UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS

ERNAST HERMANSON, et al.,	)	Civil Action No. 00-CV-30156MAP
Plaintiffs	)	PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION
v.	)	
COMMONWEALTH OF MASSACHUSETTS, et al.,	)	
Defendants	)	

INTRODUCTION

The three plaintiffs who seek relief at this juncture are all low-income, disabled, elderly individuals who, with the provision of personal care services, are able to live at home. However, due to the disparate Medicaid eligibility rules that apply to disabled elders, they are unable to obtain or are at imminent risk of losing Medicaid coverage for such services in the community.

Plaintiff Ernast Hermanson is currently institutionalized at the Holyoke Soldiers Home where the entire cost of care is borne by the Commonwealth. He desperately wants to be reunited with his wife to whom he has been married for fifty-two years. He and his wife have recently been approved for a new, handicap accessible apartment in Wales, Massachusetts effective October 1, 2000. Unless Mr. Hermanson is able to obtain Medicaid coverage for

community-based personal care services, he will be unable to occupy the apartment and it will be given to someone else. If that happens, he will have lost this unique opportunity to be reunited with his wife and retain some semblance of dignity and independence.

Plaintiffs Helen Kopec and Della Wimes both live in their respective homes with the help of personal care attendants paid for by Medicaid. However, their current Medicaid eligibility expires on September 30, 2000 and they will be unable to meet the more restrictive Medicaid rules applied to disabled elders. If they lose their Medicaid coverage for personal care services in the community, both will be forced to enter nursing homes to get the personal care services they need. Both will immediately qualify for Medicaid in the nursing homes. Both have been in nursing homes before and are desperate to remain in their homes where they retain control over their lives and their care.

These three plaintiffs seek a preliminary injunction ordering the defendants to make Medicaid coverage for community-based care available to them on the same basis as it is made available to other disabled individuals. Plaintiffs are likely to prevail on their claims that this disparate treatment violates numerous anti-discrimination provisions of the Americans with Disabilities Act and that without such relief they will suffer severe and irreparable injury.

FACTS

A. How the Massachusetts Medicaid Program Operates:

Medicaid is a joint federal-state program designed to provide medicaid assistance to low income families and individuals "to help such families and individuals attain or retain capability for independence or self care." 42 U.S.C. §1396 (emphasis added). Once a state elects to

participate in the Medicaid program, it must provide coverage to all those people who receive federally subsidized cash assistance grants under the Temporary Assistance to Needy Families (TANF, formerly known as Aid to Families With Dependent Children (AFDC) and currently known in Massachusetts as Transitional Assistance to Families With Dependent Children (TAFDC)) program or the Supplemental Security Income (SSI) program. 42 U.S.C. §1396a(a)(10)(A). Such recipients of Medicaid are known as the "categorically needy." In addition, a state may choose to provide Medicaid to those persons who would receive TAFDC or SSI except for the fact that their income or assets are above the allowable limits for those programs. People in these categories have traditionally been referred to as the TAFDC-related and SSI-related "medically needy." Massachusetts has historically chosen to provide coverage to these groups, and, prior to 1997 as federal law requires, financial eligibility for both groups was determined in the same way. See 42 U.S.C. §1396 a(a)(10)(B) and (17). However, in 1997 Massachusetts sought a waiver pursuant to 42 U.S.C. §1315 from the United States Department of Health and Human Services to permit it to deviate from a host of federal requirements including the requirements of §1396a(a)(10)(B) that the amount, duration and scope of medical assistance must be the same for the categorically and medically-needy and of 1396a(a)(17) that the standards for income eligibility must be comparable for all groups. With the waiver, Massachusetts created its own Medical Assistance Program with vastly different financial eligibility rules for those under 65 years of age and those age 65 and older. Compare 130 C.M.R. §§505.001 et seq. (under age 65 coverage) with 130 C.M.R. §519.001 et seq. (age 65 and over).

Specifically, as a result of the waiver, non-institutionalized disabled individuals under 65

years of age automatically qualify for Medical Assistance if their income is less than 133% of the poverty level ($926 /mo. for an individual), 130 C.M.R. §505.002(F), while those age 65 and over qualify only if their income is less than 100% of poverty. ($676/mo. for an individual). 130 C.M.R. §519.005(A)(1). Disabled individuals whether over or under 65 whose income exceeds the basic financial eligibility cut-off (133% of poverty for those under 65; 100% of poverty for those 65 and older) can still qualify for Medical Assistance if they have incurred medical bills over a six month period (including any unpaid bills from an earlier time) which, when deducted from their income during that period, reduce that income (pro-rated to a monthly amount) below the deductible income standard. 130 C.M.R. §§505.004(C)(4) and 506.009 (disabled adults under 65); 519.005(B) and 520.028 et seq. (disabled individuals age 65 and older). The deductible income standard for an individual is $542 per month.[1] 130 C.M.R.§§506.009(D) (chart). However, and significantly, those under age 65 only have to satisfy the six month deductible once. After once meeting the deductible, disabled individuals under age 65 have their eligibility determined based upon a generous sliding income scale. As their income increases, they may have to pay a modest premium for continued coverage. 130 C.M.R. §506.009 However, the income limits are so much higher than those for regular Medicaid and the premiums so modest that, for all practical purposes, disabled individuals under 65 who meet their one time deductible have guaranteed affordable health insurance.

[1] While the deductible income standard for elders is $522 (see 130 C.M.R. §520.030), because elders receive a $20 per month deduction from unearned income that those under age 65 do not (see 130 C.M.R. §520.013), in actual operation the amount of the deductible income standard is the same for both the under and over 65 disabled population. For purposes of simplicity, the $542 figure will be used throughout this brief and any computations using this figure will not include the $20 unearned income deduction for those 65 and older.

Not so for elders. Elders must continue to meet the deductible every six months in order to continue to qualify for Medicaid. 130 C.M.R. §520.031(B). The repeated need to incur substantial medical bills before qualifying for Medicaid coverage creates enormous cash flow problems for disabled elders who frequently cannot afford to purchase the medical care needed to meet the deductible and still pay their rent, utilities, food and clothing costs.

A few examples will hopefully clarify the workings of this complex system:

Example 1: Bill is 58 years old and wheelchair-bound. He receives $900 per month in Social Security benefits and has fixed monthly medical expenses of $600 for a personal care attendant (PCA) (approximately 3 hours/day) to assist him with dressing, bathing, toileting, cooking and cleaning. Because Bill's monthly income is less than 133% of poverty (926/mo), he qualifies for Medicaid without a deductible and Medicaid pays the full cost of his PCA plus any other medical expenses he may have.

Example 2: Assume everything in Example 1 is the same except Bill has just turned 65. Now that he is 65, Bill is income eligible for Medicaid only if his monthly income is less than $696. Bill is $204 over income. As a result he must meet the six-month deductible to qualify. Bill's deductible amount is $2148 (($900 (his income) - $542 (the deductible standard) x 6). Therefore within a 6 month period, Bill must incur $2148 of medical expenses before he qualifies for Medicaid. If his PCA costs are his only medical expenses, Bill will have to pay his PCA $600 out of his own pocket for 3 ½ months before Medicaid eligibility is established. Medicaid will pay the last 2 ½ months, but then the process will begin anew and Bill will again have to pay the PCA for 3 ½ months before Medicaid kicks in, ad infinitum. If Bill has to pay $350 per month in rent and $100 per month in utilities and $100 per month for food, he will be

unable to pay his PCA and his other fixed expenses. He is at great risk of losing his PCA, which will throw him into instant crisis, probably resulting in institutionalization.

Example 3: Assume that Bill's income is $1100 per month and his PCA costs are $1200 per month. Also assume Bill is 59 years old. Bill is over income for automatic Medicaid eligibility because his income exceeds $926. Bill must meet a deductible of $3348 (($1100-$542) x 6) over a 6 month period to qualify for Medicaid. After a little less than 3 months, Bill will qualify for Medicaid. At that point Medicaid will kick in and cover his PCA costs plus any other medical expenses he has. Because his monthly income is less than $1135 (the cut-off for no premiums on the sliding-scale), Medicaid will continue to cover all of his medical bills at no cost to him until he reaches age 65.

Example 4: Same as Example 3 except that Bill is over 65. Bill is, of course, well over income to automatically qualify for Medicaid. Therefore he will have to meet a 6 month deductible of $3348 ((1100-542) x 6) before Medicaid coverage begins. This means Bill will have to repeatedly pay for this PCA out of his own pocket for almost 3 months before qualifying for Medicaid. While Bill might be able to cover the PCA costs out of savings or contributions from family members during the initial spenddown period, he will face the same cash-flow dilemma again and again, every 6 months. Because his PCA costs exceed his monthly income, it will prove to be impossible for him to continue to pay his PCA until his deductible is met. Unless the PCA is able and wiling repeatedly to defer payment for several months, Bill will lose his PCA before he ever meets his deductible.

As the facts of the moving parties demonstrate, these examples and the consequences that flow therefrom are far from hypothetical. Fortunately, the disparate treatment accorded to elder

disabled individuals is just as illegal as it is unconscionable.

2. The Plaintiffs' Situation:

The three plaintiffs who are presently seeking preliminary relief, Ernst Hermanson, Helen Kopec, and Della Wimes, are all facing a crisis in October, 2000.

Mr. Hermanson is currently confined at the Holyoke Soldiers Home, a long term care facility funded by state appropriation. Mr. Hermanson is seventy-five years old and is married to Edith Hermanson, his wife of 52 years. Up until January 1998 he and his wife led an active life living on their farm in Monson, Massachusetts where Edith grew up. In January 1998, Mr. Hermanson had a stroke, and in February 1998 he had his right leg amputated due to a blood clot. Following the amputation, he was discharged to a rehabilitation facility and then to a nursing home where he stayed for about a month at a cost of $290 per day. Mr. Hermanson desperately wanted to leave the nursing home and return home. Because his wife, who is seventy-four, could not care for him on her own, his daughter Sheila agreed to have them move in with her in her home in Wales, Massachusetts. In April 1998 Mr. Hermanson left the nursing home and soon thereafter contacted the Stavros Center for Independent Living to apply for personal care services in the community through Medicaid. In response to this application for services, he received a letter from the defendant Division of Medical Assistance advising him that he had a six month deductible of $2878.44 that he needed to meet every six months in order to qualify for Medicaid coverage. On his fixed income of $933 per month, Mr. Hermanson cannot afford to meet this deductible. Because he could not get help from Medicaid, his daughter and other

family members pitched in and provided the care he needed in shifts. Affidavits of Ernast Hermanson, Edith Hermanson, and Sheila Chabot.

In April 1999, Mr. Hermanson was again admitted to the hospital and had his other leg amputated. Again he was transferred from the hospital to a nursing home where he stayed for about a month before returning to his daughter's home where his personal care needs were met by family members operating in shifts. In November 1999, he was admitted to the hospital yet again due to an adverse reaction to a medicine he was taking. At this time, his family made the difficult decision that they could no longer afford to continue to provide him with the personal care he needed to reside at home. As a result, Mr. Hermanson was discharged to the Wingate Nursing Home and in March 2000 he was transferred to the Holyoke Soldiers Home where he now resides. Affidavits of Ernast Hermanson and Sheila Chabot.

In the nursing home, Mr. Hermanson spends 22 out of 24 hours per day in bed. He participates in no activities. The staff does not even help him up to go to the bathroom, requiring him instead to use a bed pan. Mr. Hermanson has an electric wheelchair and could eat his meals in the dining hall, but again the staff does not help him to get into his wheelchair, preferring instead to provide him with his meals in bed where he eats alone. Mr. Hermanson feels helpless and useless in the nursing home. Affidavits of Ernast Hermanson and Sheila Chabot.

Fortunately for Mr. Hermanson, his family members visit regularly and take him home almost every weekend. During these home visits, Mr. Hermanson is able to go for drives with his wife to visit friends. With his wheelchair he can go for walks with his wife and other family members. He can go fishing. He can even go out by himself to get some fresh air or visit a

neighbor. He eats his meals with the rest of the family. Affidavits of Ernast Hermanson, Edith Hermanson and Sheila Chabot.

A new apartment complex has just opened in Wales around the corner from where one of Mr. Hermanson's daughter lives and just a few miles from his daughter Sheila's house where he had been staying. The complex has two handicap accessible units and Mr. Hermanson and his wife have been approved for one of them starting on October 1, 2000. The stove and sinks in this accessible unit are set up so that Mr. Hermanson will be able to use them in his wheelchair. He will be able to help cook and wash the dishes, and will be able to perform basic personal hygiene tasks like shaving and brushing his teeth. Because the apartment is completely wheelchair accessible, he will be able to come and go without assistance. He will, of course, still need assistance with transfers, toileting, bathing and some other tasks. He has been evaluated and determined in need of 56 hours of personal care services per week. With such help, he will be able to reunite with his wife and lead a productive and meaningful life. Affidavits of Ernast Hermanson, Edith Hermanson and Sheila Chabot.

The accessible housing unit which is available on October 1, 2000 provides Mr. Hermanson with a unique opportunity to return to the community and regain some of the dignity, independence and self worth that he has lost while confined in a nursing home. However, he has to occupy the unit soon or it will be given to someone else. Affidavit of Ernast Hermanson at ¶9.

Plaintiff Helen Kopec, is an eighty-two year old widow who lives alone in her own home in Easthampton, Massachusetts. She has had both legs amputated below the knee and suffers from arthritis, multiple sclerosis, degenerative joint disease and asthma. Ms. Kopec's source of

income is $827 per month in Social Security benefits. In order to qualify for Medicaid, she must meet recurring six month deductibles of $1710. She has met these deductibles in the past through a combination of her monthly Medex premium of $114.47 and the use of unpaid nursing home bills. Ms. Kopec has exhausted the back nursing home bills and does not have other bills to use to meet her deductible. Her current six month period of Medicaid eligibility terminates on October 1, 2000. Affidavit of Helen Kopec.

Currently, Ms. Kopec is approved for sixty-seven hours a week of personal care services plus a night attendant seven days a week. With assistance from her personal care attendant, Ms. Kopec attends town events, participates in gatherings at the Easthampton Council on Aging such as bingo and picnics, and goes to church each week. Without continuous Medicaid coverage which is currently set to expire on October 1, 2000, she will be unable to pay her personal care attendant. Without home-based personal care services, Ms. Kopec will be forced into a nursing home. She has been in nursing homes in the past and has found the experience degrading and the care inadequate. She desperately wants to remain at home where she can exercise control over her affairs and maintain some semblance of independence. Affidavits of Helen Kopec and Glayfra Ennis-Yentach.

Plaintiff Della Wimes is a sixty-six year old widow who lives alone in her house in Springfield. She is blind, her left leg is amputated below the knee, and she has diabetes and circulatory problems in her right leg. Ms. Wimes sole source of income is $990 per month in Social Security benefits. In order to qualify for Medicaid, she must meet recurring six-month deductibles of $2668. She met the deductible for the six-month period from April 1, 2000 through September 30, 2000 by using her monthly Medicare premiums and submitting bills she

had incurred but not yet paid for work performed by her personal care attendant during the uncovered portion of a previous deductible period. Affidavit of Plaintiff Della Wimes.

On October 1, 2000, Ms. Wimes current eligibility for Medicaid will terminate. Because she does not have sufficient unpaid back bills for medical care to meet her deductible, she will be unable to reinstate her Medicaid eligibility in October 2000. Without Medicaid, she will be unable to pay her personal care attendant. Without her personal care attendant, Ms. Wimes will be forced to abandon her home of 33 years and enter a nursing home. Affidavits of Plaintiff Della Wimes and her daughter, Della Wimes.

Ms. Wimes has spent time in two different nursing homes in the past. On each occasion, the amount of assistance and attention to her needs was far inferior to that which she receives at home. She felt isolated, uncomfortable and depressed in the nursing home. She desperately wants to avoid returning to the isolation of a nursing home. Affidavits of Plaintiff Della Wimes and her daughter, Della Wimes.

THE STANDARD FOR ISSUANCE OF A PRELIMINARY INJUNCTION.

The standard for issuance of preliminary relief in the First Circuit requires that the plaintiff demonstrate (1) a probability of success on the merits of the claim; (2) the danger of irreparable harm; (3) that the balance of hardships tips in plaintiffs' favor; and (4) that the public interest will be furthered by the issuance of preliminary relief. Levesque v. State of Maine, 587 F.2d 78, 80 (1st Cir. 1978); Automatic Radio Manufacturing Co. v. Ford Motor Co., 390 F.2d 113 (1st Cir.) cert. den. 391 U.S. 914 (1968). This standard is a flexible one. A-Copy, Inc. v. Michaelson, 599 F.3d 450, 451 (1st Cir. 1978). If plaintiffs' probability of success is high, the severity of the irreparable injury need not be great. Associated Builders v. Mass. Water

Resources Auth., 935 F.2d 345, 350 (1st Cir. 1991), reversed on other grounds, 507 U.S. 218, 113 S.Ct. 1190 (1993). Conversely, if the injury to the plaintiff is great, plaintiff need only demonstrate that her legal claims are sufficiently "serious, substantial, difficult and doubtful, as to make them a fair ground for litigation and thus for more deliberate investigation." Hamilton Watch Co. v. Benrus Watch Co., 206 F.2d 738, 740 (2nd Cir. 1953); accord, Cuneo Press of N.E., Inc. v. Watson, 283 F.Supp. 122 (D. Mass. 1968); Mytinger & Casselberry, Inc. v. Humanna Labs, 215 F.2d 382 (7th Cir. 1954); Alameda County v. Einberger, 520 F.2d 344 (9th Cir. 1975); Continental Oil Co. v. Frontier Ref. Co., 338 F.2d 780 (10th Cir. 1964); Wright & Miller, Federal Practice and Procedure: Civil § 2948 at pp. 453-455. As will be demonstrated, plaintiffs easily meet each of the above requirements.

ARGUMENT

1. The Plaintiffs Are Likely To Succeed On the Merits of their Claims:

The Americans With Disabilities Act, 42 U.S.C. §12101 et seq. is a far reaching statute designed “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.” 42 U.S.C. §12101(b)(1). Congress recognized that isolation, segregation and unnecessary institutionalization of individuals with disabilities are forms of discrimination that must be eliminated. 42 U.S.C. §§12101(a)(2)(3) and (5). Congress noted that discrimination persists in the provision of “health services,” 42 U.S.C. §12101(a)(3), and established as a national goal “to assure... independent living... for such individuals.” 42 U.S.C. §12101(a)(8).

In order to accomplish the goals and objective of the ADA, Congress provided that “no qualified individual with a disability shall, by reason of such disability, be excluded from

participation in or be denied the benefits of the services, programs, or activities of a public entity,[2] or be subjected to discrimination by any such entity." 42 U.S.C. §12132. In order to flesh out the meaning of this broad anti-discrimination mandate, Congress directed the Attorney General to promulgate regulations implementing the public services title of the ADA. 42 U.S.C. §12134. The Attorney General's ADA public services regulations are codified at 28 C.F.R. §35.101 et seq. 28 C.F.R. §35.130 specifically provides that a public entity in providing any aid benefit or service, may not directly or indirectly;

> (b)(1)(ii) Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit or service that is not equal to that afforded others;
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> ***
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> (b)(1)(iv) Provide different or separate aids, benefits or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others.....
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> ***
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> (b)(1)(vii) Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service,
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> ***
>
> (b)(3) A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:
> (i) That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability; [or]
> (ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entities program with respect to individuals with disabilities;
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> ***
>
> (b)(7) 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;
>
> (b)(8) A public entity shall not impose eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully

[2] It is clear that defendants the Commonwealth of Massachusetts, the Executive Office of Health and Human Service sand the Division of Medical Assistance are public entities. 42 U.S.C. §12131 (1) (definition of public entity).

> and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program or activity being offered;
>
> ***
>
> (d) A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

When the defendants' medical assistance program as it applies to disabled individuals aged 65 and over in need of personal care services is evaluated against these regulatory criteria, it falls short with respect to each and every listed requirement.

The applicable anti-discrimination standards in 28 C.F.R. §35.130 can be separated into three distinct categories: 1) Prohibitions of disparate treatment of individuals with disabilities or any class of such individuals (§§35.130(b)(1)(ii), (b)(1)(iv), (b)(i)(vii), (b)(3), and (b)(8)); 2) the obligation to make reasonable modifications in policies, practices or procedures to avoid discrimination on the basis of disability (§35.130(b) (2)); and 3) the obligation to administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities (§35.130(d)).

1. The Integration Mandate:

In the Olmstead decision, the Supreme Court specifically considered the Title II integration mandate regulation, 28 C.F.R. §35.130(d) and concluded, not only that it was within the scope of the Attorney General's rulemaking discretion, but that it was virtually required by the underlying purpose of the ADA and its text. Olmstead v. L. C, 527 U.S. 581, 591-592, 119 S.Ct. 2176, 2182-83 (1999). As the Court explained:

> Recognition that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life... [citations omitted]. Second, confinement in an institution severely diminishes life activities of individuals,

> including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment... Dissimilar treatment correspondingly exists in this key respect: In order to receive needed medical services, persons with... disabilities must, because of those disabilities, relinquish participation in community life they could enjoy given reasonable accommodations....
>
> Olmstead, 527 U.S. at 600-01, 119 S.Ct. at 2187.

Mr. Hermanson's life following placement in a nursing home underscores the discriminatory harm attendant upon unwarranted institutionalization. While in the nursing home, he is separated from his wife, children and other family members. His ability to interact with them is severely curtailed. Affidavits of Ernast Hermanson, Edith Hermanson, and Sheila Chabot. While family contact is severely diminished, social interaction with friends is virtually non-existent. Compounding the social isolation flowing from institutionalization is the almost total inactivity experienced by Mr. Hermanson in the institution. Aff. of Ernast Hermanson at ¶7 . When Mr. Hermanson's daily life in the nursing home is contrasted with his daily life during his weekend visits home, the evils of unjustified confinement become palable. Affidavit of Ernast Hermanson at ¶8. Mr. Hermanson's plight is precisely what Congress intended to remedy through enactment of Title II of the ADA.[3]

Of course, it is not all institutionalization that is outlawed by the ADA; only that which is "unjustified". In the context of the integration mandate, institutional placement is unjustified if, based "on the reasonable assessment of [the State's] professionals... an individual 'meets the essential eligibility requirements' for habilitation in a community-based program." Olmstead, 587 U.S. at 602, 119 S.Ct. at 2188. Here all three of the plaintiffs seeking preliminary relief

[3] The experiences of plaintiffs Wimes and Ashley during their confinement in nursing homes further confirm the harm attendant flowing from institutionalization. See affidavits of Kopec and Wimes.

have been screened and evaluated by the State for personal care services in the community and been determined to be in need of and qualified to receive such services in the community. Affidavits of Ernast Hermanson, Helen Kopec and Della Wimes. As the Olmstead court noted, there can be "no genuine dispute concerning the status of [the plaintiffs] as individuals "qualified" for non-institutional care: The State's own professionals determined that community-based treatment would be appropriate for [them]." Olmstead, 587 U.S. at 602-03, 119 S.Ct. at 2188; see also Kathleen S. v. Dept. of Public Welfare, 10 F.Supp. 2d 460, 470-474 (E.D. Pa. 1998).

Lower courts which have considered whether states must provide personal care services to institutionalized individuals able to reside in the community with such services have determined that the integration mandate of 28 C.F.R. §35.130(d) requires the provisions of such services. Helen L. v. DiDario, 46 F.3d 325, 336-339 (3d Cir. 1995); see also, Sanon v. Wing, 2000 N.Y. Misc. LEXIS 139 at 12-24 (Sup. Ct., N.Y. Cty. 2000)(vacating denials of community-based personal care services and remanding for further consideration). In Helen L., the Third Circuit determined that where Pennsylvania had a program to provide personal care services in the community, it could not deny or delay providing those services to an institutionalized individual who qualified for them due to a lack of funding by the state legislature. Noting that the legislative objectives of the state's attendant care program (to enable disabled persons to reach maximum independence and to live in their home or in a less restrictive living arrangement) paralleled the policy and purpose of the integration mandate of the ADA, the Court easily rejected the suggestion that provision of such services to the plaintiff would fundamentally alter the program. Helen L., 46 F.3d at 337-38. In response to the

States undue burden/cost defense, the Helen L. court first explained:

> The fact that it is more convenient, either administratively or fiscally, to provide services in a segregated manner, does not constitute a valid justification for separate or different services under Section 504... or under [title II of the ADA].

Helen L., 46 F.3d at 338 (quoting H.R. Rep. 485 (III), 101st Cong. 2d Sess. 50, reprinted in 1990 U.S.C.C.A.N. at 473 (emphasis in original)). Noting that providing the community-based services would be less costly for the state, the Helen L. court easily dismissed the states administrative hardship defense. Id.

The Olmstead court did note that an analysis of a states' administrative hardship defense should "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 diverse population of persons with mental disabilities." Olmstead, 527 U.S. at 604, 119 S.Ct. at 2189. In Olmstead, the analysis was complicated by the fact that placing increasing numbers of mentally ill individuals in community placements might require the state to operate state hospitals at less than full capacity or to incur costs associated with the closure of institutions. The court was also concerned that relief accorded to the individual plaintiffs who commenced suit did not result in their gaining preferential treatment over other similarly situated individuals in need of a community placement. Olmstead , 527 U.S. at 606, 119 S.Ct. at 2190. Neither of these factors is present here. This case involves institutional placements in nursing homes, not state institutions. Whatever incremental impact this case might have on nursing homes will not constitute a cost to the state. Furthermore, unlike Olmstead, this case does not involve a capped benefit with a waiting list, but rather an entitlement for all who are eligible. In addition, this case is brought as a class action. The

concerns raised by the Olmstead court about inequitable treatment are simply not present here.

Nevertheless, the cost to the defendants of providing the requested relief, if sufficiently substantial in relation to their total health care budget, might provide a defense to some of the relief requested. However, there are numerous factors suggesting that such a defense is unlikely to succeed[4]. First, the fact that the defendants accorded the relief sought by plaintiffs to non-elderly disabled individuals is compelling evidence that it is not prohibitively expensive. Second, this case is limited to disabled individuals aged 65 and over who are in need of personal care services in the community to avoid institutionalization. While the exact size of the class is not yet known by the plaintiffs, this is a small subset of the Medicaid population and not likely to substantially affect the overall health care budget. Finally as the Olmstead court recognized, Olmstead, 527 U.S. at 595, 119 S.Ct. at 2184, and numerous studies have shown, community-based care is almost always less expensive than institutional care. L. M. Alecxih, S. Lutzky, J. Corea, and B. Coleman, Estimated Cost Savings from the Use of Home and Community-Based Alternatives to Nursing Facility Care in Three States 23 (AARP 1996)("Even in the study's most stringent analyses--which adjusted for national trends, greater impairment in nursing facility residents, and other government costs--home and community-based care resulted in savings")(copy included in Addendum of Authorities); GAO, Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs, GAO/HEHS-94-167 at 12-13 (1994)("One result of the shift to home and community-based care in these three states is that the states have been able to serve more beneficiaries with the Medicaid and state dollars

[4] Defendants, of course, bear the burden of proof on this affirmative defense. Kathleen S, 10 F.3d at 471.

they have available. This is because on a per-beneficiary basis, home and community-based care is considerably less expensive than nursing facility care.")(copy included in Addendum of Authorities).

Even if community-based care were shown to be more costly than institutional care, that would not justify discriminatory treatment of the class of disabled elders unless the increased cost were shown to be significant when measured against the health care resources of the Commonwealth. H.Re.p. No. 101-485(III), 101st Cong. & Admin News 445, 464. As Congress explained, even substantial costs may not be significant for ADA purposes when measured against the resources of a large program. See, Messier v. Southbury Training School, 1999 U.S. Dist. LEXIS 1479 at 36 (D. Conn. 1999)("Inadequate funding ordinarily will not excuse noncompliance with the ADA."). The state Medicaid budget exceeds $2,000,000,000 per year. 2000 Mass. Acts, c.159, line items 4000-0430,-0450,-0500,-0600,-0700,-0860,-0866,-0870, and -0880. The entire state health care budget is substantially more. In light of these substantial resources, any defense based upon cost is not likely to succeed.

The defendants may argue that provision of equal treatment to disabled seniors in need of personal care services would constitute a fundamental alteration of their medical assistance program. However, because the modification that plaintiffs seek has already been made by the defendants for the majority of program participants, it can hardly be found to be fundamental for purposes of the ADA. This is not a case in which plaintiffs are seeking a service that is not already being provided. Personal care services in the community are already included as part of the Massachusetts medical assistance program. 130 C.M.R. §§422.401 *et seq.* Extending that

service on an equal basis to disabled elders would hardly fundamentally alter the medical assistance program. Indeed, the Medicaid program as conceived by Congress itself prohibited the type of disparate treatment under scrutiny here. 42 U.S.C. §1396a(a)(10)(B) requires that medical services "shall not be less in amount, duration, or scope" between or among the categorically eligible or medically needy. Rolland v. Cellucci, 52 F.Supp. 2d 231, 238-240 (D. Mass. 1999); Sobky v. Smoley, 855 F. Supp. 1123, 1140-41 (E.D. Cal. 1994). In addition, "to determine eligibility of medically needy individuals, a Medicaid agency must use a single income standard ...." 42 C.F.R. §435.811(a). For medically needy individuals who are categorically related to the SSI program (i.e. the aged, blind or disabled), determination of whether such individuals satisfy the single income standard must be the same and no more restrictive than the SSI methodology. 42 C.F.R. §435.601(b). Putting these pieces together, the Medicaid Act mandates that all medically needy individuals who are categorically related to the SSI program regardless of whether they are over or under 65 years of age be treated the same. It is only because Massachusetts has obtained a waiver of these federal requirements pursuant to 42 U.S.C. §1315 that it has been able to engage in disparate treatment of disabled elders. However, requiring the defendants to restore their medical assistance plan to a position more in line with Congressional design can hardly be considered a fundamental alteration of the program.

2. Differential Treatment

The differential eligibility criteria, particularly the need to satisfy recurring deductibles, which make it substantially more difficult for disabled individuals aged 65 and over to obtain

and retain coverage for personal care services in the community (see detailed description of the differential operation of the system, above at 2-6) certainly do not "afford" elder disabled individuals in need of personal care services "an opportunity to participate in or benefit from [the medical assistance program] that is... equal to that afforded to others." 28 C.F.R. §35.130(b)(1)(ii). By forcing disabled elders into nursing homes in order to obtain personal care services, the defendants provide different or separate benefits or services to the class of elder individuals with disabilities in violation of §35.130(b)(1)(iv) and otherwise limit elder disabled individuals in their enjoyment of the advantages and opportunities enjoyed other disabled situated individuals in contravention of §35.130(b)(1)(vii). The defendants have adopted and utilize criteria, methods of administration and eligibility criteria that screen out or tend to screen out the class of elder disabled individuals from fully and equally enjoying the program in violation of §35.130(b)(3) and (8). In light of the relatively straightforward way in which the defendants differential eligibility rules contravene all of these regulatory provisions, it is hardly surprising that the one case which evaluated the legality of almost identical differential eligibility rules in a medical assistance program easily concluded that they violated both the ADA and §504. Burns-Vidlak by Burns v. Chandler, 939 F. Supp. 765, 769-773 (D. Haw. 1996). Like Massachusetts, Hawaii obtained a Medicaid waiver which dramatically expanded financial eligibility for all Medicaid recipients except the aged, blind and disabled. Burns - Vidlak, 939 F. Supp. at 765. The Court had no difficulty in concluding that such disparate eligibility criteria violated the ADA and §504 by discriminating against the disabled and blind. Burns - Vidlak, 939 F. Supp at 771-773. That Hawaii imposed its more stringent eligibility rules on all disabled individuals while Massachusetts only imposes its more restrictive rules on

those aged 65 and over is a distinction without a difference. As the regulations both implicitly and explicitly make clear, it is just as illegal to discriminate against "any class of individuals with disabilities" as it is to discriminate against any one individual or all individuals with disabilities. 28 C.F.R. §35.130(b)(1)(iv) and (b)(8). Any doubt about this point was removed by the recent Supreme Court decision in Olmstead v. L.C., 527 U.S. at 598 n.10,119 S. Ct. at 2186 n.10. The Court characterized the argument that a plaintiff cannot prove discrimination by demonstrating that one member of a protected group has been favored over another member of that group is "incorrect as a matter of precedent and logic." Id; see also Boots v Northwestern Mut. Life Ins. Co., 77 F. Supp. 2d 211, 218-219 (D.N.H. 1999). ("The point of [anti-discrimination] statutes is to eliminate classifications based upon irrelevant criteria. Certainly no one would suggest that because an employer is not required to provide a certain benefit, Title VII would allow it to provide that benefit to Asian employees and not to black or white employees"). So, too, that Massachusetts included disabled individuals under age 65 within the scope of its more liberal eligibility rules hardly justifies or makes any less discriminatory the exclusion of disabled individuals aged 65 and over.

3. The Obligation To Make Reasonable Modifications:

The obligation to make reasonable modifications in rules, policies or procedures that operate to deny or impede that ability of qualified individuals with the disabilities to gain equal access to and enjoyment of benefits, services and opportunities has been the cornerstone of disability discrimination law. See School Bd. Of Nassau County v. Arline, 480 U.S. 273, 287-88 and n. 17 (1987) (describing the reasonable accommodation construct as "well established"). The reasonable accommodation analysis is applied not only with respect to rules

or policies that directly operate to disadvantage individuals with disabilities, but more importantly, with respect to rules or practices that, while facially neutral, have a discriminatory impact on individuals with disabilities. Alexander v. Choate, 469 U.S. 287, 295-97 (1995), Helen L. v. DiDario, 46 F. 3d 325, 334-35 (3d Cir. 1995); United States Commission on Civil Rights, Accommodating the Spectrum of Individual Abilities 17 (1983). 28 C.F.R. §35.130(b)(7) simply reiterates that this well-established approach to disability discrimination analysis applies in the public services context.

Because the disparate Medicaid eligibility rules applied to disabled individuals aged 65 and over clearly and directly impede the ability of this group to obtain equal access to the benefits and services of the medical assistance program, §35.130(b)(7) obligates the defendants to make reasonable modifications in their polices, practices and procedures. Because this case involves disparate treatment, the required reasonable modification is direct and straightforward— affording disabled seniors in need of personal care services access to medical assistance based upon the same financial eligibility rules (including the one-time deductible rule) as disabled individuals under 65 years of age. Helen L, 46 F. 3d at 338; Makin v. State of Hawaii, Civ. No. 98-00997DAE, slip op. at 38-40 (D.Haw. 1999) ("Another argument is that forcing the State to provide services to all qualified individuals would force it to reconsider the program, its eligibility criteria, services provided, and whether to terminate it. This argument lacks substance because it fails to show that the modification itself would alter the program") (copy included in Addendum of Authorities). As discussed above, such a modification of program rules would neither fundamentally alter the program nor impose an undue burden on the defendants. See above at pp 17-20.

Whether analyzed under the integration mandate, disparate treatment, or reasonable accommodation provisions of 28 C.F.R. §35.130, the defendants differential eligibility rules which discriminate against elderly disabled individuals in need of such services to remain in the community violate Title II of the ADA. Certainly plaintiffs have made a sufficient showing of likelihood of success to justify the narrowly tailored preliminary injunctive relief sought by this motion.

II The Balance of Harms Tips Decidedly In Favor of Granting The Requested Relief

The harm to the plaintiffs if an injunction is not granted is palpable. Without the requested relief, Mr. Hermanson will not be able to leave the nursing home and be reunited with his wife and family. The handicapped accessible unit for which he and his wife have been approved effective October 1, 2000 will be lost and given to someone else. As his affidavit and those of his family members document, the harm attendant upon the unnecessary institutionalization to which he has been subjected is truly irreparable. Mr. Hermanson has been separated from his wife of 52 years and his family. He and his wife have had to abandon their life-long home. His wife has moved in with one of their children. Perhaps most significantly, in the nursing home, Mr. Hermanson is condemned to a life of isolation, boredom and inactivity. He literally spends twenty-two hours per day in bed. During his visits at home, he is up and about most of the day, going for "walks" in his wheelchair with his wife and other family members, going for car rides and visits to neighbors and friends, and otherwise engaging in activity and interaction with others. And, in the handicap accessible unit he will even be able to help with daily tasks like cooking or washing the dishes. As mundane as these activities may sound, for Mr. Hermanson, who in the nursing home is not able to do anything at all, the ability

to help out around the house will provide him with a measure of self-worth that has been absent for too long.

Both Helen Kopec and Della Wimes have been in nursing homes and their experiences parallel those of Mr. Hermanson. Both are at home now with assistance from personal care attendants paid for by Medicaid. However, on October 1, 2000 their current six month period of eligibility for Medicaid will end and they will have to satisfy large deductible before qualifying again. Because they do not have back bills with which to satisfy the deductible, their Medicaid will lapse. Without Medicaid, they like Mr. Hermanson before them, will be unable to pay their personal care attendants and, without their personal care attendants, neither Ms. Kopec nor Ms. Wimes can even get out of bed. They will be forced to leave their homes and return to a nursing home where they will no longer be able to exercise control and direction over their lives, but will instead be subject to the direction, control and schedule of the nursing home staff.

Not surprisingly, courts which have considered the question have easily concluded that "[t]he possibility that the plaintiffs would be forced to enter nursing homes constitutes irreparable harm." McMillan v. McCrimon, 807 F.Supp. 475 (C.D. Ill. 1992); see also, Kathleen S. v. Department of Pub. Welfare, 10 F.Supp. 2d 476, 481 (E.D. Pa. 1998)("these class members are irreparably injured every day they remain unnecessarily segregated in violation of the ADA"); Duggan v. Bowen, 691 F. Supp. 1487, 1498 (D.D.C. 1988); Lynch v. Maher, 507 F. Supp. 1268, 1271 (D.Conn. 1981); Daniel B. v. White, 1991 U.S. Dist. LEXIS 4925 at 7 (E.D. Pa. 1991)("Continued institutionalization of the class members, even for a short period of time, will cause irreparable harm"). Plaintiffs easily satisfy the irreparable injury requirement for

issuance of a preliminary injunction.

Measured against the severe and irreparable harm that will befall the plaintiffs in the absence of court intervention, the hardship to the defendants is virtually non-existent.

If Ms. Kopec and Ms. Wimes lose their coverage for personal care services in the community, they will be forced to enter a nursing home to obtain such services. They will immediately qualify for Medicaid upon entering a nursing home. Based upon their respective incomes and conservatively assuming the cost of their nursing home care at the public pay rate to be $105 per day,[5] the cost to the defendants if Ms. Wimes is forced to go into a nursing home would be at least $2265 per month. For Ms. Kopec the cost to the state would be at least $2494.[6] Were the injunction granted, the cost to the defendants of providing personal care services to Ms. Wimes and Ms. Kopec in the community is $2422.50 and $3277.50 per month, respectively.

Mr. Hermanson is not currently on Medicaid. However, his care at the Holyoke Soldiers Home is paid for by the Commonwealth of Massachusetts which operates the Soldiers Home through the defendant Executive Office of Health and Human Services. M.G.L. ch. 6A,

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[5] The average public pay rate (rate Medicaid pays) for nursing home care in Massachusetts in 1995 was $94.25 per day. J.M. Weiner and D.G. Stevenson, Long-Term Care for the Elderly and State Health Policy at 11 (Table 3)(Urban Institute 1997) (copy included in Addendum of Authorities). Adjusted for inflation, the cost today would be $105. Because health care inflation has generally exceeded that of the Consumer Price Index, this $105 per day is probably understated.

[6] The difference in cost is due to the difference in income between Ms. Wimes and Ms. Kopec. Under current Medicaid regulations, individuals in long term care must contribute all but $60 of their countable income towards the cost of their care each month. 130 C.M.R. §§520.025-520.26. These calculations do not include the possibility that either or both of these individuals would be entitled to a deduction for maintenance of their homes. 130 C.M.R. §520.026(D). If so, the state would pay the entire $3000 cost for Ms. Kopec and $2811 for Ms. Wimes.

§16; 2000 Mass. Acts, c. 159, line items 4190-0100 et seq. Mr. Hermanson pays $39.00 per month towards his room and board, with the balance of the cost (presumably in excess of $3000 per month) borne by the Commonwealth. Mr. Hermanson has been evaluated to be in need of 56 hours per week of personal care services by Stavros Independent Living Center, the agency designated by the defendant Division of Medical Assistance to conduct such reviews in this part of the state. The defendants would save approximately $850 per month were they to provide medical assistance to Mr. Hermanson so that he could obtain home-based personal care services.

Granting the requested relief will be essentially a break even situation for the defendants. However, even if it were, on balance to cost the defendants a few hundred dollars a month more to provide the plaintiffs with community-based care, that would hardly be a hardship. The combined budget for the operation of the various Medicaid programs run by the defendant Division of Medical Assistance (MassHealth, CommonHealth and related programs) exceeds $2,000,000,000 per year. 2000 Mass. Acts, c.159, line items 4000-0430, - 0450, -0500, -0600, -0700, -0860, -0866, -0870, and -0880. The small amount of money of issue in this motion does not even amount to a drop in the bucket. The balance of hardships tips decidedly in favor of the plaintiffs. Banks v. Trainor, 525 F.2d 837, 842 (7th Cir. 1975); Becker v. Toia, 439 F. Supp. 324, 336 (S.D.N.Y. 1977); Healy v. Commissioner of Public Welfare, 414 Mass. 18, 28, 605 N.E. 2d 279, 285 (1992).

CONCLUSION

For the foregoing reasons, plaintiffs respectfully request that this Court enter a preliminary injunction enjoining the defendants from failing or refusing to provide the plaintiffs

with Medicaid coverage on the same terms and conditions as it is provided to disabled individuals under age sixty-five pending the hearing and determination of this action.

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