

**North Dakota Settlement Agreement  
with the  
US Department of Justice**



**Report of the Subject Matter Expert**

**November 2025**

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## INTRODUCTION

In December 2020 the State of North Dakota entered into a Settlement Agreement with the United States Department of Justice (USDOJ) resolving complaints alleging that the State failed to administer long-term services and supports to people with physical disabilities in the Most Integrated Setting appropriate, in violation of the Americans with Disabilities Act. The Settlement Agreement required the development and scheduled revisions of an Implementation Plan to identify benchmarks and timelines for meeting requirements, biannual data and progress reports by the State, and biannual reports from the Subject Matter Expert (SME). This report, the ninth biannual Compliance Report submitted by the Subject Matter Expert (SME), is for the recently concluded time period (December 14, 2024 – June 13, 2025).

This report focuses on multiple priority areas including Person Centered Planning. Section VIII of the Settlement Agreement focuses on Person Centered Planning, with specific benchmarks noted over the course of the Settlement Agreement. The Subject Matter Expert and his Team have made review of Person Centered Plans (PCPs) a priority in Years 4 and 5 of the Agreement, from both a compliance lens and continuous quality improvement perspective. As detailed in this report, as the State approaches the conclusion of Year 5 of the Settlement Agreement, it is clear that the State is in substantial compliance with the Person Centered Planning requirements established in the Settlement Agreement. The Parties and the SME are in agreement that the State has achieved substantial compliance on this core issue and will be formalizing this understanding in the near future.

The State continues to work on – and has improved – enrollment of Qualified Service Providers (QSPs) and their retention and provision of services over the long term. There remain areas of the State where it can still be difficult to find community providers and the State continues efforts for recruitment in those areas. There are several strategies in the State’s current Implementation Plan focused on this need.

Transitions continue, though at a lesser pace in this reporting period. Outlined later in this report are thoughts from the SME and the State on why that may be happening. Some transitions continue to take longer periods of time. Major sources of delay include medical challenges, housing, and issues of guardianship/cognitive capacity. A special focus of this report is on issues associated with guardianship and cognitive capacity.

The SME Team made two (2) site visits in North Dakota since its last report, visiting 29 Target Population Members, including those remaining in a Skilled Nursing Facility, those who have been diverted from institutional placement, and those who have returned to the community following a facility stay. Information about those visits is also included in the following pages.

The State of North Dakota has made and continues to make significant progress in meeting both the spirit and the letter of the Settlement Agreement with the USDOJ over the past four (4) and one-half years. While some challenges remain, there are hundreds of individual success stories. These success stories speak to the enhanced level of teamwork involved in supporting an unprecedented number of TPMs in North Dakota, many with increasingly complex barriers, to navigate the transition process and/or remain in the most integrated setting of their choosing while receiving adequate and high quality services and supports. In the last four (4) and one-half years, the State has diverted more than 1,300 TPMs from entering a Skilled Nursing Facility in addition to providing significant and quality transition assistance. During site visits, TPMs spoke very positively about State employees who assist them.

## **PERSON CENTERED PLANNING**

Core to the work being done by North Dakota as it serves Target Population Members (TPMs) is to ensure that appropriate planning is done for each individual to assist them in returning to the community, support their diversion from an institutional stay, and, if they choose to remain in a Skilled Nursing Facility (SNF), that they feel their needs are met and are aware they can return to the community with support at any time if their desires change. All TPMs, no matter their living status, have regular contact with State staff,

The SME Team has reviewed Person Centered Plans (PCPs) for hundreds of North Dakotans since the onset of involvement with the Parties in the Settlement Agreement. Over the course of the last five (5) years, the SME team has reviewed a total of 298 PCPs. The State was required to submit 1,565 PCPs by the end of Year 5. The 298 PCPs reviewed represents a 19% review rate. Of the 298 plans reviewed, 275 were found to be compliant. This is a compliance rate of 92.28%. The compliance rate has continued to trend up over time. In Years 3 through 5, of the 166 PCPs reviewed, 160 were deemed compliant – a 96.38% compliance rate. As mentioned in the Introduction Section of this report, a determination of substantial compliance is warranted and a process to formalize this understanding has been initiated.

## **TECHNICAL ASSISTANCE/QUALITY IMPROVEMENT**

The SME Team provides technical assistance to the State through its review of PCPs. In addition to evaluating for compliance, the team also seeks to offer the State suggestions on how to improve aspects of PCPs. This can include recommendations on enhanced risk assessments, contingency plans, and assuring that case managers and transition coordinators address each of the TPMs stated needs in plan goals. The SME Team also makes recommendations, when appropriate, to include more of the pertinent information found in detailed case notes into the actual plan.

Although a TPM's risks are identified earlier in the process of PCP development, the Health and Safety Plan developed to address the mitigation of those risks is not completed until the TPM is within seven (7) days of transition from an institution. Moving forward, the SME suggests that these plans be completed within an earlier timeframe in the process whenever possible so as to further ensure that risks are adequately addressed upon transition to a community setting.

## **SITE VISITS**

Members of the SME Team made two (2) site visits in this reporting period to engage with TPMs and gauge the effectiveness of services being delivered by the State. During the week of July 21, 2025, the SME Team visited with 19 individuals in the Bismarck, Mandan, and Minot corridor in the western part of the state. Those TPMs were primarily in SNFs and in the process of transitioning, though some community visits also occurred. The week of September 22, 2025, saw the SME Team in the eastern part of the state, visiting TPMs from Pembina (eight [8] miles south of the Canadian border) to Hankinson (seven [7] miles north of the South Dakota state line) and west to Valley City. The team visited 10 TPMs on this trip, with all but one (1) individual residing in a community setting and seven (7) having never been in an SNF setting, supported – some for decades – through Home and Community-Based Services (HCBS). Those TPMs visited have significant care needs including significant physical disabilities, traumatic brain injuries, and behavioral health disorders that add to the complexity of care.

Observations from the site visits include the following:

1. Many positive comments were made about the support TPMs receive from Transition Coordinators, Case Managers, and Housing Facilitators. Virtually all individuals knew the names of their Case Manager, Transition Coordinator, and Housing Facilitator (not all individuals had every service based on need). This speaks highly to the relationships that have been built by State staff. TPMs involved in transition also spoke to the value of the Money Follows the Person (MFP) grant.
2. Most service needs are being met at discharge from a Skilled Nursing Facility, including transportation, which in the past was a significant barrier.
3. TPMs who have not been institutionalized exhibit a great deal of independence and do not always rely on State provided transportation. Many have their own vehicles which have been adapted for their disabilities and can travel as needed or desired. Some require more assistance than others, but all express a freedom of movement in the community.
4. Securing the correct durable medical equipment in a timely manner can be a barrier to more rapid transition. The same holds true of the completion of home modifications. More efficiency and validation in determining individual need for equipment and in ordering is encouraged.

5. Those who have complex needs are at risk for longer SNF stays. This includes individuals who have a behavioral health challenge and physical disability, and those with significant physical disabilities, such as those with amputations and paraplegia. An increase in the use of inter-disciplinary teams and comprehensive planning for TPMs with complex needs is encouraged.
6. There remain comments from TPMs, at times, about the uncomfortableness of working with caregivers of different races, which could indicate bias. However, there were many instances where persons of color served as caregivers in community settings and no concerns were expressed. It is important for the State to remain aware of how this might affect individual cases in the provision of care.
7. Individuals who have strong familial support appear to be more successful with transitions. They have family members willing to provide care, advocate for their care needs, and put their “handyman” skills to work. That stated, there are also many TPMs in the community with and without family supports who have been very successful in remaining the community, some for decades. Two (2) individuals with whom the team visited had five (5) or more non-family caregivers providing 24/7 assistance.
8. The role/authority of a guardian or Power of Attorney was confusing to some, which can delay transition planning. It appears to be interpreted differently depending on the individual’s involved. Page 15 of this report suggests some activities that provide clarification on these issues.

## DIVERSIONS

Section XI – Transition Services of the Settlement Agreement, includes requirements that North Dakota must meet to be in compliance with diversion targets. By the end of Year 4 of the Agreement, the State was required to divert 250 TPMs from admittance to Skilled Nursing Facilities (SNFs). As reported in January 2025, the State had recorded over 1,300 diversions since the inception of the Settlement Agreement. They continue on the same pace, reporting this period an additional 158 TPMs diverted from Skilled Nursing Facilities.

<b>HCBS LONG TERM CARE (LTC) DIVERSIONS</b>	
<small>USDJ SETTLEMENT YEAR (DECEMBER 14TH - DECEMBER 13TH)</small>	
<b>UNDUPLICATED TOTAL NUMBER OF TPMs DIVERTED FROM A SKILLED NURSING FACILITY (SNF):</b>	<b>158</b>
<b>TOTAL MSP LEVEL B &amp; C TPM DIVERSIONS:</b>	<b>20</b>
<b>TOTAL HCBS MED WAIVER TPM DIVERSIONS:</b>	<b>138</b>
<b>TOTAL SPED TPM DIVERSIONS:</b>	<b>38</b>

*(Aging Services DOJ SA Dashboard [December 13, 2024 – June 14, 2025])*

## TRANSITIONS

In the most recent reporting period, the State indicates that 33 people have transitioned to integrated care settings. Ninety-eight (98) people were referred to transition during the period, but not all signed consent to participate in the transition process (*Aging Services DOJ SA Dashboard [December 13, 2024 – June 14, 2025]*). Of the 55 TPMs who signed consent, six (6) closed prior to transitioning, leaving 49 individuals active in the transition process. Cases close for various reasons, often due to death or the individual decides they are not ready for transition at the current time.

The Settlement Agreement requires the State to transition 70% of the TPMs that were referred for transition support by 12/13/2026. The State transitioned 67.3% in this reporting period. Five (5) additional TPMs transitioned, but they had also previously transitioned within the last four (4) years of the Settlement Agreement so they were not counted in reporting below.

<b>TPM TRANSITION REFERRALS COMPLETED SUMMA</b>					
<small>USDJ SETTLEMENT YEAR (DECEMBER 13TH - DECEMBER 13TH)</small>					
<b>TOTAL TPM TRANSITION REFERRALS THAT COMPLETED TRANSITION:</b>					<b>33</b>
TRANSITIONS	TOTAL	%	BY GRANT POPULATION		
			DD	ELDER	PD
MFP	31	94%	1	20	10
TRANSITION & DIVERSION PROGRAM	2	6%	0	0	2
HCBS MW COMMUNITY TRANSITION	0	0%	0	0	0
TRANSITIONS W/OUT COMMUNITY SUPPORTS	0	0%	0	0	0

(*Aging Services DOJ SA Dashboard [December 13, 2024 – June 14, 2025]*).

## DECREASE IN REFERRALS/COMPLETIONS

Based on a half year mark in the current reporting year (Year 5 of the Settlement Agreement) there has been a decrease in the number of individuals referred for transition and the number of people who have successfully transitioned. The State has anticipated that the number of individuals transitioning would decrease over time for two (2) reasons: (1) The number of individuals ready to transition more quickly have been served and returned to the community. Others who are considering transition are moving more slowly because of additional significant barriers. (2) The State continues to increase the number of diversions that have been accomplished, allowing people to remain in the community prior to ever entering a Skilled Nursing Facility. Many of those people have been served through HCBS for decades and many others have learned of available services in recent years, providing them new options to remain at home instead of seeking institutional care. A comparison of transition numbers at the end of Year 5 will provide a more complete picture.

## TRANSITION DELAYS

There continue to be TPMs for whom transition is more difficult and takes more time. Housing remains the primary reason. There are many individuals who do not want to move to a community where more housing and providers are available and have chosen to remain in the institution until additional housing and provider options are developed and they can live in the area of their choosing. Home modifications can also delay transition, though the State has already exceeded the number of home modifications in this reporting period than were completed in all of the Year 4 reporting period (39 versus 29). It is expected that with the new contract with ND Assistive as the QSP of record for contractors (employing the Home Modification Capital Fund) that this number will continue to grow. It should be noted that many home modifications cost tens of thousands of dollars and are not able to be completed in an expeditious manner.

The State has funding associated with a Money Follows the Person Rebalancing Project approved by the Centers for Medicare and Medicaid Services (CMS) to assist in the completion of home modifications. The State contracts with a vendor – ND Assistive – to manage projects with contractors and allow them to be paid as the home modification project is undertaken, the Home Modification Capital Fund. ND Assistive, after project completion, then bills Medicaid to restore authorized and expended resources to the fund. This allows for more contractors to consider involvement with the State without having to become a QSP on their own. The fund will replenish itself over time, excluding an administrative fee paid to the managing vendor.

The Department of Health and Human Services has asked for support from the ND Legislature each biennium for funds to support housing assistance for TPMs. In the 2025 Legislative Biennium Session, North Dakota made that fund permanent. The Department has been allocated \$300,000 each biennium to assist individuals with housing supports. The permanence of this fund can assist in locating and securing appropriate housing for TPMs to return to the community. The State estimates that this fund provides 375 months of subsidized rental assistance to help people return to or remain the community.

There are a significant number of TPMs with behavioral health issues (a reported 30% of all TPMs) making it difficult at times to find providers who will work with them or who will remain with them after beginning to work with them. There are those in SNFs who may or may not want to transition with similar presenting issues. The State has a number of strategies in place that they are developing and implementing to provide more support for caregivers and providers. These include interagency staffings with the Human Service Center regarding particular clients and the provision of train-the-trainer information to agency QSP leaders from behavioral health specialists to enhance their knowledge of behavioral health needs and how to address them, increasing the skill base of more QSPs to successfully serve TPMs who present with these challenges.

The SME Team met with individuals during their onsite visits who have significant behavioral health and Traumatic Brain Injury needs. Those who were visited in community settings were at times, though certainly not always, in an Adult Agency Foster Care (AAFC) setting. There are 12 AAFCs across the State. Each home has no more than four (4) individuals in a shared living environment and it is reported that several are not at capacity. This is “home” for the TPMs who reside there, with additional staff support. They are able to engage in the community and have choice in who their roommates are. The settings visited by the SME Team seemed appropriate for the particular TPMs, based on higher levels of need, and appear to be the most integrated setting for them at this time.

North Dakota started a pilot program around Peer Support Services, having a peer as part of the Transition Team in the Minot region with the Center for Independent Living. A peer will be deployed with every TPM seeking transition, particularly those that do not have family support. It is hoped that this pilot will ensure that there is additional and ongoing support for TPMs returning to the community. If successful, the State will look to expand this pilot to other areas of the state.

### **TRANSITION AND DIVERSION PROGRAM**

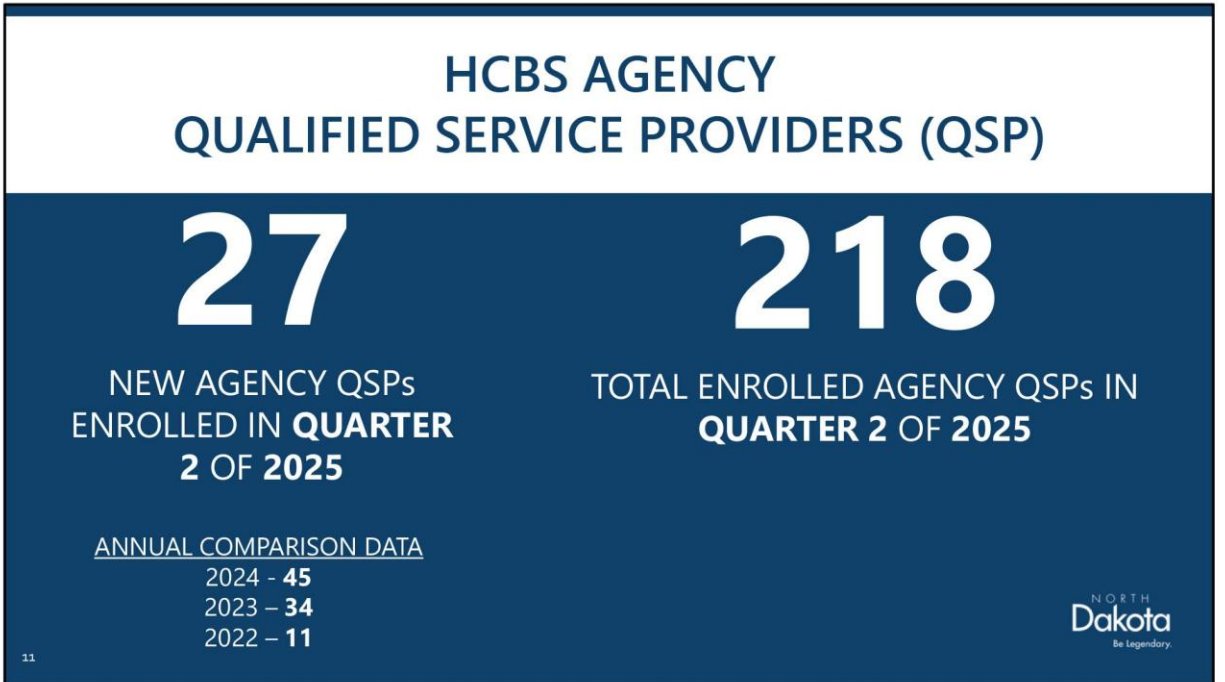
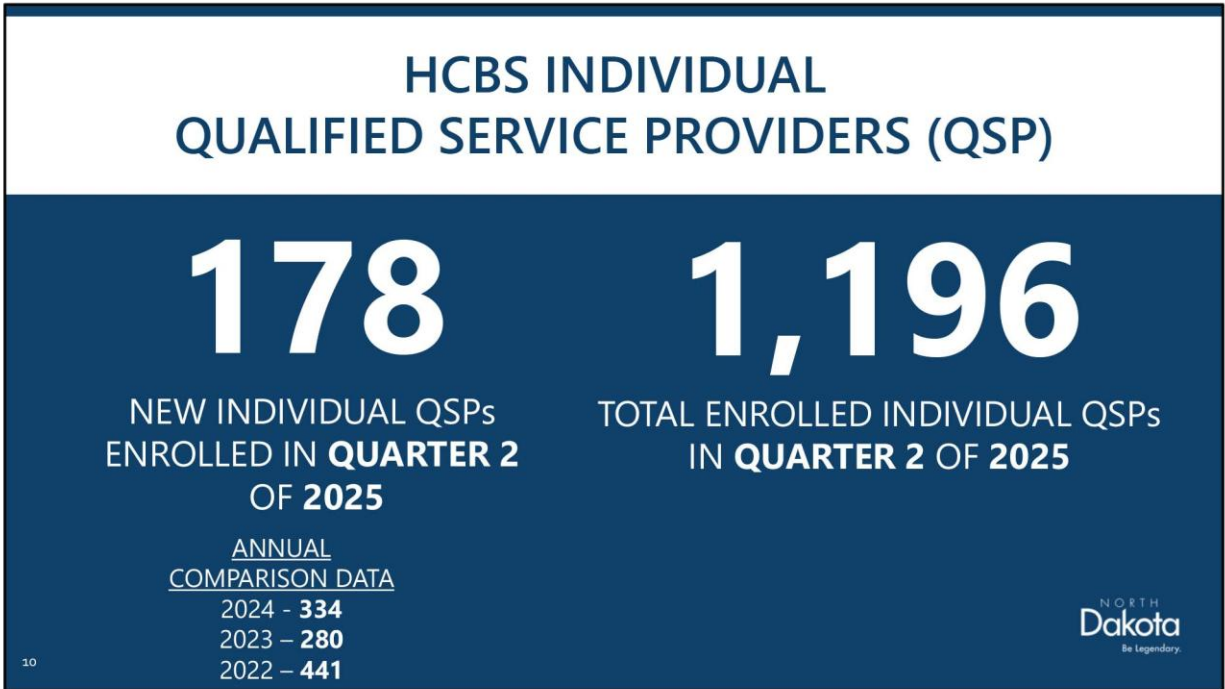
For the past several years, the State has operated a Transition and Diversion Pilot Program, using funds from the American Rescue Plan Act (ARPA) of 2021, to increase the number of people that can be transitioned. This program has been very successful. Funding through ARPA ends in June 2026. The ND State Legislature, in its’ most recent session, has made the program permanent, removing “Pilot” from the title, and will continue to fund these services as an addition to the Money Follows the Person program to help people remain at home with HCBS or return to the community from an institutional placement. The individuals served by this Transition and Diversion Program do not qualify for Money Follow the Person services. Service needs are less intensive and program assistance is provided for a shorter period of time. The pilot program began during the Covid pandemic. It allows the State to assist people more quickly who have entered a SNF, removing the requirement of a 60-day stay before intervention.

### **QUALIFIED SERVICE PROVIDERS (QSPS)**

#### **QUALIFIED SERVICE PROVIDER POOL**

North Dakota works continuously to expand its provider pool to serve more TPMs in the community. As the number of individuals wanting to remain at home instead of moving to institutional care increases, the number of Qualified Service Providers (QSPs) must also increase. The Adult and Aging Services Section of the ND Department of Health and Human Services publishes a Key Performance Indicator Report following each calendar quarter for the year

(<https://www.hhs.nd.gov/sites/www/files/documents/Adult%20and%20Aging/kpi-report.pdf>). In the second quarter of 2025, the State reports the following:



The State continues to engage new providers in serving TPMs. Individual QSPs, which also include family members, saw 178 new providers enroll in and offer services to Target Population Members. And, as noted in the graph, an additional 27 new QSP agencies enrolled. Many of the QSP agencies are small, serving a limited number of TPMs.

The State has been auditing QSP agencies, in particular, and works diligently toward not only assuring compliance to regulations for such agencies, but also toward continuous quality improvement. This is monitored through case management contacts with TPMs, Critical Incident Reports, and feedback from clients. The State, in such monitoring, has ended relationships with seven (7) agencies in this quarter for ineffective provision of services to TPMs (quality concerns) or billing issues, while welcoming new agencies to offer care. It is reported that some new agencies formed cannot, once clients are assigned, manage the requirements of the work they need to perform. The State also terminated relationships with five (5) Individual QSPs for similar reasons.

QSPs must verify that they can meet HCBS competency standards in order to provide services. In the case of individual QSPs, they must meet with a nurse who can sign off that they have verified the person who desires to be a QSP meets standards. In the case of agency QSPs, the agency is responsible for ensuring that each staff member meets necessary requirements.

### **QSP RETENTION**

In the past, retention of Qualified Service Providers was a concern for the State under the Settlement Agreement. That no longer appears to be of significant concern to the SME Team. There are some QSPs who leave service following the death of a TPM or a move to a higher level of care than can be provided in the home. These are most often family members caring for a loved one. The State has made efforts to encourage family providers to offer their services to others following the change in status of their services. To date, the outreach from the State to re-engage such persons has not borne fruit. The State continues, through the QSP Resource Hub, to follow up with such individual providers in an attempt to engage them. With that said, it should be noted how many QSPs have been retained in this reporting period. Again, according to the Key Performance Indicator report (<https://www.hhs.nd.gov/sites/www/files/documents/Adult%20and%20Aging/kpi-report.pdf>) the State notes the following:



An enhanced provider retention level speaks to the streamlined processes the State has put in place to enroll QSPs and the work of the QSP Resource Hub and the Adult and Aging Services Section to provide supports necessary for QSPs to remain successful. At the end of each Settlement Agreement year, the State provides comparison data year-over-year that provides retention level data. The next Biannual Report from the State and the subsequent SME Report (January and May 2026, respectively) will provide additional information.

**QSP ENROLLMENT**

In 2024, the State moved the enrollment of Qualified Services Providers back “in house” from a third party vendor that had been contracting for this activity on behalf of the State. In doing so, the State changed (modernized) the enrollment process to an online portal, shortening by weeks and sometimes months the amount of time required to enroll as a QSP. By moving to a fully electronic system, complete with prompts for required documentation, the process has been significantly refined. Three (3) State staff handle applications through the portal, streamlining the previously paper-based process. The system guides users through eligibility questions and includes video tutorials and tool tips to support first-time application completion. Required training, such as Fraud, Waste, and Abuse training and the QSP orientation, is also included within the portal.

There were a total of 120 applications processed in the second quarter of 2025. One hundred and five (105) individual applications were submitted and reviewed; 77 were approved within an average of 15 days. Fifteen (15) agency applications were submitted

and reviewed, and six (6) were approved within an average of 15 days. The average combined time for individual and agency applications to be approved is 23 days.



The reported length of time to enroll as a QSP has increased slightly in this reporting period from the end of Year 4 of the Settlement Agreement. The Medical Services Division of the ND Department of Health and Human Services manages the enrollment of QSPs. By State report, processing times were longer in the first two (2) quarters of 2025 due to an increased volume of applications and a higher number of providers applying for services with more complex enrollment requirements. Enrollment staff report seeing an increase in applications for residential habilitation and community support agencies, nursing services, and from individuals seeking to offer respite through adult foster care provided in private homes, which requires the extra step of getting a criminal background check.

### **COGNITIVE CAPACITY/GUARDIANSHIP**

Based on personal visits and extensive record reviews, the SME notes that an increasingly common impediment to more timely transitions arises when a TPM lacks the capacity (or someone else believes or suspects that the person lacks the capacity) to make the decision to transition and to plan for the services that would make the transition successful.

### **TPMs WITH GUARDIANS**

For a TPM who has been determined by a judge to lack capacity to make such a decision and for whom a guardian has been appointed, the impediment may be the opposition of

the guardian to transition for the individual. Such opposition may reflect a lack of awareness of or a mistrust of community-based services, reflecting or reinforcing a reliance on the perceived dependability of a facility. The Transition Team may be aware of how to arrange community-based services to appropriately meet the individual's needs, which would provide a more inclusive and less restrictive setting for the individual, but this may not be deemed sufficient to address the guardian's concerns. In these situations, the guardian's position is typically taken as a final decision and transition planning is terminated.

Under North Dakota law, a guardian is required to "safeguard the civil rights and personal autonomy of the ward to the fullest extent possible" and to ensure "the ward's maximum personal freedom by using the least restrictive forms of intervention and only as necessary for the safety of the ward or others" ([North Dakota Century Code Title 30.1. Uniform Probate Code at Subsection 30.1-28-12](#)). We note with appreciation that the State is taking a step towards addressing the impasse of such situations by developing informational materials in a "FAQ" format that will explain an individual's right to challenge the decision of a guardian or the suitability of that guardian to continue to serve in that capacity. The State will assist individuals in communicating with the court. If, during the course of an investigation by Adult Protective Services, a determination is made that a guardian should be appointed they will, if absolutely necessary, petition for guardianship. Consistent with the State's Year 5 Implementation Plan, additional educational materials and opportunities will be developed.

We encourage the State to consider taking a few further steps, though not required by the Settlement Agreement. For instance, the State could offer technical assistance or consultation to the individual with a disability or an available family member or friend willing to pursue such a review. Further, the State could consider formal or informal intervention on its own to protect the TPM's rights and interest if no one else is available to do so. Such action might be initiated by Adult Protective Services, the Long Term Care Ombudsman, the newly-authorized state Office of Guardianship and Conservatorship, or others designated by the State.

### **TPMs NOT UNDER GUARDIANSHIP**

When a TPM is not under guardianship but is *believed* to lack capacity to make and follow up on a decision to transition, other impediments arise due to various factors:

- a. There is confusion as to who has the authority to override the wishes of the TPM and halt or delay transition planning based on a *concern* about capacity. Is this the prerogative of an attending physician, a social worker, a facility administrator? The transition coordinator or team? Decisions to delay or deny transition in such situations are being made by various players and are typically made with the best interests of the individual in mind, but it is not clear who has the authority to do so if an appropriate transition plan can be developed.

- b. A common response when such a concern is raised is to request a neuropsychiatric evaluation to determine the person's competence. While this may be an appropriate step, it can seriously delay a transition (or the planning for a transition) because these are not quickly obtained. While waiting, the TPM is typically treated as lacking competency, even though the presumption in law is that an adult is competent until a court decides otherwise.
- c. A family member or friend might consider seeking guardianship or a less restrictive option that would allow that person to make the transition decision on behalf of the TPM – but this is a complicated and expensive process and may not be feasible without financial and technical assistance. In the absence of such a volunteer, no state actor appears to be available to fulfill this need. The question of who should be the petitioner is complex in some cases. There is a Guardianship Establishment Fund that is available to offset the court costs. However, the resources in the fund have been insufficient to fulfill all requests. The State generally expends the available funds in a Legislative Biennium within the first year.
- d. In a few cases, a TPM may have executed a Power of Attorney (PoA). There is confusion and misunderstanding about the role and authority of the person designated as the PoA. Facility staff or a social worker may mistakenly presume that in such a case the PoA is the *only* person who can make a transition decision, as if by executing a PoA the TPM had given up his or her own authority to do so. A PoA or other advance directive focused on *medical* decisions may well not extend to *placement* or *service* decisions. In some cases, a PoA may not become effective until a determination of incapacity has been made by more than one medical professional. Lack of knowledge or misunderstanding of these issues can lead to inappropriate delay or denial of transitions.

Situations in which an individual may not have strong decision-making skills are especially suitable for encouraging the use of supported decision-making agreements. Such individually-tailored arrangements are provided for under North Dakota law (Chapter 30.1-36 of the ND Century Code) and would allow a TPM to designate trusted others to assist the person in making a transition decision and implementing it, while avoiding arrangements such as guardianship that would take away the person's right to make their own decision. Under North Dakota's probate code, supported decision-making agreements or other alternatives should be considered before the appointment of a guardian.

## RECOMMENDATIONS

To overcome these transition barriers, the SME recommends:

- Formation of a broad-based task force, including non-State members with expertise in these areas, to explore these issues, develop and/or review drafts of informational

materials, and develop other recommended actions and solutions. There should be clear timelines for the outcomes expected of the task force.

- It is suggested that the State provide training, technical assistance, and informational materials, in consultation with or based on the work of the task force, for individuals, family members, transition staff, and others, to encourage actions in support of TPMs and to avoid misunderstandings that impede transitions. The SME Team acknowledges the challenges for the State in balancing a TPM's right to choose while addressing and adhering to health, safety, and welfare needs and obligations as required by Medicaid. The determination of the Most Integrated Setting, for at least a few individuals, can be difficult to ascertain while balancing these requirements. Parties involved in transitions can be encouraged to give TPMs the benefit of the doubt with respect to capacity until someone with appropriate authority makes a clear decision that the person lacks the capacity to make such decisions. The SME is available to assist the State when considering individual cases to provide additional expertise in determining how to balance competing considerations.
- Explore and publicize the availability of supported decision-making arrangements for the benefit of TPMs who would benefit from such support in the transition process. This includes those for whom the lack of capacity has been questioned but not determined and determinations about if the TPM can make an informed choice for a supported decision-maker when these questions persist. The State is hopeful that the recently initiated peer support pilot program can, eventually, be expanded to help assist with this issue. The State is also planning future discussions with the LTC Ombudsman and others to create further education around these issues. Strategies are noted in the Year 5 Implementation Plan and should be extended and brought to completion within Year 6.

## DATA REPORTING

Over the course of the last 18 months, the State has focused significant effort on determining authorization and utilization patterns for HCBS offerings across the State. To that end, they worked with the research team at the University of North Dakota to collate and analyze data to better understand where there may be gaps in services.

Beginning on Pg. 79 of the most recent [Biannual Report](#) from the State, there is information about this work and the analysis completed. It continues in detail in Appendix A of the State's Biannual Report.

There is acceptance of the soundness of the process used to review the data. The State's process focused on ensuring that everyone included in the review matched the same inclusion criteria. There could be benefit from ongoing analyses of this nature and strategic planning around areas where greater variances in care are noted. Data Reporting will be a topic of future SME Reports.

## WAIVER AMENDMENTS/RULE CHANGES

North Dakota has requested amendments to its 1915(c) Waiver for Home and Community Based Services (HCBS), which is done on a regular basis. The purpose of the current amendment is to implement changes in services and programming to improve access to home and community-based services and update language changes related to internal processes. The amendment would implement rate changes approved by the ND Legislature and update the rate methodology for Adult Residential Care, by rebasing rates according to updated cost reports in 2026 and 2027. The amendment would update language to allow for quarterly monitoring visits by State-employed case management to be completed via telephone. Additionally, provider limits would be updated to further clarify provider qualifications under Family Personal Care, Supervision, Waiver Personal Care, and to avoid duplication of services under HCBS Care Coordination. The State consulted with several other State departments and divisions, notified Tribal leadership of proposed changes, and held a public comment period before submitting proposed changes to the Centers for Medicare and Medicaid Services.

Included in the waiver request was information from the 2025 ND Legislative session where a targeted rate increase for services with the highest need was approved. The targeted rate increases were based on a comprehensive rate study of in-home providers and benchmark wages for providers in states across the region. The comprehensive study revealed that some of North Dakota's rates lag behind states in the region. The targeted rate increase was approved for the services of Extended Personal Care, Nurse Education, Homemaker, Chore, Respite Care, Supported Employment, Transitional Living, Companionship, Non-medical Transportation Escort, and Supervision to bring ND providers up to a comparative rate. Additionally, the 2025 ND Legislature approved updating the rate methodology for rebasing the rate for Adult Residential Care service based on updated cost reports. Rates will be rebased in January 2026 and January 2027 to reflect the rates indicated in the cost reports.

The State has proposed waiver amendments and rule changes to the ND Administrative Code that affect payment to providers offering Family Personal Care. Family Personal Care is provided by an individual who lives with the client on a 24 hour basis. The State has defined what services can and cannot be provided under Family Personal Care. A primary change is that the Department may not approve supervision services to be delivered by a provider who lives in the same home as the eligible individual. Services are capped at 10 hours per day.

The State has also developed rules related to Target Population Member rental assistance. Rental assistance is designed to temporarily support a TPM receiving HCBS who would otherwise receive services in a Skilled Nursing Facility and are on a waiting list for federal assistance. The proposed rule allows the State to cover the rental funding gap for the TPM

and housing facilitation services, which can include home modifications and assistance with locating a new affordable and accessible residence in the community.

The final rule change proposed by the State moves the Transition and Diversion Pilot Project to a permanent community program – Community Transition and Diversion Program. As noted earlier in this report, the ND Legislature made funding provision for this to become a permanent program in the State based on the success of the pilot. Services that are able to be delivered for transitions mirror those of the Money Follows the Person program. The Community and Transition Diversion Program extends services to other individuals, including those eligible for Developmental Disabilities program management, Developmental Disabilities Waiver, ND Medicaid State Plan Personal Care, Service Payments for the Elderly and Disabled (SPED) Program, Expanded SPED, Medicaid Waiver for Home and Community-Based Services, Children’s Hospice Waiver, Autism Spectrum Disorder Waiver, and the Medically Fragile Children's Waiver.

## **CONCLUSION**

The State continues to make significant progress toward meeting requirements of the Settlement Agreement. As has been noted in this report by the SME, one significant development is the State’s compliance with the Person Centered Planning requirements of the Settlement Agreement. Additional requirements of the Settlement Agreement will be reviewed during the next year to determine the status of the State’s compliance efforts.

The number of diversions from institutional placement continues to grow. This appears to have a correlation with the number of transitions having lessened, as fewer people are in an institutional placement. For those individuals requesting transition to move back to the community, the State continues efforts to ensure that those transitions happen safely and as efficiently as possible, even as the complexity of cases and multitude of challenging barriers continue to grow.

The State continues to work on the more than 100 strategies that are contained in the Implementation Plan that address every requirement of the Settlement Agreement. Some strategies are longer term and are addressed and updated over time to continue to ensure that needs of TPMs are being identified and met effectively. Other, newer strategies, have evolved from previous work that has been successfully implemented in improving the State’s HCBS system to allow for further refinements. The attention paid to making and sustaining system changes, the attention to eliminating roadblocks of any kind, and the attention given to ensuring quality services are provided by the State and its contractors is commended and lays groundwork for meeting further challenges on the road ahead.