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September 9, 2014

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Letter Submitted electronically: Carla.Crane@ky.gov on 9/9/2014

RE: Kentucky Concerned Family Network and VOR Joint Public Comments in response to the draft Kentucky's Olmstead Compliance Plan (OCP)

Dear Dr. Crane,

The Kentucky Concerned Family Network (KCFN) and VOR appreciate this opportunity to submit comments in response to the draft Kentucky Olmstead Compliance Plan, released for stakeholder input by the Kentucky Cabinet for Health and Family Services (CHFS) on August 18, 2014 (*see* Attachment A: Request for stakeholder input received by email on August 22, 2014).

Introduction:
KCFN and VOR, Speaking out for people with intellectual and developmental disabilities

The **KCFN** is a statewide nonprofit organization advocating for high quality care and human rights for all people with intellectual and developmental disabilities. As the only statewide Kentucky advocacy organization supporting a full spectrum of care options we offer hope and support for individuals and their families, who are working to protect or secure necessary high quality services regardless of where they choose to live.

The primary purpose of KCFN is to provide a single powerful advocacy voice to serve and support the families, family-guardians, friends and residents of all Kentucky Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Families and family groups from the following Kentucky ICFs/IID are KCFN members – Oakwood, Hazelwood, Bingham Gardens and the Wendell Foster's Campus for Developmental Disabilities.

VOR is a national, nonprofit organization advocating for high quality care and human rights for people with intellectual and developmental disabilities. We represent primarily families and legal guardians of individuals with intellectual and developmental disabilities, with members in every state including Kentucky. VOR is the only national advocacy organization supporting a full spectrum of care options from own home, family home, community-based options, and licensed facility homes, including ICFs/IID.

Due to the past and on-going deinstitutionalization activities in Kentucky, at least some ICF/IID residents and their families are prime candidates to transition to a community-based residence at some future date. The Kentucky Olmstead Compliance Plan (OCP) Strategy 6.3 makes this threat a current reality for **50-60%** of the current Kentucky public ICF/IID residents:

> **Strategy 6.3: Transition 175 clients from an institutional setting into various community settings with supports through the Money Follows the Person (MFP) demonstration program during calendar year 2015.**

KCFN and VOR have a responsibility and vested interest in working to address concerns regarding the effectiveness of the Commonwealth in providing high quality, medically comprehensive, safe and secure community-based residential settings with proper oversight through Medicaid and the Medicaid Home and Community Based Services (HCBS) waiver process.

In addition to proposed edits to the draft Olmstead Compliance Plan (OCP) (offered as "redline" edits and attached herein (Attachment B)), KCFN and VOR also offer the following comments in support of our vested interest.

Executive Summary

The OCP is very broad and reaches across several different disabilities. It will, if implemented as proposed, benefit many persons with disabilities, negatively impact others by limiting their residential choices, and will cause unintended consequences for an unknown number of persons as new rights are embraced, examined, and experienced without the proper oversight, services and even temporary support.

The limited public comment opportunity is a major concern.

Quotas:

In addition to Strategy 6.3 noted above, the OCP in strategy 6.4 cites a P&A lawsuit settlement against the Cabinet for Health and Family Services (CHFS) that requires 600 persons to be transitioned out of group homes and into community residences over a three year period. The first 100 transitions are to be completed by October 1, 2014, less than 30 days from now.

We view quotas as inconsistent with the letter of and spirit of the *Olmstead* Supreme Court decision. Quotas are antithetical to, and prevent, individual choice and person-centered planning. *Olmstead* does not require that individuals be forced out of a good placement against their choice and best interests; indeed the Court required that individuals do not oppose transition to the community. The overall tone of the OCP suggests an ideological deinstitutionalization bias that is unnecessary while seeking to obtain the many rights due to persons with a disability.

The role of families and legal guardians:

The OCP displays a complete disregard for the important role of families and legal guardians. We expressly request the inclusion of "individual choice and need, with required family and guardian input" in the OCP's goals, as well as an expansion of the Regional Olmstead Committee (Strategy 6.6.) to include ICF family representatives and providers (*see* Attachment B, OCP redline). Furthermore, while

we support mentoring relationships (Strategy 4.4), the OCP must expressly indicate that mentors are only assigned to individuals upon informed consent of the individual, or where appointed, his/her legal guardian, whose decision-making authority is not affected by the appointment of a mentor (*see* Attachment B, OCP redline).

Assessments:

Although assessments of the person with a disability are mentioned in the OCP, a single specific tool is not defined. In fact, different Kentucky HCBS waivers may use different assessment tools. Regardless of the assessment tool or tools used to create the Person Centered Plan of Care, it is critical that parents, guardian and family members have the right to take part in all assessment or evaluation meetings, and that the tool(s) used is/are available as public information. An appeal process for family and legal guardian concerns should be an integral part of the assessment planning in every HCBS waiver.

CMS Final HCBS Rule:

The Kentucky Department of Medicaid Services and several other CHFS departments are just now beginning a multi-year process to implement the CMS Final Rule HCBS waiver changes in the majority of Kentucky HCBS waivers. It is unclear how the OCP will add to the complexity of this effort, or even if it will be possible to manage both efforts at the same time.

Disclaimer:

Given the breadth and depth of the OCP, the Executive Summary and following comments touch on only our primary concerns. Going forward, KCFN and VOR expressly request full inclusion in any future planning, drafting and implementing effort.

Kentucky Concerned Family Network (KCFN) and VOR Concerns

Limited Public Comment Period

As noted above, the potential extent of the influence of the OCP is very broad and reaches across several different disabilities. It will, if implemented as proposed, benefit many persons with disabilities, negatively impacting many others by limiting their residential choices, and will cause unintended consequences for an unknown number of persons as new rights are embraced, examined, and experienced without the proper oversight, services and even temporary support. The limited public comment period is a major concern.

The Office of Health Policy has arbitrarily limited the period for public comment to 21 days, August 22 to September 12. There is no OCP announcement on the Office of Health Policy website. There is no schedule of public OCP meetings across the state. There is no advertised announcement of a hearing before the Legislature. Given the extent of the influence of the OCP, and this limited public comment period, and the nonexistent Legislative hearings, we are concerned. This seems to be an entirely inappropriate process.

Olmstead Supreme Court Decision

Although the *Olmstead* Supreme Court decision is cited correctly on pages 3 and 8, the OCP as a whole does not embrace the spirit of the decision, and at times is inconsistent with the letter of decision.

For example, Strategy 6.3 calls for the transition of 175 clients from an institutional setting into various community settings with supports through the Money Follows the Person (MFP) demonstration program during calendar year 2015. MFP specifically targets persons for transition to the community who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and other facilities, and provides an economic incentive of a 6% increase in the federal matching funds.

Such a strategy calling for the closure of facility settings which provide care for our most vulnerable individuals with profound cognitive /developmental disabilities is in direct contrast to the letter and spirt of the O*lmstead* decision which supports choice. Quotas are antithetical to, and prevent, individual choice and person-centered planning. *Olmstead* does not require that individuals be forced out of a good placement against their choice and best interests; indeed the Court required that individuals do not oppose transition to the community.

As correctly noted in the OCP (page 8), the Supreme Court ruled that the Americans with Disabilities Act (ADA) may require states to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when:

- The state's treatment professionals determine that such placement is appropriate;
- The affected person **does not oppose** community placement; and,
- The community-based placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.

A majority of Justices in *Olmstead* recognized an ongoing role for publicly and privately-operated institutions:

> "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...Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it." 119 S. Ct. at 2187.

A plurality of Justices noted:

> "[N]o placement outside the institution may ever be appropriate . . . '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'" (quoting Amicus Curiae Brief for the American Psychiatric Association, et al). 521 U.S. at 604-604; 119 S. Ct. at 2189.
>
> "As already observed [by the majority], the ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk... 'Each disabled person is entitled to treatment in the most integrated setting possible for that person — recognizing on a case-by-case basis, that setting may be an institution'[quoting VOR's *Amici Curiae* brief]." Id.

Justice Kennedy noted in his concurring opinion:

> "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." 119 S. Ct. at 2191.

The OCP's strategy calling for the transition of a specific number of individuals (175) without knowledge of their choice or needs, and likely resulting in the closure of facility homes which provide care for our most vulnerable individuals with profound cognitive /developmental disabilities is in direct contrast to the spirit and letter of the O*lmstead* decision which supports choice and cautions against placing individuals in need of specialized care at risk.

In several places, the OCP seems to embrace choice, but we are gravely concerned that in light of quotas and the actual limitations on "choice": and "choose" in the OCP, that there lacks any real intent by CHFS to honor *Olmstead* in the Olmstead Compliance Plan:

> In Goal 1 on pages 3, 9, and 14: All persons with any disability will experience, meaningful, inclusive and integrated lives in their community supported by an array of services, in a setting of which they chose.
>
> In Strategy 6.1 on pages 5 and 18: A new living arrangement category in the State Supplementation Program administered by DCBS, Community Integration Supplementation, will enable individuals with serious mental illness (SMI) to live in their own homes if they so choose, rather than a congregate setting, by January 1, 2014.
>
> In Goals 7 on page 6, 10, and 19: Kentuckians with disabilities will have choices for competitive, meaningful, and sustainable employment in the most integrated setting.
>
> In Goal 8 on page 7, 10, and 20: Individuals with disabilities will have access to reliable, cost-effective, and accessible transportation choices that support the essential elements of life such as employment, housing, education, and social connections.

A person with a disability living in the community will have their choices of a residential setting, choices of employment options, and choices of modes of transportation. A person with a serious mental illness will have the choice of living in their own homes.

However, the OCP never indicates that a person with an intellectual disability can choose to remain in a facility, institution, or a congregate residential setting, even though KRS 202B.010 reads:

> "Least restrictive alternative mode of treatment" means that treatment given in the least confining setting which will provide an individual with an intellectual disability appropriate treatment or care consistent with accepted professional practice. For purposes of this section, least restrictive alternative mode of treatment may include an institutional placement;

In fairness we should mention that the word "desire" is used four times in the OCP. However, it is always used in the context of a person's desire to live in the community.

The Important Role of Families and Legal Guardians

The OCP displays a complete disregard for the important role of families and legal guardians. The OCP contains 6,872 words, 234 paragraphs and 21 pages. A search on the word guardian and parent found not one match. A search for a reference to a family member of a person with a disability found only one match on page 8:

Further, the *Olmstead* decision established that States have an obligation to:

- Divert people from going into an institutional placement in the first place if they can be served in a community setting;
- Review those already in institutions to determine how many could be served in a home and community based setting and how many wish to be served in such a setting; and,
- Respond to individual requests by persons who are residing in an institution (and/or their **family members**) who wish to leave the setting for home and community based supports.

Notwithstanding the concept of due process, it appears as though the only time the CHFS Office of Health Policy, the Kentucky Protection and Advocacy Program, and the Kentucky Housing Corporation want or expect to hear from family guardians (appointed by a Kentucky District Court judge), or family members, is when they want their loved one to leave a licensed facility. Otherwise, families are left to exist as objects of the goals and strategies of OCP.

To remedy this omission, KCFN and VOR expressly request the inclusion of "individual choice and need, with required family and guardian input," in the OCP's goals, as well as an expansion of the Regional Olmstead Committee (Strategy 6.6.) to include ICF family representatives and providers (see Attachment B, OCP redline).

Furthermore, while we generally support mentoring relationships (Strategy 4.4), the OCP must expressly indicate that mentors are only assigned to individuals upon informed consent of the individual, or where appointed, his/her legal guardian. The OCP must also make clear that the appointment of a mentor in no way supplants or circumvents guardianship decision-making authority, as provided by a court of law (*see* Attachment B, OCP redline). Mentors will be in a position of heightened trust, so it is important that training addresses the limits on their authority.

Assessments

The OCP in several instances, and for several different population groups, refers to reviewing and revising assessment policies, tools, and practices as well as adopting new assessment tools. It is unclear who or what CHFS department will perform the reviews, revisions and the adoption of new assessment tools. Because of the number of HCBS waivers involved in the OCP document there are many different assessment plans involved.

From page 3 and 16:

Strategy 1.7: **Review and revise each HCB 1915c waiver assessment** to identify any necessary changes to facilitate a person-centered, comprehensive care plan for any individual, regardless of disability by December 1, 2015.

From page 5:
Strategy 4.1: DBHDID will address the needs of youth and young adults between 15-30 years old with early serious mental illness by developing the capacity to implement and sustain Coordinated Specialty Care (CSC) for this population. **The OnTrackNY model, with some modifications to include Oregon's Early Assessment and Support Alliance (EASA) model will be utilized** allowing for the flexibility needed to implement the program in both urban and rural pilot sites by December 2015, with the goal of statewide implementation within six years.

From page 13:
Strengths of the various waivers include the capacity to provide services to a diverse population across age groups, consistent oversight by the same Division within DMS, and the upcoming, streamlined changes related to Kynect. **Weaknesses include the use of one core standardized assessment that does not adequately facilitate the collection of information across populations that is both relevant to a child and an adult service needs.** Access through various No Wrong Door/Single Entry Points/Information and Referral (I&R) points are diverse and significantly overlap while eligibility determination and case management processes are fairly consistent.

From page 15:
Strategy 1.4: The Office of Health Policy will submit an application for the Centers for Medicare and Medicaid Services' Balancing Incentive Program by October 31, 2013 and will have a fully developed work-plan for implementation by April 30, 2014. Kentucky has qualified for a 2% enhanced Federal Match Assistance Plan rate to move towards expending more than 50% of Medicaid dollars on home and community based services in comparison to institutional care. The application has been accepted and approximately $25M will be expended to increase the number of slots in the following waivers: ABI, Michelle P., and SCL. The enhanced funding will be available through September, 2015. Additional deliverables include implementation of conflict free case management, **examination of core standardized assessments**, and strengthening No Wrong Door/Single Entry Points across waivers.

KCFN and VOR have a major concerns that assessment policies, plans, and tools when improperly designed and/or improperly implemented will not adequately reflect the different aspects of an individual's unique combination of needed services and supports. If the assessment is used to replace an individual's Person Centered Plan of Care, or used in lieu of a Person Centered Plan of Care, the result will not reflect a true and compelling picture of his/her disabilities, and needed services and supports. **An understated level of disability and the resultant apparent lack of need for certain services can result in a preventable death of the person with one or more disabilities.** Our concern is to prevent the denial, reduction or termination Medicaid services to qualified individuals with intellectual and other developmental disabilities due to an inappropriate assessment tool or procedure.

In January 2012, KCFN wrote to the then-Secretary of CHFS expressing concern that family members were being excluded from assessment meetings. In a written response, the then-Commissioner of the Department for Behavioral Health, Developmental and Intellectual Disabilities wrote that family members would always be invited to participate in Supports Intensity Scale (SIS) assessments. KCFN and VOR consider **family participation to be an extremely important part of every assessment process used by the CHFS. Additionally, there must be an appeal process available to address any family member concerns regarding the assessment and the resultant plan of care.**

Additional Concerns

On page 8 of the OCP, the *Olmstead v. L.C* Supreme Court decision is properly identified as a decision related to the Georgia case when two women with mental illness sued the Georgia Department of Human Resources for failing to place them in a community-based setting rather than a psychiatric unit at a state hospital.

What was not included in the OCP is the following report of the deaths which resulted from the implementation of the Department of Justice settlement agreement with the State of Georgia:

> But at least 82 patients died last year after being moved into community settings and the state halted placements of developmentally disabled patients as it worked to find better and safer placements. In a court ruling in July, the state acknowledged that Independent Reviewer Elizabeth Jones, appointed by the court to review how the state was implementing the settlement and the placements, has never found that the state was meeting its obligations to those patients in the community in terms of services and support. After giving the state time to correct that, Jones found in a recent filing that it still failed. (*Augusta Chronicle*, May 17, 2014)

KCFN and VOR are concerned that in the OCP there is little or no mention of the increased need and increased demand on CHFS resources for the effective oversight to prevent such deaths of vulnerable person with mental illness and intellectual/developmental disabilities. Ensuring civil rights must come with adequate protections to ensure death does not trump rights. Unlike some advocates, we find no solace in the notion that, "they died with their rights on."

The deaths, near deaths, abuse, neglect and exploitation of persons with disabilities are very often unreported. Even the annual and quarterly totals in Kentucky for this information, especially for Supports for Community Living (SCL) and other community residential settings, are closely held. Unless reported on the news, these individuals are harmed or die without any public awareness.

Such oversight and data is needed with regard to all transitions from facility-based homes to community settings. KCFN and VOR propose the inclusion of a new Strategy 6.9, requiring that "DBHDID will every six months collect, analyze and report data on the outcomes of individuals transitioning from ICFs to community settings, including but not limited to mortality, hospitalizations, abuse, neglect, interactions with the Department of Correction, and additional transitions following the initial transition to the community." (*See* Attachment B, OCP redline).

It is our understanding that when a person with a mental illness or an intellectual/developmental disability dies under the care of the CHFS, the responsibility of the CHFS ends. Thus, autopsies are not preformed to determine the cause of death. Such information is critical to future planning and prevention of injuries that lead to death. As such, KCFN and VOR propose Strategy 6.10, that an "autopsy will be performed in each case in which an individual is, or has been, under the care of CHFS within three months of his/her passing."

We strongly recommend that reasonable officials act in reasonable ways to provide the necessary oversight in community based residential settings geographically disbursed across the Commonwealth, to provide safe and secure, medically comprehensive care to help prevent the deaths, near deaths, abuse, neglect and exploitation of persons with disabilities.

In Conclusion

The KCFN and VOR concerns regarding the OCP are summarized below:

1. Limited public comment period
2. Nonexistent public and legislative hearing process
3. Transition quotas which are inconsistent with *Olmstead* decision
4. Misrepresentation of the spirit of the *Olmstead* decision
5. Lack of recognition of due process right of choice to remain in a facility
6. Absence of any role for parents, family members and legal guardians throughout OCP and in assessment process
7. Lack of proper consideration and clarity for assessments
8. Lack of assessment appeal process for families and guardians
9. Current status of community-based residential settings not prepared with adequate oversight, policies, procedures, and personnel to properly and safely care for the new (and current) residents with a mental illness (some serious), and an intellectual or developmental disability

The American Psychiatric Association in its *Olmstead Amicus Curiae* Brief referred to the risks and exposure of the "less protective environment of community settings":

> "[N]o placement outside the institution may ever be appropriate . . . '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'"

Justice Kennedy noted in his concurring opinion:

> "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 Kentucky Concerned Family Network (KCFN) and VOR have carefully reviewed the Olmstead Compliance Plan (OCP) and have determined that the Plan is not so much a plan as it is a recipe for a

perfect storm for a series of unintended consequences. There is no cost estimate for the collection of goals and strategies either for one, five or ten years. There is no estimate of, nor timetable for, identifying, securing and training the necessary staff and support personnel to make this a safe and secure operation. Some goals may be reached while others are not. Some strategies may be implemented while others after further review may be found unnecessary. We see only three absolutes in the document – 1) the number of persons transferred, 2) the completion dates for the transfers (less than 30 days away for the first 100) and, 3) the fact that there is little or no individual or departmental accountability as the perfect storm materializes.

We call on Secretary Audrey Haynes to suspend all further development and implementation of the OCP until a plan is in place to meet the concerns identified in this letter. We offer our services in this endeavor.

Thank you for the opportunity to submit these public comments.

Sincerely,

Don Putnam
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Member, Kentucky Commission on Services and Supports for Individuals with Intellectual and Other Developmental Disabilities
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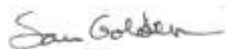

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Representative Jimmie Lee
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Attachment A

Email requesting public comments sent August 22, 2014:

During the past several months, staff across the Cabinet for Health and Family Services, Protection & Advocacy, and Kentucky's Housing Corporation have been meeting and emailing to develop a framework of current and future initiatives related to Olmstead. We are pleased to provide proposed revisions of Kentucky's Olmstead Compliance Plan for your input.

We are excited about the progress that has been made and the proposed plans for the future. As you will see, we have been operating pursuant to the goals since at least the fall of 2013, when the initial internal meetings began. As you also know, a lot of simultaneous staff energy has been spent on Medicaid expansion, Health Benefits Exchange enrollment, Medicaid State Plan amendments, and waiver enhancements, all of which support the broad themes of our Olmstead plan. Please also note the final goal which includes more frequent Olmstead Compliance Plan reviews to better ensure that Olmstead remains an integral part of CHFS operations.

We are requesting responses to the plan by September 12th, 2014. Please send comments to me directly. Please forward the draft document to anyone who is not on the distribution list. Thank you for your time and input.

Attachment B

Kentucky's Olmstead Compliance Plan

Draft for Stakeholder Input

Kentucky Cabinet for Health and Family Services
Office of Health Policy
August 18, 2014

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Draft for Stakeholder Input

Draft for Stakeholder Input

Executive Summary

Kentucky's Olmstead Compliance Plan continues to be in response to the landmark civil rights case, *Olmstead* v. L.C., 527 U.S. 581 (1999), in which the United States Supreme Court held that it is discriminatory and unlawful for governments to keep persons with disabilities in segregated settings when they are capable and desire to reside in the community. Following are nine (9) goals of Kentucky's current Olmstead Plan with corresponding strategies (FY 2013 – FY 2015):

Goal 1: All persons with any disability will experience, meaningful, inclusive and integrated lives in their community supported by an array of services, in a setting of which they chose according to individual need, with required input from their families and legal guardians.

Strategy 1.1: Medicaid expansion criteria will be fully implemented by October 1, 2013.

Strategy 1.2: The Health Benefits Exchange (Kynect) portal will provide open access to all eligible individuals who apply, into Medicaid or a Qualified Health Plan beginning October 1, ~~2103~~2013.

Strategy 1.3: Increase availability of an array of behavioral health services [i.e., Assertive Community Treatment (ACT), and Crisis Intervention/Response] within a Medicaid State Plan amendment by January 1, 2014.

Strategy 1.4: The Office of Health Policy will submit an application for the Centers for Medicare and Medicaid Services' Balancing Incentive Program by October 31, 2013 and will have a fully developed work-plan for implementation by April 30, 2014.

Strategy 1.5: Revise the Home and Community Based (HCB) waiver to include home delivered meals, broader personal services definition, increase hours of occupational and physical therapy, and increase in home modification limit by December 1, 2015.

Strategy 1.6: The Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) will collaborate with community partners to implement key components of the Building Bridges Initiative within the Cabinet for Health and Family Services. An initial implementation plan will be developed to include enhancing DBHDID policies and practices to address the top 3 priorities by December 1, 2014.

Strategy 1.7: Review and revise each HCB 1915c waiver assessment to identify any necessary changes to facilitate a person-centered, comprehensive care plan for any individual, regardless of disability by December 1, 2015.

Strategy 1.8: All assessment tools, not individual assessments, are considered public documents available for public inspection.

Strategy 1.9: To ensure that eligible individuals have opportunity to make fully informed choices about available services in settings of their choice, the DBHDID will prepare,

with opportunity for public input, a document providing information on all service options within the Commonwealth, including but not limited to family supports, HCB waiver services, private and public Intermediate Care Facilities for Persons with Intellectual and Developmental Disabilities, and psychiatric supports by January 1, 2015. This document will be made available at all Aging and Disability Resource Centers, designated as the No Wrong Door/Single Point of Entry, and to anyone inquiring about DBHDID services.

Goal 2: Education/Outreach as prevention of facility placement when the facility option is not desired by the individual with a disability, with required input from his/her family and legal guardian.

Strategy 2.1: Kynect will include a portal to seamless Medicaid and waiver eligibility by January 1, 2015, ensuring eligible beneficiaries are fully informed about service options, as required by Medicaid.

Strategy 2.2: Mental Health First Aid and Youth Mental Health First Aid training for trainers will be held by December 1, 2014 in order to allow for at least one Mental Health First Aid and Youth Mental Health First Aid Trainer in all community mental health center regions of the state.

Strategy 2.3: School based mental health screenings will be implemented in all middle and high schools in six (6) districts by May 31, 2015.

Strategy 2.4: The Regional Interagency Councils will be offered technical assistance at a minimum, each quarter or more often as needs are identified, to increase the RIACs ability to provide targeted consultation for youth in their community in need of mental health and substance abuse services by December 31, 2013.

Strategy 2.5: Expand role of Aging and Disability Resource Centers at the State level to continue to be designated as the No Wrong Door/Single Point of Entry for anyone with any disability by January 30, 2015.

Goal 3: Assure that persons with disabilities are not incarcerated for minor offenses that are a result of their disability. Assure persons with disabilities who leave correctional facilities are able to access needed ~~community-based~~ services, according to individual choice and need, with required family and legal guardian input.

Strategy 3.1: Through Senate Bill 200 of the 2014 Kentucky General Assembly, the Department for Juvenile Justice's Family Accountability Intervention Response Team will develop enhanced case management plans and opportunities for services for children who have an assessment score of "high need" to reduce the incarceration of children younger than 18 charged with noncriminal "status" offenses.

Strategy 3.3: DBHDID will continue to participate in quarterly Interagency Review meetings hosted by the Kentucky Department of Corrections (DOC) and to utilize Federal Block Grant dollars to support the Re-integration Specialist who is charged with facilitating the successful community reentry of individuals who are severely mentally ill.

Draft for Stakeholder Input

Strategy 3.4: DBHDID will seek data on the effectiveness of diversion for existing Mental Health Courts in Louisville, Hardin County, and Northern Kentucky, and make recommendations accordingly.

Strategy 3.5: Release from prison will continue to be considered as a "qualifying event" for healthcare coverage through Kentucky's Health Benefits Exchange when enrolled within sixty (60) days of reentry into the community.

Strategy 3.6: Individuals with drug felony convictions who have completed drug or alcohol treatment will remain eligible to receive Temporary Assistance for Needy Families (TANF) and/or Supplemental Nutrition Assistance Program (SNAP) upon release.

Goal 4: All transition age youth (14 – 25 years old) will have a seamless transition to adulthood through the effective and efficient use of evidence based programs and practices that are developmentally and functionally appropriate, according to individual choice and need, with required family and guardian input.

Strategy 4.1: DBHDID will address the needs of youth and young adults between 15-30 years old with early serious mental illness by developing the capacity to implement and sustain Coordinated Specialty Care (CSC) for this population. The OnTrackNY model, with some modifications to include Oregon's Early Assessment and Support Alliance (EASA) model will be utilized allowing for the flexibility needed to implement the program in both urban and rural pilot sites by December 2015, with the goal of statewide implementation within six years.

Strategy 4.2: A specialized transition age youth training (Transition Age Youth Launching Realized Dreams – TAYLRD) focusing on developmental issues, best practices related to this population and local community based resources will continue to be offered as requested by community partners across all community mental health center regions of Kentucky.

Strategy 4.3: The DBHDID will provide support in the development and coordination of a Youth Peer Support Specialist Core Competency Training in order to adequately prepare Youth Peer Support Specialists in these support roles. The first core competency training will be conducted by September 1, 2014

Strategy 4.4: The Commission for Children with Special Health Care Needs will provide trained young adult mentors with special health care needs who have successfully transitioned to assist consenting youth ages 16-20 with special health care needs who are transitioning to adulthood. Of those referred, the goal is to pair 90% ~~will be~~ successfully ~~paired~~ with a mentor. Participation is voluntary based on informed consent from individuals, or where appointed, their legal guardians. The decision-making authority of a legal guardian, provided by a court of law, is not supplanted or circumvented by the appointment of a mentor. Mentors are required to provide individuals and their families and legal guardians with information about all service

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options within the Commonwealth, including but not limited to family supports, HCB waiver services, private and public Intermediate Care Facilities for Persons with Intellectual and Developmental Disabilities, and psychiatric supports.

Strategy 4.5: The Department for Community Based Services (DCBS) will engage in multiple initiatives to increase the utilization of in-home services and community-based placements for children in foster care as measured by the Foster Care FACTS sheet.

Goal 5: Increase available, accessible, quality, and affordable community housing to accommodate individual choice according to need, with required input from families and legal guardians.

Strategy 5.1: Kentucky Housing Corporation will enter into a formal partnership with DBHDID and Department for Medicaid Services in order to apply for HUD Section 811 Project Rental Assistance, which provides funding to develop and subsidize rental housing with the availability of supportive services for adults with very low income who also have a disability, by April 1, 2014

Strategy 5.2: Kentucky Housing Corporation, in partnership with CHFS, will open a funding round for rental housing for persons with a disability by April 1, 2014.

Goal 6: Ensure a safe and appropriate transition from an institution to a community setting, when transition is not opposed by the individual, or his/her family and legal guardian, as required.

Strategy 6.1: A new living arrangement category in the State Supplementation Program administered by DCBS, Community Integration Supplementation, will enable individuals with serious mental illness (SMI) to live in their own homes if they so choose, rather than a congregate setting, by January 1, 2014.

Strategy 6.2: The DBHDID will implement a Transition Age Youth Consultation Process to provide recommendations to community partners for inclusion in a plan to support transition to an adult-oriented, permanent, stable living situation and treatment services and supports by December 1, 2014.

Strategy 6.3: Transition ~~175~~ clients from an institutional setting into various community settings with supports through the Money Follows the Person (MFP) demonstration program during calendar year 2015, according to individual choice, with required input from families and guardians.

Strategy 6.4: In response to the Interim Settlement Agreement between the Cabinet for Health and Family Services (the Cabinet) and Protection and Advocacy, the Cabinet will provide Housing Assistance to six hundred (600) individuals with Severe Mental Illness and residing or at risk of residing in a Personal Care Home, as follows:

6.1.1. By October 1, 2014 the Cabinet will provide Housing Assistance to at least 100 individuals with approximately half given to state wards and half to others.

Comment [T1]: KCFN and VOR object strongly to quotas. The pursuit of arbitrary numeric goals trump person-centered planning and choice, risking the health and welfare of those impacted. Transitions from institutional settings to community settings must be at the direction of each affected individual, not a quota.

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6.1.2. By October 1, 2015 the Cabinet will provide Housing Assistance to at least 200 additional individuals with approximately half given to state wards and half to others.

6.1.3. By October 1, 2016 the Cabinet will provide Housing Assistance to at least 300 additional individuals with approximately half given to state wards and half to others.

Comment [T2]: As stated above, we object to quotas for service planning as they are antithetical to true person-centered planning.

Strategy 6.5: DBHDID will collect data on discharges from the four state owned/contracted acute psychiatric hospitals to personal care homes (PCH) and other congregate settings beginning May 2014.

Strategy 6.6: Regional Olmstead Committees, facilitated by the four state owned/contracted acute psychiatric hospitals, will continue to meet quarterly to problem solve barriers to discharge for patients with inpatient length of stays greater than ninety (90) days. By January 1, 2015, Regional Olmstead Committees will be expanded to include ICF provider and ICF family representatives.

Strategy 6.7: DBHDID will collect and analyze data on use of voluntary outpatient commitment orders (KRS 202A) for individuals discharged from the four state owned/ contracted acute psychiatric facilities beginning July 1, 2014.

Strategy 6.8: DBHDID is committed to ensuring that those transitioning from Intermediate Care Facilities (ICF) continue to receive the ut~~p~~most quality of care in the community. Four Intermediate Care Clinics will be opened throughout the state to ensure access to specialized medical, behavioral, and other therapeutic services for individuals with developmental and/or intellectual disabilities beginning June 2014.

Strategy 6.9: DBHDID will every six months collect, analyze and report data on the outcomes of individuals transitioning from ICFs to community settings, including but not limited to mortality, hospitalizations, abuse, neglect, interactions with the Department of Correction, and additional transitions following the initial transition to the community.

Strategy 6.10: An autopsy will be performed in each case in which an individual is, or has been, under the care of CHFS within three months of his/her passing.

Goal 7: Kentuckians with disabilities will have choices for ~~competitive,~~ meaningful~~, and sustainable~~ employment in the most integrated setting according to individual choice and need.

Strategy 7.1: The Commonwealth Council on Developmental Disabilities (CCDD) will implement a pilot project on Asset Based Community Development approaches to employment by June 30, 2016. The objective is to utilize community assets and personal assets of people with disabilities to guide in integration of people with disabilities.

Strategy 7.2: Increase awareness, understanding and access to the Individual Placement and Support (IPS) model of supported employment for young adults between 18-25 years old by implementing developmentally appropriate marketing strategies,

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resource guides, and a clear business plan for the expansion of IPS in Kentucky by December 2014.

Strategy 7.4: The Department for Medicaid Services and Behavioral Health, Developmental, and Intellectual Disabilities will continue to support individual choice by offering~~offer~~ enhanced supported employment assistance within the Supports for Community Living through Day Training, Person-Centered Coaching, and Supported Employment if funding is no longer available through the Office of Vocational Rehabilitation, beginning January 1, 2014.

Goal 8: Individuals with disabilities will have access to reliable, cost-effective, and accessible transportation choices that support the essential elements of life such as employment, housing, education, and social connections.

Strategy 8.1: Fully implement the new service provision within the Supports for Community Living waiver to include transportation reimbursement. Throughout calendar year 2014, each waiver participant will be assessed for the need of transportation reimbursement sixty (60) days prior to their birth month.

Strategy 8.2: The Cabinet for Health and Family Services will continue to seek partnerships with public and private providers and convene discussions to identify innovative strategies for addressing transportation needs for individuals with a disability by June 1, 2015.

Goal 9: Ensure allocation of quantifiable, measurable tasks in regard to the elements of the Olmstead plan, including regular updates in order to ensure that the Commonwealth progresses toward the Vision of protecting the rights of persons with disabilities. In order to do, the Commonwealth will sustain a Cabinet level *Olmstead* Committee, measure progress on strategies, and update the Olmstead plan on a minimum of a biennial basis.

Strategy 9.1: The Cabinet's internal Olmstead Team will provide a draft plan to stakeholders by August 4, 2014.

Strategy 9.2: Olmstead Team will revise the Olmstead Plan based on stakeholder input by October 30, 2014.

Strategy 9.3: The Cabinet's Olmstead Plan will be used to inform budget decisions and requests by June 2015.

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Introduction

Kentucky's Olmstead Compliance Plan continues to be in response to the landmark civil rights case, *Olmstead* v. L.C., 527 U.S. 581 (1999), in which the United States Supreme Court held that it is discriminatory and unlawful for governments to keep persons with disabilities in ~~segregated settings~~institutions when they are capable and desire to reside in the community. The case originated in Georgia when two women with mental illness sued the Georgia Department of Human Resources for failing to place them in a community-based setting rather than a psychiatric unit at a state hospital. The Court established the precedent for states to meet the reasonable modification standard by demonstrating it has "…a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings…". More specifically, the Court ruled that the ADA may require states to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when:

- The state's treatment professionals determine that such placement is appropriate;
- The affected person does not oppose community placement; and,
- The community-based placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.

Kentucky's first "*Olmstead* Compliance Plan" was developed in FY 2002 and although the original *Olmstead* Planning Committee has since disbanded, the Cabinet for Health and Family Services (CHFS) established an internal committee to begin the planning process anew. The proposed plan will now be evaluated, at a minimum, every two years.

The *Olmstead* decision is about how services are provided by the government to persons with disabilities (in the most integrated setting), and a momentous civil rights case "…heralded as the impetus to finally move individuals with disabilities out of the shadows, and to facilitate their full integration into the mainstream of American life" (Perez, 2012). The *Olmstead* Court urged that services be provided in the "most integrated setting possible for that person - recognizing on a case-by-case basis, that setting may be an institution" (*Olmstead*, 527 U.S. at 605), and for others community placement will be required (Id. at 587).

States should have an objective process in place to assess the capacity of existing community based services and the number of persons currently in institutional settings who desire, and would benefit from, community services specific to population groups. Further, the Olmstead decision established that States have an obligation to:

- Provide community services to individuals who are eligible and request community services to prevent unjustified institutionalization; and~~Divert people from going into an institutional placement in the first place if they can be served in a community setting~~;
- ~~Review those already in institutions to determine how many could be served in a home and community based setting and how many wish to be served in such a setting; and,~~

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Comment [T3]: While some courts have ruled that the Olmstead decision does apply to individuals who are "at risk" of **unjustified** institutionalization, Olmstead does not support wholesale efforts to divert individual who choose facility-based care.

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- Respond to individual requests by persons who are residing in an institution (and/or their family members) who wish to leave the setting for home and community based supports.

In addition, Kentucky will Review the annual Individual Habilitation Plans (IHPs) of those already in institutions to determine how many, according to IHPs, wish to be served in a home and community based a setting; and,

On June 18, 2001, President George W. Bush issued Executive Order 113217 specific to Community Based Alternatives for Individuals with Disabilities, calling for swift implementation of the *Olmstead* decision spearheaded by federal agencies. The Order directed six federal departments to review their policies, programs, statutes and regulations and those of their respective agencies to determine whether any should be revised or modified to improve the availability of community based services.

Subsequently, on December 21, 2001, the Secretary Tommy Thompson of the U.S. Department of Health and Human Services issued an invitation for public input in the Olmstead review process and followed up with the following report "Delivering on the Promise: Preliminary Report of Federal Agencies' Actions to Eliminate Barriers and promote Community Integration". The report can be found at: http://archive.hhs.gov/news/press/2002pres/20020325.html.

Shortly after arriving at DHHS in 2009, Secretary Kathleen Sebelius, along with President Barack Obama, announced the "Year of Community Living" initiative, charging numerous Federal agencies to implement solutions that address barriers to community living for individuals with disabilities and older Americans. As the majority of the proportion of individuals is aging, the demand for community based services continues to grow during a time of State budget constraints. The Community Living Initiative was a reaffirmation of the commitment the provision of alternative home and community based services in order to build upon earlier innovations. According to some experts, some States have downsized and closed institutions but have not adequately invested in their community infrastructures, including adequate staffing, to ensure that the promise of community living, including individual protections, access to services, and true integration, is realized by those who choose to receive community services. Kentucky pledges to ensure adequate access to housing, services, health care and qualified staff before community transition for any individual.

Since 2009, the Centers for Medicare and Medicaid Services have approved multiple home and community based waivers (Table 2.) for Kentucky that serve the majority of individuals who have a disability who reside in the Commonwealth. As recent as 2014, Kentucky also received authorization for an enhanced Federal Medicaid Assistance Program match rate to increase community based capacity and continue "rebalancing" the system of care by the provision of more supports in the community rather than institutions.

Kentucky's Olmstead Compliance Plan includes the following nine (9) broad topic areas or overarching goals:

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Goal 1: All persons with any disability will experience, meaningful, inclusive and integrated lives in their community supported by an array of services, in a setting of which they chose~~.~~ According to individual need, with required input from their families and legal guardians.

Goal 2: Education/Outreach as prevention of facility placement when the facility option is not desired by the individual with a disability, and with required input from his/her family and legal guardian.

Goal 3: Assure that persons with disabilities are not incarcerated for minor offenses that are a result of their disability. Assure persons with disabilities who leave correctional facilities are able to access needed ~~community-based~~ services, according to individual choice and need, with required family and legal guardian input.

Goal 4: All transition age youth (14 – 25 years old) will have a seamless transition to adulthood through the effective and efficient use of evidence based programs and practices that are developmentally appropriate, according to individual choice and need, with required family and legal guardian input.

Goal 5: Increase available, accessible, quality, and affordable community housing to accommodate individual choice according to need, with required family and legal guardian input.

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Goal 6: Ensure a safe and appropriate transition from an institution to a community setting, when transition is not opposed by the individual, or his/her family and legal guardian, as required.

Goal 7: Kentuckians with disabilities will have choices for ~~competitive,~~ meaningful~~, and sustainable~~ employment in the most integrated setting to accommodate individual choice according to need, with required input from families and legal guardians.

Goal 8: Individuals with disabilities will have access to reliable, cost-effective, and accessible transportation choices that support the essential elements of life such as employment, housing, education, and social connections.

Goal 9: Ensure allocation of quantifiable, measurable tasks in regard to the elements of the Olmstead plan, including regular updates in order to ensure that the Commonwealth progresses toward the Vision of protecting the rights of persons with disabilities. In order to do, the Commonwealth will sustain a Cabinet level *Olmstead* Committee, measure progress on strategies, and update the Olmstead plan on a minimum of a biennial basis.

Kentucky Demographics

Comment [T4]: KCFN and VOR urge this section be dramatically expanded to include more relevant demographics, such as those provided in Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2010, University of Minnesota (2012) (an update is expected this year). On pages 30 - 41, data on the level of intellectual disability, age, gender, additional conditions and functional needs are provided for residents of state operated ICFs. KCFN and VOR request that this same data be provided in the Kentucky Olmstead Plan for all Kentuckians served by DBHDID. This data, far more than Kentucky's national health rankings, is necessary and relevant to assess service capacity across all settings.

Given Kentucky's national health rankings, Olmstead Planning is critical for the continued development of a system of care that supports individuals in their communities. According to America's Health Rankings 2013 Annual Report, Kentucky has an overall national health rank of 45. Kentucky has the highest "poor physical health days", second to worse "poor mental health days, and the highest cancer deaths in the nation. The physical inactivity affects 976,000

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Kentuckians. Further exacerbating health outcomes, are additional disease prevalence and health behavior (Table 1.)

Disease / Health Behavior	*National Rate*	*Kentucky Rate & National Ranking*
Tobacco Use	19.6%	28.3% of adults, 50th overall
Obesity	27.6%	31.3% of adults, 42nd overall
Diabetes	9.7%	10.7% of adults, 38th overall
Hypertension	30.8%	38% of adults, 46th overall
Source: America's Health Rankings 2013 Annual Report		

Table 1: Select Chronic Disease Burden in Kentucky

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Value Statements

To move the State forward toward community integration and inclusion for persons with a disability, Kentucky will address the following goals related to broad focus areas that will be narrowed through targeted strategies. As such, Kentucky envisions:

- Enabling community living for all who desire it and are appropriate for non-institutional care;
- Administering State programs, services, and activities in the most integrated setting appropriate to a person's needs; and,
- Ongoing, meaningful, stakeholder involvement.

Balancing the System of Care for Home and Community Based Services vs. Institutionalization

The Cabinet serves as the single agency for both community based and facility-based services and coordinates policies and budgets to promote options across the continuum. Various departments within the Cabinet administer both Medicaid and non-Medicaid funded programs that collectively address the needs of individuals of all ages who are aging, have physical disabilities, intellectual disabilities, brain injury, neurological disorders, and/or Alzheimer's disease and related disorders. Significant partners outside the Cabinet, include, but are not limited to, Department of Education, Department of Juvenile Justice, Kentucky Housing Corporation, Office of Vocational Rehabilitation, and Department of Corrections. The following are located within the Cabinet: Department for Aging and Independent Living (DAIL), Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID), Department for Community Based Services (DCBS), and Department for Public Health (DPH).

At the local level, various programs and parallel community agencies have historically administered services specific to population groups. Local entities include the Area

Agencies on Aging and Independent Living (AAAIL), Regional Mental Health and Intellectual Disability Boards/Community Mental Health Centers (CMHCs), Public Health Departments, Department for Community Based Services (DCBS), and Public Schools.

The majority of individuals living in their community receive services through one of six (6) Home and Community Based (HCB) waivers: Acquired Brain Injury (ABI), ABI-Long Term Care (LTC), HCB, Michelle P., Model II, and Supports for Community Living (SCL). The waivers are administered by various Departments (Table 2.) within the Cabinet and all waivers offer a Consumer Directed Option (CDO) component for non-medical, non-residential services, with the exception of Model II. Individuals must meet criteria for institutional level of care to qualify for participation in any of the HCB waivers.

ABI. The ABI waiver is a community program for rehabilitation and training during a period of transition for adults (aged 21-65) who demonstrate the potential to progress. The goal of the program is to rehabilitate and reintegrate individuals with an ABI into the community with an emphasis on improving or restoring an individual's functioning.

ABI-LTC. The ABI-LTC waiver is designed to serve individuals at least 18 years of age, with an ABI who have reached a plateau in their rehabilitation goals and in need of services and long term supports to live safely in the community.

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Table 2. Structure of HCB Medicaid Waiver Administration in Kentucky.

Waiver	*Administrating Agency*	*Description*	*Average Monthly Enrollment (FY 2013)*
ABI	DMS DAIL*	Short-term, intensive supports for those with an ABI (Adults)	166
ABI-LTC	DMS DAIL*	Long-term supports for those with an ABI (Adults)	211
HCB	DMS DAIL*	Primarily In-Home and some Community Based Services targeted to Individuals who are Elderly and/or Disabled (All Ages)	9,419
Michelle P.	DMS DBHDID	Non-residential, Community Living and Education Supports for individuals with a developmental or intellectual disability (All Ages)	7,545
Model II	DMS	In-Home Ventilator Supports for individuals who are dependent for 12 hours or more per day (All Ages)	53
SCL	DMS DBHDID	Residential, Adult Day and Non-Residential community supports for individuals with a developmental and intellectual disability (All Ages)	3,768

*NOTE: DAIL is contractually responsible for administering and monitoring the CDO component of each waiver where indicated.

HCB. Currently, the HCB waiver provides services to the largest proportion of persons across waivers and there is no waiting list. The program allows persons who are physically disabled and/or those aged 65+, who meet nursing facility level of care, to remain living at home and in the community. .

Michelle P. The Michelle P. waiver became active in 2008 in response to a class action lawsuit requiring the state to provide services to persons with an intellectual or developmental disability in a reasonably prompt manner and in an integrated community setting. Many individuals who were on the SCL waiting list are now being served through the Michelle P. waiver.

Model II. The Model II waiver is a Nursing and Respiratory Services waiver available to a person of any age who is dependent upon a ventilator for twelve hours (or greater), per day. Services include respiratory care and private duty nursing. Home Health or private duty nursing agencies provide the services.

SCL. The SCL waiver program allows for the provision of services to individuals with an Intellectual or Developmental Disability with cognitive deficits meeting Intermediate Care Facility for Individuals with Intellectual or Developmentally Disabled (ICF/IDD) disorder or nursing facility level of care. There is currently a waiting list for services and supports

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and an application will allow for inclusion on the waiting list. Individuals are served in chronological order as funding becomes available or on an emergency basis.

Strengths of the various waivers include the capacity to provide services to a diverse population across age groups, consistent oversight by the same Division within DMS, and the upcoming, streamlined changes related to Kynect. Weaknesses include the use of one core standardized assessment that does not adequately facilitate the collection of information across populations that is both relevant to a child and an adult service needs. Access through various No Wrong Door/Single Entry Points/Information and Referral (I&R) Points are diverse and significantly overlap while eligibility determination and case management processes are fairly consistent.

Comment [T5]: If not already in place, a toll free number should be established in furtherance of the "No Wrong Door/Single Entry Points/Information and Referral (I&R) Points" objective.

Non-Waiver System of Care Supports

Many significant changes have occurred throughout the system of care during the past few years and there are more proposed changes in the near future. In recent years, Medicaid Managed Care has been expanded from a sixteen-county program to statewide (120 counties), and Kentucky's state-run Health Benefits Exchange launched "Kynect" (https://www.Kynect.ky.gov) as the portal for insurance enrollment on October 1, 2013. Expansion within the Kentucky Office of Health Information Exchange (KOHIE) has provided an opportunity for a significant increase of electronic personal health records to support "Meaningful Use" of health outcome information across the Commonwealth. Governor Steve Beshear recently announced Medicaid coverage and qualified health plan expansion that has resulted in approximately 380,000 individuals qualifying for coverage. Because of the significant increase of benefits related to behavioral health parity within the Affordable Care Act (ACA), coupled with the projections of individuals who will be eligible for health insurance, the Department for Medicaid Services (DMS) has also announced readiness to directly contract with public and private providers in addition to the CMHC network. Additional supports, new and ongoing initiatives include: Assertive Community Treatment (ACT), Medication Assisted Treatment (MAT), substance use treatment, Supported Employment, Supporting Housing, Therapeutic Rehabilitation for adults, and Peer Supports for adults.

Transportation. Medicaid covers non-emergency medical transportation to and from a Medicaid-covered service for members who do not have access to free transportation. For transportation outside of a member's medical service area or for specialty care, a referral from a member's primary care physician is required. Travel to pharmacies is currently not covered. The non-emergency Medical transportation services are available through the Human Services Transportation Delivery program, which is a regional brokerage system. Depending on a member's medical needs, transportation is provided by taxi, van, bus, or public transit and wheelchair services is also provided if

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required by medical necessity. Kentucky spends approximately $50M annually on non-emergency Medical Transportation.

Money Follows the Person (MFP)/Kentucky Transitions. Kentucky has been participating in the MFP demonstration since 2007 and continues to receive an enhanced match rate from the Federal Medicaid Assistance Program to transition individuals from an institutional setting into the community.

Waiver Case Management (WCM) Portal. CHFS has contracted with Deloitte to enhance the kynect portal to include a WCM system. The portal will allow for consumer and agency assisters to apply for waiver services in addition to programs like Low Income Heat and Energy Assistance Program (LIHEAP), Temporary Assistance to Needy Families (TANF) and Women's, Infants and Children (WIC). Additionally, the system will prompt individuals to apply for additional services they may be eligible for, including waivers, based upon responses to questions related to insurance coverage and physical and behavioral health care needs.

The afore summaries are not an exhaustive list of services and supports that are available within community settings, yet provides for a "high-level" overview of the significant changes that have occurred since the initial Olmstead Plan.

Goals, Strategies and Current Progress

Following are nine (9) goals of Kentucky's current Olmstead Plan with corresponding strategies (FY 2013 – FY 2015). Given the Olmstead Plan is a "living" document, updates have been provided as indicated at the time of distribution. A complete summary will be provided in FY 2015.

Goal 1: All persons with any disability will experience, meaningful, inclusive and integrated lives in their community supported by an array of services, in a setting of which they chose, according to individual need, with required input from their families and legal guardians.

Strategy 1.1: Medicaid expansion criteria will be fully implemented by October 1, 2013.

Strategy 1.2: The Health Benefits Exchange (Kynect) portal will provide open access to all eligible individuals who apply, into Medicaid or a Qualified Health Plan beginning October 1, ~~2103~~2013.

As of April 1, 2014, 370,829 Kentuckians have enrolled in new health coverage and of that number, 293,802 qualified for Medicaid coverage whereas 77,027 purchased private insurance.

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Strategy 1.3: Increase availability of an array of behavioral health services [i.e., Assertive Community Treatment (ACT), Crisis Intervention/Response, and substance abuse treatment] within a Medicaid State Plan amendment by January 1, 2014.

As of January 2014, a Medicaid State Plan Amendment includes the addition of evidence based practices such as Assertive Community Treatment (ACT) and increased provisions of Crisis Interventions as well as substance abuse services. ACT is an intensive and highly integrated approach for community mental health service delivery. ACT teams support individuals whose symptoms of mental illness result in serious functioning difficulties in several major areas of life, often including work, social relationships, residential independence, money management, and physical health and wellness. Crisis Intervention services will be expanded to include multiple response modalities and substance abuse treatment will also be added to the state plan for the first time in Kentucky's Medicaid State Plan history.

Strategy 1.4: The Office of Health Policy will submit an application for the Centers for Medicare and Medicaid Services' Balancing Incentive Program by October 31, 2013 and will have a fully developed work-plan for implementation by April 30, 2014.

Kentucky has qualified for a 2% enhanced Federal Match Assistance Plan rate to move towards expending more than 50% of Medicaid dollars on home and community based services in comparison to institutional care. The application has been accepted and approximately $25M will be expended to increase the number of slots in the following waivers: ABI, Michelle P., and SCL. The enhanced funding will be available through September, 2015. Additional deliverables include implementation of conflict free case management, examination of core standardized assessments (subject to public input and inspection during examination and finalization), and strengthening No Wrong Door/Single Entry Points across waivers.

Strategy 1.5: Revise the Home and Community Based (HCB) waiver and corresponding regulations to include home delivered meals, broader personal services definition, increase hours of occupational and physical therapy, and increase in home modification limits by December 1, 2015.

The Department for Aging and Independent Living (DAIL) in collaboration with the Department for Medicaid Services has revised the HCB waiver and received approval from the Centers for Medicare and Medicaid Services (CMS). Next, DAIL will revise the HCB regulations to correspond with the HCB waiver amendments to enhance services to include home delivered meals, flexibility with personal services definitions (blending homemaker with personal care thereby allowing for multi-tasking), and increasing home modification limits.

Strategy 1.6: The DBHDID will collaborate with community partners to implement key components of the Building Bridges Initiative within the Cabinet for Health and Family Services. An initial implementation plan will

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be developed to include enhancing DBHDID policies and practices to address the top 3 priorities by December 1, 2014.

Strategy 1.7: Review and revise each HCB 1915c waiver assessment, as needed, to identify any necessary changes to facilitate a person-centered, comprehensive care plan for any individual, regardless of disability by December 1, 2015.

Strategy 1.8: All assessment tools, not individual assessments, are considered public documents available for public inspection.

Strategy 1.9: To ensure that eligible individuals have opportunity to make fully informed choices about available services in settings of their choice, the DBHDID will prepare, with opportunity for public input, a document providing information on all service options within the Commonwealth, including but not limited to family supports, HCB waiver services, private and public Intermediate Care Facilities for Persons with Intellectual and Developmental Disabilities, and psychiatric supports by January 1, 2015. This document will be made available at all Aging and Disability Resource Centers, designated as the No Wrong Door/Single Point of Entry, and to anyone inquiring about DBHDID services.

Goal 2: Education/Outreach as prevention of facility placement.

Strategy 2.1: Kynect will include a portal to seamless Medicaid and waiver eligibility by January 1, 2015, ensuring eligible beneficiaries are fully informed about service options, as required by Medicaid.

Strategy 2.2: Mental Health First Aid and Youth Mental Health First Aid training for trainers will be held by December 1, 2014 in order to allow for at least one Mental Health First Aid and Youth Mental Health First Aid Trainer in all community mental health center regions of the state.

Strategy 2.3: School based mental health screenings will be implemented in all middle and high schools in six (6) districts by May 31, 2015.

Strategy 2.4: The Regional Interagency Councils will be offered technical assistance at a minimum, each quarter or more often as needs are identified, to increase the RIACs ability to provide targeted consultation for youth in their community in need of mental health and substance abuse services by December 31, 2013.

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Strategy 2.5: Expand role of Aging and Disability Resource Centers at the State level to continue to be designated as the No Wrong Door/Single Point of Entry for anyone with any disability by January 30, 2015.

Goal 3: Assure that persons with disabilities are not incarcerated for minor offenses that are a result of their disability. Assure persons with disabilities who leave correctional facilities are able to access needed ~~community-based~~ services, according to individual choice and need, with required family and legal guardian input.

Strategy 3.1: Through Senate Bill 200, of the 2014 Kentucky General Assembly, the Department for Juvenile Justice's Family Accountability Intervention Response Team will develop enhanced case management plans and opportunities for services for children who have an assessment score of "high need" to reduce the incarceration of children younger than 18 charged with noncriminal "status" offenses.

Strategy 3.3: DBHDID will continue to participate in quarterly Interagency Review meetings hosted by the Kentucky Department of Corrections (DOC) and to utilize Federal Block Grant dollars to support the Re-integration Specialist who is charged with facilitating the successful community reentry of individuals who are severely mentally ill.

Strategy 3.4: DBHDID will seek data on the effectiveness of diversion for existing Mental Health Courts in Louisville, Hardin County, and Northern Kentucky, and make recommendations accordingly.

Strategy 3.5: Release from prison will continue to be considered as a "qualifying event" for healthcare coverage through Kentucky's Health Benefits Exchange when enrolled within sixty (60) days of reentry into the community.

Strategy 3.6: Individuals with drug felony convictions who have completed drug or alcohol treatment will remain eligible to receive Temporary Assistance for Needy Families (TANF) and/or Supplemental Nutrition Assistance Program (SNAP) upon release.

Goal 4: All transition age youth (14 – 25 years old) will have a seamless transition to adulthood through the effective and efficient use of evidence based programs and practices that are developmentally and functionally appropriate, according to individual choice and need, with required family and guardian input.

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Strategy 4.1: DBHDID will address the needs of youth and young adults between 15-30 years old with early serious mental illness by developing the capacity to implement and sustain Coordinated Specialty Care (CSC) for this population. The OnTrackNY model, with some modifications to include Oregon's Early Assessment and Support Alliance (EASA) model will be utilized allowing for the flexibility needed to implement the program in both urban and rural pilot sites by December 2015, with the goal of statewide implementation within six years.

Strategy 4.2: A specialized transition age youth training (Transition Age Youth Launching Realized Dreams – TAYLRD) focusing on developmental issues, best practices related to this population and local community based resources will continue to be offered as requested by community partners across all community mental health center regions of Kentucky.

Strategy 4.3: The DBHDID will provide support in the development and coordination of a Youth Peer Support Specialist Core Competency Training in order to adequately prepare Youth Peer Support Specialists in these support roles. The first core competency training will be conducted by September 1, 2014

Strategy 4.4: The Commission for Children with Special Health Care Needs will provide trained young adult mentors with special health care needs who have successfully transitioned to assist consenting youth ages 16-20 with special health care needs who are transitioning to adulthood. Of those referred, the goal is to pair 90% ~~will be~~ successfully ~~paired~~ with a mentor. Participation is voluntary based on informed consent from individuals, or where appointed, their legal guardians. The decision-making authority of a legal guardian, provided by a court of law, is not supplanted or circumvented by the appointment of a mentor. Mentors are required to provide individuals and their families and legal guardians with information about on all service options within the Commonwealth, including but not limited to family supports, HCB waiver services, private and public Intermediate Care Facilities for Persons with Intellectual and Developmental Disabilities, and psychiatric supports.

Strategy 4.5: The Department for Community Based Services (DCBS) will engage in multiple initiatives to increase the utilization of in-home services and community-based placements for children in foster care as measured by the Foster Care FACTS sheet.

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Goal 5: Increase available, accessible, quality, and affordable community housing to accommodate individual choice according to need, with required input from families and legal guardians.

Strategy 5.1: Kentucky Housing Corporation will enter into a formal partnership with DBHDID and Department for Medicaid Services in order to apply for HUD Section 811 Project Rental Assistance, which provides funding to develop and subsidize rental housing with the availability of supportive services for adults with very low income who also have a disability, by April 1, 2014

The application has been submitted to the U.S. Department of Housing and Urban Development.

Strategy 5.2: Kentucky Housing Corporation, in partnership with CHFS, will open a funding round for rental housing for persons with a disability by April 1, 2014.

Goal 6: Ensure a safe and appropriate transition from an institution to a community setting, when transition is supported by the individual, with required input from his/her family and legal guardian.

Strategy 6.1: A new living arrangement category in the State Supplementation Program administered by DCBS, Community Integration Supplementation, will enable individuals with serious mental illness (SMI) to live in their own homes if they so choose, rather than a congregate setting, by January 1, 2014.

Strategy 6.2: The DBHDID will implement a Transition Age Youth Consultation Process to provide recommendations to community partners for inclusion in a plan to support transition to an adult-oriented, permanent, stable living situation and treatment services and supports by December 1, 2014.

Strategy 6.3: Transition ~~175~~ clients from an institutional setting into various community settings with supports through the Money Follows the Person (MFP) demonstration program during calendar year 2015, according to individual choice, with required input from families and guardians.

Comment [T6]: KCFN and VOR object strongly to quotas. The pursuit of arbitrary numeric goals trump person-centered planning and choice, risking the health and welfare of those impacted. Transitions from institutional settings to community settings must be at the direction of each affected individual, not a quota.

Strategy 6.4: In response to the Interim Settlement Agreement between the Cabinet for Health and Family Services (the Cabinet) and Protection and Advocacy, the Cabinet will provide Housing Assistance to six hundred (600) individuals with Severe Mental Illness and residing or at risk of residing in a Personal Care Home, as follows:

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6.1.1. By October 1, 2014 the Cabinet will provide Housing Assistance to at least 100 individuals with approximately half given to state wards and half to others.
6.1.2. By October 1, 2015 the Cabinet will provide Housing Assistance to at least 200 additional individuals with approximately half given to state wards and half to others.
6.1.3. By October 1, 2016 the Cabinet will provide Housing Assistance to at least 300 additional individuals with approximately half given to state wards and half to others.

Comment [T7]: As stated above, we object to quotas for service planning as they are antithetical to true person-centered planning.

Strategy 6.5: DBHDID will collect data on discharges from the four state owned/contracted acute psychiatric hospitals to personal care homes (PCH) and other congregate settings beginning May 2014.

Strategy 6.6: Regional Olmstead Committees, facilitated by the four state owned/contracted acute psychiatric hospitals, will continue to meet quarterly to problem solve barriers to discharge for patients with inpatient length of stays greater than ninety (90) days. By January 1, 2015, Regional Olmstead Committees will be expanded to include ICF provider and ICF family representatives.

Strategy 6.7: DBHDID will collect and analyze data on use of voluntary outpatient commitment orders (KRS 202A) for individuals discharged from the four state owned/ contracted acute psychiatric facilities beginning July 1, 2014.

Strategy 6.8: DBHDID is committed to ensuring that those transitioning from Intermediate Care Facilities (ICF) continue to receive the utmost quality of care in the community. Four Intermediate Care Clinics will be opened throughout the state to ensure access to specialized medical, behavioral, and other therapeutic services for individuals with developmental and/or intellectual disabilities beginning June 2014.

Strategy 6.9: DBHDID will every six months collect, analyze and report data on the outcomes of individuals transitioning from ICFs to community settings, including but not limited to mortality, hospitalizations, abuse, neglect, interactions with the Department of Correction, and additional transitions following the initial transition to the community.

Strategy 6.10: An autopsy will be performed in each case in which an individual is, or has been, under the care of CHFS within three months of his/her passing.

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Goal 7: Kentuckians with disabilities will have choices for ~~competitive, meaningful, and sustainable~~ employment in the most integrated setting according to individual choice and need.

Strategy 7.1: The Commonwealth Council on Developmental Disabilities (CCDD) will implement a pilot project on Asset Based Community Development approaches to employment by June 30, 2016. The objective is to utilize community assets and personal assets of people with disabilities to guide in integration of people with disabilities.

Strategy 7.2: Increase awareness, understanding and access to the Individual Placement and Support (IPS) model of supported employment for young adults between 18-25 years old by implementing developmentally appropriate marketing strategies, resource guides, and a clear business plan for the expansion of IPS in Kentucky by December 2014.

Strategy 7.4: The Department for Medicaid Services and Behavioral Health, Developmental, and Intellectual Disabilities will continue to support individual choice by offering~~offer~~ enhanced supported employment assistance within the Supports for Community Living through Day Training, Person-Centered Coaching, and Supported Employment if funding is no longer available through the Office of Vocational Rehabilitation, beginning January 1, 2014.

The Departments submitted the provisions within the Medicaid State Plan Amendment and it has been approved by the Centers for Medicare and Medicaid Services.

Goal 8: Individuals with disabilities will have access to reliable, cost-effective, and accessible transportation choices that support the essential elements of life such as employment, housing, education, and social connections.

Strategy 8.1: Fully implement the new service provision within the Supports for Community Living waiver to include transportation reimbursement. Throughout calendar year 2014, each waiver participant will be assessed for the need of transportation reimbursement sixty (60) days prior to their birth month.

Strategy 8.2: The Cabinet for Health and Family Services will continue to seek partnerships with public and private providers and convene discussions to identify innovative strategies for addressing transportation needs for individuals with a disability by June 1, 2015.

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Goal 9: Ensure allocation of quantifiable, measurable tasks in regard to the elements of the Olmstead plan, including regular updates in order to ensure that the Commonwealth progresses toward the Vision of protecting the rights of persons with disabilities. In order to do so, the Commonwealth will sustain a Cabinet level *Olmstead* Committee, measure progress on strategies, and update the Olmstead plan on a minimum of a biennial basis.

Strategy 9.1: The Cabinet's internal Olmstead Team will provide a draft plan to stakeholders by August 25, 2014.

Strategy 9.2: Olmstead Team will revise the Olmstead Plan based on stakeholder input by October 30, 2014.

Strategy 9.3: The Cabinet's Olmstead Plan will be used to inform budget decisions and requests by June 2015.

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