

North Dakota Settlement Agreement with the US Department of Justice



Report of the Subject Matter Expert

October 2026

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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 eleventh biannual Compliance Report submitted by the SME, is for the recently concluded period (December 14, 2025 – June 13, 2026).

During this period, the Subject Matter Expert (SME) Team has been conducting key informant interviews with dozens of stakeholders across North Dakota. The team has conducted interviews at various intervals over the last five (5) and one-half years to gain a more comprehensive view of the service system and to get a sense for how the service system partners are doing, what they feel the benefits of the Settlement Agreement have been, and where challenges may still lie. One constant in these discussions over time is the impression that the Settlement Agreement has been a “game changer.” The genesis of culture change and its implementation in North Dakota began prior to the signing of a Settlement Agreement with the USDOJ. However, the Settlement Agreement significantly accelerated the movement toward enhanced home- and community-based service options and availability.

The State of North Dakota has demonstrated significant and continual progress toward meeting the goals of the Settlement Agreement with the United States Department of Justice. Over five (5) and one-half years into an agreement that currently carries an eight (8) year term, the State has transitioned more than 600 Target Population Members (TPMs) and diverted nearly 1,800 from institutional care. Recently, the State proposed an amendment to narrow the scope of the Settlement Agreement. Although this proposal remains under consideration at the USDOJ, for the time being the narrower scope of work will be the focus for the State. The proposed narrowing includes the deletion of two (2) sections of the Settlement Agreement in their entirety (Section VIII, Person-Centered Planning, and Section X, Information, Screening and Diversion). It has been determined that the State’s work in these two (2) areas has met the target of substantial and durable compliance. The State will continue to focus on multiple priority areas including Case Management (Section VII of the Settlement Agreement), Transitions (Section XI), and Qualified Service Providers (Sections IX and XIII). Other sections of the agreement have been reduced in scope, such as the reporting of critical incidents moving from a weekly reporting requirement to a quarterly reporting requirement.

One important element of the more narrowed version of the Settlement Agreement is that the term of the agreement is being considered for a reduction from eight (8) years to seven (7) years. Year 7 ends on December 13, 2027, just 15 months from the writing of this report.

As such, the State's Year 6 and 7 Implementation Plan, which has just been completed, may be its final Implementation Plan.

The focus of the revised Settlement Agreement, the State's Implementation Plan, and this Subject Matter Expert report is on the challenges that remain. The most significant of these challenges include case management capacity, which is being strained in the midst of rising caseloads and increasingly complex cases. The level of case complexity aligns with other challenges that include behavioral health service gaps and Qualified Service Provider (QSP) competency, training, and quality. In many jurisdictions throughout the nation, with areas of North Dakota being no exception, housing availability, accessibility, and affordability also remain a challenge.

Review of the State's proposed Implementation Plan reveals updated strategies designed to identify the next necessary steps to move ever closer to substantial and durable compliance with the entirety of the Settlement Agreement. It is important to keep in mind that an additional bridge requires building. As the aging of the Baby Boomer Generation continues and more people seek to remain in the community instead of entering institutional care, the State of North Dakota will also need to focus on continuing to strengthen its service delivery system infrastructure in readiness for the delivery of home- and community-based services (HCBS) far beyond the term of this Settlement Agreement.

This report highlights both accomplishments and areas in need of strengthening, and offers suggestions for the State's consideration to further address the challenges that remain.

CASE MANAGEMENT

To provide effective home and community-based services to Target Population Members in North Dakota, there are two (2) groups of individuals essential to that success. The first of these are case managers, the second QSPs. There are currently 79 members of the case management unit; 66 full-time, five (5) part-time, and eight (8) supervisors. Everyone in the unit, including supervisors, manages a caseload (*DOJ Implementation Plan Key Performance Indicators, Adult & Aging Services, Reporting Period April 1, 2026 – June 13, 2026*).

During the course of this reporting period, the SME Team hosted key informant interviews with case managers and supervisors from across all eight (8) territories in North Dakota, meeting with approximately 20% of these staff. Interviews with case managers reveal experienced service system members that are highly committed to helping individuals with physical disabilities and older adults remain safe in or return to their homes and communities. Staff consistently described their work as rewarding but increasingly complex due to growing behavioral health needs, medically complex referrals, housing

instability, workforce shortages, administrative burden, and increasing demand associated with an aging population.

A recurring theme throughout the interviews was that the traditional HCBS system is now serving a significantly different population than in previous years. Many individuals have co-occurring physical disabilities and serious behavioral health conditions, including substance use disorders; cognitive impairments; unstable housing; and limited informal supports. Case managers expressed concern that current staffing levels, provider training, and system infrastructure have not evolved quickly enough to meet these changing needs, though acknowledging as well that constant efforts are made by State administrators to address all of these areas.

CLIENT COMPLEXITY

Case managers consistently reported that the population they serve has become substantially more complex, noting across interviews the following:

- Approximately half of many caseloads involve individuals with behavioral health issues including depression, anxiety, and more significant mental health/substance use disorders in addition to physical disabilities.
- Younger adults with physical disabilities are presenting with increasingly complex medical and behavioral health needs.
- Transition referrals from hospitals and skilled nursing facilities (SNFs) are becoming more medically complex.
- More referrals involve individuals with developmental disabilities in combination with physical disabilities.
- Many clients have little or no informal support system, causing case managers to function as “life managers” rather than solely as care coordinators.
- Basic needs – including housing, transportation, food security, and social supports – remain unmet for many individuals without intervention by the State.
- Several case managers noted that HCBS services are most successful when behavioral health conditions are adequately stabilized. Without appropriate mental health and substance use treatment, community-based supports often struggle to maintain an individual in the community or prevent repeated crises.
- Significant poverty in tribal communities creates additional barriers to successful community living.
- Individuals leaving facilities often underestimate what supports they will need once they return home.

CAPACITY AND CASELOADS/ADMINISTRATIVE BURDEN

The SME Team has been focused on caseload size and capacity of current staff for several years, particularly as the complexity of clients continues to increase. Although every case manager and supervisor interviewed reported a strong commitment to the work they were doing, they did note concerns – some for themselves and some for their colleagues.

Among those is that the increasing workload is outpacing staffing increases. Since the beginning of the Settlement Agreement, the State has added an additional 15 HCBS case managers, a 24% increase in staff, requesting additional staff each biennium from the North Dakota Legislature. Despite adding additional staff, the need continues to grow. The SME has recommended that the State could use at least an additional 10 case managers this year and has spoken with executive leaders in the Department of Health and Human Service (DHHS) to share that recommendation. A request was included for consideration in the DHHS budget regarding this recommendation, but it will be some time before it is known if it will be included by the Governor's Office in presentation of the Governor's Budget to the Legislature. The Legislature begins its next session in January 2027.

North Dakota uses a weighted case management rate to determine an appropriate caseload for staff. Weighted caseloads take into account the distance that must be traveled for home visits to complete assessments and Person Centered Plans and the complexity of the case. The State has long had a goal of 100 – 110 as its average weighted caseload. During the course of the Settlement Agreement that goal has never been achieved, despite the additions of staff over time. The current average weighted caseload is 119 (*DOJ Implementation Plan Key Performance Indicators, Adult & Aging Services, Reporting Period April 1, 2026 – June 13, 2026*), with some case managers reporting that depending on the month or any staff vacancies rates as high as 130 – 140 are experienced. Staff report that this leads to a growing concern regarding burnout.

The State is working on several strategies to address concerns of hiring challenges in rural communities, anticipated retirements in coming months of experienced staff, and delays in the hiring process that contribute to temporarily heavier caseloads. There is also consideration for making some visits with TPMs virtual based on the services being received (e.g. homemaker, emergency response services) where there is less need for greater case management involvement. The State has also added the Aging and Disability Resource Link (ADRL) to the intake process. At initiation of a request for service, ADRL staff will gather necessary financial information to determine eligibility. This will take that burden off the case manager and hopefully reduce the number of pending cases that have occurred in the past while waiting for documentation. Finally, there is consideration regarding rural sign-on bonuses with a caveat of a two (2) year commitment to work. Interviewees emphasized that even organizations currently fully staffed remain concerned about future recruitment and the increased desire of people to remain in the community rather than moving to a Skilled Nursing Facility.

The burden of administrative responsibilities was consistently identified as reducing time available for direct client interaction. Many of the documentation requirements are driven by regulations across different federal requirements (Money Follows the Person, Centers for Medicare and Medicaid Services) that states must adhere to in order to maintain compliance for the program and qualify for federal financial participation.

Common concerns stated by case managers include:

- Documentation consuming 60–65% of work time.
- Extensive assessment and documentation requirements for new referrals. Every person referred to HCBS is contacted regarding an assessment for services. Case managers note that a thorough assessment takes between four (4) – six (6) hours to complete including visit time and documentation requirements.
- Therap, the electronic case management system, is cumbersome in spots, as are all Software as a Service (SaaS) electronic health records. The State has spent significant time and resources working with the vendor to make the system the best it can be for North Dakota, but there are still many steps and many screens that must be taken/accessed to complete work.

Documentation requirements grow, sometimes significantly, as a result of regulations that the State must adhere to in the provision of services, both programmatically and administratively. These additional changes tend to increase documentation that must be provided to ensure that regulations are met with the Centers for Medicare and Medicaid Services and as a deterrent to concerns of fraud, waste and abuse. These increasing requirements add to the amount of time that must be allotted to documentation, which translates to less time for direct contact between Case Managers and Target Population Members.

While it is possible to do electronic documentation in the field, case managers noted that it is something they may not prefer to do as it can take away from the experience with the client if the case manager is more focused on a computer than the person. They also noted that there is a wide variation in documentation efficiency among case managers – with some much more comfortable managing electronic system requirements than others.

Several case managers stated they wished they had substantially more time to spend directly with clients rather than completing documentation. The State has been moving to a “mailroom” for Adult & Aging Services that replicates what other divisions in the department are doing. Staff are assigned to assist case managers in addressing paperwork requirements, sending notices, and tracking some documentation – clerical functions that don’t require the skill set of a licensed social worker (case manager) to complete. This was first piloted with two (2) of the HCBS case management territories and was well received. A third territory was recently added to the workload of this group and it is the plan that eventually all eight (8) case management territories will have this level of support.

OPPORTUNITIES FOR IMPROVEMENT

Case managers, supervisors, and the SME have noted opportunities for improvement to further assist the case management unit – none of them are new and some level of attention is being paid to all of them. North Dakota is committed to ensuring that its home

and community-based service system is able to meet the needs of all citizens that qualify for assistance. Consistent priorities for improvement include:

1. Expand behavioral health services and long-term supports.
2. Increase behavioral health training for case managers, individual QSPs, and agency providers.
3. Increase case managers understanding of available behavioral health services for individuals who qualify for services for Serious and Persistent Mental Illness.
4. Improve coordination of care between the Behavioral Health Division and the Adult & Aging Services Section for individuals with co-morbidity.
5. Recruit and retain additional case managers, particularly in rural regions.
6. Reduce administrative burden through clerical support and technology improvements.
7. Strengthen provider competency standards and oversight.
8. Improve communication with the Medical Services Division.
9. Enhance hospital and facility discharge planning coordination.
10. Increase access to stable, affordable housing.
11. Prepare strategically for increased demand associated with the aging population and growing case complexity.

The interviewees reflect a dedicated workforce navigating an increasingly complex service environment. Case managers consistently expressed pride in supporting individuals to live successfully in their communities while also acknowledging that today's clients present significantly greater behavioral health, medical, social, and housing needs than in the past. Sustaining a high-quality HCBS system requires even more investments in workforce development, behavioral health integration, provider training, administrative support, housing resources, and improved cross-system coordination.

QUALIFIED SERVICE PROVIDERS (QSPs)

ENROLLMENT & RETENTION

The capacity to provide effective HCBS lies with having a sufficient and competent number of Qualified Service Providers (QSPs) available statewide to serve Target Population Members (TPMs). Section XIII.A. of the Settlement Agreement requires that the State take necessary steps to ensure an adequate supply of qualified, trained community providers to enable TPMs to transition to and live in the Most Integrated Setting. In 2024, the State moved enrollment activities back "in-house" to the DHHS Medical Services Division and modified those activities so the entire process could be completed electronically. Since that time, the State has kept a close watch on the effectiveness of this activity, with the goal of enrolling and revalidating all QSPs within 15 days. In the latest Key Performance Indicators report (*DOJ Implementation Plan Key Performance Indicators April 1, 2026 – June 13, 2026*) the State reported the following:

HCBS QUALIFIED SERVICE PROVIDERS (QSP) ENROLLMENT

17 days – Individual
59 days - Agency

AVERAGE LENGTH OF TIME TO
APPROVE QSP APPLICATIONS IN
QUARTER 2 OF 2026



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The length of time to process enrollments has increased in the first two (2) quarters of 2026 for both individual and agency applications. In December 2025, the State reported an average of 11 days for individual enrollment and 33 for agency enrollment. The State has indicated that processing time is longer in 2026 due to a continued high volume of applications and a higher number of providers applying for services with more complex enrollment requirements. While it may add to the length of time to have a continued high volume of applications, it also reflects that the recruitment efforts that the State has engaged in have proven fruitful. Additionally, the time it takes to complete an agency application and work with agency applicants to ensure they upload the required documents into the system has increased.

To combat this increase in length of time for enrollment, the State made changes, effective September 1, 2026, to the enrollment process. There are three (3) State staff who guide the enrollment process through the online portal. Those staff were under the direction of the Medical Services Division until September 1, 2026. They have now transitioned to Adult and Aging Services in an effort to provide an enhanced level of support to manage the enrollment process. Additionally, the decision was made that the QSP Resource Hub would work more directly with QSP applicants prior to them submitting an application. The QSP Resource Hub has the ability to guide a provider through every step of enrollment and onboarding for new QSPs. By working through the Hub, potential providers have resource support to assure that all documents are in order before submission for enrollment. This should reduce the amount of time it takes to process a complete application, as it has been noted for a number of years that it is often the provider not responding to the need for

additional information in a timely manner that delays enrollment. The Subject Matter Expert has recommended the State track two (2) different measures – the average length of time to approve QSP applications after submission and the average length of time the QSP Resource Hub works with a provider to assist them in preparing a complete enrollment package for submission. It is likely that the 59 days noted in the above graph is comprised of these two (2) components.

Historically, there have been parts of the state where it can be more difficult to find QSPs based on the rural and frontier nature of those areas, both individual and agency QSPs. These challenges continue to occur in the very rural parts of North Dakota. Section XIII of the Settlement Agreement, as noted, requires that the State provide HCBS statewide to ensure that TPMs can return to or remain in the community rather than be in institutional care. The State works diligently to ensure that services are available to TPMs no matter where they live, knowing that some services (e.g. residential habilitation and community support services) may never be available in remote frontier areas. Despite that, the State is constant in its efforts to implement modifications to allow TPMs to remain in their communities where not all services are readily available. In the last several months the SME Team has conducted interviews with case managers and QSPs across the State, including this topic in discussions.

Several other issues have been shared, including creative work being done to overcome these barriers where they exist. In one (1) territory, case managers spoke to their efforts at coordinating multiple providers for a single TPM to ensure coverage of all authorized services when there was not a single QSP (individual or agency) that could address all the needs of the individual. It has resulted in the case manager actually helping with scheduling QSPs (not a typical part of a case manager's role) on a routine basis to assure services are in place as authorized. The SME is not encouraging that case managers take on this additional responsibility as it is not part of their work and can create conflicts of interest. The State is aware that this has occurred and has provided additional instruction to case managers.

The largest issue of staff serving in rural areas is related to travel. While providers speak to the help of the rural differential rate in covering travel costs, they also indicate that it is not enough to cover all expenses and retain staff, especially during winter months when travel can be more difficult. Several agencies have shared plans they are considering within their own organization to improve retention of staff needed for travel, including paying a higher rate to the staff person, paying wages for travel time, or providing a gas stipend on a monthly basis for staff that must travel a significant length of time to get to a client. Several expressed a desire for the State to consider either further raising the rate for services where significant travel is needed or seeking to establish a mileage rate that could help cover expenses.

PROVIDER QUALITY

The State has placed significant focus on provider quality for the last 18 months. Routine provider audits are being performed with Agency QSPs. The State reports that 13 Agency QSPs have been terminated from the Medicaid program in those 18 months due to delivery of subpar services and/or inappropriate billing. The focus on fraud, waste, and abuse in the Medicaid program is significant. There is support throughout the Adult and Aging Services system for the State in taking these actions, with numerous individuals sharing with the SME Team that “bad actors make it worse for everyone” and that “this work can’t be about making money instead of helping people.”

The State will launch a new Learning Management System (LMS) in January 2027. This system will be used to qualify providers to deliver services across divisions within the North Dakota Department of Health and Human Services. Rather than sign-off from a nurse that the individual is able to complete necessary tasks, QSPs will have to complete an 18-hour training course that includes quizzes to prove they understand the materials and expectations of services that will be delivered. The LMS:

- establishes a standardized set of training policies and procedures across the various services, systems, and sections;
- identifies core qualifications for all providers to develop and maintain; and
- improves collaboration and coordination among State agencies and stakeholders.

There are conflicting responses in the provider community to this upcoming new requirement. Some feel that their internal training is sufficient. Of those interviewed who do feel that way, some are seeking an exemption from the State in having to do more training while others have stated they accept the importance of working with the State and will have staff complete training as required in addition to what they provide internally. It is possible that there are current providers who may not be successful in completing this training and being able to prove competence, therefore no longer being eligible to serve HCBS clients. While there may be a loss of some providers as a result of this change, the State’s actions are consistent with the goal of improving the overall quality of the service delivery system. There is a stated desire from some providers to figure out how to make additional training more client-specific – assuring that the training received will help with the direct needs of the individual being served – which may be a further extension of the LMS for consideration in the future. Training is an important component of quality.

An additional change being made by the State is to require that every QSP – including those who work for an agency – have their own National Provider Identifier (NPI) number. Each provider will have to use their number as part of billing submission to be able to tie them directly with the service that is being delivered. This is a further safeguard against inappropriate billing and serving as a quality check that services are being delivered as authorized. Some providers have noted that this will be a time consuming exercise and therefore costly for them to implement, but none of those interviewed indicated they thought it was unnecessary.

There is currently a moratorium on enrolling new providers in Cass and Burleigh counties, which is in place for six (6) months. There is an abundance of providers in these areas to deliver authorized services and many of those seeking to enroll as new providers wish to deliver the higher end services of community support and residential rehabilitation. Those services (which are offered 24/7) involve TPMs with more complex needs. There is concern that there are too many providers seeking to offer these services and that not all of them are able to deliver quality care. The State has proposed changes to its administrative code that will require a provider to have two (2) years of experience delivering other HCBS care prior to being eligible to offering this level of service to individuals with more complex needs.

CHALLENGES

There are two (2) areas noted by providers – and case managers and transition coordinators – as presenting challenges in the delivery of HCBS, neither of which are new concerns. The first of these is the availability and timely receipt of necessary durable medical equipment (DME) for individuals who choose to live in the community and ensuring the appropriateness of the equipment received (e.g. correct size, quantity). This is especially true for TPMs in Skilled Nursing Facilities who desire to transition to the community. Delays in getting necessary equipment can extend the length of stay in the SNF. Delays can be caused when the physician does not write timely prescriptions for equipment or the prescriptions are written in a way not acceptable to the Medicaid program. There can also be delays because there simply are not enough DME providers in the state and some of the equipment needed can be very specialized and must be installable in the chosen setting. The State – through work with the Centers for Independent Living and its Transition Coordinators – is working to develop a checklist for transition activities that makes it clear whose responsibility it is to assure that DME is in place to help alleviate delays.

The second area of noted concern is caregivers for whom English is a second language (ESL). A large portion of the caregiver workforce are immigrant persons for whom English is not their first language. This can create challenges in training even before the caregiver is assigned to an individual to provide care as well as at times creating a lack of understanding between the client and the caregiver due to language barriers. Those Agency QSPs interviewed by the SME are aware of the challenges that this can present and approach solutions in different ways. Some have ESL workers shadow another staff person at the beginning of service to gain a better understanding of the TPMs needs. Others have supervisors who ensure frequent check-ins with caregivers to circumvent any concerns. Still others spend additional time in training with ESL caregivers to ensure a solid understanding of what care is being required and ways to communicate with the client. The SME suggests that the State consider putting together a panel, perhaps at the next State Caregivers Summit, with some of these providers to offer suggestions to others about addressing this issue.

AUTHORIZATIONS

It has been noted by a variety of providers that dealing with the authorization process can be challenging – managing the paperwork required. Community Support Services and Residential Habilitation are noted as the easiest authorizations and billings to manage as there is a set rate for the day and all cares required to be delivered fall under that single rate.

Some providers would like the State to consider bundling other rates in a similar fashion to make Electronic Visit Verification (EVV) easier to manage. For example, a TPM receives homemaker services, personal care, and transportation. QSPs have suggested that an authorization for a period of time (e.g. three [3] hours) to complete all of those necessary activities could be more efficient than billing for them individually. The State has tried this in the past and did not have good results from the experience. It became very hard to determine what services were provided, resulting in concerns about how/what care was actually being delivered in those bundled periods of time.

TRANSITIONS AND DIVERSIONS

TRANSITION REPORTING

The State continues to work with TPMs who wish to transition from Skilled Nursing Facilities to the community with HCBS supports. The number of transitions has fluctuated year over year, but had been increasing through 2024. In 2025, there was a significant decrease in transitions from the previous year. However, in January 2026, the State noted to the SME that transition referrals and requests again started to rise. Subsequently, in its June 2026 reporting, the State indicates that 56 individuals have transitioned in the first half of the year and 65 have signed consent in that period (*2026 Aging Services DOJ SA Dashboard, Dec 14, 2025 - Jun 13, 2026*). If the current rate of those seeking to transition remains as is expected based on others who have expressed a desire to transition but have not completed the necessary steps in which to do so, the number of transitions completed in 2026 will be higher than in previous years.

TPM TRANSITION REFERRALS COMPLETED SUMMARY						
USDOJ SETTLEMENT YEAR (DECEMBER 14TH - DECEMBER 13TH)						
TOTAL TPM TRANSITION REFERRALS THAT COMPLETED TRANSITION:					56	
TRANSITIONS		TOTAL	%	BY GRANT POPULATION		
				DD	ELDER	PD
	MFP	51	91%	7	25	19
	TRANSITION & DIVERSION PROGRAM	5	9%	0	4	1
	HCBS MW COMMUNITY TRANSITION	0	0%	0	0	0
	TRANSITIONS W/OUT COMMUNITY SUPPORTS	0	0%	0	0	0

Closely followed by the State, SME, and USDOJ is the length of time it takes an individual to transition to the community after signing consent. Per the Settlement Agreement Section XI.B., transitions are to occur within 120 days. As has been described numerous times over the course of the agreement, there are reasons that some persons who desire transition are not prepared to do so within 120 days. These reasons include, among others, difficulty in coordinating with family supports or families who are unsure of the transition, individuals who have become less responsive to meeting with the Transition Team and completing activities to move forward, housing delays often due to poor back rent history and the need to find all applicable identification documents to enroll in public housing, medical issues or therapies that need to be completed prior to transition, and communication with appointed guardians. At times, there are family members who can become a barrier to the individual wishing to transition from the SNF to the community. Additionally, there are occasions when finding sufficient providers to meet staffing needs can cause a delay, though this happens much less frequently than at the start of the Settlement Agreement, due in large part to the efforts by the State to recruit and retain QSPs. The *2026 Aging Services DOJ SA Dashboard, Dec 14, 2025 - Jun 13, 2026* indicates the following longevity information for the 56 individuals who transitioned during this reporting period.

TRANSITION LONGEVITY	WITHIN 30 DAYS	31-60 DAYS	61-90 DAYS	91-120 DAYS	121-150 DAYS	OVER 150 DAYS
MFP	9	5	8	6	2	21
TRANSIT & DIV PROG	4	1	0	0	0	0
MW COMM TRANS	0	0	0	0	0	0
TRANS W/OUT SUPP	0	0	0	0	0	0

Section XI.D.2 of the Settlement Agreement requires that within six (6) years of the effective date of the agreement, the State will transition at least 70% of the Target Population Members who sign informed consent forms. The State is closely tracking this information and will include a formal report on this measure in December 2026.

THE 90+-DAY TRANSITION REPORT

As was noted in great detail in the April 2026 Subject Matter Expert report, the State maintains two (2) lists of TPMs who wish to transition, the Active List and the Pending List. These lists are part of the 90+Day Transition Report that provide information to the SME and USDOJ about those waiting to transition longer than 90 days and are likely to wait more than 120 days as outlined in the Settlement Agreement. In the latest quarterly reporting reviewed in June 2026, there were 24 individuals on the Active List. These are TPMs who are working closely with Transition Teams to return to the community. Many of those individuals, as of the writing of this report, have since completed transition. The list is a fluid and dynamic document that changes rapidly. It includes the information about what

is causing transition delays and the steps that are being taken to mitigate those delays. By the time review is completed by the SME and USDOJ each quarter, some of those on the Active List that were just reviewed will have transitioned and others will have been added. Those on the Pending List are also interested in transitioning, but are moving at a slower pace as they work to resolve some of the barriers noted earlier. As shown in the graph above, the number of individuals who required a longer period of time (beyond 120 days) to complete transition in this reporting period was 37%.

DIVERSIONS

The State continues to far exceed the number of diversions required by the Settlement Agreement in Section X. It is an area that USDOJ has indicated there no longer needs to be a significant focus in reporting. The State continues to track the number of diversions, and diversions across funding programs, as it remains essential information in budgeting and staffing considerations. The *North Dakota – Department of Justice Settlement Agreement, Biannual Report, December 14, 2025 – June 13, 2026* reports the following information:

HCBS Long Term Care (LTC) Diversions

Unduplicated total number of TPMs diverted from a SNF	149
Total MSP Level B & C TPM diversions	33
Total HCBS Med waiver TPM diversions	129
Total SPED TPM diversions	42

There are TPMs who are diverted with support from more than one program, hence the reason that the numbers following the first row do not correlate exactly. The steady and increasing number of diversions remains high for many reasons. Some of this is attributed to the aging of the Baby Boom population with an increasing number of individuals requesting services. However, the State has also made a push through its Service Payments to the Elderly and Disabled (SPED) and Expanded Service Payments to the Elderly and Disabled (ExSPED) programs to reach people early – before they have significant care needs. By doing so and offering “lower impact” services in the community (e.g. homemaker, personal care, emergency response system), the State has been able to support individuals longer in the community before they may require nursing level of care services.

CONTINUING CHALLENGES

The State continues to address challenges that arise in assisting TPMs wishing to transition to the community. Of concern this year has been the reduction in funding from the Centers for Medicare and Medicaid Services (CMS) for the Money Follows the Person (MFP) program. MFP in North Dakota is the way that the vast majority of TPMs wishing to return to community living are able to transition with necessary supports. In the current year, North Dakota has also seen a reduction in funding from CMS, attributed in part to federal continuing resolutions for funding in lieu of a comprehensive budget bill being passed. The State has reported to the SME that funding is about 80% of previous years.

This strains the State's capacity to provide 365 days of service to a TPM post-transition, as is the expectation of the program. If North Dakota continues to transition greater numbers of individuals, resources to provide that length of follow-up will become increasingly stretched. The State is considering making a request to CMS that they be allowed to offer less time by the Transition Coordinator post-transition (e.g. fewer months) in order to assure that every person transitioning through the program receives as much follow-up as possible with available resources.

The State also describes continuing challenges in communication with hospitals and Skilled Nursing Facilities, particularly around discharge planning. The State is working with MFP Transition Coordinators to develop a checklist that indicates which entity is responsible to lead which activities to enable a person to return home. This is particularly crucial for obtaining DME and ensuring that prescription medications are in place upon transition. There also continues to be sporadic challenges with some SNFs in obtaining information from the facility about the TPM who wishes to transition. Requests for case notes and other information are at times not responded to, delaying the ability of the Transition Team to have all necessary information to ensure a successful transition. The State works individually with social workers in those SNFs when this becomes a challenge.

The larger challenge with hospitals is simply knowing when a client has been admitted, why, and what recommendations occur at discharge from the hospital. There are occasions when the hospital discharges to the SNF even if the individual is involved with HCBS and there is not a rehabilitation need requiring a SNF stay. Case managers often hear about hospital admissions and discharges after the fact, preventing them from intervening and supporting the individual to return home. The State does continual outreach with SNFs and hospitals about the HCBS program on a yearly basis to try and navigate some of these challenges. Some issues come about due to rapid turnover in facilities of those individuals who need to interface with DHHS – social workers and discharge planners.

The State might consider two (2) additional strategies to address hospital discharges. The first would be more frequent outreach than annually to hospitals about HCBS and having hospital staff contact HCBS case managers on admission of a TPM to avoid the discharge to the SNF if possible. It is reported that turnover in hospitals can be high. More frequent outreach about HCBS to discharge staff could prove beneficial in allowing TPMs to return directly to the community.

The second, which may already occur, is for case managers – at HCBS intake and with additional reminders as necessary – to ensure that TPMs are aware that if they require hospitalization the case manager should be notified immediately. QSPs should also know that promptly contacting a case manager when a TPM is hospitalized will enhance the

chances of an efficient return home with the assistance of the QSP. The State remains committed to continued efforts to navigate discharge-related challenges.

Finally, a continuing challenge is the issue of the cognitive capacity of some TPMs and its effect on transitions. As has been noted in previous reports, the capacity to consent to transition can be and has been called into question by a variety of individuals – family members, SNF staff, case managers, or transition team members – when no formal determination of capacity has been made. This often delays or stops the transition planning and implementation process. This issue is complex. There are several questions that arise relative to capacity determinations:

- What is the right of the individual to consent to transition when there is no formal determination that they do not possess the competency to make that decision, and who has the authority to override that consent before a determination has been made?
- How does the HCBS staff address their concerns of the health, welfare, and safety of the person in the community when they are unsure of the individual's cognitive status?
- If there is concern by professionals that there are cognitive limitations that may affect the capacity of a TPM seeking transition, what are the appropriate steps for resolving such concerns, which may involve a formal determination of competency to make the decision to transition?
- If the TPM has previously executed a power of attorney, who determines or confirms whether the power of attorney is in effect (some go into effect only when the individual has been determined to lack capacity) and whether it conveys authority to affect the transition process? Can the person holding a power of attorney effectively veto a transition plan when the individual wishes to return to the community?

When the capacity question has been resolved and a court has appointed a guardian to make decisions for a TPM who lacks the capacity to make their own transition decisions, there may still be situations in which clearer guidance may be helpful for those involved in the transition process.

- How can Transition Teams work with guardians when the TPM desires to transition and the guardian refuses? What education/conversations could be had with these guardians to provide additional understanding of what is available through HCBS?
- Is there any recourse available to a Transition Team when the TPM expresses a desire to transition and it appears that a safe and appropriate transition could be made for a TPM currently in a nursing facility, yet the guardian refuses to allow the transition to proceed?

While each individual situation may be unique, it would be helpful for all parties involved in a transition or potential transition to have a basic understanding of how to address these issues. The SME encourages the State to continue its efforts to develop educational

materials covering these situations and to develop guidelines or policies to address them. The recently established Office of Guardianship and Conservatorship, as well as other independent parties with expertise in this area, should be able to assist in the development and review of such guidelines or policies. The Office may also be of assistance in individual cases as they arise.

BEHAVIORAL HEALTH

As has been noted in past reports and earlier in this document from the SME, behavioral health, dementia, and traumatic brain injury are significant concerns with Target Population Members. Despite the fact that behavioral health concerns are not noted as part of the Settlement Agreement, it is clear that these issues create complex barriers and cause delays in transition from facilities and the ability to retain providers in the community. Behavioral health references both mental health and substance abuse issues.

According to the World Health Organization (<https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults>) 14.75% of older adults live with a mental health disorder, anxiety and depression being the most common. Add to that the 8.2% of North Dakotan adults with a substance use disorder (<https://mhstats.org/north-dakota/substance-use-disorder>), the estimated 14,000 state citizens who experience cognitive decline/Alzheimer's (<https://www.samhsa.gov/newsroom/press-announcements/20250728/samhsa-releases-annual-national-survey-on-drug-use-and-health>), and the 13,000 North Dakotan's living with traumatic brain injury (<https://www.ndbin.org/about-us/brain-injury-nd>) and one can see how widespread the issue is.

Case managers and Qualified Service Providers indicate that with Target Population Members, those numbers are even more prevalent. Key informant interviews with many individuals from both groups independently stated that “about half” of the people they work with had one (1) or more of these concerns and that these concerns had caused delays in transition, difficulty securing care providers, difficulty at times addressing family members who do not see the need or refuse behavioral health care for their loved one, difficulty retaining providers, and not enough information generally available about how to make these situations better. Additionally, a recent review of Critical Incident Reports by the SME showed that more than 70% of the incidents in the reporting period involved a TPM struggling with behavioral health, cognitive issues, or issues resulting from traumatic brain injury.

The State has taken steps to assist case managers and QSPs alleviate their concerns. First, training was made available to all Agency QSPs with Therapeutic Options, a national organization known for their work in “helping helpers.” Fourteen (14) agencies took advantage of the training, which was delivered as a train-the-trainer model and covered intervention techniques including de-escalation and information regarding self-protection

of the staff person in light of an incident. The State is planning to offer that training again this fall. It is hoped that other Agency QSPs will take advantage of this opportunity. Second, the State has a contract in place for a behavior analyst to work with specific individuals to create a behavior plan. The State has reported that this service has only been accessed twice.

North Dakota's Human Service Centers (HSC), which are transitioning to Certified Community Behavioral Health Clinics (CCBHC) within the Behavioral Health Division, are able to provide crisis services across the state – both on a mobile basis and the ability to walk into a clinic. This availability has increased in recent years. The clinics also offer some outpatient services, peer support, behavior specialists, and have transitional living facilities where adults experiencing greater challenges and who need extensive skills training can be served.

The SME team had the opportunity to speak with the clinical lead for the Human Service Centers to discuss what additional behavioral health support could be provided to the Adult and Aging community, as well as to engage in conversations across divisions to learn how they could be of greater assistance. Ideas include:

- The ability to provide a capacity assessment to determine if the individual can make decisions for themselves when there is concern about cognition that is delaying a transition;
- Greater use of HSC clinicians as consultants in staffings in the MFP program (this had begun, but it was indicated that it currently happens infrequently);
- Making routine trainings in the HSC system available to case managers and QSPs (trainings are both virtual and in person);
- Ensuring that there is broad awareness throughout the system of what behavioral health services can be provided, both in person and through telehealth; and
- Determining how behavioral health staff can support discharge planning and assist in putting in place plans that will help the TPM be more successful at home.

The SME Team has recommendations in this area for consideration by the State:

1. Increase the amount of training available to all QSPs – individuals and agency personnel – around issues of behavioral health, coordinating with the Behavioral Health Division as well as seeking outside resources.
2. Provide higher service rates for QSPs who have received training and have a significant skill set suited to TPMs with these needs. This would perhaps require creation of a “credential” that could verify training completed in order to qualify.
3. Consider development of a program similar to that in Oregon – the Oregon Older Adult Behavioral Health Initiative – which is designed to serve older adults and persons with disabilities. It could be a cross-division program with the Aging and Adult Services section and the Behavioral Health Division in North Dakota (<https://oregonbhi.org/about/>).

Provide training to QSPs working with TPMs living with Dementia. Behavioral health concerns are predicted to always remain higher with TPMs than the general adult population noted by statistics earlier in this section. When one further analyzes the data, the filters of poverty, isolation, and physical distress increase the likelihood of struggling with these issues. The State must continue to be prepared to address these concerns that are central in the lives of many clients they serve.

HOUSING

The nationwide shortage of affordable and accessible housing is well known in every major community. North Dakota, as in most states, is using all available resources to continue to improve housing opportunities for TPMs.

As noted earlier this year, there have been funding reductions from the US Housing and Urban Development (HUD) program. Instead of anticipated increases in the coming years' budgets, states are being told they are capped at less than what has been received, currently a reduction of 10% from the previous year's budget. One change resulting from this is the inability to access more vouchers to provide rental assistance. Those individuals who already have vouchers are likely the only ones able to be served through that program at this time.

There are those individuals who have vouchers allocated to them, but who still have difficulty finding a place to live, particularly in the current rental market. Because of that, those vouchers that are allocated can be held for a longer time to try and meet the goal of securing a place to live. Frequent extensions are offered by the local Housing Authorities to those seeking a suitable place to live. If the search results in housing not being secured or something happening so that the individual is no longer seeking housing by the end of the final deadline, the voucher will become available again, but this does not happen quickly.

In a recent meeting with DHHS Adult and Aging Services and the ND Housing Finance Agency several items of note were shared with the SME.

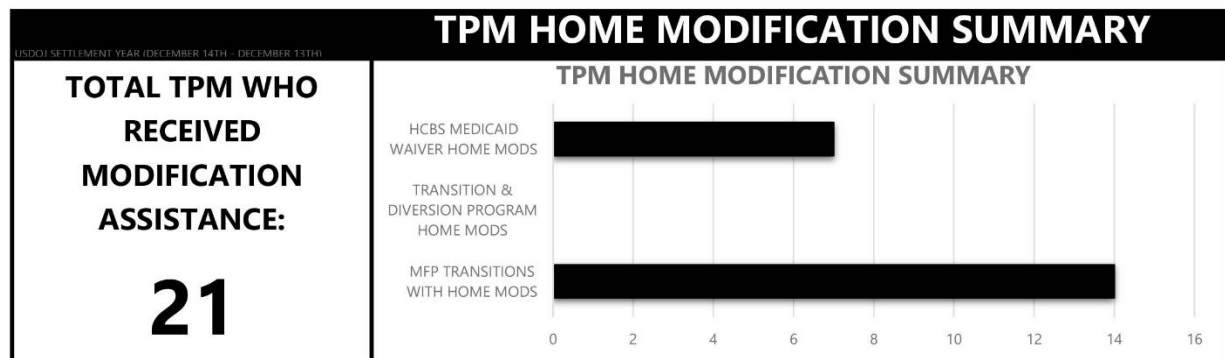
- The vacancy rate for rental units remains low, below 7% and in some places 2 – 3%. The vacancy rate in senior housing is 2%. Seven (7) percent is considered the most appropriate vacancy rate to serve people's needs.
- There are individuals in the Grand Forks area that currently hold allocated vouchers who are unable to find a place to live. Extensions have been granted on these vouchers (more than once) as people continue to seek a suitable dwelling.
- Fargo has closed its waiting list for vouchers as it is projected out three (3) to five (5) years. The waiting list in the Bismarck area is 18 – 25 months.
- Projections from the ND Housing Finance Authority is that there will be a 39% growth in the over-65 population in the next decade; the population where housing is already harder to come by.

- The State’s recently completed Housing Needs Assessment indicates that ND will need approximately 48,000 additional housing units by 2034. This would indicate a build rate of 4,800 units a year. Currently, about 3,000 units are being completed on a yearly basis.

The current 2025 – 2027 State budget has an allocation of \$300,000 to Adult and Aging Services for rental assistance. The State requested and received approval from the Centers for Medicare and Medicaid Services to provide rental assistance for six (6) months for individuals seeking transition. There are concerns, however, that these funds will be expended very quickly. There is no longer the ability to return to the federal government and request additional funding for services – including housing – now that the MFP budget has been capped at 80% of previous years.

HOUSING FACILITATION

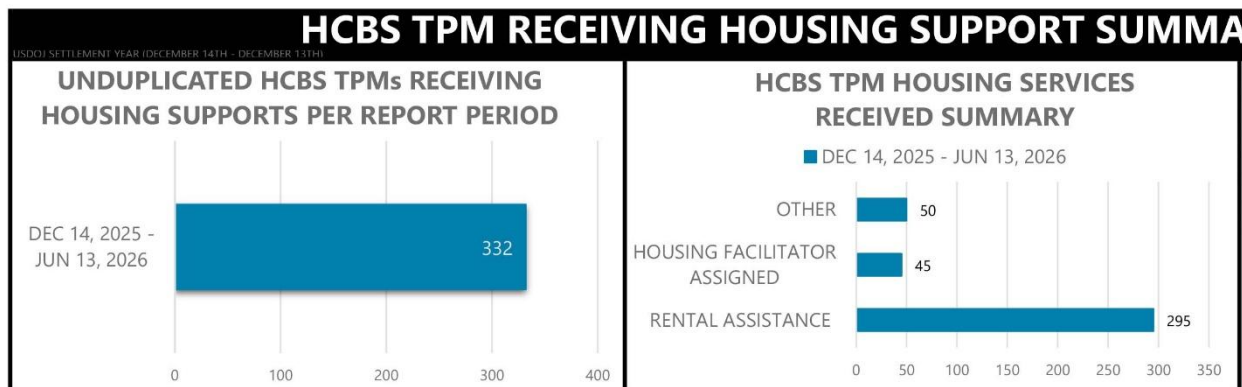
The State also continues its efforts in providing housing facilitation, permanent supported housing, and home modifications. In this reporting period, the State reported the ability to assist with 21 home modifications, which already exceeds the number for all of 2025 (2026 *Aging Services DOJ SA Dashboard December 14, 2025 – June 13, 2026*).



Home modifications are available to those who are transitioning as well as to those who receive HCBS and reside in the community. The provision of home modifications in the community can prevent or delay the need for higher levels of care in SNFs. Many of these modifications are very expensive, running in the tens of thousands of dollars, for example, to make bathrooms accessible for those requiring specialized equipment. The State has assisted in 130 home modifications over the course of the Settlement Agreement (2025 *Adult and Aging Services DOJ Settlement Agreement SA Comparison Dashboard* and 2026 *Aging Services DOJ SA Dashboard December 14, 2025 – June 13, 2026*).

North Dakota also offers housing facilitation services to TPMs, both those transitioning from an institutional setting as well as those living in the community. In keeping with that, it is important to note the number of those living in the community receiving HCBS and also accessing housing supports as well as those who are transitioning.

The 2026 Aging Services DOJ SA Dashboard, December 14, 2025 – June 13, 2026 reports the following:



Apparent here, as it has been for many years, is that the largest category of housing facilitation is in rental assistance. Housing Facilitators in some of these instances may be working to help a person in the community find a more accessible apartment, such as a ground floor unit, or are looking for alternative living arrangements but doing so independently. Housing Facilitation is available to all TPMs seeking to transition and to all TPMs and others receiving HCBS in the community. Of the 332 TPMs using housing facilitation in this reporting period, 56 received such services through the Money Follows the Person program. Thirty-eight (38) TPMs who transitioned to the community in this reporting period also received Permanent Supported Housing (2026 Aging Services DOJ SA Dashboard December 14, 2025 – June 13, 2026).

CONCLUSION

As the State completes five (5) and one-half years of work under the Settlement Agreement, an observer can compare what was happening in 2020 and how the system functioned to what happens in June 2026 and identify the major systemic changes that have taken place during that time. The State has paid significant attention to case management and ensuring that every individual has a HCBS case manager appropriately trained and able to assist the TPM and family in securing and retaining services. As part of that, the State standardized person centered planning and introduced a new electronic record keeping system. Additionally, the creation and involvement of Long Term Services and Supports Options Counselors in Skilled Nursing Facilities has allowed more individuals to be aware of the option of living in the community. The State has also spent considerable effort in growing and retaining an effective Qualified Service Provider workforce, increasing the number of new individual QSPs from 441 in 2022 to 1,267 in the current reporting period and new Agency QSPs from 11 to 245 in the same time frame.

As the State continues through the last 18 months of the Settlement Agreement (if the modified version of the agreement is formally approved by the USDOJ), the focus has been

narrowed to concentrate on those areas that still require attention, even with the successes that have been seen in those areas. Caseloads remain very high and as the number of individuals seeking HCBS continues to grow the need for more skilled case managers grows also. Behavioral health, cognitive concerns, and traumatic brain injury need greater attention and coordination of care – across DHHS – to assure that these barriers do not prevent TPMs from transitioning and living safely in the community. A focus on training and quality within the Qualified Service Provider workforce remains a high priority, ensuring that those individuals seeking to serve some of the most vulnerable citizens are appropriately equipped to do so. The State’s new Implementation Plan focuses on these issues and they will be measured and modified as necessary in ensuing months to achieve the State’s goals. The SME Team is pleased for the opportunity to assist North Dakota in achieving their remaining goals going forward.