UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

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

Plaintiffs,

-vs-

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

Defendant.

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**MEMORANDUM OF LAW**

12-CV-6134 CJS

## PRELIMINARY STATEMENT

Plaintiffs commenced this action claiming that the defendant's application of New York Social Security Law § 365a(2)(g)(iii) & (iv) or 18 NYCRR § 505.5(g) "violate federal Medicaid and disability discrimination laws." Docket #1: Complaint at ¶2.

Defendant COMMISSIONER NIRAV SHAH now moves for summary judgment based on plaintiff's failure to state a claim upon which relief can be granted as a matter of law. The defendant submits that summary judgment in its favor is warranted at this time.

## FACTS

The facts relevant to this motion are found in Defendant's Local Rule 56 Statement of Material Facts Not Subject to Genuine Dispute, submitted herewith. Therefore, they will not be repeated here.

## STATEMENT OF THE CASE

### A. Statutory and Regulatory Background

Medicaid is a joint federal-state program to fund medical care, services, and supplies for the financially needy. See 42 U.S.C. §§ 1396-1396v; Social Services Law §§ 363-369. The Medicaid Act establishes a program that pays federal funds to states that agree to maintain a medical assistance program for the benefit of aged, blind, or permanently disabled individuals and for the benefit of families with dependent children. See 42 U.S.C.A. §§ 1396 *et seq*. The Medicaid program is a cooperative program that is financed jointly by the federal and state governments. See 42 C.F.R. § 430.0. The program is voluntary, but once a state chooses to join, it must follow the requirements set forth in the Medicaid Act and its implementing regulations. See Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498, 502, 110 S. Ct. 2510, 110 L. Ed. 2d 455, 30 Soc. Sec. Rep. Serv. 100 (1990).

### B. Covered Medicaid Groups: Mandatory and Optional

State Medicaid plans must provide for making medical assistance ("Medicaid") available to certain groups of persons. These groups are commonly referred to as the "categorically needy."[1] Upon information and belief, plaintiffs Harry Davis and Patty Poole are SSI recipients and are categorically needy on that basis, as is Diane Pomeroy. [2] States are permitted, but not required, to cover certain other categorically needy groups. These are the "optional" categorically needy, which share characteristics

[1] 42 U.S.C. § 1396a(a)(10)(A)(i), Social Security Act ("SSA") § 1902(a)(10)(A)(i), 42 C.F.R. Part 435, Subpart B

[2] Ms. Pomeroy was granted interim relief under this Court's July 13, 2012, order.

of the mandatory groups but have somewhat higher income and resources.[3] New York's Medicaid program covers the optionally categorically needy groups.

States are also permitted, but not required, to cover the "medically needy."[4] If the medically needy applicant's income and resources exceed state eligibility levels, they can become eligible after incurring medical expenses sufficient to reduce their income and resources to state eligibility levels. New York's Medicaid program also covers the medically needy.[5] One example of a "medically needy" group is recipients of Social Security Disability Benefits ("SSDI"). Upon information and belief, plaintiffs Roberta Wallach and Rita-Marie Geary are SSDI recipients, and are medically needy.[6]

**C. Medicaid Coverage: Mandatory and Optional**

**I. Mandatory Coverage**

The Medicaid Act defines "medical assistance" as payment of part or all of the cost of care and services included in 29 enumerated categories.[7] Some of these services are mandatory, meaning that each state must include them for certain populations. Other services may be included at the option of the state.

Mandatory coverage for the categorically needy include the following:

- inpatient hospital services;
- outpatient hospital, rural health clinic and federally qualified health center services;
- laboratory and x-ray services;

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[3] 42 U.S.C. § 1396a(a)(10)(A)(ii), SSA § 1902(a)(10)(A)(ii), 42 C.F.R. Part 435, Subpart C

[4] 42 U.S.C. § 1396a(a)(10)(C), SSA § 1902(a)(10)(C), 42 C.F.R. Part 435, Subpart D

[5] Social Services Law ("SSL") § 366

[6] Mary Carol LaRocca and Dorothy Kurbanick, who were granted interim relief under this Court's July 13, 2012, order, are also medically needy, upon information and belief.

[7] 42 U.S.C. § 1396d(a)(1) - (29), SSA § 1905(a)(1) – (29)

- nursing facility services for persons 21 years of age or older; early and periodic screening, diagnostic and treatment services for persons younger than 21 years of age; family planning services and supplies; and tobacco cessation services for pregnant women;
- physician's services and medical and surgical services provided by dentists;
- nurse mid-wife services;
- nurse practitioner services; and
- freestanding birth center services. [8]

Mandatory coverage for the medically needy include prenatal care and delivery services and ambulatory services for children younger than 18 and those entitled to institutional services. In addition, if the state provides payment for services provided to the medically needy in institutions for mental diseases and intermediate care facilities for the mentally retarded, the state must provide payment either for: (1) inpatient and outpatient hospital care, physicians' services, nursing facility services for persons 21 years of age and older and certain other services; or (2) at least seven of the services listed in 42 U.S.C. § 1396d(a)(1)-(24).[9] None of these above-mentioned services are in contention in this case.

Mandatory coverage also provides for payment of "home health services" for any individual who, under the State plan, is entitled to nursing facility services.[10] For persons who are not entitled to nursing facility services, home health services is an optional Medicaid service.[11] Upon information and belief, none of the named plaintiffs are in receipt of home health services provided by a certified home health agency.[12]

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[8] 42 U.S.C. § 1396d(a)(1) – (5), (17), (21) and (28); SSA § 1905(a)(1) – (5), (17), (21) and (28); 42 C.F.R. § 440.210

[9] 42 U.S.C. § 1396a(a)(10)(C)(iv), SSA § 1902(a)(10)(C)(iv)

[10] 42 U.S.C. § 1396a(a)(10)(D), SSA § 1902(a)(10)(D)

[11] 42 U.S.C. § 1396d(a)(7), SSA § 1905(a)(7)

[12] Plaintiff Harry Davis is in receipt of a different type of home care service, personal care services, which is an optional Medicaid service.

Congress articulated its rationale in adding the home health services requirement for those whom the state afforded nursing facility services. Home health services needed to be added to the basic services to assure that such services are available as a more economic alternative to skilled nursing home and hospital care.[13] In New York, the State Medicaid plan provides payment for nursing facility services provided to the categorically needy as well as the medically needy. The State must thus provide payment for home health services provided to the categorically and medically needy who are appropriate for such services.

Home health services must include part-time or intermittent nursing services, home health aide services and "medical supplies, equipment and appliances suitable for use in the home." [14] In addition, such services may include physical therapy, occupational therapy or speech therapy. Pursuant to 42 C.F.R. § 440.70, home health services are provided to a recipient at the recipient's place of residence and on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days except that the recipient's need for "medical supplies, equipment and appliances" must be reviewed annually.

The federal Medicaid regulation governing home health services, 42 C.F.R. § 440.70, does not define the terms "medical supplies, equipment and appliances." On July 12, 2011, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule that, among its other purposes, would amend 42 C.F.R. § 440.70(b)(3) to

[13] The home health services requirement was originally found at SSA § 1902(a)(13)(A)(ii), as added by P.L. 90-248, § 224(c)(1). It was later relocated to its present location at SSA § 1902(a)(10)(D) by P.L. 97-35, § 2171(a)(3). With regard to the intent of the provision, see Senate Report No. 744 reprinted in 1967 USCCAN 2834, 3020.

[14] 42 C.F.R. §§ 440.70, 441.15.

define the terms “supplies” and “equipment and appliances.”[15] In describing the proposed rule, the CMS noted as follows:

> Current Medicaid regulations do not contain any specific definition of medical supplies, equipment, and appliances under the home health benefit . . . States have adopted reasonable definitions of those terms, for example, based on the Medicare definition . . . We are now taking this opportunity to propose criteria defining home health supplies, equipment, and appliances, to better align with the Medicare program’s definition of durable medical equipment found at Sec. 414.202.
>
> We propose that supplies are defined as “health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual.”
>
> We propose that medical 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.” [16]

None of the plaintiffs are recipients of home health services, in order for them to insist on mandatory "medical supplies, equipment and appliances." Regardless, neither orthopedic footwear nor compression/support stockings are “medical supplies, equipment and appliances.” They are covered as optional prosthetic benefits.

**2. Optional Coverage**

If states elect, they may extend their Medicaid coverage for the categorically needy and medically needy beyond the minimum mandatory services required by federal law.[17] New York has chosen to include optional Medicaid services in its

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[15] See proposed rule, “Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health,” at 76 FR 41032, a copy of which is appended as Exhibit A to McCloskey Declaration. The public comment period ended September 12, 2011. CMS has not yet adopted the final rule.

[16] 76 FR at 41034

[17] 42 C.F.R. § 440.225

Medicaid program. One such optional service is prosthetic devices.[18] As defined by federal Medicaid regulations:

> "Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to -
> (1) Artificially replace a missing portion of the body;
> (2) Prevent or correct physical deformity or malfunction; or
> (3) Support a weak or deformed portion of the body. [19]

Orthopedic footwear and compression/support stockings are benefits under the optional coverage for prosthetics as defined by federal and state regulations.

## ARGUMENT

### Point I: No Home Health Service Requirement is Violated.

Plaintiff's are erroneously putting the cart before the horse in this case. They have not established that they are first, recipients of home health services and second, that orthopedic footwear and compression/support stockings are covered mandated "medical supplies, equipment and appliances" pursuant to the receipt of home health services. Plaintiffs' conclusory state, "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). "Under New York law, home health services in New York must be provided by Certified Home Health Agencies ("CHHAs")." N.Y. Public Health Law §§ 3602(3), 3614(1). Catanzano by Catanzano v. Wing, 103 F.3d 223, 226 (C.A.2

[18] 42 U.S.C. § 1396d(a)(12), SSA § 1905(a)(12), Lankford v. Sherman, 451 F.3d 496, 504 (Eighth Circuit, 2006)

[19] 42 C.F.R. § 440.120(c)

(N.Y.),1996). The plaintiffs assume that orthopedic footwear and compression/support stockings are mandatory services that all states must include in their Medicaid programs. This assumption is misplaced. Orthopedic footwear and compression/support stockings, are optional services that states may include in their Medicaid programs but are not required to do so. The state's limitation on these optional benefits are rationally based and without regard to the plaintiffs' physical impairments.

**Point II: Limits on Optional Services are Reasonable and Consistent with Medicaid Laws and Regulations.**

In the court cases challenging the defendant's denial of coverage of gender reassignment surgery, the courts rejected the plaintiffs' argument that comparability means "that if [a] treatment or service is made available to a group of recipients with one diagnosis, then that treatment or service must be made available to all recipients with other diagnoses so long as they are directed by the individuals' physicians." Casillas v. Daines, 580 F.Supp 235, at 244; see also Ravenwood v. Daines, 2009 U.S. Dist. LEXIS 61547; 2009 WL 2163105 (WDNY 2009).

Federal Regulation provides that states are prohibited, with respect to mandatory services, from arbitrarily denying or reducing coverage based solely on diagnosis, type of illness, or condition. 42 C.F.R. § 440.230. Conversely, mandatory services can be limited based on diagnosis as long as the limitation is not arbitrary. The language of this regulation also suggests that states have greater flexibility in limiting coverage of optional services based on diagnosis. The court in Casillas found that the subsection (d) language, utilization control procedures, creates a "loose standard", "susceptible to multiple plausible interpretations", that "captures concepts that do not relate to the care

of any one particular patient but looks to actual or expected utilization over a broader population", and may be "based upon state-wide resources and patterns of usage."

Here, New York State has confronted difficult questions in the past few years in its effort to address the Medicaid program's ever increasing costs. Among these are whether the State can continue to pay public monies to fund services that the federal government does not obligate state Medicaid programs to include. One course would be to eliminate coverage of one or more Medicaid services that the State is not obligated to offer to its Medicaid recipients. Another far less draconian course is to retain the service while establishing reasonable standards for its availability. As this affidavit will explain, this is the course the State chose with respect to its benefit limits for orthopedic footwear and compression and support stockings. See, Bick Affidavit.

Plaintiffs reference to the federal agency guidance relating to DeSario v. Thomas, 139 F.3d 80 (2d Cir. 1998) is irrelevant to the issue in this case. Plaintiffs maintain that interpretive guidance that the federal Medicaid agency issued nearly 15 years ago entitles Medicaid recipients to request an exception from the Medicaid benefit limits on orthopedic footwear and compression and support stockings. The federal guidance to which plaintiffs cite applies only to durable medical equipment provided as part of the mandatory home health services benefit. It does not apply to orthopedic footwear, compression stockings or support stockings. Even assuming, for the sake of argument, that the federal guidance applies to orthopedic footwear and compression and support stockings, the State's practices are consistent with it.

In September 1998, the former Health Care Financing Administration ("HCFA"), which was then the federal Medicaid agency, issued a letter to all State Medicaid

Directors clarifying federal policy regarding state Medicaid programs' coverage of durable medical equipment. [20] Several months previously, the U.S. Court of Appeals for the Second Circuit had issued its decision in *DeSario v. Thomas* [21] construing a Connecticut regulation that, *inter alia*, limited Medicaid coverage of durable medical equipment to items that were specifically included on the state's pre-approved list. The district court had enjoined Connecticut, in part, from denying Medicaid coverage of an item of DME simply because the item did not appear on the state's pre-approved DME list. On appeal, the Second Circuit agreed with the district court that a list of covered DME is permissible. In so doing, the court specifically cited guidance that the federal Medicaid agency had issued previously that permitted states to develop lists of covered DME items. The Second Circuit nonetheless vacated the district court's injunction. The appellate court found, in part, that Connecticut's list was not insufficient merely because the state lacked procedures to add unlisted items of DME. In practice, Medicaid recipients were able to challenge at a fair hearing the denial of unlisted items by arguing that the state's list was inadequate because it did not meet the needs of *most* of the state's Medicaid recipients, the so-called "Medicaid population as a whole" test. The Second Circuit held that the district court abused its discretion by enjoining Connecticut from requiring those who sought unlisted DME to demonstrate that the state's DME list was inadequate with respect to the needs of the "Medicaid population as a whole."

In its guidance, HCFA specifically rejected the use of the "Medicaid population as a whole" test as a standard for coverage of unlisted items of DME. The HCFA took no

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[20] See "Dear State Medicaid Director" letter dated September 4, 1998, appended as Exhibit F to McCloskey Declaration.

[21] DeSario v. Thomas, 139 F.3d 80 (2d Cir. 1998), vacated and remanded, Slekis v. Thomas, 523 U.S. 1098 (1999)

exception with the principle that a state may develop a list of pre-approved items of durable medical equipment as an administrative convenience. It departed from *DeSario* in a significant manner, however, by rejecting that part of the court's decision that would permit a state to require Medicaid recipients who seek unlisted items of DME to show that, absent coverage of the requested item, the needs of "most" Medicaid beneficiaries would not be met. The HCFA stated that, in evaluating a request for DME, states may not use the "Medicaid population as a whole" test. In its view, requiring a Medicaid recipient to meet such a test failed to provide a reasonable and meaningful opportunity for recipients to seek modifications to a state's pre-approved DME list.

The HCFA guidance is irrelevant to the matter before this court. By its very terms, the guidance applies only to "medical equipment" that is included as part of the mandatory "home health services" benefit. It does not apply to optional prosthetic services. It thus does not apply to orthopedic footwear or to compression or support stockings. None of these items are "medical equipment" under the home health services benefit. Furthermore, the Department complies with the interpretive guidance in this HCFA letter. Although the Department has developed a list of covered items of durable medical equipment, which is included in the DMEPOS provider manual, providers may also request that the Department prior approve an item of DME that is *not* listed on the pre-approved list of DME.[22] And, the Department does not require a showing that, absent coverage of the unlisted item of DME, the needs of "most" Medicaid recipients will not be met. The Department has also developed a list of covered items of orthopedic footwear and compression and support stockings. These

[22] 18 NYCRR § 505.5(d)(1)(vi)

lists are also included in the relevant portions of the DMEPOS provider manual. But, again, providers may request that the Department issue a prior approval for coverage of items that are not specifically listed without a showing that the needs of “most” Medicaid recipients will not be met. The Medicaid recipient must still, however, satisfy the benefit limits that the State has established for these items. Nothing in the HCFA guidance of 1998 requires otherwise.

In conclusion, the State has great flexibility in deciding whether, and to what extent, to cover optional Medicaid services; conserving limited Medicaid resources is a legitimate government interest advanced by the State Legislature in enacting these limits; and (c) the regulatory impact statements articulate a rational basis for the Legislature to prioritize certain diagnoses and conditions over others. "The discussion and analysis of the state's lawful right under section 440.230(d) to place “appropriate limits” for “such criteria” as “medical necessity” or “utilization control procedures” applies with equal force to section 1396a(a)(10)(B) (i) and further supports the conclusion that neither the first nor second elements of Blessing are met." Casillas v. Daines, 580 F.Supp.2d 235, 245 (S.D.N.Y.,2008).

**Point III: No Due Process Violation Exists.**

Plaintiffs' alleged due process claim under § 1983 is without merit because it was a system-wide modification. Knapp v. Armstrong, 2012 WL 640890, 5 (D.Idaho) (D.Idaho,2012) (Denying motion to amend complaint as futile for failure to state a claim regarding system wide modification). There is no right to notice and a hearing regarding “systemic modifications” such as those caused by the State's legislative amendments. Rosen v. Goetz, 410 F.3d 919 (6th Cir.2005) (Sixth Circuit Court of Appeals decision reversed a district court injunction of a cost-saving process

implemented by a state Medicaid agency). Court found that "[a] mass change[ ] to public benefits programs ... does not give rise to hearing rights," where it involves no factual dispute beyond the impact of the change on specific individuals. M.R. v. Dreyfus, 767 F.Supp.2d 1149, 1166–67 (W.D.Wash.2011).

**POINT IV: No ADA/504 Violation Exists**

Absent invidious classifications, a State's decision about "allocating limited public welfare funds" is not "discrimination." Dandridge v. Williams, 397 U.S. 471, 487 (1970). When there are many competing demands for public assistance and only limited public funds, States "must necessarily engage in a process of line-drawing" in extending benefits. United States R.R. Ret. Bd. v. Fritz, 449 U.S. 166, 179 (1980); *accord* Schweiker v. Wilson, 450 U.S. 221, 243 (1981) ( "the apportionment of scarce benefits" for public welfare "requires painful but unavoidable line-drawing"). Where that line is drawn will necessarily disappoint some individuals who may desire and who could benefit from prosthetics (such as orthopedic footwear and compression/support stockings), but that decision is a policy choice "for legislative, rather than judicial, consideration." Fritz, 449 U.S. at 179. The ADA requires only that a particular service provided to some not be denied to disabled people. Doe v. Pfrommer, 148 F.3d 73, 83 (2d Cir.1998). Here, the optional prosthetic services that New York provides for a limited class of physically impaired Medicaid recipients. The Attorney General's Title II regulations likewise explain that public entities may provide "benefits, services, or advantages" to some persons with disabilities, 28 C.F.R. § 35.130(c), without "incurring additional obligations to . . . other classes of individuals with disabilities." 56 Fed. Reg. 35,694, 35,705 (July 26, 1991).

Because "[n]o State has unlimited resources, . . . each must make hard decisions on how much to allocate" for state-funded benefits like supported housing. Olmstead v. L.C. ex rel. Zimring 527 U.S. 581, 612; 119 S.Ct. 2176 (U.S.Ga.,1999)(Kennedy, J., concurring). That "judgment, however, is a political one . . . not within the reach of the [ADA]." Id. As the Second Circuit Court of Appeals has explained, absent proof of discrimination, "it is not [the court's] role to determine what . . . benefits New York must provide," Rodriguez v. City of New York, 197 F.3d 611, 619 (C.A.2 (N.Y.),1999), or which individuals with disabilities should be given priority in the distribution of benefits.

As Justice Kennedy noted in his *Olmstead* concurrence, it would raise "[g]rave constitutional concerns" if the ADA were read to "permit court intervention" in "basic" political decisions about state budgeting and resource allocation. Olmstead, 527 U.S. at 612-13 (Kennedy, J., concurring). While Congress may enact prophylactic legislation like the ADA "to remedy or prevent unconstitutional discrimination," Tennessee v. Lane, 541 U.S. 509, 520 (2004), the Constitution does not require states to guarantee any level of benefits to persons with disabilities, nor does it authorize Congress to enact legislation that mandates such benefits. If the ADA were read to do so, it would raise serious constitutional questions. Olmstead prudently reads the ADA as avoiding potential constitutional conflict by addressing only discrimination, not level-of-benefits claims that exist here.

**Conclusion**

Based on all the above-mentioned reasons, the complaint should be dismissed in its entirety and summary judgment granted in defendants' favor as a matter of law.

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CERTIFICATE OF SERVICE

I certify that on November 7, 2012, I electronically filed the foregoing Memorandum of Law, with the Clerk of the District Court using CM/ECF system, which sent notification of such filing to the following CM/ECF participant:

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And, I hereby certify that I have mailed, by the United States Postal Service, the document to the following non-CM/ECF participant(s):

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