14-543

United States Court of Appeals for the Second Circuit

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

Plaintiffs-Appellees,

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

BRIEF FOR APPELLANT

ERIC T. SCHNEIDERMAN
Attorney General of the State of New York
Attorney for Appellant
The Capitol
Albany, New York 12224-0341
(518) 473-4321

BARBARA D. UNDERWOOD
Solicitor General
ANDREA OSER
Deputy Solicitor General
VICTOR PALADINO
Assistant Solicitor General
of Counsel

Dated: June 9, 2014

TABLE OF CONTENTS

PAGE

Table of Authorities iii

Preliminary Statement 1

Subject Matter and Appellate Jurisdiction 4

Questions Presented 5

Statement of the Case 6

A. Nature of case and course of proceedings 6

B. Overview of the Medicaid program 8

C. New York pays for optional services for both the categorically and medically needy 11

D. Faced with a severe fiscal crisis, New York limits funding for orthopedic footwear and compression stockings 12

E. Plaintiffs and their medical conditions 14

F. The district court issues a preliminary injunction 15

G. The district court grants a permanent injunction 16

Standard of Review 18

Summary of Argument 18

Argument

Point I Neither The Reasonable-Standards Provision Nor Its Implementing Regulation May Be Privately Enforced Through 42 U.S.C. § 1983 or the Supremacy Clause 23

Table of Contents (cont'd)

Page

A. Congress did not intend for the reasonable standards provision to create rights privately enforceable through 42 U.S.C. § 1983 25

B. The federal regulation implementing the reasonable-standards provision cannot be privately enforceable either 29

C. The Supremacy Clause does not supply a private right of action 30

Point II The Challenged State Law Complies With The Medicaid Act's Reasonable Standards, Comparability, and Due Process Provisions 35

A. The challenged state law is consistent with the reasonable-standards provision 35

B. The state law at issue is consistent with the Medicaid Act's comparability provision 45

C. The enactment of the state law at issue did not violate the Medicaid Act's due process provision law 49

Point III Plaintiffs failed to establish a violation of the Americans with Disabilities Act or section 504 of the Rehabilitation Act 54

A. The state law at issue does not violate the integration mandate 54

B. The state law at issue does not discriminate on the basis of disability 59

Conclusion 61

TABLE OF AUTHORITIES

CASES **PAGE**

Alexander v. Sandoval,
532 U.S. 275 (2001) 29

Amundson ex rel. Amundson v. Wis. Dep't of Health Servs.,
721 F.3d 871 (7th Cir. 2013) 57

Atkins v. Parker,
472 U.S. 115 (1985) 51

Auburn Hous. Auth. v. Martinez,
277 F.3d 138 (2d Cir. 2002) 18

Bates v. Henneberry,
211 P.3d 68 (Ct. App. Colorado 2009) 27

Blessing v. Freestone,
520 U.S. 329 (1997) 25,26

Bontrager v. Indiana Family and Social Services Administration,
697 F.3d 604 (7th Cir. 2012) 42

Camacho v. Perales,
786 F.2d 32 (2d Cir. 1986) 46

Cannon v. University of Chicago,
441 U.S. 677 (1979) 26

Chapman v. Hous. Welfare Rights Org.,
441 U.S. 600 (1979) 31

Charleston Memorial Hosp. v. Conrad,
693 F.2d 324 (4th Cir. 1982) 41

Commack Self-Service Kosher Meats, Inc. v. Hooker,
680 F.3d 194 (2d Cir. 2012) 24

Curtis v. Taylor,
625 F.2d 645 (5th Cir. 1980) 41

Table of Authorities (cont'd)

Page

Davis v. Shah,
2013 U.S. Dist. LEXIS 175418 (W.D.N.Y. Dec. 9, 2013) ... 2

Douglas v. Independent Living Center of Southern California, Inc.,
132 S. Ct. 1204 (2012) ... 24,32,33

Goldberg v. Kelly,
397 U.S. 254 (1970) ... 11

Golden State Transit Corp. v. City of Los Angeles,
493 U.S. 103 (1989) ... 31

Gonzaga University v. Doe,
536 U.S. 273 (2002) ... 25,26

Grier v. Goetz,
402 F. Supp. 2d 876 (M.D. Tenn. 2005) ... 40

Harris v. James,
127 F.3d 993 (11th Cir. 1997) ... 29,30

Henrietta D. v. Bloomberg,
331 F.3d 261 (2d Cir. 2003) ... 55

Hines v. Sheehan,
1995 U.S. Dist. Lexis 11031 (D. Maine 1995) ... 38,60

Hobbs v. Zenderman,
579 F.3d 1171 (10th Cir. 2009) ... 27

Independent Living Center of So. Cal. v. Maxwell-Jolly,
572 F.3d 644 (9th Cir. 2009), *vacated and remanded sub nom. Douglas v. Independent Living Center of So. Cal*,
132 S. Ct. 1204 (2012) ... 31

Lankford v. Sherman,
451 F.3d 496 (8th Cir. 2006) ... 27,28,34,47

Table of Authorities (cont'd)

Page

Medical Soc. Of New York v. Toia,
560 F.2d 535 (2d Cir. 1977) 44

Olmstead v. L.C. ex rel. Zimring,
527 U.S. 581 (1999) 55

Pashby v. Dalia,
709 F.3d 307 (4th Cir. 2013) 58

Pennhurst State School and Hosp. v. Halderman,
451 U.S. 1 (1981) 26

Planned Parenthood of Hous. & Se. Tex. v. Sanchez,
403 F.3d 324 (5th Cir. 2005) 32

Planned Parenthood of Indiana, Inc. v. Comm'r of the Indiana State Dep't of Health,
699 F.3d 962 (7th Cir. 2012) 31

Planned Parenthood of Kan. & Mid-Mo. v. Moser,
747 F.3d 814, 2014 U.S. App. LEXIS 5467 (10th Cir. 2014) 31

Portland Cement Ass'n v. EPA,
665 F.3d 177 (D.C. Cir. 2011) 53

Roach v. Morse,
440 F.3d 53 (2d Cir. 2006) 17,18

Rodriguez v. City of New York,
197 F.3d 611 (2d Cir. 1999) 38,46,56

Rosen v. Goetz,
410 F.3d 919 (6th Cir. 2005) 50

Schott v. Olszewski,
401 F.3d 682 (6th Cir. 2005) 47

Table of Authorities (cont'd)

Page

Shakhnes v. Berlin,
689 F.3d 244 (2d Cir. 2012) 30,49

Shinseki v. Sanders,
556 U.S. 396 (2009) 53

Taylor v. Hous. Auth. of the City of New Haven,
645 F.3d 152 (2d Cir. 2011) 29

Taylor v. Hous. Auth. of New Haven,
267 F.R.D. 36 (D. Conn. 2010) 29

Third Christ of Church, Scientist, of New York City v. The City of New York,
626 F.3d 667 (2d Cir. 2010) 18

Torraco v. Port Auth.,
615 F.3d 129 (2d Cir. 2010) 25

Traynor v. Turnage,
485 U.S. 535 (1988) 60

Watson v. Weeks,
436 F.3d 1152 (9th Cir. 2006) 28

Wesley Health Care Center v. DeBuono,
244 F.3d 280 (2d Cir. 2001) 25

Wilderness Soc'y v. Kane County, Utah,
581 F.3d 1198 (10th Cir. 2009), *vacated on other grounds*,
632 F.3d 1162 (10th Cir. 2011) 32

FEDERAL STATUTES

Rehabilitation Act
§ 504 .... passim

Table of Authorities (cont'd)

FEDERAL STATUTES (cont'd) **Page**

28 U.S.C.
§ 1291 4
§ 1292(a)(1) 4
§ 1331 4
§ 1343(a)(3) 4
§ 1343(a)(4) 4

29 U.S.C.
§ 794 2,6

42 U.S.C.
§ 247c 31
§ 1983 .... passim
§ 1396a(a) 9
§ 1396a(a)(3) 11,49
§ 1396a(a)(5) 8
§ 1396a(a)(10)(A) 9,10
§ 1396a(a)(10)(A)(i) 47
§ 1396a(a)(10)(B) 11,17,45,46
§ 1396a(a)(10)(C) 10
§ 1396a(a)(10)(D) 16
§ 1396a(a)(17) 9,17,27,35
§ 1396a(a)(17)(A) 19,20,35
§ 1396a(a)(30)(A) 32,44
§ 1396b 9
§ 1396d(a) 10
§ 1396d(a)(1)-(5) 10
§ 1396d(a)(12) 39
§ 1396d(a)(17) 10
§ 1396d(a)(21) 10
§ 1396d(a)(28) 10
§ 1396-1396w-5 6,8
§ 12132 55
§ 12131-12134 2,6

Table of Authorities (cont'd)

FEDERAL RULES AND REGULATIONS **Page**

28 C.F.R.
Part 35, app. B 55
§ 35.130(c) 60
§ 35.130(d) 25,58
§ 35.135 55

42 C.F.R.
Part 435, Subpart B 9
Part 435, Subpart D 10
§ 431.200-431.246 11
§ 431.205(d) 11
§ 431.206 50
§ 431.206(b) 51
§ 431.206(c)(2) 51
§ 431.210 49,50
§ 431.220(b) 49
§ 440.120(c) 10,38
§ 440.210 10,37,38
§ 440.220 .... 10, 37,38
§ 440.225 10
§ 440.230 9,29
§ 440.230(b) 35
§ 440.230(c) 20,36,38
§ 440.230(d) 36,40,42
§ 440.240 11,46
§ 440.250 46

Federal Rules of Appellate Procedure
4(a)(1)(A) 5

NEW YORK CONSTITUTION

Article VII, § 2 44

Table of Authorities (cont'd)

NEW YORK STATUTES **Page**

N.Y. Social Services Law
§ 363-369 8
§ 363-a(1) 8
§ 363-a(2) 12
§ 363-a(2)(d) 12
§ 363-a(2)(g) 12,36
§ 365-a(2)(g)(iii) 1,6,15
§ 365-a(2)(g)(iv) 1,6,15

Public Health Law
§ 201(1)(v) 8

McKinney's 2011 N.Y. Sess. L. Ch.59, pt. H, § 23 13

STATE RULES AND REGULATIONS

18 N.Y.C.R.R.
§ 505.5(g)(1) 1,6,12
§ 505.5(g)(2) 1,6,12

MISCELLANEOUS

Note, *State Restrictions on Medicaid Coverage of Medically Necessary Services*, 78 Colum. L. Rev. 1491 (1978) 43

PRELIMINARY STATEMENT

This case concerns New York's authority to limit funding for services that, even if medically necessary, states are not required to fund under an approved Medicaid plan. In 2011, New York was in the midst of its most severe fiscal crisis since the Great Depression and was spending more than twice the national average on a per capita basis on Medicaid. Faced with the difficult choice of terminating coverage for certain optional services altogether or just limiting it, the New York Legislature took the less draconian approach. Among other measures, the Legislature limited coverage for orthopedic footwear and compression stockings to those Medicaid beneficiaries who suffered from certain serious conditions. *See* New York Social Services Law § 365-a(2)(g)(iii) & (iv). By singling out these serious conditions, New York assured continued coverage for the vast majority of Medicaid beneficiaries for whom such services are medically necessary. The Department of Health thereafter provided guidance for the new statute by regulation. *See* N.Y. Code R. & Regs. tit. 18, § 505.5(g)(1) & (2).

In this class action under 42 U.S.C. § 1983, the United States District Court for the Western District of New York (Siragusa, J.)

invalidated the state law and implementing regulation and enjoined New York's Commissioner of Health from enforcing them. *See Davis v. Shah,* 2013 U.S. Dist. LEXIS 175418 (W.D.N.Y. Dec. 9, 2013) (Joint Appendix [J.A.] 419-462; Special Appendix [SPA] 19-62). The court held that the state law violated three provisions of the federal Medicaid Act: (1) the requirement that states establish reasonable standards for determining the extent of medical assistance consistent with Medicaid program objectives (the "reasonable-standards provision"); (2) the requirement prohibiting discrimination based on categories of medical assistance beneficiaries (the "comparability provision"); and (3) the requirement that states give notice of and an opportunity for an administrative hearing to challenge the denial, reduction, or termination of Medicaid benefits (a statutory "due process provision"). Additionally, the district court concluded that the state law violated the integration mandate and methods of administration provisions of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12131-12134, and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794.

The district court's judgment and permanent injunction rest on legally erroneous interpretations of the Medicaid Act, the ADA, and

Section 504 of the Rehabilitation Act. First, Congress did not intend the Medicaid Act's reasonable-standards provision to be privately enforceable by Medicaid beneficiaries. But even if this provision confers enforceable rights, New York's limitation on coverage for orthopedic footwear and compression stockings is reasonable and consistent with Medicaid program objectives. It thus satisfies the reasonable-standards provision and, as we demonstrate below, is entirely consistent with the other Medicaid provisions at issue.

The Medicaid Act and its implementing regulations prohibit states from arbitrarily denying *required services* to otherwise eligible individuals solely on the basis of diagnosis. But the Act gives states much more flexibility with respect to optional services. States thus retain discretion to limit coverage for optional services to the majority of beneficiaries for whom those services are medically necessary, even if doing so means denying coverage for those same services for a few others for whom they may also be medically necessary. The district court's contrary ruling—that states providing coverage for optional services must extend such coverage to all Medicaid beneficiaries for whom those services are medically necessary—disserves the purposes

of the Medicaid Act by giving states an incentive, especially in times of fiscal crisis, to eliminate coverage for optional services altogether.

New York's limitation on coverage also does not violate the ADA or Section 504 of the Rehabilitation Act. New York's limitation does not discriminate against the disabled. It simply limits eligibility for certain optional services on the basis of diagnosis. Consistently with both the ADA and section 504, a state may provide an optional service to a category of disabled people even though it does not extend those services to all categories of disabled people. Accordingly, the judgment and permanent injunction should be vacated.

SUBJECT MATTER AND APPELLATE JURISDICTION

Plaintiffs invoked the district court's jurisdiction under 28 U.S.C. § 1331 and 28 U.S.C. §§ 1343(a)(3) & (4). This Court has jurisdiction over this appeal pursuant to 28 U.S.C. § 1291, because this appeal is timely taken from the final judgment disposing of all claims with respect to all parties. Alternatively, appellate jurisdiction is conferred by 28 U.S.C. § 1292(a)(1), because appellant has timely appealed from the district court's order filed January 28, 2014 granting a permanent injunction.

The permanent injunction was entered on January 28, 2014 (J.A. 463). The final judgment was entered on January 29, 2014 (J.A. 469). Defendant's notice of appeal was filed on February 24, 2014 (J.A. 472), within 30 days of the entry of both the final judgment and the permanent injunction, and was therefore timely. *See* FRAP 4(a)(1)(A).

QUESTIONS PRESENTED

1. Do Medicaid recipients lack a private right of action to enforce the reasonable-standards provision of the Medicaid Act under either 42 U.S.C. § 1983 or the Supremacy Clause?

2. Is a New York law that limits Medicaid coverage certain for services that are optional under Medicaid—namely orthopedic shoes and compression stockings—to beneficiaries who suffer from only certain diagnoses consistent with:

a. The reasonable-standards provision of the Medicaid Act and its implementing regulation;

b. The comparability requirement of the Medicaid Act and its implementing regulation;

c. The due process provision of the Medicaid Act and its implementing regulations; and

d. The integration mandate and methods of administration provisions of the ADA and Section 504 of the Rehabilitation Act, and their implementing regulations.

STATEMENT OF THE CASE

A. Nature of Case and Course of Proceedings

Plaintiffs brought this action in the United States District Court for the Western District of New York seeking to enforce private rights allegedly conferred by, among other things, Title XIX of the Social Security Act (42 U.S.C. §§ 1396–1396w-5), Title II of the Americans with Disabilities Act (42 U.S.C. §§ 12131–12134), and Section 504 of the Rehabilitation Act (29 U.S.C. § 794). Plaintiffs sought declaratory relief and an injunction enjoining the New York State Health Commissioner from implementing the recently enacted limitation on Medicaid funding for orthopedic footwear and compression stockings (J.A. 38-40). *See* N.Y. Soc. Servs. Law § 365-a(2)(g)(iii) & (iv); *see also* N.Y. Code R. & Regs. tit. 18, § 505.5(g)(1) & (2).

Plaintiffs moved for class certification and a preliminary injunction, and the Commissioner opposed. The district court issued a preliminary injunction enjoining the Commissioner from denying

Medicaid coverage to the named plaintiffs for orthopedic footwear or compression stockings pending further order of the court (J.A. 105-122). Thereafter, the district court certified a class consisting of all current and future New York State Medicaid recipients for whom the Commissioner has failed to provide coverage for medically necessary orthopedic footwear and compression stockings as a result of the challenged state law and regulations (J.A. 415).

On cross-motions for summary judgment, the district court granted plaintiffs summary judgment in part, finding that New York's new coverage limitation violated three provisions of the Medicaid Act—the reasonable-standards, comparability, and due process provisions—as well as the integration mandate and methods of administration provisions of the ADA and Section 504 of the Rehabilitation Act (J.A. 419-462). The court granted the Commissioner summary judgment dismissing plaintiffs' other claims and directed the parties to submit a proposed order providing for injunctive relief (J.A. 461-462). The Commissioner appealed the summary judgment order, but then withdrew the appeal as premature without prejudice to an appeal from the final judgment (J.A. 471).

The court thereafter entered a permanent injunction and a final judgment (J.A. 463-470). This appeal by the Commissioner ensued (J.A. 472).

B. Overview of the Medicaid program

This case involves services that are medically necessary, but are nonetheless not required to be covered by Medicaid, a joint state and federal program that funds medical care for needy persons. *See* 42 U.S.C. §§ 1396-1396w-5; N.Y. Social Services Law ("SSL") §§ 363-369. The New York State Department of Health is the "single State agency" (42 U.S.C. § 1396a[a][5]) designated to supervise the administration of the Medicaid program in this State. *See* SSL § 363-a(1); N.Y. Public Health Law § 201(1)(v). The United States Department of Health and Human Services' Centers for Medicare and Medicaid Services ("CMS") administers the program at the federal level.

As a general matter, to participate in Medicaid, a state must submit a plan to CMS that meets the requirements of 42 U.S.C. § 1396a(a). Among other things, the plan must identify the categories of service available to eligible beneficiaries. And under the "reasonable-

standards" provision at issue here, the plan must establish "reasonable standards . . . for determining eligibility for and the extent of medical assistance available under the plan which . . . are consistent with the objectives" of the Medicaid Act. 42 U.S.C. § 1396a(a)(17); *see also* 42 C.F.R. § 440.230. Upon CMS approval of a state plan, federal funds are available to pay a percentage of the total amount the state spends for medical assistance. *See* 42 U.S.C. § 1396b.

Participating states are required to provide medical assistance to the "categorically needy." This group is defined to include, among others, individuals who are in receipt of Supplemental Security Income benefits and qualified pregnant women or children. 42 U.S.C. § 1396a(a)(10)(A); 42 C.F.R. Part 435, Subpart B. States have the option of furnishing medical assistance to the "medically needy"; that is, individuals who do not fall within a categorically needy group, but who nonetheless cannot afford adequate medical care. *Id.* § 1396a(a)(10)(C); 42 C.F.R. Part 435, Subpart D.

Once a state decides which groups will receive medical assistance under its plan, the state determines which services it will provide. 42 U.S.C. § 1396d(a). To receive federal approval, a state plan must

include several enumerated medical services for the categorically needy, including inpatient hospital, outpatient hospital, laboratory and x-ray, family planning, physician, nurse-midwife, nurse-practitioner, home health services and, for persons 21 years of age or older, nursing facility services. *Id.* §§ 1396a(a)(10)(A), 1396d(a)(1)-(5), (17), (21), (28); 42 C.F.R. § 440.210. If a state opts to cover the medically needy, its state plan must provide certain enumerated services for those eligibility groups; these include prenatal care ambulatory services and, for individuals entitled to nursing facility services, home health services. 42 U.S.C. § 1396a(a)(10)(C), 42 C.F.R. §440.220.

A state also may elect to provide additional medical services, such as dental services, prosthetics, and prescription drugs. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a); 42 C.F.R. §§ 440.120(c), 440.225. Regardless of whether such services are medically necessary in an individual case, they are optional under Medicaid. The services at issue here—orthopedic shoes and compression stockings—are prosthetics, an optional service (J.A. 185-191).

The Medicaid Act includes a comparability provision. It provides that the medical assistance made available to any categorically needy

individual may not be "less in amount, duration, or scope" than the medical assistance made available to any other categorically needy individual, or to the medically needy. 42 U.S.C. § 1396a(a)(10)(B); *see also* 42 C.F.R. § 440.240 (implementing statutory provision).

The Medicaid Act identifies the due process rights of Medicaid applicants and participants, including written notice and the opportunity for a fair hearing when assistance or services are denied. 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-431.246. "[T]he hearing system must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional standards specified in this subpart." 42 C.F.R. § 431.205(d).

C. New York pays for optional services for both the categorically and medically needy

New York's Medicaid plan covers both the categorically needy (required) as well as the medically needy (optional). For either kind of Medicaid beneficiary, medical assistance in New York includes payment for "medically necessary medical, dental and remedial care, services and supplies" which are "necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's

capacity for normal activity, or threaten some significant handicap." SSL § 365-a(2). The care, services and supplies covered by this section include "home health services provided in a recipient's home." SSL § 365-a(2)(d). Care, services and supplies have also traditionally included "sick room supplies, eyeglasses, prosthetic appliances and dental prosthetic appliances." SSL §365-a(2)(g).

D. Faced with a severe fiscal crisis, New York limits coverage for orthopedic footwear and compression stockings

In 2011, the New York Legislature amended SSL § 365-a(2)(g) to limit Medicaid coverage for prescription (i.e., orthopedic) footwear and "compression stockings":[1]

> (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.

[1] Although compression stockings and support stockings differ in certain respects (J.A. 189-190), for simplicity's sake, unless the distinction is relevant, we will refer to them collectively as "compression stockings."

McKinney's 2011 N.Y. Sess. L. Ch. 59, pt. H, § 23. The implementing regulation states expressly that there are no exceptions to these benefit limitations. *See* N.Y. Code R. & Regs. tit. 18, § 505.5(g)(1) & (2).

The limitations on coverage introduced in 2011 were part of a cost-cutting measure proposed by a Medicaid redesign team established by Governor Cuomo (J.A. 358-361). In 2011, New York was in the midst of a severe fiscal crisis, and its Medicaid budget was unable to continue funding all optional services (J.A. 361).

Moreover, the State determined that Medicaid funds were being used for recipients whose medical needs were marginal (J.A. 362). For example, nearly half of the Medicaid payments in the prior year for orthopedic footwear were for claims involving hammertoes or bunions, common conditions that could be alleviated with off-the-shelf footwear (J.A. 362). Similarly, recipients had been using Medicaid funds to pay for compression or support stockings to address common complaints, like varicose veins or aching legs (J.A. 362-363). Rather than eliminate these optional services entirely for every Medicaid recipient, the State decided to limit their availability by giving priority to those recipients

with the most frequently occurring serious medical conditions for which the services were medically necessary (J.A. 361).

For orthopedic footwear, New York's Medicaid program now uses the same criteria as the federal Medicare program uses. For the stockings at issue here, New York's Medicaid program follows the federal Medicare criteria for compression stockings, and provides more coverage for support stockings. While federal Medicare does not cover support stockings for any purpose, New York's Medicaid program cover them for treatment of pregnant women with severe varicosities and edema. (*See* J.A. 364-365 [citing Medicare criteria].)

New York submitted a proposed state plan amendment to CMS, the federal Medicaid agency, to reflect the new benefit limitations for orthopedic footwear and compression stockings. CMS advised New York that a plan amendment was not required because the changes in medical necessity criteria were within the State's purview. (J.A. 360, ¶ 56.)

E. Plaintiffs and their medical conditions

Plaintiffs include both categorically needy and medically needy persons, and they do not suffer from any conditions listed in SSL § 365-

a(2)(g)(iii) or (iv). They suffer from conditions such as multiple sclerosis, paraplegia, lymphedema, cellulitis, psoriatic arthritis and trans-metatarsal amputation; their doctors have prescribed either orthopedic footwear or compression stockings for their conditions; and plaintiffs claim that these prescriptions are medically necessary for their conditions (J.A. 57-79, 91-93, 135-146, 377-378, 380-381). Some of the plaintiffs had been getting Medicaid coverage for these prescriptions until the 2011 amendments (J.A. 137, 139, 144). They were not personally notified of the change in law; they learned of it when their health providers declined to refill their orders (*e.g.,* J.A. 137, 139).

F. The district court issues a preliminary injunction

When plaintiffs commenced this action, they immediately moved for a preliminary injunction. In opposition, the Commissioner argued that none of the provisions of the Medicaid Act upon which plaintiffs relied conferred privately-enforceable rights on them. Thereafter, the Commissioner answered the complaint, raising as a defense the contention that these provisions of the Medicaid Act were not privately

enforceable under either 42 U.S.C. § 1983 or the Supremacy Clause (J.A. 97).

The district court granted a preliminary injunction enjoining enforcement of the state law (J.A. 105-122; SPA 1-18). The court concluded that plaintiffs were likely to succeed on their claim that the state law violated 42 U.S.C. § 1396a(a)(10)(D), which requires states to provide home health services, including durable medical equipment, to categorically needy recipients (J.A. 116-122; SPA 12-18). It rejected the Commissioner's argument that the home health services provision did not confer a private right of action (J.A. 117-119; SPA 13-15). The court did not address any of plaintiffs' other claims or whether the other provisions of the Medicaid Act on which those claims were based were privately enforceable.

G. The district court grants a permanent injunction

On the parties' cross-motions for summary judgment, the court held first that the challenged state law and implementing regulation did not violate the home health services provision of the Medicaid Act (J.A. 430-443; SPA 30-43). The district court rejected plaintiffs' argument that orthopedic footwear and compression stockings are

"durable medical equipment" and thus fall within the federal "home health services" requirement. Rather, these items were "prosthetics" under federal law, and as such were optional, and not mandatory, services (J.A. 443; SPA 43).

But the district court concluded that the state law violated four federal requirements: (1) the "reasonable standards" provision, 42 U.S.C. § 1396a(a)(17) and its implementing regulation; (2) the comparability requirement, 42 USC § 1396a(a)(10)(B); (3) the prohibition against disability discrimination contained in Title II of the ADA and Section 504 of the Rehabilitation Act; and (4) the due process provision of the Medicaid Act (J.A. 443-462; SPA 43-61).

According to the district court, it was unreasonable for the State to cover the treatments at issue for certain groups of Medicaid beneficiaries with a medical need (those with the conditions identified in the statute), while denying them to others with a medical need. The failure of the statute to authorize coverage for any other conditions, even on an individualized showing of medical need, rendered it unreasonable and discriminatory. The court further reasoned that the

failure of the State to notify beneficiaries of the change in law in advance violated their due process rights. (J.A. 443-462; SPA 43-61.)

STANDARD OF REVIEW

This Court reviews a district court's grant of a permanent injunction for abuse of discretion. *Roach v. Morse*, 440 F.3d 53, 56 (2d Cir. 2006). "A district court abuses its discretion in entering an injunction when it relies on clearly erroneous findings of fact or an error of law." *Id.*; *see Third Christ of Church, Scientist, of New York City v. The City of New York*, 626 F.3d 667, 669 (2d Cir. 2010). A district court's determination of questions of law related to an injunction, and questions of statutory interpretation, are reviewed *de novo*. *Roach v. Morse*, 440 F.3d at 56; *Auburn Hous. Auth. v. Martinez*, 277 F.3d 138, 143 (2d Cir. 2002).

SUMMARY OF ARGUMENT

Congress did not intend for the reasonable-standards provision of the federal Medicaid Act to be privately enforceable under 42 U.S.C. § 1983. This provision lacks explicit rights-creating language in favor of Medicaid recipients. And its requirement that the State establish

standards consistent with Medicaid objectives is too vague and amorphous for judicial enforcement. Because the reasonable-standards provision is not privately enforceable, its implementing regulation is not privately enforceable either.

Because Congress did not intend to provide a private right of action to enforce the reasonable-standards provision, that provision is not independently enforceable under the Supremacy Clause. Analysis of a claim that the reasonable-standards provision preempts state law under the Supremacy Clause would entail exactly the same analysis that would be applied if the provision were privately enforceable under section 1983. Accordingly, to allow plaintiffs to enforce the reasonable-standards provision under the Supremacy Clause would thwart Congress's intent to leave enforcement of the reasonable-standard provision to CMS, the federal agency that administers the Medicaid program, and achieve a complete end-run around the Supreme Court's private-right-of-action jurisprudence.

Even if the reasonable-standards provision were privately enforceable, there would be no basis for an injunction here because the New York law plaintiffs challenge complies with it. Federal law gives

states discretion to expand or restrict coverage within service categories, so long as their standards for doing so are "reasonable" and "consistent with the objectives of [the Medicaid Act]." 42 U.S.C. § 1396a(a)(17)(A). The implementing federal regulation prohibits a state from arbitrarily denying or reducing the amount, duration, or scope of a *required service* solely because of the recipient's diagnosis, type of illness, or condition. 42 C.F.R. § 440.230(c). But the services at issue here—orthopedic shoes and compression stockings—are not required services. They are optional services. Consequently, section 440.230(c) does not apply to them. Congress intended to give states flexibility to limit coverage for optional services based on diagnosis. Requiring states to pay for all optional medical services it seeks to fund would disserve the purposes of the Medicaid Act because it would discourage states from funding such services at all.

New York's limitation on funding for orthopedic footwear and compression stockings complies with the other two Medicaid provisions at issue here as well. The Medicaid Act's comparability provision precludes only discrimination against the categorically needy, as well as discrimination among recognized groups of the categorically needy

or the medically needy. New York law neither discriminates against the cateogorically needy nor between or among any of the recognized groups. To the contrary, the state law is neutral on its face; it applies to all Medicaid recipients, regardless of status as categorically needy or medically needy; and it does not extend greater Medicaid coverage to any categorically needy recipient than it extends to any other categorically needy or medically needy recipient.

The Medicaid Act's due process provision requires a state to give notice and an opportunity for an administrative hearing when it takes action affecting a Medicaid recipient's claim. When, as here, a state changes its law in a manner that, without factual dispute, ends a person's Medicaid benefits, no hearing is required. Plaintiffs raise no factual dispute as to coverage, but dispute only the legality of the state law's elimination of their eligibility for orthopedic shoes and compression stockings. Indeed, the district court did not find otherwise.

But the district court erred in finding that the implementation of the state law at issue here nonetheless violated the regulatory notice provisions of the Medicaid Act. Those provisions are designed to serve the statutory hearing requirement. Because plaintiffs were not entitled

to a hearing, they either were not entitled to any regulatory notice or the failure to provide them such notice was harmless because it would have served no purpose.

New York's decision to provide Medicaid funding for orthopedic footwear and compression stockings for some diagnoses but not others violates neither the integration mandates nor the anti-discrimination provisions in Title II of the ADA and Section 504 of the Rehabilitation Act, respectively. The parallel integration mandates of these federal laws do not require New York to provide optional Medicaid services in order to prevent disabled individuals from entering an institution. To hold otherwise would transform an optional Medicaid service into a mandatory service. But even if plaintiffs could potentially state a claim under the integration mandate, their claim would be premature because none of the plaintiffs has been placed in an institution.

And finally, New York has not engaged in disability-based discrimination in limiting Medicaid coverage for orthopedic shoes and compression stockings for certain diagnoses but not for others. For legitimate fiscal reasons, New York has chosen to expend its limited Medicaid funds on certain serious illnesses. There is no evidence that

New York's coverage decision for these optional services was motivated by animus against persons with a particular illness, like AIDS. Nothing in the ADA prevents a state from providing an optional service to a category of disabled people, even when it does not extend those services to all categories of disabled people. A contrary holding would induce states to eliminate optional services entirely.

ARGUMENT

POINT I

NEITHER THE REASONABLE-STANDARDS PROVISION NOR ITS IMPLEMENTING REGULATION MAY BE PRIVATELY ENFORCED THROUGH 42 U.S.C. § 1983 OR THE SUPREMACY CLAUSE

The district court should not have reached the merits of plaintiffs' claim that the challenged state law violates the reasonable-standards provision of the federal Medicaid Act and its implementing regulation. Congress did not intend the reasonable-standards provision to confer enforceable rights on private parties; the provision is enforceable only by CMS, the federal Medicaid agency. Because the reasonable-standards statute does not confer privately enforceable rights, its implementing regulation is not privately enforceable either. And

despite the contrary argument raised below, plaintiffs cannot thwart Congress's intent by seeking to bring their claims directly under the Supremacy Clause.

Preliminarily, this defense is preserved for this Court's review. In opposing plaintiffs' motion for a preliminary injunction, defendant argued that none of the provisions of the Medicaid Act on which plaintiffs rely confer privately enforceable rights (District Court Docket 11 [defendant's memorandum of law] at 3-4; *see also* J.A. 116-117 and n.3). And defendant's answer raised as a defense the contention that the Medicaid provisions cited in the complaint "do not provide for a right of action pursuant to either section § 1983 or the 'supremacy clause' of the U.S. Constitution." (J.A. 97 [citing *Douglas v. Independent Living Center of Southern California, Inc.*, 132 S. Ct. 1204 (2012) (dissenting op.)].) Although the Commissioner did not reassert the point in his summary judgment papers, this Court should nonetheless reach the issue as it raises a pure question of law. *Commack Self-Service Kosher Meats, Inc. v. Hooker*, 680 F.3d 194, 208 n.11 (2d Cir. 2012).

A. Congress Did Not Intend The Reasonable-Standards Provision To Create Rights Privately Enforceable Through 42 U.S.C. § 1983.

42 U.S.C. § 1983 imposes liability on anyone who, under color of state law, deprives a person "of any rights, privileges, or immunities secured by the Constitution and laws." 42 U.S.C. § 1983. "It is enforceable only for violations of federal rights, not merely violations of federal laws." *Torraco v. Port Auth.*, 615 F.3d 129, 136 (2d Cir. 2010).

To establish that a statute creates rights enforceable under § 1983, a private litigant must establish that (1) Congress intended that the statute benefit the litigant; (2) the right asserted is not too vague and amorphous to be competently enforced by the courts; and (3) the statute imposes a binding obligation on the States. *See Blessing v. Freestone*, 520 U.S. 329, 342 (1997); *Wesley Health Care Center v. DeBuono*, 244 F.3d 280, 283 (2d Cir. 2001).

As the Supreme Court has since clarified, these factors are meant to set a high bar; nothing "short of an unambiguously conferred right [will] support a cause of action brought under § 1983." *Gonzaga University v. Doe*, 536 U.S. 273, 283 (2002). "[W]here the text and structure of a statute provide no indication that Congress intends to

create new individual rights, there is no basis for a private suit, whether under § 1983 or under an implied right of action." *Id.* at 286. And the issue is not whether an expansive federal statute, like the Medicaid Act, as an "undifferentiated whole" is privately enforceable; courts must examine the particular statutory provision on which the plaintiff relies to determine if it confers enforce rights. *Blessing v. Freestone*, 520 U.S. at 342.

In the context of legislation like the Medicaid Act, adopted under the Spending Clause, "'the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State.'" *Gonzaga,* 536 U.S. at 280 (quoting *Pennhurst State School and Hosp. v. Halderman*, 451 U.S. 1, 28 [1981]). Moreover, it is not sufficient that "the plaintiff falls within the general zone of interest that the statute is intended to protect." *Id.* For a statute to create a private right of action, "its text must be 'phrased in terms of the persons benefited.'" *Gonzaga*, 536 U.S. at 284 (quoting *Cannon v. University of Chicago*, 441 U.S. 677, 692, n.13 [1979]). Only when the text of the statute contains "explicit rights-creating" language

in favor of a class of beneficiaries may the litigant maintain a private right of action. *Id.*

The reasonable-standards provision of the Medicaid Act does not satisfy this rigorous test for the creation of privately enforceable rights. The provision itself states only that a state Medicaid plan must "include reasonable standards . . . for determining eligibility for and the extent of medical assistance under this plan." 42 U.S.C. § 1396a(a)(17). Nothing in this text even suggests that Congress intended to confer privately enforceable rights, let alone establishes that it unambiguously did so. The courts of appeals that have thus far considered the question have uniformly held that the reasonable-standards provision does not confer a private right of action on Medicaid recipients. *See Hobbs v. Zenderman*, 579 F.3d 1171, 1182 (10th Cir. 2009); *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006); *Watson v. Weeks*, 436 F.3d 1152, 1162 (9th Cir. 2006); *see also Bates v. Henneberry*, 211 P.3d 68, 72 (Ct. App. Colorado 2009) (reaching same conclusion).

The reasoning of these courts is correct and should be adopted here. The reasonable-standards provision is not phrased in terms of

individual beneficiaries. Instead, it focuses on the aggregate practices of states in establishing Medicaid services. And even if the statute referenced intended beneficiaries, "the right it would create is too vague and amorphous for judicial enforcement." *Watson*, 436 F.3d at 1162; *see also Lankford*, 451 F.3d at 509 (reaching same conclusion). The statute "does not provide meaningful instruction for the interpretation of 'reasonable standards' in terms of medical need. It provides guidance only regarding the financial means of a potential beneficiary." *Watson*, 436 F.3d at 1162. Indeed, "[t]he only guidance Congress provides in the reasonable-standards provision is that the state establish standards "consistent with [Medicaid] objectives"—an inadequate guidepost for judicial enforcement." *Lankford v. Sherman*, 451 F.3d at 509. Accordingly, Congress did not intend the reasonable-standards provision to confer privately enforceable rights on Medicaid recipients. Congress intended CMS, the federal Medicaid agency, to enforce its requirements.

B. The Federal Regulation Implementing The Reasonable-Standards Provision Cannot Be Privately Enforceable Either.

The federal regulation implementing the reasonable-standards provision (42 C.F.R. § 440.230) does not change this analysis. If the statute does not confer rights privately enforceable under 42 U.S.C. § 1983, then the federal regulation by itself cannot confer such rights. *Taylor v. Hous. Auth. of the City of New Haven*, 645 F.3d 152, 153 (2d Cir. 2011); *Harris v. James*, 127 F.3d 993, 1008 (11th Cir. 1997). A regulation may be privately enforced only if it "invoke[s] a private right of action that Congress through statutory text created." *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001). But "a right of action 'can extend no further than' the personal right conferred by the plain language of the statute." *Taylor*, 645 F.3d at 153 (quoting *Taylor v. Hous. Auth. of New Haven*, 267 F.R.D. 36, 75-76 (D. Conn. 2010)). When a regulation "defines the content of a statutory provision that creates no federal right" or "goes beyond explicating the specific content of the statutory provision and imposes distinct obligations in order to further the broad objectives underlying the statutory provision," then the regulation "is too far removed from Congressional intent to constitute a 'federal right'

enforceable under § 1983." *Harris v. James*, 127 F.3d at 1009; *see also Shakhnes v. Berlin,* 689 F.3d 244, 251 (2d Cir. 2012) (quoting *Harris v. James*).

Nothing in the federal regulation undermines the conclusion of Point II(A) that the reasonable-standards provision does not confer a private right of action. In *Shaknes,* this Court explained that Congress may intend to create a private right of action, while leaving to the enforcing agency the task of defining the scope of the right created by the statute. 689 F.3d at 251-54. Regardless of whether the reasonable-standards regulation adequately defines the statutory standard at issue, the regulation does not—and cannot—supply the requisite "explicit rights-creating" language in favor of individual Medicaid beneficiaries that Congress omitted from the statute itself. The regulation thus provides no basis to conclude that Congress intended the Medicaid Act's reasonable-standards provisions to confer a private right of action.

C. The Supremacy Clause Does Not Supply A Private Right Of Action.

Plaintiffs cannot thwart Congress's intent to delegate enforcement of the reasonable-standards provision to CMS by side-

stepping 42 U.S.C. § 1983 with a direct action under the Supremacy Clause. The Supremacy Clause is "not a source of any federal rights." *Chapman v. Hous. Welfare Rights Org.,* 441 U.S. 600, 613 (1979). Rather, it "'secure[s] federal rights by according them priority whenever they come in conflict with state law.'" *Golden State Transit Corp. v. City of Los Angeles,* 493 U.S. 103, 107 (1989) (alteration in original) (quoting *Chapman*, 441 U.S. at 613).

This Court has not addressed whether litigants may use the Supremacy Clause to enforce Spending Clause legislation that is not otherwise privately enforceable. Other Courts of Appeals have divided over the issue. *Compare Planned Parenthood of Kan. & Mid-Mo. v. Moser,* 747 F.3d 814, 2014 U.S. App. LEXIS 5467 at *25-*36 (10th Cir. 2014) (Supremacy Clause does not authorize a private preemption claim for purposes of enforcing Title X of the Public Health Services Act); *Planned Parenthood of Indiana, Inc. v. Comm'r of the Indiana State Dep't of Health*, 699 F.3d 962, 983 (7th Cir. 2012) (describing plaintiff's attempt to use Supremacy Clause to enforce 42 U.S.C. § 247c as "highly doubtful" and "controversial"), *with Independent Living Center of So. Cal. v. Maxwell-Jolly,* 572 F.3d 644 (9th Cir. 2009)

(recognizing private claim under Supremacy Clause), *vacated and remanded sub nom. Douglas v. Independent Living Center of So. Cal.*, 132 S. Ct. 1204 (2012); *Wilderness Soc'y v. Kane County, Utah*, 581 F.3d 1198, 1216 (10th Cir. 2009) (same), *vacated on other grounds*, 632 F.3d 1162 (10th Cir. 2011) (*en banc*); *Planned Parenthood of Hous. & Se. Tex. v. Sanchez*, 403 F.3d 324, 331-35 (5th Cir. 2005) (same).

The Supreme Court's decision to grant certiorari to review the Ninth Circuit's decision, casts considerable doubt on the claim that the Supremacy Clause supplies a private right of action to enforce Spending Clause legislation such as the Medicaid Act. The Ninth Circuit's decision involved a claim by Medicaid recipients and providers that a recent California law violated 42 U.S.C. § 1396a(a)(30)(A), the Medicaid Act's "efficiency, economy, quality of care, and equal access" provision. Though the provision conferred no private rights enforceable under 42 U.S.C. § 1983, the Ninth Circuit held that the plaintiffs could pursue their claim under the Supremacy Clause. *See* 572 F.3d at 652-53. The Supreme Court thereafter granted certiorari, 131 S. Ct. 992, casting considerable doubt on the correctness of the Ninth Circuit's ruling. The Court ultimately did not decide the question. Before the

Supreme Court decided the case, CMS approved California's state plan amendments implementing the rate reductions. The Supreme Court therefore vacated and remanded the case to the Ninth Circuit to address the impact of this development. *See Douglas,* 132 S. Ct. at 1211.

Chief Justice Roberts and three other justices dissented. They would have retained the case to make clear that the Supremacy Clause cannot be invoked to enforce a State's obligations under Spending Clause legislation like the Medicaid Act. *See Douglas,* 132 S. Ct. at 1212-13. (Roberts, C.J., dissenting). "[I]f Congress does not intend for a statute to supply a cause of action for its enforcement, it makes no sense to claim that the Supremacy Clause itself must provide one." *Id.* In such a situation, implying a direct right of action under the Supremacy Clause "would effect a complete end-run around [the Court's] implied right of action and 42 U.S.C. § 1983 jurisprudence." *Id.* at 1213. A proper understanding of the Supremacy Clause thus compels that conclusion that "[w]hen Congress did not intend to provide a private right of action to enforce a statute enacted under the Spending Clause, the Supremacy Clause does not supply one of its own

force." *Id.* at 1215. This reasoning is persuasive and should be followed here.

The Court should reject the Eighth Circuit's contrary conclusion in *Lankford,* 451 F.3d 496. The holding of the *Lankford* Court that the reasonable-standards provision can be privately enforced through the Supremacy Clause is fundamentally inconsistent with its holding that the provision may not be privately enforced through 42 U.S.C. § 1983. In rendering the latter ruling, the *Lankford* Court expressly recognized, among other things, that the reasonable-standards provision was too vague and amorphous to be competently enforced by the courts. *Id.* at 509. For this purpose, it specifically noted that the provision contained only broad, general goals for states to implement in their discretion. *Id.* Yet in its Supremacy Clause analysis, the *Lankford* Court found the reasonable-standards provision clear enough to establish it was "inconsistent with the stated goals of Medicaid." *Id.* at 511. The reasoning of the *Lankford* Court on the Supremacy Clause issue is therefore unpersuasive and should not be followed.

POINT II

THE CHALLENGED STATE LAW COMPLIES WITH THE MEDICAID ACT'S REASONABLE STANDARDS, COMPARABILITY, AND DUE PROCESS PROVISIONS.

A. The Challenged State Law is Consistent With The Reasonable-Standards Provision.

Even if the reasonable-standards provision conferred rights enforceable by private parties, plaintiffs' claim would fail, because they failed to establish that New York's limitation on Medicaid coverage for orthopedic footwear and compression stockings violates either the reasonable-standards provision or its implementing regulations. The reasonable-standards provision requires state plans to "include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan." 42 U.S.C. § 1396a(a)(17). It gives states discretion to expand or restrict coverage within service categories, so long as their standards are "reasonable" and "consistent with the objectives of [the Medicaid Act]." *Id.* § 1396a(a)(17)(A).

The regulations implementing the reasonable-standards provision state that, among other things, each medical service covered by a state plan "must be sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b). They further

specify that states "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." *Id.* § 440.230(d). And a provision that may be referred to as the "required-services regulation" warns that states "may not arbitrarily deny or reduce the amount, duration, or scope *of a required service* under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition." *Id.* § 440.230(c) (emphasis added). Section 440.210 enumerates the medical services that state plans are required to cover for the categorically needy, and § 440.220 enumerates certain services that state plans are required cover for the medically needy, if they include coverage for the medically needy.

New York's coverage limitation satisfies all of these requirements. It provides a clear—and thus "reasonable"—standard that readily identifies those Medicaid beneficiaries who are eligible for the optional services at issue, namely those who suffer from the medical conditions identified in the statute. *See* SSL § 365-a(2)(g). In adopting this standard, New York reasonably exercised its discretion to place "appropriate limits" on coverage so that it could save scarce

Medicaid resources without altogether eliminating coverage for orthopedic footwear and compression stockings, services that are optional under the Medicaid program, even when they are medically necessary. Indeed, by imposing a limitation that retains coverage for those beneficiaries who suffer from identified medical conditions, New York assured continued coverage of these optional services for the vast majority of Medicaid beneficiaries for whom such services are medically necessary (J.A. 361-365). And New York's limitation does not run afoul of the required-services regulation because it does not deny or reduce the amount, duration, or scope *of a required service* under §§ 440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c) (emphasis added). The services affected here—orthopedic footwear and compression stockings—are not a required service; they are optional.

The district court's contrary holding flows in large part from its fundamental misunderstanding of the required-services regulation. Contrary to the district court's holding (J.A. 447-448), the limitation New York now places on coverage for orthopedic shoes and compression

stockings does not implicate the required-services regulation because it does not involve "required services" within the meaning of the regulation—namely those services specified in §§ 440.210 and 440.220.

In *Rodriguez v. City of New York*, 197 F.3d 611 (2d Cir. 1999), this Court rejected a challenge to a limitation placed by New York on Medicaid coverage for personal care services for the very reason that such services are not "required services" within the meaning of 42 C.F.R. § 440.230(c). *Id.* at 617-18; *see also Hines v. Sheehan,* 1995 U.S. Dist. Lexis 11031 at *4 (D. Maine 1995) (Maine's limitation on optional coverage for outpatient prescription drugs and over-the-counter drugs does not implicate 42 C.F.R. § 440.230[c]).

Similarly here, the coverage that New York provides for orthopedic footwear and compression stockings is optional under the Medicaid Act. Plaintiffs have argued that these services should be viewed as part of the "home health services" that states are required to cover for both categorically and medically needy individuals (J.A. 438-443), but they are mistaken. As the district court itself acknowledged (J.A. 443), orthopedic footwear and compression stocking are "prosthetics," a type of optional service (J.A. 438-443). *See* 42 U.S.C.

§ 1396d(a)(12); 42 C.F.R. § 440.120(c). The required-service regulation is therefore simply not implicated.

The district court was nonetheless under the mistaken impression that the Medicaid law precludes all distinctions on the basis of medical condition or diagnosis, even with respect to optional services. If anything, the required-services regulation suggests exactly the opposite. The existence of an express regulation precluding such distinctions only with respect to required services suggests that such distinctions are permissible with respect to optional services.

Moreover, the district court's erroneous analysis of the required-services regulation permeated its analysis of the reasonable-standards requirements as a whole. Because the required-services regulation is not implicated by the coverage limitation at issue here, New York need not establish that its coverage limitation is nonetheless authorized by some express exemption from that regulation. But that appears to be precisely what the district court required. In reviewing the other reasonable-standards provisions, and in particular, the regulation authorizing states to 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), the district court looked for express authority to relieve the state from compliance with what the court presumed to be a generally applicable regulation. By doing so, the district court read the "appropriate limits" language unduly strictly.

According to the district court, the limitations New York has placed on eligibility for orthopedic shoes and compression stockings do not constitute "appropriate limits," because they do not constitute "valid utilization control procedures" within the meaning of § 440.230(d). This is wrong for two reasons. First, the regulation authorizing states to place "appropriate limits" on services does not purport to provide an exclusive list of such limitations. To the contrary, it authorizes states to 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) (emphasis added). The district court was therefore wrong in reasoning that the coverage limitation could be upheld only if it constituted a "utilization control procedure" within the meaning of the regulation. In fact, the regulation gives states broad discretion to place limitations on coverage as appropriate. And because

New York's limitation reflects reasonable fiscal concerns, it constitutes an appropriate limitation.

Second, New York's coverage limitation is reasonably viewed as a "utilization control procedure" within the meaning of 42 C.F.R. § 440.230(d). Though the term is further not defined in the regulation, it is reasonably read to mean a measure that reasonably, i.e., appropriately, curbs the utilization of Medicaid resources. Indeed, courts have upheld as reasonable utilization control procedures analogous money-saving measures such as limitations on the number of inpatient or outpatient visits per month or year, *see Charleston Memorial Hosp. v. Conrad*, 693 F.2d 324, 330 (4th Cir. 1982); *Curtis v. Taylor*, 625 F.2d 645, 652 (5th Cir. 1980), and limitations on the number of prescriptions per month, *see Grier v. Goetz*, 402 F. Supp. 2d 876, 913 (M.D. Tenn. 2005).

New York adopted the coverage limitation at issue here because it found that its Medicaid program was paying for orthopedic footwear and compression stockings for many recipients whose medical needs were marginal and could readily be met with less expensive, off-the-shelf alternatives (J.A. 362-363). New York's coverage criteria are

essentially the same as the criteria the federal Medicare program uses for the same items (J.A. 363-364).

The contrary authority is flawed. In *Bontrager v. Indiana Family and Social Services Administration*, 697 F.3d 604, 611 (7th Cir. 2012), the Court of Appeals held that an annual monetary limit for dental services, an optional service, was not a reasonable utilization control procedure. The court concluded that a coverage limitation on an optional service—a different service from the one at issue here—is necessarily unreasonable if it excludes coverage for medically necessary procedures with no exceptions.

The premise of *Bontrager*'s conclusion is false. In contrast to the required-services regulation, the "appropriate limits" language in 42 C.F.R. § 440.230(d) leaves states with flexibility to limit the availability of optional services based on diagnosis, type of illness, or condition. As a policy matter, this makes sense. State resources for medical assistance are limited. And for medical services that are frequently prescribed, but are relatively inexpensive, it may not be cost-effective for states to maintain administrative procedures to render determinations regarding the seriousness of an underlying condition

and the medical necessity of particular services. The cost of a prior approval review combined with a post-denial administrative hearing may well exceed the cost of, say, a $300 pair of orthopedic shoes. If states were required to cover all optional medical services deemed medically necessary, regardless of the administrative cost of weeding out the medically necessary from the non-medically necessary, states would have a strong incentive to discontinue coverage for optional services entirely.

The reasonable-standards provision and its implementing regulations should thus not be read to prevent New York from opting for financial reasons to cover the optional services at issue here for the majority of beneficiaries for whom they are medically necessary, even though doing so means denying coverage for those same services for a few others for whom they may also be medical necessary. Although one of the objectives of the Medicaid Act is to provide necessary medical services, Congress also intended to give states freedom to tailor their programs in light of fiscal conditions. *See* Note, *State Restrictions on Medicaid Coverage of Medically Necessary Services,* 78 Colum. L. Rev. 1491, 1499 (1978). The objectives of the Medicaid program include

encouraging states to provide high quality medical care to indigents at the lowest possible cost, and discouraging costly and wasteful utilization of services. *See* 42 U.S.C. § 1396a(a)(30)(A); *Medical Soc. of New York v. Toia*, 560 F.2d 535, 538-539 (2d Cir. 1977). New York's coverage limitation is consistent with these objectives. The district court's contrary ruling gives states the incentive, especially in times of fiscal crisis, to discontinue optional services for everyone.

In the court below, plaintiffs argued that the failure to cover optional services for all medical conditions for which they are medically necessary will lead to more severe conditions, resulting in hospitalizations and nursing home admissions, thereby costing states more in the long run. That is a policy argument, properly addressed to the legislature of New York or to Congress, and not to this Court. New York's constitution requires the Governor to submit a balanced budget to the Legislature each fiscal year. *See* N.Y. Const., art. VII, § 2. Maintaining optional services like orthopedic shoes and compression stockings for everyone would have required New York to cut funding elsewhere for other worthy programs. Faced with a severe fiscal crisis and spiraling Medicaid costs, New York decided to cover the optional

services at issue here for the majority of beneficiaries for whom they are medically necessary. That decision is reasonable and the Court should not overturn it based on its own notion of public policy.

B. The State Law At Issue Is Consistent With The Medicaid Act's Comparability Provision.

The challenged state law complies with the comparability provision set forth in 42 U.S.C. § 1396a(a)(10)(B). Contrary to the district court (J.A. 448-449), the comparability provision does not require that all individuals with comparable medical needs receive comparable medical assistance. Rather, the comparability provision prohibits three kinds of discrimination: discrimination against the categorically needy, discrimination among the categorically needy, and discrimination among the medically needy. No such discrimination is implicated by the coverage limitation at issue here.

Under the comparability provision:

> the medical assistance made available to any individual described in subparagraph (A) [i.e., the categorically needy]—
>
> (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

> (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A) [i.e., the medically needy]

42 U.S.C. § 1396a(a)(10)(B).

CMS has explained the comparability provision in 42 C.F.R. § 440.240, which provides:

> Except as limited in § 440.250—
>
> (a) The plan must provide that the services available to any categorically needy beneficiary under the plan are not less in amount, duration, and scope than those services available to a medically needy beneficiary; and
>
> (b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all beneficiaries within the group:
>
> (1) The categorically needy.
>
> (2) A covered medically needy group.

As this Court has explained, these comparability provisions "guarantee[] that if a state elects to provide Medicaid to the medically needy, it must also provide it to the categorically needy and that it may not provide more assistance to the former group than to the latter." *Rodriguez by Rodriguez v. City of New York*, 197 F.3d at 615 (citing *Camacho v. Perales*, 786 F.2d 32, 39 (2d Cir. [1986]). "Moreover, states may not provide benefits to some categorically needy individuals but not to others." *Id.* The comparability mandate thus "prevents

discrimination against or among the categorically needy." *Lankford*, 451 F.3d at 505; *Schott v. Olszewski*, 401 F.3d 682, 686 (6th Cir. 2005) (holding that states must "provide comparable medical assistance to all Medicaid recipients within each classification, so long as the medically needy do not receive greater benefits than the categorically needy (although the reverse is permitted)").

The state law challenged here does not discriminate against the categorically needy, nor does it discriminate among the categorically needy or among the medically needy. The law is neutral on its face. It applies to all Medicaid recipients regardless of their status as categorically needy or medically needy. It does not extend greater Medicaid coverage to any categorically needy recipient than it extends to any other categorically needy recipient. Nor does it extend greater Medicaid coverage to any medically needy recipient than it extends to any categorically needy recipient.

Although the challenged state law provides orthopedic footwear and compression stockings for certain medical diagnoses but not others, that differential treatment does not violate the comparability mandate. The comparability provision does not require that all

individuals with comparable medical needs receive comparable medical assistance. It mandates only comparability between and among federally recognized "categories" of recipients—the categorically needy and the medically needy—and within these categories, certain recognized groups. The categorically needy include, among other groups, recipients of Supplemental Security Income (SSI) benefits and qualified pregnant women and children. *See* 42 U.S.C. § 1396a(a)(10)(A)(i). The challenged state law does not discriminate between any of these groups. It does not, for example, provide more Medicaid benefits to SSI beneficiaries than to qualified pregnant women or children.

Similarly, the challenged state law does not give more Medicaid benefits to any covered group of medically needy individuals than to any other group of medically needy individuals. For example, the challenged law does not give more benefits to medically needy persons who are over 65 years of age than it gives to medically needy persons who are blind. Because the comparability provision does not mandate comparable treatment between other ad hoc categories that a litigant

may seek to fashion, the state limitation at issue here does not run afoul of that provision.

C. The Enactment Of The State Law At Issue Did Not Violate The Medicaid Act's Due Process Provision.

Likewise without merit is the district court's conclusion that New York's challenged coverage limitation violates the Medicaid Act's due process provision. States participating in Medicaid must grant "an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3); *see also Shakhnes v. Berlin,* 689 F.3d at 254-55 (holding that § 1396a(a)(3) is privately enforceable under section 1983). But the hearing right conferred by this provision does not apply to a generally applicable statutory limitation such as that at issue here.

Federal regulations provide that the state Medicaid agency "need not grant a hearing if 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). This rule makes sense. When a state changes its law in a way that, without factual dispute, adversely affects a

beneficiary's benefits, the beneficiary is free to challenge the law in court. But no purpose would be served by requiring the state to provide a hearing at the administrative level. Because the state's Medicaid agency would be bound by the state law at issue, it would be unable to provide relief. Courts thus routinely hold that no hearing is required in such cases. *See, e.g., Rosen v. Goetz*, 410 F.3d 919, 926 (6th Cir. 2005).

In this case, as the district court affirmatively acknowledged (J.A. 450), plaintiffs failed to show that they had been denied a hearing on any factual matter pertaining to their coverage. Indeed, the district court recognized that plaintiffs' challenge was a purely legal challenge, a challenge to the legality of the state law and regulation limiting coverage for orthopedic shoes and compression stockings. The district court nonetheless concluded that plaintiffs established a claim under the Medicaid Act's due process provision because New York failed to notify plaintiffs in advance of the termination of their coverage, and thus violated the regulatory notice provisions set forth in 42 C.F.R. §§ 431.206 and 431.210 (J.A. 451-453). This was error.

The regulatory notice provisions entitle Medicaid recipients to written notice "[a]t the time of any action affecting [a Medicaid

recipient's] claim." 42 C.F.R. § 431.206(b), (c)(2). The notice must contain a statement setting forth the action the state intends to take, the reasons for the action, the specific regulations supporting the action, the individual's right to a hearing, and an explanation of the circumstances under which coverage will be continued if a hearing is requested. 42 C.F.R. § 431.210.

Either these regulatory notice provisions are not implicated here for the same reason the statutory hearing requirement is not implicated, or any failure to comply with them was harmless. The purpose of the regulatory notice provisions is to notify affected individuals of their right to a hearing and the circumstances under which coverage will be continued if a hearing is requested. *See* 42 C.F.R. § 431.210. But as the district court correctly found, plaintiffs did not have a right to a hearing, because state law had eliminated their entitlement to the benefits and there were no factual issues to resolve at an administrative hearing. Plaintiffs thus had no right to notice under the regulatory notice provisions.

Alternatively, any technical violation of the regulatory notice provision was harmless. The decision in *Atkins v. Parker*, 472 U.S. 115

(1985), is instructive here. *Atkins* involved a constitutional due process challenge to the adequacy of general notices issued to food stamp beneficiaries advising of a change in law that generally reduced benefits. In rejecting the challenge, the Court explained that general, rather than individualized, notice satisfied any due process concerns because it "would prompt an appropriate inquiry if it is not fully understood." *Id.* at 130-31. The Court further observed that where the reduction in benefits is the result of a "legislatively mandated substantive change in the scope of [an] entire program," *id.* at 129, the legislative determination itself provides adequate notice of the reduction. *Id.* at 130.

Similarly here, New York's amendment to the Social Services Law and the subsequent promulgation of formal regulations implementing that amendment provided plaintiffs with ample notice of the new limitations on coverage for orthopedic footwear and compression stockings. In their papers below, plaintiffs did not demonstrate how the absence of individualized notices harmed them. They did not suggest, for example, that the State's failure to provide them with individualized notice of the change in state law caused them

to fail to take action to protect their interests. To the contrary, despite the lack of individualized notice, plaintiffs brought this timely action to challenge the legality of the new state law. Accordingly, even if the regulatory notice provisions are implicated here, the failure to provide individual notice under the circumstances was harmless. *See Portland Cement Ass'n v. EPA*, 665 F.3d 177, 192 (D.C. Cir. 2011) (holding that error in notice during agency rule-making did not require invalidation of rule where the error was harmless); *Shinseki v. Sanders*, 556 U.S. 396 (2009) (approving of harmless error analysis for inadequate notices in context of veteran's disability benefits proceedings).

Finally, even assuming that a lack of notice caused plaintiffs tangible harm, any violation of the regulatory notice requirements would not warrant altogether invalidating the state limitation at issue here. It would require only the postponed enforcement of the new limitation until after plaintiffs have received any notice due.

POINT III

PLAINTIFFS FAILED TO ESTABLISH A VIOLATION OF THE AMERICANS WITH DISABILITIES ACT OR SECTION 504 OF THE REHABILITATION ACT

New York's decision to provide Medicaid funding for orthopedic footwear and compression stockings for some diagnoses but not others violates neither the integration mandate nor the prohibition against disability discrimination provided in Title II of the ADA and section 504 of the Rehabilitation Act.

A. The State Law At Issue Does Not Violate The Integration Mandate.

The district court reasoned that New York's limitation on Medicaid funding for orthopedic shoes and compression stockings violates the integration mandate of Title II of the ADA and Section 504 of the Rehabilitation Act because it places plaintiffs at risk of developing even more serious medical conditions that could require hospitalization or admission to a nursing facility. This reasoning is flawed. A state's decision not to fund an optional Medicaid service does not violate the integration mandate. To hold otherwise would transform an optional Medicaid service into a mandatory Medicaid service.

Title II of the ADA provides that "no 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. Although the ADA "does not require a public entity to provide to individuals with disabilities . . . services of a personal nature including assistance in eating, toileting, or dressing," 28 C.F.R. § 35.135, a state that decides to provide these services must do so "in the most integrated setting appropriate to the needs of qualified individuals with disabilities," *id.* § 35.130(d). Pursuant to federal regulations, the "most integrated settings" are those that "enable[ ] individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. pt. 35, app. B. Section 504 of the Rehabilitation Act imposes essentially the same integration requirements. *See Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003).

Olmstead v. L.C. ex rel. Zimring, 527 U.S. 581 (1999), examined whether the ADA "may require placement of persons with mental disabilities in community settings rather than in institutions," and

answered with "a qualified yes." *Id.* at 587. The Supreme Court held that such action is required "when the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Id.*

That is as far as the Court went. Nothing in *Olmstead*, the ADA or the Rehabilitation Act requires New York to provide optional Medicaid services in order to prevent plaintiffs from entering an institution. "In *Olmstead*, the parties disputed only—and the Court addressed only—*where* Georgia should provide treatment, not *whether* it must provide it." *Rodriguez v. City of New York*, 197 F.3d at 619. The *Olmstead* Court emphasized that it was not holding that "the ADA imposes on the states a standard of care for whatever medical services they render, or that the ADA requires states to provide a certain level of benefits to individuals with disabilities." *Olmstead*, 527 U.S. at 603 n. 14.

Although plaintiffs complain that New York funds orthopedic footwear and compression stockings for some diagnoses but not others, that differential treatment does not violate the integration mandate. If New York would not violate the integration mandate by declining to extend Medicaid coverage to an optional service for all diagnoses, even the most seriously debilitating ones, then it does not violate the integration mandate by declining to extend Medicaid coverage to that optional service for only some diagnoses.

Even if plaintiffs could state a claim under the integration mandate, their claim would be premature. In *Amundson ex rel. Amundson v. Wis. Dep't of Health Servs.*, 721 F.3d 871, 872 (7th Cir. 2013), plaintiffs challenged Wisconsin's reduction in subsidies for disabled persons living in group homes, claiming that the funding cuts might force them into institutions housing only the disabled. The Seventh Circuit held that this claim was not ripe because "[n]one of the plaintiffs has been placed in an institution," *id.* at 873, and thus "there [was] no legal injury." *Id.* at 874. This Court should adopt the Seventh Circuit's reasoning.

In nonetheless finding that New York's law violates the integration mandate, the district court relied on *Pashby v. Dalia*, 709 F.3d 307 (4th Cir. 2013) (J.A. 458 n.40). That reliance was misplaced. *Pashy* involved a North Carolina law that imposed stricter eligibility requirements for in-home personal care services, an optional Medicaid service, than those imposed for personal care services in adult homes. By doing so, the law effectively required Medicaid recipients to go to adult homes in order to obtain coverage for personal care services. A sharply divided Fourth Circuit panel concluded that plaintiffs established a likelihood of success on their claim that the law violated the ADA's integration mandate. *Id.* at 322.

Pashby does not stand for the proposition that the ADA requires states to provide optional Medicaid services in order to prevent the institutionalization of disabled persons. Rather, because North Carolina elected to provide personal care services to disabled individuals, it was required to administer those services "in the most integrated setting appropriate." 28 CFR § 35.130(d). The majority held that North Carolina's more stringent eligibility requirements for in-home personal care services as compared to personal care services in

adult homes might violate this integration mandate and result in unnecessary institutionalization.

New York does not, through the imposition of eligibility criteria for a service, effectively require plaintiffs to enter institutions in order to obtain coverage for the optional services at issue. New York has for legitimate fiscal reasons elected to reduce rather than altogether eliminate coverage for an optional service by extending coverage to those serious medical conditions that most frequently make the service medically necessary. That coverage decision does not violate the integration mandate.

B. The State Law At Issue Does Not Discriminate On The Basis Of Disability.

Nor is there merit to the district court's conclusion that New York's decision to provide Medicaid coverage for orthopedic footwear and compression stockings for certain diagnoses but not for others constitutes disability-based discrimination. New York's law does not discriminate against the disabled. New York has simply chosen for legitimate fiscal reasons to address certain illnesses but not others because it found that, in many cases, Medicaid funds were being used for marginal medical needs. There is no evidence that New York's

coverage decision for these optional services was motivated by animus against persons with a particular illness, like AIDs. Simply stated, "the ADA does not prevent a state from providing an optional service to a category of disabled people even where it does not extend the services to all categories of disabled people." *Hines v. Sheehan*, 1995 U.S. Dist. Lexis 11031 at *6 (D. Maine 1995). Nothing in the ADA or the Rehabilitation Act "requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons." *Traynor v. Turnage*, 485 U.S. 535, 549 (1988); *see* 28 C.F.R. § 35.130(c) ("Nothing in this part prohibits a public entity from providing benefits, services or advantages to . . . a particular class of individuals with disabilities beyond those required by this part.").

CONCLUSION

This Court should vacate the permanent injunction and the district court's judgment and remit the matter with instructions to dismiss the action.

Dated: Albany, New York
June 9, 2014

Respectfully submitted,

ERIC T. SCHNEIDERMAN
Attorney General of the State of New York
Attorney for Appellant

By:
VICTOR PALADINO
Assistant Solicitor General

Office of the Attorney General
The Capitol
Albany, New York 12224
(518) 473-4321

BARBARA D. UNDERWOOD
Solicitor General
ANDREA OSER
Deputy Solicitor General
VICTOR PALADINO
Assistant Solicitor General
of Counsel

14-543

United States Court of Appeals for the Second Circuit

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

Plaintiffs-Appellees,

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

CERTIFICATE OF COMPLIANCE WITH FRAP 32(a)(7)

The undersigned attorney, Victor Paladino, hereby certifies that this brief complies with the type-volume limitations of FRAP 32(a)(7). According to the word processing system used by this office, this brief, exclusive of the title page, table of contents, table of citations, statement with respect to oral argument, any addendum containing statutes, rules or regulations, and any certificates of counsel, contains 11,063 words.

/S/ Victor Paladino
VICTOR PALADINO
Assistant Solicitor General

ERIC T. SCHNEIDERMAN
Attorney General of the State of New York
Attorney for Defendant-Appellant
The Capitol
Albany, New York 12224
(518) 473-4321