THE STATES’ RESPONSE
TO THE

OLMSTEAD DECISION:
A WORK IN PROGRESS

by

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

The National Conference of State Legislatures (NCSL) serves the legislators and staffs of the nation’s 50 states, its commonwealths and territories, and the District of Columbia. NCSL provides research, technical assistance and the opportunity for policymakers to exchange ideas on the most pressing state issues. NCSL is a bipartisan organization with three objectives:

- To improve the quality and effectiveness of state legislatures,
- To foster interstate communication and cooperation, and
- To ensure states a strong, cohesive voice in the federal system.

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The Forum for State Health Policy Leadership is an entity within the National Conference of State Legislatures. The central mission of the Forum is to enhance the capacity for informed decision making and leadership within the state legislatures regarding the financing, organization and delivery of health care services to low-income and vulnerable populations. The Forum is designed to provide a range of information, training and technical assistance services to new state legislators who are potential future leaders in health policy and to serve as a mechanism for established leaders in state health policy to further develop and share their expertise.

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To better understand the effects of the *Olmstead* ruling, the National Conference of State Legislatures (NCSL) conducted a 50-state survey (published in March 2001 on NCSL’s web site at www.ncsl.org/programs/health/forum/olmsreport.htm). Results from that first survey provide an overview of the choices states are making as they act on their obligations under the *Olmstead* decision. Building on its previous work, NCSL is issuing this second study to continue its review of state planning and implementation activities related to *Olmstead* with generous support from AARP. NCSL would like to thank AARP’s Public Policy Institute and our project officer, Enid Kassner, for both their support and guidance.

The purpose of this study is to:

- Categorize overall state activities around *Olmstead*, according to their scope and purpose;
- Provide detailed descriptive analyses of *Olmstead* plans, including analyses of priorities, action steps, timetables, budgetary and legislative strategies, and other relevant factors; and
- Identify and describe targeted efforts planned on behalf of people with disabilities.

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What Is the *Olmstead* Decision?

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

NCSL initially surveyed each state’s main contact(s) for *Olmstead* activities during the summer of 2001; analysts then again called contacts in the fall for an update in those states that issued their plans or created their commissions between August and December. Therefore, this report is current as of December 2001. A list of the contacts is contained in appendix A. During the telephone interviews, survey respondents provided information on the following topics: *Olmstead* activities, consumer involvement, lawsuits, implementation deadlines, major recommendations and priorities, strategies for implementing the recommendations, costs and funding. The findings from this survey for each state are contained in appendix B. These state summaries represent only brief sketches of activities in each state.
Major Findings

1. Forty states plus the District of Columbia have task forces, commissions or state agency work groups to assess current long-term care systems; many are developing plans. Ten states—Michigan, Minnesota, Nebraska, New York, Oregon, Rhode Island, South Dakota, Tennessee, Vermont and Virginia—do not.

Governors, legislators and health commissioners in many of the 40 states created specific Olmstead task forces, while existing long-term care commissions in some states now are charged with Olmstead-related activities. Most, although not all, of the task forces are working on comprehensive plans or significant papers, many of which could serve as blueprints for public policy in the states.

2. Eighteen states have issued Olmstead plans or significant papers, and several more are working on them. Most of the plans would not be considered comprehensive because they either do not meet the Centers for Medicare and Medicaid Services (CMS) guidelines or do not contain timelines or budgets.

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

- Plans in four states—Mississippi, Missouri, Ohio and Texas—stand out because they contain a clear vision for systems change, specific strategies and goals, agencies responsible for each strategy, timelines and budgets. In addition, they meet the guidance set forth in the CMS letter of January 14, 2000, that contained the enclosure, Developing Comprehensive, Effectively Working Plans, Initial Technical Assistance Recommendations.

Mississippi’s 59-page plan issued by the task force—Mississippi Access to Care (MAC)—contains recommendations for the next 10 years. The plan is unique in that it includes proposed budgets for FY 2003-2011 for each recommendation. The cost to the state for complete implementation of the plan will be $52.7 million in FY 2003, $74.8 million in 2004, $69.1 million in FY 2005, $62.2 million in FY 2006, $48.6 million in FY 2007, $40.9 million in FY 2008, $33.1 million in FY 2009, $32.5 million in FY 2010, and $33 million in FY 2011. The purpose of the plan, as cited in state legislation, is to have community services for all disabled people by June 30, 2011. The plan can be found on the MAC web site at http://www.mac.state.ms.us.

Missouri’s 15-member Home and Community-Based Services and Consumer Directed Care Commission issued a more than 200-page plan that includes an inventory of available services; budget action, federal action and statute changes; the agency responsible for implementing each recommendation; and a FY 2001 or FY 2002 timeline for each recommendation. It issued many recommendations including those related to caregiver compensation, housing, transportation, informed choice, consumer and family directed care, making the transition to independence, and Medicaid eligibility. Since the plan was issued, the new governor has formed a new commission to continue the work and implement the plan. The report is available at www.dolir.state.mo.us/gcd/Olmsteadindex.html.
Ohio’s task force—Ohio ACCESS—issued a 79-page report that contains short-term and long-term recommendations. It also includes a comprehensive review of Ohio’s services and supports for people with disabilities and recommendations for improving services during the next six years. It contains the proposed executive budget for FY 2002-2003 of $145 million for new initiatives and expansion of programs for people with disabilities. (Budgets for the long-term solutions and the agencies responsible for them were not detailed.) The short-term recommendations for consideration in the 2002-2003 biennial budget center on expanding waiver programs; the long-term recommendations focus on labor issues. The cornerstones of the Ohio Access vision are consumer self-determination and a person-centered planning approach with assistance from family, friends and caregivers. The report is available at http://www.state.oh.us/OBM/media/reports/ohioaccessrpt.pdf.

Texas’ Promoting Independence Plan includes an inventory of available services; state budget requests and statute changes; and the agency—primarily the Department of Human Services or the Texas Department of Mental Health and Mental Retardation—responsible for implementation. The plan includes recommendations on expanding all waiver programs, increasing outreach to inform people with disabilities about community options, providing permanency planning to develop community placements for children, helping nursing facility residents make the transition into the community, providing temporary rent subsidies for consumers who are awaiting federal housing assistance, making available one-time grants to families who need to make a home modification to care for children with disabilities, and providing funds for non-medical transportation for people who are making the transition into the community. The report is available at http://www.hhsc.state.tx.us/tpip/tpip_report.html.

Nine states—Arizona, Delaware, Illinois, Indiana, Iowa, Kentucky, Maryland, Montana and South Carolina—have issued plans or significant reports, but they do not include budgets and/or timelines. Some—such as Arizona, Iowa and Kentucky—released status reports along with some options for systems change. These papers included an inventory of services and support available and some policy and programmatic recommendations. Other states—such as Illinois, Indiana, Maryland, Montana and South Carolina—issued a catalogue of recommendations in which they either disseminate a “wish list” of general, broad recommendations or include a menu of new, more specific potential policy and programmatic directions.

Five states—Connecticut, Georgia, North Carolina, Wisconsin and Wyoming—have interim drafts that are near completion; all of their final reports are expected in early 2002. Connecticut released the third draft of its community integration plan, Choices Are for Everyone, in September 2000 for public comment. Georgia completed a draft of its executive summary. North Carolina’s interim draft contains goals and strategies related to informed choice, care planning, waiting lists, the worker shortage and quality of care, but it does not include budget numbers. The Wisconsin draft focuses on budgetary recommendations in that it gives specific funding amounts and some ideas for increasing funding, i.e. waiver expansion and timelines for projects. However, it does not identify at-risk populations or assess available services. The Wyoming draft, released on April 1, 2001, has four sections: aging, developmental disabilities (acquired brain disorders), developmental disabilities (general), and mental health. Within each of these sections are numerous recommendations and an inventory of existing services. However, most sections do not include specific timelines for recommendations, potential funding sources or funding needs.
At least eight states—Alabama, Arkansas, California, Colorado, Kansas, Maine, New Jersey and West Virginia—are working on plans and reports, most of which are expected to be released during the first quarter of 2002. The timelines for these states are as follows: Alabama (January), Arkansas (Spring 2002), California (on or before January 2003), Colorado (March), Kansas (early 2002), Maine (early 2002), New Jersey (January) and West Virginia (early 2002).

3. Several states have task forces that are working on *Olmstead*-related activities but are not intending to issue comprehensive plans.

Under the ruling, states are not required to issue comprehensive plans. As a result, states and territories such as Florida, New Hampshire, Pennsylvania, Washington and the District of Columbia have meaningful projects under way, but they do not intend to write comprehensive plans. For example, the District of Columbia is designing a resource center to help the city create a service delivery model similar to Wisconsin’s Family Care program. The District also is working to amend its waiver program, which serves individuals age 65 and older, to expand to serving adults under age 65 with physical disabilities and to provide attendant care and assisted living. Pennsylvania created a Home and Community-Based Services Project, which includes an internal governance structure, to a) create a seamless system of home and community-based services for consumers by striving for consistency across various programs and state agencies, b) share information and ideas across program areas to capitalize on the skills and expertise of the Commonwealth’s human resources and c) coordinate resources and maximize efforts across program areas and agencies. Washington’s internal workgroup of state agencies plans include four overlapping phases: the development of proposals, budget requests, appropriations, and implementation (first with available funds and then with the new appropriations). The process spans the period from January 2000 to July 2004.

4. Most commissions are broad-based and have cross-disability policies in that their scope of work includes all people with disabilities and several of them publish their activities on the Internet.

Although the Supreme Court case involved two women with both mental illness and developmental disabilities, the federal government has made it clear that the decision involves all disabled people, regardless of age. Thus, most states are assessing their systems of care for people with developmental disabilities, people with physical disabilities, people with mental illness and older people with disabilities. In addition, plans include many subgroups, including 1) institutional residents whose needs can be appropriately met in the community, 2) residents in community-based settings who require institutional care, and/or 3) people who reside in the community and are at risk for institutionalization because of the absence of care. Most of the commissions have members who are consumers or disability advocates. For example, advocates representing older Americans are involved in at least 28 state task forces. (However, some state task forces do not include advocates because they are internal, state department commissions.)

Several states also have web sites that provide useful information about their *Olmstead*-related activities (see box).

5. To shift more resources into community-based settings, state commissions have issued numerous recommendations that address eight major issues—housing, transportation, assessment, waiver program expansion, helping individuals make the transition from institutions into the commu-
Housing and Transportation. Most states cited a lack of affordable and accessible housing and transportation as major barriers to serving more people in the community. As a result, a vast majority of the commissions issued recommendations that extended beyond the traditional health care system into the housing and transportation arenas.

Housing recommendations included creating:
- A continuum of housing options that emphasize consumer choice;
- Transition funds or temporary rent subsidies for people who are making the transition from institutions into the community;
- More funding for home modifications such as ramps and grab bars;
- Greater availability of Housing and Urban Development (HUD) housing and Section 8 vouchers for home ownership;
- Incentives for more universal design housing where new housing stock has wider doorways and hallways and a bedroom and bathroom that are located on the first floor;
- Higher rent allotments in Supplemental Security Income (SSI) and Supplemental Security Disability Income (SSDI) state supplements; and
- Enhanced support services for housing.

Transportation recommendations included:
- Enforcing provisions of the Americans with Disabilities Act;
- Providing non-medical transportation through general revenue (Medicaid reimburses only for medically-related uses of transportation);
- Establishing a state oversight committee; and
- Extending hours of public transportation and providing consolidated, fixed routes.

Assessment and Data Collection. Two of the most important elements of the Olmstead planning process have been to assess how many people with disabilities currently are institutionalized who are eligible for services in the community and to decide if adequate data collection and information systems are in place to make these determinations. To that end, the vast majority of states considered a variety of recommendations to evaluate whether the existing assessment procedures can ensure consumer choice and foster consumer information and referral. Some of the recommendations in these areas follow.

Assessment
- The need for a coherent identification assessment process;
- Person-centered planning and consumer choice;
- Emphasis on assessment needs and preferences of individuals living in institutions;
- Linking assessment with informing individuals of community-based options;
- Development of a centralized “one-stop shopping” model, through which clients receive consumer-friendly information from one office instead of through a maze of agencies; and
- The need for more case management.

Data Collection
- Identification of individuals in institutions, on waiting lists and at risk;
- Quality monitoring; and
- Database development and information systems.
Staffing. Most of the states acknowledged the severe shortage of long-term care workers as another major barrier to providing more home and community-based services. The key to providing good quality of care in home and community-based settings lies in having good staff, particularly competent nurses, home health aides, personal care attendants and other paraprofessional workers. Therefore, most of the commission recommendations in this area include:
- Increasing wages and benefits;
- Designing and funding new training and certification opportunities; and
- Supporting the informal network of family and friends who provide the bulk of long-term care services in the community.

Consumer/Provider/State Agency Education and Outreach. Most commissions did not think many of these sweeping reforms could happen without education for consumers, providers and state agency officials. Many states focused on strategies for publicizing and increasing the awareness of community-based services and supports through user-friendly and timely information. These strategies included:
- Toll-free assistance lines;
- Brochures and flyers;
- Interagency training to foster information sharing among agencies and organizations;
- Development of an inventory of home and community-based services;
- Training for private providers and case managers; and
- Better use of the Web as an information and outreach tool.

Helping Individuals Make the Transition from Institutions into the Community. The goal of many plans is to prevent the unnecessary institutionalization of individuals, reduce waiting lists and help people who currently reside in institutions make the transition into the community, when appropriate. Of course, the recommendations in this area often go hand in hand with the recommendations regarding evaluation and individual assessment procedures. However, some specific recommendations follow.
- Ensure that funding follows the person regardless of whether they are being served in an institution or in the community.
- Identify appropriate nursing home residents, advise them of community-based alternatives and allow them to choose the most integrated setting of their choice.
- Track the number of people who make the transition from institutions into the community.
- Create permanency planning for children who currently reside in institutions.

Medicaid Waiver Program Expansion. Every state has federal Medicaid waivers to design programs that provide a wide range of home and community-based services—including adult day care, personal services, homemaker services and respite care—that are not paid for by the traditional Medicaid program. Nearly all the commissions recommended expanding these waiver programs to accomplish many of their plans’ goals. Rather than pouring more state general revenues into home and community-based programs, the commissions focused first on the expansion of waiver programs, primarily to leverage the matching Medicaid federal funds. In addition, the states have more flexibility under the waivers than the traditional program because they can, for example, cap the amount of services and supports per individual and serve more people.
6. Implementation is not yet under way for most of the plans.

Only four commissions—Illinois, Missouri, Ohio and Texas—issued their plans in time for the 2001 legislative sessions. Of the four, three have implemented some of their recommendations. Even in these three states, however, most of the strategies have not yet been implemented. This slow pace has frustrated many disability advocates, state officials and other stakeholders.

Missouri. To implement the plan, the legislature has enacted legislation to increase salaries for aides caring for people with mental retardation and developmental disabilities; ensure training for staff and individuals who are interested in transferring from a nursing home to the community; make personal care services an entitlement and serve an additional 2,000 people, most of whom are younger people with physical disabilities, transfer to the community; and establish a fund to allow individuals who are moving from an institution to apply for a one-time grant of up to $1,500.

Ohio. The FY 2002-2003 appropriations included adding 1,300 slots in FY 2002 and another 1,600 slots in FY 2003 to the PASSPORT waiver program, which provides care to people over age 60 who otherwise would need nursing home services (the program currently has more than 24,000 slots); adding 500 slots in both FY 2002 and FY 2003 to the Home Care Waiver Program, which provides care to disabled people under age 60 or people of any age with a chronic, unstable condition who require nursing care (the program currently has 8,200 slots); adding 500 slots in both FY 2002 and FY 2003 to the Individual Options Waiver Program, which serves people who otherwise would require institutionalization in an intermediate care facility for the mentally retarded (ICF/MR); establishing an Ohio Success pilot program to fund up to $2,000 in transition costs for 75 people in FY 2002 and 125 people in FY 2003 to be used as seed money for the first month's rent, utility deposits, moving expenses and other related costs; developing cost management tools that promote choice and personal responsibility; redesigning the mental retardation and developmental disabilities Medicaid delivery system by moving the Community Alternative Funding System program to a fee schedule and by making the transition to new home and community-based waivers; and improving cost management tools within the community mental health system.

Texas. The 2001 Legislature appropriated expansion money for all six community waiver programs and for development of transition services and alternative family-based options for children.

In addition, a few states that did not yet issue their plans enacted legislation and approved budget requests in 2001 because of their Olmstead activities. For example, after hearing from disability advocates on the Olmstead task force, the 2001 Maryland General Assembly passed legislation to increase the number of people to be served through the existing Community Attendant Services and Support Program Waiver and required the Department of Health and Mental Hygiene to submit an amendment to the waiver to expand eligibility to 300 additional adults with physical disabilities by expanding an existing Medicaid waiver program. Budgeted at $10 million in FY 2002, the program permits individuals to select, manage and control their services and to choose their personal assistants, including hiring family members (except spouses).
7. State budget shortfalls and declining state revenues will likely delay *Olmstead* implementation, but several federal opportunities could enhance systems change.

Although some recommendations do not require significant revenues, new state appropriations will be needed to implement many of the plan recommendations, especially those related to increasing the number of waiver slots or residential settings available for people with disabilities. Executive branch agencies that set forth budget requests and legislators who hold the purse strings will be critical partners as they consider state program priorities in a challenging fiscal environment. It appears likely that terrorism and state safety issues will have top priority for any new resources available for distribution during 2002 sessions, although priorities are likely to vary substantially across the states.

States have reported that they also will be under pressure to contain costs due to dismal state fiscal conditions. Almost all states are experiencing revenue shortfalls, according to recent fiscal data from NCSL. At least 36 states have implemented or are considering budget cuts or holdbacks to address fiscal problems. Other states are likely to use rainy day funds to fill budget gaps in existing programs, and new initiatives may fare less well than they would in a more positive fiscal environment.

Despite the gloomy fiscal picture, however, the federal government has taken several actions—several of which are important to state legislatures—to support implementation of the *Olmstead* decision. These actions include issuing guidance letters, revising its policies to allow states more flexibility, holding meetings with the states, and giving $64 million in planning or demonstration grants to the states to expand community-based options.

Most recently, CMS awarded approximately $64 million in new grants on September 2001 to 37 states and one territory to develop programs for people with disabilities and long-term illnesses. These awards included:

1) Nursing Facility Transition grants: to help states move eligible individuals from nursing facilities into the community;
2) Community-Integrated Personal Assistance Services grants: to improve personal assistance services that are consumer-directed and/or offer maximum individual control;
3) Real Choice Systems Change grants: to help design and implement effective and enduring improvements in community long-term support systems to enable children and adults of any age who have a disability or long-term illness to live and participate in their communities; and
4) National Technical Assistance Exchange for Community Living grants: to provide technical assistance, training and information to states, consumers, families, and other agencies and organizations.

If state officials need technical assistance—offered by the National Technical Assistance Exchange for Community Living initiative—they can call Susan Reinhard at Rutgers Center for State Health Policy at (732) 932-3105, ext. 230 or Richard Petty at Independent Living Research Utilization at (713) 520-0232. These federal grant and technical assistance opportunities are, perhaps, the most promising recent development.
Conclusion

States are in the early stages of implementing the *Olmstead* decision. The short-term effects of the decision have not been dramatic on the care settings for people with disabilities. Most states did not issue their plans until after the 2001 legislative session. The most important effect thus far is that it has caused providers, consumers and state officials from various departments to jointly discuss long-term care reforms. It also has caused the federal government to revise its policies in this area and to offer states flexibility and funding to develop innovative solutions. Finally, it has forced states to look at reforms not only in the health arena but also in the areas of transportation, housing, education and other social supports to fully integrate people with disabilities into the least restrictive settings.

However, it is clear that *Olmstead* implementation—that is, ensuring that individuals receive care in the most integrated setting possible—will take many years, given the array of service delivery systems that require alteration; the erosion of state fiscal capacity, at least in the short term; and the challenge of complying with requirements of complex lawsuits related to *Olmstead*. It is likely that plans will be revised and priorities for implementation will be refined as time goes on. State plans are a work in progress that will evolve in response to funding, stakeholder input, agency-related initiatives, and continued growth and demand for community services and supports for people with disabilities.

This study also is a work in progress. Please contact Wendy Fox-Grage at (202) 624-3572 or wendy.fox-grage@ncsl.org if the authors have incorrectly reported or inadvertently omitted certain *Olmstead* activities. For more information on *Olmstead* activities in the states, please see the NCSL *Olmstead* webpage at www.ncsl.org/programs/health/disabil2.htm.
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## District of Columbia - Hawaii

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<td><strong>Name</strong></td>
<td>Steve Lutsky</td>
<td>Shelly Brantly, Administrator</td>
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<tr>
<td><strong>Division</strong></td>
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<td>Medicaid Agency</td>
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<tr>
<td></td>
<td>Medical Assistance Admin.</td>
<td></td>
</tr>
<tr>
<td><strong>Phone</strong></td>
<td>(202) 442-9076</td>
<td>(850) 487-2618</td>
</tr>
<tr>
<td><strong>E-mail</strong></td>
<td><a href="mailto:steven.lutsky@dc.gov">steven.lutsky@dc.gov</a></td>
<td><a href="mailto:brantlem@fdhc.state.fl.us">brantlem@fdhc.state.fl.us</a></td>
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<thead>
<tr>
<th>Name</th>
<th>Julie Shaw, Executive ADA Administrator</th>
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<tr>
<td><strong>Name</strong></td>
<td>Sally Carter, Olmstead Project Director</td>
<td>Dr. Susan Chandler, Director</td>
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<tr>
<td><strong>Division</strong></td>
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<td>Department of Human Resources</td>
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</tr>
<tr>
<td><strong>Phone</strong></td>
<td>(404) 657-7334</td>
<td>(808) 586-4890</td>
</tr>
<tr>
<td><strong>E-mail</strong></td>
<td><a href="mailto:scarter@dhr.state.ga.us">scarter@dhr.state.ga.us</a></td>
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<tr>
<th>Name</th>
<th>Susan Yamamoto</th>
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# State Contacts:
## Idaho - Iowa

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<tr>
<td>Name</td>
<td>Barbara Hancock</td>
<td>Michelle Piel, Olmstead Coordinator</td>
</tr>
<tr>
<td>Division</td>
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<td>-</td>
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<tr>
<td>Dept</td>
<td>Idaho Department of Health and Welfare</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>Phone</td>
<td>(800) 926-2588</td>
<td>(312) 814-1684</td>
</tr>
<tr>
<td>Email</td>
<td>-</td>
<td><a href="mailto:dhse031@dhs.state.il.is">dhse031@dhs.state.il.is</a></td>
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<tr>
<td>Name</td>
<td>Alison Becker</td>
<td>Connie B. Fanselow, Olmstead Coordinator</td>
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<tr>
<td>Division</td>
<td>Family and Social Services</td>
<td>Division of Mental Health and Developmental Disabilities</td>
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<tr>
<td>Dept</td>
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<td>Department of Human Services</td>
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<tr>
<td>Phone</td>
<td>(317) 234-1527</td>
<td>(515) 281-6086</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:abecker@fssa.state.in.us">abecker@fssa.state.in.us</a></td>
<td><a href="mailto:cfansel@dhs.state.ia.us">cfansel@dhs.state.ia.us</a></td>
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### STATE CONTACTS: KANSAS - MAINE

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<tr>
<td>NAME</td>
<td>Tanya Dorf</td>
<td>Jim Kimbrough</td>
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<tr>
<td>DIVISION</td>
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<td>Olmstead State Plan Project Director</td>
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<tr>
<td>DEPT</td>
<td>Department of Social and Rehabilitation Services</td>
<td>Interdisciplinary Human Development Institute</td>
</tr>
<tr>
<td>PHONE</td>
<td>(785) 296-3561</td>
<td>University of Kentucky</td>
</tr>
<tr>
<td>E-MAIL</td>
<td>-</td>
<td>(859) 257-9023</td>
</tr>
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</table>

| NAME | Laura Howard, Asst Secretary | Kay Alexander, M.D. |
| DIVISION | Division of Health Care Policy | - |
| DEPT | Department of Social and Rehabilitative Services | Department of Mental Health and Mental Retardation |
| PHONE | (785) 296-3773 | (502) 564-4257 |
| E-MAIL | lkzh@srskansas.org | kay.alexander@mail.state.ky.us |

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<tr>
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<th>MAINE</th>
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<tr>
<td>NAME</td>
<td>Charles Castille, Undersecretary</td>
<td>Chris Zukas-Lessard, Deputy Director</td>
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<td>DIVISION</td>
<td>Ofc of Mgmt &amp; Finance</td>
<td>Bureau of Medical Services</td>
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<td>Dept of Human Services</td>
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<tr>
<td>PHONE</td>
<td>(225) 342-6726</td>
<td>(207) 287-3828</td>
</tr>
<tr>
<td>E-MAIL</td>
<td><a href="mailto:lkzh@srskansas.org">lkzh@srskansas.org</a></td>
<td><a href="mailto:chris.zukas-lessard@state.me.us">chris.zukas-lessard@state.me.us</a></td>
</tr>
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| NAME | Fernin Eaton | - |
| DEPT | Dept of Health and Hospitals | - |
| PHONE | (225) 342-9402 | - |
| NAME | Stacey Webb | - |
| PHONE; | (225) 219-7505; | - |
| E-MAIL | webbs@idsmail.com | - |
# State Contacts:

## Maryland - Minnesota

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<th>STATE</th>
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<tr>
<td>NAME</td>
<td>Tracy DeShield</td>
<td>Deirdre Whalen</td>
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<tr>
<td>DEPT</td>
<td>Department of Health and Mental Hygiene</td>
<td>MA Developmental Disabilities Council</td>
</tr>
<tr>
<td>PHONE</td>
<td>(410) 767-6525</td>
<td>(617) 727-6374, ext. 114</td>
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<td>E-MAIL</td>
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| NAME | - | Leo Sarkissian |
| DIVISION | - | Association of Retarded Citizens of Massachusetts |
| DEPT | - | - |
| PHONE | - | (781) 891-6270 |
| E-MAIL | - | - |

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<tr>
<td>NAME</td>
<td>Mark Cody</td>
<td>Mary Kennedy, Director</td>
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<tr>
<td>DIVISION</td>
<td>Michigan Protection and Advocacy Service</td>
<td>Minnesota Medicaid</td>
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<tr>
<td>PHONE</td>
<td>(517) 374-4628</td>
<td>(651) 297-4122</td>
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<tr>
<td>E-MAIL</td>
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<td><a href="mailto:mary.kennedy@state.mn.us">mary.kennedy@state.mn.us</a></td>
</tr>
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</table>

| NAME  | Liz O'Hara | Pamela Hoopes |
| DIVISION | MI Association of Centers for Independent Living | Minnesota Disability Law Center |
| DEPT | - | - |
| PHONE | (517) 333-4253 | (612) 334-5785 |
| E-MAIL | - | - |
### State Contacts:
**Mississippi - Nebraska**

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<tr>
<td>NAME</td>
<td>Kristi Plotner</td>
<td>Mark Pickering</td>
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<tr>
<td>DIVISION</td>
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<td>Governor’s Council on Disability</td>
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<tr>
<td>PHONE</td>
<td>(601) 359-6050</td>
<td>(573) 751-2600</td>
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<td><a href="mailto:mpickering@dolir.state.mo.us">mpickering@dolir.state.mo.us</a></td>
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<tr>
<td>NAME</td>
<td>Carey Lund, Staff Attorney</td>
<td>David Babcock</td>
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<tr>
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<td>DEPT</td>
<td>Department of Human Services</td>
<td>Department of Health and Human Services</td>
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<tr>
<td>PHONE</td>
<td>(406) 444-5622</td>
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| NAME  | Joe Mathews, Director | - |
| DIVISION | Disabilities Services Division | - |
| DEPT | State Department of Public Health and Human Services | - |
| PHONE | (406) 444-2590 | - |
| E-MAIL | - | - |
**STATE CONTACTS:**
**NEVADA - NEW MEXICO**

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<tr>
<td>NAME</td>
<td>Charlotte Crawford, Director</td>
<td>Susan Fox, Director</td>
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<td>DIVISION</td>
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<tr>
<td>DEPT</td>
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<tr>
<td>PHONE</td>
<td>(775) 684-4000</td>
<td>(603) 271-5013</td>
</tr>
<tr>
<td>E-MAIL</td>
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<td><a href="mailto:SFox@dhhs.state_nh.us">SFox@dhhs.state_nh.us</a></td>
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| NAME             | Johnathan Andrew, Deputy Director | - |
| DIVISION         | -                                | - |
| DEPT             | Human Resources Department       | - |
| PHONE            | (775) 684-4000                   | - |
| E-MAIL           | jandrews@dhrmail.state_nv.us     | - |

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<td>NAME</td>
<td>William Ditto, Executive Director</td>
<td>John Foley, Executive Director</td>
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<tr>
<td>DIVISION</td>
<td>Division of Disability Services</td>
<td>Association of Retarded Citizens of New Mexico</td>
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<tr>
<td>PHONE</td>
<td>(609) 292-7800</td>
<td>(505) 883-4630</td>
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<td><a href="mailto:jfoley@arcnm.com">jfoley@arcnm.com</a></td>
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| NAME            | Joe Young, Deputy Director | Kathleen Valdes |
| DIVISION        | New Jersey Protection and Advocacy Inc. | Medicaid Division |
| DEPT            | -                           | Human Services Department |
| PHONE           | (609) 292-9742             | (505) 827-3106           |
| E-MAIL          | jyoung@njpanda.org        | -                        |
# State Contacts:
## New York - Ohio

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<tr>
<td><strong>Name</strong></td>
<td>Rose Pandozy</td>
<td>Lynda McDaniel, Assistant Secretary</td>
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<tr>
<td><strong>Division</strong></td>
<td>Policy and Program Guidance</td>
<td>Long Term Care</td>
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<tr>
<td><strong>Dept</strong></td>
<td>New York State Office of Medicaid Management</td>
<td>Department of Health and Human Services</td>
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<tr>
<td><strong>Phone</strong></td>
<td>(518) 473-5873</td>
<td>(919) 733-4534</td>
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<tr>
<td><strong>Email</strong></td>
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<td><a href="mailto:Lynda.McDaniel@ncmail.net">Lynda.McDaniel@ncmail.net</a></td>
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<td><strong>Name</strong></td>
<td>Heather Stefl, Public Information Specialist</td>
<td>Jim Downie, Sr. Policy Analyst</td>
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<tr>
<td><strong>Division</strong></td>
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<tr>
<td><strong>Phone</strong></td>
<td>(701) 328-4933</td>
<td>(614) 466-4443</td>
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<tr>
<th>Name</th>
<th>Tove Mandigo, Spcl Asst to the Exec Director</th>
<th>Mel Borkan, Asst Deputy Director, Disability Policy</th>
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<tr>
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<td>Phone</td>
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## State Contacts:
**Oklahoma - Rhode Island**

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<tr>
<td><strong>Name</strong></td>
<td>Ann Trudgeon</td>
<td>James Toews</td>
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<tr>
<td><strong>Division</strong></td>
<td>Developmental Disabilities Council</td>
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<td><strong>Dept</strong></td>
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<td>Oregon Department of Human Resources</td>
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<tr>
<td><strong>Phone</strong></td>
<td>(405) 528-0955</td>
<td>(503) 945–9819</td>
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<tr>
<td><strong>E-mail</strong></td>
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<td><a href="mailto:james.d.toews@state.or.us">james.d.toews@state.or.us</a></td>
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<tr>
<td><strong>Name</strong></td>
<td>Marilyn Eckley, Director</td>
<td>Frank Spinelli</td>
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<tr>
<td><strong>Division</strong></td>
<td>Office of Policy</td>
<td>Department of Human Services</td>
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<td><strong>Dept</strong></td>
<td>Department of Public Welfare</td>
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<tr>
<td><strong>Phone</strong></td>
<td>(717) 772-4131</td>
<td>(401) 462-1869</td>
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<td><strong>E-mail</strong></td>
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<td><a href="mailto:fspinell@gw.dhs.state.ri.us">fspinell@gw.dhs.state.ri.us</a></td>
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<tr>
<th>Name</th>
<th>Karen Kroh, Project Director</th>
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<tr>
<td><strong>Division</strong></td>
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<tr>
<td><strong>E-mail</strong></td>
<td><a href="mailto:kkroh@state.pa.us">kkroh@state.pa.us</a></td>
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## STATE CONTACTS:
### SOUTH CAROLINA - TEXAS

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<tr>
<td>NAME</td>
<td>Stanley Butkus</td>
<td>Wanda Seiter</td>
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<tr>
<td>DIVISION</td>
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<tr>
<td>DEPT</td>
<td>Department of Disabilities and Special Needs</td>
<td>Department of Developmental Disabilities</td>
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<tr>
<td>PHONE</td>
<td>(803) 898-9769</td>
<td>(605) 773-5990</td>
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| NAME    | Charles Lang, Staff/ Executive Director          | Lynn Vatenti                                   |
| DIVISION| Olmstead Task Force                              | -                                              |
| DEPT    | South Carolina Developmental Disability Council  | Department of Developmental Disabilities       |
| PHONE   | (803) 734-0465                                    | (605) 773-5990                                 |
| E-MAIL  | clang@goovoep.state.sc.us                        | -                                              |

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<tr>
<th>STATE</th>
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<tr>
<td>NAME</td>
<td>Cynthia Tyler</td>
<td>Patty Anderson</td>
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<td>Mental Health Administration</td>
<td>Promoting Independence Advisory Board</td>
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<tr>
<td>PHONE</td>
<td>(615) 532-6518</td>
<td>(512) 472-8696</td>
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<td><a href="mailto:ctyler@mail.state.tn.us">ctyler@mail.state.tn.us</a></td>
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| NAME    | Shirley Shea                                     | Adelaide Horn, Director                         |
| DIVISION| Tennessee Protection and Advocacy Agency         | Long-Term Care Coordination                     |
| DEPT    | -                                                | Health and Human Services Commission           |
| PHONE   | (615) 298-1080                                    | (512) 424-6558                                 |
| E-MAIL  | -                                                | adelaide.horn@hhsc.state.tx.us                 |
## State Contacts: Utah - Washington

<table>
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<th>State</th>
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<th>Vermont</th>
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<tr>
<td>Name</td>
<td>John Williams, Director</td>
<td>Bard Hill, Chief</td>
</tr>
<tr>
<td>Division</td>
<td>Division of Health Care Financing</td>
<td>Home and Community-Based Services</td>
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<td>Dept</td>
<td>Department of Health</td>
<td>Agency of Human Services</td>
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<tr>
<td>Phone</td>
<td>(801) 584-1914</td>
<td>(802) 241-2335</td>
</tr>
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<td>Email</td>
<td><a href="mailto:jwilliam@doh.state.ut.us">jwilliam@doh.state.ut.us</a></td>
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<tr>
<td>Name</td>
<td>Louis F. Rossiter, Secretary</td>
<td>Cathy Cochran, Olmstead Coordinator</td>
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<td>Dept</td>
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ALABAMA

In fall 2001, Alabama collected draft recommendations from four task forces. These recommendations will be considered as the draft plan is completed in January 2002.

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

The group has been holding meetings throughout the state. Four subcommittees have been formed and are actively meeting. These are Needs Assessment, Best Practices, Consumer, and Resource Development. Each subcommittee is chaired or co-chaired by a stakeholder. Each task force was expected to submit recommendations by September 1, 2001. A draft plan will be developed from these recommendations this fall, with public forums slated to begin in October. The draft plan will be revised in December 2001 and completed in January 2002 before the legislative session begins in February.

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

The state plan will expand access to home and community-based services for all disability groups mentioned in the *Olmstead* decision, but will not be limited to those groups. The state intends to look at its entire Medicaid program in the next few years, rather than looking at home and community-based services in isolation.

The primary barrier to completing the plan is funding—the state wants to be able to provide services in a different way (i.e., in the home or community), but this requires additional funding. To this end, Alabama applied for and received a Real Choice Systems Change grant from CMS. Another barrier is the disagreement among consumers, providers and the government about the best way to provide these services.
ALASKA

Alaska has not formed an *Olmstead*-specific task force, but is building partnerships between the various state departments to improve beneficiaries’ continuum of care. The intricate details of thoughtful planning and funding of home and community-based services for rural and urban beneficiaries has been emphasized during the last year. The collaborative partnerships between the Department of Health and Social Services, the Alaska Mental Health Trust Authority, the Alaska Mental Health Board, the Governor’s Council on Disabilities and Special Education, the Governor’s Advisory Board on Alcoholism and Drug Abuse, the Alaska Commission on Aging, the State Independent Living Council, statewide advocates and providers; and the beneficiaries receiving services continue to flourish.

In October 2001, the department designated a state contact for ongoing *Olmstead* correspondence, status reports and training. The state contact attended the *Olmstead* coordinator training in Washington, D.C., provided through the Substance Abuse and Mental Health and Services Administration (SAMHSA)–Center for Mental Health Services (CMHS). Alaska did not feel it was necessary to apply for the grant funds available through SAMHSA-CMHS for coalition building due to the elaborate planning process already in existence and required by state statute.

During FY 2001, Alaska authorized funds for planning services for people with disabilities, including home and community-based services. To date, no lawsuits have been filed in Alaska in response to the *Olmstead* decision.

During FY 2002, Alaska’s Department of Health and Social Services will support and advance the following projects or initiatives:

- Continue to take public comment on the Comprehensive Integrated Mental Health Plan, *In-Step*, and use the information and suggestions gathered to shape the next planning process;
- Implement the statutorily required Comprehensive Integrated Mental Health Plan in concert with the various planning entities and other Executive Branch agencies;
- Support and implement the Division of Senior Services systems change grants?Alaska’s Community Integrated PASS Project and the Nursing Facility Transition Grant;
- Facilitate the participation of the statewide stakeholders in the Georgetown University Child Development Center 2001 Policy Academy, focusing on key issues for children and youth;
- Enter into a contract for conducting a needs assessment to identify the types of services needed to reverse the flow of children and youth going out-of-state for residential psychiatric treatment services, the in-state capacity required, and actions required to develop the needed capacity to serve as many children and youth as possible within their home communities;
- Make accessible and begin implementation of the plan for Integrated Substance Abuse and Mental Health services;
- Continue implementation of the action plan developed by the long-term care committee; and
- Develop a system improvement plan for assisted living services in Alaska.
ARIZONA

The final plan was released in early September 2001. The plan addresses individuals with mental illness, the elderly, and the physically and developmentally disabled. The focus is on moving individuals from institutions into community settings and on preventing the loss of services for those already in the community. The plan is available at http://www.ahcccs.state.az.us/publications/olmstead/default.asp.

The governor directed officials in the Arizona Department of Human Services/Division of Behavioral Health Services (ADHS/DBHS), the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD), and the Arizona Health Care Cost Containment System (AHCCCS, the Medicaid agency) to prepare plans to address the issues raised in *Olmstead*. These separate plans were consolidated and revised for a final version. In developing the final plan, consumer input was sought in regional stakeholder meetings and statewide public forums. To date, *Olmstead*-specific budget requests have not been made but may be made in the future. State officials expect any program or service changes to be cost neutral and see no need for specific budgetary increases other than for normal inflation for costs and enrollment increases.

The stated goals of the Plan are to:
- Address the recommendations of the CMS and the Office of Civil Rights in meeting the principles embedded in the *Olmstead* decision.
- Demonstrate the progress Arizona has made in meeting these principles.
- Identify areas for improvements in the delivery of home and community-based setting and services.
- Ensure that consumers, advocates, and other stakeholders are included in the planning process.
- Identify the data that must be collected to achieve the goals.
- Evaluate the progress the State is making toward meeting the goals and revising them, as needed.

The outcomes from the Plan are to:
- Strengthen informed decision-making and choice for consumers
- Improve community service systems.
- Improve administrative processes to support community integration.
- Monitor the overall capacity of the service system to provide services and supports that improve access to community integration.

The common themes for all state agencies include:

1. Labor Force
   The State believes it will take a community coalition of education, employment development industries, commerce, providers and consumers to successfully address labor force issues. According to the Plan, solutions to labor force problems will require legislative support, fiscal support, changes in credentialing and scope of practice limitations and an adequate labor market.

   To address labor force issues, AHCCCS/ALTCS/EPD and ADES/DDD are considering the following options:
· Using Medicaid ALTCS funds to pay souses and parents as personal care attendants
· Providing interim pay to personal care attendants when the consumer is out of the home (e.g. hospitalization).
· Pay increases for home and community-based providers.
· Consumer-directed services.

In addition, ADHS/DBHS is reevaluating its current service matrix that includes the types of services and the recommended service reimbursement rates.

2. Education and Information to Consumers
   - AHCCCS is considering developing and distributing informational materials to help make informed choices.
   - Beginning October 1, 2001, AHCCCS is requiring all contractors to convene member/provider councils that are representative of the ALTCS/EPD consumers within a given geographical region. These councils will provide a forum for discussions and feedback on the Olmstead Plan.
   - ADHS/DBHS will provide training to consumers and providers on the philosophy of recovery. Training programs for peer mentors will also be expanded.

3. Consumer Centered Care Management
   - Provide ongoing training to consumers on consumer centered care management
   - Encourage self-advocacy

4. Provider Networks
   - Agencies are conducting an ongoing analysis of the service networks in Arizona.
   - Beginning October 1, 2001, all AHCCCS/ALTCS Program Contractors are required to have formal Network Development and Management Plans to identify the current status of the network and project future needs based on membership growth.
   - ADHS/DBHS is implementing a new system for monitoring service networks

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

The Governor’s Integrated Services Task Force was created to guide the development of the “comprehensive, effectively working state plan.” The Department of Human Services (DHS) expects the plan to be completed in spring 2002. One of the first priorities of the state is planning a pilot process to assess people in, or at risk of entering, institutions to determine if they can and want to live in the community.

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

On February 15, 2001, the Arkansas Olmstead Working Group—made up of officials from DHS, interested consumers, advocates and providers—delivered a report to the governor on the group’s progress. The report contains background information on the issue, recommendations for future work and a timeline for developing and implementing a statewide Olmstead plan. This report can be found at www.accessarkansas.org/dhs/Olmstead%20Report%20_ver_6.pdf.

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

Some of these recommendations already have been carried out. The Governor’s Integrated Services Task Force (GIST) was created to replace the working group and guide the development of the “comprehensive, effectively working state plan.” The majority of GIST members are consumers and advocates and were on the working group. A consumer advisory board established in spring 2001 successfully secured a Real Choice Systems Change grant.

The timeline has been revised since the February 2001 report. DHS now expects the plan to be completed in Spring 2002 in order for recommendations to be reflected in budgets developed for the 2003 legislative session.
The state intends to apply any expansion of home and community-based services to all age and disability groups. DHS has identified millions of dollars in new funding to expand the developmental disability home and community-based waiver.

No lawsuits have been filed in the state pursuant to the *Olmstead* decision, although two specific complaints were filed with DHS; these complaints have since been resolved.
The California Health and Human Services Agency Long-Term Care Council provides leadership in the development of a state long-term care system that supports consumer dignity and independence.

The council has six workgroups under way. These groups focus on:
1. Improving the coordination between home and community-based supportive services;
2. Creating an inventory of long-term care data currently collected to facilitate the development of more useful data elements, data linkage, and collection processes;
3. Improving the quality and availability of consumer long-term care information;
4. Developing and conducting a nursing home assessment and transition pilot project (if funded);
5. Increasing quality assurance and flexibility in the licensure of long-term care facilities and services, while also streamlining those mechanisms; and
6. Developing a Medicaid assisted living waiver pilot program.

These workgroups include a broad spectrum of long-term care stakeholders, including state and local agencies, consumers, advocacy organizations, providers, researchers, and others interested in these issues. The workgroups report to the Long-Term Care Council at its quarterly public meetings. The secretary of the California Health and Human Services Agency chairs the council, which includes all CHHS departments that administer long-term care programs in addition to the departments of Housing and Community Development, Transportation, and Veterans Affairs.

In 2000 to 2001, the Council held four public forums in different areas of the state to gain input from consumers, family caregivers, and other local stakeholders. Based in large part on input from those forums, the state submitted two federal Systems Change grants to the Center for Medicare and Medicaid Services (previously known as HCFA) in July 2001. The grant proposals did not receive funding from the federal government.

However, as noted in “Two-Year Olmstead Progress Report: Disability Advocates Assess State Implementation of Mandate to Provide Community-Based Services to People with Disabilities,” issued by the National Association of Protection and Advocacy Systems in October 2001, “the Coalition of Californians for Olmstead (COCO) was referred to the statewide Long Term Care Council (LTCC) as the body that would be coordinating California’s Olmstead efforts and as a forum where COCO’s expertise and commitment could be utilized. Unfortunately, after over a year of our efforts [to work with this group], the LTCC has failed to identify itself as the body coordinating Olmstead planning and therefore there is confusion and disagreement about its goals and mission.”

All council and workgroup meeting minutes, as well as other relevant documents, are available from the CHHS agency Web site at: www.chhs.ca.gov. The documents on the Web site indicate that a more comprehensive, formalized plan will be developed.
COLORADO

The state will review the recommendations of three working groups and develop a plan for external review by the end of 2001. The state expects a final plan to be completed by March 1, 2002.

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

One issue the plan will tackle is waiting lists for individuals receiving care in institutions who are assessed as able to obtain community-based care. The plan is not likely to address individuals who are not receiving care or individuals who are at risk of losing community-based care. To that end, state officials expect the plan to focus on the assessment procedures used and the ability to transfer individuals when they are eligible. State officials have requested input from existing advisory councils and other advocacy groups.

Several suits have been filed regarding Olmstead issues, and decisions are pending. At least one suit relates to individuals who want to remain in an institution after they have been assessed as eligible to receive community-based care. Another case, Mandy R. vs. Owens, is a class action suit on behalf of individuals with developmental disabilities on Medicaid waiver waiting lists.
In September 2000, the third draft of a community integration plan, *Choices are for Everyone*, was released for public comment. Since then, Connecticut's Community Options Task Force has held five public hearings and one forum to gain input on the plan. In spring and summer 2001, the task force focused its efforts on preparing grant applications to secure funding for *Olmstead*-related activities. The task force expects to release the final plan in early 2002, by the start of the legislative session. The most recent draft of the plan can be found at http://www.dss.state.ct.us/highlights/choices1.pdf.

The Long-Term Care Planning Committee—comprised of legislators and eight state agency representatives—was established by the Connecticut legislature in 1998 to focus on the elderly, but broadened its focus in early 2000 to also work on *Olmstead* planning.

The Long-Term Planning Committee works with the Community Options Task Force in *Olmstead* planning. The Community Options Task Force, co-chaired by officials with the Connecticut Council of Persons with Disabilities and the Department of Social Services (DSS), is comprised of individuals with disabilities and advocates. Separate from the Long-Term Care Planning Committee, the task force was created to help develop the comprehensive plan and provide advice to the Long-Term Care Planning Committee. The Department of Health and Human Services’ (DHHS) Office of Civil Rights also has been informally involved in the process through several meetings.

*Choices are for Everyone* outlines the following major goals.

1. **Developing new options related to community integration that were approved in the 2000 legislative session:**
   - Eligibility changes for certain groups;
   - Assisted living services;
   - State-funded pilot programs for elders and certain people with severe physical disabilities;
   - Possible expansion of model waiver, subject to appropriations; and
   - Increased housing options for people with psychiatric disabilities.

2. **Proposing additional services and supports for the future.** State agencies responsible for providing services for people with disabilities currently are reviewing the list of priorities identified by stakeholders and are considering possible legislative and budgetary proposals for the coming biennium.

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

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

Some initiatives for enhanced home and community-based service options already are under way. The state has identified existing waiting lists for community services, but more data analysis is
needed to determine the number of individuals who are inappropriately residing in institutions. The state intends to apply any expansion of home and community-based services to all disability and age groups. No new bills were introduced in the 2001 session relating to Olmstead.

The greatest barriers to moving forward with Olmstead compliance are resources. Specifically, the state needs to work on developing the infrastructure to carry out its plan and on finding necessary services in the community. Eventually, state officials believe Connecticut will be able to use existing institutional resources to help fund home and community-based options, but the state must sustain both at first. No new funding was provided in the 2001-2003 biennial budget for Olmstead implementation.

No lawsuits have been filed in the state pursuant to the Olmstead decision, although individual complaints have been filed with DHHS’ Office of Civil Rights about specific institutions.
DELAWARE

On May 17, 2000, Delaware’s governor issued an executive order expressing the state’s commitment to provide community-based services for people with disabilities. The order required the Delaware Department of Health and Social Services (DHSS) to submit three separate plans. The plans were issued in the summer of 2001. The first plan addresses people with developmental disabilities and mental retardation. The second addresses the elderly and people with physical disabilities. The third plan concerns those with mental illnesses. Each planning process included consumers, advocates, service providers, and the appropriate agencies. Each plan became part of the five-year strategic plan of the agency responsible for its management.

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

The state received a Real Choice Systems Change Grant in September 2001 that will help support plan implementation.

To date, no Olmstead-related suits have been filed in Delaware. However, one complaint was filed with the Office of Civil Rights on behalf of a class of mentally ill people at the inpatient facility. That action is pending.
The Medicaid agency within the Department of Health has convened the Real Choice Systems Change Advisory Committee, which will oversee the redesign of the District’s long-term care system, including the addressing *Olmstead*-related concerns. The advisory committee includes consumers, providers and the various District government agencies that influence services provided to individuals with disabilities.

Although the District of Columbia did not receive the Real Choice Systems Change grant, the department’s 2002 budget includes funding for initiatives aimed at improving long-term care service delivery. Specifically, the department is designing a resource center to help the city create a service delivery model similar to Wisconsin’s Family Care program. As now conceived, the new service delivery model would start with frail elderly people and those with physical disabilities, and then, if successful, be extended to people with developmental disabilities and those with mental illness. The model would focus both on people now in institutions and those who are applying to enter them. The department also is working to amend its 1915c waiver, which serves individuals age 65 and older to expand to serving adults under age 65 with physical disabilities and to provide attendant care and assisted living.

The District recently settled a case, *Evans vs. Williams*, on behalf of individuals with developmental disabilities who were not receiving adequate community supports. The settlement requires detailed actions that the District must take to provide community services and establishes a set of measurable outcomes to gauge the effectiveness of these services.
FLORIDA

Florida has developed a unified *Olmstead* Coalition that includes state agencies, consumers and other key stakeholders. State officials submitted a grant proposal for the HHS Systems Change Grant that includes a state plan to address *Olmstead*. Other efforts include various Ticket to Work initiatives, recent federal approval to expand the inpatient psychiatric programs for children's waiver services statewide, and a recent state plan amendment approval for assistive care services for disabled populations. Florida has received a Real Choice Systems Change grant.

Among the programmatic activities slated for implementation during fiscal year 2001 are the following:

1. Doubling the number of waiver slots?up to 26,000?for people with development disabilities;
2. Implementing a nursing home transition grant for people with traumatic brain injuries in nursing homes;
3. Continuing the operation of 10 home and community-based waivers;
4. Submitting a Medicaid state plan amendment authorizing assisted living; and
5. Making available statewide a demonstration program on assertive community treatment for people with behavioral health needs.

In August 2000, the state settled a class action suit, *Wolf Prado Steiman vs. Bush*, agreeing to improve services for individuals with developmental disabilities on Medicaid waiver waiting lists. The detailed settlement agreement provides that, effective July 1, 2001, substantial compliance with several detailed time frames will constitute reasonable promptness, including that if a waiver slot and funding are available, eligible people shall be provided with these services within 90 days of receipt of the waiver application.
In response to the Olmstead decision, Governor Roy E. Barnes named the Department of Human Resources (DHR) to lead the planning effort to improve access to community integrated services for people with disabilities.

The Olmstead Planning Committee included advocates, consumers of services, members of consumers' families, and service providers. Also participating were leaders of the Department of Community Health (Division of Medical Assistance), the Department of Mental Health, Mental Retardation and Substance Abuse, the Division of Aging Services, the Division of Children and Family Services, the Office of Regulatory Services and the Governor's Council on Developmental Disabilities.

The Olmstead Planning Committee was charged with:
· Guiding the Departments of Human Resources and Community Health in developing a set of recommended action plans for state implementation; and
· Developing action plans to facilitate service delivery in the most integrated setting appropriate to the needs of individuals with disabilities (children and adults with mental illness, children and adults with mental retardation/developmental disabilities and individuals with physical and other disabilities, including the elderly).

The committee's Final Report will be presented to the Commissioner of the Department of Community Health and the Commissioner of the Department of Human Resources on January 22, 2002. The recommendation include:
· By Executive Order, the Governor should establish the Olmstead Planning Commission to monitor, advise and suggest modifications to the implementation of the plan;
· Establish as policy that children and adults with disabilities who could be served in the community are not institutionalized to receive appropriate services;
· Establish as policy that treatment professionals in public institutions should be trained to assess and determine supports needed by each individual (using person-centered principles) to live in the most integrated setting;
· Support legislation to amend the Nurse Practice Act to permit nurses to delegate certain limited nursing tasks in various community settings, such as the administration of medications, to unlicensed personnel who have been properly trained and who are overseen by a licensed registered nurse.
· Support legislative or regulatory changes that allow for community living options for additional populations.
· Develop consistent policies and standards for all community-based long-term care services.
· Design and implement an education program to assure professionals are knowledgeable of community services available and are competent to refer to needed services.
· Implement one-on-one consumer to consumer education/information sharing activities in order to insure that people living in congregate settings have the opportunity to hear about integrated community living options.
· Increase flexibility in Medicaid Home and Community-Based Waiver programs;
· Develop programs to enhance family support, case management services, and supports for persons with high-end physical, medical and behavioral needs and persons in crisis;
· Develop a common intake process for persons needing community-based long-term care;
· Review the different layers of monitoring, regulation and accountability in community-based,
long-term care service systems and develop recommendations on an effective process for accountability;

· Provide adequate financial resources for all community-based long-term care services;
· Use data to plan and manage community-based long-term care;
· Assure that quality of service and quality of life is a priority for all parts of the service system.
· Maintain a trained, competent long-term care provider network by implementing mandatory orientation training, service standards training, policy and system change training, and training on evidence-based practices;
· Conduct service gap analyses to determine current service capacity and directions for future growth;
· Gather and disseminate information on innovative national approaches to long-term care.

This plan is a fluid document, and its action steps will be amended as the State of Georgia moves forward with implementation. Successful implementation of the plan will require the collaboration of the Governor’s Office, the General Assembly, consumers, families, advocates, and representatives of numerous state and private agencies. The committee has established the following priorities for moving people to community integrated settings:

· All children in state-operated institutions
· Individuals, regardless of disability, age or location, who choose to move or are not opposed to moving and have been identified by the clinical team as “ready to move”.


Hawaii

Hawaii has an Olmstead committee, but it has not yet issued its plan. The director of the Department of Human Services (Medicaid agency) initiated an Olmstead planning discussion in Hawaii after HCFA sent state Medicaid directors a letter regarding state compliance with the Olmstead decision. The legislature passed a concurrent resolution (HRS 196) in May 2000 to establish an Olmstead planning task force and required the task force to report to the governor by June 2001. In response, the state set up a tri-chaired Olmstead planning committee—chaired by the director of the Department of Human Services, the director of the Department of Health (Disability and Communication Access Board/Executive Office on Aging in this Department/Development Disabilities Division), and the executive director of the Center for Independent Living.

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

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

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

The Department of Human Services was awarded a Real Choices Systems Change Grant of $50,000 to support the initial planning process and for the development and submittal of a grant proposal for the President’s New Freedom Initiative for community long-term support systems. The grant funds will be used to: 1) establish a consumer and public and private agency working committee to develop a state plan for the integration of disabled individuals into the community; 2) hire a grant writer to write the grants that the Department of Human Services and the Department of Health will submit for the Real Choice System Change Grant and the Real Choices Community-Integrated Personal Assistance Services and Supports Grant under the New Freedom Initiative; and 3) establish and support a statewide consumer advisory group to provide input into the grant development process and implementation.

The planning committee has decided to focus on three major areas:
1. Development of an information portal to expand information dissemination and accessibility to individuals. These individuals can use the portal to determine how to access all the issues relevant to them for resources available, how to access the resources, and how to link the pieces.
2. An assessment mechanism to use as a basis for using the portal. This mechanism will help individuals to clarify their goals and show them how to achieve their goals.
3. Transportation, housing and labor will be highlighted so that the agencies responsible for providing these types of services include the needs in these areas in their planning process.

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

Idaho is in the early stages of developing a comprehensive plan through a working committee for community integration. The Community Integration Committee (CIC) was created by the governor's office, although not by an executive order. It is composed of members from the Idaho Department of Health and Welfare, the divisions of Family and Community Services and Medicaid along with other agencies, advocacy groups, and consumers, including the Idaho Commission on Aging. The committee ultimately will produce a plan, but it currently is focusing on assessing the existing service delivery systems in Idaho with regard to community integration. To that end, there is no projected date for plan completion.

The committee has completed one phase of its investigation and submitted recommendations to the director of the Department of Health and Welfare. Findings, so far, focus on issues that cross disability groups and cover the entire life span, such as access to housing, transportation, medications, and community-based supports. The Department of Health and Welfare has submitted applications for three of the System Change Grants for Community Living and has received a Real Choice Systems Change grant. Proposals are based on the CIC recommendations. A fourth application was submitted by the state's Independent Living Centers. All submissions are part of a statewide coordinated effort. The CIC will continue the assessment and participate in an oversight role if the grant proposals are funded.

The overall number of consumers will be increased, so they comprise at least 50 percent of committee members. Increased representation of elders?as well as housing and transportation representatives?is forthcoming. The department director will make these additional appointments.

The Legislature has not passed any laws in response to Olmstead. However, it has asked the Department of Health and Welfare, Division of Medicaid, to institute utilization review procedures to ensure that the right services are being delivered at the most appropriate level of care, based on need.

Because the plan is in its early stages, many of the details are not available. For example, it is unclear whether and, if so, how people with disabilities will be grouped. Idaho officials believe that crossover issues such as housing, transportation and medication have the greatest effect on successful community living and independence. The grant proposals, based on the recommendations of the CIC, focus on these issues, not on disability categories, and address people in all disability and age groups. It is now being recommended that the CIC itself reorganize its subcommittees around these common issues.

In addition, it is not clear whether the plan will address only those institutionalized when unnecessary or if it will include others such as those in the community who are a) not receiving necessary institutional care or b) at risk for institutionalization due to the absence of care. The committee has completed an assessment of the existing state facilities and now will move the investigation to facilities and services funded by Medicaid and provided in the private sector. Details of the investigation are not yet available.

Although no suits have been filed in direct response to Olmstead, other suits are pending that relate to similar issues. These suits have helped direct the state's efforts. As in most states, however, funding remains an issue. The System Change grant proposals, if funded, should facilitate progress toward greater community integration.
The Illinois legislature initiated activity around *Olmstead* in the spring of 2000 when it passed House Resolution 765, directing the Department of Human Services to convene a broad-based group to discuss *Olmstead* and develop a plan pursuant to it. A report on the group's proceedings and steering committee recommendations were filed with the legislature in January 2001.

The 2001 report includes position papers from each of six topic areas addressed by the group, in addition to dissenting opinions given in response to the papers. The steering committee report is available at state.il.us/agency/dhs/rawda2.pdf. Recommendations made in the position papers follow.

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

2. **Olmstead Universal Prescreening and Community Reintegration Working Group Report.** Recommended priorities include:
   - Informed choice/person-centered plan with individual budget.
   - Universal pre- and post-screening, which includes education of families regarding community-based services
   - Develop and improve community reintegration resources and services, including more than one chance for successful reintegration.
   - Educate facilities and treatment professionals regarding *Olmstead* and community resources and options to consumers.
   - Complete plan for students to make the transition from school to community to work.
3. **Olmstead Housing Working Group Report.** Recommendations were made for housing accessibility, housing integration, consumer choice of housing, housing affordability and housing finance.

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

5. **Olmstead Community Infrastructure Working Group Report.** Recommended actions include:
   
   - Present a draft “Olmstead plan” to the legislature that details the level of state compliance with the Olmstead decision.
   - Identify people in institutions who desire to move to the community, regardless of age and disability, and identify what services they need to do so, regardless of age or disability.
   - Ensure that people who are identified as wanting to move out of institutions receive transitional assistance.
   - Ensure that Medicaid money will follow an individual if that individual chooses community services instead of a nursing home.

6. **Olmstead Best Practices Working Group Report.** Recommends examples of policies and programs that already have been established in other states and in the world around the following issues:
   
   - Self-determination;
   - Informed choice;
   - Open and improved communications; and
   - Successful transition into the community.

The Department of Human Services (DHS) was named the lead agency to coordinate Olmstead activities among its offices of mental health, developmental disabilities, rehabilitation services, transitional services (housing) and other affected state agencies, including the Department of Public Aid (Medicaid agency), the Department on Aging, the Department of Children and Family Services, the Department of Public Health, and the Illinois Housing Development Authority. Illinois has received a Real Choice Systems Change grant.

Timeline of activities:

- August 2000—Stakeholders (about 250 people) convened.
- September 2000—Stakeholders selected workgroups based on the topics they wanted to work on.
- September/October/November 2000—Workgroups met. Each group worked on a position paper with specific recommendations and strategies in their topic areas.
- December 13-14, 2000—Position papers presented to the Intrastate Agency Team.
Members of the various workgroups formed a steering committee (of 33 people) that presented the position papers to the DHS secretary and other agency officials. The state agencies will analyze the feasibility of implementing the recommendations. Some recommendations may be implemented immediately, while others, requiring programmatic and or policy redesign will take more consideration.

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

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

To date, the legislature has dealt mainly with appropriations. Several bills dealing with various community integration and disability issues have been introduced, and they are pending committee action.

The governor issued an executive order in September 2000 that identified the Family and Social Services Administration (FSSA) as the agency in charge of Olmstead planning and gave it until June 1, 2001, to submit its recommendations. Details of the planning effort are available at www.in.gov/fssa/servicedisabl/olmstead/index.html. Initially, FSSA was to conduct a comprehensive study of all services and programs available to people with disabilities in Indiana. Also, employees of the several relevant departments within FSSA have been meeting with the members of three committees appointed by the FSSA secretary. These committees, the members of which include people with disabilities (physical, mental and developmental), the elderly, their families, consumer advocates, and service providers, were formed to ensure participation from outside the governmental realm.

Released on June 1, 2001, the First Edition of Indiana’s Comprehensive Plan for Community Integration and Support of Persons with Disabilities is available at www.state.in.us/fssa/servicedisabl/olmstead/comprehensive.html. It covers individuals with physical and developmental disabilities, those with mental illness and the elderly, with an emphasis on consumer choice. Further, it addresses current residents of institutions with regard to whether they can or cannot be served in a community-based setting and people living in the community who may be at risk of institutionalization due to a lack of adequate services. Currently, assessment procedures are handled on a case-by-case basis. A standardized evaluation is being developed for people with mental illness. Although one currently exists, it often is not used to determine admission to long-term care facilities.

Highlights of the plan include a goal of reducing the state psychiatric hospitals’ overall census by 100 (by January 2003), legislation (recently passed and to be implemented in FY 2002) to allow consumers to self-direct attendant care, and the reconfiguration of several administrative aspects of disability-related services.

Furthermore, the plan calls for the creation of the Real Community Choice Commission to provide ongoing oversight of the implementation, continuation of the public discussion, and a leadership resource. The commission members, to be selected by the Governor, will include consumers, advocates and state agency representatives.

Indiana officials are working to minimize institutional and to maximize community-based care. They have not made Olmstead budget requests per se, but the FSSA does request funds to deal with the general issues addressed by the Olmstead decision. Nonetheless, the legislature approved several requests made in the governor’s budget to deal with these issues. For example, 822 additional slots were approved for the aged and disabled waiver for FY 2002 and an additional 813 for FY 2003. Also, an additional $6 million was appropriated for in-home services programs for each year of the biennial budget, with money for raises for direct care staff. Other examples include 440 additional developmental disabilities waiver slots for FY 2002 and 372 for FY 2003 and the passage of legislation creating a Medicaid buy-in program for disabled workers. The plan does include timelines (based on a two-year window) and funding provisions (where the legislation has appropriated funds).
Two lawsuits, filed on behalf of physically disabled individuals, are pending. One case, *Inch vs. Humphreys*, specifically challenges a failure to provide services in the most integrated settings to individuals with disabilities living in nursing facilities. It is unclear to what extent these suits have affected the state's efforts.
IOWA

In May 2000, the governor, in response to the Olmstead decision and the January 2000 letter sent by the U.S. Department of Health and Human Services, asked the state’s Department of Human Services (DHS) to be the lead agency for Olmstead planning. The draft plan is available at www.dhs.state.ia.us/mhdd.

In mid-2000, the DHS conducted 18 public meetings and several site visits to review the status of the current system and gather information to be used in formulating its plan. In June 2000 the Iowa General Assembly’s Legislative Council authorized the creation of the Mental Health and Developmental Disabilities Services Task Force (MHDDSTF). This task force is to recommend ways to improve service delivery for these populations. A report generated for the governor identifies current initiatives, including a Medicaid buy-in for people with disabilities, case management for the elderly, and the MHDDSTF. It also identifies the gaps that exist in the service delivery system.

The first issue addressed is eligibility. The report notes that, traditionally, funding has been limited to people with mental illness or mental retardation and that such funding should be expanded to cover additional diagnoses. The other issue addressed is the capacity of the service delivery system. Like many states, Iowa faces a shortage of medical service providers. This is compounded by the nature of some disabilities (i.e., dual diagnoses, rare conditions, behavioral inconsistencies, etc.). A shortage of affordable housing further complicates efforts to move people into the community.

The steering committee that developed the draft plan included advocacy groups, providers, families, consumers, DHS employees and county administrators. All relevant issues were identified by mid-March and a draft plan was available for comment in April 2001. These comments were put into the final plan released on June 20, 2001. FY 2003 budget recommendations will be made to the governor in July and to the legislature by early fall. Iowa has received a Real Choice Systems Change grant.

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

The Kansas Department of Aging and the Kansas Department of Social and Rehabilitation Services work group formed in February 2000. This group has created two subcommittees: one to draft a report on Kansas' efforts to include people with disabilities in the community since 1990 (when the Americans with Disabilities Act [ADA] was enacted), and the other to work on how to best identify people who want to leave institutions. Both subcommittees will draw upon a larger base of state agency officials and stakeholders.

The committee is expected to give its 10-year progress report in early 2002. Analyzing the effect of the application of the ADA, as interpreted in the Olmstead decision, provides Kansas with an opportunity to describe the accomplishments of the state in developing and supporting a community-based services system. The progress report will include all people with disabilities, as well as people in institutions and those in the community who are at risk of institutionalization. All executive branch agency efforts will be outlined in the report. The committee also will identify best practices at the local level.

However, as noted in “Two-Year Olmstead Progress Report: Disability Advocates Assess State Implementation of Mandate to Provide Community-Based Services to People with Disabilities,” issued by the National Association of Protection and Advocacy Systems in October 2001, “the P&A and the Developmental Disabilities Council do not believe that these reports constitute meaningful Olmstead implementation planning. The Committee is simply releasing a report on progress made to expand services. It will not identify gaps in services or recommendations for future community infrastructure.”

The state has applied for, but did not receive, a CMS Real Choices Systems Change grant. However, it formed a consumer task force made up of stakeholders and consumers from the major disability groups—developmental disabilities, physical disabilities, head injury, mental health, aging and HIV/AIDS. The task force directed the grant applications. Although the state was not successful in obtaining a grant, it plans to continue to use the consumer task force to help with future Olmstead planning efforts.

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

A broad-based stakeholders group called the Kentucky Olmstead State Plan Committee has been working since November 2000 on a plan. Among the group’s activities were a series of public forums throughout the state in which housing, access to services, and transportation were identified as key issues. The group included four issue teams, one each for employment, housing, person-centered funding, and transportation. The state’s plan was adopted on September 25, 2001, and was submitted to the secretary of the Cabinet for Health Services.

The state conducted much of its initial Olmstead planning with funding from a Robert Wood Johnson Foundation grant. (Eight states, including Kentucky, received approximately $100,000 for a one-year period for Olmstead-related activities.) The state grantee, the Kentucky Department of Mental Health and Mental Retardation Services, contracted with the Interdisciplinary Human Development Institute (IHDI) at the University of Kentucky to spearhead development of the plan. The state received a Real Choice Systems Change grant to allow it to continue its planning and implementation activities.

The committee included five representatives from aging organizations, including the chair of the AARP State Advocacy Council, the Nursing Home Ombudsman Council, a representative from the Institute on Aging (an advisory group to the governor), the nursing home ombudsman (a state employee), and a representative from the state Office on Aging (a state employee).

The group attempted to focus its discussions on all people with disabilities. Advocates for people with developmental disabilities and advocates for the elderly and physically disabled were especially active in the commission’s work.

There have been no Office of Civil Rights complaints or lawsuits since the last report.
LOUISIANA

Although state officials initially believed an Olmstead plan was not required, several lawsuits, strong advocacy efforts and a visit from representatives of the Office of Civil Rights persuaded them to reconsider. In February 2001, the secretary of the Department of Health and Hospitals (DHH) met with representatives of the Louisiana People’s Olmstead Plan (LaPOP), an advocacy group. This meeting set out a goal to formally begin the process to develop the Olmstead plan. To achieve this, legislation was proposed by LaPOP and the DHH to amend a 1989 law to add the “most integrated setting” language used in Olmstead.

In the 2001 session, and after a rather contentious process, SB 855 was passed. The new law authorizes a planning process that will focus on “voice, choice and quality.” The plan will include individuals with physical and developmental disabilities, those with substance abuse problems, the elderly, individuals with mental illness, and others in a long-term care environment. Information about the planning process is on the Web at http://www.ladap.org/dap. To date, funding has not been requested.

The state recently settled two cases: Chisholm vs. Hood, requiring community services for children; and Barthelemy vs. Louisiana, regarding adults with disabilities in nursing facilities.
**MAINE**

Maine has developed subgroups to look at various components of *Olmstead* compliance and expect to release a draft based on these recommendations in April 2002. State officials believe they are drafting a document that creates a vision for community integration that goes beyond the Olmstead decision.

Although there has not been an executive order from the governor or any legislation enacted related to the *Olmstead* court case, Maine has actively developed a statewide home and community-based care plan, working under a grant from the Center for Health Care Strategies. The state also has received a Real Choice Systems Change grant from CMS. Representatives from five state agencies—the Department of Human Services; the Department of Mental Health, Mental Retardation and Substance Abuse; the Department of Labor; the Department of Corrections, and the Department of Education—and consumer representatives have formed the Plan Development Workgroup for Community-Based Living to meet this end.

The group meets monthly and has a set of priorities to develop a community integration plan. It now has formed into subgroups to expand the priorities before a written plan is drafted. These subgroups are Workforce Development, Coordination among State Agencies, and Services. The Plan Development Workgroup plans to conduct an assessment of all state agencies to document which services already are being provided and to collect data about groups of people with disabilities to determine who and how many are being served.

Currently, the state assesses elderly long-term care patients who are living in institutions. These patients must sign a “choice letter” if they wish to remain in the facility rather than be placed in the community. The Plan Development Workgroup plans to develop similar assessment tools for other disability groups.
MARYLAND

The Community Access Steering Committee under the Maryland Department of Health and Mental Hygiene, created by an executive order, released its recommendations to the governor on July 13, 2001.

The Plan

The recommendations focus on three major goals: 1) building community capacity, 2) helping people currently in institutions move to the community, and 3) helping people stay in the community.

1) Building Community Capacity

Recommendation A: Improve compensation for community-based direct care workers by increasing and restructuring reimbursement rates in the Medicaid Personal Care Program, making an automatic annual inflationary adjustment in public mental health system rates for community mental health services and increasing compensation for direct care staff who support people with developmental disabilities in the community.

Recommendation B: Enhance efforts to coordinate and develop affordable, accessible housing for people with disabilities by convening a workgroup to implement strategies to increase the availability of housing resources; creating a housing liaison function between the Department of Health and Mental Hygiene and the Department of Housing and Community Development to coordinate problem-solving and resource development; and initiating efforts to more effectively work with local public housing authorities to ensure they are aware of the needs of individuals with disabilities and are able to address them in ways such as setting aside a portion of their vouchers for people who want to leave institutions.

Recommendation C: Enhance the availability of accessible transportation for people with disabilities by exploring opportunities to develop pooled funding on a regional basis so limited transportation funds could be expanded and expanding the responsibilities of the State Coordinating Committee for Human Services to more comprehensively address transportation needs.

Recommendation D: Create an Inter-Agency Workgroup, including state agencies, to coordinate programs for people with disabilities.

2) Helping People Move from Institutions to the Community

Recommendation E: Fund and support department plans to help individuals make the move from state-operated facilities to the community by continuing to transition individuals with mental illness from state psychiatric hospitals to the community and people with developmental disabilities from state residential centers to the community and by conducting peer outreach and other education efforts in institutional settings.

Recommendation F: Fund and support efforts to help individuals make the transition from private facilities that serve individuals who are receiving government assistance by conducting outreach and education in nursing homes and chronic hospitals, providing assessment services to individuals who self-identify or are referred with the individual’s consent, expanding the Medicaid waiver for adults with physical disabilities and the waiver for older adults, establishing a transition fund to assist individuals who move from private facilities to the community, and making changes to the financial and medical eligibility criteria for Medicaid.
3) Helping People Stay in the Community

Recommendation G: Promote education and counseling on community options by pursuing measures to inform the public about community integration, enhancing awareness and understanding of state programs that support people with disabilities, and expanding anti-stigma programs in the community.

Recommendation H: Ensure appropriate access and coordination between various public programs and private insurance by pursuing private insurance coverage of evidence-based best practice community support services, changing Medicare and Medicaid to make allowable reimbursements comparable, developing and implementing a plan for acute and private hospitals to ensure no disincentives exist to admit and treat patients, and exploring opportunities to remove barriers to employment for people with disabilities.

Recommendation I: Expand crisis response and respite care programs for people who live in the community.

The committee consists of the secretary of Health and Mental Hygiene, the director of the Governor’s Office for Individuals with Disabilities, the secretary of Budget and Management, a representative from the governor’s office, and up to six additional members appointed by the governor. The steering committee broke into four work groups: 1) Mental Health Community Access Task Force, 2) Medicaid Community Access Task Force, 3) Developmental Disabilities Community Access Task Force, and 4) Systems Integration Task Force.

The state received $100,000 from The Center for Health Care Strategies, funded by The Robert Wood Johnson Foundation, for planning to improve long-term care services cross-disability. The state also received all three of the Real Choice Systems Change grants from the federal government. The state also supported the grant application from the Independent Living Centers.

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

Implementation

After hearing from disability advocates, the 2001 Maryland General Assembly passed legislation to increase the number of people to be served through the existing Community Attendant Services and Support Program Waiver and required the Department of Health and Mental Hygiene to submit an amendment to the waiver to expand eligibility to 300 additional adults with physical disabilities by expanding an existing Medicaid waiver program. Budgeted at $10 million in FY2002, the program permits individuals to select, manage and control their services and to choose their personal assistants, including the hiring of family members (except spouses).

The highest priority long-term care population probably will continue to be people with physical disabilities. Budget requests to move people with physical disabilities and those at risk from institutions to the community likely will be submitted in March 2002 when the budget process begins. In addition, state officials are considering intergovernmental strategies to assess services and programs in government that serve all people with disabilities.
No court cases currently are affecting the work of the committee. However, one class action suit, *Williams vs. Wasserman*, ongoing since 1996, is pending in district court on behalf of individuals with traumatic brain injury who remain institutionalized despite professional recommendations that community placement is appropriate. In addition, the Office of Civil Rights has received many complaints, but the state is working hard to resolve each of them.
Massachusetts

Governor Jane Swift has directed the executive offices of Health and Human Services, Elder Affairs, and Administration and Finance to work with an advisory group of disability advocates and providers to craft a comprehensive plan. The plan will be aimed at improving the quality of life for the disabled population by ensuring that services for eligible individuals are delivered in the most appropriate community-based settings. The planning process will include an examination of existing resources, identification and prioritization of populations, analysis of the financial effects of policy changes, and review of quality assurance measures. Massachusetts applied for and received a $50,000 planning grant and a Real Choice Systems Change grant from CMS to use as a resource in this effort.

In general, the state believes its current Medicaid system works well. Nevertheless, two suits have been filed during the last 18 months. One case, Rolland vs. Cellucci, was filed under the ADA on behalf of 1,600 nursing facility residents with mental retardation. The state entered into a settlement agreement in the Rolland case, which resulted in 75 people receiving community residential and other supports in FY 2000 and 175 people receiving community residential and other supports in FY 2001. In addition, up to 175 people in 2002, and 150 per year through 2007 are expected to receive such supports. Another case, Boulet vs. Cellucci, was settled whereby the state agreed to target a total of $85 million of new funding for development of group homes and delivery of interim at-home services during fiscal years 2002 to 2006 for class members. In addition, the state agreed to commit $29 million of its existing Department of Mental Retardation appropriation for community residential placements for class members.
MICHIGAN

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

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

Generally, state officials seem satisfied with the structure of their system, but they continue to work to improve the process by which services are monitored and delivered. Michigan has received a Real Choice Systems Change grant.
MINNESOTA

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

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

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

Created by legislation in March 2001, the task force called Mississippi Access to Care (MAC) issued its report to the Legislature on September 30, 2001. The 59-page report contains recommendations for the next 10 years. It is very detailed and comprehensive in that it contains timelines, budgets, and specific strategies and goals and also specifies the agencies responsible for implementing these strategies.

This report is unique in that it contains the proposed budgets for FY 2003-2011 for each recommendation. To implement the plan, MAC has estimated that the cost to the state for new initiatives and expansion of programs for people with disabilities will be $52.7 million in FY 2003, $74.8 million in 2004, $69.1 million in FY 2005, $62.2 million in FY 2006, $48.6 million in FY 2007, $40.9 million in FY 2008, $33.1 million in FY 2009, $32.5 million in FY 2010, and $33 million in FY 2011. As stated in the legislation, the purpose of the plan is for the state to make available community services for all people with disabilities that are recommended by professionals and requested by people with disabilities by June 30, 2001.

The Division of Medicaid was the lead agency to draft the plan, but the divisions of Medicaid, Human Services, Mental Health, Health, Education, and Rehabilitation Services also took part. Participation by state agencies, consumers, advocacy groups and consumer councils was voluntary. The group addressed the needs of all disability groups, regardless of age or residential setting.

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

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

Representative Evans sponsored the bill, which was brought to the legislator by advocates. The Division of Medicaid supported the legislation because it essentially formalized the work that had already begun. The MAC workgroup was created and is open to anyone who wants to join. The MAC Web site is http://www.mac.state.ms.us.

MAC held 14 public meetings at seven sites in February and has issued a survey to people with disabilities to determine the services they were or were not receiving and their satisfaction with these services. The state received more than 5,000 completed surveys. Although the surveys were not as useful as state officials had hoped, they did show that transportation and housing are the major concerns and that people in the waiver programs were happy. It also gave MAC some demographic data.
The Plan

The recommendations address the following issues: consumer education, database development, housing, population identification, simplification/standardization, transition from institution to community, transition from children to adult services, and transportation.

Consumer Education

1. Outreach: Announce the adoption of the 10-year plan and have periodic public updates on the status of plan implementation.
2. Communication and Education: Establish a MAC statewide, toll-free assistance line, conduct a feasibility study of kiosk-style information centers and investigate networking among public agencies and public providers via technology.
3. Training: Provide training to providers and state agencies, including interagency training.
4. Individual Assessment: Recommend to the Legislature a single point of entry referral system and that each agency develops a comprehensive assessment and evaluation procedure.
5. Transition from Institutions: By 2011, identify and move 1,035 individuals out of institutions and into the community.

Primary Support Services

1. Transportation: Establish initiatives and demonstration projects by 2003, identify agency responsible for developing and implementing a comprehensive transportation plan; conduct a feasibility study in 2004 for an interagency, consolidated transportation plan; develop partnerships between program/service providers to provide consolidated fixed route and flexible scheduling by 2004; and appoint the Developmental Disabilities Council to develop a Transportation Guide for people with disabilities in 2003.
2. Community-Based Housing: Identify a lead agency in 2003 responsible for developing a comprehensive housing plan, encourage the expansion of Section 8 Rental Vouchers, train existing case managers and traumatic grain injury providers, education, housing agencies, expand supported living services to individuals with MR/DD to 400 more people (from 400 to 800) by FY 2011, encourage the MS Development Authority to allocate 5 percent to 10 percent of all state housing funds to be used for people with disabilities, encourage regional housing authorities to implement the new Section 8 voucher program and earmark 10 percent of those vouchers for people with disabilities, expand model home ownership programs like “Home of your Own,” allow individuals with assets to set aside exempt funds for services above basic services supplied by the programs, provide subsidized assistance to Personal Care Homes to 306 adults by 2008, provide Emergency Care Shelters for 270 vulnerable adults by 2008, add 17 more group homes for individuals with serious mental illness by 2011, increase service to 136 more individuals with MR/DD and 88 more elderly individuals with MR/DD by 2011, expand supervised apartments for individuals with serious mental illness by 1,264 new units by 2011, and expand supervised apartments for individuals with MR/DD by 204 new units by 2011.
3. Home and Community-Based Waiver Program: Increase the number of individuals in the elderly and disabled waiver program by 750 per year for the next five years and also expand the array of services and provider reimbursement rates, increase the number of individuals in the independent living waiver program by 500 per year for the next five years and expand the menu of services offered, increase service to an additional 1,600 individuals in the MR/DD waiver by 2011, increase service to an additional 100 individuals in the assisted living waiver by 100 individuals per year for five years, extend the TBI and spinal cord injury waiver to serve 500 more consumers by 2004, apply for a new waiver for children with serious emotional disturbance and serve 1500 of them by 2011.
Other Support Services

1. Employment and Vocational Services: Increase the number of individuals with MR/DD in work activities to 250 more clients (from 700 to 950) by 2011, increase supported employment services to individuals with MR/DD to serve 500 more clients (from 216 to 716) by 2011, expand vocational education opportunities to assist 152 more students by 2006, and increase the number of people who receive employment/vocational services through the Department of Rehabilitation Services.

2. Prevention and Early Intervention Services: Increase mental health prevention/early intervention preventive services by 400 more children (from 800 to 1,200) by 2005, increase early intervention/child development services for children with MR/DD by 400 (from 651 to 1,051) by 2011, increase the number of children served through the First Steps Infant and Toddler Programs from 2,500 to 3,500 by 2011, increase EPSDT screening to reach 90 percent participation by 2011, and provide 149 more district transition coordinators for transitioning children through First Steps to preschool.

3. Diagnosis and Evaluation: Expand psychological evaluation service through the Community Mental Health Centers to 37,800 clients by 2011, provide flexible funding for 600 children with SED by 2007, fund a review of at least 47,000 service plans for people with mental illness by 2004, and provide additional time for intake assessment for 8,000 clients for two hours each at $62 per hour.

4. Day Treatment: provide school-based day treatment services to an additional 2,000 children by 2011.

5. Outpatient Therapy: Expand existing outpatient therapy services to 10,000 more children with mental illness (from 17,000 to 27,000) by 2011 and increase resources for outpatient therapy to an additional 13,400 individuals/families (from 26,000 to 39,400) by 2011.

6. Medication Evaluation/Monitoring: Expand number of children receiving medication evaluation and monitoring by 5,000 (from 9,500 to 14,500) by 2004 and expand medical evaluation to adults with serious mental illness by 10,000 (from 24,000 to 34,000) by 2011.

7. Therapeutic Nursing Service: Increase therapeutic nursing services to an additional 2,500 children with mental illness (from 2,176 to 4,676) by 2004 and ensure that every school has a school nurse.


9. Therapeutic Foster Care: Expand services for therapeutic foster care to 450 additional children by 2006 and expand therapeutic/treatment foster family homes by 450 children by 2011.

10. Therapeutic Group Homes: Increase the number of children served by 120 (from 370 to 490) by adding 40 beds by 2005; increase group homes for adolescents with substance abuse problems by serving 80 children more; and expand them to 60 more children with SED, medically fragile conditions, and MR/DD.

11. Making A Plan (MAP) Teams: Provide at least $20,000 per MAP team by 2006 to provide plans for youth with SED and a high risk of hospitalization.

12. Psychosocial Rehabilitation/Day Support Programs: Expand the clubhouse model to serve an additional 1,500 (from 4,212 to 5,712) adults with serious mental illness by 2011 and increase day support programs to an additional 2,000 individuals with serious mental illness by 2011.

13. Case Management: Expand case management to an additional 6,000 (from 16,000 to 22,000) children with SED by 2011, expand it to an additional 7,700 adults with SMI by 2011, expand it to 7,050 clients with mental illness by 2005, expand it to individuals with MR/DD by 400 clients by 2011, expand it to 850 children with SED through the EPSDT program by 2011, and provide targeted case management services to 960 children in MDHS custody.
14. Medication Purchase: Provide an additional $1.5 million by 2005 to community mental health centers to expand the medication purchase program for seriously mentally ill consumers.


16. Services for Elderly People with Serious Mental Illness: Increase the number of senior citizens with mental illness who are receiving community-based psychosocial services by 3,000 by 2011.

17. Adult Day Care Services: Expand adult day care services to 180 additional people with Alzheimer’s or other dementia by 2011.


20. Intensive In-Home Treatment: Provide in-home treatment to 450 more children with SED, medically fragile conditions, and MR/DD.

21. Education: Ask for funding for a secondary transition coordinator position in each school district to be responsible for helping high school age youth make the transition into vocational, mental health and other services.

22. Home and Vehicle Modifications: Increase the number of individuals by 370 through home/vehicle modifications.

23. Division of Community Services Programs: Expand services to individuals with disabilities in the eight program areas.

24. Services to Vulnerable Adults: Expand services by providing 46 more specialized social workers, expand homemaker services to 350 more adults, provide in-home sitter services for 300 adults, create Public Guardianship Assistance Program for 395 adults.

25. Department of Rehabilitation Services: Increase the number of people served through the state attendant care program by 83 by 2011, increase the number of people served in the independent living program by roughly 24,000 by 2011.

The plan also calls on the Legislature to designate a MAC Oversight Committee to coordinate the funding, implementation and needed revision of the MAC plan. The MAC Oversight Committee would require that, at least twice annually, the provider agency supply a report specifying the agency’s budgetary and program implementation response to the MAC plan.

**Implementation**

The plan’s recommendations are written in order of priority. Therefore, the systems change recommendations—housing, transportation, assessment, training and consumer education—come first, followed by support services.

Some waiver expansions could occur in 2001 because of the matching federal funds. Currently, some people are in programs funded only by the state, whereas they could be served in newly created waiver programs; some individuals in institutions could be served in the community if more services were available.

Given the fiscal shortfall, the state will likely implement the lower cost recommendations such as the housing and transportation partnerships. The Medicaid office included in its budget request funding for a full-time employee devoted to implementing the MAC. However, the plan calls for the biggest funding amounts in 2005-2007 because Nissan is building a plant in the state and tax collection is expected to increase at that time.
The Home and Community-Based Services and Consumer Directed Care Commission issued its report on December 31, 2000. Information can be found at www.dolir.state.mo.us/gcd/Olmsteadindex.html. The commission was created by an April 2000 executive order. Many of its recommendations are based on the work and recommendations issued by a stakeholder group, which convened before the commission was created.

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

The Plan

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

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

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

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

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

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

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

Recommendations in activity 5:
1. A) Improve the assessment and screening process done before a person enters an institution
and periodically thereafter. Add informed choice components to assure the individual knows all the options and rights. B) Staff must review all applications for nursing home admission or institutional placement.

2. The commission should designate a lead entity to arrange for a single source document that outlines all the services that currently are available for people with disabilities to be made available in alternative, accessible formats and be kept current.

3. A satisfaction survey process should be developed to include monitoring and incorporating into an oversight process (i.e., ombudsman).

4. A) Each department should implement statewide training to assure that all providers and agency staff are aware of Olmstead and its implications. B) This statewide training program should encourage networking across agencies such as transportation and personal care.

5. State agencies should develop and conduct statewide train-the-trainer sessions.

6. A 1-800 hotline or 211 number should be disseminated.

7. A) A Leave Behind Letter from a State Authority and the Informed Choice Sign-Off forms and brochures explaining the details for accessing state services will be provided by each government entity. B) State agencies should develop a verification process with agencies to ensure that informed choices were provided.

8. Multidisciplinary teams will participate in determining eligibility for community-based services, and each team will include an independent living advocate or any other advocate of their choice to participate in the person-centered plan process.

9. A clearly defined appeal procedure will be available to all people in state programs.

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

Summary of recommendations in activities 6 and 7:

1. Direct Care/Attendant Care: Increase wages, provide benefits, require a minimum of 20 hours of on-the-job training, mandate background screenings and have career ladder options.

2. Housing: Find incentives to increase enforcement of Fair Housing Amendments; train agency staff about housing rental options; increase the use of Section 811 grants for supportive housing for people with disabilities and Section 202 grants for supportive housing for elderly people; develop a grant program for urgently needed housing access modifications; and establish a new program for low-interest loans for assistive technology, including housing access modifications.

3. Inter-Agency Coordination and Agreements: Create an inter-agency coordinating task force to develop a plan for data linkages and service coordination. Plan will be developed by July 2001. Establish a 1-800 hotline that individuals can call and get information about community services. Have a universal application form for all home and community-based services, so a person does not have to go to several agencies and fill out several forms. Have a comprehensive chart of the community services that are available and the criteria for each program.

4. Medicaid Services: Analyze what services can be covered under the state plan and the budget instead of covering it under the waiver program; expand waiver funding to cover all individuals and families on waiting lists where cost neutrality can be maintained; establish a monitoring process to determine why someone is on a list after 90 days; expand the Medicaid state plan to include specialized medical supplies and increase the number of slots; protect the income of the spouse and allow division of assets in all waiver programs; increase Medicaid eligibility guideline to 100 percent of poverty; increase waiver income guidelines to 300 percent of
Supplemental Security Income; and develop a Medicaid buy-in program authorized by the federal Ticket to Work and Work Incentives Improvement Act.

5. Funding Mechanisms: A) Like other Medicaid providers, institutions should have to bill Medicaid for services provided. B) Money should follow the individual. C) Resources should be increased for community mental health services.

6. Transportation: A) Reactivate and expand the Coordinating Council on Special Transportation. B) Explore giving people stipends or vouchers to purchase their own transportation.

7. Employment: A) Request funding for 24 new case manager assistant positions in the Comprehensive Psychiatric Rehabilitation Program and examine the feasibility of implementing a pilot community employment support service that pays the provider when specific outcomes are achieved. B) Explore a Medicaid buy-in program authorized by the federal Ticket to Work and Work Incentives Improvement Act.

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

Recommendations in activity 8:

1. A) Develop and fund an Olmstead Transition Fund to be administered by the Governor’s Council on Disability. B) The state should look for unique ways to fund some of the needs of people with disabilities who make the transition into the community, including bringing in private sector donations for furniture or adaptive equipment, using public agencies to assist with utility deposits and rental deposits and using interest-free loans. C) Lobby for a discretionary fund to cover emergencies and unique needs to help avoid institutional placement of any individual.

2. Recommend that Missouri Senate Bill 321 for the Transition Advisory Council is fully funded.

3. A person-centered planning process should be conducted with each person who makes the transition from the institution to a community setting.

All the activities and recommendations would be implemented in FY 2001 and FY 2002. Specific timelines and budgets for each item are contained within the plan.

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

Implementation

Based on the commission’s recommendations, the following initiatives were taken up during the 2001 legislative session.

- Caregiver compensation: The legislature considered a $2 per hour increase for direct care workers each year for three years, but it appropriated a $1 per hour increase for aides caring for people with mental retardation and developmental disabilities. Although this appropriation fell short of the goal, it was significant because Missouri reduced its FY 2002 budget by $500 million.
Affordable and accessible housing: Two bills were introduced—but died—that would have encouraged or required any housing program receiving state funds to use universal design codes to improve access for people with disabilities such as wider hallways and doorways and a bedroom and bathroom on the main floor. These bills will likely be reintroduced during the 2002 session.

Transportation: A bill was introduced to require public transportation to meet the Americans with Disabilities requirements. The bill did not pass. There was no fiscal impact since the Department of Transportation should be doing this but currently is not.

Informed choice: Legislation was enacted that ensured training for staff and individuals who are interested in transferring from a nursing home to the community. The departments of aging, vocational rehabilitation and social services will use existing funds for it.

Consumer and family directed care: As noted above, the 2000 legislature enacted a law that requires a person who is eligible for or is receiving nursing home care to be given the opportunity to have those Medicaid funds follow him or her to the community and to choose the personal care option in the community that best meets the individual’s needs. Personal care services now are an entitlement for Medicaid beneficiaries. As a result, there was a $41.7 million increase in the FY 2002 budget to serve an additional 2,000 people, most of whom are younger people with physical disabilities who are living in institutions in the community.

Transition to independence: The 2001 legislature created a $125,000 fund to assist individuals who are making the transition from an institution with costs associated with setting up a home of their own. Individuals can apply for a one-time grant of up to $1,500.

Medicaid eligibility: Missouri has one of the lowest eligibility rates—$537 per month per individual (the SSI rate)—but during the 2001 special session a bill was passed to phase in increases in income limits to 100 percent of the federal poverty level over three years.

It is unclear how many people will be affected by the plan or how much it will cost if and when it is fully implemented. One criticism is that the commission did not set benchmarks for the numbers of people receiving home and community-based services. Since the plan was issued, the new governor has formed a new commission to continue the work and implement the plan, and the state received a Real Choice Systems Change grant from the federal government.
The Senior and Long-Term Care Task Force is the first of five taskforce subgroups to release a report. The report, released in August 2001, can be found at http://www.dphhs.state.mt.us/sltc/whats_new/olmstead/olmstead.full.report.htm. The Disability Services Division and Vocational Rehabilitation task force report is being finalized. Two other task forces handling broader issues (e.g., licensure, Medicaid eligibility) have not yet produced recommendations. The mental health service area has a legislatively mandated planning process that has failed to incorporate ADA/Olmstead compliance. As a result, the mental health services area is lagging behind other planning areas.

Recommendations of the Senior and Long-Term Care Olmstead Advisory Council include:

- Ensure representation of the appropriate stakeholders and share information with other state Olmstead councils.
- Develop a method to routinely identify and assess the needs of individuals in institutional and community settings. Fund independent living centers and consumer advocates to interview individuals who are institutionalized or at risk of institutionalization.
- Coordinate with other departments to investigate and ameliorate the caregiver shortage and other infrastructure concerns.
- Begin a public relations and education campaign to provide information about services and available community supports to consumers and health care and social service workers.
- Fund independent living centers and consumer advocates to assist with outreach.
- Increase adult protective services and ombudsman networks. The Olmstead Web page should be kept current.

Montana has begun addressing these recommendations. State officials have stressed strengthening the community-based care infrastructure. This is being addressed with direct-care worker wage increases passed by the Legislature in 1999 and 2001 and with the use of a Systems Change grant awarded by CMS in September 2001 for development of community-integrated personal assistance services and supports.

The Senior and Long-Term Care Olmstead Advisory Council will set up a committee to oversee the division’s progress in implementation of these recommendations.

The Montana Advocacy Program has filed a class action lawsuit, Travis D. vs. Eastmont, on behalf of individuals with developmental disabilities confined to state facilities or at risk because of a lack of community supports. The suit alleges that the state is failing to serve individuals on its Medicaid waiver waiting list with reasonable promptness. Waiting lists have not been addressed in Olmstead planning, but the Legislature has increased funding for community waiting lists in each of the last three legislative sessions.
**NEBRASKA**

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

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

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

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

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

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

No lawsuits are pending that involve Olmstead issues.
NEW HAMPSHIRE

New Hampshire is not involved in traditional Olmstead planning efforts, but state officials are engaged in significant planning efforts that are based on developing community-based services for people with disabilities. Although the state is working to reduce the developmental disability waiting list for people who are living at home and waiting for community services and to divert people from nursing homes, the state would have undertaken these activities regardless of Olmstead.

During the 2001 session, legislation passed requiring the Department of Health and Human Services to submit a plan to reduce the waiting period for developmental services to 90 days over a five-year period. The Division of Developmental Services (DDS) has held community meetings to gather input into this plan. The final plan, Renewing the Vision: New Hampshire’s Plan to Provide Essential Community Supports for Individuals with Developmental Disabilities, was submitted to the legislature in November 2001. In addition, the legislature appropriated $5 million to serve developmentally disabled people on the waiting list for home and community-based services and $3 million for people with acquired brain disorders. These funds are for FY 2002 and FY 2003. The state also received a Real Choice Systems Change grant from the federal government.

The Department of Health and Human Services (DHHS), as examples of its earlier success, cites the 1991 closure of the only institution for developmental disabilities and the subsequent creation of a comprehensive, community-based developmental services system. To ensure further progress, a task force was created in 2000 with representatives from each of the program units that provide services. These DHHS units included elders, children, physical and developmental disabilities, mental illness, and chronic health.

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

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

Planning and development continues with a goal of providing community services to allow elders to remain home rather than be admitted to nursing homes. The legislature also approved a Work Incentive Program that will allow people with disabilities to purchase Medicaid coverage if they are employed and their income makes them ineligible for Medicaid.

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

Some waiting list complaints have been filed with the U.S. Office of Civil Rights. A class action suit, *Bryson vs. Shumway*, is pending in federal court on behalf of 42 adults with acquired brain disorders in nursing homes who are on Medicaid waiver waiting lists.
New Jersey

The New Jersey Olmstead Stakeholders’ Task Force, convened by the Governor’s Office of Policy and Planning, is meeting with the goal of issuing an Olmstead plan by January 2002. That plan is not yet complete.

The plan will set forth proposals to guide the state’s action over the next five years. It will include regulatory recommendations, legislative recommendations, and new initiatives, many of them building on existing activities. Implementation of the plan will be subject to appropriations decisions to be made by the Legislature.

Many of the plan’s recommendations are likely to build on actions already under way in New Jersey, including assessments of individuals in psychiatric and developmental facilities, bridge funding to support people as they move from institutions to the community, and community living programs developed through the Nursing Home Transition Grant.

Among the key issues facing the group are 1) identifying ways to move beyond the group home model that is dominant in developmental disabilities services and 2) setting forth strategies to prepare individuals and their families for community placement. The state received funds under the Real Choice Systems Change grant program and will use the money to further efforts to strengthen its community-based services programs.

The task force includes people who have themselves made the transition from institutions to the community, and state agency, provider and advocacy representatives. Two complaints recently filed with Office of Civil Rights now are being resolved.
New Mexico

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

New York state applied for and was awarded an *Olmstead* Starter Grant. The state also has submitted applications for the Nursing Facilities Transition Grant, the Real Choice Systems Change grant, and the Community Personal Assistant Services and Supports Grant. All the grant applications were developed in consultation with the disabled community, which continues to be involved in ensuring that people with disabilities are given an opportunity to live in the most integrated setting appropriate. New York’s application for a Real Choice Systems Change grant has been denied.
The state Department of Health and Human Services (DHHS) took the initiative to develop an Olmstead plan. The proposal was generated over the span of several months in early and mid-2000. This involved a review of the current services provided by the state. The interim plan then was presented to the public in a series of meetings and via the Internet. Comments were requested and, when feasible, were used to change the proposal. Details of the plan and the process used in its development can be viewed at http://www.dhhs.state.nc.us/docs/olmstead.htm. The final plan will be issued after another round of public hearings, likely in early 2002.

The interim plan discusses significant decreases in the number of inpatients at psychiatric institutions during the past 10 years. In addition, the state cites large increases in funding for home and community-based services, particularly when compared to the spending for institutional care. Further, officials mention a 351 percent increase in the number of people served in the independent living program since FY 1990.

The North Carolina interim Olmstead plan focuses on people with disabilities who are institutionalized or are at risk of being institutionalized. To reach their goal of providing “… services and supports in the most integrated setting appropriate for their [disabled people’s] needs,” the DHHS focused on seven key areas. The first was outreach, to determine how people who potentially are eligible for community-based services would be informed of their choices. The second was assessment and identification, focusing on how the determinations of these individuals would be made. The third was development of a community transition care plan. The fourth was addressing waiting lists. The fifth was inventorying the existing community-based services. The sixth was identifying what community resources are needed to assist in the effort to integrate disabled people. The final area was determining the processes by which the system would be monitored and assessed.

Recent developments in the state include the receipt of a Real Choice Systems Change grant to support plan implementation. Grant activities will focus on workforce issues, especially recruitment and retention of personnel. The state now is developing a Mental Health State Plan. The legislature appropriated $47.5 million in nonrecurring funds that will be used to provide start-up funds and operating support for programs and services for people who are making the transition out of state facilities and to support Olmstead efforts. The draft mental health state plan can be found at http://www.dhhs.state.nc.us/mhplan/mission.htm.

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

Governor John Hoeven recently formed a Governor’s Commission on *Olmstead*. Through executive order, the Governor charged the commission to have recommendations in the form of a plan for the next legislative session. On behalf of this commission, the North Dakota Department of Human Services, in partnership with consumer and advocacy entities, has applied for and received the $50,000 Starter Grant provided through Health and Human Services to develop plans for improving support systems for community living. In addition, the state has been awarded a $20,000 *Olmstead* Financial Support Award from the Center for Mental Health Services. The department also partnered with consumers and advocates to apply for a Real Choices Systems Change grant on behalf of the commission, but it did not receive the grant. After assessment of the present nursing home population, the commission intends to reapply.

Before these latest activities, The Department of Human Services organized an internal work group in January 2000. It consisted of division directors representing Medicaid, aging, mental illness and substance abuse, developmental disabilities, and children and family services, the attorney for human services, the psychiatric hospital superintendent and one regional center director. This work group held four public hearings via interactive video network involving consumers, advocates, providers and others. Comments and suggestions from the meetings were combined with other findings to yield an *Olmstead* White Paper, which was released November 6, 2000. The recommendations include:

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

The complete report is available at lnotes.state.nd.us/dhs/dhsweb.nsf. After a period of public review, the Governor’s commission will expand the White Paper.
Ohio

Created by executive order in June 2000, the task force called Ohio ACCESS issued its comprehensive report to the governor on February 28, 2001. The report, Ohio Access for People with Disabilities, is located at www.state.oh.us/age/ohioaccessrpt.pdf and contains short-term and long-term recommendations.

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

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

The FY 2002-2003 appropriations included:

- Adding 1,300 slots in FY 2002 and another 1,600 slots in FY 2003 to the PASSPORT waiver program, which provides care to people over age 60 who otherwise would need nursing home services (the program currently has more than 24,000 slots);
- Adding 500 slots in both FY 2002 and FY 2003 to the Home Care Waiver Program, which provides care to disabled people under age 60 or people of any age with a chronic, unstable condition who require nursing care (the program currently has 8,200 slots);
- Adding 500 slots in both FY 2002 and FY 2003 to the Individual Options Waiver Program, which serves people who otherwise would require institutionalization in an intermediate care facility for the mentally retarded (ICF/MR);
- Establishing an Ohio Success pilot program to fund up to $2,000 in transition costs for 75 people in FY 2002 and 125 individuals in FY 2003 to be used as seed money for the first month’s rent, utility deposits, moving expenses and other related costs;
- Developing cost management tools that promote choice and personal responsibility;
- Redesigning the mental retardation and developmental disabilities Medicaid delivery system by moving the Community Alternative Funding System program to a fee schedule and by making the transition to new home and community-based waivers; and
- Improving cost management tools within the community mental health system.

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

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

In addition to the recommendations, the report contains:

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

The state expects its new waivers to be ready by July 1, 2002. A class action suit, Martin vs. Taft, is pending in federal court on behalf of 6,000 adults with developmental disabilities on Medicaid waiver waiting lists.
OKLAHOMA

The Olmstead Group, an informal group made up of 15 to 20 people, continues to meet monthly to identify activities to be carried out to support integrated service settings. The group is coordinated by the Oklahoma Health Care Authority, the state's Medicaid agency. Legislation to create a formal Olmstead planning group did not pass during the 2001 legislative session.

According to advocates involved in the planning process, the group issued a status report in June 2001 that outlines issues, sets forth general recommendations, and identifies future directions. At this time, the group does not intend to issue a formal plan; instead it will concentrate its efforts on identifying strategies for enhancing services.

The state's waiting list for community services for people with developmental disabilities moves fairly rapidly, due to extensive investment in these services during the past decade. The community mental health system needs additional funding and infrastructure, as do services for children in transition. The group has not identified people who currently are in nursing homes as a target group. Housing is an important issue across all population groups.

Aging representatives in the group include nursing home association representatives, the director of the Aging Services Office, and a representative from the group that manages the state's major aging waiver. No lawsuits or Office of Civil Rights complaints are pending in the state.
OREGON

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

Now, the state is giving attention to a lawsuit, *Miranda B. vs. Kitzhaber*. The suit was filed by the Oregon Protection and Advocacy System on behalf of people waiting to be released from mental hospitals who are in need of community services. A motion to dismiss has been denied and the state has appealed to the 9th Circuit Court of Appeals. There have been some preliminary discussions of settlement.

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

In the fall of 2000, an External Stakeholder Planning Team of more than 40 representatives was convened to study and discuss the guiding principles and critical elements of a successful home and community-based service system. This team was comprised of consumers, advocates, providers, county government and multiple Commonwealth agencies, representing multiple disability areas and the elderly. The team addressed the critical beliefs and goals to guide consumers, advocates, providers and government in future changes and decisions. Specific discussion areas included critical definitions, perceptions, shortcomings of the existing system, characteristics of an ideal system, major elements of the system, potential barriers to a successful outcome, realities, and responsibilities of all parties.

In the spring of 2000, the Commonwealth of Pennsylvania created a Home and Community-Based Services Project, which includes an internal governance structure, for the purposes of a) creating a seamless system of home and community-based services for consumers by striving for consistency across various programs and state agencies, b) sharing information and ideas across program areas to capitalize on the skills and expertise of the Commonwealth’s human resources and c) coordinating resources and maximizing efforts across program areas and agencies. The HCBS Project Governance structure teams are listed below.

- **The Executive Steering Committee** is comprised of top-level officials from the various program areas who oversee and manage the governance structure and function as decision makers in reviewing and approving work of the individual teams. The steering committee sets policy on budget and broad-based systems issues.

- **The Resource Facilitation Team** addresses services for aging individuals out of early and periodic screening diagnosis and treatment (EPSDT) and hard-to-serve individuals who may not fit into an existing program or may require a different package of services due to age, status change, or difficulty in meeting that individual’s needs.

- **The Assessment Team** develops appropriate principles and approaches for the assessment of eligibility and needed supports for individuals. The team reviews current assessment mechanisms and evaluates critical timeline points for assessment and reassessment of individuals, and also develops guiding principles for appropriate assessment tools and methods.

- **The Tracking and Data Management Team** develops and implements procedures to collect, track and analyze program data, including individual-specific data. The short-term goals focus on assessing current systems for compatibility, identifying relevant populations, and determining which data points to include. In the long-term, the team will develop a methodology, produce and refine reports, and coordinate its data system with other agencies.

- **The Policy, Program and Operations Team** focuses on developing and coordinating the policies and procedures for the various programs and Commonwealth agencies and on simultaneously developing a network of contacts among them. In the short-term, the team will analyze, review and recommend changes to existing policies. The long-term goal is to reduce and minimize gaps and overlaps in the home and community-based service system.
The Communications Team is responsible for outreach, education and training. The short-term goals are to research and identify appropriate outreach and educational topics, while also considering the appropriate vehicle to use. Over the long-term, the team will provide education to stakeholders and develop an effective campaign, including Internet materials, brochures and training.

The Quality Management Team focuses on quality of life and consumer satisfaction issues. To that end, it will assess its existing quality management system and recommend improvements and guiding principles for an effective quality management program. The focus of the team is on both quality assurance/measurement and continual quality improvement.

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

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

A final report was submitted to the governor on August 31, 2001. The report, which includes comprehensive recommendations for people in institutional settings who are at risk for institutionalization and can be located at www.scddc.state.sc.us/.

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

The task force broke into subgroups by disability area—mental retardation, mental illness, physical disability or aged. These subgroups met every two weeks. The report is summarized below.

Assessing the Needs of Children, Adults, and the Elderly

· The task force recommends developing an independent assessment process to offer people opportunities to live in a home or community-based setting. The first step in the assessment process should present a choice: where, how, and with whom do you want to live? Then next step will be an assessment of needs to make the preferred option possible.

Those Currently in Institutional Settings

· Making the Transition to the community: It is recommended that all those living in institutions who wish to move to a community setting be moved within a year of plan implementation, barring health and safety issues. Sufficient bed reserve capacity should be maintained for up to 90 days to allow the readmission of people whose community placement has not been successful.
· Quality of institutional care: The quality of institutional care should be improved in areas such as food, clothing, personalized spaces, day activities, employment and recreation. Consumer satisfaction and family satisfaction should be monitored.

Those at Risk of Being Institutionalized

· It is recommended that individuals deemed to be at risk of institutionalization be linked with a care/service plan and monitored.
· Health professionals should explain alternatives to institutionalization to at-risk people.
· A comprehensive, statewide crisis intervention and support system should be developed to prevent unnecessary institutionalization (e.g., community-based crisis respite beds).
· Assess all those who are seeking nursing home placement, regardless of their funding source, prior to nursing home admission.

Waiting Lists

· Waiting lists should be developed, maintained, and monitored.
· An unmet needs list should be created to document the needs of those on waiting lists and additional needs of those receiving some services.
Data Systems and Collection
- An interdepartmental task force should study the feasibility of adopting common hardware and software to assist with tracking individuals who need and receive care.

Quality Assurance/Outcomes
- Quality should be defined and measured in terms of the personal goals, outcomes and satisfaction of the individual consumer.
- A complaint system for in-home care should be developed, similar to an ombudsman program.

Community Services and Supports
- It is highly recommended that a multi-system team consisting of consumers, families, stakeholders, state agencies, and private providers continue to work together to address the needs of consumers.
- Community resources should be assessed.
- A variety of service coordination options should be available to consumers, including independent, agency-based, team coordination and self-directed service coordination.
- Direct care worker wages should be adequate to recruit and retain quality personnel.
- Specific recommendations are offered for increasing the number of housing units available in community settings to allow consumers to move from institutions into the community or from one community setting to another less restrictive setting. The plan proposes increasing community housing options by 300 units in each of the next two years. Group living opportunities also will be increased. It is recommended that home ownership be encouraged by allowing Section 8 vouchers to be used to pay a home mortgage. Funding for assistive technology and home modification also would be expanded.
- Transportation services should be improved to include door-to-door and escort provisions, and CMS policies toward non-medical transportation will be investigated. Public transportation and transportation alternatives also will be improved. One recommendation calls for labor and mileage reimbursement to friends and family who provide transportation for consumers in areas where there is no public transportation.
- Increased efforts will be made to support consumer and family choice, control and autonomy.
- Education in self-advocacy, continued financial support to consumer advocacy groups, and supported employment programs and services are recommended.
- A greater emphasis should be placed on supported employment programs.
- Recommendations also are made in the areas of day activities, family/caregiver supports, respite, and assistive technology.
SOUTH DAKOTA

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

Tennessee does not have an Olmstead specific task force. However, in March 1999, the Tennessee Long-Term Care Services Planning Council, a broad-based group of public and private sector policymakers, providers and advocates, released the Tennessee Comprehensive Plan for the Delivery of Long-Term Care Services to Elderly and Disabled Persons (located at http://www.state.tn.us/comaging/TNlongtermcare.pdf). That plan focused on extending and expanding home and community-based services, especially through Medicaid waivers, to people with disabilities and the frail elderly.

Since that time, most discussions on the issue in the state have dealt with funding levels for community-based care. Several bills that were considered by the legislature in 2001 focused on support for family caregivers, waiting list reduction and expanded Medicaid waivers. Tennessee has received a Real Choice Systems Change grant.

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

A class action lawsuit, Brown vs. Tennessee, is pending in federal court on behalf of individuals with developmental disabilities living in the community who are eligible for ICFMR/waiver services but are not receiving services. The waiting list numbers some 700 individuals, and intermediate care facilities are closed to new admissions.
Texas

Texas issued a comprehensive plan in January 2001, which is located at http://www.hhsc.state.tx.us/tpip/tpip_report.html. Since then, the Legislature has enacted several of the recommendations, and state officials currently are developing on an implementation timeline.

The Plan
In September 1999, the governor issued an executive order requiring the Health and Human Services Commission (HHSC) to conduct a comprehensive review of all services and support systems available to people with disabilities in Texas. To include stakeholder involvement, the HHSC created the Promoting Independence Advisory Board (PIAB). The charge of the PIAB was to provide guidance to the HHSC in the evaluation and implementation of a system of community-based services and supports for people with disabilities. The board consists of providers, people with disabilities and their representatives, and state agency officials. In response to the executive order, HHSC developed the Promoting Independence Plan and submitted it to the governor and the appropriate legislative committees as required in January 2001.

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

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

Phase two will be implemented over a two-year period beginning in September 2001. The department will hire and train relocation specialists, develop an identification process and assessment instrument, track data from the relocation specialists, and conduct community awareness activities. The first year would be a pilot program in three sites.

Phase three would be to divert people from institutionalization by placing additional staff in hospitals and rehabilitation centers for pre-admission and admission screening.

The Department of Mental Health and Mental Retardation will study the feasibility of developing a Medicaid waiver or other options for those individuals on the waiting list who need only community supports. Because of the lengthy waiting list for home and community-based services, people are on the waiting list for years and are assessed for the type and amount of services they need only when they reach the top of the list.

To implement the plan, each state agency submitted its budget request during the 2001 legislative session, which includes its various, specific requests. In addition, the Health and Human Services
Commission submitted its consolidated budget to the Legislature, including Tier II for the Promoting Independence Plan.

As a result, the Legislature funded some expansion for the state’s six community waiver programs. The HHSC was given some budgetary responsibility in rider language to use the expansion funds to direct services to the Olmstead population and develop transition services and alternative family-based options for children. The HHSC must use the money appropriated to the agencies for expansion of community programs in order to accomplish these goals. During the 2001 session, several other laws were enacted that relate to the Promoting Independence initiative. Some of them include:

- **SB 368**, which directs the Department of Protective and Regulatory Services to develop a permanency plan for each child who resides in an institution for whom the department has been appointed permanent managing conservator. It also directs the state to contract with various organizations to develop and implement a system under which a child who cannot reside with his or her birth family may receive necessary services in a family-based alternative instead of an institution. No additional funding was appropriated with this legislation.
- **HB 966** requires a study of costs of institutional care and the ability to move funding with the consumer as the individual moves into the community. The HHSC is required to report to the Legislature by September 1, 2002.
- **SB367** establishes an interagency task force to ensure appropriate care settings for people with disabilities and establishes a pilot program in three sites for community-based alternatives for people with disabilities. The combined stakeholder workgroup and agency staff workgroup was formed to replace the Promoting Independence Advisory Board. The new stakeholder task force is Interagency Task Force on Care Settings for Persons with Disabilities. Many of the same members were kept on the new group in an effort to maintain continuity.

The task force has met and will continue to meet to monitor the implementation of the PI Plan within the state. Agencies, through the coordination of the HHSC, are involved in the development of a tracking matrix for the task force and in developing the type of data necessary to track the efforts related to system change initiatives.

Texas has written proposals in all areas of the federal infrastructure grants. Officials have convened a consumer task force, which assisted in the application of the Real Choice System Change grant and employed a consultant with disabilities to assist the state long-term care coordinator to write the grant itself. Texas did not receive a Real Choice Systems Change grant. The HHSC is coordinating efforts of the other grant proposals in order to have a comprehensive approach directed to the intent of the Promoting Independence Initiative and its numerous system change recommendations.

In addition, in an effort to better coordinate all long-term services within the state, the HHSC long-term care coordinator has convened an internal agency work group specifically to improve inter-agency communication and eliminate barriers to coordinated services.

The state views its response to *Olmstead* as an ongoing process. With the completion of the Promoting Independence Plan, the state intends to continue moving forward in its efforts to identify individuals who are living in institutions but who are desirous of community-based services, helping these individuals make the transition into the community, reducing the waiting lists, and coordinating all long-term care services and supports to improve services to citizens of the state with disabilities. The state expects its plan to evolve over time in response to funding, stakeholder input, agency-related initiatives, and continued growth and demand for community services and supports for people with disabilities.
In September 1999, key state agencies created a long-term care (LTC) network task force to address issues raised by the Supreme Court *Olmstead vs. L.C.* decision and to extend the state's work on community-based services to broader population groups and infrastructure needs. The task force has issued a draft plan and received public comment during November 2001.

Since 1989, the Utah departments of Health and Human Services have moved forward with the implementation of five 1915(c) HCBS waivers, a long-term care managed care demonstration project, and a number of state-funded and state-federal funded long-term care initiatives to enhance home and community-based health care for people of all ages with chronic illnesses and disabilities. In 1997, the Utah Health Policy Commission established the Long-Term Care Technical Advisory Group (LTC TAG) to address concerns about long-term care in the state. In 1997, the LTC TAG produced a set of recommendations after gathering information from the public and those with experience in long-term care. The recommendations identified the need for a unifying public policy statement for long term care to enhance joint efforts based on shared goals. The Health Policy Commission conducted a Comprehensive Long-Term Care Public Policy Study to forward the development of a unifying public policy.

The Utah Department of Health’s LTC managed care demonstration project became operational in April 2000 and as of October 2001 has helped 160 Medicaid clients make the transition from acute care hospitals, Medicare skilled nursing facility beds, and Medicaid nursing facility beds to home and community service arrangements. This project will continue through March 2003 with the potential to serve up to 500 enrollees at any given time.

Under a state legislative initiative and a grant from CHCS Inc., education outreach was conducted to residents of nursing facilities and ICFs/MR. Residents were provided with information about available alternative home and community-based LTC programs and were offered individualized assessment and support in determining appropriate opportunities for transition. Education outreach activities will continue as one element of fostering informed consumers and portability within the array of LTC programs.

Reduction of waiting lists remains a priority in the state; new funds allocated by the Legislature during the past several years continue to be utilized to extend home and community-based waiver services to those with chronic illnesses and disabilities. Planning for the use of funds allocated during the 2001 legislative session is under way, although statewide budget reductions make actual use of these funds uncertain.
VERMONT

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

Vermont is in a unique position because state officials and advocates seem to concur that the state is in full compliance with the Olmstead decision. No institutions exist for individuals with developmental disabilities, and all nursing facility residents have been assessed for community-based service options. Some of the state’s accomplishments include:

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

People with disabilities and their representatives have been involved in the process through departmental advisory groups, which review major issues such as the renewal of waiver programs. In addition, the state received a Real Choice Systems Change grant from CMS.
Virginia

The state does not have a commission. The state had agents review the state situation in light of Olmstead and concluded that the new directives were sufficient to place Virginia in good standing. During the 2002 legislative session, however, legislative proposals to create a commission or task force are likely, given the interest of some state legislators and the advocacy efforts at the state and local levels.

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

The state has reduced institutional developmental disability placement by 30 percent during the past three years. It also has put $20 million into the mental health system. It recently received a Real Choice Systems Change grant from the federal government. A class action suit, Quibuyen vs. Allen, on behalf of individuals with developmental disabilities who reside in institutions and who are on Medicaid waiver waiting lists, was recently settled.
The governor has designated the state Department of Social and Health Services (DSHS) as the lead agency for Olmstead planning. The DSHS assistant secretaries were assigned positions on a steering committee and a planning workgroup was formed with representatives from DSHS divisions and several other state agencies. This workgroup reports to the steering committee, and includes representatives from the attorney general’s office; DSHS’ Mental Health Division, Developmental Disabilities Division, Children’s Administration, Aging and Adult Services Administration, Division of Alcohol and Substance Abuse, and Division of Vocational Rehabilitation; the Department of Transportation; and the Office of Community Development.

Washington officials have been moving to expand community resources and downsize institutions for years, stating that about 85 percent of the aging, developmentally disabled and mentally ill populations are served in the community. To that end, their Olmstead plan is seen as an effort to further coordinate and accelerate ongoing processes and programs. The planning process is broken into four overlapping phases that include development of proposals, budget requests, appropriations, and implementation (first with available funds and then with the new appropriations). The process spans the period from January 2000 to July 2004. Phase one has reached the second part of implementation, phase two has reached the budget request stage and phase three should begin shortly. Additional information can be found at http://www-app2.wa.gov/dshs/olmstead/index.htm.

Each of the four phases will focus on specific areas that are determined as part of the previous phase’s planning process. Phase one involved designing the workgroup, meeting with stakeholders, assessing current activities, and making requests for the FY 2001-2003 budget. Phase two (July 1, 2001 – June 30, 2002) activities include a review of current activities, implementation of phase one initiatives funded during this time frame, data collection to aid in developing new budget requests, stakeholder interaction and performance measurement.

Current appropriations include:

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

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

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

The DSHS aims to include all people with disabilities, regardless of age, including those with developmental and physical disabilities and mental illness and those who are chemically dependent. Further, DSHS planning focuses on institutional residents who wish to live in the community and are determined able to do so by the state’s treatment professionals, and individuals who reside in the community who are at risk of unnecessary institutionalization. Each of the relevant agencies (Aging, DD, etc.) has developed protocols, specific to the population served, to identify unnecessarily institutionalized people.

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

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

A class action suit, Washington Protection and Advocacy vs. Rust, was filed on behalf of individuals with mental illness who are appropriate for community placement but remain in state hospitals. The proceedings of another suit filed in late 1999 on behalf of individuals with developmental disabilities, Allen vs. Western State Hospital, were stayed by a federal district judge so long as the state continues to implement the detailed settlement, which requires three phases of community building.
The former governor issued Executive Order No: 17-00 on September 27, 2000 creating the West Virginia Olmstead Task Force. The task force originally was charged with developing a comprehensive plan by June 30, 2001, but the new governor issued another executive order (No: 12-01) extending the timeline to December 31, 2001. As of January 2002, NCSL analysts, however, had not received the plan.

The plan will include a process by which individuals are identified as eligible for participation, recommendations relating to the services required, a method for preventing unnecessary institutionalization, and a uniform grievance procedure. It also will address the potential costs and the related budgetary implications. The task force has representation from disabled people, their families, and advocates (40 percent); service providers (20 percent); and various government agencies (40 percent).

The West Virginia plan will cover people of any age who have developmental and physical disabilities or mental illness. The focus will be on institutionalized individuals to determine whether they require that level of care or if they can be better served in community-based settings. Because the state closed its last MR/DD institution in 1998 and very few ICF/MR beds exist, the main focus will be on individuals in nursing homes and the two acute-care psychiatric hospitals. It will also deal with those at risk of institutionalization. Funding and housing issues present obstacles to complete and successful implementation. State officials have applied for, but were denied a Systems Change Grant. Additional information can be found at www.wvdhhr.org/olmstead.

The Legislature, at the request of the governor and the secretary of health and human resources, provided a special appropriation of $500,000 to be used during the planning process. These funds assist community placement of individuals currently in state-operated nursing homes and psychiatric hospitals.

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

Two suits were decided prior to Olmstead that have similar implications. Medley vs. Ginsberg, decided in federal district court in 1979, ordered the discharge of mentally retarded juveniles from state-operated institutions and the provision of services in the community. The Hartley Consent Decree (E.H., et al. vs. Matin, et al.), the result of a state suit brought on behalf of institutionalized patients in state operated facilities, addressed the need to provide active treatment in facilities and to identify residents in state-run, long-term care facilities with mental health or MR/DD diagnoses who are appropriate for community placement.
A task force, Americans with Disabilities Act Title II Advisory Committee, made up of state officials, providers, advocates and consumers from about 45 organizations and legislative staff has been created to prepare a plan for strengthening compliance with the ADA. The group is looking at the state’s various long-term care systems and identifying strategies for improving service delivery. The committee will develop recommendations concerning additional funding and craft plans for lifting barriers to community care for people with disabilities. The state long-term care ombudsman is the chair of the ADA Title II Advisory Committee. The committee’s report of the first phase of their work will be ready in the fall of 2001.

The committee reviewed the issues raised by advocacy groups, including 1) access to personal assistance services for Medicaid beneficiaries, 2) waiting lists for home and community-based waiver programs, and 3) mental health issues for adolescents and older people with a focus on issues related to people living in institutions who desire to live in the community. The group is an offshoot of the Wisconsin Council on Long-Term Care (WCLTC) created through the 1999 legislation that created the Family Care Program.

The WCLTC submitted its first Annual Report to the Legislature and Governor in May 2001. Included in the report were interim recommendations based on the early work of the committee. The recommendations included items that, while improving Wisconsin’s long-term care system, also would effect on the upcoming state biennial budget. The report is available at www.wcltc.state.wi.us.

In addition to the committee, a commission created by the Legislature studied issues related to people with developmental disabilities. Staff attorneys have looked at the implications of the Olmstead decision for this group and have held hearings. The study committee issued its report and it is available at www.legis.state.wi.us/lc/studies/DEVD/prop_rl2001_07.pdf.

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

Following the Olmstead decision, Wyoming’s governor designated state Department of Health (DOH) as the lead agency for developing a comprehensive plan to address home and community-based care for the state’s disabled population. The DOH has completed a draft of that plan, which is available at http://wdhfs.state.wy.us/OLMSTEAD/index.htm and hopes to have the final plan completed in early 2002. The draft was reviewed by the Office of Civil Rights (Region 8) and was sent for public comment on April 1, 2001. The public comment period ended on May 15, 2001, and no comments received that requested substantial changes to the draft plan. In addition, the DOH has conducted 23 county visits in preparation for implementing the plan.

The plan has four divisions: aging, developmental disabilities - acquired brain disorders, developmental disabilities - general, and mental health. Each division is broken into nine elements: 1) stakeholder participation, 2) needs assessment, 3) development of new community services and support infrastructure, 4) transition services, 5) data collection, 6) outcomes measurement, 7) quality assurance, 8) resource development, and 9) revision guidelines/timelines. The plan is in draft stage, with many of the specifics still to be determined including the individual stakeholders to be involved and the assessment method to be used.

Although the work on this plan has been moving ahead, several barriers?most notably lack of adequate finances, differences of opinion among the various advocacy groups, a shortage of primary care physicians and mental health professionals, and the rurality of the state make developing a community-based infrastructure difficult. The DOH does, however, have an assessment tool for determining nursing home medical and financial necessity and will be developing assessment tools for other health care facilities, including assisted living facilities.