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January 31, 2002

Ronald Preston
Associate Regional Administrator
Center for Medicare and Medical Services
Region 1
JFK Federal Building
Government Center
Boston, MA 02203

RE: Massachusetts State Plan Amendment

Dear Dr. Preston:

We represent the plaintiffs class in the case Hermanson et al. v. Cellucci et al., Civ. No. 00-30156 MAP (D. Mass). The class consists of disabled elders in need of personal care services in the community who are unable to qualify for such services through MassHealth due to the high recurring deductibles they are required to satisfy every six months and, as a result, are now institutionalized or are at serious risk of institutionalization in the near future.

On December 31, 2001, the Massachusetts Division of Medical Assistance in order to reasonably accommodate the Hermanson class submitted State Plan Amendment (SPA) 01-015 for approval. The SPA seeks to allow medically needy aged recipients a monthly disregard of unearned income equal to the monthly cost of authorized personal care attendant services up to an amount equal to $20 less than the difference between the medically needy income standard and 133% of the federal poverty level. We urge you to approve the accommodation contained in the SPA so that disabled elders can obtain the medical care they need in their homes, surrounded by family and friends, rather than being forced into a nursing home to obtain such care.

In Olmstead v. L.C., 527 U.S. 581 (1999), the U.S. Supreme Court held that Title II of the Americans with Disabilities Act requires states to provide services to qualified individuals with disabilities in the most integrated setting appropriate to their needs. One of the major claims in Hermanson is that the current Massachusetts Medicaid program violates this requirement by pushing disabled elders into nursing homes to obtain personal care services that could more appropriately and less expensively be provided to them in the community.

Following Olmstead, HCFA(now CMS) issued a series of letters to state Medicaid directors. In those letters, you emphasized to states that they have an obligation and "DHHS [has] a commitment to expanding home and community-based services and offering consumers choices in how services are organized and delivered." (January 14, 2000 letter to state Medicaid Directors). In four subsequent letters, HCFA reiterated these obligations and urged states to collaborate with "all relevant stakeholders.... to develop and implement comprehensive and effective working plans for providing services to all qualified individuals with disabilities in the most integrated setting." Olmstead Update No.2. And in Olmstead Update No. 5, HCFA identified the very barrier at issue in Hermanson, large recurring "spenddowns," as a cause of unnecessary institutionalization. Olmstead Update No. 5, Attachment 5-A.

On June 18, 2001, President Bush issued Executive Order 13217 in which he declared that :

(a) The United States is committed to community-based alternative for individuals with disabilities.....

(2) The United States seeks to ensure that America's community-based programs effectively foster independence and participation in the community for Americans with disabilities,

(3) Unjustified isolation or segregation of qualified individuals with disabilities through institutionalization is a from of disability-based discrimination.....

(4) The Federal Government must assist States and localities to implement swiftly the Olmstead decision so as to help ensure that all Americans have the opportunity to live close to their families and friends, to live more independently.... and to participate in community life.

In order to implement these goals, the President ordered federal agencies to work cooperatively with each other and the states to deliver services in the most integrated setting possible. The President also order the federal agencies under the leadership of HHS to review procedures and policies for compliance with the integration mandate and report back to him.

On December 21, 2001, Secretary Thompson submitted to the President a status report, Delivering on the Promise: Preliminary Report of Federal Agencies' Actions to Eliminate Barriers and Promote Community Integration. In the section on Health Care Structure and Financing, the first problem noted was the "institutional bias" of the Medicaid program. One of the items in a proposed "reform package" is to "let states disregard state-specified income or assets of HCBS waiver recipients specifically served through home and community-based services waivers (rather than apply such disregards to an entire Medicaid eligibility group)."

We have reviewed these agency and administration responses to the Olmstead decision because they confirm that the reasonable accommodation contained in the SPA submitted for your review furthers the administration's New Freedom Initiative. In response to our federal district court complaint, the Division, rather that defending a practice that clearly drove numerous elders into nursing homes prematurely, invited us to sit down and discuss possible

solutions. After numerous meetings during which a variety of possible approaches were presented by both sides, the parties were able to agree upon the accommodation encapsulated in the SPA.

Indeed, this particular resolution was inspired by the January 11, 2001 regulatory change in federal Medicaid rules which enhanced state flexibility in the use of less restrictive income and resource methodologies under §1902(r)(2). The preamble to the regulations suggested that states could use this enhanced flexibility to ameliorate the impact of large recurring spenddowns on the ability of individuals in the community to financially qualify for Medicaid. The preamble specifically identified the problem faced by the Hermanson class, placement in nursing homes because of the differential financial eligibility requirements for institutional or community-based care. 66 Fed. Reg. 2316 at 2319-20 (1/11/01). On May 11, 2001 HCFA issued technical guidance on the 1902(r)(2) regulatory change in question and answer format. Question A14 clarified that states can choose to disregard different kinds of income and question A15 made clear that states can disregard income that is used for a particular purpose. Building on these instructions, the parties crafted the reasonable accommodation contained in the SPA - - disregarding from unearned income the monthly cost of authorized PCA services (subject to a dollar cap). This appears to comply with the letter of the technical guidance and certainly comports with the intent of the 1902(r)(2) regulatory change by mitigating the harsh impact of large recurring spenddowns on disabled elders seeking community-based care. This disregard is available to the entire group of medically needy elders. That only some may benefit from it is no different than disregarding income placed in medical savings accounts or interest income which only some of the group may have. The SPA also further the goals identified in Executive Order 13217, the Olmstead decision, and the Olmstead state letters.

The SPA provides a needed framework by which the Hermanson litigation can be settled. If CMS does not approve this SPA, the litigation will proceed and both the Division and HHS [1] run the risk of greater financial exposure and programmatic revision if the more expansive relief sough by the plaintiff class is awarded.

Finally CMS should keep in mind that under Section 504 of the Rehabilitation Act, federal, as well as state, agencies are obligated to modify or even waive policies, rules, regulations or practices where necessary to reasonably accommodate qualified individuals with disabilities. 29 U.S.C. §794(a); 45 C.F.R. Parts 84 and 85; see also Galvez-Letona v. Kirkpatrick, 54 F. Supp. 2d 1218, 1224-1226 (D. Utah 1999) (requiring INS to waive statutory and regulatory oath requirements for disabled alien seeking naturalization). While we are confident that the SPA complies with current Medicaid rules and policies, any doubt or ambiguity should be resolved in favor of the SPA. And, should CMS feel that the SPA has crossed the line of permissible policy under federal income methodology rules, CMS should modify those rules to reasonably accommodate the disabled elders who need the SPA in order to access needed health care in the community, rather than in a nursing home.[2]

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[1] Pursuant to 42 C.F.R. §43.1250, HHS is obligated to provide FFP for any court-ordered relief. See also, Tinoco v. Belshe, 916 F. Supp. 974, 983-84 (N.D. Cal. 1985).

[2] Some question appears to have been raised about the appropriateness of an SPA that

will impact only a relatively small subset of the Medicaid population. We are aware of nothing in the 1902(r)(2) regulatory guidance or SPA requirements that precludes SPA's or 1902(r)(2) disregards that may affect only a small number of recipients, as long as the disregard is available to the entire eligibility group, which is true of the disregard in the SPA. Furthermore, where the SPA operates to reasonably accommodate the needs of a discrete group of disabled Medicaid applicants and recipients, it would be discriminatory to reject it for that reason. Indeed, it is our understanding that CMS requires that States use SPA's (or waivers) to implement reasonable accommodations that are systemic in nature, even though they may impact only a relatively small number of participants.

We urge you to promptly approve SPA No. 01-015. Should you have any questions or would like to further discuss any of the points raised in this letter, please contact me at 413-781-7826, ext. 131.

Yours very truly,

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cc: Tommy G. Thompson, Secretary
U.S. Department of Health and Human Services

Thomas E. Hamilton, Director
Disabled and Elderly Health Programs Group, CMS