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Note

State Discretion in Funding Organ Transplants Under the Medicaid Program: Interpretive Guidelines in Determining the Scope of Mandated Coverage

C. David Flower

In 1992, Sheri Dexter died while waiting for an allogenic bone marrow transplant, the only treatment that her physicians believed could prevent leukemia from killing her. Sheri Dexter was waiting because she was in a court fight with the state of Arizona, which did not cover allogenic bone marrow transplants under her health care plan—the federal Medicaid program.2

In thirty years, the Medicaid program3 has become the second largest source of medical care in the United States, provid-

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1. Allogenic bone marrow transplants involve the replacement of the patient's bone marrow with donor marrow harvested from another person. Allogenic marrow transplants replace the patient's cancerous bone marrow after it has been destroyed by intensive chemotherapy. Dexter v. Kirschner, 972 F.2d 1113, 1115 (9th Cir.), modified, 984 F.2d 979 (9th Cir. 1992).
2. Id. at 1115-16. For a critique of the Ninth Circuit's decision in Dexter, see Richard H. Gastineau, Case Brief, Dexter v. Kirschner: Arizona's Medicaid Program and the Fundamental Right to Treatment, 2 J. Pharm. & L. 86 (1993).
ing services to more than thirty million people, nearly half of whom are children. In a context of burgeoning health care costs, some balance must be struck between access to services and states’ need to determine priorities for Medicaid dollars.


In 1991, of Americans with incomes below the federal poverty level, more than 47% received Medicaid. Approximately 13% of people living below the poverty line received health insurance through the Medicare program, and approximately 13% had health care coverage either through employment or some other source; more than 28% of the poor had no health care coverage at all. After employment-based coverage and Medicare, Medicaid is the third largest source of health care coverage in the United States. Id. at 47, 49. Given the death of comprehensive health care reform legislation in the 103d Congress, Medicaid is likely to remain the single largest source of health care for poor Americans into the foreseeable future. Thus, questions of Medicaid cost allocation seem likely to continue. For discussions of the demise of health care reform in 1994, see Monica Borkowski, The Health Care Debate: Chronology—High Fever to No Pulse, N.Y. Times, Sept. 27, 1994, at B10; Health Reform—Dead for Now, N.Y. Times, Sept. 27, 1994, at A24. On the other hand, Medicaid could well be changed considerably, both structurally and in the extent of its coverage, given the Republican takeover of Congress in the 1994 elections and increasing calls for restructuring of public welfare programs. See Carl M. Cannon, Congress Turns Debate to Welfare, Baltimore Sun, Jan. 15, 1995, at 1A; Peter G. Gosselin, Medicare, Medicaid Cuts Urged, Boston Globe, Jan. 8, 1995, at 1; Robert Pear, Welfare Debate Will Re-examine Old Assumptions, N.Y. Times, Jan. 2, 1995, at A1.


7. A spate of articles in this vein discuss the Oregon Medicaid “rationing” program proposal initially rejected by the HCFA during the Bush administration, but subsequently approved during the Clinton administration. See, e.g., Michael J. Astrue, Pseudoscience and the Law: The Case of the Oregon Medicaid Rationing Experiment, 9 Issues L. & Med. 375 (1994) (criticizing the Oregon plan as an unscientific and unjustified rationing plan that uses abhorrent “quality of life” assumptions); Sara Rosenbaum, Mothers and Children Last: The Oregon Medicaid Experiment, 18 Am. J.L. & Med. 97 (1992) (criticizing the Oregon plan’s potential curtailment of services for poor women and children); Robert L. Schwartz, Medicaid Reform Through Setting Health Care Priorities, 35 St. Louis U. L.J. 837 (1991) (defending the Oregon plan as a reasonable effort to provide basic medical care to the largest possible number of people).

The political, economic, and ethical issues involved in the allocation of limited public resources are beyond the scope of this Note, but see generally Guido Calabresi & Philip Bobbit, Tragic Choices (1978). For a discussion of allocation issues in the area of organ transplantation, see H. Tristram Engelhardt,
Although organ transplants are often the only hope for desperately ill people, they are also often risky, new, and enormously expensive.\textsuperscript{8} Tragedies such as Sheri Dexter's are perhaps the starkest illustration of the "tragic choices\textsuperscript{9}" that the federal and state governments must make in allocating finite public resources for health care.

In recent years, the federal courts have struggled to define the obligation of states to provide Medicaid funds for transplants. Two circuits have held that states have complete discretion in transplant funding decisions,\textsuperscript{10} while two other circuits have held or suggested that the Medicaid statute requires states to fund transplants for Medicaid recipients who need them.\textsuperscript{11} This Note examines the difficulty in determining the scope of mandated coverage under the Medicaid program, focusing on the split among the circuits over the obligations of states to fund organ transplant procedures. Part I describes the structure of the Medicaid program and the services that it provides. Part II describes judicial efforts to determine the obligations of states to fund transplants. Part III critiques these opinions and suggests that, by and large, the courts have pursued the wrong interpretive questions. Part IV argues for a dynamic interpretive approach to Medicaid scope-of-coverage disputes that recognizes the evolutive nature of medical technology in the context of the multiple, changing, and sometimes contradictory goals and features of the Medicaid program. This Note concludes by suggesting a view of Medicaid coverage issues that not only protects beneficiaries against arbitrary denial of service, but also realisti-
cally reserves to states a large measure of administrative discretion.

I. THE STRUCTURE AND FINANCING OF THE MEDICAID PROGRAM

Medicaid, contained in Title XIX of the Social Security Act, is a cooperative program between the federal government and the individual states. The Medicaid program pays for certain health care expenses for qualifying low-income or disabled persons. At the federal level, the Health Care Financing Administration (HCFA) of the Department of Health and Human Services administers the program. States may choose whether to participate in the Medicaid program, although all states participate to some extent. To participate, states must develop and HCFA must approve a "state plan" setting forth eligibility and coverage criteria that are in accordance with the federal statute. Once HCFA approves the state plan, the state must abide by the terms of Title XIX.

Under Title XIX, the primary responsibilities of the federal government are to set broad policy, ensure state compliance with the statute, and provide federal funds to supplement state spending on Medicaid. Federal spending on Medicaid has in-
creased nearly a hundredfold since 1966.18 State Medicaid spending has increased even more sharply,19 and Medicaid costs comprise an ever-increasing proportion of state budgets.20 Although all states have experienced increased Medicaid costs, state expenditures per recipient vary significantly.21

A. ELIGIBILITY

The eligibility provisions for Medicaid are exceedingly complex, and Congress has modified them frequently since the program's inception.22 Title XIX establishes two basic eligibility groups: the "categorically needy" and the "medically needy." The categorically needy23 include persons receiving cash assist-

reference to states' per capita income; the federal match can range from 50% to 83%. GREEN BOOK, supra note 4, at 789. In 1992, the federal match ranged from 50% in 11 states (primarily on the coasts) to 79.99% in Mississippi. ADVISORY COMM’N ON INTERGOVERNMENTAL RELATIONS, MEDICAID: INTERGOVERNMENTAL TRENDS AND OPTIONS 17 (Pub. No. A-119) (1992) [hereinafter MEDICAID TRENDS AND OPTIONS].

18. In 1966, the federal government spent approximately $790 million on Medicaid; HCFA projects federal costs of over $96 billion in 1995. GREEN BOOK, supra note 4, at 789.

19. In 1966, state Medicaid spending totaled less than $90 million. State costs in 1995 will likely total more than $72 billion. Id.

20. Medicaid consumed less than 3% of state fixed-cost expenditures in 1966, but nearly 15% in 1990. MEDICAID TRENDS AND OPTIONS, supra note 17, at 26.

21. MEDICAID SOURCE BOOK, supra note 5, at 115-21; GREEN BOOK, supra note 4, at 811-12. In fiscal year 1992, state expenditures per recipient averaged just under $3000; however, state spending per recipient ranged from $520 in Arizona to nearly $6000 in New York. Id. at 811.

22. One commentator, describing the overwhelming complexity of the statute in general, has noted that the "Medicaid statute has been described as 'blyzantine' (by Justice Powell), 'a morass of bureaucratic complexity' (by Chief Justice Burger), 'almost unintelligible to the uninitiated' (by Judge Friendly), 'an aggravated assault on the English language, resistant to attempts to understand it' and a 'Serbian bog.'" Schwartz, supra note 7, at 837-38 (citations omitted).

23. 42 U.S.C. § 1396a(10)(A) (1988 & Supp. IV 1992); 42 C.F.R. § 435.4 (1993). The "categorically needy" eligibility group includes two subgroups. The "mandatory categorically needy" subgroup includes recipients of AFDC or SSI or individuals who meet other criteria specified by Title XIX; states must offer Medicaid coverage to such individuals. 42 U.S.C. § 1396a(a)(10)(A)(i) (1988 & Supp. IV 1992); 42 C.F.R. §§ 435.1(b)(1), 435.100-.170 (1993). The Medicaid program defines the "optionally categorically needy" subgroup by a number of other criteria, but this eligibility group typically includes persons who are financially eligible for AFDC or SSI but are ineligible for other reasons; states have discretion to offer or deny Medicaid coverage to these individuals. 42 U.S.C. § 1396a(a)(10)(A)(ii) (1988 & Supp. IV 1992); 42 C.F.R. §§ 435.1(b)(2), 435.200-.238 (1993). For example, under § 1396a(a)(10)(A)(iii), states with relatively restrictive criteria for AFDC eligibility may choose to offer Medicaid
ance through Aid to Families with Dependent Children (AFDC)\(^2\) or Supplemental Security Income (SSI),\(^2\) as well as persons who are blind or severely disabled.\(^2\) In the 1980s, Congress amended the statute several times to expand “categorically needy” eligibility to include additional low-income persons, particularly women and children.\(^2\)

Title XIX grants states discretion to extend eligibility to persons who meet the “medically needy” eligibility criteria.\(^2\) Generally, medically needy recipients have income and resources that are too high to meet AFDC or SSI eligibility criteria, but are insufficient to meet medical costs.\(^2\) In most states, persons become eligible as medically needy by “spending down,” that is, by reducing assets to eligibility levels by spending on medical care.\(^2\) States have discretion to set their own criteria for the coverage to individuals who do not meet state criteria for AFDC eligibility but who would qualify if the state extended AFDC eligibility to the full extent allowed by federal law. GREEN BOOK, supra note 4, at 784. Although such a state does not have to provide Medicaid to such persons, if the state does so provide services, it may not treat those persons differently with respect to coverage than persons qualifying as “mandatory categorically needy.” 42 U.S.C. § 1396a(a)(B) (1988); see also infra note 38 and accompanying text (discussing services that must be offered to all categorically needy recipients).

25. Id. §§ 1381-1383d. Section 1396a(f) of Title XIX permits some states, known as “section 209(b) states,” to use more restrictive criteria for eligibility than the SSI criteria. Twelve states currently have 209(b) status. GREEN BOOK, supra note 4, at 785.
26. 42 U.S.C. § 1396d(q)(2) (1988). An applicant who is determined to be a “qualified severely impaired individual” is eligible for Medicaid regardless of income. An applicant qualifies under § 1396d(q)(2) if he or she is “blind or continues to have the disabling physical or mental impairment on the basis of which he [or she] was found to be under a disability and, except for his [or her] earnings, continues to meet all non-disability-related requirements for eligibility for benefits.” Id. Medicaid thus constitutes a significant source of health care for persons with disabilities. In fiscal year 1992, approximately 4.4 million persons received Medicaid coverage on the basis of blindness or disability. GREEN BOOK, supra note 4, at 800.
27. See MEDICAID SOURCE BOOK, supra note 5, at 35-37; Kinney, supra note 13, at 866.
30. GREEN BOOK, supra note 4, at 787; MEDICAID TRENDS AND OPTIONS, supra note 17, at 11. Most Medicaid expenditures for the medically needy are for long-term institutional care such as nursing homes. Id. (“As a practical matter, the medically needy program is primarily a benefit for institutionalized elderly and disabled persons.”) (quoting CONGRESSIONAL RESEARCH SERV., 100TH CONG., 2D SESS., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 70 (1988)). Spending on the medically needy comprises a disproportionate share of Medicaid expenditures. In fiscal year 1992, per capita spending for the categorically needy totaled approximately $2500, but nearly $4800 for the med-
medically needy, within statutory guidelines.31 States have complete freedom under the statute not to extend eligibility to the medically needy at all, so long as they provide services to those who qualify as categorically needy.32

Because states may set their own eligibility standards under the AFDC program,33 the number and characteristics of categorically needy Medicaid recipients vary widely among the states.34 The states also differ significantly in providing Medicaid to medically needy recipients, with some states offering relatively expansive eligibility criteria35 and other states not recognizing medically needy eligibility at all.36

B. SERVICES MEDICAID PROVIDES

Title XIX not only describes the general criteria for Medicaid eligibility, but also describes services that the program may provide.37 The statute requires states to provide to all "categorically needy" persons several different types of medical services.38 For the most part, the statute defines these mandatory services. GREEN BOOK, supra note 4, at 803. The high cost of institutional care causes this disparity: nursing home services (primarily used by the elderly medically needy) averaged more than $12,000 per person in 1990. MEDICAID TRENDS AND OPTIONS, supra note 17, at 36. The most costly service, institutional care facilities for persons with mental retardation (ICF/MR), averaged more than $50,000 per recipient in 1990; such facilities serve comparatively few persons. Id.

31. 42 C.F.R. § 435.811 (1993). States typically tie criteria for eligibility as medically needy to family income, which may not exceed 1331/3% of the state's maximum payment under its AFDC program for a family of the same size. Id.

32. In 1993, 15 states did not extend coverage to any persons deemed "medically needy" (Alabama, Alaska, Arizona, Colorado, Delaware, Idaho, Indiana, Mississippi, Missouri, Nevada, New Mexico, Ohio, South Carolina, South Dakota, and Wyoming). GREEN BOOK, supra note 4, at 787.

33. MEDICAID TRENDS AND OPTIONS, supra note 17, at 10.

34. MEDICAID SOURCE BOOK, supra note 5, at 117. "Because states have great flexibility in structuring eligibility, benefits, coverage, and payment policies, the Medicaid program is really 50 very different programs serving different populations and providing different benefits." Kinney, supra note 13, at 857.

35. MEDICAID SOURCE BOOK, supra note 5, at 117-18.

36. See supra note 32 (listing states that do not extend eligibility to "medically needy").


38. 42 U.S.C. § 1396a(10)(A) (Supp. IV 1992) requires that state plans provide "for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21)" of 42 U.S.C. § 1396d(a) to all "categorically needy" recipients. These sections make the following service categories mandatory for categorically needy recipients: inpatient hospital services, outpatient hospital services, laboratory and X-ray services, nursing home services for recipients over age 21, early and periodic
services by general categories, such as "inpatient hospital services," rather than by specific procedures. Title XIX also describes a number of optional medical services that states may choose to offer, if the state plan describes those services and if they are otherwise delivered in accordance with the terms of the statute.

States have wide latitude to limit provision of Medicaid services. At the broadest level, states have almost complete freedom to design their own mix of optional services, or may even choose to provide none of the optional services enumerated in Title XIX. States may also choose to provide fewer optional screening, diagnostic, and treatment services (EPSDT) for children under age 21, family planning services and supplies, physicians' services, nurse-midwife services, and services provided by pediatric nurse practitioners and family nurse practitioners. Id.

The early and periodic screening, diagnostic and treatment service category (EPSDT) of Title XIX, added to the Act in 1989, Pub. L. No. 101-239, § 6403, 103 Stat. 2106, 2262-64 (codified at 42 U.S.C. § 1396d(r) (Supp. IV 1992)), has played an important role in cases involving organ transplant coverage. EPSDT services are mandatory for all Medicaid recipients under age 21, and must include reasonable medical, dental, vision, hearing, and mental health screening services, as well as immunizations and laboratory tests. 42 U.S.C. § 1396d(r). The EPSDT provision also requires states to provide treatment for any condition discovered through such screening "whether or not such services are covered under the State plan." Id. § 1396d(r)(5). See infra notes 92-96 and accompanying text (discussing the Fourth Circuit's view of the effect of the EPSDT provision on coverage of transplants); infra note 108 and accompanying text (discussing the Eleventh Circuit's view of the EPSDT provision in a transplant coverage case).


40. For example, Medicaid would cover corrective surgery for a gastric ulcer because it is an "inpatient hospital service," which is a mandated service category under Title XIX, even though the statute does not mention "ulcer surgery," or even "surgery," as a mandated service.

41. Title XIX lists the following optional service categories: medical services provided by non-physicians; home health care services; private duty nursing services; clinic services; dental services; physical therapy and related services; prescription drugs, dentures, prosthetics, and eyeglasses; other diagnostic screening, preventive and rehabilitative services for physical or mental disabilities; institutional care for persons with "mental diseases"; intermediate care facilities for persons with mental retardation; inpatient psychiatric services for persons under 21; hospice care; case management services; respiratory care services; other medical or remedial care specified by the Secretary of Health and Human Services; home and community based services for the elderly; and supported living services for persons with disabilities. 42 U.S.C. § 1396d(a)(6)-(16), (18)-(20), (22)-(24) (1988 & Supp. IV 1992). These services are optional because § 1396a(10)(A) does not include these services as medical assistance that a state must provide.

42. MEDICAID TRENDS AND OPTIONS, supra note 17, at 11. As of October 1, 1991, all states provided at least some optional services. State coverage of optional services ranged from a low of 14 covered services (in Alabama, Georgia,
services to the medically needy than to the categorically needy, or to place greater limitations on services to the medically needy.\textsuperscript{43} Title XIX requires states, however, to insure that services to the categorically needy are at least as extensive as those offered to the medically needy, and prohibits states from making distinctions among recipients qualifying as categorically needy.\textsuperscript{44} Furthermore, HCFA regulations require that services be "sufficient in amount, duration, and scope to reasonably achieve [their] purpose[s]"\textsuperscript{45} and prohibit states from "arbitrarily deny[ing] or reduc[ing] the amount, duration, or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition."\textsuperscript{46} Finally, courts have generally followed Supreme Court dicta\textsuperscript{47} that indicate that, absent some other exception, states must fund all medically necessary services within mandated service categories and within optional service categories that they elected to provide.\textsuperscript{48}

\begin{itemize}
\item and Louisiana) to 30 (in California and Wisconsin). \textit{Medicaid Source Book}, \textit{supra} note 5, at 257. A number of states offer optional services to categorically needy recipients, but not to medically needy recipients. \textit{Id.} States that choose to offer some services to the medically needy must, however, offer a small number of particular services, including prenatal care and birth delivery services and certain institutional services to persons with mental illness or mental retardation. \textit{Medicaid Trends and Options}, \textit{supra} note 17, at 11; see also \textit{Medicaid Source Book}, \textit{supra} note 5, at 257 (providing table of optional services); \textit{Green Book}, \textit{supra} note 4, at 787 (discussing mandatory pregnancy services).
\item \textit{Medicaid Source Book}, \textit{supra} note 5, at 257; \textit{Green Book}, \textit{supra} note 4, at 787.
\item \textit{42 U.S.C.} § 1396a(a)(10)(B) (1988). For example, although some categorically needy recipients are "optionally" categorically needy, if a state chooses to extend eligibility to some optionally categorically needy persons, the services it provides must be the same as those it offers to "mandatory" categorically needy persons. See \textit{supra} note 23 (discussing difference between "optionally" and "mandatory" categorically needy categories).
\item \textit{42 C.F.R.} § 440.230(b) (1993).
\item \textit{Id.} § 440.230(c).
\item "Although serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary—though perhaps desirable—medical services." \textit{Beal v. Doe}, 402 U.S. 438, 444-45 (1977).
\item \textit{See, e.g.}, \textit{Weaver v. Reagan}, 886 F.2d 194, 198, 200 (8th Cir. 1989) (holding that a state may not deny reimbursement for medically necessary drug treatment for HIV/AIDS); \textit{Meyers by Walden v. Reagan}, 776 F.2d 241, 243-44 (8th Cir. 1985) (holding that a state may not arbitrarily deny funds for medically necessary electronic communications device when it has chosen to fund physical therapy services); \textit{Roe v. Casey}, 623 F.2d 829, 839 (3d Cir. 1980) (asserting that \textit{Beal} dicta reflect purpose of Medicaid to provide all medically nec-
\end{itemize}
Although Title XIX labels certain services as “mandatory,” courts have permitted states to restrict provision of those services as well.49 The Supreme Court has held that states are not obligated under the Medicaid statute to fund services or procedures for which federal funds are prohibited.50 The Court has

necessary services in mandatory service categories); Pinneke v. Preisser, 623 F.2d 546, 549 (8th Cir. 1980) (holding that state may not deny funding for sex reassignment surgery because the surgery is medically necessary and exclusion resulted from an improper denial of funding based on “diagnosis, type of illness, or condition”); Planned Parenthood of Missoula, Inc. v. Blouke, 858 F. Supp. 137, 141 (D. Mont. 1994) (holding that a state may not deny funding for abortions when the attending physician’s medical judgment indicates the procedure is necessary to protect the patient’s “physical, emotional, psychological, [and] familial needs”) (quoting Doe v. Bolton, 410 U.S. 179, 192 (1973)); Montoya v. Johnston, 654 F. Supp. 511, 514 (W.D. Tex. 1987) (holding that the state must not set “arbitrary and unreasonable” payment caps that serve to deny medically necessary services to eligible Medicaid recipients); Allen v. Mansour, 681 F. Supp. 1232, 1238-39 (E.D. Mich. 1986) (holding that a state’s denial of medically necessary liver transplant for recipient suffering from alcoholic cirrhosis was arbitrary and unreasonable and therefore violated the Act). But cf. Preterm, Inc. v. Dukakis, 591 F.2d 121, 125 (1st Cir.) (asserting that Beal dicta do not require a “flat rule that all services within the five general categories deemed ‘medically necessary’ by a patient’s physician must be provided by the State plan”), cert. denied, 441 U.S. 952, and cert. denied, 441 U.S. 952 (1979).

Courts have also struck down state caps on payment for mandated services, when the cap is so low as to effectively prevent any health provider from providing the service. See, e.g., Mitchell v. Johnston, 701 F.2d 337, 352 (5th Cir. 1983) (invalidating Texas’s elimination and limitation of preventive dental services mandated by Title XIX EPSDT provisions); Montoya, 654 F. Supp. at 514 (striking down Montana’s $50,000 cap on payment for liver transplants, when actual cost was estimated at greater than $200,000).


50. “Title XIX does not require a participating State to include in its plan any services for which . . . Congress has withheld federal funding.” Harris v. McRae, 448 U.S. 297, 309 (1980). In Harris, the Court held that, when Congress had barred the use of federal Medicaid funds for most abortions, states were not required under Title XIX to pay for abortions for which federal funds were withheld. Id. at 310-11. The Court has decided very few cases that involved the scope of coverage provided to Medicaid recipients under Title XIX; almost all of the Court’s decisions in this area came in the late 1970s and early
also held that although states generally must provide all medically necessary services, states may place constraints on the determination of medical necessity.\textsuperscript{51} Similarly, states may place some limits on use of mandatory services, such as caps on the number of days of inpatient hospitalization.\textsuperscript{52} Furthermore, HCFA has determined that "experimental" procedures are per se outside the definition of "medical necessity" and therefore will not provide federal funds for such procedures.\textsuperscript{53} Although Title XIX makes no mention of an exception for experimental procedures and HCFA has never defined "experimental" by formal rule, courts have generally followed HCFA's informal definition: experimental procedures are those that are "rarely used, novel or relatively unknown" and which lack "authoritative evidence" of safety and effectiveness.\textsuperscript{54}


\textsuperscript{51. Beal, 432 U.S. at 444, 446 n.10, 447 (holding that a state may prohibit funding of "nontherapeutic" abortions, even though family planning services are a mandated service under Title XIX).}

\textsuperscript{52. See, e.g., Charleston Memorial Hosp. v. Conrad, 693 F.2d 324, 329-30 (4th Cir. 1982) (holding that a state could impose yearly limit on number of days of inpatient hospital coverage); Curtis v. Taylor, 625 F.2d 645, 652-53 (5th Cir.) (holding that state may limit number of physician visits), modified, 648 F.2d 946 (5th Cir. 1980); Virginia Hosp. Ass'n v. Kenley, 427 F. Supp. 781, 786 (E.D. Va. 1977) (holding that state could impose 21-day limit on inpatient hospital care). In Alexander v. Choate, the Supreme Court upheld a challenge under the federal Rehabilitation Act to a 14-day cap on Medicaid-provided inpatient hospital services. 469 U.S. 287, 309 (1985). The Court, although noting Conrad and other cases, did not expressly reach the question of whether or when Title XIX permits such limits. Id. at 303 & n.23. In discussing the scope of coverage provided by Medicaid, however, the Court noted:}

\textquote{Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services...[that] has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered—not "adequate health care."}

\textquote{Id. at 303.}

\textsuperscript{53. Enclosure No. 2 to Intermediary Letters Nos. 77-4 & 77-5, [1976 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 28,152, at 10,603.}

\textsuperscript{54. Id.; see also Miller by Miller v. Whitburn, 10 F.3d 1315, 1320-21 (7th Cir. 1993) (reinforcing that a state may refuse to fund liver-bowel transplant if determined to be experimental); Rush v. Parham, 625 F.2d 1150, 1156-57 (5th Cir. 1980) (holding that state may prohibit gender reassignment surgery if it makes a reasonable determination that the surgery is experimental). The issue of Medicaid funding of experimental or investigational medical procedures is complex. No provision in Title XIX or in HCFA regulations explicitly bars funding for such procedures, or even defines "experimental" or "investigational."}
C. MEDICAID FUNDING FOR ORGAN TRANSPLANTS

In the words of Chief Judge Arnold of the Eighth Circuit, "organ transplants are a special situation" under Title XIX.55 Until 1985, Title XIX contained no specific provisions relating to Medicaid funding for organ transplant surgery. In 1985, Congress amended Title XIX to provide criteria for federal financial participation for transplants provided under state plans.56 The organ transplant provision, located at 42 U.S.C. § 1396b(i)(1),

Despite this, HCFA takes the position that Title XIX bars federal financial participation for such procedures, and appears willing to give the states discretion to determine which procedures are considered experimental. Courts facing issues in this area have little guidance, and apply varying depths of review in attempting to determine whether a state's determination that a procedure is "experimental" is reasonable. Compare Rush, 625 F.2d at 1156-57 (holding that courts should defer to a state's determination that transsexual surgery is experimental if that determination is reasonable) with McLaughlin v. Williams, 801 F. Supp. 633, 638-44 (S.D. Fla. 1992) (conducting detailed review and invalidation of state's determination that liver-bowel transplant was experimental).

For a discussion of judicial review in this area in both public and private health care systems, see Richard S. Saver, Note, Reimbursing New Technologies: Why Are the Courts Judging Experimental Medicine?, 44 STAN. L. REV. 1095, 1098-1104 (1992) (concluding that judicial response to the dilemmas embodied in experimental exclusion cases has been inadequate).

55. Ellis by Ellis v. Patterson, 859 F.2d 52, 54 (8th Cir. 1988).

(i) Payment for organ transplants; item or service furnished by excluded individual, entity, or physicians; other restrictions

Payment under the preceding provisions of this section [describing federal financial participation in state Medicaid expenditures] shall not be made—

(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

(A) similarly situated individuals are treated alike; and

(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan.

42 U.S.C. § 1396b(i) (1988). In addition to adding the organ transplant provision, Congress substantially modified eligibility standards and other provisions of Title XIX in the COBRA 1985 amendments. These changes included the expansion of optional coverage for pregnant women and children, the addition of new optional medical services, and the establishment of requirements for stronger regulation of intermediate care facilities for persons with mental retardation. Kinney, supra note 13, at 877; see also infra text accompanying notes 174-176 (describing COBRA 1985 amendments to Title XIX). Congress amended the transplant provision slightly in the Omnibus Budget Reconcilia-
requires states to develop written standards for coverage of transplants, to treat similarly situated individuals alike with respect to those standards, and to insure that state guidelines do not interfere with quality of care.\textsuperscript{57} HCFA asserts that organ transplants are optional services under Title XIX,\textsuperscript{58} although it has never promulgated a rule on this issue.\textsuperscript{59}

Coverage of organ transplants by the states varies widely.\textsuperscript{60} Almost all of the states provide funding for the most established transplant procedures, such as heart, kidney, and liver transplants, at least for categorically needy beneficiaries who meet state criteria.\textsuperscript{61} States are less likely to fund newer procedures, such as heart-lung transplants.\textsuperscript{62} In addition, some states fund some transplants for categorically needy recipients, but not for the medically needy.\textsuperscript{63} States have also set restrictions on the

\textsuperscript{57} See supra note 56 (quoting the text of the provision). The HCFA implementing regulations for § 1396b(i)(1) adopt the statutory language almost verbatim. See 42 C.F.R. § 441.35 (1993). The regulations state in addition that the statutory and regulatory guidelines for federal financial participation in transplants do not "permit[] a State to provide, under its plan, services that are not reasonable in amount, duration, and scope to achieve their purpose." 42 C.F.R. § 441.35(b) (1993).

\textsuperscript{58} Medicaid Program; Early and Periodic Screening, Diagnosis, and Treatment Services Defined, 58 Fed. Reg. 51288, 51293 (1993) ("Organ transplants are not explicitly included as a service under the definition of 'medical assistance' in [§ 1396b(i) of Title XIX] of the Act, which describes those items and services not subject to payment under State plans, makes organ transplants optional."); see also Medicaid Source Book, supra note 5, at 292 ("Individual states can make their own decisions with respect to coverage of transplants under Medicaid, provided certain requirements are met.").

\textsuperscript{59} The only HCFA rulemaking in regard to Medicaid funding of transplants is 42 C.F.R. § 441.35 (1993), which merely tracks the language of the transplant provision in Title XIX. See supra note 57.

\textsuperscript{60} Medicaid Source Book, supra note 5, at 292-94.

\textsuperscript{61} Id. at 293-94. In 1990, of the 50 states and the District of Columbia, 39 provided reimbursement for heart transplants, 47 for liver transplants, and 49 for kidney transplants. Id. at 294-95. In 1990, Wyoming stood alone in offering no transplant reimbursement of any sort. Id. at 285.

\textsuperscript{62} In 1990, 23 states reimbursed heart-lung transplants, 15 reimbursed lung transplants, and only 12 reimbursed pancreas transplants. Id. at 294-95.

types of medical conditions that will trigger reimbursement for transplant procedures, and have funded some organ transplants while choosing not to fund transplants of the same organ that use different technologies or procedures.

II. THE EXTENT OF STATE DISCRETION: THE SPLIT AMONG THE CIRCUITS

Since 1988, five United States Circuit Courts of Appeals have considered the extent to which the Medicaid statute requires states to fund organ transplants. The Eighth and Ninth Circuits have held that states have complete discretion in choosing which transplants, if any, to include in state Medicaid plans. The Fourth Circuit has held that states do not have specific statutory discretion to deny transplants for needy recipients. The Eleventh Circuit has held states must pay for transplants for children who receive Medicaid. The Seventh Circuit has avoided decision on this question by resolving a transplant coverage dispute on other grounds. Currently, therefore, the scope of discretion states have in transplant funding decisions is quite muddled, and judicial opinion is unsettled in general on how best to deal with scope of coverage issues involving innovative medical technologies in the cooperative federalism context of the Medicaid program.

64. Such restrictions, however, may well prove vulnerable to HCFA rules that prohibit denial of services "to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." 42 C.F.R. § 440.230(c) (1993). See, e.g., Pinneke v. Preisser, 623 F.2d 546, 549 (8th Cir. 1980) (holding that denial of funding for sex reassignment surgery was impermissibly based on diagnosis).

65. See, e.g., Dexter v. Kirschner, 972 F.2d 1113, 1120-21 (9th Cir.) (permitting state's denial of funding for allogenic bone marrow transplants under Title XIX, even though state did fund autologous bone marrow transplants), modified, 984 F.2d 979 (9th Cir. 1992).

66. Id. at 1117; Meusberger v. Palmer, 900 F.2d 1280, 1282 (8th Cir. 1990); Ellis by Ellis v. Patterson, 859 F.2d 52, 53 (8th Cir. 1988).

67. Pereira by Pereira v. Kozlowski, 996 F.2d 723, 727 (4th Cir. 1993). As discussed infra note 96, the Fourth Circuit's precise holding in Pereira is somewhat confusing. It is, however, safe to say that the Fourth Circuit specifically rejected Ellis, Meusberger, and Dexter. Pereira, 996 F.2d at 726.

68. Pittman by Pope v. Secretary, Fla. Dept't of Health & Rehab. Servs., 998 F.2d 887 (11th Cir.) (per curiam), cert. denied, 114 S. Ct. 650 (1993).

69. Miller by Miller v. Whitburn, 10 F.3d 1315, 1321 (7th Cir. 1993).
A. THE EIGHTH AND NINTH CIRCUITS: STATES HAVE COMPLETE DISCRETION IN TRANSPLANT FUNDING

In 1988, the Eighth Circuit became the first federal appellate court to reach a decision on state discretion in transplant funding in Ellis by Ellis v. Patterson. Brandy Ellis was a ten-month-old girl who suffered from biliary atresia, a liver condition that was likely to kill her in less than a year unless she received a liver transplant. The Arkansas Medicaid program denied assurance of payment for a transplant because the state had not chosen to fund liver transplants under its state plan. The Eighth Circuit held that the organ transplant provision, § 1396b(i)(1) of Title XIX, gives states discretion to choose “to fund organ transplants under Medicaid, and . . . [to] choose which kinds of organ transplants, if any, to cover.”

The court recognized that § 1396b(i)(1) could “be read as merely laying out additional standards the states must meet to receive federal funds for organ transplants,” rather than as an affirmative grant of discretion. The court, however, relied on the legislative history of the 1987 amendments of § 1396b(i)(1) in concluding that Congress’s intent in enacting the provision was to grant states discretion in transplant funding. The court re-

70. Ellis, 859 F.2d at 53.

Earlier in 1988, the Fourth Circuit had enjoined Virginia to provide Medicaid funding for a liver transplant for a four-year-old girl in Todd by Todd v. Sorrell, 841 F.2d 87, 90 (4th Cir. 1988). The plaintiff, who needed a liver transplant because of her condition of secondary biliary cirrhosis, had argued that Virginia’s state plan violated § 1396b(i)(1) because it funded liver transplants only for persons with a diagnosis of extrahepatic biliary atresia. Id. at 89. The court, however, declined to rule on the validity of Virginia’s criteria, reaching instead the rather odd conclusion that the plaintiff had “substantially complied” with the state’s criteria because secondary biliary cirrhosis was sufficiently comparable to extrahepatic biliary atresia. Id. at 89, 90.

71. Ellis, 859 F.2d at 53.

72. Id. at 54. At the time, Arkansas provided for cornea transplants and renal (kidney) transplants under its Medicaid plan. Ellis by Ellis v. Patterson, 713 F. Supp. 292, 295 (E.D. Ark.), vacated, 859 F.2d 52 (8th Cir. 1988). In earlier proceedings, Judge Arnold had granted an emergency injunction ordering the state to assure payment so that Brandy Ellis could have her transplant surgery. Ellis, 859 F.2d at 53 n.2; see also infra text accompanying note 199 (quoting from Judge Arnold’s grant of injunction).

73. See supra note 56 for the text of the transplant provision.

74. Ellis, 859 F.2d at 55.

75. Id. This one sentence comprised the court’s full discussion of the statutory text. The statutory provision on transplants appeared only in a footnote, with no commentary. Id. at 55 n.6.

76. Id. at 55. The court cited the House Report and the House Conference Report for the Omnibus Reconciliation Act of 1987, Pub. L. No. 100-203, § 4118,
jected Ellis’s assertion that if Congress had wanted to grant states discretion, it would have done so explicitly. The court also reasoned that state discretion in this area was “consistent with the policy behind the Medicaid Act.” Finally, the court noted that other circuits had upheld state limitations on funding of medically necessary procedures, and that it would be “unrealistic” to interpret Title XIX to require states to fund expensive and risky procedures such as organ transplants. The

101 Stat. 1330, which contained the amendments to the Medicaid statute. Ellis, 859 F.2d at 55. The court cited the following language in the House Report:

To assure that State coverage decisions for organ transplants are based on clear principles consistently applied, and not on political or media considerations, section 9507 of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), P.L. 99-272 [which first enacted the transplant provisions], requires that a State which covers organ transplant procedures set forth under its Medicaid plan written standards respecting the coverage of such procedures. Under these standards, similarly situated individuals must be treated alike.


(e) Organ Transplant Technical—States which choose to cover organ transplant procedures may restrict the facilities or practitioners from whom Medicaid beneficiaries may obtain the services, so long as the restrictions are consistent with accessibility of high quality care, and so long as similarly situated individuals are treated alike.


77. Ellis, 859 F.2d at 55.
78. Id.
79. Id.
80. The court stated:

[W]e think plaintiff’s position that all organ transplants (including hearts and lungs) must be covered by Medicaid is unrealistic. Surely Congress did not intend to require the states to provide funds for exotic surgeries which, while they might be the individual patient’s only hope for survival, would also have a small chance of success and carry an enormous price tag. Medicaid was not designed to fund risky, unproven procedures, but to provide the largest number of necessary medical services to the greatest number of needy people.

Id. at 55.

The “risky, unproven” surgery with “small chance of success” sought by Brandy Ellis was nonetheless noted by the court to have “a 90% chance [of allowing her] to live an active and normal life for the next five years.” Id. at 53, 55 (footnote omitted); see also infra text accompanying notes 143-156 (critiquing this tension and the interpretive assumption that leads to it).

Despite the Eighth Circuit’s holding on the meaning of § 1396b(i)(1), Brandy Ellis did receive assurance that her transplant would be funded. Five days before the court heard the appeal, Judge Arnold issued an injunction directing the state to give assurance of payment to Brandy’s medical provider to keep her on a waiting list for transplant surgery. Ellis, 859 F.2d at 53 n.2. Furthermore, the state of Arkansas changed its state plan prior to Ellis’s appeal, and began to fund some liver transplants; the Eighth Circuit, after declar-
Eight Circuit reaffirmed its view of complete state discretion in coverage of transplants in 1990.\textsuperscript{81}

In 1992, the Ninth Circuit adopted and extended the holding of Ellis in \textit{Dexter v. Kirschner}.\textsuperscript{82} In \textit{Dexter}, Arizona denied Medicaid funding for an allogenic bone marrow transplant to treat the plaintiff's leukemia.\textsuperscript{83} The Ninth Circuit upheld the

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\textsuperscript{81} Meusberger v. Palmer, 900 F.2d 1280, 1282 (8th Cir. 1990). Although the court in \textit{Meusberger} reiterated that states may choose to fund some or no transplants, its opinion reflects the uneasiness that courts have in denying lifesaving medical care under Medicaid. The plaintiff in \textit{Meusberger} required a pancreas transplant. The state of Iowa had chosen to fund only those organ transplants "designated nonexperimental by Medicare." \textit{Id.} at 1282 n.4. Because HCFA determined that pancreas transplants were investigational and, thus, not covered under Medicare, the state refused to fund pancreas transplants under its Medicaid plan. \textit{Id.} at 1283. The Eighth Circuit affirmed the District Court's finding that pancreas transplants were not "experimental," despite HCFA's determination not to fund pancreas transplants under Medicare. \textit{Id.} at 1283-84. The court refused to defer to the state's determination that pancreas transplants were "experimental," and affirmed the district court's injunction directing the funding of Meusberger's transplant. \textit{Id.} at 1284.

One member of the panel dissented sharply, asserting that the court's decision contradicted the holding in Ellis, that the state had rationally determined that pancreas transplants were experimental, and that the state reasonably had adopted the federal standards for Medicare in denying Medicaid funding. \textit{Id.} at 1284 (Beam, J., dissenting). The dissenting judge also rebuked the majority for determining that HCFA's characterization of pancreas transplants as "investigational" (and therefore not funded under Medicare) was not equivalent to "experimental." \textit{Id.} at 1285 n.8 (Beam, J., dissenting).

\textsuperscript{82} 972 F.2d 1113, 1117 (9th Cir.), modified, 984 F.2d 979 (9th Cir. 1992).

\textsuperscript{83} Id. at 1115. Autologous bone marrow transplants involve a harvesting of the patient's own bone marrow, which doctors later replace following chemotherapy. \textit{Id.} at 1115. Autologous bone marrow transplants are completely ineffective in treating Sheri Dexter's type of leukemia; allogenic bone marrow transplants are the only effective transplant procedure. \textit{Id.} In allogenic bone marrow transplants, the patient receives extremely intensive chemotherapy, followed by transplantation of bone marrow harvested from a donor. \textit{Id.} The court in \textit{Dexter} stated that allogenic bone marrow transplants are "not experimental" and noted that "Dexter's physicians estimated that with an allogenic bone marrow transplant, she had a 60\% to 90\% chance of long-term, disease free survival." \textit{Id.} The district court had held that the state violated both Title XIX and the 14th Amendment of the United States Constitution. \textit{Id.} at 1116. Dexter contended that allogenic bone marrow transplant was a medically necessary procedure, and that Arizona violated Title XIX by not including the procedure in its state plan. \textit{Id.} at 1117. Dexter further argued that because the
state's exclusion of allogenic bone marrow transplants from its Medicaid plan.\textsuperscript{84} The court focused on § 1396b(i)(1), stating that the provision "does not make payments mandatory," but "states only what must occur in the event a state should decide, in its discretion, to pay for organ transplants."\textsuperscript{85} The court reasoned that the Eighth Circuit had held that "organ transplants are excepted from Medicaid funding even when they are medically necessary because they are not among the listed required services"\textsuperscript{86} and agreed with this interpretation of the Ellis holding. The court, following Ellis, relied heavily on the legislative history of the 1987 amendment to § 1396b(i)(1), and found that Congress intended organ transplant funding to be discretionary.\textsuperscript{87}

The Ninth Circuit also rejected Dexter's argument that Arizona's decision to fund autologous bone marrow transplants but not allogenic bone marrow transplants violated the "similarly situated" requirement of § 1396b(i)(1).\textsuperscript{88} The court held that the "similarly situated" language only required similar treatment of patients who could be treated by the same transplant procedure, \textit{not} that all patients with similar diseases should receive the most appropriate procedure.\textsuperscript{89} The question, according to the Ninth Circuit, is whether a Medicaid recipient is "unreasonably denied a covered" transplant procedure.\textsuperscript{90} The court found that Arizona could, therefore, permissibly fund autologous transplants—so long as it treated all beneficiaries similarly with respect to that specific procedure—while refusing to fund allogenic transplants. The court noted that requiring states to provide all persons with similar diseases with the particular transplants they needed "would lead to Medicaid funding of almost all organ transplants."\textsuperscript{91}

\textsuperscript{84} Id. at 1121.
\textsuperscript{85} Id. at 1117.
\textsuperscript{86} Id. (citation omitted).
\textsuperscript{87} Id.
\textsuperscript{88} Id. at 1119-20.
\textsuperscript{89} Id. at 1120.
\textsuperscript{90} Id.
\textsuperscript{91} Id.
B. THE FOURTH AND ELEVENTH CIRCUITS: STATES MUST FUND MEDICALLY NECESSARY TRANSPLANTS

In 1993, in Pereira by Pereira v. Kozlowski, the Fourth Circuit expressly rejected the reasoning in Ellis and Dexter, and ordered the state of Virginia to provide Medicaid funding for a heart transplant for four-year-old Natalia Pereira. 92 The district court had previously ordered the state to pay on the ground that the early and periodic screening, diagnosis, and treatment (EPSDT) service category—a mandatory service for Medicaid recipients under age twenty-one—expressly provides that states pay for treatment for medical conditions discovered by EPSDT screening services 93 “whether or not such services are covered under the State plan.” 94

On appeal the Fourth Circuit affirmed, but expressly declined to rely on the EPSDT provision. 95 The court concluded instead that the state simply did not have discretion to deny medically necessary transplant procedures. 96 The court rejected

92. 996 F.2d 723, 725-27 (4th Cir. 1993). Under its state Medicaid plan, Virginia (like Arkansas in Ellis) had chosen to fund cornea transplants and kidney transplants. Id. at 724. Natalia Pereira had been a healthy child until her heart had been damaged by a viral infection during a hospital stay for treatment of chicken pox. Matt Neufeld, Heart Operation Covered: 4-year-old Wins Suit for Medicaid, WASH. TIMES, June 28, 1993, at B1. Natalia had already received a new heart by the time of the court’s ruling, and had recovered well. Id.

93. Pereira, 996 F.2d at 724.
94. 42 U.S.C. § 1396d(r)(5) (Supp IV 1992); see also supra note 38 (discussing EPSDT provisions of Title XIX).
95. Pereira, 996 F.2d at 724-25.
96. The court stated that the EPSDT provisions “indisputably required” states to fund all necessary treatment for children, 996 F.2d at 727, but expressly rejected the district court’s holding that § 1396b(i)(1) gave states initial discretion in funding of transplants, which the EPSDT provisions effectively trumped. Id. at 725.

Despite its broad construction of the non-discretionary nature of reimbursement for transplants, the court appeared to limit its holding to Medicaid recipients under age 21. “[W]here the Commonwealth is required . . . to provide funds for medically necessary transplants to children under the ages of twenty-one who are otherwise qualified under the State’s Medicaid plan.” Id. at 727. It is not entirely clear why the court so limited its holding to children, given its clear rejection of the state’s argument that transplants are an optional service. In a concurring opinion, one member of the panel noted this apparent tension between the narrow holding and the court’s reasoning:

The court’s construction of the Medicaid statute is honest and faithful to its plain language. However, its interpretation that [the transplant funding provision] does not grant states the discretion to fund organ transplants will invariably open the door to individuals over the ages of twenty-one to claim that states . . . are required to pay for their organ transplants under the Medicaid statute because the procedure is
Virginia's argument that § 1396b(i)(1) constituted an affirmative grant of discretion to states on transplant funding decisions.\textsuperscript{97} The court focused on the text of the transplant provisions and asserted that those provisions only set forth conditions that states must meet before receiving federal matching funds for transplants.\textsuperscript{98} The court noted that to interpret the transplant provision as an affirmative grant of state discretion would create inconsistencies with the other provisions of § 1396b(i).\textsuperscript{99} The court also argued that Congress had not listed organ transplant procedures in the section of the statute that described optional services.\textsuperscript{100} The court dismissed the state's argument that the legislative history of § 1396b(i)(1) indicated congressional intent to grant states discretion, and criticized the Eighth Circuit's holding in \textit{Ellis}, finding the Eighth Circuit's discussion of the text of the provision inadequate\textsuperscript{101} and the legislative history medically necessary. . . . Whether a state would be required to pay for such services presents a profoundly troubling question.

\textit{Id.} at 727-728 (Hamilton, J., concurring).

97. \textit{Id.} at 725.

98. \textit{Id.} at 725, 726.

99. \textit{Id.} at 725 ("The tenuousness of the Commonwealth's textual argument is evidenced by its need to read subparagraph one of section 1396b(i) differently from the remaining subparagraphs . . . so as to avoid the statutory inconsistencies that would otherwise result."). Specifically, the court reasoned that § 1396b(i) contains, in addition to the transplant provision, 13 other limitations imposed on state plans as conditions for federal financial participation. \textit{Id.} Because many of these restrictions involve service categories, such as physician services, that are indisputably mandatory services under Title XIX, the court reasoned that to read the transplant provision as a grant of discretion would imply that the other provisions in the section are also grants of discretion, an absurd result. \textit{Id.} See \textit{infra} text accompanying notes 113-120 for further discussion of this argument.

100. "When Congress has intended to make provision of a medical service optional within the state's discretion, it has listed that service [among the optional service categories] in section 1396d(a), but refrained from making its provision mandatory pursuant to section 1396a(a)(10)." \textit{Pereira}, 996 F.2d at 725.

101. The court explained:

[The Eighth Circuit in \textit{Ellis}] did not even attempt to rest its decision on the text of the statute; indeed, it appeared to concede that the statute's language supports our holding today. . . . We believe not only that the language [of the transplant provision] 'can be read' in the way conceded by \textit{Ellis}, but that it must be so read . . . .

\textit{Id.} at 726. The Fourth Circuit also noted and criticized the contrary holdings of \textit{Dexter}, \textit{Meusberger}, and the district court's holding in Miller by Miller v. Whitburn, 816 F. Supp. 505 (W.D. Wis.), \textit{vacated}, 10 F.3d 1315, 1321 (7th Cir. 1993). \textit{Pereira}, 996 F.2d at 726.
unpersuasive. The court, therefore, strongly rejected the state's claim of discretion and ordered payment.

Six weeks after the decision in *Pereira*, the Eleventh Circuit ordered Florida to pay for a liver-bowel transplant for fifteen-month-old Lexen Pittman in *Pittman by Pope v. Secretary, Florida Department of Health and Rehabilitative Services*. The Florida Department of Health and Rehabilitative Services, which administers the Florida Medicaid program, had not chosen to fund liver-bowel transplants and therefore denied Lexen's request for funding. The court in *Pittman* surveyed the prior cases on the scope of state discretion on transplant funding, and, agreeing with *Pereira*, expressed that § 1396b(i)(1) probably did not give states discretion in funding transplants. Despite its agreement with the Fourth Circuit, the court in

102. "The Eighth Circuit's resort to legislative history was not only unwarranted but improper. Even if it were not, however, that history does not compel (if it even supports) the conclusion reached in *Ellis*." *Pereira*, 996 F.2d at 726.

103. *Id.* at 727. The court's concluding paragraph is unusually forceful:

[We are not] unmindful of the significant jurisprudential considerations that inform this decision. It may be, as the court in *Ellis* concluded, that from a policy perspective it is "unrealistic" to believe that Congress extended Medicaid coverage to organ transplants. It may even be, as the Commonwealth vigorously argues, that Congress intended by [§ 1396b(i)(1)] to afford the states absolute discretion whether to fund organ transplants. If it did so intend, however (and there is no evidence in either the statute or its history that this was its intention), it did not embody that intention in statute. And we have no more authority to give effect to that which was never enacted than we do to give effect to that which was never intended. Such is the rule of law.

104. 998 F.2d 887 (11th Cir.) (per curiam), *cert. denied*, 114 S. Ct. 650 (1993). Lexen suffered from short-bowel syndrome, a condition that greatly impaired his digestive functioning. *Id.* at 888. Lexen received all nutrients intravenously, which—although it kept him alive—also progressively destroyed his liver. *Id.* Lexen therefore required replacement of both his liver and bowel, or he was likely to die within one year. *Id.* Although the state agency had originally asserted that it did not have to pay for liver-bowel transplants on the grounds that they are experimental procedures, the agency subsequently abandoned this argument and asserted only that § 1396b(i)(1) gave it discretion on transplant coverage decisions. *Id.*

105. *Id.*

106. *Id.* at 889-91.

107. The court stated:

We, like the Fourth Circuit [in *Pereira*], doubt that § 1396b(i)(1) gives the states discretion to elect not to cover organ transplants. It seems more likely that the subsection is a statement imposing conditions for federal funding of organ transplants, rather than an affirmative grant of discretion. We find persuasive the Fourth Circuit's analysis of the legislative history and its conclusion that that history is inconclusive. *Id.* at 891.
Pittman declined to make a specific holding on the issue of the scope of state discretion, relying instead on the clear language of the EPSDT provision requiring states to provide all medically necessary services to children receiving EPSDT services under Medicaid.  

III. PITFALLS IN INTERPRETING TITLE XIX: A CRITIQUE OF ELLIS, DEXTER, AND PEREIRA

The efforts of the circuit courts to make sense of the transplant provisions of Title XIX and to determine whether transplants are mandatory or optional services under Medicaid illustrate not only the obtuseness of the Medicaid statute, but also judicial uncertainty over how to approach an enormous federal-state program that has expanded beyond all expectations since 1965. Furthermore, the courts' efforts reveal the difficulties involved in divining the meaning of a statutory scheme that creates broad categories, such as “inpatient hospital services,” “medically necessary,” and “experimental,” which constantly change meaning in light of the emergence and development of new medical technology.

A. THE RIDDLE OF THE MEDICAID TRANSPLANT PROVISION, SECTION 1396b(i)(1)

The courts that have attempted to interpret § 1396b(i)(1) have started their analyses with two assumptions. The first assumption is that courts can find congressional intent to make

108. The court explained:

We are not compelled, in this case, to decide the question of what, if any, discretion § 1396b(i)(1) grants to the states because of the clear mandate of [the EPSDT provisions].... Thus, even if [the transplant provisions] were construed to give Florida discretion not to provide funding of organ transplants, the 1989 amendment [to the EPSDT provision] took it away for individuals under the age of twenty-one who are otherwise qualified under the state plan.

Id. at 891-92. In basing its decision on the narrower ground that the EPSDT provision required the state to provide Lexen's transplant, the Fourth Circuit essentially reached the same conclusion as the district court in Pereira. See supra text accompanying notes 93-94.

Following the decisions in Pereira and Pittman, HCFA announced that it would now consider non-experimental transplant procedures for children as mandated under the EPSDT provision. Medicaid Program; Early and Periodic Screening, Diagnosis, and Treatment Services Defined, 58 Fed. Reg. 51288, 51293 (1993) ("We have decided that the superseding EPSDT legislation makes organ transplants mandatory for EPSDT recipients."). HCFA continues to assert, however, that organ transplants for adult Medicaid recipients are optional services. Id.
transplants either mandatory or optional by reference to the text of the transplant funding provision and its legislative history. The second assumption is that states must treat organ transplants *generically* as either mandatory or optional under the statutory scheme. Both of these interpretive assumptions are incorrect, and lay the foundations for unsatisfactory decisions.

1. The Statutory Text

Although the circuits differ sharply on its import, the text of § 1396b(i)(1) is relatively short and clear in comparison to much of Title XIX. According to § 1396b(i)(1), the federal government will not supplement state payments "for organ transplant procedures unless the State plan provides for written standards." State standards must also ensure that "similarly situated individuals are treated alike" and that "any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan." The dispute among the circuits is whether this language merely states conditions for receipt of federal funds, or whether it also constitutes an affirmative grant of discretion to states to determine coverage.

As the Fourth Circuit pointed out in *Pereira*, construing the transplant funding subsection as an affirmative grant of state discretion would make the provision inconsistent with the rest of § 1396b(i). The other subsections of § 1396b(i) place conditions on receipt of federal funds for a variety of different kinds of medical services. These include inpatient hospital services, diagnostic laboratory tests, nursing facility services, and physicians' services, all of which are indisputably mandatory service categories under Title XIX. To read the transplant subsection as a grant of state discretion would imply that these other subsections are similarly grants of discretion, which would

109. See *supra* note 56 for the complete text of the provision.
111. *Id.* § 1396b(i)(1)(A).
112. *Id.* § 1396b(i)(1)(B).
113. See *supra* note 99 (citing the Fourth Circuit's view on this point).
115. *Id.* § 1396b(i)(7).
118. See *supra* note 38 (listing mandatory service categories).
be “squarely at odds”\textsuperscript{119} with the provisions of Title XIX that mandate those services.\textsuperscript{120}

In addition, if § 1396b(i)(1) were an affirmative grant of discretion to states on transplant funding, this would imply that prior to enactment of that subsection, states had no statutory basis for such discretion. The enactment of § 1396b(i)(1) would therefore represent a substantial new limitation on the services available to Medicaid recipients. The language of the provision, however, clearly protects recipients: the provision requires states to develop written standards, treat similarly situated people alike, and insure that no restrictions on the facilities or physicians who provide transplants under the state plan interfere with quality of care.\textsuperscript{121} The provision purports only to prevent states from unfairly allocating transplant funding and failing to ensure high quality of care.

Although § 1396b(i)(1) does not, by way of its text, persuasively indicate that transplants are discretionary, neither does it indicate that transplants are mandatory.\textsuperscript{122} The section’s location within the statute certainly does not compel such a conclusion; although many of the restrictions on funding described in § 1396b(i) involve mandated services, one involves provision of drug products, an optional service.\textsuperscript{123} Furthermore, some of the other restrictions in § 1396b(i) are not simply conditions that states must meet in order to receive federal funding; rather, they are prohibitions on federal funding of otherwise “mandatory” medical services when provided under certain circumstances or by particular providers. For example, one provision prohibits federal financial participation for “inpatient hospital tests . . . not specifically ordered by the attending physician or other responsible practitioner.”\textsuperscript{124} A state would not be obligated to pay for such an inpatient hospital test, even though Title XIX ordinarily mandates such tests.\textsuperscript{125} The text of the

\begin{itemize}
  \item \textsuperscript{119} Pereira by Pereira v. Kozlowski, 996 F.2d 723, 725 (4th Cir. 1993).
  \item \textsuperscript{120} See supra note 38 and accompanying text (discussing mandatory service categories).
  \item \textsuperscript{121} 42 U.S.C. § 1396b(i)(1) (1988); see also supra note 56 (stating the text of the provision).
  \item \textsuperscript{122} The Fourth Circuit in Pereira stated no statutory basis for characterizing Natalia Pereira’s heart transplant as a mandated service, other than Virginia’s fortunate (for Natalia) concession that, absent an affirmative grant in the transplant provision, organ transplants are mandated. 996 F.2d at 724.
  \item \textsuperscript{123} 42 U.S.C. § 1396b(i)(5) (1988).
  \item \textsuperscript{124} Id. § 1396b(i)(6).
  \item \textsuperscript{125} In Harris v. McRae, the Court stated:
transplant provision does not by itself, therefore, readily indicate whether transplants are mandatory or optional services.

2. The Legislative History

The sparse legislative history of the transplant provision provides little persuasive guidance on the issue of state discretion. Congress added the transplant provision to § 1396b(i) in 1985, as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1995). COBRA 1985 made substantial changes in the Medicaid statute, primarily in the eligibility provisions. The final House, Senate, and Conference reports which accompanied COBRA 1985, however, do not explain or discuss the addition of the transplant provision.

The courts in Ellis and Dexter rested their conclusions almost entirely on the legislative history of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). OBRA 1987 con-

[If Congress chooses to withdraw federal funding for a particular service, a State is not obliged to continue to pay for that service as a condition of continued federal financial support of other services. . . . Title XIX does not obligate a participating State to pay for those medical services for which federal reimbursement is unavailable. 448 U.S. 297, 309 (1980). This does not mean, however, that merely by setting restrictions on federal payment for transplants § 1396b(i)(1) “withdraws” federal funding for transplants within the meaning of Harris, because federal funds are available as long as the state comports with the requirements of § 1396b(i)(1). In contrast, in Harris, the court found that Congress had specifically withdrawn all federal funding for elective abortions under the Hyde Amendment. Id. at 302.]

126. See supra note 56 (discussing enactment of the transplant provision).
127. MEDICAID SOURCE BOOK, supra note 5, at 35-37; Kinney, supra note 13, at 876.
128. Dexter v. Kirschner, 972 F.2d 1113, 1116 (9th Cir.), modified, 984 F.2d 979 (9th Cir. 1992); Ellis by Ellis v. Patterson, 859 F.2d 52, 55 (8th Cir. 1988). The Fourth Circuit in Pereira also cited the report prepared by the House Energy and Commerce Committee, which accompanied its recommendation on Medicare and Medicaid amendments in COBRA. 996 F.2d at 727. The court noted that the report stated that “the Committee believes that the decision to extend Medicaid coverage for one or more organ transplant procedures is appropriately within the province of each state.” Id. (quoting H.R. Rep. No. 265, 99th Cong., 1st Sess., pt. 1, at 73 (1985)). The court noted, however, that the committee report does not purport to say that § 1396b(i)(1) is itself an affirmative grant of discretion, but rather that the report reflects the committee's belief that state discretion was in fact the law prior to enactment of the transplant provision. Id. The committee's comments noted by the court were not incorporated into the final House or Conference Reports that accompanied COBRA 1985.
129. Dexter, 972 F.2d at 1117; Ellis, 859 F.2d at 55. The courts moved to the 1987 legislative history with virtually no comment on the actual text or statutory context of § 1396b(i)(1). See supra note 75 (discussing the Ellis court's treatment of the statutory text).
tained minor technical amendments to the transplant provision.\textsuperscript{130} The House Conference Report basically paraphrases the text of § 1396b(i)(1); the section in its entirety reads:

(e) \textit{Organ Transplant Technical}.—States which choose to cover organ transplant procedures may restrict the facilities or practitioners from whom Medicaid beneficiaries may obtain the services, so long as the restrictions are consistent with accessibility of high quality care, and so long as similarly situated individuals are treated alike. States may restrict the facilities of practitioners from whom Medicaid beneficiaries may obtain the services, so long as the restrictions are consistent with accessibility of high quality care.\textsuperscript{131}

Similarly, the House Report on the 1987 amendments states that "to assure that State coverage decisions for organ transplants are based on clear principles consistently applied, and not on political or media considerations, [§ 1396b(i)(1)] requires that a State which covers organ transplant procedures set forth under its Medicaid plan written standards respecting the coverage of such procedures."\textsuperscript{132} The Eighth Circuit in \textit{Ellis} inter-

\begin{itemize}
\item \textsuperscript{130} The 1987 changes to the transplant provision itself were extremely minor: "or" was added to the end of the provision to clarify the distinction between the subsection on transplants and the following subsection. More significantly, the following paragraph was added to the end of § 1396b(i): "Nothing in paragraph (1) [the transplant funding provision] shall be construed as permitting a State to provide services under its plan under this title that are not reasonable in amount, duration, and scope to achieve their purpose." Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4118 (d)(1)(B), 101 Stat. 1330, 1330-155. Although this paragraph does not indicate that transplants are mandatory services, it is even less consistent with construing the transplant provision as a grant of discretion to states—like the actual text of the provision, it provides further assurance of fair procedures and adequate reimbursement for transplants. The courts in \textit{Ellis} and \textit{Dexter}, however, did not mention, much less discuss, the specific changes made by the 1987 amendments.

\item \textsuperscript{131} H.R. CoNF. REP. No. 495, supra note 76, at 756, reprinted in 1987 U.S.C.C.A.N. at 2313-1502.

\item \textsuperscript{132} The entirety of the House Report section reads:

(d) \textit{Organ transplant technical}.—Under current law, States must offer certain "mandatory" services, such as inpatient hospital and physicians’ services, each of which must be sufficient in amount, duration, and scope to reasonably achieve its purpose. States may not arbitrarily deny or reduce the amount, duration, or scope of a mandatory service solely because of an individual’s diagnosis, type of illness, or condition. To assure that State coverage decisions for organ transplants are based on clear principles consistently applied, and not on political or media considerations, [§ 1396b(i)(1)] requires that a State which covers organ transplant procedures set forth under its Medicaid plan written standards respecting the coverage of such procedures. Under these standards, similarly situated individuals must be treated alike.

The Committee wishes to clarify that the organ transplant procedures which a State covers, and the hospital, physician, and other services these procedures entail, must be sufficient in amount, duration,
interpreted the phrases “States which choose to cover” and “State which covers” as indications that § 1396b(i)(1) constitutes an affirmative grant of state discretion for transplant coverage. If analysis of the legislative history stops here, then the conclusions in Ellis and Dexter are perfectly reasonable. There are, however, several reasons to doubt this reliance on and interpretation of the legislative history.

First, relying on legislative history from the 1987 technical amendments to the transplant provision to deduce Congressional intent in enacting the provision in 1985 is problematic. Furthermore, although the phrases “states which choose” and “state which covers” may imply discretion, the purpose of the two reports is not to clarify the extent of state discretion, but simply to paraphrase the transplant provision; using after-the-fact “history” in such a case, to answer a question not directly addressed in either 1985 or 1987 but merely implied, is troubling. When the result is to deny potentially life-saving medical care, such a circuitous interpretive approach is particularly troubling.

In addition, if Congress had intended to carve out a “transplant exception” in Medicaid coverage, it is odd that the section in the House and Conference reports immediately prior to the section on the transplant provision, entitled “Further clarifica-

and scope to reasonably achieve their purpose. For example, if a State covers liver transplants for patients with one medical condition but not for patients with another, and if a liver transplant is medically indicated and not experimental with respect of each condition, the State’s plan would be out of compliance with the amount, duration, and scope requirement. The Committee amendment would clarify that the current law requirements for written standards respecting organ transplant procedures must not be construed by HCFA or the States to permit States to provide services that are not reasonable in amount, duration, and scope to achieve their purpose. The amendment is effective as if included in section 9507 of COBRA.


133. Ellis, 859 F.2d at 55. Although it did not directly quote the language of the reports, the Ninth Circuit referred to and agreed with the Eighth Circuit’s use of the legislative history in Dexter, 972 F.2d at 1116.

134. “[T]he views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one.” United States v. Price, 361 U.S. 304, 313 (1960). For a discussion of “the use and abuse of subsequent legislative history,” see William N. Eskridge, Jr. & Philip P. Frickey, Cases and Materials on Legislation: Statutes and the Creation of Public Policy 752-60 (1988). The Fourth Circuit in Pereira also criticized this use of subsequent history. Pereira by Pereira v. Kozlowski, 996 F.2d 723, 726-27 (4th Cir. 1993) (“The legislative history cited in Ellis does not even represent the belief of the Committee that approved the specific provision here at issue.”).
tion of flexibility for State Medicaid payment systems for inpatient services,” does not discuss this purported new grant of state flexibility. Instead, the amendments to § 1396b(i)(1) and the sections in the House and Conference reports discussing the amendments all appear under the bland title “Technical and miscellaneous amendments.” If Congress had intended to create a substantial new limit on life-saving medical procedures, it did so very quietly.

The most notable problem with the use of the 1987 legislative history in Ellis and Dexter is that the courts focus on two isolated phrases in the reports, without giving effect to the actual content of the reports. The House Report, in fact, could easily be read to suggest that not only are transplants not subject to state discretion, but that they are a mandatory service:

Under current law, States must offer certain “mandatory” services, such as inpatient hospital and physicians services, each of which must be sufficient in amount, duration, and scope to reasonably achieve its purpose. States may not arbitrarily deny or reduce the amount, duration, or scope of a mandatory service solely because of an individual’s diagnosis, type of illness, or condition. To assure that State coverage decisions for organ transplants are based on clear principles consistently applied, and not on political or media considerations, [§ 1396b(i)(1)] requires that a State which covers organ transplant procedures set forth under its Medicaid plan written standards respecting the coverage of such procedures. Under these standards, similarly situated individuals must be treated alike.

Thus, in three consecutive sentences, the House Report re-states that Title XIX mandates certain services; affirms that states may not arbitrarily limit mandatory services; and explains that § 1396b(i)(1) ensures that organ transplant coverage decisions are made according to clear and consistent principles. It is difficult to see why the House should, in discussing the transplant provision, articulate concerns for the fair provision of mandatory services—unless those mandatory services include transplants. The Report, therefore, reasonably may affirm that

137. H.R. Rep. No. 391(I), supra note 76, at 531-32, reprinted in 1987 U.S.C.C.A.N. at 2313-351 to -352. The rest of the section in the House Report on § 1396b(i)(1) similarly focuses primarily on the concern that states not make arbitrary coverage decisions and that states provide sufficient levels of treatment. See supra note 132 (quoting the entire text of the House Report’s discussion of § 1396b(i)(1)).
transplants are mandatory services; the purportedly discretionary grant contained in "states which cover" could refer only to reasonable denials of coverage in particular instances, in accordance with guidelines set out under the state plan pursuant to § 1396b(i)(1). Given the whole tenor of the House Report, the Eighth Circuit's argument that the isolated words "which covers" express Congressional intent to limit the scope of mandatory services loses much of its force. At the least, the 1987 legislative history—to the extent that it is a legitimate indicator of Congressional intent in 1985—could plausibly support conclusions that transplants are mandatory or that they lie within state discretion. Given the ambiguity of the statutory text, the 1987 legislative history is a slender reed on which to base a life-or-death statutory construction.

B. THE OVER-RELIANCE ON SECTION 1396b(i)(1)

The courts' interpretations of § 1396b(i)(1) are so contradictory because they rest on an incorrect assumption that the transplant funding provision provides the key to determining whether transplants are mandatory or discretionary. All of the courts attempt to extract the implications for coverage from a provision that provides funding standards. This results in textual inconsistency and strained examinations of a legislative history that, unsurprisingly, better indicates Congress's intent on funding standards than on the scope of Medicaid coverage. It is no wonder, then, that the Ninth Circuit can state that organ transplants are optional “because they are not among the listed required services” even as the Fourth Circuit declares that “when Congress has intended to make provision of a Medicaid service optional . . . it has listed that service [with the described optional service categories].” The irony with these assertions is that neither mandatory nor optional services are listed in § 1396b, where the transplant provision appears, but in § 1396d. For the question of whether transplants are mandatory or optional, § 1396b(i)(1) is simply a red herring.

The best reading of § 1396b(i)(1) is that is that the provision does not say anything at all about the scope of mandated coverage or about state discretion. To construe the various provisions

138. Dexter v. Kirschner, 972 F.2d 1113, 1117 (9th Cir.), modified, 984 F.2d 979 (9th Cir. 1992).
139. Pereira by Pereira v. Kozlowski, 996 F.2d 723, 725 (4th Cir. 1993).
140. See supra notes 38, 41 (listing mandatory and optional service categories).
of § 1396b(i) as "merely laying out additional standards the states must meet to receive federal funds"\textsuperscript{141} is to do nothing more than read the section exactly as the title of § 1396 would indicate: "Payment to States."\textsuperscript{142} In this light, the absence of persuasive legislative history makes complete sense. Section 1396b(i)(1) does not affirm or deny any substantive entitlement of beneficiaries to a certain service, but merely clarifies the criteria for federal payment for transplants. Members of Congress in 1985 may have had opinions about practice or policy on funding of transplants, but they probably did not believe that they were significantly changing the scope of mandated coverage by enacting the transplant provision. Indeed, the only intent legislators expressed was not to settle the issue of discretion, but to insure that states followed certain standards that insured equitable treatment of recipients and high quality of care. In enacting § 1396b(i)(1), Congress only changed the law on payment to states, not on the scope of coverage.

C. DEFINING THE TAXONOMIC TASK: CATEGORIZING TRANSPLANTS AS MANDATORY OR OPTIONAL

There is no reason to think that § 1396b(i)(1) must provide the key to the issue of discretion. As noted previously, Title XIX specifically characterizes few medical services as either mandatory or optional; rather, the statute defines scope of coverage categorically.\textsuperscript{143} Medically necessary transplant procedures, like other surgical procedures, would probably be mandatory services under Title XIX as "inpatient hospital services"\textsuperscript{144} or "physician's services"\textsuperscript{145} were it not for the interpretive wild goose chase that § 1396b(i)(1) has engendered. Indeed, the state of Virginia in \textit{Pereira} conceded that transplant procedures would ordinarily be mandatory services unless § 1396b(i)(1) granted discretion.\textsuperscript{146} On the other hand, the reluctance of the courts in \textit{Dexter} and \textit{Ellis} to open the door to broad mandatory coverage of transplants is perfectly under-

\textsuperscript{141}. Ellis by Ellis v. Patterson, 859 F.2d 52, 55 (8th Cir. 1988).
\textsuperscript{143}. See supra note 40 (discussing gastric ulcer example).
\textsuperscript{145}. \textit{Id.} § 1396d(a)(5)(A).
\textsuperscript{146}. Pereira by Pereira v. Kozlowski, 996 F.2d 723, 724 (4th Cir. 1993) ("The Commonwealth concedes that absent exception in the Act, Pereira's heart transplant would be covered as one of those [mandatory] services.").
standable: many transplant procedures are relatively new and all transplant procedures are expensive.147

In reaching their opposite conclusions, the courts were clearly concerned with the broader implications of their interpretive choices: for the Fourth Circuit in Pereira, the cost to recipients of making all transplants optional was too much to bear; for the Eighth Circuit in Ellis and Ninth Circuit in Dexter, the cost to states of providing all medically necessary transplants was unreasonable. With these competing concerns in mind, the courts cast the issue for decision in broad terms: Transplants, as a generic category, are either mandatory (and therefore states must pay for all needed procedures) or they are optional (and therefore states may always chose to deny life-saving medical treatment).

The courts, however, did not face plaintiffs seeking generic transplants. They dealt instead with plaintiffs seeking specific procedures: heart transplants, liver transplants, liver-bowel transplants, pancreas transplants, allogenic bone marrow transplants. A generic approach, therefore, creates two difficulties. First, it produces broad, sweeping holdings that turn the scope of mandated transplant coverage into an all-or-nothing dilemma. On the one hand, states have complete discretion under Ellis and Dexter to deny life-saving health care to recipients without reference to individual medical need or the level of professional acceptance of particular procedures. On the other hand, Pereira (and perhaps Pittman) possibly compel states to provide all requested transplants, without reference to cost-effectiveness, state health care priorities, or even whether the particular procedure has been shown to be safe or effective. Both lines of decisions leave completely unclear the limits of state discretion and recipient entitlement. If a state has initial discretion to refuse to fund any transplants under Title XIX, but chooses to fund some transplants, the question of the degree to which state distinctions or criteria for transplant funding are subject to judicial examination remains unanswered. The Eighth Circuit's decision following Ellis in Meusberger v. Palmer148 sharply illustrates this problem: the panel was divided on the extent to which the court could review the state's decision to fund some pancreas transplants but deny others.149

147. See supra note 8 (citing costs of some transplant procedures).
148. 900 F.2d 1280 (8th Cir. 1989).
149. See supra note 81 (discussing Meusberger); see also Miller by Miller v. Whitburn, 10 F.3d 1315, 1320-22 (7th Cir. 1993) (reversing district court's hold-
Conversely, the Fourth Circuit's broad holding that states lack discretion leaves unanswered the extent to which states may permissibly set restrictions on transplant funding.\(^\text{150}\)

These difficulties reveal what the courts in both lines of cases failed to address: not all transplant procedures are created equal. It may be perfectly understandable for a state to exclude coverage of allogenic bone marrow transplant surgery; such surgery is not only extremely costly but also new, controversial among medical professionals, and without much history of testing.\(^\text{151}\) It is less understandable, unless the sole criterion for decision is absolute cost, to exclude heart transplant procedures, which have been done for more than twenty-five years,\(^\text{152}\) or cornea transplants, which present patients with relatively little risk.\(^\text{153}\) *Ellis* ironically reflects this confusion of the generic with the specific. The Eighth Circuit asserted that transplants, as a *generic* category, are discretionary because "[s]urely Congress did not intend to require the states to provide funds for exotic surgeries which . . . have a small chance of success and carry an enormous price tag"\(^\text{154}\) only two pages after noting that a liver transplant, the *specific* procedure without which Brandy Ellis would die, would mean "a 90% chance to live an active and normal life for the next five years."\(^\text{155}\)

This ironic tension in *Ellis* arises from the same interpretive difficulties that forced the Fourth Circuit in *Pereira* to limit inexplicably its holding to children, after finding that Title XIX does not grant states discretion for transplant coverage choices for *any* Medicaid recipients.\(^\text{156}\) Both courts must deal with an

\(^{150}\) The court's confusing limitation of its holding to children, even though the court declined to rely expressly on the EPSDT provisions, further muddies the picture. *See supra* note 96 (discussing the tension between the court's broad reasoning and apparently narrow holding).

\(^{151}\) *Dexter v. Kirschner*, 972 F.2d 1113, 1119-20 (9th Cir.), *modified*, 984 F.2d 979 (9th Cir. 1992).


\(^{153}\) Ironically, the district court in *Ellis* recognized precisely this fact, even as it denied funding: "Clearly there are organ transplants and there are organ transplants. A corneal transplant, for instance, deals with a non-life threatening situation and is otherwise in an obviously different category than liver transplants." *Ellis* by *Ellis v. Patterson*, 713 F. Supp. 292, 296 (E.D. Ark.), *vacated*, 859 F.2d 52 (8th Cir. 1988).

\(^{154}\) *Ellis* by *Ellis v. Patterson*, 859 F.2d 52, 55 (8th Cir. 1988).

\(^{155}\) *Id.* at 53.

\(^{156}\) *See supra* note 96 (discussing the holding in *Pereira*).
inscrutable statutory provision, a scanty and contradictory legislative history, and a concern that they find the “right answer” for organ transplants as a generic category, with the consequence of either mandating all needed transplants or subjecting recipients to complete state discretion.

IV. AN EVOLUTIVE VIEW OF THE MEDICAID PROGRAM

The failure of the circuits in Ellis, Dexter, and Pereira to marshal convincing support for their broad holdings stems from a more fundamental interpretive deficiency: the lack of adequate examination of the multiple, evolving, and sometimes contradictory goals and structure of Medicaid. The rapid changes in the statute, the program, the health care industry, and medical technology demand a dynamic interpretive approach that takes into account the historical development of Medicaid and the current medical, legal, and political context in which Medicaid provides health care.

A. STATUTORY AND PROGRAMMATIC CHANGES IN MEDICAID

The futility of reaching broad holdings on states’ obligations to provide transplants through a constrained analysis of text and legislative history of § 1396b(i)(1) is not only fundamentally misguided; the substantial and continual changes in the Medicaid statute and the development of the program virtually dooms such an approach even on its own terms.

The Medicaid program and Title XIX have not merely evolved—they have mutated. Only thirty years old, Title XIX has become ever more complex, if not impenetrable, by virtue

157. For discussions of models of dynamic statutory interpretation, see William N. Eskridge, Jr., Dynamic Statutory Interpretation (1994) (describing models and their theoretical bases); T. Alexander Aleinikoff, Updating Statutory Interpretation, 87 Mich. L. Rev. 20 (1988) (arguing in favor of dynamic interpretation); William N. Eskridge, Dynamic Statutory Interpretation, 135 U. Pa. L. Rev. 1479 (1987) (arguing that dynamic interpretation is descriptively as well as normatively superior to static interpretation); William N. Eskridge, Gadamer/Statutory Interpretation, 90 Colum. L. Rev. 609 (1990) (discussing relevance of extra-legal theorists of textual interpretation). According to Eskridge, dynamic statutory interpretation is characterized by a primary textual analysis, examination of original legislative expectations and compromises, and an awareness of the “subsequent evolution of the statute and its present context, especially the ways in which the societal and legal environment of the statute has materially changed over time.” Eskridge, Dynamic Statutory Interpretation, supra, at 1483.

158. See supra note 22 (discussing frustrated judicial reaction to Title XIX).
of constant amendment.\textsuperscript{159} New provisions such as § 1396b(i)(1) have, by a process of accretion, attached to Title XIX like barnacles. The program itself has both exploded in size since 1965 and has increasingly varied from state to state.\textsuperscript{160} Because of the frequent changes in the program, HCFA often cannot promulgate timely and comprehensive implementing regulations and policies.\textsuperscript{161}

Because of this mutation in the statute and the operation of the program, it is virtually impossible to settle disputed questions by easy reference to statutory text or legislative history. This is particularly problematic in the transplant cases and similar scope-of-coverage cases, where vague, laudatory, yet critical terms such as "best interests of the recipients,"\textsuperscript{162} "sufficient in amount, duration, and scope,"\textsuperscript{163} or "similarly situated"\textsuperscript{164} exist side by side with intricate and arcane technical provisions on eligibility\textsuperscript{165} and federal payment to states.\textsuperscript{166} Courts attempting to divine the line between state discretion and recipient entitlement indeed risk "get[ting] lost in the Medicaid maze."\textsuperscript{167} This is not to suggest that text or legislative history will not sometimes give clear answers in scope-of-coverage issues in the Medicaid program.\textsuperscript{168} As the Fourth Circuit recognized in \textit{Pereira}, had the language of the Title XIX transplant funding provision been clear, the court's interpretive role would have been narrow.\textsuperscript{169} Given the complexity and evolution of the language of Title XIX and the rapid change in the Medicaid program itself, however, courts can rarely make the text speak consistently and clearly on scope-of-coverage issues.

\textsuperscript{159} See generally Kinney, \textit{supra} note 13 (describing complication of relationship between federal and state authorities resulting from constant amendment of Title XIX).

\textsuperscript{160} See \textit{supra} notes 18-21 and accompanying text (discussing growth in Medicaid spending); \textit{supra} notes 32-36 and accompanying text (discussing disparity in eligibility and coverage policies).

\textsuperscript{161} Kinney, \textit{supra} note 13, at 899-901.


\textsuperscript{163} \textit{Id.} § 1396b(i); 42 C.F.R. § 440.230(b) (1993).


\textsuperscript{168} Proponents of dynamic interpretive approaches stress that statutory text must remain an anchor for interpretation. "The statutory text . . . is the formal focus of interpretation and a constraint on the range of interpretive options." Eskridge, \textit{Dynamic Statutory Interpretation}, \textit{supra} note 157, at 1483.

\textsuperscript{169} Pereira by Pereira v. Kozlowski, 996 F.2d 723, 725 (4th Cir. 1993).
Because Title XIX is essentially silent on the scope of coverage for organ transplants, one could make the fall-back argument, suggested previously, that because they are not specifically listed as an optional service, transplants are a mandatory inpatient hospital service under Title XIX. On the other hand, one could reverse the assumption by concluding that Title XIX includes a limited set of mandatory services, and that transplant decisions are appropriately a matter of state discretion because the statute does not expressly mandate them. Because the statute's text compels neither choice, courts must make a decision by additional reference to the values and goals the Medicaid program expresses and the societal context in which it operates. By focusing on the indeterminate provisions of § 1396b(i)(1), however, the courts have failed to weigh adequately the various societal and political expectations and values bound up in the program.

For example, while the courts in Ellis and Dexter make much of the minimal language of the legislative history of § 1396b(i)(1), they ignore the larger context of Congress's amendments to Title XIX as a whole in 1985. Beginning in

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170. See supra note 100 and accompanying text (citing the Seventh Circuit's use of this argument in Pereira).

171. In Meusberger v. Palmer, the Eighth Circuit appeared to come close to making this assumption: "States have some discretion in determining which medical services to cover under their Medicaid program. Other medical services, such as inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing facility services, and physician services must be provided." 900 F.2d 1280, 1282 (8th Cir. 1990); see also Dexter v. Kirschner, 972 F.2d 1113, 1117 (9th Cir.) (quoting and agreeing with the language from Meusberger), modified, 984 F.2d 979 (9th Cir. 1992).

172. A court can duck this difficult question, however, by virtue of another method. See, e.g., Miller by Miller v. Whitburn, 10 F.3d 1315 (7th Cir. 1993) (avoiding a decision on the scope of state discretion by remanding for a determination whether a particular transplant is experimental); Todd by Todd v. Sorrell, 841 F.2d 87, 90 (4th Cir. 1988) (avoiding a decision on the scope of state discretion by holding that the Medicaid recipient "substantially complied" with state criteria for a liver transplant).

As noted below, even though Miller does indeed duck the precise question disputed in Ellis, Dexter, and Pereira, the court's course in that case is a model of the decisional process on organ transplant coverage disputes suggested by this Note. See infra text accompanying notes 212-213 (discussing the model of review suggested by Miller).

173. See supra text accompanying notes 129-133 (discussing courts' analyses of the legislative history of the transplant provision).
1984, Congress had begun to expand Medicaid coverage. In the COBRA amendments of 1985, Congress not only enacted § 1396b(i)(1), but also expanded the number of Medicaid services offered; these additional services included hospice care, case management services, and ventilator care for institutionalized children.

During this period, Congress also expanded eligibility. In 1984, Congress expanded "categorically needy" eligibility, thus placing substantial new requirements on states to extend Medicaid coverage to persons previously not covered. In 1987, when § 1396b(i)(1) was amended, Congress expanded the eligibility criteria for the "optionally categorically needy," expanded required coverage for certain poor children, and took steps to ensure the quality of care in Medicaid-funded nursing homes.

Finally, in the mid-1980s, Congress, reacting to public concern about the shortage of donor organs and the cost to patients of transplant procedures, enacted several bills that facilitated organ transplants. The National Organ Transplant Act of

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174. See generally Medicaid Source Book, supra note 5, at 35-37 (summarizing seven pieces of legislation in the 1980s that expanded Medicaid coverage, allowing, among others, additional higher income people to qualify); Kinney, supra note 13, at 875-81 (citing the Democrat-dominated Senate in 1986, the Deficit Reduction Act of 1984, the Consolidated Omnibus Reconciliation Act of 1985, and the Omnibus Budget Reconciliation Act of 1987 as contributing to Medicaid's coverage expansion, especially for pregnant women and children).


176. Kinney, supra note 13, at 877. These additions to Title XIX were optional services that states could choose to provide. Id. Unlike the transplant provision, however, Congress placed these services in § 1396d among the other defined service categories. 42 U.S.C. § 1396d(a)(18)-(20) (1988). This further supports a conclusion that in enacting the transplant provision, Congress did not create a new optional service category; had it done so, it would have included transplants in § 1396d, as it did for the truly new service categories it created in 1985. See supra text accompanying notes 138-140 (discussing the significance of the location of the transplant provision in Title XIX).


178. See supra note 23 (describing "mandatory categorically needy" and "optionally categorically needy" eligibility subgroups).


1984 established a national database on donor organ availability, and provided grants and established standards for organ procurement agencies to facilitate effective and equitable allocation of donor organs. In the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986), the 99th Congress (which also enacted § 1396b(i)(1)) extended Medicare coverage to pay for innovative drug therapy to facilitate transplant procedures. OBRA 1986 also required hospitals receiving federal Medicare funds to encourage organ donation and to follow regulations for organ procurement. The Organ Transplant Amendments of 1988 reauthorized portions of the 1984 National Organ Transplant Act and established block grants to states for immunosuppressive drugs.

The prevailing mood in Congress in the mid-1980s was of Medicaid expansion, in terms of eligibility, coverage, and protection of recipients. There was also a clear concern with the ability of needy individuals to obtain and pay for organ transplant procedures. In this context, the scant legislative history and indeterminate text cited in Ellis and Dexter to allow unilateral, discretionary restriction of transplant coverage, loses much of whatever interpretive weight it ever had. Yet this contextual analysis is completely absent in all of the circuit court transplant cases.

On the other hand, neither the prevailing mood nor even the specific intent of Congress in 1985 necessarily reflects the current social and political landscape, and it would be equally unfortunate to dismiss the current contextual factors that suggest courts should be hesitant to impose broad mandates on states to provide all transplants that recipients request. The social idealism that produced both Medicaid and Medicare in 1965 has buckled in large measure to the fiscal realities of the enormous


183. Id. § 9318, 100 Stat. at 2009.
185. For a discussion of the social and political context of the creation of Medicaid and Medicare during the early 1960s, see Robert Stevens & Rosemary Stevens, Welfare Medicine in America: A Case Study of Medicaid 19-54 (1974).
expansion in the number of beneficiaries,\textsuperscript{186} the increasing cost of health care,\textsuperscript{187} and the concomitant fiscal burden that Medicaid places on state governments.\textsuperscript{188} These burdens have increasingly led to calls for Medicaid's curtailment or restructuring.\textsuperscript{189} As is becoming increasingly clear, issues of cost are also issues of ethics; it is too facile to mandate transplants broadly and boldly as a generic category of services when health care dollars are undeniably scarce, and when the easiest way for states to reduce Medicaid costs is to exercise their undeniable discretion to cut the rolls of medically needy recipients or the array of optional, but nonetheless needed, services.\textsuperscript{190}

The courts in the cases discussed also do not clearly come to grips with the evolutive nature of medical technology.\textsuperscript{191} Pereira unrealistically opens the door to presumptive public funding of all transplant procedures, failing to acknowledge that new technologies undergo an initial period of uncertainty and transition


\textsuperscript{187} See \textit{supra} note 6 and accompanying text (describing the growth of health care costs).

\textsuperscript{188} See \textit{supra} notes 19-21 and accompanying text (describing the fiscal burdens of Medicaid on states).


\textsuperscript{190} As one commentator noted:

\begin{quote}
Cost-effectiveness is, and must be, a legitimate consideration in the publicly financed sector of the health care system. States must operate within a budget: there are limits to the tax and other revenues they can access, and consequently there are limits to what they can spend. If a State simply funds all expensive medical procedures ordered by physicians without any regard to cost-effectiveness, it does not merely violate some abstract responsibility to taxpayers in general, it threatens the availability of resources for others who may need them more.
\end{quote}

Swidler, \textit{supra} note 186, at 662-63 (footnotes omitted); see also Angela R. Holder, \textit{Funding Innovative Medical Treatment}, 57 ALB. L. REV. 795, 795-800 (1994) (discussing insurance companies' reluctance to fund innovative, experimental, but potentially life-saving treatment for desperately ill patients). For a discussion of the ethical issues in allocation of scarce resources for desired goods such as medical care, see CALABRESI & BOBBIT, \textit{supra} note 7.

\textsuperscript{191} The development and use of new medical technology is also part and parcel of the growth in health care costs. \textit{See} Swidler, \textit{supra} note 186, at 661 & n.19 (1994) (discussing the role of technological innovation in driving up health care costs). On the other hand, new technology accounts for only a small part of cost increases in the Medicaid program; general price inflation and specific health care inflation represent most of the growth in Medicaid spending. \textit{Medicaid Trends and Options}, \textit{supra} note 17, at 40.
not only in the funding arena, but also among medical professionals and providers. On the other hand, a categorical position that new technologies, such as certain organ transplants, should be entirely discretionary tends to freeze artificially the scope of coverage. Such a frozen and at least arguably inappropriate restrictiveness is stark in cases such as *Pereira*, where the "new" technology at issue, a heart transplant, had been in use for more than twenty years.

Finally, an undeniable contextual factor in the transplant cases is the compelling human suffering that judges face when deciding the scope of medical coverage under Medicaid. The choice for judges is stark: either grant the requested relief, or allow the state to deny funding for a life-saving transplant in the name of "cooperative federalism." Weighing the human cost of denying health care to people who will otherwise die is a justifiable interpretive factor, whether one views Medicaid as a program that represents a redistributive "entitlement to common goods" or because denial implicates norms of justice or fairness that courts should not readily impinge with dubious statutory interpretation. Whatever the jurisprudential rationale, such equitable concerns constitute a subtext in the organ transplant cases, as should be apparent from decisions such as *Meusberger v. Palmer* and *Todd by Todd v. Sorrell*, where the

192. Private health insurance providers typically restrict reimbursement of new medical procedures. This has led to equally bitter disputes over the contractual scope of coverage of private health plans. See Saver, *supra* note 54, at 1100-04.


194. *GuTKIND, supra* note 152, at 32-33. A similar tension is apparent in *Ellis*, where the Eighth Circuit simultaneously denied a liver transplant in part because of a reluctance to force states to pay for "risky and unproven" procedures, yet noted that the particular liver transplant had a 90% chance of prolonging Brandy Ellis's life. See *supra* note 80 and accompanying text (discussing this paradox).


196. See, e.g., Cass Sunstein, *Interpreting Statutes in the Regulatory State, 103 Harv. L. Rev 407* (1989). Sunstein suggests that welfare statutes might be construed aggressively in order "to insure against irrational or arbitrary deprivations of benefits" and to facilitate "evenhandedness in the distribution of funds to the poor in a democracy that has committed itself to a 'social safety net.'" *Id.* at 474. However one labels or formulates such an interpretive approach, there can be little doubt that most members of our society would feel substantial unease in denying life-saving organ transplants to dying patients.

197. 900 F.2d 1280, 1283-84 (8th Cir. 1990); see also *supra* note 81 and accompanying text (discussing *Meusberger* and its inconsistencies with *Ellis*).

198. 841 F.2d 87, 90 (4th Cir. 1988); see also *supra* note 70 and accompanying text (discussing the court's opinion).
courts strained to find justifications for ordering transplant reimbursement. Even in Ellis, which so strongly rejected the argument that Title XIX mandates organ transplant funding, Judge Arnold frankly acknowledged the powerful concerns at hand:

The real question in the case is how you weigh all this together. How do you weigh the chances of prevailing, the injury to the plaintiff and the injury to the state? And it seems to me that the equities, when you consider the whole thing and shake it up in a bag, so to speak, and try to come out with an answer, the answer comes out in favor of granting the relief. It isn’t possible to explain mathematically that result, it’s a matter of judgment.  

C. A SUGGESTED APPROACH TO TRANSPLANT COVERAGE UNDER TITLE XIX

The arguments marshalled by the Eighth and Ninth Circuits in finding that § 1396b(i)(1) confers discretion to states on transplant coverage decisions are unconvincing. They largely fail to deal with the actual statutory text, rest on meager and contradictory legislative history, and are not consistent with the apparent concerns of the Congress that enacted the provision. The harsh conclusion that states are completely free to deny lifesaving medical procedures to people such as Brandy Ellis and Sheri Dexter demands more justification than these decisions offer.

Courts should presume that specific transplant procedures sought by Medicaid recipients are mandated as inpatient hospital services under Title XIX. States, however, should be able to

199. Hearing Before the Honorable Richard Arnold at 3, Ellis by Ellis v. Patterson, 859 F.2d 52 (8th Cir. 1988) (No. LR-C-88-542), quoted in Ann B. Lever & Herbert A. Eastman, “Shake it up in a Bag”: Strategies for Representing Beneficiaries in Medicaid Litigation, 35 St. Louis U. L.J. 863, 863-64 (1991). Similarly, in Todd by Todd v. Sorrell, the Third Circuit directly weighed the competing interests in reviewing the denial of a preliminary injunction ordering the state of Virginia to pay for a liver transplant for four-year-old Michelle Todd: “Undoubtedly the harm to the plaintiff would have been enormous, indeed fatal, were the injunction denied, and the harm to the Commonwealth if granted, while it may not have been negligible, was measured only in money and was inconsequential by comparison.” 841 F.2d at 88. Such considerations may also undergird the Fourth Circuit’s rather cryptic allusion to “significant jurisprudential considerations” in Pereira by Pereira v. Kozlowski, 996 F.2d 723, 727 (4th Cir. 1993). See supra text accompanying note 103 (quoting the final paragraph of the court’s opinion in Pereira).

200. It is especially ironic that while the Eighth Circuit has held that states have complete discretion to choose not to cover any medically necessary organ transplants, it has also held that states must cover medically necessary sex reassignment surgery. Pinneke v. Preisser, 623 F.2d 546, 550 (8th Cir. 1980).
rebut this presumption by a showing that the state has reasonably determined that the particular procedure is currently experimental according to the definition of "experimental" that HCFA has formulated and courts already follow.\textsuperscript{201}

Construing Title XIX to favor coverage of transplants is consistent with § 1396b(i)(1), which even the Eighth Circuit in Ellis conceded could be read merely as a set of conditions for federal reimbursement, rather than as a grant of state discretion.\textsuperscript{202} Construing the provision to favor coverage is also in line with judicial practice in interpreting private health care insurance plans; courts generally treat health insurance plans as contracts of adhesion, and construe ambiguities in favor of the recipient.\textsuperscript{203}

Nor should categorizing transplants as within the scope of mandated coverage under Medicaid pose substantial new burdens for states. Most states already provide reimbursement for at least some transplants under their Medicaid plans.\textsuperscript{204} The greatest financial burden to states does not come from providing relatively infrequent high-technology procedures like transplants, but from the general inflation in the cost of health care\textsuperscript{205} and the disproportionate share of Medicaid funds going to high-cost institutional care for elderly and disabled persons.\textsuperscript{206}

In addition, this construction of Title XIX would not force states to unreasonably assume the exorbitant costs of new, risky, and unproven transplant procedures; a state could exclude a particular transplant procedure from funding if the state reasonably determines that the particular transplant procedure is "experimental." Under current law, a medical procedure is ex-

\textsuperscript{201} See supra note 54 and accompanying text (discussing HCFA policy on experimental treatment and cases that have dealt with this issue).

\textsuperscript{202} See supra text accompanying note 76 (quoting the Ellis court's discussion of the transplant provision).

\textsuperscript{203} See Saver, supra note 54, at 1100 & nn.24-26 (discussing courts' treatment of scope-of-coverage issues in private insurance plans).

\textsuperscript{204} See supra notes 60-65 and accompanying text (discussing state coverage of transplant procedures).

\textsuperscript{205} See supra notes 19-21 and accompanying text (discussing costs to states of Medicaid program). There is anecdotal evidence that mandatory coverage does not necessarily increase costs dramatically. After New York was enjoined from denying coverage for Clozapine, a new anti-psychotic medication that it had excluded because of the drug's exorbitant cost, the state turned next to pressure Clozapine's manufacturer, and succeeded in forcing a dramatic reduction in the drug's price. Swidler, supra note 186, at 666-76.

\textsuperscript{206} See supra note 30 and accompanying text (discussing the disproportionate cost of long-term institutional care).
perimental and excluded from coverage if the medical community has not generally accepted the procedure, if it is rarely used, novel, or relatively unknown, and if evidence has not established the procedure's safety and effectiveness.\textsuperscript{207} Treating transplants in this manner under Title XIX does nothing more than put them on the same level as other new medical technologies, giving states the same discretion with regard to "experimental" transplants as they currently have with experimental procedures generally.

A state's decision to exclude a certain procedure because it is "experimental" should be subject to judicial review, but with a rather narrow standard. Courts surely are not in the best position, from a standpoint of either legitimacy or capacity, to pronounce when new technologies have become part of the mainstream of medical practice.\textsuperscript{208} The Seventh Circuit's remand and articulated scope of review in \textit{Miller by Miller v. Whitburn} illustrates this suggested model of review.\textsuperscript{209} In \textit{Miller}, the court recognized that "different definitions of 'experimental' may be necessary depending upon . . . the treatment under review,"\textsuperscript{210} but also that "'experimental' . . . is an 'objective benchmark' against which . . . [state decisions] may be measured."\textsuperscript{211} States might use a number of factors in determining whether a particular kind of transplant is experimental.\textsuperscript{212} In

\begin{itemize}
  \item \textsuperscript{207} Rush v. Parham, 625 F.2d 1150, 1156 & n.11 (5th Cir. 1980) (citing Enclosure No. 2 to Intermediary Letters Nos. 77-4 & 77-5, [1976 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 28,152).
  \item \textsuperscript{208} Saver, \textit{supra} note 54, at 1117-20 (discussing the institutional incapacity of courts in acting as ultimate adjudicators of medical effectiveness).
  \item \textsuperscript{209} 10 F.3d 1315, 1320-21 (7th Cir. 1993); \textit{see also supra} note 81 and accompanying text (discussing \textit{Miller}).
  \item \textsuperscript{210} \textit{Id.} at 1320.
  \item \textsuperscript{211} \textit{Id.} (quoting Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498, 519 (1990)).
  \item \textsuperscript{212} The court in \textit{Miller} suggested factors such as patient mortality, frequency and success of use, the reputation and record of the doctors or facilities that provide the procedure, the prognosis of patients who have had the procedure, and the history of technology development in related procedures. \textit{Id.} at 1320 n.11 (citing Maxwell J. Mehlman, \textit{Health Care Cost Containment and Medical Technology: A Critique of Waste Theory}, 36 CASE W. RES. L. REV. 778, 785 (1986)). Other factors that a state might reasonably use include whether the Food and Drug Administration has approved the procedure, whether other public programs (such as Medicare) fund the procedure, whether private insurance payers generally fund the procedure, and whether professional organizations have formally accepted the procedure. Saver, \textit{supra} note 54, at 1122-24. Under such an approach, Iowa's decision not to fund pancreas transplants at issue in \textit{Meusberger v. Palmer}, 900 F.2d 1280, 1282 & nn.3-5 (8th Cir. 1990), might well be valid, because the state based its determination on HCFA's determination that pancreas transplants were investigational, and therefore were
Miller, the state had in fact developed criteria for excluding procedures as “experimental.” The court remanded for a determination of the narrow issue of whether the state had “reasonably applied” its definition to the particular transplant in issue, stressing that the state had “significant discretion” in making such determinations.

Such an approach strikes a balance between the “all or nothing” choices of either categorical mandate or utter state discretion. In this approach, the states retain the authority and obligation to place reasonable limitations on procedures that are not “medically necessary” because they are too risky, ineffective, or unproven. A deferential standard of review would allow states to make reasonable funding decisions and set reasonable criteria based on a variety of factors, including cost-effectiveness. At the same time, a presumption of coverage would encourage states to develop written standards for transplants in accordance with § 1396b(i)(1) and would prevent arbitrary denials of service and blanket, categorical decisions not to fund some or all transplants.

This suggested interpretive approach urges both a substantive coverage policy and a decisional process. This approach also encourages sensibility: states would fund established, accepted, and relatively low-risk transplants while retaining discretion in funding unproven procedures. Natalia Pereira would receive her new heart; Arizona, however, might still justifiably deny Sheri Dexter her allogenic bone marrow transplant, if such a denial is in fact reasonable. Also implicit in this approach is the

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213. The state’s criteria were:

(1) The current and historical judgment of the medical community as evidenced by medical research, studies, journals or treatises;

(2) The extent to which Medicare and private health insurers recognize and provide coverage for the service;

(3) The current judgment of experts and specialists in the medical specialty area [or areas] in which the service is applicable or used ....

214. Id. at 1321.

215. Sheri Dexter’s tragedy ironically illustrates the intersection of funding decisions with technological advances. The allogenic bone marrow transplant which Dexter needed was developed as an alternative to autologous bone marrow transplants (which were funded under the state plan), but which in the past have been as fiercely controversial as allogenic transplants. See supra note 83 and accompanying text (discussing autologous and allogenic marrow transplants). Recently, some hospitals have performed umbilical blood transplants, a new procedure that may in its turn be an alternative to allogenic bone marrow...
possibility that states may exclude certain transplants, but lose that discretion as particular procedures become more accepted and documented.

The lack of a bright line interpretive rule and the focus on specific procedures, rather than the generic category of "transplants," does create the possibility that courts will review certain procedures repeatedly. However, a presumption of coverage, attention to evolutive issues in technology and policy, and review of specific procedures encourages a full and honest weighing of competing concerns, rather than forcing courts into an essentially futile, text-bound, and interpretive analysis that produces inconsistent, inflexible, overbroad, and unjust results.216

CONCLUSION

The contradictory and confusing conclusions that courts have reached on the obligations of states to provide organ transplant procedures for Medicaid recipients suggest some of the difficulties courts face in balancing the competing concerns and values of the Medicaid program. Faced with a statute that borders on incomprehensibility, the courts in these cases have understandably pursued incorrect interpretive approaches and failed to fully consider the evolutive nature of the statute, the program, and medical technology. This Note suggests a dynamic, evolutive approach to Medicaid scope-of-coverage issues


216. Courts should not limit such an approach to transplants. New non-transplant technologies continue to appear and move from nonacceptance to acceptance. An example is magnetic resonance imaging (MRI), a powerful diagnostic tool. Prior to 1985, HCFA excluded MRI from Medicare coverage, labeling it "experimental." After HCFA determined that MRI was commonly accepted and proven, it began to reimburse Medicare claims for MRI tests. Goodman v. Sullivan, 891 F.2d 449, 451 (2d Cir. 1989) (per curiam). Unfortunately, HCFA recognized MRI's safety and effectiveness after the Food and Drug Agency had done so. This led to the rather bizarre situation that, for a time, the federal government would not pay for MRI under Medicare on the basis that it was not proven to be safe and effective, even though the federal agency responsible for insuring the safety and effectiveness of medical devices had determined MRI to be so. Id.
that places the burden on states reasonably to justify denial of funding for new technologies and treatments, but that also recognizes that questions of cost-effectiveness and professional acceptance are best determined within the medical community and not in the courts. Such an approach acknowledges the complexities of Title XIX and the "cooperative federalism" nature of Medicaid. Ultimately, this approach ensures that states exercise discretion to develop reasonable funding criteria that reflect sound medical practice and clearly articulated public policies, when deciding the scope of coverage for organ transplants under the Medicaid program.