North Dakota Settlement Agreement with the US Department of Justice

Report of the Subject Matter Expert

September 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 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 third report on progress being made by North Dakota.

> …the Settlement Agreement has been a catalyst for change.
> – *Key Informant Interview*

PROGRESS TOWARD MEETING REQUIREMENTS

The State has worked in good faith and with diligence on multiple components of the Settlement Agreement through Implementation Plan strategies.

SA Section #	Requirement
VI.A	Appoint an Agreement Coordinator
VI.F	Develop an Implementation Plan for Years 1 & 2
VI.F	Implementation Plan feedback
XIII.D	Provide technical guidance to nursing homes that commit to provide HCBS and rural community providers who commit to expand
XV.D	Submit State Biannual Data Reports
VII.F	Role specialization and training of case managers
IX.H.1	Seek CMS approval for residential habilitation, community support services, and companionship services
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.I.2	Person-centered planning training of case managers
VIII.I.3	290 TPMs receive person-centered planning
IX.D	Necessary steps to enable TPMs to self-direct care
XII.B.1. a	Permanent supported housing to 20 TPMs
XV.D	State Biannual Data Report

The State of North Dakota has met the majority of these Settlement Agreement requirements. At the end of December 2021, there was one (1) requirement that required further progress by the State to achieve compliance or substantial compliance and two (2) others that the SME believes would benefit from further development. The SME does not believe that the State is

out of compliance with these two Settlement Agreement requirements (role specialization and self-direction) but could benefit from enhancing both. Those are highlighted in the table above.

> The transition of case managers from counties to the State was…a welcomed change.
> – *Key Informant Interview*

Person Centered Planning

The Settlement Agreement, in Section VIII.I.3.a, required 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. By December 14, 2022, the State must complete person centered planning for an additional 290 individuals. The State has worked with the SME and USDOJ to improve person centered planning and has created a new Person Centered Plan (PCP) and Transition Plan to achieve these milestones. Case managers have had multiple trainings aimed at improving documentation. The SME has provided technical assistance in this area. The SME and USDOJ have had opportunities to review new plans for several Target Population Members (TPMs) in North Dakota and provided additional feedback. The State is tracking all plans that have been completed and entered into the electronic case management record and is have represented that they are making progress toward meeting both the year one and year two benchmarks by December 14, 2022. The State has reported that as of August 2022, 436 PCPs have been completed for at risk TPMs. An additional 67 transition plans have been completed with those who have returned to the community along with 192 PCPs for those residing in SNFs. More information about the person centered planning process and the State's work to achieving these benchmarks is available later in this document.

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. As was noted in previous reports, the State has taken a significant step by transitioning all case managers from county employment to State employment and developing a robust training curriculum. The SME has recommended that North Dakota continue to look for ways to further specialize the role of the case manager. More information is located in the Case Management section of this report. Multiple discussions have been held with the State about models that could be considered to meet the complex needs presented by TPMs.

Self-Direction

Section IX.D. of the Settlement Agreement requires the State to take necessary steps to enable Target Population Members who self-direct their care to receive sufficient support to do so. In its January 2022 Biannual Report, the State indicated 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. In the revised Implementation Plan for Year Three of the Settlement Agreement (December 14, 2022 – December 14, 2023) the State has included new strategies to address provider models to potentially select a formal CMS model to better provide support to TPMs. 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.

Additional Requirements in Year Two (December 14, 2021 – December 14, 2022)
This report provides information for the first six months of Year Two (2) of the Agreement (December 15, 2021 – June 14, 2022) to show progress being made toward meeting all requirements. In addition to the requirements listed in the above table, the State must also meet the following benchmarks in Year Two:

- An additional 290 Target Population Members receive person centered planning
- Permanent supported housing is provided to an additional 30 TPMs, and
- Assign a case manager to each identified TPM.

This report from the SME addresses the State's progress to date on these areas.

IMPLEMENTATION PLAN

The State is required, per Section XI.G. of the Settlement Agreement in consultation with the Subject Matter Expert and the US Department of Justice, to revise the Implementation Plan. The revised plan was to include challenges encountered by the State to date and strategies to resolve them and plans to address noncompliance if, after two years of the effective date of the Settlement Agreement, the State fails to meet any of the implementation requirements in Sections VII – XVI.

The State submitted a revised Implementation Plan to the SME and USDOJ on June 14, 2022, as required. Included in the plan are new strategies to continue to address challenges encountered. These include new strategies in the areas of:

- Qualified Service Providers,
- Provider models,
- Environmental Modifications,
- Developing new tools and collaborations to improve housing strategies, and
- Addressing the needs of every Target Population Member (TPM) through case management assignment and follow through.

The State has indicated to the SME that the most significant area of growth must be in Qualified Service Providers. 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 further suggestions for its improvement. It is anticipated that the revised Implementation Plan will be finalized in September 2022.

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 both in the June 2022 ND Biannual Report and this document. The SME utilized methodologies that, for this reporting period, included key informant interviews, data analysis, and review of documents such as person-centered plans and the State's Biannual Report. We note areas of concern and what is happening to address those areas here as well as making recommendations for the next reporting period. This report does not address every strategy or action the State is taking. It instead focuses on those areas the SME believes require the highest level of continued and focused attention.

The report includes the following sections:

- Qualified Service Providers
- Case Management
- Long Term Services and Supports Options Counseling
- Person Centered Planning
- Transitions
- Diversions
- Housing
- Data Collection and Reporting, and
- Quality Assurance and Risk Management.

This report discusses the number of transitions and diversions that have occurred during the current reporting period, based on information as reported by the State in the June 2022 ND Biannual Report. It also reflects the number of individuals who have received Permanent Supported Housing and discusses at length the work that has been done in person centered planning. The State has worked on completing the last of its four (4) data systems – the case management reporting system – to assure that data can be accurately collected and reported. Information regarding steps made in quality assurance and risk management activities is also reflected.

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 assure the State is in compliance with the Settlement Agreement. They are included in the document of the body in the sections to which they are relevant.

- Complete development and implement a revised enrollment process to assist individuals and agencies in becoming service providers. Set a timeline for necessary improvements.
- Engage provider agencies in training and support of QSPs.

- Give due consideration to a CMS recognized self-directed program that allows the individual receiving services to train QSPs to their specific care needs. A strategy to look at provider models, including the Agency with Choice/Co-employer model, is included in the revised Implementation Plan for Year Three (3) of the Settlement Agreement. The June 2022 Biannual Report from the State includes an updated target completion date of December 1, 2022.
- Consider different reimbursement models for providers that receive grants for enhancing services for TPMs so that more providers consider applying.
- Increase the amount of case management hours available to TPMs.
- Address/Streamline the administrative burden of tracking those "pending" HCBS enrollment.
- Develop a fully justified budget proposal for case management positions for inclusion in the Executive Budget Request.
- Increase communication and planning between hospitals and the State regarding discharge notification.
- Assure that transition coordinators are completing documentation in the record as required.
- Assure, by audit, that all case managers, transition coordinators, and options counselors are completing and reporting information through the data system.
- Work to move goals from the functional assessments more clearly into the PCP and further streamline documentation requirements.
- Continue training with transition coordinators on documentation requirements and how to further develop and document goals and action steps.
- Assure that all transition documentation is entered into the data system within the required timeframes.
- 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.
- For the purpose of continuity in achieving goals, consider moving transition activites such as action steps that have not been completed to the community-based PCP.
- Track the number of TPMs who return to nursing facilities (re-institutionalizations) within 90 days and the reasons for those returns.
- Review claims data for individuals who may be likely TPMs but went home from hospital stays without enrolling in HCBS.
- Enhance the ability to report aggregate numbers of different services being authorized and provided to TPMs, tracking hours delivered by service category.
- Ensure processes are in place to efficiently address the increased service needs for those at home and in the community.
- Assure that all housing facilitators are completing the Housing Service Referral Assessment in a timely fashion.
- Assure that information is available regarding modifications to the State's Medicaid HCBS Medicaid Waiver allowing handyman and assistive technology services and how they are to be accessed.

- Provide no less than quarterly updates to the SME on the status of the Housing Needs Assessment & Housing Locator
- Assure the case management system vendor provides necessary training to the State about the business intelligence tools available in the data system.
- Report in aggregate about the types and amounts of services being authorized and provided to TPMs.
- Beginning with the December 2022 Biannual Report, amend the report to ensure the inclusion of historical data.
- In concert with the SME, work on further development of key performance measures to be reported on a quarterly basis on the Department's website.
- Provide training and assistance, if requested, to SNFs to assure procedures are in place for the safe and timely transition of long-time residents of facilities that no longer screen at NF LoC to the community.
- Enhance the education of providers on timely critical incident reporting and hold habitual late-reporting providers accountable.
- Enhance the capacity to document and report steps in the remediation process for critical incidents that require remediation including correction actions.

Aging Services has a volume problem.
– Key Informant Interview

RESOURCES & BUDGETING

Over the course of 18 months, the State has been working to identify resources needed to meet all requirements of the Settlement Agreement. As the demand for Home and Community-Based Services (HCBS) grows, the SME believes that it will take additional staff and an increased budget to achieve these goals. The State has been creative within the constraints of the current General Fund budget and is maximizing use of other revenue sources, including those from Federal sources such as Money Follows the Person funding. These actions have enhanced the State's capacity to serve more Target Population Members. A pilot project that engages a service navigator to assist case managers in locating Qualified Service Providers has been developed in two locations. One position has been filled to begin this work. These individuals will assist case managers and TPMs in locating QSPs to provide community-based services. Two aging generalist positions have been created (one in Bismarck has been filled), each of which will also carry a part-time caseload for HCBS. A transition services specialist position has been created to better assist transition coordinators in assisting TPMs to return to the community more quickly. Noridian, the State's enrollment vendor, and the QSP Resource Hub at The Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences, are addressing QSP enrollment and assistance to more rapidly engage new providers to serve TPMs.

The State has indicated that it will propose that the 10 Long Term Services & Supports Options Counselor temporary positions become classified positions in the next biennial budget. It is anticipated that the Department of Health and Human Services (DHHS) will request, for

inclusion in the Executive Budget Request, additional case management staff. As of the writing of this report, State departments are engaged in internal budget request deliberations. The specifics of Executive agency budget requests will not be available until December 2022. The Legislature will convene in January 2023 for a legislative session that will last into the spring of 2023. An important aspect of the Legislature's work is to appropriate resources for the next biennium that will guide State services for FY 2023 – 2025. The highlights of both the Executive Budget Request and legislative appropriations, as they relate to the resources requested and recommended pertinent to compliance with this Settlement Agreement, will be the subject of future reports of the Subject Matter Expert.

QUALIFIED SERVICE PROVIDERS

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 that requirement. The number of people who want to be served through Home and Community-Based Services continues to increase, creating greater demand for QSPs. The State reports that the number of QSPs changes frequently. The June 2022 Biannual Report (pg. 7) from the State indicated that there are 961 individual QSPs and 139 agencies currently enrolled to provide HCBS for TPMs. The State continues to make improvements to processes in an effort to secure the services of more QSPs to serve Target Population Members more efficiently.

> It would be more efficient if the State would move to an audit process after providers have enrolled and leave the responsibility to us to maintain appropriate documentation, knowing we could be audited at any time. *– Key Informant Interview*

ENROLLMENT & TRAINING

The enrollment process as a service provider continues to be a barrier to increasing the number of QSPs. The forms required to enroll have not been sufficiently streamlined, creating continued difficulty – especially for individual providers – to begin offering services. In one key informant interview completed by the Subject Matter Expert, it was reported that seven (7) forms are required for each person for enrollment – whether they are an individual provider or work for an agency. Re-enrollment is still required by the State every two years.

It is reported that a transformation manager from the State has been assigned to support the process of streamlining enrollment. Some of the delay in completing this is attributed to the retirement and/or departure of key individuals within the Medicaid Division who were the experts in enrollment. These delays have created a sense of urgency in addressing these issues. In acknowledgement of the importance of meeting the enrollment challenges, the Agreement

Coordinator has taken more direct control of addressing the enrollment barriers. This includes more direct contract oversight of the Noridian contract (at the State's direction Noridian has increased their staff assigned to this project from four to six). The State is posting jobs internally with the hope of refilling these positions quickly. The original target date for completion of streamlining enrollment processes was April 1, 2022 (January 2022 ND Biannual Report pg. 62). The current target date is December 1, 2022 (June 2022 ND Biannual Report, pg. 71).

Noridian Healthcare Solutions has been contracted by the State to complete provider enrollment. They started services on April 1, 2022. Noridian has dedicated six (6) staff to enrollment for the State and are working to authorize providers who submit complete applications within two (2) weeks. The State has requested that Noridian prioritize the approval of agency QSPs. The State has also provided a priority list of individual QSPs that they would like Noridian to engage.

There had been some confusion at the start of the process between the State, Noridian, and the new QSP Resource Hub about who was responsible for which enrollment activities. The QSP Resource Hub was receiving frequent calls from providers when applications were denied requesting assistance. The Hub was not able to provide that assistance easily as they did not have access to determinations of why applications were being denied. Since that time, all enrollment activities are now completed by Noridian and they have created a process accessible to everyone to increase efficiency.

> I am thankful to get some funds to be able to work for my brother.
> – *Key Informant Interview*

Once a provider is enrolled, training must be completed and competency shown in 21 areas before the person is able to begin seeing clients. Other states have approached the training requirements differently, allowing training to be completed during a 90-day period after an individual is enrolled because of the high turnover rate of QSPs and allowing for a family member classification with a different enrollment process. In discussions with the SME, the State has indicated they might consider looking at this option for agency providers. The State has identified that there is a difference in training for family home care providers if services for the individual are state funded. In that instance, the State does not require proving competency in all areas. However, if the client is funded through Medicaid, the family provider must complete training and prove competency in all 21 areas. This requirement is based on assurances provided by the State to CMS and is part of the justification for the daily rate paid to family members for delivering these services. It also allows a family member to serve other non-related individuals if they desire.

Competency must be proven to a healthcare professional. This could be an RN, Occupational Therapist, Physical Therapist, or Physician. The State has an agreement with TrainND that any

potential QSP can utilize their services for comprehensive training and certification at a cost of $10 to the QSP, with the State paying the remaining costs. A provider working with TrainND is offered training on skills they have yet to master before proving competency. The agency is able to certify competency in addition to those listed above. Depending on the individual, it can be as little as a few hours or as long as a few weeks to achieve this goal. The Declaration of Competency that must be completed and submitted is SFN 750 (https://www.nd.gov/eforms/Doc/sfn00750.pdf).

RECRUITMENT & RETENTION

Efforts are being made to increase recruitment and retention of QSPs. The State has indicated that it would like to help create more opportunities for career advancement (a career ladder) for QSP work so individuals that want to do this work for a long time and exceptional providers can be incentivized to remain. Ideas that could be considered include a higher rate of pay for QSPs with certain years' experience, advanced degrees, certifications, etc.

To learn directly from QSPs about their work, the QSP Resource Hub conducted a survey of agency and individual QSPs. Highlights of data from the survey results follow.

Individual QSP Survey

- 42% of respondents work more than one job.
- 45% of respondents have been QSPs for three (3) years or less.
- Almost half of respondents are serving a family member.
- The top response regarding what would make it easier to become a QSP is streamlining the forms and application (enrollment) process.
- The top response for what would make it easier to remain as a QSP was "a higher rate for services provided."
- Suggestions for what skill training would help to improve or expand the ability to serve clients include training on specific type of diseases and medical conditions, learning how to best provide care, and client relationships.

Agency QSP Survey

- 78% of agencies responding employ 19 QSPs or less.
- 44% of agency respondents have been providing QSP services for 16 years or more.
- 57% of responding agencies provide continuing education for staff in areas such as Alzheimer's/dementia, Parkinson's, HIPAA, ethics, traumatic brain injury, and aging/disabilities.
- Respondents indicate that the reimbursement for training/tuition and an increased number of training/education opportunities would make it easier for growth opportunities for staff.
- The top three (3) responses to the question of what would make it easier for the agency to hire QSPs include a higher rate for service, increased competency training, and orientation to being a QSP.
- The top three (3) responses of what would make it easier for an agency to retain QSPs were a higher rate for service, more streamlined recertification process, and more competency training.

The QSP Resource Hub is working on the creation of an orientation packet to improve the onboarding of new providers. The Hub indicates a target completion date for the orientation packed of October 1, 2022. The Hub is actively responding to calls from providers and its website is live (NDQSPHub.org).

An additional opportunity has presented itself through Centers for Medicare and Medicaid Services (CMS) Money Follows the Person (MFP) grants. The State is considering the use of these funds to provide individualized training for QSPs while the TPM remains in the Skilled Nursing Facility, assisting in the successful transition of the individual to the community with necessary and specialized services in place.

The State is also planning to use *American Rescue Plan Act* funding to increase opportunities for behavioral health training. It is reported to the SME that TPMs have increasingly complex needs and that behavioral issues are a significant area of concern. A provider interviewee who was awarded one of the expansion grants is cross training QSPs to behavioral health and substance abuse. Outcome data is not yet available and the grant has just begun. The SME will share data available in the next report. The State has reported instances when QSPs have stopped working with a TPM due to behavioral issues of the individual and concern about staff safety. It has also been reported that TPMs, because of behavioral health issues, have quickly dismissed QSPs because of perceived conflicts between the TPM and the provider. These conflicts could relate to how care is being provided or issues such as a service recipient's racial biases and acceptance of staff.

In the June 2022 ND Biannual Report (pg. 71), the State offered the following data:

- Four (4) new agency QSPs were enrolled in the reporting period, two (2) of whom are enrolled to provide care in rural counties
- 116 individual QSPs enrolled during the reporting period; 52 individual QSPs signed up to serve in communities with a population of less than 15,000 people and 16 individual QSPs signed up to working in communities on a reservation, and
- One-hundred forty-one (141) individual QSPs and two (2) agency QSPs were closed during this reporting period.

The QSP survey indicates that 56% of QSPs have a close personal relationship or are related to the person they are serving. If that person dies or goes to a different level of care, the QSP often disenrolls as they were helping only one person. Additionally, if a QSP has not billed in the past year, the State drops them from the rolls to assure more current list of available providers. The agency providers closed during this reporting period was at their request.

The State completed a first round of incentive grants in January 2022 (June 2022 ND Biannual Report pg. 76) to help providers enhance their services. Grants were available for up to $30,000. Fourteen (14) providers were awarded grants. A second round of grants is planned for September 2022 using *American Rescue Plan Act* dollars. The State is increasing the maximum

grant award amount to $50,000. While other states such as Montana and South Dakota have allowed providers to access this funding up front, the State has indicated they are not able to do this because federal funding rules require expenditure prior to reimbursement.

Among the grant proposals received, applicants could add bonus points for agreeing to provide services in high demand, such as transition supports. Two of the grantees awarded funding agreed to develop "Community Transition Supports." Rates for this service will be reviewed during the upcoming 2023-2025 budget building process to assure they are attractive for providers to consider delivering these services. Information about the success of these efforts will be shared in the March 2023 report of the SME.

The State also offered funding for recruitment and retention bonuses to providers. To date, 39 agency QSPs have participated and $575,400 has been allocated. Twenty-one (21) providers have requested reimbursement totaling $370,527.50 (June 2022 ND Biannual Report, pg. 83.) The State would like to increase the number of QSPs who participate. There are seemingly two barriers to this: (1) the bonuses must be paid upfront by the agency and then reimbursed by the State, and (2) some providers do not appear to understand that this money does not have to be repaid. The State has hired an individual to assist with the management of this opportunity for individual QSPs as the tracking of such incentives requires considerable oversight. The State reports that 750 individual QSPs have been notified that they qualify and may apply for retention bonus funds.

The State began a rate study in April 2022 (with Optimus) to look at what services might need to be reimbursed differently. This may include specific services and it may include providing different rates for the days and times that services are provided (e.g. nights, weekends, and holidays.) Preliminary results from this study are expected in September 2022 to help inform the Aging Services budget request for the upcoming 2023-25 Biennial Legislative Session.

The State continues to use webinars regarding specific services to engage other agencies as potential community providers for the target population. In its June 2022 ND Biannual Report (pg. 75-76), the State reported an additional 12 webinars being offered between December 15, 2021 – June 14, 2022. The Department of Human Services created a communication plan (June 2022 ND Biannual Report, pg. 90) which was finalized in March 2022 in an effort to engage more individuals as potential services providers as well as to increase the awareness of HCBS for potential Target Population Members.

The workforce shortage is very big.
– Key Informant Interview

RECOMMENDATIONS FOR THE NEXT SIX (6) MONTHS

1. Complete development and implement a revised enrollment process to assist individuals and agencies in becoming service providers. Set a timeline for necessary improvements.
2. Engage provider agencies in training and support of QSPs.

3. Give due consideration to a CMS recognized self-directed program that allows the individual receiving services to train QSPs to their specific care needs. A strategy to look at provider models, including the Agency with Choice/Co-employer model, is included in the revised Implementation Plan for Year Three (3) of the Settlement Agreement. The June 2022 Biannual Report from the State includes an updated target completion date of December 1, 2022.
4. Consider different reimbursement models for providers that receive grants for enhancing services for TPMs so that more providers consider applying.

CASE MANAGEMENT

TRACKING CASELOADS

The case management function is critical to the capacity of North Dakota to ensure that Target Population Members can receive services in the Most Integrated Setting. Section VII.C. of the Settlement Agreement 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. The State has 66 HCBS case management positions. Case managers carry an average caseload of 54 and case management supervisors a part-time caseload of 13 (June 2022 ND Biannual Report, pg. 20.) To date, the State has been able to assign case managers to all TPMs as they enroll for HCBS services. However, as the State continues to see an increase in the number of referrals to HCBS (June 2022 ND Biannual Report Dashboard) it will be necessary to grow the size of the case management team to fully support TPMs. As well, beginning in June 2022 and in accordance with Section VII.B of the Settlement Agreement, the State is required to assign a case manager to every Target Population Member, including those in Skilled Nursing Facilities, further increasing the need.

The process of tracking clients from the date a referral has been 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 has been automated. The State reports (June 2022 Biannual Report pg. 14) that the length of time from referral to the assignment of a case manager is two (2) business days and that the average number of days from assignment to first contact by the case manager is two (2) business days (June 2022 ND Biannual Report, pg. 51). The State had set its standard at five (5) business days for first contact after referral. By automating these processes, the State should be able to better determine case management capacity and the need for additional resources.

The State is working to implement several initiatives to increase case management capacity. Two (2) pilot positions are available that utilize resources from other aging programs that would allow for aging generalist positions, aware of all programs, and able to support people in a variety of ways. One of those positions has been filled and recruitment continues for the second. These individuals will carry a half-time HCBS caseload in addition to other responsibilities. A second initiative being piloted is employing individuals (navigator) to assist the case manager to locate qualified service providers. This project has begun with the hiring of

one (1) service navigator. It is an administrative burden for case managers to make all the calls necessary to secure providers due to a lack of provider capacity. The State is actively recruiting for the remaining unfilled positions.

ADMINISTRATIVE BURDEN

The amount of documentation required is extensive to ensure that services planned for and received are individualized. A comprehensive functional assessment, a risk assessment, the Person Centered Plan, and ongoing case notes documenting progress are all required.

Case managers also track cases that are pending. Pending cases are active HCBS referrals that are still being addressed and do not yet have a formal outcome. More information may be needed on these cases or, for example, the Medicaid application has not been approved, financial records are not complete, or the individual may be working through the requirements of a trust. In the June 2022 Biannual Report Dashboard, the State reported that 752 cases are pending. This number is not unduplicated. If a TPM is waiting for six (6) months to be eligible, they are counted six (6) times in the current reporting dashboard. The State is aware of this issue and is working to assure that an unduplicated count of TPMs waiting to enroll in HCBS can be obtained for future reports.

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. 17 of the June 2022 ND Biannual Report.) There has been a 5.34% reduction in the amount of time spent on administrative tasks in the last six (6) months.

CM Workforce Data	**Reporting period**	**12.21 – 06.22**
Project	**Sum of Hours**	**% Of Hours**
HCBS Admin	12,927.30	24.28%
HCBS CM	40,306.93	75.72%
Grand Total	**53,234.23**	**100.00%**

The graph below represents the division of time by activity reported previously (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%**

COMPLEXITY OF NEEDS

The State has shared with USDOJ and the SME that the complexity of needs presented by Target Population Members continues to increase. Many of these needs are related to behavioral health issues. There is a need for more training for case managers and QSPs to understand how to better serve individuals with these needs. As was noted earlier, the State plans to address this need through funding opportunities within CMS and State funding available through the American Rescue Plan Act.

> Caseloads have come down for some, but cases are more complex. – *Key Informant Interview*

In addition to behavioral health, there are many individuals who would like to transition from the Skilled Nursing Facility (SNF) or remain in the community who require 24-hour care to do so. It is difficult to find QSPs who will serve these individuals due to the extent of their needs, and those that are willing are at capacity. "Find me a staff person and I'll serve that client," is a statement that has been shared with the State.

Section VII.F of the Settlement Agreement 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. As was noted in previous reports, the State made a significant step by transitioning all case managers from county employment to State employment and developing a robust training curriculum. The SME has recommended that North Dakota continue to look for ways to further specialize the role of the case manager. This could include having some case managers focus on individuals with complex medical situations and those involved with multiple/dual diagnoses.

Another way to offer further specialization would be to develop a tiered case management model, providing different levels of case management services to TPMs dependent on their

individual needs. Case management teams serving TPMs in Burleigh and Cass counties where the population is higher are considering different approaches to managing cases. Case managers who work in more rural areas of the State have indicated it would be more difficult to implement a tiered model because of the low volume of individuals being served.

TRAINING

There is a plethora of training requirements for case managers, particularly as the systems in place to serve TPMs have changed extensively in the past 18 months. The June 2022 ND Biannual Report (pg. 25) indicates that 100% of case managers have completed all required training. As part of the Implementation Plan revision drafted by the State for Year Three (3) of the Settlement Agreement (2023) the State has indicated that any new case managers hired will complete training within three (3) months of employment. In the opinion of the SME, this is a sufficient amount of time for a new staff member to complete all training. Training of case managers is an ongoing process as new forms and tools in the electronic record are completed.

> The cultural sensitivity training provided by Dr. Warne is very good. I hope that training continues to be provided… It takes a lot to learn about things like generational poverty or the extent of generational addiction and drug use.
> – *Key Informant Interview*

Of significant note, the Person Centered Plan and the Transition Plan were redrafted to meet the requirements of the Settlement Agreement. This required extensive training regarding documentation once the new plans were finalized. There is variance among case managers about how elements of the PCP are documented. Some of that is attributed simply to professional style. However, the SME has delivered additional technical assistance in this area to case managers, transition coordinators, and options counselors through training sessions to aid in more comprehensive and consistent documentation and provided a written "tip sheet" for ongoing reference.

SERVING THE NATIVE AMERICAN COMMUNITY

As of this report, the case manager that had been hired by the Standing Rock Sioux Tribe has left that position. While she had not started serving individuals in the case management role, she had been actively working to build resources in the community. MFP tribal initiative funds remain available to the tribe to fill this position.

Difficulty in getting services to the community is attributable to both the remoteness of many locations and the poverty experienced by many individuals. Key informants have indicated that elders do not wish to leave their communities, but also that it is difficult to find services because they are so remote, often hours away on gravel roads. It was shared that going to a SNF felt like the days when children were sent to residential schools away from their families. Other individuals who may wish to transition back to the community are unable to do so

because of the lack of proper housing to meet their needs. Many homes have multigenerational families living in them and many of the homes are in poor condition. In a key informant interview, it was shared that another difficulty in getting services to Native American TPMs is simply the inability to reach them. Even if someone can help them call the ADRL, there may not be a number where the individual can receive a return call. The State has in place a series of actions to help alleviate this barrier, including sending letters and case managers doing drop in visits to see if they can locate the individual.

Cultural competency is a key component of serving Native American Communities. The State continues to offer training in cultural awareness and sensitivity. Pre- and post-training surveys are done by the trainer – Dr. Warne. (Pg, 12-13, June 2022 ND Biannual Report).

Historical Trauma and ACES with Dr. Warne					
Question 1: I can identify at least three ways cultural education can positively impacts how I interact with my clients.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	11%	83%	5%	1%	0%
Post	25%	75%	0%	0%	0%
Question 2: I am knowledgeable of the impact historical trauma has on American Indian health equity.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	10%	51%	33%	5%	0%
Post	18%	67%	14%	2%	0%
Question 3: I know where to find resources to help address my own cultural biases					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	10%	50%	31%	9%	0%
Post	26%	65%	8%	1%	0%
Question 4: I am confident working across cultures.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	2%	17%	30%	44%	6%
Post	19%	72%	8%	1%	0%
Question 5: I am conscious of my biases and how they impact my professional practice.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	9%	52%	28%	11%	1%
Post	29%	68%	3%	0%	0%
Question 6: I can identify at least three ways cultural education can positively impact how I interact with my clients.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	10%	43%	37%	10%	0%

Post	20%	72%	8%	0%	0%
Question 7: The training was informative and relevant to my practice.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Post	55%	41%	4%	0%	0%

The Culture of Poverty with Dr. Warne					
Question 1: I am knowledgeable about the impact poverty has on American Indian health disparities.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	8.6%	46.7%	35.2%	8.6%	1%
Post	38.5%	59.4%	1%	0%	1%
Question 2: I can describe how the culture of poverty relates to American Indian health disparities.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	5.7%	39%	37.1%	18.1%	0%
Post	33.3%	62.5%	3.1%	0%	1%
Question 3: I can specify at least two unique factors contributing to poverty levels in tribal communities within North Dakota.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	4.8%	29.5%	43.8%	21.9%	0%
Post	36.5%	60.4%	2.1%	0%	1%
Question 4: I know where to find resources to help address my own cultural biases.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	7.6%	49.5%	33.3%	9.5%	0%
Post	28.1%	67.7%	3.1%	1%	0%
Question 5. I can identify at least three ways cultural education can positively impact how I interact with clients.					
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Pre	4.8%	37.1%	47.6%	10.5%	0%
Post	32.3%	61.5%	5.2%	1%	0%

RECOMMENDATIONS FOR THE NEXT SIX (6) MONTHS

1. Increase the amount of case management hours available to TPMs.
2. Address/Streamline the administrative burden of tracking those "pending" HCBS enrollment.
3. Develop a fully justified budget proposal for case management positions for inclusion in the Executive Budget Request.

LONG TERM SERVICES AND SUPPORTS (LTSS) OPTIONS COUNSELING

In previous reports, LTSS Options Counseling was referred to as informed choice and the staff referenced as community outreach workers. Following input from a state work group, the SME, and USDOJ, processes have been reviewed and revised to better engage Target Population Members in decision-making about their needs, available services, and where they wish to live.

There are 10 options counselors working for the State. Options counselors have a variety of roles with TPMs. During this reporting period, a shift has been made to assign options counselors to every SNF. The first role is for options counselors to do a visit with every new TPM admitted to a Skilled Nursing Facility. During those visits/interviews the counselor provides information about available Home and Community-Based Services, seeks to build a relationship with the TPM, learns 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. Documentation of that interview is captured on State Form Number (SFN) 892. In its June 2022 ND Biannual Report (pg. 23) the State reported that 588 interviews had been completed in the reporting period.

If the TPM indicates a desire/plan to return to the community, the person centered planning process begins with the transition team. The State has revised this process and now assigns a transition coordinator, housing facilitator, and case manager to work as a team with the individual. Initial contact is made by the transition coordinator within five (5) days and the first meeting is scheduled to be held within 14 days. If the individual is not ready to decide about where they want to live, the options counselor leaves additional information for them and lets the person know they are frequently in the facility and available to talk at any time. If requested by an individual, a follow-up is scheduled.

The second role of the options counselor is to conduct group in-reach visits in their assigned facilities. This allows the counselor to share information with anyone in the facility, including those who have been living in the SNF for many years to share with them options that are available in the community of which they may have been unaware. The State, in its June 2022 Biannual Report (pg. 35) indicates that another round of group in-reach presentations (the first were done in 2021) has just begun and data will be included in the December 2022 report. Approximately two (2) weeks after group in-reach visits, the options counselor schedules a follow-up meeting in the facility to provide additional information requested by any TPM and answer any questions that might have arisen.

The third role of options counselors is to visit with every TPM in the nursing home, no matter how long their length of stay. These visits began in June and are scheduled to coincide with the month the last Nursing Facility Level of Care (NF LoC) was completed with the individual. For example, if the last NF LoC was completed in April of a previous year, the options counselor will visit with that individual in April. These visits differ from those with people newly admitted. In

addition to providing information about available services in the community, the counselor is working with the individual to complete an initial PCP and Risk Assessment. This provides the opportunity for the person centered planning process and assures that the State is aware of the needs of each TPM. Many individuals in skilled nursing facilities have been there for a number of years and this is the first opportunity for them to experience the person centered planning process. The State has reported to the SME that in the first three months of engaging in this activity, 99 visits have been held and PCPs completed. In those visits, options counselors have found several individuals who, despite their length of stay, desire to return to the community. When that occurs, they are referred through the transition process.

Beginning in December 2022 every person in a skilled nursing facility is required to have an annual NF LoC screening. These, like the visits of the options counselors, will be scheduled in the month of their last NF LoC screening. While the screen is completed by the facility, a third-party contractor from the state – Maximus – does an independent review of each screen. There is concern that some individuals living in facilities will no longer screen at the appropriate level of care to stay. The State is in discussions of how best to assist these individuals to transition appropriately and with enough time to assure that they will be safe and successful in a new living situation. Medicaid rules require that if a person does not screen, they should move from a facility within 30 days. For those individuals that do screen appropriately, there remains a choice of where they want to live – in the facility or in the community. For those that choose to remain in the facility, the options counselor will continue to work with the TPM as the assigned case manager, completing and updating person centered planning as required.

As designed, the LTSS options counselors are also available to meet with TPMs who have been admitted to the hospital as part of discharge planning to assure they have the necessary information about living options beyond skilled nursing in a facility. At this time, those discharges can and do happen so rapidly that there is not sufficient notice for the options counselor to meet with the individual. The Executive Director of the ND Department of Health and Human Services (DHHS) has had meetings with hospital staff about discharge planning and community options. These efforts include consideration of building HCBS options into discharge planning discussions and to encourage earlier notification of pending discharges so that case managers can get involved and perhaps divert more individuals from nursing facility stays.

A change was made in the case management reporting system (Therap) in May 2022 that allows every person working with a TPM to have access to the complete record for that individual. This helps to assure that the options counselor is aware of any other entity already working with the TPM so that overlapping visits do not occur and the team's work can be better coordinated. If an individual in a SNF is already working with a transition coordinator, for example, the options counselor would not seek to visit that person as part of their responsibility to see every TPM. It has been noted that, on occasion, this duplication has occurred because information from the transition coordinator has not been entered into the system in a timely manner.

RECOMMENDATIONS FOR THE NEXT SIX (6) MONTHS.

1. Increase communication and planning between hospitals and the State regarding discharge notification.
2. Assure that transition coordinators are completing documentation in the record as required.

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. Person centered planning is about far more than assuring that appropriate documentation is completed. It is about assisting the TPM to determine what needs they have, how they can be addressed, and assisting on an ongoing basis so that the State can assure that each person's needs are successfully addressed.

The State did not meet the requirement in Year One (1) of the Settlement Agreement (Section VIII.I.3.a) to complete persons centered planning (resulting in a comprehensive PCP that meets all the requirements listed) with 290 TPMs. At least half of those were to be completed (145) with TPMs living in skilled nursing facilities and at least another half with those at risk of going to a SNF. Year Two (2) requirements (2022) are the same, bringing the requirement for person centered planning to be completed with 580 Target Population Members by December 2022. The Settlement Agreement (Section VIII.I.) requires the State to meet the benchmark, largely meet the benchmark, or demonstrate significant efforts and progress toward reaching the actual benchmark and important reasons why the benchmark was not completely met. During the first year of the Settlement Agreement, in efforts to meet the benchmark requirements, the State and the USDOJ worked on multiple iterations of person-centered planning documents that were refined to meet all SA provisions while continuing to adhere to core person-centered planning principles. This process contributed to unanticipated delays in meeting the prescribed requirements of plans completed, but also indicates the significant efforts undertaken.

The State has worked with the SME and USDOJ to improve the ability to meet this requirement. In the spring of 2022, the State completed revisions of all the tools used to gather the necessary information during person centered planning to meet the requirements of the Settlement Agreement. SFN 1265 is the new Person Centered Plan, SFN 1266 the new Transition Plan, and SFN 1267 the Risk Assessment. In addition, the State continues to use the Life Domain Vision Tool when working with the individual.

Case managers began working with the new documents in April, originally on paper, but uploaded to the case management information system. On August 1, 2022, those forms became live in the system so that all information is now recorded electronically. By moving into the information system, the State will be able to report on any field to provide additional data on what services are being utilized, what is being authorized and not used, where there might

be provider gaps, and aggregate numbers on progress being made by TPMs. A focus on who might have higher needs and may not be receiving enough services is critical. Section XV of the Settlement Agreement relates to data collection and reporting. A number of customized reports have been created and additional reports have been requested from the vendor's case management information system project manager to report on this information and will be referenced in that section of this document.

The SME and USDOJ have reviewed a number of plans to determine clinical sufficiency even as progress continues on furthering the efficiency and clarity of what is being presented. Clinical sufficiency indicates that the plans meet all the requirements of the Settlement Agreement in Section VIII.C. and that a licensed clinician is able to understand the scope of services and how they are being delivered. Although some evolution in the development of PCPs is recommended, in the opinion of the SME, a small sample of recent PCPs submitted by the State (August 2022) meet this standard.

The State has shared that as of June 14, 2022, they have completed 346 PCPs for at risk TPMs and that number increased by a further 90 by August 29, 2022, that meet requirements of the Settlement Agreement. Additionally, they report that 67 transition plans for TPMs who have returned to the community have been completed as of August 30, 2022, and 192 PCPs have been completed for TPMs residing in Skilled Nursing Facilities. By this count, the State is on pace to meet or largely meet the benchmarks noted in the Settlement Agreement (Section VIII.I.3.a.) by December 14, 2022. Those benchmarks are 290 person centered planning visits with comprehensive PCPs in year one (ending December 2021) and an additional 290 in year two (ending December 2022), with half of each being for TPMs at risk of entering a nursing facility and half already residing in a facility.

As has been noted, the SME has worked with State staff on documentation strategies for these new tools. Significant progress has been made. However, goals and action steps need to be more clearly defined in the PCP and how those goals and action steps translate from a transition plan, if there is one, to assure continuity of care.

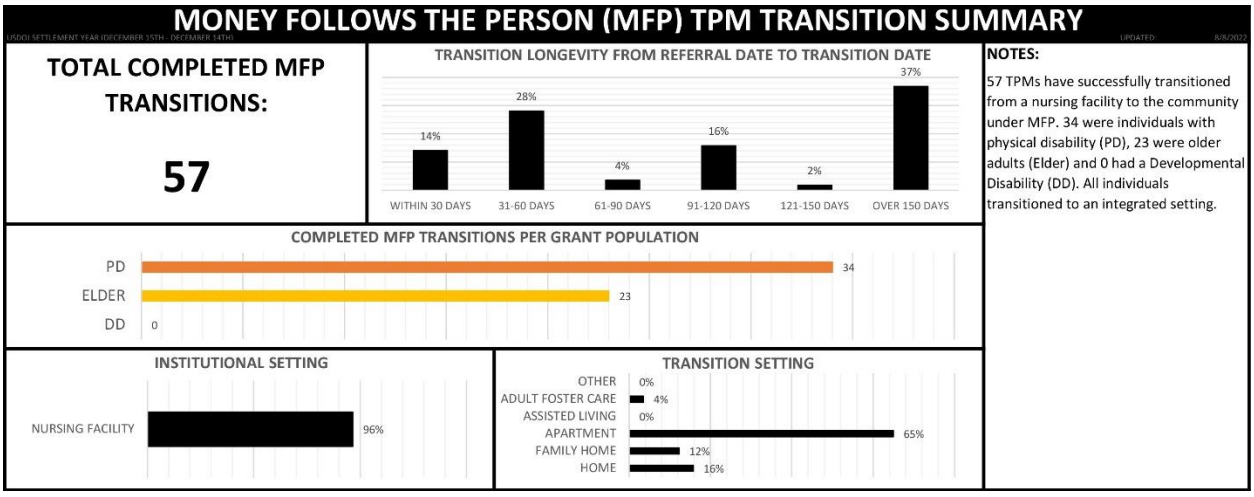
RECOMMENDATIONS FOR THE NEXT SIX (6) MONTHS

1. Assure, by audit, that all case managers, transition coordinators, and options counselors are completing and reporting information through the data system.
2. Work to move goals from the functional assessments more clearly into the PCP and further streamline documentation requirements.

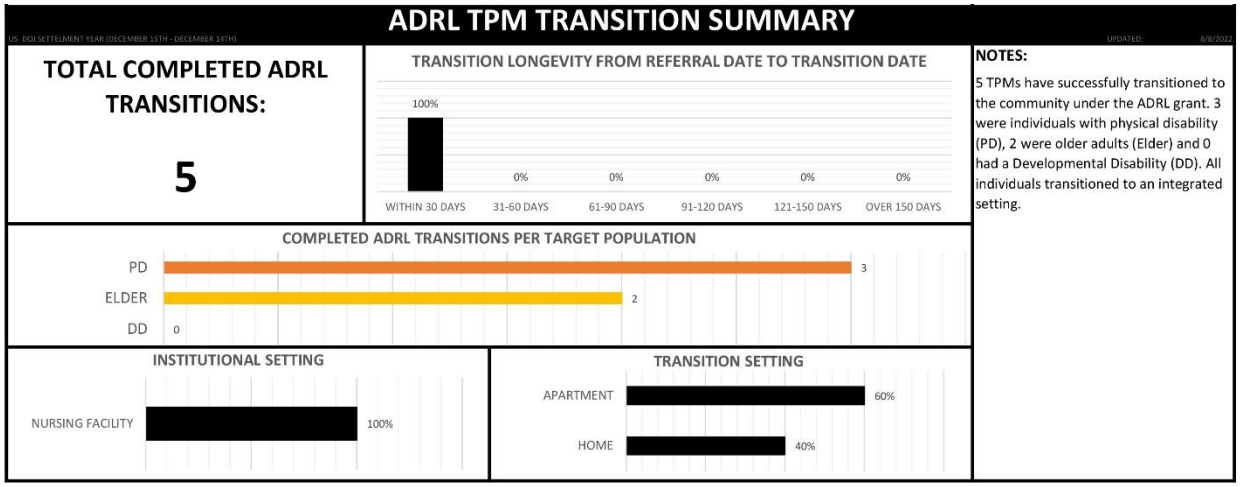
TRANSITIONS

Section XI.A. of the Settlement Agreement outlines requirements for the State to assist Target Population Members in transitioning home from the Skilled Nursing Facility, consistent with the TPMs ability to make an informed decision 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 facilities to community-based services.

The State reported that 88 individuals had transitioned in 2021 (2021 Aging Services USDOJ Dashboard). In this reporting period, the State has indicated a further 57 transitions have occurred, exceeding the benchmark for the two-year period. (June 2022 ND Biannual Report Dashboard).



An additional five (5) transitions have occurred through the ADRL grant.



Section XI.B. of the Settlement Agreement requires that within 18 months of the effective date and thereafter, transitions will occur no later than 120 days after the member chooses to pursue transition. As shown in the table above, the State works to assist people to transition as quickly as possible. At this point, 65% of those seeking to transition to the community have done so within 120 days. Given that over one-third of transitions are taking in excess of 120 days in this reporting period and the valid reasons for lengthier transitions listed below, it is recommended that the Parties and the SME discuss this subject further including how to better address barriers to more efficient transitions and what constitutes substantial compliance with this requirement.

The State has indicated that there can be numerous reasons why a transition does not occur within the required timeframe, including such things as housing modifications not being completed, a new medical condition occurring, or an insufficient number of Qualified Service Providers to meet the member's needs. The State and Centers for Independent Living (CILs) where transition coordinators work have started meeting monthly to staff everyone requesting transition who is approaching 90 days from the date of request. These meetings are designed to identify the barriers preventing transition and identify responsible parties to assist in eliminating such barriers. As well, it allows the State to track the reasons transitions are delayed looking for trends that may need to be adjusted on a more global scale. The staff involved have indicated that the meetings are helpful for the engagement of transitions teams working to address obstacles to community living for North Dakotans in all regions of the State. Information on how this data is being tracked has been shared with the SME.

The State continues to note that there remain times when adequate notice of discharge from a skilled nursing facility does not happen. Efforts are being made by the State and SNF staff to identify those individuals who are not likely to screen at a Nursing Facility Level of Care now, prior to the next screening, to assure that appropriate services and supports can be put in place in the community so that the discharge can be successful.

The number of referrals to the Money Follows the Person (MFP) Program continues to increase as more TPMs identify a desire to return to the community. In the current reporting period (December 14, 2021 – June 14, 2022), 115 individuals have been referred to the program (June 2022 ND Biannual Report Dashboard.) 17 have been referred through the ADRL grant.

To meet the increasing requests, the State has increased staff following approval from CMS to increases in the MFP budget for 2022. There are now 11 full-time transition coordinators, one (1) half-time coordinator, and funding available to hire three (3) more. These staff are located in the CILs. The State has also hired an assistant MFP director to supplement the work of the MFP office. A new MFP director was hired following the retirement of the previous director on June 30, 2022. To further assist the CIL transition coordinators the State has hired a licensed clinician as a "transition services specialist." This individual will also monitor the contracts with the CILs to assure that services are being delivered and documented as specified.

The Centers for Medicare and Medicaid Services has announced a new funding opportunity for MFP programs. Some additional services will now be paid at 100%. An option being considered by the State to use some of this funding will be to allow for individualized training with the TPM and QSP prior to transition, while the TPM is still in the nursing facility. The State, through the use of other federal funds, is also considering how to secure more behavioral support for TPMs.

RECOMMENDATIONS FOR THE NEXT SIX (6) MONTHS

1. Continue training with transition coordinators on documentation requirements and how to further develop and document goals and action steps.
2. Assure that all transition documentation is entered into the data system within the required timeframes.
3. 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.

There seems to be greater flexibility in the service system to deliver the services that people need in the community. – *Key Informant Interview*

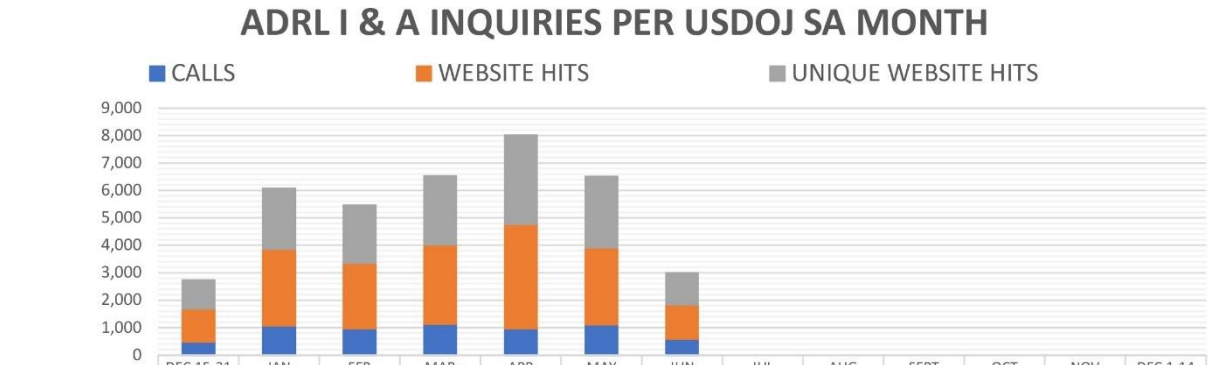
4. For the purpose of continuity in achieving goals, consider moving transition activites such as action steps that have not been completed to the community-based PCP.
5. Track the number of TPMs who return to nursing facilities (re-institutionalizations) within 90 days and the reasons for those returns.

DIVERSIONS

In keeping with Section XI of the Settlement Agreement, the State is 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 State reported it diverted 268 TPMs in the first year of the Settlement Agreement (January 2022 ND Biannual Report, pg. 46), already surpassing the benchmark for the first two (2) years combined. In the current reporting period, the State indicates that 140 additional at risk TPMs were diverted from SNFs. Diversion happens when an individual who screens at a NF LoC and is on Medicaid or at risk of becoming Medicaid eligible receives the necessary HCBS to prevent their institutional placement. (June 2022 ND Biannual Report, pg. 58) The State has far exceeded the interim benchmarks noted in the Settlement Agreement.

The number of individuals seeking more information regarding Home and Community-Based Services through the ADRL referral line continues to grow. In its June 2022 ND Biannual Report Dashboard, the State reported 27,741 inquiries to the ADRL line through a combination of telephone calls and website hits during this reporting period. This also included 540 web referrals for HCBS. Stakeholders indicated that written materials require consistent updating to ensure that the most current information is available. The State has shared an additional fact

sheet that has been added to materials about available Aging Services programs, including HCBS. This new fact sheet explains in greater detail the benefits of community living. Additionally, as part of its communication and outreach plan, the State did a second social media campaign in the spring. The increase in inquiries, following that campaign in April 2022, is reflected in the chart below.

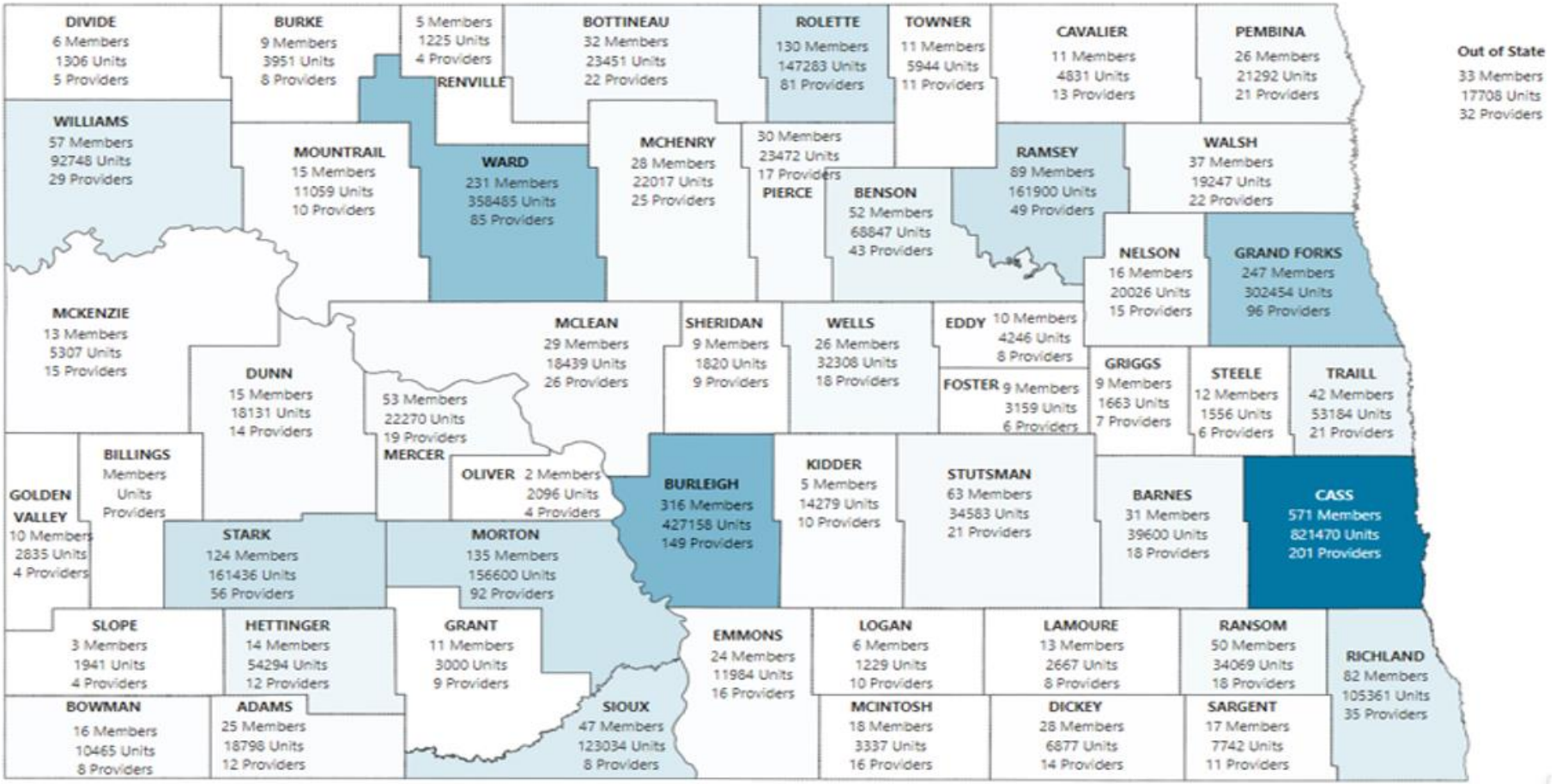


	DEC 15-31	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC 1-14
UNIQUE WEBSITE HITS	1,049	2,229	2,113	2,504	3,248	2,599	1,160						
WEBSITE HITS	1,201	2,779	2,384	2,889	3,810	2,803	1,248						
CALLS	483	1,073	963	1,129	958	1,108	585						

The SME and the US Department of Justice have had the opportunity to review "diversion PCPs" submitted by the State. As noted earlier in this report, training has been offered by the SME to supplement that of the State to further improve documentation. The SME believes that the PCPs that have been shared are clinically sufficient for those at risk TPMs who remain in the community and meet the requirements of the Settlement Agreement. Further refinement and simplification in the planning and documentation processes continues. Progress in this regard will be the subject of future SME progress reports.

The State is facing challenges in providing aggregate numbers related to how much service is being provided to TPMs and what kinds of services in efforts to assure that a sufficient amount of care is available to keep people at home. The State has provided the number of TPMs being served in each county and the number of units of service that have been delivered (June 2022 ND Biannual Report, Appendix D.) A map of this initial information is included on the following page. However, a total number of units of service does not provide a sufficient level of information. It is of note that the measure of a unit of service is different depending on the service. For example, services such as chore or homemaker are billed in 15-minute increments. Environmental modifications are paid per the cost of the job and specialized equipment is billed per item, and both are reflected as single units of service. Further, services such as family personal care are reimbursed at a daily rate. With the completion of the electronic data reporting system and in combination with claims data, the State should be able to further differentiate this information going forward. Doing so will allow the State to determine if there are significant disparities in services delivered in different regions of the state to address potential QSP needs in a more comprehensive manner.

North Dakota HCBS Services (2021)



An important area of focus for the State pertains to addressing the changing needs of TPMs at home or in the community. As TPMs needs in the community change, such that additional services (or an increased amount of the same services) are needed, there are simple processes in place to efficiently address these needs, such as:

- Direct contact from the TPM or family member, or others that interact with the TPM on a regular basis,
- Referrals from QSPs to case managers when additional needs are noted, and
- Updates during quarterly case management visits and PCP updates.

In reports offered by the State, it appears that the number of persons being served in HCBS remains fairly "flat" (June 2022 ND Biannual Report Dashboard.) However, on parsing the data further, almost as many cases are closed as are opened. The State has explained that a good portion of the population being served have unstable medical conditions or are at end of life, changing their ability to utilize HCBS either through a need for institutional care or death.

RECOMMENDATIONS FOR THE NEXT SIX (6) MONTHS

1. Review claims data for individuals who may be likely TPMs but went home from hospital stays without enrolling in HCBS.
2. Enhance the ability to report aggregate numbers of different services being authorized and provided to TPMs, tracking hours delivered by service category.
3. Ensure processes are in place to efficiently address the increased service needs for those at home and in the community.

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 the State established two work groups to guide and create policies related to housing and learn from other states what solutions have worked for them to increase the ability to offer housing support.

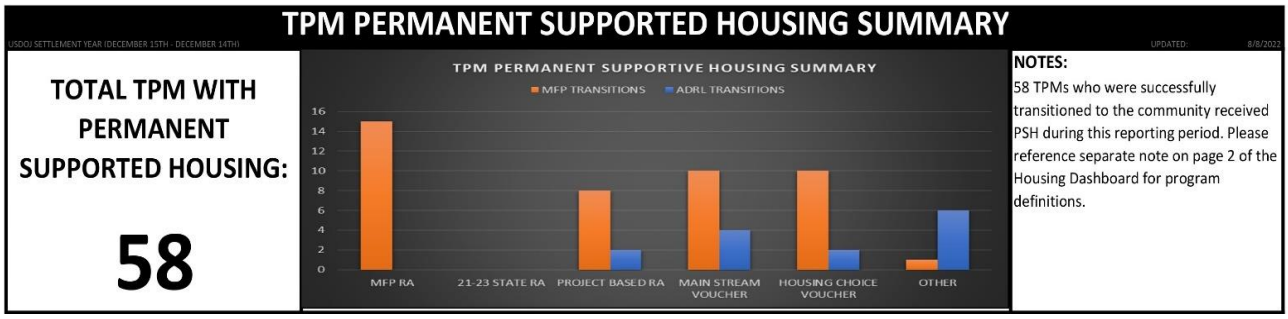
Many of the strategies outlined in Section XII of the State's Implementation Plan focused on how the State would identify new ways of collaborating, to assure connections were made between housing and home and community-based service resources. The strategies identified opportunities to gather data that could provide meaningful insight into housing barriers (XII.C.7, XII.D.1); build awareness amongst professionals who work in either housing or HCBS about the "other side of the HCBS" equation (XII.B.1, XII.C.2, XII.D.4, XII.D.7, XII.E.1, XII.F.3); and build real capacity in the State's service and

> We need to be more intentional about conversations across all programs/people in the housing arena.
> – *Key Informant Interview*

support infrastructure to make transitions and diversions much more possible than they were before (XII.B.2, XII.C.1, XII.C.4, XII.D.2, XII.F.2). This foundational work is essential to the success for North Dakota in improving housing options for TPMs and others in the community requiring assistance. It requires developing new partnerships and collaborations that did not previously exist to create sustainable systems. It has taken longer than anticipated and the State has extended the date for completing many of the strategies included in the Implementation Plan to complete this essential work.

PERMANENT SUPPORTED HOUSING (PSH)

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 PSH to at least 20 TPMs in the first year of the Agreement and at least an additional 30 in the second year of the Agreement, the current reporting period being the first half of Year two (2). North Dakota exceeded the requirement in the first year, providing PSH to 28 TPMs (January 2021 ND Biannual Report Dashboard). In the June 2022 ND Biannual Report Dashboard the State reports providing permanent supported housing to an additional 58 individuals, again exceeding the requirements of the Settlement Agreement.



Permanent Supported Housing is funded through a variety of programs including Housing Choice, rental assistance, and the Opening Doors Landlord Risk Mitigation Fund. The MFP 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 as necessary.

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 the community. These gaps contribute to delays in individuals transitioning to the community in a timelier manner. The State successfully made changes to the HCBS Medicaid Waiver renewal to include the following items as part of the waiver to improve access to housing modifications:

1. Added assistive technology professionals to the list of those that can supply a written recommendation for environmental modification and specialized equipment,
2. Allowing installation costs to be added to the coverage of specialized equipment,

3. Increased the threshold of spending on specialized equipment from $250 to $500 without prior approval,
4. Expanded 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. Allowing 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).

In the June 2022 ND Biannual Report Dashboard, the State reported completing 13 home modifications for TPMs during the reporting period.

HOUSING REFERRALS AND ASSESSMENT

Of the 155 Target Population Members referred for assistance with addressing a housing barrier, the State noted that 132 had a complete Housing Service Referral Assessment and were contacted in an average six (6) calendar days (June 2022 ND Biannual Report (pg. 64). Further training was provided to housing facilitators on the assessment and ensuring it is entered into the electronic record.

Every person desiring to transition to the community is assigned a housing facilitator along with a case manager and transition coordinator to address any potential housing barriers that would prevent the person from returning to the community. There are times when no barrier is noted. In that case, the assigned housing facilitator does not continue with the transition team. The State (June 2022 ND Biannual Report Dashboard) reported that 25 individuals received housing facilitation support and 13 received home modifications during the reporting period. If a housing barrier is identified for a TPM at risk of being able to remain in the community, the case manager has access to housing facilitators to address these issues.

HOUSING NEEDS ASSESSMENT & HOUSING LOCATOR

Two (2) items that have been delayed as the State works to build the foundations of partnership and collaboration among the many players in the housing environment are the completion of a statewide housing needs assessment and a new housing locator tool. The needs assessment currently relies on five (5)-year-old census data. The State plans to partner with state universities to reimagine the entire assessment and build a new model for the future. The target date for how and when this comes together across multiple departments is now 2024.

The housing locator and inventory tool will be built on the existing locator tool in the MFP program, with the intent to make it more robust and more easily accessible. The intent will be to focus more heavily on data elements that are of most interest to housing facilitators and TPMs who self-direct their care to address barriers. The inventory needs to identify properties by funding source and location, accessibility, unit size, and contact information for the property management company, if one exists. Completion of this new locator tool/inventory is now slated for completion in May 2024.

ADDITIONAL HOUSING CHALLENGES

The State has encountered other housing challenges as it works to assist more TPMs to return to community settings. The first of these was noted earlier as it relates to Native American communities – the lack of appropriate housing to meet the needs of the individual and the remote setting. At times a TPM has expressed a desire to return to community living but only in a specific community. There is not always housing available in those communities, preventing the State from assisting that person until appropriate housing can be secured. Finally, there are TPMs who have a housing or criminal history that prevents a landlord from wanting to rent to them. Absent a family home to move to, those individuals spend longer trying to secure appropriate housing to return to the community.

RECOMMENDATIONS FOR THE NEXT SIX (6) MONTHS

1. Assure that all housing facilitators are completing the Housing Service Referral Assessment in a timely fashion.
2. Assure that information is available regarding modifications to the State's HCBS Medicaid Waiver allowing handyman and assistive technology services and how they are to be accessed.
3. Provide no less than quarterly updates to the SME on the status of the Housing Needs Assessment & Housing Locator

DATA COLLECTION & REPORTING

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.

With the completion of the new electronic record, the State will now be able to capture and report on all data related to Section XV.A.1, XV.A.2, and XVI.D., and the required information in Section XVI.B of the Settlement Agreement pertaining to quality assurance, risk management, and reporting of critical incidents, including the timeliness of those reports.

A variety of custom reports, in addition to those already available within the data collection system, have been requested by North Dakota to meet these needs. The State has also requested that the system vendor provide training to Aging Services staff to learn about the business intelligence tools that are currently available in the case management system.

Case Management System Reports - Requested
Aging Funding Source Report
Aging Provider Transition Date
Aging Admitted Individuals that have Case Management Pre-auths
Bulk data for Person Centered Plan and Risk Management
Aging Caregiver Assessment
Aging Financial Assessment
Aging Risk Assessment and Safety Plan
Aging Informed Choice LTSS Option Counseling
Aging NCIAD Quality Survey
Aging Participant Assessment
Aging Complaints Assessment
Aging Initial Service Plan
Program Enrollments 1265-1267
MFP Transition Plan
MFP Housing
Med Waiver Funding Source from Care Plan
Med Waiver Quality Assurance
Med Waiver Recipients with Narratives and Four Quarterly Contacts
Med Waiver Goals and Assurance from Care Plan
Med Waiver Level of Care with NF Level of Care
Med State Plan B & C Level of Care
Authorized Service Report for Care Plans
Cost by Funding Source from Care Plan
Basic Provider Information
Rural Differential closures SFN 212
Count of Care Plans with TPM
Count of HCBS Cases by Funding Source
HCBS Case Management Referral

The State is planning to streamline the current dashboard report that accompanies (as Appendix A) the June 2022 ND Biannual Report and make information associated with the following key performance measures available on the Department's website.

- Number of unduplicated TPMs served in state or federally funded HCBS
- Number of TPMs being served in a SNF
- Total number of ADRL contacts
- Total number of individuals referred to HCBS case management
- Total number of TPMs who transitioned to an integrated setting
- 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

- Average annual individual cost comparison by HCBS funding source and average annual cost of SNF care
- Number of new QSPs enrolled
- Number of PCPs created with TPMs in the community and with TPMs in a SNF

RECOMMENDATIONS FOR THE NEXT SIX (6) MONTHS

1. Assure the case management system vendor provides necessary training to the State about the business intelligence tools available in the data system.
2. Report in aggregate about the types and amounts of services being authorized and provided to TPMs.
3. Beginning with the December 2022 Biannual Report, amend the report to ensure the inclusion of historical data.
4. In concert with the SME, work on further development of key performance measures to be reported on a quarterly basis on the Department's website.

QUALITY ASSURANCE AND RISK MANAGEMENT

Section XVI of the Settlement Agreement requires that the State ensure that services meet the Target Population Members' identified needs, including maintaining their health and safety.

CRITICAL INCIDENT REPORTING

The State has been reporting critical incidents through its electronic data system since July 2021 and has provided training to qualified service providers about how to complete Critical Incident Reports (CIRs). Three (3) events were held – virtually – and a total of 103 attended learning sessions. A training module for online learning was also developed and is available on the Aging Services website (https://www.cnd.nd.gov/STLPCatalog/325/PUBLICCOURSESPOSTEDONWEBSITES/CriticalIncidents/story.html).

The State distinguishes between "formal" remediation plans and/or other remediation plans or actionable and documentable steps in the remediation process. Formal remediation is a term the State uses when there is a QSP complaint or allegations of abuse/neglect/exploitation connected with the critical incident report. The State reports that 12 of the incidents required a formal remediation plan (often involving multiple entities) and that 100% of those plans were completed. Critical incidents that require reporting are:

- Deaths;
- Life threatening illness 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.

The State indicates that each incident that is reported is reviewed by a Nurse Administrator within the Aging Services Department. A remediation plan is formed based upon the type of incident that is reported. Some incidents that are received involve remediation and follow-up by the HCBS case manager that is assigned to the case. Remediation may include increasing services, request for a staffing with the State Program Administrators to discuss next steps, updating and reviewing the individual's risk assessment, along with a home visit to ensure health/welfare/safety. The HCBS case manager is always notified of the incident and involved in the remediation.

If the incident involves a qualified service provider, the complaint protocol is followed to determine next steps. The Nurse Administrator works with the QSP Complaint Program Administrator who then conducts an investigation and formulates a remediation plan if one is indicated. If the incident involves allegations of abuse/neglect/exploitation, the Nurse Administrator ensures that a Vulnerable Adult and Protective Services (VAPS) report is filed by the HCBS case manager and/or QSP. A VAPS investigator is assigned to the case and further follow up and remediation will be determined by the investigator. The HCBS Case Manager continues to be active and involved alongside the VAPS investigator in remediation efforts for these situations.

Moving forward the State and the SME have initiated discussions, that will continue into the fall of 2022, about elements of reporting/documenting that could be enhanced to more accurately depict the steps the State is taking relative to critical incidents that require remediation including corrective actions. This will coincide with enhancements in the capacity to report critical incidents through the new case management system. Updates on this issue will be included in future SME reports.

In the June 2022 ND Biannual Report (pg. 13) the State has indicated that 180 CIRs were completed for Target Population Members and that 114 (63%) were reported on time. This is a significant increase in timely reporting from the previous report from the State and the SME where only 14% of incidents had been reported in a timely fashion. Although this is a significant increase in timely reporting, more work is necessary to educate providers on the importance of timely reporting and to hold providers accountable for this requirement. The Biannual Report includes a monthly breakdown of those reports received in a timely manner.

As part of the initial two (2) years of the settlement, the SME has been reviewing all reports that have been submitted. This mandatory reporting ends in December 2022. The State is required to share these reports with the SME within seven (7) days of receiving them and has achieved that benchmark 99% of the time.

RISK ASSESSMENTS & SAFETY PLANS

The State developed a new reporting tool – SFN 1267 – to assess risk for every TPM, those transitioning and those at risk. The plan is updated as often as necessary. The risk assessment covers the areas of:

- Health, Medical and Nutritional;
- Physical Health;
- Cognitive, Behavioral Health and Lifestyle;
- Medications;
- Services/Economic Assistance;
- Home environment; and
- Abuse, Neglect, and Exploitation Concerns.

Following reviews of all these risks, a safety plan is developed for the Target Population Member and what can be done to prevent or mitigate the risk. This Risk Assessment/Health and Safety Plan is included as part of the PCP. Additional information in the assessment includes contact information for those persons involved with the TPM who provide legal, personal, or medical services. The assessment and plan is completed as part of the PCP process for every individual. In the review by the SME of Risk Assessments/Health and Safety Plans, the information included appears to be adequate.

NURSING FACILITY LEVEL OF CARE (NF LoC) SCREENING

As noted previously, the State is required to assure completion of an annual NF LoC screen for every TPM beginning in December 2022. A schedule has been established that the NF LoC screen will be completed during the month when the most recent screen was completed, no matter how long ago that was. Screens that are completed in the SNF are done by facility staff, those in the community are done by licensed case managers. All screens are sent to a third-party vendor – Maximus – for review and a final determination. The NF LoC screening tool is completed by staff following discussions with the individual about needs and options available and how and where to have those needs met. A selection of location is then noted on the administrative tool for review and final determination.

A concern has been stated about the number of TPMs in skilled nursing facilities who 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.

COMPLAINTS

Complaints are now monitored through an electronic data system. The State has reported in the June 2022 ND Biannual Report Appendix C that 35 complaints involving TPMs were received during the current reporting period. Those complaints and the remediation taken to resolve them are shown below.

Complaint Type	# by Type	Pending Outcome	Unsubstantiated	Substantiated	Remediation provided
Absenteeism	5	2	1	2	Provided technical assistance
Abuse/Neglect/Exploitation	8	3	0	5	2 terminated QSP, 1 provided technical assistance-employee was terminated, 2 AFC corrective action issued
Breach of Confidentiality	1	0	0	1	Provided technical assistance
Poor Case Management	0	0	0	0	
Criminal History/Activity	1	0	0	1	Provided technical assistance-staffed with HCBS/SURS team, not a direct bearing offence
Theft	4	3	0	1	Provided technical assistance-employee terminated
QSP Disrespectful	3	2	1		
Inappropriate Billing	3	2	1		
Poor Care	9	4	2	3	2 terminated, 1 provided technical assistance-employee terminated
QSP Damage Recipient Property	0				
QSP under the influence of Drugs/Alcohol	1	0	0	1	Technical assistance-employee was terminated
self-Neglect	0	0	0	0	
Other	0	0	0	0	
Total complaints associated with TPM	35	16	5	14	Complaint Report June 14, 2022

The State indicates that they will have improved data in the next reporting period. QSP complaints were recently added to the electronic case management system. Currently, there is also an interface being developed to allow for VAPS reports to be entered into the system. This will allow for more succinct data reporting and coordination of remediation efforts by the State.

RECOMMENDATIONS FOR THE NEXT SIX (6) MONTHS

1. Provide training and assistance, if requested, to SNFs to assure procedures are in place for the safe and timely transition of long-time residents of facilities that no longer screen at NF LoC to the community.
2. Enhance the education of providers on timely critical incident reporting and hold habitual late-reporting providers accountable.

3. Enhance the capacity to document and report steps in the remediation process for critical incidents that require remediation including correction actions.

CONCLUSION

The State has demonstrated progress in meeting the requirements of the Settlement Agreement. The State works collaboratively with the SME and USDOJ and readily integrates feedback offered. Outreach regarding the availability of Home and Community-Based Services is strong and more individuals are expressing interest in these services. The State has completed the development of the electronic case management system. Internal processes continue to be streamlined. The State has achieved almost as many transitions from Skilled Nursing Facilities in this reporting period than they did in all of 2021 and are successfully diverting people from the need to seek institutional care. Challenges in the areas of a qualified workforce and housing needs are being addressed.

The next six (6) months is a critical time for the State as it continues to implement strategies designed to meet all the requirements of the Settlement Agreement. This includes focused attention on the workforce. The enrollment process is in need of streamlining so that individuals that want to become qualified service providers are able to do so. There needs to be further focus on retaining providers working with only one individual when those circumstances change to help grow the workforce. In the next few months, the State must demonstrate that it has made progress on the Year One and Year Two benchmarks of providing person centered planning to at least 580 TPMs. The State is in the process of analyzing and maximizing current resources and providing thoroughly justified proposals, to the Executive and the Legislature, for any additional resources that may be needed to meet the requirements of the Settlement Agreement.