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FOR MENTAL HEALTH AND
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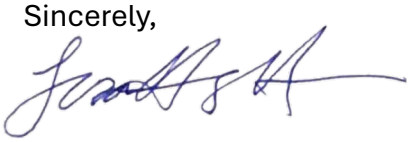
Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD)

Public Comment on Proposed Olmstead Plan – May 8, 2026

OMHDD submits the following public comments on the draft Olmstead plan. We look forward to continuing collaboration with the Olmstead Implementation Office, the Leadership Forum, the Subcabinet, the Inclusion Consultants, people with disabilities, and other stakeholders as the plan revision process moves forward.

Sincerely,



Lisa Harrison-Hadler
Ombudsman for Mental Health and Developmental Disabilities

Background

The Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD) has a statutory mission to promote the highest attainable standards of treatment, competence, efficiency, and justice for persons receiving services for mental illness, developmental disabilities, and substance use disorder. We advocate for clients' rights, health, and well-being; monitor service delivery systems; and provide recommendations for systemic improvements.

OMHDD has been involved in the Minnesota's Olmstead Plan from prior to its initial inception, as part of our work in the *Jensen* federal class action lawsuit leading to the plan's development and subsequent court approval. We have been committed to this work and appreciate the ongoing opportunities for interagency collaboration to improve the lives of Minnesotans with disabilities. We acknowledge the laudable intent of the previous plan to "put the promise of *Olmstead* in to practice". However, despite our continuous efforts between 2012 and 2023 to further that intent, the plan did not achieve many of its goals and lacked accountability when goals remained

stubbornly unmet year after year with little progress or path forward to attain them. During that time, OMHDD served in the subcabinet, as one of the first Leadership Forum co-chairs, and provided extensive informal and formal recommendations for its improvement, including submitting a comprehensive review of the plan to OIO and the Subcabinet in July of 2022.

In 2023, OMHDD supported reimagining the plan. We believed that continuing to tinker around the edges of a fundamentally flawed plan that sought minute, incremental changes that were based on what was seen as achievable was insufficient. We have worked with OIO, the Leadership Forum, the Subcabinet, agencies, and Inclusion Consultants promoting a plan with more aspirational, meaningful goals aimed at improving the lives of Minnesotans with disabilities. While we appreciate the co-creation model, the process has not been without challenges – challenges so eloquently shared by the Inclusion Consultants in the March 2026 Subcabinet meeting.

Lack of Transparency, Clarity, and Definitions

Definitions

There are a number of definitions that are missing or inaccurately represented in the plan. While OMHDD appreciates the commitment to plain language, these issues actively prevent the robust and engaged public comment Minnesotans deserve. OMHDD will not highlight every instance within the plan of missing, inaccurate, or unclear definitions but will highlight a few.

Community-Based Services

Confusion surrounding Direct Care Treatment Community-Based Services

The plan refers to "Community-Based Services (CBS)" and defines them as a range of supports for children and adults with:

- Complex behavioral health needs
- Intellectual and developmental disabilities
- Involvement in the criminal legal system
- Emotional challenges

The purpose of CBS is to support people living in the community, rather than institutions. They promote stability, independence, and community integration. CBS includes:

- Small residential homes with daily living support and medical oversight
- Vocational programs to help people prepare for and keep jobs
- Mobile clinical teams that provide individualized behavioral health services
- Intensive therapeutic foster care for youth with mental health disabilities
- Specialized programs for people who may pose a danger to the community that offer:
    - Person-centered planning
    - Positive behavioral supports

- Crisis stabilization
- Transition services

However, this definition appears to be limited to the state's *Direct Care and Treatment Community-Based Services* – where these services are delivered by DCT as the state safety net provider. Yet as written both in the definition and a goal itself, there is no mention of DCT as the provider of these services. Nor is there clarification between DCT CBS to broader home-and community-based services provided through waivers and delivered by private providers.

Civil Commitment

There is no voluntary civil commitment.

The appendix glossary defines civil commitment as "when a court orders someone to receive treatment. This could be treatment for mental illness, substance use disorder, or other conditions. Commitment can be **voluntarily or involuntary**." OMHDD, as the state's Civil Commitment Training and Resource Center, feels compelled to point out this is patently inaccurate. There is no voluntary civil commitment. There are voluntary treatment and services contemplated in the Minnesota's Civil Commitment and Treatment Act, but there is no voluntary civil commitment. In fact, the standard of proof outlined in MN Statute 253B includes that the court must consider reasonable alternatives to civil commitment including voluntary inpatient, outpatient, or community-based treatment care options. Only when the court finds, by clear and convincing evidence, that "there is no suitable alternative to judicial commitment, the court shall commit the patient…"

Mentally ill and Dangerous

This definition is oversimplified

The definitions include "Mentally ill and dangerous (civil commitment): Mentally ill and dangerous is a type of civil commitment. People who are committed as mentally ill and dangerous pose a danger to themselves or others." Again, as the state Civil Commitment Training and Resource Center, this is an oversimplification. A risk of harm to self or others is a criterion for all civil commitments. There are other elements to meeting the criteria for a Mentally Ill and Dangerous commitment.

Institutions

The term "group home" is applied inconsistently throughout the plan.

The glossary defines institutions as

> "Institutions are segregated spaces where people live. People living in institutions have limited control over their own lives. They often don't get to choose who they live with, what activities they do, or what they eat. Institutions can include places like group homes, hospitals, long-term care homes, and prisons."

OMHDD has several concerns with this oversimplification. While, in principle, we agree that some of these settings function as institutional settings, wherein people lack choice or control over their daily lives, using this as the definition throughout the plan draft quickly becomes confusing.

Among other things, what is a long-term care home? Are all group homes considered institutions for the purposes of the Olmstead draft plan? How, then, does this align with moving people from Minnesota's most segregated, institutional settings (i.e. AMRTC, FMHP, Corrections, hospitals, etc.) into community based settings?

Institutional Settings – DCYF goal

This goal does not include hospitals and hotel crisis respite as "institutional settings" which ignores the reality of many children's experience.

In this DCYF goal, the definition includes "Children who are in foster care can be placed in different types of settings. One example is in institutional settings. Institutional settings for children in foster care include:

- Children's residential facilities
- Shelters
- Corporate group homes
- Juvenile detention facilities
- Psychiatric residential treatment facilities"

Notably, unlike every other institutional setting outlined in the plan, the DCYF goals do not consider hospitals to be an institutional setting pursuant to this definition. This fails to recognize the critical issue of children boarding for days, weeks, months, or even over a year in hospital settings. Certainly, for the purposes of our state's Olmstead plan, we should consider hospitals an institutional setting given these timelines – timelines in which children are separated from their families and communities, unable to go outside, to play, to attend school or any meaningful educational activities. OMHDD appreciates DCYF's acknowledgement and intent to focus on those things within its control, but to exclude hospitals as an institutional setting seems to misrepresent the current reality far too many Minnesota children experience. OMHDD further questions the exclusion of children receiving crisis respite in hotels from this list. Again, children may spend many weeks and months in these settings, largely due to no other provider available to meet their needs. OMHDD does acknowledge hotel crisis respite being phased out following changes to the federal waiver plans, but with no clear timeline for implementation, it is unclear how much longer this practice will continue and how it is functionally different than a child receiving services in a shelter or corporate group home.

Additionally, we would point to the term "group home" being used in many different ways throughout the draft plan. Here, is corporate foster home to mean a child foster care residence setting?

Locked Setting/Facility

This definition does not include CBHH and CARE facilities, which are also locked settings.

The glossary definition describes the DCT operated settings and includes references to AMRTC and FMHP. However, the CBHHs and CARE facilities are also locked. Does this glossary definition also then include locked/secure inpatient psychiatry units operated by private hospitals? This creates some concerns about data reporting, clarity, and transparency involving some of the Transitions goals, outlined in more detail for each specific goal.

No definition for Institutes for Mental Disease (IMD)

IMD definition lacking.

The draft plan includes in Transition goal 7 to move people from segregated to integrated settings and includes among segregated settings IMDs. There is no definition in the glossary or elsewhere on what constitutes an IMD. IMDs have a very specific federal definition that carries implications for funding. Does DHS propose tracking discharges for all IMDs in MN or just those that are state operated? If state operated, why not just list those? Will DHS consider data from the new Capitol Park/Acadia freestanding psychiatric hospital? How will it access that information for people whose services are not paid via MA or the behavioral health fund? Under what data sharing authority would DHS track discharges from IMDs as a whole, not just a limited subset, to more integrated settings? How does this align with federal protections regarding SUD records?

No definition of Permanent Supportive Housing (PSH)

PSH definition lacking.

The lack of a definition for Permanent Supportive Housing (PSH) anywhere in the glossary is problematic in that while these units may serve individuals with disabilities, there are other eligibility categories as well, i.e. long-term homelessness that may not involve people with disabilities. Without a definition or acknowledgment that these settings are not exclusively accessed by people with disabilities, goals related to permanent supportive housing may be construed as misleading for those without expertise in this housing model and who it serves.

Measurable Goals by Topic Area

Measurable Goals and Strategies – SMART Goals

Many goals do not include key elements agreed upon by the Leadership Forum.

OMHDD appreciates the introduction of the goals to include "[m]easurable goals are the foundation of an effective Olmstead Plan. These are goals that are specific, measurable,

achievable, relevant, and time-bound (SMART)." However, OMHDD believes *many* of the goals lack one or more of these essential elements.

In March of 2025, the Leadership Forum discussed and recommended that goals in the new plan

- be concrete and reliable; realistic and achievable; strategic and relevant
- improve the lives of people with disabilities in a meaningful way
- Olmstead Plan goals should identify and address disparities.

In that meeting the Leadership Forum agreed to a template for goals including

- goal overview, including descriptions and benchmarks
- goal data, based on a five-year plan, including target, baseline, long-term/stretch goals
- data sources (information on underlying data)
- goal strategies and priorities, including strategies, performance accountability metrics, data disaggregation.

OMHDD notes that many of these elements are missing for many of the proposed goals. We note the following as the most often concerns or missing elements of goals:

- That they are far too narrow, with too low targets, to improve the lives of people with disabilities in a meaningful way.
- They are not based on a five-year plan.
- Data sources are missing or misleading.
- Goals do not identify or address disparities.
- Goals reflect existing state or federal requirements for agencies merely duplicated in the Olmstead plan without aspiring higher.

Crisis Services

Goal 1: Fewer children and teens in foster care will experience institutional placements

This goal has the potential to create barriers to medically necessary care for children.

OMHDD supports the intent of serving children in out-of-home placements in non-institutional, community-based, and most integrated settings. However, we do caution about a goal that has the potential to create barriers to children receiving medically necessary care.

For years, OMHDD has raised concerns about access to children's residential treatment under Chapter 260D wherein children are voluntarily placed *for treatment*. We also want to acknowledge the shrinking capacity of children's residential and psychiatric residential treatment facility capacity due to a multitude of reasons, including workforce shortage. Aspire MN reported a reduction in bed capacity in children's residential facilities during the pandemic, from 2020-2023 of 601 beds, or 30% of all licensed capacity in those settings. With sustained reductions in capacity, fewer children will enter care in institutional settings regardless.

Importantly, this goal is about all children in out-of-home placement, not specific to children with disabilities who make up only 71% according to the baseline information provided.

As a strategy, DCYF proposes partnering with DHS to "create cross-training for child welfare, children's mental health, and children's waiver case workers and residential services providers…" How are these training and proposed resources to be developed different than that already offered by DHS or DCYF?

Education

Education Goal 1: More students with disabilities will learn in integrated classrooms.

This is a one-year goal, far shy of what is needed to demonstrate meaningful change and does not address racial disparities within special education.

OMHDD concurs with the underlying intent that more MN students with disabilities will learn in an integrated classroom. However, this goal falls deeply short by limiting itself to a **one-year goal**, by January 1, 2027, to increase the number of students in integrated settings by 2.16%. In looking at the baseline data provided, an increase of 2.16% translates to 3,126 more students in one year learning in integrated classrooms compared to the 144,720 students with disabilities. Assuming a 2.16% increase is an acceptable target per year, which OMHDD believes is far too low, limiting it to a one year goal, as opposed to a five-year goal with year over year increases in students learning in the most integrated setting, leaves out an estimated **12,504** students had the goal to increase by 2.16% simply been extended to each of the draft plan's five years.

Additionally, as a state, we know that significant and harmful racial disparities persist in special education. We've known for decades that African American and American Indian children are disproportionately represented in special education and more restrictive settings. Despite knowing this, and despite the plan referencing an intent to acknowledge and address disparities in the goal development, OMHDD finds the omission disappointing.

OMHDD questions how the strategies identified will be different than existing training and best practices available from MDE to promote inclusive education. Ways to incorporate enforceability of local school districts' obligations to serve children with disabilities in the most integrated setting are sorely needed. Too often, OMHDD sees students and families pressured into accepting overly restrictive settings due to schools' lack of capacity or understanding of their obligation to students with disabilities under state and federal law.

Education Goal 2: Schools will better engage families of students with disabilities.

The data this goal relies on is unclear or unreliable and does not reflect meaningful comparisons between baselines and projected goals.

Nowhere in the draft plan is family engagement defined. As an entity providing direct special education advocacy services for students with disabilities under our purview, OMHDD has concerns about the lack of transparency and confusion in the absence of clarity on what does and does not constitute family engagement. Are families who participate in the survey predisposed to report higher engagement? For this goal to be meaningful, it would be helpful to also know how many total surveys were sent out and the corresponding response rate.

A target of 72% of families of children with IEPs will report that schools will facilitate engagement seems too low. While it may align with MDEs target as established by its federal Office of Special Education Programs obligations, incorporating the very same benchmark into the Olmstead draft plan does nothing to move Minnesota forward. MDE's starting baseline of 69.8% fails to recognize that this is lower than pre-pandemic levels, which were at a high point of 74.49% in the 2019/2020 school year per MDE's most recent report. Communicating not just percentages, but target numbers is important. Using existing data on the number of responses received in the baseline information, the goal is met with a mere five additional families to cross the 72% threshold established by the federal government. Five. Again, this does not align with the stated intent of the plan goals to have a meaningful impact.

As in education goal one, we question why only one year of a five-year plan is included. Assuming the target of 72% was achieved by February 1, 2027, why would we not strive toward continued incremental increase each year? Given the timeline of the plan's implementation, OMHDD cannot envision a scenario in which the plan is approved in the fall of 2026, MDE develops and deploys its listed strategies, *and* those strategies having had a meaningful impact prior to February 1, 2027. How will we discern the impact of those strategies without additional goals for the duration of the plan?

OMHDD appreciates the expansion of outreach efforts to underrepresented communities beyond families who speak languages other than English, Hmong, Somali, and Spanish as a strategy.

Education Goal 3: Fewer students with disabilities will be suspended and expelled.

This goal insufficiently addresses school districts identified as disproportionately disciplining students with disabilities.

Working to reduce the number of school districts known as disproportionately disciplining students with disabilities is critical. OMHDD would suggest that if the intent of the discipline definition is to mean suspension longer than ten *consecutive* days, that be clarified. Otherwise, there may be some confusion about cumulative days in a school year and manifestation determination implications.

Here again, as part of a five-year Olmstead plan, OMHDD questions why there is a single goal for February 1, 2027. If there are currently 29 districts identified as disproportionately disciplining students with disabilities, and a goal to reduce that number to 17 by 2027, and no further goals in

the plan, that suggests that some ongoing level of disproportionate discipline among districts is acceptable. OMHDD rejects that premise. The number of districts identified as disproportionately disciplining students should be zero.

With OIO anticipating plan approval in the fall of 2026 and a single goal date of February 1, 2027, OMHDD questions the feasibility of MDE developing and incorporating their enumerated strategies. If reducing the number of identified school districts by 12 schools is possible in less than the first six months of the plan, why wouldn't we as a state seek to reduce by another 12 schools in subsequent years until we reach zero? Given the civil rights implications and the number of MN school districts facing administrative or legal action from both the state and federal level in recent years, there should be no "acceptable" number of districts reporting these disparities. At a minimum, in our state's Olmstead plan, we should collectively strive to maximize equity, justice, and inclusion for all students, regardless of their district.

Lastly, does the strategy expanding use of PBIS statewide mean to all schools in MN? Or another incremental expansion in different parts of the state?

Education Goal 4: More staff will be equipped to support children with disabilities in early care and education (ECE)

The goal should focus more on the experience of the child and family, rather than care providers, to support a direct connection of increased training having an impact of informal suspensions and expulsions in ECE.

OMHDD has long been aware of the challenges for parents and families accessing consistent, quality, early care and education programs. The examples the plan cites surrounding requests to pick up early, altering schedules, or not being a good fit are consistent with what has been reported to us. That said, it is our vision that Minnesota's Omstead plan be about *people* not provider staff. This goal, as written, does not clearly connect the training staff receive with the number of informal suspensions and expulsions this goal aims to achieve. We understand staff training and support being a necessary factor, but that does not mean that the discriminatory practices of suspending or expelling preschool and pre-K programs would diminish. Having the goal focused on the child and family, rather than the provider, would be preferable.

Education Goal 5: Fewer students with disabilities will experience maltreatment at school.

The goal as stated implies that some level of abuse and neglect is acceptable. Given consequences of not meeting the goal (continued maltreatment of students with disabilities), the goal is far too conservative.

As we pointed out in our July 2022 submission to the Subcabinet, OMHDD remains concerned that the plan does not adequately seek to prevent the abuse and neglect of students with disabilities. Trying and failing to meet an aspirational goal to prevent abuse and neglect is

preferable to setting predictably achievable standards. Focusing solely on incrementally reducing abuse and neglect rather than eliminating it in the goal statement, gives the unintended impression that some level of abuse and neglect is, if not acceptable, unavoidable. OMHDD rejects that premise. Additionally, the proposed goal is far too conservative in reducing the number of victims of substantiated maltreatment by only *two* students. As the state agency that receives and reviews these reports of students shoved, punched, kicked, neglected, subject to prone restraint, prohibited seclusion, and sexually abused, we stress that the plan must aggressively act to prevent the trauma experienced by children with disabilities who are maltreated at school, a place that should be safe. In OMHDD's review, it is not uncommon for the substantiation to be largely based on video evidence after a school employee has denied the maltreatment. We maintain concern for those reports that do not have such clear, objective evidence to support a maltreatment finding and shudder at how many more students may be subjected to abuse and neglect than can be substantiated.

Again, the timelines for plan approval and the goal date of June 30, 2027 do not align. It does not seem feasible that MDE would have sufficient time to fully develop and deploy the listed strategies to achieve a reduction in maltreatment in nine months. More concerning, however, is a June 30, 2027 measurable goal date when the data is reported 24 months after the school year ends. Does this, then, mean MDE will report in 2027 using data from 2025? Or, more likely, will data on the 2027 goal not be provided until 2029, seeking to show a reduction of *two* students being abused or neglected? Both are problematic and seem to lack transparency as outlined in this draft goal.

Education Goal 6: Fewer students with disabilities will experience restrictive procedures.

The goal fails to recognize that seclusion is already prohibited for students birth to third grade, therefore misrepresenting the target of the goal.

OMHDD is disappointed to see so low a target established. Reducing the number of students subject to use of restrictive procedures by 0.1% over a three-year period is simply not ambitious enough. This goal also fails to recognize that as of September 1, 2024, the use of seclusion is prohibited for students from birth to third grade as passed by the legislature. The impact of that most certainly will reduce the overall number of restrictive procedures without any other intervention. Failure to include that context in a draft put out for public comment at best lacks transparency and, at worst, seems disingenuous.

It would be helpful if goals included both percentages and targets, as had been discussed at Leadership Forum. For this goal, a reduction of 0.1% in the number of students subject to restrictive procedures equates to **145** fewer students. With over 300 school districts in MN, that could be achieved with *less than half* the districts reporting *one fewer* student experiencing restrictive procedures. Knowing how deeply traumatic restrictive procedures can be for students, their peers, and school staff alike, and the lingering impacts of that trauma with the potential to change the trajectory of people's lives in both the short and long term, Minnesota should seek far

more aspirational goals in its Olmstead plan. As Minnesota's Olmstead Plan was initially developed as part of the *Jensen* Settlement Agreement involving the inappropriate use of restraints, it is even more incumbent upon us to hold high standards and aspirations surrounding the reduction of restrictive procedures in schools. This goal does not reflect either.

Lastly, MDE mentions the expansion of Positive Behavior Interventions and Supports (PBIS) to be expanded statewide. That may also be applicable here. OMHDD also questions whether the strategies are new or whether they are existing strategies being recycled for this draft. Will the publicly shared information about reducing the use of restrictive procedures encompass more than what is already available on the MDE website and provided to districts?

Employment

Employment Goal 1: More people with disabilities will have jobs in the community.

There is an erroneous reference on page 23 to goals 8A, 8B, and 8C. These should be updated to 1A, 1B, and 1C respectively.

Employment Goal 1A: By December 31, 2030, 45% of people served by VRS/SSB will have CIE.

The targets for this goal are too low.

OMHDD appreciates the description of the challenges outlined in the draft surrounding the timelines, from start to finish, for someone to find competitive integrated employment. That said, an increase of just 3.5% in the next four years seems low, particularly when considering people already being served by VRS/SSB in various stages of the process. OMHDD is sensitive to the budget cuts impacting VRS/SSB and the implication to this goal. However, we know that Minnesota lags behind other states in terms of CIE. In fact, information available from the Institute on Community Inclusion in Boston indicates that Minnesota steadily declined in several key outcomes between 2016 and 2023.

Department of Employment and Economic Development, Vocational Rehabilitation Services and State Services for the Blind

Table 7: Vocational Rehabilitation (VR) Case Closures and Employment Outcomes

	2016	2017	2018	2019	2020	2021	2022	2023
Total number of closures	7,986	4,788	7,438	7,358	8,897	5,146	6,223	5,798
Total number of closures with ID	648	491	834	899	939	629	863	821
Closures into an employment setting	3,255	1,914	2,796	2,704	2,369	1,568	2,017	1,949
Closures with ID into an employment setting	335	219	364	379	344	243	371	322
Closures with an IPE but no employment outcome	2,191	1,561	3,343	3,383	3,173	2,679	3,148	2,753
Closures with ID and an IPE but no employment outcome	144	161	386	430	457	346	397	420
Rehabilitation rate for all closures with an IPE	60.0%	55.0%	46.0%	44.0%	43.0%	37.0%	39.0%	41.0%
Rehabilitation rate for all closures with ID*	70.0%	58.0%	49.0%	47.0%	43.0%	41.0%	48.0%	43.0%
Percentage of all closures into employment	40.8%	40.0%	37.6%	36.7%	26.6%	30.5%	32.4%	33.6%
Percentage of all closures with ID into employment	51.7%	44.6%	43.6%	42.2%	36.6%	38.6%	43.0%	39.2%

* Rehabilitation Rate = (# closures into employment) / (# closures into employment + # closures with an IPE but without an employment outcome)

Source: Rehabilitation Services Administration 911 (RSA-911)

With employment being so critical to an individual's health and well-being, inclusion in their community, and quality of life, we must strive toward improving these outcomes beyond

incremental increases impacting few people. The proposed goal only increases that by approximately *176 people* over a span of *four years*. Broken down annually, that is 44 people per year. We must aim higher.

As we posed in our July 2022 submission to the Subcabinet, we believe other more granular, qualitative information and measures are also important in considering the number of people working in competitive integrated employment. For example, are people getting their choice of job? Are they getting the number of hours desired? Are they getting fair wages and benefits?

OMHDD notes that strategies to achieve this goal include evidence-based and promising practices and supporting existing Individualized Placement and Support Projects (IPS). Why not expand IPS? It is unavailable in many parts of Minnesota. IPS is a highly cost-effective service helping people with mental illness find and maintain employment in a very person-centered model. According to the DEED website, IPS served 1,566 people in FY 23-24, with 63% (987 people) starting a job with a median average wage of $15/hour and median hours per week of 20. OMHDD would like to see additional investment and expansion of IPS and other effective strategies resulting in people achieving and maintaining CIE.

Employment Goal 1B: VRS/SSB and Medicaid waiver services

The goal is too low and does not reflect informed choice and employment first requirements.

Similar to Goal 1A, OMHDD believes the targets are simply too low for a four-year goal. While we appreciate the percentage increase is higher, this accounts for only 100 individuals. Again, broken down annually, that is *25 people per year*. These low numbers do not align with our state's Informed Choice in Employment and Employment First policies (MN Statute 256B.4905, subdivisions 4a and 5a) that require:

> **Informed choice in employment policy.**
>
> It is the policy of this state that working-age individuals who have disabilities:
>
> (1) can work and achieve competitive integrated employment with appropriate services and supports, as needed;
>
> (2) make informed choices about their postsecondary education, work, and career goals;
>
> (3) will be offered the opportunity to make an informed choice, at least annually, to pursue postsecondary education or to work and earn a competitive wage; and
>
> (4) will be offered benefits planning assistance and supports to understand available work incentive programs and to understand the impact of work on benefits.

Employment first implementation for disability waiver services.

The commissioner of human services shall ensure that:

(1) the disability waivers under sections 256B.092 and 256B.49 support the presumption that all working-age Minnesotans with disabilities can work and achieve competitive integrated employment with appropriate services and supports, as needed; and

(2) each waiver recipient of working age be offered, after an informed decision-making process and during a person-centered planning process, the opportunity to work and earn a competitive wage before being offered exclusively day services as defined in section 245D.03, subdivision 1, paragraph (c), clause (4), or successor provisions.

Minnesota's Olmstead plan should not just conform with minimum statutory requirements; it should far surpass them. This goal falls short of doing that.

More must be done streamlining the WIOA and informed choice process for people earning subminimum wages and youth who are considering subminimum wage. We should consider strategies that provide case managers further training on employment supports for people leading to competitive integrated employment. In many parts of the state with more limited employment support access, there is an overreliance on subminimum wage and day programming.

Employment Goal 1C: Students age 16 and up who have IEPs.

This goal merely duplicates existing federal requirements and does not add additional value for students with disabilities.

OMHDD has *repeatedly* provided comment that in MN, postsecondary transition plan requirements begin at 14 years, not 16 as is the federal requirement. To date, we have not received a substantive response. As such, it appears that this goal is about simply repurposing and recycling federal requirements into Minnesota's Olmstead plan and not establishing any additional deliverables or reporting requirements. Notably, the March 2025 MDE Part B Performance Plan Indicator Guide, while the first paragraph is verbatim for the language in the proposed plan goals, the report goes on to address students in grade 9/14 years of age while the Olmstead draft goals are silent on this requirement.

State Performance Plan Indicator 13: Secondary Transition Goals and Services

Indicator 13 is a compliance indicator that measures the percentage of students with disabilities ages 16 and above with an IEP that includes appropriate, measurable postsecondary goals that are: a) updated annually, b) based on age-appropriate transition assessment and services, c) include courses of study that will reasonably enable the student to meet their postsecondary goals, and d) that the IEP goals relate to the student's transition service needs.

Minnesota Statute § 125A.08(b)(1) requires that, during grade nine, the student's IEP must address the student's needs for the transition from secondary services to postsecondary education and training, employment, community participation, recreation, and leisure and home living. Compliance for this indicator is determined by examining records of students who have completed grade nine to verify that secondary transition was addressed before the end of grade nine. Because MDE is looking at the grade and not the student's age, the sample may include students as young as 14 years of age.

Like other goals that simply duplicate agency responsibilities to state and federal entities, OMHDD considers it a missed opportunity to strive beyond minimum standards in our state's Olmstead plan. At its core, an Olmstead plan is a forward-thinking roadmap to improve the lives of people with disabilities and maximize integration, not a vehicle to simply regurgitate existing minimum requirements.

OMHDD has concerns about a plan continuing to rely on the Employment Capacity Building Cohort as a strategy surrounding students in the transition years. As we have pointed out for many years, this is an extremely small group. Focusing on strategies with a broader impact on more students with disabilities is not only more equitable but will result in a greater return on investment.

Health and Safety

OMHDD is disappointed by the exclusion of health care access goals in previous versions of the draft. That is particularly acute with the implementation of HR 1 and the anticipated loss of coverage and disruptions to care. Similarly, the omission of any references to disparities for people with disabilities is concerning. OMHDD and others have been working with MDH on disparities for people with disabilities prior to, during, and since the pandemic and we have not seen tangible outcomes from that work. It is a painfully lost opportunity not to include that work in the state's Olmstead plan.

Health Goal 2: Fewer people with disabilities will experience abuse and neglect.

Health Goal 2A: Confirmed cases of abuse and neglect in facilities MDH Licenses

The goal as stated implies that some level of abuse and neglect is acceptable. Given consequences of not meeting the goal (continued maltreatment experienced by people with disabilities), the goal is far too conservative.

OMHDD continues to have questions about the universe of facilities in this goal. The draft indicates these include nursing homes, assisted living, ICF/DD, and hospitals. Are other MDH facility license types excluded? Clarity on the scope of this goal is critical as the numbers provided do not neatly align with substantiated maltreatment reports received and reviewed by OMHDD as well as an investigation report issued by Elder Voice Advocates. It is also critical to acknowledge that the number of confirmed cases of abuse and neglect in MDH-licensed facilities does not, in any meaningful way, necessarily correlate to fewer people with disabilities experiencing abuse and neglect in these settings as only a fraction of reports are opened for investigation. OMHDD acknowledges the capacity limitations at MDH and the need to establish priorities for investigations, but we are compelled to point out that the metric used in this goal cannot be used as a single data point to extrapolate that "fewer people with disabilities will experience abuse and neglect" as written.

Considering the trauma experienced by people subject to abuse and neglect in these settings, this goal is insufficient. This equates to *three fewer* substantiated reports; only three fewer *people* subject to abuse and neglect. OMHDD has expressed concerns about increases in abuse and neglect in assisted living settings, specifically in small assisted living settings, where we have seen an increase in both maltreatment and rapid and seemingly unchecked growth of these settings. We also note the absence of anything in this goal beyond June 30, 2027. With something as critical as reducing abuse and neglect, the plan should document a commitment to a robust, multi-year, and multi-pronged effort. Anything less suggests that some degree of abuse and neglect is somehow not just unavoidable, but acceptable.

We must do more to prevent abuse and neglect, not just respond to it after the damage has been done. In reviewing OHFC maltreatment reports, required to be shared with OMHDD upon completion, we see so many instances where the abuse or neglect was preventable. We appreciate the department taking the action to substantiate when circumstances warrant, but there are often many factors known to be indicators of potential abuse and neglect that, had they been addressed previously, could have been mitigated. Examples include a clear mismatch between the setting and the intensity of a person's support plan needs, particularly if there is a need for supervision in the community, known substance use and overdose risk not being adequately identified in the service plan, a lack of adherence to the service and staffing requirements outlined in the plan, an overall lack of person-centeredness in the service planning and delivery, a lack of awareness on developmental disability or mental health conditions and de-escalation strategies, lack of notifying a waiver or other case manager when circumstances warrant, and more. We understand the workforce shortage challenges underlying some of these circumstances, but that is not the sole factor, nor does it absolve us as a system to do more to proactively prevent abuse and neglect in these settings.

Health Goal 2B: Disabled adults who experience sexual and intimate partner violence.

The target reduction is far too low, especially considering the much higher likelihood of a person with disabilities experiencing sexual and intimate partner violence as compared to those without disabilities.

While rates may vary based on the data set, we know adults with disabilities experience sexual and intimate partner violence at rates much higher than those without disabilities. OMHDD has no opinion on using the CDC BRFSS system as a data set as opposed to any other for the purpose of consistency in tracking. However, the goal to reduce sexual and intimate partner violence by 2% over seven years is far too low, less than 0.3% each year on average. This goal is also missing targets to give a sense of how many people are represented in that 2%. OMHDD also points to while that data set indicates people with disabilities experience just over double the sexual and intimate partner violence as people without disabilities generally, we should also consider the variability within the disability community. For example, some reports place the risk of individuals with developmental disabilities at a seven times higher rate for this type of abuse.

OMHDD requests that as the department "continue to gather and analyze", that information be shared with or available to the public.

Health Goal 2C: Children with disabilities who experience abuse and neglect.

The goal as stated implies that some level of abuse and neglect is acceptable. Given consequences of not meeting the goal (continued abuse and neglect of children), the goal is far too conservative and lacks a timely reporting requirement.

This goal is not clear as written, particularly when considering the MDE goal related to substantiated maltreatment in schools. OMHDD recognizes the baseline of 44.48% of ninth and eleventh grade students from the 2024 Minnesota Student Survey. However, the goal says by 2032, the percentage of "disabled students who report experiencing abuse and neglect will decrease to 42%". Is that, then, all those taking the MSS – fifth, eighth, ninth, and eleventh graders? Or just ninth and eleventh graders? To be effective and meaningful, goals must be clear and demonstrate internal consistency between baseline measure data sets and what the goal aims to achieve.

OMHDD, again, questions the very low target of a 2.8% reduction by 2032 – a full six years from now. We appreciate that the MSS is only conducted every three years, but not documenting any progress, or lack thereof, toward this goal for *six* years is a missed opportunity to identify, deploy, refine, and expand interventions to further reduce abuse and neglect reported by students with disabilities at rate that is over two and half times higher than students without disabilities. Previous drafts of MDH goals included a 2029 benchmark; why was this removed? Lastly, the sole remaining metric used – the MSS – may

not be accessible to all students with disabilities nor may all students with disabilities elect to participate even if accommodations are made. As in all reporting or survey activities, OMHDD maintains additional vulnerabilities to abuse and neglect exist for those that cannot or choose not to report.

Considering the strategies listed for this goal, it appears there is nothing new. It's also unclear how these strategies directly align with the metric, the Minnesota Student Survey. Assuming the data will be derived from ninth and eleventh graders specifically, it would be helpful to outline exactly what existing training and resources are available. Previous versions of the MDH goals included more detail on specific strategies than in this draft for public comment.

Housing

Housing Goal 1: People with disabilities will have access to more accessible housing and housing with deeply affordable rents paired with supportive services.

Housing Goal 1A: Universal design

The target is too low and reflects less additional units than achieved from 2021-2025.

The lack of affordable and accessible housing for people with disabilities has been an issue for decades. While OMHDD appreciates Minnesota Housing's commitment to increasing new rental units meeting universal design standards, and we understand budget and other constraints, a target for years 2027-2031 that results in less additional units achieved from 2021-2025 seems a step backward.

Housing Goal 1B: Units for people with disabilities

The target is too low and lacks clarity.

Similar to goal 1A, setting targets for 2027-2031 that are lower than what was achieved in 2021-2025 communicates a goal based on what is easily and readily achievable rather than aspirational. Additionally, while the goal is written to fund PSH "primarily for people with disabilities", it is unclear what that means. Is that 51% of the units for people with disabilities? 75%? 90%? If the goal is 1,000 units, those distinctions could be significant in terms of the number of people with disabilities that attain housing in these settings.

Housing Goal 2: More people with disabilities will receive affordable financing for accessibility updates to their homes.

Targets expanding by one or two projects a year, on average, are too low.

OMHDD appreciates the complexity of predicting the number of individuals impacted when projects and budgets may vary, but extending the universe number of 302 projects, it results in

seven to eight additional households as the target over five years. This seems low given the community needs requests noted in survey responses, Inclusion Consultants, and others for accessibility improvements.

Improved data collection for both Rehabilitation Loan and the Fix-Up Fund should help establish more meaningful targets in the future. It is unclear from the draft, however, what the anticipated timelines are for this work. Other data development goals included in the draft have more detail, timelines, and accountability built into the goal.

Transit and Transportation

Transportation Goal 1: Public transit will run on time.

This goal mirrors existing minimum federal requirements; incorporating them does not add additional value to the plan.

As in other goals, OMHDD questions repurposing minimum federal requirements in the state's Olmstead Plan. Meeting existing minimum standards does not improve the status quo for Minnesotans with disabilities. However, in this goal, we appreciate the addition of standards for on-time performance for services beyond Metro Mobility. For the Metro Move (on-time pickups), we question establishing a goal that is less than the current on-time performance baseline, specifically the move from 12 months to at least eight months of the year.

Transportation Goal 3: More people with disabilities will have flexible transportation funding.

This goal measures the number of counties, not people, benefiting from the pilot program expansion.

While expanding a pilot program to Greater Minnesota counties may be promising, it would be helpful to report not just on the number of counties but also the number of people potentially positively impacted by increased access and flexibility for transportation.

Transportation Goal 4: People with disabilities will have better access to transit services and information.

The goal is incomplete lacking baseline and target information.

As goals 4A and 4B do contain either baseline data or targets, it is impossible to provide public comment in any meaningful fashion.

Transition

Transition Goal 1: Fewer people will stay at Anoka Metro Regional Treatment Center (AMRTC) when they don't need hospital-level care.

The goal should be more ambitious given the fundamental *Olmstead* implications of keeping people in a locked institutional setting when they no longer need that level of care.

This is a similar goal to the previous plan, which included a goal that by December 31, 2025 the percentage of people at AMRTC who do not need hospital level of care would be reduced to 25%. That goal, as evidenced by the baseline established in December 2025 of 27%, was not met. OMHDD is sensitive to the challenges DCT faces as many barriers to discharge are elements outside its control. However, these targets are still low when we consider that people are being held in a locked hospital setting when they no longer need to be. This is at the core of the *Olmstead* decision and the integration mandate. Even if the barriers are outside DCT's immediate control, we as a state should collectively strive higher. At the same time, we do appreciate the urgency recognized in reducing the current baseline of 27% to 20% or fewer by 2028 for a problem that has stubbornly persisted for years despite previous efforts.

Transition Goal 2: Participants in the Forensic Mental Health Program (FMHP) are assessed promptly to determine when their mental health needs have been met and they are safe and ready for discharge.

There are current capacity and procedural challenges to meet this goal; however, the goal is silent on concrete strategies to reach the goal.

FMHP is Minnesota's most restrictive, most segregated setting. As such, we must ensure that individuals are not stuck there after they are ready to discharge safely. This is central to *Olmstead* and, as a state, we must be as aspirational as possible in our efforts to ensure that people do not remain at FMHP longer than they need to be. We appreciate the steady and incremental decreases but would like to see more. Again, OMHDD recognizes that many of the barriers to discharge, including needing Special Review Board approval, are outside the control of DCT. We are aware of the stigma surrounding individuals at FMHP during the discharge planning process by counties, step down services providers, communities, and others that result in discharge delays. For this reason, identifying the strategies that will be employed to achieve this goal is essential. Unfortunately, the draft plan is silent on strategies for this goal.

One thing to consider is that a subset of the individuals at FMHP experiencing barriers to discharge is that they are not the patient population FMHP was designed to serve. These are not people with acute mental illness, but rather have a primary diagnosis of developmental disabilities, autism spectrum disorders, traumatic brain injuries, and other conditions that may make it difficult to progress through FMHP's typical treatment model. Putting aside whether they ever should have been committed to FMHP, one strategy for these individuals may be to continue developing DCT-operated community settings to facilitate a swifter discharge along with a person-centered, community-based service plan commensurate with their long-term care needs and preferences.

Transition Goal 3A: More people will receive supportive services in community-based settings.

A definition that the goal is specific to the DCT-operated Community-Based Services program must be established to understand this goal and its targets.

Absent a clear, specific definition in either the glossary or the draft plan of what is meant by the Community-Based Services (CBS) program, this goal is very misleading. OMHDD interpreted this to mean solely the DCT-operated Community-Based Services programs – i.e. Minnesota State Operated Community Services (MSOCS) community residential settings, DCT-operated Intensive Residential Treatment Services (IRTS) settings, the DCT-operated Integrated Community Supports (ICS) setting, etc. We have verified this with DCT. Yet, without that specificity outlined explicitly in the plan, it has been broadly interpreted by many to mean all community-based residential settings, including those operated by private providers. From that perspective, these targets are woefully low. However, with an understanding that these are limited to the DCT-operated community residential settings, while OMHDD would still like to see higher targets, they are more understandable in the correct context. OMHDD, again, earnestly requests that the plan be updated to clearly and adequately define what is meant by these settings to improve transparency, avoid confusion amongst stakeholders, and incorporate stronger accountability. Unclear or inadequate definitions for DCT Community-Based Services, community-based services, and Home and Community-Based Services, all of which have slightly different meanings and nuances within Minnesota's service landscape, compromises the stated intention of the plan to be transparent, plain-language, and accessible to people with disabilities. Moreover, without clarity, there cannot be accountability.

Similarly, locked facilities as defined in the glossary, while referencing AMRTC and FMHP, are silent on the DCT-operated Community Behavioral Health Hospitals (CBHHs) and Community Addiction Recovery Enterprise (CARE) settings that are also locked. What about the DCT-operated IRTS settings that are "flex-locked"? Are they included in the potential data universe for this goal? If so, in which category? As a locked setting someone may be diverted *from* or as a DCT-operated community-residential setting one might be diverted *to*?

OMHDD appreciates the intent to divert people from locked DCT facilities into community-based settings. We understand that diverting people to the DCT-operated Community-Based Services settings gives DCT far more control over admission decisions aligned with achieving the goal targets. However, DCT-operated residential sites are constrained by their capacity that, according to the DHS licensing website, is limited to approximately 254 licensed MSOCS community residential setting beds, 11 approved MSOCS Integrated Community Settings apartment units, and the Minnesota Specialty Health Systems IRTS. These settings also provide long-term care and housing to individuals not included in this goal. Given those capacity limitations, which may help explain the relatively low target numbers, OMHDD does not want this goal to limit the potential for

people being diverted from locked settings to any community-based services provider willing to accept them and able to meet their person-centered care and support needs, not just those operated by DCT.

OMHDD appreciates that the goal references that increasing diversion will require action with other partners, including counties. As many of the individuals referred to locked DCT facilities are under civil commitment or have criminal justice involvement, counties or courts may be averse to diversion. OMHDD suggests expansion of current pilot programs providing support for neuroleptic medication in jails and voluntary engagement services as a potential strategy to increase the likelihood for a successful diversion.

Transition goal 3B: More people will move from segregated mental health treatment facilities to more integrated facilities.

The goal should include strategies to increase capacity across the service continuum.

See comments for goal 3A. Though OMHDD would ultimately like to see far higher targets, we understand DCT's current capacity constraints, particularly as they continue to serve and receive referrals to serve individuals not subject to these transition goals. OMHDD would, however, encourage exploration of strategies to create additional community capacity, at all points on the service continuum and not just those operated by DCT, to ensure that these foundational principles of *Olmstead* and the integration mandate are not limited by existing capacity or a systemic overreliance on DCT as the service provider.

Transition Goal 4: More people with disabilities will move from segregated settings to integrated housing of their choice, where they sign a lease and receive rent support.

The goal lacks clarity on whether it is specific to Bridges, Bridges RTC, and Section 811 or would be applicable to other housing settings falling within its broad definition. It also lacks baselines and targets.

While well-intended, this goal lacks some clarity. If this goal is limited to those receiving rent support from Bridges, Bridges RTC, and Section 811 exclusively, remove the "from certain programs such as" language. There are other housing cost support options, notably Housing Support as established in Chapter 256I, that provide rent support to people who sign a lease or lease equivalent and may live in integrated settings as defined in the glossary. For example, Integrated Community Supports settings that - despite being considered a provider-controlled setting - do require a lease or lease equivalent and may be multi-family units occupied by both people with and without disabilities. For the purpose of this goal, as the definition is written, that would seem to fall under the purview of the metrics used. If that is not what was intended, it would be clearer and more transparent to explicitly enumerate its applicability to people securing housing using Bridges and Section 811. It's also worth noting that while these programs are

essential elements of the housing access continuum, they have more narrow eligibility criteria or limited availability.

Without baselines or targets it is impossible to meaningfully comment on this goal. While other goals are missing baselines and targets, this goal is foundational to *Olmstead* and the integration mandate. For that reason, it is particularly unfortunate that the public and stakeholders will not have an opportunity to comment on the substance of this goal.

Transition Goal 5: People who receive home- and community-based services will experience less use of restrictive procedures.

The goal has unclear definitions and does not recognize changes in law that will extend BIRF reporting to a new type of service provider in 2026, making it difficult to measure any meaningful change.

OMHDD has repeatedly expressed that simply counting the number of BIRF reports submitted when we continue seeing gaps in enforcing reporting requirements by the regulatory entity is misleading.

OMHDD suggests removing "group homes" from the first bullet. This is not adequately defined in the glossary nor consistently elsewhere in the plan. Importantly for BIRF reporting, small assisted livings in single-family residential homes, funded by waivers through customized living, are often referred to as group homes by residents, case managers, and other stakeholders. These settings, while indistinguishable to many from community residential settings and referred to as group homes, are licensed by MDH and *not* subject to BIRF reporting at this time.

We also question the targets for this goal as additional programs governed by 9544 are slated to become licensed and subject to BIRF reporting in the coming months. These include services that may be provided in someone's family home. If hundreds of providers serving many thousands of clients are going to be newly subject to BIRF reporting obligations upon licensure prior to December 31, 2026, it seems unreasonable to expect that these numbers would decrease by 5% by June 30, 2027 the way the goal is currently written.

Data Collection Goals

Generally, the data collection goals vary significantly in terms of specificity, timelines, accountability, and how and when the data collected will move into actual goal development, including strategies to facilitate achievement of the goal.

Crisis Services – Data Collection Goal 1: More people will stay in the community after a crisis.

Data for this goal has been collected for many years; this is reframing what it means to remain in a community after a crisis to include children in voluntary placement for residential treatment.

OMHDD questions this being posed as a new data collection goal. The previous Olmstead plan included separate goals for children and adults "who remain in their community after a crisis". This was measured going back to the baseline of FY 2014 in the former plan. This is not a new data collection goal – it is simply redefining what constitutes "staying in community" to include voluntary placement in children's residential facilities for treatment.

While OMHDD has long advocated that we do not want to see an Olmstead plan crisis goal act as a disincentive for children accessing medically necessary mental health care at the right time and right intensity for their needs, i.e. children's residential treatment, this goal is not collecting new data. The former Olmstead plan, in its most recent 2023 annual report, acknowledges that

> "[t]here has been an overall increase in the number of episodes of children receiving mental health crisis services, and more children being seen by crisis teams. The number of children receiving treatment services after their mental health crisis has increased by more than 30% since baseline and by almost 50% since December of 2016. While children remaining in the community after crisis is preferred, it is important for children to receive the level of care necessary to meet their needs at the time."

To frame this as a new data collection goal is patently inaccurate. It is not new. We have long had the data as reported under the previous plan. Again, OMHDD does not want a plan that creates barriers to people entering voluntary residential treatment when they need that level of care, but the reality is that children may be sent hours from home, or even out of state, for months or even years. How can that be considered "staying in community"? Their connection to their families is disrupted as there are barriers to family visits when a child is hours away from their communities. They are disconnected from their schools, peers, friends, and others. OMHDD could support some carve out in the data to exclude people accessing voluntary residential treatment in alignment with our longstanding concerns about unnecessary barriers to treatment; however, to characterize this as "staying in community" is an utterly false equivalency, particularly for children sent to residential treatment facilities far from home, even out of state, where they may spend, six, twelve, or eighteen months or longer.

OMHDD also contends that it does not stand to reason that children's residential facility can be considered an institution for the purposes of a DCYF goal and staying in community for a DHS goal.

Employment Data Goal 1: More people will have jobs in the community.

The data development goal includes establishes a measure for competitive, integrated employment (CIE) but lack clarity on how new strategies will be different than existing Employment First and other efforts.

OMHDD has posed questions and concerns surrounding the $600 proxy as a measure of competitive, integrated employment (CIE) for many years. In response, we have been told that the data to replace it is not available. Why is it now possible? Will the new data set truly be a reliable source for the number of people in CIE? While we appreciate DEED's unemployment insurance database as one source, along with DHS subminimum wage reports, is there a reason VRS data is omitted? There are existing efforts aimed at increasing awareness of how work affects disability benefits; how will this be different or augment current practices?

Health and Safety Data Goal 2: More Minnesota Department of Health response staff will receive training about the access and functional needs of people with disabilities in public health emergencies?

The data development goal lacks clarity on if and how previous efforts will be incorporated.

What will the source material for this training be? Will it incorporate the previous work of MDH and interagency staff in developing training and plans to address the access and functional needs of people with disabilities in public health emergencies? Will the work during and after the pandemic be incorporated?

Housing Data Goal 1: Incarcerated individuals with disabilities will have accessible housing upon release.

The data development goal lacks clarity.

This goal is slightly unclear. In the goal, it seeks for more individuals to have accessible housing upon release. Who decides if the housing is accessible? The person? The DOC? Then, it adds a reference to accessible housing and supports. What would the housing supports be? Would this be akin to the previous Housing Stabilization Services? Or is this intended to be ongoing service and support needs related to their disability?

Housing Data Goal 2B: Minnesota Housing and DHS want to measure the share of people with disabilities who have safe, accessible, affordable housing. They also want to measure disabled people's satisfaction with their housing.

The data development goal is inconsistent or unclear citing two processes and seven bulleted activities.

In the activities conducted while developing the goal, "DHS will use two processes to work on the following while they develop this measurable goal" followed by seven bulleted activities. What are the two processes and how do these seven strategies fit within them? Here, especially, timelines would be helpful and increase accountability. OMHDD would also encourage exploration of whether the Disability Hub or HB101 could be useful resources in conducting this work.

Transition Data Goal 1: More people will have access to peer support services.

The data development goal lacks clarity on types of peer support service it plans to incorporate.

Is this goal related to mental health peer support, SUD peer support, or both? There is no definition of peer support services in the plan or in the glossary to provide clarity.

Transitions Data Goal 4: Minnesotans with disabilities will have timely access to services.

Transitions Data Goal 4A: New waiver recipients.

The data development goal appears to be duplicative of existing federal and state requirements.

How is this different than work being done with the CMS Access Rule? The timeline to develop ways to measure how long people wait to access services as 2031 seems excessive. Implementation of data collection strategies could, understandably, take more time, but developing ways to measure should not take five years. There is already a statutory obligation for a DHS to develop and maintain a dashboard on the number of days from requesting an assessment and assessment completion; this is posted on its website.

Transitions Data Goal 4C: Personal care, homemaker, homemaker, home health aide, and/or habilitation services

The data development goal duplicates CMS Access Rule requirements and, as an existing requirement, adds no additional value to the Olmstead plan.

This appears to merely reflect CMS Access Rule requirements; adding it as a data development goal is duplicative. Notably, CMS Access Rule contains a deadline of July 1, 2027. Why is the federally required timeline not included in the draft if the rest of its requirements are?

Transitions Data Goal 5: Direct support professionals and people with disabilities will shape the future of Minnesota's Medicaid program.

The data development goal duplicates CMS Access Rule requirements and, as an existing requirement, adds no additional value to the Olmstead plan.

Again, these are requirements of the CMS Access Rule. If they are existing federal requirements, what is the added value in incorporating them into the Olmstead Plan?

Transitions Data Goal 6: People with disabilities are protected from increases in the use of mechanical restraint.

The data development goal eliminates any external reporting surrounding the use of mechanical restraints.

The former plan measured the number of uses of mechanical restraint, not people subject to them. Why is it necessary to change that? OMHDD reviewed the EPRC website and its annual reports; neither showed any aggregate data on the usage of mechanical restraints. As the use of mechanical restraints was at the heart of the *Jensen* class action lawsuit and subsequent settlement agreement, removing any transparent reporting requirements is a concern. How will people know if there are increases? And increases from what baseline data?

How is the proposed training on the positive supports rule going to be substantively different than all previous training and guidance documents created over the last ten years?

Please ensure that references to *Jensen* are in italics.

Transitions Data Goal 7: More people with disabilities will move from segregated settings to integrated settings.

The data development goal definitions of segregated settings and integrated settings are inconsistent between the goal and glossary and must be clarified.

The definitions of segregated and integrated settings in the glossary do not align with what is being proposed in this goal. Without internal consistency, accountability is lacking. Group homes are considered a segregated setting and an institution per the glossary. Is the intent to exclude community residential settings, assisted living settings, integrated community supports settings, supported housing settings, and more from this goal? That could be a barrier for those exiting an institutional level of care but who need, and choose, support in these community provider-controlled settings.

Elements Lacking in Draft Plan

Racial Disparities

Despite a stated commitment to consider and begin to address racial disparities in the next plan, this draft fails to do so. Only one goal references disparities.

Children and Youth

Aside from education, crisis, and abuse and neglect, this plan is largely silent on children.

Five-year Timeline

The plan repeatedly references itself as a five-year plan, but individual goal areas are very inconsistent about its span. Some suggest work ending as early as 2027.

Person-Centered Planning

The plan does not include any goals or strategies involving person-centered planning. This is a woefully missed opportunity for Minnesota to incorporate some qualitative metrics, including a mechanism to hear from the person whether their lived experience reflects state and federal obligations to ensure person-centered services planning for waiver, HCBS, and other service recipients.

Guardianship

The draft is silent on guardianship or guardianship alternatives. Given the implications on people's civil rights, including surveys repeatedly highlighting the marked differences for people subject to guardship and those who are not, this is another missed opportunity in the draft.

Clear Organization and Flow for the Document

Organizing the strategies for each subgoal to follow it immediately in the document would be more easily understandable, and accessible, as we have previously indicated. This will prevent unnecessary scrolling or flipping between pages for anyone reviewing them.