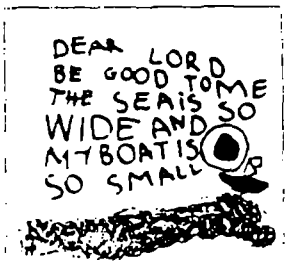

Children's Defense Fund

FAX: (202) 662-3550

FACSIMILE TRANSMITTAL SHEET

TO: Jennifer Klein

FIRM: _____

CITY/STATE: _____

FAX NUMBER: 456-2878

FROM: JIM WEILL

DEPT: GENERAL COUNSEL

IF YOU HAVE A TRANSMITTAL/RECEIVING PROBLEM, PLEASE CALL (202) 662-3571

DATE: 3-20-96 TIME: _____

NUMBER OF PAGES SENT (INCLUDING COVER SHEET): 3

COMMENTS: _____

25 E Street, NW
Washington, DC 20001
Telephone 202 628 8787
Fax 202 662 3510

Children's Defense Fund

MEMORANDUM

TO: Jennifer Klein

FROM: Jim Weill

DATE: March 20, 1996

Here's an "exhaustion" piece, for you to use as you see fit.

25 E Street, NW
Washington, DC 20001
Telephone 202 628 8787
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Requiring Exhaustion of Administrative Remedies in Medicaid Cases Would be a Terrible Mistake for Beneficiaries, States and the Courts

A number of governors have proposed that, before a Medicaid beneficiary could file a federal court lawsuit to enforce his or her federal rights, the beneficiary should first have to exhaust administrative remedies.* This is a bad idea for beneficiaries, states, the federal government, and our courts.

1) Medicaid beneficiaries and the paralegals or lawyers who represent them already take to administrative hearings those fact-based cases which are appropriate to be heard there, and take to federal court only those cases which are appropriate to be heard there. Well over 99% of all claims are made to the administrative agency, not to federal courts, and seek to resolve factual disputes.

2) Those cases that are brought in federal court use federal laws to challenge the policies of the state, or its widespread practices. These policies or practices cannot be remedied in an administrative hearing. In fact, many states bar hearing officers from even considering such issues, and in virtually all states they are not trained to interpret federal law. The cases brought in federal court do not involve those types of questions of individual fact that need to be dealt with administratively. When such factual issues are present and there are not important legal issues, lawyers and beneficiaries typically do go through administrative processes.

3) An exhaustion requirement would lead to protracted and mostly pointless litigation over the preliminary collateral issue of whether or not exhaustion in the particular case is needed. Before 1982, when the Supreme Court definitively put an end to the practice, a couple of federal courts of appeals required exhaustion of administrative remedies in welfare and Medicaid cases, when such remedies were adequate. The result was that huge amounts of agency, lawyer and judge time went into litigation over this collateral issue in courts across the nation, and significant delays occurred while courts worked through this issue. But it was rare that a judge ever wound up dismissing a Medicaid case for failure to exhaust administrative remedies because beneficiaries and lawyers were not bringing to court those cases in which exhaustion was appropriate. Nevertheless, the collateral preliminary litigation entailed probing such matters as the finality of administrative decisions, the length or formality of the state's administrative process, the impartiality of the decision-maker, etc., much of which was itself intrusive and aggravated federal-state relations. The effect was to create an additional unnecessary obstacle to resolution of important underlying federal legal issues. This extra obstacle is particularly harmful in cases involving rights to health care where the applicant's or recipient's health can be harmed during the delay.

4) Very few Medicaid cases are brought in federal court each year. The number of beneficiary lawsuits filed in federal court generally averages fewer than one per year per state. (In addition, there are provider reimbursement claims, that would no longer be brought because the underlying substantive basis for them in the federal Medicaid statute would disappear under pending Medicaid proposals.)

*A separate proposal to send all Medicaid claims to state courts is also a bad idea, and is addressed in a separate analysis.

5) Beneficiaries do not lightly go to federal court. Federal courts are often more expensive places in which to litigate. And they cannot award compensatory damages or back benefits to beneficiaries, because the Eleventh Amendment, as construed in Edelman v. Jordan, 415 U.S. 651 (1974), prohibits such relief against a state. Therefore, if state administrative or judicial remedies are effective, people will use them (state courts have concurrent jurisdiction with federal courts over 42 U.S.C.§ 1983 claims). People use the simpler, speedier, less expensive remedy so long as they perceive it to be fair. Indeed, it has been suggested that this "free market" system in which there is a choice is an incentive to agencies to keep administrative remedies cheaper and more effective. Patsy v. Florida International University, 457 U.S. 496, 513 n. 15, and sources cited there.

6) Since 42 U.S.C.§ 1983 was passed immediately after the Civil War, there has been a 125 year history of not requiring exhaustion in cases brought pursuant to section 1983 to enforce federal laws. Only one limited exception has been carved out by Congress, after extensive debate, in 1980. That exception limits federal court suits by prisoners and was passed to reduce the huge number of prisoner cases (nearly 10,000 in 1978 -- 5% of the federal courts' entire civil caseload), many of which were frivolous, filed pro se without counsel, handwritten, or otherwise a major and inappropriate burden on the federal courts. See, e.g., 125 Cong. Rec. H 3639. In other words, the only previous administrative exhaustion requirement was passed to protect federal courts from thousands of frivolous suits. Here, the states seek protection from meritorious suits numbering in the teens or the dozens rather than the thousands. Congressional imposition of an exhaustion requirement at the behest of defendants seeking relief from valid claims would be a major inroad on the right to sue to enforce federal rights, and a terrible precedent for Congressional action against other types of meritorious claims.

7) Even when exhaustion of administrative remedies is normally required, there is an exception if it would be futile. Before exhaustion is required, relief must be available within a reasonable time; procedures must be fair; interim relief must be available in appropriate cases to prevent irreparable injury (an especially urgent concern in cases involving medical benefits); the agency must be able to grant relief commensurate with the claim; the decision cannot be based on a secret policy; and other standards. See, for example, Patsy v. Florida International University, 634 F.2d 900, 912-913 (5th Cir. 1981), rev'd, 457 U.S. 496 (1982), and Bowen v. City of New York, 476 U.S. 467 (1986). Even in the prisoner exhaustion situation discussed earlier, Congress set out minimum standards. Such standards, if designed carefully and appropriately, would mean that federal courts would rarely toss out a Medicaid claim for failure to exhaust, but would face all these criteria as unnecessary threshold matters, and would involve every federal court in deciding not just whether a state violated substantive Medicaid rules, but also and unnecessarily whether large portions of a state's administrative process are fair.

For Medicaid applicants and recipients, an exhaustion requirement would present a major inappropriate obstacle to securing relief from state policies and practices challenged as contrary to federal law. The effect of an exhaustion requirement would be to delay resolution of meritorious federal challenges at great expense - both in time and money for litigants and the courts, and in injury to the health of children and other applicants and recipients.

GEORGETOWN UNIVERSITY LAW CENTER

Federal Legislation Clinic

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FAX COVER MEMORANDUM

DATE: 3-18-96

NUMBER OF PAGES, INCLUDING THIS SHEET: 4

TO: Jennifer Klein
Nan Hunter

FAX NUMBER:

FROM: Georgetown Folks

COMMENT:

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CAUSES OF ACTION IN STATE COURTS FOR MEDICAID

Under current law, suits involving Medicaid are brought through a federal private cause of action in federal court. The current debate on the future of Medicaid raises the possibility of departing from this routine. At issue is the question of whether litigation under a new statute would take place in federal or State courts. If Congress bars suits in federal courts, it could condition federal funding on one of two options: requiring State courts to hear the federal cause of action or requiring the State to create its own cause of action. Both options raise significant constitutional questions.

I. THERE ARE LIMITS TO WHAT THE FEDERAL GOVERNMENT MAY DO WITHOUT INFRINGING UPON STATE SOVEREIGNTY

The federal government exercises its powers subject to the limitations of the Constitution. A Congressional Act which "invades the province of state sovereignty reserved by the Tenth Amendment" is invalid. Both of the options listed above for a private right of action risk infringing upon State guarantees under the Tenth Amendment, and therefore raise significant constitutional questions.

II. WHAT CONSTITUTIONAL QUESTIONS ARE RAISED BY A PROPOSAL THAT THE FEDERAL GOVERNMENT REQUIRE *STATE* COURTS TO HEAR A *FEDERAL* PRIVATE CAUSE OF ACTION THAT WILL *NOT* BE PERMITTED TO BE HEARD IN *FEDERAL* COURT?

The Supreme Court has never directly answered this question because *Congress* has never passed a law in which it has *both* required States to hear a federal cause of action *and* foreclosed the federal courts from hearing that action.

The Court has never directly held that State courts *must* hear suits brought under §1983, a federal cause of action that allows challenges to violations of federal constitutional or statutory rights. See Martinez v. California, 444 U.S. 277, 283 (1980). Cf. Arkansas Writers' Project, Inc. v. Ragland, 481 U.S. 221, 234 (1987).

Whether States could be *required* to hear §1983 suits and other federal causes of action would be governed by the requirements of South Dakota v. Dole, 483 U.S. 203 (1987). In that case, South Dakota challenged a federal statute that conditions a percentage of highway funds upon the requirement that States raise their drinking age for minors. The Supreme Court, in

upholding the federal law, set forth four requirements a Congressional statute must meet in order to avoid infringing upon State sovereignty. The fourth requirement was that **a conditional grant of federal funds may not be independently barred by other constitutional provisions**. *Id* at 203.

This fourth requirement may raise questions about the constitutionality of requiring federal causes of action to be heard in State courts, as contemplated in some Medicaid proposals. To require State courts to entertain suits under a federal cause of action, when that federal cause of action will *not be heard* in federal court, *raises a 10th Amendment question.* While the Supreme Court has ruled that State courts may be required to hear a federal cause of action in certain situations (*See* Testa v. Katt, 330 U.S. 386 (1947)), in none of these cases has Congress also *closed* the federal courts to that cause of action.

III. WHAT MAY THE FEDERAL GOVERNMENT DO TO REQUIRE STATES TO *CREATE* A *STATE* CAUSE OF ACTION TO BE HEARD IN *STATE COURT*?

Another option, should Congress eliminate a federal cause of action, is to require States to create a *State* cause of action to be heard in State court as a condition of receiving federal funds. **If Congress requires a state cause of action, this would raise the question of whether State sovereignty has been violated.** The federal government would be requiring State governments to adopt a legislative program that includes substantive rights in State courts. The Supreme Court has suggested in the past that similar requirements were unconstitutional even if conditioned on federal funds:

- **"Requiring States to regulate pursuant to Congress' direction would present a simple unconstitutional command to implement legislation enacted by Congress."** County of Allegheny, New York v. United States, 505 U.S. 144 (1992).

- The **"Federal Government may not compel states to enact or administer a federal statutory program"** without usurping the power of the State Legislature. Frank v. U.S., 860 F.Supp. 1030 (1994).

- **State agencies may not be required to promulgate regulations as a matter of state law**. County of Allegheny, New York v. United States, 505 U.S. 144 (1992).

Since all agree that a private right of action is necessary to protect beneficiaries of the Medicaid program, and both options for changing the current private right of action raise significant constitutional questions, the best option is to maintain the current federal private right of action in federal court. To do so would maintain the integrity of the Medicaid program without risking infringement upon state sovereignty. In addition, ensuring that federal courts will hear Medicaid claims will advance the interests of uniformity and maximization of judicial resources.

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Federal Courts Are Preferable for Determining Questions of Federal Medicaid Law

During recent debates on Medicaid, some have proposed eliminating the private right of action from federal court and instead allowing state courts to resolve questions of federal law. This proposal would be detrimental for several reasons:

Inequity and Distortion in an Interstate System: Although several recent proposals would eliminate specific benefits deliberately to enhance state experimentation with health care, the elimination of the federal private right of action effectively undercuts even those guarantees these proposals supposedly maintain. If state courts are the only arbiters of the meaning of federal law, every state will implement the same provision differently. The result will be inequity and distortion, with similarly situated people being treated differently depending entirely on where they live.

The Race to the Bottom: In order to prevent poor people and people with disabilities from immigrating to new states solely to obtain medical services, states will have an incentive to provide the fewest benefits possible. Any state that fulfills **its guarantee** will risk becoming the safety-valve for states that do not. This "race to the bottom" will be heightened by the fact that state judges, who are elected or appointed by the Governor, will feel particular political pressure to interpret these federal guarantees as narrowly as possible.

Re-litigating Benefits Issues: To the extent that Congress decides to retain benefits from previous law, putting these suits in state courts means re-litigating benefits issues in each of the 50 States. The law has acquired detailed legal meanings over the last 30 years, without which any remaining federal guarantees will have to be reregulated or relitigated for meaning in state court—a bureaucratic and legal nightmare directly contrary to the goal of simplifying government.

Confusion and Conflict of Interest: Imagine a person's confusion and frustration with having a right that cannot be enforced consistently. For example, although a person with Alzheimer's or AIDS is qualified as "disabled" for his or her Social Security disability check, new paperwork must be filed proving eligibility under the ***new state definition*** of disability. There are new medical exams, new tests, and new forms for social workers.

All of these concerns counsel <u>against</u> removing a federal cause of action. Unlike state judges, federal judges are neutral arbiters and are detached from the controversies at hand. If Congress chooses to retain any <u>federal</u> benefits, it should at least allow challenges to the provision and interpretation of federal guarantees to be resolved in <u>federal</u> court.

Prepared by the Georgetown Federal Legislation Clinic on behalf of
Catholic Charities USA (Haltom.3/12/96.fedctpre)

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202-662-9595 Fax # 202-662-9682

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Office of the General Counsel
Washington, D.C. 20201

FACSIMILE TRANSMISSION

TO: Jennifer Klein FAX NUMBER: 456-2878

FROM: Nan D. Hunter
Deputy General Counsel

Facsimile Phone number - 202-690-7998

Telephone Number - 202-690-7780

ADDRESS: 700-E H.H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D. C. 20201

COMMENTS: A formal memo will be ready on Monday (I am out of the office through Friday). If it is needed sooner, please let Lynda Gyles in my office know.

Total number of pages 3

3/12/96

To: Nan Hunter@OGC.IO@OS.DC,Lynda Gyles@OGC.IO@OS.DC
Cc:
Bcc:
From: David Smith@OGC.HCF@OS.DC
Subject: Medicaid cases
Date: Monday, March 11, 1996 16:47:57 EST
Attach:
Certify: Y
Forwarded by:

This responds to your (Nan's) questions on the number of Medicaid cases we found in our earlier search. We reran the search and looked at case summaries to eliminate duplicates and to try to determine winners, losers, and types of cases. The following are our preliminary results:

1. After eliminating duplicate cases and cases which upon examination turned out not to be Medicaid cases (e.g. ERISA cases, criminal cases, and HUD cases) we were left with 127 cases in federal courts during the period from Feb. 1, 1991 to the present.

2. Of this number 14 were provider cases brought under the Boren amendment, 62 were beneficiary cases, and 51 were other cases. (This other category includes states suing HHS and provider suits against states or HHS on grounds other than the Boren amendment.)

3. On the win/loss distribution issue, plaintiffs won 59, defendants won 65, and 3 cases were difficult to determine the prevailing party. (Even these figures are subject to some caveats. By eliminating duplicate cases (cases which arose out of the initial litigation, whether on appeal or in different phases of the litigation) one party may have prevailed in a part of the action which was eliminated from the count.

4. We are still trying to review the data to determine the number of beneficiary cases which were class action cases. We are using the assumption that this means brought as a class action (rather than certified by the court as a class action) because the cross section of cases makes it very difficult to establish whether a class was actually certified in the case. A class may have been certified at a different portion of the proceedings than that caught by our search. We are reviewing the individual cases using this criterion to determine the number of class action beneficiary cases and individual beneficiary cases (where only the named plaintiff or plaintiffs sought relief).

5. We had originally done a separate search for Boren cases, using a different search strategy than for general Medicaid cases, which we are now trying to reproduce. Our search disclosed 30 possible Boren cases (in federal court) during the time frame. This number includes the 14 already counted in the first search. However, we are in the process of checking these cases to make sure they are actually Boren cases.

6. Carl checked with the Administrative Office of the U.S. Courts and was unable to get any useful data. That office groups Medicaid cases with welfare cases in general. Therefore, its data does not have the level of specificity you seek.

7. We have retained our notes on the types of cases which were found, included in these numbers, or eliminated based on duplication or not being Medicaid cases. If you would like to see them at some point, let me know.

3/12/96

To : Na

Cc :
Bcc :
From : David Smith@OGC.HCF@OS.DC
Subject : Medicaid case count update
Date : Tuesday, March 12, 1996 at 5:00:17 pm EST
Attach :
Certify : Y
Encrypt : N

Here are the final figures which we did not provide in yesterday's email.

Total unduplicated Boren amendment cases identified (based the Boren search which we did originally) = 27

Total unduplicated Boren amendment cases in the general "Medicaid applicant" or "Medicaid recipient" search = 14.

(Our figures presented below for the class action, individual, and other suits are based on the latter search and do not include the extra cases identified in the Boren-specific search.)

Class actions brought on behalf of beneficiaries = 42

Cases brought by individual beneficiaries = 21

Other cases = 50

Total unduplicated cases in the applicant/recipient search = 127.

There is very little correlation between our figures and those of NHelp's. This appears to be due to the search criteria we used and those they used. Their search looked for "eligibility" cases (based on a statutory citation) and "amount, duration, or scope" cases. Ours did neither.

Moreover, we do not believe that they used the same criteria for eliminating duplicate cases. They have not explained their criteria for identifying duplicate cases. While they may have eliminated some duplicate cases for each year, several of these cases appear in different year print outs. Neither our not their search strategy is perfect. It all depends upon the information sought.

Please let us know if we may be of further assistance.

On the Private Right of Action in Medicaid

How much is a contract worth that specifically says you can't enforce it? Not much.

How much is a contract worth that is only valid if the other party says it is? Not much more.

Would you rely on such a contract to provide insurance for your elderly mother or your disabled child? I hope not.

But that's exactly the contract that the National Governors' Association is saying should be the basis for the new Medicaid program. While the NGA is struggling to balance autonomy for the states with a national commitment to the poor, its new proposal to eliminate a federal private right of action carves out the very heart of the guarantee of care. to health

This matters not only to the people that depend on Medicaid. It matters also to anyone who cares about accountability for federal dollars and about the integrity of a national system. There are legal and structural reasons to have a federal private right of action, above and beyond the compassion for any one pregnant woman, sick child, or person with disabilities.

Loss of precedent means re-regulation and re-litigation. The Medicaid program is not new. The words used in the law have acquired legal meanings over the last 30 years and, however complex these meanings, at least people now understand them. If the federal private right of action is replaced with a new law that can only be dealt with in state courts, the precedents are gone. Without definitions, those words will have to be re-regulated or re-litigated to get meanings, a legal nightmare that seems the opposite of "simplifying government". In essence, this takes lawyers for plaintiffs and defendants back to Square One for everything.

Take, for example, the one simple, clear guarantee that everyone seems to agree about--that poor pregnant women should be covered for health care. If this poor pregnant woman has a miscarriage and experiences serious medical complications, is she still guaranteed care? Put bluntly, is she still a pregnant woman immediately after the miscarriage? (Today, under the federal law, the answer is yes.)

This is particularly troubling because this question is an easy one. Everyone probably agrees. But imagine the debate about a woman who's had complications from an illegal abortion instead of from a miscarriage. Or if it is a woman with HIV.

With a Federal private right of action, one decision answers such a question for the nation. Without one, it becomes necessary to re-litigate the answer in 50 different court systems.

This loss of precedent will lead to inequity and distortion in an interstate system. If the State courts are the only arbiters of the meaning of the words in the Federal law, States will all be implementing the same law but with no federal common denominator. The result will be inequity and distortion, even in those areas that are said to be uniform.

For this example, assume that you have a disabled child who requires daily nursing care and an occasional hospital stay. State A, where you live, says your child is not disabled enough to qualify for any help.

But in nearby State B, you know someone whose disabled child not only receives hospital care but visiting nurses. How long will it be until you move to State B? And then how long will it take for State B to recognize that there are a lot of disabled people moving in, to figure out what's going on, and to cut its coverage?

This is what the policy people call "the race to the bottom," and without a federal common meaning of the law, it will happen in every state with every expensive patient or service. When there is no interstate guarantee overseen by "interstate" (i.e., Federal) courts, any state with a generous court will run the risk of being the safety valve of all states whose courts are restrictive. States will have to cut back or face the possibility of needy people streaming in.

There is also the reverse problem, what some call Medicaid-lock, similar to job-lock in private insurance. Again, if you have a disabled relative in generous

State B that provides eligibility and services for your child or elderly parent, then you cannot leave State B unless you are prepared to abandon your family member. If you get a new job in faraway State C or want to retire to State C yourself, you can't go unless State C will cover your relative. Since care for the elderly and the disabled is usually ongoing and expensive, this is not a far-fetched scenario (at least until State B races to the bottom and cancels your relative's eligibility and benefits).

Loss of a Federal venue will mean conflicts of interest. Relying on states and their designees to patrol their own interpretation of the federal law will also inevitably result in an implicit or explicit conflict of interest. Already under current law, managed care organizations that get a flat payment for services have such a conflict built in. But now patients can ultimately invoke the threat of going to federal court to enforce their rights. Under the NGA proposal, they would only be able to turn to another arbiter with a built-in conflict.

Consider, for example, a patient with Alzheimer's or AIDS. First, he's likely to be placed in a Medicaid HMO, since many Medicaid patients are already in managed care and the Governors' plan is to get almost all of them in as soon as possible. If the expensive Alzheimer's or AIDS drug he needs is not supplied in his HMO, he will probably have to exhaust all avenues within the HMO, the very agency that is denying him care and has a financial incentive to do so.

If he doesn't win his appeal there, he can go to State court. In State court, he will have to sue the governor in front of a judge who was appointed by the

governor who runs the plan that is denying him care or sue the state (and its taxpayers) in front of a judge who is elected by the taxpayers who will pay for any expensive care. Again, there's no reviewer without at least a colorable conflict of interest.

Something like this often happens in Medicaid today. But now, the filing of a federal court action--or more often, the threat of filing--is usually enough to get the HMO and state processes moving. If that threat is removed, there is no incentive--financial or legal--for an HMO or a state to live up to its promise of providing adequate health care. Every expensive procedure--from chemotherapy to nursing home beds--will be allocated by someone with a clear conflict of interest in the outcome and with no overseer.

This is not to say there are no reliable state judges. Most of them are. It is to say that federal judges are usually better insulated from politics than are state judges. There are enough overt politics already in the decision to strip Medicaid of its guarantees. Conflicts of interest and covert politics should not be added to this mix.

The Governor's package looks like it cuts back on lots of rights while still maintaining a few promises. Like any contract, however, this one has fine print. In that fine print is the elimination of the only truly effective remedy, the private right of action.

There's a lawyer's aphorism about accountability: "There's no right

without a remedy." In the NGA Medicaid package, there is no right to health care for the poor because there is no effective and fair remedy to enforce the promise.

GEORGETOWN UNIVERSITY LAW CENTER

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FAX COVER MEMORANDUM

DATE: _____

NUMBER OF PAGES, INCLUDING THIS SHEET: _____

TO: Jennifer

FAX NUMBER: TM 456-9412

FROM: Tim

COMMENT: Please review.
Thanks.
Tim

On the Private Right of Action in Medicaid

How much is a contract worth that specifically says you can't enforce it? Not much.

How much is a contract worth that is only valid if the other party says it is? Not much more.

Would you rely on such a contract to provide insurance for your elderly mother or your disabled child? I hope not.

But that's exactly the contract that the National Governors' Association is saying should be the basis for the new Medicaid program. While the NGA is struggling to find new ways to cut health costs for poor Americans, its new proposal to eliminate federal enforcement of minimum standards carves out the very heart of the guarantee of care.

This matters not only to the people that depend on Medicaid, but also to anyone who cares about accountability for federal dollars and about the integrity of a national system. There are legal and structural reasons to have a federal private right of action, above and beyond the compassion for any one pregnant woman, sick child, or person with disabilities.

Loss of precedent means re-regulation and re-litigation. The Medicaid program is not new. The words used in the law have acquired legal meanings over

the last 30 years and, however complex these meanings, at least people now understand them. If the federal private right of action is replaced with a new law that can only be dealt with in state courts, the precedents are gone. Without definitions, those words will have to be re-regulated or re-litigated to get meanings, a legal nightmare that seems the opposite of "simplifying government". In essence, this takes lawyers for plaintiffs and defendants back to Square One for everything.

Take, for example, the one simple, clear guarantee that everyone seems to agree about--that poor pregnant women should be covered for health care. If this poor pregnant woman has a miscarriage and experiences serious medical complications, is she still guaranteed care? Put bluntly, is she still a pregnant woman immediately after the miscarriage?

Today, the answer is yes.

If there is a Federal private right of action, one decision would answer that question for the nation. Without one, it will be necessary to re-litigate the answer in 50 different court systems.

This is particularly troubling because this question is an easy one. Everyone probably agrees. But now imagine what the debate will be like if it is about a woman who's had complications from an illegal abortion instead of from a miscarriage. Or if it is a woman with HIV. Does anyone believe that these pregnant women will be guaranteed coverage in all 50 states, and if not, why do they keep saying that all pregnant women are covered?

Point is diff. def. will lead to race to bottom and inequity.

Loss of uniformity means inequity and distortion in an interstate system. While the Governors' package eliminates some defined benefits deliberately in order to enhance State experimentation with health care, the elimination of the federal private right of action goes further, eliminating whatever a state court says is eliminated. States will all be implementing the same law but with no federal common denominator. The result will be inequity and distortion, even in those areas that are said to be uniform.

For this example, assume that you have a disabled child who requires daily nursing care and an occasional hospital stay. State A, where you live, says your child is not disabled enough to qualify for any help. You go through state bureaucracies to appeal and you go to state court to appeal, but you lose. The state has defined the word "disabled" and that's that. There's no federal remedy.

But in nearby State B, you know someone whose disabled child not only receives hospital care but visiting nurses. How long will it be until you move to State B? And then how long will it take for State B to recognize that there are a lot of disabled people moving in, to figure out what's going on, and to cut its coverage?

This is what the policy people call "the race to the bottom," and without a federal common meaning of the law, it will happen with every expensive service. When there is no interstate guarantee overseen by "interstate" (i.e., Federal) courts, people will vote with their feet, find the best care for their families, and move there. Any generous state will have to cut back or face the possibility of

needy people streaming in. Unless the Medicaid bill is accompanied by a Constitutional Amendment restricting interstate travel, this is an inevitable result.

There is also the reverse problem, what some call Medicaid-lock, similar to job-lock in private insurance. Again, if you have a disabled relative in generous State B that provides eligibility and services for your child or elderly parent, then you cannot leave State B unless you are prepared to abandon your family member. If you get a new job in faraway State C or want to retire to State C yourself, you can't go unless State C will cover your relative. Since care for the elderly and the disabled is usually ongoing and expensive, this is not a far-fetched scenario (at least until State B races to the bottom and cancels your relative's eligibility and benefits).

Loss of a guarantee will mean confusion and conflict of interest. Finally, imagine the citizen confusion and the frustration of having a right that cannot be enforced. Consider the situation of a person with Alzheimer's or AIDS under the Governor's plan. He's qualified as disabled for his Social Security disability check. No one doubts that, and there's a uniform, nationwide standard. But now, for Medicaid, he has to file new paperwork proving that he meets the *new State definition* of disability, which is different than the Social Security definition. There are new medical exams, new tests, new social workers' forms.

If he qualifies, he goes on. If not, he's in the same situation as the miscarrying pregnant woman, i.e., no coverage and no appeal. (Imagine explaining to someone that the Social Security Administration thinks they're

disabled enough to get cash but the State doesn't think they're disabled enough to get medical care for ~~your~~ disability. Imagine the person you're talking to has Alzheimer's or AIDS.)

Even if he qualifies, his problems are not over. Next he's placed in a Medicaid HMO, not an unlikely scenario since ?% of Medicaid patients already are in managed care and the Governors' plan is to get all of them in by ?. In that HMO, the Alzheimer's or AIDS drug he needs is not supplied, and he has to file an appeal with the HMO, the very agency that is denying him care and has a financial incentive to do so. If he doesn't get his drug there, he can go to State court. In State court, he will have to sue the governor in front of a judge who was appointed by the governor who runs the plan that is denying expensive care or sue the state (and its taxpayers) in front of a judge who is elected by the taxpayers who will pay for any expensive care. Again, there's no arbiter without a conflict of interest.

And if he loses there, that's it. Even though the Federal government has paid at least half the cost of his other health care, the Federal government will have no say in whether he gets his drug or not. And if he wins, he wins only for people with Alzheimer's or AIDS in his state. Patients and families in the other 49 states will have to repeat the process.

Something like this happens in Medicaid HMO's now. But now, the filing of a federal court action--or more often, the threat of filing--is usually enough to get the HMO process moving. If that threat is removed, there is no incentive--

financial or legal--for an HMO to live up to its promise of providing adequate health care at a fixed price. Every expensive procedure--from chemotherapy to nursing home beds--will be allocated by someone with a clear conflict of interest in the outcome and with no overseer.

The Governor's package looks like it cuts back on lots of rights while still maintaining a few promises. Like any contract, however, this one has fine print. In that fine print is the elimination of the only truly effective remedy, the private right of action.

There's a lawyer's aphorism about accountability: "There's no right without a remedy." In the NGA Medicaid package, there is no right to health care for the poor because there is no effective and fair remedy to enforce the promise. If that's what they mean, the Governors should simply stop saying that they're promising anything.

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Are states swamped by waves of federal-court litigation about Medicaid eligibility? It doesn't look like it.

What follows is an estimate of the year-by-year numbers of Medicaid eligibility cases which have been resolved or otherwise gone through major developments in federal court. The estimate assesses the cases which have been reported by the major reporting services: Commerce Clearing House and the West Publishing Company. A summary:

Year	Unduplicated Federal Cases on Eligibility Issues
1988:	15 (including 4 brought by states vs. HCFA)
1989:	8
1990:	11
1991:	8
1992:	6
1993:	8 (including 1 brought by state vs. HCFA)
1994:	6
1995 (Jan-Nov):	4

To make this estimate, we reviewed the case tables in the CCH Medicare and Medicaid Guide, separating out federal cases on Medicaid eligibility from state cases and federal cases on other issues. We then cross-checked this estimate with a Westlaw search for cases citing the most important federal Medicaid eligibility statutes.

As trends go, the figure for 1988 may be unusually high, because there was extensive litigation in the mid- to late-1980s on Medicaid use of the AFDC standard filing unit. To my knowledge, this was the only issue on which cases were filed in federal court within every Circuit.

Mark Regan
National Health Law Program

This is an estimate of how many Medicaid benefits cases per year have produced reported final decisions or major rulings in federal court. The estimate depends on three searches of Westlaw and a check through tables of cases reported in the Commerce Clearing House Medicare and Medicaid Guide. Attached is a list of cases going back to 1988.

Results:

Year	Unduplicated Reported Federal Medicaid Benefits Cases
1988	8 (7 brought by recipients)
1989	2
1990	8
1991	7
1992	13
1993	16
1994	17 (including 7 Hyde Amendment/abortion cases)
1995	6
1996 (so far)	2

The primary Westlaw search, which produced 58 hits, was for Medicaid "amount, duration, and scope" cases. A typical benefits case attempting to enforce federal Medicaid law involves a claim that the amount, duration and scope of a particular service is not sufficient [42 C.F.R. sec. 440.230(b)], or that the service is being denied in a discriminatory way [42 C.F.R. sec. 440.230(c)], or that people of comparable medical need are not getting comparable services [42 C.F.R. sec. 440.240]. Here, the search was:

DATE OF REQUEST: 02/16/96
THE CURRENT DATABASE IS ALLFEDS
YOUR TERMS AND CONNECTORS QUERY:

(AMOUNT W/2 DURATION W/3 SCOPE) 440.230! 440.240 & DA(AFT 1987)

A good third of these cases were not Medicaid benefits cases. (A better request would have managed to exclude the Michigan and Sixth Circuit cases involving the Uniform Commercial Code: the Michigan UCC and the Medicaid regulations share "440.230+" as a citation.)

Secondary Westlaw searches were for Medicaid copayment cases and for cases involving the "statewideness" of Medicaid benefits. I then winnowed out those cases which were not really Medicaid benefits cases, such as reimbursement rate cases brought by providers, and added in benefits cases not captured by these searches which appeared in the CCH list.

Mark Regan
National Health Law Program

Why were relatively many cases reported during 1992-94, as opposed to previous or subsequent years?

Five types of legal problem stand out:

-- States were not fully implementing the EPSDT mandate to provide eligible children with medically necessary treatment, and HCFA did not publish draft regulations on this subject until October 1993;

-- States were confused about how Veterans Adminstration payments should be considered in computing the amount veterans should contribute towards their Medicaid-financed long term care, a matter left administratively unresolved until a recent HCFA State Medicaid Manual change;

-- The Americans with Disabilities Act became fully effective in 1992, producing several cases on state policies restricting access to community care, most of which involved some Medicaid claims as well;

-- States resisted paying on behalf of Qualified Medicare Beneficiaries the full 20% coinsurance for Medicare Part B services that doctors and other health care providers typically demand of more affluent Medicare beneficiaries; and, last but not least,

-- Congress's 1993 decision to reconfigure the Hyde Amendment led to massive resistance on the part of states which did not want to pay for abortions even in situations of rape or incest.

It's hard to see a pattern here, except that all of these types of cases involved systematic state-compliance issues arising from relatively recent changes in complex federal statutes. Those issues just happened to come to a head in a particular period.

Mark Regan
National Health Law Program

Delays in Processing Eligibility Applications

- Tennessee Medicaid agency required to comply with Federal requirements for timely processing (within 90 days) of applications for eligibility by disabled individuals who were unable to obtain needed medical care while their applications were pending, Brown v. Luna, 735 F. Supp. 762 (M.D. Tenn., 1990).

- New York Medicaid agency required to adhere to Federal "corrective action regulation" where applicants incurred out-of-pocket expenses for Medicaid-covered services due to agency delays or errors, Greenstein v. Bane, 833 F. Supp. 1054 (S.D.N.Y 1993).

Coverage of Services (EPSDT)

- California Medicaid agency required to implement Federal EPSDT provision calling for a lead blood assessment appropriate for age and risk factors, Matthews v. Coye, No. C-90-3620 (N.D.Ca.)(stipulation and dismissal, Oct. 17, 1992).

- West Virginia Medicaid agency required to adhere to Federal EPSDT requirements for outreach and education and preventive screening for eligible children in foster care system, Sanders v. Lewis, No. 2:92-0353 (S.D.W.Va.)(consent order, Aug. 16, 1993).

State Fair Hearing Experience

Last year, the Texas Legal Services Center conducted a survey of State Medicaid Agencies to determine how burdensome the Agencies felt judicial review of fair hearings to be (the Center was trying -- unsuccessfully as it turned out -- to make the case to the Texas legislature to allow State court review of fair hearing decisions).

40 States responded. In most cases, less than 5 percent of the fair hearing decisions were appealed to a court. Only 3 of the States (Minnesota, New Jersey, Tennessee) answered "YES" to the question, "Does the ability of applicants to appeal fair hearings to court impose an unreasonable burden on your agency?"

California reported holding about 4,600 fair hearings each year, of which less than 1% were appealed. The State responded that availability of judicial review of fair hearings was "a burden, but not an unreasonable burden," and that the impact on the agency of judicial review is "beneficial because it helps to update policy."

Michigan did not respond.

Missouri reported holding 4,435 fair hearings per year, of which 8 to 10 percent were appealed. The State responded that the availability of judicial review did not impose an unreasonable burden because "minimal preparation is required to defend the appeal." It also stated that the availability of judicial review has a "positive impact [on the State agency] in that it requires the agency to be objective."

Utah reported holding 75 to 100 fair hearings per year, of which 1 was appealed to court. It responded that the availability of judicial review did not impose an unreasonable burden on the agency and did not have an adverse impact on the agency.

Wisconsin reported holding 376 fair hearings per year, 8 (2 percent) of which were appealed to court. The State responded that the availability of judicial review did not impose an unreasonable burden on the State agency and does not have an adverse impact on the agency: "helps to interpret or clarify policy."

It is my understanding that in almost all, if not all of these States, the judicial review is usually taken to State court, not Federal court. Nonetheless, many of the benefits of judicial review cited by the State agencies themselves would apply whether the reviewing court was State or Federal.

Republican Proposals

Conference report. In the vetoed conference report, Title XIX, and all the judicial interpretation of that Title, are repealed. In proposed section 2154(d), the following provision appears:

"Only the Secretary, in accordance with this title, may compel a State under Federal law to comply with the provisions of this title or a MediGrant plan, or otherwise enforce a provision of this title against a State, and

no action may be filed under Federal law against a State in relation to the State's compliance, or failure to comply, with the provisions of this title or of a MediGrant plan except by the Secretary as provided under this section."

Governors' Meetings. In "Staff Summary of Medicaid Discussions Held on December 22, 1995," the following two-part "option" appeared:

"(a) States must offer individuals (or classes) a private right of action in state court as a condition of participation in the program. This would follow some State administrative appeal process. Once all State judicial remedies are exhausted, individuals may appeal to the U.S. Supreme Court.

(b) Independent of any State judicial remedy, the Secretary of HHS may bring action in Federal court on behalf of individuals (or classes)."

Medicaid Hearing Survey	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Conn.	Wash. DC
1. How many fair hearings do you hold in a year?	50-60	32	900	534	4,600	87		400
2. How many of these hearings are appealed to a court at law?	4	3	1%	9	Less than 1%	5		3
3. When fair hearing decisions are appealed to a court at law, does your state's A.G.'s office or does your agency provide its own representation?*	Agency	A.G.	Outside counsel	Agency	A.G.	A.G.		A.G. equivalent
4. What is the standard of review used in appeals to the court?	Clearly erroneous	Weight of the evidence	Substantial evidence for facts/de novo for law	Weight of the evidence	Weight of the evidence	Preponderance of the evidence/ Clear and convincing		Substantial evidence
5. Does applicant's ability to appeal fair hearings to court impose an unreasonable burden to your agency?	NO. Alerts agency to problem areas	NO. Client's right to due process. Balances power and authority of agency.	NO	NO	NO. It's a burden, but not an unreasonable burden	NO. Right to due process outweighs burden		NO. Clarifies issues of law or interpretation
6. Does the availability of judicial review for recipients have an adverse impact on your agency?	NO.	NO. But it could become expensive if number of appeals grows.	NO	NO	NO. It's beneficial because it helps to update policy	NO. Although there is some budgetary impact		NO. Few cases appealed

*A.G. = Attorney General's Office or chief prosecutorial entity for that territory.
NA = Not Available.

Medicaid Hearing Survey	Delaware	Florida	Georgia	Guam	Hawaii	Idaho	Illinois	Indiana
1. How many fair hearings do you hold	135	1,438		Few	42		616	3,493
2. How many of these hearings are appealed to a court at law?	3-5	43		Few	1		42	97
3. When fair hearing decisions are appealed to a court at law, does your state's A.G.'s office or does your agency provide its own representation?*	A.G.	Agency		A.G.	A.G.		A.G.	A.G.
4. What is the standard of review used in appeals to the court?	Weight of the evidence/ Substantial evidence	Competent and substantial evidence		Weight of the evidence	Preponderance of the evidence		Weight of the evidence	Weight of the evidence
5. Does applicant's ability to appeal fair hearings to court impose an unreasonable burden to your agency?	NO	NO. Except in the area of the additional costs which are associated with the judicial review.		YES & NO. Takes time to prepare, but it's a duty.	NO. Due process right		NO. Number of appeals is small	NO. It is their statutory right.
6. Does the availability of judicial review for recipients have an adverse impact on your agency?	NO	NO. Just budgetary impact		NO. Positive impact so that "justice be served."	YES. Court's jurisdiction encompasses equity, which is not part of administration process but affects administrative decision***		NO. Beneficial impact because it initiates needed policy change or vindicates policy	

*A.G. = Attorney General's Office or chief prosecutorial entity for that territory.
NA = Not Available.
***Equity = Justice administered according to fairness as contrasted with the strictly formulated rules of common law.

Medicaid Hearing Survey	Iowa	Kansas	Kentucky	Louisiana	Maine	Maryland	Mass.	Michigan
1. How many fair hearings do you hold in a year?	551	300				500-600	5,000	
2. How many of these hearings are appealed to a court at law?	17	5%				2-3%	12-20	
3. When fair hearing decisions are appealed to a court at law, does your state's A.G.'s office or does your agency provide its own representation?*	A.G.	Agency				A.G.	Agency	
4. What is the standard of review used in appeals to the court?	Substantial evidence	Weight of the evidence				Substantial evidence	Substantial/ Preponder-ance of the evidence	
5. Does applicant's ability to appeal fair hearings to court impose an unreasonable burden to your agency?	NO–gives important feedback	NO				NO–client's right to due process keeps agency in check	NO	
6. Does the availability of judicial review for recipients have an adverse impact on your agency?	NO–helps guide the agency	NO				NO–helps by reviewing policy	NO	

*A.G. = Attorney General's Office or chief prosecutorial entity for that territory.
NA = Not Available.

Medicaid Hearing Survey	Minnesota	Mississippi	Missouri	Montana	Nebraska	Nevada	New Hampshire	New Jersey
1. How many fair hearings do you hold in a year?	Less than 528		4,435	401	309	60	177	800-1,000
2. How many of these hearings are appealed to a court at law?	15		8-10%	1-5%	1 or 2%	2	1%	
3. When fair hearing decisions are appealed to a court at law, does your state's A.G.'s office or does your agency provide its own representation?*	A.G.		Agency	Agency	A.G.	A.G.	A.G.	
4. What is the standard of review used in appeals to the court?	Substantial evidence/ Arbitrary or capricious/ Error of law		Weight of the evidence	Clearly erroneous/ Arbitrary or capricious	Weight of the evidence	Weight of the evidence	Clearly erroneous	Preponderance of the evidence
5. Does applicant's ability to appeal fair hearings to court impose an unreasonable burden to your agency?	YES. Keeping record of each case is burdensome		NO. Minimal preparation is required to defend the appeal.	NO. Due process right and few appeals	NO. Number of appeals small	NO. Agency uses this as a review of its policy and procedure	NO. Most claimants appear pro se, which cuts down on success of appeal	YES. But due process right outweighs burden
6. Does the availability of judicial review for recipients have an adverse impact on your agency?	Somewhat		NO. Has positive impact in that it requires agency to be objective.	Mixed. Few are appealed but can have adverse impact because court considers equity. However, it's also beneficial as a tool for future cases	NO. Number of appeals small	NO	NO	NO. Acts as a quality control of our policy and regulations

*A.G. = Attorney General's Office or chief prosecutorial entity for that territory.
/A = Not Available.

Medicaid Hearing Survey	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Penn.
1. How many fair hearings do you hold in a year?	100-120	18,766	400	23	8,714		70	9,981
2. How many of these hearings are appealed to a court at law?	1%	1%	less than 1%	4	29		1-2	NA
3. When fair hearing decisions are appealed to a court at law, does your state's A.G.'s office or does your agency provide its own representation?*	Agency	A.G.	A.G.	A.G.	A.G.		A.G.	Agency
4. What is the standard of review used in appeals to the court?	Weight of the evidence	Substantial evidence	Whole record test	Preponder-ance of the record	Preponder-ance of the record		Substantial evidence	Weight of the evidence
5. Does applicant's ability to appeal fair hearings to court impose an unreasonable burden to your agency?	NO. Client's due process right outweighs burden	NO. Acts as a check on hearing system	NO	NO. Initiates policy change	NO. Number of appeals is small		NO. Few appeals	NA
6. Does the availability of judicial review for recipients have an adverse impact on your agency?	YES. If decision contradicts agency	NO. Except for budgetary impact	NO	NO. Positive impact, mostly	NO		NO	NA

A.G. = Attorney General's Office or chief prosecutorial entity for that territory.
A = Not Available.

Medicaid Hearing Survey	Puerto Rico	Rhode Island	South Carolina	South Dakota	Tennessee	Utah	Vermont	Virginia
1. How many fair hearings do you hold in a year?	15-20	NA	50	40	1,200	75-100	225	
2. How many of these hearings are appealed to a court at law?	0		Less than 1%	15%	20%	0-1	5	
3. When fair hearing decisions are appealed to a court at law, does your state's A.G.'s office or does your agency provide its own representation?*	Agency		Agency or contracted attorney	Agency	Agency	A.G.	A.G.	
4. What is the standard of review used in appeals to the court?	Clearly erroneous	Weight of the evidence/ Clearly erroneous	Weight of the evidence	Clearly erroneous	Substantial and material	Preponder-ance/ Weight of the evidence	Clearly erroneous	
5. Does applicant's ability to appeal fair hearings to court impose an unreasonable burden to your agency?	NA	NO	NO	NO	Somewhat, because some abuse the process, stringing it out over long periods, expending resources	NO	NO. Small number appealed	
6. Does the availability of judicial review for recipients have an adverse impact on your agency?	NA	NO	NO. Agency wins most of the time.	NO	Somewhat	NO	NO	

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Medicaid Hearing IV Survey	Virgin Islands	Washington	West Virginia	Wisconsin	Wyoming
1. How many fair hearings do you hold in a year?	NA	75	242	376	10
2. How many of these hearings are appealed to a court at law?		3%	1	8	5%
3. When fair hearing decisions are appealed to a court at law, does your state's A.G.'s office or does your agency provide its own representation?*		A.G.	A.G.	Agency	A.G.
4. What is the standard of review used in appeals to the court?	NA	Clearly erroneous	Weight of the evidence	Weight of the evidence	Weight of the evidence
5. Does applicant's ability to appeal fair hearings to court impose an unreasonable burden to your agency?	NA	NO	NO. Few appealed to court	NO	NO. Judicial review is a right
6. Does the availability of judicial review for recipients have an adverse impact on your agency?	NA	NO	NO	NO. Helps to interpret or clarify policy	NO. Forces agency to scrutinize policy and procedure

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NA = Not Available.

YALE LAW SCHOOL
P.O. Box 208215
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February 28, 1996

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue
Washington, DC 20500-2000

Dear Mr. President:

The nation's Governors have made a thoughtful proposal concerning the restructuring of Medicaid. Nevertheless, there are aspects of their plan that should be rejected. In particular, we believe that opportunities for beneficiary enforcement of federal requirements in federal court must be maintained.

The Governors propose a bifurcated system of enforcement. Beneficiaries would pursue remedies through state administrative and judicial processes with the remote possibility of a unifying appeal to the United States Supreme Court. Enforcement of federal standards through federal court action would be available only to federal administrators.

The problem with limiting beneficiaries to state remedies is straightforward: those remedies will be highly heterogenous and of differential effectiveness. On the other hand, were the federal government to attempt to ensure the effectiveness of state remedies, it would have to specify their structure and character as conditions on the receipt of federal Medicaid funds. This quite rightly would be perceived as a highly intrusive new set of federal requirements. In short, neither leaving beneficiaries to the vagaries of state law, nor seeking to unify or specify that law, is an attractive alternative to the current system.

The Governor's further suggestion for federal enforcement of conditions against states in federal court is unlikely to supply either remedial certainty or doctrinal uniformity. The federal government has a remarkably poor record in enforcing conditions in federal grants to the states. Only the most egregious cases can be pursued, and, even then, a host of political considerations sharply constrain federal action.

In short, we believe that the elimination of beneficiary enforcement actions in federal court is not a "legal detail" in the Governors' proposal. The maintenance of an effective enforcement scheme is, indeed, a useful test of whether there are serious and legitimate federal interests that should be defended in the restructuring of Medicaid. If so, as the Governors' proposals clearly presume, those federal interests should not be compromised by potentially lax and highly variable enforcement.

Finally, it is hard to overemphasize the degree to which the legal regime for the enforcement of beneficiary rights structures the political relationships in Medicaid policy-making. "I'll see you in federal court" is often the only effective way for beneficiary representatives to get invited to the legislative assembly or to the relevant executive departments of state government. Beneficiaries bearing federal rights thus have the possibility of providing a counterweight to the power of providers in state political processes, not to mention the opportunity to stabilize Medicaid policy in the face of state fiscal pressures. In the final analysis the ability of federal legal entitlements to give beneficiaries a voice in state Medicaid processes may be the crucial ingredient in maintaining a fair and effective Medicaid system in the years ahead.

Thank you very much for considering our unsolicited views on these matters. We wish you well in the difficult and delicate work of the current legislative session.

Yours sincerely,

Jerry Mashaw
Sterling Professor of Law

Burke Marshall
Nicholas deB. Katzenbach Professor
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Yours sincerely,

Jerry Mashaw
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Nicholas deB. Katzenbach Professor Emeritus

1988: 8 unduplicated benefits cases, 7 brought by recipients.

Todd v. Sorrell, 841 F.2d 87 (4th Cir. 1988). Transplants.

Ellis by Ellis v. Patterson, 859 F.2d 52 (8th Cir. 1988). Transplants. Note: see below for case at district court level.

Weaver v. Reagen, 701 F.Supp. 717 (W.D. Mo. 1988). AZT.

Ellis by Ellis v. Patterson, 713 F.Supp. 292 (E.D. Ark. 1988). Transplants.

Clark v. Kizer, No. Civ. S-87-1700 (E.D. Cal., May 9, 1988), CCH Medicare & Medicaid Guide 37,126. Dental care.

Allen v. Mansour, No. Civ. 86 73429 (E.D. Mich., Aug. 18, 1988), CCH Medicare & Medicaid Guide 37,498. Transplants.

Anthony v. Commissioner of Health and Environment, No. 3-88-0516 (M.D. Tenn., Aug. 22, 1988), CCH Medicare & Medicaid Guide 37,592. Long-term care.

State of La., Dept. of Health and Human Resources v. Bowen, 1988 WL 93430 (D. D.C., Aug. 22, 1988) (NO. CIV.A. 87-1330). Dispute between state and HCFA over classification of charity hospital visits within approved amount/duration/scope limits.

Burket v. Barry, No. C-1-87-0512 (S.D. Ohio, [?] 1988), CCH Medicare & Medicaid Guide 37,216. Long-term care.

1989: 2 unduplicated benefits cases.

Weaver v. Reagen, 886 F.2d 194 (8th Cir. 1989). AZT. Note: same case at district court level, 1988.

Matthews v. Ibarra, No. 88-B-180 (D. Colo., Jan. 11, 1989), CCH Medicare & Medicaid Guide 37,826. Lock-in.

Warr v. Horsley, No. 87-D-1012-N (M.D. Ala., Feb. 2, 1989), CCH Medicare & Medicaid Guide 37,850. Podiatry.

1990: 8 unduplicated benefits cases.

Meusberger v. Palmer, 900 F.2d 1280 (8th Cir. 1990). Transplants.

Beckwith v. Kizer, 912 F.2d 1139 (9th Cir. 1990). Long-term care.

Whitehouse v. Ives, 736 F.Supp. 368 (D. Me. 1990). Contribution to cost of long-term care.

Visser v. Taylor, 756 F.Supp. 501 (D. Kan. 1990). Clozaril.

Clark v. Kizer, 758 F.Supp. 572 (E.D. Cal. 1990). Dental care. Note: previous decision in this case, 1988.

Linton v. Commissioner, 779 F.Supp. 925 (M.D. Tenn. 1990). Nursing home care.

Peura v. Munson, No. J 89-004 (D. Alaska, Aug. 13, 1990), CCH Medicare & Medicaid Guide 38,973. Contribution to cost of long-term care.

Taylor v. White, No. 90-3307 (E.D. Pa., Nov. 6, 1990), CCH Medicare & Medicaid Guide 39,150. Long-term care.

Charpentier v. Kizer, 1990 WL 252191, Medicare & Medicaid Guide P 38,937 (E.D. Cal., Nov 19, 1990) (NO. S-90-758-EJG). Wheelchairs/durable medical equipment.

1991: 7 unduplicated benefits cases.

Martinez v. Ibarra, 759 F.Supp. 664 (D. Colo. 1991). Home- and community-based services.

Sherman v. Griepentrog, 775 F.Supp. 1383 (D. Nev. 1991). Contribution to cost of long-term care/VA benefits.

King by King v. Sullivan, 776 F.Supp. 645 (D. R.I. 1991). Long-term care/community placement.

Lewis v. Grinker, 794 F.Supp. 1193 (E.D. N.Y. 1991). Prenatal care for future citizen children of undocumented women.

Vigue v. Ives, 138 F.R.D. 6 (D. Me. 1991). Wheelchairs/durable medical equipment.

New York City Health & Hospitals Corp. v. Perales, 87 Civ. 4896 (MJL) (S.D. N.Y., March 14, 1991), CCH Medicare & Medicaid Guide 39,196. QMB-20%.

Cooley v. Williams, No. T-CA-91-40486 WS (N.D. Fla., Dec. 2, 1991), CCH Medicare & Medicaid Guide 40,916. EPSDT/Transplants.

1992: 13 unduplicated benefits cases.

New York City Health & Hospitals Corp. v. Perales, 954 F.2d 854 (2d Cir. 1992). QMB-20%. Note: same case at district court level, 1991.

Lewis v. Grinker, 965 F.2d 1206 (2d Cir. 1992). Prenatal care for future citizen children of undocumented women. Note: same case at district court level, 1991.

Coye v. U.S. Dept. of Health and Human Services, 973 F.2d 786 (9th Cir. 1992). Dispute between state and HCFA over payment for care provided to undocumented immigrants.

Peura v. Mala, 977 F.2d 484 (9th Cir. 1992). Contribution to cost of long-term care. Note: district court ruling in this case, 1990.

Lamore v. Ives, 977 F.2d 713 (1st Cir. 1992). Contribution to cost of long-term care/VA payments.

Dexter v. Kirschner, 984 F.2d 979 (9th Cir. 1992). Transplants.

Banks v. Sec'y of Indiana Family & Social Services Admin., 790 F.Supp. 1427 (N.D. Ind. 1992). Notice to beneficiary of agency denial of provider's reimbursement claim.

Steele v. Magnant, 796 F.Supp. 1143 (N.D. Ind. 1992). Home- and community-based care.

McLaughlin v. Williams, 801 F.Supp. 633 (S.D. Fla. 1992). Transplants/EPSDT.

King by King v. Fallon, 801 F.Supp. 925 (D. R.I. 1992). Long-term care/community placement. Note: previous ruling in this case, 1991.

Fulkerson v. Commissioner, Maine DHS, 802 F.Supp. 529 (D. Me. 1992). Copayments.

Pereira v. Kozlowski, 805 F.Supp. 361 (E.D. Va. 1992). Transplants/EPSDT.

Charpentier v. Coye, 1992 WL 48978, Medicare & Medicaid Guide P 39,791 (E.D.Cal., Jan 09, 1992) (NO. CIV.S-90-758 EJG/PAN). Wheelchairs/durable medical equipment. Note: previous ruling in this case, 1990.

Ginley v. White, No. 91-3290 (E.D. Pa., Jan. 24, 1992), CCH Medicare & Medicaid Guide 40,003. Contribution to cost of long-term care/VA payments.

Doe v. Commissioner, Maine DHS, No. 91-0333-P-C (D. Me., Feb. 20, 1992), CCH Medicare & Medicaid Guide 40,035. Drugs.

Nemnich v. Stangler, No. 91-4517-CV-C-5 (W.D. Mo., [?] 1992), CCH Medicare & Medicaid Guide 40,288. Dental care.

Jordano v. Steffen, No. 4-91-715 (D. Minn., March 12, 1992), CCH Medicare & Medicaid Guide 40,293. Long-term care.

Clark v. Coye, 1992 WL 370801, Medicare & Medicaid Guide P 40,888 (E.D. Cal., Oct 14, 1992) (NO. CIV S-87-1700 JFM). Dental care. Note: previous rulings in this case, 1988 and 1990.

Frances J. v. Bradley, No. 92 C 5190 (N.D. Ill., Dec. 14, 1992), CCH Medicare & Medicaid Guide 40,972. Assessment of need for home- and community-based services.

1993: 16 unduplicated benefits cases.

Periera v. Kozlowski, 996 F.2d 728 (4th Cir. 1993). Transplants/EPSDT. Note: district court decision in this case, 1992.

Sweeney v. Bane, 996 F.2d 1384 (2d Cir. 1993). Copayments.

Banks v. Indiana Family and Social Services Admin., 997 F.2d 231 (7th Cir. 1993). Notice to beneficiary of agency's denial of provider's reimbursement claim. Note: district court decision in this case, 1992.

Pittman by Pope v. Secretary, Florida Dept. of Health & Rehabilitative Services, 998 F.2d 887 (11th Cir. 1993). Transplants/EPSDT.

Miller v. Whitburn, 10 F.3d 1315 (7th Cir. 1993). Transplants/EPSDT. Note: see district court decision below.

Skandalis v. Rowe, 811 F.Supp. 782 (D. Conn. 1993). Home- and community-based care.

Miller by Miller v. Whitburn, 816 F.Supp. 505 (W.D. Wis. 1993). Transplants/EPSDT.

Haynes Ambulance Service v. Alabama, 820 F.Supp. 590 (M.D. Ala. 1993). QMB-20%.

Wood v. Wallace, 825 F.Supp. 177 (S.D. Ohio 1993). Home- and community-based care.

Greenstein by Horowitz v. Bane, 833 F.Supp. 1054 (S.D. N.Y. 1993). Direct payment to recipient who has paid out of pocket.

Chappell v. Bradley, 834 F.Supp. 1030 (N.D. Ill. 1993). Orthodontia/EPSDT.

Kansas Hospital Ass'n v. Whiteman, 835 F.Supp. 1548/1556 (D. Kan. 1993). Hospital copayments.

J.K. By and Through R.K. v. Dillenberg, 836 F.Supp. 694 (D. Ariz. 1993). Mental health care for juveniles.

Rehabilitation Ass'n of Virginia v. Kozlowski, 838 F.Supp. 243 (E.D. Va. 1993). QMB-20%.

Conner v. Branstad, 839 F.Supp. 1346 (S.D. Iowa 1993). Community placements.

Martin v. Voinovich, 840 F.Supp. 1175 (S.D. Ohio 1993). Placement of retarded persons.

Florida Pharmacy Ass'n. v. Williams, 871 F.Supp. 1441 (N.D. Fla. 1993). Copayments.

Ralabate v. Bane, No. 93-CV-35 (W.D. N.Y., May 3, 1993), CCH Medicare & Medicaid Guide

41,778. Durable medical equipment.

Thompson v. Raiford, No. 3:92-CV-1539-R (N.D. Tex., Sept. 24, 1993), CCH Medicare & Medicaid Guide 41,776. Lead screening/EPSDT.

1994: 17 unduplicated benefits cases, including 7 Hyde Amendment/abortion cases.

Skandalis v. Rowe, 14 F.3d 173 (2d Cir. 1994). Home- and community-based care. Note: district court ruling in this case, 1993.

Pennsylvania Medical Soc. v. Snider, 29 F.3d 886 (3rd Cir. 1994). QMB-20%.

Wood v. Tompkins, 33 F.3d 600 (6th Cir. 1994). HCBS eligibility. Note: district court ruling in this case, 1993.

Haynes Ambulance Service v. Alabama, 36 F.3d 1074 (11th Cir. 1994). QMB-20%. Note: district court ruling in this case, 1993.

Williams v. Whiteman, 36 F.3d 1106 (Table, text in Westlaw), 1994 Westlaw 504421 (10th Cir., Sept. 16, 1994). Hospital copayments. Note previous decisions in this case, 1993 and below.

Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski, 42 F.3d 1444 (4th Cir. 1994). QMB-20%. Note: district court ruling in this case, 1993.

Granato v. Bane, 841 F.Supp. 64 (N.D. N.Y. 1994). Notice of level-of-care changes.

Catanzano by Catanzano v. Dowling, 847 F.Supp. 1070 (W.D. N.Y. 1994). Home health.

Kansas Hospital Ass'n v. Whiteman, 851 F.Supp. 401 (D. Kan. 1994). Hospital copayments. Earlier decisions in this case, 1993.

Sobky v. Smoley, 855 F.Supp. 1123 (E.D. Cal. 1994). Methadone maintenance.

Planned Parenthood of Missoula v. Blouke, 858 F.Supp. 137 (D. Mont. 1994). Abortions.

Little Rock Family Planning Services, P.A. v. Dalton, 860 F.Supp. 609 (E.D. Ark. 1994). Abortions.

Methodist Hospitals, Inc. v. Indiana Family and Social Services Admin., 860 F.Supp. 1309 (N.D.Ind. 1994). Rates/equal access to care.

Nebraska Pharmacists' Ass'n v. Nebraska Dep't of Social Services, 863 F.Supp. 1037 (D. Neb. 1994). Copayments.

Wolford v. Lewis, Civ. Action. No. 2:92-1151 (S.D W.Va., March 21, 1994), CCH Medicare & Medicaid Guide 42,493. Transportation.

Hern v. Beye, No. 93 N. 2350 (D. Colo., May 12, 1994), CCH Medicare & Medicaid Guide 42,573. Abortions.

Action Alliance of Senior Citizens of Greater Philadelphia v. Snider, No. 93-4827 (E.D. Pa., July 18, 1994), CCH Medicare & Medicaid Guide 42,584. QMBs.

Scott v. Snider, No. 91-7080 (E.D. Pa., July 26, 1994), CCH Medicare & Medicaid Guide 42,608. EPSDT.

Hope Medical Group for Women v. Edwards, No. 94-1129 (E.D. La., July 28, 1994), CCH Medicare & Medicaid Guide 42,651. Abortions.

Elizabeth Blackwell Health Center for Women v. Knoll, No. 94-CV-0169 (E.D. Pa., Sept. 15, 1994), CCH Medicare & Medicaid Guide 42,675. Abortions.

Planned Parenthood Affiliates of Michigan v. Engler, Nos. 4:94-CV-49 & 59 (W.D. Mich., Nov. 3, 1994), CCH Medicare & Medicaid Guide 42,706. Abortions.

Planned Parenthood v. Wright, No. 94 C 6886 (N.D. Ill., Dec. 6, 1994), CCH Medicare & Medicaid Guide 42,992. Abortions.

Indiana Pharmacists' Ass'n v. Indiana Family & Social Services Admin., No. IP 94-328-C (S.D. Ind., Dec. 13, 1994), CCH Medicare & Medicaid Guide 42,997. Copayments.

Charpentier v. Belshe, 1994 WL 792591, Medicare & Medicaid Guide P 43,123 (E.D.Cal., Dec 21, 1994) (NO. CIV.S-90-758 EJG/PAN). Wheelchairs /durable medical equipment. Note: previous rulings in this case, 1990 and 1992.

1995: 6 unduplicated benefits cases.

Pharmaceutical Society of State of New York v. New York State Dep't of Social Services, 50 F.3d 1168 (2d Cir. 1995). Copayments.

Hern v. Beye, 57 F.3d 906 (10th Cir. 1995). Abortions. Note: district court decision in this case, 1994.

Catanzano v. Dowling, 60 F.3d 113 (2d Cir. 1995). Home health. Note: district court decision in this case, 1994.

Clark v. Coye, 60 F.3d 600 (9th Cir. 1995). Dental care. Note: district court decisions in this case, 1988 et seq.

Elizabeth Blackwell Health Center for Women v. Knoll, 61 F.3d 170 (3rd Cir. 1995). Abortions. Note: district court decision in this case, 1994.

Hope Medical Group for Women v. Edwards, 63 F.3d 418 (5th Cir. 1995). Abortions. Note: district court decision in this case, 1994.

Utah Women's Clinic, Inc. v. Graham, 892 F.Supp. 1379 (D. Utah 1995). Abortions.

Sanders v. Lewis, No. 2:92-0358 (S.D. W.Va., March 1, 1995), CCH Medicare & Medicaid Guide 43,120. EPSDT.

Fargo Women's Health Organizations, Inc. v. Wessman, 1995 WL 465830 (D.N.D., Mar 15, 1995) (NO. CIV. A3-94-36). Abortions.

Cherry v. Tompkins, 1995 WL 502403, Medicare & Medicaid Guide P 43,485 (S.D.Ohio, Mar 31, 1995) (NO. C-1-94-460). Level of care criteria.

Hines v. Sheehan, 1995 WL 463685, 64 USLW 2107, Medicare & Medicaid Guide P 43,649, 4 A.D. Cases 1413, 12 A.D.D. 451 (D.Me., Jul 26, 1995) (NO. CIV. 94-326-P-H). Liquid diet.

1996 (so far): 2 unduplicated benefits cases.

Blanchard v. Forrest, 71 F.3d 1163 (5th Cir. 1996). Recipient's out of pocket costs.

Planned Parenthood Affiliates of Michigan v. Engler, 73 F.3d 634 (6th Cir. 1996). Abortions. Note: district court decision in this case, 1994.

Granato v. Schimke, ___ F.3d ___ (2d Cir., Jan. 22, 1996), CCH Medicare & Medicaid Guide 43,993. Notice of level-of-care changes. Note: district court decision in this case, 1994.

1988: 15 cases, 11 brought by recipients

Anderson v. Harwell, CCH para 38,008 (M.D. Tenn., May 26, 1988) (consent order). Issue: procedure for making disability determinations.

Bowen v. Kizer, 108 S.Ct 1200 (1988), CCH para 37,034. Issue: medically needy protected income levels. Note: this was dispute between state and HCFA, not a recipient suit. Recipient suit on same issue went to 9th Circuit in 1986, mooted by Congress in 1987.

State of California, Dep't of Health Services, v. U.S. Dep't of Health & Human Services, ___ F.2d ___ (9th Cir. 1988), CCH para 37,222. Issue: income computations & counting of particular medical bills in medically needy program. Note: this was dispute between state and HCFA, not a recipient suit.

Cazier v. Bowen, CCH para 37,696 (D. Utah, June 6, 1988). Issue: deeming from grandparents.

Darling v. Bowen, 685 F.Supp. 1125 (W.D. Mo. 1988), CCH para 37,104. Issue: eligibility of COBRA widow(er)s.

Davis v. Hunt, CCH para 37,572 (M.D. Ala., March 15, 1988). Issue: deeming from grandparents.

Fratone v. Division of Public Welfare, CCH para 37,093 (D. N.J., February 8, 1988). Issue: independent state disability determinations.

Foley v. Suter, CCH para 37,695 (N.D. Ill., December 29, 1988). Issue: resources spenddown.

Gandenberg v. Barry, CCH paras 37,170 & 37,215 (S.D. Ohio, June 2, 1988, and March 2, 1988). Issues: resources spend down, notice of effective date of eligibility.

Georgia v. Heckler, 846 F.2d 708 (11th Cir. 1988). Issue: Medicaid use of AFDC standard filing unit rule. Note: this was dispute between state and HCFA, not a recipient suit.

Malloy v. Eichler, 860 F.2d 1179 (3d Cir. 1988). Issue: Medicaid use of AFDC standard filing unit rule.

Mitchell v. Lipscomb, ___ F.2d ___ (4th Cir., July 15, 1988), CCH para 37,203. Issue: Medicaid use of AFDC standard filing unit rule.

Ohio Dep't of Human Services v. HHS, 862 F.2d 1228 (6th Cir. 1988). Issue: allowance for spouse of nursing home resident. Note: this was dispute between state and HCFA, not a recipient suit.

Proffit v. Sorrell, 693 F.Supp. 435 (E.D. Va. 1988). Issue: Medicaid use of AFDC lump sum income rule.

Willey v. Ives, 696 F.Supp. 1388 (D. Maine 1988). Issue: fair-market-value evaluation of resources.

1989: 9 cases, including 8 unduplicated cases

Armstrong v. Palmer, ___ F.2d ___ (8th Cir., July 19, 1989), CCH para 37,972. Issue: independent state disability determinations.

Coleman v. Barry, CCH para 37,987 (S.D. Ohio, July 6, 1989). Issue: income and resources standards for Qualified Medicare Beneficiaries.

Cook v. Barry, CCH para 38,004 (S.D. Ohio, July 27, 1989). Issue: mistakes made by authorized representatives during eligibility determinations.

Cutler v. Perales, 128 F.R.D. 39 (S.D. N.Y. 1989). Issue: timely compliance with state fair hearing decisions on eligibility.

Darling v. Bowen, ___ F.2d ___ (8th Cir., June 28, 1989), CCH para 37,923. Issue: eligibility of COBRA widow(er)s. Note: same case at district court level, 1988.

Guidice v. Jackson, 726 F.Supp. 632 (E.D. Va. 1989). Issue: attempt to raise AFDC standard of need and thereby make more people eligible for AFDC and Medicaid.

Hays v. Concannon, CCH para 38,329 (D. Or., March 20, 1989). Issue: independent state disability determinations.

Mowbray v. Kozlowski, 724 F.Supp. 404, 725 F.Supp. 888 (W.D. Va. 1989). Issue: eligibility of Qualified Medicare Beneficiaries.

Perea v. Sullivan, CCH para 38,331 (D. Utah, November 29, 1989). Issue: independent state disability determinations.

1990: 16 cases, including 11 unduplicated cases

Beckwith v. Kizer, 912 F.2d 1139 (9th Cir. 1990). Issue: eligibility under HCBS waiver of recipients who had not previously been hospitalized.

Brown v. Luna, ___ F.Supp. ___ (M.D. Tenn., June 18, 1990), CCH para 38,640. Issue: time limits for making disability determinations.

Cook v. Barry, 735 F.Supp. 229 (S.D. Ohio 1990). Issue: mistakes made by authorized representatives during eligibility determinations. Note: earlier decision in same case, 1989.

Darling v. Sullivan, 914 F.2d 132 (8th Cir. 1990); see also CCH para 39,211 (W.D. Mo.). Issue: COBRA widow(er)s. Note: same case at district court level, 1988, and 8th Cir., 1989.

Disabled Rights Union v. Kizer, 744 F.Supp. 221 (C.D. Cal. 1990). Issues: independent state disability determinations; notice.

Douglas v. Babcock, ___ F.Supp. ___ (E.D. Mich., April 16, 1990), CCH para 38,645. Issue: denial of eligibility for failure to cooperate re child support.

Emerson v. Wynia, 754 F.Supp 705 (D. Minn. 1990). Issue: is money earmarked for child support countable income?

Harriman v. Commissioner, Maine DHS, CCH para 39,089 (D. Maine, November 9, 1990). Issue: resources spenddown.

Hays v. Concannon, CCH para 38,997 (9th Cir., December 19, 1990). Issue: independent state disability determinations. Note: same case at district court level, 1989.

Miller v. Ibarra, 746 F.Supp. 19 (D. Colo. 1990). Issue: income assigned to income trust.

Mowbray v. Kozlowski, 914 F.2d 593 (4th Cir. 1990). Issue: eligibility of Qualified Medicare Beneficiaries. Note: same case at district court level, 1989.

Perea v. Sullivan, CCH para 38,617 (D. Utah, May 24, 1990). Issue: independent state disability determinations. Note: earlier decision in same case, 1989.

Roloff v. Bowen, CCH para 39,066 (N.D. Ind., ? 1990). Issue: resources spenddown.

Sneede v. Kizer, 728 F.Supp. 607 (N.D. Cal. 1990); see also CCH para 38, 814 (N.D. Cal., May 3/June 8, 1990). Issue: deeming of income and resources within household.

Van Gilder v. Valdez, CCH para 41,371 (D. N.M., May 17, 1990). Issue: use of community property principles in determining nursing home eligibility.

Westmiller v. Sullivan, CCH para 38,333 (W.D. N.Y., January 2, 1990). Issue: resources

spenddown.

1991: 10 cases, including 8 unduplicated cases

Cook v. Hairston, CCH para 39,729 (6th Cir., November 26, 1991). Issue: mistakes made by authorized representatives during application process. Note: same case at district court level, 1989 and 1990.

Doe v. Perales, 782 F.Supp. 201 (W.D. N.Y. 1991). Issue: reduction in nursing home resources allowance.

Douglas v. Sullivan, CCH para 39,743 (E.D. Mich., December 9, 1991). Issue: child support cooperation. Note: earlier decision in same case, 1990.

Halford v. Ibarra, CCH para 39,604 (D. Colo., July 3, 1991). Issue: income assigned to income trust. Similar to Miller v. Ibarra, 1990 case.

Himes v. Sullivan, 779 F.Supp. 258 (W.D. N.Y. 1991). Issue: countability of money earmarked for child support & taxes.

Estate of Kaw v. Commissioner, Maine DHS, ___ F.2d ___ (1st Cir., December 20, 1991). Issue: eligibility of Qualified Medicare Beneficiaries.

Mikel v. Gourley, CCH para 39,775 (8th Cir., December 10, 1991). Issue: timeliness of hearings on eligibility.

Ruiz v. Kizer, CCH para 39,679 (E.D. Cal., October 1, 1991). Issue: alien eligibility.

Smith v. Concannon, 951 F.2d 178 (9th Cir. 1991). Issue: Medicaid use of AFDC lump sum income rule.

Winslow v. Maine DHS, CCH para 39,661 (D. Maine, ? 1991). Issue: medically needy protected income levels.

1992: 10 cases, including 6 unduplicated cases

Barile v. Commissioner, Connecticut Dep't of Income Maintenance, CCH para 41,013 (D. Conn., January 28, 1992). Issue: Medicaid use of AFDC lump sum income rule.

Emerson v. Steffen, 959 F.2d 119 (8th Cir. 1992). Issue: countability of money earmarked for child support. Note: same case at district court level, 1990.

Gonzalez v. Palmer, CCH para 40,815 (N.D. Iowa, September 18, 1992). Issue: eligibility for seasonal agricultural workers.

Harriman v. Commissioner, Maine DHS, CCH para 40,116 (D. Maine, March 4, 1992). Issue: resources spenddown. Note: earlier decision in same case, 1990.

Himes v. Sullivan, 956 F.2d 1159 (2d Cir. 1992). Issue: countability of income earmarked for child support & taxes. Note: district court decision, 1991.

Lewis v. Grinker, 965 F.2d 1206 (2d Cir. 1992). Issue: alien eligibility.

McMillan v. McCrimon, ___ F.Supp. ___ (C.D. Ill., August 17, 1992), CCH para 40,930. Issue: agency refusal to accept applications for HCBS program.

Maher v. White, 1992 Westlaw 122,912 (E.D. Pa., June 2, 1992). Issue: notice to parents' that children's eligibility for Medicaid or foster care is being terminated.

Noland v. Sullivan, 785 F.Supp. 179 (D. D.C. 1992). Issue: Pickle Amendment.

Roloff v. Bowen [Sullivan?], 975 F.2d 333 (7th Cir. 1992). Issue: resources spenddown. Note: district court decision, 1990.

1993: 12 cases, including 8 unduplicated cases

Anna W. v. Bane, CCH para 42,951 (W.D. N.Y., October 22, 1993). Issue: exemption for home for nursing home residents.

Coleman v. Glynn, CCH para 40,989 (6th Cir., January 19, 1993). Issue: eligibility of Qualified Medicare Beneficiaries. Note: district court decision, 1989.

Cherry v. Magnant, CCH para 42,078 (S.D. Ind., September 22, 1993). Issue: community spouse resources limit.

Cutler v. Bane, CCH para 41,755 (S.D. N.Y., July 12, 1993) (consent order). Issue: timely compliance with fair hearing decisions. Note: earlier decision in same case, 1989.

Douglas v. Babcock, 990 F.2d 875 (6th Cir. 1993). Issue: child support cooperation. Note: district court decisions, 1990 and 1991.

Gamboa v. Rubin, CCH para 43,087 (D. Hawaii, November 4, 1993). Issue: limit on exempt equity in automobile.

Georgia Dep't of Medical Assistance v. Shalala, ___ F.3d ___ (11th Cir., December 9, 1993), CCH para 41,947. Issue: income limit for nursing home eligibility.

Hazard v. Sullivan, ___ F.Supp. ___ (M.D. Tenn., July 21, 1993), CCH para 41,651. Issue: limit on allowable equity in automobile.

Himes v. Shalala, 999 F.2d 684 (2d Cir. 1993). Issue: countability of money earmarked for child support and taxes. Note: prior decisions in same case, 1991 and 1992.

New Mexico DHS v. Dep't of Health and Human Services, ___ F.2d ___ (10th Cir., September 6, 1993), CCH para 41,709. Issue: use of community property principles. Note: dispute between state and HCFA, recipients intervened.

Sebastian v. Commissioner of Human Services, CCH para 42,140 (M.D. Tenn., September 2, 1993). Issue: need to check all possible bases of eligibility before denying application.

Shifflett v. Kozlowski, CCH para 41,069 (W.D. Va., January 25, 1993). Issues: timeliness of appeals from eligibility determinations; scope of review.

1994: 10 cases, including 6 unduplicated cases

Blanchard v. Forrest, CCH paras 42,620 and 42,623 (E.D. La., May 3 and July 28, 1994). Issue: timely processing of applications and appeals.

Blanco v. Anderson, ___ F.3d ___ (9th Cir., November 2, 1994), CCH para 42,935. Issue: refusal to accept applications on certain days.

Cherry v. Sullivan, CCH para 42,518 (7th Cir., July 20, 1994). Issue: community spouse resources limit. Note: district court decision, 1993.

Disabled Rights Union v. Shalala, ___ F.3d ___ (9th Cir., November 18, 1994), CCH para 42,927. Issues: independent disability determinations; notice. Note: district court decision, 1990.

Golis v. Rubin, CCH para 42,654 (D. Hawaii, July 20, 1994). Issue: availability of share in real estate.

Noland v. Shalala, ___ F.3d ___ (D.C. Cir., January 7, 1994), CCH para 42,018. Issue: Pickle Amendment. Note: district court decision, 1992.

Perley v. Palmer, CCH para 43,098 (N.D. Iowa, April 21, 1994). Issue: veterans' pensions as countable income.

Shifflett v. Kozlowski, ___ F.Supp. ___ (W.D. Va., January 28, 1994), CCH para 42,178. Issues: timeliness of appeals from eligibility determinations; scope of review. Note: earlier decision in same case, 1993.

Wellington v. District of Columbia, 851 F.Supp. 1 (D. D.C. 1994). Issue: processing of applications.

White v. Snider, CCH para 42,175 (E.D. Pa., March 30, 1994). Issues: community spouse resources allowance; notice.

1995: 5 cases, including 4 unduplicated cases

Buchanan v. Whiteman, CCH para 43,532 (D. Kan., February 24, 1995). Issue: veterans' pension benefits as income.

Estate of Greer v. Chen, CCH para 43,162 (D. Ariz., March 27, 1995). Issue: conditional eligibility for person with hard-to-sell resource.

Greenery Rehabilitation Group v. Hammon, ___ F.Supp. ___ (N.D. N.Y., July 25, 1995), CCH para 43,613. Issue: alien eligibility.

Hazard v. Shalala, ___ F.3d ___ (6th Cir., January 11, 1995), CCH para 43,002. Issue: limit on exempt equity in automobile. Note: district court decision, 1993.

Vaughn v. Sullivan, ___ F.Supp. ___, 1995 Westlaw 631,672 (D. Ind., October 19, 1995). Issue: Medicaid policy of excluding income from SSA Plan to Achieve Self Support only if person is blind.

TO: Carol Rasco
Alice Rivlin
Laura Tyson
Gene Sperling
Nancy Ann Min
Chris Jennings
FROM: Jennifer Klein
DATE: 2/29/96

I thought you might be interested in this letter from Professors Jerry Mashaw and Burke Marshall at Yale Law School about federal enforcement under Medicaid.

PRIVATE RIGHT OF ACTION

A Federal Private Right of Action is Important to Maintaining the Guarantee. The Governors (and the Congressional conference report) have eliminated any federal cause of action by Medicaid beneficiaries. Claims brought by individuals to enforce their rights under Medicaid would be limited to state courts and state law. Only the Secretary of Health and Human Services could bring an action in federal court on behalf of Medicaid beneficiaries.

The Governors want to reduce the number of Medicaid cases filed. In addition, they do not want court decisions from federal courts in other states to have any effect on how they run their Medicaid programs. While, under their proposal, cases heard in other states' courts would no longer have precedential value, it is not likely that fewer cases would be filed; they would simply be filed in state court.

You have taken the position that you support maintaining the guarantee under Medicaid. Since the inception of the Medicaid program, a person eligible for Medicaid has had both a guarantee of access to certain services and the right to enforce this commitment. A "guarantee" without a right to enforce it and a remedy for its deprivation is a hollow promise. We believe that preservation of the *federal cause of action* for individuals to enforce Medicaid eligibility assures this guarantee.

- **Consistent Interpretation.** Those aspects of the Medicaid program that are common to all states -- like eligibility -- should be consistently interpreted and administered. The basic guarantee of who is covered should be uniform across the country; without a federal cause of action, it will not be. For example, under current interpretations, a woman who has a miscarriage is considered "pregnant" and therefore eligible for services for complications arising from the miscarriage. Under the Governors' plan, if a state improperly denied those services, she could no longer go to federal court to enforce her right. The issue would instead be litigated in fifty states; in some states, she would receive care while in others she might not.

- **Significant Limitation of Remedies.** The remedies available under state law are generally more limited than under federal law. Very few state laws allow beneficiaries to obtain injunctions against the continuation of policies found to be unlawful or to recover attorneys fees.

  The Governors (and the conference report) claim to maintain a right to sue in federal court through the Secretary of Health and Human Services. However, this poses three problems: (1) the Secretary can sue only if a state is in "substantial noncompliance" -- a much higher standard than exists today; (2) the Health Care Financing Administration will become involved in greater numbers of lawsuits and face significant new administrative burdens; and (3) it is unclear what remedies are available. If the only remedy that the Secretary can seek is the withdrawal of federal funds, this would cause significant harm to the beneficiaries that the Secretary is supposed to represent (and might even make this remedy unusable).

- **Departure from Other Federal Statutes.** Eliminating the federal cause of action would single out Medicaid as the one federal statute that confers individual rights that could not be enforced in federal court by its intended beneficiaries. Such an unprecedented step would be seen as a signal of second-class status and would set off a massive reaction from beneficiary groups and their allies.

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Both Republican and Democratic Governors want to reduce the number of Medicaid cases filed. In addition, they do not want court decisions from federal courts in other states to have any effect on how they run their Medicaid programs. While, under their proposal, cases heard in other states' courts would no longer have precedential value, it is not likely that fewer cases would be filed; they would simply be filed in state court.

Since the inception of the Medicaid program, a person eligible for Medicaid has had both a guarantee of access to certain services and the right to enforce this commitment. We believe that preservation of the *federal cause of action* for individuals to enforce Medicaid eligibility assures this guarantee.

- **Consistent Interpretation.** Those aspects of the Medicaid program that are common to all states -- like eligibility -- should be consistently interpreted and administered. The basic guarantee of who is covered should be uniform across the country; without a federal cause of action, it will not be. For example, under current interpretations, a woman who has a miscarriage is considered "pregnant" and therefore eligible for services for complications arising from the miscarriage. Under the NGA proposal, if a state improperly denied those services, she could no longer go to federal court to enforce her right. The issue would instead be litigated in fifty states; in some states, she would receive care while in others she might not.

- **Significant Limitation of Remedies.** Most state laws establish higher hurdles for plaintiffs and provide less relief than federal law. Under most state statutes that allow courts to review administrative actions, there is no *de novo* review (the record before the court is limited to information considered by the agency) and relief is granted only when a claimant can show that the agency action was arbitrary and capricious, not merely wrong. In addition, most state laws do not allow beneficiaries to recover attorneys' fees, making it more difficult for them to afford legal counsel.

  The NGA proposal (and the conference report) maintains a right to sue in federal court through the Secretary of Health and Human Services. However, this poses three problems: (1) the Secretary can sue only if a state is in "substantial noncompliance" -- a much higher standard than exists today; (2) the Health Care Financing Administration will become involved in greater numbers of lawsuits and face significant new administrative burdens; and (3) it is unclear what remedies are available. If the only remedy that the Secretary can seek is the withdrawal of federal

funds, this would cause significant harm to the beneficiaries that the Secretary is supposed to represent (and might even make this remedy unusable).

- **Departure from Other Federal Statutes.** Eliminating the federal cause of action would single out Medicaid as the one federal statute that could not be enforced in federal court by its intended beneficiaries. Such an unprecedented step would be seen as a signal of second-class status and would set off a massive reaction from beneficiary groups and their allies.

- **Elimination of Remedies under Civil Rights Law.** While it is not clear that the NGA intends to go this far, the conference agreement precludes the right to enforce civil rights laws. Protection against discrimination in state programs has been established under the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990. If this is what the Governors intended, the civil rights community is likely to be very concerned.

Your Proposal Increases Flexibility While Maintaining the Guarantee. Under your plan, you eliminate causes of action by providers over payment rates by repealing the Boren Amendment. This removes state officials' greatest source of concern over litigation and the most frequent basis for cases filed in federal court.

Your proposal maintains current law on private enforcement of beneficiary rights under Medicaid. You could take steps to address the Governors' concerns by separating eligibility claims from some benefits claims. On eligibility issues, which are most closely linked to the concept of a guarantee, individuals would retain their current right to bring suits in federal court. However, individuals would be required to exhaust a state administrative process before filing in court. Most claims involving benefits would be heard only in state courts. A benefits claim could be heard in federal court only if there were an allegation that the state plan or a contract between the state and a provider violated a provision of federal law.

GEORGETOWN UNIVERSITY LAW CENTER

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TELEFAX COVER MEMORANDUM

DATE: 21 Feb 96

NUMBER OF PAGES, INCLUDING THIS SHEET: 4

TO: Jennifer Klein
The White House
Office of the First Lady

FAX NUMBER: 456 2878

FROM: LARRY GOSTIN

TELEPHONE NUMBER: 202-662-9373

COMMENTS: Dear Jennifer: It was great to hear from you, and I hope you are enjoying your work in the White House. Here is the letter I promised. I believe that Judy Areen and Pat King would have been pleased to agree. However, they are at a faculty retreat until Thursday. (I am leaving for the retreat shortly). If you want me to speak with them, just give me a ring on Thursday. THANK YOU

With warm wishes,

Larry

IF THERE IS PROBLEM RECEIVING THIS FAX PLEASE CALL 202-662-9403.

600 New Jersey Avenue NW Washington DC 20001-2075

GEORGETOWN UNIVERSITY LAW CENTER

February 20, 1996

President William J. Clinton
The White House
Washington DC 20500

Dear Mr. President:

Re: A Federal Private Right of Action for Medicaid Beneficiaries

I am writing to urge support of a federal private right of action for Medicaid beneficiaries. I understand that the Governors and the Congressional conference report have eliminated any federal cause of action by Medicaid beneficiaries. The Secretary of Health and Human Services, however, could bring an action in federal court on behalf of Medicaid beneficiaries.

It may be tempting in times when the country is seen to be highly litigious and when Medicaid recipients are sometimes thought to be undeserving to severely limit access to the federal court system. However, such a limitation would be highly unjust and discriminatory. If Medicaid beneficiaries are to have certain federal entitlements, as you have so ably stated on many occasions, then they must have a federal forum to enforce their rights. Absent federal jurisdiction over Medicaid disputes, the poorest and most vulnerable of our population would be left virtually remediless. A federal guarantee of health services without any remedy for its deprivation has no meaning.

One could conceive of many circumstances where it would be inequitable to leave Medicaid beneficiaries without an effective method of enforcement. The most obvious cases are where states do not follow federal guidelines and wrongly exclude a vulnerable class of citizens from coverage. Alternatively, particular persons -- sometimes impoverished women and children -- may be found to be ineligible. These individuals are left with no federal recourse.

600 New Jersey Avenue NW Washington DC 20001-2075
202-662-9000 FAX 202-662-9444

We are entering an era of strict cost containment in the states, with many state Medicaid programs aggressively moving to managed care arrangements. I am not opposed to managed care, but it is well known that occasionally they refuse to cover costly, but potentially life saving medical treatment. In such circumstances, access to the federal judiciary may be the only way that citizens can get the medical treatment they need. When I served on the President's Task Force on Health Care Reform, we discussed possible limitations on access to the courts in depth. We concluded that, although sometimes the right of access was abused, it was absolutely essential to protect the rights and health status of vulnerable beneficiaries.

Granting access to the federal courts is also desirable on legal policy grounds. Federal review is the only method of ensuring that the Medicaid program utilizes consistent criteria, standards, and procedures for everyone in the country. It would make a mockery of the Medicaid program if one State maintained standards considerably lower than others, and where some state courts were prepared to validate claims that were ignored in other states. Lack of consistency and uniformity in a federal program which led to invidious treatment of residents in certain states would be most unfortunate.

The need for uniformity and consistency of interpretation is well understood. This proposal would make Medicaid perhaps the only federal entitlement program that did not permit an individual right of action to the federal courts.

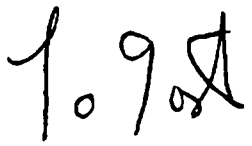
The arguments in favor of the limitation of judicial access are not well conceived. The desire to reduce the number of Medicaid cases filed is not based on any data to show that the current right of access has been significantly abused, or that the decisions of by the federal courts have been unreasonable. Moreover, it is unlikely that this proposal would result in fewer court cases; actions would simply be filed in state courts.

It is true that the Governors and the conference report would continue to allow a right to sue in federal court through the Secretary of Health and Human Services. While such a right is welcome, it is insufficient. The Secretary would likely behave quite differently depending on his or her political affiliation and the current Administration policy. This might leave beneficiaries without a rigorous supporter in the executive branch of government; it would require an executive branch decision to permit access to the judiciary. In any case, the Secretary would probably have resources only to bring cases that affect large numbers of beneficiaries; this would leave the single vulnerable beneficiary powerless if the Secretary did not take up her case. Moreover, the Secretary could only sue if the state was in "substantial noncompliance" -- a much higher standard than exists today. Finally, it is unclear what remedies would be available.

In sum, it would be unfair to single out Medicaid as the one federal statute that confers individual rights that could not be enforced in federal court by its intended beneficiaries. It is important to emphasize that the entitlement at issue here is nothing less than the health of poor people and their families. As we enter an era that understandably seeks to downsize government and reduce health care costs, we must also ensure that we treat persons with respect and dignity,

and we assure access to minimally decent levels of health care. I know that given your admirable record on health and individual rights that you have thought deeply about this subject.

Yours Sincerely,



Professor Lawrence O. Gostin
Co-Director,
Georgetown/Johns Hopkins University Program on Law and Public Health

Supreme Court noted in *Warrior & Gulf, supra*,

> [t]he labor arbitrator's source of law is not confined to the express provisions of the contract, as the industrial common law—the practices of the industry and the shop—is equally a part of the collective bargaining agreement although not expressed in it. The labor arbitrator is usually chosen because of the parties' confidence in his knowledge of the common law of the shop and their trust in his personal judgment to bring to bear considerations which are not expressed in the contract as criteria for judgment.

363 U.S. at 581-82, 80 S.Ct. at 1352-53. We conclude the district court did not err in upholding the arbitrator's use of past practice to determine the employees on layoff were entitled to insurance benefits.

[8] Franklin Electric also argues the district court erred in upholding the arbitrator's award in light of his previous finding of fact that the parties had settled the issue of insurance benefits during their effects bargaining. Appellant argues the arbitrator may not second guess the discretion of the parties under the guise of construing ambiguous contract language. *Manhattan Coffee Co. v. International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, Local No. 688*, 743 F.2d 621, 623 (8th Cir. 1984) (citing *Timken Co. v. Local Union No. 1123, United Steelworkers of America*, 482 F.2d 1012 (6th Cir.1973)). As the district court noted, however, there was some ambiguity in the correspondence between the parties as to whether the issue of insurance benefits had actually been settled during the effects bargaining. Because the record discloses there was some ambiguity, we cannot say the arbitrator exceeded his authority in resolving those ambiguities in favor of granting insurance benefits to the laid off employees.

Franklin Electric last argues that the arbitrator's award should be vacated because it violates the express limitation on awards set forth in the CBA at article 5.4: "Any claim or award made in settlement of a grievance shall not exceed 30 days prior to the date of filing of the written grievance." We agree with [illegible] that this term is not unambiguous and was, therefore, open to arbitral interpretation. Because we cannot say that the arbitrator's interpretation does not take its essence from the CBA, we likewise must uphold the judgment of the arbitrator.

We conclude that the district court's judgment that the arbitrator had jurisdiction to decide the arbitrability questions was correct. We also conclude the issue of insurance benefits was, in this case, arbitrable and that the arbitrator's award draws its essence from the parties' agreements in all respects. Therefore, the judgment of the district court enforcing the arbitrator's award is affirmed.

Glenn C. WEAVER, T.G., and Mark Momot, individually and on behalf of all others similarly situated, Appellees,

v.

Michael REAGEN, Director of the Missouri Department of Social Services; and Jane Y. Kruse, Director of the Missouri Division of Medical Services, Appellants.

No. 88-2560.

United States Court of Appeals, Eighth Circuit.

Submitted April 13, 1989.

Decided Sept. 25, 1989.

Rehearing and Rehearing En Banc Denied Nov. 8, 1989.

Class of Medicaid eligible individuals disabled by Acquired Immunodeficiency Syndrome (AIDS) brought action challenging Missouri Medicaid rule precluding certain Medicaid recipients with AIDS from receiving reimbursement for drug AZT. The United States District Court for the Western District of Missouri, Scott O. Wright, Chief Judge, entered judgment in

favor of plaintiffs. 701 F.Supp. 717, and appeal was taken. The Court of Appeals, Ross, Senior Circuit Judge, held that state could not deny Medicaid coverage of AZT to AIDS patients who were eligible for Medicaid and whose physicians had certified that AZT was medically necessary treatment.

Affirmed as modified.

1. Administrative Law and Procedure ⇐763

In reviewing nonadjudicatory federal agency action, court is limited to deciding whether action is arbitrary, capricious, abuse of discretion or otherwise not in accordance with the law.

2. Social Security and Public Welfare ⇐241.60

Although state's participation in Medicaid program is voluntary, once state chooses to participate in program it must comply with federal statutory and regulatory requirements, including requirement that participating states provide financial assistance for in-patient hospital services, out-patient hospital services, laboratory and x-ray services, skilled nursing facilities and physicians' services. Social Security Act, §§ 1901–1926, 1902(a)(10), 1905(a)(1–5), as amended, 42 U.S.C.A. §§ 1396–1396s, 1396a(a)(10), 1396d(a)(1–5).

3. Social Security and Public Welfare ⇐241.60

Once state chooses to offer optional medical services under Medicaid Act, it is bound to act in compliance with the Act and the applicable regulations in the implementation of those services, including requirement that each service be sufficient in amount, duration, and scope to reasonably achieve its purpose. Social Security Act, §§ 1902(a)(17), 1905(a)(12), as amended, 42 U.S.C.A. §§ 1396a(a)(17), 1396d(a)(12).

4. Social Security and Public Welfare ⇐241.75

State's plan for determining eligibility for medical assistance must be reasonable and consistant with objectives of Medicaid Act. Social Security Act, §§ 1902(a)(17), 1905(a)(12), as amended, 42 U.S.C.A. §§ 1396a(a)(17), 1396d(a)(12).

5. Social Security and Public Welfare ⇐241.90

State could not deny Medicaid coverage of AZT to Acquired Immunodeficiency Syndrome (AIDS) patients who were eligible for Medicaid and whose physicians had certified that AZT was medically necessary treatment. Social Security Act, §§ 1901–1926, 1902(a)(10), 1905(a)(1–5), as amended, 42 U.S.C.A. §§ 1396–1396s, 1396a(a)(10), 1396d(a)(1–5).

Bruce Farmer, Jefferson City, Mo., for appellants.

Ann B. Lever, St. Louis, Mo., for appellees.

Before FAGG, Circuit Judge, and ROSS and TIMBERS,* Senior Circuit Judges.

ROSS, Senior Circuit Judge.

Appellees/plaintiffs Glenn Weaver, T.C., and Mark Momot are members of a class of Medicaid eligible individuals (plaintiffs) who are disabled by the disease Acquired Immunodeficiency Syndrome (AIDS). Plaintiffs filed suit against Michael Reagen, Director of the Missouri Department of Social Services, and Jane Kruse, Director of the Missouri Division of Medical Services (defendants) claiming that defendants had violated their statutory right to Medicaid benefits by denying coverage of the drug Retrovir (formerly known as azidothymidine or AZT) for treatment of their AIDS.[1] Finding that AZT was medically

* The HONORABLE WILLIAM H. TIMBERS, United States Senior Circuit Judge for the Second Circuit, sitting by designation.

1. Plaintiffs premised jurisdiction in the district court on 28 U.S.C. § 1331 (original jurisdiction of all civil matters arising under the Constitution, laws, or treaties of the United States) and 28 U.S.C. § 1343(a)(3) and (4) (original jurisdiction of all civil actions to redress the deprivation, under color of State law, of any right, privilege or immunity secured by the Constitution of the United States or by any Act of Congress providing for equal rights or civil rights of

necessary treatment, the United States District Court for the Western District of Missouri granted plaintiffs' motion for summary judgment and enjoined Missouri officials from denying coverage of AZT to the plaintiff class. We affirm.

I.

Caused by an infection with the human immunodeficiency virus (HIV), AIDS is characterized by a compromised functioning of the immune system, life-threatening opportunistic infections, neoplasia or the abnormal development of tumors, and a fatal outcome. Infection with the HIV virus involves various stages from testing positive for the AIDS virus, to AIDS-related complex (ARC), to the AIDS disease itself. According to the Centers for Disease Control guidelines, a diagnosis of AIDS is made when there is laboratory evidence of HIV infection coupled with certain indicator diseases or opportunistic infections. The indicator diseases include such conditions as esophageal candidiasis, Kaposi's Sarcoma, pneumocystis carinii pneumonia (PCP), HIV encephalopathy (AIDS dementia), or HIV wasting syndrome.

On March 20, 1987, the Food and Drug Administration (FDA) announced its approval of AZT under the brand name Retrovir, for the treatment of AIDS. The labeling approved by the FDA for AZT stated:

> Retrovir capsules are indicated for the management of certain adult patients with symptomatic HIV infection (AIDS and advanced ARC) who have a history of cytologically confirmed Pneumocystis carinii pneumonia (PCP) or an absolute CD4 (T4 helper/inducer) lymphocyte count of less than 200/mm in the peripheral blood before therapy is begun.

At the time this action was filed on July 6, 1987, the State of Missouri did not provide any Medicaid coverage for AZT. Three days after the suit was filed, the Missouri Department of Social Services promulgated an emergency rule, providing Medicaid coverage of AZT under certain diagnoses or conditions. Adopted as a permanent rule with minor modifications effective November 12, 1987, Missouri regulations now provide coverage for AZT as follows:

> The availability of the drug Zidovudine, formerly known as Azidothymidine, for Missouri Medicaid coverage shall be limited to only those eligible recipients for whom the prescribing physician has established a medical diagnosis of acquired immunodeficiency syndrome (AIDS) and who have a history of cytologically confirmed Pneumocystis carinii pneumonia (PCP) or an absolute CD4 (T4 helper/inducer) lymphocyte count of less than two hundred (200) per cubic millimeter in the peripheral blood before therapy is begun.

Mo.Code Regs. tit. 13, § 70-20.110. This language is virtually identical to FDA's approval statement for the drug.

At the present time, the drug AZT is the only approved treatment of AIDS or ARC. While there are treatments for particular opportunistic infections which the AIDS patient may develop, AZT is the only approved drug which acts on the HIV virus itself.

Although plaintiff Glenn Weaver, who had suffered from pneumocystis carinii pneumonia (PCP), became eligible for Medicaid coverage of AZT as a result of the change in the Missouri Medicaid rules, the present action was continued when other plaintiffs were granted leave to intervene. The new plaintiffs suffered with AIDS and certain AIDS indicator diseases, but did not meet the restricted medical conditions necessary for coverage of AZT under Missouri's Medicaid rule (history of PCP or an absolute CD4 lymphocyte count below 200). For example, plaintiff Mark Momot was diagnosed as infected with the AIDS virus and suffering from oropharyngeal/esophageal candidiasis, an AIDS indicator disease, as well as significant diarrhea, fever, sweats and lymphadenopathy. In order to prevent or retard the progres-

all persons within the jurisdiction of the United States).

Jurisdiction of this court is invoked pursuant to 28 U.S.C. § 1291.

sion of the disease to a more serious illness, his personal physician prescribed AZT. However, because Momot had no history of PCP and his CD4 count had not dropped below 200, Missouri Medicaid denied coverage of his AZT prescription because "he did not meet the diagnosis criteria set forth in the state regulation."

The case was submitted to the district court on cross-motions for summary judgment. On September 29, 1988, the district court granted plaintiffs' motion for summary judgment and certified the plaintiff class. 701 F.Supp. 717. The class so certified is defined as:

> All persons in Missouri who would have or will be determined eligible for Medicaid and who are infected with the [AIDS virus] and whose physicians have or will in the future prescribe the drug Retrovir for their treatment and who do not meet the medical criteria set forth in [Missouri's Medicaid rule] for Medicaid coverage of AZT.

The trial court held that defendants' rule limiting Medicaid coverage of AZT to only those recipients who meet certain diagnostic criteria or conditions violated federal Medicaid law, 42 C.F.R. §§ 440.230(b), 440.240(b), and 42 U.S.C. § 1983. The district court found that AZT is medically necessary treatment for individuals in the plaintiff class who do not fit within the restrictive criteria of Missouri's Medicaid rule. The court, therefore, enjoined Missouri officials from denying coverage of AZT to "persons eligible for Medicaid and infected with the AIDS virus."

II.

[1] In reviewing nonadjudicatory federal agency action, a court is limited to deciding whether the action is arbitrary, capricious, an abuse of discretion or otherwise not in accordance with the law. *See Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416, 91 S.Ct. 814, 823, 28 L.Ed.2d 136 (1971). "Although the answer is far from clear," at least one court has assumed without deciding that a court "is entitled to review the actions of a state agency administering federal Medicaid funding as it would review the actions of a federal agency." *Mississippi Hosp. Ass'n, Inc. v. Heckler*, 701 F.2d 511, 516 (5th Cir.1988). *See also Clallam County v. Washington State Dept. of Transp.*, 849 F.2d 424, 429 n. 7 (9th Cir.1988), *cert. denied*, — U.S. —, 109 S.Ct. 790, 102 L.Ed.2d 782 (1989).

[2] Title XIX of the Social Security Act, 42 U.S.C. §§ 1396–1396s, commonly known as the Medicaid Act, is a federal-state cooperative program designed to provide medical assistance to persons whose income and resources are insufficient to meet the costs of medical care. Although a state's participation is voluntary, once a state chooses to participate in the program it must comply with federal statutory and regulatory requirements, *Alexander v. Choate*, 469 U.S. 287, 289 n. 1, 105 S.Ct. 712, 714 n. 1, 83 L.Ed.2d 661 (1985); *Ellis v. Patterson*, 859 F.2d 52, 54 (8th Cir.1988); 42 U.S.C. § 1396a, including the requirement that participating states provide financial assistance for in-patient hospital services, out-patient hospital services, laboratory and x-ray services, skilled nursing facilities and physicians' services. *See* 42 U.S.C. § 1396a(a)(10) and § 1396d(a)(1)–(5).

[3] The participating state may also elect to provide other optional medical services such as prescription drugs. *See* 42 U.S.C. § 1396d(a)(12). Once a state chooses to offer such optional services it is bound to act in compliance with the Act and the applicable regulations in the implementation of those services, *see Ellis v. Patterson, supra*, 859 F.2d at 56; *Meyers v. Reagan*, 776 F.2d 241, 243 (8th Cir.1985), including the requirement that "[e]ach service must be sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b).

[4] Although a state has considerable discretion in fashioning its Medicaid program, the discretion of the state is not unbridled: "[A state] may not arbitrarily deny or reduce the amount, duration, or scope of a required service * * * to an otherwise eligible recipient solely because of the diagnosis, type of illness or condi-

tion." 42 C.F.R. § 440.230(c). "[A]ppropriate limits [may be placed] on a service based on such criteria as medical necessity or utilization control procedures." *Id.* at § 440.230(d). Moreover, the state's plan for determining eligibility for medical assistance must be "'reasonable' and 'consistent with the objectives' of the Act." *Beal v. Doe*, 432 U.S. 438, 444, 97 S.Ct. 2366, 2371, 53 L.Ed.2d 464 (1977) (quoting 42 U.S.C. § 1396a(a)(17)). This provision has been interpreted to require that a state Medicaid plan provide treatment that is deemed "medically necessary" in order to comport with the objectives of the Act. *See id.* at 444-45, 97 S.Ct. at 2370-71 ("serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage"); *Pinneke v. Preisser*, 623 F.2d 546, 548 n. 2 (8th Cir.1980).

[5] In the present case, defendants argue that their reliance on the FDA's approval statement in limiting coverage of AZT to only those patients who meet certain medical criteria is a reasonable exercise of their discretion to place limitations on covered services based on medical necessity and utilization controls. We do not find this argument persuasive.

Contrary to defendants' assertions, FDA approved indications were not intended to limit or interfere with the practice of medicine nor to preclude physicians from using their best judgment in the interest of the patient. Instead, the FDA new drug approval process is intended to ensure that drugs meet certain statutory standards for safety and effectiveness, manufacturing and controls, and labeling, 21 C.F.R. § 314.105(c) (1988), and to ensure that manufacturers market their drugs only for those indications for which the drug sponsor has demonstrated "substantial evidence" of effectiveness. *Id.* at § 314.126.

According to a drug bulletin issued by the FDA,

> The [Food, Drug and Cosmetic] Act does not, * * * limit the manner in which a physician may use an approved drug. Once a product has been approved for marketing, a physician may prescribe it for uses or in treatment regimens or patient populations that are not included in approved labeling. Such "unapproved" or, more precisely, "unlabeled" uses may be appropriate and rational in certain circumstances, and may, in fact, reflect approaches to drug therapy that have been extensively reported in medical literature.
>
> The term "unapproved uses" is, to some extent, misleading. It includes a variety of situations ranging from unstudied to thoroughly investigated drug uses * * *. [A]ccepted medical practice often includes drug use that is not reflected in approved drug labeling. With respect to its role in medical practice, the package insert is informational only.

"Use of Approved Drugs for Unlabeled Indications," 12 FDA Drug Bulletin 4 (April 1982).

Thus, the fact that FDA has not approved labeling of a drug for a particular use does not necessarily bear on those uses of the drug that are established within the medical and scientific community as medically appropriate. It would be improper for the State of Missouri to interfere with a physician's judgment of medical necessity by limiting coverage of AZT based on criteria that admittedly do not reflect current medical knowledge or practice.

It is also defendants' position on appeal that prescribing AZT outside the FDA approved indications is per se "experimental" in the sense that there is no scientific data derived from clinical trials documenting the efficacy and safety of AZT use outside the FDA guidelines. According to defendants, because such AZT use is experimental, it can never be deemed medically necessary treatment.

In our view, defendants' definition of "experimental" in this context is overly broad. In *Rush v. Parham*, 625 F.2d 1150 (5th Cir.1980), the Fifth Circuit, in considering the "experimental" nature of treatment for purposes of Medicaid coverage, defined "experimental" as a treatment not "generally accepted by the professional medical community as an effective and proven treatment for the condition" or "rarely