

*Building Inclusive Communities  
Keeping the Promise*

# West Virginia *Olmstead Plan*

November 1, 2005



### **Acknowledgements**

The hard work and dedication of the *Olmstead* Advisory Council was instrumental throughout the process to develop a comprehensive *Olmstead Plan* for West Virginia.

It is also important to recognize the people with disabilities, families, advocates, providers, state agencies, and concerned citizens who participated in the six statewide public forums and provided vital input and feedback throughout the process.

On October 12, 2005, Governor Joe Manchin, III signed Executive Order No. 11-05 formally approving the *Olmstead Plan: Building Inclusive Communities, Keeping the Promise*.



**STATE OF WEST VIRGINIA**  
**EXECUTIVE DEPARTMENT**  
**CHARLESTON**  
**EXECUTIVE ORDER NO. 11-05**  
**By the Governor**

**WHEREAS**, *Olmstead v. L.C.*, 527 U.S. 581 (1999) is a landmark United States Supreme Court decision addressing the civil rights of people with disabilities to receive community-based service and support; and

**WHEREAS**, the *Olmstead* Court held that Title II of the Americans with Disabilities Act of 1990 may require placement of persons with disabilities in integrated and inclusive community settings; and

**WHEREAS**, the *Olmstead* Court held that institutional confinement severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment; and

**WHEREAS**, the *Olmstead* Court further ruled that the unnecessary and unjustified segregation of qualified people with disabilities through institutionalization is a form of disability-based discrimination prohibited by Title II of the Americans with Disabilities Act of 1990, which requires that states and localities administer programs, services, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities; and

**WHEREAS**, the *Olmstead* Court further held that community placement is necessary whenever treatment professionals determine such placement is appropriate, the affected persons do not oppose such placement, and the state can reasonably accommodate the placement, taking into account the resources available to the state and the needs of others with disabilities; and

**WHEREAS**, on June 19, 2001, President George W. Bush issued Executive Order No. 13217 directing the United States Attorney General, the Secretaries of Health and Human Services, Education, Labor, and Housing and Urban Development to work closely with individual states to implement the *Olmstead* decision., particularly with those states that choose to develop comprehensive, effective working plans to provide services to qualified individuals under the criteria set forth therein; and

**WHEREAS**, the State of West Virginia has taken affirmative steps in response to the *Olmstead* decision, including: (1) establishment of an *Olmstead* office and the position of *Olmstead* Coordinator; (2) establishment of an *Olmstead* Advisory Council; (3) convening six public forums and a forty-five day public comment period to gather input from people with disabilities, families, advocates, providers, and State officials for the development of a comprehensive, effectively working plan to provide services to people with disabilities in West Virginia; and (4) development of a comprehensive, effectively working *Olmstead* Plan for West Virginia; and

**WHEREAS**, the State of West Virginia is committed to ensuring access to community-based supports and the provisions of services to people with disabilities in accordance with the *Olmstead* decision and Title II of the Americans with Disabilities Act of 1990; and

**WHEREAS**, the State of West Virginia is committed to providing community-based alternatives for people with disabilities utilizing the resources available to the State, and recognizes that such services and supports advance the best interests of all West Virginians; and

**WHEREAS**, the State of West Virginia should encourage and effectuate changes in State programs and policies that will improve the State's ability to provide community-based alternatives for people with disabilities in

conformance with the requirements of the *Olmstead* decision and President Bush's Executive Order No. 13217.

**THEREFORE I, JOE MANCHIN III, GOVERNOR**, by virtue of the power and authority vested in me by the Constitution and laws of the State of West Virginia, do hereby **ORDER**

(1) the implementation of West Virginia's *Olmstead* Plan, Building Inclusive Communities; Keeping the Promise;

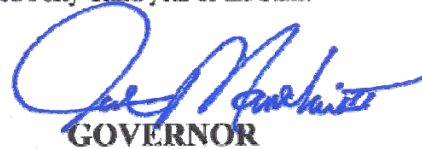
(2) the cooperation and collaboration between all affected agencies and public entities with the *Olmstead* office to assure the implementation of the *Olmstead* decision within the budgetary constraints of State agencies in West Virginia; and

(3) the submission of an annual report by the *Olmstead* office to the Governor on the progress of implementing the *Olmstead* Plan, Building Inclusive Communities; Keeping the Promise in West Virginia by the thirty-first day of August of each year.

**IN WITNESS WHEREOF**, I have hereunto set my hand and caused the Great Seal of the State of West Virginia to be affixed.



**DONE** at the Capitol, in the City of Charleston, State of West Virginia, this the twelfth day of October in the year of our Lord, Two Thousand Five, and in the One Hundred Forty-Third year of the State.

  
**GOVERNOR**

**By the Governor**

  
**SECRETARY OF STATE**







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## **SECTION I – OVERVIEW OF *OLMSTEAD v. L.C.***

### **BACKGROUND OF THE CASE**

*Olmstead v. L.C.*, (98-536) 527 U.S. 581 (1999), is a landmark United States Supreme Court decision for the civil rights of people with disabilities to receive community-based services and supports. The case was filed on behalf of two women who were residents of the Georgia Regional Hospital in Atlanta, a state psychiatric hospital. Both women were institutionalized because they had a developmental disability and co-occurring mental illness.

“Confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”

-*Olmstead v. L.C.*

The women wanted to leave the hospital to receive supports in the community. The hospital’s treatment professionals agreed the needs of these two women could be met in community-based settings. The state of Georgia had “slots” available under their Medicaid home and community-based waiver program. Nonetheless, both women remained institutionalized years after they and their team requested community placement.

These women filed a lawsuit against the Georgia Department of Human Resources alleging that the State’s failure to discharge them to a community-based setting was a form of discrimination prohibited by the *Americans with Disabilities Act* (ADA).

The first court to hear the case, a district court, ruled that Georgia violated the ADA by segregating both women in an institutional setting rather than placing them in an integrated setting under Georgia’s community-based services program. The district court rejected Georgia’s argument that inadequate funding, not discrimination, accounted for the institutionalization of the plaintiffs. The district court concluded, “Unnecessary institutional segregation of the disabled constitutes discrimination per se, which cannot be justified by a lack of funding.” The 11<sup>th</sup> United States Circuit Court of Appeals agreed with the district court that the plaintiffs were protected by the ADA and had been subjected to discrimination. Georgia appealed the ruling to the United States Supreme Court.

On June 22, 1999, the Supreme Court agreed with the judgments from the lower courts that the plaintiffs were protected by the ADA and had been subjected to discrimination by being institutionalized. This is what is known as the *Olmstead* decision. The syllabus of the Supreme Court decision is located in ***Appendix B***.

This was a landmark ruling for the civil rights of people with disabilities to live, learn, work, and socialize in the community of their choice; thereby, not being institutionalized and subjected to discrimination because of their disability.

### **DISCRIMINATION ON THE BASIS OF DISABILITY**

The decision being based on discrimination is significant in and of itself, for it rejected the method commonly used by the Supreme Court in making such determinations. In the past, courts determined discrimination by comparing two different groups to see whether one group of people received preference over the other. This set an impossibly high standard because it would require evidence that people who do not have disabilities were receiving the same services as people with disabilities. The majority opinion recognized that discrimination could also occur within a class or group, such as people with disabilities. This decision enables a person not receiving home and community-based services to prove discrimination when similar people are receiving such services.

“Specifically, we confront the question whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than institutions. The answer, we hold, is a qualified yes.”

-*Olmstead vs. L.C.*

The Supreme Court ruled that “unjustified institutional isolation” is a form of discrimination that constitutes an abridgement of a person’s basic civil rights. To correct unjustified institutionalization, states must adopt even-handed and equitable funding mechanisms for a range of services and supports for people with disabilities. Funding decisions regarding institutional and community-based programs must be consistent with the ADA mandate that programs are administered in the most integrated setting appropriate. The Supreme Court does not interpret the ADA as requiring states to phase out institutions. However, no longer will states be permitted to make funding decisions based on endeavors to keep institutions fully populated.

## THE AMERICANS WITH DISABILITIES ACT

The *Olmstead* decision was based on regulations of Title II of the ADA. The Title II of the ADA is a civil rights law administered by the United States Department of Justice. The ADA was enacted “to establish a clear and comprehensive prohibition of discrimination on the basis of disability.”<sup>1</sup>

Title II of the ADA established the requirements for public entities, or state governments and health care services that are funded and administered by state agencies. Title II of the ADA prohibits people with disabilities from being “excluded from participation in or denied the benefits of the services, programs, or activities of a public entity, or subjected to discrimination by any such entity.”<sup>2</sup> Two key mandates under Title II of the ADA were fundamental to the decision made by the U.S. Supreme Court: the “integration” regulation and the “reasonable modifications” regulation.

### **ADA Title II – Non-Discrimination Principle**

“No qualified individual with a disability, shall by reason of such disability, be excluded from participation in or denied the benefits of the services, programs or activities of a public entity, or be subjected to discrimination by any such entity.”

### **Most Integrated Setting**

The “integration” regulation requires states to administer services “in the most integrated setting appropriate to the needs of the qualified individuals with disabilities.”<sup>3</sup> The most integrated setting is defined as “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.”<sup>4</sup>

### **Reasonable Modifications**

The “reasonable modifications” regulation mandates “states will make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the [state] can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.”<sup>5</sup> While rendering unnecessary institutionalization presumptively unlawful, the *Olmstead* decision does afford states a defense to

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<sup>1</sup> *Americans with Disabilities Act* of 1990 (ADA).

<sup>2</sup> Title II of the *Americans with Disabilities Act* of 1990, 42 USC § 12132.

<sup>3</sup> Title II of the ADA, 28 CFR § 35.130(d).

<sup>4</sup> Title II of the ADA, 28 CFR § 35.170(b)(7).

<sup>5</sup> Title II of the ADA, 28 CFR 38-130(b)(7).

*Olmstead* claims. A state is not required to transfer unnecessarily institutionalized persons to the community if doing so would fundamentally alter the state’s program. Whether serving particular individuals in a more integrated setting would require a fundamental alteration depends on:

- the cost of providing the services to the individual in the most integrated setting appropriate;
- the resources available to the states; and
- the affect the provision of services has on the ability of the state to meet the needs of others with disabilities.<sup>6</sup>

A fundamental alteration defense requires courts to examine the resources available, including not only the costs of providing home and community-based services to litigants, but also the range of services the state provides to others with disabilities. The Supreme Court stated that, “...if the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons...in less restrictive settings, and a waiting list that moved at a reasonable pace, not controlled by the State’s endeavors to keep institutions fully populated, the reasonable modifications standard would be met.”

The *Olmstead* decision is not about Medicaid, it is about discrimination under the ADA. The Supreme Court viewed Medicaid as a funding source for specific supports and services with recognition that recent changes in Medicaid legislation expresses an increased flexibility and preference for funding home and community-based programs.

### **WHO IS PROTECTED BY THE *OLMSTEAD* DECISION?**

The *Olmstead* decision protects any person who has a disability covered by the ADA. This includes, but is not limited to, people who are institutionalized or “at risk” of being institutionalized. A three-pronged definition of disability is utilized for determining protection under the ADA. A person with a disability is defined by the ADA as an individual who:

- has a physical or mental impairment that substantially limits one or more major life activities;
- or
- has a record or history of such an impairment; or

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<sup>6</sup> *Olmstead vs. L.C.*



- is perceived or regarded as having such an impairment.<sup>7</sup>

The phrase “major life activities” means functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.<sup>8</sup> The complete ADA definition of disability is located in *Appendix C*.

The *Olmstead* decision and Title II of the ADA protects people of any age who meet the criteria for having a disability. The Centers for Medicare and Medicaid Services (CMS) has addressed this issue. CMS states, “No matter what specific impairment or group of people is at issue – including elderly people and children – each must meet the same threshold definition of disability in order to be covered by the ADA. With respect to elderly people, age alone is not equated with disability.”<sup>9</sup>

“Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participation in community life.”

-*Olmstead v. L.C.*

The *Olmstead* decision affects institutional and other congregate facilities operated directly by states or operated under contracts with healthcare providers. This equates to facilities where people are recipients of public funding. The types of facilities affected in West Virginia are:

- state-operated facilities and hospitals;
- ICF/MR facilities;
- skilled nursing facilities;
- nursing facilities;
- assisted living residences; and
- other segregated living settings or segregated service provision settings.

The Supreme Court ruled that, before requiring a state to move people with disabilities from institutional care to the community, three conditions must be met:

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<sup>7</sup> Title II of the ADA, 28 CFR § 35.104.

<sup>8</sup> *Ibid.*

<sup>9</sup> Centers for Medicare and Medicaid Services, State Medicaid Directors letter, *Olmstead* Update No. 2, July 25, 2000.

- the state’s treatment professionals have determined that community placement is appropriate;
- the transfer from institutional care to the most integrated setting is not opposed by the affected individual; and
- the placement can be reasonably accommodated [by the state], taking into account the resources available to the state and the needs of others with mental disabilities.<sup>10</sup>

### **State’s Treatment Professionals**

The “state’s treatment professionals” are those individuals who make up the person’s treatment or planning team. The “state’s treatment professionals” must be knowledgeable, and have a functional understanding of the available community-based options to make a professional determination about the placement needs of an individual.

### **Guardianship & Health Care Surrogacy**

The “transfer from institutional care...is not opposed by the affected individual” is the decision made by a person once they have the information necessary to make an informed choice. In addition, if the person has a guardian, the guardian has the following mandated responsibilities by the West Virginia State Code:<sup>11</sup>

- A guardian will exercise authority only to the extent necessitated by the protected person's limitations, and, where feasible, will encourage the protected person to participate in decisions; to act on his or her own behalf, and to develop or regain the capacity to manage personal affairs.
- A guardian will, to the extent known, consider the expressed desires and personal values of the protected person when making decisions, and will otherwise act in the protected person's best interests, and exercise reasonable care, diligence, and prudence.

West Virginia State Code provides for people to access health care surrogates to ensure that a person’s rights to self-determination in health care decisions be communicated and protected.<sup>12</sup> A

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<sup>10</sup> *Olmstead vs. L.C.*

<sup>11</sup> West Virginia State Code §44A-3-1

<sup>12</sup> West Virginia State Code §16-30-2

health care decision is defined by West Virginia State Code as “a decision to give, withhold, or withdraw informed consent to any type of health care; including, but not limited to, medical and surgical treatments, including life-prolonging interventions, psychiatric treatment, nursing care, hospitalization, treatment in a nursing home or other facility, home health care and organ or tissue donation.”<sup>13</sup> West Virginia State Code states the health care surrogate will make health care decisions:<sup>14</sup>

- in accordance with the person’s wishes, including religious and moral beliefs;
- in accordance with the person’s best interests if these wishes are not reasonably known and cannot with reasonable diligence be ascertained; and
- which reflect the values of the person, including the person’s religious and moral beliefs, to the extent they are reasonably known or can with reasonable diligence be ascertained.

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<sup>13</sup> West Virginia State Code §16-30-3

<sup>14</sup> West Virginia State Code §16-30-9



## **SECTION II - WEST VIRGINIA'S *OLMSTEAD* PLANNING PROCESS**

### **WHY DEVELOP AN *OLMSTEAD PLAN*?**

The Supreme Court suggests that a state could establish compliance with Title II of the *Americans with Disabilities Act* (ADA) if it has a comprehensive, effectively working plan for placing qualified people in the most integrated setting, and has waiting lists that move at a reasonable pace.<sup>15</sup> In addition to the Supreme Court ruling, the Centers for Medicare and Medicaid Services (CMS), recommend that states develop a comprehensive, effectively working plan to ensure compliance with Title II of the ADA.<sup>16</sup>

### **ESTABLISHMENT OF AN *OLMSTEAD* OFFICE**

In 2003, Governor Bob Wise directed the establishment of an *Olmstead* Coordinator to develop, implement, and monitor West Virginia's *Olmstead* activities. The Secretary of the West Virginia Department of Health and Human Resources (DHHR) designated the duties of the *Olmstead* Coordinator to be located under the supervision of the Office of the Ombudsman for Behavioral Health. The *Olmstead* Office was established on August 13, 2003.

### ***Olmstead* Advisory Council**

The *Olmstead* Coordinator assembled two groups through a statewide nomination process. The majority (70%) of both groups include people with disabilities, family members, and advocates for people with disabilities. Both groups were formed and began meeting in November 2003.

“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it’s the only thing that ever has.”

-Margaret Meade

The *Olmstead* Advisory Council is responsible for acting as an oversight committee for the *Olmstead* Office and the *Olmstead Plan*. This Council met on a monthly basis during the development phase of the *Olmstead Plan*. After the development and approval of the *Plan*, the Council will meet on a quarterly basis to monitor ongoing *Olmstead* activities; as well as provide the *Olmstead* Coordinator with assistance and support on relevant issues. The *Olmstead* Study Group was responsible for the

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<sup>15</sup> *Olmstead vs. L.C.*

<sup>16</sup> Centers for Medicare and Medicaid Services, State Medicaid Directors Letter, January 14, 2000.

research and writing activities for development of the *Olmstead Plan*. This group met on a monthly basis during the development phase of the *Olmstead Plan*.

In May of 2004, the *Olmstead* Study Group was merged with the *Olmstead* Advisory Council to create one cooperatively working group. A list of the *Olmstead* Advisory Council members is located in ***Appendix D***.

The *Olmstead* Coordinator solicited feedback and input throughout the process from stakeholders through the *Olmstead* website, mailings, attendance at conferences and meetings, and six statewide public forums.

### **Public Comments**

The draft *Olmstead* Plan was released on July 12, 2004 for public comment. The public comment period targeted people with disabilities, family members, advocates, providers, government agencies and the general public. The public comment period continued through August 30, 2004. In addition to the public comment period, the *Olmstead* Coordinator held public forums in Charleston, Parkersburg, Wheeling, Bridgeport, Martinsburg, and Beckley.

### **West Virginia *Olmstead* Funding**

The Bureau for Behavioral Health and Health Facilities (BHHF) of the DHHR receives a continuing annual improvement package budget appropriation of \$485,000 from the Legislature for *Olmstead* activities. This funding is allocated for the purposes of assisting individuals residing at the state-operated psychiatric hospitals and state-operated long term care facilities to transition to the most integrated setting appropriate to their needs. The following details the specific legislative intent of this funding:

- ***Forensic***: Individuals may be committed to the jurisdiction of the court system after a finding of “not competent to assist in their defense” and/or “lacking responsibility for the alleged crime.” Typically, the court system requires the DHHR to provide treatment and a place of residence (Sharpe Hospital). Discharge to a community-based program is possible under the law and with court approval.

- ***State-Operated Long Term Care:*** Individuals residing in state-operated long term care facilities who could live in the most integrated setting require funding for start-up costs for their transition. Start-up costs would be for potential renovations and/or training costs for support staff. It is estimated this funding could support the start-up costs to meet the community-based needs of 20 people.

## **FEDERAL *OLMSTEAD*-RELATED GRANTS**

### **Substance Abuse & Mental Health Services Administration Grant**

The Substance Abuse and Mental Health Services Administration (SAMHSA) is under the United States Department of Health and Human Services (DHHS). The SAMHSA is the federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illness.

The SAMHSA has provided financial assistance to states and territories to expand resources and opportunities for adults with serious mental illnesses and children with serious emotional disturbances to live in their home communities. The funding provided is for a three-year contract to receive up to \$20,000 per year. In 2003, West Virginia received this grant for a second three-year grant period.

SAMHSA expects this funding to support state coalition building and planning activities. The funds may be used for personnel, fringe benefits, travel, meeting expenses, and supplies. West Virginia used this funding for the *Olmstead Plan* development, training, public forums, publication of printed materials, and consultative activities.

### **New Freedom Initiative Grants**

In 2001, CMS invited proposals from states to design and implement effective and enduring improvements in community long term support systems. The CMS initiated a series of federal systems change grants intended to foster systemic changes to enable children and adults who have a disability or long term illness to:

- live in the most integrated community setting appropriate to their individual support requirements and their preferences;
- exercise meaningful choices about their living environments, the providers of services they receive, the types of supports they use and the manner by which services are provided; and
- obtain quality services in a manner as consistent as possible with their community living preferences and priorities.<sup>17</sup>

West Virginia applied for and received seven federal systems change grants. Activities produced from these grants will be used and sustained to implement various goals of West Virginia's *Olmstead Plan*. The total amount of federal funding received is \$4,281,264. The following details the goals of each federal systems change grant received by West Virginia.

1) The "Real Choice Systems Change" grant is to help design and implement effective and enduring improvements in community support systems to enable people with disabilities to live and participate in their communities. This three-year grant was awarded in fiscal year 2002 to the Bureau for Medical Services (BMS) with \$1,313,996 in federal funding. It is managed by the Center for Excellence in Disabilities at West Virginia University (CED at WVU). The following are the objectives of the grant:

- Educate multiple audiences throughout West Virginia regarding community-based issues.
- Provide people the freedom to choose from a variety of options for community living.
- Develop training initiatives with consumer/advocacy groups, and disseminate a curriculum on community-based issues to raise awareness at multiple levels.
- Construct, advertise, and maintain a toll-free line and web site, and develop a resource directory.
- Review and make recommendations regarding West Virginia's Medicaid State Plan and home and community-based waivers to enhance their compatibility for fully supporting community living.

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<sup>17</sup> Centers for Medicare and Medicaid Services.



- Review, analyze, and recommend solutions for increasing accessibility and opportunities for transportation, recreation/leisure, education, and employment.
- Fund community-based projects to serve as community support models.

2) The “Transitioning to Inclusive Communities” grant is to help transition or divert eligible individuals from nursing facilities to the community. This three-year grant was awarded to the BMS in fiscal year 2001 with \$551,678 in federal funding. It is managed by the CED at WVU. The following are the objectives of the grant:

- Increase information on community resources, supports, and services to enhance informed choices for community living for persons with disabilities or long term care needs.
- Identify persons who wish to transition or divert from nursing facilities into communities, and identify necessary services and supports.
- Develop systems of peer supports and services to improve the transition process to inclusive communities.
- Develop a “transition guide” to assist individuals and providers in the transition process.
- Identify barriers in Medicaid/Medicare service plans and home and community-based waivers and recommend changes to support community living.
- Implement transition support models and evaluate cost effectiveness and consumer satisfaction.
- Provide some transition costs to assist people in transitioning back to their community.

3) The “Community Integrated Personal Assistant Services and Supports” grant is to improve personal assistance services that are consumer-directed and offer maximum individual control. This three-year grant was awarded to the CED at WVU in fiscal year 2002 with \$725,000 in federal funding. The following are the objectives of the grant:

- Create a Consumer Oversight Board that participates in and ensures improvement and infrastructure changes that support integrated personal assistance services and promote consumer-directed services in West Virginia.
  - Research, promote, and develop community-based personal assistance services available to all eligible persons with disabilities and those with long term care needs.
  - Research, promote, and develop consumer-directed services for West Virginians.
- 4) The “Quality Assurance and Quality Improvement in Home and Community-Based Services or QA/QI” grant is to strengthen West Virginia’s ability to assure the health, welfare and dignity of individuals participating in home and community-based waiver services by developing an effective and systematic QA/QI system that enlists people with disabilities, their family members, advocates and allies as active participants in the process. This three-year grant was awarded to the BMS in fiscal year 2003 with \$499,995 in federal funding. It is managed by the CED at WVU. The following are the objectives of the grant:
- Develop, implement, and support a quality assurance process and improvement infrastructure in the design of home and community based services.
  - Develop and implement a data collection strategy to assess the performance of home and community-based waiver services.
  - Select, design, and implement QA/QI strategies for West Virginia’s home and community-based waivers.
  - Develop and implement a QA/QI system that involves home and community-based waiver participants, their families, advocates, and allies in active roles.
  - Evaluate and upgrade West Virginia’s technology-based, direct care services management and data collection system.
- 5) The “Aging and Disability Resource Center” or ADRC demonstration grant was awarded by the Administration on Aging (AOA) and the CMS to support West Virginia’s efforts in creating “one stop shop” resource centers to help consumers learn about and access long

term care services and supports. This grant was awarded to the Bureau of Senior Services (BoSS) in fiscal year 2003 with \$798,795 in federal funding. This three-year grant will establish two comprehensive Resource Centers that target West Virginia's seniors and adult citizens with disabilities. The Resource Centers will be located in the county aging programs of Marion and Ohio counties. The following are the objectives of the grant:

- Serve as “one-stops” that provide information, referral, assistance and access to all long term support programs available to the target population within the two counties.
  - Assist individuals in accessing publicly funded programs and other community resources, including private pay options.
  - Assist individuals and families in finding appropriate and affordable services in planning for future long term care needs.
  - Create a single point of entry to streamline access to multiple public programs for consumers.
  - Provide information to policymakers on rebalancing the long term care system to promote community choice and community-based care.
  - Create an infrastructure for the establishment of a statewide network of Resource Centers.
  - Provide information and training to long term support professionals and others who provide services to the elderly and people with physical disabilities, including family members and friends.
- 6) The “Cash and Counseling” grant is to replicate and expand the successful program, which allows people eligible to receive supportive services through Medicaid to direct their own care and live more independently. The grant is funded by the Robert Wood Johnson Foundation (RWJF), the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and the U.S. Administration on Aging (AOA) within the U.S. Department of Health and Human Services (DHHS). This three-year grant was awarded the BoSS in fiscal year 2004 with \$250,000 in funding.
- 7) The “Family-to-Family Health Care Information and Education Centers” or “People’s Advocacy Information and Resource Services (PAIRS)” grant is to support the development

of statewide family-run information and resource centers. This three-year grant was awarded to West Virginia Parent Training and Information (WVPIT) in fiscal year 2004 with \$141,800 in federal funding. The following are the objectives of the grant:

- Develop and maintain a website to serve as a source of health care information for families of children with disabilities.
- Establish a statewide toll-free information line staffed by parents.
- Develop a media campaign to promote the information and education center.
- Establish peer-to-peer networks across the State to provide support and information about health care and other supports to families in need.
- Develop and disseminate materials on best practices in health and long term health care.
- Develop a white paper on issues facing direct care staff and their ability to provide quality supports in the community.
- Collaborate with other statewide organizations that promote community care options to develop full access to health care services in the community.

## **SECTION III – MISSION & GOALS OF THE *OLMSTEAD PLAN***

### **KEY COMPONENTS OF THE *OLMSTEAD PLAN***

This section details the major activities and specific tasks which need to be implemented to meet the requirements mandated by Title II of the *Americans with Disabilities Act* (ADA) as upheld by the *Olmstead* decision. *Olmstead* is not “a program”; rather it sets the requirements for states to have programs and services that support the civil rights of people with disabilities to live in the most integrated setting.

This *Plan* is not intended to create a new level of bureaucracy, but to establish a way to provide community-based supports to people with disabilities in compliance with Title II of the ADA and the *Olmstead* decision. The major activities and specific tasks of this Plan will serve to develop, improve, or support processes and activities in West Virginia.

#### **CRITERIA FOR IMPLEMENTING THE *OLMSTEAD PLAN***

The goals/missions, major activities, and specific tasks of West Virginia’s *Olmstead Plan* will be implemented with respect to the criteria set forth by the U.S. Supreme Court decision in *Olmstead v. L.C.*, and considering the budgetary constraints of the state of West Virginia.

The U.S. Supreme Court ruled that before requiring a state to move people with disabilities from institutional care to the community, three conditions must be met:

- The state’s treatment professionals have determined that community placement is appropriate;
- The transfer from institutional care to the most integrated setting is not opposed by the affected individual; and
- The placement can be reasonably accommodated [by the state], taking into account the resources available to the state and the needs of others with disabilities.

The U.S. Supreme Court issued the following statement regarding the reasonable modifications regulation, and “fundamental alterations.” Whether serving particular individuals in a more integrated setting would require a “fundamental alteration” depends on:

- The cost of providing the services to the individual in the most integrated setting appropriate;
- The resources available to the state; and
- The affect the provision of services has on the ability of the state to meet the needs of others with disabilities.

The *Olmstead Plan* is categorized into 10 key components using the *Olmstead* decision and the CMS, “*Principles for State Compliance with Olmstead.*” Each key component has a goal/mission statement. Each goal /mission statement has major activities and specific tasks as the means for implementing each key component of the *Olmstead Plan*. The 10 key components of the *Olmstead Plan* are listed below:

Key Components of West Virginia’s <i>Olmstead Plan</i>	
Informed Choice	Eliminating Institutional Bias
Identification	Self-Direction
Transition	Rights Protection
Diversion	Quality Assurance and Quality Improvement
Reasonable Pace	Community-Based Supports

The *Olmstead Plan* aims to identify actions to protect and support the civil rights of people with disabilities to live in the most integrated setting appropriate. This *Plan* was developed to achieve the following fundamental precepts of implementing the *Olmstead* decision in West Virginia.

**People with disabilities in West Virginia have a civil right to choose, and be afforded the opportunity to:**

- ☞ Move to the most integrated setting appropriate to their needs;
- ☞ Stay in the community of their choice;
- ☞ Live successfully in the community of their choice while receiving appropriate, and desired supports; and
- ☞ Participate in the planning and the implementation of the *Olmstead* decision in West Virginia.

The *Olmstead Plan* categorizes the major activities and specific tasks to identify their impact on policies, procedures, regulations, and funding. This will identify the anticipated the level of fiscal and/or regulatory change required. **Category A** identifies those major activities and specific tasks that can be implemented without fiscal impact and/or regulatory change. This would apply in instances where the funding exists, and/or the current regulations do not prevent the major activities and specific tasks from being implemented. **Category B** identifies those major activities and specific tasks that can be implemented with moderate fiscal impact or regulatory change. This would be in cases where funding exists, however, a shift in funds or focus of funds would need to occur to

<u>Categorizing Major Activities and Specific Tasks</u>	
<b>A</b>	No fiscal impact and/or regulatory change
<b>B</b>	Moderate fiscal impact and/or regulatory change
<b>C</b>	Significant fiscal impact and/or regulatory change

implement the major activities and specific tasks. In addition, a moderate level of regulatory change would apply to modifying policies or procedures within state or local agencies. **Category C** identifies those major activities and specific tasks where legislative action would be needed to acquire additional funding or changes laws and/or statutes.

## INFORMED CHOICE

**Goal/Mission Statement 1.0:** Establish a process to provide comprehensive information and education so people with disabilities can make informed choices.

### 1.1 Develop a resource guide; including an interactive website and a toll free hotline, to link people to community-based supports, resources and providers.

Specific Tasks	Category	Responsible Party
a. Develop a resource guide that includes information about the available community-based supports to include, at minimum, eligibility criteria, service/program/support description, and the application process.	A	Real Choice Systems Change grant, DHHR
b. Develop a resource guide that includes information about the available providers.	A	Real Choice systems Change grant, DHHR
c. Develop a web-based system to access the resource guide.	A	Real Choice Systems Change grant, DHHR
d. Develop a toll-free hotline to access the resource guide.	A	Real Choice Systems Change grant, DHHR
e. Establish a system to ensure the sustainability of the resource guide.	B	Real Choice Systems Change grant, DHHR
f. Establish a system to ensure regular updates and revisions are made to the resource guide.	B	Real Choice Systems Change grant, DHHR

### 1.2 Develop an informed choice process to provide information and education about available community-based options.

Specific Tasks	Category	Responsible Party
a. Identify the current processes in place for providing informed choice.	A	<i>Olmstead</i> Office, DHHR
b. Identify critical points of entry into the long term care system (i.e., hospitals).	A	<i>Olmstead</i> Office, DHHR
c. Develop a process to inform people of their civil right to live and receive supports in most integrated setting appropriate.	B	<i>Olmstead</i> Office, DHHR
d. Develop a process to inform people of the available community-based options.	B	<i>Olmstead</i> Office, DHHR
e. Develop a process that provides information and education to those who reside in institutional settings and prior to people with disabilities being admitted to institutional settings.	B	<i>Olmstead</i> Office, DHHR

Specific Tasks	Category	Responsible Party
f. Train pertinent institutional and community providers regarding the informed choice process.	B	<i>Olmstead</i> Office, DHHR

**1.3 Implement the informed choice process on a statewide basis across all segregated settings.**

Specific Tasks	Category	Responsible Party
a. Identify policies, procedures, and regulations to implement the informed choice process.	A	<i>Olmstead</i> Office, DHHR
b. Propose amendments to policies, procedures, and regulations to implement the informed choice process.	B	<i>Olmstead</i> Office, DHHR
c. Amend policies, procedures, and regulations to implement the informed choice process.	C	DHHR
d. Implement the informed choice process utilizing peer mentors, program staff, and others.	C	DHHR
e. Evaluate the informed choice process on a regular basis for continuous improvements to ensure its effectiveness.	A	<i>Olmstead</i> Office, DHHR
f. Report on the outcomes of implementing the informed choice process.	A	<i>Olmstead</i> Office, DHHR

**1.4 Provide information to people with disabilities at one-stop resource centers.**

Specific Tasks	Category	Responsible Party
a. Utilize the two resource centers to implement the informed choice process.	A	BoSS
b. Recommend expansion of resource centers to act one-stop centers for providing information to all people with disabilities.	A	BoSS, DHHR
c. Develop a plan for the expansion of resource centers throughout the state utilizing existing sites.	C	BoSS, DHHR

**IDENTIFICATION**

**Goal/Mission 2.0:** Identify every person with a disability, impacted by the *Olmstead* decision, who resides in a segregated setting.

**2.1 Develop a uniform assessment tool to determine the needs and desires of people with disabilities who are institutionalized.**

Specific Tasks	Category	Responsible Party
a. Identify the various assessment tools utilized by institutional and community-based providers in West Virginia.	A	<i>Olmstead</i> Office, DHHR
b. Identify the assessment tools utilized by other states.	A	<i>Olmstead</i> Office, DHHR
c. Collaborate with agencies, providers and associations to obtain pertinent information to develop a uniform assessment tool.	A	<i>Olmstead</i> Office, DHHR



<b>Specific Tasks</b>	<b>Category</b>	<b>Responsible Party</b>
d. Coordinate with the partners and the activities of the federal Real Choice System Change grants.	A	<i>Olmstead</i> Office, DHHR
e. Develop a uniform assessment tool to evaluate the needs and desires of people to live in the most integrated setting, and the availability of such supports.	B	<i>Olmstead</i> Office, DHHR
f. Train pertinent institutional and community providers regarding the assessment tool.	B	<i>Olmstead</i> Office, DHHR

**2.2 Implement the assessment tool on a statewide basis across all segregated settings.**

<b>Specific Tasks</b>	<b>Category</b>	<b>Responsible Party</b>
a. Identify policies, procedures, and regulations to implement the assessment tool.	B	<i>Olmstead</i> Office, DHHR
b. Propose amendments to policies, procedures, and regulations to implement the assessment tool.	B	<i>Olmstead</i> Office, DHHR
c. Amend policies, procedures, and regulations to implement the assessment tool.	B	DHHR
d. Implement the assessment tool utilizing peer mentors, program staff, and others.	C	DHHR
e. Evaluate the assessment tool on a regular basis for continuous improvements to ensure its effectiveness.	B	<i>Olmstead</i> Office, DHHR
f. Report on the outcomes from implementing the assessment tool.	B	<i>Olmstead</i> Office, DHHR

**2.3 Use assessment data to monitor and track trends in the identification process.**

<b>Specific Tasks</b>	<b>Category</b>	<b>Responsible Party</b>
a. Require state-operated facilities, nursing homes, ICF/MR facilities, and assisted living residences to maintain a list of people who want to return to the community.	B	BHHF, OHFLAC, BMS
b. Require state-operated facilities, nursing homes, ICF/MR facilities, and assisted living residences to update lists on a quarterly basis or during critical times when a person's status changes.	B	BHHF, OHFLAC, BMS
c. Track the needs and desires of those who wish to return to the community.	C	DHHR
d. Track the availability of community-based options for those who wish to return to the community.	C	DHHR
e. Track trends that result in people being admitted to institutional facilities.	C	DHHR

**2.4 Use assessment data to make recommendations for current and future home and community-based supports.**

Specific Tasks	Category	Responsible Party
a. Recommend the need for expanding current community-based programs utilizing the outcomes from the assessment tool.	A	DHHR
b. Recommend the need for developing new community-based programs utilizing the outcomes from the assessment tool.	A	DHHR
c. Report on the implementation of any recommendations to expand or develop community-based programs.	A	DHHR

**TRANSITION**

**Goal/Mission 3.0:** Transition every person with a disability who has a desire to live and receive supports in the most integrated setting appropriate in accordance with the three conditions identified in the *Olmstead* decision.<sup>18</sup>

**3.1 Develop a person-centered transition process to assist people with disabilities, families, legal representatives, advocates, and interdisciplinary teams to plan successful transitions.**

Specific Tasks	Category	Responsible Party
a. Identify the transition tools and processes utilized by institutional and community-based providers in West Virginia.	A	Real Choice Systems Change grants, DHHR
b. Identify the various transition tools and processes utilized by other states.	A	Real Choice Systems Change grants, DHHR
c. Collaborate with agencies, providers, and associations to obtain pertinent information to develop a transition process.	A	Real Choice Systems Change grants, DHHR
d. Coordinate with the partners and the activities of the federal Systems Change grants.	A	Real Choice Systems Change grants, DHHR
e. Develop a person-centered process to assist and guide people in transitioning to the most integrated setting in the community.	A	Real Choice Systems Change grants, DHHR
f. Train pertinent institutional and community providers regarding the transition process.	B	<i>Olmstead</i> Office, DHHR

**3.2 Implement the transition process on a statewide basis across all segregated settings.**

Specific Tasks	Category	Responsible Party
a. Identify policies, procedures, and regulations to implement the transition process.	B	<i>Olmstead</i> Office, DHHR
b. Propose amendments to policies, procedures, and regulations to implement the transition process.	B	<i>Olmstead</i> Office, DHHR
c. Amend policies, procedures, and regulations to implement the transition process.	B	DHHR

<sup>18</sup> See page six or page 17 to reference the three conditions outlined by the *Olmstead* decision.

Specific Tasks	Category	Responsible Party
d. Implement the transition process utilizing peer mentors, program staff and others.	C	DHHR
e. Evaluate the transition process on a regular basis for continuous improvements to ensure its effectiveness.	A	<i>Olmstead</i> Office, DHHR
f. Report on the outcomes from implementing the transition process.	A	<i>Olmstead</i> Office, DHHR

### 3.3 Track trends and outcomes from implementing the transition process.

Specific Tasks	Category	Responsible Party
a. Track trends that prevent people from being able to transition from institution to community-based settings.	B	<i>Olmstead</i> Office
b. Report on trends to policymakers.	A	<i>Olmstead</i> Office
c. Implement strategies to address trends.	A	<i>Olmstead</i> Office

### 3.4 Seek funding to support transition costs for start-up needs.

Specific Tasks	Category	Responsible Party
a. Maximize existing state, federal, and private resources for funding transition costs.	A	DHHR
b. Coordinate efforts to provide funding for transition costs.	A	DHHR
c. Research and pursue additional resources to fund transition costs.	A	DHHR
d. Seek additional funding resources for transition costs.	C	DHHR

## DIVERSION

**Goal/Mission 4.0:** Develop and implement effective and comprehensive diversion activities to prevent or divert people from being institutionalized or segregated.

### 4.1. Provide funding, flexibility, and creativity to allow service coordinators to arrange community-based services and supports to prevent institutionalization or segregation.

Specific Tasks	Category	Responsible Party
a. Establish guidelines to immediately implement diversion activities once a person is identified as at-risk for institutionalization or segregation.	A	<i>Olmstead</i> Office, DHHR
b. Establish a system that provides incentives/sanctions with diversion success rates.	C	DHHR
c. Establish a process which facilitates the exploration of all available community-based supports prior to a person being institutionalized or segregated.	C	DHHR
d. Report on the outcomes from providing diversion activities.	A	<i>Olmstead</i> Office, DHHR

**4.2 Provide training and education to professionals of the community and institutional long term care system concerning diversion responsibilities and options.**

Specific Tasks	Category	Responsible Party
a. Utilize peer mentors, advocates, and community organizations to provide training to service coordinators/case managers, social workers, and intake and discharge professionals.	C	DHHR
b. Mandate minimum training requirements for those responsible for diversion activities.	C	DHHR

**REASONABLE PACE**

**Goal/Mission 5.0:** Assure community-based services are provided to people with disabilities at a reasonable pace.

**5.1 Establish policies in the event a waiting list is implemented to assure people are served at a reasonable pace.**

Specific Tasks	Category	Responsible Party
a. Maintain the waiting list procedures for the MR/DD Waiver Program in compliance with <i>Benjamin H. v. Obl.</i>	C	BMS, BHHF
b. Establish policies for the Aged and Disabled Waiver Program to assure people do not wait more than 90 days to receive services once eligibility is determined.	C	BMS, BoSS
c. Establish standards for other non-waiver community-based supports in the event waiting lists are implemented.	C	DHHR
d. Mandate timely notification of stakeholders when waiting lists are implemented.	A	DHHR

**5.2 Seek to increase the availability of funded Medicaid Waiver slots to reduce reliance on waiting lists and to meet the growing need of Waiver supports.**

Specific Tasks	Category	Responsible Party
a. Establish mechanisms to anticipate funding needs for community-based waiver programs.	B	DHHR
b. Seek adequate funding for community-based waiver supports to prevent the implementation of waiting lists.	C	DHHR

**5.3 Develop and disseminate information regarding the rights of people with disabilities to receive services at a reasonable pace.**

Specific Tasks	Category	Responsible Party
a. Develop and maintain information concerning policies, procedures, and due process rights for implementing waiting lists.	B	Olmstead Office, DHHR
b. Distribute information regarding waiting list policies and procedures during the application process.	B	Olmstead Office, DHHR
c. Distribute information regarding policies and procedures to people when supports are delayed due to a waiting list.	B	Olmstead Office, DHHR

## ELIMINATING INSTITUTIONAL BIAS

**Goal/Mission 6.0:** Provide services and supports to people with disabilities by eliminating the institutional bias in funding long term care supports.

### 6.1 Analyze the long term care system through a feasibility study to make specific recommendations for rebalancing initiatives.

Specific Tasks	Category	Responsible Party
a. Collaborate with policymakers and stakeholders to develop the scope and mission of the feasibility study.	A	<i>Olmstead</i> Office
b. Contract with an experienced consultant to complete a feasibility study.	A	<i>Olmstead</i> Office
c. Analyze the current mechanisms and policies used to make funding allocations for the long term care system.	A	<i>Olmstead</i> Office
d. Analyze initiatives or methods that West Virginia could implement to rebalance the long term care system.	A	<i>Olmstead</i> Office
e. Analyze alternative uses for nursing facilities and ICF/MR facilities.	A	<i>Olmstead</i> Office
f. Analyze the utilization of ICF/MR facilities.	A	<i>Olmstead</i> Office
g. Analyze the costs of services for ICF/MR facilities in comparison to similar community-based supports.	A	<i>Olmstead</i> Office
h. Recommend to policymakers initiatives for eliminating institutional bias in funding the long term care supports utilizing the feasibility study.	A	<i>Olmstead</i> Office
i. Report on the implementation of any recommendations for eliminating institutional bias in the long term care system.	A	<i>Olmstead</i> Office

### 6.2 Provide education and training to mental hygiene commissioners about the *Olmstead* decision and alternatives to institutional placements.

Specific Tasks	Category	Responsible Party
a. Educate mental hygiene commissioners about available community supports as alternatives to institutionalization.	B	<i>Olmstead</i> Office, DHHR
b. Educate mental hygiene commissioners about the <i>Olmstead</i> decision and Title II of the ADA.	B	<i>Olmstead</i> Office

### 6.3 Review the rate reimbursement mechanisms for Medicaid State Plan services.

Specific Tasks	Category	Responsible Party
a. Establish a cross-cutting work group(s) to study funding and reimbursement mechanisms for Medicaid State Plan services in West Virginia.	A	BMS
b. Make recommendations to policymakers to restructure funding and reimbursement mechanisms to support community-based options.	A	BMS
c. Seek funding for rate reimbursement mechanisms that support community-based options.	C	BMS

Specific Tasks	Category	Responsible Party
d. Review reimbursement rates on an annual basis.	C	BMS

## SELF-DIRECTION

**Goal/Mission 7.0:** Develop self-directed community-based supports and services that ensure people with disabilities have choice and individual control.

### 7.1 Amend existing policies and regulations to assure self-directed approaches are used for all community-based supports.

Specific Tasks	Category	Responsible Party
a. Mandate the opportunity for active involvement of people with disabilities and their families as an integral part of all policy recommendations and decisions affecting community-based supports.	A	DHHR
b. Mandate the opportunity for active involvement for people with disabilities to continuously re-evaluate how self-directed community-based supports are implemented.	A	DHHR
c. Mandate the opportunity for the active involvement of people who receive supports prior to making changes to existing programs or implementing new programs.	A	DHHR
d. Identify policies, procedures, and regulations that are barriers to implementing self-direction in community-based supports.	B	DHHR
e. Propose amendments to policies, procedures, and regulations to promote self-direction in community-based supports.	B	DHHR
f. Amend policies, procedures, and regulations to promote self-direction in community-based supports.	B	DHHR

### 7.2 Promote legislation to implement the Medicaid Community Attendant Services and Supports Act (MiCASSA).

Specific Tasks	Category	Responsible Party
a. Provide legislative committees with information concerning the <i>Olmstead</i> decision, <i>Olmstead Plan</i> , and <i>Olmstead</i> -related activities.	A	<i>Olmstead</i> Office, DHHR
b. Provide legislative committees with the outcomes from feasibility studies and other relevant outcome reports from implementing the <i>Olmstead Plan</i> .	A	<i>Olmstead</i> Office
c. Report on all legislative actions taken that coincide or conflict with the activities outlined in the <i>Olmstead Plan</i> .	A	<i>Olmstead</i> Office

### 7.3 Seek approval and funding to provide self-directed options for all current and future home and community-based waiver programs.

Specific Tasks	Category	Responsible Party
a. Include concepts and options for self-direction in all current and future waiver programs.	B	BMS

Specific Tasks	Category	Responsible Party
b. Revise policies for all licensing requirements to provide self direction in all waiver programs.	A	OHFLAC
c. Educate recipients and providers of home and community-based services about self-direction and those options available under home and community-based waiver programs.	B	BMS, BHHF, BoSS, <i>Olmstead</i> Office

## RIGHTS PROTECTION

**Goal/Mission 8.0:** Develop and maintain systems to actively protect the civil rights of people with disabilities.

### 8.1 Develop and disseminate information regarding rights under the ADA as upheld by the *Olmstead* decision.

Specific Tasks	Category	Responsible Party
a. Develop brochures, fact sheets, posters, and a website regarding the ADA, <i>Olmstead</i> decision, and due process rights, and procedures.	B	<i>Olmstead</i> Office
b. Distribute information to people with disabilities, institutional providers, community-based providers, mandated advocacy groups, independent advocate groups, and the general public.	B	<i>Olmstead</i> Office

### 8.2 Improve the current grievance, complaint, and due process systems to address *Olmstead*-related complaints or grievances.

Specific Tasks	Category	Responsible Party
a. Provide education and information to policymakers, providers, and advocates about Title II of the ADA, the <i>Olmstead</i> decision and the <i>Olmstead Plan</i> .	B	<i>Olmstead</i> Office, DHHR
b. Provide education and information to people with disabilities about Title II of the ADA, the <i>Olmstead</i> decision and the <i>Olmstead Plan</i> .	B	<i>Olmstead</i> Office, DHHR
c. Provide education and information to people with disabilities about due process rights and procedures.	B	<i>Olmstead</i> Office, DHHR
d. Establish an <i>Olmstead</i> Information, Assistance and Referral process within the <i>Olmstead</i> office.	A	<i>Olmstead</i> Office
e. Establish and maintain collaboration between all government agencies, advocacy agencies, and the <i>Olmstead</i> office concerning <i>Olmstead</i> -related issues and complaints.	A	<i>Olmstead</i> Office
f. Track trends and patterns through the <i>Olmstead</i> Information, Assistance and Referral process to identify systemic issues related to rights protection and <i>Olmstead</i> -related issues.	A	<i>Olmstead</i> Office

**8.3 Examine and modify all policies, regulations, and procedures which potentially conflict with a person’s right to live in the most integrated setting.**

Specific Tasks	Category	Responsible Party
a. Seek to amend the child custody laws to ensure parents are not required to give custody of their children to the State to receive services and supports.	C	DHHR
b. Seek alternatives to eliminate the practice of appointing DHHR employees as guardians and health care surrogates.	C	DHHR
c. Identify other policies, regulations, and procedures which potentially conflict with a person’s right to live in the most integrated setting appropriate.	B	DHHR
d. Identify other policies, regulations, and procedures which potentially conflict with a person’s right to live in the most integrated setting appropriate.	B	DHHR

**8.4 Develop and implement a process for the formal endorsement of the *Olmstead Plan* by government, providers, and advocates.**

Specific Tasks	Category	Responsible Party
a. Develop a process for the formal endorsement of the <i>Olmstead Plan</i> by government, providers, and advocates.	A	<i>Olmstead</i> Office
b. Implement a process for the formal endorsement of the <i>Olmstead Plan</i> by government, providers, and advocates.	A	<i>Olmstead</i> Office

**QUALITY ASSURANCE & QUALITY IMPROVEMENT**

**Goal/Mission 9.0:** Continuously work to strengthen the quality of community-based supports through assuring the effective implementation of the *Olmstead Plan*, and that supports are accessible, person-centered, available, effective, responsive, safe, and continuously improving.

**9.1 Monitor and report on all activities of the *Olmstead Plan* in a timely and open manner.**

Specific Tasks	Category	Responsible Party
a. Monitor and review the informed choice process every six months; make necessary modifications to assure its effectiveness.	A	<i>Olmstead</i> Office
b. Monitor and review the identification process every six months; make necessary modifications to assure its effectiveness.	A	<i>Olmstead</i> Office
c. Monitor and review the transition process every six months; make necessary modifications to assure its effectiveness.	A	<i>Olmstead</i> Office
d. Monitor and review the diversion process every six months; make necessary modifications to assure its effectiveness.	A	<i>Olmstead</i> Office
e. Monitor and review the reasonable pace activities every six months; make necessary modifications to assure its effectiveness.	A	<i>Olmstead</i> Office
f. Monitor and review the activities to eliminate institutional bias every six months; make necessary modifications to assure its effectiveness.	A	<i>Olmstead</i> Office



<b>Specific Tasks</b>	<b>Category</b>	<b>Responsible Party</b>
g. Monitor and review the self-direction activities every six months; make necessary modifications to assure its effectiveness.	A	<i>Olmstead</i> Office
h. Monitor and review the rights protection activities every six months; make necessary modifications to assure its effectiveness.	A	<i>Olmstead</i> Office
i. Monitor and review the quality assurance and quality improvement activities every six months; make necessary modifications to assure its effectiveness.	A	<i>Olmstead</i> Office
j. Monitor and review the community-based support activities every six months; make necessary modifications to assure its effectiveness.	A	<i>Olmstead</i> Office
k. Develop and disseminate an annual report on the outcomes from implementing the <i>Olmstead Plan</i> to the Governor with dissemination to the general public.	A	<i>Olmstead</i> Office
l. Develop and disseminate a quarterly report or newsletter on the current <i>Olmstead</i> -related activities.	A	<i>Olmstead</i> Office

**9.2 Develop an effective quality assurance and improvement system that enlists people with disabilities, their families, and advocates as active participants in the process to assure the health, welfare, and dignity of individuals participating in community-based supports.**

<b>Specific Tasks</b>	<b>Category</b>	<b>Responsible Party</b>
a. Develop and implement quality assurance and quality improvement infrastructures for community-based supports.	B	QA/QI grant, DHHR
b. Define core measurement criteria for assessing the quality of community-based supports using the seven focus areas of the Centers for Medicare and Medicaid Services Quality Framework.	B	QA/QI grant, DHHR
c. Develop and implement data collection strategies for assessing the performance of community-based supports.	B	QA/QI grant, DHHR
d. Implement quality improvement strategies to address identified quality issues in community-based supports.	B	QA/QI grant, DHHR
e. Develop and implement quality assurance and quality improvement systems that involve people with disabilities, families, and advocates in active roles for community-based supports.	B	QA/QI grant, DHHR
f. Evaluate and upgrade technology based data collection systems for community-based supports to assure that it supports quality assurance and quality improvement initiatives.	B	QA/QI grant, DHHR

**9.3 Revise policies to address critical incidents and deaths that take place under the direction of licensed providers.**

<b>Specific Tasks</b>	<b>Category</b>	<b>Responsible Party</b>
a. Establish policies requiring providers to report critical incidents and deaths to the licensing entity with 24 hours.	B	OHFLAC, BCF, BHHF, BoSS

Specific Tasks	Category	Responsible Party
b. Establish collaborative partnerships within licensing, protective services, and other pertinent entities to monitor and investigate critical incidents and deaths.	A	OHFLAC, BCF, BHHF, BoSS
c. Implement policies requiring providers to report critical incidents and deaths to the licensing entity with 24 hours.	B	OHFLAC, BCF, BHHF, BoSS

**9.4 Establish systems to provide information concerning licensing, certification, monitoring, and survey results to the general public in an open and timely manner.**

Specific Tasks	Category	Responsible Party
a. Require licensing and monitoring agencies to publish the outcomes and comprehensive information about provider surveys, inspections, and complaint.	B	OHFLAC, BHHF, BoSS

**9.5 Administer individual experience surveys to evaluate the quality of community-based supports received by people with disabilities.**

Specific Tasks	Category	Responsible Party
a. Develop experience surveys to provide a means to gather feedback and input into the structure of community-based supports.	B	<i>Olmstead</i> Office
b. Train teams of people with disabilities and peer mentors to administer experience surveys to individuals, with a focus on those who cannot respond independently.	B	<i>Olmstead</i> Office
c. Administer the experience surveys to people with disabilities who receive community-based supports.	B	<i>Olmstead</i> Office
d. Conduct public forums (and other methods) for people who receive community-based supports to generate input on the quality of such supports.	B	<i>Olmstead</i> Office, DHHR
e. Recommend changes to statutes, regulations, and policies to improve the quality of community-based supports.	A	<i>Olmstead</i> Office
f. Report on the implementation of any recommendations for change to improve the quality of community-based supports.	B/C	<i>Olmstead</i> Office

**9.6 Evaluate the inclusion of other segregated service provision options or settings into the *Olmstead Plan*.**

Specific Tasks	Category	Responsible Party
a. Identify other segregated services, programs, and activities provided in West Virginia to people with disabilities with public funding.	A	<i>Olmstead</i> Office
b. Identify alternatives to other segregated services, programs, and activities to provide for the most integrated setting appropriate.	A	<i>Olmstead</i> Office
c. Provide policymakers with options to provided services, programs, and activities in segregated settings.	A	<i>Olmstead</i> Office, DHHR, BoSS, DRS

Specific Tasks	Category	Responsible Party
d. Promote the use of alternatives to segregated settings in the most integrated setting appropriate.	A	Olmstead Office, DHHR, BoSS, DRS
e. Seek funding to provide alternatives to segregated settings in the most integrated setting appropriate.	C	Olmstead Office, DHHR, BoSS, DRS

## COMMUNITY-BASED SERVICES, PROGRAMS, & ACTIVITIES

**Goal/Mission Statement 10.0:** Develop, enhance, and maintain an array of community-based supports that are self-directed to meet the needs of all people with disabilities and create alternatives to segregated settings.

**10.1 Amend the Nurse Practice Act and the AMAP (Administration of Medication by Authorized Personnel) process to promote flexibility and self-direction while assuring health and safety.**

Specific Tasks	Category	Responsible Party
a. Evaluate the Nurse Practice Act and its interpretation by a cross-cutting stakeholder group.	A	DHHR
b. Evaluate the AMAP process and its interpretation by a cross-cutting stakeholder group.	A	DHHR
c. Seek to amend the Nurse Practice Act to assure flexibility and self-direction that meets the needs of people with disabilities while assuring health, safety, and welfare.	C	DHHR
d. Seek to amend the AMAP process to assure flexibility and self-direction that meets the needs of people with disabilities while assuring health, safety, and welfare.	C	DHHR

**10.2 Develop comprehensive, community-based services for people in recovery from addiction and/or mental illness.**

Specific Tasks	Category	Responsible Party
a. Develop and expand wrap-around supports for people in recovery from addiction and/or mental illness.	C	BHHF, BMS
b. Develop and implement methods to promote recover-oriented supports for people in recovery from addiction and/or mental illness, including consumer-operated services and peer supports.	C	BHHF, BMS
c. Seek funding to provide comprehensive supports for people in recovery from addiction and/or mental illness.	C	BHHF, BMS
d. Maximize existing funding to provide comprehensive supports for people in recovery from addiction and/or mental illness.	A	BHHF, BCF

**10.3 Develop comprehensive community-based supports for people with disabilities who are un-served and/or under-served.**

<b>Specific Tasks</b>	<b>Category</b>	<b>Responsible Party</b>
a. Identify barriers and propose resolutions to provide supports to un-served and/or under-served populations.	A	DHHR, DRS
b. Identify barriers and propose resolutions to provider expansion in un-served and/or under-served areas.	A	DHHR, DRS
c. Seek funding to implement programs to support individuals who are un-served and/or under-served.	C	DHHR, DRS
d. Maximize existing funding to implement programs to support individuals who are un-served and/or under-served.	A	DHHR, DRS
e. Seek funding to implement programs to expand the provider options to support individuals who are un-served and/or under-served.	C	DHHR, DRS
f. Maximize existing funding to implement programs to expand the provider options to support individuals who are un-served and/or under-served.	A	DHHR, DRS

**10.4 Develop affordable, accessible and inclusive community housing options for people with disabilities.**

<b>Specific Tasks</b>	<b>Category</b>	<b>Responsible Party</b>
a. Establish a housing task force to study opportunities to create affordable, accessible and inclusive housing options.	A	<i>Olmstead</i> Office
b. Recommend improvements to create affordable, accessible and inclusive housing options in West Virginia.	A	<i>Olmstead</i> Office
c. Maximize existing state and federal opportunities to fund affordable, accessible and inclusive housing options for people with disabilities.	A	Housing Authorities
d. Implement affordable, accessible and inclusive housing options in West Virginia.	C	Housing Authorities

**10.5 Develop accessible and affordable transportation options for people with disabilities.**

<b>Specific Tasks</b>	<b>Category</b>	<b>Responsible Party</b>
a. Establish a transportation task force (i.e., Transportation Alliance) to study opportunities to create accessible and affordable transportation options.	A	<i>Olmstead</i> Office
b. Recommend improvements to create accessible and affordable transportation options in West Virginia.	A	<i>Olmstead</i> Office
c. Maximize existing state and federal opportunities to create accessible and affordable transportation options in West Virginia.	A	Transportation Authorities
d. Implement accessible and affordable transportation options in West Virginia.	C	Transportation Authorities

**10.6 Expand and fund crisis supports throughout West Virginia.**

Specific Tasks	Category	Responsible Party
a. Identify available, community-based, crisis supports.	A	BHHF, BCF
b. Identify utilization rates for existing community-based crisis supports.	A	BHHF, BCF
c. Identify gaps in community-based crisis supports.	A	BHHF, BCF
d. Develop community-based crisis supports in un-served or under-served areas.	C	BHHF, BCF
e. Evaluate the utilization of community-based crisis stabilization supports on an annual basis to make recommendations for modifications.	A	BHHF, BCF

**10.7 Develop, implement, and enforce regulations for provider backup and substitute supports.**

Specific Tasks	Category	Responsible Party
a. Develop policies to require providers to address backup and substitute direct community-based supports.	A	OHFLAC, BMS, BHHF, BoSS
b. Implement policies to require providers to address backup and substitute direct community-based supports.	B	OHFLAC, BMS, BHHF, BoSS
c. Monitor and enforce policies to require providers to address backup and substitute direct community-based supports.	A	OHFLAC, BMS, BHHF, BoSS

**10.8 Expand the availability, use, and oversight of adult family care and specialized family care supports.**

Specific Tasks	Category	Responsible Party
a. Identify existing gaps in adult family care and specialized family care supports.	A	BCF
b. Increase recruitment activities to secure adult family care and specialized family care supports.	C	BCF
c. Enhance oversight activities to meet any increased use of adult family care and specialized family care supports.	C	BCF

**10.9 Facilitate a coordinated peer mentoring system to assist people with disabilities to choose alternatives to institutional care using a self-directed approach.**

Specific Tasks	Category	Responsible Party
a. Identify existing peer mentor supports.	A	<i>Olmstead</i> Office
b. Identify existing gaps in peer mentoring supports.	A	<i>Olmstead</i> Office
c. Identify regional areas for developing an enhanced and cohesive peer mentoring network.	A	<i>Olmstead</i> Office
d. Facilitate peer mentoring supports into collaborative regional networks.	A	<i>Olmstead</i> Office
e. Establish roles and responsibilities for peer mentoring supports.	A	<i>Olmstead</i> Office
f. Educate and train peer mentors about the available community-based resources.	B	<i>Olmstead</i> Office

<b>Specific Tasks</b>	<b>Category</b>	<b>Responsible Party</b>
g. Educate and train peer mentors about roles, responsibilities, confidentiality, and ethics.	B	<i>Olmstead</i> Office
h. Educate and train peer mentors on other relevant issues.	B	<i>Olmstead</i> Office
i. Explore the option of providing peer mentoring services as a Medicaid reimbursable service.	B/C	BMS

**10.10 Establish an effective, responsive and knowledgeable direct support profession to meet the needs of people with disabilities who receive community-based supports.**

<b>Specific Tasks</b>	<b>Category</b>	<b>Responsible Party</b>
a. Develop a skilled professional direct support staff pool by aggressive recruitment, incentive, and training efforts to attract and retain qualified candidates to the profession.	B/C	DHHR
b. Provide a career path for the direct support professional, including professional development, training, and certification.	B/C	DHHR

**SECTION IV – LONG TERM CARE INSTITUTIONAL SERVICES**

**STATE-OPERATED FACILITIES**

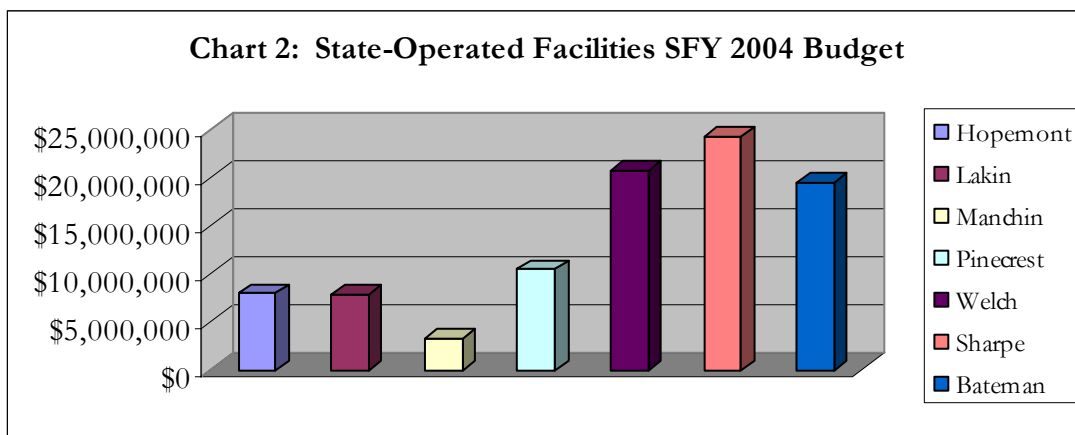
Today, West Virginia maintains seven state-operated facilities. This includes five long term care nursing facilities with a total of 511 licensed beds, and two state-operated psychiatric hospitals with a total of 175 licensed acute care beds and 65 licensed forensic beds.<sup>19</sup> The state-operated facilities and hospitals are funded by the West Virginia Legislature as an appropriation to the Bureau of Behavioral Health and Health Facilities (BHHF), Office of Health Facilities. **Chart 1** shows each state-operated facility and the number of licensed beds per facility.

**Chart 1: State-Operated Hospitals and Licensed Beds**

Name	Type	# of Beds
Mildred Mitchell-Bateman Hospital	Psychiatric Hospital	90
Sharpe Hospital	Psychiatric Hospital	150
Pinecrest Hospital	Nursing Facility	199
Hopemont Hospital	Nursing Facility	98
Lakin Hospital	Nursing Facility	114
John Manchin Sr Health Care Center	Nursing Facility	41
Welch Emergency Hospital*	Nursing Facility	59
<b>Total # of Beds</b>		<b>751</b>

\*Does not include 65 acute care beds

In State fiscal year 2004, the budget for all state-operated facilities and hospitals was \$93,627,740. **Chart 2** shows the budget appropriation for each facility.<sup>20</sup>



<sup>19</sup> Bureau for Behavioral Health and Health Facilities.

<sup>20</sup> Ibid.

### **State-Operated Long Term Care Facilities**

West Virginia has five state-operated long term care nursing facilities with a capacity of 511 beds. The following identifies each state-operated long term care facility, and their stated mission or purpose:

- **John Manchin, Sr. Health Care Center** is a 41-bed facility that offers skilled/intermediate nursing and inpatient/outpatient clinic services to individuals who are unable to obtain these services in the community.
- **Pinecrest Hospital** is a 199-bed facility that provides geriatric services to individuals requiring long term care and behavioral health care who are not served by traditional health care.
- **Hopemont Hospital** is a 98-bed facility that provides services to individuals requiring long term care and behavioral interventions to maximize their functioning ability and independence.
- **Lakin Hospital** is a 114-bed facility that provides long term care nursing services to individuals with behavioral and developmental needs that community providers will not or can not serve.
- **Welch Community Hospital** contains a 59-bed facility that offers skilled/intermediate nursing and inpatient/outpatient clinic services to individuals who are unable to obtain these services in the community.

### **State-Operated Psychiatric Hospitals**

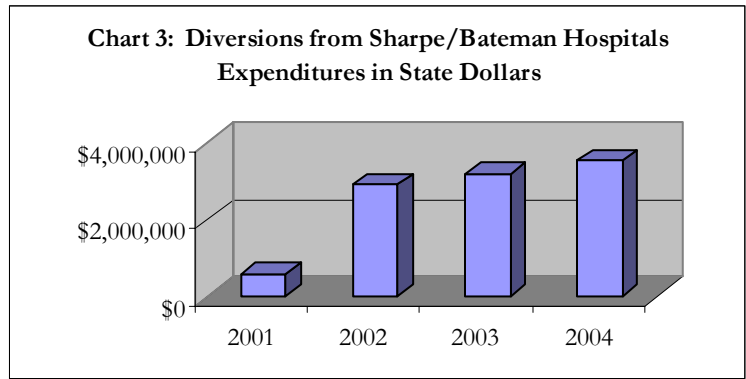
Mildred Mitchell-Bateman Hospital and William R. Sharpe, Jr. Hospital both offer a range of acute care treatment and support to adults with mental illness. Both hospitals are psychiatric facilities offering a wide range of services to individuals either committed to the hospital through civil commitment or, in the case of forensic patients, sent through the judicial system.

- **Mildred Mitchell-Bateman Hospital** has 80 acute care beds, and 10 forensic beds.
- **William R. Sharpe, Jr. Hospital** has 85 acute care beds, and 65 forensic beds.

Both facilities are fully accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), indicating an organization-wide commitment to the provision of quality patient care.

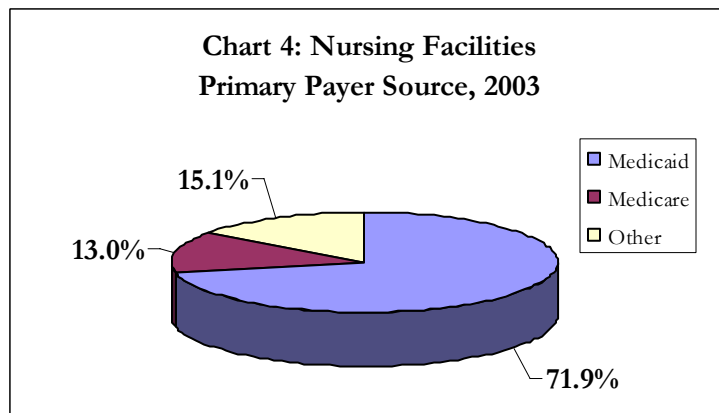


Because of the significant increase in patient census, both of these hospitals have found it necessary to divert patients to the private sector when they are at, or approaching, capacity to ensure safety and quality of care. Contractual agreements have been developed with specific organizations, also accredited by JCAHO, to accept patients on an emergency basis. The state of West Virginia pays for diversion expenditures when people are diverted from Sharpe or Bateman Hospitals due to these hospitals having reached capacity. **Chart 3** shows the diversion expenditures for fiscal year 1999 through fiscal year 2004.<sup>21</sup> In State fiscal year 2004, West Virginia spent \$3,539,318 in state funds on diversions from state-operated psychiatric hospitals.



### NURSING FACILITIES

West Virginia provides an array of nursing facilities that are privately owned and operated under a license provided by the West Virginia Department of Health and Human Resources (DHHR), Office of Health Facilities Licensure and Certification (OHFLAC). Skilled nursing facilities are defined as those facilities whose payer source is Medicare, and nursing facilities are defined as those facilities whose payer source is Medicaid.

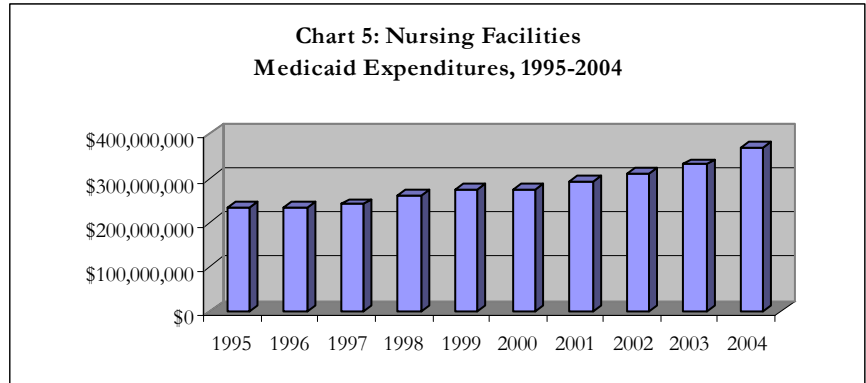


**Chart 4** above shows that Medicaid was the primary payer source for nursing facility services in 2003.<sup>22</sup>

<sup>21</sup> Bureau for Behavioral Health and Health Facilities.

<sup>22</sup> Mary Jo Gibson et al., *Access the State, Profiles of Long Term Care: West Virginia, 2004*, AARP Public Policy Institute.

As of July 2005, West Virginia had 102 nursing facilities with 9,655 beds, and 28 hospital skilled nursing facilities with 978 beds.<sup>23</sup> In 2003, these facilities operated at an 89.3% capacity or



occupancy rate.<sup>24</sup> In federal fiscal year 2004, the total Medicaid expenditures for nursing facilities was \$367,149,385. **Chart 5** shows the Medicaid expenditures for nursing facilities from 1995 through 2004.<sup>25</sup>

### ICF/MR FACILITIES

An Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) is an institution for the purposes of:

- the diagnosis, treatment, or rehabilitation of persons who have mental retardation or related condition(s); and
- the provision of a residential setting, ongoing evaluation and planning, 24-hour supervision, and, coordination of health or rehabilitation services to assist each individual function at his/her greatest ability.<sup>26</sup>

An “institution” is defined by the Centers for Medicare and Medicaid Services (CMS) as an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.<sup>27</sup>

<sup>23</sup> West Virginia Health Care Authority, *Long Term Care in West Virginia*, Legislative Oversight Commission on Health and Human Resources Accountability, August 8, 2005.

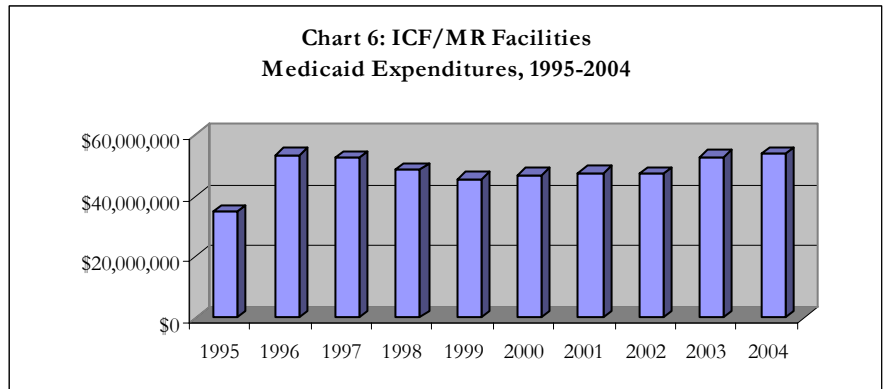
<sup>24</sup> Mary Jo Gibson et al., *Access the State, Profiles of Long Term Care: West Virginia, 2004*, AARP Public Policy Institute.

<sup>25</sup> Brian Burwell et al., *Medicaid Long Term Care Expenditures in FY 2004*, May 11, 2005, and *Medicaid Long Term Care Expenditures in FY 2000*, May 7, 2001, The Medstat Group.

<sup>26</sup> 42CFR 435.1009.

<sup>27</sup> 42 CFR 435.1009.

West Virginia has 62 ICF/MR facilities that are privately owned and operated, with an average size of eight beds. These facilities can serve up to 515 people on a statewide basis. Included in this



group are two large campus-style ICF/MR facilities. In federal fiscal year 2004, ICF/MR expenditures were a total of \$54,248,872. **Chart 6** shows the Medicaid expenditures for ICF/MR facilities from 1995 through 2004.<sup>28</sup>

The Green Acres Regional Center is a 35-bed, campus-style ICF/MR facility serving adults who have developmental disabilities. This campus program also provides day habilitation and sheltered workshop services. Green Acres is under a court ordered mandate to downsize its residential campus facilities to 16 beds by June 30, 2006. Through this downsizing, Green Acres is planning to open three ICF/MR facilities in the community that will each serve four people.

The Potomac Center operates a 24-bed campus-style ICF/MR facility in the Eastern Panhandle. The 24-bed facility has provided services on a statewide basis exclusively to school aged children since August of 2001.

### **ASSISTED LIVING RESIDENCES**

Assisted Living Residences are residential settings that provide a supervised group living situation in which four or more adults receive care, including limited nursing care. Although adults who are being considered for placement in an Assisted Living Residence are experiencing support needs in one or more areas; the support needs are not significant enough to warrant the level of care provided in a nursing home. Assisted Living Residences must be licensed and meet specific requirements established by the OHFLAC and the State Fire Marshal's office. As of September

<sup>28</sup> Brian Burwell et al., *Medicaid Long Term Care Expenditures in FY 2004*, May 11, 2005, and *Medicaid Long Term Care Expenditures in FY 2000*, May 7, 2001, The Medstat Group.

2004, there were 131 licensed Assisted Living Residences with a total of 3,904 licensed beds for an average capacity of 30 beds.<sup>29</sup>

Each Assisted Living Residence independently establishes its rate of payment for the services it provides. Most placements in this type of setting are private arrangements agreed to by the provider and the person being placed. The DHHR may provide a monthly payment to willing providers to fund an individual placement in an Assisted Living Residence. As of July 1, 2005, the monthly rate of payment was raised from \$924.50 to \$1,044.50 per month. In addition, \$84 per month is provided as a personal expense allowance.

According to the Bureau for Children and Families (BCF), there has been an increase in the numbers of people receiving services by an Assisted Living Residence through the DHHR rate of payment. **Chart 7** shows data from 2003 and 2005 on the number of people receiving Assisted Living Residence services through the DHHR rate of payment.

**Chart 7**

<b>Assisted Living Facilities</b>	<b>February 2003</b>	<b>April 2004</b>	<b>August 2005</b>
<b>People Receiving Services</b>	288	335	385
<b>Number of Facilities accepting DHHR Rate of Payment</b>	45	48	55

For the DHHR to consider the monthly payment, the individual must meet at least one of the following criteria:

- he/she must be age 65 or older;
- he/she must be at least 18 years of age and have an established disability; or
- he/she must be at least 18 years of age and currently receiving Adult Protective Services (APS).

## **INSTITUTIONAL FACILITIES FOR CHILDREN**

### **Group Residential Treatment Facilities**

Group Residential Treatment Facilities provide support and assistance through a campus-style educational program for children and adolescents with severe learning and behavioral needs. Group Residential Treatment Facilities offer three levels of service to children with oversight provided by the BCF.

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<sup>29</sup> Office of Health Facility Licensure and Certification.

**Level I** provides a structured 24-hour supervised group setting for children and adolescents who have a psychiatric diagnosis with moderate to severe adjustment difficulties in the school, home, and/or community. These children and adolescents usually function in public school and in a group residential setting with a minimal amount of supportive services and behavioral interventions. As of June 2004, there were 13 facilities with 115 beds located throughout West Virginia. During July 1, 2003 to June 30, 2004, 148 children and adolescents were authorized for Level I treatment.<sup>30</sup>

**Level II** provides a structured 24-hour supervised group setting for children and adolescents who have a psychiatric diagnosis with moderate to severe adjustment difficulties in the school, home and/or community. Children and adolescents served at this level are characterized by persistent patterns of disruptive behavior and exhibit difficulties in age-appropriate functioning and social problem solving. These children and adolescents may present some risk of causing harm to themselves or others, and cannot function in a public setting without significant psychosocial and psycho-educational support. As of June 2004, there were 20 facilities with 334 beds located throughout West Virginia. During July 1, 2003 to June 30, 2004, 880 children and adolescents were authorized for Level II treatment.<sup>31</sup>

**Level III** provides a highly structured and intensively staffed 24-hour supervised setting for children and adolescents who have a psychiatric diagnosis with severe disturbances in conduct and emotions, and as a result are unable to function in multiple areas of their lives. Residential treatment facilities provide a highly structured program with formalized behavioral programs and therapeutic interventions designed to create a therapeutic environment. As of June 2004, there were six facilities with 205 beds located throughout West Virginia. During July 1, 2003 to June 30, 2004, 614 children and adolescents were authorized for Level III treatment.<sup>32</sup>

### **Psychiatric Residential Treatment Facility Care**

Psychiatric Residential Treatment Facility Care is a free standing or physically distinct part of a facility that provides a medically supervised interdisciplinary program of behavioral health services to children and adolescents under the age of 21. This is the most restrictive type of setting for

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<sup>30</sup> 2004 West Virginia Youth Services Annual Report and Comprehensive Plan Update, Bureau for Children and Families.

<sup>31</sup> Ibid.

<sup>32</sup> Ibid.

children. A secure facility is used for treatment of children who have been clearly diagnosed as having a psychiatric, emotional, or behavioral disorder that is so severe the child is a danger to himself or others. If possible, a voluntary commitment or placement should be used to lessen the trauma experienced by the child.

Oversight of this program is provided by the BCF. As of June 2004, there were four Psychiatric Residential Treatment Facilities with 112 beds throughout West Virginia.<sup>33</sup>

### **Acute Psychiatric Inpatient Hospitalization**

Acute Psychiatric Inpatient Hospitalization provides intensive, 24-hour psychiatric care, including crisis stabilization and diagnostic assessment in a hospital setting for 30 days or less for children and adolescents. It offers a full array of psychiatric services to children, adolescents, and their families, and assures the availability of accredited educational, medical, and recreational activities.

Oversight of this program is provided by the BCF. As of June 2004, there were four facilities that provided Acute Psychiatric Inpatient Hospitalization for children and adolescents, with a bed capacity that fluctuates according to use and availability.<sup>34</sup>

## **TRANSITIONAL LIVING PROGRAMS**

### **Sharpe Hospital Transitional Unit**

The West Virginia Legislature approved an improvement package in 2004 for the creation of a step-down program for \$2.9 million. This program will provide a less restrictive alternative to inpatient hospitalization for up to 12 forensic patients at Sharpe Hospital. This facility will serve as a transitional setting for forensic patients moving from the hospital to the community, enabling them to build living skills, reintegrate to community life, and prepare for returning to their home communities. This program was approved by a *Hartley* Court Order dated May 15, 2003.

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<sup>33</sup> 2004 *West Virginia Youth Services Annual Report and Comprehensive Plan Update*, Bureau for Children and Families.

<sup>34</sup> *Ibid.*

### **Potomac Center**

Potomac Center has a 24-bed ICF/MR campus-style facility, which serves children with developmental disabilities. On August 1, 2001, a *Hartley* Court Order mandated the Potomac Center to serve only children with developmental disabilities as a transitional placement. If any child resides at the facility for a period in excess of 18 to 24 months an independent review will be conducted by the Office of the Ombudsman for Behavioral Health, OHFLAC, Division of Developmental Disabilities, West Virginia Advocates, and West Virginia Department of Education (DOE).

A *Hartley* Court Order was issued to have all children, residing at the Potomac Center, who have DHHR as legal guardians or health care surrogates to be reviewed and new arrangements to be made. In addition, the Court Order created an independent facility advocate through the designated Protection and Advocacy agency.

### **Transitional Living Supports**

The BHHF funds a 16-bed continuum of supported living for people with serious mental illness and co-occurring conditions currently residing at Sharpe Hospital. This continuum consists of five primary treatment stages following an evaluation. The five treatment stages are Stage I – Acute; Stage II – Sub-Acute at Crisis Stabilization Unit; Stage III – Transitioning from Crisis Stabilization Unit; Stage IV – Transitional Group Living; Stage V – Community/Independent Living through Assertive Community Treatment (ACT). Not all people will progress through the continuum at the same pace or through all the stages. The project goal is to help transition at least 10 people from Sharpe Hospital into independent living per year.

In addition, the BHHF is currently funding an eight bed transitional living facility in the Charleston area for people with serious mental illness and co-occurring conditions currently residing at Bateman Hospital. This program utilizes a mix of certified peer support staff, traditional staff and ACT supports to help people transition to the most integrated setting.





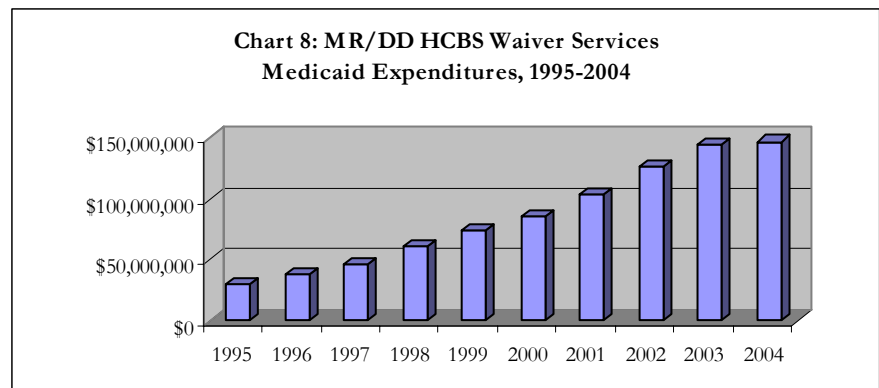
## SECTION V - COMMUNITY-BASED PROGRAMS & SUPPORTS

### HOME & COMMUNITY-BASED 1915(C) WAIVER PROGRAMS

#### Title XIX MR/DD Waiver Program

The Title XIX MR/DD Home and Community-Based Waiver Program was established in 1984 to support people with developmental disabilities to live in the community, in their own home or with their natural or adoptive

family. This program provides services to persons of any age who meet the program and financial eligibility criteria. As of September 2005, this program served 3,844



people throughout West Virginia.<sup>35</sup> In federal fiscal year 2004, MR/DD Waiver expenditures were a total of \$147,261,348. **Chart 8** shows the Medicaid expenditures for the MR/DD Waiver Program from 1995 through 2004.<sup>36</sup>

The MR/DD Waiver Program provides service coordination, residential habilitation, respite care, day habilitation, pre-vocational training, supported employment, nursing services, transportation services, Qualified Mental Retardation Professional (QMRP) services, adult companion services, and environmental accessibility adaptations. West Virginia also provides community residential habilitation, a service that is unique from other states that offer this type of waiver program. This service enables specialized family care providers, and/or biological or adoptive family members who reside with the individual to provide and receive reimbursement for residential habilitation. This service is critical for those individuals who live with their family in rural communities where direct supports are sparse or non-existent.

The MR/DD Waiver Program is administered by the Bureau for Medical Services (BMS) and managed by the Bureau for Behavioral Health and Health Facilities (BHBF).

<sup>35</sup> Office of Behavioral Health Services.

<sup>36</sup> Brian Burwell et al., *Medicaid HCBS Waiver Expenditures, FY 1999 through FY 2004*, May 9, 2005, and *Medicaid HCBS Expenditures, FY 1995 through FY 2000*, July 6, 2001, The Medstat Group.

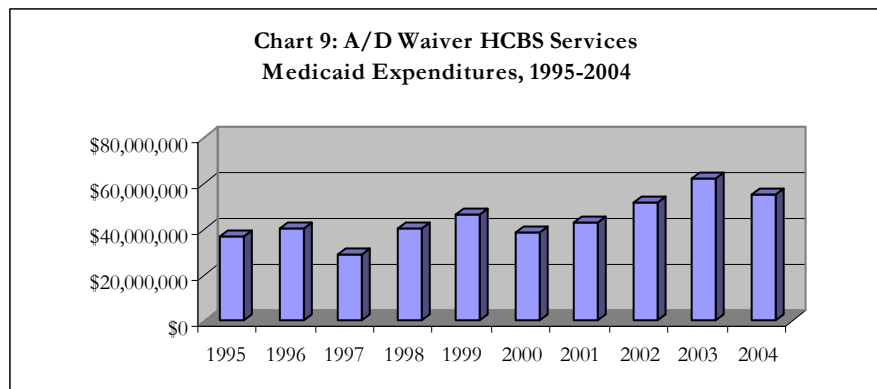
The Department of Health and Human Resources (DHHR) submitted a renewal application to the Centers for Medicare and Medicaid Services (CMS) for continued participation in the MR/DD Home Community-Based Waiver Program in 2005. The CMS approved West Virginia’s renewal application in October 2005. The following details the highlights of the renewal application:<sup>37</sup>

- Requested no growth in the program for the next five years (2005 – 2010). The program will serve no more than 3,844 people per year.
- Added “crisis services” which allows for intensive support for up to 14 days to address a crisis at the home level.
- Reduced the evaluations that are needed to determine eligibility.
- Modified the program to introduce the concept of “individualized budgeting.”
- Enhanced the use of “person-centered” philosophy.
- Increased emphasis on quality assurance.

### **Title XIX Aged & Disabled Waiver Program**

The Aged and Disabled Waiver Program (or A/D Waiver Program) was established in 1982 as a pilot project in seven counties in West Virginia. By 1992, all 55 counties were participating in the program. The A/D Waiver Program provided services to a maximum of 5,400 people in fiscal year 2004. The A/D Waiver Program provides services to people who are aged and disabled, 18 years or older, who are eligible for Medicaid or who would be eligible for Medicaid if institutionalized. This program serves many

people who live in their own homes or with their family. In federal fiscal year 2004, A/D Waiver expenditures were a total of \$55,360,421. **Chart 9** shows the Medicaid expenditures for the A/D



<sup>37</sup> Bureau for Medical Services, *Overview of 1915c Home and Community Based Waiver Services*, August 16, 2005.

Waiver Program from 1995 through 2004.<sup>38</sup>

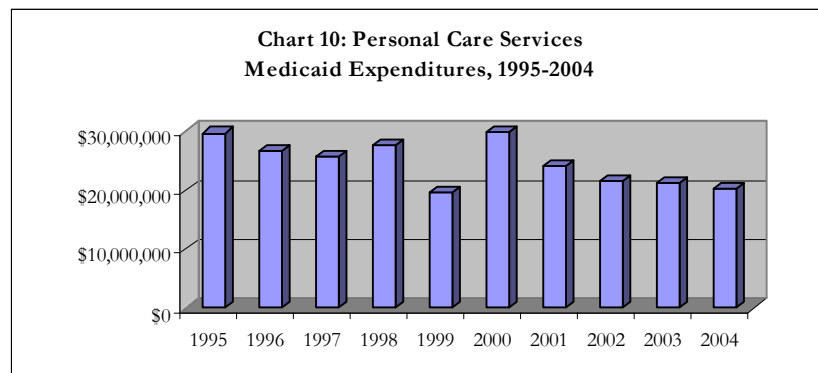
Services provided by the Aged and Disabled Waiver Program are traditional case management, self-directed case management, homemaker services, and medical adult day care services. The Aged and Disabled Waiver Program is administered by the BMS, and is managed by the Bureau of Senior Services (BoSS).

The Department of Health and Human Resources (DHHR) submitted a renewal application to the Centers for Medicare and Medicaid Services (CMS) for continued participation in the A/D Waiver Home Community-Based Waiver Program in 2005. The CMS approved West Virginia's renewal application in October 2005. The following details the highlights of the renewal application:<sup>39</sup>

- Decreased the amount of people served for the next 5 years (2005 – 2010). The decrease is a total of 1,950 by 2006.
- Introduced self-directed option for the program. Waiver participants will be able to become the employer of their in-home staff through the use of fiscal intermediaries.
- Increased emphasis on quality assurance.

## PERSONAL CARE SERVICES

Personal Care services cover those in-home services offered by the BMS. Personal Care services are medically necessary activities or tasks, ordered by a physician, which are implemented according to a nursing plan of care. The



nursing plan of care is developed and supervised by a registered nurse. These services enable people to have their physical support needs met and be treated by their physicians at home rather than

<sup>38</sup> Brian Burwell et al., *Medicaid HCBS Waiver Expenditures, FY 1999 through FY 2004*, May 9, 2005, and *Medicaid HCBS Expenditures, FY 1995 through FY 2000*, July 6, 2001, The Medstat Group.

<sup>39</sup> Bureau for Medical Services, *Overview of 1915c Home and Community Based Waiver Services*, August 16, 2005.

through institutional care. Oversight of this program is provided by the BMS. In federal fiscal year 2004, Personal Care expenditures were a total of \$20,258,184. **Chart 10** shows the Medicaid expenditures for Personal Care services from 1995 through 2004.<sup>40</sup>

Personal Care services are provided in the individual's residence, and outside the home when those services are necessary to assist individuals obtain and retain competitive employment for up to 40 hours per month. Services are designed to assist an individual of any age with a disability as defined by the Social Security Administration (SSA) program. Services include those activities related to personal hygiene, dressing, feeding, nutrition, environmental support functions, and health-related tasks. Personal Care services can be provided on a continuing basis or on episodic occasions. Services cannot be provided in a hospital, nursing facility, ICF/MR facility, or any other settings in which nursing services are provided.

Eligibility for Personal Care services must be documented on a valid PAS-2005 by the person's physician. The BMS has specific medical eligibility criteria for this service. Each eligible recipient is able to obtain up to 60 hours per month of direct Personal Care services according to the level of care needed. Prior authorization may be obtained to receive Personal Care services for up to a maximum of 210 hours per month.

## **BEHAVIORAL HEALTH REHABILITATION SERVICES**

Behavioral Health Rehabilitation includes medical and remedial services recommended by a physician or licensed psychologist for the purpose of reducing physical or mental disability and restoration of a recipient to their most independent level. Behavioral Health Rehabilitation services are available to all Medicaid members with a known or suspected behavioral health diagnosis. Oversight of this program is provided by the BMS of the DHHR.

All services are subject to a determination of medical/clinical necessity through a contracted agency by the BMS. The following four factors will be included as part of this determination: diagnosis; level of functioning; evidence of clinical stability; and available support system.

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<sup>40</sup> Brian Burwell et al., *Medicaid HCBS Waiver Expenditures, FY 1999 through FY 2004*, May 9, 2005, and *Medicaid HCBS Expenditures, FY 1995 through FY 2000*, July 6, 2001, The Medstat Group.

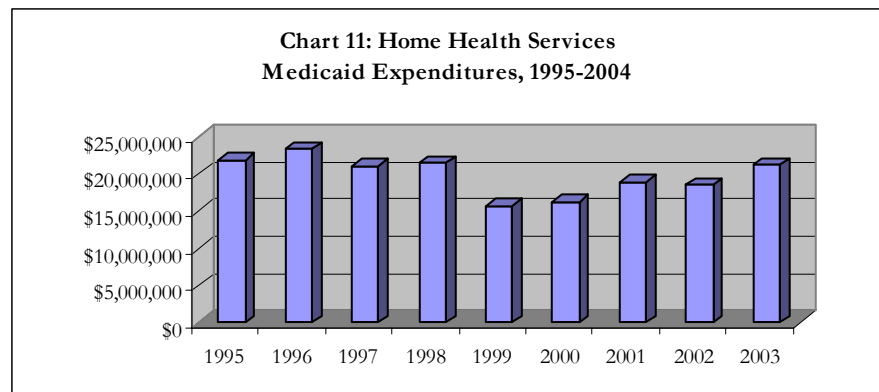
## BEHAVIORAL HEALTH CLINIC SERVICES

Behavioral Health Clinic services include preventive, diagnostic, and therapeutic services provided on an outpatient basis under the direction of a physician. These services must be furnished by a facility that is not part of a hospital, but is organized and operated to provide outpatient medical support. Behavioral Health Clinic services must be provided at the clinic; the only exception being services provided to people experiencing homelessness. Behavioral Health Clinic services are available to all Medicaid members with a known or suspected behavioral health diagnosis. A person is considered eligible for receiving Behavioral Health Clinic services at an organized medical facility which is not providing the person room and board or professional services on a continuous 24 hour-a-day basis. Oversight of this program is provided by the BMS of the DHHR.

All services are subject to a determination of medical/clinical necessity through a contracted agency by the BMS. The following four factors will be included as part of this determination: diagnosis; level of functioning; evidence of clinical stability; and available support system.

## MEDICAID HOME HEALTH SERVICES

Medicaid Home Health services are medical care services provided under the direction of a physician for individuals requiring skilled nursing and/or a rehabilitative service. Services are rendered in an individual's place of residence. To qualify for Medicaid Home Health services, the participant must require the services of skilled nursing, physical therapy, occupational therapy or



speech therapy as prescribed by the participant's physician. These services may include the use of medical supplies related to the episode of care and/or home health aides. All services are supplied on an intermittent basis. As of July 22, 2005, West Virginia has 62 Home Health agencies

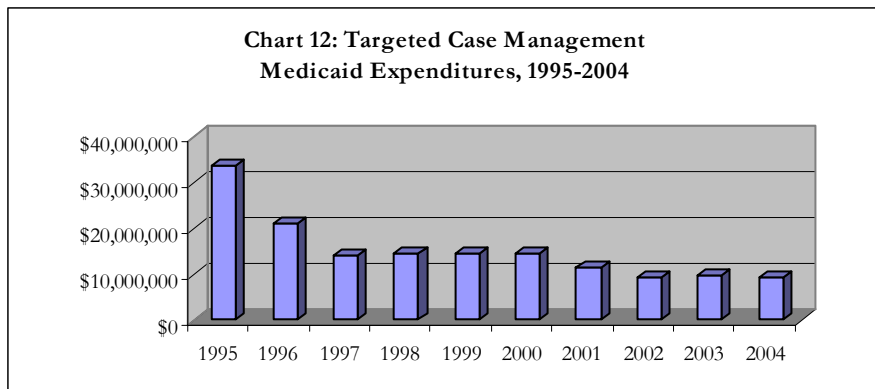
statewide.<sup>41</sup> In federal fiscal year 2003, Medicaid Home Health expenditures were \$21,227,013. **Chart 11** shows Medicaid Home Health expenditures from 1995-2003.<sup>42</sup>

Under Medicaid coverage, Home Health services are typically provided to people with acute or chronic illnesses and/or disabilities in their residence, rather than in a hospital or long term care facility. In addition, pharmaceutical services (related only to the current diagnosis, such as IV therapy and some oncology medications), equipment management, nutritional services, personal care services, and training/education are provided through Home Health services. The goal of Home Health is to increase the person’s capacity for independence, and to enable the person to advance beyond home care, avoiding institutionalization. Home Health Care services must have a predictable end point for the achievement of individual goals related to their plan of care.

**TARGETED CASE MANAGEMENT**

Targeted Case Management (TCM) services are federally defined as “those services which assist Medicaid eligible recipients to gain access to needed medical, behavioral health, social, educational, and other services.” Oversight of this program is provided by the BMS of the DHHR. In federal fiscal year 2004, TCM expenditures were \$9,299,124. **Chart 12**

shows Medicaid expenditures for TCM from 1995 through 2004.<sup>43</sup>



This chart shows a steady and significant decrease in expenditures for TCM services since 1995.

TCM is a service which can be utilized to assist individuals in obtaining community supports. The goals of TCM are to assure that: eligible recipients have access to needed services and resources;

<sup>41</sup> Office of Health Facilities Licensure and Certification  
<sup>42</sup> Brian Burwell et al., *Medicaid HCBS Waiver Expenditures, FY 1999 through FY 2004*, May 9, 2005, and *Medicaid HCBS Expenditures, FY 1995 through FY 2000*, July 6, 2001, The Medstat Group.  
<sup>43</sup> Ibid.

necessary evaluations are conducted; individual service plans are developed and implemented; and reassessment of the services provided occur on an ongoing basis.

While there are specific diagnostic, functional limitations and eligibility requirements the following identifies potentially eligible populations for TCM:

- children and adults with mental illness;
- children and adults with substance-related disorders;
- children and adults with developmental disabilities not enrolled in the MR/DD Waiver Program; and/or
- children and adults temporarily residing in licensed domestic violence centers.

## **CRISIS SERVICES**

### **MR/DD Crisis Services for Children and Adults**

The BHHF maintains contracts to provide technical assistance for the crisis service system. This assistance is in the form of training, consultation, project/product development, and monitoring of crisis sites. As of October 2005, the BHHF contracts for the following:

- Six crisis respite sites for adults with developmental disabilities to provide a total of 11 beds.
- Three crisis respite sites for children with developmental disabilities to provide a total of 11 beds.

Crisis respite sites offer a variety of services to assist individuals, families, and providers during the time of a situational or behavioral crisis. Crisis respite is approved by the crisis respite provider and the BHHF on the basis of individual needs, and site availability. Crisis respite placements are typically approved for a 30 day period.

### **Adult Emergency Shelter Care Homes**

Adult Emergency Shelter Care Homes are available as an emergency placement resource for individuals for whom no other alternative exists. These homes provide for an adult's immediate need for support in a supervised setting. Placement in an Emergency Shelter Care Home may be used for up to thirty days while safe, more permanent arrangements are being made.

Providers of Adult Emergency Shelter Care are specifically selected and trained by the DHHR to accept placements on a 24-hour a day basis. They must be available for a placement in their home at any time, often on short notice. The Adult Emergency Shelter Care provider is certified by the DHHR. Once certified, the provider may provide supervision and care for up to three adults at one time. The provider receives a monthly payment from the DHHR to ensure the availability of their home. In addition, when an adult is placed in the home, the provider receives a second payment for the care they provide to the individual. The current rate of payment for each adult placed is a monthly stipend of \$84.00 per approved bed, and a \$25.38 per day payment for each adult placed.

All placements in these homes must be made and authorized by the Bureau for Children and Families (BCF). To be eligible to receive Adult Emergency Shelter Care Home services, the individual must meet at least one of the following criteria:

- he/she must be age 65 or older;
- he/she must be at least 18 years of age and have an established disability; or
- he/she must be at least 18 years of age and currently receiving Adult Protective Services (APS).

## **FAMILY/FOSTER CARE FOR CHILDREN & ADULTS**

### **Adult Family Care Homes**

Adult Family Care Homes are placement settings for adults that provide support, protection, and security in a family setting. This may be an appropriate option for individuals who are no longer able to safely remain in their own home due to physical, cognitive, and/or emotional needs. Oversight of this program is provided by the BCF.

The Adult Family Care provider is certified by the DHHR. Once certified, the provider may provide supervision and care for up to three adults. The provider receives payment for the care provided which is based on the adult's needs and unique circumstances. This payment may be paid by the adult placed in the home, the DHHR, or a combination of these two sources. As of July 1, 2005, the rate of payment was increased to \$824.00 per month, per person. In August 2005, there were 286 Adult Family Care providers, and 385 people receiving Adult Family Care services.



All placements in these homes must be made and authorized by the BCF. In order to be eligible to receive Adult Family Care services, the individual must meet at least one of the following criteria:

- he/she must be age 65 or older;
- he/she must be at least 18 years of age and have an established disability; or
- he/she must be at least 18 years of age and currently receiving Adult Protective Services (APS).

### **Specialized Family Care Program**

The Specialized Family Care Program is a statewide placement and family support system designed to serve the needs of children and adults who have developmental disabilities. A Specialized Family Care home is a specially recruited and trained family who provides support in a family atmosphere for anyone with a developmental disability. Oversight of this program is provided by the BCF through contract agreements. This type of home provides twenty-four hour, day-to-day care, support, and training.

### **Specialized Foster Family Care**

Specialized Foster Family Care providers must have a Child Placing License with the state of West Virginia. Oversight of this program is provided by the BCF. Specialized Foster Care may be considered as a possible placement option for a child who:

- has moderate to severe social, developmental, behavioral, educational, and/or emotional support needs; or
- has a major physical disability; or
- is in need of more structure than a regular foster home, but can still benefit from an open environment where he/she can be cared for by specially trained foster parents and where appropriate community resources are available.

## **EARLY INTERVENTION SERVICES**

### **West Virginia Birth to Three Program**

The West Virginia Birth to Three Program is a statewide program of services and supports for children and their families under the age of three who have a delay in their development, or may be

at risk of having a delay. All eligible infants/toddlers and their families are entitled, as needed, to a comprehensive array of early intervention services. Eligibility is determined by the following criteria:

- 1) Age eligibility includes children up to 36 months.
- 2) There are no financial eligibility requirements.
- 3) The child must meet one of the following:
  - a) experiencing a developmental delay;
  - b) diagnosis of a physical or mental condition, which has a high probability of resulting in a developmental delay; or
  - c) is at significant risk of having substantial developmental delays if early intervention services are not provided.

Oversight of this program is provided by the Office of Maternal, Child and Family Health (OMCFH) within the DHHR. According to federal law, entitled services identified on a child/family Individualized Family Service Plan (IFSP) are to be delivered in natural environments. A variety of specialists may be called upon to help the family decide what strategies and services they need. These specialists may include: audiologists, counselors, social workers, child development specialists, nurses, occupational therapists, physical therapists, registered dietitians, speech language pathologists, and vision specialists.

## **PERSONAL ASSISTANCE SERVICES**

### **Ron Yost Personal Assistance Service Program**

In 1999, the West Virginia Legislature passed the Ron Yost Personal Assistance Services Act (RYPAS) creating a consumer-controlled program to enable individuals with severe disabilities to live in their own homes and communities. The RYPAS Program is intended to provide resources for individuals with severe disabilities to hire a personal assistant to help them perform essential daily living tasks. The RYPAS Program provides money for eligible participants to hire a personal assistant according to a sliding scale based on the individual's adjusted annual income. The RYPAS Program is managed by a seven-member, consumer-controlled board, which is a standing committee of the West Virginia Statewide Independent Living Council. In fiscal year 2005, the Ron Yost

Personal Assistance Service Program provided \$306,701 in funding for 24 people with disabilities to hire personal assistants.

## **FAMILY SUPPORT**

### **Family Support Program**

The Family Support Program has been operating under law through the BHHF since March 1991. In fiscal year 2004, the Family Support Program provided \$823,613 in funding to 1,955 families. Supports provided to families include: respite care, transportation, equipment, health-related needs, and home modifications. This funding can only be used as a last resort after all other sources for funding have been accessed or denied. The law created a statewide Family Support Council, and there are also fourteen regional Family Support programs.

## **FEDERAL MENTAL HEALTH BLOCK GRANTS**

West Virginia was awarded \$2,225,241 in federal Mental Health Block Grant funding to 29 traditional and non-traditional service providers for FY 2005. The Division of Children's Mental Health within BHHF provides support for school-based mental health, respite services, transitioning young adults, co-occurring conditions, suicide prevention, and mentoring. The Division of Adult Mental Health within BHHF provides support for drop in centers, enhanced case management, transitional living, primary and mental health linkage, community education, services for older adults, peer supports, recovery education, supported employment, transportation, suicide prevention, and the Northern Panhandle Mental Health Court. The Division of Adult Mental Health also uses Mental Health Block Grant dollars to fund the ongoing operations of the West Virginia Mental Health Planning Council, which is required but not funded by federal statute.

## **PEER SUPPORTS & INDEPENDENT LIVING SERVICES**

### **Projects for Assistance in Transition from Homelessness**

The Projects for Assistance in Transition from Homelessness (PATH) is a program funded in part by the federal Center for Mental Health Services (CMHS). The BHHF manages the PATH grant through its contract agencies. The PATH grant serves people experiencing homelessness who have

a mental illness or co-occurring mental illness and substance abuse. Each program funded must provide \$1 match for every \$3 in PATH funds. In fiscal year 2004, the PATH program provided funding for 1,915 people with \$300,000 in expenditures and \$100,000 in matching funds from provider agencies.

### **Assertive Community Treatment**

The Division of Adult Mental Health promotes the use of Assertive Community Treatment (ACT). ACT is an evidence-based approach for providing services to persons with a mental illness. This program provides highly individualized services directly to consumers. Recipients of ACT services receive multidisciplinary and round-the-clock staffing like that of a psychiatric unit, but within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. As of October 2005, only two providers participated in offering this service to 85 people. ACT is reimbursed by Medicaid through Behavioral Health Rehabilitation services in West Virginia and is overseen by APS Healthcare under contract with the BMS. The ACT rate of payment is \$23.00 per day, per person.

### **Peer Transitions**

There are currently five transitional homes located in West Virginia operated by the West Virginia Mental Health Consumers' Association. They are located in Monongalia, Kanawha, Cabell, Wyoming, and Harrison counties. These homes provide placement and transitional living opportunities to consumers.

### **Consumer Operated Independent Living Services**

Consumer Operated Independent Living Services (COILS) provide community support for persons who are transitioning from treatment back into the community, or others who may need support in daily living activities. COILS is operated by the West Virginia Mental Health Consumers' Association on a statewide basis and is supported by peers, mostly on a volunteer basis.

### **Peer Recovery Network**

The Peer Recovery Network (PRN) of West Virginia is a network of people who have received, are receiving, or are seeking addiction-related services throughout West Virginia. This program is operated by the West Virginia Mental Health Consumers' Association to provide the following non-traditional supports: peer to peer support; networking and outreach; resources to families and communities; educational opportunities for communities and organizations; and non-traditional services.

### **Independent Living Services**

West Virginia has three Centers for Independent Living (CIL) serving 20 of the 55 counties. These centers provide the four core independent living services required by the Rehabilitation Act of 1973 as amended: advocacy, independent living skills training, peer support and peer counseling, information and referral. Additional services are provided and may include ADA consultation and compliance surveys, family support, attendant care assessments, transportation and other services to address the needs of people with disabilities in a particular CIL service area. The CIL are non-profit corporations, which receive federal funding from the U.S. Department of Education, Office of Special Education and Rehabilitative Services, Rehabilitation Services Administration under Title VII, Chapter 1, Part C of the Rehabilitation Act. Some State funding for independent living services is provided through a line item in the Division of Rehabilitation Services' (DRS) budget.

### **ASSISTIVE TECHNOLOGY**

West Virginia Assistive Technology System (WVATS) provides awareness of and accessibility to assistive technology. An assistive technology device is any item or piece of equipment used to increase, maintain, or improve a person's functional capabilities. The WVATS Regional Resource Centers have assistive technology lending libraries, toll-free information hotlines, and the ability to provide free demonstrations of assistive technology devices. WVATS provides assistance to people in obtaining assistive technology through knowledge about funding and advocacy. WVATS also offers training and technical assistance to individuals with disabilities, their families and those involved in providing assistive technology devices and services.

The DRS offers the following assistive technology services: assessment; fabrication; training; and follow-up. These technology services are provided statewide by DRS and through a mobile technology unit that is also available statewide.

## **SECTION VI – PAST SUCCESSES & FUTURE CHALLENGES**

This section will focus on some of the past successes and future challenges for West Virginia in assuring the protection of the civil rights of people with disabilities. The key components discussed in this section are preventing and correcting unjustified institutionalization; informed choice, identification, and transition; funding institutional and community-based supports; rights protection and self-direction; and providing services at a reasonable pace.

### **PREVENTING & CORRECTING UNJUSTIFIED INSTITUTIONALIZATION**

#### **State-Operated Facilities & Hospitals**

West Virginia has been a national leader in the deinstitutionalization of people with developmental disabilities. Since the late 1970s, West Virginia has been committed to moving people with developmental disabilities from institutional care to community-based settings. This has been possible in large part due to the court system, dedicated advocates, and stakeholders. In 1998, West Virginia became one of six states to close all of its state-operated institutions for people with developmental disabilities. Even though West Virginia has made great efforts in providing home and community-based services to people with developmental disabilities, there are still large congregate settings operating in West Virginia that serve this population. In addition, people with mental illness, traumatic brain injury, physical disabilities, and substance abuse are often forced into institutional settings due to the lack of comprehensive community-based options.

In 1976, West Virginia operated 13 long term care facilities and two psychiatric hospitals that served a total of 4,140 people. By 1988, West Virginia had downsized their institutions to nine long term care facilities and two psychiatric hospitals that served a total of 1,860 people. As of 2004, the State operates five long term care facilities and two psychiatric hospitals that can serve a total of 751 people.

#### **ICF/MR Facilities**

The *West Virginia Home and Community Based MR/DD Waiver* report was conducted by Robin Cooper of the National Association of State Directors of Developmental Disabilities Services (NASDDDS), and Marilyn Hill of Hill Associates, for the Bureau for Behavioral Health and Health Facilities (BHBF). The following recommendation was issued concerning ICF/MR facilities: “The state may

wish to consider the continued and future role of the ICF/MR facilities in the overall mix of services, given the costs and preferences of consumers and families for home-based services and supports, and small, integrated supported living arrangements.”<sup>44</sup>

### ***Medley Consent Decree***

On April 21, 1978, a lawsuit was filed in the United States District Court against the West Virginia Departments of Health and Welfare (now the Department of Health and Human Resources). The suit was filed on behalf of a seventeen year old girl with mental retardation and others “similarly situated” who were institutionalized. The parties of the lawsuit, the *Medley Consent Decree*, stipulated to the Court that persons with mental retardation who were under the age of 23 and who lived in state-operated institutions could live in the community if residential support services were available to them. The West Virginia Department of Education (DOE) and the Division of Rehabilitation Services (DRS) were added as defendants in this case because of their responsibility to this population.

On April 4, 1978, the Court certified this group of individuals as a protected class, or *Medley* class members. This certified class included all persons who had mental retardation who were under the age of 23 and who were then or may be institutionalized in the future by reason of West Virginia’s failure to provide services. Today, the *Medley Consent Decree* is still in place and young adults who meet the criteria are placed under the protected status of the Court. In 2004, there were five people certified as *Medley* class members.

### ***Hartley Consent Decree***

On June 23, 1981, a mandamus action was filed with the West Virginia Supreme Court of Appeals by petitioners on behalf of two women involuntarily committed to Huntington State Hospital (renamed Mildred Mitchell-Bateman Hospital). This is known as the *E.H. vs. Khan Matin*, et al. civil action suit, which resulted in the *Hartley Consent Decree*. *Hartley* was a suit based on systemic issues related to the behavioral health system. Petitioners claimed that the Department of Health and Human Resources (DHHR) denied the plaintiffs their guaranteed right to individualized habilitation and treatment in the least restrictive environment and their guaranteed right to community services.

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<sup>44</sup> Robin Cooper and Marilyn Hill, *West Virginia Home and Community Based MR/DD Waiver Report*, July 10, 2000



These claims were based upon Article III, Section 10 of the West Virginia Constitution, and the West Virginia State Code §27-2A-1 and §27-5-9.

The parties to the lawsuit submitted “The West Virginia Behavioral Health Care Delivery System Plan” to the Court. This plan outlined methods to address issues of patient treatment and habilitation, environmental and general service policies, a comprehensive continuum of behavioral health care, monitoring, and training standards for staff. The plan was approved by the Court and the *Hartley Consent Decree* was entered to finalize the settlement between the parties. A *Hartley* Court Monitor was also created through this lawsuit.

A court order entered on March 27, 2002, terminated the Office of the Court Monitor and established the Office of the Ombudsman for Behavioral Health. The Office of the Ombudsman for Behavioral Health was created to assist the citizens of West Virginia in addressing concerns and grievances they may have regarding the behavioral health care system, and to provide a process to resolve those issues.

The Ombudsman also oversees and reports to the Court on six unresolved issues under *Hartley*. These remaining unresolved issues are: community placement for residents of Hopemont, Pinecrest and Lakin state-operated long term care facilities; adequate reimbursement for Assisted Living Residences, personal care, and adult family care settings; case management services; Green Acres Regional Center; forensic services; and traumatic brain injury services. In 2003, crisis services and funding for uncompensated care were deemed resolved issues by the Office of the Ombudsman and approval was provided by the parties and the Court.

A *Hartley* class member is defined as any individual who meets one or more of the following criteria:<sup>45</sup>

- An individual with a diagnosis of mental illness, substance abuse, or developmental disability who received treatment in a state-operated facility.
- An individual who meets the BHHF diagnostic and functional criteria for targeted case management, clinic, or rehabilitation services as of January 1, 1998.

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<sup>45</sup> *Hartley* Court Order, June 24, 1998.

- An individual in crisis, for whom diagnosis is not known, until such a diagnosis can be made.

### ***Medley & Hartley Accomplishments***

The *Medley* and *Hartley Consent Decrees* resulted in numerous accomplishments that have shaped West Virginia's behavioral health system. The following are some of these accomplishments:

- Closure of eight state-operated facilities for people with disabilities including the closure of all state-operated facilities for people with developmental disabilities
- Expanded infrastructure of community providers
  - 85 licensed behavioral health providers
  - 515 ICF/MR beds
  - 331 Specialized Family Care providers
  - 520 Substance-abuse “residential beds”
- Development of the licensure regulations for behavioral health centers, behavioral health patients rights rule, behavioral health consumer rights, and consumer grievance process
- Development of the Home and Community-Based MR/DD Waiver Program
- Establishment of independent advocacy at the state-operated psychiatric hospitals
- Establishment of independent *Medley* and *Hartley* advocacy services
- Improvements to case management policies and regulations
- Enhancement of the interdisciplinary team process
- Establishment and improvements to policies regarding the care and treatment of people in state-operated facilities

### **Out of State Placements for Children**

In 1997, the Bureau for Children and Families (BCF) within the DHHR instituted an approval process for all juveniles being recommended for placement in out-of-state treatment facilities. This was due in part to ensure that appropriate assessment of the treatment and service needs had been completed, the multi-disciplinary treatment team (MDT) had met to review the assessment information, and that recommendations concerning the treatment and service needs were made to the Court with jurisdiction. The goal was to ensure that appropriate in-state options have been pursued.

During the 1999 Legislative session, West Virginia State Code was amended stating that when a court is considering placing a juvenile adjudicated to be a delinquent in DHHR custody and/or placing the juvenile out-of-home at the expense of DHHR, an MDT must be convened.<sup>46</sup> In jurisdictions where the process is mandated the West Virginia State Code is followed, and recommendations and options are provided to the Court to assist in disposition. Placement out-of-state may or may not be diverted.<sup>47</sup> The process does allow for the appropriate discharge planning for the juvenile to begin. The MDT teams have made determinations for the appropriateness of continued placement according to the following classifications.

- The juvenile requires long term placement that exists in West Virginia, but for various reasons is not available (i.e., no vacancies).
- The juvenile requires long term placement with features not available in West Virginia.
- The juvenile requires continued short term placement (less than three months) following with a placement in West Virginia.
- The immediate placement could be directly into a community-based setting within West Virginia with appropriate supports and services.

The BCF has established a system where every juvenile at risk of out-of-state placement will be reviewed for possible diversion to an in-state program or support. Those juveniles who go to an out-of-state treatment program are to be reviewed regularly every three months to determine their current needs.

The Interstate Compact for the Placement of Children (ICPC) is a legal agreement between West Virginia and other states as outlined in West Virginia State Code to regulate placement activities that occur between West Virginia and other states.<sup>48</sup> According to APS Healthcare, in July 2004 West Virginia had contracts with 75 out-of-state treatment facilities for children and adolescents.

According to the BCF, as of October 31, 2004 there were 349 children who have not reached their eighteenth birthday receiving services in out-of-state treatment facilities for a psychiatric diagnosis. These facilities were identified as group residential facilities, long-term psychiatric facilities, and

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<sup>46</sup> West Virginia State Code §49-5D-3(a)(2)

<sup>47</sup> West Virginia State Code §49-5D-3(a)(2)

<sup>48</sup> West Virginia State Code §49-2A-1

short-term psychiatric facilities. Expenditures made to the out-of-state providers for care and services to children during State fiscal year 2004 totaled \$14,840,917.

In 2004, the BHHF had identified over 25 children with developmental disabilities who are currently residing in out-of-state treatment facilities.

## **INFORMED CHOICE, IDENTIFICATION, & TRANSITION**

### **Informed Choice**

“Informed choice” means that a person is provided information to make a decision between institutional care and community-based supports in ways that are meaningful. Knowledge is an empowering tool for individuals, particularly during times of decision-making. For many West Virginians who have disabilities, the process of obtaining information about their options can be a frustrating and confusing experience. However, it is not only people with disabilities and their legal representatives who need information to make an informed choice, professionals who provide this information must have sufficient resources.

### **Identification**

The identification activities of the *Olmstead Plan* will include assessment and planning initiatives. Assessment and planning should start with, and seek to implement, the premise that people with disabilities can live in the community of their choice with appropriate supports. Assessment tools and/or planning processes must not act as artificial barriers to individuals moving to the community.

West Virginia must assess each individual to determine the specific supports that are appropriate for the person to live in the community to promote integration, independence, growth, health, and welfare. The individual assessment and planning process must be person-centered and focus on the person’s goals, desires, preferences, abilities, and strengths. It should not focus primarily on the person’s diagnosis or clinical needs. People should always be involved in their own assessment and planning processes, and must be provided with information in a form they can understand to make choices and consider options. People should not be asked to make a decision about moving to the community before the assessment and planning process begins. Such decisions cannot be made until the individual understands the options possible.

### **Professional Assessments**

Professionals who prepare assessments and/or participate in planning must be qualified. In order to be qualified, the professional or planning team must have knowledge of available community-based options. Even if such options are not currently available in the geographic area, they must be considered in the assessment and planning process. Institutional staff should never be the only ones preparing assessments or determining the content of plans. Rather, professionals who work in the community must be involved in assessment and/or planning processes. Assessments and determinations as to the most integrated setting must be based on the individual person's needs and desires for community supports and not on the current availability of services and supports in the community.

### **Minimum Data Set Information**

The Minimum Data Set (MDS) is part of a federally mandated process for the clinical assessment of all residents in Medicare or Medicaid certified nursing facilities. This process provides a comprehensive assessment of each resident's functional capabilities, and helps nursing facility staff identify health problems. The MDS assessment is completed for all residents in certified nursing facilities regardless of the source of payment for the individual. In addition, the MDS assessments are required for residents upon admission to the nursing facility and then periodically, within specific guidelines and time frames. This information is transmitted electronically by nursing facilities to the MDS database in their respective states. This information from the state database is captured by the national MDS database at the Centers for Medicare and Medicaid Services (CMS).

The CMS reported on the most current MDS information from for the quarterly period ending June 30, 2005. One question on the MDS is "Resident Expresses/Indicates Preference to Return to the Community." The June 30, 2005 results from 9,779 West Virginians who reside in nursing homes show 19.7% answered "yes" to this question. This equates to 1,926 people who expressed a desire to return to the community of their choice.

### **Pre-Admission Screening Assessment**

The pre-admission screening assessment, or PAS-2005, is a required prior authorization process for several long term care programs. The current pre-admission screening process has been required

since November 1, 1999. This assessment is used to document the medical and physical needs of individuals requesting services from a nursing facility, the Aged and Disabled Waiver Program, and personal care services. The purpose of the pre-admission screening is to certify that services are medically necessary and appropriate; the screening also documents the presence of mental illness, mental retardation or related condition(s).

The CMS have established federal criteria for states to use in making pre-admission and annual review determinations for continued residence in nursing facilities for individuals who have mental illness or mental retardation. The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) sets forth three sections that addressed the pre-admission screening and annual resident review (PASAAR) requirements:

1. Any new admissions occurring on or after January 1, 1989, prohibit a nursing facility from admitting any new resident who has mental illness or mental retardation and/or related condition(s), unless the state mental health or state mental retardation authority has determined, that because of the physical and mental condition, the prospective resident requires the level of services provided in a nursing facility. In addition, where it is determined, that admission to the nursing facility is appropriate; a determination must be made as to whether active treatment is required.
2. With respect to all current residents with mental retardation or mental illness and who were admitted prior to January 1, 1989, requires the state mental health or the state mental retardation authority review and determine by April 1, 1990, whether the first criteria has been met.
3. The state is required to develop, by no later than October 1, 1988, minimum criteria for making determinations on new admissions and current residents.

The CMS have advised states that the statute mandates any person with mental illness or mental retardation must be screened to reside or be admitted to a nursing facility. The CMS proposed that each state develop its own process, and may contract or delegate the responsibility. CMS further states that decisions as to appropriate placement for current or prospective residents who have mental illness or mental retardation are not governed by the availability of placement alternatives.

In West Virginia, the PAS-2005 has a question regarding providing information about community-based options that states: “Has the option of Medicaid Waiver been explained to the applicant?” This question only requires a “yes” or “no” response. Providing information on Medicaid Waiver options or other community-based supports is not a requirement under the PAS-2005 process in West Virginia.

The Bureau for Medical Services (BMS) contracts with an agency to review all PAS-2005 assessments for eligibility determinations. For individuals who are identified as requiring a nursing facility level of care and having mental illness, mental retardation or related condition(s), a request for a Level II on the PAS-2005 review must be completed. The Level II assessment certifies the determination for services the individual needs and the recommended placement setting.

In February 2001, the *Progress and Potential in West Virginia’s Community Long-Term Care System* report provided West Virginia policymakers with an overview of the State’s community long term care system for people who are elderly and people with physical disabilities, and identified policy options to improve or enhance the system. The report focused on community-based services and long term care services. The report was prepared by Paul Saucier and Elise Bolda of the Edmund S. Muskie School of Public Service and the University of Southern Maine. The list below identifies some of the recommendations for West Virginia’s PAS-2000 (currently the PAS -2005) process that were specified in this report.

- Improvements are needed in how people enter West Virginia’s long term care system. The current system creates conflicts of interest for providers who complete the assessment form. It also limits the information that consumers receive since the entry system for nursing homes is similar to but separate from the entry system for community services.
- Entry into the long term care system should be strengthened by unifying the nursing home and community care entry systems, clarifying provider roles, and maximizing consumer choice.
- Separate the “agent of the State” functions from the “provider of services” function and allow vendors to perform one or the other, but not both.
- Develop quality assurance mechanisms to monitor the PAS-2000 (currently the PAS-2005) and choice counseling processes.

### **Targeted Case Management**

Targeted Case Management (TCM) is a Medicaid State Plan service that has six federally recognized components: assessment, service planning, linkage/referral, advocacy, crisis response planning, and service plan evaluation. In West Virginia, TCM services are authorized to be provided 30 days before an individual's discharge from an ICF/MR or an inpatient psychiatric facility. West Virginia imposes this limitation on TCM services. The State relies on social workers employed by nursing facilities to provide discharge planning and transitional case management for nursing facility residents. The CMS allows states the flexibility to define the population served (including nursing home residents) and to use TCM for up to 180 consecutive days to assist a person transitioning from an institution to the community.

### **Service Coordination**

The MR/DD Waiver Program provides service coordination to assist recipients in transitioning from institutional care to waiver services. West Virginia allows an individual to use service coordination services for transition and discharge planning for up to 30 days before discharge. Similar to targeted case management, CMS allows persons served under a 1915(c) home and community-based waiver program to receive service coordination services while they are still institutionalized, for up to 180 consecutive days before discharge. West Virginia imposes this restriction on the number of days a person can receive transitional service coordination to eligible participants.

### **Federal Flexibility in Coverage of Transition Costs**

On May 9, 2002, a letter from the CMS to state Medicaid directors issued a clarification on methods by which home and community-based waivers under section 1915(c) may aid in transitioning individuals from institutional care to their own home in the community through coverage of one-time transitional expenses. States may secure federal matching funds under home and community-based waivers for one-time, start-up expenses for individuals who make the transition from an institution to their own home or apartment in the community.

States may pay for reasonable costs of community transition services, including some or all of the following components:

- Security deposits that are required to obtain a lease on an apartment or home



- Essential furnishings and moving expenses required to occupy and use a community residence
- Start-up fees or deposits for utility or service access (e.g. telephone, electricity, heating)
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning before occupancy

West Virginia does not reimburse for the cost of community transition services to recipients of the MR/DD Waiver Program or the Aged and Disabled Waiver Program.

## **FUNDING INSTITUTIONAL & COMMUNITY-BASED SUPPORTS**

### **Eliminating Institutional Bias**

The concept of eliminating institutional bias focuses on two key principles: 1) rebalancing the long term care system and 2) money follows the person. “Rebalancing” means adjusting the State’s publicly funded long term care supports to increase the availability of community options and reduce the reliance on institutions. “Money follows the person” refers to a system of flexible financing for long term care services that enable available funds to move with the individual to the most appropriate and preferred setting.

Many states have implemented one or more of the following strategies to eliminate institutional bias:

- **Legislative actions** to create policies for balancing the long term care system and creating budgetary mechanisms to move funding from institutional to home and community-based services.
- **Market-based approaches** offer participants more community supports and more timely information, allowing participant demand to rebalance the system. Participants are offered a comprehensive selection of services and supports, with available traditional and independent providers, and with a variety of living environment options. Market-based approaches increase home and community-based supports by 1) providing free election of this option over institutionalization through equal access, service availability, and quality and 2) using managed care models to create incentives to serve people in less expensive community settings. Through fair market-based approaches, people affect rebalancing as they choose home and community-based supports over institutionalization.

- **Fiscal linkages** build connections between funding streams, either by combining them or by linking an increase in the home and community-based supports budget to a decrease in institutional expenditures.
- **Programmatic linkages** increase coordination of services throughout the system, such as the establishment of local single access points for all long term supports, and/or the introduction of person-centered planning processes.

### **Moratoriums on Increasing Institutional Facilities**

In 1987, West Virginia established a moratorium on nursing facility bed growth.<sup>49</sup> In 1990, the Legislature enacted an exemption for low occupancy rural hospitals converting acute care beds to skilled nursing facility beds.<sup>50</sup> Furthermore, in 1992 this legislation expanded the exemption, thereby, allowing additional types of hospitals to participate.<sup>51</sup> Between 1990 and 2000, five facilities (161 beds) were opened in West Virginia by using this special legislation.<sup>52</sup>

West Virginia has a moratorium on establishing additional ICF/MR beds or facilities under an August 3, 1989, *Hartley* Court Order.

### **Money Follows the Person**

In 1995, the West Virginia Legislature passed a law to close the last state-operated facility for people with developmental disabilities. The law enacted a process whereby the funding for the individuals at the facility would follow them to their community setting. This included home and community-based waiver services and ICF/MR facility services. As of 2004, this process is still being used to fund those who were deinstitutionalized.

### **Personal Assistance Retainer**

Medicaid regulation permits states to make payment to “hold” an institutional bed open for a resident while that individual is hospitalized or away from the facility for a short-term period.<sup>53</sup> The

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<sup>49</sup> Barbara Maynard, *Progress and Potential in West Virginia’s Community Long-Term Care System*, February 2001.

<sup>50</sup> Ibid.

<sup>51</sup> Ibid.

<sup>52</sup> Ibid.

<sup>53</sup> 42 CFR §447.40

CMS implemented a similar policy for states to choose payment for personal assistance services under home and community-based waivers. This would enable beneficiaries to have parity between nursing facility care and home and community-based waivers in terms of assuring continuity of care and services.

Personal assistance retainer payments are limited to services furnished under home and community-based waivers. To enable waiver participants to continue to receive services in the most integrated setting appropriate to their needs, CMS will permit continued payment to caregivers under the waiver while a person is hospitalized or absent from his or her home. The personal assistance retainer time limit may not exceed 30 consecutive days, or the number of days for which the state authorizes a payment for “bed hold” in nursing facilities.<sup>54</sup>

In West Virginia, reimbursement is paid for medical leaves of absence to an ICF/MR facility when an individual is admitted to an inpatient hospital for care and treatment that can only be provided on an inpatient basis. The maximum bed hold for medical leaves of absence is limited to 14 consecutive days, provided the individual will return to the ICF/MR facility following discharge from the hospital. Reimbursement is paid to an ICF/MR provider for non-medical leaves of absence for therapeutic home visits and for trial visits to other facilities. The maximum bed hold for non-medical leaves of absence is limited to 21 days per calendar year.

### **Mental Health Services**

West Virginia faces many challenges in providing community-based supports for people with mental illness. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), per capita expenditures in West Virginia are ranked 35<sup>th</sup> in the nation for state psychiatric inpatient services, and ranked 50<sup>th</sup> in the nation for funding community-based programs.<sup>55</sup> According to the National Survey on Drug Use and Health, serious mental illness is defined as having at some time during the past year a diagnosable mental, behavioral, or emotional disorder that met the criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4<sup>th</sup> Edition, and resulted in a functional impairment that substantially interfered with or limited one of the major life activities.

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<sup>54</sup> Centers for Medicare and Medicaid Services, State Medicaid Directors letter, *Olmstead* Update No. 3, July 25, 2000.

<sup>55</sup> Ronald W. Manderscheid, Ph.D. and Marilyn J. Henderson, M.P.A., eds, *Mental Health, United States, 2000*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

According to the National Survey on Drug Use and Health, West Virginia ranked among states with the highest rates of serious mental illness in people aged 18 or older in 2002.

Institutions for Mental Disease (IMD's) are defined by the CMS as inpatient facilities of 16 beds or more whose primary admitting diagnosis is more than 51% of people with serious mental illness. Federal Medicaid matching payments are prohibited for IMD's with a population between the ages of 22 and 64. This is what is known as the IMD Exemption which essentially prohibits states from being approved for home and community-based waivers from freestanding psychiatric hospitals. The IMD Exemption essentially places the primary financial responsibility for inpatient psychiatric treatment for most adults on state governments.

In 1999, the Bazelon Center for Mental Health Law issued a report entitled "*Under Court Order, What the Community Integration Mandate Means for People with Mental Illnesses, The Supreme Court Ruling in Olmstead v. L.C.*" One of the issues raised in this report was how states can pay for community treatment and supports for people with mental illness. Potential resources include an array of federal and state programs that can be dedicated to enabling individuals with mental illness to live in the community. A summary of some of these funding sources are:

- Medicaid's optional services for adults – targeted case management, rehabilitation, and clinic services;
- Medicaid coverage for services furnished in small community residential programs with fewer than 16 beds;
- Medicaid's array of comprehensive community services for children, mandated through the Early and Periodic Screening, Diagnosis and Treatment;
- Medicaid Home and Community-Based Services Waiver (IMD Exemption);
- Medicaid eligibility expansion through various options and waivers of federal rules for home and community-based programs, research and demonstration waivers, the option to cover people who are medically needy under Medicaid, and coverage of children with serious emotional disorders under the "Katie Beckett" option (Medicaid home and community-based waiver program);
- Assertive Community Treatment Programs;

- Resources created by closing or significantly downsizing state psychiatric hospitals, which can be applied toward the cost of community care;
- Federal mental health block grant funds;
- Federal housing assistance programs;
- Federal disability benefits under the Supplemental Security Income (SSI) program; and
- State general fund appropriations for mental health service.

### **Medicaid Home Health Services**

While current federal regulations specify that Medicaid Home Health services must be provided to an individual at his or her place of residence, it is not necessary that the person be confined to the home for the services to be covered under the Medicaid Home Health benefit. The “homebound” requirement is a Medicare requirement and does not apply to the Medicaid program.<sup>56</sup> Imposing a homebound requirement on recipients of Medicaid Home Health benefits violates Medicaid regulations related to “amount, duration, and scope of services” and “comparability of services”.<sup>57</sup> This was clarified by a July 25, 2000 letter from the CMS to state Medicaid directors titled *Olmstead* Update No.3.

If a state limits Medicaid Home Health services to persons who are homebound, while not providing medically necessary Home Health services to individuals who are not homebound, it is arbitrarily denying the home health services based on the individual’s condition in violation of Medicaid regulations.<sup>58</sup> If a state limits the provision of Medicaid Home Health services to individuals who are homebound, the state violates federal requirements by providing the services to some individuals within the eligibility group but not others of the same group.<sup>59</sup>

Furthermore, ensuring that Medicaid Home Health benefits are available to persons in need of those services who are not homebound is an important part of our efforts to offer people with disabilities

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<sup>56</sup> Centers for Medicare and Medicaid Services, State Medicaid Directors letter, *Olmstead* Update No. 3, July 25, 2000.

<sup>57</sup> 42 CFR §440.230 and 42 CFR §440.240.

<sup>58</sup> 42 CFR §440.230(c).

<sup>59</sup> 42 CFR §440.240(b).

services in the most integrated setting appropriate to their needs, in accordance with the *Americans with Disabilities Act* (ADA).<sup>60</sup>

The BMS adheres to the homebound status for receiving Medicaid Home Health services.

## **RIGHTS PROTECTION & SELF-DIRECTION**

### **Rights Protection**

West Virginia has an obligation and responsibility to assure people with disabilities receive long term care supports in the most integrated setting appropriate. In addition, the State has a responsibility to assure that people with disabilities have their rights upheld and protected, and that they are free to exercise their rights. This section of the *Olmstead Plan* will address rights protection as related to the *Olmstead* decision, the ADA, and due process within West Virginia's long term care system.

### ***Olmstead*-Related Complaints**

The issue of *Olmstead*-related grievances was discussed at length during the plan development process. The issue of the authority of the *Olmstead* Coordinator and the *Olmstead* Office was discussed. The authority to implement the *Olmstead* decision is not a power to be held by one entity. The authority of the *Olmstead* decision in West Virginia will come from the endorsement of the *Olmstead* Plan by government leaders, providers, advocates, people with disabilities and families. In addition, a commitment for stakeholders to work together to implement this *Plan* will be essential. West Virginia currently has many avenues for people and their authorized representatives to use for filing complaints and grievances within the long term care system. The following is a list of some of the processes in place in West Virginia for *Olmstead*-related grievances/complaints/appeals:

- **Local-level complaint, grievance and due process systems:** behavioral health providers, long term care providers, senior centers, and county Boards of Education.
- **State-level complaint, grievance and due process systems:** Ombudsman for Behavioral Health, Department of Health and Human Resources, Long Term Care Ombudsman, State ADA Office, Human Rights Commission, Department of Education, Medicaid Fair Hearing process, Contested Case Hearing process, and the judicial system.

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<sup>60</sup> Centers for Medicare and Medicaid Services, State Medicaid Directors letter, *Olmstead* Update No. 3, July 25, 2000.

- **Federal-level complaint, grievance and due process systems:** U.S. Department of Justice-Office of Civil Rights, U.S. Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, and the federal judicial system.
- **Advocacy-level complaint, grievance and due process systems:** State Protection and Advocacy System, Appalachian Legal Services, *Hartley* and *Medley* Advocacy System, Senior Legal Aid, and the Long Term Care Ombudsman Program.

An individual *Olmstead*-related complaint/grievance is defined as 1) a person who wants to move out of an institutional setting to a community-based setting; and/or 2) a person who is at risk of institutionalization and wants to remain in their community. This includes any and all of those issues causing or relating to a person being institutionalized or at risk of institutionalization who wishes to reside or remain in the community.

The question of whether West Virginia needs an *Olmstead* grievance process was one that created much discussion and debate. Does West Virginia need another “layer of process” to hear individual complaints? Are West Virginia’s current systems working effectively for people? Can the current mechanisms be modified to be responsive to *Olmstead*-related complaints? The *Olmstead Plan* for West Virginia will address current systems and their responsibilities to inform and protect the rights of people with disabilities.

The *Olmstead* Office will provide information, assistance, and referral to individuals, advocates, and providers for *Olmstead*-related issues. This includes providing information and referrals to appropriate resources for complaint resolution and assisting individuals and advocates when those systems are not working appropriately to resolve their issues.

The *Olmstead* Office will track and monitor systemic issues related to the *Olmstead Plan* and *Olmstead*-related issues. In addition to tracking and monitoring these issues, the *Olmstead* Office will proactively and cooperatively work to resolve systemic issues.

## **Self-Direction**

Self-direction is a philosophy and orientation for the delivery of home and community-based services whereby informed individuals make choices about the supports they receive. People with disabilities have the right to control their own lives and futures. The general concepts for having community-based supports that implement a self-directed approach are education, monitoring, policy development, funding, implementation, consequences, and enforcement.

## **PROVIDING SERVICES AT A REASONABLE PACE**

Community-based supports must be provided to people at a pace that is reasonable and prompt to meet each individual's needs. The Supreme Court, in the *Olmstead* decision, did not define reasonable pace. However, §1902(a)(8) of the Social Security Act (SSA) and associated federal regulations mandate that a state promptly determine the eligibility of persons who apply for services. The regulatory standard for processing Medicaid applications for long term care mandates determinations in no more than 90 days. Federal courts have ruled that §1902(a)(8) of the SSA prevents a state from placing people on waiting lists for entitled Medicaid services rather than providing services to them within a reasonable period of time.

The state of Georgia had secured approval for coverage of 2,100 waiver slots as part of its Medicaid plan. Georgia provided funding for only 700 of the 2,100 slots. The failure to fund this program was recognized by the Supreme Court as a major factor in Georgia's failure to move L.C. and E.W. into the community at a reasonable pace.

## ***Benjamin H. v. Ohl* Class Action Suit**

In West Virginia, a class action complaint was filed in April 1998 in the U.S. District Court for the Southern District. This is what is known as *Benjamin H. et al. v. Ohl*. This case alleged that West Virginia violated federal Medicaid law and the ADA by failing to provide Medicaid long term care services with reasonable promptness to eligible individuals.

The Court issued a preliminary injunction and found that West Virginia's practice violated the reasonable promptness, freedom of choice, and due process provisions of Medicaid. The Court declined to rule on the ADA integration mandate claim, but did say that in light of the *Olmstead v.*



*L.C.* decision, West Virginia must develop a compliance plan to eliminate waiting lists and establish reasonable timeframes.

In 2001, the parties to the lawsuit established written policies regarding screening requirements, reasonable promptness and fair hearing access. The written policy regarding waiting lists for the MR/DD Waiver Program established that an eligible applicant cannot be placed on a wait list for more than 90 days. In addition, the parties established policies that mandated the application process from the date when a person submits an application to receiving a final eligibility determination will not exceed 90 days. The *Benjamin H.* class action suit also centralized the wait list process at the state level, terminating the local level control over slot allocation and wait listing.

#### ***Cyrus et al. v. Nusbaum* Class Action Suit**

A class action suit has been filed in U.S. District Court in Huntington alleging due process violations in the Aged and Disabled Medicaid Waiver Program's medical re-evaluations. A temporary restraining order has been issued in the case to reinstate services for beneficiaries who have had their benefits terminated upon re-evaluation at any point since November 2003, when the West Virginia Medical Institute (WVMI) contract to complete the PAS-2005's became effective. There are many other aspects of due process that will be addressed as the litigation in this case progresses.

#### **MR/DD Waiver Wait List**

The MR/DD Waiver Program has implemented a waiting list on two occasions since the *Benjamin H.* class action suit was settled in 2001. As of September 2005, there were 231 people on the waiting list. These are all individuals who have been deemed eligible for the program. Due to the decision by the BMS to not request any additional "slots" for 2005 through 2010, the waiting list will continue to grow, and the length of time individuals are will wait to received services will increase.

The MR/DD Waiver Program does not have a process for managing individual emergency or crisis situations for people who are placed on a waiting list. People on the wait list are added to the program in the order of the date the person is deemed eligible.

**Aged & Disabled Waiver Wait List**

The Aged and Disabled Waiver Program implemented a wait list on January 1, 2003. To date, the wait list continues to be used with an average of 750 people placed on the list. As of September 1, 2004, there were 764 people on the waiting list. There is not a priority or emergency procedure for providing services to individuals on the wait list who are in an emergency situation, institutionalized, or at risk of institutionalization. Individuals are required to wait at least six months after medical eligibility is determined before they are added to the program.

## **SECTION VII – CONCLUSION**

### **NEXT STEPS & MONITORING**

#### ***Olmstead* Advisory Council**

In May 2004, the members of the *Olmstead* Study Group were merged to join the *Olmstead* Advisory Council. The *Olmstead* Coordinator and the *Olmstead* Advisory Council have discussed the continuing and developing role of the Council. The composition of the Council will be comprised of people with disabilities, families and advocates (70%); providers of institutional and community services (20%); and state agency representatives (10%). The role of the *Olmstead* Advisory Council will be to:

- Advise the *Olmstead* Coordinator in fulfilling the responsibilities of the *Olmstead Plan* and the duties of the *Olmstead* Office;
- Review and monitor the activities of the *Olmstead* Coordinator;
- Provide recommendations for the long term care institutional and community-based supports systems;
- Issue position papers for the identification and resolution of systemic issues; and
- Monitor, revise, and update the *Olmstead Plan* and any subsequent work plans.

The *Olmstead* Advisory Council and the *Olmstead* Study Group met on a monthly basis since November 2003. After the approval and endorsement of the *Olmstead Plan*, the *Olmstead* Advisory Council will have 90 days to develop a work plan with timelines for implementation. Once the work plan is complete the Advisory Council will meet on a quarterly basis, or more frequently as required by the *Olmstead Plan*. All meetings of the *Olmstead* Advisory Council will be recorded and made available for public access. The *Olmstead* Coordinator will issue quarterly or bi-annual newsletters on West Virginia's *Olmstead* activities in accordance with the *Plan*. A report on the successes and challenges of implementing the *Olmstead Plan* will also be issued to the Governor and the public on an annual basis.



# APPENDICES

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**GLOSSARY OF TERMS & ACRONYMS**  
**Appendix A**

## ACRONYMS & GLOSSARY OF TERMS

### ACRONYMS

<b>AOA</b>	Administration on Aging
<b>ADA</b>	Americans with Disabilities Act
<b>ACT</b>	Assertive Community Treatment
<b>BHHF</b>	Bureau for Behavioral Health and Health Facilities
<b>BCF</b>	Bureau for Children and Families
<b>BMS</b>	Bureau for Medical Services
<b>BoSS</b>	Bureau of Senior Services
<b>CED at WVU</b>	Center for Excellence in Disabilities at West Virginia University
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>CMHS</b>	Center for Mental Health Services
<b>CFR</b>	Code of Federal Regulations
<b>DOE</b>	Department of Education
<b>DHHR</b>	West Virginia Department of Health and Human Resources
<b>DHHS</b>	United States Department of Health and Human Services
<b>DRS</b>	Division of Rehabilitation Services
<b>IMD</b>	Institutions for Mental Disease
<b>ICF/MR</b>	Intermediate Care Facility for People who have Mental Retardation
<b>MICASSA</b>	Medicaid Community Attendant Services and Supports Act
<b>MR/DD</b>	Mental Retardation and/or Developmental Disabilities
<b>MDS</b>	Minimum Data Set
<b>MDT</b>	Multi-Disciplinary Team
<b>NASDDDS</b>	National Association of State Director's of Developmental Disability Services
<b>OBHS</b>	Office of Behavioral Health Services
<b>OHFLAC</b>	Office of Health Facility Licensure and Certification
<b>OMCFH</b>	Office of Maternal, Child and Family Health
<b>PATH</b>	Projects for Assistance in Transition from Homelessness
<b>SSA</b>	Social Security Act
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>TCM</b>	Target Case Management

### GLOSSARY OF TERMS

#### **A**

**Activities of Daily Living** means activities that a person ordinarily performs during the ordinary course of a day such as: mobility, personal hygiene, bathing, dressing, sleeping, eating, and skills required for community living. A person's ability to perform these activities is indicative of his or her physical ability to function independently.

**Aged and Disabled Waiver Program** provides services in a home and community-based setting to aged and disabled individuals, 18 years or older, who are eligible for Medicaid or who would be eligible for Medicaid if institutionalized in a nursing home.



**Americans with Disabilities Act** is a civil rights law administered by the United States Department of Justice and other federal agencies. The ADA was enacted to establish a clear and comprehensive prohibition of discrimination based on disability in employment, accessing public services, transportation, private business, and telecommunications.

**Assertive Community Treatment** is an evidence-based approach for providing services to people who have mental illness in a highly individualized manner.

**Assisted Living Residences** are programs that are comprised of personal care homes and residential board and care homes. *SEE personal care homes, residential board and care homes*

## ***B***

**Bureau for Behavioral Health and Health Facilities** (BHHF) is a State agency within the Department of Health and Human Resources with a mission to provide services to persons with mental illness, addictions, developmental disabilities, and those at-risk.

**Bureau for Children and Families** (BCF) is a State agency with the Department of Health and Human Resources with a mission to provide services to children and families. Some of the programs the BCF administers are: child and adult protective services, WV WORKS, child care, foster care, adoption services, adult residential services, child residential services, and homeless shelter services. In addition, all county DHHR offices are administered by the BCF

**Bureau for Medical Services** (BMS) is the single State agency within the West Virginia Department of Health and Human Resources that administers the Medicaid Program mandated under Chapter 9 of the West Virginia Code and Title XIX of the Social Security Act.

**Bureau of Senior Services** (BoSS) is a cabinet-level agency within State Government and acts as the lead entity for programs serving older West Virginians. BoSS provides a wide range of services which, may vary slightly from county to county. Services include transportation, nutrition, in-home care, legal, employment, health insurance counseling, and assistance for residents of nursing and personal care homes. BoSS also manages the Aged and Disabled Home and Community-Based Waiver Program.

## ***C***

**Centers for Medicare and Medicaid Services** (CMS) is the federal agency within the U.S. Department of Health and Human Services that administers the following: Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), Health Insurance Portability and Accountability Act (HIPAA), and Clinical Laboratory Improvement Amendments (CLIA).

**Clinic Services** are federally defined as those preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided to outpatients under the direction of the physician. These services must be furnished by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients.

**Conservator** as defined by West Virginia State Code §44A-1-4(1) means a persons appointed by the court who is responsible for managing the estate and financial affairs of a protected person.

**Consumer Directed Case Management** (under the Aged and Disabled Waiver Program) is a service that gives people the ability to direct their own case management activities personally or through a representative.

## **D**

**Department of Health and Human Resources** (DHHR) is the State agency charged with administering public health programs and social services.

**Department of Health and Human Services** (DHHS) is the organizational unit of the federal government responsible for administration of the provisions of the Social Security Act as amended.

**Developmental Disability** means a severe, chronic disability of an individual who has a physical and/or mental impairment that substantially limits one or more major life activities;

- ☼ is attributable to a mental or physical impairment, or combination of mental and physical impairments;
- ☼ is manifested before the individual attains age 22;
- ☼ is likely to continue indefinitely; or
- ☼ results in substantial functional limitation in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility; self-direction, capacity for independent living, and economic self-sufficiency.

**Disability** is defined by the ADA using a three-prong definition. A person with a disability is defined as an individual who meets at least one of the following criteria:

- ☼ has a physical or mental impairment that substantially limits one or more major life activities;
- ☼ has a record or history of such an impairment; or
- ☼ is perceived or regarded as having such an impairment.

**Diversion** is defined as the process or activities involved in preventing people from being admitted to institutional settings by providing community-based supports.

## **F**

**Fundamental Alteration** is the U.S. Supreme Court test in *Olmstead vs. L.C.* for requiring states to make reasonable modifications to programs. Fundamental alterations must take into account three factors: the cost of providing the services to the individual in the most integrated setting appropriate; the resources available to the states; and how the provision of services affects the ability of the state to meet the needs of others with disabilities.

## **G**

**Guardian** as defined by West Virginia State Code §44A-1-4(5) means a person appointed by the court who is responsible for the personal affairs of a protected person.

## ***H***

**Health Care Decision** as defined by West Virginia State Code §16-30-3(i) means a decision to give, withhold, or withdraw informed consent to any type of health care, including, but not, limited to, medical and surgical treatments, including life-prolonging interventions, psychiatric treatment, nursing care, hospitalization, treatment in a nursing home or other facility, home health care and organ or tissue donation.

**Health Care Surrogate** as defined by West Virginia State Code §16-30-3(z) means an adult who is appointed by a physician to make health care decisions on behalf of a person who does not have the capacity to make their own health care decisions.

**Home Health Care** is provided in the home to individuals as an alternative to institutional care. The most common types of home health care are skilled nursing services, speech, physical and occupational therapies.

## ***I***

**ICF/MR Facilities** are institutions for four or more persons with mental retardation that: are primarily for the diagnosis, treatment, or rehabilitation for persons with mental retardation or related conditions; and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.

**Informed Choice** means that people are provided the information and education necessary to make meaningful and informed choices about community-based options.

**Institution** is defined by CMS as an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

**Institutional Bias** refers to the historic coverage of long-term care services more readily when the person resides in an institution. This includes funding allocations for programs, services and activities.

**Integration Mandate** under Title II of the ADA requires states to administer services in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

## ***M***

**Major Life Activities** under the ADA means functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

**Medicaid** (Title XIX, Title 19) is a joint federal and state program that pays for much or all of the health care services provided to eligible persons with low incomes and limited resources.

**Medicaid State Plan** is a comprehensive written agreement between the West Virginia Bureau for Medical Services (BMS) and the Centers for Medicare and Medicaid Services (CMS) that includes eligibility requirements for clients and identifies the scope of medical services for which federal reimbursement is made.

**Medical Power of Attorney** as defined by West Virginia State Code §16-30-3(q) means a person 18 years of age or older appointed by another person to make their health care decisions.

**Medicare** is Title XVIII Health Insurance for the Aged that was enacted by the 1965 Amendments to the Social Security Act. Medicare established a broad program of health insurance for the aged and certain persons with disabilities that is federally administered through fiscal grants.

**MR/DD Home and Community Based Waiver Program** (MR/DD Waiver) is a federal and state program for individuals with mental retardation and/or developmental disabilities designed to deliver services to individuals in their home and community surrounding as an alternative to receiving services in an Intermediate Care Facility (ICF/MR).

**Money Follows the Person** refers to a system of flexible financing for long-term care services that enable available funds to move with the person from the institutional setting to the community-based setting.

**Moratorium** means a temporary halt in activity (*according to the Webster's II New Riverside Dictionary*).

**Most Integrated Setting** is defined by the ADA as a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

## ***N***

**New Freedom Initiative Grants** are a series of federal grants initiated by the Centers for Medicare and Medicaid Services to assist states in designing and implementing effective and enduring improvements in community long-term care support systems.

**Nursing Facilities** or “nursing homes” for which Medicaid is the primary payer source. These facilities are operated under license by the Office of Health Facility Licensure and Certification.

## ***O***

**Office of Health Facility Licensure and Certification** (OHFLAC) is the office designated by the West Virginia Department of Health and Human Resources to determine whether facilities comply with federal and state licensure and certification standards.

**Office of Maternal, Child and Family Health** (OMCFH) is the State agency within the Department of the Health and Human Resources that administers multiple programs targeted to mothers, families, and children including Birth to Three, Adolescent Health, Perinatal and Women’s Health, and Early Childhood Health Projects.

**Olmstead Advisory Council** is responsible for acting as an oversight committee for the *Olmstead* office and the coordinated *Olmstead* Plan.

**Olmstead Study Group** was the group responsible for the research and writing activities for the development of the *Olmstead* Plan for West Virginia.

**Olmstead vs. L.C.** (98-536) 527 U.S. 581 (1999) is a landmark United States Supreme Court decision for the civil rights of people who have disabilities to receive community-integrated services and supports.

## ***P***

**Personal Care Homes** (officially named Assisted Living Residences) refer to facilities that provide supervision and assistance with activities of daily living and medications.

**Pre-Admission Screening** (PAS-2000) is the comprehensive medical evaluation used to determine medical eligibility for nursing home, personal care and Aged and Disabled waiver services.

## ***R***

**Reasonable Modification** under Title II of the ADA is the regulation that requires states to make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination based on disability, unless the [state] can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

**Rebalancing** refers to adjusting the state's publicly funded long-term care supports to increase the availability of community options and reduce the reliance on institutions.

**Residential Board and Care Homes** (or Assisted Living Residences) refers to facilities that provide personal assistance and supervision to people who can ambulate and are capable of self-preservation.

## ***S***

**Self-Direction** is a philosophy and orientation to the delivery of home and community-based services whereby informed individuals make choices about the services they receive.

**Skilled Nursing Facilities** are defined as facilities or “nursing homes” where Medicare is the primary payer source. These facilities are operated under license by the Office of Health Facility Licensure and Certification.

**Specialized Family Care Program** is a statewide placement and family support system designed to serve the needs of children and adults who have developmental disabilities in a family setting.

**State's Treatment Professionals** are those professionals, family members, legal representatives and advocates who make up a person's treatment or planning team. The “State's treatment professionals” must have knowledge and a functional understanding of the community placement options before they can make a professional determination about the community-based needs of an individual.

## ***T***

**Title II of the ADA** established requirements for public entities, including state governments and health care services that are funded and administered by states agencies. Title II prohibits people with disabilities from being excluded from participation in or denied the benefits of services, programs, or activities of a public entity, or subjected to discrimination by any such entity.

**Transition** is the process of moving a person from an institutional setting to a community-based setting.

## **W**

**Wait List** refers to the process where people who have been deemed eligible for services are placed on a list and are subjected to waiting for such services.

***OLMSTEAD V. L.C.* SYLLABUS**  
**Appendix B**

**OLMSTEAD V. L. C. (98-536) 527 U.S. 581 (1999)**  
**138 F.3d 893, affirmed in part, vacated in part, and remanded**

**Syllabus**

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.*, 200 U.S. 321, 337.

**SUPREME COURT OF THE UNITED STATES**

**OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN  
RESOURCES, et al. v. L. C.,  
by zimring, guardian ad litem and next  
friend, et al.**

**CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR  
THE  
ELEVENTH CIRCUIT**

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No. 98—536. Argued April 21, 1999—Decided June 22, 1999

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In the Americans with Disabilities Act of 1990 (ADA), Congress described the isolation and segregation of individuals with disabilities as a serious and pervasive form of discrimination. 42 U.S.C. § 12101(a)(2), (5). Title II of the ADA, which proscribes discrimination in the provision of public services, specifies, *inter alia*, that no qualified individual with a disability shall, “by reason of such disability,” be excluded from participation in, or be denied the benefits of, a public entity’s services, programs, or activities. §12132. Congress instructed the Attorney General to issue regulations implementing Title II’s discrimination proscription. See §12134(a). One such regulation, known as the “integration regulation,” requires a “public entity [to] administer ... programs ... in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 CFR § 35.130(d). A further prescription, here called the “reasonable-modifications regulation,” requires public entities to “make reasonable modifications” to avoid “discrimination on the basis of



disability,” but does not require measures that would “fundamentally alter” the nature of the entity’s programs. §35.130(b)(7).

Respondents L. C. and E. W. are mentally retarded women; L. C. has also been diagnosed with schizophrenia, and E. W., with a personality disorder. Both women were voluntarily admitted to Georgia Regional Hospital at Atlanta (GRH), where they were confined for treatment in a psychiatric unit. Although their treatment professionals eventually concluded that each of the women could be cared for appropriately in a community-based program, the women remained institutionalized at GRH. Seeking placement in community care, L. C. filed this suit against petitioner state officials (collectively, the State) under 42 U.S.C. § 1983 and Title II. She alleged that the State violated Title II in failing to place her in a community-based program once her treating professionals determined that such placement was appropriate. E. W. intervened, stating an identical claim. The District Court granted partial summary judgment for the women, ordering their placement in an appropriate community-based treatment program. The court rejected the State’s argument that inadequate funding, not discrimination against L. C. and E. W. “by reason of [their] disabilit[ies],” accounted for their retention at GRH. Under Title II, the court concluded, unnecessary institutional segregation constitutes discrimination per se, which cannot be justified by a lack of funding. The court also rejected the State’s defense that requiring immediate transfers in such cases would “fundamentally alter” the State’s programs. The Eleventh Circuit affirmed the District Court’s judgment, but remanded for reassessment of the State’s cost-based defense. The District Court had left virtually no room for such a defense. The appeals court read the statute and regulations to allow the defense, but only in tightly limited circumstances. Accordingly, the Eleventh Circuit instructed the District Court to consider, as a key factor, whether the additional cost for treatment of L. C. and E. W. in community-based care would be unreasonable given the demands of the State’s mental health budget.

Held: The judgment is affirmed in part and vacated in part, and the case is remanded.

**138 F.3d 893, affirmed in part, vacated in part, and remanded.**

Justice Ginsburg delivered the opinion of the Court with respect to Parts I, II, and III—A, concluding that, under Title II of the ADA, States are required to place persons with mental disabilities in community settings rather than in institutions when the State’s treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. Pp. 11—18.

(a) The integration and reasonable-modifications regulations issued by the Attorney General rest on two key determinations: (1) Unjustified placement or retention of persons in institutions

severely limits their exposure to the outside community, and therefore constitutes a form of discrimination based on disability prohibited by Title II, and (2) qualifying their obligation to avoid unjustified isolation of individuals with disabilities, States can resist modifications that would fundamentally alter the nature of their services and programs. The Eleventh Circuit essentially upheld the Attorney General's construction of the ADA. This Court affirms the Court of Appeals decision in substantial part. Pp. 11—12.

(b) Undue institutionalization qualifies as discrimination “by reason of ... disability.” The Department of Justice has consistently advocated that it does. Because the Department is the agency directed by Congress to issue Title II regulations, its views warrant respect. This Court need not inquire whether the degree of deference described in *Chevron U.S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844, is in order; the well-reasoned views of the agencies implementing a statute constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance. E.g., *Bragdon v. Abbott*, 524 U.S. 624, 642. According to the State, L. C. and E. W. encountered no discrimination “by reason of” their disabilities because they were not denied community placement on account of those disabilities, nor were they subjected to “discrimination,” for they identified no comparison class of similarly situated individuals given preferential treatment. In rejecting these positions, the Court recognizes that Congress had a more comprehensive view of the concept of discrimination advanced in the ADA. The ADA stepped up earlier efforts in the Developmentally Disabled Assistance and Bill of Rights Act and the Rehabilitation Act of 1973 to secure opportunities for people with developmental disabilities to enjoy the benefits of community living. The ADA both requires all public entities to refrain from discrimination, see §12132, and specifically identifies unjustified “segregation” of persons with disabilities as a “for[m] of discrimination,” see §§12101(a)(2), 12101(a)(5). The identification of unjustified segregation as discrimination reflects two evident judgments: Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life, cf., e.g., *Allen v. Wright*, 468 U.S. 737, 755; and institutional confinement severely diminishes individuals’ everyday life activities. Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifice. The State correctly uses the past tense to frame its argument that, despite Congress’ ADA findings, the Medicaid statute “reflected” a congressional policy preference for institutional treatment over treatment in the community. Since 1981, Medicaid has in fact provided funding for state-run home and community-based care through a waiver program. This Court emphasizes that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings. Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it. In this case, however, it is not genuinely disputed that L. C. and E. W. are individuals “qualified” for

noninstitutional care: The State’s own professionals determined that community-based treatment would be appropriate for L. C. and E. W., and neither woman opposed such treatment. Pp. 12—18.

Justice Ginsburg, joined by Justice O’Connor, Justice Souter, and Justice Breyer, concluded in Part III—B that the State’s responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless. The reasonable-modifications regulation speaks of “reasonable modifications” to avoid discrimination, and allows States to resist modifications that entail a “fundamenta[l] alter[ation]” of the States’ services and programs. If, as the Eleventh Circuit indicated, the expense entailed in placing one or two people in a community-based treatment program is properly measured for reasonableness against the State’s entire mental health budget, it is unlikely that a State, relying on the fundamental-alteration defense, could ever prevail. Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities. The ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. Nor is it the ADA’s mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter, a placement the State proposed, then retracted, for E. W. Some individuals, like L. C. and E. W. in prior years, may need institutional care from time to time to stabilize acute psychiatric symptoms. For others, no placement outside the institution may ever be appropriate. To maintain a range of facilities and to administer services with an even hand, the State must have more leeway than the courts below understood the fundamental-alteration defense to allow. If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State’s endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions. The case is remanded for further consideration of the appropriate relief, given the range of the State’s facilities for the care of persons with diverse mental disabilities, and its obligation to administer services with an even hand. Pp. 18—22.

Justice Stevens would affirm the judgment of the Court of Appeals, but because there are not five votes for that disposition, joined Justice Ginsburg’s judgment and Parts I, II, and III—A of her opinion. Pp. 1—2.

Justice Kennedy concluded that the case must be remanded for a determination of the questions the Court poses and for a determination whether respondents can show a violation of 42 U.S.C. § 12132’s ban on discrimination based on the summary judgment materials on file or any further pleadings and materials properly allowed. On the ordinary interpretation and meaning of the

term, one who alleges discrimination must show that she received differential treatment vis-à-vis members of a different group on the basis of a statutorily described characteristic. Thus, respondents could demonstrate discrimination by showing that Georgia (i) provides treatment to individuals suffering from medical problems of comparable seriousness, (ii) as a general matter, does so in the most integrated setting appropriate for the treatment of those problems (taking medical and other practical considerations into account), but (iii) without adequate justification, fails to do so for a group of mentally disabled persons (treating them instead in separate, locked institutional facilities). This inquiry would not be simple. Comparisons of different medical conditions and the corresponding treatment regimens might be difficult, as would be assessments of the degree of integration of various settings in which medical treatment is offered. Thus far, respondents have identified no class of similarly situated individuals, let alone shown them to have been given preferential treatment. Without additional information, the Court cannot address the issue in the way the statute demands. As a consequence, the partial summary judgment granted respondents ought not to be sustained. In addition, it was error in the earlier proceedings to restrict the relevance and force of the State's evidence regarding the comparative costs of treatment. The State is entitled to wide discretion in adopting its own systems of cost analysis, and, if it chooses, to allocate health care resources based on fixed and overhead costs for whole institutions and programs. The lower courts should determine in the first instance whether a statutory violation is sufficiently alleged and supported in respondents' summary judgment materials and, if not, whether they should be given leave to replead and to introduce evidence and argument along the lines suggested. Pp. 1—10.

*Ginsburg, J., announced the judgment of the Court and delivered the opinion of the Court with respect to Parts I, II, and III—A, in which Stevens, O'Connor, Souter, and Breyer, JJ., joined, and an opinion with respect to Part III—B, in which O'Connor, Souter, and Breyer, JJ., joined. Stevens, J., filed an opinion concurring in part and concurring in the judgment. Kennedy, J., filed an opinion concurring in the judgment, in which Breyer, J., joined as to Part I. Thomas, J., filed a dissenting opinion, in which Rehnquist, C. J., and Scalia, J., joined.*

**ADA DEFINITION OF DISABILITY**  
**Appendix C**

## ADA Definition of Disability

[The information below was taken from “*The Americans with Disabilities Act, Title II Technical Assistance Manual, Covering State and Local Government Programs and Services*” by the Department of Justice.]

### II-2.0000 QUALIFIED INDIVIDUALS WITH DISABILITIES

*Regulatory references:* 28 CFR 35.104.

**II-2.1000 General.** Title II of the ADA prohibits discrimination against any "qualified individual with a disability." Whether a particular individual is protected by title II requires a careful analysis first, of whether an individual is an "individual with a disability," and then whether that individual is "qualified."

People commonly refer to disabilities or disabling conditions in a broad sense. For example, poverty or lack of education may impose real limitations on an individual's opportunities. Likewise, being only five feet in height may prove to be an insurmountable barrier to an individual whose ambition is to play professional basketball. Although one might loosely characterize these conditions as "disabilities" in relation to the aspirations of the particular individual, the disabilities reached by title II are limited to those that meet the ADA's legal definition -- those that place substantial limitations on an individual's major life activities.

Title II protects three categories of individuals with disabilities:

- 1) Individuals who have a physical or mental impairment that substantially limits one or more major life activities;
- 2) Individuals who have a record of a physical or mental impairment that substantially limited one or more of the individual's major life activities; and
- 3) Individuals who are regarded as having such an impairment, whether they have the impairment or not.

**II-2.2000 Physical or mental impairments.** The first category of persons covered by the definition of an individual with a disability is restricted to those with "physical or mental impairments." Physical impairments include --

- 1) Physiological disorders or conditions;
- 2) Cosmetic disfigurement; or
- 3) Anatomical loss

affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs (which would include speech organs that are not respiratory such as vocal cords, soft palate, tongue, etc.); respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine.

Specific examples of physical impairments include orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, HIV disease (symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

Mental impairments include mental or psychological disorders, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Simple physical characteristics such as the color of one's eyes, hair, or skin; baldness; left-handedness; or age do not constitute physical impairments. Similarly, disadvantages attributable to environmental, cultural, or economic factors are not the type of impairments covered by title II. Moreover, the definition does not include common personality traits such as poor judgment or a quick temper, where these are not symptoms of a mental or psychological disorder.

*Does title II prohibit discrimination against individuals based on their sexual orientation?* No. The phrase "physical or mental impairment" does not include homosexuality or bisexuality.

**II-2.3000 Drug addiction as an impairment.** Drug addiction is an impairment under the ADA. A public entity, however, may base a decision to withhold services or benefits in most cases on the fact that an addict is engaged in the current and illegal use of drugs.

*What is "illegal use of drugs"?* Illegal use of drugs means the use of one or more drugs, the possession or distribution of which is unlawful under the Controlled Substances Act. It does not include use of controlled substances pursuant to a valid prescription, or other uses that are authorized by the Controlled Substances Act or other Federal law. Alcohol is not a "controlled substance," but alcoholism is a disability.

*What is "current use"?* "Current use" is the illegal use of controlled substances that occurred recently enough to justify a reasonable belief that a person's drug use is current or that continuing use is a real and ongoing problem. A public entity should review carefully all the facts surrounding its belief that an individual is currently taking illegal drugs to ensure that its belief is a reasonable one.

*Does title II protect drug addicts who no longer take controlled substances?* Yes. Title II prohibits discrimination against drug addicts based solely on the fact that they previously illegally used controlled substances. Protected individuals include persons who have successfully completed a supervised drug rehabilitation program or have otherwise been rehabilitated successfully and who are not engaging in current illegal use of drugs. Additionally, discrimination is prohibited against an individual who is currently participating in a supervised rehabilitation program and is not engaging in current illegal use of drugs. Finally, a person who is erroneously regarded as engaging in current illegal use of drugs is protected.

*Is drug testing permitted under the ADA?* Yes. Public entities may utilize reasonable policies or procedures, including but not limited to drug testing, designed to ensure that an individual who formerly engaged in the illegal use of drugs is not now engaging in current illegal use of drugs.

**II-2.4000 Substantial limitation of a major life activity.** To constitute a "disability," a condition must substantially limit a major life activity. Major life activities include such activities as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

*When does an impairment "substantially limit" a major life activity?* There is no absolute standard for determining when an impairment is a substantial limitation. Some impairments obviously or by their nature substantially limit the ability of an individual to engage in a major life activity.

ILLUSTRATION 1: A person who is deaf is substantially limited in the major life activity of hearing. A person with a minor hearing impairment, on the other hand, may not be substantially limited.

ILLUSTRATION 2: A person with traumatic brain injury may be substantially limited in the major life activities of caring for one's self, learning, and working because of memory deficit, confusion, contextual difficulties, and inability to reason appropriately.

An impairment substantially interferes with the accomplishment of a major life activity when the individual's important life activities are restricted as to the conditions, manner, or duration under which they can be performed in comparison to most people.

ILLUSTRATION 1: A person with a minor vision impairment, such as 20/40 vision, does not have a substantial impairment of the major life activity of seeing.

ILLUSTRATION 2: A person who can walk for 10 miles continuously is not substantially limited in walking merely because, on the eleventh mile, he or she begins to experience pain, because most people would not be able to walk eleven miles without experiencing some discomfort.

*Are "temporary" mental or physical impairments covered by title II?* Yes, if the impairment substantially limits a major life activity. The issue of whether a temporary impairment is significant enough to be a disability must be resolved on a case-by-case basis, taking into consideration both the duration (or expected duration) of the impairment and the extent to which it actually limits a major life activity of the affected individual.

ILLUSTRATION: During a house fire, M received burns affecting his hands and arms. While it is expected that, with treatment, M will eventually recover full use of his hands, in the meantime he requires assistance in performing basic tasks required to care for himself such as eating and dressing. Because M's burns are expected to substantially limit a major life activity (caring for one's self) for a significant period of time, M would be considered to have a disability covered by title II.

*If a person's impairment is greatly lessened or eliminated through the use of aids or devices, would the person still be considered an individual with a disability?* Whether a person has a disability is assessed without regard to the availability of mitigating measures, such as reasonable modifications, auxiliary aids and services,



services and devices of a personal nature, or medication. For example, a person with severe hearing loss is substantially limited in the major life activity of hearing, even though the loss may be improved through the use of a hearing aid. Likewise, persons with impairments, such as epilepsy or diabetes, that, if untreated, would substantially limit a major life activity, are still individuals with disabilities under the ADA, even if the debilitating consequences of the impairment are controlled by medication.

**II-2.5000 Record of a physical or mental impairment that substantially limited a major life activity.** The ADA protects not only those individuals with disabilities who actually have a physical or mental impairment that substantially limits a major life activity, but also those with a record of such an impairment. This protected group includes --

- 1) A person who has a history of an impairment that substantially limited a major life activity but who has recovered from the impairment. Examples of individuals who have a history of an impairment are persons who have histories of mental or emotional illness, drug addiction, alcoholism, heart disease, or cancer.
- 2) Persons who have been misclassified as having an impairment. Examples include persons who have been erroneously diagnosed as mentally retarded or mentally ill.

**II-2.6000 "Regarded as."** The ADA also protects certain persons who are regarded by a public entity as having a physical or mental impairment that substantially limits a major life activity, whether or not that person actually has an impairment. Three typical situations are covered by this category:

- 1) An individual who has a physical or mental impairment that does not substantially limit major life activities, but who is treated as if the impairment does substantially limit a major life activity;

ILLUSTRATION: A, an individual with mild diabetes controlled by medication, is barred by the staff of a county-sponsored summer camp from participation in certain sports because of her diabetes. Even though A does not actually have an impairment that substantially limits a major life activity, she is protected under the ADA because she is treated as though she does.

- 2) An individual who has a physical or mental impairment that substantially limits major life activities *only* as a result of the attitudes of others towards the impairment;

ILLUSTRATION: B, a three-year old child born with a prominent facial disfigurement, has been refused admittance to a county-run day care program on the grounds that her presence in the program might upset the other children. B is an individual with a physical impairment that substantially limits her major life activities only as the result of the attitudes of others toward her impairment.

- 3) An individual who has no impairments but who is treated by a public entity as having an impairment that substantially limits a major life activity.

ILLUSTRATION: C is excluded from a county-sponsored soccer team because the coach believes rumors that C is infected with the HIV virus. Even though these rumors are untrue, C is protected under the ADA, because he is being subjected to discrimination by the county based on the belief

that he has an impairment that substantially limits major life activities (i.e., the belief that he is infected with HIV).

**II-2.7000 Exclusions.** The following conditions are specifically excluded from the definition of "disability": transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, other sexual behavior disorders, compulsive gambling, kleptomania, pyromania, and psychoactive substance use disorders resulting from current illegal use of drugs.

**II-2.8000 Qualified individual with a disability.** In order to be an individual protected by title II, the individual must be a "qualified" individual with a disability. To be qualified, the individual with a disability must meet the essential eligibility requirements for receipt of services or participation in a public entity's programs, activities, or services with or without --

- 1) Reasonable modifications to a public entity's rules, policies, or practices;
- 2) Removal of architectural, communication, or transportation barriers; or
- 3) Provision of auxiliary aids and services.

The "essential eligibility requirements" for participation in many activities of public entities may be minimal. For example, most public entities provide information about their programs, activities, and services upon request. In such situations, the only "eligibility requirement" for receipt of such information would be the request for it. However, under other circumstances, the "essential eligibility requirements" imposed by a public entity may be quite stringent.

ILLUSTRATION: The medical school at a public university may require those admitted to its program to have successfully completed specified undergraduate science courses.

*Can a visitor, spectator, family member, or associate of a program participant be a qualified individual with a disability under title II?* Yes. Title II protects any qualified individual with a disability involved in any capacity in a public entity's programs, activities, or services.

ILLUSTRATION: Public schools generally operate programs and activities that are open to students' parents, such as parent-teacher conferences, school plays, athletic events, and graduation ceremonies. A parent who is a qualified individual with a disability with regard to these activities would be entitled to title II protection.

*Can health and safety factors be taken into account in determining who is qualified?* Yes. An individual who poses a direct threat to the health or safety of others will not be "qualified."

*What is a "direct threat"?* A "direct threat" is a significant risk to the health or safety of others that cannot be eliminated or reduced to an acceptable level by the public entity's modification of its policies, practices, or procedures, or by the provision of auxiliary aids or services. The public entity's determination that a person poses a direct threat to the health or safety of others may not be based on generalizations or stereotypes about the effects of a particular disability.

*How does one determine whether a direct threat exists?* The determination must be based on an individualized assessment that relies on current medical evidence, or on the best available objective evidence, to assess --

- 1) The nature, duration, and severity of the risk;
- 2) The probability that the potential injury will actually occur; and,
- 3) Whether reasonable modifications of policies, practices, or procedures will mitigate or eliminate the risk.

Making this assessment will not usually require the services of a physician. Medical guidance may be obtained from public health authorities, such as the U.S. Public Health Service, the Centers for Disease Control, and the National Institutes of Health, including the National Institute of Mental Health.

**ILLUSTRATION:** An adult individual with tuberculosis wishes to tutor elementary school children in a volunteer mentor program operated by a local public school board. Title II permits the board to refuse to allow the individual to participate on the grounds that the mentor's condition would be a direct threat to the health or safety of the children participating in the program, if the condition is contagious and the threat cannot be mitigated or eliminated by reasonable modifications in policies, practices, or procedures.



***OLMSTEAD* ADVISORY COUNCIL**  
**Appendix D**

## **Olmstead Advisory Council Membership List**

Names appear in alphabetical order. An asterisk (\*) identifies current Advisory Council members.

Cindy Beane*	Bureau for Medical Services
Elliott Birckhead*	Bureau for Behavioral Health and Health Facilities
Becky Browning*	West Virginia Mental Health Consumers' Association
Marcus Canaday*	Centers for Excellence in Disabilities at WVU
Bill Davis*	AARP, Inc.
Karen Davis*	MR/DD Waiver Program
Brad Deel*	West Virginia EMS-TSN, Inc. – Advocacy Program
Ken Ervin*	Northern West Virginia Center for Independent Living
Laura Friend*	West Virginia Council of Home Care Agencies
Nancy Fry*	Legal Aid of West Virginia – Advocacy Program
Penney Hall*	Office of the ADA Coordinator
Clarice Hausch	West Virginia Advocates
Roy Herzbach*	Legal Aid of West Virginia – Ombudsman Program
Linda Higgs*	West Virginia Developmental Disabilities Council
Earl Hollinshead, III	West Virginia Statewide Independent Living Council
Barry Koerber	West Virginia EMS-TSN, Inc. – Advocacy Program
JoElla Legg	Mountain State Parents CAN
Ann Meadows*	West Virginia Statewide Independent Living Council
Larry Medley*	Bureau for Senior Services
Mike O'Brien*	West Virginia Advocates
Debbie Toler	West Virginia Advocates
Sam Mullett	West Virginia Brain Injury Association
Lorraine Penhos	West Virginia EMS-TSN, Inc. – Advocacy Program
David Plowright	Potomac Center
Leslie Reedy	West Virginia Mental Health Consumers' Association
Larry Rogers*	Peer Recovery Network
John Russell*	West Virginia Behavioral Health Providers' Association
David Sanders*	West Virginia Mental Health Consumers' Association
Julie Shelton	Bureau for Medical Services
David Stewart*	Fair Shake Network
Steve Wiseman*	West Virginia Developmental Disabilities Council

### **Office of the Ombudsman for Behavioral Health:**

Tina Maher	<i>Olmstead</i> Coordinator
Leesa McVay	Administrative Assistant
David G. Sudbeck	Ombudsman for Behavioral Health



**Office of the Ombudsman for Behavioral Health  
Tina Maher, *Olmstead* Coordinator  
State Capitol Complex  
Building 6, Room 850  
Charleston, West Virginia 25305**

**Phone: (304) 558-3287**

**Fax: (304) 558-2378**

**[www.wvdhhr.org/bhhf/olmstead/default.htm](http://www.wvdhhr.org/bhhf/olmstead/default.htm)**

