

West Virginia Olmstead Plan: Building Inclusive Communities, Keeping the Promise

Executive Summary



November 1, 2005

Acknowledgements

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

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

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

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

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

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

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

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

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

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

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

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

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

WHEREAS, the State of West Virginia should encourage and effectuate changes in State programs and policies that will improve the State's ability to provide community-based alternatives for people with disabilities in conformance with the requirements of the *Olmstead* decision and President Bush's Executive Order No. 13217.

THEREFORE I, JOE MANCHIN III, GOVERNOR, by virtue of the power and authority vested in me

by the Constitution and laws of the State of West Virginia, do hereby **ORDER**

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

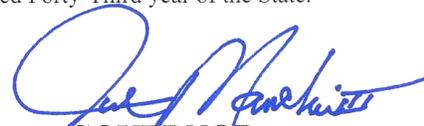
(2) the cooperation and collaboration between all affected agencies and public entities with the Olmstead Office to assure the implementation of the *Olmstead* decision within the budgetary constraints of State agencies in West Virginia; and

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

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



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


GOVERNOR

By the Governor


SECRETARY OF STATE

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

BACKGROUND OF THE CASE

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

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

-*Olmstead v. L.C.*

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

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

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

On June 22, 1999, the Supreme Court agreed with the judgments from the lower courts that the plaintiffs were protected by the ADA and had been subjected to discrimination by being institutionalized. This is what is known as the *Olmstead* decision. The syllabus of the Supreme Court decision is located on ***page 17***.

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

DISCRIMINATION ON THE BASIS OF DISABILITY

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

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

-*Olmstead vs. L.C.*

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

THE AMERICANS WITH DISABILITIES ACT

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

Title II of the ADA established the requirements for public entities, or state governments and health care services that are funded and administered by state agencies. Title II of the ADA prohibits people with disabilities from being “excluded from participation in or denied the benefits of the services, programs, or

¹ *Americans with Disabilities Act* of 1990 (ADA).

activities of a public entity, or subjected to discrimination by any such entity.”² Two key mandates under Title II of the ADA were fundamental to the decision made by the U.S. Supreme Court: the “integration” regulation and the “reasonable modifications” regulation.

Most Integrated Setting

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

ADA Title II – Non-Discrimination Principle

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

Reasonable Modifications

The “reasonable modifications” regulation mandates “states will make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the [state] can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.”⁵ While rendering unnecessary institutionalization presumptively unlawful, the *Olmstead* decision does afford states a defense to *Olmstead* claims. A state is not required to transfer unnecessarily institutionalized persons to the community if doing so would fundamentally alter the state’s program. Whether serving particular individuals in a more integrated setting would require a fundamental alteration depends on:

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

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

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

³ Title II of the ADA, 28 CFR § 35.130(d).

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

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

⁶ *Olmstead vs. L.C.*

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

WHO IS PROTECTED BY THE *OLMSTEAD* DECISION?

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

- has a physical or mental impairment that substantially limits one or more major life activities; or
- has a record or history of such an impairment; or
- is perceived or regarded as having such an impairment.⁷

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

-*Olmstead v. L.C.*

The phrase “major life activities” means functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.⁸

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

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

- state-operated facilities and hospitals;
- ICF/MR facilities;

⁷ Title II of the ADA, 28 CFR § 35.104.

⁸ Ibid.

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

- skilled nursing facilities;
- nursing facilities;
- assisted living residences; and
- other segregated living settings or segregated service provision settings.

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

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

State’s Treatment Professionals

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

Guardianship & Health Care Surrogacy

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

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

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

¹⁰ *Olmstead vs. L.C.*

¹¹ West Virginia State Code §44A-3-1

¹² West Virginia State Code §16-30-2

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

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

¹³ West Virginia State Code §16-30-3

¹⁴ West Virginia State Code §16-30-9

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

WHY DEVELOP AN *OLMSTEAD PLAN*?

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

ESTABLISHMENT OF AN *OLMSTEAD OFFICE*

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

***Olmstead* Advisory Council**

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

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

-Margaret Meade

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

In May of 2004, the *Olmstead* Study Group was merged with the *Olmstead* Advisory Council to create one cooperatively working group. A list of the *Olmstead* Advisory Council members is located on **page 23**.

¹⁵ *Olmstead vs. L.C.*

¹⁶ Centers for Medicare and Medicaid Services, State Medicaid Directors Letter, January 14, 2000.

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

Public Comments

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

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

KEY COMPONENTS OF THE *OLMSTEAD PLAN*

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

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

CRITERIA FOR IMPLEMENTING THE *OLMSTEAD PLAN*

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

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

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

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

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

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

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

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

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

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

INFORMED CHOICE

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

- 1.1 Develop a resource guide; including an interactive website and a toll free hotline, to link people to community-based supports, resources and providers.
- 1.2 Develop an informed choice process to provide information and education about available community-based options.
- 1.3 Implement the informed choice process on a statewide basis across all segregated settings.
- 1.4 Provide information to people with disabilities at one-stop resource centers.

IDENTIFICATION

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

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

- 2.2 Implement the assessment tool on a statewide basis across all segregated settings.
- 2.3 Use assessment data to monitor and track trends in the identification process.
- 2.4 Use assessment data to make recommendations for current and future home and community-based supports.

TRANSITION

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

- 3.1 Develop a person-centered transition process to assist people with disabilities, families, legal representatives, advocates, and interdisciplinary teams to plan successful transitions.
- 3.2 Implement the transition process on a statewide basis across all segregated settings.
- 3.3 Track trends and outcomes from implementing the transition process.
- 3.4 Seek funding to support transition costs for start-up needs.

DIVERSION

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

- 4.1 Provide funding, flexibility, and creativity to allow service coordinators to arrange community-based services and supports to prevent institutionalization or segregation.
- 4.2 Provide training and education to professionals of the community and institutional long term care system concerning diversion responsibilities and options.

REASONABLE PACE

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

- 5.1 Establish policies in the event a waiting list is implemented to assure people are served at a reasonable pace.
- 5.2 Seek to increase the availability of funded Medicaid Waiver slots to reduce reliance on waiting lists and to meet the growing need of Waiver supports.
- 5.3 Develop and disseminate information regarding the rights of people with disabilities to receive services at a reasonable pace.

ELIMINATING INSTITUTIONAL BIAS

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

- 6.1 Analyze the long term care system through a feasibility study to make specific recommendations for rebalancing initiatives.
- 6.2 Provide education and training to mental hygiene commissioners about the *Olmstead* decision and alternatives to institutional placements.
- 6.3 Review the rate reimbursement mechanisms for Medicaid State Plan services.

SELF-DIRECTION

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

- 7.1 Amend existing policies and regulations to assure self-directed approaches are used for all community-based supports.
- 7.2 Promote legislation to implement the Medicaid Community Attendant Services and Supports Act (MiCASSA).
- 7.3 Seek approval and funding to provide self-directed options for all current and future home and community-based waiver programs.

RIGHTS PROTECTION

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

- 8.1 Develop and disseminate information regarding rights under the ADA as upheld by the *Olmstead* decision.
- 8.2 Improve the current grievance, complaint, and due process systems to address *Olmstead*-related complaints or grievances.
- 8.3 Examine and modify all policies, regulations, and procedures which potentially conflict with people's rights to live in the most integrated setting.
- 8.4 Develop and implement a process for the formal endorsement of the *Olmstead Plan* by government, providers, and advocates.

QUALITY ASSURANCE & QUALITY IMPROVEMENT

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

- 9.1 Monitor and report on all activities of the *Olmstead Plan* in a timely and open manner.
- 9.2 Develop an effective quality assurance and improvement system that enlists people with disabilities, their families, and advocates as active participants in the process to assure the health, welfare, and dignity of individuals participating in community-based supports.
- 9.3 Revise policies to address critical incidents and deaths that take place under the direction of licensed providers.
- 9.4 Establish systems to provide information concerning licensing, certification, monitoring, and survey results to the general public in an open and timely manner.
- 9.5 Administer individual experience surveys to evaluate the quality of community-based supports received by people with disabilities.
- 9.6 Evaluate the inclusion of other segregated service provision options or settings into the *Olmstead Plan*.

COMMUNITY-BASED SERVICES, PROGRAMS, & ACTIVITIES

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

- 10.1 Amend the Nurse Practice Act and the AMAP (Administration of Medication by Authorized Personnel) process to promote flexibility and self-direction while assuring health and safety.
- 10.2 Develop comprehensive, community-based services for people in recovery from addiction and/or mental illness.
- 10.3 Develop comprehensive community-based supports for people with disabilities who are un-served and/or under-served.
- 10.4 Develop affordable, accessible and inclusive community housing options for people with disabilities.
- 10.5 Develop accessible and affordable transportation options for people with disabilities.
- 10.6 Expand and fund crisis supports throughout West Virginia.
- 10.7 Develop, implement, and enforce regulations for provider backup and substitute supports.
- 10.8 Expand the availability, use, and oversight of adult family care and specialized family care supports.
- 10.9 Facilitate a coordinated peer mentoring system to assist people with disabilities to choose alternatives to institutional care using a self-directed approach.
- 10.10 Establish an effective, responsive and knowledgeable direct support profession to meet the needs of people with disabilities who receive community-based supports.

SECTION IV – CONCLUSION

NEXT STEPS & MONITORING

***Olmstead* Advisory Council**

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

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

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

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

Syllabus

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

SUPREME COURT OF THE UNITED STATES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Olmstead Advisory Council Membership List

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

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Bill Davis*	AARP, Inc.
Karen Davis*	MR/DD Waiver Program
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Lorraine Penhos	West Virginia EMS-TSN, Inc. – Advocacy Program
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David Stewart*	Fair Shake Network
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Office of the Ombudsman for Behavioral Health:

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David G. Sudbeck	Ombudsman for Behavioral Health