



DISABILITY RIGHTS

PENNSYLVANIA

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March 28, 2022

Lisa J. Pino
Director, Office of Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Complaint concerning the unlawful reduction of personal assistance services in Pennsylvania's Community HealthChoices Waiver program

Dear Ms. Pino:

Disability Rights Pennsylvania ("DRP") submits this Complaint on behalf of itself and its constituents, including [REDACTED], a participant in Pennsylvania's Community HealthChoices home and community-based services waiver ("CHC Waiver"), against Pennsylvania's Department of Human Services ("DHS") to challenge DHS's policies and practices that result in substantial reductions to CHC participants' personal assistance services. The reductions in CHC participants' personal assistance services place participants at imminent and unnecessary risk of institutionalization and/or unnecessary segregation in the community in violation of Title II of the American with Disabilities Act ("ADA"), 42 U.S.C. §§12101-12134, Section 504 of the Rehabilitation Act ("RA"), 29 U.S.C. § 794(a), and Section 1557 of the Patient Protection and Affordable Care Act ("ACA").

I. Summary

[REDACTED], a 35-year-old woman with multiple co-occurring medical diagnoses, is enrolled in the CHC Waiver. Due to her disabilities,

she is unable to walk and uses a wheelchair for mobility. She has significant memory and cognitive impairments that require around-the-clock supervision and cueing for her health and safety and is totally dependent on her caregiver for all activities of daily living (“ADLs”), including, locomotion, eating, meal preparation, transportation, toileting, bathing, dressing, housework, shopping, medication management, phone use, and financial management.

██████████ began receiving paid attendant care under the CHC waiver, which is called “personal assistance services” (“PAS”), for 63 hours per week in March 2018. These PAS services provide ██████████ with needed assistance to complete her ADLs and supervision to ensure her safety. PAS services enable ██████████ to remain in her own home and to engage in community life, including visiting family and participating in events at her son’s preschool.

In December 2020, ██████████ weekly PAS hours were arbitrarily reduced to 28 hours per week, despite the fact that 63 hours of PAS (and, arguably, more) remained medically necessary. While ██████████ partner and paid caregiver, ██████████, is willing to provide unpaid informal support beyond the 63 paid hours per week, he cannot for financial reasons continue to provide full-time, around-the-clock care for ██████████ while only being paid for four hours per day. Instead, if ██████████ PAS hours are not restored, he will need to work outside the home as he did prior to becoming ██████████ full-time caregiver to support himself, ██████████, and their three-year-old son.

Without adequate CHC-authorized PAS, ██████████ would be at significant risk of nursing facility placement, where she would be separated from her partner and young child, because she would be unable to remain safely in her home alone and to perform her ADLs. ██████████ wants to remain in her home in the community with her family and fears that the

56% reduction in her PAS hours to 28 hours per week will result in her being institutionalized.¹

██████████, unfortunately, is not alone. She is one of many CHC Waiver participants and DRP constituents who have been subject to substantial reductions in PAS that jeopardize their ability to continue to live in the community or participate in community life. As discussed below, since the continuity of care requirements ended, many CHC Waiver participants have been informed their PAS would be reduced. DRP, the protection and advocacy system designated by the Commonwealth of Pennsylvania pursuant to the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. §§ 15401-15045, and Protection and Advocacy for Individual Rights Act, 29 U.S.C. § 794e, has represented a number of these individuals directly to challenge their PAS reductions, in many cases successfully. DRP has also provided information and advice to other CHC Waiver participants subject to PAS reductions. Further, DRP has spent significant time and resources to advocate that DHS address the widespread reductions in PAS services for CHC Waiver participants.

II. DHS is Required to Ensure Approval of PAS Sufficient to Meet CHC Waiver Participants' Needs

Until recently, DHS, through its Office for Long-Term Living (“OLTL”) administered multiple Medicaid home and community-based services waivers (“HCBS Waivers”) to enable adults who need a nursing facility level of care to move to or remain in their own homes and communities. See [OLTL, Home and Community-Based Services Provider Handbook at 6-9](#) (Jan. 2014). Those HCBS Waivers included the Independence Waiver, Attendant Care Waiver, COMMCARE Waiver, and Aging Waiver. *Id.* While private service coordinators paid by DHS helped participants in those HCBS Waivers to develop their individual service plans, OLTL reviewed

¹ In support of this Complaint, DRP will provide documentary evidence, including the documents cited herein, upon request. In addition, ██████████ is willing to speak with investigators. DRP has other constituents who may be willing to speak with investigators upon request. Some of their experiences are referenced herein.

and made the ultimate decisions as to whether to approve the requested services and amounts of services in those plans. See *id.* at 10, 20-23.

Beginning in 2018, OLTL began the process of transitioning most of the participants in its HCBS Waivers to a mandatory managed care system, called Community HealthChoices. See [DHS, Welcome to Community HealthChoices! Implementation Timeline](#). Statewide implementation of that transition was completed on January 1, 2020. *Id.*

Community HealthChoices consists of both a “Section 1915(b)” managed care waiver authorized by 42 U.S.C. § 1396n(b) and a “Section 1915(c)” HCBS Waiver authorized by 42 U.S.C. § 1396n(c). See [Community HealthChoices Section 1915\(b\) Waiver Application](#), (Apr. 2017); [Community HealthChoices Section 1915\(c\) Application](#) (Jan. 1, 2022); [DHS, Who Is Served by CHC?](#)

The Section 1915(b) waiver provides all traditional Medicaid services for adults (such as physical healthcare, hospital visits, lab tests, prescriptions, as well as nursing facility services) available through Pennsylvania’s State Plan as well as service coordination to two groups of Pennsylvanians: (1) those who are dually eligible for Medicaid and Medicare and (2) those who require long-term services and supports due to a need for nursing facility care (which includes both individuals residing in nursing facilities and those eligible for the Community HealthChoices Section 1915(c) HCBS Waiver). See [DHS, Who Is Served by CHC?](#) This Complaint focuses on the Community HealthChoices Section 1915(c) HCBS Waiver.

Effectively, the Community HealthChoices HCBS Waiver consolidated and eliminated all but one of the prior OLTL-administered HCBS Waivers. See DHS, [Community HealthChoices Questions and Answers Document: Community HealthChoices Transition](#) Q3 (Dec. 2, 2019); [DHS, Long-Term Care Handbook](#) § 489.32. As a result, all Pennsylvania adults ages 21 and older who need a nursing facility level of care (and are financially eligible) and who were enrolled in one of the prior

OLTL-administered HCBS Waivers were transitioned to the Community HealthChoices HCBS Waiver and all new (i.e., post-transition) applicants who are determined to need a nursing facility level of care (and are financially eligible) are enrolled in the Community HealthChoices HCBS Waiver. See [DHS, Long-Term Care Handbook](#) §§ 489.32, 489.321.

Unlike OLTL's prior HCBS Waivers, DHS contracts with three managed care organizations ("MCOs") – PA Health & Wellness, UPMC Community HealthChoices, and Keystone First Community HealthChoices/AmeriHealth Caritas – to implement the Community HealthChoices HCBS Waiver.² See [Community HealthChoices Questions and Answers Document: Participant Enrollment](#) Q8; [DHS, Community HealthChoices General Assembly Overview PowerPoint](#), Slide 21 (Oct. 31, 2017). Pennsylvania pays the MCOs a per-member per-month rate and the MCOs are then responsible to contract with providers and provide the required services. See [DHS, Community HealthChoices General Assembly Overview PowerPoint](#), Slides 5, 7. Also, unlike OLTL's prior HCBS Waivers, the MCOs are not required to offer independent service coordinators to participants, but rather are permitted to use their own service coordinators, contract with private agencies, or do both. See [Community HealthChoices Questions and Answers Document: Service Coordination](#) Q1, Q3; [DHS, Community HealthChoices General Assembly Overview PowerPoint](#), Slide 15.

Services available through the Community HealthChoices HCBS Waiver include, *inter alia*, PAS. See [Community HealthChoices Section 1915\(c\) Waiver Application](#) at 84-88 (Jan. 1, 2022). PAS is designed to "primarily provide hands-on assistance, including cueing and supervision" necessary to enable participants "to integrate more fully into the community" and ensure their "health, welfare and safety ..." *Id.* at 85. PAS can include: (1) assistance with activities of daily living, including cueing to prompt the participant to perform the task and supervision to ensure safety if they cannot be left alone; (2) assistance with health maintenance activities; (3) provision of routine support services, such as meal planning and supporting the participant to keep medical appointments and other

² "AmeriHealth Caritas is known as Keystone First in the southeast zone." [Community HealthChoices Questions and Answers Document: Participant Enrollment](#) Q8.

health regimens; (4) assistance with therapies; (5) provision of overnight assistance for up to eight hours; (6) accompaniment into the community; and (7) transportation associated with the provision of PAS. *Id.* PAS also encompasses homemaker tasks for the sole benefit of the participant to ensure the participant's health, welfare, and safety, such as changing linens, doing dishes associated with meal preparation, laundering towels from bathing. *Id.*

DHS cannot compel a Community HealthChoices HCBS Waiver participant to obtain informal support to reduce the need for PAS. Informal support can only be provided by unpaid caregivers if they are "available, willing, and able to perform such activities" *Id.* at 86; see 42 C.F.R. § 441.301(c)(2)(v) ("Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports."). Instead, an enrolled HCBS waiver participant is entitled to receive all the covered services that he or she needs to live in the community. See U.S. Department of Health and Human Services, Healthcare Financing Administration (now CMS), [Olmstead Update No. 4., SMDL #01-006](#) at 5 (Jan. 10, 2001). MCOs providing services under the Community HealthChoices HCBS Waiver, including PAS, must assess the need of a particular individual participant for services under a "medically necessary" standard, which means that the service must meet at least one of the following criteria:

- Will, or is reasonably expected to, prevent the onset of an illness, condition or disability;
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability;
- Will assist a Participant to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Participant and those functional

capacities that are appropriate for Participants of the same age.

- Will provide the opportunity for a Participant receiving LTSS to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of his or her choice.

[2021 Community HealthChoices Agreement](#) at 21-22. Despite the implication suggested by the nomenclature, “medical necessity” does not require approval by a physician. Indeed, neither DHS nor its MCOs have any process for consulting with the participant’s physician in connection with the authorization, reduction or denial of PAS hours. Similarly, neither DHS nor its MCOs retain their own physicians to determine the medical necessity of PAS hours or to calculate or approve the number of PAS hours that will be authorized.

DHS imposed a “continuity of care” requirement on the MCOs, which required them to maintain the services of participants who had been enrolled in OLTL’s prior HCBS Waivers for a period of at least 180 days. See [Community HealthChoices Questions and Answers Document: Participant Related](#) Q10. Since the end of the continuity of care period, the Community HealthChoices MCOs have engaged in reviews of participants’ PAS services which have often resulted in significant and seemingly arbitrary reductions in services that are untethered to the participants’ needs. Without PAS services adequate to meet their needs and keep them safe in the community, CHC Waiver participants are at imminent risk of nursing home placement.

III. The Authorized 28 Hours of PAS Hours are Insufficient to Meet [REDACTED] Needs and Place Her at Imminent Risk of Institutionalization

[REDACTED] has a complex medical history that includes Guillain-Barre syndrome, Bickerstaff brainstem encephalitis, multiple sclerosis, polyneuropathy, depression, anxiety, and anorexia. [REDACTED]

disabilities also impact her cognitively. She is forgetful and impulsive, frequently attempting to do things independently because she forgets that she is unable. On numerous occasions, she has impulsively tried to transfer herself out of her wheelchair and fallen, which is particularly concerning given her history of brain injury. She has broken her foot six times and chipped her front teeth. She has impulsively grabbed hot pots and pans in the kitchen and dropped them, causing herself burns. Since March 2018 when 63 hours of PAS were authorized, [REDACTED] cognition and ability to care for herself have not improved. To the contrary, they have declined considerably.

[REDACTED], who was unrepresented, filed a grievance to challenge the December 2020 decision by her MCO, AmeriHealth Caritas Pennsylvania Community HealthChoices (“AmeriHealth”), to reduce her PAS hours from 63 per week to 28 per week. AmeriHealth’s service reduction decision was upheld by a grievance panel³ in February 2021 and an external reviewer⁴ in April 2021. [REDACTED] requested a fair hearing before DHS’s Bureau of Hearings and Appeals (“BHA”), which is conducted by an administrative law judge employed by DHS.

In May 2021, [REDACTED] filed a separate grievance seeking 63 hours of PAS per week after an assessment conducted in March or April 2021 resulted in authorization of only 28 hours of PAS per week. A grievance panel denied this request in May 2021. [REDACTED] requested a fair

³ “The Grievance review must be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance.” [2021 Community HealthChoices Agreement](#) at 281. At least one-third of the grievance review panel shall not be employed by the MCO and at least one panelist must be “a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question.” *Id.* DRP is unaware of instances in which the specialty of the physician panelist has been disclosed.

⁴ External reviews appear to be assigned to “independent review entities” that are “certified” by the Pennsylvania Department of Health. [2021 Community HealthChoices Agreement](#) at 283.

hearing before BHA. The two fair hearing requests were consolidated to be heard together, but, ultimately, did not occur.

In the summer of 2021, [REDACTED] experienced a significant medical setback. She was hospitalized with stroke symptoms and extreme weakness. According to her neurologist, Gabriel Pilar, M.D., [REDACTED] “suffered a devastating neurologic injury due to Bickerstaff’s brainstem encephalitis and Guillan Barre syndrome.” Following a multi-day hospitalization, [REDACTED] was transferred to a rehabilitation center for 10 days.

Since her discharge from the rehabilitation center, [REDACTED] condition and ability to care for herself has deteriorated extensively. [REDACTED] shakes regularly and is extremely fatigued. She becomes dizzy and vomits daily. She is often unable to get out of bed due to weakness and numbness in her extremities, extreme dizziness, nausea and pain. Prior to her hospitalization, [REDACTED] had attended physical therapy twice per week; however, following her hospitalization, her physical therapist advised that her participation is a health/safety risk due to her being extremely fatigued, in pain, shaking and vomiting during the sessions. [REDACTED] is fully dependent on her caretaker, [REDACTED], for all activities of daily living and for around-the-clock supervision as described in more detail below:

- Locomotion: [REDACTED] is unable to ambulate and uses a wheelchair for mobility. She is completely dependent on her caretaker to transfer her in and out of her wheelchair and to propel the wheelchair.
- Meal preparation and eating: [REDACTED] cannot prepare her meals or feed herself because she cannot lift utensils and often drops items due to the weakness in her hands and fingers. She is at risk of choking because she cannot feel food in her throat. [REDACTED] prepares and cuts [REDACTED] food into small pieces to minimize the choking risk and assists her in the event that she does choke. Due to her history of anorexia, [REDACTED] eats according to a meal

plan developed by her therapist and typically does not eat the same meals as her partner or son. [REDACTED] prepares and feeds [REDACTED] meals and snacks according to the plan.

- Bathing: [REDACTED] cannot bathe herself. She has tried using a shower chair, but she has fallen out. [REDACTED] bathes her multiple times per day to ensure proper hygiene, which is particularly important given that [REDACTED] is incontinent of bowel and bladder and vomits regularly.
- Toileting and toilet transfer: [REDACTED] has frequent bowel movements and uses the bathroom eight to 10 times per day. Because she cannot feel when she needs to use the bathroom due to nerve damage caused by her encephalitis, [REDACTED] wheels [REDACTED] to the bathroom, pulls down her pants, lifts her onto the toilet, wipes her and then reverses the process on a regular schedule.
- Personal hygiene: [REDACTED] brushes and styles [REDACTED] long hair into a ponytail. [REDACTED] requires [REDACTED] to perform tasks such as putting toothpaste on [REDACTED] toothbrush. Due to daily episodes of vomiting and incontinence, [REDACTED] ensures that [REDACTED] is changed into clean clothes and washes [REDACTED] after each episode.
- Bed mobility: [REDACTED] transfers [REDACTED] in and out of bed and repositions her every hour as recommended by her physicians to prevent bed sores and discoloration of her legs and feet, to ensure that she is comfortable, and to ensure that she does not choke on her vomit.
- Housework: [REDACTED] cannot perform housework. She is unable to make her bed, wash her clothes, wash her dishes or clean. [REDACTED] launders [REDACTED] clothes and cleans various pieces of furniture and [REDACTED] wheelchair daily due to her incontinence and vomiting. [REDACTED] also changes the

bedsheets overnight if [REDACTED] vomits or has an episode of incontinence. Due to concern for urinary tract infections, [REDACTED] cannot wear briefs or pads.

- Shopping: [REDACTED] cannot go shopping or pick up her prescription medications.
- Dressing: [REDACTED] cannot assist in dressing herself and has fallen out of her wheelchair trying. She cannot get her clothing out of her drawers or pull her pants up. [REDACTED] helps [REDACTED] guide her limbs into her clothing. [REDACTED] cannot put on socks or shoes or tie her shoes.
- Managing finances: [REDACTED] is fully dependent on [REDACTED] for management of her finances.
- Phone use: [REDACTED] cannot use the phone independently. She relies upon [REDACTED] to answer, dial, and hold the phone.
- Medication management: [REDACTED] relies entirely on [REDACTED] for medication management. He gives [REDACTED] her medications, cues her to take them, and supervises her while she takes them to ensure that she does not choke.
- Transportation: [REDACTED] does not drive and could not take public transportation without significant support. She relies fully on [REDACTED] to engage in community life.
- Supervision: As directed by her neurologist, [REDACTED] needs constant supervision and cannot safely be left alone due to her decrease in cognitive function, forgetfulness, and impulsivity. [REDACTED] takes [REDACTED] with him everywhere he goes. Approximately two or three times per week, [REDACTED] wakes up during the night and attempts to crawl and wander outside of the home. [REDACTED] helps her back to bed safely. [REDACTED] has a

significant history of falling and other injuries caused by her impulsivity and forgetfulness about her limitations.

AmeriHealth conducted another assessment on October 13, 2021, triggered by [REDACTED] hospitalization. Although [REDACTED] was represented by counsel, counsel was not notified of this assessment or given the opportunity to participate. Importantly, it was not clear to [REDACTED] that the phone call she received from her service coordinator was an assessment. By letter dated November 3, 2021, only 28 hours of PAS per week were approved. [REDACTED] filed a grievance to challenge this determination.

With the fair hearing before BHA scheduled for November 30, 2021, [REDACTED] MCO, AmeriHealth, agreed to reassess her (again), which effectively mooted the fair hearing. Her caregiver and attorney participated in the assessment, which took place on December 7, 2021. AmeriHealth's service coordinator reported an acute change in mental status, that [REDACTED] ability to make decisions had declined, and that [REDACTED] ability to care for herself had declined. The assessment reflected that [REDACTED] is totally dependent on her caregiver, which means that she requires "full performance by others during all episodes," for all activities of daily living other than phone use and eating. For phone use, [REDACTED] was documented to need oversight/cueing, and for eating, [REDACTED] was noted to require "extensive assistance, which is defined as "[w]eight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subparts." In addition, the assessment also documented (1) that [REDACTED] wanders and had done so on one or two of the past three days; (2) that [REDACTED] care professional does not believe that improved performance in physical function is possible; (3) [REDACTED] daily incontinence and the fact that she cannot wear pads or briefs; and (4) that [REDACTED] had fallen in the past 30 days. Significantly, the assessment documented that [REDACTED] is unable to continue the current level of unpaid care that he is providing.

AmeriHealth utilizes a “Personal Services Support Tool” (“PSST”) to assist in the calculation of PAS hours. According to Bernadette Johnson, a senior service coordinator supervisor for AmeriHealth, the PSST “is a guide that the service coordinators use to consider the time that it might be staffed by a direct care or personal care worker.” Ms. Johnson, who testified at a fair hearing for another DRP client, who successfully challenged the reduction of her PAS hours, asserted that “[t]he times that are documented [in the PSST] are subjective and they are reflect[ive] of the times that are reported [by the participant and/or caregiver].” According to Ms. Johnson at a fair hearing for another DRP client, and without specificity beyond her general contention, “[t]his can sometimes result in inflation where the hours reported in the [PSST] are over and above the amount that is typically and customarily approved as reasonably given by Medicaid.”

The PSST tool utilized by AmeriHealth in conducting the December 2021 assessment differs from the tool used to conduct the December 2020 assessment. The 2021 PSST includes space for the service coordinator to include comments describing the needs for assistance with each task, which [REDACTED] service coordinator included. It also includes a place for the service coordinator to note a change in functional status, which was noted on [REDACTED] December 2021 assessment. The 2021 PSST also includes a place to document informal support being provided. The December 2021 assessment yielded a need for 75.91 PAS hours per week with 10 hours per week provided informally by [REDACTED]. The resultant need for PAS hours was calculated at 65.91 hours per week, which exceeds the 63 hours requested by [REDACTED].

For each level of assistance recognized by AmeriHealth, AmeriHealth caps PAS time for each task. AmeriHealth recognizes six levels of increased need for assistance as follows: set-up help only, supervision, limited assistance, extensive assistance, maximal assistance, and total dependence. According to Ms. Johnson, the maximum allowable PAS time per task derives from “what is seen to be reasonable under the Department of Human Services’ guidelines as far as being provided by the Medicaid,

Pennsylvania Medicaid Program.”⁵ The amount of time noted in [REDACTED] [REDACTED] December 2021 PSST for each task did not exceed any of AmeriHealth’s caps for the corresponding level of assistance.⁶

The PSST allows support time to be reported for the following activities: housework, shopping, meal preparation, eating, walking, locomotion, bathing, dressing, toileting, toilet transfers, personal hygiene, and bed mobility.⁷ Time needed for assistance with other activities covered by PAS, including supervision/cueing for safety, medication management, transportation, financial management and phone use, is not accounted for by AmeriHealth’s PSST.⁸ As a result, [REDACTED] PSST does not include

⁵ No such guidelines were provided in response to DRP’s June 11, 2021 request to DHS under Pennsylvania’s Right to Know Law (“RTKL”) or in response to DRP’s direct request to AmeriHealth’s counsel.

⁶ AmeriHealth’s caps on PAS services defy reason even in the context of the system AmeriHealth utilizes. For example, a participant who needs extensive assistance with personal hygiene is permitted up to 30 minutes per day of PAS, but a participant who needs more assistance, i.e., maximal assistance, is limited to 15 minutes per day of PAS. In addition, although PAS services are required to be provided, if needed, for 24 hours per day, AmeriHealth’s PSST for participants without informal supports who are “totally dependent” for each activity of daily living considered by AmeriHealth will not yield daily around-the-clock PAS care even for participants who use the bathroom 10 times per day and eat three meals per day. Notably, while it appears that AmeriHealth’s arbitrary PAS caps are unlawful because they limit individualized, need-based services, in this case, [REDACTED] PSST does not reflect a request for PAS hours beyond the maximum allowable time per task as set by AmeriHealth.

⁷ Although it appears that [REDACTED] needed level of assistance with eating is at a level higher than “extensive assistance” and that [REDACTED] provides 24 hours of care per day, rather than the 20 hours that were documented, even with these potential errors, [REDACTED] assessment and PSST support a need for PAS in excess of the requested 63 hours per week.

⁸ The other two Community HealthChoices Waiver MCOs, PA Health and Wellness and UPMC, explicitly consider transportation, financial management, medication management and phone use in their PAS calculation tools. PA Health and Wellness also considers time for “community integration supports” and “additional risk/safety support” and UPMC considers time for “health and safety.” This disparity

the time that [REDACTED] spends supervising [REDACTED] to ensure her safety, managing her finances, managing and cueing her medication, providing transportation associated with PAS, and supervising and cueing her phone usage. According to Ms. Johnson, tasks that are not specifically identified on the PSST are to be captured in the service coordinator's case notes, but there does not appear to be a method for accounting for that time in the PSST. Nor is there any indication that this time was noted or otherwise included in the calculation of [REDACTED] authorized PAS hours.

Although Ms. Johnson stated that AmeriHealth requires that requests for more than 98 hours per week of PAS undergo review by "utilization management,"⁹ for reasons that have not been explained," the PSST's determination [REDACTED] request for 63 hours of PAS per week was sent to "utilization management" for review rather than authorized following the assessment.¹⁰ On December 13, 2021, "utilization management" from "ACFC Corporate" declined to authorize the requested 63 hours per week of PAS. Instead, only 28 hours per week was authorized. According to the case note prepared by the utilization management reviewer, the request for 63 hours of weekly PAS was denied because "there has been no change in medical diagnoses, informal supports, she spends less than an hour alone daily, and has available and willing informal support from her paramour who is her paid direct care worker and resides in the same home. Also, it is reported that the caregiver is caring for their 3 year-old [sic] son. Therefore, the current 28 hours per week along with the amount of informal support she receives should be sufficient to meet her needs." As set forth above, it

highlights the arbitrariness of the authorization of PAS in a manner that falls short of meeting participants' need for services.

⁹ According to Ms. Johnson, "utilization management" is a team of reviewers with unspecified "clinical experience, who have never met or spoken with the participant or caregiver.

¹⁰ DHS has not provided utilization management guidelines or criteria, or any criteria or instructions for calculating or approving PAS hours, despite request via the RTKL.

is not true that [REDACTED] condition was unchanged or that her caregiver was willing or able to provide all needed care while only being paid for four hours per day.

By letter dated December 14, 2021, [REDACTED] was informed that her MCO had approved only 28 of the 65.91 hours indicated by the PSST. According to the letter, AmeriHealth decided that 28 hours of PAS per week was sufficient to “meet [her] needs,” including her need for assistance with housework, shopping, cooking, bathing, dressing, hygiene, walking, locomotion, toileting. The denial letter states that “[t]he additional hours to help you with these tasks is denied. It is denied because based on your answers, you described the amount of care that you needed every day to stay in your home. You said you needed 28 hours per week to complete these tasks. Your paid caregiver is able to help you complete these tasks. You also said that you have some informal support who is willing, able and available to continue care. Therefore, your request for an additional 35 hours per week to help you with these tasks is denied.” In fact, at no point did [REDACTED], her caregiver, or anyone else on her behalf inform the MCO that she only needs 28 hours per week of PAS. Nor did [REDACTED] or her caregiver inform the MCO that he was willing and able to provide unpaid care for her beyond that amount. To the contrary, her caregiver must earn a living to support himself, [REDACTED], and their young child and, if he cannot be paid to provide care to [REDACTED] then he would need to leave the home to work full-time, leaving [REDACTED] without care and supervision for significant periods of time.

[REDACTED] filed a grievance to challenge the MCO’s decision to approve only 28 hours of PAS per week. On January 12, 2022, [REDACTED] participated in a grievance meeting.¹¹ In addition to the extensive

¹¹ In violation of the requirement that grievance panelists not be involved in previous decision-making on the matter at issue, the January 2022 grievance panel included a person by the name of Jessica Scott-Ritter, who served as the “non-employee voter.” Ms. Scott-Ritter also sat on the February 2021 grievance panel that denied authorization of 63 hours of PAS for [REDACTED]. [2021 Community HealthChoices](#)

information contained in AmeriHealth's file regarding [REDACTED] medical conditions and functional limitations, as well as the limitations on the availability of informal supports, [REDACTED] also submitted a letter from her neurologist, Dr. Pillar, who stated that [REDACTED] needs "continuous care." Dr. Pilar explained that [REDACTED] medical conditions have "left her with significant motor impairments (inability to walk) as well as cognitive impairments (severe limitation in short term memory and executive function difficulties)." Dr. Pilar noted that the combination of physical and cognitive impairments leads to impulsivity which could result in "severe injuries from falls, hard time getting in and out of bath tub [sic], not being able to drive, and not being able to do normal household ADLs." Dr. Pilar concluded that [REDACTED] needs to be constantly supervised and assisted "around the clock."

During the grievance meeting, [REDACTED], [REDACTED], and [REDACTED] counsel reviewed her medical diagnoses, her impulsivity and cognitive impairments, and the assistance [REDACTED] needs with her activities of daily living and to ensure her safety so that she can continue to live in the community and engage in community life. [REDACTED] explained that [REDACTED] goes with him "everywhere he goes" because it is not possible to leave her alone. [REDACTED] also described her fear of being institutionalized and explained that her neurologists have said that without the care that she is receiving she would not be able to remain at home. While he described it as "tough," [REDACTED] explained that he is able to care for [REDACTED] and his son by using a dedicated playroom for his son with a gate while [REDACTED] spends time on the couch outside the gate.¹² As to his ability to provide informal supports, [REDACTED] told that panel that he "love[s] her very much," but the "reality of life" is that he

[Agreement](#) at 281. DRP is aware of at least one other instance in which this requirement was violated.

¹² The couple's son now attends preschool five hours per week and participates in therapy outside the home.

cannot care for [REDACTED] “for free and be broke” as his family would starve and would not be able to pay the mortgage.

By Letter dated January 14, 2022, [REDACTED] was notified that the grievance panel upheld the decision to deny the requested additional 35 hours of PAS per week with the following explanation:

Based on review of all the information provided, including any new information provided and previously completed assessment tools, necessity has not been established for the requested services. The requested hours will not assist you in maintaining maximal capacity beyond the current Personal Assistance Services (PAS) hours per week you are already receiving. Based on the assessment tool and clarifying questions during the Committee meeting, you need help with housework and meal preparation. You also need help with bathing, personal hygiene, dressing, toilet transfers, toilet use, getting into and out of your bed, and eating. You do not walk and need help moving around your home. You confirmed during the meeting, you are not able to perform tasks without help. You informed the Committee your partner is able to care for both you and your son. Personal Assistance Services (PAS) hours are approved to provide hands-on assistance to help you complete tasks of daily living when no one else is available to provide assistance. There has been no significant decline in function or documentation of necessity to support the request. The approved 28 hours per week of Personal Assistance Services can be restructured for the day and evening, and used flexibly to meet your needs to maintain health and safety in the community.

This largely boilerplate reasoning does not completely capture the amount of support needed by [REDACTED] and incorrectly states that [REDACTED] condition did not significantly decline. It also does not explain how 28 hours of PAS per week can adequately meet [REDACTED] substantial needs. Importantly, it does not address [REDACTED] statement that he cannot continue to provide around-the-clock care for [REDACTED] while only being paid for 28 hours per week. While [REDACTED] is trying to sustain the level of care [REDACTED] needs while this process is going on, as a result of the service reduction, he and his family are limited financially, particularly now that [REDACTED] unemployment benefits have ended, and have had to obtain food from food banks. [REDACTED] requested an external review and a fair hearing to challenge this decision, both of which are pending.

Again, [REDACTED] situation is not isolated. DRP has represented or provided information and advice to many CHC participants whose PAS hours have been reduced, threatening their ability to participate in community life and even to live in their own homes rather than institutional settings. A sampling is below:

- A.R., a man in his 30s, has neurological, cognitive, and physical impairments that necessitate, among other things, significant assistance with ADLs and around-the-clock supervision and cueing to prevent wandering and to ensure his safety. For example, due to his disabilities, A.R. does not recognize hunger or having to go to the bathroom. A.R. enjoys participating in the Special Olympics and being on a bocci ball team. His assessment acknowledged that “[t]here are concerns with wandering.” A.R.’s assessment further documented that A.R. has “poor cognition” and “cannot be in the community unattended by his formal or informal support.” A.R.’s assessment reflected that he “is not able to live alone due to the need for 24/7 continued supervision due to [A.R.]’s poor cognition/decision making and judgement.” Although the tool used by his MCO to record the time required to perform certain tasks reflected the need for 70.71 hours of PAS per week, A.R.’s MCO, PA Health and Wellness, reduced his hours from 70 to 41 per week. A.R.’s father serves as his caregiver and is willing

and able to provide informal supports to ensure that A.R.'s need for assistance was met beyond the 70 hours per week of PAS that he had been receiving, but could not provide more unpaid care than he had already been providing. No reason for the reduction was provided. There had been no improvement in A.R.'s condition since his last assessment. DRP represented the man at his grievance meeting after which his PAS hours were restored.

- S.G. is a woman in her 20s with cerebral palsy, who lives with her mom. She cannot perform household chores, manage her finances, or manage her medication without substantial assistance, and needs her meals to be prepared and served. She requires assistance to bathe, brush her hair, dress, shop and use the phone. She cannot access transportation without assistance. She uses mobility aids, including a motorized wheelchair for ambulation and has a history of falls. She cannot transfer on and off the toilet or reposition herself/sit up in bed without assistance. S.G. enjoys community outings, particularly to visit her sister, and does not want to be isolated at home. She requires assistance to engage in community life. Her assessment noted a decline in ADL status. S.G.'s mother was willing and able to provide only minimal informal support beyond the 70 hours per week of PAS that S.G. had been receiving, which was staffed through a provider. S.G.'s assessment documented a need for 84.67 hours of PAS per week. However, S.G.'s MCO, PA Health and Wellness, reduced her PAS hours from 70 to 56 per week with only generic explanation. This decision was upheld by a grievance panel. DRP was engaged to represent S.G. in connection with her request for a fair hearing. In lieu of a fair hearing, the MCO conducted a reassessment. Following the reassessment, PA Health and Wellness approved 101 hours per week of PAS.

- E.L. is a 70-year-old woman with a number of co-occurring conditions that impact her mobility, ability to perform activities of daily living, and cognitive function and result in the need for assistance, cueing and supervision. She lives alone in her home in the community and had been receiving PAS 24 hours every day for 13 years when her MCO, Keystone

First Community HealthChoices, reduced her PAS hours to 56 per week. She has no informal supports. She needs around-the-clock supervision and assistance as supported by her clinical care provider, who stated, “[a]t this point, due to her symptoms, she requires full assistance with activities of daily living and cannot be left alone due to the tendency to lose consciousness unpredictably.” E.L. has dementia and is forgetful. She has left the stove on, has difficulty counting change, and has gone to doctor’s appointments on the wrong day. E.L. needs hands-on assistance with ambulation, including movement of her legs to the floor, and cannot use a walker due to weakness in her arms. E.L. also needs assistance with toileting and hygiene as she is incontinent, including overnight, and cannot use a bedside commode without assistance. No explanation was provided for the reduction in her PAS hours other than the conclusory assertion that 56 hours of PAS per week would be sufficient to meet her needs. DRP represented E.L. in connection with her grievance. The service reduction was upheld by a grievance panel. E.L. requested an external review and fair hearing. Her attorneys made several requests for documents regarding the calculation of PAS hours, specific to her case and more generally. Ultimately, the MCO offered to grant E.L. a “one-time-administrative approval” of the 168 hours of PAS per week until February 18, 2022. After the expiration of the “administrative approval,” E.L.’s MCO reassessed her and reduced her PAS hours again. She is currently being represented by counsel in connection with her request for a fair hearing.

- K.P., a woman in her 40s with long history of Lyme disease, morbid obesity, anxiety, fibromyalgia, and orthopedic and neurological impairments, was receiving 54 hours of PAS for years until her MCO, PA Health and Wellness, reduced her hours to 38 per week. After a grievance meeting, K.P.’s PAS hours were increased to 42 per week. An assessment conducted months later reflected the need for 54 hours of PAS per week; however only 42 were authorized because, according to the MCO, “your assessment showed that your personal assistance needs can be met with 42 hours of PAS per week.” No further explanation was provided. K.P. uses a wheelchair for mobility but cannot sit or stand for

long periods of time and is largely bed-bound. She needs substantial assistance with many of her activities of daily living, including preparing meals, bathing, dressing, getting to the bathroom, shopping, transportation and using stairs. Due to her disabilities, K.P. is also at significant risk of falling. K.P. lives with her husband, who was willing and able to provide some informal support, but he works outside the home 50 hours per week. He also is not willing to provide informal support during time he would otherwise spend with the couple's three young children in and out of the home. After DRP became involved, K.P.'s hours were restored following reassessment in lieu of the requested fair hearing.

- H.B., a man in his 50s with a history of chronic kidney disease and orthopedic and vision impairments that impact his ability to stand, ambulate, use the stairs, shop, access transportation, get in and out of bed, and hold utensils, was receiving 49 hours of PAS per week until his MCO, PA Health and Wellness reduced his weekly PAS hours to 28 without explanation and despite the fact that his assessment reflected the need for 49 hours of PAS per week. The assessment also noted dizziness and a need for assistance with medication management due to poor judgment and decision-making and forgetfulness. H.B. lives alone and has no informal supports. The reduction was upheld by a grievance panel, which nonsensically explained that H.B. failed to provide "additional information...indicating your PAS time requirements were higher than what was previously approved." Following a reassessment in lieu of a fair hearing, which yielded the need for 49.11 hours of PAS per week, PA Health and Wellness restored H.B.'s PAS hours.

- S.T., a woman in her 50s with multiple sclerosis, was receiving 98 hours of PAS per week until her MCO, AmeriHealth, reduced her weekly PAS hours to 70 based on a telephone call with her service coordinator that was not identified or noticed as an assessment. After S.T. filed a grievance, her PAS hours were partially restored to 82 hours per week. DRP was engaged to represent S.T. at her fair hearing. Although AmeriHealth offered a re-assessment in lieu of a fair hearing, S.T. opted to proceed with the fair hearing. The administrative law judge restored S.T.'s

hours after concluding that she was not notified that a call she had with her service coordinator was an assessment and an outdated or incorrect PSST was utilized to calculate S.T.'s PAS hours.

The arbitrariness of these reductions – with no transparent standards, individualized reasoning, or inconsistent processes – is highlighted by the fact that the MCOs' often promise reassessments in order to avoid review in fair hearings.

IV. The Significant Reduction of CHC Participants' PAS Hours, Despite Medical Necessity, Violates the ADA's and RA's Integration Mandates

Title II of the ADA prohibits public entities, including state government agencies like the DHS, from excluding individuals with disabilities from their programs, services, or activities, or otherwise subjecting them to discrimination. 42 U.S.C. § 12132. Section 504 of the RA similarly bans disability discrimination by recipients of federal financial assistance, including DHS. 29 U.S.C. § 794(a). Finally, the ACA provides that no health program or activity that receives federal funds may exclude from participation, deny the benefits of their programs, services, or activities, or otherwise discriminate against a person protect by Section 504 of the RA. 42 U.S.C. § 18116(a). The prohibition on disability-discrimination embodied in Section 504 of the RA (and, therefore, Section 1557 of the ACA) is co-extensive with that of the ADA and courts construe them similarly, *see Furgess v. Pennsylvania Dep't of Corrections*, 933 F.3d 285, 288 (3d Cir. 2019); *Berardelli v. Allied Services Inst. of Rehab. Med.*, 900 F.3d 104, 114-18 (3d Cir. 2018); *Frederick L. v. Dep't of Human Services*, 364 F.3d 487, 490 n.2, 491 (3d Cir. 2004) (integration mandate case).¹³

Rather than delineate the specific forms of discrimination outlawed by Title II of the ADA, Congress instead directed the United States Department of Justice ("DOJ") to promulgate regulations that would be

¹³ Accordingly, references to the "ADA" in this Complaint are intended to encompass Section 504 of the RA and Section 1557 of the ACA as well.

consistent with the coordination regulations of Section 504 of the RA codified at 28 C.F.R. Pt. 41. 42 U.S.C. §§ 12134(a)-(b). Adhering to that directive, DOJ promulgated the “integration mandate” to implement Title II, which is virtually identical to 28 C.F.R. § 41.51(d), providing:

A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

28 C.F.R. § 35.130(d).

DOJ’s integration mandate is fully consistent with the goals of Congress. Not only is it modeled on a virtually identical regulation in 28 C.F.R. pt. 41, as required by 42 U.S.C. § 12134(b), but it also addresses a key finding that inspired Congress’s enactment of the ADA in 1990. Specifically, Congress recognized that “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 societal problem.” 42 U.S.C. § 12101(a)(2).

Interpreting the ADA’s integration mandate, the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999), determined that unnecessary segregation of individuals with disabilities in institutions violates the ADA. *Id.* at 600. Rejecting arguments that unnecessary institutionalization cannot constitute unlawful “discrimination” under the ADA because only people with disabilities are institutionalized so there is no comparison group, *id.* at 598, the Court explained that the integration mandate reflects “two evident judgments.” *Id.* at 600. First, it noted that “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life.” *Id.* Second, it wrote that “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work

options, economic independence, educational advancement, and cultural enrichment.” *Id.* at 601.

Having determined that unnecessary institutionalization can constitute “discrimination” under Title II of the ADA, the Court held that public entities must provide institutionalized persons with community-based services when: (1) such services are appropriate; (2) the individuals do not oppose community-based services; and (3) provision of community-based services can be reasonably accommodated, taking into account the resources available to the public entity and the needs of others with disabilities who are receiving services from the entity. *Olmstead*, 527 U.S. at 587, 607. Once these factors are shown, the burden shifts to the public entity to establish that the requested modifications would “fundamentally alter” its program. *Id.* at 604-07.¹⁴

While *Olmstead* involved plaintiffs who were unnecessarily institutionalized, DOJ has unequivocally concluded that the ADA’s integration mandate applies as well to individuals who are at “serious risk of institutionalization or segregation.” As DOJ explained:

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.

U.S. Dep’t of Justice, [Statement of the Dep’t of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*](#), Q6 (Rev. Feb. 25, 2020) (hereafter, *DOJ Olmstead Statement*).

¹⁴ The public entity bears the burden to prove that the proposed accommodations would fundamentally alter its program. See *Brown v. District of Columbia*, 928 F.3d 1070, 1077 (D.C. Cir. 2019); *Steimel v. Wernert*, 823 F.3d 902, 916 (7th Cir. 2016); *Frederick L.*, 364 F.3d at 492 n.4.

All federal appellate courts that have considered the issue have likewise concluded that a serious risk of institutionalization is sufficient to give rise to a claim under the ADA's integration mandate. See *Waskul v. Washtenaw County Community Mental Health*, 979 F.3d 426, 460-61 (6th Cir. 2020); *Davis v. Shah*, 821 F.3d 231, 261-63 (2d Cir. 2016); *Pashby v. Delia*, 709 F.3d 307, 322 (4th Cir. 2013); *M.R. v. Dreyfus*, 697 F.3d 706, 720, 734-75 (9th Cir. 2012); *Radaszewski ex rel. Radaszewski v. Maram*, 383 F.3d 599, 608, 615 (7th Cir. 2004); *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1181-82 (10th Cir. 2003). Federal district courts have reached the same conclusion. See *M.G. v. New York State Office of Mental Health*, No. 19-CV-639 (CS), 2021 WL 5299244, at *5, *8 (S.D.N.Y. Nov. 15, 2021); *U.S. v. Mississippi*, 400 F. Supp. 3d 546, 553 (S.D. Miss. 2019); *Parrales v. Dudek*, No. 4:15cv424-RH/CAS, 2015 WL 13373978, at *5 (N.D. Fla. Dec. 24, 2015). As the Tenth Circuit explained: "*Olmstead* does not imply that disabled persons who, by reason of a change in state policy, stand imperiled with segregation, may not bring a challenge to that state policy under the ADA's integration mandate without first submitting to institutionalization." *Fisher*, 335 F.3d at 1182.

Two federal appellate courts have further held that the ADA's integration mandate, as interpreted by *Olmstead*, also bars segregation outside of the institutional context entirely. In *Steimel*, the state involuntarily transferred individuals with developmental disabilities from one Medicaid HCBS waiver to another HCBS Waiver which offered less extensive services and supports. *Id.* at 908. As a result, the plaintiffs alleged that their ability to participate in community activities was greatly reduced. *Id.* The Seventh Circuit held that isolation in the home for a person "who can handle and benefit from' time out in the general community is also inconsistent with the integration mandate." *Id.* at 910 (citation omitted). Indeed, the court acknowledged that "although family relations might be enhanced at home if people are around, isolation in a home may often be worse than confinement to an institution on every other measure of 'life activities' that *Olmstead* recognized." *Id.* at 911. The court, citing DOJ's *Olmstead* Statement, also noted that "integrated

settings” are settings that enable individuals the opportunity to interact with nondisabled persons to the maximum extent possible and offer access to community activities at time, frequencies, and with persons of the individual’s choosing. *Id.*

The Sixth Circuit in *Waskul* followed the Seventh Circuit’s reasoning in *Steimel*. In *Waskul*, five individuals with developmental disabilities, some of whom required 24/7 care, received Medicaid services through a public managed care program. *Waskul*, 979 F.3d at 436. Like private managed care organizations, the managed care programs in *Waskul* received a fixed amount of funding to serve all persons who participate in the program and must then distribute those funds among participants with the risk that they will lose money if the amount of services it provides exceeds its capitation funds. *Id.* at 437. Participants in those programs had service plans developed and budgets allotted based on the amount of services in the plan. *Id.* In 2012, the plaintiffs’ managed care plan changed its methodology for establishing participants’ budgets. *Id.* at 438. While the services in the plaintiffs’ plans remained unchanged, plaintiffs contended that the budget methodology change effectively reduced the hourly rates they could pay providers to maintain the level of services identified in their plans because it forced them to lower rates and made it difficult to find staff willing to work for those lower rates. *Id.* at 438-39. Plaintiffs alleged, *inter alia*, that the budget change violated the ADA’s integration mandate by effectively institutionalizing them in their own homes. *Id.* at 460. The Sixth Circuit determined that plaintiffs’ isolation at home can violate the ADA’s integration mandate. *Id.* at 462-64. In doing so, the court noted that the animating reasons for the ADA’s integration mandate identified in *Olmstead* – i.e., that institutional placement perpetuates assumptions that people with disabilities are incapable or unworthy to participate in community life and that it severely diminishes their everyday activities – “are as present when individuals are confined in home settings because that situation ‘can just as severely diminish[] the everyday life activities’ of people with disabilities.” *Id.* at 462 (quoting *Olmstead*, 527 U.S. at 601). The court further determined that plaintiffs’ allegations were sufficient to state an ADA

integration mandate claim under that theory as they detailed how much less time they could spend in the community due to the budget changes. *Id.* at 462-63. Acknowledging that the plaintiffs' allegations suggested that they were able to spend "considerably more time outside the home" than the plaintiffs in *Steimel*, the court nonetheless allowed the plaintiffs' to pursue their ADA claim reasoning that "there is no numeric threshold that distinguishes 'the most integrated setting' from a less integrated one." *Id.* at 463. Although the more hours a person can spend outside the home may make a violation of the ADA's integration mandate less likely, "the simple fact that Plaintiffs have more than twelve hours outside the home per week does not foreclose their claim that they have been unjustifiably isolated at home." *Id.*

Here, CHC Waiver participants who are or in the future may be subjected to arbitrary reductions in PAS that are insufficient to meet their needs are at serious risk of institutionalization. DHS has failed to require that its CHC Waiver MCOs implement policies and practices (including training staff) to ensure that participants have consistent access to medically necessary PAS, including services needed for supervision and safety, cueing, and assistance with activities of daily living. As a result, participants have been subjected to unjustified reductions in PAS that could lead to a decline in their health, safety, or welfare and their eventual placement in nursing facilities.

The seriousness of a risk of institutionalization can be established if the reduction of services forces participants to rely on family members or other voluntary caregivers who cannot provide sustained, long-term care, placing them in a precarious situation that they will be institutionalized if that makeshift system of supports collapses. *See Waskul*, 979 F.3d at 461; *see also Mitchell ex rel. Mitchell v. Community Mental Health of Central Mich.*, 243 F. Supp. 3d 822, 840-42 (E.D. Mich. 2017) (holding that plaintiffs stated ADA integration mandate claim based on reduction of their nighttime supervisory care, which placed them at risk of institutionalization); *Parrales*, 2015 WL 13373978, at *5 (holding that plaintiffs stated ADA integration mandate claim that Medicaid MCOs' denials, delays, or

insufficient provision of in-home services could result in their institutionalization in nursing facilities); *V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1119-20 (N.D. Cal. 2009) (holding that plaintiffs were likely to succeed on merits of ADA integration mandate claim challenging statutory changes in assessment process used to determine eligibility for and needed amount of in-home services – including services to remind them to take medication and perform other health tasks, services to prevent falls, and services to assist with meal preparation – because it placed individuals at serious risk of institutionalization and rejecting “theoretical” argument by stating that family and other supports could replace the lost services).

In this case, the evidence is clear that [REDACTED] needs PAS substantially in excess of the 28 hours per week that have been authorized by her MCO. Not only is [REDACTED] completely dependent on her caregiver for nearly all activities of daily living, but, as her physician explained, she cannot be left alone for safety reasons due to her disability-related impulsivity and cognitive deficits. While AmeriHealth seems to regard a participant’s report of the time it actually takes to perform a task given the participant’s disabilities as “subjective,” it is AmeriHealth that surreptitiously, arbitrarily and subjectively denies or reduces services while ignoring medical necessity established by the participant, the participants’ caregiver, and/or the physician’s medical provider.¹⁵ Moreover, AmeriHealth unlawfully places burdens on family and others to provide unpaid PAS. [REDACTED] currently provides around-the-clock support, only a small portion of which is compensated. As he has made clear, he cannot support his family without a full-time income and, if he is not going to be paid for at least 63 hours of caregiving per week, he will need to return to work outside the home. If [REDACTED] is required to return to full-time work outside the home, [REDACTED] will likely need additional PAS beyond the 63 hours requested to remain in the community because it is

¹⁵ The external review process similarly lacks clear and transparent standards that ensure that PAS hours are authorized to the full extent needed. DRP is aware of one “Independent Review Entity” that has twice referenced that lack of “guidelines” for the calculation of PAS hours but has upheld the MCO’s service reductions anyway.

unlikely that [REDACTED], who worked varying shifts prior to becoming [REDACTED] caregiver, would be able to provide the substantial informal support that he currently provides even beyond the 63 hours of PAS per week that [REDACTED] had before the reduction. [REDACTED] explained to the January 2022 grievance panel that she feared being institutionalized if her PAS hours were not restored to 63 hours per week, and that her physicians have told her that she faces a likelihood of institutionalization if she does not have around-the clock support.

Although as discussed above, DHS cannot require a participant to reduce the need for PAS by obtaining informal support, DHS has failed to ensure that its MCOs do not compel participants to obtain informal support. In this case, for example, AmeriHealth's January 14, 2022 letter upholding the service denial, reasoned, in part, that [REDACTED] is "able" to provide informal supports. Capability is not the sole criterion; voluntariness is required. In addition, one external reviewer incorrectly declared that PAS is available only when "the patient nor anyone else in the household is capable of performing or financially providing" informal support and "where no other relative, caregiver, landlord, community/volunteer agency, or third party [sic] payer is capable of or responsible" for providing informal support. Ms. Johnson incorrectly testified that "[p]articipants are also responsible for having informal supports and, you know, I understand her husband is away from the home during the day, but the availability of a backup is, you know, always recommended."

Moreover, CHC Waiver participants whose PAS is reduced face increased isolation in their homes and an inability to participate as fully in community life as they did previously. [REDACTED] cannot engage in community life without PAS support, including visiting family and participating in her son's school events. This is similarly true of other CHC Waiver participants, including some of these referenced in this Complaint.

Having determined that the ADA's integration mandate is triggered by CHC Waiver participants' serious risk of unnecessary institutionalization, we turn to the *Olmstead* factors.

The first two elements of *Olmstead* – the propriety of community-based services and non-opposition to community-based services – cannot be disputed. DHS’s representatives determined that CHC Waiver participants are eligible for community-based services and supports when they were assessed and determined to qualify for that HCBS Waiver. CHC Waiver participants are obviously not opposed to community services. To qualify for that program, they were determined to need a nursing facility level of care, but by choosing to participate in the HCBS Waiver they demonstrated that they want to remain in the community rather than be institutionalized.

The third element – whether CHC Waiver participants’ needs can be reasonable accommodated – is also satisfied. In an ADA integration mandate case, a plaintiff only “bears the burden of *articulating a reasonable accommodation.*” *Frederick L.*, 364 F.3d at 492 n.4; *accord Duffy v. Velez*, No. 09-5539, 2010 WL 503037, at *3 (D.N.J. Feb. 8, 2010). A reasonable accommodation here is for DHS to require that its CHC MCOs adopt, implement, make publicly available, and train staff to apply appropriate policies to ensure that participants receive the level of PAS that they need to remain and participate in the community and to protect their health, safety, and welfare. Improved policies must ensure that participants’ PAS are not arbitrarily and inappropriately denied, reduced, or terminated without individualized (rather than boilerplate) explanation, including ensuring that those policies require consideration of participants’ needs for supervision, overnight monitoring, cueing, and community participation. Such an accommodation would protect participants against unnecessary institutionalization and home isolation. This accommodation is reasonable on its face. Indeed, many CHC Waiver participants whose MCOs reduced their PAS hours had previously been enrolled in the OLTL-administered HCBS Waivers that existed before Community HealthChoices and OLTL had authorized them to receive higher levels of PAS and many who have been represented by counsel have had success in getting their PAS reductions rescinded or overturned, in whole or in part. Another accommodation would be to ensure that DHS exercise more vigorous

oversight of the CHC MCOs' decisions to deny, reduce, or terminate PAS, such as through periodic, random reviews.

Although, as noted above, it is not DRP's and ██████████ burden to establish that these accommodations would not result in a fundamental alteration to DHS's programs, the accommodations we recommend would not result in a fundamental alteration. Requiring concrete and transparent standards that consider all needs of the participants and training MCO staff on application of those standards cannot be a fundamental alteration. Moreover, DHS, as the single state Medicaid agency, is responsible to ensure that Medicaid participants receive the services to which they are entitled and that their contractors, such as the CHC MCOs, comply with the federal law. DHS is also responsible to ensure that CHC Waiver participants are not subject to discrimination, such as unnecessary institutionalization or isolation. Requiring DHS to exercise greater oversight in this matter, therefore, will simply ensure that it complies with these obligations.¹⁶

IV. Conclusion

For all of the foregoing reasons, ██████████ requests that her PAS hours be restored to 63 hours per week. DRP and ██████████ further request DHS be required to ensure that its CHC MCOs authorize PAS hours sufficient to meet the needs of participants and to avoid unnecessary institutionalization, that standards for calculating PAS hours are clear and transparent so that service reductions or denials can be adequately challenged, that it use lawful standards in making PAS decisions (e.g., not imposing burdens on caregivers to provide unpaid PAS when they are not able *or* willing to do so and ensuring that participants can be authorized to

¹⁶ The courts have made plain that budgetary constraints alone are not sufficient to establish a fundamental alteration. See *Pennsylvania Protection & Advocacy, Inc. v. Dep't of Public Welfare*, 402 F.3d 374, 380 (3d Cir. 2005); *Frederick L.*, 364 F.3d at 495-96; *Fisher*, 335 F.3d at 1183. In any event, here it is unlikely that budget issues would be impacted. Again, DHS formerly funded many of the participants' more extensive PAS.

Lisa J. Pino, Director
March 28, 2022
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receive all the PAS they need) and the explanations for reductions or denials are meaningful and individualized.

I am available to discuss, answer questions, and/or provide additional information. I can be reached via email at slevin@disabilityrightspa.org or by telephone at (215) 238-8070, ext. 224.

Respectfully,

A handwritten signature in black ink, appearing to read "Shanon S. Levin". The signature is fluid and cursive, with a long horizontal stroke at the end.

Shanon S. Levin
Managing Attorney