CBIZ Optumas
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Subject: Deliverable 4.1.3. Processes and Capacity for Addressing Emergency Needs and Decompensation for HCBS Recipients in North Dakota

Current Situation

North Dakota's Aging Division currently has a settlement agreement with the federal Department of Justice (DOJ). DOJ has assigned a subject matter expert (SME) to monitor and report on the state's progress to meet requirements of the agreement. One question DOJ continues to ask North Dakota Aging Services is what they plan to do if a caregiver suddenly quits or otherwise becomes unable to care for the HCBS recipient for whom they provide care. The State reports that some QSPs have stopped providing care due to co-occurring behavioral issues with TPMs as well. This deliverable discusses current procedures in case that should occur as well as recommendations for closing gaps in access to emergency care needs for HCBS recipients. It is additionally important that the state have a plan in place should an HCBS recipient suddenly experience a change in acuity of needs. This report explores how North Dakota can put policies and procedures in place to protect HCBS recipients in either circumstance: sudden changes in client need or loss of caregiver staff.

North Dakota policy currently includes the following related to people seeking or already enrolled in HCBS when they call with emergency needs.

1. What to do if a consumer calls and may be a danger to themselves or others.
2. Instructions on how to help a consumer if they cannot follow up on the referral themselves.
3. When advocacy on behalf of the consumer may be appropriate and how to provide that.[1]

It is also understood that the state is developing behavioral health cross-training for QSPs on behavioral health and substance abuse.

The most recent report from the subject matter expert (SME) assigned by the DOJ described a new form (SFN 1267) that is a risk assessment to be completed with all individuals who receive services. A safety plan is developed to prevent or mitigate a risk. Implementing this with all individuals receiving services regardless of waiver may prevent emergency issues, allowing pre-planning to keep them safe and sustain services, should an emergency arise. If these risk assessment plans are updated regularly, contingency plans should be in place for all members.

North Dakota's foster care system uses three rate tiers for reimbursing placement of a youth in a Qualified Residential Treatment Program (QRTP). In an emergency, an increased rate is also available for the provision of respite in a QRTP. QRTPs are reimbursed using a base level rate and with an applied add-on as determined by weighted results using the Child and Adolescent Needs and Strengths (CANS)

[1] Accessed at DHS Blue (nd.gov)

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assessment. Weighted results are used to determine a "difficulty of care rate" and tier of reimbursement for a youth. The emergency payment rate is allowable for a maximum of thirty days when an individual is initially placed and denied the QRTP Level of Care (LOC).[2]

Table 1: North Dakota QRTP Tiers illustrates the tiered QRTP payments in the state.

TABLE 1: NORTH DAKOTA QRTP TIERS

Payment Rate	Daily Rate
Base Level	$297.74
Level 2	$483.04 (add-on rate is $185.30 per day)
Level 3	$702.50 (add-on rate is $404.76 per day)
Emergency Rate: Maximum of thirty days when a child is initially placed and denied the QRTP LOC	$372.74 (add-on rate is $75)

This may be a good approach for the Aging Division to use in setting rates to incentivize providers to care for individuals who receive services with co-occurring behavioral diagnoses.

Identified Gaps

Currently, North Dakota has gaps in policies and procedures to effectively respond to emergency service needs. For example, no specific policies were found in our research regarding what an individual who receives services should do if they are on the waiver and their caregiver doesn't show up or suddenly resigns. Similarly, no specific policies were found regarding how it might be handled should individuals receiving HCBS services experience a sudden increase in acuity. Individuals receiving services are directed to call their case manager in case of any emergencies. Initially, a contingency plan is developed using form SFN 1267, which should identify what should be done in emergency circumstances and who to contact.

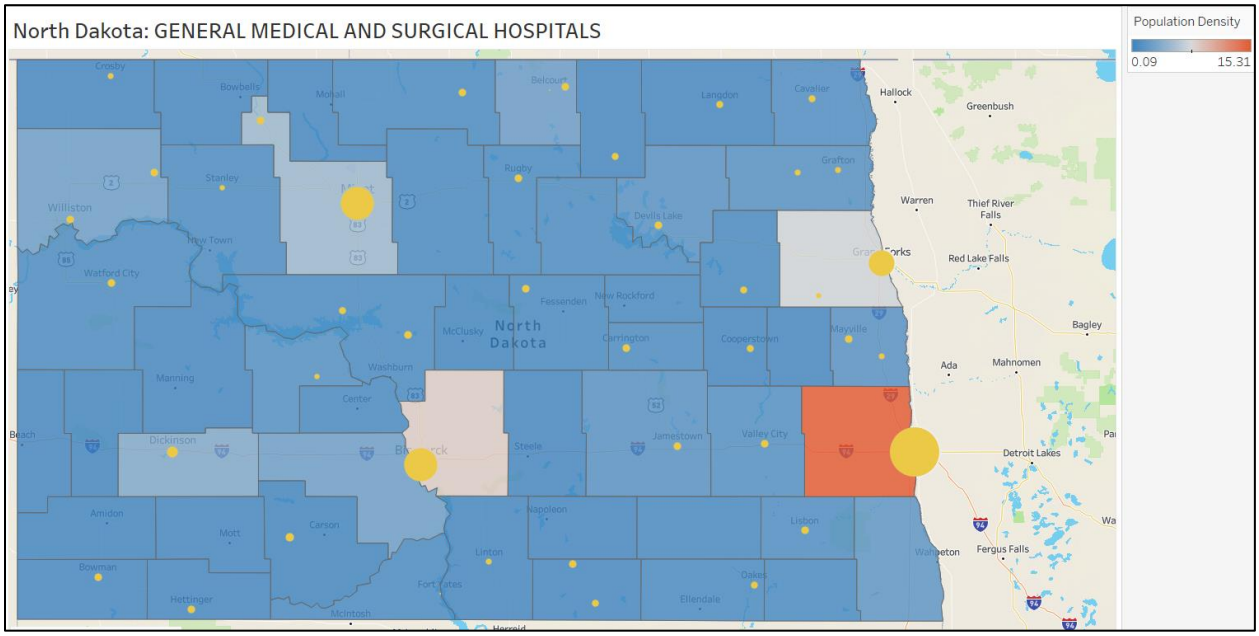
Recommendations

Given the national recommendations for assuring access to HCBS for individuals eligible for services across the state, recommendations in this section may help North Dakota close the gap for people in rural and other areas of the state who may decompensate rapidly while enrolled in HCBS services.

According to CMS, their hospitals without walls initiative, which incentivizes health care provided in the home, grew to 92 hospitals in 24 states.[3] The program grew out of the COVID-19 pandemic but has increased the number of people receiving health care at home. Optimas highlights this as a concept to inform development of an approach to assist with serving people in HCBS. The map below highlights where general medical and surgical hospitals are around the state. Larger yellow circles represent the largest hospital capacity.

[2] North Dakota Department of Human Services. "Foster Care Maintenance Payments Policies and Procedures 623-05, Residential Facility Rates 623-05-20-40, ML #3637" (2021). https://www.nd.gov/dhs/policymanuals/62305/62305.htm#623_05_20_40.htm%3FTocPath%3DFoster%2520Care%2520Maintenance%2520Payments%2520Policies%2520and%2520Procedures%2520623-05%7CPayment%2520Factors%2520623-05-20%7C____10.

[3] Accessed at More than 90 Hospitals Join CMS Hospital at Home Waiver Program | Healthcare Innovation (hcinnovationgroup.com)



Optumas recommends the Aging Division explore partnerships with health care facilities and providers across the state. Partnerships with health facilities could result in arrangements with emergency providers who receive special rates for emergency interventions. Reaching out to assisted living facilities along with other health care facilities to create a network of emergency providers across the state seems most advantageous. The department would benefit from having arrangements with multiple providers to replace QSPs in private homes or to accept individuals receiving services in a facility if an emergency arises. Additionally, a rural differential could be added when and where appropriate. Optumas recommends reaching out to hospitals, nursing facilities, assisted living facilities, and home health care agencies to discuss what it might take for those agencies to provide emergency care for consumers who lost their caregiver suddenly or who are rapidly decompensating. Those contracts could outline the regions covered, cost, and procedure in an emergency circumstance, regardless of whether the individual receiving services remains in their own home or goes to a licensed facility providing the most integrated setting.

CMS encourages states to plan for emergency circumstances. This applies to HCBS as well. CMS highlights that assisting individuals with preparing for emergency situations is key to system-wide contingency planning. In the context of state planning, helping HCBS consumers develop contingency plans should include training and information for individuals receiving services as well as those who support them, including case managers. They should all be armed with tools to ensure their contingency plans are current and realistic in case of an emergency. [4]

A payment structure, such as the one used by the state youth foster care system, may be a good model to explore for addressing emergency situations. The Aging Division could build on existing policies and

[4] APPENDIX K: Emergency Preparedness and Response Instructions (medicaid.gov) Accessed 2022, September 27.

procedures to implement an emergency rate should a consumer suddenly be without a caregiver. Optumas recommends developing contracts with health and personal care providers to develop a statewide list of emergency providers. Once a system for addressing emergency needs is developed, Optumas recommends adding training on it to the case manager's new training developed by the Department. It will be imperative to ensure those who self-direct services have contingency plans as well. Optumas also makes the following recommendations:

- Build on work with 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 to integrate recruitment and training of emergency providers into their process. This may be especially appealing to someone who was providing QSP level care for a family member but is no longer doing so. Enrolling them as an emergency provider may appeal to them since they will be helping in an emergency for a limited time rather than working full time.
- Work with TrainND to include training for emergency providers, individual or agency.
- Offer the option to become an emergency provider during QSP recruitment and provide training to include preparedness in case the provider is called to care for someone suddenly.
- Consider whether there is any way some upfront costs for becoming an emergency provider can be paid as an incentive.

State Policy Recommendations

Optumas recommends developing state policies and procedures to address the gaps identified in this report. Policies and procedures should include, but are not limited to:

- Specific steps for individuals receiving services to take if a caregiver does not show up or quits
    - Include who to contact where and how to make a request for a new caregiver
- Caregiver steps to take if an individual receiving services suddenly increases need for assistance
    - Consider providing a specific phone number for a staff person or team who can assist with this urgent need
- Emergency Provider qualifications and contract requirements
    - Invite providers to enroll as an emergency provider
    - Develop a list of emergency providers
- Establish reimbursement rates to incentivize emergency providers

Conclusion

Ensuring continuity of care for individuals receiving services is vastly important, preventing harm and possibly even death. While North Dakota currently has gaps in policies and procedures to address potential continuity of care issues, the state is working hard to implement changes to improve circumstances for this vulnerable population. Developing policies and procedures as recommended by Optumas will prevent risk of an individual who receives services suddenly being without a caregiver.

Next Steps

Optumas recommends North Dakota develop policies and procedures discussed within this deliverable. As the state develops those policies and procedures, Optumas recommends the state review for any edits or changes in approach to comply with the DOJ Settlement Agreement.