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Resource Paper

The Meaning of Community Integration: Exploring the ADA Legal Standard Within a Broader Social Context

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Introduction

This Resource Paper examines the meaning of the community integration requirement under the Americans with Disabilities Act (ADA)¹ and its predecessor, the Rehabilitation Act of 1973.² Both laws mandate the community integration of individuals with physical or mental disabilities, yet what an individual with a disability perceives to be true community integration, and what the law actually guarantees, can be quite different. A major challenge in civil rights policy is achieving compatibility between the expectations of the protected group (in this case, persons with disabilities) and applicable legal standards and remedies. The degree to which this compatibility exists in the case of the ADA and its community integration standard is the subject of this paper.

This Resource Paper begins with a background and overview of community integration as a basic element of the ADA. It then examines the legal considerations that bear on whether a particular practice in a public program could be said to meet the standard of community integration. Next, the paper explores evidence regarding how community integration is subjectively understood by three distinct and illustrative populations – persons with severe mental illness, persons with severe physical disabilities, and persons with mental retardation. Finally, it examines Medicaid in a community integration context, comparing states' legal obligations under both Medicaid and the ADA against Medicaid's actual potential to help achieve broad social integration.

Background and Overview

The ADA and its legislative predecessor, the Rehabilitation Act of 1973, reflect a basic shift in public understanding of disability and its meaning within broader society. Both laws have community integration at their core, although the ADA changed the basic terminology of the Rehabilitation Act and broadened the goal of community integration of persons with disabilities to extend to all facets of U.S. life, not merely federally assisted programs.

Community integration stands as the overarching goal of Title II of the ADA, which delineates the obligations of public agencies. Public entities are obligated under Title II to make reasonable modifications in furtherance of this goal; the point at which a proposed modification is judged to be a fundamental alteration, the authority to achieve reform shifts away from the courts and into the legislative arena.³

In essence, community integration is the *outcome* against which all modifications of public programs are to be measured under Title II. But the use of community integration as an outcome measure of course raises the inevitable question: what is community integration? Is there a fixed point at which community integration can be said to occur?

¹ 42 U.S.C. §§ 12101-12213.

² 29 U.S.C. § 794.

³ 28 C.F.R. § 35.130(b)(7).

Does the concept vary in accordance with the particular facts and individual circumstances that come into play for particular individuals? How should the standard of community integration be measured, and by what evidence? Is it a subjective standard, in which the personal opinions and preferences of individuals with disabilities are relevant? Under what circumstances, and in light of what evidence, should the opinions of officials regarding whether a modification achieves “sufficient” integration be given weight? Can a public agency ever assert that its obligation to achieve integration has been achieved as an absolute measure, or should the goal be viewed as always relative to the specific circumstances of an individual and therefore subject to change? Is there a specified legal concept of community integration in the statute, regulations, or judicial decisions interpreting Title II? If so, does the law answer these more subtle questions regarding how progress in the achievement of the standard should be measured?

The ADA Statute, Regulations, and Legislative History

The ADA can claim as its greatest achievement the establishment of an overarching goal of community integration across American society as a whole. Although community integration can be said to characterize all dimensions of the ADA, it is in the area of public services where the most explicit attention has been focused.

The ADA has its roots in the Rehabilitation Act of 1973, which, in relevant part, prohibits any program or activity that receives federal financial assistance from discriminating against individuals solely on the basis of disability, and which couches its integration directive in terms of providing opportunities to the disabled in the “least restrictive setting” possible. The ADA expanded this non-discrimination mandate by extending the reach of civil rights law to private employers as well as private entities (including health care services) that are considered “places of public accommodation” because they are open to the public. The ADA also strengthened the legal standards applicable to covered public and private entities. Most profoundly perhaps, the ADA shifted the focus *away from* the mere loosening of restrictions (i.e., least restrictive) and *toward* full participation through the concept of “community integration.”

This basic and profound shift in the terminology of the civil rights law itself can be found in the ADA’s Preamble, which sets out the law’s central goal:

The Nation’s proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency . . .⁴

This preamble suggests that evidentiary tests for community integration might include the degree to which a particular living arrangement permits “full” participation and can be characterized as a form of “independent” living not under the control of another.

⁴ 42 U.S.C. § 12101.

The precise terminology for community integration varies with each title of the ADA (a byproduct of the fact that different Congressional committees drafted different titles and at different points). At the same time, the concept of community integration underpins the law's major components, including Title I, which covers employers and employer-sponsored benefits,⁵ Title II, which applies to publicly operated and funded programs and services (i.e., publicly funded transportation systems),⁶ Title III, which applies to places of public accommodation (i.e., privately operated businesses and commercial entities),⁷ and Title IV, which addresses telecommunications access for people with hearing and speech disabilities.⁸

Implementing regulations supplement the provisions of each Title. These rules have the force of law and play a powerful role in judicial interpretation of the Act's requirements. The regulations implementing Title II make the goal of community integration explicit for "qualified individuals with disabilities," defined as persons who "meet the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity."⁹ Under these implementing rules:

A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability. . . . A public entity shall administer services, programs, and activities *in the most integrated setting appropriate to the needs of qualified individuals with disabilities.*¹⁰ [emphasis added]

The Preamble to the implementing regulations further states that "the most integrated setting" means "a setting that enables individuals with disabilities to interact with non-disabled persons *to the fullest extent possible.*"¹¹ [emphasis added]

These italicized provisions suggest some degree of judgment in evaluating whether the goal of community integration is met. But whether this judgment must be *individualized* or can in fact be *normative* is ambiguous. Furthermore, the rules are ambiguous regarding whether the judgment exercised is that of officials or the affected persons themselves. When a judgment is made by public officials, then basic principles of administrative law dictate that official judgment would have to be based on the impartial examination of relevant and reliable evidence.¹² If the judgment is one that is to be made by the affected individuals themselves, then the question of whether the judgment must be based on

⁵ 42 U.S.C. § 12112.

⁶ 42 U.S.C. § 12132.

⁷ 42 U.S.C. § 12182(a).

⁸ 42 U.S.C. § 12184.

⁹ 42 U.S.C. § 12131(2).

¹⁰ 28 C.F.R. § 35.130 (b)(7), (d)-(e)-1.

¹¹ 28 C.F.R. pt. 35, App. A.

¹² 2 Admin. L. & Prac. §§ 5.62, 5.64 (2d ed.) (Supp. 2004).

evidence is an open one, although in other ADA-related circumstances courts have held that subjective opinions are insufficient.¹³

In the Preamble to the proposed and final rules, the Department of Justice offered the following explanation of how it viewed the standard it set:

[The community integration provisions are] intended to prohibit exclusion and segregation of individuals with disabilities and the denial of equal opportunities enjoyed by others, based on, among other things, presumptions, patronizing attitudes, fears, and stereotypes about individuals with disabilities. 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 class of individuals with disabilities can or cannot do.¹⁴ [emphasis added]

One obvious and inherent limitation on the meaning of the community integration standard can be found in the limits that the ADA sets on courts' powers to order changes in public programs under Title II. Although the law prohibits discrimination against qualified individuals with disabilities, it prohibits courts from ordering changes that "fundamentally alter" (i.e., change the essential nature of) their programs and services in order to achieve its goals and aims. Thus, under Title II, no modification is required if "the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity."¹⁵ Thus, regardless of the changes that are needed from an individual's standpoint in order to make it possible to reside in "the most integrated setting appropriate," a court cannot order the change if it amounts to a "fundamental alteration," as demonstrated by a public official.

Read together, the history of the ADA, its provisions, and the regulations collectively suggest four basic propositions:

1. The standard of community integration is a contextual and relational one. It cannot be answered conclusively and normatively but instead turns on the extent to which, under the circumstances, qualified individuals with disabilities are able to relate—in their residences, their jobs, and their life opportunities—to the larger community of persons without disabilities.
2. Whether the standard is met is a question that is specific to a particular individual case and is not a normative one. The answer is to be arrived at through reliance on objective evidence furnished by both public officials and by the qualified individual regarding what is the most appropriate integrated setting given the qualified individual's needs.

¹³ For example, under the ADA and the Rehabilitation Act, the Court has held that judgments by individuals regarding whether qualified persons with disabilities pose a direct threat must rest on reasonable evidence. *See Bragdon v. Abbott*, 524 U.S. 624 (1998); *School Board of Nassau County, Florida v. Arline*, 480 U.S. 273 (1987).

¹⁴ 28 C.F.R. pt. 35, App. A.

¹⁵ 28 C.F.R. § 35.130 (b)(7), (d)-(e)-1.

3. The fact that individual circumstances must be taken into account does not prevent the establishment of normative measures of progress aimed at moving groups of individuals toward integration, so long as individuals have the right to rebut the normative measure as it applies to them, through the introduction of additional evidence.
4. Courts can order progress toward that standard as long as the changes that are ordered are reasonable modifications and not shown to amount to a fundamental alteration.

Take for example four individuals with mental retardation, who reside in a group home in a community neighborhood. Would this residence fail the test because, even though their home is in a community neighborhood, the individuals are living only with other persons with disabilities (as opposed to a “mixed” apartment)? Clearly the normative goal here – residence in small group homes located in community neighborhoods – represents a solid intermediate benchmark. Whether or not this benchmark achieves full community integration within the meaning of the ADA for any particular resident however would depend. Were the individual to present evidence that other affordable apartment locations are available in “non-dedicated use” settings, and that he or she is fully capable of living in such a setting without the special services and supports that are furnished in the dedicated setting, the state would then have to be able to show why making such an arrangement would amount to a fundamental alteration of the state’s programs.

In sum, there is no uniform method for determining what level of reasonable modification is sufficient to satisfy the Rehabilitation Act/ADA’s community integration requirement. There are, however, cases that help set the parameters for an objective, legal sense of what courts deem necessary for community integration given a specific set of facts.¹⁶

¹⁶ The overwhelming majority of cases attempting to enforce the community integration requirement involve institutionalized persons seeking community-based care through Medicaid. Because most states provide, through the Medicaid waiver program, community living arrangements for certain eligible populations, litigation is frequently used as a means of securing limited waiver slots by those on waiting lists. Unfortunately, these cases focus on whether a requested change to the state Medicaid plan (i.e. adding more waiver slots or simply adopting a waiver program) constitutes a fundamental alteration or reasonable modification – thus offering very little guidance as to what it means to be community integrated. See Smith, G. “Status Report: Litigation Concerning Home and Community Services for People with Disabilities” *Human Services Research Institute*, January 20, 2004. This report describes numerous current court cases by those claiming a lack of Medicaid Home and Community Based Waiver slots violates the ADA’s community integration mandate.

Court Rulings

Courts have considered specific factual situations that have shed light on the community integration standard. Because each case is limited to its facts, judges have been able to push ADA defendants to certain points along the community integration spectrum. But the ordering of specific relief in each case does not so much advance a monolithic rule as provide important insights.

Perhaps the best known case is *Olmstead v. L.C.*,¹⁷ in which the United States Supreme Court clarified that medically unjustifiable institutionalization constituted discrimination under the ADA and held that states could be obligated under Title II to make reasonable modifications in programs to avoid this outcome. The context for *Olmstead* was the institutionalization of two women with mental disabilities despite evidence of their ability to reside in community settings, suggesting that individual evidence of the appropriateness of community residence is an essential factor to be taken into account. But *Olmstead* did not shed light on how “integrated” the two plaintiffs would have to be before the goal of the ADA would be considered satisfied in their case. Would residence in a group facility located in a residential neighborhood be sufficient integration? There can be no definitive answer without consideration of objective evidence.

Other cases shed light on the question without directly answering it. For example, the Supreme Court in *PGA Tour, Inc. v. Martin*,¹⁸ a case involving Title III of the ADA, decided that the PGA could be ordered to permit Casey Martin to play using a cart. The specific facts in the record – the use by all golfers of carts in early tournament rounds, the fact that Casey Martin’s disability ensured the natural fatigue that (according to the PGA) is essential during the final rounds of competitive golfing, and the unique nature of his situation (realistically, how many other professional golfers ever could be expected to have a disability that requires use of a cart?) all served to sway the Court. The case serves to underscore the idiosyncratic nature of the competitive integration standard and reinforce the idea that whether there is “enough” integration to satisfy the ADA turns on the specific evidence in a specific case.

Other community integration cases show the same tendency to be decided in their particular facts. Refusing to allow a disabled student to attend classes with her service dog was considered a violation of the integration requirement.¹⁹ A court also has decided that refusing child care leave in connection with an adopted child breaches the integration rule by failing to provide a proper accommodation for the mother’s sterility disability.²⁰ Bringing public elevators into compliance with local standards²¹ and allowing

¹⁷ *Olmstead v. L.C.*, 527 U.S. 581 (1999).

¹⁸ *PGA Tour, Inc. v. Martin*, 532 U.S. 661 (2001).

¹⁹ See *Sullivan v. Vallejo City Unified School District*, 731 F. Supp. 947 (E.D. Ca 1990) (granting injunctive relief).

²⁰ See *McWright v. Alexander*, 982 F.2d 222 (7th Cir. 1992).

²¹ See *Cupolo v. Bay Area Rapid Transit*, 5 F. Supp.2d 1078 (N.D. Ca 1997).

for the use of wheelchairs in places of public accommodation²² also are community integration requirements under the law.

In a health care context, a court decided the closing (for financial reasons) of a state hospital specializing in rehabilitation services for persons with disabilities likely violated the ADA, because those services were not available anywhere else in that particular community.²³ In this case, the court did *not* order the modification of all other hospital services in the community to enable access to care but instead found that because other hospitals lacked capability to care for the population, the specialized facility could not be closed. In other words, in this case the very absence of a means of integration into general hospital care served to sustain the need for the continued use of a separate hospital, at least on an interim basis.

In contrast, when a court found that a state hospital lacked certain supports required for successful integration of individuals with developmental disabilities and mental illness into the community, it ordered, among other services, crisis intervention, a prevention of hospitalization plan, staff training, and overall program oversight.²⁴ Moreover, the state of Texas violated the integration mandate by failing to provide minimally adequate crisis intervention services that had resulted in widespread incarceration of individuals (not charged with a crime) while they awaited transport to available mental health programs.²⁵ And in New York, a court required the state to completely reform its own dysfunctional state agency in charge of assisting persons with HIV to provide better access to needed community services.²⁶

Some factual scenarios cause courts to reject certain integration requests. For example, the deaf plaintiff in *Southeastern Community College v. Davis* was not granted an auxiliary aid for sign language purposes in order to gain admission to a nursing program, for dispensing with the need for effective oral communication was considered more than a reasonable modification of nursing education programs given the overall nature of the profession.²⁷ In *Davoll v. Webb*, the court refused to eliminate the requirement that candidates for employment as police officers be able to make a forcible arrest and fire a weapon.²⁸ And in *Rodriguez v. City of New York*, the court decided that New York City's failure to pay for safety monitoring as a separate reimbursable Medicaid expense in the case of persons with mental illness living at home (even though payment would be made as an incidental service during home visits for persons with physical disabilities) did not violate the ADA's integration requirements, because adding such coverage would have amounted to a fundamental alteration of the Medicaid plan.²⁹

²² See *Leiken v. Squaw Valley Ski Corp.*, 1994 WL 494298, Civ. A. No. s-93-505, June 28, 1994 (E.D. Ca).

²³ *Rodde v. Bonta*, 357 F.3d 988 (9th Cir. 2004).

²⁴ See *Allen v. Western State Hospital*, Washington State, 2001. This case is "unreported" and therefore does not have a citation.

²⁵ See *Doe & Doe v. Hall*, State of Texas, 1998. This case is "unreported" and therefore does not have a citation.

²⁶ See *Henrietta v. Bloomberg*, 331 F.3d 261 (2nd Cir. 2003).

²⁷ See *Southeastern Community College v. Davis*, 442 U.S. 397 (1979).

²⁸ See *Davoll v. Webb*, 943 F. Supp. 1289 (D. Col. 1996), *affirmed in part and reversed in part by Davoll v. Webb*, 194 F.3d 1116 (10th Cir. 1999).

²⁹ See *Rodriguez v. City of New York*, 197 F.3d 611 (2nd Cir. 1999).

Some cases never proceed all the way to trial, but rather, result in a settlement. Although not considered legal precedent, the terms of the settlement can shed light on the legal meaning of community integration. For example, a court approved a settlement in a case that claimed inadequate safety protections for those in state hospitals and inappropriate access to community supports and services.³⁰ The settlement required the state to: develop additional community-based services for people leaving state institutions; expand protection of rights for people in state hospitals; enhance state agency oversight regarding the safety of community programs; and educate the community about mental illness and mental retardation.

These cases illustrate the fact-specific nature of how courts view community integration. But such a system – using litigation to achieve community living – is singular and necessarily provides certain benefits to specific litigants. Because no uniform definition of community integration exists under the law, a specific set of facts will drive each case and will influence when a court will decide whether integration is achieved in relation to a particular individual and whether the modifications necessary to achieve such integration are “reasonable.”

How Do Individuals with Disabilities Perceive Community Integration?

How a person with a disability conceives of living in the community can be vastly different from what a court might hold is legally required. A subjective interpretation of community living reflects a moral and ethical thought process which takes into account the individual’s personal characteristics and the amount of resources needed to provide that individual with the same freedoms enjoyed by persons without disabilities.

On the other hand, courts do not have the unbridled freedom to approve all the supports necessary for full subjective community integration, especially in the realm of public programs such as Medicaid. This, in essence, is the meaning of the ADA’s fundamental alteration test. Courts (and state and federal governments) must operate within the resource constraints imposed by state and federal budgets. In fact, this gap can be considerable: approximately 20 percent of adult community residents requiring consistent supports report they are unable to get the care they need.³¹

³⁰ See *Wyatt v. Sawyer*, 105 F. Supp.2d 1234 (M.D. Ala 2000).

³¹ Feder J., Komisar J., and Niefeld M. “Long-Term Care Systems” *Health Affairs*, May/June 2000.

Generally, persons with severe mental illness, severe physical disabilities, and mental retardation share several common life aspirations toward the goal of community integration:³²

Income security and employment opportunities: achieving and maintaining income security through full or partial economic self support, in combination with access to job-related supports and to income supplementation as needed.

Housing: achieving or maintaining a living arrangement which is the most independent and community integrated as determined by the individual and the person's current needs.

Health: achieving and maintaining optimal health status including access to preventative and rehabilitative services as needed.

Relationships: achieving and maintaining appropriate relationships with family members and peers, and increasing opportunities for interaction with individuals without severe disabilities; having protection from vulnerability to neglect, abuse, or exploitation because of the severe disability.

Education: achieving and maintaining vocational and related educational skills to enable participation in employment and community activities to the optimum level of the potential of the person with a severe disability.

In addition to these common needs, the three population groups considered here have unique requirements that drive their aims for community integration.³³

Persons with severe mental illness may require:

- Side-by-side assistance to select, initiate, and attend to work tasks safely through the use of job coaches.
- Income assistance entitlements to meet the needs of a housing arrangement compatible to the individual's needs and symptoms.
- A basic package of preventative and other health care services, appropriate medications, and assistance in accessing medical entitlements.
- Assistance in overcoming problems with social functioning and interaction.
- Provisioning of opportunities to resume vocational and general education interrupted by the onset of the mental illness.

Persons with severe physical disabilities may require:

- Special transportation equipment to get to work.

³² Jensen A. "What is a Life Goals Framework?" The George Washington University Dept. of Health Policy.

³³ Id.

- Personal Assistant Services for mobility within the home to allow for independent living.
- Financial assistance for specialty medical services or durable equipment.
- Physical accessibility to shopping, recreational, religious, and other social interaction activities that provides parity with the general population.
- Parity in access to employee training for maintaining and improving work skills.

Persons with mental retardation may require:

- Income supplements if their ability to work full time or at a full rate is limited by the disability.
- Assistance with applications, getting to appointments, and applying for income entitlements.
- Help in financing living arrangements including personal and community supports and services necessary to live as independently as possible.
- Assistance in acquiring health insurance that does not discriminate on the basis of mental retardation, as well as specialized services and therapies designed to reduce the limitations associated with mental retardation.
- Help in learning interpersonal skills, including setting boundaries and how to avoid being exploited or abused.

Clearly the scope of services and supports is vast when considering a subjective approach to community integration. Assistance in these areas represents only a fraction of the supports necessary to achieve parity in community living with those who are not disabled. For the Medicaid population, the idea of community integration takes on a whole other layer of complexity because notions of what community living entails can be restricted by financial restraints and the structure of the program – i.e., the types of living arrangements actually available to beneficiaries. Again, the specific facts of each case dictate the limited result. Adding to the confusion is *Olmstead*, a decision that hints at community integration boundaries but conflicts with certain Medicaid services that appear to achieve certain levels of integration.

Using Medicaid to Achieve Community Integration

Many view the federal/state Medicaid program as one with an institutional bias that emanates from the fact that nursing facility coverage is mandatory while community services are optional. This characterization is inaccurate for the population of children under 21, for whom all services that fall within the definition of medical assistance are mandatory.³⁴ To the extent that Medicaid can in fact be said to have an institutional bias, it also is evident that states have extensive community service investment options that would enhance integration, such as the use of home and community based care waiver benefits, greater generosity in state plan benefits for persons with specific conditions, and special enhancements to eligibility standards that permit expanded

³⁴ Rosenbaum and Rousseau, SLU (2002).

coverage for persons with disabilities. *Olmstead* and ensuing cases³⁵ underscore that courts will hesitate in ordering modifications in state Medicaid programs, particularly if the modification which is sought goes beyond additional funding to provide what the state plan already indicates is a covered benefit. More recent cases however, in particular *Townsend v. Quasim*³⁶, indicate that where courts see a blatant and seemingly senseless termination of a community residence in favor of institutionalization they will intervene. (In *Quasim*, literally a few dollars per month in additional income disqualified the plaintiff for community services as a categorically needy person and converted him into a medically needy beneficiary who qualified for nursing home care only).

A further question arises in Medicaid: what distinguishes one use of funds from another in terms of the community integration goal? For example, in *Olmstead* the Supreme Court clearly saw a medical residence (in this case a psychiatric hospital) as discriminatory. At the same time, one could imagine the use of Medicaid-financed medical residences (very small residences that qualify as ICF/MRs or fall within the IMD exception for residences with 16 beds or fewer) as nonetheless furthering a community integration goal. Thus, *what* Medicaid buys is not nearly as relevant as the contextual nature of the benefit conferred. What may be institutional discrimination for one beneficiary may be integration for another.

Olmstead v. L.C. essentially was all about the extent to – and speed with – which states must alter the manner in which they operate public health care programs such as Medicaid in order to achieve community integration. In setting the 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 professionals 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.³⁷ [emphasis added].

This excerpt suggests that the Court viewed community integration as the goal to be achieved, regardless of which funds were used to achieve it. Whether Medicaid paid for the alternative placement and what precisely were the characteristics of such placements appeared to be open questions, to be resolved in a community integration context.

³⁵ Rosenbaum S., Burke T., Teitelbaum J., *The Americans with Disabilities Act and Community Integration: An Update on Fundamental Alteration Litigation*. Center for Health Care Strategies, November 2003; Rosenbaum S., Teitelbaum J., Stewart A., *The Americans with Disabilities Act and Community Integration: Understanding the Concept of “Fundamental Alteration.”* Center for Health Care Strategies, May 2002; Rosenbaum S., Teitelbaum J., and Stewart A., *An Analysis of Olmstead Complaints: Implications for Policy and Long-Term Planning*. Center for Health Care Strategies, December 2001.

³⁶ See *Townsend v. Quasim*, 328 F.3d 511 (9th Cir. 2003).

³⁷ *Olmstead*, 527 U.S. 581 at 587.

For example, living in a group home financed through SSI payments and/or public housing subsidies might be community integration, even if the residence was located in a distinct part of the community as a result of specific zoning requirements, and even if the individual shared a bedroom with two other persons. The critical determinant would be whether the resulting arrangement furthered the ADA integration standard, as determined by the facts. Thus, simply because a residential placement is Medicaid financed would not make it violate the community integration standard. Two options in particular are worth examining:

- *The small residence exception to the IMD exclusion.* As a general rule, Medicaid excludes payment for all services furnished to persons who are residents of institutions for mental diseases, i.e., residential institutions where a majority of residents have a primary diagnosis of mental illness.³⁸ But the statute permits an exception to this rule for residential settings for 16 persons or fewer.³⁹ The use of Medicaid funds to create small group residences is clearly possible, and the applicable state licensure and zoning standards would in effect determine the degree of integration.
- *Small ICF/MRs:* The ICF/MR option also allows states discretion over size. Nothing in the statute or regulations requires a minimum bedsize for a facility to be treated as an ICF/MR. ICF/MR services simply are facilities whose primary purpose is to provide health or rehabilitative services to individuals with mental retardation or related conditions.⁴⁰ The ICF/MR must meet state licensure requirements and provide services above the level of room and board.⁴¹ Such 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 or her greatest ability. While the ICF itself may not be ideal for community integration purposes, federal regulations lend an air of community integration. Many states allow payment for therapeutic leaves of absence to visit family and friends if medically appropriate, and some states also allow leave days for residents to transition to a more integrated community setting.

Residences that fall within an IMD exception or an ICF/MR are characterized by the conditions of their residents, so in this sense, both impose some level of isolation on individuals who reside therein. Nonetheless, both options offer alternatives with room and board to large institutions that are inherently isolating by their size.

³⁸ 42 U.S.C. § 1396d.

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ 42 C.F.R. §§ 483.400-480.

Policy Implications

The ideal of community integration lies at the heart of the ADA. Whether community integration is achieved is a fact-driven and individualized test, and ADA litigation reflects this. By its nature, litigation restricts outcomes to the facts presented in each case, and community integration cases are no different. The ADA cases shed light on the meaning of community integration, but collectively also reinforce the notion that there is no hard and fast rule regarding when integration has been achieved.

It is also evident that Medicaid can be used to achieve integration, even when the facility in which an individual reside is medical in nature and thus coverage for room and board is allowed. Size is not a requirement for ICF/MRs, and of course small size is what drives the exception to the IMD exclusion. Medicaid thus can be used to support community integration even where the residence is medical in nature, depending on state licensure requirements and zoning standards.

Finally, it is worth noting perhaps that any standard susceptible to the individual facts of specific cases can be frustrating. Performance measurement hinges on norms and certainty. Unlike other efforts at performance measurement, the community integration standard does not permit states to establish hard and fast norms of integration but requires that individuals be able to show that for them, integration is more far-reaching and can be achieved with reasonable modifications. At the same time, there are valuable *intermediate* and normative measures of integration that can drive state efforts and expenditures. For example, having X percent of persons with severe mental illness residing in small group medical residences financed through the IMD exclusion exception, as opposed to larger state facilities, would be such a measure. Redesigning ICF/MR licensure and zoning laws to permit the use of very small and flexible facilities would as well. Finally, having an ongoing and active program through which individuals can be regularly re-evaluated for eligibility for increasingly integrated residential opportunities would appear to be essential to the community integration goal.