IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
AT HUNTINGTON

BENJAMIN H., et al.,
Plaintiffs,

v. **CIVIL ACTION NO.** 3:99-0338

JOAN OHL, Secretary of the Department of Health and Human Resources,
Defendant.

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

The Defendant's state Medicaid plan provides that intermediate care level services will be covered either ICF/MR facilities or in home and community-based settings. The Defendant has, however, closed the avenues to these services, making them unavailable to Plaintiffs and the putative class through either ICF/MR facilities or home and community-based placements. The Defendant's policies and practices of providing intermediate care level services on paper but not in practice violate the Medicaid Act, the Due Process Clause of the Constitution, and the Americans with Disabilities Act. The Defendant is required by law to cover intermediate care level services that are medically necessary for class members, to provide these services promptly, and to provide written notices and an opportunity to be heard when claims for eligibility and/or services are denied or not acted upon promptly.

I. The Plaintiffs are Experiencing Immediate Harm and are Likely to Succeed on the Merits of Their Medicaid and Constitutional Claims.

The Defendant must comply with the Medicaid Act, which requires timely and appropriate services for the Plaintiffs. The purpose of the Medicaid Act is to enable states to furnish medical assistance on behalf of poor families with children and individuals with disabilities. 42 U.S.C. § 1396. The Medicaid Act requires "rehabilitation and other services to help such families and

individuals attain or retain capability for independence or self-care." Id.

State participation in the Medicaid program is voluntary. However, once a state elects to participate, it "must comply with the requirements imposed both by the Act itself and by the Secretary of Health and Human Services." Schweiker v. Gray Panthers, 453 U.S. 34, 36-37 (1981). See also, Wilder, et al. v. Virginia Hosp. Ass'n, 496 U.S. 498, 500 (1990). West Virginia has chosen to participate in Medicaid; it has designated the Secretary of the Department of Health and Human Resources (DHHR) as the party responsible for administering the program at the state level; and it has received extensive federal funding to operate the program.

The Medicaid Act requires states to cover certain mandatory services, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children under age 21. See 42 U.S.C. § 1396d(a)(4)(B). States may choose to cover additional services, including intermediate care facility services for the mentally retarded and/or developmentally disabled (ICF/MR), see 42 U.S.C. § 1396d(a)(15), and home and community-based waiver services for individuals with disabilities, see 42 U.S.C. § 1396n. West Virginia has chosen to include both ICF/MR and home and community-based services in its state Medicaid plan. (Appendix 1, Complaint Exhibit B, respectively) . Once a state chooses to provide an optional Medicaid service, it must comply with all federal Medicaid requirements.[1] See, e.g., Weaver v. Reagan, 886 F.2d 194, 197 (8th Cir. 1989) ("Once a state chooses to offer . . . optional services it is bound to act in compliance with the [Medicaid] Act and the applicable regulations in the implementation

[1] As noted elsewhere in this brief, the U.S. Department of Health and Human Services may waive certain Medicaid Act provisions to allow states to implement home and community-based waivers. See 42 U.S.C. § 1396n(a). However, the provisions are waived only to the extent described and approved by the federal authorities, and those provisions not waived continue in full force and effect.

of those services[.]").

As set forth below, the Defendant is violating a number of mandatory Medicaid provisions with respect to intermediate care level services, including: 42 U.S.C. § 1396a(a)(8), which requires services to be provided with reasonable promptness; 42 U.S.C. § 1396a(a)(10), which requires services to be furnished to Plaintiffs in a sufficient amount, duration and scope; 42 U.S.C. § 1396d(a)(4)(B), which requires coverage of EPSDT treatment services for children; 42 U.S.C. §1396(n), which requires beneficiaries to receive a choice of feasible alternatives to institutionalization through the home and community-based waiver program; and 42 U.S.C. § 1396a(a)(3) and the Due Process Clause of the Constitution, which require due process protections when eligibility or services are denied or delayed.

A. The reasonable promptness claim

The Defendant is violating a Medicaid Act provision which requires that Medicaid-covered services be provided promptly. Specifically, the Medicaid Act requires the Defendant to assure "that . . . assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). Corresponding regulations provide: "The agency must: (a) furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures; [and] (b) continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible. . . ." 42 C.F.R. § 435.930. See also 42 C.F.R. § 435.911 ("agency must establish time standards for determining eligibility and inform the applicant of what they are."). These requirements apply to all services included in the state's Medicaid plan, whether mandatory (for example, EPSDT) or optional (for example, intermediate care level services and home and community-based waiver services). See McMillan v. McCrimon, 807 F. Supp. 475,

481-82 (C.D. Ill. 1992) ("The fact that the HSP [home services program] waiver is an optional service does not exempt it from the requirements of section 1396a(a)(8)").

The "reasonable promptness" requirement has been part of the Medicaid Act since it was first passed in 1965. Congress borrowed the wording for the provision from an existing chapter of the Social Security Act, which extended public assistance to poor families with children. According to legislative history, the provision was originally instituted in response to the hardship caused when needy individuals were placed on waiting lists or otherwise denied public assistance, despite the fact that they had been found eligible for that assistance. See Conf. Rep. No. 2271, 81st Cong., 2d Sess. (1950), reprinted in 1950 U.S.C.C.A.N. 3287, 3482, 3507; see also H.R. Rep. No. 1300, 81st Cong., 1st Sess. 48 (1949) (decision by states "not to take more applications or to keep eligible families on waiting lists until enough recipients could be removed from the assistance rolls to make a place for them . . . results in undue hardship on needy persons and is inappropriate in a program financed from federal funds."). In the words of the Supreme Court, the reasonable promptness requirement was

> enacted at a time when persons whom the State had determined to be eligible for the payment of benefits were placed on waiting lists, because of the shortage of state funds. The statute was intended to prevent the States from denying benefits, even temporarily, to a person who has been found fully qualified for aid.

Jackson v. Hackney, 406 U.S. 535, 545 (1972). Thus, the provision was adopted precisely to prevent states from engaging in the types of activities that form the nucleus of the Plaintiffs' complaint in this case.

Since enactment of the reasonable promptness provision, courts have consistently held it to prohibit states from responding to administrative constraints by making beneficiaries wait for services. In Doe v. Chiles, 136 F.3d 709 (11th Cir. 1998), the court was asked to address a

situation quite similar to that before this Court. In Doe, individuals with developmental disabilities were being placed on waiting lists for entry into intermediate care facilities. As in the present case, they had been waiting months, and even years, for needed services. Id. at 711. The wait-listed plaintiffs filed suit, claiming that the defendant was causing unreasonable delays in the provision of intermediate care level services in violation of 42 U.S.C. § 1396a(a)(8). The court of appeals held that the state Medicaid agency had violated the reasonable promptness mandate and, thus, had been properly enjoined to generate reasonable waiting times for intermediate care level services. In so doing, the court noted that "'inadequate state appropriations do not excuse noncompliance [with the Medicaid Act].'" Id. at 722 (quoting Alabama Nursing Home Ass'n v. Harris, 617 F. 2d 388, 396 (5th Cir. 1980)).[2]

In this case, the evidence shows that intermediate care level services are not being covered with reasonable promptness, and the situation is worsening. Since August 1989, there has been a moratorium on additional ICF/MR beds in the state. W.Va. Code §16-2D-5(h). Since July 1998, the Defendant has limited intermediate care level services provided in home and community-based settings to "emergency situations," and it does not plan to expand these services

[2]See also, e.g., Sobky v. Smoley, 855 F. Supp. 1123, 1149 (E.D. Cal. 1994) ("insufficient funding by the State and counties of methadone maintenance treatment slots has caused providers . . . to place eligible individuals on waiting lists for treatment . . . precisely the sort of state procedure the reasonable promptness provision is designed to prevent"); Morgan v. Cohen, 665 F. Supp. 1164, 1177 (E.D. Pa. 1987) (Medicaid-covered transportation services "must be furnished with reasonable promptness"); Linton v. Carney, 779 F. Supp. 925, 936 (M.D. Tenn. 1990) (policy of limiting the number of nursing home beds that could be used for Medicaid patients violated the reasonable promptness provision by causing those patients "to experience extended delays and waiting lists in attempting to gain access to long term nursing home care"); Clark v. Kizer, 758 F. Supp. 572, 580 (E.D. Cal. 1990), aff'd in part and vacated in part on other grounds sub nom., Clark v. Coye, 967 F.2d 585 (9th Cir. 1992) (granting summary judgment on reasonable promptness claim where declarations of county public health officials indicated that a shortage of Medicaid-participating dentists caused "class members frequently [to] experience delays in obtaining appointments for regular and emergency dental care[.]"); McMillan v McCrimon, 807 F. Supp. 475 (C.D. Ill. 1992) (granting preliminary injunction on plaintiffs' claim that § 1396a(a)(8) required Medicaid agency to accept applications for home and community-based waiver program). See generally Coalition for Basic Human Needs v. King, 654 F.2d 838, 843 (1st Cir. 1981) ("reasonable promptness" prohibited state from delaying AFDC benefits checks while the state legislature resolved a budget dispute).

significantly over the next five years. (Complaint, Ex. 2). The result of these actions is that Medicaid beneficiaries who have a documented need for intermediate care level services are being placed on waiting lists for services, and these lists are growing. As of January 28, 1999, 270 individuals had been found eligible for home and community-based waiver services but had been placed on waiting lists. (Complaint Ex. 3). ICF/MR facilities also are maintaining waiting lists.

The named Plaintiffs have been waiting anywhere from six months to eight years for a wide range of intermediate care level services that are vital to them, including home and community-based behavioral health care, speech and physical therapy, home health care, and personal care services. During this time, they have experienced needless deterioration and regression in their health status. See Affidavits of Patty Vaughan (describing a twelve month wait without intensive services for her young son to address communication, behaviors, social skills and other deficits) (App. 2); Sherry Eagleston (describing a twelve month wait without residential therapies and services to address her teenage son's deficits in self-help, communication, and pre-vocational skills) (App. 3); and Georgann Holbrook (describing a seven month wait without behavioral support therapies or other needed services). (App. 4).

In sum, hundreds of Medicaid-eligible beneficiaries in West Virginia have been identified as needing intermediate care level services. However, rather than cover the care, the Defendant is maintaining waiting lists -- which means that the services are delayed or covered only partially. These types of waiting list practices are precisely the sort of state procedures the reasonable promptness provision is designed to prevent. Plaintiffs are likely to succeed on their claim that the Defendant is violating 42 U.S.C. § 1396a(a)(8) and its implementing regulations.

B. The amount, duration and scope claim

The Defendant must assure that each categorically needy Medicaid beneficiary receives Medicaid assistance not less in amount, duration and scope than that received by other categorically needy persons. 42 U.S.C. § 1396a(a)(10)(B). See, e.g., White v. Beal, 555 F.1d 1146, 1149 (3rd Cir. 1977) ("[A]ll persons within a given category must be treated equally."). The categorically needy are persons who automatically qualify for Medicaid because of their low income status and the receipt of public assistance, such as Supplemental Security Income (SSI). See 42 U.S.C. § 1396a(a)(10). As recipients of Supplemental Security Income (SSI), the named Plaintiffs are categorically needy Medicaid beneficiaries who are protected by this provision.

Unfortunately, the Defendant is violating section 1396a(a)(10)(B) because it fails to fund enough placements for intermediate care level services in either ICR/MR facilities or in home and community-based settings for the categorically needy who are eligible for the service. As a result, the named Plaintiffs and members of the putative class are not receiving needed intermediate care level services while others like them are receiving these services. "By denying the same service to the categorically needy members of the plaintiff class that is received by other categorically needy persons . . ., the State violates § 1396a(a)(10)(B)." Sobky v. Smoley, 855 F. Supp. 1123, 1140 (E.D. Cal. 1994) (§ 1396a(a)(10)(B) is violated when a state allows counties to determine whether and in what amount to provide methadone maintenance treatment, with the result that some Medicaid beneficiaries were placed on waiting lists for the treatment).

The Plaintiffs are likely to succeed on their claim that the denial of medical services to some categorically needy persons violates the amount, duration and scope requirement of the Medicaid Act, 42 U.S.C. § 1396a(a)(10). A preliminary injunction should be entered on this

claim.

C. The EPSDT claim

In recognition of the special needs of children, a separate Medicaid Act provision requires particular attention to services for children. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program emphasizes the early discovery of illness and continuous and comprehensive care. See 42 U.S.C. §§ 1396a(a)(43), 1396d(r). Among other things, it requires the Defendant DHHR promptly to provide medically necessary services that are needed by children, including the range of intermediate care level services. 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). In other words, while the State has chosen to cover ICR/MR and community-based waiver services for adults, these services are mandatory for children regardless of whether or not the state elects to include them in its state plan. Thus, the EPSDT provision covering these services provides additional protection to children.

The EPSDT program has two primary, mutually supportive components. First, the state must "assur[e] the availability and accessibility of required health care resources" and, second, the state must "help[] Medicaid recipients and their parents or guardians effectively use [the required health care resources]." U.S. Department of Health and Human Services Health Care Financing Administration (HCFA), State Medicaid Manual § 5010B (April 1990) (Appendix 6).[3]

As part of the EPSDT program, states must provide eligible children with "necessary health care, diagnostic services, treatment, and other measures described in . . . [42 U.S.C. § 1396d(a)] . . . to correct or ameliorate defects and physical and mental illnesses and conditions[.]"

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[3] The Manual says: "Instructions [in this Manual] are official interpretations of the law and regulations, and, as such, are binding on Medicaid state agencies." HCFA, State Medicaid Manual, Foreword (Appendix 7). Federal courts also have cited the Manual to support their decisions. See, e.g., Stowell v. Ives, 3 F.3d 539 (1st Cir. 1993).

42 U.S.C. § 1396d(r)(5). Among the services discussed in 42 U.S.C. § 1396d(a) are intermediate care facility services, 42 U.S.C. § 1396d(a)(15). In addition, a number of the intermediate care level services needed by the Plaintiffs in home and community-based settings should also be covered through EPSDT when medically necessary. These enumerated benefits must be provided regardless of whether or not the state has a home and community-based waiver. Of particular importance to the Plaintiffs and putative class members are the following such services:

- home health care services from qualified professionals, 42 U.S.C. § 1396d(a)(7); 42 C.F.R. § 440.70;
- private duty nursing services, 42 U.S.C. § 1396d(a)(8); 42 C.F.R. § 440.80;
- physical therapy and related services, 42 U.S.C. § 1396d(a)(11); 42 C.F.R. § 440.110;
- personal care services, 42 U.S.C. § 1396d(a)(24); 42 C.F.R. § 440. 167;
- other diagnostic, screening, preventive, and rehabilitative services, including medical or remedial services in a facility, home or other setting, recommended by a licensed practitioner "for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level," 42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130.

As noted above, these services must be provided to any Medicaid eligible child who needs them to correct or ameliorate a physical or mental condition. See 42 U.S.C. § 1396d(r)(5).

Furthermore, the state Medicaid agency must make sure that necessary treatment and services are available to children by "arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment when the need for which is disclosed by child health screening services[.]" 42 U.S.C. § 1396a(a)(43). Thus, while the state generally is required only to pay for covered services when medically necessary, "the major exception involves the federal requirement that a state must provide for early and periodic, screening,

diagnosis and treatment (EPSDT) for eligible children." George Annas, et al., American Health Law 186-87 (1990) (Emphasis in original). See also, e.g., Doe v. Pickett, 480 F. Supp. 1218, 1221 (S.D.W.Va. 1979) (EPSDT "imposes on the states an affirmative obligation to see that minors actually receive necessary treatment and medical services").

Federal Medicaid regulations further require the state to "make available a variety of individual and group providers qualified and willing to provide EPSDT services." 42 C.F.R. § 441.61(b). The State is obliged to take advantage of resources that are available to provide high quality and timely services to Medicaid-eligible children. HCFA, State Medicaid Manual § 5310 (April 1995). Specifically, DHS should "[t]ake advantage of all resources available" to provide a "broad base" of providers. Id. at § 5220.

Finally, the Medicaid Act requires prompt treatment through EPSDT when a need is disclosed during a visit to a health care provider. When Senator Bentsen introduced legislation to strengthen the EPSDT provisions in 1989, he stated, "This bill . . . requires prompt treatment once a condition has been diagnosed." H.R. Rep. No. 101-247 at 399, reprinted in 1989 U.S.C.C.A.N. 1906, 2125 (Emphasis added). Regulations provide: ". . . the agency must set standards for the timely provision of EPSDT services which must meet reasonable standards of medical . . . practice . . . and must employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of 6 months after the request for screening services."). 42 C.F.R. § 441.56(e).[4]

In the present case, the Defendant DHHS has not established processes to ensure that

[4] See also 49 Fed. Reg. 43.654, 43,660 (Oct. 31, 1984) ("We have clarified this requirement . . . to make it clear that States must employ methods to ensure timely delivery and assure providers' compliance with their agreements.").

timely treatment will be initiated when the child has an identified need. Although the Defendant has determined that the child Plaintiffs (and other similarly situated class members) are eligible to receive intermediate care level services through the Medicaid program, they are not being covered through EPSDT. Rather, children are being placed on waiting lists for either home and community-based waiver slots or ICF/MR facility placement. To illustrate: Plaintiff Benjamin H., a five-year-old with autism, has significant behavioral health care needs. For seven months, he has been on a waiting list for home and community-based services which should be covered through both the Medicaid Act generally and through EPSDT. During this time, he has not received medically necessary case management services, physical and speech therapy, home health care, or personal care services. He has repeatedly placed himself in danger, and the situation is placing stress not only on Benjamin but also his family. (See, Declaration of Georgann H., App. 4). Plaintiff Thomas V, a four-year-old with Downs Syndrome, needs home and community-based speech therapy and intermediate care level behavioral health services which should be covered through both the Medicaid Act generally and through EPSDT. He has been waiting for about a year for full Medicaid coverage of these services. During this time, Thomas has failed to progress.(See Declaration of Patty V., App. 2). Plaintiff Lori Beth has moderate mental retardation and a significant number of other disabilities. She needs home and community-based intermediate care level services, including occupational therapy, speech therapy, and behavior management, which should be covered both through the Medicaid Act generally and through EPSDT. Lori Beth has been on a waiting list for services through the waiver program since she was seven-years-old. She is now fifteen. She has not received Medicaid home or community-based care to meet her needs. During this time, her condition has deteriorated, and she has been

aggressive toward her mother. (App. 5). Plaintiff Justin E. has Downs Syndrome with mental retardation and a significant hearing impairment. He is fifteen years old and non-verbal. Justin needs home and community-based intermediate care level services to increase his self-help skills, communication, his level of independence, and pre-vocational skills. (App. 3).

The Plaintiffs are likely to succeed on their claim that the Defendant is violating the Medicaid Act with its failure to provide prompt coverage of those treatment services which the child Plaintiffs need and which can be covered through EPSDT. A preliminary injunction should be issued by the Court on this claim.

D. The Freedom of Choice claims

Service options are very limited for individuals with developmental disabilities who do not have access to Waiver services, particularly those individuals with mental retardation or developmental disabilities who have significant needs (i.e. twenty-four hour supervision or one-on-one staffing). There is no funding for these services under the Defendants' current Medicaid State Plan other than through ICF/MR facilities of the MR/DD Home and Community-Cased Waiver program.[5]

Medicaid regulations require states that participate in the MR/DD Home and Community-Based Waiver program to provide Medicaid recipients needing ICF/MR-level services with a

[5]Medicaid behavioral health services available in West Virginia to people with mental retardation or developmental disabilities are limited to case management and clinic based services. Rehabilitation services off-site are not available. See, Definition of Behavioral Health Rehabilitation Services, Medicaid Regulations, Chapter 500, Section 502:

> "These services are designed for all individuals with conditions associated with mental illness, substance abuse and/or drug dependency."

choice between institutional services and community based services. 42 U.S.C. §1396(n)(c)(2).[6] In their application for renewal of their MR/DD Home and Community-Based Waiver Program, the Defendants attest to their compliance with this obligation.

Individuals placed on waiting lists are being denied freedom of choice because they are not being given access to either an ICF/MR placement or MR/DD Home and Community-Based Waiver services. Individuals in need of ICF/MR services, who are currently on waiting lists, or who will enter the behavioral health system during the five year renewal period, will not have access to ICF/MR services. The choice between institutional services versus community-based services will not be afforded these individuals. Instead, all but a small fraction will be forced into inadequate or inappropriate care that does not meet their significant needs.

Access to ICF/MR residential placements is limited. In the ten years since the moratorium on the development new of ICF/MR beds was put in place, W. Va. Code §16-2D-5(h), the Defendant has attempted to meet the service needs of eligible individuals through the allocation and distribution of approximately 200 waiver slots per year. For the current five year renewal period, FY 1999 to FY 2003, the Defendants have requested only twenty-five (25) additional slots per year, for a total of 125 slots.

Without access to MR/DD Home and Community-Cased Waiver services, individuals will be forced into unnecessary and inappropriate institutionalization at the state psychiatric hospitals. The state psychiatric hospitals are not facilities designed to serve people with developmental disabilities, but rather are institutions for mental diseases (IMD). 42 C.F.R. §435-1009(a)(2).

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[6] The MR/DD Home and Community-Based Waiver is an optional Medicaid program. "The freedom of choice provision creates binding obligations on any state that elects to provide supports and services in homes pursuant to the Home and Community-Based Waiver." Cramer v. Chiles, 33 F.Supp 2d. 1342 (S.D. Fla.)

State psychiatric hospitals are ill equipped to provide appropriate programs and services to individuals with developmental disabilities. 42 C.F.R. §482.60(a). They cannot provide the "active treatment" that the Plaintiff class is entitled to, and would receive, through the MR/DD Home and Community-Based Waiver program or an ICF/MR. 42 C.F.R. §483.440(a).

The Plaintiffs are likely to succeed on their claim that the Defendant is violating the Medicaid Act with its failure to provide prompt coverage of those treatment services which the child Plaintiffs need and which can be covered through EPSDT. A preliminary injunction should be issued by the Court on this claim.

E. The due process claims

The Defendant must comply with Constitutional and Medicaid due process protections when it denies or delays eligibility for or coverage of intermediate care level services. The Constitutional standards that guide due process for Medicaid beneficiaries were settled over 25 years ago by the U.S. Supreme Court in Goldberg v. Kelly, 397 U.S. 245 (1970). Goldberg holds that, because they are destitute, poor people have a "brutal need" for public assistance, and this assistance is guaranteed until Constitutionally-required due process protections are met. Id. at 261. As described by Goldberg, the Due Process Clause of the Constitution requires the state and its agents to provide, among other things, prior written notice, "tailored to the capacities and circumstances" of the beneficiary, explaining a decision to deny or terminate benefits and a fair hearing "at a meaningful time and in a meaningful manner" before an impartial decision maker. Id. at 267-71.

The Medicaid Act requires the State Medicaid agency to grant an opportunity for a fair hearing "to any individual whose claim for medical assistance under the plan is denied or is not

acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). The regulations require written notice when services are denied, reduced, terminated, or suspended. See 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.211.

Finally, Medicaid regulations clearly specify the content of the notice and the requirements for the fair hearing. See 42 C.F.R. § 431.200 et seq. (1996). The notice should inform the beneficiary of the action the agency intends to take and the basis for the action, of the facts and law that support the action, and of the right to a fair hearing. Id. at § 431.210.

Given the clarity of the law, it is not surprising that numerous courts have enjoined state Medicaid agencies' failures to provide written notices that meet the due process standards. For example, if the state intends to implement an across-the-board reduction in benefits, individual notice to beneficiaries affected by the change is required. See Cramer v. Chiles, 33 F. Supp. 2d 1342, 1352 (S.D. Fla. 1999) (individualized due process notices required when a state statutory change denied beneficiaries a choice between an ICF/MR facility or a home and community-based waiver program). See also, e.g., Eder v. Beal, 609 F.2d 695 (3rd Cir. 1979) (enjoining state from terminating its program for individuals in need of eyeglasses to correct ordinary refractive problems until it complied with the Medicaid due process requirements); Kimble v. Solomon, 599 F.2d 599 (4th Cir. 1979), cert. denied, 444 U.S. 950 (1979). When individual claims are denied, rejected, suspended, or changed, proper notices is also required. E.g. Parry v. Crawford, 990 F. Supp. 1250 (D.Nev. 1998) (beneficiaries required to be notified of fair hearing rights when applications for placement at ICF/MR facility rejected); Salazar v. District of Columbia, 954 F. Supp. 278, 327-28 (D.D.C. 1996) (Medicaid agency must provide individual notice when benefits are suspended or denied); King v. Fallon, 801 F. Supp. 925 (D.R.I. 1992) (Medicaid

agency must provide notice regarding level-of-care assessments governing eligibility for home and community-based waiver services). In addition, states cannot delegate away their duty to comply with the due process protections. E.g., Catanzano v. Dowling, 60 F.3d 113 (2d Cir. 1995) (certified home health agencies are state actors who must adhere to due process requirements); J.K. v. Dillenberg, 836 F. Supp. 694, 699 (D. Ariz. 1993) (regional behavioral health authorities are state actors which must adhere to due process requirements); Daniels v. Wadley, 926 F. Supp. 1305 (M.D. Tenn. 1996), vacated in part, 1998 WL 211763 (6th Cir. 1998) (Medicaid managed care program must assure that enrollees receive due process when services are denied or delayed).

In this case, a number of Constitutional and statutory due process violations have occurred. None of the named Plaintiffs' claims for Medicaid assistance have been acted upon with reasonable promptness. Rather, these Plaintiffs have been waiting for services for months and, in some cases, years. These delays in services have not been accompanied by a written due process notice describing the basis for this delay or the fair hearing rights -- an express violation of the Medicaid Act. See 42 U.S.C. § 1396a(a)(3). Moreover, Plaintiffs are entitled to, but have not received, due process notices when their applications for ICF/MR facility placement or Home and Community-Based Waiver program services are being rejected or delayed. See, Parry, 990 F. Supp. 1250 (notice required when applications for placement at ICF/MR facility rejected). Finally, none of the Plaintiffs, who have already been found eligible for the waiver program (Benjamin H., David F., Justin E., Lori Beth, and Thomas V.), received a due process notice of the Defendants' adoption of an "emergency only" waiver program -- a Medicaid program change which amounted to a reduction in services and was without the beneficiaries' consent. See

Cramer, 33 F. Supp. 2d 1342 (notice required when state statutory change denies choice between ICF/MR facility or home and community-based waiver).

If the Medicaid agency intends to take action that is adverse to an individual, the agency must provide notice of its intention which is both adequate in its content and timely. Because they have not received such notices in this case, the Plaintiffs are likely to succeed on the merits of their Constitutional and due process claims. The Court should enter a preliminary injunction in their favor on these claims.

II. The Plaintiffs are Experiencing Immediate Harm and are Likely to Succeed on the Merits of Their Americans with Disabilities Act Claims.

The defendants must comply with the Americans with Disabilities Act. On July 12, 1990, Congress enacted the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq., to establish important civil rights for individuals with disabilities. The Congressional findings of fact noted that "historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2).

Congress also found that "discrimination against individuals with disabilities persists in ... institutionalization ... access to public services." 42 U.S.C. §12101(a)(3). Further, Congress found that "individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion ... segregation, and relegation to lesser services, programs, activities, benefits, jobs or other opportunities." 42 U.S.C. §12101(a)(5).

The Americans with Disabilities Act provides a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities. 42 U.S.C. § 12101(b)1,

A. The Integration Mandate

The implementing regulations of the Americans with Disabilities Act contain a category of "general prohibitions against discrimination." 28 C.F.R. §35.130. These prohibitions do not require a showing of discrimination between different groups or subgroups of disabled individuals, Williams v. Wasserman, 937 F.Supp. 524, 530 (D.Md. 1996). Rather, the regulations mandate that:

> "[a] public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

28 C.F.R. §35.130(d).

The Third Circuit has addressed the issue of integration in services and programs and concluded that "the ADA and its attendant regulations clearly define unnecessary segregation as a form of illegal discrimination against the disabled." Helen L. v. DiDario, 46 F.3d 325, 333 (3rd Cir. 1995). This position was later reaffirmed in Kathleen S. V. Department of Public Welfare, 1998 U.S. Dist. LEXIS 9558 (E.D. Penn. 1998) wherein the court stated:

> By definition, where, as here, the State confines an individual with a disability in an institutional setting when a community placement is appropriate, the State has violated the core principle underlying the ADA's integration mandate.

Id. at *7, quoting L.C. by Zimring v. Olmstead, 138 F.3d 893 (11th Cir. 1998).

The Eleventh Circuit relied on Helen L. v. DiDario, and L.C. by Zimring v. Olmstead, in Cramer v. Chiles, 33 F.Supp. 2d 1342 (S.D. Fla. 1999). In Cramer, the court found that Florida's legislation denying Medicaid eligible individuals with developmental disabilities a choice between facility-based services and home and community-based services violated the Americans with Disabilities Act.

Similarly, in Williams v. Wasserman, 937 F.Supp. 524 (D.Md. 1996), the court discussed

the case law of the other jurisdictions noted above. Relying on the findings of Helen L., the Williams court found that making home care available to nursing home residents was a reasonable accommodation under the ADA. The court emphasized that the home care program was already in existence and was less expensive than the facility-based program. In doing so, the Williams court expressly found the Third Circuit's "reasoning plausible and consistent with the purposes of the ADA." 937 F.Supp. at 530. The court relied upon the Congressional statement of findings that:

> (2) historically, society has tended to isolate and segregate individuals with disabilities;
>
> (3) discrimination against individuals with disabilities persists in such critical areas as ... institutionalization ...
>
> (5) individuals with disabilities continually encounter various forms of discrimination, including ... segregation ...

42 U.S.C. §12101(a). Williams v. Wasserman, 937 F.Supp. at 530, n. 7.

Individuals in West Virginia with mental retardation who require an intermediate care facility level of care will be inappropriately and unnecessarily served in institutional settings by virtue of the Defendant's actions. These same individuals can receive active treatment in their own homes, and at less cost to the Defendant, through the responsible development of the MR/DD Home and Community-Based Waiver program. Because they have drastically cut this program, however, the Defendant has left no options for individuals requiring ICF/MR level of services other than state psychiatric hospitals.

Treatment of individuals with mental retardation in state psychiatric hospitals is clinically inappropriate, fiscally imprudent, and a violation of the Americans with Disabilities Act integration mandate. 28 C.F.R. §35.130(d).

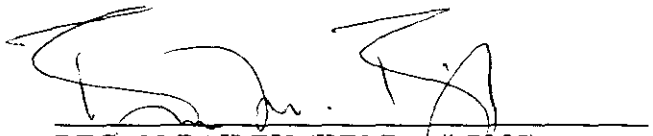
Here, as in Williams, the reasonable accommodation plaintiffs seek is the further development of a pre-existing program of home and community-based services. The cost of providing behavioral health services to individuals with developmental disabilities in a community setting is less than half of the cost of institutionalization in an intermediate care facility. Further, institutionalization in state psychiatric hospitals is exponentially more expensive for the state when you consider the fact that it cannot be paid for with federal Medicaid dollars, and must be covered with purely state funds.

CONCLUSION

The Defendant has failed to ensure sufficient amount, duration and scope of its ICF/MR-level services so as to meet the need in West Virginia. The statutory moratorium on the development of new ICF/MR institutions in West Virginia, taken with the grossly inadequate coverage of the MR/DD Home and Community-Based Waiver program, will result in individuals with mental retardation becoming inappropriately and unnecessarily institutionalized in state hospitals. These highly segregated and institutional settings are the only available service delivery mechanism for individuals with mental retardation who need intensive services and a significant amount of support in order to function at their full potential. It is this type of state action that the integration mandate of the ADA expressly forbids. 28 C.F.R. §35.130(d). The individuals need must govern the level of segregation imposed, not arbitrary caps and service limits created by the Defendant.

For the forgoing reasons, Plaintiffs have shown a likelihood of success on the merits and are entitled to a preliminary injunction.

BENJAMIN H., et al.,
By Counsel.



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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
AT HUNTINGTON

BENJAMIN H., by his next friend, Georgann H.; DAVID F., by his guardian, Carolyn B.; LORI BETH S., by her next friend, Janie J.; THOMAS V., by his next friend, Patricia V.; JUSTIN E., by his next friend, Sherry E.,

Plaintiffs,

v. **CIVIL ACTION NO. _____**

JOAN OHL, Secretary of the Department of Health and Human Resources,

Defendant.

APPENDICES TO MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

1. WV ICF/MR State Plan
2. Declaration of Patricia Vaughan
3. Declaration of Sherry Eagleston
4. Declaration of Georgann Holbrook
5. Declaration of Martha J. Johnston
6. State Medicaid Manual §5010B (4/90)
7. State Medicaid Manual, Forward

State West Virginia

4.19 Payments for Medical and Remedial Care and Services

ATTACHMENT 4.19-D-2

Methods and Standards for Determining Payment Rates for Non-State-Owned Intermediate Care Facilities for Mentally Retarded (Excludes State-Owned ICF/MR Facilities)

I. Cost Finding and Reporting

All intermediate care facilities for the mentally retarded (ICF/MRs) certified to participate in the program are required to maintain cost data and submit cost reports according to the methods and procedures prescribed by the State agency.

A. Chart of Accounts

The Chart of Accounts for Intermediate Care Facilities for the Mentally Retarded, as incorporated in the Users Reimbursement Manual for ICF/MR, must be used by all participating facilities to maintain facility cost data for cost reporting and auditing purposes.

B. Financial and Statistical Report

Facility costs for ICF/MR must be reported on the Financial and Statistical Report for ICF/MR. These reports must be completed in accordance with generally accepted accounting principles and the accrual method of accounting and must be complete and accurate. Incomplete reports or reports containing inconsistent data will be returned to the facility for correction.

C. Cost Reporting Periods

All participating ICF/MR facility costs are reported semi-annually. The semi-annual reporting period is January 1st through June 30th and July 1st through December 31st.

D. Filing Periods

Cost reports must be filed with the State agency and postmarked within 60 days following the end of the reporting period. The due dates are February 28th for the December 31st closing date and August 31st for the June 30th closing date.

An extension of time for filing cost reports may be granted by the State agency for extenuating circumstances, where requested and justified by the facility in writing, before the closing date. Requests for an extension of the filing period are to be addressed in writing to:

Director, Office of Audit, Research and Analysis
Department of Health and Human Resources
Capitol Complex, Building 6
Charleston, West Virginia 25305

E. Penalty - Delinquent Reporting

Failure to submit cost reports within the sixty days filing period where no extension has been granted to the facility, or within the time constraints of an extension, will result in a ten percent (10%) reduction in reimbursement to that facility. The penalty will be assessed for each day that the cost report is delinquent, and will be assessed on payments for services delivered on the day(s) the report is late.

Incomplete cost reports returned to the facility for correction which are not promptly completed and resubmitted within specified time constraints, may be subject to these penalty provisions. Facilities submitting cost reports after the beginning of the rate period; i.e., April 1st or October 1st, will receive rate increases effective the month following the month the cost report was received.

F. Correction of Errors

Errors in cost report data identified by the facility may be corrected, and resultant prospective reimbursement rates adjusted if cost data are resubmitted within 30 days after original rate notification. Only those corrections received by the Department within the 30-day period will be considered for rate revision. The Department will make revisions resultant from computational errors in the rate determination process at any time, including at the completion of an audit review.

G. New Facilities - Projected Rates

A projected rate will be established for new ICF/MR facilities with no previous operating experience. A change of location with the same ownership does not constitute a new facility. Each such facility on a projected rate must submit the mandated cost report during the projected rate period. Beginning with the first full three months of operating experience in a reporting period, a prospective rate will be established in the subsequent rate setting period. No projected rate may exceed twelve (12) months.

H. Change of Ownership - Projected Rates

A projected rate may be established where there has been a change of ownership and control of the operating entity and the new owners have no previous management experience in the facility.

Where there has been a change of ownership from a corporation to an individual or individuals, from an individual or individuals to a corporation, or from one corporation to another, the ownership of the stock of the corporation(s) involved will be examined by the State agency in order to determine whether there has been an actual change in the control of the facility. Where ownership changes from an individual to a partnership, and one of the partners was the former sole owner, there has been no change of control. Where the immediate former administrator and/or persons responsible for the management of a facility purchases that facility, there has been no change of control for the purpose of setting projected rates.

Each such facility on a projected rate must submit the required semi-annual cost reports during the projected rate period beginning with the first 3 months operating experience in a reporting period.

I. Change in Bed Size

Any ICF/MR facility changing bed size must submit the semi-annual cost report beginning with the first three months operating experience in the cost reporting period following the effective date of the change.

J. Maintenance of Records

Financial and statistical records must be maintained by the facility to support and verify the information submitted on cost reports. Such records must be maintained for a minimum of five (5) years from the date of the report, and will be furnished upon request to the Department or Federal officials.

The State agency will maintain cost reports for a minimum of five (5) years from date of receipt.

II. Allowable Costs

Reimbursement for ICF/MR services is limited to those costs required to provide active treatment to people with mental retardation and related conditions. These are facility operating costs, client direct service costs, and costs for the physical setting.

Allowable Costs for Cost Centers - ICF/MR

Cost center areas are standard services (operating costs), mandated services and

capital. A cost upper limit is developed in the aggregate for standard services and for mandated services, which becomes the maximum allowable cost for reimbursement purposes. Allowable costs are determined by the following methodologies:

1. Standard Services

Standard services are Dietary, Laundry and Housekeeping, Maintenance, Administration, and Utilities. Cost standards for these services are computed from the current cost report; i.e., salaries (total compensation), supplies and services as submitted by the facilities. Total allowable costs for all clients are arrayed assuming 100% occupancy; i.e., licensed beds times days, to establish a per client day cost. The costs are then arrayed. Extremes are eliminated by including only those values falling within plus or minus one standard deviation. This establishes a cost average point (CAP) which is then adjusted by a 95% occupancy level to establish the cost standard. The cost standard then establishes the maximum allowable cost for the standard services (operating costs).

2. Mandated Services

Mandated services are defined as: Living Unit, Restorative & Activities, Nursing & Medical Records, Resident Transportation, Day Programming, and Taxes & Insurance. Reported allowable cost for these services is fully recognized and reimbursable to the extent it does not exceed the upper limits established by the Department from the reports submitted by the facilities. The upper cost limits are set at the 90th percentile of costs based on an assumed occupancy of one hundred percent and a calendar year of 365 days.

3. Cost of Capital

Reimbursement for cost of capital is determined using an appraisal technique to establish a Standard Appraised Value (SAV). This value includes the necessary real property, and equipment associated with the actual use of the property as a long term care facility. The Standard Appraised Value (SAV) uses the cost approach to value modified by the Model Facility Standard, where appropriate. This valuation is the basis for capitalization to determine a per client day cost of capital. This allowance replaced leases, rental agreements, depreciation, mortgage interest, and return on equity in the traditional approach to capital cost allowance.

a. Cost Approach to Value

The value of a property is derived by estimating the replacement or reproduction cost of the improvements, deducting therefrom the

estimated accrued depreciation, and adding the market value of the land (actually used or required for use as if vacant and available for development of such use). Established sources of cost information are used to supply costs to reproduce the structure. Construction indices used are Marshall valuation services and Boeckle Building Valuation Manual.

b. Accrued Depreciation

Accrued depreciation in a cost approach is the difference between the value of a building or other improvement at a certain date and its cost of reproduction as of the same date. The method used to measure accrued depreciation is known as the "breakdown" method which involves an analysis of loss in value from the following sources:

(1) Physical deterioration; curable and incurable.
(2) Functional obsolescence; curable and incurable.
(3) Economic obsolescence.

The facility appraisal method modifies the property value by deducting accrued depreciation. Those facilities meeting the appraisal criteria will receive their maximum standard appraisal value; those not meeting a standard will have their plant valuation reduced by the amount reflected in physical and functional depreciation. This includes both physical depreciation, curable and incurable, as well as functional obsolescence, curable and incurable. The summation of each component of the process results in a final Standard Appraised Value. This value will then be treated as a cost of providing patient care.

c. Model Facility Standard

The Model Facility Standard is a composite of current regulations and criteria derived from several sources which include "Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities"–HHS Publication No. (HRS) 81-14500 and West Virginia Rules and Regulations for Licensing of Nursing Homes, where appropriate.

These criteria form a living document drawn from Federal and State regulations and guidelines, as well as from accepted industry practice. They will be updated periodically to reflect changes which foster improved patient care or cost effective measures which do not compromise patient care.

d. Appraisal Technique

A complete appraisal of each new facility will be performed after certification and approval for Medicaid program participation by a qualified appraisal firm under contract with the Department. Updates of the initial appraisal will be performed annually prior to the April rate setting period. Updates may be performed at anytime during the annual period when there have been major changes to the bed size of the facility and such changes would affect the SAV for rate purposes.

A copy of the facility appraisal report is furnished to the facility for its records.

4. Compensation

Compensation, to be allowable, must be reasonable and determined to be for services that are necessary and related to patient care, and pertinent to the operation of the facility. The services must actually be performed and paid in full less any withholding required by law. The hours worked and compensation must be documented and reported to all appropriate State and Federal authorities for income tax, Social Security, and unemployment compensation purposes.

Reasonable means that the compensation must be comparable for the same services provided by facilities in the ICF/MR class. If the services are provided less than full time, the compensation must reflect this fact. Full time is considered approximately 2,080 hours per year worked in patient-related duties.

Compensation must include the total benefit paid for the services rendered; i.e., fees, salaries, wages, payroll taxes, fringe benefits, and other increments paid to or for the benefit of those providing the services.

5. Program Directors

Compensation for directors who do not work full time will be proportionate to the total number of hours worked. This includes persons who hold administrative positions in more than one facility, as well as those who hold various other positions in the same or alternate facility.

6. Owners

Administrators/owners will be compensated for administrative duties

performed. Where the costs of administrative services are allowed, additional services performed by the administrator and/or owner are considered rendered primarily to protect their investment and are not allowable.

Compensation will not be allowed for owners, operators, or their relatives who claim to provide some administrative functions required to operate the facility where the facility has a full-time administrator and/or assistant administrator or where other full-time or part-time staff positions are filled. Owner includes any individual or organization with an equity interest in the facility operation and any member of such individual's family including spouse's family. Owner also includes all partners and all stockholders in the facility operation and partners and stockholders of organizations which have an equity interest in the facility.

7. Non-Allowable Costs

Bad debt, charity, penalties and fines, and courtesy allowances are not included as allowable costs. Other items of expense may be specified in the State agency regulations as non-allowable costs.

8. Purchase from Related Companies or Organizations

All related companies or organizations involved in any financial transactions with the facility must be identified on the cost report. Detailed data must be available in the facility records which describe the nature and extent of such business transactions.

Cost for purchases of any items or services from related companies or organizations will be allowed at the actual cost of providing the service or the price of comparable services purchased elsewhere, whichever is less.

III. Rate Determination - ICF/MR

Individual facility rates are established on a prospective basis, considering cost to be expected and allowable during the rate period. The rate is not subject to retrospective revision. This does not exclude corrections for errors or omissions of data, or reconciliation of audit findings related to falsification of data or overstatement of costs. The basic vehicle for arriving at each facility's rate is the uniform Financial and Statistical Report for ICF/MR.

The rate is subject to desk review and then converted to cost per patient day. The rate shall be based on the facility's reported costs and adjustments for the reporting period January 1, 1997 through June 30, 1997. An inflation adjustment will be made to the

rate for each six month period effective April 1 and October 1 of each year beginning April 1, 1998. The State will provide for periodic re-basing of rates based on the most recent cost report filings. In no case will facility rates, including inflation adjustments, be in effect for more than 2 years without full re-basing.

A. Cost Adjustment

Reported facility costs are subject to review and analysis through desk audit. Adjustments are made to exclude non-allowable costs and by application of the agency's established cost standards using the following methodologies:

1. Standard Services

Reported allowable costs in the standard services area are compared against the aggregate cost standard for these cost centers. If the allowable reported costs exceed the cost standard, then the facility rate is limited to the standard.

2. Mandated Services

Reported allowable cost is fully recognized for these cost centers, provided it does not exceed the upper limits established by the Department. The upper cost limits are set at the 90th percentile of reported allowable costs, based on an assumed occupancy of 100% and a calendar year of 365 days.

3. Cost of Capital

Capital costs will be determined on a facility-by-facility basis applying the Standard Appraised Value (SAV) methodology. Capital costs will be updated effective October 1st of each year..

a. Capitalization Rate

A capitalization rate is established to reflect the current SAV of the real property and specialized equipment. This overall rate includes an interest rate for land, building and equipment, and an allowance for return on equity investment in the land,

building and equipment.

The Band of Investment approach is used to blend the allowable cost of mortgage money (fixed income capital) and the allowable cost of equity money (venture income capital) and the allowable cost of equity money (venture or equity capital) which produces a rate to reflect current money values in the mortgage market at the time of original indebtedness. This band of investment sets a 75:25 debt-service to equity ratio.

The interest rate for the mortgage component is based on the Baa State and Local (Baa), plus 2 points (not to exceed 14%), current at the time of the facility's original indebtedness, modified by the use of the constant annual percent for non-profit facilities.

The yield on equity allowance (for proprietary facilities) is based on the average United States Long Term Composite Rate (USLT) current at the time of facility original indebtedness. The yield on appreciation is based on the average United States Long Term Composite Rate (USLT) allowable during the cost reporting period.

b. Capital Allowance

For proprietary ICF/MR facilities the capital allowance per patient day is determined by applying the capitalization rate for the mortgage and equity component to the valuation of the facility determined by the Standard Appraised Value (SAV) methodology, and by applying the appreciation factor to the accumulated appreciation as determined by the Standard Appraised Value (SAV) methodology. For non-profit facilities, the capital allowance is determined by applying the capitalization rate for the mortgage component to the valuation of the facility determined by the Standard Appraised Value (SAV) methodology.

4. Assumed Occupancy Standard

Ceiling class cost adjustments will be made by applying a minimum occupancy standard of 95% to all cost centers.

5. Minimum Occupancy Level

Allowable cost per patient day will be determined using actual facility occupancy if that occupancy is equal to or greater than 90%. If the actual occupancy level is less than 90%, the per patient day cost will be adjusted to assume a 90% occupancy level.

B. Efficiency Allowance

An Efficiency Incentive will be allowed where the standard service area allowable costs are less than the total of the cost ceiling. Facilities which continue to provide quality services at less than the cost ceiling, may be allowed an opportunity to share in the cost savings.

Fifty percent (50%) of the difference between the total allowable cost and the cost ceiling will be applied to the standard service area. The total of the calculated efficiency incentive may not exceed $4.00 per patient day.

C. Inflation Factor

After combining the various components, a factor is assigned to allowable costs (excluding capital costs) as a projection of inflation during the next rate-setting cycle. In setting an inflation factor, changes in industry wage rates and supply costs are compared with the CPI. The amount of change experienced during the reporting period or the CPI becomes the inflation factor applied to the next rate setting period. The inflation factor, once set for a given rate period, may be adjusted semi-annually as it represents a reasonable expectation for cost increases.

Indicators used for tracing economic changes and trends include:

1. Annual Cost Reporting

The average per patient day cost of service is compared to the cost incurred in providing the same services in the prior cost reporting period. The percentage of change is then expressed as an increase or decrease in the cost from the prior period.

2. Regulatory Costs

Regulatory costs, such as minimum wage increase, FICA increase,

and Worker's Compensation changes may be considered as a component of the inflation factor.

3. National Data

The Consumer Price Index (CPI) corresponding to the most current cost reporting period is analyzed and compared with state experience.

D. Change in Bed Size

A cost adjustment may be made during a rate period where there has been a change in the facility bed size if it affects the appraisal value of the facility. In this instance, an appraisal of the facility will be completed after the change in bed size has been certified. Any revision of the per diem rate as a result of the change in bed size will become effective with the month the facility changes were certified by the state survey agency.

E. Projected Rates

Projected rates will be established for new facilities with no previous operating experience. The facility will go off projected rate at the first normal rate setting period immediately following the first full three months actual operating experience in a cost reporting period.

Projected rates may be established for facilities where there has been a change of ownership and control of the operating entity, and the new owners have no management experience in the facility. Where there has been a change of ownership from a corporation to an individual or individuals, from an individual or individuals to a corporation, or from one corporation to another, the ownership of the stock of the corporation(s) involved will be examined by the state agency in order to determine whether there has been an actual change in the control of the facility. Where ownership changes from an individual to a partnership, and one of the partners was the former sole owner, there has been no change of control.

Where the immediate former administrator/program director and/or persons responsible for the management of a facility purchases that facility, there has been no change of control for the purpose of setting a projected rate.

At the end of the projected rate period, actual cost experience of the facility will be reconciled with the projected cost reimbursement and tested for reasonableness against the standards established for the ICF/MR class for the appropriate rate period. Overpayments resulting from over projection will be recovered by the state agency in accord with provisions of Chapter 700, Long

Term Care Regulations. Rates based on projected costs do not include management incentives.

1. New Facilities

A projected rate for new facilities with no previous operating experience will be established as follows:

a. Standard Services - The cost standard established for ICF/MR class.

b. Mandated Services - The established CAP for ICF/MR class.

c. Cost of Capital - The Standard Appraised Value (SAV) methodology applied to the facility. The facility will be appraised following certification for participation in the program.

2. Change of Ownership

A projected rate established for facilities where there has been a recognized change of ownership and control will be established as follows:

a. Standard Services - The cost standard established for ICF/MR class.

b. Mandated Services - The CAP of the costs established for ICF/MR class.

c. Cost of Capital - The Standard Appraised Value (SAV) established for the facility.

IV. Administrative Review

Procedures to be followed for administrative review and evidentiary hearings related to the per diem rate established for facility reimbursement are found in Chapter 700, Long Term Care Regulations.

V. Audits

Department audit staff will perform a desk review of cost statements prior to rate setting, and will conduct on-site audits of facility records periodically.

A. Desk Review

Financial and statistical reports submitted by the participating facilities will be subjected to desk review and analysis for rate setting within 60 days of receipt. Incomplete and inaccurate cost reports are not accepted.

B. Field Audit

Periodic on-site audits of the financial and statistical record of each participating facility will be conducted to assure the validity of reported costs and statistical data. Facilities must maintain records to support all costs submitted on the Financial and Statistical Report, and all data to support payroll and census reports. These records must be maintained at the facility or be made available at the facility for review by Department staff for audit purposes upon notice. Records found to be incomplete or missing at the time of the scheduled on-site review must be delivered to the Department within 15 days. Costs found to be unsubstantiated will be disallowed, and considered as an overpayment.

C. Record Retention

Audit reports will be maintained by the agency for five years following date of completion.

D. Credits and Adjustments

The State will account for and return the Federal portion of all overpayments to HCFA in accordance with the applicable Federal laws and regulations.

VI. Leave of Absence Policy for ICF/MR

A. Reimbursement for Authorized Absences

Reimbursement is generally limited to the actual days in the facility. However, payment may be authorized to reserve a certified bed when the ICF/MR resident is absent for temporary periods, for home visits, for trial visits to other facilities and other therapeutic purposes. Payment for days of authorized absence shall be at the full rate of the facility's approved per diem. A day of absence from the ICF/MR is defined as an absence when the resident spends a night away from the facility.

B. Medical Leaves of Absence

Full reimbursement will be paid for an ICF/MR resident who must be

transferred to an inpatient hospital for care and treatment which can only be provided on an inpatient basis.

The maximum bed reservation for such authorized medical absences shall be limited to 14 consecutive days, provided the resident is scheduled to return to the ICF/MR facility following discharge from the hospital. If the bed is used during the client's absence for emergency or respite care, it will in no way jeopardize or delay the return of the hospitalized resident to the facility. However, such short-term use of the bed is not acceptable and the facility will count these days in addition to reservation days in reporting the total census.

C. Non-Medical Leaves of Absence

Full reimbursement will be paid to an ICF/MR facility for a non-medical leave of absence for therapeutic home visits and for trial visits to other facilities. Such visits are encouraged, and the policies of the ICF/MR should facilitate rather than inhibit such absences. Non-medical absences shall be initiated as part of the resident's individual plan of care at the request of the resident, his parent(s), or his guardian with the approval of the QMRP. The Medicaid agency will pay to reserve a bed for up to 21 days per calendar year for a resident residing in an ICF/MR when the resident is absent for therapeutic home visits or for trial visits to another community residential facility. If the resident's bed is used during the individual's absence for short-term emergency or respite care--which in no way would jeopardize or delay the resident's return to the ICF/MR--no additional payment is allowed for such short-term use of the bed for emergency or respite care. The facility will count these days in addition to bed reservation days in reporting the total census.

VII. Public Process

The State has in place a public process which complies with the requirements of section 1902 (a)(13)(A) of the Social Security Act.

DECLARATION OF PATTY VAUGHAN

State of West Virginia
County of Kanawha

Patty Vaughan, being first duly sworn, states:

1. I am a resident of Putnam County, West Virginia.

2. I am over eighteen (18) years of age.

3. I am the mother of Thomas Lee Vaughan, a minor child.

4. My son, Tommy Lee, is five years old. He has Downs Syndrome with mental retardation and a hearing impairment.

5. Tommy Lee is very active and needs to be watched constantly. He is at risk of harming himself by putting foreign objects in his mouth and running off. He does not understand danger.

6. Tommy Lee has a temper, and can bite, kick and pull hair.

7. I applied for MR/DD Home and Community-Based Waiver services on May 8, 1998. I filled out the required documents at Shawnee Hills. I would have sought this service sooner if I had known it existed.

8. Tommy Lee was found to be eligible for the MR/DD Waiver, and was placed on a waiting list at Shawnee Hills.

9. My son, Tommy Lee, needs regular, constant and intensive therapies to teach him to speak, and to help him learn how to relate to others in socially appropriate ways.

10. Right now, he can only verbalize a couple of words and communicates with gestures. We are working on toilet training and self-feeding skills.

11. Tommy Lee has had more intensive services in the past, through the Birth to Three Program. He did very well when he had services four days a week, and I noticed a real deterioration of his skills when those services were cut back.

12. Tommy Lee does not receive any behavioral health services in our home.

13. I left my job when we had Tommy Lee, and my husband works for the State. Our income is very limited, and we cannot afford to pay out-of-pocket for the level of services Tommy Lee needs. We do everything we can for him.

14. Tommy Lee is a very special little boy. I want him to be able to reach his highest potential in life. This will require him having services like those available through the MR/DD Home and Community-Based Waiver Program.

Patty Vaughan
PATTY VAUGHAN

Taken, sworn to and subscribed before me this 29th day of April, 1999.
My Commission expires on 9/12/2000.

Carol A. King
NOTARY PUBLIC

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
CAROL ANN KING
WEST VIRGINIA ADVOCATES, INC.
Litton Bldg, 4th Floor, 1207 Quarrier St.
CHARLESTON, WV 25301
My Commission Expires Sept. 12, 2000

DECLARATION OF SHERRY EAGLETON

State of West Virginia
County of

Sherry Eagleston, being first duly sworn, states:

1. I am a resident of Cabell County, West Virginia.

2. I am over eighteen (18) years of age.

3. I am the mother of Justin Eagleton, a minor child residing my home. I am single parent.

4. Justin is a sixteen (16) year old with diagnosises of Down's syndrome, severe to profound hearing impairment, mental retardation, not otherwise specified. Justin is nonverbal.

5. As a result of his disability, Justin has no concept of personal or community danger thus necessitating the need for twenty-four hour a day constant supervision.

6. Justin was applied for Title XIX Mental Retardation / Developmentally Disabled Home and Community Based Waiver in April 23, 1998.

7. Justin was found to be eligible for Title XIX Mental Retardation / Developmentally Disabled Home and Community Based Waiver Program but was placed on a waiting list.

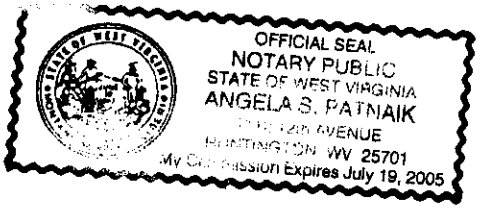
8. Justin needs a waiver slot in order to increase his level of independence, self-help skills, communication, and pre-vocational skills.

Sherry Eagleston
SHERRY EAGLESTON

Taken, sworn to and subscribed before me this 29 day of April, 1999.

My Commission expires on July 19, 2005

Angela S Patnaik
NOTARY PUBLIC



DECLARATION OF GEORGANN HOLBROOK

State of West Virginia
County of

Georgann Holbrook, being first duly sworn, states:

1. I am a resident of Cabell County, West Virginia.

2. I am over eighteen (18) years of age.

3. I am the mother of Benjamin Holbrook, a minor child.

4. Benjamin is five years old and he has autism.

5. Benjamin must be watched all the time, as he is impulsive and does not recognize danger. He needs trained staff to work with him in our home on safety training, to decrease his bolting behavior and episodes of rage.

6. Because of his tendency to run off and place himself at risk, we have had to put key-locks on all doors and frequently restrict him to inside the house.

7. Benjamin's father has a heart condition. In recent months, he has had two heart attacks. He is unable to help me much with looking after Benjamin. In fact, my husband's doctor has stated that an out-of-home placement might be necessary if we cannot reduce the level of stress in our home brought on by Benjamin's behavior.

8. The MR/DD Home and Community Based-Waiver Program would enable us to get Benjamin the staff he needs to help him to reduce his undesirable behaviors, address his aggression, and assist us in the constant supervision necessary to keep Benjamin safe.

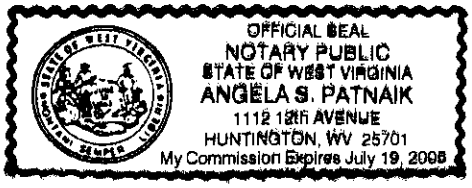
9. I applied for MR/DD Home and Community-Based Waiver services on September 30, 1998. I filled out the required documents at Autism Services Center. He was found to be eligible and has been placed on the waiting list.

10. Benjamin does not currently receive any behavioral health services in our home.

Georgann Holbrook
GEORGANN HOLBROOK

Taken, sworn to and subscribed before me this 29 day of April, 1999.
My Commission expires on July 19, 2005.

Angela S. Patnaik
NOTARY PUBLIC



DECLARATION OF MARTHA J. JOHNSTON

State of West Virginia
County of

Martha J. Johnston, being first duly sworn, states:

1. I am a resident of Marion County, West Virginia.

2. I am over eighteen (18) years of age.

3. I am the mother of Lori Beth Steele, a minor child. Lori Beth lives with me.

4. My daughter is fifteen years old. She has moderate mental retardation, attention deficit disorder with hyperactivity, seizure disorder and some mobility impairment.

5. Lori Beth has a short attention span, she gets bored easily. She can get aggressive, especially at home. When she is aggressive it is either towards herself or towards me. She will scream, gnash her teeth, and smack herself on the head.

6. I am a single parent. I have no other family members in the area that could help me watch after Lori Beth. She requires constant supervision.

7. Communication is one of Lori Beth's biggest deficits. She needs intensive speech therapy to address this. She also needs services to help her with social skills and reduce her aggressive outbursts and self-injurious behavior.

8. I originally applied for MR/DD Home and Community-Based Waiver services for Lori Beth in 1991. She has found to be eligible for the program and placed on a waiting list at Valley Health Care. I have received periodic updates as to the status/ranking of Lori Beth's application on this list. Her position has moved up and down the list. She has yet to receive these services.

Martha J. Johnston
MARTHA J. JOHNSTON

Taken, sworn to and subscribed before me this 30 day of April, 1999.
My Commission expires on June 5, 2006.

Mary Ann Gorey
NOTARY PUBLIC

OFFICIAL SEAL
NOTARY PUBLIC
STATE OF WEST VIRGINIA
MARY ANN GOREY
United Way of Marion County, Inc.
P. O. Box 225
Fairmont, West Virginia 26555-0225
My Commission Expires June 5, 2006

Introduction

5010. OVERVIEW

A. Early and Periodic Screening, Diagnostic and Treatment Benefit.--Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21. The EPSDT benefit is optional for the medically needy population. However, if the EPSDT benefit is elected for the medically needy population, the EPSDT benefit must be made available to all Medicaid eligible individuals under age 21.

B. A Comprehensive Child Health Program.--The EPSDT program consists of two, mutually supportive, operational components:

- o assuring the availability and accessibility of required health care resources and
- o helping Medicaid recipients and their parents or guardians effectively use them.

These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to systematically:

- o Seek out eligibles and inform them of the benefits of prevention and the health services and assistance available,
- o Help them and their families use health resources, including their own talents and knowledge, effectively and efficiently,
- o Assess the child's health needs through initial and periodic examinations and evaluation, and
- o Assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly. Although "case management" does not appear in the statutory provisions pertaining to the EPSDT benefit, the concept has been recognized as a means of increasing program efficiency and effectiveness by assuring that needed services are provided timely and efficiently, and that duplicated and unnecessary services are avoided.

C. Administration.--You have the flexibility within the Federal statute and regulations to design an EPSDT program that meets the health needs of recipients within your jurisdiction. Title XIX establishes the framework, containing standards and requirements you must meet.

Program Requirements and Methods

5110. BASIC REQUIREMENTS

OBRA 89 amended §§1902(a)(43) and 1905(a)(4)(B) and created §1905(r) of the Social Security Act (the Act) which set forth the basic requirements for the program. Under the EPSDT benefit, you must provide for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. You must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with your established periodicity schedules for these services. Additionally, the Act requires that any service which you are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in your Medicaid plan.

The statute provides an exception to comparability for EPSDT services. Under this exception, the amount, duration and scope of the services provided under the EPSDT program are not required to be provided to other program eligibles or outside of the EPSDT benefit. Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to recipients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

FOREWORD

A. Function of the State Medicaid Manual (SMM).--This manual makes available to all State Medicaid agencies, in a form suitable for ready reference, informational and procedural material needed by the States to administer the Medicaid program. It is an official medium by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

B. Contents and Organization.--

1. Contents.--The manual provides instructions, regulatory citations, and information for implementing provisions of Title XIX of the Social Security Act (the Act). Instructions are official interpretations of the law and regulations, and, as such, are binding on Medicaid State agencies. This authority is recognized in the introductory paragraph of State plans. Interpretations and instructions relating to common policy under Titles I, IV-A, X, XIV, XVI, and XIX of the Act are also included.

2. Organization.--The material is organized into major Parts, which are divided into chapters and sections. The manual is structured as close as possible to the codification of Medicaid regulations. A crosswalk of manual sections and regulations is also included.

The instructions interpret or clarify issues in the regulations and set forth procedures you are required to follow in implementing the regulations.

C. The SMM and Other Reference Material --Title XIX is the statutory basis for the Medicaid program and the foundation for the regulations and all manual material. Medicaid regulations are contained in Parts 42 and 45 of the Code of Federal Regulations. Regulation citations are included in the manual text.

D. Manual Revisions.--The manual is designed to accommodate new pages as text is added or revised. Substitute pages containing revised sections or chapters are, therefore, issued as needed. The transmittal pages summarize the changes and include the effective dates of the revisions. When a major change in regulations, policies, or procedures is involved, the background is provided. New or changed materials are indicated in the left margin of a page in the following manner:

Line on which change begins.

Line on which change ends.

The revision transmittal sheet identifies new page numbers and the pages replaced. If at a later date, you need to refer to the background explanation given on a transmittal sheet, you can identify the transmittal by its number which appears on each manual page.

E. Use of the Revision Transmittal Check List.--Each manual Part has its own check sheet for recording receipt of revisions since different parts of the manual have different distributions. Each Part will have its own numerical sequence of transmittals. File revised manual transmittals in transmittal number order as a safeguard against discarding a more recent page in favor of an older one.

Transmittals are not always distributed in strict numerical sequence. Therefore, if it appears that you have not received a particular transmittal, allow 15 working days after receipt of a higher numbered transmittal before requesting a transmittal that you have not received.