

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

-----X
UNITED STATES OF AMERICA ex rel., :
DR. GABRIEL FELDMAN, :

Plaintiff, :

v. :

Civil No. 09 Civ. 8381 (JSR)
ECF Case

THE CITY OF NEW YORK, :

Defendant. :

-----X
UNITED STATES OF AMERICA, :

Plaintiff, :

v. :

THE CITY OF NEW YORK, :

Defendant. :

-----X

**MEMORANDUM OF LAW OF *AMICUS CURIAE*
IN SUPPORT OF THE CITY OF NEW YORK'S
MOTION FOR SUMMARY JUDGMENT**

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INTRODUCTION AND SUMMARY OF ARGUMENT

Amici are national, state, and local advocacy organizations representing people with disabilities who need Medicaid long-term care services, and organizations that work in New York State and elsewhere to ensure that public benefits programs are designed and operated in a manner that complies with the Americans with Disabilities Act [“ADA”]. *See*, Interests of *Amici*, annexed as Appendix. We urge this Court to consider the interests and rights of those Medicaid recipients who, though not before this Court as parties, will be the most impacted by the resolution of this litigation. This population is comprised largely of elderly persons and people with disabilities for whom access to 24-hour Medicaid personal care services [“PCS”] is vital to enable them to avoid institutionalization and remain in their homes.

The plaintiff United States [“the Government”] claims that New York City [“the City”] has unlawfully authorized PCS. The Government does not allege that the City filed false claims by granting personal care to people who were not poor enough to qualify for Medicaid, or who did not need Medicaid services. Instead, the Government claims that, for the small number of PCS recipients whose mental and physical disabilities are so severe that they undisputedly need extensive personal assistance,¹ the City has unlawfully provided that assistance, even though the alternative to doing so would have been to provide those same services in a nursing home, rather

¹ Under state regulations, PCS may be authorized for an amount of time ranging from several hours per week to 24 hours of continuous care—known as “split shift”—seven days per week. *See* N. Y. COMP. CODES R. & REGS. tit 18, §§ 505.14 (a)(6)(i)(b) and (a)(3). Only 1,200—or three percent—of the 42,800 people receiving PCS in December 2007 received 24-hour “split-shift” Medicaid personal care in New York City, the highest amount of services available, while 49% of PCS recipients received fewer than 7 hours/day (49 hours/week). Alene Hokenstad, United Hospital Fund, *An Overview of Medicaid Long-Term Care Programs in New York* (2009)(Table 3.1 p. 9), available at <http://www.uhfnyc.org/publications/880507>. This proportion has reportedly not significantly changed. The small number signifies two things — that those needing split shift care are a small outlier group, and that the City rarely approves split-shift care. In fact, in the experience of *amici*, few people obtain it without going to a fair hearing held by the New York State Department of Health.

than in the recipient’s own home in the community. The Government also claims that in a small number of cases the City authorized too much care for some people with undisputedly severe disabilities. *Amici* write to demonstrate to the Court that the City’s granting of these benefits was not a “false claim,” because they were required by the ADA, the Rehabilitation Act of 1973, and state-level administrative and judicial determinations regarding the administration of the PCS program. And finally, *amici* write to correct the Government’s suggestion that nursing homes provide individuals such as those profiled in the Complaint with a “higher level of care” than is provided by PCS in the home setting.

In making determinations regarding the authorization of PCS, the City must comply with state and federal Medicaid law and regulations, including technical recordkeeping and procedural requirements. *See* 18 NYCRR 505.14. The City must also comply with Title II of the Americans with Disabilities Act of 1990² [“ADA”], which requires the City to provide services to Medicaid-eligible individuals with disabilities in the most integrated setting. *Olmstead v. LC ex rel. Zimring*, 527 U.S. 581, 600-602 (1999); *D.A.I. v. Paterson*, 653 F. Supp. 2d 184, 187 (E.D.N.Y. 2009). Finally, the City must comply with a large body of judicial and administrative precedent governing the administration of the PCS program developed over decades of litigation and administrative review. To impose financial sanctions on the City for the small number of cases in which decision makers erred, if at all, on the side of maintaining vulnerable people in the community rather than sending them to nursing homes, sends a destructive message to state Medicaid programs nationwide and threatens to undermine clear national policy favoring integration.

² 42 U.S. C. § 12132.

Since the *Olmstead* decision, federal policy has increasingly encouraged states to “rebalance” their Medicaid long-term care services toward community-based services, reduce reliance on institutional settings, and to administer all their Medicaid programs in light of *Olmstead*’s mandate to provide services in the most integrated setting possible. A decision that subjects the City to sanctions unless it blindly defers to the Local Medical Director would lead to illegal reductions and denials of personal care services. The inevitable result would be increased institutionalization, a result diametrically opposed to the ADA’s integration mandate and clear national policy.

I. The Americans with Disabilities Act Mandates the Authorization of Personal Care Services that Prevent Institutionalization of Eligible Medicaid Beneficiaries

A. Olmstead Requires New York City to Provide Services in the “Most Integrated Setting”

The Government never acknowledges that the inevitable result of denying 24-hour care to individuals with extensive needs is increased institutionalization, which implicates the ADA. In the landmark decision of *Olmstead v. L.C.*, 527 U.S. 581, 600-02 (1999), the United States Supreme Court held that Title II of the ADA prohibits a government entity from causing the “unnecessary segregation” of people with disabilities by providing services in institutions when those individuals can receive services in a community-based setting. This obligation may be excused only where the public entity demonstrates that the requested modifications would “fundamentally alter” its service system or result in an undue financial or administrative burden. The Supreme Court’s opinion was based in part upon a regulation implementing the ADA that requires states and other government entities to administer services in the “most integrated setting appropriate to the needs of the qualified individuals with disabilities.” 28 C.F.R. § 35.130(d). The preamble to the ADA states, “Historically, society has tended to isolate and

segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;” 42 U.S.C. § 12101(2). Courts interpreting the ADA in the years since *Olmstead* have repeatedly recognized that a governmental entity’s failure to provide services to a qualified person in a community-based setting violates the ADA. See, e.g., *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1181-82 (10th Cir. 2003); *D.A.I. v. Paterson*, 653 F. Supp. 2d 184, 187 (E.D.N.Y. 2009); *Brantley v. Maxwell-Jolley*, 656 F. Supp. 2d 1161 (N.D. Cal. 2009); *Peter B. v. Sanford*, C.A. No. 6:10-cv-00767-JMC, 2011 WL 824584 (D.S.C. Mar. 7, 2011) (adopting report and recommendation of Magistrate Judge reported at 2010 WL 5912259 (D.S.C.)); *Pitts v. Greenstein*, Civil Action No. 10–635–JJB–SR, 2011 WL 2193398 (M.D. La. June 6, 2011).

The provision of Medicaid PCS enables individuals to receive their Medicaid services in the most integrated setting.³ For this reason, courts have enjoined cuts to existing Medicaid programs that provide services to allow individuals to remain in community-based settings. See,

³ The Center for Medicare & Medicaid Services (“CMS”), the federal agency administering the Medicaid program, has long recognized that PCS and other home care services are a critically important tool available to states to allow them to maintain individuals in the community and thus meet their obligation to provide services in the most integrated setting. See CMS, *Olmstead Update No. #3* (July 25, 2000), available at <http://www.cms.gov/smdl/downloads/smd072500b.pdf> with other State Medicaid Director letters at <http://www.cms.gov/SMDL/SMD/list.asp>. In this letter, CMS (then HCFA), in clarifying for states that eligibility for home health services could not be limited to individuals who are homebound, stated that:

The restriction of home health services to persons who are homebound to the exclusion of other persons in need of these services ignores the consensus among health care professionals that community access is not only possible but desirable for individuals with disabilities. New developments in technology and service delivery have now made it possible for individuals with even the most severe disabilities to participate in a wide variety of activities in the community with appropriate supports. Further, ensuring that Medicaid is available to provide medically necessary home health services to persons in need of those services who are not homebound is an important part of our efforts to offer persons with disabilities services in the most integrated setting appropriate to their needs, in accordance with the Americans with Disabilities Act.

e.g., *Fisher*, 335 F.3d at 1175; *Brantley*, 656 F. Supp. 2d at 1161; *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 994 (N.D. Cal. 2010) (granting injunction against law that would heighten requirements for in-home care, in part on theory that it would lead to unnecessary institutionalization in violation of *Olmstead*); *Peter B.*, 2011 WL at 824584; *Marlo M. ex rel. Parris v. Cansler*, 679 F.Supp.2d 635(E.D.N.C. 2010); *Pitts*, 2011 WL at 2193398; *Crabtree v. Goetz*, No. Civ. A. 3:08-0939, 2008 WL 5330506 (M.D. Tenn. Dec. 19, 2008).

Even the threat of institutionalization may constitute a harm serious enough to warrant granting preliminary injunctive relief against proposed cuts to home care and personal care programs. *See Pitts*, 2011 WL at 2193398. In recent policy guidance about enforcement of *Olmstead*, the United States Department of Justice Civil Rights Division opined,

...[T]he ADA and the *Olmstead* decision extend to persons at serious risk of institutionalization or segregation and are not limited to individuals currently in institutional or other segregated settings. Individuals need not wait until the harm of institutionalization or segregation occurs or is imminent. For example, a plaintiff could show sufficient risk of institutionalization to make out an *Olmstead* violation if a public entity's failure to provide community services or its cut to such services will likely cause a decline in health, safety, or welfare that would lead to the individual's eventual placement in an institution.⁴

In New York State, *Olmstead* was applied to enjoin the state "fiscal assessment law,"⁵ which generally barred authorization of 24-hour "split-shift" Medicaid PCS, based on their cost exceeding a limit set by the same statute. The Court held that application of the law would have resulted in unnecessary nursing home placements and therefore enjoined the law's enforcement, pending a remand to the State to establish the "fundamental alteration" defense to the ADA claim. *Sanon v. Wing*, No. 403296/98, 2000 N.Y. Misc. LEXIS 139, at *5 (Supreme Court, N.Y.

⁴ United States Department of Justice, *Statement of the U.S. Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.* (June 22, 2010), available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

⁵ N.Y. Soc. Serv. L. § 367-k, added L 1991, Ch. 165, § 23, eff. July 1, 1991, expired by a sunset clause July 1, 1999.

Co. Feb. 25, 2000).⁶ The *Sanon* court ruled that:

...[New York City and State R]espondents must address the requirements of the ADA in considering the provision of services. Unless respondents can demonstrate that accommodating Medicaid recipients who otherwise qualify for 24-hour home care would result in a fundamental alteration in the Medicaid program, respondents must provide services in “the most integrated setting appropriate to the needs of” petitioners. 28 CFR 35.130(d)....

Id. The state “fiscal assessment” statute expired under a sunset clause before the government respondents conducted the ADA fundamental-alteration analysis. *See supra* n. 5. In other cases, courts have ruled that costs to the public entity are not the only factor in evaluating a fundamental alteration defense, and that a “a state defendant cannot rely on budgetary constraints alone as the basis for a fundamental alteration defense.” *V.L. v. Wagner*, 669 F.Supp.2d 1106, 1122 (N.D. Cal. 2009) (enjoining California from implementing cuts to In-Home Supportive Services program); *see also Pa. Protection & Advocacy, Inc. v. Pennsylvania Dep’t of Pub. Welfare*, 402 F.3d 374, 380 (3rd Cir. 2005); *Townsend v. Quasim*, 328 F.3d 511, 520 (9th Cir. 2003).

B. New York’s City’s Personal Care Services Program Furthers Federal Policy by Reducing the Institutional Bias in Medicaid Spending

The *Olmstead* decision has brought about a sweeping change in national long-term care policy. Motivated in part by *Olmstead*, and by the *Olmstead*-consistent philosophy of maximizing independence, both Congress and federal agencies have acted to increase access to Medicaid home- and community-based services [“HCBS”]⁷ for persons in need of long-term

⁶ The statutory cost limit essentially prohibited 24-hour “split-shift” care, the same amount of service the Government challenges as excessive in the instant case.

⁷ The term “HCBS” is used in two ways – as the title for a specific group of Medicaid “waiver” services that provide community-based alternatives to institutional care, and more generically to describe a wide variety of community-based services funded by Medicaid as well as other payors. Medicaid PCS services are not “waiver” services but are one of many HCBS services in the generic sense. See U.S. Dept. of Health & Human Services, *Understanding*

care.⁸ Most recently, the Patient Protection and Affordable Care Act of 2010⁹ [“PPACA”] further expanded state opportunities to provide services in the community to Medicaid beneficiaries needing long term care.¹⁰

Despite this progress, nationally and in New York State, however, the provision of long-term care services remains slanted unduly toward institutionalization.¹¹ In 2009, the Medicaid expenditures for nursing home care in New York State amounted to \$6.8 billion, serving an average 90,701 Medicaid recipients per month, compared to \$2.5 billion spent on PCS, serving an average of 71,199 recipients per month.¹² With nearly three times as many Medicaid dollars

Medicaid Home and Community Services: A Primer (Oct. 2000) available at <http://aspe.hhs.gov/daltcp/reports/primer.htm>.

⁸ Beginning in 2000, Congress appropriated money for states to apply for Real Choice Systems Change Grants for Community Living. In the Deficit Reduction Act of 2005, Congress added the Money Follows the Person program to fund transitions out of nursing facilities, and the HCBS State Plan Benefit program to allow state Medicaid programs to more easily offer packages of HCBS. In the 2006 reauthorization of the Older Americans Act, Congress directed the Administration on Aging (AoA) and state aging agencies to reshape the long-term care delivery system to provide more HCBS. See Eric Carlson and Gene Coffey, National Senior Citizens Law Center, *10-Plus Years After the Olmstead Ruling – Progress, Problems and Opportunities* (2010) available at <http://tinyurl.com/olmstead-nslc-report>. See also CMS *Olmstead Update No. #3*, *supra n 3*, as an example of federal guidance implementing *Olmstead*.

⁹ PPACA, Pub. L. No. 111-148.

¹⁰ The PPACA expanded the Money Follows the Person and the HCBS State Plan Benefit programs. It also initiated a Medicaid State Balancing Incentive Payments Program that will give states financial incentives to increase the percentage of persons who receive long term care services through HCBS rather than in nursing homes. The law also added a new service—the “Community First Choice Option”—to Medicaid’s menu of benefits. PPACA, Pub. L. No. 111-148.

¹¹ In describing the *status quo* in 2010, Congress stated in enacting the PPACA, “Despite the ... *Olmstead* decision, the long-term care provided to our Nation’s elderly and disabled has not improved. In fact, for many, it has gotten far worse. ... Although every State has chosen to provide certain . . . [Medicaid] home and community-based [services,] . . . these services are unevenly available within and across States, and reach a small percentage of eligible individuals.” Pub. L. No. 111-148, § 2406.

¹² New York State Dep’t of Health, *Medicaid Expenditures for Selected Categories of Service by Category of Eligibility – 2009*, posted at http://www.health.state.ny.us/nysdoh/medstat/quarterly/aid/2009/cy/docs/2009_cy_aid.xls.

spent on institutional care for only 27 percent more people than received PCS, New York reflects the national bias toward institutionalization. New York City, however, where reliance on nursing home care is significantly less than it is in the rest of the state, deviates from the institutional bias in Medicaid spending. In its recent report on Medicaid PCS usage in New York City, the United Hospital Fund stated, “Personal care is a particularly substantial and important component of Medicaid long-term care service delivery and spending; 84 percent of Medicaid personal care spending statewide takes place in the city.”¹³ In comparison, only 53 percent of all nursing home spending statewide takes place in New York City, even though twice as many Medicaid recipients live in the City as the rest of the state.¹⁴ There is no doubt that the more robust PCS program in New York City, that includes 24-hour PCS availability, accounts for a higher ratio of community-based care in New York City.¹⁵

¹³ Sarah Samis, Michael Birnbaum, United Hospital Fund, *Medicaid Personal Care in New York City: Service Use and Spending Patterns* (2010), p. 1, available at <http://www.uhfnyc.org/publications/880720> [hereinafter “UHF Report - 2010”].

¹⁴ 1.389 million Medicaid recipients live outside of NYC compared to 2.717 million in NYC. NYS Dep’t of Health, *Medicaid Eligibles & Expenditures*, available at http://www.health.state.ny.us/nysdoh/medstat/el2007/2007-cy_eligibles.xls (based on 2007, last complete year posted at <http://www.health.state.ny.us/nysdoh/medstat/medicaid.htm#table2>) (accessed August 5, 2011). \$3.59 billion was spent by Medicaid for nursing home care in NYC compared to \$3.16 billion elsewhere in New York State; *Id.* at http://www.health.state.ny.us/nysdoh/medstat/ex2007/cy_07_ex.xls (based on 2007 data).

¹⁵ The higher ratio of community-based care in New York City is further enhanced by the lower reliance in New York State on HCBS waiver services compared to other states, where there are significant waiting lists for these services. In 2009, 340,000 adults were on waiting lists for waiver services nationally, not one of whom was in New York State. Unlike PCS, which, as a service under the state Medicaid plan must be available to those determined eligible with no waiting list, states may have a waiting list for waiver services. Kaiser Family Foundation, *New York: Waiting Lists for Medicaid 1915(c) Home and Community-Based (HCBS) Waivers* (2009) posted at <http://www.statehealthfacts.org/profileind.jsp?rgn=34&cat=4&ind=247>.

C. Medicaid Costs Would be the Same or Higher if Personal Care Services Were Denied or Terminated, Undermining the Assertion of “False Claims”

This is not a case where the Medicaid program has suffered a financial loss by virtue of services being provided to individuals who did not need them and qualify for them. The Government does not allege that patients A through G in the Amended Complaint did not need long-term care services. Rather, the complaint in essence asserts that the services should have been provided in a “higher level of care” setting, which, for persons with undisputedly extensive needs, amounts to nursing home care. Similarly, those patients who the Government claims should have received less than 24-hour daily care might well have required nursing home placement absent the provision of PCS because the inadequate hours would render it unsafe to remain home. Since the average monthly Medicaid payment for nursing home care in New York City is approximately \$7,500 per month,¹⁶ it is clear that, had funds not been expended on PCS, an equal or higher amount would have been expended on nursing home services for which the patients were undeniably eligible.

When weighing the cost to Medicaid of PCS versus nursing home care, one must include more than just the *per diem, per capita* cost. In considering whether the ADA permitted the state to limit PCS services on the basis of cost, the *Sanon* court directed that the ADA analysis must include whether “... there are increased hospitalization costs incurred when people are placed in [nursing homes] compared to hospitalization for those receiving home care.” *Sanon v. Wing, supra*. On that issue, a recent study found that average annual Medicaid spending *increased* after New York City Medicaid recipients

¹⁶ Based on NYS Dep’t of Health, *New York State 2009 Nursing Home Rates*, posted at http://www.nyhealth.gov/facilities/long_term_care/reimbursement/docs/nursing_home_rates_2009.xls (calculated by taking average daily rate for all nursing homes in the five boroughs of New York City, excluding pediatric and AIDS/HIV rates, multiplying by 365, and dividing by 12)

stopped receiving Medicaid PCS.¹⁷ Annual inpatient hospital costs that averaged \$1,628 for individuals receiving PCS skyrocketed to \$5,568 after they stopped receiving personal care.¹⁸ As expected, skilled nursing facility (nursing home) costs also skyrocketed from an annual average of \$260 for the study cohort while they were receiving personal care to \$23,248 after PCS stopped. These high Medicaid costs following the cessation of Medicaid PCS refutes the Government’s implicit assumption that the Government and taxpayers spent Medicaid dollars that would not otherwise have been spent in the absence of the City’s authorization of PCS.

II. Nursing Homes Do Not Provide a “Higher Level of Care” Than Personal Care Services in the Individual’s Home

The opinion of a Local Medical Director (“LMD”), such as Relator, that some PCS recipients are ineligible for PCS services and need to be placed in a nursing home (which the Government euphemistically refers to as a “higher level of care”)¹⁹ is often reversed by the State after a fair hearing (see Point III, *infra*), and, if sustained, would likely violate the ADA. In fact,

¹⁷ See *UHF Report – 2010*, *supra* n. 13, p. 14, Table 13.

¹⁸ This is all the more notable since this study solely concerned “dual eligibles,” those receiving both Medicaid and Medicare. *UHF Report – 2010*, *supra* n. 13, p. 2. For this population, Medicare is the primary payor of hospital costs. For those personal care recipients not included in this study, whose sole insurance is Medicaid—approximately 30 percent of this service population—these hospital costs would be significantly higher. *Id.*

¹⁹ Nursing home care is the only alternative for most PCS recipients who have 24-hour per day needs. The “Lombardi” long-term home health care waiver program has a monthly cost cap with aide service limited to roughly 36 hours a week in New York City. N. Y. Soc. Serv. L. § 367-c; Hokenstad, *United Hospital Fund supra* at n. 1, p. 9. “Beneficiaries may have to disenroll and seek services elsewhere if their needs increase above the threshold.” *Id.* Services by certified home health agencies, 18 N.Y.C.R.R. § 505.23, are primarily short-term visiting nurse and home health aide services following a hospital or rehabilitation stay. Long-term patients must be transferred to the PCS program within four weeks. N.Y. Soc. Serv. L. § 367-p. Managed long term care plans may authorize 24-hour care but average hours per week ranged from 32 to 50 in 2009 cost reports. N.Y. Pub. Health L. § 4403-f, amended L. 2011 Chapter 59, § 41; See *Personal Care Aide Utilization Comparison in Managed Long Term Care Plans in NYC* (4Q 2009), posted at <http://wnylc.com/health/download/258/>.

nursing homes do not generally provide a “higher level of care.” In a nursing home, the individuals profiled in the Amended Complaint and thousands of other PCS recipients like them would receive the same unskilled “level” of services as the PCS they receive in their homes. However, because of limited staffing, nursing homes are less able to attend to each resident, and thus maintain his or her health and safety, than is the PCS attendant who assists only a single individual in the home.

While it is true that nursing homes *can* provide skilled nursing services, most nursing home residents neither need nor receive *skilled* services.²⁰ Rather, most residents need and receive only *unskilled* assistance with activities of daily living from nurse aides and feeding assistants, the same level of care that PCS aides provide in the homes of PCS recipients.²¹ The individuals profiled in the Amended Complaint and others like them may need a higher *amount* or number of PCS hours, but not a higher *level of care*.²²

Furthermore, with no meaningful minimum staffing requirements enacted on a state or federal level,²³ most nursing homes do not have sufficient staff to provide long-term custodial

²⁰ Under the Medicaid program, a “nursing facility” provides nursing services *and/or* room and board and “physical care.” See 42 U.S.C. § 1396r; 42 C.F.R. § 483.10(c)(8)(i); N.Y. Pub. Health L. §§ 2801(2) and (4)(b); 10 N.Y.C.R.R. § 415.2(k). Medicaid services in a nursing facility may be provided by either registered or licensed nurses or certified nurse aides. See 42 C.F.R. § 483.30; 18 N.Y.C.R.R. § 505.9(e); 10 N.Y.C.R.R. § 505.9(e); 42 C.F.R. §§ 440.40, 409.31-409.33 with 42 C.F.R. § 440.167.

²¹ Medicaid PCS are provided by a trained personal care aide acting under nursing supervision. See N.Y. Soc. Serv. L. § 356-a (2)(e); 18 N.Y.C.R.R. § 505.14 (d)(e) and (f).

²² As in most cases involving individuals who have no skilled needs, but only require intensive assistance with activities of daily living, it appears that Patients D and E were safely maintained in their homes with 24-hour home care services for several years until the natural ends of their lives. See First Amended Complaint ¶¶ 49 and 50.

²³ See 42 CFR § 483.30(a) and (b); 10 NYCRR § 415.13(a)(2) and (b)(3)(generally requiring “sufficient” nursing staff and requiring [unless waived] that an RN be employed for a consecutive eight-hour shift, seven days a week, with one RN or LPN to serve as a charge nurse and requiring that facilities with an average occupancy of 61 or more residents also employ an RN as a full-time director of nursing).

care and services of reasonable quality, and as such do not provide a “higher level of care.” A 2010 study by the Kaiser Family Foundation found that limited on-site staffing contributed to a measurable increase in avoidable hospitalizations for long-term Medicaid nursing home residents.²⁴ In interviews, nursing home staff attested to their inability to provide adequate assistance to all the residents for whom they were responsible—sometimes 60 at a time—with resulting injuries to some residents. *Id.* In light of this testimony, it seems ironic that for “Patient C” profiled in the Amended Complaint, the LMD denied personal care services because of concern that the patient would be at risk “during the home attendant’s bathroom breaks when she would be unsupervised.” *See* First Amended Complaint ¶ 45. A number of reports show that, not only do nursing homes not provide a higher level of care, they also do not provide a higher quality of care or better health outcomes. 2001 study conducted for CMS concluded that minimum staffing levels of 4.1 hours of direct nursing care (including professional nurses and nurse aides) per resident per day are needed to avoid “critical quality of care problems.”²⁵ Studies indicate that between 92 and 97 percent of the nation’s nursing homes reported staffing levels that did not meet these recommended staffing levels.²⁶ In addition, a 2000 government

²⁴ Michael Perry et al., The Henry J. Kaiser Family Foundation, *To Hospitalize or Not to Hospitalize? Medical Care for Long-Term Care Facility Residents* 3, 4 (2010) posted at <http://www.kff.org/medicare/8110.cfm>.

²⁵ U.S. Dep’t of Health and Human Services, Health Care Financing Administration, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Phase II Final Report to Congress* (December 2001) 3-30 - 3-31 [hereinafter “2001 Report to Congress”] (citing 4.1 - 4.65 mean total of nursing aides or 2.4-2.8 hours per resident per day). *See also* John F. Schnelle, et al., *Relationship of Nursing Home Staff to Quality of Care*, *Health Services Research* 39:2, 225-250, 248 (April 2004) (confirming correlation between nursing home staffing and quality of care, particularly for nurse aide staffing above 2.8 hours per resident per day).

²⁶ 2001 Report to Congress *supra* n 24, 3-30, 3-31 (stating that “...it would be predicted that homes that report 2.8 to 3.2 [nurse aide hours per resident per day]. . . would perform significantly better than all other homes in ... [labor-intensive daily care activities, such as

study concluded that over 50 percent of U.S. nursing homes would have to double current staffing levels to meet these minimally adequate staffing ratios.²⁷ With the correlation between the sufficiency of nursing home staff and the quality of nursing home care well established,²⁸ the enhanced quality of care available through the one-on-one care of a PCS aide is a logical corollary.

Oversight surveys also reveal significant deficiencies in nursing home care nationally and in New York.²⁹ The U.S. Government Accountability Office found that in 2007, nursing

feeding assistance, toileting assistance, repositioning, and exercise care]); *see also* Schnelle *et al.*, *supra* note 24, at 227.

²⁷ *Id.* at 227, *citing* U.S. Department of Health and Human Services, Health Care Financing Administration, Executive Summary, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* (2000).

²⁸ Inadequate staffing is associated with limited feeding assistance, poor skin care resulting in decubitus ulcers or bed sores, lower activity participation, and less toileting assistance, while increased staffing is positively associated with fewer decubitus ulcers, fewer catheterized residents, and fewer urinary tract infections. *See* W.D. Spector & H. A. Takada, *Characteristics of Nursing Facilities That Affect Resident Outcomes*, 3 *Journal of Aging and Health* 427–54 (1991). Insufficient staffing also contributes to low morale and frustration among employees, which further decreases their ability to effectively and respectfully address resident needs. U.S. Dep’t Health and Human Services Office of Inspector General, *Psychosocial Services in Skilled Nursing Facilities* OEI-02-01-00610 at i-ii (2003). Inadequate staffing also places residents of nursing homes at greater risk of falling compared with those in the community, increasing their risk for injury, loss of physical functioning, and loss of social interaction. Clemens Becker & Killian Rapp, *Fall Prevention in Nursing Homes*, 26 *Clin. Geriatr. Med.* 693, 693 (2010); Meg Butler *et al.*, *The Risk of Hip Fracture in Older People from Private Homes and Institutions*, 25 *Age and Ageing* 381, 384 (1996). In addition, nursing home residents are also more vulnerable to depression. Namkee G. Choi *et al.*, *Depression in Older Nursing Home Residents: The Influence of Nursing Home Environmental Stressors, Coping, and Acceptance of Group and Individual Therapy*, 12 *Aging & Mental Health* 536, 544 (2008); *see also* Namkee G. Choi *et al.*, *Risk Factors and Intervention Programs for Depression in Nursing Home Residents: Nursing Home Staff Interview Findings*, 52 *J. Gerontological Soc. Work* 668, 682 (2009) (finding that nursing home staff attribute patients’ depressive symptoms to loss of autonomy and independence, social isolation, and loneliness).

²⁹ States monitor their own nursing homes by performing routine on-site “certification surveys” and on-site “complaint surveys” after complaints. The deficiencies found are categorized by both severity and by the perceived scope of the problem. NYS Dep’t of Health, *Detail of Certification and Complaint Survey in About Nursing Home Reports* (Oct. 2009) posted at http://www.health.state.ny.us/facilities/nursing/about_nursing_home_reports.htm#inspection.

homes nationwide were cited for an average of 7.0 deficiencies per home, and almost 74 percent of nursing homes surveyed were cited for quality-of-care deficiencies, including improper care relating to “nutrition, hydration, pressure sores, activities of daily living, infection control practices, range of motion, vision, hearing, urinary incontinence, medications, psychosocial functioning, and ability to care for residents with specialized conditions....”³⁰ State Survey reports have indicated that 113 of New York’s 657 nursing homes were cited for deficiencies that resulted in “*actual harm or immediate jeopardy*” to residents.³¹ At least part of these deficiencies likely stem from insufficient staffing.

The evidence indicates that nursing homes would provide neither a “higher level” of care nor care of a higher quality for the vast number of elderly and disabled Medicaid beneficiaries, including those identified in the Amended Complaint. These individuals, who need frequent and regular unskilled assistance with the wide range of activities of daily living, can be safely maintained in their homes with adequate amounts of home care services. They are more likely to receive the assistance they need at the time that they need it—and in the setting they and their families prefer—if they receive care in their homes rather than in nursing homes.

See, e.g., State Dep’t of Health, Deficiency Details, Certification Survey, August 2009, *posted at* http://nursinghomes.nyhealth.gov/nursing_homes/deficiency/629/RXCW (suggesting nursing home’s inability to assist individuals with severe dementia and or aggressive behaviors); State Dept. of Health, Deficiency Details, Complaint Survey, October 2010, *posted at* http://nursinghomes.nyhealth.gov/nursing_homes/deficiency/629/7N2V/printable (issuing deficiency citation for failing to supervise resident with dementia and risk of falls who eloped from nursing home).

³⁰ CMS, *Trends in Nursing Home Deficiencies and Complaints*, Publication No. OEI-02-08-00140 at 6 (September 2008); *See also* NYS Dep’t of Health, *Deficiency Categories: Quality of Care in About Nursing Home Reports* (October 2009), *available at* http://www.health.state.ny.us/facilities/nursing/about_nursing_home_reports.htm#comdefgoc (Accessed May 2011).

³¹ U.S. Government Accountability Office, *Nursing Homes: Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses*, Publication No. GAO-08-517 at 32 (May 2008).

III. The City Must Comply with a Body of Judicial and Administrative Precedent and Regulation in Authorizing Personal Care Services

The Government portrays the assessment of PCS as one in which the Relator, as the LMD, makes a final determination based solely on his or her medical opinion regarding an individual's functional needs and the hours of PCS needed. The reality is much more complex. A plethora of court decisions and settlements, as well as state and federal administrative precedent and guidance, provide additional layers of requirements to the assessment and authorization regulations. The Government absurdly suggests that the City must refuse to comply with administrative hearing decisions or policy directives issued by the State Department of Health, or even with federal court decisions, if they conflict with the LMD opinion. This is obviously not the case.

A. Due Process Rights, Codified in State Regulation, Prohibit the City from Terminating or Reducing Services on a "Re-authorization" Absent a Showing of Medical Improvement or other Change in Circumstances

Much of the Government's claim alleges that the City unlawfully re-authorized ongoing services without conducting the series of assessments required under 18 NYCRR § 505.14(b). The mere fact that a particular nursing or other assessment was not completed, or cannot be located, is hardly proof that an individual was not eligible for continuing PCS services and that the City was engaged in fraud. On the contrary, in *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996), the federal district court granted a preliminary injunction and class certification finding that the City had engaged in a pattern of illegally reducing PCS during the periodic re-authorizations. The Court found that these reductions were arbitrary and capricious and violated due process, and enjoined the City from reducing hours on reauthorizations unless there was evidence of medical improvement or a change in circumstances. The *Mayer* provisions were

subsequently promulgated as a regulation at 18 NYCRR 505.14(b)(5)(v).³²

The types of chronic medical conditions that afflict PCS recipients generally do not improve; rather, they steadily worsen over time. *See UHF Report - 2010, supra* n. 13. Their functional need for assistance becomes greater as they age and develop other conditions. With medical conditions that are degenerative but medically stable, more than 40 percent of elderly “dual eligible” PCS recipients had been receiving PCS for at least seven years, and another 21 percent for between four and seven years. *Id.* at 3. Absent a major new medical event, the onset of a new diagnosis that in some way disqualifies the individual from eligibility, or a change in social circumstances that reduces the need for Medicaid-funded services (such as the new availability of a son or daughter to provide informal care), there are simply no grounds to reduce or discontinue services at a routine re-authorization. The fact that a particular LMD might believe that an individual previously authorized for a certain amount of services could do with less care—or now needs a “higher level of care”—would not alone justify a reduction or discontinuance under *Mayer*. The Complaint cites the absence of certain assessments in the City’s files for Patients E and F as *per se* evidence that the City illegally re-authorized services. However, absent an adequate showing that the medical conditions or other circumstances of these individuals changed substantially, rendering them ineligible for services, there is simply no merit to the Government’s allegation.

³² Similarly, in *Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996), the district court held that PCS services could not be terminated without a pre-termination hearing after a temporary hospital stay, and required that an individual’s PCS services must be reinstated upon discharge from the hospital, pending a hearing. The State DOH codified this holding in guidance issued as NYS Dept. of Health Local Comm’r. Mem. 99-OCC-LCM-2 (April 22, 1999) posted at <http://www.wnylc.net/pb/docs/99OCCLCM2.pdf>.

B. Eligibility Criteria for PCS Must be Applied According to State Guidance, Administrative Precedent, and the ADA

The City's assessment of whether an individual is eligible for PCS, or instead needs a so-called "higher level of care," most commonly referring to nursing home care, must comply with state guidance, administrative precedent, and ADA regulations. The state PCS regulations include essentially two eligibility criteria: first, that the medical condition be stable and not require the skilled care of a nurse or other professional,³³ and second, that the individual be "self-directing," or, if not mentally able to direct her own care, have someone else to direct the personal care aide and make decisions about daily activities. .

On the second criterion, whether an individual is "self-directing," state guidance expressly lists behaviors of individuals who, though not self-directing, are nonetheless eligible for PCS as long as they have someone to direct their care:

- . . . a. the recipient may be delusional, disoriented at times, have periods of agitation, or demonstrate other behavior which is inconsistent and unpredictable;
- b. the recipient may have the tendency to wander during the day or night and to endanger his or her physical safety through exposure to hot water, extreme cold, or misuse of equipment or appliances in the home; or
- c. the recipient may exhibit other behaviors that are harmful to himself or to herself or to others such as hiding medications, taking medications without his or her physician's knowledge, refusing to seek assistance in a medical emergency, or leaving lit cigarettes unattended. The recipient may not understand what to do in a medical emergency or know how to summon assistance....

New York State Dep't. of Social Services, *Fiscal Assessment and Management of Personal Care Services*, Administrative Directive No. 92-ADM-49, p 5, *available at*

http://onlineresources.wnyc.net/pb/docs/92_adm-49.pdf. The fact that this directive lists these behaviors as typical of people who *are* eligible for PCS if they have someone to direct their care,

³³ 18 N.Y.C.R.R. § 505.14(a)(4)(i)(c)(defining "stable" as "...not expected to exhibit sudden deterioration ... and... does not require frequent medical or nursing judgment to determine changes in the ... plan of care..." and not in need of "skilled professional care").

shows that the Relator and other LMD's err by citing these symptoms as reasons to infer the individual needs a "higher level of care" than PCS."³⁴

Far from approving PCS for people who are not eligible, the City frequently errs by denying eligibility for PCS based on finding that individuals do not meet PCS eligibility criteria. These determinations are frequently found to be erroneous by the New York State Department of Health ["SDOH"] in decisions after administrative hearings. As the final decision of the State agency, these decisions are binding under *stare decisis* principles. *Charles A. Field Delivery Service v. Roberts*, 66 N.Y.2d 516, 495 N.Y.S.2d 111 (1985); *Long v. Perales*, 568 N.Y.S.2d 657 (2d Dept. 1991). *Amici* have successfully represented hundreds of individuals in these "fair hearings," in which SDOH has specifically reversed LMD findings that the medical condition is not "stable," that the individual needs a higher level of care, or that PCS is "not appropriate."³⁵

³⁴ See, e.g., First Amended Complaint, ¶¶ 49-50 (referring to LMD's conclusion that patient D, who appears to have a daughter who directs her care, should receive a "higher level of care" and should no longer receive split shift PCS because she "is unable to direct care, has inappropriate judgment, wanders, is up all night, and has shown oven/stove misuse;" referring to LMD's determination that Patient E's split-shift PCS should be discontinued because her condition was "unstable," as she "threatened to jump from the window, and will turn the stove on").

³⁵ *Amici* have compiled summaries of over 150 hearing decisions in which the State ordered the City to provide 24-hour split-shift care, or reversed determinations that individuals need a "higher level of care." See Selfhelp Community Services, Inc., *Medicaid Home Care Hearing Digest*, posted at <http://wnylc.com/health/file/106/> (see decisions coded as "SS" for split-shift and "HL" for "higher level of care"). Copies of any decisions cited in this memorandum of law are compiled and posted at <http://wnylc.com/health/download/259/>. In Hearing No. 5314839J (Sept. 18, 2009)(attached to Declaration in Support of City's Motion to Dismiss Complaint, Exhibit D, Docket entry 26-4 pp. 7-8 (11-12 of 13); also available at <http://wnylc.com/health/download/259/>), SDOH rejected the opinion of the LMD—known to be the Relator -- that the medical condition of advanced cancer was "unstable" merely because it was terminal, since it was not expected to exhibit sudden deterioration or require frequent nursing judgment. In Hearing No. 5585727L (Nov.1, 2010), available at http://www.otda.ny.gov/fair%20hearing%20images/2010-11/Redacted_5585727L.pdf and <http://wnylc.com/health/download/259/>, SDOH rejected the City's determination that the individual was not able to self-administer medication and wandered, so was ineligible for PCS).

The City's application of eligibility criteria for PCS must also comply with the ADA and its regulations, which provide, in part:

A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully 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.

28 C.F.R § 35.130(b)(8). Consistent with this non-discrimination requirement, the State has reversed City determinations denying care to individuals needing PCS due to mental, rather than physical impairments.³⁶ One-quarter of all PCS recipients—and 31 percent of “high intensity” recipients—have a mental health diagnosis; 22% of “high-intensity” PCS recipients have either dementia or Alzheimer's disease. *UHF Report - 2010*, supra n 13 at 8.

When the City determines whether health and safety can be reasonably maintained by PCS, it:

. . . must ensure that its safety requirements are based on actual risks, not on mere speculation, stereotypes, or generalizations about individuals with disabilities.

28 C.F.R § 35.130(h), published September 15, 2010. The LMDs' opinions finding PCS inappropriate must be rejected when based on such speculative generalizations. The City's

³⁶ In Hearing No. 5209193H (July 6, 2009), *available at* <http://wnylc.com/health/download/259/>, the State's reversal of the City's determination corrected a blatantly discriminatory denial of services based on the LMD's opinion that the applicant had no physical impairment. “The LMD incorrectly concluded that because the Appellant's medical condition (Alzheimer's) does not physically preclude the appellant from completing various personal care and chore tasks, the Appellant does not need assistance with and is independent for such tasks. On the contrary, as contended in...the medical request and the Agency's affiliation report, the Appellant, because of her neurological condition, is unable to perform or complete such tasks by herself.”

denial of PCS based on the Relator's opinion that Patient C in the Government's complaint was ineligible based on her psychiatric condition, for example, would violate the ADA.³⁷

C. The City's Determinations Regarding the Number of Hours of PCS to Authorize are Governed by a Multitude of Court Decisions and Administrative Precedent and Guidance

The Government claims that the City unlawfully authorized 24-hour PCS when it ignored the LMD's findings that Patients A, B and D had no "excessive" or "compelling" night-time needs. The City's determinations, however, must accord with a complex web of court decisions, settlements, and administrative hearing precedent and guidance. If an LMD's determination to deny or reduce services conflicts with these authorities, and under these other authorities an individual is entitled to PCS services, the City is correct in authorizing or maintaining PCS. Moreover, given the requirements under *Olmstead* described above, the City's authorization of PCS services in difficult "borderline" cases which prevent unnecessary institutionalization cannot be illegal or "false claims."

City PCS authorizations must comply with a State Medicaid directive that requires the provision of PCS to ensure "...the appropriate monitoring of the patient while [the PCS aide is] providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed."³⁸ This directive was issued to address a pattern in which the City and other local districts were wrongfully denying PCS based on their conclusion that the

³⁷ The LMD determined that Patient C was "no longer appropriate" for PCS services because she "engages in self-endangering behavior" such as "getting out of bed without assistance" which had resulted in falls." First Amended Complaint ¶ 45.

³⁸ NYS Dep't of Health, General Information System GIS 03 MA/003, *Rodriguez v. Novello*, Jan. 24, 2003 ["GIS 03 MA/003"], *posted at* http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/03ma003.pdf.

individual needed only “safety monitoring,” and not other PCS tasks. The State directive clarifies that PCS includes:

. . . the appropriate monitoring of the patient while providing assistance with the performance of a Level II personal care services task, such as transferring, toileting, or walking, to assure the task is being safely completed.

Id.

Numerous fair hearing decisions cite this directive as authority for reversing the City’s denials of PCS, and affirm that PCS is appropriate and necessary in the very instances in which the Relator would find the applicant needs a “higher level of care.”³⁹ For example, in Hearing No. 5304352Q, dated October 22, 2009, the State reversed the City’s decision relying on the Relator’s recommendation to deny services because the applicant needed “constant safety supervision to prevent further falls.” See, Declaration in Support of City’s Motion to Dismiss Complaint, Exhibit C, Document 26-3, Decision pp. 2, 8 (7 &13 of 15). Citing GIS 03 MA/03, the decision concludes that “any safety supervision Appellant may require is ancillary to assistance with indoor ambulation.” See, *Id.* at 9 (14 of 15).⁴⁰

³⁹ See, e.g., Hearing No. 5596164J (Jan. 10, 2011), available at http://www.otda.ny.gov/fair%20hearing%20images/2011-1/Redacted_5596164J.pdf and <http://wnylc.com/health/download/259/> (reversing denial of PCS based on an alleged need for a “higher level of care,” citing GIS 03 MA/003, and ordering 8 hours/day, stating, “[t]he premise upon which the LMD and the nurse’s assessment concluded that Appellant needs safety monitoring as a stand-alone function is puzzling, considering the totality of evidence presented at the hearing.”); See also Hearing No. 5029256Z (August 5, 2008), available at <http://wnylc.com/health/download/259/>.

⁴⁰ Another standard that would supersede a conflicting LMD opinion is the so-called “Mayer-3” rule prohibiting the use of “task-based assessment” for individuals who need 24-hour care, even if some of that care is provided by informal caregivers. The State agreed to codify this prohibition at 18 NYCRR 505.14(b)(5)(v)(d), in partial settlement of *Mayer v. Wing*, 922 F. Supp. 902 (S.D.N.Y. 1996), modified in part, unpublished Orders (May 20 and 21, 1996). Examples of fair hearing decisions reversing the City based on this standard include No. 5458362P (June 24, 2010)(ordering split-shift based on Mayer-3 and expressly rejecting the conclusion of the LMD – known by amici to be the Relator); and Hearing No. 4691096K (Feb. 6,

CONCLUSION

For the foregoing reasons, the reasons stated in the brief of the City, and any other reasons that may appear to this Court, the Government's motion for summary judgment should be denied and the City's motion for summary judgment should be granted.

Dated: August 12, 2011

Respectfully submitted,

s/ David Silva

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2007)(remanding to the City to assess whether appellant, who lives with daughter, is a Mayer-3 case); both available at <http://wnylc.com/health/download/259/>.