Plaintiffs' Summary and Notes on Defendants' Draft Olmstead Plan
October 26, 2021

After the Court granted Plaintiffs' Motion for Partial Summary Judgment, finding Defendants to be in violation of the NC Persons with Disabilities Protection Act as it relates to people with I/DD, the Defendants requested that the remedy in this case be developed in the context of a cross-disability Olmstead Plan and asked for time to conduct data analysis and to put forth carefully considered remedial steps. The Court has afforded Defendants since February 2020 to prepare a plan that would provide the beginning of a path to a complete remedy. On October 12, 2021, Defendants issued a draft "North Carolina Olmstead Plan."

The Draft Plan does not provide the relief called for by the established violation and does not provide the parties or the Court with a means of effectuating a remedy in this case. As detailed below, the Draft Plan projects a continuation of the status quo, with no reform of the current system and no appreciable change in effort.

Based on the requirements for compliance with the Integration Mandate and the recommendations from the Technical Assistance Collaborative (TAC), remedial measures should have included the following:

- **a roadmap for shifting funding from institutional to community-based settings.**
- **a path for addressing the growing Registry of Unmet Need.**
- **measurable benchmarks for reducing ICF populations and the implementation of specific in-reach and diversion programs.**
- **a timeline for professional credentialling for DSPs and a mechanism to ensure that LME/MCOs (and their successors) are paying the rates necessary to reverse the desperate shortage of DSPs and other providers in the community**.
- **measurable outcomes and a means to measure progress with data.**

In order to provide a path to a remedy in this case, the Final Plan must contain key components that are not reflected in the Draft Plan.[1]

I. Defendants' Draft Plan Fails to Address Multiple Key Components Necessary to Achieve Compliance with the Integration Mandate

Remedying a systemic violation of the Integration Mandate requires a detailed plan to alter institutionally biased funding and structures. As the Department of Justice has explained:

> An *Olmstead* plan . . . must have specific and reasonable timeframes and measurable goals for which the public entity may be held accountable, and there

[1] Based on the plan development schedule Defendants have submitted to the Court, there will be a two-month period of review, discussions, and revisions by TAC and Defendants. TAC will then issue the Final Plan to DHHS in late December. No date is provided for public issuance of the Final Plan.

must be funding to support the plan, which may come from reallocating existing service dollars.

Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. (ada.gov).

Key components to an Olmstead Plan were identified in the report issued by TAC in April 2021 (TAC Report), as well as by Defendants' staff and experts designated in the litigation. The Draft Plan fails to address these key components. TAC has also extolled the importance of measurable goals, but that guidance is not reflected in the Draft Plan.[2]

A. The Final Plan must include a roadmap for shifting funding from institutional to community-based settings.

There are no provisions in the Draft Plan that reallocate funding from institutional to community-based services. In their April 30, 2021 report, TAC advised:

> DHHS cannot continue to devote more than 60% of its non-Medicaid resources to support institutional care that serves less than 10% of people with SMI, I/DD, and SUDs.…
>
> If it is to build a viable system of community services and supports, North Carolina cannot sustain the level of state-operated capacity and infrastructure that is currently funded.
>
> DHHS should determine the most efficacious method(s) of addressing the changing need for SOHFs [state-operated healthcare facilities, including Developmental Centers for people with I/DD] by considering options such as downsizing the capacity of existing facilities, consolidating facilities, or divesting of some services and facilities altogether.

TAC Report, p. 117. TAC then outlined several different options for cost-savings. *TAC Report*, pp. 117-118. Under the heading, "Repurposing Existing Funds," TAC indicated:

[2] The full, but limited and ineffective, list of arguably measurable provisions applicable to people with I/DD are as follows: 1000 new Innovations Waiver slots per year for 2 years (the same as prior years) (pending approval and funding)(Draft Plan, p. 16.); 68 Money Follows the Person program transitions to Innovations Waiver, which is the same as prior years (Draft Plan, p. 24); assistance with 100 transitions from jails/prisons in 2022 and 60 in 2023 to reduce recidivism (a program of the NC Council on Developmental Disabilities) (Draft Plan, p. 25); up to 33 more people who have an Innovations Waiver slot will use Supported Living instead of different home and community-based services (Draft Plan, p. 34); and 100 individuals/families will be educated about supported decision making as an alternative to guardianship (Draft Plan, p. 41); and DSP eligibility for $15/hour. (Draft Plan, p. 20.)

> North Carolina can correct its imbalanced expenditure of limited state resources by repurposing funding for state-operated health care facilities and increasing funding for individuals to be served in the community.
>
> DHHS should quantify the savings to North Carolina for those transitioned from institutional placement, in order to support the business case for community-based services. . . . [R]epurposing funds that currently support institutional and congregate care to options that promote community integration will assist North Carolina in complying with *Olmstead* and reduce the likelihood of further *Olmstead* litigation. . . . DHHS should continue to downsize ICF capacity and repurpose funds to enhance and support community-based services.

TAC Report, p. 119.

A number of Defendants' employees and experts noted during discovery that it is imperative to repurpose funding from institutional services to community-based services. The state's expert noted that the fiscal inefficiency of maintaining congregate settings further limits the availability of funds for community-based services. Deposition of John Agosta, pp. 113:13-114:8. "It was best practice in the United States as it continues to be to either downsize or close developmental centers." Deposition of Holly Riddle, p. 62:14-16.

In the "Proposed Strategies" section related to Priority 1, the Draft Plan indicates:

> The DHHS will continue efforts to promote serving individuals in community-integrated settings, and will assess annual expenditures for institutional and community-based care with the intent of further rebalancing state and federal resources to support more individuals with disabilities in the community.

Draft Plan, p. 15. This Proposed Strategy suggests that DHHS will undertake an assessment at some unidentified time. The data analysis and planning stages leading up to this Draft Plan were supposed to accomplish this core, necessary component of realigning the service system.

A roadmap for system realignment, including careful reduction and reallocation of spending, should have been the core work conducted over the last year and a half. The Draft Plan should have included an explanation of how specific changes in funding priorities will be accomplished, and how repurposed funds would begin to address current needs.

TAC was clear that the state cannot build a sustainable community-based system while maintaining its annual investment in institutional settings. The Draft Plan does not contain "specific and reasonable timeframes," does not forecast a process for achieving savings, and otherwise completely lacks any projections or planning on this issue. The reference to the intent to "assess" spending is devoid of content and serves only to highlight the missed opportunity that should be remedied in the Final Plan.

B. The Final Plan must outline a path for addressing the growing Registry of Unmet Need.

Defendants' plan to request 1000 additional Innovations Waiver slots each year to be funded by the General Assembly is essentially the same request that has been made each year for many years. *Draft Plan* p. 16. As TAC noted in their April 30, 2021 analysis:

> DHHS can continue to request additional funding for Innovation Waiver slots; however, additional funding alone will not likely be enough to fully address the needs of individuals on the list. . . . North Carolina should ensure that savings realized through any downsizing or consolidation of State Centers be allocated to fund additional waiver services.

TAC Report, pp. 126-127. As of January 2018, there were 11,698 people on the Registry of Unmet Need. *Strategic Plan for Behavioral Health*, p. 26. Now, there are more than 15,000. *Draft Plan* p. 16. If approved, the additional slots might keep pace with the growth of the waiting list over the next two years but would not reduce it. Notably missing is any statement of an intent to try to increase the rate of access to Innovations Waiver services in future years. As noted above, there is also no provision for downsizing or consolidation of state institutions as a means of redirecting resources. There appears to be no vision for ultimately tackling this core problem.

The Innovations Waiver is the primary means for people with I/DD to access community-based services. The 15,000 people waiting – some for more than a decade – cannot be ignored in an effective plan. The proposal for 1000 slots per year for two years is not enough for the reasons noted above. Even if the Defendants are unable to commit to the full eradication of the Registry in the short term, there must be some plan to address the unmet needs – including timeframes - to provide for a remedy in this case.

TAC has suggested that those on the Registry may be eligible for other services that could mitigate or obviate the detriment of being without Innovations Waiver services. The realization of this potential is not explored in the Draft Plan. To the extent that other sets of services could meet the current unmet need, there should be a clear path toward providing those services to more people each year.

C. The Final Plan must have measurable benchmarks for reducing ICF populations and must include the implementation of specific in-reach and diversion programs.

The Draft Plan appears to presume the continued current level of use of private ICFs (where most people with I/DD are institutionalized), failing to even hint at reducing reliance on these settings. In its April 2021 Report, TAC had recommended converting ICF settings to smaller, community-based group homes: "DHHS should reduce the size of any DHHS-funded facility with more than six beds and should consider reducing community-based settings to

housing no more than three unrelated individuals." *TAC Report*, p. 112. "DHHS should continue to downsize ICF capacity and repurpose funds to enhance and support community-based services." *TAC Report*, p. 119. There are no provisions in the Draft Plan for reducing the number of people placed in ICFs.

TAC also recommended that Defendants undertake diversion and in-reach efforts to prevent admissions to institutions like ICFs, and to assist with transitions out. Referring to a process called "RSVP" currently in place to divert people with mental illness from institutions, TAC advised:

> DHHS should expand RSVP or implement a similar process to ensure that all individuals with disabilities receive information about their service options and are able to exercise informed consent in choosing the best option for their needs.

TAC Report, p. 118. More specifically, "DHHS should provide In-reach to all ICF residents, insuring they are fully informed of their community-based living options." *TAC Report*, p. 112. TAC also recommended care coordination assistance to those in ICFs: "LME/MCOs should provide care coordination for residents of community-based ICFs, to ensure that people do not move into ICFs and live there with no one advocating for their transition to a more independent setting." *TAC Report*, p. 120.

None of the above recommendations are addressed in the Draft Plan, which makes almost no reference to ICFs.

During the past year, Defendants' staff indicated that there is work being done on an RFP to secure a contractor to assist with in-reach to the state-operated ICFs, with an eye toward expanding to private ICFs. The lack of any reference to this in the Draft Plan suggests that this initiative is not proceeding. A similar staff proposal for in-reach and diversion akin to that offered people with mental illness was under discussion in 2018 but has likewise failed to materialize. Deposition of Kathy Nichols, pp. 31-32.

While Priority Area 3 of the Draft Plan is entitled "Divert and Transition Individuals from Unnecessary Institutional and Segregated Settings," there are no new diversion and in-reach programs for people with I/DD noted, and no expansion of existing programs to include people with I/DD. *Draft Plan*, p. 20.

Apart from the continuation of the pre-existing Money Follows the Person program at current levels (Draft Plan, p. 24), the Draft Plan does not address the recommendations from TAC (and DHHS staff) for diversion and in-reach as it relates to people with I/DD. There is simply no way to effectuate a change in living situations for people with I/DD without an affirmative effort. As the Department of Justice has noted:

> Public entities must take affirmative steps to remedy [the] history of segregation and prejudice in order to ensure that individuals have an opportunity to make an informed choice.

Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. (ada.gov).

Finally, Defendants continue to ignore the necessary role of LME/MCOs in effectuating change in the state's overreliance on institutions. The contracts between DHHS and its contractors provide for performance measures. None of these performance measures relate to the success or failure in preventing institutionalization or in facilitating deinstitutionalization. The Draft Plan notes – as a pre-existing measure - that "DHHS contracts require the Behavioral Health I/DD Tailored Plans 'to identify members who are receiving care in institutional settings and help transition them to the community, if their needs can be safely met in the community.'" *Draft Plan* p. 57. The existence of a vague contract provision has been insufficient to change behavior or prompt action. Moreover, suggesting that LME/MCOs' obligation is excused when adequate community services are not already available ignores the LME/MCOs' obligation to develop the provider network that is supposed to be serving as the alternative to institutionalization. DHHS must create *and enforce* performance measures that force contractors to actively pursue in-reach and diversion.

D. The Final Plan must have a timeline for professional credentialling for DSPs and a mechanism to ensure that LME/MCOs (and their successors) are paying the rates necessary to reverse the desperate shortage of DSPs and other providers in the community.

A critical issue in staffing some community-based services is that many low skilled jobs, such as those in fast food, have comparable pay. In addition, staff working in institutional settings are generally paid more, and those working in state-operated facilities also enjoy benefits associated with state employment. This creates an inherent institutional bias in the availability and quality of staffing for those who want to live in the community.

The Draft Plan includes a provision that Direct Support Professionals (DSPs) will be "eligible" for pay of $15 per hour beginning July 1, 2022. There is no indication whether that will be a minimum rate, a top rate, or something else. The once-aspirational rate of $15 per hour is now commonplace in entry level positions, and the Draft Plan – which is constructed to serve for two years – makes no reference to increases necessary to keep pace with the marketplace, or to match compensation of DSPs working in institutional settings.

In Appendix A, the Draft Plan points to the filing of House Bill 665 under the heading "North Carolina's Additional Efforts to Date in Achieving Olmstead Plan Priorities." *Draft Plan*, p. 55. HB 665 would raise compensation *for staff in private ICFs*, with the express intent of increasing staffing in those institutions, matching compensation of those working in state-operated ICFs, and keeping pace with state salaries. *See* H665v1.pdf (ncleg.gov). The legislation

allocates $17.5 million in 2021-22 and $21.8 million in 2022-23 in recurring funds to support the increase in salary *for staff working in institutional settings*. These allocations would allow the state to draw down federal matching funds of $115 million over the course of the corresponding fiscal years. HB 665 is listed in the Draft Plan as an additional effort to address the DSP crisis, but it would exacerbate it as it relates to community services. More to the point, the inclusion of this bill reflects a fundamental failure to *counteract* barriers to the availability of DSPs to those who do not want to live in an institution.

The Draft Plan also ignores the role of LME/MCOs in ensuring – through enhanced pay, training, or other means – that DSPs are available and equipped to support people with I/DD in the community. Each LME/MCO controls its provider network and the LME/MCOs' contracts require them – as a key component of their contracts - to ensure the availability of providers. The missing component, as the TAC Report notes, has been the enforcement of the LME/MCO contracts on this and other points. *TAC Report*, p. 122. The continued failure to hold managed care contractors accountable to their core functions will only exacerbate the current problem. This failure stands in stark contrast to the above-referenced effort to increase funding for pay increases for those who work in institutional settings.

The Draft Plan's aspirational statements about professionalizing the DSP workforce is devoid of measurable content. While referencing the need to provide for training and professional credentialing, the Draft Plan has no benchmarks or target dates for implementation. This is a key omission, given the centrality of workforce development to any hope of building a sustainable community service system.

E. The Final Plan must forecast measurable outcomes and have a means to measure progress with data.

TAC has held up the Minnesota Olmstead plan as a model because it is data driven, has financial commitments, and measures progress with data. The original Minnesota plan (approved by a federal District Court as part of a class action settlement) contains numerical benchmarks by which the individual goals of the plan can be measured. They begin at page 22 of the plan document: Document-571-2.pdf (uscourts.gov).[3] The District Court had rejected prior versions of the plan because they did not contain clear and measurable goals. See *Jenson v. Minn. DHS*, No. 09-1775, pp. 7-8 (D. Minn.) (available at: Court-MN-Olmstead-09-29-15_tcm1143-463306.pdf). In accepting the 2015 plan, the court noted that:

> inclusion of specific measurable goals and timetables represents a marked improvement from prior versions of the Olmstead Plan. These goals are **supported by adequate baseline data** and are accompanied by **concrete and reasonable deadlines for completion**. The new Olmstead Plan replaces vague

[3] The current plan and updates are maintained here: Plan Documents and Reports / Minnesota Olmstead Implementation Office (mn.gov).

> assurances of future integrated options with **verifiable commitments tied to specific metrics**. (See, e.g., Doc. No. 486-1 CASE 0:09-cv-01775-DWF-BRT Document 510 Filed 09/29/15 Page 7 of 15 8 at 45 (**identifying a numeric baseline and annual goals to increase the number of individuals with disabilities living in the most integrated setting**); id. at 50-51 (identifying numeric baselines and annual goals to increase the number of individuals with disabilities working in competitive, integrated employment).) In this Olmstead Plan, the State provides a rationale for each of the metrics used, explains why each metric was chosen, and **explains how each metric will adequately reflect improvement over time**. (See id. at 21.) The State also clearly identifies those areas where additional data is needed to ensure accurate measurement moving forward and commits to obtaining such data in a timely manner.

Id. (emphases added).

The Draft Plan does not reflect adherence to the Minnesota model, notwithstanding that sufficient baseline data is available. DHHS, at the direction of the General Assembly, undertook detailed analysis of data related to I/DD and other behavioral health services in 2018. *Strategic Plan for Improvement of Behavioral Health*, pp. 83-87. TAC, likewise, undertook a data analysis in the 15 months leading up to the release of the TAC Reports. *TAC Report*, p. 7. The underlying data was supposed to be critical for the development of the Defendants' plan. The Draft Plan – in addition to containing scant benchmarks – fails to incorporate or reflect baseline data from which benchmarks can be measured. The TAC framework was also to include a system for performance evaluation and outcome measures; there is no such system apparent in the Draft Plan.

There is an opportunity in the next two months – while TAC remains engaged and the data and analyses are current – for Defendants to course-correct and provide the Court with a Final Plan that, like the Minnesota plan, has measurable goals and timelines, funding, and verifiable commitments to increase integration.

II. Conclusion

If the Final Plan is materially the same as the Draft Plan, there will be no change in the status quo for people with I/DD. Defendants have proposed to continue employing the same structure for the I/DD system that has existed since before the Court's determination that the current system violates the Integration Mandate.

It is reasonable for a plan to be a "living document" that gets adjusted when circumstances change or there are different results from what was projected. But the Draft Plan is not a "living document" that will, with periodic adjustments, remedy the Defendants' ongoing violation of the rights of people with I/DD. It does not project a result – even one in the distant future – where the I/DD service system can support people in the community. It does not show

a trajectory toward such an end point. The measures associated with people with I/DD break no new ground. They reflect the status quo. The status quo is not an effective plan.

Likewise, the deficiencies in the Draft Plan do not bode well for efforts after the first two years. The various "Proposed Strategies" and other ideas referenced in the Draft Plan have no measurable substance or outcomes. There is no way to determine whether progress is made, or even what that progress is supposed to look like. To the extent that Defendants are asking the Court to wait for two years to see what happens, there is no forecast as to what Defendants even hope to have happen in the interim that will begin to remedy the ongoing violation of the rights of people with I/DD.

Plaintiffs ask that the Court direct the Defendants to return with a Final Plan that remedies their violation of the NC Persons with Disabilities Protection Act.