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## STATE OF ALABAMA

October 9, 2012

The Honorable Tom Harkin  
Chairman, Committee on Health, Education,  
Labor and Pensions  
United States Senate  
Washington, DC 20510-6300

Dear Senator Harkin:

This report is offered in response to your letter dated June 22, 2012, regarding the State of Alabama's current or proposed use of Medicaid and other federal programs to implement the Americans with Disabilities Act (ADA). Alabama has, and will utilize numerous such means, in addition to its own state funding and programs, to expand community integration.

A summary of our activities to expand community living was prepared at the beginning of this calendar year, coordinated by our lead state agency for long term care rebalancing, our Alabama Medicaid Agency. That plan, contains highlights from each of our human service agencies that are charged with providing services and supports to various groups of individuals in community based settings. A copy of it is attached for your review. (Attachment 1) I believe it offers insight into the breadth of the many initiatives Alabama has begun since the United States Supreme Court issued its decision in the *Olmstead* case; many of which have happened during the time period that you have selected for this inquiry and data, between 2008 and 2012.

Since the time of the release of our "Gateway to Community Living, State of Alabama Long Term Care Rebalancing Initiatives, January 2012", which is our *Olmstead* Plan, Alabama has continued to expand community integration for people with disabilities. As the *Olmstead* Plan was being finalized, for example, the Partlow Developmental Center, the last state run intermediate care facility for people with intellectual disability, was closed and its 156 residents (prior to its announced closure) were transitioned to community living. Further, we announced the closure of more psychiatric hospitals and, after years of downsizing those hospitals, having already closed two, plus three state operated psychiatric nursing homes, just last week, we closed another psychiatric hospital. We are currently in the process of closing still another psychiatric hospital and anticipate its closure within the next two months. Though the earliest opportunity was passed upon several years ago to apply for the "Money Follows the Person" funding, we have recently applied for that resource and expect it, upon award, to significantly assist us in moving Alabama forward beyond our existing resources under our current Medicaid State Plan and waiver services. It will include resources for transitioning more individuals to, and keeping them in community settings for people in or threatened for psychiatric hospitalization, nursing home care and other long term institutionalization. This will also help those individuals secure housing in conjunction with resources from other federal, state and local housing agencies. The State of Alabama already operates seven home and community based services waivers in its Medicaid program. (See Attachment 2.) To summarize our most recent initiatives, Alabama was the first state to win approval for a 1915(j) state plan amendment to facilitate self-direction by

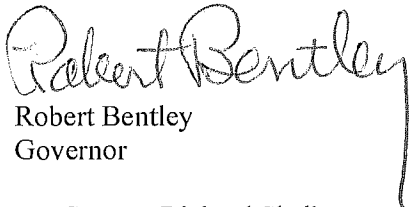
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people with disabilities and the elderly population. We began work initiatives that will hopefully lead to Alabama becoming an "Employment First" state for its people with developmental disabilities by shifting from focus on funding day programs and sheltered work to moving individuals into pre-vocational services as a prelude to attaining competitive employment. We are developing a 1915(i) state plan amendment to provide more home and community based services to people with serious and persistent mental illness and envision it becoming operational in the coming year. Resources from the "Money Follows the Person" award will assist us in development of a second, "ACT II" waiver that will target a nursing home-eligible population to receive home and community based services for people with developmental disabilities that are not currently served by Alabama's existing array of waiver programs.

Therefore, despite the challenges of the recession that has plagued the United States and Alabama since 2008, numerous changes have been, and are being implemented to serve and transition individuals who in years past would have been destined for institutional settings only. The remainder of this report will attempt to address the questions posed and data sought by this important Senate Committee, keeping in mind that in some cases, this state may not track data in the exact format in which the questions were raised. However, we have attempted to gather as many answers as we could to the Committee's questions.

Thank you for continuing to provide the States with tools to better serve the elderly and people with disabilities.

Sincerely,



Robert Bentley  
Governor

cc: Senator Richard Shelby  
Senator Jeff Sessions  
Stephanie Azar, J.D., Acting Commissioner, Alabama Medicaid Agency  
Cary Boswell, Commissioner, Alabama Department of Rehabilitation Services  
Nancy Buckner, Commissioner, Alabama Department of Human Resources  
Neal Morrison, Commissioner, Alabama Department of Senior Services  
Jim Reddoch, J.D., Commissioner, Alabama Department of Mental Health  
Don Williamson, M.D., State Health Officer, Alabama Department of Public Health

## ANSWERS TO INFORMATION REQUESTS

(1) For each year from FY 2008 to the present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long term care units of psychiatric hospitals, and board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program,

Type of Setting and/or Service	2008	2009	2010	2011	2012
Nursing Homes*					
Intermediate Care Facilities- ID	2	3	3	1 to own home/156 to ID community group homes	ICFMR closed
Long Term Care Units – Psychiatric Hospitals	20	18	25	5	1
Board and Care Homes*	NA	NA	NA	NA	NA
Into Psychiatric Foster Care	38	56	41	20	13
Psychiatric Group Homes to Independent Living (Home/Apts./Supportive Housing)	439	435	430	403	343

\* Data not collected. The Board and Care Homes are not funded by the state. As for nursing homes, while that data is not currently collected, when the “Money Follows the Person” award is received, it will allow that data collection to begin.

(2) The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.

Type of Setting and/or Service	State dollars allocated for FY12 (in millions)
Intermediate Care Facilities/ID	4.1
Boarding Homes*	0
LTC Psychiatric Hospitals	107
ID Group Homes	67
MI Group Homes	23
MI Foster Homes	1.8
MI Local Crisis/Acute Care	16
ID Living at Home Waiver	1.9
ID HCBS Waiver besides Group Homes + Case Mgt	29.7
ID Community Supports**	1.8
MI Supportive Housing	2.5

MI Semi-Independent Intensive apartments	1.7
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\*\* Unmatched state dollars spent in the community

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Other waiver and nursing home information indicating people served and dollars spent.\*\*\*:

		2008	2009	2010	2011
HIV	Recipients	65	120	129	142
	Expenditures	\$247,533	\$545,935	\$762,643	\$904,601
ID Waiver	Recipients	5,157	5,160	5,101	5,116
	Expenditures	\$239,097,927	\$268,275,927	\$270,457,495	\$279,003,301
EDW	Recipients	8,859	8,889	8,774	8,377
	Expenditures	\$84,689,595	\$91,155,467	\$90,177,052	\$92,493,151
SAIL	Recipients	605	578	539	516
	Expenditures	\$6,720,128	\$6,544,784	\$6,131,203	\$5,530,308
LAH	Recipients	447	448	527	540
	Expenditures	\$4,080,115	\$4,250,847	\$5,281,447	\$6,150,103
TA Waiver	Recipients			5	10
	Expenditures			\$614,552	\$701,123

Nursing Facility	FY08 Actual	FY09 Actual	FY10 Actual	FY11 YTD
Recipients	25,747	25,787	25,464	24,606
Expenditures	\$832,982,860	\$875,098,124	\$875,903,315	\$900,408,352

\*\*\*All expenditures here are total dollars not state only dollars. FMAP is currently approximately 68% for Alabama.

(3) For each year from FY 2008 to the present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program -- including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.

From FY08-FY12, the Alabama Department of Mental Health (ADMH) provided an array of community supports for individuals served by the department. In 2008, the following services were expanded using state dollars as indicated below.



**FY2008**

<b>Community Based Housing Service Expansion</b>	<b>FY08</b>
General/ Outpatient	2,956,847
Peer Specialist/Peer Bridger	1,000,000
Other Services	857,329
Mobile Teams	1,410,686
Crisis Stabilization	1,529,079
Crisis Evaluation & Support	2,850,050
Residential Group Care Home-Specialized	109,655
Residential Group Specialized Medical Home	692,360
Residential Group Specialized Behavioral Home	1,088,225
Residential Group Care Home	475,800
Foster Care Facility	1,477
MOMS	1,092,305
Supported Housing	
• EBP	2,012,640
• Assisted Living	623,614
Child Residential	206,744

In FY09-FY10, because of the extreme economic downturn, the Alabama Department of Mental Health was unable to expand services, but was at least able to maintain the majority of service expansions developed in FY08. In FY11 and FY12, ADMH continued with the community support expansion plan established in previous years. The following chart depicts the additional expansion services for FY11 and FY12. The following services were expanded using state dollars as indicated below. The expansion in FY11 and FY12 was created by transferring state facility budget dollars to the community services budget. ADMH did not receive any additional funds, but utilized reallocation of resources to increase community services and supports.

**FY2011**

<b>Community Based Housing Service Expansion</b>	<b>FY11</b>
Peer Specialist/Peer Bridger	700,000
Other Services	2,268,084
Mobile Teams	34,370
Indigent Drug Program	3,002,454
Residential Group Care Home	1,340,000
3 Bed Group Homes	1,690,000
MOMS	2,436,000
Supported Housing (Housing Supports)	720,000

**FY2012**

<b>Community Based Housing Service Expansion</b>	<b>FY12</b>
General Outpatient	187,125
Other Services	772,452
Mobile Teams	147,000
Specialized Behavioral Group Home for Deaf & Hard of Hearing	760,865

(4) The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.

(See Attachments 1 and 2.)

(5) Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.

While shovel ready projects' funding is understandably important, it rewards entities that have the capacity to quickly get projects underway, rather than those populations or states that have the most need. For example, the recently awarded HUD 811 program (which was revamped to be a more helpful subsidy program than was the previous 811 property development program) to help with housing for integration, rewards systems that have robust staffing and partners that already have resources. Pro rata formula funding for such housing subsidy would aid states with fewer resources that don't have as much infrastructure to compete with more resourced applicant groups.

(6) Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.

Approximately ten years ago, the Alabama Department of Mental Health partnered with the Alabama Housing Finance Authority to utilize HUD HOME funds and Low Income Housing Tax Credits to fund set asides of up to 15% of units of housing built for housing people with mental disabilities to assist with the closure of multiple institutions. It was great success for just a two-year allocation period, in providing affordable housing, even without vouchers, for hundreds of individuals to live independently.

This initiative appears to be similar in several ways to the design of the Melville Supportive Housing Investment Act of 2010, but may allow for some opportunities short of use of that Act's resources.

**ALABAMA HOME AND COMMUNITY-BASED WAIVER SERVICES**

Medicaid is a health care program for low income Alabamians. Home and Community-Based Waiver services provide additional Medicaid benefits to specific populations who meet special eligibility criteria. This chart summarizes those benefits, criteria, and informs you on how to apply for a HCBS waiver.

Applicants must meet financial, medical, and program criteria to access waiver services. The applicant must also be at risk of nursing institutionalization (nursing facility, hospital, ICF/MR). A client who receives services through a waiver program also is eligible for all basic Medicaid covered services. Each waiver program has an enrollment limit. There may be a waiting period for any particular waiver. Applicants may apply for more than one waiver, but may only receive services through one waiver at a time. Anyone who is denied Medicaid eligibility for any reason has a right to appeal. Additional information can be found on the Alabama Medicaid Agency's website: [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)

	Elderly & Disabled Waiver (Since 1982)	Intellectual Disabilities Waiver (Since 1981)	Living at Home Waiver (Since 2002)	State of Alabama Independent Living Waiver (Since 1992)
What is the purpose?	To provide services that would allow elderly and/or disabled individuals to live in the community who would otherwise require nursing facility level of care	To provide service to individuals that would otherwise require the level of care available in an intermediate care facility for the mentally retarded	To provide services to individuals who would otherwise require the level of care available in an ICF/MR	To provide services to disabled adults with specific medical diagnoses** who meet the nursing facility level of care criteria
What is the target population?	Individuals meeting the Nursing Facility Level of Care	Individuals with a diagnosis of Mental Retardation (MR); Individuals meeting an Intermediate Care Facility for the Mentally Retarded (ICF/MR)	Individuals with a diagnosis of Mental Retardation (MR); Individuals meeting the Intermediate Care Facility for the Mentally Retarded (ICF/MR) Level of Care; Persons not residing in a group home setting or environment; Persons currently on the waiting list for MR services	Individuals with a specific medical diagnoses
What are the services provided?	<ul style="list-style-type: none"> <li>• Case Management</li> <li>• Homemaker Services</li> <li>• Personal Care</li> <li>• Adult Day Health</li> <li>• Respite Care (Skilled and Unskilled)</li> <li>• Adult Companion Services</li> <li>• Home Delivered Meals</li> </ul>	<ul style="list-style-type: none"> <li>• Residential Habilitation</li> <li>• Residential Habilitation - Other Living Arrangement</li> <li>• Day Habilitation – Level 1-4</li> <li>• Day Habilitation with Transportation – Level 1-4</li> <li>• Prevocational Services</li> <li>• Supported Employment</li> <li>• Individual Job Coach</li> <li>• Individual Job Developer</li> <li>• Occupational Therapy</li> <li>• Speech and Language Therapy</li> <li>• Physical Therapy</li> <li>• Behavior Therapy– Level 1-3</li> <li>• In-Home Respite Care</li> <li>• Out-of-Home Respite Care</li> <li>• Institutional Respite Care</li> <li>• Personal Care</li> <li>• Personal Care on Worksite</li> <li>• Personal Care Transportation</li> <li>• Environmental Accessibility Adaptations</li> <li>• Specialized Medical Equipment</li> <li>• Medical Supplies</li> <li>• Skilled Nursing</li> <li>• Adult Companion Services</li> <li>• Crisis Intervention</li> <li>• Community Specialist</li> </ul>	<ul style="list-style-type: none"> <li>• Residential Habilitation In-Home</li> <li>• Day Habilitation-Level 1-4</li> <li>• Day-Habilitation with Transportation – Level 1-4</li> <li>• Prevocational Services</li> <li>• Supported Employment</li> <li>• Individual Job Coach</li> <li>• Individual Job Developer</li> <li>• Occupational Therapy Services</li> <li>• Speech and Language Therapy</li> <li>• Physical Therapy</li> <li>• Behavior Therapy- Level 1-3</li> <li>• In-Home Respite</li> <li>• Out-of-Home Respite</li> <li>• Personal Care</li> <li>• Personal Care on Worksite</li> <li>• Personal Care Transportation</li> <li>• Environmental Accessibility Adaptations</li> <li>• Specialized Medical Equipment</li> <li>• Medical Supplies</li> <li>• Skilled Nursing</li> <li>• Community Specialist</li> <li>• Crisis Intervention</li> </ul>	<ul style="list-style-type: none"> <li>• Case Management **</li> <li>• Personal Care</li> <li>• Personal Assistance Service</li> <li>• Environmental Accessibility Adaptations**</li> <li>• Personal Emergency Response System (Initial Setup)</li> <li>• Personal Emergency Response System (Monthly Fee)</li> <li>• Medical Supplies</li> <li>• Minor Assistive Technology</li> <li>• Assistive Technology**</li> <li>• Evaluation for Assistive Technology</li> <li>• Assistive Technology Repairs</li> </ul> <p align="center">**Includes Transitional Services</p>
Waiver criteria :	Nursing facility level of care	ICF/MR level of care	ICF/MR level of care	Nursing facility level of care
What groups can be eligible for this waiver?	<ul style="list-style-type: none"> <li>• Individuals receiving SSI</li> <li>• Individuals receiving State Supplementation</li> <li>• SSI related protected groups deemed to be eligible for SSI / Medicaid</li> <li>• Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate</li> <li>• Federal or State Adoption Subsidy Individuals</li> </ul>	<ul style="list-style-type: none"> <li>• Individuals receiving SSI</li> <li>• SSI related protected groups deemed to be eligible for SSI / Medicaid</li> <li>• Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate</li> <li>• Low Income Families with Children</li> <li>• Federal or State Adoption Subsidy Individuals</li> </ul>	<ul style="list-style-type: none"> <li>• SSI recipients</li> <li>• Federal or State Adoption Subsidy Individuals</li> <li>• SSI related protected groups deemed to be eligible for SSI / Medicaid</li> <li>• Low Income Families with Children</li> </ul>	<ul style="list-style-type: none"> <li>• Individuals receiving SSI</li> <li>• Individuals receiving State Supplementation</li> <li>• SSI related protected groups deemed to be eligible for SSI / Medicaid</li> <li>• Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate</li> </ul>
Enrollment Limit:	9,205	5,260	569	660
Is there an age requirement?	No age requirement	3 years and older	3 years and older	18 years and older
Who provides Case Management?	Dept of Senior Services	Dept of Mental Health	Dept of Mental Health	Dept of Rehabilitation Services
Where to go to receive information on how to apply?	Dept of Senior Services <a href="http://www.adss.alabama.gov">www.adss.alabama.gov</a>	Dept of Mental Health <a href="http://www.mh.alabama.gov">www.mh.alabama.gov</a>	Dept of Mental Health <a href="http://www.mh.alabama.gov">www.mh.alabama.gov</a>	Dept of Rehabilitation Services <a href="http://www.rehab.alabama.gov">www.rehab.alabama.gov</a>
Who are the contact persons?	Jean Stone 1-800-243-5463	DMH / ID Call Center 1-800-361-4491  Willodean Ash (334) 242-3701	DMH / ID Call Center 1-800-361-4491  Willodean Ash (334) 242-3701	Karen Coffey 1-800-441-7607
What are the reference sources?	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 35	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 35	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 52	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 57

\*\*Specific medical diagnoses include, but are not limited to: Quadriplegia, Traumatic Brain Injury, Amyotrophic Lateral Sclerosis, Multiple Sclerosis, Spinal Muscular Atrophy, Muscular Dystrophy, Severe Cerebral Palsy, Stroke, and other substantial neurological impairments, severely debilitating diseases, or rare genetic diseases (such as Lesch-Nyhan disease).

**ALABAMA HOME AND COMMUNITY-BASED WAIVER SERVICES**

	Technology Assisted Waiver for Adults (Since 2003)	HIV/AIDS Waiver A.K.A. 530 Waiver (Since 2003)	Alabama Community Transition (ACT) Waiver (Since 2011)
What is the purpose?	To provide services to adults with complex skilled medical conditions who would otherwise require nursing facility level of care	To provide services to individuals with a diagnosis of HIV, AIDS, and related illness who would meet the nursing facility level of care criteria	To provide services to individuals with disabilities or long term illnesses, who live in a nursing facility and who desire to transition to the home or community setting
What is the target population?	Individuals with complex skilled medical conditions who are ventilator dependent or who has a tracheostomy.	Individuals with a diagnosis of HIV or AIDS and related illnesses.	Individuals with disabilities or long term illnesses currently residing in a nursing facility.
What are the services provided?	<ul style="list-style-type: none"> <li>▪ Private Duty Nursing</li> <li>▪ Personal Care/Attendant Services</li> <li>▪ Medical Supplies</li> <li>▪ Assistive Technology</li> </ul> <p>**Targeted Case Management which includes transitional services. (A covered service under Medicaid's State Plan)</p>	<ul style="list-style-type: none"> <li>▪ Case Management **</li> <li>▪ Homemaker Services</li> <li>▪ Personal Care</li> <li>▪ Respite Care</li> <li>▪ Skilled Nursing</li> <li>▪ Companion Services</li> </ul> <p>**Includes Transitional Services</p>	<ul style="list-style-type: none"> <li>▪ Case Management</li> <li>▪ Transitional Assistance</li> <li>▪ Personal Care</li> <li>▪ Homemaker Services</li> <li>▪ Adult Day Health</li> <li>▪ Home Delivered Meals</li> <li>▪ Respite Care (Skilled and Unskilled)</li> <li>▪ Skilled Nursing</li> <li>▪ Adult Companion Services</li> <li>▪ Home Modifications</li> <li>▪ Assistive Technology</li> <li>▪ Personal Emergency Response Systems (PERS) Installation/Monthly Fee</li> <li>▪ Medical Equipment Supplies and Appliances</li> </ul>
Waiver criteria:	Nursing facility level of care	Nursing facility level of care	Nursing facility level of care
What groups can be eligible for this waiver?	<ul style="list-style-type: none"> <li>▪ Individuals receiving SSI</li> <li>▪ SSI related protected groups deemed to be eligible for SSI</li> <li>▪ Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate</li> </ul>	<ul style="list-style-type: none"> <li>▪ Individuals receiving SSI</li> <li>▪ Disabled individuals with income up to 300% of the SSI income level</li> </ul>	<ul style="list-style-type: none"> <li>▪ Special HCBS waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate</li> <li>▪ Individuals receiving SSI</li> <li>▪ Individuals determined to be eligible for transition into the community based upon an assessment</li> <li>▪ Individual that have been in the nursing facility for 90 days or more</li> <li>▪ Individuals that are expected to move into the community within 180 days</li> </ul>
Enrollment Limit:	40	150	200
Is there an age requirement?	21 years and older	21 years and above	No age requirement
Who provides Case Management?	Department of Rehabilitation Services	Department of Senior Services	Department of Rehabilitation Services
Where to go to receive information on how to apply?	Alabama Medicaid Agency <a href="http://www.medicaid.alabama.gov">www.medicaid.alabama.gov</a>	Department of Senior Services <a href="http://www.adss.alabama.gov">www.adss.alabama.gov</a>	Dept of Rehabilitation Services <a href="http://www.rehab.alabama.gov">www.rehab.alabama.gov</a>
Who are the contact persons?	Karen Coffey 1-800-441-7607	Jean Stone 1-800-243-5463	Karen Coffey 1-800-441-7607
What are the reference sources?	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 54	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 58	Code of Federal Regulations: 42 CFR 440.180 and 441.300 Policy provision for providers: Medicaid Admin Code Ch. 44

Revised: 02-1-2012/



THE STATE  
of **ALASKA**  
GOVERNOR SEAN PARNELL

**Department of  
Health and Social Services**

OFFICE OF THE COMMISSIONER  
Anchorage

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August 30, 2012

The Honorable Tom Harkin, Chairman  
United States Senate Committee on Health,  
Education, Labor, and Pensions  
Washington, DC 20510-6300

Dear Senator Harkin:

Thank you for your letter of June 22, 2012 to Governor Parnell regarding Alaska's services to individuals with disabilities. The Governor has requested that I respond to you on his behalf.

Alaska has been a forerunner in the promotion of community integration for individuals with disabilities. In 1997 the state's only Intermediate Care Facility for Intellectually and Developmentally Disabled individuals was closed. Shortly thereafter the private agency, Hope Cottages, also closed their small facilities thereby making Alaska the first state in the country with no public or private institutions for individuals with intellectual and developmental disabilities.

In 1999 the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded funding for the Department of Health and Social Services (DHSS) Community Mental Health/Alaska Psychiatric Institute Replacement project to develop an integrated system of care for individuals with mental health and substance induced crises. As a result of this project, the state's only public inpatient psychiatric hospital, originally equipped to house 242 patients, downsized to a bed capacity of 80.

Additionally, Alaskans are currently able to access fewer than 700 nursing home beds. As a result of these few in-state institutional resources for individuals with these very high needs, our home and community based care delivery system has become very robust and innovative in providing necessary care in the least restrictive setting possible.

Your letter references several opportunities Congress has made available to promote community based services. While these opportunities may be beneficial for some states which do not have the same high ratio of individuals with high needs being served in the community, they actually have created additional challenges for Alaska.

The Community First Choice option held promise initially for Alaska, as a way to redefine our personal care attendant (PCA) program and increase the quality of our existing program utilizing the federal Medicaid match enhancement afforded by that program. Unfortunately, the final rules

imposed a restriction that all participants meet an institutional level of care to qualify. If Alaska chose to redefine our existing state plan PCA services program using the Community First Choice option, approximately 50% of those individuals currently enrolled in the PCA would lose that service and their conditions would almost surely worsen. In order to cover the entire population receiving these services Alaska would be forced to administer two separate programs, each serving approximately 2,500 individuals. This is an unfortunate result of the final rule implemented by CMS.

Another tool you reference in your letter is the Balancing Incentives Payment Program that provides enhanced federal Medicaid match for expanding home and community-based services. The eligibility for funding for this program was based upon FFY 2009 long term support services (LTSS) Medicaid experience. Alaska's LTSS spending demonstrated that 62.7% of the LTSS funds were expended for home and community based settings (ranked 6<sup>th</sup> in the nation). Because of that benchmark performance we were not able to participate in this enhanced funding opportunity.

In your June 22, 2012 correspondence you ask for responses in some very specific areas. In the six enumerated areas below we provide you with the information that is currently available. In some cases, the specific data requested is not available.

- 1. For each year from FY 2008 to present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long term care units of psychiatric hospitals, and board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program.**

Skilled Nursing Facility residents who returned to home:

SFY2008:	79
SFY2009:	101
SFY2010:	104
SFY2011:	92

Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities (out-of-state):

SFY2008:	1
SFY2009:	2
SFY2010:	1
SFY2011:	1
SFY2012:	1

Inpatient psychiatric stay greater than 60 days who returned to community living:

CY2008:	no data
CY2009:	21
CY2010:	32
CY2011:	36

CY2012 to date: 15

- The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.

The following are approximations for the current SFY (in millions).

Skilled Nursing Facilities: \$48.0

Intermediate Care Facilities for Individuals with Intellectual or Developmental Disabilities: \$1.0

Psychiatric hospitals: not available

Supported Housing (behavioral health assisted living): \$2.7

Residential Psychiatric Treatment (child/adolescent): \$36.0

Assisted Living Homes: \$24.0

Group Homes: \$26.5

Other in-home services: \$125.0

- For each year from FY 2008 to present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.

**1915(c) Waivers – additional individuals served**

Older Alaskans Waiver

Fiscal year	Total cost	Year/year change	Cumulative change	Participants	Year/year change	Cumulative change	Cost per participant	Year/year change	Cumulative change
2007	\$16,536,844			1,563			\$10,580		
2008	\$17,439,336	5.5%	5.5%	1,612	3.1%	3.1%	\$10,818	2.3%	2.3%
2009	\$19,791,084	13.5%	19.7%	1,673	3.8%	7.0%	\$11,830	9.3%	11.8%
2010	\$21,107,435	6.7%	27.6%	1,689	1.0%	8.1%	\$12,497	5.6%	18.1%
2011	\$22,399,554	6.1%	35.5%	1,795	6.3%	14.8%	\$12,479	-0.1%	17.9%
2012*	\$27,508,782	22.8%	66.3%	2,969	65.4%	90.0%	\$9,265	-25.8%	-12.4%

Adults with Physical Disabilities

Fiscal year	Total cost	Year/year change	Cumulative change	Participants	Year/year change	Cumulative change	Cost per participant	Year/year change	Cumulative change
2007	\$9,636,011			1,073			\$8,980		
2008	\$10,918,386	13.3%	13.3%	1,114	3.8%	3.8%	\$9,801	9.1%	9.1%
2009	\$12,623,059	15.6%	31.0%	1,170	5.0%	9.0%	\$10,789	10.1%	20.1%
2010	\$14,561,753	15.4%	51.1%	1,250	6.8%	16.5%	\$11,649	8.0%	29.7%
2011	\$17,104,540	17.5%	77.5%	1,351	8.1%	25.9%	\$12,661	8.7%	41.0%
2012*	\$13,948,227	-18.5%	44.8%	1,360	0.7%	26.7%	\$10,256	-19.0%	14.2%

Intellectual with Developmental Disabilities

Fiscal year	Total cost	Year/year change	Cumulative change	Participants	Year/year change	Cumulative change	Cost per participant	Year/year change	Cumulative change
2007	\$35,693,286			1,015			\$35,166		
2008	\$38,913,197	9.0%	9.0%	1,098	8.2%	8.2%	\$35,440	0.8%	0.8%
2009	\$44,128,680	13.4%	23.6%	1,237	12.7%	21.9%	\$35,674	0.7%	1.4%
2010	\$50,472,684	14.4%	41.4%	1,407	13.7%	38.6%	\$35,873	0.6%	2.0%
2011	\$55,144,915	9.3%	54.5%	1,522	8.2%	50.0%	\$36,232	1.0%	3.0%
2012*	\$57,899,556	5.0%	62.2%	1,618	6.3%	59.4%	\$35,785	-1.2%	1.8%

Children with Complex Medical Conditions

Fiscal year	Total cost	Year/year change	Cumulative change	Participants	Year/year change	Cumulative change	Cost per participant	Year/year change	Cumulative change
2007	\$4,680,207			216			\$21,668		
2008	\$4,717,896	0.8%	0.8%	226	4.6%	4.6%	\$20,876	-3.7%	-3.7%
2009	\$5,229,546	10.8%	11.7%	235	4.0%	8.8%	\$22,253	6.6%	2.7%
2010	\$5,566,934	6.5%	18.9%	255	8.5%	18.1%	\$21,831	-1.9%	0.8%
2011	\$5,713,898	2.6%	22.1%	285	11.8%	31.9%	\$20,049	-8.2%	-7.5%
2012*	\$5,434,846	-4.9%	16.1%	276	-3.2%	27.8%	\$19,691	-1.8%	-9.1%

State Plan Personal Care Attendant (PCA) Services

Personal Care Assistant Program

Fiscal year	Total cost	Year/year change	Cumulative change	Participants	Year/year change	Cumulative change	Cost per participant	Year/year change	Cumulative change
2007	\$38,994,634			3,824			\$10,197		
2008	\$35,641,936	-8.6%	-8.6%	3,527	-7.8%	-7.8%	\$10,105	-0.9%	-0.9%
2009	\$39,422,926	10.6%	1.1%	3,577	1.4%	-6.5%	\$11,021	9.1%	8.1%
2010	\$47,301,694	20.0%	21.3%	3,994	11.7%	4.4%	\$11,843	7.5%	16.1%
2011	\$54,655,549	15.5%	40.2%	4,658	16.6%	21.8%	\$11,734	-0.9%	15.1%
2012*	\$56,547,947	3.5%	45.0%	4,934	5.9%	29.0%	\$11,461	-2.3%	12.4%

\*Billing and claims processing is not complete for 2012.

**Supported Housing**

In 2006, the Alaska Mental Health Trust Authority (The Trust) developed a targeted funding and planning initiative focusing on Safe, Affordable Housing. In partnership with Alaska Housing Finance Corporation (AHFC) and DHSS, the Trust piloted programs to address access to supported housing and the increasing rates of incarceration, homelessness and institutionalization of Trust beneficiaries. The Bridge Home project is a major component of the housing initiative and is overseen by the Division of Behavioral Health (DBH), Office of Supportive Housing with housing and support services administered by Anchorage Community Mental Health Services. The project provides a rental subsidy, based on income, and intensive in-home support services for individuals to “bridge” from institutional discharge to the HUD Housing Choice voucher program (formerly known as the Section 8 housing voucher program) administered by AHFC. Since 2010, 88 individuals have been served through the program.



The Department of Health and Social Services has recently submitted a joint application with AHFC for a HUD 811 Demonstration Project to provide 60-80 new project based housing vouchers and support services targeted towards individuals with serious mental illness and/or living in Assisted Living Homes. The target population is estimated to be 354 individuals in general relief assisted living. The Division of Behavioral Health (DBH) currently subsidizes 160 individuals in ALHs with serious mental illness. Senior and Disabilities Services (SDS) subsidize approximately 194 individuals in ALHs with serious mental illness and/or intellectual or developmental disability. Many of these individuals would be capable of transitioning to independent living if there was affordable housing and appropriate support available. Rental housing is scarce with an average overall vacancy rate in the target communities of 2%. In addition, the cost of housing particularly for the target population is unattainable for most. Rental assistance subsidies are a key component to assisting people in achieving stable housing within the community. In early 2012, AHFC closed their Section 8 waitlist due to the high volume of eligible households (over 3,000 individuals and families) and the limited number of vouchers circulating and available to provide subsidy.

- 4. The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.**

All programs managed by DHSS contemplate *Olmstead* implications in the management of existing programs and development of new programs. Our planning partners, including advocacy organizations, the Mental Health Trust Authority, consumers, providers and family members continuously evaluate the availability and promotion of community integration in all our programs.

- 5. Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.**

Removing the "institutional level of care" requirement for the Community First Choice option would be an excellent strategy to remove barriers to community integration for individuals who have functional limitations but do not require hands-on nursing assistance such as that provided in a skilled nursing facility.

- 6. Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.**

Alaska's "Bring the Kids Home" project, a partnership between the Alaska Mental Health Trust Authority, the Department of Health and Social Services, the State planning boards, Families, Youth, Providers, Tribes and other stakeholders have successfully developed and implemented

Senator Tom Harkin  
August 30, 2012  
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strategies to bring youth who were placed in out of state residential psychiatric treatment (RPTC) facilities back to Alaska and into the community whenever possible. Between 2004 and 2010 the state realized an 87.2% decrease in out-of-state RPTC admissions. In the current evolution of this project, we are developing in-state, community-based expertise to address the needs of the youth still requiring referrals to out of state facilities. These youth predominately carry diagnoses that compound behavioral health concerns with intellectual or developmental disabilities. With the use of state funds we are partnering national-level expertise with in-state community providers to bolster the array of interventions available to support these youth in their community settings. This Complex Behavior Collaboratives project is merely months old, yet we have seen a decrease in out-of-state placements, early return from out-of-state placements and successful transitions from institutional care to the community setting.

Sincerely,



William J. Streur  
Commissioner

cc: Honorable Senator Lisa Murkowski  
Honorable Senator Mark Begich  
Honorable Congressman Don Young  
Kip Knudson, Office of the Governor  
Alaska Mental Health Trust Authority



STATE OF ARIZONA

JANICE K. BREWER  
GOVERNOR

EXECUTIVE OFFICE

September 6, 2012

The Honorable Tom Harkin, Chairman  
Senate Health, Education, Labor, and Pensions Committee  
731 Hart Senate Office Building  
Washington, DC 20510

Dear Chairman Harkin:

Thank you for the opportunity to provide information about how the State of Arizona has responded to the Americans with Disabilities Act and the United States Supreme Court's decision in *Olmstead v. L.C.* Attached you will find Arizona's response to your request for information.

Arizona is committed to administering services to individuals with disabilities in the most integrated settings appropriate to their needs. Despite recovering from one of the worst budget deficits in the country, Arizona continues to lead the nation in the percentage of individuals with developmental disabilities supported in their own home or family home. Since 2008, Arizona has consistently ranked one of the top two performing states as reported by the National United Cerebral Palsy "Case for Inclusion" study, and in 2010 again ranked number one in how well people with developmental disabilities are served in the most integrated community settings.

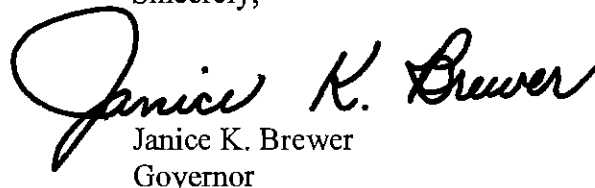
Additionally, I remain dedicated to serving the needs of individuals with Serious Mental Illness, as demonstrated by the funding I pursued for state fiscal year 2013. With the support of the legislature, \$38.7 million dollars has been allocated to the Arizona Department of Health Services to provide community based, recovery-oriented behavioral health services.

Arizona remains diligent in ensuring that individuals with disabilities have the opportunity to live, work and receive services in the greater community. Although a great deal of progress has already been made, we continually strive for better integrated, appropriate, and efficient programs and services for individuals with disabilities.

Senator Tom Harkin  
September 6, 2012  
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If you or your staff have any additional questions or you would like further information, please do not hesitate to contact Jamie Bennett or Don Hughes from my office at (602) 542-1340.

Sincerely,

  
Janice K. Brewer  
Governor

cc: Michael B. Enzi, Ranking Member, Senate Committee on Health, Education, Labor and Pensions  
Chairman Max Baucus, Senate Finance Committee  
Ranking Member Orrin G. Hatch, Senate Finance Committee  
Senator Jon Kyl  
Senator John McCain  
Andrew Imparato, Senior Counsel and Disability Policy Director

**Arizona Response: Olmstead Progress**  
**Information provided by the Arizona Health Care Cost Containment System, the Arizona**  
**Department of Economic Security, and the Arizona Department of Health Services**  
**August 6, 2012**

- (1) *Question:* For each year from FY 2008 to the present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long term care units of psychiatric hospitals, and board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program.

*Answer:* Arizona's single state Medicaid agency, Arizona Health Care Cost Containment System (AHCCCS) operates under an 1115 waiver. AHCCCS contracts with the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) to deliver Medicaid services for people with developmental disabilities. The DES/DDD offers services in institutional facilities (Intermediate Care Facilities (ICF) and skilled nursing facilities) and home and community based settings (developmental homes, group homes, and in family or individual homes).

The Arizona Department of Health Services/Division of Behavioral Health Services (DHS/DBHS) receives capitated funding through an Intergovernmental Agreement from the DES/DDD to provide behavioral health services to DDD/LTC (Long-Term Care) members. The DHS/DBHS does not serve any state-only DDD members. The benefit package for the DDD/LTC members is the same as provided to other Medicaid-enrolled members receiving behavioral health services.

The DHS/DBHS is not responsible for community housing for DDD/LTCS members; the DES/DDD has contracts directly with providers/vendors who provide in-home and group home services. The DHS/DBHS does, however, cover costs when DDD/LTCS members are admitted to behavioral health inpatient and residential facilities, as well as collaborate on discharge planning for these individuals. For members admitted to Skilled Nursing Facilities, the DHS/DBHS and the DES/DDD each complete Preadmission Screening and Resident Reviews (PASRRs) to ensure the placement is appropriate.

Less than 1% of the over 30,000 individuals served by the DES/DDD live in an institutional setting primarily because of deinstitutionalization efforts that began in the late 1970s. The only persons remaining in an institutional setting are those who choose not to leave or those unable to be served in a non-institutional setting. Therefore, the DES/DDD does not track the number of individuals who move out of institutions. The DES/DDD reports each year to the Arizona Legislature the number of new individuals who move into a state operated ICF and why the placement was deemed most appropriate. Currently, approximately 185 people live in an ICF and 50 live in a skilled nursing facility. As of March 2012, six people live in board and care homes (referred to as Assisted Living Facilities in Arizona).

The DHS/DBHS is able to report the number of individuals served by the public behavioral health system who have transitioned from nursing homes, intermediate care facilities, psychiatric hospitals or residential care facilities and are now living independently or at home with friends or family members. The table below illustrates the number of individuals who meet this criteria for state fiscal years 2008 – 2011. Of important note, the vast majority (approximately 83%) of members receiving services live independently, or with friends or family members, at admission into treatment. These individuals are not included in the table below, as they were already being served in the least restrictive setting applicable to their level of need.

<b>State Fiscal Year</b>	<b>Number of Individuals Originally in a Facility Setting at Admission (A)</b>	<b>Number of Individuals in Column 'A' who Transitioned into an Independent Living Arrangement</b>	<b>Percent of Members who Transitioned</b>
2008	3,762	1,270	33.7%
2009	4,517	1,478	32.7%
2010	3,862	1,306	33.8%
2011	3,917	1,126	28.7%

*(Information for state fiscal year 2012 was not yet available at the time of this request).*

- (2) *Question:* The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.

*Answer:* For SFY 2013, the DES/DDD and the DHS/DBHS anticipate spending the following amounts for each of the following settings:

<b>Setting</b>	<b>State Dollars to be Spent in this Fiscal Year</b>
Skilled Nursing Facility*	\$2.8 million
ICF*	\$36.9 million
Group/ Developmental Home*	\$290.4 million
Psychiatric Hospital – Inpatient Services	\$7.8 million
Permanent Supportive Housing through the DHS/DBHS	\$11.4 million
Supported Living (IDLA)*	\$26.9 million
Family / Own Home*	\$398.8 million

*\*The amounts budgeted represent total funds, which include the appropriate FMAP of approximately 33% state funds and 67% federal funds.*

- (3) *Question:* For each year from FY 2008 to the present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.

*Answer:* From the inception of its 1115 research and demonstration waiver, Arizona committed to provide available home and community based services to everyone who qualified based on the individual’s assessed need. As a result, capacity continuously expands and contracts in response to the aggregate needs of all system members, and there is no limit placed on the number of providers who can apply to deliver services to the DES/DDD. The array of in-home services includes attendant care, habilitation, respite, intensive behavioral treatment for young children with autism, and skilled nursing services for individuals with intense medical needs.

Arizona leads the nation in the percentage of individuals with developmental disabilities supported in their own home or family home as evidenced by the National United Cerebral Palsy “Case for Inclusion” study. Since 2008, Arizona has consistently ranked as one of the top two performing states and in 2010 again ranked number one in how well people with developmental disabilities are served in the most integrated community settings. Historically, the DES/DDD has served approximately 88% of its members in their own homes, including a supported housing program. The table below provides the number of people service at home and total expenditures.

<b>Federal Fiscal Year End</b>	<b>Total Number of People Served in Own Home</b>	<b>Expenditures for People Served in Own Home</b>
2008	26,071	\$359,389,400
2009	27,131	\$385,299,800
2010	27,366	\$371,006,000
2011	28,077	\$386,631,500

To achieve adequate capacity to meet all member needs, the DES/DDD maintains a robust provider network of contracted agencies (over 600) and independent providers. Using an open and continuous procurement process, interested agencies can submit applications to provide contracted services at any time rather than following a Request for Proposals (RFP) process. Similarly, these contracted providers can apply at any time to expand the geographic areas in which they serve, as well as increase the array of services they choose to provide. The Division also contracts with a network of independent providers (over 2,500), which enables individuals to select a family member, friend, or neighbor to become a certified independent service provider. Under this option, an individual or family member is the employer of record and directly supervises the home caregiver.

Below is a table that details the number of “housing units” for supported housing services that were reported by the statewide Regional Behavioral Health Authorities (RBHAs). Each “unit” represents housing for one person, whether it is one house or apartment, or one placement within a house or apartment complex that has multiple units. Supported housing services are available for individuals with disabilities—in this case, housing is only for adults determined to have a Serious Mental Illness (SMI).

The second table below details the total supported housing assistance as reported by the statewide RBHAs for each year.

RBHA / GSA	FY2009	FY2010	FY2011	FY2012
Statewide All Counties	3,608	3,764	3,860	3,936

*(FY2008 data is not available)*

	2008	2009	2010	2011	2012	2013 *	Total
<b>Rent Subsidies</b>	\$2.8 M	\$5.5 M	\$5.5 M	\$12.1 M	\$9.3 M	\$9.5 M	\$44.7M
<b>Acquisition</b>	\$3.1 M	\$2.6 M	\$3.0 M	\$400,000	\$800,000	\$2.0 M	\$11.9M
<b>Total Supported Housing</b>	\$5.9 M	\$8.1 M	\$8.5 M	\$12.5 M	\$10.1 M	\$11.4 M	\$56.5M

*(Figures are rounded to the closest hundred thousandth)*

*\*Estimated*

In addition to the above-noted figures, the DHS/DBHS offers a wide range of prevention, treatment, rehabilitation and support services to its members. The continuum of care emphasizes the rendering of services in the least restrictive environment possible, as determined by the member’s specific needs and level of acuity. The majority of the members receive treatment in licensed outpatient clinics located within their local communities.

- (4) *Question:* The contents of your state’s Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community based services, and the extent to which you have been successful in meeting any quantifiable goals identified within in.

*Answer:* Providing services in the most integrated community setting is an underlying principle of the AHCCCS, the DES/DDD and the DHS/DBHS long term care system pre-dating Olmstead. As such, many aspects of the State’s compliance with the Olmstead Decision were already incorporated into the rules, policies and practices of these agencies prior to the Arizona’s Olmstead Plan (August 2001).



The primary contents of Arizona's Olmstead Plan include: Background and Introduction; Common Components of Community Based Medicaid Programs in Arizona; Common Themes for All State Agencies; Agency Specific Actions; Time Frame for Plan Development; and Work Plan for Each Agency.

AHCCCS, the DES/DDD and the DHS/DBHS convened an initial meeting in June 2000 to discuss the Supreme Court decision and subsequent information from the Centers for Medicare and Medicaid Services. In August 2000, the state agencies identified the process to encourage consumer involvement in the plan development process. The state agencies conducted four regional stakeholder meetings, including one that was conducted via videoconference, one subcommittee for document review and several additional agency specific planning meetings.

In November and December 2000, Arizona held statewide meetings to present these preliminary plans and receive input. Consumers recommended that the agencies develop a single, consolidated plan because of the issues common to all consumers and the three agencies. Based on the input, in March 2001, Arizona developed the draft consolidated plan and requested review by a group of volunteers from the stakeholder community. During April and May 2001, Arizona revised the consolidated plan, again based on the consumer responses, and posted a copy of the revised plan on the AHCCCS website in early June.

Additional stakeholder meetings occurred to receive comments on the plan. The final plan was published and posted on the AHCCCS website in August 2001. Since that time, the agencies have periodically reviewed and updated the final plan and continued to seek consumer input on the status of the recommendations.

Arizona's Olmstead Plan included a Work Plan with specific actions to be completed by the participating agencies. AHCCCS has completed 11 of the 14 goals identified in the plan, and the DES/DDD has completed 13 of the 16 goals identified in the plan.

In 1989, Arizona implemented the innovative 1115 home and community based waiver that incorporated long term care services for the elderly, the physically disabled, and people with developmental disabilities. This enabled the DES/DDD to serve people in home and community based settings rather than institutions with no limit to the number of individuals who can reside outside of institutions. Medicaid limits expenditures to no more than the amount that would have been spent on individuals in institutions. Members' options and choices are based on need.

AHCCCS recently submitted an amendment to the State Plan indicating its intent to participate in the Community First Choice Option. While this option mirrors many of the current practices of the DES/DDD home and community based services, it is anticipated that individuals under this option will have greater control of their service delivery.

Much has been accomplished toward the DHS/DBHS' goals, including development of service planning guidelines, the adoption of the American Society of Addiction Medicine (ASAM) placement criteria, the creation and monitoring System of Care plans for adults and children throughout the system, an on-going network development and analysis process, implementation of Assertive Community Treatment (ACT)/Intensive Recovery Teams and the development of the Office of Individual and Family Affairs within the DHS/DBHS.

Additionally, the DHS/DBHS is required to "make its best efforts to identify Class Members residing at the Arizona State Hospital ("ASH") who could benefit from community living arrangements and take steps to facilitate their discharge from ASH" as part of the May 17, 2012 agreement between DHS and the plaintiffs on the Arnold vs. ADHS suit.

The Arnold vs. DHS agreement also outlines the focus on employment, case management, ACT, peer and family support, supported housing, living skills training, health promotion, personal assistance, respite care and medication. Specifically, the DHS/DBHS must provide these services with fidelity to the SAMHSA models for ACT, supported housing, supported employment and consumer operated services.

In regards to employment, the DHS/DBHS maximizes services through a collaborative partnership with the Rehabilitation Services Administration's Vocational Rehabilitation (RSA/VR). The state program solely supports competitive, community based and integrated employment outcomes.

The relationship between RSA/VR and the RBHAs is progressing and preserves the ideals of expedited eligibility (from federally mandated 60 days to determine eligibility to 30 days). Doing so allows the VR Counselors to have functional workspace at the RBHA provider sites, upholds VR Counselor presence at the RBHA Provider level, and allows communication between the parties without the necessity of a signed Release of Information, while amending the Intergovernmental Agreement between the two entities to incorporate cross-training for VR Counselors in the area of psychiatric disabilities who are working with Behavioral Health individuals. This has been accomplished through the development of region-specific services and developing the skills of Peer Support Specialists/ Recovery Support Specialists to assist in service delivery.

In regards to housing efforts, over the past five years, the DHS/DBHS has been partnering with the Arizona Department of Housing (DOH) in order to maximize funding for housing for individuals with serious mental illness. The partnership includes working together to apply for federal HUD grants to develop housing and coordinating through the RBHAs to provide matching behavioral health supportive services, which may include treatment services, rehabilitation services, medical services, support services and crisis intervention, to ensure that individuals are able to have the supports that will allow them to remain in stable housing.

The DHS recently completed an extensive input-gathering series of community meetings to hear directly from providers, individuals, family members and stakeholders and has allocated new funding for fiscal year 2013 to contractors based on the concepts developed with these groups, prioritizing integrated, peer-driven community based services.

The DHS/DBHS has also ensured the principles of the Olmstead Decision are infused throughout the DHS/DBHS/RBHA Annual Network Development and Management Plan as well as the ongoing network development process. The Network Plan manages and maintains a comprehensive, diverse and flexible provider network for enrolled members.

The Network Management Plan is designed to:

- Develop and maintain a network that promotes the values of choice, dignity, independence, self-determination, member-centered case management, consistency of services, accessibility of network services, and support the most integrated setting while collaborating with stakeholders.
- Embed the DHS/DBHS nine guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems and the 12 Principles of Care within the children's network system.
- Meet the needs of current and future members, including the special needs population(s), such as those members with cognitive impairments, behavioral health needs, and the aged and functionally disabled.
- Encompass a full continuum of network providers including medical and behavioral health care professionals, ancillary service providers, Home and Community Based Service (HCBS) providers, HCBS facilities and Skilled Nursing Facilities (SNF's) to meet the requirements of the physical and behavioral health network integration.
- Support and encourage member involvement in decision-making and network enhancement.
- Resolve member's concerns, problems and issues timely and effectively.
- Provide the framework for coordinating and integrating medical and non-medical (behavioral health and social) services.
- Provide access to care, at least equal to or better than community norms, in terms of timeliness, amount, duration, and scope of services as those available to non-Medicaid-eligible persons within the same service area.
- Promote home and community based services and settings with the ability to allow members, when appropriate, to reside in or return to their own homes versus having to reside in an institutional or alternative residential setting.
- Enhance the members' independence, well-being and safety.
- Develop services that consider the culture, race, ethnic and religious concerns of members.
- Support the member's informal support system through respite services, adult day health care and other home and community based services.
- Maximize the use of community based primary care services.
- Reduce utilization of unnecessary emergency room visits, one-day hospital visits, and hospital based outpatient surgeries when a lower cost surgery center is available.

- Support paraprofessional workforce development in nursing facilities, alternative residential facilities, and in the home (attendant care, personal care and homemaker) to increase the number of individuals participating in the behavioral health care workforce.
- Identify the most significant barriers to efficient network deployment and identify opportunities to improve the quality of care delivered to members.
- Monitor the timeliness and accessibility of care by providers to ensure that covered services are available seven days per week, with emergency medical care available 24 hours per day, seven days per week.
- Include members and their families, providers and other appropriate community organizations in the assessment and review of ongoing network strategies.

(5) *Question:* Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.

*Answer:* Regardless of the setting, planning teams need to be continuously afforded service models and opportunities to integrate people with disabilities into their communities; the potential for community placements to become 'institutionalized' by omission of opportunities to integrate people is a real and constant risk.

(6) *Question:* Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.

*Answer:* As previously noted, the DES/DDD had moved from institutional care early on, before the Olmstead mandate to deinstitutionalize. However, even with a historically low rate of institutionalization, the DES/DDD recognizes the need for new and innovative community based living models for Arizona to remain a leader in serving people with developmental disabilities in the community in a manner that is sustainable. To this end, a Sustainability Workgroup comprised of people with disabilities, family members, advocates, providers of service and state personnel was convened. This group submitted a report with recommendations which are being addressed by an action team. This strategy of convening interested stakeholders for a common purpose has been highly effective for people with disabilities in Arizona.

Arizona does have a Medicaid program for elderly and physically disabled (E/PD) Arizonans. One of the key factors in ensuring appropriate placement for this population has been the development and implementation of financial mechanisms to incentivize home and community based placement. In addition to setting a blended capitation rate, Arizona has initiated an HCBS reconciliation process within this program, which incentivizes HCBS placement and works as follows:

The Contractor's capitation rate is based in part on the assumed ratio ("mix") of HCBS member months to the total number of member months (i.e. HCBS + institutional). After

the end of the contract year, AHCCCS compares the *actual* HCBS member months to the *assumed* HCBS percentage that was used to calculate the full long term care capitation rate for that year. If the Contractor's actual HCBS percentage is different than the assumed percentage, AHCCCS may recoup (or reimburse) the difference between the institutional capitation rate and the HCBS capitation rate for the number of member months which exceeded (or was less than) the assumed percentage. This reconciliation is made in accordance with the following schedule:

- Percent *over/under* assumed percentage - Amount to be recouped/reimbursed:
  - 0 – 1% -- 0% of capitation over/underpayment
  - >1% -- 50% of capitation over/underpayment

This strategy has been successful in reducing institutional placement of the elderly and physically disabled in Arizona and could be replicated in other managed care environments.

Additionally, a program that began as a pilot initiative in 2009 has proven to be particularly successful. This program, called the Bridge Subsidy Program (BSP) has the purpose to provide tenant-based permanent supportive housing vouchers for the DHS/DBHS members with Serious Mental Illness, while creating a structured link to a permanent rental subsidy through the Section 8 Housing Choice Voucher (HCV) program. The initiative provides individuals with more housing choices and the flexibility to select a unit and neighborhood that meets their specific needs and preferences. The program is designed as a “Bridge Subsidy” to help the individuals eventually access HUD Section 8 Housing Choice Vouchers. Throughout Arizona the wait list to be awarded a HCV voucher often is two to five years.

The RBHAs contract with local Public Housing Authorities (PHAs) to administer the programs and tenants are expected to pay at least 30%, but no more than 40% of their adjusted income for rent. When the tenant's name is reached on the Section 8 waitlist, the individual is able to convert the bridge voucher to a permanent Section 8 voucher and remain in their same apartment. By working with the Public Housing Authorities, the tenants are able to transition to mainstream housing subsidies and become independent of ongoing funding from the behavioral health system. Also in partnership with the Public Housing Authorities, some of the RBHAs have submitted grant applications to expand housing stock and have applied for additional Section 8 vouchers to be dedicated to those properties.

The close, positive working relationship the DHS/DBHS fosters between the RBHAs and the Public Housing Authorities (PHAs) is resulting in positive improvements in the communities served by the PHAs. For example, the Housing Authority of the City of Yuma (HACY) and the RBHA in the region have formed a partnership to purchase three single family homes in a new housing development on the east side of Yuma. Not only did that result in new housing for individuals in the behavioral health system, but HACY assigned Section 8 vouchers to those homes, thus making permanent housing immediately available to persons with Serious Mental Illness and their families.



## Office of the Director

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September 12, 2012

The Honorable Tom Harkin  
United States Senate  
Washington, D.C. 20510-6300

Dear Senator Harkin:

The Arkansas Department of Human Services (DHS) is submitting this report to the U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP) to describe Arkansas's progress in administering services to individuals with disabilities in the most integrated settings appropriate for their needs. As such, the accompanying report provides data and information on the current status of efforts to meet the requirements of the United States Supreme Court's *Olmstead* decision.

Since convening the initial *Olmstead* working group in 2001 and producing the *Arkansas Olmstead Plan* in 2003, the state has made steady progress in addressing barriers to integrated care in home and community settings for individuals with disabilities and expanding access to these services and supports. DHS's major accomplishments and initiatives include, but are not limited to:

- The Money Follows the Person program successfully began transitioning adults out of skilled care facilities and into home and community based service (HCBS) settings.
- A long-term-care systems transformation grant enabled the state to establish the Choices in Living Aging and Disability Resource Center (ADRC), which is responsible for informally screening applicants for Medicaid eligibility and HCBS, and helping them initiate the formal application process.
- The number of HCBS waiver participants has increased steadily for ElderChoices, Alternatives for Adults with Physical Disabilities, and IndependentChoices.
- Wraparound services are available statewide to children with moderate to severe behavioral health needs and their families. Wraparound provides services and supports that allow children to remain in their home and communities.

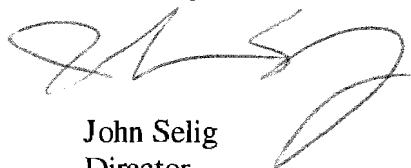
Additionally, Arkansas is currently working to design and implement an innovative multi-payer model, Arkansas Health Care Payment Improvement Initiative, and an intensive care coordination model, Health Homes. This is coupled with pursuing several options to increase access to community-based services including the Community First Choice option, 1915(i) option, and Balancing Incentives Payment Program. This broad effort will help the state build a

The Honorable Tom Harkin  
United States Senate  
September 12, 2012  
Page Two

health care system with enhanced personal choice, improved client experiences and better health outcomes. It will also support cost reduction resulting from alignment of an individual's treatment needs with the appropriate level and setting of care and the elimination of unnecessary spending due to improved care coordination.

In Arkansas, we envision a health care system that supports high quality, integrated treatment while also enhancing access to services and supports in home and community-based settings. DHS has made a commitment to partnering with other stakeholders to achieve this vision for an improved health care system for all Arkansans.

Sincerely,

A handwritten signature in black ink, appearing to read 'John Selig', written over a light blue horizontal line.

John Selig  
Director

**Arkansas Department of Human Services  
Report on the American Disabilities Act and Olmstead Plan  
September 2012**

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The purpose of the following report is to provide information on the Arkansas Department of Human Services effort to implement *The Olmstead Plan in Arkansas*. This data was compiled in response to the request from the United States Senate Committee on Health, Education, Labor, and Pensions. This report provides a snapshot of the progress made in the state since 2008 to transition individuals with disabilities into more integrated home and community based services.

***Transitions to Home and Community Settings***

The figures included in this section address the number of people for each year from 2008 to the present moved from nursing homes, intermediate care facilities for individuals with intellectual disabilities, long term care units of psychiatric hospitals, and board and care homes (often called adult day care homes or residential health care facilities), to living in their own home, including through a supportive housing program.

The Alternative Community Service (ACS) waiver under the 1915(c) option is available to a limited number of individuals with disabilities, based on the waiver limit, to provide home and community based services (HCBS). In order to receive ACS waiver services an individual must meet the institutional level of care. The waiver is an alternative to institutionalization and allows individuals with developmental disabilities to live as independently as possible in the community, in the least restrictive setting, with the necessary services and other supports. In a later section of the report, additional information is available on the expansion in waiver slots since 2008. The table below reports on transitions that have occurred since 2008 through the ACS waiver:

**Transitions to More Integrated Settings (ACS Waiver) 2008 – Present**

	<b>State Hospital</b>	<b>Human Development Center</b>	<b>Intermediate Care Facility</b>	<b>Nursing Facility</b>	<b>Total</b>
<b>2008</b>	3	15	15	10	<b>43</b>
<b>2009</b>	7	17	27	4	<b>55</b>
<b>2010</b>	10	14	15	4	<b>43</b>
<b>2011</b>	15	31	31	4	<b>81</b>
<b>2012- Present<sup>1</sup></b>	11	16	14	2	<b>43</b>
<b>Total</b>	<b>46</b>	<b>93</b>	<b>102</b>	<b>24</b>	<b>265</b>

The adult population receiving behavioral health services is a high priority for AR DHS due to many of the challenges in successfully transitioning these individuals into the least restrictive setting of care; plans are currently underway to expand access to home and community based services HCBS for this population. Additional information regarding plans to pursue the Health Homes and 1915(i) options are detailed later in the report, which would specifically benefit individuals with persistent, chronic mental illnesses and co-morbid conditions.

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<sup>1</sup> This column does not represent a full year, but provides totals through September 2012.



Arkansas community mental health centers (CMHCs) serve as the single point of entry into a state inpatient psychiatric facility by providing initial screenings. The screening for appropriate admission is based on continuity of care and treatment which provides the least restrictive setting. CMHCs must also determine if appropriate alternatives to inpatient treatment are clinically appropriate and available, and arrange for the provision of alternative outpatient services if inpatient or crisis residential services are not recommended. In addition to overseeing a psychiatric skilled nursing facility and funding local acute care beds, the Division of Behavioral Health Services (DBHS) also operates the Arkansas State Hospital (ASH), a psychiatric inpatient facility and certifies specialty clinics focused on serving adults with severe and persistent mental illness. After individuals have received the maximum benefit of acute inpatient psychiatric treatment, community placements must be identified with the appropriate level of supervision, monitoring and intervention. At any one time there are typically 10 to 12 such adult patients at ASH awaiting discharge. As such, increasing access to specialty clinics allows for appropriate treatment in the least restrictive setting.

The figures in the chart below includes discharges from any state psychiatric facility and readmissions rates at any state operated psychiatric facility at 30 days and 180 days from discharge.<sup>2</sup> There have been well over 500 discharges from state psychiatric facilities each year during this period. When compared to the readmissions targets, actual readmissions were under the target threshold for 2008-2010. Also, the number of individuals transitioned to the least restrictive and more integrated environment, a certified specialty clinic, increased by 14% between 2008 and 2011.

**Psychiatric Inpatient and Specialty Clinics 2008-2011**

	<b>Psychiatric Facility Inpatient Discharges</b>	<b>Readmissions Target 30 days</b>	<b>Actual Readmissions 30 days</b>	<b>Readmissions Target 180 days</b>	<b>Actual Readmissions 180 days</b>	<b>Specialty Clinics Clients Served</b>
<b>2008</b>	650	10%	3%	25%	16%	594
<b>2009</b>	764	5.5%	3.1%	15%	10.2%	604
<b>2010</b>	689	5.25%	5.2%	9.5%	9.4%	642
<b>2011<sup>4</sup></b>	573	-	-	-	-	679

<sup>2</sup> Discharges and readmission targets are provided as reported in the Community Mental Health Block Grant Application. Readmission targets were not required in the 2012 report which explains the lack of data for 2011.

**State Expenditures in Current Year**

The following figures represent the amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.

**Arkansas Medicaid Projections SFY 2013**

	<b>State (Medicaid Only)</b>	<b>Federal</b>	<b>Other<sup>3</sup></b>	<b>Total</b>
Private Nursing Home	\$81,057,044	\$449,427,572	\$108,723,992	\$639,208,608
Public Nursing Home	-	\$31,656,301	\$13,367,594	\$45,023,895
Infant Infirmary	\$4,761,417	\$16,866,998	\$2,361,057	\$23,989,472
Human Development Centers	-	\$87,975,323	\$37,149,585	\$125,124,908
10 Bed ICF/MR <sup>4</sup>	\$3,141,788	\$16,329,817	\$3,753,850	\$23,225,455
Inpatient Psychiatric *	\$48,155,466	\$114,038,761	-	\$162,194,227
			<b>TOTAL</b>	\$1,018,766,565

<b>Home and Community Based Waivers *</b>				
Alternative Community Services (ACS) Waiver	\$55,138,062	\$130,574,509	-	\$185,712,571
ElderChoices	\$21,481,885	\$50,872,056	-	\$72,353,941
Adults with Physical Disabilities	\$13,009,951	\$30,809,353	-	\$43,819,304
Living Choices Assisted Living	\$4,442,866	\$10,521,318	-	\$14,964,184
<b>Non-Waiver Home and Community Based Programs*</b>				
Independent Choices	\$8,724,201	\$20,660,106	-	\$29,384,307
Developmental Day Treatment Clinic Services (DDTCS)	\$48,890,519	\$115,779,467		\$164,669,986
			<b>TOTAL</b>	\$510,904,293

\* Includes projected expenditure for all Medicaid population.

<sup>3</sup> Other funds may be from a non-federal source or state funds from divisions or agencies besides Arkansas Medicaid.

<sup>4</sup> Intermediate Care Facilities for individuals with Mental Retardation (ICF/MR)

## ***Expansion in State Capacity***

This section reports on the extent to which Arkansas has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program. This includes the amount of state dollars spent on the expansion and the specific nature of the capacity added each year from 2008 to the present. These figures are reported for populations served by the DHS Divisions of Behavioral Health Services, Developmental Disabilities Services, and Aging and Adult Services.

### **DHS Division of Behavioral Health Services (DBHS)**

*Wraparound Services* – In an effort to support transitions out of residential treatment centers (RTC) and to maintain children in the community, led by the Arkansas Children’s Behavioral Health Care Commission, AR DHS launched a cross-divisional System of Care (SOC) transformation effort in 2007. In October 2009, DBHS initiated the Wraparound Demonstration Projects to provide a family driven and youth guided, team based approach that wraps services and supports around a family whose child is at risk of removal from their home, school and community due to behavioral health issues. Wraparound is a coordinated planning process that leads to an individualized care plan and development of a child and family team. The targeted population is children with severe to moderate behavioral health care needs. Wraparound funds are available to provide services and supports to prevent family crises. These services include respite, mentoring, or other nontraditional supports to prevent disruptions in the home environment. Funds were distributed to 14 sites located across the state within the mental health service areas, and the projects have moved from the demonstration phase to permanent integration in the System of Care since initial implementation. The figures below summarize expenditures since the inception of the program. Since implementing wraparound services across the state, 4002 children have received services.

**Arkansas Wraparound Program SFY 2010-2012**

<b>SFY</b>	<b>Children Served</b>	<b>Federal (Social Services Block Grant)</b>	<b>State</b>	<b>Total Expenditures</b>
<b>2010<sup>5</sup></b>	506	\$228,181	\$36,919	\$265,100
<b>2011</b>	1789	\$363,013	\$616,064	\$979,078
<b>2012</b>	1707	\$330,994	\$427,014	\$758,008
<b>Total</b>	<b>4002</b>			<b>\$2,002,186</b>

### **DHS Division of Aging and Adult Services (DAAS)**

DHS DAAS administers several programs to provide services and supports to individuals with long term care needs including ElderChoices, Alternatives for Adults with Physical Disabilities, Independent Choices, and Living Choices. Additional information is summarized below about these programs and the expansions in capacity since 2008.

*ElderChoices* - ElderChoices is a 1915(c) Medicaid home and community-based waiver program that provides in home services to individuals 65 and over. This program is an alternative to nursing home care for those who meet nursing home eligibility criteria for an intermediate level of care, as assessed by state registered nurses across the state. In April 2008, cash and counseling (Independent Choices) was added to the ElderChoices program under the 1915(j) option to allow program participants to self-direct homemaker and companion services. The waiver cap for ElderChoices has been 7950 for the reported time period.

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<sup>5</sup> This data represents a partial year due to the implementation of the project in October 2009. In subsequent years, figures are reported from July 1 through June 30.

**ElderChoices Program SFY 2008-2011**

<b>SFY</b>	<b>Client Count</b>	<b>Program Expenditures</b>
<b>2008</b>	7,153	\$43,309,102
<b>2009</b>	7,197	\$51,948,631
<b>2010</b>	7,380	\$62,778,795
<b>2011</b>	7,836	\$66,054,358
<b>Total</b>		<b>\$224,090,886</b>

*Independent Choices* - The Independent Choices program allows Medicaid individuals age 18 and older to self-direct personal care and several waiver attendant care services. The program supports in home care by providing a monthly allowance in place of personal care services. It provides participants with the autonomy to hire and supervise their personal attendants of choice through both employer and budget authority. Independent Choices Program was converted from an 1115 demonstration waiver to a 1915(j) state plan service in April 2008.

The Independent Choices Program expenditures totaled more than \$71 million between 2008 and 2012. Since 2008, the number of individuals receiving services has increased by 40%.

**Independent Choices Program SFY 2008-2011**

<b>SFY</b>	<b>Client Count</b>	<b>Program Expenditures</b>
<b>2008</b>	2,804	\$10,620,606
<b>2009</b>	3,004	\$15,632,149
<b>2010</b>	3,497	\$21,081,374
<b>2011</b>	3,934	\$24,024,130
<b>Total</b>		<b>\$71,358,259</b>

*Nursing Home Alternative* – Arkansas has one state-funded program that provides home and community based services to older adults and/or adults with physical disabilities through the Area Agencies on Aging (AAA), including adults referred by Adult Protective Services. There are no income eligibility requirements or asset limits; the intent is to target adults over the age of 60 or adults with some type of limiting disability. The program is funded exclusively with state general revenue and it provides services in the amount of \$4,765,025 per year. The total program expenditures for SFY 2008 through 2012 are \$23,825,125. The current system reports aggregate data on clients served for this program and several others. A system upgrade will be implemented soon to allow DAAS to separately track the client count for the Nursing Home Alternative program.

*Alternatives for Adults with Physical Disabilities (AAPD) Program* – AAPD is a home and community-based program that provides attendant care and environmental modification services to individuals age 21 through 64 who meet the criteria for intermediate nursing home care. The individual's income should be less than 300% of the SSI Federal Benefit Rate and meet the resource limits for Medicaid.

Since 2008, the capacity of the AAPD waiver program has expanded by 50%, adding new slots each year. For each year that the waiver cap increased, the program client count was at maximum capacity. The waiver cap for SFY 2013 has not yet been reached.

**Alternatives for Adults with Physical Disabilities SFY2008-2013**

<b>State Fiscal Year</b>	<b>Client Count</b>	<b>Program Expenditures</b>
<b>2008</b>	2,000	\$33,964,665
<b>2009</b>	2,250	\$39,653,701
<b>2010</b>	2,550	\$41,838,590
<b>2011</b>	2,600	\$41,943,273
<b>2012</b>	2,800	\$42,584,358
<b>2013</b>	3,000	-

*Living Choices* - Assisted living facilities (ALF) provide 24 hour supervision and supportive services including limited nursing services in a congregate setting to persons aged 65 and older or to persons 21 years of age and above that are blind or disabled. Assisted living is a Medicaid and community based waiver program. The capacity of the Living Choices Assisted Living waiver has been expanded.

Assisted living facility (ALF) caps have increased as indicated below. The capacity of the ALF waiver program has increased each year, having tripled since 2008. For each year that the waiver cap increased, the program client count was at maximum capacity.

<b>Time Period</b>	<b>Waiver Cap</b>
Dec 2007 – November 2008	415
Dec 2008 – November 2009	515
Dec 2009 – November 2010	615
Dec 2010 – November 2011	800
Dec 2010 – present	1,300

<b>SFY</b>	<b>Program Expenditures</b>
<b>2008</b>	\$3,387,215
<b>2009</b>	\$5,950,708
<b>2010</b>	\$8,580,547
<b>2011</b>	\$10,074,858
<b>2012</b>	\$12,428,725
<b>Total</b>	\$40,422,053

*Choices in Living* - In 2008, Arkansas was awarded a \$2 million Systems Transformation Grant. As a result of this grant, Arkansas developed an Aging and Disability Resource Center (ADRC), *Choices in Living*. This resource center has a physical location, but is also accessible by a toll free phone number and individuals are directed to the appropriate services. This single point of entry model provides options counseling to individuals and families that are in need of long term care services and supports. Additionally, individuals can complete an informal screening for Medicaid and HCBS eligibility through the ADRC. In SFY2012, the resource center received over 6,100 calls.

**Division of Developmental Disabilities Services (DDS)**

DHS DDS administers the Alternative Community Services (ACS) program under the 1915(c) Medicaid waiver. This waiver provides a variety of community-based services to eligible individuals, including services such as Case Management, Waiver Coordination, Supported Living Services, Non-Medical Transportation, Adaptive Equipment, Environmental Modifications, Supplemental Support Services, Consultation Services, and Crisis Intervention Services, through DDS licensed community providers.

DDS expanded the capacity of the DDS Home and Community Based Waiver by 65% in the past 10 years from 2500 program slots in 2002 to 4100 program slots in 2012. Program expenditures from SFY2008-2012 are included below. Additionally, DDS lowered public ICF average census by 15% in the past 10 years with more individuals being served in the community based settings. For each year that the waiver cap increased, the program client count was at maximum capacity. The current waiver waiting list is approximately 2200.

SFY	Client Count	Program Expenditures
2008	3827	\$111,785,275
2009	3970	\$128,276,687
2010	4025	\$139,067,231
2011	4055	\$158,217,942
2012	4100	\$167,346,313
<b>Total</b>		<b>\$704,693,448</b>

In addition to expanding the number of waiver program slots each year, DDS has implemented a number of measures to expand HCBS for individuals with intensive needs and to reduce the waiting list to receive these services. These policy and program changes are summarized below:

- DDS established a reserved capacity on the DDS Home and Community Based Waiver for children in state custody, thus diverting unnecessary institutionalization.
- DDS established the "pervasive" level of care on the waiver that allowed pre-authorized expenditures up to \$392 per day which was double the previous "extensive" level of care cap. The increase allowed an opportunity to provide more intense level of services to individuals with complex needs.
- In order to address the needs of many individuals on the waiting list, DDS established the priority system as well as reserved capacity that allowed people in intermediate care facilities (ICF), Arkansas State Hospital (ASH), and nursing homes to receive home and community based waiver funding immediately, upon request, to allow a move to a community setting.
- DDS implemented the Supplemental Support service category within its waiver program to assist with expenses when exiting institutional settings or in response to crisis, emergency or life threatening situations. The supplemental support service helps improve or enable the continuance of community living and includes funding for items such as deposits, essential furnishings, essential miscellaneous household appliances, etc.
- DDS created the "Transition Coordinator" position at each Human Development Center (HDC) and Arkansas State Hospital (ASH) in order to facilitate more efficient transitions from institutional to home and community based settings.
- DDS launched the Provider Electronic Solutions (PES) system to allow providers to request prior authorizations for waiver services. This significantly reduces the time needed for DDS to approve requests.
- DDS has recently requested funding to further the work of a provider cooperative for crisis planning, intervention, and respite services. Systematic Therapeutic Assessment Respite and Treatment (START), an evidence based practice, will enable people who have both a developmental disability and a mental illness to remain in the community during a behavioral crisis instead of seeking institutional services.

## Arkansas Olmstead Plan

This section includes: the contents of Arkansas's Olmstead Plan for increasing community integration; a description of the strategic planning process used to create it; revisions that have been made since its creation; the extent to which it incorporates the new tools created by the federal government to support home and community-based services; and the extent to which Arkansas has been successful in meeting quantifiable goals identified within its Olmstead Plan. Please see attached document, *The Olmstead Plan in Arkansas*, which was developed in March 2003 for contents of the state's plan.

### Development of Olmstead Plan

The Governor's Integrated Services Taskforce (GIST), created in 2001 to assist DHS with the development of the Olmstead Plan, met between 2001 and early 2003 to produce the Olmstead Plan for Arkansas. The diverse group included consumers, advocates, providers, and representatives from several state agencies. The GIST made several recommendations that target four key areas of needs: (1) additional resources to support system improvements; (2) increased community capacity; (3) new approaches to service provision; and (4) increased consumer-directed care. In 2008, the outlined goals and action steps were reviewed to assess progress and identify remaining objectives (see attachment *Arkansas Olmstead Plan 2008 Revision*).

Significant progress has been made in Arkansas since 2008. DHS has made a continuous commitment to implementing systems changes needed to achieve the vision conveyed in the Arkansas Olmstead plan. This is reflected in the reported increases in capacity and current investments in improving care for behavioral health, long term care, and developmental disabled populations, as outlined above.

### Money Follows the Person (MFP)

Many individuals in the state were able to successfully transition to the least restrictive setting through the Money Follows the Person (MFP) program. MFP has been a key tool in expanding access to HCBS for individuals with disabilities in Arkansas. The Arkansas Money Follows the Person (MFP) program transitions individuals who have resided in institutions 90 days or longer into qualified home and community-based programs. The chart below reports the number of individuals transitioned to home and community settings as a result of the MFP program in Arkansas. The following information summarizes program highlights since 2008:

- Between FY2008 and 2011, 247 individuals were moved to home and community settings.
- The number of individuals transitioned to home and community settings in 2011 was more than five times higher than in 2008, with a steady increase each year.
- The MFP Rebalancing Program expenditures were \$2.1 million for this four year period.

**Money Follows the Person SFY2008 – 2011**

SFY	Aged <sup>6</sup>	Physically Disabled	ID/DD <sup>7</sup>	Adults with MI <sup>8</sup>	Total
2008	5	2	14	0	21
2009	13	16	12	2	43
2010	20	29	15	2	66
2011	6	83	27	1	117
<b>Total</b>	<b>44</b>	<b>130</b>	<b>68</b>	<b>5</b>	<b>247</b>

<sup>6</sup> The aged population includes adults aged 65 years old and over. The remaining categories refer to individuals that are 19-64 years old.

<sup>7</sup> ID/DD is an abbreviation for intellectual disabilities and developmental disabilities.

<sup>8</sup> MI refers to adults with a mental illness diagnosis.

### **Current HCBS Expansion Efforts**

Arkansas is currently pursuing several of the opportunities afforded to states under the Affordable Care Act to support HCBS expansion, including the Community First Choice Option (CFCO), State Balancing Incentive Payment Programs (BIPP), and the 1915(i) option. DHS has developed work groups to analyze the impact and proposed state models for potential implementation of CFCO, BIPP, and 1915(i). The programs will expand access to lower cost community based services while strengthening the person-centered nature of the long term care system by providing a broad range of options and enhanced community integration.

### **Health System Transformation Initiatives**

In the face of rising health care costs and a slow growing economy, Arkansas has embarked on a broad health systems transformation initiative to support the health and well-being of all Arkansans, especially those with low household incomes and serious health conditions. A significant focus of this effort is Arkansas Health Care Payment Improvement Initiative (payment improvement), which will bring together Medicaid and private insurance companies to design and build a new payment system that will drive the shift to a higher-quality and more cost-efficient system of care. The CFCO and BIPP complement the payment improvement initiative. The primary goal of these two options is to align the level of need with the most appropriate level of services in the least restrictive care setting. This provides a framework for the episode-based payment improvement approach for community based services which will be reinforced by robust quality tracking and outcomes measures. The CFCO also provides additional resources and a mechanism to eliminate the Alternative Community Services (ACS) waiting list of over 2000 people with developmental disabilities and offers long-awaited services to those who need them.

The 1915(i) option is also being pursued as a mechanism for creating access to new home and community-based services for targeted populations of individuals with disabilities. As noted in a previous section, the reported data indicates that expanding access to home and community based services for the mentally ill population has not grown at the same pace as other populations. Many of the behavioral health services in Arkansas are currently provided under the Rehabilitation Services for Persons With Mental Illness (RSPMI) program and some desirable services, such as supported employment and peer services, are not provided under RSPMI, but could be provided under a 1915(i) state plan amendment. This model would support a recovery oriented approach for individuals with severe and persistent mental illness and enhance independent functioning and improve quality of life.

Finally, Arkansas is planning to build a health care system that complements implementation of innovative care coordination models such as Health Homes, which will be made available to many of the highest needs people in the state. In an effort to provide enhanced care coordination for individuals with chronic conditions, a health homes model will be developed to improve care coordination, patient experience, and health outcomes. Planning efforts are underway to address the fragmented health care delivery system and improve access to services for individuals with developmental disabilities, mental health issues, and elderly individuals receiving home and community-based services or receiving care in long-term care facilities. While subject to change, projected implementation for the DD health home will begin in 2013. To help guide the development of the health homes model for the identified targeted populations, the following guiding principles will ensure health home planning efforts support the intent of the provision and align with the payment improvement initiative:

- Health homes must address the comprehensive needs of individuals by utilizing a “whole-person” and “person-centered” approach while ensuring personal choice assurances throughout service planning and service delivery.
- Health homes will provide services that address issues of access to care, accountability and active participation on behalf of both providers and individuals/families receiving services, continuity of care across all medical, behavioral, and social supports, and comprehensive coordination/integration of all needed services.
- Health homes will provide services that seek to align a fragmented system of needs assessment, service planning, care coordination, transitional care , and direct care service delivery.



- Health homes must demonstrate the use of health information technology as a means to improve service delivery and health outcomes of the individuals served.

In order to support Arkansas in accomplishing the vision of this model for our health care system, an application will be submitted to the Center for Medicare and Medicaid Innovation for the State Innovation Model (SIM) grant in September 2012. The SIM funding opportunity was created to help states design and test multi-payer payment and delivery models that deliver high-quality health care and improve health system performance.

This broad effort supports integrated care planning, patient centered treatment options, and access to appropriate services to meet the specific needs for each population. It will provide seamless navigation of medical, behavioral, long term care, and other areas of services for those who have complex needs or require additional layers of support. The expected outcomes of these reforms are enhanced personal choice, improved client experience and health outcomes, as well as cost reduction due to alignment of need with the appropriate level and setting of care, and elimination of unnecessary spending due to better care coordination.

### ***Successful Strategies***

This section addresses successful strategies that Arkansas has employed to effectively implement Olmstead, highlighting particular strategies that could be replicated by another state or on a national scale.

Regarding the strategic planning process, it has been most effective to develop cross-divisional work groups or task forces to assess the needs of individuals with disabilities across systems that include AR DHS Divisions of Behavioral Health Services, Developmental Disabilities Services, and Aging and Adult Services. This approach has been successful in supporting a broad analysis of needs and gaps in the system. It has also been key in identifying policy or program barriers that impede the provision of integrated care for individuals with disabilities (i.e., the need for a single, person-centered care plan). Providers and consumers must also be included in the strategic planning process in order to provide feedback on the impact of program and policy changes in the community. Stakeholder engagement has been a vital part of the Arkansas effort to transform the health care system by involving them in each phase including: (1) needs assessment; (2) program design; (3) program implementation; and (4) program evaluation.

Multiple opportunities and new programs have been afforded to states to expand capacity to provide services for people in the most integrated settings. In addition to expanding the capacity of current programs, Arkansas is currently pursuing the Community First Choice Option, State Balancing Incentive Payment Program, Health Homes, and the 1915(i) option. As outlined in the previous section, Arkansas is working to effectively leverage these tools in order to build a robust, sustainable home and community-based care model in the State. The impact of these tools is yet to be seen, but Arkansas anticipates significant improvements in the health care system in the state that provides individual with disabilities with a full continuum of treatment options and supportive services.

EDMUND G. BROWN  
JR.  
GOVERNOR



DIANA S. DOOLEY  
SECRETARY

# State of California HEALTH AND HUMAN SERVICES AGENCY

November 14, 2012

Senator Tom Harkin  
Chairman, Senate Health, Education, Labor and Pensions Committee  
428 Senate Dirksen Office Building  
Washington, DC 20510

Senator Harkin:

Aging

Alcohol and  
Drug Programs

Child Support  
Services

Community Services  
and Development

Developmental  
Services

Emergency Medical  
Services Authority

Health Care Services

Managed Health Care

Managed Risk  
Medical Insurance Board

Public Health

Rehabilitation

Social Services

State Hospitals

Statewide Health  
Planning and  
Development

On behalf of Governor Edmund G. Brown, Jr., I am providing the State of California's response to your letter, dated June 22, 2012. In your letter, you requested information on our state's implementation of activities to meet the goals of the United States Supreme Court decision on the Americans with Disabilities Act in *Olmstead v. L.C.* (1999).

Currently, California has reached a rebalancing effort of spending 53.7% of Medicaid and long-term services and supports funding on home and community-based services.<sup>1</sup> California was just one of seven states that invested more Medicaid long-term care funding for home and community-based services than for long-term institutional care based on data from 2008-2009.<sup>2</sup> Additionally, overall in 2011-12, of the 335,289 individuals (all payer types) that were discharged from nursing homes, 49% were discharged to their homes or independent home settings (i.e., apartment, duplex, single room occupancy).<sup>3</sup>

This progress on expanding home and community-based services is in part due to the state's strong history of advocacy in the disability and aging communities that created successful models for long-term services and supports in the community. Policy leaders have also been guided by the State's Olmstead Plan and the principles articulated within it since 2003.

Of note, California's rebalancing efforts will be enhanced by our new Coordinated Care Initiative, which aligns fiscal incentives to help move and keep older adults and individuals with disabilities in the community. Specifically, the Coordinated Care Initiative positions Medi-Cal (our state Medicaid program) managed care plans to assume responsibility for integrating Medi-Cal and Medicare funding, as well as integrating medical care, behavioral health care, and long-term services and supports

<sup>1</sup> *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*, 2011, AARP, The Commonwealth Fund, and The SCAN Foundation.

<sup>2</sup> Ibid.

<sup>3</sup> California Office of Statewide Health Planning and Development.

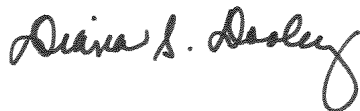
Under the Coordinated Care Initiative, four key long-term services and supports will be integrated as managed care benefits to better align financial incentives for beneficiaries to receive preventative and home and community-based options. Long-term care services that have not previously been part of managed care plan capitated rates include: Community-Based Adult Services, In-Home Supportive Services, Multi-Purpose Senior Services Program and skilled nursing facility care. These long-term services and supports will be integrated as managed care benefits starting with Community-Based Adult Services (formerly Adult Day Health Care) beginning November 1, 2012. The remaining long-term services and supports will follow between March and June 2013. This timing corresponds to California's implementation of the Duals Demonstration, which is a capitated financial alignment model for dual Medicare-Medicaid enrollees. California is currently seeking federal approval from the Centers for Medicare and Medicaid Services for the Duals Demonstration.

To guide future state policy decisions, as Secretary of the California Health and Human Services Agency, I have convened a 35-member Olmstead Advisory Committee, which focuses attention on implementing California's Olmstead Plan and provides recommendations on how our Administration can better enable individuals with disabilities and older adults to live in the community. The input of our stakeholders will continue to help inform state decision making in the area of long-term services and supports.

Appendix A responds to your questions about long-term care in California, our state's strategies to replicate, and our recommendations for federal consideration. Appendix B responds to your questions about our state's Olmstead Plan by providing an update on our progress in implementing California's Olmstead Plan.

Thank you for the opportunity to share the progress California is making in expanding home and community-based services. If your staff has any questions, please contact Kiyomi Burchill, Assistant Secretary, Program and Fiscal Affairs, at [kburchil@chhs.ca.gov](mailto:kburchil@chhs.ca.gov) or (916) 654-3454.

Sincerely,



**Diana S. Dooley**  
Secretary

Cc: Senator Dianne Feinstein  
Senator Barbara Boxer

## Appendix A

### Information and Recommendations on Long-Term Services and Supports

#### Long-Term Services and Supports in California: A Snapshot

**Nursing Home Discharges.** On average, from 2008 through 2011, California discharged 151,804 individuals (all payer types) from skilled nursing facilities to their homes or independent home settings (i.e., apartment, duplex, single room occupancy).<sup>1</sup> These discharge figures represent discharges from free-standing skilled nursing facilities and are reported on a calendar year basis. These figures do not include discharges from board and care, group homes, intermediate care facilities, psychiatric hospitals and other community based or institutional settings. The chart below summarizes the discharges to home settings by calendar year, and the average. The annual increase in the number of people transitioning home is especially important to ensure people are diverted from long-stay institutional care.

Year	2008	2009	2010	2011	Average
Discharges	139,138	146,440	157,243	164,394	151,804

**State Funding for Long Term Care.** For state fiscal year 2012-13 (July 1, 2012- June 30, 2013), California's enacted budget includes the following amounts:

- Nursing Facilities: \$3,879,931,032 (Total funds); \$1,879,725,160 (State funds)
- Intermediate Care Facilities for Individuals with Developmental Disabilities: \$332,959,863 (Total funds); \$162,013,884 (State funds)
- Civil Commitments in State Hospitals: \$1,111,977,014 (Total funds)
- In Their Communities:
  - In-Home Supportive Services: \$5,101,124,625 (Total funds; the Federal Medical Assistance Percentage (FMAP) for California is 50%, except for cases in which the additional 6% FMAP applies pursuant to California's approved Community First Choice Option (CFCO) program)
  - Community-Based Adult Services: \$288,426,000 (Total funds; the FMAP for California is 50%)
  - Multipurpose Senior Services Program: \$40,464,000 (Total funds; the FMAP for California is 50%)

**Medicaid Home and Community-Based Waivers.** California currently serves more than 110,000 participants in nine 1915(c) home and community-based waivers. The Centers for Medicare and Medicaid Services has consistently approved increases in annual caps on enrollment for these waivers. These nine waivers are:

- Acquired Immune Deficiency Syndrome (AIDS)
- Assisted Living Waiver

<sup>1</sup> California Office of Statewide Health Planning and Development.

- Home and Community-Based Services Waiver for the Developmentally Disabled
- In-Home Operations
- Multipurpose Senior Services Program
- Nursing Facility/Acute Hospital
- Developmentally Disabled/Continuous Nursing Care
- Pediatric Palliative Care
- San Francisco Community Living Support Benefit Waiver

For each of these waivers, the state and counties pay the non-federal share. The Federal Medical Assistance Percentage (FMAP) for California is 50%. Please see the end of this appendix for a description of each of these waivers and their capacity over time.

### **Strategies to Replicate**

As described throughout this letter, California has taken many opportunities to partner with the federal government to expand home and community-based services.

- *Implementation in California of a Range of Home and Community-Based Services Programs:* Specifically, California has secured funding through the Community First Choice Option, the 1915 (i) Medicaid State Plan Option (for Californians with developmental disabilities), the Money Follows the Person Demonstration, Medicaid home and community-based waivers, and finally, the personal care State Plan Option (California's In-Home Supportive Services program). Our strategies on how we have implemented these programs may be helpful to other states or the federal government.
- *Aging and Disability Resource Connection Model:* California's vision for Aging and Disability Resource Connection partnerships goes beyond networks serving single populations such as seniors or individuals with physical disabilities. Instead, the state has embraced the needs of the wider community. This strategy emphasizes meaningful day-to-day collaboration among organizations that coordinate or provide community long-term services and supports to different populations simultaneously. California's initiative has also emphasized the need to help consumers navigate a fragmented and sometimes perplexing array of community long-term services and supports. Through a core partnership between Area Agencies on Aging and Independent Living Centers, and extended long-term services and support provider networks that reflect local consumer cultures and access points, Aging and Disability Resource Connection partners provide objective information, advice, counseling, and assistance. They empower people to make informed decisions about their long-term supports needs and help them access public and private programs.

California Aging and Disability Resource Connection partnerships provide four core services:

- *Enhanced Information and Assistance:* Under the Aging and Disability Resource Connection model, call center staff are cross-trained to utilize a broader array of information and provider resources across the aging and disability provider networks.

- Options Counseling: Options Counseling is one-on-one decision support for individuals exploring their long-term services and supports options. California recently concluded a pilot Options Counseling project with six Aging and Disability Resource Centers and two Money Follows the Person lead organizations.
- Short-Term Service Coordination: Coordination assistance is provided for those who urgently need help with multiple services and programs, generally for 90 days or less and until a longer term plan is in place.
- Transition Services: Aging and Disability Resource Connection partners have become trained and staffed to conduct hospital-to-home and/or nursing facility-to-home transition services.

The overarching goals of ADRC partnerships are to:

- Improve awareness of long-term care options, especially community-based alternatives to inpatient facility care.
- Provide access to information and services on many topics and across programs and service networks.
- Provide assistance through ADRC core services, namely, enhanced Information and Assistance/Referral, Options Counseling, Short-Term Service Coordination, and Transition Services.
- Streamline access to Critical Pathways Providers creating expedited application assistance, peer mentoring, or other ways of eliminating barriers to critical services that enable independent living.

However, the future of these partnerships in California is uncertain. California did not receive adequate funding from the Administration on Community Living in its recent grant application competition, and has no dedicated funding stream moving forward.

### **Recommendations for the Federal Government**

In the decade following the Olmstead decision, economic indicators for California as well as those for most states have been declining and demand for services has been increasing. State budget processes have been tumultuous: between 1999 and 2010 the Legislature was called into Special Session 23 times to address mid-year budget deficits. The California energy crisis of 2003 and housing crash of 2008, and nationally, the collapse of major financial brokerage houses are all part of the context of progress and challenges in re-shaping policies and procedures for delivering long-term care services in line with the Olmstead decision.

California will continue to explore new opportunities to re-design its health care and long-term services and support delivery systems. Integration and flexibility in how Medicare and Medicaid resources can be utilized at state and local levels are essential to enable innovations.

- *Expand Federal Financial Participation for Home and Community-Based Services:* Current Medicaid eligibility determination (e.g., Spousal Impoverishment Provision in the Social Security Act) and federal-state sharing of long-term services and supports favor institutional placement. Families should be supported to care for their

loved ones in the community with Medicaid home and community-based services, instead of getting Medicaid-covered institutional services. A higher federal financial participation for all home and community-based services would enable states to provide more community-based services, rather than receiving the same federal financial participation for institutional services. The Community First Choice Option program is an encouraging step in the right direction, but it should be expanded to include all home and community-based Medicaid services as opposed to being limited to self-directed, personal and attendant services.

- *Increase Federal Incentives for Housing.* To effectively implement Americans with Disabilities Act (ADA) provisions, strong partnerships are needed between health and long-term services and supports providers with affordable housing developers. Federal incentives for housing developers to create housing for low-income seniors and persons with disabilities with requirements to partner with health and long-term services and supports providers would enable more supportive living environments.
- *Remove State Match Requirements for New Federal Assistance.* Given state budget realities, California recommends that any new federal assistance not require state match or state sustainability requirements that would be so potentially financially difficult that states with budget constraints cannot participate.
- *Recognize Large States in Crafting Performance Measures.* California requests that federal demonstration grant opportunities not require implementation performance measures that penalize large states from being selected. For example, requiring that a state make a demonstration program available to at least 50% of the state's population, when all states are eligible for the same amount of funding, effectively eliminates participation of large states and puts them at a disadvantage in competing for federal funding.
- *Provide Funding for Nursing Home Referrals.* Provide funding for community-based organizations that are responding to nursing home referrals pursuant to the requirements of Minimum Data Set 3.0 Section Q.
- *Reward Early Achievers.* California is just one of seven states that invests more Medicaid long-term care funding for community-based services than for long-term institutional care. Allow California and other states that took early action to be compliant with the Olmstead decision to qualify for Medicaid incentive payments when more than 50% of their long term services support expenditures are in community-based settings rather than institutions. For example, because of its rebalancing achievements to date, California is not eligible for the Balancing Incentive Program (BIP), which includes the benefit of an enhanced federal match for services.
- *Aging and Disability Resource Center Funding.* Establish a dedicated funding stream to facilitate expansion of Aging and Disability Resource Centers and the Aging and Disability Resource Centers Options Counseling service. Maintaining California's Aging and Disability Resource Connection partnerships over time without an ongoing revenue

source has been and will continue to be problematic. Given the severe economic climate in California and state budget reductions, organizations are stretched to perform their core functions. Local organizations need startup funding and ongoing technical assistance to support Aging and Disability Resource Connection partnerships. A dedicated funding source for the Options Counseling will facilitate rapid expansion and provide local support for informed choices for individuals and their families about available long-term service and support options.



## California's Medicaid 1915(c) Home and Community-Based Services (HCBS) Waivers

### Acquired Immune Deficiency Syndrome (AIDS)

Title of waiver	Federal laws or regulations waived	Description of waiver	Population served and number of enrollees	Status of waiver	State plan amendment (SPA) number and date that is applicable to the waiver	Department administering the program
<b>Acquired Immune Deficiency Syndrome (AIDS)</b>	1902(a)(1) 1902(a)(10)(B) 1902(a)(10)(C)(i)(III)	The HCBS waiver for persons living with AIDS and/or symptomatic HIV is an alternative for individuals who would otherwise qualify for institutional care. The waiver provides comprehensive and cost-effective services. Services include, but are not limited to, the following: intensive medical case management (nursing and psychosocial assessments), home delivered meals, attendant care, nutritional counseling, and Medical supplements for infants and children in foster care.	Eligible adults and children who are cognitively and functionally impaired with HIV disease or AIDS.  Enrollment: approximately 2,242.	Approved January 1, 2012 through December 31, 2016	Not a State plan service.	California Department of Public Health

Capacity	2007	2008	2009	2010	2011	2012
	3,560	3,720	3,890	4,070	4,250	4,410

## Assisted Living Waiver (ALW)

Title of waiver	Federal laws waived	Description of waiver	Population served and number of enrollees	Status of waiver	State plan amendment (SPA) number and date that is applicable to the waiver	Department administering the program
<b>Assisted Living Waiver (ALW)</b>	1902(a)(1) 1902(a)(10)(B) 1902(a)(10)(C)(i)(II) I)	The ALW succeeds the Assisted Living Waiver Pilot Project. The waiver offers assisted living services in two settings: Residential Care Facilities for the Elderly and publically subsidized housing. Qualified participants have full-scope Medi-Cal benefits with zero share of cost and are determined to meet the Skilled Nursing Facility Level of Care, A or B.	Beneficiaries over the age of 21 who would otherwise be in a nursing facility.  Enrollment: approximately 1844.	Approved March 1, 2009 through February 28, 2014.	Not a State plan service.	California Department of Health Care Services

Capacity	2007	2008	2009	2010	2011	2012
	N/A	N/A	1,300	1,720	2,260	2,920

## Home and Community-Based Services Waiver for the Developmentally Disabled (DD Waiver)

Title of waiver	Federal laws waived	Description of waiver	Population served and number of enrollees	Status of waiver	State plan amendment (SPA) number and date that is applicable to the waiver	Department administering the program
<b>Home and Community-Based Services Waiver for the Developmentally Disabled (DD Waiver)</b>	1902(a)(1) 1902(a)(10)(B) 1902(a)(10)(C)(i)(II I)	Community-based services for individuals with developmental disabilities are provided through a statewide system of 21 private, non-profit corporations known as regional centers. Regional centers provide fixed points of contact in the community for persons with developmental disabilities and their families.	Persons with developmental disabilities.  Enrollment: approximately 98,851.  The Centers for Medicare and Medicaid Services (CMS) has approved enrollment up to 120,000 by the fifth waiver year.	Approved March 29, 2012 through March 28, 2017.	Not a State plan service.	California Department of Developmental Services

Capacity	2007	2008	2009	2010	2011	2012
	75,000	80,000	85,000	90,000	95,000	105,000

## In-Home Operations (IHO) Waiver

Title of waiver	Federal laws waived	Description of waiver	Population served and number of enrollees	Status of waiver	State plan amendment (SPA) number and date that is applicable to the waiver	Department administering the program
<b>In-Home Operations (IHO)</b>	1902(a)(1) 1902(a)(10)(B) 1902(a)(10)(C)(i)(III)	This waiver serves either 1) participants previously enrolled in the Nursing Facility A/B Level of Care (LOC) Waiver who have continuously been enrolled in a DHCS administered HCBS waiver since prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse; or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the Nursing Facility/Acute Hospital Waiver for the participant's assessed LOC.	Aged population 65 and older, the physically disabled population under age 65, the medically fragile, and the technology dependent.  Enrollment: 134.	Approved January 1, 2010 through December 31, 2014.	Not a State plan service.	California Department of Health Care Services

Capacity	2007	2008	2009	2010	2011	2012
	210	210	210	170	162	154

## Nursing Facility / Acute Hospital (NF/AH) Waiver

Title of waiver	Federal laws waived	Description of waiver	Population served and number of enrollees	Status of waiver	State plan amendment (SPA) number and date that is applicable to the waiver	Department administering the program
<b>Nursing Facility / Acute Hospital (NF/AH)</b>	1902(a)(1) 1902(a)(10)(B) 1902(a)(10)(C)(i)(II I)	The NF/AH Waiver combined the previous Nursing Facility Level A/B, Nursing Facility Sub-acute, and In-Home Medical Care Waivers into one waiver. This combined waiver offers services in the home to Medi-Cal beneficiaries with a long-term medical condition who, in the absence of this waiver, would otherwise receive care for at least 90 days in an intermediate care facility, a skilled nursing facility, a sub-acute facility, or an acute care hospital.	The NF/AH Waiver serves the aged population 65 and older, the physical disabled population under age 65, the medically fragile, and the technology dependent.  Enrollment: 2,220.	Approved January 1, 2012 through December 31, 2016.  DHCS has submitted an application to CMS to merge this and the DD-CNC Waiver. DHCS is currently working with CMS.	Not a State plan service.	California Department of Health Care Services

Capacity	2007	2008	2009	2010	2011	2012
	2,392	2,552	2,712	2,872	3,032	3,192

## Developmentally Disabled Continuous Nursing Care (DD-CNC) Waiver

Title of waiver	Federal laws waived	Description of waiver	Population served and number of enrollees	Status of waiver	State plan amendment (SPA) number and date that is applicable to the waiver	Department administering the program
<b>Developmentally Disabled Continuous Nursing Care (DD-CNC) Waiver</b>	1902(a)(10)(B) 1902(a)(10)(C)(i)(III) 1902(a)(1)	The DD-CNC succeeds the 1915(b) Freedom of Choice Intermittent Care Facility/ Developmentally Disabled/Continuous Nursing waiver which expired on September 30, 2009. The waiver serves persons with severe developmental disabilities and the need for 24-hour continuous nursing care. The waiver is designed to meet the needs of a unique population of infants, children and adults with both developmental disabilities and a need for continuous skilled nursing. The waiver has its own unique level of care criteria to reflect the specific population which it serves. The criteria are similar to the sub-acute level of care but are inclusive of the developmental disability needs.	The waiver serves persons with severe developmental disabilities and the need for 24-hour continuous nursing care. DD-CNC does not have an age restriction.  Capacity: 84.  Enrollment: 44.	Approved October 1, 2009 through September 30, 2012.  Currently under CMS extension from October 1, 2012 through December 1, 2012. Pending CMS approval, this waiver will be merged with the NF/AH Waiver.	Not a State plan service.	California Department of Health Care Services

Capacity	2007	2008	2009	2010	2011	2012
	N/A	N/A	N/A	72	72	84

## Pediatric Palliative Care (PPC) Waiver

Title of waiver	Federal laws waived	Description of waiver	Population served and number of enrollees	Status of waiver	State plan amendment (SPA) number and date that is applicable to the waiver	Department administering the program
<b>Pediatric Palliative Care Waiver (PPC)</b>	1902(a)(1) 1902(a)(10)(B)	This waiver offers children with life limiting conditions a range of home-based hospice-like services while they maintain the option of receiving curative treatment. According to diagnosed need and an approved plan of care, services include: concurrent provision of the hospice-like services and therapeutic state plan services, care coordination, expressive therapies, family training, individual and family caregiver bereavement services, and respite care.	Children with life limiting conditions.  Capacity: 1,802.  Enrollment: 86.	Approved April 1, 2009 through March 31, 2012.  Currently under CMS extension until December 31, 2012.	Not a State plan service.	California Department of Health Care Services

Capacity	2007	2008	2009	2010	2011	2012
	N/A	N/A	N/A	801	1,802	1,802

## Multipurpose Senior Services Program (MSSP) Waiver

Title of waiver	Federal laws waived	Description of waiver	Population served and number of enrollees	Status of waiver	State plan amendment (SPA) number and date that is applicable to the waiver	Department administering the program
<b>Multipurpose Senior Services Program (MSSP)</b>	1902(a)(10)(B) 1902(a)(10)(C)(i)(II) I) 1902(a)(1)	Provides home and community-based services in 41 sites statewide to Medi-Cal beneficiaries who are age 65 or over and disabled as an alternative to nursing facility placement. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of frail clients. MSSP provides comprehensive care management to assist frail elderly persons to remain at home.	Medi-Cal beneficiaries who are 65 or over and disabled.  MSSP enrollment: approximately 8,987.	Approved July 1, 2009 through June 30, 2014.	Not a State plan service.	California Department of Aging

Capacity	2007	2008	2009	2010	2011	2012
	16,335	16,335	16,335	16,335	16,335	16,335



## San Francisco Community Living Support Benefit Waiver

Title of waiver	Federal laws waived	Description of waiver	Population served and number of enrollees	Status of waiver	State plan amendment (SPA) number and date that is applicable to the waiver	Department administering the program
San Francisco Community Living Support Waiver	1902(a)(1) 1902(a)(10)(B) 1902(a)(10)(C)(i)(III)	<p>Eligible individuals can move into licensed Community Care Facilities (CCFs) and Direct Access to Housing (DAH) sites.</p> <p>Services consist of care coordination, community living support benefits, and behavior assessment and planning in both CCFs and DAHs; and home delivered meals and environmental accessibility adaptations in DAH sites.</p>	<p>Residents of the city and county of San Francisco who are at least 21 years, determined to meet nursing facility level of care, are homeless and at imminent risk of entering a nursing facility, or reside in a nursing facility and want to be discharged to a CCF or DAH.</p> <p>Approved to serve up to 486 participants.</p>	Approved July 1, 2012 through June 30, 2017.	Not a State plan service.	San Francisco Department of Public Health
<b>Capacity</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
	3,560	3,720	3,890	4,070	4,250	4,410

## Appendix B

### California Olmstead Plan Update on its Implementation

November 2012

California's Olmstead Plan, released in May 2003, provides a blueprint for improving California's long-term care delivery system to ensure that persons with disabilities and older adults have appropriate access and choice regarding community-based services and long-term care options. In 2005 and 2010, the California Health and Human Services Agency released updates on the state's implementation of the recommended action steps in the plan.

During the development of the Olmstead Plan, many stakeholders and consumers throughout the state dedicated their time, commitment, and ideas to the Olmstead planning process. The planning process included a series of local Olmstead Forums hosted around the state by stakeholders to allow individuals to identify their needs and preferences for living in the community and any best practices. It also included the organization of a workgroup comprised of consumers and stakeholders to identify options and recommendations while also considering needs and preferences identified in the forums. The workgroups held meetings throughout the state.

The California Olmstead Plan is a framework and a compass for the state to ensure that laws, regulations, and program initiatives are consistent with principles of the Olmstead decision. The plan, adopted in 2003, organizes recommended future actions into twelve components. The most recent update on implementation of California's Olmstead Plan, released in 2010, combined these twelve components into four major categories. Similarly, this update is organized into those same four categories:

1. **State Commitment:** Consistency with the Olmstead Decision; Financing Long-Term Services and Supports
2. **Assessment and Transition:** Assessment; Transition from Institutional Settings; Housing; Capacity Needs in the Community
3. **Diversion:** Services that Divert Individuals at Risk of Institutionalization; Consumer Information; Community Awareness; Comprehensive Care Coordination
4. **Data and Research:** Data; Quality Assurance

#### 1. STATE COMMITMENT

**Consistency with the Olmstead Decision.** The Olmstead Plan includes goals for state policy and financing that is consistent with the Olmstead Decision.

- *Olmstead Advisory Committee:* The State of California convened the Olmstead Advisory Committee in 2005 to help inform policies and practices that impact Californians' abilities to receive services in the least restrictive environment and to avoid unnecessary institutionalization. The Olmstead Advisory Committee developed the Olmstead Policy Filter to advise the Health and Human Services Agency on the extent to which a policy (legislative, regulatory, budgetary) meets the intent of the Olmstead decision. The Olmstead Policy Filter comprises seven criteria

that promote Olmstead implementation. Please see the end of this update for a copy of the Olmstead Policy Filter.

In 2008, a revised Executive Order provided renewed commitment of the administration to the principles of the Americans with Disabilities Act (ADA) and the Olmstead decision. In 2012, Health and Human Services Secretary Diana Dooley expanded the Olmstead Advisory Committee membership to include representation of veterans, members experienced in housing development, and members with expertise in transportation services.

- *Commissioned Report on Long-Term Care.* As part of the State's Real Choice Systems Transformation project, the Health and Human Services Agency commissioned a report to improve understanding of the financial and structural barriers to increasing access to home and community-based services. The final report, *Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians*, was released on November 12, 2009. The report generated substantial discussion and related activities. Authors Robert Mollica, Ed.D., and Leslie Hendrickson, Ph.D., provided technical assistance to the Health and Human Services Agency, state departments, and legislative staff and served as subject matter experts at several legislative hearings and stakeholder meetings.

**Financing Long-Term Services and Supports.** The Olmstead Plan includes goals for financing that are consistent with the Olmstead decision. Towards this end, California has pursued every Medicaid program that Congress has approved that provides a tool to implement or expand home and community-based services, as well as pursuing grants for demonstration and research projects. The following is a brief highlight of California's successful grant submittals for waivers and grants from the federal government for developing, strengthening, and expanding our home and community-based services infrastructure and programs.

- *Nursing Facility Transition Screening Tool.* The Department of Health Care Services was selected for the Money Follows the Person demonstration in December 2007, with implementation in 2008. California's Money Follows the Person Rebalancing Demonstration, known as California Community Transitions, makes use of the Nursing Facility Transition Screening Tool. This has enabled the state to transition over 900 individuals residing in nursing facilities into the demonstration since December 2008, and inform many other individuals about their rights to informed choice.
- *Aging and Disability Resource Center Demonstration Grants.* Since 2003, California has received seven federal grants to develop and strengthen Aging and Disability Resource Connection partnerships. To date, partnerships have been established in the following counties: Riverside, Orange, San Francisco, San Diego, Del Norte, Butte, Colusa, Glenn, Tehama, Plumas and Nevada. Northern County Partnership consists of four counties together: Butte, Colusa, Glenn, Tehama, and Plumas. These seven Aging and Disability Resource Connection partnerships cover approximately 28% of California's population.

California has opted to use the modified title of Aging and Disability Resource Connections to reflect the principle of "no wrong door" as opposed to "single entry point" concept that works for smaller states. In California, Aging and Disability Resource Connections have at their core a partnership between an Area Agency on Aging and an Independent Living Center, as well as other organizations depending on specifics of the local community. These core partners are

joined by a network of "extended" partners. Collectively, Aging and Disability Resource Connection partner organizations become recognized as trusted sources of comprehensive information, counseling, and assistance. Aging and Disability Resource Connections empower consumers to consider all options, make informed decisions, and access community long term services and supports to help attain personal goals for independence, regardless of the source of financing (Medi-Cal (California's Medicaid program), Medicare, private insurance, federal or state-funded programs or consumer fees).

- *Administration on Aging Demonstration Grants.* Between 2004-2009, the Department of Aging applied for and received six competitive Administration on Aging demonstration grants to States to implement evidence based support programs to ethnically diverse families caring for a family member with Alzheimer's disease or another form of dementia. Over half of nursing home residents typically have some form of dementia.
- *Waivers for Individuals with Developmental Disabilities.* The Department of Developmental Services secured waiver amendments to provide federal financial participation for community-based services for individuals requiring Intermediate Care Facility level of care. These services play a vital role in transitioning consumers with the most significant care needs from Developmental Centers into community environments were instrumental in closing the Agnews Developmental Center and will similarly help in the closure of the Lanterman Developmental Center. The Department of Developmental Services also secured a Medi-Cal State Plan Amendment to expand federal match funds for long-term care services.
- *In-Home Supportive Services as a Medicaid Program.* The Department of Social Services converted In-Home Supportive Services to a Medicaid program. This increased federal financial participation while preserving the statewide nature of the program. *See additional detail on this program on pages 21-22.*
- *1915(k) Community First Choice Option Program.* California submitted a State Plan Amendment to implement the 1915(k) Community First Choice Option Program (CFCO) on December 1, 2011, which was approved on September 4, 2012. CFCO will enhance Medi-Cal's ability to provide community-based personal assistant services and support to seniors and persons with disabilities to certain enrollees who otherwise would need institutional care. By participating, California will receive a six percent increase in its federal medical assistance percentage for funds spent on these important services.
- *American Recovery and Reinvestment Act (ARRA).* The Department of Rehabilitation targeted American Recovery and Reinvestment Act (ARRA) funds of nearly \$650,000 to independent living organizations to advance Olmstead implementation. Projects focused on developing peer mentoring, public policy education and outreach efforts, and providing transition funds and technical assistance and training for independent living centers to become Medicaid providers or otherwise partner with Medi-Cal to support transitions from institutional settings.
- *New Freedom Transportation Grant.* In 2010, the Department of Aging applied for and received combined funding from the New Freedom Transportation Grant awarded to the Department of Transportation to convene a Mobility Management Workgroup to assist seven local agencies in identifying and securing funding to develop a local mobility management plan focused on improving transportation services to older adults and persons with disabilities.

## 2. ASSESSMENT AND TRANSITION

**Assessment.** The Olmstead Plan includes goals to conduct timely assessments for persons in institutions to determine the supports and services needed for them to live successfully in the community. It also includes goals for timely assessments for persons living in the community who are at risk of placement in an institution.

- *Section Q of the Minimum Data Set.* In 2010, the Centers for Medicare and Medicaid Services updated the Minimum Data Set, including Section Q, which addresses a resident's desire to return to the community. The Department of Health Care Services developed local partnerships to take referrals from institutional providers as required in the changes to the Minimum Data Set and is using grant funding to reimburse those organizations for handling referrals. This initial screening connects institutional residents to community-based service organizations that conduct assessments and develop and facilitate transition plans. The department is now working with the Centers for Medicare and Medicaid Services (CMS) on a method to be directly informed of residents indicating their desire to discharge home.

**Transition from Institutional Settings.** The Olmstead Plan's goals also include services that facilitate transitions of individuals from institutional settings to the most integrated settings appropriate for their needs, based on informed consumer choice. These include housing and other fundamental capacity needs in the community.

- *Developmental Center Closures.* The Department of Developmental Services successfully closed Agnews Developmental Center and the Sierra Vista Community Facility. These closures transitioned most residents into the community, ensuring continuity of services between the centers and the community and specifically enhancing community-based services in the San Francisco Bay Area by developing 60 homes that will remain available to people with developmental disabilities in perpetuity. The Department of Developmental Disabilities is also implementing the closure of Lanterman Developmental Center, which the Legislature approved as part of the 2010-2011 budget.
- *California Community Transitions (CCT).* California Community Transitions (CCT) is California's Money Follows the Person demonstration to transition long-term residents from long-term care facilities to community environments. CCT lead organizations include Independent Living Centers, Home Health Agencies, Area Agencies on Aging and Multipurpose Senior Services Program providers as well as the Department of Developmental Services. Fifteen lead organizations are currently serving potential demonstration participants in 42 counties. Another seven providers are actively pursuing lead organization status. The Department of Developmental Services serves as lead for all California Community Transitions transitions facilitated by regional centers. Through October 2010, lead organizations and the Department of Developmental Services have supported 286 individuals in their transitions with 244 individuals currently in various stages of transition planning.
- *Independent Living Centers.* The State Independent Living Plan identifies transition services as part of its 2010-2013 priorities. Approximately \$150,000 is allocated annually for independent living centers to provide necessary services to individuals they are assisting to transition to the

community, limited to \$4,000 per individual. Individuals served do not need to be on Medi-Cal. These efforts funded by the Rehabilitation Act, Title VIIB, have transitioned hundreds of people with disabilities back to community living.

- *Mental Health Services Act Housing Program.* The Department of Health Care Services and the California Housing Finance Administration jointly administer the Mental Health Services Act Housing Program. This program is funded by revenue from the state Mental Health Services Act (passed by California voters as Proposition 63 in 2004) for the development, acquisition, and rehabilitation of permanent supportive housing for individuals with mental illness and their families, especially homeless individuals with mental illness and their families. Approximately \$400 million in Mental Health Services Act funding has been set aside for this program.

### 3. DIVERSION

**Diversion.** The Olmstead Plan includes goals for services that divert individuals at risk of institutionalization.

- *Medi-Cal Home and Community-Based Services Waivers.* As mentioned throughout this letter, our departments have expanded Medicaid Home Community Based Services (HCBS) waivers to the current nine in place for California.
- *Individuals with HIV/AIDS.* The Department of Public Health, Center for Infectious Diseases, Office of AIDS administers a home and community-based services waiver designed to offer people living with HIV/AIDS an alternative to nursing facility care or long-stay hospitalization to retain quality of life within the home and community. The waiver serves approximately 2,450 Medicaid beneficiaries each year. Statewide Office of Aids contractors provide outreach to primary care providers, hospitals, federally qualified health centers, substance abuse recovery homes, HIV testing sites, HIV counseling and prevention-service sites, and residential care during community events.
- *The Multipurpose Senior Services Program.* California's Multipurpose Senior Services Program waiver was renewed in 2009, including the flexibility to hire staff who are registered nurses or public health nurses. Waiver capacity has remained at 16,000 since 2003, though enrollment is closer to 9,000 due to funding constraints.
- *In-Home Supportive Services.* The In-Home Supportive Services program serves more than 440,000 individuals in their homes, which makes it the largest personal care program in the country. This program grew over 100 percent in the number of recipients served over a ten year period (from 208,401 in FY 1998-99 to 429,786 in FY 2008-09). In 2004, California secured a Section 1115 demonstration waiver that captured federal financial participation for In-Home Supportive Services recipients with parent and spouse providers, advance pay, and restaurant meal allowance. In 2005, Congress authorized states to provide Personal Assistance Services under Section 1915(j) of the Deficit Reduction Act. The Department of Health Care Services and the Department of Social Services worked with Center for Medicare and Medicaid Services to amend California's Medicaid State Plan to offer In-Home Supportive Services as a Section 1915(j) State Plan Option in 2009.

**Consumer Information and Community Awareness.** The Olmstead Plan also focuses on consumer information and community awareness.

- *California Community Choices (Choices).* California Community Choices (the Choices project) was housed at the California Health and Human Services Agency, Office of the Secretary and was fully federally funded. It focused on developing California's long-term care infrastructure to increase access to home and community-based services and to help divert persons with disabilities and older adults from unnecessary institutionalization. Funding supported infrastructure development, including development of a pilot website, CalCareNet, a "one-stop shop" for information about long-term services and supports: <http://calcarenet.ca.gov>. CalCareNet features local services in Orange and Riverside counties, as well as statewide information about licensed care facilities and alcohol and drug programs. The site also provides general education and tips for anyone seeking information about long-term services and supports.
- *The California (Medi-Cal) Working Disabled Program.* The Department of Health Care Services established the 250 Percent Working Disabled Program, effective April 1, 2000. This program allows employed individuals with disabilities to earn up to 250 percent of the federal poverty level in countable income and maintain Medi-Cal eligibility by paying a monthly premium. A Medicaid Infrastructure Grant has supported outreach and education so that people with disabilities receiving critical Medi-Cal long-term services and supports are aware they can work and earn incomes above poverty levels without losing eligibility.

**Comprehensive Care Coordination.** And finally, the Olmstead Plan recommends comprehensive care coordination.

- *Coordinated Care Initiative.* As mentioned earlier, California is in the process of launching the Coordinated Care Initiative. This will begin with eight demonstration counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. The participating health plans are part of the state's existing network of Medi-Cal health plans and have experience providing Medicare managed care. Each underwent a rigorous selection process. Under the Coordinated Care Initiative, the participating health plans will receive a monthly payment to provide beneficiaries access to all covered, medically necessary services. This is called "capitation." These bundled payments create strong financial incentives for the health plans to ensure beneficiaries receive necessary preventative care and home-and community-based options to avoid unnecessary admissions to the hospital or nursing home.
- *Expansion of Managed Care.* In renewing California's Section 1115 Waiver, the Department of Health Care Services expanded the scope to cover more uninsured adults by extending the current county-based Health Care Coverage Initiative to increase support for public hospitals through the Safety Net Care Pool and to mandatorily enroll seniors and persons with disabilities into managed care plans to achieve care coordination, better manage chronic conditions, and improve health outcomes. Mandatory enrollment has been phased in over a 12-month period. Consumer protections are built into the process, requiring health plans to conduct a timely health risk assessment based upon the member's health status and to have accessible specialty care networks.

- *Program of All-Inclusive Care for the Elderly.* Program of All-Inclusive Care for the Elderly (PACE) organizations provide risk-based capitated care for older adults who are frail. The Department of Health Care Services contracts with these organizations to provide all medical services, home and community-based long-term care to Medi-Cal and dual Medi-Cal/Medicare beneficiaries who are at the skilled nursing or intermediate care facility level of care. Currently, the state contracts with five organizations. In 2012-13, six new PACE organizations will become operational.

#### **4. DATA AND RESEARCH**

**Data and Research.** The Olmstead Plan includes goals for quality assurance and the collection and analysis of data.

- *California Medicaid Research Institute.* The California Medicaid Research Institute (CaMRI) is currently analyzing individuals' experiences in avoiding long-term institutional placements through many home and community-based programs California. Funded by The SCAN Foundation and the Department of Health Care Services, this project will conduct a comprehensive review of Medi-Cal home and community-based services. The broad objectives of this project are to establish a robust database of 2005-2008 long-term care and home and community-based services data, analyze the use and impacts of home and community-based services and other long-term care services, and develop predictive modeling techniques that will inform California's home and community-based services policy makers.



## **The Policy Filter of the Olmstead Advisory Committee**

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On June 22, 1999, the United States Supreme Court issued a decision in the case of *Olmstead v L.C.*, finding that the unjustified institutional isolation of people with disabilities is a violation of the Americans with Disabilities Act (ADA). The Olmstead Advisory Committee will use the following criteria to advise the California Health and Human Services Agency on the extent to which a policy (legislative, regulatory, budget) meets the intent of the Olmstead decision.

1. Achieves measurable progress towards diverting individuals from institutions and transitioning individuals from less-integrated to more-integrated settings.
2. Fosters and promotes an individual's informed choice in his/her living arrangement.
3. Increases an individual's ability to participate, live and work in the community.
4. Sustains and/or builds upon home and community-based services and supports to enable an individual to choose to live, work and participate in the community.
5. Advances the implementation of the California Olmstead Plan.
6. Provides supports and services to all individuals in a culturally and linguistically competent manner.
7. Conforms to the legal rights of persons with disabilities, as identified in the Americans with Disabilities Act and other state and federal disability civil rights laws.

UNITED STATES SENATE

# Colorado's Promise of Community Living

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A Summary Report of Colorado's Efforts to  
Implement the Olmstead Mandate

9/6/2012

This report is provided as requested by Senator Tom Harkin, Chairman of the US Senate Committee on Health, Education, Labor and Pensions. The report summarizes the efforts that Colorado has pursued using various tools provided by Congress and state resources to comply with the Olmstead Decision.

**(1) For each year from FY 2008 to the present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities (ICF-ID/DD), long term care units of psychiatric hospitals and board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program.**

**State Medicaid –HCBS.** The Department of Health Care Policy and Financing (HCPF) is the single State Medicaid Agency and has primary responsibility for administering the state Medicaid program. Table 1 illustrates the total number of clients who have transitioned from a nursing home or ICFs/ID since FFY 2008 to a Home and Community-Based Services (HCBS) Program funded through Medicaid. The numbers exclude clients who have transitioned from nursing facilities following a rehabilitation stay. Table 1-2 provides data about what type of setting the clients who transitioned from nursing homes and ICF-ID/DD went to following discharge.

**TABLE 1-1**

<b>FEDERAL FISCAL YEAR</b>	<b>Transitions From Nursing Home</b>	<b>Transitions from ICF-ID/DD</b>	<b>Transitions from Long-Term Care in Psychiatric Hospital</b>
2007-08	124	4	174
2008-09	167	8	181
2009-10	151	29	150
2010-11	165	7	129
2011-12 YEAR-TO-DATE*	102	5	119

\*DATA IS THROUGH AUGUST 2012 AND DOES NOT REFLECT A FULL FEDERAL FISCAL YEAR.

**TABLE 1-2**

<b>ALL UNIQUE CLIENTS TRANSITIONED FROM A NURSING FACILITY OR ICF-ID/DD AND INTO THE COMMUNITY BY FEDERAL FISCAL YEAR AND SETTING THE CLIENT TRANSITIONED TO</b>					
<b>FEDERAL FISCAL YEAR</b>	<b>ALTERNATIVE CARE FACILITY</b>	<b>GROUP HOME</b>	<b>Home of their own</b>	<b>TOTAL TRANSITIONS</b>	
2007-08	62	8	58	128	
2008-09	75	16	84	175	
2009-10	70	32	78	180	
2010-11	78	9	85	172	
2011-12**	38	5	64	107	
<b>TOTAL</b>	<b>323</b>	<b>70</b>	<b>369</b>	<b>762</b>	

\*DATA IS THROUGH AUGUST 2012 AND DOES NOT REFLECT A FULL FEDERAL FISCAL YEAR

Only a very small percentage of Medicaid HCBS adult clients in Colorado use board and care homes. The number of adults in this type of housing is currently not tracked. The column in Table 1-2 may include individuals in board and care homes.

**Transitions from psychiatric hospitals.** The two Colorado Mental Health Institutes (state psychiatric hospitals) in Colorado are administered by the Division of Behavioral Health (DBH) in the Department of Human Services (DHS). The institutes ensure that patients are connected to a Community Mental Health Center, but do not collect data about the type of placement that the patient is discharged to. Therefore, it is not known how many of the transitions from psychiatric hospitals in Table 1-1 where transitions to the client's own home. These clients may be discharged to nursing homes, assisted living facilities, group homes, subsidized apartments with supportive services included or their own home and receiving services from a mental health center. The majority of clients more than likely move to less restricted environment than the hospital but are still in some type of supervised setting rather than their own home.

**Subsidized Housing for People with Disabilities and the Elderly.** The Division of Housing (DOH) in the Department of Local Affairs has two programs that focus on assisting persons with disabilities to move from nursing homes and other long term care into homes in the community. Funding for 40 Project Access Housing Choice Vouchers was received in 2002. After five years DOH voluntarily continued the program and expanded it by 20 additional vouchers. DOH also received 100 Certain Developments Housing Choice Vouchers in 2009. DOH was able to use 42 of the Certain Developments vouchers to assist persons with disabilities in moving from nursing homes and other long term care. The rest of the vouchers (58) assisted persons with disabilities who were on waiting lists for housing with supportive services to move into homes of their own. Finally DOH has over 5,000 Housing Choice Vouchers that provide housing to persons with disabilities in conjunction with available supportive services. These vouchers are dispersed throughout the state of Colorado. Over 50 providers contract with DOH to provide supportive services and assist with finding and maintaining housing in the community. Access to stable, affordable housing results in "staying in one's home." DOH not only assists persons with disabilities in moving from nursing homes and other long-term care facilities, it provides permanent supportive housing to help them stay in their own homes in the community. Table 1-2 below identifies the number of new subsidies that DOH and its partner agency (Supportive Housing and Homeless Programs) has developed since 2008 despite the reduced number of opportunities available.

**Table 1-2**

Year	Number Housed by DOH using Project Access and Certain Developments Vouchers	New persons with disabilities moved from a nursing home to community*
2008	34	
2009	83	61
2010	77	10
2011	97	29
2012	95	10

\*MANY PEOPLE RECEIVING HOUSING THROUGH THESE SOURCES MOVED ON TO RECEIVE HOUSING FROM OTHER SOURCES FREEING UP HOUSING SUBSIDIES FOR NEW PEOPLE

(2) **The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, ICF-ID/DD, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.**

Table 2-1 identifies state spending by setting for federal fiscal years 2010-11 and 2011-12. The Federal match for Colorado's Medicaid Program is 50 percent. The costs reflected in the table for Medicaid expenditures does not include the Federal match and reflects only state expenditures. The expenditures for clients in their own homes includes only expenditures for Medicaid Home and Community-Based Services and does not include other local, state or federal resources that the clients may have accessed, such as housing subsidies or utility assistance.

**TABLE 2-1**

SETTING	State Expenditures by Setting	
	FFY 2010-11	FFY 2011-12**
Nursing Homes	\$ 251,173,006	\$ 217,526,702
ICF-ID/DD	\$ 18,883,117	\$ 15,213,031
Board and Care Homes (ALF/ACF)*	\$ 21,200,240	\$ 17,335,124
Psychiatric Hospitals	\$ 1,227,158	\$ 1,227,158
Group Homes	\$ 133,231,100	\$ 109,240,159
Their own homes	\$ 121,292,366	\$ 106,194,126

\* PAYMENTS FOR ASSISTED LIVING FACILITIES ARE INCLUDED WITH THE BOARD AND CARE HOMES.  
 \*\*CLAIMS DATA FOR JUL, AUG AND SEP NOT COMPLETE FOR FFY 11-12.

DBH administers alternative placements to the state psychiatric hospitals. These alternatives include other institutional-like settings and options that fall between institutional level of care and the least restrictive environment, the client's own home. These other options include small group home like-settings and short-term, intensive therapeutic stays at a few community mental health centers. Table 2-2 provides a breakdown of states expenditures by alternative placement type.

**TABLE 2-2**

APPROPRIATIONS FOR ALTERNATIVE PLACEMENTS	
ALTERNATIVE PLACEMENTS FUNDED BY OBH	STATE BUDGET AMOUNT FOR STATE FISCAL YEAR 11-12
Acute Residential Facility	\$ 117,274
24 hr hospitalization and transitional services	\$ 117,274
Integrated Treatment and Intensive Treatment Houses	\$ 215,051
Assisted Living Facility	\$ 375,586
Family Care Homes – Aftercare	\$ 85,958
Senior Housing Options – Aftercare	\$ 104,120
<b>Total</b>	<b>\$1,015,263</b>

DOH will spend approximately \$26,580,000 this federal fiscal year for rental assistance payments for Housing Choice Voucher and Shelter Plus Care rental assistance payments for persons with disabilities. These subsidies are possible through the funding opportunities available through HUD. The residents of these subsidized housing units have access to services and supports available through service agencies that have contracts with DOH.

**(3) For each year from FY 2008 to the present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated they previously spent on segregated settings) and the specific nature of the capacity added.**

**State Medicaid – HCBS.** Colorado has a long history of providing HCBS to individuals in their own homes through its Medicaid Program. Colorado currently operates 12 HCBS waiver programs that target people with physical disabilities, mental illness, brain injuries and ID/DD; the elderly; and children with special health care needs. HCPF as the Single State Medicaid Agency administers eight of the waivers, while the Division for Developmental Disabilities (DDD) and the Child Welfare Unit in the Department of Human Services administers four waivers targeting people with ID/DD. Colorado currently ranks seventh in the country in AARP’s most recent state by state comparison report. This ranking is largely based on the access that Colorado has to HCBS. Table 3-1 lists new waivers that have been implemented to serve more populations since 2008:

**TABLE 3-1**

Official Name	Implementation Date	Expiration Date	Summary
HCBS Children w/Autism	01/01/2009	12/31/2013	Provides behavioral therapy for children w/autism ages 0-6
Children w/Life Limiting Illness	07/01/2010	06/30/2015	Provides palliative care for medically fragile individuals ages 0-18
HCBS for People with Spinal Cord Injuries	07/01/2012	06/30/2015	To provide an alternative to nursing home care for people with spinal cord injuries

The waiver with the highest enrollment in Colorado is HCBS for the Elderly, Blind and People with Disabilities (HCBS-EBD). HCPF has traditionally expanded the capacity of this waiver by increasing the enrollment cap. Colorado still has capacity in this waiver to enroll more clients. From FY 2008 to present, DDD has expanded its capacity to serve individuals with ID/DD in their own homes, host homes or small Residential Habilitation group homes that provide access to supervision on a 24 hour a day, seven days a week basis. The expanded capacity in the HCBS for People with Developmental Disabilities (HCBS-DD) and HCBS -Supported Living Services Program (HCBS-SLS) have allowed individuals to transition from institutional placements or diverted individuals from institutional placement. The HCBS-DD waiver serves individuals in group homes and small host homes. The HCBS-SLS program provide for services in a person’s own home.

Table 3-2 illustrates the number of new appropriations and new resources received by DDD to expand access. These appropriations were used specifically to move individuals out of nursing homes or ICF-ID/DD or to prevent institutionalization.

TABLE 3-2

STATE FISCAL YEAR	EXPANDED CAPACITY IN THE HCBS-SLS AND HCBS-DD WAIVERS				
	PROGRAM AREA / RATIONALE	APPROPRIATE D NUMBER OF RESOURCES*	NUMBER OF MONTHS**	APPROPRIATE D DOLLARS	ANNUALIZED APPROPRIATION IN FOLLOWING FISCAL YEAR***
2007-08	HCBS-DD Emergencies	30	6	\$1,343,936	\$2,687,873
	HCBS-DD Wait List	19	6	\$381,936	\$763,867
	<b>TOTAL</b>	<b>49</b>		<b>\$1,725,872</b>	<b>\$3,451,740</b>
2008-09	HCBS-DD Emergencies	62	6	\$2,531,842	\$5,063,684
	HCBS-DD Wait List	198	6	\$6,509,150	\$13,018,300
	HCBS-SLS Wait List	184.5	6	\$1,496,469	\$2,992,938
	HCBS-SLS Wait List	117	12	\$2,037,402	\$2,037,402
	<b>TOTAL</b>	<b>561.5</b>		<b>\$12,574,863</b>	<b>\$23,112,324</b>
2009-10	Transfer from Regional Centers to HCBS-DD	20	6	\$565,330	\$1,130,660
	Transition from Skilled Nursing Facility Closure to HCBS-DD	29	1.4	\$419,502	\$3,675,853
	<b>TOTAL</b>	<b>49</b>		<b>\$984,832</b>	<b>\$4,806,513</b>
2010-11	NONE	0		\$0	\$0
	<b>TOTAL</b>	<b>0</b>		<b>\$0</b>	<b>\$0</b>
2011-12	HCBS-DD Emergencies	30	6	\$916,515	\$1,833,030
	<b>TOTAL</b>	<b>30</b>	<b>6</b>	<b>\$916,515</b>	<b>\$1,833,030</b>
2012-13	HCBS-DD Emergencies	47	6	\$1,857,370	\$3,714,740
	HCBS-SLS Wait List	30	6	\$262,710	\$525,420
	<b>TOTAL</b>	<b>77</b>		<b>\$2,120,080</b>	<b>\$4,240,160</b>

\*THE NEW RESOURCES COLUMN REPRESENTS THE NUMBER OF ANNUALIZED FULL-TIME EQUIVALENTS (FTE) FOR PROGRAM ENROLLMENT.

\*\*THE NUMBER OF MONTHS COLUMN REPRESENTS THE AVERAGE NUMBER OF MONTHS THAT EACH FTE WAS ENROLLED.

\*\*\*THE ANNUALIZED APPROPRIATION COLUMN IS THE AMOUNT OF FUNDING APPROPRIATED THE FOLLOWING FISCAL YEAR TO SUSTAIN THE RESOURCES.



Table 3-3 documents the trend in funding and enrollment since FFY 2008 in Medicaid long-term services and supports (LTSS). It shows the gradual trend in increased funding and enrollment for HCBS over the last five years. Beginning in FY 09-10, HCBS expenditures narrowly exceeded nursing home expenditures. In that year, HCBS Expenditures represented 50% of Colorado's Medicaid expenditures for long-term services supports. It is important to note that these expenditures do not include long-term home health services. The data for FFY 11-12 is not complete yet, since there are still outstanding claims and enrollment data for July, August and September. However, it appears the trend of increased enrollment and expenditures in HCBS programs will continue for this fiscal year.

**TABLE 3-3**

FEDERAL FISCAL YEAR	HCBS CLIENTS AND EXPENDITURES		INSTITUTIONALIZED CLIENTS AND EXPENDITURES***	
	TOTAL UNIQUE CLIENTS	TOTAL PAID AMOUNT*	TOTAL UNIQUE CLIENTS	TOTAL PAID AMOUNT*
2007-08	29,667	\$ 453,135,533	14,575	\$ 514,519,660
2008-09	31,351	\$ 525,488,966	14,282	\$ 563,564,802
2009-10	32,527	\$ 534,979,659	14,363	\$ 534,485,430
2010-11	33,648	\$ 551,447,413	14,572	\$ 540,112,245
2011-12**	33,943	\$ 465,538,819	13,197	\$ 465,479,467

\*DOLLARS ARE ROUNDED TO THE NEAREST WHOLE DOLLAR

\*\*DATA WAS PULLED 8/24/2012, THUS THE FEDERAL FISCAL YEAR HAS NOT CONCLUDED. THE MOST RECENT 3 MONTHS OF DATA DO NOT HAVE ENOUGH PAID CLAIMS RUN-OUT TO BE CONSIDERED COMPLETE.

\*\*\*ANY CLIENT WITH A POSITIVE PAID NF/ICF-IID CLAIM IS INCLUDED

THE DATA IN THIS TABLE INCLUDES CLAIMS AND INDIVIDUALS SERVED IN GROUP HOMES, ASSISTED LIVING FACILITIES AND INDIVIDUALS IN THEIR OWN HOME.

**Colorado Public Mental Health System.** DBH administers state mental health programs offering a continuum of care for people with mental illness. The mental health services are offered through community mental health centers and psychiatric hospitals. The clients served through the community mental health centers may also be clients who are enrolled in Medicaid. For these clients, Medicaid covers mental health services through a capitated managed care plan for mental health services. Table 3-4 indicates the number of clients served through OBH's services outside of the state psychiatric hospital.

**TABLE 3-4**

State Fiscal Year	Number of Clients Residing in Supported Housing or Other Independent Living*	Percent of all Clients Served	Total Persons Served*
2007-08	60,368	87%	69,079
2008-09	66,268	88%	75,154
2009-10	66,511	86%	77,037
2010-11	69,463	87%	79,481
2011-12	75,861	88%	85,815
<b>Total</b>	<b>338,471</b>	<b>88%</b>	<b>386,566</b>

\*OBH DOES NOT TRACK WHERE CLIENTS DISCHARGE TO. THE NUMBER OF CLIENTS INCLUDES INDIVIDUALS IN ASSISTED LIVING FACILITIES, RESIDENTIAL PROGRAMS, NURSING HOMES AND THEIR OWN HOMES.

Because of state budget constraints, OBH has not seen an increase in funding in several years as illustrated by Table 3-5. In state fiscal year 2010-11, OBH experienced a 2 percent reduction in funding.

**TABLE 3-5**

State Fiscal Year	EXPENDITURES FOR INPATIENT SERVICES	EXPENDITURES FOR ALTERNATIVE SERVICES*
2007-08	\$1,252,202	\$3,022,489
2008-09	\$1,252,202	\$3,022,489
2009-10	\$1,227,158	\$2,962,041
2010-11	\$1,227,158	\$2,962,041
2011-12	\$1,227,158	\$2,962,041
2012-13	\$1,227,158	\$2,962,041
<b>Total</b>	<b>\$7,413,036</b>	<b>\$17,893,142</b>

\*OBH DOES NOT TRACK WHERE CLIENTS DISCHARGE TO. THE ALTERNATIVE SERVICES INCLUDES SERVICES PROVIDED IN NURSING HOMES, ASSISTED LIVING FACILITIES AND HOMES OWNED BY CLIENTS.

**Subsidized Housing for People with Disabilities and the Elderly.** Table 3-6 below shows the number of housing subsidies that DOH has developed that addresses the needs of persons with disabilities. The subsidies are funded through HUD.

**TABLE 4-6**

Type of New Subsidies	Year	Amount of Subsidies
VASH	2008	210
Shelter Plus Care Subsidies	2010	98
VASH	2010	100
Shelter Plus Care Subsidies	2011	16
VASH	2011	25
VASH	2012	105
Section 811 (application)	2012	425

Housing developers have created the following new housing units that target persons with disabilities:

- 2008 315
- 2009 515
- 2010 117

There are a large number of units still in development for 2011 and 2012. In 2012, the Colorado Housing and Finance Authority changed its Qualified Allocation Plan for Low Income Tax Credits. This plan now has a preference for the development of affordable housing for persons with disabilities. These credits will encourage developers to build new housing for people with disabilities.

In addition, DOH has announced a Request of Applications (RFA) for affordable housing providers. This initial RFA will provide at least 200 project based subsidies through the Housing Choice Voucher Program. It is intended to provide permanent supportive housing for persons with special needs. This funding is intended to target persons with disabilities along with other special needs populations. The priority for the State of Colorado housing funding is for permanent supportive housing.

**(4) The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.**

**Plan Development Process.** Colorado responded to the Olmstead decision and the Governor's Executive Order by establishing a unified plan that focuses on supporting the continuance of transitioning appropriate persons placed in institutional settings to a strengthened community-based service system as well as supporting those at risk of living in a more restrictive setting. DHS and HCPF's Colorado Olmstead plan was consistent with the Departments' past successful efforts to build strong, cost effective home and community-based alternatives to institutional services.

Colorado Governor Bill Ritter issued an Executive Order for a new Colorado Olmstead Plan. The lead agency for developing and implementing the plan is HCPF, the single state Medicaid Agency, which is coordinating work with many Colorado partners including the DBH and DOH. HCPF's Long Term Care Advisory (LTCAC) committee, in partnership with HCPF staff worked with a core team of stakeholders including people receiving services, case management and service providers, mental health professionals, home health providers, academics, state staff and advocacy organizations to develop recommendations and policy options to further promote community-based LTSS in response to the executive order. In the spring, 2010 the draft was circulated statewide to additional stakeholder groups for a thirty-day public comment period. After stakeholder input was incorporated, the final recommendations and policy options document was submitted to the Governor in July, 2010 to coincide with the 20th anniversary of the Americans with Disabilities Act.

**Key Recommendations of the Plan.** The Olmstead core team identified the following six key issues and strategies to address each:

- **Sustainable financing** - While there is a strong infrastructure of home and community based services available in Colorado, reimbursement methodologies for these service providers should be examined in order to maximize the availability of these services.

*Strategy* - Identify current and future potential funding sources and reimbursement methodologies.

- **Policy integration** - The process of developing policy recommendations related to community-based LTSS generates an opportunity to examine current state regulations and policies to determine if they complicate access to home and community-based services. Additionally, there is an opportunity to develop policy or regulations that may enhance access to services.

*Strategy* - Identify areas where current policies related to LTSS need to be adapted to support the Olmstead decision and the actions in this document. Additionally, create a policy that prompts systematic, on-going review of progress in implementing these recommendations as well as identification of any needed changes.

- **Increase housing options available for people with all types of disabilities** - There is a shortage of options for integrated, supportive housing for people with disabilities and others with

LTSS needs. Ideal supportive housing for people with LTSS needs is located in rural, suburban and urban areas; adaptable to the clients' needs throughout the lifespan; allows for client interaction in the community and is affordable. While there are some housing options in Colorado that meet these expectations, demand far outweighs capacity at this time.

**Strategy** - Improve access to affordable housing that is adaptable for people with physical and intellectual disabilities as well as people with severe persistent mental illness by eliminating barriers to accessing affordable housing, informing the community of existing housing options and increasing the number of affordable and accessible housing units through a number of funding strategies.

- **Expand the current array of services** - Failure to provide an adequate array of services and adaptive technologies can contribute to the unnecessary institutionalization of people with disabilities and the elderly. There is a gap between the services available to people in institutions and those available to people in the community that can contribute to unnecessary institutionalization. Currently, cost shifting occurs between systems, such as between the developmental disability system and the mental health system, as a result of services available in one waiver, but not in others.

**Strategy** – After appropriate financial analysis, work toward making many of the current HCBS waiver services available to all individuals using HCBS waiver services and expand the array of services as funding permits.

- **Stabilize and grow the direct service workforce** - Direct service workers (DSWs) are people who help individuals with disabilities perform activities of daily living, such as personal hygiene, dressing, etc. Historically, there is frequent turnover in the direct service workforce and workers often need additional training. An unstable direct service workforce contributes to reduced access to services and more individuals who could otherwise live in the community may be forced to live in more restrictive settings.

**Strategy** - Identify barriers and opportunities to improve retention and improve recruitment of DSWs. Identify and implement a method for training and credentialing of DSWs.

- **Better inform the community about the services available for people with disabilities** - While there are many existing options for long term care services outside of institutional settings, most people do not fully know about these options for themselves or family members which can result in reduced access to these services.

**Strategy** - Identify best practices to encourage informed choice for individuals in need of long term care services. Develop informational tools to disseminate to the public about available home and community-based services and resources.

**Link to the Colorado Olmstead Report:**

[Colorado Olmstead Report](#)

## **Ongoing and Future Colorado Olmstead Activities – State Medicaid:**

- Colorado was awarded a \$22 million Money Follows the Person (MFP) grant on April 1, 2011. HCPF is currently planning and developing the infrastructure needed to launch the MFP program in Colorado by early 2013. Many of the Olmstead Report recommendations were incorporated as goals for the grant. In Colorado, the MFP program is called Colorado Choice Transitions (CCT).
- Colorado is exploring the feasibility of the Community First Choice (CFC) Option and will make a decision whether to implement CFC or not in 2013. Colorado is establishing a CFC development council, consisting primarily of consumers.
- Colorado has 12 HCBS Waivers offering services to people with physical disabilities, people with mental illness, people with ID/DD and the elderly. These waivers provide alternatives to institutional placement.
- HCPF has reorganized the LTCAC over the last year to have broader stakeholder representation and to include perspectives from other state agencies that fund LTSS. The department is positioning this committee to advise HCPF on policy and regulatory changes needed to create a LTSS delivery system that expands access, choice and options; reduces overall costs per person; and improves client outcomes, such as quality of life. The majority of the recommendations of the Olmstead Report are integrated into the priorities identified by the LTCAC.
- The MFP Project Director from HCPF has joined the Colorado Housing Coalition, which has agreed to prioritize problem-solving barriers related to obtaining affordable and accessible housing for individuals who wish to transition from institutional placement. Members of the coalition include representation from the regional offices of Housing and Urban Development (HUD), Centers for Medicare and Medicaid Services, Civil Rights and the Administration on Community Living; a few public housing authorities and developers; DOH and now HCPF.

## **Ongoing and Future Colorado Olmstead Activities – Behavioral Health Care:**

- Explore innovative means of combining New Freedom Coalition and PATH funding to enhance uptake of consultation, technical assistance and trainings.
- Identify grant opportunities for Evidence-Based and Promising Practices (EBPs) in the least restrictive environment possible.
- Enhance linkage to higher education, specifically the medical school, providing training to multiple disciplines regarding the ongoing trend toward community-based care for people with behavioral health care needs.
- Collect resources through ongoing literature review, conferences, and community linkage, and disseminate this information via training, meetings, conferences, and the DBH website.

A section of the DBH website is now devoted to EBPs and materials are being disseminated to mental health providers. Additional website plans include posting of the Colorado Olmstead report and work related to support pre-transition planning for persons with behavioral health needs.

Through coordination of Olmstead and PATH funds, Certified Addiction Counselor training is being offered to community providers.

EBP trainings have been conducted with DBH staff and community leaders (e.g., Colorado Behavioral Healthcare Council). In addition, the Olmstead Coordinator at DBH now conducts monthly "brown bag" training for DBH staff which feature EBPs and statewide data.

The Olmstead Coordinator participates on the Governor's Interagency Council on Homelessness. The Council is creating recommendations to the Governor which include how multiple federal programs can be aligned to insure that persons with mental illnesses are effectively served in the least restrictive settings. One of the areas the Council is focused on is the SOAR model for benefits acquisition and retention.

In collaboration with the University of Colorado Denver Behavioral Health & Wellness Program, DBH established a sustainable peer-to-peer wellness program in the community as part of a six-state initiative that will be evaluated over several years. Multiple cohorts of peers have received peer specialist training in community wellness initiatives that will provide wellness resources to mental health consumers in such areas as tobacco use, exercise, nutrition, and coping skills that will assist individuals to live successfully in the community.

Additionally, DBH in collaboration with the Colorado Department of Health and Environment jointly created a new level of transitional care specific for persons with behavioral health issues that need inpatient psychiatric care. The Acute Treatment Unit (ATU) license allows for persons to be transitioned from inpatient hospital care to a much less restrictive setting even if a certification is in place. There are currently six ATU's operated and owned by the Colorado community mental health centers with dual licensure/designation jointly issued by the Colorado Public Health and Environment and the DBH. These ATUs are geographically located across the state to reduce accessibility issues. Also, by rule, persons may not reside in an ATU for more than five consecutive days thus discharge/transition planning must begin immediately, ensuring that clients continue progressing to the next least restrictive level of care.

Also, during the past year, the state of Colorado has revamped the forms and focus of our Pre-Admission Screen and Resident Review (PASRR) program to more closely align with the intent of Olmstead. While Colorado had historically done an excellent job ensuring that nursing facility admissions were necessary and appropriate, the state's process did not include a focus on transition potential and planning. State staff and stakeholders spent 2010 implementing online submission of initial PASRR reports, redesigning the PASRR Level II evaluation instrument, beta testing the new forms and procedures and finally training all Level II evaluators in the state on the new forms and philosophies.

The new instrument is designed to more fully identify barriers to community placement as well as identifying any and all needed services and supports for the individual to ensure a successful transition into a more integrated living situation. The state believes that identifying these barriers prior to nursing facility admission and requiring joint care planning by the receiving nursing facility and the responsible mental health provider before PASRR authorization is given will significantly improve the likelihood of shorter stays at nursing facilities and more successful moves into the community.

**(5) Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.**

Colorado believes the following recommendations would make it easier to effectively implement Olmstead's integration mandate:

- Affordable and accessible housing is a major barrier to assisting individuals to transition from nursing homes and other types of institutions. Increasing access to vouchers and other subsidized housing options for people with disabilities would greatly enhance Colorado's ability to integrate people in the community.
- The 811 Application that Colorado submitted to HUD in July is for an 811 demonstration program that requires that only 25 percent of the units in a building be allocated to people with disabilities and does not tie services directly to the units that are subsidized. These new requirements promote community integration and should be adopted for all future Section 811 funding opportunities.
- Money Follows the Person (MFP) is a great opportunity for states to build their infrastructure for transitioning clients from institutional placement to their own home. However in the law that authorizes MFP, patients of psychiatric hospitals are not eligible to receive MFP services unless they transition to a nursing home first. For some clients, this requirement to transition from one institution to another does not seem to be aligned with the Olmstead decision. For those clients where it may make sense for a short-stay in a nursing home before they return to the community, the Medicaid rules around medical necessity for nursing home placement creates a barrier for some of these clients in the psychiatric hospitals to move to a less restrictive environment. In many cases the transition process for people with mental illness may need to follow a step-down process from a restrictive environment to a less restrictive environment and finally to the least restrictive setting.
- The law authorizing MFP also have restrictions on housing that prevent clients from discharging to most assisted living facilities or other secure arrangements that may be necessary for transitioning a nursing home resident with dementia into a less restrictive environment that is secure and provides supervision. Consequently, states have been challenged with transitioning clients with dementia through MFP.
- To support the client's preparation for transition, some of the HCBS services should start prior to the transition, such as case management or behavioral health support, or be completed prior to the transition, such as home modifications. These services because of federal rules cannot be reimbursed until after the client has transitioned. Consequently, the local agencies that assist individuals with transitioning are expected to cover the costs upfront and bill Medicaid retroactively. For Colorado's local service provider agencies, covering these costs upfront presents a financial burden. Greater flexibility in allowing overlap of essential HCBS pre-transition services while the client is still in the nursing home or other type of institution would make it easier to comply with the Olmstead mandate.
- Colorado was not eligible for the Balancing Incentives Payment Program (BIP) because the state's investments in HCBS exceeded the eligibility threshold for the program. BIP is a great opportunity that encourages states to create a more customer friendly entry point system for

LTSS, establish a conflict-free case management system and develop a universal assessment for LTSS eligibility and service planning. Many states need to do this fundamental work, including Colorado, to create more responsive, person-centered LTSS systems that provide services in the most appropriate settings based on the clients' choices and needs. Because changing these entrenched systems will be a political, lengthy process at the state level, the Federal government might consider creating more opportunities to encourage more states to change their systems as required in the BIP.

- The transition process requires careful planning and coordination by the client, family, Medicaid case managers, housing authorities, service providers and other community agencies that provide non-Medicaid supports. The Federal and state rules, regulations and funding streams create obstacles in the transition process or fragment the process. For example, HIPPA and privacy laws/regulations concerning mental health data may create real and perceived barriers to coordinating or arranging community resources. Other areas that create obstacles include multiple application processes, eligibility restrictions and documentation requirements when many clients in institutional placement do not have documentation. A Federal inter-agency regulatory review to identify and eliminate barriers or regulatory conflicts that create unnecessary barriers for clients who wish to transition may assist states in supporting transitions from institutional placement.



**(6) Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.**

**Public Awareness/Education.** HCPF staff for CCT, Colorado's Money Follows the Person Program, developed a comprehensive outreach plan to increase awareness of the CCT program and to inform residents in long-term care facilities of their options for community-based services and supports.

**Housing.** CCT staff is meeting with DOH, HUD and other federal agencies and a few Colorado housing authorities to expand housing options for people who wish to transition from institutional placement. The goal is to work with housing authorities to prioritize those individuals transitioning from institutional placement and enrolling in CCT and identifying and problem-solving barriers to coordinating services and housing.

DOH partners with over 50 community-based service providers and public housing authorities across the State of Colorado, and thousands of private landlords to combine housing assistance with supportive services. These providers include: mental health centers, centers for independent living, community center boards, and homeless service providers. The four-way partnership between DOH, the service agency, the property owner and the participant provides an effective and efficient approach to providing housing and supportive services to over 5,000 of Colorado's most vulnerable citizens. Housing assistance is administered as a part of the federally funded Housing Choice Voucher and Shelter Plus Care programs. DOH has jurisdiction to serve all 64 counties in the state.

**Behavioral Health.** The Colorado Mental Health Institutes (at Fort Logan and at Pueblo) along with the community mental health programs are major components of the state's public behavioral health delivery system. Gradually, the roles of both the institutes and the community behavioral health programs have evolved, and this is expected to continue due to the identified need for increased community-based services as the State develops and implements strategies that will result in consumers' receiving treatment in the most appropriate, least restrictive settings. This will be particularly important in rural and frontier regions, such as southwest Colorado. In this region the only community mental health center in the state with more than a two hour ground transport (averaging more than seven hours) to a psychiatric hospital bed. This issue is somewhat alleviated by the launch of the Crossroads Acute Treatment unit in that only the most acutely ill persons are transferred to the psychiatric hospital in Pueblo.

Additionally, Colorado continues to pursue the following objectives despite the loss of over 30 inpatient psychiatric beds in the last three years:

- Increase Community capacity to serve adults and adolescents with serious behavioral health issues through collaborative efforts;
- Promote the ability of communities, including various mental health and other human service agencies, to address the strengths and challenges of adults and adolescents with serious behavioral health illnesses through necessary services and supports; and
- Extend services and supports to culturally diverse consumers in a manner that increases accessibility of services and supports.



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RODERICK L. BREMBY  
Commissioner

February 1, 2013

The Honorable Tom Harkin  
Chairman  
United States Senate Committee on Health, Education, Labor and Pensions  
731 Hart Senate Office Building  
Washington, DC 20510-6300

Dear Senator Harkin:

Please accept the information below in response to correspondence of June 22, 2012, in which you posed questions concerning state Olmstead activities. Thank you for your interest in this critical effort. We would be happy to provide any additional detail necessary to help further your inquiry.

- 1) For each year from FY2008 to the present: the number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long-term care units of psychiatric hospitals, and board and care homes (often called adult care homes or residential health care facilities), to living in their own homes, including through a supportive housing program.

**MFP TRANSITIONS**  
(Does not include Non-MFP Nursing Facility Transitions)

<i>ABI</i>	2008	ACT 2009	ACT 2010	ACT 2011	ACT 2012	EST 2013	EST 2014	EST 2015	Total
<i>CY Total</i>	-	10	21	23	29	54	55	27	219
<i>SFY Total</i>	-	1	18	22	23	45	55	55	219
<i>FFY Total</i>	-	3	23	22	22	53	55	41	219

<i>MI</i>	2008	2009	2010	2011	2012	2013	2014	2015	Total
<i>CY Total</i>	-	20	37	23	29	93	92	46	340
<i>SFY Total</i>	-	4	32	29	33	57	92	92	340
<i>FFY Total</i>	-	10	41	22	31	75	92	69	340

<i>DDS</i>	2008	2009	2010	2011	2012	2013	2014	2015	Total
<i>CY Total</i>	-	2	5	13	16	31	31	14	112
<i>SFY Total</i>	-	1	3	7	17	24	30	30	112
<i>FFY Total</i>	-	2	5	10	12	29	29	25	112

<i>PCA</i>	2008	2009	2010	2011	2012	2013	2014	2015	Total
<i>CY Total</i>	-	35	74	96	79	181	187	94	746

SFY Total	-	10	64	77	91	129	187	187	746
FFY Total	-	20	69	99	70	160	187	140	746

Elderly	2008	2009	2010	2011	2012	2013	2014	2015	Total
CY Total	-	51	87	169	230	440	450	225	1,652
SFY Total	-	15	75	106	208	348	450	450	1,652
FFY Total	-	31	84	141	207	402	450	337	1,652

Non-Waiver	2008	2009	2010	2011	2012	2013	2014	2015	Total
CY Total	-	6	51	52	64	147	148	74	542
SFY Total	-	-	20	66	49	111	148	148	542
FFY Total	-	2	34	64	49	134	148	111	542

Katie Beckett	2008	2009	2010	2011	2012	2013	2014	2015	Total
CY Total	-	-	1	1	3	1	2	-	8
SFY Total	-	-	1	-	3	2	1	1	8
FFY Total	-	-	1	1	3	1	1	1	8

Note: Year 2015 only represents half year figures

- 2) The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.

SFY 2012 EXPENDITURES FOR BLIND AND DISABLED IN VARIOUS SETTINGS

PROVIDER CATEGORY	AID TO BLIND	AID TO DISABLED	MED. ONLY BLIND	MED. ONLY DISABLED	Medical Employed Disabled	TOTAL BLIND AND DISABLED EXPENDITURES
	AB	AD	NB	ND	ND	
Home Health Services	75,519	34,310,507	382,786	97,057,954	7,649,101	139,475,868
MH Waiver	0	66,759	0	1,439,516	0	1,506,275
CHC Admin. Services	0	1,127	0	6,589	905	8,621
CHC Waiver Services	0	986	0	38,729	68,505	108,221
PCA Waiver Services	55,840	1,120,790	158,719	18,927,263	1,578,062	21,840,674
Model Waiver Services	0	37	0	560	0	597
ABI Waiver Services	0	4,425,482	107,468	28,593,183	4,717,594	37,843,727
<b>MED NON-LTC Sub - Total</b>	<b>131,359</b>	<b>39,925,689</b>	<b>648,973</b>	<b>146,063,794</b>	<b>14,014,168</b>	<b>200,783,983</b>
CCH Services	11,187	2,504,187	521,341	183,375,164	259,776	186,671,656
RHNS Services	2,432	24,126	39,844	2,544,887	0	2,611,289
ICF / MR	(11)	11,177	800,606	61,167,041	(198)	61,978,615
Hospice LTC Services	754	67,856	0	2,427,238	10,956	2,506,804
CDH Services	32	577,682	407,236	49,014,844	45,497	50,045,291
<b>LTC SUB-TOTAL</b>	<b>14,395</b>	<b>3,185,029</b>	<b>1,769,027</b>	<b>298,529,173</b>	<b>316,032</b>	<b>303,813,656</b>
State Mental Hospital	0	63,670	0	920,997	37,858	1,022,525

State Chronic Disease	0	0	0	3,799,895	0	3,799,895
State Nursing Home (ICF/MR)	0	31,711	982,448	157,690,104	193,039	158,897,302
State Waiver Mentally Retarded	0	118,249	0	(108,094)	(27,517)	(17,362)
DDS Waiver (IFS)	50,646	9,914,794	676,462	66,898,825	19,095,742	96,636,469
COMP DDS Waiver	6,919,778	326,145,767	1,548,494	141,946,347	52,197,379	528,757,764
Targeted Case Mgmt - MH	7,829	3,425,212	5,012	5,355,722	711,629	9,505,404
Targeted Case Mgmt - MR	36,391	2,729,958	29,172	4,450,395	1,600,259	8,846,175
DDS Employ Day Support	0	238,906	35,653	1,078,252	428,800	1,781,611
DDS Waiver Fiscal Intermediary Admin Costs		2,791,475				2,791,475
<b>TOTAL STATE SERVICES</b>	<b>7,014,643</b>	<b>345,459,743</b>	<b>3,277,241</b>	<b>382,032,442</b>	<b>74,237,189</b>	<b>812,021,258</b>
Boarding Homes	699,125	47,737,848				48,436,973
<b>TOTAL BLIND &amp; DISABLED EXPENDITURES</b>	<b>7,859,522</b>	<b>436,308,309</b>	<b>5,695,240</b>	<b>826,625,409</b>	<b>88,567,388</b>	<b>1,365,055,869</b>

Note all categories are Medicaid only except Boarding Homes which are not Medicaid. MFP Services are not included in the above table.

- 3) For each year from FY2008 to the present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.

**Total Calculated Increase in MFP Expenditures to Support Additional Capacity for Disability Transitions**

MFP Expenditure Type	SFY Expenditure Increase from Previous SFY			
	SFY 2008 to SFY 2009	SFY 2009 to SFY 2010	SFY 2010 to SFY 2011	SFY 2011 to SFY 2012
Staffing and Indirect Costs	224,156	652	44,970	407,643
Contractual	28,664	158,416	238,859	378,568
Housing Coordination and Security Deposits	96,681	(14,150)	147,017	(25,795)
Transitional Coordination	534,294	107,094	10,910	133,380
One-Time Transitional Services	1,207	53,089	(5,850)	93,185
Other	14,559	(10,932)	10,520	106,180
Program Services	29,885	1,562,645	3,547,565	2,611,854
<b>Grand Total</b>	<b>929,447</b>	<b>1,856,814</b>	<b>3,993,989</b>	<b>3,705,014</b>

**Footnotes:**

1. Connecticut uses gross funding through appropriation to pay for MFP expenditures. After claiming the expenditures, the federal share is deposited back into the General Fund.

2. Total increased expenditures above for disability related expansion are derived based upon an allocation of the total increase in expenditures. The allocation is based on MFP disability enrollment categories (excluding elderly) as a percentage of the total enrollment.



- 4) The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.

**Contents:**

*The State of Connecticut (State) has memorialized its commitments to increasing community integration in both a Long-Term Care Plan and a Strategic Rebalancing Plan. Connecticut is committed to creating a more efficient and effective long-term services and supports (LTSS) system aligned with the principles of choice, autonomy and dignity. The envisioned system will allow Medicaid recipients who need LTSS to choose whether they want to receive these services in a nursing facility (NF) or in a community setting.*

*Long-Term Care Plan. The Long-Term Care Plan sets as a goal increasing the incidence of individuals receiving community-based LTSS in Connecticut by 2025 to 75%. Further, the Plan makes the following recommendations:*

- 1. Create greater integration of State level long-term care administration and functions serving both older adults and people with disabilities and their families.*
- 2. Simplify Connecticut's Medicaid structure.*
- 3. Address access and reimbursement for key Medicaid services.*
- 4. Further reform and coordinate the nursing facility/ institutional admission prescreening process.*
- 5. Provide true individual choice and self-direction to all users of long-term care.*
- 6. Address education and information needs of the Connecticut public.*
- 7. Develop and implement a statewide system of Aging and Disability Resource Centers for providing information, referral, assistance and long-term care support options.*
- 8. Address the long-term care workforce shortage.*
- 9. Provide support to informal caregivers.*
- 10. Promote efforts to enhance quality of life in various settings.*
- 11. Address the scope and quality of institutional care.*
- 12. Provide a broader range of community-based choices for long-term care supports, foster flexibility in home care delivery, and promote independence, aging in place and other community solutions.*
- 13. Increase availability of readily accessible, affordable, and inclusive transportation.*

14. *Preserve and expand affordable and accessible housing for older adults and individuals with disabilities.*
15. *Support programs that divert or transition individuals from nursing facilities or other institutions.*
16. *Expand and improve employment opportunities and vocational rehabilitation for persons with disabilities and older adults.*

*Strategic Rebalancing Plan.* *The Strategic Rebalancing Plan incorporates goals, strategies and metrics related to the following areas:*

- *connecting people to LTSS information and services*
- *creating parity across age and disability resources based on functional support needs rather than diagnosis*
- *closing service gaps and improve existing services or identify new services to better serve the needs of all populations*
- *creating mechanisms to ensure quality in the care provided through HCBS*
- *building and improving quality provider networks aligned with the principles of person centered planning*
- *building capacity in the community workforce sufficient to sustain rebalancing goals*
- *continuously promoting workforce initiatives that are proven to support consumer choice, self-direction and quality while enhancing recruitment, retention, productivity and training of the paid and unpaid direct care workforce*
- *increasing synergy with Connecticut's workforce system and supporting their efforts to create a pipeline of direct care workers with opportunities for career ladders to health and human/social services professions*
- *creating equity across state systems*
- *raising awareness of the importance and value of the direct care worker and unpaid caregiver*
- *increasing the availability of accessible housing and transportation*
- *fostering partnership and cross-agency collaboration between agencies focused on housing and transportation*
- *providing natural supports and caregivers with transportation and housing assistance*
- *improving financing dollars for housing*
- *decreasing hospital discharges to nursing facilities among those requiring care after discharge*
- *transitioning 5,200 people from nursing homes to the community by 2016*
- *convening a statewide Person-Centered Community Care Collaborative, focused on the development and dissemination of educational tools and materials and promotion of the State's right-sizing strategy through support of the cultural change*

*necessary with the State's health care professional community, with a special emphasis on the integration of services and supports for both physical health and behavioral health issues*

- *developing and implementing standards in Transition of Care in coordination with other health care initiatives*
- *improving process for LTSS eligibility*
- *providing MFP transitional and community services and supports to qualified persons who are institutionalized*
- *adjusting the supply of institutional beds and community services and supports based on demand projections*
- *developing nursing facility (NF) services to include transitional programs that support the movement of individuals from a variety of care settings back into the community*
- *transforming NFs into continuing care providers that allow individuals to receive a continuum of services from the same entity*

#### **Description of Strategic Planning Process**

Long-Term Care Plan. *The Long-Term Care Planning Committee, created under Public Act 98-239, is charged with developing a long-term care plan for Connecticut every three years for the General Assembly. Committee membership is comprised of representatives of nine State agencies and the Chairs and Ranking Members of the General Assembly's Human Services, Public Health and Aging Committees. The Long-Term Care Advisory Council, created under Public Act 98-239, composed of providers, consumers and advocates, provides advice and recommendations to the Planning Committee. The Advisory Council has worked with the Planning Committee in four essential areas: providing data, identifying areas of need, developing recommendations, and obtaining public input from diverse organizations and individuals throughout Connecticut with an interest in long-term care.*

Strategic Rebalancing Plan. *Through a multi-month process of deliberate stakeholder briefing, engagement, data and system analysis, culminating in the November 2011 Long-Term Care Right-Sizing Strategic Planning Retreat, the State Department of Social Services has sought the input and expertise of those interested in building a sustainable LTSS system within the state. Stakeholders participating in the strategic planning process included individuals with LTSS needs, family members, advocates, ombudsmen, State staff, providers (community and institutional), Money Follows the Person Steering Committee members, academics and others. Recommendations from the right-sizing retreat provided a foundation on which this plan was developed. With an unprecedented level of partnership and collective work toward common goals, stakeholders will continue to play a key role in the implementation and evaluation of LTSS strategic initiatives.*

### ***Incorporation of New Tools***

*Connecticut has already availed itself of many of the tools that are referenced in the inquiry, and is considering others. Specifically:*

- *the Strategic Rebalancing Plan calls for conducting an impact analysis of the Community First Choice option;*
- *in 2012, Connecticut sought and was approved for a 1915(i) state plan amendment that now permits Connecticut to cover individuals served by the state-funded component of the Connecticut Home Care Program for Elders, who were financially but not functionally eligible for the Connecticut Medicaid elder waiver;*
- *Connecticut's Money Follows the Person initiative has to date transitioned over 1,400 individuals from institutional settings to the community and also stewarded associated projects relating to nursing home diversification and workforce;*
- *Connecticut was in late 2012 approved for a total of \$72.8 m. in funding through the State Balancing Incentive Payments Program; and*
- *Connecticut operates nine 1915(c) waivers serving elders, individuals with physical disabilities, individuals with intellectual/developmental disabilities, medically fragile/technology dependent children, and individuals with TBI/SCI.*

### ***Success in Meeting Goals***

*Evidence of success in meeting goals related to Olmstead can be illustrated by many facets, but notably shifting of LTSS resources and transitions of individuals by Money Follows the Person.*

*The proportion of Medicaid LTSS clients receiving services in the community has increased from 46 percent in SFY 2003 to 56 percent in SFY 2012. With regard to public spending on LTSS, between SFY 2003 and SFY 2012 the proportion of Medicaid LTSS expenditures received in the community increased by 10 percent, rising from 31 percent to 41 percent of all Medicaid LTSS expenditures – an average increase of one percent per year. Likewise, there was a 10 percent decrease in the proportion of expenditures for LTSS provided in institutional settings. Overall, total Medicaid LTSS expenditures increased by approximately 45 percent between SFY 2003 and SFY 2012 (\$1.914 billion to \$2.770 billion).*

*As noted above, the Connecticut MFP program has to date transitioned over 1,400 individuals from institutional settings to the community, with a very low recidivism rate.*

- 5) Any policy recommendations that you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of the new federally available assistance.

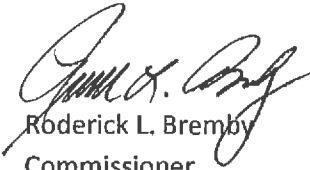


- a) *Additional flexibility with HUD institutional underwriting would be helpful. HUD should explore moving the nursing home asset from the institutional portfolio to the housing portfolio so that nursing home space could be converted to housing.*
  - b) *Expansion of the HUD Section 8 program for the purpose of supporting Olmstead.*
  - c) *Liberalization of the 180-day limit on transitional case management.*
  - d) *Expansion of the definition of case management to include assistance with housing or incorporation of this service within the 1915(c) or 1915(i) menus.*
  - e) *Improved federal coordination among various Departments so that documents can be shared rather than produced multiple times. For example, income verification is completed by the Social Security Administration, CMS for Medicaid and HUD for housing. This represents unnecessary duplication and is also frustrating for consumers.*
- 6) Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.

*The housing plus supports model created under the Connecticut Money Follows the Person (MFP) has been identified as a national model.*

Again, thank you for the opportunity to provide the requested information. Please do not hesitate to contact me with any additional questions you may have.

Sincerely,

  
Roderick L. Bremby  
Commissioner

RLB

cc: Dannel P. Malloy, Governor  
Michael B. Enzi, Ranking Member, Senate Committee on Health, Education, Labor and Pensions  
Chairman Max Baucus, Senate Finance Committee  
Ranking Member Orrin G. Hatch, Senate Finance Committee  
Senator Richard Blumenthal  
Senator Chris Murphy  
Andrew Imparato, Senate Committee on Health, Education, Labor and Pensions



**Delaware Health  
and Social Services**

**Office of the Secretary**

1901 N. DUPONT HIGHWAY, NEW CASTLE, DE 19720 \* TELEPHONE: 302-255-9040 FAX: 302-255-4429

September 14, 2012

The Honorable Senator Tom Harkin  
Chair  
Committee on Health, Education, Labor and Pensions  
United States Senate  
Washington, DC 20510-6300

Dear Senator Harkin:

On behalf of Governor Jack Markell, and as a follow up to my testimony before the HELP Committee on June 21, 2012, I am responding to your request for information relative to Delaware's continued efforts in meeting the obligations set forth by the ADA and *Olmstead*. We know that States, CMS, and disability advocates are beginning to evolve to a new understanding of the "*Olmstead* Community Integration Mandate". The fundamental question is about "how government resources can support a quality of life for people with significant disabilities that enhances full community participation, independent living and economic self-sufficiency?"

Today, in Delaware, full community participation is a value that we are committed to extending across the state through meaningful systemic reform that promotes integration of individuals with disabilities in our society. Our Governor, Gov. Jack Markell, is committed to this priority, bringing the full weight of his office and the political will to accomplish this restructuring. Since 2009, under the Markell administration, we have focused on shifting our resources and our delivery strategy to a community first focus. Individuals with disabilities should not have to prove that they are worthy of community. We ask that of no other population co-hort and community should be the norm not the exception. The level of reform, Delaware is addressing for individuals with serious persistent mental illness is seen, by us, as the proto-type for all with disabilities and the aging population in need of supports. It begins with a simple, but powerful expectation: Individuals with disabilities can live in their own home, have meaningful employment and be ordinary Delawareans. They may require some level of support, but those supports need to be provided that effectively foster independence and fully engage participation in society. This is the norm for individuals without disabilities.

As indicated in the Court Monitor's Year Report –"The State has responded to the requirements of the United States Department of Justice Settlement Agreement not only with the intent of meeting the numeric targets, but also with the goal of restructuring systems so that the its public programs produce outcomes that are consistent with the Americans with Disabilities Act ("ADA") and the U.S. Supreme Court's *Olmstead* decision.

Furthermore, leadership within the State has an understanding that the opportunities and the lessons of reform efforts pursuant to the Settlement Agreement have critical meaning for people with Serious Persistent Mental Illness, and for other populations with disabilities, as well. For this reason, in its implementation efforts Delaware's Department of Health and Social Services is increasingly including representatives of programs working on behalf of individuals with physical or intellectual/developmental disabilities. Such efforts are not at all superfluous to the Settlement Agreement, they clearly support the State in meeting its broader obligations under the ADA, and to the extent that the changes in culture and practice brought about through the Settlement Agreement are infused in public programs statewide for all individuals with disabilities, the sustainability of the reforms that are discussed in this report is heightened. As is indicated in the Monitor's Report, the State is largely meeting its benchmarks and it is making significant, sometimes ground-breaking, progress in retooling its systems in fulfillment of the ADA."

As per your request, the following information is representative of the numerical benchmarks gained since FY 2008.

(1) Request – The number of individuals who moved from facility based care to community based housing and supports, along with the number of individuals who were diverted from facility based care into community based care.

- In conjunction with the Money Follows the Person initiative 94 individuals have moved out of long term care facilities and into their own homes.
- 181 individuals with developmental disabilities have been diverted from facility based care and are living into community neighborhood homes (Typical home is 4 individuals with developmental disabilities with rotating staffing). 61 individuals with developmental disabilities are in a shared living arrangement and 13 individuals are in supported housing
- Within the discharges from DPC from January 2008 through June 2012, we have focused on those individuals with serious and persistent mental illness (SPMI) who have had a length of stay in excess of 180 days for at least one stay, recognizing that many of the DPC clients with SPMI have had multiple stays over the course of the 4.5 years. These numbers represent an unduplicated count of 306 individuals residing in the community. Out of the 306 individuals, 91 of which are in integrated housing. (This is largely due to development of housing vouchers, subsidies and bridge funding that was created in July 2011 and enabled the state to fund 151 vouchers for individuals with serious and persistent mental illness. The voucher program has been made accessible to all with disabilities as a core value of the state to reform from a state with a high reliance on facility based care to a state committed to a community based support delivery system that incorporates partners from across the Cabinet, local governments and community based who have expertise in the areas of housing, transportation and employment.)
- Since February of 2011, we developed a Care Transitions Team that is assigned to work with hospitals to assist in discharge planning to focus on creating services that will enable individuals to remain in their homes. Since that time 300 individuals have been referred and 260 of the 300 have been supported to return to their homes with supports and modifications or we have supported them in a home better equipped to meet their needs.

Prior to this team's involvement the individuals would have been placed into a nursing home or more restricted environment.

(2) The amount of state dollars that will be spent in this current state fiscal year serving individuals with disabilities by settings

State Administered LTC Facilities Medicaid	(3)	\$11,355,600
State Administered Uncompensated Care Beds	(3)	\$18,926,700
Medicaid Private LTC Beds		\$77,337,300*
ICF – Private Medicaid Beds		\$ 3,952,000
ICF – State Facility		\$10,600,700
Psychiatric Hospital		\$36,300.600
Shared Living		\$ 1,365,000
Group Homes (average size 4 individuals)		\$46,830,900
Supportive Housing (State Rental Assistance Program)		\$ 2,304,000

\*\$14.5 million of the \$77.3 million in the NH private homes is being provided beginning in FY13 and is funding that is committed to a Quality Improvement Fund which has been levied as a tax.

(3) The extent to which the state has expanded the capacity to serve individuals with disabilities in their own homes, included through a supportive housing program – including the amount of state dollars spent on the expansion:

- The state worked closely with CMS and Mercer to convert the multitude of waivers and LTC Fee for Service individuals into our Managed Care Organization contract. We found that the waivers were too restrictive from a menu of service perspective and shifting the population (exclusive of the DD population, which continues to receive services via the Home and Community Based Waiver) to MCO's enabled us to provide enhanced services geared towards the individual and is no longer directed by a disability category. We implemented the conversion to a Managed Long Term Care program, called Diamond State Health Plan Plus, on April 1, 2012, as we have been concerned for some time about our long term care service delivery system, which has historically been heavily weighted toward institutional care. Before we implemented Diamond State Health Plan Plus,
- 62% of our long term care population resided in nursing homes; and
- 87-90% of our long term care expenditures were for nursing home care.

All of our Long Term Care programs were under a "fee-for-service" arrangement, in which providers billed the Medicaid Division and we paid them directly.

Our goals in moving our long term care populations from a fee-for-service arrangement to a managed care delivery system include:

- Rebalance LTC System in Favor of HCBS
- Expand Consumer Choices
- Increase Coordination of Care and Supports
  - Avoid/Divert Need for Costly NF Services
  - Serve Consumers in Cost-Effective Settings that Meet their Needs
  - Improve Care Coordination for Dual Eligibles
- Create Budget Structure to Shift Resources from Institutions to HCBS

We used the opportunity to expand our offering of home & community based services and to tighten our medical eligibility criteria for nursing home placement - not to restrict eligibility for Medicaid, but rather to serve individuals in the least restrictive setting.

We understand that our investment in community based supports will not result in huge savings immediately, but will bend the cost curve over time while improving consumer satisfaction, quality of life and in meeting the spirit of the ADA Integration Mandate. We do project modest savings of \$2 million by the end of the program's first year, FY '13 and we converted \$175 million from the Fee for Service line into the Diamond State Health Plan Plus.

- As noted above, for decades, the state has had an over reliance on facility based care and options within community have been limited to mid to small group living homes. Far too many individuals were placed in institutions and remained there for extended periods. Delaware's institutional bias has been significant. For our state, an AARP survey found that 87 percent of the State's long-term care funds for aging and physical disability services are spent on care at facilities, compared to the national rate of 66 percent. To facilitate access to community based services we reviewed the organizational structure of the state run LTC facilities and transferred the operations from the Division of Public Health over to the Division of Services to Aging and Adults with Disabilities. This structural shift, which required approval of the legislative branch, occurred 18 months ago. The purpose of this transfer is to improve greater access to community based supports. Through this transfer we connected community staff with facility staff and provided in-depth education relative to benefits of community living, access to money management, Money Follows the Person, legal services, options counseling, home modifications, home delivered meals, etc. Independent assessments of each resident were completed which identified those interested in moving back to the community and outlined their support needs. Division staff, in conjunction with the MCO case managers are working as a team, inclusive of the individual to move them back to the community with the appropriate wrap around services and infrastructure. We also instituted a Census Reduction Plan and are in our second year of the plan.

Census Reduction of all 3 LTC Facilities

December 2010 Census – 381  
August 2012 Census – 314  
June 2012 Target - 289

As noted in #1 – The state has developed a Care Transitions Team that provides on-site support to hospitals relative to discharge planning and returning individuals back to their homes with supports. It is much more difficult to transition individuals back to community than it is to divert and support them in their community. This may not always be possible due to level of care, but we are finding that the majority of referrals are appropriate to remain with supports in the community. We also instituted a policy that all referrals to our state administered LTC facilities are routed through the Aging and Disability Resource Center and referred to the Care Transitions Team for assessment for community prior to referral to institutional care. This has lowered the admissions as noted below:

Admissions

Average per month 2010 - 8  
Average per month 2011 – 5  
Average per month 2012 - 3

To date in 2012, 24 individuals have been admitted into state facilities; two-thirds of which are crisis cases via Adult Protective Services. We are committed to developing alternative safe havens for those that need this level of care and support that is community based. We anticipate the cost would represent \$200,000

- The reference to one living in their own home may be defined in a variety of ways and may not be consistent in interpretation. The state of Delaware actively became engaged with a focus on community living for individuals with disabilities in the 1980's when ICF homes, along with neighborhood homes were established for those with developmental/intellectual disabilities. ICF's homes typically held capacity at 8 individuals with disabilities and neighborhood homes typical capacity was 4 individuals per home. In the 1990's all of the ICF homes were converted to neighborhood homes and individuals no longer had to share their bedrooms. The state partnered with two well established advocacy organizations – NAMI and The Arc – who actively solicited HUD 811 and 202 funding and these organizations became the primary real estate developers. To that end capacity was expanded that largely prevented institutionalization and enabled some to exit facility based care. Prior to FY 2012 the Division of Mental Health supported 19 – 24 hour group homes and 174 supported housing units. This was prior to the creation of the State Rental Assistance Program. The traditional housing services offered are not in compliance with the 20% and / or 2 person rule. The state is investing enhanced funding in the area of housing vouchers. Expected amount dedicated in the budget is \$1.8 million, at a minimum. As noted above, the state increased its capacity to serve individuals with developmental/intellectual disabilities in the community by an increase of 255 since FY 2008.

The state serves over 981 individuals with developmental disabilities in housing and the state budgets to support 75 additional individuals per year in need of housing supports. The Governor's budget allocates \$2.5 million for this purpose.

(4) The contents of the state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government and the extent to which the state has been successful in meeting any quantifiable goals identified within it.

- The following link will provide you with the background relative to the creation of the Governor's Commission on Community Based Alternatives for Persons with Disabilities and the strategic planning process and the past template utilized to prioritize the work. The Commission is inclusive of both private and public stakeholders.

[http://scpd.delaware.gov/pdf/2008/publications/commission\\_report.pdf](http://scpd.delaware.gov/pdf/2008/publications/commission_report.pdf)

[http://dhss.delaware.gov/dhss/admin/files/goals\\_timeline\\_complete.pdf](http://dhss.delaware.gov/dhss/admin/files/goals_timeline_complete.pdf)

We have changed the name to the Governor's Commission on Building Access to Community-Based Services. One of the current priorities of the Commission is to create a Speaker's Bureau that will educate the public on the ADA and *Olmstead* ruling, to integrate financial empowerment services within the delivery system and to address the need for stronger Data and Quality Assurance Measures that promote choice, evidence based practices and payment for performance.

- The following links to the Court Monitor Reports will provide you feedback relative to the efforts of the state to reform the mental health system and significant benchmarks within a 5 year timeframe. This work will also impact systemic reform that will impact all those with disabilities, especially in the area of housing and employment.

First 6 month Report

<http://dhss.delaware.gov/dhss/admin/files/firstreport.pdf>

First Year Report

[http://dhss.delaware.gov/dhss/admin/files/monitorreport\\_usvde.pdf](http://dhss.delaware.gov/dhss/admin/files/monitorreport_usvde.pdf)

(5) Any policy recommendations you have for measures that would make it easier for your state to effectively implement *Olmstead's* integration mandate and take advantage of new federally available assistance.

- Up until now, the focus of ADA/Olmstead has primarily been on expanding housing options (home, apartments, and independent living options with necessary supports).

However, underlying support for full community participation must be a focus on financial capability and advancing “economic self-sufficiency”. Without attacking the underlying issue of poverty, quality of life choices are diminished. We know poverty impacts adversely mental and physical health, limits community participation, and affects adversely self-concept and others’ perception of one’s status and value. The next generation of innovation has begun in Delaware and also is being initiated in cities such as San Francisco and New York City. It is the design and implementation of financial empowerment strategies embedded in social and human service delivery.

The *Olmstead* Community Integration Mandate compels us to attack poverty and financial instability through financial coaching as part of an individual’s Medicaid support plan. Providing financial education and counseling that explores new options for employment (income production), savings (income preservation), and safeguarding and building assets can give our most vulnerable citizens with disabilities hope and goals that will enhance “fuller community participation”.

There is no roadmap out of poverty. However, state Medicaid rebalancing of resources to meet *Olmstead* requirements can use a new lens to design individualized supports for working age adults with significant disabilities. CMS recognizes that community participation must include pathways to advance economic self-sufficiency. Financial coaching and financial empowerment can stabilize individuals and families and raise expectations and results about quality of life experience.

In Delaware, we will use our government infrastructure (Medicaid, Vocational Rehabilitation, Education, Social Services, and Labor) to reset the focus to change thinking and behavior about financial capability through an integrated system of supports that enhance financial empowerment skills and outcomes. We are calling this the \$tand By Me initiative: a partnership between state and the United Way of Delaware. The National Disability Institute is working on site in Delaware to integrate financial empowerment as part of our collective service delivery system.

What separates people with disabilities from the rest of the population is financial security. The majority of individuals with disabilities are of extremely low income which further disenfranchises and disempowers the population.

- Traditionally, state programs have provided support for basic needs and emergency services for low-income residents. In recent years, a shift in national perspective has moved leadership in major American cities and the federal government to pursue strategies which promote self-sufficiency. By providing low-income Delawareans with the tools and support they need to take charge of their financial lives, the cyclical dependence on benefits will be reduced, which will reduce investments for benefit programs for the state and the negative sense of self created by dependence for the individuals.



- Update HUD programs to direct more funding to support the population similar to the State Rental Assistance Program. Access to affordable housing remains a critical component of community integration and congregate living was created largely due to the fiscal reality and affordability issue.
- The state is working with HUD to address the transformation of the existing HUD housing in concert with the Settlement Agreement to support more integrative housing. The current housing portfolio via HUD cannot be altered without an extreme financial loss, which would result in a loss of housing capacity. If converting Section 811 projects from 3 or 4 bedrooms to two bedrooms there may be an issue of keeping HUD funds in state.
- Medicaid provides payment to LTC facilities for room and board, but does not support rental costs within a community based setting.
- Expansion of Medicaid Buy In program allowing those with disabilities to earn a higher salary than is currently allowable while paying a premium for Medicaid coverage that enables supports such as personal attendants.

(6) Any successful strategies that your state has employed to effectively implement *Olmstead*, particularly strategies that could be replicated by another state or a national level.

- The current focus and strategies are within this document and within the linked reports. I believe the most vital strategy is to ensure policies and practices continue to evolve and are based on the individual's informed choice. I believe that the ADA and *Olmstead* is about the civil rights of a class and requires a commitment from states to embrace the core value of one's rights. In closing I would like to re-affirm the Court Monitor, Robert Bernstein's summary of the state's progress thus far: "The State of Delaware has made impressive gains over the past year, not only in achieving the specific intermediate targets required by the Settlement Agreement, but also in taking steps to establish enduring ADA-oriented practices in its service systems. Although this Settlement Agreement focuses specifically on individuals who have serious mental illnesses, the State's increasing actions to engage in implementation efforts other populations covered by the ADA (e.g., individuals with physical, developmental or intellectual disabilities) and relevant divisions of state government beyond the Department of Health and Social Services and the Division of Substance Abuse and Mental Health demonstrates an appreciation of the importance of the ADA among Delaware's leadership."
- Governor Markell as Chairman of the National Governor's Association has an initiative which focuses on employment of persons with disabilities. Below you will find a Governor authored description of his initiative known as A Better Bottom Line.

**"A Better Bottom Line: Employing People with Disabilities** aims to increase employment among individuals with disabilities. Specifically, my initiative will focus on the employment challenges that affect individuals with intellectual and other significant disabilities and the role both state government and business can play in facilitating and advancing opportunities for these individuals to be gainfully employed in the competitive labor market.

Memo to Senator Harkin  
September 14, 2012  
Page # 9

The statistics are sobering. Iowa's senior Senator Tom Harkin recently **released a report** that said: employment outcomes for persons with disabilities have not improved since 1990; that between 2008 and 2010, workers with disabilities left the workforce at five times the average rate; that the median income for these workers is less than 2/3 the median wages for other workers. Making a difference in these numbers will not be easy, but the work is important. By this time next year, we will have created a blueprint for businesses and states that identifies best practices and outlines steps that can be put in place to increase economic opportunity and heighten awareness. It will provide governors and state policymakers with more policy options to assess the environment in their state and specific strategies designed to support this population. It doesn't matter whether someone was born with additional challenges to face or -- in the case of our wounded veterans, for example -- acquired them later in life. There are so many people with disabilities who have the time, talent and desire to make meaningful contributions to interested employers. What matters is what they have to offer and the tremendous impact this will have on their overall well-being and on the bottom line of the businesses that employ them."

<http://www.nga.org/files/live/sites/NGA/files/pdf/CI1213BETTERBOTTOMLINE.PDF>

Sincerely,



Rita M. Landgraf  
DHSS Cabinet Secretary

cc: Michael B. Enzi, Ranking Member, Senate Committee on Health, Education, Labor and Pensions  
cc: Chairman Max Baucus, Senate Finance Committee  
cc: Ranking Member Orrin G. Hatch, Senate Finance Committee  
cc: Senator Thomas Carper  
cc: Senator Christopher Coons  
cc: Governor Jack A. Markell



EXECUTIVE CHAMBERS  
HONOLULU

NEIL ABERCROMBIE  
GOVERNOR

12:062554/G106

September 19, 2012

The Honorable Senator Tom Harkin  
Chairman  
United States Senate  
Committee on Health, Education, Labor, and Pensions  
731 Hart Senate Office Building  
Washington, DC 20510-6300

Dear Senator Harkin:

The State of Hawaii is responding to your letter dated June 22, 2012 requesting information about Hawaii's efforts to meet our obligations under the Americans with Disabilities Act (ADA) and Olmstead. Our State is committed to offering a choice to live independently for the citizens of Hawaii with disabilities.

In 2008, the Department of Human Services (DHS), Med-QUEST Division (MQD) collaborated with the Centers for Medicare & Medicaid Services (CMS) to develop a program to expand home and community-based services (HCBS) in Hawaii's Medicaid program. This program, called QUEST Expanded Access (QExA), was developed under an 1115(a) demonstration waiver. The demonstration waiver is called QUEST Expanded (QEx). Two of the primary goals of the QExA program are to:

- Expand and strengthen a sense of member responsibility and promote independence and choice among members; and
- Assure access to high quality, cost-effective care that is provided, whenever possible, in a member's home and/or community.

Through the QUEST Expanded (QEx) 1115(a) demonstration waiver, HCBS are offered by managed care health plans to all QExA members, without a waitlist, who meet nursing facility level of care. Through the capitation rate structure, health plans are incentivized to care for members who require long term support and services (LTSS) in the most cost-effective manner. This aligns with supporting members to reside in their own home or in the community when clinically appropriate, settings which members typically prefer compared to institutionalization. This model has been successful in reducing institutionalization and is consistent with the requirements of both the ADA and Olmstead. Implementing QExA has been a key approach for Hawaii to support the ADA, Olmstead, and support independence of Hawaii citizens with disabilities.

Below are responses to the questions posed in your June 22, 2012 letter.

**QUESTION #1: For each year from FY 2008 to the present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long term care units of psychiatric hospitals, and board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program.**

**HAWAII RESPONSE:**

- The definition of "Home" in Hawaii's HCBS system includes a house, apartment, condominium, assisted living facility, foster home, care home or DD domiciliary home.
- Prior to implementation of Hawaii's Money Follows the Person (MFP) grant in FFY2009, Hawaii did not collect data on any post institutionalization living arrangements. Presently, Hawaii only collects this data on individuals who have lived in an institutional setting for 90 days or longer.
- The data provided in Table 1 may not include individuals residing in an institution, including a hospital, for less than 90 days who were transitioned to reside in their home or community setting.
- The number of individuals in the MFP program is 178 since FFY2009. This only reflects a percentage of the individuals that have moved from an institutional setting.
- In addition, Hawaii does not track individuals who later move from a care home, foster-home or DD domiciliary to an independent living arrangement (i.e., house, apartment, or condominium).
- Hawaii no longer has a large State or private institution for individuals with a developmental or intellectual disability (DD/ID) since 1998. In 1995, the Hawaii State legislature approved Act 189/1995 which required the State to close Waimano Training School and Hospital (WTSH), no later than June 30, 1998.
- Presently, only 80-90 institutionalized individuals with DD/ID are living in small five-bed intermediate care facilities for individuals with intellectual or developmental disabilities (ICF-MR) in the community.
- Hawaii does not have long term care units or psychiatric hospitals. In addition, Hawaii does not collect data on the number of individuals who need LTSS in the four hospitals with psychiatric units in Hawaii.

- In Hawaii, the title “board and care homes” is not used. However, community based non-institutional housing includes: adult foster homes, care homes, expanded care homes for individuals meeting nursing facility level of care, and assisted living facilities.

**Table 1. Number of Medicaid Beneficiaries Residing in Long Term Care (LTC) Institutions for >90 Days Transitioned into a Home and Community Setting**

	2008	2009	2010	2011	As of 8/31/12
Nursing Home	N/A	33	58	49	55
ICF-MR	N/A	0	0	2	2
LTC units of Psychiatric Hospitals	N/A	N/A	N/A	N/A	N/A
Money Follows the Person Grant	N/A	16	38	63	61
<b>Total</b>	<b>N/A</b>	<b>49</b>	<b>86</b>	<b>114</b>	<b>118</b>

Note: This table only includes a portion of individuals transitioning from institutional to HCBS settings due to limited data collection.

**QUESTION #2: The amount of State dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.**

**HAWAII RESPONSE:**

Hawaii’s State share of Medicaid expenditures for the federal fiscal year (FFY) 2012 is 49.52%. The table below represents actual State Medicaid expenditures for approximately 10 months of FFY2012 and a State Medicaid expenditures projection for the 12 months of FFY2012.

**Table 2. FFY 2012 State Medicaid Expenditures for Individuals in LTC Settings**

LTC Setting	Actual 10-Month State Expenditures (10/01/11-07/31/12)	Projected 12-Month State Expenditures (10/01/11-09/30/12)	
<i>Institution</i>			
Nursing Homes	\$53,014,465	\$63,617,358	
ICF-MRs*	\$3,698,679	\$4,438,415	
Psychiatric Hospitals	N/A	N/A	
<b>Institution Subtotal</b>	<b>\$56,713,144</b>	<b>\$68,055,773</b>	<b>43.2%</b>
<i>Home and Community</i>			
1115(a) Foster Homes	\$12,543,810	\$15,052,572	
1115(a) Home	\$20,338,092	\$24,405,710	
1915(c) DD/ID Waiver*	\$41,585,505	\$49,902,606	
<b>HCBS Subtotal</b>	<b>\$74,467,407</b>	<b>\$89,360,888</b>	<b>56.8%</b>
<b>Total</b>	<b>\$131,180,551</b>	<b>\$157,416,661</b>	<b>100.0%</b>

\* ICF-MR and 1915(c) DD/ID Waiver expenditures are actual for the 12-month period of Waiver Year (WY) 2011 and pro-rated for the 10-month period. Expenditure reports for WY2012 will be available in November 2012.

**QUESTION #3: For each year from FY 2008 to the present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.**

**HAWAII RESPONSE:**

- Hawaii's HCBS capacity expansion started in February 2009 when the Medicaid fee for service (FFS) program for the Aged Blind and Disabled (ABD) transitioned to a capitated managed care program QEx 1115(a) demonstration waiver that included both institutional and HCBS for provision of LTSS.
- With implementation of the QEx, four of Hawaii's five 1915(c) Medicaid Waiver Programs were combined under one HCBS program called QExA.

- In addition, under the QEx 1115(a) demonstration waiver, Hawaii was able to offer personal assistance services to individuals who did not meet nursing facility level of care. These individuals receive services that support Instrumental Activities of Daily Living (IADL) such as housekeeping, laundry, and grocery shopping (called "Chore").
- Hawaii kept one 1915(c) waiver for its DD/ID beneficiaries as well as the ICF-MR facilities outside of its QExA program. (These programs exist under Hawaii's FFS Medicaid program.)
- In 2009 under ARRA, the federal medical assistance percentage increased to 66.74% for Hawaii. Although the State share appears to decrease, the total expenditure (State and Federal combined) increased by 7% compared to 2008.

**Table 3. State Share of HCBS Expenditures for FFY 2008-2012**

	2008	2009	2010	2011	2012
1115(a) Foster Home	N/A	\$4,502,157	\$8,650,317	\$10,343,022	\$15,052,572
1115(a) Home	N/A	\$8,637,267	\$16,300,265	\$18,662,584	\$24,405,710
1915(c) DD/ID Waiver	\$46,601,835	\$35,761,041	\$32,847,729	\$38,726,921	\$49,902,606
1915(c) Other Waivers	\$21,700,513	\$7,003,059	\$280,180	N/A	N/A
Total	\$68,302,348	\$55,903,524	\$58,078,491	\$67,732,527	\$89,360,888

**Table 4. Increased Receipt of HCBS Through the QExA Program**

	1/31/09	CY2009	CY2010	CY2011	6/30/12
Institutional Beneficiaries	2,840	2,753	2,527	2,423	2,476
HCB Beneficiaries	2,110	3,807	3,963	4,413	4,572
Distribution of LTC Beneficiaries in HCB Settings	42.6%	58.0%	61.1%	64.6%	64.9%
% Increase in Beneficiaries in HCB Settings	N/A	80.4%	4.1%	11.4%	3.6%

**QUESTION #4:** The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning processing used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.

HAWAII RESPONSE:

Hawaii's Olmstead Plan, entitled *Recommended Olmstead Implementation Plan*, was adopted by the Governor in December 2005 and assigned to the DHS as the lead. The overview document is enclosed. I am happy to provide the 79-page plan electronically if desired.

The contents of Hawaii's Olmstead Plan for increasing community integration are most clearly identified under Goal 4 of the Plan: Each individual will be able to locate housing, acquire personal support personnel, use transportation, and engage in employment to sustain community-based living.

- Objective 4a: Ensure the availability of suitable housing and enable people with disabilities to acquire the homes of their choice.
- Objective 4b: Develop and maintain a suitable workforce for community-based living support personnel.
- Objective 4c: Enable people with disabilities to qualify for jobs and gain employment to help sustain their community-based living.
- Objective 4d: Optimize accessibility and mobility by developing and implementing long-range, systematic plans, to enable people with disabilities to move throughout their communities, using all means of travel.
- Objective 4e: Establish and maintain support service programs to assist people with disabilities to live in the homes of their choice.

The following summarizes the strategic planning process used to create Hawaii's Olmstead Plan. Hawaii's initial Olmstead Plan was developed in 2002. In January 2004, the Olmstead Task Force was reconvened by the Governor to identify specific actions, assignments and timelines to implement the Hawaii Olmstead Plan. Between January through December 2004, the task force of 70 individuals representing consumers, advocates, community agencies and State Department staffs met nearly every month and sometimes two times per month, to develop Hawaii's Olmstead Plan. Strategies were created for each of the objectives. For each individual strategy, the Plan identifies the specific recommended action item, the lead agency, other assisting agencies and organizations responsible for the action, and the timetable for completion.

The extent to which Hawaii's Olmstead Plan incorporates any of the new tools created by the federal government to support HCBS is not documented in the Hawaii Plan update. However, Hawaii can report that we have successfully implemented three of the six tools listed in your letter that Congress offered to the states to make it easier to provide home and community-based services.



These include:

1. Hawaii's Money Follows the Person (MFP) Program: The MFP has been serving the Elderly, Physically Disabled and DD/ID target populations since December 2008. Eligible individuals transition from nursing homes, hospitals and DD/ID Intermediate Care Facilities to community-based housing with appropriate Medicaid reimbursed HCBS. We have integrated our MFP program into our QExA program to offer a more patient-centric and seamless approach to accessing HCBS.
2. Section 1915(c) Medicaid Waiver Programs: Hawaii currently operates one (1) Section 1915(c) HCBS waiver program serving the DD/ID target population. In February 2009, when Hawaii's QExA program started, beneficiaries of four of Hawaii's five Medicaid 1915(c) Waiver Programs were consolidated as a unique HCBS benefit package through the QExA. The four Hawaii Medicaid waiver programs that transitioned to QExA were Nursing Home Without Walls, HIV Community Care Program, Residential Alternatives Care Program, and the Medically Fragile Community Care Program Children's Waiver. There are no plans to initiate any new 1915(c) waiver programs.
3. Medicaid's Rehabilitation Option (MRO) and Personal Care Options: Hawaii offers MRO Services, which include Intensive Community Based Case Management Services, Intensive Outpatient Hospital Services, Crisis Mobile Outreach, Crisis Support Management, Licensed Crisis Residential Services, and Specialized Residential Services Program. Personal Care Options is not provided through Hawaii's MRO.

Hawaii has not applied for the Community First Choice Section 1915(k) waiver, the Section 1915(i) waiver or the Balancing Incentives Payment (BIP) Program because we already provide comprehensive HCBS under our 1115(a) waiver. Individuals enrolled in Hawaii's QEx 1115(a) demonstration program requiring care services receive all their primary and acute services as well as institutional care and HCBS through a QExA health plan. The State's comprehensive HCBS benefit package provides a range of 13 different HCBS to eligible Medicaid beneficiaries and does not have a waitlist. The QEx 1115(a) demonstration waiver has been extremely successful in rebalancing long term care service delivery and expanding access to and receipt of HCBS.

**QUESTION #5: Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.**

**HAWAII RESPONSE:**

Hawaii is effectively implementing Olmstead's integration mandate. Because Hawaii was an innovator and leader in HCBS, Hawaii is relatively disadvantaged from the new federally available assistance. The new federal assistance appears to incentivize

states that do not have robust HCBS programs, and is not as beneficial to states like Hawaii that already have such programs. Increased federal funding is tied to HCBS offered through a State Plan, but Hawaii has authority and already covers the same services under its 1115(a) waiver.

**QUESTION #6: Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.**

**HAWAII RESPONSE:**

Hawaii's QExA Medicaid managed care program has effectively increased the number of Medicaid beneficiaries receiving long term care HCBS in lieu of institutional placement. Hawaii's QExA 1115(a) demonstration waiver is unique because:

- The participating QExA health plans are required to provide primary care, acute care, institutional care and HCBS services. (The only long term care service exceptions remaining in the FFS program are: the DD/ID 1915(c) Medicaid waiver Program, the DD/ID-ICF institutions, and the MRO services provided by the Department of Health Adult Mental Health Division.)
- Under QExA, every Medicaid ABD beneficiary is assigned a service coordinator or a contracted case manager to assist with coordination of needed Medicaid services. The QExA plan service coordinators and contracted case managers must conduct a face-to-face assessment of each member annually or when a significant event occurs in the life of the member (i.e., death of a caregiver, discharge from the hospital, change in health status, or change in living arrangement). The face-to-face assessment provides an opportunity for the health plan to identify beneficiaries who need home and community based services. QExA members who have disabilities, complex medical conditions and/or meet nursing facility level of care receive more frequent face-to-face visits.
- QExA members requiring LTSS are offered the opportunity to have choice and control over their providers (referred to as self-direction). Members shall have the ability to hire family members (including spouses and parents of minors), neighbors, friends, etc., as their service providers. This allows for more QExA members requiring LTSS to remain in their own home to receive long term care services.

The Honorable Senator Tom Harkin  
September 19, 2012  
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Hawaii appreciates the ability to provide information to the HELP committee regarding its programs to support the ADA and Olmstead. If you have any questions please contact Dr. Kenneth Fink, Med-QUEST Division Administrator at (808) 692-8050 or [kfink@medicaid.dhs.state.hi.us](mailto:kfink@medicaid.dhs.state.hi.us).

Sincerely,

NEIL ABERCROMBIE  
Governor, State of Hawaii

Enclosure

Hawaii Olmstead Implementation Plan  
October 1, 2004

*INTRODUCTION*

In June 1999, the United States Supreme Court, in *Olmstead v. L.C.*, 119 S. Ct 2176, ruled that it is a violation of the Americans with Disabilities Act (ADA) for states to discriminate against people with disabilities by providing services in institutions when the individual could be served more appropriately in a community-based setting. States are required to provide community-based services for people with disabilities if treatment professionals determine that it is appropriate, the affected individuals do not object to such placement, and the state has the available resources to provide the community-based services. The Court suggested that a state could establish compliance with the ADA if it has 1) a comprehensive, effective working plan for placing qualified people in less restrictive settings, and 2) a waiting list for community-based services that moves at a reasonable pace.<sup>1</sup>

To meet its obligation, the state created an Olmstead Task Force comprised of people with disabilities, their family members, advocacy groups, non-profit agencies, businesses and government agencies. The Department of Human Services, Department of Health and the Hawaii Centers for Independent Living led a series of meetings with the Task Force members to identify the principles, goals and objectives, and strategies of the Hawaii Olmstead Plan. In October 2002, Hawaii's Olmstead Plan was finalized and delivered to Governor Cayetano, who in turn, transmitted it to the Legislature via the Senate President and Speaker of the House on November 29, 2002.

In January 2004, the Olmstead Task Force was reconvened by Governor Lingle to identify specific actions, assignments and timelines to implement the Hawaii Olmstead Plan. The same Task Force members from the earlier planning process were all invited to participate in the Olmstead Implementation planning process. Nearly every month and sometimes two times per month, the Olmstead Task Force convened to discuss and decide on the various recommended actions. The attached Implementation Plan represents the final work product of the group and establishes the actions for the state for the next three years. As with other plans, it is critical that the Plan be reviewed regularly and adjusted for changes.

*OLMSTEAD IMPLEMENTATION PLANNING PROCESS*

When Governor Lingle reconvened the Olmstead Task Force, she assigned the task of finalizing the Implementation Plan to Dr. Chiyomi Fukino, Director of Health, and Lillian Koller, Director of the Department of Human Services. Each, in turn, assigned individuals within their departments to lead and work on the Olmstead Implementation Plan. In January 2004 the original membership of the Olmstead Task Force was invited for an introductory meeting at the State Capitol. There, it was agreed that the Hawaii Olmstead Plan developed in 2002 was still appropriate and applicable, and therefore, would remain unchanged. The reconvened Task Force would then concentrate its efforts in identifying specific actions to support the implementation of the Plan. Towards this end, the Olmstead Task Force organized itself into four work groups

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<sup>1</sup> Rosenbaum Sara, *The Olmstead Decision: Implications for Medicaid*, for the Kaiser Commission on Medicaid and the Uninsured: Washington, DC, March 2000

consistent with the four goals identified in the Olmstead Plan. The four groups worked to develop priorities, action steps, timelines and assignments for the following goals:

- Information, Education and Self-Empowerment
- Individual Equity, Assessment and Planning
- Financial Empowerment
- Infrastructure Development (housing, workforce, employment transportation, human services)

The individual work groups met on their own to develop recommended action items for each specific area. Although each group was able to provide recommended actions, in some instances, the work groups felt they lacked the necessary information or expertise to develop appropriate action items. In other cases, the work groups felt that the entire Task Force should be involved in the decision-making for the recommended actions. In the end, these issues and questions were discussed along with the specific work group recommendations with the Olmstead Task Force. The Task Force met formally eleven times to discuss and refine the recommendations of the four groups holding its final meeting in late September 2004.

Although the Olmstead Task Force membership was extensive (Appendix A), only a limited number of individuals actively and consistently participated in the planning process. Despite the smallness of the group, there was good participation and representation from individuals with disabilities, family members, advocates, providers, and state agencies. For this reason, the Olmstead Task Force feels confident that proposed Implementation Plan is one that can be largely supported by the state agencies and Hawaii's residents.

#### *HAWAII OLMSTEAD IMPLEMENTATION PLAN*

The Olmstead Implementation Plan is presented in Appendix B and is organized by the original four goals and the individual strategies. For each individual strategy, the Plan identifies the specific recommended action item, the lead agency, other assisting agencies and organizations responsible for the action, and the timetable for completion. The state Department of Health and Department of Human Services (DHS) are most predominantly listed as the lead agencies because both have responsibility for administering programs that support persons with disabilities. DOH operates programs to assist persons who have developmental disabilities/mental retardation, adults who are seriously and persistently mentally ill and children/youth with disabling conditions. As the state's Medicaid agency, DHS oversees the Medicaid/QUEST programs and the home and community-based waiver programs. It also has responsibility for the vocational rehabilitation program and has the state housing agency administratively attached.

The Plan recognizes that implementing real system changes to enable more people to live successfully in the community requires the contribution of many more state agencies and community groups. The administratively attached agencies such as the Executive Office on Aging (EOA), Disability and Communications Access Board (DCAB), Developmental Disabilities Council (DDC), and Housing and Community Development Corporation of Hawaii (HCDCH) are identified separately in the Plan since the departments do not have a direct supervisory responsibility over these agencies. Other agencies that are less commonly named, but assigned responsibilities, include the Department of Transportation, Department of Labor and Industrial Relations and the Department of Education. Finally, although consumers, advocates

and providers are not specifically identified for each action item, the Olmstead Task Force expects that these groups will be involved throughout the implementation process. This is more fully discussed under Guiding Principles.

The Task Force began the planning process with the intention to establish a budget for each of the action items. However, at the end, most participants felt that they were not in a position to determine the budget amount, and needed to leave the budget development with the lead agency. With two exceptions, the Implementation Plan also does not specify whether additional staffing or other resources are required to implement the action item. Again, this is left to the discretion of the lead agency. The two exceptions are the recommendations for positions to implement the actions for Strategy 4d6 (to assign a disability access liaison from the Disability and Communication Access Board (DCAB) to assist with the developing and implementing a unified transportation plan) and for Strategy 5a1 (to identify a quality assurance entity to assume responsibility for monitoring and evaluating implementation of the Olmstead Plan). Sufficient funding to assume these additional new functions is necessary for whichever organization receiving these assignments. The Olmstead Task Force is aware that the Legislature will determine whether permanent civil service positions are established and/or whether other resources (e.g., to contract services) will be provided.

All of the action steps in the Implementation Plan are identified with a timetable for immediate, intermediate and long-term. Immediate actions are those that can begin within six months of the implementation plan being accepted by the Governor. For the most part, these actions require no additional financial resources and can be performed by existing state agency staff. Additionally, the assigned tasks are consistent with the agency's current mission, objectives and responsibilities and may require only administrative action. If any data analysis is required, the data should already be available within the department. Intermediate actions will take place between six to eighteen months, and long-term actions are those which may take between eighteen months and three years to implement. Intermediate and long-term actions may require legislative changes, federal approvals, and/or additional funding from the Legislature. Certain long-term actions are reflective of the length of time required to implement new programs or to develop an appropriate infrastructure in the community to service persons with disabilities.

Throughout the various Olmstead Task Force meetings, there were many discussions on a variety of difficult topics. Although it is not possible to summarize all discussions, the following are some of the "themes":

- Available data and common sense dictate that we acknowledge a significant portion of Hawaii's population is living with a disability. In addition to individuals living longer, new treatments and technology are saving many more lives. Despite the increasing number of persons with disabilities, Hawaii's bed count in hospitals and nursing homes have remained stable. This situation poses both a challenge and opportunity for the State. Because the number of institutional beds is limited, there is a built-in incentive for the community to encourage individuals to live as long as possible either in their own or other homes in the community. The challenge, however, is find infrastructure solutions that support individuals with disabilities to live in the community as independently as possible. This means tackling difficult issues related to housing, transportation, support services, and work opportunities. The Task Force recognizes that addressing these issues will require more information, more time, more funds, and improved coordination between government agencies and private sector. The resulting Plan reflects this understanding and provides a realistic timetable for accomplishing the proposed actions.

- As noted previously, the state is not burdened with a large number of institutional beds and the infrastructure is not yet sufficiently developed that every individual with a disability can be cared for safely and appropriately in the community. Therefore, the Task Force accepts the fact that some individuals today and into the foreseeable future, will be placed in institutions. Given the current situation, it is important that activities are in place to educate and offer choice at the point of entry into the institution, and to regularly review the health status of individuals living in institutions and to plan, if appropriate, for the individual's eventual discharge.
- Information is the key to making an informed choice or decision, and the Real Choices website is a significant accomplishment in consolidating the vast range of information on long-term care and alternative community placements. The Plan supports the Real Choices website, but recognizes that additional work is needed to maintain accurate and current information and to improve accessibility. It also recognizes that Real Choices is one of many alternative information sources and that other formats and venues must be continually explored to reach the greatest number of individuals.

### *GUIDING PRINCIPLES*

The Hawaii Olmstead Plan adopted the following guiding principles from the federal guidance communicated from the Centers for Medicare and Medicaid Services (CMS) to the State Medicaid Directors.<sup>2</sup>

Principle 1: Develop and implement a comprehensive, effectively working plan (or plans) for providing services to eligible individuals with disabilities in more integrated, community-based settings.

Principle 2: Provide an opportunity for interested persons, including individuals with disabilities and their representatives, to be integral participants in plan development and follow-up.

Principle 3: Take steps to prevent or correct current and future unjustified institutionalization of individuals with disabilities.

Principle 4: Ensure the availability of community-integrated services.

Principle 5: Afford individuals with disabilities and their families the opportunity to make informed choices regarding how their needs can best be met in community or institutional settings.

Principle 6: Take steps to ensure that quality assurance, quality improvement and sound management support implementation of the plan.

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<sup>2</sup> Olmstead Plan State of Hawaii, October 16, 2002

These same principles were considered in the development of the action steps for the Implementation Plan. The Olmstead Task Force added the following principles to guide the state agencies as they implement the action items of the Plan.

- Seek participation from consumers and providers, as well as councils and advocacy organizations statewide.
- Provide these participants access to meetings and agency activities where Olmstead action items are discussed.
- Identify opportunities and to the extent possible, establish reimbursement mechanisms to compensate participants for their expertise and/or provide paid staff whose primary responsibility is to advocate for consumers.

### *PROGRESS TO DATE AND NEXT STEPS*

Long before the Olmstead decision, Hawaii had implemented programs to service persons with disabilities in the community. In addition to institutional care, the Medicaid program covers home health, hospice care and medical transportation to enable individuals to remain in their homes. The State also had elected and implemented several Medicaid home and community-based services waiver programs which include, but are not limited to, Nursing Home without Walls, HIV Community Care Program and the Medically Fragile Community Care Program. The state closed Waimano Home, the only state-operated ICF-MR facility, in June 1999. It continued to operate a crisis shelter and residential homes on the property, but these too were closed by December 2002 and all previous Waimano residents were transitioned into community placements. Prior to the Waimano closing, the Developmental Disabilities Division (DDD) of the Department of Health increased the number of community-based services and has significantly reduced the waitlist for DD/MR waiver services. DDD continues to examine and look for ways to provide more and a broader array of services to sustain current and future clients in the community.

The Adult Mental Health Division (AMHD) of the Department of Health has also been active in the recent years developing and expanding services in the community for adults who are seriously mentally ill. Most recently, AMHD began the process for discharging persons who are dually diagnosed with either mental retardation or developmental disability and a mental health diagnosis from the State Hospital into the community. Both Divisions are working jointly with the Med-QUEST Division (MQD) of the Department of Human Services to create an infrastructure to support these individuals in the community.

The Department of Human Services implemented the "Going Home" project which allows the transfer of Medicaid state plan funds (from MQD) to Medicaid home and community based waiver programs operated by the Social Services Division (SSD). This "money follows the person" concept has been applied to individuals in acute hospital beds waitlisted for skilled nursing level of care. Persons waitlisted in hospital beds are allowed to enter "slots" in the Residential Alternatives Community Care Program (RACCP), if they so choose. Previous to the funds transfer, new admissions to the RACCP would have been restricted due to funding constraints.



Despite these efforts, more work is needed to improve the delivery system. The State agencies recognize that some individuals who desire to return to the community still remain institutionalized because either the infrastructure or the technology is not yet available to safely and economically sustain the individuals in the community. Many providers do not have the array of services nor the knowledge, experience and ability to service people with complex needs. Addressing these capacity issues will require new funding and new innovations to cover the cost of more complex plans of care. Finally, more money and effort are required to prepare, consolidate, summarize and disseminate information, establish consumer-directed programs and to assist individuals to transition from institutions to communities. The state has received a number of grants to support these system change efforts. Most notably, is the \$1.35 million Real Choices grant awarded in 2001 to develop and implement a web-based single entry point system. The website was successfully launched in February 2003 and now provides information on a wide array of service options including long-term care.

Refer to Appendix C for a description of the living options and support services available through current government sponsored programs. Appendix D provides a baseline of the number of persons served and dollars expended for government sponsored services, and Appendix E provides a more complete description of other Olmstead-related activities.



## OFFICE OF THE GOVERNOR

JRTC, 100 W. RANDOLPH, SUITE 16-100  
CHICAGO, ILLINOIS 60601

**PAT QUINN**  
GOVERNOR

January 31, 2013

The Honorable Senator Tom Harkin, Chairman  
Committee on Health, Education, Labor, and Pensions  
United States Senate  
Washington, DC 20510-6300

**Re: State of Illinois Compliance with the Americans with Disabilities Act (ADA) and  
*Olmstead v. L.C.***

Dear Chairman Harkin:

On behalf of the State of Illinois, it is my pleasure to submit this response to the U.S. Senate Committee on Health, Education, Labor, and Pensions ("HELP") request for information regarding Illinois' compliance with the ADA and the *Olmstead* decision.

I share your concern that too many individuals with disabilities continue to be forced to live in segregated settings in order to receive services. For too long, Illinois has lagged behind the rest of the nation in ensuring these individuals have the least restrictive residential setting and most independent lifestyle possible.

When I took office in 2009, I established long-term care reform as a priority for my administration. I quickly instructed staff to settle the three *Olmstead* class action lawsuits that were filed in Illinois many years ago: *Williams vs. Quinn* (concerning persons with mental illness living in Institutions for Mental Diseases), *Ligas vs. Hamos* (concerning persons with developmental disabilities), and *Colbert vs. Quinn* (concerning persons with physical disabilities and mental illness living in skilled nursing facilities in Cook County). All three of these lawsuits have been settled, and Implementation Plans have been approved and are currently in process. Additionally, two years ago I introduced a Rebalancing Initiative, and committed to closing state-operated residential centers and psychiatric hospitals. This will increase the use and availability of community-based services for people with serious mental illness and developmental disabilities that is in direct alignment with the principles behind the U.S. Supreme Court's landmark decision in *Olmstead*. As with any significant change in government, there have been anticipated and unforeseen challenges. Illinois continues to strive for excellence in *Olmstead* compliance and ensure individuals with disabilities live as independently as possible. We welcome this opportunity to share with the HELP committee all of the activities underway in Illinois, and will continue to keep the United States Senate apprised of our successes and lessons learned.

In specific response to your questions:

**1) For each year from FY2008 to the present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long term care units of psychiatric hospitals and board and care homes (often called adult care homes or residential health care facilities), to living in their own home including through a supportive housing program.**

Williams Consent Decree

In FY2008, the Department of Human Services, Division of Mental Health (DMH), with guidance from national and local consultants implemented a Permanent Supportive Housing (PSH) model. DMH acknowledged that consumers of mental health services diagnosed with Serious Mental Illnesses (SMI) and who resided in institutional settings were not afforded opportunities to live independently due to the lack of “affordability” of adequate housing choices. The PSH cornerstone is a Bridge Subsidy – which is a Housing Choice Voucher (Section 8) look-alike model. DMH has identified six priority populations for PSH Bridge Subsidies - individuals diagnosed with SMI who are engaged and/or linked with a contracted vendor and who are: (a) residents of Long Term Care Nursing Facilities; (b) individuals “at risk” of NF admission, (c) residents of DMH contracted residential settings, (d) Aging-Out Youth from the Department of Children and Family Services or Individual Care Grant, (e) extended care patients of the State Psychiatric Hospitals and (f) persons who are homeless, as defined by DMH.

State Fiscal Year 2008 to Current YTD (2013) referrals moved to Permanent Supportive Housing.

Referral Source	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	Totals
Nursing Home	57	48	136	132	131	311	815
State Hospitals	1	5	1	2	6	5	20
Residential	6	94	135	85	97	12	429
<b>Totals</b>	<b>64</b>	<b>147</b>	<b>272</b>	<b>219</b>	<b>234</b>	<b>328</b>	

Ligas Consent Decree

In the *Ligas Settlement Agreement*, the State of Illinois agreed to determine which residents of private Intermediate Care Facilities (“ICF’s”) desired to be served in community integrated settings. The State expects that approximately 1,000 people will ultimately indicate a desire to move. To date, the Illinois Department of Human Services (“DHS”) has served 216 people who moved to community programs from private ICF’s. In addition, under the settlement agreement, we have agreed to move 1,000 people off of the State’s community waiting list into community programs by June 30<sup>th</sup> 2013. An additional 500 people per year will then be served over the next five years. To date DHS has served 322 individuals from the community list.

### Colbert Consent Decree

In *Colbert v. Quinn*, plaintiffs alleged that class members were being unnecessarily segregated and institutionalized in nursing facilities and forced to live with numerous other people with disabilities and in situations in violation of the ADA and the Rehabilitation Act. The suit was settled, and on December 20, 2011 a Consent Decree was entered by the Court. An Implementation Plan was approved on November 8, 2012. Illinois is beginning the evaluations of an estimated 17,000 Class Members residing in 185 nursing homes in Cook County.

The Consent Decree established benchmarks representing the numbers of transitions. By the end of Year 1, 300 Class Members shall transition to community residency. By the end of Year 2, a total of 800 Class Members shall transition to community residency and 36 months post implementation, a total of 1,100 Class Members are to have transitioned. Data collection continues as the *Colbert* Implementation Plan recently began Year 1 of implementation.

**2) The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their homes, including through a supportive housing program.**

### Colbert

Under the terms of the Colbert Consent Decree, Illinois anticipates providing housing subsidies as a bridge to receipt of other government sponsored housing programs such as Section 8 HUD vouchers or when a Class Member no longer requires a subsidy. For FY 12, Illinois anticipates spending \$554,166 out of a total of \$1,330,000 designated for Year 1 of Implementation. Overall, for the Illinois Department of Healthcare and Family Services had the following Medicaid expenditures for facilities with disabled individuals (of which 50% were federal matching funds):

- FY 08 - \$761,200,000; and \$310,600,000 for ancillary services.
- FY 09 - \$803,700,000; and \$309,900,000 for ancillary services.
- FY 10 - \$803,900,000; and \$308,200,000 for ancillary services.
- FY 11 - \$823,000,000; and \$308,700,000 for ancillary services.
- FY 12 - \$889,500,000; and \$289,300,000 for ancillary services.

### Money Follows the Person (“MFP”)

Illinois was selected as a MFP Demonstration Program in 2007. The Department plans to continue participation in the program along with our sister agencies through the end of the demonstration period – 2019. Illinois’ MFP program relies on a strong collaborative and inter-agency approach to the implementation of the program. The Department partners with the Department on Aging (DoA), Department of Human Services’ (DHS) Division of Mental Health, Division of Rehabilitation Services, and Division of Developmental Disabilities to transition individuals from institutional settings to community-based services and supports. Illinois’ MFP Program has transitioned 783 individuals since transitions were initiated in early 2009.

### Balancing Incentive Program (“BIP”)

Illinois is in the process of preparing an application for the Balancing Incentive Program. The BIP will provide Illinois with enhanced funding to continue its rebalancing efforts and

strengthen is community capacity in order to respond to the three *Olmstead* Consent Decrees and the closure of state facilities.

**Department of Human Services**

Response to Federal inquiry on expenditures for individuals with disabilities

As of 1/29/13

(\$'s in ,000) All Funds

	Total Est Liability *	Federal Match	Net Cost to state	
DD - Community Programs	\$768,999.5	\$368,124.7	\$400,874.8	
DD - ICF/DD's	\$389,160.8	\$194,580.4	\$194,580.4	
DD - SODC's	\$269,201.4	\$134,600.7	\$134,600.7	
MH - Supportive Housing	\$11,756.3	\$0.0	\$11,756.3	
MH - State Operated Hospitals	\$199,700.0	\$42,000.0	\$157,700.0	Federal Medicaid Disproportionate Share (DSH)
MH - Residential	\$51,900.0	\$0.0	\$51,900.0	
DRS - Home Services Program	\$576,201.0	\$221,500.0	\$354,701.0	Service costs only*
DRS - Comm. Reintegration	\$2,907.2	\$889.8	\$2,017.4	
<b>Total</b>	<b>\$2,269,826.2</b>	<b>\$961,695.7</b>	<b>\$1,308,130.5</b>	

\*Est. full year liability does not consider carryover cost for FY12 from FY13 or FY13 from FY14.

\*DHS Administrative cost and other operations not included

3) For each year from FY2008 to the present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.

Since FY 2008 the State has dramatically expanded the supply of Permanent Supportive Housing available to persons with disabilities allowing persons with disabilities to live in community integrated settings with appropriate supports rather than in long term care facilities such as Institutes for Mental Disease, skilled nursing facilities, State Operated Developmental Centers, and Intermediate Care Facilities for Persons with Developmental Disabilities. Specifically, the State has taken the following actions between FY 2008 and the present:

- 1) The State's Housing Finance Agency, the Illinois Housing Development Authority ("IHDA"), has implemented the following Permanent Supportive Housing Initiatives:
  - a. The Low Income Housing Tax Credit (LIHTC) Targeted Program for Persons with Disabilities. This initiative provides competitive scoring incentives, through the Qualified Allocation Plan, to developers to voluntarily set aside between 10% and 20% of units developed under the LIHTC program that are made available

for persons with disabilities. Under the program disability service providers are notified when units become available under the Set Aside Program and refer consumers with disabilities for consideration to the State's Lead Referral Agent. The State's Lead Referral Agent works with property management to facilitate the processing of applications for tenancy, including advocating where appropriate for reasonable accommodations under the Fair Housing Act. Between FY 2008 and the present 689 rental units affordable to disabled persons with incomes at or below 30% of area median income have been created under the Targeted Program in community integrated settings;

- b. In addition to the above units, IHDA has worked in partnership with the Office of Governor Pat Quinn to develop 1,226 Permanent Supportive Housing units for persons with disabilities and veterans, many of whom are physically or mentally disabled, since FY 2008 throughout the State. These Permanent Supportive Housing units are financed with LIHTC's, State Housing Trust Fund loans/grants, HOME funds and with grant financing from the Governor's Build Illinois Bond Program. Governor Quinn is the first Governor in Illinois to utilize State Capital Bonds to support the creation of affordable and supportive housing and since FY 2008 more than \$70 million in State Capital Bond funding has been utilized to support the creation of permanent supportive housing serving cross disability and veterans populations with support services available on site as needed by residents;
  - c. IHDA has provided \$10 million in rental subsidy under its Long Term Operating Support Program funded with fees on the recordation of deeds for persons with disabilities. To enable the use of these funds the State Legislature, at the urging of the Governor, amended the State Rental Housing Support Program to allow this Program to establish preferences for persons with disabilities in July, 2012;
  - d. IHDA has applied for 826 units of Section 811 rental assistance under the Frank Melville Act and is waiting for a determination on its application for this vital rental assistance that will enable tremendous expansion of community integrated housing opportunities;
  - e. IHDA applied for and has been awarded a \$1 Million grant from the Harry and Jeanette Weinberg Foundation of Maryland to buy-out market rate debt on existing rental housing for the purpose of reducing rent on up to 8 units of housing to make them affordable to persons referred by the State Referral Network.
  - f. IHDA has utilized \$12 million in proceeds from the State Low Income Housing Trust Fund, which is funded from an addition to the Real Estate Transfer Tax, to fund 19 not-for-profit organizations to conduct home modifications for homeowners and renters to enable persons with physical disabilities to maintain their occupancy in their existing home and to prevent unnecessary placement in long term care facilities;
- 2) Illinois has been a pioneer in obtaining HUD support for the encouragement of Public Housing Authorities (PHA's) to utilize their flexible authority to grant preferences for PHA housing assistance, both public housing units and Housing Choice Vouchers, for persons with disabilities. Illinois is the second State to be invited by HUD to establish a

Coordinated Remedial Plan to allow for streamlined approval of PHA resources for persons with disabilities in light of the fact that PHA's have not complied with the ADA in doing affirmative outreach to persons in long term care institutions notifying them of waiting list openings and other availability of PHA housing assistance. Under this PHA initiative the State has received the commitment of 600 units of housing assistance from PHA's in 2011-2012 in support of its efforts to provide community integrated housing opportunities for Olmstead class members.

- 3) The Illinois Department of Human Services, Division of Mental Health, has utilized its Bridge Subsidy Program, a State funded permanent supportive housing program, to provide rental subsidies to 335 persons with serious mental illness who have transitioned to community integrated housing settings since 2011 with rental subsidy and intensive social service supports pursuant to the *Williams* consent decree. Nine private mental health providers utilize funding provided under Rule 132 and from General Revenue to provide Assertive Community Treatment and Community Service Teams to support these residents in living independently;
- 4) The Illinois Department of Human Services, Division of Developmental Disabilities, has transitioned 182 residents of the State Operated Developmental Center in Jacksonville, Illinois to small, community based settings predominantly in 4 bed Community Integrated Living Arrangements (CILA's). In addition 218 residents of privately operated Intermediate Care Facilities for persons with Developmental Disabilities have been transferred to 4-8 bed CILA's in accord with the *Ligas* consent decree;
- 5) Illinois is in the process of implementing the *Colbert* consent decree which will enable residents of Cook County skilled nursing facilities who receive Medicaid to transition to community settings should they so desire and be capable of this transition based on an independent evaluation. In anticipation of the *Colbert* case, IHDA has funded the Illinois Facilities Fund, a not-for-profit intermediary, to acquire and rehabilitate up to 60 individual condominiums at short sales and to invest the necessary funds to make these units accessible since a large number of non elderly disabled persons reside in Cook County nursing homes who have physical disabilities and are in need of accessible housing.

**4) The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.**

In FY2003, former Governor Rod Blagojevich signed the Disabilities Service Act (Public Act 093-0638) to improve compliance with the Americans with Disabilities Act of 1990 and the Supreme Court's decision in *Olmstead v. L.C.*. The Disabilities Services Act of 2003 seeks to provide the foundation for a wider range of community based services and supports including residential options. The Act established a Governor-appointed advisory committee called the Disabilities Services Advisory Committee (DSAC). This committee was designed to assist in the development and implementation of a Disabilities Services Plan, which became the State's Olmstead Plan. The Olmstead Plan of 2003 was updated in July 2006. Furthermore, the State adopted the Older Adult Services Act in 2004, with the stated intention of promoting a comprehensive system of older adult

services in the community as compared to a facility-based model. This system involves funding for a primarily home-based and community-based system, taking into account the continuing need for 24-hour skilled nursing care and congregate housing with services.

In 2009, the Governor's Office initiated the Interagency Long Term Care Reform meetings as a State governmental strategizing body to focus on the overall rebalancing agenda with a focused compliance on (a) the Money Follows the Person demonstration, (b) the pending and now settled Consent Decrees (*Williams, Ligas and Colbert*), (c) the pursuit of the Balancing Incentives Payment Program, and (d) collaboration on a revised waiver option.

There are several overarching Principles that frame the policy discussions regarding the future of Illinois service system across disability populations:

Principle #1: *Emphasize and Support Choice:* Enable individuals to choose from a range of appropriate and accessible community services.

Principle #2: *Increase System Capacity for Accessible High Quality Care.*

Principle #3: *Strengthen Quality Management:* Ensure effective and accessible supports and services and appropriate outcomes for people through enhanced quality and compliance monitoring systems and improved accountability.

Principle #4: *Support the Network of persons with disabilities, the elderly, their Families, Friends, Neighbors and Communities.*

Principle #5: *Commit to Continuous Improvement of the Workforce:* Create a Workforce Development Strategy that Delivers a Stable, High-Quality Direct Care Staff.

Principle #6: *Re-engineer the Infrastructure:* Improve the State Agency Capacity to Support Choice.

The above principles represent ongoing priorities for the State.

**5) Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.**

There are several important policy recommendations for consideration that could assist in a more expedient and successful transition of individuals from institutional settings to PSH. These policy recommendations are:

- A. Local Housing Authorities should open waiting lists to accept applications of individuals who have lived in institutional settings and who either have not been afforded opportunities to apply for Housing Choice Vouchers or who may have not responded to letters due to their mental illness.



- B. Access to vouchers should be standardized such that persons with mental illnesses are not disproportionately penalized, particularly those with individuals with non-felony criminal histories.
- C. The Money Follow the Person federal demonstration should include all nursing facilities and not exclude IMDs. The population and clinical profiles of residents who are diagnosed with Serious Mental Illness in both non-IMD and IMD settings are identical. The provision for enhanced federal match for expanding home and community-based services for residents in the community should not be restricted based on the settings in which the individuals reside. Their stabilization needs and community service supports are the same.
- D. HUD should reconsider policies relating to its Section 232 FHA insurance program in the Office of Healthcare Administration that provides non-recourse mortgage loan guarantees to nursing home operators. The State's rebalancing initiative includes efforts to reduce nursing home bed supply and to achieve *Olmstead* compliance. This puts the State/Federal rebalancing policy in conflict with the HUD Section 232 insurance program that increases the supply of nursing home beds. Specific policy considerations that HUD should evaluate include:
  - a. Establishing a formal process to consult with States before originating Section 232 loans to assure that the State has made a Determination of Need for such a facility;
  - b. When a nursing home operator applies to HUD to refinance an existing Section 232-insured mortgage under either the 223(a)(7) or 223(f) programs, HUD should consult with States regarding the advisability of such refinancing and should require that excess loan proceeds be utilized: to make facility improvements, to reduce beds where market studies demonstrate an oversupply of beds, or to pay into an "*Olmstead* Fund" to support rebalancing efforts. It is critical that if HUD is going to serve as an insurer of nursing home mortgages that it reconcile its lending policies with its fair housing policies under *Olmstead*;
  - c. When a State is undertaking an enforcement action to close a facility that is HUD-insured, or such a facility is losing census due to a State's compliance with *Olmstead* obligations, HUD should work with the borrower and the State to pursue adaptive repurposing of the facility and, if necessary, enter into workout agreements or accept partial payments of claims to facilitate advancement of *Olmstead* priorities.
- E. Federal policy should reconcile the inclusion of nursing facilities as a mandatory service under the Medicaid program, and Medicaid's prohibition against paying for housing in other settings. The waiver authority under section 1915 could be liberalized to enable states to cover those costs associated with permanent supported housing or other qualified residences when the state can demonstrate overall savings or budget neutrality. Otherwise, the overall economic incentive will still favor nursing homes.

F. Support ongoing annual appropriations for incremental units under the Section 811 Project Based Rental Demonstration Program pursuant to the Frank Melville Act;

G. Support funding for an annual round of Non Elderly Disabled Vouchers for persons transitioning from long term care to community based settings

**6) Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.**

Recently, DMH convened a Statewide Institute for Mental Health System Rebalancing to explore strategies that would effectively move forward the agenda of compliance with the Olmstead decision specifically through the implementation of the Williams Consent Decree. The attached grid represents key outcomes from this strategic discussion and exploration process. We were extremely enlightened by the New Jersey model of RIST (Residential Intensive Support Teams) and plan to incorporate RIST into the DMH service taxonomy. Concurrently, while DMH has a PSH model, the ‘Housing First’ model, as enacted in the State of New York, is a high priority for this State to replicate.

We are particularly proud of DMH’s development and implementation of a Permanent Supportive Housing/Bridge Subsidy as a model. Although PSH is not a new concept to many States, the design of Bridge Subsidy and its working parts could be easily replicated by other states.

		Year II (FY2013)	Year III (FY2014)	Year IV (FY2016)
1	Develop Residential Intensive Support Teams (RISTs) <ul style="list-style-type: none"> <li>Initiate discussions on a RIST-like model for the DMH service taxonomy</li> <li>Determine eligibility criteria, staffing standards, etc.</li> </ul>	PLAN	IMPLEMENT	
2	Create additional co-occurring substance abuse and mental health treatment models <ul style="list-style-type: none"> <li>Utilize DDMHT instrument to assess providers</li> <li>Technical Assistance and follow up</li> </ul>	Begin Assessments and Analyze Findings	PLAN	IMPLEMENT
3	Enhance advance training and public awareness: <ul style="list-style-type: none"> <li>Train providers in harm reduction, health literacy and, LEAP (Listen-Empathize-Agree-Partner)</li> <li>Provide education and Public Relations on Recovery and wellness – destigmatization</li> </ul>	PLAN	IMPLEMENT	
4	Replicate New York’s ‘Housing First’ Model – Bring the New York Pathways (Tsembaris) model to Illinois	Develop and Release RF/RFP Identify & resolve contractual issues & funding mechanism	IMPLEMENT	
5	Develop ‘Housing First’ support resources for landlords: <ul style="list-style-type: none"> <li>Develop a statewide process for providing landlord support and define parameters</li> </ul>	PLAN	IMPLEMENT	

		Year II (FY2013)	Year III (FY2014)	Year IV (FY2016)
	<ul style="list-style-type: none"> <li>Develop training curriculum for landlords on the HF model</li> <li>Develop HF landlord networks</li> </ul>			
6	Enhance Performance-based contracting	PLAN	IMPLEMENT	
7a	Financing services: <ul style="list-style-type: none"> <li>Partner with HFS on a waiver feasibility</li> </ul>	Initiate Discussion	PLAN	IMPLEMENT
7b	<ul style="list-style-type: none"> <li>Develop rate methodology for the RIST-like model</li> <li>Explore feasibility of inclusion is a State Plan Amendment or Waiver.</li> </ul>	PLAN	IMPLEMENT	
7c	<ul style="list-style-type: none"> <li>Develop funding methods to support atypical costs associated in doing business with landlord, re., landlord housing/maintenance issues, i.e., bed bug eradication; damage to property (holes, water flooding), etc.</li> </ul>	PLAN	IMPLEMENT	
8	Provide coaching and cross agency expertise/ technical assistance to community mental health providers on philosophical shifts/approaches to best serve individuals transitioning from LTC: <ol style="list-style-type: none"> <li>How to engage and maintain services to this population</li> <li>Staff attitude change on the culture of deinstitutionalization and Olmstead rebalancing of care.</li> <li>Person-centered planning</li> <li>Consistent monitoring and follow up on integrated health care/ complex medical conditions</li> <li>Outcome-based TA (targeted to performance gaps)</li> </ol>	PLAN	IMPLEMENT	
9	Create a statewide “coaching” network: <ol style="list-style-type: none"> <li>Identify national experts with diverse subject matter expertise who can train on facilitating seamless transitions efforts</li> <li>Develop an instate provide network of experts to cross train on best practice transition, motivation and monitoring techniques;</li> <li>Schedule a series of ‘in-service’ coaching session</li> </ol>	PLAN	IMPLEMENT	
10	Expand peer voice, peer services and supports	PLAN	IMPLEMENT	
11	Promote new strategies for self administration of medications and monitoring of medication: <ul style="list-style-type: none"> <li>Better tools to monitor and discuss medication adherence/issues with consumers</li> <li>Assist with administrative costs to develop relationships with pharmacists</li> <li>Explore types of creative medication prompting packaging (bubble wrap) to assist with easier consumption of medications and agency’s monitoring of medication adherence</li> </ul>	PLAN	IMPLEMENT	
12	Enhance housing array – explore other housing models, including site-based PSH, clustered sites, front desk management, etc	PLAN	IMPLEMENT	
13	Incorporate use of occupational therapy in Recovery	PLAN	PLAN	IMPLEMENT

		Year II (FY2013)	Year III (FY2014)	Year IV (FY2016)
	<ul style="list-style-type: none"> <li>Develop a service model (see also waiver and RIST discussions)</li> <li>Explore rate methodology</li> </ul>			
14	Design services around the Four Quadrant Model of risks	ANALYZE	PLAN	IMPLEMENT

The State of Illinois welcomes this opportunity to highlight our extensive efforts towards *Olmstead* compliance. If we can provide any additional information, or if I can be of further assistance, please do not hesitate to contact me at (312) 814-4179.

Sincerely,

Michael Gelder  
Senior Health Policy Advisor to Governor Pat Quinn



# Iowa Department of Human Services

Terry E. Branstad  
Governor

Kim Reynolds  
Lt. Governor

Charles M. Palmer  
Director

September 21, 2012

The Honorable Tom Harkin  
Chairman  
United States Senate Committee on Health, Education, Labor and Pensions  
Washington DC 20510-6300

Dear Senator Harkin:

This letter provides further response to your letter dated June 22, 2012, regarding Iowa's services for individuals with disabilities.

Iowa has been promoting community services since the inception of Medicaid Home and Community Based Services (HCBS) in the 1980's. The State remains committed to balancing the long term care system and that commitment is clearly demonstrated through appropriations and clear goals in Iowa's Olmstead plan. The Iowa Department of Human Services (Department) has worked proactively, in conjunction with various stakeholders, including the Iowa Department on Aging, to make progress on Olmstead-related goals.

Your letter outlines several opportunities to assist States in promoting community support options for individuals in need of long term care services. However, due to unique state circumstances, not every option is viable to meet state-specific needs.

Iowa has applied and received approval for several programs made available by Congress and administered through the Centers for Medicare and Medicaid Services (CMS) and the Administration for Community Living (ACL):

- 1915(i) State Plan HCBS Option: Iowa was the first state to receive approval to implement this option beginning in 2007. Currently 4,300 individuals with chronic mental illness are served through 1915i habilitation supports. Supports provided through this SPA include services in the individual's home, community and work environment.
- Money Follows the Person (MFP): Iowa first received this grant in 2007. We are currently the only state focusing exclusively on individuals living in an intermediate care facility for individuals with a developmental disability (ICF/ID). To date, over 200 individuals have moved into their own homes and communities since implementing MFP in 2008. Similar transition services are being provided to persons residing in nursing facilities through the Aging and Disabilities Resource Centers.
- Balancing Incentives Payment Program (BIPP): Iowa received approval for this grant on July 1, 2012. The BIPP will provide enhanced funding to develop infrastructures that will assist in achievement and sustainability of community and facility expenditure balancing.
- 1915(c) Home and Community Based Waivers (HCBS): Iowa currently operates seven (7) HCBS Waiver programs targeting individuals who have been diagnosed

with AIDS/HIV, Brain Injury, Serious Emotional Disturbance (Children’s Mental Health), Elderly, Intellectual Disability, or Physical Disability. These programs are designed to offer services in the community to individuals who might otherwise require facility care. Approximately 30,000 individuals are currently enrolled.

- Aging and Disability Resource Centers (ADRC): Iowa has received Older Americans Act Title IV discretionary funds in three phases to develop the ADRC network in Iowa and Options Counseling funds from 2010-2012. It was awarded continuation funds under a cooperative agreement in September 2012.
- Lifespan Respite Care Program: Iowa was awarded funds from the ACL for three years to develop a coordinated lifespan respite care program in Iowa.
- Veterans Transportation and Community Living Initiative: Iowa was awarded funds to develop a “One-Click One-Call” system in partnership with Iowa’s ADRC system to support easier transportation support for Iowa veterans.

You requested specific information regarding Iowa’s efforts with the utilization of the tools that have been made available to States. For convenience, the information requested has been itemized below.

**1. For each year from FY 2008 to the present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long term care units of psychiatric hospitals, and board and care homes, psychiatric hospitals, group homes, and their own homes, including through supportive housing programs.**

State Fiscal Year	Facility Type		
	Nursing Facility	Residential Care Facility (Room and Board)	Intermediate Care Facility for Individuals with ID/DD
2008	352	119	64
2009	425	146	34
2010	487	116	67
2011	556	107	56
2012	717	93	63

- Iowa Medicaid does fund long term units at psychiatric hospitals.
- The above information reflects the program type authorized through Iowa Medicaid. These totals do not reflect individuals funded by other sources. The 2009 data does not capture all of the individuals who transitioned from an ICF/ID to the community; the cause is undeterminable at this time.

**2. The amount of state dollars that will be spent in the fiscal year serving individuals with disabilities in their own homes, including through a supportive housing program—including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregate settings) and the specific nature of the capacity added.**

	<b>SFY 2013</b>	<b>SFY 2014</b>	<b>SFY 2015</b>	<b>SFY 2016</b>
<b>Non-Institutional Expenditures</b>	\$888,891,420	\$941,371,225	\$996,788,945	\$1,045,677,928
<b>Institutional Expenditures</b>	\$958,831,066	\$991,428,637	\$1,016,508,229	\$1,041,377,765
<b>Total LTSS</b>	\$1,847,722,486	\$1,932,799,862	\$2,013,297,173	\$2,087,055,693
	<b>SFY 2013</b>	<b>SFY 2014</b>	<b>SFY 2015</b>	<b>SFY 2016</b>
<b>% Non-Institutional</b>	48.11%	48.71%	49.51%	50.10%
<b>% Institutional</b>	51.89%	51.29%	50.49%	49.90%
	<b>SFY 2013</b>	<b>SFY 2014</b>	<b>SFY 2015</b>	<b>SFY 2016</b>
<b>Non-Institutional Growth</b>	7.81%	5.90%	5.89%	4.90%
<b>Institutional Growth</b>	1.05%	3.40%	2.53%	2.45%

- The Balancing Incentive Payment Program will enable Iowa to expand the home and community services opportunities available to individuals.

3. *For each year from 2008 to present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own home, including through a supportive housing program—including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated setting) and the specific nature of the capacity added.*

<b>State Fiscal Year</b>	<b>Buydown Amount</b>	<b>Cumulative Buydown Amount</b>	<b>Waivers Impacted</b>
2008	\$ 2,576,023	\$ 2,576,023	Children's Mental Health
2009	\$ 2,750,000	\$5,326,023	Children's Mental Health (\$750,000); All waivers with a waiting list (\$2,000,000)
2010	-	\$ 5,326,023	N/A
2011	\$ 1,925,000	\$ 7,251,023	All waivers with a waiting list
2012	\$ 5,000,000	\$12,251,023	Brain Injury, Children's Mental Health, Intellectual Disabilities
2013	\$ 5,000,000	\$17,251,023	All waivers with a waiting list

- The Iowa Legislature continues to appropriate increased funding to support expansion of community services through Medicaid HCBS Waivers.

4. *The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and*

***community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.***

The Iowa Olmstead Mental Health and Disability Services State Plan framework was developed in 2010 and continues to provide a roadmap towards achieving the vision of Olmstead principles in Iowa. In both the 2011 and 2012 state legislative sessions, legislation was passed and signed into law by Governor Branstad to redesign the mental health and disability service system based on the Olmstead principles. This year, Iowa is also moving forward with implementation of the Balancing Incentive Payment Program, and Health Homes initiatives.

The Plan's five major goals focus on building greater capacity to support all aspects of community integration:

- Goal 1: Creation of Welcoming Communities
- Goal 2: Increased Access to Information and Supports
- Goal 3: A Full Array of Community Based Services and Supports
- Goal 4: High Quality Services and Supports
- Goal 5: Accountability for Service Results

Eleven strategic priorities have been identified to guide our progress toward each goal. Below, you will find the current priorities and highlights of accomplishments to date.

Goal 1

Strategic Priorities:

1. To educate Iowans about the potential of people with mental illness, brain injury and other disabilities to contribute to their communities.
2. To promote their full inclusion in community life, including policy development affecting their lives.

Highlights of Progress:

- Hundreds of individuals with disabilities participated in the redesign work groups and provided input and feedback through public meetings, an interactive website, and advocacy organizations.
- The Office of Consumer Affairs (OCA) has been re-established and is now fully staffed and operational with a statewide director and five regional coordinators and five regional advisory committees.
  - OCA serves as a statewide resource for information, referrals, community education, individual education, one-on-one problem solving, and system navigation.
  - OCA provides input on the development and implementation of policies and programs impacting behavioral health services and systems in Iowa.
  - OCA provides an advocacy voice to stakeholder groups throughout the state with the goal of promoting awareness of the concerns, perspectives and vision of persons and families with behavioral health recovery and disability challenges.
  - OCA assists the Department and others with disseminating information and gathering feedback from end users of behavioral health services and systems in Iowa.



- Iowa is actively engaged in a series of initiatives to increase employment options, including:
  - Organizing work incentive seminar events on employment and self-employment and promoting use of Social Security work incentives.
  - Becoming active in the State Employment Leadership Network (SELN) and working to increase collaboration between state agencies, counties, and providers to improve employment outcomes for people.
  - Aligning policies and funding to an Employment First philosophy, strengthening partnerships, and removing barriers.
  - Working with businesses to influence the creation of employment opportunities for people with disabilities.
- Iowa is actively engaged in efforts to increase community living options, including:
  - Transitioning State Resource Center residents into community settings utilizing Money Follows the Person.
  - Use of the Iowa Program Assistance Response Team (I-PART) to provide training and technical assistance that builds community provider capacity to address behaviors related to co-occurring mental illness and intellectual disabilities.
  - Promoting and providing Mental Health First Aid training and support for school systems, child welfare providers, and members of the public to create awareness of mental health and disability issues and improve the capability for individuals to recognize and appropriately respond to individuals experiencing mental health issues and crises.
  - Working with the Iowa Finance Authority to ensure availability of Home and Community Based Services Waiver Rent Subsidies to support Money Follows the Person participants and enrolled HCBS Waiver members.

## Goal 2

### Strategic Priorities:

3. To improve access to services for individuals and families in crisis.
4. To ensure appropriate services and settings by strengthening assessment tools and processes.

### Highlights of Progress:

- The enactment of State Mental Health and Disability Services Redesign legislation (Senate File 2315), which:
  - Defines and develops standards for crisis stabilization services and authorizes funding for an initial 50 beds in Iowa.
  - Designates crisis services as a core service domain which will help reduce the use of emergency rooms and divert people from acute care services.
  - Mandates development of multi-occurring capability by providers; DHS is expanding technical assistance and tools for providers.
  - Requires implementation of standardized assessment tools for the Intellectual Disabilities (ID)/Developmental Disabilities (DD), Mental Illness (MI) and Brain Injury (BI) populations.
- Successful application for the Balancing Incentives Payment Program, which:
  - Creates a network of No Wrong Doors/Single Entry Points using the Aging and Disability Resource Centers and regional offices.

- Strengthens Iowa's web-based information and referral system.
- Includes identification of a core standardized functional assessment for all populations and standardization of processes to the extent feasible.
- The enactment of legislation (Senate File 2312) which:
  - Provides a framework for improving the mental health commitment process.
  - Continues access to education and training on mental illness and alternatives to involuntary placement.
- The Iowa Department of Public Health is leading an inter-agency team in the SAMHSA-sponsored "Returning Service Members, Veterans and Their Families Policy Academy," in which states identify best practices to address the needs of veterans through VA and community based services.

### Goal 3

#### Strategic Priorities:

5. To build a service system that expands opportunities for competitive employment.
6. To advance the integration and coordination of primary care, mental health, substance abuse, and community support services.
7. To maximize support for community integration and reduce reliance on institutionally based services.

#### Highlights of Progress:

- The mental health and disability services redesign legislation includes employment supports as a core service with the goal to increase the number of people with disabilities who are competitively employed.
- The Legislature provided funds to sustain the Community Circle of Care project in Northeast Iowa, and the system of care initiative in Central Iowa, and funded a third system of care project.
- Iowa Medicaid Enterprise (IME) has been approved for a Medicaid State Plan for Health Homes to better coordinate improved services for Iowans with complex and chronic conditions.
- Iowa's Money Follows the Person demonstration helped 188 individuals transition from intermediate care facilities for persons with an ID to more integrated community living.
- Housing: IME and Iowa Finance Authority (IFA) are collaborating on difficult housing issues, including:
  - IFA secured assistance from the U.S. Department of Housing and Urban Development Regional Office in promoting the options available to independent local public housing authorities.
  - The Olmstead Consumer Taskforce submitted testimony to IFA on the elimination of incentives for development of accessible housing in IFA's Qualified Allocation Plan for Low Income Housing Tax Credits; the incentives were partially restored.

### Goal 4

#### Strategic Priorities:

8. To improve outcomes by promoting efficient and cost effective best practices.
9. To develop and expand workforce competencies.

#### Highlights of Progress:

- The new State Mental Health and Disability Services Redesign legislation (Senate File 2315):
  - Requires access be available to providers demonstrating competency in co-occurring, evidence-based, and trauma informed services.
  - Identifies initial core services and additional core services such as, positive behavior support, assertive community treatment, and peer support to be developed as resources permit.
  - Calls for the creation of a workgroup to look at ways to address workforce shortages and training needs in all pertinent job classifications, including direct support workers.
- Improved access to the web-based College of Direct Support (CDS) expanded through funding appropriated for the Iowa Association of Community Providers.
- Expanded course offerings include supported employment and services for people with mental illness.

#### Goal 5

##### Strategic Priorities:

10. To implement an effective performance and accountability structure.
11. To develop a plan for long term system financing.

##### Highlights of Progress:

- Legislation was enacted, which:
  - Establishes performance based outcomes, built in part on Olmstead principles.
  - Authorizes federal funds to be used to develop recommendations to better incentivize the development of more employment support services.

Iowa's strategic planning process for the creation of the Olmstead MHDS State Plan started with key decisions to:

- Develop one integrated plan for providing mental health and disability services in the State that reflects and supports the principles of the Olmstead Supreme Court decision.
- Initiate a five year planning cycle with a yearly review.
- Engage individuals, families, advocates and other stakeholders in all phases of plan development and review.
- Collaborate with other state agencies in order to facilitate a coordinated approach to the provision of disability services and the elimination of barriers to community living.

The State Plan for Iowa was shaped through public dialogue on the issues and the gradual coalescing of stakeholder opinion about the vision of Iowa's mental health and disability service system. Iowa's stakeholders - including individuals, family members, advocates, providers and policy-makers - were engaged in the discussion. Throughout the development, hundreds of stakeholders volunteered their time to attend public forums and serve on various work groups to provide input. The [www.iowaMHDSplan.org](http://www.iowaMHDSplan.org) website was created to share information and accept public comments.

Consistent with stakeholder values, a set of principles and a description of what a transformed system would look like were drafted. The State Plan Framework was finalized, and detailed action steps were developed. The Plan is a living document, which will continue to evolve in response to progress that is made, emerging issues, federal or state mandates, and the identification of resources to support objectives. The Framework provides guidance to decision-makers and allows for consistent application of Iowa values in system transformation.

Iowa's Plan incorporates several of the tools created by the federal government to enhance home and community based services and supports:

- **Home and Community Based Services (HCBS) Waiver Programs:** Iowa has a long history of utilizing HCBS Waiver programs as a tool to offer people choices about how and where they live and receive services. Iowa currently has seven Medicaid HCBS Waivers. The person-centered approach and flexible supports offered by these waivers allow thousands of Iowans to remain in their homes and communities and access the services and supports they need. The Consumer Choices Option is available under all the Waivers, which affords individuals the option of exercising more responsibility, choice, control, and flexibility over their own services.
- **1915(i) State Plan HCBS Option:** Iowa's Habilitation Services is a program that provides services for Iowans with functional impairments typically associated with chronic mental illnesses. Habilitation Services are designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Available services include case management, home-based habilitation, day habilitation, prevocational services, and supported employment.
- **Money Follows the Person:** Has been utilized in Iowa to assist individuals with a developmental disability to move from an intermediate care facility serving people with intellectual disabilities to community based settings. The program has been instrumental in helping address the most challenging service needs, including behavioral planning and support and employment.
- **Balancing Incentives Payment Program:** BIPP, which began on July 1, 2012, is still in the early stages. Iowa currently spends approximately 46.5% of its Medicaid long term services and support funds on home and community based services. The State is working to complete its plan to streamline access to services, improve efficiency, consistency, and fairness in eligibility determination and assessments, and ensure conflict-free case management. All of these requirements are wholly consistent with the MHDS Redesign and Iowa's Olmstead Plan.

**Revisions:** Iowa's Five-Year Plan was initially completed in January 2011, and the Plan Framework has not yet undergone any revision. An 18-month Action Agenda was developed to guide the daily work of implementing the plan objectives. The first Action Agenda covered the period from January 2011 through June 2012; it is currently being updated.

**5. Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.**

- **Housing Incentives:** Accessible, affordable housing is essential for individuals receiving Medicaid services. Previously, housing grants allowed and promoted large building structures that were designated only for individuals with disabilities. The Centers for Medicare and Medicaid Services have proposed rules that would not allow Medicaid funding in this type of segregated setting. It has recently become apparent that the Department of Housing and Urban Development and the Centers for Medicare and Medicaid Services have become aware that their policies to promote integrated housing were not aligned. We applaud their efforts to begin discussions that will promote integrated, accessible, affordable housing.
- **Level of Care:** In 2005, Iowa attempted to increase the level of care requirements for individuals entering a nursing facility through an 1115 Demonstration Waiver called IowaCare. Receiving minimal services in the home can assist in preventing an individual from entering the higher care offered in a nursing facility. Most individuals who are aging and/or disabled need preventative supports that keep them from entering a facility and the facility care should be comprehensive. Currently, Iowa became aware that this option has been approved through 1115 Demonstration Waivers. While we are excited about this new opportunity, it is very difficult for states to receive approval and operate 1115 Waivers.
- **Employment:** One of the biggest barriers for individuals moving from facilities is employment. Federal incentives for private sector employers to hire more individuals with disabilities may assist in driving this important issue on a national scale.
- **Assisted Living Facilities (ALF):** As the aging population continues to grow, the use of ALFs becomes a vital piece of the continuum of care. Currently this is a difficult service to manage due to the structure of the facility requirements and integrating individual service needs as required through HCBS. It may be of benefit to states to provide ALFs through a state plan option with specific requirements that merge the facility and HCBS principles.
- **Aging & Disability Resource Centers (ADRC):** The ADRC model requires strong local partnerships to become fully-functional. Strengthening Centers for Independent Living and continued education and support for health care entities to partner with ADRCs will ensure that consumers have genuine "no-wrong door" access to long-term supports and services that meet the promise of Olmstead. Strengthening options counseling services through ADRCs will assist in ADRC sustainability.

**6. Any successful strategies that your state has employed to effectively implement Olmstead particularly strategies that could be replicated by another state or on a national scale.**

**Successful Strategies Employed in Iowa:**

- **Stakeholder Engagement:** Engaging key stakeholders, especially persons with disabilities and their families, friends, and advocates, has been instrumental in moving toward community integration – "a life in the community for everyone." The

opportunity for all viewpoints to be presented and discussed openly and for stakeholders to work together to find consensus has enabled Iowa to make real progress.

- **Interagency Collaboration:** The Olmstead Consumer Task Force (OCTF) brings together individuals with disabilities, advocates, and representatives of twenty of Iowa's state departments and agencies to identify and recommend ways to overcome barriers to community living for people with disabilities.
- **Planned Downsizing of State Facilities:** For well over a decade, Iowa has had a commitment to downsize its two State Resource Centers (SRC) and transition residents to home and community based settings. The progress has been measured due to health and safety concerns and the need to develop greater service capacity in many communities, but SRC populations have been steadily shrinking. The Money Follows the Person project has been a very effective tool in supporting the transition of individuals with the most challenging and complex needs. Iowa has set a target goal of reducing the number of SRC residents by twenty-four persons each year.
- **Collaboration with Private Providers:** The Department has worked closely with the Iowa Association of Community Providers (IACP), the largest community provider organization in Iowa, to assist service providers in building community capacity and in changing business practices to favor greater integration and more personal choice for consumers. The IACP has been instrumental in providing training and technical assistance to members in aligning their programs and services with the goals of the Olmstead MHDS State Plan. Private providers who have historically offered services in large congregate settings have engaged in voluntary efforts to downsize those facilities and develop more integrated community living options for the people they serve.

We thank you for your continued engagement and partnership to help serve all Iowans.

Sincerely,



Charles M. Palmer  
Director

CMP/djj



**CABINET FOR HEALTH AND FAMILY SERVICES  
OFFICE OF THE SECRETARY**

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**Audrey Tayse Haynes**  
Secretary

September 13, 2012

Senator Tom Harkin  
Chairman  
Committee on Health, Education, Labor and Pensions  
United States Senate  
Washington, DC 20510-6300

RE: Kentucky Olmstead Plan

Dear Senator Harkin:

I received your letter dated June 22, 2012 requesting information about efforts to ensure that the Americans with Disabilities Act's promise of the opportunity to live, work, and receive services in the greater community is being met in Kentucky. The six specific questions that you asked are answered below.

*(1) For each year from FY 2008 to the present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long term care units of psychiatric hospitals, and board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program.*

New Transitions from Facility to Community per FY				
Year	Type	State Funded Transitions	Transfer to Community via waivers or Money Follows the Person	Total
2008	Nursing Facility		592	592
2008	State Nursing Facility (IMD)	4		4
2008	Intermediate Care Facility (DD)		29	29
2008	State Psychiatric Hospital	50		50
2008	Specialized Personal Care Home	31		31
	Total	85	621	706



Year	Type	State Funded Transitions	Transfer to Community via waivers or Money Follows the Person	Total
2009	Nursing Facility		504	504
2009	State Nursing Facility (IMD)	2		2
2009	Intermediate Care Facility (DD)		46	45
2009	State Psychiatric Hospital	32		32
2009	Specialized Personal Care Home	40		40
	Total	74	549	623
2010	Nursing Facility		453	453
2010	State Nursing Facility (IMD)	1		1
2010	Intermediate Care Facility (DD)		70	70
2010	State Psychiatric Facility	36		36
2010	Specialized Personal Care Home	36		36
	Total	73	523	596
2011	Nursing Facility		578	578
2011	State Nursing Facility (IMD)	4		
2011	Intermediate Care Facility (DD)		92	92
2011	State Psychiatric Facility	29		
2011	Specialized Personal Care Home	26		
	Total	59	670	729
2012	Nursing Facility		555	555
2012	State Nursing Facility (IMD)	0		
2012	Intermediate Care Facility (DD)		41	41
2012	State Psychiatric Facility	11		
2012	Specialized Personal Care Home	49		
	Total	60	596	656
		<b>Total State Funded Transitions</b>	<b>Total Transfer to Community via waivers or Money Follows the Person</b>	<b>Total</b>
2008-2012	Nursing Facility		2682	2682
2008-2012	State Nursing Facility (IMD)	11		11
2008-2012	Intermediate Care Facility (DD)		277	277
2008-2012	State Psychiatric Facility	158		158
2008-2012	Specialized Personal Care Home	182		182
	<b>Grand Total</b>	<b>351</b>	<b>2959</b>	<b>3310</b>



- (2) *The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with Intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.*

**State FY -13 Allocations**

<b>Program</b>	<b>Allocation</b>
Nursing Facilities (Medicaid)	\$ 257,648,000
Intermediate Care Facilities (DD) (Medicaid)	\$ 39,533,000
Psychiatric Facilities (Medicaid)	\$ 23,705,000
State Nursing Facilities (IMD)	\$ 15,443,000
State Psychiatric Facilities	\$ 107,474,000
Specialized Personal Care Homes	\$ 67,111,000
Group Homes (DD)	\$ 7,135,000
State Supplementation for Individuals Residing in Personal Care Homes	\$ 16,900,000
Model Waiver II Ventilator Dependent	\$ 1,185,000
Money Follows the Person Services (Medicaid)	\$ 2,712,000
Home and Community Based for Aged/Disabled (Medicaid Waiver)	\$ 7,608,000
Acquired Brain Injury – Acute (Medicaid Waiver)	\$ 5,873,000
Acquired Brain Injury – Long Term Care (Medicaid Waiver)	\$ 3,648,000
Traumatic Brain Injury	\$ 3,405,000
Severe Mental Illness (Medicaid I Plan)	\$ 600,000
Michelle P (Non-Residential Medicaid Waiver DD/ID)	\$ 48,605,000
Supports for Community Living (Residential Medicaid Waiver DD)	\$ 81,198,000
Supported Housing	\$ 2,598,000
HomeCare (HC)	\$ 17,032,000
Adult Day Social Care	\$ 2,755,000
Adult Day Health Care (Medicaid)	\$ 19,091,000
Personal Care Attendant Program (PCAP)	\$ 4,140,000
Hart Supportive Living (HSL)	\$ 6,907,000
<b>TOTAL</b>	<b>\$ 742,306,000</b>

**(3) For each year from FY 2008 to the present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program –including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.**

Waiver	Targeted Population	State Agency	Local Agencies
Acquired Brain Injury (ABI)*	Short-term, intensive supports for those with an acquired brain injury	Department for Medicaid Services (DMS), Department for Aging and Independent Living (DAIL)	<ul style="list-style-type: none"> <li>• Statewide network of private providers.</li> <li>• Some Community Mental Health Centers (CMHC; optional)</li> </ul>
Acquired Brain Injury – Long Term Care (ABI-LTC)*	Acquired brain injury with long-term supports	DMS	<ul style="list-style-type: none"> <li>• Statewide network of private providers.</li> <li>• Some CMHC (optional)</li> </ul>
Home and Community Based (HCB)*	Elderly or disabled who meet nursing facility level of care	DMS, DAIL	<ul style="list-style-type: none"> <li>• Area Agencies on Aging and Independent Living (AAAIL)</li> <li>• Home Health Agencies</li> </ul>
Michelle P*	Intellectual disabilities and/or developmental disabilities	DMS, Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), DAIL	<ul style="list-style-type: none"> <li>• Statewide network of private providers.</li> <li>• CMHC (optional)</li> </ul>
Model II	Ventilator dependent	DMS	<ul style="list-style-type: none"> <li>• Home Health Agencies</li> </ul>
Supports for Community Living (SCL)*	Intellectual disabilities and/or developmental disabilities	DMS, DBHDID, DAIL	<ul style="list-style-type: none"> <li>• Statewide network of private providers.</li> <li>• CMHC</li> </ul>

EXPANSIONS IN THE NUMBER OF MEMBERS SERVED IN THEIR OWN HOMES						
FUNDING CATEGORY [ANNUAL GROWTH]	2008	2009	2010	2011	2012	Cumulative Growth (2008-2012) <sup>1</sup>
<b>FUNDED THROUGH THE DEPARTMENT FOR MEDICAID SERVICES (DMS)</b>						
Acquired Brain Injury Acute	160	206	224	164	191	31
		29%	9%	-27%	16%	19%
Acquired Brain Injury CDO <sup>2</sup>	0	9	15	17	12	12
			67%	13%	-29%	33%
Acquired Brain Injury LTC	0	53	172	172	205	205
			225%	0%	19%	287%
Acquired Brain Injury LTC CDO <sup>2</sup>	0	0	6	21	41	41
				250%	95%	583%
Support for Community Living	3,124	3,346	3,434	3,433	3,689	565
		7%	3%	0%	7%	18%
Supports for Community Living CDO <sup>2</sup>	0	0	73	100	117	117
				37%	17%	60%
Michelle P Waiver	0	704	2,382	3,903	6,027	6,027
			238%	64%	54%	756%
Michelle P Waiver CDO <sup>2</sup>	0	174	1,006	2,127	3,474	3,474
			478%	111%	63%	1897%
Model Waiver	55	56	60	54	64	9
		2%	7%	-10%	19%	16%
Home and Community Based Waiver	11,635	12,017	12,056	11,587	10,263	-1,372
		3%	0%	-4%	-11%	-12%
Home and Community Based CDO <sup>2</sup>	0	1,566	1,813	2,102	2,255	2,255
			16%	16%	7%	44%
Money Follows the Person	0	16	67	183	314	314
			319%	173%	72%	1863%
Money Follows the Person CDO <sup>2</sup>	0	0	0	55	65	65
					18%	18%
<b>DMS SUBTOTAL</b>	<b>14,974</b>	<b>16,398</b>	<b>18,395</b>	<b>19,496</b>	<b>20,753</b>	<b>5,779</b>
(CDO Programs not counted twice)		10%	12%	6%	6%	39%
<b>FUNDED THROUGH THE DEPARTMENT FOR BEHAVIORAL HEALTH, DEVELOPMENTAL AND INTELLECTUAL DISABILITIES (DBHDID)</b>						
Community Based Services	7,492	8,665	8,148	8,510	7,951	459
		16%	-6%	4%	-7%	6%
Supportive Housing	41	46	72	94	122	81
		12%	57%	31%	30%	198%
<b>DBHDID SUBTOTAL</b>	<b>7,533</b>	<b>8,711</b>	<b>8,220</b>	<b>8,604</b>	<b>8,073</b>	<b>540</b>
		16%	-6%	5%	-6%	7%
<b>GRAND TOTAL</b>	<b>22,507</b>	<b>25,109</b>	<b>26,615</b>	<b>28,100</b>	<b>28,826</b>	<b>6,319</b>
		12%	6%	6%	3%	28%

1 - For those categories which were not operational in 2008, cumulative growth refers to growth from the first year of operation through 2012.

2 - Community directed options are a subset of the services provided in the larger funding category. This option allowed the member to choose their own provider. These members are included in the larger categories, but were displayed separately to demonstrate the additional autonomy afforded to members choosing to utilize it.

State Funds Utilized To Provide Care for Members in their Homes						
FUNDING CATEGORY [ANNUAL GROWTH]	2008	2009	2010	2011	2012	Cum. Growth (2008-2012) <sup>1</sup>
<b>FUNDED THROUGH THE DEPARTMENT FOR MEDICAID SERVICES (DMS)</b>						
Acquired Brain Injury - Acute	\$3,375,700	\$4,296,500	\$2,958,200	\$3,829,500	\$5,306,400	\$1,930,700
		27%	-31%	29%	39%	57%
Acquired Brain Injury - LTC	-	\$354,200	\$1,295,700	\$2,503,300	\$3,591,600	\$3,591,600
			266%	93%	43%	914%
Support for Community Living	\$63,629,400	\$68,291,200	\$47,750,100	\$59,121,000	\$74,583,900	\$10,954,500
		7%	-30%	24%	26%	17%
Michelle P. Waiver	-	\$1,036,900	\$5,924,100	\$18,762,000	\$35,792,500	\$35,792,500
			471%	217%	91%	3352%
Model Waiver	\$1,528,600	\$1,458,200	\$1,025,800	\$1,345,200	\$1,603,600	\$75,000
		-5%	-30%	31%	19%	5%
Home and Community Based Waiver	\$19,912,700	\$21,839,500	\$15,542,800	\$18,890,500	\$23,006,600	\$3,093,900
		10%	-29%	22%	22%	16%
Money Follows the Person	\$-	\$11,900	\$248,500	\$2,154,000	\$2,269,900	\$2,269,900
			1988%	767%	5%	18975%
<b>DMS SUBTOTAL</b>	<b>\$88,446,400</b>	<b>\$97,288,400</b>	<b>\$74,745,200</b>	<b>\$106,605,500</b>	<b>\$146,154,500</b>	<b>\$57,708,100</b>
		10%	-23%	43%	37%	65%
<b>FUNDED THROUGH THE DEPARTMENT FOR BEHAVIORAL HEALTH, DEVELOPMENTAL AND INTELLECTUAL DISABILITIES (DBHDID)</b>						
Community Based Services	\$24,364,600	\$23,930,200	\$16,766,300	\$16,363,400	\$16,729,300	\$(7,635,300)
		-2%	-30%	-2%	2%	-31%
Supportive Housing	\$945,700	\$1,069,000	\$1,274,400	\$1,779,800	\$1,903,000	\$957,300
		13%	19%	40%	7%	101%
<b>DBHDID SUBTOTAL</b>	<b>\$25,310,300</b>	<b>\$24,999,200</b>	<b>\$18,040,700</b>	<b>\$18,143,200</b>	<b>\$18,632,300</b>	<b>\$(6,678,000)</b>
		-1%	-28%	1%	3%	-26%
<b>GRAND TOTAL</b>	<b>\$113,756,700</b>	<b>\$122,287,600</b>	<b>\$92,785,900</b>	<b>\$124,748,700</b>	<b>\$164,786,800</b>	<b>\$51,030,100</b>
		7%	-24%	34%	32%	45%

1 - For those categories which were not operational in 2008, cumulative growth refers to growth from the first year of operation through 2012.

**(4) The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revision that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.**

**a) Contents of KY Olmstead Plan for increasing community integration:**

See attached

**b) Description of the strategic planning process used to create the plan and subsequent revisions:**

In May of 2002, the Secretary of the Cabinet for Health Services created, by Administrative Order, the Cabinet's Olmstead Consumer Advisory Council. The Council provided consumer participation in the Olmstead compliance planning process and promoted connectivity to other committees and task forces such as HB 144 Committee, HB 843 Committee and the Long Term Care Quality Task Force. Over 35 individuals representing various categories of disability, geographic regions and cultural diversity were identified for membership on the Consumer Council.

The Council was responsible for the following activities:

- Promoting accurate and timely access for consumers regarding the Commonwealth's planning efforts by sharing information with respective consumer and advocacy organizations throughout the state by utilizing the organizations' newsletters, meetings, or community forums

- Advising the Cabinet for Health Services about issues, concerns or barriers for persons with disabilities, and enhancing the Cabinet's cultural sensitivity, diversity and planning efforts throughout the long term initiatives for Olmstead compliance
- Providing on-going information to the Cabinet for Health Services regarding services and supports needed for individuals of all ages and with all types of disabilities

**c) *Process to incorporate revisions including any new tools created by the federal government to support community-based services.***

Following the creation of the Kentucky Olmstead Plan, Kentucky has continued to actively seek input from various constituent groups regarding services for individuals with disabilities. Council duties are now provided through a variety of appointed, advisory and advocacy Councils including, but not limited to: the HB 144 Commission, the Institute on Aging, ARC of Kentucky, Kentucky Partnership for Families and Children, NAMI Kentucky, Advocates to Reform Medicaid Services, AARP, Mental Health Coalition, The Long Term Living Initiative, Kentucky Voices for Health and the Medicaid Advisory Council.

**d) *The extent to which you have been successful in meeting any quantifiable goals identified within:***

**GOAL 1: Consumer Involvement**

The foundation to consumer involvement in Kentucky is the belief that people with disabilities have life experiences and expertise that are valuable resources in the development of agency policy and solutions to problems relative to the service objectives of programs. For that reason, Kentucky has made a special effort to form collaborative relationships with individuals with disabilities who are recipients of service.

Each Department within the Cabinet for Health and Family Services has developed numerous partnerships with consumers and consumer advocacy groups. In addition, each Department has revamped their websites to make them more consumer friendly which, in turn, ensures consumers will be fully informed and fully involved in policy decisions.

Since 2002, a Consumer Directed Option (CDO) was created as a component within Kentucky's Home and Community Based waivers. CDO allows waiver eligible members to choose a provider for their non-medical waiver services, giving them greater freedom of choice, flexibility and control over their supports and services. Members can choose to direct all or some of their non-medical waiver services. Waiver participants in rural areas have found this initiative provides them greater opportunity to locate much needed supportive services. The growth of this program is most significant in waivers that do not offer residential services. See CDO Tab for specific counts.

In May 2007, Kentucky was awarded a Federal demonstration grant known nationally as Money Follows the Person. This grant for Kentucky was renamed to Kentucky Transitions; its goal is to provide transition assistance and community supports to any resident of a nursing facility or ICF/MR who chooses to move back to the community. Upon award of the demonstration grant, an initial stakeholder group was expanded into the Kentucky Transitions Steering Committee.

The invitation to participate on the Steering Committee was widely circulated among consumers, stakeholders and stakeholder groups already organized around issues related to the mission and goals of the program. Participants were self-selected and no interested participant was refused. In some instances, special invitations were proffered to ensure equitable representation in the planning process. The Steering Committee was comprised of a representation of consumers, consumer advocates, service providers and personnel from a variety of state agencies.

Additional details can be found here: [http://chfs.ky.gov/nr/ronlyres/2d8814ad-c347-4f3c-b986-b4f3ac683d22/0/mfpoperational\\_protocol\\_amended12272011.pdf](http://chfs.ky.gov/nr/ronlyres/2d8814ad-c347-4f3c-b986-b4f3ac683d22/0/mfpoperational_protocol_amended12272011.pdf)

## **Goal 2 - Self-Determination**

In Kentucky, self-determination, also known as consumer directed and participant directed services, is both a movement and a mode of delivering services and supports to people with disabilities. Since the conception of the Olmstead Plan, Kentucky has greatly enhanced the system capacity to support self-determination initiatives. Currently all of the six Medicaid waivers and several programs within the Department for Aging and Independent Living offer self-directed options for receiving services.

In 2007, the Michelle P. waiver program was developed to serve Kentucky residents as an alternative to institutional care for individuals with mental retardation or developmental disability. These individuals meet the level of care criteria for placement in an Intermediate Care Facility for the Mentally Retarded or Developmentally Disabled (ICF/MR/DD) and whose services in an ICF/MR/DD would qualify for payment under the State Plan for Medical Assistance. This program is designed to allow an individual to remain in or return to the community in the least restrictive setting.

## **GOAL 3: Informed Choice**

Since the Olmstead decision, recipients of service expect and are expected to play a greater role in decisions about the care and support they receive. To make informed choices, individuals need information. Kentucky's Aging Disability Resource Center (ADRC) network is built upon the premise that all consumers and families should have meaningful information about choices that they can understand. Kentucky's ADRCs, accessible through numerous locations throughout the state as well as virtually via the web, are the first place to go to get accurate, unbiased information on all aspects of life related to aging or living with a disability. The ADRC provides information specifically tailored to individual situations encompassing a broad range of programs and services from anywhere within the state.

The ABI waivers and in the very near future the Supports for Community Living and Michelle P waiver will require conflict-free case management (i.e., no conflict of interest regarding the case managers and the service providers). One component of the State Balancing Incentives Payment Program is conflict-free case management.

Additionally waiver members or their representatives are required to sign a freedom of choice form. It is available on line here:  
<http://chfs.ky.gov/NR/rdonlyres/D6925158-4EDF-4843-925C-CEE5D38E90CC/0/MAP23.pdf>

## **Goal 4 – Appeal Process**

Kentucky strives to ensure individuals with disabilities and their families or guardians are provided with a formal means to appeal administrative decisions with which they disagree. Many of the programs within the Cabinet have revised regulations to include a formalized method for dispute resolution when conflicts arise. In addition, Kentucky is currently reviewing the current formal administrative hearing process to determine potential areas for simplification.

## **Goal 5 - Independent Assessment**

The Supports Intensity Scale which is a tool to assess the support needs of adults with I/DD is now being utilized within the SCL waiver. Results of this assessment tool define the type of supports needed (i.e. none, verbal prompting and full physical assistance), the daily support time required to support person in a wide variety of activities and the frequency of supports required for the individual to participate in the various activities (i.e. dressing, preparing food, using technology for learning and going to visit family and friends).

The Department for Aging and Independent Living has developed a Care Coordination process that creates a single point of entry and coordinated service system for consumers receiving programs within DAIL. The process for determining an individual's eligibility and need for services will be based on objective criteria focusing on functional ability and recommendations by the treatment team. As a result, current assessment tools were evaluated, and new tools are being developed. In addition, the assessment process to determine an individual's eligibility and need for services has been enhanced for the brain injury population.

### **Goal 6 – Transition to the Community**

There is a standard transition planning tool utilized by each of the four state owned ICF/DDs. This tool provides information for community based providers concerning support needs, what is important both to and for the person and any other information necessary to ease the transition process while maintaining the health, safety and welfare of the individual.

The DBHDID has approved a plan to eventually move all of the individuals who reside within a Specialized Personal Care Home program located on the grounds of a psychiatric hospital from the current facility to permanent, community-based housing settings at scattered sites in the Louisville metro area. Once all residents have moved, the program will cease to operate as a licensed personal care home. Currently, some residents of the program reside in the facility while others reside in the community. Services are provided to residents of the program by staff in both locations. It is anticipated that this transition will be completed by June 30, 2013. The ultimate purpose of the transformation of the program is to ensure that members of the target population for this type of specialized program are afforded opportunities for community integration and services that reflect a behavioral health recovery orientation. The program is therefore in the process of transitioning from a specialized personal care home model to a permanent, supportive housing model, which is an evidence-based practice approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) and DBHDID.

In 2008, the Acquired Brain Injury Long Term Care Waiver program was developed to provide an alternative to institutional care for individuals that have reached a plateau in their rehabilitation level and require maintenance services to avoid further institutionalization and to live safely in the community. This program allowed an additional 200 individuals with acquired brain injuries to move back to their community.

Information and Referral: A statewide network of Area Agencies on Aging's Aging and Disability Resource Centers (ADRC) was realized in 2007 to assist any one, and any age, with any disability to access community based services. This "one-stop shop" single point of entry into community services was further elevated when they were designated as Medicaid's Local Contact Agency for individuals who desired to be transitioned from a nursing home into the community, regardless of funding source. Referred to as "Section Q", once an individual is referred to an ADRC, transition plans are developed appropriately.

### **Goal 7 – Avoid Unwanted Institutionalization**

The DBHDID has \$1.9 million in the annual SGF budget for DD Crisis Prevention and Intervention Services available through the 14 Regional Mental Health Boards.

This program is specifically designed to keep people in their homes and jobs if they or their family/caregivers experience a crisis. In 2010, there were 527 contacts with 378 people (72%) remaining in the community, and 227 diverted from psychiatric hospitalization or facility placement. In 2011, there were 832 contacts with 645 people (78%) remaining in the community, and 435 people diverted from psychiatric hospitalization or facility placement. Between January and March 2012, there have been 209 contacts with 161 people (77%) in the community, and 91 diverted from psychiatric hospitalization or facility placement.

In 2008, the DBHDID and the Kentucky Housing Corporation (KHC) entered into an agreement to create an Olmstead Housing Initiative (OHI). The goal of the initiative is to create or identify appropriate community housing for individuals who are part of the Olmstead population. The DBHDID provides funds of \$386,000 per year for this initiative.

The DBHDID also has a partnership with the Louisville Metro Housing Authority to provide set-aside vouchers for persons that meet the Olmstead criteria. 59 people have received housing vouchers and have been transitioned into community housing or have remained in the community rather than becoming institutionalized.

#### Quality Community Supports:

- **Performance Measures:** Performance measures have been enhanced for community based providers through contractual agreements. The Department also requires satisfaction surveys across all programs. The Department is currently in the process of developing a standardized statewide program outcome and satisfaction survey. The Department is also delaying needs for services by providing evidence based prevention programs in the community. The Department has also increased the number of performance measures specific to each program through contractual agreements with community providers in order to determine program effectiveness
- **Personal Services Agencies:** Personal Services Agencies are required to meet certification standards in Kentucky that are defined by regulation. The Office of Inspector General issues initial certification as well as annual recertification. A list of agencies is maintained on the Cabinet's website for the general public. Currently, there are 141 Personal Services Agencies across the state.

#### Goal 8 - Housing Options

The Cabinet for Health and Family Services has contracted with the Kentucky Housing Corporation (KHC) to assist in the identification and development of housing opportunities for those transitioning through Kentucky Transitions. This partnership has resulted in active involvement by KHC and other public housing entities in the development and implementation of Kentucky Transitions. The goal is to offer choices in housing to each participant who requires assistance by allowing them to participate in the decision making process, including indicating their preference of county and residence.

An array of residential options was developed for the revised SCL waiver. The desires of the people to live independently, their support needs and the frequency of assistance needed were considered when establishing the types of residential options which may meet the desires and assessed needs of the person.

The DBHDID has contracted with three Olmstead Homes which serves numerous individuals yearly. Kentucky Community Mental Health Centers have also developed 345 apartment units across the state to serve persons with a mental illness.

#### Goal 9: Transportation

Currently, the Department for Medicaid Services operates a successful non-emergency medical transportation (NEMT) program. This program is a collaborative effort between the Department for Medicaid Services and the Office of Transportation Delivery located in the Transportation Cabinet. The Medicaid NEMT program provides transportation to Medicaid services for eligible members. In 2012, the program provided over 2 million trips to 154,997 members. Medicaid covered services include trips to activities outlined in a member's plan of care, such as trips to day centers for recreational activities. Many of Medicaid's waiver providers are also enrolled as NEMT providers.



During January 2012, the National Cooperative Highway Research Program released a research report in which Kentucky's NEMT program was spotlighted as a model for positive partnerships between agencies and taxi companies. The report indicated that the state achieved cost saving success through oversight provided via the brokerage model in partnership with taxi cabs. (See copy of report attached)

The Cabinet for Health and Family Services will continue to work collaboratively with the OTD to enhance transportation services for Medicaid individuals who transition to community residences. In addition, the Cabinet will collaborate with the Department for Education and the Workforce Development Cabinet to develop additional transportation services as necessary to meet the needs of individuals with disabilities and ensure that they receive safe, reliable, and necessary medical transportation.

**(5) Any policy recommendation you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of the new federally available assistance.**

- Expansion of the Community First Choice option to include all community services (supported employment, community integration, etc.) to create a "supermarket" of services for people based on functional need rather than diagnosis
- Streamline the process for states to request waiver amendments for purpose of increasing slots by using appropriated funds by state legislature
- Elimination of the Institute for Mental Disease (IMD) exclusion would allow more people to be served by freeing up state dollars to serve people in the community. This would also allow the Behavioral Health population to benefit from the Money Follows the Person program, which only serves person in Medicaid funded institutions. This could allow more people to move into the community.
- Reinstate the increase Federal Medical Assistance Percentage
- Higher federal match for community based psychosocial treatments and interventions to incentivize community based services instead of inpatient institutional services
- Eliminate requirement for budget neutrality for community waiver programs
- Eliminating the need for slots within waiver programs

**(6) Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.**

- Each of our four state psychiatric hospitals has an assigned DBH and DDID liaison that participates in Olmstead meetings, participates in Continuity of Care and/or team meetings, provides technical assistance regarding discharge planning and works with community providers and regional CMHCs to develop individualized supports. DDID is beginning to work with professionals within the ICF/DD facilities and psychiatric hospitals to provide consultation, technical assistance, training and prevention planning in an effort to divert individuals from higher levels of care and to provide families, caregivers and community providers' access to skilled clinical professionals.
- The DBHDID has a contract with the Kentucky Housing Corporation which provides a housing voucher, deposits and moving expenses for individuals meeting Olmstead Criteria. Currently, 70 people have received this assistance. We have also used these funds to help support the Olmstead Houses (Wellspring, New Beginnings, KRCC), and the SSI/SSDI Outreach (which assists with disability applications).

- The Department also has a partnership with the Louisville Metro Housing Authority to provide set-aside vouchers for persons that meet the Olmstead criteria. Currently, 59 people have received housing vouchers and have been transitioned into community housing or have remained in the community rather than becoming institutionalized.
- Consumer Directed Option was added to DD waivers in 2005 which enabled participants to have more choice and control over their services in the community. Currently, 6581 people are utilizing this option to access community services.
- The Department is also in the process of applying for a 1915(l) State Plan Amendment through Medicaid to provide intensive community services to Olmstead eligible individuals. The plan is to provide Assertive Community Treatment, Supported Employment and Peer Support Services to 200 individuals in the first year and an additional 200 individuals in the second year. \$600,000 in state funds has been allocated for the state match in the first year and \$1.2 million in the second year.
- Implemented the Michelle P. and Home/Community-Based waiver to provide in home supports to people with developmental disabilities. This waiver is currently capped at 10,000 participants with 7,000 currently enrolled.
- Amended two waivers to allow more integrated services and more options for people to remain in or move into their own homes.
- Development and implementation of Transformation Plans for state ICF/DD facilities. The plans focus on short term admissions, consultation to the community at large, development of practicum and internship opportunities for Graduate level students at KY Universities and Colleges for additional professional capacity and development of interest in field of DD and enriching relationships with stakeholders and community based providers to improve access to appropriate supports.
- Creation of a standardized process for transitions from ICF/DD to community based supports to increase the number of successful transitions. In 2008, the census was 491; the current census is 329.
- Establishment of community based 4-bed ICF/DD residences
- Development of Specialty Medical and Psychiatric Outpatient Clinics on ICF grounds which are open to all adults with an intellectual or other developmental disability that have transitioned out of a ICF. Medicaid State Plan Amendment has been submitted for approval to open the clinics to all individuals residing in eth community.
- The State Olmstead Wraparound dollars (\$800,000) provides funding for the transition of individuals who have been hospitalized for more than 90 days in state psychiatric facilities. Transition teams comprised of the representatives from the hospital, the Regional Board, DBHDID staff, and other appropriate stakeholders meet on a frequent basis to review transition plans to assure a smooth and timely discharge to the community for identified patients. Funds were first appropriated during the 2002 legislative session. Some of these funds support three Olmstead Houses (24 hour support) in the state, which has allowed nine individuals with extensive hospital stays to live in the community.
- The Olmstead Housing Initiative (\$386,000) has provided rental assistance vouchers and moving assistance to over 70 individuals, primarily adults with serious mental illness who meet the Olmstead definition; this assistance allows them to move into regular housing in the community.
- A Housing Plan was developed by DBH in 2008 in response to the Voluntary Compliance Agreement with the Office of Civil Rights (OCR). The Housing Plan identifies strategies for moving individuals with serious mental illness from institutions to the community.

- A project entitled DIVERTS (Direct Intervention: Very Early Treatment System) was implemented in the Western State Hospital Catchment area during SFY 2007 as a partnership between KDBHDID, the four respective Community Mental Health Centers (CMHC) and the National Alliance of the Mentally Ill (NAMI). \$2 million that had originally been budgeted to the psychiatric hospital in Western Kentucky, because of their rising admission numbers, was instead allocated across the four Boards serving that hospital "catchment" area. The aim of this project is to reduce admissions to the hospital. The use of telecommunications technology to establish Internet connections between the hospital and the four CMHCs, which creates a "virtual treatment team" between the community and inpatient treatment staffs, has been particularly helpful in this largely rural area of the state.
- The DBHDID has approved a plan to eventually move all of the individuals who reside within the Center for Rehabilitation and Recovery (CRR) program from the current facility on the grounds of Central State Hospital to permanent, community-based housing settings at scattered sites in the Louisville metro area. Once all residents have moved, the program will cease to operate as a licensed personal care home. Currently, some residents of the CRR program reside in the facility while others reside in the community. Services are provided to residents of the program by CRR staff in both locations. It is anticipated that this transition will be completed by June 30, 2013. The ultimate purpose of the transformation of the CRR program is to ensure that members of the target population for this type of specialized program are afforded opportunities for community integration and services that reflect a behavioral health recovery orientation. The CRR program is therefore in the process of transitioning from a specialized personal care home model to a permanent, supportive housing model, an evidence-based practice approved by the Substance Abuse and Mental Health Services Administration (SAMHSA) and DBHDID.

Thank you for the opportunity to provide information on the progress that the Commonwealth of Kentucky has made in complying with the landmark decision issued by the United States Supreme Court in the *Olmstead* case. Please contact me if you require additional information.

Sincerely,

  
Audrey Tayse Haynes



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TTY USERS CALL VIA MD RELAY

February 4, 2013

The Honorable Tom Harkin  
Chairman  
Committee on Health, Education, Labor, and Pensions  
United States Senate  
SD-428  
Washington, DC 20510-6300

Dear Senator Harkin,

Thank you for your correspondence requesting information on how Maryland has responded to the Supreme Court's *Olmstead v. L.C.* decision, which held that the Americans with Disabilities Act requires states to administer services to individuals with disabilities in the most integrated settings appropriate to their needs. Maryland is committed to serving individuals with disabilities in the most integrated settings possible. The State steadily continues to make progress toward achieving the goals outlined in *Olmstead* and has taken advantage of federal options to increase the number of individuals with disabilities served in the community. Answers to your specific requests for information are contained below.

(1) *For each year from FY 2008 to the present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long term care units of psychiatric hospitals, and board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program.*

Since 2008, Maryland has transitioned more than 2,400 Medicaid recipients out of institutions and into the community with needed supports. The number of transitions, for each year requested, is provided in **Table 1** below.

**Table 1**

	2008	2009	2010	2011	Total
Transitions	473	662	580	700	2,415

(2) *The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care*



*facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.*

The amount of dollars spent in fiscal year 2011 on serving individuals with disabilities in each of the requested settings is provide below in **Table 2**. Fiscal 2011 ended June 30, 2011.

**Table 2**

	State Expenditure in FY11
Nursing Homes	\$580,236,113
ICF for Intellectual or Developmental Disabilities	\$13,311,458
Psychiatric Hospitals	\$11,106,874
Group Homes	\$278,455,652
Individual Homes	\$287,934,715

(3) *For each year from FY 2008 to the present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program -- including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.*

Maryland has made several efforts to restructure and expand its system of long-term services and supports for individuals with disabilities and older adults since 2008. These efforts include expanding 1915(c) waiver slots, adding services to existing programs, and increasing outreach to potentially eligible individuals. Maryland's participation in the Money Follows the Person (MFP) Demonstration has increased transitions from institutions to services, which has driven the expansion. Increased enrollment and expanded service offerings represent an increase of \$77,630,035 of State funds from Fiscal Years 2008 to 2011 for home and community-based services. In addition, Maryland has invested \$6,071,134 state dollars into MFP rebalancing initiatives including expanding the Aging and Disability Resource Center sites, providing education and outreach, and improving transition coordination.

(4) *The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.*

Maryland has a vibrant community of stakeholders and advocates that have driven reform of the long-term services and support (LTSS) system over the past 5 years. Since 2008,

stakeholders have met monthly to guide the MFP demonstration efforts and quarterly to evaluate options for reform through a long-term care reform workgroup that includes advocates, providers, and legislators. These groups have aided the development of the MFP Operational Protocol that outlines the efforts to expand access to community-based services and describes the goals and efforts of the State. These efforts include enhanced outreach to institutional residents, options counseling on home and community-based services and supports, and statewide implementation of Aging and Disability Resource Center sites. Maryland has consistently met its benchmarks related to shifting spending and increasing participation in community-based services.

In addition to participation in the MFP demonstration, Maryland is participating in the Balancing Incentive Program, developing an application for the Community First Choice state plan personal care option, exploring an application for a 1915(i), and evaluating Health Homes as an option for individuals with behavioral health support needs.

*(5) Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.*

Maryland recommends the following measures to expand access to home and community-based services.

- Incentivize diversion from institutions as the Money Follows the Person Demonstration incentivized transition out of institutions. Further diversion incentive programs would reduce institutionalization for individuals currently eligible for community Medicaid and eliminate the barriers to community-living caused by the institutional stay such as loss of housing and learned dependence.
- Continue collaboration between the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Housing and Urban Development (HUD) to expand affordable housing options for people in need of long-term support. Through this partnership, HUD could designate funding for rehabilitation of vacant housing stock to create more affordable accessible housing options to support transitions from institutional settings and issue additional HUD Category II non-elderly disabled vouchers and allow nonprofit organizations to access vouchers if the applicable public housing authority chooses not to seek the new vouchers.
- Expand rural community health centers with an incentive to utilize staff and physical locations that were previously Intermediate Care Facilities for the Developmentally Disabled to support job retention and re-tooling in areas impacted by institutional closure.
- Continue to support the Aging and Disability Resource Centers (ADRCs) as a means to streamline eligibility determination for long-term services and supports.

(6) *Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.*

Maryland has been successful in several efforts to expand home and community based services. Key components of successful strategies include the following:

- Executive Leadership: Maryland's executive leadership has prioritized the reform of long-term services and supports through budget initiatives and legislation.
- Institutional Closure: In Maryland, Governor O'Malley made the decision to close the State's oldest and largest institution for individuals with intellectual disabilities. The plan incorporated best practices including: person centered planning; family engagement; and funding to build community capacity.
- Policy: Maryland created a policy that allows Medicaid-eligible institutional residents to apply for home and community-based services regardless of budgetary caps on enrollment for those services. This policy facilitates increased institutional transition.
- Multi-agency Collaboration for Housing: The Maryland Department of Disabilities convened a Task Force on Affordable Housing for People with Disabilities, comprised of State policymakers, public housing authorities and advocates. This Task Force led to increased partnerships that allowed Maryland to take advantage of recent housing opportunities presented by CMS and HUD. The partnership also serves to integrate housing into support planning for those in need of long-term supports.
- Multi-agency Collaboration for Eligibility and Access: Maryland, through MFP and the ADRC grants, has developed collaborations between several Maryland government agencies that offer services and supports for individuals with long-term support needs. These partnerships have resulted in a stronger ADRC program with a No Wrong Door approach to enhancing access to supports across silos.
- Peer Support Models: The use of peers (people with disabilities and older adults) who have successfully lived in the community to help others navigate the system and overcome obstacles. Peer support builds on the strengths and success of real life experiences to address individual and family concerns about choosing the community as an alternative than an institution.

In addition, information about how Maryland has taken advantage of federal options is addressed in the responses to Questions 3 and 4 above.

The Honorable Tom Harkin  
Chairman  
U.S. Senate Committee on Health, Education, Labor, and Pensions  
Page 5

We hope that this information is helpful to you. Thank you and your colleagues for your commitment to providing continued federal support of options that better enable states to serve more individuals with disabilities in the most integrated settings appropriate to their needs. If you have any questions about the information contained in this letter, please do not hesitate to contact Ms. Marie Grant of the Maryland Department of Health and Mental Hygiene at 410-767-6480 or [marie.grant@maryland.gov](mailto:marie.grant@maryland.gov).

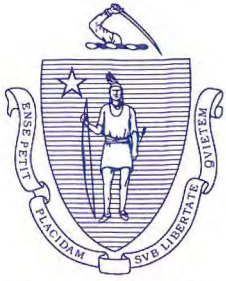
Sincerely,

A handwritten signature in black ink, appearing to read "Art Hally". The signature is written in a cursive style with a large, looping initial "A".

Governor

cc: The Honorable Barbara A. Mikulski  
The Honorable Benjamin L. Cardin





*The Commonwealth of Massachusetts  
 Executive Office of Health and Human Services  
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February 21, 2013

The Honorable Tom Harkin  
 Chairman, Senate Committee on Health, Education, Labor, and Pensions  
 United States Senate  
 Washington, DC 20510-6300

Dear Senator Harkin:

Thank you for your letter on the subject of helping individuals with disabilities who live, work, and receive services in their communities. The Commonwealth of Massachusetts' commitment to fully realizing the goals of the Americans with Disabilities Act (ADA) under the *Olmstead v. L.C.* decision could not be stronger.

Through your leadership, Congress has created groundbreaking opportunities for states and their Medicaid programs to provide options regarding community-based services to people with disabilities. As your letter describes, a number of different mechanisms were created to help states make home and community-based services and supports available to individuals who wish to avoid or are transitioning out of facility settings into stable, safe community settings. The Commonwealth of Massachusetts has made substantial use of the tools noted in your letter, as well as others. We appreciate the opportunity to update you on the strategies we are employing, the progress we have made, and our recommendations for other measures that would support these efforts. Below are our responses to the information requests enumerated in your letter.

**(1) The number of disabled people who moved from nursing homes, intermediate care facilities for individuals with intellectual disabilities, long-term care units of psychiatric hospitals, and chronic (long-stay) hospitals to living in their own home, for each year from FY 2008 through FY 2012**

**Table 1: Discharges\* by fiscal year**

Facility Type	2008	2009	2010	2011	2012
Nursing facility	724	897	1,078	1,106	956
ICF/MR	49	23	30	59	70
Psychiatric LTC units	562	599	714	567	527
Chronic (long-stay) hospitals	378	377	398	353	298



\*This chart shows discharges of disabled individuals who had been in a facility at least 90 days, who subsequently left the facility – this does not include individuals who transferred to another facility.

**(2) Massachusetts projected Medicaid spending for FY 13 for elder and disabled populations on each of the settings listed.**

**Table 2: Projected FY 13 spending**

<b>Setting</b>	<b>Projected Spending</b>
Nursing homes	\$ 1,550 M
Intermediate Care Facilities	\$ 133 M
Psychiatric hospitals	\$ 167 M
Community settings	\$ 2,444 M
Supportive housing in elder/ disabled public housing (state spending)	\$ 4 M

**(3) Expansion of the Commonwealth’s capacity to serve individuals with disabilities in the community as demonstrated by increases in Medicaid spending on home and community based services.**

Massachusetts has a relatively rich set of Medicaid State Plan benefits including Day Habilitation, self-directed Personal Care Attendant services, Adult Day Health, Adult Foster Care, and Group Adult Foster Care, as well as rehabilitation option services for chronically mentally ill members in the community. The state’s commitment to serving people at home is also evidenced by the expansion and strategic utilization of our Home and Community Based Services (1915(c) or HCBS) waivers.

<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012 projected</b>	<b>2013 projected</b>
\$1,619 M	\$1,899 M	\$2,072 M	\$2,175 M	\$2,305 M	\$2,444M

\*2012 and 2013 projected using a 6% annual trend factor

The Commonwealth began operation of our first HCBS waiver in the 1980s. Since FY08 we expanded the number of 1915(c) waivers in operation and experienced noteworthy increases in the total number of waiver participants served in these programs. In FY08, Massachusetts operated four HCBS waiver programs serving Frail Elders, Adults with Intellectual Disability, individuals with Traumatic Brain Injury, and children with Autism Spectrum Disorders. At that time, these waivers served a combined total of approximately 20,000 people.

Since then, the Commonwealth of Massachusetts initiated two new waivers for adults with Acquired Brain Injuries and recently received CMS approval for additional waivers to serve individuals in the Money Follows the Person Demonstration, further explained below. In addition, the original waiver for Adults with Intellectual Disability was replaced with three waivers that are more focused, containing service menus tailored to the specific needs of each waiver's particular population. This move to three waivers allows us to offer a wider range of services overall and to provide services to a larger number of participants with our existing state resources. Enrollment in our waiver programs has grown to approximately 26,000 participants. Approximately 40% of actual and projected HCBS expenditures is for waiver services, expected to be \$ 977.6 M in 2013.

Massachusetts continues to expand its existing commitment to supporting community living for people with disabilities across their lifespan through participation in the Money Follows the Person (MFP) Rebalancing Demonstration. The MFP Demonstration grant, received in April 2011, provides Massachusetts with federal funding to increase the use of home and community based services, eliminate barriers that prevent transitions from facility settings, and ensure quality improvements. MFP has allowed the Commonwealth to bring additional focus and resources to these efforts. In particular, the ability to address housing issues is an extremely valuable dimension that was not previously available through Medicaid funding.

The Commonwealth is proposing to further expand its use of HCBS waivers in tandem with the MFP Demonstration already in operation. We recently receive approval from CMS for two new 1915(c) waivers and a 1915(b) waiver proposed to operate concurrently, which will serve disabled individuals who transition from long stay institutional settings through the MFP Demonstration. Massachusetts' vision is to utilize these waivers to provide a cross-disability and cross-age approach to serving those eligible for the MFP Demonstration as they transition from facilities to live in the community, either into group home settings or their own or family homes. We will initially be able to serve people who are aged or disabled or both, and expect to expand the population to include individuals whose disability is based on a mental illness diagnosis. We look forward to new CMS policy which will allow combined target populations within a single waiver.

The state has utilized supportive housing in various forms, most significantly in the provision of community based supports to intellectually disabled and chronically mentally ill persons through both HCBS waivers and the rehabilitation option, as noted above. In addition, Massachusetts supports 31 Supportive Housing sites serving individuals in elder/disabled public housing sites at a cost of more than \$4 M. In a significant recent development, earlier this year we passed legislation for the development of up to 1,000 units of permanent supportive housing by 2015 for individuals who are homeless, persons with disabilities, elders and veterans. Interagency committees began meeting in June 2012 and a multi-agency memorandum of understanding was signed in October, 2012.

**(4) Massachusetts' Community First Olmstead Plan is a roadmap for improving community-based supports for elders and people with disabilities** that is built upon a strong policy framework and history of rebalancing efforts in the state. The vision of Community First is to "empower and support people with disabilities and elders to live with dignity and independence in the community by expanding, strengthening, and integrating systems of

community-based long-term supports that are person-centered, high in quality and provide optimal choice.” This vision reflects the Commonwealth’s commitment to providing community-based alternatives to facility care. Contributing to the states’ early efforts in this area, CMS awarded Massachusetts a Systems Transformation Grant (STG) in 2005 and State Profile Tool grant in 2007.

In response to the *Olmstead v. L.C.* decision, the Executive Office of Health and Human Services (EOHHS) produced an Olmstead Plan for the Commonwealth. The plan was developed by the Olmstead Planning Committee (Committee), a diverse group of stakeholders including individuals who had participated in STG activities and additional consumers, providers, advocacy organizations, and state agency staff. The Committee reviewed past and current Community First activities and EOHHS initiatives. The Committee also reviewed the contents of the People’s Olmstead Plan, a 2003 document developed by consumer advocates that included findings from public forums, recommendations and steps requiring state action.

As part of this process, the Committee identified remaining issues and barriers, prioritized initiatives to resolve them, and developed a list of discrete tasks and timeframes for completion of those tasks. Described as the Commonwealth’s roadmap for realizing the Community First vision and fulfilling the requirements of *Olmstead v. L.C.*, the Community First Olmstead Plan (Attachment A) includes principles and six goal areas with objectives and specific tasks to achieve those goals. The goals are to:

- help individuals transition from institutional care;
- expand access to community-based long-term supports;
- improve the capacity and quality of community-based long-term supports;
- expand access to affordable and accessible housing and supports;
- promote employment of persons with disabilities and elders; and
- promote awareness of long-term supports.

EOHHS continues to engage stakeholders regarding the Commonwealth’s Community First Olmstead Plan and Community First initiatives. Following the release of the Community First Olmstead Plan in September 2008, the Disability Policy Consortium, a consumer advocacy organization, organized and hosted three “Olmstead Initiatives” forums in the fall of 2009. During these forums, leadership from EOHHS, the Executive Office of Elder Affairs (EOEA), and state disability agencies received testimony from over 250 people with disabilities, their families and caregivers, and advocates and providers.

Stakeholders from inside and outside of state government were engaged in this process. While recognizing the fiscal constraints faced by the Commonwealth, these individuals acknowledged the need to prioritize incomplete and not yet implemented tasks within the Community First Olmstead Plan. The Commonwealth prioritized identifying populations in need of LTSS to inform policy recommendations and the development of financing options.

Various state agencies also developed plans and strategies to implement Community First, such as the

- Department of Developmental Services (DDS) Community Services Expansion and Facility Restructuring Plan;
- Strategic Plan to Make Massachusetts a Model Employer;

- Department of Mental Health (DMH) Inpatient Study Commission, and;
- Securing the Future: Report of the Massachusetts Long-Term Care Financing Advisory Committee.

Attachment B includes specific Community First Olmstead Plan initiatives associated with the Plan's goals, which are in process and completed.

As the STG grant came to an end in September 2010, stakeholders recommended that EOHHS and EOEA convene a Standing Olmstead Advisory Committee to discuss Olmstead-related priorities, review progress of the Community First Olmstead Plan, and propose solutions to implementation obstacles. The Advisory Committee, which meets quarterly, was convened in the fall of 2010 and initial activities focused on development of a Money Follows the Person Demonstration proposal and subsequent implementation of the demonstration. This group participated in the development of the MFP waivers mentioned above, which were recently approved by CMS. Stakeholders are actively assisting the Commonwealth to incorporate newly available rebalancing tools through the Affordable Care Act in the LTSS system.

**(5) Massachusetts recommendations that would make it easier for states to take advantage of available federal assistance in furthering the goals of Olmstead** include several ideas to lessen the administrative burden and/or costs of such assistance opportunities.

- The 1915(i) option represents a valuable opportunity to broaden availability of state plan long term services and supports in the community. Though Massachusetts has not pursued the 1915(i) option, our State Plan includes a number of community LTSS, such as personal care attendant, day habilitation, adult day health, etc. In order for the Commonwealth to take advantage of a 1915(i) in a manner that is manageable and affordable for the state, we recommend allowing slot caps to limit the population to be served at the state level via this mechanism.
- Massachusetts supports efforts to adjust current 1915(c) rules to allow states to target a waiver population across existing target categories. For example, it would be cost effective to allow persons with any type of disability, including those disabled by their mental illness, to be combined with those who are physically disabled to be served through one 1915(c) waiver.
- Current 1915(c) rules require separate quality processes for each individual waiver. Massachusetts recommends allowing cross-waiver quality monitoring and reviewing. This would greatly lessen the administrative burden on states and would improve states' abilities to take a broader view of programs serving similar target groups in concurrently operating waivers.

**(6) The many programs, ideas and approaches noted in this letter reflect the successful strategies Massachusetts has utilized to effectively implement our Olmstead Plan.** Our strategy meaningfully and integrally involves stakeholders in all aspects of planning for and implementation of initiatives we undertake. The Commonwealth's experience creating the state's Olmstead Plan itself is a fitting example of fully engaged stakeholders adding invaluable perspective to create a better product.

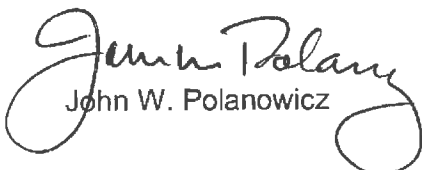
Our most recent experience engaging stakeholders in developing the Duals Demonstration has been extremely beneficial to our planning and overall approach to this initiative. As you know, Massachusetts was the first state in the nation to complete a Memorandum of Understanding with CMS on the Duals Demonstration. Massachusetts' launch of the Demonstration to Integrate Medicare and Medicaid for Dual Eligible Individuals is currently a major focus of our Medicaid program and is in keeping with our existing Senior Care Options program and Program of All-Inclusive Care for the Elderly. The approach to provide managed health care, which is integrated along the dimensions of both payment sources (Medicare and Medicaid), and the essential elements of care (medical, behavioral health, and long term services and supports) is an innovation that will promote a more rational approach to ensuring person-centered care addressing the needs of the whole person. As we move forward with implementation of the Duals Demonstration, we will maintain diverse opportunities for stakeholders to continue to inform and improve our work.

Another important successful strategy that also included wide stakeholder input and involvement is the state's efforts to decrease the number of Intermediate Care Facilities (ICFs) for individuals with intellectual disabilities and state psychiatric hospital beds. ICF capacity decreased by over 370 beds between FY 2008 and the end of FY 2012. At the same time, 176 state-operated psychiatric hospital beds were removed from the system via the development of 286 new community placement opportunities.

Similar to many states, Massachusetts has successfully utilized 1915(c) waivers to maintain individuals in the community who otherwise would be served in facilities. The availability of this mechanism is very valuable because it allows the state to focus its resources without creating unaffordable obligations. A significant advance available to MFP states is the ability to develop housing opportunities and resources. The focus on housing is critical – the work of transitioning individuals who have stayed long-term in a facility universally encounters and must address housing barriers in order to be successful. With the capability to specifically focus on multiple aspects of housing, including providing assistance in searching for appropriate housing, as well as working at several levels of the system to effect greater availability of housing, MFP incorporates an essential, and long sought-after element into states' toolkits. Combining this new housing support capacity with HCBS waivers will significantly bolster our ability to successfully transition persons to the community, both because we can help them to find housing to move into, and because we can subsequently provide community LTSS to stabilize transitioned individuals and maintain their tenure in the community.

In closing, the growing focus on opportunities for states and state Medicaid programs to provide community-based services options for people with disabilities is greatly appreciated and valued. Your leadership is essential in generating new and innovative opportunities for states. I greatly appreciate your interest in hearing from the Commonwealth and your desire to understand and share useful models.

Sincerely,

  
John W. Polanowicz

The Community First  
**OLMSTEAD PLAN**







# The Community First Olmstead Plan



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# The Community First Olmstead Plan



## A VISION FOR THE FUTURE

Empower and support people with disabilities and elders to live with dignity and independence in the community by expanding, strengthening, and integrating systems of community-based long-term supports that are person-centered, high in quality and provide optimal choice.

## I. SUMMARY

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The Commonwealth of Massachusetts is establishing its **Community First Olmstead Plan** pursuant to a Supreme Court decision compelling states to create meaningful community living plans for people with disabilities and elders. In keeping with the framework of *Olmstead v. L.C.* and the Patrick Administration’s commitment to a “community first” long-term care policy, this plan embraces a vision of choice and opportunity that requires the deliberate development of more accessible and effective long-term supports in local communities. Thus, the Plan supports the Administration’s commitment to shifting focus of long-term care financing from institutions to the community. Grounded in the 2002 *People’s Plan* and the extensive home and community-based service developments that have occurred through the efforts of the Executive Office of Health and Human Services (EOHHS), the Plan has greatly benefited from the significant input of a broad array of internal and external stakeholders (see Appendix B).

Focusing on six critical goal areas, the Plan provides a roadmap for the future of community-based support for elders and people with disabilities. Strategic short-term objectives describe an eighteen-month course of action for the Administration in crucial regulatory, fiscal and program development arenas which will, of necessity, be contingent on the availability of re-aligned as well as new public and private long-term support funding.

The public-private collaborations that have brought the Plan thus far will be the cornerstone of future efforts and hold the promise of new and meaningful opportunities for the nearly 20% of Massachusetts residents who are elder or disabled and want the opportunity to choose community first.

## II. BACKGROUND

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### What is an Olmstead Plan?

In 1999, the U.S. Supreme Court rendered a favorable decision in *Olmstead v. L.C.*, a case that challenged the state of Georgia's efforts to institutionalize people with mental disabilities. The Court ruled that the Americans with Disabilities Act (ADA) required states to provide services in the most integrated settings appropriate to the needs of individuals with disabilities; additionally, the Court indicated that each state should develop an Olmstead plan consistent with the decision. The 2001 federal New Freedom Initiative, multiple subsequent directives and grant funding from the Centers for Medicare and Medicaid Services, and extensive monitoring by the Office of Civil Rights, the National Council on State Legislatures, the American Association for Retired Persons, and others have supported and tracked the development of Olmstead plans now underway in most states.

### Why is an Olmstead Plan important to Massachusetts?

The elder and disabled populations in Massachusetts are growing. They are a diverse group of individuals and many depend on state-supported programs. With a broad array of home and community-based services, including case management and housing supports, they may live in less restrictive, and sometimes less expensive, community-based settings where many wish to remain.

- Massachusetts has a total population of over 6.4 million people, including approximately 13% (roughly 832,000) who are 65 years and older.
- In Massachusetts' general population, the likelihood of having a disability varies by age. For people between the ages of 16 and 64 years of age, 11 percent (more than 470,000 individuals) report having a disability. For those individuals over the age of 65, the percentage of people who report having a disability is 36 percent (close to 300,000 individuals).
- As of August 2008, there were approximately 25,000 kids with disabilities, 203,000 adults under the age of 65 with disabilities, and 107,000 seniors enrolled in MassHealth.
- On any given day, the average number of MassHealth clients (over the age of 18) residing in nursing homes is approximately 28,300.

- The current federal and state long-term care financing system was originally designed for institutional rather than community care and as a result, it has tended to favor institutional over community care.
- Among elder and disabled MassHealth members living in the community, as well as among those who are not MassHealth members, there is a desire for more access to home and community-based supports.
- Employment opportunities, critical for supporting elders and people with disabilities in leading self-sufficient and independent lives, are limited in Massachusetts as elsewhere.
  - People with disabilities in Massachusetts are almost three times as likely to be unemployed as their non-disabled peers.
- Access to sufficient affordable and accessible housing is often one of the greatest challenges to successful transition from institutional care to independent living.
- The ability of elders and people with disabilities to choose community over institutional care is affected by the availability of community options.

### **How was the Plan developed?**

At Governor Patrick's request, an Olmstead Planning Committee was convened in late Fall 2007. A large group of representatives including provider, consumer, and advocacy organizations, as well as elders and people with disabilities (see Appendix B), worked collaboratively with state agency staff to develop the framework and implementation strategies for the Administration's Plan. The People's Olmstead Plan, which was produced by a group of consumer advocates in 2002, provided the starting point for the discussions. Using the People's Plan goals as a foundation, the Olmstead Planning Committee reviewed prior and current EOHHS initiatives focused on achieving Olmstead-related objectives and identified gaps in needed service and policy development. The Committee articulated six over-arching goals and focused on identifying short-term action steps that now form the basis of an eighteen-month implementation plan (Appendix A).

## **What are the Principles that underlie this Plan?**

The primary principles that inform the Plan are the following:

- People with disabilities and elders should have access to community living opportunities and supports;
- The principle of “community first” should shape state elder and disability policy development and funding decisions;
- A full range of long-term supports, including home and community-based care, housing, employment opportunities, as well as nursing facility services are needed;
- Choice, accessibility, quality, and person-centered planning should be the goals in developing long-term supports;
- Systems of community-based care and support must be strengthened, expanded and integrated to ensure access and efficiency;
- Public and private mechanisms of financing long-term care and support must be expanded;
- Long-term supports developed under this plan must address the diversity of individuals with disabilities and elders in terms of race, ethnicity, language, ability to communicate, sexual orientation, and geography.

The Community First Olmstead Plan is a work in progress. Ongoing community engagement will be critical to implementation, evaluation, and revision as the Plan evolves to meet changing needs and resources.

### III. THE COMMUNITY FIRST OLMSTEAD PLAN

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The overarching purpose of the Massachusetts Olmstead Plan is to maximize the extent to which elders and people with disabilities are able to live successfully in their homes and communities. Six goals provide the framework for achieving that vision:

1. Help individuals transition from institutional care.
2. Expand access to community-based long-term supports.
3. Improve the capacity and quality of community-based long-term supports.
4. Expand access to affordable and accessible housing and supports.
5. Promote employment of persons with disabilities and elders.
6. Promote awareness of long-term supports.

Detailed objectives and timeframes for each of the goal areas are included in Appendix A. The rest of this section highlights the major objectives and provides additional background for each goal area.

#### 1. Help individuals transition from institutional care.

##### OBJECTIVES:

- Expand existing and implement new mechanisms for identifying individuals in institutions who wish to live in the community
- Implement additional mechanisms for facilitating transition from institutional settings

This goal reaches to the heart of the *Olmstead* decision and, thus, is a core obligation of this Plan. Successfully identifying institutionalized individuals who want to move back home or to other community settings can be challenging. Aging Service Access Points, Independent Living Centers, EOHHS agency staff, and other disability and elder related organizations currently work to engage individuals in transition processes, but a more systematic approach is needed to ensure greater success. Implementation of the Long-term Care Options Counseling process, mandated under Chapter 211 of the Acts of 2006, and initiation of the transition services components of the planned Community First (CF) 1115 waiver, the *Hutchinson* settlement, and the alternative *Rolland*

settlement will put in place capacity needed to facilitate successful movement of institutionalized individuals to community settings. Ongoing assessment of the effectiveness of transition interventions will provide a basis for continuous quality improvement.

## 2. Expand access to community-based long-term supports.

### OBJECTIVES:

- Improve access to necessary home and community-based services including, but not limited to, case management, medication management, behavioral health, caregiver supports, and assistive technology for elders and persons with disabilities
- Improve access to accessible transportation for elders and persons with disabilities
- Improve transition services for adolescents with disabilities who are leaving the education system

Massachusetts' public and private systems of long-term supports are unevenly available to elders and people with disabilities. In the public arena, one of the challenges to access is differing financial and clinical eligibility standards that exist across programs and funding streams that particularly affect persons as they age and/or their conditions change. In this goal area, the focus will be on reviewing eligibility standards to implement ways to broaden coverage as resources permit. Successfully launching the Community First 1115 Waiver is the major focal point of this goal during the initial Olmstead Plan implementation period; 15,600 people will be enrolled by the end of the eighteen-month timeframe. During this same period, EOHHS will also begin to meet the obligations of the resolution of both *Hutchinson v. Patrick* and *Rolland*. Over time, services developed in response to these cases will reach hundreds of individuals currently residing in nursing homes. The state will also explore the feasibility of expanded Medicaid community support coverage options for other disabled and elder MassHealth members, such as those permitted under the federal Deficit Reduction Act. Additionally, the development of expanded private and public-private financing mechanisms for long-term supports will be initiated.



The implementation plan references several current program review processes underway that will, when completed, yield solutions to other access challenges. The Personal Care Attendant Improvement Workgroup, for example, will identify and implement effective ways to improve the MassHealth program's operations. The EOHHS Turning 22 Initiative is working to guide changes in planning and supports for young adults with disabilities who are turning 22 and aging out of educational services. The absence of a clear "agency of tie" for many of these young people makes adult service planning challenging.

Even when community services exist, access is often complicated for both elders and people with disabilities by the often limited availability of accessible transportation options. Several EOHHS initiatives currently focused on increasing transportation access will expand cross-secretariat coordination and collaborative purchase mechanisms.

A core principle of the Olmstead Plan is choice, choice that is informed, supported, and secure. Work within this goal arena will assure that expanded consumer empowerment and decision-making is accompanied by improvements in current guardianship regulatory and administrative practices.

### **3. Improve the capacity and quality of community-based long-term supports.**

#### **OBJECTIVES:**

- Expand and sustain a high-quality workforce in the community
- Increase availability and diversity of residential support options
- Improve financing for community-based long-term supports
- Incorporate self-direction in the long-term supports system
- Implement system-wide quality improvement processes in the existing and future long-term support delivery systems

The success of the state's efforts to effectively assist individuals in returning to live safely in the community relies on enhancing access to high quality community-based services. This requires an adequate workforce, funding for a broad mix of services, flexible choices that respond to diverse needs and preferences, including culture and communication, and a system that is responsive to changing individual needs.

Ongoing and new efforts will focus on strategies for expanding the skills of, and sustaining, a high-quality, appropriately trained workforce in the community; expansion of the work of the Personal Care Attendant (PCA) Quality Workforce Council is an example of one such mechanism. Initiatives, such as the CF 1115 waiver, will also focus on expanding coverage and service choices, such as residential supports, which enable people to live in the community in a variety of settings including group homes, foster care and individual apartments. A Long-Term Care Financing Advisory Group will be established to determine a roadmap for public and private financing development. Lastly, a series of initiatives will focus on defining quality and measuring the performance of the long-term supports system.

#### **4. Expand access to affordable and accessible housing with supports.**

##### **OBJECTIVES:**

- Improve the coordination of long-term supports within affordable housing
- Increase access to affordable housing with long-term supports
- Increase availability of accessible low-income housing stock

Affordable and accessible housing is one of the most critical components of a system that successfully supports elders and people with disabilities to both stay living in the community and successfully move from an institutional setting. Massachusetts, like most states, struggles with ensuring not only that there is sufficient stock of affordable housing, but that there is affordable housing with access to or integrated supports for elders and persons with disabilities. Therefore, the strategies in this goal area are three-pronged, focusing on both increasing the quality and accessibility of housing stock, as well as increasing the kinds of options for support for individuals residing in community settings. To foster growth in the accessible housing market, EOHHS will collaborate with the Department of Housing and Community Development (DHCD) through the Interagency Council on Homelessness and in other efforts to expand affordable housing options and to develop and renovate housing stock to increase accessibility. EOHHS will also focus on raising the general public's awareness of accessible housing, promoting the MassAccess Housing registry and increasing use of the state's home modification and assistive technology funding options.

## 5. Promote employment of people with disabilities and elders.

### OBJECTIVES:

- Improve access to gainful employment and employment support services for elders and individuals with disabilities
- Increase access to vocational rehabilitation services and career planning for individuals with disabilities
- Ensure the effectiveness of employment initiatives

Employment enables people with disabilities and elders to sustain self-sufficient and independent lives in the community. This goal focuses on both improving access to employment opportunities and providing supports to enable individuals to remain employed. Newly established EOHHS employment goals and several federal grant initiatives provide both the framework and the support for re-engineering employment services for elders and people with disabilities. Expanded collaborations with the Department of Elementary and Secondary Education (ESE) and the Executive Office of Labor and Workforce Development (OLWD) are focusing on improving: vocational training services for transition aged youth; employer engagement strategies; market-based skill development; and job retention support. Additionally, work is underway to identify and tackle potential disincentives to employment that may be inherent in critical public support systems like CommonHealth. Improved monitoring of employment outcomes holds the promise of continuous quality improvement in this arena.

## 6. Promote awareness of long-term supports (LTS).

### OBJECTIVES:

- Implement strategy for informing Commonwealth residents of LTS options
- Develop strategy for educating clinicians in community practices and institutions, including hospitals, about availability and viability of community based LTS options

Lack of information about long-term support options may impede service decision-making by consumers, their family members, and their health and other care providers. Implementation of the Chapter 211-mandated long-term options counseling will go a long way towards ensuring that elders and individuals with disabilities have better information about their community-based options when contemplating long-term supports decisions. Outreach and education strategies will target clinicians to ensure that they have the information they need to present institutional and community options to their patients. Finally, efforts will be made to target general community members to make them more aware of both institutional and non-institutional support options.

## IV. CONCLUSION


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The Community First Olmstead Plan is a work in progress. The six goals provide a framework for ongoing and future work focused on achieving the mandate and the spirit of the *Olmstead* decision: people with disabilities across the lifespan have a right to live in their communities.



# Appendix A:

## The Community First Olmstead Implementation Plan



The following pages present all of the key objectives that the Olmstead Planning Committee has identified as essential for Massachusetts to meet the six primary goals encompassed in this Plan. Each goal is followed by objectives that include a description of main tasks required and completion dates.

The six goals, again, are:

1. Help individuals transition from institutional care
2. Expand access to community-based long-term supports
3. Improve the capacity and quality of community-based long-term supports
4. Expand access to affordable and accessible housing with supports
5. Promote employment of persons with disabilities and elders
6. Promote awareness of long-term supports

## **I. HELP INDIVIDUALS TRANSITION FROM INSTITUTIONAL CARE**

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### **OBJECTIVE 1:**

Expand existing and implement new mechanisms for identifying individuals in institutional settings who wish to live in the community

- a) Recommend mechanisms for improving the identification of individuals for transition. *(Completion Date: 12/31/08)*
- b) Implement Long-term Care Options Counseling. *(Completion Date: 12/31/08)*

### **OBJECTIVE 2:**

Implement additional mechanisms for facilitating transition from institutional settings

- a) Implement Community First (CF) 1115 waiver program (transition group benefit package will support transitions). *(Completion Date: Spring 09)*
- b) Implement a mechanism to track effectiveness of transition activities across Secretariat and institutional settings. *(Completion Date: 4/1/09)*
- c) Support the expansion of respite capacity to serve as both a diversion from intermediate care and as a step down from state psychiatric hospital/units. *(Completion Date: 7/1/09)*

## **2. EXPAND ACCESS TO COMMUNITY-BASED LONG-TERM SUPPORT**

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### **OBJECTIVE 1:**

Improve access to home and community-based services including but not limited to case management, medication management, behavioral health, caregiver supports, and assistive technology, for elders and persons with disabilities, regardless of income

- a) Implement CF 1115 Demonstration program. Implementation will include expansions to income and asset test criteria for individuals who are clinically eligible and choose to enroll in the waiver. *(Completion Date: Spring 09)*

- b) Report on feasibility of application for Home and Community Based Services (HCBS) State Plan Amendment (SPA) which would provide access to case management, medication management, cueing and monitoring of activities of daily living, and other select HCBS services. Assess and report on options for implementation. *(Completion Date: 12/31/09)*
- c) Establish Long-term Care Financing Advisory Group. *(Completion Date: 9/30/08)*  
  
Recommend options for the development of public/private and private mechanisms to fund community-based services for people who are not low-income or otherwise not eligible for MassHealth. *(Completion Date: 6/30/09)*
- d) Assess and report on options for removing barriers to community-based care, including examination of cost sharing and eligibility rules. *(Completion Date: Ongoing until 9/1/10)*
- e) Complete Personal Care Attendant improvement activities. *(Completion Date: 12/31/08)*
- f) Establish safeguards to ensure the availability of safe, accountable, and well-informed guardians and conservators and a judicial process that supports appropriate fiduciary relationships. *(Completion Date: 2/1/10)*
- g) Support collaboration between the Massachusetts Commission for the Blind (MCB), the Executive Office of Elder Affairs (EOEA), and medical community to develop strategies to address serving elders who are visually impaired. Collaboration on strategies has potential to impact many individuals currently not served by MCB. *(Completion Date: Ongoing)*
- h) EOEA in partnership with the Department of Public Health (DPH) is implementing a grant to empower at-risk older adults to take more control of their health through evidence-based prevention programs (EBDP). Programs include focuses on chronic disease self-management and healthy eating. *(Completion Date: Ongoing until June 2010)*
- i) EOEA will work with DPH on its suicide prevention task force to develop recommendations regarding initiatives focusing on elders relating to the prevention of suicide. *(Completion Date: Ongoing)*



Incorporate initiatives in the Suicide Prevention plan.

*(Completion Date: Fall 08)*

- j) Analyze variations in access to specific assistive technology such as hearing aids and captioned telephones, across public and private benefit plans. Recommend strategies to increase access to these goods and services. *(Completion Date: 12/1/08)*
- k) Create new Medicaid home and community-based services waiver options through the Department of Developmental Services (DDS) for individuals with mental retardation *(Completion Date: Summer 09)*
- l) Create a Medicaid home and community-based waiver program through the Massachusetts Rehabilitation Commission (MRC) for persons with acquired brain injuries to meet requirements of the *Hutchinson* settlement decision. *(Completion Date: TBD)*

## **OBJECTIVE 2:**

Improve access to accessible transportation for individuals with disabilities and elders

- a) Recommend options to improve access to and options for transportation services for individuals in need of LTS services. *(Completion Date: 9/1/10)*

## **OBJECTIVE 3:**

Improve transition services for adolescents with disabilities who are leaving the education system

- a) Recommend strategies regarding the Chapter 688 ("Turning 22") process, including recommendations on information dissemination to families about community-based options. *(Completion Date: 12/31/08)*
- b) Determine Department of Elementary and Secondary Education (DESE)/Executive Office of Health and Human Services (EOHHS) program development and reimbursement strategies that support transitions. *(Completion Date: 12/31/08)*

### 3. IMPROVE THE CAPACITY AND QUALITY OF COMMUNITY-BASED LONG-TERM SUPPORTS

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#### OBJECTIVE 1:

Expand and sustain a high quality workforce in the community

- a) Implement PCA Directory and provide recommendations on how to improve PCA training and PCA workforce development and stabilization. *(Completion Date: 12/31/08)*
- b) Determine options for supporting caregivers across the system of long-term supports. Analysis would include evaluation of viability and appropriateness of paying spouses as caregivers in the delivery system. *(Completion Date: 9/1/10)*
- c) Recommend mechanisms for increasing and sustaining paraprofessional and professional LTS workforce. Recommendations to consider:
  - Recruitment and retention strategies
    - Culturally competent workforce development including American Sign Language (ASL) fluent workforce and foreign language fluent workforce
    - Wage and benefit modifications
  - Initial and on-going training/ education of workforce
    - Coordination of training for certified nurse aides (CNAs) and Home Health Aides
    - Training curricula for complex, marginalized or hard-to-reach constituencies
    - Training on cultural competency, including working with interpreters, for human service workers and caregivers
    - Trainings for caregivers, as mandated reporters, to include recognizing, reporting, and responding to abuse and neglect committed against individuals with disabilities and elders
  - Development of career ladder across long-term supports system *(Completion Date: 6/30/09)*
- d) Evaluate strategies for expanding the capacity to provide certain skilled care services in the community, such as revising the state's Nurse Practice Act *(Completion Date: 2/1/10)*

## **OBJECTIVE 2:**

Increase availability and diversity of residential supports options

- a) Implement CF 1115 Waiver program. *(Completion Date: Spring 09)*
- b) Identify mechanisms to align EOHHS-funded residential supports across agencies. *(Completion Date: 12/31/08)*
- c) Determine mechanisms to expand access to supportive services in publically-funded disability/elder housing programs and other integrated public housing such as the Community-Based Housing (CBH) fund. *(Completion Date: 12/31/08)*

## **OBJECTIVE 3:**

Improve financing for community-based long-term support system

- a) Recommend short- and long-term alternative financing options for expanding the community-based long-term supports system. Collaborate with Long-Term Care Financing Advisory Group. *(Completion Date: Ongoing until 9/1/10)*
- b) Establish mechanism to measure expenditures on long-term community and institutional care and develop a 3-year plan to increase investment in community-based services. *(Completion Date: 3/1/09)*
- c) Analyze rate structures and payment methods across the community-based long-term supports delivery system and identify strategic purchasing opportunities to build capacity. *(Completion Date: 12/1/08)*

## **OBJECTIVE 4:**

Incorporate self-direction throughout the long-term supports system

- a) Recommend strategies for EOHHS on incorporating self-determination across the Secretariat, including consideration of what to require of all contracted provider types. *(Completion Date: 9/1/08)*
- b) Recommend an implementation strategy for Person-Centered Planning across the Secretariat. *(Completion Date: Ongoing until 9/1/10)*

- c) Implement Aging Services Access Points (ASAP) staff training on consumer directed philosophy and application to both agency services and self-directed programs. *(Completion Date: 12/1/08)*
- d) Implement a self-direction delivery system option within the CF 1115 Waiver program which will include a self-directed care component. *(Completion Date: Spring 10)*

**OBJECTIVE 5:**

Implement system-wide quality improvement processes in the existing and future long-term support delivery systems

- a) Adopt Quality Mission and Vision statements for the EOHHS long-term supports systems. *(Completion Date: 9/1/08)*
- b) Implement proposed strategies for increasing consumer involvement in quality management activities across long-term supports system. *(Completion Date: Ongoing)*
- c) Propose plan for establishment of comprehensive quality management system for long-term supports across EOHHS administrative agencies. *(Completion Date: Ongoing through 9/1/10)*
- d) Provide recommendations to the EOHHS Office of Health Equity regarding the adoption of a focus on disparities in accessing HCBS services. Analysis would include looking at disparities by race; language; sexual orientation; disability type, especially among individuals who are Deaf, late-deafened, hard of hearing or deaf blind; and individuals dealing with communication barriers on top of another disability (physical, cognitive, or psychiatric). *(Completion Date: Ongoing)*

#### 4. EXPAND ACCESS TO AFFORDABLE AND ACCESSIBLE HOUSING WITH SUPPORTS

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##### OBJECTIVE 1:

Improve the coordination of long-term supports within affordable housing

- a) Develop housing training processes for EOHHS staff who assist with care plan development. *(Completion Date: 1/1/09)*
- b) Propose a housing needs and preferences assessment as a supplement to current service planning processes. *(Completion Date: 1/1/09)*
- c) Expand the number of supportive housing sites, including sites that have the technology and communication accessible features for elders and individuals with disabilities across disability types. *(Completion Date: 8/1/08 and ongoing)*

##### OBJECTIVE 2:

Increase access to affordable housing with long-term supports

- a) Support expansion of the MassAccess Housing Registry. *(Completion Date: Ongoing)*
- b) Conduct outreach to consumers, providers, and housing industry on Home Modification Loan Program. *(Completion Date: 12/1/08)*
- c) Develop plan for conducting outreach to home/builders/managers re: need for accessible and affordable housing. *(Completion Date: Ongoing)*
- d) Explore alternatives to making 'existing housing with long-term supports' affordable, (e.g., assisted living, congregate, group home models, etc). *(Completion Date: Ongoing)*

### **OBJECTIVE 3:**

Increase availability of accessible low-income housing stock

- a) Develop a three-year strategic plan to identify ways to increase availability of accessible and affordable community-based housing. Plan to include consideration of:
  - housing for individuals eligible for institutional services, but capable of living in less restrictive setting
  - housing with technology and layout access for individuals with disabilities of all kinds
  - increasing capital funding for CBH and Facilities Consolidation Fund (FCF) budgets
  - collaboration with Homelessness Commission and implementation of recommendations from this group which clearly focus on people of all ages with disabilities
  - implementing ways to promote visitability of housing  
*(Completion Date: 2/1/09)*
- b) Support expanded capital funding for Alternative Housing Voucher Program for people of all ages with disabilities. *(Completion Date: 9/30/08)*

## **5. PROMOTE EMPLOYMENT OF PERSONS WITH DISABILITIES AND ELDERS**

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### **OBJECTIVE 1:**

Improve access to gainful employment and employment support services for elders and individuals of all ages with disabilities

- a) Collaborate with the Medicaid Infrastructure and Comprehensive Employment Opportunities (MICEO) Grant and EOHHS Steering Committee on Employment to make recommendations on how to improve access to employment for elders and individuals of all ages with disabilities. *(Completion Date: 4/1/09)*
- b) Develop strategies to make state government a model employer of elders and people with disabilities. *(Completion Date: 10/1/08)*

## **OBJECTIVE 2:**

Increase access to vocational rehabilitation services and career planning for individuals with disabilities

- a) Collaborate with Department of Elementary and Secondary Education (DESE) to improve Individual Educational Plan (IEP) process requirements to focus on employment. *(Completion Date: 2/1/10)*

## **OBJECTIVE 3:**

Ensure effectiveness of employment initiatives

- a) Report on rates of employment for individuals with disabilities. *(Completion Date: Ongoing)*

## **6. PROMOTE AWARENESS OF LONG-TERM SUPPORTS**

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### **OBJECTIVE 1:**

Develop strategy for educating clinicians in community practices and institutions including hospitals about availability and viability of community-based LTS options

- a) Implement CF 1115 Waiver program. Implement provider training and outreach to assist in the identification and referral of eligible applications for the 1115 waiver implementation and consider plan for on-going outreach and training. *(Completion Date: Spring 09, then ongoing)*
- b) Develop strategies on how to engage and educate clinicians on the broad array of community-based long-term supports options and availability of long-term care options counseling. *(Completion Date: 9/1/08 and ongoing)*
- c) Develop strategies for working with healthcare providers (i.e., private physicians) and community-based providers to ensure interpreter/CART services are provided when needed. Issues to consider include concerns about cost of services. *(Completion Date: Ongoing)*

## **OBJECTIVE 2:**

Implement strategy for informing the general public of LTS options

- a) Implement Aging and Disability Resource Consortium (ADRC) model statewide to serve as an access point of information for elders and individuals with disabilities. *(Completion Date: 12/31/09)*
- b) Implement Long-term Care Options Counseling processes, which will include educating residents of Massachusetts regarding the broad array of community-based long-term supports options. *(Completion Date: 12/31/08)*
- c) Conduct outreach on existence and utility of the Massachusetts Aging and Disability Information Locator (MADIL: [www.mass.gov/madil](http://www.mass.gov/madil)) to provide information on long-term supports options. MADIL pulls together information maintained by: 1-800-AGE-INFO, New England INDEX, and MassAccess Housing Registry. *(Completion Date: 7/1/08 and ongoing)*
- d) Develop recommendation regarding expansion of MADIL to include information on existing informal support networks in the community. *(Completion Date: 9/1/09)*
- e) Implement a PCA Directory which will provide access to information on available Personal Care Attendants in the community. *(Completion Date: 12/1/08)*
- f) Develop and conduct comprehensive outreach and education strategy on long-term support system issues for broad audience including legislators, providers, and the general public. Strategy should consider how to include access to information via web, presentation in multiple languages, ASL, and captioning. *(Completion Date: 12/31/08)*
- g) Create a public marketing strategy on long-term supports options. *(Completion Date: 2/1/10)*



- h) Develop recommendation on implementation of a registry/central repository of information on all direct care workers available in the community for consumers regardless of payer source.  
*(Completion Date: 9/1/10)*
- i) Provide optional training for elders and individuals with disabilities on recognizing, reporting, and responding to abuse and neglect committed against them. *(Completion Date: 9/1/10)*

## **Appendix B:** **Olmstead Planning Committee Members**

### **OLMSTEAD PLANNING COMMITTEE MEMBERS**

Al Norman	<i>Massachusetts Home Care</i>
Annette Shea	<i>Office of MassHealth</i>
Arlene Korab	<i>Brain Injury Association of Massachusetts</i>
Betty Sughrue	<i>Massachusetts Rehabilitation Commission</i>
Bill Allan	<i>Disability Policy Consortium</i>
Bill Henning	<i>Boston Center for Independent Living</i>
Blair Cushing	<i>AIDS Housing Corporation</i>
Carol Menton	<i>Massachusetts Commission for the Deaf and Hard of Hearing</i>
Carol Suleski	<i>Elder Services Plan of the North Shore (Senior Care Options (SCO)/ Program of All Inclusive Care for the Elderly (PACE))</i>
Cindy Wentz	<i>Massachusetts Rehabilitation Commission</i>
Courtney Nielsen	<i>AIDS Housing Corporation</i>
Daniel J. Greaney	<i>Stavros Center for Independent Living</i>
Ed Bielecki	<i>Mass Advocates Standing Strong</i>
Elissa Sherman	<i>Mass Aging Services Association</i>
Elizabeth Fahey	<i>Home Care Alliance</i>
Ellie Shea-Delaney	<i>Department of Mental Health</i>
Gigi Alley	<i>Advocate</i>
John Chappell	<i>Massachusetts Rehabilitation Commission</i>

John Winske	<i>Disability Policy Consortium</i>
Katherine Fox	<i>Briarcliff Lodge Adult Day Health Center</i>
Keith Jones	<i>Soul Touchin' Experiences</i>
Lisa Gurgone	<i>Massachusetts Council for Home Care Aides</i>
Lisa McDowell	<i>MassHealth Office of Long-term Care</i>
Loran Lang	<i>Massachusetts Commission for the Blind</i>
Maggie Dionne	<i>Massachusetts Rehabilitation Commission</i>
Margaret Chow-Menzer	<i>Department of Developmental Services</i>
Maria Russo	<i>The May Institute</i>
Martina Carroll	<i>Stavros Center for Independent Living</i>
Nancy Alterio	<i>Disabled Persons Protection Commission</i>
Pat Kelleher	<i>Home Care Alliance</i>
Paul Lanzikos	<i>North Shore Elder Services</i>
Paul Spooner	<i>Metro West Independent Living Center</i>
Rick Malley	<i>Massachusetts Office on Disability</i>
Rita Claypoole	<i>Advocate</i>
Rita Barrette	<i>Department of Mental Health</i>
Robert Sneirson	<i>Disability Policy Consortium</i>
Sue Temper	<i>Springwell</i>
Valerie Konar	<i>Massachusetts Assisted Living Facilities Association (Mass-ALFA)</i>

## **OLMSTEAD PLANNING COMMITTEE STAFF LEADS**

Eliza Lake	<i>Systems Transformation Grant Lead for Diversion Committee</i>
Jean McGuire	<i>EOHHS-Disability Policies and Programs</i>
Laurie Burgess	<i>EOHHS-Disability Policies and Programs</i>
Mason Mitchell-Daniels	<i>EOHHS-Disability Policies and Programs</i>
Michele Goody	<i>Office of MassHealth</i>
Peter Ajemian	<i>EOHHS-Disability Policies and Programs</i>
Ruth Palombo	<i>Executive Office of Elder Affairs</i>
Sandra Albright	<i>Executive Office of Elder Affairs</i>
Shannon Hall	<i>University of Massachusetts Medical School-Project Management Office</i>

## Attachment B. Massachusetts Community First Olmstead Plan Initiatives

Community First Olmstead Plan Goal	Examples of Initiatives Completed and In Process
<b>Help individuals transition from institutional care</b>	<ul style="list-style-type: none"> <li>• Rolland, Hutchinson, DDS, DMH Closure Plans (Additional data in Q1 above)</li> </ul>
<b>Expand access to community-based long-term supports</b>	<ul style="list-style-type: none"> <li>• Money Follows the Person (MFP) Demonstration</li> <li>• Implementation of DMH Community Based Flexible Supports</li> <li>• Two new ABI 1915(c) Waivers operational</li> <li>• Two new MFP 1915 (b) and (c) Waivers (currently in negotiation with CMS)</li> <li>• Revisions to Frail Elder 1915 (c) Waiver</li> </ul>
<b>Improve the capacity and quality of community-based long-term supports</b>	<ul style="list-style-type: none"> <li>• Implementation of Aging and Disability Resource Consortia (ADRCs) (in process)</li> <li>• Redesign of DDS 1915 (c) Waiver</li> <li>• Patient Centered Medical Home Initiative</li> <li>• Integrating Medicare and Medicaid for Dual Eligible Individuals (In process)</li> <li>• Person-Centered Planning integrated into design of EOHHS programs</li> <li>• Consumer direction expansion (DDS 1915 (c) Waivers, Home Care Program)</li> <li>• PCA Program Improvements including new PCA registry, increased wages, improved expedited authorizations for facility discharges, and multi-year authorizations</li> <li>• Personal Home Care Aide State Training (PHCAST) grant trained 498 direct service workers to date (grant still in progress)</li> </ul>
<b>Expand access to affordable and accessible housing and supports</b>	<ul style="list-style-type: none"> <li>• Joint Committee on Housing for Persons with Disability co-chaired by EOHHS and Division of Housing and Community Development (DHCD) established</li> </ul>

- 
- MOU between EOHHS and Lynn Housing Authority on administration of 35 NED vouchers for individuals transitioning to the community with supportive services from Massachusetts Rehabilitation Commission and DMH
  - Legislation passed (3/12) and committees convened for development of MOU for development of up to 1000 permanent supportive housing units
  - Statewide Housing Coordinator hired under MFP Demonstration
  - Housing Assessment Tool developed
  - Expansion of MassAccess Housing Registry

**Promote employment of persons with disabilities and elders**

- Statewide strategic plan established
- Commonwealth Model Employer activities completed
- 5 Public-Private Regional Collaboratives with Executive Office of Labor and Workforce Development
- Peer Support expansion

**Promote awareness of long-term supports**

- Long Term Care Options Counseling implemented
  - Embrace Your Future awareness campaign completed
  - Improvements to Massachusetts Aging and Disability Information Locator and 1-800-AgeInfo
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STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

RICK SNYDER  
GOVERNOR

JAMES K. HAVEMAN  
DIRECTOR

September 19, 2012

The Honorable Tom Harkin, Chairman  
United States Senate  
Committee on Health, Education, Labor, and Pensions  
428 Senate Dirksen Office Building  
Washington, DC 20510

Dear Senator Harkin:

Thank you for your letter to Governor Snyder dated June 22, 2012, requesting information pertaining to Michigan's progress for serving individuals with disabilities in the most integrated settings appropriate to their needs as required by the Americans with Disabilities Act (ADA) and the decision in *Olmstead v. L.C.* Since the 1970s, Michigan has made great progress transitioning individuals from institutions into community settings. Governor Snyder has asked me to respond on his behalf.

Michigan serves individuals with disabilities through the Department of Community Health (DCH) and the Department of Human Services (DHS). The Department of Community Health is made up of the Medical Services Administration (MSA), which is the State Medicaid Agency, the Behavioral Health and Developmental Disabilities Administration (BHDDA), which oversees the provision of services for individuals who have behavioral health or intellectual/developmental disabilities, the Office of Services to the Aging, and the Public Health Administration. DHS implements the Adult Home Help program, which is the Medicaid State Plan personal care service for people with disabilities and other groups that qualify.

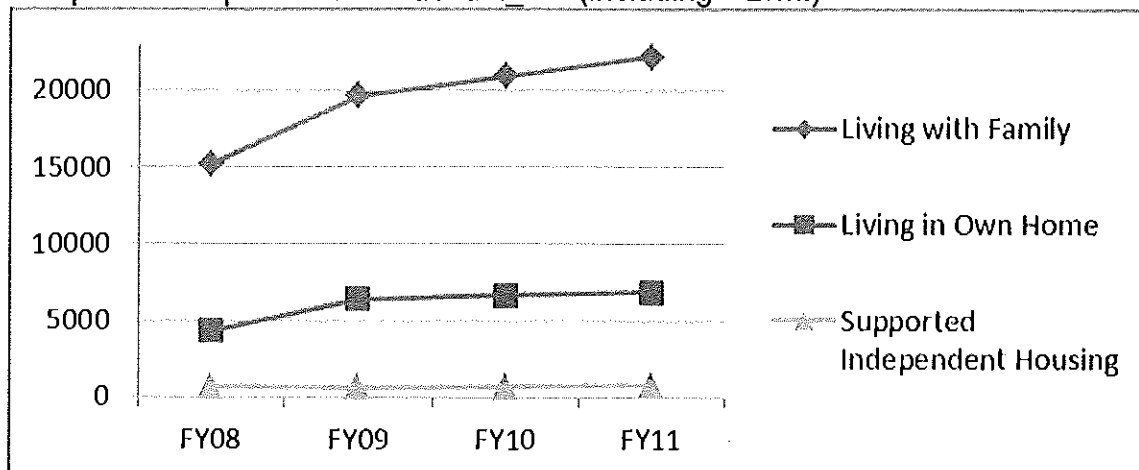
Individuals with disabilities are served through a variety of programs and services, determined by eligibility criteria and individual needs, whether they are related to physical health, behavioral health, or intellectual or developmental disability. Under the MSA, home and community-based services are available, including the 1915(c) home and community-based waiver for the elderly and adults with disabilities referred to as the MI Choice Waiver. This program provides supports and services to enable individuals to remain in the community and assists in the transition of people from nursing homes to community settings. MSA also administers the Adult Home Help program that is implemented by DHS at the local level. BHDDA provides an array of supports and services for people with serious mental illness, developmental/intellectual disabilities, substance use disorders, and children with serious emotional disturbance under the authority of the §1915(b) waiver (Managed Specialty Supports and Services Plan or MSSSP), which operates concurrently with a §1915(c) waiver (Habilitation Supports Waiver or HSW). The MSSSP includes covered Medicaid State Plan personal care, rehabilitation and clinic services, as well as additional community-based supports and services through the authority of §1915(b)(3).

The responses to your request are organized on the following pages by question as listed in your original letter. We have attempted to answer your questions to the best of our ability with the information that was readily accessible to us.

**Question 1: For each year from FY 2008 to the present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, psychiatric hospitals, and board and care homes, to living in their own home, including through a supportive housing program.**

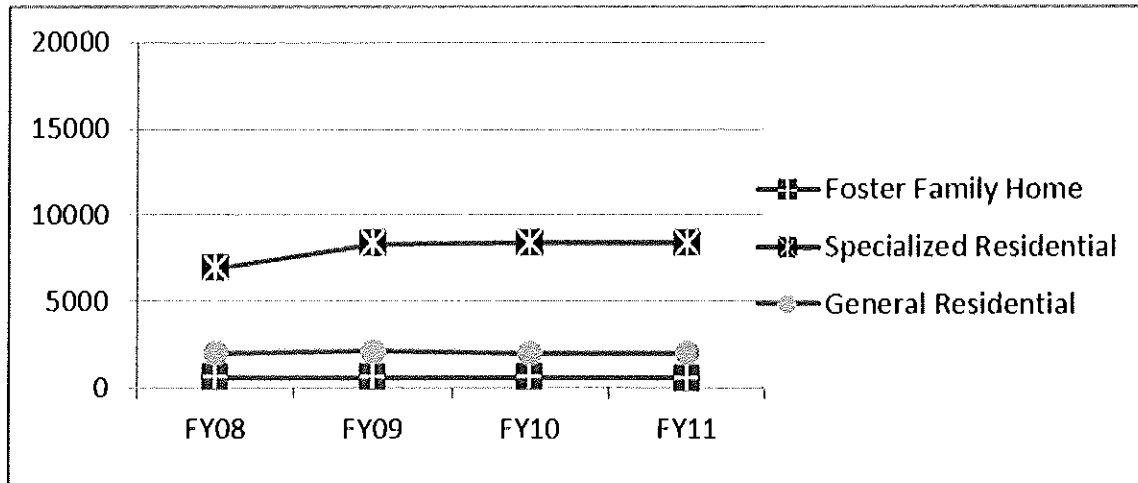
Michigan has been a leader in providing home and community-based supports and services to its citizens with disabilities. One example is the closure of the last large public Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities (ICF/ID) in 2009. Michigan is now among a small number of states nationwide with no public or private ICF/ID facilities. Michigan's public mental health system served approximately 231,000 people in FY11. The majority of people who have a developmental disability or co-occurring mental illness (DD/MI) live in a private residence with parents or other family members. Graph A shows the number of people living in a private residence (with or without family) increased 46% between FY08 and FY11. There was also a significant increase (59%) in the number of people with a developmental disability living in their own home during this time period. Between FY08 and FY09, Graph B demonstrates that there was an increase (20 percent) in the number of people with a developmental disability living in a specialized residential group home<sup>1</sup>. The rate of people living in this type of residential arrangement has been consistent since FY09.

Graph A: Independent Residential\_DD (including DD/MI)



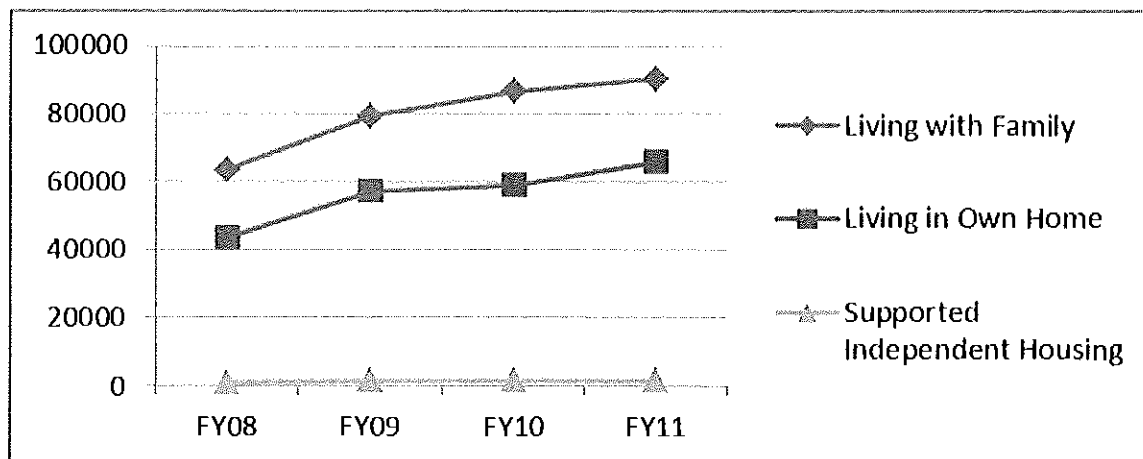
<sup>1</sup> A specialized residential home includes any adult foster care facility certified to provide a specialized program per DMH Administrative Rules, 3/9/96, R 330.1801 (includes all specialized residential, regardless of number of beds); or a licensed Children's Therapeutic Group Home

Graph B: Other Residential\_DD (including DD/MI)



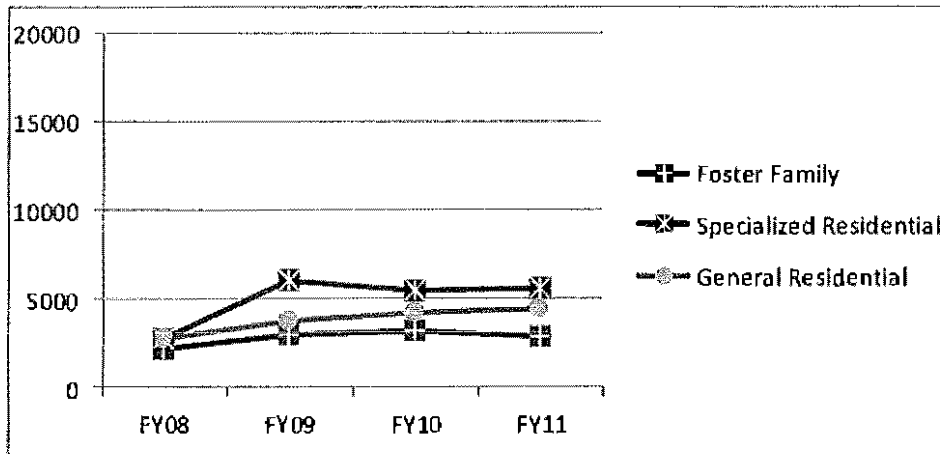
The majority of people with a mental illness live either with parents or other family members, or in their own homes. As shown in Graph C, the number of people living in a private residence (with or without family) has increased each year since FY08. The number living with family has increased 42 percent during this time period and the number in their own home has increased 51 percent. As displayed in Graph D, approximately five percent of individuals with a mental illness live in licensed adult foster care homes in the community. This percentage has remained fairly stable between FY08 to FY11.

Graph C: Independent Residential\_MI



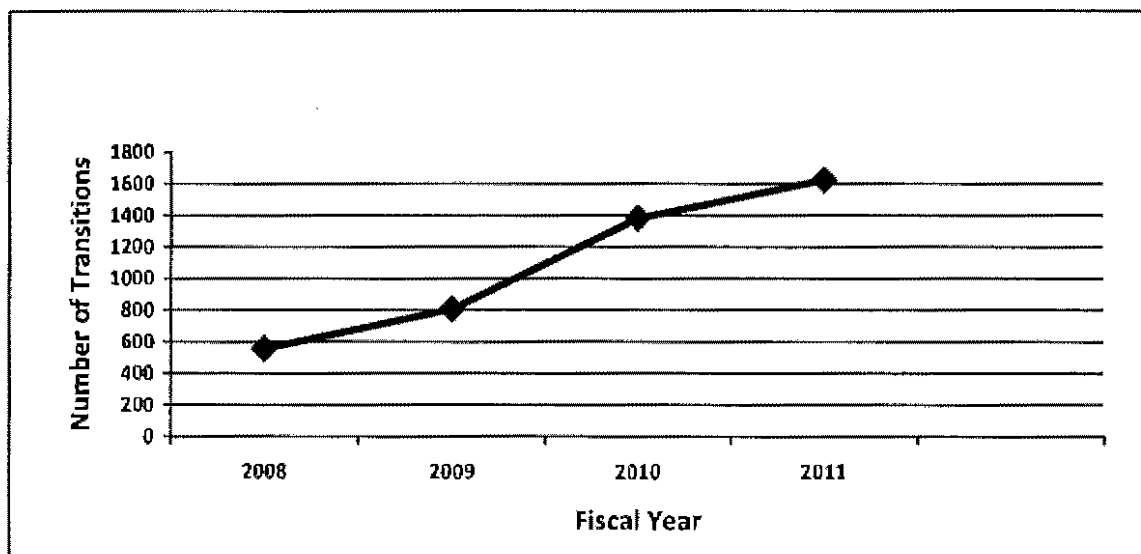


Graph D: Other Residential\_MI



The State has been actively assisting people who want to move from nursing facilities through its Nursing Facility Transition initiative. As displayed in Graph E, there has been a steady increase in transitions from nursing facilities to community settings since FY 2008.

Graph E: Number of Transitions from Nursing Facilities to Community Settings



**Question 2: The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes including through a supportive housing program.**

As displayed in Table 1, there are no expenditures to report for Intermediate Care Facilities because all such facilities in Michigan were closed prior to Fiscal Year 2011. There are expenditures in Fiscal Year 2012 for nursing facilities, State psychiatric hospitals, and various community settings.

Table 1: Expected Expenditures for Fiscal Year 2012

Type of Setting	Estimated Expenditures
Nursing Facility	Total Medicaid \$1,774.5 million; \$600.8 million Total State Share
State Psychiatric Hospitals (Adult and Children’s facilities)	\$161,981,700
Community settings including living in own home, with family or friends, Supported Housing Program, etc	MI Choice: Total Medicaid: \$282,393,100, which includes State General Fund: \$100,238,200.  Adult Home Help: Total Medicaid: \$346.1 million, which includes State General Fund: \$117.2 million  MSSSP & HSW <sup>2</sup> : Total Medicaid: \$488,150,000, which includes State General Fund: \$165,287,590  Other MSA Home and Community-Based Services (PACE program): Total: \$27.8 million, which includes State General Fund: \$9.4 million

<sup>2</sup> Because Medicaid behavioral health and developmental disabilities are provided through the concurrent §1915(b)/(c) waiver, the projected expenditures includes both the Managed Specialty Supports & Services Plan (MSSP) and the HCBS waiver, the Habilitation Supports Waiver (HSW).

**Question 3: For each year from FY 2008 to the present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion and specific nature of the capacity added.**

One example of how Michigan has expanded its capacity to serve people in the community is through the MI Choice Waiver. The MI Choice Waiver has obtained increases in funding specifically to transition individuals from nursing homes to community settings. As included in the response to Question 1 above, there have been increases in the number of individuals who have transitioned out of nursing homes. For Fiscal Year 2013 beginning October 1, 2012, there will be an \$11.8 million general increase in funding for MI Choice to serve people in the community, as well as an increase of \$40.7 million to serve people who transition from nursing facilities.

Another example of capacity expansion is related to the closure of the last ICF/ID and the need for highly individualized transition plans for the remaining 120 people with appropriate resources to assure successful re-entry into their communities. Many of these people and their families were concerned about the closure because they had experienced numerous "failures" by the system resulting in unsuccessful community placements. To address these very valid concerns, Michigan implemented a number of strategies to assist in successful transitions. Each person who left the ICF/ID facility was enrolled in the HSW. In Fiscal Year 2009, CMS approved an amendment to the HSW to permit the State to pay an additional HSW monthly capitation rate enhancement to provide the necessary financial resources for the transitions of the 120 individuals. During FY09, the amendment was approved for the last half of the year, providing the additional HSW payment for 18 people living in a private residence (with or without relatives) at a total Medicaid cost of \$1,134,985.37 which included the State General Fund cost of \$332,777.71. During FY10, the additional HSW payment was provided for 24 people living in a private residence at a total Medicaid cost of \$3,604,067.48 which included the State General Fund cost of \$963,367.24. During FY11, the additional HSW payment was provided for 27 people living in a private residence at a total Medicaid cost of \$4,214,065.53 which included the State General Fund cost of \$1,213,606.02. This trend demonstrates slow and steady increases in the number of people previously institutionalized to living in a private residence (with or without relatives).

Another strategy that BHDDA uses to expand its capacity involves contractual monetary incentives to promote individuals with disabilities receiving services in the most integrated settings appropriate to their need. Specifically, the Department has included monetary incentive language in the FY13 contract which will generate first and second place award dollars for those provider networks that show the greatest improvement in the overall number of individuals with disabilities served that are living in a private residence, either alone or with a spouse or nonrelatives, but not owned by the contracted provider.

**Question 4: The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.**

Due in part to Olmstead and the settlement in a subsequent Michigan-specific lawsuit, the state convened the Michigan Medicaid Long-Term Care Task Force. This Task Force included individuals receiving services and/or family members, advocates, state agency staff, state legislators, health professionals, and individuals from various other organizations. The Task Force developed goals and recommendations that the state has used as a guide to improve Michigan's long-term care services and supports and increase the use of home and community-based services.

One Task Force recommendation was for the state to implement person-centered planning practices. Person-centered planning has been required under the Michigan Mental Health Code since 1996, as well as requirements set forth in various policies that govern the provision of long-term care supports and services related to physical and behavioral health and intellectual/developmental disabilities. The effective implementation of person-centered planning practices is monitored by BHDDA and MSA and each respective agency's quality assurance efforts. These efforts are critical to ensure individuals are receiving adequate supports and services to meet their needs and desires. The quality assurance efforts include site reviews, and related to these site reviews are protocol and questions that guide the review process. The records of individuals are reviewed to ensure the individual's goals, desires, and preferences were considered during the planning process, the individual was involved in the planning process as were other persons of the individual's choosing, and that the plan was changed as the individual's condition changed or upon the individual's request. Individuals receiving services are also interviewed or surveyed to ensure their needs and desires have been addressed.

Person-centered planning is also critical in the planning and provision of services in Michigan's long-term care programs. A person-centered planning policy/guideline was developed by a workgroup composed of advocates, people receiving services and multiple department staff in 2008. Person-centered planning is incorporated into the MI Choice Waiver and is evaluated in its Continuous Quality Assessment Review. The Department of Human Services also requires under policy that case managers implement person-centered planning practices when planning for Adult Home Help services. These case records are also reviewed for successful implementation of person-centered planning.

Another Task Force recommendation was to improve access by adopting "Money Follows the Person" (MFP) principles. Michigan was awarded MFP funding in 2007, and funding is renewed annually through the Patient Protection and Affordable Care Act. DCH has been very successful in using the federal award to assist in the redirection of institutional funding to home and community-based services. The funding is used to transition people from nursing facilities to the community and to ensure individuals receive the services and supports responsive to each individual's choices and supportive of living in the most independent settings.

An additional recommendation of the Task Force was to strengthen the array of services and supports and expand the range of options available to individuals. Eligible individuals may participate in a large variety of services and supports offered via the Medicaid State Plan; MI Choice Waiver; the §1915(b) Managed Specialty Supports and Services Plan for mental health, intellectual/developmental disabilities, and substance use disorders; and the §1915(c) Habilitation Supports Waiver, among others. Within these programs, there have been numerous efforts to expand housing options, expand service options and increase the use of self-determination options. Both MSA and BHDDA continue to evaluate and expand services as necessary to meet the needs of the individuals they serve.

The development of a Long-Term Care Commission was also recommended. In 2005, the Michigan Long-Term Care Supports and Services Advisory Commission was created. It is made up of individuals representing the spectrum of long-term care, including persons receiving services and their advocates and allies, direct care staff, representatives from agencies that provide services, trade organizations, researchers, and State of Michigan employees. The duties of the Commission include oversight of the implementation of the recommendations made by the Long-Term Care Task Force and advising the administration on long-term care issues.

Michigan has and continues to make efforts to maximize resources and promote incentives for providing services to people in the community. One of its most recent initiatives is its proposal to the Centers for Medicare and Medicaid Services (CMS) to integrate care for individuals eligible for Medicare and Medicaid. MDCH is working with CMS and discussion is ongoing. Michigan sees integrated care as a significant opportunity to develop and implement system changes to further improve the quality of life of individuals in Michigan by providing services to people at the right time and in the most appropriate setting. MDCH is also reviewing other options to further improve efforts at community integration including Community First Choice, 1915(i), 1915(j) State Plan opportunities, and the Balancing Incentives Program. These tools are being considered as additional resources.

The Honorable Tom Harkin, Chairman  
September 19, 2012  
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Finally, the Michigan Medicaid director meets with members of the Michigan Olmstead Coalition on a monthly basis to discuss concerns of the Coalition and to accept comment on various Medicaid and department issues impacting the ability of people to receive services in the community. The state and the members of the Olmstead Coalition have found this venue to be highly effective in addressing any concerns that may arise.

**Question 6: Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.**

Michigan has implemented successful strategies in the delivery of both the behavioral health and long-term care supports and services. The BHDDA has implemented a number of strategies to facilitate the provision of supports and services in the most integrated settings. As part of the HSW renewal effective 10/1/10, the HSW strengthened language to prohibit enrollment into the HSW if applicants are residing in large group homes with 13 beds or larger. This process was implemented because large group homes are typically unable to provide home-like settings and true community integration. The process does encourage transition to smaller settings if an applicant has a clear plan to move within six months of enrolling in the HSW.

Since FY07, the capitation rates paid for the HSW include a residential factor that reimburses a higher rate to support individuals living in their own home, i.e., an unlicensed home living alone or with non-relatives. Over the last several years, there has been a shift toward people living in these types of arrangements due, in part, to the enhanced reimbursement for the supports and services needed to live independently.

Additionally, Under the Ticket to Work and Work Incentives Act of 1999, Michigan implemented its Freedom to Work/Medicaid Buy-in (FTW) in January of 2004. Enrollment has grown from less than 300 in early 2006 to over 7,000 individuals in 2012. Individuals are earning more money and paying greater portions of their medical costs. This also led to the development of a Joint Interagency Agreement in 2009 between Michigan Rehabilitation Services, Michigan Commission for the Blind, and MDCH to increase employment opportunities for persons with disabilities. Also, in 2010 the MDCH Director appointed members to the Leadership Council that is represented by citizens with disabilities, employers, and key state agencies to affect systems change.

From the long-term care perspective, the MI Choice Waiver has also implemented many successful strategies in implementing the tenets of Olmstead. MI Choice has developed partnerships with 14 Centers for Independent Living (CILs) in Michigan for the purpose of expanding nursing facility transitions and developing a statewide network of Aging and Disability Resource Centers. Additionally, MFP funding has been used to support 20 Housing Coordinator positions at each of the MI Choice Waiver agencies.

The Honorable Tom Harkin, Chairman  
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The Housing Coordinators assist with housing-related issues in an effort to address barriers to transitioning individuals from nursing facilities to the community. The MFP funding also supports 16 Outreach Specialists positions at the CILs. The Outreach Specialists develop relationships with nursing facility staff and residents and maintain a frequent presence in the nursing facilities. Michigan funds transition services for *all* individuals who have barriers to leaving a nursing facility that the normal discharge planning processes cannot resolve. The MI Choice Waiver has offered transition services since 2005 and serves many individuals in addition to those who meet the criteria for MFP participation. Approximately 25% of all transitions do not lead to enrollment in the MI Choice Waiver. These Medicaid beneficiaries either enroll in the Home Help program or do not need Medicaid-funded long-term care services in the community. Michigan uses state funds to transition those individuals who do not enroll in MI Choice.

Over the years, Michigan has also become increasingly involved in the Program of All-Inclusive Care for the Elderly (PACE), a State Plan program that provides various services to assist elderly individuals who are nursing-home eligible to remain in the community. There are now five PACE organizations in Michigan, with several other communities expressing interest in developing programs in their regions.

In summary, Michigan recognizes *Olmstead v. L.C.* as a landmark decision that has been important in the state's reduced use of institutional care and broad expansion of home and community-based services. I hope the information provided in this response meets your needs. Thank you for your interest in the progress Michigan has made. If you have questions or require additional information, please let me know. Michigan will be glad to assist further if needed.

Cordially,



James K. Haveman  
Director



# STATE OF MINNESOTA

## Office of Governor Mark Dayton

130 State Capitol ♦ 75 Rev. Dr. Martin Luther King Jr. Boulevard ♦ Saint Paul, MN 55155

September 12, 2012

The Honorable Tom Harkin  
Chairman, Committee on Health, Education, Labor and Pensions  
c/o Andrew Imparato  
Washington, DC 20510-6300

Dear Senator Harkin:

I am pleased to provide the attached response to your inquiry of June 22, 2012. My Commissioner of Human Services, Lucinda Jesson, has assembled detailed information about our efforts at the state-level to lead the nation in providing community-based options for long-term care services and to meet all our obligations under the Americans with Disabilities Act (ADA) and the Supreme Court's *Olmstead v. L.C.* decision. I share your concern that continued work is needed at the state and federal levels to ensure that no person with disabilities is ever forced to live in segregated housing just to receive necessary services.

Minnesota is a national leader in providing long-term care services and supports to people with disabilities. In a recent report by AARP, the Commonwealth Fund and the Scan Foundation, Minnesota ranked first in long-term care for older adults and people with disabilities.<sup>1</sup> Reports such as this provide evidence of our efforts over many years to increase community living and help people with disabilities live as independently as possible.

Minnesota has undergone a massive transformation in the last several decades to become a leader in long-term care. In the 1980s, Minnesota led the nation in the use of nursing homes and Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD). Policy changes at the state and federal level created opportunities to shift toward community-based care, most notably, the creation of the §1915(c) waiver option under Medicaid. Additionally, litigation in the late 1970s and early 1980s required the downsizing of state institutions and mandated the availability of home and community-based service options. Moratoriums were also placed on the development of nursing facilities and ICFs/DD.

By 2006, almost 80% of the public funds spent on long-term care services for people with disabilities in Minnesota were for home and community-based services. As of 2010, that percentage had increased to 87% of our spending.<sup>2</sup> We continue to focus our efforts on

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<sup>1</sup> *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers* (September 8, 2011), available at [http://www.longterm\\_scorecard.org/Report.aspx](http://www.longterm_scorecard.org/Report.aspx).

<sup>2</sup> MN Department of Human Services Data Warehouse, *Continuing Care Performance Report* (2011), available at [http://www.dhs.state.mn.us/main/dhs16\\_166837#](http://www.dhs.state.mn.us/main/dhs16_166837#)



community integration, person-centered services, self-direction, choice, and quality outcomes to assure Minnesotans with disabilities live independently in their communities.

In the attached detailed report, our Department of Human Services provides extensive information about our current efforts in Minnesota to increase community living options for people with disabilities and mental illness. Recommendations from our Olmstead Planning Committee this October will continue to inform the future of community-living for Minnesotans with disabilities. We look forward to continued partnership with federal government to assure individuals with disabilities live independently in the most integrated settings possible.

If you have any further questions about this information, please contact my Minnesota Department of Human Services Commissioner Lucinda Jesson, at 651-431-2923.

Sincerely,

A handwritten signature in black ink, appearing to read "Mark Dayton". The signature is fluid and cursive, with a large initial "M" and "D".

Mark Dayton  
Governor

cc: Senator Al Franken  
cc: Senator Amy Klobuchar



**DETAILED RESPONSES BY THE STATE OF MINNESOTA TO THE  
JUNE 22, 2012 LETTER FROM SENATOR TOM HARKIN**

The responses below are a collection of data and information from the Minnesota Department of Human Services, the state agency responsible for administering Minnesota's Medicaid program (Medical Assistance) as well as other supports for people with disabilities and people with mental illness. The Department works closely with many consumers, stakeholders, advocates, providers, local county and tribal governments, and other state agencies to provide services to people with disabilities across the state.

***(1) For each year from FY 2008 to the present: The number of people who moved from nursing homes, Intermediate Care Facilities for individuals with Intellectual or Developmental Disabilities, long-term care units of psychiatric hospitals, and board and care homes (often called adult care or residential health care facilities) to living in their own home, including through a supportive housing program.***

As shown in Table 1, a total of 809 individuals with disabilities moved from various facilities and into their own home in state fiscal year 2011. This includes people under age 65 receiving state funded services because of a disability or disabling condition. This number does not include people who moved from facilities to a less restrictive setting. For example, in state fiscal year 2011, 20 people moved from an ICF/DD to a group home and 30 people moved from a nursing facility to a group home. Of the total number of individuals who moved into their own home, the majority moved from a nursing facility (nursing home) or group home. The total number of people who moved to their own home has remained relatively constant since state fiscal year 2008. However, the number of individuals who remain in their own home has increased since 2008, with over 108,000 individuals remaining in their own home in 2011. As disability basic and long-term care enrollment in Medicaid has grown, more people are being served in their own homes rather than in nursing homes, ICFs/DD, or treatment facilities.

**Table 1 Number of People with Disabilities Moving to Their Own Home (SFY 2008-2011)**

<b>Number of People Moving to Their Own Home From:</b>				
	<u>SFY 08</u>	<u>SFY 09</u>	<u>SFY 10</u>	<u>SFY 11</u>
Nursing Facilities	284	292	315	306
Group Homes	255	226	257	252
Treatment Facilities	82	126	122	115
Psychiatric Hospital	101	89	49	67
ICF/DD	20	25	21	38
IMD	21	18	16	20
Board and Care Homes	23	8	18	7
Supervised Living Facility	2	1	7	4
<b>Total</b>	<b>788</b>	<b>785</b>	<b>805</b>	<b>809</b>
<b>Number of People Who Remained in Their Own Home</b>				
	<u>SFY 08</u>	<u>SFY 09</u>	<u>SFY 10</u>	<u>SFY 11</u>
<b>Total</b>	<b>91,749</b>	<b>99,360</b>	<b>104,060</b>	<b>108,370</b>

*Table 1 notes: Fiscal year represents the state fiscal year of July 1-June 30. Counts of individuals are unduplicated based on point in time data for the months of July and June of the following year. See Attachment A for setting descriptions. Source: Living arrangement from Medicaid Management Information System (MMIS), Avatar, DHS Data Warehouse; February 2012 Forecast.*

The majority of individuals with disabilities being served by public programs are being served in a community setting. Minnesota does not collect detailed living arrangement information for most Medicaid enrollees. Individuals not being served in an institutional or residential setting are often identified as being served in the community. For purposes of this question, individuals identified as living in the community are considered to be living in their own home. However, community settings may include such settings as: private residence, homeless, homeless or other shelter, car, hotel or motel, campground, medical hospital, halfway houses, detox, non-Medicaid medical or nursing facility, community behavioral health hospital or a veteran's administration home. Minnesota does collect more detailed living arrangement information for individuals who have been assessed for Home and Community-Based Services waivers; the majority indicated living with a family member or their own home.

ICFs/DD in Minnesota range in size, serving anywhere from 4 to 64 individuals. In state fiscal year 2012, 47.4% of recipient days were spent serving people in ICFs/DD with 6 or fewer beds.

Individuals with disabilities move out of different types of settings at different rates. In state fiscal year 2011, 42% of people who were in treatment facilities at the beginning of the year had moved to their own home by the end of the year (Figure 1). In comparison, 2% of people in ICFs/DD and 3% of people in group homes moved into their own home. The majority of ICFs/DD previously closed due to state policy efforts to convert funding to home and community based services. With Minnesota's *Money Follows the Person* grant, additional closures are planned in the future.

For purposes of this question, “group home” means a licensed adult foster care home that provides sleeping accommodations and services for one to four adults. There are two types of foster care: family adult foster care and corporate adult foster care. Corporate adult foster care refers to settings where the license holder does not reside at the home, and staff is typically hired. “Group home” also includes juvenile foster care homes. See Attachment A for further descriptions of setting terms.

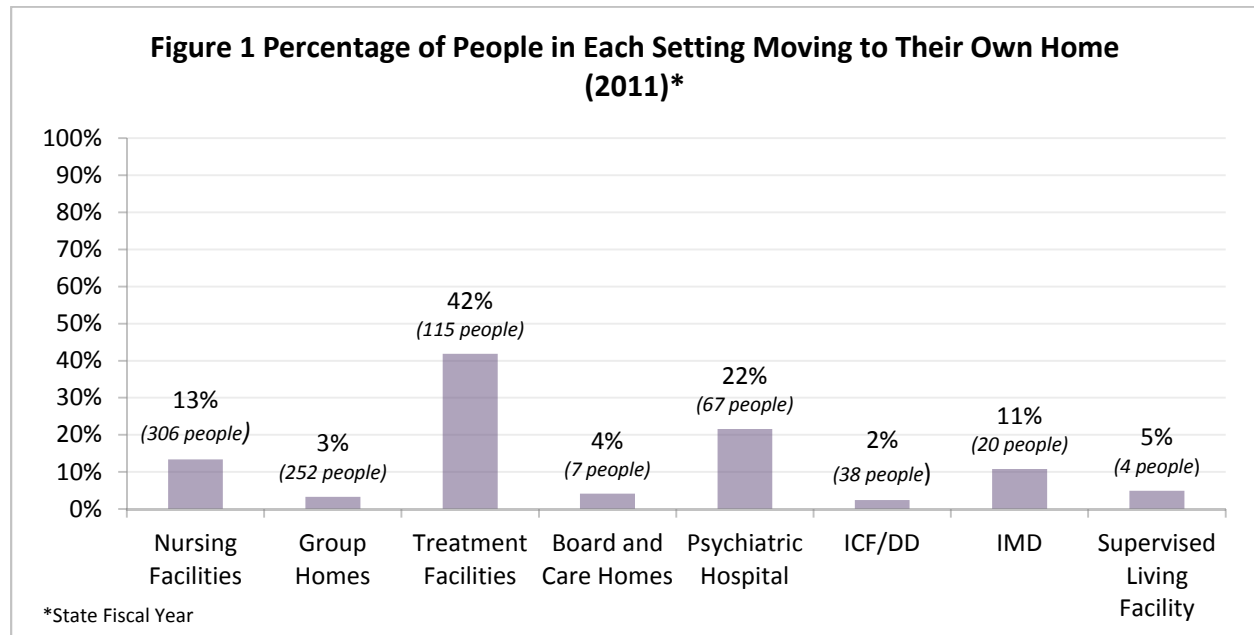


Figure 1 notes: State fiscal year 2011 represents the period of July 1, 2010 - June 30, 2011. Counts of individuals are unduplicated based on point in time data for the months of July and June of the following year. Source: Living arrangement from Medicaid Management Information System (MMIS), Avatar, DHS Data Warehouse; February 2012 Forecast.

**(2) The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.**

As shown in Table 2, Minnesota spent over \$1.1 billion in state fiscal year 2011 for services to people with disabilities in various settings, excluding basic medical care. The majority of funding (\$542 million or 46%) was spent serving individuals with disabilities in group homes, usually of four people or smaller. The next largest percentage of spending served people with disabilities in their own home (\$414 million or 35%). The smallest percentage of funding was provided to people residing in board and care homes (0.24%). Board and care homes are licensed homes for persons needing minimal nursing care. Minnesota also spent \$68 million to serve people in a supervised living facility for individuals who have been committed as mentally ill and dangerous. The supervised living facility funding includes all costs paid by the state to serve individuals in this setting, including medical care. See Attachment A for further descriptions of settings.

Descriptions of Minnesota programs that support people with disabilities in their own homes are included in the response to question three.

**Table 2 State Funding for People with Disabilities in SFY2011 (By Setting)**

Group Homes	\$	542,418,377	45.88%
Own Homes	\$	413,859,087	35.01%
Supervised Living Facility	\$	68,645,635	5.81%
ICF/DD	\$	64,203,703	5.43%
Nursing Facilities	\$	50,056,644	4.23%
Psychiatric Hospitals	\$	32,854,227	2.78%
IMD	\$	7,443,974	0.63%
Board and Care Homes	\$	2,792,675	0.24%
Total	\$	1,182,274,322	100%

*Table 2 notes: Includes people under age 65 receiving state funded services because of a disability or disabling condition. Time period reflects state fiscal year 2011: July 1, 2010-June 30, 2011. "Group home" spending includes the 1915(c) waiver cost to serve individuals receiving residential services, and Group Residential Housing funding for group homes smaller than four people. ICF/DD spending includes spending for Day Training and Habilitation (DT&H) services for individuals residing in an ICF/DD or receiving DT&H services through waiver residential services. Spending does not include basic care medical services. Source: February 2012 forecast, 2011 TAP Report, SWIFT.*

***(3) For each year from FY 2008 to the present, the extent to which Minnesota has expanded its capacity to serve people with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.***

As shown in Figure 2, Minnesota has increased the number of people served at home since 2008. Just over 33,600 people were received housing supports in their own home in FY 2008. In fiscal year 2012, that number increased to over 46,100 people. Meanwhile, state spending to serve individuals with disabilities in their own homes has fluctuated. Beginning in fiscal year 2009, Minnesota received enhanced federal match for Medicaid services through the American Recovery and Reinvestment Act (ARRA). This influx of federal dollars decreased the amount of state spending from fiscal year 2009 until fiscal year 2011.

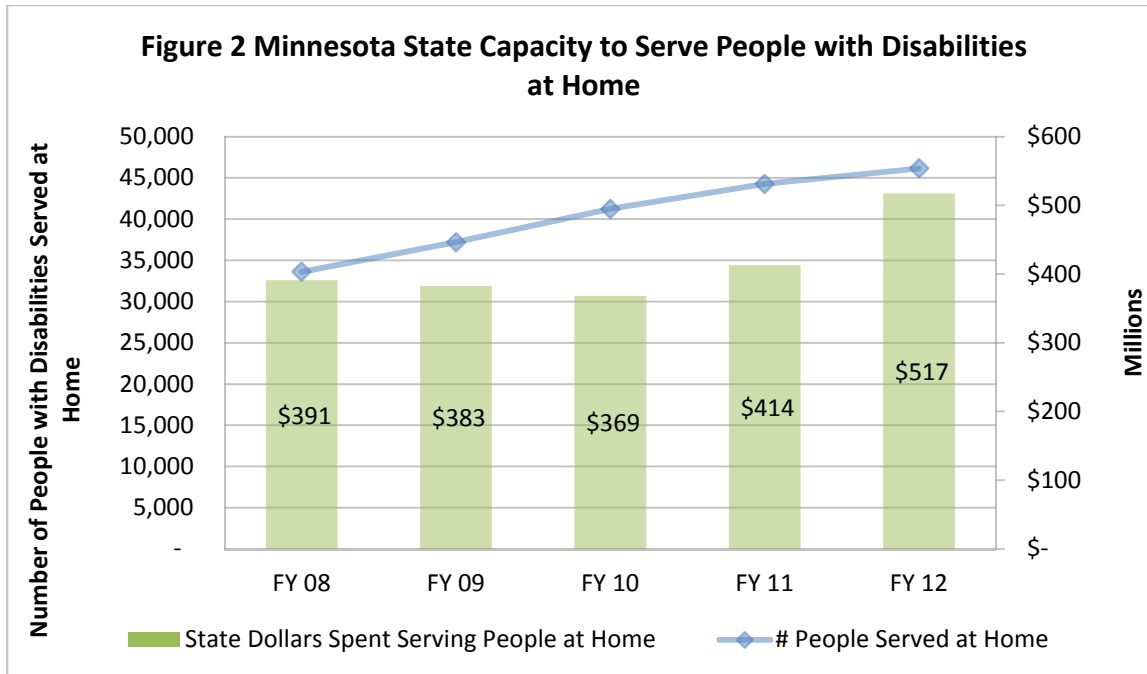


Figure 2 notes: Fiscal year represents the period of July 1-June 30. Dollars reflect state spending only; does not include federal or county shares. Counts of individuals is limited to people who received waiver, home care, Group Residential Housing, MSA-Shelter Needy, or Mental Health Supportive Housing in a community setting. State share spending is lower for the period of FY2009-2011 due in part to federal American Recovery and Reinvestment Act (ARRA) enhanced federal match. Represents some of the funding categories included in question two. Dollars do not include medical basic care. Source: June 2012 forecast; 2011 TAP Report; SWIFT.

Examining the change in capacity to serve people with disabilities in their own homes shows that while state spending decreased from 2008 to 2009 and from 2009 to 2010, the number of people served increased by 3,591 and 4,019 people, respectively (Table 3). In more recent years, the change in Minnesota’s capacity to serve individuals with disabilities in their own homes has increased but growth has slowed in both number of individuals served and state and federal dollars spent. From fiscal year 2008 to 2009, the change in total state and federal spending in Minnesota increased by \$94 million. From fiscal year 2009 to 2010 the total spending increased by \$43 million; from fiscal year 2010 to 2011 total spending increased by \$69 million; and from fiscal year 2011 to 2012, total spending increased by \$38 million.

As shown in Table 3, state spending alone has increased during this period due to federal maintenance of effort requirements, caseload growth, as well as the expiration of enhanced federal match under the ARRA.

**Table 3 Change in Capacity to Serve People with Disabilities at Home**

	<u>FY 08-09</u>	<u>FY 09-10</u>	<u>FY 10-11</u>	<u>FY 11-12</u>
Number of People Served at Home	3,591	4,019	3,029	1,886
State \$ Spent Serving People at Home	\$(8,453,830)	\$(13,786,870)	\$44,604,222	\$103,352,958

*Table 3 notes: Fiscal year represents the period of July 1-June 30. Counts of individuals is limited to people who received waiver, home care, Group Residential Housing, MSA-Shelter Needy, or Mental Health Supportive Housing in a community setting. Dollars do not include medical basic care. Source: June 2012 forecast; 2011 TAP Report; SWIFT.*

In addition to spending for non-residential home and community-based waiver services, spending for services in an individual's own home in this response includes several supportive housing programs. Minnesota has established several programs and initiatives specifically targeted at helping people move into their own homes.

*Group Residential Housing (GRH):* A state-funded income supplement program that pays for room-and-board costs for low-income adults who have been placed in a licensed or registered setting with which a county human service agency has negotiated a monthly rate.

*Minnesota Supplemental Aid-Shelter Needy (MSA-Shelter Needy):* A program that helps people with disabilities under age 65 have a choice about where they live. The program provides money to help people move into affordable housing and have their own place, or they may share housing expenses with another person.

*Housing Access Services:* Established in 2009, Housing Access Services is a partnership program with the Arc of Minnesota, a statewide nonprofit, to help eligible people with disabilities seek and locate suitable, affordable, accessible housing. The program helps people with moving, negotiating with landlords, applications for publicly financed housing, finding affordable furnishings, and other moving-related tasks.

*Housing with Supports for Adults with Serious Mental Illness (HSASMI):* Since 2008 this program has provided operating subsidy funding to supportive housing projects to fund a range of supports and non-reimbursable services that are vital for persons with serious mental illness to obtain and retain affordable rental housing. Supports vary by housing project but include tenant service coordination, front desk cost, security, and gap financing for rent stabilization for persons with very low income. HSASMI projects are located across Minnesota in metro and rural areas, in counties and on reservations. DHS partners with the Minnesota Housing Finance Agency to award funding to sustainable capital funding housing projects.

*Crisis Housing Fund (CHF):* This program provides temporary rental, mortgage, and utility assistance for persons with serious and persistent mental illness to retain their home while they are using their income to pay for needed mental health or chemical health treatment. Assistance is available for up to 90 days, and individuals may reapply if they need to return to treatment. Since 1993 the CHF has been available to eligible persons across Minnesota.

***(4) Contents of Minnesota’s Olmstead Plan for increasing community integration, including a description of the strategic planning process used to create it and any revisions that have been made since its creation, the extent to which the plan incorporates any new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.***

In December of 2011 the Department of Human Services (the Department) and the Plaintiffs in *Jensen et al. v. Minnesota Department of Human Services, et al.* Court File No. 09-CV-1775 entered into a settlement agreement that requires the development of a Minnesota Olmstead Plan.<sup>1</sup>

Minnesota’s Olmstead Planning Committee (OPC) members include individuals with disabilities, family members, providers, the Ombudsman for Mental Health and Developmental Disabilities, Plaintiffs’ counsel, advocates as well as senior decision-makers from the Minnesota Department of Human Services (DHS). Members of the OPC were either appointed as part of the Jensen Settlement Agreement or by mutual agreement between DHS and the Plaintiffs, from a diverse pool of interested persons from around the state, through a public application process.

Minnesota OPC members are not paid for their service. All members share the belief that inclusion in community life isn’t just good for people with disabilities, it’s good for everyone.

During 2012, the OPC met twice a month from March through July, three times in August, and weekly in September. The meetings included briefing session topic areas that are relevant to the Olmstead Plan.

The OPC timeline subcommittee identified six major topic areas to propose goals and recommendations relating to the following six topics:

- Where people live;
- Where people work;
- Community based services/supports that enable people to live and work in the community;
- Person centered planning (including MnCHOICES and individual plans to meet an individual’s dreams and desires);
- Other institutions where treatment is received/required; and
- Miscellaneous – Longitudinal Measurement of System Performance, training for direct care staff, workforce development, incentives for system transformation, leadership to sustain the plan.

Per the settlement agreement, (i) the OPC shall issue its public recommendations by October 5, 2012, and (ii) the State and the Department shall develop and implement a comprehensive Olmstead Plan by June 5, 2013. Full implementation by June 5, 2013 may be restricted to the extent additional legislation is required.

A copy of this response will be provided to the OPC.

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<sup>1</sup> Minnesota Olmstead Planning Committee Webpage: [http://www.dhs.state.mn.us/main/opc\\_home](http://www.dhs.state.mn.us/main/opc_home)



***(5) Any policy recommendations you have for measures that would make it easier for Minnesota to effectively implement Olmstead’s integration mandate and take advantage of new federally available assistance.***

The partnership between the federal government and states is critical to delivering community-based long-term care services and supports for people with disabilities. These recommendations reflect lessons from a variety of efforts in recent decades to move toward community integration.

**Establish consistent policies on employment supports**

In September 2011, the Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin providing clarification of existing CMS policies on employment supports under the §1915(c) Medicaid waiver programs.<sup>2</sup> While this guidance provided new insights into Medicaid options available to states, inconsistencies in definitions and principles of employment supports remain across federal funding streams. Medicaid, vocational rehabilitation services provided under the Rehabilitation Act of 1973, and the Individuals with Disabilities Education Act (IDEA), all support people with disabilities in their employment goals. Consistent policies for employment supports across these funding streams, including definitions of community-based and segregated employment, would make it easier for states to coordinate employment efforts to ensure community-based employment is the preferred outcome.

Additionally, federal eligibility criteria for disability programs continue to be based on an individual’s inability to work. Community-based employment will not become an expectation for people with disabilities receiving public assistance if eligibility criteria act as a disincentive for enrollees to earn money. Changing the federal disability determination process to move away from using work history as criteria for eligibility would make it easier for states to support employment programs.

**Streamline access to housing vouchers; strengthen waiver setting definitions; funding for permanent supportive services**

Accessible and affordable housing is a key component to serving people with disabilities in their communities rather than in institutional settings. Housing vouchers available through the US Department of Housing and Urban Development (HUD) are a critical resource to making community housing affordable for people with disabilities. Due to the long waiting list for housing assistance, many people apply for vouchers at several public housing authorities to be able to access assistance sooner. However, there are often varying applications and procedures to apply for assistance at each authority. A streamlined application process across public housing authorities would increase the ability of people with disabilities to receive housing assistance sooner.

Under Medicaid, CMS has proposed regulations on the definition of community-based settings where people with disabilities can receive services under the §1915(c) waiver programs.<sup>3</sup> These

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<sup>2</sup> CMCS Informational Bulletin. “Updates to the §1915(c) Waiver Instructions and Technical Guide regarding employment and employment related services.” September 16, 2011. Online at:

<http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf>

<sup>3</sup> Federal Register Volume 76, Number 73. April 15, 2011: <http://www.gpo.gov/fdsys/pkg/FR-2011-04-15/html/2011-9116.htm>

proposed regulations have enhanced Minnesota's ability to design Medicaid reforms around community-based expectations. Finalization of these regulations with additional enhancements to clearly define institutional settings would allow Minnesota to close loopholes to establishing institutional-like settings for people with disabilities.

Sustainable habilitative and rehabilitative housing stability services are needed which focus on establishing and stabilizing tenancy for persons with a serious mental illness. Permanent Supportive Housing (PSH) is an established Evidence-Based Practice (EBP) sponsored by SAMHSA which provides a framework for the development of housing and services for persons with serious mental illness (SMI). The principles and fidelity standards of the PSH EBP are consistent with the housing mission statement identified in the Minnesota Comprehensive Adult Mental Health Act. The implementation of PSH as an EBP is limited by the intense demand for affordable housing and supportive housing development resources, as well as the limited funding available for Housing Stability Services for persons with SMI and SMI with co-occurring needs. In order to stabilize individuals, and their families, in housing the housing must be available and affordable. Services need to be sustainable, habilitative, and rehabilitative focused on establishing and stabilizing tenancy.

#### **Funding for quality initiatives**

Provision of quality long-term care services to people with disabilities is critical to providing a functional, safe, and effective service system. However, quality activities such as monitoring and assurance can take a back seat to service provision during tough economic cycles. Similarly, quality standards may be developed but not fully enforceable without dedicated resources. A specific reimbursement methodology for quality improvement activities across funding streams would allow Minnesota and other states to implement comprehensive quality assurance measures.

#### **Enhance options to provide family/caregiver supports**

People with disabilities who are served by public programs are often also served informally by caregivers and family members without reimbursement. These individuals allow people with disabilities to be supported in their communities by caregivers of their own choosing. As the baby boomer generation ages into disability and people with disabilities live longer, reliance on informal supports will grow. Enhancements in the federal options to provide support to caregivers, regardless of the level of need of the person being served, would help retain the informal supports that maintain people in the community.

#### **Continued support for home and community-based services reforms**

CMS has provided Minnesota with a variety of opportunities to test innovation in the long-term care service system while still receiving federal financial participation. Some demonstration projects have lasted several years and are now components to our long-term care system. Other short-term projects have informed policy makers of what will and will not work in Minnesota's environment. Continued support from CMS to test innovations and to take incremental steps to implement reform projects will help Minnesota to achieve full community integration of people with disabilities.

As described below, Minnesota has recently applied for an §1115 waiver from CMS to reform elements of Minnesota's Medicaid program, Medical Assistance. CMS approval of this project will assist Minnesota to continue to enhance community services for Minnesotans with disabilities.

### **Strengthen coordination of long-term care with medical care**

Most people with disabilities served by long-term services and supports in Minnesota are also supported with health care coverage through Medicaid. Though supported through the same funding stream, health care outcomes are often considered in isolation of quality of life outcomes such as part-time employment or learning to hire support staff. Integration of these outcomes would provide researchers, planners, and policy makers a more accurate picture of the progress of people with disabilities to achieving their goals.

### **Increase Medicare payments**

Minnesota is a national leader in developing integrated products for dual Medicare/Medicaid recipients. Current Medicare payment rates in Minnesota, however, are very low. Minnesota providers are less likely to serve people with disabilities who are dually enrolled in Medicare and Medicaid due to the low reimbursement rate. Changes to the Medicare reimbursement methodology to increase states' flexibility in payments would ensure access to quality medical services for people with disabilities.

### **Technical assistance, training, and fiscal frameworks for reform efforts**

Minnesota is undertaking several reform efforts in the coming years to better meet the challenges of rising health care costs and an aging population, while still providing Minnesotans the services they need to lead fulfilling lives. Technical assistance, training, and fiscal frameworks for these efforts would be beneficial as implementation efforts begin.

*Reform 2020*, described later in this letter, is one example of a reform effort that incorporates several new federal options to provide services, including the §1915(i) and §1915(k), Community First Choice options.

In another example, Minnesota is considering and prioritizing the following services as a part of a §1915(i) application specific to adults with serious mental illness. Technical assistance, training, and fiscal frameworks for the implementation of these services would be helpful. Some examples include:

- Intensive Community Rehabilitation and Support Services would be a service for people requiring more intense community supports and rehabilitation services in regions of Minnesota that cannot afford the resources necessary to provide Assertive Community Treatment; and
- Expansion of integrated primary care services for people now receiving services from Intensive Residential Treatment Facilities or Assertive Community Treatment Teams.

***(6) Any successful strategies that Minnesota has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.***

Minnesota has undertaken several efforts to improve community outcomes for people with disabilities. The examples below represent just some of the projects Minnesota has been working on over the last few decades to improve community integration and independent living of people with disabilities. Many of these efforts are possible due to successful partnerships between Minnesota and various federal agencies and offices to innovate and test new approaches to community services.

### **Stakeholder Engagement**

Minnesota has a strong and active disability stakeholder community. The Department of Human Services works extensively with other state agencies, community organizations, providers, lead agencies, advocates, consumers, and the Legislature to develop policy recommendations and implement programs. By bringing stakeholders together, policies are designed and analyzed from multiple perspectives. This community approach helps Minnesota to better plan for changes to enhance community living.

### **Home and Community-Based Waiver Programs**

From 1984 to 1992, Minnesota established four home and community-based waiver programs under §1915(c) of the Social Security Act of 1981 to support people with disabilities in the community, rather than in institutions. Minnesota currently operates four disability HCBS waivers and one waiver for seniors that provide home and community-based services. The four disability waivers are:

- Brain Injury (BI)<sup>4</sup> – for disabled individuals meeting a nursing facility or neurobehavioral hospital level of care;
- Community Alternative Care (CAC)<sup>5</sup> – for disabled individuals meeting a hospital level of care;
- Community Alternatives for Disabled Individuals (CADI)<sup>6</sup> – for disabled individuals meeting a nursing facility level of care; and
- Developmental Disabilities (DD)<sup>7</sup> – for disabled individuals meeting in Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD) level of care.

Collectively, these programs serve approximately 37,000 people each year.<sup>8</sup>

Minnesota also offers state plan Personal Care Assistance Services and other home care services to support individuals in their homes.

These programs have undergone various changes since their establishment. Further reforms to these programs are being proposed under an §1115 Demonstration Proposal to the Centers for Medicare and Medicaid Services, titled *Reform 2020*, discussed below.

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<sup>4</sup> BI Fact Sheet: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5714-ENG>

<sup>5</sup> CAC Fact Sheet: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5711-ENG>

<sup>6</sup> CADI Fact Sheet: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5712-ENG>

<sup>7</sup> DD Fact Sheet: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5713-ENG>

<sup>8</sup> State fiscal year 2011, unduplicated count: 37,053. Source: Minnesota February 2012 forecast.

### **“Options Too” Initiative**

In 2001, Minnesota launched the “Options Too” initiative, a program designed to support people with disabilities who want to move from institutions into the community. The program created a guidebook to help people make decisions, determine what supports/services are available and navigate through the relocation process.<sup>9</sup>

### **Aging and Disability Resource Center (ADRC) and Linkage Line Programs**

In 2003, Minnesota was awarded an Aging and Disability Resource Center Grant from the U.S. Department of Health and Human Services Administration on Aging. With these funds, and other resources, Minnesota has established [www.minnesotahelp.info](http://www.minnesotahelp.info), a website designed to give all Minnesotans access to information about the services and supports available in their communities.

Also part of this network are the Disability Linkage Line and Senior LinkAge Line®. These toll-free assistance lines provide up-to-date information and assistance on community resources to people with disabilities and seniors.

### **Family Support Grants**

The Family Support Grant program provides state cash grants to eligible families of children with certified disabilities. The goal of the program is to prevent or delay the out-of-home placement of children with disabilities and promote family health and social well-being by facilitating access to family-centered services and supports.

### **Semi-Independent Living Services**

Minnesota offers semi-independent living services for individuals with developmental disabilities. These services include training and assistance in managing money, preparing meals, shopping, personal appearance, hygiene and other activities needed to maintain and improve the capacity of an adult with a developmental disability to live in the community. A goal of SILS is to support people in ways that will enable them to achieve personally desired outcomes and lead self-directed lives.

### **MnCHOICES<sup>10</sup>**

Minnesota is currently in the process of reforming the assessment process for long-term care services. Called MnCHOICES, this project creates and implements a single, comprehensive and integrated assessment and support planning application for long-term services and supports in Minnesota. MnCHOICES embraces a person-centered approach to ensure services meet the individual’s strengths, goals, preferences and assessed needs.

### **Pathways to Employment and Demonstration to Maintain Independence and Employment**

In 2000, Minnesota received a Medicaid Infrastructure Grant from CMS to build state infrastructure to increase the competitive employment and earnings of people with disabilities. Called “Pathways to Employment,” major accomplishments of the program include large scale

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<sup>9</sup> “Take the Road to Independence: The Options Too Initiative”. MN Department of Human Services. Updated 2006. Online at: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4789-ENG>

<sup>10</sup> MnCHOICES website: [http://www.dhs.state.mn.us/main/id\\_054837](http://www.dhs.state.mn.us/main/id_054837)

infrastructure developments such as the creation of Disability Benefits 101 (DB101)<sup>11</sup>—a web-based tool to help people with disabilities understand the relationship between benefits and work—and the policy support for Minnesota’s Medicaid Buy-In program, Medical Assistance for Employed Persons with Disabilities (MA-EPD).<sup>12</sup> The MA-EPD program enrolls approximately 8,000 people per month with monthly average gross income of \$1,560.

Funded from May 2006-September 2009, the Demonstration to Maintain Independence and Employment<sup>13</sup> was a demonstration project implemented by the Department of Human Services and funded under a grant from the CMS. This demonstration studied the effects of providing a comprehensive set of health and behavioral health care services and employment-related supports to employed people with serious mental illness. Results from the demonstration showed that compared to the control group, program participants were less likely to pursue a disability determination, experienced improvements in functioning and greater job stability, earned higher wages, and were less likely to delay or skip needed care due to cost. Findings from this project are a component of the *Reform 2020* efforts described below.

### **Evidence Based Practices in Mental Health Block Grant**

Minnesota was granted \$20,000 for each year from 2008 to 2010 from the Substance Abuse and Mental Health Services Administration (SAMHSA) related to the Olmstead work that was integrated into the Evidence Based Practice implementation sections of the Minnesota Mental Health Block Grant. Illness Management and Recovery efforts were expanded, documents translated, and adaptations made for the Hmong, Lao, and Somali cultures. Illness Management and Recovery modules were also translated into Braille. 2011 Olmstead dollars were used to provide training and consultation to six Minnesota inpatient psychiatric hospitals for the implementation of Illness Management and Recovery and Integrated Dual Disorder Treatment.

### **Mental health grants**

Over \$89 million was granted to counties and mental health providers in fiscal year 2012 to provide mental health services to adults and children. These grants pay for services such as children’s mental health screening, crisis services, and other non-Medicaid reimbursable services that help to keep people in their own homes and communities. These grants have been a part of the service development that has resulted in fewer and shorter hospital stays.

### **Money Follows the Person Rebalancing Demonstration Grant**

In February, 2011, Minnesota was awarded a Money Follows the Person Rebalancing Demonstration Grant from the U.S. Department of Health and Human Services.<sup>14</sup> Minnesota will leverage an award of up to \$187.4 million over five years to improve community services and support people in their homes rather than institutions. Minnesota’s goals of the demonstration are to:

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<sup>11</sup> DB101 website: [www.mn.db101.org](http://www.mn.db101.org)

<sup>12</sup> MA-EPD website: [www.dhs.state.mn.us/maepd](http://www.dhs.state.mn.us/maepd)

<sup>13</sup> Findings from the demonstration project are available online at [www.staywellstayworking.org](http://www.staywellstayworking.org)

<sup>14</sup> Money Follows the Person Rebalancing Demonstration webpage:  
[http://www.dhs.state.mn.us/main/dhs16\\_162194#](http://www.dhs.state.mn.us/main/dhs16_162194#)

- Simplify and improve the effectiveness of transition services that help people return to their homes after hospital or nursing facility stays;
- Advance promising practices to better serve individuals with complex needs in the community;
- Increase stability of individuals in the community by strengthening connections among healthcare, community support, employment, and housing systems; and
- Increase use of home and community-based services by setting priorities to address specific institutional needs for reform.

Throughout the demonstration, DHS will continue to increase the proportion of State Medicaid expenditures for HCBS relative to those spent on institutional long-term care.

### **Implementation of Evidence Based Practices in Adult Mental Health**

In 2003, SAMHSA began supporting the implementation of Evidence Based Practices that included fidelity methods to insure competent implementation of the practices. Other states have provided state dollars for demonstration and/or pilot projects to implement evidence based practices. Minnesota decided that the quality of services provided using the evidence based practices should be available to all Minnesotans with Serious Mental Illness and providers should have access to adequate ongoing funding for providing the services. Training and consultation in the delivery of Illness Management and Recovery, Integrated Dual Disorder Treatment, Supported Employment, and Assertive Community Treatment was provided at no cost to providers. Certified Peer Specialist Services and Permanent Supportive Housing were added later. Medicaid provides funding for the following Minnesota Mental Health Services:

- Adult Rehabilitation Mental Health Services (ARMHS), a community-based rehabilitation service for people with serious mental illness, provided in a person's own home and community;<sup>15</sup>
- Assertive Community Treatment Teams (ACT), a multi-disciplinary team approach to provide very intensive community based rehabilitation and support services to people with serious and persistent mental illness;
- Intensive Community Rehabilitations Services, a community based rehabilitation service that is more intense than ARMHS and less intense than ACT;
- Intensive Residential Treatment programs, residential rehabilitation services that are a step down from psychiatric hospitalization with a focus on teaching the skills necessary to function in an independent community setting. These services are provided 24 hours a day under the supervision of mental health professionals in community residential settings;
- In-patient psychiatric hospitalization provided in dispersed 16-bed community behavioral health hospitals. This model was part of a redesign effort over several years to minimize larger, institutional facilities on regional treatment center campuses;
- Day Treatment; and
- Permanent Supportive Housing, an evidence-based practice strategic initiative. Access to affordable permanent housing and supportive services are critical resource

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<sup>15</sup> ARMHS Webpage: [http://www.dhs.state.mn.us/main/id\\_004956](http://www.dhs.state.mn.us/main/id_004956)

needs for persons with serious mental illness (SMI) in order to stabilize their symptoms, healthcare, and lives in the community. Federal and state housing and homeless resources help to address homelessness through subsidies and housing resources. Minnesota is actively involved in efforts to prevent and end homelessness, and to make available housing and supportive service resources, for persons with SMI. By working with our state partners Minnesota has been able to develop a range of permanent supportive housing resources that provide persons with SMI with access to housing and health stability, and an opportunity for recovery. Using the PSH EBP as a framework for a federal strategic initiative provides a focused, evidence-based, approach for integrating individuals into their communities.

Providers that bill for the above services are expected to integrate the evidence practices into their service delivery. This integration of the evidence based practices across the mental health continuum of care provides a common language between providers, greatly improves the quality of all services, and insures funding for Evidence Based Practices. Bringing Evidence Based Practices to a state wide scale requires a serious commitment, but is worth the effort.

### **Addressing the 25-Year Lifespan Disparity for People with Serious Mental Illnesses**

On average, people with serious mental illnesses die 25 years earlier than the general public, most often from physical illnesses that are inherently preventable or treatable. In response to this alarming public health disparity, Minnesota used a small SAMHSA grant to conduct a quality improvement pilot project involving our assertive community treatment (ACT) teams. ACT is an intensive, Medicaid-reimbursed service focusing on people with psychiatric diagnoses who are at the highest risk for re-hospitalization and other adverse outcomes.

Seven of Minnesota's 26 ACT teams – serving about 500 individuals in urban, suburban, and rural settings – participated in the pilot. Since every city and town is somewhat unique, our strategy was to stimulate local creativity and initiative. Expert coaches from the Minnesota-based, nationally recognized Institute for Clinical Systems Improvement helped the pilot teams to design and test more effective methods for integrating mental health and primary care services at the local level.

The following indicators improved in just five short months:

- The number of participants who had annual physical exams increased by 19%;
- Monthly reviews of the participants' physical care needs increased by 62%;
- Monthly checks of the participants' body mass index increased by 48%; and
- Monthly checks of the participants' tobacco use status increased by 32%.

This low-cost high-yield strategy is a good model for Minnesota and other states.

### **Housing with Supports for Adults with Serious Mental Illness (HSASMI)**

Since 2008, the HSASMI program has provided operating subsidy funding to supportive housing projects to fund a range of supports and non-reimbursable services that are vital for persons with serious mental illness to obtain and retain affordable rental housing. Supports vary by housing



project but include: tenant service coordination, front desk cost, security, and gap financing for rent stabilization for persons with very low income. HSASMI projects are located across Minnesota in metro and rural areas, in counties and on reservations. DHS partners with the Minnesota Housing Finance Agency to award funding to sustainable capital funding housing projects.

### **Crisis Housing Fund (CHF)**

The CHF program provides temporary rental, mortgage, and utility assistance for persons with serious and persistent mental illness to retain their home while they are using their income to pay for needed mental health or chemical health treatment. Assistance is available for up to 90 days, and individuals may reapply if they need to return to treatment. Since 1993 the CHF has been available to eligible persons across Minnesota to prevent homelessness.

### **Bridges Regional Treatment Center (RTC) Pilot**

The Bridges RTC Pilot Program provides eligible participants transitional rental assistance, housing access, and supportive service coordination.<sup>16</sup> The program serves people with a serious mental illness that are:

- Hospitalized at the Anoka Metro Regional Treatment Center (AMRTC) and do not meet hospital level of care, have significant or complex barriers to accessing and retaining housing, are homeless, near homeless and/or rent burdened upon AMRTC admission or discharge; or
- For whom Bridges RTC Pilot assistance will divert or prevent re-admission to the AMRTC. The Bridges RTC Pilot Program assists people with serious mental illness in obtaining and retaining affordable housing along with mental health and supportive services.

The Bridges RTC Pilot Program transitions individuals out of the hospital to permanent supportive housing in the community. DHS partner with the Minnesota Housing Finance Agency (MHFA) to award fund and align the program with the MHFA Bridges transitional rental subsidy program.

### **Reform 2020**

Most recently, Minnesota has applied for an §1115 demonstration waiver to CMS to reform portions of Minnesota's Medicaid program, Medical Assistance.<sup>17</sup> This effort, named *Reform 2020*, focuses in part on transforming the long-term care system for seniors, people with disabilities or other complex needs and other Medical Assistance enrollees to:

- Achieve better health outcomes;
- Increase and support independence and recovery;
- Increase community integration;
- Reduce reliance on institutional care;
- Simplify the administration of the program and access to the program; and

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<sup>16</sup> [http://www.mnhousing.gov/initiatives/housing-assistance/rental/mhfa\\_000479.aspx](http://www.mnhousing.gov/initiatives/housing-assistance/rental/mhfa_000479.aspx)

<sup>17</sup> *Reform 2020* Waiver Submission: <https://edocs.dhs.state.mn.us/lfsrserver/Public/DHS-6535B-ENG>. Submitted to CMS August 24, 2012.

- Create a program that is more fiscally sustainable.

The goal of the reform effort is to have better individual outcomes, making sure people have access to the right services at the right time, and to ensure the future of the long-term care services and supports system in Minnesota.

The cornerstone of the proposal is a request to utilize both the Community First Choice Option (1915(k)) and 1915(i) options under Minnesota's state plan. Minnesota has proposed to redesign its state plan personal care assistance services and expand self-directed options under a new service called Community First Services and Supports (CFSS). CFSS will allow individuals who have functional needs in areas of daily living to have access to a service that is designed to flexibly respond to their needs and provide the right service at the right time, in the right way.

The CFSS will promote self-determination, and the ability for individuals to direct their support plan and service budgets to best meet their needs. There will be an option for individuals to directly employ and manage their own direct care workers, using a financial management entity under contract with the state. There will be provider agencies to deliver services for those who do not self-direct their services. Services will be delivered in accordance with a person-centered plan, regardless of whether or not the participant chooses to assume responsibility as the employer through the self-directed option.

Through this effort, Minnesota is requesting a waiver of the Institutions for Mental Diseases exclusion. The Anoka Metro Regional Treatment Center (AMRTC) is a 200 bed mental health facility. The average length of stay at this facility is 83 days. However, there are some individuals who need very specialized supports to move from AMRTC and be successful in the community. They tend to stay at AMRTC longer. Minnesota has requested the IMD exclusion waiver to increase funding and allow the development of those services for those individuals with more intensive and specialized needs.

In addition to the CFSS and AMRTC reforms, *Reform 2020* also addresses employment supports, service coordination for children receiving CFSS, reforms for seniors, establishing housing stabilization supports for adults with chronic medical conditions, transition assistance for the homeless and redesigning mental health services to enhance community-based care.

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For additional information about any topic discussed in this report, please contact Minnesota Department of Human Services Commissioner Lucinda Jesson at 651-431-2923.

## ATTACHMENT A

### Definitions of key terms:

- “Nursing facility” means a long-term care facility that offers a full array of personal, dietary, therapeutic, social, spiritual, recreational, and nursing services to residents. Also called nursing homes.
- “Board and care homes” means licensed homes for persons needing minimal nursing care. They provide personal or custodial care and related services for five or more adults or people with disabilities. They have private or shared rooms with a private or attached bathroom. There are common areas for dining and for other activities.
- “Psychiatric hospitals” means a licensed psychiatric hospital that serves people with mental illness. Minnesota has one 200-bed psychiatric hospital, the Anoka-Metro Regional Treatment Center.
- “Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD)” means a residential facility licensed as a supervised living facility under Minnesota Statute to provide services to persons who have developmental disabilities. ICFs/DD serve between 4 and 64 persons. In state fiscal year 2012, 47.4% of recipient days were spent serving people in ICF/DDs with 6 or fewer beds.
- “Institution for Mental Disease (IMD)” means a hospital, nursing facility, or other residential facility of 17 beds or more that is primarily engaged in providing diagnosis, treatment or care of people with mental diseases. Adults between the ages of 22 and 64 who are on Medical Assistance (MA) and not enrolled in managed care lose their MA eligibility while residing in an IMD.
- “Group home” means a licensed adult foster care home that provides sleeping accommodations and services for typically one to four adults. The rooms may be private or shared and the dining areas, bathrooms and other spaces are shared family style. Adult foster care homes can offer a wide array of services. There are two types of adult foster care: family adult foster care and corporate adult foster care. “Group home” also includes juvenile foster care homes.
- “Treatment facilities” means a rehabilitation facility for children with severe emotional disturbance.
- “Own home” means living arrangements including a person’s private residence, homeless, car, homeless shelter, hotel/motel, campground, medical hospital for less than 30 days, maternity shelter, VA facility, Chemical dependency halfway house, other halfway house, detox-only facilities.
- “Supervised Living Facility” means a facility in which there is provided supervision, lodging, meals and in accordance with provisions of rule of the Department of Human Services, counseling and developmental habilitative or rehabilitative services to five or more persons who are developmentally disabled, chemically dependent, adult mentally ill, or physically disabled. This includes Minnesota’s forensic services for individuals who have been committed as mentally ill and dangerous.



PHIL BRYANT  
GOVERNOR

September 27, 2012

Mr. Andrew J. Imparato  
Senior Counsel & Disability Policy Director  
U.S. Senate Committee on Health, Education,  
Labor, and Pensions  
Washington, DC 20510-6300

Dear Mr. Imparato:

As we discussed, we are in receipt of Senator Harkin's requests for certain information related to the State's mental health system and compliance with the Americans with Disabilities Act ("ADA"), as interpreted in *Olmstead v. L.C.* As I previously explained, the Department of Justice recently conducted a purportedly extensive investigation of the State's mental health system, the stated goal of which was to assess the State's compliance with the ADA and *Olmstead*. See [http://www.justice.gov/crt/about/spl/documents/miss\\_findletter\\_12-22-11.pdf](http://www.justice.gov/crt/about/spl/documents/miss_findletter_12-22-11.pdf). This office and several different state agencies have devoted countless hours of staff time to meeting with DOJ and responding to their various inquiries related to that investigation, many of which sought the same or similar information now requested in Senator Harkin's letter. Despite the State's great efforts and consistent cooperation, DOJ's "findings letter" alleges certain violations of the ADA and *Olmstead* and specifically threatens a lawsuit against the State. While discussions with DOJ regarding these issues are ongoing, the State absolutely denies that it is in violation of the ADA or *Olmstead*. DOJ's allegations are factually unsupported and/or based on seriously flawed interpretations of *Olmstead* and the ADA. Nonetheless, given the federal government's continued threats to sue the State, including the Governor in his official capacity, it would be inappropriate at this time for the State to provide written responses to questions from another arm of the federal government on the very issues on which litigation is being threatened. Therefore, we respectfully decline to provide a substantive response to Senator Harkin's letter at this time.

Sincerely,

A handwritten signature in blue ink, appearing to read "Jack Wilson".

Jack Wilson  
Legal Counsel

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September 7, 2012

The Honorable Tom Harkin  
Chairman, Committee on Health, Education, Labor, and Pensions  
United States Senate  
Washington, D.C. 20510

Dear Senator Harkin:

On behalf of Missouri Governor Jay Nixon, I am responding to your information request relating to how Missouri is helping people with disabilities to live independently at the 13<sup>th</sup> anniversary of the United States Supreme Court's *Olmstead v. L.C.* decision. Missouri has a long history of commitment to community based services and supports to its citizens. Two recent accomplishments are:

- Implementing the Partnership for Hope (PFH) program. Started in 2010, PFH provides needed community-based supports and services to individuals with developmental disabilities using local, state and federal resources. The program served 1,500 individuals by the end of June 2012 and anticipates increasing enrollment to 2,500 by the end of June 2013. To date 93 of 114 counties and the City of St. Louis are participating in the Partnership for Hope program.
- Implementing the Balancing Incentive Program (BIP) grant, which Missouri received effective July 1, 2012. This grant will provide increased funding for HCBS services which will support the design and implementation of Long Term Support Service (LTSS) enhancements, help in the development of a community infrastructure across Missouri, and strengthen the community-based network of services across the continuum of care and populations.

In addition, Missouri's previous accomplishments include:

- Adding personal care as an optional Medicaid state plan benefit in 1981.
- Being one of the first states approved for a 1915(c) Home and Community Based Services (HCBS) waiver to provide services to the aged and disabled in 1982.
- Implementing Missouri Care Options (MCO) in 1992 to allow individuals to remain in their homes moderating growth in nursing home spending while increasing funding for home and community based services.
- Implementing in 2005 a Developmental Disabilities Systems Transformation Initiative to support people of any age or payer source to live in their communities through maximized independence, dignity, choice and flexibility. This grant created many positive outcomes, some of which include enhancements

RELAY MISSOURI

FOR HEARING AND SPEECH IMPAIRED

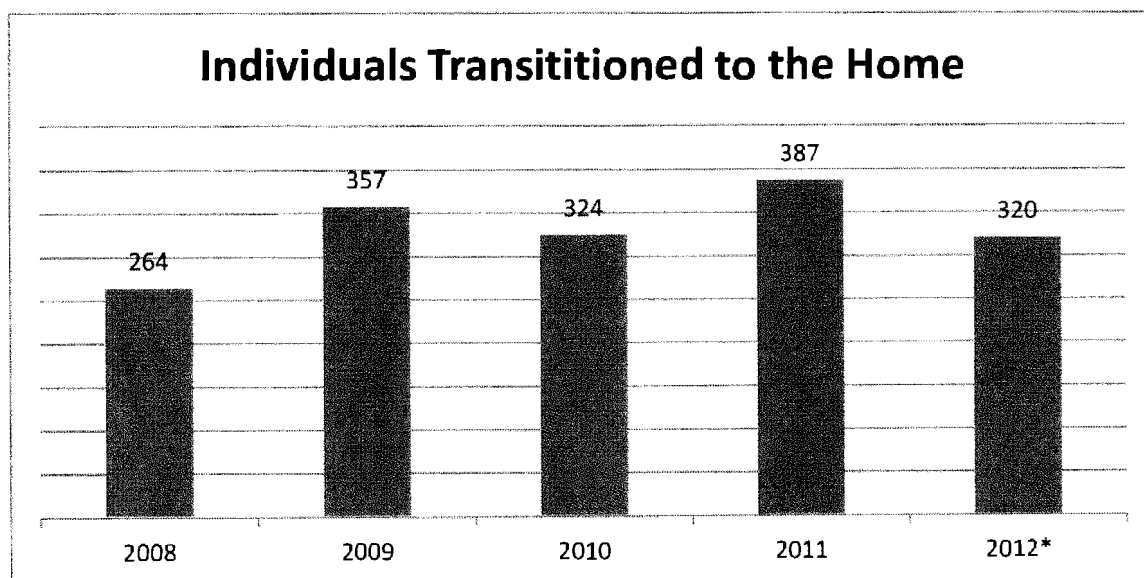
1-800-735-2466 VOICE • 1-800-735-2966 TEXT PHONE

to a parent to parent, consumer to consumer network called "Sharing our Strengths" which allows families to connect and share experiences and learn from one another, enabling Missouri to participate in the Interactive Autism Network linking the autism community with researchers, and establishing a Quality Advisory Council comprised of consumers and family members to provide input to the department.

- Reducing, incrementally, the Habilitation Center bed capacity by transitioning individuals to communities. Missouri has reduced the number of individuals in habilitation centers from a high of 1,349 in 1999 to 501 as of the date of this letter.
- Implementing a Money Follows the Person program (MFP) beginning in 2007. As of 8/1/12 a total of 545 participants have transitioned to the community with an additional 121 individuals preparing to transition.

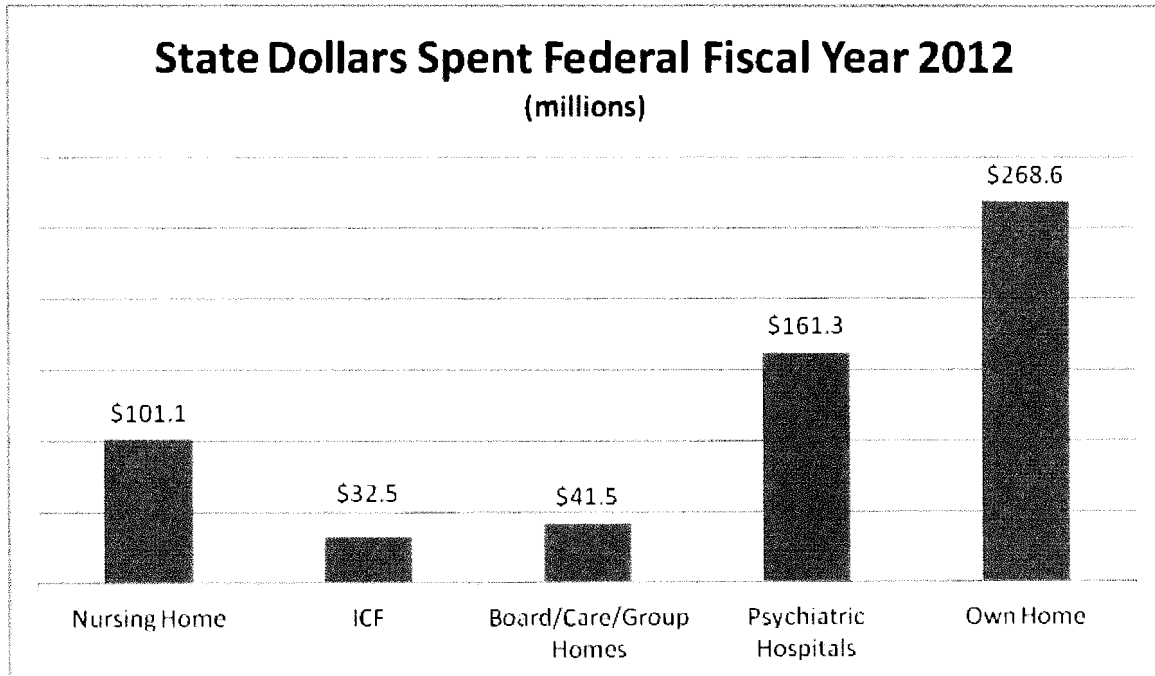
Per your request the following information is provided to show that Missouri is working hard to ensure the ADA's promise to Missouri's citizens of the opportunity to live, work and receive services in the greater community.

1. ***For each year from FY 2008 to present: The number of people who moved from nursing home, intermediate care facilities for individuals with intellectual or developmental disabilities, long term care units of psychiatric hospitals, and board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program.***



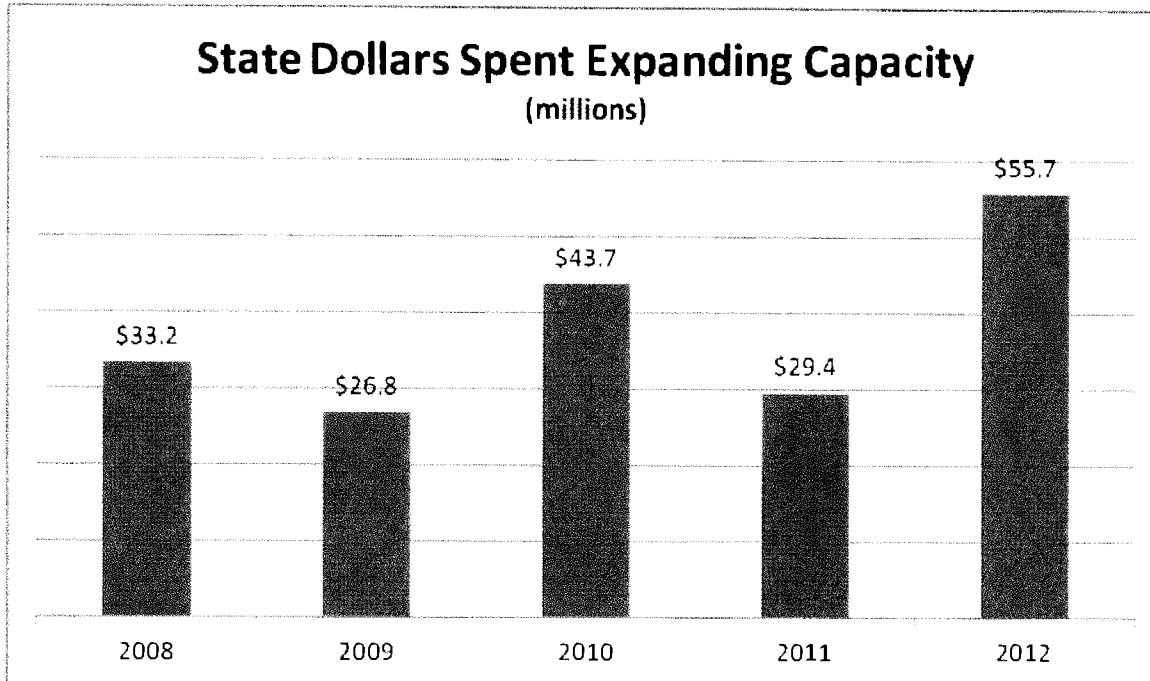
NOTE: Data reflects transitions during the federal fiscal year, 2012 data is not complete. Data is specific to individuals with disabilities.

2. *The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of those settings: nursing homes, intermediate care facilities (ICF) for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.*

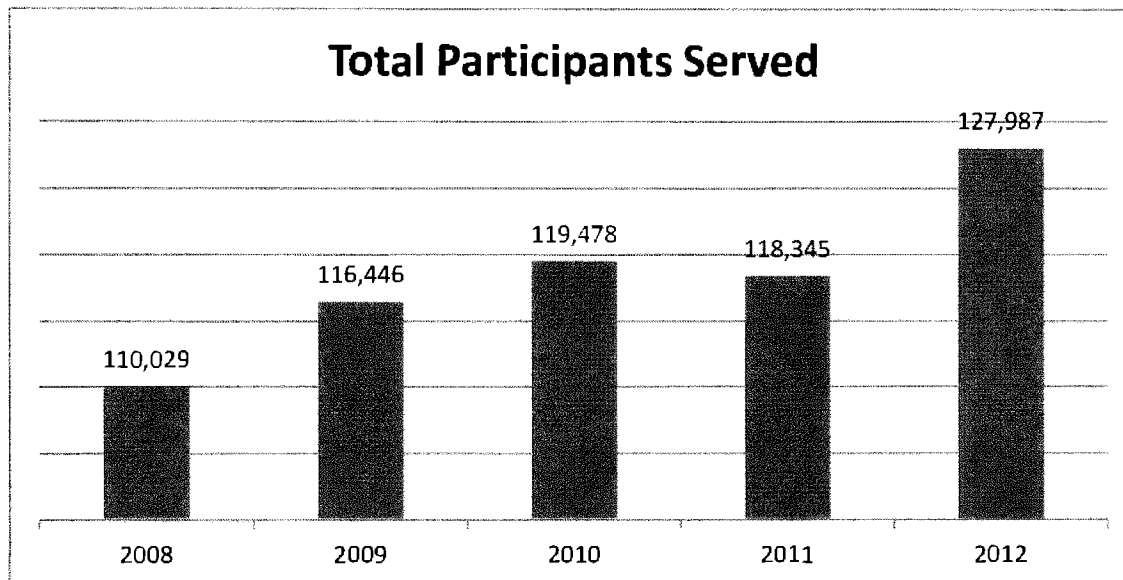


Note: Data is specific to individuals with disabilities.

3. For each year from FY 2008 to present, the extent to which your state has expanded its capacity to service individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.



Note: Data is specific to individuals with disabilities.



Note: 2011 data is lower because of a change in the claims processing system, pushing participant claims into the next year. Data is specific to individuals with disabilities.



- 4. *The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.***

Missouri's Olmstead Plan recommendations were completed in December of 2000. In April of 2000 a Commission was appointed comprised of 15 people representing consumers of community-based services, members of the Governor's Council on Disability, legislators and state agencies. The Commission was charged with reviewing Missouri's community-based and consumer-directed care services and developing a comprehensive and effective working plan to ensure that persons with disabilities are offered effective choices in their supports and services. The Commission held public hearings across the state and formed four subcommittees with the participation of over 150 persons. In total more than 600 people participated in the plan process.

In 2007, Missouri implemented Money Follows the Person. This initiative completely replaces the State's old Olmstead report. Missouri's initial goal was to transition 250 individuals from ICF/MRs and Nursing Facilities from FY 2008 through FY 2011. Missouri met and exceeded the goal, by the end of FY 2011 Missouri transitioned 276 individuals. Money Follows the Person grant was extended through 2016 through the Affordable Care Act with an additional four years to use any award in 2016. Missouri's goal is to transition 177 individuals during CY 2012; as of August 29, 2012, 123 individuals transitioned in 2012 with a cumulative transition total of 562 transitions since the grant started.

Additionally, under Money Follows the Person the state received award of the Nursing Home Diversion and Transition Grant. The state has partnered with the Aging and Disability Resource Center (ADRC) and the University of Missouri-Kansas City to develop curriculum to provide Minimum Data Set (MDS), Section Q training to all nursing facilities in the ADRC 18 county region of the state. As part of this grant, curriculum to educate the community and the judicial system is also being developed and disseminated. The trainings will be monitored to see their effectiveness. The plan is to take the trainings statewide once the demonstration is completed.

Money follows the person has implemented a new web based referral system that allows nursing facilities to directly submit Section Q referrals electronically directly to the contracted local contact agencies (Centers for Independent Living and Area Agencies on Aging). This system then allows a direct referral to the MFP program through the same system as well as transition information and case management to monitor the individual during the duration of their participation in the program.

- 5. *Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.***

Recent changes to the HUD Section 811 program have created disincentives for providers to develop affordable housing units. Specifically, under the new rules no more than 25% of the total units in eligible

properties can be used for supportive housing for people with disabilities. Although the intent of this change is to ensure fuller community integration, one consequence is that it forces small service providers who utilize 811 funding to enter the public housing market and rent to persons not in their target populations. This forces providers into the role of landlord, which many may not wish to undertake because of the lack of involvement and oversight they would normally provide for tenants with disabilities receiving supportive services. Perception of the risks involved—both legal liabilities and environmental risks to vulnerable tenants—and the costs of alleviating such risks, may exacerbate the shortage of affordable housing for people with disabilities.

**6. Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.**

Missouri has used funding through the MFP Demonstration Grant to build an infrastructure to expedite the referral process for individuals who are wishing to learn about their options about community living and also referral for actual transition to community. A couple of new developments have occurred within the last year. One of new developments include the creation of a web based referral system used by nursing facilities to refer individuals who are interested in learning about their options of returning to community. This system supports both individuals moving from nursing facilities and intermediate care facilities. Contracts have been awarded to Centers for Independent Living and Area Agencies on Aging for options counseling and transition coordination for individuals in nursing facilities. State staff has been hired specifically for the MFP program for central office oversight as well as five regions of the state for nursing home transition. Ongoing training is conducted for contracted staff as well as state staff supporting the program for both individuals transitioning from nursing facilities and intermediate care facilities. One of the largest barriers to transition is the lack of affordable accessible housing, Missouri has partnered with the Missouri Housing Development Commission (MHDC) and entered into a Memorandum of Understanding in order for MHDC to apply for HUD funding for section 811 subsidies for individuals with disabilities. If awarded this funding could allow approximately 250 individuals access to housing. Missouri has been commended by national MFP partners for the collaboration between Missouri state agencies and in implementing a successful program, this collaboration has allowed the sharing of best practices across multiple agencies.

I will be pleased to elaborate on any of the data provided herein, or provide additional information if it would be helpful to you in your inquiry.

Sincerely,



Brian Kinkade  
Interim Director

September 7, 2012

The Honorable Tom Harkin  
 U.S. Senator  
 731 Hart Senate Office Building  
 Washington, DC 20510

Dear Senator Harkin:

Thank you for your June 22, 2012 letter regarding the *Olmstead v. L.C.* decision.

I am proud of the services that the State of Nebraska offers persons with physical and developmental disabilities. Nebraska continually works to improve the delivery and coordination of those services between the multiple agencies that hold the responsibility to define and regulate the services and service providers. Our systems include options for persons with disabilities to live in the most integrated community setting possible.

Below is the information in response to your specific questions:

- (1) **For each year from federal fiscal year 2008 to the present: the number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long term care units of psychiatric hospitals, and board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program.**

**Number of Discharges**

<b>Discharge Facility</b>	<b>Oct 2007 - Sep 2008</b>	<b>Oct 2008 - Sep 2009</b>	<b>Oct 2009 - Sep 2010</b>	<b>Oct 2010 - Sep 2011</b>	<b>Oct 2011 - Sep 2012</b>
Long Term Care Psych Hospital	116	129	124	83	10
ICF/MR	62	117	86	79	13
Nursing Facility	787	845	819	742	734

- (2) **The amount of state dollars that will be spent in this federal fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a support housing program.**

**Time Period Oct 2011 - Sep 2012 Estimated Expenditures**  
(actual claims paid through July 2012)

<b>Living Arrangement Claim Group</b>	<b>Net Payment Detail</b>	<b>State Share</b>
Home	\$410,741,391	\$179,795,453
Group Home	\$148,897,546	\$68,107,622
Long Term Care Psych Hospital	\$1,375,842	\$596,565
ICF/MR	\$54,955,129	\$23,828,544
Nursing Facility	\$140,838,295	\$61,067,485
Supportive Housing (behavioral health)	\$2,100,299	\$2,100,299
Other	\$73,799,563	\$31,999,491
<b>Total</b>	<b>\$832,708,065</b>	<b>\$367,495,459</b>

- (3) **For each year from federal fiscal year 2008 to present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.**

In July 2011, the Division of Developmental Disabilities (DDD) implemented new regulations (Title 404 of the Nebraska Administrative Code) which include several provisions that encourage individuals to live in their own homes. Most importantly is the distinction in the regulations between services provided in a home the individual receiving supports owns or rents and the services provided in settings that are controlled (owned or operated in any capacity) by the provider of services. In addition, when a setting is provider controlled, it must have three or fewer individuals with developmental disabilities residing in that setting, be operated as a single setting and demonstrate that each residence operates independently; they also must be integrated into the community. DDD is committed to providing greater support options and provider capacity by increasing the number of providers who serve individuals with complex medical needs and behavioral challenges, so that individuals and/or their legal representatives who previously felt that they had no community options would have a greater selection of providers.

The Division of Medicaid & Long-Term Care (MLTC) implemented the Centers of Medicare and Medicaid Services grant funded program Money Follows the Person in June 2008. The “Money Follows the Person” Rebalancing Demonstration Program (MFP) supports Nebraska’s efforts in rebalancing the long-term care systems by transitioning people who are eligible for Medicaid from institutional living environments to community living.

In March 2011, Nebraska's MFP program utilized rebalancing funds gained from savings through transitioning individuals living in Nebraska institutions to community living to implement an electronic documentation, billing and incident reporting system that will be utilized by the community-based DDD, which manages the Developmental Disabilities Waivers. The DDD has had a contract with Therap Services, Inc., since March 2011 to develop a more integrated electronic system. Initially, the DDD began requiring all specialized providers of developmental disabilities services to report their incidents via Therap's incident reporting system. The DDD has also implemented Therap's referral module which allows state DD service coordinators to send referrals to all or some providers and allows for an exchange of information and comments between the provider and service coordinator. The DDD is working with Therap to implement their new iteration of the Individual Support Plan as well as the Individual Budget application they created specifically for Nebraska. In addition, the DDD is making progress towards providers being able to submit their billings through Therap, which will allow real-time updates to the individual's budget, giving individuals maximum flexibility for their service delivery.

In April 2012, Nebraska's MFP program funds were used to incentivize Nebraska Area Agencies on Aging (AAA) and Centers for Independent Living (CIL) to develop a sustainable process for responding to Minimum Data Set 3.0 Section Q referrals, with a goal of incorporating best practices and consumer-directed philosophy in the agency response protocols. Two AAAs and three CILs elected to participate in the two phase process, which involved first writing a protocol which included best practices and second implementing the protocol. Each agency used a model process made available by the MFP Program and customized it for their agency. There was considerable dialogue in the process of writing and approving the protocols, most of which centered on the importance of direct contact with the resident and importance of education about options using a participant directed philosophy.

In January 2012, Nebraska's MFP program initiated a new transition provider platform called Transition Planning and Support (TPS). The TPS program reimburses private and agency providers who work directly with individuals interested in transitioning to community living from institutional care. The TPS provider works to remove barriers to transition such as assisting in housing search, communicating with family and/or guardian, responding to medical concerns, securing transportation, and developing community resources.

As the Division of Behavioral Health (DBH) implemented behavioral health reform in Nebraska, the state recognized the importance of creating housing and support service options for individuals who were transitioning from services in the state Regional Centers. The Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS) has an evidence based practice called Permanent Supportive Housing (PSH). PSH provides voluntary, flexible supports to help people with disabilities choose, get, and keep housing that is decent, safe, affordable, and integrated into the community. Central to the approach is a belief that people with disabilities should have the right to live in a home of their own, without any special rules or service requirements.

For more details see the Permanent Supportive Housing Evidence-Based Practices (EBP) KIT:

<http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510>.

Nebraska Revised Statute §71-812(3) (a) established the Housing-Related Assistance program. The Housing-Related Assistance program uses state funds to provide assistance for very low-income adults with serious mental illness. By DBH policy, the program is limited to people with serious mental illness who are extremely low income with housing problems. The assistance includes rental payments, utility payments, security and utility deposits, and other related costs. The program requires the consumer to pay 30% of her/his income for the rent and utilities. Some funding is available for one-time housing start-up costs such as deposits and furniture. The first year of the program was FY2006 (from July 1, 2005 to June 30, 2006). The following report covers FY2008 to FY2012.

**Unduplicated Total Number of Served By Region by State Fiscal Year**

	<b>FY2008</b>	<b>FY2009</b>	<b>FY2010</b>	<b>FY2011</b>	<b>FY2012</b>
Region 1	42	70	61	43	29
Region 2	77	60	69	43	54
Region 3	101	154	136	151	121
Region 4	88	117	92	106	124
Region 5	209	235	263	242	273
Region 6	200	187	224	233	224
<b>Totals</b>	<b>717</b>	<b>823</b>	<b>845</b>	<b>818</b>	<b>825</b>

The rental subsidy is an important support to the persons served in this program. Without the support, these individuals most likely would be served at a higher level of care, or could be homeless or in jail.

In order to support persons living in their own homes, Nebraska's DBH also manages a Supported Employment program in cooperation with the Department of Vocational Education. About 250 persons with serious mental illness are served annually through this program.

- (4) The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.**

Although Nebraska does not have a document labeled as a formal Olmstead plan, the DDD and the DBH emphasize home and community-based services. If an individual who resides in an Intermediate Care Facility for Intellectual Disabilities, a nursing facility or psychiatric hospital and expresses a desire to transition, the DDD, as a matter of policy, prioritizes those individuals who are eligible for developmental disability services, according to state statute, for

community-based funding. In addition to the regulations discussed in question three, DDD renewed its two Home and Community Based Services (HCBS) 1915(c) waivers for adults with developmental disabilities to incorporate self-directed services in January 2010. Individuals now have the flexibility to choose specialized (agency based) or non-specialized (individual provider) services; they may also mix those types of services to create the best support options for the individual. Our objective is a more flexible, person-centered system that provides better, more attractive community-based options for individuals.

MLTC also has a strong community focus. Individuals expressing a desire to move from institutional settings that are reviewed when referred to the 1915(c) waivers for the Aged and Disabled or Traumatic Brain Injury. Nebraska does not have a wait list for either waiver so clients wishing to move to a community setting are able to do so upon meeting the waiver criteria. The MLTC utilizes the MFP program as well as the Section Q referrals to receive information from individuals, facilities, family members and community members regarding the desire of the individual and uses the information to respond with the appropriate transition or waiver service coordinators. Response protocol requires a response within 13 business days of referral.

For persons with a severe and persistent mental illness, DBH coordinates with each of the six Regional Behavioral Health Authorities to help people leave the state hospital and return to living in the community.

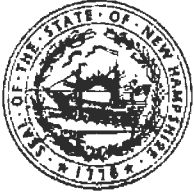
I hope this information is helpful to you.

Sincerely,



Kerry T. Winterer  
Chief Executive Officer  
Department of Health and Human Services

cc: Michael B. Enzi, Ranking Member, Senate Committee on Health, Education, Labor & Pensions  
Chairman Max Baucus, Senate Finance Committee  
Ranking Member Orrin G. Hatch, Senate Finance Committee  
Senator Mike Johanns  
Senator Ben Nelson  
Governor Dave Heineman



# State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES

129 PLEASANT STREET, CONCORD, NH 03301-3857

~~603-271-9200~~ FAX: 603-271-4912 TDD ACCESS: 1-800-735-2964

New Number: 603-271-9200

NICHOLAS A. TOUMPAS  
COMMISSIONER

June 3, 2013

The Honorable Senator Tom Harkin  
Chairman  
United States Senate Committee on Health, Education, Labor and Pensions  
428 Senate Dirksen Office Building  
Washington, DC 20510

Dear Senator Harkin:

I write in response to your request for information about how New Hampshire is working to meet its obligations under the ADA and the Olmstead decision. New Hampshire is the defendant in a lawsuit filed in the United States District Court for the District of New Hampshire. The case is Amanda D., et al v. NH Governor, et al (Civ. No. 1:12-cv-53-SM). Due to this current and ongoing litigation, we are unable to fully respond to your request. However, New Hampshire is responding to the allegations brought by the plaintiffs and has articulated that response in pleadings filed in the U.S. District Court. We will provide copies of significant pleadings if they would be helpful to you.

New Hampshire shares the interest of you and the HELP Committee in maintaining compliance with ADA and Olmstead obligations. Toward this end, New Hampshire employs a number of tools created by Congress to deliver quality services to individuals with disabilities in integrated settings appropriate to the needs of the individuals.

Sincerely,

A handwritten signature in black ink, appearing to read "N. A. Toumpas", written over a large, stylized circular flourish.

Nicholas A. Toumpas  
Commissioner





# State of New Mexico

Susana Martinez  
*Governor*

September 6, 2012

The Honorable Thomas Harkin, Chairman  
United States Senate  
Committee on Health, Education, Labor and Pensions  
428 Senate Dirksen Office Building  
Washington, DC 20510

Dear Senator Harkin:

Thank you for granting the state of New Mexico the opportunity to comment on the **successes** of our home and community-based services. We are proud of the dual efforts that have been implemented to move individuals from an institutional setting back into the community while also maintaining service to current community residents who can safely live among their relatives and friends. Today, New Mexico is first in the nation in providing home and community-based services for its elderly and disabled residents, dedicating between 61 and 69 percent of its Medicaid long-term care budget on such services.<sup>1</sup>

## **I. BACKGROUND**

With a population around 2 million, New Mexico is the 5<sup>th</sup> largest state in the country, with remote access and a rural population primarily living below the poverty level. Like many states, New Mexico has struggled to manage its budgetary constraints while recognizing that many New Mexicans are living longer, requiring additional support. In fact, based upon current projections, by the year 2030, New Mexico will rank 4<sup>th</sup> in the nation in percentage of population age 65 and older – significantly jumping from its

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<sup>1</sup> According to the AARP Public Policy Institute, *Across the States 2009: Profiles of Long-Term Care and Independent Living*, New Mexico spent approximately 61% of its Medicaid long-term care budget on home and community based services while The Hilltop Institute has the figure at closer to 69%. The Hilltop Institute's analysis is based on the Thomson Reuters data, "National and State Long-Term Spending for Adults Ages 65 and over and Persons with Physical Disabilities," 2011. See, Attachment A, The Hilltop Institute's bar graph.

current ranking of 39th.<sup>2</sup> And, for almost twenty years, the State has been actively working to identify residents in need of certain services and making every effort to keep those individuals at home.

New Mexico recognizes that non-institutional long-term services and supports are provided primarily through three main home and community-based services programs: waivers, personal care, and home health. Since the 1990s, the State has taken a multi-faceted approach in rebalancing its long-term care systems, including:

- The use of various 1915(c) waivers (permitted under the Social Security Act) to provide additional Medicaid services to specific populations: developmentally disabled; aged and elderly; medically fragile; and HIV/AIDS;<sup>3</sup>
- Closing state institutions for people with intellectual disabilities and related developmental disabilities;<sup>4</sup>
- The addition of a Personal Care Option to its State Medicaid Plan, utilizing this vehicle to create home and community-based services, including consumer directed services to keep people in the community;
- Creating a new cabinet level Aging and Long-Term Services Department (“ALTSD”) which now has a resource center to help individuals identify community supports;
- Creating the “Mi Via” program, a “cash and counseling” self-directed option program for individuals currently receiving waiver services and for individuals with brain injuries to allow these participants to self-direct their care; and
- The implementation of the Coordination of Long-Term Services (“CoLTS”), a long-term care program that focuses on dual eligibles and requires the managed care plans to actively identify institutional residents and, if appropriate, move these residents back into the community.

The linchpin of New Mexico’s program is the Personal Care Option (“PCO”). The PCO program is designed to improve the quality of life for those with disabilities and health

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<sup>2</sup> See, New Mexico State Plan for Aging & Long-Term Services, October 1, 2009 – September 30, 2013, <http://www.nmaging.state.nm.us/uploads/FileLinks/93d89f60b10b4732be44e6c31f403060/2009-2013-New-Mexico-State-Plan.pdf>.

<sup>3</sup> Home and community-based waivers, such as 1915(c) waivers, provide an array of medical and nonmedical services, including personal assistance with daily activities, to selected populations identified by each state, generally based on age and type of disability.

<sup>4</sup> See, Kane, Mollica, Priester, “Rebalancing Long-Term Care Systems in New Mexico: Case Study as of December 2007,” submitted to the Centers for Medicare and Medicaid Services (May 2008), [http://www.hpm.umn.edu/ltrresourcecenter/research/rebalancing/attachments/2007\\_case\\_studies/New\\_Mexico\\_final\\_case\\_study\\_as\\_of\\_December\\_2007.pdf](http://www.hpm.umn.edu/ltrresourcecenter/research/rebalancing/attachments/2007_case_studies/New_Mexico_final_case_study_as_of_December_2007.pdf).

conditions, and to prevent them from needing to enter nursing facilities. Personal care attendants provide a range of in-home services that enable individuals to live in their own homes and achieve the highest level of independence possible. Individuals receive: bowel and bladder services; meal preparation and assistance; eating assistance; household support services; and hygiene/grooming support services.<sup>5</sup>

The program expenditures have grown steadily from \$65,567,791 in 2001 to \$584,304,879 in SFY12.<sup>6</sup> The PCO program was incorporated into CoLTS, which began implementation in August 2008. In order to qualify for PCO services and 1915(c) waiver services in CoLTS (to the extent that there are available slots) an individual must meet the state's nursing home level of care: at least two requirements related to assistance with daily living (ADL) and be at or under 300 percent of the federal benefit rate.<sup>7</sup>

The State's CoLTS program began in August 2008 and was fully implemented by April 1, 2009. CoLTS is a managed long-term care system designed to serve New Mexico's Medicaid recipients who reside in nursing facilities, receive PCO services, 1915(c) waiver services for the disabled and elderly, and/or are covered by Medicare ("dual eligibles"), whether or not they are in need of long-term services.<sup>8</sup> By integrating dual eligibles, the State leveraged its costs and is able to provide a seamless array of services.<sup>9</sup> Currently, there are approximately 40,000 individuals in CoLTS, 85 percent of whom are dual eligibles. In addition, almost 18,000 CoLTS members receive PCO services.<sup>10</sup>

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<sup>5</sup> See, NMAC 8.315.4.16.

<sup>6</sup> See, Note 4 (for the 2004 amount) and Attachment C for the SFY12 amount. These costs are total program costs which include both the state share and federal matching funds. Note that the SFY12 figure is calculated based on a percentage of a capitation rate paid to the CoLTS contractors.

<sup>7</sup> The federal benefit rate is established by the Social Security Administration.

<sup>8</sup> Dual eligibles are individuals, who, by reason of age, income, and/or disability qualify for Medicare and full-Medicaid benefits under section 1902(a)(10)(A) or 1902(a)(10)(C) of the Social Security Act, by reason of section 1902(f) of the Social Security Act, or under any other category of eligibility for medical assistance for full benefits.

<sup>9</sup> See, Attachment B, Transition of Fragmented System to Coordinated System of Long-Term Services chart.

<sup>10</sup> See, Attachment C, SFY12 expenditures.

Under the CoLTS contract, the managed care organizations (“MCOs”) are required to assist the State with “Money Follows the Person” initiatives.<sup>11</sup> The MCOs identify and screen all individuals who can be moved back into the community. Once an individual is identified, the MCO provides relocation assistance and transitional services, such as security deposits, furnishings, and moving expenses.<sup>12</sup>

Through the New Mexico Department of Health (“DOH”), the State implemented various programs to provide early identification, intervention, and appropriate services. For example, the Family, Infant, Toddler (“FIT”) program provides early intervention services to infants and toddlers who have or are at risk for developmental delays, and families in New Mexico.<sup>13</sup> DOH also offers autistic spectrum disorder services for individuals diagnosed with some form of autism.<sup>14</sup>

DOH works collaboratively with the New Mexico Human Services Department (“HSD”) to administer certain 1915(c) waivers: developmentally disabled (“DD Waiver”), medically fragile, HIV/AIDS, and Mi Via. With over 4,000 individuals receiving these waiver services for SFY12, the state has spent approximately \$90,000,000.<sup>15</sup>

By working through the HSD, DOH, and ALTSD, the State’s rebalancing efforts have been appropriate and effective.<sup>16</sup>

## II. PROJECTED NEEDS AND CENTENNIAL CARE

On January 1, 2011, the oldest baby boomers turned 65 years of age.<sup>17</sup> Every day for the next 19 years, about 10,000 more will cross that threshold.<sup>18</sup> By 2030, when all

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<sup>11</sup> In 2006, the New Mexico Legislature adopted the Money Follows the Person in New Mexico Act. See, NMSA 1978, 27-15-1 et seq.

<sup>12</sup> See, Attachment D, the full CoLTS contract can be found the HSD Medical Assistance Division website: <http://www.hsd.state.nm.us/mad/Contracts.html>.

<sup>13</sup> See, DOH website: <http://www.health.state.nm.us>

<sup>14</sup> See, Note 11, above.

<sup>15</sup> See, Attachment C, SFY12 expenditures.

<sup>16</sup> The New Mexico Human Services Department is the single state agency authorized by the New Mexico Legislature to administer the State’s Medicaid program. See, NMSA 1978, 27-2-2 et seq. Through an interagency agreement, the New Mexico Department of Health administers the State’s 1915(c) waivers for the developmentally disabled, medically fragile, and HIV AIDS. The New Mexico Aging & Long-Term Services Department is responsible for developing strategies to assist New Mexicans to maintain lifelong independence and healthy aging.

<sup>17</sup> See, Note 12, above.

baby boomers will have turned 65, 18 percent of the nation's population will be at least that age.<sup>19</sup> As New Mexico's older population increases, the percentage of New Mexicans who are disabled will increase, putting greater pressure on the State's resources. For example, as New Mexico's population ages, per capita hospital and nursing home care expenditures will continue to rise. Per capita health care spending is 3.5 times greater for the elderly than for those under age 65.<sup>20</sup>

New Mexico, like many other states, is looking at ways to modernize Medicaid and offer an array of services that are individually focused and based on the person's needs. On August 17, 2012, the State resubmitted its proposed 1115(a) research and demonstration project waiver, "Centennial Care." Centennial Care is a managed care program designed to slow the rate of growth in the State's Medicaid program while avoiding program cuts.<sup>21</sup> Under its current system, the Medicaid program budget accounted for 16 percent of the State's budget.<sup>22</sup> At the same time, Medicaid healthcare costs were projected to increase at a rate of 5.8 percent per year through 2020.<sup>23</sup> Moreover, under the current system, seven (7) managed care entities were providing Medicaid services in two-separate programs, Salud! (generally for low-income pregnant women and children) and CoLTS; with behavioral health services being carved out and delegated to a statewide entity.<sup>24</sup> As a result, the State saw the need to modernize its Medicaid program.

The goals of Centennial Care are to:

- Create a unified, comprehensive service delivery system to assure cost-effective care and to focus on quality over quantity; and

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<sup>18</sup> See, Note 12, above.

<sup>19</sup> See, Note 12, above.

<sup>20</sup> See, Note 2, above.

<sup>21</sup> Information on Centennial Care can be found at: <http://www.hsd.state.nm.us/>.

<sup>22</sup> See, Budget Bills, passed and enacted during the 2012 New Mexico Legislative session at: <http://www.nmlegis.gov/lcs/>.

<sup>23</sup> See, CMS actuarial study for the projected costs of providing Medicaid services.

<sup>24</sup> See, the Interagency Behavioral Health Purchasing Collaborative established by statute, NMSA 1978, §9-7-6.4.

- Slow the rate of cost growth (bend the cost curve) in the program over time through better management of care while avoiding costs.<sup>25</sup>

To develop a comprehensive service delivery system, the State intends to unite the number of managed care plans while still delivering the full range of services, including the current service packages provided under Medicaid Fee-for-Service (“FFS”) and all existing waivers except for the DD Waiver. Thus, the State is going to “carve in” all Medicaid behavioral health services and all home and community based and institutional services now provided under the non-DD waivers. Managed care plans will be expected to manage this full array of services as well as to take primary responsibility for the management of the self-directed services offered under the Mi Via waiver that is available to those who meet the nursing facility level of care.<sup>26</sup>

The crux of the State’s approach under Centennial Care is to implement a better care coordination system based on creating a patient-centered environment in which members receive the care they need in the most efficient and appropriate manner. The care coordination approach will be continuous and includes:

- Assessing each member’s physical, behavioral, functional, and psychosocial needs;
- Identifying the medical, behavioral, and long-term care services and other social support services and assistance (e.g., housing, transportation or income assistance) necessary to meet the identified needs;
- Ensuring timely access and provision, coordination and monitoring of services needed to help each member maintain or improve his or her physical and/or behavioral health status or functional abilities, and maximize independence; and
- Facilitating access to other social support services and assistance needed in order to promote each member’s health, safety, and welfare.<sup>27</sup>

As you can see, the State has made significant progress in complying with the Americans with Disabilities Act and the United States Supreme Court’s decision in *Olmstead v. L.C.*. More New Mexicans are being served in the community rather than in institutions and, as the State moves forward with Centennial Care, Medicaid recipients will receive the right services in the right setting at the right time.

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<sup>25</sup> See, Centennial Care Concept Paper, found at: <http://www.hsd.state.nm.us/>.

<sup>26</sup> Mi Via is the State’s Self-Directed Waiver approved by CMS pursuant to 1915(c) of the Social Security Act.

<sup>27</sup> See, Note 85, above.

### III. QUESTIONS

The State provides the following answers to the questions presented in your letter:

1. ***For each year from FY 2008 to the present: The number of people moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long term care units of psychiatric hospitals, and board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program.***

#### ANSWER:

To the extent the State has the information requested, it is provided herein and is based on the State's Fiscal Year which runs from July 1 through June 30, with SFY12 being the current year for purposes of this letter.

<b>SFY08</b>	<b>Total Placements</b>	<b># of Placements Reintegrated Full Medicaid</b>	<b># of Placements Reintegrated Other (QMB, etc)</b>
ICF/MR	278	12	0
NF	5,986	588	52
<b>SFY09</b>	<b>Total Placements</b>	<b># of Placements Reintegrated Full Medicaid</b>	<b># of Placements Reintegrated Other (QMB, etc)</b>
ICF/MR	290	9	0
NF	6,007	387	60
<b>SFY10</b>	<b>Total Placements</b>	<b># of Placements Reintegrated Full Medicaid</b>	<b># of Placements Reintegrated Other (QMB, etc)</b>
ICF/MR	280	10	0
NF	5,955	389	63
<b>SFY11</b>	<b>Total Placements</b>	<b># of Placements Reintegrated Full Medicaid</b>	<b># of Placements Reintegrated Other (QMB, etc)</b>
ICF/MR	286	11	1
NF	6,165	472	60
<b>SFY12</b>	<b>Total Placements</b>	<b># of Placements Reintegrated</b>	<b># of Placements Reintegrated</b>

		<b>Full Medicaid</b>	<b>Other (QMB, etc)</b>
ICF/MR	282	17	0
NF	6,098	560	41

2. ***The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.***

**ANSWER:**

State figures are divided into two categories: nursing facility level of care ("NF LOC") and ICF/MR level of care ("ICF/MR LOC"). Subcategories under the NF LOC include the State's 1915(c) waiver populations: HIV/AIDS ("AIDS"), the Disabled and Elderly ("D&E"); Brain Injured ("BI"), nursing facility residents ("NF"), PCO services and Program of All-Inclusive Care for the Elderly ("PACE"). Under the ICF/MR LOC are: the State's 1915(c) waivers for DD and the Medically Fragile ("MF") and residents living in ICF/MRs.

<b>NF LOC</b>	<b>Program</b>	<b>Number of Individuals Served (unduplicated)</b>	<b>State Share</b>
	AIDS	20	\$ 237,785
	BI	328	\$ 4,315,840
	D&E	3,050	\$ 29,555,957
	PCO	17,656	\$178,380,196
	PACE	464	\$ 3,387,292
	NF	6,098	\$ 44,336,116
	<b>TOTAL</b>	<b>26,882</b>	<b>\$260,213,186</b>
<b>ICF/MR LOC</b>			
	DD	3,859	\$ 92,453,213
	MF	220	\$ 2,013,583
	ICF/MR residents	282	\$ 7,824,983
	<b>TOTAL</b>	<b>4,353</b>	<b>\$102,291,779</b>
<b>GRAND TOTAL OF STATE EXPENDITURES</b>			<b>\$362,504,965</b>



3. ***For each year from FY 2008 to the present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated money previously spend on segregated settings) and the specific nature of the capacity added.***

**ANSWER:**

One of the main concerns in moving individuals back into the community is the back-fill of beds, whether the individual resides in a nursing home or ICF/MR. This is primarily due to population growth and the needs of certain residents that require the full skill set only offered in the institutional setting. That being said, New Mexico **has** continued to promote individuals staying in their homes, either through transitioning out of an institution or through diversion programs. Throughout the years, the number of individuals served through PCO and other programs has increased along with companion dollars. As you can see, while the cost of keeping individuals in the community is less, the total dollars expended by the State to serve more individuals continues to increase.

**SFY08**

<b>Program</b>	<b>Number of Individuals Served</b>	<b>State Share</b>
AIDS	12	\$ 108,562
BI	140	\$ 1,173,303
D&E	3,958	\$ 26,985,121
PCO	12,920	\$ 89,280,420
PACE	411	\$ 2,765,528
DD	3,788	\$ 84,866,345
MF	200	\$ 1,357,896

**TOTAL** **\$206,537,175**

**SFY09**

AIDS	16	\$ 144,188
BI	350	\$ 3,877,832
D&E	3,727	\$ 28,241,502
PCO	14,408	\$ 98,339,530
PACE	473	\$ 3,678,787

	DD	3,873	\$103,868,866
	MF	236	\$ 1,613,912
	<b>TOTAL</b>		<b>\$239,764,616</b>
<b>SFY10</b>			
	AIDS	16	\$ 118,968
	BI	362	\$ 3,015,804
	D&E	3,395	\$ 21,321,518
	PCO	15,563	\$102,769,017
	PACE	456	\$ 2,213,126
	DD	3,824	\$ 62,392,706
	MF	232	\$ 1,202,138
	<b>TOTAL</b>		<b>\$193,033,277</b>
<b>SFY11</b>			
	AIDS	19	\$ 156,313
	BI	347	\$ 3,094,680
	D&E	3,254	\$ 22,072,649
	PCO	16,945	\$123,893,550
	PACE	451	\$ 2,359,969
	DD	3,854	\$ 65,117,559
	MF	234	\$ 1,316,017
	<b>TOTAL</b>		<b>\$218,010,737</b>
<b>SFY12</b>			
	AIDS	20	\$ 237,785
	BI	328	\$ 4,315,840
	DE	3,050	\$ 29,555,957
	PCO	17,656	\$178,380,196
	PACE	464	\$ 3,387,292
	DD	3,859	\$ 92,453,213
	MF	220	\$ 2,013,583
	<b>TOTAL</b>		<b>\$310,343,866</b>

4. *The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the*

***new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.***

**ANSWER:**

Although the State of New Mexico does not have an "Olmstead Plan," it has coordinated its efforts to increase community integration primarily through three State agencies: HSD, DOH, and ALTSD. Through these agencies, the State has implemented 1915 Waiver programs in CoLTS and Mi Via. Under CoLTS, the MCOs are required to comply with the State law for Money Follows the Person (see Attachment A). The MCOs are required to:

- Identify eligible nursing home residents that wish to move from the institutional setting to home and community-based waiver programs;
- Screen the individuals, including a comprehensive assessment and identify the appropriate services needed to move the individual to the community;
- Upon discharge, provide the individual with relocation services (including the assistance of a relocation specialist) and follow-up to ensure a healthy and safe transition; and
- Provide transition services, which can include a complete array of services from specialized medical equipment to security deposits.

In addition, the Mi Via program allows individuals to self-direct their home and community-based waiver services. In Mi Via, participants are empowered to among other things, hire and retain their caregivers, and receive non-traditional Medicaid services. Any individual that qualifies for the State's various 1915(c) waivers can choose Mi Via. Under the program, consultants are provided to assist participants in developing their respective budgets and, once services are received, submit bills to the State's fiscal management agent.

5. ***Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.***

**ANSWER:**

Two key components are needed in order to successfully integrate more individuals back into the community and divert those that meet the level of care from ever entering the facility: funding and flexibility. Often times, federal initiatives are cumbersome to administer and fail to encompass the complete array of need. For example, to keep an

individual in the community, there has to be adequate housing and transportation. Many individuals need specialized housing and other environmental modifications such as larger doorways, ramps, and grab bars. If a community does not have the appropriate housing, conversion costs are incurred. Other barriers include:

- Inadequate reimbursement for many service providers;
- Increase behavioral health services through an integrated model as many individuals with disabilities fear institutionalization and the stigma that is part of their daily lives;
- Transportation, employment, and education are often inadequate to meet the needs of these special populations; and
- Enhanced training should be required throughout the community, including cultural competency.

Every state is different and has unique needs. States, such as New Mexico, need more flexibility in order to provide adequate services to urban, rural, and frontier areas. Block grants that permit the state to serve its population would be more appropriate than simply increasing Medicaid funding because: (1) while Medicaid serves approximately 1 in 4 New Mexicans, it does not cover many individuals that need assistance to remain (or be diverted) in the community; and (2) the special needs of this population cross various agencies that require specific coordination.

Current funding is inadequate to meet the need; it is not just provider reimbursement. Fully funding the following would enhance a state's ability to increase serving these unique populations:

- **Community/Assessment:** Outreach will be needed to identify individuals that could benefit from services at an earlier stage to keep those individuals in the community. Once identified, a comprehensive assessment should be conducted by qualified assessors. In New Mexico, assessments in an urban area can cost between: \$400 - \$750 per assessment; out in rural areas this can increase to \$1,000. For example, if the State (or its contractor) has identified a Navajo speaking individual, an interpreter will be needed. In addition, many elders are reluctant to tell a "stranger" about their health issues. Additional training/methods are needed to obtain the necessary information.
- **Infrastructure Development:** There are two components that require additional funding: (1) direct care givers; and (2) capital expenditures. Recruiting and retaining quality caregivers are barriers in every state. It is heightened when you consider the needs of these populations. In addition, as the population ages more revenue will be required for capital investments, such as increasing

the number of assisted living facilities, day habilitation centers, and nursing facility beds.

- Heightened Coordination/Outcomes is needed to ensure that individuals are receiving the correct array of services, the quality of those services and in the proper setting of care. A care/service coordinator is needed to assist individuals in navigating the system, which includes the community infrastructure and outside resources, if needed.

**6. *Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.***

**ANSWER:**

There are two specific strategies that the State of New Mexico has employed that would be beneficial for other states: (1) integrating Medicare and Medicaid; and (2) the Mi Via program.

In August 2008, the State implemented CoLTS with a specific requirement to integrate the care of individuals receiving Medicare and Medicaid services – the dual eligibles. This was significant because 85 percent of CoLTS members were duals. From a recipient's perspective, under FFS, each dual eligible member would have three identification cards: Medicare, Medicaid, and Medicare Part D (for prescription drugs). Under CoLTS, the member receives one identification card and is assigned a specific service coordinator. The service coordinator is responsible for assisting the member in obtaining the full Medicare/Medicaid services regardless of payer source. This was the State's first attempt to ensure that the individual received the right care in the proper setting. Under the proposed Centennial Care, this approach has been widened to include all Members, not just dual eligibles.

The State's Mi Via program allows individuals to self-direct their care. It provides the participants with minimal assistance and permits the broadest opportunities for individuals to select their care providers and purchase needed goods. Strong oversight is needed to ensure that participants do not over-extend their budgets and are purchasing goods and services that are appropriate for their needs.

The Honorable Thomas Harkin  
Page 14  
September 6, 2012

## CONCLUSION

Again, let me thank you for the opportunity to comment on the State of New Mexico's efforts to keep individuals living well in their communities. Should you need any further information, please do not hesitate to contact Mr. Larry Heyeck at 505-827-7240 or [Larry.Heyeck@state.nm.us](mailto:Larry.Heyeck@state.nm.us).

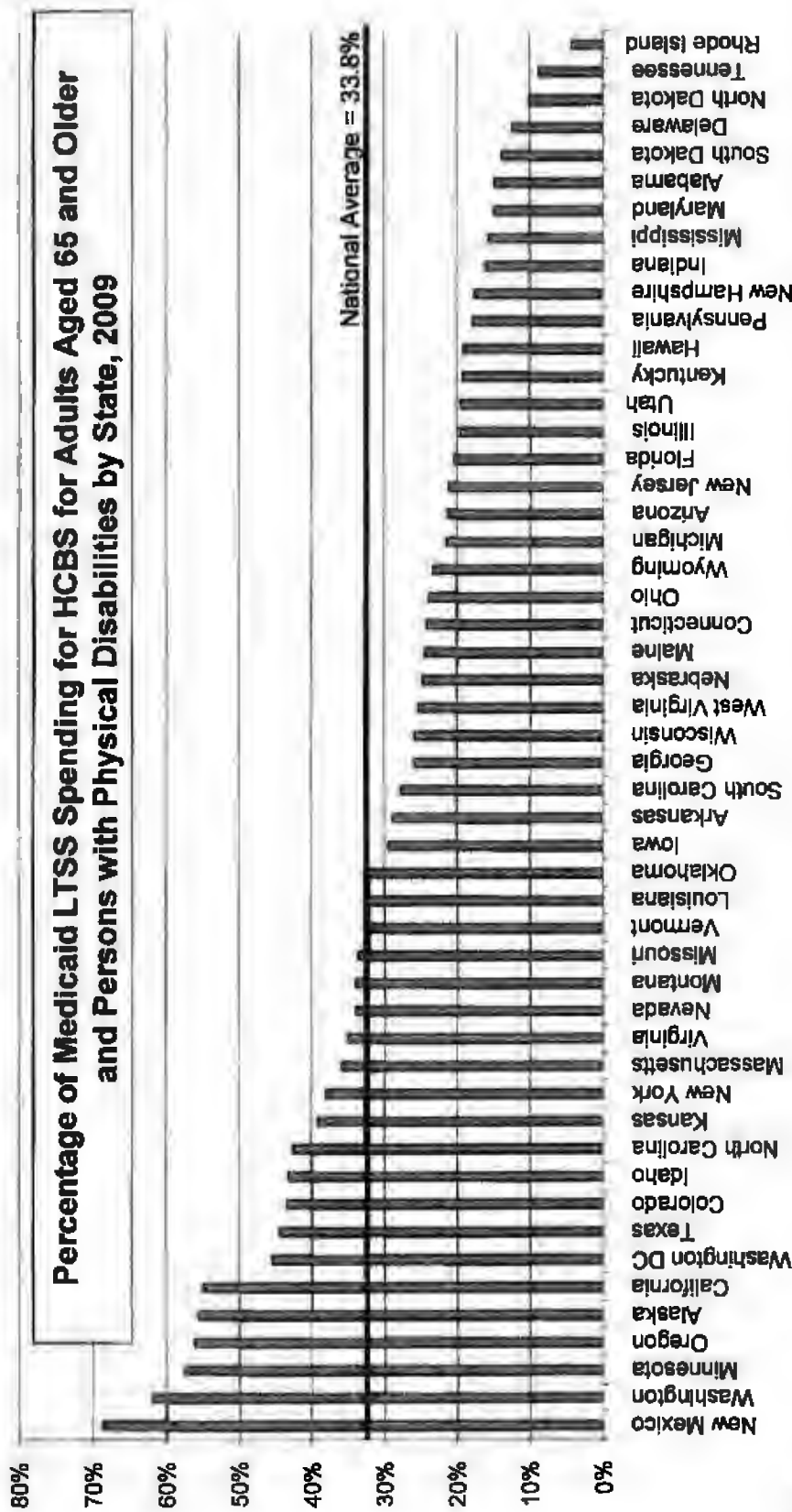
Sincerely,

A handwritten signature in black ink that reads "Martinez". The signature is written in a cursive style with a large, stylized "M" and a small dot above the "i".

Susana Martinez  
Governor

**ATTACHMENT**  
**A**

# Even as progress has occurred on a national level, there remains tremendous variation across states . . .



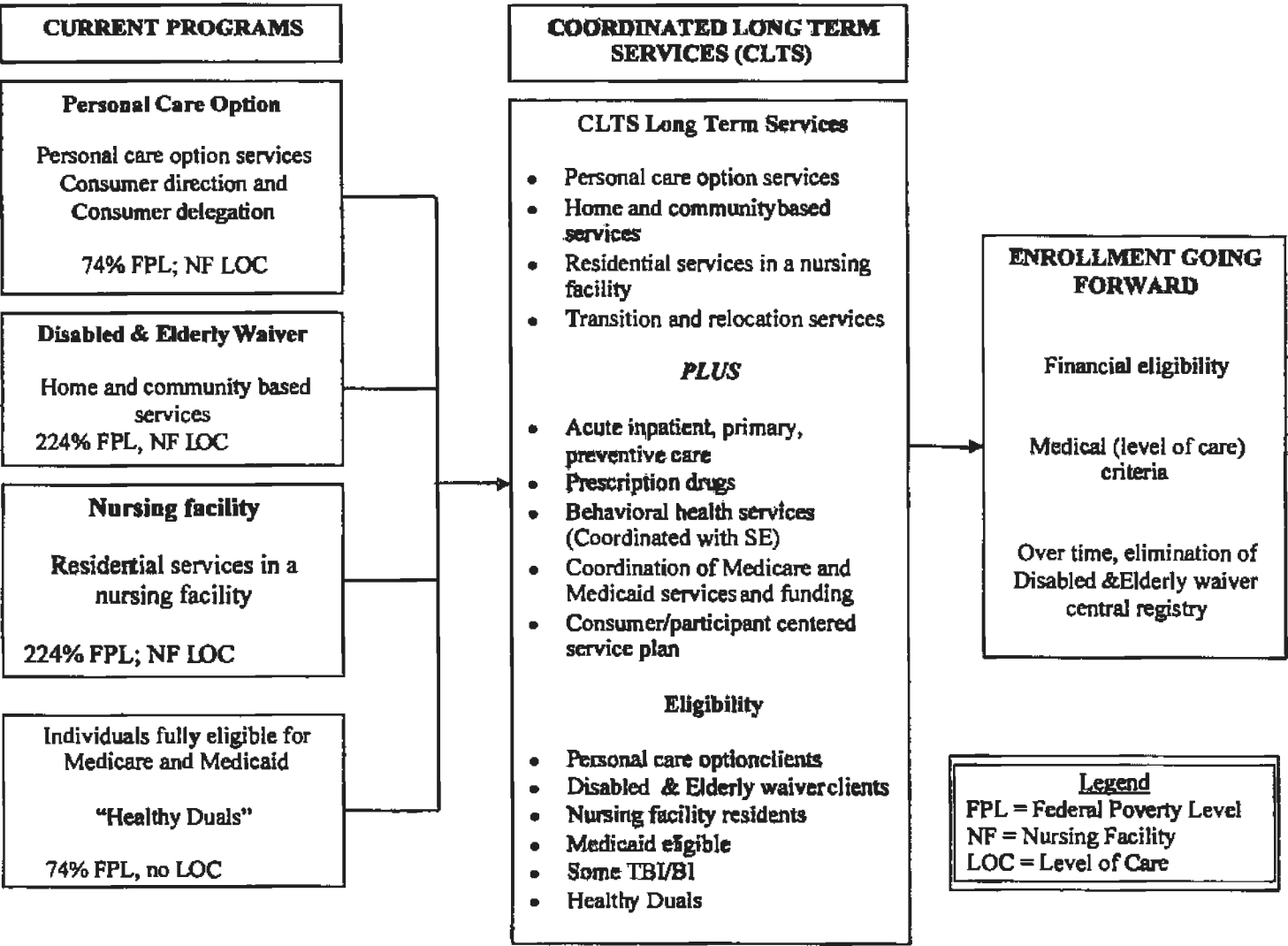
Source: National and State Long-Term Care Spending for Adults Ages 65 and over and Persons with Physical Disabilities. 2011. Analysis of Thompson Reuters data by The Hilltop Institute.





**ATTACHMENT  
B**

**Figure 1: Transition of Fragmented System to Coordinated System of Long-Term Services**



**ATTACHMENT**  
**C**

New Mexico  
Human Services Department  
Medical Assistance Division

State Fiscal Year 2008

FMAP (blend)

Medical Assistance Division				LTS program Fee For Svc		Acute				CoLTS capt	Total FFS, CoLTS capt and acute capt\$	71.26				
prog	catg elig n	served n	FFS \$	admin FFS	FFS \$	beh capt \$	Salud capt \$	sum any acute care, nonCoLTS \$ unsorted	CoLTS \$ not in 08	Svc Cost State Share \$		state share admin svc	Svc + admin State Share	distribution		
NF Level of Care	1915c HCBS	AIDS*	15	12	\$ 322,213	\$ 3,730	\$ 11,163	\$ 4,934	\$ 35,009	\$ 51,107	\$ -	\$ 373,319	\$ 107,292	\$ 1,270	\$ 108,562	0%
		BI*	179	140	\$ 1,951,980	\$ 991,947	\$ 69,947	\$ 57,112	\$ 277,706	\$ 404,766	\$ -	\$ 2,356,746	\$ 677,329	\$ 495,974	\$ 1,173,303	1%
		DE*	4,143	3,958	\$ 77,450,807	\$ 3,181,460	\$ 6,581,247	\$ 962,350	\$ 4,008,153	\$ 11,551,750	\$ -	\$ 89,002,557	\$ 25,579,335	\$ 1,405,786	\$ 26,985,121	15%
	Oth HCBS	PCO	n.a.	12,920	\$ 222,454,342	\$ -	\$ 34,832,615	\$ 6,834,593	\$ 46,527,092	\$ 88,194,299	\$ -	\$ 310,648,642	\$ 89,280,420	\$ 0	\$ 89,280,420	50%
		PACE	n.a.	411	\$ 9,572,406	\$ -	\$ 11,273	\$ 25,644	\$ 13,251	\$ 50,168	\$ -	\$ 9,622,574	\$ 2,765,528	\$ 0	\$ 2,765,528	2%
	HCBS subtotal		undup	17,321	\$ 311,751,748	\$ 4,177,137	\$ 41,506,246	\$ 7,884,633	\$ 50,861,211	\$ 100,252,090	\$ -	\$ 412,003,838	\$ 118,409,904	\$ 1,903,030	\$ 120,312,934	68%
	Nursing Facilities †			5,986	\$ 183,705,538	\$ -	\$ 13,481,502	\$ 252,333	\$ 58,119	\$ 13,791,954	\$ -	\$ 197,497,491	\$ 56,760,779	\$ 0	\$ 56,760,779	32%
NF Level of Care Programs		undup	22,678	\$ 495,457,285	\$ 4,177,137	\$ 54,987,748	\$ 8,136,966	\$ 50,919,330	\$ 114,044,044	\$ -	\$ 609,501,329	\$ 175,170,683	\$ 1,903,030	\$ 177,073,713		
ICF /MR level of Care	1915c HCBS	DD*	3,816	3,788	\$ 269,522,844	\$ 1,487,526	\$ 1,457,293	\$ 5,031,354	\$ 17,489,968	\$ 23,978,615	\$ -	\$ 293,501,459	\$ 84,352,319	\$ 514,026	\$ 84,866,345	91%
		MF*	214	200	\$ 1,827,617	\$ 142,969	\$ 597,364	\$ 626,718	\$ 1,448,291	\$ 2,572,373	\$ -	\$ 4,499,990	\$ 1,293,297	\$ 64,599	\$ 1,357,896	1%
	HCBS subtotal		undup	3,985	\$ 271,350,460	\$ 1,630,495	\$ 2,054,657	\$ 5,658,073	\$ 18,938,259	\$ 26,650,989	\$ -	\$ 298,001,449	\$ 85,645,616	\$ 578,625	\$ 86,224,241	93%
	ICF/MR Facilities			278	\$ 22,583,473	\$ -	\$ 976,943	\$ 20,630	\$ 4,177	\$ 1,001,751	\$ -	\$ 23,585,224	\$ 6,778,393	\$ 0	\$ 6,778,393	7%
	ICF/MR LOC Totals		undup	4,254	\$ 293,933,934	\$ 1,630,495	\$ 3,031,600	\$ 5,678,703	\$ 18,942,436	\$ 27,652,739	\$ -	\$ 321,586,673	\$ 92,424,009	\$ 578,625	\$ 93,002,634	
total expenditures				\$ 789,391,219	\$ 5,807,632	\$ 58,019,348	\$ 13,815,669	\$ 69,861,766	\$ 141,696,783	\$ -	\$ 931,088,002	\$ 267,594,692	\$ 2,481,655	\$ 270,076,347		

Moved from Facility to Community while still eligible for Medicaid

	Full medicard	Other (QMB, etc)
ICF/MR	12	0
NF	588	52

\*1915c waiver population by category of eligibility for budget tracking. Includes both traditional / managed waiver model and self-directed Mi Via waiver program

† Nursing Facilities expenditures include either Medicare Crossover type "A" or Long-term Inpatient Stay under Medicaid

New Mexico  
Human Services Department  
Medical Assistance Division

State Fiscal Year 2009

FMAP (blend)

	prog	categ eligen	served n	LTS program Fee For Svc		Acute				acute/LTS blend	Total FFS, CoLTS capt and acute captS	% of 2008 cost	76.05				% of 2008 state cost		
				FFS \$	admin FFS	FFS \$	beh capt \$	Salud capt \$	sum any acute care, nonCoLTS \$ unsorted	CoLTS capt \$ (regardless of cohort rate †)			State Share \$	+ state share admin svc	Svc + admin State Share	distrib- ution			
NF Level of Care	1915c	AIDS*	17	16	\$ 520,757	\$ 13,645	\$ 12,515	\$ 5,467	\$ 34,810	\$ 52,792	\$ -	\$ 573,550	154%	\$ 137,365	\$6,823	\$ 144,188	0%	133%	
	HCBS	BI*	367	350	\$ 10,399,909	\$ 1,481,657	\$ 137,543	\$ 305,925	\$ 446,262	\$ 889,729	\$ 1,808,497	\$ 13,098,135	556%	\$ 3,137,003	\$740,829	\$ 3,877,832	2%	331%	
		DE*	3,928	3,727	\$ 45,781,954	\$ 3,111,108	\$ 3,858,164	\$ 1,209,181	\$ 1,535,118	\$ 6,602,463	\$ 59,811,375	\$ 112,195,791	126%	\$ 26,870,892	\$1,370,610	\$ 28,241,502	16%	105%	
		Oth	PCO ‡	n.a.	14,408	\$97,046,059	\$ -	\$15,192,470	\$ 5,277,171	\$ 18,914,205	\$ 39,383,846	\$ 274,173,559	\$ 410,603,465	132%	\$ 98,339,530	\$0	\$ 98,339,530	56%	110%
		HCBS	PACE	n.a.	473	\$ 15,342,625	\$ -	\$ 14,809	\$ 1,490	\$ 1,357	\$ 17,656	\$ -	\$ 15,360,281	160%	\$ 3,678,787	\$0	\$ 3,678,787	2%	133%
		HCBS subtotal	undup	18,858	\$ 169,091,305	\$ 4,606,410	\$ 19,215,500	\$ 6,799,234	\$ 20,931,752	\$ 46,946,486	\$ 335,793,431	\$ 551,831,222	134%	\$ 132,163,577	\$2,118,261	\$ 134,281,838	77%	112%	
		Nursing Facilities †		6,007	\$ 78,907,769	\$ -	\$ 6,600,462	\$ -	\$ -	\$ 6,600,462	\$ 84,019,012	\$ 169,527,243	86%	\$ 40,601,775	\$0	\$ 40,601,775	23%	72%	
	NF Level of Care Programs	undup	24,380	\$ 247,999,073	\$ 4,606,410	\$ 25,815,962	\$ 6,799,234	\$ 20,931,752	\$ 53,546,948	\$ 419,812,444	\$ 721,358,465	118%	\$ 172,765,352	\$2,118,261	\$ 174,883,613	99%			
ICF /MR level of Care	1915c	DD*	3,881	3,873	\$ 406,074,757	\$ 2,437,013	\$ 2,095,339	\$ 5,595,417	\$ 16,378,657	\$ 24,069,413	\$ -	\$ 430,144,171	147%	\$ 103,019,529	\$849,337	\$ 103,868,866	91%	122%	
	HCBS	MF*	227	236	\$ 3,342,178	\$ 235,238	\$ 694,044	\$ 686,457	\$ 1,558,267	\$ 2,938,768	\$ -	\$ 6,280,946	140%	\$ 1,504,287	\$109,625	\$ 1,613,912	1%	119%	
		HCBS subtotal	undup	4,102	\$ 409,416,935	\$ 2,672,251	\$ 2,789,383	\$ 6,281,874	\$ 17,936,924	\$ 27,008,182	\$ -	\$ 436,425,117	146%	\$ 104,523,816	\$958,962	\$ 105,482,778	93%	122%	
		ICF/MR Facilities		290	\$ 33,995,916	\$ -	\$ 1,671,463	\$ -	\$ -	\$ 1,671,463	\$ -	\$ 35,667,379	151%	\$ 8,542,337	\$0	\$ 8,542,337	7%	126%	
		ICF/MR LOC Totals	undup	4,388	\$ 443,412,851	\$ 2,672,251	\$ 4,460,846	\$ 6,281,874	\$ 17,936,924	\$ 28,679,645	\$ -	\$ 472,092,495	147%	\$ 113,065,153	\$958,962	\$ 114,025,115	123%		
<b>total expenditures</b>					\$ 691,411,924	\$ 7,278,661	\$ 30,276,808	\$ 13,081,108	\$ 38,868,676	\$ 82,276,593	\$ 419,812,444	\$1,193,450,960	128%	\$ 285,831,505	\$3,077,223	\$ 288,908,728	107%		

Moved from Facility to Community while still eligible for Medicaid

	Full Medicaid	Other (QMB, etc)
ICF/MR	9	0
NF	387	60

\*1915c waiver population by category of eligibility for budget tracking, includes both traditional / managed waiver model and self-directed Mi Via waiver program

† Nursing Facilities expenditures include either Medicare Crossover type "A" or Long-term Inpatient Stay under Medicaid or CoLTS capt with Inpatient NF Setting of care

‡ CoLTS captations were summed for each program row by clients' enrolled setting of care (INF, PCO, DEW, MIV) record, regardless of cohort (NFL, Mi Via, or "health dual")

§ PCO served count n includes any client, other than 1915c, with FFS PCO claim marked with a PCO prior auth plan of care, or had a CoLTS capitation with a "PCO" setting of care

New Mexico  
Human Services Department  
Medical Assistance Division

State Fiscal Year 2010

FMAP (blend)

	prog	categ eligen	served n	LTS program Fee For Svc		Acute					acute/LTS blend	Total FFS, CoLTS capt and acute capt \$	% of 2008 cost	80.23				
				FFS \$	admin FFS	FFS \$	beh capt \$	Salud capt \$	sum any acute care, nonCoLTS \$ unsorted	CoLTS capt \$ (regardless of cohort rate †)	State Share \$			+ state share admin svc	Svc + admin State Share	distrib- ution	% of 2008 state cost	
NF Level of Care	1915c	AIDS*	19	16	\$ 472,622	\$ 30,101	\$ 20,276	\$ 6,018	\$ 33,170	\$ 59,464	\$ -	\$ 532,086	143%	\$ 105,193	\$ 13,775	\$ 118,968	0%	110%
	HCBS	BI*	371	362	\$ 8,426,502	\$ 1,311,943	\$ 73,518	\$ 264,265	\$ 70,616	\$ 408,399	\$ 3,253,462	\$ 12,088,362	513%	\$ 2,389,869	\$ 625,935	\$ 3,015,804	2%	257%
		DE*	3,699	3,395	\$ 11,692,720	\$ 1,845,559	\$ 88,274	\$ 1,164,704	\$ 35,196	\$ 1,288,173	\$ 90,403,934	\$ 103,384,827	116%	\$ 20,439,180	\$ 882,338	\$ 21,321,518	13%	79%
	Oth HCBS	PCO ‡	n.a.	15,563	\$ 983,658	\$ -	\$ 213,881	\$ 256,497	\$ 461,695	\$ 932,073	\$ 517,907,320	\$ 519,823,052	167%	\$ 102,769,017	\$ 0	\$ 102,769,017	65%	115%
		PACE	n.a.	456	\$ 11,194,294	\$ -	\$ 23	\$ 47	\$ -	\$ 70	\$ -	\$ 11,194,364	116%	\$ 2,213,126	\$ 0	\$ 2,213,126	1%	80%
	HCBS subtotal	undup		19,768	\$ 32,789,795	\$ 3,187,603	\$ 395,972	\$ 1,691,532	\$ 600,676	\$ 2,688,180	\$ 611,564,716	\$ 647,022,692	157%	\$ 127,916,385	\$ 1,522,048	\$ 129,438,433	82%	108%
	Nursing Facilities †			5,955	\$ 3,923,158	\$ -	\$ 1,598,391	\$ -	\$ -	\$ 1,598,391	\$ 139,260,205	\$ 144,781,753	73%	\$ 28,623,353	\$ 0	\$ 28,623,353	18%	50%
NF Level of Care Programs	undup		25,165	\$ 36,692,953	\$ 3,187,603	\$ 1,994,363	\$ 1,691,532	\$ 600,676	\$ 4,286,571	\$ 750,824,921	\$ 791,804,445	130%	\$ 156,539,738	\$ 1,522,048	\$ 158,061,786	89%		
ICF /MR level of Care	1915c	DD*	3,874	3,824	\$ 291,192,183	\$ 2,261,609	\$ 1,494,279	\$ 4,693,986	\$ 14,356,628	\$ 20,544,893	\$ -	\$ 311,737,076	106%	\$ 61,630,420	\$ 762,286	\$ 62,392,706	91%	74%
	HCBS	MF*	242	232	\$ 2,803,297	\$ 293,324	\$ 346,568	\$ 716,437	\$ 1,555,877	\$ 2,618,881	\$ -	\$ 5,422,178	120%	\$ 1,071,965	\$ 130,173	\$ 1,202,138	2%	89%
		HCBS subtotal	undup	4,054	\$ 293,995,480	\$ 2,554,933	\$ 1,840,847	\$ 5,410,423	\$ 15,912,504	\$ 23,163,774	\$ -	\$ 317,159,254	106%	\$ 62,702,385	\$ 892,459	\$ 63,594,844	93%	74%
	ICF/MR Facilities		280	\$ 24,458,587	\$ -	\$ 1,200,248	\$ -	\$ -	\$ 1,200,248	\$ -	\$ 25,658,835	109%	\$ 5,072,752	\$ 0	\$ 5,072,752	7%	75%	
	ICF/MR LOC Totals	undup	4,332	\$ 318,454,067	\$ 2,554,933	\$ 3,041,095	\$ 5,410,423	\$ 15,912,504	\$ 24,364,022	\$ -	\$ 342,818,089	107%	\$ 67,775,137	\$ 892,459	\$ 68,667,596	74%		
total expenditures				\$ 355,147,019	\$ 5,742,536	\$ 5,035,458	\$ 7,101,955	\$ 16,513,181	\$ 28,650,594	\$ 750,824,921	\$ 1,134,622,534	122%	\$ 224,314,875	\$ 2,414,507	\$ 226,729,382	84%		

Moved from Facility to Community while still eligible for Medicaid

	Full Medicaid	Other (QMB, etc)
ICF/MR	10	0
NF	389	63

\*1915c waiver population by category of eligibility for budget tracking, includes both traditional / managed waiver model and self-directed Mi Via waiver program

† Nursing Facilities expenditures include either Medicare Crossover type "A" or Long-term Inpatient Stay under Medicaid or CoLTS capt with Inpatient NF Setting of care

‡ CoLTS capitations were summed for each program row by clients' enrolled setting of care (INF, PCO, DEW, MFV) record, regardless of cohort (NFL, Mi Via, or "health dual")

§ PCO served count n includes any client, other than 1915c, with FFS PCO claim marked with a PCO prior auth plan of care, or had a CoLTS capitation with a "PCO" setting of care

New Mexico  
Human Services Department  
Medical Assistance Division

State Fiscal Year 2011

FMAP (blend)

				LTS program Fee For Svc		Acute				acute/LTS blend	Total FFS, CoLTS capt and acute capt \$	% of 2008 cost	78.61					
		prog	categ elign	served n	FFS \$	admin FFS	FFS \$	beh capt \$	Salud capt \$	sum any acute care, nonCOLTS \$ unsorted	CoLTS capt \$ (regardless of cohort rate †)		State Share \$	+ state share admin svc	Svc + admin State Share	distrib- ution	% of 2008 state cost	
NF Level of Care	1915c	AIDS*	24	19	\$ 485,728	\$ 36,395	\$ 140,770	\$ 9,623	\$ 49,501	\$ 199,894		\$ 685,622	184%	\$ 146,655	\$ 9,658	\$ 156,313	0%	144%
	HCBS	BI*	350	347	\$ 9,677,632	\$ 1,071,136	\$ 5,439	\$ 207,445	\$ 555	\$ 213,438	\$ 3,265,698	\$ 13,156,768	558%	\$ 2,814,233	\$ 280,447	\$ 3,094,680	2%	264%
		DE*	3,557	3,254	\$ 15,270,120	\$ 1,578,170	\$ 76,173	\$ 1,042,211	\$ 17,094	\$ 1,135,478	\$ 84,838,619	\$ 101,244,217	114%	\$ 21,656,138	\$ 416,511	\$ 22,072,649	12%	82%
	Oth HCBS	PCO ‡	n.a.	16,945	\$ 958,771	\$ -	\$ 207,689	\$ 231,599	\$ 316,502	\$ 755,790	\$ 577,497,922	\$ 579,212,483	186%	\$ 123,893,550	\$ 0	\$ 123,893,550	68%	139%
		PACE	n.a.	451	\$ 11,032,487	\$ -	\$ 457	\$ 103	\$ -	\$ 560		\$ 11,033,047	115%	\$ 2,359,969	\$ 0	\$ 2,359,969	1%	85%
	HCBS subtotal		undup	20,983	\$ 37,424,738	\$ 2,685,701	\$ 430,528	\$ 1,490,981	\$ 383,651	\$ 2,305,160	\$ 665,602,239	\$ 705,332,137	171%	\$ 150,870,545	\$ 706,616	\$ 151,577,161	83%	126%
	Nursing Facilities †				6,165	\$ 3,119,599	\$ -	\$ 950,809	\$ -	\$ -	\$ 950,809	\$ 141,233,733	\$ 145,304,141	74%	\$ 31,080,556	\$ 0	\$ 31,080,556	17%
NF Level of Care Programs		undup	26,466	\$ 40,544,338	\$ 2,685,701	\$ 1,381,337	\$ 1,490,981	\$ 383,651	\$ 3,255,969	\$ 806,835,972	\$ 850,636,278	140%	\$ 181,951,101	\$ 706,616	\$ 182,657,717	103%		
ICF /MR level of Care	1915c	DD*	3,883	3,854	\$ 282,387,483	\$ 2,440,399	\$ 1,665,148	\$ 4,413,348	\$ 12,355,248	\$ 18,433,745		\$ 300,821,228	102%	\$ 64,345,661	\$ 771,898	\$ 65,117,559	91%	77%
	HCBS	MF*	245	234	\$ 3,267,129	\$ 289,339	\$ 328,793	\$ 733,854	\$ 1,426,369	\$ 2,489,015		\$ 5,756,144	128%	\$ 1,231,239	\$ 84,778	\$ 1,316,017	2%	97%
		HCBS subtotal		undup	4,083	\$ 285,654,611	\$ 2,729,738	\$ 1,993,941	\$ 5,147,202	\$ 13,781,617	\$ 20,922,760		\$ 306,577,372	103%	\$ 65,576,900	\$ 856,676	\$ 66,433,576	92%
	ICF/MR Facilities				286	\$ 24,855,902	\$ -	\$ 911,343	\$ -	\$ -	\$ 911,343		\$ 25,767,245	109%	\$ 5,511,614	\$ 0	\$ 5,511,614	8%
ICF/MR LOC Totals		undup	4,369	\$ 310,510,513	\$ 2,729,738	\$ 2,905,284	\$ 5,147,202	\$ 13,781,617	\$ 21,834,103	\$ -	\$ 332,344,617	103%	\$ 71,088,514	\$ 856,676	\$ 71,945,190	77%		
total expenditures					\$ 351,054,851	\$ 5,415,439	\$ 4,286,621	\$ 6,638,183	\$ 14,165,268	\$ 25,090,072	\$ 806,835,972	\$ 1,182,980,895	127%	\$ 253,039,615	\$ 1,563,292	\$ 254,602,907	94%	

Moved from Facility to Community while still eligible for Medicaid

	Full Medicaid	Other (QMB, etc)
ICF/MR	11	1
NF	472	60

\*1915c waiver population by category of eligibility for budget tracking, includes both traditional / managed waiver model and self-directed Mi Via waiver program

† Nursing Facilities expenditures include either Medicare Crossover type "A" or Long-term Inpatient Stay under Medicaid or CoLTS capt with Inpatient NF Setting of care

‡ CoLTS captations were summed for each program row by clients' enrolled setting of care (INF, PCO, DEW, MIV) record, regardless of cohort (NFL, MI Via, or "health dual")

§ PCO served count n includes any client, other than 1915c, with FFS PCO claim marked with a PCO prior auth plan of care, or had a CoLTS captation with a "PCO" setting of care

New Mexico  
Human Services Department  
Medical Assistance Division

State Fiscal Year 2012

FMAP (blend)  
69.47

	prog	categ eligen	served n	LTS program Fee For Svc		Acute			acute/LTS blend	Total FFS, CoLTS capt and acute capt\$	% of 2008 cost	State Share \$	+ state share admin svc	Svc + admin State Share	distrib- tion	% of 2008 state cost		
				FFS \$	admin FFS	FFS \$	beh capt \$	Salud capt \$	sum any acute care, nonCoLTS \$ unsorted								CoLTS capt \$ (regardless of cohort rate %)	
NF Level of Care	1915c	AIDS*	25	20	\$ 584,184	\$ 32,875	\$ 102,242	\$ 8,714	\$ 55,356	\$ 166,312	\$ -	\$ 750,496	201%	\$ 229,126	\$ 8,659	\$ 237,785	0%	219%
	HCBS	BI*	330	328	\$ 10,055,047	\$ 986,904	\$ 594	\$ 236,315	\$ -	\$ 236,909	\$ 2,990,435	\$ 13,282,392	564%	\$ 4,055,114	\$ 260,726	\$ 4,315,840	2%	368%
		DE*	3,417	3,050	\$ 16,869,394	\$ 2,313,555	\$ 124,732	\$ 1,311,618	\$ 26,012	\$ 1,462,363	\$ 76,816,346	\$ 95,148,103	107%	\$ 29,048,716	\$ 507,241	\$ 29,555,957	11%	110%
	Oth HCBS	PCO §	n.a.	17,656	\$ 563,419	\$ -	\$ 24,521	\$ 8	\$ -	\$ 24,529	\$ 583,690,455	\$ 584,278,402	188%	\$ 178,380,196	\$ 0	\$ 178,380,196	69%	200%
		PACE	n.a.	454	\$ 11,094,098	\$ -	\$ 433	\$ 430	\$ -	\$ 863	\$ -	\$ 11,094,961	115%	\$ 3,387,292	\$ 0	\$ 3,387,292	1%	122%
	HCBS subtotal	undup		21,473	\$ 39,166,142	\$ 3,333,334	\$ 252,523	\$ 1,557,085	\$ 81,368	\$ 1,890,976	\$ 663,497,237	\$ 704,554,355	171%	\$ 215,100,444	\$ 776,626	\$ 215,877,070	83%	179%
	Nursing Facilities †			6,098	\$ 2,700,241	\$ -	\$ 633,827	\$ -	\$ -	\$ 633,827	\$ 142,387,406	\$ 145,221,473	74%	\$ 44,336,116	\$ 0	\$ 44,336,116	17%	78%
NF Level of Care Programs	undup		26,882	\$ 41,366,383	\$ 3,333,334	\$ 886,350	\$ 1,557,085	\$ 81,368	\$ 2,524,803	\$ 805,884,642	\$ 849,775,828	139%	\$ 259,436,560	\$ 776,626	\$ 260,213,186	147%		
ICF /MR level of Care	1915c	DD*	3,888	3,859	\$ 276,625,612	\$ 4,790,928	\$ 1,681,183	\$ 4,251,868	\$ 13,961,576	\$ 19,934,627	\$ -	\$ 296,560,239	101%	\$ 90,539,841	\$ 1,913,372	\$ 92,453,213	90%	109%
	HCBS	MF*	237	220	\$ 3,535,154	\$ 315,115	\$ 288,882	\$ 804,586	\$ 1,669,856	\$ 2,763,334	\$ -	\$ 6,298,489	140%	\$ 1,922,929	\$ 90,654	\$ 2,013,583	2%	148%
		HCBS subtotal	undup	4,079	\$ 280,160,766	\$ 5,106,043	\$ 1,970,066	\$ 5,096,454	\$ 15,631,442	\$ 22,697,962	\$ -	\$ 302,858,728	102%	\$ 92,462,770	\$ 2,004,026	\$ 94,466,796	92%	110%
	ICF/MR Facilities			282	\$ 24,766,907	\$ -	\$ 863,566	\$ -	\$ -	\$ 863,566	\$ -	\$ 25,630,473	109%	\$ 7,824,983	\$ 0	\$ 7,824,983	8%	115%
ICF/MR LOC Totals	undup		4,353	\$ 304,927,673	\$ 5,106,043	\$ 2,833,632	\$ 5,096,454	\$ 15,631,442	\$ 23,561,528	\$ -	\$ 328,489,201	102%	\$ 100,287,753	\$ 2,004,026	\$ 102,291,779	110%		
<b>total expenditures</b>					\$ 346,294,056	\$ 8,439,377	\$ 3,719,981	\$ 6,653,539	\$ 15,712,810	\$ 26,086,330	\$ 805,884,642	\$ 1,178,265,029	127%	\$ 359,724,313	\$ 2,780,652	\$ 362,504,965	134%	

Moved from Facility to Community while still eligible for Medicaid

	Full Medicaid	Other (QMB, etc)
ICF/MR	17	0
NF	560	41

\*1915c waiver population by category of eligibility for budget tracking, includes both traditional / managed waiver model and self-directed Mi Via waiver program

† Nursing Facilities expenditures include either Medicare Crossover type "A" or Long-term inpatient Stay under Medicaid or CoLTS capt with inpatient NF Setting of care

‡ CoLTS capitations were summed for each program row by clients' enrolled setting of care (INF, PCO, DEW, MIV) record, regardless of cohort (NFL, Mi Via, or "health dual")

§ PCO served count n includes any client, other than 1915c, with FFS PCO claim marked with a PCO prior auth plan of care, or had a CoLTS capitation with a "PCO" setting of care



**ATTACHMENT  
D**

## **APPENDIX C**

### **C.1 MONEY FOLLOWS THE PERSON (MFP) INITIATIVES**

The State is mandated to move individuals, where appropriate, from an institutional setting to community-based living. The CONTRACTOR shall:

1. **identify** eligible Medicaid-funded nursing facility residents using federal **eligibility** criteria and, **as requested** by HSD, residents that wish to **move** from the **institutional** setting to home and community based programs and may be eligible for participation in the Money Follows the Person Project initiatives. If a Member wishes to request an exemption of federal criteria, the CONTRACTOR shall explore the hardship exception;
2. **screen** all individuals identified in paragraph 1 to determine if the individual is a probable MFP consumer/participant; and, if so, complete a comprehensive assessment utilizing the State's assessment tool or another appropriate assessment/screening tool chosen by the CONTRACTOR and approved by HSD/MAD;
3. **identify** any and all appropriate home and community based programs for each identified eligible institutional recipient;
4. if, and when an eligible institutional resident is discharged from the institution (and before such date, if appropriate), the CONTRACTOR shall designate a transition specialist who will assist the individual with the following:
  - (A) **relocation specialist services, which are specialized services provided while the individual is a resident in an institutional setting and during the individual's transition to and residence in the community. These services may include but are not limited to:**
    - (1) **assessing** the individual's needs and assisting the individual to arrange for and procure needed resources for the move from the institution to the community, such as establishing Medicaid medical and financial **eligibility** for home and community-based services and eligibility for other HSD programs; identifying needed State plan or other services; coordinating the array of services and providers needed on or after the move, and arranging the time-sensitive transition services;
    - (2) **develop** a comprehensive person-centered, community-based services and transition plan using the HSD MFP template;
    - (3) **carefully monitoring** the first sixty (60) days the individual resides in the community to make certain that services are delivered

according to the plan and are sufficient to meet the individual's needs, and that the individual is comfortable and safe in their environment;

- (4) ensure that individuals have an opportunity to educate/train their respective caregivers; and
  - (5) ensure that the individual's service plan is implemented as written; and
  - (6) link the individual to appropriate home and community-based services.
- (B) transitional services incurred by individuals who are transitioning from an institutional setting to the community to establish a basic household. These services may include such things as security deposits, essential household furnishings and moving expenses required to occupy a community domicile, set-up fees or deposits for utility or service access, and services necessary for the individual's health and safety;
- (C) non-medical transportation services which would enable the individual to gain access to community services, events, activities and resources, or other activities or events that support independence and cannot be obtained from other sources;
- (D) assistive technology which includes devices and services, which may include training or technical assistance for the individual or, where appropriate, family members or others;
- (E) specialized medical equipment and supplies, including devices, controls or appliances which enable an individual to increase his/her ability to perform activities of daily living and perceive, control or communicate with his/her living environment;
- (F) nutrition services including an assessment of the individual's nutritional needs, development and/or revision of the individual's nutritional plan, counseling and nutritional intervention, and observation and technical assistance related to implementation of the nutritional plan;
- (G) substance abuse services which may include short-term education and counseling, and linkage to education and support groups for prevention or treatment of potential or acute substance abuse;
- (H) family support services which may include education on the crucial informal support network in areas such as service availability, expectations, and health and safety issues; and

- (I) purchase of service animals.
- 5. developing a brochure, under the direction of HSD/MAD, to provide information to institutional recipients, their families, advocates, State employees and other interested parties regarding the Money Follows the Person program;
- 6. provide HSD/MAD with a list of individuals that have been identified as eligible for the Money Follows the Person program on a monthly basis;
- 7. provide HSD/MAD with a list of individuals that have transitioned back to home and community based programs on a monthly basis;
- 8. provide HSD with a report detailing the pre-transition and post-transition services rendered for each eligible individual on a monthly basis, to include all fields and format agreed to by the parties;
- 9. collect data, implement strategies and provide reports regarding quality management initiatives, as identified by HSD/MAD; and
- 10. provide ad-hoc reports relating to the Money Follows the Person initiative as requested by HSD.

**C.2 IDENTIFICATION OF BARRIERS FOR HOME AND COMMUNITY BASED PROGRAM SUPPORTS**

The CONTRACTOR shall identify any current and potential barriers to providing home and community based programs throughout the State. This identification may include workforce shortages in current and future programs; facility shortages for current and future programs; statutory and regulatory barriers to address future long-term care service needs; and other information that the CONTRACTOR deems appropriate. The CONTRACTOR shall collaborate with MFP stakeholder groups, or other groups identified by HSD/MAD in the identification of these issues and potential resolutions. The CONTRACTOR shall provide HSD/MAD with a report identifying these barriers and potential solutions every six (6) months or more often as needed.

**C.3 IDENTIFICATION OF COMPLEX CASES**

The CONTRACTOR shall receive uniform person-level individual data, based upon the initial assessment and the ongoing assessment process. Based on this data, the CONTRACTOR shall identify complex cases, such complex cases being identified on criteria developed by the CONTRACTOR and approved by HSD/MAD. The CONTRACTOR shall monitor the health and safety of the identified person, coordinate his/her care and take steps to ensure his/her health and safety is maintained in a reasonable manner. The CONTRACTOR shall

report identified complex cases on a quarterly basis or more often as needed, including all information set forth in a Letter of Direction (LOD) to be completed by HSD/MAD, in consultation with the CONTRACTOR.

#### **C.4 PERFORMANCE MEASURES**

The CONTRACTOR shall substantially perform all Performance Measures as agreed to by the Parties.



STATE OF NEW YORK  
EXECUTIVE CHAMBER  
ALBANY 12224

April 19, 2013

Honorable Tom Harkin  
Chairman,  
Committee on Health, Education, Labor and Pensions  
United States Senate  
Washington, DC 20510

Dear Senator Harkin,

Thank you for your letter and subsequent request for information regarding New York State's implementation of the Supreme Court's 1999 *Olmstead v. L.C.* decision. Governor Andrew Cuomo shares your commitment to serving persons with disabilities in the most integrated setting and has announced a comprehensive strategy to accomplish this goal.

On November 30, 2012, Governor Cuomo signed Executive Order 84 (copy attached) creating the Olmstead Plan Development and Implementation Cabinet (the "Cabinet") to provide guidance and advice to the Governor. The Cabinet, composed of state agencies providing services to persons with disabilities, is charged with making recommendations to the Governor concerning the development, implementation and coordination of an Olmstead Plan (the "Plan") for the State of New York. Specifically, the Cabinet is directed to make recommendations regarding:

- a. identification of the essential requirements of compliance with Olmstead and the Americans with Disabilities Act;
- b. assessment procedures to identify people with disabilities who could benefit from services in a more integrated setting and the development of a coordinated assessment process for individuals of all ages with disabilities in need of services;
- c. measurable progress goals for achieving integrated residential living, including transition goals from segregated to residential housing, and employment opportunities for people with disabilities;

- d. measurable goals for providing supports and accommodations necessary for successful community living;
- e. statutory and regulatory changes to implement the Plan;
- f. a coordination strategy for the work of state agencies and authorities to implement the Plan, including specific and reasonable timeframes for implementation;
- g. actions to promote community understanding of and support for integrated residential living for people with disabilities;
- h. other appropriate measures to achieve and implement a comprehensive and unified Plan; and
- i. how best to maximize available resources in support of the Plan.

The expectation is that the Cabinet will develop a comprehensive strategy for meeting the obligations of the *Olmstead* decision. The order calls for a final report with recommendations concerning establishment, implementation and coordination of the Olmstead Plan to the Governor by May 31, 2013.

Since he took office in January 2011, Governor Cuomo has already taken significant new steps to improve services to individuals with disabilities in the most integrated setting. These initiatives include:

- The establishment of the Justice Center for Persons with Special Needs, to protect individuals with disabilities from abuse and neglect,
- The creation of health homes, through the Medicaid Redesign Task Force, to provide integrated care coordination for people with more complex health needs, including individuals with disabilities;
- A significant expansion of supportive housing and supported housing; and
- Ongoing efforts to reduce the State's reliance on institutional care.

Below is information regarding New York's use of identified federal programs to assist in the implementation of the Olmstead mandate.

1. Community First Choice Option: New York is in the process of preparing a state plan amendment to implement the Community First Choice Option, with an effective date of October 1, 2013. New York has been meeting with internal and external stakeholders to prepare for the filing of this amendment.
2. 1915(i) option: New York is actively exploring this option, but has not submitted an application.

4. Balancing Incentives Payment Program: New York State has an approved application to establish this program.

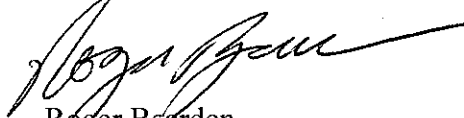
5. Medicaid home and community based waivers: New York State operates numerous waivers including the TBI, NHTD, Long Term Home Health Care, and Care at Home waivers. These waivers currently serve over 90,000 Medicaid recipients in the community.

6. Medicaid rehabilitation and personal care options: New York State's Medicaid plan includes one of the most expansive personal care programs in the country. New York also has the rehabilitation service as part of the state plan.

Attached please find a chart describing New York's implementation of Home and Community Based Services and waiver programs.

Please feel free to contact Roger Bearden, Special Counsel for Olmstead, at [roger.bearden@exec.ny.gov](mailto:roger.bearden@exec.ny.gov) if you have further questions regarding New York's implementation of the *Olmstead* decision.

Sincerely,

A handwritten signature in black ink, appearing to read "Roger Bearden", written over a horizontal line.

Roger Bearden  
Special Counsel for Olmstead



September 6, 2012

Senator Tom Harkin, Chairman  
Committee on Health, Education, Labor and Pensions  
428 Senate Dirksen Office Building  
Washington, DC 20510

Re: Committee on Health, Education, Labor and Pensions

Dear Senator Harkin:

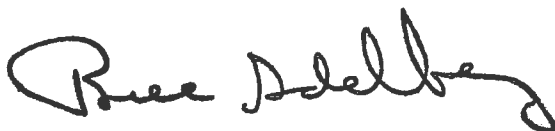
I write in response to your letter dated June 22, 2012 to Governor Kitzhaber, regarding the Supreme Court's landmark decision in *Olmstead v. L.C.* Your letter requests several pieces of information, and the State of Oregon has done its best to provide information to the extent reasonably available, as quickly as is reasonably possible. We appreciate the sensitivity to budgetary constraints that you noted in your letter.

Attached are some materials for your review, which provide detailed information that responds to a number of your requests. Some of these documents have been produced by the State, and others have not. The State does not agree with all of the statements in each of the documents, but they do provide information that you may find helpful. The documents are:

1. Community Leadership for Employment First in Oregon, 2010 report;
2. Supported Employment for Oregonians with Developmental Disabilities: Recommendations for Action, prepared for the Oregon Council on Developmental Disabilities, November 2005;
3. Employment First Strategic Planning Workgroup planning document, dated June 14, 2012;
4. Responses to Questions Posed in Letter Dated June 22, 2012;
5. Olmstead Plan for Addictions and Mental Health (AMH)

We hope that this information is helpful. We hope to work with you to determine whether, after reviewing the attached information, you find this response satisfactory, or whether you desire further information in order to satisfy your requests.

Respectfully,



Bruce Goldberg, Director  
Oregon Health Authority



Erinn Kelley-Siel  
Department of Human Services

cc: Michael B. Enzi, Ranking Member, Senate Committee on Health, Education, Labor and Pensions  
Chairman Max Baucus, Senate Finance Committee  
Ranking Member Orinn G. Hatch, Senate Finance Committee  
Senator Jeff Merkley  
Senator Ron Wyden  
Duke Shepard, Labor and Human Services Policy Advisor  
Sean Kolmer, Health Policy Advisor  
Mike Bonnetto, Healthcare Policy Advisor

Attachments



# *Community Leadership for Employment First in Oregon*

## A Call to Action

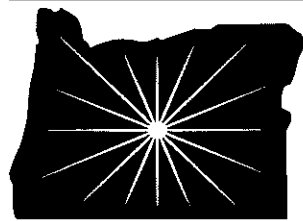
### *THE EMPLOYMENT FIRST OUTREACH PROJECT*

2010

Joyce Dean, Dean/Ross Associates, and  
Cesilee Coulson, The Washington Initiative for Supported Employment

With contributions by the Oregon *Employment First* Outreach Team,  
State personnel, and stakeholders from throughout Oregon  
who participated in the 2010 *Employment First* Outreach Events

# Supported Employment for Oregonians with Developmental Disabilities: Recommendations for Action



OREGON  
COUNCIL ON  
DEVELOPMENTAL  
DISABILITIES

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Prepared for the Oregon Council on  
Developmental Disabilities

November 2005

Submitted by:

Janet Steveley, *Workable Solutions*

# **EMPLOYMENT FIRST STRATEGIC PLANNING WORKGROUP**

JUNE 14, 2012

## **I. OVERVIEW**

The Oregon Office of Developmental Disability Services (ODDS) convened a Strategic Planning Workgroup (SPW) with representation from varied constituents in the community of developmental disabilities. Members included employment and residential service providers, families, Community Developmental Disabilities Program, Support Service Brokerages, Washington Supported Employment Initiative (WISE), Disability Rights Oregon, Oregon Department of Education (ODE), Vocational Rehabilitation (OVRS), Oregon Council on Developmental Disabilities (OCDD) and ODDS. The invited self-advocates were not in attendance. The group met from January 20, 2012 through April of 2012.

The basic charge to the group was to assist ODDS to build a 5-year plan with accompanying recommendations to accomplish the following three objectives:

- Decrease the number of individuals transitioning from school into sheltered workshops
- Increase the number of people who move from sheltered workshops to supported employment
- Increase the number of people with developmental disabilities who are actively engaged in Paths to Employment

The first meeting was convened January 27, 2012 with subsequent meetings on February 29, March 16 and April 4. An outside party was engaged to facilitate all meetings. The SPW met over each objective and provided feedback on issues and barriers, strategies that should be used to meet the objective and metrics over a five year period that could be used to determine success. The following is the ODDS report on the SPW including the metrics that will be used to meet the five year strategy to meet the objectives based on group's feedback and recommendations.

## **II. DATA and DEFINITIONS**

In order to address the stated objectives the SPW reviewed and agreed to the definitions of individual supported employment, group supported employment, sheltered employment, path to employment and alternatives to employment (see

Please note that the following information has been provided by three different offices which are (a) Addictions and Mental Health (AMH) in the Oregon Health Authority, (b) Aging and People with Disabilities (APD) in the Department of Human Services and (c) Developmental Disabilities (DD) in the Department of Human Services. We have identified each of their responses to each question.

**1) For each year from FY 2008 to the present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including a supportive housing program.**

APD:

Oregon is proud to have been the first state in the nation to elect a 1915(c) waiver, which allowed us to offer home and community based alternatives to nursing facility care. Each year, Oregon seeks to serve a smaller and smaller percentage of its long term care caseload in nursing facilities. Rather than provide a number without context, Oregon has provided relevant percentages for this time period.

2008: 18.1% of the long term care population was served in nursing facilities.  
2009: 17.1% of the long term care population was served in nursing facilities.  
2010: 16.5% of the long term care population was served in nursing facilities.  
2011: 16.3% of the long term care population was served in nursing facilities.

While Oregon is proud of these results, we seek further improvement. We have established a goal to have only ten percent of the long term care populated served in nursing facilities by 2020.

DD:

Currently, Oregon is one of three states that have no private or public intermediate care facilities for individuals with intellectual disabilities (ICF/ID). In February 2000, Oregon closed Fairview Training Center, which had housed 860 persons with IDD as recently as 1989. In October 2009, Oregon closed the Eastern Oregon Training Center, which had housed 40 persons as recently as 2006. The Eastern Oregon Training Center was the last ICF/ID in the state. The table below indicates the number of individuals last leaving that institution – 9 persons in 2008 and 23 persons in 2009.

The last line of the table below also shows the numbers of people with intellectual or other developmental disabilities (I/DD) leaving intermediate care facilities (ICF). While these individuals were in an ICF consistent with Pre-admission Screening Resident Review (PASRR) procedures, the numbers below

# **Oregon Department of Human Services/Oregon Health Authority**

## **Addictions and Mental Health Division**

### **Olmstead Plan**

**February 11, 2011**

To achieve the intent of the Olmstead decision (*Appendix A*) Oregon intends to move healthy people to independent housing that promotes recovery, resiliency, independence and wellness in a system that is consumer driven and assists people in obtaining “a key to their own door.” Oregon will achieve this goal by reducing the length of stay (LOS) at the Oregon State Hospital (OSH), establishing independent living environments statewide and preventing hospitalization at OSH.

This Olmstead plan will provide the reader with a brief history of the current barriers, Oregon’s solution to those barriers as well as future plans and projects to prevent these and other barriers from recurring. The plan consists of three sections and thirteen strategies to assure that people transition to the community expeditiously as they work towards self-sufficiency.

## **Section I**

### **OSH Length of Stay (LOS)**

The emphasis on community-based treatment for mental health services grew in the 1980s, based on recommendations by a series of commissions, task forces appointed by the Governor and Department of Human Services (DHS) and Executive Orders. The closure of Dammasch State Hospital in 1995 was a landmark step to move from state hospital care to community mental health services. The “deinstitutionalization” movement in Oregon paralleled a national movement. Oregon has been intentional in its goal of keeping people as independent as possible, as demonstrated by the closure of the Dammasch State Hospital, moving approximately 375 people to Oregon communities primarily in smaller, structured, state licensed residential facilities.

To reduce the LOS at the OSH, the Addictions and Mental Health Division (AMH) is working closely with consumers of mental health services and supports, OSH staff, community mental health programs, providers of mental health services and supports, stakeholders and advocates to identify past practice, current barriers and future solutions to more timely discharges that would contribute to a reduced LOS at OSH. Currently the average LOS across the state hospital system is 338 days. This work was done in concert with the Transformation efforts that are being utilized throughout the Oregon Department of Human Services. In 2007, DHS embarked on a Transformation effort which is a systematic approach to fundamentally changing the way business is done. At AMH, these transformation structures and tools are being used to provide more and effective client services and to improve accountability throughout the department. The goal is to build a foundation for continuous improvement by repeatedly measuring performance, quickly resolving problems and efficiently using resources. OSH, AMH and community mental health partners currently have several initiatives underway which will address the barriers to diversion, de-institutionalization and community integration previously outlined in this plan. Communities in Oregon have developed a series of crisis facilities and crisis/respite beds across the state; these are seen as some of the buildings blocks necessary to provide a solid foundation for successful community living while helping to decrease readmissions to the state hospital system. There are crisis resolution centers in 6 counties of western Oregon and crisis/respite beds available in 7 other counties across the state. The purpose of these crisis centers and crisis/respite beds is to promote community-based treatment for people experiencing mental health difficulties while diverting



## **Section I**

### **OSH Length of Stay (LOS)**

them from a state hospital admission when successful treatment can be provided in the community.

Another example of using community-based treatment services and supports to help decrease state hospital lengths of stay is Project Respond, located and serving the Portland Metropolitan area. Project Respond provides mobile crisis intervention that addresses the needs of individuals with mentally illness. Project Respond offers several specialized programs, including a team that creates alternatives to inpatient admission or incarceration for those people experiencing mental health difficulties. Crisis response teams provide engagement, evidence-based risk assessment, development and implementation of short-term safety and treatment planning, information and referrals, and linkage to ongoing services. Project Respond specialized services include a culturally specific team providing direct care as well as consultation to other team members. The Project Respond Emergency Department team is available to hospital emergency departments to assist individuals who present with lack of access to services and treatments. One pilot component of Project Respond, proven successful and received funding of position(s), allows a mental health professional to accompany city police in what is known as “ride alongs” to assist law enforcement when called to the aid of people in mental health crises.

#### **I. Transitioning People to the Community**

Staff from OSH and AMH, consumers of mental health services and supports, community mental health program representatives, providers of mental health services and supports worked together and identified several barriers that resulted in people staying too long at OSH. These barriers and accompanying solutions are the basis for AMH’s transformation initiative for transitioning people to the community. The main goal is to assure that people are discharged from OSH more quickly using both a standardized set of readiness discharge criteria and a standardized level of care tool.

*(Appendix B)* The tool selected is the Level of Care Utilization of Services 10<sup>th</sup> edition. *(Appendix C)* AMH is implementing training of the LOCUS using a “train the trainer methodology” to train a core group of individuals from OSH, AMH, the community mental health programs, providers of mental health services and supports as well as consumers of mental health services and supports how to apply the tool as part of both the OSH discharge process and to determine the level of care, supports and services an individual needs to be successful in the community. These representatives

## **Section I**

### **OSH Length of Stay (LOS)**

can then provide training to their peers so that a large number of people will be trained to the same assessment tool across the state. Oregon believes that this current transformation initiative will be successful in decreasing the LOS at OSH by providing standardization to both the discharge criteria and standardization in the use of an assessment tool used statewide. Those standardization components, increased statewide training capacity to those who administer and provide the services and supports, plus improving the entire discharge process from OSH to the community will prove successful for Oregonians in obtaining “a key to their own door.” Both the standardized ready to place criteria and the LOCUS were adopted April 2010 and are scheduled for implementation May 2010.

#### **II. Psychiatric Security Review Board (PSRB)**

In 2009, the Governor directed the Department of Human Services (DHS) and AMH to research and make recommendations to improve the process for moving people under the jurisdiction of the Psychiatric Security Review Board (PSRB) into the community when they were deemed ready. The research included reviewing current process, policies, procedures, Oregon Administrative Rules and Statutes, and interviewing OSH staff, patients, patient families, advocates, community providers, AMH staff, PSRB staff and board members. After gathering data, recommendations were created and a Coalition group was formed in 2010 to review and approve them. The Coalition group includes the Executive Director of PSRB, OSH Superintendent, and Assistant Director of AMH with assistance from the Governor’s Office, the AMH researchers, and Oregon Department of Justice (ODOJ). The Coalition’s charge is to determine goals, create implementation strategies, and implement approved recommendations.

At this time, work is being done on several approved short term goals to ensure the conditional release readiness determinations and community placements of patients under PSRB jurisdiction by OSH and PSRB occur more smoothly by decreasing delays caused by inconsistencies, lack of information, lack of training, and backlogs. OSH in conjunction with both AMH and the PSRB is developing a standardized assessment of need in order to identify appropriate treatment resources both in the community and the forensic hospital for persons under the jurisdiction of the PSRB.

## **Section I**

### **OSH Length of Stay (LOS)**

#### **III. Community Residential Capacity Utilization Review**

To determine “patient flow” within the community residential system, AMH conducted a utilization review of ten residential care providers. These providers were selected for interview because their residents typically experience unusually long lengths of stay. The ten providers represented five residential treatment facilities, two secure residential treatment facilities, and three residential treatment homes. This study yielded some interesting information and allowed AMH staff to refine its tools and methodology. Subsequently, AMH contracted with Acumentra Health, a nonprofit organization whose focus is improving the quality and effectiveness of healthcare by providing external quality reviews of services and supports, to conduct a more comprehensive system-wide utilization review. The basic goals for the utilization review work of Acumentra are to assess the appropriateness of current placements with the provision of objective data. The Acumentra Health utilization study was completed September 2010 with results posted on the AMH website.<sup>1</sup> The results of this study indicated that approximately 60% of those people currently receiving residential treatment services could receive appropriate treatment services in lower levels of care in residential, supported housing and independent living settings. When this fact is coupled with the policy decision of AMH leadership to increase the investment in community based supported housing efforts, system change occurs. Increasing community based supported housing provides more permanent affordable housing. This results in people moving from residential treatment settings to supported housing, leaving residential treatment vacancies available for those people leaving the OSH system and returning to the community.

#### **IV. Peer Bridger Program (OSH)**

The fourth strategy that will help address the LOS concerns at OSH will build on the current Peer Bridgers Program that OSH adopted in 2008. The program uses peers who have received inpatient public mental health services to formally support and mentor patients ready to be discharged. A Peer Bridgers’ representative will work closely with the person once s/he has been discharged into the community. This program is modeled on a New York state program. A multi-year evaluation of the New York Peer Bridgers program demonstrated that state hospital patients participating in the program were re-hospitalized an average of 19%, while a control group of

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<sup>1</sup> [AMH \[web link\]](#)

## **Section I**

### **OSH Length of Stay (LOS)**

patients averaged a 60% re-hospitalization rate. OSH has four Peer Bridgers/Recovery Specialists. In addition Oregon is expanding its work with peer delivered services in the community as well with the belief that increased peer services and supports with people receiving mental health treatment will enhance and provide the necessary bridge, when combined with community based treatment for both successful community living and decreased re-hospitalizations. This initiative will be more fully addressed later in this plan. (*Appendix E*)

#### **V. New Treatment Model at OSH**

Oregon believes that providing at least 20 hours of active treatment in a treatment setting that more closely mirrors treatment in the community will promote recovery, resiliency, independence and wellness for those people receiving services. In anticipation of the new Oregon State Hospital physical facility and in keeping with Oregon's Olmstead goals, OSH has adopted and is currently implementing an innovative "treatment mall" approach to treatment and service delivery for people needing state hospital level of care. The purpose of this strategy is to better prepare people for a more independent living setting after leaving the hospital.

The new treatment mall is based on a treatment philosophy utilized by new and renovated psychiatric hospitals. It employs a community design of centralized care in which the patients' living areas are connected to a "neighborhood" mall that connects to a larger "downtown" mall so that patients can access at least 20 hours of active treatment services per week. These services will be provided on the treatment mall that will encourage and enhance more opportunities for healthy socialization and wellness activities. While patients will live on a unit, they will receive treatment, eat meals, attend classes and participate in activities in the mall areas. There is growing evidence that this centralized model can provide lasting benefits, including a decrease in hospital readmission rates, increased skills in symptom management and improved quality of life. This also prepares the person for a treatment experience that more closely mirrors how community members receive treatment, services and supports; that is to say we leave our homes to seek treatment, employment, services and supports in the communities in which we live. Current new treatment malls operating are the Gero Psychiatric Mall which opened June 1<sup>st</sup>, 2008, the 40 Treatment Mall which opened March 3<sup>rd</sup>, 2009, Portland Mall which opened February 2007 and the 50 Treatment Mall which opened January 19<sup>th</sup>, 2010. For the

## **Section I**

### **OSH Length of Stay (LOS)**

new facility, the treatment malls and scheduled opening dates are: ABC Harbors, scheduled to open December 3<sup>rd</sup>, 2010 with the remaining malls to open based on the facility construction schedule.

## **Section II**

### **Establishment of Independent Living Environments**

#### **VI. Supported Housing**

Prior to the 1999 Olmstead decision, Oregon closed the Dammasch State Hospital, (Damasch) located in Wilsonville in July 1995. To accomplish this Oregon focused on providing less restrictive community based services for those people living in Dammasch. Dammasch opened in 1961 and was successfully closed 1995, moving approximately 375 people to Oregon communities primarily in smaller, structured, state licensed residential facilities. The former Dammasch site is now home to Villebois, a planned community.<sup>2</sup> Currently at Villebois, there are 10 beds available in two residential treatment homes (Hearthstone and Fieldstone) and 64 supported housing opportunities in three settings (The Charleston, Renaissance Court and Rain Garden).

The current average length of stay in Oregon's residential treatment programs varies by the type of facility and ranges from just under 400 days in adult foster homes to nearly 600 days in residential treatment facilities. The average length of stay in Oregon state hospitals for the civilly committed population is just over one year with a small group of clients staying more than five years. The time many people are staying in these institutions is far too long. The length of stay can only be reduced with an investment in supportive housing resources.

To meet the growing need for community services for people with mental illness, over the past 15 years Oregon had focused on increasing facility-based care in local communities rather than expanding state hospital services for people who are civilly committed. For the past several biennia, the Oregon legislature has approved funding to increase facility-based care which resulted in an increase in residential treatment facilities throughout the state. This increase has provided community treatment opportunities for

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<sup>2</sup> Inspired by traditional European villages, Villebois, which translates to "village near the woods," is a 500-acre master-planned community in Wilsonville, Ore. At the heart of Villebois will be the Village Center, characterized by elements such as apartments and row homes as well as ground level retail and commercial space. Surrounding the Village Center are three distinct neighborhoods, Villebois features diverse housing types, including apartments, community housing and condominiums, attached row and town homes, as well as single-family detached homes on lots of varying sizes. The entire community is connected by more than 130-acres of trails and open green spaces, including parks and nature preserves that join to trails that lead well beyond Villebois.

## Section II

### Establishment of Independent Living Environments

people who are discharged from OSH and Blue Mountain Recovery Center (BMRC).

The current service delivery system is overly reliant on the use of residential facilities, which are less flexible and more costly than a community-based supportive housing system. The residential facility system lacks the supportive housing resources that keep people living in their own homes rather than small or large group settings.

To address these deficiencies, housing opportunities in the community with an array of supportive services is not only more effective treatment for many, but it provides an increase in capacity by reducing the length of stay in residential facilities by providing more permanent housing plus services. Without an investment in supportive housing, intensive outpatient and peer services Oregon will not be able to move individuals from state or community facilities to self-sufficiency.

Central to Oregon's mental health policy direction is the need for an individually driven treatment system that promotes recovery, resiliency, independence and wellness while providing people with "a key to their own door." A foundational component of recovery is safe and affordable housing with access to treatment services and supports when they are needed; in other words the right amount of services at the right time for the right amount of time. To create an effective and efficient array of housing services and supports and in response to the aforementioned utilization study results, Oregon is establishing more independent living environments through increased supportive housing capacity, increased rental subsidies and associated housing supports and services and increased supported employment opportunities. This strategy is captured and documented in AMH's supportive housing initiative. (*Appendix E*) AMH will work with community partners to provide rental assistance for at least 400 people by June 30, 2011, through a combined effort of the supportive housing initiative and the Adult Mental Health Initiative (AMHI).

The AMHI initiative and related goals has a direct connection to the implementation of the Olmstead integration mandate. The emphasis to move consumers to lower levels of care presents a step towards the intent of Olmstead. However, the move towards independence into permanent supportive housing is slow compared to the needs as the program is in early

## **Section II**

### **Establishment of Independent Living Environments**

stages of implementation. Movement to lower levels of care is not necessarily in accordance with integration as intended within Olmstead. Consumer choice is limited based on the pressures of AMHI goals, and person-centered planning processes are not uniform statewide. There is hope for AMHI to adapt to the goals of the Olmstead integration mandate but at present it would require additional work to address the intent of the ruling.

Oregon's array of residential programs is largely focused on linking housing and services. For some consumers, housing is temporary at best and permanent housing options in development do not meet the needs of enough consumers. If offered the choice, for example, would consumers choose permanent housing over traditional residential services? The current array is weighted to traditional residential programs, an issue when implementing the Olmstead integration mandate.

Patients' rights groups like the Bazelon Center for Mental Health Law and the supportive housing field have steadily worked to institute a model that de-links (or unbundles) housing from services and vice versa. This ensures that consumers are not required to use services in exchange for housing or that the refusal of services would not result in homelessness or placement in higher levels of care. Olmstead planning will maintain a clear separation between housing and services in development and implementation activities.

The development of an inventory and visual roadmap that outlines all community supports or any service other than institutional services will be created. It is important to include all community services, even those that are needed but not currently funded. Community-based services that are researched and shown to promote community tenure will be identified.



## **Section III**

### **Prevention of State Hospitalization**

Oregon is working to provide treatment to people at the earliest point possible within the course of their illness. Understandably, this will occur at different times for every person but the primary goal is to prevent state hospitalization and the associated stigma that accompanies a person when they re-enter the community.

Oregon is focusing investments on several key issues to prevent people from being hospitalized at OSH; those issues are the establishment, promotion and sustainment of a recovery oriented system of care, investment in early psychosis and early assessment screening, peer delivered services and wellness programs.

#### **VII. Improving Service Access Through Local Accountability**

The seventh strategy that Oregon is developing is the Adult Mental Health Initiative (AMHI). AMHI is designed to promote more effective utilization of current capacity in facility based treatment settings, increase care coordination and increase accountability at a local and state level. It is also designed to promote the availability and quality of individualized community-based services and supports, so that adults with mental illness are served in the least restrictive environment possible and use of long-term institutional care is minimized.

AMHI is working with local or regional MHOs, Community Mental Health Programs (CMHPs), providers and stakeholders, to design and implement financing, contracting and service delivery strategies that bring together isolated service components to assist individuals in a collaborative clinically appropriate approach to recovery. Services will be community-based with management, decision-making and service delivery occurring at the local level. AMHI will build on and compliment other efforts currently under way such as implementing a standardized assessment tool, utilizing a standardized discharge processes from state institutions and introducing newly approved Medicaid State Plan Amendments. The intent of AMHI is to manage utilization to the get the right level of service to individuals at the right time and place. AMHI will be system-wide care management to move individuals to self sufficiency.

Oregon believes that the AMHI initiative will provide the ongoing framework, continued development and support of a statewide initiative to improve the integration and collaboration among providers of mental health,

## **Section III**

### **Prevention of State Hospitalization**

substance abuse treatment and physical health care. In addition, there will be coordinated care for people accessing publicly funded health services and early intervention for mental health and substance abuse issues will be maximized. This intervention will help prevent avoidable illnesses and provide treatment of chronic conditions. Ramifications of these health disparities and chronic conditions will be addressed in the Wellness section of this plan.

#### **VIII. Recovery-oriented System of Care**

Recovery is a lifelong process that brings with it many experiences of both success and temporary setbacks. For a successful recovery-oriented system of care to thrive, there needs to be adequate funding for services and supports, adequate access to services and supports at the time a person needs them and for the right amount of time for people to succeed in treatment. In March 2007 the AMH Community Services Workgroup (CSWG) published its final report. The purpose of the report was to inform AMH, the Department of Human Services (DHS), the Governor and the Legislature about the range of community-based services needed to complement the replacement of state hospital facilities and to assure the successful operation of the new hospitals.

*(Appendix D)*

The CSWG report indicated that without a fully funded and operational services and supports system, the staff would be frustrated in its efforts to provide treatment to people in the community versus the state hospital. Unless the state invests in community services, the demand for state hospital beds will exceed the capacity of the new state hospital facilities. If the new state hospitals are to succeed, a significant new investment must also be made to develop and enhance a robust array of community services that support individual recovery goals.

#### **IX. Early Psychosis and Early Assessment Screening**

Early intervention in psychosis is a well-researched model. It is based on the observation that identifying and treating someone in the early stages of a psychosis can significantly improve their longer-term outcome. Beginning in 2007, HB 2144 created the Children's Wraparound Initiative in order to build a system of care that collaborates across agencies, families and youth to improve access and expand the array of coordinated community-based, culturally and linguistically appropriate services and natural supports for

## **Section III**

### **Prevention of State Hospitalization**

children and youth with serious mental health needs. The Children's Wrap Around initiative is cross-divisional with the Children, Adults and Families (CAF) division of DHS, touching the lives of children from birth to age 18, who have been in the custody of DHS for more than one year and have had at least four placements or who come into custody and immediately need specialized behavioral health services and supports. (*Appendix E*)

The 2007 Oregon legislature funded Early Assessment Support Alliance (EASA) to bring the most current, evidence-based treatment to individuals in the early stages of illness. This approach advocates the use of an intensive multi-disciplinary approach during what is known as the critical period, where intervention is the most effective, and prevents the long term morbidity associated with chronic psychotic illness. There are currently seven community mental health programs with EASA sites representing nine counties. EASA uses evidence-based practices to do early assessment and intervention for young adults having their first experience with psychosis. Its primary purpose is to reduce the disability associated with psychosis.

#### **X. Peer Delivered Services**

Research increasingly demonstrates the effectiveness of peer delivered services, and people receiving mental health services voice the positive effect of services provided by people who have had similar experiences. Mental health disorders are chronic conditions requiring treatment of acute symptoms and on-going management, supports and monitoring to avoid relapse. Individuals with mental health disorders need recovery support services to help them navigate systems, understand the issues related to these chronic diseases and provide them with the tools and skills to begin healing and rebuilding their lives. These support services are often best provided by people who themselves have received mental health services.

Oregon is expanding its work with peer delivered services with the knowledge that increased peer services and supports combined with community based treatment will enhance and provide people the necessary bridge for both successful community living and decreased re-hospitalizations.

Providing community-based treatment to both young adults in transition and adults needing mental health treatment, services and supports is a cornerstone of recovery. AMH, in collaboration with local community

## **Section III**

### **Prevention of State Hospitalization**

mental health programs, funded a “warm” line. This warm line is designed and provided by people who have or have had mental health challenges and are able to support their peers telephonically when they are struggling with a variety of mental health concerns. For 2009, the average number of calls responded to per month was approximately 350-400, with an average call length of 30 minutes, using 100 trained operators statewide.

AMH is implementing rules, policies and procedures to promote and increase the utilization of peer delivered services (PDS) in Oregon. AMH is streamlining and consolidating service delivery through the March 2010 adoption of the Integrated Services and Supports Administrative Rules (ISSR) that includes defining peer delivered services and identifying service areas for employment and volunteer opportunities. AMH aligns its focus with national and international recovery thinking, person-centered health care planning, client self-determination and a holistic wellness approach in its mental health and addiction services delivery transformation. This focus is demonstrated by a policy and procedure for reviewing and approving peer delivered services training and curricula which meet Center for Medicare and Medicaid Services (CMS) and national consumer operated organization standards.

#### **XI. Wellness**

In its report, *Measuring Premature Mortality among Oregonians* (AMH, 2008) AMH reported that clients with mental illness die approximately 16 years younger than the average population. Individuals with dual diagnosis die even earlier. This disparity is due to heart disease, diabetes and problems related to side effects of medications, smoking, obesity and lack of holistic medical care, according to research by a national mental health council. AMH will build on current activities within the Wellness Initiative by working closely with AMH Wellness Task Force, DHS Core Integration Team, the Public Health Division, Oregon State Hospital, mentors, consumers, family members, community stakeholder groups and providers with national experts to move from knowing about health inequities to taking immediate action steps to prevent these disparities.

The Community Services Workgroup report states that AMH “. . . should include the establishment and ongoing support of a wellness task force. AMH should also develop a quality improvement process that supports increased access to physical health care and ensures appropriate prevention,

## **Section III**

### **Prevention of State Hospitalization**

screening and treatment services for persons with addictions and/or mental health disorders.” The Oregon study concludes that premature mortality among people receiving mental health services is a health care crisis and recommends AMH (via a Wellness Task Force) work with community agencies to implement changes in care coordination, wellness screening and use of peer-to-peer support services to empower people with serious mental illness and/or substance use disorders in achieving lifestyle changes that will improve their overall health. The AMH Wellness Initiative strengthens integration efforts already underway between physical health and behavioral health care providers. It blends the work of the AMH Wellness Task Force, DHS Core Integration Team, the Oregon Public Health Division, hospitals, mentors, consumers, family members, community stakeholder groups, providers and national experts to move as a united force to end health inequities and take immediate action to eliminate contributing factors to preventable diseases. Here are three current wellness projects:

**A Public Health Approach** – Health integration is our future and will translate into increased access to appropriate health care services through a public health care approach across the lifespan. Integrated physical health care and behavioral health care experts are joining forces to provide a full range of health promotion and intervention services – collaborating, collocating, cross-training with our health care workforce to reach individuals and families where they live...in their community.

The Oregon Public Health Division (PHD) and Oregon AMH are taking a lead role in our statewide AMH Wellness Initiative. Currently, we are working on new policy recommendations to dramatically address the use of tobacco products at all DHS-AMH treatment or residential service sites. In addition to the local projects reflected below, PHD and AMH are teaming up with statewide representatives from the mental health and addictions recovery community to build community wellness champions in every county and/or region of the state to build a local peer wellness program.

**Tobacco Freedom** – AMH has adopted an approach to support self-determination, utilizing a person’s motivation to choose to be free from an addictive substance by equipping individuals, residential treatment settings and community consumer run organizations with cessation supports and treatment strategies.

## **Section III**

### **Prevention of State Hospitalization**

**Community Peer Wellness Forums** – Quarterly education forums bring together providers, consumers, family members, and local complimentary healing vendors to increase awareness of health promotion and wellness options in the community, promote a healing network, and raise community action to increase prevention efforts and health care services to meet the needs of all citizens. The face-to-face interaction between community members from all walks of life breaks down social barriers, dispelling myths about mental illness and eliminate stigma.

**Nutrition and Exercise** – A multi-pronged approach to increase adoption of healthy food options and appropriate levels of exercise; i.e., dance, yoga, walking for the populations we serve in all therapeutic and independent settings.

The goals for the above initiatives include:

- Decrease access and use of tobacco products by clients and staff.
- Health promotion with appropriate Nicotine Replacement Therapy (NRT) supports in place for AMH clients.
- Expansion of a peer services network in the community providing wellness coaching.
- Increase access to holistic, person-centered healthcare in the public service arena through collaboration and collocation.
- Increase in opportunities for workforce development in health care services; promoting physical health and behavioral health care integration.
- Increase in complimentary therapeutic interventions available to persons receiving services.
- Increase in client self-empowerment and self-determination in fulfilling their personal wellness plans.
- Statewide agency coordination on health and wellness efforts.

## **Section III**

### **Prevention of State Hospitalization**

- Shared resources and resource savings through greater state and community partnership.
- Decrease in the number of productive years of life lost to preventable conditions.

#### **XII. Oregon Health Authority**

Oregon has a unique opportunity to provide services and supports in a more integrated manner through the Oregon Health Authority (OHA). The OHA was created by legislation in 2009 (House Bill 2009) to be implemented at the beginning of the July 2011 biennium. The mission of the OHA is to help people and communities achieve optimum physical, mental and social well being through partnerships, prevention and access to quality, affordable health care. The ultimate aim of the OHA is to ensure access to health care while making changes that will stem rising costs, improve quality and promote good health. This provides Oregon with an opportunity to have the needs of this population considered in important health care reform. OHA knows what it needs to do to improve health care: focus on health and preventive care, provide care for everyone and reduce waste in the health care system. OHA will be tackling these problems in both the public and private sectors.

#### **XIII. Consumer Participation**

Oregon Revised Statute (ORS) 430.075 provides that at least 20 percent membership of task forces, commissions, advisory groups and committees primarily related to mental health or addictions issues must be composed of consumers of services. This important legislation was passed in 2007 with the full support of local and statewide consumer groups, ensuring that the voice of people who are currently receiving mental health or addiction services or have received services are included in policy and decision making. In order to encourage statewide participation, individuals receive compensation for their travel expenses. Reimbursement comes from a combination of federal (i.e. Mental Health Block Grant) and General Fund sources. To expand consumer voice statewide, Oregon is promoting consumers as educators of mental health and addiction services. Oregon will continue to actively seek consumer participation in the development of community based programs. Oregon will actively seek and support

## **Section III**

### **Prevention of State Hospitalization**

consumer participation as members of quality improvement site reviews and will provide increased consumer education regarding Olmstead and policy development and implementation. AMH will seek funding to support community based consumer organizations thru an Office of Consumer Activities.



## Summary

Looking to the future, Oregon is embarking on 15 new policy driven initiatives. Many of which are identified in this document. (*Appendix E*) These initiatives will move Oregon to a more recovery focused system and will substantially increase the availability, utilization and quality of individualized, integrated, culturally competent, home and community-based services for children, youth, and adults.

Oregon's goal to achieve the intent of the Olmstead decision is to move healthy people to independent housing that promotes recovery, resiliency, independence and wellness while providing people with "a key to their own door." Oregon will achieve this goal by reducing the length of stay (LOS) at the Oregon State Hospital (OSH), establishing independent living environments statewide and preventing hospitalization at OSH through early diagnosis and treatment, effective use of community-based services and supports such as peer delivered services, warmline referrals and use of community crisis centers and crisis/respite beds.

AMH will convene a stakeholder group in December 2010 to establish an implementation plan and identify outcome measurements for the Olmstead plan. Benchmarks and outcomes will be tied directly to the Olmstead implementation plan. This implementation plan will be developed together with a broad range of stakeholders. Accountability will be linked to state and local community-based programs and agencies that are integral to a successful implementation plan. AMH will use planning processes that include Olmstead goals and implementation outcomes which would result in a comprehensive state approach for the implantation plan. This is vital and will form the inextricable connections between Olmstead, mental health systems policy and planning, and mental health reform.

Oregon's system is now under stress because the state had relied on creating a facility-based approach to service delivery. The mental health system at present is meeting less than 50 percent of the need for public services for adults and children. As identified in the CSWG report ". . . without the investment in community services, the demand for state hospital beds will exceed the capacity of the new state hospital facilities. If the new state hospitals are to succeed, a significant investment must also be made to develop and enhance a robust array of community services that support individual recovery goals." These services and supports must be consumer driven not only at the clinical level, but with consumer's providing an active voice through participation in local and state governance bodies.

## Summary

It is critical that each community or regional system of care in our state have enough resources to fund a set of core services and supports or Oregon will not be successful with the replacement state hospital facilities envisioned by the Oregon State Hospital Master Plan. The facilities will not be successful in operating with limited beds, shorter lengths of stay and a manageable occupancy rate if every region is not funded comprehensively and comparably, based on objective analysis of the relative need in each geographic area. A robustly funded community-based system of care is not only essential to the operation of the state hospital it is essential in meeting Oregon's Olmstead goals.

## **Appendix A**

**Olmstead v. L.C. (98-536) 527 U.S. 581 (1999)**

OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.* v. L. C.,  
*by zimiring, guardian ad litem and next*  
*friend, et al.*

certiorari to the united states court of appeals for the eleventh circuit

No. 98-536. Argued April 21, 1999--Decided June 22, 1999

In the Americans with Disabilities Act of 1990 (ADA), Congress described the isolation and segregation of individuals with disabilities as a serious and pervasive form of discrimination. 42 U. S. C. §§12101(a)(2), (5). Title II of the ADA, which proscribes discrimination in the provision of public services, specifies, *inter alia*, that no qualified individual with a disability shall, "by reason of such disability," be excluded from participation in, or be denied the benefits of, a public entity's services, programs, or activities. §12132. Congress instructed the Attorney General to issue regulations implementing Title II's discrimination proscription. See §12134(a). One such regulation, known as the "integration regulation," requires a "public entity [to] administer ... programs ... in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR §35.130(d). A further prescription, here called the "reasonable-modifications regulation," requires public entities to "make reasonable modifications" to avoid "discrimination on the basis of disability," but does not require measures that would "fundamentally alter" the nature of the entity's programs. §35.130(b)(7).

Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W., with a personality disorder. Both women were voluntarily admitted to Georgia Regional Hospital at Atlanta (GRH), where they were confined for treatment in a psychiatric unit. Although their treatment professionals eventually concluded that each of the women could be cared for appropriately in a community-based program, the women remained institutionalized at GRH. Seeking placement in community care, L. C. filed this suit against petitioner state officials (collectively, the State) under 42 U. S. C. §1983 and Title II. She alleged that the State violated Title II in failing to place her in a community-based program once her treating professionals determined that such placement was appropriate. E. W. intervened, stating an identical claim. The District Court granted partial summary judgment for the women, ordering their placement in an appropriate community-based treatment program. The court rejected the State's argument that inadequate funding, not discrimination against L. C. and E. W. "by reason of [their] disability[ies]," accounted for their retention at GRH. Under Title II, the court concluded, unnecessary institutional segregation constitutes discrimination *per se*, which cannot be justified by a lack of funding. The court also rejected the State's defense that requiring immediate transfers in such cases would "fundamentally alter" the State's programs. The Eleventh Circuit affirmed the District Court's judgment, but remanded for reassessment of the State's cost-based defense. The District Court had left virtually no room for such a defense. The appeals court read the statute and regulations to allow the defense, but only in tightly limited circumstances. Accordingly, the Eleventh Circuit instructed the District Court to consider, as a key factor, whether the additional cost for treatment of L. C. and E. W. in community-based care would be unreasonable given the demands of the State's mental health budget.

*Held:* The judgment is affirmed in part and vacated in part, and the case is remanded.

138 F. 3d 893, affirmed in part, vacated in part, and remanded.

*Justice Ginsburg* delivered the opinion of the Court with respect to Parts I, II, and III-A, concluding that, under Title II of the ADA, States are required to place persons with mental disabilities in community settings rather than in institutions when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. Pp. 11-18.

(a) The integration and reasonable-modifications regulations issued by the Attorney General rest on two key determinations: (1) Unjustified placement or retention of persons in institutions severely limits their exposure to the outside community, and therefore constitutes a form of discrimination based on disability prohibited by Title II, and (2) qualifying their obligation to avoid unjustified isolation of individuals with disabilities, States can resist modifications that would fundamentally alter the nature of their services and programs. The Eleventh Circuit essentially upheld the Attorney General's construction of the ADA. This Court affirms the Court of Appeals decision in substantial part. Pp. 11-12.

(b) Undue institutionalization qualifies as discrimination "by reason of ... disability." The Department of Justice has consistently advocated that it does. Because the Department is the agency directed by Congress to issue Title II regulations, its views warrant respect. This Court need not inquire whether the degree of deference described in *Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837, 844, is in order; the well-reasoned views of the agencies implementing a statute constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance. *E.g.*, *Bragdon v. Abbott*, 524 U. S. 624, 642. According to the State, L. C. and E. W. encountered no discrimination "by reason of" their disabilities because they were not denied community placement on account of those disabilities, nor were they subjected to "discrimination," for they identified no comparison class of similarly situated individuals given preferential treatment. In rejecting these positions, the Court recognizes that Congress had a more comprehensive view of the concept of discrimination advanced in the ADA. The ADA stepped up earlier efforts in the Developmentally Disabled Assistance and Bill of Rights Act and the Rehabilitation Act of 1973 to secure opportunities for people with developmental disabilities to enjoy the benefits of community living. The ADA both requires all public entities to refrain from discrimination, see §12132, and specifically identifies unjustified "segregation" of persons with disabilities as a "for[m] of discrimination," see §§12101(a)(2), 12101(a)(5). The identification of unjustified segregation as discrimination reflects two evident judgments: Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life, *cf.*, *e.g.*, *Allen v. Wright*, 468 U. S. 737, 755; and institutional confinement severely diminishes individuals' everyday life activities. Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice. The State correctly uses the past tense to frame its argument that, despite Congress' ADA findings, the Medicaid statute "reflected" a congressional policy preference for institutional treatment over treatment in the community. Since 1981, Medicaid has in fact provided funding for state-run home and community-based care through a waiver program. This Court emphasizes that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings. Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it. In this case, however, it is not genuinely disputed that L. C. and E. W. are individuals "qualified" for noninstitutional care: The State's own professionals determined that community-based treatment would be appropriate for L. C. and E. W., and neither woman opposed such treatment. Pp. 12-18.

*Justice Ginsburg*, joined by *Justice O'Connor*, *Justice Souter*, and *Justice Breyer*, concluded in Part III-B that the State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless. The reasonable-modifications regulation speaks of "reasonable modifications" to avoid discrimination, and allows States to resist modifications that entail a "fundamenta[l] alter[ation]" of the States' services and programs. If, as the Eleventh Circuit indicated, the expense entailed in placing one or two people in a community-based treatment program is properly measured for reasonableness against the State's entire mental health budget, it is unlikely that a State, relying on the fundamental-alteration defense, could ever prevail. Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities. The ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. Nor is it the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter, a placement the State

proposed, then retracted, for E. W. Some individuals, like L. C. and E. W. in prior years, may need institutional care from time to time to stabilize acute psychiatric symptoms. For others, no placement outside the institution may ever be appropriate. To maintain a range of facilities and to administer services with an even hand, the State must have more leeway than the courts below understood the fundamental-alteration defense to allow. If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions. The case is remanded for further consideration of the appropriate relief, given the range of the State's facilities for the care of persons with diverse mental disabilities, and its obligation to administer services with an even hand. Pp. 18-22.

*Justice Stevens* would affirm the judgment of the Court of Appeals, but because there are not five votes for that disposition, joined *Justice Ginsburg*'s judgment and Parts I, II, and III-A of her opinion. Pp. 1-2.

*Justice Kennedy* concluded that the case must be remanded for a determination of the questions the Court poses and for a determination whether respondents can show a violation of 42 U. S. C. §12132's ban on discrimination based on the summary judgment materials on file or any further pleadings and materials properly allowed. On the ordinary interpretation and meaning of the term, one who alleges discrimination must show that she received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic. Thus, respondents could demonstrate discrimination by showing that Georgia (i) provides treatment to individuals suffering from medical problems of comparable seriousness, (ii) as a general matter, does so in the most integrated setting appropriate for the treatment of those problems (taking medical and other practical considerations into account), but (iii) without adequate justification, fails to do so for a group of mentally disabled persons (treating them instead in separate, locked institutional facilities). This inquiry would not be simple. Comparisons of different medical conditions and the corresponding treatment regimens might be difficult, as would be assessments of the degree of integration of various settings in which medical treatment is offered. Thus far, respondents have identified no class of similarly situated individuals, let alone shown them to have been given preferential treatment. Without additional information, the Court cannot address the issue in the way the statute demands. As a consequence, the partial summary judgment granted respondents ought not to be sustained. In addition, it was error in the earlier proceedings to restrict the relevance and force of the State's evidence regarding the comparative costs of treatment. The State is entitled to wide discretion in adopting its own systems of cost analysis, and, if it chooses, to allocate health care resources based on fixed and overhead costs for whole institutions and programs. The lower courts should determine in the first instance whether a statutory violation is sufficiently alleged and supported in respondents' summary judgment materials and, if not, whether they should be given leave to replead and to introduce evidence and argument along the lines suggested. Pp. 1-10.

*Ginsburg*, J., announced the judgment of the Court and delivered the opinion of the Court with respect to Parts I, II, and III-A, in which *Stevens*, *O'Connor*, *Souter*, and *Breyer*, JJ., joined, and an opinion with respect to Part III-B, in which *O'Connor*, *Souter*, and *Breyer*, JJ., joined. *Stevens*, J., filed an opinion concurring in part and concurring in the judgment. *Kennedy*, J., filed an opinion concurring in the judgment, in which *Breyer*, J., joined as to Part I. *Thomas*, J., filed a dissenting opinion, in which *Rehnquist*, C. J., and *Scalia*, J., joined.

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TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.* ,  
PETITIONERS *v.* L. C., *by* JONATHAN ZIMRING, *guardian ad litem and next friend* , *et al.*

on writ of certiorari to the united states court of appeals for the eleventh circuit

[June 22, 1999]

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*Justice Ginsburg* announced the judgment of the Court and delivered the opinion of the Court with respect to Parts I, II, and III-A, and an opinion with respect to Part III-B, in which *O'Connor*, *Souter*, and *Breyer, JJ.*, joined.

This case concerns the proper construction of the anti-discrimination provision contained in the public services portion (Title II) of the Americans with Disabilities Act of 1990, 104 Stat. 337, 42 U. S. C. §12132. Specifically, we confront the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions. The answer, we hold, is a qualified yes. Such action is in order when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. In so ruling, we affirm the decision of the Eleventh Circuit in substantial part. We remand the case, however, for further consideration of the appropriate relief, given the range of facilities the State maintains for the care and treatment of persons with diverse mental disabilities, and its obligation to administer services with an even hand.

## I

This case, as it comes to us, presents no constitutional question. The complaints filed by plaintiffs-respondents L. C. and E. W. did include such an issue; L. C. and E. W. alleged that defendants-petitioners, Georgia health care officials, failed to afford them minimally adequate care and freedom from undue restraint, in violation of their rights under the Due Process Clause of the Fourteenth Amendment. See Complaint ¶¶ 87-91; Intervenor's Complaint ¶¶ 30-34. But neither the District Court nor the Court of Appeals reached those Fourteenth Amendment claims. See Civ. No. 1:95-cv-1210-MHS (ND Ga., Mar. 26, 1997), pp. 5-6, 11-13, App. to Pet. for Cert. 34a-35a, 40a-41a; 138 F. 3d 893, 895, and n. 3 (CA11 1998). Instead, the courts below resolved the case solely on statutory grounds. Our review is similarly confined. Cf. *Cleburne v. Cleburne Living Center, Inc.* , 473 U. S. 432, 450 (1985) (Texas city's requirement of special use permit for operation of group home for mentally retarded, when other care and multiple-dwelling facilities were freely permitted, lacked rational basis and therefore violated Equal Protection Clause of Fourteenth Amendment). Mindful that it is a statute we are construing, we set out first the legislative and regulatory prescriptions on which the case turns.

In the opening provisions of the ADA, Congress stated findings applicable to the statute in all its parts. Most relevant to this case, Congress determined that

"(2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;

"(3) discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization . . . ;

.....

"(5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, . . . failure to make modifications to existing facilities and practices, . . . [and] segregation . . ." 42 U. S. C. §§12101(a)(2), (3), (5).<sup>1</sup>

Congress then set forth prohibitions against discrimination in employment (Title I, §§12111-12117), public services furnished by governmental entities (Title II, §§12131-12165), and public accommodations provided by private entities (Title III, §§12181-12189). The statute as a whole is intended "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." §12101(b)(1).<sup>2</sup>

This case concerns Title II, the public services portion of the ADA.<sup>3</sup> The provision of Title II centrally at issue reads:

"Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." §12132.

Title II's definition section states that "public entity" includes "any State or local government," and "any department, agency, [or] special purpose district." §§12131(1)(A), (B). The same section defines "qualified individual with a disability" as

"an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." §12131(2).

On redress for violations of §12132's discrimination prohibition, Congress referred to remedies available under §505 of the Rehabilitation Act of 1973, 92 Stat. 2982, 29 U. S. C. §794a. See 42 U. S. C. §12133 ("The remedies, procedures, and rights set forth in [§505 of the Rehabilitation Act] shall be the remedies, procedures, and rights this subchapter provides to any person alleging discrimination on the basis of disability in violation of section 12132 of this title.").<sup>4</sup>

Congress instructed the Attorney General to issue regulations implementing provisions of Title II, including §12132's discrimination proscription. See §12134(a) ("[T]he Attorney General shall promulgate regulations in an accessible format that implement this part.").<sup>5</sup> The Attorney General's regulations, Congress further directed, "shall be consistent with this chapter and with the coordination regulations . . . applicable to recipients of Federal financial assistance under [§504 of the Rehabilitation Act]." 42 U. S. C. §12134(b). One of the §504 regulations requires recipients of federal funds to "administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons." 28 CFR §41.51(d) (1998).

As Congress instructed, the Attorney General issued Title II regulations, see 28 CFR pt. 35 (1998), including one modeled on the §504 regulation just quoted; called the "integration regulation," it reads:

"A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 CFR §35.130(d) (1998).

The preamble to the Attorney General's Title II regulations defines "the most integrated setting appropriate to the needs of qualified individuals with disabilities" to mean "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 CFR



pt. 35, App. A, p. 450 (1998). Another regulation requires public entities to "make reasonable modifications" to avoid "discrimination on the basis of disability," unless those modifications would entail a "fundamenta[l] alter[ation]"; called here the "reasonable-modifications regulation," it provides:

"A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 CFR §35.130(b)(7) (1998).

We recite these regulations with the caveat that we do not here determine their validity. While the parties differ on the proper construction and enforcement of the regulations, we do not understand petitioners to challenge the regulatory formulations themselves as outside the congressional authorization. See Brief for Petitioners 16-17, 36, 40-41; Reply Brief 15-16 (challenging the Attorney General's interpretation of the integration regulation).

## II

With the key legislative provisions in full view, we summarize the facts underlying this dispute. Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W., with a personality disorder. Both women have a history of treatment in institutional settings. In May 1992, L. C. was voluntarily admitted to Georgia Regional Hospital at Atlanta (GRH), where she was confined for treatment in a psychiatric unit. By May 1993, her psychiatric condition had stabilized, and L. C.'s treatment team at GRH agreed that her needs could be met appropriately in one of the community-based programs the State supported. Despite this evaluation, L. C. remained institutionalized until February 1996, when the State placed her in a community-based treatment program.

E. W. was voluntarily admitted to GRH in February 1995; like L. C., E. W. was confined for treatment in a psychiatric unit. In March 1995, GRH sought to discharge E. W. to a homeless shelter, but abandoned that plan after her attorney filed an administrative complaint. By 1996, E. W.'s treating psychiatrist concluded that she could be treated appropriately in a community-based setting. She nonetheless remained institutionalized until a few months after the District Court issued its judgment in this case in 1997.

In May 1995, when she was still institutionalized at GRH, L. C. filed suit in the United States District Court for the Northern District of Georgia, challenging her continued confinement in a segregated environment. Her complaint invoked 42 U. S. C. §1983 and provisions of the ADA, §§12131-12134, and named as defendants, now petitioners, the Commissioner of the Georgia Department of Human Resources, the Superintendent of GRH, and the Executive Director of the Fulton County Regional Board (collectively, the State). L. C. alleged that the State's failure to place her in a community-based program, once her treating professionals determined that such placement was appropriate, violated, *inter alia*, Title II of the ADA. L. C.'s pleading requested, among other things, that the State place her in a community care residential program, and that she receive treatment with the ultimate goal of integrating her into the mainstream of society. E. W. intervened in the action, stating an identical claim.<sup>6</sup>

The District Court granted partial summary judgment in favor of L. C. and E. W. See App. to Pet. for Cert. 31a-42a. The court held that the State's failure to place L. C. and E. W. in an appropriate community-based treatment program violated Title II of the ADA. See *id.*, at 39a, 41a. In so ruling, the court rejected the State's argument that inadequate funding, not discrimination against L. C. and E. W. "by reason of" their disabilities, accounted for their retention at GRH. Under Title II, the court concluded, "unnecessary institutional segregation of the disabled constitutes discrimination *per se*, which cannot be justified by a lack of funding." *Id.*, at 37a.

In addition to contending that L. C. and E. W. had not shown discrimination "by reason of [their] disabilit[ies]," the State resisted court intervention on the ground that requiring immediate transfers in cases of this order would "fundamentally alter" the State's activity. The State reasserted that it was already using all available funds to provide services to other persons with disabilities. See *id.* , at 38a. Rejecting the State's "fundamental alteration" defense, the court observed that existing state programs provided community-based treatment of the kind for which L. C. and E. W. qualified, and that the State could "provide services to plaintiffs in the community at considerably *less* cost than is required to maintain them in an institution." *Id.* , at 39a.

The Court of Appeals for the Eleventh Circuit affirmed the judgment of the District Court, but remanded for reassessment of the State's cost-based defense. See 138 F. 3d, at 905. As the appeals court read the statute and regulations: When "a disabled individual's treating professionals find that a community-based placement is appropriate for that individual, the ADA imposes a duty to provide treatment in a community setting--the most integrated setting appropriate to that patient's needs"; "[w]here there is no such finding [by the treating professionals], nothing in the ADA requires the deinstitutionalization of th[e] patient." *Id.* , at 902.

The Court of Appeals recognized that the State's duty to provide integrated services "is not absolute"; under the Attorney General's Title II regulation, "reasonable modifications" were required of the State, but fundamental alterations were not demanded. *Id.* , at 904. The appeals court thought it clear, however, that "Congress wanted to permit a cost defense only in the most limited of circumstances." *Id.* , at 902. In conclusion, the court stated that a cost justification would fail "[u]nless the State can prove that requiring it to [expend additional funds in order to provide L. C. and E. W. with integrated services] would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service [the State] provides." *Id.* , at 905. Because it appeared that the District Court had entirely ruled out a "lack of funding" justification, see App. to Pet. for Cert. 37a, the appeals court remanded, repeating that the District Court should consider, among other things, "whether the additional expenditures necessary to treat L. C. and E. W. in community-based care would be unreasonable given the demands of the State's mental health budget." 138 F. 3d, at 905. <sup>7</sup>

We granted certiorari in view of the importance of the question presented to the States and affected individuals. See 525 U. S. \_\_\_\_ (1998). <sup>8</sup>

### III

Endeavoring to carry out Congress' instruction to issue regulations implementing Title II, the Attorney General, in the integration and reasonable-modifications regulations, see *supra* , at 5-7, made two key determinations. The first concerned the scope of the ADA's discrimination proscription, 42 U. S. C. §12132; the second concerned the obligation of the States to counter discrimination. As to the first, the Attorney General concluded that unjustified placement or retention of persons in institutions, severely limiting their exposure to the outside community, constitutes a form of discrimination based on disability prohibited by Title II. See 28 CFR §35.130(d) (1998) ("A public entity shall administer services . . . in the most integrated setting appropriate to the needs of qualified individuals with disabilities."); Brief for United States as *Amicus Curiae* in *Helen L. v. DiDario* , No. 94-1243 (CA3 1994), pp. 8, 15-16 (unnecessary segregation of persons with disabilities constitutes a form of discrimination prohibited by the ADA and the integration regulation). Regarding the States' obligation to avoid unjustified isolation of individuals with disabilities, the Attorney General provided that States could resist modifications that "would fundamentally alter the nature of the service, program, or activity." 28 CFR §35.130(b)(7) (1998).

The Court of Appeals essentially upheld the Attorney General's construction of the ADA. As just recounted, see *supra* , at 9-10, the appeals court ruled that the unjustified institutionalization of persons with mental disabilities violated Title II; the court then remanded with instructions to measure the cost of caring for L. C. and E. W. in a community-based facility against the State's mental health budget.

We affirm the Court of Appeals' decision in substantial part. Unjustified isolation, we hold, is properly regarded as discrimination based on disability. But we recognize, as well, the States' need to maintain a range of facilities for the care and treatment of persons with diverse mental disabilities, and the States' obligation to administer services with an even hand. Accordingly, we further hold that the Court of Appeals' remand instruction was unduly restrictive. In evaluating a State's fundamental-alteration defense, the District Court must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably.

## A

We examine first whether, as the Eleventh Circuit held, undue institutionalization qualifies as discrimination "by reason of . . . disability." The Department of Justice has consistently advocated that it does.<sup>9</sup> Because the Department is the agency directed by Congress to issue regulations implementing Title II, see *supra*, at 5-6, its views warrant respect. We need not inquire whether the degree of deference described in *Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837, 844 (1984), is in order; "[i]t is enough to observe that the well-reasoned views of the agencies implementing a statute 'constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance.'" *Bragdon v. Abbott*, 524 U. S. 624, 642 (1998) (quoting *Skidmore v. Swift & Co.*, 323 U. S. 134, 139-140 (1944)).

The State argues that L. C. and E. W. encountered no discrimination "by reason of" their disabilities because they were not denied community placement on account of those disabilities. See Brief for Petitioners 20. Nor were they subjected to "discrimination," the State contends, because " 'discrimination' necessarily requires uneven treatment of similarly situated individuals," and L. C. and E. W. had identified no comparison class, *i.e.*, no similarly situated individuals given preferential treatment. *Id.*, at 21. We are satisfied that Congress had a more comprehensive view of the concept of discrimination advanced in the ADA.<sup>10</sup>

The ADA stepped up earlier measures to secure opportunities for people with developmental disabilities to enjoy the benefits of community living. The Developmentally Disabled Assistance and Bill of Rights Act (DDABRA), a 1975 measure, stated in aspirational terms that "[t]he treatment, services, and habilitation for a person with developmental disabilities . . . *should be* provided in the setting that is least restrictive of the person's personal liberty." 89 Stat. 502, 42 U. S. C. §6010(2) (1976 ed.) (emphasis added); see also *Pennhurst State School and Hospital v. Halderman*, 451 U. S. 1, 24 (1981) (concluding that the §6010 provisions of the DDABRA "were intended to be hortatory, not mandatory"). In a related legislative endeavor, the Rehabilitation Act of 1973, Congress used mandatory language to proscribe discrimination against persons with disabilities. See 87 Stat. 394, as amended, 29 U. S. C. §794 (1976 ed.) ("No otherwise qualified individual with a disability in the United States . . . *shall*, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." (Emphasis added)). Ultimately, in the ADA, enacted in 1990, Congress not only required all public entities to refrain from discrimination, see 42 U. S. C. §12132; additionally, in findings applicable to the entire statute, Congress explicitly identified unjustified "segregation" of persons with disabilities as a "for[m] of discrimination." See §12101(a)(2) ("historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem"); §12101(a)(5) ("individuals with disabilities continually encounter various forms of discrimination, including . . . segregation").<sup>11</sup>

Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. Cf. *Allen v. Wright*, 468 U. S. 737, 755 (1984) ("There can be no doubt that [stigmatizing injury often caused by racial discrimination] is one of the most serious consequences of discriminatory government action."); *Los Angeles Dept. of Water and Power v.*

*Manhart*, 435 U. S. 702, 707, n. 13 (1978) (" `In forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes.' " (quoting *Sprogis v. United Air Lines, Inc.*, 444 F. 2d 1194, 1198 (CA7 1971)). Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. See Brief for American Psychiatric Association et al. as *Amici Curiae* 20-22. Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice. See Brief for United States as *Amicus Curiae* 6-7, 17.

The State urges that, whatever Congress may have stated as its findings in the ADA, the Medicaid statute "reflected a congressional policy preference for treatment in the institution over treatment in the community." Brief for Petitioners 31. The State correctly used the past tense. Since 1981, Medicaid has provided funding for state-run home and community-based care through a waiver program. See 95 Stat. 812-813, as amended, 42 U. S. C. §1396n(c); Brief for United States as *Amicus Curiae* 20-21.<sup>12</sup> Indeed, the United States points out that the Department of Health and Human Services (HHS) "has a policy of encouraging States to take advantage of the waiver program, and often approves more waiver slots than a State ultimately uses." *Id.*, at 25-26 (further observing that, by 1996, "HHS approved up to 2109 waiver slots for Georgia, but Georgia used only 700").

We emphasize that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings. Title II provides only that "qualified individual[s] with a disability" may not "be subjected to discrimination." 42 U. S. C. §12132. "Qualified individuals," the ADA further explains, are persons with disabilities who, "with or without reasonable modifications to rules, policies, or practices, . . . mee[t] the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." §12131(2).

Consistent with these provisions, the State generally may rely on the reasonable assessments of its own professionals in determining whether an individual "meets the essential eligibility requirements" for habilitation in a community-based program. Absent such qualification, it would be inappropriate to remove a patient from the more restrictive setting. See 28 CFR §35.130(d) (1998) (public entity shall administer services and programs in "the most integrated setting *appropriate* to the needs of qualified individuals with disabilities" (emphasis added)); cf. *School Bd. of Nassau Cty. v. Arline*, 480 U. S. 273, 288 (1987) ("[C]ourts normally should defer to the reasonable medical judgments of public health officials.").<sup>13</sup> Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it. See 28 CFR §35.130(e)(1) (1998) ("Nothing in this part shall be construed to require an individual with a disability to accept an accommodation . . . which such individual chooses not to accept."); 28 CFR pt. 35, App. A, p. 450 (1998) ("[P]ersons with disabilities must be provided the option of declining to accept a particular accommodation."). In this case, however, there is no genuine dispute concerning the status of L. C. and E. W. as individuals "qualified" for noninstitutional care: The State's own professionals determined that community-based treatment would be appropriate for L. C. and E. W., and neither woman opposed such treatment. See *supra*, at 7-8.<sup>14</sup>

## B

The State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless. The reasonable-modifications regulation speaks of "reasonable modifications" to avoid discrimination, and allows States to resist modifications that entail a "fundamenta[l] alter[ation]" of the States' services and programs. 28 CFR §35.130(b)(7) (1998). The Court of Appeals construed this regulation to permit a cost-based defense "only in the most limited of circumstances," 138 F. 3d, at 902, and remanded to the District Court to consider, among other things,

"whether the additional expenditures necessary to treat L. C. and E. W. in community-based care would be unreasonable given the demands of the State's mental health budget," *id.* , at 905.

The Court of Appeals' construction of the reasonable-modifications regulation is unacceptable for it would leave the State virtually defenseless once it is shown that the plaintiff is qualified for the service or program she seeks. If the expense entailed in placing one or two people in a community-based treatment program is properly measured for reasonableness against the State's entire mental health budget, it is unlikely that a State, relying on the fundamental-alteration defense, could ever prevail. See Tr. of Oral Arg. 27 (State's attorney argues that Court of Appeals' understanding of the fundamental-alteration defense, as expressed in its order to the District Court, "will always preclude the State from a meaningful defense"); cf. Brief for Petitioners 37-38 (Court of Appeals' remand order "mistakenly asks the district court to examine [the fundamental-alteration] defense based on the cost of providing community care to just two individuals, not all Georgia citizens who desire community care"); 1:95-cv-1210-MHS (ND Ga., Oct. 20, 1998), p. 3, App. 177 (District Court, on remand, declares the impact of its decision beyond L. C. and E. W. "irrelevant"). Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.

When it granted summary judgment for plaintiffs in this case, the District Court compared the cost of caring for the plaintiffs in a community-based setting with the cost of caring for them in an institution. That simple comparison showed that community placements cost less than institutional confinements. See App. to Pet. for Cert. 39a. As the United States recognizes, however, a comparison so simple overlooks costs the State cannot avoid; most notably, a "State . . . may experience increased overall expenses by funding community placements without being able to take advantage of the savings associated with the closure of institutions." Brief for United States as *Amicus Curiae* 21. <sup>15</sup>

As already observed, see *supra* , at 17, the ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. Cf. *post* , at 2-3 ( *Kennedy, J.* , concurring in judgment). Nor is it the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter, a placement the State proposed, then retracted, for E. W. See *supra* , at 8. Some individuals, like L. C. and E. W. in prior years, may need institutional care from time to time "to stabilize acute psychiatric symptoms." App. 98 (affidavit of Dr. Richard L. Elliott); see 138 F. 3d, at 903 ("[T]here may be times [when] a patient can be treated in the community, and others whe[n] an institutional placement is necessary."); Reply Brief 19 (placement in a community-based treatment program does not mean the State will no longer need to retain hospital accommodations for the person so placed). For other individuals, no placement outside the institution may ever be appropriate. See Brief for American Psychiatric Association et al. as *Amici Curiae* 22-23 ("Some individuals, whether mentally retarded or mentally ill, are not prepared at particular times--perhaps in the short run, perhaps in the long run--for the risks and exposure of the less protective environment of community settings"; for these persons, "institutional settings are needed and must remain available."); Brief for Voice of the Retarded et al. as *Amici Curiae* 11 ("Each disabled person is entitled to treatment in the most integrated setting possible for that person--recognizing that, on a case-by-case basis, that setting may be in an institution."); *Youngberg v. Romeo*, 457 U. S. 307, 327 (1982) (Blackmun, J., concurring) ("For many mentally retarded people, the difference between the capacity to do things for themselves within an institution and total dependence on the institution for all of their needs is as much liberty as they ever will know.").

To maintain a range of facilities and to administer services with an even hand, the State must have more leeway than the courts below understood the fundamental-alteration defense to allow. If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. See Tr. of Oral Arg. 5 (State's attorney urges that, "by asking [a] person to wait a short time until a community bed is available, Georgia does not exclude [that] person by reason of disability, neither does Georgia discriminate against her by reason of disability"); see



also *id.* , at 25 ("[I]t is reasonable for the State to ask someone to wait until a community placement is available."). In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions.<sup>16</sup>

\* \* \*

For the reasons stated, we conclude that, under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. The judgment of the Eleventh Circuit is therefore affirmed in part and vacated in part, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

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TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.* ,  
PETITIONERS *v.* L. C., *by* JONATHAN ZIMRING, *guardian ad litem and next friend* , *et al.*

on writ of certiorari to the united states court of appeals for the eleventh circuit

[June 22, 1999]

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*Justice Stevens* , concurring in part and concurring in the judgment.

Unjustified disparate treatment, in this case, "unjustified institutional isolation," constitutes discrimination under the Americans with Disabilities Act of 1990. See *ante* , at 15. If a plaintiff requests relief that requires modification of a State's services or programs, the State may assert, as an affirmative defense, that the requested modification would cause a fundamental alteration of a State's services and programs. In this case, the Court of Appeals appropriately remanded for consideration of the State's affirmative defense. On remand, the District Court rejected the State's "fundamental-alteration defense." See *ante* , at 10, n. 7. If the District Court was wrong in concluding that costs unrelated to the treatment of L. C. and E. W. do not support such a defense in this case, that arguable error should be corrected either by the Court of Appeals or by this Court in review of that decision. In my opinion, therefore, we should simply affirm the judgment of the Court of Appeals. But because there are not five votes for that disposition, I join *Justice Ginsburg* 's judgment and Parts I, II, and III-A of her opinion. Cf. *Bragdon v. Abbott* , 524 U. S. 624, 655-656 (1998) ( *Stevens* , J. concurring); *Screws v. United States* , 325 U. S. 91, 134 (1945) (Rutledge, J. concurring in result).

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TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.* ,  
PETITIONERS *v.* L. C., *by* JONATHAN ZIMRING, *guardian ad litem and next friend* , *et al.*

on writ of certiorari to the united states court of appeals for the eleventh circuit

[June 22, 1999]

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*Justice Kennedy* , with whom *Justice Breyer* joins as to Part I, concurring in the judgment.

I

Despite remarkable advances and achievements by medical science, and agreement among many professionals that even severe mental illness is often treatable, the extent of public resources to devote to this cause remains controversial. Knowledgeable professionals tell us that our society, and the governments which reflect its attitudes and preferences, have yet to grasp the potential for treating mental disorders, especially severe mental illness. As a result, necessary resources for the endeavor often are not forthcoming. During the course of a year, about 5.6 million Americans will suffer from severe mental illness. E. Torrey, *Out of the Shadows* 4 (1997). Some 2.2 million of these persons receive no treatment. *Id.* , at 6. Millions of other Americans suffer from mental disabilities of less serious degree, such as mild depression. These facts are part of the background against which this case arises. In addition, of course, persons with mental disabilities have been subject to historic mistreatment, indifference, and hostility. See, *e.g.* , *Cleburne v. Cleburne Living Center, Inc.* , 473 U. S. 432, 461-464 (1985) (Marshall, J., concurring in judgment in part and dissenting in part) (discussing treatment of the mentally retarded).

Despite these obstacles, the States have acknowledged that the care of the mentally disabled is their special obligation. They operate and support facilities and programs, sometimes elaborate ones, to provide care. It is a continuing challenge, though, to provide the care in an effective and humane way, particularly because societal attitudes and the responses of public authorities have changed from time to time.

Beginning in the 1950's, many victims of severe mental illness were moved out of state-run hospitals, often with benign objectives. According to one estimate, when adjusted for population growth, "the actual decrease in the numbers of people with severe mental illnesses in public psychiatric hospitals between 1955 and 1995 was 92 percent." Brief for American Psychiatric Association *et al.* as *Amici Curiae* 21, n. 5 (citing Torrey, *supra* , at 8-9). This was not without benefit or justification. The so-called "deinstitutionalization" has permitted a substantial number of mentally disabled persons to receive needed treatment with greater freedom and dignity. It may be, moreover, that those who remain institutionalized are indeed the most severe cases. With reference to this case, as the Court points out, *ante* , at 7-8, 17-18, it is undisputed that the State's own treating professionals determined that community-based care was medically appropriate for respondents. Nevertheless, the depopulation of state mental hospitals has its dark side. According to one expert:

"For a substantial minority. . . deinstitutionalization has been a psychiatric *Titanic* . Their lives are virtually devoid of 'dignity' or 'integrity of body, mind, and spirit.' 'Self-determination' often means merely that the person has a choice of soup kitchens. The

'least restrictive setting' frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies." Torrey, *supra* , at 11.

It must be remembered that for the person with severe mental illness who has no treatment the most dreaded of confinements can be the imprisonment inflicted by his own mind, which shuts reality out and subjects him to the torment of voices and images beyond our own powers to describe.

It would be unreasonable, it would be a tragic event, then, were the Americans with Disabilities Act of 1990 (ADA) to be interpreted so that States had some incentive, for fear of litigation, to drive those in need of medical care and treatment out of appropriate care and into settings with too little assistance and supervision. The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference. It is a common phenomenon that a patient functions well with medication, yet, because of the mental illness itself, lacks the discipline or capacity to follow the regime the medication requires. This is illustrative of the factors a responsible physician will consider in recommending the appropriate setting or facility for treatment. *Justice Ginsburg's* opinion takes account of this background. It is careful, and quite correct, to say that it is not "the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter . . ." *Ante* , at 20.

In light of these concerns, if the principle of liability announced by the Court is not applied with caution and circumspection, States may be pressured into attempting compliance on the cheap, placing marginal patients into integrated settings devoid of the services and attention necessary for their condition. This danger is in addition to the federalism costs inherent in referring state decisions regarding the administration of treatment programs and the allocation of resources to the reviewing authority of the federal courts. It is of central importance, then, that courts apply today's decision with great deference to the medical decisions of the responsible, treating physicians and, as the Court makes clear, with appropriate deference to the program funding decisions of state policymakers.

## II

With these reservations made explicit, in my view we must remand the case for a determination of the questions the Court poses and for a determination whether respondents can show a violation of 42 U. S. C. §12132's ban on discrimination based on the summary judgment materials on file or any further pleadings and materials properly allowed.

At the outset it should be noted there is no allegation that Georgia officials acted on the basis of animus or unfair stereotypes regarding the disabled. Underlying much discrimination law is the notion that animus can lead to false and unjustified stereotypes, and vice versa. Of course, the line between animus and stereotype is often indistinct, and it is not always necessary to distinguish between them. Section 12132 can be understood to deem as irrational, and so to prohibit, distinctions by which a class of disabled persons, or some within that class, are, by reason of their disability and without adequate justification, exposed by a state entity to more onerous treatment than a comparison group in the provision of services or the administration of existing programs, or indeed entirely excluded from state programs or facilities. Discrimination under this statute might in principle be shown in the case before us, though further proceedings should be required.

Putting aside issues of animus or unfair stereotype, I agree with *Justice Thomas* that on the ordinary interpretation and meaning of the term, one who alleges discrimination must show that she "received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic." *Post* , at 1-2 (dissenting opinion). In my view, however, discrimination so defined might be shown here. Although the Court seems to reject *Justice Thomas's* definition of discrimination, *ante* , at 13, it asserts that unnecessary institutional care does lead to "[d]issimilar treatment," *ante* , at 16. According to the Court, "[i]n order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable



accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice." *Ibid* .

Although this point is not discussed at length by the Court, it does serve to suggest the theory under which respondents might be subject to discrimination in violation of §12132. If they could show that persons needing psychiatric or other medical services to treat a mental disability are subject to a more onerous condition than are persons eligible for other existing state medical services, and if removal of the condition would not be a fundamental alteration of a program or require the creation of a new one, then the beginnings of a discrimination case would be established. In terms more specific to this case, if respondents could show that Georgia (i) provides treatment to individuals suffering from medical problems of comparable seriousness, (ii) as a general matter, does so in the most integrated setting appropriate for the treatment of those problems (taking medical and other practical considerations into account), but (iii) without adequate justification, fails to do so for a group of mentally disabled persons (treating them instead in separate, locked institutional facilities), I believe it would demonstrate discrimination on the basis of mental disability.

Of course, it is a quite different matter to say that a State without a program in place is required to create one. No State has unlimited resources and each must make hard decisions on how much to allocate to treatment of diseases and disabilities. If, for example, funds for care and treatment of the mentally ill, including the severely mentally ill, are reduced in order to support programs directed to the treatment and care of other disabilities, the decision may be unfortunate. The judgment, however, is a political one and not within the reach of the statute. Grave constitutional concerns are raised when a federal court is given the authority to review the State's choices in basic matters such as establishing or declining to establish new programs. It is not reasonable to read the ADA to permit court intervention in these decisions. In addition, as the Court notes, *ante*, at 6-7, by regulation a public entity is required only to make "reasonable modifications in policies, practices, or procedures" when necessary to avoid discrimination and is not even required to make those if "the modifications would fundamentally alter the nature of the service, program, or activity." 28 CFR §35.130(b)(7) (1998). It follows that a State may not be forced to create a community-treatment program where none exists. See Brief for United States as *Amicus Curiae* 19-20, and n. 3. Whether a different statutory scheme would exceed constitutional limits need not be addressed.

Discrimination, of course, tends to be an expansive concept and, as legal category, it must be applied with care and prudence. On any reasonable reading of the statute, §12132 cannot cover all types of differential treatment of disabled and nondisabled persons, no matter how minimal or innocuous. To establish discrimination in the context of this case, and absent a showing of policies motivated by improper animus or stereotypes, it would be necessary to show that a comparable or similarly situated group received differential treatment. Regulations are an important tool in identifying the kinds of contexts, policies, and practices that raise concerns under the ADA. The congressional findings in 42 U. S. C. §12101 also serve as a useful aid for courts to discern the sorts of discrimination with which Congress was concerned. Indeed, those findings have clear bearing on the issues raised in this case, and support the conclusion that unnecessary institutionalization may be the evidence or the result of the discrimination the ADA prohibits.

Unlike *Justice Thomas* , I deem it relevant and instructive that Congress in express terms identified the "isolat[ion] and segregat[ion]" of disabled persons by society as a "for[m] of discrimination," §§12101(a)(2), (5), and noted that discrimination against the disabled "persists in such critical areas as . . . institutionalization," §12101(a)(3). These findings do not show that segregation and institutionalization are always discriminatory or that segregation or institutionalization are, by their nature, forms of prohibited discrimination. Nor do they necessitate a regime in which individual treatment plans are required, as distinguished from broad and reasonable classifications for the provision of health care services. Instead, they underscore Congress' concern that discrimination has been a frequent and pervasive problem in institutional settings and policies and its concern that segregating disabled persons from others can be discriminatory. Both of those concerns are consistent with the normal definition of discrimination--differential treatment of similarly situated groups. The findings inform application of that definition in specific cases, but absent guidance to the contrary, there is no reason to think they displace

it. The issue whether respondents have been discriminated against under §12132 by institutionalized treatment cannot be decided in the abstract, divorced from the facts surrounding treatment programs in their State.

The possibility therefore remains that, on the facts of this case, respondents would be able to support a claim under §12132 by showing that they have been subject to discrimination by Georgia officials on the basis of their disability. This inquiry would not be simple. Comparisons of different medical conditions and the corresponding treatment regimens might be difficult, as would be assessments of the degree of integration of various settings in which medical treatment is offered. For example, the evidence might show that, apart from services for the mentally disabled, medical treatment is rarely offered in a community setting but also is rarely offered in facilities comparable to state mental hospitals. Determining the relevance of that type of evidence would require considerable judgment and analysis. However, as petitioners observe, "[i]n this case, no class of similarly situated individuals was even identified, let alone shown to be given preferential treatment." Brief for Petitioners 21. Without additional information regarding the details of state-provided medical services in Georgia, we cannot address the issue in the way the statute demands. As a consequence, the judgment of the courts below, granting partial summary judgment to respondents, ought not to be sustained. In addition, as *Justice Ginsburg's* opinion is careful to note, *ante*, at 19, it was error in the earlier proceedings to restrict the relevance and force of the State's evidence regarding the comparative costs of treatment. The State is entitled to wide discretion in adopting its own systems of cost analysis, and, if it chooses, to allocate health care resources based on fixed and overhead costs for whole institutions and programs. We must be cautious when we seek to infer specific rules limiting States' choices when Congress has used only general language in the controlling statute.

I would remand the case to the Court of Appeals or the District Court for it to determine in the first instance whether a statutory violation is sufficiently alleged and supported in respondents' summary judgment materials and, if not, whether they should be given leave to replead and to introduce evidence and argument along the lines suggested above.

For these reasons, I concur in the judgment of the Court.

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TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, *et al.*,  
PETITIONERS *v.* L. C., *by* JONATHAN ZIMRING, *guardian ad litem and next friend*, *et al.*

on writ of certiorari to the united states court of appeals for the eleventh circuit

[June 22, 1999]

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*Justice Thomas*, with whom *The Chief Justice* and *Justice Scalia* join, dissenting.

Title II of the Americans with Disabilities Act of 1990 (ADA), 104 Stat. 337, 42 U. S. C. §12132, provides:

"Subject to the provisions of this subchapter, no qualified individual with a disability shall, *by reason of such disability*, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, *or be subjected to discrimination* by any such entity." (Emphasis added.)

The majority concludes that petitioners "discriminated" against respondents--as a matter of law--by continuing to treat them in an institutional setting after they became eligible for community placement. I

disagree. Temporary exclusion from community placement does not amount to "discrimination" in the traditional sense of the word, nor have respondents shown that petitioners "discriminated" against them "by reason of" their disabilities.

Until today, this Court has never endorsed an interpretation of the term "discrimination" that encompassed disparate treatment among members of the *same* protected class. Discrimination, as typically understood, requires a showing that a claimant received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic. This interpretation comports with dictionary definitions of the term discrimination, which means to "distinguish," to "differentiate," or to make a "distinction in favor of or against, a person or thing based on the group, class, or category to which that person or thing belongs rather than on individual merit." Random House Dictionary 564 (2d ed. 1987); see also Webster's Third New International Dictionary 648 (1981) (defining "discrimination" as "the making or perceiving of a distinction or difference" or as "the act, practice, or an instance of discriminating categorically rather than individually").

Our decisions construing various statutory prohibitions against "discrimination" have not wavered from this path. The best place to begin is with Title VII of the Civil Rights Act of 1964, 78 Stat. 253, as amended, the paradigmatic anti-discrimination law.<sup>1</sup> Title VII makes it "an unlawful employment practice for an employer ... to *discriminate* against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin." 42 U. S. C. §2000e-2(a)(1) (emphasis added). We have explained that this language is designed "to achieve equality of employment opportunities and remove barriers that have operated in the past to favor an identifiable group of white employees over other employees." *Griggs v. Duke Power Co.*, 401 U. S. 424, 429-430 (1971).<sup>2</sup>

Under Title VII, a finding of discrimination requires a comparison of otherwise similarly situated persons who are in different groups by reason of certain characteristics provided by statute. See, e.g., *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U. S. 669, 683 (1983) (explaining that Title VII discrimination occurs when an employee is treated "in a manner which but for that person's sex would be different") (quoting *Los Angeles Dept. of Water and Power v. Manhart*, 435 U. S. 702, 711 (1978)). For this reason, we have described as "nonsensical" the comparison of the racial composition of different classes of job categories in determining whether there existed disparate impact discrimination with respect to a particular job category. *Wards Cove Packing Co. v. Atonio*, 490 U. S. 642, 651 (1989).<sup>3</sup> Courts interpreting Title VII have held that a plaintiff cannot prove "discrimination" by demonstrating that one member of a particular protected group has been favored over another member of that same group. See, e.g., *Bush v. Commonwealth Edison Co.*, 990 F. 2d 928, 931 (CA7 1993), cert. denied, 511 U. S. 1071 (1994) (explaining that under Title VII, a fired black employee "had to show that although he was not a good employee, equally bad employees were treated more leniently by [his employer] if they happened not to be black").

Our cases interpreting §504 of the Rehabilitation Act of 1973, 87 Stat. 394, as amended, which prohibits "discrimination" against certain individuals with disabilities, have applied this commonly understood meaning of discrimination. Section 504 provides:

"No otherwise qualified handicapped individual ... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

In keeping with the traditional paradigm, we have always limited the application of the term "discrimination" in the Rehabilitation Act to a person who is a member of a protected group and faces discrimination "by reason of his handicap." Indeed, we previously rejected the argument that §504 requires the type of "affirmative efforts to overcome the disabilities caused by handicaps," *Southeastern Community College v. Davis*, 442 U. S. 397, 410 (1979), that the majority appears to endorse today. Instead, we found that §504 required merely "the evenhanded treatment of handicapped persons" relative to those persons who do not have disabilities. *Ibid.* Our conclusion was informed by the fact that some

provisions of the Rehabilitation Act envision "affirmative action" on behalf of those individuals with disabilities, but §504 itself "does not refer at all" to such action. *Ibid.* Therefore, "[a] comparison of these provisions demonstrates that Congress understood accommodation of the needs of handicapped individuals may require affirmative action and knew how to provide for it in those instances where it wished to do so." *Id.*, at 411.

Similarly, in *Alexander v. Choate*, 469 U. S. 287, 302 (1985), we found no discrimination under §504 with respect to a limit on inpatient hospital care that was "neutral on its face" and did not "distinguish between those whose coverage will be reduced and those whose coverage will not on the basis of any test, judgment, or trait that the handicapped as a class are less capable of meeting or less likely of having," *id.*, at 302. We said that §504 does "not ... guarantee the handicapped equal results from the provision of state Medicaid, even assuming some measure of equality of health could be constructed." *Id.*, at 304.

Likewise, in *Traynor v. Turnage*, 485 U. S. 535, 548 (1988), we reiterated that the purpose of §504 is to guarantee that individuals with disabilities receive "evenhanded treatment" relative to those persons without disabilities. In *Traynor*, the Court upheld a Veterans' Administration regulation that excluded "primary alcoholics" from a benefit that was extended to persons disabled by alcoholism related to a mental disorder. *Id.*, at 551. In so doing, the Court noted that, "[t]his litigation does not involve a program or activity that is alleged to treat handicapped persons less favorably than nonhandicapped persons." *Id.*, at 548. Given the theory of the case, the Court explicitly held: "There is nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons." *Id.*, at 549.

This same understanding of discrimination also informs this Court's constitutional interpretation of the term. See *General Motors Corp. v. Tracy*, 519 U. S. 278, 298 (1997) (noting with respect to interpreting the Commerce Clause, "[c]onceptually, of course, any notion of discrimination assumes a comparison of substantially similar entities"); *Yick Wo v. Hopkins*, 118 U. S. 356, 374 (1886) (condemning under the Fourteenth Amendment "illegal discriminations between persons in similar circumstances"); see also *Adarand Constructors, Inc. v. Peña*, 515 U. S. 200, 223-224 (1995); *Richmond v. J. A. Croson Co.*, 488 U. S. 469, 493-494 (1989) (plurality opinion).

Despite this traditional understanding, the majority derives a more "capacious" definition of "discrimination," as that term is used in Title II of the ADA, one that includes "institutional isolation of persons with disabilities." *Ante*, at 13-14. It chiefly relies on certain congressional findings contained within the ADA. To be sure, those findings appear to equate institutional isolation with segregation, and thereby discrimination. See *ante*, at 14 (quoting §§12101(a)(2) and 12101(a)(5), both of which explicitly identify "segregation" of persons with disabilities as a form of "discrimination"); see also *ante*, at 2-3. The congressional findings, however, are written in general, hortatory terms and provide little guidance to the interpretation of the specific language of §12132. See *National Organization for Women, Inc. v. Scheidler*, 510 U. S. 249, 260 (1994) ("We also think that the quoted statement of congressional findings is a rather thin reed upon which to base a requirement"). In my view, the vague congressional findings upon which the majority relies simply do not suffice to show that Congress sought to overturn a well-established understanding of a statutory term (here, "discrimination").<sup>4</sup> Moreover, the majority fails to explain why terms in the findings should be given a medical content, pertaining to the place where a mentally retarded person is treated. When read in context, the findings instead suggest that terms such as "segregation" were used in a more general sense, pertaining to matters such as access to employment, facilities, and transportation. Absent a clear directive to the contrary, we must read "discrimination" in light of the common understanding of the term. We cannot expand the meaning of the term "discrimination" in order to invalidate policies we may find unfortunate. Cf. *NLRB v. Highland Park Mfg. Co.*, 341 U. S. 322, 325 (1951) (explaining that if Congress intended statutory terms "to have other than their ordinarily accepted meaning, it would and should have given them a special meaning by definition").<sup>5</sup>

Elsewhere in the ADA, Congress chose to alter the traditional definition of discrimination. Title I of the ADA, §12112(b)(1), defines discrimination to include "limiting, segregating, or classifying a job applicant

or employee in a way that adversely affects the opportunities or status of such applicant or employee." Notably, however, Congress did not provide that this definition of discrimination, unlike other aspects of the ADA, applies to Title II. Ordinary canons of construction require that we respect the limited applicability of this definition of "discrimination" and not import it into other parts of the law where Congress did not see fit. See, e.g., *Bates v. United States*, 522 U. S. 23, 29-30 (1997) ("Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion'") (quoting *Russello v. United States*, 464 U. S. 16, 23 (1983)). The majority's definition of discrimination--although not specifically delineated--substantially imports the definition of Title I into Title II by necessarily assuming that it is sufficient to focus exclusively on members of one particular group. Under this view, discrimination occurs when some members of a protected group are treated differently from other members of that same group. As the preceding discussion emphasizes, absent a special definition supplied by Congress, this conclusion is a remarkable and novel proposition that finds no support in our decisions in analogous areas. For example, the majority's conclusion that petitioners "discriminated" against respondents is the equivalent to finding discrimination under Title VII where a black employee with deficient management skills is denied in-house training by his employer (allegedly because of lack of funding) because other similarly situated black employees are given the in-house training. Such a claim would fly in the face of our prior case law, which requires more than the assertion that a person belongs to a protected group and did not receive some benefit. See, e.g., *Griggs*, 401 U. S., at 430-431 ("Congress did not intend by Title VII, however, to guarantee a job to every person regardless of qualifications. In short, the Act does not command that any person be hired simply because he was formerly the subject of discrimination, or because he is a member of a minority group").

At bottom, the type of claim approved of by the majority does not concern a prohibition against certain conduct (the traditional understanding of discrimination), but rather imposition of a standard of care.<sup>6</sup> As such, the majority can offer no principle limiting this new species of "discrimination" claim apart from an affirmative defense because it looks merely to an individual in isolation, without comparing him to otherwise similarly situated persons, and determines that discrimination occurs merely because that individual does not receive the treatment he wishes to receive. By adopting such a broad view of discrimination, the majority drains the term of any meaning other than as a proxy for decisions disapproved of by this Court.

Further, I fear that the majority's approach imposes significant federalism costs, directing States how to make decisions about their delivery of public services. We previously have recognized that constitutional principles of federalism erect limits on the Federal Government's ability to direct state officers or to interfere with the functions of state governments. See, e.g., *Printz v. United States*, 521 U. S. 898 (1997); *New York v. United States*, 505 U. S. 144 (1992). We have suggested that these principles specifically apply to whether States are required to provide a certain level of benefits to individuals with disabilities. As noted in *Alexander*, in rejecting a similar theory under §504 of the Rehabilitation Act: "[N]othing ... suggests that Congress desired to make major inroads on the States' longstanding discretion to choose the proper mix of amount, scope, and duration limitations on services ... ." 469 U. S., at 307; see also *Bowen v. American Hospital Assn.*, 476 U. S. 610, 642 (1986) (plurality opinion) ("[N]othing in [§504] authorizes [the Secretary of Health and Human Services (HHS)] to commandeer state agencies ... . [These] agencies are not field offices of the HHS bureaucracy and they may not be conscripted against their will as the foot soldiers in a federal crusade"). The majority's affirmative defense will likely come as cold comfort to the States that will now be forced to defend themselves in federal court every time resources prevent the immediate placement of a qualified individual. In keeping with our traditional deference in this area, see *Alexander, supra*, the appropriate course would be to respect the States' historical role as the dominant authority responsible for providing services to individuals with disabilities.

The majority may remark that it actually does properly compare members of different groups. Indeed, the majority mentions in passing the "[d]issimilar treatment" of persons with and without disabilities. *Ante*, at 15. It does so in the context of supporting its conclusion that institutional isolation is a form of discrimination. It cites two cases as standing for the unremarkable proposition that discrimination leads to deleterious stereotyping, *ante*, at 15 (citing *Allen v. Wright*, 468 U. S. 737, 755 (1984); *Manhart*, 435 U. S., at 707, n. 13)), and an *amicus* brief which indicates that confinement diminishes certain everyday



life activities, *ante* , at 15 (citing Brief for American Psychiatric Association et al. 20-22). The majority then observes that persons without disabilities "can receive the services they need without" institutionalization and thereby avoid these twin deleterious effects. *Ante* , at 15. I do not quarrel with the two general propositions, but I fail to see how they assist in resolving the issue before the Court. Further, the majority neither specifies what services persons with disabilities might need, nor contends that persons without disabilities need the same services as those with disabilities, leading to the inference that the dissimilar treatment the majority observes results merely from the fact that different classes of persons receive different services--not from "discrimination" as traditionally defined.

Finally, it is also clear petitioners did not "discriminate" against respondents "by reason of [their] disabili[ties]," as §12132 requires. We have previously interpreted the phrase "by reason of" as requiring proximate causation. See, e.g., *Holmes v. Securities Investor Protection Corp.* , 503 U. S. 258, 265-266 (1992); see also *id.*, at 266, n. 11 (citation of cases). Such an interpretation is in keeping with the vernacular understanding of the phrase. See American Heritage Dictionary 1506 (3d ed. 1992) (defining "by reason of" as "because of"). This statute should be read as requiring proximate causation as well. Respondents do not contend that their disabilities constituted the proximate cause for their exclusion. Nor could they--community placement simply is not available to those without disabilities. Continued institutional treatment of persons who, though now deemed treatable in a community placement, must wait their turn for placement, does not establish that the denial of community placement occurred "by reason of" their disability. Rather, it establishes no more than the fact that petitioners have limited resources.

\* \* \*

For the foregoing reasons, I respectfully dissent.

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## FOOTNOTES

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### Footnote 1

The ADA, enacted in 1990, is the Federal Government's most recent and extensive endeavor to address discrimination against persons with disabilities. Earlier legislative efforts included the Rehabilitation Act of 1973, 87 Stat. 355, 29 U. S. C. §701 *et seq.* (1976 ed.), and the Developmentally Disabled Assistance and Bill of Rights Act, 89 Stat. 486, 42 U. S. C. §6001 *et seq.* (1976 ed.), enacted in 1975. In the ADA, Congress for the first time referred expressly to "segregation" of persons with disabilities as a "for[m] of discrimination," and to discrimination that persists in the area of "institutionalization." §§12101(a)(2), (3), (5).

### Footnote 2

The ADA defines "disability," "with respect to an individual," as

"(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;

"(B) a record of such an impairment; or

"(C) being regarded as having such an impairment." §12102(2).

There is no dispute that L. C. and E. W. are disabled within the meaning of the ADA.

### **Footnote 3**

In addition to the provisions set out in Part A governing public services generally, see §§12131-12134, Title II contains in Part B a host of provisions governing public transportation services, see §§12141-12165.

### **Footnote 4**

Section 505 of the Rehabilitation Act incorporates the remedies, rights, and procedures set forth in Title VI of the Civil Rights Act of 1964 for violations of §504 of the Rehabilitation Act. See 29 U. S. C. §794a(a)(2). Title VI, in turn, directs each federal department authorized to extend financial assistance to any department or agency of a State to issue rules and regulations consistent with achievement of the objectives of the statute authorizing financial assistance. See 78 Stat. 252, 42 U. S. C. §2000d-1. Compliance with such requirements may be effected by the termination or denial of federal funds, or "by any other means authorized by law." *Ibid.* Remedies both at law and in equity are available for violations of the statute. See §2000d-7(a)(2).

### **Footnote 5**

Congress directed the Secretary of Transportation to issue regulations implementing the portion of Title II concerning public transportation. See 42 U. S. C. §§12143(b), 12149, 12164. As stated in the regulations, a person alleging discrimination on the basis of disability in violation of Title II may seek to enforce its provisions by commencing a private lawsuit, or by filing a complaint with (a) a federal agency that provides funding to the public entity that is the subject of the complaint, (b) the Department of Justice for referral to an appropriate agency, or (c) one of eight federal agencies responsible for investigating complaints arising under Title II: the Department of Agriculture, the Department of Education, the Department of Health and Human Services, the Department of Housing and Urban Development, the Department of the Interior, the Department of Justice, the Department of Labor, and the Department of Transportation. See 28 CFR §§35.170(c), 35.172(b), 35.190(b) (1998).

The ADA contains several other provisions allocating regulatory and enforcement responsibility. Congress instructed the Equal Employment Opportunity Commission (EEOC) to issue regulations implementing Title I, see 42 U. S. C. §12116; the EEOC, the Attorney General, and persons alleging discrimination on the basis of disability in violation of Title I may enforce its provisions, see §12117(a). Congress similarly instructed the Secretary of Transportation and the Attorney General to issue regulations implementing provisions of Title III, see §§12186(a)(1), (b); the Attorney General and persons alleging discrimination on the basis of disability in violation of Title III may enforce its provisions, see §§12188(a)(1), (b). Each federal agency responsible for ADA implementation may render technical assistance to affected individuals and institutions with respect to provisions of the ADA for which the agency has responsibility. See §12206(c)(1).

### **Footnote 6**

L. C. and E. W. are currently receiving treatment in community-based programs. Nevertheless, the case is not moot. As the District Court and Court of Appeals explained, in view of the multiple institutional placements L. C. and E. W. have experienced, the controversy they brought to court is "capable of repetition, yet evading review." No. 1:95-cv-1210-MHS (ND Ga., Mar. 26, 1997), p. 6, App. to Pet. for Cert. 35a (internal quotation marks omitted); see 138 F. 3d 893, 895, n. 2 (CA11 1998) (citing *Honig v. Doe*, 484 U. S. 305, 318-323 (1988), and *Vitek v. Jones*, 445 U. S. 480, 486-487 (1980)).

### Footnote 7

After this Court granted certiorari, the District Court issued a decision on remand rejecting the State's fundamental-alteration defense. See 1:95-cv-1210-MHS (ND Ga., Jan. 29, 1999), p. 1. The court concluded that the annual cost to the State of providing community-based treatment to L. C. and E. W. was not unreasonable in relation to the State's overall mental health budget. See *id.*, at 5. In reaching that judgment, the District Court first declared "irrelevant" the potential impact of its decision beyond L. C. and E. W. 1:95-cv-1210-MHS (ND Ga., Oct. 20, 1998), p. 3, App. 177. The District Court's decision on remand is now pending appeal before the Eleventh Circuit.

### Footnote 8

Twenty-two States and the Territory of Guam joined a brief urging that certiorari be granted. Seven of those States filed a brief in support of petitioners on the merits.

### Footnote 9

See Brief for United States in *Halderman v. Pennhurst State School and Hospital*, Nos. 78-1490, 78-1564, 78-1602 (CA3 1978), p. 45 ("[I]nstitutionalization result[ing] in separation of mentally retarded persons for no permissible reason . . . is 'discrimination,' and a violation of Section 504 [of the Rehabilitation Act] if it is supported by federal funds."); Brief for United States in *Halderman v. Pennhurst State School and Hospital*, Nos. 78-1490, 78-1564, 78-1602 (CA3 1981), p. 27 ("Pennsylvania violates Section 504 by indiscriminately subjecting handicapped persons to [an institution] without first making an individual reasoned professional judgment as to the appropriate placement for each such person among all available alternatives."); Brief for United States as *Amicus Curiae* in *Helen L. v. DiDario*, No. 94-1243 (CA3 1994), p. 7 ("Both the Section 504 coordination regulations and the rest of the ADA make clear that the unnecessary segregation of individuals with disabilities in the provision of public services is itself a form of discrimination within the meaning of those statutes."); *id.*, at 8-16.

### Footnote 10

The dissent is driven by the notion that "this Court has never endorsed an interpretation of the term 'discrimination' that encompassed disparate treatment among members of the *same* protected class," *post*, at 1 (opinion of *Thomas, J.*), that "[o]ur decisions construing various statutory prohibitions against 'discrimination' have not wavered from this path," *post*, at 2, and that "a plaintiff cannot prove 'discrimination' by demonstrating that one member of a particular protected group has been favored over another member of that same group," *post*, at 4. The dissent is incorrect as a matter of precedent and logic. See *O'Connor v. Consolidated Coin Caterers Corp.*, 517 U. S. 308, 312 (1996) (The Age Discrimination in Employment Act of 1967 "does not ban discrimination against employees because they are aged 40 or older; it bans discrimination against employees because of their age, but limits the protected class to those who are 40 or older. The fact that one person in the protected class has lost out to another person in the protected class is thus irrelevant, so long as he has lost out *because of his age.*"); cf. *Oncale v. Sundowner Offshore Services, Inc.*, 523 U. S. 75, 76 (1998) ("[W]orkplace harassment can violate Title VII's prohibition against 'discriminat[ion] . . . because of . . . sex,' 42 U. S. C. §2000e-2(a)(1), when the harasser and the harassed employee are of the same sex."); *Jefferies v. Harris County Community Action Assn.*, 615 F. 2d 1025, 1032 (CA5 1980) ("[D]iscrimination against black females can exist even in the absence of discrimination against black men or white women.").

### Footnote 11



Unlike the ADA, §504 of the Rehabilitation Act contains no express recognition that isolation or segregation of persons with disabilities is a form of discrimination. Section 504's discrimination proscription, a single sentence attached to vocational rehabilitation legislation, has yielded divergent court interpretations. See Brief for United States as *Amicus Curiae* 23-25.

#### **Footnote 12**

The waiver program provides Medicaid reimbursement to States for the provision of community-based services to individuals who would otherwise require institutional care, upon a showing that the average annual cost of such services is not more than the annual cost of institutional services. See §1396n(c).

#### **Footnote 13**

Georgia law also expresses a preference for treatment in the most integrated setting appropriate. See Ga. Code Ann. §37-4-121 (1995) ("It is the policy of the state that the least restrictive alternative placement be secured for every client at every stage of his habilitation. It shall be the duty of the facility to assist the client in securing placement in noninstitutional community facilities and programs.").

#### **Footnote 14**

We do not in this opinion hold that the ADA imposes on the States a "standard of care" for whatever medical services they render, or that the ADA requires States to "provide a certain level of benefits to individuals with disabilities." Cf. *post*, at 9, 10 ( *Thomas, J.*, dissenting). We do hold, however, that States must adhere to the ADA's non-discrimination requirement with regard to the services they in fact provide.

#### **Footnote 15**

Even if States eventually were able to close some institutions in response to an increase in the number of community placements, the States would still incur the cost of running partially full institutions in the interim. See Brief for United States as *Amicus Curiae* 21.

#### **Footnote 16**

We reject the Court of Appeals' construction of the reasonable-modifications regulation for another reason. The Attorney General's Title II regulations, Congress ordered, "shall be consistent with" the regulations in part 41 of Title 28 of the Code of Federal Regulations implementing §504 of the Rehabilitation Act. 42 U. S. C. §12134(b). The §504 regulation upon which the reasonable-modifications regulation is based provides now, as it did at the time the ADA was enacted:

"A recipient shall make reasonable accommodation to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the recipient can demonstrate that the accommodation would impose an undue hardship on the operation of its program." 28 CFR §41.53 (1990 and 1998 eds.).

While the part 41 regulations do not define "undue hardship," other §504 regulations make clear that the "undue hardship" inquiry requires not simply an assessment of the cost of the accommodation in relation to the recipient's overall budget, but a "case-by-case analysis weighing factors that include: (1) [t]he overall size of the recipient's program with respect to number of employees, number and type of facilities,

and size of budget; (2) [t]he type of the recipient's operation, including the composition and structure of the recipient's workforce; and (3) [t]he nature and cost of the accommodation needed." 28 CFR §42.511(c) (1998); see 45 CFR §84.12(c) (1998) (same).

Under the Court of Appeals' restrictive reading, the reasonable-modifications regulation would impose a standard substantially more difficult for the State to meet than the "undue burden" standard imposed by the corresponding §504 regulation.

## FOOTNOTES

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### Footnote 1

We have incorporated Title VII standards of discrimination when interpreting statutes prohibiting other forms of discrimination. For example, Rev. Stat. §1977, as amended, 42 U. S. C. §1981, has been interpreted to forbid all racial discrimination in the making of private and public contracts. See *Saint Francis College v. Al-Khazraji*, 481 U. S. 604, 609 (1987). This Court has applied the "framework" developed in Title VII cases to claims brought under this statute. *Patterson v. McLean Credit Union*, 491 U. S. 164, 186 (1989). Also, the Age Discrimination in Employment Act of 1967, 81 Stat. 602, as amended, 29 U. S. C. §623(a)(1), prohibits discrimination on the basis of an employee's age. This Court has noted that its "interpretation of Title VII ... applies with equal force in the context of age discrimination, for the substantive provisions of the ADEA `were derived *in haec verba* from Title VII.'" *Trans World Airlines, Inc. v. Thurston*, 469 U. S. 111, 121 (1985) (quoting *Lorillard v. Pons*, 434 U. S. 575, 584 (1978)). This Court has also looked to its Title VII interpretations of discrimination in illuminating Title IX of the Education Amendments of 1972, 86 Stat. 373, as amended, 20 U. S. C. §1681 *et seq.*, which prohibits discrimination under any federally funded education program or activity. See *Franklin v. Gwinnett County Public Schools*, 503 U. S. 60, 75 (1992) (relying on *Meritor Savings Bank, FSB v. Vinson*, 477 U. S. 57 (1986), a Title VII case, in determining that sexual harassment constitutes discrimination).

### Footnote 2

This Court has recognized that two forms of discrimination are prohibited under Title VII: disparate treatment and disparate impact. See *Griggs*, 401 U. S., at 431 ("The Act proscribes not only overt discrimination but also practices that are fair in form, but discriminatory in operation"). Both forms of "discrimination" require a comparison among classes of employees.

### Footnote 3

Following *Wards Cove*, Congress enacted the Civil Rights Act of 1991, Pub. L. 102-166, 105 Stat. 1071, as amended, which, *inter alia*, altered the burden of proof with respect to a disparate impact discrimination claim. See *id.*, §105 (codified at 42 U. S. C. §2000e-2(k)). This change highlights the principle that a departure from the traditional understanding of discrimination requires congressional action. Cf. *Field v. Mans*, 516 U. S. 59, 69-70 (1995) (Congress legislates against the background rule of the common law and traditional notions of lawful conduct).

### Footnote 4

If such general hortatory language is sufficient, it is puzzling that this or any other court did not reach the same conclusion long ago by reference to the general purpose language of the Rehabilitation Act itself. See 29 U. S. C. §701 (1988 ed.) (describing the statute's purpose as "to develop and implement, through research, training, services, and the guarantee of equal opportunity, comprehensive and coordinated programs of vocational rehabilitation and independent living, for individuals with handicaps *in order to maximize their employability, independence, and integration* into the workplace and the community" (emphasis added)). Further, this section has since been amended to proclaim in even more aspirational terms that the policy under the statute is driven by, *inter alia*, "respect for individual dignity, personal responsibility, self-determination, and pursuit of meaningful careers, based on informed choice, of individuals with disabilities," "respect for the privacy, rights, and equal access," and "inclusion, integration, and full participation of the individuals." 29 U. S. C. §§701(c)(1) - (3).

#### **Footnote 5**

Given my conclusion, the Court need not review the integration regulation promulgated by the Attorney General. See 28 CFR §35.130(d) (1998). Deference to a regulation is appropriate only "if Congress has not expressed its intent with respect to the question, and then only if the administrative interpretation is reasonable." *Reno v. Bossier Parish School Bd.*, 520 U. S. 471, 483 (1997) (quoting *Presley v. Etowah County Comm'n*, 502 U. S. 491, 508 (1992)). Here, Congress has expressed its intent in §12132 and the Attorney General's regulation--insofar as it contradicts the settled meaning of the statutory term--cannot prevail against it. See *NLRB v. Town & Country Elec., Inc.*, 516 U. S. 85, 94 (1995) (explaining that courts interpreting a term within a statute "must infer, unless the statute otherwise dictates, that Congress means to incorporate the established meaning of that term") (internal quotation marks omitted).

#### **Footnote 6**

In mandating that government agencies minimize the institutional isolation of disabled individuals, the majority appears to appropriate the concept of "mainstreaming" from the Individuals with Disabilities Education Act (IDEA), 84 Stat. 175, as amended, 20 U. S. C. §1400 *et seq.* But IDEA is not an antidiscrimination law. It is a grant program that affirmatively requires States accepting federal funds to provide disabled children with a "free appropriate public education" and to establish "procedures to assure that, to the maximum extent appropriate, children with disabilities ... are educated with children who are not disabled." §§1412(1), (5). Ironically, even under this broad affirmative mandate, we previously rejected a claim that IDEA required the "standard of care" analysis adopted by the majority today. See *Board of Ed. of Hendrick Hudson Central School Dist., Westchester Cty. v. Rowley*, 458 U. S. 176, 198 (1982) ("We think ... that the requirement that a State provide specialized educational services to handicapped children generates no additional requirement that the services so provided be sufficient to maximize each child's potential commensurate with the opportunity provided other children") (internal quotation marks omitted).

## **Appendix B**

### **AMH Transformation 01 Initiative Charter**

**AMH Transformation Initiative O1-**

**Streamlining transitions through the addictions and mental health system**

<p><b>Situation/Problem Definition</b> <i>(What problems are we trying to solve with this initiative? Please create context for the initiative by referring back to the team's larger situation as described in your team charter.)</i></p>	<p>Children, adults, and older adults who receive mental health and addiction services require individualized services. There are system-wide hindrances to individualized care and appropriate transitions.</p> <ul style="list-style-type: none"><li>▪ Criteria for admission, continued stay and discharge are not agreed upon or routinely addressed during the referral and step down processes. Roles and responsibilities are not standardized across the state.</li><li>▪ No standardized means to determine what type or intensity of care a person could transition into;</li><li>▪ There is disagreement in the system about the types of treatment services that need to be developed.</li><li>▪ The Oregon system of community based, residential mental health system has much work to do in terms of integrating the transitional model. Residential treatment homes still often resemble “mini-institutions” with long lengths of stay. The current system is not research or criteria based resulting in a “bottleneck” phenomenon and the belief that more secure placements are needed.</li><li>▪ People may have to go a long distance to receive the particular service they need because not all services are provided in all area (requires integration with Initiative 02)</li><li>▪ The system of residential mental health service delivery in Oregon consists of OSH, AMH, CMHP’s, and community providers. The components are isolated from one another and lack communication or common purpose.</li><li>▪ Accountability &amp; incentives with providers are lacking, which contributes to bottlenecks in transitioning people through the system and inefficient use of resources; (requires integration with Initiative 05)</li></ul>
<p><b>Vision for Success, objectives, and metrics</b> <i>(What does success look like for this initiative? What specific benefits, tangible and intangible, will we achieve and when? Please create context by referring back to the team's vision for</i></p>	<p>The AMH vision for success means that people receive the right type and intensity of services, for the right amount of time, and that they get better. A vision of success looks like people living and healing in their communities, in the safest and least restrictive environment, with a focus on recovery and resiliency. People and their families need facilities,</p>

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<p><i>success, objectives, and metrics as described in your team charter.)</i></p>	<p>services, and programs in rural and urban areas, close to home.</p> <p>AMH can accomplish this by:</p> <ul style="list-style-type: none"> <li>▪ Clarifying roles, responsibilities, policies, &amp; procedures between AMH staff and community mental health programs;</li> <li>▪ Adopting a standardized client assessment of acuity for people receiving mental health services;</li> <li>▪ Decreasing the amount of time a person remains in services that do not match their acuity or need;</li> <li>▪ Simplifying and standardizing documentation requirements for providers;</li> <li>▪ Simplifying and standardizing a funding and payment system for providers;</li> <li>▪ Simplifying the data process to gather real-time information from providers about the quality and quantity of services they are providing;</li> <li>▪ Agreeing on how the different levels, types, and intensities of care are used. For example, are placements temporary for treatment only? Or are they intended to be a home base for people stabilized in that level of care?</li> </ul> <p>AMH will be tracking the following potential benefits:</p> <ul style="list-style-type: none"> <li>▪ Cost savings: Decrease spend in higher intensities of care than the person is assessed as needing &amp; decrease spend in vacant beds</li> <li>▪ Cycle time: Decrease the amount of time it takes to transition people who are clinically ready to move to a less intense or restrictive type of care;</li> <li>▪ Customer satisfaction;</li> <li>▪ Error rates with referrals; and</li> <li>▪ Waitlists.</li> </ul>
<p><b>Guiding Principles</b>  <i>(How will we operate as an initiative team as we achieve success?)</i></p>	<p>The teams working on this initiative will be creating and implementing more streamlined processes and standardized policies, with that in mind, they will operate with the following principles when making decisions:</p> <ul style="list-style-type: none"> <li>▪ Integrate co-occurring assessment and treatment options into the transition process through different levels of care;</li> <li>▪ Responsible and accountable parties will be identified</li> </ul>

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	<p>at the community level for the client at every transition through the different levels of care;</p> <ul style="list-style-type: none"> <li>▪ Documentation requirements will be kept to a minimum, decreasing the number of steps, and increasing the speed of the process of transitioning clients through the different types of care;</li> <li>▪ Standardized placement, continued stay and discharge criteria in all program areas;</li> <li>▪ Change regulatory framework to promote client transitions through the different levels of care;</li> <li>▪ Create a financial system to promote client transitions through the different types of care, including incentives for providers to transition clients through the different types of care; and</li> <li>▪ Track the progress of transitioning clients through the different levels of care with a core set of outcomes and use this information to make corrections mid-stream; flexibility and making changes based on what data is telling us is a must.</li> </ul>
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<p><b>Approaches to be used</b> to solve the problems and achieve success  <i>(What tools and techniques will we use on this initiative?)</i></p>	<p>This initiative involves children, adults, and older adults in multiple types of care across the continuum. There will be several projects and events planned to clarify definitions, roles, responsibilities, philosophies, policies, &amp; procedures. Using the principles listed in this charter, the teams focusing on this initiative will employ:</p> <ul style="list-style-type: none"> <li>• Base lining &amp; Benchmarking;</li> <li>• Current &amp; Future State Mapping;</li> <li>• Rapid &amp; Continual Process Improvement Principles;</li> <li>• Lean Principles;</li> <li>• Project Management; and</li> <li>▪ Metric Review &amp; benefit tracking.</li> </ul>
<p><b>Scope</b> -- organizational unit, process, function, and geographic  <i>(Which parts of our agency, which processes, which functions, and which offices will be in scope for this initiative?)</i></p>	<p>This initiative includes the various systems and processes that touch the OSH system, the community mental health program system, the mental health organization system, and the addiction services system, from prevention through acute care.</p>
<p><b>Deliverables</b>  <i>(What specific documents will we</i></p>	<p>Each event and project will have a charter, a final report, an implementation plan, and metrics to monitor. A weekly</p>

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<p><i>develop and deliver to our sponsors as we achieve success on this initiative?)</i></p>	<p>status report will track the progress of the initiative as a whole. A document describing the benefits as they are realized will also be developed.</p>
<p><b>Timing and milestones</b>  <i>(When will our work occur? What milestones must we meet for this initiative?)</i></p>	<p>By Jan 2009 Initiative leader identified          By Jan 2009 Initiative roadmap          By Jan 2009 Initiative charters          By Feb 2009 Initiative sponsor &amp; steering team identified          By Feb 2009 Initiative status &amp; progress reporting begins</p>
<p><b>Major activities</b>  <i>(What are the major activities required for this initiative? If you are planning to use Lean, please describe here the approximate number and scope of the RPI Events required. Note that you will have the opportunity prior to those events to create event charters.)</i></p>	<p>The O1 initiative roadmap will outline the timelines and sequencing for specific projects and events that will contribute to the success of the initiative. This initiative includes those processes and services that are touched by children, adults, and older adults, in the full continuum of care administered by AMH.</p> <ul style="list-style-type: none"> <li>▪ The first part of the O1 Initiative will include two projects. These projects will focus transitioning adults, including those young adults identified as in a transitional age, into community-based services from Acute care settings, long-term care (OSH and SAIP), , and high-intensity residential settings such as secure residential facilities.</li> <li>▪ The second part of the O1 Initiative includes three projects that focus on services for adults, children, and older adults. For example, these projects will look at those services that don't fit in traditional mental health provisions such as the gero-psych services located at OSH, and site development for enhanced care.</li> <li>▪ Part three will focus on Addiction services for children and adults, and case management between residential and outpatient treatment.</li> </ul> <p>Each event will be outlined in its own charter; will have an event team, which will include an event sponsor and an event lead. Several events will utilize Lean to assist with simplifying the current process.</p>
<p><b>Dependencies</b>  <i>(What major dependencies on others</i></p>	<p>This initiative affects children, adults, and older adults in Oregon who are a part of a large and complex system of</p>



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<i>does this initiative have?)</i>	services. AMH is dependent on the flexibility of the system to respond to the treatment and service needs of Oregonians.
<b>Decision making</b> <i>(How will we make decisions on this initiative?)</i>	The initiative's work team along with the Initiative Lead will strive for consensus in the decision process. Decisions reached by the work team will be sent simultaneously to lean leaders, transformation project manager, and AMH sponsor for correction and revision if needed. The Initiative Lead will log decisions.
<b>Issue resolution</b> <i>(How will we identify and resolve issues that impede progress on this initiative?)</i>	Issue resolution will follow the same path as decision making. If the initiative's work team cannot resolve issues in a reasonable period of time, the team will seek external assistance. The Initiative Lead will log issue resolutions.
<b>Risk mitigation</b> <i>(How will we identify and plan to mitigate risks we uncover on this initiative?)</i>	A risk benefit analysis will be completed on all initiatives. Risk areas will be viewed in terms of dependent, independent, and extraneous variables for each initiative
<b>Initiative Sponsor and steering body members</b> <i>(Who will guide our work, set scope, provide resources, and approve our recommendations? When choosing, consider in particular the scope of this initiative – scope may suggest specific individuals who might be natural candidates to be sponsors.)</i>	Initiative Sponsor: Len Ray Initiative Steering Body Members: Nancy Griffith: Oregon State Hospital Ralph Summers: Medicaid Unit Edie Woods: Contracts Unit
<b>Initiative leader</b> <i>(Who will drive the daily work for this initiative?)</i>	Initiative Lead: Tim Pea
<b>Initiative core team members</b> <i>(Who will be on the initiative's core working team?)</i>	Rebecca Curtis, Cissie Bollinger, Shannon Casey, Elaine Sweet, Dean Carlisle, Melanie Tong, Rick Wilcox, Chris Potter

## **Appendix C**

### **Level of Care Utilization of Services 10<sup>th</sup> edition**

# LOCUS

## LEVEL OF CARE UTILIZATION SYSTEM FOR PSYCHIATRIC AND ADDICTION SERVICES

Adult Version 2010

AMERICAN ASSOCIATION  
OF COMMUNITY PSYCHIATRISTS



March 20, 2009

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## INTRODUCTION TO ADULT VERSION 2010

With the arrival of managed care programs and principles, the use of quantifiable measures to guide assessment, level of care placement decisions, continued stay criteria, and clinical outcomes is increasingly important. In the past there have been no widely accepted standards to meet these needs. The development of LOCUS has provided a single instrument that can be used for these functions in a wide variety of settings, including both mental health and addictions. It provides a common language and set of standards with which to make such judgements and recommendations. Clinicians now have an instrument, which is simple, easy to understand and use, but also meaningful and sufficiently sensitive to distinguish appropriate needs and services. It provides clear, reliable, and consistent measures that are succinct, but sufficient to make care or quality monitoring judgments.

LOCUS has three main objectives. The first is to provide a system for assessment of service needs for adult clients, based on six evaluation parameters. The second is to describe a continuum of service arrays which vary according to the amount and scope of resources available at each “level” of care in each of four categories of service. The third is to create a methodology for quantifying the assessment of service needs to permit reliable determinations for placement in the service continuum.

This system is a dynamic one, and it has evolved over the years of its development. Since its inception, LOCUS has included content related to recovery status, stage of change, and choice. Its simple style and structure has invited use not only by a variety of clinicians with various levels of training, but by consumers themselves, allowing assessment to become a collaborative process. Engagement in this collaboration is central to person centered treatment planning. With this new revision of LOCUS, the first since 2000, language within the rating scales has been further simplified and stages of change (as conceived by Prochaska and DiClemente) have been assigned to ratings in Dimension VI, now called Engagement and Recovery Status. We strongly encourage collaboration between the clinician and the person being assessed whenever this is possible. As systems develop services and processes that facilitate recovery, these changes will allow LOCUS to be an even more powerful tool to assist these transformations.

Version 2010 makes these changes to address semantic concerns, but once again, there are no significant changes in content from Version 2000. Reliability and validity testing results will not be affected by these changes, but additional testing is planned in the future.

The instrument has multiple potential uses:

- To assess immediate service needs (e.g., for clients in crisis)
- To plan resource needs over time, as in assessing service requirements for defined populations
- To monitor changes in status or placement at different points in time.

As with previous versions, the current document is divided into three sections. The first section defines six evaluation parameters or dimensions: 1) Risk of Harm; 2) Functional Status; 3) Medical, Addictive and Psychiatric Co-Morbidity; 4) Recovery Environment; 5) Treatment and Recovery History; and 6) Engagement and Recovery Status. A five-point scale is constructed for

each dimension and the criteria for assigning a given rating or score in that dimension are elaborated. In dimension IV, two subscales are defined, while all other dimensions contain only one scale.

The second section of the document defines six “levels of care” in the service continuum in terms of four variables: 1) Care Environment, 2) Clinical Services, 3) Support Services, and 4) Crisis Resolution and Prevention Services. The term “level” is used for simplicity, but it is not our intention to imply that the service arrays are static or linear. Rather, each level describes a flexible or variable combination of specific service types and might more accurately be said to describe levels of resource intensity. The particulars of program development are left to providers to determine based on local circumstances and outcome evaluations. Each level encompasses a multidimensional array of service intensities, combining crisis, supportive, clinical, and environmental interventions, which may vary independently. Patient placement criteria are then elaborated for each level of care. Separate admission, continuing stay, and discharge criteria are not needed in this system, as changes in level of care will follow from changes in ratings in any of the six parameters over the course of time.

The final section describes a proposed scoring methodology that facilitates the translation of assessment results into placement or level of care determinations. Both a grid chart and a decision flow chart are provided for this purpose.

We hope that this version of LOCUS will continue to stimulate considerable comment, discussion, and testing as reliability and validity studies continue. It is recognized that a document of this type must be dynamic and that adjustments or addendums may be required either to accommodate local needs or to address unanticipated or unrecognized circumstances or deficiencies. The specific needs of special populations, such as children, adolescents, and the elderly will not be adequately addressed in this adult version. It does not claim to replace clinical judgment, and is meant to serve only as an operationalized guide to resource utilization that must be applied in conjunction with sound clinical thinking. It is offered as an instrument that should have considerable utility in its present form, but growth and improvement should be realized with time and further testing. The AACP welcomes any comments or suggestions. Please send your comments to:

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## Acknowledgments

This document was prepared by the American Association of Community Psychiatrists' Health Care Systems Committee Task Force on Level of Care Determinations. It was developed in cooperation with St. Francis Medical Center of Pittsburgh and the suggestions from multiple reviewers across the country. We would also like to acknowledge the intellectual stimulation provided by the review of multiple documents previously developed to address similar issues. Of particular influence in the conceptualization of LOCUS were the Patient Placement Criteria-1 of the American Society of Addiction Medicine (ASAM-PPC), the Level of Care Assessment Tool of US Healthcare (LOCAT), and the Level of Need-Care Assessment (LONCA) Method.

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## Level of Care Utilization System for Psychiatric and Addiction Services

### Instructions for Use

Each evaluation parameter is defined along a scale of one to five. Each score in the scale is defined by one or more criteria, which are designated by separate letters. Only one of these criteria need be met for a score to be assigned to the subject. The evaluator should select the highest score or rating in which at least one of the criteria is met.

There will, on occasion, be instances where there will be some ambiguity about whether a subject has met criteria for a score on the scale within one of the parameters. This may be due to inadequate information, conflicting information, or simply to difficulty in making a judgment about whether the available information is consistent with any of the criteria for that score. Clinical experience must be applied judiciously in making determinations in this regard, and the rating or criterion that provides the closest approximation to the actual circumstance should be selected. However, there will be instances when it will remain difficult to make this determination. In these cases the highest score in which it is more likely than not that least one criterion has been met should generally be assigned. The result will be that any errors will be made on the side of caution.

Since LOCUS is designed as a dynamic instrument, scores should be expected to change over time. Scores are generally assigned on a here and now basis, representing the clinical picture at the time of evaluation. In some of the parameters, historical information is taken into account, but it should not be considered unless it is a clear part of the defined criteria. In certain crisis situations, the score may change rapidly as interventions are implemented. In other situations, where a subject may be living under very stable circumstances, scores may not change for extended periods of time. Clinical judgment should prevail in the determination of how frequently scores should be reassessed. As a general rule, they will be reassessed more frequently at higher levels of acuity and at the higher levels of care or resource intensity.

Once scores have been assigned in all six evaluation parameters, they should be recorded on a worksheet and summed to obtain the composite score. Referring to the LOCUS Placement Grid, a rough estimate of the placement recommendation can be obtained. For greatest accuracy, the LOCUS Level of Care Decision Tree should be employed and it is recommended that it be used in most cases.

In assigning levels of care, there will be some systems that do not have comprehensive services for all populations at every level of the continuum. When this is the case, the level of care recommended by LOCUS may not be available and a choice will need to be made as to whether more intensive services or less intensive services should be provided. In most cases, the higher level of care should be selected, unless there is a clear and compelling rationale to do otherwise. This will again, lead us to err on the side of caution and safety rather than risk and instability.

## LOCUS Instrument Version 2010

### Evaluation Parameters for Assessment of Service Needs

#### Definitions

##### I. Risk of Harm

This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to adequately care for oneself, or from altered states of consciousness due to use of intoxicating substances in an uncontrolled manner. For the purposes of evaluation in this parameter, deficits in ability to care for oneself are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as; past history of dangerous behaviors, inability to contract for safety (while contracting for safety does not guarantee it, the inability to do so increases concern), and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past. Risk of harm may be rated according to the following criteria:

##### 1 - Minimal Risk of Harm

- a- No indication of suicidal or homicidal thoughts or impulses, and no history of suicidal or homicidal ideation, and no indication of significant distress.
- b- Clear ability to care for self now and in the past.

##### 2 - Low Risk of Harm

- a- No current suicidal or homicidal ideation, plan, intentions or severe distress, but may have had transient or passive thoughts recently or in the past.
- b- Occasional substance use without significant episodes of potentially harmful behaviors.
- c- Periods in the past of self-neglect without current evidence of such behavior.

##### 3 - Moderate Risk of Harm

- a- Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
- b- No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
- c- History of chronic impulsive suicidal/homicidal behavior or threats, but current expressions do not represent significant change from usual behavior.
- d- Binge or excessive use of substances resulted in potentially harmful behaviors in the past, but there have been no recent episodes.
- e- Some evidence of self-neglect and/or decrease in ability to care for oneself in current environment.

#### **4 - Serious Risk of Harm**

- a- Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
- b- History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from usual behavior.
- c- Recent pattern of excessive substance use resulting in loss of self-control and clearly harmful behaviors with no demonstrated ability to abstain from use.
- d- Clear compromise of ability to care adequately for oneself or to be adequately aware of environment.

#### **5 - Extreme Risk of Harm**

- a- Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior...
  - without expressed ambivalence or significant barriers to doing so, or
  - with a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or
  - in presence of command hallucinations or delusions which threaten to override usual impulse control.
- b- Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
- c- Extreme compromise of ability to care for oneself or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits.

## **II. Functional Status**

This dimension of the assessment measures the degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care. This ability should be compared against an ideal level of functioning given an individual's limitations, or may be compared to a baseline functional level as determined for an adequate period of time prior to onset of this episode of illness. Persons with ongoing, longstanding deficits who do not experience any acute changes in their status are the only exception to this rule and are given a rating of three. If such deficits are severe enough that they place the client at risk of harm, they will be considered when rating Dimension I in accord with the criteria elaborated there. For the purpose of this document, sources of impairment should be limited to those directly related to psychiatric and/or addiction problems that the individual may be experiencing. While other types of disabilities may play a role in determining what types of support services may be required, they should generally not be considered in determining the placement of a given individual in the behavioral treatment continuum.

### **1 - Minimal Impairment**

- a- No more than transient impairment in functioning following exposure to an identifiable stressor.

### **2 - Mild Impairment**

- a- Experiencing some problems in interpersonal interactions, with increased irritability, hostility or conflict, but is able to maintain some meaningful and satisfying relationships.
- b- Recent experience of some minor disruptions in aspects of self-care or usual activities.
- c- Developing minor but consistent difficulties in social role functioning and meeting obligations such as difficulty fulfilling parental responsibilities or performing at expected level in work or school, but maintaining ability to continue in those roles.
- d- Demonstrating significant improvement in function following a period of difficulty.

### **3 - Moderate Impairment**

- a- Recently conflicted, withdrawn, alienated or otherwise troubled in most significant relationships, but maintains control of any impulsive, aggressive or abusive behaviors.
- b- Appearance and hygiene falls below usual standards on a frequent basis.
- c- Significant disturbances in physical functioning such as sleep, eating habits, activity level, or sexual appetite, but without a serious threat to health.
- d- Significant deterioration in ability to fulfill responsibilities and obligations to job, school, self, or significant others and these may be avoided or neglected on some occasions.
- e- Ongoing and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities.
- f- Recent gains and/or stabilization in function have been achieved while participating in treatment in a structured and/or protected setting.

### **4 - Serious Impairment**

- a- Serious decrease in the quality of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive, aggressive or abusive behaviors.
- b- Significant withdrawal and avoidance of almost all social interaction.
- c- Consistent failure to maintain personal hygiene, appearance, and self-care near usual standards.
- d- Serious disturbances in physical functioning such as weight change, disrupted sleep, or fatigue that threaten physical well being.
- e- Inability to perform close to usual standards in school, work, parenting, or other obligations and these responsibilities may be completely neglected on a frequent basis or for an extended period of time.

## **5 - Severe Impairment**

- a- Extreme deterioration in social interactions which may include chaotic communication, threatening behaviors with little or no provocation, or minimal control of impulsive, aggressive or otherwise abusive behavior.
- b- Development of complete withdrawal from all social interactions.
- c- Complete neglect of personal hygiene and appearance and inability to attend to most basic needs such as food intake and personal safety with associated impairment in physical status.
- d- Extreme disruptions in physical functioning causing serious harm to health and well being.
- e- Complete inability to maintain any aspect of personal responsibility as a citizen, or in occupational, educational, or parental roles.

## **III. Medical, Addictive, and Psychiatric Co-Morbidity**

This dimension measures potential complications in the course of illness related to co-existing medical illness, substance use disorder, or psychiatric disorder in addition to the condition first identified or most readily apparent (here referred to as the presenting disorder). Co-existing disorders may prolong the course of illness in some cases, or may necessitate availability of more intensive or more closely monitored services in other cases. Unless otherwise indicated, historical existence of potentially interacting disorders should not be considered in this parameter unless current circumstances would make reactivation of those disorders likely. For patients who present with substance use disorders, physiologic withdrawal states should be considered to be medical co-morbidity for scoring purposes.

### **1 - No Co-morbidity**

- a- No evidence of medical illness, substance use disorders, or psychiatric disturbances apart from the presenting disorder.
- b- Any illnesses that may have occurred in the past are now stable and pose no threat to the stability of the current condition.

### **2 - Minor Co-morbidity**

- a- Existence of medical problems which are not themselves immediately threatening or debilitating and which have no impact on the course of the presenting disorder.
- b- Occasional episodes of substance misuse, but any recent episodes are self-limited, show no pattern of escalation, and there is no indication that they adversely affect the course of a co-existing psychiatric disorder.
- c- May occasionally experience psychiatric symptoms which are related to stress, medical illness, or substance use, but these are transient and have no detectable impact on a co-existing substance use disorder.

### **3 - Significant Co-morbidity**

- a- Medical conditions exist, or have potential to develop (such as diabetes or a mild physiologic withdrawal syndrome), which may require significant medical monitoring.
- b- Medical conditions exist which may be created or adversely affected by the existence of the presenting disorder.
- c- Medical conditions exist which may adversely affect the course of the presenting disorder.
- d- Ongoing or episodic substance use occurring despite negative consequences with significant or potentially significant negative impact on the course of any co-existing psychiatric disorder.
- e- Recent substance use which has had clearly detrimental effects on the presenting disorder but which has been temporarily arrested through use of a highly structured or protected setting or through other external means.
- f- Significant psychiatric symptoms and signs are present which are themselves somewhat debilitating, and which interact with and have an adverse affect on the course and severity of any co-existing substance use disorder.

### **4 - Major Co-morbidity**

- a- Medical conditions exist, or have a very high likelihood of developing (such as a moderate, but uncomplicated, alcohol, sedative, or opiate withdrawal syndrome, mild pneumonia, or uncontrolled hypertension), which may require intensive, although not constant, medical monitoring.
- b- Medical conditions exist which are clearly made worse by the existence of the presenting disorder.
- c- Medical conditions exist which clearly worsen the course and outcome of the presenting disorder.
- d- Uncontrolled substance use occurs at a level, which poses a serious threat to health if unchanged, and/or which poses a serious barrier to recovery from any co-existing psychiatric disorder.
- e- Psychiatric symptoms exist which are clearly disabling and which interact with and seriously impair ability to recover from any co-existing substance use disorder.

### **5 - Severe Co-morbidity**

- a- Significant medical conditions exist which may be poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe or complicated alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).
- b- Presence and lack of control of presenting disorder places client in imminent danger from complications of existing medical problems.

- c- Uncontrolled medical condition severely worsens the presenting disorder, dramatically prolonging the course of illness and seriously impeding the ability to recover from it.
- d- Severe substance dependence with inability to control use under any circumstance and which may include intense withdrawal symptoms or continuing use despite clear worsening of any co-existing psychiatric disorder and other aspects of well being.
- e- Acute or severe psychiatric symptoms are present which seriously impair client's ability to function and prevent recovery from any co-existing substance use disorder, or seriously worsen it.

#### **IV. Recovery Environment**

This dimension considers factors in the environment that may contribute to the onset or maintenance of addiction or mental illness, and factors that may support a person's efforts to achieve or maintain mental health and/or abstinence. Stressful circumstances may originate from multiple sources and include interpersonal conflict or torment, life transitions, losses, worries relating to health and safety, and ability to maintain role responsibilities. Supportive elements in the environment are resources which enable persons to maintain health and role functioning in the face of stressful circumstances, such as availability of adequate material resources and relationships with family members. The availability of friends, employers or teachers, clergy and professionals, and other community members that provide caring attention and emotional comfort, are also sources of support. For persons being treated in locked or otherwise protected residential settings, ratings should be based on the conditions that would be encountered upon transitioning to a new or returning to the usual environment, whichever is most appropriate to the circumstances.

##### **A) Level of Stress**

###### **1 - Low Stress Environment**

- a- Essentially no significant or enduring difficulties in interpersonal interactions and significant life circumstances are stable.
- b- No recent transitions of consequence.
- c- No major losses of interpersonal relationships or material status have been experienced recently.
- d- Material needs are met without significant cause for concern that they may diminish in the near future, and no significant threats to health or safety are apparent.
- e- Living environment poses no significant threats or risk.
- f- No pressure to perform beyond capacity in social role.

## **2 - Mildly Stressful Environment**

- a- Presence of some ongoing or intermittent interpersonal conflict, alienation, or other difficulties.
- b- A transition that requires adjustment such as change in household members or a new job or school.
- c- Circumstances causing some distress such as a close friend leaving town, conflict in or near current residence, or concern about maintaining material well being.
- d- A recent onset of a transient but temporarily disabling illness or injury.
- e- Potential for exposure to alcohol and/or drug use exists. \*
- f- Performance pressure (perceived or actual) in school or employment situations creating discomfort.

## **3 - Moderately Stressful Environment**

- a- Significant discord or difficulties in family or other important relationships or alienation from social interaction.
- b- Significant transition causing disruption in life circumstances such as job loss, legal difficulties or change of residence.
- c- Recent important loss or deterioration of interpersonal or material circumstances.
- d- Concern related to sustained decline in health status.
- e- Danger in or near habitat.
- f- Easy exposure and access to alcohol and drug use. \*
- g- Perception that pressure to perform surpasses ability to meet obligations in a timely or adequate manner.

## **4 - Highly Stressful Environment**

- a- Serious disruption of family or social milieu which may be due to illness, death, divorce or separation of parent and child, severe conflict, torment and/or physical or sexual mistreatment.
- b- Severe disruption in life circumstances such as going to jail, losing housing, or living in an unfamiliar, unfriendly culture.
- c- Inability to meet needs for physical and/or material well being.
- d- Recent onset of severely disabling or life threatening illness.
- e- Difficulty avoiding exposure to active users and other pressures to partake in alcohol or drug use. \*
- f- Episodes of victimization or direct threats of violence near current home.
- g- Overwhelming demands to meet immediate obligations are perceived.



## **5 - Extremely Stressful Environment**

- a- An acutely traumatic level of stress or enduring and highly disturbing circumstances disrupting ability to cope with even minimal demands in social spheres such as:
  - ongoing injurious and abusive behaviors from family member(s) or significant other.
  - witnessing or being victim of extremely violent incidents brought about by human malice or natural disaster.
  - persecution by a dominant social group.
  - sudden or unexpected death of loved one.
- b- Unavoidable exposure to drug use and active encouragement to participate in use. \*
- c- Incarceration or lack of adequate shelter.
- d- Severe pain and/or imminent threat of loss of life due to illness or injury.
- e- Sustained inability to meet basic needs for physical and material well being.
- f- Chaotic and constantly threatening environment.

\* These criteria apply to persons with past or present difficulties with substance use.

## **B) Level of Support**

### **1 - Highly Supportive Environment**

- a- Plentiful sources of support with ample time and interest to provide for both material and emotional needs in most circumstances.
- b- Effective involvement of Assertive Community Treatment Team (ACT) or other similarly highly supportive resources.  
*(Selection of this criterion pre-empts higher ratings)*

### **2 - Supportive Environment**

- a- Supportive resources are not abundant, but are capable of and willing to provide significant aid in times of need.
- b- Some elements of the support system are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.
- c- Professional supports are available and effectively engaged (i.e. ICM).  
*(Selection of this criterion pre-empts higher ratings)*

### **3 - Limited Support in Environment**

- a- A few supportive resources exist in current environment and may be capable of providing some help if needed.
- b- Usual sources of support may be somewhat ambivalent, alienated, difficult to access, or have a limited amount of resources they are willing or able to offer when needed.
- c- Persons who have potential to provide support have incomplete ability to participate in treatment and make necessary changes.
- d- Resources may be only partially utilized even when available.
- e- Limited constructive involvement with any professional sources of support that are available.

#### **4 - Minimal Support in Environment**

- a- Very few actual or potential sources of support are available.
- b- Usual supportive resources display little motivation or willingness to offer assistance, or they are themselves troubled or hostile toward client.
- c- Existing supports are unable to provide sufficient resources to meet material or emotional needs.
- d- Client may be on bad terms with and unwilling to use supports available in a constructive manner.

#### **5 - No Support in Environment**

- a- No sources for assistance are available in environment either emotionally or materially.

### **V. Treatment and Recovery History**

This dimension of the assessment recognizes that a person's past experience provides some indication of how that person is likely to respond to similar circumstances in the future. While it is not possible to codify or predict how an individual person may respond to any given situation, this scale uses past trends in responsiveness to treatment exposure and past experience in managing recovery as its primary indicators. Although the recovery process is a complex concept, for the purposes of rating in this parameter, recovery is defined as a period of stability with good control of symptoms. While it is important to recognize that some clients will respond well to some treatment situations and poorly to others, and that this may in some cases be unrelated to level of intensity, but rather to the characteristics and attractiveness of the treatment provided, the usefulness of past experience as one predictor of future response to treatment must be taken into account in determining service needs. Most recent experiences in treatment and recovery should take precedence over more remote experiences in determining the proper rating.

#### **1 - Fully Responsive to Treatment and Recovery Management**

- a- There has been no prior experience with treatment or recovery.
- b- Prior experience indicates that efforts in all treatments that have been attempted have been helpful in controlling the presenting problem.
- c- There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.

#### **2 - Significant Response to Treatment and Recovery Management**

- a- Previous or current experience in treatment has been successful in controlling most symptoms but intensive or repeated exposures may have been required.
- b- Recovery has been managed for moderate periods of time with limited support or structure.

### **3 - Moderate or Equivocal Response to Treatment and Recovery Management**

- a- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms.
- b- Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved.
- c- Unclear response to treatment and ability to maintain a significant recovery.
- d- At least partial recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.

### **4 - Poor Response to Treatment and Recovery Management**

- a- Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure.
- b- Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings.

### **5 - Negligible Response to Treatment**

- a- Past or current response to treatment has been quite minimal, even with intensive medically managed exposure in highly structured settings for extended periods of time.
- b- Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure.

## **VI. Engagement and Recovery Status**

This dimension of the assessment considers a person's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process. Factors such as acceptance of illness, stage in the change process, ability to trust others and accept assistance, interaction with treatment opportunities, and ability to take responsibility for recovery should be considered in defining the measures for this dimension. These factors will likewise impact a person's ability to be successful at a given level of care.

### **1 - Optimal Engagement and Recovery**

- a- Has complete understanding and acceptance of illness and its effect on function.
- b- Actively maintains changes made in the past (Maintenance Stage).
- c- Is enthusiastic about recovery, is trusting, and shows strong ability to utilize available resources and treatment.
- d- Understands recovery process and takes on a personal role and responsibility in a recovery plan.

## **2 - Positive Engagement and Recovery**

- a- Has significant understanding and acceptance of illness and its effect on function.
- b- Willing to change and is actively working toward it (Action Stage).
- c- Positive attitude toward recovery and treatment, capable of developing trusting relationships, and uses available resources independently when necessary.
- d- Shows recognition of personal role in recovery and accepts significant responsibility for it.

## **3 - Limited Engagement and Recovery**

- a- Has some variability, hesitation or uncertainty in acceptance or understanding of illness and disability.
- b- Has limited desire or lacks confidence to change despite intentions to do so (Preparation Stage).
- c- Relates to treatment with some difficulty and establishes few, if any, trusting relationships.
- d- Does not use available resources independently or only in cases of extreme need.
- e- Has limited ability to accept responsibility for recovery.

## **4 - Minimal Engagement and Recovery**

- a- Rarely, if ever, is able to accept reality of illness or any disability that accompanies it, but may acknowledge some difficulties in living.
- b- Has no desire or is afraid to adjust behavior, but may recognize the need to do so (Contemplation Stage).
- c- Relates poorly to treatment and treatment providers and ability to trust is extremely narrow.
- d- Avoids contact with and use of treatment resources if left to own devices.
- e- Does not accept any responsibility for recovery or feels powerless to do so.

## **5 – Unengaged and Stuck**

- a- Has no awareness or understanding of illness and disability (Pre-contemplation Stage).
- b- Inability to understand recovery concept or contributions of personal behavior to disease process.
- c- Unable to actively engage in recovery or treatment and has no current capacity to relate to another or develop trust.
- d- Extremely avoidant, frightened, or guarded.

## LEVELS OF CARE

### Definitions

#### **BASIC SERVICES - Prevention and Health Maintenance**

##### **Definition:**

Basic services are designed to prevent the onset of illness or to limit the magnitude of morbidity associated with already established disease processes. These services may be developed for individual or community application, and are generally carried out in a variety of community settings. These services will be available to all members of the community with special focus on children.

- 1. Care Environment** - An easily accessible office and communications equipment. Adequate space for any services provided on-site must be available. Central offices are likely to be most conveniently located in or near a community health center. Most services will be provided in the community, however, in schools, places of employment, community centers, libraries, churches, etc., and transportation capabilities must be available.
- 2. Clinical Services** - Twenty-four hour physician and nursing capabilities will be provided for emergency evaluation, brief intervention, and outreach services.
- 3. Support Services** - As needed for crisis stabilization, having the capability to mobilize community resources and facilitate linkage to more intense levels of care if needed.
- 4. Crisis Stabilization and Prevention Services** - In addition to crisis services already described, prevention programs would be available and promoted for all covered members. These programs would include: 1) Community outreach to special populations such as the homeless, elderly, children, pregnant woman, disrupted or violent families and criminal offenders; 2) Debriefing for victims of trauma or disaster; 3) Frequent opportunities to screen for high risk members in the community; 4) Health maintenance education (e.g., coping skills, stress management, recreation); 5) Violence prevention education and community organization; 6) Consultation to primary care providers and community groups; 7) Facilitation of mutual support networks and empowerment programs; 8) Environmental evaluation programs identifying mental health toxins; and 9) Support of day care and child enrichment programs.

##### **Placement Criteria:**

These Basic Services should be available to all members of the community regardless of their status in the dimensional rating scale.

## I. LEVEL ONE - Recovery Maintenance and Health Management

### Definition:

This level of care provides treatment to clients who are living either independently or with minimal support in the community, and who have achieved significant recovery from past episodes of illness. Treatment and service needs do not require supervision or frequent contact. Recovery Maintenance programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress can not be restricted. In some cases, services may be provided in community locations or in the place of residence.
2. **Clinical Services** - Treatment programming will be available up to two hours per month, and usually not less than one hour every three months. Psychiatric or physician review and/or contact should take place about once every three to four months. Medication use can be monitored and managed in this setting. Capabilities to provide individual or group supportive therapy should be available in at this level.
3. **Supportive Services** - Assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Facilitation in linkage with mutual support networks, individual advocacy groups, and with educational or vocational programming will also be available according to client needs.
4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all Basic Services (see page 17) will be accessible.

### Placement Criteria:

1. **Risk of Harm** - clients with a rating of two or less may step down to this level of care.
2. **Functional Status** - clients should demonstrate ability to maintain a rating of two or less to be eligible for this level of care.
3. **Co-morbidity** - a rating of two or less is generally required for this level of care.
4. **Recovery Environment** - a combined rating of no more than four on Scale "A" and "B" should be required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two or less should be required for treatment at this level.
6. **Engagement and Recovery Status** - a rating of two or less should be obtained in this dimension for placement at this level of care.
7. **Composite Rating** - placement at this level of care implies that the client has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past. A composite rating of more than 10 but less than 14 should generally be obtained for eligibility for this service.

## II. LEVEL TWO - Low Intensity Community Based Services

### Definition:

This level of care provides treatment to clients who need ongoing treatment, but who are living either independently or with minimal support in the community. Treatment and service needs do not require intense supervision or very frequent contact. Programs of this type have traditionally been clinic-based programs. These programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but the way out cannot be restricted. In some cases services may be provided in community locations or in the place of residence.
2. **Clinical Services** - Treatment programming will be available up to three hours per week, but usually not less than one hour every two weeks. Psychiatric or physician review and/or contact should be available according to need as indicated by initial and ongoing assessment. Medication use can be monitored and managed in this setting. Capabilities to provide individual, group, and family therapies should be available in these settings.
3. **Supportive Services** - Case management services will generally not be required at this level of care, but assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Liaison with mutual support networks and individual advocacy groups, and coordination with educational or vocational programming will also be available according to client needs.
4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all other Basic Services (see page 17) will be accessible.

### Placement Criteria:

1. **Risk of Harm** - a rating of two or less would be most appropriate for this level of care. In some cases, a rating of three could be accommodated if the composite rating falls within guidelines.
2. **Functional Status** - ratings of three or less could be managed at this level.
3. **Co-Morbidity** - a rating of two or less is required for placement at this level.
4. **Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the "A" and "B" scales is required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three could be attempted at this level if stepping down from a more intensive level of care and a rating of two or less is obtained on scale "B" of dimension four.

6. **Engagement and Recovery Status** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three may be placed at this level if unwilling to participate in treatment at a more intensive level.
7. **Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 14 but no more than 16 is required for treatment at this level.

### III. LEVEL THREE - High Intensity Community Based Services

#### Definition:

This level of care provides treatment to clients who need intensive support and treatment, but who are living either independently or with minimal support in the community. Service needs do not require daily supervision, but treatment needs require contact several times per week. Programs of this type have traditionally been clinic based programs. These programs must provide the following:

1. **Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress can not be restricted. These services may be provided in community locations in some cases, including the place of residence.
2. **Clinical Services** - Treatment programming (including group, individual and family therapy) will be available about three days per week and about two or three hours per day. Psychiatric/medical staffing should be adequate to provide review and/or contact as needed according to initial and ongoing assessment. On call psychiatric/medical services will generally not be available on a 24-hour basis. Skilled nursing care is usually not required at this level of care, and medication use can be monitored but not administered. Capabilities to provide individual, group, family and rehabilitative therapies should be available in these settings.
3. **Supportive Services** - Case management or outreach services should be available and integrated with treatment teams. Assistance with providing or arranging financial support, supportive housing, systems management and transportation should be available. Liaison with mutual support networks and individual advocacy groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.
4. **Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. All other Basic Services (see page 17) will also be available.



## Placement Criteria:

1. **Risk of Harm** - a rating of three or less can be managed at this level.
2. **Functional Status** - a rating of three or less is required for this level of care.
3. **Co-Morbidity** - a rating of three or less can be managed at this level of care.
4. **Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the “A” and “B” scales is required for treatment at this level.
5. **Treatment and Recovery History** - a rating of two is most appropriate for management at this level of care, but in many cases a rating of three can be accommodated.
6. **Engagement and Recovery Status** - a rating of three or less is required for this level of care.
7. **Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 17 and no more than 19 is required for treatment at this level.

## IV. LEVEL FOUR - Medically Monitored Non-Residential Services

This level of care refers to services provided to clients capable of living in the community either in supportive or independent settings, but whose treatment needs require intensive management by a multi disciplinary treatment team. Services, which would be included in this level of care, have traditionally been described as partial hospital programs and as assertive community treatment programs.

1. **Care Environment** - Services may be provided within the confines of a clinic setting providing adequate space for provision of services available at this level, or they may in some cases be provided by wrapping services around the client in the community (i.e. ACT team).
2. **Clinical Services** - Clinical services should be available to clients throughout most of the day on a daily basis. Psychiatric services would be accessible on a daily basis and contact would occur as required by initial and ongoing assessment. Psychiatric services would also be available by remote communication on a 24-hour basis. Nursing services should be available about 40 hours per week. Physical assessment should be provided on-site if possible and access to ongoing primary medical care should be available. Intensive treatment should be provided at least five days per week and include individual, group, and family therapy depending on client needs. Rehabilitative services will be an integral aspect of the treatment program. Medication can be carefully monitored, but in most cases will be self-administered.
3. **Supportive Services** - Case management services will be integrated with on site treatment teams or mobile treatment teams and will provide assistance with providing or arranging financial support, supportive housing, systems management, transportation and ADL maintenance. Liaison with mutual support networks and individual groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.

- 4. Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, as will other Basic Services.

#### **Placement Criteria:**

- 1. Risk of Harm** - a rating of three or less is required for placement at this level independent of other variables, and a rating higher than three should not be managed at this level.
- 2. Functional Status** - a rating of three is most appropriate for this level of care independent of other variables. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “A” and “B” in dimension four. (Availability of Assertive Community Treatment (ACT) would be equivalent to a rating of one on scale “B”. An “A” scale rating of two could generally be managed in conjunction with ACT).
- 3. Co-Morbidity** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “A” and “B” in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale “B”. An “A” scale rating of two could generally be managed in that circumstance).
- 4. Recovery Environment** - an “A” scale rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “B”. (Availability of Assertive Community Treatment would merit a rating of one on scale “B”). A “B” scale rating of three or less could otherwise generally be managed at this level.
- 5. Treatment and Recovery History** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “A” and “B” in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale “B”. An “A” scale rating of two could generally be managed in conjunction with ACT).
- 6. Engagement and Recovery Status** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale “A” and “B” in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale “B”. An “A” scale rating of two could generally be managed in conjunction with ACT).
- 7. Composite Rating** - in many cases, utilization of this level of care will be determined by the interaction of a variety of factors. A composite rating of 20 requires treatment at this level with or without ACT resources available. (The presence of ACT reduces scores on dimension four enabling these criteria to be met even when scores of four are obtained in other dimensions.)

## V. LEVEL FIVE - Medically Monitored Residential Services

### Definition:

This level of care refers to residential treatment provided in a community setting. This level of care has traditionally been provided in non-hospital, free standing residential facilities based in the community. In some cases, longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included at this level. Level five services must be capable of providing the following:

- 1. Care Environment** - Facilities will provide adequate living space for all residents and be capable of providing reasonable protection of personal safety and property. Physical barriers preventing egress or access to the community may be used at this level of care but facilities of this type will generally not allow the use of seclusion or restraint. Food services must be available or adequate provisions for residents to purchase and prepare their food must be made.
- 2. Clinical Capabilities** - Access to clinical care must be available at all times. Psychiatric care should be available either on site or by remote communication 24 hours daily and psychiatric consultation should be available on site at least weekly, but client contact may be required as often as daily. Emergency medical care services should be easily and rapidly accessible. On site nursing care should be available about 40 hours per week if medications are being administered on a frequent basis. On site treatment should be available seven days a week including individual, group and family therapy. In addition, rehabilitation and educational services must be available either on or off site. Medication is monitored, but does not necessarily need to be administered to residents in this setting.
- 3. Supportive Services** - Residents will be provided with supervision of activities of daily living, and custodial care may be provided to designated populations at this level. Staff will facilitate recreational and social activities and coordinate interface with educational and rehabilitative programming provided off site.
- 4. Crisis Resolution and Prevention** - Residential treatment programs must provide services facilitating return to community functioning in a less restrictive setting. These services will include coordination with community case managers, family and community resource mobilization, liaison with community based mutual support networks, and development of transition plan to supportive environment.

### Placement Criteria:

- 1. Risk of Harm** - a rating of four requires care at this level independently of other parameters.
- 2. Functional Status** - a rating of four requires care at this level independently of other dimensional ratings, with the exception of some clients who are rated at one on dimension four on both scale "A" and "B" (see level three criteria).
- 3. Co-Morbidity** - a rating of four requires care at this level independently of other parameters, with the exception of some clients who are rated at one on dimension four on both scale "A" and "B" (see level three criteria).
- 4. Recovery Environment** - a rating of four or higher on the "A" and "B" scale and in conjunction with a rating of at least three on one of the first three dimensions requires care at this level.

5. **Treatment and Recovery History** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.
6. **Engagement and Recovery Status** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.
7. **Composite Rating** - while a client may not meet any of the above independent ratings, in some circumstances, a combination of factors may require treatment in a more structured setting. This would generally be the case for clients who have a composite rating of 24 or higher.

## VI. LEVEL SIX - Medically Managed Residential Services

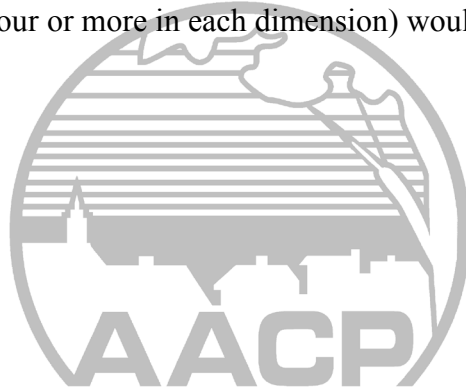
### Definition:

This is the most intense level of care in the continuum. Level six services have traditionally been provided in hospital settings, but could, in some cases, be provided in freestanding non-hospital settings. Whatever the case may be, such settings must be able to provide the following:

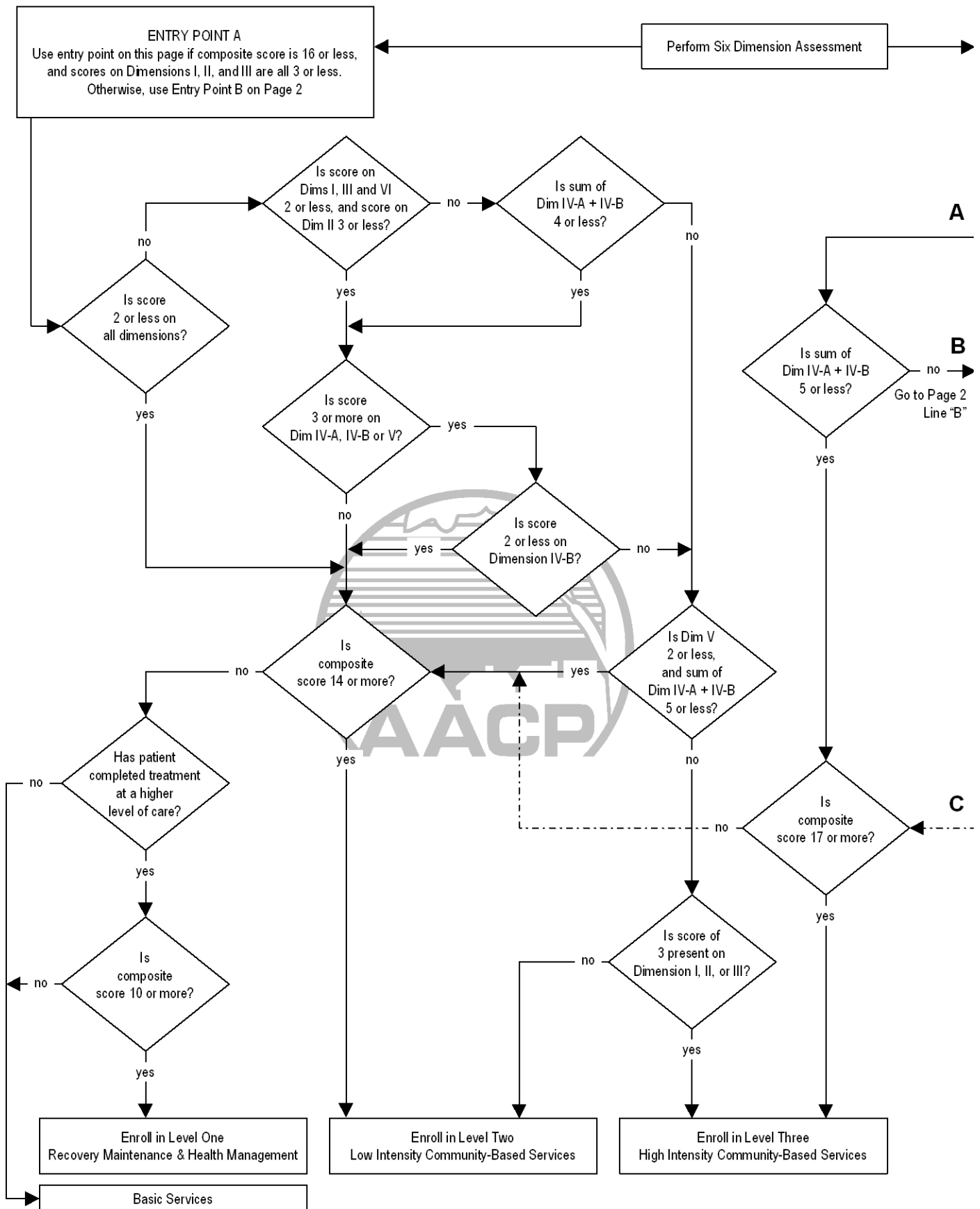
1. **Care Environment** - The facility must be capable of providing secure care, usually meaning that clients should be contained within a locked environment (this may not be necessary for services such as detoxification, however) with capabilities for providing seclusion and/or restraint if necessary. It should be capable of providing involuntary care when called upon to do so. Facilities must provide adequate space, light, ventilation, and privacy. Food services and other personal care needs must be adequately provided.
2. **Clinical Services** - Clinical services must be available 24 hours a day, seven days a week. Psychiatric, nursing, and medical services must be available on site, or in close enough proximity to provide a rapid response, at all times. Psychiatric/medical contact will generally be made on a daily basis. Treatment will be provided on a daily basis and would include individual, group and family therapy as well as pharmacologic treatment, depending on the client's needs.
3. **Supportive Services** - All necessities of living and well being must be provided for clients treated in these settings. When capable, clients will be encouraged to participate in and be supported in efforts to carry out activities of daily living such as hygiene, grooming and maintenance of their immediate environment.
4. **Crisis Resolution and Prevention Services** – These residential settings must provide services designed to reduce the stress related to resuming normal activities in the community. Such services might include coordination with community case managers, family and community resource mobilization, environmental evaluation and coordination with residential services, and coordination with and transfer to less intense levels of care.

## Placement Criteria:

1. **Risk of Harm** - a rating of five qualifies an admission independently of other parameters.
2. **Functional Status** - a rating of five qualifies placement independently of other variables.
3. **Medical and Psychiatric Co-Morbidity** - a rating of five qualifies placement independently of other parameters.
4. **Recovery Environment** - a rating of four or more would be most appropriate for this level, but no rating in this parameter qualifies placement independently at this level, nor would it disqualify placement if otherwise warranted.
5. **Treatment and Recovery History** - a rating of four or more would be most appropriate for this level but, no rating in this dimension qualifies placement independently at this level, nor would it disqualify an otherwise warranted placement.
6. **Engagement and Recovery Status** - a rating of four or more would be most appropriate for this level but no rating in this parameter qualifies or disqualifies placement independently at this level.
7. **Composite Rating** - in some cases, patients not meeting independent criteria in any one category, may still need treatment at this level if ratings in several categories are high, thereby increasing the risk of treatment in a less intensive setting. A composite rating of 28 (an average rating of four or more in each dimension) would indicate the need for treatment at this level.

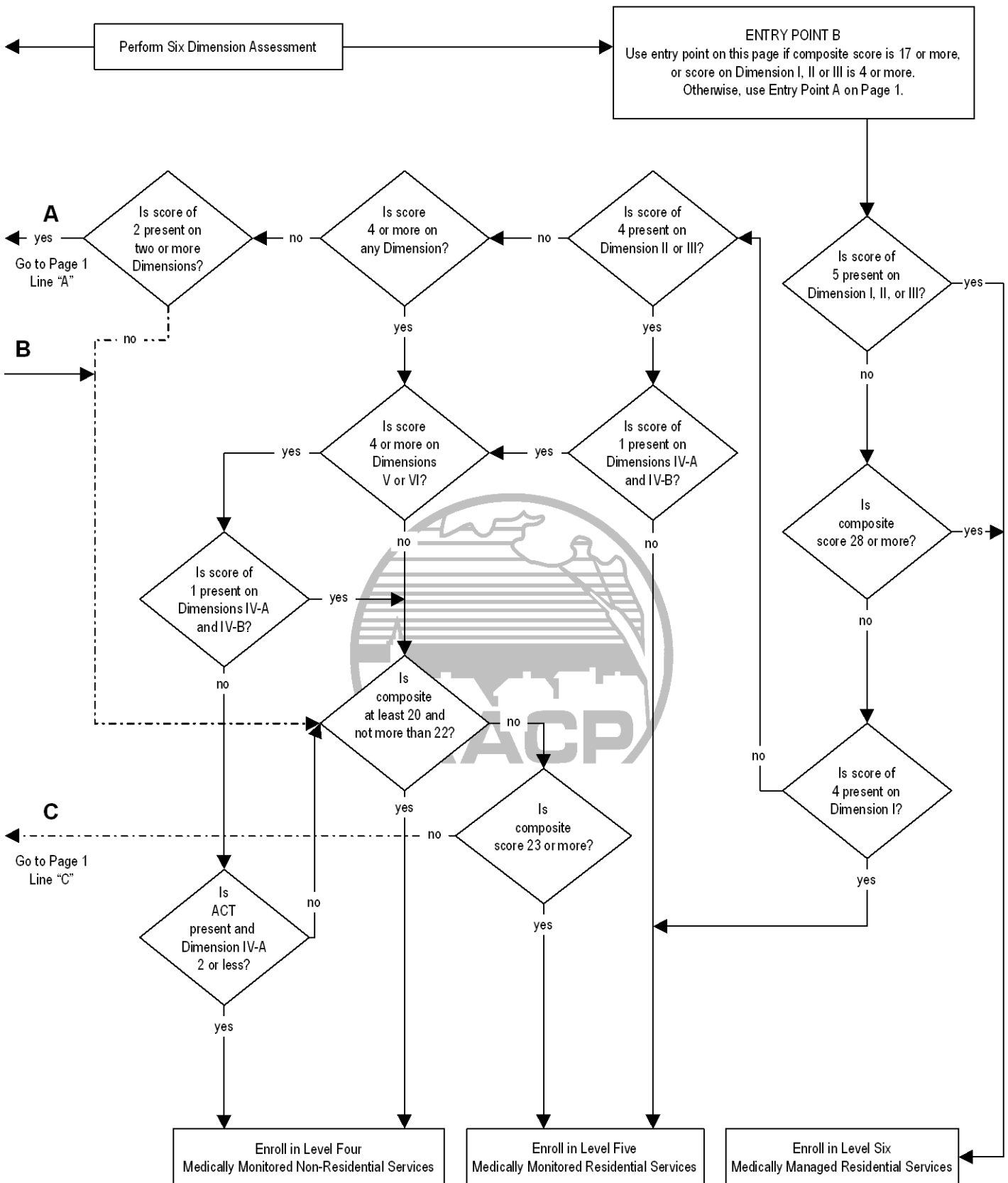


# AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 1

# AACP LEVEL OF CARE DETERMINATION DECISION TREE



Decision Tree, Page 2

# AACP LEVEL OF CARE DETERMINATION GRID

Level of Care	Recovery Maintenance Health Management	Low Intensity Community Based Services	High Intensity Community Based Services	Medically Monitored Non-Residential Services	Medically Monitored Residential Services	Medically Managed Residential Services
Dimensions	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
I. Risk of Harm	2 or less	2 or less	3 or less	3 or less	④ 3	⑤ 4
II. Functional Status	2 or less	2 or less	3 or less	3 or less	④* 3	⑤ 4
III. Co-Morbidity	2 or less	2 or less	3 or less	3 or less	④* 3	⑤ 4
IV A. Recovery Environment "Level of Stress"	Sum of IV A + IV B is 4 or less	Sum of IV A + IV B is 5 or less	Sum of IV A + IV B is 5 or less	3 or 4	4 or more	4 or more
IV B. Recovery Environment "Level of Support"	2 or less	2 or less	3 or less	3 or less	4 or more	4 or more
V. Treatment & Recovery History	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
VI. Engagement & Recovery Status	2 or less	2 or less	3 or less	3 or 4	3 or more	4 or more
<b>Composite Rating</b>	10 to 13	14 to 16	17 to 19	20 to 22	23 to 27	28 or more

○ indicates independent criteria - requires admission to this level regardless of composite score

\* Unless sum of IV A and IV B equals 2



**Appendix D**

**Community Services Work Group Report**

**&**

**Funding Recommendations**



**Oregon Department of Human Services  
Community Services Workgroup Report**

*A Complement to the Master Plan Phase II Report  
on the Replacement of the Oregon State Hospital*

**Version II, March 2009**

## **Introduction**

The State Hospital Master Plan Phase II Report released in February 2006 recommended significant investment in community mental health services in Oregon. The report stated, “Without the enhanced community programming, demand for Oregon State Hospital (OSH) beds will substantially exceed projections of size and cost.”

To address in more detail the need for community mental health services, the Addictions and Mental Health Division (AMH) convened the Oregon State Hospital Master Plan Community Services Workgroup (CSWG) in September 2006. Over the succeeding months, the CSWG received extensive input into the types of services needed, especially for those services that prevent individuals from needing more expensive and intensive services. The report provided a narrative description of each type of service, systematic estimates of the need for and costs of these services, and a timeline for implementing the services. The CSWG issued its report, including comprehensive program and financial recommendations in February 2007.

## **Update on 2007 recommendations**

The Oregon Legislature provided an additional \$20.9 million in general fund for adult-focused community mental health services. This initial investment was a first step in improving Oregon’s mental health system. However, the amount provided was only 1/6 the amount recommended by the Community Services Workgroup. The funding was released to local Community Mental Health Programs (CMHPs) in late 2007 and early 2008.

The following are examples of how local communities utilized funds to develop and/or enhance services:

- **Crisis and Acute Care Services**
  - Development of programs to assist in the diversion of clients from hospital level of care.
  - Development of respite beds.
  
- **Jail Diversion**
  - Implementation of mental health courts and other programs that enhance the relationship of the mental health care system with law enforcement and county jails.

- **Supported Employment**
  - Funding for 440 indigent clients, who for various reasons were not able to be part of the Oregon Health Plan.
- **Early Assessment and Support Alliance (EASA)**
  - Program staff trained, and programs are in the early phases of implementation.
  - Approximately 180 additional non-Medicaid youth, age 16-24, and their families are being served.
- **Case Management**
  - Enhancement of existing services to improve quality of services for clients.

## **Current Status**

In 2008, AMH reconvened the CSWG to update the original report as Oregon moves forward on building the new state hospitals. The 2008 CSWG agreed with the philosophy and recommendations in the 2007 report. The CSWG continued to stress that there is one mental health system and the full continuum of mental health services needs to be enhanced to successfully improve the quality and efficiency of services. The significant difference in this report is that the CSWG no longer defines front-end and back-end services. The CSWG recommends that the system should be seen as a continuum of services that individuals may need to access at different points in their lives, as they manage their illness and progress in their recovery.

The CSWG issues this revised report as an addendum to the previous year's report, in order to inform the Department of Human Services (DHS)/AMH, the Governor, and the Legislature on the continuum of services required to complement the replacement of the state hospital facilities and to assure the new hospitals' success.

The CSWG acknowledges that the realities of available funding will influence the decisions made in response to this report. The CSWG recognizes that there are not yet sufficient numbers of qualified mental health professionals and other trained staff to fully implement the recommendations in the immediate future. However, the community system must be fully funded and functional by 2015. This allows both funding and staff development to occur over the next three biennia.

Regardless of funding realities, this revised report needs to be seen in its entirety. The components of the system are interconnected and interdependent. An array of services must be available that support individuals in recovery by allowing them to access services that meet their needs and desires. These services must be available regardless of the individual's location. Funding must be sufficient to develop sustainable programs throughout the state, and not to be so small that there is no way to create and maintain the programs and services.

## **Values**

As has been articulated in previous reports and recommendations, community mental health services must be developed with values that support and empower individual recovery. The following statements, adapted from the Governor's 2004 Mental Health Task Force Report, summarize the values that drive the recommendations in this report.

- Recovery is a journey of personal healing and transformation, and is the goal of all mental health services.
- Treatment and supports must be consumer-directed.
- Services provided by persons who are recovering from mental health problems serve an invaluable role in supporting other people in recovery.
- Services must be available in communities where people live.
- Services must be evidenced-based.
- Safe and affordable housing is key to recovery.
- Services must be culturally and age specific.
- Services must recognize the effects of and support recovery from trauma.
- An effective mental health system coordinates and collaborates with the broader system of community services.

## **Determining the level of unmet need in Oregon**

The prevalence rate for severe mental illness among adults in Oregon is 5.4 percent, which translates into 154,867 individuals in Oregon.<sup>1</sup> Some of these individuals are served in the public system while others receive services through the private sector.

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<sup>1</sup> Based on estimates from the United States Department of Health and Human Services Substance Abuse and Mental Health Services Administration.

A national research report states that approximately one-third of individuals with a serious mental illness are uninsured.<sup>2</sup> The same report states that under-insurance, even in states with parity, is a large barrier to accessing mental health services. Therefore, these rates under-report the number of individuals needing publicly funded services.

Extrapolating this data to Oregon, approximately 27,609 persons with a mental illness are currently uninsured and not receiving services in Oregon. Due to the nature of mental illness, with people fluctuating in their level of need during different stages of their illness, this report estimates that approximately 21,000 additional individuals need publicly funded mental health services at some time during a biennium.

These recommendations also assume a three percent population growth per biennium. All funding for services described in this report are General Fund dollars. This report assumes that new funding invested in one biennium will be included in the department's Essential Budget Level for the following biennium, so funding identified for each biennium is new funding.

Another category of unmet need is for the individuals who are not able to fully access services. They may be receiving some services through community programs. However, due to funding restrictions, regional differences, lack of treatment providers or other barriers, these individuals cannot obtain the full array of services they need. At this time, AMH cannot determine this level of unmet need. Still, the CSWG believes that the recommendations and assumptions specified in this report under represent the true need in our communities.

Traditional funding and targeted programmatic funding silos do not serve the best interest of the individuals we need to serve. Services must be seen as an array of options that allow people to access appropriate services depending on their individual need and desires. Local communities should be encouraged to develop innovative services that meet the needs of their communities and the people they serve.

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<sup>2</sup> Coverage for All: Inclusion of Mental Illness and Substance use Disorders in State Healthcare Reform Initiatives  
June 8th, 2008, NAMI

## **Recommendations for community services**

Services needed in an effective community mental health system are outlined in these recommendations. In addition to identifying new services, the expansion of current services to meet the unmet needs is outlined. The costs for this expansion are stated in terms of additional funds needed each biennium from 2009-2011 through 2013 - 2015. Actual funding estimates are attached in Appendix A.

The recommendations are encompassed in the following categories:

- Expand early intervention and prevention services;
- Increase the availability of crisis services;
- Ensure access to acute care and alternative services;
- Increase the availability of case management services;
- Provide access to medications and medication management services;
- Develop supported employment and supported education services;
- Decrease criminal justice involvement with the correct treatment and services;
- Treat co-occurring disorders;
- Reduce health disparities through wellness;
- Increase safe, affordable and permanent housing;
- Institute culturally appropriate mental health services;
- Create services and programs for elders and young adults;
- Invest in peer-delivered and trauma informed services;
- Develop appropriate residential capacity; and
- Ensure proper oversight of the mental health service delivery system.

### *Recommendations details*

#### **Early intervention and prevention services**

##### *Overview*

Early intervention and prevention services provide the best opportunity for ensuring an individual's long-term recovery. These services focus on early identification, support and mental health treatment for the individual, including supports for the family as well. Educating individuals regarding their illnesses and assisting them in developing skills to manage their symptoms are key components of the services.

##### *Recommendations*

All newly identified individuals should have access to early assessment and support. The state needs to invest enough resources to provide a complete range of services to this population.

### *Assumptions*

Based on epidemiological research, the statewide need for services is estimated to be 360 new clients and their families per year. About 270 persons per year would require services funded by General Fund monies. The average length of service would be 24 months.

## **Crisis services**

### *Overview*

Crisis services at the community level are critical. Mobile Crisis Outreach Services provide crisis intervention in the community, at the location of need. Mobile crisis outreach increases the opportunity of stabilization in a client's community and not in the hospital. Crisis respite services provide a place in the community to stabilize a crisis, avoiding unnecessary hospitalization.

### *Recommendations*

Oregonians should have access to appropriate crisis services in every community. The particular services would vary depending upon the specific needs in each community. The state should provide guidance on a core set of services.

### *Assumptions*

To accurately determine the unmet need for crisis services can be difficult. Individuals without ongoing supports often bounce in and out of crisis. The Mental Health Alignment Workgroup (MHAWG) estimated that 25% of those not receiving ongoing services will need crisis services.<sup>3</sup> CSWG believes this is still a valid starting point.

## **Acute care and alternative services**

### *Overview*

Acute care hospitals serve as an entry point to the public mental health system and play a vital role in the continuum of care. Unfortunately, due to lack of funding, limited number of mental health professionals and expertise, acute in-patient psychiatric services are limited to just a few hospitals. Access in community hospitals for Psychiatric Hold Rooms (for short term involuntary care) and sub-

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<sup>3</sup> Report to the Governor from the Mental Health Alignment Work Group; January 2001.



acute residential programs are also limited. Access issues are compounded in rural areas due to the considerable distance from hospitals with psychiatric units.

### *Recommendation*

Acute care hospitals must be adequately compensated for the services they provide. Aside from the challenges facing hospital acute care service, options need to be expanded to provide sub-acute care when appropriate. This opportunity provides less expensive care options for patients who do not need hospital level of care, as well as providing a “step down” level of care for people leaving the hospital. Special consideration must also be given to the challenges in rural communities.

### *Assumptions*

In calendar year 2007, AMH served 5873 adults in acute care;<sup>4</sup> local hospitals have estimated that this is only 50% of the need. The existence of significant administrative burdens, financial losses for community hospitals and the shortage of state-owned psychiatric beds have contributed to the closure of hospital acute care beds. It is likely that if these issues are not addressed additional acute care beds will close, placing increased pressure on other parts of the system.

## **Case management services**

### *Overview*

Case management services are provided to persons in and out of a clinic setting. As part of the continuum of care, these services provide the linkage to services and supports. Case managers help individuals stay in their local communities and provide the additional supports for successful community reintegration after stays in the state hospitals.

### *Recommendation*

Case managers play a critical role in an individual’s recovery by linking them to treatment services, community services and naturally occurring supports. Individuals needing ongoing mental health services and supports should have regular access to case managers. Every person leaving the state hospital should also have access to case management services. The level of case management services should be determined based on each individual’s specific needs.

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<sup>4</sup> Oregon Patient Resident Care System.

### *Assumptions*

The MHAWG estimated that 85 percent of the individuals not currently receiving mental health services would need access to case management services.

Approximately 15 percent of persons with a serious mental illness require Assertive Community Treatment (ACT) level of service.

## **Access to Medications and Medication Management**

### *Overview*

For many persons with a serious mental illness medications are essential to healthy living in the community. However, for individuals without medical coverage, medications are too expensive to obtain. Accessing the medical professionals who can prescribe medications and monitor reactions is also problematic for individuals without medical coverage.

### *Recommendation*

Community mental health programs need funding to cover the cost of medications for persons who have a gap in medical coverage and do not qualify for medication scholarship programs. Medication funding and access to licensed medical professionals who can assess and prescribe medications are a necessity.

### *Assumption*

The MHAWG estimated that 85 percent of the individuals not currently receiving mental health services would need access to medications subsidized by the state.

## **Supported employment and education**

### *Overview*

Ensuring access for persons with a serious mental illness to evidenced based services that place and support them in competitive employment or education that leads to employment is necessary for continued recovery. As part of the continuum of care, supported employment and supported education assist clients in becoming productive community members and improves quality of life.

### *Recommendation*

Oregon is a leader in the development of both supported employment and supported education. Supported employment is an evidence-based practice that has proven results. Supported education is a promising best practice. These services are currently only available in select Oregon counties; however, they should be available to all individuals who want them.

### *Assumptions*

Studies estimate that 70 percent of persons with a serious mental illness express a desire to work. This means that more than 14,000 individuals may need supported employment or supported education services. Because studies have not been conclusive regarding the optimum length of supported employment services, this report assumes that 25 percent of those not receiving services should have supported employment or education services.

## **Reducing criminal justice involvement**

### *Overview*

In 2005 AMH and the Oregon Jail Managers Association survey reported nine percent of inmates have severe mental illness and the Oregon Sheriffs Jail Command Council reports 20 percent of their inmates have a mental illness. Jail systems are ill equipped to handle inmates with mental illnesses. When incarcerated, individuals with mental illness deteriorate quickly due to lack of treatment services. Reducing criminal justice involvement includes: jail diversion services, mental health courts and re-entry programs, all of which help individuals successfully manage their illness while they are in prison or jail, and develop a plan for when they return to their community.

### *Recommendation*

As a result of inadequate resources for non-Medicaid eligible individuals, law enforcement has had to accept a far more central role in handling mental health crises in the community than it should have to assume. Services need to be in place to divert people with a serious mental illness from the criminal justice system, providing immediate services when a person is released from a local jail. These services are not widely available in every Oregon county.

### *Assumptions*

According to the survey referenced above, the average number of daily jail bookings in Oregon is 540, which means that about 100 people with a serious mental illness are booked every day. Assuming that some of the bookings are repeat offenders, and some individuals can be served in traditional ACT programs, approximately 1,030 non-Medicaid eligible people per year will need forensic intensive case management services. Every county needs enhanced liaisons with local law enforcement.

## Co-occurring disorder services

### *Overview*

Individuals with Co-occurring Disorders (COD) are more likely to be homeless and die at the average age of 43.9 years compared to 74.9 for the rest of the population. COD is defined as a person with both a severe psychological disorder and a substance abuse disorder. Treatment for persons with a co-occurring disorder is most effective when addiction and mental health services are integrated.

### *Recommendation*

Communities need access to specialized COD services. The system needs a standardized and universal screening protocol for all persons enrolling in mental health and addictions services. Addictions and mental health providers and physical health care providers must be trained to use these screening tools. Communities throughout Oregon have also identified detox for people with COD services as a high priority. Beds are particularly needed to serve the indigent population, which is growing as a result of the economic downturn.

### *Assumptions*

Research indicates that the prevalence of co-occurring disorders in the population of adults accessing community-based mental health services averages between 20-30 percent, with outlying variables being age and mental health diagnosis.<sup>5</sup> Washington State prevalence data note that 27 percent of individuals entering state treatment programs have a COD.<sup>6</sup>

## Focusing on wellness

### *Overview*

In its report, *Measuring Premature Mortality among Oregonians* (AMH, 2008) AMH reported that clients with mental illness die almost 25 years younger than the average population. Individuals with dual diagnosis die even earlier. This disparity is due to heart disease, diabetes and problems related to side effects of medications, smoking, obesity and lack of holistic medical care, according to research by a national mental health council.

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<sup>5</sup> Rush, B. & Koegel, C.J. (2008). Prevalence and Profile of People with Co-occurring Mental and Substance Use Disorders Within a Comprehensive Mental Health System. *Canadian Journal of Psychiatry*; 53 (12): 810-821. **Note:** Research conducted in the United States.

<sup>6</sup> Washington State Department of Social and Health Services; Division of Alcohol and Substance Abuse. (2008). *Abuse Trends in Washington State*.

### *Recommendation*

Oregon must develop and support a statewide initiative to improve the integration and collaboration among providers of mental health, substance abuse treatment and physical health care. Coordinated care for people accessing publicly funded health services will maximize early intervention for mental health and substance abuse issues. This intervention will help prevent avoidable illnesses and provide treatment of chronic conditions.

AMH should build on current activities within the Wellness Initiative. This should include the establishment and ongoing support of a wellness task force. AMH should also develop a quality improvement process that supports increased access to physical health care and ensures appropriate prevention, screening and treatment services for persons with addictions and/or mental health disorders.

### *Assumption*

In the study referenced above, DHS gathered data on 527,564 persons who were treated for substance abuse, mental health problems or both, between 1996 and 2005, and matched with death records from 1999 to 2005. The data showed that people with mental illness die much younger than others in their age cohort. Based on these numbers, an important tool to adequately address this level of disparity is for Oregon to develop a wellness model focused on people with mental illness.

## **Housing that is safe, affordable and permanent**

### *Overview*

Stable housing is an essential element for anyone living with mental illness. Unfortunately many individuals become homeless, or lack safe and affordable housing. The stability of safe, permanent housing plays a vital role in an individual's recovery.

### *Recommendations*

To help individuals locate and remain in safe, affordable and permanent housing, there needs to be:

- Appropriate transitional housing,
- Supportive housing options, and
- Rental assistance.

Additional funding is critical to the ongoing ability of the system to provide stable and affordable housing for individuals with mental illness. While developing additional facilities and providing supported housing are critical, rental assistance plays a vital role in keeping individuals in safe and stable environments. In

combination, supportive housing and rental assistance provide critical alternatives to group homes and other structured facilities.

### *Assumption*

A 2005 state survey conducted by AMH found that more than 12,861 people were in immediate need of affordable housing, that over 2,500 needed supportive or structured housing, and that an estimated 3,000 adults with mental illness were homeless at the time of the survey.

## **Institute culturally appropriate mental health services**

### *Overview*

Oregon population is mostly Caucasian with a growing percentage of population being Hispanic, African American, Native American, Asian, and other ethnic populations. AMH data indicate that African Americans and American Indians/Alaska Natives tend to be represented in outpatient services at rates higher than their rates in the general population while Asian and Hispanic populations are served at lower rates.

### *Recommendation and Assumptions*

The mental health system needs to provide culturally competent mental health services. The state and community mental health programs must provide culturally competent services. This requirement must go beyond the current requirement that information be provided to potential consumers, family members and others in a multi-lingual format.

AMH should develop outreach and intervention tailored to communities and populations by providing resources to pay for culturally-specific positions. These positions would function as project *promotores de salud* or community mental health workers to act as links between communities and the mental health care system, organizing their communities to achieve better mental health.

AMH should also continue efforts to reach African-Americans. Services should be delivered close to where individuals live, in settings that these individuals are willing to attend. Services could be modeled after many of the peer-programs that have proven successful.

## **Age specific services**

### *Overview*

Two populations of Oregonians require specific attention in the development of mental health resources due to barriers preventing their access to the mental health

system. These are youth, ages 16 to 24, and older adults, age 65 and over.

According to AMH's 2009 Report to the Oregon Legislature on Planning for Mental Health Services, almost every county noted a gap in mental health services for its older adult population.

Transition age youth and young adults are difficult to engage in services. They often do not understand how to access benefits. They do not have access to professionals who can help them navigate into adult services. The system has not developed the appropriate tools to be relevant to this age cohort. Additionally, the children's delivery system and the adult delivery system speak different languages and there is little connection and interface between the two distinct system. Currently, service rates drop by 80 percent for these youth and young adults.

#### *Recommendation*

CMHPs should have specialized staff that can help coordinate services and develop the capacity needed to serve these youths and older adults.

#### *Assumptions*

According to US census data, Oregon is projected to have the fourth highest proportion of elderly people (age 65+) by 2025. Oregon needs to position itself to provide more services for this age cohort.

More than 34,000 children under the age of 17 receive mental health services. Since 80 percent drop from services, often entering the adult system much more impaired, Oregon is missing the opportunity to help more than 27,000 youths transition to adulthood smoothly and with the resources that they need.

## **Peer delivered services**

#### *Overview*

Research is mounting that demonstrates the effectiveness of peer delivered services, and people receiving mental health services voice the positive effect of services provided by people that have had similar experiences. Mental health disorders are chronic conditions requiring treatment of acute symptoms and on-going management, supports and monitoring to avoid relapse. Individuals with mental health disorders need recovery support services to help them navigate systems, understand the issues related to these chronic diseases and provide them with the tools and skills to begin healing and rebuilding their lives. These support services are often best provided by people who themselves have received mental health services.

An excellent example of peer-supported services is the establishment of Dual Diagnosis Anonymous of Oregon, Inc. (DDA). DDA conducts meetings throughout Oregon that are based on the 12 Steps of Alcoholics Anonymous plus 5 steps that focus on dual disorders of substance abuse and mental illness. In less than 3 years, DDA has grown to over 2,500 people attending meetings with more than 90 groups in 24 counties. As another example, the David Romprey Oregon Warm Line, staffed by peers, is a valuable companion to the delivery system.

### *Recommendation and Assumptions*

Peer delivered services can and should be included in all the categories described above. For example, ACT services are enhanced when the team includes a peer counselor or case manager, and peers can provide support even in acute care settings. As the mental health services are funded and directed to the CMHPs, peer-delivered services should be incorporated into the development of services.

## **Contractual oversight**

The community mental health system in Oregon relies on a strong partnership between AMH and CMHPs. Nearly all of the community mental health services are contracted through the CMHPs. Frequently when mental health service funding is enhanced, the CMHPs are expected to implement additional services without consideration of the costs associated with the administration of those services. Proper administration ensures that the planning, development, and delivery of mental health services occur with regulatory assurance and quality.

## **Residential Programs**

### *Overview*

Community residential programs provide a stepping-stone for people leaving the state hospital. The State Hospital Master Plan Phase II Report emphasizes the importance of a strong residential system as part of an effective mental health system. The report states, "...availability and access to these programs (*community residential*) are keys to 1) reducing the patient population, 2) decreasing the length of stay at the State Hospital, and 3) maximizing mental health services in the community."<sup>7</sup> The table below demonstrates the needed residential services by region between 2005 and 2030.

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<sup>7</sup> Oregon State Hospital Master Plan Phase II Report.



*Community Residential Bed Need by Region<sup>8</sup>*

Region	2005 <sup>a</sup>		2011b		2030b	
	Civil	Forensic	Civil	Forensic	Civil	Forensic
North Willamette Valley	749	118	865	233	996	365
South Willamette/Central Coast	356	27	380	51	430	101
North Coast	22	8	38	24	41	28
Southern Oregon	281	11	292	25	318	52
Central Oregon	29	7	67	45	87	66
Eastern Oregon	116	5	119	9	129	20
<b>TOTAL</b>	<b>1,553</b>	<b>176</b>	<b>1,761</b>	<b>387</b>	<b>2,001</b>	<b>632</b>

*a Actual distribution of beds in 2005*

*b Assumes 50% civil and 50% forensic development*

AMH developed 283 community placements in the 2005-2007 biennium and is projected to develop 299 in the 2007-2009 biennium. If funding for mandatory caseload growth is continued as part of the department’s base budget, AMH has determined that the need for community residential placements can be met with projected budget. AMH will plan future development to address current disparities in residential bed distribution. Special attention will need to be paid to the Central Oregon region, as it is the region that is most in need for residential development.

## **Further considerations**

The CSWG identified additional issues but did not make specific recommendations for funding. The following warrant consideration as “front end” services are implemented:

### ***Transportation***

Mental health services need to be accessible to all who need them. While a majority of the population is located in areas with a public transportation system, many counties and municipalities have limited or non-existent public transportation. Distances to mental health services are significant in the rural areas. These issues need to be addressed as communities plan mental health services.

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<sup>8</sup> Ibid.

## **Rural costs**

Another concern for rural communities is delivering mental health services on a much smaller scale. This often increases the cost of those services. CMHPs should work closely with AMH to assure the cost of rural services is considered as new funding is allocated. Additionally, rural communities should be encouraged to partner across traditional county lines. Regionalization could provide a mechanism to maximize resources.

## **Improved information system infrastructure**

Effective planning for mental health services and effective monitoring of outcomes require information systems that can produce timely meaningful data. Electronic medical records would improve the coordination of individuals care across the system. Funding for the replacement state hospital facilities includes some funding for the Behavioral Health Improvement Project (B-HIP) to replace the hospital components of the archaic data systems upon which the mental health system relies. It is critical that the community services portion of the new data system also be funded.

## **Funding disparities**

Each community or regional system of care in our State must have enough resources to fund a set of core services and supports. The Oregon State Hospital Master Plan will not be successful in operating with limited beds, shorter lengths of stay and a manageable occupancy rate unless every region is funded comprehensively and comparably, based on objective analysis of the relative need in each geographic area.

Our current system has great disparity in the level and type of state investment in our regions and communities. Historical precedent, insufficient funding of behavioral health care, significant cuts in indigent and Oregon Health Plan funds in recent years, extraordinary population growth in a handful of counties and an inability to fully address disparity all contribute to the current unmet need. AMH should work with the CMHPs as plans for the allocation of new funds are determined. AMH and the CMHPs have agreed that the use of the Kessler Prevalence Formula<sup>9</sup> would guide future allocations of new funds.

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<sup>9</sup> Epidemiological estimate of how common a condition is within a population over a certain period of time.

## **Conclusion**

The Oregon State Hospital Master Plan Phase II Report focuses on the replacement of hospital facilities. However, the number of patients to be served and the costs associated with building and running the new facilities, are predicated on a significant enhancement of the community mental health system. Without the investment in community services, the demand for state hospital beds will exceed the capacity of the new state hospital facilities. If the new state hospitals are to succeed, a significant investment must also be made to develop and enhance a robust array of community services that support individual recovery goals.

This report serves as an addendum to the 2007 report, informing the Governor, the Legislature and DHS what community-based services are needed to support the new state hospitals.

Community Services Workgroup Report 2009  
Funding Recommendations

Service Categories	Early intervention & prevention	Crisis services	Acute Care	Case management services
Unmet need: 21,000	270	5,250	6,000	17,850
<i>Assumptions</i>	360 newly identified individuals per year - 75% would need state funded services	25% of those not receiving services will need crisis services	Currently only funding approximately 50% of need	85% of not receiving services need access to CM & medication support; 15% need ACT level of services
Length of Service	2 years	1.5 episodes	7 days acute, 14 days sub acute	Ongoing
Other	Includes statewide coordination & evaluation		Need funding for acute care specialist - \$200,000	ACTs serve 10-12 people
Cost per person, per:	\$14,000 (year)	\$735 (episode)	\$1,000(acute daily) \$800 (daily subacute)	\$14,000 (ACT - year) \$2,500 (CM - year) \$600 (medications -
<i>Funding Need</i>				
100%	\$7,560,000	\$5,788,125	\$131,396,800	\$92,820,000
50%	\$3,780,000	\$2,894,063	\$65,698,400	\$46,410,000
25%	\$1,890,000	\$1,447,031	\$32,849,200	\$23,205,000
<i>New Biennial Funding Targets</i>				
07-09 LAB	\$4,300,000	\$3,000,000	\$2,500,000	\$2,000,000
09-11 (50%)	\$3,091,000	\$4,342,748	\$66,252,955	\$47,045,345
11-13 (50%)	\$86,866	EBL	\$32,198,936	\$26,582,577
13-15	\$84,434	EBL	\$31,297,366	\$28,032,750

Community Services Workgroup Report 2009  
Funding Recommendations

Service Categories	Supported employment & education	Alternatives to criminal justice involvement	Co-occurring disorder services	Focus on wellness
Unmet need: 21,000	5,250	1,030	3,659	154,867
<i>Assumptions</i>	25% need support at any given time	The majority of those involved in the criminal justice system can be served by ACTs		Provide ongoing leadership & coordination on statewide wellness activities
Length of Service	Ongoing	Ongoing	Ongoing	Support task forces
Other	Includes 1 time investment of new VR staff (\$8,700,000)			3 staff
Cost per person, per:	\$6,000 (year)	\$25,000 (year)	\$5,000 per client	
<i>Funding Need</i>				
100%	\$71,700,000	\$51,500,000	\$36,590,000	\$602,463
50%	\$35,850,000	\$25,750,000	\$18,295,000	\$301,232
25%	\$17,925,000	\$12,875,000	\$9,147,500	\$150,616
<i>New Biennial Funding Targets</i>				
07-09 LAB	\$2,000,000	\$4,000,000		
09-11 (50%)	\$33,850,000	\$24,415,000	\$18,807,260	\$602,463
11-13 (50%)	\$17,925,000	\$11,865,690	\$9,140,328	EBL
13-15	\$17,925,000	\$11,533,451	\$8,884,399	EBL

Community Services Workgroup Report 2009  
Funding Recommendations

Service Categories	Safe & affordable housing	Culturally appropriate services	Age specific services	Peer Programs
Unmet need: 21,000	5,420			
<i>Assumptions</i>	5,420 need rental assistance (RA), 2,000 people need supportive housing (SH)	Support for Afrocentric center & outreach to targeted communities	Need specialized staff in CMHPs to serve older adults & transition age youth	Establish peer services coordinators in every CMHP, Support Peer Bridgers & Dual Diagnosis Anonymous
Length of Service	Ongoing		Ongoing	Ongoing
Other	Need additional supports for people in Villebois		Need to provide training for the specialists	
Cost per person, per:	\$500 (RA - month) \$1,875 (SH - month)		\$92,226 (Youth - year) \$72,000(Older Adults - year)	\$92,226 (Peer Specialists - yearly)
<i>Funding Need</i>				
100%	\$15,504,000	\$2,924,606	\$10,838,916	\$6,086,916
50%	\$7,752,000	\$1,462,303	\$5,419,458	\$3,043,458
25%	\$3,876,000	\$731,152	\$2,709,729	\$1,521,729
<i>New Biennial Funding Targets</i>				
07-09 LAB	\$1,000,000	\$1,000,000		
09-11 (50%)	\$7,455,056	\$1,924,606	\$7,943,012	\$3,128,675
11-13 (50%)	\$3,623,157	EBL	\$1,488,495	\$1,520,536
13-15	\$3,521,709	EBL	\$1,446,817	\$1,477,961

Community Services Workgroup Report 2009  
Funding Recommendations

Service Categories	Local oversight	Total
Unmet need: 21,000		
<i>Assumptions</i>	Provide CMHPs 10% of new funding to ensure proper programmatic oversight	
Length of Service		
Other		
Cost per person, per:		
<i>Funding Need</i>		
100%	\$43,331,183	<b>\$476,643,009</b>
50%	\$21,665,591	<b>\$238,321,504</b>
25%	\$10,832,796	<b>\$119,160,752</b>
<i>New Biennial Funding Targets</i>		
07-09 LAB	\$2,100,000	<b>\$21,900,000</b>
09-11 (50%)	\$21,192,828	<b>\$240,050,948</b>
11-13 (50%)	\$10,299,714	<b>\$114,731,300</b>
13-15	\$10,011,322	<b>\$114,215,209</b>

## **Appendix E**

### **AMH Strategic Planning 2009 – 11 Initiatives**



**DHS Addictions and Mental Health Division (AMH)**  
**Strategic Planning 2009-11 Initiatives**  
**October 13, 2009**

**1915(i) Medicaid Home and Community Based State Plan Amendment –  
Ralph Summers**

AMH will submit to the federal Centers for Medicare and Medicaid Services an amendment to the Oregon, Medicaid State Plan. The State Plan Amendment will authorize both Rehabilitative and Habilitative services for people with serious mental illness, a history of hospitalization and need for daily service contact. AMH expects to be able to expand the array of services available in community based settings to better meet needs of consumers and simplify the billing and documentation requirements for providers. Target date for submitting the request is January 1, 2010. Target date for authorization is July 1, 2010.

**Alcohol and Drug Policy Commission – Karen Wheeler**

HB 3353 abolished the Governor's Council on Alcohol and Drug Abuse and established the Alcohol and Drug Policy Commission. AMH is responsible for hiring the Executive Director to support the commission. The commission will provide the following deliverables: A blueprint for funding and effective delivery of alcohol and drug treatment and prevention services in Oregon. This includes:

- A strategy for organizing and delivering state-funded treatment and prevention services.
- Funding priorities for treatment and prevention services.
- Strategies to maximize accountability and measure performance of treatment and prevention services.
- Methods for standardizing data collection and reporting.
- A policy and funding strategy that supports a consolidated treatment and prevention system, reducing fragmentation in the delivery of services.
- A plan for sustaining focus and leadership on alcohol and drug services and for building a lasting constituency for continuing effective state action.
- A plan for evaluating the state action based upon the "blueprint" in future years/biennia.

## **Blue Mountain Recovery Center: The Future – Richard Harris**

The purpose of this initiative is to consider alternative and current use of the facility and program to determine what use would best meet the needs of Oregonians, patients, staff and the local community and region. The goal is to develop a plan for the future of BMRC. The first objective is to develop a plan and strategy to determine the method of developing an array of options for the future BMRC. The second phase would engage all stakeholders in developing and defining the realistic possible options for the future of BMRC. The third phase would be to engage DHS, the Legislature and the community, staff and patients/consumers in developing a plan for the future of BMRC.

## **OSH Geriatric Downsizing – Linda Hammond**

The purpose of this initiative is to develop a new program called the Community Based Care (CBC) Hospital Diversion program. Service models within this new program will be designed to provide the intensity and type of services that will address behaviors that cause people to be referred to the state hospital and that slow their return to the community. The program would target persons with psychiatric and medical needs who qualify for the SPD 1915© Home and Community Based Care waivers or the “Dollars Follow the Person” initiative and who have needs that exceed all existing CBC resources. Models will promote policies of self direction, and person centered care; provide access to necessary medical, nursing and licensed specialists and care planning necessary to support the persons return to a permanent placement. The pilot is expected to lead to a new service model that will retain or rapidly return to community care, people with physical disabilities, head injuries or dementia that frequently spend too much time in the Oregon State Hospital.

## **Impaired Health Professionals – Karen Wheeler**

The 2009 Legislature passed HB 2345-B which will become effective July 1, 2010. HB 2345-B requires DHS, AMH to establish a consolidated impaired health professionals program. This program monitors the substance use disorder and mental health treatment of impaired health professionals who are either self-referred or diverted by their licensing boards in lieu of disciplinary action. AMH will work closely with the health licensing boards during 2009/2010 to build a

consolidated program including a plan to transition participants who are participating in the separate programs by July 1, 2010.

### **Integrated Services and Supports Rule Implementation – Mike Morris**

The Integrated Services and Supports Rule was filed for public review September 15, 2009 and is expected to be finalized this fall. This rule integrates the standards for most of the mental health and addiction services in the state. The implementation will address training for providers, developing guidelines for reviewers and providers, and redesigning site review processes.

### **Children's Wraparound – Bill Bouska**

Near the end of the 2009 Legislative session, Governor Kulongoski signed House Bill (HB) 2144, and the Children's Wraparound Initiative became law. The implementation of children's Wraparound is a major cross-division transformation initiative. The beginning phase of the Children's Wraparound Initiative is to develop an integrated system of care to maximize positive outcomes for children with behavioral health care needs and who are in the custody of DHS. Initially efforts will focus on children, from birth to age 18, who have been in the custody of DHS for more than one year and have had at least four placements or who come into custody and immediately need specialized behavioral health services and supports. In late fall, DHS will release system of care project site descriptions. This will give communities the opportunity to evaluate their readiness as a system of care project site and decide if they are ready to apply. Applications will be due during the month of January 2010. In February, as part of HB 2144, the work group must present its findings and a progress report to the legislature. Community system of care project sites will begin to take shape in March 2010.

### **Integrated Services & Management Demonstration – Jane-ellen Weidanz**

The Addictions and Mental Health Division recommended to the legislature a system change effort focused on an integrated management and service model including health, mental health and addictions services. The legislature directed AMH to initiate demonstration projects to test different methods of integrating management, financing and services. The goal is to discover system improvements that will result in a simpler, more efficient use of state, federal and local resources and provide better services to those in need.

## **Peer Delivered Services – Len Ray**

AMH believes that developing, funding and supporting peer delivered services (PDS) follows a national trend that is proving to be a key component of a successful service delivery system and an important addition to the health care workforce. AMH recognizes the indisputable value of PDS in transforming the mental health and addiction service delivery system that is based on a recovery model. AMH will work with service population stakeholder groups to develop strategies to increase the use and availability of PDS. The focused investment in this initiative is an investment in the future, an investment in the workforce, and an investment that will demonstrate significant results in transforming and redesigning the service delivery system in the development of new policies, procedures, and partnerships within the state and across the nation.

## **Strategic Prevention Framework – Rick Cady**

SAMHSA's Center for Substance Abuse Prevention awarded Oregon a State Prevention Framework Grant July 1, 2009; \$2,135,724 per year for five years. AMH must submit and have approved by April, 2010 a statewide plan. Once approved, AMH will be able to begin working with ten counties – communities and tribes. The implementation of the Strategic Prevention Framework will provide the Oregon prevention system a common framework for assessing state and local needs and priorities, making data-driven decisions about the right Evidence-based Programs delivered to the right audiences and mobilize communities and tribes in the implementation of the Evidence-based Programs. Also, the SPF will identify gaps in the prevention system infrastructure and afford AMH and the communities and tribes methods for evaluating Evidence-based Program outcomes. The initial phase of the implementation process will install the prevention framework in ten communities/tribes. Of the ten communities at least two to three will be rural and one or more of the recognized tribes. The long term five year plan is to roll out the framework to the balance of the state.

## **Supportive Housing Increase – Darcy Strahan**

AMH is transitioning housing development for people with mental illness to a supportive housing model and away from a structured housing model (residential

treatment homes or facilities) to more fully integrate individuals into their communities. The current focus on structured housing development has been to fill the gaps in the housing needs for people leaving the state hospital. Residential facilities should be seen as one part of the service delivery system, not an end placement as some have become. As individuals move through the service delivery system, the end result should be full integration into their community of choice, living in their own homes with appropriate and flexible support services available as needed.

### **MH Adults Residential Utilization Analysis – Jon Collins**

To better understand current efficiency, effectiveness, and utilization, a comprehensive review of adult mental health residential services is being conducted. Results will help guide planning for further usage and development of this level of care. The review includes but is not limited to analysis of current utilization data to better understand:

#### **Capacity**

- In-flow and out-flow
- Exchange between various levels of care
- Length of stay impact
- Financial modeling

In addition to a review of data, information will be gathered through direct interviews with providers and chart reviews and interviews with two or three model states. Information from all sources will be synthesized to better describe current state and future goals for service delivery to clients currently utilizing residential services.

### **Wellness – Pat Davis-Salyer**

The AMH Wellness Initiative strengthens integration efforts already underway between physical health and behavioral health. It blends the excellent work of the AMH Wellness Task Force, DHS Core Integration Team, the Public Health Division, Oregon State Hospital, mentors, consumers, family members, community stakeholder groups and providers with national experts to move from knowing about health inequities to taking immediate action steps to prevent these disparities. It gives voice to those who have not been heard and acknowledges the tragedy of life lost of those who have passed. AMH is restructuring how we work

to better share resources, reconfigure provider systems to improve access, remove barriers to health care, equip community grass root organizations to provide healthy lifestyle education, enhance prevention, and early intervention programs across the lifespan, and therefore, promote and ensure recovery. Wellness is the goal of all interventions.

### **Young Adults in Transition – Damien Sands**

The Young Adults in Transition includes young adults aged 14 to 25. The initiative will promote access to a system of services and supports that are young adult-directed, and developmentally appropriate. This initiative will implement strategies that promote a Young Adult system through the elimination of barriers to access and through the creation of developmentally appropriate and effective services and supports. This initiative will effectively bridge adolescent and adult systems; and thereby provide young adults with opportunities to realize their full potential and have healthy, productive lives.

### **The Criminal Justice Door to the Mental Health Systems – Richard Harris and Jane-ellen Weidanz**

AMH funds, administers, coordinates, regulates and provides direct mental health and restorative services to individuals who have been determined to be unfit to stand trial or who have been found Guilty Except for Insanity. Both entry points do not allow the community mental health system or AMH the ability to determine if someone needs the level of services provided by the state hospital or if the person could be appropriately served in other settings or if the person does not need mental health services at all. The state is the recipient not the participant in the entire process.

This initiative will begin the dialogue between all parties, including consumers, the court system, community mental health programs, law enforcement, to determine if there are more appropriate processes and options available so that only those individuals who need services, receive them, and only those individuals in need of hospital level services are committed to the hospital. The goals are to identify and implement system changes to improve the “criminal justice door” to the mental health system and may result in legislation, rule or policy process changes.

reflect an ongoing effort to provide community-based service alternatives to individuals with I/DD that meet PASRR requirements and have long-term services in nursing home facilities. At present our data indicates that 110 individuals with I/DD have long-term services in ICF's.

Virtually every person qualifying for I/DD services is served in a community-based setting, with none living in ICF/ID's.

<b>Institutional to Community Services</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
ICF/ID to Community	9	23	0	0
ICF to Community	5	15	8	5

AMH:

The tables below contain transition data for both civil and forensic patients served by the Addictions and Mental Health Division of the Oregon Health Authority, both in the state hospital and in 24 hour state licensed community – based facilities that provide treatment and structured living environments for adults with serious mental illness.

<b>Transitions for Civil Patients</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
State Hospital to Community	66	60	76	100
24 hr to Community	904	343	1,019	847
State Hospital to 24 hr	198	213	183	184

Source: OPRCS July 2012

<b>Forensic Transition</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
State Hospital to Community	5	6	13	21
24 hr to Community	11	16	26	33
State Hospital to 24 hr	6	15	22	36

Source: OPRCS July 2012

*2) The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.*

APD:

Since Oregon's long term care system serves both seniors and people with physical disabilities, we are unable to extract the amount spent serving individuals with disabilities in nursing facilities. We would refer you to question 1, which shows the outcomes Oregon is achieving for both of these populations.

DD:

Over the last three decades Oregon has worked diligently to provide only community-based services for individuals with intellectual or other developmental disabilities (I/DD). The majority of this reduction occurred in the year 2000 with the closure of Fairview Training Center, the largest institution in the State. As described above, this process was completed October of 2010, with the closure of only remaining ICF/ID in the state.

As a result, all resources for services are now allocated to community-based services. The table below provides the state general fund costs for those services. This table distinguished those community-based that are licensed or certified and operated by provider entities. This included primarily group and foster homes. Also included in the chart are the in-home supports, provided generally using a self-directed model where the individuals with I/DD or their families craft individual services based on a defined benefit level. In these services the individual with I/DD or the family engages directly the desired provider with support from case management or support broker entities.

<b>Setting</b>	<b>Licensed or Certified Residential Care (group homes, foster care, etc.) for children or adults.</b>	<b>In-home supports (service in individual or family home)</b>
<b>Expenditure</b>	\$ 152,920,639	\$ 26,744,532

AMH:

The information below describes those served by the Addictions and Mental Health Division of the Oregon Health Authority:

<b>2012 Budgeted Expenditures</b>				
<b>Setting</b>	<b>Psychiatric Hospitals</b>	<b>Licensed Residential Care (board and care homes, group homes, residential treatment</b>	<b>Supported housing</b>	<b>In-home supports</b>



		facilities, adult foster care, etc.)		
<b>Expenditure</b>	<b>\$ 154,547,105*</b>	<b>\$ 43,138,066</b>	<b>\$ 839,460</b>	<b>\$ 3, 124, 880</b>

Note: These figures are only state general fund and do not include Medicaid funding.

\* This figure does not represent expenditures for patients hospitalized in psychiatric units in medical hospitals.

**3) For each year from FY 2008 to the present: the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program—including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.**

APD:

As shown in answer 1, Oregon has achieved improved outcomes in serving seniors and people with disabilities in home and community based settings. Oregon is in the process of transforming its long term care system so that even more individuals can be served independently. A comprehensive assessment of the barriers to in-home services is currently in process; resulting strategies will be formulated to break down those barriers.

DD:

Oregon provides in-home support services for both children and adults with intellectual or other developmental disabilities (I/DD). In 2001, the state undertook a massive expansion of these services in order to eliminate a list of adults waiting for services.

The data requested was not available by year so what is provided is the number at the end of each two year funding cycle ending on 6/30 of every odd numbered year. The 2013 data is that projected through the entire budget period.

As noted in our response above, these services are in-home, using a self-directed model. Oregon has experienced a steady growth in these services since 2001. The decline in the last year was based on Legislative action due to state budget issues resulting from the decline in the economy. Some individuals did not qualify for Medicaid or CMS Home and Community-Based Waiver services, so they were funded by state general fund resources only. Even with that specific reduction, the trend upward in the expansion of in-home services for individuals with I/DD.

The dollars represented in the table below are state general fund only expenditures. For the 2013 period this is the projected number of expenditures for the entire budget period.

Year	2007	2009	2011	2013
Capacity	6,693	8,498	8,636	7,661
Expenditure	\$32,757,351	\$34,605,552	\$34,182,673	\$57,411,094

AMH:

The information below describes those served by the Addictions and Mental Health Division of the Oregon Health Authority:

Supported Housing Developments FY 2008-FY2012					
Year	2008	2009	2010	2011	2012
Capacity	92	85	27	66	59
Expenditure	\$534,960	\$658,300	\$300,000	\$725,000	\$839,460

Data Sources Community Mental Health Funding Report 2008-present  
AMH Residential Report, July 2012

**Special Capacity-** Of the 329 supported housing beds opened since FY 2008, 31 of these were developed for Young Adults in Transition, and 14 were created for individuals over age 65. While not specifically designated for individuals with co-occurring disorders, virtually all of Oregon's Supported Housing programs either provide these services, or help arrange for them.

**4) *The contents of your state's Olmstead Plan for increasing community integration, a description of the planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified with it.***

AMH:

Oregon's 2011—2012 Olmstead Plan (Plan) was developed over a year long planning process by a group comprised of consumers, advocates, state, county, and local government officials, providers of mental health services, and insurers. The group developed strategies and goals after analyzing comprehensive statewide mental health system data. Based on this analysis, the Plan is divided into five focus areas (Reducing State Hospitalization, Reducing State Hospital Length of Stay, Ensuring Individuals Get the Residential Services They Need, and Increasing the Availability and Quality of Community Supports).

Each focus area contains strategies and goals for improving service quality, increasing accountability for outcomes, and increasing independence and integration for consumers of mental health services and supports. Goals and

strategies for increasing community integration and independence within Oregon's current Plan consist of:

- Expand community based integrated services such as Early Psychosis and Assessment Screening (EASA) programs, Assertive Community Treatment (ACT), Intensive Case Management (ICM) services and Patient Centered Primary Care Homes.
- Further community integration by separating services and supports from housing by implementing initiatives such as the CMS Building Sustainable Partnerships for Housing, which creates incentives for property owners to provide affordable housing for individuals with disabilities.
- Implement the 1915(i) Home and Community Based State Plan option to improve the local community's ability to provide services to individuals in their own homes.
- Strengthen the ability of the local community to maintain or improve a person's level of independence in the community by expanding early identification and intervention strategies to avoid hospitalization, and require that Local Mental Health Authorities (LMHA) do comprehensive, localized needs assessments to identify service gaps and needs.
- Standardize residential admission, continuing stay, and discharge criteria, using a standardized tool to ensure individuals receiving residential services are in the most independent setting possible.
- Initiate comprehensive residential utilization review and management efforts to ensure people are in the right level of care for their needs, and moving toward maximum independence.
- Initiate a requirement for local communities to craft a stigma reduction plan to address access and integration at the local level.

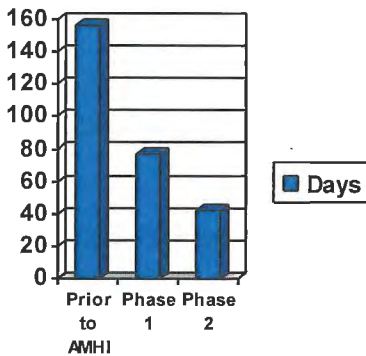
The Adult Mental Health Initiative (AMHI) is a key strategy of the Plan. AMHI is a comprehensive effort to provide incentives and accountability for providers and LMHAs to ensure individuals are constantly moving toward independence.

AMHI requires local and regional contractors to actively engage with individuals who are admitted to the state hospital from their region. They are expected to meet with the individuals from their region and take the lead in discharge planning and to participate in Interdisciplinary Team meeting (IDTs) at the hospitals.

AMHI Phase I began on September 1, 2010, and concluded on June 30, 2011. During the first 10 months of AMHI, 494 individuals successfully transitioned to lower levels of care.

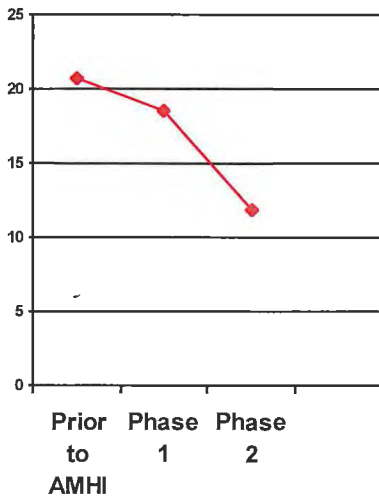
During the first phase of AMHI, AMH assisted local and regional contractors in transitioning individuals to the least restrictive setting, and provided technical assistance and support. In Phase II, the contractors assumed full responsibility for this work. During the second phase of AMHI, July 1, 2011 through January 31, 2012, 440 individuals were transitioned to lower levels of care.

In addition increasing discharges to more independent levels of care. AMHI has also been effective in reducing lengths of stay for patients deemed Ready to Transition (RTT), and has helped reduce re-admission rates to the state hospital.



The graph at left illustrates patient length of stay post RTT prior to AMHI (August 31, 2010-just under 160 days), at the end of AMHI Phase I (June 30, 2011-just under 80 days), and AMHI at the end of Phase II (June 30, 2012) post RTT length of stay had dropped to just under 40 days.

Data Source: AMHI E-submission data



The second graph illustrates the reductions in readmissions to the state hospital within one year, prior to AMHI, and at the conclusion of the first two Phases. From September 1, 2010, to June 30, 2012, readmission rates (within a year of discharge) to the state hospital were reduced from 22 per year to 12.

Data Source: OPRCS

*5) Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.*

AMH:

Recommendation 1: Provide a Medicaid Federal Financial Participation (FFP) rate of 100% for 24 months for individuals being discharged from the state hospital to the community. This will assist states in funding community intensive services and supports that make transition to independence possible.

Recommendation 2: Eliminate maintenance of effort requirements in any legislation seeking to increase the utilization of home and community based services.

Recommendation 3: Do not exclude high-performing states such as Oregon from long term care balancing programs.

A copy of AMH's Olmstead Plan is attached.

*6) Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.*

AMH:

Oregon ranks 27<sup>th</sup> among U.S. states in population. Last census estimates are the state's population is 3,825,657 US Census estimate. Current State Hospital Capacity at Oregon State Hospital (two campuses) and Blue Mountain Recovery Center is a total of 700 beds. This is a relatively small state hospital capacity compared to the overall state population.

(<http://www.census.gov/compendia/statab/2012/ranks/rank01.html>)

**6a)** The Adult Mental Health Initiative described earlier, combines performance incentives and additional resources for local contractors to engage with consumers to promote timely transitions from psychiatric hospitals to the most independent level of care possible. This engagement occurs throughout the continuum of care, and is proving effective in transitioning individuals into the most independent level of care possible.

**6b)** Another strategy that has proven effective in transitioning individuals out of the state hospital has been Oregon's Co-Management process. Co-management is a cost sharing policy of the State, designed to promote timely discharges from the state hospital. In essence, the Co-Management program requires local communities (as opposed to the State) to bear a progressively larger portion of the state hospital costs the longer a patient awaits discharge. The Co-Management policy has resulted in shorter wait times for patients after they have been deemed ready to discharge. Co-management has also provided the opportunity for the local community to assume the responsibility for ensuring individuals receive services

**6c)** Oregon operates two state hospitals on three campuses. Effective strategies to minimize the use of institutional care are not limited to changes in the community. At both state hospital campuses, on site cottages are used to provide a more normative treatment environment for some patients, thereby assisting with the transition to community living. At the Oregon State Hospital, in conjunction with the completion of major new construction the strategies and location of patient treatment has been re-designed. Most patients now attend individual, group or other therapies at a "treatment mall". This model more closely resembles community based outpatient treatment settings, and helps ease the eventual transition to community based care.

attachment 1). The SPW also reviewed in detail the data the department collects through the Employment Outcome System (EOS). This data is provided in attachment 2.

### **III. DISCUSSION THEMES**

Prior to addressing each of the three objectives, the SPW identified issues that would need to be addressed overall. There were several themes, normally posed as concerns or questions that appeared to emerge as the group's work moved forward. Examples include:

- **Capacity building** – Increasing both provider and community capacity through training, technical assistance and adequate resource support.
- **Thoughtful and caring movement of people** – Carefully addressing the needs and desires of people with more significant disabilities when planning employment related activities. The desired outcome is to assure lives were actually improved and that employment or a Path to Employment was what the person actually desires based on informed choice.
- **Choice of Service Providers** – Improving funding fluidity and flexibility in funding rate setting and funding structures, and accompanying regulations, to enhance the process of choosing or moving to an alternative service provider(s).
- **Funding** – Revising funding models that reinforce implementation of the Employment First agenda, prioritize integrated employment and provide for adequate employment resources. Included in this discussion was benefits analysis and counseling.
- **Success** – Determining clearly what and how a successful experience towards Employment First will be determined?
- **Baseline and Data Collection** – Improving the data collection and dissemination process. This theme and subsequent discussion also involved the ODDS service monitoring processes.
- **Waivers** – Rewriting or revising Home and Community Based Waivers as necessary.
- **Public Policy** – Revising public policy, as needed, to address a strengthened Employment First agenda.
- **Timelines for Policy Implementation** – Providing clear, trackable path for implementation of the Employment First agenda, including the use of metrics.

- **Planning** – Reviewing and revising as necessary the individual service planning process and include the Person Centered Planning principles and activities. This theme is to include individual planning processes for ODDS, ODE, and OVRS.
- **ODDS/ODE/OVRS Expectations** – Provision of clearly written expectations and processes required by the state agencies as Oregon continues to implement the Employment First policy. Coordinating efforts by ODDS, ODE and OVRS to maximize the referral, funding and placement processes.
- **Technical Assistance and Training** – Providing additional technical assistance and training to enhance and move toward an Employment First agenda. Including efforts to increase awareness of potential cultural adjustment(s) statewide to embrace innovation through collaboration and inclusion.
- **Sustainability** – Identifying additional leaders across the state to support the Employment First agenda. Including identification of emerging leaders and developing a strong monitoring process to address the final strategic plan. Also including efforts to build natural supports, implement employer driven initiatives, and expand business leadership.

#### **IV. STRATEGIES/ ISSUES/ RECOMMENDATIONS**

The SPW identified issues for each objective that should be addressed in the strategic plan.

##### **Objective #1: Decrease the number of individuals transitioning from school into sheltered workshops**

###### **Issues/Recommendations:**

- Align, define and clarify state agency policies and practices regarding Discovery in the Individual Support Plan (ISP), Individual Education Plan (IEP) and Individual Plan of Employment (IPE).
- The Supports Services Waiver and related Oregon Administrative Rules (OAR's) puts all of the service priority determinations in the hands of the customer. The SPW did not recommend an immediate change that would restrict funds being used only for employment but did recommend consideration of future restrictions where access to some supports funds



would only be available for funding a path to integrated employment or ongoing employment support.

- Work with stakeholders (OCDD, Arc, Family to Family networks, etc.) to build demand and expectations for integrated employment services.
- Strengthen and grow Employment First Teams (EFT) statewide. Including the continuing support to the Employment First Teams that have focused on school to work priorities and providing job coach capacity building at the same time as mentoring to the teams.
- Provide technical assistance and training that focuses on job coach capacity building, best practice strategies, supporting provider agency re-tooling to move from facility to community employment, and expand provider agency capacity to provide enhanced Discovery and Pathways leading to integrated employment.
- Work with OVRs and ODE to implement changes in policies, practices and expectations that clarify roles of education, vocational rehabilitation and Support Service Brokerages to best support a wrap around service that results in students leaving schools with fully discovered work interests, goals and assessments that result in community based employment. Stop the practice of schools using sheltered workshops as a component of the school transition program. Develop ODDS/OVRs/interagency tracking and data collections systems
- Target training and technical assistance to work with OVRs to increase employer engagement.
- Work with the technical assistance providers and other stakeholders to develop additional resources, federal and foundation grants and enhance human capital that would further promote desired outcomes for Transition services towards an Employment First agenda.
- Enhance Support Service Brokerage policies and procedures to move towards an Employment First agenda in regard to transition age individuals.
- Use pilot model strategies to discover and enhance innovation practices. Create two pilots for school/provider partnerships from school to work.
- Explore use of Project Search – especially in transition from school to work.

## **Objective #2: Increase the number of people who move from sheltered workshops to supported employment**

### **Issues/Recommendations:**

- Build provider expertise and capacity to promote and achieve an Employment First agenda with desired outcomes. Assess current capacity

and strategically identify ten (10) provider agencies, statewide, to provide technical assistance for Organizational Transformation. Each agency will develop a five year plan with metrics that will be reviewed by statewide planning group.

- Match technical assistance and training to current capacity by identifying and addressing supported employment core competencies.
- Support capacity for Discovery and a Path to Employment outlined in Objective #1.
- Work with technical assistant providers and Oregon service providers to increase the number of marketing and job developers and employment consultants with a priority for integrated employment.
- Work with technical assistance providers to create presentations with coaching follow-up in organizational transformation.
- Create pilots for interagency cross training of service providers, service coordinators, personal agents, etc., related to planning, development implementation and monitoring of integrated supported employment.
- ODDS establish a clear monitoring system for the ISP.
- Work with technical assistance providers to lead on-going communications to all stakeholders – especially for key policy revisions, data creation and collection, best practice stories of success, and monitoring. Include what practices and policies are working, what are not.
- Refine ODDS/OVRS interagency data and tracking systems to improve and track all relevant providers and the status to date regarding a Path to Employment.
- Implement ReBAR funding recommendations for comprehensive service rates for employment and day services.
- Work with ODDS/OVRS and the technical assistance providers to develop and implement braided funding to support customized and coordinated employment assessments.
- Work with stakeholders and the technical assistance providers to streamline portability of services, fluidity in funding and bureaucratic nimbleness to increase efficiency in services and movement based on informed choice.
- Work with families and self-advocates in implementing the Employment First agenda. Strengthen family and self-advocate knowledge on employment benefits, models of employment, system navigation, etc.
- Establish clear lines of communication with residential providers on policies, values and practice that support community employment.
- Explore WorkSource and an employer engagement initiative with partners such as Governor's Office, OVRS, Business Leadership Network, etc.

- Expand and enhance Employment First teams statewide. Include a written plan that includes: benefits analysis/counseling, information technology, assistive technology, funding priorities, and community capacity. Focus on the Employment First Agenda, further revisions in public policy, family needs and improvements in relationships with schools and additional partners.
- Continue to build service provider expertise through year five of the strategic plan to achieve successful employment and desired outcomes in the Employment First agenda.

**Objective #3: Increase the number of people with developmental disabilities who are actively engaged in Paths to Employment**

**Issues/Recommendations:**

The SPW engaged in conversation as to the definition of a Path or Pathway to Employment and continued similar conversation as per the Discovery process. Listed are both the terms per the collective conversation and then list a few examples or strategies of the work in progress:

**Pathway to Employment** - Is a broad term for a series of activities and strategies to achieve integrated community paid employment. Examples of activities and strategies included as a pathway are:

- Use of volunteer sites to determine interest's skills and abilities.
- Community skill assessment or interest inventory completed by an agency also providing sheltered employment.
- Travel training to access community and neighborhood by an agency also supporting community inclusion.
- Identification of long term support needs and resources that would impact a plan and Path to Employment.

The implementation assumptions, examples or strategies associated with a Pathway for Employment are:

- Everyone in employment services considered under-employed or anyone asking for integrated, supported employment will have a "Pathway to Employment" based upon their needs, preferences, situation and goals.
- Activities need to be individualized and flexible – design and length needs will fit an individual, their community and local employers.
- Services and activities may be provided through schools, OVRs, ODDS, or a combination of those entities.
- Strategies may be used within sheltered employment or non-work.

- The length of time someone is on a Pathway to Employment will vary depending on need.
- Those on a Pathway will have this strategy and activities clearly documented in their ISP, as part of their Employment Action Plan, and in relationship to their IEP and IPE as appropriate.
- Implementation of these plans will be effectively tracked and monitored.

**Discovery** - Initially, Discovery was identified as a defined process, prior to job development for an individual when establishing a vocational goal. Discovery may require intensive individualized effort to identify tasks the individual can perform at competitive levels and gather information necessary to ensure employment success. Discovery is a time limited service providing person centered employment planning and support focusing on direction for achieving competitive integrated employment at or above minimum wage. The outcome is a Vocational Profile regarding the job seekers interests, abilities, strengths, environments, etc, that foster success. It further identifies activities and learning situations in which the job seeker is at their best. Types and methods of effective support, assistive technology needs, accessibility needs, the present level of employment performance or potential of the individual, and agency recommendations for an employment goal are premised upon all that has been learned. The implementation assumptions, examples or strategies associated with Discovery are:

- It will be a distinct time limited service (for example, 6 months).
- It will result in a completed employment profile that will guide progress and long term support strategies towards employment.
- Not everyone will need Discovery as a service if the outcome can be achieved within their present service.
- Activities will be individualized and flexible.
- Services and activities may be provided through schools, OVRS, ODDS, or a combination of those entities.
- Discovery activities will be clearly documented in the person's ISP as part of their Employment Action Plan, and in relationship to their IEP and IPE as appropriate. Implementation of these plans will be effectively tracked and monitored.

## V. METRICS for PLANNING and IMPLEMENTATION

The SPW considered the data review and scope and nature of recommendations for each goal as it reviewed the Metrics.

1. By 2016, no brokerage young adults will enter sheltered workshops when leaving school.
2. By 2017, decrease the census of adults on the Comprehensive waiver served in sheltered workshops by 492 individuals or 30%.
3. Increase integrated supported employment opportunities for Comprehensive adult sheltered workshop participants.
4. By 2017, increase the Statewide census of individuals in supported employment by 32% or a total of 1000 individuals, with 80% of capacity growth and placements in individual employment.
5. Between 2013 and 2017, Increase by at least 100% the census of individuals on Path to Employment.

A more complete description and display of each metric follows:

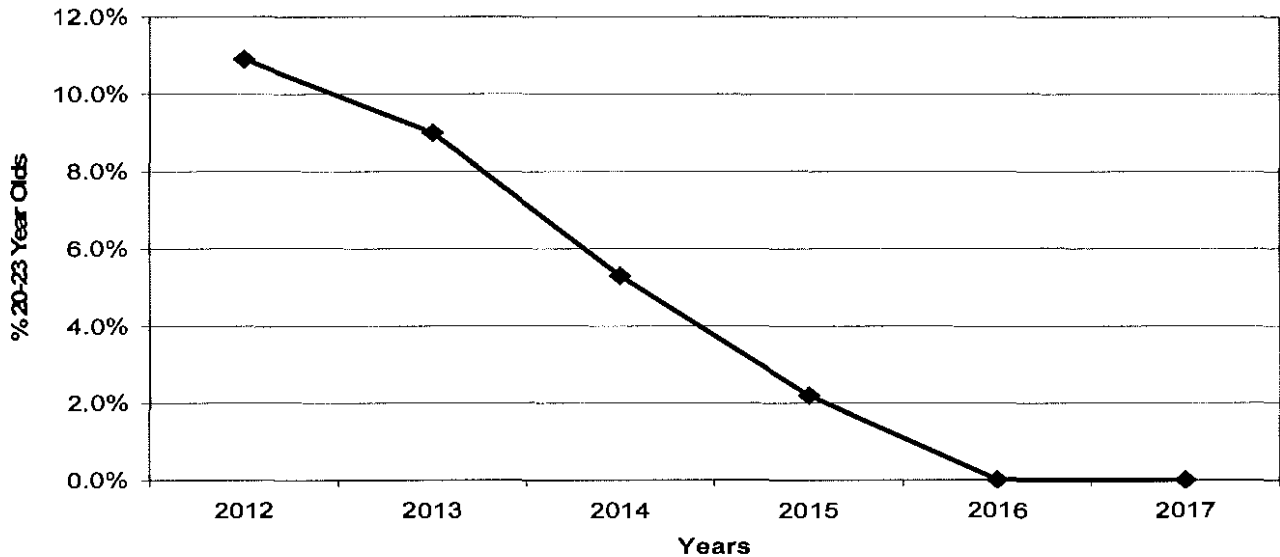
**1. By 2016, No brokerage young adults will enter sheltered workshops when leaving school.**

*Baseline and Estimates:* March 2012 ad hoc review of 1083 Brokerage/ Supports waiver customers aged 20-23 identified 118 or 10.9% presently in sheltered workshops. Estimates of 20-23 year olds based upon projected service growth.

*Data Source:* Additional questions will be added to the Supports/Brokerage EOS report to identify the status of this target population.

<b>Metric 1. Brokerage Young Adults Transitioning From School To Sheltered Workshops</b>						
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
Brokerage Customers Aged 20-23	1083	1421	1759	2071	2401	2721
# in Sheltered Workshop	118	128	93	47	0	0
<b>Target % In Sheltered Workshop</b>	<b>10.9%</b>	<b>9%</b>	<b>5.3%</b>	<b>2.2%</b>	<b>0</b>	<b>0</b>

**Percentage Brokerage Young Adults  
Entering Sheltered Workshops**



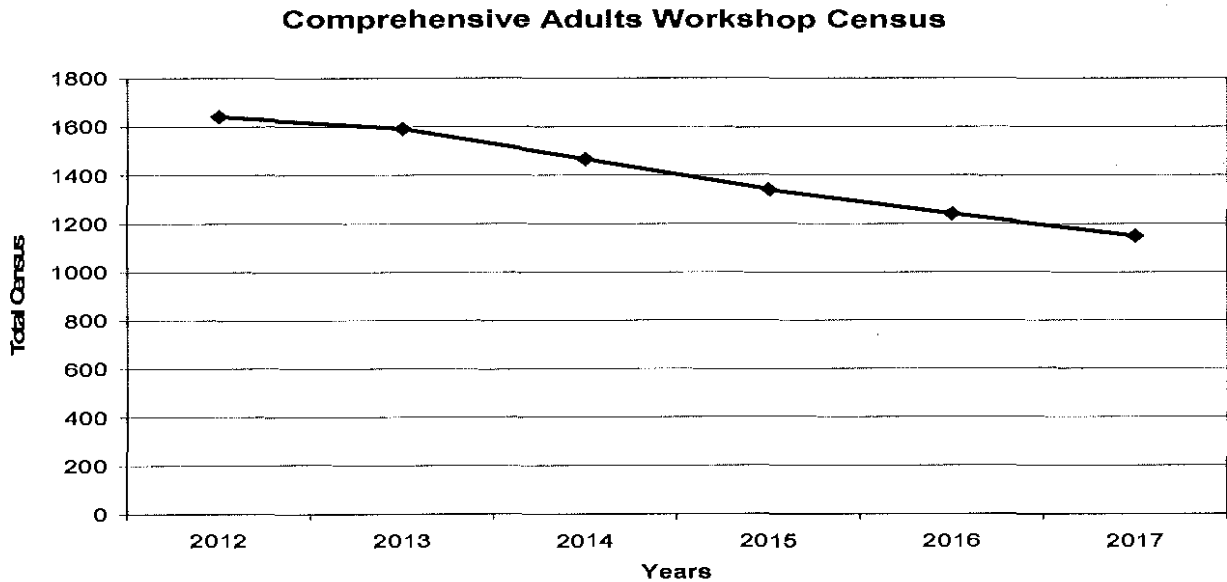
**2. By September 2017 decrease the census of adults on the Comprehensive waiver served in sheltered workshops by 492 individuals or 30%.**

**Data Source:** Comprehensive Service Employment Outcomes Summary, Count of total number and % of adults on the comprehensive waiver receiving any service within a sheltered workshop.

**Baseline:** September 2011, EOS sheltered workshop population (full or part time) is 1641.

**Note:** During 2012-2013 the focus will be on building provider and community capacity. It is also possible that the census of workshops may rise during the baseline year due to movement from ATE to sheltered employment for assessment purposes. Significant change occurs 2014-2016 with a slowing of the pace in 2017 expected resulting from individuals with more challenging issues or greater resistance.

<b>Metric 2. Comprehensive Waiver Adult Sheltered Workshop Census</b>						
	<b>2012 Baseline</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
Beginning census	<b>1641</b>	1591	1516	1441	1341	1241
Annual lost capacity	50	75	75	100	100	92
Ending September Census	1591	1516	1441	1341	1241	<b>1149</b>
Decreased sheltered workshop capacity	50	125	200	300	400	<b>492</b>



### **3. Increase Integrated Supported Employment Opportunities for Comprehensive Adult Sheltered Workshop Participants**

**Data Source:** Comprehensive Service Employment Outcomes Summary, Count of total number and % of adults on the comprehensive waiver receiving sheltered workshop and at least part time individual and or group supported employment.

**Baseline:** September 2011 EOS sheltered workshop population (full or part time) is 1641. At present 8.8% (145) individuals also spend some time in

integrated employment; while others do sheltered work only (17%) or a mix of sheltered work and non-work (74.2%).

**Rationale:** In the period when agencies are building their skills and capacity for supported employment (2013-2015), individuals are likely to receive both sheltered workshop and integrated services to maximize wages. In the final years of the plan this mix will drop as full time supported employment becomes more available.

<b>Metric 3. Increase Integrated Employment Opportunities For Comprehensive Adult Sheltered Workshop Participants</b>						
	<b>2012 Baseline</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
Total Workshop Population	<b>1641</b>	1591	1516	1441	1341	1241
Annual increased opportunities for facility plus integrated jobs	145	193	303	432	268	124
% of population	8.8%	12%	20%	30%	20%	<b>10%</b>
Cumulative increased opportunities	145	338	641	1073	1341	<b>1465</b>

- 4. By 2017, increase the Statewide census of individuals in supported employment by 32% or a total of 1000 individuals, with 80% of capacity growth and placements in individual employment.**

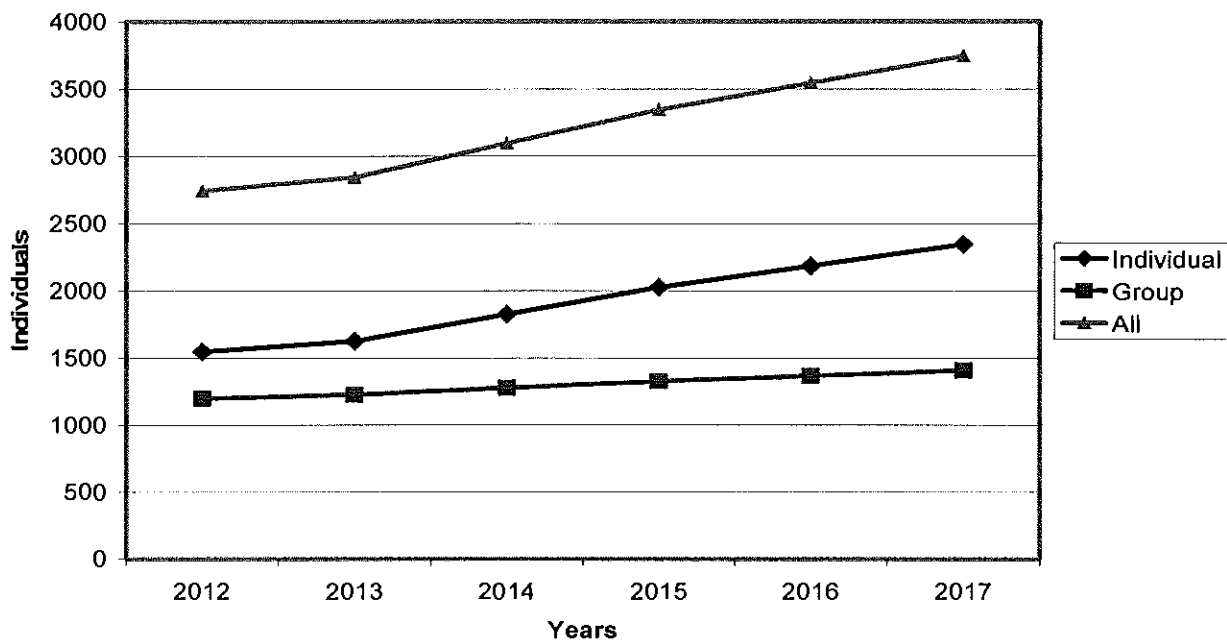
**Data Source:** Statewide Employment Outcomes Report including all adults on both the Comprehensive and Supports waivers and all work settings full or part time.

**Baseline:** September 2011 data shows 2745 of the 10,791 or 25.5% of adults on both waivers in integrated employment. 43.6% of present supported employment placements are in group supported employment.



<b>Metric 4. Statewide Supported Employment Outcomes</b>						
	<b>2012 Baseline</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
Total adult Census	<b>10,791</b>					
Total Individual Employment	1547	1627	1827	2027	2187	2347
Total Group Employment	1198	1227	1277	1328	1368	<b>1408</b>
Annual increased Supported Employment Capacity		100	250	250	200	<b>200</b>
Total Integrated Employment Census	2745	2845	3095	3345	3545	<b>3745</b>

**Metric 4 Individuals in Supported Employment**



**5. Between 2013 and 2017, Increase by at least 100% the census of individuals on Path to Employment.**

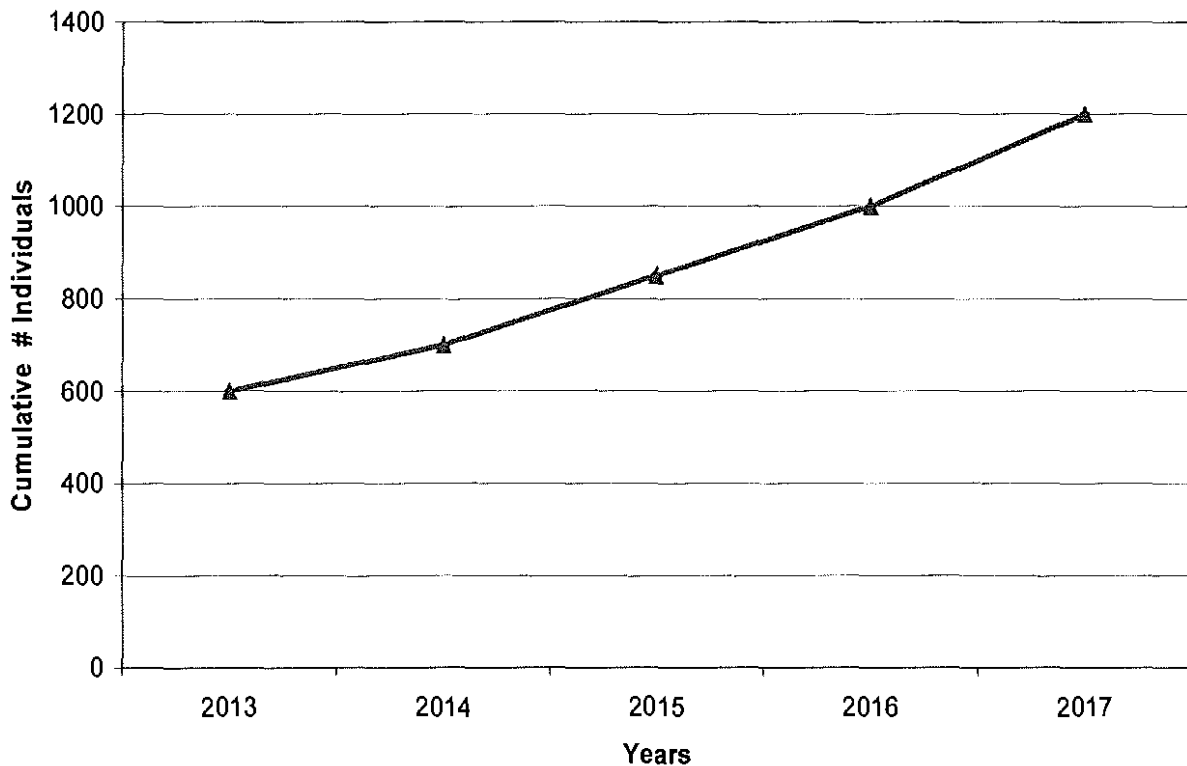
**Definition:** Path To Employment is a term used to reflect activity designed to achieve a goal of individualized employment in the period of one to two years (discovery, assessment, job preparation, development, training etc.).

**Baseline:** We do not have a dependable baseline at this time. We have trained on Path to Employment for some time, but expectation to identify within ISP just became effective in January 2012. Expect to track Path based upon EOS data, and ISP tracking systems.

The following are estimates of the minimum number of new individuals and the cumulative total individuals on a Path to meet other goals and metrics. We know the average time on a Path will be more than 1 year and there will be both job placements and drop outs, but will need to test or revise this metric based on actual experience.

<b>Metric 5. Individuals on Path to Employment</b>						
	<b>2012 Baseline</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
Minimum # new individuals on Path		600	200	360	500	600
Cumulative Total of Individuals on Path		600	700	850	1000	1200

## Metric 5 Path To Employment



## VI. NEXT STEPS

- ODDS has awarded a Training and Technical Assistance contract to the Washington Initiative for Supported Employment (WISE) in collaboration with Oregon Technical Assistance Corporation (OTAC). This contract is to implement statewide training and technical assistance activities targeted at increasing sustainable capacity within Oregon to implement the Employment First policy.
- Oregon was awarded a Federal contract from the U.S. Department of Labor, Office of Disability Employment Policy, to further develop and implement an Employment First strategic plan. Implementation of this contract will be done consistent and in coordination with this report.
- ODDS staff will develop an implementation plan inclusive of the issues and strategies as well as the metric contained in this report. The plan will use

the strategy guidelines and recommendations from the work group to develop a Year 1 Implementation Plan.

- Oregon will present the summary of the work including the Metrics to the Sustainability and Innovation Group 2 (SIG2) for their review and comments. SIG 2 will be the designated stakeholder group to monitor the strategies and metric outcomes.
- Oregon will use national subject matter experts identified through the ODEP grant to develop a full, long range strategic plan on all employment and related day services. The SIG 2 will provide the stakeholder input to this process.

## ATTACHMENT 1

### **DEFINITIONS:**

In order to address the stated objectives the SPW reviewed and agreed to the definitions of individual supported employment, group supported employment, sheltered employment, path to employment and non-work time as stated below.

**Individual Supported Employment** - Individual has a full or part time job for which wages are earned. This job is based on their identified needs and interests, located in a community business, or is self-employed/owns his/her own business.

**Group Supported Employment** - A small group of 2 to 8 individuals with developmental disabilities working in the community under the supervision of a provider agency. May include small groups in industry (enclave) or a provider small business or crew. Group Supported Employment includes crews or enclaves

**Sheltered Employment** - Individuals are paid a wage in exchange for their production-related activities. Supports typically take place in settings such as sheltered workshops in which there is little or no contact with other workers without disabilities.

**Path to employment: Job Development** - Individual is seeking employment and is receiving assistance for job placement. Includes provision of Job Development services from any funding source.

**Path to employment: Volunteer** - Individuals are engaged in volunteer work with civic, religious, public service or humanitarian organizations consistent with the regulations of the Department of Labor.

**Alternatives To Employment** - Any service, conducted away from an individual's residence that addresses the academic, recreational, social, or therapeutic needs of the individuals for whom it serves.

## ATTACHMENT 2

### DATA REVIEW:

The SPW also reviewed data the department collects through the Employment Outcome System (EOS). The data for individuals who are in the Comprehensive Waiver are reported by the contracted providers. For individuals who are in the Supports Waiver, the Brokerage Personal Agents complete a survey on individual customers. All of the data is collected twice a year for the months of September and March. And all of the data is reported on the Employment Outcome web site. The table below looks at all individuals in employment and day services (Service Element 54) who are in comprehensive services.

Service Type /Service Setting	ATE Only	ATE/Work	Work Only	Total
Facility Based only	442	812	284	1538
Community Based Only	304	246	380	930
Combination of Settings	635	942	24	1601
Total	1381	2000	688	4069

The second table is the data for 2011 for individuals in Support Services:

## SUPPORT SERVICES FOR ADULTS

### 1. General Summary

Total Enrolled	7291	
Total Reported	7268	
High School Students	667	
Net Working Age Adults	6601	
Paid Employment	2415	
No Paid Employment	4186	

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The third table looks at the individuals who are working in Support Services and where they are working.

## SUPPORT SERVICES FOR ADULTS

### 2. What are the employment settings?

Setting/Service	Total	
Employed: w/o paid support	672	
Supported Employment: Individual & Self Employed	452	
Supported Employment: Group	386	
Sheltered Employment	905	
Total	2415	19

**Supported Employment for Oregonians with Developmental Disabilities:  
Recommendations for Action  
Executive Summary**

Supported employment, a strategy for assisting persons with severe disabilities to obtain and maintain employment through the provision of on-going support, offers people with developmental disabilities opportunities to work in the community for real wages and to build relationships with non-disabled co-workers. Oregon was once a national leader in supported employment, utilizing federal grants to provide training and support to agencies in conversion efforts. Many people who at one time worked in sheltered settings held community jobs.

Several events have led to a movement back to sheltered employment or facility based day care/socialization (i.e., ATE programs). First, the closure of Fairview Hospital and Training Center required immediate placement options for individuals leaving the institution. Secondly, an economic downturn in Oregon and nationally cost many supported employees to lose their jobs, many who re-entered sheltered employment as funding to assist them in finding new jobs was limited. In addition, the loss of federal funding to support training and technical assistance activities led to a loss of focus on supported employment statewide.

Major changes have occurred in services to Oregonians with developmental disabilities in the past three years. In response to a lawsuit, *Staley vs. Kitzhauber*, services are now available to larger numbers of people with developmental disabilities through nine Support Services Brokerages statewide. Individuals served by the brokerages now have access to needed services and supports that help them become more involved in their communities, creating a renewed interest in, and demand for, supported employment services.

To respond to this demand, the state must reestablish expectations and capacity for supported employment for person with developmental disabilities. Resources available through a variety of public and private agencies need to be joined in an effort to make this happen. The Medicaid Infrastructure Grant can assist the state in rejuvenating support for meaningful employment opportunities for individuals with developmental disabilities, but if there is not a commitment from state agencies to continue these efforts, short-term efforts will not be sustained. The specific recommendations outlined in this paper are designed to develop leadership, an accurate data system, an educated customer base, and build the capacity of local communities to provide quality supported employment services.

***Recommended Actions for State Agencies and Organizations Serving Individuals with Developmental Disabilities:***

1. Provide leadership in expanding supported employment opportunities and capacity;
2. Increase access to, and knowledge of, benefits planning through training and the establishment of a fee-for-service process for purchasing services;
3. Provide on-going opportunities for customer and family education;
4. Strengthen partnerships with other entities responsible for employment outcomes and services;
5. Build the capacity of providers to deliver supported employment services; and
6. Evaluate employment outcomes.



## **Supported Employment for Oregonians with Developmental Disabilities: Recommendations for Action**

### **Overview:**

Supported employment, a strategy for assisting individuals with disabilities to obtain and maintain employment by providing needed support to insure success, has been a model for employment services since the early 1980's. Implementation of supported employment services within Oregon has fluctuated, from being a national leader in the late 1980's, to a decline in services presently.

While the definition of supported employment has changed over time, it is generally accepted that supported employment involves competitive work in an integrated work setting for persons with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom, because of their disability, need intensive support services or extended services to perform such work. Time limited supports that might typically be provided include: job development or assistance in getting a job, intensive job training, and adaptive aids and devices. The provision of on-going supports to keep a the job might include training and technical assistance to co-workers and employers to maximize natural supports, employment consultation, transportation and/or mobility assistance, personal assistance services, etc. The key features of supported employment are:

1. Real work. Work that would be performed by someone without a disability.
2. Real wages. Wages commensurate to wages paid to for comparable work performed by someone without a disability.
3. Integrated work environments. Most co-workers are people without disabilities who work in close proximity and regularly interact with employees with disabilities..
4. On-going support. Supported employment assumes that people with developmental disabilities will need support over time, even if that support is provided by a co-worker.

The decline in numbers of individuals who have access to supported employment, a loss of focus and training efforts directed at supported employment, and a renewed interest in supported employment by advocates is the impetus for this paper. In addition, there are currently opportunities to impact the availability and quality of supported employment services through both the award of the Medicaid Infrastructure Grant to Oregon, and the five-year planning process of the Oregon Council on Developmental Disabilities. This paper explores strategic actions that might be taken, desired outcomes, policy implications and strategic opportunities to consider, as well as potential lead and partner agencies.

### **Background:**

In the 1980's through 1990's, support for community employment initiatives was strong. Three federal Systems Change grants were awarded to Oregon, as well as other states, to support the development of supported employment and high school transition services. These projects focused primarily on three approaches: 1) converting sheltered employment programs to supported employment; 2) developing new programs that provided supported employment

services; and 3) focusing on customer choice and control of both funding and the job search process.

Conversion projects have had varied results. Nationally, few Community Rehabilitation Programs (approximately 2%) reported total conversion, or elimination of more traditional employment or alternatives to employment. Most expanded services to include supported employment as one more option in the continuum of services. Often conversion efforts resulted in small business approaches as opposed to individual placements.

The second strategy focused on developing new programs that provided supported employment services only. At one time, Education and Community Supports (formerly the Specialized Training Program) at the University of Oregon was a national leader in the development of training strategies and model programs for supported employment services. Personnel preparation programs trained graduates in supported employment in both special education and rehabilitation programs. Small agencies that focused solely on supported employment, such as McKenzie Personnel Systems and Alternative Work Concepts, began to appear around the state as leaders in the field began to be trained differently.

Projects in Oregon and nationally have also focused on increasing customer and family education, choice and control in the employment process. For example, the Family Opportunity Grant (later called Careers, Communities and Families) provided small stipends and training to families interested in helping their sons and daughters direct their own job and career search. This strategy produced good results for a limited number of individuals, while beginning to build the capacity of community resources.

What did we learn from these past initiatives? A group of people interested in supported employment services in Oregon has been meeting recently to reflect on what has happened and what has been learned and offer the following suggestions:

1. When grants and special funding disappear the mission gets lost. Agencies need to dedicate staff time to focus on supported employment (with or without external funding) and lead roles need to be established.
2. People with disabilities and their families need to understand employment services. A grass roots demand will only emerge from an educated customer base.
3. We need to address safety, concerns about the stability of supports, and social isolation in a meaningful way. Customers and families will not choose supported employment over sheltered options if these concerns are not addressed.

### **Present Situation in Oregon:**

The Oregon Council on Developmental Disabilities and the Developmental Disability Coalition base prevalence estimates on 1% of the total population. In 2005 it is estimated that 34,214 Oregonians have developmental disabilities. These individuals fall into one of three categories: 1) those who receive funding through the Comprehensive Services Waiver; 2) those who receive funding through the Support Services Waiver (Brokerage customers); and 3) those not currently

receiving state funded services or who are on a waiting list for services. What we know about employment outcomes for each of these groups is that:

1. Comprehensive Services Waiver –

- Most people with developmental disabilities do not access supported employment. Eighty percent (80%) of those included in the Employment Outcome System (EOS) data are not employed, attend an Alternative to Employment (ATE) program, or are in sheltered employment.
- Only 6-7% are working in individual jobs.
- People supported in individual community jobs earn far greater wages than those served in sheltered employment or off-site groups settings (enclaves, crews), increasing their ability to access other community activities, contribute meaningfully to their communities, and become less dependent on social services.

2. Support Services Waiver (Brokerage Customers) –

- About 7% of *spending* goes to support people on individual jobs
- 30% - 40% of *spending* is used to maintain people in crew or sheltered employment
- At any given time, approximately 250 customers are accessing Vocational Rehabilitation services statewide, indicating active pursuit of community employment.

3. Those not receiving services or on a wait list – Little is known about the employment status of this group.

A summary of the Employment Outcome System data is available in Appendix A of this paper or the entire report is available at <http://www.oregon.gov/DHS/spd/data/> Note – this data currently reflects only people funded through the Comprehensive Waiver who reported this information (discussed in more detail later).

**A Call For Action:**

New opportunities in the State of Oregon warrant a new look at supported employment services. The Support Services Brokerages are relatively new and serve many people who, for the first time, have an opportunity to receive supports to help them obtain and maintain a full life. These funds can be used for employment if it is prioritized by the individual (and family). Individuals with developmental disabilities are empowered to make decisions about the types of services they need and the support providers whom they select to work with. It is an opportune time to commit to educating customers and families about the possibilities and benefits of employment, and how they might use existing resources to achieve a life beyond poverty.

The Office of Vocational Rehabilitation, Seniors and Persons with Disabilities, and the Brokerages have worked in close partnership over the past two years to insure timely and efficient access to employment services and resources. Local plans have been established in ten

communities around the state, joint training has occurred, and local working groups have been established in many communities to address capacity needs. An infrastructure has been created to support expanded opportunities for many more people with developmental disabilities in Oregon and can be strengthened with an effort to engage counties, providers and other who are part of the comprehensive waiver services.

Agencies such as the Department of Human Services/Seniors and Persons with Disabilities (SPD), the Office of Vocational Rehabilitation Services (OVRs), the Oregon Department of Education, and the Oregon Council on Developmental Disabilities (OCDD) might all benefit from a closer look at the current state of supported employment services and how agencies can work in partnership to improve employment outcomes. The second Medicaid Infrastructure Grant (MIG) to the State of Oregon provides an opportunity to assist in supported employment revitalization efforts in Oregon over the next three years.

### **Strategic Actions:**

The following actions are designed to increase awareness and demand for supported employment; increase the ability to provide effective and efficient services, and to know when services are making a difference. Each recommendation includes a rationale, specific actions to take, intended outcomes, policy implications or policies to be reviewed, strategic opportunities, and recommendations on who might take primary responsibility. An overview of this information can be found in Appendix C.

The strategic actions list below are supported by research, as outlined in the following article:  
*Research to practice: High performing states in integrated employment* (February 2003).  
Institute on Community Inclusion, University of Massachusetts Boston, Volume 9,  
Number 1. <http://www.communityinclusion.org/publications/pdf/rp32.pdf>

Specific actions around employer education and training, while acknowledged as an important and needed strategy, are not specifically noted here as they are addressed in the White Paper prepared by the Oregon Business Leadership Network.

### **1. PROVIDE LEADERSHIP IN EXPANDING SUPPORTED EMPLOYMENT OPPORTUNITY AND CAPACITY STATEWIDE.**

*Rationale:* The state seems to have lost focus on supported employment in the past decade as other priorities were addressed (i.e., closing Fairview; development of Support Services brokerages). Seniors and Persons with Disabilities (SPD) has a split focus, with much of their attention going to issues related to Senior Services. Even within the disability side, much of the agency's efforts focus on residential services. Central staff has seen a steady reduction during recent budget cutting years, which has stretched their personnel resources thin. At one time, SPD (under the former organization within Mental Health) had a full time equivalent at the state level focused on supported employment. This has gradually been reduced over time. Currently, two SPD employees have limited FTE assigned to the array of employment and other day services. No one person focuses on either employment or supported employment.

*Action:* FTE assigned within state level agencies needs to reflect a renewed commitment to supported employment. Designate appropriate amount of FTE and funding within SPD to accomplish the following:

- Coordinate on-going training opportunities for DHS and brokerage staff;
- Take a lead role in facilitating the development of a state training plan with partner agencies committed to supported employment;
- Develop policies that encourage employment as a desired outcome, while working toward changing policies that serve as disincentives to employment; and
- Maintain and disseminate data on employment outcomes of all individuals with developmental disabilities with long term funding through SPD.

*Outcomes:* SPD takes a lead role coordinating consistent training activities to educate personal agents, case managers, other staff and customers, in collaboration with partner agencies. Leadership is present to coordinate efforts to maximize effectiveness and efficiency of scarce resources currently available for technical assistance and training across agencies.

*Policies to be reviewed:*

**State of Washington, Division of Developmental Disabilities – DDD Policy Manual, County Services for Working Age Adults, Policy 4.11.** A bold policy prioritizing employment support services as the primary use of employment/day program funds for working age adults. Individuals of working age who are not interested in employment are referred to generic services. Working age adults who currently participate in “non-work” programs may continue receiving services until July 1, 2006 as long as they are in the process of considering employment and developing an employment plan. Payments to providers are based on employment outcomes. Exceptions to policy can be requested based on individual needs.

*Policy issues that currently require attention:* Current Oregon policies that seem to impede employment are listed below. For readers unfamiliar with these policies, a more detailed explanation and recommendation can be found in Appendix B.

- Employment Outcome System Data – A policy that requires that information be collected and reported for people served through both the Comprehensive Services Waiver and the Support Services Waiver (currently is only collected on the Comprehensive Waiver).
- Funding based on employment outcomes – Consider developing a policy that provides higher reimbursement for employment outcomes. The Washington policy (referenced above), while perhaps extreme, has made a bold statement that employment is an expectation for working age adults.
- Rate Structures under the Support Services Waiver – Inconsistencies in rates between time-limited and long-term supports creates a disincentive for providers to offer follow along services.

- Rate Structures under the Comprehensive Waiver - Current practice of paying providers on a blended rate does not take into account individualized needs or real cost of services. Distribution of funding should be based on individual needs and services provided.
- Residential off-set – Change policies on service contribution payments so that people can keep their earned income, at least to the point of being eligible for the Employed Persons with Disabilities (EPD) program;
- Brokerages current inability to use support service dollars to assist with benefit planning.

*Strategic Opportunities:* Rate restructuring under the Comprehensive Waiver is in initial discussion stages, making it is a good time to carefully explore strategies that would encourage supported employment. The work that has been conducted through the VR/DD partnership over the past two years sets the stage for joint planning, training and evaluation activities. The Oregon Advocacy Center (OAC), the Oregon Council on Developmental Disabilities (OCDD) and Seniors and Persons with Disabilities (SPD) have been working to eliminate the off-set rules and have made some advances in this area. For instance, people who receive SSDI (unearned income) as a Childhood Disability Benefit are no longer required to pay a service contribution.

*Primary Responsibility:* Seniors and Persons with Disabilities (SPD)

## **2. INCREASE ACCESS TO, AND KNOWLEDGE OF, BENEFITS PLANNING THROUGH TRAINING AND THE ESTABLISHMENT OF A FEE-FOR-SERVICE PROCESS FOR PURCHASING SERVICES.**

*Rationale:* Benefit Planning is critical to helping people obtain and maintain employment over time. It is often complicated, and not well understood by customers or service providers. This is not an issue specific to people with developmental disabilities, but to all people with disabilities who are interested in working. Past efforts at increasing access to benefits planning have included both the Department of Human Services' Employment Initiative, and efforts through the former MIG which trained benefit planners based in local Independent Living Centers around the state. Unfortunately, when grant funding ended, these positions were terminated. In some cases, trained personnel remained within in those agencies and may, in part, continue to assist customers with benefits planning, though other duties may limit their availability.

Awareness level training is needed for all personnel working directly with customers on employment. Vocational Rehabilitation counselors, brokerage personal agents and county case managers need, minimally, a basic understanding of benefits and how earned income effects benefits. They are the first people in contact with people with disabilities who are expressing interest in employment, and they need this information to counsel and support individuals in early stages of considering employment. This is not to replace the need for certified Benefits Planners.

Trained and certified benefits planners are needed for more in depth counseling on the implications of earnings on benefits. Implementing a fee for service structure for benefits planning would provide incentives for both provider agencies and independent contractors to obtain training and certification. It will allow more people to be trained, and for funding agencies

to contract with people they feel are competent in this area. Standards regarding on-going training will need to be developed to insure that high quality professionals who remain up-to-date will be available.

**Actions:**

- Provide benefits awareness training statewide to customers, families and agency personnel on the impact of earnings on benefits and use of work incentive programs.
- Assure all DHS staff (case managers, personal agents, VR counselors and others) have a basic understanding of Social Security benefits and implications of earned income on benefits.
- Provide training opportunities to develop a cadre of certified Benefits Planners based geographically across Oregon.
- Develop standards, a fee-for-service structure, and a system for on-going training and support of Benefits Planners.

*Outcomes:* Customers, families and agency personnel are aware of the impact of earnings on benefits, the work incentives that might be utilized, and the resources available to assist with benefits planning. Customers have access to certified Benefits Planners who have demonstrated competency to perform these services. Benefits Planners stay current on issues through collaboration with state and national projects focused on benefits counseling.

*Policies to Review:*

**Vermont's Work Incentives Initiative** – A benefit planning project that has collected extensive data on how benefits counseling has impacted employment, earnings and cost of dependency on benefits. Contact information: Alice Porter (802) 241-4260 or [alicep@datd.state.vt.us](mailto:alicep@datd.state.vt.us)

**Florida Freedom Initiative** – A cutting edge demonstration program that allows people with disabilities who work to set aside income in Individual Development Accounts (IDA) to save for housing, additional education, transportation or developing a small business. These accounts can generate up to \$8 for every dollar saved up to a maximum contribution of \$10,000 per year. Participants are also able to protect the first \$280 of earned income from being counted as a resource for Social Security purposes. <http://apd.myflorida.com/ffi/how-works.htm>

*Strategic Opportunities:* The federal government has invested in making benefits planning a service available to people with disabilities by providing Benefits Planning Assistance and Outreach (BPAO) grants to states. Many states have taken the BPAO and used it as a means to expand Benefits Planning services. In Oregon, the first Medicaid Infrastructure Grant assisted the Oregon Advocacy Center in training benefits planners based in Independent Living Centers statewide. Oregon Advocacy Center staff have technical expertise and connections to the BPAO project and could potentially act in a lead role in developing standards, providing training, and supporting Benefits Planners statewide through networking activities.

*Primary Responsibility:* Medicaid Infrastructure Grant and the Oregon Advocacy Center

*Partners:* Office of Vocational Rehabilitation Services (OVRS); Seniors and Persons with Disabilities (SPD); Independent Living Centers; Benefits Planning Assistance and Outreach (BPAO)

### **3. PROVIDE ON-GOING OPPORTUNITIES FOR CUSTOMER AND FAMILY EDUCATION**

*Rationale:* Customers and family members need information and training to become informed consumers. People seldom choose options that they are unfamiliar with. Training is needed that highlights employment successes, use of person centered planning, roles of support personnel, and development of natural supports in the workplace. This information is particularly need to assist customers and families plan for the transition from school to adult life.

*Actions:*

- Develop and implement an annual plan to integrate training on supported employment into existing conferences and training opportunities statewide, with an emphasis on sharing successes, resources, and impact on benefits.
- Encourage local planning teams to take a lead in customer and family education., perhaps through awarding small grants to interested local teams.
- Assist organizations that support consumers with disabilities and families to disseminate information regarding supported employment (e.g., Oregon Parent Training and Information; Self Advocates As Leaders).

*Outcomes:* Customers and families are aware of supported employment as a desired outcome of services. They are aware of, and able to advocate for community resources to gain meaningful employment opportunities. Awareness level training is available in local communities, and often provided by individuals with disabilities and family members who can speak from their own experiences.

*Strategic Opportunities:* Several family-focused conferences and training events already occur providing opportunities to infuse information on supported employment. For example:

- Oregon Parent Training and Information conference;
- The Arc annual conference;
- Self Advocates As Leaders (SAAL) training events;
- The Conference on Direct Supports; and
- The UCP family conference.

Success stories and a power point presentation on supported employment that were developed by the SPD will soon be available. The Careers, Community and Families project created both a Storybook and Toolkit (comprehensive manual) for families interested in assisting family members to find jobs. These materials can be found on the SPD website:

<http://www.oregon.gov/DHS/dd/adults/employment.shtml>



In addition, training models and materials exist that could be replicated with or without modification. An example is the “Dream Café”, conducted annually in Southern Oregon, to provide high school age students and their families with information on adult services and resources.

*Primary Responsibility:* Oregon Council on Developmental Disabilities (OCDD), Oregon Parent Training and Information (OR-PTI) and Self Advocates as Leaders (SAAL).

*Partners:* Seniors and Persons with Disabilities (SPD), Office of Vocational Rehabilitation (OVR); Department of Education; local supported employment planning teams.

#### **4. CONTINUE TO BUILD AND STRENGTHEN PARTNERSHIPS WITH OTHER ENTITIES RESPONSIBLE FOR EMPLOYMENT OUTCOMES AND SERVICES**

*Rationale:* Supported employment is a service that requires active involvement and collaboration between agencies providing time-limited and long-term support services, individuals with disabilities, their families and support providers, and community employers. Only by working together can we effectively provide needed supports over time to enable individuals to be successful in jobs of their choice.

*Actions:*

- Continue to develop and expand the partnerships involving OVR and brokerage staff at both the state and local levels. Expand planning teams to include Community Developmental Disability Programs, customer and family representatives, school personnel, provider organizations and employers.
- Provide training to interagency teams on school to work transition with an emphasis on addressing policy and funding issues to insure a smooth transition to adult life.
- Develop a system for sharing information on successful strategies across local planning teams, such as newsletters, joint training opportunities and/or annual supported employment conference.

*Outcomes:* Agency personnel work in partnership to assist customers achieve employment goals. Local planning teams exist within each community and participate in joint planning and capacity building activities that address procedural and capacity issues which support effective and efficient services.

*Policy Implications:* Local teams, especially those focusing on school to work transition, may want to look to the following resource for ideas on how funding and policy issues can be addressed to support timely and effective transition services:

**Point of Transition Service Integration Project, San Diego State University.** A pilot project in twelve communities that focuses on creating seamless transitions for students through partnerships, changes in practice, policy and funding during the students final year of school. Their motto: “The last day of school should be no different than the day after school”. [http://interwork.sdsu.edu/web\\_programs/potsip.html](http://interwork.sdsu.edu/web_programs/potsip.html)

*Strategic Opportunities:* Much work has occurred over the past two years to develop partnerships between the Office of Vocational Services (OVRs) and Seniors and Persons with Disabilities (SPD) to achieve employment for persons with developmental disabilities. A workgroup with state and local staff was established and met over a period of eight months to develop resources and guidelines for supported employment services. Three guides were developed that focus on the basics of supported employment, supported employment staff tools, and a customer's guide to supported employment:

- 1) *Working Together to Reach Employment Goals for Persons with Developmental Disabilities Guide #1 The Basics of VR/DD Supported Employment for Support Service Brokerage and OVRs Staff*  
[http://www.oregon.gov/DHS/spd/pubs/dd/adults/employment\\_basics1.pdf](http://www.oregon.gov/DHS/spd/pubs/dd/adults/employment_basics1.pdf)
- 2) *Working Together To Reach Employment Goals for Persons with Developmental Disabilities Guide #2 Supported Employment Guidelines & Toolkit for Support Service Brokerages and OVRs Staff*  
[http://www.oregon.gov/DHS/spd/pubs/dd/adults/employment\\_tools2.pdf](http://www.oregon.gov/DHS/spd/pubs/dd/adults/employment_tools2.pdf)
- 3) *Working Together to Reach Employment Goals: A Customer's Guide To Using Vocational Rehabilitation and Other Resources to Get and Keep a Job in the Community*  
[http://www.oregon.gov/DHS/spd/pubs/dd/adults/employment\\_2004.pdf](http://www.oregon.gov/DHS/spd/pubs/dd/adults/employment_2004.pdf)

In 2005 Seniors and Persons with Disabilities (SPD) and the Office of Vocational Rehabilitation Services (OVRs) continued to work together and funded essential training and technical assistance activities. A fourth guide: "Building Supported Employment Capacity Through Local Planning Teams" was developed. This tool is presently being used by several local planning groups to collaboratively address local capacity building issues in supported employment (data collection, planning; recruitment, training and support of providers). The Careers, Communities and Families Project also developed planning tools that likely will be useful to expanding local supported employment opportunities:  
<http://oregon.gov/DHS/spd/pubs/dd/adults/employment>

In addition, the Youth Transition Learning Collaborative at the Oregon Health Sciences University, Oregon Center for Children and Youth with Special Health Needs, through a grant from the Bureau of Material and Child Health, has provided training and support to six counties in Oregon (Coos, Curry, Lincoln, Jackson, Hood River, and Union) to establish local level planning teams focused on transition services. For more information:  
[www.ohsu.edu/outreach/cdrc/oseshn/about/youthtransitionlearningcollaborative](http://www.ohsu.edu/outreach/cdrc/oseshn/about/youthtransitionlearningcollaborative)

*Primary Responsibility:* Seniors and Persons with Disabilities (SPD); Office of Vocational Rehabilitation Services (OVRs);

*Partners:* Oregon Rehabilitation Association (ORA); Local Supported Employment Planning Teams (interagency groups which include OVRS, Brokerage personal agents, school/ESD staff, County DD programs, customer and family representatives)

## **5. BUILD THE CAPACITY OF PROVIDERS TO DELIVER SUPPORTED EMPLOYMENT SERVICES**

*Rationale:* A key element in the ability to provide supported employment services is the availability of skilled personnel. Branch Managers from the Office of Vocational Rehabilitation Services and Brokerage Executive Directors statewide have reported that their highest need related to providing supported employment services is the lack of quality employment providers (job developers, job coaches, and personnel to assist with self employment ventures). Both agencies recognize the need for developing quality providers but report a lack of time and/or expertise to address this locally. They want assistance from the state level to provide training opportunities that:

- a. are based on a set of defined competencies
- b. are required (similar to the OIS training requirements);
- c. address customer demands for individualized job placements;
- d. are affordable for both provider agencies and independent contractors; and
- e. address the needs of both new providers and existing providers.

### *Actions:*

- Develop standards or basic competencies for employment providers (job developers, job coaches, employment consultants).
- Provide at least an annual training opportunity (an “Academy”) for employment personnel with strands for new and veteran providers. Work with local planning teams to actively recruit and support providers who demonstrate good outcomes (or seem to have good potential) and encourage attendance of personal agents, case managers, and VR counselors to partner with providers and increase their skills in monitoring effective services.
- Assist local planning teams in assessing the effectiveness of providers and assisting them in developing skills that meet customer needs and demand for services.
- Local planning teams share information with customers and families regarding providers’ skills, level of training, and outcomes.

*Outcomes:* Providers have a base level of skill. Training is available to develop skills of new providers as well as expand the skills of existing providers. Communities have providers who are capable of meeting local demands, and customers choose providers after considering their expertise, training and demonstrated outcomes.

*Policy Implications:* Consider developing a policy that would require a base level of training to enable employment providers to offer these services, similar to the OIS system for training behavior consultants. Training requirements would need to be flexible (i.e., “attend basic training within the first six months”), as many communities find it difficult to recruit providers and too many demands would make it harder for new providers to get started.

*Strategic Opportunities:* Many resources might be tapped to assist with provider training. For example, the Office of Vocational Rehabilitation has discussed the possibility of a Job Developer Academy. Mental Health agencies are also currently converting funding for services toward employment outcomes and could potentially join forces in training providers. Western Washington University offers a variety of courses within Oregon as well as other agencies, such as Asai & Associates. The Association for Persons in Supported Employment (APSE) has developed a list of competencies for supported employment personnel that might be used or modified. The College of Direct Supports, Training Resources Network (TRN), Western Washington University, among others, provide on-line courses and other resources that could augment hands-on training. Changes in the Ticket to Work regulations offer more incentive for providers to become Employment Networks, work in cooperation with Vocational Rehabilitation, and be rewarded for long-term placement. In addition, the standards developed could also be used to assess Oregon's pre-service programs and gain understanding of how we are training potential future teachers and program managers.

*Primary Responsibility:* Medicaid Infrastructure Grant (MIG); Seniors and Persons with Disabilities (SPD); and Office of Vocational Rehabilitation Services (OVRs).

*Partners:* Oregon Technical Assistance Corporation (OTAC); Oregon Rehabilitation Association(ORA); Department of Education (DOE); Providers, & Oregon Commission for the Blind (OCB).

## **6. EVALUATE EMPLOYMENT OUTCOMES**

*Rationale:* In the 1983-85 biennium, the State of Oregon enacted legislation requiring measurement of how employment services enhance the social integration, independence, and productivity of people with developmental disabilities. The Employment Outcome System (EOS) was developed for contracted employment agency providers to collect data on thirteen specific employment measures for all funded individuals. The data was, and continues to be, collected twice a year and was designed to support:

- State reports to the legislature
- Provider quality improvement efforts
- Communities and customers knowledge of local agencies
- Individual outcomes for review of ISP goals

The EOS systems potential has never been fully utilized. EOS snapshots or reports are now only available on working persons on the comprehensive waiver. Data submitted is often incomplete, especially for people who don't report employment outcomes (those in ATE).

When the Brokerages were formed, and many individuals shifted from the Comprehensive Waiver to the Support Services Waiver, much data was lost. The Coleman Institute at the University of Colorado reports in its "State of the States Report" that numbers of individuals served in supported employment in Oregon decreased from 4,780 individuals in 2002 to 3,564

individuals reported in 2004 (a decrease of approximately 25%). While there has been a decline in the number of individuals receiving supported employment services, the data that we have does not allow us to know how many individuals left supported employment and how many are simply no longer being reported in the data.

There was much debate about outcome measurement when the Brokerages were initiated. Employment Outcome System was not seen as a fitting evaluation measure of services characterized by customer satisfaction and diverse (employee, contractor and agency) providers. The Brokerages have not been required to use EOS, and there is no other method or requirement for reporting employment.

This leaves the State in the following situation: (1) SPD can provide a snapshot of employment outcomes, required by the Department of Human Services (DHS) and the Legislature, for approximately half of the persons with developmental disabilities; (2) Some comprehensive agency providers (those providing ATE services) are advocating to abolish the EOS requirement, (3) Some Community Rehabilitation Providers (CRPs) report that the evaluation system could be redesigned to be more useful and accurate; and (4) No method of or requirement for gathering similar employment data for brokerage customers has been established. Therefore both changes in what is reported and who is required to report it need to be considered.

*Actions:*

- Improve the system for collecting and reporting data based on input from Community Rehabilitation Programs (CRPs), Brokerage staff and others who will be required to report this information.
- Develop a policy on how employment outcome data will be collected. Given the broader array of service providers used for people who receive funding under the Support Services Waiver, brokerage staff will likely need to be involved in collecting data from multiple providers and employers.
- Collect and analyze employment outcome data on all individuals with developmental disabilities served through SPD.

*Outcomes:* The State maintains information on the overall employment status of people developmental disabilities served in both comprehensive services and through the support service brokerages. Data collection tracks the movement of customers to supported employment over time. Information is available that will help guide future actions to expand the availability and quality of supported employment services.

*Policy Implications:* A policy or requirement to report employment outcomes on a regular basis (probably biannually) needs to be developed. Employment providers should be required to submit data gathered to brokerages and county DD programs who would then submit that data to the state to summarize. Brokerage personal agents or county case managers would also be responsible for reporting individuals who work without paid supports.

*Strategic Opportunities:* The Employment Outcome System already exists and is maintained by SPD. It has been reported that it takes 2.5 minutes per individual to report this information, based on a study conducted by the University of Oregon in April 2000.

*Primary Responsibility:* Seniors and Persons with Disabilities

*Partners:* Office of Vocational Rehabilitation Services; Providers; Brokerages; & the Oregon Council on Developmental Disabilities

**Summary** Oregon is poised to be able to meet a renewed demand for supported employment services. The interest of advocates in employment, coupled with a new system of providing services based on self direction and individualized budgeting serves as a base for change. The partnership that has been built over the past two years between OVRS and brokerage personnel builds the foundation for effective and efficient service delivery. Continued efforts to provide leadership, build an informed customer base, and develop partnerships and capacity within local communities will sustain efforts and improve employment outcomes over time.

## Appendix A Employment Outcome System Data

The Employment Outcome System data as of March 2005, provides the following information about a majority of individuals served through the Comprehensive Services Waiver only:

### Paid Work:

On average, 2539 individuals were scheduled for 15.24 hours of paid work each week, with the largest proportion (24.66%) scheduled for 0-4 hours. Over thirty two percent (32.03%) receive no pay. Over fifty percent (51.05%) receive their paycheck from the agency that providing the support services. Only 16.92% receive a paycheck from an employer, other than the support agency. Of those individuals who do receive a paycheck, average wages are as follows:

- \$ 2.50/hour = sheltered employment
- \$ 4.24/hour = off-site group employment (crews, enclaves)
- \$ 6.88/hour = individual jobs

Note that the minimum wage in Oregon during 2005 is \$ 7.25/hour. The vast majority do not receive benefits. The most common benefit people receive is vacation or paid holiday time (20.59%).

### Integrated Environment:

Of those responding, 35.10% are attending ATE programs and an additional 45.03% report sheltered employment. Together, over 80% of people reporting spend their days in segregated settings. Over forty five percent (45.79% indicate there are NO people without disabilities in their immediate environment and 38.25% reported that there were 1-5 individuals without disabilities. Over 60% report rare interactions, or only exchanging greetings with people without disabilities in the work setting, excluding paid staff.

### On-going Support Services:

Very little information is available on the amount of support people receive and how it is provided. We can assume that people in segregated settings have access to support throughout the day, as likely do people in off-site group settings. The amount and cost of supports that are provided to the 6-7% who have individual jobs (or self employment) is not reported.

Again, the data above is collected on individuals served under the Comprehensive Services Waiver ONLY. It does not take into account those served under the Support Services Waiver, or those who do not receive services from the state who may be working, with or without support.

## **Appendix B**

### **Explanation of Current Policy Issues**

**Employment Outcome Data.** The Employment Outcome System (EOS) currently only on individuals served under the comprehensive waiver. With the establishment of the Support Services Waiver (Brokerages) there was no requirement to report employment outcome data. Many brokerage customers who work may not be attached to a provider agency, but may receive support from an independent contractor or co-worker. Some receive support that they don't pay for, and therefore reporting tied to funding does not accurately reflect what is happening. A system that tracks useful and valid data on employment outcomes for *all* individuals with developmental disabilities is needed to accurately identify current and future needs.

**Rate structures of the Support Services Waiver.** An inconsistency in rates paid for time-limited and long term employment supports, both within the brokerage system and across OVRs and brokerage systems, creates a disincentive for many providers to engage in long-term support services. Higher rate ranges may mean higher cost to customers, spreading support service dollars thinner. Brokerage personnel, in an effort to help people stretch personal budgets, lean toward finding providers who charge the least. Most professionals in the field will agree that assisting people to KEEP their jobs has proved to be the greatest challenge over time. We need to acknowledge that job maintenance activities require more skill, not less, and compensate providers accordingly. A policy or mechanism for paying providers a reasonable wage, while encouraging the development and use of natural supports on the job site, needs to be implemented. System that recognizes the higher cost of supporting employees in community jobs and compensating providers accordingly will motivate providers to change service delivery options and perhaps decrease overall costs over time.

**Rate structures of the Comprehensive Services Waiver.** A major restructuring of how providers are paid to serve people on the comprehensive side of the system needs to be discussed. While this might be a longer term goal, the need for initial discussion and planning should begin now. A system that encourages individualized budgeting will help both customers and providers see the real cost of services in light of outcomes achieved. A system that continues to pay more for segregated services that keep people in poverty, limit community integration, and offer little in terms of meaningful activity, will not provide incentives for employment providers to focus on supported employment.

**Funding based on employment outcomes.** Oregon needs alternative incentives for provider agencies to create and/or continue to develop individualized supported employment services, as it is far easier and less expensive to manage alternatives to employment programs, sheltered work, or group employment. The State of Washington policy that designates support service dollars to employment services, while perhaps extreme, has made a bold statement that employment is an expectation for working age adults. Establishing a performance based funding policy in Oregon will require looking at how funds are currently distributed through both the comprehensive and support services waivers. For customers served under the Support Services Waiver, a strategy might be to establish a higher annual cap on services for individuals who work (and thus increase their own ability to pay for community inclusion support or other services, as well as paying FICA). This may require lowering the annual cap for those who do



not choose employment. Under the Comprehensive Waiver, restructuring the payment system to provide individualized budgeting based on need and type of outcomes will be necessary. If employment becomes an expected outcome of services, people will be earning more money and at risk of losing Medicaid benefits. Systems that allow people to save money to put toward items that truly support self sufficiency should be encouraged. For example, the use of Individual Development Accounts to save money to pay for their own employment supports or increase use of Social Security Work Incentives might be investigated as options to shift the funding of on-going support services back to the individual after a period of time. (Note – IDA’s at present are set up to buy a home, go to school, or start a business. Using an IDA for on-going support services would not fall into existing IDA funded services).

**Residential service contribution (“off-set”).** Currently some individuals with developmental disabilities who receive residential services must make a “service contribution” (also called “client liability” or “off-set”) to pay for a portion of their services. These individuals are not eligible for Supplemental Security Income and do not receive Childhood Disability Benefit (formerly known as Disabled Adult Child or DAC) under the Social Security Disability Insurance program. Any unearned income over the “SSI Standard” (the SSI federal benefit rate for the current year plus state supplement), and earned income in excess of \$65.00 per month, must be contributed toward their cost of care. Not being able to keep earned income is major disincentive for people to work. People with developmental disabilities need to be able to keep the income they earn to understand the benefit of working and experience the benefits of having additional income. A policy that allows people to keep their earned income, at least to the point of being eligible for the Employed Persons with Disabilities (EPD) program, needs to be considered. Without this there is no incentive for people to try work, and no incentive for providers to develop supported employment services. Agencies in Oregon have been trying to address this issue and have made some advances, but earned income is still subject to service contribution at this time.

**Inability to use Home and Community Based Waiver support service dollars to assist with benefits planning.** Currently, support service dollars can not be spent on benefits planning or assistance with utilizing work incentive programs. There needs to be clarification on whether this is Medicaid rule or an issue that can be addressed in the State Medicaid Plan. The issue has been raised by the Staley Implementation Group and through community input, with no clear resolution. Perhaps what is needed is a better distinction between basic awareness of benefits and implications of wages and professional benefits planning. Training opportunities will increase the ability of vocational rehabilitation counselors, personal agents, and case managers to understand and assist customers understand Social Security rules regarding earned income and work incentive programs, but they rules are complicated and staff often have a difficult time staying abreast at a level that they are comfortable advising customers. Accessing benefits planning services at no costs is preferable (through staff skill development, accessing local Independent Living Center benefit planners, or through phone consultation with the Oregon Advocacy Center), but there are circumstances that may require more intensive, on-site assistance. Clarifying the rules, and hopefully amending the State Plan, regarding purchasing of essential benefits planning services, could potentially benefit many customers.

*Janet Steveley is the owner and operator of Workable **Solutions**, a private consulting firm based in Ashland, Oregon. Workable **Solutions** provides training and consultation to help people with disabilities realize their employment goals, emphasizing choice, personal control, and the creative use of resources.*

*Janet holds a masters degree in Special Education from Indiana University and Bachelors degree in Psychology from the University of Oregon. Over the past twenty years, she has worked on a number of state and national projects related to employment of people with disabilities. She was formerly an Area Director for the Helen Keller National Center's national technical assistance project, which focused on meeting the transition needs of youth who are deaf and blind. More recently she has provided assistance to Seniors & People with Disabilities and the Office of Vocational Rehabilitation Services in facilitating employment opportunities for people with developmental disabilities in Oregon.*

*Janet serves on the board of Creative Supports, Inc., her local Support Service Brokerage and provides consultation locally to clients of the Office of Vocational Rehabilitation Services and the Oregon Commission for the Blind. In the past, she has also worked as a classroom teacher, a transition specialist, and in various adult service programs. Her primary interests are in person-centered planning, transition, employment, and utilizing Social Security Work Incentives.*

**APPENDIX C**  
**SUPPORTED EMPLOYMENT WHITE PAPER OVERVIEW**

1. PROVIDE LEADERSHIP IN EXPANDING SUPPORTED EMPLOYMENT OPPORTUNITY AND CAPACITY STATEWIDE.

ACTIONS	OUTCOMES	POLICY IMPLICATIONS	STRATEGIC OPPORTUNITIES	RESPONSIBILITY
<p>Designate appropriate FTE and funding within SPD to:</p> <ul style="list-style-type: none"> <li>- Work in partnership with other agencies to develop a state training plan;</li> <li>- Coordinate training activities;</li> <li>- Develop policies that encourage and support employment;</li> <li>- Maintain and share data on employment outcomes.</li> </ul>	<p>FTE and funding designated within SPD to focus on supported employment.</p> <p>On-going training opportunities available for all DHS staff.</p> <p>Leadership established to insure effective and efficient coordination of scarce resources.</p>	<p><u>Policies to look at:</u></p> <p>Washington policy regarding employment as a valued support services.</p> <p><u>Current policies to change:</u></p> <ul style="list-style-type: none"> <li>• Employment Outcome System data</li> <li>• Funding based on employment outcomes</li> <li>• Rate structures for both the Comprehensive and Support Services Waivers</li> <li>• Residential Off-Set</li> <li>• Brokerages inability to fund benefits planning</li> </ul>	<p>Work that has been conducted over the past two years to develop the VR/DD partnership.</p> <p>Rate restructuring of the Comprehensive Service Waiver (in initial planning stages)</p> <p>Efforts to address residential off-set issues.</p>	<p><u>Primary:</u> Seniors and Persons with Disabilities (SPD)</p>

2. INCREASE ACCESS TO, AND KNOWLEDGE OF, BENEFITS PLANNING THROUGH TRAINING AND THE ESTABLISHMENT OF A FEE-FOR-SERVICE PROCESS FOR PURCHASING SERVICES

ACTIONS	OUTCOMES	POLICY IMPLICATIONS	STRATEGIC OPPORTUNITIES	RESPONSIBILITY
<p>Provide training statewide to customers, families, and agency personnel on the impact of earnings on benefits.</p> <p>Assure all DHS staff have a basic understanding of benefits and implications of earnings.</p> <p>Provide training opportunities to develop a cadre of certified Benefits Planners based geographically across Oregon</p> <p>Develop standards and a system for on-going training and support of benefits planners.</p>	<p>Customers, families, are aware of the impact of earned income on benefits.</p> <p>Agency personnel are knowledgeable of the impact of earnings on benefits and the resources available for more in depth benefits planning.</p> <p>Customers and families have access to a pool of certified benefit planners.</p> <p>Benefits Planners stay current through on-going training and networking opportunities.</p>	<p><u>Policies to look at:</u></p> <p>Vermont system of providing benefits planning and collecting data on outcomes.</p> <p><u>Current policies to change:</u></p> <p>Policies that prevent Brokerages from using support service dollars for benefits planning.</p> <p>Consider new policy requiring responsibility for assisting customer in reporting earnings and work incentive information be added to agency planning forms.</p>	<p>Oregon Advocacy Center, has technical expertise and connections to the Benefits Planning Outreach and Assistance (BPOA) project. They potentially could act in a lead role in setting standards for Benefits Planners, providing training for people interested in becoming certified, and forming a network for on-going training.</p>	<p><u>Primary:</u> Medicaid Infrastructure Grant and Oregon Advocacy Center</p> <p><u>Partners:</u> SPD; OVRS; Independent Living Centers; Oregon Council on Developmental Disabilities; Oregon Technical Assistance Corporation(OTAC)</p>

3. PROVIDE ON-GOING OPPORTUNITIES FOR CUSTOMER AND FAMILY EDUCATION

ACTIONS	OUTCOMES	POLICY IMPLICATIONS	STRATEGIC OPPORTUNITIES	RESPONSIBILITY
<p>Develop an and implement an annual plan to integrate training on supported employment into existing conferences and training opportunities statewide.</p> <p>Encourage local planning groups to take a lead in customer and family education, perhaps through the award of small grants.</p> <p>Assist organizations that support customers and families to disseminate information on supported employment.</p>	<p>Customers and families are: 1) aware of supported employment as a desired outcome; 2) aware of community resources; and 3) able to advocate for vocational services and supports.</p> <p>Awareness level training occurs in local communities. Customer and family connections to local services.</p>		<p>The Oregon Parent Training and Information conference, The Arc annual conference, the UCP family conference, The conference on Direct Supports, Self Advocates As Leaders (SAAL) training events.</p> <p>Materials developed by SPD highlighting success stories.</p> <p>“Dream Café” as a model for customer and parent education.</p>	<p><u>Primary:</u> Oregon Council on DD; Oregon Parent Training and Information; Self Advocates as Leaders (SAAL)</p> <p><u>Partners:</u> SPD; OVRs, local school districts and Education Services Districts; County Developmental Disability Programs</p>

4. STRENGTHEN PARTNERSHIPS WITH OTHER ENTITIES RESPONSIBLE FOR EMPLOYMENT OUTCOMES AND SERVICES.

ACTIONS	OUTCOMES	POLICY IMPLICATIONS	STRATEGIC OPPORTUNITIES	RESPONSIBILITY
<p>Continue to expand the VR/DD partnership and bring in other entities (employers, Community Developmental Disability Programs, school personnel, provider organizations).</p> <p>Provide training to interagency teams in the area of school to work transition.</p> <p>Develop a system for sharing information on successful strategies and challenges across local planning teams (e.g., newsletters, joint training opportunities; annual supported employment conference).</p>	<p>Agency personnel work in partnership to assist customers achieve employment goals. Local planning teams participate in joint planning and capacity building activities that address procedural and capacity issues which support effective and efficient services.</p>	<p><u>Policies to look at:</u></p> <p>Point of Transition Project – looks at funding and policy issues to facilitate a smooth transition from school to adult life.</p>	<p>The VR/DD partnership that has developed over the past two years based on the efforts of a state workgroup. Four guides were developed to assist local practitioners and local planning teams have been established in many communities.</p> <p>The OHSU Youth Transition Learning Collaborative has established interagency teams in six counties.</p>	<p><u>Primary:</u> Seniors and Persons (SPD) with Disabilities and the Office of Vocational Rehabilitation Services (OVR)</p> <p><u>Partners:</u> Department of Education, Employers, Providers, Oregon Commission for the Blind</p>

5. BUILD THE CAPACITY OF PROVIDERS AND PROVIDER ORGANIZATIONS TO DELIVER SUPPORTED EMPLOYMENT SERVICES

ACTIONS	OUTCOMES	POLICY IMPLICATIONS	STRATEGIC OPPORTUNITIES	RESPONSIBILITY
<p>Develop standards or basic competencies for employment providers (job developers, job coaches, employment consultants).</p> <p>Provide at least an annual training opportunity (an “Academy”) for all employment personnel with strands for new and veteran providers.</p> <p>Assist local planning teams in assessing the effectiveness of providers and assisting them in developing skills that meet customer needs and demand for services.</p> <p>Local teams share information about providers’ skills with customers and families.</p>	<p>Providers have a base level of skill.</p> <p>Training is available to develop new providers as well as expand the skills of existing providers. Communities have providers who are capable of meeting local demands.</p> <p>VR counselors, personal agents and case managers are knowledgeable of effective employment practices and can monitor effectiveness of providers.</p>	<p>Consider a policy which requires a base level of training, such as what is required for OIS training (behavior support).</p>	<p>Connections with training and technical assistance organizations such as: 1) Western Washington University – Center on Continuing Education in Rehabilitation (WWU-CCER); 2) Oregon Technical Assistance Corporation (OTAC); 3) Oregon Rehabilitation Association (OR); 4) Oregon Council on Developmental Disabilities (OCDD).</p> <p>Supplement training with on-line courses and resources such as Training Resource Network; College of Direct Supports; WWU-CCER on-line courses.</p> <p>Consider use of ORCA data, collected by OVRS on vendor effectiveness.</p>	<p><i>Primary:</i> MIG; SPD; OVRS</p> <p><i>Partners:</i> OTAC, ORA, OCB, DOE, Providers</p>

5. EVALUATE EMPLOYMENT OUTCOMES

ACTIONS	OUTCOMES	POLICY IMPLICATIONS	STRATEGIC OPPORTUNITIES	RESPONSIBILITY
<p>Improve system for collecting and reporting employment outcome data based on input for CRPs, brokerage staff and others who will likely be involved in data collection.</p> <p>Develop a policy on how employment outcome data will be gathered.</p> <p>Collect and analyze employment outcome data on all individuals with DD funded by SPD.</p>	<p>Accurate information exists on the employment status of Oregonians with developmental disabilities.</p> <p>Information is available that will help guide future actions to expand the availability and quality of supported employment services.</p>	<p><u>Current policies to change:</u></p> <p>A policy is needed that requires Brokerages to also collect and report employment outcome data.</p> <p><u>Policies to look at:</u></p> <p>Vermont data on impact of benefits counseling.</p>	<p>SPD already collects Employment Outcomes System data biannually on individuals served under the Comprehensive Waiver.</p>	<p><i>Primary:</i> SPD</p> <p><i>Partners:</i> OVRS; provider organizations; Brokerages; Western Oregon University.</p>



The Washington Initiative for Supported Employment (WiSe) *Employment First* Outreach Team consists of the following personnel and consultants who carried out the Oregon *Employment First* Outreach Project and contributed to this paper:

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The Oregon *Employment First* Outreach Project is a joint project of the Office of Developmental Disabilities Services (ODDS), Oregon Vocational Rehabilitation Services (OVRs), and the Oregon Council on Developmental Disabilities (OCDD). Development of this report was sponsored by the Oregon Competitive Employment Project, which is part of the Oregon State Department of Human Services, Office of Vocational Rehabilitation Services. **The project is funded through a Medicaid Infrastructure Grant from the U.S. Centers for Medicare and Medicaid Services (CFDA # 93.768).** Content of the paper reflects the opinions of the author and other WiSe Team members and includes the team's recommendations for future strategies for implementing *Employment First* in Oregon. Opinions expressed in this paper do not necessarily reflect the position of the state agencies supporting this project.

*Community Leadership for Employment First in Oregon: A Call to Action* was published by the Washington Initiative on Supported Employment (WiSe), Seattle, Washington. Copies of this manuscript may be obtained through the ODDS Employment Support website at [http://www.dhs.state.or.us/dd/supp\\_emp/](http://www.dhs.state.or.us/dd/supp_emp/), the WiSe website at [www.theinitiative.ws](http://www.theinitiative.ws) or by contacting WiSe:

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*Reference Citation:* Dean, J. E., & Coulson, C. (2010, December). *Community Leadership for Employment First in Oregon: A Call to Action*. Seattle: Washington Initiative for Supported Employment.

## Acknowledgements

The WiSe Team would like to thank Mike Maley, Manager, Community and In-Home Services; Molly Holsapple, *Employment First* Implementation; and Marilee Bell, Case Management Specialist, all from the Department of Human Services, Seniors and People with Disabilities Division, Office of Developmental Disabilities (ODDS) for their very strong commitment to and resolute leadership of *Employment First*. Their vision, active participation, and support of the project both within ODDS and in communities around Oregon have set the stage for dramatically improving employment outcomes for Oregonians with intellectual and developmental disabilities. We also appreciate the contributions of numerous other ODDS staff members who are responsible for planning for, contracting for and monitoring services and supports with counties and brokerages and who supported our work.

We also would like to thank Stephaine Parrish-Taylor, Administrator, OVRs. Stephaine has taken on the very difficult task of addressing systems within OVRs to ensure the success of *Employment First* and, with it, achieve improved employment outcomes for Oregonians with intellectual and developmental disabilities. Sara Kendall and Ann Balzell each held the position of Project Manager of the Oregon Competitive Employment Project in OVRs during the course of this project. Their willingness to allocate resources to support *Employment First* outreach activities allowed this project to reach hundreds of stakeholders in communities across Oregon. Travis Wall, OVRs Planning and Program Manager, Sandy Cooper and Joe Miller, OVRs Field Services Managers, provided their strong support as well, both within OVRs for the success of the project as a whole and by actively participating at events.

Finally, we are grateful to Bill Lynch, Director, OCDD, and other staff of OCDD for their support for this project and their ongoing commitment to improving the employment outcomes for Oregonians with intellectual and developmental disabilities.

The WiSe Team:   Cesilee Coulson  
                          Jim Corey  
                          Paula Johnson  
                          Joyce Dean  
                          December, 2010

# Community Leadership for Employment First in Oregon

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## A Call to Action



### We Believe . . .

1. Everyone can work and there is a job for everyone. Our job is to be creative and tenacious in providing support.
2. Not working should be the exception. All individuals, schools, families and businesses must raise their expectations.
3. People will be hired because of their ability not because they have a disability.
4. Communities embrace people who contribute.
5. Everyone has something to contribute and needs to contribute.
6. People are healthier, safer and happiest with meaningful work.
7. True employment is not a social service.
8. Employment is a win/win for everybody.

Created by a group of stakeholder leaders from throughout Oregon at  
the *Employment First* Policy Summit, Silver Falls Conference Center,  
September 2, 2010

## Introduction

On September 1-2 2010, over 50 stakeholders representing service providers, Community Developmental Disabilities Programs (CDDP), Support Services Brokerages, schools, the Oregon Council on Developmental Disabilities (OCDD), the Office of Vocational Rehabilitation Services (OVRS), Seniors and People with Disabilities' (SPD) Office of Developmental Disabilities Services (ODDS), statewide organizations, families/advocates and individuals with intellectual and developmental disabilities came together at Oregon's Silver Falls Conference Center for the *Employment First Summit*, the kick-off event for the *Employment First* Outreach Project. Brought together as a group of "believers," participants began the conversation that will lead to implementation of SPD's *Employment First* policy (Appendix 1) and full employment for working age adults with intellectual and developmental disabilities in Oregon. As a group, these leaders were ready to begin to struggle with the tough public policy and implementation questions that are inherent in the *Employment First* policy.

Between September and December, 2010, ODDS, OVRS, and OCDD cosponsored 14 events for a broad range of integrated employment stakeholders. Guided by a statewide Advisory Committee and entitled "*Employment First* Outreach," OVRS, after issuing a request for proposals, contracted with the Washington Initiative for Supported Employment (WiSe) to plan and lead stakeholder forums, orientations for Personal Agents from Support Services Brokerages ("Support Services Waiver") and Services Coordinators from CDDPs ("Comprehensive Waiver"), and a presentation at a statewide provider conference. At least

From the very start of the project, the team's fundamental strategy was to identify local leaders and support them to organize community efforts toward *Employment First*.

500 participants attended these events. The purpose of the events was to initiate a statewide conversation on the *Employment First* policy that would generate the initial momentum for creating an *Employment First* culture in Oregon. At these events, state personnel, team members, and local leaders provided: 1) background presentations on *Employment First*, some of which are summarized here; 2) tools to assist communities to implement *Employment First*; and 3) support to local teams to identify first steps in community action planning.

As part of the goal of generating momentum, the event staff sought to listen to the important perspectives provided by stakeholders. From the very start of the project, the team's fundamental strategy was to identify local leaders and support them to organize community efforts toward *Employment First*. Thus, the project endeavored to support local teams to engage in the goal, be passionate about it, and, after leaving the events, achieve

more than they ever believed they could do. This paper summarizes recommendations from the WiSe Team that arose based on this work.

## The Need for an *Employment First* Policy in Oregon

### The Issue

Both the *Employment First* policy and Summit came as a result of a growing level of frustration experienced by advocates and individuals with intellectual and developmental disabilities due to continuing unacceptable rates of unemployment among Oregonians with disabilities. In the 1980s, Oregon was a national leader in defining and growing supported employment. The University of Oregon's (UO) *Specialized Training Program* (now renamed *Educational and Community Supports*) conducted research and demonstration projects, published a lengthy list of articles, book chapters, books, and guides (e.g., Albin, 1992; Bellamy, Rhodes, Mank, & Albin, 1988; Buckley, Mank, and Sandow, 1990; Rhodes & Valenta, 1985); presented numerous seminars on integrated employment; presented at local, state, national and international conferences; and coordinated both the state and national technical assistance centers on supported employment. Along with universities in other states, the UO's early work led to a federal definition of supported employment in 1984 (Office of Special Education and Rehabilitative Services, 1984; 34 CFR, Part 373). Around the same time, the U.S. Department of Education began to issue a series of state systems change grants designed to support states all over the country to design statewide strategies to changeover existing sheltered employment, work activities, and day habilitation services with real jobs for real work.

In the 1980s, Oregon was a national leader in defining and growing supported employment.

During its two state systems change grants spanning eight years starting in 1986, Oregon was able to expand the number of individuals with intellectual and developmental disabilities in paid, integrated employment settings that met the federal definition of supported employment. A state report on the second quarter of 1988 reported: "About 29% of the 2,225 persons receiving employment services were working in supported employment situations" (DD Program Office, 1988, p.iii). By the end of the first state grant in 1991, which focused entirely on individuals in developmental disability services, approximately 50% of the roughly 2300 persons on the Comprehensive Services Waiver at that time were in supported employment. However, the growth in supported employment for individuals experiencing disabilities that occurred between the mid-1980's and 1990's not only stalled, but returned to pre-systems change grant levels. As of April, 2010, it is reported that of the 10,109 persons with data available, 21.4% of individuals served through either the

Comprehensive Waiver (services offering 24-hour supports) or by the Support Services Waiver (an entitlement service for individuals living on their own or with family that offers limited funding that is directed by the individuals) combined were in paid, individual or group integrated employment. Data also indicate that at that time, statewide 1635 individuals served through the Support Services Waiver and 658 youth still in school expressed the desire to gain employment in a community job.

### Oregon Results within the National Perspective

Based on data collected in FY2008 for a national study, Oregon ranked 16th of 39 states reporting on integrated employment (Butterworth, Smith, Cohen Hall, & Winsor, 2010). In this study, state agencies serving individuals with intellectual and developmental disabilities reported outcomes ranging from 4.5% to 87.5% of individuals served in integrated community jobs in FY2008. Also based on that report, 71% of Oregonians with disabilities were in facility-based programs, supporting the claim that a majority of working age adults with significant disabilities are supported today in programs that offer segregation and long-term dependency regardless of cost.

As the population receiving funded adult developmental disability employment and day services nationally has expanded to an estimated half a million persons the growth in services

Based on current Oregon data, approximately 78.8% of individuals in the Comprehensive Services system are served in "alternatives to employment" for at least part of their day, and 42% are served in sheltered, facility-based employment.

has largely been in non-work programs (Butterworth et al., 2010). This result is paralleled in Oregon. Based on current Oregon data, approximately 78.8% of individuals in the Comprehensive Services system are served in "alternatives to employment" for at least part of their day, and 42% are served in sheltered, facility-based employment. A total of 12.3% of those served by Brokerages are in sheltered employment. It is estimated that about 60% of those served through Brokerages are not in a job and are not receiving employment-related support services.

Both nationally and at a state level, there has been a huge loss of momentum from previous employment efforts. As a result, over the last 15-20 years, there has been an increase in dependency on state services and a growing acceptance of a culture of poverty for people with intellectual and developmental disabilities.

The loss of momentum for supported employment in Oregon has been due to a variety of reasons: conclusion of the federal financial support for state systems change; an unstable

budget that began with significant budget cuts based on a property tax limitation measure passed by voters in 1990 ("Measure 5"); a focus on downsizing and ultimately closing its two state residential institutions for individuals with intellectual and developmental disabilities (Fairview Hospital and Training Center was closed in 2000 and Eastern Oregon Hospital and Training Center in 2009); and the development of the Support Services Waiver Brokerage system in response to the December 2000 court settlement in *Staley v. Kitzhaber*. Concurrent with funding losses, ODDS' budget for training and technical assistance dwindled to nearly nothing as of 2006. As a state, Oregon has been very busy in several arenas, unfortunately at the cost of a loss of focus on employment. During this period, as well—including during institutional downsizing efforts—the focus was on increasing the capacity of *the service system* to serve people with disabilities rather than increasing the capacity of *natural communities* to be able to support their own.

As a state, Oregon has been very busy in several arenas, unfortunately at the cost of a loss of focus on employment.

### What is *Employment First*?

Despite the current global economic downturn, or perhaps because of it, approximately half of the states have adopted or are considering some form of *Employment First* policies. Oregon's *Employment First* policy (see Appendix 1) requires that employment in fully integrated work settings be the first and priority option explored in the service planning for working age adults with developmental disabilities. Established with a stakeholder group in 2008, the policy states that:

- Integrated employment is more valued than non-employment, segregated employment, facility-based employment, or day habilitation in terms of employment outcomes.
- Employment services shall be specifically addressed in the Individual Support Plan.
- For individuals already employed in an integrated setting, future service planning must focus on maintaining employment as well as considering additional career or advancement opportunities.
- Employment services shall be considered and provided using person-centered planning concepts, based on informed choice, and consistent with the philosophy of self-determination.
- Minimum or competitive wages and benefits shall be the goal of integrated employment.
- All natural as well as paid supports will be considered in service planning.



- Employment supports will be provided outside of the individual's living environment unless necessary for a self-employment plan or for the individual's medical or safety needs.

At the *Employment First* Outreach Project events, ODDS staff discussed the meaning of the policy and the need for:

- Supporting an individual on a path to employment to pursue a career matching the individual's interests and skills.
- Personal Agents and Service Coordinators to hold at least an annual conversation about employment with the individual and their family and/or other team members.
- The annual Individual Support Plan (ISP) to identify the individual's place on a path to employment, and to list clearly defined activities to move closer to an employment outcome or an improved outcome.
- Measuring the impact of *Employment First* at an individual level through the semi-annual review of plan, services, programs, and outcomes using information available from the Employment Outcomes System (EOS), eXPRS payment system, site visits, and other documentation.

ODDS staff presented four paths to employment at these events:

- 1) Individuals already in an integrated community job who may need support for job improvement (e.g., wages, hours or tasks) or career advancement;
- 2) Individuals who indicate, "I want a job" but are not now in one, and may reasonably achieve a job within a year;
- 3) Individuals who say, "Maybe" but don't have a clear vision about the kind of job they might have. These individuals may need to engage in a discovery process and may be on a path longer than one year.
- 4) Individuals or their guardians who indicate, "No, I don't want to work."

Staff asked Services Coordinators and Personal Agents to review their caseloads to select five to ten individuals who are on one of the first three paths and focus on getting them a plan that will lead to employment or improved employment. As a sign of their agency's commitment, ODDS has told the governor the state will achieve an increase of at least 5% each year in integrated employment. Although

As a sign of their agency's commitment, ODDS has told the governor the state will achieve an increase of at least 5% each year in integrated employment. Although the *Employment First* policy is not yet supported by Administrative Rule or other state infrastructure, ODDS was clear at the events that implementing the policy is now an expectation.



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### Why *Employment First*?

The *Employment First* policy is grounded in a framework of Oregon Revised Statutes and Oregon Administrative Rules which identify increased productivity, integration, and independence as the desired outcomes of services and supports for adults with developmental disabilities. The policy also is in alignment with the stated goals of the Oregon Department of Human Services:

- People are healthy
- People are living as independently as possible
- People are safe
- People are able to support themselves and their families<sup>1</sup>.

These goals emphasize the importance of being a part of the workforce, contributing to the economy, and becoming as self-sufficient as possible. Services Coordinators, Personal Agents, families and service providers together try to plan for and provide supports to individuals with intellectual and developmental disabilities to help them achieve these goals and a meaningful and purposeful life.

Behind the *Employment First* policy is a fundamental belief that employment is the key to full citizenship.

Behind the *Employment First* policy is a fundamental belief that employment is the key to full citizenship. A job can dramatically change the dynamics of an individual's life—providing a structure to the day, a paycheck that can be used for purchasing goods and services, an identity as a contributing member of the community, an increase in personal self-esteem, expanded choices, and opportunities to develop

friends and relationships. In short, employment is an avenue to a richer and fuller life. Employment is a key to becoming a valued member of our society. It is the position of ODDS and the *Employment First* Outreach Project that all people with intellectual and developmental disabilities should be provided the opportunity to work and gain these benefits; to not live in the shadow as marginalized citizens, but to be embraced fully by their community.

<sup>1</sup> Drawn from <http://www.oregon.gov/DHS/aboutdhs/mission.shtml> on December 21, 2010.

The service system, however, cannot use public funds to help people buy a valued lifestyle. The responsibility of the system is to support the conditions by which a valued lifestyle can be achieved. Supporting working age adults with intellectual and developmental disabilities to get and maintain meaningful work is Oregon's key strategy for achieving this goal.

Everyone has the right to work, as confirmed by the United Nations Universal Declaration of Human Rights in 1948<sup>2</sup>. As early as 1986, self-advocates in Oregon's *People First* movement developed a Bill of Rights that included:

- We have the right to a job in the community.
- We want to work regardless of productivity.
- We have the right to be respected on the job.
- We do not want to live in poverty.
- We want to work for fair wages.

Despite these statements, developed 25 years ago, people with disabilities as a class are impoverished. The *Employment First* policy seeks to address this issue. The policy is rooted in the belief that meaningful employment for working age adults plays a major role in maximizing personal choices, achieving economic self-sufficiency, and contributing to the sustainability of our communities.

### Why *Employment First* Now?

Beyond values-based reasons for *Employment First*, research data show that the cumulative costs generated by sheltered employees may be as much as three times higher than the cumulative costs generated by supported employees—\$19,388 versus \$6,618 (Cimera, 2008). Even in good economic times, it is the responsibility of public services to be good stewards of public funds. Thus, a shift from sheltered employment to support for integrated employment makes good sense from the perspective of public funding.

Over the last two years, Oregon, along with other states, has been affected dramatically by a global economic downturn. High unemployment rates have reduced taxes paid to the state resulting in substantial budget cuts or elimination of service programs. States are struggling with maintaining

With public sentiment shouting "cut taxes" growing across the country, it is clear that the balance of personal versus public responsibility for needed supports is shifting.

<sup>2</sup> United Nations General Assembly, December 10, 1948, [General Assembly resolution 217 A \(III\)](http://daccess-dds-ny.un.org/doc/RESOLUTION/GEN/NR0/043/88/IMG/NR004388.pdf?OpenElement), Article 23. <http://daccess-dds-ny.un.org/doc/RESOLUTION/GEN/NR0/043/88/IMG/NR004388.pdf?OpenElement>

necessary supports for vulnerable individuals with disabilities (Hoff, Holsapple, Lizotte, & Moseley, 2009).

With public sentiment shouting "cut taxes" growing across the country, it is clear that the balance of personal versus public responsibility for needed supports is shifting. Families and individuals with intellectual and developmental disabilities can no longer depend on state funds to support their choices. As funding for programs decreases, states across the country are having to make difficult decisions regarding how to allocate their reduced budgets. In Oregon, for example, ODDS has had to eliminate its rent subsidy program, which assisted individuals to live in a home of their choosing. Now, if individuals want to live on their own, they and their teams will likely need to figure out the money to do that. The locus of responsibility has shifted. Taxpayers expect that individuals with disabilities will be able to fund their own supports to some extent. One way that can happen is by helping them to have jobs.

We can expect that, over time, the economy will improve. As the economy recovers, we can anticipate that the first jobs will grow in the private sector. As that occurs, it is important that our service system is supporting adults with intellectual and developmental disabilities to be in the front of the line for those jobs, to take advantage of the economic recovery.

Beyond the economy, funding, and federal grants, however, if we believe employment is a fundamental human right and is a key to full citizenship, we must ask, "If not now, when?"

Now also is a critical time because extra resources are available in the state to support implementation of *Employment First*, through the Medicaid Infrastructure Grant on competitive employment held by OVRs. That project has already funded a substantial portion of the first phase of the *Employment First* Outreach Project and is expected to fund its second phase as well. However, no funds have been identified to continue to provide technical assistance, training, and other support to *Employment First* implementation after that federal grant project ends.

Beyond the economy, funding, and federal grants, however, if we believe employment is a fundamental human right and is a key to full citizenship, we must ask, "If not now, when?"

## A Call to Action: Strategic Recommendations for Making *Employment First* a Reality

Oregon cannot rely on increased federal or state funding to support implementing *Employment First*. Instead, both the involved state agencies and community stakeholders will need to find ways to shift resources and energy to support growth of this initiative at the community level. To that end, the WiSe *Employment First* Outreach Team has developed a set of recommendations that build on Stevely's 2005 paper on supported employment, but are grounded in our belief that the best hope for the future of *Employment First* lies in Oregon's communities and neighborhoods. The team's fundamental strategy continues to be to identify and support local leaders who will organize community efforts around *Employment First*, be zealous advocates for it, and find ways to engage other community stakeholders to make *Employment First* a reality for all working age Oregonians with intellectual and developmental disabilities.

The WiSe Team's recommendations listed below are organized under four major goals that together will support full implementation of *Employment First*:

- The Statewide Infrastructure is in Alignment with and Promotes *Employment First*
- Communities Have the Capacity to Implement *Employment First*
- Individuals with Disabilities and their Family Members Promote *Employment First*
- Communities Implement *Employment First*

### Goal: The Statewide Infrastructure is in Alignment with and Promotes *Employment First*

While implementation of this policy must grow one person at a time, state agencies have both a critical voice that must be heard and the power to restructure state infrastructures to promote *Employment First*.

- ***Provide consistent and strong state leadership toward a common vision for employment for all persons with intellectual and developmental disabilities.*** State leadership will be critical as this initiative proceeds. Communicating this vision clearly across time will help all stakeholders to work in alignment, improving the effectiveness of individual and group actions. After focusing on growing supported employment for several years during the 1980s and 1990s, ODDS turned its attention to other priorities, leading communities to focus elsewhere as well. This cannot happen again, as many stakeholders already view this initiative with an attitude of "this, too, shall pass." Further, this state leadership must be visible at the highest levels of ODDS, OVRS, ODE and OCDD,

as champions for employment, as well as from staff at all levels, demonstrating collaboration across these state agency silos.

- **Develop a definition of "integrated employment."** ODDS has long used a definition of employment that recognizes group models (i.e., mobile crews and enclaves), pay based on subminimum wages, and jobs that are arranged as a contract from the business to the rehabilitation organization. But typical jobs are established for individuals to fill, pay in most businesses for regular employees is at least at minimum wage, and temp agencies are usually the only other community organizations that contract with employers for filling jobs. It is time that ODDS challenge communities to employ Oregonians with intellectual and developmental disabilities in jobs that place these individuals with typical co-workers rather than in groups of people with disabilities, that pay a living wage, and in which they are employed directly by the community business. Other arrangements promote a commitment by the business to the rehabilitation organization over the individuals employed and perpetuate poverty for Oregonians with disabilities. Some of these arrangements may be appropriate interim activities on the path to employment, but they are no longer the goal of employment services. It is important to set the standard for people with disabilities as the same as for everyone else, if we are to transform the experience of Oregonians with disabilities and their communities. Changing the definition of integrated employment to accepting only individual jobs likely will reduce the current reported "success rate" from 21.4% to less than 7%, but presents a vision that supports real lives in real jobs and true community membership.
- **Assure that everyone who receives state funding for services—whether they are funded through the Comprehensive or Support Services Waiver—has an allocation that is dedicated to supports for gaining, maintaining, or improving employment outcomes.** Currently, Support Services funds may be used within any of 15 different types of services defined in the waiver. Under the Comprehensive Waiver, individuals receiving funds identified as "DD54" for employment services may be used for ongoing alternatives to employment, i.e., non-work services, rather than to gain or maintain employment. An allocation dedicated to employment support would give individuals and their

It is time that ODDS challenge communities to employ Oregonians with intellectual and developmental disabilities in jobs that place these individuals with typical co-workers rather than in groups of people with disabilities, that pay a living wage, and in which they are employed directly by the community business.

teams resources to move along a path to obtain and maintain employment. For example, these funds could be used for job exploration, job development, job support, or even to address needs like establishing a communication system. Individuals and their teams would have a choice to either use the employment support allocation or not use it, if they choose not to pursue employment. However, dedicating the funding for paths to employment clarifies the state's position on the primacy of team conversations on *Employment First* and aligns funding in both sides of the service system with state policy.

- **By the end of 2011, implement a funding model that prioritizes and rewards quality employment outcomes.** Integrated employment providers are frustrated with the existing funding model that does not recognize the very different nature of developing and supporting individualized community-integrated jobs as compared with alternatives to employment or facility-based work services. While the ODDS Restructuring Budgets and Rates (ReBAR) Program has completed substantial work toward designing a new funding model for the Comprehensive Services system, no employment services rate model has yet been implemented. This must be a priority. Shifting the funding model now will give a clear message to communities about ODDS' view of the immediacy of the need for *Employment First* implementation.
- **Update state policy and administrative rules.** Policy and rules related to employment on both sides of the service system require substantial change to be in alignment with the values of *Employment First* to increase motivation of providers to embrace the policy. As a result of the revised rules, licensing must adjust to the new direction and learn how to assess provider systems for health and safety support in

"One does not have the ability under the law to choose anything one wishes. Some options are excluded or forbidden, either in the interest of the community's overall welfare or as a result of governmental authority to set priorities and allocate its resources." (Ferleger, 1995)

community businesses without interfering with business operations or bringing "social services" into natural settings. ODDS, OVRs, and the Oregon Department of Education (ODE) also must consider their position on the future of sheltered workshops and alternatives to employment, and the degree to which those agencies will support ongoing placements in these programs. Because these services rely on public funding, the formal system may choose which options may be offered. As David Ferleger (1995) states in an excellent chapter exploring choice, "One does not have the ability under the law to choose anything one wishes.



Some options are excluded or forbidden, either in the interest of the community's overall welfare or as a result of governmental authority to set priorities and allocate its resources."

- **Define a new service that provides for the discovery process and employment-related day activities.** Sheltered workshops and alternatives to employment, although a part of the history of day services in Oregon and elsewhere, need to transform and retool into services that support and focus on the paths to employment and economic self-sufficiency. Identifying how congregate facilities and day activities may be used under the new system, as well as renaming, redefining, and rebranding this service will help communities to achieve the transformation. ODDS may choose to address this recommendation by involving key stakeholders to work collaboratively to design and develop the new service and its implementation plan.
- **Ensure that employment is promoted in the ISP system.** As currently implemented, ISPs focus on residential supports, health and safety in the Comprehensive system, and on self-determination and choice in the Support Services system. ISP teams need both tools and support to strengthen the employment focus of this system. Tools for assessing an individual's employment possibilities, strategies for gaining work experience, and a format that insists on planning for *Employment First* are needed to help Services Coordinators, Personal Agents, and ISP teams to become expert at helping individuals to get and maintain meaningful employment in integrated settings.
- **Develop agreements between ODDS and ODE's Special Education Unit.** These agreements must address strategies for imbedding the expectation for work from an early age, improving the process and outcomes of transition services, and establishing relationships in local communities. Schools are an important part of the equation for success and they will need leadership from ODE to shift what they are doing to work in alignment with *Employment First*. Changing the experience and expectations of youth (and their families) who are entering the adult service system may be the state's best hope for large-scale system transformation.

Changing the experience and expectations of youth (and their families) who are entering the adult service system may be the state's best hope for large-scale system transformation.

- ***Continue work between ODDS and OVRS.*** ODDS and OVRS are already working together to improve the statewide consistency, availability, and effectiveness of OVRS services for persons with intellectual and developmental disabilities, increase the compatibility of OVRS services with services funded through ODDS, and clarify/streamline interagency procedures. This work must continue so that all Oregonians with intellectual and developmental disabilities experience effective supports through both of these agencies.
- ***Collect, publish, and use performance data at a statewide, county and provider level.*** It is often said that people will do what is measured. While ODDS has collected data since at least the late 1980s from the Comprehensive Services side, it has not taken advantage of the full power of the data system. The recent addition of an employment outcomes measurement system for Brokerages and compiling and reporting regional-level data for both systems are excellent first steps. In addition, ODDS should: 1) Review both the Comprehensive and Support System measures to verify that the right things are being collected that will support evaluating progress at multiple levels; 2) Take steps to ensure that the data reported are valid (actually measure what is meant to be measured) and reliable (accurate across time or across reporters); 3) Compile and publicly report performance information at the county and provider levels in addition to current state- and regional-level reports; 4) Increase to quarterly the frequency of collecting and reporting data to make data more useful; 5) Present data across time, within a context, so that reports can be most informative; and 6) Use the data for decision-making at state, regional, county, Brokerage and provider organization levels. An improved information system can be a powerful tool for both current and emerging leaders at both local and state levels.
 

An improved information system can be a powerful tool for both current and emerging leaders at both local and state levels.
- ***Establish statewide public and private sector employer initiatives, including working with the Oregon Business Development Department ("Business Oregon").*** At the state level, ODDS is able to promote public policy that encourages the public sector as well as the private sector to employ people with developmental disabilities. Governmental jurisdictions in other states have issued policy orders asking state, county or city agencies to hire a target percentage of individuals with disabilities. ODDS also can work with the state's Business Development Department to support private sector employer development, e.g., through developing relationships with large private employers with multiple locations seeking their



support for *Employment First* throughout their companies or by bringing together an employer leadership group to guide *Employment First* efforts with employers.

### **Goal: Communities Have the Capacity to Implement *Employment First***

Central to full implementation of *Employment First* will be finding ways to support communities to build their capacity to implement the policy.

- ***Develop emerging leaders for the future.*** As current state and local leadership approaches (and passes) retirement age, it is critical that Oregon invest in supporting emerging leaders to share in conversations, offer ideas, take risks, lead by example, and to continue learning. These bright, energetic and committed young professionals and parents bring great hope for the future if we can support them to do that.
- ***Find ways to support high quality employment-focused training and technical assistance.*** To make employment a reality for all who desire it, ODDS must make training and technical assistance available and functioning as part of the delivery of employment services. Technical assistance and training are necessary to improve community-level skills for: 1) developing jobs based on individual interests and skills, 2) providing training and support to both employers and individuals supported in jobs, and 3) developing natural supports. If ODDS establishes a new definition of employment, as described above, it will need to help communities and service providers to transition to achieving it.

Over the last two decades, service providers have lost touch with systematic training skills and best practice strategies for engaging employers and their employees. The current model for job development approved by OVRS, for example, uses traditional techniques, and while these may be appropriate for some individuals, a more person-centered approach is needed to gain employment for all working age adults with intellectual and developmental disabilities. ODDS needs to seek resources for supporting continued training and technical assistance that promotes best practices, including regional training, on-site technical assistance, and annual statewide *Employment First* conferences. However, whether or not state general funds are available for training and technical assistance, ODDS and OVRS should be able to research and make available information on best practices; coordinate with training and technical assistance providers to ensure effective training programs are available across the state with the support of a mixture of funding from ODDS and/or other sources; and target bringing together stakeholders such as Vocational Rehabilitation (VR) counselors, schools personnel, rehabilitation providers, Brokerage and CDDP

staff, individuals and family members in joint events to support common vision and skills, as well as relationship development.

- ***Find a way to invest in ongoing research, development and innovation.*** Oregon was a leader of supported employment and can again lead the national *Employment First* movement. However, there is still much to be learned. Supporting research, development and innovation by establishing collaborations with university-based research programs and training and technical assistance providers to develop innovations that can be disseminated to communities will breathe life into *Employment First*, discovering ways to solve the most difficult implementation issues and to improve the quality of employment outcomes achieved.
- ***Expand the use of technology to support the message of Employment First.*** Given the limited resources available, current technologies offer a great resource for promoting *Employment First*. The Employment Support website replete with resources and links, communications/marketing software for managing frequent mass communications with stakeholders, use of social networking sites such as Facebook and Twitter, regular teleconferences for discussing issues and successful strategies, on-line courses, and interactive video-conferencing, for example, all offer low-cost avenues for keeping the message alive all over Oregon.

### **Goal: Individuals with Disabilities and their Family Members Promote Employment First**

State agencies, state associations, and local organizations will need to play a role in helping individuals and families to fully participate in *Employment First*. OVRs, ODDS, and OCDD each have an important role, along with local schools, Services Coordinators, Personal Agents, integrated employment providers, and rehabilitation programs. Certainly, Self-Advocates as Leaders (SAAL), People First, The Arc, and Oregon Parent Training and Information should hold an important role in achieving this goal.

- ***Provide training and support to self-advocates and family members to elevate their voice in the state conversation about Employment First.*** Training should help family members and self-advocates understand and advocate for access to integrated employment, as well as address fears related to employment in an integrated job in a typical community business. Self-advocates must have the ability to advocate for their own employment within their ISPs. Self-advocates, family members, and others also should learn about *Employment First* so they can provide leadership both within their communities and in state and local forums,

including the legislature or state conferences. VR counselors, adult service providers, Services Coordinators, and Personal Agents will be driven by demand that can only be created by individuals and their families.

- **Help individuals, family members, and representative payees to complete benefits planning related to employment.** Work incentives are complex and

While *Employment First* success will require the support of a statewide infrastructure, the real work of this initiative must be done locally, community by community, recognizing the unique perspectives that vary by locality and with differing ethnic and minority groups.

vary by the type of income support received by individuals. Probably the best strategy will be to ensure that individuals, families and representative payees access the Work Incentives Network (WIN) so that they understand the work incentives available to them, how to avoid or deal with an overpayment, and overcome existing fears and myths about employment. Achieving this will require that Oregon has good benefits planning available beyond the life of the Medicaid Infrastructure Grant. Advocates at state and local levels must, therefore, support the OVRs legislative initiative to assure WIN's continuation.

### **Goal: Communities Implement *Employment First***

While *Employment First* success will require the support of a statewide infrastructure, the real work of this initiative must be done locally, community by community, recognizing the unique perspectives that vary by locality and with differing ethnic and minority groups. Without additional funding—and likely with further cuts to existing funding before the end of this economic downturn—communities must assume responsibility for changing the way they think about what is an appropriate outcome for adults with intellectual and developmental disabilities who are supported with public funding, and the methods they use to achieve those outcomes. Therefore, the following recommendations are directed to community stakeholders, as well as to state leadership.

- **Believe in *Employment First*.** Achieving this change will require that state and local leaders firmly believe in the *Employment First* policy, in the right of people with disabilities to work, and in the ability of people with disabilities to work. The belief is fundamental. As Margaret Wheatley

Advocates at state and local levels must, therefore, support the OVRs legislative initiative to assure WIN's continuation.

states, "There is no power for change greater than a community discovering what it cares about."<sup>3</sup>

- **Build and support leadership within communities to promote**

**Employment First.** The *Employment First* Outreach Project worked to establish regional leadership for this initiative, including inviting regional leadership teams representing a variety of

One of the most effective strategies to begin the effort is simply to talk about it.

stakeholders to the Silver Falls *Employment First* Summit. While understanding that local leadership is critical, the project quickly learned through the forums and orientations that in most cases, "region" was not a viable geographic unit for leadership teams. As the project continued, we encouraged participants to sit together in community-level groups for joint planning activities at these events. We left "community" to be defined by participants—whatever geographic area or subgroup that just made sense. Although working at a more local level, the communities still need a leadership group that helps to: 1) communicate the state's vision, 2) recruit stakeholders to participate, 3) share best practices, 4) promote collaboration across agencies, and 5) coordinate community activities based on an informal plan for "what it will take" locally to expand *Employment First*. These leadership teams will need some level of support and communication—website, video and teleconferences, and even face-to-face forums and conferences—to maintain their momentum and share information on successful strategies.

- **Hold conversations about Employment First.** Changing the experience of individuals with intellectual and developmental disabilities to include employment will require a substantial cultural and attitudinal shift across the state. One of the most effective strategies to begin the effort is simply to talk about it. "Believers" must talk about *Employment First* in staff meetings, in meetings with other organizations, at ISP meetings, in community meetings, with schools, with employers, with staff, with family members, and with individuals. These conversations must include talking about success stories, about the dream, and about how communities can work together to achieve the dream. Services Coordinators and Personal Agents sit in a vital position to hold conversations with individuals and families to support their shift to expecting to work. They must act as strong advocates for *Employment First*, even in uncomfortable situations.

<sup>3</sup> Drawn from: <http://www.thecommunitycafe.com/> on December 21, 2010

- **Build relationships with media, community leadership, and others who can help to build a public awareness of the capacity of people with intellectual and developmental disabilities to work and contribute to their communities.** Those involved with *Employment First* must use a planful, strategic approach to public messaging about people with disabilities. Relationships are needed at the national, state and local levels that ensure that opinion leaders,

All children should be asked, "What do you want to be when you grow up?" so that at an early age they begin to develop the expectation to work.

print, and electronic media portray positive images of people with disabilities, so individuals and their families can see people like them successfully working and participating as contributing citizens, and so the general community can as well. Oregon must take full advantage of national programs such as "Think Beyond the Label," but take state and local action as well.

- **Expand and improve local relationships with schools, Educational Service Districts, and OVRs to work together as a team for Employment First.** All children should be asked, "What do you want to be when you grow up?" so that at an early age they begin to develop the expectation to work. In most communities, schools could improve by adopting integrated employment as a goal for all students, including students with disabilities in typical places and routines of the school, and advancing inclusion within their communities. By establishing effective programming that assists students to be successful at home, in the community, and at workplaces, schools can ensure a successful transition to adult services. OVRs transition-focused projects need to expand and include all students with intellectual and developmental disabilities. Expanded relationships between the adult systems and schools can support these shifts.
- **Ensure that individuals have relevant preparation for work.** This will require that individuals have opportunities for work exploration to identify preferences for future jobs; develop personal networks and social skills that will support job finding and success at work; and be included in their communities in many different ways. This will require most schools and adult service providers, including those providing alternatives to employment, to retool to ensure that at all times what they do is relevant to supporting community inclusion and employment.
- **Restructure local relationships around collaboration rather than competition.** One challenge faced by *Employment First* is that it must rely on existing relationships, as well as new ones. Unfortunately, in some communities, service

providers compete with each other rather than cooperate, and in some cases even draw boundaries around employers that they "own."

"Collaboration" is a well-worn term. However, it reflects a level of working together that goes well beyond coordination and cooperation among stakeholders. According to Pollard (2005) the following features are critical to collaborative partnerships:

" Collaboration entails finding the right group of people (skills, personalities, knowledge, work-styles, and chemistry), ensuring they share commitment to the collaboration task at hand, and providing them with an environment, tools, knowledge, training, process and facilitation to ensure they work together effectively."

(Pollard, 2005, p.1)

For true local collaborations, according to Pollard, as opposed to lower-level partnership models (i.e., coordination or cooperation), *Employment First* must bring together at the community level:

1. Partners with a history of working in cooperative and collaborative projects.
2. Partners whose purpose is to achieve collective results in complex environments and systems that they understand would not be possible by working alone.
3. Partners who work in alignment around a common vision, core values, and shared goals, objectives and plans. Through a dynamic process to articulate their shared vision, values and goals, they can build on mutual trust and respect and practice sharing open communication.
4. Partners who agree to work interdependently in designing and carrying out the work plan.
5. Partners who bring diverse but complementary skills and knowledge to the project and are able to work together.
6. Powerful leadership to ensure the partners stay focused and work together most effectively.
7. Partners with a sense of urgency and commitment about achieving the vision of *Employment First*.
8. Partners who are committed to achieving the desired outcome efficiently, realizing savings in time and cost, while seeking innovative, extraordinary, breakthrough results, and collective "we did that!" accomplishment.
9. Partners who understand that there must be individual latitude in carrying out the agreed-upon design, because the implementation work is necessarily more improvisational than highly structured.



- **Build and use personal networks to support Employment First.** One very successful job-finding strategy is to use personal networks. Often a job may be found through the serendipity of talking with one person who talks with another who knows about a job opening. People with intellectual and developmental disabilities can find jobs in the same way. Communities must work to build the personal networks of people with disabilities and explore the networks of their family members and friends, as well as those of program staff. Someone in those networks will be able to help support *Employment First*. Everyone is a job developer.

Communities must work to build the personal networks of people with disabilities and explore the networks of their family members and friends, as well as those of program staff.

- **Change the language used around non-work programs.** At one of the events, participants indicated that when an individual attends a non-work alternative to employment program, both residential and program staff refer to it as "going to work." This is a great disservice to individuals with intellectual and developmental disabilities—confusing them about the difference between non-work activities and real work. Conversations about *Employment First* will be more meaningful to individuals and their families if "work" is reserved to mean "real work" and other activities are called what they really are.
- **Develop relationships with employers based on the benefits to businesses of hiring people with disabilities.** Videos available through the Oregon *Employment First* Outreach Project document business people from around the Northwest describing why hiring people with disabilities makes good business sense. We need to include employers in discussions as we look for ways to expand employment opportunities, as they know their businesses—and other businesses in the community—very well.

## Challenges

The *Employment First* policy will face many challenges over the next few years. Some of the most critical of these—those to which all involved state agencies and local leaders must pay attention—are reflected here.

**Opposition to Employment First.** The *Employment First* Outreach Project purposely began by bringing together "believers." As Oregon implements this initiative in communities across the state, those who oppose the change for any of a variety of reasons will come forward, impeding progress at both the local and state levels. However, addressing opposition is not the first priority. The project team continues to sense that working with

With limited resources and energy, our first work should continue to be focused on stakeholders who believe, and on individuals with disabilities who think they want to go to work.

believers is where our work both at the state and local levels should continue. With limited resources and energy, our first work should continue to be focused on stakeholders who believe, and on individuals with disabilities who think they want to go to work. Addressing naysayers now will diminish the project's ability to make change. Working with believers first will help Oregon to reach a "tipping point" where the *Employment First* movement will gain momentum of its own.

Despite this stand, ODDS will need to address Brokerages and CDDPs that did not send representatives to the project forums and orientations. Because Services Coordinators and Personal Agents play such a critical role in planning and supporting individuals to achieve positive futures, their participation in *Employment First* is vital.

Budget cuts that already have been implemented with more to come over at least the next two to four years will severely test both state and local commitment to *Employment First*. Helping communities and service providers to view *Employment First* as an opportunity, rather than a demand, is an important challenge that needs to be addressed by this initiative.

**The culture around employment.** Oregon has allowed employment to ebb for over a decade. With less than 25% of Oregonians with disabilities working in integrated jobs, employment has faded from the statewide—and local—conversation. Now, however, Oregon needs to create a culture of employment in the developmental disability services system so everyone expects they will go to work. A significant piece of creating that culture will be to get people to believe in the purpose,

At multiple levels, Oregon needs to change the perception that employment is an option for persons with intellectual and developmental disabilities to an understanding that employment is an expectation.



function, outcome *and possibility* of employment. *Employment First* is about raising expectations of all stakeholders that people, regardless of their barriers to employment, must be given an opportunity to work. At multiple levels, Oregon needs to change the perception that employment is an option for persons with intellectual and developmental disabilities to an understanding that employment is an expectation.

**Self-determination and choice.** An unexpected challenge within the developmental disabilities system will be to address the issue of choice and integrated employment. As the Brokerage system and person-centered planning have grown in Oregon, self-determination and choice have led service planning within the constraints of waiver-approved services. Over time, "self-determination" has been interpreted to mean "nearly anything you want." However, in reality, all choices have boundaries. The issue for *Employment First* is to determine what are reasonable boundaries and how will they be identified and described. Choice must reflect ongoing trade-offs that yield a balance between what is important to and important for each individual. In addition, informed choice requires that individuals have an opportunity to explore and have experience with different options to develop preferences. It is not sufficient to say "Fred doesn't want to work" if Fred has never experienced work that matches his interests outside of a sheltered setting, or if Fred's only understanding of the word "work" is attending an alternatives to employment program. As *Employment First* unfolds, both state and local stakeholders will need to be clear about how to negotiate the many sides of choice. (See, for example, Smull, 1995; Ferleger, 1995; Callahan & Mank, 1998.)

As *Employment First* unfolds, both state and local stakeholders will need to be clear about how to negotiate the many sides of choice.

**OVRs ability to partner in *Employment First*.** OVRs also faces significant challenges to: 1) adjust their systems and procedures (including the approved job development model) to better serve people with intellectual and developmental disabilities; 2) improve the skills of VR counselors related to working with people with intellectual and developmental disabilities; and 3) make sure that individuals with individual and developmental disabilities are welcomed by and receive equal access to and support from all OVRs offices, consistently, across the state.

**Existing roles and relationships within communities.** Because *Employment First* must grow as a grassroots movement, existing relationships among service providers, between service providers and employers, and among all stakeholders must shift. There is great inertia associated with "how we have done things in the past" and maintaining momentum

for change will require forming new or improving partnerships, and overcoming the inertia of what is.

***Learning to support organizing by local communities while providing needed training and technical assistance on best practices for developing integrated employment.*** Traditional training and technical assistance roles center on increasing the capacity and skills of the formal service system.

However, *Employment First* implementation must proceed even as federal and state funding for services shrinks. The local nature of this effort calls for future projects designed to support *Employment First* implementation maintaining a careful balance between being welcoming to diverse strategies and opinions of local community stakeholders and promoting best practices. In addition, these projects also must build on the strengths of businesses and communities to expand capacity beyond the formal service system, for it is through their efforts that *Employment First* will achieve its dream.

The local nature of this effort calls for future projects designed to support *Employment First* implementation maintaining a careful balance between being welcoming to diverse strategies and opinions of local community stakeholders and promoting best practices.

## Closing

Making the change to integrated employment with diminishing funding, and at first, with a state infrastructure—including a funding system, administrative rules, definitions, and

In the very least, the *Employment First* initiative must create a culture of possibility, supporting local leaders full of tenacity, persistence, and joy about the possibility of *Employment First*.

licensing, for example—that does not value integrated individual jobs over group or facility-based sheltered employment or alternatives to employment presents a formidable mountain to climb. Issues at the community level about relationships, skills, focus, and fears also present tremendous barriers. It is critical that *Employment First*, while acknowledging barriers, not become mired in addressing barriers, but rather be opportunistic in growing *Employment First*. The limited resource and energy available for *Employment First* could be quickly overtaxed if the strategy were to address identified barriers. Instead, stakeholders at all levels need to find strengths, build on them, and move forward.

We also need to understand that moving forward with *Employment First* is largely about business development, economic self-sufficiency for individuals with intellectual and developmental disabilities, and maximizing the independence of individuals while minimizing their reliance on the social services system.

The tasks are not easy. In the very least, the *Employment First* initiative must create a culture of possibility, supporting local leaders full of tenacity, persistence, and joy about the possibility of *Employment First*. *Employment First* is very much like the effort launched four decades ago to go to the moon. In a 1962 speech, President John F. Kennedy spoke eloquently of the reasons for taking on such an unbelievable goal at that time and the challenges in achieving it. (See Appendix 2 for the full text of the speech.) His references to both the place where he spoke (Rice University in Houston, Texas) and the vision for space exploration for which he provided powerful leadership serve as apt analogies for Oregon and for the vision for *Employment First*.

We meet at a college noted for knowledge, in a city noted for progress, in a State noted for strength, and we stand in need of all three, for we meet in an hour of change and challenge, in a decade of hope and fear, in an age of both knowledge and ignorance. The greater our knowledge increases, the greater our ignorance unfolds...

So it is not surprising that some would have us stay where we are a little longer to rest, to wait. But this city of Houston, this State of Texas, this country of the United States was not built by those who waited and rested and wished to look behind them. This country was conquered by those who moved forward--and so will space.

William Bradford, speaking in 1630 of the founding of the Plymouth Bay Colony, said that all great and honorable actions are accompanied with great difficulties, and both must be enterprised and overcome with answerable courage... We set sail on this new sea because there is new

"We choose to go to the moon. We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win..."  
(John F. Kennedy, September 12, 1962)

knowledge to be gained, and new rights to be won, and they must be won and used for the progress of all people...

But why, some say, the moon? Why choose this as our goal? And they may well ask why climb the highest mountain? Why, 35 years ago, fly the Atlantic? Why does Rice play Texas?

We choose to go to the moon. We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win...<sup>4</sup>

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<sup>4</sup> Drawn from: <http://er.jsc.nasa.gov/seh/ricetalk.htm> on December 21, 2010.

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## Appendices

1. *Employment First Policy* (2008)
2. John F. Kennedy Moon Speech - Rice Stadium, September 12, 1962: Full text.

## Appendix 1

### Office of Developmental Disability Services State Policy on: Employment for Working Age Individuals (9-18-08)

#### Policy Framework

1. Oregon Revised Statutes identify increased productivity, integration and independence as the desired outcomes resulting from provision of services and supports for adults with developmental disabilities.
2. The Oregon Department of Human Services, in order to implement its mission, has several stated goals. Among the goals are:
  - a. People are living as independently as possible; and
  - b. People are able to support themselves and their families.
3. It is important for Oregon that working age adults, including individuals with developmental disabilities:
  - a. Contribute to our economy;
  - b. Become part of our workforce; and
  - c. Become as self-sufficient as possible.
4. Individuals with developmental disabilities have a right to the opportunity for meaningful work and:
  - a. A vast majority want to pursue employment opportunities; and
  - b. Meaningful work can be accomplished regardless of disability; and
  - c. Partnerships, vision, and creativity are necessary to overcome perceived or real barriers to employment.
5. The benefits of meaningful work have significance and importance to all working age adults, including individuals with developmental disabilities. Benefits include the:
  - a. Ability to earn and keep meaningful wages;
  - b. Development and expansion of relationships;
  - c. Identity as a contributing member to one's community;
  - d. Increase in personal self-esteem; and
  - e. Pursuit of desired lifestyles.

## Policy Statement

In order to achieve the intent outlined in the framework of this policy, employment opportunities in fully integrated work settings shall be the first and priority option explored in the service planning for working age adults with developmental disabilities. While all options are important and valued, integrated employment is more valued than non-employment, segregated employment, facility-based employment, or day habilitation in terms of employment outcomes for individuals with developmental disabilities.

For those who successfully achieve the goal of employment in an integrated setting, future service planning must focus on maintaining employment as well as the consideration of additional career or advancement opportunities. For those not yet achieving employment, annual service planning must include and reflect employment opportunities as the first and priority service explored.

## Key Procedures and Principles

Implementation of this policy shall be based on the following procedures and principles:

1. Employment services shall be specifically addressed in the Individual Support Plan
2. Employment services shall be considered and provided using person-centered planning concepts, based on informed choice, and consistent with the philosophy of self-determination;
3. Minimum or competitive wages and benefits shall be the goal of integrated employment;
4. All natural as well as paid supports will be considered in service planning; and
5. Employment supports will be provided outside of the individual's living environment unless necessary for a self-employment plan or for the individual's medical or safety needs.

This policy statement will be accompanied by a more thorough implementation statement that further details definitions, desired outcomes, and operational procedures.



## Appendix 2

### John F. Kennedy Moon Speech - Rice Stadium



September 12, 1962

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#### TEXT OF PRESIDENT JOHN KENNEDY'S RICE STADIUM MOON SPEECH

President Pitzer, Mr. Vice President, Governor, Congressman Thomas, Senator Wiley, and Congressman Miller, Mr. Webb, Mr. Bell, scientists, distinguished guests, and ladies and gentlemen:

I appreciate your president having made me an honorary visiting professor, and I will assure you that my first lecture will be very brief.

I am delighted to be here, and I'm particularly delighted to be here on this occasion.

We meet at a college noted for knowledge, in a city noted for progress, in a State noted for strength, and we stand in need of all three, for we meet in an hour of change and challenge, in a decade of hope and fear, in an age of both knowledge and ignorance. The greater our knowledge increases, the greater our ignorance unfolds.

Despite the striking fact that most of the scientists that the world has ever known are alive and working today, despite the fact that this Nation's own scientific manpower is doubling every 12 years in a rate of growth more than three times that of our population as a whole, despite that, the vast stretches of the unknown and the unanswered and the unfinished still far outstrip our collective comprehension.

No man can fully grasp how far and how fast we have come, but condense, if you will, the 50,000 years of man's recorded history in a time span of but a half-century. Stated in these terms, we know very little about the first 40 years, except at the end of them advanced man had learned to use the skins of animals to cover them. Then about 10 years ago, under this standard, man emerged from his caves to construct other kinds of shelter. Only five years ago man learned to write and use a cart with wheels. Christianity began less than two years ago. The printing press came this year, and then less than two months ago, during this whole 50-year span of human history, the steam engine provided a new source of power.

Newton explored the meaning of gravity. Last month electric lights and telephones and automobiles and airplanes became available. Only last week did we develop penicillin and television and nuclear power, and now if America's new spacecraft succeeds in reaching Venus, we will have literally reached the stars before midnight tonight.

This is a breathtaking pace, and such a pace cannot help but create new ills as it dispels old, new ignorance, new problems, new dangers. Surely the opening vistas of space promise high costs and hardships, as well as high reward.

So it is not surprising that some would have us stay where we are a little longer to rest, to wait. But this city of Houston, this State of Texas, this country of the United States was not built by those who waited and rested and wished to look behind them. This country was conquered by those who moved forward--and so will space.

William Bradford, speaking in 1630 of the founding of the Plymouth Bay Colony, said that all great and honorable actions are accompanied with great difficulties, and both must be enterprised and overcome with answerable courage.

If this capsule history of our progress teaches us anything, it is that man, in his quest for knowledge and progress, is determined and cannot be deterred. The exploration of space will go ahead, whether we join in it or not, and it is one of the great adventures of all time, and no nation which expects to be the leader of other nations can expect to stay behind in the race for space.

Those who came before us made certain that this country rode the first waves of the industrial revolutions, the first waves of modern invention, and the first wave of nuclear power, and this generation does not intend to founder in the backwash of the coming age of space. We mean to be a part of it--we mean to lead it. For the eyes of the world now look into space, to the moon and to the planets beyond, and we have vowed that we shall not see it governed by a hostile flag of conquest, but by a banner of freedom and peace. We have vowed that we shall not see space filled with weapons of mass destruction, but with instruments of knowledge and understanding.

Yet the vows of this Nation can only be fulfilled if we in this Nation are first, and, therefore, we intend to be first. In short, our leadership in science and in industry, our hopes for peace and security, our obligations to ourselves as well as others, all require us to make this effort, to solve these mysteries, to solve them for the good of all men, and to become the world's leading space-faring nation.

We set sail on this new sea because there is new knowledge to be gained, and new rights to be won, and they must be won and used for the progress of all people. For space science, like nuclear science and all technology, has no conscience of its own. Whether it will become a force for good or ill depends on man, and only if the United States occupies a position of pre-eminence can we help decide whether this new ocean will be a sea of peace or a new terrifying theater of war. I do not say that we should or will go unprotected against the hostile misuse of space any more than we go unprotected against the hostile use of land or sea, but I do say that space can be explored and mastered without feeding the fires of war, without repeating the mistakes that man has made in extending his writ around this globe of ours.

There is no strife, no prejudice, no national conflict in outer space as yet. Its hazards are hostile to us all. Its conquest deserves the best of all mankind, and its opportunity for peaceful cooperation many never come again. But why, some say, the moon? Why choose this as our goal? And they may well ask why climb the highest mountain? Why, 35 years ago, fly the Atlantic? Why does Rice play Texas?

We choose to go to the moon. We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win, and the others, too.

It is for these reasons that I regard the decision last year to shift our efforts in space from low to high gear as among the most important decisions that will be made during my incumbency in the office of the Presidency.

In the last 24 hours we have seen facilities now being created for the greatest and most complex exploration in man's history. We have felt the ground shake and the air shattered by the testing of a Saturn C-1 booster rocket, many times as powerful as the Atlas which launched John Glenn, generating power equivalent to 10,000 automobiles with their accelerators on the floor. We have seen the site where the F-1 rocket engines, each one as powerful as all eight engines of the Saturn combined, will be clustered together to make the advanced Saturn missile, assembled in a new building to be built at Cape Canaveral as tall as a 48 story structure, as wide as a city block, and as long as two lengths of this field.

Within these last 19 months at least 45 satellites have circled the earth. Some 40 of them were "made in the United States of America" and they were far more sophisticated and supplied far more knowledge to the people of the world than those of the Soviet Union.

The Mariner spacecraft now on its way to Venus is the most intricate instrument in the history of space science. The accuracy of that shot is comparable to firing a missile from Cape Canaveral and dropping it in this stadium between the 40-yard lines.

Transit satellites are helping our ships at sea to steer a safer course. Tiros satellites have given us unprecedented warnings of hurricanes and storms, and will do the same for forest fires and icebergs.

We have had our failures, but so have others, even if they do not admit them. And they may be less public.

To be sure, we are behind, and will be behind for some time in manned flight. But we do not intend to stay behind, and in this decade, we shall make up and move ahead.

The growth of our science and education will be enriched by new knowledge of our universe and environment, by new techniques of learning and mapping and observation, by new tools and computers for industry, medicine, the home as well as the school. Technical institutions, such as Rice, will reap the harvest of these gains.

And finally, the space effort itself, while still in its infancy, has already created a great number of new companies, and tens of thousands of new jobs. Space and related industries are generating new demands in investment and skilled personnel, and this city and this State, and this region, will share greatly in this growth. What was once the furthest outpost on the old frontier of the West will be the furthest outpost on the new frontier of science and space. Houston, your City of Houston, with its Manned Spacecraft Center, will become the heart of a large scientific and engineering community. During the next 5 years the National Aeronautics and Space Administration expects to double the number of scientists and engineers in this area, to increase its outlays for salaries and expenses to \$60 million a year; to invest some \$200 million in plant and laboratory facilities; and to direct or contract for new space efforts over \$1 billion from this Center in this City.

To be sure, all this costs us all a good deal of money. This year's space budget is three times what it was in January 1961, and it is greater than the space budget of the previous eight years combined. That budget now stands at \$5,400 million a year--a staggering sum, though somewhat less than we pay for cigarettes and cigars every year. Space expenditures will soon rise some more, from 40 cents per person per week to more than 50 cents a week for every man, woman and child in the United States, for we have given this program a high national priority--even though I realize that this is in some measure an act of faith and vision, for we do not now know what benefits await us.

But if I were to say, my fellow citizens, that we shall send to the moon, 240,000 miles away from the control station in Houston, a giant rocket more than 300 feet tall, the length of this football field, made of new metal alloys, some of which have not yet been invented, capable of standing heat and stresses several times more than have ever been experienced, fitted together with a precision better than the finest watch, carrying all the equipment needed for propulsion, guidance, control, communications, food and survival, on an untried mission, to an unknown celestial body, and then return it safely to earth, re-entering the atmosphere at speeds of over 25,000 miles per hour, causing heat about half that of the temperature of the sun--almost as hot as it is here today--and do all this, and do it right, and do it first before this decade is out--then we must be bold.

I'm the one who is doing all the work, so we just want you to stay cool for a minute. [laughter]

However, I think we're going to do it, and I think that we must pay what needs to be paid. I don't think we ought to waste any money, but I think we ought to do the job. And this will be done in the decade of the sixties. It may be done while some of you are still here at school at this college and university. It will be done during the term of office of some of the people who sit here on this platform. But it will be done. And it will be done before the end of this decade.

I am delighted that this university is playing a part in putting a man on the moon as part of a great national effort of the United States of America.

Many years ago the great British explorer George Mallory, who was to die on Mount Everest, was asked why did he want to climb it. He said, "Because it is there."

Well, space is there, and we're going to climb it, and the moon and the planets are there, and new hopes for knowledge and peace are there. And, therefore, as we set sail we ask God's blessing on the most hazardous and dangerous and greatest adventure on which man has ever embarked.

Thank you.

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Drawn from: <http://er.jsc.nasa.gov/seh/ricetalk.htm> December 21, 2010.



State of Rhode Island and Providence Plantations

State House, Room 224  
Providence, Rhode Island 02903  
401-222-2080

Lincoln D. Chafee  
Governor

January 31, 2013

The Honorable Tom Harkin  
Chairman, U.S. Senate Committee on Health,  
Education, Labor and Pensions  
Washington, DC 20510-6300

Dear Chairman Harkin:

This letter responds to your request for information regarding Rhode Island's Olmstead activities. I appreciate the importance of the questions you have asked and hope that you are willing to share a summary of the responses you receive as part of your process.

Mr. Craig Stenning, Director of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, can answer any follow up questions you may have regarding these issues at (401) 462-6252 or [CStenning@bhddh.ri.gov](mailto:CStenning@bhddh.ri.gov).

Sincerely,

A handwritten signature in black ink, appearing to read "Lincoln D. Chafee".

Lincoln D. Chafee  
Governor





## STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

OFFICE OF THE DIRECTOR  
14 Harrington Road  
Cranston, RI 02920-3080

TEL: (401) 462-3201  
FAX: (401) 462-3204

January 31, 2013

The Honorable Tom Harkin  
Chairman, U.S. Senate Committee on Health, Education, Labor and Pensions  
Washington, DC 20510-6300

Dear Senator Harkin:

I am writing in response to your letter to Governor Chafee asking for an overview of RI's Olmstead activities as it relates to adults with developmental disabilities. The Governor's office has asked me to reply to your letter as the Director of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

The State of Rhode Island is proud to have been an early pioneer among states in taking a proactive approach to integrating our citizens with developmental disabilities into the community. Our state closed its state-run institution beginning in 1985 and completed the work in the early 1990's. Since that time, we have built a community-based provider network to support persons with developmental disabilities with choices for residential settings, day program activities, supported employment, and other community integration activities. Currently, we contract with 39 providers that are located in every part of the state that enable participants in our waiver program to choose which agency (or multiple agencies) that they would like to work with to receive community-based supports.

Since the early 1990's, Rhode Island has continued to push for more community integration. Based on a nationally-recognized report that tracks the trends in state program expenditures for programs serving people with intellectual/developmental disabilities (I/DD), Rhode Island provided coverage to participants in ICF/MRs coverage to 1.1% of its total eligibles in 2009 while the national average was 13.8%<sup>1</sup>. When analyzing placement in ICF/MR and Skilled Nursing Facilities combined, Rhode Island only has 4.3% of its participants in these settings and over 95% in community settings.

Among the 3,590 persons with I/DD that we serve in community settings, our constituents reside in the following settings:

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<sup>1</sup> *Residential Services for Persons with Developmental Disabilities: Status and Trends 2009*. Lakin, K. Charlie, Sheryl Larson, Patricia Salmi, and Amanda Webster.

- 450 live independently or with others in their own home or apartment
- 1419 live with their own families
- 224 live with a host family of their choosing
- 1234 live in group home settings in the community, most of which are 4 bedroom homes

In an effort to continue to offer options in the most integrated community setting, one initiative of Rhode Island's Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) in recent years was to enhance the choice for participants seeking to live with host families (called Shared Living Arrangements, or SLAs). BHDDH has adopted a policy that when 24-hour residential placement is necessary, SLAs are always the first option when clinically appropriate. Since January 2009, the number of SLA placements has increased from 113 to 224 today. This was done through state initiatives without the need for federal or state grant support. When Project Sustainability began in 2010, we had 1323 individuals in group home residential placements. Residential placements decreased from 1307 in 2012 to 1234 today.

In 2010, Rhode Island's BHDDH embarked on a system-wide reform to the way that it delivers and pays for services to persons with I/DD that reside in the community. Project Sustainability, as the effort is called, included a review of all services available to individuals in the community. The focus of Project Sustainability was to increase transparency for parents and participants, increase choice and to ensure that individuals are allowed to be integrated into their community. As a result of this review, new services were added to stimulate placement in the least restrictive community setting. For example, services related to transportation to and from day activities as well as training provided to natural support providers were added to assist individuals in maintaining their independence. All of these new services were part of our efforts to allow individuals to remain in their homes with additional home-based and community based services. The movement away from automatic group home placements has greatly reduced our per-person expenditures and allowed individuals to remain in their own communities, not just a community.

Another aspect of Project Sustainability was to review the rates paid to providers that deliver community-based services. BHDDH has taken the position to incentivize services that encourage stability and integration in the community and away from center-based day programs. For example, another new service that was developed was for a Job Developer. This service, in addition to Supported Employment, has rates that are higher than other traditional day program services. Even within the non-job related day program services, BHDDH rewards providers who provide day program activities in the community at a higher rate than those who offer the traditional center-based option.

Participants also have the option to self-direct their services as another means to tailor their individual budget to support independence whenever feasible. As of today, 291 individuals, or 8% of the total community-based I/DD population, self-directs their service package as opposed to 237 in 2009.

All of the rate changes and system financial incentives under Project Sustainability were completed under the 1115 Waiver in RI (formerly called the Global Waiver). This CMS Waiver added greater flexibility and allowed for many of the innovations that have driven the system.

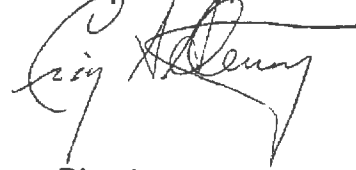


Generally, Rhode Island general revenue appropriation for this current state fiscal year 2013 is \$129.5 million and breaks down as follows:

- Rhode Island Community Living and Supports, the state supported group home system: \$14.5 million;
- Community Provider Programs (Day Centers; In-Home services, etc.): \$91.3 million;
- Hospital, Psychiatric Care: \$23.7 million.

If I can provide any additional information or answer any questions, please feel free to contact me at 401-462-6252 or at [CStenning@BHDDH.RI.Gov](mailto:CStenning@BHDDH.RI.Gov).

Respectfully,

A handwritten signature in black ink, appearing to read "Craig Stenning". The signature is written in a cursive style with a long horizontal stroke extending to the right.

Director

cc: Senator Jack Reed  
cc: Senator Sheldon Whitehouse

9262  
DHS



STATE OF SOUTH DAKOTA  
DENNIS DAUGHAARD, GOVERNOR

September 5, 2011

The Honorable Tom Harkin  
United States Senate  
Committee on Health, Education, Labor, and Pensions  
Washington, D.C. 20510-6300

Dear Senator Harkin:

Thank you for your letter about the 13<sup>th</sup> anniversary of the United States Supreme Court's decision in *Olmstead v. L.C.* and your request for information about South Dakota's efforts to ensure we are providing high quality and cost effective services so people with disabilities can live as independently as possible. I am proud of the work we have done in South Dakota over the past four decades to ensure people with disabilities live the life they want and deserve.

As you may know, South Dakota has a long history of fulfilling the *Olmstead* promise, many years before the United States Supreme Court's decision. Based on the philosophy that people should live, work, and recreate in the community of their choice, we have worked diligently to develop the services and supports people need to live in the least restrictive and most integrated setting possible.

Under the direction of the Governor's Office, the staff of the Department of Human Services (DHS) prepares an annual budget request which has included the capacity to expand community supports for people with disabilities and meet the demand for people transitioning from institutional and other settings into the home and community based settings of their choice. In cooperation with the Executive and Legislative branches of government, DHS has met this demand in partnership with the Community Support Providers that provide the direct supports for people to live as independently as possible in the community. These ongoing efforts and appropriations to meet the community living demands in South Dakota have resulted in no waiting list for home and community based services in South Dakota. This is something for which we are very proud of and work hard to maintain.

South Dakota continues to utilize four Medicaid home and community-based waivers to meet the demand for community living for people with disabilities. In addition, we were recently awarded a Money Follows the Person Planning (MFP) grant and we continue MFP planning activities. The demonstrating grant application was recently submitted by our State Medicaid agency and we are awaiting an award decision in the very near future. We are hopeful we will be able to use

The Honorable Tom Harkin  
September 5, 2012  
Page 2

this opportunity to afford South Dakotans with disabilities additional options to transition to community living. Last but not least, we continue with the process of examining the feasibility of implementation of the Community First Choice and Agency Model Domiciliary Care models in South Dakota.

I appreciate the opportunity to share with you what we are doing here in South Dakota to fulfill the Olmstead promise and make South Dakota a great place to live, work, and play for all of our citizens. Thank you for your work and dedication on this important issue.

Sincerely,



Dennis Daugaard

Dennis Daugaard

DDA/vh

## Tennessee Response Letter

- 1) For each year from FY 2008 to the present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long-term care units of psychiatric hospitals, and board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program.**

The State’s systems do not identify transitions between non-institutional residential settings in the community (i.e., from community-based “board and care homes” to one’s “own home”). The following chart represents the total number of persons who received Medicaid-reimbursed services in an institution, i.e., Nursing Facility (NF) or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), at any time during each of the requested fiscal years, and of those, the total number of persons who were subsequently discharged from the institution during that same year and enrolled in a Medicaid home and community based services (HCBS) program, including a Section 1915(c) waiver, or since 2010, a Managed Long-Term Services and Supports (MLTSS) program operating under the authority of an 1115 waiver. If a person was readmitted to the institution during the same year, the person is not counted as “transitioned” below.

FY	Unduplicated Individuals receiving Institutional Care	Individuals Transitioned to HCBS
FY2008	33,064	213
FY2009	32,461	284
FY2010	31,999	196
FY2011	31,432	668
FY2012	31,457	1,006

- 2) The amount of state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.**

Projected State FY 2013 expenditures for NF services are \$326,234,400. Projected State FY 2013 expenditures for ICF/IID services are \$68,021,200. The State does not have separate budget line items for HCBS based on the type of non-institutional residential settings in the community in which care is received (i.e., community-based “board and care homes” or “group homes” versus personal assistance and other care provided in a person’s “own home”), but instead budgets HCBS in the aggregate by program. Further, many of the HCBS provided under the State’s programs, including Supported Employment and other Day Services, Individual Transportation Services, etc., are not provided in the person’s residence at all, but in the community. Projected State FY 2013 expenditures for all HCBS in the MLTSS program are \$61,053,600. Projected State FY 2013 expenditures for HCBS waivers for persons with ID are \$208,734,500.

Inpatient services in a psychiatric hospital are part of the integrated managed care program, and payment for those services is part of a blended capitation payment to MCOs that is inclusive of all physical and behavioral health services and as applicable, LTSS. Thus, there is not a discreet budgeted

amount for inpatient psychiatric services, the overwhelming majority of which are short-term (and not long-term) acute inpatient stays. These services are instead incorporated into the actuarially developed capitation budget.

**3) For each year from FY 2008 to the present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.**

The charts below represent total program expenditures during the course of each year from FY 2008 to the present by population, as well as enrollment in HCBS programs (excluding PACE) for the Elderly and Adults with Physical Disabilities for each year. It is worth noting that FMAP percentages changed significantly during the period (with enhanced FFP during SFY 2009, 2010 and 2011), such that State expenditures are not necessarily reflective of changes in total program spending. For example, total expenditures for NF services actually declined from 2011 to 2012; however, the State match rate increased from 26.326 percent to 33.767 percent, resulting in higher State expenditures in 2012. Likewise, total expenditures for ICF/IID expenditures decreased each year from 2008 to 2012 (from a high of \$264,048,200 to a low of \$171,284,200), which is not apparent from looking only at State expenditures for 2011 and 2012. Particularly noteworthy is that the percentage of total LTSS funding spent on HCBS increased every year for both populations. Additional information regarding the dramatic expansion of capacity for HCBS enrollment for the elderly and adults with physical disabilities is included in the response to question #s 4 and 6 below.

	2008	2009	2010 <sup>a</sup>	2011 <sup>b</sup>	2012
<b>Expenditures</b>					
Nursing Home	\$329,043,600	\$249,423,700	\$228,912,500	\$255,706,600	\$321,183,900
HCBS (E/PD)	\$15,289,500	\$19,209,400	\$26,956,500	\$32,317,000	\$53,244,800
Total	\$344,333,100	\$268,633,100	\$255,869,000	\$288,023,600	\$374,428,700
Percent HCBS	4.4%	7.2%	10.5%	11.2%	14.2%
<b>Average # of Persons Served</b>					
HCBS (E/PD)	2,331	4,517	5,057	6,597	9,991

- a. CHOICES Program implemented in Middle TN in March 2010. Expenditure totals combine Fee-For-Service expenditures with all MCO payments to NFs (for Middle TN Grand Region).
- b. CHOICES Program implemented in East and West TN in August 2010. Expenditure totals combine Fee-For-Service expenditures with all MCO payments to NFs (statewide).

	2008	2009	2010	2011	2012
<b>Expenditures</b>					
ICF/IID	\$95,849,500	\$73,524,300	\$55,702,100	\$51,551,500	\$57,837,500
HCBS (ID)	\$201,070,500	\$164,454,800	143,891,800	\$153,994,000	\$185,390,700
Total	\$296,920,000	\$237,979,100	\$199,593,900	\$205,545,500	\$243,228,200
Percent HCBS	67.7%	69.1%	72.1%	74.9%	76.2%

Further, the number of individuals with ID receiving Supported Living services (a residential service that is provided in a home “under the control and responsibility of the residents,” i.e., their “own home”) in

two of the three HCBS waivers for persons with ID has increased each year between 2008 to 2012, from 3,141 individuals receiving the service in 2008 to 3,647 receiving the service in 2012. Likewise, total expenditures for Supported Living services increased every year between SFY 2009 to 2012 (from \$320,378,116.12 in 2009 to \$367,212,009.50 in 2012).

	Total Dollars	State Dollars	# of individuals in Supported Living on June 30
SFY 2008	\$325,632,566.08	\$118,220,903.12	3,141
SFY 2009	\$320,378,116.12	\$92,550,830.18	3,260
SFY 2010	\$321,007,961.33	\$79,969,503.33	3,348
SFY 2011	\$335,737,539.38	\$88,386,264.62	3,473
SFY 2012	\$367,212,009.50	\$123,996,479.25	3,647

**4) The contents of your state’s Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.**

While there is not a specific document entitled “Tennessee Olmstead Plan,” the State of Tennessee does have a comprehensive effectively working plan that promotes the delivery of long-term services and supports (LTSS) in the most integrated setting. The State has passed comprehensive legislation and implemented transformational reforms of the LTSS service delivery system that are specifically intended to promote the expansion of Home and Community Based Services (HCBS) and to rebalance LTSS expenditures.

The delivery system for individuals who qualify for and need the level of care provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) includes three Section 1915(c) HCBS Waiver Programs, serving a combined total of 7,686 individuals as of November 2012. One of the programs, the Self-Determination Waiver, permits self-direction of selected services, including personal assistance. Established as an Independence Plus Waiver, this program offers participants the ability to manage a budget of up to \$30,000 (with emergency increases up to \$36,000), using the services of a contracted fiscal employer agent. For individuals with intellectual disabilities (ID) not participating in consumer direction (including participants in all three waivers), services are delivered through a statewide network of more than 300 contracted HCBS provider agencies.

The three HCBS waiver programs for persons with ID offer a comprehensive array of more than twenty services that are specifically designed to meet the needs of individuals who, but for these services, would require the level of care provided in an ICF/IID, and to enable the individuals to reside in the most integrated community setting appropriate and to participate fully in employment and community

activities. The waivers also include community-based residential alternatives to institutional placement, including Supported Living, Residential Habilitation, Medical Residential, and Family Model Residential Support. Recent amendments have added Semi-Independent Living Services to the Self-Determination waiver and Intensive Behavioral Residential Services to the more comprehensive waivers. Both services are designed to offer specific flexibilities that will allow individuals to receive the type and level of assistance they need to live successfully in the most integrated community setting.

There is active involvement of stakeholders in these programs, including an Advisory Council. The Council is comprised of consumers, family members, guardians, advocates, and providers, as well as state staff. Feedback from stakeholders is used on an ongoing basis to help inform program design and to promote the delivery of care in integrated settings.

The delivery system for persons with intellectual disabilities also includes two remaining large state institutions (i.e., Developmental Centers) located in the middle and eastern regions of the state. In Middle Tennessee, Clover Bottom Developmental Center is scheduled to close once smaller homes in the community are ready for transition of remaining residents. As of November 2012, there were 43 individuals residing at Clover Bottom, with an additional five people at Harold Jordan Center, a state-operated forensic center on the Clover Bottom campus. Greene Valley Developmental in the eastern region of the state will remain open for now, but is undergoing significant census reduction—with 137 residents as of November 2012 (down from 238 two years before). The remaining large state institution in West Tennessee, which at its maximum occupancy served some 643 residents, was closed in October 2010, with remaining residents successfully transitioned into other residential settings.

In addition to state-operated ICF/IIDs, there are private ICF/IID facilities. There is a statutory limit on the total number of private ICF/IID beds within the state, currently set at 828 of which 744 are actually established. This is an increase over the 668 bed limit that had been placed in 2006, with the additional 160 beds statutorily limited to persons transitioning out of large State institutions.

Even if all private ICF/IID beds were at 100% occupancy, when combined with current occupancy in the State's Developmental Centers and the State's small, four-bed ICF/IID homes, more than 88 percent of persons in this population are receiving services in home and community-based (i.e., non-institutional) settings, and more than 75 percent of the State's LTSS services expenditures for persons with intellectual disabilities (including state match and FFP) is spent on HCBS rather than institutional care. The LTSS system for persons with intellectual disabilities is heavily weighted in favor of HCBS rather than institutional services.

While ID Waiver and ICF/IID services remain carved out of Tennessee's 1115 Research and Demonstration Waiver (the TennCare Medicaid managed care program), persons receiving such services are nonetheless enrolled in the TennCare program for physical and behavioral health services. An integrated health services delivery model, called SelectCommunity, permits individuals participating in an ID waiver program to enroll in a specific managed care organization and have access to a nurse care manager that will work closely with the member's Independent Support Coordinator (ISC or waiver case manager) to ensure that the individual's physical and behavioral health needs are coordinated across services and service delivery settings.

The second primary group receiving long-term care services in Tennessee comprises a number of different target populations, all of whom qualify for and need the level of care provided in a NF.

The State has one PACE (Program of All-Inclusive Care for the Elderly) site located in Hamilton County which serves up to 325 participants and typically operates at or near maximum capacity. Funding provided in the 2010 Appropriations Bill has been used to support planning and infrastructure development for a potential second PACE site in Shelby County.

The current statewide HCBS alternative to NF level of care, the TennCare CHOICES in Long-Term Services and Supports Program (or CHOICES), serves persons who are age 65 and older and adults age 21 and older with physical disabilities. These are the same target populations covered under the former Section 1915(c) Elderly and Disabled HCBS Waiver that were transitioned into CHOICES upon statewide implementation of the new program. Prior to CHOICES implementation, the State had experienced a 430% increase in HCBS enrollment for the E/D population over a three-year period (from 2006 to 2009); however, continued expansion of the HCBS population was subject to the availability of new appropriations.

Excluding PACE participants, as of February 1, 2013, there are 20,237 persons receiving Medicaid-reimbursed NF services in just under 300 licensed and certified NFs located across the State, and 12,104 persons receiving HCBS as an alternative to NF placement in the CHOICES in Long-Term Services and Supports Program. Since the implementation of the CHOICES program in 2010, the percentage of persons enrolled in HCBS (versus NF services) has increased by 120% (from 17% at the program's inception to 37.4% as of February 2013). During the same period, the number of persons enrolled in HCBS has increased by nearly 150% (from 4,861 to 12,104) and the number of persons enrolled in NF services has decreased by more than 12%.

CHOICES is an integrated Medicaid Managed Long-Term Services and Supports (MLTSS) program. At-risk MCOs accredited by the National Committee on Quality Assurance and selected via a competitive bid process are responsible for coordinating the full array of physical and behavioral health and long-term care services that eligible members need. A global budget strategy is achieved for long-term care services via a fully blended capitation payment that encompasses all of the long-term care services (NF or HCBS) needed by the member, as well as services for physical and behavioral health needs. Members who qualify for NF care have freedom of choice of the setting in which care will be received, so long as their needs can be safely met in the community at a cost that does not exceed institutional care. Thus, "money follows the person" into the most integrated care setting of their choice.

While there is an enrollment target for persons receiving HCBS as an alternative to NF care, the State has been able (except for a brief period while awaiting CMS approval to increase the target) to keep pace with demand, eliminate any waiting list for these services, and significantly expand the numbers of persons receiving HCBS, as well as the percentage of LTSS participants in HCBS (versus institutional) settings. Further, pursuant to the terms and conditions of the State's approved demonstration waiver, persons transitioning from a nursing home are exempt from the enrollment target and can be enrolled into HCBS even if the enrollment target has been reached, as can certain persons at risk of placement in a NF unless HCBS are provided.

Because MCOs operate at full risk for institutional as well as community-based care, financial incentives are appropriately aligned for MCOs to assist members in receiving more cost-effective care in the community for as long as it can be safely provided. A comprehensive risk assessment and planning process serves to identify potential risks of community living, to develop strategies to help mitigate those risks, and to help ensure each participant's health, safety, and welfare.



The CHOICES program is the result of comprehensive long-term care reform legislation passed unanimously by both houses of the Tennessee General Assembly in 2008: the Long-Term Care Community Choices Act of 2008 (LTC CCA). Key to its passage was overwhelming support from a diverse stakeholder community, including the AARP and numerous disability advocacy groups, who helped to inform the legislation and how the LTSS reforms would be structured.

From the announcement in January 2008 of the State's plans to fundamentally restructure long-term care, TennCare worked closely with stakeholder groups, including representatives from the NF and HCBS provider community, as well as advocacy groups and other constituents to design the new delivery system. This collaborative process continued throughout the program's implementation and is integral to its success. Representatives from the CHOICES stakeholder community also serve on a Money Follows the Person (MFP) Demonstration Advisory Group, along with members of an ID Advisory Council and individuals representing both target populations that have successfully transitioned from institutional to home and community-based settings.

The LTSS CCA specifically called for the State to expand access to HCBS and to rebalance long-term care expenditures for the elderly and disabled populations, in addition to numerous other structural reforms—including a single point of entry, streamlined enrollment processes, consumer directed options, and the development of additional community-based residential alternatives (CBRAs) to NF placement. (TennCare already provided coverage of services in an Assisted Care Living Facility or ACLF.)

In 2009, a second piece of legislation introduced the first new CBRA—Adult Care Homes. These are small, home-like residential settings in the community where the person primarily responsible for delivering services lives onsite with individuals receiving long-term care. While originally intended to serve persons with differing types and levels of need (offering assistance with activities of daily living as well as more complex medical and behavioral supports), the legislation was modified prior to its passage to serve only two (2) populations at this time—namely persons who are ventilator dependent and adults with traumatic brain injury.

While room and board charges in the community cannot be covered by Medicaid, the State has established limitations on the room and board costs than can be charged to a CHOICES member in order to help facilitate access to the Medicaid benefit for lower income individuals.

In addition to a community-based provider network encompassing more than a thousand contracted providers, participants in CHOICES can elect to participate in Consumer Direction and to employ their own staff for specified HCBS—namely personal care visits, attendant care, in-home respite care, and a CBRA option that is available only through Consumer Direction called Companion Care. Companion Care affords persons who need assistance with activities of daily living at intermittent intervals throughout the day and night (but who do not have family members or other natural supports to provide such assistance) the availability of a 24-hour live-in caregiver or attendant. While care is not provided 24/7, the paid caregiver is available at intervals throughout the 24 hour period as needed to offer support, allowing the individual to continue living safely in his or her own home.

The Consumer Direction model in CHOICES is an Employer Authority model. The person's Care Coordinator completes a comprehensive assessment and works with the member to develop a person-centered plan which includes the HCBS needed by the member. If the member needs any of the services available through Consumer Direction, he or she is then given the option of electing to receive such services from a traditional provider agency contracted with the MCO, or through Consumer

Direction. Members set the rate of reimbursement for their workers from a range of rates established by the State. Financial administration and supports brokerage functions are performed by a single statewide fiscal employer agent contracted with TennCare. Members who want to participate in Consumer Direction, but who are unable to direct their own services and/or to serve as the Employer of Record are permitted to designate a Representative for Consumer Direction to employ workers and direct services on their behalf.

Pursuant to the authorizing statute for CHOICES (LTSS CCA), Contractor Risk Agreements (CRAs) with the MCOs include specific requirements pertaining to NF diversion and transition. MCOs have responsibility for managing care transitions, and in particular, for discharge planning following acute inpatient stays in order to facilitate transition to the most integrated and appropriate setting.

As part of coordinating care for NF residents, MCOs are responsible for periodically screening each resident in order to determine whether a member is a candidate for transition to the community, and for completing transition screenings within 14 days of receipt of referral. MCOs are permitted to use proprietary instruments for conducting such screenings, but must conform to certain minimum requirements established by TennCare.

When a member verbalizes an interest in transition from a NF to a community placement or is identified as a candidate for transition (by the MCO, through MDS Section Q referral, self-referral, or by a family member, provider, advocate, LTSS Ombudsmen or other person acting on the member's behalf), and a screening suggests that the member is in fact a candidate for transition, a transition assessment is completed. Such assessment must fully encompass a comprehensive needs assessment that will be used to determine the services and supports needed by the member upon return to the community. It is also used to determine the actions that must be taken by the care coordinator and others to help facilitate the member's safe and timely transition to community living.

Under CHOICES, MCOs are permitted to authorize a transition allowance of up to \$2,000 per member to assist with the cost of rental and/or utility deposits, basic home furnishings and goods that are needed to facilitate transition from the NF to the community. This is not currently permitted, however, as part of the State's Section 1915(c) ID Waivers, and is thus a service that is needed to help support community transitions for that target population. Accordingly, this has been included as a supplemental demonstration service under the State's MFP Rebalancing Demonstration, which proposes to transition roughly 10 percent of the current number of persons residing in NFs and additional persons residing in ICFs/IID into home and community-based settings over the course of the demonstration.

Changes in the new MDS 3.0 Assessment process have been integrated into CHOICES program requirements, with Area Agencies on Aging and Disability (the Single Point of Entry for non-Medicaid eligible individuals seeking long-term care) serving as the Local Contact Agency for non-Medicaid eligible individuals and MCOs providing assistance to current members expressing interest in transition to the community.

At the CHOICES program's inception, the State developed and CMS approved a baseline data plan which contains measures specifically designed to ensure that the program achieves the State's primary program objectives around expanded access to and utilization of HCBS and LTSS rebalancing including:

- Expand access to HCBS
- Rebalance LTSS spending
- Provide cost-effective HCBS as an alternative to institutional care

- Delay or prevent the need for institutional placement
- Facilitate transition from NF to HCBS

These same measures were used as the basis of a CHOICES Special Study, and will continue to be monitored over time, with program adjustments as needed. In addition to increased numbers of persons receiving HCBS and increased percentage of persons receiving LTSS in HCBS settings, early successes include:

- The percentage of NF eligible individuals entering LTSS choosing HCBS (rather than NF services) upon entry into LTSS increased from 18.66% prior to CHOICES to 33.11% during the first year of the program.
- A 32-day reduction in average NF length of stay during first year of the program.

**5) Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead’s integration mandate and take advantage of new federally available assistance.**

- Flexible strategies to integrate care for dual eligibles

One of the most significant challenges facing the State’s rebalancing efforts is the impact that utilization of Medicare benefits has on how people who are dual eligible enter the Medicaid LTSS system. Roughly 90 percent of the total CHOICES population is dual eligible. Most often, a dual eligible member enrolls in CHOICES after an acute event which results in a Medicare hospitalization, followed by a Medicare Skilled Nursing Facility (SNF) stay. Once the Medicare SNF benefit is exhausted, the person enrolls into CHOICES for receipt of Medicaid NF services, entering the MLTSS program in the most expensive, institutional setting. Better coordination of care for dual eligibles, particularly at the point of hospital admission and discharge planning, with consideration of the full array of Medicaid LTSS available, would help to increase utilization of more integrated and cost-effective HCBS, or when a short-term SNF stay is needed, facilitate more timely discharge back to the community as appropriate. Unfortunately, in a system where Medicare benefits are accessed through a FFS system, or even through a Medicare Advantage plan that is not also responsible for administering Medicaid (including LTSS) benefits, there is little if any coordination with the Medicaid MCO, and because Medicare is the payer, the Medicaid MCO is often not even aware of the hospital or SNF admission until the person enters the MLTSS program.

To that end, more flexible options for States to participate in integrated care programs, where dual eligibles are enrolled in the same health plan for all of their Medicare and Medicaid benefits, would help to facilitate improved coordination of care, including discharge and transition planning, and more cost-efficient delivery of services and supports in integrated community settings. We would strongly encourage federal policies which permit states the ability to enroll all dual eligible beneficiaries in integrated and coordinated delivery systems that will result in better quality and more cost-efficient delivery of services in these integrated settings, with streamlined administrative requirements that permit a more seamless delivery system for dual eligible members.

Further, we strongly encourage the reauthorization and approval of D-SNPs (pursuant to Medicare Part C authority) only in circumstances where that entity will also be contracted with the State Medicaid program to provide the full array of Medicaid (including LTSS) benefits pursuant to the State’s program requirements.

- Modify Section 10202 of the ACA (the Balancing Incentive Payment Program or BIPP)

We recommend clarification of Section 10202 regarding the Balancing Incentive Payment Program that would allow states' spending on LTSS to be calculated by LTSS population. As it is currently applied, only one state qualifies for the 5% enhanced FMAP because spending is combined across populations served by each state in their LTSS programs. A 2% match is often not substantial enough to offset the significant administrative burden that will be required to achieve program requirements pertaining to a "no wrong door SPOE," a "conflict-free case management system," and "core standardized assessment instruments" across all LTSS populations.

In nearly every state, spending on persons with intellectual and developmental disabilities is overwhelmingly balanced in favor of home and community based care. This is not true for the elderly and adults with physical disabilities. Separate consideration of funding for different LTSS populations would allow more states to qualify for the 5% FMAP and increase the likelihood that States will elect to participate in the BIPP program in order to assist in their rebalancing efforts.

- Modify Section 2401 and 2402 of the ACA (Section 1915(k) Community First Choice and Section 1915(i) State Plan HCBS)

While both Section 2401 and 2402 of the ACA are intended to provide increased options for States to offer HCBS and in the case of Section 2401, to receive enhanced FMAP for Attendant Care services, limitations in both sections have discouraged many states from participating in these programs. The Community First Choice option requires that States make Attendant Care services available statewide, with no caps on the numbers of people who can receive the benefit, and no ability to target the benefit based on age, severity of disability, etc. The State Plan HCBS option no longer permits states to limit the number of eligible individuals who can receive 1915(i) State plan HCBS or establish a waiting list for State plan HCBS. Additionally, States may not limit the availability of 1915(i) services to specific geographic areas or political subdivisions of the State (statewideness). This lack of flexibility to manage programs within each State's budgetary constraints and ensure an adequate community infrastructure to deliver the benefits will likely continue to impact the numbers of States electing to pursue these options.

- Tremendous caution should be exercised with respect to the broad authority granted to the Secretary under Section 2402(a) of the ACA to define HCBS

While the notion of a common definition of HCBS is laudable, there is tremendous potential for severe unintended negative consequences, depending on how this authority is exercised.

To date, CMS has issued two sets of proposed rules regarding HCBS settings. In both instances, Tennessee and numerous other states and interested stakeholder groups have expressed significant concerns regarding the potential negative consequences of the proposed rule—in many cases, restricting individual choice and forcing persons into institutional settings.

In the first set of proposed rules, focused primarily on what makes a location a home and community based setting, the exclusion of several types of facilities in which HCBS waiver participants have chosen to receive services would interfere with their freedom of choice, and result in unnecessary institutionalization of waiver participants that could otherwise be safely and cost-effectively served in more integrated settings of their choice. States would likely not have a ready supply of alternatives which CMS proposed to deem "home and community based" under its interpretation, and residents

who have chosen to live in these settings would be forced into institutions. Moreover, this proposed interpretation would greatly impede States' efforts to develop new community-based residential alternatives, as providers who could survive the economic impact of these changes will be wary of assuming additional risk in developing new alternatives that may also be deemed (over time) to be not home and community-based "enough."

With respect to other (i.e., non-location based criteria), these were highly subjective and impractical to apply, leaving virtually every HCBS provider subject to the whims of whoever is defining the "qualities of an institutional setting" and whoever is making the determination based on those criteria at a particular moment in time. The broad discretion left to the Secretary to determine the "qualities of an institutional setting" (and to change the interpretation over time) would leave States vulnerable to an ever-changing, highly subjective and likely impossible to attain set of expectations that would result in persons being unable to receive home and community based care (as CMS has defined it) and instead, forced into institutional settings.

The second set of rules proposed to instead define the "qualities of a home and community based setting." While again, the efforts were laudable, the same unintended consequences that would have resulted from the prior attempt to focus on the physical location would also result from defining the "qualities" of a home and community based setting.

Again, the criteria—this time for the "qualities of a home and community based setting" – were highly subjective and impractical to apply, leaving virtually every HCBS provider subject to the whims of whoever is interpreting the proposed "qualities" and whoever is making the determination based on those criteria at a particular moment in time. The broad discretion left to the Secretary to determine the "qualities of a home and community based setting" (and to change the interpretation over time) leaves States vulnerable to an ever-changing, highly subjective and likely impossible to attain set of expectations that will result in persons being unable to receive home and community based care (as CMS has defined it) and instead, forced into institutional settings.

If a person resides with his or her family and is not permitted by the family to pursue employment, engage in community activities of interest, and control personal resources, the family home would not meet the requirements of a home and community based setting. If a State is then prohibited from providing services to the individual because his family home does not have the "qualities" of a home and community-based setting, he will not be able to receive the kinds of services that, over time, might offer the very opportunities we all desire him to have for more integrated community living.

If a setting must be "selected by the individual among all available alternatives..." would this mean that States are now obligated to offer a single person placement to any person who desires one, even if the person's needs can be safely met in a small, integrated, shared residential setting at a much lower cost? Single person placements are far more expensive than small shared residential settings where certain cost efficiencies in shared staffing can be achieved while still supporting individual choice and opportunities for integrated community living. The cost of achieving compliance with this requirement alone in our existing Section 1915(c) waivers would be in the hundreds of millions of dollars, and would require that we dedicate virtually unlimited resources to those who "prefer" to live alone, while having no resources left over to offer even a moderate level of services to others who also need support. States must have the flexibility to offer a continuum of services based on the needs (as well as preferences) of waiver participants, and to take into account the State's obligations to consider how best to stretch limited resources to serve as many people as possible.

In Tennessee's Section 1915(c) waivers, while we have residential services where the person owns or leases his residence, we offer other services where the residence is owned or rented by the provider, and is licensed pursuant to State law as a community-based residential facility. These include Medical Residential Services, where the scope of the benefit includes the availability of 24-hour nursing services as needed, for persons with medical needs that require frequent intermittent care by a licensed or registered nurse that cannot be achieved through the provision of a part-time and intermittent home health benefit. As you know, skilled nursing care is extraordinarily expensive to provide on a one-on-one basis (in excess of \$300,000 per person per year). Beyond the cost efficiencies of shared nursing, part of the value of this model is that the provision of nursing services is the responsibility of the provider agency. The result is no gaps in care, greater consistency of the staff who actually deliver care, and the integration of professional with supportive services which allows for persons with complex medical needs to nonetheless participate in community live in integrated settings. It would be impossible to allow a person to choose a provider of Medical Residential Services, and then choose to receive the component parts of that benefit, (e.g., the nursing services or the non-professional support services), from another provider. Residential benefits such as these that have been successful in allowing people with incredibly complex needs to be safely supported in the community would no longer be available, forcing people into institutional settings.

While programs can be structured to support and encourage values-based principles, attempts to regulate values will, more often than not, undermine the very objectives we seek in earnest to achieve.

We believe that CMS should instead establish in the rules the values and principles States are to employ in their delivery of HCBS. States should then have flexibility in designing a continuum of service options and settings. Accordingly, we recommend the following steps:

1. Define a set of values-based principles for the delivery of HCBS that States are expected to integrate into the design and implementation of HCBS programs, in particular, with respect to person-centered planning and service delivery, and require States submitting new waivers or renewing existing waivers to describe, through their Quality Assurance strategy, how they will monitor to assure that these principles are in fact being followed in person-centered planning processes and in the delivery of services and supports.
2. Define a limited set of physical locations that cannot be home and community based settings, i.e., NFs, ICFs/IID and hospitals.
3. Continue to allow flexibility, however, for certain HCBS to be provided when they are necessary to facilitate transition from those institutional settings to the community.
4. Identify other physical locations where heightened scrutiny is appropriate, i.e., former institutions or residences on the campus of or adjacent to a public institution, but allow flexibility for States proposing to include such settings as home and community based to explain how the State will assure that services are delivered in accordance with the core set of values-based principles for the delivery of HCBS.
5. Recognize that integration exists on a continuum that is impacted by the needs and preferences of those receiving services, and that not every person receiving services will ascribe to the level of integration perceived by some as "ideal" for everyone. To that end, a narrowly defined and restrictive set of subjective criteria will undermine the very goals of choice and autonomy that these rules purport to achieve.

We are happy to work with CMS and with other States to develop an approach that would help to further the person-centered values that we all share, while preserving the flexibility and choice that persons receiving these services want and need.

- Implementation of proposed rules regarding expansion of fair labor protections to domestic workers providing certain types of HCBS

In addition to unintended negative consequences for persons receiving care (critical loss of continuity in established caregiving relationships) and the very workers the proposed rule purports to help (reductions in base pay, fewer pay raises, few hours of actual work and loss of employee benefits), implementation of proposed rules regarding expansion of fair labor protections to domestic workers providing certain types of HCBS (RIN 1235-AA05) will have a significant negative impact on State's abilities to comply with the Olmstead decision. If States are forced to pay higher rates for these services, the result will be reductions in the numbers of people that can be served or the amount of services that can be provided, as States simply do not have an unlimited supply of resources. More people will be forced into expensive institutional settings because care at home is no longer affordable, placing States at significant risk of litigation regarding the Americans with Disabilities Act—not because they have reduced their funding for home and community based care, but rather, because these regulations will require that more of a State's limited resources are required in order to provide a lesser amount of home-based care.

**6) Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.**

- Managed Long-Term Services and Supports (MLTSS) Program

For the elderly and adults with physical disabilities, Tennessee has achieved remarkable success in its rebalancing efforts through the implementation of a Managed Long-Term Services and Supports (MLTSS) Program, i.e., CHOICES, with nearly 150% more people enrolled in HCBS since the program's inception and a 120% increase in the percentage of persons receiving LTSS in HCBS (versus institutional) settings—from 17 percent at the program's inception to 37.4% as of February 2013.

Through the use of a fully blended capitation payment encompassing all of the physical and behavioral health and LTSS a member may need, regardless of the setting in which services are received, financial incentives are appropriately aligned to encourage the provision of services in more cost-effective home and community based settings when appropriate. By the same token, incentives are also aligned to ensure that the array of HCBS provided to members living in the community is appropriate and sufficient to safely meet their needs, as the MCO will otherwise be financially responsible for the more expensive institutional benefit.

In the MLTSS program, MCOs are required to have NF diversion and transition programs. Requirements to screen members' interest and potential for transition on at least an annual basis are integrated into ongoing Care Coordination requirements specified in the MCO contracts, with prescribed timeframes for transition planning and implementation once a member is identified for transition, and intensive follow-up upon transition to ensure that HCBS services and supports are in place, and that the member's needs are met. During the first year of the program, there were 567 transitions from NFs to HCBS in the community, prior to the implementation of the State's MFP Rebalancing Demonstration.

- MFP Rebalancing Demonstration and Incentive Payment Structure

Upon award of an MFP Rebalancing grant, MFP was "layered onto" the MLTSS program in its second year. A unique incentive structure allows MCOs to earn additional payments when an eligible person transitions into MFP, and again when the person has successfully resided in the community for a year.

Additional payments are also tied to helping the State achieve other MFP program benchmarks, including rebalancing LTSS expenditures, expanded participation in consumer direction, and increasing the availability of contracted community-based residential alternative services to CHOICES members who can no longer alone, but who can remain in the community with these supports.

More recently, the State received approval to provide incentive payments to its contracted fiscal employer agent for consumer direction based on helping members who want to consumer direct certain HCBS complete program requirements and initiate consumer directed services more expeditiously.

- Raising the Level of Care Standard for NF Admission

In July, 2012, the State implemented changes to its NF level of care (LOC or medical eligibility) standards in order to better target the expensive institutional benefit to persons with higher acuity of need, while continuing to make HCBS more broadly available. Individuals who do not meet the new higher standard for NF admission are able to receive a more moderate package of HCBS, allowing them to live safely in the community and to delay or prevent the need for institutional placement. This was part of the original CHOICES program design; however implementation was initially delayed by the Maintenance of Effort provisions of the American Recovery and Reinvestment Act and subsequently the ACA. Since implementing the changes, the State has achieved a roughly 20% diversion rate of all new NF applicants to more cost-effective home and community-based care.

- Eligibility Requirements

Tennessee has elected to permit application of Institutional eligibility rules (i.e., up to 300 percent of the SSI federal benefit rate) under each of its Section 1915(c) waivers and the CHOICES program in order to facilitate access to HCBS, and has extended for many years the spousal impoverishment provisions to spouses of Medicaid enrollees receiving HCBS that are required under ACA beginning in 2014.

- Application of Community Personal Needs Allowance for Short-Term NF Stay

Having sufficient resources to secure and establish affordable housing is one of the challenges that persons seeking to transition from a NF often face. In most cases, once a person is institutionalized, the majority of his income is required, pursuant to federal post-eligibility provisions, to pay for his institutional care. Unless there is a community spouse, it is often impossible for the person to maintain his or her residence for return to the community once institutional care is no longer needed.

In the CHOICES program, if a person receiving HCBS requires short-term placement in a NF, the State's approved 1115 waiver permits the person's patient liability to continue to be calculated based on a community (rather than institutional) personal needs allowance for up to 90 days or until it is determined that the person will not be able to return to the community. This affords the person sufficient resources to pay his community living expenses and to maintain his or residence for return once he is able to be discharged from the NF.

- Transition Allowance

As an additional strategy to help persons establish housing to support transition from an institution, the CHOICES program permits MCOs to provide a transition allowance to members moving from a NF to the community. Items that may be purchased or reimbursed to facilitate the member's safe and timely transition include rent and/or utility deposits, essential kitchen appliances, basic furniture, and essential basic household items, such as towels, linens, and dishes.



Under the State's MFP Rebalancing Demonstration, a similar option is available as a supplemental benefit for persons transitioning from an ICF/IID to the community.



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**OFFICE OF THE GOVERNOR**

RICK PERRY  
GOVERNOR

October 5, 2012

The Honorable Tom Harkin  
Chairman  
Committee on Health, Education, Labor and Pensions  
U.S. Senate  
731 Hart Senate Office Building  
Washington, D.C. 20510-6300

Dear Senator Harkin:

Thank you for your letter inquiring about Texas' response to the U.S. Supreme Court's *Olmstead v. L.C.* decision. Texas was one of the first states to act on the *Olmstead* decision through two Governor's Executive Orders; legislation passed in June 2001, which created the Promoting Independence Initiative; the establishment of Money Follows the Person (MFP) in 2001; and participation in the Centers for Medicare and Medicaid Services federal MFP program, which was modeled in part on Texas' successful program. More than 35,000 individuals have relocated from Texas' institutions to community settings since September 2001.

Enclosed is specific information in response to your inquiry. All data are provided by state fiscal year versus federal fiscal year. Texas' fiscal year is from September 1 to August 31. Texas has been a leader in responding to *Olmstead* and will continue to be a leader in future years. With the recent approval to participate in the Balancing Incentive Program, Texas will build on its current success to strengthen its community-based long-term services and supports system to ensure that all individuals have a choice on where they want to live.

If you have additional questions, please contact my office.

Sincerely,

A handwritten signature in black ink that reads "Rick Perry".

Rick Perry  
Governor

RP:afp

Enclosures

Counts are based on individuals authorized to receive services in DADS Waiver Programs through the Promoting Independence initiative in State Fiscal Years 2008 - 2012. Counts include both Money Follows the Person Demonstration participants and traditional Promoting Independence participants. Individuals are counted in the State Fiscal Year in which the transition from the institution occurred. Some individuals transition more than once during a given year, therefore Unduplicated Totals may be less than the sum of counts broken out by Prior Institutional Setting and Waiver Residential Setting. Participation in Promoting Independence determined by waiver enrollment records.

<b>2008</b>	<b>Prior Institutional Setting</b>				<b>Unduplicated Total</b>
	<b>Nursing Facility</b>	<b>ICF/ID</b>	<b>SSLC</b>	<b>Other</b>	
<b>Waiver Residential Setting</b>					
3 Bed Home	0	90	100	12	<b>202</b>
4 Bed Home	0	42	58	7	<b>107</b>
Community - Alternative. Living/Res. Care	1,067	0	0	1	<b>1,068</b>
Community - w/Other Waiver Participants	98	0	0	0	<b>98</b>
Foster/Companion Care	25	62	23	5	<b>115</b>
Other	19	0	0	1	<b>20</b>
Own Home/Family Home	2,624	2	5	2	<b>2,633</b>
<b>Unduplicated Total</b>	<b>3,833</b>	<b>196</b>	<b>186</b>	<b>28</b>	<b>4,243</b>

<b>2009</b>	<b>Prior Institutional Setting</b>				<b>Unduplicated Total</b>
	<b>Nursing Facility</b>	<b>ICF/ID</b>	<b>SSLC</b>	<b>Other</b>	
<b>Waiver Residential Setting</b>					
3 Bed Home	0	121	134	3	<b>258</b>
4 Bed Home	0	29	68	1	<b>98</b>
Community - Alternative. Living/Res. Care	528	0	0	2	<b>530</b>
Community - w/Other Waiver Participants	45	0	0	0	<b>45</b>
Foster/Companion Care	23	27	31	3	<b>84</b>
Other	6	0	0	4	<b>10</b>
Own Home/Family Home	2,371	8	5	5	<b>2,389</b>
<b>Unduplicated Total</b>	<b>2,973</b>	<b>185</b>	<b>238</b>	<b>18</b>	<b>3,414</b>

<b>2010</b>	<b>Prior Institutional Setting</b>				<b>Unduplicated Total</b>
	<b>Nursing Facility</b>	<b>ICF/ID</b>	<b>SSLC</b>	<b>Other</b>	
<b>Waiver Residential Setting</b>					
3 Bed Home	0	211	207	16	<b>434</b>
4 Bed Home	0	94	85	11	<b>190</b>
Community - Alternative. Living/Res. Care	569	0	0	3	<b>572</b>
Community - w/Other Waiver Participants	60	0	0	0	<b>60</b>
Foster/Companion Care	13	65	18	17	<b>113</b>
Other	4	0	0	3	<b>7</b>
Own Home/Family Home	2,615	4	3	18	<b>2,640</b>
<b>Unduplicated Total</b>	<b>3,261</b>	<b>374</b>	<b>313</b>	<b>68</b>	<b>4,016</b>

<b>2011</b>	<b>Prior Institutional Setting</b>				<b>Unduplicated Total</b>
	<b>Nursing Facility</b>	<b>ICF/ID</b>	<b>SSLC</b>	<b>Other</b>	
<b>Waiver Residential Setting</b>					
3 Bed Home	0	164	115	11	<b>290</b>
4 Bed Home	0	42	64	9	<b>115</b>
Community - Alternative. Living/Res. Care	1,039	0	1	2	<b>1,042</b>
Community - w/Other Waiver Participants	88	0	0	0	<b>88</b>
Foster/Companion Care	30	28	11	18	<b>87</b>
Other	7	0	0	8	<b>15</b>
Own Home/Family Home	3,361	2	2	26	<b>3,391</b>
<b>Unduplicated Total</b>	<b>4,525</b>	<b>236</b>	<b>193</b>	<b>74</b>	<b>5,028</b>

<b>2012</b>	<b>Prior Institutional Setting</b>				<b>Unduplicated Total</b>
	<b>Nursing Facility</b>	<b>ICF/ID</b>	<b>SSLC</b>	<b>Other</b>	
<b>Waiver Residential Setting</b>					
3 Bed Home	0	11	62	0	<b>73</b>
4 Bed Home	2	12	32	1	<b>47</b>
Community - Alternative. Living/Res. Care	578	0	0	5	<b>583</b>
Community - w/Other Waiver Participants	69	0	0	1	<b>70</b>
Foster/Companion Care	27	6	8	0	<b>41</b>
Other	13	0	0	2	<b>15</b>
Own Home/Family Home	2,441	0	5	12	<b>2,458</b>
<b>Unduplicated Total</b>	<b>3,130</b>	<b>29</b>	<b>107</b>	<b>21</b>	<b>3,287</b>

## FY 2012 Long Term Care expenditures by setting

		All funds	State funds
Institutional	Nursing Facilities NF	\$2,202,569,479	\$915,828,389
Institutional	Nursing Facilities SNF	\$154,021,523	\$64,042,149
Institutional	SSLC	\$669,936,418	\$278,559,563
Institutional	ICF/ID community	\$292,850,494	\$121,767,235
Home-based	HCS Residential	\$409,565,688	\$170,297,413
Home-based	HCS non-residential	\$406,952,828	\$169,210,986
Home-based	CBA	\$257,204,469	\$106,945,618
Home-based	CLASS	\$196,337,036	\$81,636,940
Home-based	DBMD	\$7,881,621	\$3,277,178
Home-based	MDCP	\$41,750,047	\$17,359,670
Home-based	Texas Home Living	\$39,217,936	\$16,306,818
Home-based	PI services	\$104,077,784	\$43,275,543
Home-based	PACE	\$35,728,327	\$14,855,838
Home-based	PHC	\$308,926,939	\$128,451,821
Home-based	CAS	\$494,460,811	\$205,596,805
Home-based	DAHS	\$62,061,395	\$25,805,128
Home-based	STARPLUS LTCSS	<u>\$1,343,175,160</u>	<u>\$558,492,232</u>
	Total	\$7,026,717,955	\$2,921,709,326
Institutional		\$3,319,377,914	\$1,380,197,336
Home-based		\$3,707,340,041	\$1,541,511,990

<b>(IN THOUSANDS)</b> TYPE OF SERVICE	<b>FFY 2008</b>	
	TOTAL QTR'S	QTRS FFP
1. Inpatient Hospital	3,409,682	2,066,495
DSH Adj. Payments	1,087,914	658,840
2. Mental Health Facility	22,489	13,620
DSH Adj. Payments	268,706	162,729
3. Skilled Nursing Facility	1,938,116	1,173,723
4. ICF/IID		
A. Public Facilities	587,819	355,982
B. Private Facilities	302,624	183,271
5. Physician	832,571	504,395
6. Outpatient Hospital	754,188	458,351
7. Prescribed Drugs	1,967,856	1,196,945
7A Drug Rebate Offset	<b>(793,139)</b>	<b>(482,472)</b>
National Agreement	0	0
State Sidebar Agreement	0	0
8. Dental	790,408	478,670
9. Other Practitioner	707,138	434,084
10. Clinic	56	34
11. Laboratory & Radiological	228,521	139,905
12. Home Health	236,154	143,032
13. Sterilizations	5,500	4,950
14. Abortions	0	0
15 EPSDT Screening Services	105,585	63,943
16. Rural Health Clinic	56,726	34,356
17. Medicare Health Ins Payments		
A. Part A Premiums	243,856	147,680

(IN THOUSANDS) TYPE OF SERVICE	FFY 2008	
	TOTAL QTR'S	QTRS FFP
B. Part B Premiums	573,500	347,311
C. Qualifying Individuals		
1. 120%-134% of Poverty	17,859	17,859
2. 135%-175% of Poverty	0	0
D. Co-Ins & Deductibles	0	0
18. Medicaid Health Ins Pmts		
A. Managed Care Org (MCOs)	3,821,877	2,320,029
B. Prepaid Health Plans (PHPs)	0	0
C. Group Health Plan Payments	17,214	10,425
D. Co-Ins & Deductibles	12,986	7,864
E. Other	14,554	8,815
19. Home & Community-Based Waivers	1,250,656	757,397
20. Func Disabled Eld Care	332,756	201,519
21. Com Supt Liv Arr	0	0
22. All-Inclusive Care Elderly (PACE)	29,730	18,004
23. Personal Care	451,993	273,731
24. Targeted Case Mgmt	225,833	136,766
25. Primary Care Case Management (PCCM) Services	37,317	22,600
26. Hospice	177,261	107,349
27. Emergency Svcs Undoc Aliens (Allotment States Only)	285,211	172,811
28. Fed Qual Health Cntr	49,955	30,260
29. Other Care Services	891,467	540,310
30. Subtotal	20,942,939	12,711,583
31. Collections	(341,626)	(207,936)



<b>(IN THOUSANDS)</b> TYPE OF SERVICE	<b>FFY 2008</b>	
	TOTAL QTR'S	QTRS FFP
32. Prior Period Adjustments	495,862	301,735
33. Total Medicaid (NON-CHIP)	21,097,175	12,805,382
34. Medicaid Chip Expansions	0	0
35. Total Medicaid	21,097,175	12,805,382

<b>(IN THOUSANDS)</b> TYPE OF SERVICE	<b>FFY 2009</b>	
	TOTAL QTR'S	QTRS FFP
1. Inpatient Hospital	3,536,200	2,440,535
DSH Adj. Payments	1,323,034	786,412
2. Mental Health Facility	18,147	12,497
DSH Adj. Payments	292,457	173,837
3. Skilled Nursing Facility	2,151,951	1,486,100
4. ICF/IID		
A. Public Facilities	600,052	414,363
B. Private Facilities	298,653	206,169
5. Physician	987,940	682,180
6. Outpatient Hospital	921,662	636,891
7. Prescribed Drugs	2,133,122	1,475,965
7A Drug Rebate Offset	<b>(793,353)</b>	<b>(549,791)</b>
National Agreement	0	0
State Sidebar Agreement	0	0
8. Dental	966,914	667,892
9. Other Practitioner	777,405	541,743
10. Clinic	40	27
11. Laboratory & Radiological	264,261	183,431
12. Home Health	272,301	187,974
13. Sterilizations	5,151	4,634
14. Abortions	5	4
15 EPSDT Screening Services	126,056	87,154
16. Rural Health Clinic	57,605	39,745
17. Medicare Health Ins Payments		
A. Part A Premiums	226,312	156,289

(IN THOUSANDS) TYPE OF SERVICE	FFY 2009	
	TOTAL QTR'S	QTRS FFP
B. Part B Premiums	588,589	406,339
C. Qualifying Individuals		
1. 120%-134% of Poverty	18,767	18,767
2. 135%-175% of Poverty	0	0
D. Co-Ins & Deductibles	0	0
18. Medicaid Health Ins Pmts		
A. Managed Care Org (MCOs)	4,366,281	3,020,230
B. Prepaid Health Plans (PHPs)	0	0
C. Group Health Plan Payments	17,646	12,189
D. Co-Ins & Deductibles	19,891	13,736
E. Other	15,696	10,838
19. Home & Community-Based Waivers	1,385,395	956,606
20. Func Disabled Eld Care	365,850	252,597
21. Com Supt Liv Arr	0	0
22. All-Inclusive Care Elderly (PACE)	29,945	20,677
23. Personal Care	531,126	366,745
24. Targeted Case Mgmt	39,050	26,953
25. Primary Care Case Management (PCCM) Services	35,946	24,816
26. Hospice	208,007	143,648
27. Emergency Svcs Undoc Aliens (Allotment States Only)	273,645	188,809
28. Fed Qual Health Cntr	55,364	38,216
29. Other Care Services	631,091	435,407
30. Subtotal	22,748,204	15,570,624
31. Collections	(656,303)	(435,830)

<b>(IN THOUSANDS)</b> TYPE OF SERVICE	<b>FFY 2009</b>	
	TOTAL QTR'S	QTRS FFP
32. Prior Period Adjustments	908,114	575,713
33. Total Medicaid (NON-CHIP)	23,000,015	15,710,507
34. Medicaid Chip Expansions	0	0
35. Total Medicaid	23,000,015	15,710,507

<b>(IN THOUSANDS)</b> TYPE OF SERVICE	<b>FFY 2010</b>	
	TOTAL QTR'S	QTRS FFP
1A. Inpatient Hospital Regular	2,059,015	1,461,396
1B. DSH Adj. Payments	1,389,671	816,153
1C. Inpatient Hospital UPL	2,592,663	1,839,236
1D. Inpatient Hospital GME	17,939	12,727
2. Mental Health Facility	23,673	16,793
DSH Adj. Payments	292,514	171,793
3A. Skilled Nursing Facility Reg pmts	2,307,456	1,636,910
3B. Skilled Nursing Facility Supp	0	0
4. ICF/IID		
A. Public Facilities	629,516	446,578
B. Private Facilities	308,038	218,523
5A. Physician Svcs Regular	1,113,415	789,863
5B. Physician Svcs Supp UPL	21,451	15,218
6A. Outpatient Hospital Regular	1,100,934	781,307
6B. Outpatient Hospital Supp UPL	1,657	1,175
7. Prescribed Drugs	2,273,488	1,616,601
<b>7A Drug Rebate Offset (negative)</b>	<b>(990,841)</b>	<b>(704,568)</b>
National Agreement	0	0
State Sidebar Agreement	0	0
7A5 Rebate Offset ERQOA	<b>(5,160)</b>	<b>(5,160)</b>
8. Dental	1,278,910	907,258
9. Other Practitioner	839,779	601,373
10. Clinic	112	80
11. Laboratory & Radiological	295,512	210,635
12. Home Health	313,485	222,387
13. Sterilizations	5,045	4,541
14. Abortions	5	3

(IN THOUSANDS) TYPE OF SERVICE	FFY 2010	
	TOTAL QTR'S	QTRS FFP
15 EPSDT Screening Services	172,886	122,645
16. Rural Health Clinic	64,741	45,928
17. Medicare Health Ins Payments		
A. Part A Premiums	255,110	180,975
B. Part B Premiums	655,964	465,341
C. Qualifying Individuals		
1. 120%-134% of Poverty	29,199	29,199
2. 135%-175% of Poverty	0	0
D. Co-Ins & Deductibles	0	0
18. Medicaid Health Ins Pmts		
A. Managed Care Org (MCOs)	4,810,885	3,418,257
B. Prepaid Health Plans (PHPs)	0	0
C. Group Health Plan Payments	21,554	15,291
D. Co-Ins & Deductibles	22,192	15,743
E. Other	17,503	12,417
19. Home & Community-Based Waivers	1,540,208	1,092,623
22. All-Inclusive Care Elderly (PACE)	32,971	23,390
23A. Personal Care	1,043,580	740,315
23B. Personal Care	2,167	1,537
24A. Targeted Case Mgmt	31,311	22,212
24B. Targeted Case Mgmt	39,537	28,047
25. Primary Care Case Management (PCCM) Services	40,184	28,506
26. Hospice	226,996	161,031
27. Emergency Svcs Undoc Aliens (Allotment States Only)	301,937	214,209
28. Fed Qual Health Cntr	64,654	45,873
29. Non Emergency Med Trans	35,247	25,002

<b>(IN THOUSANDS)</b> TYPE OF SERVICE	<b>FFY 2010</b>	
	TOTAL QTR'S	QTRS FFP
40. Rehab Services (non-school based)	120,632	85,576
49. Other Care Services	721,924	512,439
50. Subtotal	26,119,658	18,347,380
<b>51. Collections (enter as negative)</b>	<b>(841,138)</b>	<b>(592,644)</b>
52. Prior Period Adjustments	1,052,163	721,835
53. Total Medicaid (NON-CHIP)	26,330,683	18,476,571
54. Medicaid Chip Expansions	0	0
55. Total Medicaid	26,330,683	18,476,571

<b>(IN THOUSANDS)</b> TYPE OF SERVICE	<b>FFY 2011</b>	
	TOTAL QTR'S	QTRS FFP
1A. Inpatient Hospital Regular	1,976,667	1,316,278
1B. DSH Adj. Payments	1,286,628	779,183
1C. Inpatient Hospital UPL	1,696,272	1,126,004
1D. Inpatient Hospital GME	274	186
2. Mental Health Facility	17,107	11,392
DSH Adj. Payments	292,512	177,147
3A. Skilled Nursing Facility Reg pmts	2,273,903	1,510,465
3B. Skilled Nursing Facility Supp	0	0
4. ICF/IID		
A. Public Facilities	475,943	316,342
B. Private Facilities	297,277	197,694
5A. Physician Svcs Regular	1,236,859	821,295
5B. Physician Svcs Supp UPL	8,912	5,841
6A. Outpatient Hospital Regular	1,124,483	749,669
6B. Outpatient Hospital Supp UPL	30,404	20,137
7. Prescribed Drugs	2,526,835	1,686,589
<b>7A Drug Rebate Offset (negative)</b>	<b>(1,035,819)</b>	<b>(691,214)</b>
National Agreement	0	0
State Sidebar Agreement	0	0
7A5 Rebate Offset ERQOA	<b>(34,505)</b>	<b>(34,505)</b>
8. Dental	1,425,240	944,960
9. Other Practitioner	807,580	546,007
10. Clinic	80	52
11. Laboratory & Radiological	281,831	189,412
12. Home Health	308,518	205,764
13. Sterilizations	2,064	1,858
14. Abortions	3	2



(IN THOUSANDS) TYPE OF SERVICE	FFY 2011	
	TOTAL QTR'S	QTRS FFP
15 EPSDT Screening Services	144,752	95,879
16. Rural Health Clinic	62,875	42,094
17. Medicare Health Ins Payments		
A. Part A Premiums	261,343	173,712
B. Part B Premiums	708,610	469,722
C. Qualifying Individuals		
1. 120%-134% of Poverty	75,287	75,287
2. 135%-175% of Poverty	0	0
D. Co-Ins & Deductibles	0	0
18. Medicaid Health Ins Pmts		
A. Managed Care Org (MCOs)	5,613,245	3,728,394
B. Prepaid Health Plans (PHPs)		
C. Group Health Plan Payments	26,274	17,396
D. Co-Ins & Deductibles	22,841	15,114
E. Other	13,520	9,148
19. Home & Community-Based Waivers	1,570,605	1,044,352
22. All-Inclusive Care Elderly (PACE)	34,993	23,285
23A. Personal Care	1,121,067	745,144
23B. Personal Care	3,092	2,065
24A. Targeted Case Mgmt	81,945	53,684
24B. Targeted Case Mgmt	49,094	32,404
25. Primary Care Case Management (PCCM) Services	43,359	28,843
26. Hospice	219,922	145,951
27. Emergency Svcs Undoc Aliens (Allotment States Only)	247,804	164,467
28. Fed Qual Health Cntr	63,383	42,297
29. Non Emergency Med Trans	82,115	52,971

<b>(IN THOUSANDS)</b> TYPE OF SERVICE	<b>FFY 2011</b>	
	TOTAL QTR'S	QTRS FFP
40. Rehab Services (non-school based)	71,478	47,846
42. Freestanding Birth Centers	15	10
49. Other Care Services	717,160	487,739
50. Subtotal	26,233,848	17,378,362
<b>51. Collections (enter as negative)</b>	<b>(695,015)</b>	<b>(469,200)</b>
52. Prior Period Adjustments	2,308,610	1,597,605
53. Total Medicaid (NON-CHIP)	27,847,443	18,506,767
54. Medicaid Chip Expansions	28,841	20,859
55. Total Medicaid	27,876,284	18,527,626

**(IN THOUSANDS)**

TYPE OF SERVICE	AF	Federal	State
1A. Inpatient Hospital Regular			
1B. DSH Adj. Payments			
1C. Inpatient Hospital UPL			
1D. Inpatient Hospital GME			
2. Mental Health Facility DSH Adj. Payments			
3A. Skilled Nursing Facility Reg pmts			
3B. Skilled Nursing Facility Supp			
4. ICF/IID			
A. Public Facilities			
B. Private Facilities			
5A. Physician Svcs Regular			
5B. Physician Svcs Supp UPL			
6A. Outpatient Hospital Regular			
6B. Outpatient Hospital Supp UPL			
7. Prescribed Drugs			
<b>7A1 Drug Rebate Offset (negative)</b>			
National Agreement			
State Sidebar Agreement			
7A2 Rebate Offset - State			
7A3 Rebate Offset - National			
7A5 Rebate Offset - FFS 100%			
8. Dental			
9. Other Practitioner			
10. Clinic			
11. Laboratory & Radiological			
12. Home Health			
13. Sterilizations			

**(IN THOUSANDS)**

TYPE OF SERVICE	AF	Federal	State
14. Abortions			
15. EPSDT Screening Services			
16. Rural Health Clinic			
17. Medicare Health Ins Payments			
A. Part A Premiums			
B. Part B Premiums			
C. Qualifying Individuals			
1. 120%-134% of Poverty			
2. 135%-175% of Poverty			
D. Co-Ins & Deductibles			
18. Medicaid Health Ins Pmts			
A. Managed Care Org (MCOs)			
B. Prepaid Health Plans (PHPs)			
C. Group Health Plan Payments			
D. Co-Ins & Deductibles			
E. Other			
19. Home & Community-Based Waivers			
22. All-Inclusive Care Elderly (PACE)			
23A. Personal Care			
23B. Personal Care			
24A. Targeted Case Mgmt			
24B. Targeted Case Mgmt			
25. Primary Care Case Management (PCCM) Services			
26. Hospice			
27. Emergency Svcs Undoc Aliens (Allotment States Only)			
28. Fed Qual Health Cntr			

<b>(IN THOUSANDS)</b>	AF	Federal	State
TYPE OF SERVICE			
29. Non Emergency Med Trans			
30. Physical Therapy			
31. Occupational Therapy			
32. Services for Speech, Hearing, Language			
33. Prosthetic Devices			
34 Diagnostic Screen			
35. Mid-Wife			
36. Emergency Hospital Svcs			
37. Critical Access Hospital			
38. Nurse Practitioner Svcs			
39. School Based Services			
40. Rehab Services (non-school based)			
42. Freestanding Birth Centers			
49. Other Care Services			
50. Subtotal			
<b>51. Collections (enter as negative)</b>			
52. Prior Period Adjustments **			
53. Total Medicaid (NON-CHIP)			
54. Medicaid Chip Expansions			
55. Total Medicaid			

**(IN THOUSANDS)**

## TYPE OF SERVICE

	AF	Federal	State
lines 19-23	2,320,630	1,351,070	969,560
STARPLUS	1,343,175	781,996	561,179
Total	3,663,805	2,133,066	1,530,739

		<b>Harkin letter- VT data</b>	<b>by ahs/dail/ddas staff</b>	
		<b>9/14/2012</b>		
			<b><u>sfv08</u></b>	
<u>data source</u>	<u>staff</u>	<u>program/service</u>	<u># people</u>	<u>\$</u>
<i>paid claims</i>	<i>Dale B</i>	CFC NF	3,543	\$115,647,247
<i>paid claims</i>	<i>Dale B</i>	CFC HCBS	3,830	\$45,173,340
<i>paid claims</i>	<i>Dale B</i>	CFC ERC	467	\$6,957,645
<i>paid claims</i>	<i>Dale B</i>	ACCS	1,292	\$13,978,751
	<i>Mary W</i>	SASH	<i>na</i>	<i>na</i>
	<i>Will R</i>	HomeShare	<i>na</i>	<i>na</i>
<i>allocation</i>	<i>June B</i>	ICF/DD	6	\$ 1,242,996
<i>paid claims?</i>	<i>Dale B</i>	# people moving from CFC NF to CFC HCBS	309	XX
<i>paid claims?</i>	<i>Dale B</i>	# people moving from CFC NF to CFC ERC	65	XX
<i>waiver cost report</i>	<i>June B</i>	DS Group living [3-6 persons/home, 24 hr support]	92	\$ 7,124,662
<i>waiver cost report</i>	<i>June B</i>	DS Home providers [aka shared living, with 24 hr support; does not include cost of respite]	1,209	\$ 31,436,834
<i>waiver cost report</i>	<i>June B</i>	DS Staffed living [1-2 persons per home with paid staff, 24 hr support]	38	\$ 2,850,519
<i>waiver cost report waiver spreadsheets</i>	<i>June B</i>	DS supported/assisted living [people who live in their own apartments who receive < 24 hr support]	113	\$ 1,814,549
<i>waiver cost report waiver spreadsheets</i>	<i>June B</i>	DS family [people who live with family; does not include cost of respite]	81	\$ 571,068

<u>sfy09</u>		<u>sfy10</u>		<u>sfy11</u>	
<u># people</u>	<u>\$</u>	<u># people</u>	<u>\$</u>	<u># people</u>	<u>\$</u>
3,581	\$118,097,538	3,605	\$114,826,406	3,504	\$ 113,113,494
3,936	\$45,956,384	3,671	\$45,217,660	3,389	\$ 43,812,933
465	\$5,559,377	467	\$5,830,369	487	\$ 6,153,281
1,347	\$14,296,654	1,347	\$14,320,991	1,395	\$ 14,494,534
<i>na</i>	<i>na</i>	<i>na</i>	<i>na</i>	<i>na</i>	<i>na</i>
<i>na</i>	<i>na</i>	<i>na</i>	<i>na</i>	104	\$142,545
6	\$ 1,274,070	6	\$ 1,274,070	6	\$ 1,261,329
321	XX	316	XX	310	XX
40	XX	29	XX	38	XX
101	\$ 7,667,107	97	\$ 7,671,097	99	\$ 7,553,766
1,260	\$ 33,149,331	1325	\$ 35,368,686	1,345	\$ 36,691,845
43	\$ 3,513,539	41	\$ 3,426,583	41	\$ 3,629,471
148	\$ 1,939,587	169	\$ 2,320,114	175	\$ 2,507,194
83	\$ 874,563	90	\$ 947,245	114	\$ 1,684,814



<b><u>sfy12</u></b>	
<b><u># people</u></b>	<b><u>\$</u></b>
3,364	\$115,189,573
3,601	\$44,191,065
499	\$6,616,318
1,580	\$15,102,230
<i>na</i>	\$773,912
112	\$142,545
<i>na</i>	<i>na</i>
332	XX
46	XX
<i>na</i>	<i>na</i>
<i>na</i>	<i>na</i>
<i>na</i>	<i>na</i>
<i>na</i>	<i>na</i>
<i>na</i>	<i>na</i>



# COMMONWEALTH of VIRGINIA

## Office of the Governor

Robert F. McDonnell  
Governor

September 5, 2012

The Honorable Tom Harkin, Chair  
Committee on Health, Education, Labor, and Pensions  
United States Senate  
428 Senate Dirksen Office Building  
Washington, DC 20510

Dear Senator Harkin:

Thank you for your letter of June 22, 2012, recognizing the anniversary of the *Olmstead* decision requiring that individuals be served in the most integrated settings appropriate to meet their needs consistent with their choice.

As you no doubt are aware, a final order has been issued from the Eastern District Court in regard to the agreement reached between Virginia and the US Department of Justice (DOJ) on January 26, 2012. The agreement represents the resolution of DOJ's investigation of Virginia's training centers and community programs and the Commonwealth's compliance with the ADA and *Olmstead* with respect to individuals with intellectual and developmental disabilities. Information about the agreement is available on the Department of Behavioral Health and Developmental Services' web site at <http://www.dbhds.virginia.gov/settlement.htm>.

The Virginia General Assembly received two recent documents from my Administration while the final order was pending. First, in February, a plan was submitted to the General Assembly to cease residential operations at four of Virginia's training centers with the first closure scheduled for 2014 and the last scheduled for 2020. State officials adhered to two overarching goals when considering these proposals and developing the plan:

- 1) To ensure the agreement results in the best possible outcomes for Virginians with intellectual and developmental disabilities, and
- 2) To ensure the agreement and plan are fiscally responsible.

More recently, the first semi-annual report on Virginia's progress in meeting the milestones in the Settlement Agreement was provided in July for the period of March 6, 2012 – June 30, 2012. The report also describes expenditures associated with the Agreement for Fiscal Year 2012. The next implementation update is due on December 1, 2012. Both documents are available at the web address listed above, and are attached to this letter for your convenience.

Of your list of six specific requests, the latter three are specific to Virginia's *Olmstead* Plan. Attached is a copy of Virginia's *Olmstead* Strategic Plan from 2011 and the newly restructured 2012 Plan which is currently under review. These documents provide historical

The Honorable Tom Harkin, Chair  
September 5, 2012  
Page Two

background on where Virginia has been as well as challenges to and recommendations for improving integrated community living options for individuals with disabilities.

Your interest in the services for individuals with disabilities is commendable. I hope you find this information helpful.

Sincerely,



Robert F. McDonnell

Cc: The Hon. William A. Hazel, Jr., MD  
The Hon. Jeannemarie D. Davis

Enclosures

# **VIRGINIA'S COMPREHENSIVE CROSS-GOVERNMENTAL STRATEGIC PLAN**

**TO ASSURE CONTINUED COMMUNITY INTEGRATION  
OF VIRGINIANS WITH DISABILITIES**



## **2011 Interim Updated Plan**

**Approved by the CIIT December 6, 2011**

***By the Community Integration Implementation Team and the  
Community Integration Advisory Commission***



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## APPENDICES

Appendix I	Definition of Planning Terms
Appendix II	A Guide to Acronyms Used in This Plan
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**VIRGINIA'S COMPREHENSIVE, CROSS-GOVERNMENTAL  
STRATEGIC PLAN TO ASSURE CONTINUED COMMUNITY INTEGRATION  
OF VIRGINIANS WITH DISABILITIES  
2011 Updated Plan**

## **I. INTRODUCTION**

On August 2, 2007, four Secretariats, two Council Executive Branch entities, and seven local government and agency representatives comprising the Community Integration Implementation Team (Team), and the 21-member stakeholder Community Integration Advisory Commission (Commission) jointly adopted Virginia's first *Comprehensive, Cross-Governmental Strategic Plan to Assure Continued Community Integration of Virginians with Disabilities* (the Plan) pursuant §§ 2.2-2524 – 2529 of the Code of Virginia and Executive Directive 6 (Kaine, 2007). This Plan was submitted to the Governor on a yearly basis.

Executive Directive 6 (Kaine, 2007) charges the Team to complete and annually update the Plan by August 31 of each year. The original Plan was first updated in 2008. The Team respectfully submits this 2011 Updated Plan as an interim document with the intent to create a new Plan in 2012 that more concisely and effectively addresses community integration of Virginians with disabilities.

### **A. Our Mission**

The Team shall continue its “collaborative efforts to complete and annually update a comprehensive, cross-governmental strategic plan designed to assure continued community integration of Virginians with disabilities....The plan shall be submitted to (the Governor) for (his) approval no later than August 31, 2011, and shall be updated and submitted annually by August 31 of each succeeding year. The Plan shall be accompanied by a report on statewide progress in addressing these issues.”<sup>1</sup>

*Executive Directive 6 (2007)*

### **B. Our Vision**

We envision Virginia as “one community” for all citizens—one that welcomes individuals with disabilities and supports them as active members of their own communities. By “own community,” we mean any location an individual with a disability chooses that affords the individual the opportunity for maximum possible autonomy over his or her daily life.

We believe that individuals, of all ages and with any disabilities, have the right to decide where to live, and live as independently as possible, in the most integrated setting. This is the same right—no more and no less—enjoyed by individuals who do not have disabilities.

—*One Community: Final Report of the Task Force to Develop an Olmstead Plan for Virginia (August 28, 2003)*, as adopted in 2004/2005 by the EO 61 and EO 84 Oversight Advisory Committee, in 2006 by the EO 2 Oversight Advisory Board, and in 2007, 2008 and 2009 by the Team and Commission.

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<sup>1</sup> At the request of the Commission, the 2009 Progress Report was developed as a stand-alone document and will be available at [www.olmsteadva.com](http://www.olmsteadva.com) by August 31, 2009.

## **C. Our Goals**

**Goal #1: Virginians with disabilities who currently reside in a mental health, mental retardation (now intellectual disability), nursing or assisted living facility will have the opportunity to choose to move from these facilities to an appropriate, more integrated setting and stay there.**

**Goal #2: Virginians with disabilities who are at risk of unwanted admission to a mental health, mental retardation (now intellectual disability), nursing or assisted living facility, will have the opportunity to receive services and supports that prevent admission.**

## **D. Our Critical Success Factors**

### ***1. Virginians with disabilities plan, fully understand and choose among services and supports they need, self-directing them to the extent possible.***

**Choices must be meaningful and driven not by disability “labels,” but by the unique needs and preferences of individuals with disabilities. We believe that, in order to assure meaningful choices, the Commonwealth must:**

- **Provide services and supports that are appropriate to and respectful of the individual, affordable, accessible, available, diverse, reliable, safe and accountable;**
- **Allow self-determination and consumer direction<sup>2</sup> of services and supports to the extent possible;**
- **Provide maximum opportunities for individuals with disabilities and their families to participate in planning and developing services and supports as well as policy planning;**
- **Assure that individuals with disabilities and their families know about these services and supports and the choices that are available to them;**
- **Encourage independence and community involvement through livable/ walkable communities<sup>3</sup>, beginning with local comprehensive plans and continuing through implementation that provides transportation, housing, employment and access to services; and**
- **Address the institutional bias in the State Medicaid Plan by balancing community and institutional services.**

### ***2. Virginians with disabilities choose among individuals and agencies qualified to provide the services and supports they select.***

**In order that individuals with disabilities have the opportunity to live, work, and participate in activities in the community of their choosing, needed services and supports must be available from qualified providers. Qualified providers can be individuals or organizations that have a variety of backgrounds, professional expertise and skills that maximize the ability and capacity of individuals with disabilities to live independently in the community of their choosing, with a quality of life that empowers**

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<sup>2</sup> In this Plan, the term “consumer direction” and the term “self direction” are synonymous.

<sup>3</sup> A “livable/walkable community” is one that has affordable and appropriate housing, supportive community features and services, adequate mobility options and encourages employment opportunities for all who want to work, which together facilitate the public sense of safety, personal independence and engagement of residents in civic and social life.

them to fully participate in society. To increase the availability of qualified providers, Virginia should embrace creative solutions, including public/private partnerships, and ensure that adequate compensation is provided for services rendered.

***3. Virginians with disabilities locate and obtain housing appropriate to their needs and preferences.***

Services and supports mean little unless Virginians with disabilities have access to housing that enables them to live as independently as possible according to their individual needs and preferences. A full array of permanent and transitional housing options must, therefore, be available. Transitional and permanent housing for individuals with disabilities must be affordable and accessible to all individuals who are: 1) institutionalized; 2) living in a setting they consider to be restrictive; 3) at risk of institutionalization; 4) on residential services waiting lists; and 5) homeless. Housing should be separate from supportive services and not be contingent on the receipt of services; however, supportive services must be available, accessible if needed and desired, flexible and individualized. The use of Universal and EasyLiving Home Design should become standard practice in the development of new housing. If embraced at the beginning of the planning process, Universal and EasyLiving Home Design can be an affordable development option.

***4. Virginians with disabilities locate and obtain a job if appropriate.***

A true measure of integration into the community, for every individual who is able and wants to do so, is the individual's opportunity to work. The dignity, responsibility, and economic independence resulting from gainful employment is the most effective way of reducing dependence on public benefits, enhancing self-reliance, changing attitudes, and promoting full community integration of individuals with disabilities.

***5. Virginians with disabilities access transportation appropriate to their needs.***

Transportation is basic in the integration into and survival in community living for individuals with disabilities; it is what allows all citizens to work, go to the doctor, visit friends, shop, and participate in activities in the manner they choose. Transportation of all kinds must be consistently available, affordable, accessible, reliable, and safe, and meet the needs of individuals with disabilities throughout the Commonwealth, in both rural and metropolitan areas. Transportation also includes safe and appropriate pedestrian and bicycle facilities ("complete streets") and paratransit, which provides complete needs of all individuals participating within the community.

***6. Virginians with disabilities—if they lack capacity to make decisions—have the same choices, options and benefits as other Virginians with disabilities through a surrogate/supportive decision-maker qualified to act on their behalf.***

Most individuals with disabilities are fully capable of making choices and decisions for themselves, just as individuals without disabilities are. We acknowledge that some individuals with disabilities lack the capacity to make some or all decisions and choices for themselves. Every such individual should have a means by which decisions and choices may be made on his or her behalf. Among many other examples, some individuals may have an advance directive, and others may need a surrogate decision-maker appointed and available to act on their behalf. The surrogate/supportive decision-maker could be a family member chosen in the order set forth in the Health Care Decisions Act (Va. Code § 54.1-2986), a guardian, or other legally authorized representative. Unless the context indicates otherwise, wherever



reference is made to a decision or choice by an individual with a disability in the report that follows, the decision or choice may be made by an appropriate surrogate/supportive decision-maker if the individual cannot make the decision or choice independently.

*7. Virginians with disabilities access ongoing supports in order to stay in the most integrated setting of choice, self-directing them to the extent possible.*

In order to assure choices to individuals with disabilities, ongoing community support and services must be available and reflect the importance of Virginia's full continuum of care.

**\* Additional changes will be made commensurate with the Department of Justice resolution**

**II. GOALS #1 AND #2: ACTION PLANS THAT APPLY TO ALL FOUR TYPES OF FACILITIES**

**Critical Success Factor #1: Plan, Understand, Choose and Self-Direct Services and Supports**

**Action Plan #1.1**

<b>Objective</b>	Individuals with disabilities will plan, fully understand, choose and direct their own services.				
<b>Strategy</b>	Identify individuals with disabilities or their families who have had successful experiences with directing their services and supports and include them in state and local initiatives (for example, training and mentor programs) to assure that service providers and disability communities share a commitment to maximize principles of self-direction and choice.				
<b>Measurable outcomes</b>	1) The number of Self direction Service Policies will increase in service delivery State Agencies. 2) Policy changes will be monitored by the Team on a yearly basis.				
<b>Action Items</b>			<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
1. Incorporate self-direction language and promotion of person-centered practices (PCP) in policies and documents of state and local agencies, including training materials. Follow progress of Systems Transformation Grant (STG) implementation.			Ongoing	IT	\$0
2. Develop strategies to monitor policy changes at State Agencies			Ongoing	Agencies collaborating on STG	\$0

**Action Plan #1.2**

<b>Objective</b>	Individuals with disabilities will have a variety of choices to support their selected community integration option.				
<b>Strategy</b>	Expand self-direction options in all service environments to increase utilization.				
<b>Measurable outcome</b>	Community Integration Choices will increase.				
<b>Actions Items</b>			<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
1. Continue to develop new self-direction community integration options for Virginians, including, where applicable, adding self-direction to home and community-based waivers.			2011	Agencies collaborating on the STG	TBD

• Models identified in 2008.		Ongoing		
2. Promote increased usage of self-direction options through education and outreach.		Ongoing	Agencies collaborating on the STG	TBD
3. Continue to Involve the SILC, the CILs, AAAs, CSBs, and private case management organizations in creating implementation plans for new targeted community integration best practices referenced above including transitional start-up costs.		Ongoing	Agencies collaborating on the STG	TBD
•				
Strategy #1.2.2	Develop an infrastructure to support individuals with disabilities to choose how their allocated funding is spent, with appropriate accountability.			
Measurable outcome	The number of individuals using individualized budgeting will increase.			
Action Items		Date/s	Responsible agency/cies	Cost/s
1. Adopt Money Follows the Person(MFP) initiatives. Follow progress of Systems Transformation Grant (STG) implementation:		2011	Agencies collaborating on the STG	TBD
• Determine budget authority and methodology; amend waivers.				
• Monitor MFP and consumer directed models.				

**Critical Success Factor #2: Choose Among Quality Community Providers and Direct Support Professionals**

**Action Plan #2.1**

<b>Objective</b>	Foster and support an environment conducive to attracting and maintaining an adequate network of quality community providers and direct support professionals will be created.			
<b>Strategy</b>	Publish/communicate complete career ladder of certifications and licensure for individuals serving individuals with disabilities.			
<b>Measurable outcome</b>	The number of quality community providers and direct support professionals in Virginia will increase.			
	<b>Actions Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
	1. Track the implementation of recommendations from the Health Reform Commission. Work with OSHHR regarding disability-related recommendations and any implementation progress.	Ongoing	IT, DBVI, DRS, DBHDS, DMAS	TBD
<b>Strategy #2.1.2</b>	Adequately reimburse quality community providers and direct support professionals so that they can afford to do business.			
<b>Measurable outcome</b>	Reimbursement of quality community providers and direct support professionals in Virginia will increase.			
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
	1. Continue to monitor compensation and pay rate for direct support professionals. Ensure that all Personal Care, Respite, and Companion Services through DRS, DMAS, and DSS are allotted new funds for comparable increases.	Ongoing	DRS, DMAS, DSS	TBD
	2. Convene a short-term Team task group to determine how to implement a 25% differential in ID and IFDDS Medicaid Waiver reimbursement rates for providers of residential services who serve four or fewer people per home to make smaller settings more financially feasible and promote the Money Follows the Person initiative.	Spring 2012	DBHDS, DMAS	TBD
<b>Strategy 2.1.3</b>	Identify methods of encouraging exemptions of publicly-funded skilled services where appropriate so that individuals who direct their own services have sufficient flexibility to choose to have a direct support professional to perform the duties.			
<b>Measurable outcome</b>	The number of quality community providers and direct support professionals in Virginia will increase.			
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
	1. Implement policies and practices to pay family members serving as provider of services in publicly funded programs. Recommend specific regulatory, policy and procedural changes (with safeguards) to the DRS PAS program and Consumer Directed services in the DMAS Waivers that would allow family members over age 18 to be employed as personal assistants. The same standard currently used in the MR/ID Waiver should be considered for use in the other waivers.	Fall 2011	DRS, DMAS, DBHDS	\$0



Critical Success Factor #3: Obtain Housing

**Action Plan #3.1**

<b>Objective</b>	<b>Housing will be accessible for individuals leaving institutions or at risk of becoming institutionalized.</b>			
<b>Strategy</b>	Eliminate physical, social and other barriers that impede an individual's ability to live in the most integrated environment possible. (Accessibility means different things for different individuals. For an individual with a mobility limitation the elimination of structural barriers might result in accessibility. For an individual with a developmental disability, accessibility might be a system of supports that mitigate limitations and perhaps include a congregate living model.)			
<b>Measurable outcomes</b>	1) Accessible Housing Units for people with disabilities will increase to meet the needs of individuals leaving institutions or at risk of becoming institutionalized			
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
	<p>1. Continue to identify the barriers to accessible housing and determine how best to address them.</p> <ul style="list-style-type: none"> <li>• Work with building code officials who are responsible for ensuring that buildings are in compliance to develop recommendations on addressing barriers through programmatic responses.</li> <li>• Promote acceptance of Universal and EasyLiving Home Design as the standard for development of new housing; offer training courses related to universal design, EasyLiving Homes and accessibility requirements on a continuing basis.</li> <li>• Determine the need to address attitudes, beliefs, and misconceptions of housing providers related to the disability community.</li> <li>• Support the work of the SILC and CILs to educate the housing community on the accessibility needs of people with disabilities.</li> </ul>	Ongoing	DPOR, VHDA, DHCD	TBD
	<p>2. Evaluate the need for additional program resources to assist the development of accessible units in appropriate locations, and recommend the allocation of additional resources as needed.</p> <ul style="list-style-type: none"> <li>• Recommend that the General Assembly Housing Commission participate.</li> <li>• Explore funding sources for the fund expansion.</li> <li>• Identify appropriate agencies to submit grant applications or to take the lead on state budget initiatives.</li> <li>• Encourage Universal and EasyLiving Home Design features for all new construction.</li> </ul>	Ongoing	VBPD, DHCD, VHDA, DBHDS, DRS, OCI, DSS, DMAS	\$35,000
	<p>3. Foster implementation of the accessibility recommendations in the MFP Annual Housing and Transportation Action Plan, which are hereby incorporated by reference into this Plan, and the report of the Housing Study work group convened by DBHDS, due by October 2009. -ARCHIVE</p>	Ongoing	DHCD, VHDA, DMAS, DBHDS, DRS, VBPD	\$0
	<p>4. Assist the disability and aging communities to work together to educate decision-makers on the need for accessible housing options for older adults and individuals with disabilities.</p>	Ongoing	DHCD, VHDA, DMAS, DBHDS, DRS, VBPD, DBVI, VDDHH, VDA, DVS	\$0

**Action Plan #3.2**

<b>Objective</b>	<b>Housing will be affordable for individuals leaving institutions or at risk of becoming institutionalized.</b>			
<b>Strategy 3.2.1</b>	Produce more units for individuals above 60% of the area median income that can be occupied using no more than 30% of their available income.			
<b>Strategy 3.2.2</b>	Provide income supplements to individuals below 60% of the area median income such that no more than 30% of their available income is spent for housing.			
<b>Measurable outcomes</b>	1) The number of units to house individuals at or below 60% of the area median income will increase. 2) The number of individuals receiving subsidies sufficient to meet their housing needs will increase.			
<b>Action Items</b>		<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
<b>1. Work with VBPD, VHDA, DHCD, the SILC and the Disability Commission to develop and fund a mechanism for collecting statewide annual data on:</b> <ul style="list-style-type: none"> <li>• The number of individuals currently in nursing homes, state mental health facilities, ICFs/MR and ALFs who need affordable housing units or rental vouchers in order to move to the community.</li> <li>• The number of individuals at risk of admission to one of these facilities if they cannot find affordable housing in the community.</li> <li>• The type of affordable housing needed by these individuals by income level and geographic region.</li> <li>• The number of affordable housing units needed by these individuals by geographic region.</li> </ul>		By 1/1/12	OCI, VBPD, DRS, DSS, DMAS, DBHDS, DBVI, VDA	TBD
<b>2. Evaluate the need for additional program subsidies to increase affordability.</b> <ul style="list-style-type: none"> <li>• Research current fair market rents throughout Virginia.</li> <li>• Develop program structures to make housing more affordable.</li> <li>• Project costs for such programs.</li> <li>• Maximize opportunities for leveraging funds through investment in community housing.</li> </ul>		Ongoing	DHCD, VHDA, VBPD, DBHDS, DRS	\$35,000
<b>3. Preserve affordable, accessible housing where it exists.</b> <ul style="list-style-type: none"> <li>• Identify the funding stream that maintains the affordability of these units.</li> <li>• Develop strategies that consider geography and funding sources.</li> <li>• Provide resources for rental assistance to help maintain affordability.</li> </ul>		Ongoing	VHDA, DHCD	TBD

<p>4. Encourage development of affordable housing where it does not exist.</p> <ul style="list-style-type: none"> <li>Stay abreast of potential federal programs and educate decision-makers on the need for options for people with disabilities with very low incomes through such mechanisms as the federal housing trust fund, the former Virginia Housing Partnership Fund or similar funds.<sup>4</sup></li> <li>Develop a press release for the Governor's consideration to educate the public on the opportunities provided by the Community Development Block Grant ARRA funding (going beyond Section 504 compliance), HUD's non-elderly disability vouchers and new vouchers; EasyLiving Homes; the Livable Homes Tax Credit; and the possibility of combining Neighborhood Stabilization Program funding with voucher funding. DELETE ENTIRE BULLET</li> <li>Encourage use of the Greenhouse Project Model. ARCHIVE</li> </ul>	Ongoing	IT	TBD
<p>5. PROMOTE implementation of the housing affordability recommendations in the MFP Annual Housing and Transportation Action Plan which are hereby incorporated by reference into this Plan. Monitor and participate in all current housing Workgroups, including the current GOVERNOR'S HOUSING WORKGROUP.</p>	Ongoing	DHCD, VHDA, DMAS, DBHDS, DRS, VBPD	\$0

**Action Plan #3.3**

Objective	Housing will be available and appropriately located.			
Strategy 3.3.1	Make specific financing resources available.			
Strategy 3.3.2	Increase local capacity to undertake development.			
Strategy 3.3.3	Insure appropriate enforcement of laws and regulations.			
Measurable outcomes	<p>1) The number of new units will increase.</p> <p>2) The number of developers and design professionals capable of building new units, built to Universal and EasyLiving Home Design standards, in appropriate regions will increase.</p> <p>3) The number of Fair Housing Complaints, including failure to make reasonable modifications, will decrease.</p> <p>4) The number of local communities' comprehensive plans that reflect the needs of individuals with disabilities and address issues of safe, livable/walkable communities including accessibility, affordability and availability will increase.</p>			
Action Items		Date/s	Responsible agency/cies	Cost/s
1. Support the work of the CILs to review and evaluate comprehensive plans to address issues of accessibility, affordability, and availability. Consult VACO and VML to assess data availability.		Ongoing	DHCD, VHDA, DMAS, DBHDS, DRS, VBPD	\$0
2. Develop a plan to expand outreach and promote awareness of existing financial and capacity building resources available to the general public, local governments, PHA's, housing providers, developers, and builders.		Ongoing	VHDA, DHCD	\$10,000

<sup>4</sup> The Team recognizes that the economy may preclude funding of state initiatives in the upcoming year and will update the plan next year based on changes on the federal level and state of the economy at that time.

<ul style="list-style-type: none"> <li>• <b>Develop additional informational publications as needed and distribute them.</b></li> <li>• <b>Conduct information sessions as needed for the general public, local governments, PHA's, housing providers, developers, and builders.</b></li> <li>• <b>Support expansion of the Accessible Housing Registry, <a href="http://www.accessva.org">www.accessva.org</a>, as a marketing and outreach tool through Socialserve.com. Investigate and recommend incentive opportunities to ensure that accessible housing is included and updated on <a href="http://www.accessva.org">www.accessva.org</a>.</b></li> <li>• <b>Incorporate a comment and rating option on, <a href="http://www.accessva.org">www.accessva.org</a>.</b></li> <li>• <b>Ensure that accessible housing developed with the Community Development Block Grant, HOME, Low Income Housing Tax Credit, and other public resources, is included and updated on <a href="http://www.accessva.org">www.accessva.org</a>.</b></li> </ul>			
<p><b>3. Develop methods of enhancing compliance with laws and regulations.</b></p> <ul style="list-style-type: none"> <li>• <b>Continue to work with private fair housing organizations and advocacy groups to enhance enforcement efforts related to the design and construction requirements of the Virginia Fair Housing Law. Assess fair housing violation trends and target training based on the most frequent violations.</b></li> <li>• <b>Educate builders, developers, and state and local housing officials about their obligations under federally financed housing programs.</b></li> <li>• <b>Work with the SILC and CILs to educate individuals with disabilities and disability advocates about the obligations of builders and developers.</b></li> </ul>	Ongoing	DHCD, DPOR	\$40,000



Critical Success Factor #4: Locate and Obtain a Job

**Action Plan #4.1**

<b>Objective</b>	<b>Individuals with significant disabilities transitioning out of institutions will have the option to become employed.</b>			
<b>Strategy</b>	<b>Make available information and resources to pursue and obtain employment.</b>			
<b>Measurable outcome</b>	<b>The number of referrals to organizations that provide services to assist individuals with disabilities to become employed will increase.</b>			
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
	<b>1. Ensure that all information about job location, availability and training/education needed is up to date and available to those who are transitioning into the community. Work with DMAS to ensure that this information is being captured on MFP transition plans, and if it is not, add it to transition plans.</b>	<b>Ongoing</b>	<b>IT, VEC, Workforce Office, DRS, DBVI, DMAS, DBHDS</b>	<b>TBD</b>

**Action Plan #4.2**

<b>Objective</b>	<b>Individuals with disabilities will have informed choice in their employment options, including self-employment.</b>			
<b>Strategy</b>	<b>Develop knowledge of available employment options and the means to attain them.</b>			
<b>Measurable outcome</b>	<b>At least 100 individuals in nursing homes, 100 individuals in institutions, and 100 other individuals transitioning to the community under the Money Follows the Person Demonstration will receive employment services options packages and will understand the various options.</b>			
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
	<b>1. Working with advocates, disseminate the employment services options package to appropriate bodies, including those assisting individuals who are transitioning, in hard copy and through websites.</b>	<b>Ongoing</b>	<b>DRS, DBVI, DBHDS, DMAS</b>	<b>TBD</b>
	<b>2. Working with CILs and ESOs, train staff, including staff involved in institutional discharge planning, on employment services options and informed choice so that they can support individuals with disabilities to obtain desired employment. Ensure that there is a process and tracking in place for this to happen. At a minimum, request DMAS to ensure that this is happening with individuals transitioning under MFP.</b>	<b>Ongoing</b>	<b>DRS, DBVI, DMAS, DBHDS</b>	<b>TBD</b>

**Action Plan #4.3**

<b>Objective</b>	<b>Opportunities for employment will exist.</b>		
<b>Strategy</b>	Increase job opportunities and the capacity of employment support services.		
<b>Measurable outcome</b>	The unemployment of individuals with disabilities will decrease.		
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>
	1. Expand personal assistance services by increasing appropriations for the DRS program and by increasing rates for both the DRS program and DMAS providers. Ensure that increases for DRS and DMAS Personal Assistants are consistent.	Ongoing	DRS, DMAS, OCI
	2. Continue to monitor and ensure that supported employment, assistive technology, and home modifications as applicable, are an option in all Medicaid waivers; fund supported employment consistently with DRS rates.	Ongoing	DMAS
			<b>Cost/s</b>
			TBD
			TBD

**Critical Success Factor #5: Access Transportation**

**Action Plan #5.1**

<b>Objective</b>	<b>Individuals with disabilities leaving institutions or at risk will be aware of available transportation options.</b>		
<b>Strategy</b>	Educate and publicize available transportation options to individuals with disabilities.		
<b>Measurable outcome</b>	The number of individuals utilizing transportation services will increase.		
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>
	1. Support DRPT in coordinating local plans. <ul style="list-style-type: none"> <li>DRPT will finalize the statewide plan and submit it to the Governor.</li> <li>Reinforce and strengthen the regional mobility teams.</li> </ul>	12/09 and ongoing	IT, DRPT
	2. Develop a mechanism to educate individuals with disabilities and other stakeholders about transportation access and opportunities, including the benefits of collaboration/cooperation between local jurisdictions through VirginiaNavigator and disability services.	10/11	DRPT
	3.. Develop concrete recommendations for implementing a voucher system. <ul style="list-style-type: none"> <li>Research other states' mileage reimbursement, volunteer driver, and voucher programs.</li> <li>Research other states' incentive programs for individuals with disabilities.</li> </ul>	10/11	VBPD, DRPT, DMAS
	4. Foster implementation of the transportation awareness recommendations in the MFP Annual Housing and Transportation Action Plan, which are hereby incorporated by reference into this Plan.	Ongoing	IT
			<b>Cost/s</b>
			TBD
			\$0
			TBD
			\$0

**Action Plan #5.2**

<b>Objective</b>	Individuals with disabilities leaving institutions or at risk will know how to take advantage of available transportation services and the process to file an appropriate			
<b>Strategy</b>	Train CILs, CSBs, AAAs, ESOs, case managers and other key personnel to train end users.			
<b>Measurable outcome</b>	The number of individuals trained to take advantage of their transportation choices will increase.			
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
	1. PROMOTE implementation of the travel training recommendations in the MFP Annual Housing and Transportation Action Plan, which are hereby incorporated by reference into this Plan.	Ongoing	IT	\$0

**Action Plan #5.3**

<b>Objective</b>	The State will leverage funding to support current and increased transportation services.			
<b>Strategy</b>	Coordinate transportation services to maximize efficiencies to support additional transportation services.			
<b>Measurable outcome</b>	The current level of transportation services will increase as measured by the number of trips, miles, and riders.			
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
	1. Local Coordination plans will identify coordination/improved efficiency opportunities. Include coordination with housing, medical, and employment transportation.	Ongoing	DRPT, VHDA, DHCD, DRS	\$0
	2. Establish mobility long range goals with performance measures in cooperation with other modal agencies during development of the next Statewide Transportation Plan.	Ongoing	VDOT, DBVI	\$0
	3. Explore options to develop a strategy to hold transportation services accountable to individuals with disabilities for failure to provide agreed services.	TBD	IT	\$0

**Critical Success Factor #6: Surrogate/Supportive Decision-Making**

**Action Plan #6.1**

<b>Objective</b>	A qualified surrogate or supportive decision-maker will be available to each individual statewide who needs one; if an individual cannot afford one, one will be provided.			
<b>Strategy</b>	Identify appropriate human and financial resources needed and develop mechanisms to make the resources accessible.			
<b>Measurable outcome</b>	There will be no unmet surrogate or supportive decision-making needs.			
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
	1. Conduct a statewide assessment of individuals who have unmet surrogate/supportive decision-making service needs. Determine the need based on current data available and identify gaps where data are not	3/12	DBHDS, DSS, DRS, DMAS, VDA	\$0



available.			
2. Develop an estimate of the cost for the appropriate level of service based on the data available regarding unmet need.	7/12	DBHDS, VDA, DSS, DRS, DMAS	\$0
3. Develop a budget amendment to implement the action steps.	8/12	DBHDS, VDA, DSS, DRS, DMAS	\$0

**Action Plan #6.2**

<b>Objective</b>	For those who have a surrogate or supportive decision-maker, the decision-maker will represent the best interests of the individual without exceeding the level of services required in accordance with applicable law and regulations.		
<b>Strategy</b>	Provide training for surrogate or supportive decision-makers on respect for individual values, person-centered practices, self direction, appropriate standards, and consistency with the needs of the individual.		
<b>Measurable outcome</b>	All surrogate or supportive decision makers will receive training prior to serving as decision-makers.		
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>
	1. Form a short-term Task Group of the IT to develop implementation actions in collaboration with the Virginia Guardianship Association.	10/11	IT
			<b>Cost/s</b>
			\$0

**Critical Success Factor #7: Access Ongoing Supports**

**Action Plan #7.1**

<b>Objective</b>	All individuals with disabilities will have accessible, quality medical, dental, vision and hearing care in their communities.		
<b>Strategy</b>	Increase the number of accessible (including physically accessible) medical, dental, vision and hearing providers in communities that offer services to individuals with disabilities.		
<b>Measurable outcome</b>	The number of accessible medical, dental, vision and hearing providers offering services to individuals with disabilities will increase by 20%.		
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>
	1. Follow implementation of recommendations of the Governor's Health Reform Commission in "Roadmap for Virginia's Health." Follow implementation of the VCU Health Promotion Grant.	Ongoing	IT
	2. Educate and train appropriate staff on available resources and service options.	Ongoing	DSS, DBHDS
			<b>Cost/s</b>
			TBD
			TBD

**Action Plan #7.2**

<b>Objective</b>	Waiver services will be available AS AN OPTION. DELETE for all who want them.			
<b>Strategy</b>	Expand existing waiver services.			
<b>Measurable outcome</b>	100% of individuals eligible for existing waivers will receive desired waiver services.			
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
	1. Monitor the waiting list phase out plan adopted by the 2011 General Assembly.	Ongoing	IT	\$0
	2. Identify additional needed services. Utilize the MR/ID System Study as a model for how to identify additional needed services. Identify additional needed services for other waivers.	Ongoing	OSHR, DMAS, DBHDS	TBD
	3. Obtain appropriation for additional services.	Ongoing	OSHR, DMAS, DBHDS	TBD
	4. Change the urgent care criteria to include length of time on the waiting list			TBD
	5. Work with and monitor all local agencies to assure that all waiver slots allocated to the MFP Demonstration are being filled in a timely manner by individuals wishing to transition to the community.	Ongoing	OCI, DBHDS, DMAS, VDA, DRS	\$0

**Action Plan #7.3**

<b>Objective</b>	Virginia will cover all needed services for individuals with mental illness.			
<b>Strategy</b>	Expand funded wellness management, peer supports, and supported employment services.			
<b>Measurable outcome</b>	At least three new services will be expanded.			
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
	1. Seek additional SGF in Governor's budget to collaborate with statewide partners and individuals with mental health issues to design, create and support a Virginia Mental Health Recovery Institute to provide comprehensive training/recovery education/ongoing consultation to state and local mental health agency staff and consumers in the transformation of the mental health system to one that truly embraces a culture of recovery and promotes wellness management, Peer Supports and supported employment. <ul style="list-style-type: none"> <li>Work with DBHDS to ensure services identified above</li> </ul>	Ongoing	DBHDS	\$700,000
	2. In conjunction with CSBs, promote recovery supports and wellness management practices. <ul style="list-style-type: none"> <li>Continue Peer Training Programs in Wellness Recovery Action Plan (WRAP) development and facilitation.</li> <li>Continue trainings in recovery and support consumer-run programs in each planning region.</li> </ul>	Ongoing	DBHDS	\$600,000
	3. In conjunction with CSBs and DRS, promote supported employment practices. DBHDS, DRS, and DMAS will coordinate operational guidance to providers.	Ongoing	DBHDS, DRS, DMAS	\$0



**Action Plan #7.4**

<b>Objective</b>	Specialized services and supports will be available to permit individuals to continue to live in their homes, through such supports as the Older Blind Program, the Companion Program, and the Caregivers Grant.			
<b>Strategy 7.4.2</b>	Provide increases to the companion program.			
<b>Strategy 7.4.3</b>	Provide grants to caregivers of older individuals.			
<b>Strategy 7.4.4</b>	Support individuals with all types of disabilities who do not qualify for Medicaid or Medicaid waivers to obtain community services and supports through state general funds or Medicaid State Plan Option.			
<b>Measurable outcomes</b>	1) The frequency of rehabilitation teacher contacts with older blind customers will increase. 2) The percentage of eligible individuals receiving services will increase. 3) Caregiver grants will be available statewide. 4) The number of individuals with disabilities receiving community services and supports will increase.			
<b>Action Items</b>		<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
1. Request budget increases to make sufficient older blind services available to all eligible individuals. (Current budget levels are \$750,000+)		Ongoing	DBVI	\$
2. Request a budget increase for home-based services for older adults and adults with disabilities who are on the waiting list.		Ongoing	DSS	\$2 million
3. Form a Team Task Group to examine ways in which community services and supports can best be made available to individuals who do not currently qualify for Medicaid or Medicaid waivers.		Fall 2011	DBHDS, DRS, DMAS, VDA, VDDHH, DBVI, DSS	\$0

**III. GOALS #1 AND #2: ACTION PLANS THAT APPLY TO A SPECIFIC TYPE OF FACILITY**

**Critical Success Factor #7: Access Ongoing Supports**

**Action Plan #7.1-F: Assisted Living Facilities**

<b>Objective</b>	Information about community-based options will be readily available.			
<b>Strategy</b>	Provide information on all community living opportunities to individuals with disabilities who receive auxiliary grants.			
<b>Measurable outcome</b>	100% of individuals of auxiliary grant recipients living in assisted living facilities will receive community-based options information.			
<b>Action Items</b>		<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
1. Utilize lessons learned from VACIL's nursing home transition grant for assisted living facilities.		Ongoing	DBHDS, DSS, VBPD, VDA	TBD
2. Educate and train appropriate staff on available resources and service options.		Ongoing	DSS, DBHDS	TBD
3. Mandate communication of options to all individuals covered by this Plan.		Ongoing	DSS, DBHDS	TBD

**Action Plan #7.2-F: Assisted Living Facilities**

*Please note that the ability to implement the following actions is dependent upon resolution of risks, recently identified by the Social Security Administration, to the state Maintenance of Effort and Virginia's Medicaid program if a third AG category is created. If the pilot cannot proceed, the Team Task Group will instead explore recommendations for 1) educating the Social Security Administration on the impact of these risks on the ability of individuals with disabilities to choose to live in settings other than ALFs, and 2) alternatives to AG portability that will enable individuals to choose to live in settings other than ALFs.*

<b>Objective</b>	Money will follow the person.			
<b>Strategy</b>	Use auxiliary grants for other community living options.			
<b>Measurable outcome</b>	The auxiliary grant will fund 250 individuals living in other community options.			
	<b>Action Items</b>	<b>Date/s</b>	<b>Responsible agency/cies</b>	<b>Cost/s</b>
	1. Implement the pilot to test a portable auxiliary grant option.	2012	DSS, DBHDS, DHCD	\$160,000
	2. Evaluate for program outcomes and costs; identify needed policy changes.	2012	OSHHR, DSS, DBHDS, DHCD	TBD
	3. If pilot is successful, seek approval and appropriation for statewide implementation.	2012	OSHHR, DSS, DBHDS, DHCD	TBD
	4. Revise regulations.	2012	OSHHR, DSS, DBHDS, DHCD	TBD
	5. Through an IT Task Group, monitor all phases of pilot implementation and evaluation to develop strategies for expansion to all disability populations.	Ongoing	IT	\$0

## Appendix I

### Definition of Planning Terms

**Action plan:** A brief outline of expectations, strategies, measurable outcomes, implementation actions, dates, responsible agency/cies, and cost/s that would result in success for the applicable critical success factor.

**Cost/s:** If known, the cost of implementing each action.

**Critical success factor:** A key area in which the Commonwealth's satisfactory performance is required in order for Virginians with disabilities who currently reside in, or are at risk of unwanted admission to, a state mental health, mental retardation/intellectual disabilities, nursing or assisted living facility to achieve their goal of community integration.

**Date/s:** For each implementation action, the date by which implementation should begin.

**Expectation:** A sentence that describes what Virginians with disabilities expect.

**Implementation Actions:** Action statements that describe sequentially how each strategy would be implemented.

**Measurable outcome/s:** For each strategy, a sentence that describes how success would be measured if the strategy were implemented.

**Responsible agency/cies:** For each implementation action, the agency or agencies that would actually implement the action.

**Strategy:** A phrase that describes what is needed to meet the expectations. There can be more than one strategy for an expectation.



## A Guide to Acronyms Used in this Plan

<b>AAAs</b>	<b>Area Agencies on Aging</b>
<b>ALF</b>	<b>Assisted Living Facility</b>
<b>ARRA</b>	<b>American Recovery and Reinvestment Act</b>
<b>CILs</b>	<b>Centers for Independent Living</b>
<b>CSBs</b>	<b>Community Services Boards</b>
<b>DBHDS</b>	<b>Department of Behavioral Health and Developmental Services</b>
<b>DBVI</b>	<b>Department for the Blind and Vision Impaired</b>
<b>DHCD</b>	<b>Department of Housing and Community Development</b>
<b>DHP</b>	<b>Department of Health Professions</b>
<b>DMAS</b>	<b>Department of Medical Assistance Services</b>
<b>DPOR</b>	<b>Department of Professional and Occupational Regulation</b>
<b>DRPT</b>	<b>Department of Rail and Public Transportation</b>
<b>DRS</b>	<b>Department of Rehabilitative Services</b>
<b>DSS</b>	<b>Department of Social Services</b>
<b>DVS</b>	<b>Department of Veterans Services</b>
<b>ESO</b>	<b>Employment Services Organization</b>
<b>FTA</b>	<b>Federal Transit Administration</b>
<b>GA</b>	<b>General Assembly</b>
<b>HUD</b>	<b>U.S. Department of Housing and Urban Development</b>
<b>IHE</b>	<b>Institutions of Higher Education</b>
<b>ID</b>	<b>Intellectual Disability</b>
<b>ICF/MR</b>	<b>Intermediate Care Facility for Individuals with Mental Retardation/Intellectual Disabilities</b>
<b>IT</b>	<b>Implementation Team</b>
<b>MFP</b>	<b>Money Follows the Person</b>
<b>MH</b>	<b>Mental Health</b>
<b>MHSS</b>	<b>Mental Health Support Services</b>

<b>MOU</b>	<b>Memorandum of Understanding</b>
<b>MR</b>	<b>Mental Retardation</b>
<b>OCI</b>	<b>Office of Community Integration</b>
<b>OSHR</b>	<b>Office of the Secretary of Health and Human Resources</b>
<b>PAS</b>	<b>Personal Assistance Services</b>
<b>PCP</b>	<b>Person-Centered Practices</b>
<b>PHA</b>	<b>Public Housing Agency</b>
<b>RFP</b>	<b>Request for Proposals</b>
<b>SCHEV</b>	<b>State Council of Higher Education for Virginia</b>
<b>SGF</b>	<b>State General Funds</b>
<b>SILC</b>	<b>Statewide Independent Living Council</b>
<b>STG</b>	<b>Systems Transformation Grant</b>
<b>TBD</b>	<b>To Be Determined</b>
<b>VACIL</b>	<b>Virginia Association of Centers for Independent Living</b>
<b>VACO</b>	<b>Virginia Association of Counties</b>
<b>VBPD</b>	<b>Virginia Board for People with Disabilities</b>
<b>VCCS</b>	<b>Virginia Community Colleges System</b>
<b>VDA</b>	<b>Virginia Department for the Aging</b>
<b>VDDHH</b>	<b>Virginia Department for the Deaf and Hard of Hearing</b>
<b>VDH</b>	<b>Virginia Department of Health</b>
<b>VDOE</b>	<b>Virginia Department of Education</b>
<b>VDOT</b>	<b>Virginia Department of Transportation</b>
<b>VEC</b>	<b>Virginia Employment Commission</b>
<b>VHDA</b>	<b>Virginia Housing Development Authority</b>
<b>VML</b>	<b>Virginia Municipal League</b>
<b>WRAP</b>	<b>Wellness Recovery Action Plan</b>

# **DBHDS**

Virginia Department of  
**Behavioral Health and  
Developmental Services**

## **DOJ Implementation Update**

**Pursuant to**

**Code of Virginia §37.2-319 (HB2533/SB1486, 2011)  
and Item 315.V.I. of the 2012 *Appropriation Act***

**to the Governor and the Chairs of the  
Senate Finance and House Appropriations Committees**

**July 23, 2012**

**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF VIRGINIA  
Richmond Division**

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	CIVIL ACTION NO:
	)	
COMMONWEALTH OF VIRGINIA,	)	
	)	
Defendant.	)	
	)	
	)	
	)	

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**SETTLEMENT AGREEMENT**

**I. Introduction**

- A. The Commonwealth of Virginia (“the Commonwealth”) and the United States (together, “the Parties”) are committed to full compliance with Title II of the Americans with Disabilities Act (“ADA”), 42 U.S.C. § 12101, as interpreted by *Olmstead v. L.C.*, 527 U.S. 581 (1999). This Agreement is intended to ensure the Commonwealth’s compliance with the ADA and *Olmstead*, which require that, to the extent the Commonwealth offers services to individuals with intellectual and developmental disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs. Accordingly, throughout this document, the Parties intend that the goals of community integration, self-determination, and quality services will be achieved.
  
- B. On August 21, 2008, the United States Department of Justice (“United States”) initiated an investigation of Central Virginia Training Center (“CVTC”), the largest of Virginia’s five state-operated intermediate care facilities for persons with intellectual and developmental disabilities (“ICFs”), pursuant to the Civil Rights of Institutionalized Persons Act (“CRIPA”), 42 U.S.C. § 1997. On April 21, 2010, the United States notified the Commonwealth that it was expanding its investigation under the ADA to focus on the Commonwealth’s compliance with the ADA’s integration mandate and *Olmstead* with respect to individuals at CVTC. During the course of the expanded investigation, however, it became clear that an examination of the Commonwealth’s measures to address the rights of individuals at CVTC under the ADA and *Olmstead* implicated the statewide system for serving individuals with intellectual and developmental disabilities and required a broader scope of review. Accordingly, the policies and practices that the United States examined in its expanded investigation were statewide in scope and application. On February 10, 2011, the United States issued its findings, concluding that the Commonwealth fails to provide services to individuals with intellectual and

developmental disabilities in the most integrated setting appropriate to their needs as required by the ADA and *Olmstead*.

- C. The Commonwealth engaged with the United States in open dialogue about the allegations and worked with the United States to resolve the alleged violations of the ADA arising out of the Commonwealth's provision of services for individuals with intellectual and developmental disabilities.
- D. In order to resolve all issues pending between the Parties without the expense, risks, delays, and uncertainties of litigation, the United States and the Commonwealth agree to the terms of this Settlement Agreement as stated below. This Agreement resolves the United States' investigation of CVTC, as well as its broader examination of the Commonwealth's compliance with the ADA and *Olmstead* with respect to individuals with intellectual and developmental disabilities.
- E. By entering into this Settlement Agreement, the Commonwealth does not admit to the truth or validity of any claim made against it by the United States.
- F. The Parties acknowledge that the Court has jurisdiction over this case and authority to enter this Settlement Agreement and to enforce its terms as set forth herein.
- G. No person or entity is intended to be a third-party beneficiary of the provisions of this Settlement Agreement for purposes of any other civil, criminal, or administrative action, and, accordingly, no person or entity may assert any claim or right as a beneficiary or protected class under this Settlement Agreement in any separate action. This Settlement Agreement is not intended to impair or expand the right of any person or organization to seek relief against the Commonwealth or their officials, employees, or agents.
- H. The Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331; 28 U.S.C. § 1345; and 42 U.S.C. §§ 12131-12132. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b).

## II. Definitions

- A. "Developmental disability" means a severe, chronic disability of an individual that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before the individual attains age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in 3 or more of the following areas of major life activity: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; (g) economic self-sufficiency; and (5) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. 42 U.S.C. § 15002.
- B. "Intellectual disability" means a disability characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills. This disability originates before the age of 18. An intellectual disability is a type of developmental disability.

- C. Home and Community-Based Services Waivers ("HCBS Waivers") means the program approved by the Centers for Medicare and Medicaid Services ("CMS") for the purpose of providing services in community settings for eligible persons with developmental disabilities who would otherwise be served in ICFs. For purposes of this Settlement Agreement, "HCBS Waivers" includes the Intellectual Disabilities Waiver ("ID Waiver") and the Individual and Family Developmental Disabilities Support Waiver ("DD Waiver"), or any other CMS approved waivers that are equivalent to the ID or DD Waivers that may be created after the execution of this Agreement.
- D. Individual and family supports are defined as a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting family members with intellectual or developmental disabilities ("ID/DD") or individuals with ID/DD who live independently have access to person-centered and family-centered resources, supports, services and other assistance. Individual and family supports are targeted to individuals not already receiving services under HCBS waivers, as defined in Section II.C above. The family supports provided under this Agreement shall not supplant or in any way limit the availability of services provided through the Elderly or Disabled with Consumer Direction ("EDCD") waiver, Early and Periodic Screening, Diagnosis and Treatment ("EPSDT"), or similar programs.

### **III. Serving Individuals with Developmental Disabilities In the Most Integrated Setting**

- A. To prevent the unnecessary institutionalization of individuals with ID/DD and to provide them opportunities to live in the most integrated settings appropriate to their needs consistent with their informed choice, the Commonwealth shall develop and provide the community services described in this Section.
- B. Target Population:
1. The target population of this Agreement shall include individuals with ID/DD who meet any of the following additional criteria:
    - a. are currently residing at any of the Training Centers;
    - b. who (i) meet the criteria for the wait list for the ID waiver, or (ii) meet the criteria for the wait list for the DD waiver; or
    - c. currently reside in a nursing home or ICF.
  2. The Commonwealth shall not exclude any otherwise qualifying individual from the target population due to the existence of complex behavioral or medical needs or of co-occurring conditions, including but not limited to, mental illness, traumatic brain injuries, or other neurological conditions.
  3. Individuals shall remain in the target population if they receive HCBS waiver services or individual and family supports under this Agreement.
  4. Individuals who are otherwise in the target population and who have been released from forensic status or placed on conditional release by a court shall not be excluded

from the target population solely on the basis of their former forensic status or current conditional release status.

5. Inclusion in the target population does not guarantee or create a right to receipt of services.

C. Enhancement of Community Services

1. By June 30, 2021, the Commonwealth shall create 4,170 waiver slots for the target population, to be broken down as follows:

- a. The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community according to the following schedule:
  - i. In State Fiscal Year 2012, 60 waiver slots
  - ii. In State Fiscal Year 2013, 160 waiver slots
  - iii. In State Fiscal Year 2014, 160 waiver slots
  - iv. In State Fiscal Year 2015, 90 waiver slots
  - v. In State Fiscal Year 2016, 85 waiver slots
  - vi. In State Fiscal Year 2017, 90 waiver slots
  - vii. In State Fiscal Year 2018, 90 waiver slots
  - viii. In State Fiscal Year 2019, 35 waiver slots
  - ix. In State Fiscal Year 2020, 35 waiver slots
- b. The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities), according to the following schedule:
  - i. In State Fiscal Year 2012, 275 waiver slots
  - ii. In State Fiscal Year 2013, 225 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs
  - iii. In State Fiscal Year 2014, 225 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs

- iv. In State Fiscal Year 2015, 250 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs
  - v. In State Fiscal Year 2016, 275 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs
  - vi. In State Fiscal Year 2017, 300 waiver slots
  - vii. In State Fiscal Year 2018, 325 waiver slots
  - viii. In State Fiscal Year 2019, 325 waiver slots
  - ix. In State Fiscal Year 2020, 355 waiver slots
  - x. In State Fiscal Year 2021, 360 waiver slots
- c. The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities), according to the following schedule:
- i. In State Fiscal Year 2012, 150 waiver slots
  - ii. In State Fiscal Year 2013, 25 waiver slots, including 15 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs
  - iii. In State Fiscal Year 2014, 25 waiver slots, including 15 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs
  - iv. In State Fiscal Year 2015, 25 waiver slots, including 15 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs
  - v. In State Fiscal Year 2016, 25 waiver slots, including 15 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs
  - vi. In State Fiscal Year 2017, 25 waiver slots, including 10 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs



- vii. In State Fiscal Year 2018, 25 waiver slots, including 10 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs
  - viii. In State Fiscal Year 2019, 25 waiver slots
  - ix. In State Fiscal Year 2020, 50 waiver slots
  - x. In State Fiscal Year 2021, 75 waiver slots
- d. If the Commonwealth creates more waiver slots than are required in Sections III.C.1.a, b, or c above for a particular fiscal year, the number of slots created above the requirement shall be counted towards the slots required to be created in the subsequent fiscal year in the relevant Section.
2. The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization, according to the following schedule:
- a. In State Fiscal Year 2013, a minimum of 700 individuals supported
  - b. In State Fiscal Year 2014, a minimum of 1000 individuals supported
  - c. In State Fiscal Year 2015, a minimum of 1000 individuals supported
  - d. In State Fiscal Year 2016, a minimum of 1000 individuals supported
  - e. In State Fiscal Year 2017, a minimum of 1000 individuals supported
  - f. In State Fiscal Year 2018, a minimum of 1000 individuals supported
  - g. In State Fiscal Year 2019, a minimum of 1000 individuals supported
  - h. In State Fiscal Year 2020, a minimum of 1000 individuals supported
  - i. In State Fiscal Year 2021, a minimum of 1000 individuals supported
3. If the Commonwealth substantially changes or amends its ID or DD waivers, the Parties shall meet within 15 days of final approval from CMS to determine if any provisions of this Agreement should be amended. The Parties agree that under any new terms, at least as many individuals in each category in Sections III.C.1.a, b, and c and C.2 above shall receive HCBS waivers and individual and family supports under the Agreement. If the Parties cannot reach agreement within 90 days, the Court shall resolve the dispute.
4. With the consent of the United States and the Independent Reviewer, the Commonwealth may re-allocate any unused waiver slot from one category of III.C.1.a-c to another in any State Fiscal Year covered by this Agreement.
5. Case Management

- a. The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.
- b. For the purposes of this agreement, case management shall mean:
  - i. Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs;
  - ii. Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP; and
  - iii. Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.
- c. Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.
- d. The Commonwealth shall establish a mechanism to monitor compliance with performance standards.

## 6. Crisis Services

- a. The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall:
  - i. Provide timely and accessible support to individuals with intellectual and developmental disabilities who are experiencing crises, including crises due to behavioral or psychiatric issues, and to their families;
  - ii. Provide services focused on crisis prevention and proactive planning to avoid potential crises; and
  - iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual from his or her current placement whenever practicable.
- b. The crisis system shall include the following components:
  - i. Crisis Point of Entry

- A. The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about and referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week and staffed with clinical professionals who are able to assess crises by phone and assist the caller in identifying and connecting with local services. Where necessary, the crisis hotline will dispatch at least one mobile crisis team member who is adequately trained to address the crisis.
  - B. By June 30, 2012, the Commonwealth shall train CSB Emergency Services personnel in each Health Planning Region ("Region") on the new crisis response system it is establishing, how to make referrals, and the resources that are available.
- ii. Mobile crisis teams
- A. Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services, support, and treatment to de-escalate crises without removing individuals from their current placement whenever possible.
  - B. Mobile crisis teams shall assist with crisis planning and identifying strategies for preventing future crises and may also provide enhanced short-term capacity within an individual's home or other community setting.
  - C. Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with ID/DD comes into contact with law enforcement.
  - D. Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.
  - E. Mobile crisis teams shall provide local and timely in-home crisis support for up to 3 days, with the possibility of an additional period of up to 3 days upon review by the Regional Mobile Crisis Team Coordinator.
  - F. By June 30, 2012, the Commonwealth shall have at least one mobile crisis team in each Region that shall respond to on-site crises within three hours.
  - G. By June 30, 2013, the Commonwealth shall have at least two mobile crisis teams in each Region that shall respond to on-site crises within two hours.
  - H. By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond on site to crises as follows: in urban areas, within one hour, and in rural areas, within two hours, as measured by the average annual response time.

iii. Crisis stabilization programs

- A. Crisis stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services.
- B. Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.
- C. If an individual receives crisis stabilization services in a community-based placement instead of a crisis stabilization unit, the individual may be given the option of remaining in the placement if the provider is willing and has capacity to serve the individual and the provider can meet the needs of the individual as determined by the provider and the individual's case manager.
- D. Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.
- E. With the exception of the Pathways Program operated at Southwestern Virginia Training Center ("SWVTC"), crisis stabilization programs shall not be located on the grounds of the Training Centers or hospitals with inpatient psychiatric beds. By July 1, 2015, the Pathways Program at SWVTC will cease providing crisis stabilization services and shall be replaced by off-site crisis stabilization programs with sufficient capacity to meet the needs of the target population in that Region.
- F. By June 30, 2012, the Commonwealth shall develop one crisis stabilization program in each Region.
- G. By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.

7. Integrated Day Activities and Supported Employment

- a. To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.
- b. The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disability Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy. The Employment

First policy shall, at a minimum, be based on the following principles: (1) individual supported employment in integrated work settings is the first and priority service option for individuals with intellectual or developmental disabilities receiving day program or employment services from or funded by the Commonwealth; (2) the goal of employment services is to support individuals in integrated work settings where they are paid minimum or competitive wages; and (3) employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in ISPs. The Commonwealth shall have at least one employment service coordinator to monitor implementation of Employment First practices for individuals in the target population.

- i. Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreational opportunities, and other integrated day activities. The plan will be under the direct supervision of a dedicated employment service coordinator for the Commonwealth and shall:
  - A. Provide regional training on the Employment First policy and strategies throughout the Commonwealth; and
  - B. Establish, for individuals receiving services through the HCBS waivers:
    1. Annual baseline information regarding:
      - a. The number of individuals who are receiving supported employment;
      - b. The length of time people maintain employment in integrated work settings;
      - c. Amount of earnings from supported employment;
      - d. The number of individuals in pre-vocational services as defined in 12 VAC 30-120-211 in effect on the effective date of this Agreement; and
      - e. The length of time individuals remain in pre-vocational services.
    2. Targets to meaningfully increase:
      - a. The number of individuals who enroll in supported employment each year; and
      - b. The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.

- c. Regional Quality Councils, described in Section V.D.5 below, shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly to the Regional Quality Councils and the Quality Management system by the providers. Regional Quality Councils shall consult with those providers and the SELN regarding the need to take additional measures to further enhance these services.
- d. The Regional Quality Councils shall annually review the targets set pursuant to Section III.C.7.b.i.B.2 above and shall work with providers and the SELN in determining whether the targets should be adjusted upward.

#### 8. Access and Availability of Services

- a. The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.
  - b. The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.
9. The Commonwealth has made public its long-standing goal and policy, independent of and adopted prior to this Agreement or the Department of Justice's findings, of transitioning from an institutional model of care to a community-based system that meets the needs of all individuals with ID/DD, including those with the most complex needs, and of using its limited resources to serve effectively the greatest number of individuals with ID/DD. This goal and policy have resulted in a decline in the population of the state training centers from approximately 6000 individuals to approximately 1000 individuals. The Commonwealth has determined that this significant and ongoing decline makes continued operation of residential services fiscally impractical. Consequently, and in accordance with the Commonwealth's policy of transitioning its system of developmental services to a community-based system, the Commonwealth will provide to the General Assembly within one year of the effective date of this Agreement, a plan, developed in consultation with the Chairmen of Virginia's House of Delegates Appropriations and Senate Finance Committees, to cease residential operations at four of the five training centers by the end of State Fiscal Year 2021.

#### D. Community Living Options

1. The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.
2. The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or

apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources, including local, State, or federal affordable housing or rental assistance programs (tenant-based or project-based) and the fund described in Section III.D.4 below.

3. Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments. The Commonwealth undertakes this initiative recognizing that comparatively modest housing supports often can enable individuals to live successfully in the most integrated settings appropriate to their needs.
  - a. The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services ("DBHDS") and in coordination with representatives from the Department of Medical Assistance Services ("DMAS"), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations as determined appropriate by DBHDS.
  - b. The plan will establish, for individuals receiving or eligible to receive services through the HCBS waivers under this Agreement:
    - i. Baseline information regarding the number of individuals who would choose the independent living options described above, if available; and
    - ii. Recommendations to provide access to these settings during each year of this Agreement.
4. Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing, from a one-time fund of \$800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii, to as many individuals as possible who receive HCBS waivers under this Agreement, express a desire for living in their own home or apartment, and for whom such a placement is the most integrated setting appropriate to their needs.
5. Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.
6. No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant and, under circumstances described in Section III.E below, by the Regional Support Team.
7. The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive



community options on at least an annual basis to any individuals living outside their own home or family's home (and, if relevant, to their authorized representative or guardian).

**E. Community Resource Consultants and Regional Support Teams**

1. The Commonwealth shall utilize Community Resource Consultant ("CRC") positions located in each Region to provide oversight and guidance to CSBs and community providers, and serve as a liaison between the CSB case managers and DBHDS Central Office. The CRCs shall provide on-site, electronic, written, and telephonic technical assistance to CSB case managers and private providers regarding person-centered planning, the Supports Intensity Scale, and requirements of case management and HCBS Waivers. The CRC shall also provide ongoing technical assistance to CSBs and community providers during an individual's placement. The CRCs shall be a member of the Regional Support Team in the appropriate Region.
2. The CRC may consult at any time with the Regional Support Team. Upon referral to it, the Regional Support Team shall work with the Personal Support Team ("PST") and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual's needs, consistent with the individual's informed choice. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CRC.
3. The CRC shall refer cases to the Regional Support Teams for review, assistance in resolving barriers, or recommendations whenever:
  - a. The PST is having difficulty identifying or locating a particular community placement, services and supports for an individual within 3 months of the individual's receipt of HCBS waiver services.
  - b. The PST recommends and, upon his/her review, the CRC also recommends that an individual residing in his or her own home, his or her family's home, or a sponsored residence be placed in a congregate setting with five or more individuals.
  - c. The PST recommends and, upon his/her review, the CRC also recommends an individual residing in any setting be placed in a nursing home or ICF.
  - d. There is a pattern of an individual repeatedly being removed from his or her current placement.



#### **IV. Discharge Planning and Transition from Training Center**

By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this Section, excluding other dates agreed upon, and listed separately in this Section.

- A. To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.
- B. Discharge Planning and Discharge Plans
  1. Discharge planning shall begin upon admission.
  2. Discharge planning shall drive treatment of individuals in any Training Center and shall adhere to the principles of person-centered planning.
  3. Individuals in Training Centers shall participate in their treatment and discharge planning to the maximum extent practicable, regardless of whether they have authorized representatives. Individuals shall be provided the necessary support (including, but not limited to, communication supports) to ensure that they have a meaningful role in the process.
  4. The goal of treatment and discharge planning shall be to assist the individual in achieving 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 settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).
  5. The Commonwealth shall ensure that discharge plans are developed for all individuals in its Training Centers through a documented person-centered planning and implementation process and consistent with the terms of this Section. The discharge plan shall be an individualized support plan for transition into the most integrated setting consistent with informed individual choice and needs and shall be implemented accordingly. The final discharge plan (developed within 30 days prior to discharge) will include:
    - a. Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;
    - b. Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;

- c. Assessment of 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;
  - d. Listing 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;
  - e. Documentation of barriers preventing the individual from transitioning to a more integrated setting and 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.
6. Discharge planning will be done by the individual's PST. The PST includes the individual receiving services, the authorized representative (if any), CSB case manager, Training Center staff, and persons whom the individual has freely chosen or requested to participate (including but not limited to family members and close friends). Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.
7. Discharge planning shall be based on the presumption that, with sufficient supports and services, all individuals (including individuals with complex behavioral and/or medical needs) can live in an integrated setting.
8. For individuals admitted to a Training Center after the date this Agreement is signed by both parties, the Commonwealth shall ensure that a discharge plan is developed as described herein within 30 days of admission. For all individuals residing in a Training Center on the date that this Agreement is signed by both parties, the Commonwealth shall ensure that a discharge plan is developed as described herein within six months of the effective date of this Agreement.
9. In developing discharge plans, PSTs, in collaboration with the CSB case manager, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan as described above, and the opportunity to discuss and meaningfully consider those options.

- a. The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.
  - b. PSTs and the CSB case manager shall coordinate with the specific type of community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representative with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family and peer programs to facilitate these opportunities.
  - c. PSTs and the CSB case managers shall assist the individual and, where applicable, their authorized representative in choosing a provider after providing the opportunities described above and ensure that providers are timely identified and engaged in preparing for the individual's transition.
10. The Commonwealth shall ensure that Training Center PSTs have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting; present individuals and their families with specific options for community placements, services, and supports; and, together with providers, answer individuals' and families' questions about community living.
- a. In collaboration with the CSBs and community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of this Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.
  - b. Person-centered thinking training will occur during initial orientation and through annual refresher courses. Competency will be determined through documented observation of PST meetings and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches throughout the state will have regular and structured sessions with person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person-centered thinking practices throughout all levels of the Training Centers.

11. In the event that an individual or, where applicable, authorized representative opposes the PST's proposed options for placement in a more integrated setting after being provided the information and opportunities described in Section IV.B.9, the Commonwealth shall ensure that PSTs:
  - a. Identify and seek to resolve the concerns of individuals and/or their authorized representatives with regard to community placement;
  - b. Develop and implement individualized strategies to address concerns and objections to community placement; and
  - c. Document the steps taken to resolve the concerns of individuals and/or their authorized representatives and provide information about community placement.
12. All individuals in the Training Center shall be provided opportunities for engaging in community activities to the fullest extent practicable, consistent with their identified needs and preferences, even if the individual does not yet have a discharge plan for transitioning to the community.
13. The State shall ensure that information about barriers to discharge from involved providers, CSB case managers, Regional Support Teams, Community Integration Managers, and individuals' ISPs is collected from the Training Centers and is aggregated and analyzed for ongoing quality improvement, discharge planning, and development of community-based services.
14. In the event that a PST makes a recommendation to maintain placement at a Training Center or to place an individual in a nursing home or congregate setting with five or more individuals, the decision shall be documented, and the PST shall identify the barriers to placement in a more integrated setting and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager and Regional Support Team in accordance with Sections IV.D.2.a and f and IV.D.3 below, and such placements shall only occur as permitted by Section IV.C.6.

#### C. Transition to Community Setting

1. Once a specific provider is selected by an individual, the Commonwealth shall invite and encourage the provider to actively participate in the transition of the individual from the Training Center to the community placement.
2. Once trial visits are completed, the individual has selected a provider, and the provider agrees to serve the individual, discharge will occur within 6 weeks, absent conditions beyond the Commonwealth's control. If discharge does not occur within 6 weeks, the reasons it did not occur will be documented and a new time frame for

discharge will be developed by the PST. Where discharge does not occur within 3 months of selecting a provider, the PST shall identify the barriers to discharge and notify the Facility Director and Community Integration Manager in accordance with Section IV.D.2 below, and the case shall be referred to the Regional Support Teams in accordance with Section IV.D.3 below.

3. The Commonwealth shall develop and implement a system to follow up with individuals after discharge from the Training Centers to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission, crises, or other negative outcomes. The Post Move Monitor, in coordination with the CSB, will conduct post-move monitoring visits within each of three (3) intervals (30, 60, and 90 days) following an individual's movement to the community setting. Documentation of the monitoring visit will be made using the Post Move Monitoring Checklist. The Commonwealth shall ensure those conducting Post Move Monitoring are adequately trained and a reasonable sample of look-behind Post Move Monitoring is completed to validate the reliability of the Post Move Monitoring process.
4. The Commonwealth shall ensure that each individual transitioning from a Training Center shall have a current discharge plan, updated within 30 days prior to the individual's discharge.
5. The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services to ensure successful transition in the new living environment, including what is most important to the individual as it relates to community placement. The Commonwealth, in consultation with the PST, will determine the essential supports needed for successful and optimal community placement. The Commonwealth shall ensure that essential supports are in place at the individual's community placement prior to the individual's discharge from the Training Center. This determination will be documented. The absence of those services and supports identified as non-essential by the Commonwealth, in consultation with the PST, shall not be a barrier to transition.
6. No individual shall be transferred from a Training Center to a nursing home or congregate setting with five or more individuals unless placement in such a facility is in accordance with the individual's informed choice after receiving options for community placements, services, and supports and is reviewed by the Community Integration Manager to ensure such placement is consistent with the individual's informed choice.
7. The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.

#### **D. Community Integration Managers and Regional Support Teams**

- 1. The Commonwealth will create Community Integration Manager ("CIM") positions at each operating Training Center. The CIMs will be DBHDS Central Office staff members who will be physically located at each of the operating Training Centers. The CIMs will facilitate communication and planning with individuals residing in the Training Centers, their families, the PST, and private providers about all aspects of an individual's transition, and will address identified barriers to discharge. The CIMs will have professional experience working in the field of developmental disabilities, and an understanding of best practices for providing community services to individuals with developmental disabilities. The CIMs will have expertise in the areas of working with clinical and programmatic staff, facilitating large, diverse groups of professionals, and providing service coordination across organizational boundaries. The CIMs will serve as the primary connection between the Training Center and DBHDS Central Office. The CIMs will provide oversight, guidance, and technical assistance to the PSTs by identifying strategies for addressing or overcoming barriers to discharge, ensuring that PSTs follow the process described in Sections IV.B and C above, and identifying and developing corrective actions, including the need for any additional training or involvement of supervisory staff.**
- 2. CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances:**
  - a. The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals;**
  - b. The PST is having difficulty identifying or locating a particular type of community placement, services and supports for an individual within 90 days of development of a discharge plan during the first year of the Agreement; within 60 days of development of a discharge plan during the second year of the Agreement; within 45 days of development of a discharge plan in the third year of the Agreement; and within 30 days of development of a discharge plan thereafter.**
  - c. The PST cannot agree on a discharge plan outcome within 15 days of the annual PST meeting, or within 30 days after the admission to the Training Center.**
  - d. The individual or his or her authorized representative opposes discharge after all the requirements described in Section IV.B.9 have been satisfied or refuses to participate in the discharge planning process;**
  - e. The individual is not discharged within three months of selecting a provider, as described in Section IV.C.2 above. The PST shall identify the barriers to discharge and notify both the facility director and the CIM; or**

- f. The PST recommends that an individual remain in a Training Center. If the individual remains at the Training Center, an assessment by the PST and the CIM will be performed at 90-day intervals from the decision for the individual to remain at the Training Center, to ensure that the individual is in the most integrated setting appropriate to his or her needs.
3. The Commonwealth will create five Regional Support Teams, each coordinated by the CIM. The Regional Support Teams shall be composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs. Upon referral to it, the Regional Support Team shall work with the PST and CIM to review the case and resolve identified barriers. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CIM. The CIM may consult at any time with the Regional Support Teams and will refer cases to the Regional Support Teams when:
  - a. The CIM is unable, within 2 weeks of the PST's referral to the CIM, to document attainable steps that will be taken to resolve any barriers to community placement enumerated in Section IV.D.2 above.
  - b. A PST continues to recommend placement in a Training Center at the second quarterly review following the PST's recommendation that an individual remain in a Training Center (Section IV.D.2.f), and at all subsequent quarterly reviews that maintain the same recommendation. This paragraph shall not take effect until two years after the effective date of this Agreement.
  - c. The CIM believes external review is needed to identify additional steps that can be taken to remove barriers to discharge.
4. The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed, including recommendations that individuals remain at a Training Center.

## **V. Quality and Risk Management System**

- A. To ensure that all services for individuals receiving services under this Agreement are of good quality, meet individuals' needs, and help individuals achieve positive outcomes, including avoidance of harms, stable community living, and increased integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships), and to ensure that appropriate services are available and accessible for individuals in the target population, the Commonwealth shall develop and implement a quality and risk management system that is consistent with the terms of this Section.



B. The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.

C. Risk Management

1. The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm. Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes.
2. The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol. The protocol shall require that any staff of a Training Center, CSB, or community provider aware of any suspected or alleged incident of abuse or neglect as defined by Virginia Code § 37.2-100 in effect on the effective date of this Agreement, serious injury as defined by 12 VAC 35-115-30 in effect on the effective date of this Agreement, or deaths directly report such information to the DBHDS Assistant Commissioner for Quality Improvement or his or her designee.
3. The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken. The Commonwealth shall be required to implement the process for investigation and remediation detailed in the Virginia DBHDS Licensing Regulations (12 VAC 35-105-160 and 12 VAC 35-105-170 in effect on the effective date of this Agreement) and the Virginia Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services ("DBHDS Human Rights Regulations" (12 VAC 35-115-50(D)(3)) in effect on the effective date of this Agreement, and shall verify the implementation of corrective action plans required under these Rules and Regulations.
4. The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.
5. The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The Commissioner shall establish the monthly mortality review team, to include the DBHDS Medical Director, the Assistant Commissioner for Quality Improvement, and others as determined by the Department who possess appropriate experience, knowledge, and skills. The team shall have at least one member with the clinical experience to conduct mortality reviews who is otherwise independent of the State. Within ninety days of a death, the monthly mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurses notes, and all incident reports, for the three months preceding the individual's death;



(ii) the most recent individualized program plan and physical examination records; (iii) the death certificate and autopsy report; and (iv) any evidence of maltreatment related to the death; (b) interview, as warranted, any persons having information regarding the individual's care; and (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any. The team also shall collect and analyze mortality data to identify trends, patterns, and problems at the individual service-delivery and systemic levels and develop and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.

6. If the Training Center, CSBs, or other community provider fails to report harms and implement corrective actions, the Commonwealth shall take appropriate action with the provider pursuant to the DBHDS Human Rights Regulations (12 VAC 35-115-240), the DBHDS Licensing Regulations (12 VAC 35-105-170), Virginia Code § 37.2-419 in effect on the effective date of this Agreement, and other requirements in this Agreement.

#### D. Data to Assess and Improve Quality

1. The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers; identification, response and prevention of occurrences of abuse, neglect and exploitation; administrative oversight of all waiver functions including contracting; and financial accountability. Review of data shall occur at the local and state levels by the CSBs and DBHDS/DMAS, respectively.
2. The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement. The Commonwealth shall use data to:
  - a. identify trends, patterns, strengths, and problems at the individual, service-delivery, and systemic levels, including, but not limited to, quality of services, service gaps, accessibility of services, serving individuals with complex needs, and the discharge and transition planning process;
  - b. develop preventative, corrective, and improvement measures to address identified problems;
  - c. track the efficacy of preventative, corrective, and improvement measures; and
  - d. enhance outreach, education, and training.
3. The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas

in State Fiscal Year 2012 and will ensure reliable data is collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area:

- a. Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations);
  - b. Physical, mental, and behavioral health and well being (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status));
  - c. Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system);
  - d. Stability (e.g., maintenance of chosen living arrangement, change in providers, work/other day program stability);
  - e. Choice and self-determination (e.g., service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services);
  - f. Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals);
  - g. Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency); and
  - h. Provider capacity (e.g., caseloads, training, staff turnover, provider competency).
4. The Commonwealth shall collect and analyze data from available sources, including, the risk management system described in Section V.C. above, those sources described in Sections V.E-G and I below (e.g., providers, case managers, Quality Service Reviews, and licensing), Quality Management Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.
  5. The Commonwealth shall implement Regional Quality Councils that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.
    - a. The councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.
    - b. Each council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement

initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.

6. At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in this Agreement) and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.

#### E. Providers

1. The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program, including root cause analyses, that is sufficient to identify and address significant service issues and is consistent with the requirements of the DBHDS Licensing Regulations at 12 VAC 35-105-620 in effect on the effective date of this Agreement and the provisions of this Agreement.
2. Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration, and will be selected from the relevant domains listed in Section V.D.3. above. The measures will be monitored and reviewed by the DBHDS quality improvement committee, with input from Regional Quality Councils, described in Section V.D.5 above. The DBHDS quality improvement committee will assess the validity of each measure at least annually and update measures accordingly.
3. The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.

#### F. Case Management

1. For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.
2. At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs. If any of these observations or assessments identifies an

unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.

3. Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals who:
  - a. Receive services from providers having conditional or provisional licenses;
  - b. Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale ("SIS") category representing the highest level of risk to individuals;
  - c. Have an interruption of service greater than 30 days;
  - d. Encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;
  - e. Have transitioned from a Training Center within the previous 12 months; or
  - f. Reside in congregate settings of 5 or more individuals.
4. Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.
5. Within 24 months from the date of this Agreement, key indicators from the case manager's face to face visits with the individual, and the case manager's observations and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration, and will be selected from the relevant domains listed in Section V.D.3 above.
6. The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.

#### G. Licensing

1. The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.
2. Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals under this Agreement, including:

- a. Providers who have a conditional or provisional license;
  - b. Providers who serve individuals with intensive medical and behavioral needs as defined by the SIS category representing the highest level of risk to individuals;
  - c. Providers who serve individuals who have an interruption of service greater than 30 days;
  - d. Providers who serve individuals who encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;
  - e. Providers who serve individuals who have transitioned from a Training Center within the previous 12 months; and
  - f. Providers who serve individuals in congregate settings of 5 or more individuals.
3. Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.

#### H. Training

1. The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.
2. The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.

#### I. Quality Service Reviews

1. The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice. QSRs shall collect information through:
  - a. Face-to-face interviews of the individual, relevant professional staff, and other people involved in the individual's life; and
  - b. Assessment, informed by face-to-face interviews, of treatment records, incident/injury data, key-indicator performance data, compliance with the service requirements of this Agreement, and the contractual compliance of community services boards and/or community providers.

2. QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals). Information from the QSRs shall be used to improve practice and the quality of services on the provider, CSB, and system wide levels.
3. The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.
4. The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.

#### **VI. Independent Reviewer**

- A. The Parties have jointly selected Donald J. Fletcher as the Independent Reviewer for this Settlement Agreement. In the event that the Independent Reviewer resigns or the Parties agree to replace the Independent Reviewer, the Parties will select a replacement. If the Parties are unable to agree on a replacement within 30 days from the date the Parties receive a notice of resignation from the Independent Reviewer, or from the date the Parties agree to replace the Independent Reviewer, they shall each submit the names of up to three candidates to the Court, and the Court shall select the replacement from the names submitted.
- B. The Independent Reviewer shall conduct the factual investigation and verification of data and documentation necessary to determine whether the Commonwealth is in compliance with this Settlement Agreement, on a six-month cycle continuing during the pendency of the Agreement. The Independent Reviewer is not an agent of the Court, nor does the Independent Reviewer have any authority to act on behalf of the Court. The Independent Reviewer may hire staff and consultants, in consultation with and subject to reasonable objections by the Parties, to assist in his compliance investigations. The Independent Reviewer and any hired staff or consultants are neither agents nor business associates of the Commonwealth or DOJ.
- C. The Independent Reviewer shall file with the Court a written report on the Commonwealth's compliance with the terms of this Agreement within 60 days of the close of each review cycle. The first report shall be filed nine months from the effective date of this Agreement. With the consent of the Court, the Court will hold a status conference after the filing of each written report. The Independent Reviewer shall provide the Parties a draft of his/her report at least 21 days before issuing the report. The Parties shall have 14 days to review and comment on the proposed report before it is filed with the Court. The Parties may agree to allow the Independent Reviewer an additional 20 days to finalize a report after he/she receives comments from the Parties, and such an agreement does not require Court approval. In preparing the report, the Independent

Reviewer shall use appendixes or other methods to protect confidential information so that the report itself may be filed with the Court as a public document. Either Party may file a written report with the Court noting its objections to the portions of the Independent Reviewer's report with which it disagrees. The Commonwealth shall publish and maintain these reports on the DBHDS website.

D. The Independent Reviewer, and any hired staff or consultants, may:

1. Have ex parte communications with the Court upon the Court's request or with the consent of the Parties.
2. Have ex parte communications with the Parties at any time.
3. Request meetings with the Parties and the Court.
4. Speak with stakeholders with such stakeholders' consent, on a confidential basis or otherwise, at the Independent Reviewer's discretion.
5. Testify in this case regarding any matter relating to the implementation or terms of this Agreement, including the Independent Reviewer's observations and findings.
6. Offer to provide the Commonwealth with technical assistance and, with the Commonwealth's consent, provide such technical assistance, relating to any aspect of this Agreement or its stated purposes.
7. Conduct regular meetings with both Parties. The purpose of these meetings shall include, among other things, to prioritize areas for the Independent Reviewer to review, schedule visits, discuss areas of concern, and discuss areas in which technical assistance may be appropriate.

E. The Independent Reviewer and any hired staff or consultants shall not be liable for any claim, lawsuit, or demand arising out of their duties under this Agreement. This paragraph does not apply to any proceeding before this Court for enforcement of payment of contracts or subcontracts for reviewing compliance with this Agreement.

F. The Independent Reviewer and any hired staff or consultants shall not be subject to formal discovery, including, but not limited to, deposition(s), request(s) for documents, request(s) for admissions, interrogatories, or other disclosures. The Parties are not entitled to access the Independent Reviewer's records or communications, or those of his/her staff and consultants, although the Independent Reviewer may provide copies of records or communications at the Independent Reviewer's discretion. The Court may review all records of the Independent Reviewer at the Court's discretion.

G. In order to determine compliance with this Agreement, the Independent Reviewer and any hired staff or consultants shall have full access to persons, employees, residences, facilities, buildings, programs, services, documents, records, including individuals' medical and other records, in unredacted form, and materials that are necessary to assess the Commonwealth's compliance with this Agreement, to the extent they are within the State's custody or control. This shall include, but not be limited to, access to the data and



records maintained by the Commonwealth pursuant to Section V above. The provision of any information to the Independent Reviewer pursuant to this Agreement shall not constitute a waiver of any privilege that would otherwise protect the information from disclosure to third parties. The Independent Reviewer and any hired staff or consultants may also interview individuals receiving services under this Agreement with the consent of the individual or his/her authorized representative. Access to CSBs and private providers and entities shall be at the sole discretion of the CSB or private provider or entity; however, the Commonwealth shall encourage CSBs and private providers and other entities to provide such access and shall assist the Independent Reviewer in identifying and contacting them. The Independent Reviewer shall exercise his/her access to Commonwealth employees and individuals receiving services under this Agreement in a manner that is reasonable and not unduly burdensome to the operation of Commonwealth agencies and that has minimal impact on programs or services being provided to individuals receiving services under this Agreement. Such access shall continue until the Agreement is terminated. The Parties agree that, in cases of an emergency situation that present an immediate threat to life, health, or safety of individuals, the Independent Reviewer will not be required to provide the Commonwealth notice of such visit or inspection. Any individually identifying health information that the Independent Reviewer and any hired staff or consultants receive or maintain shall be kept confidential.

#### H. Budget of the Independent Reviewer

1. Within 45 days of appointment, the Independent Reviewer shall submit to the Court for the Court's approval a proposed budget for State Fiscal Year 2013. Using the proposed budget for State Fiscal Year 2013, the Independent Reviewer shall also propose an equivalent amount prorated through the remainder of State Fiscal Year 2012 as the budget for State Fiscal Year 2012.
2. The Independent Reviewer shall provide the Parties a draft of the proposed budget at least 30 days in advance of submission to the Court. The Parties shall raise with the Independent Reviewer any objections they may have to the draft of the proposed budget within 10 business days of its receipt. If the objection is not resolved before the Independent Reviewer's submission of a proposed budget to the Court, a Party may file the objection with the Court within 10 business days of the submission of the proposed budget to the Court. The Court shall consider such objections and make any adjustments it deems appropriate prior to approving the budget.
3. Thereafter, the Independent Reviewer shall submit annually a proposed budget to the Court for its approval by April 1 in accordance with the process set forth above.
4. At any time, the Independent Reviewer may submit to the Parties for approval a proposed revision to the budget, along with any explanation of the reason for the proposed revision. Should the Parties and Independent Reviewer not be able to agree on the proposed revision, the Court will be notified as set forth in Section V.H.2 above.



5. The approved budget of the Independent Reviewer shall not exceed \$300,000 in any State Fiscal Year during the pendency of this Agreement, inclusive of any costs and expenses of hired staff and consultants, without the approval of the Commonwealth or the Court pursuant to Sections V.H.2. or H.4. above.

I. Reimbursement and Payment Provisions

1. The cost of the Independent Reviewer, including the cost of any consultants and staff to the Reviewer, shall be borne by the Commonwealth in this action up to the amount of the approved budget for each State Fiscal Year. All reasonable expenses incurred by the Independent Reviewer in the course of the performance of his/her duties as set forth in this Agreement shall be reimbursed by the Commonwealth. In no event will the Commonwealth reimburse the Independent Reviewer for any expense that exceeds the approved fiscal year budget or the amount approved under Sections V.H.4 or H.5 above. The Court retains the authority to resolve any dispute that may arise regarding the reasonableness of fees and costs charged by the Reviewer. The United States shall bear its own expenses in this matter. If a dispute arises regarding reasonableness of fees or costs, the Independent Reviewer shall provide an accounting justifying the fees or costs.
  2. The Independent Reviewer shall submit monthly statements to DBHDS, with copies to the United States and the Court, detailing all expenses the Independent Reviewer incurred during the prior month. DBHDS shall issue payment in accordance with the monthly statement as long as such payment is within the approved State Fiscal Year budget. Such payment shall be made by DBHDS within 10 business days of receipt of the monthly statement. Monthly statements shall be provided to: Assistant Commissioner for Developmental Services, DBHDS, P.O. Box 1797, Richmond, Virginia 23238-1797.
  3. In the event that, upon a request by the United States or the Independent Reviewer, the Court determines that the Commonwealth is unreasonably withholding or delaying payment, or if the Parties agree to use the following payment procedure, the following payment procedure will be used:
    - a. The Commonwealth shall deposit \$100,000.00 into the Registry of the Court as interim payment of costs incurred by the Independent Reviewer. This deposit and all other deposits pursuant to this Order shall be held in the Court Registry Investment System and shall be subject to the standard registry fee imposed on depositors.
    - b. The Court shall order the clerk to make payments to the Independent Reviewer. The clerk shall make those payments within 10 days of the entry of the Order directing payment. Within 45 days of the entry of each Order directing payment, the Commonwealth shall replenish the fund with the full amount paid by the clerk in order to restore the fund's total to \$100,000.00.
- J. The Independent Reviewer, including any hired staff or consultants, shall not enter into any contract with the Commonwealth while serving as the Independent Reviewer. If the

Independent Reviewer resigns from his/her position as Independent Reviewer, he/she may not enter into any contract with the Commonwealth on a matter related to this Agreement during the pendency of this Agreement without the written consent of the United States.

- K. Other than the semi-annual compliance report pursuant to Section VLC above or proceedings before the Court, the Independent Reviewer, and any hired staff or consultants, shall refrain from any public oral or written statements to the media, including statements "on background," regarding this Agreement, its implementation, or the Commonwealth's compliance. In addition, the Independent Reviewer shall not establish or maintain a website regarding this Agreement, its implementation, or the Commonwealth's compliance.

## **VII. Construction and Termination**

- A. The Parties agree jointly to file this Agreement with the United States District Court for the Eastern District of Virginia, Richmond Division.
- B. The Parties anticipate that the Commonwealth will have complied with all provisions of the Agreement by the end of State Fiscal Year 2021. Compliance is achieved where any violations of the Agreement are minor or incidental and are not systemic. The Court shall retain jurisdiction of this action for all purposes until the end of State Fiscal Year 2021 unless:
  - 1. The Parties jointly ask the Court to terminate the Agreement before the end of State Fiscal Year 2021, provided the Commonwealth has complied with this Agreement and maintained compliance for one year; or
  - 2. The United States disputes that the Commonwealth is in compliance with the Agreement at the end of State Fiscal Year 2021. The United States shall inform the Court and the Commonwealth by January 1, 2021, that it disputes compliance, and the Court may schedule further proceedings as appropriate. The Party that disagrees with the Independent Reviewer's assessment of compliance shall bear the burden of proof.
- C. The burden shall be on the Commonwealth to demonstrate compliance to the United States pursuant to Section VII.B.1 above. If the Commonwealth believes it has achieved compliance with a portion of this Agreement and has maintained compliance for one year, it shall notify the United States and the Independent Reviewer. If the United States agrees, the Commonwealth shall be relieved of that portion of the Settlement Agreement and notice of such relief shall be filed with the Court. The Parties may instead agree to a more limited review of the relevant portion of the Agreement.
- D. With the exception of conditions or practices that pose an immediate and serious threat to the life, health, or safety of individuals receiving services under this Agreement, if the United States believes that the Commonwealth has failed to fulfill any obligation under this Agreement, the United States shall, prior to initiating any court proceeding to remedy such failure, give written notice to the Commonwealth which, with specificity, sets forth the details of the alleged noncompliance.

1. With the exception of conditions or practices that pose an immediate and serious threat to the life, health, or safety of individuals covered by this Agreement, the Commonwealth shall have forty-five (45) days from the date of such written notice to respond to the United States in writing by denying that noncompliance has occurred, or by accepting (without necessarily admitting) the allegation of noncompliance and proposing steps that the Commonwealth will take, and by when, to cure the alleged noncompliance.
  2. If the Commonwealth fails to respond within 45 days or denies that noncompliance has occurred, the United States may seek an appropriate judicial remedy.
  3. If the Commonwealth timely responds by proposing curative action by a specified deadline, the United States may accept the Commonwealth's proposal or offer a counterproposal for a different curative action or deadline, but in no event shall the United States seek an appropriate judicial remedy for the alleged noncompliance until after the time provided for the Commonwealth to respond under Section VII.D.2 above. If the Parties fail to reach agreement on a plan for curative action, the United States may seek an appropriate judicial remedy.
  4. Notwithstanding the provisions of this Section, with the exception of conditions that pose an immediate and serious threat to the life, health, or safety of individuals receiving services under this Agreement, the United States shall neither issue a noncompliance notice nor seek judicial remedy for the nine months after the effective date of this Agreement.
- E. If the United States believes that conditions or practices within the control of the Commonwealth pose an immediate and serious threat to the life, health, or safety of individuals in the Training Centers or individuals receiving services pursuant to this Agreement, the United States may, without further notice, initiate a court proceeding to remedy those conditions or practices.
- F. This Agreement shall constitute the entire integrated Agreement of the Parties.
- G. Any modification of this Agreement shall be executed in writing by the Parties, shall be filed with the Court, and shall not be effective until the Court enters the modified agreement and retains jurisdiction to enforce it.
- H. The Agreement shall be applicable to, and binding upon, all Parties, their employees, assigns, agents, and contractors charged with implementation of any portion of this Agreement, and their successors in office. If the Commonwealth contracts with an outside provider for any of the services provided in this Agreement, the Agreement shall be binding on any contracted parties, including agents and assigns. The Commonwealth shall ensure that all appropriate Commonwealth agencies take any actions necessary for the Commonwealth to comply with provisions of this Agreement.
- I. The Commonwealth, while empowered to enter into and implement this Agreement, does not speak for the Virginia General Assembly, which has the authority under the Virginia Constitution and laws to appropriate funds for, and amend laws pertaining to, the Commonwealth's system of services for individuals with developmental disabilities. The

Commonwealth shall take all appropriate measures to seek and secure funding necessary to implement the terms of this Agreement. If the Commonwealth fails to attain necessary appropriations to comply with this Agreement, the United States retains all rights to enforce the terms of this Agreement, to enter into enforcement proceedings, or to withdraw its consent to this Agreement and revive any claims otherwise barred by operation of this Agreement.

- J. The United States and the Commonwealth shall bear the cost of their fees and expenses incurred in connection with this case.

### **VIII. General Provisions**

- A. The Commonwealth agrees that it shall not retaliate against any person because that person has filed or may file a complaint, provided assistance or information, or participated in any other manner in the United States' investigation or the Independent Reviewer's duties related to this Agreement. The Commonwealth agrees that it shall timely and thoroughly investigate any allegations of retaliation in violation of this Agreement and take any necessary corrective actions identified through such investigations.
- B. If an unforeseen circumstance occurs that causes a failure to timely fulfill any requirement of this Agreement, the Commonwealth shall notify the United States and the Independent Reviewer in writing within 20 calendar days after the Commonwealth becomes aware of the unforeseen circumstance and its impact on the Commonwealth's ability to perform under the Agreement. The notice shall describe the cause of the failure to perform and the measures taken to prevent or minimize the failure. The Commonwealth shall take reasonable measures to avoid or minimize any such failure.
- C. Failure by any Party to enforce this entire Agreement or any provision thereof with respect to any deadline or any other provision herein shall not be construed as a waiver, including of its right to enforce other deadlines and provisions of this Agreement.
- D. The Parties shall promptly notify each other of any court or administrative challenge to this Agreement or any portion thereof, and shall defend against any challenge to the Agreement.
- E. Except as provided in this Agreement, during the pendency of the Agreement, the United States shall not file suit under the ADA or CRIPA for any claim or allegation set forth in the complaint.
- F. The Parties represent and acknowledge this Agreement is the result of extensive, thorough and good faith negotiations. The Parties further represent and acknowledge that the terms of this Agreement have been voluntarily accepted, after consultation with counsel, for the purpose of making a full and final compromise and settlement of any and all claims arising out of the allegations set forth in the Complaint and pleadings in this Action, and for the express purpose of precluding any further or additional claims arising out of the allegations set forth in the Complaint and pleadings in this Action. Each Party to this Agreement represents and warrants that the person who has signed this Agreement on behalf of his or her entity is duly authorized to enter into this Agreement and to bind

that Party to the terms and conditions of this Agreement.

- G. Nothing in this Agreement shall be construed as an acknowledgement, an admission, or evidence of liability of the Commonwealth under federal or state law, and this Agreement shall not be used as evidence of liability in this or any other civil or criminal proceeding.
- H. This Agreement may be executed in counterparts, each of which shall be deemed an original, and the counterparts shall together constitute one and the same agreement, notwithstanding that each Party is not a signatory to the original or the same counterpart.
- I. "Notice" under this Agreement shall be provided to the following or their successors:

For the United States:

Chief of the Special Litigation Section  
United States Department of Justice  
Civil Rights Division  
601 D Street, N.W.  
Washington, D.C. 20004

For the Commonwealth:

Attorney General of Virginia  
900 E. Main Street  
Richmond, VA 23219

Counsel to the Governor  
Patrick Henry Building, 3<sup>rd</sup> Floor  
1111 E. Broad Street  
Richmond, VA 23219

For the Independent Reviewer:

Donald J. Fletcher  
P.O. Box 54  
16 Cornwell Road  
Shutesbury, MA 01072-0054

#### **IX. Implementation of the Agreement**

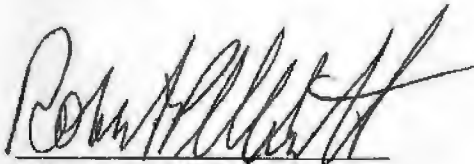
- A. The implementation of this Agreement shall begin immediately upon the Effective Date, which shall be the date on which this Agreement is approved and entered as an order of the Court.
- B. Within one month from the Effective Date of this Agreement, the Commonwealth shall appoint an Agreement Coordinator to oversee compliance with this Agreement and to serve as a point of contact for the Independent Reviewer.
- C. The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented and shall make such records available

to the Independent Reviewer for inspection and copying upon request and on a reasonable basis.

- D. The Commonwealth shall notify the Independent Reviewer and the United States promptly upon the unexplained or unexpected death or serious physical injury resulting in on-going medical care of any individual covered by this Agreement. The Commonwealth shall, via email, forward to the United States and the Independent Reviewer electronic copies of all completed incident reports and final reports of investigations related to such incidents, as well as any autopsies and death summaries in the State's possession. The provision of any information to the Independent Reviewer and the United States pursuant to this Agreement shall not constitute a waiver of any privilege that would otherwise protect the information from disclosure to third parties.
- E. The United States shall have full access to persons, employees, residences, facilities, buildings, programs, services, documents, records, and materials that are within the control and custody of the Commonwealth and are necessary to assess the Commonwealth's compliance with this Agreement and/or implementation efforts.
  - 1. Such access shall include departmental and/or individual medical and other records in unredacted form.
  - 2. The United States shall provide notice at least one week in advance of any visit or inspection.
  - 3. The Parties agree that, in cases of an emergency situation that presents an immediate threat to life, health, or safety of individuals, the United States will be required to provide the Commonwealth with sufficient notice of such visit or inspection as to permit a Commonwealth representative to join the visit.
  - 4. Such access shall continue until this case is dismissed.
  - 5. The Commonwealth shall provide to the United States, as requested, in unredacted form, any documents, records, databases, and information relating to the implementation of this Agreement as soon as practicable, but no later than within thirty (30) business days of the request, or within a time frame negotiated by the Parties if the volume of requested material is too great to reasonably produce within thirty days.
  - 6. The provision of any information to the United States pursuant to this Agreement shall not constitute a waiver of any privilege that would otherwise protect the information from disclosure to third parties.

FOR THE UNITED STATES:

NEIL H. MacBRIDE  
United States Attorney  
Eastern District of Virginia



ROBERT McINTOSH  
Assistant United States Attorney  
600 East Main St., Suite 1800  
Richmond, VA 23219  
(804) 819-5400  
Fax: (804) 819-7417  
[Robert.McIntosh@usdoj.gov](mailto:Robert.McIntosh@usdoj.gov)  
VA Bar #66113

Respectfully submitted,

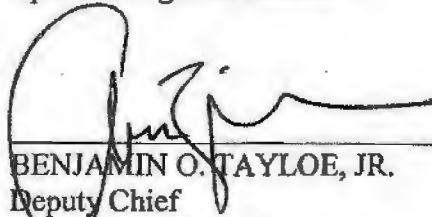


THOMAS E. PEREZ  
Assistant Attorney General  
Civil Rights Division

EVE HILL  
Senior Counselor

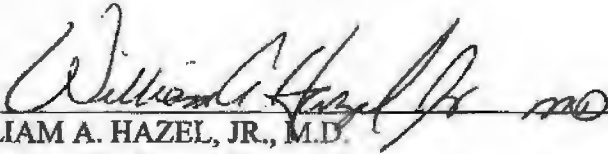
ALISON N. BARKOFF  
Special Counsel for Olmstead Enforcement  
Civil Rights Division

JONATHAN SMITH  
Chief  
Special Litigation Section

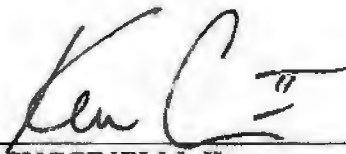


BENJAMIN O. TAYLOE, JR.  
Deputy Chief  
AARON B. ZISSER  
JACQUELINE K. CUNCANNAN  
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U.S. Department of Justice  
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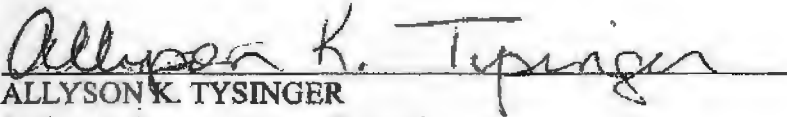
FOR THE COMMONWEALTH:



WILLIAM A. HAZEL, JR., M.D.  
Secretary of Health and Human Resources  
on Behalf of Governor Robert F. McDonnell



KENNETH T. CUCCINELLI, II  
as Attorney General of Virginia pursuant to Virginia Code § 2.2-514



ALLYSON K. TYSINGER  
Senior Assistant Attorney General  
900 East Main Street  
Richmond, Virginia 23219  
(804) 786-1927  
Fax: (804) 371-8718  
ATysinger@oag.state.va.us  
Virginia State Bar No. 41982



ENTERED THIS \_\_\_\_\_ day of \_\_\_\_\_, 2012.

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UNITED STATES DISTRICT JUDGE

**Appendix B:  
July 1, 2012 – June 30, 2013 Milestones in DOJ Settlement Agreement**

DOJ Milestone	Compliance Date
<p>C.1.a. The Commonwealth shall create a minimum of 805 slots to enable individuals in the target population in the Training Centers to transition to the community according to the following schedule:</p> <p style="padding-left: 40px;">ii. In State FY 2013, 160 waiver slots</p>	By June 30, 2013
<p>C.1.b. The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent wait list for a waiver...</p> <p style="padding-left: 40px;">ii In State FY 2013, 225 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs</p>	By June 30, 2013
<p>C.1.c. The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than ID in the target population who are on the waitlist for a waiver...</p> <p style="padding-left: 40px;">In State FY 2013, 25 waiver slots, including 15 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs</p>	By June 30, 2013
<p>C.2.a. The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization, according to the following schedule:</p> <p style="padding-left: 40px;">a. In State Fiscal Year 2013, a minimum of 700 individuals supported</p>	By June 30, 2013
<p>C.6.b.ii.G. By June 30, 2013, the Commonwealth shall have at least two mobile crisis teams in each Region that shall respond to on-site crises within two hours.</p>	By June 30, 2013
<p>C.6.b.iii.F. By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.</p>	By June 30, 2013

DOJ Milestone	Compliance Date
C.7.b.i. Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreational opportunities, and other integrated day activities.	September 6, 2012
C.9. ...the Commonwealth will provide to the General Assembly within one year of the effective date of this Agreement, a plan, developed in consultation with the Chairman of Virginia's House of Delegates Appropriations and Senate Finance Committees, to cease residential operations at four of the five training centers by the end of the State Fiscal Year 2021.	March 6, 2013
D.3. Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments.	March 6, 2013
D.4. Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing, from a one-time fund of \$800,000 to provide and administer rental assistance in accordance with the recommendations described in the [Housing Plan].	March 6, 2013
<p>V.D.3. The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal year 2012 and will ensure reliable data is collected and analyzed from each these areas by June 30, 2014...</p> <ul style="list-style-type: none"> <li>i. Safety and freedom from harm</li> <li>j. Physical, mental, and behavioral health and well being</li> <li>k. Avoiding crises</li> <li>l. Stability</li> <li>m. Choice and self-determination</li> <li>n. Community inclusion</li> <li>o. Access to services</li> <li>p. Provider capacity</li> </ul>	By June 30, 2013, additional measures in additional domains must be added
V.E.2. Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program....The measures will be monitored and reviewed by the DBHDS quality improvement committee, with input from the Regional Quality Councils.	March 6, 2013

DOJ Milestone	Compliance Date
<p>V.F.3. Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face to face at least every 30 days, and at least one such visit every two months must be in the individual's place of resident, for any individuals who:</p> <ul style="list-style-type: none"> <li>a. Receive services from providers having conditional or provisional licenses;</li> <li>b. Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale ("SIS) category representing the highest level of risk to individuals;</li> <li>c. Have an interruption of service greater than 30 days;</li> <li>d. Encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;</li> <li>e. Have transitioned from a Training Center within the previous 12 months; or</li> <li>f. Reside in congregate settings of 5 or more individuals.</li> </ul>	<p>March 6, 2013</p>
<p>V.F.4. Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.</p>	<p>March 6, 2013</p>
<p>V.F.6. The Commonwealth shall develop a statewide core-competency-based training curriculum for case managers within 12 months of the effective date of this Agreement.</p>	<p>March 6, 2013</p>
<p>V.G.2. Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals under this Agreement, including:</p> <ul style="list-style-type: none"> <li>g. Providers who have conditional or provisional licenses;</li> <li>h. Providers who serve individuals with intensive behavioral or medical needs as defined by the Supports Intensity Scale ("SIS) category representing the highest level of risk to individuals;</li> <li>i. Providers who serve individuals who have an interruption of service greater than 30 days;</li> <li>j. Providers who serve individuals who encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;</li> <li>k. Providers who serve individuals who have transitioned from a Training Center within the previous 12 months; or</li> <li>l. Providers who serve individuals in congregate settings of 5 or more individuals.</li> </ul>	<p>March 6, 2013</p>
<p>V.H.3. Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains and that these data and assessments are reported to DBHDS.</p>	<p>March 6, 2013</p>

**Appendix C:  
DBHDS Settlement Agreement Stakeholder Group**

Category	Appointee Name	Designee
<b>HOST AGENCY</b>		
DBHDS	Mr. James W. Stewart, III, Commissioner	
DBHDS	Dr. Olivia J. Garland, Ph.D., Deputy Commissioner	
DBHDS	Ms. Heidi R. Dix, Assistant Commissioner, Developmental Services	
<b>OTHER STATE AGENCIES</b>		
DMAS	Ms. Cheryl J. Roberts, Deputy Director for Programs	
DARS and CIAC	Ms. Catherine Harrison	
OSHR	Ms. Kristin Burhop, Trust Fund Coordinator	
<b>SERVICE RECIPIENTS</b>		
Parent/Family of Individual	Ms. Betty Thompson	
Parent/Family of Individual	Ms. Vicki Beatty	
Parent/Family of Individual	Ms. Cathleen S. Lowery	
Parent/Family of Individual	Ms. Pat Bennett	
<b>PROVIDERS/ASSOCIATIONS</b>		
VNPP	Ms. Ann Bevan, President	Ms. Jennifer Fidura
VACIL	Ms. Karen Michalski-Karney, Chair	
vaACCSES	Mr. Dave Wilber, President	
VACSB	Ms. Karen Grizzard, Chair	
CSB ID Director	Ms. Michelle Johnson, Henrico CSB	
CSB Executive Director	Ms. Lisa Moore, Mt. Rogers CSB	
DD Case Management	Ms. Josie Williams, Commonwealth Catholic Charities	
CSB Case Manager	Ms. Linda Wilson, Rappahannock Area CSB	
Non-Congregate Setting Provider	Mr. Peter Leddy, President	Ms. Lynne Seagle
<b>ADVOCACY/OTHER</b>		
The Arc of Virginia	Mr. Glenn Slack, President	Ms. Jamie Liban
Autism Org: Autism Society of Central Va.	Ms. Sandi Wiley, President	Ms. Bradford Hulcher
State Human Rights Committee	Mr. Donald H. Lyons, Chair, SHRC	
VBPB	Mr. John Kelly, Chair	Ms. Heidi Lawyer
Peer Advocate DD	Ms. Marisa Loais, Member, The Arc of Northern Virginia	
Peer Advocate ID	Ms. Katherine Olson, Voices of VA	



# COMMONWEALTH of VIRGINIA

JAMES W. STEWART, III  
COMMISSIONER

DEPARTMENT OF  
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Post Office Box 1797  
Richmond, Virginia 23218-1797

Telephone (804) 786-3921  
Fax (804) 371-6638  
[www.dbhds.virginia.gov](http://www.dbhds.virginia.gov)

July 23, 2012

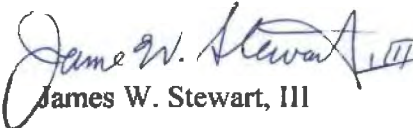
The Honorable Robert F. McDonnell  
Office of the Governor  
Patrick Henry Building, Third Floor  
Richmond, Virginia 23219

Dear Governor McDonnell:

Pursuant to Code of Virginia §37.2-319 (HB2533/SB1486, 2011) and Item 315.V.1. of the 2012 *Appropriation Act*, enclosed is the first semi-annual report on Virginia's progress in meeting the milestones in the Settlement Agreement for the period of March 6, 2012 – June 30, 2012. This report also describes expenditures associated with the Agreement for FY12. The next report is due on December 1, 2012.

If you have any questions, please feel free to contact me at (804) 786-3921 or via email at [jim.stewart@dbhds.virginia.gov](mailto:jim.stewart@dbhds.virginia.gov).

Sincerely,

  
James W. Stewart, III

Enc.

Cc: Hon. William A. Hazel Jr., M.D.  
Keith Hare, Deputy Secretary, HHR  
Matt Cobb, Deputy Secretary, HHR  
Kristin Burhop, Trust Fund Coordinator  
Olivia J. Garland, Ph.D., Deputy Commissioner, DBHDS  
Heidi R. Dix, Assistant Commissioner – Developmental Services, DBHDS  
Cynthia B. Jones, Director, DMAS  
Allyson K. Tysinger, Senior Assistant Attorney General, OAG



# COMMONWEALTH of VIRGINIA

DEPARTMENT OF  
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

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JAMES W. STEWART, III  
COMMISSIONER

July 23, 2012

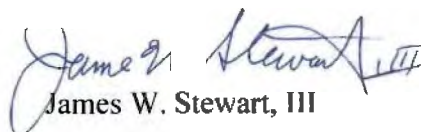
The Honorable Walter A. Stosch, Chair  
Senate Finance Committee  
10th Floor, General Assembly Building  
910 Capitol Street  
Richmond, VA 23219

Dear Senator Stosch:

Pursuant to Code of Virginia §37.2-319 (HB2533/SB1486, 2011) and Item 315.V.1. of the 2012 *Appropriation Act*, enclosed is the first semi-annual report on Virginia's progress in meeting the milestones in the Settlement Agreement for the period of March 6, 2012 – June 30, 2012. This report also describes expenditures associated with the Agreement for FY12. The next report is due on December 1, 2012.

If you have any questions, please feel free to contact me at (804) 786-3921 or via email at [jim.stewart@dbhds.virginia.gov](mailto:jim.stewart@dbhds.virginia.gov).

Sincerely,

  
James W. Stewart, III

Enc.

Cc: Hon. William A. Hazel Jr., M.D.  
Hon. Emmett W. Hanger, Jr.  
Joe Flores, Legislative Analyst, Senate Finance Committee  
Keith Hare, Deputy Secretary, HHR  
Matt Cobb, Deputy Secretary, HHR  
Kristin Burhop, Trust Fund Coordinator  
Olivia J. Garland, Ph.D., Deputy Commissioner, DBHDS  
Heidi R. Dix, Assistant Commissioner – Developmental Services, DBHDS  
Cynthia B. Jones, Director, DMAS  
Allyson K. Tysinger, Senior Assistant Attorney General, OAG



# COMMONWEALTH of VIRGINIA

DEPARTMENT OF

BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

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COMMISSIONER

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July 23, 2012

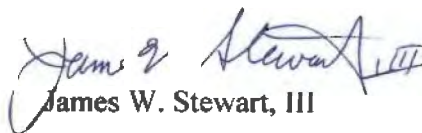
The Honorable Lacey E. Putney, Chair  
House Appropriations Committee  
General Assembly Building  
P.O. Box 406  
Richmond, VA 23218

Dear Delegate Putney:

Pursuant to Code of Virginia §37.2-319 (HB2533/SB1486, 2011) and Item 315.V.1. of the 2012 *Appropriation Act*, enclosed is the first semi-annual report on Virginia's progress in meeting the milestones in the Settlement Agreement for the period of March 6, 2012 – June 30, 2012. This report also describes expenditures associated with the Agreement for FY12. The next report is due on December 1, 2012.

If you have any questions, please feel free to contact me at (804) 786-3921 or via email at [jim.stewart@dbhds.virginia.gov](mailto:jim.stewart@dbhds.virginia.gov).

Sincerely,

  
James W. Stewart, III

Enc.

Cc: Hon. William A. Hazel Jr., M.D.  
Hon Riley E. Ingram  
Susan E. Massart, Legislative Fiscal Analyst, House Appropriations Committee  
Keith Hare, Deputy Secretary, HHR  
Matt Cobb, Deputy Secretary, HHR  
Kristin Burhop, Trust Fund Coordinator  
Olivia J. Garland, Ph.D., Deputy Commissioner, DBHDS  
Heidi R. Dix, Assistant Commissioner – Developmental Services, DBHDS  
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## DOJ Implementation Update for General Assembly July 23, 2012

### Executive Summary

This report was developed to meet the requirements set forth in both *Code of Virginia* §37.2-319 (HB2533/SB1486, 2011) and Item 315.V.1. of the 2012 *Appropriation Act*. Specifically, Item 315.V.1 addresses the management of the general fund appropriation for the expansion of community-based services in anticipation of an Agreement with the U.S. Department of Justice (DOJ), and states:

*The Department of Behavioral Health and Developmental Services shall provide updates on July 1 and December 1 of each year to the Governor and the Chairmen of the Senate Finance and House Appropriations Committees regarding expenditures and progress in meeting implementation targets established in the agreement.*

The enactment clause associated with §37.2-319 addresses the plan to transition individuals with [intellectual disability] from state training centers to community-based settings, and states:

*The Secretary shall submit reports on the development and implementation of the plan to the Governor and the Chairmen of the House Committee on Appropriations and the Senate Committee on Finance on the first of July and December of each year beginning July 1, 2011.*

This report addresses Virginia's progress in meeting the milestones in the Settlement Agreement for the period of March 6, 2012 – June 30, 2012, and describes expenditures associated with the Agreement for FY12.

### Current Legal Status of the Settlement Agreement

In August 2008, DOJ initiated an investigation of the Department of Behavioral Health Developmental Services (DBHDS) Central Virginia Training Center (CVTC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). In April 2010, DOJ notified the Commonwealth that it was expanding its investigation to focus on Virginia's compliance with the Americans with Disabilities Act (ADA) and *Olmstead*. It first began this phase of the investigation at CVTC and then expanded it to the statewide system serving individuals with intellectual and developmental disabilities.

In February 2011, DOJ submitted a findings letter to Virginia, concluding that the Commonwealth fails to provide services to individuals with intellectual and developmental disabilities (ID and DD, respectively) in the most integrated setting appropriate to their needs. DOJ found that Virginia lacks the community capacity to support individuals who would choose to live there and prevent unnecessary institutionalization. It also found that Virginia's current discharge process from training centers was flawed, inconsistent, and not timely.

In March 2011, Virginia entered into negotiations with DOJ. On January 26, 2012, Virginia and DOJ reached a 10 year Settlement Agreement resolving DOJ's findings. On joint motion of the DOJ and the Commonwealth, the Settlement Agreement was filed with the U.S. District Court for the Eastern District of Virginia for entry as a court order. Several family members of current training center residents were granted permission by the court to intervene in the case.

On March 6, 2012, Judge John A. Gibney, Jr., signed a temporary order entering the Settlement Agreement. Virginia and DOJ agreed to use this date, pending final signature, as the effective date of the Agreement. Throughout this document that date is used as the start date for purposes of implementation.

On June 8, 2012, Judge Gibney conducted a hearing to listen to arguments regarding the Agreement. He expressed a willingness to sign the Agreement at the close of the hearing if three proposed language changes were made to the Agreement. These changes were considered by the parties and discussed with Judge Gibney during a conference call on June 29, 2012. As of the publication of this report, the Judge has not issued a final order entering the Agreement.

### Implementation Status Update

Virginia is moving forward with implementation of the Agreement. The 2011 General Assembly provided funds to begin implementation through the Behavioral Health and Developmental Services Trust Fund (the 'Trust Fund,' §§ 37.2-316 through 319). The 2012 General Assembly continued these efforts by appropriating additional funds through Item 315 V.1. for implementation. DBHDS is moving forward with implementation based on these directives.

#### Major Accomplishments:

- SIXTY-ONE (61) INDIVIDUALS MOVING FROM TRAINING CENTERS TO THE COMMUNITY:** In November 2012, 60 waiver slots were established out of the Behavioral Health and Developmental Services Trust Fund to move 40 individuals from Southside Virginia Training Center (SVTC) and 20 individuals from Central Virginia Training Center (CVTC) to the community. As of June 30, 2012, 61 individuals have moved from these two training centers to the community. Twenty-two of the 60 waiver slots were used for these individuals. Thirty-four individuals moved using Money Follows the Person (MFP) waiver slots. The remaining individuals chose a community ICF or had an existing waiver slot that was used. The following reflects the current and historical census in all five training centers:

Name	2000 Census	2005 Census	2010 Census	Current Census
CVTC	679	564	426	350
NVTC	189	182	170	153
SEVTC*	194	192	143	106
SVTC	465	371	267	201
SWVTC**	218	214	192	173
Total	1,745	1,523	1,198	983

\*Southeastern Virginia Training Center (SEVTC)

\*\*Southwestern Virginia Training Center (SWVTC)

- ESTABLISHING CRISIS SERVICES:** DBHDS is implementing the Systemic Therapeutic Assessment Respite and Treatment (START) program to provide crisis services to individuals with ID/DD statewide. Program operations in all five regions of the Commonwealth will begin in July 2012 and full operations will be online in all regions by January 2013.

The program will provide 24 hour/7 day a week support to individuals in crisis, including a face-to-face assessment with an individual within one hour in urban regions and two hours in rural areas. The program will provide in-home supports and out-of-home crisis respite services when they are needed. The goal of the program is to maintain individuals in their home and prevent crises when possible. At the time of this report, over 60 individuals had been referred to these programs for assessment and support.

- **TRANSFORMATION OF DISCHARGE PLANNING PROCESSES:** DBHDS has moved to a standardized discharge process at all five training centers and is currently training staff at the facilities as well as Community Services Boards (CSBs) and service providers on the new process. The new process is consistent with the terms of the Settlement Agreement that discharge processes be person-centered and timely and that they provide individuals and authorized representatives with informed choice about community-based options.

Today, all training centers are following a 12 week process for discharge planning. This process engages individuals, the authorized representative, clinical professionals at the training centers, and CSB case managers to identify what is important to individuals when they move to the community, what clinical supports are needed, and what health and safety supports must be in place prior to a move. These desires and needs are compiled in a discharge plan. Individuals and authorized representatives are presented, if available, at least three options for consideration, and allowed to make several visits, including overnights stays with a potential provider to determine if the placement is the best choice.

The discharge process includes active Post-Move Monitoring at 3, 7, 10, 17, and 30 day intervals post-move from a combination of training center staff, licensing specialists, human rights staff, and the CSB case manager to ensure the discharge plan has been implemented properly by the new provider. The discharge process and post-move monitoring were successfully implemented for the 61 individuals transitioning from SVTC and CVTC.

The body of the report describes in detail these and other implementation activities that DBHDS and its partner agencies are undertaking to move the Settlement Agreement forward.

#### Barriers to Implementation:

At the time of this report, Virginia has encountered few barriers to implementing the milestones in the DOJ Settlement Agreement for the period of March 6, 2012 – June 30, 2012. One item that will need additional consideration is in the area of Crisis Services:

- **CRISIS SERVICES FOR CHILDREN WITH ID/DD in the TARGET POPULATION:** Virginia is required to implement a “statewide crisis system for individuals with intellectual and developmental disabilities.” This system would include children. DBHDS is currently implementing the START program for adults with ID/DD. Expanding the program to include children will likely create new challenges and barriers for DBHDS to overcome.

## **Summary**

Virginia continues to move forward with implementation of the DOJ Settlement Agreement and the directives established by the 2011 and 2012 General Assembly related to transitioning individuals who currently reside in training centers to the community. Virginia is largely on track with meeting the major milestones of the Agreement for the period of March 6, 2012 – June 30, 2012. Virginia is actively working to address the major milestones of the Settlement Agreement for FY13 as outlined in Appendix B.

## **DOJ Implementation Update for General Assembly July 23, 2012**

### **Introduction**

This report was developed to meet the requirements set forth in both *Code of Virginia* §37.2-319 (HB2533/SB1486, 2011) and Item 315.V.1. of the 2012 *Appropriation Act*. Specifically, Item 315.V.1 addresses the management of the general fund appropriation for the expansion of community-based services in anticipation of an Agreement with the U.S. Department of Justice (DOJ), and states:

*The Department of Behavioral Health and Developmental Services shall provide updates on July 1 and December 1 of each year to the Governor and the Chairmen of the Senate Finance and House Appropriations Committees regarding expenditures and progress in meeting implementation targets established in the agreement.*

The enactment clause associated with §37.2-319 addresses the plan to transition individuals with [intellectual disability] from state training centers to community-based settings, and states:

*The Secretary shall submit reports on the development and implementation of the plan to the Governor and the Chairmen of the House Committee on Appropriations and the Senate Committee on Finance on the first of July and December of each year beginning July 1, 2011.*

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### **Current Legal Status of the Settlement Agreement**

In August 2008, DOJ initiated an investigation of the Department of Behavioral Health Developmental Services (DBHDS) Central Virginia Training Center (CVTC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). In April 2010, DOJ notified the Commonwealth that it was expanding its investigation to focus on Virginia's compliance with the Americans with Disabilities Act (ADA) and *Olmstead*. It first began this phase of the investigation at CVTC and then expanded it to the statewide system serving individuals with intellectual and developmental disabilities.

In February 2011, DOJ submitted a findings letter to Virginia, concluding that the Commonwealth fails to provide services to individuals with intellectual and developmental disabilities (ID and DD, respectively) in the most integrated setting appropriate to their needs. DOJ found that Virginia lacks the community capacity to support individuals who would choose to live there and prevent unnecessary institutionalization. It also found that Virginia's current discharge process from training centers was flawed, inconsistent, and not timely.

In March 2011, Virginia entered into negotiations with DOJ. On January 26, 2012, Virginia and DOJ reached a 10 year Settlement Agreement resolving DOJ's findings. On joint motion of the DOJ and the Commonwealth, the Settlement Agreement was filed with the U.S. District Court for the Eastern District of Virginia for entry as a court order. Several family members of current training center residents were granted permission by the court to intervene in the case.

On March 6, 2012, Judge Gibney signed a temporary order entering the Settlement Agreement. Virginia and DOJ agreed to use this date, pending final signature, as the effective date of the Agreement. Throughout this document that date is used as the start date for purposes of implementation.

On June 8, 2012, Judge Gibney conducted a hearing to listen to arguments regarding the Agreement. He expressed a willingness to sign the Agreement at the close of the hearing if three proposed language changes were made to the Agreement. These changes were considered by the parties and discussed with Judge Gibney during a conference call on June 29, 2012. As of the publication of this report, the Judge has not issued a final order entering the Agreement.

### **Overview of the Settlement Agreement**

This section provides a brief overview of the many elements of the Settlement Agreement. Items with parentheses indicate specific elements that tie to the expenditure table in Item 315.V.1. of the 2012 *Appropriation Act*. The full Settlement Agreement is attached in Appendix A or it can be accessed online at [www.dbhds.virginia.gov](http://www.dbhds.virginia.gov)

#### *Serving Individuals in the Most Integrated Settings:*

The Agreement is based on the following premise, which was mutually agreed to by DOJ and Virginia:

“To prevent the unnecessary institutionalization of individuals with ID/DD and to provide them opportunities to live in the most integrated settings appropriate to their needs consistent with their informed choice, the Commonwealth shall develop and provide the community services described...”

The language regarding integrated settings and informed choice is used throughout the Agreement as a principle for implementation. DBHDS and partner agencies implementing the Agreement for the Commonwealth must develop policies, guidelines, and regulations that reinforce these principles.

#### *Target Population:*

The target population of the Agreement includes individuals with ID/DD who meet any of the following additional criteria:

1. Are currently residing at any of the Training Centers;
2. Who meet the criteria for the ID waiver or Individual and Family Developmental Disabilities Waiver (IFDDS) wait lists; or
3. Currently reside in a nursing home or ICF.

Individuals remain in the target population for the entire ten year period. For example, if an individual living in a training center moves to a community home, they will continue to be part of the target population for the entire term of the Agreement. Being part of this population does not guarantee services, but it requires the Commonwealth to ensure those receiving services do so under the principles outlined in the Agreement.

#### *Medicaid Waiver Slots (Facility Transition and Community Waiver Slots):*

The Commonwealth will provide 4,170 waiver slots for the target population under this Agreement. The waiver slots are available to several distinct populations as itemized in the Agreement. Table 1 below shows the slots for each population for years FY12, FY13, and FY14.

- **TRAINING CENTER RESIDENT SLOTS:** A minimum of 805 waiver slots are provided from FY12 to FY2021 to transition individuals from training centers to community placements.
- **COMMUNITY ID WAIVER SLOTS:** A minimum of 2,915 waiver slots are provided from FY12 to FY2021 for individuals who are on the urgent ID waiver wait list. Twenty-five slots each in FY13 and FY14 are available for youth with ID ages 22 and under who reside in nursing facilities or large ICFs.
- **INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SERVICES (DD) WAIVER SLOTS:** A minimum of 450 waiver slots are available for individuals on the DD waiver wait list. Fifteen slots each in FY13 and FY14 are available for youth with DD ages 22 and under who reside in nursing facilities or large ICFs.

Table 1: Waiver Slots Available under Agreement, FY12-14

Fiscal Year	Training Center Resident Slots	Community ID Waiver Slots	IFDDS Waiver Slots
2012	60	275	150
2013	160	225	25
2014	160	225	25
<b>Total (FY12-14)</b>	<b>380</b>	<b>725</b>	<b>200</b>

**Family Supports (Program of Individual and Family Supports):**

The Agreement requires implementation of an individual and family support program for individuals with ID/DD that the Commonwealth determines are most at risk of institutionalization. In FY13, a minimum of 700 individuals will be supported. In FY14 through FY21 a minimum of 1,000 individuals will be supported.

Family supports provide a minimal level of support to individuals who do not have alternative services through a waiver; typically these are individuals on the waiver wait lists. Family supports can include respite services, environmental modifications, dental services, professional consultative services, or other supports that enable individuals to remain in their own home or their family's home.

**Crisis Services (Crisis Stabilization):**

The Agreement requires implementation of a statewide crisis system for individuals with ID/DD. The system must provide 24/7 support to individuals experiencing crisis and their families through in-home supports and community-based crisis services. It must also provide crisis prevention and proactive planning to avoid potential crises.

The Commonwealth must establish mobile crisis teams to be available 24/7 and respond to an on-site crisis within three hours in FY12, within two hours by the end of FY13, and one hour (urban)/two hours (rural) in FY14. It must also establish crisis stabilization programs as short-term alternatives to hospitalization for individuals in crisis. These programs were required to be developed by June 30, 2012, and additional programs are required to ensure adequate supports are available by the end of FY13 and beyond.

**Employment:**

The Commonwealth is required to provide individuals in the target population who are receiving services under the Agreement with integrated day opportunities, including supported employment. Under the Agreement, Virginia must establish a state Employment First policy. Such a policy requires case managers and training center personal support teams to discuss employment in integrated work



settings as the first and priority service option with individuals. If individuals choose this option, the Commonwealth must seek options to provide these supports to the individual.

The Commonwealth must also develop a plan to increase integrated day opportunities, including supported employment within 180 days of the Agreement. The plan must use Employment First principles and establish baseline information regarding those individuals receiving supported employment, the length of time they are employed, and the amount they earn. The plan must then establish targets to increase the number of individuals in supported employment each year and increase the amount of time and earnings in such employment over time. This plan must be developed in concert with members of the Virginia chapter of the State Employment Leadership Network (SELN).

*Community Living Options (Rental Subsidies):*

The Commonwealth must develop a plan within 365 days of the Agreement to increase access to independent living options such as individuals' own homes or apartments. The plan must be developed under the direct supervision of a dedicated housing coordinator at DBHDS in concert with representatives from the Department of Medical Assistance Services (DMAS), the Virginia Board for People with Disabilities (VBPD), the Virginia Housing Development Authority (VHDA), the Department of Housing and Community Development (DHCD), and others. The plan must establish baseline information regarding the number of individuals who would choose independent living options and make recommendations to provide access to these settings. \$800,000 is set aside to provide and administer rental assistance associated with recommendations in this plan.

*Discharge Planning and Transition from Training Center:*

The Agreement requires changes to Virginia's discharge processes at each of its training centers. It requires every individual residing at a training center to have a person-centered discharge plan based on the individual's strengths, preferences, and clinical needs. The plans must document barriers to discharge and be done by the individual's Personal Support Team. The Personal Support Team is a group of clinical professionals at the training center who knows the individual best, the individual, the authorized representative, and the CSB case manager. All discharge plans must be developed using informed choice and individuals and authorized representatives must be offered a choice of community providers, if available, prior to discharge. Once an individual is discharged, post-move monitoring must occur to ensure their health and safety during the critical time after discharge.

The Agreement also calls for the establishment of Community Integration Managers at each training center to oversee discharge processes and requires the implementation of a Regional Support Team to review specific situations where barriers to discharge are identified.

*Quality and Risk Management:*

The Settlement Agreement requires several changes to Virginia's system of quality oversight and improvement:

- **RISK MANAGEMENT:** Virginia shall require that all training centers, CSBs, and other community providers of residential and day services to implement risk management processes. Virginia must implement a real-time, web-based incident reporting system and reporting protocol to monitor and investigate serious incidents and deaths and establish a mortality review committee. Training must be offered to providers on how to reduce risks.
- **DATA:** Virginia must collect and analyze reliable data from many different sources to identify trends, patterns, and problems at the state, regional, and provider level and develop preventive or corrective actions. This data must be used to enhance training and outreach to providers.

Data must be collected on safety, freedom from harm, physical, mental, and behavioral health, avoiding crises, stability, choice, self-determination, community inclusion, access to services, and provider capacity. DBHDS must also establish Regional Quality Councils to examine data at the regional level.

- **PROVIDERS:** All providers will be required to develop and implement a quality improvement program and report key indicators from these programs to DBHDS. DBHDS must assess the adequacy of providers' quality improvement strategies.
- **CASE MANAGEMENT:** Case managers are required to meet with an individual face-to-face every 30 days, if they meet certain high-risk categories. At least one of these visits every other month must occur in the individual's place of residence. High-risk categories include those who:
  - Receive services from providers having conditional or provisional licenses;
  - Have more intensive behavioral or medical needs;
  - Have an interruption in service of greater than 30 days;
  - Encounter the crisis system for a serious crisis or for multiple less serious crises in a three-month period;
  - Have transitioned from a training center within the previous 12 months; or
  - Reside in congregate settings with 5 or more individuals.

Virginia must also establish a case management training program within one year of the Agreement.

- **LICENSING:** DBHDS will conduct more frequent licensure inspections for those individuals who are high-risk (as described above) within 12 months of the Agreement.
- **TRAINING:** Virginia must establish a statewide core-competency-based training program for all staff who provider services under the Agreement.
- **QUALITY SERVICE REVIEWS:** Virginia must use Quality Service Reviews (QSRs), which are face-to-face interviews with individuals in the target population, to evaluate the quality of services at the individual, provider, and statewide level.

*Independent Reviewer (Independent Review):*

Donald Fletcher is serving as the court-appointed Independent Reviewer for the Agreement and is monitoring Virginia's progress with implementation and its compliance with the terms of the Agreement. If the Court enters the Agreement as a Consent Decree, the Independent Reviewer will be required to provide reports to the Court on Virginia's progress twice per year. These reports will be publicly available.

## **Implementation Status Update**

Virginia is moving forward with implementation of the Agreement. The 2011 General Assembly provided funds to begin implementation through the Behavioral Health and Developmental Services Trust Fund (the 'Trust Fund,' §§ 37.2-316 through 319). The 2012 General Assembly continued these efforts by appropriating additional funds through Item 315 V.1. for implementation. DBHDS is moving forward with implementation based on these directives.

Table 2 below shows the milestones in the Agreement between March 6, 2012 and June 30, 2012, the date by which compliance must be shown, and a brief description of Virginia's progress in implementation. The next report will provide updates on implementation of these milestones as well as those for FY13. The milestones for FY13 are shown in Appendix B.

**Major Accomplishments:**

Some of the major accomplishments that are reflected in Table 2 include:

- **SIXTY-ONE (61) INDIVIDUALS MOVING FROM TRAINING CENTERS TO THE COMMUNITY:** In November 2012, 60 waiver slots were established out of the BHDS Trust Fund to move 40 individuals from SVTC and 20 individuals from CVTC to the community. As of June 30, 2012, 61 individuals have moved from these two training centers to the community. Twenty-two of the 60 waiver slots were used for these moves. Thirty-four individuals moved using Money Follows the Person (MFP) waiver slots. The remaining individuals chose a community ICF or had an existing waiver slot that was used. The following reflects the current and historical census in all five training centers:

Name	2000 Census	2005 Census	2010 Census	Current Census
CVTC	679	564	426	350
NVTC	189	182	170	153
SEVTC	194	192	143	106
SVTC	465	371	267	201
SWVTC	218	214	192	173
Total	1,745	1,523	1,198	983

- **ESTABLISHING CRISIS SERVICES:** DBHDS is actively working on implementation of the Systemic Therapeutic Assessment Respite and Treatment (START) program to provide crisis services to individuals with ID/DD in Virginia. Program operations in all five regions of the Commonwealth will begin in July 2012, and full operations will be online in all regions by January 2013.

The program will provide 24 hour/7 day support to individuals in crisis, including a face-to-face with an individual within one hour in urban regions and two hours in rural areas. The program will provide in-home supports and out of home crisis respite services when they are needed. The goal of the program is to maintain individuals in their home and prevent crises when possible. At the time of this report, over 60 individuals had been referred to these programs for assessment and support.

DBHDS received \$5M in FY12 to establish a crisis services program for individual adults with ID and co-occurring mental health issues or behavioral problems. DBHDS elected to implement the nationally recognized START model in all five regions. Funding awards to begin start-up and program development were given to all five regions in September 2011. In order to comply with the terms of the Settlement Agreement, which was concluded after initial program start-up began, DBHDS expanded coverage to the adult DD population in June 2012.

- **TRANSFORMATION OF DISCHARGE PLANNING PROCESSES:** DBHDS has moved to a standardized discharge process in all five training centers and is currently training staff at the facilities as well as CSBs and providers on the new process. The new process is consistent with the terms of the Settlement Agreement that discharge processes be person-centered and timely and that they provide individuals and authorized representatives with informed choice about community-based options.

Today, all training centers are following a 12 week process for discharge planning. This process engages individuals, the authorized representative, clinical professionals at the training centers, and CSB case managers to identify what is important to individuals when they move to the community, what clinical supports are needed, and what health and safety supports must be in place prior to a move. These desires and needs are compiled in a discharge plan. Individuals and authorized representatives are presented, if available, at least three options for consideration, and allowed to make several visits, including overnights stays with a potential provider to determine if the placement is the best choice.

The discharge process includes active Post-Move Monitoring at 3, 7, 10, 17, and 30 day intervals post-move from a combination of training center staff, licensing specialists, human rights staff, and the CSB case manager to ensure the discharge plan has been implemented properly by the new provider. The discharge process and post-move monitoring were successfully implemented for the 61 individuals transitioning from SVTC and CVTC.

**Barriers to Implementation:**

At the time of this report, Virginia has encountered few barriers to implementing the milestones in the DOJ Settlement Agreement for the period of March 6, 2012 – June 30, 2012. One item that will need additional consideration is in the area of Crisis Services:

- **CRISIS SERVICES FOR CHILDREN WITH ID/DD in the TARGET POPULATION:** Virginia is required to implement a “statewide crisis system for individuals with intellectual and developmental disabilities.” This system would include children. DBHDS is currently implementing the START program for adults with ID/DD. Expanding the program to include children will likely create new challenges and barriers for DBHDS to overcome.

**Table 2: March 6, 2012 – June 30, 2012 Milestones in DOJ Settlement Agreement**

DOJ Milestone	Compliance Date	Summary of Activity
<p>C.1.a. The Commonwealth shall create a minimum of 805 slots to enable individuals in the target population in the Training Centers to transition to the community according to the following schedule:</p> <p>i. In State FY 2012, 60 waiver slots</p>	<p>By June 30, 2012</p>	<p>In November 2012, 60 waiver slots were established out of the DBHDS Trust Fund to move 40 individuals from SVTC and 20 individuals from CVTC to the community. Funding was also approved for one-time start-up funds and CSB case management for these 60 individuals.</p> <p>As of June 30, 2012, 61 individuals have moved from these two training centers to the community. 22 of the 60 waiver slots were used for these moves. 34 individuals moved using Money Follows the Person (MFP) waiver slots and the remaining individuals moved to a community-based ICF or had an existing slot.</p> <p>DBHDS will work with DPB, DMAS, and OSHHR to determine how the unexpended balances associated with the unused slots will be used to move forward with implementation of the Settlement Agreement.</p>
<p>C.1.b. The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent wait list for a waiver...</p> <p>i. In State FY 2012, 275 waiver slots</p>	<p>By June 30, 2012</p>	<p>DBHDS uses a CMS-approved slot allocation methodology to distribute community ID waiver slots to CSBs. The CSBs then distribute these slots to individuals on their urgent needs wait list.</p> <p>In June 2011, DBHDS notified CSBs of their slot allocation and the slots were distributed.</p>
<p>C.1.c. The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than ID in the target population who are on the waitlist for a waiver..</p> <p>i. In State FY 2012, 150 waiver slots</p>	<p>By June 30, 2012</p>	<p>DMAS uses a CMS-approved slot allocation methodology to distribute DD waiver slots to individuals on the DD waiver wait list.</p> <p>In July 2011, DMAS notified individuals on the DD waiver wait list that they had received a slot.</p>

DOJ Milestone	Compliance Date	Summary of Activity
<p>C.6.b.i.B. By June 30, 2012, the Commonwealth shall train CSB Emergency Services personnel in each Health Planning Region ("Region") on the new crisis response system it is establishing, how to make referrals, and the resources that are available.</p>	<p>By June 30, 2012</p>	<p>DBHDS is actively working on implementation of the Systemic Therapeutic Assessment Respite and Treatment (START) program to provide crisis services to individuals with ID/DD in Virginia.</p> <p>At the state level, training and information has been provided to the VACSB Emergency Services Council in January 2012 and May 2012.</p> <p>At the regional level, each region has been with CSB emergency services staff to introduce them to the START program and establish memorandum of understanding with each emergency services team in that region to coordinate referrals to the START program.</p>
<p>C.6.b.ii.F. By June 30, 2012, the Commonwealth shall have at least one mobile crisis team in each Region that shall respond to on-site crises within three hours.</p>	<p>By June 30, 2012</p>	<p>All five regional START programs are recruiting and hiring staff. Two regions will operate using a private provider, UCP/Easter Seals, and three regions will operate CSB programs.</p> <p>Regional START teams are providing some consultation to individuals and professionals in each region. Operations of mobile crisis teams will begin according to the schedule below with modified hours of operation. All programs will be fully operational with 24/7 support by January 2013.</p> <p>Region I (Central Virginia): October 2012  Region II (Northern Virginia): October 2012  Region III (Southwest Virginia): August 2012  Region IV (Greater Richmond/Petersburg Area): September 2012  Region V (Hampton Roads): October 2012</p>

DOJ Milestone	Compliance Date	Summary of Activity
<p>C.6.b.iii.E. By June 30, 2012, the Commonwealth shall develop one crisis stabilization program in each Region.</p>	<p>By June 30, 2012</p>	<p>START crisis respite homes are under renovation or construction in each of the five regions. They will begin operations according to the schedule below, with full operations by January 2013.</p> <p>Region I (Central Virginia): October 1  Region II (Northern Virginia): October 1  Region III (Southwest Virginia): January 1  Region IV (Greater Richmond/Petersburg Area): November 1  Region V (Hampton Roads): January 1</p> <p>Regions have partnership agreements with each other so that those homes coming online earlier can admit individuals from other regions, when beds are available. This will ensure individuals receive some crisis respite supports while the homes are completed.</p>
<p>IV. By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the term of this Section, excluding other dates agreed upon, and listed separately in this section.</p>	<p>By June 30, 2012</p>	<p>Discharge process standardization began prior to completion of the Settlement Agreement.</p> <ul style="list-style-type: none"> <li>-All individuals residing at the training center have a discharge plan</li> <li>-All training center staff involved with discharges have been trained</li> <li>-All five Community Integration Managers have been hired (December 2011)</li> <li>-Internal DBHDS guidelines finalized and issued to training centers</li> <li>-Regional meetings with CSBs to learn about process began in May 2012 and will conclude in July 2012</li> <li>-Information regarding barriers to discharge are collected and aggregated for training center, regional, and statewide analysis</li> <li>-Post-move monitoring process in place</li> <li>-All discharge plans updated within 30 days of discharge</li> <li>-Monthly reports to Central Office regarding individuals moved and types of placements</li> </ul> <p>Other items that are under development include:</p> <ul style="list-style-type: none"> <li>-Develop training center education and training plan for Person-Centered Thinking (PCT), terms of the Agreement, discharge process, and community options</li> <li>-Regional Support Teams established</li> </ul>

DOJ Milestone	Compliance Date	Summary of Activity
<p>IV.B.8. For individuals admitted to a Training Center after the date this Agreement is signed by both parties, the Commonwealth shall ensure that a discharge plan is developed as described herein within 30 days of admission. For all individuals residing in a Training Center on the date that this Agreement is signed by both parties, the Commonwealth shall ensure that a discharge plan is developed as described herein within six months of the effective date of this Agreement.</p>	<p>By June 30, 2012</p>	<p>All individuals residing at training centers have a discharge plan.</p>
<p>V.D.3. The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal year 2012 and will ensure reliable data is collected and analyzed from each these areas by June 30, 2014...</p> <ul style="list-style-type: none"> <li>a. Safety and freedom from harm</li> <li>b. Physical, mental, and behavioral health and well being</li> <li>c. Avoiding crises</li> <li>d. Stability</li> <li>e. Choice and self-determination</li> <li>f. Community inclusion</li> <li>g. Access to services</li> <li>h. Provider capacity</li> </ul>	<p>Some data collected by June 30, 2012</p>	<p>This section of the Agreement requires Virginia to begin collection of some data in FY12 and to expand to include measures in each of the domains (a-h) by June 30, 2014.</p> <p>DBHDS collects data through its Office of Human Rights and the Office of Licensing regarding deaths, serious incidents, and allegations of abuse and neglect. This data addresses domain (a) and satisfies the requirement to collect data in selected areas for FY12.</p> <p>DBHDS will be working with providers and CSBs to identify additional measures that will be collected by June 30, 2014 in each of the domains. DBHDS will also work with providers and CSBs to determine the most efficient methodology to collect this data and how it will provide regular reports on the measures to providers, CSBs, and the public.</p>



## Future Milestones in the DOJ Settlement Agreement

Achieving the implementation milestones in the Settlement Agreement for the period of March 6, 2012 – June 30, 2012, has not been the only focus of Virginia’s efforts to advance the terms of the Settlement Agreement. As Appendix B shows, there are several milestones that must be accomplished within one year of the March 6, 2012, enactment date or by the end of FY13.

DBHDS and other state agency partners are working actively to address several of these future milestones. Workgroups composed of CSBs, providers, advocacy organizations, peer-advocates, and other interested stakeholders have been formed to begin development of the Individual and Family Supports Program, further define the new case management expectations, identify case management data collection needs, define provider and CSB measures that will be collected, develop provider training curriculum, address the Employment First plan, and address the housing plan. Updates on the work of these groups will be outlined in the December 1, 2012, update.

On July 9<sup>th</sup>, DBHDS hosted a Settlement Agreement Stakeholder Group to share implementation activities to date and listen to stakeholder input about implementation strengths and areas for improvement. The group will meet at least quarterly and serve as a means to share information about implementation and discuss how Virginia will move forward with future years’ implementation. Appendix C contains information about the group’s membership. There is an opportunity for public comment at each meeting.

### Training Center Closures

The Settlement Agreement with DOJ does not require closure of Virginia’s training centers. However, in order to afford the implementation of the terms of the Settlement Agreement, closure of 4 of 5 of Virginia’s training centers has been planned. An outline of the plan to close is provided in the Secretary of Health and Human Resources report on the Trust Fund (Report Document No. 86), “Plan to Transform the System of Care for Individuals with ID in the Commonwealth of Virginia”, submitted to the General Assembly in February 2012 (available at <http://www.dbhds.virginia.gov/Settlement.htm>). SEVTC, with capacity to serve 75 individuals, will remain open to serve those with the most significant long-term medical and behavioral needs. Table 3 shows the projected facility-specific reduction targets and timeframes for downsizing. The table shows projected closures of SVTC in FY15, NVTC in FY16, SWVTC in FY18, and CVTC in FY20.

**Table 3: Training Center Downsizing and Closure Projections**

Fiscal Year	SVTC	NVTC	SWVTC	CVTC	Estimated Waiver Slots Required**
2012	40			20	60
2013	97	51		25	160
2014	97	51		25	160
2015		50		48	90
2016			58	48	85
2017			58	48	90
2018			58	48	90
2019				48	35
2020				47	35

\*\*An annual natural death rate is factored into the waiver slots estimate.

The General Assembly has indicated that DBHDS should move forward with the plan to close SVTC and NVTC through approval of the facility closure costs and facility savings in Item 315 V.1. for the FY13-FY14 biennium. As mentioned earlier in this report, DBHDS has moved 61 individuals from SVTC and CVTC in FY12 and has begun working with families to move additional individuals in FY13 and FY14.

DBHDS is working closely with staff at SVTC to provide assistance to employees as the facility continues to downsize. DBHDS is collaborating with training center leadership; the Virginia Community College System Rapid Response Team; The Department of Human Resources Management (DHRM) and other agencies identified below. The following bullets outline current, planned, and previous human resource activities supporting the DOJ agreement and DBHDS employees:

- **Progressive Retention Bonus Plan** has been approved by the Administration and will be implemented 7/1/12, at SVTC to help retain critical positions and maintain a viable working staff as the facility moves forward with closure in 2014. The plan provides for a progressive retention bonus, paid according to performance and criticality of skill sets needed to maintain CMS certification until all individuals are safely placed in the community. Similar retention plans will be developed at the other training centers as they progress toward closure. The facility will absorb the cost of implementing this retention plan through existing finances.
- **Internal Newsletter**, "The Bridge", has been developed and is distributed quarterly to enhance communications and help staff cope with the closure and to keep them aware of planned activities that support further career development and their individualized interests/needs.
- **Entrepreneurial Express** - A partnership was developed with the Small Business Administration, the Department of Minority Business Enterprise, Virginia's Community Colleges, Rapid Response, Workforce Development Services, the Department of Business Assistance, representatives from private provider organizations and DBHDS staff. After surveys were conducted, "The Entrepreneurial Express" training sessions for employees were developed by the team and as held on 7/11/12. These have been tailored to the individual needs of the employees expressing an interest in "starting their own business".
- **The Career Center** will open on 7/18/12, with the assistance of the Rapid Response Team, to provide employees with a library of resources to assist them with their personal and professional development and job search. It will also provide group and individual consultations and workshops.
- **Consultation and Guidance** – The Human Resources Office staff from Southside Virginia Training Center and Central State Hospital are continuing to provide consultation and guidance on "enhanced retirement and severance benefits". Individual estimates are anticipated to be completed by the end of August, 2012. The Human Resources Office will expand its hours of operation during peak periods of layoffs/retirements in order to effectively meet the needs of impacted staff on all shifts.
- **Job Fair** - A licensed provider job fair is anticipated to be held on the Southside Campus during the fall of 2012.
- **Managers/Supervisors/Leadership Transition Training** – How to Manage Employees in a Change Environment. As a result of the DBHDS partnership with the VA Community College System, the Rapid Response Team offered a workshop for supervisors of SVTC and NVTC. This workshop provided practical, actionable guidance and resources on how supervisors could effectively maintain a productive environment during this business transition. Sessions were held at SVTC on March 29<sup>th</sup> and at Northern Virginia Training Center on April 11<sup>th</sup>.

Approximately 100 supervisors attended, and sessions will also be scheduled for Southwest Virginia Training Center and Central Virginia Training Center supervisors.

- **Employee Information Sessions** – In collaboration, DBHDS Human Resource Development & Management, SVTC Human Resources, NVTC Human Resources, the VCCS Rapid Response Team, VEC, and VRS offered employee informational sessions on services provided to dislocated workers and the upcoming resources available to them on site. Over a three-day period, sessions were held on all three shifts and employees had an opportunity for questions and answers, including one-on-one discussions with the various representatives after the sessions. Over 930 employees attended the Southside sessions and over 276 employees attended the Northern Virginia sessions. Additional employee information sessions for SWVTC and CVTC will be held in the future.
- **Commissioner’s Employee Forums** – From January 27<sup>th</sup> to February 22<sup>nd</sup>, the Commissioner, Deputy Commissioner, Assistant Commissioner of DD and the Human Resources Director conducted employee forums at the four training centers (SVTC, NVTC, SWVTC, CVTC) planned for closure. These sessions were held on all three shifts, communicating information regarding the settlement agreement between the Commonwealth of Virginia and the Department of Justice; timeframe for closures, community capacity, projected reduction in census and discharge process; quality of continuing services to individuals served; and, human resources employee retention assistance and resources were discussed. Over 1700 employees attended the forums.

#### **Waiver Programs**

Both the DD waiver and ID waiver are up for renewal with CMS in the next two years. The Settlement Agreement does not require changes to Virginia’s waiver programs. However, in order to efficiently and effectively execute the terms of the Agreement, particularly those related to supporting individuals in the most integrated setting appropriate to their needs, Virginia must consider making significant changes to its current waiver programs. A preview of these changes was described in the DMAS study submitted in accordance with Item 297. BBBB. of the 2011 *Appropriation Act*, “Review of Potential Waiver Changes and Associated Costs Related to Improving Intellectual Disability (ID), Day Support (DS), and Individual and Family Developmental Disabilities Support Waivers “ (Report Document No. 76, 2012).

During FY13 and FY14, DBHDS and DMAS will be undertaking major initiatives with stakeholders to update the waiver programs, restructure how they operate, and examine potential rate increases. Some of the fundamental changes that will be made include:

- Move from a system that serves individuals with intellectual disability and individuals with other developmental disabilities separately, based on diagnosis, to a system that provides supports to individuals with developmental disabilities based on their needs.
- Establish two waiver programs for individuals with developmental disabilities, including those with intellectual disability. One waiver will provide an array of services to support individuals in their current residential environment or assist them in moving to their own home or apartment (i.e. “Basic Supports” Waiver). The other waiver will provide these same services as well as residential services for individuals who may have more significant support needs (i.e. “Comprehensive Waiver”).

These fundamental changes are associated with many very significant operational details that DBHDS and DMAS must work through with providers, CSBs, DD case managers, and others. Issues include case management, wait list management, services and rate changes, and incentives for employment and integrated housing.

## Expenditures

Item 305.W of the 2012 *Appropriation Act* provided \$30M to the DBHDS Trust Fund, which was established in §37.2-319 during the 2012 General Assembly. The Code requires:

*For each fiscal year starting with the Commonwealth's 2011-2012 fiscal year, any funds directed to be deposited into the Fund pursuant to the general Appropriation Act shall be appropriated for financing (i) a broad array of community-based services including but not limited to Intellectual Disability Home and Community Based Waivers or (ii) appropriate community housing, for the purpose of transitioning individuals with mental retardation from state training centers to community-based care.*

Based on this directive, the Secretary of Health and Human Resources approved the expenditures detailed in Table 4 in FY12 from the Trust Fund. The expenditures included funding for 60 waiver slots to transition individuals from SVTC and CVTC to the community. One-time start-up funds and case management funds for individuals living in training centers were also provided. Funding was provided for the Independent Reviewer to begin working in Virginia between March 6, 2012 and June 30, 2012.

Funding was also approved to begin hiring critical staff to assist in implementing the discharge process and increasing community oversight. Remaining balances from the FY12 \$30M DBHDS Trust Fund were shifted to FY13 for use in implementing the DOJ Settlement Agreement in Item 315. U. of the 2013 Appropriations Act.

**Table 4: FY12 Trust Fund Expenditures**

Item	Expenditure (GF)	
	Estimated	Through 6/19/2012
60 facility waiver slots	\$ 1,542,240	\$ 398,405
Start-Up Funds	\$ 240,000	\$ 114,000
Training Center Case Management	\$ 97,800	\$ 11,755
DOJ Consultant –Fletcher	\$ 86,535	\$ 56,062
<b>Positions*</b>		
START Coordinator	\$ 100,000	\$ 51,760
Community Integration Managers (2)	\$ 100,000	\$ 58,624
Trust Fund Manager (P14)	\$ 80,000	\$ 58,340
<b>TOTAL</b>	<b>\$ 2,246,575</b>	<b>\$ 748,946</b>

\*Includes salary, fringe benefits, and operating

Item 315.V.1. of the 2012 *Appropriation Act* includes the following categories for disbursement of the appropriation. The December 1, 2012, report update will show estimated versus actual expenditures in these categories and report on progress in implementing the DOJ Settlement Agreement:

**Table 5: Estimated and Actual FY13 and FY14 Expenditures (GF)**

Item	Estimate FY13	Actual FY13	Estimate FY14	Actual FY14
Facility Transition	\$11,309,540		\$19,534,660	
Community Waiver Slots	\$19,615,150		\$27,642,275	
Individual and Family Supports	\$2,400,000		\$3,200,000	
Rental Subsidies	\$800,000		\$0	
Crisis Stabilization	\$5,000,000		\$10,000,000	
Facility Closure Costs	\$2,749,885		\$8,397,855	
Administration	\$1,313,682		\$1,807,338	
Quality Management	\$1,787,000		\$1,537,000	
Independent Review	\$300,000		\$300,000	
Facility Savings	(\$5,846,989)		(\$23,364,535)	
<b>TOTAL</b>	<b>\$39,428,269</b>		<b>\$49,054,594</b>	

**Appendix A:**  
**Settlement Agreement between the US Department of Justice and the**  
**Commonwealth of Virginia**

CHRISTINE O. GREGOIRE  
Governor



STATE OF WASHINGTON  
OFFICE OF THE GOVERNOR

P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 753-6780 • [www.governor.wa.gov](http://www.governor.wa.gov)

September 10, 2012

The Honorable Tom Harkin  
United States Senate  
731 Hart Senate Office Building  
Washington, DC 20510

Dear Senator Harkin:

I'd like to thank you for the opportunity to describe Washington's actions to implement the Olmstead decision and our ongoing efforts to assure that more people can live, work, and receive services in their community. In your letter to me dated June 22, 2012, you posed six questions about the impact on states of the Olmstead decision. My Department of Social and Health Services, Aging and Disability Services Administration, is responsible for Long Term Care, including nursing facilities; Developmental Disabilities, including institutions; and Behavioral Health, including the state hospitals. I have asked them to provide a detailed response to your questions in the enclosed document.

Washington State has a 30-year commitment to supporting people to avoid admission to nursing facilities and avoid institutionalization in Intermediate Care Facilities for People with Intellectual or Developmental Disabilities and State Hospitals whenever possible. Washington State has made significant use of all federal help available to implement this community-based approach. We have maximized the use of Waivers, successfully applied for innovation grants, and are national leaders in the implementation of successful employment supports for working age people with disabilities.

It is my pleasure to provide you with this important information. Should you have any additional questions about the data provided in this response, please contact Secretary Robin Arnold-Williams, Washington State Department of Social and Health Services, at (360) 902-7800 or [robin.arnold-williams@dshs.wa.gov](mailto:robin.arnold-williams@dshs.wa.gov).

Sincerely,

A handwritten signature in blue ink that reads "Chris Gregoire".

Christine O. Gregoire  
Governor

Enclosure



Please see below for Washington State's answers to the six questions posed regarding the impact of the Olmstead decision.

1. *For each year from FY 2008 to the present (defined as SFY 08 - SFY 11): The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, long term care units of psychiatric hospitals, and board and care homes (often call adult care homes or residential health care facilities), to living in their own homes, including through a supportive housing program.*

The data you requested is in Attachment I. In Washington State, people sometimes move out of institutional placements such as nursing facilities (NF), intermediate care facilities (ICF/ID-DD) or state hospitals (SH) into supervised living situations in the community other than the person's own home. They may also return to their own homes or may be supported to rent, lease or buy new homes. We have provided data about where people moved when leaving NFs, ICF/ID-DD or SH for the State Fiscal Years (SFY) of 2008 through 2011. The data for SFY 12 are not complete. We have also provided definitions of all settings so that you may choose the information that best answers your question.

2. *The amount of state dollars that will be spent in this fiscal year (defined as SFY11) serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual or developmental disabilities, board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.*

#### SFY11 Expenditures

Category	LTC	DDD	Total
Nursing Homes	\$205,635,000	-	\$205,635,000
ICF/ID-DD	-	61,881,000	61,881,000
Group Homes	-	7,876,000	7,876,000
Board and Care Homes	35,917,000	793,000	36,710,000
Adult Family Homes	42,546,000	12,972,000	55,518,000
Medicaid Personal Care, including all waiver personal care service	224,045,000	90,687,000	314,732,000
<b>Total</b>	<b>\$508,143,000</b>	<b>\$174,209,000</b>	<b>\$682,352,000</b>

\*LTC Long Term Care

\*\*DDD - (Division of) Developmental Disabilities

Data Source: AFRS - SFY 2011 (July 1, 2010 through June 30, 2011)

Figures represent only GF-State; federal and local funds are excluded.



Category: State Psychiatric Hospitals (SH) Mental Health

Budget Unit	SFY11 Disbursements			Total Expenditures
	GF-S	Federal	Private/Local	
Hospital Revenue/Projects	446,271	2,066		448,336
Eastern SH	17,859,583	22,914,047	12,565,595	53,339,224
Western SH	78,082,970	47,607,664	18,049,005	143,739,639
CSTC*	2,479,355	7,287,690	15,320	9,782,364
CSS**	3,771,266	12,988		3,784,253
Grand Total Expenditures				211,093,816

\*Child Study & Treatment Center serves children

\*\*Consolidated Support Services (maintenance/operations)

3. *For each year from FY 2008 to the present (defined as SFY08-SFY11), the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.*

Washington State has worked hard to develop a community based service system. The state has implemented a robust State Plan Personal Care Services program. The state has also made maximum use of Waiver supports, as ADSA currently supports six (6) Waivers that relate to your questions. The data below identifies the increase in number of people served in State Plan for Personal Care services and the increase in the number of people participating in the 6 Waivers for SFY08-11. All personal care and waiver services enable people to avoid admission to NFs, ICFs, or SHs. It is important to note that between state fiscal years 2009-2012, Washington experienced a significant state budget crisis, which required the state to cut \$11 billion in current and projected spending from our general fund. Despite these remarkable cuts, you will note that Washington was able to increase the number of people we served in community settings.

MOVES TO COMMUNITY FROM INSTITUTIONS

		SFY-2008	SFY-2009	SFY-2010	SFY-2011
LTC	COPEs	19,537	20,202	21,174	22,216
	MPC	25,692	27,259	26,874	27,321
	NEW FREEDOM	146	413	611	795
DDD	Waiver	9,688	11,472	11,970	12,369
	Basic	2,933	4,243	4,662	4,961
	Basic Plus	2,149	2,520	2,583	2,662
	CP*	472	486	479	479
	Core	4,134	4,223	4,246	4,267
	MPC In-Home	6,660	7,130	6,379	6,493

\*Community Protection

One critical action imbedded in this data is the closure of the Frances Haddon Morgan Center, an ICF/ID facility for people living with developmental disabilities. During the 2010 Legislative Session, Governor Gregoire ran Executive Request legislation that called for the closure of two of the state's five ICF/ID facilities and the development of more community-integrated residential alternatives. The bill that passed the Legislature closed one ICF/ID facility (Frances Haddon), stopped admission to a second ICF/ID facility, and barred admission for any child 16 years of age or younger into any ICF/ID, effective July 1, 2012. This was the first full scale closure of an ICF/ID in nearly 20 years. The legislation also called for the creation of community-based crisis stabilization and respite services. Of the fifty-two (52) residents that lived at the ICF/ID that closed, thirty-one (31) moved to community based options - seventeen (17) moved to State Operated Living Alternatives (SOLA) and fourteen (14) to privately operated residences certified as supported living. A "SOLA" is a community-based residential alternative, certified as supported living and is staffed with state employees. Twenty-one (21) people chose to move to other larger state-operated ICF/ID facilities.

Using savings from the closure, the state also created a crisis residential treatment facility to provide short-term intervention and stabilization for up to three (3) children. In addition, a statewide Community Crisis Stabilization team was created to provide behavioral and other clinical supports to children enabling them to remain in their family home.

4. *The contents of your state's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.*

Washington's Olmstead Plan was updated in 2005. Since then, Washington has continued the activities described in that report and added activities associated with application for and use of Money Follows the Person (MFP), Real Choices, and Roads to Community Living (RCL) federal grants to improve the state's capacity to help people either avoid institutionalization in NFs, ICFs or SHs, or help people return to their home communities if use of these facilities is unavoidable.

For example, the Money Follows the Person demonstration program requires states to report annually on benchmarks that establish empirical measures to assess the state's progress in transitioning individuals to the community and rebalancing its long-term care system. The first two benchmarks are required by all awardees and include the numbers of eligible individuals transitioned from an inpatient facility to a qualified residence, and qualified expenditures for HCBS during each year of the demonstration program.

Washington projected moving 660 individuals through the project over the course of the first five years of the demonstration (2007 – 2011). We began transitioning people in the fall of 2008. Through calendar year 2011, Washington State transitioned over 1800 individuals from institutional settings, including seniors, individuals with physical disabilities, developmental disabilities, and mental illness, far exceeding our projections.

The remaining three benchmarks are developed by each state individually to reflect indicators relevant to them. Washington’s state-specific benchmarks follow:

Benchmark 3: Captures the increase in community caseload pursuant to the implementation of Roads to Community Living (the state MFP program).

Annual percent increase in total HCBS (Home and Community Based Services) Caseload (with the inclusion of expected counts of RCL participants)

	Target	Actual	Percent of target achieved
2008	3.38	3.9	115%
2009	3.27	4.5	138%
2010	2.24	4.27	191%
2011	1.55	4.2	271%

Benchmark 4: Captures rebalancing efforts by measuring the decrease in nursing home caseload as a proportion of the total long-term care caseload (nursing homes and home and community services combined).

The percent of institutional care as proportion of total LTC caseload

	Target	Actual	Percent of target achieved
2008	22.5	21.86	103%
2009	21.6	21.08	102%
2010	20.80	18.12	115%
2011	20.20	17.57	115%

5. *Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead’s integration mandate and take advantage of new federally available assistance.*

Over the last 30 years, Washington State has implemented a robust community based service system. The latest congressional efforts to encourage states to develop community based services and avoid institutionalization are not especially helpful to Washington since 76 percent of current funding is spent in home and community based services and 24 percent of funding is spent on institutional based systems of care. Washington State is, however, evaluating whether or not options offered in Title 1915 (i) and (k) may be helpful to continuing the work being done to ensure people may remain in their home communities. It would be helpful if Congress recognized those states that have already done much to rebalance their systems with additional federal support rather than only using additional federal support to encourage states who have done little in that regard. For example, Congress could allow high performing states to claim more FMAP for community based services than it claims for institutional services.

Since most of the federal support for Washington's community based service system is federal Medicaid funding, many of the challenges to building a community based system are related to the rules that govern the institutional/medically related portions of the system. Examples follow:

- Eligibility criteria for waiver programs is tied to eligibility for institutions, requiring states to loosen criteria for institutional admission (making more people eligible) or conversely prohibiting states from implementing higher eligibility criteria for institutional settings than community based services. The result is waiting to intervene until the person requires a much higher level of services. Eligibility criteria should be different for Waiver services so that states may intervene earlier with less costly services and help people avoid crisis.
- Employment is one of the most effective ways of helping people that rely on human services avoid crisis, homelessness, reduced capacity, etc. Yet federal rules require people that apply for benefits because of disability to prove that they are "unable to work at a substantial gainful activity (SGA)" level. In addition, current federal rules governing the provision of behavioral health services require that authorization of supported employment fit into the medical/clinical model that governs the rest of the services delivered. It would be useful for states to have funding streams for employment that encouraged implementation of evidence-based and promising employment practices for working age people with disabilities, including supported employment. Such practices would result in employment at a living wage (which could be confirmed through reports from the state's Unemployment Insurance system). Even better would be funding streams that rewarded success with a percentage of the UI earnings of target workers that states could reinvest in employment support infrastructure and technical assistance.
- The FMAP rate is the same for institutional programs and for community based programs. If community based services are preferred, an improved FMAP rate for the community based services described in this letter, i.e. "truly integrated settings, living in their own homes, engaged with family, friends and their communities" would encourage states and provide resources needed to further develop these settings.
- Rules are under development by the Center for Medicare and Medicaid Services (CMS) to define community based settings. The populations served in Washington State's home and community based care system varies widely, with respect to both care needs and housing preferences. These rules, if implemented as proposed, could limit access to housing settings that offer a non-institutional setting, which is preferred by some seniors in Washington. If there are regulatory changes, states will need support and reasonable timelines to implement the fundamental changes in the definition of community-based settings.
- Current discussion of policy at the federal level appears to support employment in integrated settings at minimum wage or better. Data/research show that one of the most important factors in successful job placement for working age people with disabilities is if they have jobs in high school and particularly summer jobs. Currently students with disabilities have access to school programs past the typical graduation age of 18.

Changes in high school curriculum requirements in the transition programs affecting students after 18 that emphasize job experience and connection to adult employment agencies would leverage the funding available in high school to encourage long-term job success.

6. *Any successful strategies that your state has employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.*

- In addition to utilizing Medicaid home and community-based services waivers since the 1980's, Washington has been particularly successful in using the optional Medicaid personal care (MPC) state plan service to successfully support people to remain in their own homes or family homes. That strategy may be used by other states and in fact is suggested by the Balancing Incentive Payment Program and the Medicaid 1915 (i) and (k) options.
- Washington's successful implementation of its Money Follows the Person (MFP) grant helped convince the State Legislature to approve \$2,898,000 in additional state only funding in the 2009-11 state budget to relocate adults who desire to move from institutions to a home and community based setting. This state funding is used to assist the transition of individuals that do not meet the MFP institutional length of stay requirement or who are moving to a setting that is not qualified for MFP funding. For example, it means that an individual has been living in an institutional setting for at least 30 continuous days but less than the MFP required 90 days.
- The federal funding available in the MFP Roads to Community Living grants to support each person for the first year that the person returns to her/his community has been very persuasive for Washington's Legislature. The Legislature has appropriated sufficient additional funding to support every person that has moved after the first year of primarily federal funding.
- Federal grant funding has supported people with behavioral health issues and has helped 127 individuals secure community based housing in the first year of direct services. Sixty-five individuals were living in an institutional setting in the six months prior to enrollment in the project. Sixty-seven percent of the individuals reported being homeless or unstably housed in the six months prior to enrollment. The majority of the services are provided by certified peer specialists.

# ATTACHMENT I

## DEFINITIONS

### **ADULT FAMILY HOME SERVICES (AFH)**

Adult Family Homes (AFHs) are residential homes located in typical neighborhoods. The homes provide the residents with a room, meals, laundry, supervision, assistance with activities of daily living, and personal care. Some provide nursing or other special care and services. Adult Family Home providers are private businesses and are licensed to care for up to six residents.

### **ASSISTED LIVING SERVICES (AL)**

Assisted Living facilities provide private apartments to residents that include kitchenettes, private bathrooms and a living/sleeping area. Meals may be prepared in the living unit or taken in the dining room. Assisted Living services include personal care, assistance with activities of daily living, medication oversight, intermittent nursing services and therapeutic social and recreational programming. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs.

### **ADULT RESIDENTIAL CARE AND ENHANCED ADULT RESIDENTIAL CARE (ARC/EARC)**

ARC and EARC facilities provide shared living units and bathrooms and common living areas and dining rooms in which meals are provided. Services include personal care, assistance with activities of daily living, medication oversight and 24-hour on-site response staff to meet scheduled or unpredictable needs.

### **GROUP HOME**

The Division of Developmental Disabilities (DDD) Group Homes are community-based residences serving two or more adult clients in a licensed facility. Group homes provide 24-hour support and training. Clients participate toward room and board expenses.

### **SUPPORTED LIVING**

The Division of Developmental Disabilities (DDD) Supported Living (SL) services offer instruction and support to adults who live in their own homes in the community. Supports may vary from a few hours per month up to 24 hours per day of one-on-one support. Clients pay their own rent, food, and other personal expenses. DDD contracts with private agencies to provide Supported Living services.

### **STATE HOSPITALS (SH-E AND SH-W)**

The two state psychiatric hospitals work to help patients attain enough stability with their psychiatric symptoms to transfer to a reduced level of care. Patients are placed on a civil detention if they are assessed by medical staff as gravely disabled, a danger to others, or a danger to themselves based on a mental illness. Patients still may be symptomatic when they are discharged, but they are assessed to no longer needing this level of care or no longer meet commitment criteria. Patients committed under a civil detention can be discharged to placements based on their service needs.

**ATTACHMENT I**  
**MOVES TO COMMUNITY FROM INSTITUTIONS**  
 Response to Question 1

	SFY-2008	SFY-2009	SFY-2010	SFY-2011
<b>IMR</b>	<b>1</b>		<b>2</b>	<b>3</b>
SUPPORTED LIVING	1		2	3
<b>Nursing Home</b>	<b>3146</b>	<b>3361</b>	<b>3776</b>	<b>3787</b>
AFH	647	661	750	762
AL	643	658	740	699
ARC/EARC	202	236	257	261
GROUP HOME	6	6	4	1
IN-HOME	1594	1743	1970	2017
SUPPORTED LIVING	54	57	55	47
<b>SH-E</b>	<b>1</b>	<b>79</b>	<b>72</b>	<b>95</b>
AFH		16	12	18
AL		6	10	6
ARC/EARC		27	20	40
IN-HOME	1	15	19	21
SUPPORTED LIVING		15	11	10
<b>SH-W</b>	<b>71</b>	<b>108</b>	<b>121</b>	<b>118</b>
AFH	41	67	76	79
AL	1	4		2
ARC/EARC	11	11	17	13
IN-HOME	6	14	16	14
SUPPORTED LIVING	12	12	12	10
<b>ICF/ID-D (RHC)</b>	<b>184</b>	<b>173</b>	<b>151</b>	<b>149</b>
AFH	5	14	6	4
ARC/EARC	3	4	1	
GROUP HOME	2	4	1	3
IN-HOME	130	117	107	118
SUPPORTED LIVING	44	34	36	24

\*\*\*Duplicated client count

\* Client may be counted more than once (small number) if returned to facility and came back to community more than once during year



STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Office of the Secretary

One Davis Square, Suite 100, East

Charleston, West Virginia 25301

Telephone: (304) 558-0684 Fax: (304) 558-1130

Earl Ray Tomblin  
Governor

Rocco S. Fucillo  
Cabinet Secretary

August 30, 2012

The Honorable Tom Harkin, Chairman  
United States Senate  
Committee on Health, Education, Labor and Pensions  
Washington, DC 20510-6300

Dear Senator Harkin:

The State of West Virginia is pleased to provide you with the information you requested on June 22, 2012 in regards to the progress which we have made toward compliance with the Olmstead v. L.C. decision of the Supreme Court.

- (1) For each year from FY 2008 to the present: The number of people who moved from nursing homes, intermediate care facilities for individuals with intellectual disabilities, long term care units of psychiatric hospitals, and board and care homes, to living in their own home, including through a supported housing program.

**Response:** Unfortunately, West Virginia has not collected the data on the people who have transitioned from institutional settings into the community. However, West Virginia had a limited Transition Navigator Pilot Program which diverted individuals from having to go into an nursing home as well as helping them transition out of the nursing home. This program was funded solely by state dollars and did not cover all 55 counties in the state. This Program was overseen by the Olmstead Coordinator's office within the WV Department of Health and Human Resources. The number for each year of this program is listed below:

FY 2008: 9 transition/2 diversion  
FY 2009: 28 transition/101 diversion  
FY 2010: 38 transition/96 diversion  
FY 2011: 50 transition/101 diversion  
FY 2012: 13 transition/54 diversion

In FY 2012, the Olmstead Coordinator diverted most of the funds which were being used for the pilot program to the Bureau for Medical Services, the State's Medicaid agency, to use as matching funds for the *Money Follows the Person Rebalancing Grant*.



Honorable Tom Harkin  
August 30, 2012  
Page Two

The number of people who transitioned into a supported housing program:

FY 2010: 32 people  
FY 2011: 53 people  
FY 2012: 40 people

Total number of people who can be served in a supported housing program in a year can be 125 people.

- (2) The amount in state dollars that will be spent in this fiscal year serving individuals with disabilities in each of these settings: nursing homes, intermediate care facilities for individuals with intellectual disabilities, long term care units of psychiatric hospitals, and board and care homes, psychiatric hospitals, group homes, and their own homes, including through a supportive housing program.

**Response:** For State Fiscal year 2013 (July 1, 2012 to June 30, 2013) the estimated amount of state dollars which will be spent serving individuals with disabilities in the following settings:

Nursing Homes: \$153 million \*Nursing home cost includes both people with disabilities and the geriatric population.  
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFMR): \$18.6 million  
Long Term Care Units of Psychiatric Hospitals: \$54.3 million  
Psychiatric Hospitals: \$65.9 million  
Psychiatric Transitional Facility: \$1.3 million  
Supportive Housing Program: \$5 million  
Group Homes: \$3.3 million

- (3) For each year from FY 2008 to the present, the extent to which your state has expanded its capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of state dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.

**Response:** The Transition Navigator Program, which was 100% state funded:

FY 2008/2009: \$409,471 \*State FY 2008 was added to SY 2009 because the program started at the end of 2008 and was only active for 2 months during that time.

Honorable Tom Harkin  
August 30, 2012  
Page Three

FY 2010: \$274,405  
FY 2011: \$272,536  
FY 2012: \$123,873

**Supportive Housing:**

FY 2010: \$780,898  
FY 2011: \$2.6 million  
FY 2012: \$4.6 million

Since State Fiscal Year 2008, the number people served through the Intellectual Developmental Disabilities Waiver (IDD) has increased from 3,844 to 4,534 for State Fiscal Year 2013. During this time period IDD Waiver expenditures increased from \$252M to estimated \$288M or approximately \$36M more spent in services. Assuming the blended match rate in effect today, this would equate to approximately \$95 million.

The number of people served in the Aged and Disabled Waiver increased from 5,400 in SFY 2008 to 8,165 for SFY2011, an increase of 2,765. Funds spent for this program increased from \$98,795,109 in SFY 2008 to \$156,085,232 or \$57.3 million more dollars spent. This represents an approximate \$16 million (based on SFY13 blended FMAP) in additional State funding.

- (4) The contents of your State's Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which is incorporates any of the new tools created by the federal government to support home and community-based services, and the extent to which you have been successful in meeting any quantifiable goals identified within it.

**Response:** On August 13, 2003, the Olmstead Coordinator's office was established within the WV Department of Health and Human resources. The Coordinator was given the following responsibilities: develop, implement and monitor West Virginia's Olmstead activities in compliance with Title II of the ADA; provide support to the Olmstead Council in carrying out their duties; manage grant funding to carry out Olmstead-related projects; facilitate the implementation of the Transition Navigator Program; and provide information, referral and assistance to West Virginia citizens about Olmstead-related issues and needs.

The West Virginia Olmstead Plan was developed by the Olmstead Council through extensive planning and meeting sessions. In addition to the Council's work, statewide stakeholder input was gathered through public forums, targeted focus groups, and a public comment period. The Council also used the Centers for Medicare and Medicaid Services technical assistance recommendations, (Medical State Directors

Honorable Tom Harkin  
August 30, 2012  
Page Four

Letter issued on January 14, 2000) or principles, for developing a comprehensive, effectively working Olmstead plan as a framework.

The Plan addresses 10 major components of Olmstead compliance: informed choice, identification, transition, diversion, reasonable pace, eliminating institutional bias, self-direction, rights protection, quality, and community-based supports.

In the past, the Council has used work plans to address any updates to the Olmstead Plan and to track progress or barriers to its implementation. The Olmstead Council decided to formally update the Plan as a result of the release of the *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.* Statewide public forums and targeted focus groups were held in June and July of 2012. The Council will use this information to assist with updating the Plan. In addition, questionnaires will be used to gather future input from stakeholders, including those who attended a public forum or focus group, as the Council completes their work. Once the Olmstead Council has completed a draft plan, it will be released for a 30-day public comment period. The goal is to have the Plan updated by early 2013.

West Virginia has incorporated federal tools to assist with meeting its obligation under the ADA and Olmstead. Early on, West Virginia used federal Cash and Counseling grants to develop self-directed options for the Aged and Disabled Waiver Program. A self-directed option was then successfully implemented for the Intellectual and Developmental Disabilities (I/DD) Waiver and the Traumatic Brain Injury Waiver.

The federal Transition to Inclusive Communities (TIC) grant was used as the model for the West Virginia Transition Navigator Pilot Program. This program was funded through State general revenue to assist people in transitioning (or being diverted) from institutional settings back to their home and community. This program had full-time, hands-on transition navigators in 22 of West Virginia's 55 counties. Start-up funding was available statewide under this program.

The Bureau for Medical Services (BMS) recognized the success of this program and has plans to expand its use by incorporating it as a key part of the Money Follows the Person (MFP) Rebalancing Program, "Take Me Home, West Virginia," which will begin in the Fall of 2012. West Virginia plans to transition at least 600 people from institutions into the community during the five year period of the grant.

Honorable Tom Harkin  
August 30, 2012  
Page Five

The Olmstead Office continues to implement a transition and diversion program under a new name, the Olmstead Transition and Diversion Program (2011). This program supports people to transition (or be diverted) from institutional care. Since 2008, the program has assisted 492 people to transition (or be diverted) for an average cost of \$1,849 per person in start-up costs. This program assists people who are otherwise not eligible for the Take Me Home, West Virginia Program.

Another federal tool that West Virginia has used to address the ADA and Olmstead compliance is the Aging and Disability Resource Center's (ADRC) Bureau of Senior Services in partnership with WVDHHR. In 2003, West Virginia used federal grant funding to establish two pilot ADRCs. In 2006, West Virginia was awarded a two-year extension grant. Building on the success of the federally funded ADRCs, in 2007 the Governor and Legislature provided funding to expand the program statewide. Today, this program has an integral role in the West Virginia MFP program, for transition navigator service provision.

- (5) Any policy recommendations you have for measures that would make it easier for your state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.

**Response:** None

- (6) Any successful strategies that your state has employed to effectively implement Olmstead, particularly that could be replicated by another state or on a national level.

**Response:** As discussed above, the role of the ADRCs, the transition and diversion programs, and the self-direction programs have all been critical to moving West Virginia forward as we address our obligations under the ADA and Olmstead. In 2010, the Olmstead Transition and Diversion Program was recognized as a model program at the National Olmstead Coordinators Conference sponsored by the U.S. Substance Abuse and Mental Health Administration. The ADRC's will also play a key role in the *Money Follows the Person Rebalancing Grant* by helping to identify potential participants for the grant and outreach.

Honorable Tom Harkin  
August 30, 2012  
Page Six

I would like to express my appreciation for your inquiry into how West Virginia is addressing its obligation under the ADA and Olmstead. If you have any questions, please contact my office.

Sincerely,



Rocco S. Fucillo  
Cabinet Secretary

RSF/ph

cc: The Honorable Earl Ray Tomblin, Governor  
Hallie Mason, Director of Public Policy  
Nancy Atkins, Commissioner, Bureau for Medical Services  
Vickie Jones, Commissioner, Bureau for Behavioral Health and Health Facilities  
David Bishop, Inspector General  
The Honorable Joe Manchin III, U. S. Senate  
The Honorable John Rockefeller IV, U. S. Senate



State of Wisconsin  
Department of Health Services

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Scott Walker, Governor  
Dennis G. Smith, Secretary

September 18, 2012

The Honorable Tom Harkin  
United States Senate  
731 Hart Senate Office Building  
Washington, DC 20510

Dear Senator Harkin:

Thank you for your recent letter to Governor Walker regarding the Americans with Disabilities Act (ADA) and Wisconsin's success in changing where Medicaid long term care, supports, and services (LTCSS) are delivered. Wisconsin has long been a leader in health care innovation and that proud tradition has continued under Governor Scott Walker. For example, we have set a goal of tripling the number of individuals who self-direct their LTCSS.

Medicaid spending on LTCSS reached nearly \$2.9 billion in 2011 and accounts for 43 percent of total Medicaid spending in Wisconsin. We have reduced the number of individuals waiting for Family Care, our largest home and community based LTCSS waiver program. In January 2011, there were 7,462 individuals on waiting lists for Family Care. The waiting lists have been reduced to 1,257.

Since 2002, Medicaid spending on LTCSS for institutions has declined from 62 percent of LTCSS expenditures to 31 percent in 2011 while community based expenditures have increased from 38 percent of LTCSS spending to 69 percent. Only 28 percent of individuals enrolled in December 2011 and receiving LTCSS services resided in an institutional setting. Enclosed is a series of charts and tables that illustrate the Wisconsin experience in LTCSS enrollment and spending.

Finally, you asked for policy recommendations that would make administration of our programs easier. We urge you to support a block grant model that will stabilize Medicaid funding for both the federal government and the states and provide flexibility to the states to usher in the next generation of service delivery reforms that will support the goals of *Olmstead*. In response to the critics who insist that federal controls are necessary, please keep in mind that approximately two-thirds of Medicaid spending occurs nationally because states have expanded eligibility and benefits beyond the federal minimum requirements.

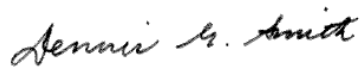
We believe that eliminating the institutional bias in Title XIX is long overdue. This would be a defining moment for Congress to demonstrate its support of *Olmstead*. States now have more

The Honorable Tom Harkin  
September 18, 2012  
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than 30 years of experience with home and community based waivers. States should not be required to continually apply and reapply for HCBS waivers. The changes provided under the Patient Protection and Affordable Care Act (PPACA) do not provide sufficient flexibility to states.

I hope this information is helpful.

Sincerely,



Dennis G. Smith  
Secretary

Cc: Michael B. Enzi, Ranking Member, Senate Committee on Health, Education, Labor, and Pensions  
Chairman Max Baucus, Senate Finance Committee  
Orrin G. Hatch, Ranking Member, Senate Finance Committee  
Senator Ron Johnson  
Senator Herb Kohl

# REPORT TO THE JOINT LEGISLATIVE AUDIT COMMITTEE ON FAMILY CARE

AUGUST 31, 2012

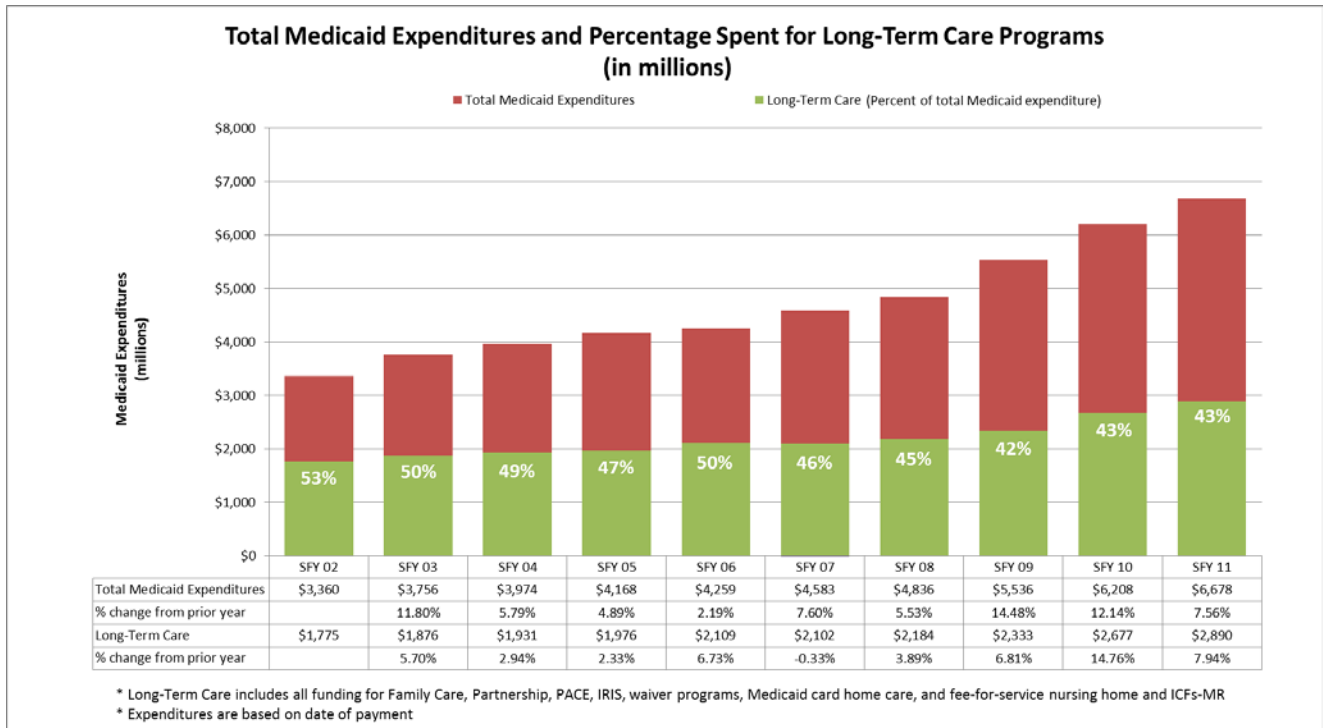
## HISTORICAL DATA ON LTC EXPENDITURES AND ENROLLMENT

### OVERVIEW OF HISTORICAL DATA

- This section provides data on Medicaid expenditures and enrollment in long term care (LTC) programs in the past decade.
- The graphs highlight key indicators and trends in the data both compared to overall Medicaid spending across the LTC programs.
- The data and graphs show that:
  - Medicaid expenditures on LTC programs have declined as a proportion of overall Medicaid expenditures in the last decade, falling from 53% in SFY 02 to 43% in SFY 11, and the average growth rate in LTC spending was also more moderate than overall Medicaid spending during this time.
  - Since SFY 02, LTC spending for institutions, such as nursing homes and ICFs, have declined from 62% of the budget to 31%, while spending for Family Care and community services has grown from 38% to 69% of LTC expenditures.
  - After the significant increase in enrollment with expansion in 2010, Family Care PMPM costs have fallen in the past two years.
  - While the people eligible for LTC programs has increased somewhat since SFY 04, enrollment has been driven by enrolling people in Family Care and IRIS who were previously on the wait list.
  - Over the last decade, expenditures for Medicaid LTC programs have transitioned from primarily fee-for-service payments for institutional services, such as nursing homes, to managed care programs that enable people to live in their own homes and community-based settings.
  - The majority of individuals enrolled in a LTC program reside in a community-based setting or their own homes. A key to ensuring cost-effectiveness and fiscal sustainability is to strengthen supports to ensure that people are safely cared for in their own homes as long as possible.



Graph 1

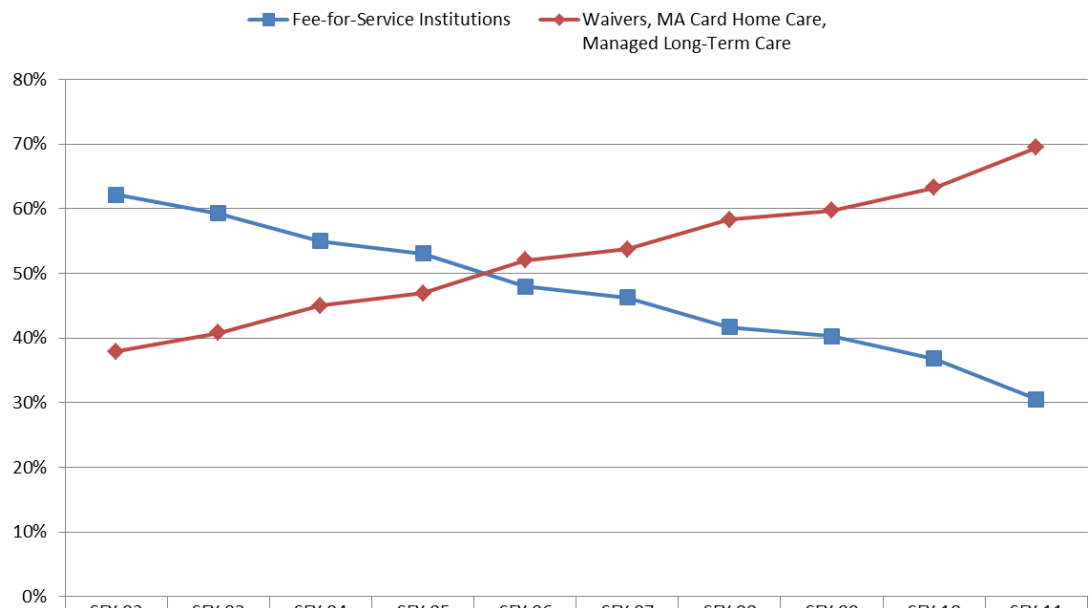


**SUMMARY OF THE DATA**

- Medicaid expenditures on long-term care programs have declined as a proportion of overall Medicaid expenditures over the last decade.
- While overall Medicaid expenditures nearly doubled between State Fiscal Years 2002 and 2011, expenditures on long-term care programs grew by less than two-thirds.
- As a result, long-term care program expenditures, which constituted the majority of Medicaid expenditures in SFY 2002, made up 43 percent of Medicaid expenditures in SFY 2011.

Graph 2

### Medicaid Long-Term Care Expenditures: Fee-For-Service Institutional vs. Home- and Community-Based Programs



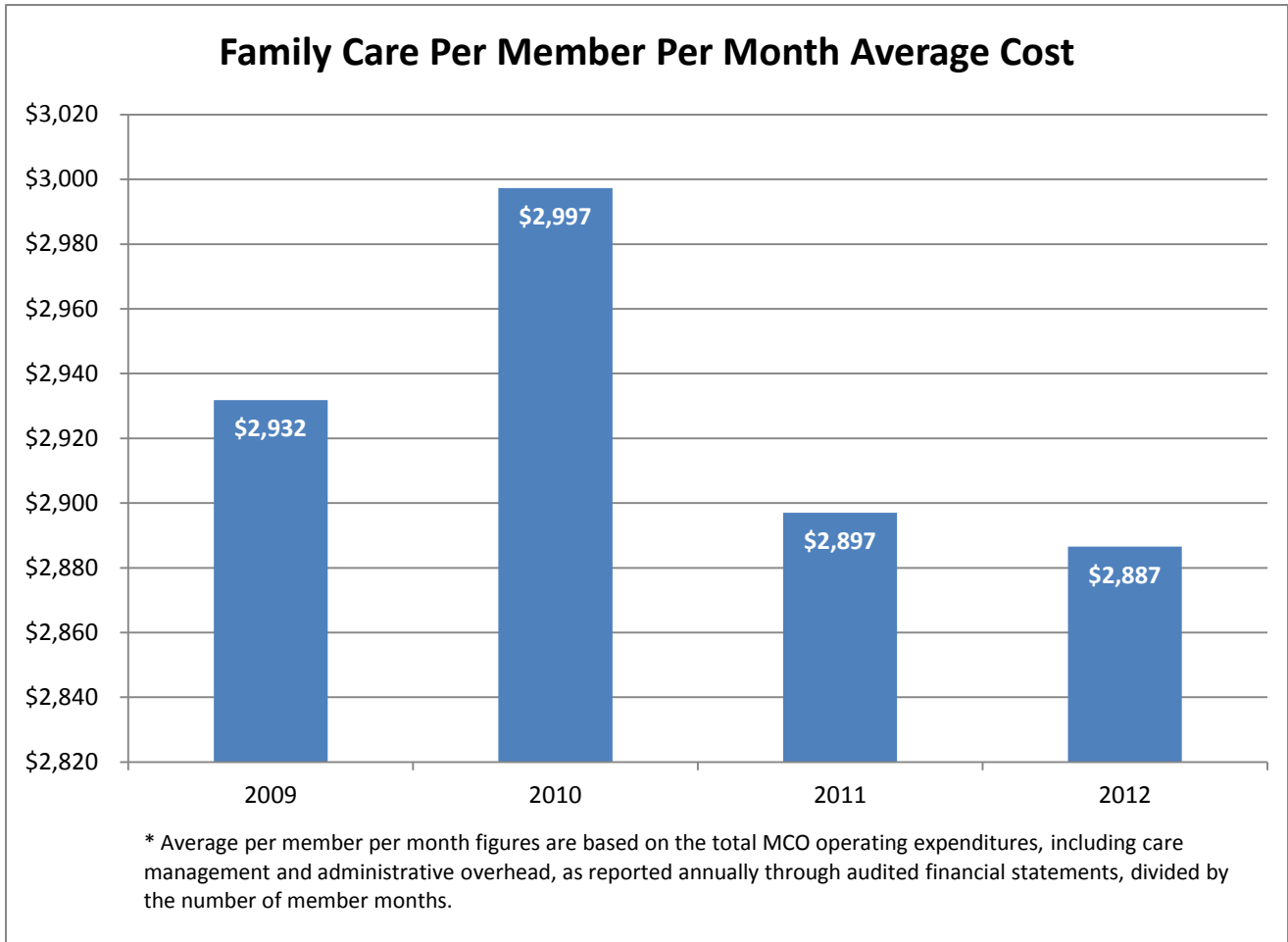
	SFY 02	SFY 03	SFY 04	SFY 05	SFY 06	SFY 07	SFY 08	SFY 09	SFY 10	SFY 11
Fee-for-Service Institutions	62%	59%	55%	53%	48%	46%	42%	40%	37%	31%
Waivers, MA Card Home Care, Managed Long-Term Care	38%	41%	45%	47%	52%	54%	58%	60%	63%	69%

\* Managed long-term care expenditures include services in both community and institutional settings and acute and primary care services in PACE/Partnership programs  
 \* Expenditures are based on date of payment

#### SUMMARY OF THE DATA

- Since SFY 02, LTC spending for institutions, such as nursing homes and ICFs, have declined from 62% of the budget to 31%, while spending for Family Care and community services has grown from 38% to 69% of LTC expenditures.

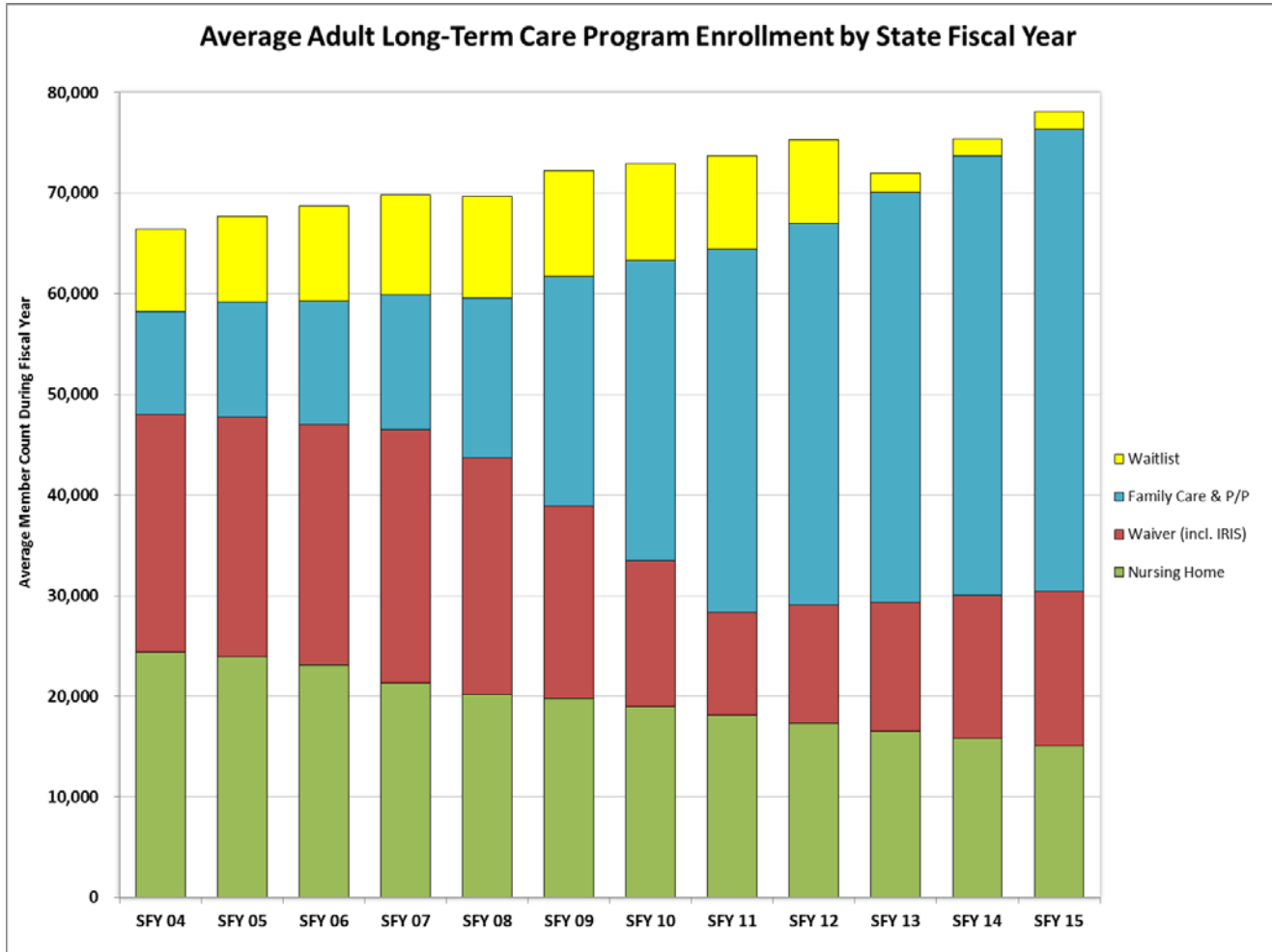
Graph 3



#### SUMMARY OF THE DATA

- After the significant increase in enrollment with expansion in 2010, Family Care PMPM costs have fallen in the past two years.

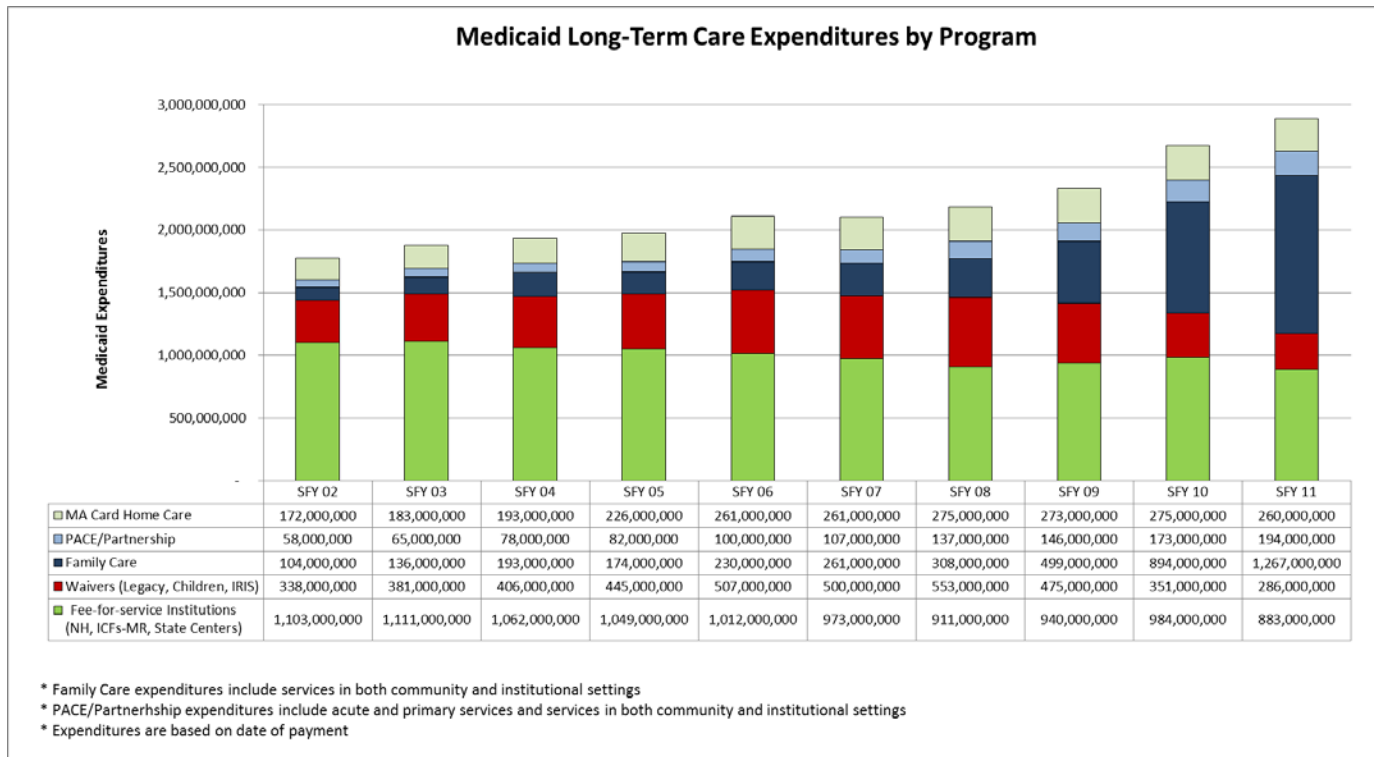
Graph 4



### SUMMARY OF THE DATA

- While the people eligible for LTC programs has increased somewhat since SFY 04, enrollment has been driven by enrolling people in Family Care and IRIS who were previously on the wait list.

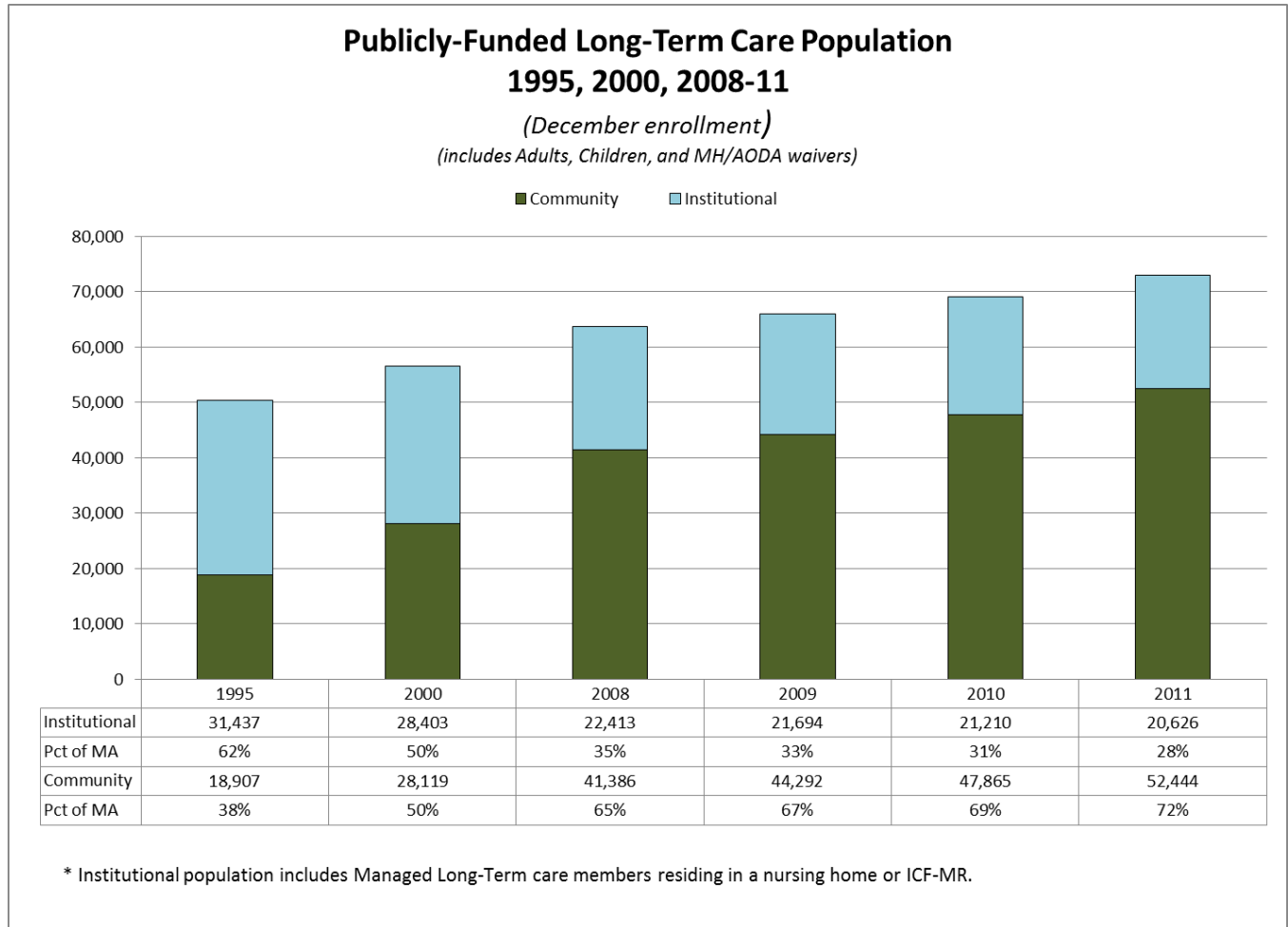
Graph 5



**SUMMARY OF THE DATA**

- Over the last decade, expenditures for Medicaid long-term care programs have transitioned from primarily fee-for-service payments for institutional services, such as nursing homes, to managed care programs that enable members to live in their own homes and community-based settings.
- While Family Care members may reside in an institution, the overwhelming majority live in community settings or their own homes.

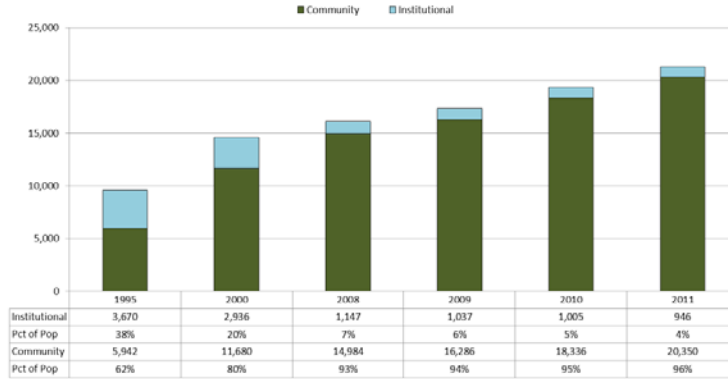
Graph 6



#### SUMMARY OF THE DATA

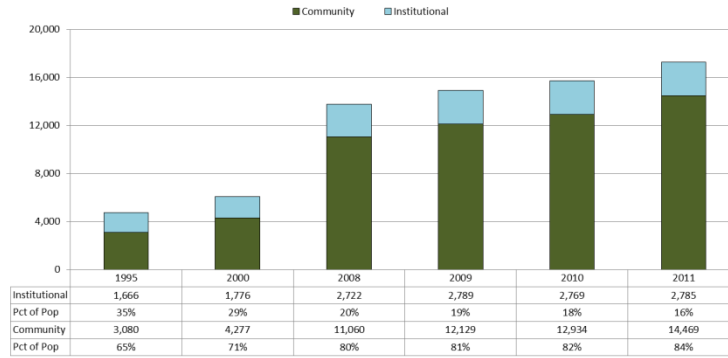
- The majority of individuals enrolled in a Medicaid long-term care program reside in a community-based setting or their own homes.
- Prior to 2000, the majority of Medicaid members receiving long-term care lived in a nursing home or ICF-MR.
- Since that time, a growing number and proportion of individuals have received services in a home or community-based setting.
- In December 2011, fewer than 30% of individuals receiving long-term care services resided in an institution funded either through Medicaid fee-for-service or managed long-term care.

**Publicly-Funded Long-Term Care Population  
Adults with a Developmental Disability  
1995, 2000, 2008-11**  
*(end of year counts)*



\* Institutional population includes managed long-term care members residing in a nursing home or ICF-MR.

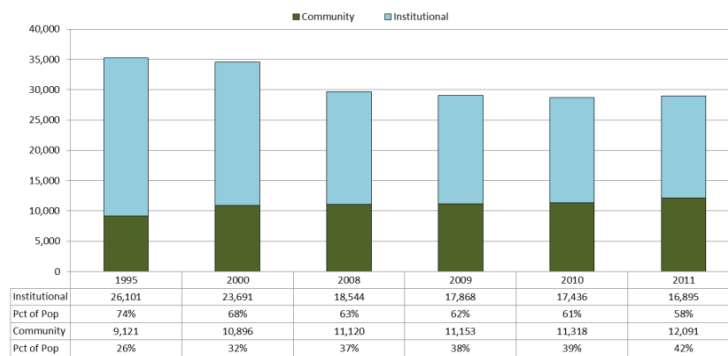
**Publicly-Funded Long-Term Care Population  
Adults with a Physical Disability  
1995, 2000, 2008-11**  
*(end of year counts)*



\* Institutional population includes managed long-term care members residing in a nursing home or ICF-MR.

\* Fee-for-service institutional and legacy waiver programs use an age-adjusted target group that is not used in managed long-term care and IRIS programs. As a result, older individuals with an existing diagnosis of physically disabled who are served in fee-for-service or a legacy waiver program will not be included in these counts.

**Publicly-Funded Long-Term Care Population  
Frail Elderly  
1995, 2000, 2008-11**  
*(end of year counts)*



\* Institutional population includes managed long-term care members residing in a nursing home or ICF-MR.

\* Fee-for-service institutional and legacy waiver programs use an age-adjusted target group that is not used in managed long-term care and IRIS programs. As a result, older individuals with an existing diagnosis of physically disabled who are served in Family Care, PACE, Partnership, or IRIS programs will not be included in these counts.

**Table 1**  
**Long Term Care Spending as a Proportion of Medicaid Expenditures**  
**(State Fiscal Year 2002 – 2010)**

	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011
<b>Total MA</b>	\$ 3,359,566,889	\$ 3,755,979,037	\$ 3,973,580,016	\$ 4,167,792,670	\$ 4,259,117,753	\$ 4,582,708,312	\$ 4,836,027,252	\$ 5,536,293,381	\$ 6,208,239,462	\$ 6,677,502,121
<b>LTC Spending</b>	\$ 1,775,241,957	\$ 1,876,349,834	\$ 1,931,437,948	\$ 1,976,409,350	\$ 2,109,469,647	\$ 2,102,430,379	\$ 2,184,123,778	\$ 2,332,897,927	\$ 2,677,210,875	\$ 2,889,891,134
<i>Fee-for-service Institutions (NH, ICFs-MR, State Centers)</i>	\$ 1,102,848,552	\$ 1,111,387,020	\$ 1,061,692,522	\$ 1,049,089,623	\$ 1,011,722,664	\$ 973,273,620	\$ 911,060,876	\$ 940,286,091	\$ 984,190,869	\$ 882,659,229
<i>MA Card Home Care</i>	\$ 172,462,986	\$ 182,735,554	\$ 193,055,201	\$ 226,425,900	\$ 261,279,592	\$ 261,370,897	\$ 275,083,100	\$ 273,273,860	\$ 275,096,443	\$ 259,953,133
<i>Waivers (CIP, COP, BIW, Children, IRIS, MFP)</i>	\$ 337,909,491	\$ 381,037,298	\$ 405,869,535	\$ 444,783,049	\$ 506,521,870	\$ 500,217,463	\$ 552,911,853	\$ 474,617,896	\$ 350,501,701	\$ 285,798,043
<i>Family Care</i>	\$ 104,212,479	\$ 135,924,596	\$ 192,916,770	\$ 173,711,795	\$ 230,091,573	\$ 260,538,308	\$ 307,651,323	\$ 498,687,110	\$ 894,270,222	\$ 1,267,176,236
<i>PACE/Partnership</i>	\$ 57,808,449	\$ 65,265,367	\$ 77,903,921	\$ 82,398,983	\$ 99,853,948	\$ 107,030,091	\$ 137,416,626	\$ 146,032,970	\$ 173,151,640	\$ 194,304,493
<b>LTC Spending as a proportion of MA spending</b>	53%	50%	49%	47%	50%	46%	45%	42%	43%	43%
<i>Fee-for-service Institutions (NH, ICFs-MR, State Centers)</i>	33%	30%	27%	25%	24%	21%	19%	17%	16%	13%
<i>MA Card Home Care</i>	5%	5%	5%	5%	6%	6%	6%	5%	4%	4%
<i>Waivers (CIP, COP, BIW, Children, IRIS, MFP)</i>	10%	10%	10%	11%	12%	11%	11%	9%	6%	4%
<i>Family Care</i>	3%	4%	5%	4%	5%	6%	6%	9%	14%	19%
<i>PACE/Partnership</i>	2%	2%	2%	2%	2%	2%	3%	3%	3%	3%
<b>LTC Spending by Area</b>										
<i>Fee-for-Service Institutions</i>	62%	59%	55%	53%	48%	46%	42%	40%	37%	31%
<i>Waivers, MA Card Home Care, Managed Long-term Care</i>	38%	41%	45%	47%	52%	54%	58%	60%	63%	69%



**Table 2**  
**Enrollment in Long Term Care Programs**

	1995	2000	2008	2009	2010	2011
<b>Community</b>						
<i>Frail Elderly</i>	9,121	10,896	11,120	11,153	11,318	12,091
<i>Physical Disability</i>	3,080	4,277	11,060	12,129	12,934	14,469
<i>Developmental Disability</i>	5,942	11,680	14,984	16,286	18,336	20,350
<b>Total - Community</b>	18,142	26,853	37,164	38,568	42,588	46,910
Percent of Total	36%	49%	64%	66%	69%	71%
<b>Institutional</b>						
<i>Frail Elderly</i>	26,101	23,694	18,544	17,868	17,436	16,895
<i>Physical Disability</i>	1,666	1,776	2,722	2,789	2,769	2,785
<i>Developmental Disability</i>	3,670	2,936	1,147	1,037	1,005	946
<b>Total - Institutional</b>	31,437	28,403	22,413	21,694	21,210	20,626
Percent of Total	64%	51%	36%	34%	31%	29%
<b>Total</b>	48,579	55,445	62,566	64,682	67,698	71,247

Thomas O. Forslund, Director

Governor Matthew H. Mead

September 13, 2012

Ref.: F-2012-351

The Honorable Tom Harkin  
United States Senate  
Committee on Health, Education,  
Labor, and Pensions  
Washington, DC 20510-6300

Dear Senator Harkin:

Governor Matthew Mead referred your letter concerning Wyoming's compliance with obligations under the Americans with Disabilities Act (ADA) and *Olmstead v. L.C.*, 527 U.S. 581 (1999) to the Wyoming Department of Health for a direct response. The State of Wyoming is proud of the community services available to people with disabilities throughout our frontier state and we have made significant progress in serving people in the least restrictive, most integrated settings. This is the right approach to services, and has resulted in significant improvements in peoples' quality of life and involvement in their local communities. But, as your letter states, there is more work to be done.

Before providing responses to the six areas of information requested in your letter, I would like to take the opportunity to provide you with a picture of where Wyoming is today in regards to *Olmstead*. Since the landmark decision in 1999, Wyoming has made significant strides in rebalancing the systems of care for people with disabilities from segregated settings, such as nursing homes, psychiatric hospitals, and intermediate care facilities for intellectual disabilities, to community-based settings. Below are several statistics based on state and national data that highlight the progress we have made:

- Sixty-two percent of the total long term disability spending in Wyoming for people with mental health, intellectual disabilities and physical disabilities goes to community-based services, compared to 49% for the United States (State of the States in Developmental Disabilities, 2009 data).
- Wyoming relies heavily on Medicaid home and community-based waivers to fund community-based services, with waiver spending per citizen of the Wyoming general population for people with intellectual disabilities at \$176, compared to \$79 for the United States (State of the States in Developmental Disabilities, 2009 data).
- The census for the Wyoming Life Resource Center, which includes the state's only intermediate care facility program for people with intellectual disabilities, has decreased 34% from 142 clients in 2002 to 94 clients in 2012.
- Between 2005 and 2012, Project Out, Wyoming's nursing home transition/diversion program, has transitioned or diverted an average of 160 individuals a year from nursing homes.

- The point-in-time capacities of the Long Term Care Home and Community-Based Services (HCBS) Waiver and the Assisted Living Facility HCBS Waiver, which serve individuals ages 19+ who meet nursing home level of care, were expanded by the Wyoming State Legislature in 2007 from 1,150 to 1,450 and 146 to 168 respectively. Both waivers have relatively short waiting lists with an average wait time of one to two months and priority on the waiting list of both waivers is given to individuals who are transitioning from a nursing home.
- Wyoming has been ranked to be the fourth largest state by capita for persons 60 years of age and older by 2015. Wyoming is working to decrease the waiting list on the state funded Community-Based In Home Services (CBIHS) Program as the needs of those that are at risk of premature institutionalization are increasing. The meal program that serves seniors has increased over 7% over each of the last several years. Wyoming senior programs served over 39,650 seniors in all programs and served over one million meals last year.
- In 2007, the Wyoming State Legislature passed an appropriations bill for mental health and substance abuse that essentially added regional treatment and support services to the current community system of care. The purpose of regionalization was to assure that all Wyoming citizens with mental health and substance abuse illnesses had access to needed services, if not within their immediate community, at least within the region in which they live. Beginning in Fiscal Year (FY) 2008, approximately \$11,697,887 of these appropriations went directly to the five regions of Wyoming to develop or expand the following services: regional residential treatment for persons with co-occurring disorders, supported housing (to include group homes), telepsychiatry, expansion of psychiatric personnel, nursing supports, client transportation, physician training on mental health and substance abuse, respite care, early childhood intervention, expansion of substance abuse residential treatment, transitional substance abuse programs, social detoxification, Native American Wellness Program, and substance abuse quality of life funds.

Below are responses to the six areas of information you requested in your letter, along with background information on each of these areas.

1. **For each year from FY 2008 to the present: The number of people who moved from nursing homes, Intermediate Care Facilities for Intellectually Disabled (ICF/ID), long term care units of psychiatric hospitals, board and care homes (often called adult care homes or residential health care facilities), to living in their own home, including through a supportive housing program.**

Table #1 summarizes the number of people who moved from segregated settings to integrated settings from FY 2008 through FY 2012.

**Table #1: Number of People Moving from Facilities to Integrated Settings**

Type of Setting	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Nursing Homes –Project Out	126	88	23	36	20
Wyoming Retirement Center	3	8	5	6	0
Wyoming Life Resource Center (ICF/ID)	4	1	4	0	0
Wyoming State Hospital	N/A	117	129	81	103
Board and Care Homes	N/A	N/A	0	0	0

**Descriptions and Background Information on the Settings:**

- **Project Out**, which is Wyoming’s nursing home transition/diversion program, provides short term intervention to assess, identify, and if possible, resolve barriers to community placement for individuals in nursing homes or at imminent risk of entering a nursing home. The program began as a grant program and was transitioned to a Medicaid program on July 1, 2006. Project Out is a unique hybrid program providing targeted case management through the Medicaid State Plan and other direct services through a re-occurring general revenue appropriation. When the program was first created, the focus was primarily on identifying and transitioning individuals already in the nursing homes. As time has gone by, the program has begun doing more diversions than transitions as there are fewer individuals in nursing homes who have expressed in interest in returning to the community and can be safely served in that setting.
  - **The Wyoming Retirement Center (WRC)** is the only State operated skilled nursing facility. The WRC’s census was 64 as of June 30, 2012.
  - **The Wyoming Life Resource Center (WLRC)** includes the only State operated intermediate care facility for people with intellectual disabilities, and provides therapeutic and medical support services. The WLRC’s census for the ICF/ID program was 79 as of June 30, 2012. The total census for the WLRC was 93, with 12 people served in the brain injury program and two people served in the health care center.
  - **The Wyoming State Hospital (WSH)** is the only State operated psychiatric hospital and offers several treatment services, including adult psychiatric services and criminal justice treatment services. The WSH’s average census as of June 30, 2012, was 61 for the adult psychiatric services unit and 17 for the criminal justice treatment services unit.
  - **Board and Care Homes** are minimally funded at \$15,000 each year for the operation of these homes. In the past three years, there have been no applications requesting to access this funding.
2. **The amount of State dollars that will be spent in this Fiscal Year serving individuals with disabilities in each of these settings: nursing homes, ICF/ID, board and care homes, psychiatric hospitals, group homes, and their own homes, including those on a supported housing program.**

Table #2 provides information on the total State dollars spent in each setting, funding for community services, and other support programs that assist people in remaining in their own homes and communities. The table is organized by the level of care or need of the people with disabilities, and the settings range from the most segregated to the most integrated.

**Table #2: FY12 State General Fund Expenditures**

<b>Type of Setting/Service</b>	<b>FY 2012 State Funding</b>
<i>Nursing Home Level of Care</i>	
Nursing Home placements	\$ 36,758,869
Wyoming Retirement Center	\$ 2,583,500
Assisted Living Facility Waiver Services	\$ 1,833,927
In Home Services on Long Term Care Waiver	\$ 20,849,330
Community-Based In Home Services	\$ 3,154,000



<b><i>Intermediate Care Facility Level of Care</i></b>	
Wyoming Life Resource Center	\$ 17,300,000
Residential Habilitation Services	\$ 28,984,442
Supported Living Services	\$ 2,878,423
All other DD/ABI waiver services supporting persons in their home	\$ 1,202,549
Self-Directed services through the waiver	\$ 1,176,004
<b><i>Mental health/Behavioral Challenges</i></b>	
Wyoming State Hospital	\$ 30,347,112
Therapeutic Living Environment	\$ 3,988,434
Crisis Stabilization Services	\$ 1,545,743
Outpatient Mental Health and Substance Abuse Services	\$ 39,510,957
<b><i>Other Support Programs</i></b>	
National Family Caregiver Program	\$ 60,000
Wyoming Senior Citizens Boards	\$ 5,750,000
Administration on Aging Home Delivered Meal Program	\$ 115,199
Wyoming Aging and Disabilities Resource Centers	\$ 200,000
Veteran's Outreach and Advocacy	\$ 333,874

**Background Information on Settings/Services:**

More information on each of the types of settings and/or services not covered under Table #1 is provided below.

- **The Community-Based In Home Services Program** provides Wyoming senior citizens and adults with disabilities ages 18 years of age and older with in home services that are at risk of institutional care.
- **Project Out** is a unique hybrid program providing targeted case management through the Medicaid State Plan and other direct services through a re-occurring general revenue appropriation.
- **Residential Habilitation** is a service available on three HCBS waivers and offers funding for group home placements and other 24-hour support and supervision needs for participants who qualify for the service. The majority of funding is for group home placements.
- **Supported Living** is a service available on three HCBS waivers and offers funding to assist persons with disabilities to live in their own home, family home, or rental unit for individuals that do not require ongoing 24-hour supervision but do require a range of community-based support to maintain their independence.
- The two developmental disability waivers and the Acquired Brain Injury Waiver added the option of self-direction in July 2009 in order to allow participants more control over their budget, allow them to hire employees to provide services to them, and exercise more control over the quality and delivery of services.

- **Therapeutic Living Environments** are a service within the larger mental health/substance abuse treatment program and include mental health group homes (both long term and transitional), supported apartments, and supported living environments. These living environments allow individuals with mental illness and substance abuse to remain in their communities while receiving the necessary treatment and supports to live as independently as possible.

TYPE OF FACILITY	NUMBER OF FACILITIES	NUMBER OF BEDS
Transitional Group Home	4	19
Long Term Group Home	5	38
Transitional and Long Term Group Home	1	8
Supervised Living	4	46
Long Term Apartments	3	46
Transitional and Long Term Apartments	2	22
Transitional Supported Apartments	1	12
<b>TOTAL</b>	<b>21</b>	<b>191</b>

- **Crisis Stabilization** - Three crisis stabilization facilities with a total of 19 beds are located around the state. When appropriate, individuals with a mental illness crisis can be diverted from inpatient care at the WSH, and treated locally closer to their home community, thus allowing families to more easily be involved in their loved one's care.
- **Mental Health Outpatient Treatment Services** includes the core treatment services (clinical screening assessment, individual, group, and family therapy, case management, consultation, emergency services, medication management, and rehabilitative services), specialized programs for specific populations, peer specialists, and quality of life supports. These services are contractually funded through community mental health centers throughout Wyoming, and individuals access these services under a sliding fee scale. No one is turned away for services based on ability to pay.
- **National Family Caregiver Program** supports qualified caregivers in continuing to provide care to their loved one(s) and helps relieve the daily stresses of care giving and encourages natural supports instead of paid services.
- **Wyoming Senior Services Board (WSSB)** enhances and supplements existing programs for Wyoming's growing elderly population and strengthens the opportunity for senior citizens to live in the least restrictive environment possible. Over the last five years, the program has increased to an \$11.5 million biennium budget to enhance the local senior centers to help those most at risk. This funding is 100% State General Funds to help the local senior centers provide home-delivered meals (Meals on Wheels) and other services within their community.
- **Administration on Aging Home Delivered Meal Program (C2)**, which is called the Elderly Nutrition Program, Title III-C2, and provides nutrition services, including nutrition education, counseling and meals to eligible clients that are frail, homebound and usually 60 years of age and older.
- **Wyoming Aging and Disabilities Resource Center (ADRC)** provides a comprehensive and coordinated system of information and assistance for older Wyoming residents and adults with disabilities and assists clients with finding the supports and resources they need to remain living at home. The role of ADRCs will continue to evolve and expand to fill in gaps in the provision of information, referral, counseling, and streamlining access to supports for persons of all ages with long term care needs. The ADRCs help link people with various disabilities with resources and

supports in their community or from other areas of the state to keep people from needing nursing homes or other institutionalization.

- **Veterans Outreach and Advocacy Program** supports three advocates who provide outreach, non-clinical assessment, referral, case management and follow up to Operation Iraqi Freedom and Operation Enduring Freedom veterans and their families, increases access to appropriate services to ensure reintegration back into the community and family after deployment.

**3. For each year from FY 2008 to the present, the extent to which we have expanded our capacity to serve individuals with disabilities in their own homes, including through a supportive housing program – including the amount of State dollars spent on the expansion (which may include reallocated money previously spent on segregated settings) and the specific nature of the capacity added.**

Table #3 summarizes the growth in community-based services for the three major disability groups. Given our smaller numbers in Wyoming, the data is more meaningful when you show the percent increase from FY 2008 to FY 2011 instead of reporting each year. FY 2012 data has not been finalized so this table provides information through FY 2011. More detailed information on these groups is provided below.

**Table #3: Expenditures on Expansion of Services**

Program	Expenditure Increase	Percent Expenditure Increase	Recipient Increase	Percent Recipient Increase
<i>Intermediate Care Facility Level of Care</i>				
Acquired Brain Injury Waiver	\$ 1,500,534	21.4%	2	1.1%
Adult DD Waiver	\$ 2,096,760	2.4%	44	3.3%
Child DD Waiver	\$ 1,347,443	6.7%	4	0.5%
<i>Nursing Home Level of Care</i>				
Assisted Living Facility Waiver	\$ 242,253	7.4%	20	8.1%
Long Term Care Waiver	\$ 6,581,581	29%	210	11.8%
Community Based in Home Services	\$ 850,000	36%	(-15)	(-1.60%)
<i>Mental Health/Behavioral Needs</i>				
Crisis Stabilization	\$ 924,655	148%	Additional 11 Beds	137%
Therapeutic Living Environments	\$ 949,684	31%	Additional 59 Beds	66%
Mental Health Outpatient Treatment	\$ 2,640,351	13%	1430	9%

*Data from Medicaid Options Study, Report 1*

- **Home and Community-Based Waivers** are designed to support people in their own communities in the least restrictive setting possible. While Wyoming has been able to increase the number of people served on the waivers, the waiting lists for the waivers continue to grow, especially for the developmental disabilities and acquired brain injury waivers.

The capacities of the Long Term Care Waiver and the Assisted Living Facility Waiver, which serve individuals ages 19+ who meet nursing home level of care, were last expanded in 2007 from 1,150 to 1,450 and 146 to 168 respectively. Both waivers have a short waiting list with an average wait time of one to two months and priority on the waiting list of both waivers given to individuals who are transitioning from a nursing home.

- **Community-Based in Home Services Program (CBIHS)** has maintained its funding over the last five years in helping those persons at risk of premature institutionalization. The average cost per client to keep the person at risk at home is \$1,900 per year. The CBIHS program is not a medical program i.e., home health; hospice. The CBIHS program only offers services that are considered to meet the clients' basic need(s) to stay in their home. I.e., personal care, meal preparation, home making services, personal emergency response systems, etc.

During FY 2008, there was a change for admitting clients to the CBIHS Program. The CBIHS Program now looks at the client's Activities of Daily Living. Therefore, the client's needs are now increasing for the amount of time needed, but less people are being served in the program than in years prior to the policy change.

- **Therapeutic Living Environments** – Five of the 21 therapeutic living environments were developed since 2008, adding an additional 44 beds to the community system.
- **Crisis Stabilization** – One of the three crisis stabilization facilities currently in the state was opened in 2008 with six beds. This facility also takes individuals on emergency holds and begins immediate treatment while the individual is processing through the Title 25 involuntary commitment process. In FY 2012, of eight individuals admitted on an emergency hold, seven were able to be released from hold and continued treatment at the crisis facility until discharged back into community-based aftercare.

**4. The contents of our Olmstead Plan for increasing community integration, a description of the strategic planning process used to create it as well as any revisions that have been made since its creation, the extent to which it incorporates any of the new tools created by the federal government to support HCBS and the extent to which we have been successful in meeting any quantifiable goals identified within it.**

- Wyoming's Olmstead Plan dates back to 2002, and since that time, with the support of the Wyoming State Legislature, the State has increased community capacity for all people with disabilities. The State is currently in the process of revising its Olmstead Plan, much of which will be driven by the redesigns the State is currently considering in Medicaid, the Medicaid Waivers, and the community mental health system. The current role of the State operated facilities is being evaluated and options are being considered to downsize and/or refocus some of the facilities. The goal of these redesigns is to support people in the least restrictive setting, to increase the capacity of local communities to support people with disabilities, to provide services to more Wyoming citizens in need, and to assure the State has a safety net system in place when needed.



- These redesigns may include utilizing the 1915(i) State Plan amendment, focusing on people with co-occurring developmental disabilities/acquired brain injuries and mental health challenges, and on people with serious and persistent mental illness. The State is also considering implementing health homes for people with chronic illnesses, including behavioral health homes for people with serious mental illness. Throughout the redesign process the State is engaging stakeholders in the process, and when final decisions are made the Olmstead Plan will be formally updated to include these changes.
- In 2008, the Wyoming Department of Health initiated a project with the WSH, the designated hospitals, and the State funded community mental health treatment providers to develop a communication protocol to facilitate a seamless transition for the admission/discharge process between the hospital and the communities. The purpose of this protocol was to enhance treatment outcomes for individuals with mental illness, and to assure continuity of care. The resulting document, Communication Process for Continuity of Care, outlines how and when relevant information is shared between the hospitals and providers from admission to discharge. As a result of this project, State funded community treatment providers are contractually required to designate a staff liaison to communicate regularly with the WSH to coordinate information regarding patients in the WSH as they are transitioned back into the communities. Many of these liaisons have regular weekly or monthly phone calls with a designated WSH staff member to accomplish this coordination.
- In regards to new programs and tools developed by the federal government, Wyoming is not participating in certain programs. Because of the favorable ratio of community to institutional expenditures, Wyoming does not qualify for the Balancing Incentives Program. Also, Wyoming analyzed the potential cost and benefits of Money Follows the Person and decided that for the nursing home population, the program would not bring significant added value because of the continued success of Project Out.

**5. Any policy recommendations we have for measures that would make it easier for our state to effectively implement Olmstead's integration mandate and take advantage of new federally available assistance.**

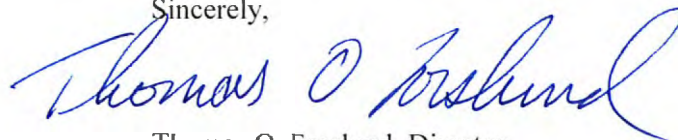
- The integration mandate, which was explained with more guidance in a question and answer document developed by the Department of Justice (DOJ) in June 2011, has helped clarify the meaning and expectations of integration in Olmstead. Also, the federal rules currently going through the promulgation process for the 1915(k) Community First program define "community" fairly narrowly, which will result in states having to limit funding to residential programs and instead focus on funding other supported living and independent living options. While the State supports this refocusing of services, many long term community providers will be required to drastically change their business model, and many could close if they fail to do so. These types of significant systems changes must be allowed to occur over time, with a solid strategic plan in place.
- A significant barrier that providers face is the restrictive nature of HUD housing contracts. Providers are unable to redesign their service delivery which would support people moving out of group homes into more inclusive settings due to the occupancy and other HUD policies. Additional funding for public housing assistance and the release of providers from some HUD contracts would improve the provider efforts to reduce the number and size of group homes and more readily support people in smaller, more integrated settings.

**6. Any successful strategies that we have employed to effectively implement Olmstead, particularly strategies that could be replicated by another state or on a national scale.**

- Beginning in FY 2008 and still being enhanced annually, the Department's Behavioral Health Division funds a number of regional mental health and substance abuse programs throughout the state to help address service gaps in small communities by assuring that all critical services are, at a minimum, available on a regional basis. Some of these services have already been noted above, but they include group homes, supported independence programs, medication management services, early intervention services, substance abuse residential and transitional beds, crisis stabilization, and social detoxification. Other rural or frontier states may be able to benefit from this type of structure.
- Targeting criteria for residential habilitation services was added to the higher cost residential service option on the developmental disability waivers and the Acquired Brain Injury Waiver. People can request funding for supported living services, which provides them with supports in their own home or apartment. The goal is to provide appropriate supports in the least restrictive setting, and reduce the State's reliance on larger group home settings for residential habilitation services.
- The Division convened a State Integrated Employment Team and received technical assistance from the State Employment Leadership Network (SELN) in FY 2012 to begin developing a comprehensive strategic plan for increasing employment outcomes for people with developmental disabilities. The goals of the team are to collaborate with other State agencies and various stakeholders to research and support the best practices in supported employment, and build partnerships and develop realistic transition plans to move people into competitive employment. The anticipated outcome is that more people in our programs working and making livable wages will also want to live more independently, build and rely on natural supports, have a greater quality of life and have less dependence on governmental programs and assistance. The team wants to have competitive and integrated employment be considered the first option when serving persons with disabilities who are of working age.
- Project Out has used MDS Section Q information for several years to follow up with Medicaid eligible individuals in nursing homes to assess the barriers and appropriateness of returning to a community setting. The new federal requirement for nursing facilities to report all individuals who express a desire to return to the community allows the state to refer non-Medicaid individuals to the ADRC and allows the State to receive MDS Section Q referrals more timely.

Senator Harkin, I hope this information fully addresses your requests. If you require additional information, please contact me at the Wyoming Department of Health, 401 Hathaway Building, Cheyenne, Wyoming 82002 or (307) 777-7656.

Sincerely,



Thomas O. Forslund, Director

TF/CN/es

c: Governor Matthew Mead  
Lee Clabots, MPH, Deputy Director, Wyoming Department of Health  
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Teri Green, State Medicaid Agent and Senior Administrator, Division of Health Care Financing  
Chris Newman, MHA, Senior Administrator, Behavioral Health Division