

***Olmstead* Plans Revisited: Lessons Learned from the U.N. Convention on the Rights of Persons with Disabilities**

Megan Flynn†

Introduction

In May of 1992, L.C., a woman with mental retardation and schizophrenia, was voluntarily admitted to a psychiatric unit of a Georgia hospital.¹ By May of 1993, L.C.'s condition had stabilized, and her treatment professionals determined that community-based treatment was appropriate, and she could be discharged from the hospital.² Despite this determination, L.C. remained institutionalized until February of 1996—less than one year after filing suit against the State of Georgia³—when the State finally placed her in a community-based treatment program.⁴ E.W., a woman diagnosed with mental retardation and a personality disorder, entered the same hospital psychiatric unit in February of 1995.⁵ By the next year, E.W.'s psychiatrist had decided that “she

†. J.D. expected 2011, University of Minnesota Law School. This Article is dedicated to the persons with intellectual disabilities with whom I have worked throughout the years: your struggle for independence has taught me much about myself. I would like to thank Professor Stephen Befort for his direction with this Article, and the staff and editors of *Law and Inequality: A Journal of Theory and Practice* for their tireless efforts. I also want to thank my parents, Bill and Elena Flynn, for their love and support, and Margaret Garvey for her mentorship.

1. *Olmstead v. L.C.*, 527 U.S. 581, 593 (1999).

2. *Id.* Community-based treatment, also called supported housing, provides care and other support services to people with disabilities (amongst other populations) in their communities, rather than in institutional settings. *See, e.g.*, *Disability Advocates, Inc. v. Paterson*, 653 F. Supp. 2d 184, 227 (E.D.N.Y. 2009) (“Supported housing is an integrated, community-based setting . . .”). Such treatment programs allow people with disabilities similar opportunities for community interaction to those available to people without disabilities. *See, e.g., id.* (“Supported housing . . . enables interaction with nondisabled persons to the fullest extent possible. People who live in supported housing have the autonomy to live and participate in their communities in essentially the same ways as people without disabilities.”).

3. L.C. filed suit in May 1995 in district court, “alleg[ing] that the State’s failure to place her in a community-based program, once her treating professionals determined that such placement was appropriate, violated, *inter alia*, Title II of the ADA.” *Olmstead*, 527 U.S. at 593–94.

4. *Id.* at 593.

5. *Id.* One month after her admittance, the hospital sought to discharge E.W.

could be treated appropriately in a community-based setting," but E.W. still remained institutionalized until 1997.⁶ These women's stories, typical at the time for people with intellectual disabilities, became the foundation for the landmark Supreme Court case *Olmstead v. L.C.*⁷ In *Olmstead*, the Supreme Court held that "unjustified isolation" of qualified individuals with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act (ADA).⁸ This decision signaled that a multitude of individuals with intellectual disabilities warehoused in nursing homes and institutions have the right to live in the community if "the State's treatment professionals have determined that community placement is appropriate" and the placement "is not opposed by the affected individual,"⁹ regardless of states' general reluctance to integrate on the basis of cost.¹⁰

Around the same time that *Olmstead* was decided, the international disability rights movement was gaining momentum.¹¹ In 2001, the United Nations first discussed forming an ad hoc committee to consider proposals to form an "international convention to promote and protect the rights and dignity of persons with disabilities."¹² The committee met for the first time in August of 2002, and spent the next five years drafting

to a homeless shelter, but canceled these efforts when E.W.'s attorney intervened. *Id.*

6. *See id.* (noting that E.W. was released from her institutionalization in the Georgia Regional Hospital a few months after the district court decided her case).

7. 527 U.S. 581 (1999).

8. *Id.* at 597, 600–01, 602–03; *see* Americans with Disabilities Act (ADA) of 1990, Pub. L. No. 101-336, § 202, 104 Stat. 327, 337 (current version at 42 U.S.C. § 12132 (2006)) (prohibiting public services from discriminating against persons with disabilities).

9. *Olmstead*, 527 U.S. at 587; *see* NAT'L COUNCIL ON DISABILITY, *OLMSTEAD: RECLAIMING INSTITUTIONALIZED LIVES* (2003), available at <http://www.ncd.gov/newsroom/publications/2003/reclaimlives.htm> (describing how, at the time of the report, "the number of people with disabilities who currently are denied the opportunity to live in the most integrated setting is large indeed," and explaining that a large number of these individuals were residing in Intermediate Care Facilities for persons with Mental Retardation, nursing homes, and psychiatric institutions).

10. Traditionally, states have justified continued institutionalization on the basis of cost, despite the fact that community-based care is usually more cost-effective. *See* Laura C. Scotellaro, *The Mandated Move from Institutions to Community Care: Olmstead v. L.C.*, 31 LOY. U. CHI. L.J. 737, 775 (2000).

11. *See, e.g.,* PAUL T. JAEGER & CYNTHIA ANN BOWMAN, UNDERSTANDING DISABILITY: INCLUSION, ACCESS, DIVERSITY, AND CIVIL RIGHTS 46 (2005) ("A plethora of nations . . . adopted laws or amended their constitutions in the 1990s to provide the first real legal rights for individuals with disabilities." (citation omitted)).

12. United Nations Enable-Timeline of Events, <http://www.un.org/disabilities/default.asp?navid=22&pid=153> (last visited Feb. 24, 2010).

the United Nations Convention on the Rights of Persons with Disabilities (Convention) and Optional Protocol.¹³ On December 13, 2006, the United Nations General Assembly adopted the Convention, and on March 30, 2007, it was opened for signature at U.N. Headquarters in New York City.¹⁴ After much encouragement from the disability rights community, the United States signed the Convention on July 30, 2009.¹⁵ At the time of this Article, however, President Obama had not yet submitted the Convention to the Senate for advice and consent.¹⁶ Considering the United States' record of exempting itself from human rights treaties,¹⁷ it is unlikely that the United States will ratify the Convention without adding reservations (rendering the treaty non-self-executing) or attaching a declaration of non-self-execution.¹⁸

13. *Id.*; United Nations Convention on the Rights of Persons with Disabilities, opened for signature Mar. 30, 2007, 46 I.L.M. 443 (entered into force May 3, 2008).

14. United Nations Enable-Timeline of Events, *supra* note 12.

15. Press Release, Statement by Kathleen G. Sebelius, Sec'y of Health and Human Servs., On US Signing of the United Nations Convention on the Rights of Persons with Disabilities (July 30, 2009), available at <http://www.hhs.gov/news/press/2009pres/07/20090730a.html> ("Today, the United States joins 141 [other nations who have signed the *United Nations Convention on the Rights of Persons with Disabilities*. The signing of the UN Convention sends an important message that this country is committed to equal rights for people with disabilities, in the United States and around the world.").

16. As of February 24, 2010, a search of <http://www.senate.gov/> reveals no indication that the Convention is on the Senate calendar or that President Obama has taken any actions to submit the Convention to the Senate. *Cf.* President Barack Obama, Remarks on Signing of the U.N. Convention on the Rights of Persons With Disabilities Proclamation (July 24, 2009) (transcript available at http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-on-Rights-of-Persons-with-Disabilities-Proclamation-Signing/) ("I hope that the Senate can give swift consideration and approval to the Convention once I submit it for their advice and consent."). Until the Senate has advised on and consented to a treaty, it is not considered binding. U.S. CONST. art II, § 2, cl. 2 ("[The president] shall have Power, by and with the Advice and Consent of the Senate, to make Treaties, provided two-thirds of the Senators present concur . . .").

17. See Natsu Taylor Saito, *Human Rights, American Exceptionalism, and the Stories We Tell*, 23 EMORY INT'L L. REV. 41, 42 (2009) (defining "American exceptionalism" as "the United States' practice of unilaterally exempting itself from participation in international organizations and human rights treaties while simultaneously insisting that the rest of the world comply with international norms.").

18. Ann M. Piccard, *U.S. Ratification of CEDAW: From Bad to Worse?*, 28 LAW & INEQ. 119, 142-43 (2009) ("[H]uman rights treaties have long been considered to be non-self-executing."); Carlos Manuel Vázquez, *Treaties as Law of the Land: The Supremacy Clause and the Judicial Enforcement of Treaties*, 122 HARV. L. REV. 599, 677 (2008) ("Treatymakers can attempt to make a treaty non-self-executing by attaching either a reservation or a declaration to this effect. The difference between a reservation and a declaration is that a reservation modifies the legal effect of certain provisions of a treaty, whereas a declaration does not.").

This Article argues that, in light of the United States' signing the Convention on the Rights of Persons with Disabilities, the states should abandon their cost-driven deinstitutionalization plans based on the *Olmstead* holding (*Olmstead* plans)¹⁹ in favor of programs which guarantee the rights of persons with disabilities under the Convention. Part I of this Article details the development of states' deinstitutionalization plans arising from the Supreme Court's decision in *Olmstead*. Part II describes the problematic aspects of these *Olmstead* plans. Part III introduces the applicable provisions of the Convention which run contrary to aspects of states' cost-centered plans. Finally, Part IV asserts that states should incorporate the rights guaranteed under the Convention into their *Olmstead* plans and proposes a standard to integrate them.

I. The Development of *Olmstead* Plans

A. History of Legislation Protecting People with Disabilities

As Justice Marshall pointed out in *City of Cleburne v. Cleburne Living Center*,²⁰ "the mentally retarded have been subject to a 'lengthy and tragic history' of segregation and discrimination that can only be called grotesque."²¹ In the late 1950s and early 1960s, the country began to take notice of the dismal conditions in state hospitals treating individuals with mental disabilities.²² In response to segregation and other injustices, the disability rights community began gaining strength

19. *E.g.*, *Sanchez v. Johnson*, 416 F.3d 1051, 1063–64 (9th Cir. 2005) ("One state defense under the ADA, which was explicitly approved by the [Supreme] Court, is the existence of a state plan for deinstitutionalization (an '*Olmstead* Plan').").

20. 473 U.S. 432 (1985).

21. *Id.* at 461 (Marshall, J., concurring in part, dissenting in part) (quoting *Univ. of Cal. Regents v. Bakke*, 438 U.S. 265, 303 (1978)) (citation omitted).

22. Michael L. Perlin, *International Human Rights Law and Comparative Mental Disability Law: The Universal Factors*, 34 SYRACUSE J. INT'L L. & COM. 333, 335 (2007) (quoting a witness' 1961 congressional hearing testimony that "[s]ome . . . physicians I interviewed frankly admitted that the animals of nearby piggeries were better housed, fed[,] and treated than many of the patients on their wards.") (quoting *Constitutional Rights of the Mentally Ill: Hearings Before the Subcomm. on Constitutional Rights of the S. Comm. on the Judiciary*, 87th Cong. 41–42 (1961) (statement of Albert Deutsch, author and journalist)). During this period, the chairman of the Northeast Regional Legal Action Committee of the National Association for Retarded Children described *Pennhurst State School and Hospital*, the subject of *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981), as "Dachau, without ovens." *Id.* (citing LEOPOLD LIPPMAN & I. IGNACY GOLDBERG, *THE RIGHT TO EDUCATION: ANATOMY OF THE PENNSYLVANIA CASE AND ITS IMPLICATIONS FOR EXCEPTIONAL CHILDREN* 17 (1973)).

in the 1970s²³ and advocating for legislation that would “prohibit[] discrimination against and require[] accommodation of people with disabilities.”²⁴ Congress responded by passing the Rehabilitation Act of 1973,²⁵ which proscribed discrimination against persons with disabilities in the public sector,²⁶ and the Developmentally Disabled Assistance and Bill of Rights Act in 1975,²⁷ which indicated that services for people with disabilities “should be provided in the setting that is least restrictive of the person’s personal liberty.”²⁸ This legislation, however, did not quell the dissatisfaction of the disability rights community, portions of which continued to criticize the government’s “disability welfare programs”²⁹ as “support[ing] large segments of the population in relatively idle dependency.”³⁰ Equality and independence, to the fullest extent possible, were disability rights activists’ ultimate goals.³¹

In 1990, Congress passed the Americans with Disabilities Act,³² described by Professor Ruth Colker as “the culmination of more than two decades of law-reform efforts by the disability community.”³³ This legislation had significant benefits for people with intellectual disabilities in institutions. Generally, the ADA prohibits discrimination against people with disabilities on the basis of these disabilities in the employment,³⁴ public services,³⁵ and public accommodation sectors.³⁶ More specifically, it defines segregation as a form of discrimination, and indicates that

23. Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L.J. 1, 12 (2004).

24. *Id.*

25. Rehabilitation Act of 1973, Pub. L. No. 93-112, 87 Stat. 354.

26. *Id.*

27. Developmentally Disabled Assistance and Bill of Rights Act, Pub. L. No. 94-103, § 111, 89 Stat. 486, 502 (1975).

28. *Id.*

29. Bagenstos, *supra* note 23, at 12–18 (discussing disability rights activists’ critiques that coalesced in the 1970s and challenged the disability benefits system as, inter alia, being paternalistic, encouraging disabled individuals’ complacency, and fostering dependence).

30. *Id.* at 16 (quoting PEG NOSEK ET AL., A PHILOSOPHICAL FOUNDATION FOR THE INDEPENDENT LIVING AND DISABILITY RIGHTS MOVEMENTS 11 (1982)).

31. *See id.* at 14–18.

32. Americans with Disabilities Act (ADA) of 1990, Pub. L. No. 101-336, 104 Stat. 327 (current version at 42 U.S.C. §§ 12101–12213 (2006 & Supp. 2009)).

33. RUTH COLKER, THE DISABILITY PENDULUM: THE FIRST DECADE OF THE AMERICANS WITH DISABILITIES ACT 22 (2005).

34. § 102(a), 104 Stat. at 331–32 (current version at 42 U.S.C. § 12112(a) (2006 & Supp. 2009)).

35. § 202, 104 Stat. at 337 (current version at 42 U.S.C. § 12132 (2006)).

36. § 302(a), 104 Stat. at 355 (current version at 42 U.S.C. § 12182(a)).

"discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization . . ." ³⁷ While Title I of the ADA focuses on proscribing discrimination against people with disabilities in the workplace,³⁸ Title II prohibits public entities from excluding a "qualified individual with a disability . . . , by reason of such disability" from "[public] services, programs, or activities," including state-funded care.³⁹ In addition, Congress instructed the Attorney General to "promulgate regulations" to enforce Title II,⁴⁰ leading to what has come to be known as the "integration regulation," requiring that "public entit[ies] . . . administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."⁴¹ Together, these portions of the ADA and its subsequent regulations provided the legislative backdrop for the *Olmstead* holding.

B. *Olmstead v. L.C.*

In *L.C. v. Olmstead*,⁴² the Eleventh Circuit affirmed the district court's judgment that Georgia's failure to place L.C. and E.W. in community-based settings violated Title II of the ADA.⁴³ The court remanded the case, instructing the lower court to determine whether the state could meet its burden of proving "that requiring . . . these additional expenditures would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service it provides" ⁴⁴ Because this instruction would defeat nearly any cost defense a state could raise,⁴⁵ the Supreme Court granted Georgia's petition for certiorari on the issue of cost.⁴⁶

37. § 2(a)(3), 104 Stat. at 328 (current version at 42 U.S.C. § 12101(a)(3)).

38. Tit. I, 104 Stat. at 330 (current version at 42 U.S.C. §§ 12111–12117 (2006 & Supp. 2009)) (codified within Subchapter I—Employment).

39. 42 U.S.C. § 12132 (2006).

40. *Id.* § 12134(a).

41. 28 C.F.R. § 35.130(d) (2006). This "integration regulation," or the "integration mandate," is also attributed to *Olmstead*, due to its holding interpreting the regulation. *See, e.g., Disability Advocates, Inc. v. Paterson*, 653 F. Supp. 2d 184, 187 (E.D.N.Y. 2009) ("The 'integration mandate' . . . as expressed in federal regulations and *Olmstead* requires that when a state provides services to individuals with disabilities, it must do so 'in the most integrated setting appropriate to their needs.'" (citations omitted)).

42. 138 F.3d 893 (11th Cir. 1998).

43. *Id.* at 895.

44. *Id.* at 905.

45. Justice Ginsburg described how the Eleventh Circuit's construction would leave states "virtually defenseless" when plaintiffs are shown to be qualified for community placement because the "expense entailed in placing one or two people"

In *Olmstead*, the Supreme Court affirmed the Eleventh Circuit's decision in substantial part, interpreting Title II of the ADA and the integration mandate to prohibit "unjustified placement or retention of persons in institutions" as a form of discrimination.⁴⁷ The *Olmstead* majority approved the Eleventh Circuit's finding that "the State's duty to provide integrated services 'is not absolute.'"⁴⁸ The Court agreed with the Eleventh Circuit that the ADA proscribed the continued institutionalization of the *Olmstead* respondents.⁴⁹ The majority, however, also held that the Eleventh Circuit erroneously instructed the lower court on the State's "fundamental alteration" defense,⁵⁰ reasoning that such a defense should be used "only in the most limited of circumstances."⁵¹ To correct this error, Justice Ginsburg, writing for a plurality,⁵² provided instructions to lower courts on the appropriate use of the fundamental alteration defense:

In evaluating a State's fundamental-alteration defense, the District Court must consider, in view of the resources

in the community would always be miniscule when measured "against the State's entire mental health budget." *Olmstead v. L.C.*, 527 U.S. 581, 603 (1999) (plurality opinion).

46. *Id.* at 595–96 (majority opinion). After the Supreme Court granted certiorari, the district court issued a decision on remand holding that "the annual cost . . . of providing community-based treatment to L.C. and E.W. was not unreasonable in relation to the State's overall mental health budget." *Id.* at 596 n.7.

47. *Id.* at 596–97.

48. *Id.* at 595 (quoting *Olmstead*, 138 F.3d at 904). Compare *id.*, with *id.* at 603 (plurality opinion) ("The State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless.").

49. *Id.* at 597 (majority opinion) ("Unjustified isolation, we hold, is properly regarded as discrimination based on disability.").

50. See 28 C.F.R. § 35.130(b)(7) (2009) ("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 service, program, or activity." (emphasis added)). Compare *Olmstead*, 527 U.S. at 595 ("The appeals court thought it clear . . . that 'Congress wanted to permit a cost defense only in the most limited of circumstances.'" (quoting *Olmstead*, 138 F.3d at 902)), with *id.* at 603–04 (plurality opinion) (noting that the Eleventh Circuit's interpretation that cost-based defenses are allowed only in the most limited of circumstances is too restrictive, and that "[s]ensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the state has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.").

51. *Olmstead*, 527 U.S. at 595 (quoting *Olmstead*, 138 F.3d at 902).

52. Justice Ginsburg wrote the majority opinion for the Court, but was joined in the final Part of her opinion by only Justices O'Connor, Souter, and Breyer. *Id.* at 587.

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.⁵³

A state, therefore, can prevail on a fundamental alteration defense if it is able to show that providing community-based services to the litigants would disrupt its ability to provide services to "others with mental disabilities."⁵⁴ In such an instance, a state need only "demonstrate that it ha[s] a comprehensive, effectively working plan" for deinstitutionalizing qualified individuals with disabilities and "a waiting list that move[s] at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated . . ."⁵⁵ Under Justice Ginsburg's opinion, such an *Olmstead* plan can help support a state's fundamental alteration defense.

Justice Ginsburg provided virtually no guidance as to what constitutes an effectively working plan for deinstitutionalization, and she supplied only minimal clarification of what constitutes a "reasonably paced waiting list." Justice Ginsburg explained that this list does not require immediately placing qualified individuals in community-based care.⁵⁶ Rather, the State can require a person to wait for an available spot, thereby preventing a court from "order[ing] displacement of persons at the top of the community-based treatment waiting list by individuals lower down who commence[] civil actions."⁵⁷ As a result, states do not have to provide "immediate relief" to people with intellectual disabilities for whom community placement is deemed appropriate if such relief would be "inequitable."⁵⁸ Apart from these limitations, however, states can construct their waiting lists as they please. Considering the ambiguous "effectively working" and "reasonably paced waiting list" standards,⁵⁹ states have broad leeway in

53. *Id.* at 597. Justice Ginsburg also reminded courts to apply a "case-by-case analysis," assessing the "nature and cost of the accommodation needed" in relation to the State's budget, pursuant to regulations implementing § 504 of the Rehabilitation Act. *Id.* at 606 n.16 (plurality opinion); see 42 U.S.C. § 12134(b) (2006); 28 C.F.R. § 42.511(c) (2009).

54. See *Olmstead*, 527 U.S. at 597, 607 (plurality opinion).

55. *Id.* at 605–06.

56. See *id.* at 606 (citing Transcript of Oral Argument at 25, *Olmstead*, 527 U.S. 581 (No. 98-536)).

57. *Id.*

58. *Id.* at 603–04.

59. See 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, 743 (2001)

developing their *Olmstead* plans, allowing them “[t]o maintain a range of facilities and to administer services with an even hand.”⁶⁰

C. *Olmstead Plans: A Surge of Community Integration?*

After *Olmstead*, states began developing deinstitutionalization plans, using Medicaid waiver homes as the prime vehicle for community integration.⁶¹ In 2001, to support states’ endeavors, President George W. Bush announced the “New Freedom Initiative,” followed by Executive Order 13217, to support states in meeting *Olmstead* goals and as “a nationwide effort to remove barriers to community living for people of all ages with disabilities and long-term illnesses.”⁶² Under the New Freedom Initiative, the Centers for Medicare and Medicaid Services provide funding for states to integrate people with disabilities into the community.⁶³ President Bush also enacted “Money Follows the Person” as part of the Deficit Reduction Act of 2005,⁶⁴ to “assist States in their efforts to reduce their reliance on

(explaining that the *Olmstead* majority “left undefined key terms” such as “effectively working” and “reasonable pace”).

60. *Olmstead*, 527 U.S. at 605 (plurality opinion).

61. See Julia Gilmore Gaughan, *Institutionalization as Discrimination: How Medicaid Waivers, the ADA, and § 1983 Fail*, 56 U. KAN. L. REV. 405, 406 (2008) (explaining how the federal government is “pouring money” into Medicaid programs to achieve community integration); Amy Tidwell, *Deinstitutionalization: Georgia’s Progress in Developing and Implementing an “Effectively Working Plan” as Required by Olmstead v. L.C. ex rel.*, 25 GA. ST. U. L. REV. 699, 700, 707–13 (2009) (noting that states, “prompted by the *Olmstead* decision, . . . began developing ‘*Olmstead Plans*’ for moving individuals out of institutions and providing services to people with disabilities in community settings” and comparing holdings in the Third and Ninth Circuit Courts of Appeals—the only circuit courts to have defined “effectively working plans”—in cases originating with state plans that included Medicaid waivers); see also Henry Korman, *Clash of the Integrationists: The Mismatch of Civil Rights Imperatives in Supportive Housing for People with Disabilities*, 26 ST. LOUIS U. PUB. L. REV. 3, 12 (2007) (“[I]t is . . . true that after out-of-pocket personal expenditures, the largest source of funds for long-term care and community-based supportive services is the Medical Assistance or Medicaid Program.”). Medicaid waivers allow states to use federal Medicaid funding to provide community-based care for people with disabilities. See, e.g., STATE OF TENNESSEE DIVISION OF MENTAL RETARDATION SERVICES, A FAMILY GUIDE TO MEDICAID WAIVER SERVICES (2002), available at http://www.state.tn.us/dids/consumer_services/fgmwb.pdf.

62. U.S. Dep’t of Health and Human Servs., Ctrs. for Medicare and Medicaid Servs., Overview New Freedom Initiative, <http://www.cms.hhs.gov/NewFreedomInitiative/> (last visited Feb. 24, 2010).

63. Peter Blanck, *Justice for All? Stories About Americans with Disabilities and Their Civil Rights*, 8 J. GENDER RACE & JUST. 1, 16 (2004).

64. Deficit Reduction Act of 2005, Pub. L. No. 109-171, Subchapter B, 120 Stat. 4, 102–10 (2006) (outlining “Money Follows the Person Rebalancing Demonstration” provisions). According to President George W. Bush, the Deficit Reduction Act was enacted to “restrain federal spending,” especially in the realm of

institutional care while developing community-based long-term care opportunities, enabling the elderly and people with disabilities to fully participate in their communities.”⁶⁵ Together, these two programs enabled the federal government to assist states with establishing their deinstitutionalization plans in compliance with *Olmstead*’s integration mandate.⁶⁶

As Justice Ginsburg mentioned in *Olmstead*, however, states do not have a “boundless” duty to provide community-based care.⁶⁷ Rather, Medicaid regulations with which states must comply in order to receive funding⁶⁸ and the “reasonably paced waiting list” analysis of *Olmstead*⁶⁹ both limit states’ duties. Medicaid regulations not only allow the federal government to control its costs, but also enable states to minimize their own costs while implementing *Olmstead* plans. State plan and payment provisions outlined in federal law prevent states from granting a waiver unless the Secretary of Health and Human Services agrees that the estimated costs of community care do not exceed the reasonable estimated costs of institutional care.⁷⁰ Health and Human Services regulations require a state to submit documentation “indicat[ing] the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program,” thereby imposing “a limit on the size of the waiver program unless the State requests and the Secretary

“mandatory spending,” such as Medicaid, Medicare, and Social Security, which were “growing faster than the economy, faster than the population, and nearly three times the rate of inflation.” President George W. Bush, President Signs S.1932, Deficit Reduction Act of 2005 (Feb. 8, 2006) (transcript available at <http://georgewbush-whitehouse.archives.gov/news/releases/2006/02/20060208-8.html>).

65. U.S. Dep’t of Health and Human Servs., *supra* note 62.

66. Although both programs involve providing states with additional funding, this funding can be viewed as a long-term investment because community-based care for qualified individuals is often cheaper than institutional care. See Scotellaro, *supra* note 10, at 777 (“[A] 1995 study conducted for the *American Journal of Mental Retardation* found that providing community-based care to individuals with disabilities is more cost effective than providing care within an institution. It also found that state-owned institutions were the most expensive setting in which to provide services to the disabled. Furthermore, in addition to being more expensive than community care, the costs of institutional care are rising. Therefore, in the future, states will benefit more from transferring qualified disabled individuals into community-based settings.” (footnotes omitted)).

67. *Olmstead v. L.C.*, 527 U.S. 581, 603 (1999) (plurality opinion).

68. See, e.g., 42 U.S.C. § 1396n(c) (2006 & Supp. 2009); 42 C.F.R. § 441.303 (2009).

69. *Olmstead*, 527 U.S. at 605–06 (plurality opinion).

70. 42 U.S.C. § 1396n(c)(2)(D) (2006 & Supp. 2009); see also *id.* § 1396n(c)(6) (detailing that the Secretary cannot deny a waiver because the *actual* costs exceed *estimated* costs of community-based care).

approves a greater number of waiver participants in a waiver amendment.”⁷¹ Slots under this limited number of placements, or cap, will not open up unless “individuals . . . die or become ineligible for services under the State plan.”⁷²

The “reasonably paced waiting list” analysis presented in *Olmstead* also limits states’ responsibilities to provide community-based care and allows them to control costs.⁷³ However, because Justice Ginsburg’s opinion does not define the term “reasonable pace” and provides only limited guidance on wait lists, the lower courts have been forced to decipher the ambiguous “reasonably paced wait list” standard (if it can be called a standard at all) in post-*Olmstead* litigation.⁷⁴ When taken together, Medicaid legislation and the “reasonably paced waiting list” analysis, though limiting in some aspects, supply each state with broad leeway to determine the size and speed of its Medicaid waiver program, without any pressure from the federal government to increase the size of such programs or hasten community integration.

In short, states have nearly unrestricted freedom to develop their *Olmstead* plans in a manner that minimizes costs. As long as states are able to show that they are complying with Medicaid waiver regulations and that they have reasonably paced waiting lists in place, they can often prevail with fundamental alteration defenses when contesting *Olmstead* claims.⁷⁵ As subsequent case law demonstrates, this freedom often allows states to keep qualified individuals with disabilities institutionalized, even when community-based placement would be appropriate.⁷⁶

71. 42 C.F.R. § 441.303(f)(6) (2009).

72. 42 U.S.C. § 1396n(c)(9) (2006 & Supp. 2009).

73. See *Olmstead*, 527 U.S. at 605–06 (plurality opinion).

74. Kubo, *supra* note 59, at 743.

75. See Samantha A. DiPolito, *Olmstead v. L.C.—Deinstitutionalization and Community Integration: An Awakening of the Nation’s Conscience?*, 58 MERCER L. REV. 1381, 1399 (2007) (“[M]easuring the progress of *Olmstead* implementation is problematic because ‘there are no clearly stated objectives, budgets, or timetables.’ In fact, an emerging theme from post-*Olmstead* cases is judicial encouragement of policy change, but minimal desire to actually enforce the change process. Lower courts have generally decided that evidence of states’ active commitment, yet slow progress towards community integration, satisfies the ADA. Commentators criticize these decisions as ‘[r]ewarding rather than sanctioning states that move slowly toward change.’” (footnotes omitted)).

76. See, e.g., *Arc of Wash. State v. Braddock*, 427 F.3d 616 (9th Cir. 2005); *Bryson v. Shumway*, 308 F.3d 79 (1st Cir. 2002).

II. The Shortcomings of *Olmstead* Plans

Since there are few statistics or studies on the number of qualified individuals with disabilities awaiting community placement,⁷⁷ it is difficult to accurately measure states' compliance with *Olmstead's* integration mandate. Case law, however, demonstrates the states' failures to develop *Olmstead* plans that transfer qualified individuals to community placements in a timely manner, thereby contravening the integration mandate.⁷⁸ By examining two representative cases, one can see that states often utilize unreasonably paced wait lists and unreasonable caps on Medicaid waiver programs in their *Olmstead* plans,⁷⁹ forcing wait-listed individuals to remain on such lists for indefinite periods of time.⁸⁰ First, in *Bryson v. Shumway*⁸¹ the First Circuit Court of Appeals held that qualified individuals with disabilities are not "entitled to reasonable promptness" for community-based services unless they are on a wait list.⁸² Second, the Ninth Circuit Court of Appeals' decision in *Arc of Washington State, Inc. v. Braddock*⁸³ allowed states to limit the size of their Medicaid waiver programs, permitting states to engage in practices that inhibit significant progress in integrating qualified individuals with disabilities into their communities.⁸⁴

A. *Bryson v. Shumway*

Bryson v. Shumway involved a New Hampshire Medicaid waiver program that did not have room for all qualified

77. See NAT'L COUNCIL ON DISABILITY, *OLMSTEAD: RECLAIMING INSTITUTIONALIZED LIVES* (2003), available at <http://www.ncd.gov/newsroom/publications/2003/reclaimlives.htm> (stating that "[a]lthough formal assessment data are lacking," related studies lead to the conclusion that nearly all qualified disabled individuals could be placed in a community setting).

78. See *infra* Part II.A-B.

79. See *infra* Part II.A-B.

80. Cf. Sean Jessee, *Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights*, 58 EMORY L.J. 791, 815 (2009) (noting that, while circuit courts have consistently held that Medicaid patients have an enforceable right under the reasonable promptness clause, Medicaid patients face substantial legal obstacles if they attempt to file lawsuits because the clause is unclear on whether it requires states to *pay* for services with reasonable promptness or to *provide* services with reasonable promptness, and the Supreme Court has never answered the question).

81. 308 F.3d 79 (1st Cir. 2002).

82. *Id.* at 88.

83. 427 F.3d 615 (9th Cir. 2005).

84. See *id.* at 620 ("So long as states are genuinely and effectively in the process of deinstitutionalizing disabled persons 'with an even hand,' we will not interfere.").

individuals with disabilities who wanted to participate.⁸⁵ The plaintiffs, individuals seeking placement in the waiver program, sued for injunctive and declaratory relief under 42 U.S.C. § 1983,⁸⁶ arguing, in part, that Medicaid services must be provided “with reasonable promptness to all eligible individuals” under 42 U.S.C. § 1396a(a)(8).⁸⁷ The court rejected the plaintiffs’ argument that “reasonable promptness” required the State to request a waiver program that accommodated at least 200 people.⁸⁸ The case, however, was ultimately remanded for fact-finding to determine whether the State had violated “reasonable promptness” through an alleged failure to fill the individual waiver slots it had already requested.⁸⁹ Most importantly, the court held that “[t]hose patients who are on the waiting list and for whom slots are available are, we think, ‘eligible’ under the statute such that they are entitled to reasonable promptness.”⁹⁰ In other words, the First Circuit determined that patients not on Medicaid program waiting lists are not entitled to “reasonable promptness” in receiving services.

Although presented as dicta in *Bryson*, this sentiment demonstrates the First Circuit’s reluctance to challenge states’ waiting lists. The court simply deferred to the State’s discretion in both the size of the waiver program and the speed of placement, leaving it up to the State to determine what is reasonably prompt. The practical result of this holding is that a plaintiff cannot prevail on a reasonable promptness claim unless he or she is already on a waiting list *and* there is a waiver slot open and

85. *Bryson*, 308 F.3d at 81.

86. *Id.* at 83. Forty-two U.S.C. § 1983 allows litigants to bring civil claims against persons or entities whom they consider to have deprived them of “rights, privileges[,] or immunities” secured by a law of the United States. 42 U.S.C. § 1983 (2006).

87. *Bryson*, 308 F.3d at 83–84; 42 U.S.C. §§ 1396a(a), (a)(8) (2006 & Supp. 2009) (“A State plan for medical assistance must . . . provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals . . .”).

88. *Bryson*, 308 F.3d at 84–86 (indicating that plaintiffs relied upon outdated statutory language of 42 U.S.C. § 1396n(c)(10) and stating that the Department of Health and Human Services’ interpretation that the statute is not intended to require providing service to exactly 200 individuals should receive deference).

89. *Id.* at 89–90. On remand, the district court ruled that the relief plaintiffs sought—expansion of the waiver program—would constitute a fundamental alteration because it was impractical for the State to provide a sufficient number of slots to eliminate its wait list altogether. *Bryson v. Stephen*, Civil No. 99-CV-558-SM, 2006 WL 2805238, at *1 (D.N.H. Sept. 29, 2006).

90. *Bryson*, 308 F.3d at 88 (footnote omitted).

available.⁹¹ While the district court subsequently determined that an average wait of one year for an open slot is not unreasonable, this year does not include the time it takes for a person with a disability to apply and be determined eligible for services.⁹² Further complicating these requirements is the simple fact that the population of persons with disabilities is not static and will likely grow, while a state's budget may not.⁹³ States have few incentives for growing waiver programs, and, on the contrary, have financial incentives to keep more individuals in institutions.⁹⁴ As a result, in order to avoid the legal obligation to provide community placements with reasonable promptness, states can maintain waiting lists that are either short or static. The *Bryson* dicta demonstrates lower courts' laissez-faire attitudes towards states and their questionably "reasonably paced" waiting lists.

B. Arc of Washington State, Inc. v. Braddock

In *Arc of Washington State, Inc. v. Braddock*, the Arc of Washington State, Inc. and three developmentally disabled individuals (Arc)⁹⁵ argued that Title II of the ADA prohibited

91. See Gaughan, *supra* note 61, at 423.

92. Bryson, 2006 WL 2805238, at *6 ("While there are exceptions due to circumstances peculiar to the individual needs of persons on the list, by and large the wait for an open slot in the program is about a year—shorter for some, longer for others An average wait of approximately twelve months on the list, *from qualification to assignment of a program slot*, is not an unreasonable period." (emphasis added)).

93. See, e.g., OR. DEP'T OF HUMAN SERVS., SENIORS AND PEOPLE WITH DISABILITIES DIV., WAYS AND MEANS PRESENTATION 4 (2007), available at http://www.oregon.gov/DHS/aboutdhs/budget/07-09budget/ways_means/spd_wm_overview_3.doc.pdf ("After years of expanding caseloads, [Oregon's Department of Human Services] was forced in 2002 and 2003 to eliminate programs and services to selected groups of people. In 2003, to balance the state's budget, the Legislature approved eliminating services to approximately 4,874 seniors and people with physical disabilities who did not meet more limited eligibility criteria.").

94. See, e.g., DiPolito, *supra* note 75, at 1403 (using the state of Georgia's financial arrangements for mental health care as an illustration of systems in which "the cost of institutional care, unlike that of community-based services, is not required to be a line-item budget expense. Rather, the funding of institutional care can be amortized, which amounts to a much more politically suitable financial arrangement. As a result, the government's bias in favor of institutions is perpetuated.").

95. The Arc is an organization with national and statewide chapters which supports people with disabilities and their families. The Arc of the United States, About Us, <http://www.thearc.org/NetCommunity/Page.aspx?pid=1386> (last visited Feb. 16, 2010). "Arc" once stood for "Association for Retarded Citizens," but in 1992, its name changed to the more politically correct "the Arc." See The Arc of the United States, The Arc's Name Changes Throughout Its History,

Washington “from maintaining any fixed [Home and Community-Based Services (HCBS)] cap.”⁹⁶ The Arc claimed that “Washington’s HCBS program [was] too small to accommodate the state’s population of eligible participants” and therefore Washington should have requested an increase in the size of the program.⁹⁷ In its decision, the court stated that it had to consider whether forcing the state to comply with the Arc’s request would constitute a “‘reasonable modification’ (which is required) or a ‘fundamental alteration’ (which is not),”⁹⁸ but did not actually conduct a case-specific analysis of the proposed expansion cost in relation to Washington’s budget, as *Olmstead* instructed.⁹⁹ The

<http://www.thearc.org/NetCommunity/Page.aspx?pid=403> (last visited Feb. 11, 2010). Although this suit was initially a class action, the class was decertified. *Arc of Wash. State, Inc. v. Braddock*, 427 F.3d 615, 617 n.2 (9th Cir. 2005).

96. *Braddock*, 427 F.3d at 617. HCBS caps, or limits on the size of HCBS waiver programs, are required under federal regulations. 42 C.F.R. § 441.303(f)(6) (2009) (“The State must indicate the number of unduplicated beneficiaries to which it intends to provide waiver services in each year of its program. This number will constitute a limit on the size of the waiver program”); see also 42 U.S.C. § 1396n(c)(9) (2006 & Supp. 2009) (providing rules for waiver programs “which contain[] a limit on the number of individuals who shall receive home or community-based services . . .”).

97. *Braddock*, 427 F.3d at 619.

98. *Id.* Twenty-eight C.F.R. § 35.130(b)(7) requires a state to make “reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the [state] can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.” 28 C.F.R. § 35.130(b)(7) (2009); see also *Olmstead v. L.C.*, 527 U.S. 581, 603 (1999) (plurality opinion) (noting that the states must make “reasonable modifications” to avoid discrimination, but are allowed to resist modifications that entail “fundamental alterations” to the states’ services and programs (citing 28 C.F.R. § 35.130(b)(7) (1998))).

99. *Braddock*, 427 F.3d at 621; *Olmstead*, 527 U.S. at 606 n.16 (plurality opinion). The *Braddock* court explained that it had “twice explored the boundary between ‘reasonable modifications’ and ‘fundamental alterations’ in the context of Medicaid waiver programs for the disabled.” *Id.* at 619. It drew parallels between the *Braddock* plaintiffs’ claims and those of the plaintiffs in *Sanchez v. Johnson*, who had challenged California’s waiver program. *Braddock*, 427 F.3d at 620; *Sanchez v. Johnson*, 416 F.3d 1051, 1063 (9th Cir. 2005). Both cases, said the court, challenged the size of the State’s waiver program. *Braddock*, 427 F.3d at 620 n.4 (noting that the *Sanchez* plaintiffs challenged program size based on funding, rather than the waiver program’s cap); see *Sanchez*, 416 F.3d at 1062–63. In *Sanchez*, the court affirmed a district court holding that the state “already ha[d] in place an acceptable plan for deinstitutionalization, the disruption of which would involve a fundamental alteration of the State’s current policies and practices in contravention of the Supreme Court’s instructions in *Olmstead*.” *Sanchez*, 416 F.3d at 1063, 1068. The *Braddock* court explained that the record in *Sanchez* indicated that California’s “commitment to the deinstitutionalization of those [disabled persons] for whom community integration is desirable, achievable[,] and unopposed, is genuine, comprehensive[,] and reasonable.” *Braddock*, 427 F.3d at 620 (quoting *Sanchez*, 416 F.3d at 1067). Though the district court in *Braddock* had granted partial summary judgment and dismissed the action, the Ninth Circuit ruled that “the record . . . already contain[ed] all [it] need[ed] to make this

court bypassed such analysis in affirming the district court's summary judgment grant and dismissal,¹⁰⁰ holding that:

[W]hen there is evidence that a State has in place a comprehensive deinstitutionalization scheme, which, in light of existing budgetary constraints and the competing demands of other services that the State provides, including the maintenance of institutional care facilities, is "effectively working," the courts will not tinker with that scheme.¹⁰¹

To support its holding, the court cited statutory provisions indicating that Congress intended limitations on the size of waiver programs.¹⁰² The court's holding, based on this cursory examination, failed to address the heart of the plaintiffs' claim that Washington's waiver program should be expanded. Washington could essentially do as it pleased, as long as it demonstrated a "reasonable" level of "commitment to deinstitutionalization."¹⁰³

Braddock, like *Bryson*, leaves open the possibility that there could be any number of qualified individuals waiting indefinitely for community placement due to the limited size of waiver

determination. There [wa]s . . . no need for further factual development" because "[t]he record reflect[ed] that Washington's commitment to deinstitutionalization [wa]s as 'genuine, comprehensive and reasonable' as the state's commitment in *Sanchez*." *Braddock*, 427 F.3d at 616, 620; see *Olmstead*, 527 U.S. at 606 n.18 (1999) (plurality opinion) (instructing the lower courts to apply a "case-by-case analysis," assessing, among other factors, the "nature and cost of the accommodation needed" in relation to the State's budget).

100. *Braddock*, 427 F.3d at 616, 622.

101. *Id.* at 621 (citing *Sanchez*, 416 F.3d at 1067–68) (citation omitted).

102. *Id.* at 618. Forty-two C.F.R. § 441.303(f)(6) imposes a limit on the number of "unduplicated recipients" a state provides with waiver services, unless the state requests and the Secretary of Health and Human Services approves a greater number. 42 C.F.R. § 441.303(f)(6) (2009). Forty-two U.S.C. § 1396n(c)(9) allows states to keep their numbers of waiver recipients consistent by "replac[ing] any individuals who [are currently eligible for waiver slots only when they] die or become ineligible for services under the State plan." 42 U.S.C. § 1396n(c)(9) (2006 & Supp. 2009). However, the Secretary is prohibited from limiting the number of individuals who may receive HCBS services under a waiver to fewer than 200 (though states themselves may choose to make a lower number available). 42 U.S.C. § 1396n(c)(10) (2006 & Supp. 2009); see *Bryson v. Shumway*, 308 F.3d 79, 85–86 (2002) (discussing states' ability to choose to limit their Medicaid waiver programs to fewer than 200 individuals).

103. *Braddock*, 427 F.3d at 621. The court determined that Washington was committed to deinstitutionalization because its HCBS program:

(1) is sizeable, with a cap that has increased substantially over the past two decades; (2) is full; (3) is available to all Medicaid-eligible disabled persons as slots become available, based only on their mental-health needs and position on the waiting list; (4) has already significantly reduced the size of the state's institutionalized population; and (5) has experienced budget growth in line with, or exceeding [that of], other state agencies.

Id. at 621–22.

programs. States have minimal incentives to increase the size of their waiver programs by requesting more slots or waivers. Although waiver programs were designed to “provide individuals with individualized services that allow [people with disabilities] to live at home, . . . [states’] program[s] as implemented [have] been driven more by cost concerns than by . . . individual[s’] special needs.”¹⁰⁴

III. The “Right” to Deinstitutionalization Under the United Nations Convention on the Rights of Persons with Disabilities

The United Nations Convention on the Rights of Persons with Disabilities¹⁰⁵ provides an alternative approach to the issue of deinstitutionalization, focusing more on the individual needs of people with disabilities. While *Olmstead* affirms states’ freedom to provide community-based services in the most cost-effective manner,¹⁰⁶ the Convention emphasizes “the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices.”¹⁰⁷ Although both support community integration, the Convention’s human rights focus champions the needs and desires of the individual over financial concerns.

The Convention sets forth several human rights common to all persons, including persons with disabilities, that States Parties are obligated to enforce.¹⁰⁸ Several of these provisions are applicable to institutionalization. Article 14, clause 1 requires that:

States Parties . . . ensure that persons with disabilities, on an equal basis with others:

(a) Enjoy the right to liberty and security of person;

104. Kubo, *supra* note 59, at 738–39. *But cf.* H.R. REP. NO. 97-208, at 966 (1981) (Conf. Rep.), reprinted in 1981 U.S.C.C.A.N. 1010, 1328 (“The determination of which long-term care options are feasible in a particular instance should be based on an individual’s needs, as determined by an evaluation, and not short-term cost-savings.” (emphasis added)).

105. United Nations Convention on the Rights of Persons with Disabilities, *supra* note 13.

106. See *Olmstead v. L.C.*, 527 U.S. 581, 603–07 (1999) (plurality opinion) (discussing costs associated with institutionalization and how states can and should balance them); see also Kubo, *supra* note 59, at 743 (noting that the Supreme Court’s deference to state funding decisions was apparent in *Olmstead*).

107. United Nations Convention on the Rights of Persons with Disabilities, *supra* note 13, at pmb1., ¶ n.

108. See *id.* art. 4.

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.¹⁰⁹

Unnecessary institutionalization constitutes a "deprivation of liberty" prohibited by the Convention,¹¹⁰ because it is based on disability and deprives individuals with disabilities of reasonable accommodation.¹¹¹ Moreover, Article 19, titled "Living independently and being included in the community," speaks directly to the issue of institutionalization.¹¹² This provision states that:

States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

(b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.¹¹³

Together, these provisions guarantee persons with disabilities' rights to enjoy freedom from institutionalization and live in the community setting of their choice.

The Convention recognizes, however, that States Parties' duties to enforce the Convention are not boundless. Article 2 of the Convention defines "reasonable accommodation" as "necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms."¹¹⁴ This provision indicates that a State

109. *Id.* art. 14, cl. 1.

110. *See id.*

111. *See id.* art. 14, cl. 1-2.

112. *Id.* art. 19.

113. *Id.*

114. *Id.* art. 2.

Party's obligations under the Convention could be limited upon a showing that an accommodation a person with a disability requests poses a "disproportionate or undue burden," somewhat comparable to the fundamental alteration defense established in *Olmstead*.¹¹⁵ But the Convention also indicates that a State Party's duty to enforce the rights of persons with disabilities' could vary depending upon its resources:

With regard to economic, social[,] and cultural rights, each State Party undertakes to take measures to the *maximum of its available resources* and, where needed, within the framework of international cooperation, with a view to achieving progressively the full realization of these rights, without prejudice to those obligations contained in the present Convention that are immediately applicable according to international law.¹¹⁶

A State Party is therefore obligated to take measures to promote and protect the economic, social, and cultural rights of persons with disabilities. Considering that cost concerns primarily drive states' deinstitutionalization plans,¹¹⁷ it appears that the United

115. Compare *id.* ("Reasonable accommodation' means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms . . ."), with *Olmstead v. L.C.*, 527 U.S. 581, 604 (1999) (plurality opinion) (noting that a state could affirmatively raise a fundamental alteration defense by showing that "immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities.").

116. United Nations Convention on the Rights of Persons with Disabilities, *supra* note 13, art. 4, cl. 2 (emphasis added). This language is similar to that of the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which the United States has refused to ratify. International Covenant on Economic, Social and Cultural Rights art. 8, *adopted* Dec. 16, 1966, S. Exec. Doc. D, 95-2 (1978), 993 U.N.T.S. 3; see UNCHR: The UN Refugee Agency, Refworld, International Covenant on Economic, Social and Cultural Rights List of States Parties <http://www.unhcr.org/refworld/docid/3ae6b36c0.html> (last visited Feb. 26, 2010) (noting that the United States signed the ICESCR on October 5, 1977, but has not yet ratified it); see also Linda M. Keller, *The American Rejection of Economic Rights as Human Rights & the Declaration of Independence: Does the Pursuit of Happiness Require Basic Economic Rights?*, 19 N.Y.L. SCH. J. HUM. RTS. 557, 562 (2003) ("[T]he United States refuses to recognize that 'economic, social and cultural rights' are rights."). Some critics suggest that it is the "maximum of its available resources" language that prevents the United States from ratifying the ICESCR. See, e.g., Hannah A. Saona, *The Protection of Reproductive Rights Under International Law: The Bush Administration's Policy Shift and China's Family Planning Practices*, 13 PAC. RIM L. & POL'Y J. 229, 251 (2004) ("[T]he United States has acted in direct opposition to its responsibility to act in accordance with the object and purpose of the ICESCR: to contribute international economic assistance to the maximum of its available resources . . .").

117. See *supra* notes 70–73 and accompanying text.

States must reassess the broad leeway it provides states in implementing their *Olmstead* plans if it wants to fulfill legal obligations under the Convention.

IV. Incorporating the Rights Protected Under the Convention into *Olmstead* Plans

A. *The Negative Aspects of the United States' Approach to Disability Rights and Community Integration*

In comparison to the rest of the world, the United States exhibits progressive attitudes towards people with disabilities.¹¹⁸ The U.S. disability rights community paved the way for legislation¹¹⁹ that ensures individuals with disabilities access to public education “in the least restrictive environment,”¹²⁰ protects against discrimination by state and local governments,¹²¹ protects against discrimination in the employment¹²² and public accommodation sectors,¹²³ and, eventually, ensures the right to live in the community if community-based treatment is deemed appropriate.¹²⁴ Unlike their foreign counterparts,¹²⁵ people with disabilities in the United States, like L.C. and E.W. in *Olmstead*,¹²⁶ have access to free legal counsel when “facing commitment to psychiatric institutions, . . . [when] being treated in such institutions, and . . . [when] seeking release from such

118. See Michael L. Perlin, “Chimes of Freedom.” *International Human Rights and Institutional Mental Disability Law*, 21 N.Y.L. SCH. J. INT’L & COMP. L. 423, 423 (2002) (describing the disability rights “revolution” as “by and large . . . an American revolution”).

119. See SAMUEL R. BAGENSTOS, LAW AND THE CONTRADICTIONS OF THE DISABILITY RIGHTS MOVEMENT 12 (2009) (“The disability rights movement has been a remarkably successful social movement in the United States. Barely visible in 1970, by 1990 the movement had secured achievement of its greatest legislative priority—the adoption of the ADA.”).

120. Individuals with Disabilities Education Improvement Act of 2004, Pub. L. No. 108-446, § 612(a)(5), 118 Stat. 2647, 2677 (current version at 20 U.S.C. § 1412(a)(5) (2006)).

121. Americans with Disabilities Act (ADA) of 1990, Pub. L. 101-336, §§ 201(1)(a), 202, 104 Stat. 327, 337 (current version at 42 U.S.C. §§ 12131(1)(A), 12132 (2006)).

122. § 102(a), 104 Stat. at 331–32 (current version at 42 U.S.C. § 12112(a) (2006 & Supp. 2009)).

123. § 302(a), 104 Stat. at 355 (current version at 42 U.S.C. § 12182(a) (2006)).

124. *Olmstead v. L.C.*, 527 U.S. 581, 596–97 (1999) (interpreting Title II of the ADA to prohibit unnecessary institutionalization); see § 202, 104 Stat. at 337 (current version at 42 U.S.C. § 12132 (2006)); 28 C.F.R. § 35.130(d) (2009).

125. Perlin, *supra* note 22, at 341 (explaining that people with disabilities in many countries lack access to legal counsel and “regular judicial review” in commitment proceedings).

126. See *supra* notes 1–6 and accompanying text.

institutions.”¹²⁷ Arguably, such advancements ensure that people with disabilities enjoy greater protection under U.S. law than in any other country in the world.¹²⁸

Despite this progress, however, some critics argue that the United States’ disability law focuses more on determining whether individuals meet the statutory requirements to receive the protections they seek than on the individuals’ actual rights or needs.¹²⁹ Plaintiffs bringing suit under Title I of the ADA often have difficulty prevailing on their claims,¹³⁰ because they frequently fail to meet the strict requirements of being both “disabled” and “qualified” for employment.¹³¹ Title II plaintiffs seeking remedies against a state, on the other hand, often succumb to the state’s cost-based defense.¹³² Similarly, a litigant seeking community placement from a state under Medicaid legislation faces daunting odds:

First, the wide discretion accorded to states in the structuring of Medicaid benefits makes the program a less than sure means of promoting the interests of people with disabilities. Tight state budgets can lead to massive reductions in Medicaid benefits. Second, the structure of the Medicaid

127. Perlin, *supra* note 22, at 341

128. See *Living History Interview with Iowa Senator Tom Harkin*, 15 TRANSNAT’L L. & CONTEMP. PROBS. 717, 727 (2006) (“The United States leads the world in efforts to address the needs of people with disabilities, and we can share our expertise with the international community.”).

129. See BAGENSTOS, *supra* note 119, at 34 (describing criticism of “definition-of-disability decisions as betraying the promises of the ADA” insofar as they focus more on determining whether the plaintiff is a qualified individual “rather than on whether the defendant engaged in improper discrimination”); cf. WAYNE THOMAS OAKES, PERSPECTIVES ON DISABILITY, DISCRIMINATION, ACCOMMODATIONS, AND LAW: A COMPARISON OF THE CANADIAN AND AMERICAN EXPERIENCE 64 (2005) (explaining how, in the context of Title I, the current process of determining disability status makes it “difficult to establish a claim”).

130. Plaintiffs bringing claims based on the ADA prevail in approximately one-third of cases in jury trials, though many cases are cut short at the summary judgment level and never see a jury. COLKER, *supra* note 33, at 71. Furthermore, defendants in ADA cases are far more likely to win on appeal than are plaintiffs. *Id.* at 81. Although Professor Colker confines her statistical study to Title I plaintiffs, she later states, “[t]he Supreme Court has decided three cases that undercut the ability of private parties to attain effective relief under ADA Title II[, including *Olmstead*] . . .” *Id.* at 129.

131. *Id.* at 70. However, it is important to note that the ADA Amendments Act of 2008 has broadened the definition of “disability” to include impairments that the ADA previously did not cover, expanding the number of individuals covered under the ADA. ADA Amendments Act of 2008, Pub. L. No. 110-325, § 4(a), 122 Stat. 3553, 3555–56 (current version at 42 U.S.C. § 12102 (2006 & Supp. 2009)).

132. COLKER, *supra* note 33, at 127 (explaining that the Supreme Court’s handling of the cost defense has created a disturbing trend in ADA Title II litigation, “mak[ing] it difficult, if not impossible, for individuals to obtain effective remedies against the state”).

program itself imposes significant obstacles to the ability of people with disabilities to live and work in the community, because the program has a strong bias toward paying for the needs of institutional rather than community placements.¹³³

In addition to the difficulties litigants face under both Title I and Title II, there is no heightened scrutiny for discrimination on the basis of disability,¹³⁴ making it more challenging to combat disability-based discrimination.¹³⁵ Although U.S. disability legislation is considered to be human rights legislation,¹³⁶ the human rights of people with disabilities seem to have gotten lost in the shuffle.¹³⁷

B. *Alternative Approaches*

Although considered a world leader in disability rights,¹³⁸ the United States should look to the examples of countries such as Canada for ideas on how to improve its disability legislation by focusing on the needs and rights of persons with disabilities. Canada has rights-based disability legislation "structured upon a very broad equality clause contained in Canada's constitution, as well as human rights laws that define disability quite broadly."¹³⁹ Section 15(1) of the Canadian Charter of Rights and Freedoms (Charter), Canada's constitution, states that "[e]very individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical

133. BAGENSTOS, *supra* note 119, at 139 (footnotes omitted).

134. See *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 443 (1985) ("Heightened scrutiny inevitably involves substantive judgments about legislative decisions, and we doubt that the predicate for such judicial oversight is present where the classification deals with mental retardation.").

135. Anita Silvers & Leslie Pickering Francis, *A New Start on the Road Not Taken: Driving With Lane to Head off Disability-Based Denials of Rights*, 23 WASH. U. J.L. & POL'Y 33, 33-34 (2007) (describing the Supreme Court's *Cleburne* ruling that a city zoning ordinance discriminating against persons with mental retardation violated the Equal Protection Clause of the Constitution as a "pyrrhic victory," as it made it more difficult for litigants challenging classifications on the basis of disability to prevail).

136. See, e.g., Theresia Degener, *International Disability Law—A New Legal Subject on the Rise: The Interregional Experts' Meeting in Hong Kong, December 13-17, 1999*, 18 BERKELEY J. INT'L L. 180, 183 (2000) ("The United States and Canada were the first countries to adopt anti-discrimination laws and other human rights legislation for persons with disabilities . . .").

137. See OAKES, *supra* note 129, at 44-46 (explaining how U.S. disability law focuses on limiting costs, while Canadian disability law focuses less "on costs and benefits" and more on human rights).

138. See *supra* notes 118-128 and accompanying text.

139. See OAKES, *supra* note 129, at 64.

disability.”¹⁴⁰ Because the Charter does not define “mental or physical disability,” there was an expectation in early equal rights debates that courts would construe the phrase broadly, and Canadian courts eschewed using levels of scrutiny to decide equal rights claims.¹⁴¹ As the Supreme Court of Canada indicates, such flexibility allows Canadian courts to avoid the strict biomedical analysis¹⁴² utilized by U.S. courts: “[H]andicap’ must not be confined within a narrow definition that leaves no room for flexibility. Instead, courts should adopt a multidimensional approach that considers the socio-political dimension of ‘handicap.’ The emphasis is on human dignity, respect[,] and the right to equality rather than merely a biomedical condition.”¹⁴³

This “emphasis on human dignity” demonstrates Canada’s commitment to an individualized, rights-based approach to disability. In addition, unlike the United States, Canada views the duty to accommodate as a “human rights obligation.”¹⁴⁴ Although Canadian disability legislation is far from perfect, especially with regard to institutionalization,¹⁴⁵ the United States should adopt a legislative approach that promotes the dignity and individuality of persons with disabilities, rather than placing so much focus on strict definitional requirements and cost-effectiveness.

140. Canadian Charter of Rights and Freedoms, pt. I, § 15(1), Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11 (U.K.).

141. OAKES, *supra* note 129, at 66–70. Though the various Canadian provinces have different statutes which prohibit discrimination against people with disabilities, “the definitions of disability used in each instance . . . signal a desire to be broadly inclusive.” *Id.* at 73.

142. See Elizabeth A. Pendo, *Disability, Doctors and Dollars: Distinguishing the Three Faces of Reasonable Accommodation*, 35 U.C. DAVIS L. REV. 1175, 1195 (2002) (“[C]urrent ADA jurisprudence suggests a recommitment to a narrow and individualistic biomedical model as the primary understanding of disability.” (footnote omitted)).

143. OAKES, *supra* note 129, at 78 (citing *Quebec v. Boisbriand*, [2000] 1 S.C.R. 665 (Can.)).

144. Patti Bregman, *Disability Law: Canada*, in *ENCYCLOPEDIA OF DISABILITY* (2005), http://www.sage-e-reference.com/disability/Article_n231.html (last visited Feb. 11, 2010). The United States, on the other hand, views a “reasonable accommodation” analysis from a cost-benefit perspective. See, e.g., *Vande Zande v. Wis. Dep’t of Admin.*, 44 F.3d 538, 543 (7th Cir. 1995) (discussing the connection between “reasonable accommodation” and “undue hardship” and advocating that costs of an accommodation be measured “in relation to the benefits of the accommodation to the disabled worker as well as to the employer’s resources”).

145. See DAVID MECHANIC, *INESCAPABLE DECISIONS: THE IMPERATIVES OF HEALTH REFORM* 189 (1994) (describing how Canada was slower to deinstitutionalize people with disabilities than the United States).

C. Incorporating the Convention: The Solution

In order to implement a more rights-based approach to deinstitutionalization, the United States should revamp applicable ADA and Medicaid legislation by incorporating the ideals of the United Nations Convention on the Rights of Persons with Disabilities. By making these changes, the United States will increase states' compliance with *Olmstead's* integration mandate, promote national goals, and fulfill the purpose of the ADA to "provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities . . ."¹⁴⁶ The applicable provisions of the Convention provide a framework for reworking the United States' disability legislation to maximize community integration.

First, the Preamble of the Convention supplies a natural starting point for reworking U.S. disability legislation. In the present day, persons with disabilities in the United States have little control over whether they obtain community placements.¹⁴⁷ By allowing states to keep Medicaid waiver programs small and their waiting lists short, Medicaid legislation promotes institutional bias and cost-centered, rather than need-centered, services.¹⁴⁸ Instead, the United States should advance the "individual autonomy and independence" of persons with disabilities, as the Convention requires,¹⁴⁹ by changing 42 U.S.C. § 1396n(c)(2)(D), which currently states that Medicaid waiver services will not be provided if the estimated cost of community-base care exceeds the estimated cost of institutional care.¹⁵⁰ Courts have acknowledged that this legislation may keep institutionalized individuals with costly medical impairments who are otherwise quite capable of exercising "autonomy and independence" in home and community-based placements.¹⁵¹ Personal autonomy allows

146. Americans with Disabilities Act (ADA) of 1990, Pub. L. 101-336, § 2, 104 Stat. 327, 328 (current version at 42 U.S.C. § 12101(b)(1) (2006)); *see also* 42 U.S.C. § 12101(a)(7) (2006 & Supp. 2009) (setting forth a national goal of "assur[ing] equality of opportunity, full participation, independent living, and economic self-sufficiency for . . . individuals [with disabilities]").

147. *See supra* notes 67–76 and accompanying text.

148. Bagenstos, *supra* note 23, at 61 (describing Medicaid's "strong institutional bias" against non-institutional care).

149. United Nations Convention on the Rights of Persons with Disabilities, *supra* note 13, pmb. ¶ n.

150. 42 U.S.C. § 1396n(c)(2)(D) (2006 & Supp. 2009).

151. *See, e.g., Radaszewski ex rel. Radaszewski v. Maram*, 383 F.3d 599, 612, 614 (7th Cir. 2004) (noting that, while the plaintiff was "by no means . . . an 'unqualified' disabled person in the sense that *Olmstead* emphasized—he is not someone who is 'unable to handle or benefit from community settings,' . . . [t]he

individuals the freedom to make choices in their everyday lives, and in general, people who have the opportunity to make meaningful choices in their lives will suffer from fewer emotional and psychological problems.¹⁵² Though moving institutionalized individuals into community settings may increase costs initially, these costs will likely decrease over time; if individuals with developmental disabilities are given the opportunity to make meaningful choices, they may consequently become less likely to suffer from emotional and psychological problems, in turn decreasing mental health spending.¹⁵³ Although waiver legislation such as 42 U.S.C. § 1396n(c) confers upon states the ability to bypass institutionalization by creating waiver programs that have more flexible eligibility standards,¹⁵⁴ they have little incentive to do so.¹⁵⁵ As a result, Congress should modify 42 U.S.C.

State is obliged to maintain a full range of facilities in order to provide care for its disabled citizens, [which means] it may not always be able to fully realize the cost savings of placing an individual person in a community setting rather than an institution.” (citations omitted)).

152. Cf. Shannon Kim, Sheryl A. Larson & K. Charlie Lakin, *Behavioral Outcomes of Deinstitutionalization for People with Intellectual Disabilities: A Review of Studies Conducted Between 1980 and 1999*, POLY RES. BRIEF (Research and Training Center on Community Living, Univ. of Minn.), Oct. 1999, at 8, available at <http://ici.umn.edu/products/prb/101/101.pdf> (noting that thirty-eight statistical surveys addressing adults moved from institutions to community placements “demonstrate strongly and consistently that people who move from institutions to community settings have experiences that help them to improve their adaptive behavior skills. The studies suggest that community experiences increasingly provide people with environments and interventions that reduce challenging behavior. And, a growing body of research suggests that people enjoy a better quality of life . . .”).

153. *Compare Olmstead v. L.C.*, 527 U.S. 581, 604 (1999) (plurality opinion) (disapproving of the district court’s cost analysis that compared the cost of community placement to the cost of institutionalization—and determined that community placement was less expensive—by noting that “a comparison so simple overlooks costs the State 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.’” (citation omitted) (quoting Brief for the United States as Amici Curiae Supporting Respondents at 21, *Olmstead v. L.C.*, 527 U.S. 581 (1999) (No. 98-536)), with Sandra L. Harris & Beth A. Glasberg, *Functional Behavioral Assessment in Practice: Concepts and Applications*, in HANDBOOK OF INTELLECTUAL AND DEVELOPMENTAL DISABILITIES 317, 323 (John W. Jacobson et al. eds., 2007) (explaining that providing people with developmental disabilities with more choices in their daily lives has a positive impact on behavior), and Kim, Larson & Lakin, *supra* note 152, at 8.

154. See 42 U.S.C. § 1396n(c) (2006 & Supp. 2009); Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6071(a), 120 Stat. 4, 102 (2006) (authorizing the Secretary of Health and Human Services to fund Demonstration Waiver Project homes).

155. See, e.g., DiPolito, *supra* note 75, at 1403 (using the state of Georgia as an example to show the financial incentives of keeping individuals with disabilities

§ 1396n(c)(2)(D) to provide that individual needs, not costs, determine the most appropriate placement for individuals with disabilities. If treatment professionals, family members, and the individual in question agree that community placement is best, legislation should allow for the individual to receive community-based treatment, regardless of the cost, without requiring that the state resort to a waiver to effectuate the placement.

Second, Article 14 of the Convention, titled "Liberty and security of the person,"¹⁵⁶ could be utilized to strengthen the integration mandate set out in *Olmstead* and U.S. disability legislation. Abiding by this provision, which prohibits the unlawful or arbitrary deprivation of liberty of persons with disabilities,¹⁵⁷ requires reconsidering the legislation creating caps on the number of community placements available under Medicaid waivers¹⁵⁸ and Justice Ginsburg's "reasonably paced waiting list" analysis in *Olmstead*.¹⁵⁹ The Medicaid waiver legislation imposing limits on the size of waiver programs¹⁶⁰ and providing that slots under waiver programs will not open up unless "individuals . . . die or become ineligible for services"¹⁶¹ constructively deprives persons with disabilities of their liberty by restricting their ability to obtain spots on waiting lists, and, subsequently, community placement.¹⁶² Because it perpetuates institutionalization, legislation for persons with disabilities should require states to request more waiver slots to meet the demand of qualified individuals with disabilities who are seeking community placement, thereby reducing the size of waiting lists. This requirement would impact the "reasonably paced waiting list" analysis from *Olmstead*, creating a fair and uniform standard in place of the ambiguous one by which state waiver programs are currently judged.¹⁶³ Under the proposed standard, a "reasonably paced waiting list" would truly move at a reasonable pace, with

institutionalized).

156. United Nations Convention on the Rights of Persons with Disabilities, *supra* note 13, art. 14.

157. *Id.* art. 14(1)(b).

158. 42 C.F.R. § 441.303(f)(6) (2009) (imposing "a limit on the size of the waiver program unless the State requests and the Secretary approves a greater number of waiver participants in a waiver amendment").

159. *Olmstead v. L.C.*, 527 U.S. 581, 606 (1999) (plurality opinion).

160. 42 C.F.R. § 441.303(f)(6) (2009).

161. 42 U.S.C. § 1396n(c)(9) (2006 & Supp. 2009).

162. *See supra* notes 67–73 and accompanying text; Part II.A.

163. *See Kubo, supra* note 59, at 743 (discussing the "wide deference" given to states and the difficulties at the lower court level in addressing ambiguities after *Olmstead*).

the size of waiver programs and waiting lists fluctuating relative to the demand of qualified individuals seeking community placement. Plaintiffs seeking injunctive relief in the form of community-based treatment would enjoy greater success,¹⁶⁴ thereby supporting the autonomy and independence of people with disabilities, and preventing the deprivation of their liberty.

Article 19 of the Convention, requiring States Parties to ensure that “[p]ersons with disabilities have access to a range of in-home, residential[,] and other community-support services . . . to prevent isolation or segregation from the community,”¹⁶⁵ should be incorporated into the integration regulation.¹⁶⁶ In order to “administer services, programs, and activities in the most integrated setting appropriate” for persons with disabilities,¹⁶⁷ the United States must expand its range of services to accommodate the residential needs of this varied population. This includes offering home and community-based services to those individuals who would not qualify for Medicaid waiver services because of the cost-of-care maximums imposed by 42 U.S.C. § 1396n(c)(2)(D),¹⁶⁸ and expanding the size of the waiver programs in general. Congress can amend 28 C.F.R. § 35.130(d)¹⁶⁹ to state that determining “the most integrated setting appropriate” for individuals with disabilities must be done on a case-by-case basis, and to require proper measures to ensure that each individual can be placed in such a setting. Additionally, because the Convention recognizes the basic right to choose one’s place of residence without being “obliged to live in a particular living arrangement” as a human right,¹⁷⁰ the United States should revise its legislation to correspond with and protect this right,¹⁷¹ unless doing so “impos[es] a disproportionate or undue burden.”¹⁷²

164. Cf. COLKER, *supra* note 33, at 129 (noting the difficulty in winning an ADA claim after *Olmstead* and other related cases).

165. United Nations Convention on the Rights of Persons with Disabilities, *supra* note 13, art. 19(b).

166. 28 C.F.R. § 35.130(d) (2009).

167. *Id.*

168. 42 U.S.C. § 1396n(c)(2)(D) (2006 & Supp. 2009).

169. 28 C.F.R. § 35.130(d).

170. United Nations Convention on the Rights of Persons with Disabilities, *supra* note 13, art. 19(a).

171. See Daniel Barstow Magraw & Lauren Baker, *Globalization, Communities and Human Rights: Community-Based Property Rights and Prior Informed Consent*, 35 DENV. J. INT’L L. & POL’Y 413, 415 (2007) (“Eventually, the[] human rights [enshrined in binding international agreements, including the Convention,] became recognized as customary international law, some even reaching the status of *jus cogens*.” (footnotes omitted)).

172. United Nations Convention on the Rights of Persons with Disabilities,

Finally, Article 2 of the Convention, which defines “reasonable accommodation,”¹⁷³ and Article 4, which requires that States Parties take measures to achieve the rights recognized by the Convention “to the maximum of [their] available resources,”¹⁷⁴ provide a rights-based alternative to states’ fundamental alteration defense. Although the United States would likely resist this modification,¹⁷⁵ it is necessary to secure the rights championed by the Convention. Under Article 2 of the Convention, a State Party is obligated to provide “reasonable accommodation” unless doing so would “impos[e] a disproportionate or undue burden.”¹⁷⁶ As with reasonable accommodation analysis under the ADA, the Convention’s concept of reasonable accommodation is intertwined with the concept of undue burden,¹⁷⁷ and a State Party’s duty is not boundless. Incorporating the Convention’s “reasonable accommodation” standard into U.S. disability legislation, therefore, appears to make for a seamless process.

The Convention, however, carefully points out that what is “reasonable” for one country may not be for another.¹⁷⁸ Article 4

supra note 13, art. 2.

173. *Id.*

174. *Id.* art. 4, cl. 2.

175. As an example of U.S. attitudes towards financial considerations in addressing individuals with disabilities’ needs, compare the United Nations’ “maximum available resources” language with *Olmstead*, which holds that states that provide community-based treatment to individuals with disabilities have a cost-based defense to making “reasonable modifications” to avoid discrimination. *Id.*; *Olmstead v. L.C.*, 527 U.S. 581, 603 (1999) (plurality opinion). According to the Court, this cost-based defense should be based on a state’s entire mental health budget, rather than all of the United States’ “available resources” as the Convention would require. *Olmstead*, 527 U.S. at 603 (plurality opinion); United Nations Convention on the Rights of Persons with Disabilities, *supra* note 13, art. 4, cl. 2.

176. United Nations Convention on the Rights of Persons with Disabilities, *supra* note 13, art. 2.

177. The ADA equivalent is “undue hardship,” which applies to both Titles I and II. Compare Americans with Disabilities Act (ADA) of 1990, Pub. L. No. 101-336, § 101(10)(A)–(B), 104 Stat. 327, 331 (current version at 42 U.S.C. §§ 12111(10)(A)–(B) (2006)) (defining “undue hardship”), and Nina Golden, *Access This: Why Institutions of Higher Education Must Provide Access to the Internet to Students with Disabilities*, 10 VAND. J. ENT. & TECH. L. 363, 382 (2008) (“While the reasonable modification requirement in Title II does not explicitly include an undue hardship or burden defense, courts have incorporated that defense into the fundamental alteration defense.”), with United Nations Convention on the Rights of Persons with Disabilities, *supra* note 13, art. 2 (“‘Reasonable accommodation’ means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms . . .”).

178. United Nations Convention on the Rights of Persons with Disabilities, *supra* note 13, art. 4.

requires that each nation “take measures to the maximum of its available resources” to protect the rights recognized by the Convention,¹⁷⁹ which conflicts with historic United States policy towards “entitlement spending.”¹⁸⁰ Given the United States’ status as one of the world’s wealthiest countries,¹⁸¹ utilizing the “maximum of its available resources” could involve allocating significantly more resources than the nation currently does to achieve the level of deinstitutionalization the Convention advocates.¹⁸² Prior to the Convention’s drafting, the United Nations indicated that States Parties should supply “special measures designed to meet the particular requirements of persons who, for reasons such as sex, age, disablement, family responsibilities[,] or social or cultural status, are generally recognised to require special protection or assistance,” even if doing so is expensive.¹⁸³ In 2006, the United Nations “affirmed its position” that people with disabilities should be afforded these “special measures” regardless of the additional costs involved:

The obligation of States Parties to the Covenant to promote progressive realization of the relevant rights to the maximum of their available resources clearly requires Governments to do much more than merely abstain from taking measures which might have a negative impact on persons with disabilities. The obligation in the case of such a vulnerable and disadvantaged group is to take positive action to reduce structural disadvantages and to give appropriate preferential treatment to people with disabilities in order to achieve the objectives of

179. *Id.* art. 4, cl. 2.

180. The United States seeks to cut costs by reducing its services to vulnerable populations, rather than using the “maximum of its available resources” as Article 4 of the Convention requires. *Id.*; see Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006); see also President George W. Bush, President Signs S.1932, Deficit Reduction Act of 2005 (Feb. 8, 2006) (transcript available at <http://georgewbush-whitehouse.archives.gov/news/releases/2006/02/20060208-8.html>) (“The bill I sign today restrains spending for entitlement programs . . .”).

181. See, e.g., James Forman, Jr., *Exporting Harshness: How the War on Crime Helped Make the War on Terror Possible*, 33 N.Y.U. REV. L. & SOC. CHANGE 331, 343, fig.2 (2009) (illustrating the Gross Domestic Product of many wealthy nations, with the United States among those countries near the top).

182. See United Nations Convention on the Rights of Persons with Disabilities, *supra* note 13, art. 4 (describing the lengths to which States Parties should incorporate the Convention’s protections into their legislation).

183. Convention Concerning Discrimination in Respect of Employment and Occupation, art. 5, cl. 2, *opened for signature* June 25, 1958, 362 U.N.T.S. 31, 36 (entered into force June 15, 1960); see Arlene S. Kanter, *The United Nations Convention on the Rights of Persons With Disabilities and Its Implications for the Rights of Elderly People Under International Law*, 25 GA. ST. U. L. REV. 527, 535-37 (2009) (discussing United Nations documents that address the resources and protections that states should extend to elderly individuals and others, including the disabled).

full participation and equality within society for all persons with disabilities. *This almost invariably means that additional resources will need to be made available for this purpose and that a wide range of specially tailored measures will be required.*¹⁸⁴

According to this analysis, the United States should rework its legislation to model the Convention by changing Medicaid waivers and ADA legislation which presently incentivize states operating their *Olmstead* plans in the cheapest manner possible.¹⁸⁵ This legislation must be changed to force the allocation of additional state and federal resources to deinstitutionalizing individuals, despite the recent push to reduce "entitlement spending."¹⁸⁶ As a result, the fundamental alteration defense must be completely revamped. Congress must amend 28 C.F.R. § 35.130(b)(7), setting forth a much stricter standard than the current requirement that public entities make reasonable modifications unless they can demonstrate that doing so would fundamentally alter the nature of their programs.¹⁸⁷ Accordingly, the "sensibly construed" fundamental alteration defense established in *Olmstead*¹⁸⁸ must also be reconsidered. Although states should still have to consider delivering services to people with disabilities in an equitable manner,¹⁸⁹ they should have a much higher burden in showing that modifications would significantly alter the nature of their programs, allowing people with disabilities a more meaningful opportunity to assert their rights under the Convention.

Conclusion

Considering the fact that it is one of the world's wealthiest countries and the forerunner in disability rights, the United States

184. U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc. and Cultural Rights, General Comment No. 5, *Persons with Disabilities*, ¶ 9, U.N. Doc. No. E/1995/22 (Sept. 12, 1994) (emphasis added).

185. See Bagenstos, *supra* note 23 at 80 n.350 ("This country certainly has a history of attempting to implement deinstitutionalization 'on the cheap,' . . . with devastating results for deinstitutionalized populations.") (quoting *Olmstead v. L.C.*, 527 U.S. 581, 610 (1999) (Kennedy, J., concurring)).

186. See Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006) (demonstrating the United States' goal to reduce spending on vulnerable populations); President George W. Bush, President Signs S.1932, Deficit Reduction Act of 2005 (Feb. 8, 2006) (transcript available at <http://georgewbush-whitehouse.archives.gov/news/releases/2006/02/20060208-8.html>).

187. 28 C.F.R. § 35.130(b)(7) (2009).

188. *Olmstead*, 527 U.S. at 604 (plurality opinion).

189. See *id.* at 605 ("Each disabled person is entitled to treatment in the most integrated setting possible for that person . . .") (quoting *Youngberg v. Romeo*, 457 U.S. 307, 327 (1982) (Blackmun, J., concurring)).

should set an example for the rest of the world by not only ratifying the United Nations Convention on the Rights of Persons with Disabilities, but also by changing its disability legislation to provide people with disabilities the superior community-based care for which the Convention calls. Although doing so may seem costly at the outset, the process of incorporating the Convention rights into U.S. disability legislation would result in several long-term benefits for the country. First, by increasing community integration, overall long-term care spending would likely decrease, as community-based care is drastically less expensive than institutional care.¹⁹⁰ Second, the quality of life for individuals with disabilities who would then have access to community placements would markedly improve.¹⁹¹ With this increased quality of life, total health care expenditures for the population of people with disabilities would likely decrease.¹⁹² Finally, creating a more rights-based system would further the purpose of the ADA, reinvigorating the nation's commitment to promoting the equality of people with disabilities and eliminating discrimination.¹⁹³ As Professor Ann Hubbard states,

If the ADA stands for anything, it is the proposition that all Americans—with or without disabilities—want the same things for themselves and their families and have the same desires, needs, aspirations[,] and ambitions. They therefore must all have the same opportunities to develop their skills and talents and to envision and obtain their personal conception of the good life, or, if you like, the American dream.¹⁹⁴

By incorporating the rights established under the Convention, the United States would enable people with disabilities to pursue this dream.

190. See Scotellaro, *supra* note 10, at 777.

191. Cf. John F. Muller, *Olmstead v. L.C. and the Voluntary Cessation Doctrine: Toward a More Holistic Analysis of the "Effectively Working Plan,"* 118 Yale L.J. 1013, 1013 (2009) ("In *Olmstead*, the Court reasoned that institutional placement of individuals capable of living in the community 'perpetuates unwarranted assumptions' about such individuals and 'severely diminishes' their quality of life." (quoting *Olmstead*, 527 U.S. at 600–01 (plurality opinion))).

192. Increased quality of life has a positive impact on both mental and physical health. See WORLD HEALTH ORG., *THE WORLD HEALTH REPORT 2001: MENTAL HEALTH: NEW UNDERSTANDING, NEW HOPE* xvi (2001) ("[S]cientific evidence from the field of behavioural medicine has demonstrated a fundamental connection between mental and physical health . . .").

193. See Americans with Disabilities Act (ADA) of 1990, Pub. L. No. 101-336, §§ 2(a)(8), (b)(1), 104 Stat. 327, 329 (current version at 42 U.S.C. §§ 12101(a)(7), (b)(1) (2006 & Supp. 2009)).

194. Ann Hubbard, *Meaningful Lives and Major Life Activities*, 55 ALA. L. REV. 997, 998 (2004) (footnote omitted).

