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**DEINSTITUTIONALIZATION: GEORGIA'S
PROGRESS IN DEVELOPING AND
IMPLEMENTING AN "EFFECTIVELY
WORKING PLAN" AS REQUIRED BY
*OLMSTEAD V. L.C. EX REL***

INTRODUCTION

Hailed as “the *Brown v. Board of Education* for Disability Rights,”¹ the United States Supreme Court declared in *Olmstead v. L.C. ex rel Zimring* that the institutionalization of people with disabilities who are capable and desirous of receiving treatment in the community is a form of unlawful discrimination.² The case originated in Georgia when two women with mental illnesses, who resided in the psychiatric unit of a state hospital, sued the Georgia Department of Human Resources for failing to place them in community-based treatment programs for which they qualified.³ This unnecessary institutionalization, the women claimed, was a form of unlawful discrimination and violated the Americans with Disabilities Act.⁴ The Supreme Court agreed, holding that once a disabled person qualifies for community-based treatment, it is unlawful for the State to confine them to an institution.⁵ The Court acknowledged that under the ADA, states do not have to make modifications that would result in a “fundamental alteration” of their programs or services.⁶ The Court said that a state could meet the reasonable modification standard by showing that it has “a comprehensive, effectively working plan for

1. Mary C. Cerreto, *Olmstead: The Brown v. Board of Education for Disability Rights: Promises, Limits, and Issues*, 3 LOY. J. PUB. INT. L. 47, 47 (2001); Ruth Colker, *The Section Five Quagmire*, 47 UCLA L. REV. 653, 654 (2000).

2. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999).

3. *Id.* at 593–94.

4. *Id.* at 594. The ADA requires that states (1) make “reasonable modifications” to their programs in order to avoid disability-based discrimination and (2) provide services to people with disabilities “in the most integrated setting appropriate.” 28 C.F.R. § 35.130(b)(7), (d) (2008).

5. *Olmstead*, 527 U.S. at 597 (citing 28 C.F.R. § 35.130(b)(7) (1998)). See *infra* Part I for a discussion of the *Olmstead* decision.

6. *Olmstead*, 527 U.S. at 603 (citing 28 C.F.R. § 35.130(b)(7) (1998)).

placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moves at a reasonable pace.”⁷

Prompted by the *Olmstead* decision, states began developing “*Olmstead* Plans” for moving individuals out of institutions and providing services to people with disabilities in community settings.⁸ Although the Supreme Court left open the questions of what constitutes an “effectively working plan” or a waiting list that moves at a “reasonable pace,”⁹ the Ninth Circuit Court of Appeals and Third Circuit Court of Appeals have addressed these questions.¹⁰

Applying the two approaches of the circuit courts, this Note will assess Georgia’s progress in developing and implementing an effectively working plan. Part I provides, as background, an overview of the *Olmstead* decision.¹¹ Part II discusses the Ninth and Third Circuit approaches to evaluating an effectively working plan.¹² Part III discusses Georgia’s progress in developing and implementing its own plan and assesses whether Georgia has an effectively working plan as defined by the circuit courts.¹³ Ultimately, this Note

7. *Id.* at 605–06. Although the *Olmstead* decision “concerned adults with mental illness,” it applies to all people who are disabled and either currently institutionalized or at risk for institutionalization. Sara Rosenbaum, *The Olmstead Decision: Implications for State Health Policy*, 19 HEALTH AFF. 228, 230 (2000) (“*Olmstead* concerned adults with mental illness. However, it is clear that the case applies to persons of all ages with both physical and mental disabilities.”); Letter from Timothy M. Westmoreland, Director, Center for Medicaid and State Operations Health Care Financing Administration (HCFA) to State Medicaid Director (Jan. 14, 2000), available at <http://www.cms.hhs.gov/SMDL/SMD/list.asp> [hereinafter HCFA Letter 1] (“This decision confirms what this Administration already believes: that no one should have to live in an institution or a nursing home if they can live in the community with the right support Although *Olmstead* involved two individuals with mental disabilities, the scope of the ADA is not limited only to such individuals In addition, the requirement to provide services in the most integrated setting appropriate applies not only to persons already in institutional settings but to those being assessed for possible institutionalization.”).

8. See MARTIN KITCHENER ET AL., UCSF NATIONAL CENTER FOR PERSONAL ASSISTANCE SERVICES, HOME AND COMMUNITY-BASED SERVICES: INTRODUCTION TO OLMSTEAD LAWSUITS AND OLMSTEAD PLANS, Table 1 (4th rev. 2006), available at <http://pascenter.org/olmstead/index.php> (showing that twenty-nine states had *Olmstead* Plans in 2006).

9. Cerreto, *supra* note 1, at 69 (quoting *Olmstead*, 527 U.S. at 605–06).

10. See *Sanchez v. Johnson*, 416 F.3d 1051, 1067 (9th Cir. 2005); *Arc of Wash. State, Inc. v. Braddock*, 427 F.3d 615, 620–22 (9th Cir. 2005); *Frederick L. v. Dep’t of Pub. Welfare*, 422 F.3d 151, 156 (3d Cir. 2005) [hereinafter *Frederick III*]; see also *infra* Part II for an in-depth discussion of these decisions.

11. See *infra* Part I.

12. See *infra* Part II.

13. See *infra* Part III.

concludes that Georgia has failed to implement an effectively working plan under the Third Circuit's approach, though its plan may satisfy the Ninth Circuit.¹⁴ If the state wants to continue complying with the Ninth Circuit's requirements, it cannot allow funding shortages to impede its future progress in moving people out of institutions, expanding its HCBS waiver programs, and increasing spending on community-based services.¹⁵

I. BACKGROUND: *OLMSTEAD V. L.C. EX REL ZIMRING*

Congress passed the Americans with Disabilities Act (ADA)¹⁶ in 1990 to eliminate discrimination against people with disabilities.¹⁷ Title II of the ADA prohibits discrimination against people with disabilities¹⁸ by public entities in their services, programs, or activities.¹⁹ Regulations promulgated pursuant to Title II of the ADA²⁰ require that public entities "administer services, programs,

14. *See infra* Part III.

15. *See infra* Part III.

16. Americans with Disabilities Act (ADA) of 1990, 42 U.S.C. §§ 12101-12213 (2000).

17. 42 U.S.C. § 12101(b) (2000). In the preamble to the Act, Congress recognized that, among other things: (1) millions of Americans have disabilities and the number of people with disabilities is growing as people age; (2) society has historically isolated and segregated people with disabilities and this "continue[s] to be a serious and pervasive social problem;" (3) discrimination continues in many "critical areas," including "access to public services" and institutionalization; and (4) "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." *Id.* § 12101(a).

18. *Id.* § 12101(b). According to the ADA, an individual has a "disability" if that person has "a physical or mental impairment that substantially limits one or more of [the individual's] major life activities." *Id.* § 12102(2)(A). The definition of disability also includes individuals who have "a record of such an impairment" or are "regarded as having such an impairment." *Id.* § 12102(2)(B)-(C).

19. *Id.* § 12132 ("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 any such entity."). A person is a "qualified individual with a disability" if she "meets the essential eligibility requirements" to receive the services or participate in the programs of the public entity. *Id.* § 12131(2). A "public entity" for purposes of the ADA includes state and local governments as well as departments, agencies, and other divisions thereof. *Id.* § 12131(1).

20. The Attorney General was responsible for promulgating the regulations to implement Title II of the ADA. 42 U.S.C. § 12134(a) (2000); *Olmstead v. L.C.*, 527 U.S. 581, 591 (1999). As required by Title II of the ADA, the Attorney General's regulations are consistent with regulations promulgated under §504 of the Rehabilitation Act. *Olmstead*, 527 U.S. at 591 ("The Attorney General's regulations, Congress further directed, 'shall be consistent with this chapter and with the coordination regulations . . . applicable to recipients of Federal financial assistance under [§ 504 of the Rehabilitation Act].'").

and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”²¹ Furthermore, the regulations require that public entities “make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability.”²² A public entity may only avoid making such modifications if it “can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.”²³

In 1995, L.C. and E.W., two women diagnosed with mental retardation and mental illnesses,²⁴ brought claims against the State of

Section 504 of the Rehabilitation Act prohibits handicap-based discrimination in “any program or activity that receives or benefits from federal financial assistance.” 28 C.F.R. § 41.51(a) (2008). Furthermore, Section 504 requires that recipients of federal financial assistance “administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons.” *Id.* § 41.51(d). The Attorney General, in the preamble to the Title II regulations, defined “the most integrated setting appropriate to the needs of qualified individuals with disabilities” to mean “a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.” *Olmstead*, 527 U.S. at 592 (quoting 28 C.F.R. pt. 35, App. A, p. 450 (1998)).

21. 28 C.F.R. § 35.130(d) (2008). The Attorney General’s regulations incorporated Congress’ definition of disability from Title II: “a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.” *Id.* § 35.104. But, the Attorney General parsed the definition of disability even further. Under the regulations, “physical or mental impairment” includes “(A) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; (B) Any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.” *Id.* Additionally, “[t]he phrase *physical or mental impairment* includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.” *Id.* The phrase “major life activities,” for the purposes of the Attorney’s General’s regulations, “means functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.” *Id.*

22. *Id.* § 35.130(b)(7).

23. *Id.* When a state claims that it cannot make accommodations for persons with disabilities because doing so would result in a fundamental alteration of its programs or services, the state has asserted a “fundamental alteration defense.” *See, e.g., Olmstead v. L.C.*, 527 U.S. 581, 594–95, 597, 605 (1999) (where the Court uses term “fundamental-alteration defense”).

24. L.C. was diagnosed with schizophrenia and E.W. with personality disorder. *Olmstead*, 527 U.S. at 593.

Georgia under Title II of the ADA.²⁵ The two women had “a history of treatment in institutional settings.”²⁶ L.C. was “voluntarily admitted to Georgia Regional Hospital at Atlanta (GRH)” in May 1992 and “confined for treatment in a psychiatric unit.”²⁷ A year later, her doctors at GRH determined that “her needs could be met appropriately in one of the community-based programs the State supported.”²⁸ Despite her doctors’ recommendations, L.C. remained institutionalized at GRH.²⁹ Similarly, E.W. was “voluntarily admitted to GRH in February [of] 1995” and “confined for treatment in a psychiatric unit.”³⁰ Although her doctors said that “she could be treated appropriately in a community-based setting,” E.W. remained institutionalized at GRH.³¹ The women claimed that “the State’s failure to place [them] in a community-based program, once [their] treating professionals determined that such placement was appropriate, violated, *inter alia*, Title II of the ADA.”³²

The State argued that inadequate funding, not discrimination on the basis of disability, accounted for the continued [institutionalization] of the two women.³³ The State also argued that “requiring immediate transfers in cases of this order would ‘fundamentally alter’ the State’s activity” because the State was “already using all available funds to provide services to other persons with disabilities.”³⁴ However, the U.S. District Court for the Northern District of Georgia rejected the State’s cost-based defense and fundamental alteration defense and granted partial summary judgment in favor of the two women.³⁵

25. The Commissioner of the Department of Human Resources, the Superintendent of Georgia Regional Hospital, and the Executive Director of the Fulton County Regional Board (collectively, the State) were named as defendants. *Id.* at 593–94.

26. *Id.* at 593.

27. *Id.*

28. *Id.*

29. L.C. was placed in a community-based treatment program in February 1996, nine months after filing suit against the State. *Olmstead*, 527 U.S. at 593.

30. *Id.*

31. E.W. remained institutionalized at GRH until a few months after the District Court’s judgment in this case in 1997. *Id.*

32. *Id.* at 594.

33. *Id.*

34. *Id.*

35. *Olmstead*, 527 U.S. at 594–95.

The Court of Appeals for the Eleventh Circuit affirmed the district court's judgment, but remanded the case for an assessment of "whether the additional expenditures necessary to treat L.C. and E.W. in community-based care would be unreasonable given the demands of the State's mental health budget."³⁶ The Eleventh Circuit made it clear, however, that the State's cost justification would fail if the State did not prove that requiring it to expend additional funds in order to provide L.C. and E.W. with integrated services "would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service [the State] provides."³⁷

The U.S. Supreme Court granted certiorari³⁸ to decide "whether the proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions."³⁹ First, the Supreme Court outlined the key provisions of the Americans with Disabilities Act and the regulations promulgated under the Act.⁴⁰ Next, the Court acknowledged that the Attorney General and the Department of Justice had already determined that unjustified institutionalization is a form of discrimination prohibited by Title II of the ADA.⁴¹ The Court also recognized that "Congress explicitly identified unjustified 'segregation' of person with disabilities as a 'form of discrimination.'"⁴² The Court then addressed two policy reasons for providing disability services in community-based settings rather than in institutions.⁴³ The continued institutionalization of people "who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."⁴⁴ Additionally,

36. *Id.* at 595–96.

37. *Id.* at 595 (quoting *L.C. v. Olmstead*, 138 F.3d 893, 905 (11th Cir. 1998)).

38. *Id.* at 596.

39. *Id.* at 587.

40. *Id.* at 588–93.

41. *Olmstead*, 527 U.S. at 596–98.

42. *Id.* at 600.

43. *Id.*

44. *Id.*

“confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.”⁴⁵ Ultimately, the Court concluded that under Title II of the ADA, states are responsible for providing “community-based treatment to qualified persons.”⁴⁶

The Court said that the requirement to provide community-based treatment, however, is not limitless.⁴⁷ States have to make “‘reasonable modifications’ to avoid discrimination,” but do not require a “fundamental alteration” of their services and programs.⁴⁸ The Supreme Court thought that the Eleventh Circuit’s standard for evaluating a state’s fundamental alteration defense was too restrictive.⁴⁹ The Court recognized that states need “[t]o maintain a range of facilities and to administer services with an even hand.”⁵⁰ Therefore, the Supreme Court instructed the district court to “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.”⁵¹ Specifically, the Court determined that a state could meet the reasonable-modifications standard if, for example, it could “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.”⁵²

45. *Id.* at 601.

46. *Id.* at 597, 603. According to the court, a person would be “qualified” for community-based treatment once such treatment was determined appropriate by the State’s treatment professionals and not opposed by the affected individual. *Id.* at 607.

47. *Olmstead*, 527 U.S. at 603.

48. *Id.*

49. *Id.* at 597.

50. *Id.* at 605; *see also id.* at 597.

51. *Id.* at 597.

52. *Id.* at 605–06.

The Supreme Court did not say that each state is *required* to have a comprehensive and effectively working plan and a waiting list that moves at a reasonable pace.⁵³ Rather, this was just one an example of how a state could meet the reasonable-modifications standard under the ADA.⁵⁴ However, the federal government views the development of an effectively working plan as a critical component of *Olmstead* compliance.⁵⁵ Within months of *Olmstead*, the federal government's Center for Medicaid and State Operations Health Care Financing Administration (HCFA)⁵⁶ wrote a series of letters to State Medicaid Directors emphasizing the importance of the *Olmstead* decision and advising states how they could comply with the Court's holding.⁵⁷ The first letter, dated January 14, 2000, strongly urged states to "increase access to community-based services for individuals with disabilities by developing comprehensive, effectively working plans for ensuring compliance with the ADA."⁵⁸

53. See *Olmstead*, 527 U.S. at 605–06.

54. *Id.*

55. See discussion *infra* notes 56–61. Additionally, the Third Circuit has stated that it views "a comprehensive . . . working plan [as] a necessary component of a successful 'fundamental alteration' defense." *Frederick III*, 422 F.3d 151, 157 (3d Cir. 2005).

56. The HCFA is now the Centers for Medicare and Medicaid Services (CMS). This federal agency is a branch of the U.S. Department of Health and Human Services, and it administers the Medicaid program. See Centers for Medicare & Medicaid Services, History Overview, <http://www.cms.hhs.gov/History/> (last visited Jan. 30, 2009).

57. HCFA Letter 1, *supra* note 7; Letters from Timothy M. Westmoreland, Director, Center for Medicaid and State Operations Health Care Financing Administration (HCFA) to State Medicaid Director, Update No. 2 and Update No. 3 (July 25, 2000), available at <http://www.cms.hhs.gov/SMDL/SMD/list.asp>; Letters from Timothy M. Westmoreland, Director, Center for Medicaid and State Operations Health Care Financing Administration (HCFA) to State Medicaid Director, Update No. 4 and Update No. 5, (Jan. 10, 2001), available at <http://www.cms.hhs.gov/SMDL/SMD/list.asp>. The HCFA wrote to State Medicaid directors, because it recognized the critical role that Medicaid programs play in making community services available to people with disabilities. HCFA Letter 1, *supra* note 7. Medicaid is the "major source of public financing for long-term services and supports for people with disabilities." KAISER COMMISSION ON MEDICAID AND THE UNINSURED, POL'Y BRIEF, *OLMSTEAD V. L.C.: THE INTERACTION OF THE AMERICANS WITH DISABILITIES ACT AND MEDICAID 2* (2004), available at <http://www.kff.org/medicaid/upload/Olmstead-v-L-C-The-Interaction-of-the-Americans-with-Disabilities-Act-and-Medicaid.pdf> [hereinafter KAISER COMMISSION]. When it comes to paying for long-term care, Medicaid finances about 49%, Medicare pays about 20%, and the rest come from other public and private sources. ENID KASSNER, ET AL., AARP PUBLIC POLICY INSTITUTE, A BALANCING ACT: STATE LONG-TERM CARE REFORM 1 (2008).

58. HCFA Letter 1, *supra* note 7.

The HFCA provided states with “key principles”⁵⁹ for developing their plans, and said that these principles would “be used by the Office for Civil Rights as it investigates complaints and conducts compliance reviews involving ‘most integrated setting’ issues.”⁶⁰

Although the guidance letters greatly assisted states in determining their obligations, the Supreme Court itself left open the question of what constitutes a comprehensive and effectively working plan and a waiting list that moves at a reasonable pace.⁶¹ Several years after *Olmstead*, the Ninth Circuit Court of Appeals and the Third Circuit Court of Appeals provided different interpretations of *Olmstead*, explaining what it means for a state to have an effectively working plan and when states may avail themselves of the fundamental alteration defense.⁶²

II. DEFINING AN EFFECTIVELY WORKING PLAN

Following the *Olmstead* decision, many states began developing *Olmstead* plans in order to satisfy the Court’s requirements.⁶³ Unfortunately, the *Olmstead* Court did not explain what it meant by an effectively working plan.⁶⁴ The Ninth Circuit and the Third Circuit are the only appellate courts that have addressed the question of what

59. *Id.* According to the HFCA, a state’s plan would build upon the foundation of existing programs and identify improvements that could be made to strengthen that foundation. *Id.* The plan would establish procedures for identifying and evaluating individuals who may be eligible to receive services in community-based settings rather than in institutions. *Id.* Additionally, the plan should assess the adequacy of current community-based programs and identify what improvements are needed to make the system “better” and more “comprehensive” in order to “[e]nsure the [a]vailability of [c]ommunity-[i]ntegrated [s]ervices.” *Id.* The HFCA advised states to include people with disabilities and their representatives in the planning and implementation process. *Id.*

60. *Id.*

61. Cerreto, *supra* note 1, at 69; Sara Rosenbaum et al., *Defining “Reasonable Pace” in the Post-Olmstead Environment 1* (Ctr. for Health Care Strategies, Consumer Action Series, Working Paper, 2002), available at www.chcs.org/usr_doc/reasonablepace.pdf.

62. See *Sanchez v. Johnson*, 416 F.3d 1051, 1067 (9th Cir. 2005); *Arc of Wash. State, Inc. v. Braddock*, 427 F.3d 615, 620–22 (9th Cir. 2005); *Frederick III*, 422 F.3d 151, 156 (3d Cir. 2005); see also *infra* Part II.

63. See generally KITCHENER ET AL., *supra* note 8.

64. See *Olmstead*, 527 U.S. at 603; Melody M. Kubo, *Implementing Olmstead v. L.C.: Defining Effectively Working Plans for Reasonably Paced Wait Lists for Medicaid Home and Community-Based Services Waiver Programs*, 23 U. HAW. L. REV. 731, 733 (2001).

constitutes an effectively working plan.⁶⁵ The two circuit courts have diverging approaches to evaluating a state's *Olmstead* plan.⁶⁶

A. *The Ninth Circuit Approach*

As illustrated by *Sanchez v. Johnson* and *Arc of Washington State, Inc. v. Braddock*, the Ninth Circuit does not require states to produce written *Olmstead* plans with measurable outcomes and target deadlines.⁶⁷ A state may demonstrate that it has an effectively working plan if it has made significant progress in (1) moving people out of institutions, (2) increasing its budget for community services in spite of fiscal constraints, and (3) increasing the size of its Home and Community Based Services (HCBS) waiver program⁶⁸ over time.⁶⁹

In *Sanchez v. Johnson*, a class of developmentally disabled individuals and service providers claimed that the State of California violated Title II of the ADA and Section 504 of the Rehabilitation Act by paying lower wages and benefits to community-based service

65. For a list of *Olmstead* related cases through October 2006, see KITCHENER ET AL., *supra* note 8, Table 2.

66. See *infra* Part II(A)–(B) for a discussion of each court's approach.

67. See discussion of *Sanchez*, *infra* notes 72–88 and accompanying text and the discussion of *Arc of Wash. State*, *infra* notes 89–95 and accompanying text.

68. HCBS waivers permit (but do not require) states to use part of their Medicaid funds to provide home and community-based services as an alternative to institutionalization. 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, 1229 (1999). The HCBS waiver program has been central to most states' *Olmstead* plans. See DEBRA LIPSON, ET AL., MONEY FOLLOWS THE PERSON DEMONSTRATION GRANTS: SUMMARY OF STATE MFP PROGRAM APPLICATIONS 8 (Aug. 2007) (reporting that HCBS spending as a percentage of Medicaid total long-term care (LTC) spending increased 52.7% in the U.S. from 2001 to 2006); Centers for Medicare and Medicaid Services, *HCBS Waivers* - Section 1915 (c), [http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915\(c\).asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp) (last visited Jan. 22, 2009) ("The HCBS waiver program in particular is a viable option for states to use to provide integrated community-based long-term care services and supports to qualified Medicaid eligible recipients . . . Forty-eight States and the District of Columbia offer services through HCBS waivers.").

69. *Sanchez*, 416 F.3d at 1067; *Arc of Wash. State*, 427 F.3d at 621–22. In order for states to receive HCBS waivers, they must apply "for a certain number of waiver slots." Karger, *supra* note 68, at 1229. The number of waiver "slots" that the state applies for acts as a cap on the number of services it can provide under the HCBS Waiver Program. KAISER COMMISSION, *supra* note 57, at 3. The waiver program is budget neutral, so the cost of providing services in the community cannot exceed the cost of institutionalization. KAISER COMMISSION, *supra* note 57, at 3.

providers than it paid to institutional employees.⁷⁰ They argued that this disparity resulted in “some developmentally disabled persons remaining unnecessarily institutionalized” and sought an injunction to compel increased payments to community-based service providers by state officials.⁷¹ The district court granted summary judgment in favor of the State, holding that the relief sought by Sanchez and the providers was “not a ‘reasonable modification’ of California’s current policies and practices.”⁷² Furthermore, the court held, the State already had an acceptable plan for deinstitutionalization, and disrupting that plan “would involve a fundamental alteration of the State’s current policies and practices in contravention of the Supreme Court’s instructions in *Olmstead*.”⁷³ The Ninth Circuit agreed that California had a comprehensive and effective plan for deinstitutionalization, and thus was in compliance with *Olmstead*.⁷⁴ Specifically, the Ninth Circuit concluded that “California ha[d] a successful record of personalized evaluations leading to a reasonable rate of deinstitutionalization and, moreover, that California ha[d] undertaken to continue and to increase its efforts to place [institutionalized individuals] into the community when such placement [was] feasible.”⁷⁵

The appellate court explained that the State had a system for identifying the services that institutionalized individuals needed to live in the community and a database that indicated whether the institutionalized individuals were recommended for community placement.⁷⁶ The State also utilized a system of individualized “Community Placement Plans” to move institutionalized persons to community residential settings.⁷⁷ These plans often involved “enhancing and developing the local resources” that the individual

70. Sanchez v. Johnson, 416 F.3d 1051, 1055 (9th Cir. 2005).

71. *Id.* at 1055, 1062.

72. *Id.* at 1063.

73. *Id.*

74. *Id.* at 1067–68.

75. *Id.* at 1068.

76. Sanchez, 416 F.3d at 1065–66.

77. *Id.* at 1066.

would need in the community.⁷⁸ Furthermore, the State had twenty-one Regional Centers that “determine[d] if a consumer need[ed] to be institutionalized” based on an Individual Program Plan that was prepared and reviewed annually by the responsible Regional Center.⁷⁹

The district court found, and the Ninth Circuit agreed, that California’s commitment to deinstitutionalization of developmentally disabled persons was “genuine, comprehensive, and reasonable.”⁸⁰ They based their finding on evidence that the State had: (1) increased its spending for community-based services over the previous ten years,⁸¹ (2) expanded its HCBS waiver program by 25,000 slots in the last three years,⁸² (3) decreased its institutionalized population by 20% over the previous four years,⁸³ (4) budgeted to develop fifty-two additional community-based treatment facilities,⁸⁴ and (5) expected the reduction in its institutional population to result in the closure of at least one institution by 2007.⁸⁵

In *Arc of Washington State, Inc. v. Braddock*, a privately operating residence and three individuals with disabilities claimed that the State of Washington violated Title II of the ADA by not applying for enough HCBS waivers for all eligible developmentally disabled individuals.⁸⁶ The Ninth Circuit found that Washington had a comprehensive, effectively working plan, and that the State’s

78. *Id.*

79. *Id.* at 1064.

80. *Id.* at 1067.

81. *Id.* (“Overall, California’s expenditures for individuals in community settings increased 196% between 1991 and 2001, while caseload . . . increased fifty-five percent in the same period.”) (internal quotations omitted).

82. *Sanchez*, 416 F.3d at 1067. Although California had more than 45,000 waiver places approved and received matched funds for about 35,000 registered persons in 2002, waiver places increased to nearly 70,000 by October, 2005. *Id.* at 1065.

83. *Id.* at 1067.

84. *Id.* At the time of this case, in California, developmentally disabled individuals received care in the community through Intermediate Care Facilities, Community Care Facilities, or through a variety of non-residential day programs and residential support services. *Id.* at 1065.

85. *Id.* at 1067. At the time of this case, in California, “approximately 3,800 [developmentally disabled persons] live[d] in one of seven large, congregate institutions called Developmental Centers.” *Id.* at 1064.

86. *Arc of Wash. State, Inc. v. Braddock*, 427 F.3d 615, 617–19 (9th Cir. 2005).

commitment to deinstitutionalization was “genuine, comprehensive and reasonable.”⁸⁷ The court focused its analysis on the State’s HCBS waiver program.⁸⁸ The court found that the HCBS program was full with new participants receiving waivers as they became available.⁸⁹ The State increased its waiver program by 8,750 slots between 1983 and 1998 and had increased its annual budget for community-based disability programs from \$167 million in 1994 to \$350 million in 2001, during which time other state agencies experienced significant cutbacks.⁹⁰ Additionally, the state decreased its institutional population by 20%, leaving only 1,000 individuals in institutions.⁹¹ The court decided that forced expansion of Washington’s HCBS waiver program would be a “fundamental alteration” and thus was not required under *Olmstead* or the ADA.⁹²

As *Sanchez* and *Arc of Washington State* illustrate, a state is not required to have a written plan for moving a specific number of people out of institutions or off of the HCBS waiver waiting list by a set date. Rather, a state may prove that it has an effectively working plan if it demonstrates its past progress in moving people out of institutions, expanding its HCBS waiver programs, and increasing its spending on community-based services.

B. Third Circuit Approach

Unlike the Ninth Circuit, the Third Circuit requires that states show more than a past commitment to deinstitutionalization in order to utilize the fundamental alteration defense.⁹³ As expressed in *Frederick L. v. Dep’t of Public Welfare*, the Third Circuit requires that states have plans with specific and measurable goals for which they may be held accountable.⁹⁴ In *Frederick L.*, a class of

87. *Id.* at 621 (quoting *Sanchez*, 416 F.3d at 1067).

88. *See id.* at 620.

89. *Id.* at 621.

90. *Id.*

91. *Id.*

92. *Arc of Wash. State*, 427 F.3d at 621–22.

93. *Frederick III*, 422 F.3d 151, 156 (3d Cir. 2005).

94. *Id.* at 156.

institutionalized mental health patients, who were eligible to receive community-based treatment, claimed that the State violated the ADA by keeping them in a state hospital.⁹⁵ In *Frederick I*, the district court found that the accommodation requested by the plaintiffs would amount to a fundamental alteration of the state's mental health program.⁹⁶ The Third Circuit vacated and remanded the case, directing the lower court to "instruct [the Department of Public Welfare] to devise a plan which would demonstrate a commitment to community placement 'in a manner for which it can be held accountable by the courts.'"⁹⁷ On remand, the district court again ruled in favor of the State, and the mental health patients appealed.⁹⁸ The Third Circuit vacated and remanded once more, providing specific guidelines to the district court for evaluating the state's deinstitutionalization plan.⁹⁹

Although the Third Circuit noted that it was "aware of [the state's] strong commitment in the past to deinstitutionalization (viz., Pennsylvania's mental health hospital population ha[d] declined from 40,000 in the 1950s to fewer than 3,000 at the time of trial)," it did not find this record sufficient to meet the requirements of *Olmstead*.¹⁰⁰ The court was looking for verifiable benchmarks or timelines.¹⁰¹ The court found that the State's deinstitutionalization plan¹⁰² was inadequate.¹⁰³ The draft plan included measurable goals, such as reducing the number of state hospital beds by a minimum of 250 each year and "closing 'all civil beds in at least three state

95. *Id.* at 154 (citing *Frederick L. v. Dep't of Pub. Welfare*, 217 F. Supp. 2d 581, 594 (E.D. Pa. 2002) [hereinafter *Frederick I*]).

96. *Frederick III*, 422 F.3d at 155 (citing *Frederick I*, 217 F. Supp. 2d at 594).

97. *Frederick III*, 422 F.3d at 155 (quoting *Frederick L. v. Dep't of Pub. Welfare*, 364 F.3d 487, 500 (3d Cir. 2004) [hereinafter *Frederick II*]).

98. *Frederick III*, 422 F.3d at 155.

99. *Id.* at 160.

100. *Id.* at 156.

101. *Id.*

102. "The cornerstone of [the State's] deinstitutionalization plan [was] the Community/Hospital Integration Projects Program (CHIPP)," which was designed to "reorient 'the focus of mental health services away from reliance on large [mental health] institutions to community based treatment.'" *Id.* at 157.

103. *Id.* at 158.

psychiatric hospitals.”¹⁰⁴ However, the State did not include these specific goals in its final plan.¹⁰⁵ Rather, in its final plan, the State “substituted the more amorphous, *i.e.*, non-specific, goal of closing ‘up to 250 [] beds a year.’”¹⁰⁶

The court explicitly rejected the State’s “general assurances and good faith intentions to effectuate deinstitutionalization.”¹⁰⁷ Such “general assurances and good faith intentions,” said the court, “neither meet the federal laws nor a patient’s expectations.”¹⁰⁸ The court also worried that the State’s commitment to “implementation may change with each administration or Secretary of Welfare,” if the State did not “articulate this commitment in the form of an adequately specific comprehensive plan for placing eligible patients in community-based programs by a target date.”¹⁰⁹ The Third Circuit refused to accept the State’s fundamental alteration defense without a plan that would:

[S]pecify the time-frame or target date for patient discharge, the approximate number of patients to be discharged each time period, the eligibility for discharge, and a general description of the collaboration required between the local authorities and the housing, transportation, care, and education agencies to effectuate integration into the community.¹¹⁰

III. DOES GEORGIA HAVE AN EFFECTIVELY WORKING PLAN?

Georgia, as the ‘*Olmstead* State,’ should be leading the country in the process of deinstitutionalization.¹¹¹ But nine years after the decision, the State has come up short in the development and implementation of its own *Olmstead* Plan.¹¹² Although “*Olmstead*

104. *Frederick III*, 422 F.3d at 158.

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.* at 158–59.

110. *Frederick III*, 422 F.3d at 160.

111. Georgia is the ‘*Olmstead* State’ because the *Olmstead* case originated in Georgia.

112. *See infra* Part III (discussing Georgia’s *Olmstead* Plan).

Plans form the foundation for compliance with the Court's decision in *Olmstead* and the marker against which their compliance can be assessed,"¹¹³ Georgia has failed to produce a plan for which it can be held accountable.¹¹⁴ Under the Third Circuit's approach to evaluating a State's deinstitutionalization plan, Georgia's plan is grossly inadequate.¹¹⁵ The state has, however, made progress toward transitioning individuals out of institutions—expanding its HCBS waiver programs and increasing its spending on community-based services—which would probably satisfy the Ninth Circuit's standard for an effectively working plan.¹¹⁶ However, in order to continue meeting the Ninth Circuit's requirements, Georgia cannot allow fiscal constraints to impede its progress in the future.¹¹⁷

A. *Olmstead Planning in Georgia*

Georgia began its *Olmstead* planning process shortly after the Supreme Court's decision with the creation of its Blue Ribbon Task Force (BRTF) by Governor Roy Barnes in December 1999.¹¹⁸ The BRTF had seventeen members, including consumers (people with disabilities), parents, advocates, and other professionals.¹¹⁹ The group's purpose was to gather information and advise the Governor and the state legislature on the status of and future need for community services in Georgia; to identify barriers that prevent access to those services; to make funding recommendations; to give advice on how to prioritize services; and to identify possible waiting list criteria.¹²⁰ The group gathered information through public

113. Cerreto, *supra* note 1, at 64.

114. *See infra* Part III (discussing Georgia's *Olmstead* Plan).

115. *Id.*

116. *See infra* Part III.C.

117. *See id.* (discussing Georgia's *Olmstead* Plan).

118. GOVERNOR'S BLUE RIBBON TASK FORCE ON HOME AND COMMUNITY-BASED SERVICES, FINAL REPORT 1 (Jan. 2001) (on file with author) [hereinafter BRTF REPORT].

119. *Id.* at 2.

120. *Id.* at 1.

meetings, hearings, and surveys and provided their recommendations in the *Final Report*, dated January 2001.¹²¹

A month later, the Georgia Department of Human Resources (DHR) received a grant from the Center for Health Care Strategies to develop an Olmstead Plan.¹²² After receiving the grant, the state established an Olmstead Planning Committee.¹²³ The Planning Committee held eight meetings between February and October 2001, during which time the committee members reviewed the recommendations from the Governor's Blue Ribbon Task Force as well as the guidelines provided in the January 2000 Letter to State Medicaid Directors.¹²⁴ The committee's task was to develop an action plan for providing services in compliance with the ADA and the *Olmstead* decision.¹²⁵ The committee divided into workgroups, which included consumers, family members, service providers, state hospital representatives, advocates, and state agency staff members.¹²⁶ The Committee completed its *Final Report and Recommendations* in November 2001.¹²⁷

The Olmstead Planning Committee's final report contained recommendations for moving people out of institutions and increasing system capacity in communities.¹²⁸ Their report included a list of action steps, the agency responsible for each action item, and the target date for completion of the action item.¹²⁹ With the estimates available to it, the committee made recommendations for moving specific numbers of individuals out of institutions by certain dates.¹³⁰ Additionally, the committee provided the following recommendations for increasing system capacity: infrastructure

121. *Id.* at 3–4.

122. OLMSTEAD PLANNING COMMITTEE, FINAL REPORT AND RECOMMENDATIONS 8 (Nov. 2001) (on file with author) [hereinafter OLMSTEAD COMMITTEE REPORT].

123. *Id.*

124. *Id.* at 8–9. *See supra* notes 57–60 (discussing the HCFA letters).

125. OLMSTEAD COMMITTEE REPORT, *supra* note 122, at 8.

126. *Id.* at 8–9.

127. *See generally id.*

128. *Id.* at 4–7.

129. *Id.* at 9.

130. *Id.* at 20–57. *See also infra* text accompanying notes 154–55, 170–71.

improvements in the areas of housing and transportation; service expansion; provider development; and workforce development.¹³¹ Unfortunately, Governor Barnes would not commit to implementing the committee's recommendations, and "[n]o plan [was] formally submitted."¹³²

Two years after the Olmstead Planning Committee completed its report, Governor Sonny Perdue announced the release of Georgia's Strategic Olmstead Plan.¹³³ The plan was a modified version of the committee's report, with no measurable outcomes, no target dates, and "[n]o mechanism for accountability."¹³⁴ Rather, it was merely a "document of intents."¹³⁵

The plan "sets the strategic direction and broad parameters for addressing community-integrated service delivery."¹³⁶ It calls for (1) the identification of individuals in state hospitals, nursing homes and those at risk for institutionalization who would be affected by the plan, (2) an evaluation of those individuals to see if they would benefit from community services, and (3) subsequent periodic assessments of the individuals.¹³⁷ The plan, however, fails to specify who will conduct the assessment, what the assessment will entail, or what schedule the initial and subsequent evaluations will follow.¹³⁸ Additionally, under the plan, the state is supposed to respond to the assessments in a timely and effective manner by providing individuals with services or placing them on a waiting list.¹³⁹

131. OLMSTEAD COMMITTEE REPORT, *supra* note 122, at 58–91.

132. Governor's Council on Developmental Disabilities, Georgia Advocacy Office, Institute on Human Development and Disability & Marcus Institute, *State of Developmental Disabilities in Georgia* (PowerPoint Presentation), slide 4, available at <http://www.gcdd.org/ppt/presentation/> (follow link to DD_Show Final.ppt) [hereinafter GCDD PPT].

133. Press Release, Office of Communications of Governor Sonny Perdue, Governor Perdue Releases Georgia's Olmstead Plan (Feb. 4, 2004), available at <http://www.gov.state.ga.us/press/2004/press362.shtml> [hereinafter Gov. Perdue Press Release].

134. GCDD PPT., *supra* note 132, at slide 4; see also Governor Sonny Perdue, *State of Georgia Olmstead Strategic Plan* (Mar. 2003), available at http://www.files.georgia.gov/DHR/DHR_CommonFiles/16739455Olmstead_Plan__Perdue_.pdf [hereinafter Olmstead Strategic Plan].

135. GCDD PPT, *supra* note 132, at slide 4.

136. Olmstead Strategic Plan, *supra* note 134, at 7.

137. *Id.* at 8.

138. See generally *id.*

139. *Id.* at 9–10.

However, the plan does not say when individuals will be moved from institutions, how many will receive services before the waiting list goes into effect, or what the state will do to get people moved off the waiting list.¹⁴⁰

While the governor presented the Olmstead Strategic Plan as “a working document that [would] continue to evolve over time,”¹⁴¹ no effort was made to update the plan until 2008 when Georgia entered into a settlement agreement with the U.S. Department of Health and Human Services, Office for Civil Rights.¹⁴² Under the Settlement Agreement, Georgia is required to update its Olmstead Plan by February 2009, providing “new, concrete and realistic annual Olmstead goals.”¹⁴³ Specifically, Georgia’s plan must “include an annual schedule of anticipated discharges” for those institutionalized individuals with intellectual and developmental disabilities (DD) and/or mental health disabilities (MH) who are capable of receiving treatment in the community and who would like to do so.¹⁴⁴ Additionally, the plan must specify how the state will “obtain and/or maintain necessary community services for those at risk for institutionalization.”¹⁴⁵ Georgia’s new plan must be approved by an Olmstead Committee, which includes people with disabilities and their representatives as well as service providers and key decision-makers from state agencies.¹⁴⁶ The state must regularly report to the Olmstead Committee regarding its progress in implementing the new

140. *Id.*

141. Georgia Department of Community Health, *What Is the Olmstead Decision?*, http://dch.georgia.gov/00/channel_title/0,2094,31446711_31848276,00.html (last visited Jan. 31, 2009).

142. Voluntary Compliance Agreement Between the State of Georgia and the United States Department of Health and Human Services, Office for Civil Rights, Preamble (July 2008), *available at* <http://www.hhs.gov/ocr/civilrights/activities/agreements/georgiaagree.html> [hereinafter Compliance Agreement]. The State entered the settlement agreement after the Georgia Advocacy Office, the Atlanta Legal Aid Society, Inc., the Georgia Legal Services Program, and the Disability Law Policy Center of Georgia, Inc. filed class complaints with the U.S. Dept. of Health and Human Resources, Office for Civil Rights, claiming that the State failed to treat qualified persons with disabilities in the most integrated setting appropriate in violation of Title II of the ADA. *Id.*

143. *Id.* art. I, § IV(A).

144. *Id.*

145. *Id.*

146. *Id.* art. I, § IV(B).

plan, and the Olmstead Committee is responsible for releasing a progress report to the public each December.¹⁴⁷

B. Georgia's Progress in Implementing Olmstead

Despite the fact that Georgia has been operating under a “document of intents” since 2003, the state has made progress in implementing the *Olmstead* decision.¹⁴⁸ Below is a summary of the progress Georgia has made with respect to (1) moving people out of institutions, (2) expanding the waiver programs, and (3) moving people off the waiting lists.¹⁴⁹

1. Moving Individuals out of Institutions

In its November 2001 report, Georgia's Olmstead Planning Committee made recommendations for moving a specific number of people with mental retardation and developmental disabilities (MR/DD) and people with mental illnesses out of institutions and into more integrated settings within a set timeframe.¹⁵⁰ Although Georgia has not complied with the recommendations of the Committee, the state has made some progress in moving people with MR/DD and mental illnesses out of institutions.¹⁵¹

a. Individuals with Mental Retardation and Developmental Disabilities

In its November 2001 report, the Olmstead Planning Committee estimated that over 1,568 individuals with mental retardation and developmental disabilities (MR/DD) lived in public and private

147. *Id.* art. I, § IV(E)–(F).

148. *See supra* Part III.A.

149. *See infra* Part III.B.1–3.

150. *See, e.g., infra* notes 152–54, 170–71. The committee noted that there was “no single, comprehensive survey indicating the number of institutionalized persons who are appropriate for community-based services,” and the committee struggled to obtain reliable numbers, so its recommendations are based on the best data available at the time of the report. OLMSTEAD COMMITTEE REPORT, *supra* note 122, at 20.

151. *See infra* Part III.B.1.a–b.

institutions in Georgia.¹⁵² The Committee noted that since 1996, the state had succeeded in reducing the number of persons living in state-operated institutions by more than 500 people.¹⁵³ The committee recommended that the state move an additional 1,507 individuals with MR/DD from institutions by 2008.¹⁵⁴

In 2001, the state closed Bainbridge State Hospital (BSH), a 100 bed mental retardation facility.¹⁵⁵ This closure, the state claimed, allowed it to move “100 people with mental retardation . . . into comprehensive community based services.”¹⁵⁶ In his FY 2004 Budget Report, Governor Purdue announced that Georgia would be spending \$10 million in FY 2003 to implement some of the Olmstead Planning Committee’s recommendations, including their suggestion to move sixty-five children with developmental disabilities out of state institutions.¹⁵⁷ Additionally, the Governor recommended that the state transition fifty adults with developmental disabilities to community services in FY 2004.¹⁵⁸ Between 2001 and 2006, Georgia reduced the number of institutionalized individuals with MR/DD by a total of 493, a 14% reduction.¹⁵⁹

152. OLMSTEAD COMMITTEE REPORT, *supra* note 122, at 39. There were 1,458 persons living in public Intermediate Care Facilities for Mental Retardation (ICFs/MR) and Skilled Nursing Facilities (SNFs); another 110 were living in a private ICF/MR. *Id.* An additional 1,619 individuals with MR/DD lived in nursing homes. *Id.* Sixty-five of the individuals residing in state institutions were children (age twenty-one or younger). *Id.* at 42.

153. *Id.* at 39.

154. Specifically, the committee recommended that the state transfer all sixty-five children with MR/DD out of state hospitals by the end of 2001. *Id.* at 42. Each year, starting in FY 2003 and continuing through FY 2007, the committee wanted the State to move 301 adults with MR/DD out of public and private institutions. *Id.* at 45–46. Additionally, the Committee recommended moving 419 adults with MR/DD from nursing homes each year. *Id.*

155. Olmstead Strategic Plan, *supra* note 134, attachment A. The state closed three additional hospitals between 1996 and 2001: River’s Crossing (a thirty-seven bed facility for children with mental retardation), Brook Run (a 326 bed mental retardation facility), and Georgia Mental Health Institute (a 141 bed psychiatric hospital). *Id.*

156. *Id.*

157. *Id.*

158. *Id.* Of course, this recommendation fell very short of meeting the Olmstead Committee’s recommendation of moving 720 individuals. OLMSTEAD COMMITTEE REPORT, *supra* note 122, at 45.

159. At the end of FY 2006, there were 1,075 persons with MR/DD living in public and private institutions (not including nursing homes) in Georgia. Interview with Dave Blanchard, Director, Atlanta Alliance on Developmental Disabilities (AADD) (Nov. 15, 2007) (on file with author) [hereinafter Blanchard Interview]. *But see* LIPSON, ET AL., *supra* note 68, at 6 (reporting that 1,085 persons with

In 2006, the state applied for and received \$34,091,671 through the Centers for Medicare & Medicaid Services, Money Follows the Person (MFP) Grant program.¹⁶⁰ The grant program was designed to help states transition individuals from institutions into more integrated settings.¹⁶¹ In its grant application, the state set goals for transitioning a certain number of individuals out of institutions each year for five years, beginning in 2007.¹⁶² With respect to developmentally disabled individuals, the state planned to move seventy-five in FY2008, 150 in FY 2009, 150 in FY 2010, and 187 in FY 2011.¹⁶³ Georgia also planned to reduce the number of beds in Intermediate Care Facilities for the mentally retarded (ICF-MR) by 70% as patients transitioned to the community.¹⁶⁴

As of January 19, 2009, there were 925 individuals with developmental disabilities residing in institutions.¹⁶⁵ This number

MR/DD lived in public and private ICFs/MR). There were still 110 individuals living in private ICFs/MR, and 1,620 individuals with MR/DD lived in nursing homes in 2006. *Id.*

160. LIPSON, ET AL., *supra* note 68, at 36. In July 2006, the CMS announced that it would provide funding to states for alternatives to nursing home care under the Money Follows the Person Rebalancing Initiative. News Release, U.S. Dep't of Health and Human Servs., HHS Provides Funding to States for Alternatives to Nursing Home Care in Medicaid (July 26, 2006), *available at* <http://www.hhs.gov/news/press/2006pres/20060726.html> [hereinafter HHS News Release]. CMS planned to give \$1.75 billion over five years in demonstration grants to states "to help shift Medicaid from its historical emphasis on institutional long-term care services to a system that offers more choices for seniors and persons with disabilities from all age groups, including home and community-based services." *Id.* As of August 2007, CMS has awarded grants to thirty states and the District of Columbia, committing over \$1.4 billion for a five year period. LIPSON, ET AL., *supra* note 68, at 3.

161. HHS News Release, *supra* note 160. Through these grants, the federal government effectively "will pay for 75 to 90 percent of the costs" to transition individuals out of nursing homes and provide services to them in the community for one year. *Id.*

162. LIPSON, ET AL., *supra* note 68, at 2. During five years, the State planned to move 375 elderly people, 375 individuals with physical disabilities and/or traumatic brain injury, and 562 individuals with mental retardation and/or developmental disabilities. *Id.* at 37. The first year of the grant program was devoted to developing "Operational Protocols" with "measurable benchmarks of state progress towards program goals, and . . . a step-by-step guide to program implementation." *Id.* at 2. During the remaining four years, the state planned to move 1312 individuals out of institutions and into home and community-based programs. *Id.* at 37.

163. *Id.*

164. *Id.* at 36.

165. E-mail from Pat Nobbie, Deputy Director, Governor's Council on Developmental Disabilities (GCDD), to author (Jan. 20, 2009) (on file with author) [hereinafter Nobbie E-mail I]. There were an additional sixty-five individuals residing in the Skilled Nursing Facility at Central State who were not technically classified as developmentally disabled. *Id.*

was down from 1,075 at the end of FY 2006,¹⁶⁶ which means that the state moved at least 150 individuals with MR/DD between FY 2007 and FY 2008. Thus the state has met its goal to move seventy-five individuals in FY 2008 under the MFP grant.¹⁶⁷

Since 2001, Georgia has transitioned a total of 643 individuals with MR/DD from institutions.¹⁶⁸ While Georgia has made progress toward deinstitutionalization, it has fallen short of the Olmstead Planning Committee's recommendation to move 1,507 individuals by 2008.¹⁶⁹

b. Individuals with Mental Illness

The Olmstead Planning Committee reported that in 2000, an estimated 237 adults and 698 children with mental illness resided in public mental health institutions.¹⁷⁰ The Committee recommended that the state reduce the number of individuals with mental illness living in public institutions by 20% between FY 2003 and FY 2008.¹⁷¹ In his FY 2004 Budget Report, the Governor said that the state had already committed funds to “[c]reate four state-run community homes for forty hard-to-place, severely emotionally disturbed adolescents currently in state hospitals” in FY 2003.¹⁷² He recommended that the state move another fifteen mental health patients into the community in FY 2004.¹⁷³ When it applied for the MFP grant in 2006, the state promised to transition thirty-five individuals with mental illness out of state mental institutions using

166. See sources cited *supra* note 159.

167. LIPSON, ET AL., *supra* note 68, at 37.

168. In 2001, 1,568 individuals with MR/DD resided in institutions. See *supra* text accompanying note 152. Nine hundred and twenty-five individuals with MR/DD resided in institutions as of Jan. 19, 2009. See *supra* text accompanying note 165. Thus, a total of 643 individuals with MR/DD have been removed from institutions since 2001.

169. See *supra* text accompanying note 154.

170. OLMSTEAD COMMITTEE REPORT, *supra* note 122, at 27, 31. An additional 2,907 people with mental illnesses were living in private nursing facilities. *Id.* at 32. Approximately 500 of the people with mental illness living in private nursing homes were also diagnosed with mental retardation. *Id.*

171. *Id.* at 30, 35. Specifically, the Committee recommended that the State transition the first 140 children into more integrated settings by FY 2003. *Id.* at 30.

172. Olmstead Strategic Plan, *supra* note 134, attachment A.

173. *Id.*

state funds.¹⁷⁴ As of January 19, 2009, there were 523 adults and 44 children residing in mental institutions.¹⁷⁵ While it is not clear from these statistics whether the state succeeded in meeting the specific goals that it set, overall the state has succeeded in reducing the number of individuals with mental illness living in institutions.¹⁷⁶

2. Expanding HCBS Waiver Programs

Georgia's primary means of funding community-based services for the disabled is through its HCBS waiver programs.¹⁷⁷ These programs serve those who are transitioned from institutions as well as those who are at risk for institutionalization.¹⁷⁸ The Mental Retardation Waiver Program (MRWP) and Community Habilitation and Community Habilitation and Support Services Program (CHSS) provide home and community-based support services to "people who have been diagnosed with mental retardation or other developmental disabilities, such as autism, cerebral palsy or epilepsy."¹⁷⁹ The

174. LIPSON, ET AL., *supra* note 68, at 37.

175. Nobbie E-mail I, *supra* note 165.

176. In 2000, there were 935 adults and children with mental illnesses residing in institutions. *See supra* text accompanying note 170. As of January 19, 2009, there were 567 adults and children with mental illnesses living in institutions. Nobbie E-mail I, *supra* note 165. It is not clear how many people the state actually transitioned because patients cycle in and out of public hospitals and may not stay long-term. OLMSTEAD COMMITTEE REPORT, *supra* note 122, at 31. The Olmstead Committee reported that 14,284 persons with mental illness were admitted to public institutions in FY 2000, but estimated that there were only 237 long-term (more than sixty days) mental health patients in the institutions at the time of the report. *Id.* at 31–32. Additionally, it is not clear how the data from year 2000 corresponds to the data from year 2008 because many of the children who resided in institutions in 2001 were probably adults in 2008. This may explain why the number of children in institutions has decreased so dramatically and the number of adults in institutions has risen.

177. Olmstead Strategic Plan, *supra* note 134, at 11. Georgia's waiver programs include the Mental Retardation Waiver Program (MRWP), the Independent Care Waiver Program (ICWP), the Community Habilitation and Support Services Program (CHSS), and the Community Care Services Program (CCSP). *Id.*

178. *Id.*

179. *Id.* The MRWP and CHSS waiver programs were replaced by the New Options Waiver (NOW waiver) and the Comprehensive Waiver (COMP waiver) in November 2008. Georgia Department of Human Resources, Division of MHDDAD, Office of DD, *New Options Waiver (NOW) and Comprehensive Waiver (COMP) Frequently Asked Questions (FAQ)* (2008) [hereinafter GDHR New Waivers]; Interview with Steve Hall, Director, Division of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD) (Nov. 21, 2007) [hereinafter Steve Hall Interview]. For a discussion of the new waivers, *see infra* text accompanying notes 199–203.

Independent Care Waiver Program (ICWP) offers home and community-based services to people with physical disabilities and people with traumatic brain injuries.¹⁸⁰ Georgia has expanded both of these waiver programs over the last ten years.¹⁸¹

Between 1999 and 2003, Georgia increased the number of consumers served by community-based mental retardation waivers (MRWP) by 5,975.¹⁸² The Georgia General Assembly allocated funding for an additional 740 waivers between FY 2003 and FY 2005.¹⁸³

In February 2005, the Georgia Legislature adopted a multi-year funding plan to increase the number of waivers that Georgia provides under the MRWP and ICWP over the course of five years.¹⁸⁴ Through the multi-year funding plan, the legislature planned to increase the number of MRWP waivers each year, but as Table 1 illustrates, the state has not met its goals for several years.¹⁸⁵

180. Olmstead Strategic Plan, *supra* note 134, at 11.

181. *See infra* text accompanying note 196–97.

182. Olmstead Strategic Plan, *supra* note 134, attachment A.

183. Specifically, the General Assembly allocated funding for 507 waiver services in FY 2003; 203 waiver services in FY 2004; and thirty waiver services in FY 2005. *See generally* Blanchard Interview, *supra* note 159.

184. Letter from Tim Burgess, Commissioner, to Glenn Richardson, Speaker of the Ga. House of Representatives (Feb. 3, 2003), *available at* <http://www.unlockthewaitinglists.com/pdf/UnlockMultipleYearPlan.pdf> [hereinafter Multi-Year Funding Plan].

185. *Id.*

TABLE 1 COMPARISON OF MULTI-YEAR FUNDING PLAN TO ACTUAL INCREASE IN MRWP WAIVERS¹⁸⁶

<u>Fiscal Year</u>	<u>Multi-Year Funding Plan</u>	<u>Actual/Approved</u>
FY 2006	1,000 new services	925 new services
FY 2007	1,500 new services	1,500 new services ¹⁸⁷
FY 2008	2,000 new services	1,500 new services
FY 2009	2,500	365 new services ¹⁸⁸
FY 1010	2,500	150 new services ¹⁸⁹
Total	9,500	4,440 new services

Under the multi-year funding plan, the state was also supposed to increase the number of individuals served by the ICWP waiver program from 321 to 2,101 over five years, which amounts to 356 new waivers per year.¹⁹⁰ As Table 2 illustrates, the state did not meet the goals of the Multi-Year Funding Plan for ICWP waivers.

186. See *id.*; *Conversations that Matter: Town Hall Meetings—School Transition to Adult Supports*, Shamrock Middle School (Oct. 29, 2007) (remarks by Steve Hall, Director of the Division of Mental Health, Developmental Disabilities and Addictive Diseases) (on file with author) [hereinafter *Conversations that Matter*]; *Unlock the Waiting Lists!, How Many People Are Waiting?*, <http://www.unlockthewaitinglists.com/peoplewaiting.html> (last visited Nov. 25, 2007). See generally Blanchard Interview, *supra* note 159; Telephone interview with Pat Nobbie, Deputy Director, Governor's Council on Developmental Disabilities (GCDD) (Jan. 13, 2009) (on file with author).

187. Even though the governor only proposed funding for 750 waivers, the legislature budgeted for 1,500 new waivers in FY 2007, which kept the state on track with the multi-year funding plan. *FY2007 General Budget: The current proposal within to fund 750 services for Georgia's Waiting Lists for disability supports is a step backwards* (Nov. 25, 2007) [hereinafter *A Step Backwards*] (on file with author); Blanchard Interview, *supra* note 159.

188. The legislature approved 500 waivers for FY 2009 during the 2008 legislative session, but the governor has proposed an amended budget for FY 2009 that would cut out 135 waivers. E-mail from Dave Blanchard, Director, Atlanta Alliance on Developmental Disabilities (AADD), to author (Jan. 15, 2009) (on file with author) [hereinafter *Blanchard E-mail II*].

189. The governor proposed 150 new services. Telephone interview with Pat Nobbie, Deputy Director, Governor's Council on Developmental Disabilities (GCDD) (Jan. 14, 2009) (on file with author). This proposed number of waivers would meet the minimum obligations that the State has under the Money Follows the Person Grant but does not provide additional waivers to help move individuals off the waiting list.

190. *Id.*

TABLE 2 COMPARISON OF MULTI-YEAR FUNDING PLAN TO ACTUAL ICWP WAIVERS¹⁹¹

<u>Fiscal Year</u>	<u>Multi-Year Funding Plan</u>	<u>Actual/Approved</u>
FY 2006	356 new services	46 new services
FY 2007	356 new services	152 new services ¹⁹²
FY 2008	356 new services	0 new services ¹⁹³
FY 2009	356 new services	75 new services ¹⁹⁴
FY 1010	356 new services	100 new services ¹⁹⁵
Total	1,780	373 new services

Although the state has not complied with the multi-year funding plan, there has been a net increase of 4,440 MRWP waivers and 373 ICWP waivers between FY 2006 and FY 2010.¹⁹⁶ Because Georgia has expanded its waiver programs, the state's overall spending on community-based services has increased as well. Between 2001 and 2006, Georgia increased its spending on HCBS Waiver programs from \$178,743,578 to \$402,099,710—a 125% increase.¹⁹⁷ The State's spending on HCBS MR/DD waivers increased 188.8% from

191. See Multi-Year Funding Plan, *supra* note 184; E-mail from Pat Puckett, Executive Director, Statewide Independent Living Council of Georgia, Inc., to author (Jan. 22, 2009) (on file with author) [hereinafter Puckett E-mail].

192. The Governor's budget proposal did not include any funding for new ICWP waiver slots for FY 2007. Unlock the Waiting Lists!, *FY2007 General Budget: The Governor's current proposal recommends no new funding for the Independent Care Waiver Program (ICWP)*, <http://www.unlockthewaitinglists.com/pdf/ICWP.pdf> (last visited Nov. 26, 2007). But, thanks to the lobbying efforts of advocates such as the Atlanta Alliance for Developmental Disabilities (AADD), the legislature eventually included 152 ICWP waiver slots in the FY 2007 budget. Puckett E-mail, *supra* note 191.

193. The state should have funded at least fifty ICWP waivers under the Money Follows the Person (MFP) grant to transition fifty people with physical disabilities or traumatic brain injuries out of institutions. LIPSON, ET AL., *supra* note 68, at 37.

194. The state should have funded at least 100 waivers to transition people with physical disabilities and traumatic brain injuries from institutions in FY 2009. *Id.*

195. The Governor has proposed 100 ICWP waivers for the FY 2010 budget, which would match the state's commitment under the MFP grant. Blanchard E-mail II, *supra* note 188; LIPSON, ET AL., *supra* note 68, at 37.

196. See *supra* Tables 1 and 2.

197. LIPSON, ET AL., *supra* note 68, at 8.

2001 to 2006 while spending on ICF/MR (institutions) remained constant over the same time period.¹⁹⁸

Not only has Georgia increased the number of HCBS waivers that it provides, the state has also made new services and options available under the waiver programs. For example, Georgia has replaced the MRWP and HCSS waiver programs with two new waivers: the New Options Waiver (NOW waiver) and the Comprehensive Waiver (COMP waiver).¹⁹⁹ The new waivers provide dental services, transportation services, and the option for individuals to self-direct their services rather than relying on third-party service coordinators.²⁰⁰ Additionally, the new waivers include quality assurance components and community guides who work with disabled individuals to create personal budgets and find community-based services.²⁰¹ The new waivers were approved by the Centers for Medicare and Medicaid Services (CMS) in October of 2007 and became effective on November 1, 2008; individuals have the option to transfer to the new waivers on the date of their birthday.²⁰²

3. *Moving Individuals off of the HCBS Waiting Lists*

The Governor's Blue Ribbon Task Force on Home and Community Based Services summarized the status of the HCBS waiting lists in Georgia in its January 2001 report.²⁰³ According to the Task Force, 2,156 people with mental retardation and/or developmental disabilities and 250 people with physical disabilities

198. *Id.* at 9.

199. GDHR New Waivers, *supra* note 179; *see also* Steve Hall Interview, *supra* note 179. The NOW waiver provides supports for people with MR/DD who live with their parents while the COMP waiver provides residence for people with MR/DD. *Conversations that Matter*, *supra* note 186.

200. GDHR New Waivers, *supra* note 179. For example, the new waivers provide dental services, transportation services, and the option for individuals to self-direct their services rather than relying on a third-party service coordinator. *Id.*

201. Steve Hall Interview, *supra* note 179.

202. *Id.* Although the transition from the old waivers to the new waivers was supposed to begin in October, 2007, the process was delayed because the Georgia Department of Community of Health had to update its Medicaid payment system. *Id.* The payment system update cost the State \$1 million. E-mail from Pat Nobbie, Deputy Director, Governor's Council on Developmental Disabilities (GCDD), to author (Nov. 28, 2007) (on file with author) [hereinafter Nobbie E-mail II].

203. BRTF REPORT, *supra* note 118, at 1.

were waiting to receive waivers; 3,758 older Medicaid-eligible adults were on HCBS waiting lists; and 5,885 older adults who were not eligible for Medicaid were waiting to receive state funded community-based services.²⁰⁴ Furthermore, the Task Force said, an undocumented number of people were waiting to receive mental health services.²⁰⁵

The state's efforts to expand the MRWP waiver programs have not been adequate to meet the demands of the growing waiting list.²⁰⁶ Although the state has increased the number of available MRWP waivers each year between FY 2004 and FY 2008, the number of people on the waiting list has gone up instead of down, as the chart below illustrates.²⁰⁷

<u>Fiscal Year</u>	<u>No. of People on the Waiting List</u>	<u>No. of New Waiver Services Provided</u>
FY 2004	4,894	230
FY 2005	5,960	30
FY 2006	6,948	925
FY 2007	5,182	1,500
FY 2008	5,542	1,500

There are three reasons that the waiver list continues to grow despite the state's efforts to expand the MRWP program. First, the MRWP waiting list, on average, increases by over 1,000 people each year while the number of individuals leaving the waiver program is only about 2–8%.²⁰⁸ Second, individuals on the waiting list may be

204. *Id.*

205. *Id.*

206. In adopting the multi-year funding plan, the General Assembly acknowledged that it was “barely adequate to address” the growing waiting list. Multi-Year Funding Plan, *supra* note 184. The plan was meant to keep pace with the growth of the waiting list, but since the State has not met the goals of the multi-year funding plan, the growth of the waiting list has outpaced the expansion of the waiver program. *Id.* See also *supra* text accompanying notes 184–95 (discussing the multi-year funding plan).

207. See generally Blanchard Interview, *supra* note 159; E-mail from Dave Blanchard, Director, Atlanta Alliance on Developmental Disabilities (AADD), to author (April 4, 2008) (on file with author) [hereinafter Blanchard E-mail I].

208. *A Step Backwards*, *supra* note 187; Multi-Year Funding Plan, *supra* note 184.

eligible to receive more than one waiver service, so the number of waivers funded by the state does not equal the number of people that are removed from the waiting list.²⁰⁹ Third, the waiting list only represents those who are currently living in the community and need services; the number of people transitioning from institutions is not reflected on the MRWP waiting list.²¹⁰

C. Evaluation of Georgia's Olmstead Plan Under the Circuit Courts' Standards

The Third Circuit Court of Appeals requires a state to develop a plan with specific measures and outcomes for which it may be held accountable.²¹¹ The Ninth Circuit, on the other hand, looks at the state's past progress in moving people out of institutions, expanding its Medicaid waiver programs, and increasing funds for community-based services despite fiscal constraints.²¹² Under both approaches, Georgia fails to demonstrate that it has an effectively working plan.

1. Third Circuit Approach

The Olmstead Planning Committee report from November 2001 contained specific measures and outcomes and thus would have satisfied the Third Circuit's definition of an effectively working plan.²¹³ However, the Committee Report was not adopted as Georgia's Olmstead Plan.²¹⁴ The Olmstead Strategic Plan that was published in 2003 did not contain any measurable outcomes, target

209. *A Step Backwards*, *supra* note 187. For example, in FY 2007 the State allocated funding for 1500 waiver services which were provided to 1300 people on the waiting list. *See* Blanchard Interview, *supra* note 159.

210. *A Step Backwards*, *supra* note 187. Thus, if the state only provides funding for 150 MRWP waiver services in FY 2010 and that is the number of people with developmental disabilities who are going to be transitioned out of institutions under the Money Follows the Person Grant, then the new waivers do not help reduce the number of people on the waiting list.

211. *Frederick III*, 422 F.3d 151, 157 (3d Cir. 2005).

212. *Sanchez v. Johnson*, 416 F.3d 1051, 1067 (9th Cir. 2005); *see also* *Arc of Wash. State, Inc. v. Braddock*, 427 F.3d 615, 620–22 (9th Cir. 2005).

213. *Frederick III*, 422 F.3d at 160.

214. *See supra* text accompanying note 132.

dates, or “mechanism for accountability.”²¹⁵ Rather, the Olmstead Strategic Plan was a “document of intents” with a broad list of goals and no specific guidance for accomplishing those goals.²¹⁶ This type of plan is unacceptable to the Third Circuit, which said that a state’s “general assurances and good faith intentions to effectuate deinstitutionalization” may be genuine, but they “neither meet the federal laws nor a patient’s expectations.”²¹⁷

The fact that the state has made progress in reducing the number of people with developmental disabilities in institutions over the last nine years is not enough to satisfy the Third Circuit.²¹⁸ Without a plan that provides “concrete, measurable benchmarks and a reasonable timeline,” patients are not able “to ascertain when, if ever, they will be discharged to appropriate community services.”²¹⁹

Through the multi-year funding plan and the MFP Grant, the state established five-year goals for which it can be held accountable, as required by the Third Circuit.²²⁰ Unfortunately, Georgia has not met the goals of the multi-year funding plan and the MFP grant for the last few years.²²¹

In July 2008, Georgia entered into an *Olmstead* settlement agreement with the U.S. Department of Health and Human Services, Office of Compliance, which requires the state to develop an *Olmstead* plan with “new, concrete and realistic annual Olmstead goals.”²²² If, as required by the settlement agreement, the new plan includes an annual schedule of anticipated discharges and specifies how the state will “obtain and/or maintain necessary community

215. GCDD PPT, *supra* note 132, at 4. *See generally* Olmstead Strategic Plan, *supra* note 134.

216. GCDD PPT, *supra* note 132, at 4; Olmstead Strategic Plan, *supra* note 134; *see also supra* text accompanying notes 133–40.

217. *Frederick III*, 422 F.3d at 158.

218. *Id.* at 155.

219. *Id.* (noting that Pennsylvania had reduced its mental health hospital population from 40,000 in 1950 to less than 3,000 at the time of trial, but that the state had failed to provide measurable goals for community integration for which it could be held accountable).

220. *See supra* text accompanying notes 160–64, 174 for a discussion of the Money Follows the Person Grant and text accompanying notes 184–96 for a discussion of the multi-year funding plan.

221. *See supra* text accompanying notes 184–95.

222. Compliance Agreement, *supra* note 142, art. I, § IV(A).

services for those at risk for institutionalization,” then it would meet the expectations of the Third Circuit.²²³

2. Ninth Circuit

Although a post-hoc assessment of Georgia’s progress toward deinstitutionalization is not enough to satisfy the Third Circuit’s definition of an effectively working plan, it might be enough to satisfy the Ninth Circuit if the state can demonstrate that it has (1) made significant progress in moving people out of institutions, (2) increased its budget for community services in spite of fiscal constraints, and (3) increased the size of its HCBS programs over time by applying for more Medicaid waivers.²²⁴

Between 2001 and 2008, Georgia transitioned 643 individuals with developmental disabilities out of institutions.²²⁵ This is a 41% reduction in the number of persons with MR/DD who are confined in institutions.²²⁶ Additionally, Georgia has reduced the mental illness institutional population by 368 individuals, which is a 39% change.²²⁷ In *Sanchez*, the court found that California decreased its institutional population by 20% in four years.²²⁸ Similarly, in *Arc of Washington State, Inc.*, the Ninth Circuit found that Washington decreased its institutional population by 20%.²²⁹ As in *Sanchez* and *Arc of Washington State, Inc.*, the Ninth Circuit would likely consider Georgia’s decrease of 39% or 40% in the institutional population to be an indication that the state has an effectively working plan.

Between 2001 and 2006, Georgia increased its spending on HCBS waiver programs by 125% and increased spending on waivers for individuals with MR/DD by 188.8%, while spending on institutions for people with MR/DD remained constant over the same time

223. Compliance Agreement, *supra* note 142, art. I, § IV(A).

224. *Sanchez v. Johnson*, 416 F.3d 1051, 1067 (9th Cir. 2005). *See also* *Arc of Wash. State, Inc. v. Braddock*, 427 F.3d 615, 620–22 (9th Cir. 2005).

225. *See supra* note 168 and accompanying text.

226. *Id.*

227. *See supra* text accompanying note 176.

228. *Sanchez*, 416 F.3d at 1067.

229. *Arc of Wash. State*, 427 F.3d at 621–22.

period.²³⁰ In *Sanchez*, the Ninth Circuit found that California increased spending on community services by 196% over 10 years.²³¹ The court similarly found, in *Arc of Washington State, Inc.*, that Washington had increased its annual budget for community-based disability programs by 109.5% over 7 years.²³² Just as the Ninth Circuit found that a spending increase of 196% over ten years and 109.5% over seven years for community-based services was evidence that the state had an effectively working plan, Georgia's increase of 125% over five years would probably indicate that it has an effectively working plan.

The State's past progress in moving people out of institutions, expanding its waiver program, and increasing spending on community-based services may be adequate to meet the Ninth Circuit's requirements for an effectively working plan. However, the state must be careful that it does not allow fiscal constraints to impede its progress in the future. One of the factors that the Ninth Circuit considered when reviewing the *Olmstead* plan in *Arc of Washington State, Inc.* was evidence that the state had increased spending on community-based services while other agencies were dealing with cutbacks.²³³ Georgia has failed to meet its goals for increasing MRWP waivers in FY 2007, 2008, and 2009 under the multi-year funding plan.²³⁴ The state has also fallen short of meeting its goals for increasing ICWP waivers under the multi-year funding plan and the Money Follows the Person grant for several years.²³⁵ Although the state is complying with the Money Follows the Person Grant with respect to moving individuals with MR/DD out of institutions, its overall commitment to funding community-based services has been scaled back.²³⁶ If the state wants to persist in

230. LIPSON, ET AL., *supra* note 68, at 8–9.

231. *Sanchez*, 416 F.3d at 1067.

232. *Arc of Wash. State*, 427 F.3d at 621–22 (finding that the State had increased its annual budget for community-based disability programs from \$167 million in 1994 to \$350 million in 2001).

233. *Arc of Wash. State*, 427 F.3d at 621.

234. *See supra* text accompanying notes 184–89.

235. *See supra* notes 190–95 and accompanying text.

236. *See Blanchard E-mail II, supra* note 188.

meeting the standards of the Ninth Circuit for having and effectively working plan, it must continue its progress despite fiscal constraints.

CONCLUSION

In *Olmstead*, the Supreme Court determined that the unnecessary institutionalization of a disabled person is a form of unlawful discrimination under the ADA.²³⁷ States are required to provide home and community-based services to people with disabilities when the states' treatment professionals determine that community-based treatment is appropriate and the individuals do not object.²³⁸ However, states only have to make reasonable modifications; they do not have to make modifications that will result in a fundamental alteration of their programs or services.²³⁹ According to *Olmstead*, a state can meet the reasonable modification standard by showing that it has a "comprehensive, effectively working plan for placing qualified individuals with mental disabilities in less restrictive settings, and a waiting list that move[s] at a reasonable pace."²⁴⁰

The *Olmstead* Court did not explain what it means for a state to have an effectively working plan and a waiting list that moves at a reasonable pace, but the Ninth and Third Circuits have addressed the question.²⁴¹ The Ninth Circuit looks at a state's progress in moving people out of institutions, expanding their HCBS waiver programs, and increasing funding for community-based services in spite of fiscal constraints.²⁴² The Third Circuit, however, says that a state's past progress is not enough to prove that it has an effectively working plan.²⁴³ Rather, the Third Circuit requires that a state's plan contain specific and measurable goals for which it can be held accountable.²⁴⁴

237. *Olmstead v. L.C.*, 527 U.S. 581, 597 (1999). See *supra* Part I (discussing the *Olmstead* decision).

238. *Olmstead*, 527 U.S. at 597.

239. *Id.* at 603.

240. *Id.* at 605–06.

241. See *supra* Parts I–II.

242. See *supra* Part II.A.

243. See *supra* Part II.B.

244. *Id.*

Georgia has failed to implement an effectively working plan as defined by the Third Circuit.²⁴⁵ However, the state may meet the standards of the Third Circuit by complying with the *Olmstead* settlement agreement.²⁴⁶ Under that agreement, the state must develop a plan that contains “an annual schedule of anticipated discharges” for institutionalized individuals who are capable and desirous of receiving treatment in the community and specifies how the state will “obtain and/or maintain necessary community services for those at risk for institutionalization.”²⁴⁷

Georgia’s past progress in moving people out of institutions, expanding its waiver programs, and increasing spending on community-based services may satisfy the Ninth Circuit’s requirements for an effectively working plan.²⁴⁸ However, the state must continue its progress in order to comply with the Ninth Circuit’s standards in the future.²⁴⁹ Specifically, the state must continue moving people out of institutions, expanding its waiver programs, and increasing its spending on community-based services despite difficult economic times.²⁵⁰

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245. *See supra* Part III.C.1.

246. *Id.*

247. *Id.*

248. *See supra* Part III.C.2.

249. *Id.*

250. *Id.*

