

**North Dakota Olmstead Commission
Meeting Minutes of
May 13, 2026**

Voting Members Present

Christopher Joseph, Veronica Zietz, Donene Feist, Reuben Panchol, Tawnya Taylor, Julianne Horntvedt, and Senator Kathy Hogan

Voting Members Absent

Rep. Alisa Mitskog, Judge Bobbi Weiler, and Carey Goetz

Non-Voting Members Present

Zach Greenberg – DOL; Pat Traynor – DHHS; Maggie Williams – DPI; Jesse Carlsen – DOT; Anthony Bauer – ND Indian Affairs; Jennifer Henderson and Brandon Dettlaff – HFA

Other Attendees

Becky Rosenkranz and Stephanie Bouche – P & A Project; Sheryl Beard, Nicole Livedalen, Tami Ternes, Trevor Vannett – Olmstead Advisory Council; Hilory Liccini, Holly Pederson, and Lori Garnes – NDCPD; Chandler Esslinger – Fargo Moorehead Coalition to End Homelessness; Heather Brandt and Pam Sagness – Behavioral Health; Nikki Wegner – Long Term Care Association; Kristen Vandervorst and Toby Lunstad,

Welcome and Introductions

The meeting was called to order at 1:04 p.m. and attendance was taken.

Approval of Agenda

The agenda for today's meeting was reviewed: Approval of Agenda; Approval of February 2026 Minutes; Rural Health Transformation Program Presentation; Olmstead Plan Review – Goal #4 Improve and expand housing options; February Follow Up; Invitation to 2026 Olmstead Conference; Public Comment; and Upcoming Meeting Dates. The agenda was approved as presented.

Approval of February 2026 Minutes

MOTION: A motion was made by Ms. Zietz, and seconded by Mr. Bauer, that the February 4, 2026 meeting minutes be approved as typed. The motion passed.

Member renewal of appointment to Olmstead Commission:

Chair Joseph noted that the terms of Mr. Panchol (Co-Chair), Ms. Horntvedt (DD Council), and Ms. Feist (Family Voices) are eligible for reappointment to the Olmstead Commission as of June 30, 2026. These individuals were asked to submit their applications to the Governor's Office for approval and to let Chair Joseph know if they will be reapplying.

Rural Health Transformation Program (RHTP) Presentation – Pat Traynor, Commissioner of HHS

Mr. Traynor introduced himself and shared that his team has been traveling across ND to discuss the RHTP. He noted that DHHS has \$1 billion to invest over five years and is releasing funding opportunities weekly. He defined rural communities as those with populations under 50,000, with Fargo, West Fargo, Grand Forks, and Bismarck considered urban.

Mr. Traynor discussed how diet and exercise can reduce the risk and progression of chronic diseases. He emphasized that improving nutrition and increasing physical activity could help address ND's chronic disease crisis, noting that 30 minutes of exercise five days a week can reduce the risk of Type II diabetes and prediabetes.

Mr. Traynor presented a map of ND's healthcare system, showing critical access hospitals and referral centers that support access to quality care in rural areas and advance healthcare transformation efforts.

Mr. Traynor shared the Strategic Priorities and Funding for Year 1 (through Sept. 30, 2026). He added that these dollars are targets because they can move things around depending upon the grant applications received. They need to make sure that groups have good plans to spend the dollars they are getting. There are four buckets: Workforce, Connecting Tech and Data with providers, Bringing High Quality Care Closer to Home, and Making ND Healthy Again. There might be more healthcare recruitment and retention grants in the first year because they may be able to spend those dollars quicker. It takes a long time to get Healthy ND type projects up and running. Mr. Trayner stated that year 2 starts on October 31, 2026. DHHS's two-year budget will be submitted in August of this year. DHHS is expanding the pipelines to improve retention in rural and tribal communities. They are using technology as an extension for rural providers. There will be technical assistance for existing workforce.

Mr. Traynor said DHHS wants rural health care facilities to have healthy, high-performing teams and plans to develop a statewide health dashboard to better connect data with providers. He emphasized the importance of physical activity, nutrition, and human connection in improving health outcomes. He noted that 17.5% of ND high school students have contemplated suicide, highlighting the need for trusted adults, strong relationships, and community support. He stressed that building connection and resiliency is essential, as an increasing reliance on technology often contributes to feelings of isolation.

Mr. Traynor emphasized the need for significant funding to bring high-quality health care closer to home, support critical access hospitals, and improve transportation. He described DHHS's focus on sustaining revenue and "right-sizing" through assessments of all 37 critical access hospitals to establish a baseline for each facility's long-term success. Critical Access Hospitals understand how difficult it is to serve the rural area because the volumes aren't the same as in the urban areas. An assessment will be done so they have a baseline of where the current state is for viability of each facility. They ultimately want to get the hospitals to thrive-ability. Viability, survivability and then thrive-ability will be the key to sustaining revenue.

Mr. Traynor noted that the University of North Dakota Rural Health has already begun a workforce survey. They need a workforce that wants to live in a rural area. They are encouraging young people to be in great health care careers. They want to keep care close to home so we don't have to fly people out of state unless it's absolutely necessary.

Connecting Technology, Data and Providers for a Stronger ND will be extremely important. Data is very difficult to map, to assemble, and to validate. They want to ensure that every healthcare facility has an electronic health record that is hooked up to an overall data warehouse. They could then use all that data in such a way that it can't be compromised.

Leveraging AI will be an important part of using the data on the clinic side of things for the individual and the collective. Mr. Traynor mentioned kiosks and the ability to go into a local pharmacy and get your blood pressure checked. The kiosks will be able to provide a virtual physical and let you know if you need to be seen today.

Mr. Traynor noted that Critical Access Workforce Retention is the number one funding area to be addressed. There have already been applications submitted for this funding. They want to retain the existing workforce in the critical access hospitals. There is a scenario where money could be added to that area. This would include the Make ND Healthy Again option. Community gardens are successful in rural and urban areas and get people to experience community together and gets people thinking about health and whole foods. They also want to be the number one state for community-based walking. This will also help with everyone's overall mental health. The social connection is a huge element to reinvigorate communities across ND. Behavioral health is a passion for Mr. Traynor. They want local grassroots groups to apply for funding to step up some major community initiatives that focus on mental well-being.

Mr. Traynor shared that community-based walking programs may receive grants of up to \$125,000 to support community-wide physical activity initiatives. Funding could be used to hire a coordinator and engage schools, health care providers, businesses, faith communities, and other local organizations. The goal is to create lasting cultural change around physical activity, which can improve both physical and mental health. Regional partnerships may share a coordinator.

Senator Hogan asked who is going to apply for this type of grant and how do they know to apply. Mr. Traynor stated that anyone can sign up for the notice of funding opportunities. They will also be working with local community newspapers to get the word out about the program. They are stepping up the communications infrastructure so they can get people knowledgeable about the program. It is anticipated that year one is going to be much more difficult and not as well-known as it could be. They are always open to more ideas in getting the word out. The walking program, the healthy whole food program, and the behavioral health grants all need to be activated.

Mr. Traynor noted that new wellness programs are in development and may take time to fully launch due to hiring and training needs. Equipment grants are available in year one, with funds required to be obligated and spent by September.

Information was provided on the Mindfulness in Motion Burnout Training, which aims to address burnout among health care workers. Mr. Traynor highlighted planned community wellness projects in Jamestown and Dickinson, rural school wellness initiatives, and efforts focused on resilience and suicide prevention. Additional projects may support child care, early education, and parenting programs. Workforce retention and thrive-ability will follow.

EMS was identified as a key area of focus due to workforce and equipment challenges. Grant funding supports safety-net services, including collaboration with legislative committees, EMS surveys, and residency programs through NDSU Pharmacy and UND Family Medicine. Sustainability remains a primary concern for both the programs and CMS.

Another area would be mobile units. These are significant, but very expensive. They are working with Ronald McDonald to try and get one of those committed this year and then try and get one or two mobile mammography units. Again, they need to be sustainable. They need to work with the vendors on technical assistance. DHHS does have a tribal liaison that was hired, along with the regional economic development groups.

Mr. Traynor encouraged everyone to go to the DHHS website (hhs.nd.gov/rural-health-transformation) to see funding opportunities, to sign up for e-mail updates and get resources. Calls will begin with CEOs of the critical access hospitals, along with technical assistance calls for each funding opportunity. Mr. Traynor thanked the Commission for allowing him to present today and opened the floor for questions.

Senator Hogan stated that she is hearing from a lot of non-traditional healthcare providers like federally qualified health centers, DD, and private mental health providers. Things seem very focused on traditional providers, particularly the workforce. Will this group be considered for workforce retention? The kind of non-traditional health care provider, not in your basic hospital or clinic setting. Senator Hogan also asked about the interface with public healthcare system providers, particularly the ND State Hospital that serves the whole state. Is any of this available to the NDSH? 40% of the NDSH population is rural. How can we use RHTP to expand resources like 211 for behavioral health issues.

Mr. Vannett stated that he would like to add that we need to look at wheelchair providers and give them some incentives. He noted that there is only one wheelchair provider in the state. It takes approximately six weeks to even order a foot strap and that is unacceptable.

Ms. Feist stated that she is hearing a lot about the general population of individuals across the state, but she is not hearing about organizations that serve children and adults with disabilities. She asked if Mr. Traynor could expand on that a little bit. Mr. He would say that it will probably be in the latter stages of this year, or the beginning of next year before this population will enter the mix. He asked Ms. Feist if she could give him a list of things that she feels would be super helpful to ensure access to better care for all. And if there is a population that is not being addressed, maybe we should list it out in one of these notices of fundings more particularly. He would really appreciate hearing from Ms. Feist on this issue.

Ms. Bouche asked if there were any other comments or questions about Mr. Traynor's presentation. There were none.

Olmstead Plan Review – Goal #4 Improve and expand housing options

Presentation on Behavioral Health Funding

Ms. Heather Brandt, Manager of Behavioral Health Community Supports, was introduced at this time. She presented on housing related programs and behavioral health funding provided by DHHS and the Behavioral Health Division.

Ms. Brandt highlighted the Recovery Housing Assistance Program (RHAP), which is a supportive living environment that provides substance-free, peer-supported recovery for individuals with substance use disorders. The program, launched in 2022, helps ND residents (18+) with a substance use disorder cover up to 12 weeks of living expenses in approved

recovery homes and connects participants to supportive services. A map of ND was shared reflecting where the RHAP providers are found across the state. Since its start, RHAP has served 1,764 individuals, including 304 in the current biennium. As employment rates increase among RHAP participants, their ability to manage and stabilize the impact of substance use on their daily lives improves significantly.

Ms. Brandt stated that the second program she would like to share with the group is the Permanent Supportive Housing (PSH) Program. PSH is a model that combines an affordable housing assistance voucher with voluntary supportive services to address the needs of people who are considered chronically homeless. These are individuals who are homeless for at least 12 months and have a disability or who have at least four separate occasions of homelessness in the past three years that add up to that 12 months of homelessness and they also have a disability. During the 2021 legislative session, DHHS was directed to distribute funding to qualified entities that were utilizing best practices in PSH, providing recovery-oriented, and person-centered services. They submit process and outcome measures to the department and authorize DHHS to conduct on-site visits to review their program operations.

PSH combines affordable housing with voluntary, flexible services for individuals experiencing chronic homelessness with complex needs. Individuals are assessed and prioritized through a system called coordinated entry. For the person living in PSH, they want early and continuous outreach, engagement, and connection to services. They want to ensure that tenants feel supported and are connected to all of these services within their communities. These are fully integrated settings where each tenant has an individual lease, with outreach, engagement, and service connections as key supports.

Ms. Brandt shared current supportive housing contracts in Grand Forks, Fargo, and Bismarck, which include single-site and scattered-site options. Single-site housing consists of apartment buildings dedicated to PSH, while scattered-site housing is integrated within the community.

The third housing program she would like to talk about is Projects for Assistance in Transition from Homelessness (PATH). This is a SAMHSA grant of \$300,000, with a state match of a minimum of \$100,000. This program is designed to support individuals with serious mental illness who are experiencing homelessness or who are at risk of homelessness. To be eligible for PATH, an individual must be 18 years of age or older, homeless or at risk of homelessness, and have a serious mental illness. Case managers provide outreach and engagement, whether that individual is in a homeless shelter, transition center, living in a treatment center and getting ready to discharge and is homeless. They help them navigate behavioral health services in connection to any housing related resources.

Ms. Zietz asked if Ms. Brandt could talk about the capacity to meet the needs for these three programs. Do we have people on waitlists, and do we have a lot of people that could benefit from this service?

Ms. Brandt stated that RHAP has a wait list of 45 people that has been growing each month. The PSH is a little more complicated. She feels the wait list is pretty low for these units but could get more information on that. The PATH program does not have a wait list for those services. Ms. Zietz stated that as we prepare to go into another Legislative Session, she

assumes that much of this funding comes from the state. She was wondering if there should be an ask for something more so that everyone that needs the service can get help. Senator Hogan asked about the average length of stay in PSH, noting that many participants have serious, chronic mental illnesses. The Legislature has discussed this issue extensively. Ms. Brandt emphasized that PSH is based on individual choice, including length of stay. Some individuals remain long term and eventually transition to a Mainstream Voucher, others benefit from the support for a shorter period. Ms. Brandt noted she could share additional data on this topic with the Commission.

Ms. Brandt highlighted three behavioral health programs: the SUD Voucher, Community Connect, and Free Through Recovery. The SUD Voucher program helps improve access to substance use disorder treatment by allowing individuals to choose community providers when cost is a barrier. Eligible participants must be ND residents age 12 or older, meet income requirements (up to 200% of the federal poverty level), have no other funding source, and have a professional recommendation for SUD services. The program supports individuals in a variety of living situations, including shelters, hotels, or temporary housing. Senator Hogan stated that she was surprised to see that the SUD voucher was available to kids 12 to 18. She wondered if Ms. Brandt has data on what percentage of kids are using that voucher program, because it's been generally seen as a shortage and a limitation of accessing additional service for youth. Ms. Brandt stated that she can get this data for the Commission. She noted that at least two legislative sessions ago there were people testifying to the need for the voucher to be for those younger than 18, so the age changed.

Ms. Brandt described the Community Connect program, which expands recovery support services for adults in ND with behavioral health conditions impacting multiple areas such as housing, employment, parenting, or health. The program includes about 50 peer-run, culturally specific, faith-based, and community-based providers contracted with NDHHS to offer care coordination, peer support, and connections to services like housing, transportation, and treatment. She noted that 78% of participants achieve a housing outcome each month, and 60% were homeless or recently homeless at intake, with ongoing risk of housing instability even after placement.

Senator Hogan asked about the program's outcome-based funding model and whether payments are tied to results. Ms. Brandt explained that providers report monthly participant income data. Funding is based on outcomes rather than a traditional fee-for-service model.

Ms. Brandt also highlighted the Free Through Recovery program, which expands community-based behavioral health supports for individuals involved with the criminal justice system. The program is administered in collaboration with the ND DOCR and serves adults referred by parole, probation, pretrial services, or case managers who have behavioral health needs and challenges with daily functioning. It includes 38 providers statewide offering care coordination, recovery services, and peer support. The program is outcome-based, with 76% of participants achieving a housing outcome each month during the current biennium, and 36% of participants being homeless at the time of referral as of November 2025.

Ms. Henderson asked what the housing outcome shared about Community Connect and Free Through Recovery actually means. Ms. Brandt stated that what they are looking for

each month is to know that that person is working towards or maintaining their goals in that area. Progress for one person might not be progress for another person. That is not the measurement of homelessness or housing that the group would want to be looking at; it's more of that admission and discharge data.

Ms. Brandt was thanked for her very informative presentation.

Presentation on Homelessness – Chandler Esslinger, Executive Director of Fargo-Moorhead Coalition to End Homelessness

Ms. Esslinger, Executive Director of the Fargo-Moorhead Coalition to End Homelessness and Board Chair of the North Dakota Coalition for Homeless People, discussed the connection between homelessness and the Olmstead principles of community integration and independence. She noted that homelessness often results in instability, isolation, and cycling through shelters, hospitals, jails, and crisis systems, raising concerns about the availability of community-based supports. More than 50% of people experiencing homelessness in ND have a disability, and about 20% meet the definition of chronic homelessness.

In the homelessness response system, disability is defined as a condition that is expected to be long continuing or of indefinite duration which substantially impedes the individual's ability to live independently, could be improved by the provision of more suitable housing conditions, and is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, PTSD, or brain injury. Chronic homelessness requires a disability but also has time restrictions for how long you have to be homeless.

Senator Hogan stated that she was surprised recently by the number of individuals who are experiencing chronic homelessness who have brain injuries. She asked Ms. Esslinger to talk a little bit about the survey on this issue that was completed. Ms. Esslinger stated that the survey was conducted by the Brain Injury Network of ND and Fargo/Cass Public Health. They surveyed individuals who are accessing homelessness services primarily through the Downtown Engagement Center. There is a very high number of individuals who experience homelessness who have a brain injury. That could be as high as 80%. She added that over 50% of these individuals sustained their brain injury prior to becoming homeless. Ms. Esslinger shared that people are having these behavioral health issues, impulse control issues, and mood issues and want to blame it on mental health or substance use, when in fact it's a combination of many things, often born out of a brain injury. Mr. Greenberg asked what is referred to when using the term brain injury. Ms. Esslinger stated that brain injury can constitute a multitude of different things. She asked everyone to refer to the ND Brain Injury Network website that talks specifically about brain injuries.

Ms. Esslinger outlined how homelessness and disability intersect in ND, noting that people may become homeless due to disability or develop disabilities through prolonged homelessness. She emphasized that extended homelessness can worsen health, lead to unmet/undiagnosed conditions, and increase reliance on crisis systems. She noted system strain and barriers to services, particularly when residency is required to access supports.

Senator Hogan stated that ND is seeing a significant increase in the number of people in shelters over the age of 65. Rules prevent them from getting HCBS and other services

because they are in a shelter. They are housed, but there are no service options. Ms. Esslinger stated that ND has an aging population in general. There are seniors who have been living independently for much of their life but are reaching a point where they can no longer sustain that standard of living. Often, these people fall into hard times, are on limited incomes, and become homeless. They enter the homelessness response system and are not being served by other parts of the system that are most suited to their needs. Emergency shelters are not designed to serve people who have age-related disabilities or age-related complex health conditions. This is a difficult environment for those aging folks.

Senator Hogan stated that when they end up in a shelter, they are not eligible for HCBS, the cycle is closed off and there are no options available. This has generated some pretty significant discussion. Ms. Esslinger stated that aging folks and people with disabilities tend to be high acuity populations who need additional supports beyond what currently exists. Mr. Panchol asked if they fall into one of these categories or is there a different category for them. Ms. Esslinger stated that they would fall into the last category because they are excluded from supports because of their homeless status. If someone loses their housing, their homelessness becomes the priority identifier of their issue versus the disability or maybe the health or economic conditions that led to that.

Mr. Bauer stated that this has been a very engaging presentation. He noted that the aging population is very prevalent in the tribal communities across ND. In those communities they either move in with the individual or we take them in. There are zero services on the reservations right now. They are starting to look at some stuff through the Rural Health Transformation program. Multi-generational and three generation housing is what we are trying to produce in the tribal communities so that we can stay together. This is obviously a large problem. Mr. Bauer stated that he sits on the Housing Subcommittee. He sees how even refurbishing some of those homes within the urban communities may not be suitable for some of these aging individuals or some of the people that need assistance in the day-to-day life. Mr. Bauer wants to make sure that this sector of individuals is being looked at.

Ms. Esslinger called this shared housing where someone is living with someone else, whether it's a friend or a relative. She questioned how we are reimbursing the person providing the housing or providing some basic care for that person. How are we supporting them for their ability to do that. Mr. Bauer stated that in our tribal communities they do what they have to do he knows that most people don't try to recoup any of the costs.

Ms. Esslinger stated PSH is a combination of housing and services that is particularly designed for those with serious mental illnesses or other disabilities who need support in order to live stably in their communities. PSH has been proven over and over again.

PSH is typically for people who have complex behavioral health or physical health needs and face complex barriers to housing, including unemployment, mental illness, substance use disorder, history of incarceration, long-term homelessness, and other challenges. PSH improves housing stability. It actually reduces or stops active substance use and then those folks live more supportive, stable, productive lives. There is still a gap and often people with disabilities have to be homeless long enough in order to get the type of housing support that is most effective for their situation. Ms. Esslinger shared some additional information on fixed

site vs scattered site models. She noted that both models can be effective depending on the individual's needs.

Ms. Esslinger shared the challenges of PSH. These included: the availability of PSH across the state is insufficient to meet the need; on-site supportive services are essential, but often under-funded; PSH requires highly skilled and trained service providers due to acuity of population; the target population for PSH can be screened out of PSH due to their complex background; and the limited availability of community-based supports including treatment, behavioral health, etc.

Ms. Zietz asked who set the rules for screening people out, say for their criminal history. Is this something that each PSH provider sets up or is this done with the funding mechanism. Ms. Esslinger stated that it often has to do with the relationship between the public housing authority that maintains the vouchers that support those PSH units and the property manager who oversees it. Often there is a building owner, the public housing authority that supplies the voucher, and then a property manager. And then there is another agency coming in to provide services to the people who live there. Ms. Brandt added that they do a lot of training and technical assistance support to these entities.

Ms. Esslinger stated that there are other external constraints that kind of limit success or the scalability of success of some of these models. It is rooted in the limited availability of some of these community-based supports, like treatment options and behavioral health options. Ms. Esslinger shared some of the opportunities for PSH. These included: expanding scattered-site and fixed-site PSH models; partnering with community-based organization to expand successful housing programs with focus on individuals who are both homeless and disabled; state-funded TBRA or Voucher Program for target population; increasing funding for supportive services activities; and increased partnership with community-based organizations to provide comprehensive, wrap-around services.

Ms. Esslinger provided some information on the Georgia Housing Voucher Program (GHVP), which was designed in response to their Olmstead lawsuit. Georgia has a robust housing program that has been developed through their settlement. Ms. Esslinger shared some facts about how they use this program to meet the needs of people who are both experiencing homelessness and have a disability. Georgia's model is rooted in evidence-based practices of housing first and PSH. Eligibility for this program is an inclusive definition of people who could benefit from a program like this. People who are eligible are adults who have a diagnosis of a serious and persistent mental illness; are currently experiencing homelessness or in a residential program and meet one of the following criteria: they are either chronically homeless, being served by a behavioral health center, or have three or more hospitalizations or residential program visits in the last 12 months. The question was raised whether the three hospitalizations or ER visits must be related to the diagnosis of serious or persistent mental illness, or if they went to the hospital three times could it be for a fractured ankle. Ms. Esslinger stated that this program states that the visits would be specific to psychiatric issues. She noted that changes are being made and they are trying to capture if people are using emergency services as their primary form of health care, instead of focusing on people who are using emergency services for their psychiatric needs.

Ms. Esslinger shared information on GHVP Bridge Funding. This gap funding can support startup household expenses, security deposits, landlord incentives, inspection repair assistance, eviction prevention or landlord risk mitigation funds, or temporary shelter if somebody needs a place to stay until a unit becomes available. Ms. Esslinger shared that because of this program and the work of Georgia's Behavioral Health Department, they were released from over 60 behavioral health provisions, and they have ended all of their federal monitoring requirements related to their settlement.

Ms. Esslinger asked the Commission how they can help advance housing access, stability, and community integration for North Dakotans experiencing both homelessness and disability. Maybe it would take a more coordinated community-based system of supportive housing and services capable of preventing institutional and crisis system cycling specifically for people who are homeless and have a disability. There are people falling through the gaps. What role could the Olmstead Commission play in helping to close those gaps?

Ms. Esslinger was thanked for her very informative presentation. She noted that if the Commission is interested in additional data specific to disability and homelessness or the number of individuals who might qualify for PSH, the continuum of care would be a great resource for that.

Chair Joseph asked Commission members if there were any points of discussion or any recommendations regarding homelessness or from the presentation regarding the RHTP.

Senator Hogan emphasized that the growing need for homeless services is closely tied to disability and that policymakers must recognize this changing trend. She noted that many communities have lost their low-cost housing options, such as single-room occupancy hotels and small apartments, as they have been replaced by higher-end developments. As a result, planning and zoning decisions can contribute to homelessness when affordable housing is eliminated. She stressed that disability, homelessness, housing, and aging are interconnected issues that require coordinated attention across government.

Ms. Zietz suggested that the Commission look at gathering some of these statistics and following up on some of this additional information they requested. They aren't ready to go forward with a full proposal, but perhaps they could have Ms. Bouche start drafting a position statement on disability and housing, identifying some of the needs and possible solutions. Ms. Bouche stated that she would be happy to start that statement.

February Follow Up

Ms. Bouche shared the letter she sent to HHS on behalf of the Commission on the waiver talking about the three-bid requirement. This presentation also shares HHS's response.

Ms. Bouche also sent a letter to HHS on Workers with Disabilities (WWD) Medicaid. She has not gotten a response back on that one. She did, however, hear back from Ms. Joyce Johnson, who presented on WWD Medicaid to the Commission on the enrollment fee issue. It was noted that there is no federal requirement to have an enrollment fee. Both the State and CMS approved of the fee. She said it helps to share in the Medicaid expenses.

Senator Hogan noted that the enrollment fee was enacted during the 2003 legislative session and has remained in statute for many years without a comprehensive review. Senator Hogan suggested obtaining the legislative history from 2003 to better understand the intent behind the fee. Ms. Bouche stated that she would follow up and obtain legislative history.

Ms. Bouche shared that she sent a letter to Vocational Rehabilitation (VR) on customized employment and met with the new VR Director and Assistant Director. VR is reviewing the Commission's recommendations and updating the fee structure. Options under consideration include expanding provider training statewide, designating providers by region, or partnering with Minot State University to conduct discovery and refer individuals to providers. VR is still seeking input on the approach.

Senator Hogan stated that we are seeing a huge growth in the youth 18-22 being homeless. She questioned the overlap between employment and homelessness. There is concern about transition and making sure that they have the skills to live on their own and have a job.

Ms. Bouche discussed the DSP workforce pipeline. She met with Leslie Hockert at TrainND, which provides workforce training, and they expressed interest in developing a DSP training program. She also met with Jeff Anderson from the Arc of Cass County, who is interested in launching a pilot program called *Pathway to a Career in Caring*. In addition, Minot State is exploring a DSP pipeline modeled after its Aspire program. Ms. Zietz suggested sharing this information with Mr. Traynor to explore workforce development proposals. Ms. Bouche will do that and inquire about funding opportunities for children and adults with disabilities, housing options for individuals with mental health diagnoses, and eligibility for grants to retrofit older homes for multigenerational living.

Senator Hogan mentioned rural communities that have 2 or 3 individuals with developmental disabilities or physical disabilities residing in the same facility. We have gotten so compartmentalized about our housing supports in rural communities; can we do cross-systems integration.

Ms. Henderson stated that the ND Housing Finance Agency, in partnership with HHS Environmental Modification did do some accessibility upgrades to units at the Anne Carlsen Center. They are limited in what they can do. The Community Action Partnership Network is able to do some repair type programs as well. The Centers for Independent Living also do work to assess the needs of individuals and what upgrades they might need. Money Follows the Person is also a resource that could be tapped into.

Invitation to 2026 Olmstead Conference

Ms. Bouche provided a flyer to the Commission on the upcoming Olmstead Conference, scheduled for July 20, 2026 from 8:30 – 4:30 P.M. at Bismarck State College. All are welcome to attend and to share the flyer as they see fit.

Public Comment

Ms. Lori Garnes, a representative with the North Dakota Center for Persons with Disabilities (NDCPD) and Minot State University, shared some information on their Aspire program. She would like to offer more information at another meeting if the Commission is interested.

Upcoming Meeting Dates

The next meeting of the Olmstead Commission will be held on August 12, 2026 from 1:00-3:00 p.m. Following meetings include November 4, 2026 from 1:00-3:00 p.m.

Adjourn

The meeting was adjourned by Chair Joseph at 3:12 p.m.