14-543

IN THE

United States Court of Appeals

FOR THE SECOND CIRCUIT

HARRY DAVIS; RITA-MARIE GEARY; PATTY POOLE; AND ROBERTA (BOBBI) WALLACH, on behalf of themselves and all others similarly situated

Plaintiff-Appellee,

v.

NIRAV SHAH, individually and in his official capacity as Commissioner of the New York State Department of Health,

Defendant-Appellant.

On Appeal from the United States District Court
for the Western District of New York

RESPONSE BRIEF FOR PLAINTIFFS-APPELLEES

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PRELIMINARY STATEMENT

Plaintiffs Harry Davis, Rita-Marie Geary, Patty Poole, and Bobbi Wallach are all individuals with disabilities. They suffer from conditions ranging from multiple sclerosis and peripheral neuropathy to severe lymphedema, diabetes, and bilateral foot amputations. As a result of their conditions, Plaintiffs depend on modest medical services – compression stockings and orthopedic footwear – to maintain the ability to walk and remain safely at home. Without these services, Plaintiffs' doctors expect them to develop significant medical complications, such as severe infection or further amputation that will require unnecessary hospitalization or institutionalization.

For years, Defendant recognized that these services are medically necessary for individuals with the Plaintiffs' conditions. But now Plaintiffs risk losing these items, because the New York State Legislature chose only to cover them for a few beneficiaries with particular conditions while denying them to all others no matter how severe the need.

In 2011, the Legislature passed sweeping changes to New York's Medicaid program. Joint Appendix (J.A.) 358-61. Among them were two that imposed strict benefit limits on compression stockings and orthopedic footwear. The benefits would now only be covered for Medicaid recipients who suffered from one of the few conditions identified by statute. *See* N.Y. Soc. Serv. Law § 365-

1(2)(g)(iii) and (iv). Defendant's implementing regulation permits absolutely no exceptions. 18 N.Y.C.R.R. § 505.5(g). According to Defendant's calculations, these benefit limits would save the state roughly $8 million. J.A. 55. Of Defendant's $50 billion-plus Medicaid program, these benefit limits result in undisputed savings of at most 0.0167%. J.A. 56.

While Defendant predicts minimal savings from these cuts, the elimination of these medically necessary services for Plaintiffs and class members poses dire hardship. According to the uncontested opinions of their doctors, loss of these items exposed Plaintiffs to risk of serious injury from falls, J.A. 169-70 (Geary), serious infection requiring hospitalization, J.A. 168-69 (Davis), 171-72 (Poole), further amputation, J.A. 169 (Davis), 173 (Poole), and possible death from deep venous thrombosis, J.A. 176 (Wallach). The uncontested expert opinion of vascular surgeon Jerry Svoboda, M.D. (Board certified in both General and Vascular Surgery by the American Board of Surgery, and former Professor of Surgery at the University of Rochester), J.A. 78, 81-82, identifies these items as effective treatments that prevent potentially catastrophic health consequences. J.A. 164-66. The hospitalizations and medical procedures that will result if they are not provided are hazardous for the patients and thousands of times more expensive than modest costs associated with compression stockings and orthopedic

footwear. *Id.* These costly consequences are not factored into Defendant's projected savings.

Plaintiffs brought suit, charging that Defendant's benefit limits violated the Medicaid Act, the Due Process clause of the Fourteenth Amendment, and the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act (Section 504). The District Court agreed and granted Plaintiffs' motion for summary judgment, finding Defendant's benefit limits violate the reasonable standards and comparability requirements of the Medicaid Act, the Due Process Clause, the ADA and Section 504. Defendant Shah now appeals from that judgment, arguing that fiscal concerns justified these benefit limits and that the State has discretion to balance its budget by imposing unreviewable benefit limits on admittedly medically necessary services.

Defendant does not contest the likelihood of serious or fatal consequences, if these services are not provided. Nonetheless, Defendant contends that, just because he chooses to call these services "optional," he may categorically exclude them for most individuals based on diagnosis. Defendant's contention is incorrect. As explained below, Defendant's benefit limits violate the reasonable standards and comparability requirements of the Medicaid Act, his obligation to provide home health services under the Act, Plaintiffs' rights to due process, and the ADA and Section 504. Furthermore, while fiscal savings cannot excuse violations of

federal law, the uncontested savings of 0.0167% does not support Defendant's contention that his restrictions resolve the purported shortfall.[1]

ISSUES PRESENTED

1. Whether providing Medicaid coverage for medically necessary compression stockings and orthopedic footwear only for those suffering certain specific conditions and not for others whose conditions are no less severe violates the reasonable standards provision of the Medicaid Act;
2. Whether Plaintiffs may bring an action to enjoin the state law because it is inconsistent with the reasonable standards provision of the Medicaid Act and are thus preempted under the Supremacy Clause of the U.S. Constitution;
3. Whether providing Medicaid coverage for compression stockings and orthopedic footwear only for some Medicaid-eligible individuals while denying it to all others similarly situated violates the comparability requirement of the Medicaid Act;

[1] The state now reports a surplus of $2.6 billion in the General Fund and anticipates an additional $3.6 billion surplus in the coming months. *Comptroller's Fiscal Update: Revenue Trends through the First Quarter, State Fiscal Year 2014-15,* July 2014. http://www.osc.state.ny.us/reports/budget/2014/2014-15_1st_quarter_review.pdf.

4. Whether failure to cover services that fall within the meaning of "medical supplies, equipment and appliances" violates the home health requirement of the Medicaid Act;
5. Whether denial of coverage for Medicaid services without providing written notices or the opportunity for a hearing violates the due process provisions of the Medicaid Act and the Fourteenth Amendment;
6. Whether the risk of unwarranted institutionalization posed by the denial of medically necessary services to people with disabilities violates the ADA and Section 504; and
7. Whether the provision of Medicaid services to some individuals with certain disabilities while denying them to others amounts to disability discrimination prohibited by the ADA and Section 504.

STATEMENT OF THE CASE

A. Background on the Medicaid Program

Congress created the Medicaid program in 1965 by adding title XIX to the Social Security Act, 42 U.S.C. §§ 1396-1396w-5 (hereinafter "the Act"). The purpose of Medicaid is, in part, to enable each state to furnish rehabilitation and other services to help . . . [aged, blind, or disabled] individuals attain or retain capability for independence or self-care [...]." 42 U.S.C. §1396-1. State participation in Medicaid is optional. However, once a state chooses to participate

in Medicaid, and thereby receive federal matching funds for program expenditures, it "must comply with requirements imposed both by the Act itself and by the Secretary of Health and Human Services." *Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981); *see also Sai Kwan Wong v. Doar*, 571 F. 3d 247, 251 (2d Cir. 2009).

Medicaid is not available to everyone who is poor. Participating states must provide medical assistance for individuals identified as "categorically needy," a group that consists of individuals who are aged, blind, or disabled, working disabled individuals, and children and pregnant women who meet eligibility requirements for specified cash assistance programs or fall below federal poverty level standards. 42 U.S.C. § 1396a(a)(10)(A)(i). The categorically needy, as Congress has stated, "are the most needy in the country and it is appropriate for medical care costs to be met, first, for these people." H.R. Rep. No. 213, 89th Cong., 1st Sess; S. Rep. No. 404, 89th Cong., 1st Sess., Pt. 1, reprinted in 1965 U.S.C.C.A.N 2020-21. States may also provide medical assistance to other categorically needy individuals as well as the "medically needy" – those who would qualify for a federal assistance program but for excess income. 42 U.S.C. §§ 1396a(a)(10)(A)(ii) and (C); *Gray Panthers*, 453 U.S. at 37.

New York has opted to provide Medicaid coverage for both mandatory and optional coverage groups. J.A. 183. Once a state decides which groups will receive medical assistance under the plan, it then determines which services it will

provide. *See* 42 U.S.C. § 1396d(a). The Act mandates inclusion of eight enumerated services. 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(1)-(5), (17), (21), (28) (listing: inpatient hospital, outpatient hospital, laboratory and x-ray, nursing facility, physician, nurse-midwife, nurse-practitioner, and freestanding birth center services). A state may also elect to provide optional medical services such as dental services and prescription drugs. *Id.* at §1396a(a)(10) and 1396d(a) (listing categories of optional medical assistance). For all Medicaid beneficiaries entitled to nursing facility services, states must also provide home health services. 42 U.S.C. § 1396a(a)(10)(D). This mandatory home health service includes "medical supplies, equipment, and appliances suitable for use in the home." 42 C.F.R. §§ 440.70(b)(3), 441.15(a)(3). New York has opted to cover both mandatory and optional services. N.Y. Soc. Serv. L. § 365-a.

Once a state elects to provide a service, whether optional or mandatory, it becomes part of the state Medicaid plan and the state "must comply with all federal statutory and regulatory mandates." *Lankford v. Sherman*, 451 F.3d 496, 504 (8th Cir. 2006), citing *Ellis v. Patterson*, 859 F.2d 52, 54 (8th Cir. 1988); *see also Weaver v. Reagen*, 886 F. 2d 194, 197 (8th Cir. 1989), *Eder v. Beal*, 609 F. 2d 695, 701-02 (3d Cir. 1979).

B. Defendant's Benefit Limits

The New York State Medicaid statute requires coverage of prescribed, medically necessary services, including orthopedic footwear and compression stockings. N.Y. Soc. Serv. L. § 365-a(2). However, in 2011, the Legislature implemented Medicaid cost-cutting measures, some of which targeted specific services. J.A. 360. According to the revised New York Social Services Law:

> (iii) prescription footwear and inserts are limited to coverage only when used as an integral part of a lower limb orthotic appliance, as part of a diabetic treatment plan, or to address growth and development problems in children; and
>
> (iv) compression and support stockings are limited to coverage only for pregnancy or treatment of venous stasis ulcers [. . .].

N.Y. Soc. Serv. Law § 365-1(2)(g)(iii) and (iv).

Defendant promulgated amendments to 18 N.Y.C.R.R. § 505.5 eliminating coverage of orthopedic footwear and compression stockings for most, but not all, Medicaid recipients. Compression stockings are now covered only during pregnancy and for venous stasis ulcers. 18 N.Y.C.R.R. § 505.5(g)(1). Coverage of orthopedic footwear is limited to:

> treatment of children to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; as a component of a comprehensive diabetic treatment plan to treat amputation, ulceration, pre-ulcerative calluses, peripheral neuropathy with evidence of callus formation, a foot deformity or poor circulation; or to form an integral part of an orthotic brace.

18 N.Y.C.R.R. § 505.5 (g)(2). "The department shall not allow exceptions to defined benefit limitations." 18 N.Y.C.R.R. § 505.5(g).

Defendant Shah communicated these changes to suppliers through a series of *Provider Updates for Pharmacy and DME Providers*. J.A. 161-62. At no point did he make any effort to notify the beneficiaries themselves, even when their requests for coverage were expressly denied. Plaintiffs, most of whom have had these items covered by Medicaid for years, only learned of Defendant's decision to deny their coverage when they went to a supplier to obtain the items and were turned away empty-handed. Defendant provided them with no written notice telling them: why the coverage had changed, whether there were any available exceptions, or that they had a right to request a fair hearing to contest Defendant's action and how to exercise that right. J.A. 168, 170, 172, 176.

The uncontested factual record[2] in this case indicates that Defendant's policy to deny coverage for medically necessary compression stockings and orthopedic footwear will fail to treat potentially life-threatening conditions, putting Plaintiffs and other class members at risk of serious infection, possible amputation, and the otherwise avoidable hospitalizations and institutionalizations that may follow.

[2] Defendant contests "none of the alleged facts relating to the individual [Plaintiffs]." J.A. 166.

Compression stockings increase blood circulation in the lower extremities by providing graduated pressure on the leg and foot to alleviate circulatory problems associated with edema, phlebitis, and thrombosis. J.A. 163. They are known to prevent dangerous health conditions from developing and offer an effective, inexpensive remedy for excess swelling caused by Chronic Venous Insufficiency (CVI). *Id.* According to the Medicaid DME Fee Schedule, reimbursement rates for compression stockings are either $18.88 or $26.96. J.A. 54. Class members need these services to treat a variety of conditions, including CVI, lymphedema, congenital blood vessel malformation, and paralysis of the lower extremities. J.A. 163. The majority of people requiring compression stockings need them to treat CVI. J.A. 164. By Defendant's own calculations, Medicaid covered 4,578 claims for compression stockings for CVI alone in the 2010-11 fiscal year. J.A. 363. CVI causes chronic swelling of the legs. Left untreated, the swelling will increase, causing capillaries to burst and resulting in serious medical conditions such as open venous stasis ulcers and significant infections. J.A. 164. Compression stockings are used to prevent such ulcers from forming in the first place. J.A. 164.

Failure to treat the infections and uncontrolled swelling in the lower extremities with compression stockings often results in hospitalizations and expensive treatments. J.A. 165. When a patient is hospitalized for treatment, costs

quickly escalate into the tens of thousands of dollars. Inexpensive compression stockings can avoid such unnecessary expenditures. *Id.*

Similarly, orthopedic footwear is medically necessary to treat a number of different conditions, including transmetatarsal amputation, peripheral neuropathy, and neuropathic ulcers on the bottoms of the feet. J.A. 165. When most of the foot has been removed, prescription footwear is necessary to protect what remains of the foot and permit safe ambulation. J.A. 166. Peripheral neuropathy, which has many causes, also makes prescription footwear necessary; yet, the challenged state laws only permit coverage of footwear for peripheral neuropathy when the beneficiary has diabetes. *Id.*

C. Plaintiffs Need Orthopedic Footwear and Compression Stockings to Treat Disabling Medical Conditions, Prevent Catastrophic Medical Complications, and Remain in the Community.

Plaintiffs' conditions and the serious risks they face should their orthopedic footwear and compression stockings not be covered by Medicaid exemplify the unreasonableness and arbitrariness of Defendant's chosen policy and also demonstrate the violations of due process and the ADA.

a. Harry Davis Needs Orthopedic Footwear to Enable Him to Walk and Remain in his Home Subsequent to Bilateral Foot Amputations.

Plaintiff Harry Davis was stricken with bacterial meningitis in March of 2001, which was complicated by multiple comorbidities, including congestive

heart failure, acute respiratory distress syndrome, toe necrosis and ulceration of the feet and hands. J.A. 166. Both of Mr. Davis's feet had to be amputated up to the heel, leaving him with stumps instead of feet. *Id.* Following the bilateral transmetatarsal foot amputations, Mr. Davis spent a year in rehabilitation, where he required a wheelchair for mobility. Upon discharge, his doctors prescribed molded shoes so that he could walk. J.A. 167.

Mr. Davis qualifies for SSI because of his disabilities. He therefore also receives Medicaid. Medicaid has paid for virtually all of his medical care since 2001. Medicaid covered his initial hospitalization, amputations, rehabilitation, and one pair of orthopedic shoes a year from 2002 until the challenged policy went into effect in 2011. J.A. 167-68.

Orthopedic shoes allow Mr. Davis to walk, move about his apartment, and care for himself independently. He requires only limited personal care services at home and no other medical equipment to remain in the community. J.A. 168. Denial of his shoes, however, puts all of that at risk. Without them, he would require a wheelchair, would no longer be able to live in his apartment, and would require additional services to remain in the community. *Id.* More than that, according to his physician, his health would be at serious risk. He risks developing skin ruptures and additional infections. He would likely face further amputation of his legs and institutionalization. J.A. 169. Should these consequences befall him,

Medicaid would have to cover the additional treatments, hospitalizations, and eventual institutionalization. One pair of orthopedic shoes a year has helped Mr. Davis avoid these dire outcomes for over a decade.

Mr. Davis did not know about Defendant's decision not to cover his medically necessary shoes until he took his prescription for a new pair of shoes to the vendor. The vendor, Dr. John Jacobs, then informed him about the new restrictions and said that he would not receive the shoes. Mr. Davis received no written notice from the Defendant, no explanation of the new coverage policy and that the shoes could be covered for other conditions, and no indication that he had a right to a fair hearing if he disagreed with Defendant's determination. J.A. 168.

b. Rita-Marie Geary Needs Orthopedic Footwear to Walk Safely and Prevent Serious Harm.

Plaintiff Rita-Marie Geary suffers a host of serious medical conditions, including psoriatric arthritis, osteoarthritis, scoliosis, osteoporosis, fibromyalgia, patellofemoral stress syndrome, and peripheral neuropathy. J.A. 169. Ms. Geary is disabled and unable to work; she depends on Social Security Disability Insurance benefits and qualifies for Medicaid on the basis of her disability and low income. *Id.*

Ms. Geary's doctor prescribed orthopedic footwear to address her peripheral neuropathy. But because she does not have diabetes, Defendant will not cover her shoes. Without orthopedic footwear, Ms. Geary would be unable to walk safely

and risks further nerve damage to her feet, increased injury from falling, increased ulceration, and infection – injuries made all the more serious by her multiple comorbidities. J.A. 170.

Ms. Geary first learned of Defendant's decision not to cover her shoes when she attempted to fill her prescription. *Id.* She was given a print-out of the computer screen showing they would not be covered by Medicaid. She received no written notice from Defendant about his decision and nothing about the new policy. She was also not told of her right to request a fair hearing if she disagreed with Defendant's determination in her case. J.A. 170.

c. Patty Poole Needs Compression Stockings to Treat Severe Lymphedema, and to Prevent Re-infection Requiring Hospital Treatment, Amputation, and Institutionalization.

Plaintiff Patty Poole suffers from lymphedema, diabetes, depression, morbid obesity, hyperthyroidism, and hyperlipidemia. J.A. 171. Ms. Poole is disabled and qualifies for SSI and Medicaid on the basis of her disability. J.A. 171.

Ms. Poole learned of Defendant's coverage limitations for her compression stockings when she tried to get her prescription filled after a month-long hospitalization for treatment of a major cellulitic infection. That treatment required I.V. antibiotics for two weeks, surgical removal of the infection, and then another two weeks in recovery. *Id.* Although Defendant did send her a letter denying her provider's prior approval request, that notice was legally inadequate.

It mentioned only that the new statute prevented coverage of her compression stockings, but was silent about the conditions that would allow for coverage and silent about her right to request a fair hearing if she disagreed with Defendant's determination. J.A. 172.

Without the compression stockings, Ms. Poole was forced to rely on alternative remedies. *Id.* These alternatives failed to treat her condition and left her virtually bed-ridden and home-bound. J.A. 173. They also failed to treat the underlying swelling that had caused the cellulitic infection in the first place. The swelling in her lower extremities returned to pre-operative levels, putting her at serious risk of recurrence of the infection. J.A. 172. Failure to treat her lymphedema with compression stockings could result in diabetic complications including possible amputation. J.A. 173. The denial of adequate treatments caused her lymphedema to progress and increased her depression. *Id.* Although Ms. Poole requires custom-fitted compression stockings that would cost her around $900 out of pocket, her primary care providers attest that that cost would be "dwarfed by the costs of subsequent hospitalizations and wound care treatments." J.A. 173-74.

d. Roberta (Bobbi) Wallach Needs Compression Stockings to Prevent Fatal Pulmonary Embolism Resulting from Complete Paralysis in her Extremities.

Plaintiff Wallach suffers from multiple sclerosis. J.A. 174. First diagnosed more than three decades ago, the disease has progressed and now causes paraplegia of the lower extremities and monoplegia of her left arm. J.A. 174. Ms. Wallach requires compression stockings to prevent swelling in her paralyzed legs. Untreated, excess swelling would cause potentially fatal deep venous thrombophlebitis and pulmonary embolism. *Id.*

Ms. Wallach is disabled and unable to work. She qualifies for Medicaid on the basis of her disability. *Id.*

As a result of her multiple sclerosis, Ms. Wallach had entered a nursing home in 2007. She received compression stockings while in the nursing home. J.A. 175. Medicaid covered the nursing home and compression stockings. She remained in the nursing home until April of 2011, the month in which Defendant's statutory limitations became effective. *Id.* She first learned of Defendant's benefit limits when she tried to replace her worn-out and ineffective compression stockings. The vendor told her that Medicaid no longer covered them. She received no written notice from the Defendant about the benefit limits and nothing informing her about the basis of Defendant's decision in her case. She received no notice that Medicaid would cover the stockings if she had a different medical condition and that she had a right to a hearing, if she disagreed with Defendant's decision. J.A. 176.

Without compression stockings, Ms. Wallach faces serious risk of hospitalization or death from potentially fatal conditions. J.A. 176. Because of this risk, Ms. Wallach paid for compression stockings herself at an out-of-pocket cost of $13.50. *Id.*

D. Procedural History

Plaintiffs filed this class action suit challenging the elimination of Medicaid coverage for compression stockings and orthopedic footwear for all Medicaid recipients who did not suffer from one of the conditions expressly identified in N.Y. Soc. Serv. Law § 365-1(2)(g)(iii) and (iv), as implemented through Defendant's regulation 18 N.Y.C.R.R. § 505.5(g)(1) and (2). J.A. 10-41. Plaintiffs challenged the state laws as violations of the Medicaid Act, the Supremacy Clause, the Due Process Clause, the ADA and Section 504. Specifically, Plaintiffs alleged that Defendant's benefit limits are inconsistent with the reasonable standards provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(17), and violate Defendant's obligation to provide mandatory home health services, 42 U.S.C. § 1396a(a)(10)(D), as well as the comparability requirement, 42 U.S.C. § 1396a(a)(10)(B), by failing to provide the same amount, duration, and scope of services to similarly situated beneficiaries. By distinguishing among disabled recipients on the basis of their medical conditions, Plaintiffs also alleged that Defendant's benefit limits violated the ADA and Section 504 and put Plaintiffs at

risk of institutionalization in violation of the ADA and *Olmstead v. L.C.*, 527 U.S. 581 (1999).

Plaintiffs filed this class action along with motions for class certification and a temporary restraining order. Following a hearing, the District Court granted Plaintiffs' motion as a preliminary injunction. J.A. 105-22. The Court found a likelihood of success on the merits based on Plaintiffs' claim under 42 U.S.C. § 1396a(a)(10)(D), requiring Defendant to provide medically necessary home health services. Defendant then consented to provide compression stockings and orthopedic footwear to additional class members, provided their requests were supported by a court order. The court issued two such orders in the course of these proceedings. J.A. 123-126. Following class certification, J.A. 411, the court extended preliminary injunctive relief to all class members, J.A. 416-18.

Thereafter, the District Court considered the parties' cross motions for summary judgment. It granted in part Plaintiffs' motion for summary judgment, finding that Defendant's benefit limits on compression stockings and orthopedic footwear violate the reasonable standards requirement of the Act, 42 U.S.C. § 1396a(a)(17), and the comparability requirement, 42 U.S.C. § 1396a(a)(10)(B). The opinion also concluded that Defendant's action violated the due process provision of 42 U.S.C. § 1396a(a)(3) by failing to provide notices. The Court also found that Defendant's limits discriminated among people with different

disabilities and subjected class members to likely institutionalization in violation of the integration mandates of the ADA and Section 504. The court granted Defendant's motion for summary judgment in part, finding that the failure to provide a hearing did not violate 42 U.S.C. § 1396a(a)(3) and that the limits did not violate the mandatory home health requirement in 42 U.S.C. § 1396a(a)(10)(D).

Judgment was issued on January 29, 2014. J.A. 469. Defendant appealed from that judgment. J.A. 472.

SUMMARY OF THE ARGUMENT

Defendant's benefit limits on orthopedic footwear and compression stockings violate the Medicaid Act, the ADA and Section 504, and the Due Process clause of the Fourteenth Amendment. Specifically, the benefit limits violate the comparability and home health requirements of the Act and are incompatible with the Act's reasonable standards requirement; they violate Plaintiff's constitutional rights to due process as incorporated into the Act; and they violate the ADA and Section 504 by blatantly discriminating among individuals with disabilities and by placing them at risk of unnecessary institutionalization.

Defendant seeks to limit the availability of these items to only those Medicaid recipients who suffer from one of the few conditions listed in the challenged statute, N.Y. Soc. Serv. Law § 365-1(2)(g)(iii) and (iv), while denying

them to all others no matter how dire the need or severe the consequences. Federal regulations allow states to place appropriate limits on services based on medical necessity or utilization control procedures. However, categorical limits that exclude medically necessary services for certain individuals without the opportunity for review fail to meet this standard. Defendant admits that the limits are not based on any consideration of medical necessity. Defendant urges this Court to take the novel position that a federal utilization control regulation permits him unbounded discretion to impose limits based on other considerations. However, while states have considerable discretion under the Act, the law does not support the arbitrary, categorical elimination of coverage for medically necessary services only for certain beneficiaries.

Alternatively, relying on the dissent in *Douglas v. Independent Living Center of S. Cal.*, 132 S. Ct. 1204 (2012), Defendant alleges that the Supremacy Clause does not provide Plaintiffs a cause of action to enjoin state laws that conflict with the reasonable standards provision. This argument is not properly before the Court. Moreover, the *Douglas* Court did not address the Supremacy Clause in its controlling opinion and thus did nothing to change the law on this issue. Courts have routinely held that the Supremacy Clause creates an implied right of action for plaintiffs to challenge state laws that conflict with federal law, even where no cause of action is available under 42 U.S.C. § 1983.

The District Court correctly found that denying medically necessary compression stockings and orthopedic footwear to categorically needy class members while providing them to other individuals on the basis of their conditions violated the comparability requirement by discriminating among categorically needy individuals and between categorically needy and medically needy individuals. The District Court's opinion should therefore be affirmed.

The District Court erred in finding that Defendant's benefit limits do not violate the obligation to cover home health services. The Act requires states to cover home health services for all beneficiaries entitled to nursing facility services. It is uncontested that Defendant covers nursing facility services for all Medicaid beneficiaries and thus must also cover their medically necessary home health services. Under federal law, these services include "medical supplies, equipment and appliances." 42 C.F.R. § 440.70(b)(3). The District Court erred by not deferring to a CMS definition of these terms and by supporting Defendant's attempt to redefine them exclusively as "prosthetics." None of these items fall exclusively within Defendant's subcategory of "prosthetic devices," but all of them fall within the federal understanding of medical supplies, equipment and appliances. Defendant cannot pick and choose which category to apply for purposes of defending against litigation.

Defendant alleges that, because the benefit limits were adopted by statute, Plaintiffs are not entitled to either written notices or hearings when they are denied coverage. This is incorrect. Defendant's benefit limits deny coverage of medically necessary compression stockings and orthopedic footwear to individuals for whom he had provided these services for years. Thus, the District Court correctly found that Plaintiff class members are entitled to notices that inform them of Defendant's denials. The District Court erred, however, in finding that no hearing is required. Hearings are not required to address changes in law that affect all recipients equally. However, they are required to address factual disputes. Because Defendant's denials are based on factual determinations of class members' conditions, both notices and hearings are required.

Finally, the District Court correctly found that Defendant's benefit limits violate the ADA and Section 504. Defendant's benefit limits blatantly discriminate among people with disabilities by providing benefits only to those disabled individuals who suffer from certain conditions, while denying them to all others who suffer from any other condition. Such distinctions, the Court below found, constitute discrimination based on disability. Moreover, the uncontested facts in this case clearly establish that Plaintiffs are likely to require hospitalization and institutionalization without the benefit of these essential services. Such

unwarranted institutionalization constitutes clear violation of the integration mandates of the ADA and Section 504.

ARGUMENT

I. Denial of Medically Necessary Orthopedic Footwear and Compression Stockings on the Basis of Diagnosis or Condition is Inconsistent with the "Reasonable Standards" Requirement.

The District Court correctly found for the Plaintiffs on their First Claim for Relief regarding the Act's reasonable standards provision. States have some discretion in determining the scope of Medicaid coverage. *See* 42 C.F.R. § 430.0; *Beal v. Doe,* 432 U.S. 438, 444 (1977). However, the Medicaid Act limits that discretion by requiring states to employ "reasonable standards … for determining … the extent of medical assistance under the plan which … are consistent with the objectives of this subchapter." 42 U.S.C. § 1396a(a)(17). *See Wisconsin Dept. of Health and Family Serv. v. Blumer*, 534 U.S. 473, 479 (2002); *Gray Panthers*, 453 U.S. at 36-37; *Herweg v. Ray*, 455 U.S. 265 (1982); *Sai Kwan Wong*, 571 F. 3d at 251 (2d Cir. 2009). *See also Lankford*, 451 F. 3d at 506 (while "a state has considerable discretion to fashion medical assistance under its Medicaid plan, this discretion is constrained by the reasonable-standards requirement").

It makes no difference whether the service is listed as mandatory or optional in the Act. "Once a state offers an optional service, it must comply with all federal statutory and regulatory mandates." *Lankford*, 451 F. 3d at 504; *Gray Panthers*,

453 U.S. at 37 (Medicaid-participating states "must comply with requirements imposed both by the Act itself and by the Secretary of Health and Human Services"). *See also Bontrager v. Indiana Family and Social Services Admin.*, 697 F. 3d 604, 608 (7th Cir. 2012) ("[A] state is required to cover all medically necessary treatments in those service areas in which the state opts to provide coverage."); *Doe v. Chiles*, 136 F.3d 709, 714 (11th Cir. 1998) (covered optional services are subject to federal requirements); *Hern v. Beye*, 57 F. 3d 906, 911 (10th Cir. 1995); *Weaver*, 886 F. 2d at 197; *Eder*, 609 F.2d at 702; *Hunter v. Chiles*, 944 F. Supp. 914, 919 (S.D. Fla. 1996).

Medicaid regulations further limit state discretion by requiring states to cover a service in "sufficient amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b). States "may not arbitrarily deny the amount, duration, and scope of a required service [...] solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c).[3] However, states may "place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 C.F.R. § 440.230(d). Although the term is not

[3] The services at issue here come within more than one of the Act's listings of covered services. For example, the services are medical equipment and supplies and, thus, are required home services under 42 U.S.C. § 1396a(a)(10)(D); 42 C.F.R. § 440.70. As discussed *infra* at 45-47, it is not unusual for a service as clinically named to fit within more than one of the legal listings in the Medicaid Act.

defined in the regulation, utilization control procedures are understood to include prior authorization processes, step therapies or similar systems to control appropriate use of covered services. *See Bontrager*, 697 F. 3d at 610-11 (reviewing cases and noting that categorical limits to services do not constitute permissible utilization control procedures); S.P.A. 47.

Analyzing Defendant's limitations on compression stockings and orthopedic footwear under 42 U.S.C. § 1396a(a)(17) and its implementing regulation, 42 C.F.R. § 440.230(d), the District Court correctly found that Defendant's absolute benefit limits are neither based on medical necessity nor do they constitute any sort of utilization control procedure. Indeed, Defendant does not dispute that these services are medically necessary for Plaintiffs. J.A. 166. The Court then correctly found that categorical elimination of these services for some beneficiaries is not a utilization control procedure, because it is neither a prior authorization process nor a system to control access, prevent fraud, or streamline efficiency. S.P.A. 48.

Courts have routinely found categorical eliminations of medically necessary services to some beneficiaries incompatible with the Act's reasonable standards provision. *See, e.g., Bontrager* , 697 F.3d at 610 (finding $1,000 annual cap on dental service that eliminated access to whole categories of medically-necessary dental services inconsistent with the reasonable standards provision); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581 (5th Cir. 2004) (striking down provision

prohibiting coverage of incontinence supplies for beneficiaries 21 and older); *Weaver*, 886 F.2d 194 (limiting coverage of AZT based on diagnosis violates the reasonable standards provision); *William T. ex rel. Gigi T. v. Taylor*, 465 F.Supp.2d 1267 (N.D. Ga. 2000) (categorical denial of coverage for augmentive and alternative communication devices is inconsistent with the reasonable standards provision).

Defendant nevertheless contends that his benefit limits are consistent with the reasonable standards requirement, because references to "medical necessity" and "utilization control procedures" in § 440.230(d) are merely examples of "appropriate limits," and budget cuts to save money are also appropriate utilization control procedures. Br. for Appellant at 36-37, 40-41. This argument goes too far. It would permit states to impose *any* limitations on *any* medically necessary services based on a stated desire to cut spending (or for *any* reason for that matter). Such broad discretion is not "reasonable" within the meaning of the Act and is not the intent of the utilization control regulation, which is aimed at curbing inappropriate use of covered services by recipients. *See Alvarez v. Betlach*, _ F. App'x _, 2014 WL 1891007 (9th Cir. May 13, 2014) (stating that 42 U.S.C. § 1396a(a)(17) and 42 C.F.R. § 440.230(d) "prohibit[s] states from denying coverage of 'medically necessary' services that fall under a category covered in their Medicaid plans" and requiring coverage of incontinence supplies as a preventive

service (citing *Beal v. Doe*, 432 U.S. 438, 444 (1977)); 58 Fed. Reg. 14477, 14578 (Mar. 18, 1993) (Notice) (Medicaid agency disapproval of Arkansas plan to impose a combined quantitative limit on six separate Medicaid services (so that the number of visits covered under one service category would reduce the number of services available under the other categories), noting that 42 C.F.R. § 440.230(d) authorizes appropriate limits but finding that the proposed limit "does not appear to be based on either criteria. The limit does not purport to exclude any medical services on the grounds that they are not medically necessary. Also, the limit does not appear to be a control over the utilization of covered services since services will be reduced even though recipients have never used them.") Just as the District Court found nothing to support Defendant's contention of such wide-ranging discretion, Defendant provides no legal authority to support his position on appeal.

Cases cited by Defendant as allegedly permitting benefit limits are distinguishable. Each of Defendant's cases involves *quantitative* limits to services rather than categorical exclusions. *Charleston Memorial Hospital v. Conrad*, 693 F.2d 324 (4th Cir. 1982), upheld numeric restrictions on inpatient and outpatient hospital services; *Curtis v. Taylor*, 625 F. 2d 645 (5th Cir. 1980), upheld a limitation on the number of physician visits per month; and *Grier v. Goetz*, 402 F .Supp. 2d 876 (M.D. Tenn. 2005), upheld a limitation on the number of prescriptions. In limiting the quantity of services available to all beneficiaries, the

states in question never eliminated services outright as Defendant here has done. Physician services, hospital services, and pharmaceutical services remain available to all beneficiaries within each of these permissible limits. Under Defendant's policy, however, medically necessary compression stockings and orthopedic footwear are *wholly unavailable* to *all* beneficiaries who do not suffer from specifically identified conditions. This categorical elimination of indisputably medically-necessary services runs afoul of the reasonable standards provision. *Beal*, 432 U.S. at 444-45; *see also Bontrager*, 697 F.3d at 611; *Lankford*, 451 F. 3d at 511 ("a state's failure to provide Medicaid coverage for non-experimental, medically-necessary services within a covered Medicaid category is both per se unreasonable and inconsistent with the stated goals of Medicaid").

Ultimately, Defendant rests his assertion of the reasonableness of the benefit limits on a single basis: state fiscal policy.[4] Yet, neither the facts nor the law support his contention. It is undisputed that the combined impact of Defendant's benefit limits will result in at best modest savings, amounting to no more than 0.0167% of the Medicaid budget. J.A. 56. It is also undisputed that denial of these

[4] Defendant never argues that his benefit limits are "reasonable" because they correspond to any process identified in §440.230(d). Instead, he argues that the regulation does not delimit all the procedures that might be considered "appropriate." Thus, he argues, a limitation that is "clear" (Br. of Appellant at 36) and implemented for a reason – here, state fiscal concerns – must also satisfy the reasonable standards provision. No court has ever adopted this position.

cost-effective services put Plaintiffs and other class members at risk of serious health outcomes requiring difficult and expensive procedures that Defendant would have to cover, including hospitalization, amputation, and institutionalization. J.A. 164-67. These treatments are hundreds, if not thousands of times more expensive than the cost-effective treatments at issue here. J.A. 165. And they were not figured into the mix when arriving at the 0.0167% savings.

Defendant's budgetary concerns, however, are of no legal consequence. The purpose of the Medicaid program is to cover the healthcare costs of "the most needy in the country." *Schweiker*, 457 U.S. 569, 590 (1982). "Although we are mindful of potential budgetary concerns, these interests do not outweigh Medicaid recipients' interests in access to medically necessary health care." *Bontrager*, 697 F. 3d at 612, *citing, e.g., Dominguez v. Schwarzenegger*, 596 F.3d 1087, 1098 (9th Cir. 2010) ("[W]e have repeatedly recognized that individuals' interests in sufficient access to health care trump the State's interest in balancing the budget"), *vacated on other grounds, Douglas,* 132 S.Ct. 1204.

Because the only reason Defendant proffers to support his benefit limits is legally insufficient, because he does not dispute that his benefit limits are neither based on medical necessity nor are they any sort of utilization control, the District Court correctly struck down Defendant's benefit limits. This Court should affirm.

II. The Reasonable Standards Claim for Relief Properly Rests on the Supremacy Clause.

The district court granted Plaintiffs' First Claim for Relief, which enforces the Supremacy Clause to enjoin the challenged state law because it is inconsistent with the Medicaid "reasonable standards" provision, 42 U.S.C § 1396a(a)(17). Defendant introduces a new argument on appeal that the Supremacy Clause does not supply a private right of action. Br. of Appellant at 30-34.[5] As shown below, decades of Supreme Court and Second Circuit precedent, along with two on-point cases from other circuits, defeat Defendant's contention.

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[5] The Complaint's Second through Fourth Claims for Relief seek to enforce specified provisions of the Medicaid Act pursuant 42 U.S.C. § 1983. Defendant does not challenge the Medicaid beneficiaries' right to bring these claims. Nor could he plausibly do so. The cited provisions meet the Supreme Court's enforcement test under § 1983,which requires that the federal provision in question be (1) intended to benefit the plaintiff; (2) written with sufficient clarity so that a court knows what to enforce; and (3) create a binding obligation on the state. *See Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002). The Second Claim for Relief concerns 42 U.S.C. § 1396a(a)(10)(B), which requires a comparable amount of services for "any individual" described in the eligibility provisions. This provision has been held to be privately enforceable under § 1983. *See, e.g., Bontrager*, 697 F.3d 604. The Third Claim concerns the mandatory home health requirement, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(10)(D), and 1396d(a)(4). Courts have consistently allowed enforcement of §§ (10)(A) and d(a)(4), *see Bontrager*, 697 F.3d 604 (regarding (10)(A)); *Watson v. Weeks*, 436 F.3d 1152 (9th Cir. 2006) (same); *S.D.*, 391 F.3d 581 (same); *see also Westside Mothers v. Olszewski,* 454 F.3d 532 (6th Cir. 2006) (same, also regarding d(a)(4)); *Sabree v. Richman*, 367 F.3d 180 (3d. Cir. 2004) (same); *Pediatric Specialty Care, Inc. v. Ark. Dept. of Human Servs.*, 293 F.3d 472 (8th Cir. 2002) (same). The district court found § (10)(D) to be enforceable under § 1983. *Davis v. Shah*, 12-CV-6134, 2012 WL 1574944 (W.D.N.Y. May 3, 2012). The provision is worded almost exactly like the fair hearing provision, 42 U.S.C. § 1396a(a)(3), which was found enforceable in *Gean v. Hattaway*, 330 F.3d 758 (6th Cir. 2003) and *Shakhnes v. Berlin*, 689 F.3d 244 (2d Cir. 2012). The Fourth Claim for Relief in this case concerns §1396a(a)(3).

a. Defendant Waived his Ability to Challenge Plaintiffs' Supremacy Clause Claims.

"The law in this Circuit is clear that where a party [...] advances arguments available but not pressed below, waiver will bar raising the issue on appeal." *Wal-Mart Stores, Inc. v. Visa U.S.A., Inc.*, 396 F.3d 96, 124 (2d Cir. 2005), quoting *United States v. Braunig*, 553 F.2d 777, 780 (2d Cir.1977). "This rule is not an absolute bar to raising new issues on appeal; the general rule is disregarded when we think it necessary to remedy an obvious injustice [...]. Entertaining issues raised for the first time on appeal is discretionary with the panel hearing the appeal." *Greene v. United States*, 13 F.3d 577, 586 (2d Cir. 1994) (internal citations omitted).

Defendant cannot now challenge Plaintiffs' enforcement of the Supremacy Clause. The issue was available to him. While he mentioned it once in his Answer to the Complaint, J.A. 97, Defendant neither briefed nor argued it below. Although Defendant challenged Plaintiffs claims under 42 U.S.C. § 1983, Defendant's Response Memorandum of Law, cited in Br. of Appellant at 24, Plaintiffs never alleged that they had a cause of action under § 1983 to enforce the reasonable standards requirement, J.A. 34. Defendant offers no reason for his failure to raise the argument below, nor does he suggest there will be any great injustice should this Court refuse to resolve it. Defendant has therefore waived his

right to raise it now. *See Wal-Mart Stores*, 396 F.3d at 124 (finding one sentence in a 10-page brief insufficient to preserve matter for appeal).

b. Should the Court Review the Matter, Controlling Precedent Recognizes the Cause of Action.

Under the Supremacy Clause, U.S. Const. art. VI, cl. 2, the laws of the United States are the supreme law of the land, notwithstanding state laws to the contrary. The underlying rationale for this preemption doctrine, "stated more than a century and a half ago, is that the Supremacy Clause invalidates state laws that 'interfere with or are contrary to, the laws of congress.'" *Chicago & N.W. Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311, 317 (1981) (quoting *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 211 (1824)).

Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983), confirmed that it is "beyond dispute" that federal courts have jurisdiction under 28 U.S.C. § 1331 to hear claims for injunctive and declaratory relief asserting that a state law is preempted by a federal statute. *Id.* at 96 n.14 (internal citations omitted). The Court resolved *Shaw* on the merits, holding that the state law was preempted insofar as it prohibited practices that were permitted under federal law. *Id.* at 108-09. The Court reaffirmed *Shaw* in *Verizon Maryland., Inc. v. Public Service Commission of Maryland.*, 535 U.S. 635 (2002). *Verizon* verified that courts must find at least an "arguable" cause of action to uphold jurisdiction, and it thereafter held that Verizon's claim that the Telecommunications Act preempted state regulation

presented a federal question over which the federal courts have jurisdiction. *Id.* at 642-43 (citing *Shaw*).

On numerous occasions, the Supreme Court has held that beneficiaries of Social Security Act programs, such as Medicaid, can bring preemption actions to enjoin state laws that conflict with federal law and are, thus, "invalid under the Supremacy Clause." *Townsend v. Swank*, 404 U.S. 282, 285 (1971). *See, e.g., Blum v. Bacon*, 457 U.S. 132, 138 (1982) (holding New York welfare regulations that conflicted with Social Security Act regulations "are invalid under the Supremacy Clause"); *N.Y. State Dep't of Social Servs. v. Dublino*, 413 U.S. 405, 423 n.29 (1973) ("Conflicts [in Social Security Act programs], to merit judicial rather than cooperative federal-state resolution, should be of substance and not merely trivial or insubstantial. But if there is a conflict of substance as to eligibility provisions, the federal law of course must control."). More recently, Justice Kennedy's opinion for a 6-3 majority in *Wos v. E.M.A.*, 133 S. Ct. 1391, 1398 (2013) found a state law ran afoul of the Supremacy Clause because it conflicted with the Medicaid Act and was "pre-empted for that reason."

The Second Circuit has followed the Court's precedent, stating that "[i]t is elemental that the Supremacy Clause … vitiates any state law inconsistent with an act of Congress." *Kreigbaum v. Katz*, 909 F.2d 70, 73 (2d Cir. 1990). *See also, e.g., Fetterusso v. State of N.Y.*, 898 F.2d 322, 327 (2d Cir. 1990) ("Under the

Supremacy Clause of the United States Constitution, conflict between state and federal [Social Security Act] laws must be resolved in favor of the overriding federal interest."); *Lynch v. Philbrook*, 550 F.2d 793 (2d Cir. 1977) (finding state AFDC law inconsistent with federal law under Supremacy Clause).

In addition, the Second Circuit has explicitly recognized that "the Supremacy Clause creates an implied right of action for injunctive relief against state officers who are threatening to violate the federal Constitution or laws." *Burgio and Campofelice, Inc. v. N.Y. State Dep't of Labor*, 107 F.3d 1000, 1006 (2d Cir. 1997). *See also* 13B Charles Alan Wright & Arthur R. Miller, Federal Practice and Procedural Jurisdiction 2d § 3566 (2d ed. 1983 & Supp. 2004) ("[T]he Supremacy Clause creates an implied right of action for injunctive relief against state officers who are threatening to violate the federal Constitution and laws."); Richard Fallon Jr. et al., Hart and Weschler's The Federal Courts and The Federal System at 903 (5th ed. 2003) ("[t]he rule that there is an implied right of action to enjoin state or local regulation that is preempted by a federal statutory or constitutional provision [...] is well-established.").

Other federal circuits have also recognized the well-established precedent. *See, e.g., Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 334-35 (5th Cir. 2005) (discussing Court precedents and stating, "We have little difficulty in holding that Appellees have an implied right of action to assert a

preemption claim seeking injunctive and declaratory relief."). In *Pharmaceutical Research & Manufacturers of America [PhRMA] v. Concannon*, the First Circuit recognized that the preemption action arises from the Constitution, not from a statute, and thus congressional intent is irrelevant to the existence of the cause of action: "In this type of action, it is the interests protected by the Supremacy Clause, not by the preempting statute, that are at issue." 249 F.3d 66, 73 (1st Cir. 2001), *aff'd*, 538 U.S. 644 (2003) (citations omitted). The First Circuit continued:

> We know of no governing authority to the effect that the federal statutory provision which allegedly preempts enforcement of local legislation by conflict must confer a right on the party that argues in favor of preemption. On the contrary, a state or territorial law can be unenforceable as preempted by federal law even when the federal law secures no individual substantive rights for the party arguing preemption.

Id. (citation omitted). *Id.* (citing *Burgio*, 107 F.3d at 1006 and concluding Supremacy Clause creates implied right of action for injunctive relief).

The Supreme Court has consistently recognized the validity of Supremacy Clause claims brought by plaintiffs, including beneficiaries of Social Security Act programs. Consistent with this binding precedent, the Second Circuit and other courts recognize an implied cause of action under the Supremacy Clause to enjoin state laws that violate federal law.

c. Other Federal Courts of Appeal Have Ruled on Point in Plaintiffs' Favor.

Two appellate courts have previously rejected the arguments raised by Defendant's appeal. In *Lankford*, 451 F.3d 496, beneficiaries challenged a state law that significantly reduced Medicaid coverage of durable medical equipment. They claimed an express private right of action under § 1983 to enforce the reasonable standards provision (§ 1396a(a)(17)) and an implied right of action under the Supremacy Clause to enjoin the state law as conflicting with the provision. The court rejected the § 1983 claim but held the state law conflicted with the Medicaid provision and was, thus, preempted under the Supremacy Clause. *Id.*

Defendant argues that the *Lankford* reasoning is "fundamentally inconsistent." Br. of Appellant at 34. But as *Lankford* explains, preemption under the Supremacy Clause "concerns the federal structure of the Nation rather than the securing of rights, privileges and immunities to individuals" under § 1983. *Id.* (quoting *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 117 (1989) (Kennedy, J. dissenting)). Thus, "[p]reemption claims are analyzed under a different test than section 1983 claims, affording plaintiffs an alternative theory for relief when a state law conflicts with a federal statute or regulation." *Id.* (citing *Golden State*, 493 U.S. at 108); *see also Golden State*, 493 U.S. at 117 (Kennedy, J., dissenting) (stating that preemption under the Supremacy Clause "concerns the federal structure of the Nation rather than the securing of rights, privileges, and

immunities to individuals."). *Lankford* notes that "[w]hile Medicaid is a system of cooperative federalism, the same analysis applies; once the state voluntarily accepts the conditions imposed by Congress, the Supremacy Clause obliges it to comply with federal requirements." 451 F.3d at 510.

The Fifth Circuit also held Medicaid beneficiaries have an implied cause of action under the Supremacy Clause to enjoin state laws that conflict with the reasonable standards provision. *See Detgen ex rel. Detgen v. Janek*, 752 F.3d 627 (5th Cir. 2014). Noting that the *Douglas* Court had "dodged the question" of Supremacy Clause enforcement, the court held that the "Supremacy Clause confers an implied private cause of action to enforce all Spending Clause legislation by bringing preemption actions." *Id.* at 630 (citing *Douglas*, 132 S. Ct. 1205 (2012) and adhering to *Planned Parenthood of Houston*, 403 F.3d 324).

d. Defendant Improperly Relies on a Supreme Court Dissent and a Case Outside the Second Circuit.

Defendant does not identify any precedent to support his argument. Br. of Appellant at 31-33. He relies on the dissent in *Douglas*, but "[a] dissenting opinion is, of course, not binding precedent...." *U.S. v. Romain*, 393 F.3d 63, 74 (1st Cir. 2004). Notably, the *Douglas* Court refused to decide whether the Ninth Circuit properly recognized a Supremacy Clause action to enforce a federal Medicaid provision. 132 S. Ct. at 1211. Rather, it remanded the case for reconsideration after the federal Medicaid agency expressly approved of the state's position in the

underlying substantive dispute. *Id.* at 1210. Thus, *Douglas* has no effect on this case, and all of the precedent discussed above remains in effect. *See also, e.g.*, *Exceptional Child Ctr., Inc. v. Armstrong*, _ F. App'x _, 2014 WL 1328379 (9th Cir. Apr. 4, 2014) (Medicaid case acknowledging *Douglas* but allowing Supremacy Clause claim under "well-established" law of the Supreme Court and the circuit courts); *Lewis v. Alexander*, 685 F.3d 325, 345, 346 & n.20 (3d Cir. 2012), *cert. denied*, 133 S. Ct. 933 (2013) (Medicaid case noting that *Douglas* expressly declined to address the Supremacy Clause issue, acknowledging that "the Supreme Court is free to revisit *Shaw* if it so desires, we are not," and holding "*Shaw* is binding precedent unless and until it is abrogated by the Supreme Court").

In addition, Defendant cites *Planned Parenthood of Kansas & Mid-Missouri v. Moser*, 747 F.3d 814 (10th Cir. 2014). This Court should not side with the *Moser* majority, which relied on the *Douglas* dissent. As the dissent in *Moser* points out, the majority ignored fundamental principles of how courts work:

> Litigants and the public at large are entitled to receive decisions from our court rooted in precedent and based on rigorous analysis of the parties' submissions. Today's decision meets neither test. Instead, the majority conveniently defenestrates controlling precedent and proceeds on substituted premises.

Id. at 843 (Lucero, dissenting); *cf. Detgen*, 752 F.3d at 630 & n.4 (declining to follow *Moser* because *Douglas* did not change current precedent).

III. Defendant's Policy to Cover Orthopedic Footwear and Compression Stockings Only for Medicaid Recipients with Certain Conditions Violates the Comparability Requirement.

Defendant advances a limited theory of the comparability requirement mandated under 42 U.S.C. § 1396a(a)(10)(B). Rather than reading the statute to prohibit discrimination among all categorically needy Medicaid recipients, Defendant alleges that the statute only prohibits discrimination "among federally recognized 'categories' of recipients – the categorically needy and the medically needy – and within these categories, certain recognized groups" identified as the subsets of categorically needy individuals set out in 42 U.S.C. § 1396a(a)(10(A)(i). Br. of Appellant at 48. Defendant, however, offers no support for this contention.

To the contrary, the plain language of the statute clearly prohibits discrimination among all categorically needy individuals, not groups: "The medical assistance made available to any [categorically needy] *individual* … shall not be less in amount, duration or scope than the medical assistance made available to any other such *individual*." 42 U.S.C. § 1396a(a)(10)(B)(i) (emphasis added). The implementing regulation mirrors the statute, requiring that "the services available to any *individual* in the following groups are equal in amount, duration, and scope for all recipients within that group: (1) The categorically needy." 42 C.F.R. § 440.240(b) (emphasis added). Thus, services made available to *any* categorically needy individual must be made available to all such individuals. *See*

Schweiker, 457 U.S. at 573 n. 6. *See also Lankford*, 451 F. 3d at 505; *V.L. v. Wagner*, 669 F. Supp. 2d at 1114-15 (comparability requirement is "violated when some recipients are treated differently than others where each has the same level of need"); *Sobky v. Smoley*, 855 F. Supp. 1123, 1140 (E.D. Cal 1994) (holding that § 1396a(a)(10)(B) prohibits discrimination between groups of the categorically needy as well as between individuals within the same group).

This Court has held that under the comparability requirement, "states may not provide some benefits to some categorically needy individuals but not to others." *Rodriguez v. City of New York*, 197 F.3d 611, 615 (2d Cir. 1999). This requirement "thus precludes states from discriminating against or among the categorically needy." *Id.* (citing cases). Indeed, "[i]ts only proper application is in situations where the same benefit is funded for some recipients but not for others." *Id.* at 616.

Defendant's actions here run directly counter to the Second Circuit's admonitions: his implementation of N.Y. Soc. Serv. L. § 365-1(2)(g)(iii) and (iv) provides orthopedic footwear and compression stockings only to those individuals who suffer from one of the conditions identified in the statute and to no others. Defendant's policy thus discriminates against all those categorically needy individuals who need these items for any other medical reason. The Court below

correctly held that Defendant's policy violates 42 U.S.C. § 1396a(a)(10)(B). That holding should be affirmed.

IV. Failure to Cover Medically Necessary Orthopedic Footwear and Compression Stockings Violates the Home Health Services Requirement of the Medicaid Act.

Alternatively, relief awarded by the District Court may be supported by a finding that Defendant's benefit limits violate the Medicaid mandatory home health care requirement. 42 U.S.C. § 1396a(a)(10)(D).[6]

The District Court erred in finding that orthopedic footwear and compression stockings did not fall within the federal requirement to cover home health services. In reaching this conclusion, the Court erroneously relied on Defendant's narrowly circumscribed classification system rather than the federal standard set out in 42 U.S.C. § 1396a(a)(10)(D), misapplied relevant authority, and relied in part on an inapplicable regulation.

As noted, the Medicaid Act requires states to cover home health services for all Medicaid recipients entitled to nursing facility services. 42 U.S.C. § 1396a(a)(10)(D). It is undisputed that Defendant covers nursing facility services

[6] This Court is "free to affirm an appealed decision on any ground which finds support in the record, regardless of the ground upon which the trial court relied." *Millares Guiraldes de Tineo v. United States*, 137 F.3d 715, 719 (2d Cir. 1998), *quoting Leecan v. Lopes,* 893 F.2d 1434, 1439 (2d Cir.), *cert. denied,* 496 U.S. 929 (1990). *See also Langnes v. Green,* 282 U.S. 531, 535–39 (1931) (appellee may, without filing a cross-appeal, advance any theory in support of the judgment that is supported by the record, whether it was ignored by the court below or flatly rejected); *Shumway v. United Parcel Service, Inc.,* 118 F.3d 60, 63 (2d Cir.1997).

for both categorically and medically needy Medicaid beneficiaries. J.A. at 183. Defendant must therefore cover home health services. Home health services must include, "medical supplies, equipment and appliances suitable for use in the home," 42 C.F.R. §§ 440.70(b)(3), 441.15(a)(3).

Federal law does not further define these terms. In 2011, however, the federal Medicaid agency, the Centers for Medicare & Medicaid Services (CMS), proposed amending the regulation in order to, "ensure [that] beneficiaries are receiving needed items." Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health, 76 Fed. Reg. 41032, 41034 (proposed July 12, 2011) (to be codified at 42 C.F.R. § 440.70(b)(3)); J.A. 204.

According to CMS, "supplies" are "health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual." 76 Fed. Reg. at 41034; J.A. 204. "Equipment and appliances" are: "items that are primarily and customarily used to serve a medical purpose, generally not useful to an individual in the absence of an illness or injury, can withstand repeated use, and can be reusable or removable." *Id.* If healthcare-related items fall within the scope of these definitions, states must cover them within their Medicaid programs.

Although not yet adopted in regulation, the Agency's proposed amendments to §447.70(b)(3) are entitled to "respectful consideration." *Wisconsin Dept. of Health and Family Services*, 534 U.S. at 497. Indeed, this Court has itself relied on proposed regulations by the Health Care Financing Administration (HCFA), the predecessor agency to CMS, to clarify a rule and reach its holding. *Liegl v. Webb*, 802 F.2d 623 (2d Cir. 1986) (relying on proposed rule to find six-month retroactive budget period consistent with federal Medicaid law).[7]

Defendant contends that compression stockings and orthopedic footwear do not fall within the federal definition because they are not "durable medical equipment" or "medical/surgical supplies" as defined in state policy manuals. Instead, and inconsistent with his own policy manuals, Defendant now chooses to classify these items for purposes of this litigation exclusively as "prosthetics," and therefore optional rather than mandatory services. 42 C.F.R. § 440.120(c); J.A. 186, 190. The Court below agreed. S.P.A. 43. This holding is incorrect. Defendant's definition of medical equipment is too narrow and his classification scheme does not comport with his litigation position that compression stockings and orthopedic footwear are viewed exclusively as "prosthetics."

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[7] Similarly, the Supreme Court vacated and remanded a decision by the Second Circuit in reliance on informal agency rulemaking subsequent to the Circuit Court's decision. *See Slekis v. Thomas*, 523 U.S. 1098 (1999), *vacating and remanding, Desario v. Thomas*, 139 F. 3d 80 (2d Cir. 1998).

a. Defendant Classifies neither Orthopedic Footwear nor Compression Stockings Exclusively as "Prosthetics."

Defendant's guidelines place coverage for compression stockings and orthopedic footwear within multiple categories, but all generally characterized as medical equipment. His policy for coverage of these items is laid out in 18 N.Y.C.R.R. § 505.5. Section 505 governs the provision of medical care in the Medicaid program in general, and § 505.5 in particular covers collectively the provision of "Durable medical equipment; medical/surgical supplies; orthotic and prosthetic appliances; [and] orthopedic footwear." Defendant's benefit limits are set out in subparagraph (g) of this regulation without reference to any particular subcategory. The collective treatment of these items in the regulation is mirrored in the *Durable Medical Equipment, Orthotics, Prosthetics, and Supplies Procedure Codes and Coverage Guidelines.* J.A. 216-339. These guidelines divide the services into seven different subcategories: Medical/Surgical Supplies; Enteral Therapy; Hearing Aid Battery; Durable Medical Equipment; Orthotics; Prescription Footwear; and Prosthetics. J.A. 217. Orthopedic footwear is covered in its own separate subcategory, "Prescription Footwear." J.A. 186. Compression stockings are listed in two subcategories: Prosthetics and Medical/Surgical Supplies. J.A. 189. Thus, the provider manuals on which Defendant seeks to rely demonstrate both that no orthopedic footwear is classified under "prosthetics" and

that, while some compression stockings do appear under "prosthetics," the rest are indisputably "supplies," a mandatory home health service under federal law.

Defendant's regulation and manual are better understood to implement a comprehensive medical supplies and equipment policy within the meaning of 42 C.F.R. § 440.70(b)(3). The fact that these items appear in various sub-categories in Defendant's policy manuals does not defeat their characterization as equipment for purposes of the federal regulation, and Defendant cannot force them exclusively into the singular optional category of prosthetics solely for purposes of defeating this litigation.[8]

Indeed, it is well settled that a needed medical service may fall within multiple Medicaid service categories – both mandatory services and optional services the state has elected to cover – and that it must be covered if it does fall within one or more of those categories. *See, e.g., S.D.*,391 F. 3d 581 (finding that incontinence supplies can fit within multiple Medicaid service definitions, including home health); *Fred C. v. Texas Health and Human Services Commission,* 924 F. Supp. 788, 791-92 (W.D. Tex. 1996, *affirmed without decision*, 167 F.3d 537 (5th Cir. 1998) (same, finding augmentative communication devices are both

[8] Defendant cannot pick and choose its categorization scheme simply to fit the response to litigation, and a position conjured solely for purposes of litigation should be rejected. *See, e.g., Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 212-13 (1988) (rejecting counsel's *post-hoc* rationalizations for agency action during ongoing litigation).

medical equipment and prosthetic devices); *accord William T. ex rel.Gigi T. v. Taylor*, 465 F.Supp.2d 1267, 1284-87 (N.D.Ga 2000) (alternative communication devices are home health services, prosthetic devices, and speech-language pathology equipment, and must therefore be covered by the state Medicaid program); 53 Fed. Reg. 8507 (Mar. 15, 1988) (Notice) (federal Medicaid agency statement that "the State may not administer a State plan which denies coverage of any medically necessary service or procedure within the five required categories even if it is also coverable as an optional service.").[9]

Here, too, even if the District Court is correct in viewing compression stockings and orthopedic footwear as prosthetic devices, that does not preclude their classification as supplies and medical equipment.[10] *See, e.g., Lankford*, 451

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[9] The District Court erred in dismissing the guidance provided in *Fred C.*, because it was vacated at 117 F.3d 1416 (5th Cir. 1997). S.P.A. 37, n. 19. The Fifth Circuit vacated and remanded the case solely to determine whether the plaintiff was eligible for Texas' home health services. The Circuit affirmed the holding that augmentative communication devices are both medical equipment and prosthetic devices. On remand, the District Court again held that ACDs are both medical equipment and prosthetic devices and that plaintiff is eligible for home health services. 988 F. Supp. 1032 (W.D. Tex. 1997), *aff'd*, 167 F.3d 537 (5th Cir. 1998).

[10] The Court also erred in relying on a regulation, 38 C.F.R. § 17.150, to support its conclusion that orthopedic shoes be exclusively classified as prosthetic devices. S.P.A. 43. That regulation, promulgated by the Department of Veterans Affairs, applies to the administration of veterans benefits and has no bearing on the Medicaid program, administered by CMS within the Department of Health and Human Services. Further, the cited regulation covers "prosthetics and similar appliances," including: "artificial limbs, braces, orthopedic shoes, hearing aids, wheelchairs, medical accessories, including invalid lifts and therapeutic and

F.3d 496, 501 (enjoining limitations to state durable medical equipment program that includes wheelchairs, orthotics, orthopedic devices, parenteral nutrition, augmentive communication devices, hospital beds, bed rails, lifts, and "other prosthetics"). These items fall squarely within the federally defined home health benefit, which must include medically necessary "equipment, supplies, and appliances." Defendant must therefore include coverage of orthopedic footwear and compression stockings within the home health benefit of the New York State Medicaid program.

b. The District Court Failed to Apply the Appropriate Federal Standard Regarding "Medical Supplies, Equipment and Appliances."

Ultimately, this Court need not engage in the sort of hair-splitting exercise necessary to decide which of Defendant's multiple categories singularly capture the medical items at issue in Defendant's benefit limits. The appropriate standard is set out in 42 U.S.C. § 1396a(a)(10)(D) as defined in 42 C.F.R. §§ 440.70(b)(3) and clarified in CMS's proposed regulations. The federal requirement is met where the services in question fit within the federal interpretation of home health services established in 42 C.F.R. § 440.70(b)(3), whether or not the state chooses to subsume them within a category of its own design. *See S.D.*, 391 F.3d at 593-94

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rehabilitative devices, and special clothing made necessary by the wearing of such devices." By this logic, even items identified in Defendant's limited category of "durable medical equipment" would be prosthetic devices.

(applying *Chevron* deference to the federal agency's interpretation of 42 C.F.R. § 440.70(b)(3), "[g]iving effect to the natural and plain meaning" of the term "medical supplies" without reference to state categories).

Here, both orthopedic footwear and compression stockings fit within the federal agency's understanding of "medical supplies, equipment and services." They are "primarily and customarily used to serve a medical purpose, generally not useful in the absence of an illness or injury, can withstand repeated use, and can be reusable or removable." 76 Fed. Reg. at 41034; J.A. 204. The Defendant cannot legitimately carve out subcategories within its provider manual and declare them exempt from the federal mandate. Thus, the District Court's application of Defendant's criteria to find that compression stockings and orthopedic footwear are optional "prosthetics" does not comport with the federal agency's understanding of "medical supplies, equipment and appliances." Plaintiffs were therefore entitled to summary judgment on this ground as well.

V. Defendant's Failure to Provide Plaintiffs with Adequate Notice and a Hearing Violated the Due Process Clause of the Fourteenth Amendment and the Medicaid Act.

The Fourteenth Amendment prohibits states from denying, reducing, or terminating Medicaid services without due process of law. The constitutional right includes the right to adequate written notice prior to the termination of Medicaid benefits, continued benefits pending a pre-termination hearing, and a fair and

impartial pre-termination hearing. *Goldberg v. Kelly,* 397 U.S. 254 (1970); *Catanzano by Catanzano v. Dowling*, 60 F.3d 113,115 (2d Cir. 1995). Federal Medicaid regulations explicitly implement the due process requirements set forth in *Goldberg*. 42 C.F.R. §§ 431.200-.250.

Federal regulations require written notice when the state terminates, suspends, or reduces Medicaid eligibility or covered services. *Id.* at §§ 431.206(c)(2), 431.210. Such notice must describe the action that the state intends to take, the reasons for the intended action, the specific regulation supporting the action, and the individual's right to request a hearing. *Id.* at § 431.210. Recipients are entitled to request a hearing when they believe that the state Medicaid agency has taken action erroneously. *Id.* § 431.220(a)(2). There is an exception when "the *sole* issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients." *Id.* at § 431.220(b) (emphasis added). However, even when a state is proposing action based upon a change in law, individuals are still entitled to a written notice that describes the specific action that the agency plans to take and the circumstances under which a hearing will be granted. *Id.* at § 431.210(d)(2).

The uncontested facts demonstrate that:

- Defendant has covered Plaintiffs' medically necessary orthopedic footwear and compression stockings for years.

- Defendant did not provide written notice to Plaintiffs of the decision to terminate coverage of these items in their cases or of the circumstances under which a hearing would be granted.
- Plaintiffs first learned that Defendant's policy would eliminate their services when they went to their respective suppliers to obtain them.
- The suppliers then orally told Plaintiffs they would not be able to receive the orthopedic footwear or compression stockings.

See J.A. 137 (Davis); 139-40 (Geary); 141, (Poole)[11]; 145-46 (Wallach).

Plaintiffs were entitled to individual written notices informing them that the compression stockings or orthopedic shoes they needed were no longer covered for certain conditions, what legal change ended their coverage, under what circumstances they would be covered, or whether, and under what circumstances, a fair hearing was available to contest the denial. Defendant's complete failure to provide written notice to Plaintiffs about the reductions in services violates the Fourteenth Amendment, the Medicaid statute and the regulations implementing *Goldberg*.[12] The District Court correctly found that Defendant failed to provide

[11] Ms. Poole did receive a letter from Defendant denying her physician's request for coverage of her compression stockings, but it made no mention of any of the conditions for which they would be covered and did not advise her of the circumstances under which she could obtain a fair hearing. J.A. 141-42.

[12] *Atkins v. Parker,* 472 U.S. 115 (1985), cited by Defendant in his Brief at p. 52, is inapposite because, unlike the facts in this case, in *Atkins* the state sent two written

the written notice required by 42 U.S.C. § 1396a(a)(3) and implementing regulation, 42 C.F.R. § 431.210(d)(2). J.A. 453.

Defendant argues that his violation should be overlooked because he alleges the violation was "technical" and "harmless." Br. of Appellant at 51. The federal regulation contains no exceptions, and the failure to provide written notice is far from "harmless." If class members received the written information required by the regulation, they could determine whether or not their condition is one of the ones for which compression stockings or orthopedic shoes are allowed, and, if so, could request a fair hearing to assert coverage was improperly terminated. If a class member became pregnant she would become eligible for compression stockings. Or if a class member's condition worsened, s/he could also become eligible.[13] Defendant did not contest the expert testimony provided by Dr. Svobada, J.A. 163-65, which demonstrates how, left untreated, the conditions for

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notices to each of the families affected by the change. *Id.* at 119-20. The Court held that a Food Stamp regulation, 7 C.F.R. §273.12(e) (2)(ii), required that individual written notices about the change in law must be mailed to the households affected. *Id.* at 126.

[13] Medicaid Fair Hearings are de novo hearings where the Administrative Law Judge decides based upon eligibility as of the date of the hearing. *See Taylor v. Bane*, 199 A.D.2d 1071, 606 N.Y.S.2d 112 (4th Dep't 1993) (evidence needed to support eligibility can be presented for the first time at the fair hearing). Subsequent to *Taylor,* New York adopted a "Correct when made" category of fair hearing reversals of initial agency actions to cover situations when eligibility is first established at the hearing.

which compression stockings are medically necessary can quickly escalate into much more dangerous and expensive conditions that will qualify for Medicaid coverage. The Defendant's argument that, since the legislative and rulemaking processes were conducted in public, somehow class members should have known about the changes is no substitute for compliance with the explicit requirement of the regulations.

The District Court correctly held that Defendant's actions violated Plaintiffs' due process rights and should therefore be affirmed.

VI. The District Court Correctly Found a Violation of the ADA's Integration Mandate.

Defendant's attempt to evade *Olmstead* is unavailing. In *Olmstead*, the Supreme Court examined the ADA's "integration mandate" and held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. *Olmstead*, 527 U.S. at 607.

The ADA charges the Department of Justice with implementing regulations, and these regulations set forth requirements for community integration.[14] The

[14] The applicable regulations provide that "a public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of

Department of Justice has also issued guidance that interprets *Olmstead* and its ADA regulations. This guidance states unequivocally, "[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." U.S. Dep't of Justice, *Statement of the 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, 2011) http://www.ada.gov/olmstead/q&a_olmstead.htm. The agency's interpretation of the regulation is entitled to deference. *See Llanos–Fernandez v. Mukasey*, 535 F.3d 79, 82 (2d Cir.2008) (holding agency's interpretation of its own regulations is entitled to deference and is "controlling unless plainly erroneous or inconsistent with the regulation") (quoting *Auer v. Robbins*, 519 U.S. 452, 461 (1997)).

In finding that Defendant's scheme violated *Olmstead*, the District Court properly relied on *Pashby v. Delia*, 709 F.3d 307 (4th Cir. 2013). In *Pashby*, the Fourth Circuit was "swayed by the DOJ's determination that the ADA and the *Olmstead* decision extend to persons at serious risk of institutionalization or

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qualified persons with disabilities." 28 C.F.R. § 35.130(d); *see also id.* at § 41.51(d). The preamble discussion of the ADA "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. § 35.130(d), App. A. at 571 (2009).

segregation and are not limited to individuals currently in institutional or other segregated settings." 709 F.3d at 322 (citations omitted) (citing regulation and DOJ guidance). The *Pashby* plaintiffs alleged that, due to obstacles in obtaining Medicaid coverage of personal care services at home, they were more likely to require institutionalization. The Fourth Circuit found that they were likely to succeed on the merits of their ADA and Section 504 claims, as they "face[d] a significant risk of institutionalization." *Id.*[15]

Here, in applying *Pashby*, not only is Plaintiffs' *Olmstead* claim "ripe," but the facts underlying that claim are arguably even more compelling than the facts at

[15] The Defendant cites *Amundson v. Wis. Dept. of Health Servs.*, 721 F.3d 871, 874 (7th Cir. 2013), for the proposition that, unless individuals have actually been *placed* in an institution, their *Olmstead* claims are not ripe. *Amundson* is distinguishable. The *Amundson* plaintiffs challenged Wisconsin's reductions to reimbursement rates for individuals living in group homes. Wisconsin disputed the contention that its rate reductions would lead to institutionalization and pointed out that the plaintiffs had not alleged that they would be unable to find other group homes that would accept the reduced rates. *Id.* at 873. There is nothing to indicate that the court was holding that, *as a general matter*, an individual cannot state a claim for relief under *Olmstead* unless he is institutionalized. Here, New York has not contested any of the evidence that the Medicaid services cuts will lead to increased risk of institutionalization. Moreover, the clear weight of authority supports the DOJ interpretation that the threat of institutionalization is actionable. "Because the [DOJ] is the agency directed by Congress to issue regulations implementing Title II, its views warrant respect," *Olmstead*, 527 U.S. at 597-98, and the Fourth, Ninth, and Tenth Circuits have all adhered to the DOJ guidance on this point. *See Pashby*, 709 F.3d at 322; *M.R. v. Dreyfus*, 697 F.3d 706, 734 (9th Cir. 2012); *accord Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1181-82 (10th Cir. 2003). This Court should follow suit.

issue in *Pashby*. The undisputed facts in the record show that Defendant's failure to cover essential medical treatments will lead to increased risks of institutionalization. Bobbi Wallach, who has already been confined to a nursing home in the recent past, was threatened with health crises that could lead to a return to the nursing home. J.A. 176. Similarly, in the absence of medically-necessary orthopedic footwear, Harry Davis risked severe medical complications, including further amputations, which could require institutionalization. J.A. 168-69. *See also*, J.A. 163 (compression stockings and orthopedic footwear prevent dangerous health conditions from developing and offer inexpensive remedies that prevent unnecessary hospitalization).

Because of the looming risk of institutionalization caused by the challenged policies, Plaintiffs were properly granted summary judgment on their ADA and Section 504 claims.[16] Defendant does not claim that covering compression stockings and orthopedic shoes would cause a fundamental alteration to his program – nor could he, since he has been covering these services for years and continues to do so. Furthermore, the hospitalization and institutionalization costs

[16] Because "the standards adopted by Title II of the ADA . . . are generally the same as those required under section 504," the courts "ordinarily treat claims under the two statutes identically." *Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003) (citations omitted). The same analysis applies in the context of *Olmstead* claims, for Title II and Section 504 "impose the same integration requirements." *Pashby*, 709 F.3d at 321.

resulting from the failure to cover these items would overwhelm the cost of actually providing the coverage. *See* J.A. 165 ("when a patient is hospitalized for treatment, *costs quickly escalate into the thousands and tens of thousands of dollars*. Inexpensive compression stockings can avoid such unnecessary expenditures") (uncontested testimony of Dr. Svoboda) (emphasis in original).

The District Court had ample basis for granting summary judgment to Plaintiffs on their "integration mandate" claim, and that ruling should be affirmed.[17]

VII. The Categorical Exclusion from Coverage of People with, *Inter Alia*, Transmetatarsal Amputation, Peripheral Neuropathy, Lymphedema, Multiple Sclerosis, and Paralysis Constitutes Blatant Disability Discrimination Under the ADA, and the District Court's Conclusion to that Effect Should Be Affirmed.

To establish a violation of Title II of the ADA, a party must demonstrate:

> (1) that he is a "qualified individual" with a disability; (2) that he was excluded from participation in a public entity's services, programs or activities or was otherwise discriminated against by a public entity; and (3) that such exclusion or discrimination was due to his disability.

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[17] Contrary to Defendant's assertion, *see* Br. of Appellant at 59, Plaintiffs are not required to show that compression stockings and orthopedic footwear would be covered in nursing homes in order to assert an *Olmstead* claim. In *M.R. v. Dreyfus*, 697 F.3d at 713-14, "[T]he record . . . [did] not reflect that the State [was] . . . providing services to individuals in institutions that it [had] . . . declined to provide to individuals living in community-based settings" (Bea, J., dissenting from denial of rehearing *en banc*); yet, the Ninth Circuit still held that the plaintiffs were entitled to a preliminary injunction based upon the risks of institutionalization imposed by Medicaid cutbacks.

> A qualified individual with a disability is defined as an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.
>
> A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity. A defendant need not make an accommodation at all if the requested accommodation would fundamentally alter the nature of the service, program, or activity.

Mary Jo C. v. New York State & Local Ret. Sys., 707 F.3d 144, 153 (2d Cir. 2013) (citations omitted).

Here, it is undisputed that Plaintiffs, who have been diagnosed with conditions such as transmetatarsal amputation, peripheral neuropathy, lymphedema, multiple sclerosis, and paralysis, are qualified individuals with disabilities. The only question remaining is whether depriving them of the Medicaid benefits based on their diagnoses constitutes disability discrimination.

The District Court found that it did, reasoning that the "State [must] not discriminate . . . solely on the basis of diagnosis." *Davis v. Shah*, J.A. 461. Indeed, when a defined class of people with disabilities is categorically excluded from receiving Medicaid benefits, Title II is violated. *Lovell v. Chandler*, 303 F.3d 1039 (9th Cir. 2002). In *Lovell*, the State of Hawaii redefined eligibility for

Medicaid, under which most previous recipients remained eligible "but several hundred blind and disabled [persons] . . . were denied any coverage." 303 F.3d at 1045. The Ninth Circuit concluded that this "categorical exclusion of the disabled" from Medicaid eligibility violated the ADA and Section 504. *Id.* at 1053. The *Lovell* court reasoned that "[t]he State's appropriate treatment of *some* disabled persons does not permit it to discriminate against *other* disabled people under any definition of 'meaningful access.'" *Id.* at 1054 (emphasis added).

The Ninth Circuit's analysis applies in full force here. People with significant disabilities have been wholly denied essential services, based purely on an arbitrary decision to exclude certain conditions and diagnoses.[18] *See also Rodde v. Bonta*, 357 F.3d 988, 997 (9th Cir. 2004) (Medicaid cutbacks that deny "treatment for complex and disabling medical conditions, such as paralysis and

[18] The failure to provide reasonable accommodations to these persons, which could allow them to qualify for benefits on a case-by-case basis, bolsters the conclusion that the current scheme violates the ADA. *See Mary Jo C.*, 707 F.3d at 165 (citations omitted) ("T]he question of what constitutes a reasonable accommodation under the ADA requires a fact-specific, individualized analysis of the disabled individual's circumstances and the accommodations that might allow him to meet the program's standards . . . We conclude that the ADA's reasonable modification requirement contemplates modification to state laws, thereby permitting preemption of inconsistent state laws, when necessary to effectuate Title II's reasonable modification provision"). *See also Davis v. Shah*, J.A. 458 n. 39 ("it appears that modification of a program's eligibility requirements can constitute a reasonable accommodation under the ADA and Section 504," citing *Pashby, supra*).

conditions associated with severe diabetes" violate the ADA) (upholding preliminary injunction).

The *Lovell* court rejected the contention that discriminating *among* people with disabilities was not actionable, 303 F.3d at 1054; and indeed, the case to the contrary cited by Defendant, *Traynor v. Turnage*, 485 U.S. 535, 549 (1988), has been discredited and superseded. *Olmstead*, issued 11 years after *Traynor*, "established a broader conception of discrimination under the ADA, one that *extended to discrimination amongst classes of the disabled.*" *Iwata v. Intel Corp.*, 349 F. Supp. 2d 135, 148 (D. Mass. 2004) (emphasis added). *Accord Amundson*, 721 F.3d at 874 (earlier courts "thought that 'discrimination' requires a comparison to the treatment of someone outside the protected class; *Olmstead* holds otherwise"); *see also Henrietta D*, 331 F.3d at 272-77.

Accordingly, the fact that Defendant covers compression stockings and orthopedic footwear for some people with other disabling conditions does not cure the violation. The categorical exclusion from coverage of people with significant disabilities amounts to blatant disability discrimination under Title II and Section 504, and the District Court's holding to that effect should be affirmed.

CONCLUSION

The District Court correctly held that Defendant's absolute benefit limits providing compression stockings and orthopedic footwear only to those few

Medicaid recipients who suffer from certain conditions while denying them to all others without the opportunity for review violate the reasonable standards and comparability requirements of the federal Medicaid Act, the notice requirements of the Act's due process provision and the Fourteenth Amendment, and the ADA and Section 504. Additionally, Defendant's benefit limits violate the obligation to cover home health services, and Defendant's failure to provide the opportunity for a hearing also violates Plaintiffs due process rights. For all of these reasons, the District Court opinion should be affirmed.

Dated: Rochester, New York
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UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

Harry Davis, Rita-Marie Geary, Patty Poole, Roberta (Bobbi) Wallach, on behalf of themselves and all others similarly situate

Plaintiffs-Appellees, **Docket No. 14-543**

v.

Nirav Shah, individually and in his official capacity as Commissioner of the New York State Department of Health

Defendant-Appellant.

CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P 32(a)(7)(B) because this brief contains 13,993 words, excluding the parts exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it was prepared in a proportionally spaced typeface using Mircosoft Word in14-point Times New Roman font.

Dated: Rochester, New York
September 8, 2014

Respectfully Submitted,

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Certificate of Service

I, Geoffrey A. Hale, certify that on September 8, 2014, I filed the foregoing Plaintiff-Appellant Brief electronically in PDF in accordance with CM/ECF requirements and in compliance with Local rule 25.1(c). Additionally, I served on the Court six (6) copies of the brief in compliance with Local Rule 31.1.

I further certify that a copy of the Plaintiffs-Appellees Brief was served electronically on September 8, 2014, to Victor Paladino, Attorney for Defendant-Appellant via CM/ECF.

Dated: September 8, 2014

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