LEGAL REPORT

The Olmstead Decision: Implications For State Health Policy

This important case establishes a legal standard to measure the adequacy of publicly funded health programs for disabled Americans.

by Sara Rosenbaum

In 1999 the supreme court issued a landmark decision that interpreted the antidiscrimination provisions of the Americans with Disabilities Act (ADA) as they apply to public services. Olmstead v. L.C. builds on several decades of federal legislation aimed at securing community services for persons with disabilities. The decision goes well beyond prior law, however, because it establishes a legally enforceable remedy for measuring the nation’s progress toward this goal. Indeed, the standard against which future state efforts will be measured in the wake of Olmstead bears a striking resemblance to the “deliberate speed” remedy in Brown v. Board of Education.

Background

The plaintiffs in Olmstead, which arose in Georgia, were two women with mental retardation and mental illness, both of whom resided in a mental institution despite the fact that they had been found by state-employed health professionals to be capable of living in the community. Like many states, Georgia offered home and community-based services through its Medicaid program but had only partially funded its program; the waiting list was lengthy. At one point the defendants had proposed to discharge one of the plaintiffs to a homeless shelter in response to her requests for community services.

The legal arguments in the case focused on Title II of the Americans with Disabilities Act (ADA), which provides the following:

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

ADA implementing regulations require public entities to “administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons” and to make “reasonable modifications to avoid discrimination on the basis of disability unless the public entity can demonstrate that making modifications would fundamentally alter the nature of the service, program or activity.”

Writing for the majority, Justice Ruth Bader Ginsburg identified the central issue as “whether the proscription against discrimination [under Title II] may require placement of persons with mental disabilities in community settings rather than institutions.” The Court’s answer was a “qualified yes.”

The Court first held that “unjustified isolation” of persons with disabilities constituted discrimination under the ADA, because of its stigmatizing basis and effects:

In order to receive needed medical services, persons with mental disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reason-
able accommodations, while persons without mental disabilities can receive the medical services they need without similar sacrifices. In reaching this conclusion, the Court rejected as irrelevant the state’s argument that the placements were simply a function of the “institutional bias” of Medicaid program design and law. The majority dismissed this argument as a matter of law, clearly moved by evidence of long waiting lists for Medicaid-funded community services.

The Court then outlined a remedy designed to achieve the ADA’s goal of community care in the most integrated setting appropriate to an individual’s needs, to the extent that such a result can be effectuated with “reasonable modifications.” The Court also clarified the critical issue of which party bears the burden of proof in a claim for community services.

The Court first held that in response to its obligations under the law, a state may “generally...rely on the reasonable assessments of its own professionals.” Second, noting that the “state’s responsibility is not boundless,” the Court held that in fashioning community placements, states were obligated to make only reasonable modifications in programs and services and in doing so could weigh the needs of all persons, including those who required institutional level care.

The Court then set forth its standard:

If...the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace [emphasis added] not controlled by the State’s endeavors to keep its institutions fully populated, the reasonable modifications standard would be met.

The Court also provided guidance regarding the point at which reasonable modifications would become “fundamental alterations.” It identified three relevant factors: the cost of providing services to the individual in the most integrated setting appropriate; the resources available to the state; and how the provision of services affects the ability of the state to meet the needs of others with disabilities. At the same time, the Court placed the burden of proving the existence of a “fundamental alteration” on the state:

Sensibly construed, the fundamental alteration component of the reasonable modifications test would allow the state to show [emphasis added] that in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the state has undertaken for the care and treatment of a large and diverse population of persons with disabilities.

Implications For State Policy And Program Design

In the year since the decision, the questions raised by the Olmstead standard have become clearer. Recent guidance issued by the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR, the lead enforcement agency) as well as several judicial developments, begin to offer answers.

Will complying with Olmstead require states to spend more money? An overriding question on states’ minds is whether complying with Olmstead will require that they spend more money. The legal answer to this question turns on whether additional expenditures would constitute “fundamental alteration” or simply a “reasonable modification.” The answer, hinted at in the decision and more fully addressed in recent cases, is that additional costs alone do not necessarily signify a fundamental alteration. Indeed, the U.S. Department of Justice, whose position was largely adopted by the Court, specifically recognized in its brief that compliance with the ADA could result in “increased overall expenses.”

The ADA defines a fundamental alteration as a modification that requires a basic change in the nature of the service or goods offered. Thus, were persons with disabilities to seek new services and programs that the state had never offered, such a request might be considered to amount to a fundamental alteration. However, where the request is for greater funding of or to modify an existing service, whether the expenditure constitutes a fundamental alteration would depend on the cir-
circumstances identified by the Court.

The likelihood that more money alone would not equal a fundamental alteration is particularly true in the case of Medicaid-financed services. Medicaid provides the lion’s share of all financing for community health services for persons with disabilities. A legally enforceable individual entitlement, Medicaid contains its own standards relating to coverage adequacy, reasonableness, and nondiscrimination. Insufficient funds to support current state plan services has never been a legal defense to a claim for benefits. While neither the ADA nor Medicaid requires that states add services to their state plans as part of their Olmstead implementation plans, courts do not view greater expenditures for existing services as a “fundamental alteration.” Putting the ADA aside, adequate support for covered benefits is a basic Medicaid condition of participation.

Thus, to the extent that states use Medicaid to fund community-based health services for persons with disabilities (and all states do so), their expenditures must be reasonable. In this regard, stagnant waiting lists for home and community care services, particularly in those states that like Georgia have failed to fund the community service slots approved by the Health Care Financing Administration (HCFA), appear to offer courts striking evidence of ADA-related unreasonableness, as well as a violation of federal Medicaid requirements. Furthermore, to the extent that a state attempts to reduce its waiting list by barring additional persons from coming onto this list, such an attempt would be considered a violation of federal law and a basic due-process violation.

Similarly, at least one recent court decision suggests that states cannot unreasonably underven on the level of Medicaid-funded community services furnished to any particular covered person, nor can they require persons who risk institutionalization as a result of inadequate community care to prove that admission would be harmful. This is an important issue. In the case of community services furnished under the Medicaid home and community-based care waiver program, federal regulations place per capita limits on federal contributions to state waiver programs that are tied to a state’s estimates of Medicaid’s annual average per capita Medicaid institutional cost for persons covered by the waiver. Were HCFA to terminate federal financial participation for one or more persons on the ground that a state exceeded this upper limit, then the “fundamental alteration” test might be satisfied. However, available evidence suggests that HCFA permits states to limit their per capita community service expenditures at levels well below the average per capita cost of institutional care. Thus, there would appear to be room for additional expenditures without risking the loss of federal funds.

In short, if additional expenditures could be characterized as a fundamental alteration, such a defense does not seem to be available where Medicaid expenditures on existing services are concerned. To the extent that states have underfunded their Medicaid community service programs in relation to need (as evidenced by stagnant waiting lists for care) or have underfunded services on an individual per capita basis, the “fundamental alteration” defense would not appear to be available.

What populations are covered by the decision? Olmstead concerned adults with mental illness. However, it is clear that the case applies to persons of all ages with both physical and mental disabilities. The HHS OCR and HCFA have interpreted the decision to apply universally.

Furthermore, the Olmstead decision appears to have created three separate subclasses of persons whose needs must be considered: (1) institutional residents whose...
needs can be appropriately met in the community with reasonable modifications; (2) residents who require institutional care; and (3) persons who reside in the community and are at risk for institutionalization because of the absence of care. This last subclass clearly constitutes a large group that extends well beyond existing waiting lists (anecdotal evidence suggests that at least some states have attempted to close their waiting lists). Particularly in those cases in which persons raise both Medicaid and ADA claims and thus trigger federal Medicaid legal protections as well as those afforded under the ADA, courts appear willing to take the needs of all three subclasses into account. HCFA and the OCR also recognize this last subclass. As a result, existing HCFA restrictions on the use of the home and community-based care waiver program to afford care to persons at imminent risk of institutionalization merit careful review.

What level of planning effort will be needed? The OCR/HCFA guidance calls for the development and implementation of a compliance plan as a means of demonstrating compliance with Olmstead. The guidelines indicate that to meet the Olmstead standard, a plan will need to address all population groups as well as the three major subclasses of affected persons. Although the guidelines do not require the compliance timetables being ordered by courts, they do require states to demonstrate that they can “act in a timely and effective manner in response to the findings of any assessment process” to determine need.

Conclusion
The Olmstead decision is new, and it is difficult to fully gauge its long-term effects. As this UpDate indicates, the case contains certain qualifiers regarding the outer limits of states’ obligations under the law, and in the coming years policymakers can expect considerable litigation aimed at applying and enforcing the Olmstead standard. Furthermore, as those who are involved with the development of community services and supports for persons with disabilities will attest, Olmstead’s practical limits are significant, because of the widespread lack of community-based housing, services, and supports.

At the same time, the decision accomplishes what no prior effort has achieved: the establishment of a legal standard for measuring the adequacy of publicly funded health program design for persons with disabilities. In this regard, the case has dramatic implications for the shape and structure of publicly financed health care programs, most notably Medicaid, the largest source of public health care financing for persons with disabilities.

States have the lead responsibility for reshaping health systems to meet the Olmstead standard, if only because in the United States the structure and organization of health care is a uniquely state and local function. However, since Olmstead is a federal civil rights case, it is the federal government—specifically, the HHS Office for Civil Rights—that will set the compliance standards and the courts that will most publicly measure the adequacy of progress.

Because the responsibility for reshaping the most challenging part of the U.S. health care system—service systems for persons with disabilities—falls to the states, adequate federal support will be critical. To that end, Medicaid will play a principal role in financing states’ response to Olmstead. Thus, it is essential that unnecessary federal funding limits be removed. In particular, this will require careful reassessment of the appropriateness of the existing per capita cost formula under the home and community-based care program, as well as the extent to which waived services can be offered to persons at risk for institutionalization.

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NOTES


3. 119 S.Ct. 2187. The court’s record showed that two-thirds of the 2,100 approved “waiver slots” remained unused.

4. 119 S.Ct. 2189.

5. 42 U.S. Code, sec. 12132. A “qualified” person with a disability is one who, with or without reasonable modifications of rules, policies, or practices, meets the “essential eligibility requirements for the receipt of services.” 42 U.S. Code, sec. 12131(2). The term *disability* means a “physical or mental impairment that substantially limits one or more major life activities,” having “a record of such an impairment,” or “being regarded as having such an impairment.” 42 U.S. Code, sec. 12012(2).

6. 28 CFR, sec. 41.51(d) and sec. 35.130(b)(7).

7. 119 S.Ct. 2181. As with many cases in the modern Supreme Court era, the decision was split. Six justices concurred in the judgement (Ginsburg, O’Connor, Souter, Stevens, Breyer, and Kennedy), and three (Thomas, Rehnquist, and Scalia) dissented.

8. Ibid.

9. 119 S.Ct. 2185; and 119 S.Ct. 2187. The dissent vigorously argued that the state’s program design simply called for this form of treatment for individuals with certain conditions and thus drew no discriminatory distinctions. 119 S.Ct. 2194–2195.

10. 119 S.Ct. 2187.

11. 2176 S.Ct. 2189.

12. 119 S.Ct. 2188.

13. Ibid. The plaintiffs had favored (and had won below) an individual-specific balancing test, which would have considered only the cost of institutional care for an individual against the cost of caring for that particular individual in a community setting.

14. 119 S.Ct. 2189.

15. Ibid.

16. 2176 S.Ct. 2189.

17. 119 S.Ct. 2189.

18. 28 CFR, sec. 36.302(a).


20. *Rodriguez v City of New York*, 197 F.3d 611 (2d Cir., 1999) (state is not obligated under the ADA to add coverage for safety-monitoring services to its scope of Medicaid-covered personal care services in the case of persons with mental disabilities).

21. The clearest evidence of the impact of waiting lists on courts can be seen in *Benjamin*, in which the court-ordered settlement included provisions that set a ninety-day timeline for the movement of individuals off of community service waiting lists. See also the settlement in *Rolland v Celluci* (Civ. Action No. 98-30208-KPN, D. Mass., 2000), which establishes a legal presumption of community placement and provides for the scheduled movement of a specified number of individuals into community placements.

22. 42 CFR, sec. 302(d); and *Benjamin v Ohl*.

23. *Sanon v Wing* (No. 403296/98, New York State Supreme Court, County of New York, 2000).

24. 42 CFR, sec. 441.303(f).

25. In the *Sanon* decision, plaintiffs were required to justify their continued eligibility for community services in lieu of institutional placements when community expenditures reached 90 percent of the average cost of institutional care.


27. One of the specific aspects of the *Benjamin* order is that the state ease individual access to waiting list signup.


29. For example, HCFA has rejected a proposal by Maryland to extend home and community-based care waiver services to persons who risk institutionalization within thirty days of assessment.