

Department of Human Services

OAD Narratives by Strategic Initiative

Behavioral Health & Addiction

AC609: Expand access to community-based behavioral health supports through 1915i Medicaid State Plan amendment

This OAR would expand access to community-based recovery supports for Medicaid enrollees age 18 and older who have a behavioral health condition and/or brain injury and currently are experiencing one or more of the following needs-based criteria: housing instability, intensive service utilization such as frequent emergency room (ER) visits, and/or criminal justice involvement.

For persons who qualify, services proposed under this 1915i Medicaid State Plan amendment include supports for housing, employment, education, transitions out of homelessness or institutional living, and peer support. Housing supports include tenancy support services to help individuals access and maintain stable housing in the community; employment supports include individualized services to assist individuals to obtain and keep competitive employment at or above the minimum wage. Educational supports assist persons who want to continue their education or formal training with a goal of achieving skills necessary to obtain employment. Transition supports include coverage for goods and services specified in an individual's person-centered plan to address barriers to recovery and to support community integration and may include: security deposits, furniture and transportation. Peer supports include services delivered by trained and certified individuals who have experience as recipients of behavioral health services and share personal, practical experience, knowledge and first-hand insight to benefit service users. Funding these community-based services and supports through Medicaid has the advantage of leveraging existing payor infrastructure while securing over 50% federal match for services.

To implement this solution, the state will submit the 1915i state plan amendment to the Centers for Medicare and Medicaid Services (CMS) and expects to spend about 12 months developing the state plan, securing the stakeholder input, and working with CMS to gain approval. Implementation is expected at the start of State Fiscal Year 2021. Accompanying this implementation, DHS also expects that increased costs for community-based services will be partially offset by decreases in the costs of treatment and other health-care expenditures such as emergency department utilization and inpatient psychiatric treatment.

AC607: Enable access to peer support by certifying peer support specialists

The rapid growth of peer support nationally in recent years is due to the increasing evidence supporting its effectiveness. Supporting and expanding peer support is an effective way for the state to improve the current behavioral health system by expanding access to behavioral health supports in rural areas of the state and at vital places like emergency departments, as part of crisis teams, local public health units and homelessness services.

During the first nine months of 2018, over 100 individuals participated in free peer support specialist trainings hosted by the Behavioral Health Division (BHD). For peer support to be a reimbursable service through Medicaid or other third-party parties, a minimum standard must be established. Without peer support certification, access to this service will be lacking in the state.

This OAR supports recommendation 7.6 in the North Dakota Behavioral Health System Study to continue establishing training/credentialing program for peer services and recommendation 7.8 to support a robust peer workforce through training, professional development and competitive

wages and to support the development of a program for the certification of peer support specialists.

AC610: Expand crisis services capacity across regions to meet statutory requirements

Individuals experiencing a behavioral health crisis who need emergency behavioral health intervention currently have inconsistent access to crisis response services in the state. The response from afterhours crisis lines for behavioral health triage differs from region to region, and the response from human service center staff, if needed, is inconsistent. Some people have access to a thorough triage and crisis assessment process and risk reduction while others do not and often must go the local emergency room, which is costlier, or they may call 911 and engage with first responders (law enforcement/ambulance providers) who are not trained behavioral health professionals. This can result in higher costs and unnecessary admissions to local hospitals. It can at times lead to an admission to the North Dakota State Hospital if acute psychiatric beds are unavailable locally.

In addition, special populations such as older adults, child and adolescents and people with intellectual disabilities may require modified crisis intervention approaches. Crisis treatment approaches for these special populations have not been appropriately vetted or consistently used.

North Dakotans would greatly benefit from a standardized crisis response and emergency behavioral health service delivery system across all eight human service center regions; only three human service centers currently have regional intervention service (RIS) teams with dedicated clinical staff to respond to behavioral health crises. This OAR will provide resources to eliminate regional gaps in access, improve the quality of crisis response services statewide; it could also enable more people in crisis to avoid unnecessary and costly ER visits and hospitalizations.

The state's rural nature makes it harder for citizens to access crisis behavioral health services locally in many areas. As of March 2018, Field Service leadership staff has been receiving technical assistance through the 2018 National Governor's Association Learning Lab examining proven methods to build capacity, which would reduce the cost of care for high need, high cost populations with behavioral health needs. Through collaboration with other states, an assessment of the delivery of services and current resources was completed in each region. Specific services evaluated were related to call center capability, daytime and after hour crisis response, and crisis residential unit capacity to provide crisis stabilization and withdrawal management (social detox).

This OAR would provide:

* One centralized call center across the state by expanding current services provided in one region to all regions statewide. This would allow for the standardization of the phone triage process, which would improve consistency and quality statewide. This standardized, phone-based approach has resolved up to 70% of crisis issues in other states.

* Behavioral health FTE across the state to expand crisis response services to 24 hours/day, 7 days per week. An analysis of current staffing resource and staffing patterns needed for a responsive, 24/7 system of care to meet the needs of North Dakotans would increase staffing across Williston, Minot, Devils Lake, Grand Forks, Bismarck, and Dickinson. The credentials of these FTE would be a combination of master's degree, advanced licensed and bachelor's degree, licensed social worker staff.

* Enhancement of crisis stabilization and withdrawal management beds and services in the Dickinson and Minot regions and fund FTE in those regions to enhance the staffing patterns due to the increased acuity of the clients served for crisis stabilization and withdrawal management. This request also includes enhancement of crisis residential contracts in Williston, Devils Lake, Grand Forks, Fargo, Jamestown and Bismarck regions. This OAR would add one direct care associate FTE per shift and supports changing the primary treatment focus of the regional crisis units to individuals needing crisis stabilization and withdrawal management, which will significantly increase the acuity level of the individuals served. There will be a greater need for close monitoring and occasionally one-on-one or line-of-sight staffing. Additionally, there will be an increased need for transporting individuals in need of medical attention or screening for continued stay under withdrawal management at the facilities. On-site supportive services will include crisis monitoring, substance withdrawal monitoring, medication monitoring, crisis psychotherapy and crisis groups. A long-term treatment plan will be created to help individuals reintegrate back into the community after the crisis issue has been resolved.

AC616: Sustain Behavioral Health Prevention & Early Intervention in Schools

Enacted in House Bill 1040, the Department of Human Services was to establish a children's prevention and early intervention behavioral health services pilot project in the school system of the department's choice. This OAR will continue supporting the school system selected during the 2017-2019 biennium as well as expand to a second department-selected school.

This OAR supports recommendations 2 and 5 from the HSRI behavioral health system study.

AC617: Sustain Human Services Research Institute Behavioral Health Study Implementation Support

In April of 2018, the North Dakota Behavioral Health System Study was published – identifying 13 recommendations to improve the system of behavioral health care for North Dakotans. Implementation of these recommendations is a priority of the Governor's Office, legislators, and the Department of Human Services. The Human Services Research Institute – the author of the study – is beginning the early stages of supporting implementation of the recommendations, with a focus on the first and last recommendations. It is vital the work of implementing these recommendations continue, and to be most effective, coordination should live outside the department.

This OAR supports the widespread implementation of all 13 recommendations in the North Dakota Behavioral Health System Study.

AC606: Expand access to Substance Use Disorder (SUD) Voucher services and supports

Senate Bill 2048 initiated the Substance Use Disorder (SUD) Voucher program in the 2015-2017 biennium. The SUD Voucher program was established to address barriers to treatment and increase individuals access to services for substance use disorders. During the 2017 legislative session, this voucher program also became the state's payor for methadone for the treatment of opioid use disorder through specialized opioid treatment programs. The budget for the 2017-2019 biennium is approximately \$4.7 million.

Based on current projections, there will be a shortfall in the budget to continue serving individuals currently benefitting from voucher-funded services. Due to the nature of the services being reimbursed (treatment, medication, etc.), discontinuation of services would be detrimental to clients.

The Behavioral Health Division did not receive administrative support to implement this program. From July 1, 2017 through August 2018, the division served over 1,400 individuals through the SUD Voucher program. On average, the division receives over 90 applications and processes over 250 prior authorizations per month.

This OAR supports recommendation 12.4 in the North Dakota Behavioral Health System Study to sustain/expand voucher funding and other flexible funds for recovery supports. Because FTE were not provided to support the design, implementation and maintenance of this program, other required efforts have not been implemented.

AC611: Restore funding for behavioral health-related FTE positions at the regional human service centers

Seven positions in the regional human service centers were reduced to meet the department's 5% FTE reduction. These positions provide direct behavioral health services and had been vacant due to difficult in hiring for them. Restoring them will enable more North Dakotans to access needed mental health and/or substance abuse services.

The positions include one direct care associate in Williston, four licensed addiction counselors (one each) in Bismarck, Fargo, Grand Forks and Minot; and one mental illness case managers in Bismarck and Grand Forks.

AC615: Restore funding for Parents Lead prevention program

House Bill 1302 allocated \$360,000 of general fund in the 2013-2015 biennium for the Parents Lead evidence-based prevention program. This funding was adjusted to \$260,000 as part of the DHS allotment savings plan and then further adjusted to \$100,000 for the 2017-2019 biennium.

Parents Lead provides parents and caregivers with tools and resources to support them in creating a safe environment for their children that promotes behavioral health and well-being. Parents Lead includes a website full of resources for parents, communities and professionals and disseminates these resources through social media, statewide marketing efforts and community prevention efforts.

A goal of the North Dakota Behavioral Health System is to ensure access to a full range of high quality services. Prevention is a key component of the continuum of services, creating an environment that promotes health and well-being and prevents problems before they occur. Effective prevention is rooted directly in science, and it makes economic sense, saving as much as \$64 for every \$1 invested.

Nearly one in three (29.1%) of North Dakota high school students currently drink alcohol, and one in six (15.5%) use marijuana. And, 13.5% of North Dakota high school students report having attempted suicide one or more times in the past year.

Healthy bonding and attachment between parent and child is one of the biggest factors preventing behavioral health-related issues like drinking, drug use, depression and anxiety. Youth continually report that their parents are the biggest influence in their decision whether to drink alcohol or engage in risky behaviors. This means that whether a child is two or 20, the guidance and support provided by their parents are essential to their health and safety.

This OAR supports recommendation 2.2 in the North Dakota Behavioral Health System Study to expand existing substance use prevention efforts and restore funding for the Parents Lead program to broaden the reach.

AC612: Enable LaGrave residents to access on-site mental health technician support

This OAR will provide funding to LaGrave on First, a permanent supportive housing facility for people in the Grand Forks region who have experienced chronic homelessness due to behavioral health disorders. The 42 one-bedroom units offer safe, decent and affordable housing and onsite support services without prerequisites and other housing barriers. A scheduled, certified mental health technician staff will provide year-round 24/7 front door coverage, including all holidays. The 24-hour front door service provides the necessary support and monitoring to create and maintain a safe and supportive environment for residents. This service will include guest and service provider check in, monitoring of residency rules and the video camera-based security system. The mental health technician will also provide periodic support and motivation to residents, regular feedback to clinical outreach staff regarding resident activities, and medication monitoring as required. This program is based on the “housing first” approach to address homelessness. People with behavioral health needs and other disabilities first need a safe place to live before they can pursue other goals related to health, well-being and quality of life.

AC613: Sustain transition assistance initiated through Money Follows the Person (MFP)

This OAR would provide funds to assist homeless individuals transitioning from the State Hospital who need help with initial rent and utility deposits and household needs. Without this help, individuals would not be able to transition from the State Hospital to community living and outpatient services resulting in higher costs and lower quality of life. The average daily rate at the State Hospital is \$745. Over the last two years, the MFP grant has served 101 individuals and the need continues. Transitioning people with disabilities from institutional to community living complies with the federal Olmstead Decision about serving people with disabilities in the least restrictive, appropriate setting. However, Federal MFP grant funding is ending and will be gone in July 2020.

AC608: Expand access to community-based behavioral health supports through Medicaid-funded Peer Support

This OAR would fund North Dakota Medicaid coverage for peer support for Medicaid-eligible individuals with substance use disorders (SUD), serious mental illness (SMI) and/or traumatic brain injury (TBI).

These diagnoses are common and often serious, but treatable, and many people can effectively manage their condition with the proper supports. People who are in recovery from substance use disorders, serious mental illness or brain injury have a unique capacity to help their peers, based on a shared affiliation and an understanding of the other person’s experience. Peer support promotes personal growth, wellness and recovery, research has shown that it facilitates recovery and can reduce health care costs.

If a 1915i Medicaid State Plan amendment OAR is funded in addition to Medicaid state plan peer support services, the budgetary allocation for peer support services would decrease and no FTE will be needed.

AC602: Expand access to the Free Through Recovery program

Enacted in Senate Bill 2015, Free Through Recovery is a community-based behavioral health program designed to increase access to recovery support services by individuals involved with the criminal justice system who have significant behavioral health concerns. This model has shown promise in serving this population. These vital services are also needed by individuals with significant behavioral health concerns who are not involved in the criminal justice system.

The North Dakota Behavioral Health System Study 2018 reported that stakeholders noted that North Dakota's current behavioral health system is "primarily crisis oriented and pays inadequate attention to rehabilitative and community-based services."

Expanding access to the Free Through Recovery program beyond the criminal justice system population is projected to cost approximately \$6 million in operating funds for service delivery. The program uses an outcome-based payment model. The six FTEs will be distributed like the current program, with one FTE overseeing the statewide program and the other five FTEs located in different regions across the state. Regional administration of the program is vital due to the need to continue developing workforce and securing providers to deliver services. In addition, as an outcome-based payment program, these positions are instrumental in monitoring progress, vetting outcomes and processing wellness-based payments.

This OAR supports recommendation 4.1 in the North Dakota Behavioral Health System Study to ensure access to needed recovery support services – providing funds to support the implementation of a Free through Recovery program outside of the criminal justice system.

AC604: Fund the behavioral health Recovery Home Grant program

Recovery Housing refers to safe, healthy and substance-free living environments that support individuals in recovery from addiction. While recovery housing varies widely in structure, all are centered on peer support and a connection to services that promote long-term recovery. Recovery housing benefits individuals in recovery by reinforcing a substance-free lifestyle and providing direct connections to other peers in recovery and recovery services and supports.

Many residents live in recovery housing during and/or after outpatient addiction treatment. Length of stay is self-determined and can last for several months to years. Residents often share resources, give experiential advice about how to access health care and social services, find employment, budget and manage finances, handle legal problems and build life skills. Many recovery homes are organized under the leadership of house manager and require residents to participate in a recovery program.

Recovery housing is a part of the larger continuum of housing, recovery support and treatment options available to individuals in recovery from addiction and helps them avoid addiction setbacks and move toward employment and healthy and fulfilling lives. Recovery housing often operates outside the traditional addiction treatment and supportive housing systems. Sometimes this is by choice, but it's also because the public sector has not broadly included this model in policies and resources. Because of this, and without codified recovery housing standards or protections, there have been inconsistencies in the quality of recovery housing, including substandard housing, insurance schemes and exploitative operators.

North Dakota has significant gaps in access to recovery housing. In many regions of the state, there are not recovery homes. In the regions where recovery homes are present, they are not currently meeting the need and often do not provide service to those most in need. For example, many programs in the state do not serve individuals on physician-prescribed medications for their substance use disorder or their mental illness. The lack of recovery housing has also had an impact on the state's capacity to provide residential treatment services to individuals needing high level services like withdrawal management. These much vital beds (resources) are often not available when needed because individuals needing recovery home services are utilizing a higher level of care.

The National Council for Behavioral Health recommends that states support efforts to: adopt a common definition of recovery housing and establish a recovery housing certification program based on national standards; incentivize recovery housing operators to adhere to nationally-

recognized quality standards; and expand investment in and technical assistance for recovery housing. Currently, there are at least 10 states that have enacted legislation to improve the quality of recovery housing, and other states have introduced legislation or regulation in 2018 (Arizona, California, Maryland, Maine and New Jersey).

This OAR supports recommendation 4.5 in the North Dakota Behavioral Health System Study to address housing needs alongside behavioral health needs – funding to assist in the development of these recovery housing opportunities.

AD204: Transfer North Dakota State Hospital services to a new, 80-bed complex and enable DOCR transfer

The Department of Human Services and the Department of Corrections (DOCR) are collaborating to allow for improvements in both efficiency and quality in the services provided to clients. This OAR would allow the DOCR to expand their footprint in Jamestown to include several buildings that were previously used by the North Dakota State Hospital (NDSH), allowing DOCR the opportunity to consolidate services from another campus to the Jamestown campus. To facilitate this move, NDSH would need to build a new hospital facility on land already owned by the state, adjacent to the existing campus. The new facility will be an 80-bed psychiatric hospital and include an attached facility that will allow South Central Human Service Center to relocate from its current leased space to the new hospital campus in Jamestown. Efficiencies in resources and facility improvements will be realized by co-locating the center with hospital.

AC603: Create consistency and quality in mental health technician certification

In North Dakota, individuals that bill Medicaid for skills integration services must be certified as mental health technicians. The Behavioral Health Division currently certifies mental health technicians; however, the training required is outdated and the division does not have the resources to develop a new training and to continue certifying individuals. Currently, there is no cost for an individual to become certified. On average, 500 individuals request to be certified per year.

A national certification program already exists. To avoid costs associated with updating training and operating a duplicative state certification program, the division will discontinue certification of mental health technicians. The funding requested would be available for providers currently utilizing the state mental health technician program to assist in the transition and utilization of the national certification program.

It is vital to continue to build all levels of the behavioral health workforce and maintain quality of these professionals. This OAR supports recommendation 7.0 in the North Dakota Behavioral Health System Study to engage in targeted efforts to recruit/retain competent behavioral health workforce – providing funding to support individuals to become nationally certified as mental health technicians through <https://www.nccboard.org/certification/mental-health-technician-certification-cmht>. Changing the certification program to the national program will ensure standards are met and will be more sustainable. <https://www.nccboard.org/certification/mental-health-technician-certification-cmht>. Changing the certification program to the national program will ensure standards are met and will be more sustainable. <https://www.nccboard.org/certification/mental-health-technician-certification-cmht>. Changing the certification program to the national program will ensure standards are met and will be more sustainable. <https://www.nccboard.org/certification/mental-health-technician-certification-cmht>. Changing the certification program to the national program will ensure standards are met and will be more sustainable.

Reinventing Government

AG101: Transfer administration of Medicaid Expansion from a managed care organization to the Department of Human Services under a fee-for-service (FFS) model

This OAR simplifies administration of Medicaid. Currently Medical Services operates three distinct programs – traditional Medicaid (FFS), Children’s Health Insurance Program (CHIP) (managed care), and Medicaid Expansion (managed care) – that require duplicative administrative layers. Streamlining operational focus to the fee-for-service model improves program efficiency and effectiveness. The efficiency savings for CHIP is in DHS base budget; the efficiency savings from moving Medicaid expansion from managed care to FFS is captured in this OAR. The operational simplicity achieved from single FFS model also improves program effectiveness by allowing Medicaid’s staff to focus attention and resources toward administering a single benefit plan.

While these changes generate savings overall, there are additional FTEs needed. The additional FTE are needed for claims processing, program integrity (PI) and utilization review (UR). The current FTE assigned to administer Medicaid Expansion would be repurposed to focus on additional (Third Party Liability or PI) efforts expected when Expansion is transitioned from managed care to FFS.

The transition from managed care to FFS would be effective January 1, 2020.

AC508: Sustain social services funding and support 2206 social services implementation plan

This OAR request would sustain funding for Social Services – which includes economic assistance programs and child, family, and adult services – and support the implementation plan requested in S.B. NO. 2206. Accompanying this funding, there are expected changes to the method of funding distribution, the operational governance of services, and the scope of services.

In changes to funding distribution, the goal is to distribute funds in a more flexible manner to more efficiently and effectively meet the needs of families and individuals experiencing instability or vulnerability; where efficiencies are achieved in administrative costs, money will be redirected to direct client services. To support changes to operational governance, this funding request also includes appropriation for one-time investments for transition-related expenditures to move to a more effective and efficient delivery model; these transition-related expenditures may include additional training or other infrastructure to support improved models of service delivery. Finally, included in the request are appropriations for expanding the scope of services (e.g., parent aids).

AC503: Expand capacity of guardianship services for vulnerable adults

Strategy: Increase capacity to establish guardianships and reimburse public guardianship providers for individuals with intellectual disabilities/developmental disabilities and indigent adults and streamline payments for petitioning and guardianship services. The number of adults who need these types of services continues to grow and there are not enough funds to meet the need. There is currently a waiting list for corporate guardianship services.

Descriptions of client need: If I am a family member or interested party who is assisting a person with an intellectual disability/developmental disability or a low-income or Medicaid-eligible adult who does not have the capacity to make their own decisions and does not have access to a guardian, the challenge I face is that the adult does not have sufficient funds to either cover

the costs of the guardianship petitioning process and/or they cannot afford to hire a corporate guardian.

Driver of problem and proposed solution: This challenge arises because the number of individuals in need of guardianship continues to increase. In addition, the guardianship standards have changed, which has required additional time for all parties involved in the petitioning process and expanded the guardian's duties. Therefore, additional funds are needed to hire corporate guardians which are in short supply.

Alternative solutions and potential limitations: Another approach would be to continue funding these services at the current level. This solution does not address the immediate need and will leave vulnerable adults at risk.

Additional benefits: Increasing the capacity of the number of individuals served would ensure that the most vulnerable have guardians who are able to ensure that their basic needs are met, and they are receiving the necessary support services. This may also reduce the reliance on higher cost institutional care.

24) AC505: Provide financial support for foster care relative caregivers

Strategy: Provide financial support to caregivers caring for a relative child in foster care.

Description of client need: Foster children can be placed in the care of a relative; unlicensed or licensed. A foster child placed with an unlicensed relative is not eligible for foster care financial assistance to cover their basic needs; such as food, clothing, daycare, transportation, activities, etc.

Driver of problem and proposed remedy: Federal financial assistance is restricted to licensed foster care providers. Providing financial assistance to unlicensed relative caregivers can stabilize placements, maintain family connections, and divert children from unfamiliar licensed foster homes. Financial assistance will provide support for the child's basic needs, while also allowing opportunities to engage in normalcy activities (sports, camp, field trips) similar to that of their peers. Relative caregivers not licensed for foster care or receiving TANF Kinship benefits would be eligible for these funds.

Additional benefits:

* This solution is more cost-effective than licensing all relative caregivers as foster parents.

* Relative foster care is preferable to non-relative foster care because of the emotional benefit to the child. This also allows the child to remain in the most familiar, least-restrictive environment.

AC513: Expand the Supplemental Nutrition Assistance Program (SNAP) Employment and Training Program (E&T)

This request is to expand the SNAP Employment and Training (E&T) Program.

The current pilot request was to serve 110 individuals in two counties, Grand Forks and Ramsey. Able-bodied adults who are between the ages of 18 and 60 and employed less than 30 hours per week will be referred to Community Options, Inc. when they apply for SNAP benefits.

This request is to expand the current pilot program by 350 to include all individuals who meet the referral criteria in these two counties. This request also includes an increase to the current pilot supportive services from \$25 to \$50, and an increase to the current pilot transportation allowance from \$50 to \$120 for the current 110 individuals in the pilot. Increasing these will

allow SNAP E&T to align these reimbursements with the Temporary Assistance for Needy Families (TANF) Job Opportunities and Basic Skills Program (JOBS).

In addition, the request includes an expansion of SNAP E&T to an additional 460 individuals for a total of 960 individuals statewide. The goal is to partner with one or more private for profit, private nonprofit, or government agencies who can meet the 50% matching funds (non-federal) to expand the E&T Program. The 50% funds will be used to obtain federal matching funds.

State General Fund will be used to obtain matching funds for the transportation and other supportive services for all individuals participating in E&T.

Federal matching fund is dependent on Federal approval of the ND State E&T plan along with Federal allocations.

Long-term Services & Supports

AC306: Add Residential Habilitation and Community Residential Services to Medicaid Home and Community-Bases Services (HCBS) waiver

Strategy: Add Residential Habilitation and Community Residential Services to the Medicaid HCBS waiver for eligible older adults and individuals with physical disabilities who meet a nursing facility level of care, live alone, want to remain in a home and community-based setting, and can benefit from care coordination, skills training or maintenance and community integration.

Descriptions of client need: If I am an older person or person with a disability who lives alone and needs support staying at home, the challenge that I face is that I do not have access to 24-hour support options that also provide me with care coordination, skills training or maintenance, and community integration so that I can avoid or delay institutional placement.

Driver of problem and proposed solution: The reason clients face this challenge is because older adults and individuals with physical disabilities on the Medicaid HCBS waiver do not have access to the same type of services as individuals with an intellectual disability/ developmental disability on the IID/DD waiver. These types of services and supports have been very successful in helping individuals with a developmental disability/ intellectual disability and should be available to older adults and individuals with physical disabilities who are eligible for the Medicaid HCBS waiver.

Alternative solutions and potential limitations: Another approach would be to make no changes to the service package for older adults and individuals with physical disabilities. This solution does not increase access to home and community-based care.

Additional benefits: The Americans with Disabilities Act (ADA) requires public agencies to eliminate unnecessary segregation of persons with disabilities and provide services in the most integrated setting appropriate to the needs of the individual. The Olmstead decision affirmed the ADA requirements and increasing access to HCBS will assist DHS in meeting this requirement. More people will be able to stay at home in a least restrictive environment.

AC511: Redesign the Aging and Disability Resource Link (ADRL) Strategy

Increase awareness, access, and consistency in the long-term services and supports (LTSS) service delivery system by creating a centralized intake process for home and community-based services (HCBS) based on the No Wrong Door (NWD) approach that is used by all populations i.e. individuals with intellectual disability/ developmental disability, physical disability, older adults and children. This strategy coincides with recommendations from the Adult Subcommittee which is part of the Social Services Redesign Project (SB 2206).

Centralized intake would build upon the Departments existing ADRL system that connects individuals to information about LTSS using a toll-free phone number staffed by information and assistance specialists or through an online searchable database. Expansion of the ADRL would allow this system to become an entry point to not only receive information but also to apply for services. Trained intake staff working from anywhere in ND would conduct phone intake and review online applications to determine initial eligibility. Eligible cases would then be forwarded to a local case manager who will make a home visit to verify eligibility and coordinate services. NWD Systems simplify access to LTSS and can be a key component of LTSS systems reform.

Descriptions of client need (problem): If I am a consumer and need services for myself or a family member, the challenge I face is that I may need to make several calls to find the services or service provider to meet my needs and may not receive information or may receive conflicting or different information.

Driver of problem and proposed solution: The challenge arises because each agency focuses on the services they provide and may not have information about other services that could better assist the consumer. The centralized intake process would allow consumers to reach out to a central location via phone or online to access information about all necessary services. Public outreach will also be needed to educate the public about an ADRL.

Additional benefits: The Americans with Disabilities Act (ADA) requires public agencies to eliminate unnecessary segregation of persons with disabilities and provide services in the most integrated setting appropriate to the needs of the individual. The Olmstead decision affirmed the ADA requirements and increasing access to HCBS will assist the Department in meeting this requirement. Consumers will be able to access services through one location increasing consistency of information and access to home and community-based services.

AC601: Expand Clinical Assistance, Resources, and Evaluation Services (CARES) Team capacity to enhance Life Skills and Transition Center (LSTC) community outreach services

Strategy: CARES outreach services expansion

Description of client need: If I am part of the developmental disability population in North Dakota who needs integrated and specialized developmental disability professional services exceeding those available in the local community, the challenge I face is getting the assessment, evaluations, and ongoing consultation services without losing my community presence.

Driver of problem and proposed remedy: The reason clients face this challenge is because of complex needs of people with developmental disability and behavioral health diagnoses requiring more specialized services. This specialization of expertise and team coordination is difficult to accumulate. Currently, there are limited crisis and complex services in most North Dakota communities. Therefore, expansion of the successful LSTC statewide CARES outreach program which enhances and supplements the community capacity will address these clients' needs.

Alternative solutions and potential limitations:

* Another approach to addressing these clients' needs would be increasing use of psychiatric centers, correctional settings, out of state placement, and state facilities and while this could address health and safety it also has demonstrated reduced return-to-home opportunities and does not promote building community capacity.

* Another approach to addressing these clients' needs would be crisis intervention teams operated regionally (like Cass County area program). While this has immediate health and safety support benefits (stabilization), it also has limitations to the often unusual and unique needs of the developmental disability/behavioral health population, which may not result in adequate supports for their needs. Such crisis service systems will need a developmental disability specialty component accessible to them (such as CARES).

* Another approach to addressing these clients' needs would be a developmental disability provider-based crisis intervention teams operated regionally. While this has potential to address immediate health and safety support benefits where provider capabilities are available, it also has the problem that only a few areas of the state have enough providers and provider capacity to operate such a system. This type of crisis service systems will need a state-level safety net component accessible to them (i.e., CARES).

Additional benefits:

* General behavioral health challenges could be working interactively and coordinated to provide the full spectrum of supports needed in communities throughout the state. As a result, people remain in their home community with family and friends and reduce higher levels (cost) of services.

* Response time would be more immediate to access experienced, integrated developmental disability/behavioral health specialized services (psychology, behavior analysis, occupational therapy, physical therapy, speech language, nursing, healthcare provider, program coordination, direct support professionals) resulting in a wholistic approach to person centered services.

AC301: Expand access to home and community-based services (HCBS) through Service Payments for the Elderly and Disabled (SPED) by amending functional eligibility criteria

Strategy: Reduce the functional eligibility criteria for SPED to serve individuals who are impaired in at least two activities of daily living or in at least four instrumental activities of daily living totaling six or more points (if living alone - totaling four points) to increase access to home and community-based services for older adults and individuals with physical disabilities who cannot access long term care services and supports under Medicaid.

Description of client need: If I am an older person or person with a disability I must be very impaired to functionally qualify for SPED services. I may not meet the eligibility criteria, but I still need help to safely live at home. Because I cannot get the help I need, I may go without services until my health fails, at which time I might be so impaired I need a higher, costlier, level of care.

Driver of problem and proposed solution: The reason people face this challenge is because many older adults and individuals with physical disabilities have some impairments but may not meet the strict functional eligibility criteria for SPED. Therefore, those individuals go without services that are necessary to help them remain in their home and community or they enter basic care where the functional eligibility criteria is easier to meet.

Additional benefits: The Americans with Disabilities Act (ADA) requires public agencies to eliminate unnecessary segregation of persons with disabilities and provide services in the most integrated setting appropriate to the needs of the individual. The Olmstead decision affirmed the ADA requirements and increasing access to HCBS will assist DHS in meeting this requirement. More people will be able to stay at home in a least restrictive environment in a more cost-effective manner and avoid or delay institutional care.

AC510: Leverage the National Core Indicators to measure service quality in DD continuum

Strategy: To gather in depth information regarding the quality of service delivery from individuals served as well as their families/guardians, and the DD providers.

Alternative solutions and potential limitations:

* Another approach to addressing these clients' needs would be to have DDPMs gather this information and while a version of this has been done in the past called "System Indicators", clients and their families/guardians expressed concern over DDPMs conducting these and there was no provider component.

* Another approach to addressing these clients' needs would be to mail survey's out to clients, families/guardians and providers, and while this may gather some of the information, a mailed-out survey will not garner the return rate nor the depth of information the DD division requires to make decisions that impact services.

Additional benefits: Participation in this program would provide valuable feedback on the service delivery system in ND. The division would be able to use this information to implement new services, modify existing services, change policies/procedures and compare our performance with other states.

AC308: Expand access to home and community-based services (HCBS) through Service Payments for the Elderly and Disabled (SPED) by lowering client contribution levels

Strategy: Increase the SPED sliding fee schedules and annually adjust them based on Social Security Cost of Living Adjustment (COLA) to increase access to home and community-based services for older adults and individuals with physical disabilities who cannot access long-term care services and supports under Medicaid.

Descriptions of client need: If an older person or person with a disability applies for SPED their countable income is used to determine how much of a client cost share they will have to participate in the program. The amount of income used to calculate their cost share has not changed since 2009 which has contributed to the lack of growth in the SPED program and some individuals going without services that are necessary to help them remain in their home and community.

Driver of problem and proposed solution: The reason many older adults and people with disabilities face this challenge is because they have limited income and cannot afford to pay for a large portion of the services they would receive under SPED. Adjusting the fee schedule annually will assure the dollar amount used to determine the clients SPED cost share corresponds with any increases in social security income which many older adults and people with physical disabilities rely on to meet their daily needs.

Alternative solutions and potential limitations: Another approach would be to require these individuals to pay privately for the service until they can access long-term care services and supports under Medicaid. This solution does not increase access to home and community-based care.

Additional benefits: The Americans with Disabilities Act (ADA) requires public agencies to eliminate unnecessary segregation of persons with disabilities and provide services in the most integrated setting appropriate to the needs of the individual. The Olmstead decision affirmed the ADA requirements and increasing access to HCBS will assist DHS in meeting this

requirement. More people will be able to stay at home in a least restrictive environment in a more cost-effective manner and avoid or delay institutional care.

AC302: Expand access to Children’s Medically Fragile waiver by increasing slots

Strategy: Increase the number of slots for the Medicaid Children’s Medically Fragile waiver from 25 to 183 (increase of 158 slots by the end of the 2019-2021 biennium). ND Medicaid estimates the need for 302 slots per year. According to the 2015 National Health Interview Survey, 1.9 percent of ND children ages 5-17 have activity limitations resulting from one or more chronic health conditions. Estimates were generated by calculating 1.9 percent of the total live births in the state for each calendar year and then assuming that 10 percent of those children would qualify for the Children’s Medically Fragile waive ($158,998 \times 0.019 \times .1 = 302$ eligible children).

Based on these factors, the projected need is 302 children per year; however, it is not realistic to increase the waiver enrollment by 277 children in 18 months. ND Medicaid staff feel that it is feasible to enroll up to 158 new children during the 2019-2021 biennium. This estimate includes projections for increasing the number of slots from 183 to 302 during the 2021-2023 biennium.

Description of client need: Children who are medically fragile need assistance with medical cares and equipment to remain living at home with their families. They may need nursing care, specialized medical equipment or supplies to enable them to stay at home. Their families may need respite care and care coordination to manage the complex needs of the child. The challenges families face includes finding a child care provider that can meet their needs for care as well as the high costs associated with care and equipment. By providing children who are medically fragile with resources and support, it is more likely that they will be able to remain at home instead of living in a nursing home or hospital.

Driver of problem and proposed remedy: Children and their families face challenges because of health issues that require substantial medical care and equipment. Currently, the Children’s Medically Fragile waiver has 25 slots and the projected need surpasses the number of slots available. Increasing the number of slots for the waiver will enable more families to receive assistance with medical cares, respite care and equipment required to address their needs, allowing them to remain in their home setting.

Alternative solutions and potential limitations:

* Another approach to addressing medically fragile children’s needs would be to enhance the Department of Health’s Special Health Services Program to accommodate more children with medically fragile needs. Currently, Special Health Services offers financial support for children with special healthcare needs to pay for medical care and treatment, but the support does not include services such as respite care, transportation or environmental modifications – services that are included in the Children’s Medically Fragile waiver. Special Health Services also is unable to serve children who do not have a condition approved by their Medical Advisory Committee.

* Another approach would be to examine the eligibility requirements of the Medicaid Developmental Disabilities (DD) waiver. The DD waiver covers most of the services needed for medically fragile children; however, the waiver currently requires an intellectual and/or developmental disorder diagnosis or related condition. Many children who are medically fragile are not affected intellectually, which prohibits them from accessing the DD waiver.

Change requirements: Additional slots for the waiver would need to be approved by the Centers for Medicare and Medicaid Services. Depending on how many slots are added, Medical Services may need additional administrative staff and funding for outreach to increase awareness of the increased availability of slots for eligible children. There would also need to be additional program managers to assist families with the waiver. Currently, all children enrolled in this waiver receive case management through the DD program managers at the human service centers. Alternative case management options through the private sector could also be explored. There would also be an increased cost for the fiscal agent used to assist families.

Additional considerations:

* More children who are medically fragile will be able to stay within their family's home, preventing higher cost institutional services. Also, by providing adequate care within the home, inpatient hospital stays are more likely to be prevented.

* Health care providers would receive less reimbursement from coinsurance/deductibles from families that have primary coverage and are currently paying these for their child. Medicaid will likely pay \$0 on a secondary claim.

AC305: Expand community grants to support older adults

Strategy: Since 2009, DHS has received an appropriation to grant funds to Community of Care, an organization based in Arthur, ND, for a pilot project to provide support services designed to assist older adults to remain safely in their rural homes. DHS is proposing to expand this project to make grant funds available to additional communities through a competitive application process.

Description of client need: Older adults may need support to remain living safely in their homes, especially in rural areas. They may need assistance with transportation to medical appointments, understanding their options for health care coverage, care coordination or someone to stop in and check on them. Without these community supports, older adults may need to seek care in an assisted living or nursing facility.

Driver of problem and proposed remedy: Older adults often have chronic health conditions that require medical care and follow up. They may be isolated, especially if they live alone in a rural area. By providing more assistance to older adults, they are more likely to be able to remain in their homes and avoid having to move into more urban areas or to a facility for needed support.

Alternative solutions and potential limitations: Another approach is to continue to grant funds only to Community of Care. This approach, however, leaves out the other communities whose rural older adult population needs supportive services.

AC502: Evaluate options for new eligibility tools for developmental disabilities (DD) continuum

Strategy: To gather and assist the state in the implementation of the appropriate tools based on age and level of need that will ensure consistent eligibility determinations to clients in the DD system.

Description of client need: If I am a person applying for DD services, the challenge I face is that there may not be an assessment tool appropriate for my age or level of need to be used to determine my eligibility.

Driver of problem and proposed remedy: The reason people face this challenge is that the state does not currently have available a tool that accurately assess different age points. Currently, the same tool is used for a three-year-old as a 24-year-old. Therefore, changing the eligibility process, criteria and tools used for the determination will address these clients' needs.

Alternative solutions and potential limitations:

* Another approach to addressing these clients' needs would be for the state to internally work on this project and while this has been tried, it was ultimately found that not enough in state resources existed to implement change.

* Another approach to addressing these clients' needs would be to leave it the same and have inaccurate eligibility.

Tribal Partnerships

AC701: Expand Temporary Assistance for Needy Families (TANF) Kinship Care funding coverage to include children in Tribal custody

Strategy: Expand TANF Kinship Care to children living with relatives, who are in the care, custody, and control of tribal social services.

Description of client need: A child in the care, custody and control of tribal social services, is not eligible for TANF Kinship Care. For the family to receive financial support, they are required to become a licensed foster care provider.

Driver of problem and proposed remedy: Current TANF administrative code limits TANF Kinship Care to only those children who are in the care, custody and control of a county agency, the executive director of the Department of Human Services, or the Division of Juvenile Services.

Change requirements:

* Change to the TANF administrative code at 75-05-01.2-05.2. Kinship Care to add eligibility for children in the care, custody and control of tribal social services.

* Changes to TANF Kinship Care policy at 400-19-140

* Based on information received from North Dakota tribes, there are approximately 329 Native American children in tribal custody that could be eligible for TANF Kinship Care. The potential fiscal impact of including these children in TANF Kinship Care would be the additional monthly TANF Kinship Care maintenance payment per household (monthly average \$300 for 161 households) along with the additional support service payments per child (monthly average \$225 for 329 children).

Unknown Factors: The above is a conservative estimate, as the following are not known with certainty.

* TANF Kinship Care financial assistance consists of the TANF benefit, Kinship Care maintenance payment and TANF Kinship Care supportive services. This optional adjustment request does not include the cost of a TANF benefit for these children as it is unknown the number of these children that may already be receiving TANF.

* Accurate number of Non-IV-E children under tribal care, custody and control.

* Number of households that qualify based on a home study and background check.

* Number of households/children who qualify based on income

Provider Inflation

AC402: Increase reimbursement for physical therapy, occupational therapy, and Speech professionals for 2019-2021

This optional adjustment request would increase the Medicaid fee schedule for physical, occupational and speech therapy to 100% of the rate established utilizing the Medicare Resource-Based Relative Value Scale (RBRVS) pricing methodology with the ND Medicaid conversion factor on July 1, 2019. (Note: Rates for codes that are above 100% of the rates established utilizing the Medicare RBRVS pricing methodology with the ND conversion factor will be reduced to 100% of the rate established utilizing the Medicare RBRVS pricing methodology with the ND conversion factor. ND Medicaid would also expect to implement the Multiple Procedure Payment Reduction (MPPR) methodology, consistent with Medicare. Implementing MPPR would be contingent on changes to the Medicaid Management Information System (MMIS)-).

The Department of Human Services and the Department of Public Instruction would need additional general fund for this optional adjustment request.

AC605: Increase Medicaid reimbursement to providers of behavioral health services

This OAR would increase the Medicaid fee schedule for behavioral health services reimbursed from the professional fee schedule and provided by Licensed Independent Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists and Licensed Addiction Counselors.

Historically, most behavioral health providers have been reimbursed at 75% of the professional fee schedule. The OAR would increase the Medicaid fee schedule for services reimbursed from the professional fee schedule for the specified behavioral health providers to the same level as other providers/practitioners paid 100% of the professional fee schedule.

This increase is one of the components of growing the private behavioral health provider workforce. Without the increase, other efforts to improve the available workforce will likely not be as effective.

The Medical Services Division would need to secure federal CMS approval for the rate methodology change and ensure MMIS can support the fee schedule change. Therefore, this increase would be effective for dates of service on or after January 1, 2020.

Operational Investments

AG102: Funding source change for Medicaid grants

This change package is used to meet the 3% optional general fund savings plan. The Department will use anticipated increased federal retained dollars from County Social Services Financing to offset general fund expenditures in Medicaid Grants. The 2017-2019 biennium budget included 18 months of revenue due to the Jan 1, 2018 implementation date, while the Department anticipates 24 months of revenue in the 2019-2021 biennium based on the County Social Services Financing OAR included in the budget request.

AC512: Create compensation equity for DHS staff relative to other classified employees

The average compa ratio of Department staff is significantly lower than other classified state employees, thereby resulting in increased turnover within specific classifications within

DHS. DHS is also experiencing compression, lower morale and lack of transparency relative to employee compensation.

This OAR will bring up the compa ratio for identified classifications of DHS employees in comparison to the median of other classified state employees.

AD205: Replace broken coal boiler at State Hospital with natural gas boiler and building to house it

The state hospital plan supplies heat to both the State Hospital and the James River Correctional Facilities. Joint Commission accreditation requirements for the State Hospital include a primary and secondary back-up source of heat.

The coal boiler at the State Hospital needs major tubing repairs. It resides in a building containing vast amount of asbestos piping currently wrapped and contained. The building needs structural repairs, as it sits on the original hospital foundation that was built in 1885.

Total estimated costs of repairing the current coal boiler, fixing the foundation and structure of the building, removing some asbestos and making the necessary track repairs (for the railroad tracks that are needed to transport coal to the plant building) are over \$2.9m. IN comparison, replacing the coal boiler in the existing structure would cost \$2.5m. There is a third alternative: replace the current coal boiler with a new natural gas boiler and build a new plant building to house the new boiler. Estimated costs for this third option are \$1.9m, an estimated savings relative to other options. Once operational, additional cost savings would be achieved through reduced overtime hours and improved workforce safety and risk reduction.

AD103: Replace child welfare information technology systems (FRAME and CCWIPS)

The OAR would enable Child and Family Services to replace the currently utilized legacy systems (FRAME and CCWIPS) with modern system technology to ensure timely compliance with federal and state policy changes for child welfare programs and case management.

The ongoing and future needs of the child welfare programs require North Dakota to have a flexible system that can be readily configured and adapted for new demands and easily provide program administrators with the data needed to provide quality, efficient, and effective services. The legacy systems are using deprecated technology and high demand for changes is stressing the limits of resource availability.

CCWIPS was established in 1993 using what is now legacy mainframe code and database technology. FRAME was custom built in 2010 for identified use cases that have now rapidly expanded beyond the original scope. Federal, state, and operational reporting needs are limited, and the current system makes it difficult to keep pace with increased changes and demand. System changes and extracting data to make informed programmatic decisions is costly, time consuming, and inefficient.

AD105: Upgrade Medicaid Management Information System (MMIS) Tech Stack

This OAR would provided for a full technical stack upgrade for the ND Health Enterprise Medicaid Management Information System (MMIS). This upgrade includes most software components and migration of the system's hardware from IBM P8 computers to PC Virtual servers. The major components included are: IBM WebSphere framework (Portal, Process and Application Server); COTS products (FileNet, xPressions, Cognos, Informatica, Blaze Rules Engine); Oracle database; IBM Identity; and Access Manager middleware and the migration of many of these software components from AIX operating software to Linux.

This upgrade is necessary, as most hardware is out-of-date and the current versions for most of the core software components are reaching or are already out of vendor maintenance and support. This presents major application support and security risks as security patches and service packs are not available for software past its final support. Furthermore, this upgrade will enhance performance, security, and reduce the overall footprint of the MMIS tech stack, which could potentially reduce license and lease costs.

AC106: Replace one-time federal revenue adjust due to Medicaid Management Information System (MMIS) certification

When the 2017-2019 budget was prepared, DHS projected to receive the additional Federal Financial Participation (FFP) for MMIS operations. This projection assumed that MMIS would be certified by the Centers for Medicare and Medicaid Services CMS in the 2017-2019 biennium. DHS expects the additional FFP to include the period from MMIS go-live (October 2015) through current. The additional FFP is a result of CMS providing 75% FFP for MMIS operations, once certified. Prior to certification, DHS has only been able to claim 50% FFP for MMIS operations. As the retroactive (to October 2015) FFP will be one-time funding, this optional adjustment request is to replace general fund for the one-time additional FFP that DHS expected to receive in the 2017-2019 biennium. The additional FFP reduced the general fund need in 2017-2019; however, the true general fund needs is not in the 2019-2021 cost to continue. At this time, DHS is uncertain if MMIS will be certified during the 2017-2019 biennium. Regardless of when the system is certified, once the additional FFP is received, DHS will deposit the enhanced FFP related to prior biennium in the general fund. This optional adjustment request will ensure the general fund need to support ongoing MMIS operations is accurately reflected in the 2019-2021 budget request.

When preparing the 2019-2021 biennium budget, the costs related to the operations of the MMIS system were funded with the knowledge that the MMIS system will be certified. Therefore, the costs related to the Medicaid share of the system were budgeted at the enhanced 75% FFP.

AD201: Invest in Life Skills and Transition Center (LSTC) maintenance projects

Ongoing physical plant improvements are essential in maintaining safe, efficient and effective operations of the LSTC campus.

Due to census reductions, it is necessary for the LSTC to obtain a smaller footprint necessitating the relocation of programmatic and residential space. To accomplish this, remodeling of physical space is necessary in Maplewood and Cedar Grove. Remodeling of the residential space requires attention to meeting Centers for Medicare and Medicaid Services Life Safety Codes and Americans with Disabilities Act requirements. Remodeling of residential kitchens will help to accommodate future downsizing of the Centralized Nutrition Services.

If physical plant improvements are not completed it could impact health and safety of people served and employees; if capital improvements are not maintained on an ongoing basis, the result would be increased operating expenses for emergency repairs and replacement.

AD202: Replace Roof for GM Building at the state hospital

The GM Building, built in the 1960s, has a dated roof more than 15 years old with current leaks during rain or melting snow. This building houses the sex offender evaluation and treatment program and is necessary for safety and security of the individuals in this program and the continued operations of this statutorily required service.

AD108: Extend Self-Service Portal and Consolidated Eligibility System (SPACES) functionality to include the Basic Care application

Add the Basic Care (BCAP) application into SPACES and retire the current application off the mainframe. This was originally intended to be a part of the SPACES Release 2 implementation but was removed to gain development credits from Deloitte and to pull in the schedule. This would be needed as a part of the larger effort to move all legacy applications off the mainframe.

AC107: Restore postproduction support for Self-Service Portal and Consolidated Eligibility System (SPACES)

This optional adjustment request is to restore general and federal funding for SPACES post-production support contract to maintain support for the current eligibility programs that are running on the application. Without this continued support, system fixes, maintenance issues, and federal program updates could fall behind and could lead to inaccurately determining eligibility. The current maintenance contract that DHS has with the vendor is expected to increase due to additional eligibility programs being added to the system.

AD102: Extend Self-Service Portal and Consolidated Eligibility System (SPACES) functionality to include the Disaster Supplemental Nutrition Assistance Program (SNAP) application

Add the Disaster SNAP application into SPACES and retire the current application off the mainframe. This was originally intended to be a part of the SPACES Release 2 implementation but was removed to gain development credits from Deloitte and to pull in the schedule. This would be needed as a part of the larger effort to move all legacy applications off the mainframe.

AD203: Demolish Refectory and Pleasant View buildings at the Life Skills and Transition Center (LSTC)

There are two unused buildings (Pleasant View and Refectory) at the LSTC require demolition. Pleasant View was built in 1926 and the Refectory was built in 1921. These buildings have not been utilized since the mid-1980s when new Centers for Medicare and Medicaid Services certified buildings were built and/or remodeled. Since the utilities have been turned off, the buildings have deteriorated considerably. The roof leaks causing contaminated water leakage in the underground tunnels. Also, pigeons can enter the building and their droppings could cause health and air quality concerns and the floors and walls are unsafe. These buildings are brick structures, so there is also risk of falling debris. There have been reported instances of unauthorized attempts of entry into the buildings.

If these buildings are not demolished there is a potential health and safety hazard for employees and people residing at the LSTC.

AD101: Migrate child welfare information technology system (CCWIPS) off the mainframe to web-based program

This optional adjustment request is to move the comprehensive child welfare information and payment system (CCWIPS) off the mainframe to a web-based Java program. Currently, the legacy nature of CCWIPS code, natural, and database (ADABAS) are a maintenance and growth constraint due to limited developer availability coupled with exponential expansion of required changes to keep pace with business growth and need. This situation is an impediment to keeping the two systems in sync for ever-increasing and changing regulatory requirements, and case efficiency improvements.

This request is to modernize CCWIPS, in a minimally invasive way using a discrete technological uplift process, to the same platform standards as FRAME, another child welfare system (Java/Oracle). This will greatly expand the potential resource pool for development and subsequently increase the speed changes can be made. The interoperability of these two systems can improve cross-system transactions and overall data integrity.

This request is dependent on whether FRAME/CCWIPS replacement optional adjustment request is approved (AC103).

AC104: Evaluate opportunities to utilize MCI/MDM to improve program administration

Evaluate opportunities to utilize Master Client Index/Master Data Management (MCI/MDM) to improve program administration. Assess benefits that could be derived include having a more accurate “client golden record” that would update the client’s information across all DHS programs, and to maximize the usage of the MCI/MDM by DHS programs. For example, this would allow all programs to have the most up-to-date information (i.e. changes in addresses, names, etc.). This would save time for individual programs to contact clients to obtain this information. There would also be opportunities in analytics and reporting and providing holistic client services. The goal of this assessment would be to have potential solutions to benefits identified above.

AC109: Evaluate opportunities to migrate applications off the mainframe

A mainframe migration assessment is needed to assist with the long-term plan to migrate legacy data systems and data off the mainframe. There are legacy systems currently running on the mainframe containing historical program data, which correspond to implemented new systems, but for various project reasons at the time, went live without all program data being converted. Generally, the reasons for that systemic split were due to funding constraints, organizational change management difficulties, data retention challenges, technical challenges and business staff availability. Migrating or archiving these systems off the mainframe removes the need to maintain similarly purposed data systems, provides operational cost savings, and removes legacy resource requirements, which allows for information technology and business staff focus to be solely on current systems. Data retention rules can be applied to minimize risk, lower storage costs, and validate compliance with state and federal program rules.