2010

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

Utah Court of Appeals

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Robert B. Denton; Laura Boswell; Disability Law Center; Attorneys for Petitioners/Appellants.

IN THE UTAH COURT OF APPEALS

NICHOLAS CONLEY and PATTY OLGUIN,	:	
Petitioners/Appellants,	:	
v.	:	Case No. 20100496
UTAH DEPARTMENT OF HEALTH, DIVISION OF MEDICAID AND HEALTH FINANCING,	:	
Respondent/Appellee.	:	

Petition for Review of Final Agency Action of the Utah Department of Health, Division of Medicaid and Health Care Financing

AMENDED BRIEF OF APPELLEE

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ORAL ARGUMENT REQUESTED BY RESPONDENT/APPELLEE

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

CASES

Page

Page

CONSTITUTIONAL PROVISIONS, STATUTES, AND RULES

PRIOR AND RELATED APPEALS

To the best knowledge of respondent/appellee, there are no prior or related judicial appeals in this matter.

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Petition for Review of Final Agency Action of the Utah Department of Health, Division of Medicaid and Health Care Financing

BRIEF OF RESPONDENT/APPELLEE

JURISDICTION AND NATURE OF PROCEEDINGS

The Petition for Review of this Medicaid claim is taken from the Final Agency Order of the Department of Health, Division of Medicaid and Health Financing, issued on May 20, 2010. R. 97-98. The order adopted the Recommended Decision of the Administrative Law Judge (ALJ), R. 99-109, denying petitioners' requests for Medicaid-provided speech augmentative communication devices (SACDs). Petitioners' timely petition for review was filed on June 18, 2010. Utah Code Ann. § 78A-4-103(2)(a) (West 2009) gives this Court jurisdiction over "the final orders and decrees resulting from formal adjudicative proceedings of state agencies."

ISSUE PRESENTED UPON APPEAL

Did the Utah Department of Health unreasonably deny SACDs for petitioners as non-covered benefits in violation of the Medicaid Act's "reasonable standards" and "amount, duration, or scope," or comparability of services, requirements?

STANDARD OF REVIEW: "This appeal requires us to construe federal and state statutes, regulations and rules governing the Medicaid program. Thus, it presents questions of law" that are reviewed for correctness. *Bleazard v. Utah Dep't of Health*, 861 P.2d 1048, 1049 (Utah App. 1993).

CONSTITUTIONAL PROVISIONS, STATUTES, AND RULES

All relevant text of constitutional provisions, statutes, and rules pertinent to the issue before the Court is contained in the body of this brief.

STATEMENT OF THE CASE

A. Nature of the Case, Course of Proceedings, and Disposition Below

Petitioners each filed a timely Request for Hearing/Agency Action after having sought and been denied an SACD. R. 5 and 30 (denial: Conley), 1 (Request for Hearing: Conley), 8 and 44 (denial: Olguin), 7 (Request for Hearing: Olguin). Following the filing of prehearing memoranda (R. 13-47: petitioners; 50-77: respondent; 81-96: petitioners' reply), the matter was submitted to the ALJ. The ALJ issued a Recommended Decision on May 18, 2010, affirming the denials as reasonable on the ground that under Utah's Medicaid program, the devices are non-covered benefits for individuals over 21 years of age. R. 99-109. The Utah Department of Health, Division of Medicaid and

Health Financing (Department) reviewed and adopted the Recommended Decision in its entirety two days later. R. 97-98. This appeal followed.

B. Statement of Relevant Facts

The ALJ stated that "[t]he facts are not in dispute. Both Petitioner [sic] and Respondent submitted statements of fact, and while in different format, contain the same information. Those fact statements are hereby adopted for the purposes of this decision." R. 103. As enumerated in Respondent's prehearing memorandum, the facts are as follows:

> **Nicholas Conley**
> 1. Nicholas is a 22 year old male with spastic quadriplegia related to cerebral palsy.
> 2. Nicholas has limited motor control and uses a power wheelchair for mobility purposes.
> 3. Nicholas is not able to produce any intelligible words due to motor difficulties secondary to his medical diagnosis.
> 4. Nicholas uses a Dynamite 3100 augmented speech device to communicate.
> 5. Nicholas' Dynamite 3100 is seven years old and not functioning properly and has a recent history of needing repeated repairs.
> 6. When the Dynamite 3100 is not working, Nicholas attempts to express himself using gestures, facial expressions and pointing to objects.
> 7. The cost of repairing Nicholas' Dynamite 3100 far exceeds the cost of a new device.
> 8. Based on an evaluation, Nicholas's care providers determined that a Dynavox VMax currently will meet Nicholas' communication needs.
> 9. A request for prior authorization for a Dynavox VMax was submitted to the respondent.
> 10. The respondent denied the request on February 22, 2010, stating that the service is not a covered benefit.
> **Patty Olguin**
> 11. Patty is a 38 year old female who was diagnosed with multiple sclerosis at the age of 8.

12. In 2002, Patty suffered a stroke during a surgical operation to her leg which caused severe dysarthria, a motor speech disorder resulting from a neurological injury.
13. Patty's care provider recently evaluated her communication ability and determined that a Dynavox V and related accessories are necessary to meet her functional communication needs.
14. A request for a prior authorization for the Dynavox V was submitted to the respondent.
15. The request was denied on February 22, 2010, stating the service is not a covered benefit.

R. 51-52.

SUMMARY OF ARGUMENT

Petitioners' argument begins by "reframing" the ALJ's decision and starting from the premise that all state Medicaid provisions must be measured against the Medicaid Act's "reasonable standards" requirement in fulfillment of the Act's broad objectives: to furnish medical assistance, rehabilitation, and other services to help disabled individuals "attain or retain capability for independence or self-care." 42 U.S.C.A. § 1396-1 (West, Westlaw through P.L. 111-255 (excluding P.L. 111-203 and 111-240) approved 10-5-10). Petitioners complain that the ALJ erroneously started from the principle that states have substantial discretion in developing and implementing their plans and, by doing so, gave undue weight to "specific Medicaid statutes, regulations, Utah state administrative rules, and the Agency's policies." Pet'r Brief at 11. But to accept petitioners' framework would deprive states of any of the discretion to which the Act entitles them.

The ALJ correctly focused on the precise requirements of the Act, as implemented by Utah's federally approved plan. She then looked at whether those requirements

violated the Act's general provisions regarding "reasonable standards" and "amount, duration, or scope" of coverage, concluding that they did not. Petitioners have not addressed the ALJ's rationale for concluding that neither the "reasonable standards" nor the "amount, duration, or scope" provisions are applicable to the question of whether optional coverage can be restricted on the basis of age.

The ALJ's conclusions are supported by the relevant statutes, regulations, and rules. Under the federal act and associated regulations, speech pathology services are not a mandatory coverage category for adults. Even under plans that cover "home health services," federal regulations defining that term explicitly exclude speech pathology services from mandatory coverage, and Utah does not cover them as a general benefit. While the Act does require necessary health care services to correct or ameliorate defects and conditions identified in Medicaid-eligible individuals under the age of 21–regardless of whether those services are covered under the state plan–nothing in the Act mandates extension of optional coverage to adults. If it did, such coverage would no longer be optional–a result contrary to the plain language of the Act. Utah statutes and rules do no more than implement what is required and what is permitted under the federal legislation. Moreover, Utah's Medicaid program, in compliance with statutory requirements, has been approved by the Secretary of Health and Human Services, confirming that it is consistent with federal Medicaid law.

For these reasons, as more fully explained below, the decision of the Utah Department of Health warrants this Court's affirmance.

ARGUMENT

I. THE "REASONABLE STANDARDS" REQUIREMENT IS UNRELATED TO AGE-BASED RESTRICTIONS ON OPTIONAL COVERAGE

Petitioners' argument relies substantially on the concept that the Act's "reasonable standards" provision mandates a general reasonableness test for all Medicaid decisions. In making that assumption, petitioners fail to acknowledge the statutory context of the "reasonable standards" language. A careful examination shows that, as the ALJ correctly concluded, the "reasonable standards" requirement speaks to "financial eligibility such as income and resources, and insures that individuals are not wrongly denied general assistance on the basis of their financial standing. It does not reach the issue of medical eligibility or need, and there is no question that both Petitioners are financially qualified to receive Medicaid." R. 104. To the extent that the "reasonable standards" requirement applies to "determining eligibility for and the extent of medical assistance under the plan[,]" it mandates only that the extent of medical assistance is not unfairly curtailed on the basis of inequitably applied financial criteria. 42 U.S.C.A. § 1396a(a)(17) (West, Westlaw through P.L. 111-264 (excluding P.L. 111-203, 111-257, and 111-259) approved 10-8-10). But petitioners' financial qualification for services is not at issue here.

The text of the statute supports the ALJ's conclusion. The "reasonable standards" requirement is found in 42 U.S.C.A. § 1396a(a)(17), which sets forth eligibility criteria for financial assistance under four subsections. While subsection (A) requires that the eligibility criteria be consistent with the objectives of the subchapter, subsections (B),

(C), and (D) set out limitations on what income and resources can be considered and how they should be evaluated. Nothing in the text suggests a broader applicability to non-financial decisions. The "reasonable standards" requirement lacks any bearing on the validity of a limitation based on age.

Petitioners contend that the Tenth Circuit Court's decision in *Hern v. Beye*, 57 F.3d 906 (10th Cir. 1995), and the federal district court decision in *Utah Women's Clinic, Inc. v. Graham*, 892 F. Supp. 1379 (D. Utah 1995), support their position that the "reasonable standards" requirement limits the state's discretion to deny them access to SACDs. But, as the *Hern* court noted, "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*, 57 F.3d at 911 (emphasis added). *See also id.* ("'Title XIX . . . mandates that [seven] basic categories of medical assistance be provided to all categorically needy persons when the assistance is medically necessary.'") (quoting *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980)) (alterations in *Hern*). *Utah Women's Clinic* does no more than follow *Hern.*

The seven mandatory services are inpatient services, outpatient services, laboratory and x-ray services, nursing facility services, physicians' services, nurse-midwife services (if authorized by state law), and services of certified pediatric or family nurse practitioners. But these categories do not include the provision of SACDs. Instead, federal regulations specifically address SACDs in 42 C.F.R. 440.110, which defines the optional category of physical therapy and related services found at 42 U.S.C.A.

§ 1396d(a)(11). Under 42 C.F.R. 440.110 (c) (2010), captioned "Services for individuals with speech, hearing, and language disorders[,]" subsection (1) includes "any necessary supplies and equipment." A second optional category, found at 42 U.S.C.A. § 1396d(a)(7), is "home health care services," a category that Utah has chosen to cover. The federal regulations defining that term show that, under this optionally-covered category, nursing service, home health aide service, and medical supplies, equipment, and appliances suitable for home use must be covered, but speech pathology services need not be. *See* 42 C.F.R. 440.70(b)(4) (2010). Whatever *Hern* may mean with respect to the seven mandatory coverage categories, it has no applicability to the optional services petitioners seek.

McMillan v. McCrimon, 807 F. Supp. 475 (C.D. Ill. 1992), cited without analysis by petitioners, is not to the contrary. The *McMillan* case dealt with Illinois' refusal to accept applications for the home services program (HSP) of the state's Medicaid plan, an optional coverage category that Illinois chose to provide, under an emergency budget reduction measure. The court concluded that "[t]he fact that the HSP is an optional service does not exempt it from the requirements of section 1396a(a)(8)." *McMillan*, 807 F. Supp. at 481-82. Section 1396a(a)(8) requires that a state plan must "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals[.]" 42 U.S.C.A. § 1396a(a)(8) (West, Westlaw through P.L. 111-264 (excluding P.L. 111-203, 111-257, and 111-259) approved

10-8-10). In the present case, petitioners were not precluded from applying for medical assistance, nor were they denied benefits for which they are eligible. *McMillan* has no application here.

Even if the Court were to conclude that the "reasonable standards" requirement applies to medical, as well as financial, decisions, the rules of statutory construction do not permit the result petitioners seek. As the ALJ correctly pointed out, in resolving a conflict between two legal provisions, the more specific provision will prevail over the more general. R. 104. The regulations making coverage of speech pathology services and their related supplies and equipment optional are specifically targeted in a way that the general "reasonable standards" requirement is not. Under well established Utah precedents, these explicit regulations must govern: "We acknowledge the well-settled principle of statutory construction that 'when two provisions address the same subject matter and one provision is general while the other is specific, the specific provision controls.'" *Emergency Physicians Integrated Care v. Salt Lake County*, 2007 UT 72, ¶ 19, 167 P.3d 1080 (quoting *Dairyland Ins. Co. v. State Farm Mut. Auto. Ins. Co.*, 882 P.2d 1143, 1146 (Utah 1994); *accord Lyon v. Burton*, 2000 UT 19, ¶ 17, 5 P.3d 616. Given the clear language placing SACDs outside the mandatory coverage categories, and even outside required coverage under the optional category of home health care services, petitioners' "reasonable standards" argument cannot succeed.

Nor does *William T. v. Taylor*, 465 F. Supp. 2d 1267 (N.D. Ga. 2000), establish that limitation of SACDs to minors violates the "reasonable standards" provision.

Acknowledging that speech pathology services are an optional category, the court in that case found it "undisputed that Georgia has elected to cover these services." *William T.*, 465 F. Supp. 2d at 1273. The court noted that "the State does not oppose plaintiffs' contention that ACDs should be covered under Georgia's plan for medical assistance." *Id.* at 1285. *See also id.* at 1286 (observing that "[d]efendants do not contradict" plaintiffs' contention that ACDs meet all the criteria for durable medical equipment and that "defendants do not address plaintiffs' contention that ACDs meet the criteria for prosthetic devices"); *id.* at 1287 (stating that "[a]s defendants do not address plaintiffs' contention that ACDs meet the criteria for SLP [speech language pathology] equipment, it appears that they do not oppose plaintiffs' [summary judgment] motion in this regard."). Moreover, the court expressly "reserve[d] ruling on the scope of any injunctive relief to be granted in this case until after the completion of the parties' efforts to draft a reasonable ACD coverage criteria [sic]". *Id.* at 1289. The court left open the question of whether limiting SACD coverage to beneficiaries under the age of 21 would violate the Medicaid Act's "reasonable standards" and "amount, duration, and scope" provisions or a September 4, 1998 policy letter from the Health Care Financing Administration (HCFA) providing guidance on coverage of mandatory services. *Id.* at 1288-89. In fact, the court expressed skepticism about the letter's entitlement to deference, but concluded it was bound by Eleventh Circuit precedent deferring to HCFA transmittal letters. *See* Point II, below. In light of these circumstances, it is not surprising that the court did not address the language of 42 C.F.R. § 440.70(b)(4), exempting speech pathology services from

mandatory coverage under the optional category of home health services (if included in the state plan). Given Georgia's apparent lack of opposition to including SACDs in the sate plan and the absence of a definitive ruling regarding the coverage criteria, *William T* bears little weight as to what "reasonable standards" require.

II. THE "AMOUNT, DURATION, OR SCOPE" REQUIREMENT FOR COMPARABLE SERVICES HAS NO BEARING ON AGE-BASED LIMITATIONS

Petitioners also assert that the denial of SACDs violates the Act's provision requiring comparability of services–that medical assistance be the same in amount, duration, or scope among all qualifying individuals. However, petitioners have not argued that they are being deprived of benefits that are being provided to other qualifying persons. Instead, they argue that they are being denied SACDs solely on the basis of age. But, as the ALJ correctly observed, "denial on the basis of age is not one of the prohibitions contained in this provision." R. 105. Instead, under 42 C.F.R. 440.230(c) (2010), "[t]he Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a *required* service under §§ 440.210 [for the categorically needy] and 440.220 [for the medically needy] to an otherwise eligible recipient *solely because of the diagnosis, type of illness, or condition*" (emphasis added). Petitioners' argument is doubly flawed: first, because the services they seek are not required, and second, because nothing in the comparability language forecloses the application of an age-based standard. Consequently, the "amount, duration, or scope" requirement does nothing to assist their age-based claim. Petitioners have provided no binding authority supporting the

proposition that an age-based limitation on an optional service is a violation of the "amount, duration, or scope" requirement.

Petitioners' citation to *Hodecker v. Blum*, 525 F. Supp. 867 (N.D.N.Y. 1981), is not on point. In *Hodecker*, the issue was whether the state's Commissioner of Social Services could treat the income of financially responsible relatives differently in the process of qualifying adults and minors for services. The comparability requirement was violated by the application of different methodologies to determine adults' and minors' financial eligibility. The case has no bearing on whether different services can be limited to minors.

Sobky v. Smoley, 855 F. Supp. 1123 (E.D. Cal. 1994), is equally unavailing. In *Sobky*, the issue was whether the state could permit individual counties to determine, in their discretion, "the appropriate mix and level of drug abuse services needed in the community." 855 F. Supp. at 1128. The court concluded that the local discretion given to counties ran afoul of the Medicaid requirement that a state plan "shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them[.]" 42 U.S.C.A. § 1396a(a)(1) (West, Westlaw through P.L. 111-264 (excluding P.L. 111-203, 111-257, and 111-259) approved 10-8-10). There is no question in petitioners' case that the same standards are applied statewide.

42 C.F.R. § 440.200 implements the statute requiring comparability of services. It distinguishes between mandatory and optional coverage categories. *See* 42 C.F.R. § 440.210 (identifying the seven statutory coverage categories mandated for the

categorically needy, plus mandatory coverage for certain pregnancy-related services and services for eligible aliens); 42 C.F.R. § 440.220 (identifying required services for the medically needy under state plans that choose to cover them). The mandatory services for the medically needy, which Utah's plan covers, do include home health services, as defined in 42 C.F.R. § 440.70, for those individuals entitled to skilled nursing facility services. But under home health services, as explained in Point I, above, coverage for speech pathology services is optional, not mandated. *See* 42 C.F.R. § 440.70(b)(4). And, under 42 C.F.R. § 440.110(c)(1) (2010), those optional services for individuals with speech disorders include "any necessary supplies and equipment."

42 C.F.R. § 441.15 (2010), cited by petitioners, is not to the contrary. It regulates home health services "as defined in § 440.70 of this subchapter." Although subsection (a)(3) requires coverage for medical supplies, equipment, and appliances, that requirement is subject to section 440.70's definition of home health services–which, as shown above, excludes speech pathology services (and, under section 440.110(c)(1), related supplies and equipment). *See* 42 C.F.R. § 440.70(b)(4). To read the regulation as requiring coverage of SACDs for adults would render subsection (b)(4) a nullity–a result this Court does not condone. "In asking us to rule that an entire sentence of the statute had absolutely no meaning at all, [defendants] have ignored our fundamental duty to give effect, if possible, to every word of the statute." *Madsen v. Borthick*, 769 P.2d 245, 252 n.11 (Utah 1988); *see also State v. Duncan*, 812 P.2d 60, 63 (Utah App. 1991) (quoting *Madsen*).

Utah's Medicaid plan complies fully with controlling federal law. Under Utah Admin. Code R414-54-4(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." Petitioners are neither.

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is established by 42 U.S.C.A. § 1396d(a)(4)(B) to provide services as defined in subsection (r) to eligible individuals under the age of 21. Subsections (r)(1) through (4) contain minimum requirements for screening, vision, dental, and hearing services. Subsection (r)(5) requires state plans to provide "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, *whether or not such services are covered under the State plan.*" 42 U.S.C.A. § 1396d(r)(5) (West, Westlaw through P.L. 111-255 (excluding P.L. 111-203 and 111-240) approved 10-5-10) (emphasis added). Subsection (a) includes all 29 enumerated categories of services, only seven of which are mandatory coverage categories. *See* Point I, above. In other words, while the Act mandates that EPSDT recipients be provided coverage in all 29 categories–optional as well as mandatory–it permits states to differentiate between minors and adults by providing coverage under

only the seven mandated categories for non-EPSDT individuals–persons over the age of 20.[1]

Lankford v. Sherman, one of the cases cited by petitioners, makes this distinction clear. In *Lankford*, disabled adult Medicaid recipients challenged a state regulation that precluded durable medical equipment (DME) as a stand-alone benefit except to individuals who are blind, pregnant, needy children, or recipients of home health care benefits under the Act. A limited list of DME was available to all other adult Medicaid recipients. In an action seeking to enjoin the regulation, the court noted the plaintiffs' agreement that under the Act, the state "may lawfully provide additional benefits only to needy children and pregnant women[,]" *Lankford v. Sherman*, 451 F.3d 496, 502 (8th Cir. 2006)–precisely what Utah's plan does here.

Petitioners point to *Meyers v. Reagan*, 776 F.2d 241 (8th Cir. 1985), as precedent for requiring a state plan to fund SACDs for adults. In that case, the Eighth Circuit noted that Iowa's Medicaid plan included the optional category of physical therapy and related services. Observing that related services included professional assistance for persons with speech disorders, the court concluded that Iowa could not deny the plaintiff an

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[1]The coverage Utah provides for pregnant women is equally unavailing to petitioners. Under the Act, a state plan that makes available to pregnant women services relating to any conditions that may complicate pregnancy does not require the state to supply "such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan[.]" 42 U.S.C.A. § 1396a(a)(10)(G)(V) (West, Westlaw through P.L. 111-264 (excluding P.L. 111-203, 111-257, and 111-259) approved 10-8-10).

SACD. *Meyers* is distinguishable from the case at bar on two grounds. First, there was no issue in *Meyers* regarding age. Second, *Meyers* was decided in 1985–four years before the EPSDT program, requiring the provision of a broad range of services to minors regardless of whether they were made available to nonpregnant adults, was strengthened by 1989 amendments to the federal Medicaid Act. Under these circumstances, *Meyers* cannot serve as precedent to mandate the expansion of EPSDT services to adult Medicaid recipients. In addition, *Meyers*, like *William T.*, contains no mention, let alone analysis, of 42 C.F.R. 440.70(b)(4)'s exclusion of speech pathology services.

Nor does *Fred C. v. Texas Health and Human Servs. Comm'n*, 924 F. Supp. 788 (W.D. Tex. 1996), require the result petitioners seek. In reaching its conclusion that SACDs could not be restricted to minors under the EPSDT program, the district court cited to *Salgado v. Kirschner*, 179 Ariz. 301, 878 P.2d 659 (1994). But the *Salgado* case dealt with organ transplants, which are governed by a different statute requiring like treatment for similarly situated individuals. *See* 878 P.2d at 662. Moreover, the *Fred C.* opinion to which petitioners cite was vacated and remanded by the Fifth Circuit for a determination of whether the plaintiff was a qualified recipient of home health services. *Fred C. v. Texas Health and Human Servs. Comm'n*, 117 F.3d 1416 (5th Cir. 1997). The district court's decision on remand was essentially the same as the former decision. *Fred C. v. Texas Health and Human Servs. Comm'n*, 988 F. Supp. 1032 (W.D. Tex. 1997). On appeal, the Fifth Circuit concluded that it was bound by its prior remand order not to revisit issues outside the scope of the remand. It did, however, state: "Accordingly, in

affirming the district court's second summary judgment, we are not passing on the correctness of, nor do we adopt, the district court's opinion; we hold merely that reconsideration of the issues presented in the first appeal is barred under the law of the case doctrine." *Fred C. v. Texas Health and Human Servs. Comm'n*, 167 F.3d 537 (5th Cir. 1998), 1998 WL 915385 at *3. The Fifth Circuit's unenthusiastic affirmance of the district court's opinion suggests that it may have arrived at a different decision had it exercised jurisdiction to engage in a full review.

Reading the statute as broadly as petitioners suggest would obliterate the distinction between mandated and optional categories, rendering the latter inoperative. The Utah Supreme Court has cautioned against such a result under "the rule of construction requiring us to give meaning to all provisions in a statute." *A.C. Fin., Inc. v. Salt Lake County*, 948 P.2d 771, 779 (Utah 1997). As the court observed, "'any interpretation which renders parts or words in a statute inoperative or superfluous is to be avoided.'" *State v. Hunt*, 906 P.2d 311, 312 (Utah 1995) (quoting *United States v. Rawlings*, 821 F.2d 1543, 1545 (11th Cir. 1987)). Because petitioners' interpretation would nullify the state's statutory discretion under the Act's plain language, it cannot be credited.

III. BECAUSE SACDs ARE SEPARATELY DEFINED IN FEDERAL REGULATIONS, THEY NEED NOT BE COVERED AS DURABLE MEDICAL EQUIPMENT OR PROSTHETIC DEVICES

"'When language is clear and unambiguous, it must be held to mean what it expresses, and no room is left for construction.'" *Salt Lake Child and Family Therapy*

Clinic, Inc. v. Frederick, 890 P.2d 1017, 1020 (Utah 1995) (quoting *Hanchett v. Burbidge*, 59 Utah 127, 135, 202 Pl 377, 379-80 (1921)). Because the language of the federal regulations explicitly and unambiguously addresses equipment related to speech pathology services, there is no room to speculate that SACDs may also fit into other categories of coverage such as durable medical equipment (DME) or prosthetic devices. Even if they could, the more specific provisions are controlling, as shown above.

Petitioners concede that "[t]here is no definition of DME in the Medicaid Act or its implementing regulations." Pet'r Brief at 16. As defined in Utah's administrative code, "'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; and (d) is suitable for use in the home." Utah Admin. Code R414-70-2(1). The Department does not deny that SACDs may fit under this description. But so may a number of other devices or kinds of equipment that Medicaid does not cover for nonpregnant adults, such as hearing aids and eyeglasses. While durable medical equipment must meet the defining criteria, petitioners make the logical error of presuming that anything meeting the criteria must be a covered device. As explained in Points I and II, above, SACDs, as equipment necessary to speech pathology services, are specifically excluded from the coverage mandated by 42 C.F.R. § 440.210(a)(1) for home health services for the categorically needy. That they may meet the definitional criteria for DME does not change this fact.

The same principles apply to petitioners' attempt to categorize SACDs as prosthetic devices. Under federal regulations, prosthetic devices 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) (2010). But, as above, even if the definition can be construed to include SACDs, it does not alter the fact that coverage of SACDs falls outside the federal mandate. Meeting the criteria for definition as a prosthetic device is not the same as meeting the criteria for coverage. Petitioners' argument proves the point. Petitioners state that 49 states cover SACDs for adults as DME, and seven states cover them both as DME and prosthetic devices. Pet'r Brief at 15. If the definitional criteria were, by themselves, sufficient to require inclusion of SACDs, every state would have to cover them under both categories.

That other states may have chosen to cover SACDs as DME or prosthetic devices is irrelevant to whether Utah's plan complies with federal law. As the Department explained in its Prehearing Response Memorandum, in order to participate in the Medicaid program, state Medicaid plans must be approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). R. 52. This approval "indicates federal confirmation that a state's Medicaid program is in compliance with federal Medicaid law." R. 54. As a CMS-approved plan,

R. 58, Utah's Medicaid plan has been scrutinized and passed for compliance with federal standards. If limiting SACDs to pregnant women and EPSDT recipients were not in keeping with federal law, the state plan could not have been approved. And "[w]ith Utah's state plan not providing the optional service of speech pathology to general Medicaid recipients, Utah Medicaid would be out of compliance with its state plan and federal Medicaid law if Utah Medicaid began covering speech augmentation devices that fall within this non-covered service." R. 54.

IV. PETITIONERS' CLAIM THAT THE DEPARTMENT'S MEDICAL SUPPLIES LIST MAKES AN UNLISTED DEVICE UNAVAILABLE TO THEM IS RAISED FOR THE FIRST TIME ON APPEAL

"'It is axiomatic that, before a party may advance an issue on appeal, the record must clearly show that it was timely presented to the trial court *in a manner sufficient to obtain a ruling thereon.*'" *Holmstrom v. C.R. England, Inc.*, 2000 UT App 239, ¶ 26, 8 P.3d 281 (quoting *Salt Lake County v. Carlston*, 776 P.2d 653, 655 (Utah App. 1989)) (emphasis omitted and added in *Holmstrom*). On appeal, petitioners raise for the first time a claim that the Department's list of medical supplies constitutes a categorical denial of all unlisted devices that violates federal Medicaid guidelines under a September 4, 1998 letter to state Medicaid directors. This contention appears nowhere in the administrative record. As this Court further observed in *Holmstrom*,

> Moreover, the party must specifically raise the issue, such that it is brought "to a 'level of consciousness' before the trial court." This requirement 'serve[s] the interests of judicial economy and orderly procedure" by not only giving the trial court a chance to correct error, but by making the parties "crystallize issues prior to appeal." When issues are not brought to

> the trial court's attention in a timely manner, they are "deemed waived, precluding this court from considering their merits on appeal."

Id. (internal citations omitted) (alteration in *Holmstrom*). Because petitioners did not raise and the ALJ did not rule on this issue in the course of the administrative proceedings, petitioners have waived it for purposes of appeal.

Even if the Court chooses to address this newly raised claim, it is without merit. Notably, the federal district court in *William T.* expressed doubt about the credibility of the HCFA's September 4, 1998 guidance letter, but concluded it was bound by the Eleventh Circuit's demonstrated deference to HCFA transmittals:

> This Court is somewhat skeptical about according a letter the same deference as a regulation. In this court's experience, letters written by officials in a bureaucracy are sometimes inconsistent with each other and have not undergone the focus of a review and comment process that accompanies the promulgation of a regulation. *Chevron*'s deference toward an administrative agency's interpretation already gives that agency great power in effectively acting as a legislative body; further deferring to the agency's letters interpreting its own regulations arguably expands *Chevron* beyond its own language and beyond the limits of prudence. Indeed, the Eleventh Circuit has noted that "a rule would be preferable," but has also tempered this observation with a recognition that "the agency is not required to promulgate rules pursuant to every subsection of the widely-acknowledged complex Medicaid statute." The Eleventh Circuit has further held that this is especially true when "HCFA spoke directly to the states on this question through [a transmittal], which we recognize as administrative practice." Accordingly, the Court believes that it must defer to the transmittal letter in question.

William T., 465 F. Supp.2d at 1280 n.12 (internal citations omitted; alteration in original). As in *Fred C.*, this qualified endorsement suggests that a court not bound by precedent may well reach a different conclusion regarding deference to the HCFA letter.

In fact, the HCFA letter does not preclude states from developing and using non-exclusive lists of pre-approved DME, so long as they provide a reasonable and meaningful procedure for requesting nonlisted items. 465 F. Supp. at 1279. That is exactly what happened in the present case. The record shows that the letters denying petitioners' requests for SACDs apprised petitioners of their right to appeal the decision (R. 30 and 44), and both petitioners took advantage of that opportunity by appealing the decision to the ALJ. The administrative process provided them the opportunity to submit prehearing briefs and participate in an evidentiary hearing. The ALJ's recommended decision informed petitioners that it would be automatically reviewed by the Department director, R. 108, which resulted in a final agency order. R. 97-98. In light of those extensive administrative proceedings, a claim that petitioners lacked a reasonable and meaningful procedure for requesting the devices is unsupportable. The process is not unreasonable or meaningless simply because it did not yield petitioners' preferred result.

CONCLUSION

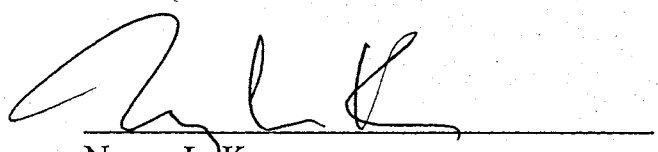
"This court cannot ignore or strike down an act because it is either wise or unwise. The wisdom or lack of wisdom is for the legislature to determine. If the act is unjust, amendments to correct the inequities should be made by the legislature and not by judicial interpretation." *Masich v. U.S. Smelting, Refining & Mining Co.*, 113 Utah 101, 126, 191 P.2d 612, 625 (1948); *see also Gottling v. P.R. Inc.*, 2002 UT 95, ¶ 23, 61 P.3d 989 (quoting *Masich*). That the legislature has chosen to commit the state's limited resources to providing enhanced medical assistance for children, in compliance with its duties under

the Medicaid Act's EPSDT program, is not a reason to second-guess the legislative wisdom. Because the controlling statutes, rules, and regulations give the state discretion over whether to cover optional Medicaid categories for general Medicaid recipients, the Department correctly determined that the rule providing SACDs only to minors does not violate the Medicaid Act. The Department therefore respectfully requests the Court to affirm its decision.

STATEMENT REGARDING ORAL ARGUMENT

The Department believes oral argument is necessary due to the complexity of the issue before the Court.

Dated this 12th day of January, 2011.



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CERTIFICATE OF DELIVERY

I hereby certify that on this 12th day of January, 2011, I caused to be delivered two true and correct copies of the foregoing AMENDED BRIEF OF APPELLEE to the following:

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