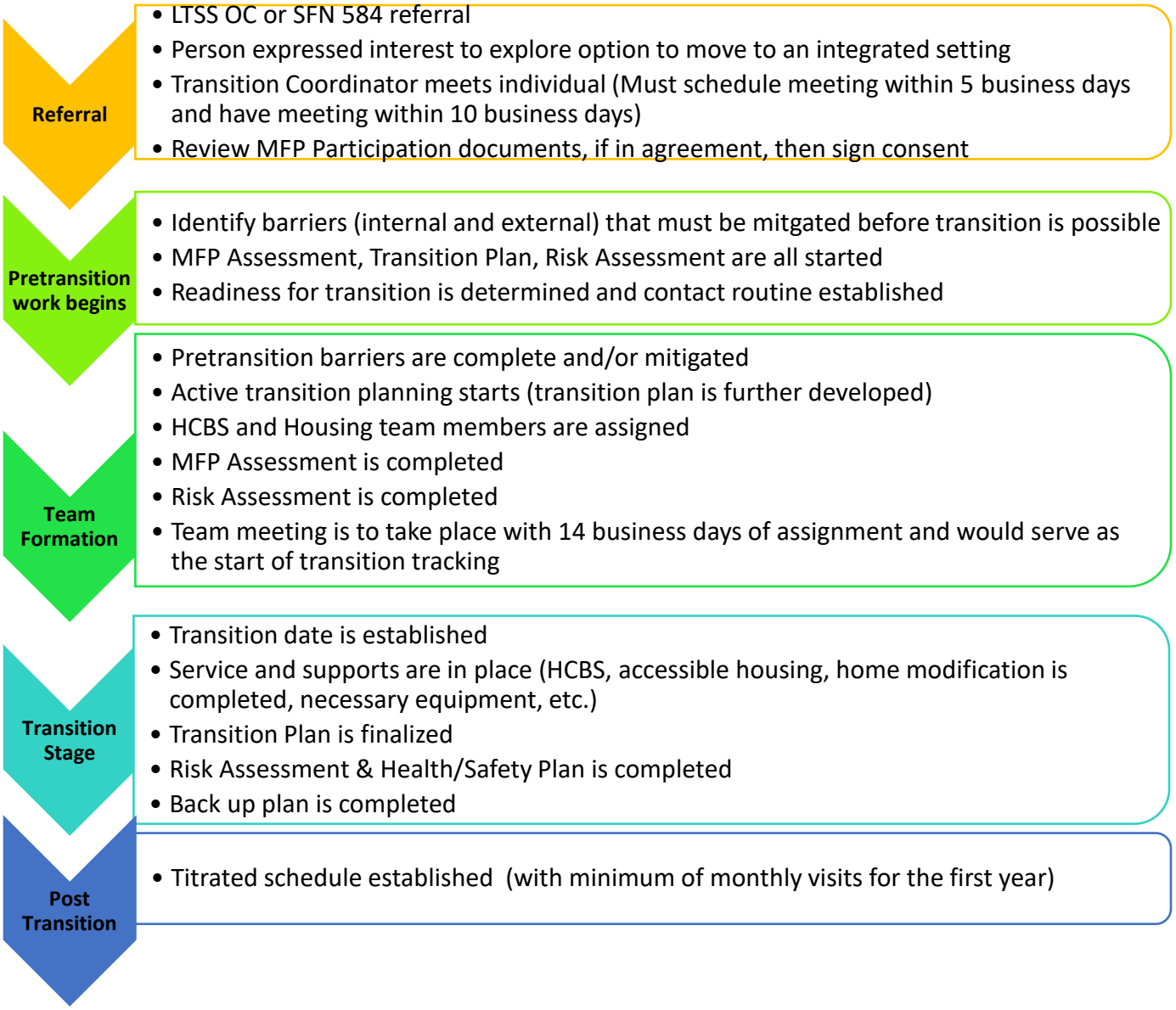

The transition team model is enhanced by the State's efforts to include, for example, support from the Human Service Centers around behavioral health issues for many TPMs or including the paratransit system (or agency QSPs who can provide this support) regarding transportation needs. The State offers weekly opportunities for staffing by teams that are addressing more complex cases.

Of equal importance in transition (and diversion) work is assuring that all known risks are identified in the transition (and diversion) plan and action steps have been included to mitigate those risks. The SME notes that the most difficult of these may be behavioral health issues. For example, if an individual lives with a serious persistent mental illness (e.g. schizophrenia) and the needs are currently being met it takes little for that to change due to something like a

medication error or noncompliance such as an individual who stops taking prescribed medication or attending counseling appointments. Each of those examples present risks that could be anticipated and identified in the risk assessment. A contingency plan should also be put in place to address these potential risks. The SME believes that there is a need to identify ongoing risks, even if they are currently mitigated, so that if something should occur an appropriate response is in place.

DIVERSIONS

Target Population Members (the At-Risk Population) are considered "diverted" when the member screens at a NFLoC, is on Medicaid or at risk of Medicaid, and receives the necessary home and community-based services to prevent institutional placement.

Section XI.E.2.a of the Settlement Agreement indicates, in part, that within two (2) years "…the State will…divert at least 100 At Risk Target Population Members…from nursing facilities to Community-Based Services."

The State has far exceeded this requirement, reporting that 581 diversions occurred during the initial two (2) years of the Settlement Agreement. A total of 273 diversions occurred in 2021 and 308 occurred in 2022. Additional data shows that 168 individuals were diverted from nursing facility placement during the recently completed six (6) month reporting period. There is an upward trend as reflected in a 13% increase in diversions from Year 1 to Year 2 and further reflected in a 20% increase from the first half of 2022 to the second half of 2022 (Aging Services Transitions DOJ SA Annual Comparison Dashboard).

HCBS LONG TERM CARE (LTC) DIVERSIONS

USDOJ SETTLEMENT YEAR (DECEMBER 14TH - DECEMBER 13TH)

DOJ YEAR	TOTAL UNDUPLICATED TPMs DIVERTED FROM A SNF	TOTALS BY PROGRAM		
		TOTAL MSP LEVEL B & C TPM DIVERSIONS	TOTAL HCBS MW TPM DIVERSIONS	TOTAL SPED TPM DIVERSIONS
2021:	273	65	144	104
2022:	308	52	221	92
TOTAL:	581	117	365	196

Most TPMs receive diversion services through the HCBS Medicaid Waiver. Of the 581 TPMs diverted over the last two years, 365 have been served through the waiver, representing 62.8% of all diversions. The use of the HCBS Medicaid Waiver has shown significant growth from Year 1 to Year 2 of the Settlement Agreement. Seventy-seven (77) more diversions were supported through waiver services in 2022 than in 2021, a 53.5% increase.

It is apparent that the State is doing the work necessary to provide HCBS to as many at-risk TPMs as possible with a goal of mitigating risks to delay or prevent long-term facility stays. The SME has offered, in the PCP section of this report (pg. 21), recommendations for improvements in identifying and addressing risks through contingency planning and the further development

of individualized goals and action steps. This work will produce beneficial outcomes including getting individuals home and keeping them home with stronger plans for how they can remain at home for as long as possible.

PERSON CENTERED PLANS (PCPs)

During the last quarter of 2022, prior to the completion of the second year of the Settlement Agreement, the SME Team analyzed, evaluated, and provided feedback to the State on 61 Person Centered Plans (PCPs). This review aligns with the Settlement Agreement requirements contained in SectionVIII.I.3a-3b that set a person centered planning benchmark for 580 Target Population Members to be completed within two (2) years of the effective date. Additionally, VIII.I.3.g indicates that, "at least half of the Target Population members who receive Person Centered Planning each year will be Nursing Facility Target Population members."

During the most recent period, the State reports the completion of 764 PCPs for TPMs that reside in a Skilled Nursing Facility (December 2022 Biannual Report, pg. 4). As of this writing, 2,367 TPMs currently reside in a SNF (December 2022 Biannual Report, pg. 4). The State, by this data, has reached 31% of TPMs residing in a SNF in six (6) months since they started this comprehensive outreach. Additionally, the State reports 716 approved PCPs have been completed (of 740 possible) with TPMs living in the community during this reporting period as noted in the December 2022 Biannual Report, pg. 25. While all TPMs living in the community have a person centered plan, the State has acknowledged that three (3) percent of those plans in the community are not fully compliant with Settlement Agreement requirements (December 20222 Biannual Report pg. 26). That is a total of 1,480 unduplicated TPMs that the State indicates have PCPs compliant with the Settlement Agreement in Year 2.

The SME has had the opportunity to review two (2) different "sets" of Person Centered Plans in this reporting period. The SME analyzed, evaluated, and provided feedback to the State on an initial set of 61 person centered plans. This represents approximately 10% of the required 580 plans. These included plans for TPMs that the SME met with during an onsite visit in September 2022, TPMs who have been awaiting transition to the community for 90 days or more, and TPMs currently living in the community receiving services and supports intended to prevent a long-term facility placement. The SME provided the State with an opportunity to incorporate feedback and resubmit for additional review. In some cases, the State incorporated the SME's feedback, such as those related to missing documents, and produced revisions that moved "the needle" both toward and to full compliance.

It is important to recognize that the State did not submit the requested 61 PCPs strictly for compliance purposes. This review was designed to determine how new procedures were working, where gaps might exist, and to make improvements. The State has recently submitted to USDOJ and the SME an additional 60 PCPs that they believe are fully compliant with the aforementioned Settlement Agreement requirements. This new group of 60 PCPs is currently under review by USDOJ. As of the writing of this report, the SME has reviewed a random sample of these 60 additional PCPs. Twenty percent (20%) of the plans were reviewed (12) and

11 out of the 12 plans (91.7%) are in compliance with the Settlement Agreement requirements contained in Section VIII.C.

It is of note that during the first two (2) years of the Settlement Agreement, the State and its partners in the service delivery system have undergone significant changes. This included major alteration and/or elimination of documents that had been used for planning and reporting purposes for many years; case management operations transitioning from county-based to state-based oversight; processes for transitions of individuals to the home and community were being redeveloped; and the State implementing a new case management data system. Forms necessary for review and evaluation of PCPs were in transition and some of the PCPs were submitted with a combination of "old" forms and "new" forms. The submission of plans with a combination of old and new forms or old forms only did not necessarily prevent an initial determination of full compliance. As of the end of February 2023, all PCPs are in the case management data system and are in the newly designed format.

The compliance statements made in this report relative to person centered planning will be consistent with the Settlement Agreement requirements contained in Section XIII.C.1 – 8. All plans reviewed met the majority of these requirements, though not all plans would be considered fully compliant. The SME considers nearly three-quarters (73.7%) of the initial 61 plans reviewed to have met the mark of full compliance. The majority of those that were not compliant with the required PCP elements were often only a requirement or two short of meeting all eight (8) required elements of the Settlement Agreement.

The most common element determined to be lacking was the need for the plan to reflect health, safety, and other risk factors and strategies to address them, including contingency plans, to avoid unnecessary institutionalization. The evaluation of plans that meet this requirement, contained in Section VIII.C.6, is based on review of a recently developed State forms (SFN 1265, SFN 1266, and SFN 1267) as well as previous documents that contained health and safety plans. These forms that are completed by case managers and transition coordinators are designed to comprehensively identify risks and address the mitigation of such risks. In some cases, some significant risks were listed (such as a fall risk) along with preventative measures for an individual, while others, such as mental health/behavioral health risks, tended to not be as consistently identified and addressed in the plan. An additional issue relative to risk mitigation planning is to focus on contingency planning if a provider is unavailable or a risk event occurs.

Other elements of the SME review and feedback focused on how PCPs could be strengthened over time as the State gains experience in the use of recently redesigned person centered planning tools. One such area is the further development of individualized goals and action steps, their implementation and updates, parties responsible for effectively meeting challenges, efficiently addressing barriers, and achieving desired outcomes. A tool available and part of person centered planning in North Dakota is the Vision tool, a tool that covers eight (8) life domains and is completed in conversation(s) with the TPM and/or family member. Effective use of these domains when crafting the PCP allows for goals and objectives to extend further.

Continuous training in using all tools available is a routine part of the State's focus. Greater encouragement of addressing all eight (8) life domains in the PCP is recommended.

It is clear that the State has navigated a number of challenges in the redevelopment of Person Centered Plans and has made significant progress in ensuring that person centered plans contain comprehensive documentation. As the State has additional Settlement Agreement PCP benchmarks to achieve by the end of year four (December 2024) with an additional 650 PCPs, it is imperative for the State to continue this progress with a particular focus on risk identification and mitigation, contingency planning, and further development of individualized goals and action steps.

HOUSING

Section XII of the Settlement Agreement provides the requirements for housing supports and Permanent Supported Housing (PSH) for Target Population Members. The State Department of Health and Human Services works closely with the State Housing Authority to assure that TPMs needing some level of housing supports can be adequately served.

PERMANENT SUPPORTED HOUSING

Permanent Supported Housing (PSH) refers to affordable, permanent housing coupled with housing supports and other community-based services. The Settlement Agreement includes benchmarks that must be achieved or substantially achieved to show compliance. In Year 1 the State was to provide PSH to 20 Target Population Members. In Year 2 an additional 30 TPMs were to receive PSH (Settlement Agreement Section XII.B.1). The State has far exceeded the requirements as shown by the following 2022 Aging Services HCBS DOJ SA Annual Comparison Dashboard.

DOJ YEAR	TOTAL TRANSITIONED TPM RECEIVING ASSISTANCE/SUPPORT	TYPES OF ASSISTANCE/SUPPORT SUMMARY		
		PSH	MODIFICATION ASSISTANCE	HOUSING FACILITATION
2021:	95	28	11	56
2022:	175	99	24	52
TOTAL:	270	127	35	108

Much of the PSH provided involves rental assistance for the TPM. Rental assistance derives from MFP funds along with support from ND Rent Help. The State has proposed, in the Executive Budget Request for the 2023 – 2025 biennium, an additional $300,000 in General Fund financing for rental assistance. ND Rent Help was described by a stakeholder in a March 2023 meeting as a "huge resource." The State indicates that it has created a streamlined connection for housing facilitators working with TPMs to quickly access the ND Rent Help portal. This temporary assistance from ND Rent Help (it can be for up to 12 months) allows time to establish a more permanent source of assistance should continuing help be necessary (e.g. housing authority-administered resources).

The State also tracks housing costs as a percent of household income to assure that there is no housing burden related to rent/mortgage. The State reports that housing costs for TPMs range between nine (9) percent and 30% of household income (December 2022 Biannual Report, pg. 65).

HOUSING FACILITATION

Housing facilitation/supports provide the individual with necessary tools to secure appropriate housing. It might consist of rental application assistance, locating an appropriate residence, securing furniture, affordability, accessibility, etc. Each individual transitioning back to the community is offered housing facilitation. The housing facilitator is part of the TPM's team which also includes the transition coordinator and case manager.

The availability of a dedicated housing workforce has grown since the beginning of the Settlement Agreement. Seven (7) State housing facilitators are currently working and are supported by Money Follows the Person funding. The State is looking to add an additional MFP housing facilitator and fund four (4) positions for ADRL housing services in the next biennium (December 2022 Biannual Report, pg. 66). The ADRL workforce uses the same database currently available to MFP staff to access housing resources for TPMs.

It is of note that the State has incorporated the early identification of housing barriers as an essential element of the person centered planning and transition processes. This early identification and the dedication of transition teams to include a housing facilitator addressing complex challenges through actionable planning contributes to more successful (timely and sustainable) transitions. One initiative developed is Opening Doors, enabling CIL staff to be more active participants in this program that includes a Landlord Risk Mitigation Fund ensuring that TPMs with rental history challenges could secure housing with additional guarantees. This program is comparable to an insurance pool that covers potential damages in rented settings to further provide support for the landlord in the event of an issue. The maximum for damages is $2,000 per instance.

ENVIRONMENTAL MODIFICATIONS

Providing home modifications, and providing them in a timely manner, has been challenging for the State. Barriers include the lack of available workers and the lack of desire by those workers to become a provider in the Medicaid Management Information System (MMIS) as a prerequisite to receiving compensation for modifications. The State has made efforts to increase the workforce of those who would like to provide environmental modifications by allowing a "trusted handyman" that may not hold a contractor's license to complete jobs that do not exceed $4,000 and be reimbursed.

The State is working on multiple fronts to both expand and coordinate resources relative to the installation of home modifications and working with developers and builders to make those happen more quickly. The State is proposing to increase the resources available in the Housing Incentive Fund and there is also consideration about attending builder's trade shows to connect with people who can do the work of home modifications. The State continues to hold planning

meetings and is coordinating a housing services collaborative of all parties involved with housing for low income persons. The collaborative is scheduled to meet again in April 2023. This group looks to reduce housing barriers with those providers that offer housing to marginalized individuals and assuring support of QSPs to those persons.

As noted in the previous chart the State has provided modification assistance to 35 persons since the beginning of the Settlement Agreement. While the number more than doubled in Year Two, as the number of TPMs requiring this essential assistance continues to grow, the State's capacity to provide this service must also grow. The State has reported verbally that requests for home modification can be anything from a wheelchair ramp to get into the home at around $3,000 to bathroom remodels that may run as high as $20,000. The State has been using funds from the *American Rescue Plan Act* resources to pay for some of the smaller modifications.

The State is considering a request to the Centers for Medicare and Medicaid Services (CMS) to allow North Dakota to use some rebalancing dollars to create a new fund. One idea being considered is putting $500,000 into a fund for home modifications that could be used to pay contractors directly. When the claim is paid, the money is returned to the fund for use by the next person. This would create a sustainable environmental modification funding stream, reducing the risk of not providing this essential support to TPMs. The State would have to determine how to administer such a fund if it can be developed. The State has also asked CMS if it possible that a contractor receive 50% of the estimated costs of a home modification on the front end of the job, billing for the remainder on completion. The State has been told that this occurs in other jurisdictions.

MAINTAINING HOUSING DURING A TEMPORARY NURSING FACILITY STAY

The Settlement Agreement in Section XII.C.3 states that "Upon admission of a Target Population Member to a hospital or nursing facility, the member's Case Manager or a Housing Specialist will work proactively with the member and the member's property manager, landlord, or mortgage company to preserve the member's tenancy or ownership for at least 90 days."

The State reports that five (5) TPMs maintained their housing in the community during a SNF stay in this reporting period (December 2022 Biannual Report, pg. 72).

HOUSING INVENTORY

In the December 2022 Biannual Report (pg. 62) the State reports work of several areas noted in the Housing Access Plan drafted by the SME in 2021. Included is a note about progress toward establishing an enhanced housing inventory resource. The Housing Service Workgroup has discussed the housing inventories currently being used in North Dakota. In doing so they have identified an opportunity to strengthen those resources by adding additional relevant information. The updated inventory tool will be based upon the existing MFP locator tool. The intent is to focus more heavily on data elements that are of most interest to housing facilitators and TPMs who self-direct their care to assess barriers, including not only if the unit is

accessible, but what accessible features are in place. The inventory will identify properties by funding source and location, accessibility, unit size, and contact information for the property management company, if one exists.

Another component of the new database will be to allow the State to add information regarding the units it has updated through home modifications. While housing facilitators currently add information to the database on units they are accessing that may not have been previously known, the State has no way, in the system, to indicate what units they have improved/modified. This is an essential piece moving forward so that all the accessible units available in any current market can be adequately tracked across the state.

All housing facilitators have access to the current housing locator tool and use this as part of their daily work. This housing database is also available through the ADRL so the public also has access to the information (https://carechoice.nd.assistguide.net/quick-links).

The State notes that in its data system that Referral and Transition Questionnaires have also been updated to gather more comprehensive data on housing stability and inventory of Permanent Supported Housing.

QUALITY ASSURANCE AND RISK MANAGEMENT

CRITICAL INCIDENT REPORTS (CIRs)

Section XVI.B in the Settlement Agreement lists the following incidents that, "…will trigger reporting to the Agreement Coordinator, United States, and Subject Matter Expert within 7 days of the incident:

- Deaths;
- Life-threatening illnesses or injuries;
- Alleged instances of abuse, neglect, or exploitation;
- Changes in health or behavior that may jeopardize continued services;
- Serious medication errors;
- Illnesses or injuries that resulted from unsafe or unsanitary conditions; or,
- Any other critical incident that is required to be reported by state law or policy."

Section XVI.C indicates that:
"All reports of the above incidents, with the exception of death by natural causes, will include a remediation plan designed to mitigate harm to the TPM and a timeline to complete the plan."
The SME recommends minor revisions to the reporting structure in order to more fully comply with this Settlement Agreement requirement.

According to data provided by North Dakota, 322 critical incidents were reported by the State and to the SME and USDOJ during the most recent six (6)-month period (December 2022 Biannual Report, pg. 109). The State is reviewing and reporting on hundreds of critical incident reports, including CIRs for persons being served by Aging Services who are not TPMs for the

purposes of this Settlement Agreement. While 25 of these incidents reported to the SME and USDOJ on behalf of TPMs involved QSP complaints and 40 incidents involved Vulnerable Adult Protective Services (VAPS), many of these reported involve instances of self-neglect. Not all these reports require a "formal" remediation plan. For example, incidents reported such as those that involve minor illnesses and brief hospital stays have straightforward conclusions (e.g. TPM treated by a physician for the illness, TPM returned from hospital on [date].) However, incidents alleging abuse, neglect, or exploitation do require a more formalized remediation plan that includes specific steps and timelines for resolution.

The SME understands that Aging Services does not have direct control over the timing of investigations being led by other State entities, such as law enforcement, the Medicaid Fraud Control Unit (MFCU), the Health Facilities Section, or Medical Services. Aging Services does, however, have reporting requirements relative to any potential investigations and a responsibility to follow-up with investigatory entities on the status of investigations in as much as it impacts Target Population Members. The State, working in concert with the Subject Matter Expert, has implemented a process by which relevant updates and follow-up actions to other investigations can be captured so that the record for the TPM is complete and Aging Services is aware of outcomes of those activities.

The SME has reviewed hundreds of CIRs during the initial two years of the Settlement Agreement. The SME meets with the State monthly to discuss questions and/or concerns that may be noted on submitted Critical Incident Reports to suggest further actions and/or request additional information. The SME has observed the progress the State is making, including regular reporting of relevant updates to previous incidents. It is apparent to the SME that the State is responding appropriately and effectively to critical incidents.

Critical Incident Reports contain a "Remediation/Follow-Up Section." It is here that the State needs to spell out the specific actions steps necessary for remediation and timelines for completing these action steps. The State has made progress in providing an enhanced level of specificity to action steps, including investigatory processes initiated. It is suggested by the SME that minor alterations to the structure of the report be made and that the content for these Critical Incident Reports more consistently include timelines for resolution. In this way, the reported action steps can be considered a "plan of action," including timelines as required by the Settlement Agreement, Section XVI.C.

CIR reports are generated by providers, submitted to the State, and the State sends them to USDOJ and the SME. The State sends received CIRs to the SME on a weekly basis where they are reviewed. The State is fully compliant with reporting (to the SME and USDOJ) within seven (7) days relative to when it becomes aware of the incident (Settlement Agreement, Section XVI.B). However, approximately 62% of providers are reporting critical incidents in a timely manner to the State. To address this, the State has increased its level of education and re-education with providers on the importance of timely reporting including one-on-one training for those providers struggling with this issue. The State should also consider implementing more stringent corrective action plans for those agencies, facilities, and individuals that are

repeatedly tardy in reporting critical incidents. CIR reporting requirements are an ongoing training need given the high level of provider turnover.

COMPLAINTS

Section XVI.F required the State to create a complaint process related to the provision of Home and Community-Based Services that can be used by Target Population Members. The State reports in each Biannual Report complaints received and the resulting action from those complaints. Appendix C of the December 2022 Biannual Report (pg. 124) provides the following grid reflecting 61 complaints received in the reporting period.

Complaint Type	# by Type	Pending Outcome	Unsubstantiated	Substantiated	Remediation provided
Absenteeism	16	3	6	7	4 resulted in a remediation plan and 3 resulted in technical assistance
Abuse/Neglect/Exploitation	4	0	4	0	Technical Assistance-employee was terminated, AFC Corrective Action
Breach of Confidentiality	1	0	0	1	remediation plan
Poor Case Management	0	0	0	0	
Criminal History/Activity	3	0	2	1	Provided Technical Assistance and recoupment of payments
Theft	0	0	0	0	
QSP Disrespectful	4	2	1	1	provider completed remediation
Inappropriate Billing	6	1	0	5	3 resulted in technical assistance and recoupment of payments. 1 resulted in termination, 1 was referred to program integrity
Poor Care	24	9	5	10	1 termination, 1 technical assistance a recoupment of payments, 8 resulted in a remediation plan
QSP Damage Recipient Property	2	0	1	1	remediation plan
QSP under the influence of Drugs/Alcohol	1	0	0	1	1 remediation was complete, employee was terminated
Self-Neglect	0	0	0	0	
Other	0	0	0	0	
Total complaints associated with TPM	61	15	19	27	

NURSING FACILITY LEVEL OF CARE (NFLoC) SCREENING

Beginning in December 2022, the State is required to assure completion of an annual NFLoC for every Target Population Member. This process has begun and a schedule established to complete all screens. The annual NFLoC screen will be completed during the month when the most recent screen was completed, no matter how long ago that was. A monthly list of SNF TPMs has been produced by annual NFLoC determination month. The LTSS Options Counselors use this list to organize and plan visits to each facility. For TPMs living in the community, the licensed case managers complete the screenings. All screens are sent to a third-party vendor – Maximus – for review and a final determination.

A concern has been stated about how many TPMs in skilled nursing facilities may no longer screen at that level of care and how the State will assist in helping these individuals return to community-based living. There may be long-time residents who do not wish to transition, even if they no longer qualify. Medicaid requires that in this instance the individual should remain in the facility no longer than 30 days, creating challenges to assure safe transitions and that sufficient services and supports are available. There will also be the need to reassure the individual that they can live safely in the community with HCBS assistance. The State has been discussing with facility staff that if they believe they know of individuals who may no longer qualify that they should begin planning immediately for future needs. It is the responsibility of the facility to timely and safely discharge Medicaid eligible recipients when they have a change in condition and no longer screen at the Nursing Facility Level of Care. The State has reported two (2) individuals who do not meet the necessary level of care since comprehensive screening has started. The State has made additional provisions, enhancing the Medicaid requirement, that individuals who no longer meet NFLoC can take up to 120 days to transition from the SNF and, if more time is needed, an extension can be requested.

DATA & REPORTING

The State has been working diligently to meet the reporting requirements noted in Section XV of the Settlement Agreement. An Aging Services business analyst worked with the case management vendor to design specific reports. On Pg. 96 of the December 2022 Biannual Report the State indicates the creation of the following reports:

Case Management System Reports
Medicaid Waiver Quality Assurance Report
Medicaid Waiver Recipients with Narratives
Medicaid Waiver Goals and Assurance
Monthly Cost by Funding Source
Rural Differential SFN 212 and Rate
Count of Care Plans Completed with TPM
HCBS Cases Worked Summary
HCBS Care Plans by Service Support
HCBS Care Plans by Funding Source
Aging NCIAD Report

I&R Module Report
Housing Facilitator Transition Plan Report
Housing Services Referral Assessment Report
MFP Referrals
MFP Transitions
Financial Assessment
Informed Choice LTSS Option Counseling
Risk Assessment and Safety Plan
Participant Assessment
DOJ Complaints Assessment Report

The State has indicated that all but the last three reports have been completed. In December 2022 the vendor provided training to Aging Services staff to learn about the business intelligence tools currently available in the system. The State's transition to the data system and the inclusion of all components required for reporting will reduce the level of manual reporting and the use of additional databases to track required elements. The State has moved toward one system that contains and can report on essential data points and trends. The final step in this data system is the ability for QSPs to document the work they are doing in the case management database rather than having to keep that documentation externally in the event that it is needed in the future.

LOOKING FORWARD

North Dakota can continue to improve how it communicates progress and add more specificity to assist the reader in understanding the work that is underway and the things that have been accomplished. The State currently educates stakeholders about progress toward the Settlement Agreement through presentations, testimony with the State Legislature, and dashboard reports that are part of the Biannual Reports produced. The SME recommends the State consider creating a "Biannual Report in Brief" as well as an "Implementation Plan in Brief" that highlights the primary strategies, points of progress including challenges met, challenges that remain, and direct action steps being taken to address those challenges to enhance this information. The documents should be professionally produced and printed and include more graphs associated with Key Performance Indicators (KPIs) to more easily guide the reader than a report exceeding 120 pages.

The State has indicated that it plans to streamline the current reporting dashboard. The SME and the State have jointly developed a list of Key Performance Indicators. There are approximately 60 performance measures scattered throughout the State's Biannual Report and, for many of these, the State has provided data that is responsive to these measures. The State will continue to report on these measures twice a year through its Biannual Reports. The State and the SME are in agreement that not all performance measures are equal in importance. As such, and consistent with a model co-developed by the SME, beginning with the first quarter of 2023, the State will report on the Key Performance Indicators listed below on a quarterly basis. Data Dashboards displaying information on these KPIs will be posted on the

Department's website where all information related to the Settlement Agreement is housed (https://www.hhs.nd.gov/us-department-justice-settlement-agreement).

- Number of unduplicated TPMs served in the state or federally funded HCBS.
- Number of TPMs being served in a SNF.
- Total number of contacts to the ADRL.
- Total number of individuals referred to HCBS case management.
- Total number of TPMs who transitioned to an integrated setting.
- Total number of LTSS Option Counseling visits that resulted in a TPM transitioning to the community.
- Total number of TPMs receiving home modifications.
- Total number of TPMs who were diverted from an SNF because they are receiving HCBS in the community.
- Total number of TPMs receiving permanent supported housing.
- Total number of TPMs receiving rental assistance.
- Total number of TPMs who maintained their housing in the community during a SNF stay.
- Average annual individual cost comparison by HCBS funding source and average annual cost of SNF care.
- Total number of new QSPs enrolled per calendar year.
- Total number of new QSP applications processed within 14 calendar days.
- Total number of QPS who received enrollment assistance from the QSP Hub.
- Total number of new QSP Agencies serving tribal and other underserved/rural communities per year.
- Total number of QSPs by county.
- Total number of TPM complaints responded to within the required timeframe.
- Total number of PCPs created with TPMs in the community and with TPMs in a SNF.
- Average monthly weighted caseload per Case Manager.
- Percent of provider CIRs reported within the required timeframe.
- Percent of remediation plans completed by quarter.

CONCLUSION

North Dakota has made significant progress in meeting both the spirit and letter of the Settlement Agreement during the two (2) years since its inception. As reflected in the table in the Executive Summary of this Report, based on preliminary analysis and pending more complete data verification, the State has satisfied multiple interim benchmarks or "...largely met the benchmark and demonstrated significant efforts to reach the actual benchmark and important reasons why the benchmark was not completely met."

There remains work to be done and important issues that require the State's focus. These issues include, but are not limited to, enhancing provider capacity particularly in tribal and rural regions; streamlining provider enrollment; increasing timely reporting of critical incidents by providers; accessing additional behavioral health training; and continued refinement of person-centered planning documentation.