Olmstead Implementation

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INTRODUCTION

On June 22, 1999, the U.S. Supreme Court issued its decision in *Olmstead v. LC*, a lawsuit against the State of Georgia which questioned the state's continued confinement of two individuals with disabilities in a state institution after it had been determined that they were ready to return to the community. The court described Georgia's actions as "unjustified isolation" and determined that Georgia had violated these individuals' rights under the Americans with Disabilities Act (ADA). Because of the *Olmstead* decision, many states are now in the process of: (1) implementing "*Olmstead* Plans" that expand community-based supports, including new integrated permanent supportive housing opportunities; (2) implementing *Olmstead*-related settlement agreements that require thousands of new integrated permanent supportive housing opportunities to be created in conjunction with the expansion of community-based services and supports; or 3) implementing other related activities, such as Medicaid reform, that will increase the ability of individuals to succeed in integrated, community-based settings.

ADMINISTRATION

The U.S. Department of Justice (DOJ) is the federal agency charged with enforcing the ADA and *Olmstead* compliance. Other federal agencies, including the Departments of Housing and Urban Development (HUD) and Health and Human Services (HHS), have funding, regulatory and enforcement roles related to the ADA and *Olmstead*. Protection and Advocacy (P&A) agencies in each state are federally authorized and also have legal, administrative and other appropriate remedies to protect and advocate for the rights of individuals with disabilities.

HISTORY

In its 1999 decision in *Olmstead v. L.C.,* the Supreme Court found that the institutionalization of persons with disabilities who were ready to return to the community was a violation of Title II of the ADA. In its decision, the court found that indiscriminate institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life. The court also found that confinement in an institution severely diminishes everyday life activities, including "family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

The court was careful to say that the responsibility of states to provide health care in the community was "not boundless." States were not required to close institutions, nor were they to use homeless shelters as community placements. The court said that compliance with the ADA could be achieved if a state could demonstrate that it had a "comprehensive and effectively working plan" for assisting people living in "restrictive settings," including a waiting list that moved at a "reasonable pace not controlled by the state's endeavors to keep its institutions fully populated."

Historically, community integration was achieved by moving people out of large, state-run institutions into community settings — deinstitutionalization. But in the past decade, there has been increasing scrutiny on ways that certain types of large, congregate residential settings in the community are restrictive, have characteristics of an institutional nature, and are inconsistent with the intent of the ADA and *Olmstead*. Such facilities are known by a variety of names (e.g., adult care homes, residential care facilities, boarding homes, nursing homes, assisted living), but share similar characteristics, including a large number of residents primarily with disabilities, insufficient or inadequate services, restrictions on personal affairs, and housing that is contingent upon compliance with services. Some states, including North Carolina, Illinois, and New York, have been sued for over-reliance on such facilities, and are now implementing settlement agreements with DOJ and/or state P&A agencies to correct for these issues. Recent *Olmstead* settlement agreements, for example in New Hampshire and

Delaware, also cover people with mental illness who are at risk of institutionalization, such as those who are homeless or have insufficient services to support integrated community living. Advocacy groups and potential litigants are now also examining the lack of integrated employment opportunities in an *Olmstead* context. For example, settlement agreements now exist in Rhode Island and Oregon regarding persons with intellectual and developmental disabilities unnecessarily segregated in "sheltered workshops" and related day activity service programs.[1]

SUMMARY

On its *Olmstead* website,[2] DOJ defines the most integrated setting as:

> "a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible. Integrated settings are those that provide individuals with disabilities opportunities to live, work, and receive services in the greater community, just like individuals without disabilities. Integrated settings are located in mainstream society; offer access to community activities and opportunities at times, frequencies, and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with nondisabled persons to the fullest extent possible. Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings. By contrast, segregated settings often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities."

States with *Olmstead* litigation or settlement agreements, as well as states trying to comply with *Olmstead* through proactive strategies, are intently focused on expanding access to integrated permanent supportive housing opportunities for people with significant and long-term disabilities. *Olmstead*-related settlement agreements in Illinois, Georgia, North Carolina, Virginia, New Jersey, Delaware, and New Hampshire could result in 30,000–40,000 new permanent supportive housing opportunities, and the likelihood of future litigation in other states would increase this estimate.

Housing affordability is a critical issue for states working to comply with ADA requirements because most people with disabilities living in restrictive settings qualify for federal Supplemental Security Income (SSI) payments that average only 20 percent of median income nationally. As federal housing assistance is so difficult to obtain, several states (including Georgia, Mississippi, New Jersey, and North Carolina) have created or expanded state-funded rental subsidies directly related to their *Olmstead* efforts. These state rental subsidies are typically designed as "bridge" subsidies to help people until a permanent HUD subsidy can be obtained.

In June of 2013, HUD issued *Olmstead* guidance to provide information on *Olmstead*, to clarify how HUD programs can assist state and local *Olmstead* efforts, and to encourage housing providers to support *Olmstead* implementation by increasing integrated housing opportunities for people with disabilities.[3] HUD's guidance emphasizes that people with disabilities should have choice and self-determination in housing, and states that "HUD is committed to offering individuals with disabilities housing options that enable them to make meaningful choices about housing, health care, and long-term services and supports so they can participate fully in community life."

HUD also advises that "for communities that have historically relied heavily on institutional settings or housing built exclusively and primarily for individuals with disabilities, the need for additional integrated housing options scattered through the community becomes more acute." HUD 504 regulations require that HUD and its grantees/ housing providers administer their programs and

1 http://www.justice.gov/opa/pr/department-justice-reaches-landmark-americans-disabilities-act-settlement-agreement-rhode

2 http://www.ada.gov/olmstead/q&a_olmstead.htm

3 http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2013/HUDNo.13-086

activities in the most integrated setting appropriate to the needs of individuals covered by the ADA. HUD's guidance does not change the requirements for any existing HUD program, but points out that requests for disability-specific tenant selection "remedial" preferences may be approved by HUD's Office of General Counsel (OGC) if they are related to *Olmstead* implementation.

PROGRESS MADE IN 2016

Several states continued to address *Olmstead* in 2016 as a result of proactive planning and implementation, investigations, and settlement agreements. Key federal initiatives that assisted states in making progress toward *Olmstead* compliance included:

- In February 2016, the Centers for Medicare and Medicaid Services (CMS), HUD, and SAMHSA implemented technical assistance (TA) to states through the Innovation Accelerator Program (IAP) for community integration.[4] The TA supported the efforts of over 30 states to increase their capacity to use Medicaid to pay for housing-related services[5] for vulnerable populations and to increase access to integrated supportive housing by strengthening relationships between Medicaid and other state services and housing agencies. State Medicaid, Mental Health, and Substance Use Disorder agencies spent much of 2016 exploring new, as well as expanding existing, Medicaid authorities to provide coverage for Pre-tenancy and Tenancy Sustaining services and supports.
- Also in February 2016, the United States Interagency Council on Homelessness (USICH) issued a brief on the alignment of *Olmstead* and homelessness, highlighting the importance of aligning policy and practices as a means to maximize access to supportive housing resources rather than fragmented approaches that address supportive housing for disabled and homeless groups separately.[6]
- States awarded HUD Section 811 Project Rental Assistance (PRA) continued making new units available in integrated multifamily developments (see article in this Guide). States also began accessing national Housing Trust Fund (HTF) allocations to support the availability of rental housing for extremely-low-income (ELI) households for the production, preservation, rehabilitation, and operation of rental housing, primarily for ELI households.
- State Medicaid agencies and their Mental Health and Intellectual/Developmental Disabilities counterparts began or continued implementation of their approved Home- and Community-Based Services (HCBS) transition plans to ensure compliance with the HCBS Final Rule. States have a strong interest in achieving compliance with the Final Rule, as a substantial amount of Medicaid HCBS funds are used by states to reimburse services provided to individuals living in integrated settings, thereby reducing the high costs of serving persons with disabilities in institutional settings.[7] Only persons living in community-integrated settings as defined in the rule will be eligible for HCBS funded services beginning in 2019.
- On October 31, 2016 the Department of Justice issued guidance on the application of the ADA's Integration Mandate and *Olmstead* to state and local governments' employment service systems.[8] In its statement, DOJ affirms that the integration mandate applies not only to where an individual with disabilities lives, but also to where they spend their days, including at work. The guidance includes criteria to determine "the most integrated setting" for employment services for an individual with a disability, and a process to ensure that individuals with disabilities have access to competitive, integrated employment. The DOJ has entered into settlement agreements that require states to expand the services and supports available in integrated employment settings.

4 https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/community-integration-ltss/ci-ltss.html

5 Housing-related services are services designed to support successful tenancy in an integrated housing setting. Medicaid is statutorily prohibited from paying for actual housing costs such as capital and ongoing rental assistance.

6 https://www.usich.gov/resources/uploads/asset_library/Olmstead_Brief_02_2016_Final.pdf

7 The HCBS Rule, including its *settings* requirement, applies to Medicaid 1915(c), 1915(i), 1915(k) authorities only.

8 Statement of the Department of Justice on Application of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. to State and Local Governments' Employment Service Systems for Individuals with Disabilities, October 31, 2016.

- In December 2016, President Obama signed into law the CURES Act.[9] The bill authorizes one billion dollars to be allocated to states over the next two years to combat the nation's opioid abuse epidemic. The bill's mental health provisions re-authorize a number of existing federal grant programs that assist states in affording individuals with mental health and substance use disorders the opportunity to live and thrive in their communities. Reauthorized grants include a focus on the use of evidence-based practices, suicide prevention, workforce education and training, jail diversion, and mental health awareness training. A pending Continuing Resolution would provide these grant programs level funding through April 28, 2017, after which their continued funding will be subject to Congressional appropriations process. In addition to these reauthorizations, the bill includes policy clarifications and technical assistance resources such as:

– Mental Health Parity enforcement, requiring HHS to issue new compliance guidance to health plans.
– A requirement for HHS to pass Final HIPAA regulations clarifying when a healthcare provider can release protected health information.
– Provisions from the Comprehensive Justice and Mental Health Act to help states better identify and appropriately respond to a person with a mental health condition who might otherwise become involved with the criminal justice system. These provisions include support for mental health courts and diversion programs (as authorized in the Mentally Ill Offender Treatment and Crime Reduction Act), crisis intervention teams, corrections-based programs, and training for law enforcement officers on how to safely handle and deescalate mental health crises.

FORECAST FOR 2017

Title II of the Americans with Disabilities Act (ADA) is the law, upheld by the Supreme Court in *Olmstead v. L.C.* States will continue to be responsible for ensuring that all individuals with disabilities have the civil right to live in integrated, community-based settings. Complying with *Olmstead* is not a one-time exercise, and states need to plan and implement integration strategies actively. Through the end of the Obama administration, the DOJ continued to investigate and address *Olmstead* compliance issues, with a complaint filed in August (Mississippi) and a findings letter in December (Louisiana nursing homes).

The new administration and congressional members should be educated about Title II of the ADA and *Olmstead*, and shown that serving people with disabilities in integrated settings requires access to affordable housing and community-based services. Whether or not the DOJ's current enforcement approach is modified, watchdogs such as the National Disability Rights Network, Bazelon Center for Mental Health Law, and states' Protection and Advocacy organizations will continue to monitor *Olmstead* compliance and may take legal action when warranted.

President Donald Trump and the Republican-controlled Congress are intent on repealing the Affordable Care Act (ACA), including Medicaid expansion, and on converting Medicaid to a block grant or per capita-based program. At this time, it is uncertain what this will look like, how long it will take, and what impact any reforms or replacement of the ACA will have on access to services. However, many health care and disability experts are concerned that access to insurance and services will become increasingly limited for persons with disabilities. Some states are already stepping back and holding off on implementing strategies that would have supported community integration, for example by eliminating housing-related services and supports from 1115 Medicaid Waiver submissions. Others are moving full speed ahead, operationalizing expanded Medicaid coverage based on the experience that it's more difficult to dismantle a program or service that has already implemented than one that's still in the planning stage. There is considerable uncertainty ahead, but there are also important areas of focus for states that are not likely to change and that deserve their full attention.

The repeal of Medicaid expansion under the ACA, absent an alternative, would have significant

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implications for states and low-income individuals and families. States are just beginning to see the impact of access to healthcare coverage among populations that have been historically uninsured. While states have had varying rates of success with reducing the unnecessary use of emergency departments and inpatient beds by the newly insured, it's clear that eliminating Medicaid expansion will undo the progress that has been made.

Data-informed decisions will be critical for states as they determine how to get the most benefit from limited resources. If enacted, Medicaid block grants and per capita funding will require states to make difficult decisions about eligibility, services to fund, and service limits. Data will be critical to identify high utilizers within and across systems, to avoid duplicative spending and cost-shifting back to state- and locally funded services such as jails, prisons, and state institutions.

Every state in the nation is struggling to address the opioid crisis. The ACA includes substance use disorders as one of the ten elements of essential health benefits. All health insurance sold on Health Insurance Exchanges or provided by Medicaid to certain newly eligible adults must include services for substance use disorders. The Mental Health and Addictions Parity Act requires that plans provide coverage for SUD treatment to the same degree as coverage for the treatment of physical conditions. Finally, the ACA allows parents to keep their children on their health insurance policy up to age 26. These provisions have afforded more individuals access to SUD treatment which is critical at a time when jails and prisons are filled with inmates with drug-related convictions. Repeal of the ACA will leave jails and prisons as the only alternative for individuals with addictions, who also often have co-occurring mental health disorders.

Housing affordability is predicted to continue to be a problem in 2017, especially for persons with disabilities with extremely low-income households. Most of the affordable housing programs targeted to serve people with disabilities specifically have not been funded for some time. For example, the HUD Section 811 PRA program - designed to create integrated affordable housing for people with disabilities - has not received funding for new units since 2014. The exceptions have been new permanent supportive housing for people who are homeless (through HEARTH) including homeless veterans (VASH). The housing advocacy community is also very concerned about funding for those affordable housing programs available to low-income households including (but not targeted to) people with disabilities. The Housing Choice Voucher (HCV) program, for example, only recently reversed the impact of the 2013 federal budget sequestration and now faces potentially damaging cuts. Because of rising rents, even level funding for this program means fewer units, and any cuts in or caps imposed on the federal budget will mean another step backward. In addition, as described elsewhere in this Guide, the fate of the national Housing Trust Fund is uncertain. Any reduction to federal housing assistance will impede states in their ability to provide individuals with disabilities the opportunity to live in community-integrated settings.

Several states have created state-funded housing assistance programs that resemble the federal Housing Choice Voucher program, but these generally do not create enough affordable housing opportunities for people with disabilities who are stuck in institutional settings, such as psychiatric hospitals, developmental centers, nursing homes, or correctional facilities.

WHAT TO SAY TO LEGISLATORS AND SOME ACTIONS TO TAKE

States are legally obligated to ensure that all individuals with disabilities have the civil right to live and work in integrated, community-based settings. With access to housing assistance and comprehensive health care services and supports, people with mental illness, intellectual or developmental disabilities, and physical or sensory disabilities can live and thrive in the community. There is a growing body of research that links access to safe, decent housing and adequate health care to positive health outcomes with reduced health care costs. Conversely, individuals with unstable housing and inadequate health care are high utilizers of costly services, and are likely to have poor health outcomes. States are beginning to realize the benefits from innovative initiatives that integrate physical and behavioral health care for individuals who have multiple chronic conditions. Reducing federal support for housing and health care may provide initial budgetary relief, but will end up swelling costs overall by increasing

uncompensated health care, increasing unnecessary reliance on nursing facilities, further stressing the criminal justice and child welfare systems, and adding to homelessness in communities.

Stakeholders should also increase advocacy with national and state organizations on *Olmstead*. Groups such as state Protection and Advocacy organizations and other legal rights groups can provide leverage with state agencies to comply with *Olmstead*, and initiate litigation against states when necessary. For information on state protection and advocacy networks, see the National Disability Rights Network http://www.ndrn.org/index.php.

FOR MORE INFORMATION

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