FOIA Number: 2018-0764-F

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Correspondence - SLT - Incoming - 7/97 [Folder 3] [2]

Stack:	Row:	Section:	Shelf:	Position:
S	66	6	6	2

Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. form	re: Correspondence routing slip (Personal) (1 page)	07/21/1997	b(6)
001b. letter	Concerned patient to Cigna re: Insurance coverage (Personal) [partial] (2 pages)	00/00/0000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19394

FOLDER TITLE:
Correspondence - SLT - Incoming - 7/97 [Folder 3] [2]

2018-0764-F
jm2048

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Office of
National AIDS Policy

FILE COPY

Correspondence Routing Slip

Tracking Number: G3855

Date Rcvd: 7-21-97

From: Chai R. Feldblum

Georgetown Univ. Law Center

Staff Action:

Reviewed By Sandy:_____ **Reviewed By:** _____

Assigned To:_____

RCVD:_____ **DONE:**_____

Recommendations/Instructions:

no response needed (TC)

To Support Staff:_____

Date of Response:_____

n:\corresli

GEORGETOWN UNIVERSITY LAW CENTER

Federal Legislation Clinic

Dean
Judith C. Areen

Director
Associate Professor of Law
Chai R. Feldblum

Deputy Director
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Senior Policy Fellow
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Loretta C. Moss

Visiting Professor
Ralph G. Neas

Supervising Attorneys
David P. Rapallo
Sharon N. Perley

July 17, 1997

Dear Friends ~~& Colleagues~~ Sandy:

Congress has finally given us a (slight) break by going out on its Fourth of July recess. I am, therefore, grabbing this opportunity to send you some materials about the Federal Legislation Clinic. We prepared these materials for the Clinic's Open House this past April. I think they provide a good picture of what we are trying to achieve in the Clinic -- and so I wanted to send them along to my friends and colleagues.

I hope you enjoy this glimpse into legislative lawyering and clinical legal education. I welcome all comments and suggestions!

The materials enclosed include:

☞ A packet containing the following documents:

* *About the Federal Legislation Clinic*
* *Five Circles of an Effective Coalition*
* Diagrams describing *The (Ideal) Coalition and The Coalition and the [Political] World*
* *The Concept of Legislative Lawyering: An Autobiographical Account*
* The Federal Legislation Clinic's *Teaching Staff*

☞ A document describing the *Clients and Projects* of the Clinic

☞ One (or more) of the following sample document packages prepared on behalf of our clients, Catholic Charities USA or NAPAS/CCD, as the case may be (the document package(s) enclosed is indicated below):

☑ *Preserving Medicaid for Immigrants Losing SSI payments*
☑ *Preserving a Private Right of Action in the Medicaid Program*

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- ☐ *Non-Profit Charitable Organization: Exemption from Immigration Verification*
- ☑ *Removing Barriers in the Naturalization Process: Reasonable Accommodations for Immigrants with Disabilities*
- ☐ *Protecting the Safety of Children in Foster Care and Adoption*
- ☑ *Providing Alternatives to Assisted Suicide*
- ☑ *Protecting the Privacy of Personal Health Information*
- ☑ *Opposing Amendments to the Fair Housing Act*

If you would like a sample document package on any of the other issues described above, please call Loretta Moss at 202-662-9595, or send us an e-mail at *fedlegis@law.georgetown.edu.*

Best wishes,

Chai

Chai R. Feldblum

CRF:lcm

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ABOUT THE FEDERAL LEGISLATION CLINIC

The Federal Legislation Clinic is designed to teach students how to become effective "legislative lawyers." A "legislative lawyer" is a person who is trained to:

- **recognize policy and legal issues in a proposed piece of legislation;**
- **perform legal research and engage with litigation lawyers with regard to a piece of legislation;**
- **develop creative solutions to legal and political problems;**
- **present solutions and background information in clear and persuasive oral and written forms; and**
- **work with the relevant coalition and Congressional staff to negotiate the adoption of legislative solutions.**

A legislative lawyer works on legislative initiatives as part of a team. Ideally, this team includes a **strategist**, a **lobbyist**, a **grassroots** organizer, a **media** person, and a **legislative lawyer.**

THE CLINIC'S DUAL MISSION

We undertake projects that advance the public interest and provide quality representation to non-profit clients who need legislative lawyering services.

We provide Georgetown's law students with the training, supervision, and field experience necessary for them to become effective legislative lawyers.

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Five Circles of an Effective Coalition

by Chai Feldblum

The "Five Circles Theory" postulates that for a legislative campaign to be effective, five categories of people (imagine each inhabiting a separate circle) must work together. The five circles are:

*** Strategist**

*** Lobbyist**

*** Legislative Lawyer**

*** Grassroots Person**

*** Media Person**

Usually, the person in each circle has a full-time job doing the work of his or her circle. Indeed, resources are wasted and used ineffectively if people in one circle try to do the jobs that are best done in another circle.

The circles can be compressed when resources are short. Indeed, in many past successful advocacy efforts, certain people have occupied more than one circle. The basis of the Five Circles Theory, however, is that the *most effective* structure is one in which there is a *different* lead person in each circle -- each exercising different skills and talents.

The five circles are not autonomous. The system works only if people in each circle *understand* what people in the other circles are doing and if there is effective communication among people in all circles. Ensuring that the necessary *communication* occurs is the joint responsibility of the strategist and the lead person in each circle.

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I. The Strategist

The strategist is responsible for thinking through the "big picture" of how to get a bill (or amendment) passed, halted, or modified. The strategist must know how to use the information generated in each of the other circles to guide strategic decision-making. Of key importance, the strategist must ensure the strategic plan stays "on-track." The strategist must also engage in the innumerable personal interactions -- with people within the inner circles, with people in the larger coalition, and with Congressional and Administration personnel -- that are necessary for any coalition effort to be successful.

The strategist must know how to analyze and incorporate information developed within each circle. The strategist must receive from people within each circle the following types of information:

- From the legislative lawyer: the legal and policy implications of various legislative alternatives;
- From the lobbyist: estimated vote counts for various alternatives and advance notice of looming issues;
- From the grassroots person: information about grassroots support for various alternatives and advance notice of looming issues; and
- From the media person: the proposed media message for different alternatives.

A strategist must also be attuned to electoral politics and, in moving forward policy goals, effectively use the realities and pressures attendant on the need of Members of Congress to get reelected.

II. The Lobbyist

The lobbyist is the person ultimately responsible for the numbers: making sure the votes are counted, that they are counted as accurately as possible, and that the numbers are as high as possible (a majority or 2/3 if necessary). This last job includes within it a *myriad* of skills -- the ability to talk to Congressional staff and truly understand what they are saying; the ability to persuade; the ability to write clearly; the ability to perceive political realities; the ability to be creative in suggesting legislative strategies -- and the ability to stay *persistent* in the face of ongoing adversity.

III. The Legislative Lawyer

The legislative lawyer (LL) is responsible for ensuring the strategist and lobbyists are informed of the legal and policy implications of different alternatives that arise in any particular issue area and with regard to different proposed pieces of language. The LL must be well-practiced at "cramming" and absorbing a great deal of information about whatever issue is currently "hot." Over time, the LL will accumulate a body of knowledge about a range of issues.

The LL is able to advise on a range of issues because the person will not be responsible for assuming the duties engaged in by a lobbyist. For example, the LL will not be assigned a geographic region to be monitored for lobbying purposes and will not be assigned specific issues on which he or she is expected to be the lobbyist. An LL will have contact with Congressional staff only as requested by the lobbyist or strategist. The LL probably will have significant contact with the staff person (or people) with whom the lobbyist and strategist are working most closely to develop language and strategy -- and will have less contact with staffers who are simply being visited for education or persuasion purposes.

On any issue that may come up before Congress, a LL would have the following responsibilities:

- *Get up-to-speed on the legal information that exists on the issue.* A LL must find and summarize necessary legal information in a manner than can be quickly understood and absorbed by the strategist, the lobbyists, the media people and the grassroots people.

- *Establish and maintain connections with litigation lawyers in the field who are working in a particular substantive area.* The LL must be aware of and understand the substantive legal concerns of the litigation lawyers, so the LL may effectively advise the strategist and lobbyists regarding the bounds of acceptable compromise for litigation lawyers in the field.

- *Be up-to-speed on the political realities and dynamics of the legislative process.* The LL must understand the bottom-line political needs and assessments of the strategist and the lobbyist, so the LL may serve as a conduit and ***translator*** to the litigation lawyers in the field regarding political realities.

- *Be creative in devising solutions.* The LL must be creative in devising solutions that meet political and legal/policy needs. A good LL is a person who does the background legal research thoroughly and quickly, understands the political realities, works with the coalition to come up with a proposed solution to a legislative issue that makes the strategist, lobbyists, ***and*** litigation lawyers in the field ***all*** relatively happy, and helps get that solution adopted by all parties. ***That's good LL work.***

- *Be a very good writer.* The LL must be able to quickly come up with proposed legislative language, legislative history, talking points, questions & answers, etc. In the heat of a legislative battle, the LL must be able to write any piece of language that is needed by the team -- including, but not limited to, legislative language and history.

- *Be a very clear and persuasive talker.* The LL will often be called upon to explain, in clear and simple language, the legal and policy implications of proposed alternatives. In addition, the LL will be a player in helping coalitions reach consensus on an issue, and subsequently, a player in negotiations with the opposition.

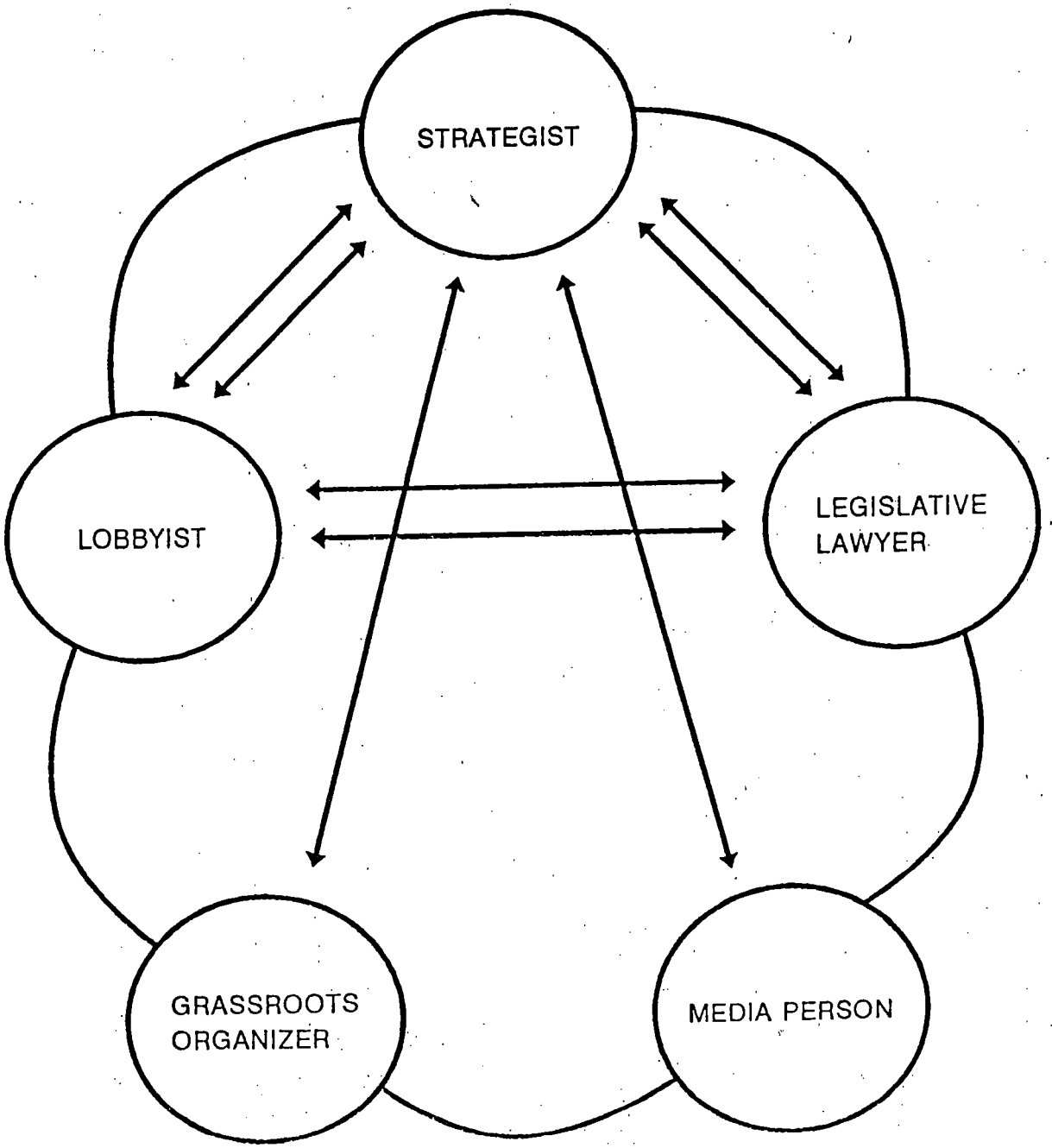
IV. The Grassroots Person

This person must have a savvy understanding of community organizing on the local level. The person must be organized and detail-oriented, but also creative in the area of organizing. Because effective grassroots usually requires the use of additional staff and interns, the person must also be a good manager. The person's job responsibilities should include: collecting and analyzing data from the field ("what do the people we represent care about?"); developing and packaging information that can be used to educate and energize people in the field; and disseminating that information effectively to the field. Materials written for grassroots purposes should be reviewed by the media department (for message); by the lobbyist (for conformity with lobbying materials); by the legislative lawyer (to ensure no unintentional or adverse legal or policy implications); and by the strategist (for the final O.K.).

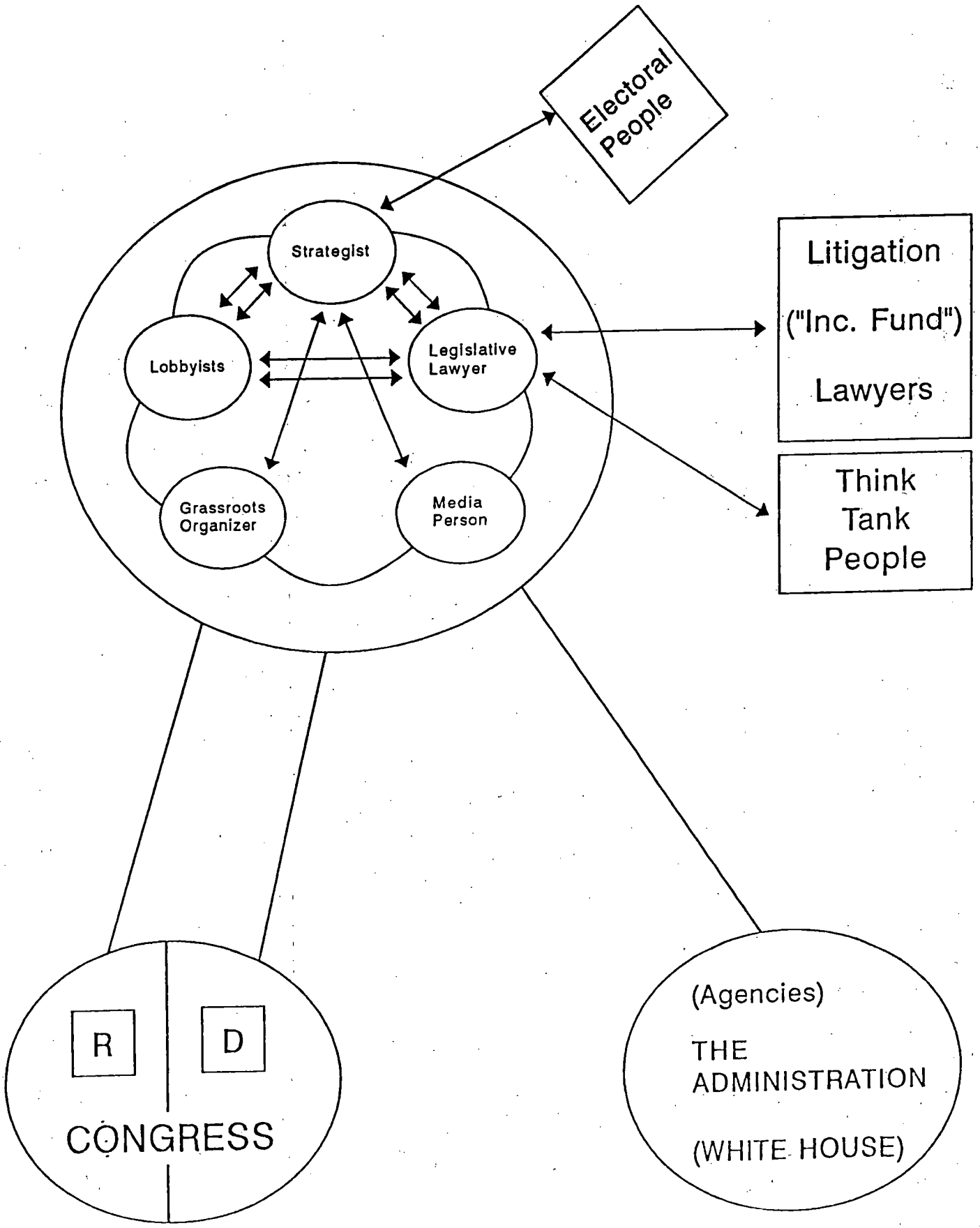
V. The Media Person

The media person must understand enough of the legal/policy and political dimensions of an issue to enable the person to develop an appropriate message for the media. The strategist, lobbyist, and legislative lawyer are responsible for providing the legal, policy, and political background on the issue to the media person; the grassroots person is responsible for providing field information. In turn, the media person must counsel the strategist, lobbyist, legislative lawyer, and grassroots person regarding the media implications of any particular message or stance on an issue.

THE (IDEAL) COALITION



THE COALITION AND THE [POLITICAL] WORLD



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The Concept of Legislative Lawyering:
An Autobiographical Account

by Chai R. Feldblum

***Legislative lawyering**: the discipline of combining knowledge of political realities with a thorough understanding of legal issues in the drafting, negotiating, or modifying of legislation.*

In the "Five Circles Theory," a legislative lawyer has a role different from the strategist (who "runs the overall show" in getting a bill passed or halted) and different from the lobbyist (who engages in the daily effort of garnering votes from Members of Congress). The legislative lawyer is the individual responsible for developing the content of proposed legislation, or the content of amendments that may stop or effectively alter proposed legislation. The legislative lawyer must be well versed in both politics and law in order to craft the content of legislation effectively.

There have always been, and there are now, individuals on the legislative scene who are turned to by coalition members, Congressional staff, and Administration officials for counsel and drafting of legislative language. For example, in the civil rights arena, individuals such as Joe Rauh and Bill Taylor have combined a keen understanding of law and politics in the development of legislative language. But such individuals have not always been identified as playing a uniquely *different* role than that played by the lobbyists and strategists.

I stumbled onto the concept of the "legislative lawyer" by playing such a role for the disability community from 1988-1990 in the development of the Americans with Disabilities Act (ADA). The role I filled was that of a lawyer who combined a knowledge of the law with an understanding of legislative politics, and whose advice would thus be accepted by strategists, lobbyists, and Congressional staff.

I didn't apply for the job of "legislative lawyer" on the ADA; I was handed the job by the strategist for the disability community. I had already been working as a lawyer for the AIDS community for about a year, had a good sense of the legislative political landscape, and had already engaged in a number of activities (such as designing creative second-degree amendments) that I now term legislative lawyering.

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But my work on the ADA took me to a different level. In preparation for work on the bill, I read every case that had been decided under Section 504 of the Rehabilitation Act of 1973 (about 200 cases in total) -- the legal model I knew we would be using for the ADA. I then proceeded, over the next two years, to talk to lawyers around the country who wanted specific provisions in the ADA, to make sure I understood their particular legal concerns.

Arlene Mayeson, from the Disability Rights Defense and Education Fund (who had served as a legislative lawyer on previous disability rights bills), was a key role model for me both in learning disability law and in interacting with litigation lawyers. During the course of two years of work on the ADA, I and additional lawyers drafted different pieces of language to address particular concerns, learned about the political realities that weighed against the demands and needs of the litigation lawyers, and engaged in negotiations with representatives of the business community, the Bush Administration, and staff people for both Democratic and Republican Congressional Members. Sometimes we prevailed in getting the original language desired by the litigation lawyers accepted; sometimes we negotiated compromise language with the opposing party (or parties) which gave the litigation lawyers most of what they wanted, but still accommodated Congressional political concerns; and sometimes we just lost the language completely.

My experience working on the ADA taught me two things. First, many lobbyists and staff people, even if they happen to be lawyers, do not have time to engage in extensive legal analysis when they work on a bill. For example, such individuals are not likely to read thirty cases to decide how a particular legislative provision should be drafted -- even if those cases might be directly relevant to how the provision should be drafted to achieve their goals or directly relevant to how that provision might later be interpreted by the courts.

The decision not to read thirty cases is not because lobbyists are lazy. To the contrary, these individuals are some of the hardest-working people I have met. But there is no way these people can do their essential jobs -- that of gaining intelligence on the Hill, going to coalition meetings, working with the grassroots and media people, persuading staff people of the merits of their positions -- and still have time to read thirty cases that may be relevant to a particular legislative provision. The same is true for most staff people.

Second, the lawyers who *do* have the time and the background to read and assimilate the thirty cases relevant to a legislative provision often have no idea about the *realities* of the legislative process -- and when they are informed of those realities, are often unwilling to accept and work with those realities.

For example, based on his or her reading of the relevant thirty cases, a litigation lawyer may insist that a particular provision, which currently reads "ABC," must be redrafted to read "XYZ." The lobbyist or strategist, knowing "XYZ" will alienate a key Senator and undermine the possibility of passage of the overall bill, attempts to explain this political reality to the litigation lawyer -- only to met with adamant insistence that "XYZ" is essential and *only* "XYZ"

will work. In many cases of this kind, the strategist will ultimately tell the litigation lawyer: "we tried really hard but we just couldn't get XYZ" and the provision will remain "ABC."

The fact that the provision in question *could* have been *redrafted* to read "DEF" -- which would have met the political concern of the key Senator and still have achieved 85% of what the litigation lawyer was seeking -- is sometimes never even floated as a possibility. The reason? A person who is almost as knowledgeable as the litigation lawyer about the law, and almost as knowledgeable as the strategist on the political realities, is often the best type of person to come up with "DEF." That's the person I call a "legislative lawyer."

There is a final piece that contributes to my concept of a "legislative lawyer." In 1991, I came to Georgetown University Law Center as a Visiting Professor. One of the courses I taught was Legislation, a course that focuses almost exclusively on the principles and theories of statutory interpretation. Teaching that class made clear to me that the individuals who shape laws in Congress, and the judges (and clerks) who interpret these laws, often have little understanding of the rules and realities governing each other's worlds. A legislative lawyer may help bridge that gap by advancing an understanding of the rules of statutory interpretation on the part of Congressional staff and advocates, and by heightening the understanding of the realities of Congress on the part of litigation lawyers and courts.

My goals in establishing, directing, and teaching in a Federal Legislation Clinic are thus manifold. I want to teach my students how to combine a rigorous knowledge of the law (including the rules of statutory interpretation, the law concerning a specific policy issue, and a keen appreciation of text) with a sophisticated understanding of political realities. I want to give my students the field experience that will allow them to see how such a combination may result in the development of creative and sophisticated legal solutions to difficult problems. I want to convey to my students the intellectual joy and stimulation I experience in engaging in this form of lawyering. And, finally, I want to create an understanding in the general Washington community -- the advocacy community, the Congressional community, and the Executive branch -- regarding what type of lawyer a "legislative lawyer" is and why such lawyers should be a critical component of any successful advocacy effort.

The Federal Legislation Clinic attempts to achieve these goals by serving as the legislative lawyer to public-interest organizational clients that have legislative objectives in Congress. The clients provide the expertise in strategy, lobbying, grassroots, and media; the Clinic students and staff provide the legislative lawyering services. The students receive legislative lawyering training; other advocacy groups with whom the clients work in coalition are exposed to the concept of legislative lawyering; and the clients, the coalition, Congressional staff and Members all receive the benefits of the Clinic's legislative lawyering work.

FEDERAL LEGISLATION CLINIC
Teaching Staff

Chai Feldblum, Director

The Clinic is directed by Associate Professor Chai Feldblum. Professor Feldblum served as a legislative lawyer for the AIDS community and the general disability community while working as a staff attorney with the American Civil Liberties Union AIDS Project. Professor Feldblum played a key role on the AIDS and disability components of the Civil Rights Restoration Act of 1987, and the Fair Housing Amendments Act of 1988. Professor Feldblum also helped draft the Americans with Disabilities Act (ADA) and served as the lead lawyer coordinating the legal work on the bill. At Georgetown, in addition to her clinical teaching, Professor Feldblum has taught courses in Legislation, Disability Discrimination Law, and Sexual Orientation and the Law. She received her J.D. from Harvard Law School in 1985 and clerked for Judge Frank M. Coffin on the First Circuit Court of Appeals and for Justice Harry A. Blackmun on the U.S. Supreme Court.

Tim Westmoreland, Senior Policy Fellow

The Clinic's Senior Policy Fellow is Tim Westmoreland. Mr. Westmoreland spent fifteen years as Counsel to the U.S. House Subcommittee on Health and the Environment. Mr. Westmoreland managed the Subcommittee's consideration of issues involving public health, reproductive health, biomedical ethics, and health regulation. He was the Subcommittee's principal staff member on AIDS issues, including research, prevention and education, treatment, and finance. In that capacity, Mr. Westmoreland was responsible for policy analysis, arranging legislative and oversight hearings, developing legislation, drafting statutes, and preparing committee reports on specific pieces of legislation. Mr. Westmoreland received his B.A. from Duke University and his J.D. from Yale Law School.

Scott Foster, Deputy Director

The Clinic's Deputy Director is Scott Foster. During law school, Mr. Foster worked at two Washington law firms. At Swidler & Berlin, Mr. Foster clerked for the firm's legislative practice; at Gurman, Kurtis, Blask & Freedman, Mr. Foster tracked legislation for the firm's telecommunications clients. Prior to coming to the Clinic, Mr. Foster was the Deputy Director of the legal arm of the Campaign for Military Service, a short-term coalition of civil rights groups, where he provided research and other assistance to Senate and House members and their staffs. Mr. Foster was the Clinic's first Teaching Fellow from 1993-95. Mr. Foster received his LL.M. from Georgetown in 1995, his J.D. from the National Law Center at the George Washington University in 1993, and graduated from Harvard College in 1985.

David Rapallo, Teaching Fellow

David Rapallo is a Clinic Teaching Fellow for the 1995-97 academic years. During law school, Mr. Rapallo won the State Championship in California's Traynor Advocacy Competition. Prior to coming to Georgetown, Mr. Rapallo served as a Public Policy Fellow in the California Executive Fellowship Program, during which he worked in the Legal Affairs Office of the Governor. His responsibilities there included advising Governor Pete Wilson on proposed legislation, executive orders, and initiatives. In addition, he provided research assistance in state and federal suits involving immigration, voting rights, affirmative action, and issues of federalism. Mr. Rapallo received his J.D. from Hastings College of the Law in 1994 and graduated from UCLA in 1991.

Sharon Perley, Teaching Fellow

Sharon Perley is a Clinic Teaching Fellow for the 1996-98 academic years. Prior to teaching at the clinic, Ms. Perley was a trial attorney with the Disability Rights Section of the Civil Rights Division of the United States Department of Justice. Ms. Perley entered the Department through its Honors Program and litigated a number of cases there under the Americans with Disabilities Act (ADA). In particular, Ms. Perley worked on cases involving the discriminatory refusal of medical care to persons with HIV/AIDS, as well as cases challenging the constitutionality of the ADA. Ms. Perley received her B.A. from Harvard University and her J.D. from New York University School of Law.

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CLIENTS AND PROJECTS

104th Congress, 2nd Session
105th Congress, 1st Session

CLIENT: Catholic Charities U.S.A.

PROJECT: *Protection of range of benefits for immigrants; modification of welfare and Medicaid reform proposals that impact adversely on poor people, including poor women and children.*

ACCOMPLISHMENTS:

On behalf of Catholic Charities USA, Clinic students worked during the 104th Congress to retain for the poorest and most vulnerable members of society some essential safety net of services and benefits, including Temporary Assistance for Needy Families, Supplemental Security Income, Food Stamps and Medicaid. During work on the Welfare Act, the Clinic handled issues involving teenage pregnancy, work requirements, and limits on aid to families with additional children.

Clinic students were heavily involved in the issue of benefits for poor immigrants during Congressional action on the welfare reform bill and the immigration bill. The students prepared documents, briefings, and proposals on behalf of Catholic Charities USA with regard to preserving services necessary for life and safety, fighting increased income and asset requirements for immigrant sponsorship, and exempting nonprofit, charitable organizations from the requirements of immigration verification.

Clinic students also prepared numerous documents and briefings demonstrating the negative effects of Medicaid reform plans proposed throughout the year. Specific legislative efforts included maintaining a federal guarantee to medical services for various categories of individuals, preserving an individual beneficiary's right to sue a State that wrongly refuses to provide services, and ensuring that services provided are adequate in amount, duration, and scope to address individual illnesses and injuries.

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During the first session of the 105th Congress, Clinic students have worked on mitigating various aspects of the welfare reform and immigration laws through the development of arguments and materials presented to the administrative agencies. In addition, Clinic students have worked extensively on the problems that immigrants with disabilities face in the naturalization process, proposing both administrative and legislative solutions. Clinic students have continued work on Medicaid and have begun to work on the issues of adoption and foster care.

CLIENT: Consortium for Citizens with Disabilities (CCD) Education Task Force; NAPAS/CCD Rights Task Force

PROJECT: *Reauthorization of the Individuals with Disabilities Education Act (IDEA); Range of civil rights issues for people with disabilities.*

ACCOMPLISHMENTS:

On behalf of the Education Task Force of the Consortium for Citizens with Disabilities, Clinic students worked on several issues involved in the reauthorization of the Individuals with Disabilities Education Act (IDEA) during the 104th Congress. IDEA provides for diagnosis, evaluation, and services for students with disabilities.

Clinic students drafted comments on behalf of CCD analyzing different Senate and House drafts of the bill and providing alternative legislative language regarding the development of individualized educational programs (IEPs) and regarding the discipline of children with disabilities. In addition, Clinic students produced numerous talking points, briefing papers, and question & answer documents on issues ranging from attorneys fees provisions to remedies under the law to basic requirements of the law.

Finally, Clinic students and staff researched and drafted over 30 potential amendments during Senate committee consideration of the IDEA bill and took part in negotiations between Congressional staff and coalition members from both school organizations and disability rights groups.

Clinic students also responded to the Advisory Commission on Intergovernmental Relations (ACIR) report that called for major restrictions in the Americans with Disabilities Act (ADA) & IDEA. One student produced a 21 page comment on behalf of the Rights Task Force and a 21 page document on behalf of the Education Task Force. In addition, Clinic Director Chai Feldblum was asked to testify on behalf of CCD at a public hearing.

During the first session of the 105th Congress, Clinic students and staff have returned to full-time representation of the Rights Task Force of CCD, with the National Association of Protective and Advocacy Systems, Inc. (NAPAS) as the Clinic's client contact. In this capacity, Clinic students have worked on the issues of: services for individuals at risk of requesting

physician-assisted suicide; the interaction between the Americans with Disabilities Act and disability benefits plans; the privacy of medical information; and potential legislative amendments to the Fair Housing Act.

CLIENT: Medicaid & AIDS Project

PROJECT: *Legislative analysis and briefing materials on Medicaid and AIDS for AIDS groups (with support from the Henry J. Kaiser Family Foundation).*

ACCOMPLISHMENTS:

Clinic students worked on developing a primer on Medicaid for AIDS policy advocates. The 100+ page primer draft, produced with the support of the Henry J. Kaiser Family Foundation, provides a general overview of Medicaid law for persons who are familiar with AIDS issues but do not have much familiarity with the Medicaid system. To that end, the primer contains sections on Medicaid eligibility and services, provider reimbursement, waivers and managed care, enforcement mechanisms, and federal legislative proposals.

CLIENT: The Pediatric AIDS Foundation (PAF)

PROJECT: *Expansion of biomedical research and pharmaceutical development for children, and provision of health care services for pregnant women and children with HIV/AIDS.*

ACCOMPLISHMENTS:

Pediatric AIDS Foundation students engaged in research and developed proposals on the reauthorization of Title IV of the Ryan White CARE Act with respect to services and biomedical research for pregnant women and children. The Clinic prepared proposed compromise statutory language (as well as the range of supporting legislative documents) in connection with PAF's work to oppose legislative proposals that would have mandated the testing of pregnant women for HIV disease.

In addition, PAF students worked on ensuring that drugs marketed in the United States are safe and effective for use by children. One avenue they pursued was the Better Pharmaceuticals for Children Act, which would have provided additional market exclusivity for drugs for which the manufacturers had conducted pediatric studies. Students participated in teleconferences with the pharmaceutical industry, FDA, and Congressional staff persons; helped draft numerous versions of the bill; and drafted Congressional floor statements.

Clinic students also spent time conducting careful legislative analysis of existing law and concluded that a credible argument could be made that the Food, Drug, and Cosmetic Act *already* requires pediatric studies for drugs. Students drafted proposed regulations that could be presented to the Administration.

PAF students were also active members of the Patients' Coalition, which worked on the various FDA reform bills introduced in the 104th Congress.

CLIENT: The Privacy Project of the Center for Democracy and Technology (CDT)

PROJECT: *Passage of legislation to protect the confidentiality of individually identifiable health information in electronic and paper-based systems.*

ACCOMPLISHMENTS:

One of CDT's primary goals for the 104th Congress was to pass a strong federal medical records confidentiality statute. CDT Clinic students worked on the development and refinement of a bill that restricts disclosure of personally identifiable health information by doctors, insurers, and other health information "trustees"; creates a right for individuals to inspect and correct their records; and impose civil and criminal penalties for violations of the Act.

Clinic students spent time "perfecting" the language of the bill after receiving comments from many different groups (privacy advocates, patients' rights representatives, health care industries, pharmaceutical companies, doctors, insurers, the research community, etc.). Students attended meetings and conference calls with parties (including ACLU, AIDS Action Council and health "information systems" people such as the American Hospital Association) who had particular concerns about the bill, and then worked to write language that would address those concerns. Clinic students and staff also consulted regularly with staff of the Department of Health and Human Services.

* * *

In the 105th Congress, the Clinic (for resources purposes) has limited its representation to Catholic Charities, USA, and the Rights Task Force of the Consortium for Citizens with Disabilities (with NAPAS as the Clinic's client contact.)

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PRESERVING MEDICAID FOR IMMIGRANTS LOSING SSI PAYMENTS

Sample Documents

The Federal Legislation Clinic is supporting Catholic Charities USA in its work on several regulatory interpretations of statutory provisions in the recently passed Welfare Act. In particular, the Clinic has prepared materials and attended meetings with the staff from Catholic Charities USA to ensure that hundreds of thousands of legal immigrants who will lose their Supplemental Security Income payments this summer as a result of the Welfare Act will not be arbitrarily cut off from Medicaid as well.

The Welfare Act bars legal immigrants from receiving SSI, but allows each State to determine whether or not immigrants will be provided Medicaid within that State. Many immigrants qualify for Medicaid through the SSI program. Preliminary guidance issued by the Health Care Financing Administration stated that immigrants losing their SSI would also lose Medicaid coverage unless they demonstrated eligibility through other criteria, or unless a State amended its State Medicaid plan.

Catholic Charities USA presented to HCFA an alternative reading of the statute, developed by the Federal Legislation Clinic, that would allow States—without making any affirmative changes to their Medicaid plans—to continue providing Medicaid services to immigrants who lose their SSI payments. The Clinic currently is in the process of working with Catholic Charities USA to refine this proposal and follow up with Administration officials and Congressional staff. Some of the documents prepared by the Clinic on this issue include the following:

- ☐ Letter to Dr. Bruce Vladeck, Administrator, HHS (11/12/96)
- ■ Memo: State Discretion to Determine Medicaid Eligibility for Qualified Aliens (11/14/96) (attached)
- ☐ Letter to Rondalyn Haughton, Director, Office of Professional Relations, HHS (12/5/96)

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STATE DISCRETION TO DETERMINE MEDICAID ELIGIBILITY FOR QUALIFIED ALIENS

I. INTRODUCTION

Prior to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the "Welfare Act"), one of the primary ways in which immigrants qualified for Medicaid was through the receipt of Supplemental Security Income ("SSI") cash payments. Section 402(a) of the Welfare Act now prohibits certain immigrants who are lawfully residing in the United States ("legal immigrants") from receiving SSI payments. Section 402(b) of that Act gives States the discretion to determine whether legal immigrants otherwise eligible for Medicaid under a State plan will remain eligible for Medicaid.

Section 402(b) allows States to ask and answer a single question: "Will we, as a State, continue Medicaid eligibility for legal immigrants who are otherwise eligible for Medicaid under our State plan?" If a State answers this question in the negative, legal immigrants will be denied Medicaid in that State. Conversely, if a State answers affirmatively, legal immigrants will be treated *as if they were citizens* for purposes of Medicaid eligibility in that State. Immigrants who used to be receiving SSI payments will be "deemed" as if they were receiving SSI and will be eligible for Medicaid as part of that "categorically needy" group.

If a State fails to notify the Federal government of its decision regarding Medicaid eligibility for legal immigrants, such immigrants will continue to be eligible for Medicaid under current categories for which they qualify *as immigrants*. In other words, legal immigrants who were receiving Medicaid through the receipt of AFDC, as pregnant women or children, or through any category other than SSI, will automatically continue to be covered under Medicaid in any State that has not notified the Federal government of its desire to eliminate Medicaid coverage for such individuals.

Legal immigrants who previously received SSI cash payments and who live in a State that has elected to cover individuals who meet the income, resource, and disability requirements of SSI, but are not actually receiving SSI cash payments, will automatically fall into this "SSI/optional categorically needy" group and will receive Medicaid. Conversely, legal immigrants who previously received SSI payments in a State that has not elected to create a "SSI/optional categorically needy" group will lose Medicaid coverage if the State fails to notify the Federal government of its intention to cover such individuals.

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II. STATE DISCRETION TO PROVIDE MEDICAID TO IMMIGRANTS

The discretion provided to States by §402(b) of the Welfare Act is both broad and limited. It is *broad* in the sense that States are allowed to decide, notwithstanding any previous restriction in the Medicaid statute, whether or not to provide Medicaid coverage to immigrants lawfully residing in the United States. It is *limited* because States were given the authority to decide only *one* question: whether or not they will treat legal immigrants *as citizens* for purposes of Medicaid eligibility.

The broad discretion granted to States was the end result of a long political process. The House-passed version of the Welfare Act had barred current legal immigrants from Medicaid. In contrast, the Senate-passed version of the legislation gave States discretion to bar legal immigrants from Medicaid. The final conference agreement for the Welfare Act followed the Senate approach, recognizing that a number of States that wished to maintain Medicaid coverage for current legal immigrants would lose considerable Federal funds if the House approach was adopted. Thus, Congress' ultimate political resolution was to provide States the broad discretion and flexibility to grant or deny Medicaid eligibility to legal immigrants.

The limitation on State discretion arises from the convergence of §402(b)(1) and §433 of the Welfare Act. Section 402(b)(1) provides the following:

> Notwithstanding any other provision of law . . . a State is authorized to determine the *eligibility* of an alien who is a qualified alien for [Medicaid].

Section 433(a)(1) provides the following definition of "eligibility:"

> For purposes of this title, eligibility relates only to the *general issue* of eligibility or ineligibility *on the basis of alienage* (emphasis added).

The combination of §402(b)(1) and §433 makes clear that States are allowed to make one decision: whether they will consider individuals eligible or ineligible *because of* their alienage. If a State decides aliens will be eligible, the State has decided to *disregard alienage* and to treat immigrants legally residing in the United States *as if they were citizens* for the purposes of Medicaid eligibility.

If a State exercises its authority to consider legal immigrants as if they were citizens, these immigrants will be *"deemed"* as if they were receiving SSI payments for purposes of Medicaid eligibility. The concept of "deeming" is not a foreign one. Congress has amended Medicaid to create several categories of individuals who are "deemed" to be receiving SSI or AFDC for purposes of Medicaid eligibility,[1] and the Health Care Financing Administration

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[1] *See, e.g.*, 42 U.S.C. §1396v(a)(3) (Medicaid eligibility maintained for foster children who would have been eligible for AFDC except for removal from the family home by court order

("HCFA") has often issued regulations implementing these statutory changes.[2] Indeed, Congress took an analogous action in the Welfare Act with regard to families losing AFDC as a result of the repeal of that program. In §114 of the Welfare Act (the "Chafee-Breaux provision"), Congress required States to continue providing Medicaid to individuals who *would have* received AFDC prior to the enactment of the Welfare Act. Section 114 states: "For purposes of this title . . . in determining eligibility for medical assistance, an individual *shall be treated as receiving [AFDC] aid or assistance.*"

In the context of SSI and immigrants, however, rather than amend the Medicaid statute to create a category of individuals deemed as receiving SSI payments, and rather than mandate States to create such a category, Congress chose to delegate the *decision* to create such a category, and the *authority* to do so, to the States. Once a State decides to provide Medicaid coverage to legal immigrants, it has chosen to exercise the option provided it by Congress to deem such individuals as if they were receiving SSI payments. Thus, Congress acted to deny SSI *cash* payments to immigrants legally residing in the United States, but chose to delegate the consequential question of *Medicaid* coverage to the States.

By contrast, the reading of §402 offered by HCFA[3] fails to give appropriate weight to Congress' ultimate political resolution with regard to Medicaid and the States, and fails to implement the discretion granted by Congress to the States as part of that resolution. Under HCFA's reading, many States would be required to *expand* their Medicaid program in order to continue covering the *same* people they cover now. At the present time, twenty-nine States have chosen to provide Medicaid to individuals who meet the income and resource requirements, and the disability standard, of SSI but do not actually receive SSI payments.[4] If these States wish to cover legal immigrants as before, they need do nothing more than recertify such individuals as "SSI/optionally categorically needy." But if any of the remaining twenty-one States wishes to cover the same immigrants they had been covering before, these States must create a *new* "SSI/optional categorically needy" group for *both* citizens and immigrants.

There is no evidence in the legislative history that Congress intended to require States to expand Medicaid coverage in order to serve the same people they were serving before. Indeed, such a result would have been contrary to the spirit of the political resolution reached by Congress to accommodate the States.

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or voluntary placement by deeming them as receiving AFDC); *see also* 42 U.S.C. § 1396v(a)(5)(E) (Medicaid eligibility restored for individuals who lost Medicaid because a Social Security cost of living increase made them ineligible for SSI by deeming them as receiving SSI); see also CFR cites.

[2] *See, e.g.*, 42 C.F.R. §435.113, 42 C.F.R. §435.122 .

[3] *See* HCFA's October 4, 1996 letter to State Medicaid Directors (Fact Sheet #3).

[4] In its fact sheet, HCFA calls this group "non-cash SSI-related." We call this group "SSI/optionally categorically needy," based on "Yellow Book" terminology.

Moreover, forcing a State to continue its identical Medicaid coverage for legal immigrants *only* by significantly expanding its existing Medicaid program would be a sufficiently dramatic change that one would expect to see such an intent reflected somewhere in the committee reports or the Congressional Record. As the time-honored principle of statutory interpretation teaches, the "dog didn't bark" in this case.[5]

III. "NOTWITHSTANDING ANY OTHER PROVISION OF LAW"

Section 402(b)(1) provides the following:

> *Notwithstanding any other provision of law* . . . a State is authorized to determine the eligibility of an alien who is a qualified alien for [Medicaid].

For States that wish to continue Medicaid coverage for legal aliens, the phrase "notwithstanding any other provision of law" provides these States with the necessary authority to do so. That is, *notwithstanding* §402(a), which bars SSI cash payments to immigrants lawfully residing in the United States, and *notwithstanding* 42 U.S.C. §1396a(a)(10)(i)(II), which mandates Medicaid coverage solely for individuals "with respect to whom supplemental security income benefits are being paid under title XVI," States are authorized to deem such immigrants *as if* they were receiving SSI cash payments for purposes of Medicaid eligibility.

For States that wish to deny Medicaid coverage for legal immigrants, the phrase "notwithstanding any provision of law" provides States with the authority to take that course of action. That is, *notwithstanding* the legal requirements of the statute authorizing Medicaid,[6] States may discriminate against immigrants as a group in their Medicaid programs.

Any broader reading of the phrase "notwithstanding any other provision of law" would be inappropriate. There is no evidence in the legislative history that the phrase was intended to encompass a wholesale repeal of all Medicaid rules, such as statewideness, comparability, and amount, duration, and scope, or a wholesale repeal of all statutory civil rights rules.[7] Such an interpretation would have been a monumental change in healthcare and civil rights principles and would not have been accompanied by silence. (See, e.g., Shine v. Shine, 802 F.2d 583 (1986).)

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[5] *See, e.g.*, Shine v. Shine, 802 F.2d 583 (1986)(explaining principle that a statute "should not be read to effect a reversal of . . . long-standing principles" without legislative history affirmatively evincing such Congressional intent, including "not[ation] in the congressional discussions").

[6] *See, e.g.*, Medicaid Source Book: Background Data and Analysis ("Yellow Book"), CRS 103-A, Jan. 1993, p. 244.

[7] For example, Title VI of the Civil Rights Act of 1964 provides that no person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of or be subject to discrimination under, any program or activity receiving Federal financial assistance. (42 U.S.C. § 2000(d) (1996).)

Instead of such a bizarre and far-reaching interpretation, the phrase "notwithstanding any other provision of law" must be understood in light of the explicit *limited* definition of "eligibility" provided by Congress in §433. Congress intended for States to be given the authority to decide whether alienage would *matter* in the initial decision of whether to provide Medicaid coverage. The phrase "notwithstanding any provision of law" was inserted to provide States with the statutory leeway to exercise this one particular decision. Thus, once States choose to disregard alienage and provide Medicaid, they remain bound by existing Medicaid requirements of statewideness, comparability, and amount, duration and scope.

IV. CONCLUSION

HCFA's guidance to States should read as follows:

> The authority granted to States in §402(b)(1) to determine Medicaid eligibility for qualified immigrants requires States to answer a single question: *"Will we, as a State, consider qualified immigrants eligible for Medicaid?"* If a State answers in the negative, all qualified immigrants, subject to certain statutory exceptions, will be barred from receiving Medicaid in that State. If a State answers affirmatively, qualified immigrants will be treated as citizens for the purposes of Medicaid eligibility.
>
> In States that elect to consider qualified immigrants eligible for Medicaid, immigrants who previously qualified because they received SSI cash payments will be deemed as if they were receiving those payments, notwithstanding §402(a), and will be eligible for Medicaid as members of that "categorically needy" group.
>
> A State must inform the Health Care Financing Administration of its choice by stating explicitly in a letter signed by the State Medicaid Director that the State has elected or declined to consider qualified immigrants eligible for Medicaid. A State may also notify HCFA of its decision by amending its State plan.
>
> Once a State makes a decision to provide Medicaid to qualified immigrants, the State must abide by existing Medicaid requirements of statewideness, comparability, and amount, duration, and scope with respect to the class of qualified immigrants.
>
> If a State fails to notify the Federal government of its decision regarding Medicaid eligibility for immigrants, qualified immigrants will continue to be eligible for Medicaid under current categories for which they qualify *as immigrants*. In other words, qualified immigrants who were receiving Medicaid

through the receipt of AFDC, as pregnant women or children, or through any category other than SSI, will automatically continue to be covered under Medicaid in that State.

Qualified immigrants who previously received SSI cash payments in States that have elected to cover individuals who meet the income, resource, and disability requirements of SSI, but are not actually receiving SSI cash payments, will continue to be covered under Medicaid as members of that group. However, if a State has not previously elected to create such a group, and chooses not to do so at the present time, qualified immigrants who had previously received SSI will lose their Medicaid coverage through the State's failure to notify HCFA of its intentions regarding this group of individuals.

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Catholic Charities USA presented to HCFA an alternative reading of the statute, developed by the Federal Legislation Clinic, that would allow States—without making any affirmative changes to their Medicaid plans—to continue providing Medicaid services to immigrants who lose their SSI payments. The Clinic currently is in the process of working with Catholic Charities USA to refine this proposal and follow up with Administration officials and Congressional staff. Some of the documents prepared by the Clinic on this issue include the following:

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I. INTRODUCTION

Prior to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the "Welfare Act"), one of the primary ways in which immigrants qualified for Medicaid was through the receipt of Supplemental Security Income ("SSI") cash payments. Section 402(a) of the Welfare Act now prohibits certain immigrants who are lawfully residing in the United States ("legal immigrants") from receiving SSI payments. Section 402(b) of that Act gives States the discretion to determine whether legal immigrants otherwise eligible for Medicaid under a State plan will remain eligible for Medicaid.

Section 402(b) allows States to ask and answer a single question: "Will we, as a State, continue Medicaid eligibility for legal immigrants who are otherwise eligible for Medicaid under our State plan?" If a State answers this question in the negative, legal immigrants will be denied Medicaid in that State. Conversely, if a State answers affirmatively, legal immigrants will be treated *as if they were citizens* for purposes of Medicaid eligibility in that State. Immigrants who used to be receiving SSI payments will be "deemed" as if they were receiving SSI and will be eligible for Medicaid as part of that "categorically needy" group.

If a State fails to notify the Federal government of its decision regarding Medicaid eligibility for legal immigrants, such immigrants will continue to be eligible for Medicaid under current categories for which they qualify *as immigrants*. In other words, legal immigrants who were receiving Medicaid through the receipt of AFDC, as pregnant women or children, or through any category other than SSI, will automatically continue to be covered under Medicaid in any State that has not notified the Federal government of its desire to eliminate Medicaid coverage for such individuals.

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II. STATE DISCRETION TO PROVIDE MEDICAID TO IMMIGRANTS

The discretion provided to States by §402(b) of the Welfare Act is both broad and limited. It is *broad* in the sense that States are allowed to decide, notwithstanding any previous restriction in the Medicaid statute, whether or not to provide Medicaid coverage to immigrants lawfully residing in the United States. It is *limited* because States were given the authority to decide only *one* question: whether or not they will treat legal immigrants *as citizens* for purposes of Medicaid eligibility.

The broad discretion granted to States was the end result of a long political process. The House-passed version of the Welfare Act had barred current legal immigrants from Medicaid. In contrast, the Senate-passed version of the legislation gave States discretion to bar legal immigrants from Medicaid. The final conference agreement for the Welfare Act followed the Senate approach, recognizing that a number of States that wished to maintain Medicaid coverage for current legal immigrants would lose considerable Federal funds if the House approach was adopted. Thus, Congress' ultimate political resolution was to provide States the broad discretion and flexibility to grant or deny Medicaid eligibility to legal immigrants.

The limitation on State discretion arises from the convergence of §402(b)(1) and §433 of the Welfare Act. Section 402(b)(1) provides the following:

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The combination of §402(b)(1) and §433 makes clear that States are allowed to make one decision: whether they will consider individuals eligible or ineligible *because of* their alienage. If a State decides aliens will be eligible, the State has decided to *disregard alienage* and to treat immigrants legally residing in the United States *as if they were citizens* for the purposes of Medicaid eligibility.

If a State exercises its authority to consider legal immigrants as if they were citizens, these immigrants will be *"deemed"* as if they were receiving SSI payments for purposes of Medicaid eligibility. The concept of "deeming" is not a foreign one. Congress has amended Medicaid to create several categories of individuals who are "deemed" to be receiving SSI or AFDC for purposes of Medicaid eligibility,[1] and the Health Care Financing Administration

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In the context of SSI and immigrants, however, rather than amend the Medicaid statute to create a category of individuals deemed as receiving SSI payments, and rather than mandate States to create such a category, Congress chose to delegate the *decision* to create such a category, and the *authority* to do so, to the States. Once a State decides to provide Medicaid coverage to legal immigrants, it has chosen to exercise the option provided it by Congress to deem such individuals as if they were receiving SSI payments. Thus, Congress acted to deny SSI *cash* payments to immigrants legally residing in the United States, but chose to delegate the consequential question of *Medicaid* coverage to the States.

By contrast, the reading of §402 offered by HCFA[3] fails to give appropriate weight to Congress' ultimate political resolution with regard to Medicaid and the States, and fails to implement the discretion granted by Congress to the States as part of that resolution. Under HCFA's reading, many States would be required to *expand* their Medicaid program in order to continue covering the *same* people they cover now. At the present time, twenty-nine States have chosen to provide Medicaid to individuals who meet the income and resource requirements, and the disability standard, of SSI but do not actually receive SSI payments.[4] If these States wish to cover legal immigrants as before, they need do nothing more than recertify such individuals as "SSI/optionally categorically needy." But if any of the remaining twenty-one States wishes to cover the same immigrants they had been covering before, these States must create a *new* "SSI/optional categorically needy" group for *both* citizens and immigrants.

There is no evidence in the legislative history that Congress intended to require States to expand Medicaid coverage in order to serve the same people they were serving before. Indeed, such a result would have been contrary to the spirit of the political resolution reached by Congress to accommodate the States.

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Moreover, forcing a State to continue its identical Medicaid coverage for legal immigrants *only* by significantly expanding its existing Medicaid program would be a sufficiently dramatic change that one would expect to see such an intent reflected somewhere in the committee reports or the Congressional Record. As the time-honored principle of statutory interpretation teaches, the "dog didn't bark" in this case.[5]

III. "NOTWITHSTANDING ANY OTHER PROVISION OF LAW"

Section 402(b)(1) provides the following:

> *Notwithstanding any other provision of law* . . . a State is authorized to determine the eligibility of an alien who is a qualified alien for [Medicaid].

For States that wish to continue Medicaid coverage for legal aliens, the phrase "notwithstanding any other provision of law" provides these States with the necessary authority to do so. That is, *notwithstanding* §402(a), which bars SSI cash payments to immigrants lawfully residing in the United States, and *notwithstanding* 42 U.S.C. §1396a(a)(10)(i)(II), which mandates Medicaid coverage solely for individuals "with respect to whom supplemental security income benefits are being paid under title XVI," States are authorized to deem such immigrants *as if* they were receiving SSI cash payments for purposes of Medicaid eligibility.

For States that wish to deny Medicaid coverage for legal immigrants, the phrase "notwithstanding any provision of law" provides States with the authority to take that course of action. That is, *notwithstanding* the legal requirements of the statute authorizing Medicaid,[6] States may discriminate against immigrants as a group in their Medicaid programs.

Any broader reading of the phrase "notwithstanding any other provision of law" would be inappropriate. There is no evidence in the legislative history that the phrase was intended to encompass a wholesale repeal of all Medicaid rules, such as statewideness, comparability, and amount, duration, and scope, or a wholesale repeal of all statutory civil rights rules.[7] Such an interpretation would have been a monumental change in healthcare and civil rights principles and would not have been accompanied by silence. (See, e.g., Shine v. Shine, 802 F.2d 583 (1986).)

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[6] *See, e.g.*, Medicaid Source Book: Background Data and Analysis ("Yellow Book"), CRS 103-A, Jan. 1993, p. 244.

[7] For example, Title VI of the Civil Rights Act of 1964 provides that no person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of or be subject to discrimination under, any program or activity receiving Federal financial assistance. (42 U.S.C. § 2000(d) (1996).)

Instead of such a bizarre and far-reaching interpretation, the phrase "notwithstanding any other provision of law" must be understood in light of the explicit *limited* definition of "eligibility" provided by Congress in §433. Congress intended for States to be given the authority to decide whether alienage would *matter* in the initial decision of whether to provide Medicaid coverage. The phrase "notwithstanding any provision of law" was inserted to provide States with the statutory leeway to exercise this one particular decision. Thus, once States choose to disregard alienage and provide Medicaid, they remain bound by existing Medicaid requirements of statewideness, comparability, and amount, duration and scope.

IV. CONCLUSION

HCFA's guidance to States should read as follows:

> The authority granted to States in §402(b)(1) to determine Medicaid eligibility for qualified immigrants requires States to answer a single question: *"Will we, as a State, consider qualified immigrants eligible for Medicaid?"* If a State answers in the negative, all qualified immigrants, subject to certain statutory exceptions, will be barred from receiving Medicaid in that State. If a State answers affirmatively, qualified immigrants will be treated as citizens for the purposes of Medicaid eligibility.
>
> In States that elect to consider qualified immigrants eligible for Medicaid, immigrants who previously qualified because they received SSI cash payments will be deemed as if they were receiving those payments, notwithstanding §402(a), and will be eligible for Medicaid as members of that "categorically needy" group.
>
> A State must inform the Health Care Financing Administration of its choice by stating explicitly in a letter signed by the State Medicaid Director that the State has elected or declined to consider qualified immigrants eligible for Medicaid. A State may also notify HCFA of its decision by amending its State plan.
>
> Once a State makes a decision to provide Medicaid to qualified immigrants, the State must abide by existing Medicaid requirements of statewideness, comparability, and amount, duration, and scope with respect to the class of qualified immigrants.
>
> If a State fails to notify the Federal government of its decision regarding Medicaid eligibility for immigrants, qualified immigrants will continue to be eligible for Medicaid under current categories for which they qualify *as immigrants*. In other words, qualified immigrants who were receiving Medicaid

through the receipt of AFDC, as pregnant women or children, or through any category other than SSI, will automatically continue to be covered under Medicaid in that State.

Qualified immigrants who previously received SSI cash payments in States that have elected to cover individuals who meet the income, resource, and disability requirements of SSI, but are not actually receiving SSI cash payments, will continue to be covered under Medicaid as members of that group. However, if a State has not previously elected to create such a group, and chooses not to do so at the present time, qualified immigrants who had previously received SSI will lose their Medicaid coverage through the State's failure to notify HCFA of its intentions regarding this group of individuals.

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PRESERVING A PRIVATE RIGHT OF ACTION IN THE MEDICAID PROGRAM

Sample Documents

During the 104th Congress, the Federal Legislation Clinic supported Catholic Charities USA in the battle against the repeal of the Medicaid program. Republican Governors proposed a block grant that would have stripped beneficiaries of much of the guaranteed services on which they now rely. In addition, the block grant proposal would have removed the primary mechanism for beneficiaries to ensure the accountability of State Medicaid plans—the "private right of action."

As a result of the dedication of many coalitions, organizations, and individuals, the campaign against the repeal of Medicaid ultimately was successful. The President vetoed the Republican proposal twice and preserved both the benefits and the enforcement mechanism for Medicaid beneficiaries. Unfortunately, the President, in his budget for 1998, has proposed a "per capita cap" proposal that may result in similar substantial cuts to Medicaid. The Federal Legislation Clinic will continue its work assisting Catholic Charities USA to ensure the preservation of the most essential medical care for those in need. Some of the documents prepared by the Federal Legislation Clinic on this topic include the following:

- ☐ Memo: The Budget Reconciliation Bill: The Issue of Accountability in the Medicaid Program (11/28/95)
- ☐ Memo: Proposed Limitations on Private Causes of Action in the Medicaid Bills (11/28/95)
- ■ Talking Points: Ensuring Access to Health Care Services for our Most Vulnerable Populations (4/17/96) (attached)
- ☐ Proposed Amendment to NGA Medicaid Proposal (4/17/96)
- ☐ Memo to Client: The Definition of "Disability" in Medicaid (12/18/96)
- ☐ Talking Points: Causes of Action in State Courts for Medicaid (3/15/96)
- ☐ Talking Points: Federal Courts are Preferable for Determining Questions of Federal Medicaid Law (3/12/96)
- ☐ Talking Points: The Private Right of Action as Enforcement Mechanism -- Not as Substantive Right (3/15/96)
- ☐ Talking Points: Requiring Federal Remedies in State Court (3/4/96)

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- ☐ Talking Points: Maintaining State Accountability in the Medicaid Program (12/7/95)
- ☐ Memo: Use of Private Causes of Action in the Current Medicaid Act (12/7/96)
- ☐ Talking Points: Medicaid--Critical Issues (2/6/96)
- ☐ Memo: Cases Using a Private Cause of Action to Enforce Medicaid Guarantees (2/6/96)

For copies of these documents, or for more information on the private right of action in the Medicaid program, please contact David Rapallo at (202) 662-9595.

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ENSURING ACCESS TO HEALTH CARE SERVICES FOR OUR MOST VULNERABLE POPULATIONS

Any proposal to preserve important guarantees within the Medicaid bill must also retain a beneficiary's right to go to **federal court** to enforce those guarantees.

Since the inception of the Medicaid program, a person eligible for Medicaid has had:

1) a **guarantee** of access to certain services, and
2) the **right to enforce** this commitment in federal court.

Without a mechanism for accountability and enforcement, a guarantee of access is a hollow promise.

Private Right of Action:

Although some initial block grant proposals in Congress have threatened to eliminate **all** guarantees in the Medicaid program, the current proposal from the National Governors Association **keeps guaranteed coverage and benefits for certain populations** (i.e. poor pregnant women, children under 6, individuals with disabilities and poor elderly individuals).

Since the Governors realize that even these more limited guarantees are meaningless without some form of accountability, they have recommended a private right of action. Although the Governors' proposal is still insufficient because it limits the private right of action to **state** court, the proposal does recognize the following benefits of the private right of action:

> ***Effectiveness of Private Right of Action***: The private right of action is a well-established enforcement mechanism. Through its use, states are cognizant of their obligations and are more likely to comply. The private right of action gives states a strong incentive to provide the medical services promised in their own state plans.
>
> ***Efficiency of Private Right of Action***: A private right of action is cost-effective. No wasteful state or federal administrative mechanism is required to enforce state compliance. Additional funding is unnecessary and beneficiaries receive individual consideration of their particular situation. In addition, one individual's case could resolve a policy issue that may affect thousands of Medicaid recipients.

The Governors' Limitation to State Court Undermines Accountability

Although the National Governors Association recognizes the virtues of a private right of action, they, unfortunately, propose limiting individual claims to state court. In their proposal, federal review would occur only in the U.S. Supreme Court, which consents to hearing a limited number of cases each year. A private right of action in state court would be detrimental for several reasons:

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

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

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

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

Undermining Congressional Intent: Congress' commitment to guarantee Medicaid services to some of our most vulnerable populations will not be fulfilled if individuals cannot keep States accountable. The private right of action prevents states from circumventing federal law and undermining Congressional intent by allowing beneficiaries to bring their claim to **federal court**.

All of these concerns counsel **against** removing a federal cause of action. Unlike state judges, federal judges are neutral arbiters and are detached from the controversies at hand. If Congress chooses to retain any more **federal** benefits, it should at least allow challenges to the provision and interpretation of federal guarantees to be resolved in **federal** court. At a time when the Supreme Court is interpreting States rights more broadly than it has in decades (see Seminole, U.S. Lexis 2165), it is imperative that the federal government maintain its sovereignty over State compliance with **federally funded programs**.

Recommended Action:

A private right of action in federal court must be retained in any new Medicaid legislation to ensure that states provide essential medical services to our most vulnerable populations.

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REMOVING BARRIERS IN THE NATURALIZATION PROCESS: REASONABLE ACCOMMODATIONS FOR IMMIGRANTS WITH DISABILITIES

Sample Documents

With the recent passage of the Welfare Act, naturalization has become particularly important because noncitizens are now faced with losing federal benefits such as SSI and Medicaid. Yet, the naturalization process remains inaccessible for many immigrants who are most in need of these benefits—immigrants with disabilities. INS officers, swamped with an enormous backlog of applications, often fail to grant reasonable accommodations for immigrants with disabilities, in violation of section 504 of the Rehabilitation Act of 1973. Without these accommodations, immigrants with disabilities cannot become naturalized citizens.

Catholic Charities USA, with the legislative support of the Federal Legislation Clinic, has been working with the INS to ensure that immigrants with disabilities have an equal opportunity to become naturalized citizens. Congress recently amended the Immigration and Nationality Act to allow elderly immigrants and immigrants with disabilities to be exempted from certain testing requirements of the naturalization process. Exemptions such as these are fairly narrow and sometimes confuse the issue of reasonable accommodations. To remedy this confusion, the Federal Legislation Clinic has prepared several documents that interpret these statutory exemptions and reconcile them with the reasonable accommodations requirement:

- ☐ Letter to the INS Regarding the Proposed Exemption of People with Disabilities from Portions of the Naturalization Examination (10/11/96)
- ☐ Talking Points: INS Naturalization Regulations for Individuals with Disabilities (11/10/96)
- ☐ Memo: INS Testing Exception for Persons Over Sixty-Five (1/28/97)
- ☐ Memo to Representative Pelosi and Representative Sanchez Regarding the Naturalization of Immigrants with Disabilities (2/26/97)
- ☐ Talking Points: Naturalization Requirements: Immigrants with Disabilities (2/26/97)
- ■ Model Guidance Memorandum: Reasonable Accommodations During the Naturalization Process (3/10/97) (attached)

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- ☐ Memo: Bills Relating to the Naturalization Process (3/17/97)
- ☐ Memo: Oath Attestation for Naturalization Applicants with Incapacitating Disabilities (4/1/97)
- ☐ Letter to the INS Regarding the Model Guidance Memorandum on Reasonable Accommodations During the Naturalization Process (4/18/97)

For copies of these documents, or for more information on the issue of reasonable accommodations during the naturalization process, please contact David Rapallo at (202) 662-9595.

*** DRAFT ***

Subject	Date
Guidance on Reasonable Accommodations for Naturalization Applicants with Mental, Physical, or Developmental Disabilities	

To

All District Directors
All Officers-in-Charge
All Regional Directors
All Service Center Directors

From

This memorandum provides guidance on the reasonable accommodations that must be granted to naturalization applicants who have mental, physical, or developmental disabilities. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) requires that all Executive agencies provide reasonable accommodations to individuals with disabilities. However, agencies need not provide accommodations that would "result in a fundamental alteration in the nature of a program or activity or in undue financial and administrative burdens" (28 C.F.R. § 39.160(d)). If agency personnel believe a reasonable accommodation will cause such results, they must bear the burden of proof before the Attorney General or her designee. If the agency sustains this burden, the agency is still required to provide a less burdensome accommodation.

The Immigration and Naturalization Service is covered by section 504 (see 28 C.F.R. Part 39, at 675). Accordingly, reasonable accommodations must be provided throughout the naturalization process. This reasonable accommodations requirement must not be confused with statutory waivers and exemptions granted to elderly, ill, and disabled naturalization applicants. The existence of a statutory waiver or exemption at a particular stage of the naturalization process does not necessarily fulfill the section 504 reasonable accommodations requirement.

This memorandum provides guidance on four stages of the naturalization process: 1) the application, 2) the interview, 3) the English literacy and United States history and government examinations, and 4) the oath of allegiance. For each stage, the relevant statutory waivers and exemptions are identified and appropriate reasonable accommodations are suggested.

A range of disabilities are covered under section 504. Individuals who have a "physical or mental impairment that substantially limits one or more major life activities, [have] a record of such an impairment, or [are] regarded as having such an impairment" are covered under section 504 (28 C.F.R. § 39.103). This definition includes disabilities such as: a learning disability, mental retardation, emotional or mental illness, an organic brain syndrome, cerebral palsy, and visual, speech, or hearing impairments. Naturalization applicants who have one of these disabilities or a similar disability must be afforded reasonable accommodations at every stage of

the naturalization process. Reasonable accommodations may be required under section 504 even if the applicant qualifies for one of the statutory waivers or exemptions.

1. The Application

Sections 333 and 334 of the INA (8 U.S.C. §§ 1444, 1445) require that an applicant file an application (INS Form N-400) and three photographs, all signed by the applicant, in the office of the Attorney General. Applicants with disabilities may not be able to complete INS Form N-400 or sign the photographs that must accompany the application. The regulations governing the naturalization process provide two relevant exceptions: 1) a preparer may fill out and sign Form N-400 for applicants who are physically unable to write (8 C.F.R. § 334.2(a)), and 2) photographs may be signed by an INS employee or by the guardian of an applicant who is physically unable to write (8 C.F.R. § 333.1(c)(2)).

Apart from these exceptions, additional reasonable accommodations may be required by section 504. For instance, an applicant may be *physically* able to write but may have a mental impairment or developmental disability that prevents the applicant from completing Form N-400 or signing their name. In such cases, allowing a preparer to fill out and sign Form N-400 or sign the applicant's photographs would be an appropriate reasonable accommodation under section 504.

Applicants with disabilities may not be able to file Form N-400 at the office of the Attorney General. There is a statutory exception that applies in this case: an applicant is not required to file Form N-400 in the office of the Attorney General if "the Attorney General determines that the person has an illness or other disability which: (1) is of a permanent nature and is sufficiently serious to prevent the person's personal appearance, or (2) is of a nature which so incapacitates the person as to prevent him from personally appearing" (8 U.S.C. § 1445(e)).

This statutory exception, however, does not address all possible section 504 reasonable accommodation requirements. For example, in the case of an applicant with a disability that makes personal appearance quite difficult but not impossible, allowing a friend, family member, or social worker to file Form N-400 on behalf of the applicant would be an appropriate reasonable accommodation.

2. The Interview

Sections 332 and 335 of the INA (8 U.S.C. §§ 1443, 1446) authorize INS officials to interview the applicant in order to verify information on the application, investigate the applicant's background, and conduct required examinations. Applicants with disabilities may not be able to appear at an INS office for these interviews. The regulations permit the district director to select an alternative location for interviews if an applicant has a sickness or disability

"of a nature which so incapacitates the applicant as to prevent the applicant's appearance at a Service office" (8 C.F.R. § 334.4).

Notwithstanding this exemption for applicants who are incapacitated, section 504 requires that reasonable accommodations be granted when an INS office is inaccessible to an applicant with a disability that is not incapacitating. In these cases, a reasonably accessible alternative interview site, such as the applicant's home or nursing facility, should be selected.

Applicants with disabilities may need assistance in answering questions during the interview. In such cases, a variety of reasonable accommodations may be required under section 504. For example, if an applicant has a hearing impairment, a sign language interpreter, as well as a foreign language interpreter, should be allowed to assist the applicant during the interview. Also, if an applicant has a learning disability or mental retardation, a family member, friend, or social worker should be permitted to help explain questions to the applicant. Specifically, applicants with learning disabilities or mental retardation often have difficulty understanding questions about their willingness or capacity to take a meaningful oath of allegiance. In these cases, an assistant or interpreter should be allowed to explain the oath requirements and elicit some form of verbal, written, or demonstrative assent from the applicant.

3. The Examinations

Section 312 of the INA (8 U.S.C. § 1423) requires that naturalization applicants pass an English literacy examination and a U.S. history and government examination. There are a number of statutory waivers and exemptions that apply to these exams. Of greatest importance to people with disabilities, applicants who are "unable because of physical or developmental disability or mental impairment" to complete one or both of the examinations are exempted from the tests (8 U.S.C. § 1423(b)(1)).

This exemption does not necessarily satisfy the section 504 requirement. For instance, applicants with disabilities may be able to take one or both of the tests, but may need a reasonable accommodation in order to do so. Alternative testing sites, including the applicant's home, should be selected when an INS office is inaccessible to an applicant with a physical disability. A sign language interpreter or a braille version of a test should be provided to applicants with hearing or visual impairments. Applicants with mild learning disabilities should be permitted extra time to answer questions and should be allowed to have a friend, family member, or social worker assist in explaining the questions.

4. The Oath of Allegiance

Section 337 of the INA (8 U.S.C. § 1448) requires that naturalization applicants take an oath of allegiance in a public ceremony before the Attorney General or a court of jurisdiction.

Rather than participating in a public oath ceremony, applicants with disabilities may obtain an expedited oath administration ceremony if they have a permanent disability that is "sufficiently incapacitating as to prevent the applicant's personal appearance at a scheduled ceremony" or if a developmental disability or advanced age "would make appearance at a scheduled ceremony inappropriate" (8 C.F.R. § 337.3(a)). Furthermore, expedited oath administration ceremonies may be granted in "special circumstances of a compelling or humanitarian nature" (8 C.F.R. § 337.3(a)).

Again, however, these regulatory exemptions do not exhaust the section 504 reasonable accommodation requirement with regard to applicants taking the oath. In the case of an applicant with a learning disability or mental retardation, an assistant or interpreter should be permitted to explain the content of the oath to an applicant, who would then give a verbal, written, or demonstrative signal of her willingness to abide by the oath. A family member, guardian, or social worker should be allowed to serve as the applicant's assistant or interpreter. Section 504 also requires that a third party, such as a family member, guardian, or social worker, be permitted to take a more active role in the oath administration when the applicant is in a coma or has a similarly incapacitating disability. In these severe cases, a third party should be permitted to attest to the applicant's willingness and ability to abide by the oath if the third party had knowledge of the applicant's wishes expressed before the onset of the coma or incapacitation.

The accommodations suggested in this memorandum are not intended to be an exhaustive list of reasonable accommodations that may be provided at each stage of the naturalization process. Rather, they are designed to highlight the range of accommodations that field offices may be called upon to provide to applicants with disabilities. Accommodations must be tailored to meet an applicant's individual needs and disabilities and should serve the purpose of allowing applicants with disabilities to participate equally in the naturalization process.

A special office has been established to answer questions about the section 504 reasonable accommodations requirement. Please do not hesitate to contact this office if you have questions about a specific case, as applications can be processed more efficiently if accommodations are addressed as soon as possible.

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PROVIDING ALTERNATIVES TO ASSISTED SUICIDE

Sample Documents

In anticipation of the pending Supreme Court decision on the issue of assisted suicide, Members of Congress introduced bills in the 105th Congress prohibiting the use of federal funds for assisted suicide. Absent from these bills were any provisions addressing what the Clinic's client, NAPAS/Rights Task Force of the Consortium for Citizens with Disabilities (CCD), believed to be the critical issue underlying the assisted suicide debate -- the lack of access to services for persons with disabilities and chronic illnesses.

The Federal Legislation Clinic prepared a range of documents, including testimony, background papers and proposed amendments, on behalf of CCD, to address this issue. Although the Clinic's ambitious proposal was not passed by Congress, the final bill as passed did contain a provision that (1) funds research and demonstration projects designed to reduce the rate of assisted suicide among persons with disabilities and chronic illnesses, and (2) requires a GAO study to assess the quality of graduate medical education concerning alternatives to assisted suicide. This amendment is a small, but significant, step towards addressing the health problems that make people seek assisted suicide in the first place.

Documents prepared by the Federal Legislation Clinic on this issue include:

- ☐ Brief Analysis of *Compassion in Dying v. State of Washington* and Quill v. Vacco (Memo) (1/21/96)
- ☐ Assisted Suicide Funding Restriction Act: Implications for Legal Advocacy (Talking Points) (1/22/97)
- ☐ Section-by-Section Analysis of the Assisted Suicide Funding Restriction Act (1/23/97)
- ☐ General Overview of the Assisted Suicide Funding Restriction Act (Memo) (1/23/97)
- ☐ Providing Alternatives To Physician Assisted Suicide: The Position of the CCD Rights Task Force (Talking Points) (2/4/97)
- ■ A Proposal to Fund Programs and Services Providing Alternatives to Assisted Suicide (Memo) (2/17/97) (attached)

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- ☐ Written Testimony of Mark Shaffer on behalf of the CCD Rights Task Force before the Subcommittee on Health and the Environment (3/6/97)
- ☐ Talking Points on the Proposed Brown Amendment to Prevent Assisted Suicide (3/9/97)
- ☐ CCD Rights Task Force Update on Physician Assisted Suicide Bill (3/17/97)
- ☐ Proposed Amendment to H.R. 1003 (Talking Points) (3/19/97)
- ☐ What the Brown Amendment Would Do (Talking Points (3/19/97)

For copies of these documents, or for more information on this issue, please contact Sharon Perley at (202) 662-9595.

Consortium for Citizens with Disabilities

A Proposal to Fund Programs and Services Providing Alternatives to Assisted Suicide

I. A prohibition on the use of federal funds for assisted suicide does not address the *reasons* why people seek assisted suicide in the first place.

Members of both the House and the Senate have introduced bills that would prohibit the use of federal funds for assisted suicide. In explaining the purpose of the bills, sponsors of the Senate bill have stressed that federal tax dollars should be used *"to support and enhance human health and life*, not to promote the destruction of human life."[1]

The bills, however, address only one of these two stated goals. While the bills prohibit the use of federal funds for the *provision* of assisted suicide, they do not address the *reasons* why people seek assisted suicide. The bills, as currently drafted, would limit access to assisted suicide without taking steps to prevent people from seeking assisted suicide in the first place.

The need for such services is evidenced by real life stories. Larry McAfee, a 34-year-old quadriplegic, wanted to be taken off his respirator because he had "nothing to look forward to." However, when he was given an electric wheelchair, a computer for drafting (he's an engineer), and an accessible group home, he changed his mind. Another example is that of Elizabeth Bouvia. Ms. Bouvia, a person with cerebral palsy, checked herself into a hospital and informed the staff she wished to starve herself to death while taking physician-prescribed painkillers to mitigate her discomfort. While a court battle ensued over her right to die, she received counseling and support from private groups. By the time she had won the "right to die," she decided she wanted to live.

The need for medical and mental health services is also supported by those who actually receive requests for assisted suicide. In its amicus brief in *Quill v. Vacco* (a case recently argued before the Supreme Court), the American Medical Association explained ". . . many patients today do not receive proper treatment for their pain, depression, or psychological distress. . . [O]ur society . . . should recognize the urgent necessity of extending to all patients the palliative

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[1] 143 Cong. Rec. S1302, February 12, 1997 (Statement of Senator Ashcroft).

care they need and redouble our efforts to provide such care to all."[2] The AMA further suggested that societal pressure to contain health care costs often inappropriately drives individuals to seek assisted suicide. "[T]he continuing pressure to reduce costs can only constrain the availability and quality of palliative care and support services that patients and families need. These limitations on the availability of proper care clearly can place pressure on patients to express a wish for suicide that they might not otherwise feel."[3]

II. Any public policy in the area of physician-assisted suicide should include a proposal to fund mental health services and services necessary for basic living.

An amendment to any bill prohibiting federal funds for physician assisted suicide could establish an entitlement program that would fund psychological and medical services to a discrete group of individuals. To be eligible for such services, an applicant for federal monies would need to demonstrate that he or she: (1) has been certified by a health care provider as having either an irreversible condition, a degenerative condition, a terminal illness, or as suffering from intractable pain; (2) satisfies a means test; and (3) is at risk of seeking assisted suicide.

Significant overhaul of the health care delivery system would be needed to address *all* segments of the population at risk of suicide. A more targeted proposal, however, would address only those individuals who actually have unmet needs that, if met, might reduce their desire for assisted suicide.

To limit the proposal's scope, services could focus on two categories: services necessary for basic living and mental health counseling. Absence of these services most often underlies an individual's desire to seek assisted suicide.

(1) *Services Necessary for Basic Living*: Funds would be allocated to provide access to medical equipment, home care, attendant care, and/or pain management to individuals who have satisfied the eligibility criteria. Provision of such services could help prevent cuts in Medicaid, Medicare and welfare from being manifested in increases of the assisted suicide rate.

(2) *Mental Health Services*: Funds would be allocated to provide mental health services to individuals who have satisfied the eligibility criteria. Mental health services would include psychotherapy, psychotropic medications, and appropriate support services. Untreated depression would no longer be mistaken as a desire to die.

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[2] Brief for the American Medical Association and et al. at 24, Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996) (opinion from the Supreme Court pending).

[3] *Id.* at 31.

Funds under this program could be provided directly to the program beneficiaries. Alternatively, public hospitals and community and migrant health care centers could act as financial intermediaries. Under any funding scenario, existing State, local, and nonprofit organizations should be utilized. There is no need to establish a new bureaucracy to manage this program.

Apart from the direct provision of services, the proposal should also include funding for demonstration projects. States, political subdivisions of States, and nonprofit agencies should compete for funds to establish demonstration projects focused on creative ways to reduce the desire and pressure for physician assisted suicide.

III. Conclusion

Sponsors of bills to prohibit federal funds for physician assisted suicide recognize that "institutionalizing physician-assisted suicide as a medical treatment would put many more patients at serious risk for *unwanted* and *unnecessary* death."[4] However, prohibiting the use of federal tax dollars for assisted suicide does not address the *reasons* why people seek assisted suicide in the first place. By funding medical services for basic living and mental health services, this proposal could ensure that undiagnosed depression and lack of access to support services do not cause Americans to choose assisted suicide.

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[4] 143 Cong. Rec. S1304, February 12, 1997 (Statement of Senator Nickles).

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PROTECTING THE PRIVACY OF PERSONAL HEALTH INFORMATION

Sample Documents

Bills to ensure privacy of personal health information have been introduced in Congress for the past twenty years. Because of the competing interests of the consumer and industry groups, however, no bill has ever been enacted. Passage of the Health Insurance Portability and Accountability Act (otherwise known as the Kennedy-Kassebaum bill) changes the political landscape. The law requires Congress to enact privacy legislation -- at least with respect to the electronic exchange of medical information -- by August 1999. If Congress fails to act, HHS is mandated to promulgate privacy regulations regarding such data within the following six months.

A number of bills governing the privacy of personal health and/or genetic information have been introduced in the 105th Congress. The Federal Legislation Clinic, on behalf of its client, NAPAS/Rights Task Force of the Consortium for Citizens with Disabilities (CCD), has analyzed these bills and their potential impact on persons with disabilities. A working group, composed of CCD Health and Rights Task Force members, is focusing on these bills.

Documents prepared by the Federal Legislation Clinic on this issue include:

- ☐ Talking Points: What Does It Mean To Have No Nationwide Law Governing Your Health Information? (2/7/97)
- ☐ Memo: Pending Privacy Legislation and its Effect on Persons with Disabilities: A Detailed Analysis (Memo) (2/12/97)
- ■ Talking Points: Pending Privacy Legislation: Its Effect on Persons with Disabilities (2/12/97) (attached)
- ☐ Talking Points: Pending Privacy Legislation: The Political Landscape (2/12/97)
- ☐ Section-by-Section Analysis of the 3/11/96 Draft of the Medical Records Privacy Protection Act (3/3/97)
- ☐ Section-by-Section Analysis of the September 1996 Draft of S. 1360 (The Medical Information Confidentiality Act) (3/3/97)
- ☐ Side-by-Side Comparative Analysis of the Medical Records Privacy Protection Act and the September Draft of S.1360 (Bennett/Leahy Bill) (3/10/97)

For copies of these documents, or for more information on this issue, contact Sharon Perley at (202) 662-9595.

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202-662-9595 Fax # 202-662-9682
fedlegis@law.georgetown.edu

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Senior Policy Fellow
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Pending Privacy Legislation: Its Effect on Persons with Disabilities

Persons with disabilities have particular interests in the pending privacy legislation, and unique perspectives to offer to the debate.

- ***Medical records contain vast amounts of information and may be widely circulated within the ordinary course of business.*** In addition to medical information, medical records often contain personal, demographic, and financial data. Yet numerous persons -- including health care providers, insurers, and employers -- have access to these records, and, as records become more automated, this access will increase. Persons with disabilities have a strong interest in ensuring they retain the ultimate right to decide *when*, and *under what circumstances*, their personal information will be shared with others.

- ***Privacy protections for identifiable personal health information would fill the gaps left open by the Americans with Disabilities Act.*** The ADA provides confidentiality protections for medical information derived from employer exams and inquiries, but information obtained from other sources -- for example, information obtained through a company health insurance plan -- is *not* protected. Federal privacy protections would (a) provide remedies for the *disclosure* of private health information, regardless of whether discrimination actually occurred; (b) prevent some instances of disability-based discrimination from occurring in the first place, by preventing employers from even *knowing* of their employees' medical conditions; and (c) remove a deterrent to bringing ADA lawsuits by assuring victims of discrimination that irrelevant medical records and non-medical data in those records would be protected from discovery.

- ***A lack of privacy protections and the fear of discrimination or stigma may directly affect an individual's health care choices.*** Lack of privacy protections has caused many individuals to withhold information from their health care providers, pay out-of-pocket, or avoid treatment altogether. All persons, but in particular, persons with disabilities, have a strong interest in developing and maintaining trusting relationships with their health care providers. Without strong privacy protections, trust between patient and provider will often not be established.

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- ***Persons with disabilities need access to their own medical records to correct mistakes, remove extraneous material, and make informed treatment decisions.*** Currently, whether an individual has access to his or her records depends upon the State in which the individual resides, the policies of the individual's health plan or provider, or, in some instances, the case-by-case decisions of the individual or institution holding the information.

- ***Genetic information raises unique concerns.*** Advances in genetic research bears much promise for persons with disabilities: more early diagnoses, more preventive treatments, and more successful treatments once a condition manifests itself. Improper use of genetic information, however, may prove to be yet another basis for discrimination. Persons with disabilities need assurances that their genetic information will not be disclosed without their consent.

- ***Persons with disabilities cannot assume that their interests in health care reform and privacy will necessarily be the same as those of other interested parties.*** Federal privacy legislation can offer protection against stigmatization and discrimination. At the same time, increased efficiency in research and administrative simplification can benefit those who utilize the health care system the most. Persons with disabilities may bring a unique voice to the privacy debate because of their interests in both these goals.

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OPPOSING AMENDMENTS TO THE FAIR HOUSING ACT

Sample Documents

The Fair Housing Act (FHA) of 1968, as amended in 1988, provides critical protection for people with disabilities in the sale and rental of private housing. The FHA has been particularly important in ensuring that people with disabilities who need to live in group homes are given a fair opportunity to live in residential neighborhoods. Several bills introduced in the 105th Congress are designed to address the fears and misunderstanding of municipalities and local citizen groups who oppose group homes. Unfortunately, the bills would roll back significant and balanced protections of the FHA, to the detriment of persons with disabilities.

The Federal Legislation Clinic, on behalf of its client, NAPAS/Rights Task Force of the Consortium for Citizens with Disabilities (CCD), is working with the civil rights community to oppose the proposed amendments to the Fair Housing Act.

Documents prepared by the Federal Legislation Clinic on this issue include:

- ☐ Proposed Amendments to the Fair Housing Act (Talking Points)
- ☐ Proposed Amendments to the Fair Housing Act: S. 142 and H.R. 589 (Memo)
- ☐ H.R. 589: Fair Housing Act Under Attack (Talking Points)
- ■ The Fair Housing Act and Local Zoning Laws (Talking Points)
- ☐ If H.R. 589 Were To Become Law (Talking Points)
- ☐ Comments on H.R. 589 (Talking Points)

For copies of these documents, or for more information on the proposed amendments to the Fair Housing Act, contact Sharon Perley at (202) 662-9595.

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202-662-9595 Fax # 202-662-9682
fedlegis@law.georgetown.edu

Consortium for Citizens with Disabilities

The Fair Housing Act and Local Zoning Laws

- ***The Fair Housing Act (FHA) prohibits discrimination on the basis of disability in the sale or rental of housing.*** Discrimination in housing includes the *"refusal to make reasonable accommodations in rules, policies [and] practices,"* or other actions that have the effect of denying or making housing unavailable to persons with disabilities.
- ***Cities are required to make reasonable accommodations in order to allow persons with disabilities to live in the community.*** Reasonable accommodations must be provided when neutral zoning laws have the effect of denying housing to persons with disabilities. For example, a reasonable accomodation might be to grant a variance to a single-family zoning restriction to an organization that wants to establish a group home for six adults with mental retardation.
- ***Neutral zoning laws that have the effect of discriminating against persons with disabilities are not, however, automatically in violation of the FHA.*** The FHA is not a blanket waiver of all facially neutral zoning rules. Cities need only make reasonable accomodations -- *i.e.*, those that do not impose an undue burden or require a fundamental alteration -- to local zoning laws. For example, if a city would have to take extraordinary steps in order to permit the construction of a group home, it would not be required to do so.
- ***Where there is evidence that a <u>particular</u> home for persons with disabilities will negatively affect a neighborhood's quality of life, a variance need not be granted.*** A city does not need to grant a variance if it can establish that the proposed housing will negatively affect the quality of life in an area protected by a zoning law. For example, the city would not be required to grant a variance to allow a group home if it could show there would be an unnacceptable increase in traffic in the neighborhood. Similarly, the city could refuse to grant a variance to allow a group home if the owners of the home wanted to house an individual who had a long record of violent crimes perpetrated in the community.
- ***<u>City of Edmonds v. Oxford House</u> does not undermine the ability of localities to pass effective zoning laws.*** In <u>Edmonds,</u> the Supreme Court held that a city whose local zoning law limited only the total number of *unrelated* persons -- but not the number of *related* persons -- who could occupy a dwelling was not exempted by an FHA provision that permitted reasonable occupancy restrictions. The Court did *not* hold that unrelated occupant restrictions, *per se,* violate the FHA, but instead remanded the case to the lower court.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. form	re: Correspondence routing slip (Personal) (1 page)	07/21/1997	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19394

FOLDER TITLE:
Correspondence - SLT - Incoming - 7/97 [Folder 3] [2]

2018-0764-F
jm2048

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001b. letter	Concerned patient to Cigna re: Insurance coverage (Personal) [partial] (2 pages)	00/00/0000	b(6)

COLLECTION:
Clinton Presidential Records
National AIDS Policy Office

OA/Box Number: 19394

FOLDER TITLE:
Correspondence - SLT - Incoming - 7/97 [Folder 3] [2]

2018-0764-F
jm2048

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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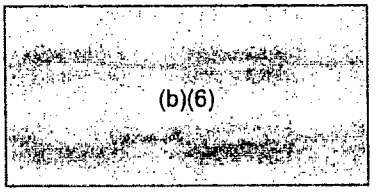
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]



[0016]

Cigna Health Care
Dea Niewiemski, coordinator
P.O. Box 42005
Phoenix, Arizona 85080-2005

Dear Ms. Niewiemski: re: COBRA (b)(6)

Saturday June 28, 1997, I was very ill and was referred by my primary care physician to the Rose Medical Center emergency room for treatment. The physicians there diagnosed my condition as pneumonia and urinary tract infection and later as having a low RBC of twenty. I was treated at the ER with one dose of IV Azithromycin antibiotic and giving a prescription for oral Azithromycin 250mg caps to take 2 capsules that day and follow with one capsule daily thereafter for four days.

When my pharmacist entered this prescription into his computer for payment authorization from Cigna Health Care, a message came back from CIGNA: **patient ineligible.** I fortunately was able to pay the cost of the medication of $37.79. If this medication would have cost several hundred dollars as several other medications I take, I would not have been able to pay for and would have been deprived of this medication.

I checked with CIGNA's automated computer by phone on June 28, 1997, which indicated that the premium on my COBRA medical insurance coverage was paid through **July 21, 1997**, which would indicate to me that there should not have been a problem of eligibility especially since I had not been notified of any such problem.

On Monday, June 30, 1997, I telephoned CIGNA member services at 1-800-325-2471 and was told by Kelly (supervisor) that because of **human error** I was eliminated in the computer system even though my premiums were paid through July 21, 1997 and that the error would be corrected sometime after mid-night in the computer.

My complaint is: I do not choose to become seriously ill on week-ends. There seems from what I was told by at least four different CIGNA representatives that there is no way to correct such errors except Monday through Friday from 8 AM to 5PM EST. This is the third time such a **"human error"** has occurred since I have been on COBRA CIGNA medical insurance coverage. To get this error corrected took over one hour of my being on the telephone waiting for a human to answer and being switched to four different people to finally find the problem.

I feel that such errors should not be made in the first place which have occurred to me repeatedly. Secondly there should be some simple method of correcting such errors seven days

a week since I do not have a choice of when I become ill and that **a person with a name needs to be responsible**. The answer I always get when an error has been made by some unknown person is: I am sorry. Well, I am beginning to feel that "SORRY" isn't enough!!!!! and is completely inadequate especially when I am denied qualified benefits for which I have paid.

Secondly since I have your attention I would like to complain about the bureaucratic process that has been involved in the requirement of my physician getting pre-approval for payment for drugs that he prescribes for me, often repeated for the same drug even though I am going to be taking the drug for an extended period of time. There seems to be no way of knowing in advance that your are requiring pre-approval for a drug and requires that my pharmacist send by computer the filling of the prescription and getting a message back that pre-approval is required. Then I must contact my physician again and ask him to phone CIGNA for pre-approval. My physician then must phone me, then I again phone my pharmacist to try again and about 75% of the time the prescription gets filled. The other 25% of the time the pharmacist phones me back that it (the prescription) didn't go through and I have to phone Cigna again. I think the process is rather lacking especially when I am feeling very ill and have to have someone else perform the process for me. You are asking an awful lot.

Sincerely,

(b)(6)

cc:
Budget Rent A Car
Employee Benefits
4225 Naperville Road
Lisle, IL 60532

State of Colorado
Insurance Division
Complaints-Inquires
1560 Broadway
Denver, Colorado 80200

Sharon Brydon
Colorado Dept. HCP&F
Attn: HIBI program
1575 Sherman St.
Denver, Colorado 802034-1714

Mr. Wilson H. Taylor, C.E.O.
CIGNA Health Care
1601 Chestnut St.
Philadelphia, PA 19192

Ms. Laurie Tomlinson
Colorado AIDS Project
P.O. Box 18529
Denver, Colorado 80218-529

Ms. Sandy Thurmond
Director of the office of National AIDS Policy
White House
1600 Pennsylvania Ave.
Washington, C.D.

CIGNA Health Care of Colorado
3900 E. Mixico Ave
Denver, CO 80210

Federal Cobra Ins. Comm.
UDOL
PWBA, suite 1200
1100 Main Street; Kansas City, MO 64105

FILE COPY

Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G3845

Date Rcvd: 7-18-97

From: Velba Chavez

SAMHSA

Staff Action:

Reviewed By Sandy:_____ **Reviewed By:** _____

Assigned To:_____

RCVD:_____ **DONE:**_____

Recommendations/Instructions:

no response needed - TD

To Support Staff:_____

Date of Response:_____

n:\corresli

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Substance Abuse and Mental
Health Services Administration
Rockville MD 20857

JUL 16 1997

Ms. Sandra Thurman
Director
White House Office of National AIDS Policy
808 17th Street, NW, 8th Fl
Washington, D.C. 20006

Dear Ms. Thurman:

I would like to take this opportunity to express my deep appreciation for your participation in the May 29 meeting of the Substance Abuse and Mental Health Services Administration (SAMHSA) National Advisory Council. Your presence as the recently appointed Director of the White House Office on National AIDS Policy was important to me, staff, and members of the Council. Thank you for making time from your busy schedule to join us for the HIV, Substance Abuse and Mental Health panel presentation. I enjoyed meeting you and hope that I will have the opportunity to discuss with you in more detail HIV/AIDS activities at SAMHSA at a later date.

You and other members of the panel provided me, SAMHSA staff, and Council members with much to consider and incorporate into the Agency's Strategic Plan. In addition, the meeting helped to refocus our energies on a problem that remains a national crisis.

Once again, thank you for your participation and involvement in this important process. Let me assure you that the essence of HIV/AIDS remains a priority for SAMHSA and its Centers.

We are now summarizing the minutes. A final document will be shared with you.

Sincerely yours,

Nelba Chavez, Ph.D.
Administrator

Office of
National AIDS Policy

FILE COPY

Correspondence Routing Slip

Tracking Number: 63861

Date Rcvd: 7-23-97

From: Seth Kilbourn, HRC

Staff Action:

Reviewed By Sandy:_____ **Reviewed By:** _____

Assigned To:_____

RCVD:_____ **DONE:**_____

Recommendations/Instructions:

no response needed —
cc: to Daniel
TS

To Support Staff:_____

Date of Response:_____

n:\corresli

HUMAN
RIGHTS
CAMPAIGN

July 21, 1997

Ms. Sandra Thurman
Office of National AIDS Policy
808 17th St. Suite 820
Washington , D.C. 20006

Dear Sandy:

Thank you very much for meeting with the National Organizations Responding to AIDS (NORA) needle exchange workgroup on July 10. I know that the demands on your time are great and I appreciate both your willingness to hear our concerns and your efforts to convene the meeting.

As you know, the Human Rights Campaign (HRC) strongly supports allowing local communities to use federal funds for needle exchange programs. We look forward to continuing to work with the Administration on this vital public health issue .

Please do not hesitate to call if I can be of further assistance. Thanks again for meeting with us.

Sincerely,

Seth Kilbourn
Senior Health Policy Advocate

Thanks for all your work on this, Sandy. Please pass our appreciation to Janice also. See you soon!

SK

1101 14th Street NW, Suite 200 Washington, DC 20005
phone (202) 628 4160 *fax* (202) 347 5323 *e-mail* hrc@hrcusa.org

Office of
National AIDS Policy

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Correspondence Routing Slip

Tracking Number: G3846

Date Rcvd: 7-18-97

From: Ann Kauth, Mothers' Voices

Staff Action:

Reviewed By Sandy:_____ **Reviewed By:** _____

Assigned To:_____

RCVD:_____ **DONE:**_____

Recommendations/Instructions:

Best wishes... TS

To Support Staff:_____

Date of Response:_____

n:\corresli

MOTHERS' VOICES
United to end AIDS©

July 1, 1997

Dear Friend: Director Thurman

I write to inform you that this fall I will be leaving my role as Executive Director of Mothers' Voices. I have enjoyed the job and this organization immensely, and it is only after personal soul-searching that I have come to this decision (a new baby coming and a husband who has been offered a job in Seattle, Washington, making commuting from New York not a viable option). The Board of Mothers' Voices is now initiating a search for my replacement.

In looking for a new Executive Director, I turn to you for recommendations of excellent candidates whom you feel may fit our need for a dynamic leader. As the only national non-profit organization mobilizing mothers as AIDS and sexual health educators and advocates, the opportunity is ripe for an experienced leader to help grow our movement at a critical time.

We would appreciate your posting and/or passing along the attached description. We would appreciate names of any possible candidates whom we might approach, or candidates can call our office directly and in confidence at 212 - 720 - 2777, extension 229. Our search consultant, Lois Mirabella, also will be in contact with your office shortly by phone, to see if additional candidate names come to mind. Thank you in advance for your consideration and ideas.

Thanks also for your work and the work of your organization. We look forward to our organizations collaborating on shared goals, and appreciate your support.

Sincerely,

Ann Kurth, MPH, MSN
Executive Director

I wish you the very best in your critical role. Know that Mothers' Voices will continue to work with your office to achieve necessary goals!
— Ann Kurth

Ann Kurth,
Executive Director

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Flo Spierer

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Suite 701
New York, NY 10036

telephone
212.730.2777
facsimile
212.730.4378
internet
http://www.mvoices.org

EXECUTIVE DIRECTOR

Mothers' Voices, the only national nonprofit organization mobilizing mothers as AIDS/sexual health educators and advocates, seeks a dynamic executive director to lead organization expansion and establishment of chapters throughout the country. Join us as we build a national grassroots network of educated and empowered mothers, and promote public policies that advance the efforts for AIDS education, prevention, research, treatment, and ultimately a cure.

Responsibilities include: strategic planning to ensure successful growth of the organization; board and policy development; program design and implementation; development of fundraising goals and strategies with an emphasis on diversifying our funding sources; expansion of public policy programs and advocacy efforts; implementation of public relations and communications programs.

Requirements: 10 years' experience in nonprofit leadership roles. Demonstrated success working with coalition groups. Must be knowledgeable about AIDS and the AIDS community. Experience in complex organizations and/or a nationwide chapter structure preferred. Demonstrated leadership skills with particular strengths in board development, fundraising, strategic planning, team building, and program design and implementation (including AIDS prevention/education programs). Must have outstanding communication skills including public speaking. Commitment to the mission of Mothers' Voices is paramount.

This position is based in New York City. Please send your resume in confidence to: Lois A. Mirabella, Search Consultant, Mothers' Voices, 165 West 46th Street, Suite 701, New York, NY 10036 or Fax to: (212) 730-4378

EOE - Committed to Diversity!

Office of
National AIDS Policy

FILE COPY

Correspondence Routing Slip

Tracking Number: G 3838

Date Rcvd: 7-16-97

From: Jane Silva
AmFAR

Staff Action:

Reviewed By Sandy:_____ **Reviewed By:** _____

Assigned To:_____

RCVD:_____ **DONE:**_____

Recommendations/Instructions:

no response needed - TS

To Support Staff:_____

Date of Response:_____

n:\corresli

AmFAR
1828 L Street, N.W., Suite 802
Washington, DC 20036-5104
Tel 202-331-8600
Fax 202-331-8606

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Sharon Stone
Chairman,
The Campaign for AIDS Research

Arthur J. Ammann, M.D.
President

Jerome J. Radwin
Executive Vice-President and
Chief Executive Officer

July 15, 1997

Sandra Thurman
National AIDS Policy Director
808 17th Street, N.W., Room 820
Washington, DC 20006

Dear Sandy:

Thank you for taking time to meet with the National Organizations Responding to AIDS (NORA) Research Working Group. We very much appreciate your interest and attention to AIDS research.

As we indicated, the Administration's commitment to the Office of AIDS Research (OAR), and in particular the OAR coordinating and budget authority, are critical to an effective and well-managed AIDS research effort.

We look forward to working with you on the National Institutes of Health appropriations and reathorization process as part of the "triple-track" of AIDS prevention, research and care.

Sincerely,

Jane

Jane Silver, MPH

Thanks for meeting with the group - We know how busy you are

Office of
National AIDS Policy

FILE COPY

Correspondence Routing Slip

Tracking Number: G3826

Date Rcvd: 7-14-97

From: Amy Sleemer
Mothers Voices

Staff Action:

Reviewed By Sandy:_____ **Reviewed By:** _____

Assigned To:_____

RCVD:_____ **DONE:**_____

Recommendations/Instructions:

8/26/97 – Came back w/out attachments

To Support Staff:_____

Date of Response:_____

n:\corresli

Office of
National AIDS Policy

FILE COPY

Correspondence Routing Slip

Tracking Number: G3824

Date Rcvd: 7-11-97

From: Hamid Shirvani

Queens College - The City Univ. of NY

Staff Action:

Reviewed By Sandy:_____ **Reviewed By:** _____

Assigned To:_____

RCVD:_____ **DONE:**_____

Recommendations/Instructions:

No response necessary (TS)

To Support Staff:_____

Date of Response:_____

n:\corresli

QUEENS COLLEGE
THE CITY UNIVERSITY OF NEW YORK
FLUSHING, NEW YORK 11367

HAMID SHIRVANI
VICE PRESIDENT FOR
GRADUATE STUDIES AND
RESEARCH

718 997-5503
718 997-5493 FAX
ham@qc.edu

July 8, 1997

Honorable Sandra L. Thurman
Director
Office of National AIDS Policy
808 17th Street NW, 8th floor
Washington DC 20006

Dear Ms. Thurman:

Thank you so much for your letter of June 19, 1997 regarding the new Center for Molecular and Cellular Biology at Queens College of the City University of New York.

Your letter was both affirming and inspiring for all of those individuals involved in the establishment of the Center at Queens College. It communicated effectively your support of our efforts, and has allowed us to envision an important place within the Clinton Administration's plan for the fight against HIV/AIDS. Additionally, your support of the Center will assist us in encouraging potential collaborators to join us in our efforts to establish this $30 million facility.

Once again, many thanks for your vote of confidence. I look forward to our work together on this crucial and timely issue.

Best regards,

c: Allen Lee Sessoms
President

QUEENS COLLEGE
THE CITY UNIVERSITY OF NEW YORK
FLUSHING, NEW YORK 11367

HAMID SHIRVANI
VICE PRESIDENT FOR
GRADUATE STUDIES AND
RESEARCH

718 997-5503
718 997-5493 FAX
ham@qc.edu

July 2, 1997

Mrs. Hillary Clinton
The White House
Washington DC, 20500

Dear Mrs. Clinton:

On behalf of the students, faculty, and staff of Queens College, City University of New York it is my privilege to cordially extend an invitation for your honorable attendance at the opening celebration of our new Center for Molecular and Cellular Biology this fall 1997.

As the enclosed materials describe, the Center for Molecular and Cellular Biology, focusing on investigations of the HIV virus, will be established at Queens College of the City University of New York. The Center will be directed by Dr. Luc Montagnier, a world renowned research virologist at the Pasteur Institute who, with his team of researchers, first isolated the Human Immunodeficiency Virus (HIV-1). The Queens based Center for Molecular and Cellular Biology will become a major hub for global research in HIV/AIDS vaccination and treatment. The Center will also support educational efforts to promote prevention of HIV/AIDS and other chronic infectious diseases.

We are inspired and motivated by the Clinton administration's active commitment to fighting HIV/AIDS infection and the effects of this devastating disease. In addition, we are appreciative of the valuable support we have received from the Honorable Sandy Thurman and are excited that we will be working closely with her office on the establishment of the Center.

The opening reception will be held in conjunction with Queens College's 60th anniversary celebration, an achievement of which we are particularly proud. Currently, we are considering various dates in late October and November for this event, and would determine a date convenient to your schedule if you are, indeed, able to attend.

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Your commitment to the medical and social well being of citizens across the country is evident through programs that the Clinton administration has initiated. It exemplifies the true leadership role you have embraced in improving the quality of life for all Americans regardless of their economic, social or racial background. Because of this, your presence at this opening celebration will be a testament to the vital work which will be accomplished at the Center, and will provide a clear message to potential collaborators as to the importance of these efforts.

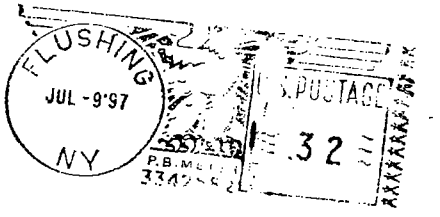
In addition, it will support our mutual belief that representatives from all facets of our community must work together in a timely manner to combat the tragic effects caused by this disease, a belief which you have clearly outlined in the White House National AIDS Strategy policies.

We will be extremely honored if you accept this invitation to the opening of our new Center. Therefore, I look forward to hearing from your office regarding this, and to providing you with further information regarding the establishment of the Center for Molecular and Cellular Biology at Queens College.

Best Regards,

cc: Honorable Sandy Thurman

Office of the Vice President
for Graduate Education and Research
Queens College/CUNY
Flushing, NY 11367-1597



Honorable Sandra L. Thurman
Director
Office of National AIDS Policy
808 17th Street NW, 8th Floor
Washington, DC 20006

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Office of
National AIDS Policy

Correspondence Routing Slip

Tracking Number: G 3890

Date Rcvd: 7-9-97

From: Mark Caranova et al
HIV Drug & Alcohol Task Force

Staff Action:

Reviewed By Sandy:_____ **Reviewed By:** _____

Assigned To:_____

RCVD:_____ **DONE:**_____

Recommendations/Instructions:

no response needed TS

To Support Staff:_____

Date of Response:_____

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HIV DRUG AND ALCOHOL TASK FORCE

Chairs

Mark Casanova Daryl Flynn Loretta Menchaca Suzi Rodriguez

Steering Committee

Mark Briggs Dick Browne Danny Jenkins Anna Long, Ph.D. Percy Magee
Mireya A. Medrano Stephen Mitchell Meredith Portnoff Cathy Reback, Ph.D.

Ms. Sandra Thurman
Director
Office of National AIDS Policy
The White House
1600 Pennsylvania Ave. NW
Washington, DC 20500

June 20, 1997

Sandy, Love

Dear Ms. Thurman,

We would like to take this opportunity to thank you for the meeting with members of our HIV-Drug and Alcohol Task Force and others who were privileged to be part of the CAEAR Coalition Business Meeting on May 18, 1997. Your warmth and compassion illuminated the room and your genuine dedication and concern was apparent to all present. It seems nearly impossible to express what it was like to be in your presence and be considered colleagues rather than merely constituents.

The announcement of President Clinton's dedication to the development of an HIV/AIDS vaccine was encouraging, but to know that you will continue to advocate on behalf of those of us who are already infected with HIV and/or living with AIDS until that cure is found is extremely reassuring.

We welcome the opportunity to develop closer ties with the Clinton Administration and stand ready to offer our support and activism in any way we can. We want to do whatever we can to insure that your tenure in this position is a successful one. Do not hesitate to call on those of us who now feel honored to know you.

It was exciting to return to Los Angeles and tell the rest of our membership about you. The numerous men and women we represent who are living with this dehumanizing disease and struggling to fight their addictions to drugs and alcohol send their regards, their support and their gratitude for all the good work we know you will do on our behalf.

Again, we thank you for being the incredibly strong and compassionate woman that you are. We look forward to meeting with you again as we bridge this road to our destiny.

Yours in the Struggle,

HIV-DATF Co-Chairs

Mark Casanova Daryl Flynn Loretta Menchaca Suzi Rodriguez

An advisory group to the Los Angeles County Commission on HIV Health Services since 1989
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