STATE OF NORTH CAROLINA	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION
WAKE COUNTY	17CVS006357-910
SAMANTHA R., by her Guardian, TIM R., MARIE K., by her guardian, EMPOWERING LIVES GUARDIANSHIP SERVICES, LLC CONNIE M., by her guardian CHARLOTTE R., JONATHAN D., by his guardian MICHAEL D., MITCHELL T., by his guardian, BETSY S., and DISABILITY RIGHTS NORTH CAROLINA, Plaintiffs, v. STATE OF NORTH CAROLINA, NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, and KODY KINSLEY, in his official capacity as Secretary of the North Carolina Department of Health and Human Services, Defendants.	**CONSENT ORDER**

This matter came before the Undersigned on a Joint Motion of the parties for a Consent Order proposed by the parties. The Court grants the Motion and enters the following Consent Order.

I. Reasons for Issuance of the Consent Order

On February 4, 2020, summary judgment was granted in favor of Plaintiffs on their Persons with Disabilities Protection Act claim that Defendants unnecessarily institutionalize, or place at risk for institutionalization, people with intellectual and developmental disabilities (I/DD). In summary, the record in this case established the following:

- People with I/DD enter and remain in institutions when there is no viable community-based alternative.

- North Carolina does not have in place adequate community-based services for all individuals with I/DD who prefer a community-based setting to institutionalization.
- North Carolina is over-reliant on institutions with regard to people with I/DD.
- There are thousands of people with I/DD living in institutions in North Carolina, including over 4,000 in public and private Intermediate Care Facilities, with the remainder in Adult Care Homes.
- Innovations Waiver services are an alternative to institutionalization for people with I/DD. The waiting list for Innovations Waiver services, called the Registry of Unmet Need ("RUN"), exceeds 17,000 people.
- The lack of availability of Direct Support Professionals ("DSPs") and other health care workers is a significant barrier for individuals with I/DD in need of community-based support.
- Addressing the gaps in community-based services is necessary to prevent institutionalization, including the need to increase access to DSPs.

Since entry of summary judgment, several initiatives have been undertaken by Defendant DHHS to address underlying systems issues bulleted above. These are detailed here as context for the remainder of this Consent Order.

LME/MCO Accountability Measures

Because North Carolina's service system for people with I/DD is operated largely through contractual relationships with LME/MCOs, the availability of community-based services depends on LME/MCOs making those services available to beneficiaries in their catchment areas who need them. Defendant DHHS is responsible for oversight of and compliance by the LME/MCOs.

On August 17, 2021, Defendant DHHS issued Joint Communications Bulletin (JCB) 400, which was developed to address issues raised in this action regarding the LME/MCO role in, and accountability for, *Olmstead* compliance, and to articulate Defendant DHHS's activities and policies regarding *Olmstead* planning and compliance. JCB 400, entitled *To Reiterate Olmstead Obligations and Address Department's Current Initiatives and Planning*, includes the following principles, directives, and guidance to LME/MCOs:

1. Individuals are presumed to be able to live in the community with all appropriate supports.

2. Policies and procedures must be made available to NC DHHS by each LME/MCO, outlining the on-going work of In-reach and Diversion teams in helping people to make informed decisions about where they wish to live, work, receive services, and integrate into the community of their choice.

3. DHHS expects that reliance on institutions will decrease over time. This includes both State operated and private facilities.

4. LME/MCOs have affirmative obligations to provide for quality community-based alternatives to institutionalization. It is not feasible to make significant Olmstead-driven care only relying on the current providers and their current performance outcomes. To accomplish this, LME/MCOs must train, monitor, and shape their current and additional network providers' services and staff to be wholly focused on Olmstead outcomes for all individuals in their care.

5. LME/MCOs must identify and use any and all funding sources that could support an individual to reside in the community. With regard to those on an HCBS waiver, the LME/MCO must identify other supports that may be available.

6. Providers should inform and create person-centered plans and provide services to maintain a person in their chosen community.

7. Institutional placement should be a rare exception and there must be clear and convincing habilitative, physical, and/or clinical reasons to support the placement.

In addition to the above, Defendant DHHS has incorporated (or is in the process of incorporating) the following principles into its contracts with the LME/MCOs:

1. Per the managed care regulations, state law, and their contracts, LME-MCOs are responsible for developing and maintaining an adequate provider network. This is a core function of managed care.

2. LME-MCOs must assess their rates and other practices as frequently as necessary to ensure that services are not disrupted due to provider loss.

3. LME-MCOs must ensure growth and continuity of the provider network and related staffing. Providers may make anonymous complaints to a designated ombudsman if an LME-MCO imposes unnecessarily onerous requirements or processes on providers.

4. DHHS will monitor and assess LME-MCOs network adequacy and will, when appropriate, take corrective action if an LME-MCO does not maintain an adequate provider network, up to and including termination of the managed care contract. LME/MCOs are empowered to pay rates that are adequate to attract and retain providers. DHHS will develop and implement appropriate network adequacy standards.

5. Historically, provider adequacy has been measured by the existence of a provider within a specific geographic region. This measure does not directly correlate to the actual availability of services. Going forward, adequacy will be determined by an array of additional measures, such as availability of a service to a beneficiary within a reasonable period of time (reasonable period of time depends on the nature of the service).

6. The benchmark(s) to be used to measure provider adequacy will be published and updated from time to time, and LME-MCO contracts will include, or be amended to include a recognition that DHHS may periodically impose reporting requirements with regard to specific types of services or providers. An initial benchmark will be a minimum utilization rate for Community Living and Supports as designated in the benchmark specified below.

7. DHHS designates ombudsmen who will resolve beneficiary and provider complaints regarding LME-MCOs' fulfillment of their obligations with regard to ensuring access to and support of providers. The ombudsman should report periodically to DHB regarding the complaints received and the resolution of those complaints, including LME-MCO responsiveness.

8. DHHS will ensure that data regarding network adequacy is made available to the Plaintiffs and the public as detailed in Section IV, below.

Medicaid 1915(i) Services

Defendants have made provision for additional services for people with I/DD who are Medicaid eligible available beginning July 1, 2023. These services are offered under the

authority of Section 1915(i) of the Social Security Act (42 U.S. Code § 1396n(i)) and have been incorporated into the State Medicaid Plan. For those with I/DD who are eligible for Medicaid, 1915(i) services may include Community Living and Supports, Community Transition, Respite, and Supported Employment. If an individual is eligible for 1915(i) services, those services are an entitlement within the limits set under the State Plan.

Defendants estimate that over 70% of people on the Registry of Unmet Need are Medicaid eligible. Based on this estimate, the parties believe a significant percentage of individuals waiting for services will be able to access some or all of the services they need through 1915(i). It will be necessary to gather additional data to evaluate the impact of 1915(i) and to plan for addressing ongoing unmet needs.

Defendant DHHS has incorporated (or is in the process of incorporating) the following principles into its contracts with the LME/MCOs:

- 1915(i) services are subject to *Olmstead* and DHHS Joint Communication Bulletin 400. In administering 1915(i), LME-MCOs must make reasonable exceptions to any service limits that impair access to medically necessary services needed to avoid institutionalization. If an individual needs services to exit or avoid institutionalization or the risk of institutionalization, the LME-MCO must ensure that all medically necessary services are reasonably provided.

- LME-MCOs will not discourage the use of 1915(i) services or condition receipt of services on forfeiting a position on the RUN. Beneficiaries will be notified that applying for or receiving 1915(i) services does not affect their position on the RUN. Beneficiaries may voluntarily forego an Innovations Waiver slot if they are satisfied with their 1915(i) or other services, or they may transition to an Innovations Waiver slot when one is made available to them.

DSP Availability

Defendants commissioned an analysis from the North Carolina Area Health Education Centers (AHEC) regarding DSP workforce development. AHEC has recommended the following:

- Implement an umbrella system for credentialing direct care workers that incorporates new and existing training options.
- Adopt common core competencies for all DSPs.
- Ensure training is accessible for all workers, including paid training time.
- Develop infrastructure for the administration and oversight of credentialing.
- Connect competency attainment with wage and rate differentials.
- Provide additional wraparound support services to direct care workers.

Defendant DHHS sought and obtained additional recurring funding for DSPs in the 2023-25 state budget. *See* Session Law 2023-134, Sec. 9E.15.(a) *et seq*. These funds do not supplant the obligation of LME/MCOs to adjust rates as needed to enable providers to attract and retain DSPs.

In addition to the steps detailed above, and based on the presumed continuation of those efforts, the remaining provisions of this Consent Order reflect an agreed-upon process to remedy to address the needs of people with I/DD who are institutionalized, as well as those who are at risk for institutionalization. The numbers in the Benchmarks below are minimums; Defendants may provide for home and community-based services, including transition services, at levels that exceed the Benchmarks in keeping with their commitment to support and transition individuals with I/DD to the extent possible as system capacity expands over time to allow this.

II. Definitions

The following definitions apply to the terms of this Consent Order:

Adult Care Home. An assisted living facility licensed under N.C. Gen. Stat. Chapter 131D; *see also*, *Pashby v. Delia*, 709 F.3d 307, 322 (4th Cir. 2013) (holding that residing in an Adult Care Home qualifies as institutionalization).

Divert or ***diversion***. The process of identifying individuals living in the community who are at risk of requiring care in an institutional setting or an adult care home, and providing additional, more intensive supports and services to prevent further deterioration of their condition that could result in placement in an institutional setting or an adult care home. These services could include waiver slots, Medicaid home and community-based services, Medicaid in lieu of services (ILOS), or state-funded services.

Informed choice. A decision made by an individual residing in an institution about whether to transition to community-based supports and services. Informed choice may require sustained education and opportunities for visits to community-based settings, as well as efforts to remove barriers to transition.

Innovations Waiver. The federal Medicaid 1915(c) Home and Community Based Services (HCBS) waiver approved by the Centers for Medicare and Medicaid Services. In the event the name or designation of the Innovations Waiver changes, references to Innovations should be deemed to refer to the then-current I/DD HCBS waiver.

In-Reach. Frequent education efforts targeted to individuals in institutional settings. In-Reach includes providing information about the benefits of community-based services; facilitating visits in community-based settings; and offering opportunities to meet with other individuals with disabilities who are living, working and receiving services in integrated settings, with their families, and with community providers. In-Reach involves face-to-face interaction to engage with each individual and establish rapport.

Institution or ***institutional setting***. A state operated or privately operated Intermediate Care Facility, including without limitation the three DHHS state operated developmental centers, a Skilled Nursing Facility, a Psychiatric Residential Treatment Facility, an Adult Care Home, or

any residential setting defined as an institution by the Centers for Medicare and Medicaid Services.

Intellectual and Developmental Disabilities. An intellectual disability (ID) is defined as having "significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested before age 22." N.C. Gen. Stat. § 122C-3 (22). A developmental disability (DD) is a condition that manifests before age 22, is likely to continue indefinitely, reflects a need for lifelong or extended services, and produces functional limitations in three or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. N.C. Gen. Stat. § 122C-3 (12a).

Intermediate Care Facility / ICF. A state operated developmental center (Developmental Center) or private facility meeting the federal Medicaid definition for ICF/IID.

Registry of Unmet Need *or* ***Registry***. The waiting list for an Innovations Waiver slot or services.

Transition. Providing an individual with the necessary supports and services to move to a community-based setting, often after a period of sustained In-Reach activities designed to ensure that the individual may make an informed choice about community-based options. Individuals transitioning between institutional settings or ACH are not considered transitions.

Community-Based Services. Provide support for individuals with intellectual/developmental disabilities to live in the setting and community of their choice outside of an institutional setting. Community-based service settings support full access to the greater community. Community-based services may be habilitative or non-habilitative in nature. Examples of community-based services include Community Living and Supports (CLS), Respite Care, Supported Employment

(SE), Residential Services, Supported Living, Supervised Living, etc. Individuals receiving community-based services have choice of how, when, where, by whom, and how many services are provided.

III. Terms of Injunction

Benchmark 1: Transitions and Diversions from Institutional Settings

A. Transitions.

Defendants will support increased access to community-based services by transitioning eligible individuals who make an informed choice to transition to a community-based setting, and for whom a community-based setting is appropriate, as provided in the schedule below. These transitions may be facilitated and funded through Money Follows the Person and/or other appropriate funding sources.

Defendants will transition 249 people with I/DD as follows:

- For the fiscal year ending June 30, 2025, Defendants will transition at least 78 individuals with I/DD from institutional settings to community-based settings;
- For the fiscal year ending June 30, 2026, Defendants will transition at least 83 individuals with I/DD from institutional settings to community-based settings; and
- For the fiscal year ending June 30, 2027, Defendants will transition at least 88 individuals with I/DD from institutional settings to community-based settings.

- Defendants will require LME/MCOs to engage in and track In-Reach efforts, as defined above, with regard to individuals with I/DD living in the following settings: (1) Intermediate Care Facilities for Individuals with Intellectual Disabilities not operated by the State, (2) State Developmental Centers, (3) State psychiatric hospitals, (4) Psychiatric Residential Treatment Facilities, and (5) Adult Care Homes (at the present time, for member with Serious Mental Illness only). With respect to In-reach within Adult Care Homes, DHHS will update its contract language with LME/MCOs to remove the limitation that In-reach obligations pertain to members with Serious Mental Illness only.

- Defendants will adjust their contracts with vendors and LME/MCOs as needed to achieve Benchmark 1.A.

- At the end of the fiscal quarter two years from the date of this Consent Order, the parties may, jointly or separately, propose changes or additions to Benchmark 1.A.

If an individual returns to an institutional setting after having been counted toward compliance with this section that individual shall be deducted from the total, with the following exceptions. Individuals who transition and no longer receive community-based services due to death, moving out of state, declining services and/or completion of one year of transition will not be deducted from this total; provided that Plaintiffs may pursue (through consent or by order of the Court) the deduction of any individual who returns to an institutional setting after one year where the cause of the return is a lack of availability of community based services. Individuals who no longer qualify for Medicaid or State-Funded services shall not be deducted from the total.

Nothing in this Consent Order may be deemed to require an individual to transition from an institution when that individual does not wish to transition, or when a transition is not medically appropriate. The benchmarks above shall track the successful transitions of those who want to receive services and supports in the community.

Defendants shall reduce reliance on institutional settings based on the informed choice of residents. This Consent Order does not require the closure of specific institutional settings, and nothing in this Consent Order shall be deemed to require closure of any institutional setting.

The parties will advocate cooperatively to the General Assembly for additional Innovations Waiver slots, provided that neither Defendants nor Plaintiffs may be constrained to accept or advocate positions supported by the other. Nothing in this Consent Order may be

deemed to deprive the Court of jurisdiction to consider and/or provide for a schedule for elimination of the Registry of Unmet Need in the future.

DHHS will collect and report data pertaining to the transition schedule in Benchmark 1.A as detailed in Section IV below.

B. Diversion and Addressing Unmet Needs Through the Medicaid 1915(i) Service Option and Collecting Data Relating to Its Implementation.

The parties and the Court anticipate that the provision of Medicaid 1915(i) services to qualified individuals who are Medicaid eligible will benefit a significant number of individuals with I/DD who are on the Registry of Unmet Need ("RUN"). Because the Medicaid 1915(i) service option was added in July 2023, time will be needed to assess the impact of the service on the unmet needs of those on the RUN.

Benchmark 1B is as follows::

a. By June 30, 2024, Defendants will have completed the assessment and approval process for 3,000 individuals with I/DD for eligibility for 1915(i) services. Completing the approval process may include approving for services, denying services, or approving in part and denying in part requested services. DHHS will document evidence of the number of individuals with I/DD who are not interested in being assessed for 1915(i) services, in the quarterly report. After June 30, 2024, eligible individuals with I/DD who express interest in 1915(i) services will receive assessments and Defendants will complete the approval process within 90 days of a documented interest. The parties agree and understand that the assessment and approval process addressed in this paragraph is distinct from, and necessarily proceeds, the

LME/MCO's subsequent processes for utilization management, approval of the ISP/Care Plan, and provision of services.

b. By June 30, 2024, all 1915(i) eligible individuals with I/DD with open authorizations for 1915(b)(3) services will be transitioned to appropriate 1915(i) services.

To advance implementation of 1915(i) services, DHHS will do the following:

1. Adjust contracts with vendors and LME/MCOs as needed to achieve this Benchmark.

2. Initiate and participate in quarterly and as-needed discussions with LME/MCOs, providers, community stakeholders and the general public about the implementation of 1915(i) services.

3. Create a plain-language messaging campaign for potential beneficiaries of the 1915(i) service. DHHS will issue at least one communication using plain language to explain the 1915(i) service, and the implementation of same, to potential beneficiaries by June 30, 2024.

4. Ensure that trainings are in place for LME/MCOs, Tailored Care Management entities, and Tailored Care Management providers.

The parties and the Court anticipate that it will take no less than two years from the date of this Order to collect sufficient data and gain sufficient experience from implementing 1915(i) services to assess how many individuals with I/DD on the Registry of Unmet Needs have their needs met through the 1915(i) service option benefits. During this two year period, in order to inform the parties and the Court on appropriate next steps if any toward *Olmstead* principles and deinstitutionalization, including the potential development of one or more new benchmarks,

DHHS will collect data pertaining to transitions, diversions, and the implementation of the 1915(i) service option and report that data as specified below in Section IV, revising its contracts with LME/MCOs as needed in order to collect and report the specified data.

During the period of two years from the date of this order, DHHS is directed to share reports based on the data identified above with Plaintiffs through counsel on the schedule specified below in Section IV. Within 45 days following the expiration of that time period, the parties through counsel shall meet and confer on:

1. whether and how the existing data can be used to develop a baseline and/or a schedule providing for the transition of additional individuals with I/DD from institutional settings to community settings over time; and

2. the remaining unmet needs of individuals with I/DD, taking into account the number of individuals on the Registry of Unmet Need whose needs are being fully met through other services, including 1915(i), In Lieu Of, or state-funded services.

Within 45 days after that initial meeting and conference, the parties may exchange and/or submit one or more proposed benchmarks to the Court for its consideration. Notwithstanding this requirement, all parties retain and reserve the right to petition the Court at any time for the end of Benchmark 1 requirements, dismissal of this case and/or the termination of the obligations in this Consent Order. The Court retains jurisdiction to consider any and all available options to ensure that individuals with I/DD are able to receive services in the most integrated setting appropriate to their needs.

Benchmark 2: Increase Access to Direct Support Professionals and Community-Based Services

A. Establish minimum utilization rates for Community Living and Supports.

Defendants will support increased access to community-based services by increasing access to Direct Support Professionals (DSP) as measured by increased utilization of Community Living and Supports (CLS) for individuals with I/DD on the Innovations Waiver.

The best available statewide data for State Fiscal Years 2019, 2020 and 2021 indicates that the number of hours (or units) authorized for CLS compared with the number of hours (or units) actually utilized by the beneficiary (and paid by Medicaid) yields an overall, average utilization rate of approximately 80 percent. Data collected prior to State Fiscal Year 2023 did not indicate with specificity the reason(s) that service hours were not utilized.

To increase access to CLS, DHHS will provide for the following minimum utilization percentages for CLS, revising or amending its contracts with the LME/MCOs as needed:

- By June 30, 2024, the minimum utilization rate of authorized CLS services provided to qualified individuals on the Innovations Waiver will be 82 percent.
- By June 30, 2025, the minimum utilization rate of authorized CLS services provided to qualified individuals on the Innovations waiver will be 85 percent.

The percentages in the Benchmark 2.A schedule are the minimum percentages for CLS utilization each year. Defendants may seek to achieve higher utilization numbers for CLS, including by amending or revising LME/MCO performance requirements.

To determine the extent to which authorized hours (or units) for CLS are different than actually utilized hours (or units) as a result of provider or DSP unavailability, DHHS will collect data showing the reason(s) for non-utilization. The categories to be collected will isolate provider or staffing availability as a basis for underutilization and DHHS will amend or revise its LME/MCO contracts to collect data that at a minimum indicates the hours (or units) of services

not provided due to provider or staffing availability. DHHS will regularly publish this data as specified is Section IV, below.

Within 45 days following the end of two years after the entry of this Consent Order, the parties through counsel shall meet and confer on whether and how the existing data can be used to develop and propose any appropriate modifications to Benchmark 2.A. The parties may propose that one or more other measures may be appropriate in addition to, or instead of, the minimum utilization rate for CLS.

B. Issues Relating to Training and Credentialing for DSPs.

DHHS will:

- Evaluate recommendations from the AHEC Report and Best Practices to determine actionable activities to address the DSP Training and Credentialing Needs.
- Present a draft DSP Workforce Plan to address DSP workforce deficits to an advisory committee consisting of stakeholders including individuals with IDD, family members, DSPs, providers, and other stakeholders to garner feedback.
- Provide a draft DSP Workforce Plan to Plaintiffs' Counsel by May 1, 2024. Plaintiffs' Counsel will provide any input or proposed changes to the draft to Defendants within 21 days of receipt. Defendants will receive and evaluate Plaintiffs' proposed changes, if any. The parties agree to meet and confer on or before June 5, 2024 on any issues that cannot reasonably be resolved.
- Develop a final DSP Workforce Plan with specific actions and identified implementation dates no later than June 14, 2024. Plaintiffs retain the right, after evaluation of the final DSP Workforce Plan, to file a motion to challenge one or more terms of the Plan.

- Launch implementation of DSP Workforce Plan no later than July 1, 2024. Nothing in this Consent Order shall be construed to preclude future orders by the Court regarding training or credentialing for DSPs or other matters related to availability of DSPs.

Both parties retain and reserve the right to petition the Court at any time for the end of the Benchmark 2 requirements, dismissal of this case and/or the termination of the obligations in this Consent Order.

IV. Quarterly or Semi-Annual Reporting

Defendants shall report quarterly or semi-annually on their compliance with this Consent Order as follows. The parties acknowledge that certain required reports may only be available semi-annually at the current time; for these, Defendants shall report semi-annually until such reports become available on a quarterly basis. For purposes of Section IV only, any reporting pertaining to "institutional settings" will pertain to Intermediate Care Facilities, State Developmental Centers, State Psychiatric Hospitals, Psychiatric Residential Treatment Facilities and Adult Care Homes.

1. Matters to be reported:

Diversion and Transition Services

a. number of individuals diverted from institutional settings during the preceding fiscal quarter, each preceding fiscal year (if applicable), and cumulatively.

b. number of people transitioned from institutional settings during the preceding fiscal quarter, each preceding fiscal year (if applicable), and cumulatively.

c. number and percentage of individuals with I/DD eligible for In-reach activities who are engaged for In-reach activities;

d. number and percentage of individuals with I/DD who began transition planning following In-reach;

e. number and percentage of individuals with I/DD eligible for diversion activities;

f. number and percentage of individuals with I/DD who remain in the community after engaging in diversion activities;

g. number and percentage of individuals with I/DD age 18 and above identified for transition who are discharged through the transition planning process;

h. information related to both successful and unsuccessful transitions;

1915(i) Implementation

i. number of individuals with I/DD for whom the 1915(i) assessment and approval process has been completed;

j. number of individuals with I/DD receiving 1915(i) services;

k. number of individuals who received an assessment for 1915(i) services within 90 days of requesting an assessment;

l. number of individuals who waited, or have waited, more than 90 days for an assessment, including the number of additional days waiting;

Continuing Unmet Need

m. number and percentage of people on the Registry receiving I/DD-related services for the reporting quarterly period including 1915(i), HCBS, State-Funded Services, or In-Lieu of Services;

n. number and percentage of individuals receiving 1915(i) services who need additional services in addition to their approved 1915(i) services;

o. number of people remaining on the Registry, and the number removed from the Registry during the data reporting fiscal quarter, each preceding fiscal year (if applicable), and cumulatively;

p. status of the use of waiver slots and reserve capacity;

DSP Availability

q. overall percentage of authorized hours of Community Living and Supports (CLS) that were billed.

r. number of units of CLS authorized, by LME/MCO;

s. number of units of CLS billed, by LME/MCO;

t. number of units of CLS not utilized because of lack of provider or staff availability, by LME/MCO; and

u. any additional data required by subsequent orders of the Court.

2. Any information reported by Defendants to Plaintiffs may be made subject to the Qualified Protective Order entered in this matter on August 31, 2018, pursuant to the terms of that Order and under circumstances of confidentiality contemplated in that Order.

3. Reporting schedule:

Defendants shall begin reporting on currently available data after the entry of this Consent Order, on the schedule below. For data that is not being collected as of the date of this Consent Order, reporting will begin after the first full quarter when the relevant data is available, either directly or through contractor reporting requirements, with all categories of data being available by January 1, 2025. Reporting schedule shall be as follows for defined reporting frequencies:

Frequency	Reporting Period	Report Due
Quarterly	July – September	January 15
	October – December	April 15
	January – March	July 15
	April – June	October 15

If the 15th day falls on a weekend or a state holiday, reporting shall be made by the following day that is not a weekend day or a state holiday. Additional reports may be required by the Court on such schedule as the Court may set.

4. Dissemination of quarterly reports: Defendants shall provide each quarterly report to the Court and counsel to the Plaintiffs. Defendants shall make the quarterly report data, without individually identifying information, readily available on the NC DHHS website and in accessible formats.

V. Jurisdiction and Further Orders

The Undersigned retains jurisdiction of this matter and may issue further orders regarding injunctive relief and other matters, including but not limited to Plaintiffs' pending motions related to attorneys' fees and costs.

Nothing in this Consent Order shall be construed to limit future relief or to limit the ability of any party to move for dissolution or modification of this Consent Order. Plaintiffs consent to the dismissal of their Second Claim for Relief (procedural due process) without prejudice.

Plaintiffs consent to the dismissal of their Third Claim for Relief in this matter with prejudice based upon Defendants' dismissal of their appeal of the February 4, 2020 summary judgment order.

WHEREFORE, IT IS ORDERED THAT:

1. Defendants shall comply with the benchmarks in Section III and the reporting requirements of Section III and IV;
2. The parties shall confer before July 1, 2026 regarding the implementation of Benchmark 1 to assess the continued unmet needs of people with I/DD.
3. The parties shall report to the Court July 1, 2026 on the continued unmet needs of people with I/DD and will advise the Court on either joint or separate recommendations for further orders to address the continued unmet needs.
4. Plaintiffs' Second Claim for Relief is dismissed without prejudice.
5. Plaintiffs' Third Claim for Relief is dismissed with prejudice.

SO ORDERED this 16 day of May, 2024.
5/16/2024 1:39:52 PM

THE HONORABLE R. ALLEN BADDOUR, JR.
SUPERIOR COURT JUDGE PRESIDING

CERTIFICATE OF SERVICE

This is to certify that the undersigned has served a copy of the **Consent Order** entered 5/16/24 on Defendants by email to counsel for the Defendants as follows:

Michael T. Wood
mwood@ncdoj.gov
N.C. Department of Justice
Post Office Box 629
Raleigh, North Carolina 27602

This 17th day of May, 2024.

DISABILITY RIGHTS NORTH CAROLINA

/s/ Lisa Grafstein

_____

Lisa Grafstein
North Carolina Bar No. 22076
lisa.grafstein@disabilityrightsnc.org
801 Corporate Center Drive, Suite 118
Raleigh, North Carolina 27607
Telephone: (919) 856-2195
Facsimile: (919) 856-2244