

Community Integration of Individuals with Disabilities: An Update on *Olmstead* Implementation

By Jennifer Mathis

In June 1999 the U.S. Supreme Court issued a landmark decision in disability rights law, *Olmstead v. L.C.*¹ The plaintiffs in *Olmstead* were two women who had mental retardation and mental illness and were confined in a Georgia state psychiatric hospital for years after the state's professionals determined that they were ready for discharge to a community setting. In a 6-to-3 opinion the Court ruled that unnecessary institutionalization of persons with disabilities is a form of discrimination prohibited by Title II of the Americans with Disabilities Act.² My primary purposes in this article are to review post-*Olmstead* case law on the boundaries of the Act's integration mandate and to discuss arguments that defendants commonly raise on matters other than the merits of the claim, such as the applicability of sovereign immunity. I also briefly discuss states' progress in implementing the integration mandate based on infor-

mation recently collected in two nationwide surveys.

I. The *Olmstead* Decision

The *Olmstead* Court relied on the statutory language of the Americans with Disabilities Act, the interpretations of the U.S. Department of Justice, and a common-sense interpretation of "discrimination" to reach its decision. Title II of the Act provides that "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 subjected to discrimination by any such entity."³ Congress instructed the attorney general to issue regulations that implemented Title II's nondiscrimination provision and were consistent with the "coordination regulations" applicable to recipients of federal financial assistance under Section 504 of the Rehabilitation

¹ *Olmstead v. L.C.*, 527 U.S. 581 (1999) (Clearinghouse No. 52,203).

² *Id.* at 595.

³ 42 U.S.C.A. § 12132 (2001). A public entity includes "any state or local government" and "any department, agency, [or] special purpose district." *Id.* § 12131(1)(A), (B).

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Act.⁴ The coordination regulations contain an “integration mandate,” which states that “[r]ecipients shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons.”⁵

The Justice Department promulgated a regulation requiring public entities to administer their programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities.⁶ Another regulation requires public entities to make reasonable modifications to avoid disability-based discrimination, unless doing so would fundamentally alter the nature of the entities’ programs.⁷

In determining that unnecessary institutionalization violates the Americans with Disabilities Act, the *Olmstead* Court relied on Congress’ explicit finding in the Act that unjustified segregation of persons with disabilities was a form of discrimination and on the Justice Department’s long-standing position that unnecessary institutionalization qualified as discrimination by reason of disability.⁸ The Court concluded that where a person with a disability could appropriately live in a community setting, Title II required a state or

other public entity to provide community-based treatment unless doing so would fundamentally alter the states’ services and programs.⁹

States may generally rely on the reasonable assessments of their own professionals to determine whether a person is appropriate for discharge to the community.¹⁰ If an individual who is found suitable for discharge opposes community placement, the Americans with Disabilities Act does not require a public entity to accommodate the individual with a transfer into the community.¹¹ In determining what would constitute a fundamental alteration of programs, courts must consider the cost of the community placement and the state’s need to serve other individuals with disabilities in an even-handed manner, in light of the resources available to the state.¹² A state could meet the “fundamental alteration” defense by demonstrating “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 not controlled by the State’s endeavors to keep its institutions fully populated.”¹³ Although

⁴ 42 U.S.C.A. § 12134(a) (2001); *Olmstead*, 527 U.S. at 591. The Section 504 “coordination regulations” were promulgated pursuant to Executive Order 11914, 41 Fed. Reg. 17871 (Apr. 28, 1976), which directed the U.S. Department of Health, Education and Welfare to coordinate implementation of Section 504 by all federal departments and agencies that extend financial assistance to any program or activity. The coordination regulations were published in 43 Fed. Reg. 2132 (Jan. 13, 1978) and in 45 C.F.R. pt. 85 (1979). In 1980 responsibility for coordination of Section 504 rules went to the attorney general pursuant to Executive Order 12250. On August 11, 1981, the U.S. Department of Justice issued its own coordination regulations, which are identical to the U.S. Department of Health and Human Services (formerly Department of Health, Education, and Welfare) coordination regulations and appear in 28 C.F.R. pt. 41 (2001).

⁵ 28 C.F.R. § 41.51(d) (2001). The original coordination regulation containing the integration mandate appeared in 45 C.F.R. § 85.51(d) (1979).

⁶ 28 C.F.R. § 35.130(d) (1979); *Olmstead*, 527 U.S. at 592.

⁷ 28 C.F.R. § 35.130(b)(7) (2001); *Olmstead*, 527 U.S. at 592.

⁸ 42 U.S.C.A. § 12101(a)(2), (a)(5) (2001); *Olmstead*, 527 U.S. at 597. The Justice Department took this position in *Olmstead* and previously took the same position in briefs interpreting the Americans with Disabilities Act as well as briefs interpreting Section 504 of the Rehabilitation Act dating back to 1978.

⁹ *Olmstead*, 527 U.S. at 606

¹⁰ *Id.* at 602.

¹¹ *Id.*

¹² *Id.* at 597.

¹³ *Id.* at 605–6. Ira Burnim and Jennifer Mathis’s *After Olmstead v. L.C.: Enforcing the Integration Mandate of the Americans with Disabilities Act*, 33 CLEARINGHOUSE REV. 633 (Mar.–Apr. 2000), analyzes the legal issues raised by the *Olmstead* decision.

the *Olmstead* decision was of tremendous significance to the disability rights community, only a handful of lower-court decisions have interpreted its meaning. Advocates have turned to other theories to seek more or different types of community-based services, particularly the obligation under Medicaid to provide services with reasonable promptness and to give individuals likely to require an institutional level of care a choice between institutional services and feasible community alternatives.¹⁴

II. Litigation Review: Case Law Interpreting *Olmstead*

One issue that has arisen following the *Olmstead* decision is whether states have to expand or alter their Medicaid programs, by either including new optional or waiver services or expanding the services already provided, in order to comply with *Olmstead*.¹⁵

A. Are States Required to Alter Their Medicaid Programs?

At least one district court has held that *Olmstead* may require states to expand their Medicaid waiver programs. In *Makin v. Hawaii* individuals who had mental retardation and were on a waiting list for Hawaii's Medicaid home and community-based waiver program claimed that the program failed to offer all qualified disabled people services in the most appropriate integrated setting because it was placing them at risk of institutionalization.¹⁶ The court found material questions of fact as to whether reasonable modifications should be made to the program in order to satisfy the integration mandate and, if so, whether these modifications would fundamentally alter the program.¹⁷ While the Medicaid statute permits states to "cap" their waiver programs to serve only a limited number of individuals (and thus permits waiting

¹⁴ On the obligation under Medicaid to provide services with reasonable promptness see, e.g., *Doe v. Chiles*, 136 F.3d 709, 721 (11th Cir. 1998) (Clearinghouse No. 51,898); *Kirk T. v. Houston*, No. 99-3253, 2000 WL 830731 (E.D. Pa. June 27, 2000) (Clearinghouse No. 53,375); *Boulet v. Cellucci*, 107 F. Supp. 2d 61, 78-79 (D. Mass. 2000), *Lewis v. N.M. Dep't of Health*, 94 F. Supp. 2d 1217, 1235-36 (D.N.M. 2000), *aff'd on other grounds*, No. 00-2154, 2001 WL 930006 (10th Cir. Aug. 16, 2001) (Clearinghouse No. 54,004); *Rolland v. Cellucci*, 52 F. Supp. 2d 231, 239-40 (D. Mass. 1999) (Clearinghouse No. 52,838); *Benjamin H. v. Ohl*, No. 3:99-0338, slip op. at 29 (S.D. W. Va. July 15, 1999) (Clearinghouse No. 52,677). On giving individuals a choice between institutional services and feasible community alternatives see 42 U.S.C.A. §§ 1396n(c)(2)(C), 441.302(d) (2001); *Boulet*, 107 F. Supp. 2d at 76-77; *Cramer v. Chiles*, 33 F. Supp. 2d 1342, 1352 (S.D. Fla. 1999); *Benjamin H.*, slip op. at 25-27; *Rolland*, 52 F. Supp. 2d at 240-41.

¹⁵ I based section II in part on my *Community Integration of Individuals with Disabilities: An Update on Olmstead Litigation*, 25 MENTAL & PHYSICAL DISABILITY LAW REP. 158 (2001). Medicaid is a joint federal-state program in which participating states receive federal funding to cover part of the cost of providing medically necessary services to eligible low-income individuals. 42 U.S.C.A. § 1396-1396u (2001). The program requires participating states to provide certain "mandatory" services, such as nursing home services and physician services (*see id.* § 1396a(10)(A)), and gives states flexibility to choose among other "optional" services, such as personal care services, prescription drugs, occupational therapy services, dental services, and rehabilitation services (*see id.* § 1396d(a) (setting forth mandatory and optional Medicaid services)). For adult Medicaid recipients, states have some flexibility to determine the amount, duration, and scope of services they will provide within an optional service category. *See Alexander v. Choate*, 469 U.S. 287, 303 (1985). States are also permitted to choose to provide services under "waiver" programs, where certain Medicaid requirements are waived to provide the services to a limited number of eligible individuals. Medicaid waiver programs—which include home and community-based services for individuals who have mental retardation and otherwise would require institutional care and for individuals who otherwise would require nursing home placement—have become an important mechanism for expanding community-based services for individuals with disabilities.

¹⁶ *Makin v. Hawaii*, 114 F. Supp. 2d 1017, 1034 (D. Haw. 1999).

¹⁷ *Id.* at 1035.

lists), Title II's integration mandate may not allow the caps.¹⁸ In other words, the Americans with Disabilities Act may require states to alter the structure of their Medicaid programs in ways the Medicaid statute does not require.

Hawaii failed to show that it had a comprehensive plan "to keep the wait list 'moving at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated,'" or that it otherwise met the fundamental alteration defense.¹⁹ The court rejected the state's argument that increasing the cap would fundamentally alter the waiver program by making it an unlimited program or by forcing the state to fund some individuals in the program exclusively with state funding. The state could always apply to the federal government for an expansion of its waiver program and obtain more federal funding to serve additional individuals, the court said.²⁰ Moreover, the state's plan to increase the number of slots for services over the next several years in order to decrease the waiting list did not, by itself, indicate compliance with the integration mandate.²¹

The Second Circuit in *Rodriguez v. City of New York* addressed a related question: whether *Olmstead* may require a state to offer a new type of Medicaid service.²² Plaintiffs—a class of Medicaid-eligible persons with mental disabilities—sought to have the city include "safety-monitoring" services along with other personal care services in its Medicaid personal care program. They claimed that

without safety-monitoring services they would be unable to continue living in their homes and would require institutionalization.²³ The Second Circuit denied relief; it ruled that the Americans with Disabilities Act did not require a state to offer a new type of Medicaid service in order to comply with the integration mandate.²⁴ The court relied on an *Olmstead* footnote, which provided that "[s]tates must adhere to the [American with Disabilities Act]'s nondiscrimination requirement with regard to the services *they in fact provide*."²⁵ Plaintiffs were requesting new services.²⁶

However, nothing in this footnote or in the *Olmstead* court's discussion of the fundamental alteration defense states that new services would never be required to comply with the Americans with Disabilities Act. In fact, the Court's discussion of the defense makes clear that the only factors to be considered in determining what constitutes a fundamental alteration are the cost of providing integrated services, the resources available, and the needs of others.²⁷ The language cited in *Rodriguez* appears simply to reflect the Court's clarification that the Act does not create an entitlement to a specific "standard of care" but instead requires that, once a state chooses to provide services, it must not discriminate by providing those services in an unnecessarily segregated setting. The language is responsive to the dissent's argument that the majority had interpreted the Act to impose a standard of care.²⁸ Whether other courts will adopt the

¹⁸ *Id.* at 1034–35.

¹⁹ *Id.* (quoting *Olmstead*, 527 U.S. at 605–6).

²⁰ *Id.*

²¹ *Id.*

²² *Rodriguez v. City of New York*, 197 F.3d 611 (2d Cir. 1999), *cert. denied*, 121 S. Ct. 156 (2000) (Clearinghouse No. 52,696).

²³ *Id.* at 613.

²⁴ *Id.* at 619.

²⁵ *Olmstead*, 527 U.S. at 603 n.14.

²⁶ *Rodriguez*, 197 F.3d at 619. New York previously provided safety monitoring services through its Medicaid program but eliminated those services, resulting in the *Rodriguez* lawsuit.

²⁷ *Olmstead*, 527 U.S. at 603–7.

²⁸ *Id.* at 623–24 (Thomas, J., dissenting).

Rodriguez analysis to conclude that *Olmstead* does not require the provision of new services remains to be seen. But the *Rodriguez* analysis appears to rest on a dubious interpretation of *Olmstead*.

Another way in which *Olmstead* may require a public entity to alter its Medicaid program is by altering cost-effectiveness formulas used to determine whether particular services will be covered. In *Sanon v. Wing* a New York state court vacated a local Medicaid agency's decisions to terminate twenty-four-hour personal care services for three women based on a state law forbidding the provision of these services if their cost exceeded 90 percent of the average Medicaid cost of a nursing home placement.²⁹ The women's personal care services were terminated because they exceeded the permissible cost. All three women would require placement in a nursing home when the personal care services were discontinued. The court found that the agency failed to consider what the most integrated setting appropriate would be for these women, as *Olmstead* required.³⁰ Defendants would have to provide personal care services, notwithstanding that they exceeded the maximum permissible cost under state law, unless they could show that doing so would result in a fundamental alteration of the program.³¹ Because defendants had provided twenty-four-hour personal care to other individuals, they could not claim that these services were "new" under the *Rodriguez* analysis.³² Accordingly the agency was ordered to reconsider its determinations in light of *Olmstead* and to weigh any relevant costs not addressed previously such as the possibility of increased hospitalization costs for nursing home residents as compared to hospitalization costs for individuals living at home.³³

B. Are Individuals at Risk of Institutionalization Covered?

An issue that has arisen frequently is whether *Olmstead* applies to individuals who are not currently being served in institutional settings but who are at risk of being institutionalized if they do not receive services in community settings. In *Makin* defendants argued that *Olmstead* was inapplicable because plaintiffs were living at home while the *Olmstead* plaintiffs were institutional patients who challenged their segregation in that setting. The court found "this argument misplaced

The Second Circuit ruled that the Americans with Disabilities Act did not require a state to offer a new type of Medicaid service in order to comply with the integration mandate, but this analysis appears to rest on a dubious interpretation of Olmstead.

since the only alternative for Plaintiffs presently is institutionalization if they seek treatment under the [Medicaid] statute."³⁴ The Medicaid waiver program was designed to serve individuals who would otherwise be institutionalized, so individuals who did not need an institutional level of care were ineligible. Consequently plaintiffs were able to raise a claim under *Olmstead* because they were at risk of institutionalization if they sought services.

Similarly plaintiffs in *Sanon* and *Rodriguez* were living at home when these actions were filed. The *Sanon* court did not require the plaintiffs to wait until they were actually transferred to a nursing facility in order to raise claims under *Olmstead*. While the Second Circuit ultimately dismissed the *Rodriguez* plaintiffs' Title II claim because plaintiffs sought new ser-

²⁹ *Sanon v. Wing*, No. 403296/98, slip op. at 1 (N.Y. Sup. Ct. Feb. 25, 2000) (Clearinghouse No. 52,995).

³⁰ *Id.* at 11–12.

³¹ *Id.* at 12.

³² *Id.* at 13.

³³ *Id.* at 12, 14–15.

³⁴ *Makin*, 114 F. Supp. 2d at 1033.

vices, the district court granted a preliminary injunction based on the irreparable harm of unnecessary institutionalization in a nursing home that would occur without safety-monitoring services.³⁵

The position taken by the U.S. Department of Health and Human Services Health Care Financing Administration and Office for Civil Rights gives further support for the coverage of individuals at risk of institutionalization. Their first guidance to state Medicaid directors regarding the *Olmstead* requirements clarifies that these apply not only to individuals already in institutional settings but also to persons being assessed for possible institutionalization.³⁶ This guidance is consistent with the general law of ripeness: affected individuals need not wait until they are actually harmed before challenging actions that will result in their imminent harm.

C. How Much Is a State Required to Do to Meet the Fundamental Alteration Defense?

In a recent decision a Maryland district court held that Maryland did not violate *Olmstead* by unnecessarily institutionalizing individuals who had traumatic brain injury and individuals who had developmental disabilities but did not have mental retardation.³⁷ The court concluded that all except one of the twelve plaintiffs qualified for community-based treatment but held that for the state to place them in community settings sooner than it did would have been a fundamental alteration.³⁸ The court considered the “totality of the expenses and programs undertaken by the State” and noted that Maryland had a long policy of supporting community-based treatment, had been

gradually closing institutions and expanding community-based programs for people with severe disabilities, was in the forefront of developing certain types of small community settings, had made “dramatic” progress in deinstitutionalizing individuals with disabilities, had developed various Medicaid waiver programs for individuals with certain disabilities to receive community-based services, was the “acknowledged leader” in supporting individuals with severe developmental disabilities in the community, and had initiated a special project to fund community placements for individuals with traumatic brain injury.³⁹

The evidence indicated that, while community-based services were cheaper than institutional services, no immediate cost savings would be realized through downsizing of institutions due to the rise in per-capita costs as the census of an institution decreased.⁴⁰ The most significant cost savings of downsizing would occur after three to five years.⁴¹ Considering the state’s progress in placing individuals with disabilities in the community, the time frame needed to achieve cost savings through institutional downsizing, and the need to maintain a minimum number of hospital beds and fund other individuals needing community-based treatment, the court found that the “immediate shift of resources” sought by the plaintiffs would have resulted in a fundamental alteration.⁴²

D. Does *Olmstead* Create a Right to Remain in an Institution?

While the *Olmstead* decision was based on Congress’ desire to prevent unnecessary institutionalization of individuals with disabilities, litigants have argued that the decision establishes a right

³⁵ *Rodriguez v. City of New York*, 44 F. Supp. 2d 601 (S.D.N.Y. 1999).

³⁶ Letter from the U.S. Department of Health and Human Services Health Care Financing Administration and Office for Civil Rights to State Medicaid Directors 2 (Jan. 14, 2000), available at www.hcfa.gov/medicaid/smd1140a.htm.

³⁷ *Williams v. Wasserman*, No. CIV. CCB-94-880, 2001 WL 1148175 (D. Md. Sept. 27, 2001).

³⁸ Several of the plaintiffs were placed in community settings after the lawsuit was filed. *Id.* at *3.

³⁹ *Id.* at *38–40.

⁴⁰ *Id.* at *41–42.

⁴¹ *Id.* at *42.

⁴² *Id.* at *43.

to remain in an institutional setting. Courts have uniformly rejected these arguments.

In *Richard C. v. Houstoun* family members and legal guardians of residents of a state intermediate care facility for persons with mental retardation attempted to intervene in a settled class action lawsuit that alleged violations of the Medicaid statute, Section 504 of the Rehabilitation Act, and the Fourteenth Amendment.⁴³ As part of the settlement, the state Department of Public Welfare was required to evaluate each resident to determine if community services were appropriate and to develop community placements for eligible class members. As a result, the number of residents diminished, and the governor closed the facility.

Plaintiff intervenors sought to stay further outplacement of class members into the community, as well as to reopen admissions to the facility and give all out-placed members the chance to return.⁴⁴ They interpreted the Supreme Court's decision in *Olmstead* to preclude the placement of an institutionalized person with a disability in a community-based treatment program unless all three of the *Olmstead* criteria were met: (1) the state's professionals determine that such placement is appropriate, (2) the affected persons do not oppose community placement, and (3) the placements can be reasonably accommodated.⁴⁵ The court rejected this interpretation; it noted that *Olmstead* considered the circumstances under which the Americans with Disabilities Act required community placement of institutionalized persons with disabilities. The court said that "it does not logically follow that institutionalization is required if any one of the three *Olmstead* criteria is not met."⁴⁶

A California state court considered a similar argument in *Black v. Department of Mental Health*.⁴⁷ There the administrator of the estate of a decedent with mental illness claimed that the state violated the Americans with Disabilities Act's integration mandate by inappropriately discharging him from a state hospital to a community facility. Plaintiff interpreted *Olmstead* to require that the community placement be consistent with the individual's treatment needs.⁴⁸ He claimed that the decedent was discharged not because discharge served the decedent's medical needs but because the state hospital had closed and other placement alternatives were not available.

The court found that, while the state's conduct might have been actionable under other theories, nothing in the Americans with Disabilities Act, its regulations, or the case law interpreting the integration mandate appeared to prohibit inappropriate discharges into the community.⁴⁹ Interpreting *Olmstead* to mean that a mere failure to provide an appropriate treatment setting violated the integration mandate would effectively delete the phrase "most integrated setting" from the integration regulation and convert incorrect treatment decisions into discriminatory conduct.⁵⁰ Further, the Supreme Court in *Olmstead* clarified that the integration mandate did not impose a standard of care requirement on the states.⁵¹

Like the court in *Black*, a California federal court in *Richard S. v. Department of Developmental Services* ruled that a premature discharge into the community, while perhaps a bad medical decision or poor policy, did not constitute disability-based discrimination pursuant to *Olmstead*.⁵² In *Richard S.* several residents of

⁴³ *Richard C. v. Houstoun*, 196 F.R.D. 288, 289 (W.D. Pa. 1999).

⁴⁴ *Id.* at 291.

⁴⁵ *Id.* at 292.

⁴⁶ *Id.*

⁴⁷ *Black v. Dep't of Mental Health*, 100 Cal. Rptr. 2d 39 (Cal. Ct. App. 2000).

⁴⁸ *Id.* at 48.

⁴⁹ *Id.* at 51.

⁵⁰ *Id.*

⁵¹ *Id.* (citing *Olmstead*, 527 U.S. at 603 n.14).

⁵² *Richard S. v. Dep't of Developmental Servs.*, No. SA CV 97-219-GLT (ANX) (C.D. Cal. Mar. 27, 2000).

a state center for individuals with developmental disabilities and a physician practicing at the center sought to stop discharges from developmental centers; the discharges were occurring as a result of previous litigation. Plaintiffs argued that the discharges violated the integration mandate because the community placements were not equipped to handle the individuals being discharged.⁵³

In addition to plaintiffs' claims that *Olmstead* creates the right to remain in an institution, defendants have raised a related argument: that an integration-mandate plaintiff must specifically plead no opposition to placement in the community. In *Frederick L. v. Department of Public Welfare* the court rejected this argument; it held that a plaintiff's authorization of a lawsuit to enforce the right to services in a community setting meant that the plaintiff did not oppose community placement.⁵⁴

E. When Is an Individual Qualified for Community Placement?

The *Frederick L.* decision held that a formal recommendation of community placement by the state's treatment professionals is not required.⁵⁵ One of the *Frederick L.* plaintiffs did not have a recommendation for community placement apparently because her treatment professional did not believe that a placement was available.⁵⁶ The court held that a state may not avoid its obligations under *Olmstead* by failing to require its professionals to make recommendations for discharge where they are appropriate based on a person's needs rather than on the availability of community placements.⁵⁷

Difficulties in placing an individual in the community do not necessarily render

the individual unqualified for community placement. The *Frederick L.* court held that a community provider's rejection of an individual did not, by itself, render that individual inappropriate for community placement.⁵⁸ A provider had rejected one of the plaintiffs, and the court dismissed the defendants' argument that, based on that rejection, the individual could no longer be considered appropriate for the community. In *Williams v. Wasserman* the court rejected defendants' arguments that plaintiffs were not qualified for community placement because their treatment needs were too specialized to be met in "ordinary community placements."⁵⁹ Notably the *Williams* court also rejected the argument that plaintiffs were not qualified for community placement because hospital environments were at least as integrated as community settings.⁶⁰

F. What Are the Arguments Against Reaching the Merits of Integration Claims?

State defendants in integration cases have begun raising numerous arguments aimed at preventing courts from reaching the merits of integration claims. These include arguments that state entities may not be sued under Title II or Section 504 because Congress did not validly abrogate sovereign immunity under these laws; that state officials in their official capacity are not "public entities" covered by the Americans with Disabilities Act or programs or activities receiving federal financial assistance under Section 504; and that there is no private right of action to enforce the integration regulations under the Americans with Disabilities Act or Section 504. While an in-depth analysis of these arguments is beyond the scope

⁵³ *Id.*, slip op. at 2, 5.

⁵⁴ *Frederick L. v. Dep't of Pub. Welfare*, No. 00-4510, 2001 WL 830480, at *28 (E.D. Pa. July 27, 2001).

⁵⁵ *Id.* at *29.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *Williams*, 2001 WL 1148175, at *34-35.

⁶⁰ *Id.*

of this article, a brief discussion of the relevant case law is in order.

The arguments that Congress did not validly abrogate states' sovereign immunity under the Americans with Disabilities Act and Section 504 are based on the recent U.S. Supreme Court decision, *Board of Trustees of University of Alabama v. Garrett*.⁶¹ In a 5-to-4 decision the Court held that the Eleventh Amendment barred suits in federal court by private individuals seeking money damages for a state's failure to comply with Title I of the Americans with Disabilities Act, which covers disability-based discrimination in employment.⁶² Some courts held that *Garrett's* reasoning applied as well to Title II of the Act.⁶³ Other courts held that Congress did validly abrogate sovereign immunity under Title II of the Act despite *Garrett's* ruling that Congress did not do so for Title I.⁶⁴

Assuming *arguendo* that *Garrett's* holding also applies to Title II, much of the litigation to enforce Title II's integration mandate would not be affected. Notably the *Garrett* Court held that its decision affected only suits for money damages, not suits for prospective injunctive relief against state officials in their official capacities under *Ex parte Young*.⁶⁵ Most suits brought under the integration mandate seek only injunctive relief. The federal government may still enforce Title I against the states in money damage actions.⁶⁶ For the same reasons that *Ex*



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parte Young actions and federal government enforcement are available under Title I, they would also be available under Title II. Finally Section 504 of the Rehabilitation Act may be used to seek more integrated services.⁶⁷ Courts and federal agencies stated that Section 504, which also prohibits discrimination by reason of disability, should be read similarly to the Americans with Disabilities Act

⁶¹ Bd. of Trs. of Univ. of Ala. v. Garrett, 121 S. Ct. 955 (2001).

⁶² *Id.* at 960.

⁶³ See Garcia v. SUNY Health Sciences Ctr., No. 00-9223, 2001 WL 1159970, at *5-10 (2d Cir. Sept. 25, 2001) (saving monetary damage claims only for Title II violations that are based on discriminatory animus or ill will toward people with disabilities); Thompson v. Colorado, 258 F.3d 1241, 1248-55 (10th Cir. 2001) (Clearinghouse No. 54,038); *Frederick L.*, 2001 WL 830480, at *12-18; Neiberger v. Hawkins, 150 F. Supp. 2d 1118, 1121-25 (D. Col. July 9, 2001); Doe v. Division of Youth & Fam. Servs., 148 F. Supp. 2d 462, 484-89 (D.N.J. 2001).

⁶⁴ See Wroncy v. Or. Dep't of Transp., No. 00-35356, 2001 WL 474550 (tbl.) (9th Cir. May 4, 2001) (unpublished); Miranda B. v. Kitzhaber, No. CV-00-1753-HU, slip op. at 18-22 (D. Ore. Aug. 10, 2001); Edwards v. Cal. Dep't of Corr., No. C00-0813VRW, slip op. at 4-10 (N.D. Cal. July 30, 2001); Patricia N. v. Lemahieu, 141 F. Supp. 2d 1243, 1248-50 (D. Haw. Apr. 16, 2001).

⁶⁵ *Garrett*, 121 S. Ct. at 968 n.9.

⁶⁶ *Id.*

⁶⁷ 29 U.S.C.A. § 794 (2001).

to bar unnecessary institutionalization.⁶⁸ Section 504, unlike the Act, is authorized by the Spending Clause, and courts held repeatedly that Congress had authority to condition federal financial assistance on states' waiver of sovereign immunity under Section 504.⁶⁹

To ensure that integration claims survive Eleventh Amendment immunity defenses, plaintiffs in integration cases have begun to name state officials in their official capacity as defendants. Doing so has generated litigation over whether officials are proper defendants under the Americans with Disabilities Act and Section 504. In recent cases defendants argued that Title II of the Act covered only "public entities," and a state official was

not a public entity.⁷⁰ Similarly defendants argued that public officials were not a "program or activity receiving federal financial assistance" for purposes of Section 504. The majority of courts rejected these arguments and held that *Ex parte Young* claims against state officials in their official capacity might be brought to enforce Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.⁷¹

Defendants tried to prevent *Ex parte Young* claims from proceeding under the Americans with Disabilities Act and Section 504 by arguing that *Ex parte Young* claims could not be brought where "special state sovereignty interests" were at stake.⁷² These arguments were reject-

⁶⁸ See, e.g., *Frederick L.*, 2001 WL 830480, at *22-24; *Makin*, 114 F. Supp. 2d at 1035-36 (D. Haw. 1999); Olmstead Update No. 2, Questions and Answers, Letter from the U.S. Department of Health and Human Services Office for Civil Rights and Health Care Financing Administration to State Medicaid Directors 2 (July 25, 2000) (Question 15), available at www.hcfa.gov/medicaid/smd72500.htm.

⁶⁹ *Jim C. v. United States*, 235 F.3d 1079, 1081-82 (8th Cir. 2000) (*en banc*) (Clearinghouse No. 53,607); *Sandoval v. Hagan*, 197 F.3d 484, 492 (11th Cir. 1999), *rev'd on other grounds sub nom.* *Alexander v. Sandoval*, 121 S. Ct. 1511 (2001) (Clearinghouse No. 51,706); *Pederson v. La. State Univ.*, 213 F.3d 858, 875-76 (5th Cir. 2000); *Stanley v. Litscher*, 213 F.3d 340, 344 (7th Cir. 2000); *Litman v. George Mason Univ.*, 186 F.3d 544, 549 (4th Cir. 1999) (Clearinghouse No. 52,564), *cert. denied*, 120 S. Ct. 1220 (2000); *Clark v. California*, 123 F.3d 1267, 1271 (9th Cir. 1997), *cert. denied*, 524 U.S. 937 (1998); *Mrs. C. v. Wheaton*, 916 F.2d 69, 75-76 (2d Cir. 1990). *But see Garcia*, 2001 WL 1159970, at *10-11.

⁷⁰ See, e.g., *Walker v. Snyder*, 213 F.3d 344, 346-47 (7th Cir. 2000) (Clearinghouse No. 53,130), *cert. denied sub nom.* *United States v. Snyder*, No. 00-554, 2001 WL 178198 (Feb. 26, 2001). The Supreme Court's remark in *Garrett* that Title I of the Americans with Disabilities Act may still be enforced through *Ex parte Young* actions can be read as repudiating *Walker's* reasoning. *Garrett*, 121 S. Ct. at 968 n.9. While *Walker* concerned Title II rather than Title I, the result should be no different. In fact, *Walker* was based on the conclusion that there could be no individual liability under Title II because the courts barred individuals from being sued under Title I of the Act. 213 F.3d at 346-47. See *Gibson v. Ark. Dep't of Corr.*, Nos. 01-1038, 01-1114, 2001 WL 1041845, at *1-4 (8th Cir. June 13, 2001) (relying on footnote 9 of *Garrett* to conclude that *Ex parte Young* actions are permissible under Title II of the Americans with Disabilities Act), *Boudreau v. Ryan*, No. 00-5392, slip op. at 14 n.5 (N.D. Ill. May 1, 2001) (Clearinghouse No. 53,950) (questioning the vitality of *Walker* in light of *Garrett* footnote 9).

⁷¹ See, e.g., *Roe #2 v. Ogden*, 253 F.3d 1225, 1233-34 (10th Cir. 2001); *Randolph v. Rodgers*, 253 F.3d 342, 345-47 (8th Cir. 2001) (Clearinghouse No. 53,868); *J.B. v. Valdez*, 186 F.3d 1280, 1286-87 (10th Cir. 1999) (Clearinghouse No. 52,608); *Nelson v. Miller*, 170 F.3d 641, 646-47 (6th Cir. 1999); *Armstrong v. Wilson*, 124 F.3d 1019, 1025-26 (9th Cir. 1997), *cert. denied*, 524 U.S. 937 (1998); *Brennan v. Stewart*, 834 F.2d 1248, 1251-53, 1260 (5th Cir. 1988); *Miranda B. v. Kitzhaber*, No. CV-00-1753-HU, slip op. at 23-30; *Frederick L.*, 2001 WL 830480, at *19-20.

⁷² This argument is based on a portion of the principal opinion in *Idaho v. Coeur d'Alene Tribe of Idaho*, 521 U.S. 261 (1997), concluding that the *Ex parte Young* doctrine was inapplicable in the unique circumstances of that case, which was the functional equivalent of an action to quiet title, based on the impact on "special sovereignty interests" and the fact that a state court forum was available. *Id.* at 281-87. Seven justices rejected this portion of the principal opinion. *Id.* at 291-97 (O'Connor, J., concurring in part); *id.* at 297-319 (Souter, J., dissenting).

ed repeatedly in disability discrimination cases.⁷³

Defendants in integration cases attempted to use the Supreme Court's decision in *Alexander v. Sandoval* to argue that there was no private right of action to enforce the integration regulations of the Americans with Disabilities Act and Section 504.⁷⁴ In *Sandoval* the Court held that there was no private right of action to enforce a "disparate effects" regulation implementing Title VI, which bars discrimination in federally funded programs based on race, color, or national origin.⁷⁵ The Court's decision was based on its conclusion that the regulation went beyond the scope of the statute, which prohibited only intentional discrimination and not conduct that had a disparate effect on minorities. Defendants in disability rights cases argued that particular Americans with Disabilities Act and Section 504 regulations—including the integration regulations, regulations prohibiting the use of "methods of administration" that result in disability discrimination, and regulations requiring reasonable modifications—were beyond the scope of the Act and Section 504. Courts rejected these arguments; they held that unlike Title VI the Americans with Disabilities Act and Section 504 were not limited to redressing intentional discrimination.⁷⁶

III. Other Legal Developments

Besides the courts, the executive branch of government has taken steps to promote the implementation of the *Olmstead* mandate. The U.S. Department of Health and Human Services issued to state Medicaid directors a series of five letters providing guidance on the requirements of *Olmstead*, suggestions for achieving compliance, clarifications of federal rules affecting community services, and policy changes to facilitate states' ability to comply with *Olmstead*.⁷⁷ On June 19, 2001, President Bush issued an executive order supporting swift implementation of *Olmstead*.⁷⁸ The order requires the attorney general and the secretaries of the Departments of Health and Human Services, Education, Labor, and Housing and Urban Development to help states and localities assess their compliance with the *Olmstead* decision, provide technical guidance, work cooperatively with states to achieve the goals of Title II, and ensure that federal resources are used in the most effective manner to support the goals of the Americans with Disabilities Act.⁷⁹ These federal officials must also evaluate the policies, programs, statutes, and regulations of their respective agencies to determine whether any modifications are required to improve the availability of community-based services for qualified individuals with disabilities.⁸⁰

⁷³ See, e.g., *Lewis v. N.M. Dep't of Health*, No. 00-2154, 2001 WL 930006, at *5 (10th Cir. Aug. 16, 2001) (finding no special sovereignty interest in administering Medicaid waiver program receiving federal funding); *J.B.*, 186 F.3d at 1287 (finding no special sovereignty interest in administering welfare program funded in part by federal money); *Marie O. v. Edgar*, 131 F.3d 610, 616–17 & n.13 (7th Cir. 1997) (Clearinghouse No. 51,863) (finding no special sovereignty interest in administering early intervention services); *Robinson v. Kansas*, 117 F. Supp. 2d 1124, 1136–37 (D. Kan. 2000) (finding no special sovereignty interest in financing school system); *Neiberger v. Hawkins*, 70 F. Supp. 2d 1177, 1189–90 (D. Colo. 1999) (finding no special sovereignty interest in welfare of patients adjudicated not guilty by reason of insanity).

⁷⁴ See, e.g., *Frederick L.*, 2001 WL 830480, at *25; *Sandoval*, 121 S. Ct. at 1511.

⁷⁵ *Sandoval*, 121 S. Ct. at 1523.

⁷⁶ *Frederick L.*, 2001 WL 830480 at *25–28; *Access Living v. Chi. Transit Auth.*, No. 00 C 0770, 2001 WL 492473, at *6–7 (N.D. Ill. May 9, 2001).

⁷⁷ Letters from the U.S. Department of Health and Human Services Health Care Financing Administration and Office for Civil Rights to State Medicaid Directors (Jan 14, 2000; July 25, 2000; Jan. 10, 2001), available at www.hcfa.gov/medicaid/olmstead/smdltrs.htm.

⁷⁸ The text of the order can be found at www.whitehouse.gov/news/releases/2001/06/20010619.html.

⁷⁹ *Id.*

⁸⁰ *Id.*

IV. *Olmstead* Implementation: States' Progress

While my primary aim here is to give a litigation update, I also include a brief summary of the efforts states are undertaking to implement *Olmstead*. My intent is not to describe in detail the substance of these efforts, set forth best practices, or analyze state-by-state *Olmstead* responses and bar-

Defendants in integration cases attempted to use the U.S. Supreme Court's decision in Alexander v. Sandoval to argue that there was no private right of action to enforce the integration regulations of the Americans with Disabilities Act and Section 504. Courts rejected these arguments.

riers to *Olmstead* implementation. Rather, based on survey information from the National Association of Protection and Advocacy Systems and the National Conference of State Legislatures, I offer a brief overview of states' progress in their planning.⁸¹

Most states are currently engaged in a fairly preliminary stage of planning to implement the integration mandate. That states are making serious efforts to determine the measures necessary to end unwarranted confinement of individuals in state hospitals, nursing facilities, inter-

mediate care facilities for individuals with mental retardation and developmental disabilities, residential treatment centers, and other segregated facilities is heartening. However, large-scale planning efforts have not progressed very far considering that the integration mandate became effective for state and local governments nine years ago, the first federal appeals court decision confirming that the Americans with Disabilities Act prohibits unnecessary institutionalization was issued seven years ago, and the Supreme Court confirmed this principle of law more than two years ago in the *Olmstead* decision.⁸²

A. National Conference of State Legislatures' Survey

In March 2001 the National Conference of State Legislatures issued a report based on a fifty-state survey of responses to the *Olmstead* decision.⁸³ The conference reported that thirty-six states created task forces or work groups to develop *Olmstead* plans or papers, and some of those states issued progress reports or recommendations not intended to be comprehensive.⁸⁴ Only a few states issued final comprehensive plans.⁸⁵ Most states engaged in planning intended to complete their plans in 2001.⁸⁶ The report attributed the slow pace of planning to such factors as the challenges of reaching consensus among stakeholders and the complexities of planning. The complexities include the need to assess which individuals are at

⁸¹ Elizabeth Priaux, community integration specialist, National Association of Protection and Advocacy Systems, and Wendy Fox-Grage of the National Conference of State Legislatures kindly shared this information with me. The association is compiling information from a survey of advocates in each state concerning the progress of *Olmstead* implementation. The conference, which issued an initial status report in March 2001, is compiling updated information from its survey of state officials and advocates concerning state responses to the *Olmstead* decision. WENDY FOX-GRAGE ET AL., THE STATES' RESPONSE TO THE *OLMSTEAD* DECISION: A STATUS REPORT (Mar. 2001), available at www.ncsl.org/programs/health/forum/olmsreport.htm. The conference will be issuing an updated report within the next few months.

⁸² For the first federal appeals court decision, see *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir. 1995), cert. denied sub nom. Pa. Sec'y of Pub. Welfare v. Idell S., 516 U.S. 813 (1995).

⁸³ FOX-GRAGE ET AL., supra note 81.

⁸⁴ *Id.* at 2.

⁸⁵ *Id.* The National Conference of State Legislatures reported that Missouri, North Carolina, Ohio, and Texas had issued comprehensive plans. North Carolina considered its plan to be in draft version at that time.

⁸⁶ *Id.*

risk of institutionalization, to measure placement activities at institutions, to develop a service infrastructure amid a shortage of direct care staff, to find accessible and affordable community housing, to supply necessary transportation, and to identify funding sources.⁸⁷

The National Conference of State Legislatures has updated its survey and will issue a new report by January 2002. While the conference had expected about 25 state plans to be completed by this time, only about half are complete.⁸⁸ Planning in many states has not proceeded as rapidly as anticipated in part because some state officials were diverted from developing *Olmstead* plans in order to compile applications for “Real Choice Systems Change Grants” made available by the federal government to assist states in enhancing community-based services for individuals with disabilities.⁸⁹ Forty states currently have *Olmstead* task forces. Several of them are opting to expand community-based services without developing a formal plan.⁹⁰ While some states have taken steps to implement portions of their plans, the bulk of the state *Olmstead* plans do not yet have funding appropriated to implement them; in many instances plans await funding deliberations in the upcoming state legislative session.⁹¹ Where states have attempted to rank certain populations according to priority for purposes of short-term planning, they have tended to plan for individuals with developmental and physical disabilities ahead of those with mental illness.⁹²

B. National Association of Protection and Advocacy Systems’ Survey

The National Association of Protection and Advocacy Systems is in the final stages of gathering information from its own nationwide survey of advocates concerning states’ progress in implementing *Olmstead*.⁹³ Common themes emerged from a review of the survey responses from thirty states at the time of my review. Among the problems repeatedly identified by advocates are the lack of time lines for implementing state plans, the lack of a process to assess the appropriateness of individuals for community-based services and the types of services needed, the inappropriateness of assessment tools for particular populations (most frequently for individuals with mental illness and children), the lack of time lines for assessments when such are contemplated at all, the lack of specific planning to move individuals into more integrated settings, the failure to tie recommendations to specific funding requests, the general failure to plan for particular populations (most frequently individuals with mental illness, individuals with brain injury, children, and individuals with multiple disabilities), and the lack of effective *Olmstead* enforcement by the Office for Civil Rights of the Department of Health and Human Services. Significantly advocates from all but a handful of states indicated that the percentage of unnecessarily institutionalized individuals moving out of institutions or off waiting lists had not increased since the *Olmstead* ruling. In those states that did see some increase in movement, the

⁸⁷ *Id.* at 4.

⁸⁸ Telephone interview with Wendy Fox-Grage (Sept. 12, 2001).

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

⁹³ The National Association of Protection and Advocacy Systems distributed a questionnaire concerning various aspects of *Olmstead* implementation to the protection and advocacy agencies for individuals with disabilities in each state as well as other disability advocacy organizations. The questionnaires were distributed in August 2001 and submitted to the association in September 2001. The association was to issue a report summarizing the findings of the survey, which was to be available on www.protectionandadvocacy.com by the end of October 2001. I obtained the survey information from Prialux, *supra* note 81.

increase generally resulted from litigation or the threat of litigation.

1. Assessments

A large number of survey respondents were dissatisfied with the state's assessment of the needs of individuals who are institutionalized or at risk of institutionalization. In many cases, advocates noted that such assessments were not being considered as part of the state's planning. In some cases, advocates expressed concern about the assessment process itself. In South Carolina, for example, advocates claimed from experience that assessments often were based on policy or procedure rather than on an individual's functional needs. Advocates said that Kentucky conducted assessments according to a diagnostic, medical model rather than a consideration of needs. Montana tailored assessments only toward the needs of individuals with developmental disabilities, according to advocates. Some states, such as Wisconsin, did review the adequacy of assessment tools for different populations.

The National Association of Protection and Advocacy Systems, in conjunction with Protection and Advocacy Inc. in California and treatment professionals, has developed a set of general parameters that may be helpful in developing appropriate assessment tools for individuals who have disabilities and are in institutions or at risk of institutionalization.⁹⁴ Some of the key principles in these parameters include the following:

- States must assess each individual to determine the specific supports and services—to promote community inclusion, independence, growth, health, and well-being—that are appropriate and necessary for the individual to live in the community.
- Assessment should be “person-centered” and focus on the person's goals, desires, preferences, abilities, strengths, and skill development needs as well as relevant health, wellness, or behavioral

issues rather than on diagnosis or clinical condition.

- Professionals who prepare assessments or participate in the planning must be qualified, with a knowledge of relevant professional standards, of the full variety of community living arrangements, including the most integrated options, and of the capacities of community systems to meet challenging needs.
- Assessments of the most integrated setting appropriate must be based on an individual's needs and desires for community services and not on the current availability of services and supports.
- People should always be involved in their own assessment and planning and must receive information in a form they can understand to help them make choices.

2. Populations Covered

Many survey responses indicated that certain populations of individuals with disabilities were not being targeted in *Olmstead* planning efforts. For example, almost none of the surveys indicated any *Olmstead* planning for individuals with brain injury. While individuals with mental illness are discussed in virtually every *Olmstead* plan, many of the plans lack any specifics to increase community-based services for this population. Delaware advocates note that individuals with mental illness face huge barriers to community integration because the state has made virtually no efforts to expand available community placements for that population, although it has made substantial efforts to expand community-based services for individuals with developmental or physical disabilities and children through Medicaid waivers. Ohio's plan contains specific recommendations for reducing the number of individuals unnecessarily confined in nursing homes and retardation centers, but with respect to reducing the number of individuals confined in state hospitals for mental health services, it contains mainly vague

⁹⁴ These parameters may be found at www.protectionandadvocacy.com/AssessmentParameters4.htm.

generalities and few plans other than moving Medicaid mental health services into a managed care system. Texas has focused largely on expanding Medicaid waiver services, which do not include community services for most adults with mental illness. It has recommended specific time frames for moving individuals from retardation facilities but not from state hospitals.

Many plans do not provide for the identification and assessment of individuals at risk of institutionalization. For example, many states have not specifically planned for individuals in homeless centers, individuals leaving detention centers, children leaving the school system, children in foster care, children leaving the juvenile justice system, and other individuals who are living in community settings and are at risk of institutionalization. Some plans do include the “at risk” population in their plans but do not state whom they include or how the state plans to identify individuals at risk of institutionalization.

3. Enforcement by the Office for Civil Rights

Many survey responses discussed a lack of effective enforcement of the integration mandate by the Office for Civil Rights of the Department of Health and Human Services. Advocates cited the office’s inadequate resources or power to do anything beyond participate in meetings with the state. New York advocates said that the state openly refused, without any consequence, to cooperate with the office’s investigations. Wisconsin advocates felt that they were “working-together to death” by civil rights officials and that the office was willing to accept any state effort as movement toward compliance. Kentucky advocates said that the office declined to investigate complaints from individuals with state guardians unless the state gave written authoriza-

tion. Colorado advocates indicated that their regional office was holding most complaints in abeyance pending the completion of state *Olmstead* plans.

C. The Health Insurance Flexibility and Accountability Demonstration Initiative

I must say a word about the new Health Insurance Flexibility and Accountability Demonstration Initiative that the federal government announced on August 4, 2001.⁹⁵ In this initiative the Bush administration invited states to apply for Medicaid waivers that would enable them to cover currently uninsured individuals but would require that spending stay at the same level without the additional individuals. The waivers would permit states to make drastic cuts in benefits to Medicaid beneficiaries who are covered through optional eligibility categories and impose new cost-sharing requirements on them. Instead of the comprehensive package of Medicaid services currently available to these individuals, the new initiative would permit states to reduce their benefits to the levels in one of the following benchmark plans: the Blue Cross-Blue Shield option under the federal employees health plan, the state’s plan for state employees, or coverage offered by the health maintenance organization with the largest enrollment in the state.⁹⁶ According to an analysis done by the Center on Budget and Policy Priorities, the initiative

invites states to cut critical health benefits and increase cost-sharing for up to 12 million low-income elderly and disabled individuals, parents, pregnant women, and children without any requirement that states use the resulting savings to expand coverage. As a result, through these waivers, states that wish to do so appar-

⁹⁵ The initiative may be found at the Center for Medicare and Medicaid Services’ www.hcfa.gov/medicaid/hifademo.htm.

⁹⁶ Ctr. on Budget & Policy Priorities, Administration Medicaid and SCHIP Waiver Policy Encourages States to Scale Back Benefits Significantly and Increase Cost-Sharing for Low-Income Beneficiaries (Aug. 15, 2001), *available at* www.centeronbudget.org/8-15-01health.htm.

ently will be able to take actions that can reduce the access of current beneficiaries to health services (because certain services are no longer covered or because some beneficiaries cannot afford the higher copayments they are charged) in order to finance other non-health expenditures or tax cuts.⁹⁷

Thus many Medicaid beneficiaries who are covered under optional categories could lose the community-based services they currently receive if states choose to implement the new waivers in that manner. Many of these individuals are the very people who require the full array of Medicaid services to remain in the community and avoid institutionalization. Whether states will choose to adopt the new health insurance flexibility waivers and how they will implement

them remains to be seen, but these waivers pose a threat of rolling back *Olmstead* implementation.

THE *OLMSTEAD* DECISION'S RECOGNITION OF THE right to receive services in integrated settings continues to have far-reaching effects. In addition to the litigation to enforce the integration mandate and the executive branch's promoting its implementation, a majority of states are fostering community integration of individuals with disabilities. Their progress, however, has been remarkably slow. Nine years after the integration mandate of the Americans with Disabilities Act became binding law for public entities, states are largely engaged in the preliminary stages of planning to reduce unnecessary institutionalization of individuals with disabilities. What plans they have developed appear in many cases to have significant gaps.

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⁹⁷ *Id.*