UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

HARRY DAVIS; RITA-MARIE GEARY; PATTY POOLE; and ROBERTA WALLACH, on behalf of themselves and all others similarly situated,	)	
Plaintiffs	)	
v.	)	12-CV-6134-CJS-MWP
NIRAV SHAH, individually and in his official capacity as Commissioner of the New York State Department of Health,	)	
Defendant	)	

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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PRELIMINARY STATEMENT

Plaintiffs, Harry Davis, Rita-Marie Geary, Patty Poole, and Roberta Wallach are low-income New York residents who depend on the New York State Medicaid program for their health services. Plaintiffs suffer from a range of disabling conditions including multiple sclerosis, lymphedema, peripheral neuropathy, and transmetatarsal amputation. Plaintiffs' physicians have identified either orthopedic footwear or compression stockings as medically necessary to control or remedy serious medical conditions and to prevent potentially catastrophic or even fatal consequences. Defendant, however, has prevented Plaintiffs from obtaining these medically necessary treatments. As of April 1, 2011, Defendant ceased covering medically necessary orthopedic footwear and compression stockings for all Medicaid beneficiaries who do not meet one of a few statutorily prescribed exceptions.

Early in 2011, the New York State Legislature enacted New York Soc. Serv. Law § 365-a(2)(g)(iii) and (iv), covering compression stockings and orthopedic footwear only for Medicaid recipients with one of a few specified conditions. Defendant then promulgated a regulation, 18 N.Y.C.R.R. § 505.5(g)(1) and (2), to implement these new restrictions. The regulation expressly prohibits any exceptions to the new limitations, no matter how severe the underlying condition or how dire the consequences of doing without these treatments. Defendant Shah has also gone to great lengths to ensure that providers and suppliers are aware of the new restrictions by issuing several *Medicaid Updates* and *Provider Updates for Pharmacy and DME Providers*. At no point did Defendant Shah make any effort to notify the recipients themselves. Plaintiffs, most of whom have had these items covered by Medicaid for years, only learned of Defendant's decision when they went to a supplier, prescription in hand, to obtain the medically necessary items. Plaintiffs were turned away empty-handed. They were not provided by the Defendant with a written decision telling them: 1) why the coverage had changed; 2) about available exceptions;

or 3) anything about their right to request a fair hearing to contest Defendant's action and how to exercise that right..

Defendant's restrictions violate federal Medicaid and disability discrimination mandates. Plaintiffs therefore seek declaratory and injunctive relief for themselves and all those similarly situated to require Defendant to provide Medicaid coverage for their medically necessary orthopedic footwear and compression stockings. Plaintiffs seek a fair process by which they can establish the medical necessity of these treatments as required by Federal law.

PROCEDURAL HISTORY

On March 14, 2012, Plaintiffs filed this class action challenging New York Soc. Serv. Law § 365-a(2)(g)(iii) and (iv) under the federal Medicaid Act, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Plaintiffs' rights to due process under the Fourteenth Amendment to the U.S. Constitution. Complaint (Dkt. #1) ¶¶ 151-169. Together with the Complaint, Plaintiffs filed Motions for Class Certification (Dkt. # 2) and for Preliminary Injunction (Dkt. #3).

On March 27, 2012, Plaintiffs filed a Motion for Temporary Restraining Order seeking preliminary relief on behalf of three of the named Plaintiffs. (Dkt. # 8). After briefing by the Parties, argument was heard by this Court on April 20, 2012. By Decision and Order issued May 2, 2012, this Court granted Plaintiffs' request and required Defendant Shah to cover Plaintiffs' medically necessary orthopedic footwear and compression stockings. (Dkt. # 15).

In response to the Scheduling Order (Dkt. # 18), the Parties agreed that there were no issues of fact in contention and that the only remaining issues were matters of law. Proposed Discovery Plan (Dkt. # 21) ¶¶ 2,4. The Parties agreed that the matter is ripe for final adjudication. In accordance with the Order of July 18, 2012 (Dkt. # 22), Plaintiffs now submit this Motion for Summary Judgment.

STATEMENT OF FACTS

I. 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 to enable each state, as far as practicable, to furnish "rehabilitation and other services to help ... [low-income] ... families and 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 the Medicaid program, 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 Rabin v. Wilson-Coker*, 364 F. 3d 190, 192 (2d Cir. 2004); *Sai Kwan Wong v. Doar*, 571 F. 3d 247, 251 (2d Cir. 2009).

Medicaid is not available to everyone who is poor. It only covers certain groups of needy individuals, with almost all of those groups listed or referenced in 42 U.S.C. § 1396a(a)(10)(A). States have the option of covering certain categories of individuals, referred to as the "categorically needy," which consist 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 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.

II. NEW YORK'S POLICY ON ORTHOPEDIC FOOTWEAR AND COMPRESSION STOCKINGS

During the 2011 Legislative Session, Governor Andrew Cuomo established the Medicaid Redesign Team (hereinafter "MRT") to develop recommendations for cutting costs in the state Medicaid program. The MRT proposed sweeping changes to the Medicaid program through nearly 200 specific recommendations. The New York State Legislature enacted virtually all the changes proposed by the MRT, authorizing an estimated $2.2 billion in cuts.

The New York State Medicaid statute requires coverage of prescribed, medically necessary durable medical equipment. N.Y. Soc. Serv. L. § 365-a(2). However, as a result of the MRT recommendations, Section 365-a(2)(g) of the New York Social Services Law now covers orthopedic footwear and compression stockings only when the Medicaid beneficiary has a particular medical condition: "(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 has promulgated amendments to 18 N.Y.C.R.R. § 505.5 eliminating coverage of orthopedic footwear and compression stockings for most, but not all, categorically needy Medicaid recipients. The regulation now limits compression stockings to coverage only during pregnancy and for venous stasis ulcers. 18 N.Y.C.R.R. § 505.5(g)(1). The regulation also limits coverage of orthopedic footwear 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 regulation explicitly mandates that: "The department shall not allow exceptions to defined benefit limitations." 18 N.Y.C.R.R. § 505.5(g).

Defendant has communicated these statutory and regulatory changes directly to suppliers through a series of *Provider Updates for Pharmacy and DME Providers*.[1] Defendant made no attempt to communicate its decision to any Medicaid beneficiaries, many of whom–like Plaintiffs here–have had these medically necessary items covered by Medicaid for years.

Defendant's policies eliminate coverage for effective, affordable treatments known to prevent serious medical complications. Plaintiffs' Statement of Uncontested Facts (hereinafter "Facts") ¶¶ 19, 28, 29, 30, 33. The vast majority of those who need compression stockings, for example, suffer from chronic venous insufficiency (CVI). Facts ¶ 21. CVI is not included amonth the available exceptions. Yet, left untreated, CVI may cause life-threatening infections, ulceration, and cellulitis. Facts ¶¶ 22, 24. These conditions are difficult to treat and often require hospitalization and I.V. antibiotics. Facts ¶ 27. When a patient is hospitalized for treatments, costs quickly escalate into the thousands and tens of thousands of dollars. Facts ¶ 28. Inexpensive compression stockings can avoid such unnecessary expenditures. *Id.* Similarly, Defendant's limitations on orthopedic footwear will also deny Medicaid beneficiaries cost-

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[1] The New York State Department of Health *Provider Update for Pharmacy and DME Providers* of April 5, 2011, describes the new limits on orthopedic footwear, at: https://www.emedny.org/providermanuals/communications/Prescription%20_Footwear_Benefit%20_Update_20110405.pdf. The New York State Department of Health *Provider Update for Pharmacy and DME Providers* of May 25, 2011, describes the new limits on compression stockings, advising them that coverage for compression stockings is available "**only** when used in the treatment of open venous stasis ulcers" and "**only** for treatment of severe varicosities and edema **during pregnancy**"; the stockings are not covered "**for any other conditions, including** the prevention of ulcers, prevention of the recurrence of ulcers, treatment of lymphedema without ulcers, varicose veins, or circulation disorders." See: https://www.emedny.org/providermanuals/communications/Compression_Stockings_Notice_revised_20110520.pdf. (Emphasis in the original.) Defndant also communicated the new limits on the coverage of compression stockings and prescription footwear to providers in *The New York State Medicaid Update*, vol. 27, no. 6 (May 2011), at http://www.health.ny.gov/health_care/medicaid/program/update/2011/may2011mu.pdf.

effective treatments that provide for safe ambulation and prevent foot injury and infection. Facts ¶¶ 30-33, 54, 60.

III. PLAINTIFFS' NEED FOR ORTHOPEDIC FOOTWEAR AND COMPRESSION STOCKINGS

Plaintiffs are all disabled and meet Medicaid's income eligibility criteria. Facts ¶¶ 39, 56, 70, 95. Plaintiffs are therefore categorically needy under the Act.

A. Orthopedic Footwear is Medically Necessary for Plaintiff Harry Davis.

Plaintiff Harry Davis had transmetatarsal amputations of both feet close to the heel as the result of a meningitis infection in 2001. Facts ¶ 36. He became eligible for Medicaid while he was in the hospital recovering from the meningitis and amputations. Facts ¶ 39. Because his feet were amputated, Mr. Davis requires molded shoes in order to walk and to ride a bicycle, his primary means of transportation. Facts ¶ 44. The shoes also allow Mr. Davis to care for himself in his apartment and to engage actively with his community. Facts ¶ 45. Medicaid has covered one pair of shoes each year since he was discharged from the hospital in 2002. Facts ¶ 45.

Medicaid last covered Mr. Davis's shoes in December 2010. Facts ¶ 45. In September 2011, Mr. Davis learned from the supplier that Medicaid would no longer pay for them. Facts ¶ 48. Defendant gave Mr. Davis no notice of its change in policy and no notice of its decision not to cover his shoes. Mr. Davis was not informed that there were exceptions to the policy, and he was not informed that he had a right to request a fair hearing. Facts ¶ 50.

Because of Defendant's refusal, Mr. Davis had to make do with one pair of shoes for over a year. He wore through the inner padding that protects the sumps of his feet and began wearing through the hard rubber sole from the inside. Facts ¶ 51. The deterioration of his shoes left him in such unbearable pain that he was forced to remain at home most of the time, and could no longer engage in his community. Facts ¶ 52.

Without his shoes, Mr. Davis will no longer be able to walk, and will be required to use a wheelchair, for which Medicaid will have to pay. Facts ¶ 53. He will also be forced to leave his home, because it is not wheelchair-accessible. *Id.* He will require additional aide services to assist him at home, which Medicaid will also be expected to cover. Facts ¶ 53. Without shoes, he risks serious medical consequences, including increased callous formation, infection, and further loss of limb. As a result, Mr. Davis is at serious risk of institutionalization. Facts ¶ 54.

B. Orthopedic Footwear is Medically Necessary for Plaintiff Rita-Marie Geary.

Plaintiff Rita-Marie Geary suffers from a number of disabling ailments, including ankylosing spondylitis, psoriatic arthritis, osteoarthritis, scoliosis, osteoporosis, patellofemoral stress syndrome, and peripheral neuropathy. Facts ¶ 56. Ms. Geary has needed prescription footwear to manage her foot-related conditions since the 1990s. Facts ¶ 61. Medicaid has covered one pair of prescription shoes for her every year ever since she first needed them. Facts ¶ 61. While it is the peripheral neuropathy in particular that makes her orthopedic footwear medically necessary, the combination of her multiple impairments places her at increased risk of serious injury from falls resulting from improper footwear. Facts ¶ 60.

Her podiatrist, Dr. David E. High, D.P.M., wrote a prescription for a new pair of shoes for Ms. Geary on December 27, 2011. Facts ¶ 62. On January 3, 2012, when she attempted to fill the prescription, she was told that Medicaid would not cover her shoes. Facts ¶ 64. She had no prior notice of the new limitation, and no notice of the decision to deny coverage of her shoes in this instance. Facts ¶ 66. She was not told that there were exceptions to Defendant's new policy; nor was she informed that she had a right to request a fair hearing, if she disagreed with Defendant's denial. Facts ¶ 67. Without the shoes, Ms. Geary is at risk of additional falls, which, because of her many health issues, will likely cause significant injury. Facts ¶ 60..

C. Compression Stockings are Medically Necessary for Plaintiff Patty Poole.

Plaintiff Patty Poole suffers from lymphedema. Facts ¶ 69. Lymphedema causes excess swelling in Ms. Poole's legs, ankles, and feet. Facts ¶ 72. Because of the lymphedema, Ms. Poole is prone to develop skin infections or cellulitis. Facts ¶ 73. Early in 2011, Ms. Poole developed a cellulitic infection on the back of her right leg that grew to a mass about a foot in diameter. Facts ¶ 74. In order to remove the mass, Ms. Poole spent nearly a month in the hospital: two weeks of I.V. antibiotic treatments to eliminate the infection followed by an operation to remove the mass on April 4, 2011, and then two weeks of recovery before being discharged on April 18, 2011. Facts ¶ 75-77. Her surgeon, Dr. Samuel Pejo, M.D., then prescribed compression stockings to control the swelling in her legs. Facts ¶ 78. Defendant's policy had recently gone into effect, and Ms. Poole was unable to get the prescription for compression stockings filled. Facts ¶ 80. Ms. Poole requires custom-fitted compression stockings that would cost her about $900 out-of-pocket. Facts ¶ 86. She cannot afford to pay for them herself. Facts ¶ 87.

As the result of a prior authorization request, Ms. Poole received a letter from Defendant informing her that the prescription could not be filled, because the law had changed and compression stockings would no longer be covered. Facts ¶ 80. The letter said nothing about any exceptions to the policy and also failed to inform her of her right to request a fair hearing should she disagree with Defendant's decision. *Id.*

Since that time, Ms. Poole had to make do with alternate treatments that fail to control the swelling in her legs. Facts ¶ 81. Without proper treatment, her legs returned to their pre-operative size and the lymphedema spread into her abdomen. Facts ¶ 82. The complications attributable to these alternate treatments and their failure to effectively treat her condition have rendered her virtually home-bound. Facts ¶ 83, 84. Without compression stockings, Ms. Poole faces what her surgeon calls a "major medical disaster" due to the catastrophic effects of further

infection, massive edema, and ulceration of the skin. Facts ¶ 85. Because she suffers from diabetes, complications could result in loss of an extremity. *Id.*

D. Compression Stockings are Medically Necessary for Plaintiff Roberta Wallach.

Plaintiff Roberta Wallach suffers from Multiple Sclerosis. Facts ¶ 93. She was first diagnosed with the disease over 30 years ago. Facts ¶ 96. As the disease progressed, she lost more functional ability. Both of her legs and her left arm are now paralyzed, leaving her with no function in anything but her right arm and mouth. Facts ¶ 93, 96. Because her legs are paralyzed, she suffers from edema, which causes excess fluids to collect in her lower extremities. Facts ¶ 94. Ms. Wallach is therefore prone to develop deep venous thrombophlebitis and pulmonary embolism. These conditions can be fatal. *Id.*

Ms. Wallach has needed compression stockings since 2007, when she went into a nursing home. Facts ¶¶ 97, 100. On April 1, 2011—the same day that Defendant's policy went into effect—Ms. Wallach was able to leave the nursing home and move into her own apartment. Facts ¶ 101. Her compression stockings were last replaced before she left the nursing home. Facts ¶ 102. Ms. Wallach made do with her last pair of compression stockings through the end of the year, when they could no longer effectively control her condition. Facts ¶ 103. She ordered a new pair of compression stockings in January 2012, and was told that Medicaid would not cover them. Facts ¶ 106. Defendant had not informed Ms. Wallach of its decision not to cover her compression stockings. Defendant also did not notify her of any available exceptions in its policy, and did not inform her of her right to request a fair hearing. Facts ¶ 107.

Because of the severe risk of foregoing this treatment, Ms. Wallach was forced to pay for her compression stockings out-of-pocket. Facts ¶ 108, 109.

ARGUMENT

I. STANDARD FOR SUMMARY JUDGMENT.

Rule 56 of the Federal Rules of Civil Procedure provides that a moving party is entitled to summary judgment, if, based on the pleadings, depositions, answers to interrogatories and any affidavits submitted, there is no "genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *See Sista v. CDC Ixis North America, Inc.,* 445 F. 3d 161, 169 (2d Cir. 2006) ("[S]ummary judgment is appropriate where there exists no genuine issue of material fact and, based on the undisputed facts, the moving party is entitled to judgment as a matter of law") (internal quotation marks omitted). Whether a fact is material is determined for summary judgment purposes by looking to the relevant substantive law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 247, 248 and 254 (1986). A disputed fact is material if it might affect the outcome of the suit under the governing law. *Id.* If a party fails to establish the existence of an essential element of its case on which it has the burden of proof, the other party is entitled to judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986).

Under this standard, Plaintiffs' Motion for Summary Judgment must be granted.

II. STANDARD FOR PERMANENT INJUNCTION.

"The party requesting permanent injunctive relief must demonstrate (1) irreparable harm . . . and (2) actual success on the merits." *Cartier v. Symbolix, Inc.,* 454 F.Supp.2d 175, 186 (S.D.N.Y.2006); *see also Amoco Prod. Co. v. Vill. of Gambell, AK,* 480 U.S. 531, 546 n. 12, 107 S.Ct. 1396, 94 L.Ed.2d 542 (1987) ("The standard for a preliminary injunction is essentially the same as for a permanent injunction with the exception that the plaintiff must show a likelihood of

success on the merits rather than actual success.") *Ognibene v. Parkes*, 671 F.3d 174, 182 (2d Cir. 2012).[2]

Under this standard, Plaintiffs are entitled to permanent injunctive relief.

III. DEFENDANT'S FAILURE TO COVER MEDICALLY NECESSARY ORTHOPEDIC FOOTWEAR AND COMPRESSION STOCKINGS CAUSES PLAINTIFFS IRREPARABLE HARM.

It is well settled that a loss of Medicaid benefits constitutes irreparable harm in and of itself. *See, e.g., Henrietta D. v. Bloomberg*, 331 F. 3d 261, 290 (2d Cir. 2003) (failure to provide access to Medicaid and other public assistance programs constitutes irreparable harm and supports injunctive relief); Caldwell v. Blum, 621 F. 2d 491, 498 (2d Cir. 1980) (finding irreparable harm for denial of essential health benefits due to loss of Medicaid coverage); *Olson v. Wing*, 281 F. Supp. 2d 476, 486 (E.D.N.Y. 2003) ("to indigent persons, the loss of even a portion of subsistence benefits constitutes irreparable injury") (quoting *Reynolds v. Giuliani*, 35 F. Supp. 2d 331, 339 (S.D.N.Y. 1999), and *Morel v. Giuliani*, 927 F. Supp. 622, 635 (S.D.N.Y. 1995)). *See also, e.g., Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161, 1176-77 (N.D. Cal. 2009) (finding irreparable harm where disabled plaintiffs were losing Medicaid services "critical to ensuring that their tenuous physical and mental conditions remain stable, enabling them to remain in the community"); *V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1121-22 (N.D. Cal. 2009) (finding irreparable harm where lack of Medicaid-covered services could destabilize families and cause recipients to be unable to leave their homes); *Edmonds v. Levine*, 417 F. Supp. 2d 1323, 1342 (S.D. Fla. 2006) (summarizing eight Medicaid cases finding irreparable harm or imminent

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[2] The Second Circuit has maintained this standard for Preliminary Injunction after *Winter v. Natural Resources Defense Council*, 555 U.S. 7 (2008). *See Citigroup Global Markets, Inc. v. VCG Special Opportunities Master Fund Limited*, 598 F. 3d 30 (2d Cir. 2010). Should this Court nevertheless infer the additional requirement that the balance of hardships tip in favor of Plaintiffs, Plaintiffs have clearly also met this burden as explained in the Plaintiffs' Memorandum of Law in Support of Preliminary Injunction (Dkt. # 3-1) at 23-24.

risk of irreparable harm due to a variety of Medicaid cuts); *McMillan v. McCrimon*, 807 F. Supp. 475, 482 (C.D. Ill. 1992) ("possibility" that plaintiffs would have to enter nursing home due to loss of Medicaid services "constitutes irreparable harm").

Without the prescribed orthopedic footwear and compression stockings, Plaintiffs face increased risk of a host of severe and potentially fatal harms, including, but not limited to: infection, cellulitis, skin ruptures, ulceration, serious injury from falls, deep venous thrombophlebitis, pulmonary embolism, hospitalization, and institutionalization.

Plaintiff Harry Davis had bilateral metatarsal amputations of his feet a decade ago and is unable to walk without prescription molded shoes. Without the shoes, he will require a wheelchair and be forced to move from his home. He will risk further infection and further loss of limb. He will also face possible institutionalization.

Plaintiff Rita-Marie Geary suffers from numerous, disabling conditions, including peripheral neuropathy, making her unstable and prone to falls. The loss in bone density caused by her osteoporosis places her at risk of broken bones and other traumatic injuries from even the smallest of falls.

Plaintiff Patty Poole suffers from lymphedema and needs compression stockings to control the swelling in her lower extremities. She has already endured a month-long hospitalization and an operation to treat a cellulitic infection and remove a large mass. Lack of compression stockings rendered her virtually homebound; the swelling returned to pre-operative levels—even spreading into her abdomen—placing her at significant risk of infection and loss of limb.

Plaintiff Roberta Wallach has multiple sclerosis and is paralyzed in both legs. She needs compression stockings to control the edema in her legs and prevent potentially fatal deep venous thrombophlebitis and pulmonary embolism. Medicaid covered her compression stockings until

April 2011. Coverage of such medically necessary treatments as compression stockings enable Ms. Wallach to remain in the community rather than returning to the confines of a nursing home. Because she faces potentially fatal consequences without these medically necessary items, Ms. Wallach is forced to pay out of pocket for them.

Plaintiffs have clearly established irreparable harm sufficient to obtain a permanent injunction. Defendant has denied medically necessary treatments to all four Plaintiffs, and they have already suffered palpable harms as a result of Defendant's denials. Furthermore, Defendant did not challenge Plaintiffs' establishment of irreparable harm at the preliminary injunction level. Decision and Order (Dkt. # 15) at 11. Because the irreparable harm standard is the same for a permanent injunction, Plaintiffs have satisfied their burden.

IV. PLAINTIFFS WILL SUCCEED ON THE MERITS OF THEIR CLAIMS

A. Coverage of Medically Necessary Orthopedic Footwear and Compression Stockings Limited to Medicaid Recipients Who Meet an Exception Violates the Home Health Services Requirement of the Medicaid Act.

Federal laws and regulations require States participating in the Medicaid program to provide home health services to "any individual who, under the State plan, is entitled to nursing facility services...." 42 U.S.C. § 1396a(a)(10)(D). All categorically needy individuals are entitled to nursing facility services. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a); 42 C.F.R. §§ 440.70, 440.210(a)(1), and 441.15(b)(1). Thus, states must provide home health services to all categorically needy individuals.

Under federal Medicaid law, home health services are provided to the Medicaid recipient at his or her place of residence, and include "medical supplies, equipment, and appliances suitable for use in the home." 42 C.F.R. §§ 440.70(a)(1) and (b)(3); *see also* 42 C.F.R. § 441.15 ("a State Plan must provide that ... the [state Medicaid] agency provides home health services to ... Categorically needy recipients age 21 and over"); 42 C.F.R. § 440.210 ("a State Plan must

specify that, at a minimum, categorically needy recipients are furnished ... the services defined in ... 440.70.); 42 C.F.R. §440.210(a)(1).

A number of courts have struck down state Medicaid policies that denied or limited access to home health services, including medical equipment and supplies. Noting that "[h]ome health care services are generally a mandatory service for the categorically needy," the court in *Esteban v. Cook* struck down a restriction that denied coverage of wheelchairs—a home health service—in violation of the Medicaid Act. 77 F. Supp. 2d 1256, 1259 (S.D. Fla. 1999). *See also Ladd v. Thomas*, 962 F. Supp. 284, 288 (D. Conn. 1997) (citing 42 C.F.R. § 440.70(b)(3) and finding that "Federal law mandates that participating states provide home health services, including durable medical equipment, to Medicaid recipients where such equipment is medically necessary"); *Hodges v. Smith*, 910 F. Supp. 646, 649 (N.D. Ga. 1995) (Georgia could not rely on its state plan to deny home health services because "inclusion of home health services in the state medical plan is mandated by federal law").

In the instant case, New York excludes coverage of medically necessary orthopedic footwear and compression stockings for all those who do not also suffer one of the statutorily prescribed conditions. Because these items are mandatory home health services to which all categorically needy Medicaid recipients are entitled, Defendant's written policies, regulation 18 N.Y.C.R.R. § 505.5(g)(1) and (2), and New York Soc. Serv. L. § 365-1(2)(g)(iii) and (iv) violate 42 U.S.C. § 1396a(a)(10)(D). This Court has already found that, for purposes of the preliminary injunction, Plaintiffs have established the likelihood of success that the challenged statute and Defendant's challenged policies violate the home health requirement in 42 U.S.C. § 1396a(a)(10)(D). Decision and Order (Dkt. #15) at 13. As part of the preliminary injunction decision and order, the Court applied the *Blessing/Gonzaga* enforcement test and concluded that 42 U.S.C. § 1396a(a)(10)(D) creates a federal right that Plaintiffs can enforce pursuant to 42

U.S.C. § 1983. Decision and Order (Dkt. # 15) at 12-17 (applying *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997) and *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002)).[4] There is no cause to revisit the Court's decision finding plaintiffs can enforce § 1396a(a)(10)(D) under § 1983.[5]

B. Denial of Medically Necessary Orthopedic Footwear and Compression Stockings Without an Individualized Exceptions Process Violates the "Reasonable Standards" Requirement of the Medicaid Act.

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); *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981); *Herweg v. Ray*, 455 U.S. 265 (1982); *Sai Kwan Wong v. Doar*, 571 F. 3d 247, 251 (2d Cir. 2009). *See also Lankford v. Sherman*, 451 F. 3d 496, 506 (8th Cir. 2006) (while "a state has considerable discretion to fashion medical assistance under its Medicaid plan, this discretion is constrained by the reasonable-standards requirement"). Medicaid regulations further limit state discretion by requiring that "appropriate limits" be "based on such criteria as medical necessity

[4] Since the preliminary injunction was issued on May 3, 2012, the Court's reasoning has been reinforced by the Second Circuit Court of Appeals. *Shakhnes v. Berlin*, 689 F.3d 244, 251-56 (2d Cir. 2012) holds Medicaid beneficiaries can enforce a similarly worded Medicaid provision, 42 U.S.C. § 1396a(a)(3), as construed by an implementing regulation. *Compare* 42 U.S.C. § 1396a(a)(3) (requiring State Medicaid agency to provide for a fair hearing to "any individual" whose Medicaid claim is denied or delayed) *with* 42 U.S.C. § 1396a(a)(10)(D) (requiring State Medicaid agency to provide for home health services "for any individual" who is entitled to nursing facility services).

[5] Furthermore, the Defendant does not dispute that Plaintiffs may bring a Supremacy Clause action to obtain relief through the Supremacy Clause of the U.S. Constitution, U.S. Const. Art. VI, cl. 2. *See Lankford v. Sherman*, 451 F.3d 496, 509-13 (8th Cir. 2006) (finding plaintiffs likely to succeed on claim that a Missouri medical equipment regulation was preempted by the Supremacy Clause, because it conflicted with Medicaid's reasonable-standard requirements).

or on utilization control procedures." 42 C.F.R. § 440.230(d). 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). Thus, limits on mandatory services based solely on diagnosis or condition, and not on medical necessity, are "arbitrary" and unreasonable. *See Lankford*, 451 F. 3d at 511) (citing cases) ("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").

Courts, therefore, have long invalidated state Medicaid policies that arbitrarily restrict access to medical equipment, services, and supplies based on criteria other than medical necessity as violations of the "reasonable standards" requirement. *See Lankford,* 451 F. 3d at 511-12 (invalidating state limitations on durable medical equipment to most categorically needy Medicaid beneficiaries); *Hern v. Beye*, 57 F. 3d 906, 910-11 (10th Cir. 1995) (state agency cannot deny abortion coverage for qualified women who are victims of rape or incest); *Preterm, Inc. v. Dukakis*, 591 F. 2d 121, 126, 131 (1st Cir. 1979) (abortion services only to prevent the death of the mother violate the reasonableness requirement); *Zbaraz v. Quern*, 596 F. 2d 196, 199 (7th Cir. 1979) (concurring with *Preterm*); *Hiltibran v. Levy*, 793 F. Supp. 2d 1108, 1115 (W.D. Mo. 2011) (denial of non-experimental, medically necessary DME violates Medicaid's reasonable standards requirement).

Nevertheless, the Second Circuit Court of Appeals once held that it was permissible for the Connecticut Medicaid program to maintain "exclusive lists" of medical equipment, and thereby deny individual recipients coverage of medically necessary DME. *DeSario v.Thomas*, 139 F. 3d 80 (2d Cir. 1998). In response to this decision, the Health Care Financing Administration of the federal Department of Health and Human Services, the agency charged with implementing the Medicaid Act (now the Centers for Medicare and Medicaid Services)

(hereinafter "CMS"), issued a *Dear State Medicaid Director* letter explaining the appropriate DME policy for state Medicaid programs.[6] In its letter, CMS summarized each state's federal obligations under the Medicaid reasonableness-standards requirement, and described the minimum standards that all state DME policies are required to maintain:

> An ME [medical equipment] policy that provides no reasonable and meaningful procedure for requesting items that do not appear on a State's pre-approved list, is inconsistent with the federal law [. . .]. [T]he process for seeking modification or exception must be made available to all beneficiaries and may not be limited to sub-classes of the population (e.g., beneficiaries under the age of 21) [. . .]. [A] state will be in compliance with federal Medicaid requirements only if, with respect to an individual applicant's request for an item of ME, the following conditions are met: The process is timely and employs reasonable and specific criteria by which an individual item of ME will be judged for coverage under the State's home health services benefit.

CMS, *Dear State Medicaid Director* (September 4, 1998).

On the basis of this agency guidance, the Supreme Court vacated the *DeSario* decision and remanded the case for further consideration in light of the CMS guidance. *See Slekis v. Thomas*, 523 U.S. 1098 (1999), *vacating and remanding, Desario v. Thomas*, 139 F. 3d 80 (2d Cir. 1998). Since then, courts ruling directly on the issue have struck down categorical denials of coverage for mandatory services without an individualized exceptions process as violations of the reasonable standards and comparability requirements. *See Lankford*, 451 F. 3d at 513 (invalidating state elimination of DME where no meaningful procedure for requesting non-covered DME was provided); *Hiltibran*, 793 F. Supp. 2d at 1115.

In *Lankford*, the Eighth Circuit faulted a Missouri policy that excluded several items of medical equipment and supplies (e.g., respiratory care equipment, parenteral nutrition [feeding tubes], decubitus care equipment, wheel chair batteries, and hospital beds) for certain disabled adults without regard to medical necessity. 451 F. 3d at 501, 511. New York's arbitrary

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[6] *See*, CMS, *Dear State Medicaid Director* (Sept. 4, 1998), at http://www.cms.gov.hhs.gov/states/letters/smd90498.asp

exclusion of coverage for orthopedic footwear and compression stockings is equally unreasonable. The state's policy will cover orthopedic shoes for someone with diabetes *and* peripheral neuropathy, but not peripheral neuropathy without diabetes; a patient with swelling in his or her legs so severe that venous stasis ulcers have already developed will get compression stockings, but a patient with lymphedema who has already suffered massive cellulitic infection that required surgical treatment at Defendant's expense will not—even when Defendant's own health policy strongly recommends use of compression stockings to treat the condition.[7] Such distinctions have nothing to do with medical necessity, are improperly based solely on diagnosis or condition, and therefore violate the reasonableness requirement in 42 U.S.C. § 1396a(a)(17).[8]

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

The Medicaid Act requires that "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); *see also* 42 C.F.R. § 440.240(b) (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.") This requirement is known as the "comparability requirement." Thus, services made available to any categorically needy

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[7] Defendant's New York State Department of Health publication on lymphedema. http://www.health.ny.gov/publications/0399.pdf.

[8] The Defendant does not dispute that Plaintiffs may bring a Supremacy Clause action to obtain relief through the Supremacy Clause of the U.S. Constitution, U.S. Const. Art. VI, cl. 2. *See Lankford v. Sherman*, 451 F.3d 496, 509-13 (8th Cir. 2006) (finding plaintiffs likely to succeed on claim that a Missouri medical equipment regulation was preempted by the Supremacy Clause, because it conflicted with Medicaid's reasonable-standard requirements); *cf. Hiltibran v. Levy*, 793 F. Supp. 2d 1108 (W.D. Mo. 2011) (granting summary judgment and permanent injunction on plaintiffs' Supremacy Clause claim regarding § 1396a(a)(17).

individual must be made available to all such individuals. *See Schweiker v. Hogan*, 457 U.S. 569, 573 n. 6 (1982) (finding 42 U.S.C. § 1396a(a)(10)(B)(i) to mean that "the amount, duration, and scope of medical assistance provided to an individual who qualified to receive assistance for the aged could not be different from the amount, duration, and scope of benefits provided to an individual who qualified to receive assistance for the blind"). *See also Lankford*, 451 F. 3d at 505 (state policy that provides various items of DME to some categorically needy but not others violates the comparability requirement); *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 42 U.S.C. § 1396a(a)(10)(B) prohibits discrimination between groups of the categorically needy as well as between individuals within the same group).[9]

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[9] 42 U.S.C. § 1396a(a)(10)(B) creates a right that the Plaintiffs in this case can enforce pursuant to § 1983. Section (10)(B) requires the State Medicaid agency to ensure that the medical assistance made available to "any [categorically needy] individual ... shall not be less in amount, duration or scope that the medical assistance made available to any other such individual." This provision has an unmistakable individual focus; its enforcement does not strain judicial competence; and the provision creates a binding obligation on the State Medicaid agency. Finally, the Supreme Court has recognized that the Medicaid Act does not include a remedial scheme that forecloses a remedy under § 1983. *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 521 (1990) ("The Medicaid Act contains no . . . provision for private judicial or administrative enforcement."); *see also City of Rancho Palos Verdes v. Abrams*, 544 U.S. 113, 121-22 (2005) (citing *Wilder* and listing Medicaid as a statute whose enforcement is not foreclosed). Notably, this case is clearly distinguishable from cases previously decided by this Court that refused to allow private enforcement of section (a)(10). In *Casillas v. Daines*, 580 F. Supp. 2d 235 (S.D.N.Y. 2008) and *Ravenwood v. Daines*, No. 06-cv-6355, 209 WL 2163105 (S.D.N.Y. July 17, 2009), the Plaintiffs, citing § 1396a(a)(10), asked the Court to order the State Medicaid agency to cover their transsexual surgery even though the State did not cover such surgery for anyone under Medicaid. Under this argument, as the Court pointed out, "any treatment that is reimbursable for one diagnosis would be a reimbursable treatment for a different diagnosis if it were deemed by the patient's doctor to be a medical necessity." *Casillas*, 580 F. Supp. 2d at 244. However, this case is nothing like *Casillas*. Here, the Defendants cover orthopedic footwear and compression stocking under the Medicaid program for some categorically needy beneficiaries but not for others. Under these facts, the Plaintiffs' have a right under 42 U.S.C. § 1396a(a)(10)(B) that is enforceable under § 1983. *See, e.g., Botrager v. Ind. Fam. & Soc. Servs. Admin.*, _ F.3d _, 2012 WL 4372524 (7th Cir. Sept. 26, 2012), *aff'g*, 829 F. Supp. 2d 688 (N.D.

Defendant's current policy to cover orthopedic footwear and compression stockings only for individuals who have conditions discriminates among Medicaid beneficiaries in violation of comparability requirement in federal Medicaid law. Defendant's policy is therefore invalid.

D. Defendant's Elimination of Coverage for Medically Necessary DME Without Notice and Without Informing Recipients of their Right to Request a Fair Hearing Violates the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution and the Medicaid Act.

The Fourteenth Amendment to the U.S. Constitution prohibits states from denying, reducing, or terminating Medicaid services without due process of law. The constitutional right includes the right to meaningful 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). Federal Medicaid regulations explicitly implement the due process requirements set forth in *Goldberg*. 42 C.F.R. § 431.200-.250. Under these requirements, recipients are entitled to receive timely, adequate, and understandable written notices of their hearing rights when an action affects their claim for health services; the hearing must be fair and impartial and held at a meaningful time; coverage of services must be continued at the prior level until a final *de novo* hearing decision if: (a) a Medicaid recipient requests a fair hearing before the date that the services are to be stopped or reduced; (b) the recipient requests the hearing within 10 days of the mailing of the notice; or (c) the requisite notice is not sent. 42 C.F.R. Part 431. *See Catanzano by Catanzano v. Dowling*, 60 F. 3d 113 (2d Cir. 1995) (notice and hearing required where certified home health agency, as state actor, reduces or terminates a recipient's aide services); *Olson*, 281 F. Supp. 2d at 486 (termination of Disaster Relief Medicaid benefits without pre-termination hearing and aid continuing violates due process requirements);

Ind. 2011). Finally, the Defendant does not dispute that Plaintiffs may bring a Supremacy Clause action to obtain relief through the Supremacy Clause of the U.S. Constitution, U.S. Const. Art. VI, cl. 2. *See Lankford*, 451 F.3d at 509-13.

Mayer v. Wing, 922 F. Supp. 902, 910 (S.D.N.Y. 1996) (finding Medicaid benefits are a protected property interest under the Fourteenth Amendment).

Federal regulations require written notice when the state terminates, suspends, or reduces Medicaid eligibility or covered services. 42 C.F.R. §§ 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. 42 C.F.R. § 431.210. Recipients are entitled to request a hearing when they believe that the agency has denied a claim or taken action erroneously. *Id.* § 431.220(a)(1) and (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." 42 C.F.R. § 431.220(b) (emphasis added). Even when a state is proposing action based upon a change in state or federal law, however, individuals are still entitled to notice that describes the specific action that the agency plans to take and the circumstances under which a hearing will be granted. 42 C.F.R. § 431.210(d)(2).

In the instant case, Defendant has covered Plaintiffs' medically necessary orthopedic footwear and compression stockings for years. Defendant did not notify Plaintiffs of its decision to terminate coverage of these items in their cases. Plaintiffs only learned that Defendant would not cover their treatments when they went to their respective suppliers to obtain them. Defendant failed to provide adequate and timely written notice informing Plaintiffs that the equipment they needed was no longer covered, why it was not covered, under what circumstances it would be covered, or whether a fair hearing was available to contest the denial. Accordingly, Defendant's failure to notify Plaintiffs of reductions in mandatory home health services and available fair hearing rights violate the Fourteenth Amendment as well as the Medicaid statute and regulations.

E. Denial of Medically Necessary Compression Stockings and Orthopedic Footwear Violates The ADA and Section 504.

1. The ADA and Section 504 Prohibit Discrimination Against Individuals with Disabilities.

Congress enacted the Americans with Disabilities Act (hereinafter "ADA") to prohibit discrimination by all public entities against people with disabilities. 42 U.S. C. §§ 12131-12165; H.R. Rep. No. 101-485, pt. 3, at 49 (1990), *reprinted in* 1990 U.S.C.C.A.N. 267, 472. The goals of the ADA "are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for each individual [with disabilities]." 42 U.S.C. § 12101(a)(8). The Supreme Court has held that unjustified isolation is properly regarded as discrimination based on disability under the ADA. *Olmstead v. L.C.* 527 U.S. 581, 597 (1999).

Title II of the ADA, which governs public programs such as the New York State Medicaid program, provides:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132; *Disability Advocates, Inc. v. Patterson*, 598 F. Supp. 2d 289, 316 (E.D.N.Y.2009), *rev'd on other grounds sub nom. Disability Advocates, Inc. v. New York Coalition for Quality Assisted Living, Inc.*, 675 F. 3d 149 (2d Cir. 2012) (Title II of the ADA applies to "all programs, services, and activities of a state or local government entity *without* any exception") (emphasis in original). Section 504 of the Rehabilitation Act applies the same standards to entities that receive federal financial assistance. 29 U.S.C. § 794(a). *Gorman v. Barnes*, 536 U.S. 181, 184-85 (2002); *Bragdon v. Abbott*, 524 U.S. 624, 631-32 (1998).

Under the ADA, a "qualified individual with a disability" is a person who "with or without reasonable modifications to rules, policies or practices" meets the "essential eligibility

requirements for the receipt of services or the participation in programs or activities provided by a public entity." 42 U.S.C. § 12132(2). Section 504's definition is substantially similar. *See* 29 U.S.C. § 705(20).[11] All Plaintiffs are eligible for Medicaid and are qualified persons with disabilities within the meaning of the ADA and Section 504.

2. The "Integration Mandate" of the ADA and Section 504 Prohibit Unjustified and Unnecessary Institutionalization.

In enacting the ADA, Congress found that segregation of persons with disabilities, especially in institutions, is a form of discrimination. 42 U.S.C. § 12101(a)(2), (3), and (5). The ADA's integration mandate requires public entities to "administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." *Olmstead*, 527 U.S. at 592; 28 C.F.R. § 35.130(d). The Court interpreted the ADA's "integration mandate" to require persons with disabilities to be served in the community rather than in institutions when community placement is appropriate, the community setting is not opposed by the affected individual, and the State cannot demonstrate a fundamental alteration of its programs and services. *Id.* at 587, 591-92, 602-03. Only where states can show that compliance would require a fundamental change in their service systems may they avoid this obligation. *Olmstead*, 527 U.S. at 591-92, 603; *Townsend v. Quasim*, 328 F. 3d 511, 516-17 (9th Cir. 2003); *Radeszewski v. Maram*, 383 F. 3d 599, 607 (7th Cir. 2004); *Fisher v. Okla. Health Care Auth.*, 335 F. 3d 1175, 1183 (10th Cir. 2003); *Disability Advocates, Inc., v. Patterson*, 653 F. Supp. 2d 184, 191 (E.D.N.Y. 2009). Plaintiffs do not need to wait until they are institutionalized to bring a claim under the integration mandate. Plaintiffs who currently reside

[11] ADA regulations define disabilities, with respect to an individual, to include "a physical or mental impairment that substantially limits one or more of the major life activities of such individual ... such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 28 C.F.R. § 35.104. The Section 504 requirements are essentially the same. 28 C.F.R. § 41.32.

in community settings may assert ADA integration claims to challenge state actions that give rise to a risk of unnecessary institutionalization. *See Fisher*, 335 F. 3d at 1181-82; *Brantly v. Maxwell-Jolly*, 656 F. Supp. 2d 1161 (N.D. Cal. 2009).

The integration mandates of the ADA and Section 504 are virtually identical and are applied in the same way. *See Radaszewski*, 383 F. 3d at 607; *Fisher*, 335 F. 3d at 1179 n. 3 (10th Cir. 2003); *Disability Advocates, Inc.*, 653 F. Supp. 2d at 190-91.

In this case, Plaintiffs' providers have identified unnecessary institutionalization as one of the consequent risks of Defendant's denials of their treatments. Plaintiff Wallach has already resided in a nursing home, and could very well be forced to return there without the services necessary to maintain her health in the community. Defendant's failure to cover their treatments has already rendered Plaintiffs Davis and Poole virtually home-bound, isolating them from the community in violation of *Olmstead*, the ADA, and Section 504. Finally, covering orthopedic footwear and compression stockings will not require any fundamental alteration of Defendant's services where Defendant has already covered these medically necessary items for Plaintiffs for years and where Defendant continues to provide these items for all those who meet the statutorily prescribed exceptions. The cost of providing these services pales in comparison to the potential costs of doing without, including unnecessary hospitalizations, increased aide services, and forced institutionalization.

3. Defendant's Denial of Coverage for Compression Stockings and Orthopedic Footwear for Qualified Individuals with Disabilities Violates the ADA and Section 504 Methods of Administration Requirements.

The ADA prohibits methods of administration that have a discriminatory effect:

> Directly or through contractual or other arrangements utilize ... methods of administration (i) [t]hat have the effect of subjecting qualified individuals with a disability to discrimination on the basis of disability; [and] (ii) [t]hat have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disability.

28 C.F.R. § 35.130(b)(3).[12]

Defendant's policies on orthopedic footwear and compression stockings discriminate against Plaintiffs by arbitrarily refusing to make an exception or prior authorization process available to them under *any* circumstances.

Moreover, Defendant's methods of administration defeat the purpose of the Medicaid program, which is to enable each state, "to furnish (1) medical assistance to disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) … to help such families and individuals attain or retain capability for independence or self-care." 42 U.S.C. § 1396-l. Defendant's orthopedic footwear and compression stockings policies contradict these purposes by requiring individuals with disabilities to use their own "insufficient" resources to "meet the costs of necessary medical services." *See Brantley v. Maxwell-Jolly,* 656 F. Supp. 2d at 1175 (finding plaintiffs likely to succeed on their claims that the state violated the methods of administration requirement by, *inter alia*, failing to provide advance notice of cuts to services). Defendant's policies thus violate the methods of administration requirements of the ADA and Section 504.

CONCLUSION

This Court should grant Plaintiffs' Motion for Summary Judgment and permanently enjoin Defendant from enforcing its illegal policies, regulation and New York Soc. Serv. L. § 365-a(2)(iii) and (iv), and from arbitrarily denying medically necessary orthopedic footwear and compression stockings through any other means.

Dated: Rochester, New York
October 1, 2012

[12] Section 504 contains similar requirements that prohibit methods of administration that result in disability-based discrimination. *See* 28 C.F.R. § 41.51(b)(3)(i); 45 C.F.R.§ 84.4(b)(4).

Respectfully Submitted,

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