

***Olmstead v L.C.*: Federal Implementation Guidelines, and Analysis of Recent Cases Regarding Medicaid Coverage of Long Term Care Services for Persons with Disabilities**

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Introduction

This analysis reviews the key elements of the United States Supreme Court's 1999 decision in *Olmstead v L.C.*¹ as well as Federal implementation guidelines issued by the United States Department of Health and Human Services (HHS). The *Olmstead* decision interprets the Americans with Disabilities Act (ADA), whose requirements apply to the use of all public funds. However, Medicaid represents the single largest source of public funding for both institutional and non-institutional services for persons with disabilities. As a result, when States expend Medicaid funds on care for persons with disabilities, two independent sets of legal requirements are triggered: those that are contained in the ADA, and those that are part of Federal Medicaid law. Therefore, this analysis also reviews recent judicial decisions concerning Medicaid coverage requirements in the case of institutional and non-institutional services for beneficiaries with disabilities.

The *Olmstead* Decision and Implementing Federal Guidance

A Brief Overview of the Americans with Disabilities Act

A part of the overall Federal civil rights statutory scheme, the ADA was enacted in response to overwhelming evidence of discrimination against persons with disabilities in employment and employment benefits, the provision of public accommodations, and the operation of services and activities by public entities.² The ADA does not provide specific services or benefits. Instead, as with other civil rights laws, it is remedial in nature and is intended protect persons with disabilities against segregation and discrimination by both public and private entities.

^a This analysis has been supported by both the Substance Abuse and Mental Health Services Administration and the Center for Health Care Strategies, Princeton, N.J.

¹ 119 S. Ct. 2176 (1999).

² *Olmstead* 119 S. Ct. at p. 2181.

An individual is considered disabled within the ADA if he or she experiences one or more physical or mental impairments that “substantially limits” one or more “major life activities.”³ Most forms of mental illness are recognized as disabilities under Federal rules. Persons with substance abuse problems are covered if they have an ADA-level disability unless they are currently using illegal drugs.

The ADA applies regardless of age or disability.⁴ It builds on earlier, more limited efforts to address discrimination against individuals with disabilities.⁵ Title I applies to employment and employment-related health benefits. Title II applies to public services furnished by governmental agencies. Title III applies to certain services classified under the law as “public accommodations.”⁶ Regulations implementing Title II, adopted from the earlier body of regulatory law developed under the Rehabilitation Act of 1973, prohibit discrimination by public entities and require recipients of Federal funds to “administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons.”⁷

The Olmstead Decision

Olmstead v L. C. concerned the meaning of the anti-discrimination provisions under Title II of the ADA. The case involved the long-term institutionalization of two women with mental illness and other conditions, both of whom had been found capable of living in the community with proper supports. In *Olmstead* the Supreme Court held that Title II’s prohibition against discrimination is violated when persons with disabilities are unnecessarily subjected to institutionalization. While the decision confers upon the States the power to determine the necessity of institutionalization through their own health professionals, the Court also held that the Act obligates States to make reasonable modifications in the administration of their public programs in order to eliminate discrimination. States are excused from this obligation only if they are able to demonstrate that a particular modification would constitute a fundamental alteration of their programs and services.⁸ The decision also holds that States can demonstrate compliance with the reasonable modification obligation through a “comprehensive effectively working plan for placing qualified persons” in “less restrictive settings” as well as “a waiting list that moves at a reasonable pace not controlled by the State’s endeavors to keep its institutions fully populated.”⁹

As of August, 2000, more than 200 “Olmstead” complaints (i.e., complaints alleging unlawful segregation or failure to provide public services in the most integrated setting) had been filed with the HHS Office for Civil Rights (OCR), which oversees the implementation of the decision in consultation with the Health Care Financing Administration, which is responsible for Medicaid, the largest of all public programs affected. A review of the first 128 complaints conducted by the George Washington University (GWU) School of Public Health and Health Services during the summer of 2000 revealed that complainants tended to

³ 42 U.S.C. §12102(2).

⁴ 42 U.S.C. §12101; OCR/HCFR Questions and Answers (July 25, 2000) www.hhs.gov/ocr/olmltr2.html.

⁵ Id.

⁶ Id.

⁷ 28 C.F.R. §41.51(d).

⁸ Id. at 2188.

⁹ Id. at 2189.

be non-elderly adults who were institutionalized at the time of filing.¹⁰ Forty-six percent of all complainants whose complaints contained sufficient information to permit findings indicated that they suffered from physical health problems alone; the majority suffered from physical, developmental, and mental disabilities. None of the complaints that could be diagnostically identified indicated mental illness or developmental disabilities alone.

The GWU analysis indicated that services most frequently sought by complainants were housing; home based health care (home health, personal care, homemaker chore); social services (transportation, communication); educational/vocational (cognitive coaching, special educational services under the Individuals with Disabilities Education Act (IDEA), occupational); and durable medical equipment (environmental control unit, hoist lift, other). Only 4% of the complaints sought an assessment of appropriateness for community placement or treatment planning assistance. These low numbers suggest that among the complainants, there was a strong feeling regarding the appropriateness of community residence and that few felt a need for assistance in treatment planning.

Among the complaints that contained sufficient information for analysis, one third indicated that complainants faced a wait for community services. Of these, approximately one third reported waits of between 6 months and one year, a number consistent with the Medicaid waiting list cases discussed below.

Like many landmark civil rights cases, the *Olmstead* decision leaves many matters unanswered. A sample of the major issues that arise as States implement the decision follows. Some of these issues are unique to the decision, while others (such as minimum procedural due process requirements for persons who seek community assessments) are long-standing questions that have arisen in other contexts:

- What is meant by the terms “reasonable modification” and “fundamental alteration” in the context of community based services for persons with mental illness? Would the need to expend additional funds to increase the availability of limited health and support services be considered reasonable or fundamental? What if the issue were not insufficient services but no services at all? Would the creation of new services be considered fundamental or reasonable?
- What powers does a State have to determine the appropriateness of community care? Can a State treat the opinions of its own personnel conclusive and binding? Must a State create a system for resolving disputes regarding the appropriateness of a community placement? What minimum due process elements must the assessment process contain, in light of the fact that the basic issues of segregation and liberty may be at stake?
- What is an “effectively working plan”? Must States have a planning process and if so, what are its minimum elements?

¹⁰ Sara Rosenbaum and Alexandra Stewart, *An Analysis of Olmstead Complaints* (George Washington University School of Public Health and Health Services for the Center for Health Care Strategies, Washington D.C., September, 2000).

- What does it mean for a waiting list to move “at a reasonable pace”?
- What is the meaning of “most integrated setting” in the *Olmstead* context? When does a State’s proposed resolution of a community placement request constitute discrimination, and when are its efforts to be deemed “reasonable modifications”?

Complicating any effort to establish general guidelines for resolving these difficult questions is the fact that the particular answer to any particular question may be very factually sensitive, with the response turning on the facts of an individual case, the types of modifications a State is proposing, and the State’s efforts in light of the full panoply of interests in any given case, including the interests of individuals who do in fact need institutional care.

Federal Guidance

HHS has issued a guidance series since the *Olmstead* decision was handed down.¹¹ These guidelines address a range of issues related to State implementation of the decision and options for using Medicaid to promote services in home and community settings. The guidance is part of a broader Departmental effort involving HHS, the Department of Housing and Urban Development, and other related agencies to undertake a comprehensive review of their programs to ensure that the ADA’s most integrated setting standards are reflected in Federal policy.

1. Initial Guidance (January 14, 2000)

On January 14, 2000, OCR and the Health Care Financing Administration (HCFA) released a joint letter providing a framework for assessing State progress in implementing the decision. The letter also describes a series of key implementation activities.

- A planning process that promotes communication among stakeholders and decision-makers and that places emphasis on the transition of qualified individuals into community settings.
- An individual assessment¹² process that determines how community living might be possible without limiting consideration to what is currently available in the community and with informed choice
- Objective and periodic reviews of all individuals with disabilities in institutional settings (such as State institutions, ICFs/MR, nursing facilities, psychiatric hospitals, and residential service facilities for children) to determine the extent to which they can and

¹¹ Both the Health Care Financing Administration and the HHS Office for Civil Rights maintain “Olmstead” addresses at their websites, where the guidances can be found. See <http://www.hcfa.gov/medicaid/olmstead/olmshome.htm>.

¹² While the letter does not define the term “assessments”, it implies an individual, face to face and thorough assessment of health status, health care needs, and ability with various services and supports, to reside in one or more forms of community settings (e.g., the individual’s own home, a group residence, or with family members).

should receive services in a more integrated setting.

- The involvement of persons with disabilities in individual transition plan development.
- A process for estimating the number of individuals with disabilities who are in institutions and eligible for community services and the development of estimation capabilities.
- The development of assessment protocols that are adequate to identify not only persons who could be de-institutionalized, but also those persons who reside in the community and are at risk of placement in an unnecessarily restrictive setting.
- An assessment of available community based services and the extent to which they are able to serve persons in the most integrated setting as well as identification of improvements that are needed.
- Procedures to ensure that a State can act in a timely and effective manner in response to the findings of any assessment process.
- An assessment of the State's waiting list system and an analysis of mechanisms to improve its operation.
- Assurance that individuals will be able to make informed choices regarding their options.
- An assessment of long term infrastructure improvement needs.

2. July 25, 2000 Letter (Olmstead Update No. 3)

The letter dated July 25, 2000 includes a series of questions and answers and describes options for improving the use of Medicaid to enable persons with disabilities to serve persons in the most integrated setting. Notably, the letter:

- Allows States to begin the transition to community services at the earliest point by allowing approval of a provisional written plan of care covering the first 60 days of transition, while a fuller plan of care is being developed. The provisional plan of care is available to persons who are admitted into the State's waiver program and select community care.
- Clarifies the availability of case management during a 180 day period preceding transition from institution to home
- Allows Federal financial participation (FFP) for environmental modification assessments and clarifies how the service is to be reported for FFP purposes.
- Permits FFP for environmental modifications (e.g., a wheelchair ramp) and clarifies that the death of the individual would not disqualify the State from the receipt of FFP.

- Allows States to make “retainer” payments for personal assistance services for up to 30 consecutive days during periods when individuals may be temporarily institutionalized
- Allows Medicaid coverage of habilitation services (i.e., services designed to assist individuals acquire, retain, and improve self help, socialization, and adaptive skills to reside successfully in home and community settings) regardless of the age of the patient. (Services previously had been restricted to individuals with a disability onset before age 22).
- Broadens, in order to expand community options, the conditions under which payments can be made for services furnished out-of-state to include situations in which convenience or necessity make such care “advisable.”
- Broadens State authority to cover “nurse delegated” services (nursing services that a nurse can legally delegate under State law to a lower level qualified provider) so that beneficiaries can receive care in the most integrated setting possible.
- Prohibits States from requiring that beneficiaries be homebound before they can receive home health services.

3. July 25, 2000 OCR/HCFE Questions and Answers

The July 25, 2000 “Q and A’s” contain important clarifications regarding ADA coverage of persons with substance abuse problems and also expand on the relationship between State planning efforts and OCR investigations of ADA complaints. Specifically, this issuance:

- Restates elements of an “effectively working plan” and encourages State planning
- Indicates that active planning may prompt OCR (the agency empowered to investigate ADA complaints) to “allow plan development to proceed in lieu of investigation” of individual complaints, where the planning process contains the elements outlined by HCFA and OCR.
- Allows States to determine the form of their plans
- Clarifies that the *Olmstead* holding applies to all individuals with disabilities.
- Clarifies that persons with substance abuse problems are covered if they have a disability within the meaning of the ADA, unless they are currently using illegal drugs. Specifically, the OCR/HCFE guidance states as follows:

People with substance abuse problems, except those currently using illegal drug, are covered by the ADA if they have a disability that substantially limits a major life activity. This means that people who have alcoholism, people who are

addicted to non-controlled substances, and people who have a history of drug addiction are covered by the ADA if important life activities are restricted as to the condition, manner, and duration under which they can be performed in comparison to most people. In addition although current illegal drug users are not covered under the Act, persons who use illegal drugs may still be covered if they are discriminated against based on another disability, such as mental or physical impairment that substantially limits a major life activity.¹³

4. January 10, 2001 Letter (Olmstead Update No. 4)

The January 10, 2001 letter addresses State flexibility under the Medicaid §1915(c) home and community waiver program, which is used to finance community services for persons in or at risk of institutionalization. As described in the next section, State obligations under §1915(c) have been the subject of considerable litigation in recent years, as individuals have challenged limits on the availability of services, the under-funding of approved waiver slots,¹⁴ the use of waiting lists, problems of service delay, and the absence of basic due process standards for administering State home care programs.

The January 10, 2001 letter provides the following:

- Clarifies that under the Federal statute, a State must establish a specific upper limit on the number of persons to be furnished with waiver services. This number constitutes a limit on the State's program unless the State asks for more services and the Secretary approves a higher number. In this respect the waiver program is different from normal State plan services in that Federal law authorizes – and requires – States to place an express limit on the number of persons who can receive waiver services.¹⁵ The letter also notes that, to the extent that the ADA requires a greater commitment to community services by a State, the State can either use non-Medicaid funds to meet its obligations or request an increase in the number of approved slots. The letter also clarifies that States may seek approval to expand their waiver programs at any time during the year.
- Clarifies that a State may limit the total number of waiver slots either by placing an express number of persons served in its application to HCFA or through an express appropriations dollar limit.

¹³ <http://www.hcfa.gov/Medicaid/smd72500.htm> (p. 7).

¹⁴ One of the critical facts in *Olmstead* specifically noted by the Court was that at the time that the plaintiffs were being denied home and community services, the State of Georgia had 2200 approved waiver slots but had funded only 700.

¹⁵ Under normal Federal law, any covered service must be sufficient in amount duration and scope to reasonably achieve its purposes. Furthermore, States cannot furnish services to certain categories of individuals and not to others. In these respects, the letter clarifies that the waiver provisions of the law differ from normal State plan requirements.

- Indicates that a State may include in its waiver application a schedule by which the number of persons to be served will be accepted into the program, and that the State must notify HCFA if its actual appropriation is insufficient to meet this schedule.
- Clarifies that once individuals are accepted into a waiver program, they must have the “opportunity for access to all needed services covered by the waiver and the State Medicaid plan.” States may not develop separate service packages for separate sub-groups within the waiver. The access opportunity pertains to “all services available under the waiver that an enrollee is determined to need on the basis of an assessment and a written plan of care/support.”
- Clarifies that States may place reasonable limits or utilization control procedures based on individual needs. Also clarifies that States may not cap the number of persons within the waiver who can receive a particular covered waiver service.
- Clarifies that a State may not limit access to a covered waiver service simply because the spending for such a service category exceeds the amount anticipated in the budget. Only the “overall budget amount” for the waiver can be used to “derive the total number of persons that States will serve in the waiver.”
- Clarifies that the concept of “reasonably prompt” services within waivers (see Medicaid discussion below) is governed by tests of reasonableness.
- Clarifies that the basic Medicaid requirement that services be sufficient in amount, duration and scope to reasonably achieve their purpose applies to waiver programs as well. Also clarifies that a waiver “wraps around” basic State plan services and supplements these services rather than being in lieu of such services. Thus, the sufficiency of a waiver depends on the needs of the select target group, the State plan services available under Medicaid, and the type and extent of waiver services. States are expected to submit waiver proposals that are reasonable and that do not threaten the health or welfare of beneficiaries through insufficient services.
- Clarifies that States may lower the number of persons to be served in a waiver¹⁶ but requires a State to notify OCR and HCFA when the adequacy of an existing waiver is a “material item” in any ongoing litigation or legal proceeding.
- Clarifies that States may lower the number of individuals to be served under their waiver programs¹⁷ but may do so only in a manner that is consistent with their obligation to

¹⁶ See the *Boulet* case in the accompanying table.

¹⁷ Some have suggested that, in light of the findings of fact in the *Olmstead* case regarding the State’s unfunded waiver program as well as longstanding Federal cases (discussed below) that prohibit States from under-funding their Medicaid programs, States might want to reduce the number of approved waiver slots they hold in order to avoid being ordered to fully fund a larger program. The HCFA guidance makes clear that this can be done as an amendment to the State program, but only with certain

protect the health and welfare of persons enrolled in the waiver. Therefore, HCFA must assess the impact of the reduction on the “current waiver population” (i.e., the population approved for coverage under the waiver) before a reduction can be made. The guidance specifically states that “An important consideration is whether a proposed reduction in waiver services would adversely affect the rights of current waiver enrollees to receive services in the most integrated setting appropriate, consistent with the ADA.”¹⁸ The guidance sets forth specific assurances that a State may wish to provide in order to demonstrate that its request will not violate the ADA. Specifically these would include the following types of assurances:

- If the request is approved, the State will still have sufficient capacity to serve current participants in the waiver;
 - No individuals will be removed from the program or institutionalized inappropriately due to the amendment; and
 - The waiver slots are no longer necessary because the State has added the needed services to its basic State plan.
- Clarifies State options to target certain subgroups for waiver services and also clarifies that States may use overlapping target groups since individuals may fall into more than one target group (e.g., physical disability and developmental disability).
 - Clarifies that since waiver services supplement State plan services, States may not require children in waiver programs to receive waiver services in lieu of their EPSDT services.

5. January 10, 2001 Letter (Olmstead Update No. 5, New Tools for States)

This guidance, also dated January 10, 2001, appraises States of options under Medicaid, including the use of §1902(r)(2), to establish higher eligibility standards for persons in need of long term services, the availability of a HUD grant program to assist States develop transition housing, new “real choice” systems change grants to support home and community based services planning, and community based personal assistance grants.

The Medicaid eligibility changes are permanent changes in State coverage options and broaden State flexibility without the need for waivers.

- The letter clarifies that under §1902(r)(2) of the Social Security Act, States have the flexibility *as part of their State plans* (and without the need for any special waivers) to develop special “standards and methodologies” that effectively increase eligibility levels for persons with disabilities so that they can retain Medicaid while living in a community. This means that States are not required to obtain Federal waivers in order to liberalize financial eligibility rules for community residence. The option would permit States to recognize the far higher cost of living incurred by individuals with serious disabilities,

assurances designed to ensure that the reduction in the program does not itself become an ADA violation.

¹⁸ <http://www.hcfa.gov/medicaid/smd11001.pdf> (p. 8).

disregard additional levels of earned income, establish savings accounts, or disregard other types of income that might interfere with eligibility.

Recent Medicaid Cases Addressing Services for Persons with Disabilities

In recent years a series of important cases have been decided regarding State obligations under Federal Medicaid law in the area of long term care. These cases raise claims that are based on the Federal Medicaid statute (as opposed to the ADA). The HCFA letters described above in effect adopt many of the holdings of these cases, particularly in the relationship drawn between States' obligations under Medicaid and the ADA. This section reviews these cases.

Methods

Using standard legal research techniques including computerized case searches of recent decisions and relevant case law reporters, as well as searches of data bases maintained by organizations with legal expertise in Medicaid and the ADA, a total of 10 relevant Federal court decisions¹⁹ from seven of the 11 Federal judicial circuits were identified. These cases are relevant, because they were decided within the past decade (i.e., since the enactment of the ADA)²⁰ and contain holdings that bear centrally on the meaning of the Federal Medicaid statute and regulations in the context of health care for persons with disabilities. In addition, four of the cases also appear to interpret the ADA within a publicly funded health care context. Excluded from these cases are pending cases (i.e., cases in which there has been no decision yet), as well as cases that (at least for the time being) have ended in negotiated settlements.²¹

The results of this search are displayed on the accompanying table. Together these cases appear to form the principal body of evidence to date regarding the most current Federal judicial thinking on the requirements of the ADA in a Title II health care context, as well as the applicable requirements under Federal Medicaid law. Several of the cases were decided in the wake of the *Olmstead* decision, while others precede *Olmstead* and are included because they involve a relevant interpretation of the Medicaid statute.

After the cases were identified, they were reviewed by the author and disaggregated into a series of "decision domains." These decision domains, which were identified through a

¹⁹ Federal courts do not have exclusive jurisdiction under claims brought to enforce the ADA or Medicaid. However, the tendency among advocates is to bring these cases in Federal court where judicial experience with the law tends to be more substantial. For this reason, this analysis is confined to the Federal courts.

²⁰ While these cases are relatively recent, many aspects of their Medicaid holdings, in particular those portions of the holdings that address the procedural due process rights of Medicaid beneficiaries, reflect and are consistent with several decades of Medicaid litigation.

²¹ Two recent settlements were entered in *Rolland v Celluci* (MA) and *Kathleen S. v DPW* (PA).

review of the decisions themselves,²² correspond to the principal decision areas that arise in the course of litigating an ADA/Medicaid case involving treatment-related claims brought by Medicaid beneficiaries with disabilities. For each domain, each court's holding in each case was extracted and presented on the table that accompanies this paper. The table includes several dozen annotations that summarize the key points made by the courts in their holdings.

The cases vary considerably in their posture (e.g., some are at a final judgment stage while others are preliminary rulings and still others are at the appellate stage). In addition, the cases span the entire decade and are relatively few in number. At the same time, by disaggregating the decisions into their principal domains and analyzing the domains across the cases, it is possible to draw certain early conclusions regarding the judicial meaning of the ADA and Medicaid claims in the context of publicly furnished health care for persons with disabilities.

Major Findings

Cases tend to be resolved in favor of plaintiffs. The majority of all decisions to date have been resolved in favor of plaintiffs. Seven of the 10 cases were decided either wholly or principally in favor of the plaintiffs.

Plaintiffs tend to have distinct disability patterns. With respect to the three cases decided in the defendants' favor (*Rodriguez*, *Fallon*, and *Sullivan*), factors not present in the other cases help explain their results. In the case of *Rodriguez*, plaintiffs sought a benefit that, according to the evidence presented in the case, fell outside of the parameters of the State's Medicaid plan, and the parameters were not found to violate any Federal Medicaid law. Because, as discussed below, courts appear to consider an ADA violation to occur under Medicaid only when the State discriminates within the limits of its plan, *Rodriguez* involved a violation of neither Medicaid nor the ADA. The *Fallon* and *Sullivan* cases both were decided either before or immediately after the effective date of the ADA, and years before the *Olmstead* decision construing the obligations of State public programs under Title II. Neither case raised §504 claims (the predecessor statute). Furthermore, in a Medicaid context, the plaintiffs in both the *Sullivan* and *Fallon* cases failed to offer the type of proof that is essential in these cases, namely, evidence that the defendant is not furnishing them with covered services in a prompt fashion and/or is discriminating in provision of ostensibly covered service classes. In short, in *Sullivan* and *Fallon* the plaintiffs appeared to be claiming a right to a service that is *qualitatively* different from what the defendant offers (i.e., small group homes rather than large public residences), but they failed to present evidence that what was offered was not timely or appropriate.²³

With respect to the more recent cases, all of the decisions, with the exception of *Rodriguez*, are wholly or substantially in favor of the plaintiffs. In all cases, plaintiffs were able to show that the services they sought fell well within the limits of the State Medicaid plan and that in

²² Judicial decisions tend to be highly structured. They begin with procedural matters (e.g., is the case properly before the court? Can a plaintiff proceed with his or her action? Is the court empowered to grant a remedy?) and then proceed to the merits.

²³ Indeed the court in *Sullivan* pointedly commented on the poor job done by the plaintiffs' lawyers in briefing the Medicaid issues and offering proof.

failing to furnish the services, the State was in violation of one or more provisions of the Medicaid statute itself. As noted, in several of the cases the relationship of the ADA to the Medicaid claims was addressed, although, with the exception of the *Cramer* decision, discussed below, this typically occurred in a tangential fashion.

The cases tend to involve persons with mental disabilities, typically manifested as a combination of mental retardation and developmental disabilities with additional physical disabilities and mental illness. The frequency of cases involving persons with MR/DD diagnoses may be attributable to the tendency on the part of States to make particularly extensive use of waiver services and community programs for these populations. Children also tend to be significantly represented in the plaintiff population, with the least commonly named subpopulation group being elderly beneficiaries.

Courts find that plaintiffs have enforceable rights under Medicaid and the ADA and view themselves as having the authority to hear the case and fashion a remedy. As with any governmental proceeding, the process is fundamental to litigation. In this regard, cases are won or lost at the point at which courts must decide if the plaintiffs are properly before them and if they have the power to hear the case and fashion a remedy. The accompanying table shows that in the cases displayed that contained decisions on procedural matters, the courts found in favor of the plaintiffs. That is, the court determined that the Medicaid claims at issue involved legally enforceable Federal rights, that (where applicable) the ADA created such rights, and that the court had the power to fashion and impose a remedy. The courts are in no way deterred by the fact that they must make factual determinations from the evidence regarding what is reasonable, although it is clear from cases such as *Sullivan* and *Fallon* that the cases are intensively factual in nature and that a plaintiff would be ill-advised to seek to win such a case on stipulated facts and summary judgment.

With respect to their own powers, in all of the cases that considered the issue, the courts held that the claims for relief fell within the rule of *Ex parte Young*,²⁴ which creates an exception to the Eleventh Amendment prohibition against suits by individuals against States and permits such actions where the individual brings suit for violation of a Federal law and seeks prospective injunctive relief against individuals acting in their official State capacity.²⁵

Finally, it is also worth noting that in the *Lewis* case, which is presented in the table and that was decided subsequent to the Supreme Court's decision in *Kimel v Florida Board of Regents*,²⁶ the court held that, because the ADA is squarely grounded in the Fourteenth Amendment and has a statutory nexus to Constitutional violations, Congress has the power to create individually enforceable remedies under the ADA against State officials. Given the Court's actions in recent years to narrow Congressional powers to enact laws that create individual

²⁴ 209 U.S. 123 (1908).

²⁵ Even where the relief can be characterized as equitable (e.g., back pay of monies owed as a result of ongoing state violations of federal welfare entitlement laws), the *Young* doctrine precludes recovery of a financial award. *Edelman v Jordan* 415 U.S. 651 (1974). This doctrine, however, does not preclude a court from ordering remedies that may have even a significant ancillary impact on a State treasury.

²⁶ 120 S. Ct. 631 (2000).

rights against States, this is an issue around which major litigation can be expected in the coming years.

Courts attach important legal obligations and rights to the benefits and services that are part of a State Medicaid plan design. All of the decisions in favor of the plaintiffs share certain common attributes. In each case, the court determined that the benefits that plaintiffs sought fell within the parameters of the State's Medicaid plan, either as an optional or mandatory benefit. In each case, the courts held that, regardless of whether a benefit is required or optional, once a State includes it in its plan, Federal law imposes certain legal rights and duties, including the right to reasonable coverage levels, the right to select the benefit from among several appropriate benefits, and most importantly in the context of these cases, the right to receive the benefit itself in a reasonably prompt fashion. See *Boulet, Cramer, Doe, Benjamin, McMillan, and Sobky* on the accompanying Table.

In other words, once a court determines that a benefit in fact is covered under a State's plan, it appears to reject any arguments on the State's part that the right is somehow diminished because the benefit is optional or furnished pursuant to a waiver. Similarly, these cases suggest that courts refuse to distinguish between the legal duties that attach to covered required benefits and those that are optional, unless the legal duty itself turns on this classification.²⁷ Thus, courts reject arguments that, with respect to covered optional benefits (which tend to include most of the benefits and services at issue in these cases) States have the legal authority to prevent individuals from applying for the benefits, take unreasonable periods of time to furnish the benefit, or fail to furnish the benefit at a level sufficient to meet Federal requirements of reasonableness.

In applying Federal Medicaid and ADA law, courts reject budgetary defenses in the case of services covered under a State Medicaid plan. In all of the cases that considered this issue, once the court found that the service fell within the limits of the State's Medicaid plan, it also rejected a State's budgetary defenses regarding its obligation to furnish the service (*Cramer, Doe, Benjamin, Boulet, Sobky*). The fact that States cannot raise a budgetary defense for their failure to furnish the Medicaid services they cover (whether required or optional) up to the law's legal requirements is not only a long-standing tenet of Federal Medicaid judicial case law but is consistent with the essence of Medicaid itself (i.e., an individual entitlement to a defined set of services).²⁸ As a corollary, in at least one case (*Boulet*), the court found that the State must live up to its representations regarding State plan coverage regardless of whether Federal financial participation was available to meet the cost of the service in the plan (in this case, room and board).

²⁷ For example, in *Rodriguez* the court held that the Medicaid non-discrimination regulation did not apply because the case concerned a benefit that was optional for adults (i.e., personal care services). Were the case to focus on a §1905(a) benefit for a child, presumably the result would have been different, since all §1905(a) benefits are required. The *Rodriguez* reading of the required/optional distinction is not shared by all courts. See, e.g., *White v Beal* 555 F. 2d. 1146 (3d Cir., 1976).

²⁸ See, e.g., *Alabama Nursing Home Association v Harris*, 617 F. 2d 388 (5th Cir., 1980), which has been relied on by virtually all of the Federal courts that ever have considered this issue.

The most interesting decision in the context of budgetary defenses is the *Cramer* decision, noted on the table. In *Cramer*, the court held that the State's failure to adequately fund the community services it purported to cover in its State plan not only constituted a violation of Federal Medicaid law but also was evidence of unlawful discrimination under the ADA, particularly where the evidence showed that the State simultaneously provided funding for large institutional placements. It is the *Cramer* decision therefore that provides real insight into how courts view at least one of the dimensions of the ADA/Medicaid intersection. That is, where a plaintiff can show that the defendant is not only failing to fund its Medicaid program up to legally required levels but also is failing to fund properly the very services and supports that are essential to community placement (e.g., hundreds or thousands of approved but unfunded community placement slots under a §1915(c) waiver), a court might also find an ADA violation.

Similarly, a court might find a violation of the ADA were a plaintiff to show that a defendant furnishes large-scale institutional services within a prompt time-frame but maintains a much slower pace with respect to community placements, even when funded, or places steep restrictions on community services while refraining from such restrictions for institutional care. Thus, in *Cramer* and *Benjamin* the issue was not just the long wait for care but the inadequacy of the service that was made available.

Simultaneously, courts refuse to read either Medicaid or the ADA as requiring States to make substantive modifications in the design of their Medicaid plans in the absence of a clear Federal obligation to do so, regardless of the beneficial nature of the service. Just as courts reject a budgetary defense in cases in which a service is shown to be covered, they also appear to reject as not supported by either Federal Medicaid or ADA legal principles any argument that as a matter of law, a State must add or expand services covered under its Medicaid plan, regardless of the merits of the services that are sought. The *Rodriguez* case, which is consistent with earlier case law under §504 of the Rehabilitation Act,²⁹ best illustrates this issue in the court's rejection of both ADA and Medicaid claims regarding services that the plan did not cover and in the court's view had no legal obligation to cover. Thus, while no case appears to have squarely confronted the issue yet, it would appear that a State could defend as a fundamental alteration a claim for a Medicaid benefit that is not already enumerated under the State plan and whose addition to the plan is not required as a separate matter of Federal Medicaid law. This is the essence of the *Rodriguez* holding.

²⁹ *Alexander v Choate* 105 S. Ct. 712 (1985) (holding that a State Medicaid plan need only extend covered services to all similarly situated beneficiaries equally and without regard to disability and that a State need not provide additional coverage to persons with disabilities).

Lessons and Implications

From this review of relevant Federal ADA and Medicaid decisions to date in the context of Medicaid funded health services for persons with disabilities, it appears that several lessons can be drawn.

- 1. At least for the time being, Federal courts recognize the existence of individually enforceable rights under both Medicaid and the ADA and consider themselves empowered to enforce the law on a prospective, injunctive basis.**

Taken together, the decisions point to a consensus among lower courts regarding the procedural matters that determine whether or not cases such as these can be tried at all. It is possible that the Supreme Court, which has spent considerable time in recent years on issues related to Congressional regulation of States and State liability to individuals under Federal law, ultimately may narrow the field still further. For now, however, States can expect active efforts by affected individuals to enforce the law.

Given the presence of advocacy organizations and the emphasis on the deinstitutionalization of persons with mental disabilities and cognitive impairments, States perhaps also can expect a particular emphasis on litigation by individuals whose primary disabilities place them within this overall group. Furthermore, given the strength of the coverage mandate in the case of children, States probably can expect numerous individual enforcement actions by children.

- 2. Underlying the decisions is an assumption on the part of Federal courts that, within the coverage limits set out in their Medicaid plans, States have an obligation not merely to pay for a service when it is received, but actually to assure that a beneficiary is actually able to secure the covered service within a reasonable time period and up to reasonable levels.**

If there is a single theme that binds the principal decisions for the plaintiffs together, it is the theme that beneficiaries are entitled to the Medicaid services up to the level that coverage is federally mandated and furnished in a reasonably prompt fashion. The obligation of a State once it represents a service goes well beyond mere payment for it, and at least one court has had no problem holding the State obligated to a coverage level based on the wording of its State plan that exceeds the level of services for which FFP is available. For the courts, this principle of an absolute duty to cover benefits up to the limits of the State plan and to furnish services in a timely fashion is the essence of what separates Medicaid as an entitlement from other public sources of health care financing.

- 3. Courts do not appear to hesitate about getting involved in an effort to determine from the evidence what is “reasonable,” both service-wise and time-wise and tend to see these issues as matters that fall well within their judicial competence. This inclination is a reflection of not only longstanding judicial conduct but also of both the fabric of Medicaid and the ADA as well as the *Olmstead* decision itself, all of which turn on the meaning of the term “reasonable.” Finding an answer to this question is a manifestly judicial activity.**

Consistent with their willingness to find enforceable rights and duties, the courts in these cases show little hesitation regarding their enforcement role. These cases are intensely factual in nature, and their resolution turns on carefully weighing evidence regarding what is a reasonable set of expectations. Courts view these cases not as amorphous statements of Congressional preferences but as involving judicially enforceable rights, and thus well within their purview.

What is also evident here is the parallel nature of many of the key ADA and Medicaid concepts. The notion of reasonableness lies at the heart of both Medicaid and the ADA, just as non-discrimination is a concept that is common to both laws (in Medicaid's case, arguably for required services only). Under neither law is a public entity obligated to furnish a particular service or benefit in the absence of a clear Federal obligation to do so. However, under both laws, public entities incur an obligation to furnish what they promise in a reasonable and non-discriminatory way. Thus, just as a budgetary defense under Medicaid would be rejected because of the program's entitlement nature, such a defense appears not to be viable in an ADA context at least where the defense is raised in the context of claims regarding discrimination in public expenditures. Cases such as *McMillan*, *Cramer*, and *Lewis* all suggest that a State cannot fund large public Medicaid institutions while failing to fund the community services it purports to offer under its plan without running afoul of not only Medicaid but also, Title II of the ADA.

4. Medicaid cases involving persons with disabilities are heavily factual in nature and turn on the ability of plaintiffs to show discriminatory *administration* through the denial of appropriate, *covered* community services. Thus, the distinction between design and administration is of overwhelming importance in determining how far a court will go in deciding whether the services sought must be furnished.

It is evident that these cases are heavily factual in nature. To prevail, plaintiffs must show that in their cases they have not been given access to medically appropriate covered services. They might be in an institution when they mount their cases or they might be living unserved or underserved in communities. Regardless, within a health care context, both Medicaid and the ADA essentially require the same type of proof.

At the same time, the cases at least suggest that States will be able to defend by showing that the services that plaintiffs seek fall outside of the four walls of their State plans and that revising the plan would be tantamount to a fundamental alteration under the ADA. Thus, unless the alteration is required under Federal Medicaid principles, the defense would appear to turn on the same set of factual elements.

In this regard, the cases also underscore the extraordinary importance of the actual wording of State plans. Reading the cases is a strong reminder of how unclear the limits of coverage can be. What is in or out of the State plan, what HCFA specifically has or has not approved, probably will make the difference between a prevailing plaintiff or defendant.

In many respects, what States cover under their plans is a function of Federal statutory requirements and agency interpretation of what these requirements mean in a State plan context. Services that may be optional in certain aspects may be required in others, as is the case with services for beneficiaries under age 21. In the end, the decision regarding what services will go into a plan is a function of the policy and politics of Medicaid coverage. But the clear message of these decisions is that the courts will pay very close attention for both ADA and Medicaid purposes to what a State promises in its Medicaid plan, regardless of whether the service is required or optional, traditional State plan or waiver. Courts will respect the flexibility of States to make judgments within the limits of Federal law, but they will hold States accountable for their decisions once they are made.

It is obviously impossible to give a long-term projection of the Medicaid/ADA legal framework, since ultimately its structure turns on cases yet to be decided. But this preliminary analysis of the two laws, as they have been interpreted by courts to date, suggests that the answers to the basic questions that flow from the *Olmstead* decision will come over years, not months.

5. **While a State cannot be required to expand its Medicaid plan design, at the same time, reducing the availability of Medicaid services may be the type of plan administration activity that triggers ADA scrutiny**

The HCFA letter dated January 10, 2001 discussed above makes clear that while States have the option to change their State plans, the alteration of a State plan is in and of itself an act of plan administration that must be scrutinized for its potential impact on individuals with disabilities. An effort to alter a Medicaid State plan that unnecessarily forces individuals into institutions or lengthens the delay in securing services in the most integrated settings may in fact be a violation of the ADA. Thus, while a State cannot be required to expand its plan to offer services that previously were uncovered, a State's efforts to reduce the scope of its plan may be scrutinized for its ADA implications.