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Forward to Fundamental Alteration: Addressing ADA Title II Integration Lawsuits after Olmstead v. L. C

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FORWARD TO FUNDAMENTAL ALTERATION: ADDRESSING ADA TITLE II INTEGRATION LAWSUITS AFTER *OLMSTEAD V. L.C.*

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ABSTRACT

In 1999 the Supreme Court reviewed the case of *Olmstead v. L.C. by Zimring*, which has been called the *Brown v. Board of Education* for the law of disability discrimination. The Court ultimately agreed with the Department of Justice ("DOJ") and held that the Americans with Disabilities Act ("ADA"), along with its supplementary Integration Regulation, requires a State that offers treatment to persons with disabilities to provide such treatment in a community setting where such a placement would not be an unreasonable change or a fundamental alteration in the State's program. Advocates of community care have long argued that such care is superior to institutionalized care in cost, treatment success, and equity. The ADA is the latest in a long line of legal avenues whereby advocates of disability rights have attempted to fashion some right to community care for developmentally disabled and mentally ill people. Opponents argue that the application of the Integration Regulation adopted by courts and the Department of Justice is beyond the reach of the ADA, which is limited to situations of uneven treatment as between disabled and non-disabled individuals. Left open by the current debate, and by the opinions interpreting the relevant provisions of the ADA, is

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what measures might constitute "unreasonable modifications" or "fundamental alterations" such that the ADA would not require them.

I. INTRODUCTION—THE MOVE TO INTEGRATION

A. The L.C. *Case and Title II of the ADA*

In June 1999, the United States Supreme Court decided the landmark case of *Olmstead v. L.C. by Zimring*.[1] The case has been

1. 527 U.S. 581 (1999). This paper refers to the case as *L.C.* rather than as *Olmstead*, due to the large number of cases in the Eleventh Circuit with the latter

lauded by disability advocates and described as the "*Brown v. Board of Education* for the law of disability discrimination."[2] In *L.C.*, the Court concluded that the Georgia Department of Human Resources ("DHR") had violated Title II of the Americans with Disabilities Act[3] ("ADA") by confining two mentally disabled individuals, L.C. and E.W.,[4] in a segregated institution despite concessions by the individuals' treating professionals that a community setting would be appropriate.[5]

L.C. and E.W. are mentally retarded individuals who also have mental disorders.[6] Before litigation, both were voluntary patients at the Georgia Regional Hospital at Atlanta ("GRH-A"),[7] where they were confined in a locked psychiatric unit.[8] L.C.'s most recent institutionalization began in 1992.[9] Her condition stabilized one year after her institutionalization, and the State's treating physician determined that she could

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moniker.

2. Ruth Colker, *The Section Five Quagmire*, 47 UCLA L. REV. 653, 654 (2000) (footnote omitted); *see also* Robin Toner & Leslie Kaufman, *Ruling Upsets Advocates for the Disabled*, N.Y. TIMES, June 24, 1999, at A24 (reporting that disability rights groups viewed *L.C.* as a victory).

3. 42 U.S.C. §§ 12131-12165 (2000). Title II of the ADA "sets forth prohibitions against discrimination in . . . public services furnished by governmental entities." *L.C.*, 527 U.S. at 589. The ADA also contains Title I, 42 U.S.C. §§ 12111-12117 (1994), which deals with discrimination in employment, and Title III, 42 U.S.C. §§ 21181-12189 (1994), which deals with discrimination in public accommodations provided by private entities.

4. Given the publicity of the case, the parties' identities are no longer secret. L.C.'s actual name is Lois Curtis, and E.W.'s name is Elaine Wilson. *See* Linda Greenhouse, *States Limited on Institutionalization*, N.Y. TIMES, June 23, 1999, at A16. To be consistent with the monikers used in the legal materials, this Article will use the shortened forms. Also note that throughout this Article "mental disability" will refer to both developmental disability and mental illness.

5. *L.C.*, 527 U.S. at 593, 597. Community care generally refers to residential based settings in which patients are afforded substantially greater freedom and flexibility in treatment and living than they would experience in an institutional environment. *See* L.C. by Zimring v. Olmstead, 138 F.3d 893, 897, 905 (11th Cir. 1998); Smith-Berch, Inc. v. Baltimore County, 68 F. Supp. 2d 602, 609 (D. Md. 1999).

6. *See* Brief for Petitioners at *8, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 54623. L.C. was diagnosed as having undifferentiated schizophrenia and mild retardation. *See id.* E.W. was diagnosed with a borderline personality disorder and mild retardation. *See id.*

7. *See L.C.*, 527 U.S. at 593. According to the Court, both were voluntarily admitted. The Petitioners' brief, however, alleges that E.W. was involuntarily admitted after hallucinations and L.C. involuntarily after violent behavior.

8. *See* Brief for Petitioners at *6-*7, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 54623.

9. *See L.C.*, 527 U.S. at 593. This Article follows the fact pattern set forward by the Court in *L.C.* rather than the Petitioners' brief.

appropriately be treated in a community setting.[10] She was still institutionalized at GRH-A, however, when suit was filed two years later.[11] E.W. was most recently admitted in 1995.[12] In 1996, her condition stabilized, allowing her treating physician and a clinical psychologist at GRH-A to conclude that she could be cared for in a community setting.[13] E.W. nonetheless remained institutionalized until the district court ordered the provision of community care.[14]

L.C. brought suit in May 1995, and E.W. intervened in the suit in January 1996.[15] They alleged, *inter alia*, that the State had violated Title II of the ADA and its implementing regulations by failing to provide treatment in a community setting after such a setting was deemed appropriate. The district court granted them summary judgment.[16] Title II of the ADA provides, in pertinent part, that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to *discrimination* by such entity."[17] Under Title II of the ADA, a public entity may avoid making changes to its programs if it can make out a *fundamental alteration* or *unreasonable modification* defense.[18] Department of Justice ("DOJ") regulations provide, in consonance with ADA (and Rehabilitation Act) case law, that:

> 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, *unless* the public entity can demonstrate that making the modifications would *fundamentally alter* the nature of the

10. *See id.*
11. *See id.*
12. *See id.*
13. *See* Brief for the United States as Amicus Curiae Supporting Respondents at *2, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 149653.
14. *See id.*; L.C. by Zimring v. Olmstead, 1:95-cv-1210-MHS, 1997 WL 148674 (N.D. Ga. Mar. 26, 1997) (ordering the provision of community care).
15. *See* L.C. by Zimring v. Olmstead, 138 F.3d 893, 895 (11th Cir. 1998).
16. *See L.C.*, 527 U.S. at 594.
17. 42 U.S.C. § 12132 (2000) (emphasis added).
18. 28 C.F.R. § 130(b)(7) (2000). Although there is a conceptual distinction between the two terms, "unreasonable modification" and "fundamental alteration" are frequently used interchangeably as a convenient shorthand.

service, program, or activity.[19]

On appeal before the Eleventh Circuit, the State argued that the plaintiffs had not been discriminated against "by reason of such disability" because they had not been denied anything available to non-disabled people.[20] The State asserted that the plaintiffs were denied community placements not because of their disability, but because of a lack of funding.[21] Thus, it was argued, no violation of the ADA should be found.[22]

> In other words, the State argue[d] that the ADA requires a comparison of the treatment of individuals with disabilities against that of healthy non-disabled persons. . . . Reduced to its essence, the State's argument is that Title II of the ADA affords no protection to individuals with disabilities who receive public services designed only for individuals with disabilities.[23]

The circuit court rejected the State's argument. The court relied on the "Integration Regulation" issued by the Department of Justice, which is entrusted with the task of promulgating regulations to give content to the general provisions of Title II. The court also gave deference to the DOJ's interpretation of the regulation and the ADA.[24] The Integration Regulation provides that a "public entity shall administer services, programs, and activities in the *most integrated setting appropriate* to the needs of qualified individuals with disabilities."[25] To support such deference, the court cited legislative history suggesting that Title II of the ADA is intended in part to stamp out unnecessary segregation of disabled people.[26] Further, the court determined that a malevolent motive was not necessary to constitute a violation; even if the denial of community care was motivated by a lack of funds, a violation could still result.[27] Essentially, the court adopted the view that the regulation provides that unnecessary segregation is itself a type of discrimination redressable by

19. *Id.* (emphases added).
20. *L.C.*, 138 F.3d at 896.
21. *Id.* at 902.
22. *Id.*
23. *Id.* at 896.
24. *Id.* at 896-98.
25. 28 C.F.R. § 35.130(d) (2000) (emphasis added).
26. *L.C.*, 138 F.3d at 898.
27. *Id.* at 902.

Title II.

The Eleventh Circuit, however, did not conclusively order the provision of community care. Instead, the court returned the case to the trial court for a determination of whether the plaintiffs' suggested relief would constitute a fundamental alteration, including a determination of whether the additional expenditures necessary to treat the plaintiffs in community-based care would be unreasonable given the demands of the mental health budget.[28]

Few cases and little scholarship have discussed the boundaries of the fundamental alteration defense in the context of community-care cases or have even provided a framework on which arguments could hang. Indeed, the absence of clear limits is a trait that Title II community-care cases share to a degree with other ADA cases under all titles.[29] This problem is worsened, however, by Title II's lack of specific regulatory guidance (which is available in the employment and public accommodations contexts) and the absence of well-developed Title II case law.

Before the district court had a chance to consider the fundamental alteration issue on remand, the Supreme Court elected to review the Eleventh Circuit's opinion.[30] The Supreme Court agreed that the Integration Regulation, when properly interpreted to require community care where appropriate, was in accord with the ADA's statutory language and congressional intent, and thus within the implementation powers of the DOJ.[31] It confirmed that the unnecessary institutionalization of

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28. *Id.* at 905.

29. *See generally* Steven B. Epstein, *In Search of a Bright Line: Determining When an Employer's Financial Hardship Becomes "Undue" Under the Americans with Disabilities Act*, 48 VAND. L. REV. 391 (1995) (noting that the ADA provides no clear limits to its application and proposing a methodology in the employment context to limit that application).

30. Olmstead v. L.C. by Zimring, 525 U.S. 1054 (1998) (granting certiorari). Following the Supreme Court's

> grant of the petition for a writ of certiorari, the district court issued a decision on remand, rejecting [the State's] fundamental alteration defense. The court found that the annual cost to the State of providing community-based treatment to L.C. and E.W.—about $20,000 each—was not unreasonable in relation to the State's overall mental health budget, which was $706.8 million in fiscal year 1998.

Brief for the United States as Amicus Curiae Supporting Respondent at *5 n.1, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 149653 (citations omitted).

31. *See* Olmstead v. L.C. by Zimring, 527 U.S. 581, 581 (1999).

individuals amounted to segregation and discrimination prohibited by Title II. In an effort to afford states greater discretion, though, the Supreme Court recognized that the fundamental alteration test, as restrictively articulated by the Eleventh Circuit, may sometimes prove too difficult for states to satisfy.[32] As the Court noted, it is unlikely that a state could ever prevail if courts simply compared (1) the expense entailed in placing a mentally disabled plaintiff in a community-based treatment program against (2) the state's entire mental health budget.[33]

The Court announced a new formulation of the fundamental alteration component of the reasonable modifications regulation that would allow the states some deference. The Court's formulation requires the defendant state to show that, in the allocation of available resources, providing immediate relief for the plaintiff would be inequitable given the State's overall obligation to a large and diverse population of mentally disabled individuals.[34] The Court added that the ADA was not meant to compel states to phase out institutions and that states must have more leeway than the courts below understood the fundamental alteration defense to allow.[35]

Courts, advocates, states, and practitioners, however, still do not have precise guidance as to what would be considered an unreasonable modification or a fundamental alteration. Given the tremendous expense of large scale public interest litigation and the tendency of such cases to be resolved by way of settlement, the further development of these principles in the common law fashion will be slow. This Article explores some of the boundaries that the Supreme Court left undefined. Part I.B details the arguments made in favor of community care for the mentally disabled and provides a history of efforts to improve treatment of the mentally disabled, including the creation and application of the ADA. Part I.C argues that the Supreme Court was correct in rejecting the narrow view of ADA Title II proffered by the State in *L.C.* Part I.D offers a partial explanation of why federal intervention in the community-care area was necessary and appropriate. Part I.E

32. *Id.* at 603.
33. *Id.*
34. *Id.* at 604.
35. *Id.*

highlites problems that could result from an overbroad implementation of the Integration Regulation and notes the need to cabin its application. Finally, Part II provides a guide to advocates and scholars for analyzing arguments attempting to create a narrow interpretation of the Integration Regulation, and discusses the various arguments in two classes. The first class, *program integrity* arguments, are discussed in Part II.B in the context of three general categories—or "ideal types"—of suits. The second class, *magnitude* arguments, are discussed in Part II.C generally—as they might apply to a large class action of any of the three ideal types.

B. Efforts Towards Community Care

1. A Brief Treatment of the Case for Community Care

Community-care advocates argue that such care is superior to institutional care in terms of quality, cost, and equity. In the 1980s, studies were conducted in which mentally disabled individuals were randomly placed in either institutional or residential settings. These studies led to a "general conclusion . . . that alternative care is more effective and less costly than mental hospitalization."[36] "In fact, regardless of the outpatient setting used, the outcome indices by which their effectiveness is measured, or the patient population using them, alternative care programs have universally provided more positive results more cheaply than institutionalization."[37]

By contrast, opponents of institutional care decry its conditions and its conditioning. Instances of abuse and neglect have been documented regarding institutional care.[38] Residents and their families complain of unsanitary conditions, abuse by residents, and neglect by caregivers.[39] Even for those who do

36. Antony B. Klapper, Comment, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 768-69 (1993) (quoting CHARLES A. KIESLER & AMY E. SIBULKIN, MENTAL HOSPITALIZATION: MYTHS AND FACTS ABOUT A NATIONAL CRISIS 179 (1987)).

37. *Id.* at 769 (citing KIESLER & SIBULKIN, *supra* note 36, at 158-59, 172-73).

38. *See* Dana M. Bessette, Note, *Reinterpreting the ADA: Finding a Freedom from Unnecessary Segregation*, 24 NEW ENG. J. CRIM. & CIV. CONFINEMENT 131, 166 (1998) (citing DAVID J. ROTHMAN & SHEILA M. ROTHMAN, THE WILLOWBROOK WARS 19-20 (1984)).

39. *See, e.g.*, Savidge v. Fincannon, 836 F.2d 898, 900-01 (5th Cir. 1988) (plaintiffs alleging, among other things, that "residents were left to 'play in each other's feces' . . . medications were poorly monitored . . . [and the plaintiff] was

not suffer egregious neglect, life in large institutions often leads to a degree of institutional dependence, which manifests in a loss of social and vocational competencies and atrophy of the ability to live outside the institution.[40] Studies show that those in community-based treatment programs spend more time with friends and social groups, have a higher level of self-esteem, show fewer symptoms, and comply more consistently with medication and treatment plans.[41]

Proponents of community care also contend that community-based programs can be provided and maintained at less *cost* than large institutions. Strong evidence shows that per-patient costs of community care are lower than per-patient costs in large institutions.[42] One representative study of the costs of treating 321 formerly institutionalized individuals with psychiatric disorders found that community services cost roughly half as much as institutional care.[43] Costly overhead is often cited as a reason for the high cost of institutional care. Advocates argue that institutions must recreate many of the services that exist as part of the background of daily life in the community—in effect, that institutions suffer from diseconomies of scale.[44] Community programs, on the other hand, often need not be built from scratch, but can be created by making funding available to lease facilities. Further, individuals placed in community programs often need less assistance from state personnel because of family or friend support. Likewise, some individuals receiving community-care services can procure employment and be less dependent upon

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repeatedly bitten by other residents").

40. *See* KIESLER & SIBULKIN, *supra* note 36, at 148.

41. *See id.* at 158-59.

42. *See* Klapper, *supra* note 36, at 770. For instance, a study completed two years after the Kiesler and Sibulkin study "concluded that 'an intensive residential treatment program was able to achieve comparable results in a short period of time, with greater cost efficiency.'" *Id.* at 770 n.127 (quoting Jeffery Bedell & John C. Ward, *An Intensive Community-Based Treatment Alternative to State Hospitalization*, 40 HOSP. & COMMUNITY PSYCHIATRY 533, 535 (1989)); *see also* Herbert Bengelsdoff et al., *The Cost Effectiveness of Crisis Intervention: Admission Diversion Savings Can Offset the High Cost of Service*, 181 J. NERVOUS & MENTAL DISEASE 757 (1993) (documenting cost savings achieved by community-based services).

43. *See* Aileen B. Rothbard et al., *Service Utilization and Cost of Community Care for Discharged State Hospital Patients: A 3-Year Follow-Up Study*, 156 AM. J. PSYCHIATRY 920, 925 (1999); *see also* Laird W. Heal, *Institutions Cost More than Community Services*, 92 AM. J. MENTAL DEFICIENCY 136, 136 (1987) (stating that the 1986 per diem institutional cost was $127, compared with $81 for community care).

44. *See* Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 TEMP. L. REV. 393, 464 (1991).

public financial support.

Community-care advocates argue that incompetence and ignorance on the part of institution staff and administrators, rather than cost or quality concerns, have led to the failure to provide community placements.[45] Further, activists argue that administrative officials in institutions are slow to transfer patients out of institutions because of their desire to maintain a high occupancy rate. State officials are reluctant to downsize and thereby jeopardize the jobs of institution employees.[46] Essentially, activists tell a story of regulatory "capture" and bureaucratic inertia by state employees and administrators.[47]

Most directly relevant to the issue of disability discrimination under the ADA is the activists' contention that community care provides a greater level of social *equality* for otherwise institutionalized individuals. Opponents of institutional care maintain that unnecessary segregation as a condition of receiving necessary care constitutes discrimination.[48] Martha Minow has written that institutionalization results in the stigmatization of the institutionalized individuals, which only aggravates the discriminatory treatment of those that the powerful in society deem different.[49] The U.S. Commission on Civil Rights issued a report prior to the enactment of the ADA that concurred generally with Minow's view and included institutionalization as a cause of discrimination against individuals with

45. *See* Amicus Curiae Brief of 58 Former State Commissioners and Directors of Mental Health and Developmental Disabilities in Support of Respondents at *25-26, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 143935.

46. *See id.*

47. *See generally* Paul B. Stephan III, *Barbarians Inside the Gate: Public Choice Theory and International Economic Law*, 10 AM. U. J. INT'L L. & POL'Y 745 (1995) (discussing public choice theory generally, i.e., the notion that regulatory statutes are often enacted, or blocked, at the behest of interest groups who stand to benefit).

48. *See* A. Arrigo, *The Logic of Identity and the Politics of Justice: Establishing a Right to Community-Based Treatment for the Institutionalized Mentally Disabled*, 18 NEW ENG. J. CRIM. & CIV. CONFINEMENT 1 (1992); Bessette, *supra* note 38; Cook, *supra* note 44; Klapper, *supra* note 36; Bruce Stacy E. Seicshnaydre, Comment, *Community Mental Health Treatment for the Mentally Ill—When Does Less Restrictive Treatment Become a Right?*, 66 TUL. L. REV. 1971 (1992).

49. Martha Minow, *When Difference Has Its Home: Group Homes for the Mentally Retarded, Equal Protection and Legal Treatment of Difference*, 22 HARV. C.R.-C.L. L. REV. 111 (1987); *see also* 136 CONG. REC. H2603 (daily ed. May 22, 1990) (statement of Rep. Collins) ("To be segregated is to be misunderstood, even feared.").

disabilities.[50] Minow's and the Civil Rights Commission's view accords with the view of community-care activists that community care is not merely a medically and financially superior option, but a morally and legally superior one as well.

2. *A Brief History of Efforts To Increase the Use of Community Care*

The history of discriminatory treatment towards the mentally disabled has deep roots. John Locke wanted full citizenship to be denied them: "Lunatics and Id[i]ots . . . [and] Madmen" are not born into the "full state of Equality" because they rely on others to "seek and procure their good for them."[51] According to John Stuart Mill, the principle of freedom from interference does not apply to those "still in a state to require being taken care of by others."[52] For these people, according to Mill, despotism was a legitimate form of government.[53]

Before the proliferation of institutions in the mid-1800s, the care of mentally disabled individuals was left to families, jails, poorhouses, and ad hoc community arrangements.[54] Population growth and reaction to reformers such as Dorothea Dix spurred the building of hospitals,[55] but overcrowding resulted in physical restraint, seclusion, brutality, and neglect.[56] Community-care activists have argued that prejudice, as much as altruism, motivated the proliferation of these segregated hospitals,[57] with government officials concluding that people with disabilities were "not much above the animal"[58] and "not far removed from the brute."[59]

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50. U.S. COMM'N ON CIVIL RIGHTS, ACCOMMODATING THE SPECTRUM OF INDIVIDUAL ABILITIES 32-34 (1983).

51. JOHN LOCKE, TWO TREATISES OF GOVERNMENT 346-50 (Peter Laslett ed., Cambridge Univ. Press 1965) (1690).

52. JOHN STUART MILL, ON LIBERTY 11 (David Spitz ed., W.W. Norton & Company 1975) (1859).

53. *Id.*

54. *See* SUSAN M. CHANDLER, COMPETING REALITIES: THE COMPETING TERRAIN OF MENTAL HEALTH ADVOCACY 11-12 (1990).

55. *See* Samuel W. Hamilton, *The History of American Mental Hospitals, in* ONE HUNDRED YEARS OF AMERICAN PSYCHIATRY 73-78 (J.K. Hall et al. eds., 1944).

56. *See* GERALD N. GROB, FROM ASYLUM TO COMMUNITY: MENTAL HEALTH POLICY IN MODERN AMERICA 3 (1991).

57. *See* Cook, *supra* note 44, at 400.

58. *Id.* at 401 (quoting *District of Columbia Appropriations Bills: Hearings Before the House Comm. on Appropriations*, 67th Cong. 96 (1923)).

59. *Id.* (quoting STATE BD. OF CHARITIES AND CORRECTIONS, SPECIAL REPORT TO

The efforts to supplant the large institutions with community care began in earnest in the mid-1950s and continued in force in the 1960s and 1970s. Political and legal activism led to the deinstitutionalization of large numbers of the mentally ill—particularly of the civilly committed. In response to the clamor for reform, Congress enacted several laws, including the Rehabilitation Act of 1973,[60] to protect various interests of disabled individuals. Advances in psychotropic medications, the development of the community-health-center movement, and litigation brought by mental health advocates and civil rights lawyers contributed to a dramatic reduction in the number of individuals housed by the public mental health system.[61] Since the 1960s, nearly 1.5 million people have been released into community settings.[62] The movement, however, did not eliminate institutional care, nor did it accomplish comparable deinstitutionalization of the *voluntarily* committed—such as the developmentally disabled individuals in *L.C.*

Advocates have, without great success, pursued several avenues for establishing a right to treatment in the least restrictive environment. Courts held that there was no such right under the Due Process Clause of the Constitution because, given the voluntary nature of the care, it could not be said that the State was denying liberty.[63] In 1981 in *Pennhurst State School v. Halderman*,[64] the Supreme Court refused to find

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THE GENERAL ASSEMBLY, MENTAL DEFECTIVES IN VIRGINIA 20 (1916)).

60. Pub. L. No. 93-111, 87 Stat. 355 (1973) (codified as amended at 29 U.S.C. §§ 701-796 (2000)). Other notable laws include the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. §§ 6000-6083 (1994 & Supp. IV 1998), *repealed by* Disabilities Assistance and Bill of Rights Act of 2000, Pub. L. No. 106-402, 114 Stat. 1677 (2000) (to be codified at 42 U.S.C. §§ 15001-15115) (setting guidelines and providing partial funding for state-run programs in §§ 6021-6030); the Fair Housing Amendments Act of 1988, Pub. L. No. 100-430, 102 Stat. 1619 (1988) (codified in scattered section of 42 U.S.C.) (protecting disabled individuals from discrimination in private housing); and the Individuals with Disabilities Education Act, 20 U.S.C. §§ 1400-1491 (2000) (requiring appropriate integration of disabled students).

61. *See* Bessette, *supra* note 38, at 132.

62. *See id.* at 163 (citing Linda Shaw, *Stigma and the Moral Careers of Ex-Mental Patients Living in Board and Care*, 20 J. CONTEMP. ETHNOGRAPHY 285, 288 (1991)).

63. *See, e.g.*, Society for Goodwill to Retarded Children, Inc. v. Cuomo, 737 F.2d 1239 (2d Cir. 1984) (overruling a deinstitutionalization decree based on due process principles); Doe v. Public Health Trust, 696 F.2d 901 (11th Cir. 1983) (holding that minors voluntarily committed by their parents did not have a right to treatment in the least restrictive environment).

64. 451 U.S. 1 (1981).

an articulated right to treatment in the least restrictive environment under the Developmental Disabilities Assistance and Bill of Rights Act ("DDA").[65] Four years later, in *City of Cleburne v. Cleburne Living Center*,[66] the Supreme Court determined that mentally retarded persons do not constitute a suspect class subject to heightened protection under the Equal Protection Clause.[67]

Courts also refused to find a right to the least restrictive treatment in Section 504 of the Rehabilitation Act of 1973, the precursor to Title II of the ADA. Section 504 possesses substantially similar language to Title II but is limited in its application to entities receiving federal funds.[68] U.S. Courts of Appeals consistently held that the Rehabilitation Act did *not* require that states place handicapped persons in the least restrictive setting appropriate to their needs.[69] In fact, the Rehabilitation Act and its regulations have practically become a dead letter as a remedy for segregated public treatment.[70]

Even early efforts under the ADA and the Integration Regulation met checkered results.[71] In 1993 in *Williams v.*

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65. 42 U.S.C. §§ 6000-6083 (1994 & Supp. IV 1998), *repealed by* Developmental Disabilities Assistance and Bill of Rights Act of 2000, Pub. L. No. 106-402, 114 Stat. 1677 (2000) (to be codified at 42 U.S.C. §§ 15001-15115 (2000)).

66. 473 U.S. 432 (1985).

67. The Court struck down the classification, finding quasi-suspect classification unnecessary to adequately protect the interests of the mentally retarded. *See id.* at 442-46.

68. *See* 29 U.S.C. § 794 (2000).

69. *See, e.g.*, P.C. v. McGlaughlin, 913 F.2d 1033, 1041 (2d Cir. 1990) (holding the Rehabilitation Act "does not require all handicapped persons to be provided with identical benefits," and that the Act "did not clearly establish an obligation to meet [the plaintiff's] particular needs vis-à-vis the needs of other handicapped individuals, but mandated only that services provided nonhandicapped individuals not be denied [the plaintiff] because he is handicapped"); Ciampa v. Ma. Rehabilitation Comm'n, 718 F.2d 1, 5 (1st Cir. 1983) (stating that health care provider did not discriminate when it failed to develop greater capacity to treat disabilities); Phillips v. Thompson, 715 F.2d 365, 368 (7th Cir. 1983) (holding that the State had no affirmative duty under the Rehabilitation Act "to create less restrictive community residential settings for them"). *But see* Jackson v. Fort Stanton Hosp. and Training Sch., 757 F. Supp. 1243, 1299 (D.N.M. 1990) (determining that defendant's failure to integrate individuals with severe developmental disabilities in the community, while developing community placements for less disabled individuals, violated Section 504).

70. *See* Cook, *supra* note 44, at 394-408 (arguing for application of the ADA to the provision of segregated services).

71. For a relatively thorough history of ADA Title II and the Integration Regulation, see generally Joanne Karger, Note, *"Don't Tread On The ADA:"* Olmstead v. L.C. *ex rel.* Zimring *and the Future of Community Integration for Individuals with Mental Disabilities*, 40 B.C. L. REV. 1221 (1999) (cataloging the

Secretary of the Executive Office of Human Services,[72] the Supreme Judicial Court of Massachusetts refused to find that the ADA required states to provide specific levels of community care and refused to impose the provision of such care to a small class of mentally ill patients. In the same year, two federal district courts split on the question of whether the ADA applied to unnecessarily institutionalized individuals.[73]

The courts' treatment of the applicability of the Integration Regulation solidified somewhat after the 1995 landmark case of *Helen L. v. DiDario*.[74] In *Helen L.*, the Third Circuit held that the regulation required the provision of community care to one physically handicapped individual who qualified for the State's community treatment program and, in general, held that the Integration Regulation does indeed apply to unnecessarily institutionalized individuals.[75] Research discovered that, since *Helen L.*, *eleven* additional federal court cases have issued opinions respecting the question of whether the Integration Regulation applies to make unnecessary institutionalization a type of discrimination under the ADA, and *ten* courts have followed the reasoning of *Helen L.* for individuals qualified for outpatient treatment.[76] In *L.C.*, the Supreme Court determined

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Olmstead v. L.C. case and its history, and arguing that the Supreme Court should have taken even a broader view of ADA Title II's integration mandate); *see also* Olmstead v. L.C. by Zimring, 527 U.S. 581, 588-92 (1999) (laying out the history of the ADA).

72. 609 N.E.2d 447 (Mass. 1993).

73. *Compare* Conner v. Branstad, 839 F. Supp. 1346, 1357 (S.D. Iowa 1993) (holding that "the ADA does not require deinstitutionalization of mentally disabled individuals"), *with* Martin v. Voinovich, 840 F. Supp. 1175, 1192 (S.D. Ohio 1993) (holding that mentally retarded plaintiffs had succeeded in stating a claim under the ADA).

74. 46 F.3d 325 (3d Cir. 1995). For a discussion of *Helen L.*, see *infra* Part II.B.3.a.

75. *See Helen L.*, 46 F.3d at 328-29, 331-33.

76. *See* L.C. by Zimring v. Olmstead, 138 F.3d 893 (11th Cir. 1998); Cramer v. Chiles, 33 F. Supp. 2d 1342, 1354 (S.D. Fla. 1999); Messier v. Southbury Training Sch., No. 3:94-CV-1706(EBB), 1999 WL 20910, at *8 (D. Conn. Jan. 5, 1999); Kathleen S. v. Dep't of Pub. Welfare, 10 F. Supp. 2d 460, 469 (E.D. Pa. 1998); Cable v. Dep't of Developmental Servs., 973 F. Supp. 937, 941 (C.D. Cal. 1997); Greist v. Norristown State Hosp., No. CIV. A. 96-CV-8495, 1997 WL 661097, at *3 (E.D. Pa. Oct. 22, 1997); Charles Q. v. Houstoun, No. CIV. A. 1:CV-95-280, 1996 WL 447549, at *3 (M.D. Pa. April 22, 1996) (unpublished opinion); Williams v. Wasserman, 937 F. Supp. 524, 530 (D. Md. 1996); K.L. v. Valdez, No. 93-1359 BB/LCS (D.N.M. 1995) (refusing to dismiss ADA claims of children with developmental disabilities) (unpublished); Wyatt v. Hanan, No. 3195-N (M.D. Ala. 1995) (stating that ADA "requires that services of programs provided by a public entity 'integrate' qualified disabled) (unpublished). *But cf.* Jeffrey v. St. Clair, 933 F. Supp. 963, 970 (D. Haw. 1996) (finding no discrimination by reason of disability where State shut down experimental group care program and deinstitutionalized

that the latter ten were right. The Court explicitly held that "[u]njustified isolation . . . is properly regarded as discrimination based on disability" prohibited by the ADA.[77]

C. Application of the Integration Regulation

The Petitioners in *L.C.* argued that the application of the Integration Regulation to unnecessarily institutionalized individuals exceeded the scope of that regulation and the scope of the DOJ's authority to define the forms of discrimination that are prohibited by Title II. The State argued that the ADA requires merely evenhanded treatment as between disabled and non-disabled individuals in the provision of state benefits.[78] Although a full treatment of the arguments that the Supreme Court addressed in *L.C.* is beyond the scope of this discussion, legislative intent, traditional deference to implementing agencies, and the weight of current case law counseled in favor of the Supreme Court's adoption of the DOJ's interpretation of the Integration Regulation, which applied the regulation to unnecessarily institutionalized individuals.

The Supreme Court was right to follow the DOJ's interpretation. The DOJ is entrusted with the responsibility of implementing ADA Title II and issuing regulations to define prohibited forms of discrimination. Title II does not spell out the forms of discrimination it prohibits. Instead, Congress instructed that "the Attorney General shall promulgate regulations in an accessible format that implement this part."[79] That section directed the Attorney General (the head of the DOJ), "to issue regulations setting forth the forms of discrimination prohibited."[80] In this way the ADA resembles other vague statutes enacted by Congress, such as the Sherman Act in antitrust law, whereby executive agencies take the lead in defining the boundaries of the statute. Pursuant to this congressional command, the DOJ promulgated the Integration

involuntarily criminally committed mentally ill individuals). The *Jeffrey* court found that, because neither the experimental program nor the institution provided contact with non-disabled individuals, a transfer from the former to the latter did not implicate the Integration Regulation. *Id.*

77. Olmstead v. L.C. by Zimring, 527 U.S. 581, 597 (1999).

78. *Id.* at 598.

79. 42 U.S.C. § 12134(a) (2000).

80. H.R. REP. NO. 101-485, pt. 3, at 52 (1990).

Regulation. The Integration Regulation provides that "[a] public entity shall administer services, programs, and activities in the *most integrated setting appropriate* to the needs of qualified individuals with disabilities,"[81] and described "the most integrated setting appropriate" as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[82]

In *L.C.* and *Helen L.*, the Supreme Court and Third Circuit, respectively, relied upon and embraced the DOJ interpretation of the Integration Regulation as articulated in briefs submitted by the Government as amicus curiae. The DOJ described "the most integrated setting appropriate" as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."[83] The DOJ therefore interpreted the Integration Regulation to require

> a State that offers treatment to persons with disabilities to provide such treatment in a community setting that offers opportunities for interaction with persons without disabilities, rather, than in an institution, when (1) the State's treatment professionals have determined, in the exercise of reasonable professional judgment, that community placement of the individual is appropriate, and (2) such a placement would not require an unreasonable change in state policy or a fundamental alteration in the nature of the State's treatment program.[84]

Thus, according to the DOJ and now the Supreme Court,[85] where (as in *L.C.*) the plaintiff is segregated unnecessarily, the Integration Regulation applies and the remaining question is whether the imposition of community placement—a "setting that offers opportunities for interaction with persons without disabilities"—would effect an unreasonable modification or a fundamental alteration.

The Supreme Court soundly decided to afford the DOJ interpretation of the Integration Regulation the deference normally granted to an agency's interpretation of its own

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81. 28 C.F.R. § 35.130(d) (2000) (emphasis added).

82. 28 C.F.R. pt. 35, app. A, at 469 (1996) (discussing 28 C.F.R. § 35.130(d)-(e)).

83. *Id.*

84. Brief for the United States as Amicus Curiae Supporting Respondents at *i, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 149653.

85. Olmstead v. L.C. by Zimring, 527 U.S. 581, 597 (1999).

regulations. Under settled Supreme Court precedent, an agency's interpretation of its own regulations is "controlling" unless it is "plainly erroneous,"[86] "inconsistent with the regulation,"[87] or a mere "'*post hoc* rationalizatio[n]' of . . . past agency conduct."[88] The State argued that the regulation should apply only to services provided to both disabled and non-disabled persons, but there is no such limitation in the regulation. The regulation on its face applies to *all* services administered by a public entity, thereby apparently including those that are offered only to persons with disabilities. Thus, the DOJ's interpretation accords with the regulation's plain language and is neither "plainly erroneous" nor "inconsistent." Further, the interpretation has been a matter of public record since 1995 and is not a "post hoc rationalization" of past agency conduct.[89] Therefore, under the traditional deferential standard, the Supreme Court accorded the DOJ its due discretion.

Moreover, statutory intent and traditional deference to agencies assigned the responsibility of promulgating regulations to implement a statute suggest that the DOJ and the Supreme Court were justified in concluding that unnecessary institutionalization constitutes a form of ADA discrimination and that therefore their interpretation of the Integration Regulation was within the bounds of Title II. A basic principle of administrative law provides that where a governmental agency is granted authority to give content to a general statutory provision, the agency is entitled to deference.[90] This general principle was recently applied to the ADA by the Supreme Court, and the Court held that the DOJ's views regarding the application of the statute warranted such deference.[91] The Court acknowledged that the DOJ was

86. Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 512 (1994).

87. *Id.*

88. Auer v. Robbins, 519 U.S. 452, 462 (1997) (alteration in original) (quoting Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 212 (1988) (citation omitted)).

89. *See* Brief for the United States as Amicus Curiae Supporting Respondents at *10-11, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 149653.

90. *See* Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 844 (1984) (stating that such interpretation is entitled to "controlling weight" unless it is "arbitrary, capricious, or manifestly contrary to the statute").

91. Bragdon v. Abbott, 524 U.S. 624, 646 (1998) ("As the agency directed by Congress to issue implementing regulations, to render technical assistance explaining the responsibilities of covered individuals and institutions, and to enforce Title III [of the ADA] in court, the [Justice] Department's views are

directed by Congress to issue implementing regulations and was the agency principally responsible for the ADA's enforcement.[92] Thus, the DOJ interpretation of the statute was entitled to controlling weight unless it was "arbitrary, capricious, or manifestly contrary to the statute." Following this principle, the Court properly afforded controlling weight to the DOJ interpretation that unnecessary institutionalization constitutes a form of discrimination prohibited by Title II.

The legislative history behind the enactment of the ADA provides further support for the DOJ's and the Supreme Court's view that unnecessary institutionalization constitutes a form of prohibited discrimination.[93] Although an exhaustive legislative history is beyond the scope of this discussion, a thumbnail sketch provides support for the Court's holding. In findings accompanying the ADA, Congress determined that "historically, society has tended to isolate and segregate individuals with disabilities, and . . . such forms of discrimination . . . continue to be a serious and pervasive social problem."[94] It also held that discrimination occurs in various contexts including "institutionalization,"[95] and that "individuals with disabilities continually encounter various forms of discrimination, including . . . segregation."[96] Legislative debates and hearings bear out that those findings reflect an understanding that unjustified segregation constitutes a form of discrimination.[97] Former Attorney General Edwin Meese, who oversaw passage of the ADA and participated in its hearings, has joined in the opinion that the DOJ (and now Supreme Court) view accords with the statutory authority granted the Department under Title II.[98]

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entitled to deference." (citations omitted)).

92. *Id.*

93. *See* Olmstead v. L.C. by Zimring, 527 U.S. 581, 599-600 (1999).

94. 42 U.S.C. § 12101(a)(2) (2000).

95. *Id.* at § 12101(a)(3).

96. *Id.* at § 12101(a)(5).

97. *See, e.g.*, 134 Cong. Rec. S5116 (daily ed. Apr. 28, 1988) (statement of Sen. Simon) (stating that persons with disabilities "are hidden in institutions [and they] are hidden in nursing homes"); 135 Cong. Rec. S4986 (daily ed. May 9, 1989) (statement of Sen. Harkin) (the ADA is intended, in part, to get people "out of institutions"); 136 Cong. Rec. H2447 (daily ed. May 17, 1990) (statement of Rep. Miller) ("[I]t has been our unwillingness to see all people with disabilities that has been the greatest barrier to full and meaningful equality. Society has made them invisible by shutting them away in segregated facilities . . . .").

98. *See* Brief of Edwin Meese as Amicus Curiae, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536).

Aside from statutory intent and agency discretion, the Supreme Court held that unnecessary institutionalization can properly be viewed as "discrimination" under traditional definitions of the term.[99] First, as mentioned above, unjustified segregation can stigmatize those segregated, and this can lead to further inferior treatment. Second, unjustified segregation imposes a burden on the disabled not placed on the non-disabled. Whereas the institutionalized disabled person must sacrifice involvement in community life to get the services they need, non-disabled persons need not sacrifice community living to get needed services. Third, unnecessary segregation denies disabled persons public benefits offered to the non-disabled. This argument responds to the Petitioners' argument that the ADA should not apply unless disabled individuals fail to receive the same services received by non-disabled individuals. Disabled people must indeed give up such benefits: Where individuals must by reason of their disability obtain needed services in a segregated setting, they are deprived of equal access to the benefits of community living—public commons, parks, museums, and most other public services.

This definition of discrimination is arguable, because it may be contended that unnecessary institutionalization is not "by reason of disability" but by reasons of poverty, administrative inefficiency, or lack of public funds. Still, in the face of this indeterminacy, Supreme Court deference to the DOJ under *Chevron* was justified. Indeed, nearly every court that has considered the question has concluded likewise: The DOJ acted well within its regulatory and statutory authority to apply the Integration Regulation to unnecessary institutionalization.[100] Given the foregoing legislative history and the deferential standard applied to agency interpretations of their own regulations, not to mention the policy benefits of community care discussed above, the Supreme Court took the proper position that the Integration Regulation does in fact apply to unnecessarily institutionalized people. Thus, we now move beyond the question of whether or not the Integration

99. *See L.C.*, 527 U.S. at 600 (1999).

100. *See supra* note 76 and accompanying text (cataloguing cases ruling on Integration Regulation).

Regulation applies, and forward to the reasons behind the Court's intervention in this arena.

D. The Need for Federal Intervention

While the above discussion highlights the reasons supporting the Supreme Court's conclusion in *L.C.*, another concern weighed in favor of the Court's holding—the need for federal legislative and judicial intervention. In ruling that the ADA and the Integration Regulation applied to bar discrimination against unnecessarily institutionalized individuals, the Supreme Court implicitly recognized the need for federal involvement when major state power centers (here, state legislatures and the corresponding state mental hospitals that they funded) are not well suited to correct the problem at hand.[101] It is well chronicled that mentally disabled individuals are limited in their capacity to represent their interests in majoritarian power centers; mentally handicapped people vote less frequently, donate less money, and lobby less loudly. The Supreme Court acknowledged this explicitly in *Cleburne*—though mentally handicapped residents were able to "attract the attention of the lawmakers," they could not "mandate the desired legislative responses" to deal with the prejudice they faced.[102] One commentator has argued that such relative disenfranchisement and vulnerability justifies intervention by courts and legislatures.[103]

Ample evidence indicated that state institutions were providing poor care to the mentally disabled, and that institutions continued to do so despite the data demonstrating that community care was both less expensive and more effective at improving patients' lives.[104] This reality provides a measure of empirical evidence that states were not sufficiently equipped, or perhaps not sufficiently motivated, to resolve the problems facing the unnecessarily institutionalized mentally disabled population.

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101. *See* City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432 (1985).

102. *Id.* at 445.

103. Steve P. Calandrillo, *Corralling Kevorkian: Regulating Physician Assisted Suicide in America*, 7 VA. J. SOC. POL'Y & L. 41 (1999) (discussing the vulnerability of infirm elderly persons and the need for legislative and judicial intervention to protect their interests in the physician assisted suicide context).

104. *See* Klapper, *supra* note 36, at 769-70.

Why have states demonstrated such inability, or at least such a lack of success, in fixing the problem? A number of explanations are possible, including the institutional inertia, regulatory capture, and ratcheting effects that can burden state power centers. Too commonly,

> [p]olitical goals to save money, bureaucratic pressures to allocate mental health funds primarily to state institutions, and neighborhood resistance to the establishment of alternative community facilities have brought about the failure of deinstitutionalization. These forces have created a "revolving door" for persons with mental disabilities . . . . Unfortunately, the legislative response at the state level, shaped by political and fiscal pressures, does not adequately weigh the interests of this population.[105]

Moreover, legislatures can fall victim to "ratcheting" effects. Once state legislatures have granted the funding to build and run state mental hospitals, eliminating them becomes hard even if they are not performing as desired. Once the funding is ratcheted up, it becomes difficult to ratchet back. The cries of politically powerful groups who support the status quo can drown out the voices of less powerful mentally disabled individuals.[106] As Jonathan Zasloff has argued, "[o]fficials will focus on satisfying their political masters because they can do little else: political pressure becomes a means of rationing scarce resources."[107]

In some instances, this inertia might affect state power centers while not handcuffing federal ones. Given the smaller number of people that run state governing bodies and mental hospitals, it is understandable that there would be anomalies and problems in some of the results. Thus, we witness a wide

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105. Susan Lee, Heller v. Doe*: Involuntary Civil Commitment and the "Objective" Language of Probability*, 20 AMER. J.L. & MED. 457, 458 (1994).

106. *See* Frank H. Easterbrook, *Statutes' Domains*, 50 U. CHI. L. REV. 533, 547 (1983). Easterbrook argues that "although legislators have individual lists of desires, priorities, and preferences, it turns out to be difficult, sometimes impossible, to aggregate these lists into a coherent collective choice." *Id.* Rather, because of flaws in legislative voting processes, it "is fairly easy to show that someone with control of the agenda can manipulate the choice so that the legislature adopts proposals that only a minority support." *Id.* This idea relates also to the notion of capture, in which larger power centers are captured by smaller power centers. *See* JOHN H. ELY, DEMOCRACY AND DISTRUST: A THEORY OF JUDICIAL REVIEW 120-25 (1980).

107. Jonathan Zasloff, *Children, Families, and Bureaucrats: A Prehistory of Welfare Reform*, 14 J.L. & POL. 225, 257 (1998).

range in state treatment of the mentally disabled; some states have been quite good while others have been quite poor, showing little sign of improvement.[108]

In the context of a smaller system, there is arguably more potential for that system to be a closed one, and certainly more potential for legislative capture.[109] Viewed through a public choice optic, a state legislature is easier to capture than the federal Congress. State legislatures typically have fewer members than Congress, and successful campaigns for seats on state legislatures typically require far smaller war chests.[110] Thus, organizations with funds and voters can strongly influence the composition and conduct of state legislatures.

This reality relates to James Madison's notion, presented in *The Federalist Papers* and counseling in favor of a strong federal government, that tyranny of the majority is more likely to occur in a small group than in a large one:

> The smaller the society, the fewer probably will be the distinct parties, . . . the more frequently will a majority be found of the same party; and . . . the more easily will [that majority] concert and execute [its] plans of oppression. Extend the sphere, and you take in a greater variety of parties and interests; you make it less probable that a majority of the whole will have a common motive to invade the rights of other citizens. . . .[111]

When relatively fewer people control decisions (i.e., as in state legislatures), chances are greater that we will see more

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108. *See* DAVID BRADDOCK, THE STATE OF THE STATES IN DEVELOPMENTAL DISABILITIES: 2000 STUDY SUMMARY 6 (2000), *available at* http://www.uic.edu/depts/idhd/StateoftheStates/StatesSummary2000.pdf ("In 1998, 21 states provided 70% or more of their residential services in settings for six or fewer persons. However, in the 14 states of Kentucky, Mississippi, Texas, Georgia, Oklahoma, Illinois, New Jersey, Alabama, Virginia, Utah, Tennessee, Ohio, Delaware, and Louisiana, at least 40% of all persons living in out-of-home residential placements were in institutional facilities for 16 or more persons.").

109. *See* Easterbrook, *supra* note 106.

110. *Compare* Samantha Sanchez, *Average Contribution Size in State Legislatures, at* http://www.followthemoney.org/issues/contribsize.html (July 2, 1999). ("*Total funds raised* by all legislative candidates in the 12 states range from a low of $1.5 million in Idaho to $41.1 million in Illinois.") (emphasis in original), *with* The Center for Responsive Politics, 2000 Election Overview: Stats at a Glance, *at* http://www.opensecrets.org (last visited May 21, 2001) (showing that national senate races in 2000 between just two candidates resulted in an average total spending of nearly $11 million). Both organizations are non-partisan research centers.

111. THE FEDERALIST NO. 10, at 63-64 (James Madison) (Jacob E. Cooke ed., 1961).

extreme results than those which we would see on a national scale where far more voices may be heard—and more publicly. In this context—one of institutional inertia, capture, and ratcheting—a more powerful, more comprehensive federal force may be required to come in, break down barriers, and make state institutions change their course, where state institutions are not so able.[112]

This phenomenon is analogous to what our country experienced during the Civil Rights Movement of the 1960s.[113] States were the bodies causing the discrimination problem and showed little capacity to resolve it, due to a combination of political, social, and institutional inertia.[114] Accordingly, it was the federal government, along with its courts, that instigated change, just as we have witnessed with the ADA and in *L.C.* The Supreme Court's holding in *L.C.* thus exemplifies federal intervention as a route to solve problems that trouble states. The states' demonstrated incapacity counsels in favor of such intervention. All three branches of the government came together in an attempt to remedy the problem of discrimination against the mentally disabled in state institutions. An Article I legislative body (Congress) passed a federal law (the ADA), an Article II executive arm (the DOJ) promulgated a regulation interpreting that legislation, and Article III federal courts stepped in to affirm the law's validity and force.

This is not to suggest that the federal legislative and executive branches are unconstrained by institutional inertia and regulatory capture—merely that there are some occasions in which states will be fettered and the federal government will

112. Somewhat tangentially, however, there has been speculation that federal lawsuits against the states under Title II constitute unconstitutional abrogations of state sovereign immunity. For an in depth discussion on the topic, see generally James Leonard, *A Damaged Remedy: Disability Discrimination Claims Against State Entities Under the Americans with Disabilities Act After* Seminole Tribe *and* Flores, 41 ARIZ. L. REV. 651 (1999). From a policy perspective, the weaknesses of state power centers might cut against such a restrictive view of federal authority. Although interesting, these issues are beyond the reach of this paper, as they were beyond the reach of the Supreme Court's opinion in *Olmstead v. L.C. by Zimring*, 527 U.S. 581, 588 (1999) (ruling that "[t]he case, as it comes to us, presents no constitutional question").

113. *See* Gabriella Davi, *A Progression Toward Freedom: Protecting the Disabled Under the Ku Klux Klan Act*, 20 CARDOZO L. REV. 1019, 1028-30 (1999).

114. *See generally* Swann v. Charlotte-Mecklenburg Bd. of Educ., 402 U.S. 1 (1971); Cooper v. Aaron, 358 U.S. 1 (1958); Brown v. Bd. of Educ., 347 U.S. 483 (1954).

be less so.[115] Federal courts likewise do not act with complete freedom—with traditional reliance on stare decisis, no institution may be subject to institutional inertia to as large a degree as our court system.[116] Still, in public choice terms, the life tenure afforded federal judges by Article III[117] allows federal courts to be relatively free from capture. Thus, again, there are some occasions in which states will be fettered and federal courts will be less so. In *L.C.*, the Supreme Court confronted just such an occasion.

E. Problems of Broad Application of Title II and the Integration Regulation: The Need for a Discussion of Fundamental Alteration and Unreasonable Modification

Notwithstanding the Supreme Court's opinion in *L.C.*, if no meaningful boundaries are placed on the sweep of the Integration Regulation, it could expand beyond intended practicable limits. For example, two recent district court opinions issued before the Supreme Court's *L.C.* decision stretched the limits of states' duties. In *Cramer v. Chiles*,[118] a federal district court within the Eleventh Circuit (the Circuit that issued the opinion in *L.C.*) relied in part on the ADA to bar the implementation of a Florida statute that would have eliminated funding for private Intermediate Care Facilities for the Developmentally Disabled ("ICF/DDs").[119] The court held that the statute would have impermissibly denied meaningful choice and resulted in unnecessary institutionalization.[120] Notably, the court failed to address the fundamental alteration issue, or even to acknowledge its existence, and in a fashion harking back to the judicial activism of the school desegregation era, maintained jurisdiction to appoint a panel of experts to develop a transitional plan.[121]

In *Kathleen S. v. Department of Public Welfare*,[122] a district court

115. *See* Easterbrook, *supra* note 106.

116. *See* Rafael Gely, *Of Sinking and Escalating: A (Somewhat) New Look at Stare Decisis*, 60 U. PITT. L. REV. 89, 123 (1998).

117. *See* U.S. CONST. art. III, § 1.

118. 33 F. Supp. 2d 1342 (S.D. Fla. 1999).

119. *Id.* at 1353-54.

120. *Id.* at 1353.

121. *Id.* at 1354.

122. 10 F. Supp. 2d 460 (E.D. Pa. 1998). This case is discussed *infra* at Part II.B.3.a.

within the Third Circuit (the same Circuit that decided *Helen L.*) held a violation of the ADA when Pennsylvania closed a hospital and failed to create sufficient community-care facilities for the released persons. Whereas *Helen L.* and *L.C.* involved few plaintiffs and did not purport to alter the design of the state programs, *Cramer* openly wrested control from the state of the decisions as to what programs to provide and fund, and *Kathleen S.* required the state to create substantial new programs. In addition to these cases, in several jurisdictions community-care activists have brought pending litigation seeking sweeping consequences, including claims to force the closure of institutions and the creation of vast new community-care systems.

Five rules of action illustrate the need for limits. First, individuals have different conditions and needs.[123] Where failing to provide care in the "most integrated setting appropriate" constitutes a prima facie case of discrimination, the wide range of individual needs poses problems. Presumably a state should not be required to create *infinite* types of community-care programs in order to provide the *most* integrated setting appropriate for each person of infinite human variation. Second, conditions change. At times certain types of care will suffice for a particular person when at other times such care will not suffice for that person, and when conditions change placements must be found and services must be adjusted. Thus, barring the creation of unused excess capacity, there will *always* be some number of individuals who could be cared for in more appropriate facilities, even if only temporarily.

Third, determining ex ante the popularity of newly developed programs is difficult. Under a sweeping application of Title II, states would be deterred from creating experimental programs with limited enrollment, because such creation provides one more option for plaintiffs to demand, claiming that states violated the ADA by not offering the benefit to everyone who could qualify for it.[124]

Fourth, we live in a world of limited resources. Unlimited

123. *See* Brief for States at *1, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 60990 (discussing that individuals have widely varying needs).

124. *See* discussion *infra* at Part II.B.3.a.

funds, staff, and facilities are not available to care for the country's sick. Whereas per patient costs of community care may be lower than those of institutional care, overhead costs, and the possibility of changing conditions suggest the conclusion that a shift to community care might not save money, and might in fact be quite costly.[125]

Fifth and finally, deinstitutionalization is not without risks, nor is it a panacea for the ills of the mentally disabled. For some mentally disabled individuals, institutional care can in fact be superior to many types of community care.[126] Indeed the experience of deinstitutionalization of the mentally ill illustrates the need for caution. Deinstitutionalization of the mentally ill is responsible for much of the current homeless population and is widely regarded as a far reaching failure.[127] Samuel Brakel has written:

> The deinstitutionalization movement has not lived up to its promises and . . . the ideal of community treatment has resulted in the abandonment of many mentally disabled persons to virtually unsupervised, unprotected lives in flophouses located in dangerous or dilapidated areas or even in "psychiatric ghettoes" that have sprung up in some of our larger cities.[128]

Unchecked deinstitutionalization today could have the same effect. Closing hospitals risks putting people into communities where they are unable to cope, and where they lack the structured environment and monitoring of an institution.[129]

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125. *See* discussion *infra* at Part II.C.1.c.

126. In *Messier v. Southbury Training Sch.*, No. 3:94-CV-1706(EBB), 1999 WL 20910 (D.Conn. Jan. 5, 1999), over 600 institutionalized individuals moved to enter a community-care suit on the *defendant's* side, because of the fear that the suit would close the institutions. *Id.* at *2-*3. *See generally* Christopher Slobogin, *Treatment of the Mentally Disabled: Rethinking the Community-First Idea*, 69 NEB. L. REV. 413 (1990) (challenging the notion that society should always favor the current community placement over segregated institutions).

127. *See generally* ANN BRADEN JOHNSON, OUT OF BEDLAM: THE TRUTH ABOUT DEINSTITUTIONALIZATION (1990) (discussing the problems of deinstitutionalization of the mentally ill); DAVID A. ROCHEFORT, FROM POORHOUSES TO HOMELESSNESS: POLICY ANALYSIS AND MENTAL HEALTH CARE (1993) (discussing same); Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 98-108 (1991) (describing the problem of homelessness resulting from deinstitutionalization).

128. Samuel J. Brakel, *Involuntary Institutionalization*, *in* THE MENTALLY DISABLED AND THE LAW 31 (3d ed. 1985).

129. *See* EDWIN FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 11 (1997) ("For a substantial minority, however, deinstitutionalization has been a psychiatric *Titanic*."); *see also* Olmstead

This lack of coping ability can lead to homelessness, which can worsen the conditions of the mentally disabled person in addition to presenting a discrete social problem.[130]

In *Alexander v. Choate*,[131] a Rehabilitation Act case, the Supreme Court recognized the importance of "keep[ing] § 504 within manageable bounds." The same applies to Title II. In light of this need for limits, the fundamental alteration and unreasonable modification limitations become the indispensable siblings of the Integration Regulation. While the application of the Integration Regulation is grounded on the supportable premise that there can be a *better* system, the fundamental alteration defense is grounded on the reality that in a world of finite resources, there can be no *perfect* system. A quixotic quest for one could compound the crisis.

Given how recently the Supreme Court decided *L.C.* and the relative youth of Title II jurisprudence, it is not clear what limits the fundamental alteration principle provides. Title II fails to provide clear guidance, and courts have yet to explore deeply the question.[132] Moreover, the scholarship gives the fundamental alteration question only cursory treatment. The possibility of an unchecked Title II raises several questions. In response to litigation, would a state be required to deinstitutionalize involuntarily committed and dangerous, mentally ill individuals? Would a state be required to eliminate its current eligibility requirements for existing treatment programs so that more individuals would qualify? Would a state be required to fashion entirely new programs? Would a state be required to undertake unlimited cost to provide integrated programs? Would a state be required to shut down

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v. L.C. by Zimring, 527 U.S. 581, 609 (Kennedy, J., concurring) (quoting TORREY, *supra*, and noting that "the depopulation of state mental hospitals has its dark side").

130. *See* Ellen Baxter & Kim Hopper, *Troubled on the Streets: The Mentally Disabled Homeless Poor*, *in* THE CHRONIC MENTAL PATIENT: FIVE YEARS LATER 49-56 (John A. Talbott ed., 1984) (describing the difficulties mentally ill individuals face in homeless conditions).

131. 469 U.S. 287, 299 (1985).

132. *Cf.* Brief for States at *8, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 60990 ("[T]he 'fundamental alteration' standard provides no criterion at all by which a state can . . . plan and fund the services it will provide to individuals with disabilities."); Lucille D. Wood, *Costs and the Right to Community-Based Treatment*, 16 YALE L. & POL'Y REV. 501, 501 (1998) ("Very little attention, however, has been paid to the way in which the costs of community-based treatment have entered into courts' opinions.").

all or a substantial portion of its state hospitals? The Supreme Court's opinion in *L.C.* directly answers some of these questions, but the more difficult ones are left for future cases and controversies.

With these questions in mind, the remainder of this Article explores the fundamental alteration defense (and the conceptually related unreasonable modification limitation to Title II) and attempts to do two things to promote and facilitate discussion of the issue. First, looking back to instruct the future (in common law fashion), Part II uses Rehabilitation Act and ADA case law to provide advocates a practical guide to the current arguments available. Second, using those arguments and cases, Part II provides a theoretical framework for the fundamental alteration and unreasonable modification question.

II. FORWARD TO FUNDAMENTAL ALTERATION

Title II does not require that fundamental alterations or unreasonable modifications be made to state programs. There is no clear test to determine whether or not a proposed modification is unreasonable or constitutes a fundamental alteration, and courts will look to a variety of factors to make this largely factual determination. The issue traditionally arises as an affirmative defense, although the issue can also arise in the context of the plaintiff's prima facie case. Rather than focusing on advocacy of particular positions (with frequent exceptions), this section attempts to explain, categorize, and place into an intellectual framework the arguments and issues extant in community-care cases, as well as to do some casual predicting of courts' possible resolutions of some of those issues.

The first theoretical category of arguments presented regards *program integrity*. These arguments rest on differences in *kind* between the benefit offered by the public entity and the benefit requested by the plaintiff. Where a defendant shows that a proposed modification would alter the essential nature of a program, by, for example, precluding the realization of essential purposes or by eliminating essential eligibility requirements, that modification may be deemed a fundamental alteration. These arguments are raised in the context of three general types of cases. First, if plaintiffs are not medically fit for

community-based treatment of any form, then requiring community treatment would constitute a fundamental alteration of the state program's essential purpose of patient protection assuming deference to professional discretion.[133] Second, if future plaintiffs are medically fit for some form of community treatment, but fail to meet some criteria for the particular community treatment program requested, then requiring release might constitute a fundamental alteration in light of the elimination of an essential eligibility requirement, to the extent a court does not deem the exercise of regulatory discretion to be discriminatory. Third, if future plaintiffs satisfy eligibility criteria for an existing community treatment plan, but have not been transferred due to error, administrative convenience, or a lack of available slots, then a court is less likely to deem a required transfer to be a fundamental alteration based on administrative discretion as an essential feature.

The second theoretical category of arguments presented regards *magnitude*. These arguments rest on changes in *degree* of the public entity's system. In a large class action suit of any of the three general types, a court may find a fundamental alteration if the transfer of the plaintiffs would significantly harm the fiscal well being of the state program. Further, a fundamental alteration may be found if the requested transfer would force broad deinstitutionalization.

A. Fundamental Alteration and Unreasonable Modification Generally

1. Title II of the ADA Does Not Require Unreasonable Modifications or Fundamental Alterations

The unreasonable modification/fundamental alteration limitation to the ADA has its roots in Supreme Court precedent under the Rehabilitation Act. The Supreme Court held in

133. This Part discusses three types of discretion in the context of program integrity arguments: professional discretion (respecting a treating doctor's medical judgment), regulatory discretion (respecting the State's essential eligibility requirements), and administrative discretion (respecting decisions made for reasons of administrative necessity or interest). *See* Olmstead v. L.C. by Zimring, 527 U.S. 581, 602-08 (1999) (describing limits to the State's obligations).

Southeastern Community College v. Davis[134] that Section 504 of the Rehabilitation Act does not require "affirmative action" on the part of a public entity. The *Davis* Court held that requiring a nursing school to accommodate a deaf student, including providing individualized assistance, would amount to a "fundamental alteration in the nature of [the] program . . . far more than the 'modification' [Section 504] requires."[135] Subsequently, in *Alexander v. Choate*,[136] the Court interpreted the "affirmative action" discussed in *Davis* to mean those modifications that would be "substantial" or those that "would constitute fundamental alteration[s] in the nature of a program." Under this newly formulated fundamental alteration defense, the *Choate* Court held that a state was not precluded from reducing the number of hospital days that Medicaid would reimburse hospitals on behalf of Medicaid recipients, even though this funding decision dispro-portionately affected disabled individuals.[137]

The fundamental alteration defense, as an extension of the principle that the ADA requires only reasonable modifications, has been expressly recognized by DOJ regulation. Furthermore, the regulation has been applied in the context of Integration Regulation cases under Title II.[138] The regulation does not clearly define what sorts of changes would be deemed fundamental, nor do the regulations provide further guidance on the elements of the fundamental alteration defense. Likewise, in neither *Davis* nor *Choate* did the Supreme Court clarify the bounds of what constituted a fundamental alteration, except to say that "substantial" changes were not required.[139] Herein lies the problem. Defining "fundamental" alterations as those changes that are "substantial" brings to mind the proverbial Push and Shove Dictionary, under which the definition of "Push" is "shove," and the definition of "Shove" is "push."[140] The discussion below uses ADA case law

134. 442 U.S. 397, 411 (1979).

135. *Id.* at 410.

136. 469 U.S. 287, 300-01 n.20 (1984) (quoting *Davis*, 442 U.S. at 413, 410).

137. *Id.* at 302-03.

138. *See, e.g.*, L.C. by Zimring v. Olmstead, 138 F.3d 893, 904 (11th Cir. 1998).

139. *Choate*, 469 U.S. at 301 n.20.

140. The authors' knowledge of this "proverb" is owed to the father of co-author Jefferson Smith, R.P. Joe Smith. As a rural district attorney in Umatilla County, Oregon, Mr. Smith used the saying to lament the circularity of the

to posit possible principles to define the term and break the circularity.

2. Factual Inquiry Without a Clear Test

Law under Title II of the ADA is still developing,[141] and before *Olmstead v. L.C.* no clear test had emerged for whether or not a modification would be held unreasonable or a fundamental alteration.[142] Courts have looked to a wide variety of factors. Factors that courts have considered are discussed below as they might apply to a defendant in a suit claiming community care.[143]

Whether a proposed modification constitutes a fundamental alteration is a fact-intensive determination.[144] The necessity for a factual context to determine the reasonableness of a modification under Title II parallels Rehabilitation Act principles.[145] The factual nature of the fundamental alteration inquiry suggests two conclusions germane to advocates. First, specific cases might produce widely varying results, given the potential for different factual records and the possible leeway accorded fact finders. Second, the fact intensive nature of the inquiry may increase the expense of litigation. Not only will investigation and analysis of facts require resources, but courts may also be reluctant to resolve cases quickly in the defendant's favor by means of summary judgment.[146]

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arguments of defense attorneys.

141. *See, e.g.*, Heather K. v. City of Mallard, 946 F. Supp. 1373, 1383 (N.D. Iowa 1996) (noting that "there is still very little case law interpreting Title II of the ADA").

142. *See, e.g.*, DeBord v. Bd. of Educ. of Ferguson-Florissant Sch. Dist., 126 F.3d 1102, 1106 (8th Cir. 1997) (noting that "there is no precise reasonableness test").

143. *See* discussion *infra* at Part II.B.

144. *See* L.C. by Zimring v. Olmstead, 138 F.3d 893, 905 (11th Cir. 1998) (remanding for specific findings of fact); Easley v. Snider, 36 F.3d 297, 304-05 (3d Cir. 1994) (creating a fact intensive inquiry to determine whether the modification was reasonable); *see also* William Christian, *Normalization as a Goal: The Americans with Disabilities Act and Individuals with Mental Retardation*, 73 TEX. L. REV. 409, 435-36 (1994) ("[T]he 'undue burden' or 'fundamental alterations' defenses . . . have always required subjective inquiries to balance the particular equities of a given situation.").

145. *See* Nathanson v. Med. Coll. of Penn., 926 F.2d 1368, 1385, 1392 (3d Cir. 1991) ("What is to be considered to be a 'reasonable accommodation' of course must be decided on a case-by-case basis."). The court reversed summary judgment for the defendant on the issue of whether a medical school was required to make accommodation for a handicapped student. *Id.* at 1386, 1392.

146. *See, e.g.*, Messier v. Southbury Training Sch., No. 3:94-CV-1706(EBB), 1999 WL 20910, at *1 (D. Conn. Jan. 5, 1999) (refusing to grant summary judgment in a large class action suit because several factual questions remained); *Heather K.*, 946

3. *Arises as Affirmative Defense or Within Plaintiff's Prima Facie Case*

The issue of fundamental alteration typically arises as an affirmative defense whereby the public entity defendant attempts to resist modification of an existing program despite plaintiff's showing that the program was discriminatory.[147] For example, before *L.C.* reached the Supreme Court, the Eleventh Circuit noted that the plaintiff had made a prima facie showing of unlawful discrimination, including a general showing that requiring community care was a reasonable modification "in the run of cases."[148] The appellate court then remanded to the trial court to make a specific determination of whether the defendant fulfilled its burden of proving that the provision of community care would "fundamentally alter" the service it provides.[149] Treating the fundamental alteration issue as an affirmative defense comports with the traditional treatment of other provisions of the ADA.[150]

However, some courts have raised the issue of fundamental alteration in the context of determining whether the plaintiff has made a prima facie showing that a proposed modification is generally reasonable in the run of cases.[151] While potentially

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F. Supp. at 1389 (holding that the "reasonableness of proposed modifications is generally a fact question not amenable to summary judgment") (citing Crowder v. Kitagawa, 81 F.3d 1480, 1485-87 (9th Cir. 1996) (stating that application of an animal quarantine on seeing eye dogs could potentially violate the ADA, but finding that the question of reasonableness of modifications was a fact intensive inquiry not appropriate for determination on summary judgment)).

147. *See, e.g.*, Zukle v. Regents of UC, 166 F.3d 1041, 1046-47, 1050-51 (9th Cir. 1999) (describing and adopting the burden-shifting rule under Title II and holding that a medical school did not need to lower standards substantially to accommodate a learning disabled student).

148. *L.C.*, 138 F.3d at 904 (quoting Barth v. Gelb, 2 F.3d 1180, 1187 (D.C. Cir. 1993)).

149. *Id.* at 904-05 (quoting 28 C.F.R. § 35.130(b)(7) (2000)).

150. Under the communications provisions of Title II, "a public entity has the burden of proving that compliance . . . would result in [a fundamental] alteration . . . ." 28 C.F.R. § 35.164 (2000); *see also* Anne B. Thomas, *Beyond the Rehabilitation Act of 1973: Title II of the Americans with Disabilities Act*, 22 N.M. L. REV. 243, 255 (1992) (discussing the "fundamental alteration and undue financial and administrative burdens standards" of 28 C.F.R. § 35.164 (2000)). Further, treating fundamental alteration as an affirmative defense comports with Titles I and III. Under Titles I and III, the plaintiff must make a showing that "the requested modification is reasonable in the general sense, that is, reasonable in the run of the cases." Johnson v. Gambrinus Co., 116 F.3d 1052, 1059 (5th Cir. 1997). The burden then shifts to the defendant, who must show that the requested modification would constitute a fundamental alteration in light of "the specifics of the plaintiff's or defendant's circumstances." *Id.* at 1059-60.

151. *See, e.g.*, Greist v. Norristown State Hosp., No. CIV.A.96-CV-8495, 1997 WL

confusing, the divergent treatment of the burden issue can be reconciled and need not be interpreted as a split among courts. Title II requires the plaintiff to demonstrate the possibility of a reasonable accommodation or modification, and courts have defined "reasonableness" to exclude that which would require a fundamental alteration.[152] Thus, the issue of fundamental alteration might arise in two contexts. First, the issue might arise in the course of arguing that the proposed modification or accommodation is *generally* unreasonable "in the run of the cases" and thus that the defendant's failure to make them did not constitute discrimination. Indeed, for the most part the arguments raised below could just as well serve a claim that proposed modifications were "unreasonable."[153] Second, even if the plaintiff makes such a prima facie showing of discrimination, the defendant may still argue as an affirmative defense that the modification constitutes a fundamental alteration in light of *specific* facts.

B. Analysis of Program Integrity Arguments in the Context of Three Ideal Types

This section has a Janus-like mission; it attempts not only to describe the past but also to use the past with a view to the future—much like the progression of the common law itself.[154]

661097, at *4 (E.D. Pa. Oct. 22, 1997) (considering the issue of fundamental alteration in dismissing the plaintiff's prima facie case); Heather K. v. City of Mallard, 946 F. Supp. 1373, 1388 (N.D. Iowa 1996) ("[A] modification that would 'fundamentally' alter or change a program or policy is not a 'reasonable modification.'") (quoting Sandison v. Mich. High Sch. Athletic Ass'n, 64 F.3d 1026, 1037 (6th Cir. 1995)).

152. *See, e.g.*, DeBord v. Bd. of Educ. of Ferguson-Florissant, 126 F.3d 1102, 1106 (8th Cir. 1997) ("[A]n accommodation is unreasonable if it either imposes undue financial or administrative burdens, or requires a fundamental alteration in the nature of the program." (citations omitted)); McPherson v. Mich. High Sch. Athletic Ass'n., 119 F.3d 453, 461 (6th Cir. 1997) (finding accommodation to be unreasonable if it imposes undue financial burden or "require[s] a fundamental alteration in the nature of [the] program" (quoting Sch. Bd. of Nassau County v. Arline, 486 U.S. 273, 287 n.17 (1987))); Aughe v. Shalala, 885 F. Supp. 1428, 1432-33 (W.D. Wash. 1995) (finding same).

153. The fundamental alteration/reasonable accommodation inquiry is best seen as just a part of the more general discrimination inquiry. By this view, the ADA does *not* proclaim that an entity may discriminate if to avoid it would entail an unreasonable accommodation. Rather, under this view, the ADA declares: an entity that fails to make a reasonable accommodation is by definition discriminating.

154. Karl Llewellyn tells us that stare decisis is "Janus-faced." KARL N. LLEWELLYN, THE BRAMBLE BUSH: SOME LECTURE ON LAW AND ITS STUDY 74 (1930); *see also* Karl N. Llewellyn, *My Philosophy of Law, in* MY PHILOSOPHY OF LAW:

Addressing future potential legal controversies is inherently difficult, which might partly account for the dearth of scholarship that explicitly intends to inform advocates and judges of how to deal with future cases.

This paper attempts to negotiate the difficulty by referring to "ideal types," as described by German scholar Max Weber.[155] An "ideal type" creates a model of thought by abstracting and summarizing the core features of complex, empirical phenomena, and it combines, clarifies, and emphasizes the most important of these. The ideal type itself need not necessarily exist anywhere in reality, but thinking in and communicating by way of such ideal types can assist understanding and coping with complex reality. Essentially, the tool allows this paper to explore future cases—and thereby help legal practitioners—while still maintaining academic rigor and avoiding undue speculation. Nonetheless, it is important to bear in mind that no ideal type can substitute for an analysis of the meaning and the approximate actual significance of each element. Put simply, the foregoing is intended to be helpful rather than definitive—a compass, not a map.

1. Plaintiffs Who Are Medically Unfit for Community Treatment

In a case brought by plaintiffs who seek community-based care but who are not medically fit for it, requiring community care would constitute a fundamental alteration of the state program and would not be required by ADA Title II. One of the essential purposes of institutional care is protecting the institutionalized individual, and requiring release to that individual's own detriment would make the essential purpose impossible to accomplish, thus constituting a fundamental

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CREDOS OF SIXTEEN AMERICAN SCHOLARS 183, 189 (1941) (remarking that the American legal tradition is "equipped with a whole set of Janus-faced techniques").

155. For more on Weberian ideal types, see MAX WEBER, ECONOMY AND SOCIETY 19-22 (Guenther Roth & Claus Wittich eds., Ephriam Fischoff et al. trans. 1978); James Bohman, *Weber, Max*, in THE CAMBRIDGE DICTIONARY OF PHILOSOPHY 848-49 (Robert Audi ed., 1995) (describing "Weberian ideal types"); Richard H. Fallon, Jr., *"The Rule of Law" as a Concept in Constitutional Discourse*, 97 COLUM. L. REV. 1, 5 n.21 (1997) ("Although not perfectly reflected in reality, ideal types can be approached or approximated."). Much of this paper's textual discussion on the subject is borrowed from the excellent, lucid, and brief discussion by Gunther A. Weiss, *The Enchantment of Codification in the Common-Law World*, 25 YALE J. INT'L L. 435, 455 (2000).

alteration that is not required by Title II.[156] But one issue remains: the extent to which the judgments of the institution's or the state's professionals must be granted deference.

a. Essential Nature and Program Integrity Generally

The ADA does not require alteration of the essential nature of a program, and changing the essential nature of a program can constitute a fundamental alteration.[157] The essential nature concept originated in the Supreme Court's opinion in *Southeastern Community College v. Davis*.[158] The Court held that the ability to hear a patient's speech was "necessary" and "indispensable" to a nurse's functioning.[159] The Court determined that the hearing impaired plaintiff would not receive even a "rough equivalent of the training a nursing program normally gives."[160] The Court went on to announce that such a "fundamental alteration" was not required.[161]

Arguing that a proposed modification is an unreasonable modification or a fundamental alteration because it would alter the essential nature of a program or eliminate an essential feature is admittedly circular, but it highlights the presence of a class of arguments that this discussion dubs *"program integrity"* arguments.[162] These program integrity arguments can be seen as resting on differences of *kind*, as distinct from differences of

156. Further, the Integration Regulation only requires the most integrated care "appropriate," and thus provides that inappropriate care should not be required even absent a fundamental alteration argument. Still, the following discussion illustrates the issues of fundamental alteration generally.

157. *See, e.g.*, Easley v. Snider, 36 F.3d 297, 302 (3d Cir. 1994) (allowing plaintiffs to receive community care only if it would not change the "essential nature" of the program); *cf.* Tugg v. Towey, 864 F. Supp. 1201, 1210 (S.D. Fla. 1994) (holding in a Title III case that requiring a mental health agency to hire a counselor adept in sign language would not alter the "essential nature" of mental health counseling, and thus would not constitute a "fundamental alteration").

158. 442 U.S. 397 (1979). Cases of inclusion/exclusion in a benefit provided to everyone, such as nursing school, require a different application than cases concerning institution/integration uniquely needed by the disabled. *Compare id.* at 162 (holding inclusion ineffectual where individual unable to perform necessary duties), *with* Greist v. Norristown State Hosp., No. CIV. A. 96-CV-8495, 1997 WL 661097, at *5 (E.D. Pa. Oct. 22, 1997) (denying integration where individual dangerous and unqualified for out-patient treatment).

159. *Davis*, 442 U.S. at 407.

160. *Id.* at 410.

161. *Id.*

162. *See* Wood, *supra* note 132, at 523 (dividing the defenses under the ADA into "cost" and "integrity" notions and arguing that costs should be considered in community-care cases).

degree.[163] For example, a police department may not be required to hire a police officer who cannot effect a forcible arrest, because effecting a forcible arrest is an essential function of police work.[164] Likewise, a museum is not required to accommodate blind patrons by eliminating or waiving a policy against touching the artwork, because protecting artwork is an essential feature of a museum.[165] Viewed another way, the benefit provided by the museum is the viewing of artwork, not the touching of it, and requiring touching is a fundamental alteration of this intended benefit. The defense in these contexts rests not on the cost or level of burden to the entity, but simply on the nature of the benefit granted by the entity and its difference with the nature of the requested accommodation.

b. Essential Purposes

Concerning the ideal-type case in which the patient is not deemed to be medically fit for community treatment, a defendant can apply a program integrity argument and maintain that protection of institutionalized individuals is an essential purpose the elimination of which would constitute a fundamental alteration, thus precluding Title II from requiring the provision of community care. Precluding the realization of an essential purpose can constitute a fundamental alteration. For example, in *Davis*, "the purpose of [the nursing] program" was to train nurses in many skills, and allowing hearing impaired students would frustrate that purpose.[166]

Greist v. Norristown State Hospital[167] provides an example of a case in which a fundamental alteration was found because the individual was unfit for community care. In *Greist*, a federal district court held that Title II did not require the release into

163. Of course, at some point differences in kind dovetail with differences in degree, and vice-versa.

164. *See* Davoll v. Webb, 943 F. Supp. 1289 (D. Colo. 1996) (holding that a police department need not rehire a disabled police officer).

165. *See* 28 C.F.R. § 36 App. B at 643 (2000) (noting that "[d]amage to the museum piece would clearly be a fundamental alteration" under the rules regarding places of public accommodation under Title II and III).

166. *Davis*, 442 U.S. at 413.

167. No. CIV.A.96-CV-8495, 1997 WL 661097 (E.D. Pa. Oct. 22, 1997); *cf.* Jeffrey v. St. Clair, 933 F. Supp. 963 (D. Haw. 1996) (holding that involuntarily committed hospital patients were not discriminated against on the basis of their disability merely because they were placed in a more restrictive setting after their residential program was closed).

the community of a particular mental patient.[168] After a brutal incident in 1978, Richard Greist had been involuntarily committed to Norristown State Hospital after being found not guilty of murder by reason of insanity.[169] In 1996, the staff psychiatrist at Norristown determined that Greist still posed a danger to others and required further inpatient treatment, and Greist brought suit under Title II of the ADA to demand a transfer to community facilities.[170] However, the court held that "[t]o require state courts to release such individuals into the community would fundamentally alter the nature of Pennsylvania's involuntary commitment program by making an essential purpose of the program—protecting the community—impossible to accomplish."[171] Thus, the court granted the defendant's motion to dismiss for failure to state an ADA claim.[172]

The *Greist* case can be distinguished on its facts from the bulk of other cases; many developmentally disabled or mentally ill individuals will not be dangerous to the community, and many patients are not involuntarily committed. Still, prospective plaintiffs under Title II may be dangerous to *themselves*, and an institution may provide such individuals with necessary care. Under the broader principle illustrated by *Greist*—that eliminating essential purposes is a fundamental alteration—releasing individuals who require institutional care would thwart the essential purpose of patient protection.

Commentators have suggested that effective institutions are better suited than community programs for treating the severely disabled, because institutions provide a more supervised and structured environment.[173] People who enter institutions are often dangerous to themselves or are gravely disabled.[174] Institutions provide monitoring, structure, and support, and this function of institutions—"total responsibility

168. *Greist*, 1997 WL 661097, at *4.

169. *See id.* at *1. In 1978, Greist stabbed his grandmother, removed the eye of his daughter, and killed his wife and unborn child. *Id.*

170. *See id.*

171. *Id.* at *4.

172. *Id.*

173. *See* Bessette, *supra* note 38, at 163 (reviewing the scholarship and arguing in favor of community care for less severely disabled individuals).

174. *See* JOHN PARRY, MENTAL DISABILITY LAW 57 (A.B.A. Comm'n Mental & Physical Disability ed., 5th ed. 1995).

for patient care"—is missing in typical community programs.[175] Institutionalization advocates argue that "an effective institution is more able to meet the needs of those who are seriously ill."[176] For seriously disabled people, "without the coercive structure of the hospital, there is no way to assure that basic human services will be provided through either formal or informal means."[177]

Indeed, efforts have been made on behalf of some severely disabled individuals to *resist* deinstitutionalization. In a California case, a staff physician was fired after allegedly criticizing the manner in which community care was being offered.[178] That physician, Dr. William Cable, contended that severely disabled people were being transferred into the community, resulting in high morbidity and mortality rates.[179] In *Messier v. Southbury Training School*,[180] an ongoing community-care class action suit in Connecticut, 618 residents of Southbury moved to intervene on the side of the defendants because they feared that community placements would be imposed. Where individuals are not suited for community care, imposing such care would eliminate an essential purpose of the state's program, and thus constitute a fundamental alteration.

This view, later embraced by the Supreme Court,[181] was foreshadowed by principles announced by pre-*L.C.* opinions in the Third Circuit. In *Easley v. Snider*,[182] the Third Circuit held that plaintiffs had no Title II claim for community care where plaintiffs were not mentally alert, because requiring such care would change the "essential nature" of the program. Moreover, the Third Circuit's decision in *Helen L.* required the deinstitutionalization only in light of the stipulation by both

175. JOHN Q. LAFOND & MARY L. DURHAM, BACK TO THE ASYLUM 105 (1992).

176. John Martin, *Deinstitutionalization: What Will It Really Cost?*, SCHIZOPHRENIA DIG., Apr. 1995, at 12 (quoted in Bessette, *supra* note 38, at 168).

177. LAFOND & DURHAM, *supra* note 175, at 105.

178. Cable v. Dep't of Developmental Servs., 973 F. Supp. 937 (C.D. Cal. 1997) (holding that plaintiff physician had stated a claim for retaliatory termination under the ADA).

179. *See id.* at 939.

180. No. 3:94-CV-1706, 1999 WL 20910, at *2-*3 (D. Conn. Jan. 5, 1999) (describing the procedural history of the five year old class action, in which two motions to intervene were denied, and denying cross motions for summary judgment).

181. *See* Olmstead v. L.C. by Zimring, 527 U.S. 581, 601-02 (1999).

182. 36 F.3d 297, 304 (1994).

sides that community care was medically appropriate.[183] The *Helen L.* court held that the provision of community care would not constitute a fundamental alteration because such a modification would not alter the program's "requirements" or its "substance." Requiring release of individuals who were not medically fit for community care, however, would manifestly change the substance of the state program. Thus, public entity defendants supporting continued institutional care would almost certainly prevail in a suit against plaintiffs who required institutionalization for reasons of treatment.

The Supreme Court's opinion in *L.C.* reflects this notion that the ADA does not mandate releasing patients who require institutional care. In *L.C.*, the Supreme Court held "that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings."[184] Although there is still substantial room to argue which persons are "unable to handle or benefit from community settings,"[185] and the *L.C.* opinion still begs the question of what states must do if they have been lax in creating programs that potential plaintiffs would be able to "handle" and "benefit" from,[186] the Supreme Court's opinion squarely preserves and emphasizes the essential purpose arguments that were earlier announced and exemplified by *Greist*, *Easley*, and *Helen L.*

c. *The Limitation of Reasonable Professional Discretion*

Potential remaining problems with the foregoing rule warrants mention. Where a professional judgment is not *reasonable* with regard to a determination of a disabled individual's fitness for community treatment, a court might not defer to that judgment. For example, in *Kathleen S.*, a subclass consisting of sixty-eight individuals had been evaluated and deemed unfit for community treatment.[187] However, the State

183. Helen L. v. DiDario, 46 F.3d 325, 328 (3d Cir. 1995) ("The parties agree that, although Idell S. is not capable of fully independent living, she is not so incapacitated that she needs the custodial care of a nursing home.").

184. *L.C.*, 527 U.S. at 601-602.

185. *Id.* This question, however, will be one for a battle of the experts, rather than a battle of the administrators and accountants.

186. *Id.*

187. Kathleen S. v. Dep't of Pub. Welfare, 10 F. Supp. 2d 460, 474 (E.D. Pa. 1998) (discussed *infra* at Part II.B.3.a.).

stipulated at the time of litigation that several members of the subclass were fit for community care, and there was a diversity of opinion among experts with regard to the designations of several others.[188] In response to the misdiagnoses, the court refused to defer to the previous judgments regarding fitness, ordering independent evaluations for *all* members of the subclass and holding further that those individuals determined by the independent evaluator to be fit for community care must be provided such care.[189]

This portion of *Kathleen S.* illustrates two things. First, the program integrity arguments in this general type of case depend in part on the extent to which courts defer to *professional discretion.* Second, deference to such professional judgment discretion depends on whether it is exercised *reasonably.* Where a judgment is patently false, or where it serves as a mere cloak for discrimination or administrative convenience, deference for professional judgment is unlikely.[190]

However, given the Supreme Court's opinion in *L.C.* and the traditional deference granted to the decisions of state professionals,[191] this portion of *Kathleen S.* may rarely be applicable, and potential controversies remain after *L.C.* Indeed, the DOJ view provides that community care is required only if the "*State's* treatment professionals have determined, in the exercise of reasonable professional judgment" that it is appropriate.[192] To the extent that the State's professionals differ

188. *Id.*

189. *Id.* at 474-75.

190. *Cf.* Williams v. Wasserman, 937 F. Supp. 524, 527 (D. Md. 1996) ("The [State] defense experts' opinions are not, however, conclusive on the issue of professional judgment."). *But cf.* Messier v. Southbury Training Sch., No. 3:94-CV-1706(EBB), 1999 WL 20910, at *13 (D. Conn. Jan. 5, 1999) (relying on the judgment of the state treating professionals). Of course, what is reasonable is another issue for debate and will no doubt be subject to the Janus-faced development of the law.

191. *See, e.g.*, Bowen v. Am. Hosp. Ass'n, 476 U.S. 610 (1986) (concluding professional judgment governs in the constitutional context unless unreasonable); Youngberg v. Romeo, 457 U.S. 307 (1982) (observing the proper standard for determining whether a state has protected constitutional rights is whether reasonable professional judgment was exercised); Jackson v. Fort Stanton Hosp., 964 F.2d 980 (10th Cir. 1992) (noting the Due Process Clause requires that states ensure professional judgment is exercised in care and training decisions).

192. Brief for the United States as Amicus Curiae Supporting Respondents at *5 n.1, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 149653 (emphasis added); *accord* Olmstead v. L.C. by Zimring, 527 U.S. 581, 607 (1999) (noting that community-based treatment is required only "when the State's treatment professionals determine that such placement is appropriate").

in judgment from other professionals—such as independent doctors hired by families or advocates of mentally handicapped people—and to the extent courts defer to the State's treatment professionals, issues like those raised by *Kathleen S.* retain their relevance.

2. Plaintiffs Who May be Medically Fit for Some Type of Community Treatment, but Who Fail To Meet Requirements for the State Community-Care Program

a. Eliminating Essential Eligibility Requirements Can Constitute a Fundamental Alteration

In a case brought by plaintiffs who seek some type of community care for which they are medically fit, but who do not fulfill the state program's eligibility requirements, a court might find that requiring a shift to community care would constitute an unreasonable modification or a fundamental alteration. The success or failure of this argument may depend on the extent to which a court deems the criteria essential, traditionally non-waivable, and non-discriminatory. Of the three ideal types addressed, this type presents the most potential for controversy.

The Supreme Court's opinion in *Davis* supports the proposition that eliminating essential standards for eligibility constitutes a fundamental alteration. In the course of determining that a fundamental alteration of a nursing program was not required, the Court wrote that Section 504 imposes no requirement "to lower or to effect substantial modifications of standards to accommodate a handicapped person."[193] Moreover, the ADA provides that "[q]ualified individuals" under the statute are those that fulfill "essential eligibility requirements."[194] Citing that provision, the Supreme Court in *L.C.* acknowledged that the provision of community care was limited to those individuals who fulfilled "essential eligibility requirements," but did not elucidate what may constitute such a requirement.[195]

193. S.E. Cmty. Coll. v. Davis, 442 U.S. 397, 413 (1979).

194. 42 U.S.C. § 12131(2) (2000).

195. *L.C.*, 527 U.S. at 602 ("[T]he State generally may rely on the reasonable assessments of its own professionals in determining whether an individual 'meets the essential eligibility requirements' for habilitation in a community setting.").

Courts outside the community-care context have respected program integrity and held that elimination of essential eligibility requirements for a public program constitutes a fundamental alteration. The Sixth Circuit in *McPherson v. Michigan High School Athletic Association*[196] held that maximum age and semester requirements for participation in high school sports need not be waived for learning disabled students under Title II. The court held that forcing a waiver of an eight semester rule for a learning disabled child would "work a fundamental alteration in the Michigan high school sports programs."[197] The *McPherson* court reasoned that the rule was a necessary eligibility requirement that contributed to maintaining safety and competitiveness.[198] Additionally, a federal district court in the State of Washington held that waiver of an "essential" Medicaid plan eligibility requirement was not required where waiver would impose an undue financial burden or would "fundamentally alter the nature of the program."[199] The plaintiffs argued that waiving the graduation-by-age-nineteen requirement would be a reasonable modification, but the court disagreed. Rather, the court held that the requirement was an "essential" one that need not be waived.[200] By deferring to the eligibility requirements, these courts can be viewed as effectively deferring to the *regulatory discretion* of the programs' framers—allowing the creators of the programs to define the benefit offered, and respecting the limits of that benefit.[201]

This manner of program integrity argument can be applied to the community-care context. If a defendant state program has specific standards for admission into its attendant care

196. 119 F.3d 453, 462 (6th Cir. 1997).

197. *Id.*

198. *Id.*; *see also* Sandison v. Mich. High Sch. Athletic Ass'n, 64 F.3d 1026, 1036-37 (6th Cir. 1995) (holding that age requirement for participation in sports was "necessary" and that waiver would "fundamentally change" the bright line age restriction).

199. Aughe v. Shalala, 885 F. Supp. 1428, 1432-33 (W.D. Wash. 1995) (citing Sch. Bd. of Nassau County v. Arline, 480 U.S. 273, 287 n.17 (1987)).

200. *Id.* at 1430, 1432-33.

201. This line of reasoning is quite similar to the judiciary's method for evaluating claims of gender discrimination—that is, the effect of discrimination is rarely determinative where there is no intent to classify by gender. *See, e.g.*, Keevan v. Smith, 100 F.3d 644, 650-52 (8th Cir. 1996) (demonstrating disparate impact does not violate the Equal Protection Clause where the challenged policy is facially neutral and there is no discriminatory intent).

program, then plaintiffs who do not fulfill those requirements may fail in an attempt to modify those requirements. For instance, if a public entity required that applicants to its community-care program meet certain self-sufficiency criteria then, in response to a challenge by non-self-sufficient applicants the public entity might argue that those requirements were at least as essential as an age requirement in sports or a graduation requirement for receipt of federal benefits. Thus, requiring waiver would be an unreasonable modification or a fundamental alteration of the community-care program. The Third Circuit's holding in *Helen L.* would not cut against an essential eligibility requirements argument.[202] In *Helen L.*, the plaintiff fulfilled all eligibility requirements for the state community-care program, and the failure to place her in the appropriate program was based simply on a budgetary mechanism.[203]

The paradigmatic community-care case respecting eligibility requirements is the Third Circuit's opinion in *Easley v. Snider*.[204] In *Easley*, two severely disabled institutionalized persons brought a Title II challenge to the state requirement that that they be mentally alert in order to participate in the State's attendant care program.[205] The court rejected the claim. The first plaintiff, Tracey Easley, was paralyzed in a car accident and could not speak. The second plaintiff, Florence Howard, suffered from multiple sclerosis and undifferentiated schizophrenia.[206] The State's attendant care program required that applicants be sufficiently mentally alert (1) to select, supervise, and fire an attendant; and (2) to manage their own financial affairs.[207] Both Easley and Howard failed these criteria, both were rejected, and both sued.

At issue in the case was whether the mental alertness eligibility requirement was part of the essential nature of the program, such that the ADA would not require its elimination.[208] The court relied on the *State's* definition of the

202. Helen L. v. DiDario, 46 F.3d 325 (3d Cir. 1995).
203. *Id.* at 329.
204. 36 F.3d 297 (3d Cir. 1994).
205. *Id.* at 298-99.
206. *Id.* at 299.
207. *Id.*
208. *Id.* at 300.

benefit, and held that the program endeavored to provide independence and to enable the disabled to procure employment.[209] The court determined that personal control of the attendant, and therefore the mental alertness sufficient to exercise that control, was an essential dimension of the state program without which its objectives could not be realized. Easley and Howard argued that they could receive the benefits of the attendant care program with the assistance of surrogate decisionmakers, and that the ADA demanded this accommodation.[210] However, the court rejected their argument: "[T]he use of surrogates, would, at the very least, change the entire focus of the program . . . . The proposed alteration would create a program that the State never envisioned . . . ."[211] Thus, the court deferred to regulatory discretion and did not impose the requested accommodation.

b. Determining Whether or Not an Eligibility Requirement Is "Essential" May Turn on the Agency's History of Granting Waivers

If a state agency is accustomed to making waivers of its eligibility requirements for release into community care for people situated similarly to the prospective plaintiffs, then requiring such waivers for the prospective plaintiffs might not constitute a fundamental alteration. Previous waivers may suggest that the eligibility requirement in question is not in fact "essential." The district court in *Williams v. Wasserman*[212] expressed the view that a history of providing care for similarly situated individuals weakened a claim of fundamental alteration. In *Wasserman*, twelve institutionalized, developmentally disabled, and traumatically brain injured plaintiffs sought community-care placements that had allegedly been recommended by their treating physicians.[213] In response to the defendants' arguments that community transfers would be unreasonable, the court noted that the State had recently approved community-treatment slots for several of the plaintiffs. The court wrote that "[t]hese placements indicate that what the plaintiffs seek is not a 'fundamental

209. *Id.* at 303.
210. *Id.* at 304.
211. *Id.* at 305.
212. 937 F. Supp. 524, 528 (D. Md. 1996).
213. *Id.* at 526.

alteration.'"[214]

Similarly, in *Tatum v. NCAA*,[215] a district court indicated that an accommodation does not constitute a fundamental alteration under Title III of the ADA where there is a history of such accommodations. The *Tatum* court held that the NCAA's failure to allow the plaintiff to take the college entrance examination under untimed conditions did not constitute discrimination under Title III, because the disability itself was not sufficiently substantiated. The court noted, however, that in the case of a properly substantiated disability, "the acceptance of untimed tests would *not* fundamentally alter the nature of the NCAA eligibility criteria in the case of a confirmed disability with a *history of accommodations*."[216]

There are two reasons *Wasserman* and *Tatum* may fail to be influential precedent. First, in *Wasserman*, the court found no eligibility requirements that the plaintiff failed to fulfill. Second, the *Tatum* dictum arose under Title III outside the context of a community-care case, and a given eligibility requirement may be more essential for a community-care program than a test-taking protocol is for athletics. Still, the principle survives and may be persuasive. A history of granting waivers would appear to cut against the assertion that an eligibility requirement is "essential," so requiring further waivers may not effect a fundamental alteration.

The matter does not end there. To counter the contention that a history of waivers indicates that an eligibility requirement is not essential, defendants first might argue that while occasional waivers have been allowed, requiring waivers would open the floodgates to further waivers, thus effecting a fundamental alteration of the state program. The cost of considering large numbers of waiver applications and the magnitude of the change presented by the increased number of granted waivers might constitute an unreasonable modification or a fundamental alteration even where a few waivers might not. This very argument motivated the *McPherson* court decision not to require waivers for participation in high school

214. *Id.* at 528.
215. 992 F. Supp. 1114, 1123 n.5 (E.D. Mo. 1998).
216. *Id.* (emphasis added).

athletics.[217] Moreover, defendants might argue that the current system of granting waivers is itself an essential feature, because the system allows the agency experts to make decisions in a manner that best serves the disabled community as well as the particular disabled individuals. In essence, defendants would rely not on regulatory discretion (the power to define the program) but on administrative discretion (the power to implement the program). As discussed below at Part II.A.2.c, a court should not allow discretion qua discretion to constitute an essential feature, because this could grant a license to discriminate.

c. *Discriminatory Requirements or Purposes Should Not Be Deemed Essential*

Where a court deems a program eligibility requirement or purpose to be discriminatory, it should extend *Wasserman* and *Tatum* by requiring that states eliminate policies that intentionally discriminate among equally functional people, and by refusing to find that the elimination of that feature constitutes a fundamental alteration. At least two courts have done so. In *Helen L.*, the Third Circuit held that elimination of a discriminatory funding mechanism did not constitute a fundamental alteration.[218] The court noted that the state agency "cannot rely upon a funding mechanism of the General Assembly to justify administering its attendant care program in a manner that *discriminates* and then argue that it can not comply with the ADA without fundamentally altering its program."[219] In *Doe v. Stincer*,[220] a district court refused to allow the fundamental alteration defense to save a statutory scheme whereby patients with mental or emotional conditions could not access their medical records. The court held that the scheme was not saved by the fundamental alteration defense, given that the *entire scheme* discriminated against all patients receiving treatment for a mental condition.[221] Bolstering that

217. McPherson v. Mich. High Sch. Athletic Ass'n, 119 F.3d 453, 462-63 (6th Cir. 1997) (holding that waiver of maximum semester eligibility requirement would risk "opening the floodgates for waivers," which would increase the cost of making assessments as well as increase the risk of doing so incorrectly).

218. Helen L. v. DiDario, 46 F.3d 325, 338 (3d Cir. 1995).

219. *Id.* (emphasis added).

220. 990 F. Supp. 1427, 1433 (S.D. Fla. 1997).

221. *Id.*

argument is a regulation issued by the DOJ pursuant to ADA Title II: "A public entity may not . . . utilize criteria or methods of administration . . . that have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability . . . ."[222]

When examining the most discriminatory rules, the argument that eliminating a discriminatory feature does not constitute a fundamental alteration is particularly convincing. A court would presumably not preserve a state program that locked developmentally disabled individuals in underground bunkers for the express purpose of shielding them from view. Likewise, a court would be unlikely to preserve a program that allowed the release of institutionalized individuals into integrated settings only on the condition that those individuals appear to the untrained eye to be non-disabled. Even though destroying the bunkers would eliminate the stated purpose of segregation, and even though modifying the "untrained eye" program would eliminate the eligibility requirement of physical appearance, a court would seem unlikely to deem those features "essential" or their elimination "fundamental" alterations.[223] In short, a court likely would prohibit discriminatory criteria when the stated criteria is a obvious sham used to justify discriminatory treatment. The interesting question is, how obvious does the discriminatory intent have to be before the courts will prohibit the use of the stated criteria?

To the extent that a court may embrace the notion that discriminatory features are not "essential," defendants should

222. 28 C.F.R. § 35.130(b)(3) (2000); *see also* 28 C.F.R. § 35.130(b)(8) (2000) ("A public entity shall not . . . apply eligibility requirements that screen out . . . individual[s] with a disability from fully enjoying any service program or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered."); *cf.* Easley v. Snider, 36 F.3d 297, 302 (3d Cir. 1994) ("A court cannot rely solely on the stated benefits because programs may attempt to define the benefit in a way that 'effectively denies otherwise handicapped individuals the meaningful access to which they are entitled.'" (quoting Alexander v. Choate, 469 U.S. 287, 301 (1985))).

223. At least one commentator has argued that the defenses under the ADA should not apply in full force in the context of *intentional* discrimination. *See* Leonard S. Rubenstein, *Ending Discrimination Against Mental Health Treatment in Publicly Financed Health Care*, 40 ST. LOUIS U. L.J. 315, 341-43 (1996). Further, at least one court has held that eligibility criteria could not be based on overbroad generalizations about the handicapped. *See* Pushkin v. Regents of Univ. of Colo., 658 F.2d 1372 (10th Cir. 1981) (holding that under the Rehabilitation Act a medical school may not deny admission based on general assumptions about the effects of multiple sclerosis on the individual applicant).

frame their fundamental alteration defenses in terms of features that are less likely to be deemed discriminatory. A segregative purpose whose essential nature is the advancement of segregation itself is likely to be deemed discriminatory. Further, an arbitrary funding mechanism (as in *Helen L.*) or an arbitrary organizational mechanism (such as unnecessary institutionalization) may be deemed discriminatory. On the other hand, preserving patient safety, protecting facility viability, or facilitating patient care may be less likely to be deemed discriminatory, and thus the elimination of those features may more likely constitute a fundamental alteration. At the very least, this suggests advocacy advice: Presumably a court would be more likely to deem "essential" a feature that seemed to aid the disabled than a feature that seemed intentionally discriminatory or an arbitrary vestige of traditional discriminatory practices.

d. A Creative Court Could Shrink the Fundamental Alteration Defense

A creative court could wield two arguments to shrink the ambit of the reasonable modification limitation to Title II, thereby enlarging Title II's application. First, a creative court might broaden the foregoing "discriminatory requirement" exception and hold that any requirement that prevented medically qualified individuals from receiving the most integrated care appropriate would constitute a discriminatory or nonessential eligibility requirement. The argument would proceed as follows: If (1) the elimination of discriminatory eligibility requirements does not constitute a fundamental alteration; and if (2) the Integration Regulation indicates that unnecessary segregation constitutes discrimination; then (3) any eligibility requirement that caused medically unnecessary segregation would be discriminatory; and thus (4) waiver or elimination of such an eligibility requirement would not constitute a fundamental alteration. Second, essentially the same argument can be framed another way: Rather than asserting that the *community*-care program unlawfully discriminated (the position rejected by *Easley*), a court could find that the *entire* care program unlawfully discriminated—by creating criteria that kept individuals in institutions unnecessarily.

For these propositions, a court could loosely cite *L.C.*, which holds that unnecessary segregation violates Title II. Interestingly, the Eleventh Circuit's opinion in *L.C.* did not expressly rely on the plaintiff's eligibility under the State's own requirements (as the Third Circuit did in *Helen L.*) but merely held broadly that Title II requires care in the most integrated manner medically appropriate.[224] The "discriminatory requirement" arguments above would both suggest an opposite result in *Easley*. Arguably the most integrated setting appropriate for the plaintiffs in *Easley* was attendant care, either with or without the added assistance of surrogates.[225] If the mental alertness requirement could be satisfied by the most integrated care appropriate to their medical needs, then that requirement could not be deemed essential, and thus its elimination or waiver would not constitute an unreasonable accommodation or fundamental alteration. Viewed in the second frame, the entire state program would have committed unlawful discrimination by creating an overall system that caused unnecessary segregation. In these ways, a court could shrink the fundamental alteration defense and thereby enlarge the application of Title II.

Three arguments could counter the broadening of the "discriminatory requirement" exception. First and foremost, the language of the Supreme Court's *L.C.* opinion gives states significant leeway and specifically provides that the integration mandate be limited to situations that "can be reasonably accommodated."[226] Moreover, nothing in the *L.C.* case indicates that the plaintiffs failed to meet state eligibility requirements; indeed, L.C. herself was put in a community placement before judgment was ever entered.[227] Thus, nothing in the opinion requires that a court disregard eligibility requirements.

Second, if a court were to accept the aforementioned "shrinking" arguments to their extreme, the fundamental alteration defense would essentially be swallowed whole, because any feature (other than medical fitness) that thwarted integration would be deemed discriminatory and thus its

224. L.C. by Zimring v. Olmstead, 138 F.3d 893, 898 (11th Cir. 1998).

225. Easley v. Snider, 36 F.3d 297, 304-05 (3d Cir. 1994) (describing the plaintiff's request for surrogates as a modification of the attendant care program).

226. Olmstead v. L.C. by Zimring, 527 U.S. 581, 607 (1999).

227. *Id.* at 593.

elimination would not rise to the level of a fundamental alteration. A court might eschew such a drastic result.

Third, such a result would appear to require substantial affirmative action on the part of the public entity. Assume, for sake of illustration, that a state offered a community-care program for which an institutionalized individual was ineligible, such as in the case of an individual who could survive community care with extra assistance but who did not fulfill certain eligibility requirements. If the State were required to provide community care in such a context, then it would be required to create a substantially *new* program. Defendants could argue that such "affirmative action" is not required under *Alexander v. Choate*.[228]

In the end, the success of program integrity arguments in this context will turn on particular facts and a particular court's deference to regulatory discretion, i.e., the entity's power to define the benefits it offers. Nonetheless, even if a creative court were to refuse to respect the state-created eligibility requirements, and thereby reject the program integrity argument, a public entity could still argue that the modification effects a fundamental alteration on other grounds discussed below.[229]

3. *Plaintiffs Who Are Medically Fit for Community Treatment, Meet State Requirements for Release, but Nonetheless Still Have Not Been Transferred*

a. Finding of Fundamental Alteration Less Likely

The third general type of case concerns plaintiffs seeking community treatment who are both medically fit and satisfy state eligibility criteria for such care, but who still have not been transferred due to error, administrative convenience, or a lack of available community slots. In this context, a court is less likely to deem a court ordered transfer to be a fundamental alteration or an unreasonable modification. Although a public entity may argue that requiring transfer would impede agency discretion, such discretion might not be deemed an essential non-discriminatory feature.

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228. *See* S.E. Cmty. Coll. v. Davis, 442 U.S. 397, 411 (1979).

229. *See* discussion *infra* at Part II.C (discussing "magnitude" arguments).

Four courts have held that requiring community care of eligible plaintiffs is not a fundamental alteration or an unreasonable modification. First, in *Helen L.*,[230] the Third Circuit held that releasing a single eligible physically handicapped patient into community care did not constitute a fundamental alteration under Title II, even though no community-care slots were available within the State's budget. One of the plaintiffs, Idell S., had been deemed eligible for the attendant care program, but she was placed on a waiting list due to a lack of funding.[231] The Third Circuit held that Title II and the Integration Regulation required that she be transferred to the State's attendant care program.[232]

After concluding that the Integration Regulation applies to unnecessarily institutionalized individuals, the Third Circuit held that the requested accommodation was neither unreasonable nor a fundamental alteration, because the transfer would not change the "requirements" or "substance" of the state programs.[233] Further, the court emphasized that the attendant care placement would be cheaper than institutionalized care: "Ironically, DPW asserts a justification of administrative convenience to resist an accommodation that would save an average of $34,500 per year, would allow Idell S. to live at home with her children, and which would not require a single change in attendant care or nursing home programs."[234] The court further held that the failure of the state legislature to apportion funds appropriately between the nursing care program and the attendant care program provided no defense, because Title II applied to the legislature as well.[235]

Second, in *Wasserman*, the district court held that where developmentally disabled individuals had been placed in community care, providing such care for similarly situated individuals did not constitute a fundamental alteration.[236] The court noted that the placements of some of the class action

230. Helen L. v. DiDario, 46 F.3d 325, 337 (3d Cir. 1995).
231. *Id.* at 329.
232. *Id.* at 337.
233. *Id.* at 331-35.
234. *Id.* at 338.
235. *Id.*
236. Williams v. Wasserman, 937 F. Supp. 524, 526 (1996).

plaintiffs indicated that "what the plaintiffs seek is not a 'fundamental alteration' in programs already offered by the state."[237] Thus, the court rejected the defendants' program integrity arguments and deferred the determination of cost issues for further fact finding.

Third, in *Kathleen S.*, one of the most sweeping applications of Title II and the Integration Regulation to date, a Pennsylvania federal district court recently held that the state program had violated the ADA by failing to initiate plans for community placements of institutionalized individuals.[238] Haverford State Hospital was scheduled to close on June 30, 1998, and plaintiffs brought a class action suit consisting of three sub-classes: (A) eighty-eight individuals deemed ready for a community placement but who had not yet been placed due to a scheduled delay; (B) ninety-five individuals deemed ready for a community placement but who would be placed into a different state hospital because community services were not presently available; and (C) sixty-eight individuals deemed unsuited for a community placement who would be transferred to another state hospital.[239]

With regards to subclasses A and B, the court relied on *Helen L.* and *L.C.* to conclude that the DPW had violated ADA Title II, and the court ordered that both groups be placed in community-care services.[240] The court also held, with slender rationale, that the planning and creation of the community services did not constitute a fundamental alteration.[241] The court noted that DPW had failed to present evidence to support a finding of fundamental alteration. The court also noted that DPW had an obligation under state law to provide mental health care in the least restrictive means available—implying, although the court did not explicitly make the connection, that an order requiring fulfillment of an existing obligation did not interfere with an essential feature or otherwise constitute a fundamental alteration.

Fourth, although the Eleventh Circuit in *L.C.* did not squarely resolve the question of fundamental alteration, the

237. *Id.* at 528.
238. Kathleen S. v. Dep't of Pub. Welfare, 10 F. Supp. 2d 460 (E.D. Pa 1998).
239. *Id.* at 471-74.
240. *Id.* at 471-73.
241. *Id.* at 471.

court did hold that providing community care to medically eligible plaintiffs did not constitute an unreasonable modification "in the run of cases."[242] Further, on remand, the district court held that an imposed community transfer would *not* constitute a fundamental alteration.[243] The district court held that the $20,000 additional expenditure to provide community care to both L.C. and E.W. was not substantial in light of the State's overall mental health budget.[244]

The Supreme Court, however, did not fully embrace the Eleventh Circuit's view on that score. Indeed, a broad reading of the Supreme Court's opinion in *L.C.* would counsel in favor of a fundamental alteration defense where the reason for the failure to transfer is a lack of available community slots. The Court announced the following:

> To maintain a range of facilities and to administer services with an even hand, the State must have more leeway than the courts below understood the fundamental-alteration defense to allow. If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met. . . . In such circumstances, a court would have no warrant effectively to order displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commenced civil actions.[245]

Under the circumstances addressed by that language, then, refusing to transfer a given individual due to the lack of available slots in the community program would apparently not violate Title II.

Nonetheless, the lack-of-slots defense would appear to be effective only where the state has a "comprehensive, effectively working plan . . . and a waiting list that moved at a reasonable

242. L.C. by Zimring v. Olmstead, 138 F.3d 893, 904 (11th Cir. 1998) (citations omitted).

243. *See* Brief for the United States as Amicus Curiae Supporting Respondents at *5 n.1, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 149653 (citing court order).

244. *See id.*

245. Olmstead v. L.C. by Zimring, 527 U.S. 581, 605-06 (1999) (citations omitted).

pace."[246] Thus, a prospective plaintiff who is denied community care on the grounds that the required program lacked space would still be able to attack the *entire system* on the grounds that the system unnecessarily segregates, and that it is not one that is "comprehensive" and "effectively working." At this point, the program integrity arguments dovetail with the magnitude arguments discussed below at Part II.C.

b. Administrative Discretion Offers a Possible but Controversial Essential Feature

A defendant state program might also argue that allowing state hospital experts and officials to have ultimate control over who is released is an essential purpose, given that they are best situated to understand the needs of the patients as well as the requirements for smoothly running the institution. Thus, requiring community care would effect a fundamental alteration, because the experts would be less able to use their fiscal and medical expertise to ensure the hospital's viability and effectiveness. Petitioners in *L.C.* made essentially this contention, in a moderate form, in the course of their argument before the Eleventh Circuit:

> [The *L.C.* opinion] fails to give deference to medical and administrative judgment, by restricting state officials from considering the legitimate and traditional factors they would normally weigh in making these decisions (including the patients' and family members' preferences, quality of care, cost, and availability), and substituting therefore an over-reaching commitment to least restrictive environment.[247]

The success of this argument will rest on a court's willingness to grant deference to *administrative discretion*, as distinct from professional discretion[248] and regulatory discretion.[249] Two arguments might persuade a court to reject such deference. First, where individuals medically qualify for community care and satisfy the state requirements for such care, a court might conclude that such decisions are merely a matter of administrative convenience, not an alteration of the

246. *Id.*

247. Brief for Petitioners at *38, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 54623 (citations omitted).

248. *See* discussion *supra* at Part II.B.1.d.

249. *See* discussion *supra* at Part II.B.2.a.

"requirements" or "substance" of the program.[250] The House Judiciary Report accompanying ADA Title II explains that "[t]he fact that it is more convenient, either administratively or fiscally, to provide services in a segregated manner, does not constitute a valid justification for separate or different services under Section 504 of the Rehabilitation Act, or under this title."[251]

Second, courts might view such administrative discretion as a license to violate Title II and the Integration Regulation and thus refuse to deem such discretion an essential feature. As with other forms of discretion as potential essential features, extreme deference to entity discretion would all but eliminate the application of Title II and the Integration Regulation. Any refusal to provide community care could be defended by the sanctity of the judgment of the administrators of a public program. That conclusion accords with the extreme view offered in the Petitioners' Brief in *L.C.* shortly after asserting the essential nature of administrative discretion: "[The *L.C.* opinion] fails to recognize that a decision requiring the 'least restrictive' treatment will always 'fundamentally alter' Georgia's provision of mental health services."[252] If the application of the Integration Regulation would *always* result in an uncalled-for fundamental alteration, then the Integration Regulation would be reduced to empty verbiage. To the extent that courts embrace the application of the Integration Regulation, they may be unwilling to destroy it through the back door of an overbroad fundamental alteration defense. Indeed, the pre-*L.C.* opinions discussed above—*Helen L.*, *Wasserman*, and *Kathleen S.*, in addition to the Eleventh Circuit's *L.C.* opinion—scream with their silence by declining to recognize administrative discretion as an essential feature.

An argument similar to the one a public entity defendant might pursue failed in the recent and highly publicized *Martin*

250. *See* Helen L. v. DiDario, 46 F.3d 325, 337 (3d Cir. 1995) (no fundamental alteration where neither "requirements" or "substance" of the program were changed).

251. H.R. REP. NO. 101-485(III), at 50 (1990), *reprinted in* 1990 U.S.C.C.A.N. at 473; *see also* L.C. by Zimring v. Olmstead, 138 F.3d 893, 902 (11th Cir. 1998) (quoting the House Judiciary Report); *Helen L.*, 46 F.3d at 338 (quoting same).

252. Brief for Petitioners at *38, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 54623 (citations omitted).

v. PGA Tour,[253] in which the Ninth Circuit determined (and the Supreme Court subsequently affirmed) that fettering the discretion of those who implemented Professional Golf Association ("PGA") rules did not constitute a fundamental alteration, because allowing the PGA unfettered authority would effectively exempt the PGA from Title III. Casey Martin, a physically handicapped professional golfer, sued the PGA in order to force the organization to allow him to use a golf cart during tournament play.[254] The PGA argued that any modification of the PGA's power to make and enforce the rules of golf would be a fundamental alteration.[255] However, if a fundamental alteration were found, the Ninth Circuit determined that PGA rule makers would be permitted to defend wanton discrimination on the grounds that their discretion was an essential feature. Of course, *Martin* is distinguishable on its facts. A hospital's control over its patients is perhaps more central to the hospital's essential functions than the PGA's control over arguably minor rules. Still, the underlying principle may be persuasive, and a court might hold that allowing state employees complete discretion over the release of individuals would be the same as exempting the state agency from Title II and the Integration Regulation. As in *Martin*, a court might eschew such a result.

The Supreme Court's opinion in *L.C.* provides a hook for these arguments. The Court's opinion indicates that failure to provide community care to an eligible individual is not justified "by the State's endeavors to keep its institutions fully populated."[256] There still lies a risk that the wolf of untamed administrative discretion will cloak itself in the sheep's clothing of professional discretion.[257] For this reason, some

253. 204 F.3d 994 (9th Cir. 2000), *aff'd*, – U.S. –, 2001 WL 567717 (May 29, 2001).

254. *Id.* at 996.

255. *Id.* at 999.

256. Olmstead v. L.C. by Zimring, 527 U.S. 581, 606 (1999).

257. Susan Stefan writes:

> Professionals . . . who work in state institutions have conflicting obligations: to the state, whose budgetary demands restrict state employees' behavior; to the institution, which might be more concerned about safety and security than treatment; and to the patients, who did not seek their care and who, for the most part, have no desire to be patients in the first place.

Susan Stefan, *Leaving Civil Rights to the "Experts": From Deference to Abdication Under the Professional Judgment Standard*, 102 YALE L.J. 639, 661 (1992); *see also* Joanne Karger, Note, *"Don't Tread on the ADA"*: Olmstead v. L.C. ex rel. Zimring

level of independent inquiry into the reasonableness of the state program's determinations is probably appropriate, notwithstanding the Supreme Court's stated deference to the "State's treatment professionals."[258]

On the other hand, as the Supreme Court's *L.C.* opinion notes, purely administrative discretion must be respected at some level.[259] Given the fact that an individual's conditions change, absent frictionless transfer between programs, there will often be individuals waiting for transfers. Further, difficult judgments of whether and how much to deinstitutionalize can bind administrators. The Integration Regulation has been cited for the proposition that a state may not keep people in institutions when community care is appropriate,[260] and for the proposition that a state may not release an individual into community care when they require institutional care.[261] Thus, states may be caught between the Scylla of not shifting to community care enough and the Charybdis of shifting too much. This strait would counsel towards some deference to administrative discretion. However, the weight of the case law suggests that such discretion will be tightly fettered. Unfettered administrative discretion could operate as a shield for neglect, the very thing disability legislation intends to remedy.[262] But even if a court rejects administrative discretion as an essential feature, thus leaving a public entity defendant without an institutional integrity argument, that defendant could still

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and the Future of Community Integration for Individuals with Mental Disabilities, 40 B.C. L. REV. 1221, 1252-53 (1999). Indeed, a federal district court has addressed a case in which state mental health professionals failed to recommend community treatment for mentally disabled patients who admittedly would have been better served in such settings, because the state had not provided sufficient funding. *See* Jackson v. Fort Stanton Hosp. & Training Sch., 757 F. Supp. 1243, 1312 (D.N.M. 1990), *rev'd in part*, 964 F.2d 980 (10th Cir. 1992).

258. *L.C.*, 527 U.S. at 607. At least one commentator has argued that "the Court should have created room for an adversarial contest in which patients would be able to challenge the adverse judgments of their state treatment teams." *The Supreme Court, 1998 Term—Leading Cases*, 113 HARV. L. REV. 200, 332 (1999).

259. *See L.C.*, 527 U.S. at 605-06 (recognizing the possibility of waiting lists even in efficiently run programs).

260. *See, e.g.*, Helen L. v. DiDario, 46 F.3d 325, 328 (3d Cir. 1995); *L.C.*, 527 U.S. at 607.

261. *See* Cable v. Dep't of Developmental Servs., 973 F. Supp. 937 (C.D. Cal. 1997).

262. *See* Alexander v. Choate, 469 U.S. 287, 295 (1985) ("Discrimination against the handicapped was perceived by Congress to be most often the product, not of invidious animus, but rather of thoughtlessness and indifference—of benign neglect.").

assert fundamental alteration defenses in terms of magnitude.

C. Magnitude Arguments

Arguments respecting the *kind* of change may give way to, or at least be strengthened by, arguments respecting the *degree* of a change. If courts fail to grant relevant deference to professional, regulatory, and administrative discretion, and thus reject a finding of fundamental alteration based on program integrity arguments, defendants may still pursue arguments of *magnitude*. A large class action suit presents these magnitude arguments most strongly, and thus presents a greater likelihood that a court will find a fundamental alteration. First, accommodating the plaintiffs in a large class would presumably result in a greater financial burden.[263] Second, accommodating a large class would present a greater risk of broad deinstitutionalization.[264] The intermediate appellate court in *L.C.* highlighted the distinction of the class action suit context:

> We note that this case is not a class action, but a challenge brought on behalf of two individual plaintiffs. Our holding is not meant to resolve the more difficult questions of fundamental alteration that might be present in a class action suit seeking deinstitutionalization of a state hospital.[265]

Notably, the courts in *L.C.* and *Helen L.* required community care for a combined total of *three* individuals. Thus, in those cases defendants' arguments relating to the magnitude of a change rang quietly.[266]

The small numbers involved in the *L.C.* and *Helen L.* cases are not shared in all cases, however. The first reported class action suit in the ADA Title II community-care context was *Conner v.*

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263. *See* discussion *supra* at Part II.B.1.

264. *See* discussion *supra* at Part II.B.2.

265. L.C. by Zimring v. Olmstead, 138 F.3d 893, 905 n.10 (11th Cir. 1998).

266. Nonetheless, the Supreme Court broadened the fundamental alteration defense such that placement in community care may be avoided if "in the allocation of available resources, immediate relief would be inequitable, given the . . . large and diverse population of persons with mental disabilities." Olmstead v. L.C. by Zimring, 527 U.S. 581, 604 (1999). This fits well into the program integrity rubric, in which courts will resist changes to a program that contravene essential elements of the State's system—presumably including in some general way the State's system for ranking the preference for placements.

Branstad.[267] In *Conner*, a district court held in the context of a class action suit that Title II did not require community care for disabled individuals.[268] The court held with limited reasoning that Iowa was not required to create alternative community-based services because Title II does not require "fundamental" or "substantial" modifications.[269] Since *Conner*, recent, large class actions such as *Kathleen S.* and *Cramer v. Chiles* have gone the way of the plaintiffs. The forthcoming discussion uses existing precedent to articulate potentially successful magnitude arguments.

1. Financial Burden

First among the magnitude related arguments is cost. According to the following analysis, a financial burden may contribute to a finding of fundamental alteration under Title II, provided that (1) the burden is significant (i.e., it changes the substance of the program); (2) the alteration requires more than merely a shift of funds from one item to another within an agency's budget; and (3) facts support the claim. Each of these would be more likely in a large class action suit.

a. A Cost Defense Accompanies Title II Through the Backdoor

The regulations and legislative history do not clarify the availability of a cost defense in the context of community-care cases, but the weight of judicial authority counsels towards the recognition of such a defense. The Supreme Court's opinion in *Olmstead v. L.C.* removed any doubt about the existence of a cost defense; courts are explicitly instructed to "tak[e] into account the resources available to the State."[270] Whereas the existence of a cost defense is clear, its origin is less so.

Regulations under the Rehabilitation Act and the portions of Title II-B regarding communication and architectural barriers have led courts to recognize two primary defenses to claims under those sections. In addition to the "fundamental alteration" defense, which typically operates to limit required changes to those that would not compromise a program's

267. 839 F. Supp. 1346 (S.D. Iowa 1993).
268. *Id.* at 1357-58.
269. *Id.* at 1358.
270. *L.C.*, 527 U.S. at 587, 607.

integrity,[271] the "undue burden" defense allows defendants to argue that the accommodation sought by the plaintiff is simply too costly to bear. However, the DOJ, following congressional instruction, included only the fundamental alteration defense in the regulations specifying the scope of the Integration Regulation.[272] At least one commentator has thus argued that a cost defense should not constrain the operation of the Integration Regulation.[273] On the other hand, the DOJ itself has applied the undue burden defense to the integration context in providing examples of the limits of the Integration Regulation.[274] The apparent contradiction breeds confusion.[275]

Still, the weight of authority even before *L.C.* embraced at least a limited cost defense. Despite the unclear legislative history (or perhaps because of it), the cost defense has entered the community-care discussion through the backdoor of fundamental alteration; a financial burden is not required where it would fundamentally alter the program. This treatment has some support from opinions outside the community-care context.[276] The exercise of defining the cost defense by reference to fundamental alteration is inherently circular—the very task at hand is to define the *fundamental alteration* defense by reference to *costs*. The recognition of the undue burden defense as a subset of the fundamental alteration inquiry was set forth explicitly in *Messier*: "To establish [the fundamental alteration defense], the defendants must prove

271. *See* Wood, *supra* note 132, at 504-05 (citing Cook, *supra* note 44, at 430-31).

272. *See* 28 C.F.R. § 35.130(b)(7) (2000); Wood, *supra* note 132, at 505.

273. *See* Cook, *supra* note 44, at 430-31, 457-65; *cf.* Robert L. Burgdorf Jr., *Equal Members of the Community: The Public Accommodations Provisions of the Americans with Disabilities Act*, 64 TEMP. L. REV. 551 (1991) (arguing that the fundamental alteration limit imposes a higher level of obligation upon operators of public accommodations than does the undue hardship limit upon employees).

274. *See* Wood, *supra* note 132, at 505 ("For example, it may constitute an undue burden for a public accommodation, which provides a full-time interpreter in its special guided tour for individuals with hearing impairments, to hire an additional interpreter for those individuals who choose to attend the integrated program.") (quoting 28 C.F.R. pt. 35 app. A at § 35.130 (1997)).

275. *See id.* at 503 ("[T]he muddy legislative history of the ADA . . . seems both to invite courts to and to preclude courts from considering costs.").

276. *See, e.g.*, McPherson v. Mich. High Sch. Athletic Ass'n, 119 F.3d 453, 462 (6th Cir. 1997) (requiring no waivers where such a requirement would "increase the cost of making the assessments"); *cf.* Nathanson v. Med. Coll. of Penn., 926 F.2d 1368, 1386 (3d Cir. 1991) (noting that in a Rehabilitation Act case, "[a]ccommodations that are reasonable must not unduly strain financial resources").

that plaintiffs' requested relief would: (1) alter the essential nature of its program; or (2) impose an undue burden or hardship in light of the overall program."[277] In *Wasserman*, the district court noted that that "undue financial burden must be considered in analyzing the reasonableness of a requested modification accommodation" and determined that issues of material fact existed as to the relative cost of institutionalization as compared to community-based treatment.[278] The Supreme Court shared the express recognition of cost as an element of the fundamental alteration defense. The *L.C.* opinion expressly instructs district courts to consider both "the cost of providing community-based care to the litigants" and also "the range of services the state provides others with mental disabilities, and the state's obligation to mete out those services equitably."[279] This formulation of the cost defense accords with the Department of Justice view, which was set forth in its amicus brief in *L.C.*[280]

The Third Circuit's treatment of the cost defense was less clear. In *Easley*, the court apparently embraced the undue burden defense when determining that the use of surrogates would be unreasonable because it would "create an undue and perhaps impossible burden on the State."[281] Moreover, the Third Circuit in *Helen L.* refused to find a fundamental alteration where community care would be less burdensome to the State.[282] Although the Third Circuit did not explicitly embrace an undue burden defense, the court did emphasize the cost savings in rejecting defendants' arguments.[283] Likewise, the Pennsylvania district court in *Kathleen S.* examined at some length the comparative costs between institutionalized care and

277. Messier v. Southbury Training Sch., No. 3:94-CV-1706(EBB), 1999 WL 20910, at *11 (D.Conn. Jan. 5, 1999) (citations omitted).

278. Williams v. Wasserman, 937 F. Supp. 524, 528 (D. Md. 1996).

279. Olmstead v. L.C. by Zimring, 527 U.S. 581, 597 (1999).

280. Brief for the United States as Amicus Curiae Supporting Respondents at *7, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 149653 ("If a State can show that any additional costs of providing placement in a community setting are unreasonably high in comparison to a State's budget, however, a State would not be required to provide placement in a community setting.").

281. Easley v. Snider, 36 F.3d 297, 305 (3d Cir. 1994).

282. Helen L. v. DiDario, 46 F.3d 325, 338 (3d Cir. 1995).

283. *Id.*

the requested accommodation.[284] However, in *Charles Q. v. Houstoun*,[285] another district court in Pennsylvania refused to consider costs. Still, even the *Charles Q.* court did not mandate a significant outlay of funds, and the court merely required community care for two individuals who qualified for it.[286] The Supreme Court's recent opinion resolves the confusion, at least as to the *existence* of a cost defense, if not as to the scope of such a defense.

Several related arguments contend that the ADA requirements should be limited to avoid undue financial burdens. First and obviously, states have a legitimate need to budget. Second, if costs do not enter the legal inquiry, then in order to cabin runaway expenses states will have incentive to favor options that cut the types of care offered, allowing them to rest on their program integrity arguments. If a state cannot limit the amount of dollars explicitly, then it may do it implicitly by scaling back services or the number of covered individuals. Such categorical cuts will leave certain people without needed care. Further, such cuts might not lead to optimal uses of resources—some individuals might receive the benefits of significant resources, whereas others get none. This state of affairs would not only be inequitable, but might also be inefficient if the person receiving care is suffering from diminishing marginal utility. That is, a dollar of care to a person receiving little or no state-funded care might be worth more than a dollar of care to a person receiving a lot of care.

Commentators have argued that costs inevitably enter the disability discrimination discussion given the inherent nature of the problem.[287] Unlike traditional discrimination contexts where the goal is strictly the removal of barriers to *equal* treatment, equality for disabled individuals under the ADA requires *special* treatment. Thus, the relationship between

284. Kathleen S. v. Dep't of Pub. Welfare, 10 F. Supp. 2d 460, 475 (E.D. Pa. 1998) (concluding that community care would be significantly cheaper than institutional care).

285. No. CIV. A. 1:CV-95-280, 1996 WL 447549, at *6 (M.D. Pa. April 22, 1996) (unpublished opinion) ("An agency's claim that it lacks funding to serve a disabled person is not sufficient [to constitute a fundamental alteration].").

286. *See id.* at *2-*6.

287. *See* Robert Burt, *Pennhurst: A Parable*, *in* IN THE INTEREST OF CHILDREN: ADVOCACY, LAW REFORM, AND PUBLIC POLICY 265, 309-11 (Robert H. Mnookin ed., 1985); Wood, *supra* note 132, at 507-08.

litigants does not end after the plaintiff wins a lawsuit, but rather the plaintiff remains dependent on the defendant. This creates the problem of "insatiable demand," in the context of which a discussion of resource limits on such demand becomes inevitable.[288] In light of these considerations, the arguments favoring a cost defense are even weightier.

b. Legal and Factual Limits Constrain a Cost Defense

Three hurdles confront a defendant in its efforts to assert a cost defense. First, a court is more likely to find a fundamental alteration when the financial burden is *substantial,* meaning that it (1) is so unreasonable in light of the whole program; (2) amounts to more than mere fiscal inconvenience; and (3) alters the substance of the program. A small burden is less likely to be deemed a fundamental alteration, except as a matter of program integrity as discussed earlier. The House Judiciary Report suggests that a mere fiscal inconvenience would not constitute a valid defense.[289] Further, prior to the Supreme Court's opinion in *Olmstead v. L.C.,* the Eleventh and Third Circuits had taken the position that a burden will not constitute a fundamental alteration where there is no alteration to the *substance* of the program. The Eleventh Circuit in *L.C.* held that the State must show that expenditures are so unreasonable that they would "fundamentally alter[] the *service* [the agency] provides." [290] The *Helen L.* court likewise refused to hold that a fundamental alteration or unreasonable modification had occurred where neither the "requirements" nor the "substance" changed.[291] Additionally, the DOJ view and the Supreme Court opinion in *L.C.* explain that a fundamental alteration will accrue only if the burden is viewed in light of the entire program.[292] In essence, these authorities suggests that any cost

288. *See* Wood, *supra* note 132, at 507-08 (citing Burt, *supra* note 287).

289. *See supra* note 251 and accompanying text.

290. L.C. by Zimring v. Olmstead, 138 F.3d 893, 904 (11th Cir. 1998) (emphasis added).

291. Helen L. v. DiDario, 46 F.3d 325, 338 (3d Cir. 1995).

292. Olmstead v. L.C. by Zimring, 527 U.S. 581, 597 (1999) ("In evaluating a State's fundamental-alteration defense, the District Court must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably."); Brief for the United States as Amicus Curiae Supporting Respondents at *5 n.1, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at*

defense is limited in its application.[293] The district court in *Messier* recently offered a formulation of the cost defense that clearly related back to program integrity concepts:

> Inadequate funding ordinarily will not excuse noncompliance with the ADA or Section 504. . . . Yet, integration cannot be achieved at any cost. Where plaintiffs' requested relief would be so unreasonable, given the demands of the State's mental health budget and resources, that it would alter the essential nature of its service, defendants may avoid making an accommodation.[294]

A small burden would presumably require only minor changes in the budget and thus not force a change in the substance of a program. A large financial burden, on the other hand, would reduce the quantity and quality of care that the defendant public entity could offer, and thus such a burden would change the substance of a program.

Second, a court perhaps should be reluctant to find a fundamental alteration based solely upon a required *shift of funds* from an institutional care program to a community-care program. That is, if requiring the provision of community care to prospective plaintiffs would impose no increased overall financial burden, the fact that the community-care program was insufficiently funded in comparison to the institutional care program would not likely justify a finding of fundamental alteration. The Eleventh Circuit in *L.C.* noted that insufficient funds would not justify a failure to offer community care, where the budget could be reasonably modified by the public entity defendant.[295] The court noted that where a reasonable fund shift could suffice, "the ADA does not permit the State to justify its discriminatory treatment of individuals with disabilities on the grounds that providing non-discriminatory treatment will require additional expenditures of State funds."[296]

1999 WL 149653 (arguing that modification is not required if cost is "unreasonably high in comparison to a State's . . . budget").

293. The reference of the cost defense to the effect on a program's substance again shows the conflation of program integrity and magnitude concepts.

294. Messier v. Southbury Training Sch., No. 3:94-CV-1706(EBB), 1999 WL 20910, at *11 (D.Conn. Jan. 5, 1999) (citations omitted).

295. L.C. by Zimring v. Olmstead, 138 F.3d 893, 904 (11th Cir. 1998).

296. *Id.* at 904-05 (citing United States v. Univ. of Ala., 908 F.2d 740 (11th Cir. 1990) (holding that $15,000 bus system modification did not unduly burden university)).

The Third Circuit in *Helen L.* went even further and held that requiring a fund shift would not constitute a fundamental alteration even where the agency defendant *lacked* the power to authorize the shift.[297] Pennsylvania provided funds to the community-care program and the institutional care program under separate lines of the budget, and under state law the agency was not qualified to authorize a shift of funds from line to line. However, the court held that Title II applied to the legislature as well as to the state agency, and thus such a funding mechanism could not justify discriminatory treatment.[298] Correspondingly, in *Charles Q.*, another case concerning Pennsylvania's Norristown State Hospital, the district court rejected a defense based on the insufficient funding of the community-care program.[299] The court noted that "[a]n agency's claim that it lacks funding to serve a disabled person is not sufficient" to justify a failure to provide community care to those patients who qualified.[300] If a court follows the Third Circuit view, a required shift of funds (without a demonstrable increase in overall financial burden) would not constitute a fundamental alteration even in the absence of agency power to authorize the shift. Even if a court does not embrace the Third Circuit's view, where the agency is empowered to authorize the shift, a finding of fundamental alteration is unlikely.

The pains taken by the Supreme Court's opinion in *L.C.* to disagree with the Eleventh Circuit's narrow cost defense casts doubt on any argument that would greatly shrink a cost defense, but the Court did not explicitly address the issue of fund shifts. Still, the Court's opinion suggests one important exception: A fund shift is unlikely to be required if it threatens to harm the institution.[301]

Third, a significant hurdle to a cost defense will be *factual*; integrated care may in fact be cheaper than institutionalized care. Proponents of community care cite evidence that care can be provided in the community more cheaply than in

297. Helen L. v. DiDario, 46 F.3d 325, 337-38 (3d Cir. 1995).

298. *Id.* at 338.

299. Charles Q. v. Houstoun, No. CIV. A. 1:CV-95-280, 1996 WL 447549, at *6 (M.D. Pa. April 22, 1996) (unpublished opinion).

300. *Id.*

301. *See* discussion *infra* at Part II.C.2.

institutions.[302] Indeed, courts that have ordered the provision of community care, perhaps not coincidentally, have found it to be the cheaper option. The Eleventh Circuit in *L.C.*, although remanding for further findings, noted the district court's determination that "the State currently provided community-based services . . . and that such services could be provided at less cost than segregated services."[303] Further, in *Cramer v. Chiles*, a district court within the Eleventh Circuit stated generally that community care is cheaper than, as well as superior to, institutional care: "Today, it is uniformly agreed among experts that non-institutional living is far superior, economically and medically, to traditional institutional housing for persons with developmental disabilities."[304]

Likewise, the *Helen L.* court held in the context of specific facts that community care would be less expensive than institutionalized care. The court found that providing community care would save an average of $34,500 per year.[305] Within the same circuit, the district court in *Kathleen S.* found that provision of community care to plaintiffs would not result in additional unreasonable expenditures.[306] The court noted that whereas the annual per person cost inside the large Pennsylvania institutions was roughly $110,000, the amount paid to counties per deinstitutionalized individual was only about $65,000.[307] The court acknowledged but did not calculate additional costs that would arise from the transfer to community care, but merely asserted that these would be shared by the counties and the federal government.[308]

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302. *See* discussion *supra* at Part I.B.1.

303. L.C. by Zimring v. Olmstead, 138 F.3d 893, 905 (11th Cir. 1998).

304. 33 F. Supp. 2d 1342, 1350 (S.D. Fla. 1999).

305. Helen L. v. DiDario, 46 F.3d 325, 338 (3d Cir. 1995).

306. Kathleen S. v. Dep't of Pub. Welfare, 10 F. Supp. 2d 460, 475 (E.D. Pa. 1998).

307. *Id.*

308. *Id.* Note that federal money is also available for the treatment of the mentally handicapped, and commentators have argued that the funding schemes favor community-based services because a state can potentially receive more federal money from increasing its provision of community care relative to institutional care. *See, e.g.*, Amicus Curiae Brief of 58 Former State Commissioners and Directors of Mental Health and Developmental Disabilities in Support of Respondents at 9-13, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 143935 (discussing financial ramifications of federal preference for community care); Gary A. Smith et al., *The HCB Waiver Program: The Fading of Medicaid's "Institutional Bias"*, *in* MENTAL RETARDATION 262 (1996).

c. Factual Cost Arguments Are Available

Of course, these findings of fact are not binding on future cases. Further, as defendants' emphasis shifts from trying to prevent application of the Integration Regulation to trying to formulate arguments and evidence to support a finding of fundamental alteration, several avenues may be available. Over the short run, the task of operating both community and institutional systems and the difficulty of shifting the focus towards community care will likely result in large expenditures. First, in states where few community programs exist, the cost of starting them up must be added to the calculus. For instance, Texas offers extensive institutional care but limited community care, and a mandate of community care would result in costs associated with designing and developing new services.[309] Second, requiring the least restrictive alternative would effectively require states to review individually each institutionalized individual and determine whether they could be treated in the community.[310] Assuming the superiority of community care, these costs are laudable and inevitable. However, they at least must be added to the balancing as courts consider interposing their will on the State's budget.

Over the medium term, constant overhead costs could combine with the increased costs of conferring community care to create a significant economic burden. As institutions begin to empty, the facility-based reimbursement schemes will confront problems. Institutions are typically reimbursed based on a daily bed rate, and due to fixed overhead costs they must remain at or near capacity. As the population in institutions decreases, the daily per capita rate rises as the relatively fixed costs are spread over fewer residents.[311] This is merely one

309. *See* Amicus Curiae Brief of the States in Support of Petitioners at app. A, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (98-536), *available at* 1999 WL 60990. Texas houses 5,332 individuals in thirteen state schools, and 14,152 in private intermediate care facilities, but provides only limited community-care programs. *See* DAVID BRADDOCK ET. AL, THE STATE OF THE STATES IN DEVELOPMENTAL DISABILITIES 25-27, 437-38 (5th ed. 1998).

310. *See* L.C. by Zimring v. Olmstead, 138 F.3d 893, 904-05 (11th Cir. 1998) (requiring the State to perform individualized review to determine whether community-based care would be unreasonable); *see also* Amicus Curiae Brief of the States in Support of Petitioners at *17, Olmstead v. L.C. by Zimring, 527 U.S. 581 (1999) (No. 98-536), *available at* 1999 WL 60990.

311. *See* BRADDOCK ET AL., *supra* note 309, at 27 ("Aggregate staffing of

effect of the fixed nature of the costs of running a large institution. For instance, Georgia (the defendant in *L.C.*) spent $3.3 million annually to maintain the hospital buildings, and that cost does not shrink as the census shrinks. Thus, if transfers to community care were ordered, the aggregate costs of the community-care program would rise (due to increased enrollment), but the aggregate costs of institutional care program would remain relatively flat (while providing for a fewer number of patients).

The Supreme Court acknowledged the problem with "costs the States cannot avoid; most notably, a State . . . may experience increased overall expenses by funding community placements without being able to take advantage of the savings associated with the closure of institutions."[312] This fixed-cost problem was explained succinctly by the Eleventh Circuit in *L.C.*:

> There is evidence in the record that suggests that, because of the fixed overhead costs associated with providing institutional care, the State will be able to save money by moving patients from institutionalized care to community-based care only when it shuts down entire hospitals or hospital wings, but not when it moves one or two patients from a hospital into the community.[313]

L.C., of course, concerned only two patients. However, where there are tens or hundreds of plaintiffs, or where a court recognizes that its opinion will effect overall state policy (and thus hundreds of non-plaintiff patients), a strong case may be made that transfer to a community-care setting will result in expanded costs even absent changing conditions or increased demand for services.[314] Thus, states may achieve overall savings through transfer of large numbers of patients to community-care programs only by simultaneously closing

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institutions has declined substantially but less rapidly than the residential census. As a result, average daily costs have risen substantially . . . .").

312. Olmstead v. L.C. by Zimring, 527 U.S. 581, 604 (1999) (internal quotation marks and citation omitted).

313. *L.C.*, 138 F.3d at 905.

314. Williams v. Wasserman, 937 F. Supp. 524, 531 (D. Md. 1996) ("*Helen L.* does not support the imposition of court-ordered relief that would require transferring millions of dollars from institutions to the community or otherwise fundamentally altering the state's programs."); *cf.* Easley v. Snider, 36 F.3d 297, 305 (3d Cir. 1994) ("[T]he test to determine the reasonableness of a modification is whether it alters the essential nature of the program or imposes an undue burden or hardship in light of the entire program.").

existing institutions.

Further, community-based treatment may not be less expensive than institutionalization over the long term due to potentially changing conditions of both institutional and community care.[315] First, the employment and operating conditions of community care could change. In the *Pennhurst* case, for example, an expert testified that personnel costs were the largest expenditure item for both community and institutional residences and that the personnel costs were higher for institutions because of the higher salaries there, which were driven by seniority differences.[316] As more resources are directed towards community programs, institutional employees may not continue to hold such an experience advantage and may not continue to merit higher salaries.

Second, if the pool of recipients of community-care changes, costs may increase. As larger numbers of severely handicapped people exit institutions, the costs of providing adequate care to those people in the community might turn out to be higher than the costs of treating the average individual receiving care now, and that average cost could rise. That is, current cost figures of community care may be artificially low due to the sample of care recipients. If and when institutions close, that sample will change.

Third, costs will rise if demand for services rises. Demand for community care may be relatively higher than demand for institutional care, and as the supply and range of community programs is increased, demand may rise as well.[317] For example, some individuals who would qualify for state institutional care may not partake of such care, but would take advantage of community programs if more widely offered. For instance, imagine a developmentally disabled individual who has extended family that takes care of him, given the family's preference for self-funded community living over state-funded institutional care. However, if community programs were more widely available, and thus community living were to coexist

315. *See* Burt, *supra* note 287, at 329-30; Wood, *supra* note 132, at 531 (citing Burt and noting that the cost inquiry could become more complex as defendants start challenging the economic superiority of community care).

316. *See* Burt, *supra* note 287, at 330.

317. *See id.*

with the receipt of state-funded care, families might be less willing to provide self-funded care, and the subscription rate for the state programs overall might rise as a consequence.

In the final analysis, the cost calculus is indeterminate. And all of this assumes the irrelevance of potential *social costs*—such as increased crime (both by and against handicapped individuals), increased homelessness, and decreased property values, and of potential *social benefits*—such as increased participation of handicapped individuals in the workforce. Still, it is clear that cost arguments will be at the fore of community-care battles, and this prospect counsels in favor of the continuation of research and dialogue on the subject.

2. *Broad Deinstitutionalization*

In a context in which the required shift of institutionalized individuals into community-care programs threatens to deinstitutionalize care by emptying and bankrupting state hospitals, such accommodation would likely constitute a fundamental alteration and, therefore, Title II would not require it. This result of course appears more likely in the context of a large class action suit. If state programs are required to apportion funds to the community programs away from the institutional care programs, the remaining funds might be insufficient to maintain a viable institutional care facility. Due to the high overhead costs, pulling away large numbers of patients could render inefficient the operation of a large institution. Closed institutions could harm the individuals who are medically better served by such care. Further, such deinstitutionalization could result in the same problems that followed the deinstitutionalization of mentally ill individuals—wide ranging homelessness and the creation of ghettos inhabited by the mentally disabled. Especially in this context of past failure, requiring broad deinstitutionalization could constitute a fundamental alteration.

Deinstitutionalization would preclude the realization of important purposes of state programs—including caring for those who require institutionalized care and preventing homelessness. Moreover, deinstitutionalization would change the essential nature of a state program, in *Easley*'s words—

"change the entire focus of the program" and "create a program that the State never envisioned."[318] States could arguably cope with court orders by scaling back state-operated institutions and paying private hospitals to take care of the remaining individuals who required institutional care, but remedies that would shut down or substantially burden existing institutions might lead to hasty responses and individuals slipping through the cracks. Although indeterminate under this brief analysis, to the extent that the arguments could be made *factually*, they would be available *legally*.

Even before *L.C.*, Courts have generally held that Title II and the Integration Regulation do not mandate deinstitutionalization per se. *Helen L.* notes that "deinstitutionalization" is "something which the ADA does not require."[319] For that proposition, the court relied on the Supreme Court's opinion in *Pennhurst*, in which the Court concluded that deinstitutionalization involved "massive" changes in state programs and was not required absent clear statutory command.[320] The Eleventh Circuit in *L.C.* likewise noted that "our holding does not mandate the deinstitutionalization of individuals with disabilities."[321] Several lower courts have echoed this general principle that whatever level of integrated care the ADA requires, it does *not* mandate such a level that might be deemed deinstitutionalization.[322] The district court in the ongoing

318. *Easley*, 36 F.3d at 305.

319. Helen L. v. DiDario, 46 F.3d 325, 336 (3d Cir. 1995) (citing Pennhurst State Sch. and Hosp. v. Halderman, 451 U.S. 1, 24 (1981)).

320. *Pennhurst*, 451 U.S. at 24.

321. *L.C.*, 138 F.3d at 902.

322. Greist v. Norristown State Hosp., No. CIV.A.96-CV-8495, 1997 WL 661097, at *4 (E.D. Pa. Oct. 22, 1997) (citing *Helen L.*, 146 F.3d 325, for the proposition that the ADA does not mandate deinstitutionalization); Williams v. Wasserman, 937 F. Supp. 524, 531 (D. Md. 1996) ("*Helen L.* does not support . . . 'transferring millions of dollars from institutions to the community . . . .'" (internal quotations omitted)); Conner v. Branstad, 839 F. Supp. 1346, 1357 (S.D. Iowa 1993) ("'[N]either the explicit language of the ADA nor its legislative history call for or require deinstitutionalization of mentally disabled individuals."); *cf.* Kathleen S. v. Dep't of Pub. Welfare, 10 F. Supp. 2d 460, 470 (E.D. Pa. 1998) ("It is abundantly clear that the Plaintiffs in this legal action . . . are not seeking an order to 'deinstitutionalize.'"); Messier v. Southbury Training Sch., 916 F. Supp. 133, 140 (D. Conn. 1996) (noting, in an earlier incarnation of the *Messier* litigation, that "neither Section 504 nor the ADA confers 'a right to community placement'" but holding that plaintiff succeeded in stating a claim of discrimination based on severity of disability); Williams v. Sec'y of Human Servs., 609 N.E. 2d 447, 452 (Mass. 1993) (rejecting claim of community care brought by mentally disabled

Messier litigation applied this principle in order to limit the relief available to plaintiffs. The court in *Messier* precluded from potential relief the following: "(1) the ending of all new admissions to STS [Southbury Training School]; (2) the transferring of all residents to community settings; and (3) the closure of STS."[323]

Although the intermediate appellate courts in *Helen L.* and *L.C.* rejected the defendant's claim that requiring the plaintiffs to be placed in community care constituted deinstitutionalization, those cases concerned only few individuals and did not threaten the viability of the State's institutional care program. The Third Circuit relied on the minor nature of the burden on the state program[324] and expressly indicated that deinstitutionalization was not required.[325] The Eleventh Circuit was careful to note likewise.[326] It also observed that "[t]he State does not argue that the relief requested by [the plaintiffs] L.C. and E.W. will effect a fundamental alteration by requiring it to dismantle its provision of individualized care to individuals with disabilities."[327] Thus, *L.C.*, like *Helen L.*, is distinguishable from a case involving a massive shift to community care. Indeed, if fundamental alteration means anything at all, it presumably means that a state would not be forced to dismantle substantial portions of its system to the possible detriment of patients.[328]

With the issuance of the Supreme Court's opinion in *L.C.*, more and stronger legal authority exists to cut against litigation that would prematurely shut down state institutions. "[T]he ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. Nor is it the ADA's mission to drive States to move institutionalized

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individuals and noting that "nothing in the ADA requires that a specific proportion of housing placements . . . be in integrated housing").

323. Messier . Southbury Training Sch., No. 3:94-CV-1706(EBB), 1999 WL 20910, at *2 (D.Conn. Jan. 5, 1999).

324. *Helen L.*, 46 F.3d at 338.

325. *Id.* at 336-37; *see also Pennhurst*, 451 U.S. at 24 (noting that deinstitutionalization not required absent statutory command).

326. *L.C.*, 138 F.3d at 902.

327. *Id.* at 904.

328. *See* William D. McCants, Note, *Disability & ADA: Supreme Court Rule on Institutional Confinement of Disabled*, 27 J.L. MED. & ETHICS 281, 283 (1999) ("If the principle of liability announced by the Court is not applied with caution, states might be pressured, for fear of litigation, into placing marginal patients into integrated settings lacking necessary services.").

patients into an appropriate setting, such as a homeless shelter."[329] Such drastic changes would not only effect large burdens, but also radically change the essential nature of the state programs. At this point, arguments of magnitude dovetail with arguments of integrity. A change in degree becomes also a change in type. Perhaps a somewhat circular ending is fitting in an Article concerning the ADA. What is more clear is that the issuance of the Supreme Court's opinion in *L.C.* should serve as a beginning, rather than an end, to the inquiry and dialogue of the issues surrounding community care.

III. CONCLUSION

Current scholarship and current case law have focused on the application of the Integration Regulation and ADA Title II, and with them the location of an important and justified prima facie claim for community care, but little discussion has regarded the extent of its stated limits. Given the apparent benefits of community care, the legislative history of Title II, the traditional deference for agency interpretations, and the apparent relative weakness of states to solve the problem without federal intervention, the Supreme Court in *L.C.* wisely sided with the bulk of pre-existing case law and gave effect to the Integration Regulation in the context of unnecessary institutionalization. Now however, advocates must begin to focus on the *limits* of Title II as signaled by the fundamental alteration defense.

Program integrity arguments will serve defendants, particularly where the discretion in question regards patient welfare and legitimate concerns of program design, rather than mere convenience. Defendants have strong integrity claims where plaintiffs do not qualify for requested programs, but such claims should have far less force when the criteria are deemed traditionally waivable, discriminatory, or otherwise nonessential. Defendants' claims also weaken where plaintiffs qualify for requested programs but weak administrative concerns have prevented transfer. In those cases in particular, a discussion of magnitude arguments will become important. Where substantial economic burdens would attach, or where broad deinstitutionalization would result, defendants have

329. Olmstead v. L.C. by Zimring, 527 U.S. 581, 584 (1999) (citations omitted).

credible fundamental alteration claims. No clear statutory limits give guidance, and in the end any limits, however vague, may have to come from courts. Thus, using precedent as a guide, advocates and scholars must fully comprehend the possible and prudent nature of these limits in approaching their ADA Title II practice and jurisprudence.