

REPORT TO THE TWENTY-EIGHTH LEGISLATURE

**STATE OF HAWAII
2015**

**PURSUANT TO HOUSE CONCURRENT RESOLUTION 17,
SESSION LAWS OF HAWAII, 2014,**

**REQUESTING THE DEPARTMENT OF HEALTH,
DEVELOPMENTAL DISABILITIES DIVISION
TO ESTABLISH A TASK FORCE TO REVIEW
HAWAII'S STATUTORY DEFINITION OF
"DEVELOPMENTAL DISABILITIES"**



PREPARED BY:

**STATE OF HAWAII
DEPARTMENT OF HEALTH**

December 2014

EXECUTIVE SUMMARY

Researchers estimate the prevalence of intellectual and developmental disabilities (I/DD) to be 1.58% to 2% of the population.¹ Hawaii, with a population of 1.3 million, would have approximately 21,493 to 27,206 citizens with I/DD.² The 2014 Hawaii State Legislature passed House Concurrent Resolution (HCR) 17 - Requesting the Department of Health, Developmental Disabilities Division (DDD), to establish a task force to review Hawaii's statutory definition of "developmental disabilities." The purpose of the task force was to:

- 1) Review the current state statutory definition of "developmental disabilities" in comparison to other states, and study the impacts of changing the definition of "developmental disabilities";
- 2) Discuss general eligibility issues relating to the current statutory definition of "developmental disabilities";
- 3) Identify gap groups that are currently ineligible for developmental disabilities services, but are a part of the intellectual and developmental disabilities population; and
- 4) Determine strategies to meet the increasing needs of the intellectual and developmental or physical disabilities population including but not limited to identifying and engaging agencies that can address such needs with a focus on identifying and attempting to provide appropriate safety net processes or services to as large a segment as feasible of the identified gap groups specified in (3).

The Task Force met on four occasions: July 24, 2014, September 17, 2014, October 29, 2014, and November 20, 2014. At the first meeting, the group received an overview of the DDD, the background that led to the development of federal and state laws on DD, and a comparison of the definitions of DD in other states. During the following two meetings, the Task Force identified and discussed options based on other states' definitions of DD and issues unique to Hawaii. This approach enabled the Task Force to examine eligibility issues, identify gap groups and explore cost and programmatic implications. At the final meeting, the Task Force refined its priority recommendations that follow on page 3.

¹ Larson, S.L., et al. (2000) Prevalence of Mental Retardation &/or DD: Analysis of 1194/1995 NHIS-D, MR/DD Data Brief. Minneapolis, MN: Institute on Community Integration, University of Minnesota.

² Krahn, G.L., et al. (2006) A Cascade of Disparities: Health & Health Care Access for People with Intellectual Disabilities, *Mental Retardation & DD Research Reviews* 12:70-82, Wiley-Liss, Inc.

Recommendations:

In order of priority, the Task Force makes the following recommendations:

1. A. Amend the current definition of developmental disabilities in Section 333F-1, Hawaii Revised Statutes (HRS) to clarify that infants and young children (an individual from birth to age 9, inclusive) who have one or more substantial developmental delays may be considered to have a developmental disability, in alignment with Chapter 333E, HRS and the federal definition.

B. Request that the Legislature consider support for respite programs for families of individuals with I/DD.
2. Explore federal and state funding options to address service and support needs for individuals with mild intellectual disabilities.
3. A. Use existing options to provide services and supports for individuals with mental health and physical disabilities without an intellectual or developmental disability.

B. Develop a process to meet the needs of individuals and families for accessing and navigating QUEST Integration long-term services and supports, which may be met by Med-QUEST Division (MQD) eligibility workers who are cross-trained in helping people to access appropriate services and supports.
4. Use existing options to provide services for youth with co-occurring mental health diagnoses and mild intellectual disabilities.
5. Continue the work of the Task Force through the Legislative appointment of a Task Force to monitor the implementation of these recommendations; examine the service needs of other vulnerable populations where there may be service gaps or barriers to access, such as workforce capacity issues; and engage all relevant state agencies and stakeholders.

REPORT TO THE LEGISLATURE IN COMPLIANCE TO HCR 17 OF THE 2014 LEGISLATURE

Introduction

The Hawaii statutory definition of developmental disabilities (DD) is a functional definition derived from the federal definition of DD in the *Developmental Disabilities Assistance and Bill of Rights Act of 1978*. Hawaii is one of eight states with this type of DD definition where the functional criteria “are based on a person’s adaptive abilities or capacity to perform tasks at a specific level.”³

The “developmental disabilities” definition is a legal one and each state defines it a bit differently. Unlike Hawaii, many states “use ‘categorical’ criteria referencing specific related conditions by medical diagnoses or type.”⁴ Although licensed physicians and clinical psychologists use criteria to make diagnoses, laws and related rules are necessary to determine if the diagnoses an individual has are considered to be developmental disabilities. The definition of DD is paramount because it is used to determine eligibility for state services. In 2014, the Department of Health (DOH) proposed a concurrent resolution through the Executive Branch, and the Hawaii State Legislature adopted HCR17 – Requesting the Department of Health, Developmental Disabilities Division (DDD), to establish a task force to review Hawaii’s statutory definition of “developmental disabilities.”

The Task Force was asked to:

- 1) Review the current state statutory definition of "developmental disabilities" in comparison to other states, and study the impacts of changing the definition of "developmental disabilities";
- 2) Discuss general eligibility issues relating to the current statutory definition of "developmental disabilities";
- 3) Identify gap groups that are currently ineligible for developmental disabilities services, but are a part of the intellectual and developmental disabilities population; and
- 4) Determine strategies to meet the increasing needs of the intellectual and developmental or physical disabilities population including but not limited to identifying and engaging agencies that can address such needs with a focus on

³ Zaharia, R. and C. Moseley. (2008). "State Strategies for Determining Eligibility and Level of Care for ICF/MR and Waiver Program Participants," New Brunswick, NJ: Rutgers Center for State Health Policy, July.

⁴ Ibid.

identifying and attempting to provide appropriate safety net processes or services to as large a segment as feasible of the identified gap groups specified in (3).

Background and Legislative Intent of the Federal and Hawaii Definitions of DD

To understand why a functional definition of DD was used in federal and state statutes, it helpful to understand how the definition of DD evolved and Hawaii's legislative intent when it adopted the current statutory definition.

Federal Definition of DD

The federal definition of "developmental disability" evolved from earlier legislation, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, which focused only on people with intellectual disability (formerly called "mental retardation"). In the 1970's as knowledge and understanding increased, Congress amended the 1963 Act to broaden the definition of the eligible target population. This legislation was known as the Developmental Disabilities Services and Facilities Construction Amendments of 1970. These amendments introduced the term "developmental disability," thus expanding the population covered under the law beyond individuals with intellectual disability, specifically including individuals with cerebral palsy, epilepsy, and certain other neurological conditions that originated before the age of 18 years.

In 1975, the federal Developmentally Disabled Assistance and Bill of Rights Act modified the original DD definition to autism and, under specified circumstances, dyslexia originating before age 18.⁵ Congress also directed the Secretary of Health, Education and Welfare to establish a task force to conduct an independent study on the definition of DD.

As a result of the study, in 1978 the definition of DD was again amended to a more generalized *functional definition* of DD that focused on the impact of, rather than simply the presence of, a particular condition or diagnosis. In 2000, the functional definition of a "developmental disability" was revised to include infants and young children with substantial developmental delays or specific congenital or acquired conditions where, due to their age, functional criteria standardized on adolescents and adults could not be reliably assessed.

⁵ "History of the Act". (2013, September 19). Administration on Intellectual and Developmental Disabilities (AIDD). U.S. Department of Human Services, Administration for Community Living Washington DC 20201. Retrieved December 9, 2014 from www.acl.gov/Programs/AIDD/DD_History/index.aspx .

The current federal definition under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act) PL 106-402 Sec. 102 defines “developmental disability” as follows:

DEVELOPMENTAL DISABILITY.—

A. IN GENERAL.—The term “developmental disability” means a severe, chronic disability of an individual that—

- i. is attributable to a mental or physical impairment or combination of mental and physical impairments;
- ii. is manifested before the individual attains age 22;
- iii. is likely to continue indefinitely;
- iv. results in substantial functional limitations in 3 or more of the following areas of major life activity;
 - v. Self-care;
 - vi. Receptive and expressive language;
 - vii. Learning;
 - viii. Mobility;
 - ix. Self-direction;
 - x. Capacity for independent living;
 - xi. Economic self-sufficiency; and
- xii. Reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

B. INFANTS AND YOUNG CHILDREN.—An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting 3 or more of the criteria described in clauses (i) through (v) of subparagraph (A) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

Definitions Tied to Federal Funding Streams

In 1971, Congress added a special Medicaid coverage option for individuals living in intermediate care facilities for persons with mental retardation and related conditions. The statutory language authorizing this new coverage option delegated to the Department of Health and Human Services (HHS)* responsibility for defining the terms “mental retardation” and “related conditions” and establishing operating standards for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).^ Initially, HHS interpreted the term “related conditions” to include persons with cerebral

* Known at the time as the Department of Health, Education and Welfare.

^ Known at the time as Intermediate Care Facilities for Individuals with Mental Retardation or ICF/MR

palsy, epilepsy and other related neurological conditions. Later autism was added as a qualifying disability. Following the adoption of the functional definition of a “developmental disability” in the DD Act, HHS’ regulatory definition of a “related condition” for Medicaid purposes was modified to reflect the revised DD Act language with two exceptions. First, the “related conditions” definition uses six, rather than seven, areas of major life activity (with economic self-sufficient eliminated). Second, individuals with mental illnesses as a stand-alone disability are excluded from the term “related condition.” Because eligibility for Medicaid funded home and community-based waiver services is linked to an individual’s need for institutional services (ICF/IID services in the case of a person with a developmental disability), the Medicaid “related conditions” definition applies to HCB waiver services as well as institutional services.

A person can be “developmentally disabled” under Hawaii’s definition of the term and not be eligible to receive ICF/IID services because he or she does not meet the additional federal regulatory requirements that apply under the latter programs. Under both the ICF/IID and HCBS waiver programs, states must (a) require the level of services provided by an ICF/IID; and (b) have a diagnosis of intellectual disability or a related condition (42 CFR 435.1010; 42 CFR 441.302). Eligibility for home and community-based services under Section 1915(c) waiver program is extended to individuals who, “but for the provision of waiver services,” would otherwise require the level of support and assistance furnished by an ICF/IID program (42 CFR 442.302(c)(1)). The definitions found in 42 CFR 435.1010 and 42 CFR 441.302 were used to describe the population that DDD currently serves as part of the DD HCBS waiver. This is consistent with the purpose statement within the federal waiver application: “[t]he program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization.”⁶ States are required to use level of care evaluation instruments or processes for waivers that yield equivalent outcomes to those used for the ICF/IID program. After a person is admitted to the waiver program, states are required to re-certify at least annually that he or she continues to need the “level of care provided” (42 CFR 441.302 (c)(2)), during an annual level of care determination process.⁷

Hawaii’s Definition of DD

According to the archival Hawaii State Legislature House Journal - Standing Committee Reports of 1987, House Bill (HB) 598 on developmental disabilities was considered to be:

⁶ Application for 1915(c) HCBS Waiver; HI.0013.R0500 – Jul 01, 2011

⁷ Zaharia, R. and C. Moseley. (2008). "State Strategies for Determining Eligibility and Level of Care for ICF/MR and Waiver Program Participants," New Brunswick, NJ: Rutgers Center for State Health Policy. July.

“...landmark legislation addressing the rights and needs of the developmentally disabled population of our State and their parents and guardians. It will ensure the best possible use of State and federal funds by continuing the deinstitutionalization policy of the State for those who would thrive best in smaller, community based, care homes; and to clarify the responsibilities of the Department of Health in the licensing, monitoring, and maintenance of programs and standards for community services. It also is intended to ensure that parents who take upon themselves the responsibilities and burdens of care for their disabled children will have more support and services available to them....

There is no doubt that as we seek to develop the most humane and appropriate services and support for these most vulnerable citizens of our state, more resources will be required. It is thus imperative that we make the most efficient use of alternatives which encourage the private sector to finance residential care facilities, to capture the maximum amount of federal Medicaid funds available, and to reward those courageous parents who are willing and able to care for their own relatives with developmental disabilities....”⁸

House Bill (HB) 598 demonstrated the legislative intent to provide a framework for supporting people with developmental disabilities in their communities. It was passed by the State Legislature as Act 341 of 1987 and subsequently codified as Chapter 333F, HRS.

At that time, the definition in Chapter 333F conformed to Chapter 333E, HRS, which also included a functional definition of “developmental disabilities” in establishing the Hawaii State Council on Developmental Disabilities (also known as DDC). In 2001, DDC’s definition of DD was expanded to include children 0-9 years with substantial developmental delays or a congenital or acquired condition, thus aligning it with the federal definition; DDD’s current statutory definition of DD, in contrast, does not include this provision.

Process Used by the Task Force

Since the Hawaii Statutory definition of DD is based on the federal Developmental Disabilities Act of 2000, Robert M. Gettings, founder of the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and contributor to the formulation of federal laws on developmental disabilities, was invited to assist the Task Force in its work. Dr. David F. Fray, DDD Chief, served as Chairperson of the Task Force. Upon Dr. Fray’s departure, he was succeeded as Task Force chair by Dr. Jeffrey Okamoto, Interim DDD Chief. Members, staffers and attendees of the HCR17 Task Force meetings are listed at the end of this report.

⁸ House Journal - Standing Committee Reports of 1987 and Senate Journal- - Standing Committee Reports of 1987.

The Task Force met on four occasions: July 24, 2014, September 17, 2014, October 29, 2014, and November 20, 2014. At the first meeting, the group received an overview of DDD programs and activities, background information on the development of federal and state DD laws and a comparison of the definitions of DD in other states. During the following two meetings, the Task Force identified and discussed several options based on other states' definitions of DD and issues unique to Hawaii. This approach enabled the Task Force to examine eligibility issues and identify gap groups. As part of the discussions, the Task Force considered multiple variables, such as impacts on the existing service system, funding considerations, service array needs, statutory vs. regulatory impacts, and other issues such as programmatic implications.

After these thorough discussions, the Task Force members voted on options to amend the Hawaii statutory definition of DD according to priority. One option was to maintain the "status quo" but no one voted to keep the Hawaii statutory definition "as is." The majority was in favor of amending the definition to include a provision regarding children aged 0-9 years old. The Task Force also refined its recommendations during the final meeting in November.

Response to the Legislature's HCR17 Requests

1. Review Hawaii's current statutory definition of DD in comparison to other states and impacts of changing the definition of "developmental disabilities";

The Task Force reviewed information summarizing other states' statutory definitions of "developmental disability" during its first meeting. The definitions of DD used by other states may be categorized as follows:

- Functional Definition based on the federal definition of DD – eight (8) states (Hawaii, Louisiana, Michigan, North Carolina, North Dakota, New Jersey, Ohio and South Dakota);
- Intellectual Disability (ID) and related conditions (e.g., autism spectrum disorder, cerebral palsy, epilepsy, chromosomal disorders, Rett Syndrome, spina bifida, etc.) – 22 states; and
- Intellectual Disability (ID) is required (services may be permitted if the person has a co-occurring diagnosis with ID) – 24 states.

Task Force members identified several "gap groups" under the state's existing DD definition and considered the potential implications of expanding the definition. A common theme was Task Force members' concerns expressed about the State's ability to fund services for an expanded group while maintaining the current services

and supports. Each gap group's potential impact was discussed (see discussion under #3 below).

2. Discuss general eligibility issues relating to the current statutory definition of "developmental disabilities";

According to Robert Gettings, who served as a consultant to the Task Force, states are reluctant to adopt the functional definition of DD for three main reasons. First, the functional definition included in the federal DD Act was intended to be a planning, rather than a service eligibility definition. Consequently, the definition has to be adapted to determine eligibility on a person-by-person basis. As noted previously in the Background (see page 5 of this report), a person who meets Hawaii's functional definition may not qualify for HCBS waiver services because the federal regulatory requirements for waiver program eligibility are more stringent. Second, many states are hesitant to use a functional definition of "developmental disability" because they may already have long and persistent waitlists for I/DD services. Expanding eligibility parameters could worsen the situation in those states. In Hawaii, there are no waitlists for services for people with I/DD, and there have not been waitlists for many years. Third, the federal regulatory definition of "related conditions" has influenced state decisions given the states' heavy reliance on Medicaid funding, particularly Section 1915(c) waivers that are tied to institutional level of care and the regulatory definition of "related conditions."

The Task Force examined a number of issues and options related to eligibility for the DD HCBS waiver and other services. Members discussed the initial legislative intent to provide community-based supports to everyone who met the DD definition; however, federal regulatory requirements governing HCBS waiver services had to be met in addition to the Hawaii DD definition in Chapter 333-F, HRS. In order for a person with I/DD to qualify for DD Medicaid waiver services, he or she must meet DD definitional criteria as statutorily defined, must be at ICF/IID level of care (see above *Requirements Tied to Federal Funding Streams*) and also qualify for Medicaid. Those that meet DD criteria and are at ICF/IID but not Medicaid-eligible may be eligible for some services, such as case management and the Long-Term Adult Supports and Resources (LASR) program administered by the DDD.

The Task Force considered a number of scenarios that apply to people who may meet the DD definition but are ineligible for DD HCBS waiver services or might not be eligible for any DDD services. For example, people who have mild intellectual disabilities and mild deficits in adaptive functioning were identified as a significant "gap group" by the Task Force. People in this population represent approximately 85% of Hawaii's residents who have an intellectual disability. Because of the size of

this group, expanding eligibility for this group to receive DDD services would have significant programmatic and fiscal implications (see the next subsection for details).

3. Identify gap groups that are currently ineligible for developmental disabilities services, but are a part of the intellectual and developmental disabilities population;

The Task Force identified a number of “gap groups” that do not meet eligibility requirements for services provided by the Developmental Disabilities Division as found in Chapter 88.1, HAR. These include groups that may be eligible for services but the current statute may not define how functional limitations and service needs are determined for the particular population.

In the discussion of gap groups, particular ranges of the intelligence quotient (IQ) are used as a way to identify populations of people and their service and support needs. The definition of intellectual disability requires IQ tests. Although not all people with disabilities in a certain IQ range are alike, IQ was used in the Task Force’s discussions as a general benchmark of eligibility, service and support needs, and qualification for funding of specialized services that are available to particular target populations.

The six “gap groups” the Task Force identified were:

Group One: Youth with Co-occurring Mental Health Diagnoses and Intellectual Disabilities (85 IQ and Under);

Group Two: Individuals with Mild Intellectual Disabilities (without Moderate, Severe or Profound Impairments in Adaptive Behavior);

Group Three: Children Age 0-9 without Significant Functional Limitations in Three or More Areas of Major Life Activities;

Group Four: All Individuals with Mental or Physical Disabilities without an Intellectual or Developmental Disability;

Group Five: Move to a Developmental Disability Definition that Includes Individuals who meet both Functional and Categorical (Diagnostic) Criteria; and

Group Six: Move to a Definition that Includes Individuals who meet the “Brain-Based” Definition.

The following provides detailed information about each group and reflects the Task Force discussions:

Group One: Youth with Co-Occurring Mental Health Diagnoses and Intellectual Disabilities (85 IQ and Under)

This group is defined as youth who have a mental health diagnosis and also have borderline intellectual functioning (70-84 IQ) or a mild intellectual disability (50-69 IQ). Borderline intellectual functioning is a cognitive impairment that applies to people who have lower than average intelligence but do not meet the federal definition to have an intellectual disability. Children and adolescents with borderline intelligence account for a disproportionately high number of youth who drop out of school, are held back in school, are referred for special education, become pregnant, are incarcerated, use drugs, exhibit aggression and other mental health problems, and are underemployed or unemployed. Compared to other disability categories, youth with mild intellectual disabilities tend to have more general, delayed development in academic, social, and adaptive skills. This delayed development is often reflected in low achievement across content and skill areas as well as significantly lower scores on measures of intelligence and adaptive behavior when compared with students who are not identified with intellectual disabilities. These youth may have difficulty interacting socially, and may run into problems in school and with peers.

Youth with a co-occurring mental health diagnosis and borderline intellectual functioning or mild intellectual disabilities may have complex needs that have traditionally been difficult to address by schools, mental health and other categorical programs. The numbers of youth in this group have also been difficult to determine because they are often a true gap group, not receiving services from DDD or children's mental health programs. While epidemiological literature suggests that between 30% and 40% of individuals with an intellectual disability will also show a significant emotional/behavioral disturbance, youth with borderline intellectual functioning or mild intellectual disabilities are a subset of this group. Project Laulima, a federally funded grant project sponsored by the Child and Adolescent Mental Health Division's (CAMHD), conducted a survey of CAMHD offices in 2010 to determine the number of youth with a combination of a mental health diagnosis and borderline to mild ID who had received services during the past 12 months. These youth all are eligible for CAMHD services. They fall into the underserved group because they are receiving mental health services that are not designed to meet the needs of youth with I/DD. A total of 102 children who meet this description were served in CAMHD programs over this one-year period. Workers in the field, parents of youth with complex needs, and state agency administrators report that there is a

significant number of youth with co-occurring mental health issues and I/DD who are either not served or underserved by Hawaii's current system of care. Many of these youth have co-occurring mental health issues that emerge during the teen years and/or signal the onset of serious mental health issues that can reduce cognitive functioning in adulthood.

Discussion:

- Service and support needs for this population can include pre-employment supports, transition to adult programs/higher education, specialized programming, family support, behavioral supports, and respite. CAMHD recently released a request for proposal (RFP) to provide Comprehensive Behavioral Intervention (CBI) for this gap group. CBI is a specialized, intensive home and community-based service used to provide treatment and support to youth with a mental health diagnosis and cognitive abilities in the 55-85 IQ range and their families. CBI is designed to enhance the family's capacity to sustain the youth in their current living environment and to prevent the need for placement outside the home due to behavioral challenges. CBI also may be used to help reunify the family after the youth has been placed outside the home or to support the transition to a new resource family for foster youth with both developmental disabilities and behavioral difficulties. The Task Force discussed the need to identify available or potential resources that would be available beyond the Project Laulima grant period, the cost impact for providing a sustainable array of services and supports, and capacity and skill building for providers to enhance outcomes for this gap group. The Task Force recognized that Hawaii needs to build its overall capacity to provide intensive behavioral interventions. It is questionable whether the state can rely on grant funding as a long-term strategy.

The Task Force explored the current funding streams available to provide services for this population. One barrier to serving such youth is financial eligibility. If the child is living with his/her family, family income and resources are taken into account in determining the child's Medicaid eligibility. Only children in low-income families, therefore, would qualify to participate in Medicaid-funded programs. Current resources include:

- CAMHD if the youth meets eligibility criteria;
- 1115 Waiver if youth are Medicaid eligible; and
- Private insurance for non-Medicaid.

If this group of youth does not meet the ICF/IID level of care, they are not eligible for the DD HCBS Waiver. Therefore, the cost of services would need to come from general funds or other sources.

Potential funding mechanisms, other than the Section 1915 (c) waiver authority, used by other states to provide services to this gap group include the 1915(i) State Plan coverage of home and community-based services; and Individualized Health Homes.

Group Two: Individuals with Mild Intellectual Disabilities (without Moderate, Severe or Profound Impairments in Adaptive Behavior)

Of the different subcategories of intellectual disability, the mild form is the most prevalent, representing 85% of those with intellectual disabilities (or an estimated 2.14% of the entire population). Profound intellectual disability is the least prevalent, at much less than 1% of the entire population.

Individuals with mild intellectual disabilities without concurrent moderate to profound impairments in adaptive behaviors do not currently meet eligibility for DDD services, and additionally, because they do not meet the ICF/IID level of care, do not qualify for the DD HCBS Waiver. Although the 85% of people with intellectual disability that are mildly affected often get jobs, are married and lead satisfied lives, many have challenges and require supports. They can have difficulties in problem-solving and are likely to have fewer opportunities in competitive employment.

Discussion:

- Members of the Task Force would like to see the State explore mechanisms for public systems to serve this population which may include available resources under the 1115 Medicaid Waiver including the pre-institutional at-risk category; Early Periodic Screening, Diagnosis and Treatment (EPSDT) for children; or other waivers available through Medicaid that the state does not currently have. Potential strategies could include support waivers that might contain employment or case management supports.
- Because of the size of this population, there may be a significant general fund impact that would be even larger if federal Medicaid funds were not leveraged. The Task Force is concerned that this may have impact on the DD HCBS Waiver budget.

- The Task Force identified assistance and outreach needs for this population that may be met by Med-QUEST Division (MQD) eligibility workers who are cross-trained in helping people to access appropriate services and supports.
- There is a need to leverage other employment supports for this group of individuals, by increasing the capacity to provide supported employment in integrated settings within the provider network, augmenting pre-employment services furnished through the public school system and forging stronger partnerships with the business community.

Group Three: Children Age 0-9 without Significant Functional Limitations in Three or More Areas of Major Life Activities

The current federal definition under the DD Act (adopted in 2000) (42 USC 15001 Sec. 102) defines “developmental disability” as a severe, chronic disability of an individual that:

- “(i) is attributable to a mental or physical impairment or combination of mental and physical impairments;
- (ii) is manifested before the individual attains age 22;
- (iii) is likely to continue indefinitely;
- (iv) results in substantial functional limitations in 3 or more of the following areas of major life activity:
 - (I) Self-care.
 - (II) Receptive and expressive language.
 - (III) Learning.
 - (IV) Mobility.
 - (V) Self-direction.
 - (VI) Capacity for independent living.
 - (VII) Economic self-sufficiency; and
- (v) reflects the individual’s need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.”

The 2000 law also further clarified the application of the “developmental disability” definition for children from birth through age 9. A child may be considered to have a developmental disability without meeting three (3) or more of the above criteria [items (i) through (v)] if the individual, without services and supports, has a high probability of meeting these criteria later in life.

Discussion:

- There may be other support needs for children in the birth to age 9 population not currently being addressed. An assessment of these needs may be warranted.
- Adding the language: “An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) of subparagraph (A) if the individual, without services and supports, has a high probability of meeting those criteria later in life” would align the state statute with the federal definition as it applies to infants and young children. There was very strong support to institute this change due to the preventive impact of early intervention supports and services to children and families. The current DDD administrative rules and the specifications of the DD HCBS Waiver would have to be amended. There would be minor cost impact under this scenario.
- The Task Force discussed the need for the State to consider having respite funds as this is a low-cost, high impact support for families. Respite funds were previously available through general funds and were effective in helping families who provide care to provide temporary relief, prevent crisis, promote stability, and prevent out-of-home placements.

Group Four: All individuals with mental or physical disabilities without an intellectual or developmental disability

This group includes individuals who are currently served by the MQD qualified health plans, many through Long Term Services and Supports (LTSS), and the Mental Health divisions of the Department of Health. The qualified health plans offer an extensive array of services and multiple supports to individuals in this category. For individuals with mental disabilities, the DD HCBS Waiver specifically excludes individuals with only a mental health diagnosis. Under QUEST Integration, the State allows beneficiaries who meet an institutional level of care to choose between institutional services or community-based LTSS. Access to both institutional and community-based services through QUEST Integration is based on a functional level of care (LOC) assessment that is performed by the health plans or other entities with delegated authority. Each beneficiary who has a disability, or who may need LTSS, receives a functional assessment at least every twelve months, or more frequently when there has been a significant change in the beneficiary’s condition or circumstances. Any QUEST member who requests a functional assessment can receive one.

There are a number of issues related to expanding a DD definition that includes all individuals with mental health or physical disability who do not have an intellectual or developmental disability or functional limitations as defined in the federal definition. As noted on page 7, the regulatory definition initially adopted in 1986 and still in effect excludes services to persons with mental illnesses. The specific regulation is found in 42 CFR 435.1009 in the section *Persons with related conditions*, which categorically excludes mental illnesses from the definition. Subsequent interpretive guidelines made it clear that it was not the intent of the rule to exclude individuals with a mental illness in combination with a recognized developmental disability. Since, for purposes of waiver services, eligibility is linked to an individual determination of institutional need, the "related conditions" definition carries over to the provision of DD HCBS Waiver services.

The Task Force discussed the following in relationship to this population:

- Unless individuals meet the "related conditions" definition, they cannot receive services through the DD HCBS Waiver. To participate in HCB waiver services, individuals must meet the state's institutional level of care, which in the case of individuals with intellectual and developmental disabilities is tied to ICF/IID level of care criteria. Further, DDD staff does not have the capacity or specialized expertise to address the needs of individuals with behavioral health or physical disability challenges unrelated to a qualifying developmental disability.
- The LTSS services furnished through QUEST Integration program were discussed extensively by the Task Force, including the need to disseminate information about LTSS to the community and the barriers families face in accessing QUEST Integration services. Families would like to receive assistance in navigating the LTSS service system, including the appeals process.
- Members of the Task Force expressed concerns about any strategies that would combine the DD HCBS Waiver with the 1115 Waiver program. Parents and advocates reminded the Task Force that they fought many years to have the DD (HCBS) Waiver.
- The Task Force recommended exploring whether DHS can modify the current 1115 Waiver program so that it better addresses the needs of individuals with physical and behavioral disabilities. Alternatively, DHS might explore the feasibility of operating a separate waiver program for children with mental health issues and physical disabilities. Such a program might include children receiving case management only. The Task Force also discussed the necessity for DHS to have adequate resources to manage any new waivers as they have no current capacity to do so.

- Previously there were state-funded services for gap groups. The Task Force suggested that one option would be to restore state funding for services to this gap group.

Group Five: Move to a developmental disability definition that includes Individuals who meet both functional and categorical (diagnostic) criteria.

Several other states use both functional and diagnostic criteria in their DD definition. For example, Arkansas uses the following: must have a diagnosis present before age 22 of mental retardation, cerebral palsy, autism, or any other condition closely related to mental retardation, including dyslexia, and substantial handicap to the person's ability to function without appropriate support services.

Discussion:

- Those without cognitive limitations need services and supports to meet their goals and sustain independence.
- The American Association on Intellectual and Developmental Disabilities (AAIDD) made the shift from categorical to supports needed in different domains. It also added functional limitations to the IQ criteria as there were errors with diagnosing based on IQ testing alone.
- Diagnosis is less useful unless it helps to identify types of supports needed.
- Flexible funding makes provision of supports easier.
- There is a need to build a holistic picture of each person through the person-centered planning process.
- Many people have functional limitations; this is a very large group. Covering certain categories of medical conditions narrows this group down. Any groups not currently covered that the DDD might serve will add to the cost for the Division. Costs will depend on which categories are included in the definition.
- Currently the 1115 Waiver provides services to most categories of individuals with chronic disabilities. It will provide medically necessary services and long term care supports and services (LTSS) for appropriate individuals.
- The service array for this population depends on the type and severity of the impairment. For example, people with mild cerebral palsy may need some physical therapy and possibly bracing of the ankle and foot. However, those with

severe cerebral palsy require wheelchairs with specialized seating, extensive personal assistance to turn them and prevent decubitus ulcers, skilled nursing to feed using gastrostomy tubes, and require medication including possibly an intrathecal pump to give anti-spasticity medication directly to the spinal cord.

- The current DDD Hawaii Administrative rules have certain categories, like Arkansas, that are covered and certain ones that are not. The gap groups that could be considered for coverage include any of the exclusionary categories: dementia, mental illness, emotional disorders, substance abuse, sensory impairment, learning disabilities, attention deficit hyperactivity disorder, spinal cord injuries, or neuromuscular disorders. Policy decisions would be required to determine which category or categories to include.

Group Six: Move to a definition that includes Individuals who meet the “brain-based” definition

An example of this type of definition can be found in the Oregon code, which bases eligibility for DD services on a neurologically-based condition: a disability that impacts in childhood and impacts adaptive behavior, includes intellectual disability, autism, cerebral palsy, epilepsy or other neurologically disabling condition that results in significant impairment in adaptive behavior and manifests before age 22 (age 18 for mental retardation). Another example can be found in the State of Washington. Washington’s definition states: a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism or other neurological condition related to intellectual disability, manifested before age 18 and resulting in substantial limitations to the individual’s adaptive functioning; must meet criterion on the Supports Intensity Scale over age 16 and over, for under 16, the Support Assessment for Children is used.

Discussion:

- This scenario would exclude disabilities that are not caused by brain-based conditions.
- For young children 0-9, it is often difficult to know what is causing their disabilities.
- The definition on its face may include other neurologically-based disorders, such as learning disabilities. Currently, the DDD is providing services for people that have the original groups of disorders in the federal definition, such as people with autism, cerebral palsy, seizure disorder and intellectual disability. If the severity criteria remain the same, DDD would not be covering most people with a learning

disability as these usually cause milder effects on functioning day-to-day. People with severe brain-based or neurological conditions occurring during the developmental period may be diagnosed with intellectual disabilities, but there may be some individuals that have deficits that are less global, but if severely affected, would then be covered.

- 4. Determine strategies to meet the increasing needs of the intellectual and developmental or physical disabilities population including but not limited to identifying and engaging agencies that can address such needs with a focus on identifying and attempting to provide appropriate safety net processes or services to as large a segment as feasible of the identified gap groups specified in paragraph (3);**

Funding and Policy Options Used by Other States: States have a number of options under various federal authorities to develop and support programs, including the Affordable Care Act and sections of the Social Security Act.

“Supports Waivers”: Support waivers are usually developed through the authority of Medicaid’s 1915(c) HCBS Waiver program, 1915(i) HCBS State Plan Option, and 1915(k) Community First Choice in the Social Security Act. Some states implement “support” waivers under a Medicaid 1915(c) waiver authority to furnish a relatively narrow range and intensity of home and community-based services to broaden the number of eligible individuals with particular needs or characteristics. Supports waiver programs are designed to operate in conjunction with a state’s “comprehensive” waiver program.

ACA Health Home provision: The health home provision authorized by Section 2703 of the Affordable Care Act (ACA) provides an opportunity to build a person-centered care delivery model that focuses on improving outcomes and disease management for beneficiaries with chronic conditions and obtaining better value for state Medicaid programs. Under the health home state plan benefit, a health home provider delivers a comprehensive system of care by integrating and coordinating all primary, acute, behavioral health (including mental health and substance use) and long term services and supports for individuals with chronic conditions to treat the “whole-person.” States will receive a 90% enhanced Federal Medical Assistance Percentage (FMAP) for the specific health home services in Section 2703. The enhanced match does not apply to the underlying Medicaid services also provided to individuals enrolled in a health home. The 90% enhanced match is good for the first eight quarters in which the program is effective. A state may receive more than one period of enhanced match, understanding that they will only be allowed to claim the enhanced match for a total of eight (8) quarters for one beneficiary.

General Funds: States use general funds only for services for people who do not meet eligibility criteria for other federal programs. While this can enable a state to expand eligibility to additional groups of individuals in need, the practice places significant pressure on state officials to explain the differential admission criteria between the various programs.

Task Force Recommendations

The Task Force, after reviewing the various gap groups and eligibility scenarios, recommends the following in the order of priority.

1. A. Amend the current definition of developmental disabilities in Section 333F-1 to clarify that infants and young children (an individual from birth to age 9, inclusive) who have substantial developmental delays or specific congenital or acquired conditions may be considered to have a developmental disability without meeting three or more of the criteria described in clause (4) of the current definition if the infant or child, without services and supports, has a high probability of meeting those criteria later in life.

Clause (4) currently reads: “Results in substantial functional limitations in three or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic sufficiency.”

Addition of the language for infants and young children would:

- 1) Align Section 333F-1 with Chapter 333E, HRS and the current federal definition under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act) PL 106-402 Sec. 102;
- 2). Clarify that infants and young children, by definition, have different abilities than older children and adults in major life activities. It is challenging to apply the functional limitations established in statute to this population. Therefore, before the age of ten, an infant or child with developmental delays may be considered to have an intellectual or developmental disability if his or her disabilities are likely to meet the above functional criteria if there were no interventions; and
- 3). Restore the ability to determine eligibility for young children through this definition that was allowed through the previous Administrative Rules (Chapter 11-88, HAR).

Acceptance of this recommendation will require amendments to Section 333F-1, HAR Section 11-88.1-5, and the 1915(c) HCBS Waiver Application. There is no recommendation to amend other clauses of the definition of developmental disabilities in Section 333F-1.

The Task Force recommends the amendment to Chapter 333F as it meets the intent of the statute, correctly reflects the developmental abilities of infants and young children, and allows for early intervention and supports that can have a profound impact on quality of life. It is expected that this recommendation will have minimal cost impact.

- B. Request that the Legislature consider support for respite programs for families of individuals with I/DD.
2. Explore federal and state funding options to address service and support needs for individuals with mild intellectual disabilities.

The Task Force does not recommend changing the statutory definition of developmental disabilities to address this recommendation but does recommend exploring funding options that may include using available resources through the 1115 Waiver, EPSDT or pursuing other available support waivers through Medicaid. Other states have used options under the authority of Medicaid's 1915(c) HCBS Waiver program, 1915(i) HCBS State Plan Option, or 1915(k) Community First Choice. Some states implement "support" waivers under a Medicaid 1915(c) waiver authority to furnish a relatively narrow range of home and community-based services to eligible individuals with particular needs or characteristics. Supports waiver programs are designed to operate in conjunction with a state's "comprehensive" waiver program. While these ideas warrant further research, it is clear that DHS does not currently have the resources to implement or administer other waivers. More information is needed to understand what services are needed by this population, what options are best suited to address these needs including options that best address access to services.

A strategy raised by DHS and discussed by the Task Force would explore how services can be provided within the current Medicaid program through current waivers or the State plan to address the needs of people with mild intellectual disabilities who do not qualify for DDD services that could include services similar to the Long Term Services and Supports "at-risk" category. This might involve adding additional services for people who do not meet the DD HCBS Waiver level of care.

While a comprehensive assessment of needs and cost should be conducted as part of any development of new services, individuals with mild intellectual disabilities

without substantial functional limitations will generally require less personal assistance, nursing, day habilitation services and other types of services that are found in the DD HCBS Waiver. Individuals with mild intellectual disabilities may need case management that places a stronger focus on employment and supporting community integration but because these individuals do not meet eligibility for DDD services, they cannot obtain case management services through the DD Division. Family support services, case management to help people navigate the applications processes, and support for transitions may also be service needs by this population. The Task Force was particularly concerned about addressing the needs of adults with borderline intellectual functioning and mental illnesses, a population that have unique needs that are often unaddressed.

Key to addressing this recommendation is developing community and state agency agreement about the best strategy possible.

3. A. Use existing options to provide services and supports for individuals with mental health and physical disabilities without an intellectual or developmental disability.

Options for this population include using services provided through CAMHD; Adult Mental Health Division (AMHD); Early Periodic Screening, Diagnosis and Treatment (EPSDT); primary care and Long Term Services and Supports (LTSS) under QUEST Integration. This includes services to individuals who are assessed to be “at risk” of deteriorating to the institutional level of care (the “at risk” population).

Very few Task Force members knew about the LTSS under QUEST Integration, and wanted information about how the community will learn more about this service option.

- B. Develop a process to meet the needs of individuals and families for accessing and navigating QUEST Integration LTSS, which may be met by Med-QUEST Division (MQD) eligibility workers who are cross-trained in helping people to access appropriate services and supports.

4. Use existing options to provide services for youth with a mental health diagnosis and co-occurring mild intellectual disability.

The Task Force recognizes that there are likely existing mechanisms to address the service and support needs for this population, but there may need to be specialized expertise – and dedicated funding -- developed to address the needs of this population. Project Laulima, the federally-funded grant activity currently being implemented by CAMHD, has identified many of the service needs of this population

and has issued a Request for Proposal (RFP) for Comprehensive Behavioral Interventions (CBI) to provide treatment and support to youth with a mental health diagnosis and mild intellectual disabilities. CAMHD reports that part of the grant requirements is to convene an interagency planning group to look at sustainability including the availability of Medicaid-reimbursable services. The Task Force recommends the State develop a sustainable strategy for addressing the needs of this population once the grant funding is over, with a special emphasis on ensuring any out-of-home treatment settings are individualized and have full capacity to serve these youth. The Task Force supports developing inter-disciplinary teams to conduct comprehensive assessments, service plans and service coordination for this population.

The Task Force does not recommend expanding the definition of developmental disabilities to address this population.

5. Continue the work of the Task Force through the Legislative appointment of a Task Force to monitor the implementation of these recommendations; examine the service needs of other vulnerable populations where there may be service gaps or barriers to access, such as workforce capacity issues; explore options and opportunities for funding, and engage all relevant state agencies and stakeholders.

HCR17 Task Force Members

The following people contributed to/attended the HCR17 Task Force Meetings:

- **Hawaii State Council on Developmental Disabilities (DDC)** - Waynette Cabral, Daintry Bartoldus & Tammy Evrard;
- **Hawaii Disability Rights Center (HDRC)** - Louis Erteschik, Ann Collins, and Kathleen Delahanty;
- **University of Hawaii, Center on Disability Studies (CDS)** - Becky Ozaki, William Mihalke and Chin Lee;
- **Department of Human Services, Med-QUEST Division** - Kenneth Fink, MD, Leslie Tawata and Curtis Toma, MD;
- **House Committee on Health** - Representative Della Au Belatti Office's John Kawamura & Representative Mele Carroll & Tupua Fanoga;
- **Senate Committee on Health** - Senator Josh Green and Senator Rosalyn Baker's Office - Janice Salcedo & Kelli-Rose Hooser;
- **National Association of State Directors of Developmental Disabilities Services (NASDDDS)** - Robert M. Gettings;
- **Self Advocates** - (as represented as Self Advocacy Advisory Council (SAAC)): Vaipapa Soliai (President), Bathey Fong (Vice President), Mark Mortimer, Michelle Muralt, Timothy Renken, and Christopher Toyama;
- **Family members and designated representatives of individuals with intellectual and developmental disabilities** – Dale Kehau Kanae (also representing DDD Staff), Susan Rocco (also representing Disability & Communication Access Board aka DCAB), Tiffany Vara, Josie Woll, Joanne Yuen;
- **Other individuals:**
 - Senator Suzanne Chun-Oakland, Senate Human Services Committee Chair;
 - Mark Fridovich, Adult Mental Health Division Administrator;
 - Patricia Heu, MD, Children with Special Health Needs Branch Chief;
 - Stanton Michels, MD, Child & Adolescent Mental Health Division Administrator;
 - Pratima Musburger, CAMHD, Project Laulima Director, Dorothy Sekowski & Brenda Kosky;
 - Leolinda Parlin, Hilopa'a Family to Family Health Information Center;
 - Dan Ulrich, MD, CAMHD Medical Director
 - Brian Yanamine, Representative Joseph Souki
 - Lynn Fallin, Deputy Director of Behavioral Health

DDD Staff: David Fray, DDS; Aaron Arakaki; Kimberly Arakaki; Jenny Gong; Evan Murakami; Jeff Okamoto, MD; Debra Tsutsui; and Valerie Yin.

Office of Performance Improvement & Excellence (OPIE): Mary Brogan

The Hawaii State Department of Health, Developmental Disabilities Division, would like to acknowledge Dr. David F. Fray and Dr. Jeffrey Okamoto for their leadership of the division.

Dr. Fray was chief of the division for 12 years and Dr. Okamoto served as interim chief intermittently. Dr. Fray initiated HCR17 for the 2014 legislature.

Acronyms
(in alphabetical order)

1115	A federal authority, section 1115 of the Social Security Act
1915(c)	A federal authority, section 1915(c) of the Social Security Act
1915(i)	A federal authority, section 1915(i) of the Social Security Act
1915(k)	A federal authority, section 1915(k) of the Social Security Act
ACA	Affordable Care Act
AAIDD	American Association on Intellectual and Developmental Disabilities
AMHD	Adult Mental Health Division
CAMHD	Child and Adolescent Mental Health Division
CBI	comprehensive behavioral intervention
CFR	Code of Federal Regulations
CMS	The Centers for Medicare and Medicaid Services
DD	developmental disabilities
DDC	Hawaii State Council on Developmental Disabilities
DDD	Developmental Disabilities Division (within Department of Health)
DD HCBS Waiver	Medicaid Developmental Disabilities Home and Community Based Services Waiver program serving participants with intellectual and developmental disabilities
DHS	Hawaii Department of Human Services
DOE	Hawaii Department of Education.
DOH	Hawaii Department of Health
HB	House bill
EPSDT	Early Periodic Screening, Diagnosis & Treatment
FMAP	Federal Medical Assistance Percentage
HCBS	Home and Community Based Services
HCR	House Concurrent Resolution
HCR-17	House Concurrent Resolution 17 of 2014
HHS	U.S. Department of Health and Human Services
HRS	Hawaii Revised Statutes
ICF/IID	intermediate care facility for individuals with intellectual disabilities (formerly called ICF/MR or intermediate care facility for mental retardation)
ID	intellectual disability
I/DD	intellectual and developmental disabilities
IQ	intelligence quotient
LASR	Long-Term Adult Supports and Resources
LOC	level of care
LTSS	long term services and supports
MQD	Med-QUEST Division (within Department of Human Services)
NASDDDS	National Association of State Directors of Developmental Disabilities Services
PL	Public Law
QUEST	Quality care, Universal access, Efficient utilization, Stabilizing costs, and Transforming the way health care is provided
RFP	request for proposals
SSI	Social Security Income
USC	United States Code

HOUSE CONCURRENT RESOLUTION

REQUESTING THE DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES
DIVISION TO ESTABLISH A TASK FORCE TO REVIEW HAWAII'S
STATUTORY DEFINITION OF "DEVELOPMENTAL DISABILITIES".

1 WHEREAS, the definition of "developmental disabilities" in
2 section 333F-1, Hawaii Revised Statutes, is a federal definition
3 that was meant to be a functional or planning definition for
4 states to further define; and

5
6 WHEREAS, all states except Hawaii have further defined
7 "developmental disabilities" in their respective state statutes
8 or regulations; and

9
10 WHEREAS, the state statutory definition of "developmental
11 disabilities" is not a clinical definition but a legal
12 definition; and

13
14 WHEREAS, developmental disabilities diagnoses are
15 determined by licensed physicians or psychologists; and

16
17 WHEREAS, in section 333F-1, Hawaii Revised Statutes,
18 "developmental disabilities" is defined as "a severe, chronic
19 disability of a person which:

- 20
21 (1) Is attributable to a mental or physical impairment or
22 combination of mental and physical impairments;
23
24 (2) Is manifested before the person attains the age of
25 twenty-two;
26
27 (3) Is likely to continue indefinitely;
28
29 (4) Results in substantial functional limitations in three
30 or more of the following areas of major life activity;
31 self-care, receptive and expressive language,



1 learning, mobility, self-direction, capacity for
2 independent living, and economic self-sufficiency; and

3
4 (5) Reflects the person's need for a combination and
5 sequence of special, interdisciplinary, or generic
6 care, treatment, or other services which are of
7 lifelong or extended duration and are individually
8 planned and coordinated."; and
9

10 WHEREAS, eligibility for Department of Health Developmental
11 Disabilities Division services is based on the statutory
12 definition of developmental disabilities; and
13

14 WHEREAS, many people with behavioral challenges, including
15 fetal alcohol syndrome, may not be covered by the current
16 definition; and
17

18 WHEREAS, the Department of Health seeks to collaborate
19 across divisional statutory responsibilities and supports
20 persons with disabilities and their families; and
21

22 WHEREAS, the current program has limited funding that
23 precludes adding new groups to the existing home- and community-
24 based services without legislative appropriation; and
25

26 WHEREAS, the United States Department of Health and Human
27 Services, Centers for Medicare and Medicaid has instituted new
28 options for Hawaii Medicaid programs that can benefit persons
29 with developmental or physical disabilities through different
30 state agencies; now, therefore,
31

32 BE IT RESOLVED by the House of Representatives of the
33 Twenty-seventh Legislature of the State of Hawaii, Regular
34 Session of 2014, the Senate concurring, that the Department of
35 Health Developmental Disabilities Division is requested to
36 establish a task force to:
37

38 (1) Review the current state statutory definition of
39 "developmental disabilities" in comparison to other
40 states, and study the impacts of changing the
41 definition of "developmental disabilities";
42



- 1 (2) Discuss general eligibility issues relating to the
2 current statutory definition of "developmental
3 disabilities";
4
- 5 (3) Identify gap groups that are currently ineligible for
6 developmental disabilities services, but are a part of
7 the intellectual and developmental disabilities
8 population; and
9
- 10 (4) Determine strategies to meet the increasing needs of
11 the intellectual and developmental or physical
12 disabilities population including but not limited to
13 identifying and engaging agencies that can address
14 such needs with a focus on identifying and attempting
15 to provide appropriate safety net processes or
16 services to as large a segment as feasible of the
17 identified gap groups specified in paragraph (3); and
18

19 BE IT FURTHER RESOLVED that the Director of Health or the
20 Director's designee is requested to serve as chair of the task
21 force; and
22

23 BE IT FURTHER RESOLVED that the Director of Health or the
24 Director's designee is requested to solicit representatives from
25 the following entities to serve on the task force, provided that
26 the persons who are selected to serve on the task force have
27 background and knowledge of developmental disabilities within
28 their respective organizations:
29

- 30 (1) Hawaii State Council on Developmental Disabilities;
31
- 32 (2) Hawaii Disability Rights Center;
33
- 34 (3) University of Hawaii Center on Disability Studies;
35
- 36 (4) Department of Human Services, Med-QUEST Division;
37
- 38 (5) House Committee on Health;
39
- 40 (6) Senate Committee on Health;
41
- 42 (7) National Association of State Directors of
43 Developmental Disabilities Services;
44



- 1 (8) Individuals with intellectual and developmental
- 2 disabilities;
- 3
- 4 (9) Family members and designated representatives of
- 5 individuals with intellectual and developmental
- 6 disabilities; and
- 7
- 8 (10) Any other individuals or entities that may contribute
- 9 to the work of the task force; and

10
11 BE IT FURTHER RESOLVED that members of the task force serve
12 without compensation for time and expenses associated with task
13 force activities; and

14
15 BE IT FURTHER RESOLVED that the task force is requested to
16 submit its findings and recommendations to the Legislature no
17 later than 20 days before the convening of the Regular Session
18 of 2015; and

19
20 BE IT FURTHER RESOLVED that certified copies of this
21 Concurrent Resolution be transmitted to the Governor, Attorney
22 General, Director of Health, Director of Human Services,
23 Executive Director of the Hawaii State Council on Developmental
24 Disabilities, Executive Director of the Hawaii Disability Rights
25 Center, Acting Director of the University of Hawaii Center on
26 Disability Studies, and the National Association of State
27 Directors of Developmental Disabilities Services.

28

