UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION

THE UNITED STATES OF AMERICA, Plaintiff, v. STATE OF NORTH CAROLINA, Defendant.	Case No. 5:12-cv-557-D

SIXTH MODIFICATION OF SETTLEMENT AGREEMENT

1. This document modifies the Settlement Agreement ("Agreement") in the above-referenced matter between the United States and the State of North Carolina (collectively, the "Parties"). The original version of the Agreement, D.E. 2-2, was filed with this Court on August 23, 2012, and the Court retained jurisdiction to enforce the Agreement by Order of October 5, 2012, D.E. 13. The Agreement has previously been modified four times, with the Court retaining jurisdiction each time. The Agreement, with its prior modifications, is incorporated here by reference. The five prior "Modifications" are:

a. First Modification, D.E. 30-1, entered by this Court on November 1, 2017, D.E. 32;

b. Second Modification, D.E. 36-1, entered by this Court on October 21, 2020, D.E. 37;

c. Third Modification, D.E. 39-1, entered by this Court on March 1, 2021, D.E. 40;

d. Fourth Modification, D.E. 41-1, entered by this Court on March 29, 2021, D.E. 42;

e. Fifth Modification, D.E. 45-1, entered by this Court on March 6, 2023, D.E. 46.

The Fourth Modification discharged the obligations in Sections III(B)(3), III(B)(4), III(B)(6), III(E)(13)(a), III(E)(13)(b), III(E)(13)(d), III(F)(1), and III(F)(2) of the Agreement, subject to certain caveats. D.E. 41-1 ¶¶ 2(a)–(b), (d). The Parties, in consultation with the Independent Reviewer, now agree that the State has also achieved substantial compliance with its obligations in additional Sections of the Agreement, and thus again modify the Agreement.

2. The Parties, in consultation with the Independent Reviewer, agree that the State has met the substantive obligations of Sections III(B)(2), III(B)(8), III(B)(9), III(D)(3), III(E)(9), III(E)(14), III(F)(3), and III(G)(1)–(8) of the Agreement. The obligations in each of these

subsections will be discharged as of the date on which the Court approves the Parties' Joint Motion to Enter Sixth Modification of Settlement Agreement and retains jurisdiction to enforce the modified Agreement, provided that the State's performance shall not materially regress over the remaining term of the Agreement as modified in paragraph 3 below. As now modified, the entirety of Section III of the Agreement, which contains the State's substantive obligations, is reproduced in Attachment A to this Sixth Modification. Each subsection of Section III whose obligations were previously discharged according to the terms of the Fourth Modification, D.E. 41-1, is denoted with "[*Substantial Compliance – Discharged by Fourth Modification*]" on Attachment A. Each subsection of Section III that will be discharged according to the terms of the present Sixth Modification is denoted with "[*Substantial Compliance – Discharged By Sixth Modification*]" on Attachment A. The Parties agree that Attachment A is intended to be a helpful guide but that the language of the Agreement, D.E. 2-2, as modified by its subsequent Modifications, controls. The Parties further agree that review of any discharged obligation shall be limited to that necessary to determine whether the State has materially regressed and to interpret other, continuing obligations in the Agreement.

3. In their Fifth Modification, the Parties amended Sections I(H) and IV(L) of the original Agreement, redesignated Section V of the original Agreement as Section VI, added a new Section V to the Agreement, and amended the newly redesignated Sections VI(A)–(C) & (G). D.E. 45-1 ¶¶ 2(a), (c)–(i). The Parties now re-amend Sections VI(B)–(C) to read as follows:

> "**B.** The implementation of this Agreement shall begin immediately upon execution. The Parties anticipate that the State will have substantially complied with all provisions of this Agreement by July 1, 2027, unless the Agreement is otherwise terminated, cancelled, or extended. Substantial compliance is achieved if any violations of the Agreement are minor and occasional and are not systemic. Any Agreement deadline may be extended by mutual agreement of both Parties or pursuant to the process described in Section VI(C) below in the event that the State has not achieved compliance with the Agreement on or before July 1, 2027. This paragraph applies to all provisions of this Agreement to the extent that provisions have not expressly been discharged as set forth in subparagraphs 2(a)–(d) of the Fourth Modification of Settlement Agreement, or in paragraph 2 of the Sixth Modification of Settlement Agreement.
>
> **C.** The Court shall retain jurisdiction of this action for the purposes specified in Section VI(A) until July 1, 2027 unless: (1) the Parties jointly ask the Court to terminate the Agreement before July 1, 2027; or (2) the United States disputes that the State is in substantial compliance with the Agreement as of July 1, 2027. If the State has substantially complied with the Agreement before July 1, 2027, the United States shall not unreasonably decline to join the State in a motion to terminate the Agreement early. If the United States disputes that the State is in substantial compliance with the Agreement as of July 1, 2027, then the United States shall inform the Court and the State by April 1, 2027, and the Court may schedule further proceedings as appropriate. In any such proceedings, the burden shall be on the State to demonstrate substantial compliance."

4. The Parties anticipate that the State may achieve early substantial compliance with its obligations in Sections III(B)(1), III(B)(5), III(B)(7), III(D)(2), III(E)(1)–(8), and III(E)(13)(c) of

the Agreement. Therefore, the Parties will meet and confer no later than May 16, 2025, to determine whether discharge of any of these obligations is appropriate at that time.

5. This Sixth Modification incorporates by reference and amends the Agreement the Parties filed with the Court on August 23, 2012 and the prior Modifications that the Parties filed with the Court on October 27, 2017, October 21, 2020, March 1, 2021, and March 26, 2021, and March 1, 2023. This Sixth Modification supplements and does not supplant the Agreement or the prior Modifications. Unless otherwise noted, all definitions, obligations, and terms and conditions in the Agreement and prior Modifications remain in force for the Agreement's term as extended.

Executed on this 11th day of December, 2024.

FOR THE UNITED STATES OF AMERICA:

KRISTEN CLARKE
Assistant Attorney General

JENNIFER MATHIS
Deputy Assistant Attorney General
Civil Rights Division
U.S. Department of Justice

REBECCA B. BOND
Chief
ANNE S. RAISH
Principal Deputy Chief
ELIZABETH E. MCDONALD
Deputy Chief
JULIA M. GRAFF
H. JUSTIN PARK
Trial Attorneys
Disability Rights Section
Civil Rights Division
U.S. Department of Justice

Executed on this 11th day of December, 2024.

FOR THE STATE OF NORTH CAROLINA:

KODY H. KINSLEY, MPP
Secretary of the North Carolina Department of Health and Human Services

ATTACHMENT A TO SIXTH MODIFICATION OF SETTLEMENT AGREEMENT

III. SUBSTANTIVE PROVISIONS

A. The State agrees to develop and implement effective measures to prevent inappropriate institutionalization and to provide adequate and appropriate public services and supports identified through person centered planning in the most integrated setting appropriate to meet the needs of individuals with SMI, who are in or at risk of entry to an adult care home, pursuant to the details and timelines set forth below.

B. COMMUNITY-BASED SUPPORTED HOUSING SLOTS

1. The State will develop and implement measures to provide individuals outlined in Section III(B)(2)(a)-(e) access to community-based supported housing. Nothing in this Agreement will require the State to forgo federal funding or federal program participation, for housing that meets all the criteria in Section III(B)(7), to provide community placements for individuals pursuant to this Agreement.

2. [*Substantial Compliance – Discharged by Sixth Modification*]

3. [*Substantial Compliance – Discharged by Fourth Modification*]

4. [*Substantial Compliance – Discharged by Fourth Modification*]

5. As of January 1, 2024, the State shall provide Housing Slots to 1,449 of the individuals described in Sections III(B)(2)(a), (b), and (c) of this Agreement. The State shall provide Housing Slots to 1,633 such individuals by July 1, 2024; to 1,817 such individuals by January 1, 2025; to 2,000 such individuals by July 1, 2025. While achieving these totals, the State shall take all reasonable steps so that any individuals described in Section III(B)(2) of the Agreement who are eligible for the State's Transitions to Community Living program and who have Housing Slots as of March 1, 2023 continue to retain their Housing Slots as long as they do not oppose supported housing and supported housing remains appropriate for them.

6. [*Substantial Compliance – Discharged by Fourth Modification*]

7. Housing Slots will be provided for individuals to live in settings that meet the following criteria:

    a. They are permanent housing with Tenancy Rights;

    b. They include tenancy support services that enable residents to attain and maintain integrated, affordable housing. Tenancy support services offered to people living in supported housing are

flexible and are available as needed and desired, but are not mandated as a condition of tenancy;

c. They enable individuals with disabilities to interact with individuals without disabilities to the fullest extent possible;

d. They do not limit individuals' ability to access community activities at times, frequencies and with persons of their choosing;

e. They are scattered site housing, where no more than 20% of the units in any development are occupied by individuals with a disability known to the State, except as set forth below:

i. Up to 250 Housing Slots may be in disability-neutral developments, that have up to 16 units, where more than 20% of the units are occupied by individuals with a disability known to the State;

f. They afford individuals choice in their daily life activities, such as eating, bathing, sleeping, visiting and other typical daily activities;

g. The priority is for single-occupancy housing.

i. If single-occupancy housing is not available when a person is ready to transition to community-based housing, he or she can choose to either live with a roommate, or wait for single-occupancy housing. If an individual chooses to live with a roommate, after being fully informed about his or her options as described in Section III(B)(9) below, each roommate must have his or her own bedroom and the individual must have the opportunity to choose his or her roommate. If an individual chooses to wait for single-occupancy housing or housing with a particular roommate, after being fully informed about his or her options as described in Section III(B)(9), he or she will receive the in-reach and discharge planning services described in Section III(E), and will remain eligible to receive a Housing Slot in single-occupancy housing or with a particular roommate once one is available.

ii. Single-family housing is not preferred; however, Housing Slots may be in single-family houses, if the individual, after being fully informed about his or her options as described in Section III(B)(9), affirmatively seeks to rent a house or room in a house. Additionally, such single family houses must meet all other criteria listed in Section III(B)(7). Housing Slots may not be offered in a home in which the owner is the service provider unless the home has no more

than two bedrooms, and the transition team has obtained assurances that the individual is offered choice of service provider and that his or her right to reside in the home is not contingent on the service provider the individual chooses. The State will also make efforts to minimize use of homes in which the owner is the service provider when located in an area where there are other available housing providers. If an individual chooses to live in a single-family house because no other housing is available, that individual will receive the in-reach services described in Section III(E) and will remain eligible to receive a Housing Slot in single-occupancy housing once one is available.

8. [*Substantial Compliance – Discharged by Sixth Modification*]

9. [*Substantial Compliance – Discharged by Sixth Modification*]

C. COMMUNITY-BASED MENTAL HEALTH SERVICES

1. The State shall provide access to the array and intensity of services and supports necessary to enable individuals with SMI in or at risk of entry in adult care homes to successfully transition to and live in community-based settings. The State shall provide each individual receiving a Housing Slot under this Agreement with access to services for which that individual is eligible that are covered under the North Carolina State Plan for Medical Assistance, the Centers for Medicare and Medicaid Services ("CMS") approved Medicaid 1915(b)/(c) waiver, or the State-funded service array.

2. The State shall also provide individuals with SMI in or at risk of entry to adult care homes who do not receive a Housing Slot under this Agreement with access to services for which that individual is eligible that are covered under the North Carolina State Plan for Medical Assistance, the CMS-approved Medicaid 1915(b)/(c) waiver, or the State funded service array. Services provided with State funds to non-Medicaid eligible individuals who do not receive a Housing Slot shall be subject to availability of funds and in accordance with State laws and regulations regarding access to those services.

3. The services and supports referenced in Sections III(C)(1) and (2), above, shall:

   a. be evidence-based, recovery-focused and community-based;

   b. be flexible and individualized to meet the needs of each individual;

   c. help individuals to increase their ability to recognize and deal with situations that may otherwise result in crises; and

d. increase and strengthen individuals' networks of community and natural supports, as well as their use of these supports for crisis prevention and intervention.

4. The State will rely on the following community mental health services to satisfy the requirements of this Agreement: Assertive Community Treatment ("ACT") teams, Community Support Teams ("CST"), case management services, peer support services, psychosocial rehabilitation services, and any other services as set forth in Sections III(C)(1) and (2) of this Agreement.

5. All ACT teams shall operate to fidelity to either, at the State's determination, the Dartmouth Assertive Community Treatment ("DACT") model or the Tool for Measurement of Assertive Community Treatment ("TMACT"). All providers of community mental health services shall adhere to requirements of the applicable service definition.

6. A person-centered service plan shall be developed for each individual, which will be implemented by a qualified professional who is clinically responsible for ensuring that all elements and components of the plan are arranged for the recipient in a coordinated manner. Individualized service plans will include psychiatric advance directives and/or crisis plans so that such measures can be incorporated into the response to any behavioral health crisis.`

7. The State is in the process of implementing capitated prepaid inpatient health plans ("PIHPs") as defined in 42 C.F.R. Part 438 for Medicaid-reimbursable mental health, developmental disabilities and substance abuse services pursuant to a 1915(b)/(c) waiver under the Social Security Act. These plans are currently operated by LMEs. The State will monitor services and service gaps and, through contracts with PIHP and/or LMEs, will ensure that the number and quality of community mental health service providers is sufficient to allow for successful transition of individuals with SMI, who are in or at risk of entry to an adult care homes, to supported housing, and for their long-term stability and success as tenants in supported housing. The State will hold the PIHP and/or LMEs accountable for providing access to community-based mental health services in accordance with 42 C.F.R. Part 438, but the State remains ultimately responsible for fulfilling its obligations under the Agreement.

8. Each PIHP and/or LME will provide publicity, materials and training about the crisis hotline, services, and the availability of information for individuals with limited English proficiency, to every beneficiary consistent with federal requirements at 42 C.F.R. § 438.10 as well as to all behavioral health providers, including hospitals and community providers, police departments, homeless shelters, and department of corrections facilities. Peer supports, enhanced ACT, including employment support

from employment specialists on ACT teams for individuals with SMI, Transition Year Stability Resources, Limited English Proficiency requirements, crisis hotlines and treatment planning will be implemented in coordination with the current PIHP implementation schedule. Finally, each PIHP and/or LME will comply with federal requirements related to accessibility of services provided under the Medicaid State Plan that they are contractually required to provide. The State will remain accountable for implementing and fulfilling the terms of this Agreement.

9. Assertive Community Treatment Team Services: ACT teams will be expanded according to the below timelines, contingent upon timely CMS approval of a State Plan Amendment ("SPA") requiring all ACT teams to comply with a nationally recognized fidelity model (e.g., DACT or TMACT), if one is necessary. By July 1, 2013, all individuals receiving ACT services will receive services from employment specialists on their ACT teams. If it is necessary, the State will initiate the process of submitting a SPA within 45 days after the Agreement is signed.

   a. By July 1, 2013, all ACT teams in the State will operate in accordance with a nationally recognized fidelity model and the State will increase the number of individuals served by ACT teams to 33 teams serving 3,225 individuals at any one time.

   b. By July 1, 2014, the State will increase the number of individuals served by ACT teams to 34 teams serving 3,467 individuals at any one time, using the DACT or TMACT model.

   c. By July 1, 2015, the State will increase the number of individuals served by ACT teams to 37 teams serving 3,727 individuals at any one time, using the DACT or TMACT model.

   d. By July 1, 2016, the State will increase the number of individuals served by ACT teams to 40 teams serving 4,006 individuals at any one time, using the DACT or TMACT model.

   e. By July 1, 2017, the State will increase the number of individuals served by ACT teams to 43 teams serving 4,307 individuals at any one time, using the DACT or TMACT model.

   f. By July 1, 2018, the State will increase the number of individuals served by ACT teams to 46 teams serving 4,630 individuals at any one time, using the DACT or TMACT model.

   g. By July 1, 2019, the State will increase the number of individuals served by ACT teams to 50 teams serving 5,000 individuals at any one time, using the DACT or TMACT model.

10. Crisis Services

a. The State shall require that each PIHP and/or LME develops a crisis service system that includes crisis services sufficient to offer timely and accessible services and supports to individuals with SMI experiencing a behavioral health crisis. The services will include mobile crisis teams, walk-in crisis clinics, community hospital beds, and 24-hour-per-day/7-day-per-week crisis telephone lines.

b. The State will monitor crisis services and identify service gaps. The State will develop and implement effective measures to address any gaps or weaknesses identified.

c. Crisis services shall be provided in the least restrictive setting (including at the individual's residence whenever practicable), consistent with an already developed individual community-based crisis plan or in a manner that develops such a plan as a result of a crisis situation, and in a manner that prevents unnecessary hospitalization, incarceration or institutionalization.

D. SUPPORTED EMPLOYMENT

1. The State will develop and implement measures to provide Supported Employment Services to individuals with SMI, who are in or at risk of entry to an adult care home, that meet their individualized needs. Supported Employment Services are defined as services that will assist individuals in preparing for, identifying, and maintaining integrated, paid, competitive employment. Services offered may include job coaching, transportation, assistive technology assistance, specialized job training, and individually-tailored supervision.

2. Supported Employment Services will be provided with fidelity to an evidence-based supported employment model for supporting people in their pursuit and maintenance of integrated, paid, competitive work opportunities. Supported Employment Services will be assessed by an established fidelity scale such as the scale included in the Substance Abuse and Mental Health Services Administration supported employment toolkit.

3. [*Substantial Compliance – Discharged by Sixth Modification*]

E. DISCHARGE AND TRANSITION PROCESS

1. The State will implement procedures for ensuring that individuals with SMI in, or later admitted to, an adult care home or State psychiatric hospital will be accurately and fully informed about all community-based options, including the option of transitioning to supported housing, its benefits, the array of services and supports available to those in supported

housing, and the rental subsidy and other assistance they will receive while in supported housing.

2. In-Reach: The State will provide or arrange for frequent education efforts targeted to individuals in adult care homes and State psychiatric hospitals. The State will initially target in-reach to adult care homes that are determined to be IMDs. The State may temporarily suspend in-reach efforts during any time period when the interest list for Housing Slots exceeds twice the number of Housing Slots required to be filled in the current and subsequent fiscal year. The in-reach will include providing information about the benefits of supported housing; facilitating visits in such 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. The in-reach will be provided by individuals who are knowledgeable about community services and supports, including supported housing, and will not be provided by operators of adult care homes. The State will provide in-reach to adult care home residents on a regular basis, but not less than quarterly.

3. The State will provide each individual with SMI in, or later admitted to, an adult care home, or State psychiatric hospital operated by the Department of Health and Human Services, with effective discharge planning and a written discharge plan. The goal of discharge planning is to assist the individual in developing a plan to achieve outcomes that promote the individual's growth, well being and independence, based on the individual's strengths, needs, goals and preferences, in the most integrated setting appropriate in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare and relationships).

4. Discharge planning will be conducted by transition teams that include:

   a. persons knowledgeable about resources, supports, services and opportunities available in the community, including community mental health service providers;

   b. professionals with subject matter expertise about accessing needed community mental health care, and for those with complex health care needs, accessing additional needed community health care, therapeutic services and other necessary services and supports to ensure a safe and successful transition to community living;

   c. persons who have the linguistic and cultural competence to serve the individual;

   d. peer specialists when available; and

e. with the consent of the individual, persons whose involvement is relevant to identifying the strengths, needs, preferences, capabilities, and interests of the individual and to devising ways to meet them in an integrated community setting.

5. For individuals in State psychiatric facilities, the PIHP and/or LME transition coordinator will work in concert with the facility team. The PIHP and/or LME transition coordinator will serve as the lead contact with the individual leading up to transition from an adult care home or State psychiatric hospital, including during the transition team meetings and while administering the required transition process.

6. Each individual shall be given the opportunity to participate as fully as possible in his or her treatment and discharge planning.

7. Discharge planning:

   a. begins at admission;

   b. is based on the principle that with sufficient services and supports, people with SMI or SPMI can live in an integrated community setting;

   c. assists the individual in developing an effective written plan to enable the individual to live independently in an integrated community setting;

   d. is developed and implemented through a person-centered planning process in which the individual has a primary role and is based on the principle of self-determination.

8. The discharge planning process will result in a written discharge plan that:

   a. identifies the individual's strengths, preferences, needs, and desired outcomes;

   b. identifies the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;

   c. includes a list of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;

d. documents any barriers preventing the individual from transitioning to a more integrated setting and sets forth a plan for addressing those barriers;

i. Such barriers shall not include the individual's disability or the severity of the disability.

ii. For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.

e. sets forth the date that transition can occur, as well as the timeframes for completion of all needed steps to effect the transition; and

f. prompts the development and implementation of needed actions to occur before, during, and after the transition.

9. [*Substantial Compliance – Discharged by Sixth Modification*]

10. The DHHS transition team will ensure that transition teams (both State hospital facility staff and leadership and PIHP and/or LME Transition Coordinators) are adequately trained. It will oversee the transition teams to ensure that they effectively inform individuals of community opportunities. The training will include training on person-centered planning. The DHHS transition team will assist local transition teams in addressing identified barriers to discharge for individuals whose teams recommend that an individual remain in a State hospital or adult care home, or recommend discharge to a less integrated setting (e.g., congregate care setting, family care home, group home, or nursing facility). The DHHS transition team will also assist local transition teams in addressing identified barriers to discharge for individuals whose teams cannot agree on a plan, are having difficulty implementing a plan, or need assistance in developing a plan to meet an individual's needs.

11. If the individual chooses to remain in an adult care home or State psychiatric hospital, the transition team shall identify barriers to placement in a more integrated setting, describe steps to address the barriers and attempt to address the barriers (including housing). The State shall document the steps taken to ensure that the decision is an informed one and will regularly educate the individual about the various community options open to the individual, utilizing methods and timetables described in Section III(E)(2).

12. The State will re-assess individuals with SPMI who remain in adult care homes or State psychiatric hospitals for discharge to an integrated community setting on a quarterly basis, or more frequently upon request;

the State will update the written discharge plans as needed based on new information and/or developments.

13. Implementation of the In-Reach, Discharge and Transition Process

a. [*Substantial Compliance – Discharged by Fourth Modification*]

b. [*Substantial Compliance – Discharged by Fourth Modification*]

c. Transition and discharge planning for an individual will be completed within 90 days of assignment to a transition team. Discharge of an individual will occur within 90 days of assignment to a transition team provided that a Housing Slot, as described in Sections II(A) and III(B), is then available. If a Housing Slot is not available for an individual within 90 days of assignment to the transition team, the transition team will maintain contact and work with the individual on an ongoing basis until the individual transitions to community-based housing as described in Section III(B)(7).

d. [*Substantial Compliance – Discharged by Fourth Modification*]

14. [*Substantial Compliance – Discharged by Sixth Modification*]

F. PRE-ADMISSION SCREENING AND DIVERSION

1. [*Substantial Compliance – Discharged by Fourth Modification*]

2. [*Substantial Compliance – Discharged by Fourth Modification*]

3. [*Substantial Compliance – Discharged by Sixth Modification*]

G. QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT

1. [*Substantial Compliance – Discharged by Sixth Modification*]

2. [*Substantial Compliance – Discharged by Sixth Modification*]

3. [*Substantial Compliance – Discharged by Sixth Modification*]

4. [*Substantial Compliance – Discharged by Sixth Modification*]

5. [*Substantial Compliance – Discharged by Sixth Modification*]

6. [*Substantial Compliance – Discharged by Sixth Modification*]

7. [*Substantial Compliance – Discharged by Sixth Modification*]

8. [*Substantial Compliance – Discharged by Sixth Modification*]