Annual *Olmstead* Report

July 1, 2011 – June 30, 2012

Building Inclusive Communities, Keeping the Promise

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"Power yields nothing without demand. It never did and it never will. Find out just what any people will submit to and you have found out the exact measure of injustice and wrong which will be imposed upon them."

-Fredrick Douglass

Vision Statement

The vision of the *Olmstead* Council is that all West Virginians with disabilities live, learn, work, and play in the community of their choice.

Mission Statement

The mission of the *Olmstead* Council is to develop and monitor the implementation of a plan that will promote equal opportunities for people with disabilities to live, learn, work, and play in the community of their choice through West Virginia's compliance with *Title II of the Americans with Disabilities Act*.

Guiding Principles

1. People with disabilities, regardless of the severity of the disability, can be supported to live in the community and setting of their choice.
2. People with disabilities must have choice and control over where and with whom they live.
3. People with disabilities must have opportunities to live integrated lives in communities with their neighbors, and not subjected to rules or requirements that are different from those without disabilities. Integration does not just mean physical presence in a neighborhood, but valued and meaningful participation in community services and activities.
4. People with disabilities must have access to information, education and experiences that foster their ability to make informed choices, while respecting dignity of risk.
5. People with disabilities must have opportunities to develop valued social roles, meaningful personal relationship and activities of their choice.
6. People with disabilities must have meaningful opportunities for competitive employment.

THE *OLMSTEAD* CASE

In 1995, the landmark case now known as *Olmstead* was brought by the Atlanta Legal Aid Society on behalf of Lois Curtis and Elaine Wilson, who were confined in a state psychiatric hospital in Georgia. Hospital staff agreed that both women should be discharged to supportive community programs. But no such placements were available. The state of Georgia offered nursing facility placements. Ms. Curtis and Ms. Wilson believed this violated their rights under *Title II of the Americans with Disabilities Act* (ADA).

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Olmstead v. L.C. went through the judicial process with the plaintiffs successful at all judicial levels. The Georgia Department of Human Resources appealed to the United States Supreme Court the lower court's decision that the State had violated the ADA's integration mandate by segregating Ms. Curtis and Ms. Wilson.

On June 22, 1999, the U.S. Supreme Court issued their ruling that such segregation is discriminatory both because it "perpetuates unwarranted assumptions" that people with disabilities "are incapable or unworthy of participating in community life" and because "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Olmstead has been called the *Brown v. Board of Education* for people with disabilities. And like *Brown*, it is forcing change very slowly, and then only through determined and vigorous advocacy.

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The memories of living in institutional settings since the age of 13 will remain with Lois Curtis. Her story did not end after the landmark Supreme Court decision. Ms. Curtis lived in staffed residential settings after her discharge from the institution. She now rents a beautiful home in Stone Mountain, Georgia with a fellow artist and friend. Ms. Curtis is a successful artist. When asked what her artwork means to her, she responded, "My art been around a long time. I came along when my art came along. Drawing pretty pictures is a way to meet God in the work like it is."

On June, 20, 2011, Lois Curtis presented President Obama with a gift of one of her original paintings in the Oval Office. The "Girl in Orange Dress" is one in a series of three pastel self-portraits Ms. Curtis created since she has no photographs to mark her childhood.

INTRODUCTION

Six years ago, a public signing ceremony was held on December 14, 2005 to commemorate the October 12, 2005 signing of Executive Order 11-05. It has been 12 years since the United States Supreme Court ruling in *Olmstead v. L.C.*

> *"Confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."*
>
> *-U.S. Supreme Court*
> *Olmstead v. L.C.*

Olmstead v. L.C. upheld the rights of people with disabilities to live and receive supports in the most integrated setting in their community. *Title II of the Americans with Disabilities Act* (ADA) was the basis for this landmark decision. *Title II of the ADA* applies to state and local government entities and the programs funded and administered by them. Two regulations under Title II were fundamental to the *Olmstead* decision:

1. The **integration regulation** mandates that states "shall administer services in the most integrated setting appropriate to the needs of individuals with disabilities." The **most integrated setting** is "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."

2. The **reasonable modifications regulation** mandates that states "shall make reasonable accommodations in its policies, practices, or procedures when necessary to avoid discrimination, unless modifications would fundamentally alter the nature of the services, programs, or activities." The Supreme Court stated that, "…if the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons…in [most integrated] settings, and a waiting list that moved at a reasonable pace, not controlled by the State's endeavors to keep institutions fully populated, the **reasonable modification standard** would be met."

On October 12, 2005, *Executive Order 11-05* was signed formally approving and directing the implementation of the *West Virginia Olmstead Plan: Building Inclusive Communities*. *Executive Order 11-05* directs:

1. the implementation of the *West Virginia Olmstead Plan*;

2. the cooperation and collaboration between all affected agencies and public entities with the *Olmstead* Office to assure the implementation of the *Olmstead* decision within the budgetary constraints of the State; and

3. the submission of an annual report by the *Olmstead* Office to the Governor on the progress of the implementation of the *Olmstead Plan*.

Appendix A provides a list of *Olmstead Plan* goals.

OLMSTEAD ON THE NATIONAL LEVEL

Since 1999, there have been four (4) major federal initiatives to assist states with compliance with Title II of the ADA and the *Olmstead* decision. The four (4) major initiatives are: 1) the New Freedom Initiative (2000); 2) the Deficit Reduction Act (2005); 3) the Year of Community Living (2009); and 4) the Affordable Care Act (2010). **Appendix B** provides a summary of opportunities offered by these federal initiatives.

Year of Community Living

In 2009, President Obama launched "The Year of Community Living," to commemorate the 10th anniversary of the *Olmstead* decision. "The Year of Community Living" was launched to reaffirm the commitment to "vigorous enforcement of the civil rights for Americans with disabilities." The "Community Living Initiative" was developed to coordinate the efforts of Federal agencies and underscored the importance of the ADA and *Olmstead*.

> *"The Olmstead decision recognized the rights of individuals with disabilities to live the lives they choose, but its promise has not yet been fully realized. Far too many people remain segregated in institutions when they would rather be thriving in their communities."*
>
> *-Thomas E. Perez, Assistant Attorney General for the Civil Rights Division*

In the time since this start of this new initiative, the Department Housing and Urban Development, and the Department of Health and Human Resources (DHHS) released $40 million in Housing Choice vouchers for 5,300 people over 12 months. The Money Follows the Person Rebalancing Demonstration Program, through grant funding awards to States has helped almost 12,000 individuals transition from institutions to the community. This program was extended for current State participants and opened up for additional States to apply. West Virginia applied and received an MFP Rebalancing demonstration grant under this initiative.

Olmstead Enforcement

The United States Department of Justice, Civil Rights Division's Disability Rights Section, which enforces Title II and Title III of the ADA, and Special Litigation Section which enforces the *Civil Rights of Institutionalized Persons Act* (CRIPA), have made *Olmstead* enforcement a top priority. The first year of the Obama Administration proved to be a landmark year, with a record number of amicus briefs, lawsuits, and intervention into state *Olmstead* cases.

In addition to stepping up enforcement, investigatory work has significantly changed. In the past the first question asked was whether the institutions under investigation are safe, and whether conditions of confinement are constitutional. This is now the second question asked. The first question is whether there are individuals in those institutions who could appropriately receive supports in a more integrated setting.

In 2011, the Civil Rights Division, of the Department of Justice released the *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and*

Olmstead v. L.C[1]. This technical assistance guide was created to assist individuals in understanding their rights under Title II of the ADA and its integration mandate, and to assist state governments in complying with the ADA.

Since "The Year of Community Living" was announced the DOJ has been involved in 21 states, the District of Columbia and Puerto Rico in 47 cases.[2] The following summarizes this DOJ intervention:

- DOJ has joined or initiated litigation in the following 7 states in 8 cases: Arkansas, Delaware, Georgia, New Hampshire, New York, Texas, and Virginia.
- The DOJ has filed amicus briefs in the following 17 states and the District of Columbia in 31 cases: Alabama, California, Connecticut, Florida, Georgia, Illinois, Louisiana, Mississippi, Missouri, New Jersey, North Carolina, Pennsylvania, Oregon, Tennessee, Texas, Virginia and Washington.
- In addition, "findings letters" were issued following DOJ investigations in the following 8 states and 1 territory: California, Delaware, Mississippi, Nebraska, New Hampshire, North Carolina, Oregon, Virginia, and Puerto Rico.

[1] A copy of this document can be found at: http://www.ada.gov/olmstead/q&a_olmstead.htm
[2] A summary of DOJ litigation and investigations can be found at: http://www.ada.gov/olmstead/olmstead_cases_list2.htm

STATE OF THE STATE

This section will discuss the state of West Virginia's *Olmstead* implementation. First, examples of institutional bias will be identified with recommendations for reducing our reliance on institutional care. Then accomplishments and barriers to the implementation of the *West Virginia Olmstead Plan* will be outlined.

It is important to note that there are at least 11,000 people institutionalized in nursing facilities, ICFs/MR, state supplemented assisted living residences and state psychiatric facilities across West Virginia. Both ICFs/MR and nursing facilities have moratoriums on new development, but this has not stopped the construction or expansion of these programs. West Virginia has assisted living residential services that are primarily private pay arrangements. However, approximately 500 people receive a state supplemental payment for assisted living services.

West Virginia has continued to increase its reliance on institutional settings in the past 12 years since the *Olmstead* decision. ICFs/MR have been constructed to replace older or larger structures. Nursing facilities have been permitted to be developed at critical access hospitals. Both State-owned and operated psychiatric facilities have expanded (or have plans to expand) their bed capacity. This reverses downsizing that occurred for both facilities in the 1990s.

One achievement that will hopefully have a profound impact on the long term care system is the Money Follows the Person Rebalancing grant that West Virginia received from the Centers for Medicare and Medicaid Services in 2011.

Institutional Bias

One of the major barriers to achieving compliance with the *Olmstead* decision is the institutional bias of federal and state Medicaid and long term care regulations. Historically, Medicaid has covered long term care supports more readily when an individual resides in an institutional setting. Federal Medicaid law requires states to provide institutional care to all eligible individuals as a mandatory benefit, and permits (but does not require) states to make services available in the community as an optional benefit.

In response to the *Olmstead* decision, the Centers for Medicare and Medicaid Services (CMS) have offered various opportunities to states for clarification, guidance, increased flexibility, modifications to rules, and demonstration grant funding with the goal to assist states to implement the *Olmstead* decision and reduce the reliance on institutional

> *"To live in my own home, well I feel very grateful to all the people who helped me to get my own home and I feel very good about my home. I have a great life and I can make my own decisions. And I can handle my own business, and I feel good about myself."*
>
> *-Elaine Wilson, from an interview published by ILRU#*

care. While West Virginia has taken advantage of some of this federal assistance, we have lagged behind other states in moving to balance the long term care system.

Forty-four (44) states have been actively engaged for decades in formal statewide activities to balance their long term care system. This includes legislation, institutional closure initiatives, transition initiatives, streamlining eligibility criteria and processes, and CMS Money Follows the Person Rebalancing grants.

In February 2011, West Virginia received a grant from CMS for the Money Follows the Person Rebalancing Demonstration Grant. This program will begin in late 2011. This is the biggest step West Virginia has taken to actively reduce the reliance on institutional settings, since the last institutional closure in 1998. The *Olmstead* Office and Council have identified the following eleven (11) examples of institutional bias in West Virginia:[3]

1. West Virginia spends a greater percentage of its overall Medicaid long term care funding for institutional care when compared to community-based supports.

2. West Virginia's Aged and Disabled Waiver Program does not provide a comparable or functional alternative to nursing facility care.

3. West Virginia lacks affordable, accessible, and available housing for people with disabilities.

4. West Virginia restricts access to Medicaid Personal Care services to all recipients of the Aged and Disabled Waiver Program.

5. West Virginia utilizes waiting lists for eligible applicants of the I/DD Waiver Program, and (historically with) the Aged and Disabled Waiver Program.

6. West Virginia does not provide an adequate education (informed choice) on support options for home and community-based services prior to institutional placement.

7. West Virginia implements a complicated and lengthy eligibility process Medicaid Waiver Programs when compared to institutional care settings.

8. West Virginia incentivizes institutional care through a cost-based reimbursement methodology.

9. West Virginia has a fragmented and inadequate service system for people with mental illness and co-occurring disabilities.

10. West Virginia does not effectively use unlicensed, trained personnel to administer medications in the community through exemption and delegation methods.

11. West Virginia does not effectively use case management services to support people in transitioning from institutional care to the community.

[3] This is not an all-inclusive list.

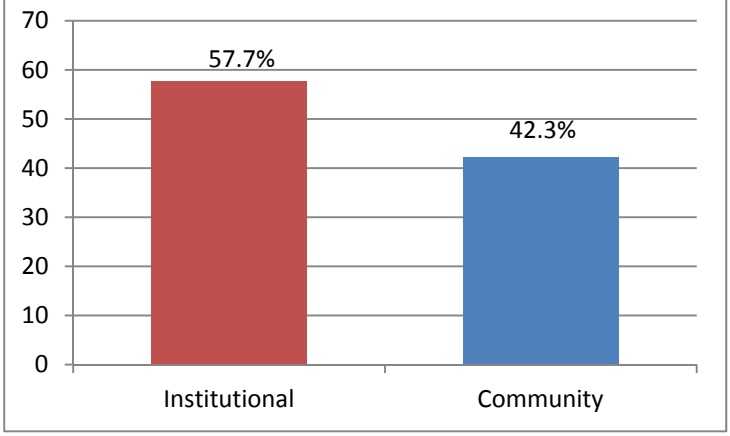
12. West Virginia requires institutionalization for applicants of the Traumatic Brain Injury Waiver Program.

The *Olmstead* Office and Council have identified recommendations to eliminate or reduce the institutional bias that results in the costly overuse or inappropriate use of institutional settings.

1. *West Virginia spends a greater percentage of its overall Medicaid long term care funding for institutional care when compared to community-based supports.*

In 2010, West Virginia spent 57.7% of Medicaid long term care funding on institutional care, and 42.3% on community-based supports.[4] West Virginia has slowly decreased this gap in spending over the last 5 years by 4.6%. ***Figure 1*** shows the comparison of institutional and community-based spending for 2010.

Figure 1. WV Medicaid LTC Spending, 2010



However, West Virginia's national ranking continues to remain the same or even decline in some cases. Thomson Reuters is under contract with the Centers of Medicare and Medicaid Services to issue an annual report on Medicaid long term care spending and state rankings. Since 2004, West Virginia has dropped in the national rankings from 17th in the nation to 21st in 2009. The lowest ranking during this time period was 24th. It is important to note that the 2009 rankings did not include 11 states due to insufficient data. Ten out of these 11 states have historically ranked higher than West Virginia. Therefore, this could place West Virginia much lower that 21st in the national rankings.

Recommendation: West Virginia should take advantage of the State Balancing Incentive Payments Program. In combination with the West Virginia MFP grant these are two excellent ways to increase the percentage of funding for home and community-based services.

The *Patient Protection and Affordability Act* includes Medicaid options and incentives to expand long term care services and supports. The State Balancing Incentive Payments Program offers opportunities for states to receive increases in Federal Medicaid Assistance Program (FMAP). States in which less than 50 percent of Medicaid long term care spending was for non-institutional supports and have a target of 50 percent on home and community-based services by 2015 would receive FMAP incentive payments of two percentage points. All incentive payments received by states must be used to expand the

[4] West Virginia Bureau for Medical Services report issued on 05/06/2010. Institutional care includes nursing facility and ICF/MR care. Community-based supports include the Aged and Disabled Waiver, I/DD Waiver, home health and personal care services.

availability of Medicaid home and community-based services. This program goes into effect October 1, 2011.

When the two percentage points to the home and community-based expenditures for fiscal year 2009 are applied, the result is an additional $7,188,133 in federal match.

2. West Virginia lacks affordable, accessible, and available housing for people with disabilities.

Disability rates in West Virginia range from 18 percent to 25 percent in any given region. The West Virginia Coalition to End Homelessness show an over 200 percent increase from 2008 to 2011 in the number of people with disabilities with extremely low income who have accessed Community Action or Homelessness assistance.

The "Priced Out in 2010" report prepared by the Technical Assistance Collaborative and the Consortium for Citizens with Disabilities (CCD) Housing Task Force indicated the average Social Security Income (SSI) payment in West Virginia is $674 per month. This monthly SSI payment represents 72 percent of the cost of a one-bedroom unit and 64 percent of the cost of an efficiency unit. This monthly SSI payment equals an hourly rate of $3.39; however, an individual in West Virginia will need to earn at least $9.51/hour in order to be able to afford a modest one-bedroom unit at Housing and Urban Development's (HUD) Fair Market Rents.

In transitioning (or diverting) individuals from institutional settings, the number one issue is the ability to secure safe, affordable, and accessible housing.

Recommendation: West Virginia needs to access federal funding opportunities for increasing and improving the housing stock for people with disabilities. The *Take Me Home, West Virginia Program* will begin to systematically address the housing needs of people with disabilities through a full-time housing coordinator and housing committee. In addition, it is anticipated that West Virginia will apply for the federal Section 811 Rental Assistance Demonstration grant.

3. West Virginia's Aged and Disabled Waiver (ADW) Program does not provide a comparable or functional alternative to nursing facility care.

West Virginia Bureau for Medical Services defines the Aged and Disabled Waiver Program "as a long term care alternative that provides services that enable an individual to remain at or return to home rather than receiving nursing facility (NF) care."[5]

The traditional model of the ADW Program offers eligible members 62 to 155 hours per month of in-home support based on an assessed level of care that is defined by the BMS. This equates to an average of only 2 to 5 hours a day of in-home direct support. While a nursing facility is required to provide hands-on nursing staff time of only 2.25 hours per 24 hour day. Nursing facilities are staffed 24 hours per day seven days a week to address an individual's needs.

[5] West Virginia Bureau for Medical Services, Aged and Disabled Waiver Manual, Section 501.1

West Virginia is one of only 4 states that does not provide respite care under their aging and disability waiver. The other states are Louisiana, Rhode Island, and Washington.

Recommendation: West Virginia should assess the waiver program to better meet the needs of people it serves and those that cannot access it due to an inadequate service package. Aggressive planning needs to take place to develop a long range plan to enhance the service package to offer a responsive and functional alternative to nursing facility care.

4. West Virginia restricts access to Medicaid Personal Care services to all recipients of the Aged and Disabled Waiver Program.

Medicaid Personal Care services may only be accessed by members who are receiving ADW services at level of care D. Medicaid Personal Care services are not available to ADW members receiving level of care A through C. This restriction is not based on individual need, but on arbitrary levels of service for the ADW program established by the State. The eligible ADW member is fit into a level of service as opposed to the level of service being defined by the eligible member's needs.

Personal Care services can provide an additional 2 – 7 hours of direct in-home support per day.

Recommendation: The Bureau for Medical Services should eliminate this restriction, especially in light of the fact that the ADW program does not have an equitable service or benefits package when compared to nursing facility level of care. Due to this and the level of burden placed on informal supports, the addition of personal care services is necessary to support people from being institutionalized.

5. West Virginia utilizes waiting lists for eligible applicants of the I/DD Waiver Program, and the Aged and Disabled Waiver Program.

The I/DD Waiver Program has had a waiting list for services since 2005. As of June, 30, 2011, 473 people were on the waiting list and 383 have been waiting longer than 90 days. During this same time period, the longest period of time any one individual has been on the waiting list was 532 days.[6]

In 2009, the average cost for per I/DD Waiver member was $61,794, and the average cost per resident in an ICF/MR was $115,884.[7]

West Virginia has 66 ICF/MR facilities with 511 beds. There is a moratorium on adding ICF/MR beds and facilities in West Virginia. However, the State continues to rely, redistribute, and reconstruct facilities under the current system. BMS reported that data for occupancy rates are not collected by the Bureau for the ICF/MR program.

BMS plans to add 300 unduplicated slots to the I/DD Waiver Program over the next 5 years (through 2015). In addition, unused slots from discharges throughout the year are reallocated every July 1st.

[6] Data Source: APS Healthcare
[7] Data Source: WV Bureau for Medical Services

On December 5, 2011, West Virginia implemented a wait list for the Aged and Disabled Waiver Program. In response, the *Olmstead* Office wrote a letter to the Secretary Lewis and Commissioner Atkins expressing concern for the initiation of this wait list.

In 2010, the average cost for per ADW member was $22,788, and the average cost per Medicaid patient in a nursing facility was $46,667.[8]

BMS plans a reduction of 2,301 unduplicated slots to the ADW Program over the next 5 year (through 2015). As of June 30, 2012, the state occupancy rate for West Virginia nursing facilities was 88.4%, and a median facility occupancy of 92.1%.[9]

Waiting lists result in eligible individuals being unable to access services at a reasonable pace. Often, eligible individuals are forced to wait extensive periods of time, which results in inappropriate institutionalization or undue stress on family and informal supports.

West Virginia has a moratorium on adding nursing facility beds and facilities. However, this did not prevent the legislature from passing a law during the 2011 regular legislative session to permit the development and operation of a nursing facility on the grounds of a critical access hospital. This law not only exempts the moratorium, but exempts the requirement to obtain a certificate of need from the WV Health Care Authority. This is the second time legislation of this type has been enacted.

When long term care budgets are cut or reductions are made these rarely affect institutional supports for nursing facilities or ICF/MR care.

Recommendation: West Virginia should develop a long range plan to meet the needs of people seeking community-based waiver services. Historical (monthly and yearly) data exists on the number of people applying and determined eligible for the waiver programs. This data could be used to project future need. Money Follows the Person and other rebalancing techniques should be utilized.

In addition, the Balanced Incentive Program could be used to apply enhancing federal match to eliminate the reliance on waiting lists.

6. West Virginia does not provide an adequate education (informed choice) on support options for home and community-based services prior to institutional placement.

Benefits or options counseling is not required prior to any institutional placement in West Virginia for nursing facility or ICF/MR care.

The BMS uses the Pre-Admission Screening Assessment (PAS-2000) tool for determining eligibility for the ADW Program, personal care services, and nursing facility care.

[8] Data Source: WV Bureau for Medical Services

[9] American Health Care Association based on CMS OSCAR data. State occupancy is calculated by dividing the sum of patients occupying certified beds by the sum of all certified beds in the state. http://www.ahcancal.org/research_data/oscar_data/Nursing%20Facility%20Operational%20Characteristics/OperationalCharacteristicsReport_Jun2012.pdf

Question 17 on the PAS-2000 states: Has the option of Medicaid Waiver been explained to the applicant?

This question only requires a "yes or no" response. This results in people being intentionally or unintentionally steered towards institutional care without being fully informed of their options.

Individuals being admitted to an ICF/MR sign an informed consent document stating they are choosing ICF/MR services over home and community-based waiver services. There is no requirement to provide information to support individuals in making an informed choice.

Recommendation: The process for nursing facility and ICF/MR services should be modified to eliminate require a benefits or options counseling process for every applicant prior to institutionalization.

7. West Virginia implements a complicated and lengthy eligibility process Medicaid Waiver Programs when compared to institutional care settings.

The I/DD Waiver Program has a mandated (court ordered) 90 day eligibility determination process. However, West Virginia has a waiting list which significantly impacts the time an eligible individual must wait before services can be provided.

BMS policy permits ICF/MR services to be provided prior to the eligibility determination being made. This is known as presumptive eligibility. To establish eligibility, a completed packet of the required information must be submitted within 30 days after placement in the ICF/MR facility. For those admitted after their eligibility has been determined, the ICF/MR manual states that eligibility determinations will be made as quickly as possible (a maximum of 45 days).[10]

During calendar year 2009, 58% of the eligibility reviews for I/DD Waiver services were denied, and 2% of the eligibility reviews (or one applicant) for ICF/MR were denied.[11]

West Virginia has one of the most restrictive eligibility criteria in the nation for its I/DD Waiver Program.

Recommendation: West Virginia should redesign the eligibility and enrollment process to ensure equitable processes for ICF/MR and I/DD Waiver programs. The I/DD waiver should redefine its eligibility criteria to use the federal definition and national standards used by nearly every other state in the nation. There needs to be equal access to community-based and institutional care.

Like the I/DD Waiver, the ADW has a lengthy and cumbersome eligibility and enrollment process. This process has numerous steps and takes months to complete. In comparison, the nursing facility process takes an average of 24-48 hours to complete.

During calendar year 2009, 53% of the initial eligibility reviews for ADW were denied, and 4% of nursing facility eligibility reviews were denied.[12]

[10] BMS ICF/MR Manual, Section 513.5.3
[11] Data source: WV Bureau for Medical Services

Recommendation: West Virginia should redesign the eligibility and enrollment process to ensure equitable processes for nursing facility and ADW programs. There needs to be equal access to community-based and institutional care.

8. West Virginia incentivizes institutional care through a cost-based reimbursement methodology.

Institutional services for ICF/MR and nursing facility care are paid for through a cost-based reimbursement methodology.[13] I/DD Waiver and the ADW programs are paid for on a fee-for-service basis.

For nursing facilities, the cost-based reimbursement methodology results in a comprehensive per diem rate that is recalculated every six months. These per diem rates are cost related and not developed based on acuity. Case mix is an add-on to the rate.

For ICF/MR programs, the cost-based reimbursement methodology is based on actual costs and client specific needs assessments. In addition, per diem rates reimburse for allowable cost for room and board, laundry, housekeeping, administrative costs, cost of capital and cost of inflation.

This creates an incentive to provide institutional care over home and community-based services. Some examples of this are:

- Institutional care is reimbursed for services that are also required of home and community-based waiver programs. These are required but not reimbursed under the fee-for-service model of the waiver programs. For example, training, supervision, cost of living increases, cost of inflation.
- Documentation requirements are typically more extensive under a fee-for-service model. For example, fee-for-service documentation is typically required for every 15 minute to one hour unit. Cost-based reimbursement is billed on a daily basis as opposed to a per unit basis.

Recommendation: West Virginia should fund programs in a manner that does not give incentives or advantages for institutional care.

9. West Virginia has a fragmented and inadequate service system for people with mental illness and co-occurring disabilities.

As evidenced by the long-standing court action under the *Hartley* consent decree the mental health system continues to struggle with meeting the mental health needs of West Virginians. In addition, the findings of the national President's New Freedom Commission on Mental Health identified the following findings for West Virginia's mental health system:[14]

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[12] Data source: WV Bureau for Medical Services 7/13/2010

[13] The I/DD Waiver Program uses a managed care style algorithm to set individual budgets.

[14] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

a. children with emotional disturbances are unnecessarily and precipitously being sent out of state for services;
b. families are split because of a perceived need to place children in custody before providing services;
c. psychiatric hospitals are overcrowded, with millions of dollars expended on inpatient services for people who could and should be served in community programs;
d. there is a severe lack of safe, affordable housing for people with psychiatric disabilities;
e. apathy about jobs for people with disabilities fosters an inappropriate and disproportionate reliance on expensive and restrictive treatment services.

In 2008, the West Virginia Mental Health Planning Council issued a report entitled, *Synopsis of Current Recommendations for Mental Health and Substance Abuse Services in West Virginia, with a Blueprint for Transformation.* This report identified 14 recommendations for systems change.

Recommendation: Recommendations made in study, commissions or councils on behalf of the West Virginia behavioral health system should be implemented. Some examples are:

a. Re-design Medicaid reimbursement to support effective community-based services.
b. Develop and implement a true performance-based contract for Community Behavioral Health Centers.
c. Create a policy to achieve integration of physical health care and behavioral health care.
d. Develop a plan, in collaboration with the Housing Development Authority, to expand availability of a variety of safe, affordable housing.
e. Increase the qualifications for entry-level positions in community-based mental health services.
f. Develop a system to provide quicker access to services and enable consumers to obtain services better matched to their needs at the beginning of treatment.
g. Create an annual process to identify and support with State funds services and programs that have achieved desired outcomes for at least two years, using "demonstration funding" from sources like the Community Mental Health Services Block Grant.
h. Develop and implement a plan to assure cultural competence that includes addressing issues of rurality in the State, including better use of technology.

10. West Virginia does not effectively use unlicensed, trained personnel to administer medications and perform health maintenance tasks in the community through exemption and delegation methods.

In 2011, the American Association of Retired Persons or AARP issued the report "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Care Givers." **This report ranked West Virginia last in the nation for delegating health maintenance tasks to trained direct care workers.**

The report assessed 16 common health maintenance tasks: administer oral medication, administer as needed medications, pre-filled insulin or insulin pen, draw up insulin for dosage measurement, intramuscular injections, glucometer test, medications through tubes, suppositories, eye/ear drops,

gastrostomy tube feedings, enemas, intermittent catheterizations, ostomy care, nebulizer treatment, oxygen therapy, and ventilator/respiratory care.

West Virginia does not permit any of the 16 health maintenance tasks to be performed by a trained and certified direct care worker for the population receiving services through the Aged and Disabled Waiver, Traumatic Brain Injury Waiver, Personal Care, and Home Health. Only one task is permitted under the Intellectual and Developmental Disabilities (I/DD) Waiver, oral medication administration.

Eleven (11) states permit 14-16 of the tasks to be delegated to unlicensed personnel.

Medication administration is a regular service provided to patients of nursing facilities, and residents of ICF/MR programs.

ADW members are required to self-administer medications or have informal supports to perform this function. Medication administration by unlicensed personnel (AMAP) is not permitted within the ADW Program as a matter of policy, not statute.

I/DD Waiver Program permits the use unlicensed personnel to administer medications, but this service is severely underutilized. In addition, the statute is in need of revision to include the lessons learned of the past decade to better address the needs of people living in their community.

Recommendation: West Virginia should develop and implement a program for unlicensed personnel to administer medications for the ADW program, personal care, and home health. West Virginia should support legislation to increase the flexibility of the AMAP program for the I/DD Waiver to increase its utilization and decrease the overall costs of the program. West Virginia should pass legislation to permit a full range of health maintenance tasks to be delegated to trained and certified direct care staff.

11. West Virginia does not effectively use case management services to support people in transitioning from institutional care to the community.

The BMS states the following about Targeted Case Management (TCM): "A Medicaid eligible individual over age 20 who has been determined in need of discharge, disposition, placement and after care follow up from a long term care facility may access TCM services to assist with transition planning. In this capacity, TCM is not permitted to exceed 30 days prior to the estimated date of discharge."[15]

The Centers for Medicare and Medicaid Services permits case management services under Medicaid to be provided for transition or discharge planning 180 consecutive days prior to discharge date from an institutional facility.[16]

The I/DD Waiver Program permits service coordination to be used for discharge or transition planning 30 day prior to the date of discharge.

[15] West Virginia BMS Targeted Case Management Manual, Section 523.2
[16] State Medicaid Directors Letter, Olmstead Update No. 3, July 25, 2000

Recommendation: West Virginia should review the experiences of other states that use TCM more effectively to cover a wider range of support and increase utilization. Once this review is completed, West Virginia should develop a plan to enhance its TCM services to better serve Medicaid members.

12. West Virginia requires institutionalization for applicants of the Traumatic Brain Injury Waiver Program.

Individuals who have a traumatic brain injury must be institutionalized to apply for the WV Traumatic Brain Injury Waiver Program. The requirement for applicants to be a patient of a licensed nursing facility, or licensed rehabilitation facility at the time of application creates an incentive to institutionalize individuals. The State should not incentivize institutionalization as a means to obtain home and community-based services. As of June 30, 2012, the program had only one (1) enrolled participant.

This requirement is contrary to the integration mandate of *Title II of the Americans with Disabilities Act* as upheld by the *Olmstead* decision. The U.S. Department of Justice released a technical assistance guide, *"Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C."* This document provided a question and answer section to address specific *Olmstead*-related issues. The following is taken directly from the technical assistance guide and is very relevant to this issue:

> *The ADA's integration mandate is implicated where a public entity administers its programs in a manner that results in unjustified segregation of persons with disabilities. More specifically, a public entity may violate the ADA's integration mandate when it: (1) directly or indirectly operates facilities and or/programs that segregate individuals with disabilities; (2) finances the segregation of individuals with disabilities in private facilities; and/or (3) through its planning, service system design, funding choices, or service implementation practices, promotes or relies upon the segregation of individuals with disabilities in private facilities or programs.*

Recommendation: West Virginia should end the eligibility requirement of institutionalization for applicants of the TBI Waiver Program. This is not a practice used for other waiver programs in West Virginia.

OLMSTEAD INITIATIVES IN WEST VIRGINIA

Since August 2003, West Virginia has had a full-time Olmstead Coordinator. The Olmstead Coordinator assembled an Olmstead Council in November 2003.

West Virginia *Olmstead* Council and Plan

The West Virginia *Olmstead* Council was established in 2003 to advise and assist the *Olmstead* Coordinator to develop, implement, and monitor West Virginia's *Olmstead* activities. The mission of the *Olmstead* Council (Council) is to assist all West Virginia citizens with disabilities to have the opportunity to receive supports and assistance in the most integrated setting in the community. The Council has the following responsibilities as outlined in the *Olmstead Plan*:

1. Advise the Coordinator in fulfilling the position's responsibilities and duties;
2. Review the activities of the Coordinator;
3. Provide recommendations for improving the long term care system;
4. Issue position papers for the identification and resolution of systemic issues; and
5. Monitor, revise, and update the *Olmstead Plan* and any subsequent work plans.

> *"Much can be done when we raise our voices and join together. We cannot simply stand by and wait for someone else to take action. We must make our own history."*
>
> *-the late Ken Ervin, ADAPT-WV founder and Olmstead Council member*

The Council is a 30-member body consisting of eight (8) people with disabilities and/or immediate family members; eleven (11) advocacy and/or disability organizations; six (6) providers of institutional and community supports; four (4) state agencies; and one (1) housing representative. **Appendix C** provides a list Olmstead Council members who served between July 1, 2011 and June 30, 2012.

The *Olmstead* Office and Council oversee four (4) initiatives during state fiscal year 2011. These initiatives are:

1. the West Virginia *Olmstead Plan*;
2. the *Olmstead* Information, Referral and Assistance Program;
3. the *Olmstead* Transition and Diversion Program;
4. the U.S. Substance Abuse Mental Health Administration *Olmstead* Initiative grant.

On October 12, 2005, *Executive Order 11-05* was signed formally approving and directing the implementation of the *West Virginia Olmstead Plan: Building Inclusive Communities (Olmstead Plan or Plan)*. *Executive Order 11-05* directs:

1. the implementation of the *West Virginia Olmstead Plan*;

2. the cooperation and collaboration between all affected agencies and public entities with the *Olmstead* Office to assure the implementation of the *Olmstead* decision within the budgetary constraints of the State; and

3. the submission of an annual report by the *Olmstead* Office to the Governor on the progress of the implementation of the *Olmstead Plan*.

In response to the increased federal Olmstead enforcement and technical assistance, the Council has decided to update the *Plan*. The Council has established a process to update the plan which will include public forums, focus groups, planning sessions, and a 30-day public comment period.

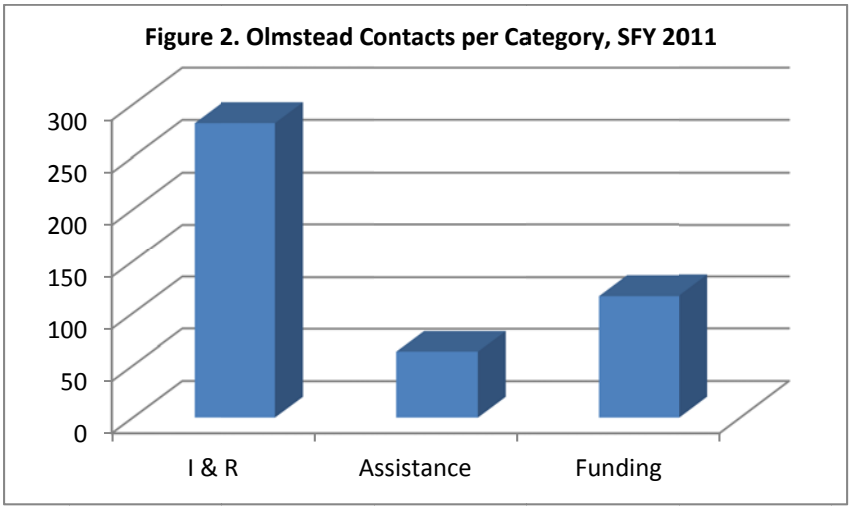
As previously mentioned, **Appendix A** provides a list of *Olmstead Plan* goals.

Appendix D provides a timeline of *Olmstead* Accomplishments.

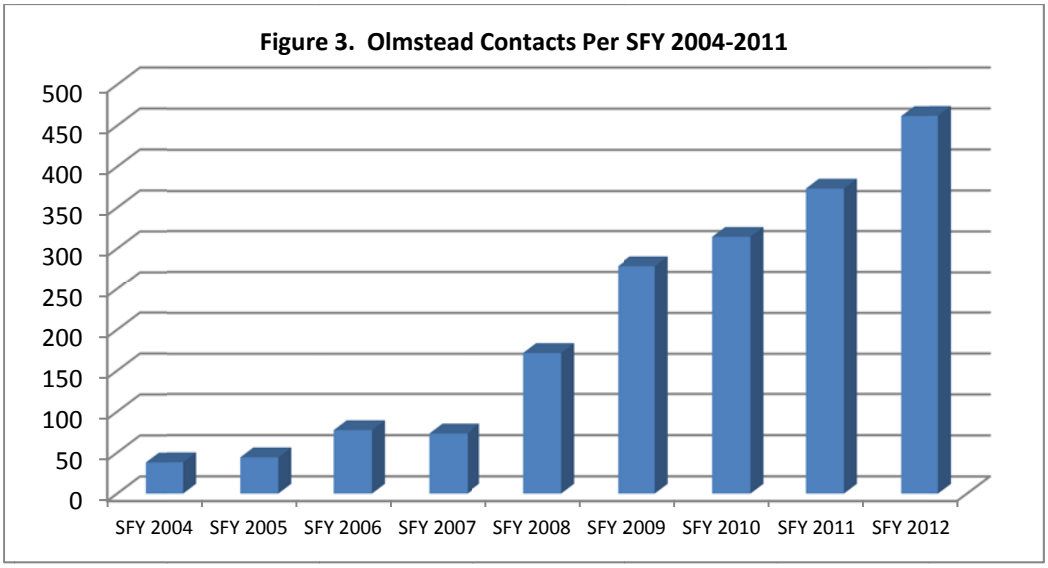
Olmstead Information, Referral and Assistance Program

The *Olmstead* Office provides information, referral and assistance to West Virginia citizens with disabilities and their families concerning Olmstead-related issues. In addition to information and referral, the *Olmstead* Office provides citizens with assistance on *Olmstead*-related complaints or grievances.

In state fiscal year 2011, the *Olmstead* Office received 462 documented (and unduplicated) contacts for information, referral and assistance. ***Figure 2*** shows the number of contacts per category for the fiscal year. Information and referral means the typical contact is providing basic information with no further contact needed. Assistance means the typical contact is requesting help that requires additional time and contact to the individual. Assistance includes help with *Olmstead*-related grievances, complaints, and requests for funding to return to or remain in the home.



The *Olmstead* Office has been tracking *Olmstead*-related contacts since the office was established in August 2003. ***Figure 3*** shows the number of contacts for state fiscal years 2004 through 2011.



There was a documented 24% increase in the number of contacts the *Olmstead* Office received in 2012 as compared to 2011. The biggest barrier to providing assistance is the need for systems change to decrease the institutional bias and make community-based services and supports more readily available and accessible.

Olmstead Transition and Diversion Program

Since 2007, the purpose of the *Olmstead Transition and Diversion Program* (formerly, the Transition Navigator Program) has been to assist West Virginians with disabilities residing in institutional facilities (or at-risk of institutionalization) to be supported in their home and community.

In 2010, the Program experienced a major change as a result of the Take Me Home, West Virginia Program. This is the federal Money Follows the Person and Rebalancing grant. The Bureau for Medical Services (BMS) is in the process of expanding this program statewide. The *Olmstead* office has provided the BMS with $292,000.00 in state general revenue funding to expand this program statewide.

The *Olmstead* Office continues to offer a smaller grant program called the *Olmstead Transition and Diversion Program*. This program will support people for transition and diversion, and will focus on those not otherwise supported by the Take Me Home, West Virginia Program.

During state fiscal year 2012, the program supported 67 people through the transition and diversion process. ***Figure 4*** identifies the number of people the program supported for transition and diversion for state fiscal years 2012 compared to 2011 and 2009.

Figure 4. Olmstead Transition and Diversion Program Totals, SFY 2009 - 2012

	SFY 2012	%	SFY 2011	%	SFY 2010	%	SFY 2009	%
Total # People Transitioned	13	19%	50	33%	38	28%	37	26%
Total # People Diverted	54	81%	101	67%	96	72%	103	74%
TOTAL	**67**		**151**		**134**		**140**	

In SFY 2012, 13 people were transitioned and 54 were diverted from institutional care.

The program has helped support 492 people in four (4) years to return to or remain in their home and community.

Each participant is eligible to receive up to $2,000 to pay for reasonable and necessary one-time start-up costs. One-time start-up costs included: security deposit for housing; set-up fees for utilities; moving expenses; essential home furnishings and supplies; and home accessibility modification. ***Figure 5*** details the funding allocated for participants during state fiscal year 2012 as compared to previous years.

Figure 5. Olmstead Transition and Diversion Program Start-Up Funding, SFY 2009 - 2012

Transition Navigator Start-Up Funding	SFY 2012	%	SFY 2011	%	SFY 2010	%	SFY 2009	%
Housing Security Deposit	$2,659.00		$12,990.12	5%	$9,030.85	3%	$3,748.58	1%
Utility Set-Up Fees or Deposits	$762.50		$5,148.20	2%	$3,420.53	1%	$5,005.34	1%
Essential Home Furnishings and Supplies	$20,292.07		$80,598.20	3%	$59,441.17	22%	$125,802.34	31%
Moving Expenses	$15.00		$2,394.20	<1%	$5,680.13	2%	$8,027.33	2%
Home Modifications	$100,143.99		$171,405.41	63%	$196,832.00	72%	$266,887.02	65%
TOTAL	**$123,872.56**		**$272,536.15**		**$274,404.68**		**$409,470.61**	
PER PERSON AVERAGE	**$1,848.84**		**$1,804.88**		**$2,047.80**		**$2,924.79**	
NUMBER SERVED	**67**		**151**		**134**		**140**	

The average start-up funding allocated per participant was $1,848.84. The program has worked to effectively use the funding available and to serve the most people possible.

The Olmstead Office submitted a state fiscal year 2014 improvement package request for $300,000 in additional state general revenue funding to support the *Olmstead Transition and Diversion Program*.

SAMHSA *Olmstead* Grant

Since 2000, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) have issued state *Olmstead* initiative grants to states and territories every three (3) years in the amount of $60,000. The purpose of this grant funding is to expand resources and opportunities for adults with serious mental illnesses and children with serious emotional disturbances to live in their home communities.

The funding for this program is used to assist people to transition from the state-operated psychiatric facilities and can be used in combination with the *Olmstead Transition and Diversion Program*.

Priorities & Recommendations

The *Olmstead* Council identifies priorities and recommendations each year to be release for the regular legislative session. The *Olmstead* Council has identified the following four (4) priorities for 2012:

On October 12, 2005, Executive Order 11-05 was signed formally directing the implementation of the West Virginia *Olmstead* Plan. The Order furthers directs the cooperation and collaboration between all affected agencies and public entities with the *Olmstead* Office to assure the implementation of the *Olmstead* decision.

Priority 1: Implementation of the West Virginia Olmstead Plan to ensure compliance with Title II of the Americans with Disabilities Act.

1. Revise the West Virginia *Olmstead Plan* to ensure federal guidelines are addressed.
2. Establish a formal agreement to ensure the cooperation and collaboration between all affected agencies and public entities with the *Olmstead* Office to implement the *Olmstead Plan*.
3. Inclusion of the *Olmstead* Office and Council in state processes that affect the institutional and/or community-based long term care system.

Priority 2: Elimination of the institutional bias in West Virginia's long term care system.

1. Support the development and implementation of the Centers for Medicare and Medicaid Services Money Follows the Person (MFP) grant.
2. Increase access and availability of home and community-based services while reducing reliance on institutional settings.
3. Implement legislation and policies that address the elimination of institutional bias.
4. Issue an annual report that identifies institutional bias and recommendations for change.

Priority 3: Secure additional state funding to support a statewide, comprehensive transition and diversion program.

1. Obtain additional funding to support the *Olmstead Transition and Diversion Program* as outlined in the SFY 2013 Improvement Package request.

Priority 4: Implementation of a formal plan to address the major barrier of affordable, accessible and integrated housing options for people with disabilities.

1. Support the inclusion of a full-time housing coordinator under the MFP grant.
2. Identify local, state and federal housing resources either under-utilized or un-utilized to address the critical housing gap in West Virginia for people with disabilities.

Appendix A: West Virginia *Olmstead* Plan Goals

The *Olmstead* Council through extensive public input developed 10 *Olmstead* goals. Each goal has a series of specific objectives. The following lists these 10 goals:

1. **Informed Choice:** Establish a process to provide comprehensive information and education so people with disabilities can make informed choices.

2. **Identification:** Identify every person with a disability, impacted by the Olmstead decision, who resides in a segregated setting.

3. **Transition:** Transition every person with a disability who has a desire to live and receive supports in the most integrated setting appropriate.

4. **Diversion:** Develop and implement effective and comprehensive diversion activities to prevent or divert people from being institutionalized or segregated.

5. **Reasonable Pace:** Assure community-based services are provided to people with disabilities at a reasonable pace.

6. **Eliminating Institutional Bias:** Provide services and supports to people with disabilities by eliminating the institutional bias in funding and administering long term care supports.

7. **Self-Direction:** Develop self-directed community-based supports and services that ensure people with disabilities have choice and individual control.

8. **Rights Protection:** Develop and maintain systems to actively protect the civil rights of people with disabilities.

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

10. **Community-Based Supports:** Develop, enhance, and maintain an array of self-directed community-based supports to meet the needs of all people with disabilities and create alternatives to segregated settings.

Appendix B: Major Federal Initiatives

Affordable Care Act (2010)

- CLASS Act
- Health Insurance Reform
- HCBS Options under State Plan and Waivers
- Expansion of the Money Follows the Person (MFP) grant
- Medicaid infrastructure grants
- Medicaid State Balancing Incentive Program

Year of Community Living (2009)

- Statement of the DOJ on Olmstead enforcement and technical assistance
- Managed long-term service and supports
- Advancing access to affordable housing
- HCBS participant experience measures
- Aging and Disability Resource Centers
- Minimum Data Set (MDS) 3.0
- Person-Centered Hospital Discharge Planning Model Grants
- Housing supports and initiatives

Deficit Reduction Act (2005)

- State option to provide HCBS
- Cash and counseling options
- Monthly Follows the Person (MFP) Rebalancing Initiative
- Expanded coverage under Medicaid

New Freedom Initiative (2000)

- Federal Executive Order
- New Freedom Commision on Mental Health
- Recommendations for Developing a Comprehensive, Effectively Working Plan
- Federal Medicaid Changes
- Federal Medicaid Policy Clarifications
- Health care coverage options under Section 1902(r)(2)
- Nursing facility transition grants and "Access Housing"iInitiative
- Real Choice System Change Grants
- Community-based attendant services with consumer control
- Aging and Disability Resource Center grants
- Minimum Data Set (MDS) 2.0

Appendix C: *Olmstead* Council Membership

Elliott Birckhead	Bureau for Behavioral Health and Health Facilities
Tomi Burnside	Stonerise Healthcare
Marcus Canaday	Bureau for Medical Services
Ardella Cottrill	West Virginia Mental Health Planning Council
Karen Davis	Charleston, West Virginia
Jan Derry	Northern West Virginia Center for Independent Living
Mark Drennan	West Virginia Behavioral Health Providers' Association
Jeannie Elkins	Ashford, West Virginia
Darla Ervin	Morgantown, West Virginia
Rachael Fetty	West Virginia EMS-TSN Hartley Medley Advocacy Program
Laura Friend	West Virginia Council on Home Care Agencies
Nancy Fry	Legal Aid of West Virginia, Behavioral Health Advocacy Project
Clarice Hausch	West Virginia Advocates
Brenda Hellwig	Job Squad, Inc.
Roy Herzbach	Legal Aid of West Virginia, Long Term Care Ombudsman Program
Cathy Hutchinson	Mountain State Center for Independent Living
E. Mark Knabenshue	Committee for Hancock County Senior Citizens
Linda Maniak	Charleston, West Virginia
Ann McDaniel	West Virginia Statewide Independent of Living Council
Suzanne Messenger	Bureau of Senior Services
Kim Knuckles	State ADA Coordinator
David Sanders	Bureau for Behavioral Health and Health Facilities
Christine Shaw	Res-Care, Inc.
Kevin Smith	Parkersburg, West Virginia
David Stewart	West Virginia ADA Coalition
Vanessa VanGilder	Fair Shake Network
Steve Wiseman	West Virginia Developmental Disabilities Council

Appendix D: West Virginia *Olmstead* Accomplishments

While much has been said of the barriers to implementing the Olmstead decision in West Virginia, there have been many *Olmstead*-related accomplishments.

2012

- Worked as a collaborative partner collaboratively with the WV Developmental Disabilities Council, WV Fair Shake Network, and the WV Statewide Independent Living Council on the passage on Senate Bill 109, expanding medication administration for unlicensed personnel and self-administration of medications. This was an effort that began in 2005. Worked passage of Senate Bill 109 to increase the flexibility of medication administration by unlicensed personnel in home and community-based programs.
- Provided start-up funding under the *Olmstead Transition and Diversion Program* to 493 people since the beginning of the program in 2008.
- Participated on a committee working to re-write teh Behavioral Health Licensure Rules and Chapter 27 of the West Virginia Code.

2011

- Participated as a committee member working to re-write the Behavioral Health Rules.
- Participated on the Disability Policy Summit hosted by the West Virginia Statewide Independent Living Council and the State Rehabilitation Council. This effort resulted in the endorsement of a disability policy agenda as ratified by 23 organizations.
- Participated as a member of the In Home Direct Care Worker Committee that worked to get HB 4062 passed, creating an in-home direct care workforce registry.
- Collaborated with the BoSS and BMS to design implement the new federal regulations for the MDS 3.0 assessment required for nursing facilities.

2010

- Collaborated with the West Virginia Developmental Disabilities Council on an awarded WV LTC Partnership grant to study the current and future use of the ICF/MR program. Created a report with recommendations and received $5,000 in funding.
- Presented at the National Olmstead Coordinators Conference in Washington D.C. on the Transition Navigator Program. This program was selected by SAMHSA to showcase national models for transition programs.
- Collaboarted with BMS to develop the CMS MFP grant application. The *Olmstead* Office will provide $292,000 in annual funding to support the statewide expansion of the Transition Navigator Program.

2009

- Assisted the U.S. Office of Civil Rights (Region III) concerning several state-related Olmstead complaints.
- Participated on the self-direction committee for the I/DD Waiver Program.
- Presented to the Legislative Oversight Commission on Health and Human Resources Accountability on the Nurse Practice Act and medication administration by unlicensed personnel.
- Supported the passage of House Bill 3268, Long Term Care Redistribution Act (or Community-Based Services Act).

2008

- Developed a comprehensive reference guide to home and community-based services in West Virginia.
- Issued the *Money Follows the Person and Long Term Care System Rebalancing Study*" by the Public Consulting Group. PCG presented to legislative committees on the study report.
- Co-sponsored a national speaker, Steve Gold, civil rights attorney, to speak at the Fair Shake Network Disability Training Day.
- Co-sponsored the committee to develop a self-directed option for the I/DD Waiver program. In addition, the *Olmstead* Office provided stipends and expense reimbursement for individuals with disabilities and family members to participat on this committee.

2007

- Developed the *Olmstead Transition and Diversion Program* (formerly called the Transition Navigator Program) to assist people in transitioning from (or avoiding) institutional placements. This included a comprehensive transition process.
- Sponsored statewide public forums on Money Follows the Person and Rebalancing.
- Advocated successfully for BMS to change the language in the Medicaid manual to better explain the exemption of the homebound language for Medicaid Home Health program. In addition, a letter was mailed by BMS to all home health providers.
- Advocated successfully for BMS to include people transitioning from nursing facilities as being eligible for receiving targeted case management. This had previously been omitted from the targeted case management manual.

2007 (continued)

- Co-hosted a visit by Patrick Flood to discuss Vermont's successfully rebalancing strategies with legislators and state officials about how to successfully rebalance the LTC system. WV Department of Health and Human Resources Secretary directed Bureau for Medical Services (BMS) to implement a self-directed option for the I/DD Waiver Program. *Olmstead* Coordinator presented to the WV Legislative Oversight Commission on Health and Human Resources Accountability on rebalancing initiatives across the country.
- Assembled a committee to identify proactive steps related to the identification of indiviudal who have been forced to leave the state due to the need for ventilator services. Issued formal recommendations to the Governor's office.
- Developed the application for the *CMS State Profile Tool: Assessing a State's Long Term Care System* grant.

2006

- Advocated successfully for West Virginia to apply for the Money Follows the Person grant opportunity offered by CMS.
- Hired a national consulting firm to conduct a Money Follows the Person (MFP) and rebalancing study of the West Virginia system.

2005

- Developed the first to annual report on identified areas of institutional bias in WV and developed functional solutions to DHHR to eliminate these barriers.
- Secured on-going annual state general revenue funding in the amount of $300,000 for specific Olmstead activities.
- Obtained approval when Governor Manchin signed Executive Order 11-05 directing the implementation of the *Olmstead Plan* and the cooperation and collaboration of all affected state entities. A public signing ceremony was also held.

2004-2003

- Developed a state *Olmstead Plan* was developed through the *Olmstead* Council and public forums, and public focus groups.
- Since 2003, successfully applied for the federal *Olmstead* Initiative grant from the U.S. Substance Abuse Mental Health Administration. The total amount received is $200,000. This funding was used to support the development of the *Olmstead* Council for stipends and expense reimbursement for members, public forums, MFP study, Legal Aid FAST Program, and supplemental funding for the *Olmstead Transition and Diversion Program*. This grant funding has continuously be awarded to West Virginia annually since 2003.
- In 2003, developed the *Olmstead Information, Referral and Assistance Program*.
- In 2003, existing *Olmstead* funding in the amount of $194,000 was moved under the authority of the newly created Olmstead Office.
- In 2003, a full-time *Olmstead* Coordinator and *Olmstead* Council were established.