DOJ SETTLEMENT
AGREEMENT SUMMARY
DHS AGING SERVICES DIVISION LISTENING SESSIONS

February 2021
Purpose is to ensure that the State will meet the ADA requirements by providing services, programs, and activities for individuals with physical disabilities in the most integrated setting appropriate to their needs.

**Effective December 14, 2020**

Agreement will terminate eight years after effective date if Parties agree that the state has attained substantial compliance with all provisions and maintained that compliance for a period of one year.
...complaints we received which allege that the State of North Dakota fails to serve individuals in nursing facilities in the most integrated setting...

49
PER 1000
PEOPLE OVER 65 IN
CERTIFIED NURSING
FACILITIES
HIGHEST RATE IN THE U.S.

VARIETY OF CONCERNS

EXAMPLES PROVIDED BY DOJ

- **Unnecessary segregation** of disabled individuals in skilled nursing facilities

- Adults in skilled nursing facilities who would **rather be in their community**

- **Imbalance of funds** to skilled nursing facilities and community-based services

- **Lack of awareness** about existing transition services and available tools
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.

In 1999 the Federal Supreme Court Olmstead decision affirmed the ADA requirements.
A *living environment* that allows individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

*December 2020 U.S. Dept of Justice
Settlement with State of North Dakota*

**For Example**

<table>
<thead>
<tr>
<th>Single Family Home</th>
<th>Farm or Ranch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apartment</td>
<td>Adult Foster Care</td>
</tr>
<tr>
<td>Townhome</td>
<td>Living with family</td>
</tr>
<tr>
<td>Condominium</td>
<td></td>
</tr>
</tbody>
</table>
Public entities are required to provide **community-based services** when:

- Community-based services are **appropriate** for the individual; **and**
- The individual **does not oppose** community-based treatment; **and**
- Community-based treatment can be **reasonably accommodated**, taking into account:
  - Resources available to the entity and
  - Needs of others receiving disability services.
1. **Expands and raises awareness** about community-based care options available to adults with physical disabilities.

2. Allows individuals to make **informed choices**, including the option to receive care while enjoying the benefits of community living in the least restrictive setting.

3. Builds upon the investments made by the 2019 Legislature and our **shared goal** of improving services to citizens.
Informed Choice

The process by which the State ensures that Target Population members have an opportunity to make an informed decision about where to receive services.

December 2020 U.S. Dept of Justice Settlement with State of North Dakota

For Example

- Person-centered planning
- Info about benefits of integrated settings
- Facilitated visits or other experiences in integrated settings
- Opportunity to meet with peers (other individuals with disabilities who are living, working and receiving services in integrated settings)
- Reasonable efforts to identify and address concerns
What do we need to do to help someone make an informed choice about how they may want to access services in the most integrated setting that is right for them?
AGREEMENT VISION

- Long-term care system & supports reform
- Increase access to community-based services
- Increase awareness about service options
- Increase provider capacity & training

Builds upon shared goal of improving services to citizens providing care closer to home.
I. Introduction
II. Jurisdiction
III. Definitions
IV. Target Population
V. Subject Matter Expert
VI. Implementation Plan
VII. Case Management
VIII. Person Centered Plans
IX. Access to Community Based Svc
X. Information, Screening & Diversion
XI. Transition Services
XII. Housing Services
XIII. Community Provider Capacity & Training
XIV. In-reach, Outreach, Education & Natural Supports
XV. Data Collection & Reporting
XVI. Quality Assurance & Risk Management
XVII. Enforcement
XVIII. General Provisions
IV. TARGET POPULATION MEMBERS (TPM)

COMMUNITY MEMBERS

▪ Adults with disabilities living in an integrated community setting, but at risk of Medicaid-funded nursing facility care.

▪ Adults with disabilities in need of additional community-based services to continue living in an integrated community setting.

NURSING FACILITY MEMBERS

▪ Adults with disabilities who reside in a nursing facility and receive Medicaid-funded long-term care services.

▪ Adults with disabilities who reside in a nursing facility who are at risk of becoming eligible for Medicaid-funded services.
Who are we trying to reach?

**Target population**

**Basic Eligibility**
- Individual with physical disability
- Over age 21
- Eligible or likely to become eligible to receive Medicaid long-term services and supports (LTSS)
- Is likely to require LTSS for at least 90 days.

**IF in skilled nursing setting**
- Receive Medicaid-funded nursing facility services AND
  - Likely to require long term services and supports
- Receive nursing facility services AND
  - Likely to become eligible for Medicaid within 90 days, have submitted a Medicaid application, and have approval for a long-term nursing facility stay

**IF in hospital or home setting**
- Referred for a nursing facility level of care determination AND
  - Likely to need services long term
- Need services to continue living in the community AND
  - Currently have a HCBS Case Manager or have contacted the ADRL
“Physical Disability” – means an impairment that substantially limits major life activity, including one or more major bodily functions, see 42U.S.C 12102: 28 C.F.R 33.108 such that the individuals meets ND’s Nursing Facility Level of Care (LOC) by requiring for example, assistance with activities of daily living such as toileting, eating, or mobility.

ND Admin code 75-02-09, as may be amended.
WHO IS NOT A MEMBER OF THE “TARGET POPULATION”

Individuals under age 21

Individuals who are not Medicaid eligible

Individuals who are not expected to need services for at least 90 days

Individuals with an intellectual disability or mental illness who do not screen at a nursing facility level of care
Individual chosen by the parties with expertise in management, administration and finance of HCBS

Provide technical assistance and compliance reviews
Within 120 days of effective date produce draft plan

- Establish a method to address challenges to implementation
- Assign agency and division responsibility for achieving benchmarks
- Identify benchmarks and timelines for meeting Agreement's requirements
- Review relevant services, capacity and barriers
- Engage Stakeholders

VI. IMPLEMENTATION PLAN

State received approval from DOJ to extend deadline 45 days.
Plan due 5.28.21
VII. CASE MANAGEMENT

- Provide case management for older adults & individuals with physical disabilities receiving:
  - Service Payments for the Elderly and Disabled (SPED)
  - Expanded SPED (Ex-SPED)
  - Medicaid 1915-(c) Waivers
    - Aged and Disabled
    - Tech Dependent
  - Medicaid State Plan Personal Care (MSP-PC) in community

- Conduct informed choice referral visits

64 HCBS Case Managers

Served 2300 individuals (Nov 2020)
AGING & ADULT SERVICES
Types of Support Services available via HCBS

- Adult Day Care - 24.12 – 56.18/ ½ day
- Adult Foster Care - Max 94.06/day
- Adult Residential Care - 107.08 -198.24/day
- Attendant Care – 7.31/5.32 /15 min
- Case Management – 123.58-342.99/ month
- Chore Service - 7.31/5.32 /15 min
- Community Support Services / Residential Habilitation – 36.33/hour
- Community Transition Services -10.98/15 Min
- Companionship – 6.58/4.79 /15 min
- Emergency Response System – per month
- Environmental Modification – Max 22,320

- Extended Personal Care - 5.32-16.26 /15 min
- Family Home Care & Family Personal Care - Max 47.06 -76.67 /day
- Home Delivered Meals - 9.01/ meal
- Homemaker Services - 6.58/4.79 / 15 min
- Non-Medical Transportation – 3.27/3.53 /15 min
- Personal Care Services - 7.31/5.32 /15 min
- Respite Care - 7.31/5.32 /15 min
- Specialized Equipment – per piece
- Supervision – 2.49 /15 min
- Supported Employment - 7.31/ 15 min
- Transitional Living - 7.31 /15 min
ND / DOJ AGREEMENT STRATEGY

- In-Reach & Outreach
- Person Centered Plans
- Diversion
- Transition
**XIV. STRATEGY**

**IN-REACH**

In-reach:

Informing individuals in skilled nursing facilities and hospitals of their care options

**OUTREACH**

Outreach:

Informing individuals and stakeholders in the community about their care options

**GOALS**

<table>
<thead>
<tr>
<th>Within 9 months</th>
<th>Year 2</th>
<th>Year 4</th>
<th>Year 5 and after</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual or group in-reach to all skilled nursing facilities</td>
<td>Develop peer support system</td>
<td>Individual in-reach to at least 1,000 Skilled Nursing Facility target population members</td>
<td>In-reach to all newly admitted or identified Skilled Nursing Facility target population members</td>
</tr>
</tbody>
</table>
VIII. STRATEGY

PERSON CENTERED PLANNING

Medicaid mandated process, developed by individual and case manager to identify supports and services that are necessary to meet the individual’s needs in the most integrated setting.

GOALS

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 4</th>
<th>Year 6</th>
<th>Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>•290 Target Population Members (TPM)</td>
<td>•Additional 290 TPM</td>
<td>•Additional 650 TPM</td>
<td>•Additional 670 TPM</td>
<td>•Additional 670 TPM</td>
</tr>
</tbody>
</table>
**DIVERSION: COMMUNITY LIVING**

Set of activities that allow a target population member to avoid placement in a skilled nursing facility and remain living in their home and community.

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 4</th>
<th>Year 6</th>
<th>Total 400 diverted</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 Target Population Members (TPM)</td>
<td>150 additional TPM</td>
<td>150 additional TPM</td>
<td></td>
</tr>
</tbody>
</table>
XI. STRATEGY

TRANSITION TO COMMUNITY

Services to prepare an individual currently residing in a skilled nursing facility to return to an integrated community setting

GOALS

<table>
<thead>
<tr>
<th>Year 2</th>
<th>Year 4</th>
<th>Year 6</th>
<th>Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Transition 100</td>
<td>• Transition 60% identified through person centered planning (PCP)</td>
<td>• Transition 70% identified through PCP</td>
<td>• Transition all remaining individuals identified PCP</td>
</tr>
</tbody>
</table>
Federal Grant designed to assist states to increase the use of home and community-based services (LTSS System Rebalancing)

- Eliminate barriers that prevent individuals from receiving LTSS in the settings of their choice
- Original award - $8.9 million (2007)
- Award through 2020 - $29 million (fed) and $1.7 million (state)
- Transitioned 528 individuals from institutional settings back to the community
Federal, state, or local assistance to TPM who need help accessing available integrated housing and support for TPM where lack of housing has been identified as a barrier to community-based services

**Goals**

**Year 1**
- Assist 20 Target Population Members (TPM)

**Year 2**
- Assist additional 30 TPM

**Year 3**
- Assist additional 60 TPM

**Year 4-8**
- Assist additional number of TPM based on aggregate need
Affordable, permanent housing coupled with housing supports and other community-based services. Individual lives in a private home alone, with family, significant other, or roommates of their choosing.

*December 2020 U.S. Dept of Justice Settlement with State of North Dakota*

**Notes**

- Tenants must have access to community provider for intermittent on-call, planned and back up community-based services
- Must be scattered site housing
Housing cannot be provided in group homes, nursing facilities, boarding homes, residential care facilities or assisted living residences; or any building where more than 25% of the occupants are TPM.

Requires state to provide funding for rental assistance including reasonable expansion of existing capacity by funding and providing rental assistance to support permanent housing for TPM.

Requires state to provide for assistance with identifying housing, coordinating housing modifications, applying for subsidized housing, as well as help preserving tenancy if temporarily admitted to a Nursing Home.
XIII. PROVIDER CAPACITY AND TRAINING

State will ensure an adequate supply of qualified trained community providers to enable target population members to transition and live in most integrated setting.

Provide guidance and training to nursing homes and other community providers who make a commitment to provide community-based services.

Draft plan to addresses provider capacity, reimbursement rates, incentives to serve individuals with significant medical/supervision needs, those living on Native American reservations and in rural areas.
CONTINUUM OF CARE
LONG-TERM CARE SERVICES & SUPPORTS

HOME-BASED SERVICES
2,300 RECIPIENTS
$5,000 - $27,000
PRIVATE PAY

ASSISTED LIVING
3,064 UNITS

BASIC CARE
750 RECIPIENTS
$34,000

SKILLED NURSING FACILITY
2,950 RECIPIENTS / 2,400 PRIVATE PAY
$95,000

COST PAID BY THE STATE PER RECIPIENT IN FY2019

RECIPIENTS IN FY2019

LEAST RESTRICTIVE

CONTINUUM OF CARE

MOST RESTRICTIVE
DHS FUNDED LONG TERM CARE AND HCBS SERVICES

Cost Per Recipient Per Year
Cost paid by state by service in $ in State Fiscal Year 2020

<table>
<thead>
<tr>
<th>Program</th>
<th>Number of Recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>ExSPED</td>
<td>~150</td>
</tr>
<tr>
<td>SPED</td>
<td>~1150</td>
</tr>
<tr>
<td>MSP-PC</td>
<td>~300</td>
</tr>
<tr>
<td>HCBS Waiver</td>
<td>~600</td>
</tr>
<tr>
<td>Basic Care</td>
<td>~750</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>~2900</td>
</tr>
</tbody>
</table>

XX = Number of recipients

• Service Payments for the Elderly and Disabled (SPED): Provides services for people who are older or physically disabled, have limited assets, and who have difficulty completing tasks that enable them to live independently at home.

• Expanded SPED (Ex-SPED): Pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility.

• Home and community-based services (HCBS) waiver: This waiver from the federal government allows the state to use Medicaid funds to provide services enabling eligible individuals who would otherwise require nursing home services to remain in their homes or communities.

• Medicaid State Plan personal care (MSP-PC): Personal care services available under the Medicaid state plan and enable persons with disabilities or chronic conditions accomplish tasks they would normally do for themselves if they did not have a disability.

• Basic Care: Room and board and personal care services for persons eligible for Medicaid.
OPPORTUNITIES FOR COLLABORATION

Internal and external partners

- State Agencies
- Advocacy Organizations
- Hospitals, Skilled Nursing and Basic Care Facilities
- Home Health, Community-Based Providers and Health Care Professionals
LISTENING SESSION

Stakeholder Engagement

Public input, questions or concerns can be submitted at anytime.

Email: carechoice@nd.gov

Phone: 1-855-462-5465 or 711 (TTY)

Mail: North Dakota Department of Human Services
Attn: Aging Services Division/HCBS
1237 W. Divide Ave., Suite 6
Bismarck, ND 58501
ACCESS TO COMMUNITY-BASED SERVICES

- What services are needed to help people stay home instead of having to go into a nursing facility when they need care?
- What services do we need but are not currently provided?
- What makes it difficult for people to get community-based services? (Barriers)
- What is working well?
ACCESS TO COMMUNITY-BASED SERVICES

Transition Supports

- How do we improve our discharge/transition from nursing home to community services?
- What service would make it easier for people to discharge from a nursing facility?
- How can we improve our case management service?
PROVIDER CAPACITY & TRAINING

- What can the state do to attract more Qualified Service Providers?
- How can the state better meet the needs of people that may need 24 hour a day support?
- What might be done to get more Qualified Service Providers in rural ND?
- What do Qualified Service Providers need to be successful?
- What can we do to improve provider skills and training?
What can the state do to make community services more person-centered?

What would be important for individuals receiving services to know about Person-Centered Planning?

How can case management staff provide individuals with more choices and options in the planning process?
STAKEHOLDER INVOLVEMENT

- How do you as a stakeholder want to be involved in the process and how often?
- What are the best ways or methods to communicate with stakeholders?
- What are your suggestions for involving people in nursing homes or at risk of going into a nursing home in the stakeholder process?
- What would be the best ways to keep stakeholders aware of the states’ progress?
HOUSING SERVICES

- What makes it hard for people to get into affordable housing when leaving a nursing home?
- What makes it hard for people to keep the housing they have in the community?
- How can we make it easier for people to find affordable housing?
- How can we make more integrated affordable housing available?
- What can be done to help people get a home modification?
Contact Information

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Division, Department of Human Services

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Bismarck, North Dakota 58501-1208
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E-mail: carechoice@nd.gov