



OVERVIEW OF THE OLMSTEAD DECISION AND HOME AND COMMUNITY BASED SERVICES IN KANSAS

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SUMMARY

Prior to the 1960s, children and adults with disabilities in Kansas, as well as other states, were either in institutional settings, or in their homes without the services necessary to become as independent as possible. Beginning in the 1850s, Kansas began building institutions to house those with mental health disabilities, and later those with intellectual and developmental disabilities. Living conditions in these institutions were often substandard.

As a result of the passage of Federal and State laws, Kansas began moving away from institutionalization and toward community integration. Initially, people with disabilities were moved to smaller settings closer to their communities, such as intermediate care and nursing facilities. As these were still institutional settings, there was still a push for individuals to live in their own homes with support. Federal authority to fund Home and Community Based Services (HCBS) versus institutional settings, as well as the passage of the Americans with Disabilities Act in 1990 and the Supreme Court's "Olmstead decision" in 1999, resulted in a major and positive impact on the lives of youth and adults with disabilities.

In 1982, nine years before the passage of the Americans with Disabilities Act of 1990 and its subsequent protections for individuals with disabilities, and seventeen years before the Supreme Court's 1999 Olmstead decision, Kansas Medicaid received approval for its first HCBS waiver for people with disabilities and the elderly. Throughout the 1990s and into 2000, Kansas received approval for seven HCBS waivers to provide services that would meet the needs of youth and adults with different disabilities. At the same time, Kansas began closing its institutions, maintaining several for specific populations with specific needs. As of December 2019, 24,453 youth and adults with disabilities were receiving HCBS services.

The Kansas Department of Aging and Disability Services (KDADS) is responsible for overseeing the seven HCBS Waiver programs, which includes insuring compliance with the Centers for Medicare and Medicaid Services (CMS) requirements for home and community-based settings. KDADS is also responsible for individuals in institutional settings, i.e., the remaining State institutions, intermediate care facilities and nursing facilities, as well as addressing advocate concerns about these facilities and their residents.

Finally, while considerable progress has been made in moving people from institutions and other isolating settings to community settings, employment of youth and adults with disabilities lags their peers without disabilities. The Kansas Department of Health and Environment (KDHE) Division of Health Care Finance (DHCF), the Medicaid oversight agency, manages two employment incentive programs, *Working Healthy* and *Work Opportunities Reward Kansans (WORK)*. DHCF also has approval to implement a supported employment pilot program in their 1115 Demonstration Waiver.

INSTITUTIONS FOR INDIVIDUALS WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES

In 1881, a State Asylum for Idiotic and Imbecile Youth was established in Lawrence, Kansas. The asylum and its residents were moved to a location near Winfield, KS in 1897, eventually becoming Winfield State Hospital. In 1903 a State Hospital for Epileptics was established in Parsons, KS, and most of the patients came from the State asylums for the insane located in Topeka and Osawatomie, KS. Winfield also transferred some residents to Parsons because it did not want its residents without epilepsy to imitate epileptic seizures. In 1909 the Winfield institution was re-named the State Home for the Feeble-Minded and its upper age limit of 15 years old was removed. Eventually, the State Hospital for Epileptics in Parsons became over-crowded, resulting in Winfield adding three new buildings on their property to house the increasing number of residents.

By the early 1950s, nearly 2,400 individuals were residents in the two institutions. In 1959, the Kansas Legislature authorized the establishment of a new facility in Topeka, named the Kansas Neurological Institute. KNI opened its doors in 1960, helping to reduce the population at Winfield, although not at Parsons. In another effort to reduce over-crowding, the State Sanitorium for Tuberculosis in Norton, KS, was authorized to serve residents from both Parsons and Winfield. These individuals were housed in an empty building on the Norton grounds. 1967 saw the peak population of institutionalized residents; 2,979 individuals were residing in the four institutions. In 1968 the remaining patients with tuberculosis were transferred from Norton to a hospital in Chanute, KS, and the institution at Norton was re-named Norton State Hospital.

INSTITUTIONS FOR INDIVIDUALS WITH MENTAL HEALTH DISORDERS

Three asylums for the insane were established in Kansas during the 1800s and early 1900s, including the Kansas Insane Asylum near Osawatomie in 1857, the Topeka Insane Asylum in 1872 and Larned State Hospital for the Criminally Insane in 1914. All three asylums were later re-named State Hospitals. While woman and children were not originally placed in these institutions, by the second half of the 20th century the hospitals were accepting them as well as adult males. Rainbow Mental Health Facility, a 50-bed mental health facility, was opened in 1974 to alleviate some of the overcrowding at the other institutions.

NURSING HOMES

The number of nursing homes and residents increased in the United States between 1950 and 1970. It is roughly estimated that by 1970 there were 15,300 nursing homes in the United States housing 793,000 residents. This increase in utilization of nursing homes occurred after financial assistance for nursing home construction was made available by the Federal Housing Administration (FHA) in 1959, and again after Medicare and Medicaid were enacted in 1965, when the percentage of the cost borne by the federal government increased far more than that borne by state and local government.

While Kansas specific date is not readily available, nursing facilities were used to provide care for individuals with severe developmental and physical disabilities requiring acute and long-term care. Teens and adults in their prime were housed with people age 60 and above years with conditions such as dementia and age-related disabilities. Despite very different independent living, rehabilitation, recreational and social needs, young people were placed with elderly individuals whose health was declining and on average resided there three years before dying.

INSTITUTION CLOSURES

The conditions at the State institutions were, for the most part, substandard. Overcrowding, substandard nutrition, harsh punishment, and sporadic education and training dependent on the institution's administration and the climate of the times, were the rule rather than the exception. Families of people with intellectual disabilities were discouraged from maintaining contact with their institutionalized family member. Death at institutions, including murder, was taken lightly; deceased residents were buried on the grounds with only a number to mark their graves. Public policies promoting eugenics, castration, sterilization and isolation impacted these individuals lives for approximately the first half of 20th century. Human rights, personal choice, and independence were not concepts afforded these individuals.

The State began closing state hospitals for people with intellectual/developmental disabilities. In 1988 Norton State Hospital closed its program for this population and became a correctional facility. Winfield State Hospital closed in 1998. A recommendation to close KNI was made in

2009, however, based on concerns of some stakeholders, it was later decided not to close this facility.

As of December 31, 2019, there are 295 residents residing in the KNI and Parsons State Hospital; 134 at KNI and 161 at Parsons. For the most part, residents of KNI have medical needs, and Parsons State Hospital houses those with behavioral health issues, in addition to their intellectual/developmental disabilities.

Mental health services also moved away from a hospital to a community-based model. Children were no longer placed in the institutions. Topeka State Hospital closed in 1997. Rainbow Mental Health Facility, a 50-bed facility opened in 1974, closed in 2011. (It was briefly re-opened in 2014 as a 10-bed crisis stabilization resource). Larned and Osawatome State Hospitals remain open to serve specific populations. Larned currently has a 90-bed Psychiatric Services Program for voluntary and court committed individuals, the State Security Program for forensic evaluations and in-patient treatment and the Sexual Predator Treatment Program (SPTP). Osawatome State Hospital primarily houses individuals who are court committed. Children and adolescents requiring out-of-home mental health treatment receive this in Psychiatric Residential Treatment Facilities (PRTFs) for short-term periods, as a general rule less than two months

INTERMEDIATE CARE FACILITIES AND NURSING FACILITIES FOR MENTAL HEALTH

In 1971, Medicaid funds for Intermediate Care Facilities for Persons with Mental Retardation (ICF/MRs), now referred to as Intermediate Care Facilities for Individuals with Intellectual/Developmental Disabilities (ICF/IDDs), were authorized by the Federal Medicaid program. There are currently four private providers of ICF/IDD operating a total of 21 licensed facilities with 118 licensed “beds.” As of December 2019, 99 individuals were residing in these facilities.

During this same period, some individuals with less severe mental health issues were being placed in Nursing Facilities for Mental Health (NFMHs) as an alternative to state hospitals. These have resulted in unintended consequences. These were intended to be facilities for people with less severe conditions, shorter term stays and closer to their home, advocates are expressing concern that people are being sent to NFMHs unnecessarily and residents of NFMHs are remaining there

too long because of inefficient continued stay screening policies and processes, a lack of community services and a system incentivizing for private entities to keep people there motivated by profit.

While nursing homes continued to house individuals who were elderly and infirm, the implementation of the Nursing Facility (NF) Home and Community Based Services Waiver in the early 1980s saw the movement of both younger people with physical disabilities, as well as older adults with less acute needs, from institutional to community placement.

ESTABLISHMENT OF A COMMUNITY SUPPORT SYSTEM

Beginning in the 1960s, Kansas began to establish a community-based system to provide support and services for people with disabilities, including:

COMMUNITY MENTAL HEALTH CENTERS (CMHCS)

In 1961 a state law authorized counties to designate an entity as a community mental health center, either to serve a specific county or to cooperate with other counties to provide services. Legislation passed in 1964 allowed a mill levy in each of the 105 counties to support the community mental health centers.

Mental Health Reform Act of 1990 (K.S.A. 39-1601 through 39-1613) established the Community Mental Health Centers (CMHCs) as “gate keepers” and stated that no person may be admitted to a state psychiatric hospital for evaluation or treatment unless a qualified mental health professional employed by a mental health center has screened the person, and that the mental health professional must authorize the admission in writing.

COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATIONS (CDDOS)

In 1963 the Governor of Kansas appointed a Council on Mental Retardation. By 1967 there were 21 licensed Mental Retardation/Developmental Disability Centers in Kansas. 1974 saw the enactment of legislation establishing Community Mental Retardation Centers and a mechanism for state grants and local mill levies to fund them.

The Developmental Disability Reform Act of 1995 (K.S.A. 39-1801 - 39-1810), establishing the Community Developmental Disability Organizations (CDDOs) as the “gatekeepers” for intellectual/developmental services, and establishing that the policy of the State was to assist persons who have a developmental disability to have:

- a) services and supports which allow persons opportunities of choice to increase their independence and productivity and integration and inclusion into the community;
- b) access to a range of services and supports appropriate to such persons; and
- c) the same dignity and respect as persons who do not have a developmental disability.

CENTERS FOR INDEPENDENT LIVING (CILS)

Title VII Part B of the Rehabilitation Act of 1973 established grant funding for Centers for Independent Living (CILS). CILs are consumer-controlled, community-based, cross-disability, nonresidential, private nonprofit agencies that provide independent living services. At a minimum, CILS are required to provide the following core services:

- Information and referral
- Independent living skills training
- Peer counseling
- Individual and systems advocacy
- Services that facilitate transition from nursing homes and other institutions to the community

Beginning in 1978, Kansas received Federal Title VII, Part C funds to establish four CILs in the state; the Whole Person in Kansas City, Independence Inc. in Lawrence, Topeka Independent Living and Resource Center and LINK in Hays. In 1985, three additional CILS were established were funded with State General Fund (SGF) grants from Kansas Rehabilitation Services. Eventually there were 13 CILS covering the State using Federal or State funds. Currently there are ten CILS located throughout the state.

AREA AGENCIES ON AGING

Area Agencies on Aging (AAAs) were established under the Older Americans Act (OAA) in 1973 to respond to the needs of Americans 60 years old and over in every local community. By providing a range of options that allow older adults to choose the home and community-based services and living arrangements that suit them best, AAAs make it possible for older adults to “age in place” in their homes and communities. Title VI, Grants for Indian Tribal Organizations, was included in the 1978 Amendments to the OAA. Title VI Native American aging programs provide nutrition, supportive and caregiver services to older American Indians, Alaska Natives and Native Hawaiians. The Area Agencies on Aging serve as the designated “Single Point of Entry” for senior services in Kansas. While they may choose to provide other services, each AAA is required to provide the following services:

- Legal Services
- Nutrition--both congregate and home-delivered
- In-Home Services--which might include homemaker, chore, personal care or respite
- Disease Prevention/Health Promotion
- Access--which includes transportation, information and assistance, advocacy, outreach, and case management at some AAAs

The Kansas Department for Aging and Disability Services (KDADS) entered into a contract with the Southwest Kansas Area Agency on Aging, which sub-grants with the other 10 AAAs, to function as Aging and Disability Resource Centers (ADRC). ADRCs were implemented to provide a “one-stop” location for people to access all available information related to aging and disability services. KDADS also contracted with the AAAs to conduct functional assessments for several of the HCBS programs, including the Brain Injury, Frail Elderly and the Physical Disability Waivers.

OVERVIEW OF STATE AND FEDERAL DISABILITY LEGISLATION

During the first half of the 20th century, individuals with disabilities had little in the way of civil rights, and often experienced discrimination regarding their education, housing, mental health, training, employment and environmental access. The latter half of the century saw the passage of

both State and Federal legislation addressing the rights of children and adults with disabilities, culminating in the passage of the Americans with Disabilities Act of 1990.

STATE LEGISLATION

In addition to several of the Acts mentioned above, the Kansas Act Against Discrimination was passed by the Kansas Legislature in 1953. The original Act was limited to employment practices and did not include enforcement provisions. The act was amended several times, eventually including enforcement against discrimination in employment, free and public accommodation or in housing because of race, religion, color, sex, disability national origin and ancestry. In 1974, one year before the passage of Federal legislation, K.S.A. 72-961 mandated special education for children with disabilities with the passage of the Exceptional Children's Act.

FEDERAL LEGISLATION

From the 1960s on, Federal legislation addressing discrimination related to air travel and use of public transportation, architectural barriers, fair housing, mental health parity, telecommunications, voting accessibility and voter registration, assistive technology and electronic and information technology.

Three key pieces of legislation were the Mental Retardation and Community Mental Health Centers Construction Act of 1963, the Rehabilitation Act of 1973 and the Education of All Handicapped Children Act of 1975 (now called the Individuals with Disabilities Education Act), all of which addressed discrimination based on disability.

The above legislation would ultimately prove the framework for the key piece of legislation passed that addressed discrimination and supported the inclusion of people with disabilities; the Americans with Disabilities Act of 1990 (ADA). The ADA addressed discrimination in several areas, including employment, State and local government activities, public transportation, public accommodations, and telecommunication relay services.

Title II of the ADA specifically applies to State and local government entities, providing protection for qualified individuals with disabilities from discrimination based on disability in services,

programs, and activities provided by State and local government entities. The Supreme Court Olmstead Decision is related to Title II of the ADA.

OVERVIEW OF THE “OLMSTEAD DECISION”

Olmstead, Commissioner, Georgia Department of Human Resources, et al. v. L.C. by Zimring, guardian ad litem and next friend, et al

The “Olmstead Decision” was the result of a 1995 lawsuit filed by the Atlanta Legal Aid Society on behalf of two individuals with disabilities against the then Commissioner of the Georgia Department of Human Resources, Tommy Olmstead. The two individuals, Lois Curtis and Elaine Wilson, had diagnoses of a combination of mental health conditions and intellectual disabilities. The two women had been in and out of Georgia’s mental hospitals dozens of times. Following each stay in the hospital, they would return home and, lacking supports, would return to the hospital. Staff working with the two women agrees that they were better placed in the community if they had the appropriate supports.

The basis of the lawsuit was that the plaintiff’s representatives believed that the Georgia Department of Human Resources was violating their rights under Title II of the Americans with Disabilities Act (ADA). The ADA, Civil Rights legislation that prohibits discrimination against individuals with disabilities, also assures equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals. Title II of the ADA specifically provides that "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 the subject of discrimination by any such entity." 42 U.S.C. § 12132. Department of Justice regulations implementing this provision require that "a public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

The lawsuit was initially filed in May 1995 in the United States District Court for the Northern District of Georgia. In March 1997, Judge Marvin Shoob ruled in favor of the two plaintiffs, stating that the failure of the Georgia Department of Human Resources to place the two individuals in an appropriate community-based treatment program violated Title II of the ADA. The judge rejected the Department's argument that inadequate funding, rather than discrimination based on their disabilities, was the basis for their institutionalization. The Georgia Department appealed this decision in the 11th Circuit Court of Appeals, and again the decision came down in favor of the two plaintiffs. The Georgia Department then appealed to the United States Supreme Court. In December 1998 the Supreme Court agreed to hear the case; oral arguments were heard in April 1999. On June 22, 1999, the Supreme Court's decision was handed down in favor of the two plaintiffs.

Justice Ruth Bader Ginsberg wrote the opinion for the majority. In her opinion she stated that “institutional placement of person with disabilities who can handle and benefit from community setting perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life”, and that “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”. She concluded 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 reasonable accommodated, taking into account the resources available to the State and the needs of others with mental disabilities”.

CENTERS FOR MEDICARE AND MEDICAID SERVICES DIRECTIVES RE THE OLMSTEAD DECISION AND TITLE II

One method that the Centers for Medicare and Medicaid Services (CMS) uses to provide guidance to States regarding legislation, regulations, policies, etc., is through State Medicaid Director (SMD) letters. CMS, under their previous name of the Health Care Finance Administration

(HCFA), issued four such letters regarding the Olmstead Decision between July 1998 and January 2001.

In the Appendix A table, Kansas is listed as having an alternative plan, a 2006 publication titled Rebalancing Kansas' Long-Term Care System. This publication was the final product for a federal grant received by SRS in 2002.

JULY 29, 1998 SMD LETTER

This initial letter summarized three Medicaid cases related to the ADA in order to make States “aware of the recent trends involving Medicaid and the ADA”. Included in these summaries was the Olmstead Decision. CMS basically informed States that the Attorney General and the Department of Justice supported the ADA’s “most integrated setting” standard, and that:

- States have an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs.
- Reasonable steps should be taken if the treating professional determines that an individual living in a facility could live in the community with the right mixture of support services to enable them to do so.

CMS also pointed out that States were “to do a self-evaluation to ensure that their policies, practices and procedures promote, rather than hinder, integration”, and that this self-evaluation should include consideration of the ADA’s integration requirement. States that had not yet done their self-evaluation were told to do so.

JANUARY 14, 2000 SMD LETTER

The second SMD letter reiterated the Supreme Court’s decision, and pointed out that the Court’s suggestion that a State could establish compliance with Title II of the ADA if it demonstrated that it had:

- a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive setting, and

- a waiting list that moves at a reasonable pace not controlled by the State's endeavors to keep its institution fully populated.

CMS noted the responsibility of States to periodically review the services of all individuals in Medicaid-funded institutional placements to determine appropriateness of the placement.

While CMS did not require the development of a plan, they recommended that States do so to ensure the transition of qualified individuals into community-based services at a reasonable pace, as well as identify improvements that should be made. Recognizing that there is no single model plan appropriate for all States, CMS recommended that the following elements be included:

- Plan Development - Individuals with disabilities, and their families as appropriate, be involved in plan development, as well as an assessment of what partnerships are needed to ensure that the plan is comprehensive and works effectively.
- Assessments – A State should have a reliable sense of how many individuals are currently institutionalized and are eligible for services in community-based setting. Existing assessment procedures should adequately identify institutionalized individuals who can benefit from services in a more integrated setting, as well as individuals in the community who are at risk of placement in an unnecessarily restrictive setting. Finally, ensure the State can act in a timely and effective manner in response to the findings of any assessment process.
- Availability of Services – The plan should identify what services are available, what types of services may be needed, whether assistance is needed for individuals and families to access services, how services support integration, what funding sources are available, whether there is timely access to services and how services will be coordinated. The plan should examine the operation of waiting lists and what can be done to move individuals from waiting lists to services. The plan should also address how the current service system works for different populations and a discussion of what changes are needed, if necessary.
- Informed Choice – The plan should ensure informed choice on the part of individuals with disabilities and their families, and include what information, education and referral system are necessary to support informed choice.

- Quality – The State should ensure quality assurance, quality improvement and sound management to support the implementation of a health and long-term care system that results in placement in the most integrated setting becoming the norm.

JULY 25, 2000 SMD LETTER

The third SMD letter was primarily a policy clarification letter, summarizing CMS’s efforts to review Federal policies in three areas in order to facilitate fulfillment of the ADA.

JANUARY 10, 2001 LETTER

In this final letter SMD letter regarding Olmstead, CMS addressed questions related to State discretion in the design and operation of Home and Community Based (HCBS) waivers under section 1915(c) of the Social Security Act, as well as principals they would apply in their review of waiver applications and amendments.

1. Overall Number of Participants:

- a. May a State establish a limit on the total number of people who may receive services under an HCBS waiver?
 - i. Yes. Under 42 CFR 441.303(f)(6). Unlike Medicaid State Plan services, the waiver provides an assurance of service only within the limits on the size of the program established by the State and approved by the Secretary. The State does not have an obligation under Medicaid law to serve more people in the HCBS waiver than the number requested by the State and approved by the Secretary. States are required to specify the number of unduplicated recipients to be served under HCBS waivers. This number constitutes a limit on the size of the waiver program unless the State requests, and the Secretary approves, a greater number of waiver participants in a waiver amendment. If a State finds that it is likely to exceed the number of approved participants, it may request a waiver amendment at any time during the waiver year.

2. Fiscal Appropriation:

- a. May a State use the program’s funding appropriation to specify the total number of people eligible for an HCBS waiver?
 - i. CMS allows States to indicate that the total number of people to be served may be the lesser of either (a) a specific number pre-determined by the State and approved by CMS, or (b) a number derived from the amount of money the legislature has made available (together with corresponding Federal match).

3. Access to Services Within a Waiver

- a. May a State have different service packages within a waiver?
 - i. No, a State is obliged to provide all people enrolled in the waiver with the opportunity for access to all needed services covered by the waiver and the Medicaid State plan.

4. Sufficiency of Amount, Duration, and Scope of Services

- a. What principles will CMS apply in reviewing limitations that States maintain with respect to waiver services?
 - i. Federal regulations at 42 CFR 440.230(b) require that each Medicaid service must be sufficient in amount, duration, and scope to achieve the purpose of the service category. Within this broad requirement, States have the authority to establish reasonable and appropriate limits on the amount, duration and scope of each service.

5. Amendments that Lower the Potential Number of Participants

- a. May a State reduce the total number of people who may be served in an HCBS waiver? Are there special considerations that need attention in such a case?

- i. A State may amend an approved waiver to lower the number of potential eligible individuals subject to certain limitations. CMS specified those limitations in the letter.

6. Establishing Targeting Criteria for Waivers

- a. How much discretion does a State have in establishing the targeting criteria that will be used in a waiver program? May a State define a target group for the waiver that encompasses more than one of the categories of individuals listed in 42 CFR 441.301(b)(6)?
 - i. Under 42 CFR 441.301(b)(6), HCBS waivers must “be limited to one of the following targeted groups or any subgroup thereof that the State may define: (i) aged or disabled or both, (ii) mentally retarded or developmentally disabled or both, (iii) mentally ill.” States have flexibility in establishing targeting criteria consistent with this regulation. States may define these criteria in terms of age, nature or degree or type of disability, or other reasonable and definable characteristics that sufficiently distinguish the target group in understandable terms.

In his 2013 Paper, *The ADA, Olmstead and Medicaid: Implications for People With Intellectual and Developmental Disabilities*, Charles Moseley, Ed.D. states:

“It is important to note that states may use alternative strategies that accomplish the goals of an Olmstead plan. As of 2010, 26 states had written Olmstead plans while 18 states had published alternative strategies. The remaining seven states were reported to have neither an Olmstead plan nor an alternative response to Olmstead.” See **Appendix A: A Table of State Olmstead plans and related state activity** by Marshall Alameld, MSN; Martin Kitcehner, PhD, MBA; Alice Wong, MS; Charlene Harrington, PhD, RN, FAAN. September 2008

Kansas is listed as having an alternative activity, and provides a 2006 publication, *Rebalancing Kansas’ Long Term Care System*, the final product for a federal grant received by SRS in 2002. In 2001, CMS began funding *Real Choice System Change* grants to assist states to change their

long-term care system from an institutional model to a community-based model. Additional information regarding the Kansas grant can be found in **Appendix B**.

COMMUNITY INTEGRATION IN KANSAS

1915(C) HOME AND COMMUNITY BASED SERVICES WAIVER AUTHORITY

Congress authorized Home and Community Based Service (HCBS) waiver under section 1915(c) amendment of the Social Security Act, created as a part of the Omnibus Budget Reconciliation Act of 1981. Section 1915(c) allowed states to provide home and community-based services for individuals who preferred to receive their services at home rather than in an institution. This authority was a result of findings that a disproportionate percentage of Medicaid resources were being used for institutional long-term care and that there was an “institutional bias” in the Medicaid benefit and eligibility system, studies showing that at least one-third of persons residing in Medicaid-funded institutional settings were capable of living at home or in the community if support services were provided, residents in institutions and intermediate care facilities frequently reported an unsatisfactory quality of life, and that a number of court cases resulted in orders to deinstitutionalize persons with intellectual/developmental disabilities.

Unlike Medicaid state plan services, Section 1915(c) waiver authority allows states to target a specific population for community-based services, disregard the state-wideness requirement, and provide services for people whose income and/or resources are above the Medicaid allowed limit. States may apply for and operate any number of waivers, addressing the needs of different target populations. States may also provide a combination of medical and non-medical services, e.g., home-health, personal care assistance, adult day services, supported employment, etc. HCBS waivers must:

- demonstrate that providing services in the home and community will not cost more than those provided in an institutional setting
- ensure the protection of the health and welfare of HCBS participants

- provide adequate and reasonable provider standards to meet the needs of the target population.

HOME AND COMMUNITY BASED SERVICES FINAL RULE

In 2014, the Centers for Medicare and Medicaid Services (CMS) published a revised version of regulations for HCBS. The regulation defines covered authorities as 1915(c), 1915(i) and 1915(k), however, CMS has made clear that other vehicles for providing Home and Community-Based (HCB) long term services and supports (LTSS), including 1115 Demonstration Waivers, will also be subject to these requirements. The statute specifies that home and community-based settings do not include a nursing facility, institution for mental diseases, or an intermediate care facility for individuals with intellectual disabilities.

The HCBS Final Rule involves several changes for HCBS waivers and imposes new requirements on what is considered appropriate in these settings. The final rule requires that all home and community-based settings meet certain requirements. The transition period to come into compliance with the HCBS Final Rule ends March 17, 2022. Requirements include that the setting:

- is integrated in and supports full access to the greater community
- is selected by the individual from among setting options
- ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint
- optimizes autonomy and independence in making life choices
- facilitates choice regarding services and who provides them.

The Final Rule also includes additional requirements for provider-owned or controlled home and community-based residential settings, including:

- the unit or dwelling is a physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services,
- the individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit

- the individual controls his/her own schedule including access to food at any time
- the individual can have visitors at any time
- the setting is physically accessible.

KDADS is responsible for ensuring that HCBS settings are compliant with the final Rule.

KANSAS HOME AND COMMUNITY BASED SERVICE WAIVERS

In 1982, Kansas was among the first states to apply for a waiver. Designed to provide services in the community for individuals who were elderly, and those with intellectual/developmental and physical disabilities, this HCBS program was referred to as the Nursing Facility (NF) Waiver. By the passage of the ADA, Kansas Medicaid had implemented two HCBS waivers; in 1982, the Department of Social and Rehabilitation Services (SRS), at that time the single-state Medicaid agency, implemented the Nursing Facility Waiver, providing services for individuals with disabilities and those who were elderly. In 1991, CMS approved the Mental Retardation/Developmental Disability Waiver (MR/DD) Waiver, which included community services specifically designed for this population. The MR/DD Waiver is now referred to as the Intellectual/Developmental Disability Waiver (I/DD). The Nursing Facility (NF) Waiver continued to provide community services people who were elderly and those with significant physical disabilities.

Prior to the Olmstead decision, three additional waivers were approved and implemented, including the Head Injury (HI) Waiver in 1986, the Technology Assisted (TA) Waiver for children in 1995, and the Serious Emotional Disturbance Waiver (SED) for children in 1997. In 1997 advocacy efforts resulted in the NF Waiver being divided into two waivers, the Frail Elderly (FE) and the Physical Disability (PD), to better meet the needs of each population. By the year 2000, SRS had implemented and was administering six HCBS waivers. A seventh waiver, the Autism Waiver designed to provide early intervention services for young children, was added in 2007.

Currently, Federal law does not allow Medicaid to pay for care in most psychiatric hospitals. This is referred to as the Institutions for Mental Disease (IMD) Exclusion. Specifically, the law prohibits payment for adults between ages 21- 64 in hospitals or treatment facilities that have more than 16 beds and that *primarily* provide mental health or substance use care.

Due to the IMD Exclusion, it was not possible for SRS to use 1915(c) waiver authority to provide HCBS for adults with mental health issues. Under this authority, States must demonstrate that the cost of the HCBS would be no higher than costs in an institutional setting. As State mental health institutions are funded by State government and do not involve Federal Financial Participation (FFP), there is no Federally funded institutional equivalent by which to demonstrate cost neutrality.

AUTISM WAIVER

The Autism Waiver provides support and training for parents with children with an Autism Spectrum Disorder (ASD) diagnosis to help ensure children, age 0 – 5 years can remain in their home and avoid placement in an in-patient psychiatric treatment facility for children up to the age of 21. To be eligible for the Autism Waiver, a child must meet the following criteria:

- 0-5 years of age
- diagnosed with an Autism Spectrum Disorder, Asperger's Syndrome or a Pervasive Developmental Disorder – Not Otherwise Specified
- meet the level of care eligibility score
- financially eligible for Medicaid

Autism services are limited to three years; however, an additional year of service is available in some cases based upon a review process. Requirements for this one-year extension of services include the following:

- the child must meet eligibility based on the Level of Care assessment at the annual review on the third year of services
- data collected by the child's Managed Care Organization must demonstrate a need for continued Autism Waiver services.

Services include

- Family Adjustment Counseling
- Parent Support and Training (peer to peer)
- Respite Care

CMS approved the most recent Autism Waiver application for a maximum of 65 children. As of December 31, 2019, 48 children were receiving Autism Waiver Services; 328 were on the Proposed Waiver Recipient list. This list is used to identify children who may be eligible for Autism Waiver services once a slot becomes available. If parents are interested in obtaining services for their child, functional and financial eligibility are determined. If both eligibility requirements are met, waiver services are offered if available. 22 offers were made in late September 2019; the majority are still waiting for services to begin due to a lack of providers.

BRAIN INJURY WAIVER

The Brain Injury (BI) waiver is a habilitative/rehabilitation and independent living program with an emphasis on the development of new independent living skills and/or re-learning of lost independent living skills due to an acquired or traumatic brain injury. Participants who have a medically diagnosed brain injury receive intensive therapies and services

To be eligible for the BI waiver, an individual must be:

- age 16 to 65 years of age (ages 0 to 16 to be added momentarily)
- a resident of the state of Kansas;
- determined disabled or have a pending determination by the Social Security Administration;
- financially eligible for Medicaid

Eligibility requirements also include that the individual:

- have a documented medical diagnosis of acquired or traumatic brain injury or acquired brain injury verified by an accepted medical provider. (Brain injuries due to chromosomal or congenital diagnosis do not qualify for the BI waiver). To qualify under a Brain Injury diagnosis the participant must meet the criteria for placement in a Traumatic Brain Injury Rehabilitation Facility. For ages 0 to 3 years, the participant must have documentation from a physician indicating a Brain Injury diagnosis; for ages four years and older, the participant must meet level of care required for hospital placement
- have an active habilitation/rehabilitation need for Brain Injury therapies

Participants between the ages of 4-65 years must meet the level of care criteria based on the state approved Medicaid Functional Eligibility Instrument (MFEI) completed by the Aging and Disability Resource Center

BI Waiver Services include:

- Assistive Services
- Financial Management Services
- Home-Delivered Meals
- Medication Reminder Services
- Personal Emergency Response System and Installation (PERS)
- Personal Care Services (PCS)
- Rehabilitation Therapies: Behavior Therapy, Cognitive Rehabilitation, Physical Therapy, Speech-Language Therapy, and Occupational Therapy
- Enhanced Care Services (ECS)
- Transitional Living Skills (TLS)

CMS approved the most recent Brain Injury application for a maximum of 534 individuals. As of December 2019, 451 individuals are receiving services.

FRAIL ELDERLY WAIVER

The Frail Elderly Waiver provides home and community-based services for individuals over age 65 as an alternative to nursing home care. To be eligible for the FE waiver, an individual must:

- be 65 years old or older
- meet the Medicaid nursing facility threshold score
- be financially eligible for Medicaid

FE Waiver services include:

- Adult Day Care
- Nursing Evaluation Visit
- Oral Health Services

- Personal Emergency Response
- Enhanced Care Services
- Wellness Monitoring
- Medication Reminder
- Assistive Technology
- Personal Care Services
- Comprehensive Support
- Financial Management Services
- Home Telehealth

The most recent FE Waiver application was approved by CMS for a maximum of 7,618 individuals. As of December 2019, there are 4,882 individuals receiving services. There is no waiting list for the FE Waiver services.

INTELLECTUAL/DEVELOPMENTAL DISABILITY WAIVER

The I/DD Waiver serves individuals age five and above who meet the definition of intellectual disability, having a developmental disability or are eligible for care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). Those with a developmental disability may be eligible if their disability was present before age 22 and they have a substantial limitation three or more areas of life functioning. To be eligible for I/DD Waiver services, and individuals must:

- be five years of age or older
- have Intellectual Disability that began before the age of 18
- have a diagnosis of a Developmental Disability that began before the age of 22
- be determined program eligible by the Community Disability Determination Organization
- meet the Medicaid long-term care institutional threshold score
- be financially eligible for Medicaid

I/DD Waiver services include:

- Assistive Services
- Adult Day Supports
- Financial Management Services

- Medical Alert-rental
- Overnight Respite
- Personal Care Services
- Residential Supports for Adults
- Residential Supports for Children
- Enhanced Care Services
- Specialized Medical Care
- Supported Employment
- Supportive Home Care
- Wellness Monitoring

Targeted Case Management is also available through the Medicaid State Plan to anyone eligible for I/DD services.

The most recent I/DD Waiver application was approved by CMS for a maximum of 9,111 individuals. As of December 31, 2019, there are 9,112 individuals receiving services. At that time there were 4,098 individuals on the waiting list. It should be noted that, at the peak, 2,979 were residing in the four I/DD State Hospitals versus triple that number currently receiving I/DD Waiver services.

PHYSICAL DISABILITY WAIVER

The PD Waiver serves individuals 16 to 64 years of age who meet the criteria for nursing facility placement due to their physical disability, are determined disabled using Social Security criteria, and are Medicaid eligible. To be eligible for the PD waiver, an individual must meet the following criteria:

- at least 16 years of age, and no older than 64 years
- determined disabled by the Social Security Administration
- need assistance to perform activities of daily living
- meet the Medicaid nursing facility threshold score
- financially eligible for Medicaid

Services include:

- Assistive Services
- Financial Management Services
- Home-Delivered Meals
- Medication Reminder Services
- Personal Emergency Response System and Installation
- Personal Care Services
- Enhanced Care Service

The most recent PD Waiver application was approved by CMS for a maximum of 6,147 individuals. As of December 2019, there are 6,098 individuals receiving services. At that time there were 1,459 individuals on the waiting list.

SEVERE EMOTIONAL DISTURBANCE WAIVER

The SED Waiver provides children with some mental health conditions special intensive support to help them remain in their homes and communities and avoid placement in a PRTF. The term “serious emotional disturbance” refers to a diagnosed mental health condition that substantially disrupts a child's ability to function socially, academically, and/or emotionally. Parents and children are actively involved in planning for all services. To be eligible for SED Waiver services, the child must:

- be age 4-18 years old
- have a diagnosed mental health condition which substantially disrupts the ability to function socially, academically, and/or emotionally
- be at risk of inpatient psychiatric treatment
- meet the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child Behavior Checklist (CBCL) threshold for eligibility
- be financially eligible for Medicaid

Services include:

- Parent Support and Training
- Independent Living/Skills Building
- Short Term Respite Care
- Wraparound Facilitation
- Professional Resource Family Care
- Attendant Care

The most recent SED Waiver application was approved by CMS for a maximum of 6,147 individuals. As of December 2019, there are 3,289 youth receiving services. There is no waiting list for the SED Waiver.

TECHNOLOGY ASSISTED WAIVER

The Technology Assisted (TA) waiver provides services for children ages 0 through 21 years who are chronically ill or medically fragile and dependent upon a ventilator or medical device to compensate for the loss of vital bodily function. Eligible individuals require substantial and ongoing daily care by a nurse comparable to the level of care provided in a hospital setting to avert death or further disability. To be eligible for the TA waiver, the child must meet the following criteria:

- be between 0 and 21 years of age
- meet the HCBS Technology Assisted Program definition
- require one or more of the identified primary medical technology(ies) and meet the minimum technology score for the specified age group
- meet the minimum nursing acuity level of care threshold for the specified age group
- be financially eligible for Medicaid

Services include:

- Health Maintenance Monitoring

- Home Modification
- Financial Management Services (FMS)
- Intermittent Intensive Medical Care
- Personal Care Services (PCS)
- Medical Respite
- Specialized Medical Care (SMC)

The State does not limit the number of children that can be on the TA Waiver. As of December 2019, there are 573 individuals receiving services. There is no waiting list for the TA Waiver.

MONEY FOLLOWS THE PERSON

Money Follows the Person (MFP) was a federal demonstration grant program designed to support state efforts to re-balance their long-term programs so that individuals have a choice of regarding where they live and receive services and supports. In Kansas the program began in 2008. Target populations included individuals with intellectual/developmental disabilities, the frail elderly, and those with physical disabilities and traumatic brain injury. Between 2008 and 2018, 1,728 individuals were moved from institutional to community settings as a result of MFP. During the grant period, the federal government provided an enhanced federal match to enable states to move individuals who had lived in a nursing facility a minimum of six months to move into the community. In addition to HCBS, participants received services that allowed them to transition to community living. MFP ended in December 2018, with a short-term funding extension through December 2019.

EMPLOYMENT INCENTIVE PROGRAMS

WORKING HEALTHY

Working Healthy, the Kansas Medicaid Buy-In program, was authorized under the Ticket-to-Work and Work Incentives Improvement Act of 1999 (TWWIIA). Medicaid Buy-In programs were one of several work incentives within TWWIIA. The intent of the Act was to:

- increase Social Security beneficiary's choice in obtaining rehabilitation and vocational services

- remove barriers that require people with disabilities choose between health care coverage and employment
- eliminate employment disincentives, thereby encouraging people with disabilities to reduce their reliance on public benefits by becoming employed or increasing employment.

Fear of losing health care coverage is a major barrier to employment for individuals with disabilities. Implemented in 2002 by SRS based on a Legislative directive, *Working Healthy* allows individuals with disabilities to work, increase their income and accumulate assets, without losing Medicaid coverage. It provides Kansans with disabilities the opportunity to participate in the workforce, become more economically independent, decrease their dependence on public benefits, and still maintain health care.

To be eligible for *Working Healthy*, individuals must:

- be between the ages of 16 and 65
- determined disabled using Social Security Administration criteria
- be employed and provide proof of employment paying FICA or SECA
- earning at least the minimum hourly wage
- a Kansas resident

Working Healthy incentives include:

- elimination of a spenddown or client obligation (participants in the program whose countable income is above 100% of the Federal Poverty Level pay a premium for their coverage)
- income up to 300% of the Federal Poverty Level (FPL)
- resources up to \$15,000 per household
- full and consistent Medicaid coverage
- unlimited retirement accounts

- assistance with Medicare expenses
- payment of employer premiums in some instances
- Medicaid coverage when determined by Social Security to be “Medically Improved”
- Benefits planning and assistance by certified *Working Healthy* Benefits Specialists
- personal assistance and other services provided through a program called *Work Opportunities Reward Kansans (WORK)*

As of November 2019, 1,150 individuals were enrolled in *Working Healthy*.

WORK OPPORTUNITIES REWARD KANSANS (WORK)

WORK is the program through which individuals enrolled in *Working Healthy* who require services to live and work in the community receive them. *WORK* is not authorized under the 1915(c) HCBS Waiver authority. *WORK* was originally authorized as a Benchmark Benefit Plan under the Deficit Reduction Act of 2005, and later re-authorized under the Patient Protection and Affordable Care Act of 2010 as an Alternative Benefit Plan (ABP). Under this authority, States may offer a State Plan package of services targeting a specific population without regard to comparability. Kansas Medicaid used this authority to develop a “package” of services targeting individuals enrolled in *Working Healthy* who demonstrate a need for these services.

To be eligible for *WORK* services, individuals must be:

- eligible for *Working Healthy*
- eligible for BI, I/DD or PD Waiver services, however individuals cannot receive HCBS Waiver services
- on the waiting lists to receive services through these waivers
- living and working in the community

Services include:

- Personal Assistance Services

- Supported Employment/Individual Employment Support Services
- Assistive Technology
- Independent Living Counseling

Of the 1,150 individuals enrolled in *Working Healthy* in November 2019, 263 receive *WORK* services. As *WORK* is a Medicaid State Plan package of services, there is no waiting list.

DISABILITY AND BEHAVIORAL HEALTH EMPLOYMENT SUPPORT PILOT PROGRAM

CMS approved a Disability and Behavioral Health Employment Support Pilot in the current Kansas 1115 Waiver for up to 500 participants. The pilot is designed to assist participants to obtain and maintain employment by providing supportive services. The pilot program is scheduled to operate during the KanCare 2019-2023 demonstration extension, with a possibility of renewal and expansion through an applicable title XIX authority if shown to be effective.

The intent of the pilot is to:

- incentivize individuals on the I/DD Waiver waiting list to choose community living and employment waiting list by providing services that support living and working in integrated settings in the community
- determine whether providing this package of services is a less costly and more appropriate option for people with intellectual and developmental disabilities capable of living and working in the community
- provide individuals with behavioral health issues with the supports needed to live and work in the community and avoid the need for in-patient hospitalizations

Pilot Program eligibility includes individuals:

- ages 16 through 65
- with any of the following behavioral health primary diagnoses and who receive services through Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)

- Schizophrenia
- Bipolar and major depression
- Delusional disorders
- Personality disorders
- Psychosis not otherwise specified
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Substance use disorder (SUD) or co-occurring SUD
- SSI Members currently enrolled in Medicaid and on the waiting list for I/DD, PD or any potential BI waiver services
- Members who have an intellectual or developmental disability (I/DD), physical disability (PD), or Brain Injury Waiver, who are willing to leave their HCBS waiver.

Services include

- Prevocational Services
- Supported Employment
- Independent Living Skills Training
- Personal Assistance Services
- Transportation to and from Employment Sites

Benefits planning by certified *Working Healthy* Benefits Specialists will be provided.

APPENDIX A

A Table of State *Olmstead* plans and related state activity
Marshall Alameida, MSN; Martin Kitchener, PhD, MBA; Alice Wong, MS; Charlene Harrington, PhD, RN, FAAN.
September 2008

State	Plan Yes/no	Alternative Activity Yes/no	Date first published	Details online Yes/no	Title of plan (or title of alternative activity)	Further information
AL ^a	No	Yes	N/A	Yes	Alabama Medicaid: The Olmstead decision and Alabama's response	State Olmstead website: http://www.medicaid.alabama.gov/programs/long_term_care/olmstead.aspx
AK ^a	No	Yes	Mar 07	Yes	<i>Moving Forward Comprehensive Integrated Mental Health Plan: 2006-2011</i> , published April 2006, revised March 2007	Report: http://hss.state.ak.us/dph/healthplanning/movingforward/assets/CompPlan_03-2007.pdf
AZ ^a	Yes	X	Aug 2001	Yes	Arizona's Olmstead Plan	Plan: http://www.ahcccs.state.az.us/Publications/PlansWaivers/Plans/Olmstead/default.asp
AR ^a	Yes	X	Feb 2001	Yes	The Olmstead Plan in Arkansas	Plan: http://www.state.ar.us/dhs/aging/opfpt1.pdf Update: http://www.arkansas.gov/dhhs/aging/olmarplan0303.html
CA ^a	Yes	X	May 2003	Yes	The California Olmstead Plan	Plan: http://www.chhs.ca.gov/initiatives/Olmstead/Documents/01Section%20I%20-%20V%20combined.pdf Update: Governor Arnold Schwarzenegger issued a recent Executive Order regarding California's Olmstead state plan that replaces a previous Executive Order in 2004. The 2008 Executive Order states the Director of the California Health and Human Services Agency appoints members of the Olmstead Advisory Group and the members serve at the pleasure of the Director. To view Executive Order S-10_08: http://gov.ca.gov/executive-order/10606 State Olmstead website : http://www.chhs.ca.gov/initiatives/Olmstead/Pages/OlmsteadPlan.aspx
CO ^a	No	N/A	X	X	X	N/A
CT ^a	Yes	X	Mar 2002	Yes	Choices are for everyone: continuing the movement toward community-based supports in Connecticut	Plan: http://www.ct.gov/dss/LIB/dss/pdfs/CommIntPlan.pdf
DE ^a	Yes	X	Jul 2007	Yes	<i>A Path Forward: Building a Community-Based Plan for Delaware</i>	Report: http://www.udel.edu/cds/ccba/pdfs/commission/A_Path_Forward.pdf

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						Governor's Commission on Community-Based Alternatives for Individuals with Disabilities website: http://www.udel.edu/cds/ccba/index.html
DC^a	No	No	X	X	X	Progress: Focus on HCBS waiver program development.
FL^a	No	N/A	X	X	X	Progress: Focus on HCBS waiver program development.
GA^a	Yes	X	Mar 2003	Yes	State of Georgia Olmstead strategic plan	Plan: http://www.files.georgia.gov/DHR/DHR_CommonFiles/16739455Olmstead_Plan_Perdue_.pdf
HI^a	Yes	X	Oct 2002 ^b	No	Recommended Olmstead Implementation Plan (As of December 30, 2005)	Update: http://www.hawaii.gov/dhs/protection/social_services/adult_services/Olmstead%20Implementation%20Plan.pdf
ID^a	No	No	X	X	X	Progress: Community Integration committee developing a plan.
IL^a	No	Yes	Jul 2006	Yes	Illinois Disabilities Services Plan Update	Update: The Illinois Disabilities Services Advisory Committee assists in the development and implementation of a plan to help the state comply with the ADA and Olmstead decision. As of July 2006, the action plan for the Illinois Disability Services plan (that will address Olmstead issues) was approved. Full implementation is expected in FY 2007. http://www.dhs.state.il.us/page.aspx?item=33842 Illinois Disabilities Services Advisory Committee meeting summary (July 25, 2006): http://www.dhs.state.il.us/OneNetLibrary/27897/documents/Initiatives/DSAC/dsac7-25-06meeting.pdf Illinois Disabilities Services Plan Update (July 2006): http://www.dhs.state.il.us/OneNetLibrary/27897/documents/Initiatives/DSAC/DSAC7-06Update.pdf
IN^a	Yes	X	Jun 2001	Yes	Comprehensive plan for community integration & support of persons with disabilities	Plan: http://www.in.gov/fssa/ddrs/5469.htm State Olmstead website: http://www.in.gov/fssa/ddrs/5384.htm
IA^a	No	Yes	May 2005	Yes	Targeted Capacity Expansion: Meeting the	Report: http://www.dhs.state.ia.us/mhdd/docs/TCEOlderadultsSAMSHAGRA

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					Mental Health Needs of Older Adults in Iowa	NTFINAL0504.doc Iowa Olmstead Information: http://www.dhs.state.ia.us/mhdd/reports_publications/Reports_Publications.html
KS^a	No	Yes	Oct 2003	Yes	Rebalancing Kansas' Long Term Care System	Progress: Rebalancing Kansas' Long Term Care System (Nov 2006): http://www.khpa.ks.gov/AuthorityBoard/TownhallMeetings/ShannonJonesStateLCCouncil11-21-06.pdf
KY^a	Yes	X	N/A	Yes	Cabinet for Health Services: Olmstead Compliance Plan for FY 2004 through FY 2012	State Olmstead website: http://chfs.ky.gov/os/Olmstead.htm
LA^a	No	Yes	Sep 2003	No	Disability Services & Supports Systems: long-term care reform draft plan	Report no longer available online.
ME^a	Yes	X	Oct 2003	Yes	Roadmap for change: Maine's response to the <i>Olmstead</i> decision	Plan: http://mainerealchoices.org/workgroup_roadmap.htm
MD^a	No	Yes	2007	No	2007 Maryland State Disabilities Plan	Progress: As of 2004, Olmstead plan is being developed. Workgroups are formed, composed of Maryland Commission on Disabilities. One accomplishment listed in the 2007 Maryland State Disabilities Plan was the establishment of baseline data to measure Maryland's Olmstead progress with regard to assessment, diversion and transition efforts to the least restrictive environment (p. 15). Maryland Commission on Disabilities: http://www.mdod.maryland.gov/Advisory%20Commission.aspx 2007 Maryland State Disabilities Plan: http://www.mdod.maryland.gov/uploadedFiles/About_Us/related_publications/2007%20State%20Disabilities%20Plan.pdf

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MA^a	Yes	X	Jan 2002 ^c	Yes	The People's Olmstead Plan: the plan to provide comprehensive community-based services	Plan: http://mass.gov/resources/ecbs_plan.pdf
MI^a	No	Yes	2004	Yes	Modernizing Michigan Medicaid Long-Term Care: Toward an Integrated System of Services and Supports	Progress: Michigan Long-Term Care Supports and Services Commission http://www.michigan.gov/ltc Modernizing Michigan Medicaid Long-Term Care: Toward an Integrated System of Services and Supports: http://www.ihcs.msu.edu/LTC/Reports/Final_LTC_Task_Force_Report.pdf
MN^a	No	Yes	Jan 2001	Yes	Long-term care taskforce: reshaping long-term care in Minnesota	Progress: Status of Long-Term Care in Minnesota 2005: A Report to the Minnesota Legislature (2006): http://www.dhs.state.mn.us/main/idcplg?ldcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterupt=1&noSaveAs=1&dDocName=dhs_id_059536 Long-term care plan for older people (2001): http://www.dhs.state.mn.us/main/idcplg?ldcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&Redirected=true&dDocName=id_005812
MS^a	Yes	X	Sep 2001	Yes	Mississippi Access to Care	Plan: http://www.mac.state.ms.us/MAC_Final.pdf Update: Mississippi Access to Care Implementation Report #1, May 30, 2003 http://www.mac.state.ms.us/Services_Available/Implementation_Report1/implementation_report1.html
MO^a	Yes	X	Dec 2000	Yes	Working Plan of the Home and Community-Based Services and Consumer-Directed Care Commission	Plan: http://www.gcd.ia.mo.gov/test/Olmstead/reportindex1.shtml State Olmstead website: http://www.gcd.ia.mo.gov/Olmstead/olmstead.shtml
MT^a	Yes	X	Jul 2006	Yes	Senior and Long Term Care Division, Dept. of Public Health & Human	Plan: http://www.dphhs.mt.gov/sltc/services/communityservices/csOlmsteadPlan.shtml

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					Services, Olmstead Plan Update, 2006	
NE^a	No	Yes	Jun 2007	Yes	Nebraska Health and Human Services, Developmental Disabilities System, Three-Year State Plan	Nebraska Health and Human Services, Developmental Disabilities System, Three-Year State Plan, 2007 http://www.dhhs.ne.gov/dip/ded/DDS-State-Plan-6-07.pdf
State	Plan Yes/no	Alternative Activity Yes/no	Date first published	Details online Yes/no	Title of plan (or title of alternative activity)	Further information
NV^a	Yes	X	Jul 2007	Yes	Nevada's Strategic Plan for People with Disabilities	The Strategic Plan Accountability Committee (SPAC) was created by executive order in 2003 to hold the State accountable for the implementation of Nevada Strategic Plan for People with Disabilities. This plan serves as a blueprint for improving disability services in the state, and as Nevada's Olmstead Plan in response to the mandates of the US Supreme Court's Olmstead Decision in 1999. Strategic Plan Accountability Committee, Agendas and Minutes http://dhhs.nv.gov/StrategicPlanAccCommitteesPWD.htm Update: Nevada's Strategic Plan for People with Disabilities (Nevada's Olmstead plan), 2007 http://dhhs.nv.gov/SP-AccComm04/Documents/StatusReports/Disabiities/SP-PeoplewithDisabilities_AnnualReport2007.pdf Nevada's Strategic Plan for People with Disabilities (Nevada's Olmstead plan), 2006 http://dhhs.nv.gov/SP-AccComm04/Documents/StatusReports/Disabiities/SP-PeoplewithDisabilities_Annual%20Report2006.pdf
NH^a	No	Yes	N/A	No	Community Support Plan ^b	Progress Plan compiled from those for community-based services for people with MR/DD, mental health, children and aging. ^b
NJ^a	No	Yes	N/A	No	N/A	Progress: No plan as of yet. See the Public Advocate's testimony in 2006 on the need for a state Olmstead Plan. http://www.state.nj.us/publicadvocate/divisions/disabled/testimony.html

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						In 2006 the Division of Developmental Disabilities posted a request for proposal regarding customized supports and services for people transitioning from developmental centers to communities. http://www.state.nj.us/humanservices/ddd/publications/Olmstead%20RFP%20Guidelines.pdf
NM^a	Yes	X	N/A	No	N/A	Progress: Information Bulletin http://legis.state.nm.us/lcs/lcsdocs/148087.pdf
NY^a	No	Yes	Feb 2003	Yes	Developing a comprehensive, effectively working Olmstead plan in NY state	Progress: NY has established an Olmstead planning process. Developing a Comprehensive, Effectively Working Olmstead Plan in New York State (2003): http://www.coalitionforaging.org/CTIONYOlmstead1.pdf Governor Pataki established the Most Integrated Setting Coordinating Council: http://www.health.state.ny.us/nysdoh/misccc/index.html The Coalition to Implement Olmstead in New York, New York State Coalition for the Aging, Inc. http://www.coalitionforaging.org/ctionysum.htm
NC^a	Yes	X	May 2008	Yes	Olmstead report to North Carolina state legislature, 2008	North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services, Olmstead project website: http://www.ncdhhs.gov/mhddsas/olmstead/index.htm Olmstead report to North Carolina state legislature, 2008 http://www.ncdhhs.gov/mhddsas/statspublications/reports/LOC/loc-05-08-olmsteadreport.pdf
ND^a	No	Yes	Nov 2002	Yes	Olmstead Update: Serving People with Long-Term Care and Support Needs in Communities, November 2002	Progress: State has received systems change grant, amongst other activities. ^b 2001-2003 Biennial Report, North Dakota Department of Human Services: http://www.nd.gov/dhs/info/pubs/docs/biennial-2003-report.pdf Olmstead Update: Serving People with Long-Term Care and Support Needs in Communities, November 2002 http://www.nd.gov/dhs/info/pubs/docs/olmstead-update-long-term-care-and-support-services.pdf White Paper, Olmstead Workgroup, North Dakota Department of

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September 2008

						<p>Human Services (Nov 2001): http://www.nd.gov/dhs/info/pubs/docs/olmstead-white-paper.pdf</p> <p>In 2001, the governor established an Olmstead Commission whose mission is to develop a plan to implement the Olmstead decision. http://www.governor.state.nd.us/boards/boards-query.asp?Board_ID=127</p>
OH^a	Yes	X	Feb 2001	Yes	Ohio Access for People with Disabilities	<p>Plan: http://www.ohioaccess.ohio.gov/pdf/ohioaccessrpt2001.pdf</p> <p>Update: Ohio Access for People with Disabilities 2004 http://www.ohioaccess.ohio.gov/pdf/ohioaccessrpt2004.pdf</p>
OK^a	No	Yes	N/A	No	N/A	<p>Progress: Olmstead strategic planning work group developing plan.</p> <p>Interim Report of the Oklahoma Olmstead Strategic Planning Committee - July 2004 http://www.csctulsa.org/images/OLMSTEAD%20INTERIM%20REPORT071504%20(3).doc</p> <p>Community Service Council of Greater Tulsa's Olmstead website: http://www.csctulsa.org/olmstead.htm</p>
OR^a	No	No	N/A	No	X	<p>Progress: Developmental disabilities 6-year plan to eliminate waiting lists.</p> <p>Future of Long-Term Care for Seniors and People with Disabilities website: http://www.oregon.gov/DHS/spwpd/ltc/fltc/index.shtml</p> <p>Riding the Wave: A Call to Action. A Report on the Future of Long-Term Care in Oregon and Long-Range Planning for Oregon's Communities (Nov 2006): http://www.oregon.gov/DHS/spd/adv/gcss/fltc_rpt.pdf</p> <p>Recommendations on the Future of Long-Term Care in Oregon, Department of Human Services (May 2006): http://www.oregon.gov/DHS/spwpd/ltc/fltc/report1.pdf</p>

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PA^a	No	Yes	Jul 07	Yes	Home and Community Based Services Stakeholder Planning Team Strategic Plan for July 2004-December 2006	<p>Progress: Money Follows the Person Concept Paper, ARC Pennsylvania, 2006 http://www.dpw.state.pa.us/Resources/Documents/Presentations/ARC.pdf</p> <p>Community Living Advisory Committee report and recommendations on Nursing Facility Transition, Gaps in Services and No Wrong Door, 2003 http://www.dpw.state.pa.us/Resources/Documents/Pdf/AnnualReports/CLACReport-Nov03.pdf</p> <p>Home and Community Based Services Stakeholder Planning Team http://www.dpw.state.pa.us/PartnersProviders/MedicalAssistance/AdvocatesStakeholders/AdvisoryCommittees/HCBSTeam/</p> <p>Home and Community Based Services Stakeholder Planning Team Strategic Plan for July 2004-December 2006 http://www.dpw.state.pa.us/resources/documents/pdf/publications/hcbs_spt_strategicplan2004.pdf</p>
RI^a	No	No	N/A	N/A	X	<p>Progress: Representative Eileen S. Naughton introduced a bill in 2006 to create a commission to establish Olmstead Decision Task Force. The House passed the bill on May 31, 2006. http://www.rilin.state.ri.us/news/pr1.asp?prid=3262</p> <p>Community-Based Long-Term Care Services in Rhode Island: A Report Issued Pursuant to Joint Resolution 05-R 384 (2005) http://www.dhs.ri.gov/dhs/reports/ltc_services.pdf</p>
SC^a	Yes	X	Aug 2001	Yes	South Carolina Home and Community-based services Task Force: report	Plan: http://www.sccdc.state.sc.us/olmstd.pdf
SD^a	No	No	X	No	X	N/A
TN^a	Yes	X	Mar 1999	Yes	Tennessee Comprehensive plan for the delivery of long-term care services to elderly and disabled persons	<p>Plan: http://www.state.tn.us/comaging/TNlongtermcare.pdf</p> <p>Update: Tennessee Department of Mental Health and Developmental Disabilities Three-Year Plan FY 2007-2009 http://tennessee.gov/mental/3yrplan/planbody.pdf</p>

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TX^a	Yes	X	Dec 2002	Yes	Revised Texas Promoting Independence Plan	<p>Plan: http://www.hhsc.state.tx.us/pubs/tpip02/02_12TPIPrev.pdf</p> <p>Update: 2004 Revised Texas Promoting Independence Plan http://www.hhsc.state.tx.us/PUBS/12xx04_TPIP_Rev.pdf</p> <p>Promoting Independence Advisory Committee 2004 Report http://www.hhsc.state.tx.us/pubs/101204_PAC.pdf</p> <p>Project CHOICE targets individuals who are elderly and persons with disabilities who either reside in nursing facilities or who are at immediate risk of doing so. http://www.hhsc.state.tx.us/si/project.htm</p>
State	Plan Yes/no	Alternative Activity Yes/no	Date first published	Details online Yes/no	Title of plan (or title of alternative activity)	Further information
UT^a	Yes	X	Mar 2002	Yes	Comprehensive plan for public services in the most integrated setting	<p>Plan: http://www.dhs.utah.gov/pdf/TheOlmstead-Plan.pdf</p> <p>Update: http://www.dhs.utah.gov/pdf/Olmstead-planupdate.pdf</p>
VT^a	Yes	Yes	N/A	No	Vermont Olmstead Plan, Prepared by the Vermont Olmstead Commission, February 6, 2006	<p>Progress: Vermont Olmstead Commission set up http://humanservices.vermont.gov/publications/olmstead-commission/</p> <p>Plan: Vermont Olmstead Commission-Comprehensive Plan 2006 http://humanservices.vermont.gov/publications/olmstead-commission/vermont-olmstead-commission-comprehensive-plan/view,</p> <p>State Olmstead website: http://humanservices.vermont.gov/publications/olmstead-commission/</p>
VA^a	Yes	X	Aug 2003	Yes	One Community – final report of the Task Force to develop an Olmstead plan for Virginia	<p>Plan: http://www.olmsteadva.com/downloads/FinalReport/FINALTFREPOR T.pdf</p> <p>Update: Third Annual Report of the Community Integration Team to the Community Integration Olmstead Oversight Advisory Board, 2006 http://www.olmsteadva.com/downloads/ThirdAnnualImplementationTeamReport.doc</p> <p>State Olmstead website: http://www.olmsteadva.com/</p>
WA^a	Yes	X	Jun 2005	No	Washington's Olmstead Plan	Plan no longer available online.

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						<p>Expanding Community Services, Washington State Department of Social & Health Services, Mental Health Division</p> <p>At the national and state level, there is continued pressure to assure that individuals residing in institutions have the option for community living. These efforts have been highlighted through litigation such as the <i>Olmstead</i> lawsuit in Georgia where the Supreme Court found that the state was violating the rights of two plaintiffs by keeping them in a state psychiatric hospital despite their desire to live in the community.</p> <p>As part of the 2001-2003 budget process, DSHS developed a proposal included in the Governor's budget for serving state hospital patients in community settings. The 2001-2003 Operating Budget supported this proposal by providing for the development and operation of community support services for long term Western State Hospital (WSH) patients who no longer required active inpatient psychiatric treatment. The 2002-2003 Supplemental Budget increased the scope of the project to include patients from Eastern State Hospital (ESH) and residents of the Program for Adaptive Living Skills (PALS) on the grounds of WSH. In accordance with the proviso, the Department of Social and Health Services (DSHS) formally implemented the Expanding Community Services (ECS) initiative.</p> <p>http://www.dshs.wa.gov/mentalhealth/ecs.shtml</p> <p>System Transformation Initiative, Presentation for the Washington State House Committee on Health Care and Wellness, January 24, 2008 http://www.dshs.wa.gov/pdf/hrsa/mh/sti_presentation_for_1_24_hearing_final.pdf</p> <p>System Transformation Initiative, Department of Social and Health Services http://www.dshs.wa.gov/Mentalhealth/STI_Main.shtml</p>
WV^a	No	Yes	Sep 2003	Yes	Olmstead Position Paper	<p>Progress: <i>Olmstead</i> Position Paper (Sept 2003): http://www.wdohr.org/bhbf/olmstead/olmstead%20position%20paper.pdf</p> <p>State <i>Olmstead</i> website: http://www.wdohr.org/bhbf/olmstead/ Plan no longer available online.</p>
WI^a	Yes	X	Jan 2002	No	Wisconsin's ADA Title II	

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					Plan: phase 1	Principles to Guide Long-Term Care Reform in Wisconsin, WI Council on LTC Reform, 2005 http://www.wcltc.state.wi.us/pdf/LTCRprinciples1005.pdf
WY^a	Yes	X	Mar 2001	No	Wyoming Draft <i>Olmstead</i> Plan	<i>Olmstead</i> state plan not available online. Project Out is a key component of Wyoming's <i>Olmstead</i> Plan, and provides Medicaid eligible individuals, who are residing in nursing homes or are at risk of residing in a nursing home, the opportunity to live in the community, rather than in an institution. In previous years, Project Out was funded through a CMS grant, which was administered the Aging Division and piloted by one provider. Because of its success, beginning July 1, 2006, Project Out is now funded by a mix of state and federal dollars through the Wyoming Medicaid Program. http://wdh.state.wy.us/aging/matrix.html Wyoming Department of Health, Aging Division Four Year State Plan (2006-2010): http://wdh.state.wy.us/Media.aspx?mediaId=4244

Notes on the table

1. *Olmstead* plans are those which have been included in the NCSL report^a as being *Olmstead* plans, and commonly specifically mention that (at least) part of their aim is to address the issues raised by the Supreme Court decision in *Olmstead v. LC & EW*
2. In the 'Further information' column:
 - **'Plan'** indicates the link is to the first edition of the plan (PDF version),
 - **'Update'** indicates the link leads to a plan update or progress report on the plan or other *Olmstead*-related activities (PDF version),
 - **'Draft Plan'** indicates that the link is to the draft state plan (PDF version),
 - **'State *Olmstead* website'** indicates a state website describing *Olmstead* activities with a direct link to the plan and other resources (if available)
 - **'Progress'** indicates any reported information about state activity in states where there is no plan or website.
3. N/A indicates that the data is not available.
4. X indicates that the column is not applicable.

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^a Fox-Grage, W; Folkemer, D; Lewis, J (February 2003) *The States' Response to the Olmstead Decision: how are states complying?* Forum for state Health Policy Leadership, the National Conference of State Legislatures (NCSL), Washington DC.

^b Information obtained through direct contact with State officials in February and March 2004.

^c Date taken from plan, reported by Fox-Grage, W et al (2003) as July 2002.

APPENDIX B

KANSAS

Grant Information

Name of Grantee

Department of Social and Rehabilitation Services, Resource Development

Title of Grant

Kansas 21st Century Long-Term Care Project

Type of Grant

Real Choice Systems Change

Amount of Grant

\$1,385,000

Year Original Funding Received

2002

Expected Completion Date

September 2006

Contact Information

Brent Widick, Grant Manager

Docking State Office Building, 6th Floor

915 SW Harrison Street

Topeka, KS 66612

785-296-4723

BAZW@srskansas.org

Subcontractor(s)

Rucker, Powell and Associates, Ltd.

Mental Health Association of the Heartland

North Central-Flint Hills Area Agency on Aging, Inc.

Kansas Association of Centers for Independent Living

Target Population(s)

Individuals of all ages with disabilities or long-term illness.

Goals

- Develop a strategic plan to guide future systems change.
- Investigate the potential of improved screening instruments for functional eligibility determination and de-institutionalization.
- Enhance the Diversion project by providing short-term case management services to divert individuals who are at risk of institutional placement upon discharge from a hospital.
- Provide technical assistance to expand capacity to deliver community-based services based on currently identified needs, and needs articulated in the strategic plan, including increasing the systems' flexibility to accommodate both the unique needs of consumers and the State.
- Develop and present effective education materials among the broad range of service providers and other long-term care stakeholders.

Activities

- Convene a strategic planning task force comprised of relevant stakeholders to develop a 3-year action plan to articulate a philosophy and direction for systems change.
- Implement new or modified long-term care level-of-care screening tools.
- Establish a technical assistance pool to provide technical assistance to local service providers in developing local resources to meet the needs of individuals to remain in (or return to) and participate in the community.
- Conduct professional development/continuing education programs aimed at changing referral patterns from institutional dependence to the fullest possible participation in the community.

Abstract

The Real Choice Systems Change project seeks to build upon the incremental improvements in long-term care, which Kansas has implemented through Medicaid Home and Community Based Services waivers. The primary purpose of the project is to make home and community based services as accessible to individuals with disabilities or long-term illness as institutional care.

A Strategic Planning Committee including consumer, provider, funding, and regulatory stakeholders will address legal, regulatory, and policy barriers to a community-first long-term care system, including funding issues, capacities of service providers to provide access to necessary supports and services, and employment-related issues. The 3-year action plan seeks to expand self-determination by providing additional control over supports and services for all individuals with disabilities or long-term illness based on the premise of self-determination, independent living, and personal autonomy.

TOC

HYPERLINK

["http://www.advancingstates.org/sites/nasuad/files/hcbs/files/89/4406/Compendium5thEdition.htm#toc"](http://www.advancingstates.org/sites/nasuad/files/hcbs/files/89/4406/Compendium5thEdition.htm#toc)

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