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ABCD Policy Synthesis: Community Integration -- Exploring the Americans with Disabilities Act (ADA) Legal Standard

This Policy Synthesis is based upon a Center for Health Care Strategies Resource Paper written by Taylor Burke, JD and Sara Rosenbaum, JD from George Washington University, July 2004

The Resource paper examines the meaning of community integration in the context of the ADA law, regulations, and court decisions.

The ideal of community integration is at the heart of the Americans with Disabilities Act (ADA). Whether community integration is achieved is based upon the facts and individualized aspects of specific court cases. Current ADA litigation and case law reinforce the notion that there is no hard and fast rule that delineates when integration is achieved.

Medicaid can be used to achieve integration, even when the facility in which an individual resides is medical in nature, depending upon state licensure and zoning standards.

Performance standards for community integration do not permit states to establish norms of integration, but do require that individuals be able to show that, for them, integration is more far reaching and can be achieved with reasonable modifications.

There are valuable intermediate and normative measures of integration that can drive State efforts and expenditures. According to the Resource Paper, examples are:

> Redesign of ICF/MR licensure and zoning laws to permit the use of very small and flexible facilities (federal law or regulations do not require large ICF/MRs);
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> Allow a specific number of persons with severe mental illness to reside in the small residences using the exception to Institutions for Mental Disease (IMD) exclusion, as opposed to large state facilities.

Essential to a community integration goal is having an ongoing and active program through which individuals can be regularly re-evaluated for eligibility in increasingly integrated residential opportunities.

ADA Statute, Regulations and history

The ADA has its roots in the Rehabilitation Act of 1973, which prohibits any program or activity that receives federal assistance from discriminating against individuals solely on the basis of disability. Integration is defined in terms of providing opportunities for people in the least restrictive setting possible.

The ADA shifted the focus away from loosening of restrictions (i.e.,. least restrictive environment) toward full participation through the concept of community integration.

The terminology of community integration varies with each title of the ADA. Title I covers employers and employer sponsored programs; Title II applies to publicly operated and funded programs and services. Title III applies to places of public accommodations and Title IV addresses telecommunication access for people with hearing and speech disabilities. Therefore, a review of the regulations implementing the law is in order.

According to the regulations, community integration allows individuals with disabilities to receive services, or participate in programs or activities, in the most integrated setting appropriate to their needs.

The most integrated setting appropriate to their needs, according to the Preamble to the Title II regulations of the Americans with Disabilities Act, "means a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible".

The community integration standard is intended to prohibit exclusion and segregation of individuals with disabilities and the denial of equal opportunities enjoyed by others. Consistent with these standards, public entities are required to ensure that their actions are based on facts applicable to individuals and not on presumptions as to what a specific class of individuals with disabilities can or cannot do.

The ADA does limit a court's power to change public programs under Title II. ADA limits the courts from ordering changes that "fundamentally alter" (change the essential nature of) public programs and services in order to achieve the goals of community integration.

The standard of community integration is contextual and relational focusing on whether qualified individuals with disabilities are able to relate (in their residences, jobs and their life opportunities) to the larger community of people without disabilities.

The standard is specific to an individual case and must be reviewed through the objective evidence furnished by public officials and the qualified individual as to what is the most appropriate integrated setting, given the qualified individual's needs.

Establishment of normative measures of progress to move a group of individuals towards integration is allowed, as long as individuals have the right to rebut those measures as it applies to them as individuals through the introduction of additional evidence.

Courts can order progress toward the standard as long as the changes that are ordered are reasonable modifications and not shown to amount to a fundamental alteration.

Court Rulings

Courts have considered specific factual situations and their rulings have defined the community integration standard.

The best known case is the Supreme Court's decision in Olmstead v. L.C. This decision set a standard for state conduct in cases involving medically unnecessary institutionalization under public programs. The Court stated:

> [Community Integration] is in order when the state's treatment professional have determined that the community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities.

The courts have viewed community integration as the goal to be achieved regardless of the funding stream to be used. Simply because Medicaid finances a residential placement would not violate the community integration standard. The Supreme Court in Olmstead v. L.C. found that a medical residence (a psychiatric hospital) as discriminatory. However, the critical determinant is whether the resulting arrangement furthers the ADA integration standard as determined by the individual facts in the case. The individual facts are important because what may be institutional discrimination for one individual may be integration for another.

Using Medicaid to Achieve Community Integration

Courts do not have the freedom to approve all supports necessary for full subjective community integration, especially in public programs such as Medicaid. The ADA prohibits courts from ordering changes that "fundamentally alter" (i.e., change the essential nature of) programs and services in order to achieve its goals and aims. State and federal governments must operate within the resource constraints of their budgets. The courts may not alter the nature of the service, program, or activity (including the funding).

Many view the federal/state Medicaid program as one with an institutional bias that emanates from the fact that nursing facility coverage and ICF/MR coverage is mandatory while community services are optional. However, states have extensive community service investment options that enhance community integration.

The Resource Paper suggests two Medicaid financed residential options which should be examined in the context of community integration.

> **1) <u>Small ICF/MRs:</u>** The ICF/MR option allows states discretion over size. Nothing in the statute or regulations requires a minimum bed size for a facility to be treated as an ICF/MR.
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> The ICF/MR are facilities whose primary purpose is to provide health or rehabilitative services to individuals with mental retardation or related conditions. An ICF/MR must meet state licensure requirements and provide services above the level of room and board.

These facilities provide (in a protected residential setting): ongoing evaluation, planning, twenty-four hour supervision, coordination, and integration of health or rehabilitative services to help each resident function at his/her greatest ability. Federal regulations allow for community integration including giving states options to allow for payment for therapeutic leaves of absence to visit family and friends if medically appropriate and allowing leave days to transition to a more integrated community setting.

2) <u>The small residence exception to the IMD exclusion:</u> Medicaid excludes payment for all services rendered to persons who are residents of institutions for medical diseases (IMD) (residential institutions where a majority of residents has a primary diagnosis of mental illness). But the statute permits an exception to this rule for residential settings for 16 persons or fewer. The use of Medicaid funds to create small group residences is possible and the applicable state licensure and zoning standards would in effect determine the degree of integration.

Both of these residential options are based upon the conditions of their residents. The options impose some level of isolation on the individuals who reside there. Nonetheless, both options offer alternatives (with room and board) to large institutions that are inherently isolating by their size.

Issues for New Jersey to Consider

New Jersey has a greater reliance on institutional care than other States. Only 3 other states have more individuals per 100,000 in large institutions.

According to the national study, State of the States in Developmental Disabilities (2004), New Jersey ranked 48th in the country in 2002 for residents living in State operated MR/DD institutions with more than 16 persons.

New Jersey had 39.2 persons in public institutional placements per 100,000 in the general population, compared to 15.4 persons per 100,000 nationally.

Currently, about 10% of all individuals served by the Division of Developmental Disabilities live in Developmental Centers, but comprise approximately 35% of the Division's total budget.

Approximately 60% of individuals living in Developmental Centers are between the ages of 30 and 49, and 30% are age 50 or over age 89.

Some states (including our neighbor states of Pennsylvania and New York) have utilized smaller ICF/MRs in the community.