IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Richmond Division

UNITED STATES OF AMERICA,	:	
Plaintiff,	:	
	:	
and	:	
	:	**CIVIL ACTION NO: 3:12-cv-059**
COMMONWEALTH OF VIRGINIA,	:	
Defendant,	:	
	:	
against	:	
	:	
PEGGY WOOD, by and through her	:	
father, Wriley Wood, et al.	:	
Intervenors.	:	

AMICI CURIAE BRIEF OF TRAINING CENTER RESIDENTS IN OPPOSITION TO THE PROPOSED SETTLEMENT AGREEMENT

The residents of the Commonwealth's five training centers, by counsel, and pursuant to the Court's March 6, 2012 Order requesting Amicus Briefs by all interested parties, submit the following Memorandum as Amici Curiae.

I. INTERESTS OF AMICI CURIAE

The Amici are residents of the Commonwealth's five (5) training centers (Central Virginia Training Center, Southeastern Virginia Training Center, Southwestern Virginia Training Center, Southside Virginia Training Center, and Northern Virginia Training Center). The Commonwealth has deemed these individuals, currently approximately one thousand (1,000) in number, as eligible for state operated ICF/MR level of care.

According to a recently published study, the majority of the population of Virginia's training center residents, 47.7 %, are ages 40-54. See, "Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2010", see also, Research and Training

Center on Community Living Institute on Community Integration/UCEDD, College of Education and Human Development University of Minnesota (2012) (http://rtc.umn.edu/docs/risp2010.pdf). Approximately 88.8 % of the individuals residing at the centers have been diagnosed with profound or severe intellectual disabilities. Almost all individuals residing at the centers have been diagnosed with additional disabilities. According to the 2010 University of Minnesota data, nearly 61.8% have two or more additional disabling conditions such as cerebral palsy, blindness, hearing impairments, seizure disorders, psychiatric and behavioral disorders. A majority of residents cannot communicate "basic desires verbally" (68.8%), and a large percentage cannot "understand simple verbal requests" (35.4%). Many residents also need assistance walking (46.4%), transferring (18.6%), eating (58.3%), dressing (63.5%) or toileting (62.5%). Id.[1] The primary service needs of individuals residing at the training centers require a variety of extensive services and supports. Services provided at the centers include a full continuum of care including dental, laboratory, medical, neurological, nursing, psychiatric, physical and occupational therapy, and nutritional management. Extensive personal care is required for those who need total assistance and care provided by direct service staff who are specially trained on individualized programs developed by residents' treating professionals, including physicians, psychiatrists, psychologists, nurses, physical therapists, occupational therapists, speech language pathologists, and many other licensed clinicians who treat residents at the centers. Significant health care services are provided by treating professionals at the centers who have determined that nursing intervention and monitoring are required to effectively treat many of the residents with significant health care needs. This service

[1] Nationally, 76% of all ICF/MR residents experience severe and profound intellectual disabilities. They also endure multiple disabilities, chronic medical conditions and/or behavioral challenges. Many also have seizure disorders, behavior problems, mental illness, are visually-impaired or hearing-impaired, or have a combination of these conditions. Id.

includes the need for 24-hour monitoring and immediate availability of treating professionals for intermittent pressure breathing, inhalation assistive devices, tracheotomy care, and treatment for recurrent pneumonias or apnea. Many residents are non-ambulatory or require special assistance or supervision to address such need. Many residents require significant behavioral support. This support addresses individuals who have behaviors that require intervention for the safety of themselves or others, as developed by psychologists and medical personnel and implemented in conjunction with direct service staff.

Residents are consistently and routinely evaluated by their treating professionals and have been determined to be in need of ICF/MR level services. Many residents who reside in the Commonwealth's Training Centers have such severe disabilities that community placement is not preferred by the resident, their guardian or their treating professionals. See, Exhibit A (Guardian Letters to Judge Gibney) (filed under seal). For example:

- R.S. suffers from brain damage due to an oxygen deficiency at birth, epilepsy with uncontrolled mixed seizures, profound swallowing problems, brittle bones, optic atrophy with myopia, incontinence, stenosis of his neck and back, peripheral neuropathy and hyper-salivation. R. is non-verbal and completely non-ambulatory. He gets all nutrition, hydration and medication via a gastrostomy tube. See, February 11, 2012 Letter from guardian A.S.

- C.W.C.'s brother describes him as being "profoundly retarded with severe obsessive-compulsive disorder" such that any item out of place poses a real danger because of C.'s compulsive reactions. C., who is sixty-six years old and has been at Northern Virginia Training Center ("NVTC") since he was three years old, cannot leave the building without two staff members to accompany him. See, March 13, 2012 Letter from guardian, T.D.C. Jr.

- S.B.C. suffered from spinal meningitis when she was seven weeks old and was left mentally and behaviorally disabled with "explosive-type" outbursts during which she kicks, screams, bites, and throws things requiring her to be separated from others for her safety and that of those around her. See, March 12, 2012 Letter from parents, D.C. and L.C. She

has been a resident of the Southwestern Virginia Training Center ("SWVTC") for twenty-one years.

- K.M. has been a resident of NVTC for thirty-two years. He was born with severe brain damage resulting in many medical issues including a seizure disorder. K.'s father describes his son's intellectual ability as being "that of a new born baby." He is blind, a quadriplegic with little control of his limbs, and he receives nourishment through a feeding tube. See, March 9, 2012 Letter from father, D.M.

- J.K., a thirty-two year resident of NVTC, suffers from Angelman Syndrome and has the intellectual development of a six-month to one-year-old. J. is not toilet trained; he is entirely non-verbal; he tends to place everything in his mouth and chew on items that become choking hazards; and, when excited and agitated, he is prone to grab and hold onto whoever is nearby. J. has an exceptionally high pain threshold as illustrated by his not showing even a whimper of pain after he broke his collarbone a few years ago. This condition poses a constant risk of accident or medical emergency. His mother described a recent situation in which J. ate eleven inches of his quilt, which has since been encased in parachute material, and another incident in which J. picked at a sore on his elbow to the point that he pulled tissue out of his arm requiring surgery. See, February 11, 2012 Letter from his mother, J.A.

- T.K., who has been a resident of SVTC since the 1970s, is classified as moderately retarded with autistic tendencies. Her sister, J., states that T.K. has regularly exhibited violent behavior for most of her adult life including hitting, pushing, biting and breaking things. On one occasion, T. tried to put a piece of glass in her sister's eye and, on another occasion, she turned her bed upside down and ripped a water fountain out of the ground. T. is unable to live anywhere but on a locked ward where she is secure and cannot run out. Her sister fears that losing the only home T. has ever known will devastate and create an on-going crisis for her. See, March 15, 2012 Letter from sister, J.K.

Although some so-called advocacy organizations claim that residents of Training Centers are all "better off" if they had an opportunity to live in the community, the experiences of the Virginia parents and guardians is contrary to this belief. In fact, many Training Center residents have previously lived in waiver-funded placements in the community and have seen horrible results. Some residents were sent to live in homeless shelters after the waiver-funded provider forced them out of the home. Others were refused admission all together and the Training

Centers were the only place that had the proper supports to adequately serve the individual. For example:

- A.B.'s sister S.M. was placed at the NVTC (where she has resided for over thirty years) after a group home was unable to deal with S's multiple problems. See, February 9, 2012 Letter from sister, A.B.

- Before moving to NVTC, L.C.'s son, C., who suffers from Lennox Gasteau Syndrome (different types of seizures with an unknown cause), a degenerative brain disease, osteoporosis, and mental retardation, lived in an intermediate (group) care home for one and a half years. During that time, C. "had constant seizures, constant urinary tract infections, an unexplained black eye, an unexplained broken finger, and a huge weight loss." As a result, C. spent the majority of that year and a half at Fairfax Hospital and each time he returned to the group home, he suffered additional seizures and constantly became sick. When C. was accepted at NVTC in 1998 he stabilized and then "blossomed to be the best he can be." See, February 12, 2012 Letter from his mother, L.C.

- S.B.C. was moved from SWVTC to a local group home four years after first coming to SWVTC. "The group home did not work" with S.B.'s behaviors and panic attacks and she was re-admitted to SWVTC after only six months at which point she had regressed by two years. Based on this experience, her parents worry that group home staffing will not have the additional security necessary to help S.B. if she runs out of her home, which if located on a street, could place her in immediate danger. See, March 12, 2012 Letter from parents.

- A.B., a severely autistic fourteen year old resident of the NVTC, resided in two group homes in the 1990s, both of which are well known in Virginia for their excellence in dealing with individuals with disabilities. A., however, could not be managed in this community based setting due, in part, to his need for 24/7 supervision. See, March 11, 2012 Letter from guardian L.B.

- R., who has lived at the Central Virginia Training Center ("CVTC") his entire life, is totally disabled, bed/wheelchair bound, tube fed, spastic with rigid muscles, diapered and medicated for seizures. Following a 2009 hospital visit, CVTC called three in state facilities to determine if they could handle a patient with a feeding tube that was inserted into his neck. Each facility refused saying that Robert was "too much trouble." See, March 17, 2012 Letter from guardian L.J.

- H.W. is fifty six years old and has lived at the NVTC for thirty nine years. He suffers from an intellectual disability and autism. When H.'s behavior improved at or around age eighteen, he was placed in a group home during which time H. stuck a pencil up his nose and almost killed himself. He returned to the NVTC

where he requires 24/7 supervision. H. remains prone to property destruction having destroyed his mattress, ripped his clothing, smashed glass, and ripped shower heads and faucets from the walls. See, February 8, 2012 Letter from H.'s sister and co-guardian, N.A.

- N.T.'s son, D., spent ten years in a community residence before the facility claimed that D.'s extensive needs conflicted with those of others in the community. D. was transferred to a homeless shelter before coming to NVTC. See, February 8, 2012 Letter from his mother, N.T.

- M.K., mother of F.A.K., who has lived at CVTC since he was seven years old (he is now fifty-eight years old) described the challenges presented by a group home she visited as follows:

  "This tri-level group home is adjoining the lot of a garage/repair shop situation at a very busy 4-way intersection. The manager was polite but obviously had no training of safety. Eight special needs people lived here. There was no fence to prevent residents from wandering. My granddaughter lives next-door and has observed one of the residents on her back patio. Men are enticed by cars and motors and could easily wander to that area and be in the street. The lawn was not fenced in. There was no elevator in this home. There was no gate/restraint to prevent residents from climbing the stairs then falling down … On the counter sat a bottle of dish detergent beside coffee creamer and a Mr. Coffee machine. I actually shivered when I saw it. I brought it to the attention of the manager, who immediately placed the detergent under the non-childproof sink and said she didn't know not to store the two items together. Had F. seen this, I'm sure he would have drank it. Thank God for the safety of CVTC."

  See, February 17, 2012 Email from M.K.

A. The Settlement Agreement Necessarily Will Negatively Affect Training Center Residents And Will Prevent Them From Receiving Appropriate Services

This Memorandum provides analysis of the Training Center residents and of how the Settlement Agreement, if entered, will impact the safety of these residents and their access to appropriate care. The Court has received other memoranda from advocacy groups, including the Virginia Office for Protection and Advocacy (VOPA) and ARC of Virginia. The VOPA and ARC of Virginia do not represent Training Center residents, instead pursuing a detached

philosophical ideology without regard to reality, and are often actually hostile to proper care options for severely disabled citizens who require and choose ICF/MR services. More importantly, these organizations have extremely biased views which do not take into account the actual needs of the residents in the Training Centers or their choice to reside there. The VOPA filed an Amicus Brief arguing in favor of the approval of the Settlement Agreement, which they are aware will take away rights of Training Center residents, while part of their stated mission is to allegedly protect the residents.[2] In its Amicus Brief, it pursues sensationalism over factual analysis by simply listing investigations for seven (7) pages alleging that abuse and neglect occurred.[3] However, what they do not tell the Court is that a certain amount of abuse and neglect occurs in all settings where services to individuals with intellectual disabilities are provided despite best efforts, not just at Training Centers only. In fact, there is literature that has found community settings to have higher incidents of abuse and neglect than Training Centers. See, New York Times Article "In State Care, 1200 Deaths and Few Answers" at

[2] The Amicus Brief filed by the Virginia Office of Protection and Advocacy [Dkt. #50] uses 7 pages to list out incidents which allege abuse and neglect occurred since 2007 in various institutions. It is unclear whether these investigations were substantiated by the Department of Health and Human Resources. Further, they are especially biased when VOPA do not fairly state how many investigations were completed in community-based facilities or private residences that are similar if not worse than those cited in their brief. Virginia's Adult Services Program Report found that 82% of substantiated reports of abuse occurred in these settings while only 2% occurred in the Commonwealth's Training Centers.

[3] The P&A attempts to obtain an undue emotional response from the Court by citing statistics out of context and without any reasoned analysis. It does not provide any comparative data to other ICFs/MR around the country which would show how well Virginia is doing at its Training Centers; to community-based settings which have a higher incidence of abuse, neglect, and death; or to school settings that have a comparable incidence of alleged abuse and neglect. There is no basis for comparison provided by P&A for the Court to determine whether the occurrence of alleged abuse and neglect is reasonable. There is no analysis of individual cases to determine the reasonableness of the occurrence and of the response by the Training Centers. This misuse of statistics by P&A is merely an attempt to unfairly inflame the Court and to play to the press. This type of deception has not survived challenge in courts, and will similarly fail here if this Court allows proper challenge to these claims specifically and to the Settlement Agreement generally. This is exactly why groups like P&A and ARC oppose intervention so that their exaggerated and incorrect claims will not be subjected to proper testing in our judicial system.

Of further note is that many of these alleged instances of abuse and neglect were not substantiated by investigations, were of a very minor nature, or did not even cause any injury at all. And, unlike the Training Centers where all questionable occurrences must be reported on incident forms, such as even bumps into furniture where there is no injury, community-based settings greatly under-report abuse and neglect because there is much less supervision and much more opportunity to hide such incidents.

http://www.nytimes.com/2011/11/06/nyregion/at-state-homes-simple-tasks-and-fatal-results.html?pagewanted=all. The Commonwealth of Virginia has extensive records regarding instances of abuse and neglect for the fiscal year 2011 "Adult Services Program Report" of the Virginia Department of Social Services, which examines data regarding vulnerable adults (older individuals and adults with disabilities), and which found a record number of 17,936 Adult Protective Services (APS) reports of abuse, neglect and exploitation. Of these reports 8,941 were substantiated instances, but more importantly, 6,250 occurred in the individual's "own Home or Apt," 984 occurred in "Other's House or Apt," and only 194 of these incidents occurred in a "BHDS Facility/Group Home."

The position of Protection and Advocacy is a good example of advocacy groups providing skewed, incomplete information in order to weigh in on individual rights which is in direct conflict with their stated mission and purpose, and without regard for the wishes of the individuals whom they are charged with serving. The Amicus Brief submitted by the Virginia Office of Protection and Advocacy states that they are aware that their position is contrary to that of the guardians of residents in the Centers but that they simply disagree with them. [Dkt. #50 at 14]. The Court's Order has been interpreted as giving individuals an opportunity to be heard on how this Agreement may potentially cause them harm and deprive them of their rights. Thus, the Training Center residents provide in this memorandum, information about the ICF/MR model, why this Settlement Agreement will violate their rights, why the terms of the agreement will be in direct conflict with ICF/MR regulations, and why their voice should be given more weight than that of advocacy organizations that are advancing their own philosophical agendas.

B. The Limits Of Amicus Curiae Status

The Training Center residents have petitioned this Court for intervention into the pending action, by Motion to Intervene, dated March 2, 2012. [Dkt. #19, #20]. In response to their Motion to Intervene, both the United States and the Commonwealth of Virginia filed responses opposing the intervention of the Training Center residents, even though these residents are the main subject of the Settlement Agreement at issue. In addition to the opposition filed by the existing parties, who have seemingly worked together to actively exclude the Training Center residents from negotiations and who seek to implement an agreement which drastically affects how they will receive services, the ARC of Virginia and other corporate entities filed an Amici Brief, also in opposition to the Court allowing intervention. The Court has not ruled on the Motion to Intervene as of this date, thus, the Training Center Residents are forced to file this Brief as Amici Curiae to further explain their interests in this matter and their opposition to this Court's approval of the Settlement Agreement. Although the Training Center residents do not believe that their views should be limited to that of an Amici Brief or that the status of an amici is an adequate substitute for intervention, given the current posture of the case, the Training Center residents must continue to protect their interests in this litigation by filing this Brief as Amici Curiae.

II. ARGUMENT

A. There Are Fatal Flaws With The Settlement Agreement Which Will Be Detrimental to Training Center Residents

The Settlement Agreement contains fatal flaws which will be detrimental to the Training Center residents. Not only does the Settlement Agreement conflict with federal ICF/MR regulations, but it circumvents treating professionals' recommendations and encourages coercive

practices in order to reduce ICF/MR participation. If the Settlement Agreement is approved, the residents of Training Centers will be subject to coercion and receive inadequate services in violation of ICF/MR regulations.

1. The Settlement Agreement Seeks To Misuse The Authority Of This Court To Enact And Enforce A Regulatory System That Contravenes The Centers For Medicare And Medicaid Services Regulation Of The Training Centers

Consistent with the Olmstead decision, the Centers for Medicare and Medicaid Services ("CMS") has promulgated ICF/MR regulations that only permit the discharge of residents from Virginia's Training Centers under specific conditions. 42 CFR § 483.440(b)(4). All of Virginia's Training Centers are currently licensed by CMS and the Virginia Department of Health.[4] The proposed Settlement Agreement in this matter will impact the "discharge" of residents from Virginia's Training Centers, as that term is used in the federal regulations. See, Guideline to 42 CFR § 483.440(b)(4)(i) ("'Discharge' means the permanent movement of an individual to another facility or setting which operates independently from the ICF/MR."). Section IV of the proposed Settlement would displace the CMS regulations for discharge. [Dkt. # 2-2 at IV].

The Settlement Agreement contains discharge planning provisions which conflict with ICF/MR regulations and the Olmstead decision in terms of timing and in the inclusion of individuals in discharge planning who are not the person's treating professionals. The CMS regulations, which are exclusively for CMS to enforce, dictate the only circumstances under which such action can occur. They only allow discharge from an ICF/MR when that facility cannot meet an individual's needs, the individual no longer requires an active treatment program in an ICF/MR setting, the individual or guardian chooses to reside elsewhere, or when a determination is made that another level of service or living situation, either internal or external,

[4] See, 42 CFR § 440.150 and 42 CFR §§ 483.400-483.480 for the definition of and regulations pertaining to an intermediate care facility for the mentally retarded.

would be more beneficial, or for any other good cause, including any reason that is in the best interest of the individual. See, 42 CFR § 483.440(b)(4)(i).

The proposed Settlement Agreement fails to even acknowledge the existence of these regulations. Instead, the proposed Settlement ignores those regulations and surreptitiously seeks to have this Court abrogate those lawfully enacted and enforceable regulations in favor of the DOJ's and Commonwealth's self-serving system identified in their agreement. It is illogical that the DOJ and Commonwealth would ask this Court to create a system that would discharge Training Center residents according to the system in the proposed Settlement while another agency of the United States (CMS) simultaneously has concluded that those facilities meet all of the requirements of the federal regulations, certifies them as eligible for federal funds, and continues to provide federal funding for those facilities. It is unconscionable that the DOJ and Commonwealth would seek to use this Court to enact and enforce a system to discharge these Amici (residents of the Training Centers) in contravention of CMS regulations.

Provisions for discharge planning for individuals leaving the Commonwealth's Training Centers are found in Section IV of the proposed Settlement Agreement. Several aspects of these new procedures conflict with regulations of the federal ICF/MR program that already govern individual program planning and discharge planning in Virginia's Training Centers. Additionally, discharge planning procedures outlined in the Settlement Agreement contravene ICF/MR regulations as well as provisions of the Olmstead decision by including individuals who are not properly considered the person's "treating professionals." ICF/MR requirements provide for a 30-day period after admission during which a comprehensive, interdisciplinary functional assessment is carried out by treating professionals who constitute members of the person's interdisciplinary team (IDT). In Virginia's Training Centers, as in all ICFs/MR, this assessment

process leads, at the end of 30 days, to the development of a comprehensive Individual Program Plan (IPP) which then governs and directs appropriate services to be delivered to the individual. Thereafter, should discharge or transfer from the facility become a possibility for the person, based on the judgment of his or her treating professionals, ICF/MR regulations require that the facility: (a) provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge, (b) develop a final summary of the individual's program and (c) provide a post-discharge plan of care. Arguably none of these provisions can be met when the proposed Settlement Agreement requires that discharge planning "begin upon admission" and "drive treatment" of individuals in Training Centers and that an actual discharge plan be developed "within 30 days of admission" to a Training Center. See, [Dkt. #2-2 at 14]. The imposition of such discharge planning practices directly contravenes and precludes the appropriate professional judgment of the treating professionals as well as the normal development and implementation of the Individual Program Plan as required by federal ICF/MR guidelines.

The Settlement Agreement also bypasses the requirements of Olmstead that an individuals' treating professional make a judgment on whether discharge is appropriate. The Settlement Agreement also provides (in Section IV.B.6) that "Discharge planning will be done by the individual's PST" although existing ICF/MR regulations require that discharge planning be carried out by the individual's duly-authorized interdisciplinary team of professionals." However, as defined in the agreement, the Personal Support Team ("PST") includes individuals who are not part of the person's ICF/MR interdisciplinary treatment team (e.g., the Community Service Board case manager). The Community Service Board case manager and other unallied members of the Personal Support Team cannot be considered as part of the person's "treating

professionals" because they will not have participated in the person's comprehensive functional assessment or creation of the person's individual program plan in the Training Center. Therefore, these individuals will not have professional knowledge of the person's treatment needs and may not even know the person. Regardless, it is the person's treating professionals that the Olmstead Decision empowered to make judgments about the appropriateness of services, including community-based services.

Furthermore, discharge planning processes outlined in the Settlement Agreement empower the Community Service Board ("CSB") case manager to identify community-based providers for individuals as part of the discharge planning process (that ostensibly begins at admission). In order to be able to do this the case manager must share at least some personal information about the individual with the potential provider agencies. However, ICF/MR regulations require that such information is only released "with the consent of the client, parents (if the client is a minor) or legal guardian…." See, 42 CFR § 483.440(b)(5)(i). Therefore, it would only be possible for Community Service Board case managers to carry out these parts of the discharge process (e.g., identifying and presenting potential community providers to the person or his/her authorized representative) by releasing personal information in advance of receiving consent. The Settlement Agreement does not recognize this problem and following it would place the state in the position of violating ICF/MR regulations governing the Training Centers.

2. The Settlement Agreement Encourages Coercive Practices

Although individuals or their guardians have the right to make placement and treatment decisions, including placement referrals for congregate care settings, the Settlement Agreement

outlines procedures that permit repeated review and questioning of such decisions. These provisions are fostering the outright harassment of individuals about their decisions.

The Settlement Agreement, especially in Section IV (Discharge Planning and Transition for Training Center), outlines various steps that the Community Service Board case manager and others will take with respect to an individual's or an authorized representative's decisions in favor of congregate care. This section repeatedly outlines the "provision of reliable information" about community options to individuals and authorized representatives to include the "listing of specific providers," a delineation of "placements, services, and supports," opportunities to "speak with those providers," to "visit community placements," and to "facilitate conversations and meetings" among service recipients and engage in "family-to-family and peer programs." These and similar efforts outlined in the Settlement Agreement incorrectly and dangerously presuppose that the decisions of individuals and/or their authorized representatives are somehow deficient or inappropriate and/or that those making the decisions are either misinformed and somehow incorrect. [Dkt. #2-2 at 14].

Then, when a person or an authorized representative "opposes the Personal Support Team's proposed options for placement in a more integrated setting," an additional series of procedures is brought to bear on individuals and/or their authorized representatives. These procedures direct the Personal Support Team (which is not the individual's Interdisciplinary Team) to engage the individuals and/or their authorized representatives and to develop "individualized strategies to address concerns and objections to community placement" as well as to "document the steps taken to resolve the concerns…about community placement." In the event that a person's or authorized representative's wishes prevail (i.e., a decision is made in favor of congregate placement), the Personal Support Team must then "identify barriers" and

describe the steps needed to "address the barriers" to community placement. Such decisions will, further, be referred to a Community Integration Manager and the Regional Support Team which will, in turn, become engaged in "address(ing) the barriers" and if the person remains in the Training Center, they will be required to review the case "at 90-day intervals." Such review itself is a usurpation of the proper role of the Training Center's ICF/MR interdisciplinary team (i.e., the state's treating professionals as designated by Olmstead).

Taken together, these various procedures clearly point to a relentless process designed to second-guess authorized decision-makers (guardians) and to have them repeatedly revisit informed decisions that they have made for their loved ones. There is no reason to think that authorized representative/guardian's decisions about continued placement in a Training Center are not bona fide, informed and considered decisions that should not be respected. Additionally, according to the proposed Settlement Agreement, which will have the enforcement of a consent decree, the Commonwealth will actually be held in contempt if they refuse to participate in the continuous badgering of guardians that is described in the proposed Settlement.

3. The Settlement Agreement Fails To Recognize The Differences Between The Medicaid ICF/MR Program And The HCBS Waiver Program

The Settlement Agreement does not recognize the critical funding and service model differences between the Medicaid ICF/MR program and the HCBS waiver program. The language of the institutional closure debate ("institution vs. community") masks important differences in the two major Medicaid programs that fund services. Federal payments are received by Virginia for both "institutional" (e.g., Training Centers) and community services – but under two separate Medicaid programs: (1) the *Intermediate Care Facilities/Mental*

Retardation (ICF/MR) program[5] for Virginia's Training Centers (and also certain private ICF/MR facilities in the Commonwealth) and (2) the *Home and Community-Based Services* (HCBS) waiver. These programs offer fundamentally different models of treatment.

- **ICF/MR.** This program requires comprehensive interdisciplinary planning and treatment services as well as *active treatment* according to strict federal guidelines. "Active treatment" is a specific program of interdisciplinary training and treatment interventions delivered on-site by licensed professionals according to federal ICF/MR guidelines. Continued federal funding is contingent on the facility meeting these guidelines.

- **HCBS Waiver.** This program provides community-based care to individuals who may otherwise need institutional-level care. In this program certain requirements of the ICF/MR model are *waived*. Under the waiver, services are unbundled such that the agency that provides residential services will not necessarily be the same agency that provides health care, behavioral supports, nursing, medical care, or other therapies. Instead, such services must be accessed through various existing funding mechanisms (e.g., Medicaid for health care) just as they are accessed by nondisabled citizens. There is no common body of federal service guidelines in the HCBS waiver program because each state's HCBS waiver program is different; thus providers must meet guidelines established by the Commonwealth.

When someone becomes eligible for long-term care services, Medicaid regulations require that the person be given a choice between receiving services in an institutional setting or

[5] Terminology in the field has discouraged the use of the term "mental retardation" (MR) in favor of "intellectual disability" (ID); in some texts reference to the ICF/MR program (the historical name) will be made as ICF/DD or ICF/ID.

receiving them in a community setting. If the state offers ICF/MR services, service under this model rises to the level of an entitlement and must be provided immediately if chosen by the person. Services funded under the HCBS waiver in the community, however, are permitted to have a waiting list. This has given rise to waiting lists for HCBS waiver services in most states, including Virginia. Neither the ICF/MR nor the waiver model is inherently superior to the other. The best model is the one which best meets the needs of each individual. Decisions about which to choose must be made on an individual basis by the person, his/her guardian, and the person's treating professionals, and not based upon the ideological belief of any outside advocacy group. People who have lived in Training Centers and have extensive and multiple disabilities often prefer the ICF/MR model because of the assured and consolidated access to a wide range of professional services and supports. Individuals with fewer service needs often find that the flexibility of the HCBS waiver suits them better. In short, where one lives and which model of services is best for a person is an *individual* decision, a decision that has been guaranteed to all individuals who receive services by both Medicaid rules as well as the Supreme Court's Olmstead decision.

4. The Settlement Agreement Mischaracterizes The Use Of Person-Centered Planning In The ICF/MR Model Currently Used In Virginia's Training Centers

Throughout the Settlement Agreement the terms "person-centered planning" and "person-centered thinking" are used without recognition of the ideological underpinnings of the terms. Additionally, there is no recognition in the Settlement Agreement that traditional service planning within the Training Centers (i.e., ICF/MR model) is wholly individualized by an interdisciplinary team through an Individual Program Plan that places the person at the center of the treatment and service planning process. The Settlement Agreement attempts to

mischaracterize community-based care as being person-centered while ICF/MR care is something other than person-centered, when, in reality, person-centered planning is being practiced in Virginia's Training Centers, and guardians of residents currently living in the Centers experience it firsthand.

The so-called "Person-Centered" planning (PCP) approach to life and service/support planning arose as a reaction to what a particular group within the field of developmental disabilities saw as "service-centered" planning which they argued "devalued" the person and permitted segregated services. Therefore, PCP sought to "empower" the served and to support social inclusion, and is a planning model that is common in HCBS waiver settings. In short, the PCP movement sought to expand "individual planning" to include individual budgeting and control of funds in creating individualized service packages in community-based settings.

As such, the person-centered planning approach clearly espoused a particular "agenda" that had the effect of de-emphasizing the role of treating professionals (physicians, nurses, psychologists, therapists, and social workers) organized in interdisciplinary or multidisciplinary teams in favor of groups of interested advocates often termed "circles of support," the members of which did not need any specific credentials other than allegedly caring about the person (i.e., neighbors, employers, community members, friends). The person-centered planning ideology contends (often incorrectly) that traditional planning by professionals focuses solely on clinical needs while the PCP model is based on human rights, choice, social inclusion, and what is important to the person. A reasonable person would find benefits, and potential problems, in both approaches. For individuals with few disabilities, who have modest needs and the ability to manage their own affairs, with perhaps some support, the person-centered planning model is well-suited to enable the person to create a purposeful and rewarding life in the community. However,

for most individuals in Training Centers, who have severe and profound cognitive disabilities – and who may not speak, walk, feed themselves or carry out the most basic of their needs independently – the traditional professional, individualized interdisciplinary planning model employed in ICF/MR settings may be by far preferable.

Although perhaps to the chagrin of an avid person-centered planning advocate, a planning meeting in a Training Center meeting ICF/MR guidelines often finds 10 – 12 individuals sitting at a table (the person, his/her guardian, a social worker, physician, nurse, psychologist, a nutritionist, therapists such as OT/PT/Speech, and day program and residential workers). Such a team is often needed to plan for the complex and interconnected conditions presented by individuals with severe and profound disabilities. At the same time, such a team is rarely, if ever, convened in waiver-funded settings using the person-centered planning model (for example, there would be no easy way to pay for or to schedule the time of a medical practitioner to attend every such meeting). The danger for people who currently live in Training Centers is that the person-centered planning model utilized by waiver-funded services can easily overlook the effects of physical and mental conditions that would be taken into account by treating professionals in the facilities who are regularly interacting with each other with regard to the resident. In this regard, the person-centered planning found in the Commonwealth's Training Centers is far superior than any person-centered model found in any waiver-funded placement.

Unfortunately, the Settlement Agreement touches on none of these concerns; the authors of the agreement are seemingly unaware of the complexities in the interactions between planning models and implementation aspects of services and supports. Instead, the Settlement Agreement repeatedly uses "person-centered planning" (in lower case letters) as if it were far preferable to the

ICF/MR individualized planning model, which is equally focused on the person at the center, and is currently employed in the Training Centers.

In fact, the Settlement Agreement, in Section IV.B.10(b), seeks to actually implant "person-centered thinking" in Training Centers through person-centered planning trainings, annual refresher courses, person-centered planning coaches, and competency monitoring. None of this type of training in "how to think" arises in research or practice conducted by the various professions, rather it arises from an ideological and advocacy perspective. Whether or not such an approach is actually more beneficial than the existing approach has not been unequivocally supported by research; thus, one wonders whether it is entirely appropriate for the Commonwealth and the Department of Justice to espouse this perspective in the Settlement Agreement that they propose for this Court's approval.

B. DOJ And The Commonwealth Are Using ADA And Olmstead To Create New Programs To The Detriment Of The Amici

The proposed Settlement Agreement does not resolve any alleged violations of the ADA or Olmstead. The proposed Settlement Agreement would only create or perpetuate violations of the ADA and Olmstead by the Commonwealth. The proposed Settlement Agreement does not provide for any creation or expansion of services that would replace or improve the services that the Amici currently receive at the Commonwealth's Training Centers. Instead, the DOJ and Commonwealth are using the ADA and Olmstead as a false premise to create new programs to the detriment of the Amici. The ADA and Olmstead afforded rights to people living in institutions to live in a less restrictive environment if (1) their treating professionals determined community placement is appropriate; (2) the individual does not oppose transfer to a less restrictive environment; and (3) and the placement can be reasonably accommodated, taking into account the

resources available to the state and the needs of others with mental disabilities. Olmstead, 527 U.S. 581 (1999).

While Amici support the expansion of services to all disabled Virginians, the only individuals who would benefit from the proposed Settlement Agreement are not necessarily entitled to those services pursuant to the ADA and Olmstead. Under normal circumstances, the Commonwealth is entitled to expand those services at its discretion, but the expansion of those services has no direct basis or relationship to the Commonwealth's obligations arising from the ADA or Olmstead. In this matter, the Commonwealth has either volunteered to expand those services or is doing so because it seeks to avoid liability from the litigation threatened by the DOJ. In either event, the beneficiaries of the new and expanded programs that would be required by the proposed Settlement Agreement would receive those additional benefits gratuitously. The services to be provided by the Commonwealth pursuant to the proposed Settlement Agreement are largely unhinged from the ADA and Olmstead decision.

Olmstead created rights exclusively for individuals residing in institutions, who may or may not seek discharge to an alternative setting. ARC of Virginia, Inc. v. Kaine, 2009 U.S. Dist. LEXIS 117677 (E.D. Va. 2009). Olmstead did not create rights for people receiving services in non-institutional settings. Unlike the instant matter, in Olmstead, the state actually defended its administration of services. In Olmstead, the Supreme Court recognized something that the Commonwealth in this matter apparently does not: the "States' need to maintain a range of facilities for the care and treatment of persons with diverse mental disabilities, and the States' obligation to administer services with an even hand." Olmstead, 527 U.S. 581, 597 (1999). The Commonwealth spends significant resources on "community-based treatment" but neither the

ADA nor Olmstead creates an entitlement to those services even if the Commonwealth provides them.

The Olmstead Court specifically noted that "[t]he State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless." Olmstead, 527 U.S. 581, 603 (1999). The DOJ and Commonwealth have misrepresented that their proposed Settlement Agreement was brought about to cure the Commonwealth's alleged violations of the ADA and Olmstead. The proposed Settlement Agreement does nothing to cure or even ensure that the rights of the Amici, to whom the Olmstead decision expressly affords certain rights, are protected. Among other things, Olmstead sought to ensure that institutionalized individuals would not have their services diminished if they were discharged to a less restrictive setting. The Court in Olmstead cautioned against discharging institutionalized individuals to a less restrictive setting that could not adequately meet their needs. The proposed Settlement Agreement does nothing to create or expand, in an allegedly less restrictive setting, the extensive medical and therapeutic services that Amici currently receive at the Training Centers. Instead, the proposed Settlement creates and expands programs for disabled Virginians who do not reside in the Training Centers.

The potential beneficiaries of the Settlement Agreement are individuals who receive services through the Commonwealth's waiver system or are on the waiting list to receive waiver services. In 1981, the Social Security Act was amended to allow states to choose to offer Medicaid funding for long term care services when those services are provided in the person's home or community. See, 42 U.S.C. § 1396n(c). That amendment defined the rights of waiver participants to receive services. The program has specific limitations; among other things, that the

states do not have to serve every eligible person and states may establish waiting lists so long as they move at a reasonable pace. See, Olmstead, 527 U.S. 581, 605-06 (1999).

The proposed Settlement Agreement's gratuitous expansion of services to individuals who have no ADA rights implicated would be laudable if it was not to be done at the sake of Amici. Even if the proposed Settlement Agreement merely ensured that Amici's rights were protected, while expanding services to others, the agreement may be defensible. However, the proposed Settlement in this matter is being used to accomplish precisely what the Olmstead Court warned against. The Supreme Court specifically stated: "We emphasize that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings." Olmstead, 527 U.S. 581, 601-602 (1999). The Court's use of the word "condones" must be read to mean that the ADA should not be used as a justification to directly or constructively limit institutional services for Amici. Amici's treating professionals have all determined that Amici are in the least restrictive setting appropriate for their needs.

The Commonwealth cannot fund the proposed Settlement and maintain its current Training Centers. See, VA Sen. Fl. Debate, 3/25/2012, Amendment to Bill No. 1301; Status Conf. Tr. at 50:9-15; 13:12-18; 44:23-45:12]; [Dkt. # 2 at III.C.9]. The proposed Settlement will expand non-entitlement services to individuals who have no right to additional services, while doing so with resources that are taken away from Amici. The DOJ and Commonwealth have proposed depriving Amici of their services by cutting off rights afforded to them by the ADA and the Supreme Court's decision in Olmstead.

C. The DOJ And The Commonwealth Have Colluded To Keep The Public Out Of Their Secretive Agreement

Since the filing of the Complaint and accompanying Settlement Agreement, the DOJ and the Commonwealth have made active attempts to mislead the public as well as the Virginia legislature, and to keep the public out of participating in the Court proceedings on the proposed Settlement Agreement. To begin, the DOJ and the Commonwealth entered into a Settlement Agreement which they filed simultaneously with the Complaint which, on its face, takes rights away from Training Center residents. This maneuver was done to give the appearance that an Agreement was already reached and it was out of the Court's control. The DOJ and Commonwealth exercised this strategy without truly consulting with even one Training Center resident, their guardian, any members of Training Center parents' organizations, or any other representative of the Amici. The terms of the Agreement were reached without the voice of any Training Center resident's or their guardian's participation, even though the purpose of the Agreement is to close the facilities in which they live. Once the guardians for these residents attempted to intervene in the action, the DOJ and the Commonwealth both submitted extensive briefs in opposition to intervention and, within their briefs, knowingly misstated the intervenors' interests in the litigation.

On January 31, 2012 the Secretary of Health and Human Services, Dr. William Hazel, gave a presentation to the Virginia Senate Finance Committee regarding the current system of care for those with ID and DD and the plan for closing four of the Virginia Training Centers and downsizing the fifth, which he indicated was necessary based on costs. See, Exhibit B (Power Point presentation given to the Senate Finance Committee). This presentation was riddled with mistakes containing inaccurate information and misstatements regarding the statistics in the Commonwealth of Virginia as well as misrepresentations regarding the Settlement Agreement

proposed to the Court, rendering cost justifications for closure useless. See, Exhibit G-2 (Report of Dr. Anthony). On March 1, 2012, a parent of a Training Center resident, Dr. Robert Anthony, sent a FOIA request for information to the Secretary of Health and Human Services, William Hazel, regarding the supporting data for his presentation. See, Exhibit C (FOIA Request to Secretary Hazel). In response to his FOIA request, Secretary Hazel's office responded to each request by either stating that the "documents requested constitute working papers of the Office of the Governor and are being withheld pursuant to Virginia Code §2.2-3705.7(2)" or "[n]o documents responsive to this request." See, Exhibit D (Letter from the Office of the Governor). As is seen from this correspondence, the State has taken steps to actively keep the public out and withhold vital information so that it could not be analyzed. Training Center residents provide proof in this brief that State officials are presenting inaccurate information to the Senate Finance Committee which would cause the Committee to think that it must provide funding to carry out the terms of the Settlement Agreement and that Training Centers are a drain on the budget, when they are not. Additionally, counsel for the Commonwealth presented these inaccurate statistics to the Court at the Status Conference in this matter on February 23, 2012, in an attempt to obtain approval for the Settlement Agreement. See, argument regarding supposed cost savings, pages 24-29 of this brief, see also, Exhibit E (Status Conference Transcript).

As a result of these misrepresentations by the Secretary of Health and Human Services, state officials were misled. For example, State Delegate, Dave Albo sent an email on March 28, 2012, to an interested constituent, explaining his confusion with the proposed Settlement Agreement and how it affects the closure of the Training Centers. See, Exhibit F (Email from State Delegate, Dave Albo). This email clearly shows that the proposed Settlement Agreement is unnecessarily vague and contains terms that are misleading to the public and state officials.

There has been a common theme of the actions of the Commonwealth and the DOJ to keep the public out of the approval of the proposed Settlement Agreement and to bypass the rights of the citizens, particularly the residents of the training centers, to inaccurately inform the General Assembly and the Senate Finance Committee as well as this Court, and to go forward with the Agreement without any constructive input from any affected citizen or state government entity.

D. The Settlement Agreement Will Not Result In Cost Savings

The Commonwealth and DOJ have incorrectly stated the cost of providing services to Amici. See, Exhibit E (Stat. Conf. at 52:25 - 53:5); [Dkt. # 35-1 at 3]; see also, Exhibit B (Sec. Hazel's Presentation to Senate Finance Comm.). The Commonwealth has incorrectly represented that "63.8% of all appropriations that fund services for individuals with intellectual disabilities, but only support 15.6% of [the] ID population in Virginia." Exhibit E (Commonwealth Assistant Attorney General, Alyson Tysinger's comments to the Court during the Status Conference in this matter). The source the Commonwealth has cited to support that proposition actually states that 36.2% of all appropriations fund all ICFs/MR in Virginia. See, Lakin et al., "Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2009," at 78, College of Education and Human Development, University of Minnesota, Minneapolis, MN 5545, 2010 available at http://rtc.umn.edu/docs/risp2009.pdf; See, Exhibit G-2 (Report of Dr. Anthony at 1, 4-5), see also, Exhibit D (Secretary Hazel's response to a FOIA request providing the source for these figures). According to the source identified by the Commonwealth (Secretary of the Commonwealth's Department of Health and Human Resources, William A. Hazel) to support its claim, the Commonwealth actually spends 63.8% of

all of its appropriations on Home and Community-Based Waiver Services. Id. This misstatement has been unfairly used to cast Amici as a financial burden, who consume the Commonwealth's resources disproportionately, and justify taking away resources from Amici, despite the protections of the ADA and Olmstead. The Court should reject the proposed Settlement Agreement, because the principal justification of the proposed Settlement is based on faulty data.

Amici have worked with a nationally-recognized expert of quantitative analysis, Robert W. Anthony, Ph.D., to better understand the Commonwealth's and the DOJ's assumptions in their proposed Settlement Agreement. Dr. Anthony prepared a report, which, along with his professional background, is attached to his declaration. Dr. Anthony's declaration is attached here as Exhibit G (Declaration of Robert W. Anthony, Ph.D.). Dr. Anthony has authored over ninety (90) academic publications related to government programs that affected a wide variety of stakeholders and involved forecasting unanticipated impacts. He has spent over 25 years of his career employing quantitative methods to evaluate diverse sets of problems and judging scientifically sound work. See, Exhibit G-1 (Professional Background of Robert W. Anthony, Ph.D.). Dr. Anthony's conclusions note that there are specific, dangerous errors in the proposed Settlement Agreement, most notably the false financial information and assumptions about the impact of the proposed Settlement.

Even if the cost of complying with the proposed Settlement Agreement, which the DOJ and Commonwealth seek to give the force of a consent decree, was neutral, the alternative system proposed by the Settlement would likely result in little or no cost savings to the Commonwealth. Neither the DOJ nor the Commonwealth has undertaken any effort to determine the actual cost decreases or increases associated with their proposed Settlement. Cost

comparisons are complex and difficult to achieve and often reflect differences in the population served and the differences between public and private workforces. Comparing costs between Training Centers and community settings is a complex and difficult task and the results of comparisons have often been inconclusive. Peer-reviewed, published literature on the topic identified a number of factors that affect such cost comparisons. Walsh, K.K., Kastner. T.A. & Green, R.G. "Cost comparisons of community and institutional residential settings: Historical review of selected research." MENTAL RETARDATION. 41, 103-122 (2003). That study presented a review of published cost comparison research studies going back to the 1970s and concluded that the "findings do not support the unqualified position that community settings are less expensive than are institutions and suggest that staffing issues play a major role in any cost differences that are identified." Id. at 103.[6] Given that the only citation the Commonwealth and DOJ have provided for their assumption that the proposed Settlement will result in cost savings was erroneous, it would be reckless to assume that any cost savings would result from implementing the proposed Settlement Agreement.

If legitimate cost savings were important to the Commonwealth or DOJ, they would have undertaken an analysis comparable to their extensive research into how to expand community-based services. An appropriate analysis of cost increases or decreases relative to institutional and community residential services would at least include an analysis of: (1) cost shifting; (2) case mix and functional level of individuals served; and (3) cost variations and staffing.

[6] The Commonwealth should consider whether it wants to obtain any unlikely savings only on the backs of workers who will receive lower salaries in community-based settings because they will be not be state employees with state benefits. Furthermore, and arguably more importantly, these lower wages to service providers can result in lower qualified individuals and much higher turnover rates, which can result in a lower quality of care to the residents of community-based settings. Also, fewer staff are often used in community settings which can be detrimental to the residents.

When comparing the location for providing services, whether in an "institution" or elsewhere, it is common sense to conclude that, for someone with a given set of service and support needs, the costs of services and supports of equal quality are not likely to be drastically different solely because of *where* the services and supports are provided. For example, it is not likely that the costs of an hour of nursing care, or an hour of behavioral consultation, or an hour of physical therapy, will differ drastically in a Training Center or in a group home.

However, what is drastically different between a Training Center and a group home is the source of the funds used to pay for the services. Services in a Medicaid ICF/MR-funded model (i.e., a Training Center) are "bundled," such that all of the services (room, board, professional services, etc.) are included in the rate paid by the Department of Behavioral Health and Developmental Services (DBHDS). In other settings, however, services funded under the Medicaid Home and Community-Based Services waiver (HCBS) program, are "unbundled," such that various components of the cost can be shifted elsewhere. For example, the costs of medical care for a person living in a group home will be paid by the Department of Medical Assistance Services (DMAS, that is, Medicaid) and will no longer be from the DBHDS budget. Therefore a direct comparison between costs paid by DBHDS for a person in an institution and a person in a group home is not an appropriate comparison because the individual's medical services are paid from a different agency. Of course, from the perspective of the taxpayer the costs are the same. Thus, although there may be a cost savings on the DBHDS budget when a person is discharged from a Training Center to a community setting, there is not likely to be a substantial cost savings to the state as a whole when the costs that are shifted elsewhere are included. Although it would be difficult to identify and capture all of the costs in such

comparisons, the Commonwealth and DOJ have made attempt whatsoever. Their representations to the Court and the public are irresponsible.

The comparisons of current costs of serving Amici in Training Centers and individuals served by the waiver programs is equally misleading because they fail to consider the relative mix of services and functioning levels of individuals. There are stark differences between Amici, who are served in Training Centers, and individuals served in community settings. Over the past quarter century, as more individuals have been served in community-based settings, the average functioning level of individuals remaining in Training Centers declined while, in general, the average age increased. In Virginia, more than eighty percent (80%) of individuals residing in Training Centers have severe or profound disabilities. Most Training Center residents have multiple disabilities or associated medical conditions. It is estimated that fifty percent (50%) have associated psychiatric disorders and even more than that exhibit behavioral problems requiring special staff attention. Additionally, more than seventy-five percent (75%) of Training Center residents have some problems with simply walking, dressing, eating, or toileting independently. Although there are a few individuals in community settings with similarly complex disabilities, there certainly is not the same concentration of individuals that reside in the Training Centers.

Comparing the costs associated with these vastly different groups, without adjusting for their striking differences, what researchers call "correcting for case mix," renders comparisons meaningless. When corrections are made for "case mix," comparisons of resource needs in Training Centers and alternative settings are similar.

Research studies tracking the costs of individuals who move from 'institutional" to community settings actually identify costs in excess of the average community costs. For

example, a 1999 deinstitutionalization study analyzing costs of residents moved from an ICF/MR institution into community settings showed that this group, on average, cost $34,000 more (1999 dollars) and had staffing ratios that were nearly 2.5 times higher than existing community residents. Jones, J., Conroy, J.W. & Spreat, S. "Costs of support for the former residents of Hissom Memorial Center" REPORT NO. 8 IN THE OKLAHOMA OUTCOME SERIES (Submitted to the Oklahoma Department of Human Services, Developmental Disabilities Services Division), Rosemont, PA, Center for Outcome Analysis (June 1999).

Further, service costs are known to vary between and within agencies, service systems, and regions. Costs are affected by geography, ownership (state operated or private), funding sources, availability of staffing resources, staffing ratios, and other factors. Such cost variations have been consistently identified in literature addressing service costs. Additionally, service systems change over time as do the costs of services. Finally, workforce costs vary greatly between public and private workers due to pay levels and benefits.

The proposed Settlement Agreement states that the reduction in statewide Training Center census has led to the determination that the Commonwealth continuing to operate "residential services [is] fiscally impractical." [Dkt. # 2-2 at in Section III.C.9]. To the contrary, the Commonwealth's motivation appears to be to fulfill the requirements of an ideology that only values privately-operated community-based services and reduce the number of state workers. Privatizing the services at Training Centers could theoretically save some labor costs, but if it does, it would be because the workforce of private providers are simply paid less than the current state-employed workforce, including treating professionals. The concern, of course, is whether the less well-paid private workforce is able to maintain the extent and quality of services of the Training Centers.

E. Portions Of Settlement Agreement Should Be Stricken Because They Go Beyond The Relief Sought In The Complaint And Are Necessarily Vague Rendering Them Completely Useless And Potentially Harmful To Training Center Residents

"A consent decree must remain within the scope of the pleadings and further the objectives of the law sought to be enforced. Specifically, 'any federal decree must be a tailored remedial response to illegality.'" U.S. v. McKinley County, 941 F. Supp. 1062 (D. New Mexico 1996) (citing Internat'l. Assoc. of Firefighters v. City of Cleveland, et al.. 478 U.S. 501, 525; League of United Latin American Citizens v. Clements, 999 F.2d 831, 847 (5th Cir. 1993), cert. denied, 510 U.S. 1071, 127 L. Ed. 2d 74, 114 S. Ct. 878 (1994)). Given the limited argument that Amici can properly present to the Court, Amici are unable to show fully here that the terms of the proposed Settlement go far beyond the DOJ's lawful enforcement of the ADA.[7] Whether by collusion or other unacceptable cause, the Commonwealth has failed to properly defend this matter and limit relief to the claims asserted in the DOJ's Complaint. Even if the Commonwealth desired to settle this matter, it should have insisted that the Complaint, created only to support the involvement of this Court, only alleged claims that the DOJ could properly maintain. Instead, the overly-broad Complaint, which is discussed more fully in Amici's Memorandum of Law in Support of Intervenors' Motion to Dismiss, which was attached to Amici's Motion for Intervention, has created a false premise on which the DOJ and Commonwealth build an overly broad and oppressive Settlement Agreement. See, [Dkt. # 19-1 at 6].

Nevertheless, significant portions of the proposed Settlement Agreement should be stricken because they are overly-broad and the terms go well beyond the relief that the DOJ could have ever received if this matter was tried to judgment. As noted above, the ADA and

[7] As an intervenor, the Amici would have a full and fair opportunity to develop this argument.

Olmstead only extend rights to individuals residing in institutions. Individuals who are threatened with institutionalization do not have rights to assert pursuant to Olmstead. See, ARC of Virginia, Inc. v. Kaine, et al., 2009 U.S. Dist. LEXIS 117677 (E.D. Va. 2009). Accordingly, the portions of the proposed Settlement Agreement that create programs and services for anyone other than Amici should be stricken. For example, Section III.C. of the proposed Settlement Agreement creates over 3,000 waivers and ancillary services for individuals who do not reside in institutions. [Dkt. # 2-2 at III.C.]. Other sections of the proposed Settlement Agreement assume that those additional individuals are to be served. The Court should strike those provisions of the proposed Settlement because the DOJ could never have obtained such relief based on the causes of action in its Complaint. Arguably, the individuals who would benefit from those waivers could assert a private action based upon the Settlement if they believed the Commonwealth was required to provide specific services that it was not providing. However, no cause of action could be based on the potential risk of institutionalization, which is the DOJ's only allegation in the Complaint that could possibly be a basis for that relief proposed in the Settlement. Independently, the terms of even that overly broad Settlement are so ambiguous that the proposed Settlement should not be approved.

The terms of a settlement agreement must be objective. "Ultimately, the district court should withhold approval of a consent decree 'only if any of the terms appear ambiguous, if the enforcement mechanism is inadequate, if third parties will be positively injured, or if the decree otherwise makes a 'mockery of judicial power'." U.S. v. Archer-Daniels-Midland Co., 272 F. Supp. 2d 1 (D.D.C. 2003) (citing Mass. Sch. Of Law at Andover, 118 F.3d at 783 (quoting Microsoft, 56 F.3d at 1462)). In this matter, the proposed Settlement Agreement contains ambiguous terms, is not clear about the scope of enforcement, will be used to injure Amici, and

mocks the power of the judiciary by proposing to supplant, surreptitiously CMS's ICF/MR regulation of the Training Centers with a system created in a closed room by attorneys for the Commonwealth and DOJ.

The DOJ and Commonwealth have proposed a Settlement that will affect Virginians for at least ten (10) years, but will most likely be extended indefinitely. For instance, in a case brought by the DOJ against the State of Connecticut with much more limited allegations, the parties entered into a consent decree, and the matter took over 23 years to resolve. U.S. v. Conn., et al., 3:86-cv-00252 (D. Conn). More recently, in 2009, Texas settled a similar matter with the DOJ to avoid litigation, entering into a five-year agreement. TX Leg. Bdgt. Bd. Rpt. Jan. 2011 at 13. The estimated annual cost of the agreement to Texas was $112 million. Id. Since it entered its agreement with the DOJ, the Texas legislature has appropriated all funds requested and Texas' Department of Aging and Disability Services has implemented all of the programs demanded by the DOJ. Yet, those changes have not yielded positive results for Texas' disabled citizens. See, SSLC Monitor Reports prepared for DOJ available at http://www.dads.state.tx.us/monitors/reports/index.html. The DOJ will no doubt hold Texas accountable for those shortcomings despite that State's budget crisis. Amici challenge the DOJ to identify any matter where it entered into a settlement agreement like the one proposed in this matter that would function as a consent decree, and the agreement ended by the date identified in the agreement. Given that the proposed Settlement Agreement in this matter is likely to be interpreted by individuals who did not draft it and possibly by other courts, the Court must ensure that the terms of the consent decree are objective. Any subjectivity in the terms will no doubt create inconsistent interpretations later.

The Court should amend, or require the amendment of, the proposed Settlement Agreement, to ensure that the DOJ and the Commonwealth's executive branch cannot use the agreement to compel the legislature to appropriate money. The proposed Settlement should also expressly state what role and rights the legislature retains. The Court's limited reference to the role of the legislature in its March 6, 2012 Order has been repeatedly relied on by legislators, who have contrasted that clarification with contrary information conveyed to the legislature from the executive branch. See e.g,. VA Sen. Fl. Debate, 3/25/2012, Amendment to Bill No. 1301. Such clarification also would be helpful for the Commonwealth's counsel, who, at the Status Conference in this matter responded to the Court's question about whether the proposed Agreement was actually a consent decree because it compels the General Assembly to fund the proposed changes with the following:

> MS. TYSINGER: I don't think this agreement does compel the General Assembly to fund these changes, Your Honor. Now, I think we'd have trouble if they don't.

Status Conf. Tr. at 44:23-45:2. Apparently, this is a reference to the trouble that would result when the Court issues sanctions for non-compliance with the Settlement. If the Commonwealth can be sanctioned for not carrying out the Agreement, which could be many thousands of dollars per day or burdensome injunctive relief that must be paid for, then the General Assembly is compelled to fund the changes.

Similarly, the provisions of the proposed Settlement Agreement that require the Commonwealth to spend resources prior to July 2012 should also be stricken. The Commonwealth operates on a biennium budget. The 2011 General Assembly passed and the Governor signed an amended 2010-2012 budget for the Commonwealth of Virginia which began on July 1, 2010 and will end on June 30, 2012. The resources expended pursuant to that budget

have already been spent or are specifically allocated to services and programs through June 2012.

III. CONCLUSION

The residents of the five Training Centers come now, as friends of the Court, through their guardians, and ask this Court to take notice of their findings with regard to how the Settlement Agreement will adversely affect them and how the States' cost analysis is severely flawed, resulting in a faulty settlement agreement which is in violation of individual rights and is largely incapable of being enforced.[8] The Training Center residents also beg the Court to take notice of how vigorously the DOJ and Commonwealth, and the typical allied advocacy groups that seek to eliminate all public ICFs/MR, have fought to exclude them from this litigation. Also, the Court should note how the DOJ and Commonwealth have misinformed Virginia citizens, the General Assembly and this Court about the ramifications of the agreement, its vague terms, any supposed cost savings, the data supporting its justification, the role of ICF/MR regulations, who can properly assert the rights and protections of Olmstead, and how the Agreement will bind the legislature and Virginians indefinitely. The ramifications of this proposed Settlement Agreement are enormous. Given their disabilities, among other things, most Training Center residents have severe difficulties with any changes to their environment which often makes them incapable of coping with even the most minor change to their daily lives, thus it is imperative that transitions and discharges be done in accordance with the guidelines set forth in the ADA as interpreted by Olmstead as well as the federal ICF/MR guidelines. The guardians of these individuals have a great amount of knowledge about their

[8] Counsel for Amici have received over ninety (90) unsolicited, written requests from guardians of Training Center residents, who have requested that counsel for Amici speak on their behalf at any hearing where such comments would be received by the Court. Amici, who are also the Proposed Intervenors in this matter, intend to file a separate, formal request for permission to have counsel to speak on their behalf.

loved ones' needs and in many instances, have done extensive research with regard to residential options. The Court will surely hear from advocacy groups, as it already has, who will attempt to convince the Court that other issues are at the heart of this litigation, like the Virginia Office of Protection of Advocacy which attempts to convince the Court that this case has some relation to abuse and neglect, when the Complaint contained no such allegation. The Training Center residents urge this Court to ignore irrelevant arguments and to refuse approval of the proposed Settlement Agreement until the parties can produce an appropriate agreement which is not riddled with vague terms, but rather, is consistent with Olmstead, and does not trample on the rights of the individuals it supposedly is meant to benefit.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I, hereby certify that on the 6th day of April, 2012, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which will then send a notification of such filing (NEF) to the following:

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