

Law and the Public's Health

OLMSTEAD V. L.C. AND THE AMERICANS WITH DISABILITIES ACT: IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

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This installment of *Law and the Public's Health* examines the meaning of *Olmstead v. L.C.*¹ for public health agencies administering personal health care programs. Handed down by the U.S. Supreme Court in 1999, *Olmstead* was a landmark decision that interpreted the Americans with Disabilities Act (ADA or the Act) as it applies to public programs and thus is of great relevance to many public health agencies. Following an overview of the decision and its interpretation by lower federal courts, this column concludes with a discussion of the implications of *Olmstead* and its progeny for public health policy and practice.

THE OLMSTEAD DECISION

At the heart of the *Olmstead* decision lies the Supreme Court's interpretation of two intertwined and fundamental legal concepts under the ADA that determine when a court can intervene on behalf of persons with disabilities covered by the Act and order a public agency to alter its programs and services. Under the ADA, courts can order public agencies to make "reasonable modifications" to its programs; however, the modifications may not amount to "fundamental alterations" of the programs, since these types of changes lie beyond the reach of what courts can require and thus are matters for the legislative reform process.

The *Olmstead* case began in Georgia when two women, both of whom were institutionalized in a state inpatient psychiatric hospital, sued the state for failure to provide them with services in a more integrated setting, which they alleged was required under the ADA. The staff of the state institution had deemed community-based services appropriate for both women, and Georgia's Medicaid agency operated a "home- and community-based waiver" program that provided community-based health care and support services for persons deemed at risk of institutionalization. However, of the 2,109 slots approved under the federal waiver program, the legislature funded only 700, leav-

ing Georgia's Medicaid agency unable to fill some two-thirds of the slots; other persons eligible for the waiver program remained institutionalized and were put on a waiting list for community services. The plaintiffs alleged that their unnecessary institutionalization violated the ADA and sought immediate community placement.

It was in this context that the Supreme Court explored in *Olmstead* the tension between reasonable modifications and fundamental alterations under the ADA. The Court began by reviewing Title II of the Act, which prohibits discrimination or exclusion of any "qualified individual with a disability" by public programs.² (The two plaintiffs were "qualified" for the program at issue as defined by the ADA because their mental impairments significantly affected activities of daily life and they were eligible for Medicaid.) Title II and its implementing rules require public entities to make "reasonable modifications"³ to their programs to avoid discrimination on the basis of disability and to offer their services in the "most integrated setting"⁴ appropriate to the needs of qualified persons with disabilities. At the same time, however, the Act limits the reach of the "reasonable modification" requirement, providing that no modification is required if "the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity."⁵

The Court ruled that medically unjustifiable institutionalization of disabled individuals constitutes an ADA violation. Concluding that the power to decide the medical appropriateness of institutional care resides with state employees, the Court also held that agencies must make reasonable modifications to achieve integration in programs and services. The Court refused to establish a "bright line" test for what changes are reasonable as opposed to fundamental because such questions involve a complex determination of fact for courts to determine. At the same time, the Court set out the evidentiary matters that lower courts should consider in Title II reasonable modification/fundamental alteration cases, including evidence of a "comprehensive, effectively working plan for placing qualified persons . . . in less restrictive settings and a waiting list that moved at a reasonable pace not controlled by the state's endeavors to keep the institutions fully populated."⁶ The Court also held that in determining the magnitude of its remedial obligation toward any particular individual seeking a modification,

a state can appropriately weigh the welfare of the entire "class" to which the individual belongs (in this case, the group of mentally disabled individuals in Georgia's Medicaid program), and this includes "taking into account the resources available to the [s]tate. . . ."⁷ Finally, the Court clarified that the burden of proof lay with the state to show that a requested change would fundamentally alter a program and therefore lie beyond the power of the courts to order.

In sum, *Olmstead* set out a complex test for determining when public agencies must make changes in their programs in order to achieve community integration of qualified persons with disabilities. Federal guidance issued by the Department of Health and Human Services (DHHS) in the wake of the decision clarifies that the case applies to all persons with disabilities, not only those with mental disabilities.⁸ The guidance also establishes general standards for planning.⁸ Congress and the Bush Administration also have developed a series of health care, employment, education and training, and housing initiatives that are aimed at supporting state efforts to integrate persons with disabilities into community settings.⁹

COMMUNITY INTEGRATION IN A POST-OLMSTEAD ENVIRONMENT

The standards established by the Court for identifying the circumstances when courts can order modifications in their programs are by no means crystal clear. As is the case with many major Supreme Court decisions involving social policy, the critical issue thus becomes how lower courts reconcile the competing principles in *Olmstead*: on the one hand, the Court's ruling that medically unjustified institutionalization is illegal under the ADA and must be remedied through appropriate integration; on the other, the Court's deference to states' medical discretion and affirmative defenses.

Three post-*Olmstead* cases—all of which involved disabled individuals eligible for their states' Medicaid program—are instructive in terms of how courts have analyzed *Olmstead*'s competing principles. In each case, the court's decision appears to depend on whether the court views the plaintiff's request as one to change a program's essential design or character or merely as one to change program administration. When a court concludes that a case involves program design, it classifies the request as a fundamental alteration and therefore appropriately handled not by the courts, but through the legislative process. When, however, a case is viewed as raising matters of discrimination in program administration, the request is viewed as simply

one for a reasonable modification and therefore within the purview of a court to order.

For example, soon after *Olmstead* was decided, a federal court of appeals ruled in *Rodriguez v. City of New York*¹⁰ that efforts by individuals with mental disabilities to secure "safety monitoring" services in their homes amounted to a request for a change in Medicaid program design. The state covered safety monitoring when tied to a physical care service in the home but not as a freestanding service. As a result, the court concluded that it did not have the power to alter an expansion of coverage and that plaintiffs were seeking a "new benefit."¹¹

Two recent community integration cases also at the federal appellate level preserve the *Rodriguez* rule that changes in what constitutes a covered Medicaid benefit under a state plan amount to a "fundamental alteration"; at the same time, these decisions make clear that some courts may be willing to adopt a more "global" analytic approach to Medicaid coverage when examining community integration claims. Rather than focusing on specific categories of medical assistance services and benefits included in a state plan (e.g., nursing home services; home- and community-based care services), a court may instead frame the request as one to modify an already covered generic long-term care benefit, particularly when there is evidence that the state already covers the services for persons in the plaintiffs' class. Viewed this way, changes in Medicaid coverage become matters of administration (and therefore, subject to the reasonable modification rule) rather than of program design.

This "global" approach to analyzing community integration claims can be seen in *Townsend v. Quasim*,¹² a case in which a group of medically needy Medicaid recipients sued the state of Washington under the ADA over a distinction in how it structured the long-term care services offered under its plan. Categorically needy persons were entitled to both institutional and home care, but the medically needy could receive only institutional care. The plaintiffs were persons receiving home care whose very modest income increases (approximately \$35.00 per month) flipped them from categorically needy to medically needy status. On the basis of this change, they were ordered into institutions.

Rather than framing the case as one that concerned benefit design, the court characterized the case as one that involved Medicaid "long-term care" administration:

Characterizing community-based provision of services as a new program of services not currently provided by the state fails to account for the fact that the state is already providing those very same services. If services

were determined to constitute distinct programs based solely on the location in which they were provided, Olmstead and the integration regulation would be effectively gutted. . . .¹³

Essentially, according to the court, the plaintiffs' claim simply was a request to move the location of long-term care services covered under the state plan, and thus it amounted to a request for a reasonable modification in how the state administered its Medicaid program.

The "global" approach to analyzing community integration claims similarly underpinned the decision in *Fisher v. Oklahoma Health Care Authority*,¹⁴ which involved restrictions on prescription drug coverage for outpatients but not for nursing home residents. The court in *Fisher* concluded that claimants "are not demanding a separate service or one not already provided by the state,"¹⁵ but rather a potential mere change in how the state was administering its prescription drug benefit. Importantly, the *Fisher* court also noted that ". . . [i]f every alteration in a program or service that required an outlay of funds were tantamount to a fundamental alteration, the ADA's integration mandate would be hollow indeed. . . ."¹⁵

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In both *Quasim* and *Fisher*, the facts were particularly important, since both cases involved community residents who faced immediate institutionalization because of program choices made by Medicaid agencies. The cases can be read as evidence of courts' willingness to look beyond Medicaid's detailed statutory structure in order to ensure that states are investing their considerable outlays in long-term care in order to achieve integration. *Quasim* and *Fisher* further suggest that if a state is covering and paying for specific services under its state plan but has configured the benefits so as to cause inappropriate institutionalization for certain groups of beneficiaries, a court may not accept a "coverage design" defense as the end of the matter. Nor will courts accept as a fundamental alteration defense the argument that changing how Medicaid programs are administered might cost more.

These cases carry two implications for public health policy and practice. First, for ADA enforcement purposes, it may be more appropriate to think of Medicaid as underwriting "health care" rather than specific, defined classes of benefits. For example, if a state limits outpatient prescriptions to three per month, as in *Fisher*, it may wish to consider allowing a "medical

necessity" override of the limit to permit additional coverage where the limit raises the risk of unnecessary institutionalization. Similarly, states may wish to seek Medicaid long-term care waivers from DHHS to permit greater flexibility in moving long-term care funds between institutional care and community residence care, as appropriate to need.

Second, the cases also appear to support the notion of aggressive, proactive, and specific state planning in the area of long-term care community integration. Instead of creating legal exposure for states, active planning that delineates the steps to be taken, establishes timetables, and creates plans for state legislatures actually appears to make courts more willing to permit a lengthy time period for achieving the modifications themselves. For example, in *Williams v. Wasserman*,¹⁶ waits for community services of as long as five years were deemed reasonable because the state of Maryland presented strong evidence regarding its years-long effort to restructure its long-term Medicaid program through a combination of state plan amendments and increased appropriations for community care.

In the end, a state conducting its *Olmstead*-related planning efforts might wish to focus on how Medicaid is deployed to achieve reform in the area of long-term care, rather than as a means of covering specific benefits. In other words, in an ADA context, Medicaid programs should be thought of less as a precise insurance contract and more as a means for supporting important revisions in services and supports for persons with disabilities.

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