INCREASED ACCESS TO HOME AND COMMUNITY-BASED SERVICES (HCBS) FOR ADULTS WITH PHYSICAL DISABILITY

Interim Human Services Committee, Senator Judy Lee, Chair
April 27, 2022, Nancy Nikolas Maier, Director, ND DHS Adults and Aging Services Division
INCREASED ACCESS TO HCBS

- **Presentation Focus**
  - Provide a brief summary of efforts to increase access and awareness of HCBS for older adults and adults with physical disabilities
  - ND U.S. Department of Justice (USDOJ) Settlement Agreement year one progress report
  - Summary U.S. DOJ settlement agreement year two priorities
ND DHS Aging & Adult Services administers the following state and federally-funded HCBS programs for older adults and adults with physical disabilities, including dementia and traumatic brain injury.

- Service Payments to the Elderly and Disabled (SPED)
- Expanded Service Payments to the Elderly and Disabled (Ex-SPED)
- Medicaid State Plan Personal Care (MSP-PC)
- HCBS Medicaid waiver
- Older Americans Act (OAA) services

Division team members supervise the HCBS case managers that work out of the human service zones. They are all state employees.
SETTLEMENT AGREEMENT BETWEEN U.S. DEPARTMENT OF JUSTICE & STATE OF ND

Purpose is to ensure that the state will meet the Americans with Disabilities Act (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.
NOTIFICATION FROM U.S. DOJ

December 2, 2015

SOMETHING 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.

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.
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.
WHO ARE WE TRYING TO REACH?

Target population members (TPM)

Basic Eligibility

- Individuals with physical disabilities
- 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
- 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 Aging and Disability Resource Link (ADRL)

IF in hospital or home setting
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
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 and providing care closer to home
AGREEMENT STRATEGY & BENCHMARKS

In-Reach & Outreach:
Individual or group in-reach to all skilled nursing facilities (SNF)

Person Centered Plans:
Complete 290 plans with TPMs; 50% (145) must be residents of SNF

Diversion:
Within two years, divert 100 TPMs from placement in a SNF

Transition:
Within two years, transition 100 TPMs from SNF to home and assist 20 TPMs with permanent supported housing
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
- Engage stakeholders
- Review relevant services, capacity and barriers

Plan approved 5.28.21

IMPLEMENTATION PLAN
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- **Increase access** to community-based service options through policy, process, resources, tools, and **capacity building** efforts.

- Increase **individual awareness** about community-based service options and create **opportunities** for informed choice.

- Widen the **array of services** available, including more **robust housing-related supports**.

- Strengthen **interdisciplinary connections** between professionals who work in behavioral health, home health, housing, and home and community-based services (HCBS).

- Implement broad access to **training and professional development** that can support improved **quality** of service, highlighting practices that are **culturally-informed**, streamlined, and rooted in **person-centered** planning.

- Support **improved quality** across the array of services in all areas of the State.
Year-One Major Accomplishments

Shifted to centralized intake using the Aging and Disability Resource Link (ADRL) website and toll-free phone line linking people with disabilities to HCBS support.

- Provided **10,854 callers** with information and assistance about HCBS, which is an average of **905 calls** per month.
- Case managers responded to **1,744 referrals** for HCBS, which is an average of **159 referrals** per month.
- **48%** of HCBS referrals become **open cases**, which is an average of **76 new cases** per month.

**Diverted 268 new individuals from a SNF** by providing necessary services and supports so they can remain at home with their family and friends.

Provided state or federally-funded **HCBS to 3,143 unduplicated adults** in 2021.
Year-One Major Accomplishments

- Provided information about HCBS through options counseling visits to 936 TPMs referred for a long-term stay in SNF.

- Received 225 requests for transition support services. Transitioned 88 TPMs from a SNF to integrated community housing where they can receive necessary support while enjoying the freedom and benefits of community living.

- Provided permanent supported housing assistance to 28 TPMs who transitioned out of a SNF.

- Increased our administrative capacity to serve additional TPMs by adding three additional full-time case managers and ten community outreach specialists temporary FTE to conduct options counseling visit in hospitals and SNFs.

- Engaged with stakeholders to inform the strategies used to implement settlement agreement in a person-centered and culturally responsive way.
AGREEMENT STRATEGY & YEAR TWO BENCHMARKS

In-Reach & Outreach
Annual in-reach SNF and build peer support system

Person Centered Plans
Complete 580 plans with TPMs 50% (290) must be residents of SNF

Diversion
Within two years, divert 100 TPMs from placement in a SNF

Transition
Within two years, transition 100 TPMs from SNF to home and assist 30 new TPMs with permanent supported housing
Address need for more case management capacity to meet the increasing demand for HCBS

Address Qualified Service Provider workforce shortage

Implement the strategies outlined in the ARPRA 10% funding bill to enhance the HCBS delivery system

Streamline and simplify the QSP enrollment process
Contact Information

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