UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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JAMIE TAYLOR; EDDY LEMIEUX by his NEXT FRIEND MARIE LADINY; and ANIBAL SANTIAGO by his NEXT FRIEND DENISE RIVERA, individually and on behalf of all others Similarly situation,

Plaintiffs,

-against-

No. 14-CV-05317 (CM)

HOWARD ZUCKER, as Acting Commissioner of The New York State Department of Health; SHARON DEVINE, as Executive Deputy Commissioner of the New York State Office of Temporary and Disability Assistance,

Defendants.

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MEMORANDUM DECISION AND ORDER ON MOTION FOR LEAVE TO FILE AMENDED CLASS ACTION COMPLAINT AND MOTION FOR CLASS CERTIFICATION

McMahon, J.:

Before the Court are Plaintiffs' motions to amend the complaint and to certify a class under Rule 23(b)(2).

For the reasons set forth below, Plaintiffs' unopposed motion to amend the complaint is GRANTED. Plaintiffs' motion for class certification is DENIED.

BACKGROUND

Plaintiffs bring this action against Howard Zucker, the Acting Commissioner of the New York State Department of Health, and Sharon Devine, the Executive Deputy Commissioner of the New York State Office of Temporary and Disability Assistance ("Defendants"). Plaintiffs allege Defendants' practices have led to the reduction and termination of home services for

Medicaid recipients without timely and adequate notice and without any change in plaintiffs' conditions which would merit such reduction or termination. (Docket # 1 at 1).

Medicaid is a joint state and federal program created under Title XIX of the Social Security Act to provide medical insurance for needy individuals. 42 U.S.C. § 1396, et. seq. ("Medicaid"). Under Medicaid, the federal government provides funding to participating states to establish medical assistance programs. The states are not required to participate in the Medicaid program; however, states that participate must conform to federal regulations. 42 U.S.C. §§ 1396a, 1396c. Of particular relevance here, participating states must administer the Medicaid program through a single state agency and must adopt a plan overseen by the federal Center for Medicare and Medicaid Services ("CMS"). 42 U.S.C. § 1396a(a)(5).

New York has elected to participate in Medicaid and administers the program through the New York Department of Health. N.Y. Soc. Serv. L. § 363-a(1). The New York Medicaid plan includes access to long-term "home care" services. These services include visiting nursing, home-based therapy, assistance with personal hygiene, mobility assistance, and nutritional support. (Docket #1 at 9).

Under Section 1115 of the Social Security Act, CMS may grant waivers to states from certain requirements of the Medicaid program. In 1997, the CMS granted New York a Section 1115 waiver for the New York Partnership Plan, which mandates that individuals eligible for Medicare enroll in managed care organizations ("MCOs"). N.Y. Soc. Serv. Law § 364-j(2)(a). MCOs are independent health insurance plans that coordinate the provision of Medicare to their enrollees. (Docket # 33 at 1). They can be either for-profit or not-for-profit organizations.

Delivering care through MCOs replaced a system whereby county-level social service districts administered Medicaid services and health care providers were responsible for paying for the services provided. (Docket # 33 at 4).

MCOs are obliged by law to assess their patients "to ensure that all participants are provided with appropriate services, including special care." N.Y. Soc. Serv. Law § 364-j(4)(j)(2). MCOs are responsible for mailing timely notices to the patients regarding any change in patient care or benefits. 42 C.F.R. § 438.404. Additionally, MCOs must have an internal appeals process in place in which enrollees may challenge any changes in care.

There are two different types of MCOs for Medicaid recipients in New York, depending on whether the recipient receives Medicare in addition to Medicaid. (Docket #1 at 11). Since 2010, when New York's Section 1115 waiver was amended, Medicaid recipients who need long term care services but who do not receive Medicare must enroll in a different class of MCO, a Medicaid Managed Care plan ("mainstream MCO")(Docket #1 at 11). Beginning in November 2012, Medicaid recipients who are on Medicare were required to enroll in Managed Long Term Care plans ("MLTC") (Docket #35 at 2). There are a total of 19 mainstream MCO plans and 49 MLTC plans in New York. (Docket #33 at 10). There are three different types of MLTCs: the Medicaid MLTC (partial cap) plans, Medicaid Advantage Plus ("MAP"), and Programs of All-Inclusive Care for the Elderly ("PACE") plans. (Docket #33 at 10). Plaintiffs Lemieux and Santiago are enrolled in mainstream MCOs, whereas Plaintiffs Taylor and Tsvilikhovsky are enrolled in MLTCs. (Docket # 33 at 11).

In his capacity as the Acting Commissioner of the New York State Department of Health, Defendant Zucker has contracted with each mainstream MCO and MLTC. The contract terms require that "the services … be furnished in an amount, duration, or scope to reasonably be

expected to achieve the purpose for which the services are furnished." 42 C.F.R. § 438.210(a)(3)(i). Federal law requires that Medicaid recipients be given adequate and timely notice of their opportunity for a fair hearing when their benefits are denied, reduced, or terminated. 42 U.S.C. § 1396(a)(3). Under certain circumstances, when a recipient requests a fair hearing, his or her level of care cannot be reduced until the hearing is concluded and a final decision rendered. 42 U.S.C. § 1396(a)(3); (Docket #33 at 9).

Under the New York Medicaid plan, fair hearings are administered by the Office of Temporary and Disability Services' Office of Administrative Hearings ("OAH"), which holds such hearings on behalf of the Department of Health. (Docket #33 at 9). OAH receives requests for, schedules, and conducts these hearings. (Docket #33 at 9).

Recipients who are members of mainstream MCO plans have the right to appeal adverse determinations by filing an internal appeal or by demanding a fair hearing. While an internal appeal is not a prerequisite for a fair hearing, recipients who first follow the internal appeal procedure do not give up their right to demand a fair hearing. (Docket #1 at 14). If recipients pursue an internal appeal and lose, they have 60 days from initial adverse determination notice to file an appeal for a fair hearing. (Docket #1 at 28).

Recipients who are covered by MLTC plans must appeal adverse determinations through an internal appeals process before they may be granted a fair hearing – in other words, for senior citizens who are covered by Medicare, an internal appeal is a prerequisite to a fair hearing. (Docket #1 at 15).

All MCOs, regardless of type, are required to "give enrollees any reasonable assistance in completing forms and taking other procedural steps." 42 C.F.R. § 438.406(a)(1). MCOs must also provide enrollees with adequate notice whenever there has been a determination to deny,

reduce, or terminate services (42 C.F.R. § 438.404). The state must monitor whether MCOs are complying with these rules. (42 C.F.R. § 438.100(a)).

Plaintiffs claim that Defendant Zucker has a custom and practice of reducing or terminating without adequate notice of opportunities to appeal and when there has been no change in an enrollee's medical condition. (Docket #1 at 30-31). Plaintiffs claim that Defendant Zucker fails to provide timely and adequate notices of opportunities for appeal and continuously fails to authorize continued care to enrollees pending the results of the appeals process. (Docket #1 at 28). Plaintiffs also claim that Defendant Zucker does not give adequate notice explaining that requesting an internal appeal will not toll the time period to request a fair hearing. (Docket #1 at 28). Plaintiffs further claim that Defendant Zucker does not adequately explain that under MLTC plans, enrollees must have been issued a final decision from an internal appeal before they may request a fair hearing. (Docket #1 at 28).

As of various dates in 2015 (April 15 for mainstream MCOs and July 1 for MLTCs), DoH has begun to require the use of standardized forms to give recipients notice about the appeals process. (Docket #33 at 12). While these standardized forms of notice were intended to ensure that the notice process complied with the law, Plaintiffs claim that their adoption is "not a panacea for all of the systemic harms suffered by Plaintiffs." (Docket #38 at 6).

Named Plaintiffs

Janie Taylor

Plaintiff Janie Taylor is 84 years old and suffers from several medical conditions including diabetes, hypertension, unsteady gait, and high blood pressure. (Docket #18, Exhibit B ¶ 1-3). She lives alone in Harlem.

Plaintiff Taylor needs assistance with basic mobility – moving from room to room, preparing meals, bathing, dressing, etc. (Docket #18, Exhibit B at ¶ 3). Prior to November 2012, she was authorized by her local social services district to receive Medicaid home care services 10 hours a day for 7 days a week. (Docket #19, Exhibit B ¶ 1-2). Due to the November 2012 waiver change, Plaintiff Taylor was mandatorily enrolled in the VNS Choice MLTC plan in March 2013. At first she was authorized for the same level of home care: 10 hours a day, 7 days a week, as previously authorized. (Docket #18, Exhibit B at ¶ 5).

On June 23, 2014, Plaintiff Taylor was mailed a document (dated June 19, 2014) informing her that she was only authorized to receive 5 hours of care, seven days a week, beginning on July 1, 2014 and ending December 31, 2014. (Docket #18, Exhibit B at ¶ 7). Plaintiff Taylor had not asked to change the amount of home care she was receiving; the notice was labeled as a "new authorization" rather than a reduction. (Docket #18, Exhibit B at ¶ 8). The notice did not explain any reason for the reduction in care and there was no change in Plaintiff Taylor's condition. The notice did not advise Plaintiff of her right to an appeal. (Docket #18, Exhibit B ¶ 8-11).

A social worker at Plaintiff's doctor's office filed an internal appeal, which was denied on July 1, 2014. That same day, the New York Legal Assistance Group ("NYLAG") demanded a fair hearing for Plaintiff Taylor and contacted the Office of Temporary and Disability Assistance for aid-continuing services. Plaintiff Taylor's original level of care (10 hours a day) resumed on July 16. Plaintiff's lawyer advised Plaintiff that her fair hearing was held on July 30. Plaintiff won at the hearing by default; neither the State nor the VNS sent a representative to defend the reduction in care.

Anibal Santiago

Plaintiff Anibal Santiago is a 65-year old resident of Manhattan. Due to his condition his niece, Denise Rivera, brings the action as his next friend.

Plaintiff Santiago, who suffers from diabetes, high blood pressure, and schizoaffective disorder, needs assistance with outdoor mobility, personal hygiene, meal preparation, etc. (Docket #18, Exhibit C at ¶ 4). He has been enrolled in Healthfirst, a mainstream MCO plan, since 1997. (Docket #18, Exhibit C at ¶ 1-3).

Healthfirst authorized personal care services for Santiago for 12 hours a day, 7 days a week for three years. On April 2, 2014, Healthfirst sent Plaintiff Santiago a notice that he was "approved" for personal care in the amount of only 4 hours, 7 days a week. (Docket #18, Exhibit C at ¶ 7-8). There was no change in Plaintiff Santiago's condition.

The notice informed Plaintiff of his right to file an internal appeal but did not give any reason for the reduction of care, inform Plaintiff Santiago about his right to a fair hearing (to which he was entitled without first filing an internal appeal), or notify him of his ability to file for aid-continuing.

On April 22, 2014, Plaintiff Santiago's sister filed an internal appeal. Healthfirst responded on May 2, 2014 by reassessing Plaintiff's case and restoring half of Plaintiff's lost care; he was told that he was entitled to care 8 hours a day, 7 days a week. This notice advised Santiago of his right to a fair hearing. Santiago was not given aid-continuing at his prior level until the New York Legal Assistance Group called the Office of Temporary and Disability Services.

Santiago was reassessed by Healthfirst on February 18, 2015, and was advised that an appropriate level of care from February 2, 2015 to July 31, 2015 would be 8 hours a day, 7 days a week. On February 23, 2015, NYLAG demanded a fair hearing on behalf of Plaintiff Santiago.

Eddy Lemieux

Plaintiff Eddy Lemieux is an 18 year old who lives with his aunt and severely disabled uncle in Brooklyn. Because of his condition, Plaintiff Lemieux's aunt, Marie Ladiny, brings this action as his next friend.

Plaintiff Lemieux suffers from Noonan's syndrome, pulmonary stenosis, severe scoliosis, lymphedema, bone disease, congenital stenosis, and pulmonary insufficiency. (Docket #18, Exhibit D at ¶1-3). Due to these conditions, Plaintiff Lemieux is extremely frail and needs assistance with virtually all basic activities. Plaintiff's uncle also receives home care for his disabilities and Plaintiff's aunt works is unable to provide care to both individuals because she works two jobs. (Docket #18, Exhibit D at ¶ 4-5). Plaintiff Lemieux was authorized to receive 24 hour continuous home care "for many years." (Docket #18, Exhibit D at ¶ 9-10).

Plaintiff Lemieux has been enrolled in Healthfirst, a mainstream MMC plan, since 2012.

On January 14, 2014, Healthfirst sent Plaintiff Lemieux a document explaining that his care would be reduced from 24 hours a day to "12 hours 7 days per week for 4 weeks then 8 hours, 7 days per week for 4 weeks, then 5 hours, 3 days per week for 4 weeks" -- after which, services would be discontinued. (Docket #18, Exhibit D at ¶ 11). The notice explained that "the requested service(s) is not/are no longer medically necessary because after review of the clinical information provided the Medical Director has determined that the amount of/level of Personal Care Services requested is not medically necessary." (Docket #18, Exhibit D at ¶ 12).

Plaintiff's next of friend requested an internal appeal. On January 27, 2014, Healthfirst informed Plaintiff Lemieux that he was approved for services 12 hours a day for 6 weeks, at which time Healthfirst would reassess his condition. Plaintiff Lemieux did not experience a change in his condition.

On February 7, 2014, Plaintiff Lemieux demanded a fair hearing to challenge the reduction of services. The Office of Temporary and Disability Assistance did not enable aid-continuing until contacted by NYLAG on April 23, 2014.

On August 8, 2014, NYLAG informed Plaintiff that Healthfirst withdrew the notice of intent to reduce Plaintiff's care. (Docket #18, Exhibit D at ¶ 35).

After a routine assessment in January of 2015, Plaintiff's Lemieux's care was again scheduled to be cut in half. (Docket #18, Exhibit D at ¶ 38). After NYLAG requested another fair hearing, Plaintiff Lemieuz was informed on February 2 that his care would instead be reduced to 16 hours a day on weekdays and would remain at 24 hours a day for the weekends. Two days later, on February 4, 2015, Healthfirst advised Plaintiff Lemieux that he would continue to receive full time care. (Docket #18, Exhibit D at ¶ 44-46). Plaintiff Lemieux's previously-filed hearing was held on February 19, 2015; neither the state nor Healthfirst was present for the hearing. (Docket #18, Exhibit D at ¶ 48).

Alexander Tsvilikhovsky

Alexander Tsvilikhovsky is nearly 90 years old. He suffers from cardiovascular disease, arrhythmia, vertigo, dementia, and macular degeneration in both eyes. (Docket #18, Exhibit E at ¶ 2-5). His vertigo make him dizzy and nauseous and he needs assistance with basic mobility. Because of his condition, his daughter, Galina Tsvilikhovsky, brings this action as his next friend.

He is enrolled in a Medicaid MLTC administered by Fidelis.

Plaintiff Tsvilikhovsky granted four hours of care per day upon his enrollment in 2012. As his condition worsened, the amount of care was gradually increased, first to six, then eight hours.

In October 2014, Fearing that he might injure himself during the night, Plaintiff's daughter asked that he be authorized to receive 24 hour care. Fidelis called Ms. Tsvilikhovsky in November 2014 and verbally told her that the request to increase her father's care had been denied. Plaintiff was not informed that he could appeal the decision and did not do so. (Docket #19, Exhibit E at ¶ 9).

In December 2014, Plaintiff fell during the night and was hospitalized for seven days. (Docket #18, Exhibit E at ¶ 10-11). After her father's hospitalization, Galina Tsvilikhovsky again sought increase to 24 hours care. Fidelis responded in writing in late December that Plaintiff Tsvilikhovsky was approved for 8 hours of care, seven days a week but did not inform Plaintiff of his right to an internal appeal or fair hearing and did not seek either. (Docket #18, Exhibit E at ¶ 13).

Plaintiff was hospitalized again for another fall for 6 days in late January of 2015, and his daughter made a third request for an increase in his level of care. In response to that request, Plaintiff received five letters from Fidelis: four indicated that Plaintiff would continue to receive 8 hours of care seven days per week, while the fifth stated that he would receive a total of 36 hours of care per week from January 29, 2015 through February 12, 2015. (Docket #18, Exhibit E at ¶ 19). Then, on February 17, 2015, Fidelis called Plaintiff's daughter and informed her that Plaintiff's care would be increased to 10 hours a day, seven days a week.

Plaintiff's daughter attended a fair hearing in March of 2015 and is still awaiting the result. (Docket #18, Exhibit E at ¶ 20-23). Plaintiff Tsvilikhovsky currently receives 10 hours of care seven days a week). (Docket #18, Exhibit E at ¶ 23).

DISCUSSION

I. Motion to Amend Complaint

Pursuant to Rule 15 of the Federal Rules of Civil Procedure, courts should freely give leave to parties to amend their complaints "when justice so requires." Fed. R. Civ. P. 15. Under Rules 20 and 21, a court may add a plaintiff "on just terms" (Fed. R. Civ. P. 21) "if they assert any right to relief jointly, severally, or in the alternative with respect to or arising out of the same transaction, occurrence, or series of transaction or occurrences; and any question of law or fact common to all plaintiffs will arise in the action." Fed. R. Civ. P. 20(a)(1).

Plaintiffs seek to amend the complaint to add Alexander Tsvilikhovsky as a Named Plaintiff, to add factual allegations based on Tsvilikhovsky's claim, and to clarify a few aspects of the original complaint. Defendants have raised no objections to the amendment and there is no reason not to grant the motion. Therefore, the motion to amend the complaint is GRANTED. The amended complaint must be filed within ten days.

II. The Motion for Class Certification is Denied.

Plaintiffs seek to maintain this action as a class action pursuant to Fed. R. Civ. P. 23(b)(2), which provides that an action may be maintained as a class action when "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." The class that Named Plaintiffs seek to represent consists of:

> All current and future Medicaid recipients in New York State who receive home care services through Medicaid Managed Care Organizations and who have suffered or will suffer threatened or actual denials, reductions, or terminations of their home care services without timely and adequate notice, and/or without any change in their condition or circumstances which would justify a reduction or termination, and/or without aid-continuing benefits to which they are entitled.

The proposed class does not specify a commencement date and so is presumably measured by the statute of limitations.

When confronted with a motion for class certification, the court must determine whether the requirements of Rule 23(a) are met; that is (1) the proposed class is so numerous that joinder of all members is impracticable; (2) there are questions of law or fact common to the class; (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and (4) the representative parties will fairly and adequately protect the interests of the class." Rule 23(a)'s four requirements "effectively limit the class claims to those fairly encompassed by the named plaintiff's claims." *General Tel. Co. of Nw. v. EEOC*, 446 U.S. 318, 330 (1980).

Beyond the Rule 23(a) requirements, a class must be certified under one of the Rule 23(b) subcategories. *See Brown v. Kelly*, 609 F.3d 467, 475 (2d Cir. 2010). When the proposed class will be proceeding under Fed. R. Civ. P. 23(b)(2), the Supreme Court "has clarified that certification of a class for injunctive relief is only appropriate where 'a single injunction … would provide relief to each member of the class.'" *Sykes v. Mel S. Harris and Associates LLC*, 780 F.3d 70, 80 (2d Cir. 2015) (quoting *Wal-Mart v. Dukes*, 131 S.Ct. 2541, 2557 (2011)).

Twombly and *Iqbal* have no relevance to class certification allegations; the party seeking certification must be prepared to demonstrate that there are "in fact sufficiently numerous parties, common questions of law or fact, etc." *Wal-Mart,* 131 S.Ct. at 2551 (emphasis in original).

While class certification is not supposed to be a mini-trial on the merits, or delve into factual issues unrelated to the Rule 23 requirements, district judges are required to resolve any factual disputes that are relevant to a finding on each Rule 23 requirement. *See In re Initial Pub. Offerings Sec. Litig.*, 471 F.3d 24, 41 (2d Cir. 2006).

This case is paradigmatic of a type of case that was routinely certified as a class action prior to *Dukes v. Wal-Mart*. The question facing the court is whether it is appropriate to certify it as a class action now.

The answer is no.

a. The proposed class meets the numerosity requirement.

Rule 23(a)(1) requires that "the class is so numerous that joinder of all members is impracticable." Fed. R. Civ. P. 23(a)(1). In this circuit, the numerosity requirement is presumed once plaintiffs number 40. *See, e.g., Marisol A. v. Giuliani*, 126 F.3d 372, 376 (2d Cir. 1997). In this case, there is no doubt the proposed class is sufficiently numerous. Over 140,000 New Yorkers receive home care services through Medicaid. (Docket #20 at 17). Defendants do not challenge that the numerosity requirement would be met.

b. Plaintiffs would adequately represent the class.

Rule 23(a)(4) requires that "class counsel is qualified, experienced, and generally able to conduct litigation." *In re Drexel Burnham Lambert*, 960 F.2d 285, 291 (2d Cir. 1992). In this instance, Plaintiffs are represented by the New York Legal Assistance Group, which has a history of successful and competent litigation before this Court. *See* (Docket #1 at 7). Defendants do not allege that Plaintiffs' counsel in inadequate and there is no reason to believe otherwise.

Plaintiffs must also demonstrate that "there is no conflict of interest between the named plaintiffs and other members of the plaintiff class." *Marisol,* 126 F.3d at 378. In *Marisol*, the

Second Circuit reasoned that because "plaintiffs [sought] broad based relief which would require the child welfare system to dramatically improve the quality of all its services, including proper case management … the interests of the class members are identical." *Marisol*, 126 F.3d at 378. Here, the Court perceives no conflict between the named plaintiffs and other class members. Named Plaintiffs seek to improve the administration of the Medicaid home health care program in two ways -- by improving the manner in which notice is to be given to persons who are denied care, or whose care is going to be reduced; and also by prohibiting the Commissioner from denying or reducing care to recipients whose medical circumstances have not changed in ways that would justify a denial or reduction. Such an injunction would presumably be advantageous to all home health care recipients without prejudicing any of them. The requirements are Rule 23(a)(4) are met.

c. Class certification is denied because the claims of the named plaintiffs do not meet the "commonality" and "typicality" requirements after *Wal-Mart*.

"Commonality requires the plaintiff to demonstrate that the class members have suffered the same injury. This does not mean merely that they have all suffered a violation of the same provision of law." *Wal-Mart*, 131 S.Ct. at 2551. The common injury "must be of such a nature that it is capable of class wide resolution – which means that determination of its truth or falsity will resolve *an issue* that is central to the validity of each one of the claims in one stroke." *Wal-Mart*, 131 S.Ct. at 2551 n. 5 (quoting *Gen. Tel. Co. of Sw. v. Falcon*, 457 U.S. 147, 157-58 (1982)).

The requirements of commonality and typicality "tend to merge into one another, so that similar considerations animate analysis of Rule 23(a)(2) and (3)." *Marisol*, 126 F.3d at 376. The typicality requirement "is satisfied when each class member's claim arises from the same course

of events, and each class member makes similar legal arguments to prove the defendant's liability." *In re Drexel Burnham Lambert*, 960 F.2d 285, 291 (2d Cir. 1992).

The motion rests on the question of commonality/typicality. Each of the named plaintiffs has a similar narrative – s/he was receiving home health care via Medicaid for a certain number of hours each day or week; the care was cut back, allegedly without any change in the recipient's medical condition; the recipient was not given any reason for the change in the level of care; the recipient was not given notice that was reasonably designed to apprise him/her of his/her appellate rights or right to demand that there be no change in the level of care while any appeals were being decided. The wrongs done to each named plaintiff – having the level of care reduced arbitrarily and without any medical justification, receiving notice that does not meet the standards of the statute – are the same. The proposed class is defined in a way that, read literally, encompasses only those Medicaid home health care recipients who suffer the same injury as the named plaintiffs.

After *Wal-Mart*, that is not enough to meet the test of commonality or typicality.

In *Wal-Mart v. Dukes*, a woman who had been fired from her job at Wal-Mart employee brought a Title VII action for employment discrimination. She sought to certify a class of all women employed at the company. Dukes claimed that the company followed a practice of giving store managers discretionary decision-making authority about employment matters within their stores, which led to discrimination against women throughout the corporation. The Ninth Circuit upheld the district court's certification of the lawsuit as a class action. The Supreme Court reversed.

The Supreme Court held that though all the members of the proposed class claimed a common violation of the same law (Title VII), the commonality requirement of Rule 23(a) was

not met because "respondents have not identified a common mode of exercising discretion that pervades the entire company." *Wal-Mart*, 131 S.Ct. at 2555. The Court adopted and cited the dissent authored by Chief Judge Kozinski of the Ninth Circuit, which argued that the proposed class members "held a multitude of different jobs, at different levels of Wal-Mart's hierarchy, for variable lengths of time, in 3,400 stores, sprinkled across 50 states, with a kaleidoscope of supervisors (male and female) …." *Wal-Mart*, 131 S.Ct. at 2555. The Court found that Dukes wished

> "to sue about millions of employment decisions at once … [but] [w]ithout some glue holding the alleged *reasons* for all those decisions together, it will be impossible to say that examination of all the class members' claims for relief will produce a common answer to the crucial question *why was I disfavored.*"

Wal-Mart, 131 S.Ct. at 2552. Dukes presented the Court with statistics that suggested there was a regional pay disparity between women and men at the Wal-Mart, however the Court felt that such disparities "may be attributable to only a small set of Wal-Mart stores, and cannot by [themselves] establish the uniform, store-by-store disparity upon which the plaintiffs' theory of commonality depends." *Wal-Mart*, 131 S.Ct at 2555 (emphasis in original). "One named plaintiff's experience of discrimination" does not suggest that "discriminatory treatment of typical of [the employer's employment] practices." *Wal-Mart*, 131 S.Ct at 2555 (citing *General Telephone Co. of Sw. v. Falcon*, 457 U.S. 147, 158 (1982)).

Wal-Mart precludes certification of the class that named plaintiffs seek to certify. Named Plaintiffs in the case at bar seek to litigate hundreds of independent decisions regarding different individuals at the same time. As in *Wal-Mart*, Plaintiffs at bar fail to provide "glue" connecting the *reason* for each enrollee's reduction or termination of care together. Plaintiffs are unable to demonstrate how Named Plaintiffs are indicative of a systematic failure in the administration of Medicaid in New York State. Named Plaintiffs are all from New York City even though they

seek to represent a statewide class. Furthermore, the Named Plaintiffs represent only three of 68 MCOs – VNS, Healthfirst, and Fidelis. This is not a representative sample of all the MCOs in New York State.

Plaintiffs cite a case virtually identical to this one, *Strouchler v. Shah (Strouchler I)*, 891 F.Supp.2d 504, (S.D.NY. 2012); *Strouchler v. Shah* (*Strouchler II)* 286 F.R.D. 244 (S.D.N.Y. 2012), in which my colleague, Judge Scheindlin, did find sufficient commonality to certify a class. In *Strouchler I*, elderly and disabled recipients of 24-hour home care in New York City (a subset of the proposed plaintiff class in this case) brought a class action against the New York Commissioner of Health and the New York State Office of Temporary and Disability Services (the same defendants as in this case or more precisely, the individuals who held the same jobs as defendants back in 2012), seeking an injunction to prevent the defendants from "reducing or terminating these services without adequate notice and legitimate reasons ...." *Strouchler I*, 891 F.Supp.2d at 507 (the very same relief that is requested in this case). My colleague, Judge Scheindlin, without discussing *Wal-Mart*, certified a class consisting of:

> All New York City Medicaid recipients of continuous personal care services who, at any time, since January 1, 2011, have been threatened with unlawful reduction or discontinuance of these services or whose care has been unlawfully reduced or discontinued because the City Defendant has determined that they do not meet the medical criteria for these services.

Strouchler II, 286 F.R.D. at 247. Her reason for doing so was that the New York City program was highly centralized and decisions were ultimately made by a single individual:

> Although the facts of each class member's diagnosis and evaluations are unique to that individual, the following facts regarding the centralization of the program are likely sufficient to satisfy the commonality requirement. All putative class members are recipients of medical care administered by the City pursuant to Medicaid; their eligibility for the care is determined by a set of doctors working in one department; that department is run by one individual, Dr. Anita Aisner, who is personally supervising the review of "all split-shift cases"....

Strouchler II, 286 F.R.D. at 246. Unlike *Wal-Mart*, where each alleged instance of discrimination involved a store manager with his/her own discretionary authority, a single individual ultimately decided whether a patient's care would be reduced, and the recommendations she received came from the small staff that she personally supervised. As a result, Judge Scheindlin believed that an injunction directed to the Department of Health would address the plaintiff's concerns "in one stroke." *Wal-Mart*, 131 S.Ct. at 2551.

Judge Scheindlin's decision, being the decision of a coordinate jurist, is not binding on this court. But there are numerous differences between the case filed in her court and the case before this Court.

First, the proposed class is this case is not limited to New York City residents, as was the case in *Strouchler*. Rather, plaintiffs seek to certify a statewide class. The common administrator in *Strouchler* was an employee of the New York City Department of Health, who was administering only the claims of New York City residents. Even under the scheme that was in place back in 2012, recipients of home health care in locations elsewhere in the State (Albany, say, or Buffalo) had their programs administered locally -- not by a single doctor in New York City. Had the plaintiffs in *Strouchler* been seeking to certify a statewide class, the factors that obviously overcame *Wal-Mart* for Judge Scheindlin -- unity of administration under the supervision of a single ultimate decisionmaker -- would have been absent. It is, therefore, highly unlikely that she would have reached the same result.

Second, the proposed class in this case is not limited to elderly split-care Medicaid home health care recipients (who also qualify for Medicare), as was the case in *Strouchler*. It includes individuals who do not receive Medicare (insurance for those older than 65) but who are nonetheless receiving Medicaid home health care. But since 2010, those individuals have been

required to be enrolled in a mainstream MCO as a condition of receiving home health care. It is the mainstream MCO – not the State, and not any local health care agency – that has made the decision about whether and how much home health care the recipient would get. There is more than one agency – to be precise, there are at present 19 mainstream MCOs – performing that task. Again the fact underpinning Judge Scheindlin's reasoning – centralized decision-making residing in the hands of a single individual – is lacking for this particular subclass of recipients.

Third, for dual eligible recipients (a subset of which were certified in *Strouchler*), the rules have changed since Judge Scheindlin certified the class in *Strouchler*. Beginning in November 2012, dual eligible (Medicare/Medicaid) recipients who were receiving home health care have been required to enroll in MLTCs—at least, in counties where MLTCs are available (at present, a total of 49 of New York's 62 counties). (Docket # 35 at 2). Once a recipient is enrolled in an MLTC, care decisions work exactly like care decisions for participants in mainstream MCOs -- the MLTC, not the State Department of Health or any public agency, decides what and how much home health care the recipient is to receive. (Docket #35 at 5). There are 49 MLTCs performing this task at the present time – creating an even more fractured decision-making process.

True, the State maintains regulatory oversight over all mainstream MCOs and MLTCs, to ensure they comply with Medicaid and other relevant federal law (Docket # 34 at 1). But the state Health Commissioner does not make any decision to "terminate" or "reduce" services. The managed care organizations do. Decision-making is not centralized.

Plaintiffs argues that since the state is ultimately responsible for ensuring that the 68 mainstream MCOs and MLTCs comply with federal law, the state is responsible for any wrongful adverse terminations of a patient's care, so a single injunction running to the

Commissioner of the Department of Health can right all wrongs. But that is foolish. The state may have oversight responsible, but the state is neither making decisions to reduce or terminate care for individual patients or sending out notice of those decisions. Each of the 68 MCOs and MLTCs has its own procedures for making these decisions, and at least until the last few months, each had its own procedure for sending notifications. This is precisely the sort of "class action" that runs afoul of *Wal-Mart*.

Plaintiffs rely for the propriety of certification on *Marisol A. v. Giuliani*, 126 F.3d 372 (2d Cir. 1997), in which the plaintiffs alleged that the City failed to adequately administer its welfare services to children who qualified and that such failure represented a systematic deficiency for which the City was responsible. In *Marisol*, the Second Circuit affirmed certification of a purported class of, "All children who are or will be in the custody of the New York City Administration for Children's Services ("ACS") …." *Marisol*, 126 F.3d at 375. However, Marisol actually suggests that a class ought not be certified here. Not only is *Marisol* a pre-*Wal-Mart* case, which lessens its precedential value, but even back in 2007 the Second Circuit cautioned that the expansive class it had certified was "near the border of the class action device" although in had not crossed into forbidden territory." *Marisol*, 126 F.3d at 377. If the *Marisol* class was near the border in 2007, it is highly doubtful that the class would be certified today.

Furthermore, the Circuit directed the district court to divide the *Marisol* class into numerous subclasses. That is eloquent testimony that *Marisol* was not really a case in which a single injunction (other than an injunction to "obey the law") could have resolved all the many issues confronting the Court. Again, it is highly unlikely that *Marisol* could have proceeded as a class action post-*Wal-Mart*.

Additionally, *Marisol* was like *Strouchler*, in that commonality and typicality were found because the plaintiffs' injuries "derive from a unitary course of conduct by a single system" *Marisol*, 126 F.3d at 377 – which, in *Marisol*, was the New York City Child Welfare Administration. Here, where plaintiffs ask the Courts to certify a class of persons who are serviced by 68 independent entities, we have crossed well into what Marisol identified as "forbidden territory."

Plaintiffs also rely on *Shaknes v. Eggleston*, 740 F.Supp.2d 602, 625 (S.D.N.Y. 2010), a case in which this Court certified a class of New York City Medicaid recipients who alleged various procedural deficiencies in the processing of Medicaid appeals. Though *Shakhnes* sounds very similar to the case at bar (indeed, it was brought by the same organization representing the Plaintiffs at bar), the issue in that case was the failure by the Office of Administrative Hearings of the New York State Office of Temporary and Disability Assistance – which schedules all fair hearings statewide – to arrange for fair hearings within 90 days of a recipient's request, as required by 42 U.S.C. § 1396(a)(3). Any issues with the scheduling of hearings in *Shakhnes* could be addressed by a single office in "one stroke," to use Justice Scalia's language from *Wal-Mart*. Here, an injunction running to the Defendant Commissioners would have no such effect.

In short, this is not a case in which class certification is appropriate, because it is not a case in which Plaintiffs come close to establishing the kind of commonality and typicality required after *Wal-Mart*. While each named Plaintiff, and presumably each member of the putative class, has been injured by the alleged violation of the same provision of the law, their common injury is not of such a nature that it is capable of classwide resolution. Neither does each class member's situation arise out of "the same course of events." *In re Drexel Burnham Lambert,* 960 F. 2d 285, 291 (2d Cir. 1991), because, as was the case in *Wal-Mart*, the plaintiffs

here have been and are being evaluated by numerous medical personnel, working under multiple supervisors, in 68 different decision-making agencies spread across the vast geographic area that is the State of New York. The fact that these 68 decision-makers fall under the general supervisory authority of the Commissioner of the State Department of Health is of no more relevance than was the fact that everyone in authority in *Wal-Mart* ultimately worked for a single corporation governed by a single Board of Directors with a nationwide Chief Executive Officer.

The only common thread in this case that comes close to meeting the post *Wal-Mart* commonality requirement is New York's implementation of model notices. However, the Named Plaintiffs have not yet received these standardized notices; they were notified of their care reduction under the old, fragmented system in which each MCO had its own form of notice. (See Docket #33 at 12). Therefore, Named Plaintiffs' claims are not typical of the claims of individuals who are now beginning to receive the new notice in the form mandated by the Commission.

There is no need to discuss whether Plaintiffs have satisfied the requirements for class certification under Rule 23(b)(2). Because they have failed to meet their burden under Rule 23(a), their motion for class certification is DENIED.

The Clerk of the Court is directed to remove Docket No. 19 from the Court's list of pending motions and to close the file.

Dated: July 27, 2015

U.S.D.J.

BY ECF TO ALL COUNSEL