For Opinion See 139 F.3d 80

United States Court of Appeals,
Second Circuit
Concetta DESARIO and Betty Emerson, Individually and o/b/o all others similarly situated, Plaintiffs-Appellees,
Caroline Stevenson and Thomas Slekis, Intervenors,
v.
Joyce A. THOMAS, Commissioner CT Dept. of Social Services, Defendant-Third-Party Plaintiff-Appellant,
Donna Shalala, Commissioner, United States Department of Health and Human Services, Third-Party Defendant.
No. 97-6027.
April 10, 1997.

On Appeal from the United States District Court for the District of Connecticut

Brief of Defendant-Third-Party Plaintiff-Appellant

Office of the Attorney General of the State of Connecticut, Attorneys for Defendant-Third-Party Plaintiff-Appellant, 55 Elm Street, Hartford, Connecticut 06141, (860) 566-7279Defendant-Appellant, Joyce Thomas, Commissioner, Richard Blumenthal, Attorney General, Richard J. Lynch, Assistant Attorney General, By: Judith A. Merrill, Assistant Attorney General, Federal Bar #ct05561, 55 Elm Street, P.O. Box 120, Hartford, CT 06141-0120, Tel.: (860) 566-7334

i *TABLE OF CONTENTS

TABLE OF CONTENTS ... i

TABLE OF AUTHORITIES ... iii

PRELIMINARY STATEMENT ... 1

JURISDICTIONAL STATEMENT ... 1

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW ... 2

STATEMENT OF THE CASE ... 2

STATEMENT OF THE PROCEEDINGS ... 2

STATEMENT OF FACTS ... 4

SUMMARY OF ARGUMENT ... 4

ARGUMENT ... 9

I. The Standard Of Review Of The Trial Court's Decision Granting The Plaintiffs' Motion For Preliminary Injunction Is Plenary For Issues Of Law And For Abuse Of Discretion For Issues Of Fact. ... 9

II. The Trial Court Erred In Finding That The Plaintiffs Did Not Have An Adequate Remedy At Law. ... 10

III. The Plaintiffs' Desario And Emerson And Intervenor Stevenson's Claims Are Precluded By Res Judicata. ... 16

IV. The Equipment Requested By The Plaintiffs Does Not Fall Within The Definition Of Durable Medical Equipment. ... 19

V. The District Court Erred In Entering A Preliminary Injunction In The Absence Of Allegations, Proof And Findings That The Benefit Package Offered By The Department Is Unreasonable Because It Fails To Provide A Meaningful Benefit Package For The Medicaid Population As A Whole. ... 22

***ii A. The Commissioner Is Authorized To Restrict The Amount, Duration And Scope Of Covered Medicaid Services By Employing An Exclusive List Of Covered Medical Equipment. ... 22**

B. The District Court Abused Its Discretion By Not Applying The Correct Legal Standard In Granting Plaintiffs' Motion For A Preliminary Injunction ... 34

C. The Department's Policies Do Not Constitute Illegal Irrebuttable Presumptions ... 39

VI. The Trial Court Erred In Issuing A Preliminary Injunction In The Absence Of An Evidentiary Record That Would Support The Necessary Findings Of Fact. ... 43

CONCLUSION ... 48

iii *TABLE OF AUTHORITIES

CASES

Able v. U.S., 44 F.3d 128 (2d Cir. 1995) ... 15

Alexander v. Choate, 469 U.S. 287 (1985) ... 34, 35, 41, 43

Anderson v. Director of Social Services, 101 Mich. App. 488 300 N.W. 2d 921, 924 (1980) ... 38

Beal v. Doe, 432 U.S. 438 97 S.Ct. 2366, 2371-72 (1977) ... 35, 40

Budnicki v. Beal, 450 F.Supp. 546 (E.D. Pa., 1978) ... 37

Burinskas v. Department of Social Services, 240 Conn. 141 691 A.2d 586 (1997) ... 18

Califano v. Boles, 443 U.S. 282, 99 S.Ct. 2767 (1979) ... 47

Carpenter v. Planning & Zoning Commission, 176 Conn. 581 409 A.2d 1029 (1979) ... 23

Charleston Memorial Hospital v. Conrad, 693 F.2d 324 (4th Cir. 1982) ... 36

Commissioner v. Shapiro, 424 U.S. 634 n.15, 47 L.Ed.2d 278, 96 S.Ct. 1062 (1976) ... 20

Convalescent Center of Bloomfield, Inc. v. Department of Income Maintenance, 208 Conn. 187 544 A.2d 604 ... 23

Curtis v. Taylor, 625 F.2d 645 (5th Cir. 1980) ... 36, 43

Daly v. Delponte, 225 Conn. 499, 624 A.2d 876 (1993) ... 17, 23

District of Columbia Podiatry Society v. District of Columbia, 407 F.Supp. 1259 (D.D.C. 1975) ... 37

***iv** *Doe v. State of Conn. Dept. of Health Services*, 75 F.3d 81 (2d Cir. 1996) ... 18, 24

Dougherty v. Department of Human Services, 449 A.2d 1235 (N.J. 1982) ... 38

Gedulig v. Aiello, 417 U.S. 484, 94 S.Ct. 2485 (1974) ... 47

Greenberg v. Bd. of Gov. of Federal Reserve System, 968 F.2d 164 (2d Cir. 1992) ... 22

Griffin Hosp. v. Comm'n on Hosps, and Health Care, 200 Conn. 489 512 A.2d 199, 203-04 ... 18, 23

Harrison v. Commissioner of Income Maintenance, 204 Conn. 672 529 A.2d 188 (1987) ... 20

Jackson Dairy, Inc. v. H.P. Hood & Sons, Inc., 596 F.2d 70 (2d Cir. 1979) ... 15

Laurel Park, Inc. v. Pac, 194 Conn. 677 (1984) ... 23

Lavine v. Milne, 424 U.S. 577, 47 L.Ed.2d 249 (1976) ... 19, 20, 44

Medical Soc. of the State of N.Y. ... v. Toia, 560 F.2d 535 (2d Cir. 1977) ... 14

Morales v. Trans World Airlines, Inc., 504 U.S. 374, 112 S.Ct. 2031 (1992) ... 16

New York State Dept. of Social Services v. Dublino, 413 U.S. 405 93 S.Ct. 2507 (1973) ... 27

O'Shea v. Littleton, 414 U.S. 488 ... 16

Patsy v. Florida Board of Regents, 457 U.S. 496 (1982) ... 21

Pennhurst State School and Hospital v. Halderman (Pennhurst I), 451 U.S. 1 (1981) ... 11, 27

Plaza Health Laboratories Inc. v. Perales, 878 F.2d 577 (2d Cir. 1989) ... 15

Potwora v. Dillon, 386 F.2d 74 (2d Cir. 1967) ... 16

Preterm, Inc. v. Dukakis, 591 F. 2d 121 (1st Cir. 1979) ... 37, 41

***v** *Romm Arts Creations, Ltd. v. Simcha Intern., Inc.*, 786 F.Supp. 1126 (E.D.N.Y. 1992) (citations omitted) ... 14

SEC v. Frank, 388 F.2d 486 (2d Cir. 1968) ... 50

Scalzo v. Danbury, 224 Conn. 124 617 A.2d 440 (1992) ... 22

Skandalis v. Rowe, 14 F.3d 173 (2d Cir. 1994) ... 34

State of New York v. Lyng, 829 F.2d 346 (2nd Cir. 1987) ... 14

Steiberger v. Bowen, 801 F.2d 29 (2d Cir. 1986) ... 15

Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747 (1986) ... 13

United States v. Larionoff, 431 U.S. 864 97 S.Ct. 2150 (1977) ... 34

United States v. Utah Construction & Mining Co., 384 U.S. 394 (1965) ... 23

University of Tennessee v. Elliott, 478 U.S. 788 ... 21

Virginia Hospital Assn. v. Kenley, 427 F.Supp. 781 (E.D. Va. 1977) ... 37

Visual Sciences, Inc. v. Integrated Communications, Inc., 660 F.2d 56 (2nd Cir. 1981) ... 49

Wallace v. Kern, 520 F.2d 400 (2d Cir. 1975) ... 16

Weaver v. Reagan, 886 F.2d 194 (8th Cir. 1989) ... 45

Weinberger v. Salfi, 422 U.S. 749, 95 S.Ct. 2457 (1975) ... 46, 47

Williams v. McKeithen, 939 F.2d 1100 (5th Cir. 1991) ... 49

Women's Health Services v. Maher, 482 F.Supp. 725 (D. Conn. 1980) ... 37

Zanghi v. Incorporated Village of Old Brookville, 752 F.2d 46 (2d Cir. 1985) ... 22

***vi STATUTES** ...

28 U.S.C. § 1292 ... 5

28 U.S.C. § 1331 ... 5

42 U.S.C. § 1395x(n) ... 25

42 U.S.C. § 1396 ... passim

42 U.S.C. § 1396a(a)(10) ... 30, 43, 48

42 U.S.C. § 1396a(a)(17) ... 43, 48

42 U.S.C. § 1983 ... 21, 22

Conn. Gen. Stat. § 4-176 ... 40

Conn. Gen. Stat. § 4-180 ... 17

Conn. Gen. Stat. § 4-183 ... passim

Conn. Gen. Stat. § 17b-60 ... 16

Conn. Gen. Stat. § 17b-61 ... 16

Conn. Gen. Stat. § 17b-61(b) ... 17

RULES AND REGULATIONS ...

42 C.F.R. § 414.202 ... 25

42 C.F.R. § 430.0 ... 33, 34

42 C.F.R. § 440.230 ... 31, 34, 43, 48

42 C.F.R. § 440.240 ... 32

42 C.F.R. § 440.70 ... 24, 29

F.R.C.P. Rule 52 ... 48

F.R.C.P. Rule 65 ... 49

Regulations of Connecticut State Agencies Sec. 17-2-80B ... 12, 26

OTHER AUTHORITIES

Conn. MAP Manual § 189.E.II.a and § 189.E.III.a ... 8, 41, 42

H. Rep. N. 92-231, reprinted in, 1972 U.S.C.C.A.N. 4989, 5086 ... 31

Medical Assistance Manual, § 5-50.1-00 ... 33, 34, 40

Moore's, Federal Practice, § 65.04[3] ... 49, 50

***vii** Note, State Restrictions on Medicaid Coverage of Medically necessary Services, 78 Column. L. Rev. 1491, 1498 (1978) ... 26

Pub. L. 89-97, 79 Stat. 286 ... 30

Pub. L. 92-603 ... 31

1 *PRELIMINARY STATEMENT

This appeal is taken from the orders of the United States District Court for the District of Connecticut (Arterton, J.) granting, clarifying and extending plaintiffs' motions for preliminary injunction.

JURISDICTIONAL STATEMENT

The named plaintiffs filed a complaint alleging jurisdiction in the District Court under 28 U.S.C. § 1331 and claimed violations by the Commissioner of the Medicaid provisions of the Social Security Act, 42 U.S.C. § 1396 *et seq*., on April 11, 1996. J.A. A-16, A-17. Intervenors Stevenson and Slekis were subsequently permitted to intervene. The applications of both the named plaintiffs and the intervenors for preliminary injunctions were granted on January 10, 1997. J.A. A-1703. The preliminary injunction was clarified on February 13, 1997. J.A. A-1797, and was extended to the class on March 6, 1997. J.A. A-1821. A timely notice of appeal was filed on February 7, 1997. J.A. A-1789. An amended notice of appeal was timely filed on February 14, 1997 in response to the clarification of February 13, 1997. A second amended notice of appeal was timely filed on March 6, 1997 after the court entered its order extending preliminary injunctive relief to the class. J.A. A-1821. This Court has jurisdiction over this appeal pursuant to 28 U.S.C. § 1292 (from the District Court's orders granting and modifying injunctions). The appeal is from three interlocutory orders, granting clarifying and extending a preliminary injunction.

2 *STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

1. Was a preliminary injunction inappropriate because the plaintiffs had an adequate remedy at law?

2. With respect to the plaintiffs DeSario, Emerson and Stevenson, were their claims barred by res judicata?

3. Did the Court err by issuing preliminary relief to the plaintiffs, Emerson, DeSario and Stevenson when the equipment they were requesting was not durable medical equipment?

4. Did the Court err in entering a preliminary injunction in the absence of allegations, proof and findings that the Medicaid benefit package offered by the Commissioner is unreasonable because it fails to provide a meaningful benefit package to the Medicaid population as a whole?

5. Did the court err in issuing a preliminary injunction in the absence of an evidentiary record that would support the necessary findings of fact?

STATEMENT OF THE CASE

STATEMENT OF THE PROCEEDINGS

The plaintiffs DeSario and Emerson filed this action, on behalf of themselves and all others similarly situated, April 11, 1996, challenging on various grounds the Defendant Joyce Thomas' use of an exclusive list to determine coverage of items of durable Medical equipment provided pursuant to the Medicaid Act, 42 U.S.C. § 1396 *et sep*., under the State of Connecticut Department of Social Services' Medicaid Program. The defendant is Joyce Thomas in her official capacity as Commissioner of the ***3** Connecticut Department of Social Services (hereinafter DSS). J.A. A-16, A-17. At the same time plaintiffs DeSario and Emerson moved for a preliminary injunction. J.A. A-145-A-247. On April 24, 1996, the court heard argument on the motion for a preliminary injunction. On May 20, 1996, the court heard evidence limited by the court to the issue of whether the equipment requested by plaintiffs DeSario and Emerson constituted durable medical equipment. J.A. A-342-A-496. The court did not decide the issue or rule on the motion at that time.

On May 3, 1996 the plaintiffs filed a motion for class certification. J.A. A-143. While those motions were pending, Caroline Stevenson moved to intervene on May 6, 1996. J.A. A-248, A-253. Intervenor Stevenson moved for preliminary injunction with regard to her requests for equipment on May 8, 1996. J.A. A-264. On May 15, 1996, the court granted Stevenson's motion to intervene and her complaint was docketed. J.A. A-6. On December 13, 1996, intervenor Thomas Slekis moved to intervene and for a preliminary injunction. J.A. A-607, A-612. On December 30, 1996 an evidentiary hearing was held on intervenor Slekis' motion for preliminary injunction. On that date the court ordered the commissioner to pay for intervenor Slekis' rental of a RIK mattress pending the conclusion of the hearing. J.A. A-988-A-989. The court entered an order certifying a class on January 7, 1997. J.A. A-1679. The hearing regarding intervenor Slekis continued on January 9, 1997 and was scheduled to continue on January 10, 1997 as well. J.A. A-1190, A-1193; A-1211. However, on that date the court announced her ruling and ***4** entered preliminary injunctions on behalf of the plaintiffs DeSario and Emerson and the intervenors Stevenson and Slekis supported by a fifty-eight page memorandum of decision. J.A. A-1217.

The defendant filed a timely notice of appeal from the court's order on February 7, 1997, and amended notices of appeal on February 14, 1997 from the trial court's February 13, 1997 clarification of its January 10, 1997, ruling and on March 6, 1997 from the trial court's order extending preliminary injunctive relief to the class.

STATEMENT OF FACTS

SUMMARY OF ARGUMENT

In this case the trial court entered a preliminary injunction on January 10, 1997 with respect to plaintiffs DeSario and Emerson and intervenor Stevenson as follows:
(1) The defendant is enjoined from using Conn. MAP Manual § 189.E.II.a and § 189.E.III.a as the exclusive determinant of plaintiffs' preauthorization requests for durable medical equipment.
(2) Plaintiffs shall be permitted to resubmit their requests for prior authorization of DME based on a recent physician's prescription and/or report reflecting the medical necessity for the requested item. Such requests must be acted upon by the defendant within seven (7) working days after receipt, and may not be denied solely on the grounds that the requested DME is or is not listed in Conn. MAP Manual § 189.E.II.a or § 189.E.III.a. If defendant denies any of the plaintiffs' requests for prior authorization, the plaintiffs may appeal the defendant's fair hearing procedures which shall also reflect defendant's discontinuation of the currently constituted MED list as dispositive for such appeals of denials of prior approvals. Plaintiffs may thereafter appeal ***5** adverse fair hearing decisions to state court pursuant to Conn. Gen. Stat. § 4-183.

Joint Appendix A-1757, A-1758.

With respect to intervenor Slekis the court entered the following injunction:
(1) The defendant shall reconsider Mr. Slekis's request for prior authorization within seven (7) working days of this order. In determining whether to grant prior authorization for the RIK mattress, the defendant may not rely solely on the MEDS fee schedule, but must take into consideration its assessment of Mr. Slekis's medical needs and the adequacy of alternative devices to meet those needs.
(2) During the pendency of Mr. Slekis's request for prior authorization, including any fair hearing or appeals process, the defendant shall pay the charges necessary for Mr. Slekis to retain the RIK mattress. If defendant's determination and any subsequent ultimately prove adverse to Mr. Slekis, defendant shall continue to make the requisite payments for the RIK mattress until some alternative product deemed by defendant to meet Mr. Slekis's medical needs is provided to him.

Joint Appendix A-1759-A-1760.

On February 13, 1997, the court issued a "clarification" of its former injunctions and ruled that:
defendant may not require those plaintiffs who receive redeterminations of their requests for prior authorization pursuant to the preliminary injunction, to demonstrate that medical equipment covered by the department is inadequate with respect to the Medicaid population as a whole.

Joint Appendix A-1802-A-1803.

Finally, on March 6, 1997, the court expanded the preliminary injunction to all members of the certified class:
The preliminary relief provided to the plaintiff DeSario shall be extended to all members of the redefined "DeSario" subclass (see Doc. 90), while ***6** the preliminary relief provided to plaintiff Emerson sill be extended to all members of the redefined "Emerson" subclass (see Doc. 90).[FN1]

FN1. The referenced subclasses were redefined by the court on February 13, 1997 as:

the "DeSario" subclass will consist of:
All Connecticut Medicaid recipients who have been, or who in the future will be, denied Medicaid coverage for equipment which they allege to be durable medical equipment on the basis that such equipment is not included on the Connecticut Department of Social Services' fee schedule list for such equipment.

the "Emerson" subclass will consist of:
All Connecticut Medicaid recipients who have been, or who in the future will be, denied Medicaid coverage for equipment which they allege to be durable medical equipment on the basis that such equipment is not included on the Connecticut Department of Social Services' fee schedule list for such equipment, because such equipment is identified by the Department as being specifically excluded from coverage.

Joint Appendix A-1823.

The trial court based these rulings on its finding that the plaintiffs had established irreparable harm, inadequacy of a remedy at law and likelihood of success on the merits of their claim that the Commissioner's use of an exclusive list of covered durable medical equipment in the State of Connecticut's Medicaid program violated the Medicaid provisions of the Social Security Act, 42 U.S.C. § 1396 *et seq*.

The Medicaid program is a joint state federal program enacted under the spending clause of the U.S. Constitution. Because the Social Security Act was enacted pursuant to Congress' spending power, the legitimacy of which "rests on whether the ***7** state voluntarily and knowingly accepted the terms of the 'contract,'" the States may only be required to comply with conditions of participation that are "clearly" and "unambiguously" expressed in the court as conditions for federal financial participation. *Pennhurst State School and Hospital v. Halderman* (*Pennhurst I*). 451 U.S. 1, 17, (1981).

In their complaints, the plaintiffs alleged that the Commissioner had failed to provide for them certain equipment which they characterized as durable medical equipment and which they claim is medically necessary. The plaintiff Emerson complained that the Commissioner had refused to provide her with an air conditioner and air

purifier. The plaintiff DeSario complained that the commissioner had failed to provide her with an environmental control unit. J.A. A-20-A-26. The intervenor Stevenson claimed that the commissioner had failed to provide her with an air purifier, air conditioner, and humidifier. J.A. A-269-A-271. They acknowledged in their complaints that they have received adverse decisions on their requests in administrative hearings before the Department of Social Services. Intervenor Slekis, although alleging that his request for equipment had been denied, had not pursued it through the administrative hearing process.

Injunctive relief is inappropriate where the plaintiffs have an adequate remedy at law. The trial court erred on this point in confusing the issue of the adequacy of the remedy at law with the doctrine of abstention. The court was correct in finding that abstention was unnecessary since there were no pending ***8** proceedings in any state forum. However, the court was incorrect in concluding therefore that there was no adequate remedy at law. The plaintiffs had an adequate remedy in the form of administrative hearings before the Commissioner and the right to appeal from the Commissioner's decisions denying their requests to the Superior Court. Equity will not act to benefit plaintiffs whose remedy at law is only inadequate because they failed to pursue it.

Further litigation on the legality of the Commissioner's decision regarding this equipment was precluded under those principals of claim preclusion also known as **res judicata**. To the extent that the court was correct in holding that the plaintiffs' claims were not precluded, the court erred in finding that no evidentiary hearing was necessary to inquire into the factual background of the plaintiffs' claims of medical necessity, particularly since a finding of medical necessity was not necessary to the determination made by the hearing officer in any of the plaintiffs' fair hearings.

In addition, the Commissioner contends that the plaintiff cannot prevail on their claims on the merits. Most of the equipment[FN2] requested by the plaintiffs does not meet the regulatory definition of durable medical equipment in that it is useful to persons in the absence of illness or injury and is generally and customarily used for other than medical purposes. (Regulations of Connecticut State Agencies Sec. 17-2-80B). Air ***9** conditioners, air purifiers and environmental control units, are all useful to healthy persons for other than medical purposes.

> FN2. The only exception is the special mattress requested by the Intervenor Slekis which the defendant does not dispute constitutes durable medical equipment.

The Commissioner also contends that she has the authority to place limitations on the amount, duration and scope of the services she provides in the Medicaid program notwithstanding that some individuals may be denied necessary services as a result.

The Department's policies do not constitute illegal irrebuttable presumptions.

Finally, the court erred in erred in issuing a preliminary injunction in the absence of an evidentiary record that would support the necessary findings of fact.

ARGUMENT

I. The Standard Of Review Of The Trial Court's Decision Granting The Plaintiffs' Motion For Preliminary Injunction Is Plenary For Issues Of Law And Abuse Of Discretion For Issues Of Fact.

This appeal challenges the trial court's order of preliminary injunctive relief to the plaintiffs.

The standard of appellate review applicable to the issuance of a preliminary injunction varies with the nature of

the claims raised. "If a district court's ruling rests solely on a premise as to the applicable rule of law, and the facts are established or of no controlling relevance, that ruling may be reviewed even though the appeal is from the entry of a preliminary injunction." *Thornburah v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 757 (1986); "When such is the case, and with a full record before it, an appellate court need not accord the ***10** customary deference to the district court's discretion, but instead may employ its own plenary scope of review." *State of New York v. Lyng*, 829 F.2d 346, 349 (2nd Cir. 1987). In the present case, the following issues raised are pure issues of law. The Commissioner claims that as a matter of law, the trial court erred by entertaining the plaintiffs' request for a preliminary injunction; a) when they had an adequate remedy at law pursuant to their statutory remedy of administrative appeal pursuant to Conn. Gen. Stat. § 4-183; b) with respect to the named plaintiffs and intervenor Stevenson, their claims were barred by res judicata; c) the commissioner had the discretion, pursuant to the Medicaid Act, to impose amount, scope and duration limitations and was not required to meet all medical need; and d) the court found facts without holding an evidentiary hearing over the persistent and unwavering objections of the commissioner.

II. *The Trial Court Erred In Finding That The Plaintiffs Did Not Have An Adequate Remedy At Law.*

A preliminary injunction "is an extraordinary and drastic remedy which should not be routinely granted." *Medical Soc. of the State of N.Y.... v. Toia*, 560 F.2d 535, 537 (2d Cir. 1977). The movant must show that she clearly is entitled to a remedy. *Romm Arts Creations, Ltd. v. Simcha Intern., Inc.*, 786 F.Supp. 1126, 1133 (E.D.N.Y. 1992) (citations omitted). The usual test for the granting of a preliminary injunction is that the moving party must show: (1) irreparable harm; and (2) either (a) likelihood of success on the merits, or (b) sufficiently serious ***11** questions going to the merits *plus* a balancing of hardships tipping decidedly in favor of the movant. *Plaza Health Laboratories Inc. v. Perales*, 878 F.2d 577, 580 (2d Cir. 1989); *Jackson Dairy, Inc. v. H.P. Hood & Sons, Inc.*, 596 F.2d 70, 72 (2d Cir. 1979). Where the moving party seeks to stay governmental action taken in the public interest pursuant to a statutory or regulatory scheme, the district court should not apply the less rigorous fair-ground-for-litigation standards and should not grant the injunction unless the moving party establishes, along with irreparable injury, a likelihood that he will succeed on the merits of his claim. *Plaza Health Laboratories*, 878 F.2d at 580. The Second Circuit has held, "when significant public interests are involved, courts have a special obligation to assess carefully the propriety of preliminary injunctive relief." *Steiberger v. Bowen*, 801 F.2d 29, 34 (2d Cir. 1986). Significantly, that statement was made in support of the lower court's further review of the propriety of issuing an injunction against the Government even after the lower court had satisfied itself that both irreparable harm and a probability of success on the merits had been shown. *Steiberger*, 801 F.2d at 33. In accord, *Able v. U.S.*, 44 F.3d 128, 130 (2d Cir. 1995).

***12** Injunctive relief is inappropriate when an adequate legal remedy exists. This concept has been applied in suits for injunctions under the civil rights act. *Potwora v. Dillon*, 386 F.2d 74 (2d Cir. 1967). "... [T]he [Supreme] Court surely had no intention to abrogate in civil rights cases the historic rule... that suits in equity shall not be sustained in courts of the United States 'In any case where a plain, adequate and complete remedy may be had at' law.'" *Id*. at 77. "We recognize of course that exhaustion of state judicial remedies is not required in actions brought under section 1983.... This rule does not, however, alter the traditional principle that a Plaintiff seeking equitable relief must demonstrate that no adequate remedy at law exists and that, absent injunctive relief, he will suffer irreparable injury." *Wallace v. Kern*, 520 F.2d 400, 407 (2d Cir. 1975). *See also Q'Shea v. Littleton*, 414 U.S. 488, 499; *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 112 S.Ct. 2031, 2035 (1992). In the instant case a plain, adequate and complete remedy exists.

The State of Connecticut has established an elaborate statutory scheme for the review of decisions of adminis-

trative agencies. Conn. Gen. Stat. §§ 17b-60 and 17b-61 provide for the right to hearing by persons aggrieved by decisions of the Commissioner. These statutes also provide that the applicant for ***13** a fair hearing may appeal an adverse decision pursuant to Conn. Gen. Stat. § 4-183. Conn. Gen. Stat. § 4-183 provides for an appeal by a person aggrieved by the decision of an administrative agency to the Connecticut state courts.

Of special interest in the context of this case are the provisions that provide for an application to court for an order mandating that the agency issue a decision "forthwith" if the agency fails to issue a decision in a contested case within ninety days of the close of evidence; Conn. Gen. Stat. § 4-180; second, make appeals from the decision of the Commissioner privileged cases; Conn. Gen. Stat. § 17b-61(b); and third, provide for reversal of agency action upon appeal for violations of constitutional or statutory provisions or other error of law, Conn. Gen. Stat. § 4-183(j)(1)(4).

Pursuant to Conn. Gen. Stat. § 4-183(j), the Court may reverse if it finds, inter alia, that: "the administrative findings, inferences, conclusions, or decisions are: (1) in violation of constitutional or statutory provisions.... [or] (4) affected by other error of law." Conn. Gen. Stat. § 4-183(j). In the course of determining appeals from administrative agencies, the courts of Connecticut have taken up not only issues of claimed constitutional violations, *Daly v. Delponte*, 225 Conn. 499, 624 A.2d 876 (1993); but claims that an agency has failed to ***14** comply with governing federal statutes. *Griffin Hospital v. Commission on Hospitals and Health Care*, 200 Conn. 489, 512 A.2d 199 (1986). Indeed, this court has specifically found that the provisions of Conn. Gen. Stat. § 4-183 provide an adequate means of addressing both statutory and constitutional claims. *Doe v. State of Conn. Dept. of Health Services*, 75 F.3d 81 (2d Cir. 1996).

The content of the injunction issued by the trial court highlights the adequacy of the plaintiffs' and intervenors' remedy at law. The court essentially reviewed the hearing previously held for the plaintiffs Emerson and DeSario and intervenor Stevenson and found that certain evidence was inappropriately relied on by the agency and its hearing officers. The court remanded the case to the agency to process the request for equipment without reference to the exclusive list of covered durable medical equipment and ordered that at any rehearing the hearing officer was not to rely on the list to deny the plaintiffs' and intervenors' requests. This is precisely the type of relief the administrative hearing process and appeal to the Connecticut Superior Court was designed to provide. *See*, *e.g.*, *Burinskas v. Department of Social Services*, 240 Conn. 141 691 A.2d 586 (1997), (holding in a Medicaid eligibility case that a hearing officer applied the wrong test to the facts and remanding for a new hearing at which the proper test was to be applied.) In the case of intervenor Slekis, the court ordered that the agency consider his request for a RIK mattress without ***15** reliance on its exclusive list and that the agency pay for the equipment in question pending all hearings and appeals on any denial even though Slekis had never availed himself of the administrative hearing procedure before the Department. In essence, in the case of Mr. Slekis, the court acted as a substitute for both the administrative hearing process and the administrative appeal through the Connecticut state courts.

With respect to intervenor Slekis, the trial court's error was in substituting its finding of medical necessity for the specialty mattress he requested and proceeding to order the Commissioner to pay for his mattress without regard to the requirement in this, as in other welfare programs, that Mr. Slekis prove his eligibility to the agency staff and then, if denied by the staff, to the agency hearing officer before such coverage was provided to him. "Certainly nothing in the Constitution requires that benefits be initiated prior to the determination of an applicant's qualifications at an adjudicatory hearing." *Lavine v. Milne*, 424 U.S. 577, 586, 47 L.Ed.2d 249 (1976). The court appeared to find that intervenor Slekis could be provided with the equipment he sought by persuading her, not the agency staff, or its hearing officers, of his eligibility for it. The court also erred by placing on the Com-

missioner the burden of proving that items on her exclusive list would be adequate to meet Mr. Slekis's need. J.A. A-1752. The 'burden on intervenor Slekis, however, is to prove his eligibility to the agency not to the trial court. "At all times, the burden of establishing eligibility is on the applicant. ***16***Lavine v. Milne*, 424 U.S. 577, 583-84, 96 S. Ct. 1010, 47 L.Ed.2d 249 (1976)." *Harrison v. Commissioner of Income Maintenance*, 204 Conn. 672, 679, 529 A.2d 188 (1987). "... the failure of an applicant to prove an essential element of eligibility will always result in the denial of benefits, much as the failure of a tort or contract plaintiff to prove an essential element of his case will always result in a nonsuit." *Lavine*, *supra* at 584 47 L.Ed.2d 249 (1976).

"If... the... Court concludes that the absence of a remedy at law at this time is due to respondent's failure to pursue that remedy, then equity will not intervene and the complaint should be dismissed. The inadequacy of his legal remedy would then be due to his own choice not to pursue it." *Commissioner v. Shapiro*, 424 U.S. 614, 634 n.15, 47 L.Ed.2d 278, 96 S.Ct. 1062 (1976). The fact that the legal remedy may be time-consuming to pursue does not make it inadequate. There is no constitutional right to welfare benefits and thus no fundamental right to have a review of a decision on eligibility made in some specific time frame. *See*, *e.g.*, *Lavine v. Milne*, 424 U.S. 577, 47 L.Ed.2d 249 (1976) in which the disqualification of a person from the New York Home Relief program for voluntary termination of employment for a period of seventy-five days was upheld in the face of a challenge claiming that the length of time necessary to obtain relief made the right to review meaningless.

In any event, as noted above, the state statutory scheme governing administrative agency proceedings and appeals therefrom provides a mechanism which can be used to expedite the process. ***17** In summary the Plaintiffs' claims are subject to a plain, adequate and complete remedy under the laws of the state of Connecticut; and they were, therefore, not entitled to an injunction.

III. ***The Plaintiffs' Deaario And Emerson And Intervenor Stevenson's Claims Are Precluded By Res Judicata***

.

The plaintiffs Desario and Emerson and intervenor Stevenson have each applied for and received an administrative hearing regarding the same claims that they made before the district court. J.A. A-16, A-22, A-25, A-26, A-306. The hearing in each of their cases is concluded and the result was adverse to each of the plaintiffs. The plaintiffs and intervenor affirmatively allege these matters in their complaints. Through this action they are attempting to mount a collateral attack on the results of the administrative hearings. Such an attack is barred by the principal of **res judicata.**

While a plaintiff in a 42 U.S. C. § 1983 need not exhaust administrative remedies, *Patsy v. Florida Board of Regents*, 457 U.S. 496 (1982), she is bound, in an appropriate case, by the adverse outcome of an administrative remedy she chose to pursue. *University of Tennessee v. Elliott*, 478 U.S. 788, 796-799. While that case addressed the binding nature of findings of fact in an administrative proceeding, this Court has applied the same principals to findings of law as well.

The doctrine of **res judicata**, or claim preclusion, provides that a final judgment on the merits in one action bars subsequent relitigation of the same claim by the same parties and by those in privity with the parties.... That bar extends ***18** both to issues actually decided in determining the claim asserted in the first action and [to] issues that could have been raised in the adjudication of that claim....

....

Res judicata applies to judgments by courts and by administrative agencies acting in an adjudicative capacity....

Greenberg v. Bd. of Gov. of Federal Reserve System, 968 F.2d 164, 168 (2d Cir. 1992).

This Court looks to the applicable state law to determine whether to give preclusive effect to the determination of a state administrative proceeding in a 42 U.S.C. § 1983 action. If a Connecticut court would give preclusive effect to the result of the administrative hearings which the plaintiffs received, then this court must also do so. *Zanghi v. Incorporated Village of Old Brookville*, 752 F.2d 42, 46 (2d Cir. 1985).
Under claim preclusion analysis, a claim - that is, a cause of action - includes all rights of the plaintiff to remedies against the defendant with respect to all or any part of the transaction, or series of connected transactions, out of which the action arose.... Moreover, claim preclusion prevents the pursuit of any claims relating to the cause of action which were actually made or might have been made.(Citations omitted; internal quotation marks omitted.)

Scalzo v. Danbury, 224 Conn. 124, 127-28, 617 A.2d 440 (1992).

It is clear that the Connecticut courts would accord the administrative hearing decisions in this case claim preclusive effect. The Connecticut Supreme Court has long disapproved collateral attacks on administrative decisions in lieu of administrative appeal. "We have frequently stated that when a ***19** party has a statutory right of appeal from the decision of an administrative agency, he may not, instead of appealing, bring an independent action to test the very issue which the appeal was designed to test.' *Carpenter v. Planning & Zoning Commission*, 176 Conn. 581, 598, 409 A.2d 1029 (1979)..." *Laurel Park, Inc. v. Pac*, 194 Conn. 677, 685 (1984).

In determining whether to give preclusive effect to the decision of an administrative tribunal, the Connecticut Supreme Court has focused on whether the parties to an administrative proceeding have "an adequate opportunity to litigate." *Convalescent Center of Bloomfield, Inc. v. Department of Income Maintenance*, 208 Conn. 187, 195, 544 A.2d 604, *quoting United States v. Utah Construction & Mining Co.*, 384 U.S. 394, 422 (1965). In *Convalescent Center*, *supra*, the Court determined that the opportunity to appeal and raise a full panoply of legal issues was determinative of the question of whether the administrative process afforded the requisite adequate opportunity to litigate.

There is no question but that the Connecticut scheme for the appeal of an administrative agency ruling provides an "adequate opportunity to litigate."
"On appeals from agency actions, the Connecticut courts have addressed claims based on federal statutes and state and federal constitutional law. *See Daly v. DelPonte*, 225 Conn. 499, 624 A.2d 876 (1993) (addressing claims under state and federal constitutional law); *Griffin Hosp. v. Comm'n on Hosps, and Health Care*, 200 Conn. 489, 493-495, 512 A.2d 199, 203-04 (considering whether federal Medicare statute preempted administrative agency from regulating costs at medical facilities), *appeal dismissed*, 479 U.S. 1023 (1986). Connecticut law therefore affords... an adequate ***20** means of addressing any asserted violations of federal law...."

Doe v. State of Conn., Dept. of Health Services, 75 F.3d 81, 85 (2d Cir. 1996).

In this case, the plaintiffs are requesting the precise relief that they requested from the administrative tribunal. The claims they are making are the same claims arising out of the same requests that gave rise to the fair hearing decisions which they in essence requested the trial court to overturn. This case presents a clear example of administrative **res judicata**. For this reason, the plaintiffs have no chance of prevailing on the merits on the case; and, therefore, the trial court erroneously granted them preliminary injunctive relief.

IV. ***The Equipment Requested By The Plaintiffs Does Not Fall Within The Definition Of Durable Medical***

Equipment.

This case also involves the state's categorization of items as durable medical equipment. 42 U.S.C. § 1396d(a)(7) provides that "[t]he term 'medical assistance' means *payment* of part or all of the cost of the following care and services... (7) home health services." (emphasis added). The Medicaid statute does not further define what is meant by "home health services" and does not provide for the payment of the cost of any medical equipment whatsoever.

42 C.F.R. § 440.70(b)(3), however, defines home health services as including:
***21** (3) Medical supplies, equipment, and appliances suitable for use in the home.

Medical equipment is not further defined under the Medicaid act or federal regulations relating to Medicaid. However, under Medicare, durable medical equipment is described:
The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home....

42 U.S.C § 1395x(n).

In addition, durable medical equipment is further defined in regulations relating to the Medicare Act as follows:
Definitions. Durable medical equipment means equipment, furnished by a supplier or a home health agency that-
(1) Can withstand repeated use;
(2) Is primarily and customarily used to serve a medical purpose;
(3) Generally is not useful to an individual in the absence of an illness or injury; and
(4) Is appropriate for use in the home. (*See* § 410.38 of this chapter for a description of when an institution qualifies as a home.)

42 C.F.R. § 414.202

The preceding definition was adopted almost verbatim by the Commissi'oner in regulation:
***22** B. Procedures for Securing Durable Medical Equipment. Providers including those who have contracted with the Department are to supply durable medical equipment which meets the following criteria:
1. Equipment capable of repeated use 2. Equipment primarily and customarily used to serve a medical purpose; 3. Equipment generally not useful to a person in the absence of any illness or injury.

Regulations of Connecticut State Agencies Sec. 17-2-80B. The definition is reiterated in the Commissioner's Medical Services Policy DME section 189B1.

The equipment requested by the named plaintiffs and intervenor Stevenson is useful to persons in the absence of illness or injury. An air conditioner is common household equipment used to increase the comfort level of persons in the heat. Air purifiers are commonly used to decrease the level of dust and pollen in the air. An environmental control unit is marketed and sold as a convenience to healthy individuals. All of these items are useful to persons in the absence of illness or injury. They also are generally and customarily used for other than medical purposes. They therefore do not meet the definition of durable medical equipment and cannot be supplied to these plaintiffs without regard to whether or not the Commissioner is permitted to utilize an exclusive list of covered medical equipment.[FN3] In its discussion on this point the trial court simply assumed that the equip-

ment in question was durable medical equipment without even ruling on whether it fell within the defendant's definition. J.A. A-1735.

FN3. As noted previously, the Commissioner does not dispute that the mattress requested by intervenor Slekis falls within the definition of durable medical equipment.

23 V. *The District Court Erred In Entering A Preliminary Injunction In The Absence Of Allegations. Proof And Findings That The Benefit Package Offered By The Department Is Unreasonable Because It Fails To Provide A Meaningful Benefit Package For The Medicaid Population As A Whole.

A. The Commissioner Is Authorized To Restrict The Amount, Duration And Scope Of Covered Medicaid Services By Employing An Exclusive List Of Covered Medical Equipment.

1. Rules of Construction

Plaintiffs' claims arise out of the Medicaid program, which is a program of "cooperative federalism" wherein Congress allows federal financial participation to the states that agree to comply with the statutory conditions of participation, but intentionally affords a wide range of discretion to the states to design their state Medicaid programs within the outer confines of federal law. *New York State Dept. of Social Services v. Dublino*, 413 U.S. 405, 421, 93 S.Ct. 2507, 2516 (1973). Because plaintiffs' statutory claims arise out of a cooperative joint federal-state funding program whose "legitimacy... rests on whether the State voluntarily and knowingly accept(ed) the terms of the 'contract,"' plaintiffs must establish that *the Act* "clearly" and "unambiguously" imposes a mandatory "requirement" that the states fund all medically necessary services. ***24***Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17, 101 S. Ct. 1531, 1540 (1981).

2. Statutory Provisions

The purpose of the Act is to authorize federal funds for the purpose of assisting the states in providing "medical assistance" to needy aged, blind and disabled persons and to families with dependent children "*as far as practicable* under the conditions in such State." 42 U.S.C. § 1396.[FN4]

FN4. Congress therefore recognizes, even in the section of the Act that establishes the precatory goals of the Program (as opposed to the mandatory conditions of participation), that the extent to which "medical assistance" will be provided can depend upon the conditions in, and upon the elections made by, each participating state.

"Medical assistance" is defined in 42 U.S.C. § 1396d(a) as "payment of *part or all* of the cost of the ... care and services (listed in § 1396d(a)(1)-(25). "(emphasis added).[FN5] The Act then lists in 42 U.S.C. § 1396d(a)(1)-(25) broad categories of services that may, or must, be covered by state Medicaid programs, including physicians services, hospital services, home health services, etc.

FN5. The definition of "medical assistance" as payment for "*part* or all" of the listed categories of services suggests that the states may limit the "amount, scope, or duration" of each category of service that they cover under their state Medicaid programs.

"Home health services" is not defined in the Act. However implementing regulations define "home health services" as including part time or intermittent nursing, home health aide, physical therapy, occupational therapy, and speech pathology services provided by a home health agency, and "medical supplies, ***25** equipment, and

appliances suitable for use in the home." 42 C.F.R. § 440.70. Plaintiffs in this action challenge the Department's denial of their requests for Medicaid coverage of items that allegedly constitute "medical equipment." The legitimacy of their claim, therefore, depends upon the scope of the state's obligation to provide "medical equipment" as "home health services."

Even as to mandatory categories of services, the participating states have wide discretion to determine the extent to which *each* category of service will be covered. The text of the Act, as it is currently codified, repeatedly recognizes the authority of each participating state to limit the "amount, scope, or duration" of each service that is to be covered by the state. Specifically, the Act provides that each state must specify the standards "for determining eligibility for *and the extent of medical assistance under the plan* which are (A) consistent with the objectives of this subchapter...." 42 U.S.C. § 1396a(a)(17). (emphasis added) Furthermore, 42 U.S.C. § 1396a(a)(10)(B), which applies to individuals who qualify for Medicaid as "categorically needy," provides:
(B) that the medical assistance made available to any individual described in subparagraph (A) [i.e., the "categorically needy"]-
(i) shall be not less in *amount, duration, or scope. than the medical assistance made available to any other such individual,* and
(ii) shall *not be less in amount, duration, or scope than the medical assistance made available to individuals* not described in subparagraph (A). (emphasis added)

***26** Similarly, 42 U.S.C § 1396a(a)(10)(C)(i)(II) provides, as to those who qualify for Medicaid as "medically needy," that:
(i) the plan must include a description of...
(ii) the *amount, duration. and scope of medical assistance made available to individuals* in the group.[FN6] (emphasis added)

FN6. *Also see* 42 U.S.C. § 1396a(a)(2) which provides that a state's use of local funding to meet the state's financial contribution towards the cost of the program "will not result in lowering the amount, duration, scope, or quality of care and services provided under the plan."

3. History of the Act

The history of the Act further supports the discretion of the states to limit the extent of services that are covered under their state Medicaid programs. Specifically, the Medicaid Act, as originally adopted by Sec. 121 of the Social Security Amendments of 1965, Pub. L. 89-97, 79 Stat. 286, originally contained a provision, formerly codified at Sec. 1903(e) of the Act, 42 U.S.C. § 1396b(e)(1967), which required the states to work towards the goal of providing a comprehensive package of covered health care benefits. It provided as follows:
"The Secretary shall not make payments under the preceding provisions of this section to any State unless the State makes a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance, with a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care.

***27** Congress then *repealed* the requirement that states progressively provide a comprehensive package of health care benefits. Sections 230 and 231 of the Social Security Amendments of 1972, Pub. L. 92-603. The history to the 1972 amendments indicates, that, "Your committee has been concerned with the burden of the Medicaid pro-

gram on state finances and has included a provision in the bill which would remove section 1903(e) from the Act. When the operation of State Medicaid programs have been substantially improved, and there is assurance that program extensions will not merely result in more medical costs inflation, the question of required expansion of the program could then be reconsidered." H. Rep. N. 92-231, *reprinted in*, 1972 U.S.C.C.A.N. 4989, 5086.

The foregoing history is relevant to this Court's deliberations because it clearly reveals that Congress considered, and expressly rejected, imposing a statutory obligation upon the states to provide "comprehensive" services, which is the "obligation" that plaintiffs claim is the basis for their claim of "entitlement" to Medicaid payment for the cost of the "medical equipment" that is sought in this action.

4. Regulations

The Secretary's implementing regulations similarly provide that the states have discretion to limit the amount, scope, or duration of covered services. Specifically, 42 C.F.R. § 442.230 provides:
(a) The plan must specify *the amount, duration, and scope of each service that it provides* for -
***28** (1 The categorically needy; and
(2) Each covered group of medically needy.
(b) *Each service must be sufficient in amount, on and scoe to reasonabl achieve its purpose.*[FN7]

FN7. The fact that the services that are covered by a state are only required to "reasonably" achieve their purpose is inconsistent with the broad claim that whatever services are needed by an individual Medicaid recipient must be provided.

(c) The Medicaid agency must not arbitrarily deny or reduce the *amount, deration, or scope* of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.
(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.
42 C.F.R. § 440.240 provides:
Except as limited in § 440.250-
(a) The plan must provide that the services available to any categorically needy recipient under the plan are *not less in amount, duration, and scope than those services available to a medically needy recipient*; and
(b) The plan must provide that the services available to any individual in the following groups are equal in *amount, duration, and scope* for all recipients within the group: (1) The categorically needy. (2) A covered medically needy group[FN8]

FN8. Plaintiffs' claim that the states must cover all medically necessary services is rebutted by this regulation. It makes no sense for the implementing regulation to provide that the amount, scope, and duration must be "comparable" among eligibility groups if all medically necessary services must be covered for all recipients of assistance irrespective of how the person qualifies for assistance.

***29** Finally, 42 C.F.R. § 430.0 similarly provides that:
Within broad Federal rules, each State decides eligibility groups, *types* and *ranges* of services, payment levels for services, and administrative and operating procedures, (emphasis added).[FN9]

FN9. The use of the words "types" and "ranges" in § 430.0 is significant. The word "types" presumably refers to the broad categories of medical services that may be covered as "medical assistance" pursuant to 42 U.S.C. § 1396d(a). The word "ranges," then, must be given effect to mean something different, i.e., "ranges" must refer to what extent that services falling within the broad categories listed in § 1396d(a) will actually be covered by a State.

5. Administrative Interpretation

The Health Care Financing Administration of the Department of Health and Human Services (hereinafter, "HCFA") provides its authoritative administrative interpretation of the Act and its implementing regulations on the authority of the states to limit the amount, scope, and duration of covered medical equipment in its Medical Assistance Manual, § 5-50.1-00, transmitted by AT-77-26 (MSA). This authority provides as follows:
States may place a money ceiling upon medical supplies and equipment based on a reasonable, fixed dollar amount per month or per year; or may require prior authorization for items costing more than a certain amount; *or may list those items for which it will reimburse*; or may require prior authorization for durable equipment. (copy attached, emphasis added).

The Medical Assistance Manual is a manual that is utilized by HCFA to provide "an organized method of issuing material related ***30** to the implementation of MSA (Medical Services Administration now HCFA) regulations." The 1977 interpretation of federal law contained in the Medical Assistance Manual remains HCFA's official statement of agency interpretation.[FN10] At least for twenty years HCFA has interpreted the Act and its implementing regulations as authorizing the states to limit the scope of medical equipment by employing an exclusive list of covered equipment.[FN11]

FN10. The federal Secretary also filed a brief in the District Court as a third-party defendant, dated June 19, 1996. *See* Record. The Secretary indicates at p. 3 of her brief that, "In sum, the Secretary submits that, under federal law, the States may employ lists to define coverage (but not medical necessity) under the home health benefit, and may adopt a reasonable definition of 'medical supplies, equipment and appliances.'" The Secretary further indicates at pp. 6, 7 of her brief that, "In the Amended Complaint, Plaintiffs appear to confuse two separate concepts: coverage and medical necessity.... As discussed above, federal law requires that States deny Medicaid payment for services which are not described in the approved state plan (and implementing regulations or policies) as a *covered* item or services.... Thus for Medicaid payment to be proper, the item or services furnished must be *both* covered and medically necessary. Payment would not be appropriate for a medically necessary item which is not covered. *Alexander v. Choate,* 469 U.S. 287, 303 (1985) ("the benefit provided remains the package of individual services offered--not "adequate health care."')" (emphasis in original)

FN11. HCFA's interpretation of its own regulations must be accepted by this Court unless its interpretation is "plainly inconsistent with the wording of the regulations." *United States v. Larionoff*, 431 U.S. 864, 873, 97 S.Ct. 2150, 2156 (1977); *Skandalis v. Rowe*, 14 F.3d 173, 178 (2d Cir. 1994). Since HCFA's interpretation of its own regulations is not expressly precluded by the plain language of the regulations, and since plaintiffs do not challenge the validity of the regulations which have the force of substantive law, this Court is *required* to find that the state agency's limitation on the scope of covered medical equipment is consistent with 42 C.F.R. §§ 430.0, 440.230(b), and 440.240.

***31 6. Case Law**

The applicable judicial authority recognizes the authority of each state to set reasonable limitations on the extent to which medically necessary services will be covered. For example, in *Beal v. Doe*, 432 U.S. 438, 444, 97 S. Ct. 2366, 2371-72 (1977), our Supreme Court recognized, in *dicta*, that:

But nothing in the statute suggests that participating states are required to fund every medical procedure that falls within the delineated categories of medical care. Indeed, the statute expressly provides:

"A State plan for medical assistance must include reasonable standards for determining eligibility for and the extent of medical assistance under the plan which... are consistent with the objectives of this (Title).... "42 U.S.C. § 1396a(a)(17) (1970) ED., Supp. V). This language confers broad discretion on the States to adopt standards for determining the extent of medical assistance, requiring only that such standards be "reasonable" and "consistent with the objectives" of the Act." (emphasis added)[FN12]

FN12. Technically, the holding in *Beal* is limited to the ruling that the states are not required to fund "unnecessary--though perhaps desirable--medical services." 97 S.Ct. at 2371.

Subsequently, in *Alexander v. Choate*, 469 U.S. 287, 303, 105 S.Ct. 712, 721 (1985), the Supreme Court confronted a challenge to Tennessee's fourteen day per recipient annual durational limit on Medicaid payment for inpatient hospital services, which ***32** durational limit was inadequate to meet the needs of some handicapped recipients of assistance. In the context of ruling on the certified question of whether § 504 of the Rehabilitation Act precluded the state of Tennessee from adopting the challenged Medicaid durational limit, the Court ruled:

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 package of services 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."

The *Alexander* Court's construction on the scope of the Medicaid program is a *holding* which must be followed by the Court. It was necessary for the Court in *Alexander* to construe the Medicaid Act in order to rule on the certified § 504 question.

The applicable lower court authority is generally in accord, including: *Charleston Memorial Hospital v. Conradf* 693 F.2d 324, 330 (4th Cir. 1982) (upholding limitation on coverage of hospital care to 14 days per year); *Curtis v. Taylor*, 625 F.2d 645, 652 (5th Cir. 1980) (upholding a limitation on the amount of covered physician visits to three visits per month, ruling that the reasoning of the District Court, which had required all medically necessary services to be covered, "renders meaningless the power given the states to define the scope of service so long as what is provided is sufficient to reasonably achieve its purpose."); ***33** *Preterm, Inc. v. Dukakis,* 591 F. 2d 121 (1st Cir. 1979) ("... we find no mandate that all "medically necessary1 services be provided."); *Women's Health Services v. Maher*, 482 F.Supp. 725, 728 (D. Conn. 1980) (ruling that, "... Title XIX does not require state plans to cover, all necessary medical services," in the context of a ruling on a claim for Medicaid coverage for the cost of medically necessary abortions); *Budnicki v. Beal*, 450 F.Supp. 546, 557 (E.D. Pa., 1978) ("... [a state's Medicaid coverage policy] which is not irrational or arbitrary and counterproductive to the medical well-being of all Medicaid recipients must be sustained. The court is not in a position to determine which medical services should be provided to poor people given limited state finances and how to optimize that system."); *Virginia Hospital Assn. v. Kenley*, 427 F.Supp. 781 (E.D. Va. 1977); (upholding 21 day durational limit on coverage for in-patient hospital services); *District of Columbia Podiatry Society v. District of Columbia*, 407 F.Supp. 1259, 1264 (D.D.C. 1975) ("Title XIX is a welfare assistance program with limited funding.... Therefore, it is necessary for Medicaid funds to be used in the most economical manner possible, and it is left to the States, operating within

the Federal guidelines, to make such economic determinations. It is clear that podiatrists are not compensated under the D.C. plan for all services they may legally ***34** perform. But for that matter, neither is any other provider of medical services compensated for all such services"); *Anderson v. Director of Social Services*, 101 Mich. App. 488, 495, 300 N.W. 2d 921, 924 (1980) (recognizing that "it is generally accepted that fiscal restraints play a legitimate role in a state's decision making," in the context of upholding a limitation on the scope of covered dental services which excluded coverage of root canals and dental plates); Note, State Restrictions on Medicaid Coverage of Medically necessary Services, 78 Column. L. Rev. 1491, 1498 (1978) ("Thus while section 1396 establishes that one of Medicaid's objectives is to provide necessary medical services, it also reflects a congressional intent that each state have the freedom to tailor programs that are responsive to the fiscal conditions prevalent in that state.").

Dougherty v. Department of Human Services, 449 A.2d 1235 (N.J. 1982) is particularly relevant because it upheld a state Medicaid policy that denied coverage of Medicaid coverage for the cost of "equipment" that is remarkably similar to the "equipment" that is sought by several of the plaintiffs in this action. *Dougherty* upheld New Jersey's exclusion of coverage of an "air cleaner [because it] was included in a class of environmental control equipment whose primary and customary use is non-medical." *Id*. at 1236. *Dougherty* also noted that:
***35** "Title XIX does not require states to provide funding for all medical treatment falling within the five general categories.... We have never held that our statutory program requires state reimbursement for all medically necessary services for every patient." *Id*. at 1236.

Finally, *Dougherty* noted that each state has wide latitude to set limitations on the scope of covered benefits depending upon the conditions in each state, which coverage decisions are entitled to substantial deference. The Court ruled that:
"Judicial supervision of such (coverage) classifications would be unwise. Establishment of priorities is best left to the legislative branch and executive agencies. Since the standards adopted were reasonable and consistent with the objectives of the Medicaid Act, the Appellate Division found the regulation to be valid. We agree." Id. at 1238.

The New Jersey Court upheld the limitation on coverage by use of a list, the mechanism that Connecticut has chosen.

B. The District Court Abused Its Discretion By Not Applying The Correct Legal Standard In Granting Plaintiffs' Motion For A Preliminary Injunction

As noted *supra*, plaintiffs' complaint nowhere alleged, and plaintiffs offered no proof, that the equipment listed in the Department's exclusive fee schedule constitutes an unreasonable package of medical equipment for the Medicaid population as a whole. Plaintiffs *only* alleged that the Department's use of its exclusive fee schedule was illegal because it deprived plaintiffs of the equipment that *they* allegedly needed. Amended Complaint, P. 17, J.A. A-311. Since plaintiffs are not entitled to receive whatever services and equipment they "require," and are only entitled to receive those services and equipment that are *both* ****36*** *covered* by the Department *and medically necessary* for them, plaintiffs' Complaint fails to state a claim upon which relief can be granted.[FN13] Therefore, plaintiffs' request for a preliminary injunction should have been denied.

> FN13. As noted *supra*, with the arguable exception of intervenor Slekis, plaintiffs did not even offer proof that the requested equipment was medically necessary for them. Certainly, *no* evidence was offered by any of the plaintiffs, including intervenor Slekis, that the other equipment covered by the

> Department on its exclusive fee schedule is inadequate to meet their individual needs, much less that the equipment covered by the Department is inadequate to provide a meaningful medical equipment benefit for the Medicaid population as a whole (notwithstanding that some individual needs may be left uncovered).

The District Court's treatment of these claims is confusing and contradictory. First, the District Court ruled that it "does not find that the plaintiffs have established a likelihood of success that the use of a list is unlawful *per se*." citing language in *Beal v. Doe,* 432 U.S. at 444, to the effect that "the Medicaid Act 'confers broad discretion on the States to adopt standards for determining the extent of medical assistance1 offered in their Medicaid programs," and the provision of the Health Care Financing Administration's Medical Assistance Manual, § 5.50.1-00, which provides that a state "*may list those items for which it will reimburse*." 1/10/97 Slip Op. p. 26, J.A. A-1728 (emphasis in original). The District Court, however, then inexplicably found that the Department's use of an exclusive list "violates federal law insofar as it relies on an exclusive list for which there are no reasonably available procedures for seeking modifications or exceptions."[FN14] 1/10/97 Slip Op., p. 28, ***37** J.A. A-1730. The District Court also ruled that "the Medicaid Act requires a state to consider the medical necessity of an item at some point before denying coverage of the prescribed article of DME," 1/10/97 Slip op. 31, J.A. A-1733, and ruled that:

> FN14. Pursuant to Conn. Gen. Stat. § 4-176 any member of the public may utilize the declaratory ruling procedure under the State Administrative Procedure Act for this purpose. The trial court was informed of the existence of this procedure on April 24, 1996. J.A. A-217-A-218.

while the defendant may have proper grounds to categorically deny coverage of certain pieces of DME in all cases, the defendant may not categorically exclude a piece of DME without considering the medical necessity of an item either on a "macro" or "micro" level *See Preterm,* 591 F. 2d at 125. By never considering the "medical necessity" of air conditioners, air purifiers, and room air conditioners, the defendant has established an "irrebuttable presumption" that these pieces of DME can never be medically necessary... By not considering any evidence regarding the "medical necessity" of air conditioners, air purifiers, and room humidifiers, defendant appears to have ignored the possible necessity that *some* Medicaid recipients might have for these items "that may be merely palliative for others."... Thus Conn. MAP Manual § 189.III.a. improperly denies plaintiffs "meaningful access" to a mandatory package of Medicaid services, *See Alexander v. Choate,* 469 U.S. at 309, leading this Court to find that this policy is not "reasonable" and "consistent with the objectives of Title XIX." [FN15]

> FN15. The court's reasoning is internally inconsistent because it begins by stating that certain pieces of DME may be categorically excluded in all cases, but ends by holding that no item of DME may be categorically excluded if some Medicaid recipients might have a need for it.

January 10, 1997 Slip Op. pp. 33, 34, J.A. A-1735, A-1736.

The court then entered a preliminary injunction enjoining the Department "from using Conn. MAP Manual § 189.E.II.a and § 189.E.III.a. as the exclusive determinant of plaintiffs' ***38** preauthorization requests," and enjoining the Department from denying any resubmitted prior authorization requests "solely on the grounds that the requested DME is or is not listed in Conn. MAP Manual § 189.E.II.a or § 189.E.III.a. 1/10/97 Slip Op. pp. 55, 56., J.A. A-1757, A-1758.

In accordance with the Court's order, intervenor Slekis then resubmitted his request for prior authorization for

coverage for the cost of a RIK mattress, a specialty bedding support surface which he claims is necessary as a result of his history of recurring skin breakdowns. The Department denied his resubmitted request on a number of grounds, including that Mr. Slekis had not demonstrated that the Department's exclusive fee schedule is "illegal" because it does not provide a meaningful benefit for the Medicaid population as a whole. Plaintiffs moved for clarification, and the court "clarified" its order as *only* contemplating that the Department could "take into account Mr. Slekis's medical condition, the appropriateness of the RIK mattress as a device to meet Mr. Slekis's medical needs, and the ability of other items on the MEDS fee schedule to meet his. needs." 2/13/97 Slip op. p. 5, J.A. A-1801. The Court further ruled:

Imposing such a requirement (regarding the adequacy of the fee schedule for the population as a whole) on an applicant who is seeking an item of DME not on the MEDS fee schedule operates virtually to restore the MEDS fees schedule as a ***39** dispositive criterion in evaluating requests for prior authorization. This is plainly prohibited by the Court's preliminary injunction.

2/13/97 Slip Op. p. 6, J.A. A-1802.

The District Court erred in entering the injunctive orders that are the subject of this appeal since it did not properly identify and apply the statutory provisions that define the scope of plaintiffs' "entitlement." In the absence of any finding that the use of the Department's exclusive list fails to provide meaningful benefits for the Medicaid population as a whole,[FN16] the scope of plaintiffs "entitlement" is limited to the package of services and equipment that happen to be covered by the Department's Medicaid program. 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(17); 42 C.F.R. § 440.230(b); *Alexander v. Choate*, *supra*; *Curtis v. Taylor*, *supra*; *Virginia Hospital Ass'n v. Kenley*, *supra*.

FN16. To the extent that the District Court found that the Department's exclusive fee schedule was "unreasonable," its finding was predicated *solely* on the Court's finding that the Department had not made a finding of medical necessity for each requested item, for each Medicaid recipient.

The District Court never found that the Department failed to provide a meaningful package of benefits for the population as a whole, but *only* found that the Department was required to determine whether the requested equipment was medically necessary for each individual recipient.[FN17] The District Court thereby ***40** improperly deprived the Department of its discretion to employ "amount, scope, and duration" limitations that limit the extent to which services and equipment will be provided to any Medicaid recipient under the Department's Medicaid program, whether or not the equipment is medically necessary in an individual case.[FN18]

FN17. The District Court even forbade the Department from requiring the recipient to demonstrate at the remanded administrative fair hearing that Department's fee schedule is inadequate to provide a meaningful benefit for the Medicaid population as a whole (notwithstanding its apparent reliance on the claimed lack of procedures available to a recipient to challenge the scope of the Department's fee schedule as a basis for the entry of injunctive relief). When an administrative forum was made available for intervenor Slekis to submit his required proof that the Department's fee schedule is inadequate for the population as a whole, the District Court then "clarified" its preliminary injunction to enjoin the Department from denying coverage on that basis.

FN18. To the extent that the court may have suggested that the burden of proof is on the Department to establish that the medical equipment covered on its exclusive fee schedule is adequate to provide a meaningful benefit package for the Medicaid population as a whole and to make that determination

through some undefined administrative notice and hearing process, the court thereby erred. The burden of establishing that the Department's policies are unreasonable rested at all times upon the plaintiffs. *Lavine v. Milne*, *supra*. Furthermore, there is no textual basis in the Act supporting any requirement that the Department determine the extent to which it will cover services through some form of notice and hearing process.

C. The Department's Policies Do Not Constitute Illegal Irrebuttable Presumptions

One of the claims asserted in plaintiffs' Amended Complaint is that the exclusion of coverage of the requested items constitutes an "irrebuttable presumption" that the requested ***41** items can never be "medically necessary", which "irrebuttable presumption" is alleged to be in violation of the due process clause of the U.S. Constitution. The trial court never found a likelihood of success on this constitutional claim; however, in support of its finding of a likelihood of success on plaintiffs' "statutory" Medicaid Act claim, the court indicated that, "By never considering the 'medical necessity1 of air conditioners, air purifiers, and room humidifiers, the commissioner has established an 'irrebuttable presumption1 that these pieces of DME can never be medically necessary.'' 1/10/97 Slip op. p. 33, J.A. A-1735. The court also cited *Weaver v. Reagan*, 886 F.2d 194, 199 (8th Cir. 1989) for the proposition that an exclusion of coverage can constitute an improper "irrebuttable presumption."

Our reading of the court's decision indicates that the court did not rely on any likelihood of success on this "irrebuttable presumption" due process claim as support for the entry of the preliminary injunction; however, out of an abundance of caution, in case this Court disagrees with our analysis and finds that the trial court *did* find a likelihood of success on this claim, we offer the following points in response. To the extent that the trial court may have relied on the "irrebuttable presumption" doctrine, the court erred because the doctrine is not applicable to a state's administration of public benefit programs, which ***42** inevitably draw lines defining what benefits are provided to which individual. In addition, the court erred because whatever validity the doctrine may have as applied to public benefit programs, the doctrine does not apply to the facts of this case.

In *Weinberger v. Salfi*, 422 U.S. 749, 95 S.Ct. 2457 (1975), the Supreme Court considered an "irrebuttable presumption" challenge to a Social Security Act statutory classification that precluded a wage earner's widow and stepchild from recovering insurance benefits if their relationship with the wage earner commenced less than nine months prior to the wage earner's death. The Three-Judge District Court relied on congressional history to discern that the "purpose" of the rule was to prevent the use of sham marriages to obtain benefits, 95 S.Ct at 2468, and struck down the classification, applying the "irrebuttable presumption" doctrine because it is not necessarily and universally true that recently established relationships were established to obtain benefits. 95 S.Ct. at 2468. The Supreme Court reversed ruling that:

We think that the District Court's extension of the holdings of *Stanley*, *Vlandis*, and *LaFleur* to the eligibility requirement in issue here would turn the doctrine of those cases into a virtual engine of destruction for countless legislative judgments which have heretofore been thought wholly consistent with the Fifth and Fourteenth Amendments to the Constitution.... *If we were to follow the District Court's analysis, we would first try to ascertain the congressional "purpose" behind* the provision, and probably would conclude that it was to prevent stale claims from being ***43** asserted in court. *We would then turn to the questions of whether such a flat cutoff provision was necessary to* protect the Secretary from stale claims.... This would represent a degree of judicial involvement in the legislative function which we have eschewed except in the most unusual circumstances, and which is quite unlike the judicial role mandated by *Dandridge*, *Belcher*, and *Nestor*, as well as by a host of cases arising from legislative efforts to regulate private business enterprises.

Weingberger v. Salfi, 95 S.Ct. 2470-71.

The Court expressly rejected the validity of such an approach, instead ruling that the legislative classification is subject to the same "rational basis" test as any other statutory classification of property interests, and that the administrative convenience of such classifications provided the rational basis which required the classification to be upheld. Specifically, *Weinberger* ruled that, "the question raised is *not* whether a statutory provision precisely filters out those, and only those, who are in a factual position which generated the congressional concern reflected in the statute." 95 S.Ct. 2472 (emphasis added). Instead, it is up to Congress to choose that "the Social Security system, and its millions of beneficiaries, would best be served by a prophylactic rule...." 95 S.Ct at 247. In accord: *Gedulig v. Aiello*, 417 U.S. 484, 94 S.Ct. 2485 (1974); *Califano v. Boles*, 443 U.S. 282, 99 S.Ct. 2767 (1979).

Furthermore, even *if* the "irrebuttable presumption" doctrine applied to public benefit classifications, it is inapplicable here based upon the facts of this case. The entire thrust of ***44** this claim is dependent upon plaintiffs' claim that the *only* legitimate basis for a denial of coverage is that the requested equipment is not medically necessary. Plaintiffs, and the trial court, *assume* that the State's regulation excluding coverage of certain items is unlawful if some individuals, in fact, need the equipment. We demonstrated, *supra*, however that states are *not* required to cover all services that are medically necessary for each individual recipient, but, instead, that the states have wide discretion to design their benefit packages, including imposing amount, scope, and duration limitations, as long as the benefit package provided by the state is "reasonable" and "consistent with the objectives of the Act." 42 U.S.C. §§ 1396, 1396a(a)(10), 1396a(a)(17); 42 C.F.R. § 440.230(b). Accordingly, plaintiffs' irrebuttable presumption argument fails because it is predicated upon the erroneous assumption that the only legitimate basis for the denial of a request for Medicaid coverage of an item is for reasons of individual medical necessity.[FN19]

> FN19. To the extent that the trial court may have relied on this doctrine, the trial court *also* erred because it *assumed* that the requested items constitute "medical equipment." It was demonstrated, *supra*, however, that many of the items requested by the plaintiffs and the intervenors (including air conditioners, air purifiers, humidifiers, and environmental control units) do *not* meet the Department's definition of "medical equipment", and that the Department may properly deny the requested items accordingly.

VI. *The Trial Court Erred In Issuing A Preliminary Injunction In The Absence Of An Evidentiary Record. That Would Support The Necessary Findings Of Fact.*

F.R.C.P. Rule 52 requires findings of fact whenever the Court grants preliminary injunctive relief. It provides that:

***45** In all actions tried upon the facts without a jury or with an advisory jury, the court shall find the facts specially and state separately its conclusions of law thereon... and in granting or refusing interlocutory injunctions the court shall similarly set forth the findings of fact and conclusions of law which constitute the grounds for the action.

F.R.C.P. Rule 65 provides that:

(a) Preliminary Injunctions

(1) Notice. No preliminary injunction shall be issued without notice to the adverse party.

(2) Consolidation of Hearing with Trial on Merits. Before or after the commencement of the hearing of an application for a preliminary injunction, the court may order the trial of the action on the merits to be advanced

and consolidated with the hearing of the application.

"A notice requirement implies a hearing, and it has consistently been held that the defendant must be given a fair opportunity to oppose the motion for a preliminary injunction." Moore's, Federal Practice, § 65.04 [3], p. 65-103. Accordingly, in the absence of special circumstances *not present here,* it has been held that the failure of the District Court to hold an evidentiary hearing, and to make findings of fact based upon that evidentiary record, constitutes reversible error. *Id.*, *citing* *Williams v. McKeithen*, 939 F. 2d 1100 (5th Cir. 1991) and *Visual Sciences, Inc. v. Integrated Communications, Inc.*, 660 F.2d 56 (2nd Cir. 1981). The only exceptions to the foregoing rule apply where the plaintiffs assert a pure claim of law and are attempting to maintain the status quo (as opposed to obtaining affirmative mandatory relief), or where the plaintiffs rely upon a verified complaint or affidavits that are undisputed by the ***46** defendant, or where the right to an evidentiary hearing is waived by a party; however, where the right to an evidentiary hearing is not waived, and the verified complaint or affidavits are disputed, the preliminary injunction must be denied if no additional evidence is offered. Moore's, § 65.04[3], pp. 65-106-65-113, citing *SEC v. Frank*, 388 F. 2d 486 (2d Cir. 1968) (Friendly, J.).

The only "hearings" noticed by the Court in connection with plaintiffs motion for a preliminary injunction were for *oral argument only* on April 24, 1996, and for a limited evidentiary hearing, *limited to the question of whether the requested equipment constitutes durable medical equipment*, on May 20, 1996. No other opportunity for an evidentiary hearing was noticed or provided by the Court until the hearing on intervenor Slekis' motion for preliminary injunction which commenced on December 30, 1996 and continued on January 9 and 10, 1997. J.A. A-679-A-1678.

The limited nature of the evidentiary hearing noticed by the Court was presumably a result of the indication *from plaintiffs* that *they* would waive *their* right to an evidentiary hearing because plaintiffs were content to rely on their claim that the Department was precluded from contesting the administrative findings of fact of its hearing officers made in connection with administrative "fair hearings" conducted in reference to plaintiffs DeSario, Emerson, and Stevenson. The Court subsequently noticed an evidentiary hearing, on the limited issue of whether the requested equipment is "medical equipment," presumably because the Court determined that the administrative ***47** hearing decisions did not address the question of whether the requested equipment is "medical equipment"--which is a necessary element to plaintiffs' proof in order to obtain a preliminary injunction in this action.

The commissioner, however, never waived *her right* to an evidentiary hearing. Specifically, even *if* plaintiffs were correct that the findings of fact of the administrative hearing officers are preclusive, and *if* those findings of fact were properly before the Court, the *commissioner* would *still* have been entitled to offer any additional proof relevant to the Court's deliberations.

Furthermore, the findings of fact of the administrative hearing officers were not even properly before the trial court because they were not averred to in an uncontested affidavit or verified complaint, authenticated by an appropriate affidavit, or admitted into evidence at an evidentiary hearing. The administrative hearing decisions were merely attached as exhibits to plaintiffs' motion for a preliminary injunction--*which is not evidence.*

Despite the lack of any evidentiary hearing on these matters, the trial court proceeded to accept the claims of the plaintiffs and intervenors as true and to issue preliminary injunctive relief.[FN20] This was plain error requiring reversal of the trial court's decision.

FN20. The trial court appeared to base these findings on the administrative hearing record. However, as noted, the hearing officers' findings were not as stated by the court, which appeared to accept the under-

lying evidence as fact despite the failure of the hearing officers to so find. This is clear error and goes far beyond any preclusive effect the court might have assigned to the hearing officers' findings of fact.

***48** The trial court's finding of medical necessity and irreparable harm with respect to DeSario, Emerson and Stevenson appears at J.A. A-1721-A-1723. Because no evidentiary hearing was ever held as to this issue these findings could only be derived from the plaintiffs' pleadings and the attachments thereto.

With respect to Ms. DeSario, the court quotes from the "Notice of Decision Re: Concetta DeSario, March 28, 1996." J.A. A-1721. This document is attached as Exhibit D to the Memorandum in Support of Motion for Preliminary Injunction. J.A. A-44, A-49, A-90-A-94.

The Court quoted from a letter from plaintiff Emerson's physician. J.A. A-1722. This letter was attached to Plaintiffs Memorandum in Support of Motion for Preliminary Injunction. J.A. A-100-A-102. A document titled Notice of Decision and addressed to Ms. Emerson was attached as Exhibit H to the plaintiff's Memorandum in Support of Motion for Preliminary Injunction J.A. A-103-A-108.

With respect to Ms. Stevenson the court referenced a letter from her physician. This letter along with a document titled Notice of Decision and addressed to Ms. Stevenson appears attached to an affidavit from Ms. Stevenson. J.A. A-268-A-281.

CONCLUSION

For all of the foregoing reasons, the order of the trial Court granting the preliminary injunction must be vacated, and ***49** the case remanded for further proceedings consistent with this Court's ruling.

Appendix not available.

Concetta DESARIO and Betty Emerson, Individually and o/b/o all others similarly situated, Plaintiffs-Appellees, Caroline Stevenson and Thomas Slekis, Intervenors, v. Joyce A. THOMAS, Commissioner CT Dept. of Social Services, Defendant-Third-Party Plaintiff-Appellant, Donna Shalala, Commissioner, United States Department of Health and Human Services, Third-Party Defendant.
1997 WL 33544218 (C.A.2) (Appellate Brief)

END OF DOCUMENT