2010

Nicholas Conley and Patty Olguin v. Utah Department of Health, Division of Medicand and Health Financing : Brief of Petitioner

Utah Court of Appeals

IN THE UTAH COURT OF APPEALS

NICHOLAS CONLEY and PATTY OLGUIN,	)	
Petitioners/Appellants,	)	Appeal No. 20100496
v.	)	Agency Decision Nos. 10-056-03; 10-061-13
UTAH DEPARTMENT OF HEALTH, DIVISION OF MEDICAND AND HEALTH FINANCING,	)	
Respondent/Appellee.	)	

PETITIONER'S AMENDED OPENING BRIEF

Oral Argument Requested

Petition for Review of the Final Agency Order of the Division of Medicaid and Health Financing

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JURISDICTION OF THE COURT

This court has jurisdiction to hear this appeal pursuant to UTAH CODE ANN. § 78A-4-103(2)(a) and UTAH CODE ANN. § 63G-4-403(1). This is an appeal of a final order in a formal adjudicative proceeding of a state agency.

STATEMENT OF THE ISSUES

This case addresses whether Respondent/Appellee Department of Health's (hereinafter "Agency") policy excluding funding of Speech Augmentative Communication Devices (SACDs)[1] for adults violates the Medicaid Act, specifically 42 U.S.C. § 1396a(a)17, 42 U.S.C. § 1396a(a)(10)(B) and 42 C.F.R. §§ 440.230(b). The only facts relevant to this issue are that the Petitioners/Appellants Nicholas Conley and Patty Olguin are adults, and that SACDs are not covered devices for adults under Utah's Medicaid program. The parties stipulated, for the purposes of addressing this issue below, that Nicholas Conley and Patty Olguin are adults, and that the devices requested are not covered under Utah's Medicaid program for adults. (Conley/Olguin's Prehearing Memorandum, pp. 2, 3) (r. 14, 15); (Agency's Prehearing Response Memorandum,

[1] SACDs, (also known as speech generating devices (SGDs or augmentative communication devices (ACDs)) generate authentic digitized speech output. Noted physicist Stephen Hawking uses such a device. For more information on these devices and their capabilities including video demonstrations, see www.dynavoxtech.com/start/cerebral-palsy; www.prentrom.com/casestudies.

pp. 2, 3) (r. 51, 52) This issue is addressed throughout the parties' prehearing memoranda.

This appeal presents only an issue of law. As such, the standard of appellate review is for the court to review the Administrative Law Judge's (ALJ) statutory interpretations for correctness. *Frito-Lay v. Labor Commission*, 193 P.3d 665, 669 (Utah Ct. App. 2008). Under the review of correctness standard no particular deference is given for rulings on questions of law. *Ellsworth Paulsen Constr. Co. v. 51-SPR-L.L.C.*, 183 P.3d 248, 252 (Utah 2008).

DETERMINATIVE OR IMPORTANT STATUTORY AND REGULATORY PROVISIONS

The following Medicaid Act statutes and implementing regulations are of central importance to the issues presented.

42 U.S.C. § 1396-1:

> "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, . . ."[2]

42 U.S.C. § 1396a(a)(10)(B):

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[2] This provision was previously codified as 42 U.S.C. § 1396 until recently "editorially" transferred to this section. Full section in Addendum.

"(a) A state plan for medical assistance must... (10) provide ... that the medical assistance made available to any individual described in subparagraph (A)-- (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);[3]

42 U.S.C. § 1396a(a)(10)(D):

"(a) A state plan for medical assistance must...(10) provide ... (D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services;"

42 U.S.C. 1396a(a)(17):

"A state plan for medical assistance must . . . (a) . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, . . ."

42 U.S.C. 1396d(a)(7):

"For the purposes of this subchapter ...
(a)Medical assistance: The term "medical assistance" means payment of part or all of the cost of the following care and services or the care and services themselves, or both... (7) home health care services;"[4]

42 C.F.R. 440.70(b)(3):

"(b) Home health services include the following services and items. Those listed in paragraphs (b)(1), (2) and (3) of this section are required services; those in paragraph (b)(4) of this section are optional.
(3) Medical supplies, equipment, and appliances suitable for use in the home."[5]

42 C.F.R. 440.120:

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[3] Full text of 42 U.S.C. § 1396a(a) in Addendum.
[4] Full text of 42 U.S.C. § 1396d in Addendum.
[5] Full test of 42 C.F.R. § 440.70 in Addendum.

"(c) "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."

42 C.F.R. § 440.230:

"(a) The [state Medicaid] plan must specify the amount, duration, and scope of each service that it provides for (1) The categorically needy; and (2) Each covered group of medically needy.
(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
(c) The Medicaid agency 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 recipient solely because of the diagnosis, type of illness, or condition.
(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."

42 C.F.R. § 441.15(a)(3):

"With respect to the services defined in § 440.70 of this subchapter, a State plan must provide that-- (a) Home health services include, as a minimum-- (3) Medical supplies, equipment, and appliances."[6]

Utah Admin. Code R414-54-4(1):

"(1) Speech-language pathology services are available only to clients who are pregnant women or who are individuals eligible under the Early and Periodic Screening, Diagnosis and Treatment Program."

Utah Admin. Code R414-70-2(2):

"As used in this rule:

[6] Full text of 42 C.F.R. § 441.15 in Addendum.

"Durable medical equipment" or "DME" means equipment that: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of an illness or injury; (d) is suitable for use in the home."

STATEMENT OF THE CASE

Nature of the Case, Proceedings and Disposition Below.

This is an appeal of the final agency order issued by the Executive Director of the Agency, adopting in full the recommended decision of the ALJ. The ALJ's decision upheld the Agency's denial of prior approval of the purchase of Speech Augmentative Communication Devices (SACD) for Conley/Olguin. The prior approval request for Medicaid funding of an SACD for Conley was denied by the Agency in a notice dated February 22, 2010. (r. 30) The rationale for the denial was that it is not a covered benefit. The prior approval request for Medicaid funding of an SACD for Olguin was denied by the Agency in a notice also dated February 22, 2010. (r. 44) The denial stated that the requested device is not a covered benefit. Conley requested administrative review of the denial on February 25, 2010. (r. 1) Olguin requested administrative review of the denial on February 26, 2010. (r. 7)

Prior to a hearing the parties presented memoranda on the principle legal issue involved in each appeal -- whether the Agency can categorically deny funding for SACDs for adults. For the purpose of addressing this question only,

the two cases were combined. On May 20, 2010, The Executive Director of the Agency approved a final agency order (r. 97-98),[7] approving—without modification—the ALJ's recommended decision (r. 99-108).[8] This completed the administrative review process.

Statement of Facts Relevant to the Issues Presented

For the purposes of the motions below, and this appeal, the relevant facts are few, and were identified in both parties' prehearing memoranda. They are as follows:

Nicholas Conley

Nicholas Conley is a 22-year-old gentleman with spastic quadriplegia caused by cerebral palsy. (r. 23) He lives at home with his mother who is his primary caretaker. He has limited motor control throughout his body, and uses a power wheelchair for mobility purposes. (r. 23–24) Nicholas understands language at the conversational level. He attempts to initiate communication, respond to questions, and indicate wants, needs, and desires. (r. 24) Throughout his school years, Nicholas participated in his education by using an SACD provided by the school district. He used it to make his medical needs known, to ask and answer questions in class, and to make friends. When Nicholas turned twenty-two, he aged out of special education services. Nicholas' treating physician and speech therapist both

[7] *See* Addendum for full text.
[8] *See* Addendum for full text.

found that an SACD was medically necessary for him to continue into adulthood by allowing him functional communication ability across a variety of contexts. (r. 27; r. 29) Without such a device, Nicholas has no way to communicate any of his basic wants or needs to the outside world. He has no way to carry on meaningful conversations, or to interact with friends or family members. The medical necessity for the requested device was never at issue.

Patty Olguin

Patty Olguin is a thirty-eight year- old woman who was diagnosed with multiple sclerosis at the age of eight. In 2002, she suffered a cerebrovascular accident (stroke) during a surgical operation to her leg which caused severe dysarthria. (r. 31)[9] Patty currently resides in a nursing home. Her cognitive function and her expressive and receptive communication skills are within normal limits, but her ability to express herself is severely limited due to her medical condition. (r. 31–32) Patty is her own legal guardian and thus retains full control of her medical and financial decision-making. Her treating physician and speech therapist both found an SACD to be medically necessary. (r. 38; r. 43) Without an SACD, Patty cannot communicate to her nursing staff when she is in pain or having a medical complication. She cannot express her desires concerning advanced medical directives. She cannot adequately govern her financial affairs.

[9] Dysarthria is a motor speech disorder resulting from neurological injury, characterized by poor articulation. *See* http://asha.org/public/speech/disorders/dysarthria.htm.

She is prevented from engaging in social activities in the facility, interacting with people in the community, and from having conversations with friends or family. The medical necessity of the requested device was never at issue.

SUMMARY OF THE ARGUMENTS

A. SACDs are considered durable medical equipment and prosthetic devices. Durable medical equipment (DME) is covered under Utah's Medicaid plan in the category of services Home Health Services. The prosthetic devices category of services is also included in Utah's Medicaid plan. The Agency covers DME and prosthetics for adults. However, it does not cover SACDs for adults.

B. The Agency's policy to exclude coverage of SACDs for adults as DME violates the Medicaid Act. Under the Act a state Medicaid agency must have reasonable standards for the services and devices it provides that are consistent with the objectives of the Act. 42 U.S.C. § 1396a(a)(17). The purpose of the Medicaid program is to provide medical assistance to individuals and families "whose income and resources are insufficient to meet the costs of necessary medical services" and "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." 42 U.S.C. § 1396-1.

C. The reasonable standards requirement of the Medicaid Act limits the discretion a state agency has to limit or deny particular services or devices.

Durable medical equipment, and thus SACDs, are mandatory services. SACDs are a covered service in that prosthetic devices are included in Utah's Medicaid plan. For many individuals SACDs are critical to their ability to function independently and engage in activities most take for granted. Numerous courts have found that an artificial distinction in coverage of SACDs between children and adults, not based on medical need, is unreasonable. It violates 42 U.S.C. § 1396a(a)(17), which requires that all Medicaid services must be sufficient in amount, duration, and scope to reasonably achieve their purpose.

D. By categorically excluding coverage of SACDs as DME for adults, the Agency has created an exclusive list with no reasonable and meaningful process for requesting medically necessary services that are not included on the agency's list of covered durable medical equipment. The Center for Medicare and Medicaid Services (CMS) of the federal Department of Health and Human Services, the agency that administers the Medicaid program on the federal level, has determined that such exclusive lists violate 42 U.S.C. § 1396a(a)(17). Numerous court decisions have relied on this directive by CMS to strike down exclusive lists.

E. The reasonable standards mandate of the Medicaid Act precludes state agencies from categorically denying prior approval of medically necessary services or devices that are within a category of services included in a state's Medicaid

plan. SACDs, as durable medical equipment, fall within the category of Home Health Services that must be included in the Agency's plan. They also fall within the category of prosthetic devices, which is also a covered category of services under Utah's Medicaid plan. The policy at issue categorically denies medically necessary services within two covered category of services, and therefore violates the reasonable standards provisions of the Medicaid Act and implementing regulations.

F. The policy at issue also violates the "Comparability of Services" mandate of the Medicaid Act, 42 U.S.C. § 1396a(a)(10)(B) and 42 C.F.R. §§ 440.230(b) and (c). That provision requires that medical services and devices be available in comparable amount, duration and scope to different groups of Medicaid eligible groups. By treating adults and children differently in the coverage of SACDs, the Agency is not making SACDs available in amount, duration and scope between the two groups, thus violating the Medicaid Act. It also creates an arbitrary and unreasonable distinction in coverage based on age that makes the device insufficiently available to meet its purpose, and discriminates based on the diagnosis and condition of the adult.

ARGUMENT

To assist in the understanding of the ALJ's decision below, Nicholas Conley and Patty Olguin reframe that decision as follows. The premise of the ALJ's

decision is that a state Medicaid agency has considerable discretion in developing and implementing its Medicaid plan. She then, in essence, rejected all of Nicholas Conley's and Patty Olguin's statutory-based arguments, and went on to determine that what was left was an issue of policy between the statement of purposes found in 42 U.S.C. § 1396-1 and specific Medicaid Act statutes, regulations, Utah state administrative rules, and the Agency's policies. She held that these specific provisions trump the more general statement of purpose. With that she dismissed Nicholas Conley's and Patty Olguin's appeal.

Congress created the Medicaid program in 1965 by adding Title XIX to the Social Security Act, 42 U.S.C. §§ 1396-1396v. The purpose of Medicaid is to enable each State,

> "as far as practicable...to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."

42 U.S.C. § 1396.

State participation in Medicaid is optional. However, a state that chooses to participate, and thereby receive federal matching funds for program expenditures, "must comply with requirements imposed both by the Act itself and by the Secretary of Health and Human Services." *Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981); *see also Weaver v. Reagen*, 886 F.2d 194, 197 (8th Cir. 1989).

I. THE ALJ MISCHARACTERIZED THE LEVEL OF DISCRETION A STATE MEDICAID AGENCY HAS IN DEVELOPING AND IMPLEMENTING ITS MEDICAID PROGRAM.

The ALJ based her decision on her conclusion that a state Medicaid agency has substantial discretion when fashioning its Medicaid program and developing the policies to implement it. She cites dicta in *Alexander v. Choate*, 469 U.S. 287, 105 S.Ct. 712 (1985), where the Supreme Court stated that "The Act gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in 'the best interests of the recipients.'" *Id.* at 303. (Recommended Decision, p. 7) (r. 105)

It should be noted that the question before the Court in *Alexander v. Choate* was not the scope of discretion a state Medicaid agency has under the Medicaid Act, but whether a limitation of coverage for inpatient surgical days to 14 annually violated § 504 of the Rehabilitation Act. The Court was not looking at all Medicaid Act provisions that limit the scope of a state Medicaid agency's discretion. It was addressing whether the limitation of 14 days of inpatient surgical days annually constituted "meaningful access to Medicaid services" for the purposes of § 504. *Id.* at 302-03. The Court found that this reduction did not violate § 504 of the Rehabilitation Act.

This dicta from *Alexander v. Choate* is frequently quoted in the beginning of the analysis of Medicaid Act requirements, but rarely is used directly to define the boundaries of a state Medicaid agency's discretion. To the extent it is more than a simple statement that a state Medicaid agency has some level of discretion, it should be noted that the Court was only addressing a limitation to the amount of a covered service. It was not addressing the more drastic policy of categorically excluding altogether an otherwise covered service for a class of recipients.

The ALJ also cited 42 C.F.R. § 440.230(d) to define a state Medicaid agency's discretion. (Recommended Decision, p. 7) (r. 105) The language of 42 C.F.R. § 440.230(d) is also a general statement of a state Medicaid agency's discretion: "The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." This general language does not help to define the parameters of a state agency's discretion.

These basic statements of discretion have been limited in subsequent cases. Various specific parts of the Medicaid Act limit this discretion. As the Tenth Circuit Court of Appeals stated in *Hern v. Beye*, 57 F.3d 906 (10th Cir. 1995):

> Rather, Title XIX "confers broad discretion on the States to adopt standards for determining the extent of medical assistance" offered in their Medicaid programs. *Id.* at 444, 97 S.Ct. at 2370-71. In addition, federal Medicaid regulations expressly permit participating 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).

> Nonetheless, there are important restrictions on states in their exercise of this discretion. Two of those restrictions are particularly relevant here. First, Title XIX requires participating states to establish "reasonable standards ... for determining ... the extent of medical assistance under [their Medicaid] plan which ... are consistent with the objectives of [Title XIX]." 42 U.S.C. § 1396a(a)(17). Second, state Medicaid plans "may not arbitrarily deny or reduce the amount, duration, or scope of [such] service [s] ... to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c).

Id., at 910. *See also Lankford v. Sherman*, 451 F.3d 496, 506 (8th Cir. 2006); *Utah Women's Clinic, Inc. v. Graham*, 892 F.Supp. 1379, 1383 (D. Utah 1995); *McMillan v. McCrimon*, 807 F.Supp. 475, 481-82 (C.D. Ill. 1992) (discretion limited by 42 U.S.C. § 1396a(a)(8) – Reasonable Promptness mandate). Nicholas Conley's and Patty Olguin's arguments are premised on these statutory limitations. The discretion referred to by the ALJ does not impact these mandates. They must be met.

II. MEDICAL SERVICES AND DEVICES CAN FALL WITHIN MULTIPLE MEDICAID AUTHORIZED CATEGORIES OF SERVICES.

There are 29 different categories of services that can be included in a state's Medicaid plan. 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. § 1396d. Seven of those categories of services must be included in a state plan. 42 U.S.C. § 1396a(a)(10)(A). Each of those 29 different categories of services include many specific types of services or devices.

A particular medical service or device can fall within more than one category of services. *Hern v. Beye*, 57 F.3d 906, 910 (10th Cir. 1995) (noting that abortion procedures fall within four different categories of services.) The Federal District Court for Western Texas recognized that SACDs are both DME and prosthetic devices. *Fred C. v. Texas Health and Human Services Commission*, 924 F.Supp. 788, 791-92 (W.D. Tex. 1996). In *William T. v. Taylor*, 465 F.Supp.2d 1267, 1284–1285 (N.D. Ga. 2000) the court noted that in 2000, forty-seven state Medicaid programs covered SACDs without age restriction, and did so under multiple service categories. *Id., at* 1284-85 (holding that SACDs fall under "Home Health Services-DME" "prosthetic devices", and "speech language pathology equipment"). [10] At this juncture, forty-nine states cover SACDs for adults. The large majority of states provide them for beneficiaries under the DME category, while a few categorize them as *both* DME, prosthetics, and/or speech language pathology equipment.[11] Utah's Medicaid program is the only traditional Medicaid program that does not provide SACDs for adults.[12]

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[10] As discussed by the ALJ in her decision, a state must provide SACDs to children. This figure therefore represents the number of states that cover SACDs for adults.

[11] Due to length and complexity, a list of citations regarding coverage criteria for each state are provided in the *Addendum Table of Contents*, rather than included here as a footnote. The citations reference to administrative rule where applicable. 19 states address SACD coverage explicitly through administrative rule; 25 states incorporate by reference their SACD coverage policies through administrative rule and Medicaid policy manual; 5 states address SACD coverage solely through Medical policy manual without reference to an administrative rule. The individual state citations are further separated by state in alphabetical order.

There is no definition of DME in the Medicaid Act or its implementing regulations. Each state defines the term. The Agency defines the term as: "equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in the home." Utah Admin. Code R414-70-2(2). SACDs meet this definition. They are made for repeated use, designed for medical purpose -- restoring the ability to communicate previously limited by a defect in speech system, not useful to one who does not have such a physiological impairment, and certainly would be used in the home.

Prosthetic devices are defined by federal regulation. They are

> 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.

42 C.F.R. 440.120(c). SACDs are prosthetic devices. They are a corrective device that remediates a deformity or malfunction, i.e. physiological speech mechanism. They also support a weak or deformed physiological speech mechanism.

Durable medical equipment falls within the covered category of services Home Health Services. 42 C.F.R. § 441.15(a)(3). Home Health Services is a mandatory category of services that must be included in a state Medicaid plan.

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[12] *TennCare*, a *Medicaid waiver program* in Tennessee that serves part of Tennessee's Medicaid population, does not currently cover SACDs for adults, see *Addendum.*

"(a) A State plan must specify that, at a minimum, categorically needy recipients are furnished the following services: (1) The services defined in §§ 440.10 through 440.50, 440.70, ..." 42 C.F.R. § 440.210(a)(1). "44.70" is 42 C.F.R. § 440.70, in which Home Health Services are defined. Thus, DME is a mandatory service for all categorically needy Medicaid recipients.

Prosthetic devices fall within the category of services "prescribed drugs, dentures, and prosthetic devices." 42 U.S.C. § 1396d(12). It is an optional category of services. 42 U.S.C. § 1396a(a)(10)(A). The Agency has included this category of services in its state Medicaid plan.

While SACDs fall within the covered categories of services Home Health Services as durable medical equipment, and Prescribed Drugs, Dentures, and Prosthetic Devices, the Agency identifies them only as speech language devices under the Speech Language category of services. In doing so it has de facto excluded them from coverage for adults as DME or prosthetic devices.

III. THE AGENCY'S CATGORICAL EXCLUSION OF MEDICALLY NECESSARY SACDS FROM COVERAGE FOR ADULTS AS DME VIOLATES THE REASONABLE STANDARDS MANDATE OF 42 U.S.C. § 1396a(a)(17).

A state Medicaid agency's policies implementing its Medicaid plan must be reasonable and consistent with the fundamental purposes of the Medicaid Act. "A state plan for medical assistance must ... (17) include reasonable standards ... for

determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, ..." 42 U.S.C. § 1396a(a)(17) Agency's categorical denial of coverage of SACDs for adults is unreasonable and in violation of the Medicaid Act in three respects: (1) denying a device that meets a basic human need and promotes independence for reasons other than medical need is fundamentally unreasonable; (2) maintaining a list of available DME and categorically excluding SACDs from that list for adults creates an exclusive list without any reasonable and meaningful procedure for requesting medically necessary items that do not appear on its pre-approved coverage list, and is inherently unreasonable; (3) denying a medically necessary service that falls within a covered category of services in a state's Medicaid plan is unreasonable.

The reasonable standards mandate applies to durable medical equipment. *William T. v. Taylor*, 465 F.Supp.2d 1267, 1282–1283 (N.D. Ga. 2000). In that decision the court relied in part on a letter from the director of the federal agency that oversees the Medicaid program, the Health Care Financing Administration[13]:

> As you know, the mandatory home health services benefit under the Medicaid program includes coverage of medical supplies, equipment, and appliances suitable for use in the home (42 C.F.R. § 440.70(b)(3)). A state may establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of such coverage (42 U.S.C. § 1396(a)(17)) based on such criteria as medical necessity or utilization control (42 C.F.R. § 440.230(d)). In doing so, a State must ensure that the

[13] The agency was subsequently renamed Center for Medicare and Medicaid Services (CMS).

> amount, duration, and scope of coverage are reasonably sufficient to achieve the purpose of the service (42 C.F.R. § 440.230(b)). Furthermore, a State may not impose arbitrary limitations on mandatory services, such as home health services, based solely on diagnosis, type of illness, or condition (42 C.F.R. § 440.230(c)).

Id, at 1279. *See also Lankford v. Sherman*, 451 F.3d 496, 512-513 (8th Cir. 2006); *Esteban v. Cook*, 77 F. Supp. 2d 1256, 1260 (S.D. Fla. 1999); *Bell v. Agency for Health Care Admin.*, 768 So.2d 1203, 1204 (Fla. Ct. App. 2000).

A. THE AGENCY'S POLICY THAT EXCLUDES COVERAGE OF MEDICALLY NECESSARY SACDS FOR ADULTS AS DME IS UNREASONABLE IN THAT IT MAKES UNAVAILABLE A DEVICE THAT IS ESSENTIAL FOR ENGAGING IN A FUNDAMENTAL AND ESSENTIAL HUMAN PROCESS, COMMUNICATING ORALLY, AND LIMITS THE INDIVIDUAL'S INDEPENDENCE.

A fundamental purpose of the Medicaid Act is to "furnish . . . (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." 42 U.S.C. § 1396-1. SACDs make an individual who cannot speak more independent – they enhance the ability to communicate needs, choices, and develop the type of normal relationships that others without this limitation enjoy. "Language is the principal skill distinguishing human beings from other animals. The inability to speak can be the single most devastating aspect of any handicap. Augmentative communication devices are on the market today which enable many people with severe speech impairments to communicate verbally." Ellen M. Saideman, *Helping the Mute to Speak: The*

Availability of Augmentative Communication Devices Under Medicaid, 17 N.Y.U. REV.L. & SOC.CHANGE 741, 741 (1989/1990), (quoted in *Fred C. v. Texas Health and Human Services Commission*, 988 F.Supp. 1032, 1034 (W.D. Tex. 1997):

> Because the ability to speak and communicate is vital, augmentative communication devices have enabled adult Medicaid recipients with severe speech impairments to live on their own, maintain employment, pay taxes and become productive members of the community rather than wards of the State. This limits the cost of other medical services, such as nursing expenses, and reduces or eliminates the costs of disability and other welfare benefits. *Helping the Mute to Speak,* 17 N.Y.U. REV. L. & SOC. CHANGE at 741. This Court cannot divine a rational basis to make available the blessings of speech to one who is twenty years three hundred sixty-four days old and deny the same blessing to one who is two days older.

Id., at 1036.

Nicholas Conley currently has an SACD, and will be significantly impacted when that device no longer works. Where he once was able to make friends, he will lose those relationships because he can no longer communicate with them. His ability to interact with family will likewise be limited. Communicating with members of the public, and establishing new relationships will be difficult at best.

Patty Olguin is currently in a nursing home because of various medical needs. Without an SACD she is denied the ability to communicate when she is in pain or having a medical complication. She cannot adequately govern her financial

affairs. She is unable to engage in social activities in the nursing home, interact with others in the community, or have conversations with family members.

The court in *Fred C. v. Texas Health and Human Services Commission*, 988 F.Supp. 1032 (W.D. Tex. 1997) clearly found that a policy that denies a class of people a device that is fundamental to promoting their independence is inconsistent with the basic purposes of the Medicaid Act, and thus in violation of the reasonable standards requirement of 42 U.S.C. § 1396a(a)(17). *Id.* at 1036. Other courts that have reviewed policies restricting SACDs to beneficiaries less than twenty-one years old have found them unreasonable and inconsistent with the Medicaid Act. *Meyers v. Reagan*, 776 F.2d 241 (8th Cir. 1985); *Hunter v. Chiles*, 944 F. Supp. 914 (S.D. Fla. 1996). Courts, in reference to different Medicaid services, have likewise held that a categorical child/adult distinction in coverage is unreasonable and violates the Medicaid Act. *See generally Radaszewski v. Garner*, 346 Ill.App.3d 696, 805 N.E.2d 620 (Ill Ct App 2004); *Salgado v. Kirschner,* 878 P.2d 659 (Ariz.1994) (en banc), cert. denied, 513 U.S. 1151, 115 S.Ct. 1102, (1995).

B. THE AGENCY'S CATEGORICAL EXCLUSION OF MEDICALLY NECESSARY SACDS FOR ADULTS AS DME CREATES AN EXCLUSIVE LIST FOR WHICH THERE IS NO REASONABLE AND MEANINGFUL PROCEDURE FOR REQUESTING THE DEVICE.

A state may not maintain a list of durable medical equipment that it will cover, except for purposes. The failure to preclude access to durable medical

equipment that is not included on that list violates the Reasonable Standards mandate. In *William T. v. Taylor*, 465 F.Supp.2d 1267, 1279 (N.D. Ga. 2000), the court relied in part upon the CMS letter mentioned previously:

> An ME [medical equipment] policy that provides no reasonable and meaningful procedure for requesting items that do not appear on a State's pre-approved list, is inconsistent with the federal law discussed above. In evaluating a request for an item of ME, a State may not use a "Medicaid population as a whole" test, which requires a beneficiary to demonstrate that, absent coverage of the item requested, the needs of "most" Medicaid recipients will not be met. This test, in the ME context, establishes a standard that virtually no individual item of ME can meet. Requiring a beneficiary to meet this test as a criterion for determining whether an item is covered, therefore, fails to provide a meaningful opportunity for seeking modifications of or exceptions to a State's pre-approved list. Finally, the process for seeking modifications or exceptions must be made available to all beneficiaries and may not be limited to sub-classes of the population *(e.g., beneficiaries under the age of 21).*

Id. (emphasis added).[14] On the basis of this CMS guidance, the United States Supreme Court vacated a court of appeals decision that had allowed the Connecticut Medicaid program to categorically exclude coverage of medically necessary medical equipment not listed in the state's coverage list. *See Sleki*s *v. Thomas*, 525 U.S. 1098 (1999)(vacating and remanding *Desario v. Thomas*, 139 F.3d 80 (2d Cir. 1998). Other cases have followed the CMS guidance in ruling that exclusive lists violate 42 U.S.C. § 1396a(a)(17). *Lankford v. Sherman*, 451 F.3d 496, 513 (8th Cir. 2006); *Esteban v. Cook*, 77 F. Supp. 2d 1256, 1260-1261

[14] CMS obviously takes the stance that durable medical equipment cannot be categorically excluded from coverage based upon age.

(S.D. Fla. 1999); *Bell v. Agency for Health Care Admin.*, 768 So.2d 1203, 1204 (Fla. Ct. App. 2000). The Agency has a list of what durable medical equipment is covered, and the limitations on that coverage. In effect, it has an exclusive list. Since SACDs are not a covered service for adults there is no "reasonable and meaningful procedure" for requesting prior approval for them. Such a policy violates the reasonable standards mandate of 42 U.S.C. § 1396a(a)(17).

C. THE AGENCY'S CATEGORICAL EXCLUSION OF MEDICALLY NECESSARY SACDS, WHICH FALL WITHIN THE COVERED CATEGORY OF SERVICES DURABLE MEDICAL EQUIPMENT/HOME HEALTH SERVICES, VIOLATES THE REASONABLE STANDARDS MANDATE OF 42 U.S.C. § 1396(a)(17).

As discussed above, SACDs are durable medical equipment. Durable medical equipment is a part of the Home Health Services category of services. Home Health Services is included in Utah's Medicaid plan. The Agency categorically excludes coverage of SACDs for adults as durable medical equipment. It does cover many other types of DME for adults. This categorical denial of a service that falls within a covered category of services violates the reasonable standards mandate of 42 U.S.C. § 1396a(a)(17). The Tenth Circuit Court of Appeals in *Hern v. Beye*, stated:

> The purpose of Medicaid as stated in the Act is to enable states to provide medical treatment to needy persons "whose income and resources are insufficient to meet the cost of *necessary medical services.*" *Id.* § 1396 (emphasis added). This circuit, as well as several other courts, has interpreted Title XIX and its accompanying regulations as imposing a

> general obligation on states to fund those mandatory coverage services that are medically necessary."

Hern v. Beye, 57 F.3d 906, 910-911 (10th Cir. 1995). *Hern v. Beye* has consistently been interpreted to hold that, in general, categorically excluding medically necessary services that fall within a covered category of services violates the Medicaid Act. The Eight Circuit Court of Appeals applied this specifically to DME in *Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006). The court stated that "While a state has discretion to determine the optional services in its Medicaid plan, a state's failure to provide Medicaid coverage for non-experimental, medically-necessary services within a covered Medicaid category is both per se unreasonable and inconsistent with the stated goals of Medicaid." *Id.* at 511. The court held that maintaining and exclusive list of covered DME items, while categorically excluding from coverage other types of DME, violates 42 U.S.C. § 1396a(a)(17) and 42 C.F.R. § 440.230(b) (amount, duration and scope to reasonably achieve its purpose). *Id. See also Smith v. Rasmussen,* 57 F.Supp.2d 736, 763 (N.D. Iowa 1999); *Smith v. Palmer*, 24 F.Supp.2d 955, 966 (N.D. Iowa 1998); *T.L. v. Colorado Department of Health Care Policy and Financing*, 42 P.3d 63, 66 (Colo. Ct. App. 2001). The Second Circuit acknowledged this sweeping holding of *Hern* when rejecting this rule in general. *DeSario v. Thomas*, 139 F.3d 80, 96 (2nd Cir. 1997.) However, the Tenth Circuit precedence and ruling of law govern this case. Utah's categorical exclusion of SACDs for adults runs afoul of

Hern v. Beye. The categorical exclusion of SACDs for adults denies otherwise medically necessary DME that falls within a covered category of services -- Home Health Services.

IV. THE AGENCY'S CATGORICAL EXCLUSION OF MEDICALLY NECESSARY SACDS FROM COVERAGE FOR ADULTS AS DME VIOLATES THE COMPARABILITY OF SERVICES MANDATE OF 42 U.S.C. § 1396a(a)(10)(B) AND ITS IMPLEMENTING REGULATIONS.

The Comparability of Services mandate of 42 U.S.C. § 1396a(a)(10)(B) requires "**(B)** that the medical assistance made available to any individual described in subparagraph (A) -- **(i)** shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and ..." This provision is fleshed out more fully in regulations promulgated under the Medicaid Act:

> (a) The [state Medicaid] plan must specify the amount, duration, and scope of each service that it provides for (1) The categorically needy; and (2) Each covered group of medically needy.
> (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
> (c) The Medicaid agency 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 recipient solely because of the diagnosis, type of illness, or condition.

42 C.F.R. § 440.230. This regulatory provision implements the requirements of 42 U.S.C. § 1396a(a)(10)(B). *See* 42 C.F.R. § 440.200(a)(1) ("amount, duration and scope" referred to includes 42 C.F.R. §§ 400.230(a), (b) and (c)).

A. THE AGENCY'S EXCLUSION OF COVERAGE OF SACDS FOR A GROUP OF CATEGORICALLY NEEDY INDIVIDUALS FOR REASONS OTHER THAN MEDICAL NEED VIOLATES THE COMPARABILITY OF SERVICES MANDATE OF 42 U.S.C. § 1396a(a)(10)(b).

Numerous cases have applied the Comparability of Services mandate where a state's policies make clear distinctions between individuals within the same categorically needy group based on factors other than medical need. The New York federal district court applied 42 U.S.C. § 1396a(a)(10)(B) to distinctions based on age, finding that the distinction violated the comparability of services requirement. *Hodecker v. Blum*, 525 F.Supp. 867, 873 (D.C.N.Y. 1981); *see also Sobky v. Smoley*, 855 F. Supp. 1123, 1142 (E.D. Cal. 1994) (distinction based upon location found to violate 42 U.S.C. § 1396a(a)(10)(B)).

The Agency's policy creating a distinction in coverage between adults and children precludes coverage for some categorically needy groups as opposed to others based on factors other than medical need. This distinction, based on factors other than medical need, violates that statutory mandate.

B. THE AGENCY'S CATEGORICAL EXCLUSION OF SACDS FOR ADULTS VIOLATES THE AMOUNT, DURATION AND SCOPE REQUIREMENTS OF 42 C.F.R. §§ 440.230(b) AND (c).

The Agency's policy violates the amount, duration and scope requirements of 42 C.F.R. §§ 440.230(b) and (c) in three distinct ways: (1) the categorical denial of coverage of SACDs specifically for reasons other than medical need renders

those devices unavailable given the medical purpose of the device; (2) a policy which categorically denies coverage of SACDs for adults, while covering other types of DME, is insufficient to reasonably achieve its purpose; (3) excluding coverage of SACDs for adults who have impairments of their speech processes, while providing other types of DME to people with different types of physical impairments arbitrarily denies an otherwise covered service based upon the diagnosis or condition of the individual. This is disallowed under the Medicaid Act.

1. The Categorical Exclusion of SACDs for Adults Makes Those Devices Insufficiently Available Given the Medical Purpose of the Device.

Clearly age does not preclude an individual from using and benefitting from an SACD. Nicholas Conley's and Patty Olguin's treating health care professionals determined that for them the device is medically necessary. Being twenty-two as opposed to twenty years of age, as Nicholas Conley is, has absolutely nothing to do with the purpose of the device, his medical need for it, or the fact that will greatly enhance his independence. At 38 years of age Patty Olguin will still benefit significantly from the SACD recommended for her by her treating health care professionals, as well as many other purposes.

A state Medicaid agency must assure that each service that falls within a covered category of services must be sufficient in amount, duration, and scope

to reasonably achieve its purpose. 42 C.F.R. § 440.230(b). The courts in *Fred C. v. Texas Health and Human Services Commission* and *Hunter v. Chiles* ruled that not only did a limitation on the coverage of SACDs to children violate the Reasonable Standards requirements of 42 U.S.C. § 1396a(a)(17), it also violates 42 C.F.R. § 440.230(b). The age-based distinction rendered the device insufficient in amount, duration, and scope to reasonably achieve its purpose. *Fred C. v. Texas Health and Human Services Commission*, 988 F. Supp. 1032, 1036 (W.D. Tex. 1997); *Hunter v. Chiles*, 944 F. Supp. 914, 920 (S.D. Fla. 1996). Courts have found similar exclusions of DME for adults violate 42 C.F.R. § 440.230(b). In *Esteban v. Cook*, 77 F. Supp. 2d 1256, 1260-1262 (S.D. Fla. 1999) the court determined that a policy excluding the coverage of wheelchairs costing more than $582 for adults effectively excluded coverage of power wheelchairs. This limitation made power wheelchairs insufficient in amount to reasonably achieve their purpose. The categorical exclusion of SACDs here entirely excludes SACDs from meeting their purpose for adults. The unreasonableness of the age-based distinction applies equally to 42 U.S.C. § 1396a(a)(17) and 42 C.F.R. § 440.230(b).

2. The Categorical Exclusion of SACDs for Adults Makes Those Devices Insufficiently Available When Compared to Other Types of DME.

The Agency's age-based distinction in the availability of SACDs when compared to other types of DME likewise violates 42 C.F.R. § 440.230(b). It is clearly unreasonable that an adult that needs one type of DME (e.g., a wheelchair), can receive reimbursement for that wheelchair, while the same person who needs another type of DME, an SACD, has no access to that device. He or she would be able to access the community, but be unable to communicate with anyone there. The dichotomy happens more frequently between two adults. That discrimination in the scope of DME covered for adults has no relationship to medical need. The exclusion of SACDs for adults as compared to other forms of DME unreasonably makes the availability of SACDs as DME insufficient in scope to reasonably achieve their purpose.

3. The Categorical Exclusion of SACDs for Adults With Impairments in Their Communication Process is Discriminatory When Compared to Individuals Who Are Eligible for Other Forms of DME Because of a Different Physical Impairment.

The Agency's limitation on the availability of SACDs, based upon age, as compared to other types of DME that are not limited in their coverage by age, creates a distinction based upon the diagnosis or condition of the individual and not upon medical need. Individuals with physical impairments that limit their ability to communicate orally have no access to a particular type

of medically necessary DME. An adult with a different physical impairment who needs a different type of DME to be more functional will have access to that medically necessary type of DME. Again, an example of this is the adult who has a mobility impairment. He or she will have access to a wheelchair to meet their medical need. The consequence of this difference in coverage of different forms of DME is discriminatory based upon the condition of the individual.

The Agency "may not arbitrarily deny or reduce the amount, duration, or scope of a required service under 42 C.F.R. §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c). For Nicholas Conley and Patty Olguin, who are categorically needy for purposes of eligibility for Medicaid, SACDs fall under 42 C.F.R. § 440.210.

More generally, the Tenth Circuit Court of Appeals has held that distinctions in coverage of a specific device or service based on something other than medical need violates 42 C.F.R. § 440.230(c). *Hern v. Beye*, 57 F.3d 906, 910 (10th Cir. 1995). In *Hern*, which involved the availability of Medicaid funding for abortion, the court concluded that "abortions to terminate pregnancies resulting from rape or incest" constituted a "diagnosis, type of illness, or condition." *Id.* at 907, 910. This is a far broader definition of those terms than what Nicholas Conley and Patty

Olguin suggest here – a distinction in the type of physical impairment two adults have. The categorical exclusion of SACDs for adults, when other types of DME are covered for adults with different physical impairments, constitutes an arbitrary limitation of a device within a covered category of services based upon the diagnosis or condition of the individual.

V. THE AGENCY'S CATGORICAL EXCLUSION OF MEDICALLY NECESSARY SACDS FROM COVERAGE OF SACDS FOR ADULTS AS PROSTHETIC DEVICES VIOLATES THE REASONABLE STANDARDS MANDATE OF 42 U.S.C. § 1396a(a)(17) AND THE COMPARABILITY OF SERVICES MANDATE OF 42 U.S.C. § 1396a(a)(10)(B) AND ITS IMPLEMENTING REGULATIONS.

Prosthetic devices are defined as:

> 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.

42 C.F.R. 440.120(c). SACDs are prosthetic devices. They are a corrective device that corrects a deformity or malfunction (i.e. physiological speech mechanism). They support a weak or deformed physiological speech mechanism. *See Fred C. v. Texas Health and Human Services Commission*, 924 F. Supp. 788, 792 (W.D. Tex. 1996)(determining that SACDs are a prosthetic device).

The exclusion of SACDs as a prosthetic device generally, and exclusively placing them in the speech language category of services, de facto excludes them

from coverage as a prosthetic device for adults. The category of prescribed drugs, dentures, and prosthetic devices is included in Utah's State Medicaid Plan.

The analysis in Arguments III and IV above applies equally to the Agency's policy at issue here in regards to SACDs as prosthetic devices. The policy violates the reasonable standards mandate of 42 U.S.C. § 1396a(a)(17) in that it categorically denies coverage for adults of a device that is essential for engaging in a fundamental and essential human process, communicating orally, and limits the independence of those that need an SACD to communicate. (Argument IIIA.) It also categorically denies a medically necessary service within a covered category of services for reasons other than medical need. (Argument IIIC.) The analysis of Argument IV, that the exclusion of SACDs as DME violates the mandates of 42 U.S.C. § 1396a(a)(10)(B) and 42 C.F.R. § 440.230(b), also applies here. The same groups are impacted. The analysis does not change simply because of the category into which the device falls. The Agency's categorical exclusion of SACDs as prosthetic devices for adults violates the Medicaid Act.

VI. THE ALJ ERRED IN HOLDING THAT THE CATEGORICAL DENIAL OF SACDS FOR ADULTS DOES NOT VIOLATE THE REASONABLE STANDARDS MANDATE OF 42 U.S.C. § 1396a(a)(17) and THE COMPARABILITY OF SERVICES MANDATE OF 42 U.S.C. § 1396a(a)(10)(B) AND 42 C.F.R. § 440.230(b) and (c).

The ALJ began her analysis by concluding that a state Medicaid agency has wide discretion in developing and implementing its state Medicaid plan.

(Recommended Decision, p. 7) (r. 105) This was the premise for the rest of her analysis. The ALJ found that 42 U.S.C. § 1396a(a)(17) was not applicable to this matter. She asserted that it only applies to financial eligibility for the Medicaid program in general, not to eligibility for specific Medicaid services or devices. (Recommended Decision, p. 6) (r. 104). She did not directly address whether the age distinction in the coverage of SACDs violates either 42 U.S.C. § 1396a(a)(10)(B) or 42 C.F.R. § 440.230(b). She did distinguish cases that support Conley's/Olguin's arguments under those statutory and regulatory provisions. The ALJ dismissed Nicholas Conley's and Patty Olguin's argument related to coverage of SACDs as DME or prosthetic devices, stating that just because SACDs can be covered under those categories does not mean they need to be. (Recommended Decision, p. 7) (r. 105) In her opinion, the Agency has the discretion to place all of speech language pathology and associated equipment and supplies under speech language, thereby denying coverage of SACDs to adults under that category of services. (Recommended Decision, p. 7-8) (r. 105-06)

Once the ALJ disposed of these legal arguments she characterized the case as one of policy. She characterized Nicholas Conley's and Patty Olguin's reference to 42 U.S.C. § 1396-1 as a policy argument. She implicitly stated that this is not an enforceable statute. Invoking the statutory construction rule used in resolving conflict between statutes, that more specific provisions prevail over more

general ones, she determined that federal regulations, state statutes, rules and policies cited by the Agency "trump" the more general policy statement of 42 U.S.C. § 1396-1. (Recommended Decision, p. 6, 7) (r. 104-05)

The ALJ's faulty analysis of a state Medicaid agency's discretion is laid out in Argument I above. Her interpretation of the scope of 42 U.S.C. § 1396a(a)(17) is inconsistent with the plain wording of that statute. It states "(a) A state plan for medical assistance must . . . (17) . . . include reasonable standards . . . for determining eligibility for *and the extent of medical assistance* . . ." 42 U.S.C. § 1396a(a)(17) (emphasis added). The second clause clearly adds the provision of specific services or devices to its reasonable standards requirement. All of the cases cited above in Argument III apply the reasonable standards mandate to the provision of specific services. *See also Harris v. McCrae*, 448 U.S. 297, 302, 100 S.Ct. 2671, 2679 (1980); *William T. v. Taylor*, 465 F.Supp.2d 1267, 1282–83 (N.D. Ga. 2000).

Nicholas Conley and Patty Olguin cited various cases in support of their arguments under 42 U.S.C. § 1396a(a)(17) and 42 C.F.R. § 440.230(b). The ALJ distinguished *Hern v. Beye*, 57 F.3d 906 (10th Cir. 1995) by stating that it only applied to arguments made under 42 C.F.R. § 440.230(c) (Recommended Decision, p. 8) (r. 106). However, the Tenth Circuit Court of Appeals relied in part on 42 U.S.C. § 1396a(a)(17) in finding that the limitation imposed by Colorado on

abortion coverage violated the Medicaid Act. *Id.* at 910-11. She also failed to acknowledge the broader interpretation given to *Hern*, that in most all circumstances the denial of a medically necessary service that falls within a covered category of services violates the Medicaid Act.

Nicholas Conley and Patty Olguin cited *Fred C. v. Texas Health and Human Services Commission*, 988 F. Supp. 1032 (W.D. Tex. 1997) and *Hunter v. Chiles*, 944 F. Supp. 914 (S.D. Fla. 1996) in the administrative proceedings below for the proposition that an age-based distinction in covering SACDs violates 42 U.S.C. § 1396a(a)(17.) The ALJ distinguished those cases by pointing out that Utah's categorical age-based restrictions differ from Texas' and Florida's because Utah reserves all speech pathology services and benefits to the Speech Language Services category explicitly. Texas and Florida did not address SACDs specifically anywhere in their rules. They both provided them for children as DME or prosthetic devices. (Recommended Decision, p. 8-9) (r. 106-7)

The distinction drawn between *Fred C.* and *Hunter* and this matter is one of form over substance. The ALJ never explained how this distinction impacted Nicholas Conley's and Patty Olguin's legal analysis. The fact that the age based distinction is related to different categories of services does not make it any more reasonable. According to *Fred C. and Hunter* SACDs are critical to the independence of individuals who need them. As stated by the court in *Fred C.*

"This Court cannot divine a rational basis to make available the blessings of speech to one who is twenty years three hundred sixty-four days old and deny the same blessing to one who is two days older." *Fred C. v. Texas Health and Human Services Commission*, 988 F. Supp. 1032, 1036 (W.D. Tex. 1997). The court's inability to find any rationality to the age-based distinction would not be remedied by SACDs being placed in a Speech Language category of services rather than the Home Health Services or Prescribed Drugs, Dentures, and Prosthetic Devices categories of services.

It should be noted that Nicholas Conley and Patty Olguin do not cite 42 U.S.C. 1396-1 as an enforceable statute. It simply identifies the purposes of the Medicaid Act, and helps define whether the Agency's age-based distinction is reasonable within the context of 42 U.S.C. § 1396a(a)(17) (reasonable standards) and 42 C.F.R. § 440.230(b) (services sufficient in amount, duration and scope to reasonably achieve their purpose).

Clearly this is not a case of conflicting policies. The categorical exclusion of coverage of SACDs for adults violates 42 U.S.C.§ 1396a(a)(17), 42 U.S.C.§ 1396a(a)(10)(B) and 42 C.F.R. § 440.230(b).

CONCLUSION

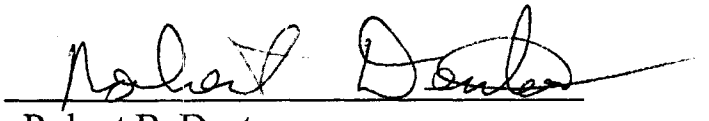
Nicholas Conley and Patty Olguin have been denied prior authorization of medically necessary Speech Augmentative Communication Devices by the Agency

because they are adults. Their opportunity to communicate orally as most of us do, and as a consequence their ability to live independently and make their wants and needs understand and met, has been denied to them. This denial of the ability to engage in a fundamental human function solely because of their age is unreasonable and inconsistent with the purposes of the Medicaid Act. The Agency's policy makes unavailable devices within a category of services with no reasonable and meaningful way to request coverage of a medically necessary service. It excludes coverage of a device that falls within a covered category of services.

The Agency's policy creating a distinction in coverage between adults and children is discriminatory. It creates an unreasonable difference in coverage between two groups, children and adults that is not based on medical need. It makes SACDs unreasonably unavailable in amount, both between adults and children, and between adults that require different forms of DME. It also makes SACDs arbitrarily unavailable, in comparison to other forms of DME needed by other adults with different physical impairments, based upon the diagnosis or condition of the adult. The policy at issue violates the Medicaid Act.

Nicholas Conley and Patty Olguin respectfully request that this matter be remanded to the Agency to further administrative appeal proceedings addressing whether the devices requested for them are medically necessary.

Respectfully submitted this 29th day of December, 2010.



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CERTIFICATE OF SERVICE

I hereby certify that I caused to be mailed, postage prepaid, first class mail, a true and correct copy of the foregoing Petitioners' Opening Brief, this 29th day of December, 2010, to the following:

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