

TO: Olmstead Planning Committee and Advisory Council

FROM: Hillary Dunn, Staff Attorney; Richard M. Glassman, Director of Advocacy; Linda Landry, Senior Attorney; Caitlin Parton, Staff Attorney; and Angelica Vargas, Staff Attorney – Disability Law Center, Inc.

RE: Written Comments on Draft Olmstead Plan

DATE: March 1, 2018

I. Introduction

We write to follow up on our submitted written comments of August 29, 2017 and in response to the Planning Committee’s invitation to share further written comments on the February 9, 2018 Massachusetts Olmstead Plan draft.

The Disability Law Center (DLC) is the federally mandated Protection and Advocacy (P&A) agency for Massachusetts. The P&A system is a national network of disability rights agencies that investigate allegations of abuse and neglect against people with disabilities and provide legal representation and other advocacy services to people with disabilities. To aid P&A agencies in fulfilling their mandate, Congress gave P&As extensive access authority.¹

One aspect of this role is the authority to engage with policymakers on issues of concern to our constituents. In that role, we have provided extensive comments and recommendations to the state and EOHHS regarding its State Transition Plan and effort to comply with the CMS regulations regarding Home and Community Based-Services (“CMS regulations”). These recent CMS regulations are consistent with and further codify many of the requirements of Title II of the Americans with Disabilities Act (“Title II”) and *Olmstead*, such as meaningful integration, choice, person centered planning, and optimizing individual autonomy and independence.

In addition to representing individual clients, in our role as the P&A, we monitor facilities and program sites across the state, including DDS community residences and day/work programs, as well as psychiatric facilities (this includes state institutions,

¹ This authority was first codified through the passage of the Protection & Advocacy for People with Developmental Disabilities (PADD) Act, 42 U.S.C. § 15043(a)(2)(B). Over time, Congress extended the protections of the PADD Act, incorporating them by reference into legislation protecting persons with other forms of disabilities. This includes both the Protection & Advocacy for Individual Rights (PAIR) Act, 29 U.S.C. § 794e(f)(1), and the Protection & Advocacy for Individuals with Traumatic Brain Injury (PATBI) Act, 42 U.S.C. § 300d-53 (eff. April 28, 2008). Similarly, Congress expanded the P & A system through passage of the Protection & Advocacy for Individuals with Mental Illness (PAIMI) Act, 42 C.F.R. § 51.42(c)(2) and the Protection & Advocacy for Beneficiaries of Social Security (PABSS), 42 U.S.C. § 1320b-21.

private/nonprofit psychiatric facilities, and DMH-licensed psychiatric units within medical facilities).

The Draft Olmstead Plan needs more specificity, accountability and benchmarks for success. The first third of the Plan (Pages 1-12) is backward looking, focused on past accomplishments. Toward the end, Section IV is devoted to describing the process in developing this plan, along with a list of additional accomplishments (Appendix B). This leaves little substance in the middle of the Plan for identification of challenges and specific strategies for overcoming them. Instead, the middle section (Pages 13-21) as currently drafted contains a mostly aspirational list of goals, rather than clear benchmarks with deadlines for the Commonwealth to meet in order to satisfy its *Olmstead* integration obligations. Being “committed to a goal” does not equal compliance. Stating that we will “continue to work towards a goal” does not explain how results will be achieved. In places, the current Draft Plan answers the question of “what” generally the Commonwealth seeks to accomplish, but not “how” or “how much” or “by when.” These sections should be rewritten to include forward looking, concrete planning to operationalize the lofty goals, with numerical targets and accountability.

For your reference, we have attached an Appendix that outlines the legal requirements for what is supposed to be included in an Olmstead Plan. We have also attached Olmstead Plans and work plans from Connecticut, Maryland, Minnesota and New York. We think these plans illustrate some best practices in incorporating specific implementation strategies, metrics, numerical targets, and outcome measurements, with clarity and transparency.

II. Recommendations

We offer the following recommendations, specifically to page numbers where applicable and generally on important issues we did not see highlighted or expanded upon in enough detail in the Draft Plan.

Number of Individuals Served by DDS in Home and Community-Based Settings (Page 9):

It appears the numbers contained in the Draft Plan regarding the number of individuals served by DDS in home and community-based settings may be incorrect. If that is not the case, the information in that sentence needs clarification. As written, the sentence seems to say that DDS serves a total of 9,641 people through all of the DDS-administered HCBS waivers (Intensive Supports, Community Living, and Adult Supports). To the best of our knowledge, DDS presently serves over 9,000 individuals in 24/7 community residence (group home) settings, the vast majority, if not all, of whom are on the Intensive Supports HCBS waiver. Thousands more individuals receive non-residential services (day or work programs, for example) through DDS-administered HCBS waivers. As such, DDS serves more than 9,641 individuals in home and community-based settings.

However, if the intent of the sentence, as written, is to refer to only individuals who receive residential services through DDS HCBS waivers, then it needs clarification. A possible revision could be:

Currently DDS serves 9,641 individuals in **24/7 residential** home- and community based settings **as well as** 3,651 individuals in their own living environment, 1,186 in Shared Living arrangements, and 104 supported via DMH/DDS MassHousing 3% Priority Program.

Sheltered Workshops (Page 10):

The statement that Massachusetts has closed all of its sheltered workshops is factually incorrect. To the best of our knowledge, there remain four open sheltered workshops run by two vendors. Class Inc. has one large sheltered workshop which takes up an entire locked basement floor of a large mill building in Lawrence. In addition, Road to Responsibility operates sheltered workshops in three separate locations. We have been to all of these sites over the past year under our P&A monitoring authority. All are funded by DDS.

The Olmstead Plan should state that there remain four open sheltered workshops funded by DDS and should set a specific date for closing those segregated subminimum wage facilities within the next six (6) months.

Group Supported Employment (Page 10):

Also, in contrast to the language on Page 10, not all group supported employment (mobile enclaves, segregated parts of privately owned factory floors, etc.) is integrated. In our monitoring, we have found most of these programs to be largely segregated and many still also pay subminimum wage. These sites were to have been closed by June 2018. The plan should say if that is still the case, and if not, why not. If DDS is extending this deadline for good cause, it should do so in a case-by-case basis and should require the closure of segregated and subminimum wage group supported employment sites by no later than six (6) months past the original deadline of January 2019.

Community Based Day Supports (Pages 10, 19):

DDS serves thousands of individuals who participate in Community Day Supports (CBDS) yet the draft Plan makes no mention of CBDS programs. CBDS should be helping many individuals move towards employment. The draft Plan also makes no mention of how the state will bring people from CBDS programs into competitive integrated employment. Based on our monitoring work as the P&A as well as individual case work, we have seen many individuals who are in a day habilitation program who would be more appropriately served in a CBDS program. There is no

mention in the Plan as to how the state will bring people in day habilitation programs who are more appropriately served into a CBDS program.

Disability Specific Housing (Page 15):

Massachusetts should not support disability specific housing except under exceptional circumstances. Such housing models are antithetical to *Olmstead* and the community integration mandate and implicate Title II of the ADA and the Fair Housing Amendments Act (FHAA). In addition, if a limited amount of disability specific housing were to be adopted, this decision should first be the subject of broad public discussion. It is particularly inappropriate to delegate such a decision to the Autism Committee, which lacks any direct political accountability.

Policy Incentives and DHCD (page 16):

The DCHD centralized statewide portal for applications must be fully accessible to people with disabilities. All aspects of the portal, the application, links to information, etc. must be accessible to screen reader technology and compliant with the WCAG 2.0 AA guidelines for website accessibility. If there are any videos explaining the application process or how to obtain assistance, the videos should have both captions and audio description.

Accountable Care Organizations and Access to Services (Pages 17-18):

While the intent is for Accountable Care Organizations (ACOs) to improve health outcomes for MassHealth recipients through care coordination and integration of long term services and supports (LTSS) and certain social services, it is not clear how many people with disabilities will benefit. MassHealth recipients who also have private insurance, through their work or through that of a spouse, as well as people with Medicare, are not eligible to join an ACO. In addition, if the contract relationship is with Community Partners, while intended to improve quality of care for people with complex LTSS and behavioral health needs, it is in practice overly bureaucratic and/or medicalized. The potential for promoting independent living may not be realized.

More critical to increasing community living are renewal and expansion of the MFP and ABI HCBWs, as well as increasing the Supported Living Program. These programs include more community living supports for people with the most severe disabilities. Also critical is maintaining efforts on and attention to rebalancing LTSS and institutional MassHealth spending.

Additionally, it is essential to ensure a sufficient supply and quality of Personal Care Attendants (PCAs) through living wages, sick leave and health benefits. In addition, the Commonwealth must ensure that implementation of Electronic Visit verification (EVV) for PCA and home health services does not result in reducing the

numbers of people who want these jobs due to privacy and other concerns. The importance of the availability of quality PCA and home health services to community living for many people with disabilities cannot be overstated.

While access to assistive technology is important for people with disabilities, there is also a great need for consistent access to repairs of equipment. For example, speedy repair of MassHealth-covered mobility equipment is important to community living. When mobility equipment is in need of repair, the individual may be stuck at home or even in bed for extended periods, which is not consistent with good health or *Olmstead* principles. Yet, problems getting timely repairs have plagued users of mobility equipment for a long time.

Increase in PCA Wage (Page 18):

If MassHealth has not already committed to do so, MassHealth should also commit to increase the current wage of direct-care staff in day habilitation programs to \$15/hour effective July 1, 2018. The Plan should reflect the same.

Day Habilitation (Page 18):

MassHealth operates day habilitation, a Medicaid state plan service which serves between 8,000 and 9,000 people and currently provides largely, and sometimes entirely, segregated services. Many, if not most, day habilitation participants rarely spend time in the community during their day and have little or no exposure to persons without disabilities other than staff. Massachusetts must develop a concrete transition plan to bring community integration to day habilitation to align program operations with the requirements of Title II of the ADA. In addition, because millions of DDS dollars also fund day habilitation supplemental wrap funding under the HCBS waiver, day habilitation programs must also comply with the HCBS Community Rule when those provisions take full effect.

This is perhaps the greatest *Olmstead* challenge facing the Commonwealth, and yet the draft *Olmstead* Plan currently makes no mention of this issue.

Promoting Services That Facilitate Transitions from Institutional Settings (Page 18):

MRC should not merely “explore” the benefits of accessible technology (AT) for people with disabilities in community settings. They should be providing direct services to individuals they serve that include implementing AT tools that would give individuals the ability to interact with their roommates and service providers, as well as community members. Many of the individuals we encounter during monitoring visits do not have AT tools, such as communication devices, tablets, or even simple picture boards.

Regarding community inclusion efforts for individuals who are served by the Department of Mental Health, the stated goals appear to be well-intentioned, but as with

other areas mentioned above, they are vague and aspirational. We have several recommendations.

First, the plan says that “DMH will seek to increase community-based living opportunities with appropriate supports for individuals who are determined discharge ready and able to safely transition from DMH state hospital continuing-care beds.” There is no detailed description about how this will be accomplished. Is DMH committed to building new community placements as necessary to be able to accommodate individuals who are difficult to place? What will DMH do to get the necessary funding to increase community-based living opportunities?

It is important that there be a detailed plan with action steps to be taken and a timeline for said action steps. It is difficult to envision what is meant by the phrase “will seek” given that this could entail budget challenges that without a strong commitment to achieve the goal, could result in a quick withdrawal of any plans to increase community-based living opportunities. Additionally, DMH should have data indicating what is needed in terms of different types of community-based living opportunities, based on tracking of in-patient populations waiting to be discharged. This type of data can be used to determine what exactly DMH intends to do to increase community-based living opportunities, given that there may be a need for Group Living Environments, in different regions of the state, as well as supported living environments, subsidized apartments, and more.

Second, the plan also states that “DMH will establish a DMH State Hospital Discharge Review Team to provide Peer-to-Peer case consultation to facilitate discharge planning for individuals with challenging needs.” This again sounds like a move in the right direction, but it needs to be significantly more specific. There are possibly hundreds of clinically discharge-ready patients right now in continuing care facilities, who will not be discharged within 30 days. As this goal is stated, there is no description about who will be in this Review Team, when it will be established, who will oversee it, what it will review and how often it will do so. When it comes to what the Team will review, DMH should specify whether it plans to ensure all facilities have a uniform and consistent discharge readiness tracking list generated and overseen by the Central Office. Additionally, it is important to know what the Review Team will do to help alleviate the problems facing many discharge-ready patients with barriers to discharge and if this Review Team makes recommendations, who will follow up and decide what happens next.

Finally, there should also be increased oversight by DMH to ensure that hospitals are doing everything possible to move people towards being clinically ready for discharge. Some hospitals have patients who have very long lengths of stay (2+ years and some closer to 10 years) and are not considered discharge ready. DMH could create a plan to make sure those patients are getting the best mental health treatment available. If they are truly not discharge ready, DMH should ensure that those patients continue to require in-patient level of care after years of hospitalization.

HCBS Community Rule (Page 19):

There should be a more detailed discussion of compliance with the HCBS community rule and its deadline of March 2022. The plan is overly optimistic about the current state of community integration. It does not chart a path forward with any concrete planning to deal with geographically isolated settings, former institutions such as Templeton, community residences built on institutional land, high density settings, and places that are supposedly in the “community” but where people with disabilities rarely have meaningful integrated experiences. DLC has a practical vantage point from regularly monitoring community residences and interviewing individuals, family members and staff.

Direct Support Staff (Page 19):

The discussion of “exploring strategies” for raising direct care salaries contains vague, aspirational language in lieu of specific planning for implementation. For example, the Commonwealth could decide that future Chapter 257 increases, or a minimum percentage of them, will go only to direct care staff and not managers and executives. Furthermore, the abuse and neglect of individuals with disabilities remains far too common. In community-based settings, such as community residences or day programs, abuse by staff continues to be an issue. High quality, consistent and trained staff is vital in decreasing abuse and neglect, and attracting and retaining such a work force will not happen without increasing wages.

DDS Family Supports (Page 28):

The majority of adults served by DDS live at home with parents, siblings, or other family members. In other words, families are the largest provider of residential services for people with intellectual and developmental disabilities, many of whom may require physical assistance or constant supervision. The plan ought to identify the need to increase Family Support resources to families and identify specific steps to address the issue. Currently, Family Support resources provided to families are often insufficient to make a meaningful impact. An allotment of two hundred dollars does little to assist families in obtaining qualified respite providers or paying for recreational programs that would provide integration opportunities. Living at home with family members who are exhausted from daily caregiving and unable to assist with accessing the community on a regular basis is not integration.

Subminimum Wages:

In continuing to allow subminimum wages under state labor law, Massachusetts has fallen behind best practices adopted by other jurisdictions. Many states have formally abolished subminimum wages, such as New Hampshire, Maryland, and most recently, Alaska. Other states such as Vermont may have no formal prohibition, but

have no listed subminimum wage employers. See e.g., <https://www.dol.gov/whd/specialemployment/CRPlist.html>.

Unlike many other jurisdictions, a decision to eliminate state subminimum wages would be extraordinarily simple. It would require no legislation and no new regulation, since the authority to take this action immediately already rests with the Department of Labor Standards (DLS). DLS should provide notice to vendors and then take this step within the next twelve months.

Trainings:

Trainings conducted for private management companies of reasonable accommodation requirements and resources are necessary. However, the Plan as currently drafted does not include information on how often the training will be offered and what the training will consist of in detail.

Remaining Institutions in the Commonwealth:

Massachusetts still has large-scale institutions in operation (Wrentham, Hogan). Through DLC's monitoring, we visited these institutions, along with DDS-sponsored group homes, in FY '17. Far too many individuals with disabilities who could be receiving community-based support remain in these institutions. Wrentham appears to be accepting new individuals with disabilities, who are very young (in their 20s and 30s) who would be more appropriately placed in the community. In addition, each one of these individuals becomes a class member with entitlement interests after 30 consecutive days at Wrentham or 60 days during any 12-month period. 115 CMR 6.05(1). We believe this is an ill-advised way to allocate the scarce resources of the Department. The Plan should address robust transition materials, outreach, and intervention for the individuals who still remain in the Commonwealth's institutions.

III. Conclusion

We support the Commonwealth's efforts to revise and update its Olmstead Plan to set forth the steps the Commonwealth will continue to take to end the segregation of people with disabilities. With careful planning, the Commonwealth can ensure that people with disabilities are incorporated fully into our communities and receive the services they need in the most integrated setting possible. Thank you for the opportunity to comment on the Draft Plan.

If you have any questions about the content of our memorandum, we are available at 617-723-8455 and via email: hdunn@dlc-ma.org; rclassman@dlc-ma.org; llandry@dlc-ma.org; cparton@dlc-ma.org; and avargas@dlc-ma.org.

Appendix - Requirements for State Olmstead Plan

For a state Olmstead Plan to be legally sufficient, it must include specificity, accountability, and benchmarks for success (including specific timeframes). The Department of Justice (“DOJ”) issued a Statement in order “to assist state and local governments in complying with the ADA.”¹ The Statement says the following:

A comprehensive, effectively working plan must do more than provide vague assurances of future integrated options or describe the entity’s general history of increased funding for community services and decreased institutional populations. Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain **concrete and reliable commitments** to expand integrated opportunities. The plan must have **specific and reasonable timeframes and measurable goals for which the public entity may be held accountable**, and there must be funding to support the plan, which may come from reallocating existing service dollars.²

(Emphasis added)

Consistent with the DOJ Statement, federal courts have held that specificity, accountability, and clear timeframes are all integral for the legal sufficiency of state Olmstead Plans. In 2005, the 3rd Circuit found that the Pennsylvania Department of Public Welfare’s (“DPW”) Olmstead Plan failed the obligations of the Americans with Disabilities Act (ADA), Rehabilitation Act, and state law because it did not “adequately demonstrate[] a **reasonably specific and measurable commitment** to deinstitutionalization **for which DPW may be held accountable**.”³ (Emphasis added). In another case, the 3rd Circuit further stressed the need for specific accountability, finding that for a state Olmstead plan to be legally sufficient, it “must demonstrate a commitment to action in a manner **for which it can be held accountable by the courts**.”⁴ Similarly, the U.S. District Court for the District of Columbia found that “there is

¹ U.S. Department of Justice, Statement of Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. (2011), *available at* https://www.ada.gov/olmstead/q&a_olmstead.htm.

² The DOJ Statement notes that “[t]o be effective, the plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan... Any plan should be evaluated in light of the length of time that has passed since the Supreme Court’s decision in Olmstead, including a fact-specific inquiry into what the public entity could have accomplished in the past and what it could accomplish in the future.” DOJ Statement at 7.

³ The PA DPW’s plan initially contained specific numerical goals, but “the final plan adopted by DPW abandoned those specific goals... so that the plan did not contain any measurable goals for deinstitutionalization.” *Frederick L. v. Dep’t of Pub. Welfare of Pa.*, 422 F.3d 151, 157 (3d Cir. 2005).

⁴ *Penn. Prot. & Advocacy, Inc. v. Penn. Dep’t of Public Welfare*, 402 F.3d 374, 381 (3d Cir.2005) (internal quotations omitted) (emphasis added).

wide-spread agreement that one essential component of an ‘effectively working’ plan is a **measurable** commitment to deinstitutionalization.”⁵ In addition, the Northern District of Illinois found that states are required to establish specific timeframes for integration under the ADA and the Rehabilitation Act.⁶

State codes have also incorporated requirements of specificity, accountability, and clear timeframes for their state Olmstead Plans. The Virginia code explains that the state’s plan shall “include **facility specific objectives and timeframes** to implement changes.”⁷ The D.C. code also establishes a timeframe for compliance,⁸ as does the New York state code.⁹ New York also maintains that its Olmstead Plan must include “**measurable progress goals** for achieving integrated residential living, including transition goals from segregated to residential housing, and employment opportunities for people with disabilities,” as well as “**measurable goals** for providing supports and accommodations necessary for successful community living.”¹⁰

The Olmstead Plans and work plans from Connecticut, Maryland, Minnesota and New York illustrate how states may effectively incorporate the specificity, accountability, and benchmarks for success required to make their plans legally sufficient under the ADA and the Rehabilitation Act.

⁵ *Day v. D.C.*, 894 F. Supp. 2d 1, 28 (D.D.C. 2012), citing *Frederick L. v. Dep’t of Pub. Welfare of Pa.*, 422 F.3d 151 (3d Cir. 2005); *Penn. Prot. & Advocacy, Inc. v. Penn. Dep’t of Public Welfare*, 402 F.3d 374 (3d Cir. 2005); *Williams v. Quinn*, 748 F.Supp.2d 892 (N.D.Ill. 2010); *The Arc of Wash. State, Inc. v. Braddock*, 427 F.3d 615, 620 (9th Cir.2005) (State must be “genuinely and effectively in the process of deinstitutionalizing disabled persons”); *Sanchez v. Johnson*, 416 F.3d 1051, 1066 (9th Cir. 2005) (State had legally sufficient plan where it had “a successful record of personalized evaluations leading to a reasonable rate of deinstitutionalization”).

⁶ *Williams v. Quinn*, 748 F.Supp.2d 892, 897–98 (N.D.Ill. 2010) (finding that the state’s *Olmstead* obligations were met because the state’s consent decree delineated specific timeframes for transition and integration) (emphasis added).

⁷ Va. Code Ann. § 37.2-319 (emphasis added).

⁸ D.C. Code Ann. § 2-1431.01: (9), noting that the district’s Olmstead Plan must be a “comprehensive working plan, developed in collaboration with individuals with disabilities and with District agencies serving individuals with disabilities, which shall include annual legislative, regulatory, and budgetary recommendations for the District to serve qualified individuals with disabilities in accordance with *Olmstead v. L.C.*, 527 U.S. 581, and in the most integrated setting as provided in 28 C.F.R. Part 35, App. A.”

⁹ N.Y. Comp. Codes R. & Regs. tit. 9 § 8.84, explaining that the duties of the state’s Olmstead Plan Development and Implementation Cabinet includes “coordination strategy for the work of state agencies and authorities to implement the Plan, including specific and reasonable timeframes for implementation.”

¹⁰ *Id.* (emphasis added).