

THE STATES' RESPONSE TO THE
OLMSTEAD DECISION:
A STATUS REPORT

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March 2001



The States' Response to the Olmstead Decision is a publication of the Forum for State Health Policy Leadership at the National Conference of State Legislatures.

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- To foster interstate communication and cooperation, and
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The Forum is funded principally by grants from the David and Lucile Packard Foundation, the Henry J. Kaiser Family Foundation, the W.K. Kellogg Foundation, The Robert Wood Johnson Foundation, and the Commonwealth Foundation.

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Printed in the United States of America.

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Acknowledgements

The Forum for State Health Policy Leadership at NCSL is grateful to The Robert Wood Johnson Foundation for its generous support. The authors also would like to thank our state contacts; Elizabeth Priaulx at the National Association of Protection and Advocacy Systems; Nikki Highsmith at the Center for Health Care Strategies; and Martha King, Jo Donlin, Carrie Farmer, Julie Scales, Elizabeth Devore, Leann Stelzer and Joy Johnson Wilson at NCSL.

In June 1999, the Supreme Court ruled in *L.C. & E.W. vs. Olmstead* that it is a violation of the Americans with Disabilities Act for states to discriminate against people with disabilities by providing services in institutions when the individual could be served more appropriately in a community-based setting. States are required to provide community-based services for people with disabilities if treatment professionals determine that it is appropriate, the affected individuals do not object to such placement and the state has the available resources to provide community-based services. The Court suggests that a state could establish compliance with the Americans with Disabilities Act if it has 1) a comprehensive, effective working plan for placing qualified people in less restrictive settings, and 2) a waiting list for community-based services that ensures people can come off the list at a reasonable pace and receive services. □

Purpose of the Study

In light of this ruling, the National Conference of State Legislatures (NCSL) conducted a 50-state survey to determine initial state responses to the *Olmstead* decision. The purpose of this study is to enhance informed decision making by helping state policymakers understand the choices states are making and the options that are available to meet the needs of people with disabilities. The study is appropriately called a status report because states are in the early stages of implementing the *Olmstead* decision. The long-term effects of the decision are still unknown. NCSL will continue to track activity involving the implementation of the *Olmstead* decision and update this report regularly, pending permanent funding which NCSL is currently seeking.

NCSL surveyed each state's main contact(s) for *Olmstead* activities. A list of these contacts is contained in appendix A. During the telephone interviews, survey respondents provided information on the following topics: what activities are under way or planned in the next 12 months related to the *Olmstead* court case; the status of the state's plan, including who is involved, its charge and its timelines, level of involvement of people with disabilities and their representatives, and who the plans include; and the barriers to implementing the *Olmstead* decision.

The findings from these questions can be found for each state in appendix B. These state summaries are only thumbnail sketches of activities in each state. In addition, NCSL has collected executive orders, legislation and draft plans from the states. □

Major Findings

A major strategy in response to the *Olmstead* decision has been the creation of task forces or commissions to assess current long-term care systems and to develop plans.

Thirty-seven states—Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Mississippi, Missouri, Montana, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, Utah, Washington, West Virginia, Wisconsin and Wyoming—plus the District of Columbia have task forces or work groups to develop comprehensive plans or significant papers, many of which could serve as blueprints for public policy in the states. The North Dakota executive director of the Human Services Department organized an internal work group that held public hearings through an interactive video network and issued a white paper which requested the governor to appoint a commission to develop a comprehensive state plan.



All of these groups are state-funded. In addition, seven of them—Alabama, Georgia, Kentucky, Maine, Maryland, Missouri and Utah—have received matching planning grants from the Center for Health Care Strategies under The Robert Wood Johnson Foundation’s Medicaid Managed Care Program.

Only a few states have finalized their plans, but most will complete them in 2001.

States are in various stages of the planning process. A few have issued their final, comprehensive plans. Some are working on them; others have issued progress reports and/or papers with recommendations that are not intended to be comprehensive.

□ Four of the plans—Missouri, North Carolina, Ohio and Texas—are comprehensive, using the Health Care Financing Administration’s (HCFA) guidance letter from January 14, 2000 as the benchmark. That letter contains an enclosure entitled *Developing Comprehensive, Effectively Working Plans, Initial Technical Assistance Recommendations*. These states’ plans appear to meet HCFA’s recommendations. They can be downloaded from the Web: Missouri (<http://www.dolir.state.mo.us/gcd/Olmsteadindex.html>) North Carolina (<http://www.dhhs.state.nc.us/docs/Olmstead.htm>); Ohio (<http://www.state.oh.us/OBM/>); and Texas (http://www.hhsc.state.tx.us/tpip/tpip_index.html). (The North Carolina plan is currently in draft form, but the final version is due in spring 2001. Also, Ohio issued its Ohio Access for People with Disabilities which contains long-term care recommendations as well as short-term priorities that are in the FY 2002-2003 executive budget recently submitted to the General Assembly. Although work on the Ohio plan began before the Olmstead decision was issued and state officials refer to it as “our plan to plan,” this paper is quite comprehensive.) None of these plans have yet been implemented because they were very recently issued, and their full implementation is contingent upon new state appropriations.

□ Some states have issued significant papers—many of which contain thoughtful recommendations—that are not intended to be comprehensive. For example, California’s Long-Term Care Council has issued short-term recommendations; Illinois (http://www.state.il.us/agency/dhs/od_scr.html) issued six position papers with significant recommendations; and North Dakota issued a white paper of accomplishments and some recommendations.

□ The following states expect to issue their plans later in 2001: Alabama (summer); Arizona, (July); Arkansas (November); Colorado (June); Connecticut; Delaware (May); Georgia (August); Hawaii (June); Indiana (June); Iowa (May); Kentucky (August); Maine (December); Maryland (June); Mississippi (May); Montana (July); New Jersey; North Carolina (spring); South Carolina (June); Utah (October); Wisconsin (September); and Wyoming (July).

Governors, legislators, state health and Medicaid officials, people with disabilities and their representatives and the federal government have played strong roles in the planning process in most states.

The Role of Governors. The governors in 17 states have created the commissions; several of them also have appointed many of the commission members. Governors in 10 states—Arkansas, Delaware, Indiana, Kentucky, Maryland, Missouri, Ohio, South Carolina and Texas—issued executive orders to create their work groups. Governors in the remaining eight states also played proactive roles in creating the commissions but did not do so through executive orders. As a result, these commissions will issue their reports to the governors and, in many cases, to the legislatures as well.

The Role of State Legislatures. Planning also has been closely tied to the legislative process. Legislatures in California, Hawaii, Illinois and Kentucky enacted legislation to form their commissions. The Alaska Legislature enacted a law in 2000 requiring the state Department of Health and Social Services to submit an annual report concerning the waiting list for people with developmental disabilities. The governor in Kentucky issued an executive order to create an *Olmstead* Coordinating Council, but the legislature established two commissions to work on state plans for mental retardation/developmental disabilities and mental health. Likewise, although Iowa's governor had directed the Department of Human Services to be the lead agency for *Olmstead* planning in May 2000, the General Assembly's Legislative Council authorized the creation of the Mental Health and Developmental Disabilities Services Task Force in June 2000 to recommend ways to improve service delivery for these populations.

Legislators and legislative staff sit on the commissions in Missouri, Utah and Wisconsin. However, legislatures will likely play their most significant roles during the next legislative session when most of the commissions have developed their plans and agencies will be submitting budget requests to implement the plans.

The Role of State Executive Branch Agencies. In the vast majority of states, the lead agency for the commissions is either the health and human services department or the Medicaid agency. In fact, commissioners of these departments formed many of the work groups. For the most part, agencies such as Medicaid, health and human services, mental health, aging, housing, education and rehabilitation services are directly involved in creating their state plans.

The Role of People with Disabilities. Most states are involving people with disabilities throughout the planning process. In fact, several of the executive orders and some legislation directly resulted from the efforts of people with disabilities, and these orders often include provisions requiring that *Olmstead* task forces and work groups include people with disabilities as members. Even in those states where the plans are being created as an interdepartmental effort, state officials are trying to involve people with disabilities by holding forums across the state and sharing draft copies of the plan for feedback. In some states, the commissions are building upon the prior work of advocates. In New Jersey, for example, an independent coalition of consumers, advocates and family members-called the New Jersey ADA Coalition-had been meeting since September 1999. This coalition prompted the governor to engage in interdepartmental planning and to develop a plan. Before Missouri's Home and Community-Based Services and Consumer Directed Care Commission was formed, there was a stakeholders group of consumers, providers and state officials. The commission's work contains many stakeholder recommendations.

The Role of the Federal Government. The federal government has taken many actions to implement the *Olmstead* decision-several of which are important to state legislatures. These actions include issuing guidance letters, revising its policies, holding meetings with the states and giving more than \$70 million in planning or demonstration grants to the states to expand community-based options.

The Office of Civil Rights (OCR) has been given the authority to oversee *Olmstead* enforcement. As part of this effort, OCR has formed an *Olmstead* Workgroup, comprised of its representatives as well as HCFA officials, which meets on a monthly basis to respond to questions received from states and to discuss the need for written guidance. Both OCR and HCFA officials have participated in meetings with state officials to discuss the importance of the decision and to review current policy directions. Additionally, between January 2000 and the present, HCFA and OCR have jointly

released five “*Olmstead*” letters to state Medicaid directors and other state agencies providing guidance for developing comprehensive, effectively working plans for implementing the *Olmstead* decision. The letters also include HCFA clarifications and modifications to federal Medicaid policy to facilitate state efforts to enable people with disabilities to be served in the most integrated settings appropriate to their needs.

In January 2001, HCFA announced new awards exceeding \$70 million that will be distributed to states in September 2001. They include 1) \$50 million in “Real Choice Systems Change Grants,” designed to help states improve health and long-term care systems for seniors and people with disabilities; 2) \$15 million in grants, along with Section 8 housing vouchers, to help all people with disabilities move from institutions to community-based settings; and 3) \$8 million to enhance community-based personal assistance services to ensure maximum control by people with disabilities of all ages. More information about these grants is available at <http://www.hcfa.gov/medicaid/smd110a1.pdf>.

The scope of the work of most commissions is broad and includes all people with disabilities.

Although the *Olmstead* case involved two women with both mental illness and developmental disabilities, the federal government has made it clear that the Supreme Court decision involves all disabled people, regardless of age. Thus, most states are assessing their systems of care for people with developmental disabilities, people with physical disabilities, people with mental illness as well as older people with disabilities. In addition, plans include many subgroups, including 1) institutional residents whose needs can be appropriately met in the community, 2) residents in community-based settings who require institutional care, and/or 3) people who reside in the community and are at risk for institutionalization because of the absence of care.

The planning process has been rather slow, given the many barriers, pending lawsuits and arising complexities.

The slow pace of the planning and implementation efforts has frustrated many advocates, given that it already has been almost two years since the *Olmstead* ruling. However, state officials point to the challenges of reaching consensus among the different stakeholders. This work is essential if the plans are to be implemented, but such a process generally is lengthy. In addition, the task forces are working on complex issues that go beyond Medicaid and health care; the issues extend to transportation, education, housing and other supports. The biggest issues of complexity identified are how to:

- Assess people who are at risk for institutionalization;
- Define institutionalization and review and measure placement activities in institutions;
- Develop the service infrastructure within the constraints of the personal care attendant and nursing aide shortage;
- Find accessible, affordable community-based housing;
- Access transportation; and
- Identify sources of funding within state budgets.

In addition, several lawsuits are pending. The effect of these cases is mixed. Lawsuits filed or pending in many states are influencing state efforts, either by making this issue a higher priority for attention or by raising the degree of caution among state officials who are fearful of releasing information. In the long run, however, lawsuits in individual states may clarify the scope and breadth of the *Olmstead* decision.



Although several states do not have a commission or any other Olmstead-specific activities planned or under way, they are responding to the ruling in other ways.

Fourteen states are not engaged in or do not plan to engage in any specific *Olmstead* activities. Some already had the planning processes for home and community-based care in place before the *Olmstead* decision. Some are in the midst of lawsuits, and some have chosen to move toward more community-based care through the budgetary process.

As a result of a 1999 lawsuit settlement, for example, Oregon already had a six-year plan to eliminate the waiting list of more than 5,000 people for its waiver program that serves people with developmental disabilities. The state will create 50 new non-crisis placements per year for six years and will increase personal and respite care. Of its available total Medicaid long-term care funds, Oregon spent more of its budget on home care (56 percent) than on institutional care (44 percent). As of FY 1999, it was the only state to do so.

Vermont, which often is cited as a model state, is not working on an *Olmstead*-specific plan because it has implemented a range of activities over the years that are related to downsizing institutions and moving toward home and community-based care. State officials and advocates seem to concur that the state is in full compliance with the *Olmstead* decision. No institutions exist for individuals with developmental disabilities, and all nursing facility residents have been assessed for community-based service options. As one advocate stated, “*Olmstead* is not being used because it is not needed. The commitment is already there.”

Nebraska’s governor has requested significant increases in spending for home and community-based services for people with mental illness and people with developmental disabilities. Nebraska’s approach to the *Olmstead* decision is somewhat different than that of other states. It is their position that the decision requires not an overall plan but a plan for each individual. State officials believe the current system meets this requirement. Therefore, the state is focusing on improving the processes and applications of the existing policies. To that end, agencies within the Department of Health and Human Services have made budget requests focusing on client-specific plans within the framework in place, but they have not necessarily identified the requests as directly related to *Olmstead*.

Conclusion

At this point in time, it is too early to determine the full effects of the *Olmstead* decision. Every state is moving toward more home and community-based services, although some are moving faster than others. However, this study shows that most states are responding to the *Olmstead* decision by developing a plan, appropriating more money toward home and community-based services or, in many cases, are doing both.

The Court decision has caused providers, consumers and state officials to come together with the shared commitment to provide more community-based services and reduce the waiting lists for such services. It also has caused the federal government to revise its policies in this area and to offer states flexibility and funding for them to develop innovative solutions. At the same time, several lawsuits have been filed or are pending in the states as a result of a lack of home and community-based alternatives. *Olmstead* implementation will take many years, and it involves not only health care but transportation, housing, education, and other social supports to fully integrate people with disabilities into the least restrictive settings.

This study is a work in progress. Please contact Wendy Fox-Grage at (202) 624-3572 or wendy.fox-grage@ncsl.org if the authors have incorrectly reported or inadvertently omitted certain *Olmstead* activities. □



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Last Updated: 04/17/01

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Alabama

Alabama received a grant from the Center for Health Care Strategies to develop a comprehensive plan in response to the *Olmstead* decision. Officials from the Long Term Care Division of Alabama Medicaid are spearheading this effort. They are working with state officials from the Department of Mental Health, the Department of Human Resources, the Department of Public Health, the Governor's Office on Disabilities, representatives from provider groups, consumer advocates and people with disabilities.

The group has been holding meetings throughout the state and has established several subcommittees to work on developing the plan, which should be completed by early summer.

The state already facilitates assessment of institutionalized disabled people for movement into less restrictive care settings, immediately acting on requests from people who want to move back to the community. This resulted from the *Wyatt vs. Sawyer* settlement agreement signed in January 2001, which established specific assessment procedures and called for a plan to be developed to identify people with mental illness and with developmental disabilities to begin on October 1, 2000 to September 30, 2003. The plan discusses: reduction of institutional beds, discharge planning procedures, development of community placement and certification of providers. Attorneys working on *Wyatt* sit on the Governor's Olmstead Committee, so similar procedures will be included and extended to address those individuals in nursing homes as well as those who are at-risk. For future assessments under the *Olmstead* plan, the group also has been in touch with the Department of Rehabilitation Services' Independent Living Unit to identify specialists who will be able to identify unnecessarily institutionalized or at risk people.

The state plan will expand access to home and community-based services for all disability groups mentioned in the *Olmstead* decision, but will not be limited to those groups.

The primary barrier to completing the plan is funding-the state wants to be able to provide these services in a different way (i.e., in the home or community). Without money, however, they will not be able to do all that they would like to do. Another barrier is the disagreement among consumers, providers and the government about the best way to provide these services.



Alaska

Like some states, Alaska has a history of planning for and providing services to people with disabilities that predates both the Americans with Disabilities Act and the *Olmstead* decision. There are several state planning and advocacy boards with formal, and, in many cases, statutory responsibilities related to disabled individuals and most of these entities have established planning processes and publish formal plans. To some degree, they all include representation of Alaskans with disabilities or their advocates and provide for public participation in their planning processes. State officials believe it would be inappropriate to establish a separate *Olmstead* comprehensive plan or task force when existing entities already have the statutory responsibilities for formal planning.

Within the executive branch, several departments work together to coordinate the implementation of long-term care services. Historically the administration has drawn on input from many sources, including the planning and advocacy boards mentioned above, to develop their implementation plans for long-term care services. Recently, the administration asked these entities to review an implementation plan to determine whether it captures the key elements of their proposals.

Because of the efforts of many Alaskans - the state planning and advocacy entities, the executive branch, the legislature, as well as advocates and consumer groups - Alaska officials feel they have made solid progress both in planning and in making efforts to serve people in the most integrated setting. Alaska was the first state to close its intermediate care facilities for the mentally retarded and has the lowest ratio of nursing home beds to population and the highest ratio of residential beds to nursing home beds. State officials have used Medicaid Home and Community-Based Services (HCBS) waivers to fund the development of integrated services that now provide almost \$50 million in HCBS serving 2,000 people annually.

To date, no lawsuits have been filed in Alaska in response to the *Olmstead* decision.



Arizona

The governor directed officials in the Department of Human Services (Behavioral Health Services), the Department of Economic Security (Division of Developmental Disabilities), and the Arizona Health Care Cost Containment System (the Medicaid agency) to prepare plans to address the issues raised in *Olmstead*. These officials are in the process of completing their plans, with a target of July 2001. Details of their progress can be found at <http://www.ahcccs.state.az.us/Regulations/Olmstead/Attachments.asp>. To date, *Olmstead*-specific budget requests have not been made.

Each of the three agencies is committed to obtaining input from stakeholders. Several public forums have been held, and each agency has delivered (or has pledged to deliver) its draft plan to advocates, providers, families and consumers and, where feasible, to include recommended changes into the final version.

As evidenced by the involvement of the three agencies, Arizona's plan will address individuals with mental illness, the elderly, and the physically and developmentally disabled. The plans will focus on moving individuals from institutions into community settings and on preventing the loss of services for those already in the community.

One of the biggest problems faced in the planning process is the extreme shortage of providers. That, combined with the relatively low reimbursement rates (partially the result of tight budgets), has raised concern among officials about successful implementation. Because they are at an early stage in the process, it is difficult to estimate what effect this will have. A suit, *Bell vs. Beidess*, addressing this issue was filed against the Medicaid director and currently is pending in federal district court. The plaintiffs, a group of disabled individuals, claim they have been or will be denied adequate attendant care services prescribed in their care plans. The state is arguing that they are unable to find providers who are willing to work for the low wages.



Arkansas

On May 16, 2000, the governor of Arkansas issued an executive order directing the Department of Human Services (DHS) to develop a working group to conduct a comprehensive review of the state's existing services and support systems for Arkansas' disabled citizens and to identify ways to increase community-based services for this population.

On February 15, 2001, the Arkansas *Olmstead* Working Group—made up of officials from DHS, interested consumers, advocates and providers—delivered a report to the governor on the group's progress. The report contains background information on the issue, recommendations for future work and a timeline for developing and implementing a statewide *Olmstead* plan. Recommendations include the following.

1. State officials and other interested parties should identify legislation and funding priorities, both at the state and federal levels, that would improve access to home and community-based services.
 2. The state should adequately fund existing developmental disability (DD) waiver programs.
 3. The state should provide periodic treatment assessments for all people subject to Title II of the ADA, give disabled consumers the option of receiving home and community-based services when recommended, and develop an assessment program to gauge a consumer's choice of receiving these services.
 4. The state should organize transition teams that will assist people who are making the transition from institutional care to home or community-based care.
 5. An ongoing task force should be appointed to continue the work of the *Olmstead* Working Group.
 6. The state should reconvene a Supported Housing Task Force that will focus on developing additional housing options for people with disabilities.
 7. The state should apply for a Real Choice grant from HCFA to facilitate the development and implementation of a comprehensive, effectively working plan.
- According to the report's proposed timeline, a complete draft of the state plan will be complete by October or November 2001.

The state intends to apply any expansion of home and community-based services to all age and disability groups.

There have been no lawsuits filed in the state pursuant to the *Olmstead* decision, although there have been two specific complaints filed with DHS; these complaints have since been resolved.

California

The Legislature enacted AB 452 during its 1999 legislative session to create a Long-Term Care Council, chaired by secretary of the California Health and Human Services Agency. The Council is directed by law to coordinate long-term care policy development and program operations and to develop a strategic plan for long-term care policy.

The council is an interdepartmental, interagency council that coordinates long-term care policy and program operations. Directors of the following departments—Department of Aging, Department of Developmental Services, Department of Veteran Affairs, Department of Health Services, Department of Mental Health, Department of Social Services, Department of Rehabilitation, and the Office of State-wide Health Planning and Development—sit on the council. They have been charged with developing a strategic plan for long-term care policy. Thus, the law requires the council to provide to the Legislature, on or before January 1, 2003, a study of trends affecting the need for long-term care services and other supports for seniors and younger adults with disabilities. Before January 2001, the council, as required by the law, reported annually to the Legislature.

The council recommended short-term priorities for September 2000 to June 30, 2001, that provide a foundation for some of the long-range strategic activities under consideration. They are:

1. Seeking input from long-term care stakeholders by holding at least four “Listening Sessions” throughout the state to hear from consumers and their families;
2. Developing a consumer information work group to improve consumer information on long-term care options;
3. Implementing the Challenge Grant to expand community alternatives to nursing home placement;
4. Improving interagency coordination, streamlining the consumer referral process and simplifying the state data reporting process;
5. Reviewing and developing assessment tools and assessing the process for identifying consumers for assessment, where and when to conduct these assessments, who should be conducting these assessments, and determining how this process and information gathering would tie into the consumer’s next step whatever it may be;
6. Establishing a work group to collect and inventory the long-term care data currently being collected by public programs at the state level;
7. Establishing another work group to assist in the development of a Medicaid waiver request to conduct assisted living pilot projects;
8. Examining innovative models and strategies in the long-term care licensing process; and
9. Developing a draft Long-Term Care Strategic Plan.

A lawsuit currently is pending in the state that relates to large public nursing homes. *Davis vs. California*, a class action lawsuit, alleges that the city and county of San Francisco, as well as several state agencies, are violating the Americans with Disabilities Act by failing to utilize Medicaid funding for home and community-based services and instead committing the vast majority of available funding to a 1,200 bed nursing facility, the largest of its kind in the U.S. The state also recently settled a case, *Richard S. vs. California*, after a district court ruled that a hospital policy giving family members the right to veto a treating professional’s finding that community placement is appropriate violates the Americans with Disabilities Act.

Colorado

The Colorado Attorney General's Office has interpreted the *Olmstead* decision as not requiring a comprehensive plan. Nonetheless, and absent legislative action or an executive order, state officials are in the process of developing a plan. The plan will be developed in three areas—developmental disabilities, mental illness, and physical disabilities and aging. The Department of Human Services will oversee the first two, with the respective divisions handling each section of the plan. The Department of Health Care Policy and Finance will oversee the physical disabilities and aging area.

Because the plans are still being developed, little information is available. The proposed timeline has drafts available by June 2001. However, it appears that the main issue to be addressed by the plan will be waiting lists for individuals receiving care in institutions who are assessed as able to obtain community-based care. The plan is not likely to address individuals who are not receiving care or individuals who are at risk of losing community-based care. To that end, the plans probably will focus on the assessment procedures used and the ability to transfer individuals when they are eligible. State officials have requested input from existing advisory councils and other advocacy groups.

Several suits have been filed regarding *Olmstead* issues, and decisions are pending. At least one of the suits relates to individuals who want to remain in an institution after they have been assessed as eligible to receive community-based care. Another case, *Mandy R. vs. Owens*, is a class action suit on behalf of individuals with developmental disabilities on Medicaid waiver waiting lists.



Connecticut

Connecticut is in the process of developing a comprehensive plan for community integration. The Long-Term Care Planning Committee-comprised of legislators and eight state agency representatives-was established by the Connecticut legislature in 1998 to focus on the elderly, but broadened its focus in early 2000 to also work on *Olmstead* planning. State officials view the issue of providing home- and community-based services as a priority independent of the *Olmstead* decision, so the implications are important in a broader sense.

Although the legislature has shown some interest in *Olmstead*, the Department of Social Services (DSS) has spearheaded and coordinated *Olmstead* compliance efforts. Linda Mead is with DSS and is overseeing the planning process. She is co-chair of the Community Options Task Force, along with Cathy Ludlum of the Connecticut Council of Persons with Disabilities. The task force-comprised of individuals with disabilities and advocates-is separate from the Long-Term Care Planning Committee. It was created to help develop the comprehensive plan and provide advise to the Long-Term Care Planning. The Department of Health and Human Services' (DHHS) Office of Civil Rights also has been informally involved in the process through several meetings.

DSS and the Community Options Task Force are developing a community integration plan-called Choices Are for Everyone-that is in draft form. The third draft was released in September 2000, and since then the Task Force has held five public hearings and one forum to gain input on the plan. The next draft is expected to be more detailed and will be made available in February 2001. The final plan will likely be released in June 2001.

Choices Are for Everyone outlines the following major goals.

1. Developing new options related to community integration that were approved in the 2000 legislative session:

- Eligibility changes for elders receiving home care;
- Eligibility changes for people with disabilities who are working;
- Minor home modifications;
- Assisted living services;
- Increase adult day care and home care rates;
- State-funded pilot program of personal assistance services for elders;
- Possible expansion of model waiver, subject to appropriations;
- Pilot program to provide additional housing benefits for certain people with severe physical disabilities;
- Integrated behavioral health service delivery system for children;
- Increased housing options for people with psychiatric disabilities;
- Interagency collaboration between departments of Mental Health and Addiction Services and Department of Children and Families regarding families at risk and transitioning youth;
- Funding to continue development of community services;
- Special funding to people with acquired brain injury to assist them in accessing the Medicaid waiver; and
- Several Department of Mental Retardation community support initiatives.



2 **Proposing additional services and supports for the future.** State agencies responsible for providing services for people with disabilities currently are reviewing the list of priorities identified by stakeholders and are considering possible legislative and budgetary proposals for the coming biennium. The final report will include any proposals recommended in the governor's budget.

3 **Developing a system for monitoring quality and outcomes.** The state will need to develop a system for monitoring quality and outcomes of this comprehensive plan. This may include conducting surveys and focus groups, reporting and tracking complaints, and enhancement of data systems.

4 **Developing targets for deinstitutionalization.** Development of targets has been difficult from the state's point of view because the executive branch is just beginning to plan its budget proposals for the coming biennium. This topic is still under discussion.

The state is pursuing initiatives that are already under way for enhanced home and community-based service options. Any new funding for community integration efforts will need to be decided by the Connecticut legislature; its current session ends in June 2001. The state has identified existing waiting lists for community services, but more data analysis is needed to determine the number of individuals who are inappropriately residing in institutions. The state intends to apply any expansion of home and community-based services to all disability and age groups.

The greatest barriers to moving forward with *Olmstead* compliance are resources. Specifically, the state needs to work on developing the infrastructure to carry out its plan and on finding necessary services in the community. Eventually, state officials believe the state will be able to use existing institutional resources to help fund home and community-based options, but the state must sustain both at first. No lawsuits have been filed in the state pursuant to the *Olmstead* decision, although there have been individual complaints filed with DHHS' Office of Civil Rights. State officials believe they have worked hard to involve various constituent groups in the planning process to garner support for the plan.



Delaware

On May 17, 2000, Delaware's Governor issued an Executive Order expressing the state's commitment to provide community-based services for people with disabilities. The order required the Delaware Department of Health and Social Services (DHSS) to submit three separate plans. The first, with a deadline of November 1, 2000, was to address persons with developmental disabilities and mental retardation. The second, with a deadline of March 1, 2001, is to address the mentally ill. The third, with a deadline of May 1, 2001, is to be a "comprehensive review of all services and support systems available to all people with disabilities in Delaware." Each of the plans was to include consumers, advocates, service providers, and the appropriate agencies in its processes.

The first plan was completed on or about its deadline date but was not accepted and has been returned to the committee for additional work. The second and third plans are still in the developmental stages. Plan two will not make the March 1st deadline and the committee for plan three has met only once or twice.

The Delaware plans will address institutional residents who could be cared for in community-based settings as well as persons at risk of institutionalization due to lack of available care. One of the principal issues to be dealt with is the waiting list for home and community-based services (HCBS). Like other states, Delaware is faced with a shortage of providers. In addition to HCBS providers, nurses are in short supply. Their sole mental health inpatient facility has been warned by HCEA for low nurse to patient ratios. Reportedly, there are nearly 60 openings on their nursing staff.

Funding is also an issue in Delaware. However, it is compounded by the incomplete status of their plans. The FY 2001 appropriations had approximately \$1.8 million for community-based services. The legislature held its FY 2002 health and social service appropriations hearings in March 2001- well before any of the three plans were finished. This will likely push any significant implementation into FY 2003.

To date, no Olmstead related suits have been filed in Delaware. However, one complaint was filed with the Office of Civil Rights on behalf of a class of mentally ill persons at the inpatient facility. That action is pending.

District of Columbia

The Medicaid agency within the Department of Health has convened an advisory council of providers and consumers to advise them on the Olmstead decision. D.C. Medicaid is meeting with a group of consumer and provider representatives to address Olmstead-related activities. The agency will expand this effort and add more representatives, including across-DC government component.

Currently, the Department is seeking budget authority within the 2002 budget for initiatives aimed at improving long-term care service delivery. Specifically, the Department is hoping to develop a Resource Center to help the city create a service delivery model similar to Wisconsin's Family Care program. As now conceived, the new service delivery model would start with frail elderly persons and persons with physical disabilities, and then, if successful, be extended to persons with developmental disabilities and persons with mental illness. The model would focus both on persons now in institutions and persons who are applying to enter them. The department also is working on amending its 1915 c waiver serving individuals age 65 and older to expand to serving adults with physical disabilities under age 65, attendant care and assisted living. The District recently settled a case, *Evans vs. Williams*, on behalf of individuals with developmental disabilities who were not receiving adequate community supports. The settlement requires detailed actions that the District must take to provide community services and establishes a set of measurable outcomes to gauge the effectiveness of these services.



Florida

Executive branch agencies are unlikely to begin a formal planning process around Olmstead in the absence of legislative authority. As of yet, there has been no legislative action related to creation of such a group. Among the programmatic activities slated for implementation during Fiscal Year 2001 are the following:

1. Doubling the number of waiver slots —up to 26,000— for persons with development disabilities;
2. Implementing a nursing home transition grant for persons with Traumatic Brain Injuries in nursing homes;
3. Continuing the operation of ten home and community-based waivers;
4. Submitting a Medicaid state plan amendment authorizing assisted living; and
5. Making available statewide a demonstration program on assertive community treatment for people with behavioral health needs.

Last August, the state settled a class action suit, *WolfPrado Steiman vs. Bush*, agreeing to improve services for individuals with developmental disabilities on Medicaid waiver waiting lists. The detailed settlement agreement provides that, effective July 1, 2001, substantial compliance with several detailed time frames will constitute reasonable promptness, including that if a waiver slot and funding are available eligible people shall be provided with these services within 90 days of receipt of the waiver application.



Georgia

The Governor ordered the formation of the “Blue Ribbon Task Force on Home and Community-Based Services” to deal with issues covered by the Olmstead decision. He later directed the Department of Human Resources (DHR) to apply for, and then carry out the activities of, a grant from the Center for Health Care Strategies. Thereafter, the Governor and the DHR Commissioner named the Division of Mental Health, Mental Retardation and Substance Abuse (DMHM RSA) as responsible for planning. DMHM RSA is working with the Department of Community Health (Division of Medical Assistance), the Division of Aging Services, the Division of Children and Family Services, the Office of Regulatory Services and the Governor’s Council on Developmental Disabilities. Additionally, several groups of consumer advocates, service providers, and families have been, and will be, involved in the planning.

These groups are to have a draft plan developed by August 2001. The plan will address individuals with developmental and physical disabilities, mental illness, the elderly, and other individuals with chronic long-term care needs. It will also encompass those currently in facilities, if they require that care or if they could receive community-based care, and those at risk of institutionalization.

Because the planning is in its early stages, it is unclear to what extent financing will be a barrier. Other than the Olmstead decision itself, no other suits have been filed in Georgia though, reportedly, several have been threatened.



Hawaii

The director of the Department of Human Services (Medicaid agency) initiated an *Olmstead* planning discussion in Hawaii after HCFA sent state Medicaid directors a letter regarding state compliance with the *Olmstead* decision. The legislature passed a concurrent resolution (HRS 196) in May 2000 to establish an *Olmstead* planning task force and required the task force to report to the governor by June 2001. In response, the state set up a tri-chaired *Olmstead* planning committee-chaired by Dr. Chandler, director of the Department of Human Services; Bruce Anderson, director of the Department of Health (Disability and Communication Access Board/Executive Office on Aging in this department/Development Disabilities Division); and the executive director for the Center for Independent Living.

The committee has held four meetings and set up four task forces based on different planning areas: 1) assessment (who is eligible for what services); 2) information (this is the committee's top priority: awareness of what is available, working on single point of entry system); 3) finance; and 4) infrastructure. The infrastructure task force covers three areas, including a focus on housing, transportation (especially to neighbor islands) and personnel. The personnel issue is an emerging concern; training programs have been initiated but people are not showing interest.

The committee's approach is to include a broad range of disability groups in the planning efforts, rather than focusing on specific groups. Using this approach, the committee is trying to work on crossover issues such as housing, transportation and information that apply to all groups, rather than catering to specific interests. One problem-solving exercise committee members have performed is having a case manager discuss opportunities and barriers in the community in front of agency officials and members of the private sector. This has been a way of making the issues more concrete.

The legislature began its 2001 session on January 17. The *Olmstead* committee will report its progress to legislators, but it is not ready to submit a plan. The governor has approved \$2 million for expansion of home and community-based services, but no requests have been made by state agencies specific to *Olmstead*.

A lawsuit against the state in response to *Olmstead* was settled recently. The case, *Makin vs. Cayetano*, was filed because the defendants believed the developmental disabilities waiting list was not moving quickly enough. The state agreed to fund 700 additional community placements over three years. In the case, the federal district court confirmed that the *Olmstead* decision applies to not just individuals currently institutionalized but also to individuals living in the community who are at risk of institutionalization because of a lack of community supports.



Idaho

Idaho is in the early stages of developing a comprehensive plan through a working committee for community integration. The committee was created by the governor's office, although not by an executive order. The Legislature has not passed any laws in response to *Olmstead*. However, it has instituted some measures that limit spending for certain Medicaid items, including community services for people with mental illness or developmental disabilities. In the same appropriations bill, funding was approved for a new 60-bed inpatient facility.

The Community Integration Committee includes representatives from the Division of Medicaid, the state hospitals, the Developmental Disabilities Program, the Mental Health Program, the Commission on Aging, the state Mental Health Planning Council, the attorney general's office, vocational rehabilitation agencies, consumer advocates and consumers (including family members). A representative from the governor's office attends committee meetings, and the governor has been meeting with the co-chairs.

Because the plan is in its early stages, many of the details are not available. For example, it is unclear whether-and, if so, how-people with disabilities will be grouped. Additionally, it is not clear whether the plan will address only those institutionalized when unnecessary or if it will include others such as those in the community who are a) not receiving necessary institutional care or b) at risk for institutionalization due to the absence of care. Likewise, the committee hopes to address how it will assess the number of unnecessarily institutionalized people.

Although no suits have been filed in direct response to *Olmstead*, other suits are pending that relate to similar issues. These suits have helped direct the state's efforts. As in most states, however, funding remains an issue.



Illinois

The Illinois legislature initiated activity around *Olmstead* in the spring of 2000 when it passed House Resolution 765, directing the Department of Human Services to convene a broad-based group to discuss *Olmstead* and develop a plan pursuant to it. A report on the group's proceedings and steering committee recommendations were filed with the legislature in January 2001.

The 2001 report included position papers from each of six topic areas worked on by the group, in addition to dissenting opinions given in response to the papers. The steering committee report is available at http://www.state.il.us/agency/dhs/od_scr.html. Recommendations made in the position papers follow.

1. **Olmstead Financing Working Group Report.** Recommended action steps include:
 - The state develop by February 28, 2001, a list of the type and quality of services that need to be developed in the community to support people with disabilities.
 - The state assess by August 31, 2001, the needs of all those waiting for community services and those individuals exiting the special education systems, and make an annual assessment.
 - The state immediately support the development of new services and supports that are the “most integrated settings” in the community.
 - Make available by December 31, 2001, freestanding independent service coordination to all state residents with disabilities to assist those individuals and families by assessing the availability of community services in the “most integrated setting.”
 - Fund by December 31, 2001, self-determination projects-such as Centers for Independent Living and People First-in every county in the state, with Cook County divided into subdivisions.
 - Develop and promote regional assistive technology centers by December 31, 2001, to assist individuals with disabilities in their life needs.
 - Adjust the annual cost of doing business increases automatically in line with the consumer price index for that fiscal year.
 - Policymakers establish reasonable rates that cover actual costs to assist individuals to move to and remain within the “most integrated setting” within their communities.
 - Provide institutional services to individuals until the transition to community services has been determined successful.
 - Develop by December 31, 2001, a quality assurance/monitoring program.
 - Ensure that the quality assurance/monitoring program is conducted by independent, freestanding entities.
 - Develop a consumer satisfaction survey by July 30, 2001.

2. **Olmstead Universal Prescreening and Community Reintegration Working Group Report.** Recommended priorities include:
 - Informed choice/person-centered plan with individual budget;
 - Universal pre- and post-screening, which includes education of families regarding community-based services.



- Develop and improve community reintegration resources and services, including more than one chance for successful reintegration.
- Educate facilities and treatment professionals regarding *Olmstead* and community resources and options to consumers.
- Complete plan for students to make the transition from school to community to work.

3. Olmstead Housing Working Group Report. Recommendations were made for housing accessibility, housing integration, consumer choice of housing, housing affordability and housing finance.

4. Olmstead Service Coordination and Public Policy Working Group Report. Recommendations were made to:

- Remove institutional bias from state funding, statutes, regulations and policies;
- Provide equal access and rights to community services and supports available, regardless of age and disability;
- Make available community-based coordination of care for people with disabilities who choose this mechanism to ensure their needs are periodically evaluated and met with appropriate services and supports;
- Maintain a reasonably paced waiting list for individuals who are not fully funded to make the transition to the most integrated setting; and
- Establish a standing committee of all stakeholders to monitor the coordination of entities and efforts and offer ongoing oversight of multi-agency implementation.

5. Olmstead Community Infrastructure Working Group Report. Recommended actions include:

- Presenting a draft “*Olmstead* plan” to the legislature that details the level of state compliance with the *Olmstead* decision.
- Identifying people in institutions who desire to move to the community, regardless of age and disability, and identifying what services they need to do so, regardless of age or disability.
- Ensuring that people who are identified as wanting to move out of institutions receive transitional assistance.
- Ensuring that Medicaid money will follow an individual if that individual chooses community services instead of a nursing home.

6. Olmstead Best Practices Working Group Report. Recommends examples of policies and programs that already have been established in other states and in the world around the following issues:

- Self-determination;
- Informed choice;
- Open and improved communications; and
- Successful transition into the community.

The Department of Human Services (DHS) was named the lead agency to coordinate *Olmstead* activities among its offices of mental health, developmental disabilities, rehabilitation services, transitional services (housing) and other affected state agencies, including the Department of

Public Aid (Medicaid agency), the Department on Aging, the Department of Children and Family Services, the Department of Public Health, and the Illinois Housing Development Authority.

Timeline of activities:

- August 2000-Stakeholders (about 250 people) convened.
- September 2000-Stakeholders selected workgroups based on the topics they wanted to work on.
- September/October/November 2000-Workgroups met. Each group worked on a position paper with specific recommendations and strategies in their topic areas.
- December 13-14, 2000-Position papers presented to the Intrastate Agency Team.

Members of the various workgroups formed a steering committee (of 33 people) that presented the position papers to the DHS Secretary and other agency officials. The state agencies will analyze the feasibility of implementing the recommendations. Some recommendations may be implemented immediately, while others, requiring programmatic and or policy redesign will take more consideration.

Similarly, the intrastate agency team that was established to bring together all government agencies involved will evaluate current service delivery in a cross-disciplinary way so that improvements can be coordinated. One early outcome of the *Olmstead* decision is that it provides a framework where people who would not ordinarily engage in joint problem solving are finding it possible and even necessary to work collaboratively.

The *Bureau vs. Ryan* class action suit is pending on behalf of individuals with developmental disabilities who are eligible for Medicaid services under the waiver but are not receiving them because of overly restrictive application procedures.



Indiana

Indiana officials are in the early stages of planning their response to the *Olmstead* decision. The first meetings were held in November 2000, following an executive order issued in September. The planning effort was designed to effect the governor's wishes in a way that recognizes and responds to existing and potential problems. It was also intended to be attentive to the needs and priorities of the disabled, their families and advocacy groups. Details of their planning effort can be viewed at <http://www.state.in.us/fssa/servicedisabl/olmstead/index.html>. To date, the legislature has dealt mainly with appropriations. Several bills dealing with various community integration and disability issues have been introduced, and they are pending committee action.

The governor identified the Family and Social Services Administration (FSSA) as the agency in charge of *Olmstead* planning and gave it until June 1, 2001, to submit its recommendations. The initial part of the plan was to have FSSA conduct a comprehensive study of all services and programs available to people with disabilities in Indiana. Also, employees of the several relevant departments within FSSA have been meeting with the members of three committees appointed by the FSSA secretary. These committees, the members of which include people with disabilities, their families, consumer advocates, and service providers, were formed to ensure participation from outside the governmental realm.

The Indiana plan will include individuals with physical and developmental disabilities, as well as those with mental illness and the elderly. Further, it addresses current residents of institutions in regard to whether they can or cannot be served in a community-based setting and people living in the community who may be at risk of institutionalization due to a lack of adequate services. Currently, assessment procedures are handled on a case-by-case basis. A standardized evaluation is being developed for people with mental illness. Although one currently exists, it often is not used to determine admission to long-term care facilities.

Indiana officials, recognizing the heavy institutional bias which has existed for many years in the state, are working to minimize institutional and to maximize community-based care. They have not made *Olmstead* budget requests per se, but the FSSA does request funds to deal with the general issues addressed by the *Olmstead* decision. Nonetheless, as in most states, funding is one of the major obstacles to a completely successful plan. Other difficulties are providing community-based services and identifying appropriate housing.

Two lawsuits, filed on behalf of physically disabled individuals, are pending. One case, *Inch vs. Humphrey's*, specifically challenges a failure to provide services in the most integrated settings to individuals with disabilities living in nursing facilities. Although these suits have almost certainly affected the state's efforts, it is unclear to what extent.



Iowa

In May 2000, the governor, in response to the *Olmstead* decision and the January 2000 letter sent by the U.S. Department of Health and Human Services, asked the state's Department of Human Services (DHS) to be the lead agency for *Olmstead* planning. Currently, officials are in the late stages of developing their comprehensive plan. Details of their progress can be found at <http://www.dhs.state.ia.us/mhdd/mhddolmstead.htm>. No *Olmstead*-specific line items have been appropriated, or requested. In June of 2000, however, the Iowa General Assembly's Legislative Council authorized the creation of the Mental Health and Developmental Disabilities Services Task Force (MHDDSTF). This task force is to recommend ways to improve service delivery for these populations.

In mid-2000, the DHS conducted 18 public meetings and several site visits to review the status of the current system and gather information to be used in formulating its plan. A report, generated for the Governor, can be found at <http://www.dhs.state.ia.us/mhdd/MHDDOlmstead%20Report.doc>. The report identifies current initiatives, including a Medicaid buy-in for people with disabilities, case management for the elderly, and the MHDDSTF. It also identifies the gaps that exist in the service delivery system. The first issue addressed is eligibility. The report notes that, traditionally, funding was limited to people with mental illness or mental retardation and this should be expanded to cover additional diagnoses. The other issue addressed is the capacity of the service delivery system. Like many states, Iowa faces a shortage of medical service providers. This is compounded by the nature of some disabilities (i.e., dual diagnoses, rare conditions, behavioral inconsistencies, etc.) Additionally, a shortage of affordable housing further complicates efforts to move people into the community.

The steering committee includes advocacy groups, providers, families, consumers, DHS employees and county administrators. The goal is to identify all relevant issues by mid-March and have a draft plan available for comment by April 15. These comments will be put into the final plan by May 15. FY 2003 budget recommendations will be made to the governor in July and to the legislature by early fall.

To date, no *Olmstead*-related lawsuits have been filed in Iowa.



Kansas

The Kansas Department of Aging and the Kansas Department of Social and Rehabilitation Services work group formed in February 2001. This group has created two subcommittees: one to draft a report on Kansas' efforts to include people with disabilities in the community since 1990 (when the Americans with Disabilities Act (ADA) was enacted), and the other to work on how to best identify people who want to leave institutions. Both subcommittees will draw upon a larger base of state agency officials and stakeholders.

The committee will give its 10-year progress report to the 2001 Legislature. Analyzing the effect of the application of the ADA, as interpreted in the *Olmstead* decision, provides Kansas with an opportunity to describe the accomplishments of the state in developing and supporting a community-based services system. The progress report will include all people with disabilities, as well as people in institutions and those in the community who are at risk of institutionalization. All executive branch agency efforts will be outlined in the report.

In addition, the committee will identify best practices at the local level. The techniques that system managers and service providers have implemented to meet the challenges of developing and maintaining capacity across populations validate what has been successful.

No lawsuits currently are affecting the content or pace of the state's activities.



Kentucky

The governor issued an executive order to establish the *Olmstead* Coordinating Council, and the legislature enacted House Bill 144 and House Bill 843 to create two commissions to work on state plans for people with mental retardation/developmental disabilities and mental health. The *Olmstead* Coordinating Council will submit its report to the governor in August 2001. The coordinating council received funding from The Robert Wood Johnson Foundation to work on the plan. In 2002, the commissions will report to the legislature.

The coordinating council is working to 1) create peer education groups; 2) develop mechanisms for evaluating outcomes; and 3) move to consumer-driven authority.

The Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders and Dual Diagnoses—created by HB 843—consists of 10 department commissions and cabinet secretaries, three members of the House of Representatives and three members of the Senate. The commission is developing a comprehensive plan regarding program development, funding and the use of state resources for delivery of the most effective continuum of services in integrated, statewide settings for people with mental illness, alcohol and other drug abuse disorders and dual diagnoses. After the commission reports to the legislature in 2002, it will update its plan annually until the commission ceases to exist.

The Kentucky Commission on Services and Supports for Individuals with Mental Retardation and Other Developmental Disabilities—created by HB144—consists of the secretary of the Cabinet for Health Services, the secretary of the Cabinet for Families and Children, the commissioner of the Department for Mental Health and Mental Retardation Services, the commissioner of the Department for Medicaid Services, the commissioner of the Department of Vocational Rehabilitation, the director of the Interdisciplinary Human Development Institute of the University of Kentucky, the director of the Developmental Disabilities Council, two members of the House of Representatives, two members of the Senate, three family members, three people with mental retardation or other developmental disabilities, two business leaders, three direct service providers, and one representative from a statewide advocacy group. The commission is charged with developing a 10-year statewide plan to increase access to community-based services and supports for people with mental retardation and other developmental disabilities. The strategy must include identification of funding needs and related fiscal effects, as well as the criteria for establishing priority for services for individuals who are approved for slots that consider timeliness and service needs.

This report was delivered to the Governor's office and the legislature on April 17, 2001. It can be found at http://dmhmrs.chr.state.ky.us/mr/commission/Kentucky_Plan.pdf. The report focuses on five key areas: prevention, choice, quality, access, and financing. With 1,700 Kentuckians on waiting lists for various services provided by the Supports for Community Living Program, financing will likely be the key. In the 2000 *State of the States Summary Report*, Kentucky ranked 50th in funding for community-based services for individuals with mental retardation/developmental disabilities - a level that is about half the national average. To reach their goals, the

commission hopes to increase appropriations while simultaneously improving the cost-effectiveness of the system through reductions in facility-based care and by taking advantage of options like the *Ticket to Work Act*. The commission plans to make the proposal widely available to consumers, family members, and service providers to solicit suggestions for change or improvement.

The biggest systemic problems are 1) the long waiting lists for slots in the developmental disability waiver program; 2) the conflict about whether to serve new people or people in institutions first through waivers; and 3) the vacant slots in the elderly waiver program.

The Office of Civil Rights has at least 10 complaints from people in long-term psychiatric care. The state is attempting to learn how to deal with these cases from the Office of Civil Rights.

A case, *G.M vs. Morse*, alleges the improper use of Medicaid EPSDT funds to reimburse providers for inpatient psychiatric hospitalizations of approximately 135 children in unnecessarily restrictive settings.



Louisiana

Although state officials initially believed an *Olmstead* plan was not required, several lawsuits, strong advocacy efforts and a visit from representatives of the Office of Civil Rights persuaded them to reconsider. In February 2001, the secretary of the Department of Health and Hospitals (DHH) met with representatives of the Louisiana People's *Olmstead* Plan (LAPOP), an advocacy group. This meeting set out a goal to formally begin the process to plan the *Olmstead* plan. To achieve this, legislation will be proposed by LAPOP and the DHH to amend a 1979 law to add the "most integrated setting" language used in *Olmstead*. To date, funding has not been requested.

The plan will include individuals with physical and developmental disabilities, those with substance abuse problems, the elderly, individuals with mental illness, and others in a long-term care environment. Information about the planning process is on the web at <http://www.laolmstead.net>. The state is the defendant in two cases 1) *Chisholm vs. Hood*, requiring community services for children, and 2) *Barthelemy vs. Louisiana*, regarding adults with disabilities in nursing facilities.



Maine

Although there has not been an executive order from the governor nor any legislation enacted related to the *Olmstead* court case, Maine has actively developed a statewide home and community-based care plan-working under a grant from the Center for Health Care Strategies-a draft of which will be released in September and a final plan in December. Representatives from five state agencies-the Department of Human Services, the Department of Mental Health, Mental Retardation and Substance Abuse, the Department of Labor, the Department of Corrections and the Department of Education-and consumer representatives have formed the Plan Development Workgroup for Community-Based Living to meet this end.

The group meets monthly and has a set of priorities to develop the plan. It now has formed into subgroups to expand the priorities before a written plan is drafted. In addition, it plans to conduct an assessment of all state agencies to document which services already are being provided and to collect data about groups of people with disabilities to determine who and how many are being served.

Currently, the state assesses elderly long-term care patients who are living in institutions. These patients must sign a “choice letter” if they wish to remain in the facility rather than be placed in the community. For more information go to <http://community.muskie.usm.maine.edu/>



Maryland

The governor issued an executive order to establish the Community Access Steering Committee under the Maryland Department of Health and Mental Hygiene to work on a comprehensive plan that is due June 1, 2001.

The committee consists of the secretary of Health and Mental Hygiene, the director of the Governor's Office for Individuals with Disabilities, the secretary of Budget and Management, a representative from the governor's office, and up to six additional members appointed by the governor. The steering committee is responsible for identifying "effective practices" and other proven strategies that have allowed people with disabilities to expand their community options and for making recommendations to accelerate the placement of people with disabilities in more integrated, community-based settings.

The steering committee has broken up into four work groups that are examining assessment tools and data systems, among many other aspects of the planning process. The state received \$100,000 from The Center for Health Care Strategies by The Robert Wood Johnson Foundation, and the state matched that amount in order to develop data systems for the elderly and physically disabled nursing home populations. To date, the data systems are in place for people with developmental disabilities and people with mental illness, but it is not available for the other long-term care populations.

The steering committee is addressing the overall needs of all populations - regardless of age or residential setting - when developing its plan. The most significant barriers are addressing how to pay for housing, since the Medicaid program does not pay for housing. Given the shortage of nursing aides and personal care attendants, the committee also is encountering the low wages of these direct care workers. Finally, the committee is struggling with how to assess who is unnecessarily institutionalized or at risk. For example, the four state institutions for people with developmental disabilities each use different assessment tools.

The committee is considering many of the recommendations that were issued in *Report and Recommendations to Parris N. Glendening, Governor: Moving People with Disabilities to the Community with Appropriate and Quality Supports*. Bea Rodger, director of the Governor's Office for Individuals with Disabilities, submitted the report in December 1999 on behalf of a large group of individuals with disabilities.

There are no court cases that currently are affecting the work of the committee. However, one class action suit, *Williams vs. Wasserman*, which has been ongoing since 1996, is pending in district court on behalf of individuals with traumatic brain injury who remain institutionalized despite professional recommendations that community placement is appropriate. In addition, the Office of Civil Rights has received 13 complaints, but the state has resolved each of them.

Massachusetts

Massachusetts is in the early stages of addressing *Olmstead*. A task force of Department Human Services (DHS) and Medicaid officials reportedly has been chosen but has not generated much information. Neither the Legislature nor the governor has acted specifically in response to *Olmstead*. In FY 2000, however, the Legislature increased the Division of Mental Retardation Waiting List account by \$2 million to provide services for nursing home residents with developmental disabilities.

It appears that the state is not moving quickly because it believes its current Medicaid system works well. Nevertheless, several suits related to *Olmstead* have been filed during the last 18 months. One case, *Boulet vs. Cellucci*, was decided against the state and required it to provide appropriate services for individuals on the Medicaid developmental disabilities services waiting list. Another, *Rolland vs. Cellucci*, was filed on behalf of 1,600 long-term care facility residents with developmental disabilities. These residents were not receiving medically necessary services in the most integrated setting. The settlement agreement stipulates that 75 people will receive residential and other supports in FY 2000. An additional 175 in both 2001 and 2002, and 150 per year through 2007 will receive such supports.



Michigan

Neither the Legislature nor the governor's office have acted in direct response to the *Olmstead* decision. According to state officials, Michigan has done quite a bit "in the spirit" of *Olmstead*. Particularly, they refer to Michigan's record of deinstitutionalization in the mental illness arena and in regard to developmental disabilities. Since 1991, the state has aggressively developed community health plans. Additionally, in 2000 the Legislature created a long-term care work group to address these issues on an as-needed basis.

In September 1999, the Michigan Protection and Advocacy Services (MPAS) filed suit on behalf of several individuals and nursing home residents against the Michigan Department of Community Health (DCH), alleging that they were unnecessarily institutionalized; the parties currently are in settlement talks. MPAS also is in pre-litigation discussions with the DCH on another, similar issue.

Generally, state officials seem satisfied with the structure of their system, but they continue to work to improve the process by which services are monitored and delivered.



Minnesota

Neither the governor nor the Legislature has acted in response to the *Olmstead* decision. Additionally, state officials believe a planning process specifically to comply with *Olmstead* and the Americans with Disabilities Act is unnecessary. Instead, officials prefer the continuation of initiatives designed to improve community integration.

One of the main arguments for this method was the recent discharge of the last developmentally disabled individual from a state facility. Although a few developmentally disabled individuals remain in private ICF/MR facilities and several hundred people with mental illness still are in state facilities, state officials feel their progress is sufficiently rapid. The main barriers to full integration are affordable housing, service providers and general funding.

No *Olmstead*-related suits have been filed in Minnesota.



Mississippi

The governor gave a verbal directive to the Division of Medicaid to be the lead agency to draft a plan. The divisions of Medicaid, Human Services, Mental Health, Health, Education, and Rehabilitation Services are drafting a plan that they expect to be complete by May 2001.

Beginning its work in November 2000, the entity has been charged to identify services currently available to people with disabilities and to develop a plan for ensuring that all Mississippi residents have access to appropriate services in the most integrated setting. Participation by state agencies, consumers, advocacy groups and consumer councils is voluntary. The group is addressing the needs of all disability groups, regardless of age or residential setting.

As this group continued to meet, legislation—House Bill 929—moved quickly through the Legislature in order to formalize the work of the group. The bill, passed in March of 2001, formally designates the Division of Medicaid as the lead agency and mandates the inclusion of the following in the plan:

- 1) An estimate of the number of people with disabilities in the state who need services or who will need services;
- 2) A proposed schedule for expanding home and community-based services, services networks, support services, and providers networks, and for maintaining institutional services so that all people with disabilities in Mississippi will have an opportunity to access services in the most integrated setting appropriate
- 3) An estimate of the amount of appropriations necessary over the course of the proposed schedule to accomplish the plan; and
- 4) A proposal for funding the proposed plan.

Representative Evans sponsored the bill, which was brought to the legislator by advocates. The Division of Medicaid supported the legislation because it essentially formalized the work the had already begun.

The most significant barrier to the group's work is finding transportation to allow full consumer participation. No court cases currently are affecting the work of the group.



Missouri

The governor issued an executive order in April 2000 to create the Home and Community-Based Services and Consumer Directed Care Commission, which issued its report on December 31, 2000. Many of its recommendations are based on the work and recommendations issued by a stakeholder group, which convened before the commission was created.

The commission had 15 members, four of whom were directors of the departments of Social Services, Mental Health, Health and Elementary and Secondary Education; four of whom were from the Governor's Council on Disability; three of whom were consumers or family members; and four of whom were from the General Assembly. The directors of the departments of Social Services and Mental Health co-chaired the commission.

The commission studied all disability groups, regardless of age or residential setting when it issued its recommendations. It centered its work around the following eight activities and corresponding recommendations.

Activity 1: Identify the current number of and current level of funding for home and community-based services and consumer-directed care programs for individuals with disabilities in the State of Missouri.

Activity 2: Develop a tool or mechanism for assessing the effectiveness of these services and programs in addressing the needs of individuals with disabilities.

Recommendations in activity 2:

1. Identify one entity to take leadership on the development of outcome measures that will assure that services are effective and address the needs of individuals with disabilities.
2. Measure the rate of people moving into the community at the end of each year.
3. Develop a process evaluation that will assess whether the activities of the plan have been met.
4. Develop a provider agency listing or profile for consumers that will identify staff turn over, consumer residential movement, consumer satisfaction and other such factors.
5. Identify the number and type of individuals trained on informed choices.
6. Develop processes to interview individuals who entered the system during the last year to determine if they had informed choice.

Activity 3: Identify the number of individuals with disabilities in the state of Missouri who are institutionalized.

Activity 4: Identify the number of waiting lists for home and community-based services or consumer-directed care programs and evaluate the pace at which individuals move from these lists.

Activity 5: Examine whether existing programs and services provide individuals with disabilities who may be eligible for community-based treatment with information regarding this option. Recommendations in activity 5:

1. A) Improve the assessment and screening process done before a person enters an institution and periodically thereafter. Add informed choice components to assure the individual knows all of the options and rights. B) Staff must review all applications for nursing home admission or institutional placement.
2. The commission should designate a lead entity to arrange for a single source document that outlines all the services that currently are available for people with disabilities to be made available in alternative, accessible formats and be kept current.
3. A satisfaction survey process should be developed to include monitoring and incorporating into an oversight process (i.e., ombudsman).
4. A) Each department should implement statewide training to assure that all providers and agency staff are aware of *Olmstead* and its implications. B) This training program should be statewide, and it should encourage networking across agencies such as transportation and personal care.
5. State agencies should develop and conduct statewide train-the-trainer sessions.
6. A 1-800 hotline or 211 number should be disseminated.
7. A) A Leave Behind Letter from a State Authority and the Informed Choice Sign-Off forms and brochures explaining the details for accessing state services will be provided by each government entity. B) State agencies should develop a verification process with agencies to ensure that informed choices were provided.
8. Multidisciplinary teams will participate in determining eligibility for community-based services, and each team will include an independent living advocate or any other advocate of their choice to participate in the person-centered plan process.
9. A clearly defined appeal procedure will be available to all people in state programs.

Activities 6 and 7: Recommend any modifications or changes that may be needed to improve existing home and community-based services and consumer-directed care programs and recommend any potential means of expanding home and community-based services or consumer-directed care programs.

Summary of recommendations in activities 6 and 7:

1. Direct Care/Attendant Care: Increase wages, provide benefits, require a minimum of 20 hours of on-the-job training, mandate background screenings and have career ladder options.
2. Housing: Find incentives to increase enforcement of Fair Housing Amendments; train agency staff about housing rental options; increase the use of Section 811 grants for supportive housing for people with disabilities and Section 202 grants for supportive housing for elderly people; develop a grant program for urgently needed housing access modifications; and establish a new program for low-interest loans for assistive technology, including housing access modifications.
3. Inter-Agency Coordination and Agreements: Create an inter-agency coordinating task force to develop a plan for data linkages and service coordination. Plan will be developed

by July 2001. Establish a 1-800 hotline that individuals can call and get information about community services. Have a universal application form for all home and community-based services, so a person does not have to go to several agencies and fill out several forms. Have a comprehensive chart of the community services that are available and the criteria for each program are.

4. Medicaid Services: Analyze what services can be covered under the state plan and the budget instead of covering it under the waiver program; expand waiver funding to cover all individuals and families on waiting lists where cost neutrality can be maintained; establish a monitoring process to determine why someone is on a list after 90 days; expand the Medicaid state plan to include specialized medical supplies and increase the number of slots; protect the income of the spouse and allow division of assets in all waiver programs; increase Medicaid eligibility guideline to 100 percent of poverty; increase waiver income guidelines to 300 percent of Supplemental Security Income; and develop a Medicaid buy-in program authorized by the federal Ticket to Work and Work Incentives Improvement Act.
5. Funding Mechanisms: A) Like other Medicaid providers, institutions should have to bill Medicaid for services provided. B) Money should follow the individual. C) Resources should be increased for community mental health services.
6. Transportation: A) Reactivate and expand the Coordinating Council on Special Transportation. B) Explore giving people stipends or vouchers to purchase their own transportation.
7. Employment: A) Request funding to fund 24 new case manager assistant positions in the Comprehensive Psychiatric Rehabilitation Program and examine the feasibility of implementing a pilot community employment support service that pays the provider when specific outcomes are achieved. B) Explore a Medicaid buy-in program authorized by the federal Ticket to Work and Work Incentives Improvement Act.

Activity 8: Develop a process for helping individuals with disabilities who are institutionalized and who are eligible for community-based treatment to make the transition into community-based treatment settings.

Recommendations in activity 8:

1. A) Develop and fund an *Olmstead* Transition Fund to be administered by the Governor's Council on Disability.
B) The state should look for unique ways to fund some of the needs of people with disabilities who make the transition into the community, including bringing in private sector donations for furniture or adaptive equipment, using public agencies to assist with utility deposits, and rental deposits and using interest-free loans.
C) Lobby for a discretionary fund to cover emergencies and unique needs to help avoid institutional placement of any individual.
2. Recommend that Missouri Senate Bill 321 for the Transition Advisory Council is fully funded.
3. A person-centered planning process should be conducted with each person that makes the transition from the institution to a community setting.
All the activities and recommendations would be implemented in FY 2001 and FY 2002. Specific timelines and budgets for each item are contained within the plan.



Before development of the plan, the Legislature enacted House Bill 1010 and House Bill 1111 (2000), which allow money to follow the individual. As required by House Bill 1010, the Department of Mental Retardation and Developmental Disabilities would allow funds to follow a person who moved from a state-operated habilitation center to a community living option. State habilitation center funds would be used to pay for services in the community for residents who are evaluated as able to live in the community and who want to live in the community. House Bill 1111 provides that an individual who is eligible for or is receiving nursing home care must be given the opportunity to have those Medicaid funds follow him or her to the community and to choose the personal care option in the community that best meets the individual's needs.

Since the plan was submitted to the governor, House Bill 612, The Missouri Community First Act, has been introduced. This legislation would reestablish a commission to continue the work that has begun on Missouri's plan. The Community First Act also codifies several recommendations of the Home and Community-Based Services and Consumer-Directed Care Commission including establishment of a transition fund to assist individuals who are making the transition from an institution with costs associated with setting up a home of their own.

Additional information can be found at www.dolir.state.mo.us/gcd/Olmsteadindex.html.

Montana

With the support of the governor's office, Montana's Department of Health and Human Services is in the process of developing a comprehensive plan. The plan will create an integrated system for those with developmental disabilities, physical disabilities, mental illness and/or the elderly, providing them with community based-services.

It will consider all people with disabilities and will focus on budget needs, the number of people referred to community services and the number of people waiting to be put into community-based housing. Each disability group has been assigned its own task force to evaluate wait list information, number of individuals in institutions, and the number of those who have been moved from institutions to communities.

State officials anticipate the plan will be completed by July 2001. A proposed budget already has been submitted to the state Legislature and currently is being reviewed. Two barriers that may halt the progress are 1) funding to enhance community infrastructure, and 2) political concerns regarding potential closure(s) of residential facilities.

A class action lawsuit, *Travis D. vs. Eastmont*, has been filed in district court by the Montana Advocacy Program on behalf of individuals with developmental disabilities confined to state facilities or at risk because of a lack of community supports. The suit alleges that the state is failing to serve individuals on its Medicaid waiver waiting list with reasonable promptness.



Nebraska

The Nebraska Legislature has not passed a bill in the wake of the *Olmstead* decision, although several are under consideration. Likewise, the governor has issued no executive orders. The governor has, however, requested significant increases in spending for home and community-based services (HCBS) for the mentally ill and developmentally disabled.

Nebraska's interpretation of the *Olmstead* decision is somewhat different than that of other states. The state's position is that the decision requires not an overall plan, but a plan for each individual. State officials believe the current system meets this requirement. Therefore, the state is focusing on improving the processes and applications of the existing policies. To that end, agencies within the Department of Health and Human Services (HHS) have made budget requests to deal with the issues raised in *Olmstead*, but have not necessarily identified the requests as directly related to *Olmstead*. As in other states, the main barrier to a completely effective system is funding.

Nebraska categorizes disabled people as those with mental illness and those with developmental disabilities. Additionally, traditional subclasses are utilized (institutional residents whose needs can be appropriately met in the community, residents who require institutional care, and those living in the community who are at risk for institutionalization due to the absence of care). The individual treatment teams and service coordinators identify potential issues and make decisions based on their evaluation of each case or situation. The state has involved - and continues to involve - advisory councils, family members, and disabled people to evaluate and improve their efforts.

No specific timelines are proposed due to the ongoing nature of the state's process. To date, no lawsuits have been filed in Nebraska in response to the *Olmstead* decision.



Nevada

In response to a proposal in the Governor's budget, the 2001 Nevada Legislature approved funding for a long-term strategic plan to: 1) ensure the availability and accessibility of a continuum of services that appropriately meet the basic needs of persons with disabilities, 2) support the ability of persons with disabilities to lead independent and active lives within their community, 3) continue the effort of the State of Nevada to provide community based services which match the need of the client and provide choice between appropriate services, and 4) ensure that persons with disabilities receive the services that they are entitled to pursuant to state and federal law and case law. Advocates for the disabled will be included in the planning process.

The approved budget also included new funding for independent living assistance for disabled persons and an 88% expansion of Medicaid home and community based waiver services for individuals with physical disabilities. Additionally, increases in mental health and developmental services case management, community placements, family support and respite, jobs and day training, and residential support were included. The Medicaid Community Home-Based Initiative Program (CHIP) was expanded by 34%, the capacity of the Medicaid Group Care Waiver for the Elderly Program was doubled, and the Homemaker Program was expanded by 16%.

There are no pending lawsuits involving *Olmstead* issues.



New Hampshire

Because New Hampshire officials believe there is a long history of support for community-based care in their state, no specific *Olmstead* planning is taking place. The Department of Health and Human Services (DHHS), as examples of its success, cites the 1991 closure of the only institution for developmental disabilities and the subsequent creation of a comprehensive, community-based developmental services (DS) system. To ensure further progress, a task force was created in 2000 with representatives from each of the program units providing services. These DHHS units included elders, children, physical and developmental disabilities, mental illness, and chronic health.

In 1997 the legislature required full funding of the waiting list for DS to be a part of the DHHS budget. Further, in 1998 the legislature established an oversight committee to review the allocation of DS wait list funds. Officials also note that, by 1998, \$123.5 million was being spent annually for developmental services and 99 percent of that total went to community-based services. State officials, however, do recognize the existence of wait lists for home and community-based care, but they point to the decline in average waiting time as evidence of improvement in their system. In 1997, the average time was 302 days, in 1998 it was 249, in 1999 it was 203, and in 2000 it was 160.

In the 2000 session - although it is not clear if any were in direct response to *Olmstead* - the legislature passed several more initiatives. These include the creation of a study committee to consider proposals to reduce the DS wait list to zero and the allocation of \$4.5 million for direct care provider salary increases for providers for individuals with developmental or acquired brain disorders.

State officials also feel consumers, advocates and family members are intimately involved in ongoing planning. Using a combination of existing groups (the Family Support Council for DD, the Brain Injury Advisory Council, the Governor's Long-Term Care Task Force, and the Alliance for the Mentally Ill), town meetings and individual consumer feedback, they are able to assess and improve their system.

There have been at least two wait list complaints filed in the past 18 months with the USDHHS Office of Civil Rights. One was dropped after the claimant died, and the other is pending. A class action suit, *Bryson vs. Shumway*, is pending in federal court on behalf of 42 adults with acquired brain disorders in nursing homes who are on Medicaid waiver waiting lists.

New Jersey

The New Jersey Americans with Disability Act (ADA) Coalition—an independent coalition of consumers, advocates and family members—has been meeting since September 1999. This prompted Governor Whitman to engage in interdepartmental planning and to develop a plan in 2001. The interdepartmental task force, appointed by the governor, is now working with the ADA Coalition to develop a comprehensive plan to ensure that individuals with disabilities are removed from institutions and to provide them with community-based services. The plan will target all groups: people with developmental and physical disabilities, people with mental illness and/or the elderly.

In compliance with the *Olmstead* ruling, New Jersey has shut down three major institutions and used the funds to set up integrated community housing for those with disabilities. In addition, a \$9.3 Million Bridge Fund was included in the FY 2001 budget to guarantee that community programs are up and operating before hospital patients are discharged. Since 1995, developmental centers and annual admissions to state psychiatric hospitals have been declining. In addition to the coalition, DDD and the Division of Mental Health Services (DMHS) are in the process of evaluating current institutional populations. The analysis will help future planning efforts and should present ideas for developing community-based infrastructure. The Department of Human Services is encouraged to continue community development and funds are allocated in the state FY 2001 budget.

At this time, no lawsuits or complaints are affecting the content or pace of the state's activity.



New Mexico

New Mexico has not formally addressed the U.S. Supreme Court's decision in the *Olmstead* case. A task force has been created, but no action has been taken. The Long-Term Managed Care Advisory Committee and the Human Services Department are working simultaneously on a plan, but a draft has not been submitted nor have budget requests been made. Since a lawsuit is pending internal review, the Human Services Department was unable to elaborate on its progress. The lawsuit, *Lewis vs. New Mexico*, is in federal court and was filed on behalf of 3,000 individuals with developmental disabilities in nursing facilities on Medicaid waiver waiting lists.

New York

Although neither the governor nor the Legislature has acted in response to the *Olmstead* decision, the state Department of Health (DOH) has formed a committee of the relevant divisions to discuss potential planning efforts.

It should be noted that NY CARES was implemented in August 1998. One goal of this five-year plan is to eliminate the waiting list for residential services for individuals with developmental disabilities. However, this plan does not address other disabled populations.

The main barriers to complete integration are housing - particularly in rural and urban areas - and service providers in rural areas.



North Carolina

The state Department of Health and Human Services (DHHS) has taken the initiative, without a formal request from the governor or legislature, to develop and implement an *Olmstead* plan. The proposal was generated over the span of several months in early and mid-2000. This involved a review of the current services provided by the state. This interim plan then was presented to the public in a series of meetings and via the Internet. Comments were requested, and, when feasible, were used to change the proposal. Details of their plan, and the process used in its development, can be viewed at <http://www.dhhs.state.nc.us/docs/olmstead.htm>. A final version is expected in the spring of 2001.

Like many other states, North Carolina believes it has a long standing tradition of treating disabled people in the most appropriate environment. To demonstrate this, its report points to significant decreases in the number of inpatients at psychiatric institutions during the past 10 years. Additionally, the state cites the large increases in funding for home and community-based services, particularly when compared to the spending for institutional care. Further, officials mention a 351 percent increase in the number of people served in the independent living program since FY 1990.

The North Carolina plan focuses on people with disabilities who are institutionalized or are at risk of being institutionalized. To reach their goal of providing ... “services and supports in the most integrated setting appropriate for their [disabled people’s] needs,” the DHHS focused on seven key areas. The first was outreach, to determine how people who potentially are eligible for community-based services would be informed of their choices. The second was assessment and identification, focusing on how the determinations of these individuals would be made. The third was development of a community transition care plan. The fourth was addressing waiting lists. The fifth was inventorying the existing community-based services. The sixth was identifying what community resources are needed to assist in the effort to integrate disabled people. The final area was determining the processes by which the system would be monitored and assessed. With their plan essentially complete, state officials now must face the crucial funding issue. North Carolina is dealing with an extremely lean budget. To date, \$3 million has been appropriated for the development, further budget projections, and initial implementation. Because of this, it is unclear what funds will be necessary to adequately implement the plan and whether those funds will be available in the budget.

To date, no lawsuits have been filed in North Carolina relating to *Olmstead*.



North Dakota

The executive director of the Human Services Department organized an internal work group, which issued a white paper on November 6, 2000, and held four public hearings via interactive video network. The recommendations included:

1. A request to the governor to appoint a commission to develop definitions and a comprehensive State plan;
2. Regularly scheduled information/discussion sessions via the Department of Human Services;
3. The creation of a pre-assessment screening process to be completed prior to nursing home admissions; and
4. The development of nursing home alternatives.

The complete report is available at www.state.nd.us/humanservices.

The *Olmstead* Workgroup which began its work in January 2000, consisted of directors of the departments of Medicaid, aging, mental illness and substance abuse, developmental disabilities, and children and family services, as well as the attorney for human services, the psychiatric hospital superintendent and one regional center director.



Ohio

The governor issued an executive order in June 2000 to create a task force called Ohio ACCESS. It issued a report to the governor on February 28, 2001, entitled Ohio Access for People with Disabilities located at <http://www.state.oh.us/OBM/> that contains short-term and long-term recommendations.

As part of Ohio ACCESS, the governor directed the director of the Office of Budget and Management, along with the Ohio departments of aging, alcohol and drug addiction services, health, job and family services, mental health, and mental retardation and developmental disabilities, to conduct a comprehensive review of Ohio's services and supports for people with disabilities and to make recommendations for improving services over the next six years. The governor also mandated that people with disabilities and their representatives participate in the review and development of the recommendations.

Ohio ACCESS is working to increase community capacity, ensure quality and access, and provide for cost-effectiveness. Ohio ACCESS, led by the Medicaid program, consists of the directors of all the relevant agencies. The short-term recommendations for consideration in the 2002-2003 biennial budget focus on customer services; the long-term recommendations focus on labor issues. The commission is giving priority to the needs of people with developmental disabilities and people with physical disabilities. Within these disability groups, the commission is focusing on strategies for moving people out of institutions.

The FY 2002-2003 executive budget in the report includes:

- Adding 1,300 slots in FY 2002 and another 1,600 slots in FY 2003 to the PASSPORT waiver program, which provides care to people over age 60 who otherwise would need nursing home services (the program currently has more than 24,000 slots);
- Adding 500 slots in both FY 2002 and FY 2003 to the Home Care Waiver Program, which provides care to disabled people under age 60 or people of any age with a chronic, unstable condition who require nursing care (the program currently has 8,200 slots);
- Adding 500 slots in both FY 2002 and FY 2003 to the Individual Options Waiver Program, which serves people who otherwise would require institutionalization in an intermediate care facility for the mentally retarded (ICF/MR);
- Establishing an Ohio Success pilot program to fund up to \$2,000 in transition costs for 75 people in FY 2002 and 125 individuals in FY 2003 to be used as seed money for the first month's rent, utility deposits, moving expenses and other related costs;
- Developing cost management tools that promote choice and personal responsibility;
- Redesigning the Mental Retardation and Developmental Disabilities Medicaid delivery system by moving the Community Alternative Funding System program to a fee schedule and by making the transition to a new Consumer Choice Waiver Program;
- Improving cost management tools within the community mental health system; and
- Slowing the growth of nursing home spending by using Medicaid funds to purchase services for Medicaid residents, not to subsidize the Medicare program; removing fiscal incentives that subsidize excess nursing home capacity; removing the incentive to build more nursing home beds; stopping the bail-out of nursing homes that are in bankruptcy; making Medicaid payments only once for the depreciation of property; closing the loophole that discourages nursing home operators who owe the state money from giving notice when they sell their business;

and protecting the current reimbursement formula for patient care.

Overall, the cornerstones of the Ohio Access vision are consumer self-determination and a person-centered planning approach with assistance from family, friends and caregivers. The recommended strategies for overcoming barriers to achieving the vision include:

- Matching capacity with the demand for community-based services;
- Generating and sustaining the necessary resources to expand community services;
- Overcoming federal policy constraints such as the federal Medicaid waiver;
- Addressing the health care workforce shortage by creating a public-private workgroup; conducting a labor market analysis; studying wage and rate issues; creating demonstration projects to examine career ladders, scholarship opportunities, and payments to family members and other informal caregivers on a controlled basis; examining alternatives to the traditional provision of long-term care by looking at scope of practice issues, assistive technology and the increased use of independent service providers; and
- Overcoming policy constraints on self-sufficiency and personal and family responsibility by providing better information and assistance for consumers and their caregivers.

In addition to the recommendations, the report contains:

- An overview of state-supported, community-based long-term care services in Ohio;
- The currently offered community services for people with disabilities;
- Federal constraints that have contributed to the current institutional bias present in publicly funded programs; and
- Challenges to state policy that exist and must be addressed for the vision of the report to be implemented.

The state expects its new waivers to be ready by July 1, 2001, for targeted case management, residential services and nursing support. A class action suit, *Martin vs. Taft*, is pending in federal court on behalf of 6,000 adults with developmental disabilities on Medicaid waiver waiting lists.



Oklahoma

An informal group-including representatives from Oklahoma Health Care Authority, the nursing home association, the Developmental Disabilities Division of the Department of Human Services, the public Intermediate Care Facilities for the Mentally Retarded, ARC and the Developmental Disabilities Council-began meeting in August 2000. In response to concerns identified in public forums and public hearings, the group is devising strategies for bringing services for people with developmental disabilities other than mental retardation into line with services for people with mental retardation. The Health Care Authority is taking the lead. The first draft of the group's plan will be ready by late February 2001 and then will go to the public for comment. While the primary focus of the group is on people with developmental disabilities other than mental retardation, the group will be giving some attention to people with physical disabilities. The group is targeting July 1, 2002 as a likely implementation date for the plan.

Legislation being considered during the 2001 legislative session would create a more formal commission to examine *Olmstead* issues. If such a group is created, the activities of the informal group will serve as important groundwork for that commission.



Oregon

Oregon's efforts related to expansion of community-based care currently focus on people with developmental disabilities. As an outgrowth of legislation enacted in 1999, the state developed a six-year plan that has as its goal the elimination of the waiting list for community-based services for people with developmental disabilities. The plan was the basis for the state's recent settlement of a lawsuit, *Staley vs. Kitzhaber*, filed on behalf of more than 5,000 people on a waiting list for care. The state has agreed to create 50 new non-crisis placements annually for the next six years and will increase the availability of personal care and respite services. The governor proposed adding \$40 million to the budget over two years for these services.

Now, the state is giving attention to a lawsuit, *Miranda B. vs. Kitzhaber*. The suit was filed by the Oregon Protection and Advocacy System on behalf of people coming out of mental hospitals who are in need of community services. The state has committed \$4 million to \$5 million over two years for services for this group of people.

The issues of under-service in the state center on the developmental disabilities and mental health populations. There are no waiting lists for services for people with physical disabilities or the frail elderly.



Pennsylvania

The governor directed the Department of Public Welfare (DPW) in 2000 to draft a plan to deal with *Olmstead* issues. Details of the Home and Community-Based Services Project are available at <http://www.dpw.state.pa.us/omap/geninf/maac/hcbspresent.pdf>. The DPW created a steering committee, consisting of executive level DPW staff, and several topic-specific teams to address the various planning issues. Because state officials feel this is an evolutionary project, no specific time line has been created. Each team will meet twice monthly (except for the Communications team, which meets monthly, and Quality Management team, which will not meet until later in the process) and will work until an acceptable plan is developed. The teams are listed below.

- The Resource Facilitation team will deal with individuals who may not fit into an existing program or may require a different package of services or program due to age, status change, or difficulty in meeting that individual's needs. The general goal of this team is to review assessments to ensure that each individual is receiving appropriate services.
- The Assessment and Placement team is to develop appropriate methods for assessment that maximize placement of disabled individuals in the most appropriate settings. In the short-term, this team will attempt to analyze current procedures, identify the effects of the limited number of home and community-based service (HCBS) providers, and develop a reassessment timeline. The long-term goals focus on improving initial and subsequent assessment processes - with a focus on consumer choice - and on developing a mechanism by which consumer and family satisfaction can be assessed and incorporated into the overall process.
- The Tracking and Data Management team is charged with developing and implementing a procedure to track program data, including consumer-specific data. The short-term goals focus on assessing current systems for compatibility, identifying relevant populations, and determining which data points to include. In the long-term, the team will develop a methodology, produce and refine reports, and coordinate its data system with other agencies.
- The Policy, Program and Operations team is focused on coordinating the policies and procedures of the various divisions, programs and departments and on simultaneously developing a network of contacts among them. In the short-term, the team will analyze and review the existing policies. The long-term goal is to eliminate (or minimize) gaps and overlaps and implement the contacts network. This team also has specific areas on which it will focus. Particularly, it is concerned with the proper placement of children who are medically fragile or who receive Early Periodic Screening, Diagnosis and Treatment (EPDST). Finally, this team will address the needs of all individuals who are institutionalized but who could be served in a community-based setting.
- The Communications team is responsible for outreach, education and training. The short-term goals are to research and identify appropriate outreach and educational topics while also considering the appropriate vehicle to use. Over the long-term, the team hopes to provide education to stakeholders and develop an effective campaign, including Internet materials, brochures and informational sessions.
- The Quality Management team will focus on quality of life and consumer satisfaction issues. To that end, it will compare Pennsylvania's quality assurance system with that of other states to identify potential areas for improvement. Also, it will look into HCBS provider credentialing and research procedures for outcomes measurement.

Although, all the individuals selected were from state agencies, the project documents identify stakeholder consultation and consumer-directed service provision as major goals. In the fall of 2000, an external stakeholder planning team was convened. This team was comprised of individuals from the advocacy community, services providers, consumers and other governmental (county level) agencies.

In their plan, state officials will focus on deinstitutionalizing people in state facilities and on addressing the needs of those who currently are living in the community but are facing institutionalization due to a loss of services. Further, the plan will include those with physical and developmental disabilities, people with mental illness and the elderly. Because state officials believe they already provide services in a manner consistent with *Olmstead*, there will likely be a clear focus on process improvement, technological advancements and efficiency. In addition, it has been suggested that the state shift away from building facilities in favor of funding additional services.

Some barriers exist to a complete and successful implementation of an *Olmstead* plan. Like other states, Pennsylvania has issues with housing, transportation, and funding. Recently, however, a request was made to use some of the state's tobacco settlement funds to supplement other federal and state funds. That notwithstanding, funding for home and community-based services has increased significantly since the 1996-1997 fiscal year.

A number of lawsuits have been filed in Pennsylvania. A major court decision related to *Olmstead* was issued in July 2000. The Third Circuit Court of Appeals, in *Richard C. vs. Houston*, held that opposition to community placement by an individual residing in an institution does not create a right to remain in an institution if a treatment team has found that community placement is the most integrated setting appropriate. Another settlement in *Kathleen S. vs. Pennsylvania* resulted after a federal court ruled that the state was administering its institutional discharges in a discriminatory fashion by failing to initiate discharge planning in a timely manner. As a result, individuals who were ready for discharge remained in the institution while community placements were made available. A class action suit, *Frederick L. vs. Department of Public Works*, is pending on behalf of individuals with mental illness in state hospitals who have been found appropriate for community placement but are on long waiting lists.

Rhode Island

The state is currently not working on a comprehensive plan, and officials do not know at this point in time if they will be developing one. The state has five home and community-based waiver programs, none of which have waiting lists. In addition, the state has continued to move people from nursing homes to community-based settings under a nursing home transition grant the state received from the federal government. Throughout the years, the Human Services Department has internally reviewed its long-term care systems and made improvements as needed.



South Carolina

Following a November 2000 executive order from South Carolina's governor, the South Carolina Home and Community-Based Services Task Force was established. This task force, composed of more than 35 stakeholders from groups representing people with mental retardation, mental illness, physical disability and the aged, is charged with conducting a comprehensive review of the state's services and support systems for people with physical, mental or developmental disabilities and with developing a plan for improving access to home and community-based services for this population.

The task force has met several times and has since broken into subgroups by disability area—mental retardation, mental illness, physical disability or aged. These subgroups meet every two weeks.

The timeline for the completion of the plan sets April 2001 to complete a draft of the plan; May 2001 to conduct public hearings on the plan; and June 30, 2001, to submit a completed report and plan to the governor.



South Dakota

The state is not conducting any *Olmstead*-specific activities. There have been modest increases specific to expanding staffing to enhance care for people with developmental disabilities. Officials from the Department of Human Services reported that waiting lists are not a problem. The state uses an annual service plan review mechanism to determine the appropriateness of continuing placement at developmental disability state facilities. If a person is committed to a mental health facility, there is periodic review by the placement board. If placement is voluntary, a periodic service plan review is used to determine appropriateness. In summary, state officials do not perceive the state to have problems with regards to the *Olmstead* decision and, therefore, are not directing any specific activities.



Tennessee

In March 1999, the Tennessee Long Term Care Services Planning Council, a broad-based group of public and private sector policymakers, providers and advocates released the Tennessee Comprehensive Plan for the Delivery of Long Term care Services to Elderly and Disabled Persons located at <http://www.state.tn.us/comaging/TNlongtermcare.pdf>. That plan focused on extending and expanding home and community-based services, especially through Medicaid waivers, to people with disabilities and the frail elderly. Since that time, most of the discussions in the state have been around funding levels for community-based care. Several bills are being considered by the legislature this year focused on support for family caregivers, waiting list reduction and expanded Medicaid waivers.

Due to concerns about a fragmented delivery system, the Department of Finance and Administration (the agency that houses Medicaid) is seeking to hire a Disability Coordinator soon to coordinate activities across departments and funding sources.

A class action law suit, *Brown v. Tennessee*, is pending in federal court on behalf of individuals with developmental disabilities (living in community settings) on waiting lists for Medicaid waiver (ICF/MR) services. The waiting list numbers some 700 individuals, and the facilities are closed to new admissions.



Texas

In September 1999, the governor issued an executive order, requiring the Health and Human Services Commission (HHSC) to conduct a comprehensive review of all services and support systems available to people with disabilities in Texas. To include stakeholder involvement, the HHSC created the Promoting Independence Advisory Board (PIAB). The charge of the PIAB was to provide guidance to the HHSC in the evaluation and implementation of a system of community-based services and supports for people with disabilities. The board consists of providers, people with disabilities and their representatives, and state agency officials.

In response to the executive order, HHSC developed the Promoting Independence Plan and submitted it to the governor and the appropriate legislative committees as required in January 2001. It can be found at http://www.hhsc.state.tx.us/tpip/tpip_report.html.

The Promoting Independence Plan has multiple recommendations related to the system of long-term care services and supports for the populations affected by the *Olmstead* decision. The plan also coordinates the efforts of the multiple agencies that provide long-term care services within the state. The two largest agencies are the Texas Department of Human Services and the Texas Department of Mental Health and Mental Retardation.

The Texas Department of Human Services is using a multi-phase approach to identify and assess individuals to whom *Olmstead* applies. Phase one of the plan was implemented effective December 1, 2000. Phase one activities involve informing nursing home residents about community-based alternative programs, training agency staff, promoting community awareness about choice and community options, collecting baseline data about nursing home residents who are seeking to make the transition into the community and developing permanency planning for community placements for children in facilities.

The phase one contingency plan would be implemented in FY2001 if additional funds were allocated to the Department of Human Services. The activities would center on relocation and community awareness in five urban areas.

Phase two could be implemented over a two-year period beginning in September 2001. If the money is appropriated, the department would hire and train relocation specialists, develop an identification process and assessment instrument, track data from the relocation specialists and conduct community awareness activities. The first year would be a pilot program in five urban counties and, in year two, the project would be implemented statewide.

Phase three would be implemented in 2004 and 2005, and the long-term goal would be to divert people from institutionalization by placing additional staff in hospitals and rehabilitation centers for pre-admission and admission screening.

The Texas Department of Mental Health and Mental Retardation has implemented the Community Living Options Assessment to identify those individuals to whom *Olmstead* applies who are seeking community placement. They have requested funding of additional home and com-



munity-based waiver slots to accommodate the community placement of these individuals. In addition, the Department of Mental Health and Mental Retardation is requesting funding to develop a Medicaid waiver or other options for those individuals on the waiting list that only need community supports. Because of the lengthy waiting list for home and community-based services, people are on the waiting list for years and are assessed for the type and amount of services they need only when they come to the top of the list. Therefore, the HHSC supports the funding request for a new Medicaid waiver that provides only non-residential supports as well as more slots in the existing waiver programs.

The plan also includes \$4.3 million to be used for housing subsidies for those individuals who transfer from institutions to the community. This funding would help with monthly rent for housing while they are on waiting lists to receive federal funds for housing subsidies. The plan also would appropriate \$780,000 for non-medical transportation; Medicaid covers medical transportation.

To implement the plan, each state agency submitted its budget request during the 2001 legislative session, which includes its various, specific requests. In addition, the Health and Human Services Commission submitted its consolidated budget to the Legislature. It includes Tier II for the Promoting Independence Plan, which requests \$119.5 million in general revenue to fund the various components of this initiative.



Utah

In 1998, the Utah Departments of Health and Human Services began intensive work on community care for that state's developmentally disabled population. At that time, 1,000 people were on the critical needs waiting list for the developmental disabilities waiver program. In September 1999, key state agencies created the Network Task Force to extend the state's work on community-based services to broader population groups. The task force will issue a draft plan by the end of June 2001 and a final plan by October 2001.

The task force, which meets quarterly, consists of representatives from key state agencies, the Legislature, provider groups and consumers. The task force is using guidance from the Health Care Financing Administration as a foundation for its plan. The primary focus of the network are institutional residents within the developmental disabilities and the physically disabled and frail elderly populations. At the same time, the Division of Mental Health is assessing the situation with regard to people in mental hospitals.

Beginning in 1999, officials assessed all people with developmental disabilities living in institutions and have offered them various community-based alternatives. The state will continue this activity. The state recently received funding from The Robert Wood Johnson Foundation to assess nursing home residents and to offer them less restrictive options. This program started in four pilot homes in 2000 and was offered statewide early in 2001.

Reduction of waiver waiting lists is a priority in the state; new funds have been allocated annually for this purpose in recent years. During the 2001 legislative session, the governor has proposed about a 25 percent increase in funding for all waiver programs.

The Office of Civil Rights has received 10 complaints recently from people with physical disabilities in nursing homes. State officials intend to use the nursing home pilot program to address some of the issues related to nursing home placement.

Vermont

The state is not working on an *Olmstead* specific plan because it has implemented a range of activities over many years related to downsizing institutions and moving toward home and community-based care. Thus, when state officials met with Region 1 of the Office of Civil Rights (OCR) to review current policy directions, OCR supported the direction in which the agency is going.

Vermont is in a unique position because state officials and advocates seem to concur that the state is in full compliance with the *Olmstead* decision. No institutions exist for individuals with developmental disabilities, and all nursing facility residents have been assessed for community-based service options. As one advocate stated, “*Olmstead* is not being used because it is not needed. The commitment is already there.” Some of the state’s accomplishments include:

- Closing the last developmental disability facility in 1993;
- Having only 50 people in the state mental hospital;
- Creating home and community-based care waiver programs for all populations;
- Moving 100 people from nursing homes to waiver programs; and
- Managing home and community-based services and nursing homes for senior citizens in a single budget so that the savings can remain in the system.

People with disabilities and their representatives have been involved in the process through departmental advisory groups, which review major issues such as the renewal of waiver programs. For the 2002 budget, the governor is requesting 100 new slots in the aging waiver program. However, the barriers to home and community-based services continue to be 1) providing housing for people in the community and 2) prioritizing access to waiver programs.



Virginia

The state has reduced institutional developmental disability placement by 30 percent during the past three years. It also has put \$20 million into the mental health system. The state had agents review the state situation in light of *Olmstead* and concluded that the new directives were sufficient to place Virginia in good standing.

However, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has issued the Comprehensive State Plan 2000-2006, which contains numbers of people in state facilities that could be served in the community. DMHMRSAS has projected that during 2000-2002 biennium, 783 mental health beds and 185 mental retardation beds could be reduced in state facilities if funds were available.

During the 2001 legislative session, the legislature is not likely to fund many new or expanded programs. Instead, it will deal with the budget shortfall that resulted from a repealed car tax. A class action suit, *Quibuyen vs. Allen*, is pending in federal court on behalf of individuals with developmental disabilities who reside in institutions and are on Medicaid waiver waiting lists.



Washington

The governor has designated the state Department of Social and Health Services (DSHS) as the lead agency for *Olmstead* planning. The DSHS assistant secretaries were assigned positions on a steering committee and a planning workgroup was formed with representatives from DSHS divisions and several other state agencies. This workgroup reports to the steering committee, and includes representatives from the Attorney General's Office; DSHS' Mental Health Division, Developmental Disabilities Division, Children's Administration, Aging and Adult Services Administration, Division of Alcohol and Substance Abuse, and Division of Vocational Rehabilitation; the Department of Transportation; and the Office of Community Development.

Washington officials believe they have been moving to expand community resources and downsize institutions for years, stating that about 85 percent of the aging, developmentally disabled and mentally ill populations are served in the community. To that end, their *Olmstead* plan is seen as an effort to further coordinate and accelerate ongoing processes and programs.

Current budget requests include:

- § \$10.5 million to provide community placement for 80 individuals with developmental disabilities who currently reside in state and community institutions.
- § \$1.1 million savings by providing COPEs as an option for clients on the medically needy program, which will create opportunities for many people currently served in nursing homes to move to other settings if desired.
- § \$1 million to serve clients with mental illness (who currently are in state psychiatric hospitals) in other settings.
- § \$3.2 million to establish a 35-bed chemical dependency involuntary treatment program in Eastern Washington.
- § \$1.5 million to expand behavior rehabilitation services for youth that might be at risk of institutionalization.

The following items further DSHS' policy of expanding community services/ placements, and fall within the *Olmstead* penumbra:

- § \$15.6 million to expand opportunities for clients with traumatic brain injury and geriatric patients with dementia and Alzheimer's in a new residential service licensure category.
- § \$5.1 million to provide skilled health providers for certain tasks above the home-care aid level for in-home clients, which will help clients to remain at home.
- § \$6.4 million to expand treatment to adult substance abusers who have co-occurring mental illness disorders.

The DSHS aims to include all people with disabilities, regardless of age, including those with developmental and physical disabilities and mental illness and those who are chemically dependent. Further, DSHS planning focuses on institutional residents who wish to live in the community and are determined able to do so by the state's treatment professionals, and individuals

who reside in the community who are at risk of unnecessary institutionalization. Each of the relevant agencies (Aging, DD, etc.) has developed protocols, specific to the population served, to identify unnecessarily institutionalized people.

The DSHS meets with stakeholders in public forums and communicates regularly with individuals and advocacy groups by phone, mail and email. However, the Washington State Disability Initiative Advisory Committee serves as the primary conduit for stakeholder input. Additionally, and as a result of the 1999 ruling, Washington Protection and Advocacy will play a major role in selecting members of an oversight committee for the plan.

There are some significant barriers to complete success. Additional funding, as in most states, is the key. Affordable, accessible and barrier-free housing, as well as general and special needs transportation also are major issues.

A class action suit, *Washington Protection and Advocacy vs. Rust*, was filed on behalf of individuals with mental illness who are appropriate for community placement but remain in state hospitals. The proceedings of another suit filed in late 1999 on behalf of individuals with developmental disabilities, *Allen vs. Western State Hospital*, were stayed by a federal district judge so long as the state continues to implement the detailed settlement, which requires three phases of community building.



West Virginia

The Governor issued Executive Order No: 17-00 on September 27, 2000 creating the West Virginia Olmstead Task Force. The Task Force was charged with developing a comprehensive plan by June 30, 2001. The plan will include a process by which individuals are identified as eligible for participation, recommendations relating to the services required, a method for preventing unnecessary institutionalization, and a uniform grievance procedure. It will also address the potential costs and the related budgetary implications. The Task Force has representation from disabled people, their families, and advocates (40%), service providers (20%), and various government agencies (40%).

The West Virginia plan will cover people, of any age, with developmental and physical disabilities as well as mental illness. The focus will be on institutionalized individuals to determine whether they require that level of care or if they can be better served in community-based settings. It will, however, also deal with those at risk of institutionalization. Additional information can be found at www.wvdhhr.org/olmstead.

The Legislature, at the request of the Governor and the Secretary of Health and Human Resources, provided a special appropriation of \$500,000 to be used during the planning process. These funds assist community placement of individuals currently in state-operated nursing homes and psychiatric hospitals. It is unclear to what extent the Legislature will fund any proposals from the Olmstead Task Force.

Several suits have helped to shape the activities in West Virginia. Shortly after the *Olmstead* decision, the U.S. District Court for the Southern District of West Virginia handed down a ruling in the case of *Benjamin H. vs. Ohl*. Citing *Olmstead*, the court found West Virginia's practice of limiting home and community-based service waivers to those with an emergent need a violation of the due process and equal protection requirements of the Medicaid Act and the ADA. The court ordered that individuals on the waiting lists must receive services within 90 days of when their eligibility is determined. Additionally, they required the waiting lists to move at a "reasonable pace." As a result of this decision, state officials established a centralized process by which to review the waiting lists at the 14 mental health facilities and the four developmental disability centers. The FY 2001 budget included a "*Benjamin H.* improvement package." This package funded 400 additional MR/DD waiver slots by adding almost \$5 million.

Two suits were decided prior to *Olmstead* but have similar implications. *Medley v. Ginsberg*, decided in federal district court in 1979, ordered the discharge of mentally retarded juveniles from state operated institutions and the provision of services in the community. The Hartley Consent Decree (*E.H., et.al. v. Matin, et. al*), the result of a state suit brought on behalf of institutionalized patients, addressed the need to provide active treatment in facilities as well as identify residents in state-run long-term care facilities with mental health or MR/DD diagnoses who are appropriate for community placement.



Wisconsin

A task force called the Americans with Disabilities Act Title II Advisory Committee—made up of state officials, providers, advocates and consumers from about 45 organizations as well as legislative staff—has been created to prepare a plan for strengthening compliance with the ADA. The group will look at the state’s various long term care systems and identify strategies for improving service delivery. The committee will develop recommendations concerning additional funding and craft plans for lifting barriers to community care for people with disabilities. The state long-term care ombudsman is the chair of the ADA Title II Advisory Committee. The committee’s plan will be ready in September 2001.

The committee is likely to focus its attention on issues raised by advocacy groups, including 1) access to personal assistance services for Medicaid beneficiaries, 2) waiting lists for home and community-based waiver programs, and 3) mental health issues for adolescents and older people and issues related to people living in institutions. The group is an offshoot of a legislatively mandated advisory council on long term care created through the state’s 1999 legislation that created the Family Care Program

In addition to the advisory committee, a study commission created by the Legislature is studying issues related to people with developmental disabilities. Staff attorneys have looked at the implications of the *Olmstead* decision for this group and have held hearings. This committee meets monthly.

State officials report that some complaints have been filed with the Office of Civil Rights by people with developmental disabilities and people with physical disabilities. The complaints generally are from people on waiver waiting lists.



Wyoming

For several years prior to the Supreme Court's *Olmstead* decision, state agencies in Wyoming had actively pursued home and community-based care options for the state's disabled population. Several state agencies had requested funding for waiver services, while others had begun work on a state plan to place institutionalized disabled individuals in community care settings.

Following the *Olmstead* decision, Wyoming's governor gave priority to this activity by designating the state's Department of Health (DOH) as the lead agency for developing a comprehensive plan to address home and community-based care for the state's disabled population. The DOH, in collaboration with consumer advocates, has completed a draft of that plan and hopes to have the final plan completed by July 1, 2001. The draft was approved by the Office of Civil Rights (Region 8) and was sent out for public comment April 1, 2001. In addition, the DOH has conducted 23 county visits in preparation for implementing the plan.

The plan includes all disabled groups and subclasses mentioned in the court decision. The DOH already has an assessment tool for determining nursing home medical necessity and will be developing assessment tools for all other groups and living situations, including assisted living and boarding homes.

Although the work on this plan has been moving ahead, there are several barriers to completing the plan quickly, most notably lack of adequate finances, differences of opinions among the different advocacy groups, and the rurality of the state, which makes developing a community infrastructure very difficult.

