ELDER LAW IN THE 90s

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MCCA Updates: Qualified Medicare Beneficiaries and Restrictive Medicaid Rules

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I. Introduction

One of the most important provisions of the Medicare Catastrophic Coverage Act of 1988 (MCCA) /1/ affecting the elderly poor is the mandatory state payment of Medicare cost-sharing for the elderly and disabled. This benefit, enacted in Section 301 of the MCCA, is known as the Medicare "buy-in" for a group identified by the statute as Qualified Medicare Beneficiaries (QMBs). /2/ This article describes the QMB benefit, its implementation, and issues for advocacy. It also describes legal developments under a lesser known Medicaid provision, also enacted as a part of the MCCA, which delineates rules regarding income and resource methodologies. /3/ A previous article /4/ detailed provisions governing spousal impoverishment /5/ and transfer of assets /6/ --the other crucial MCCA Medicaid provisions affecting older people.

II. Qualified Medicare Beneficiary Program

A. Background

The Medicare buy-in was first introduced into Medicaid law as a state option in 1986. /7/ The purpose of the program was to enable low-income Medicare beneficiaries, who were not otherwise eligible for Medicaid, to benefit more from Medicare by having the state pay Medicare premiums, deductibles and coinsurance amounts for which Medicare beneficiaries are generally personally liable. /8/

In the MCCA, Congress changed the 1986 option into a mandate, and shortly thereafter, amended the definition of QMBs to eliminate the requirement that in order to be a QMB, an individual must not otherwise be eligible for Medicaid. Thus, QMBs currently include individuals who receive a full range of Medicaid services, as well as those entitled only to payment for Medicare cost-sharing. /9/
B. Eligibility

States must certify people entitled to Part A Medicare benefits (whether automatically or through the payment of the monthly premium) whose income do not exceed 100 percent of federal poverty guidelines, /10/ and whose resources do not exceed twice the Supplemental Security Income (SSI) resource level, as QMBs. /11/ Medicare beneficiaries who are either aged or disabled can qualify, with the exception of a limited group of disabled working individuals. /12/

To determine QMB eligibility, the $20 per month unearned income disregard allowed for all SSI applicants, and other SSI disregards applicable to individual situations, must be added to the poverty level amount. Income and resources are evaluated "as determined under" the SSI statute, /13/ but states can use methodologies less restrictive--although not more restrictive--than those used by SSI. /14/ Individuals cannot "spend-down" to the QMB eligibility limit by deducting medical bills, as they can to become "medically needy." If their income exceeds the limit, they simply are not QMBs. /15/ Section 209(b) states are explicitly precluded from using standards more restrictive than those used in SSI, in determining QMB eligibility. /16/

Cost-of-living increases under Title II of the Social Security Act, effective each January, are not counted as income until two months after new poverty guidelines are published, usually in February. /17/ The qualification was enacted to prevent individuals from suffering the harsh consequence of losing QMB eligibility due to a cost-of-living increase effective in January, only to become eligible for QMB benefits again in March, after the poverty guideline levels have increased.

C. Issues

1. Eligibility for Couples and Families

In determining eligibility for a couple, a reasonable argument can be made that a state must add the couple's incomes together, divide that amount by two, and apply the standard for a single individual to the resulting amount. Although the statute itself contains no explicit direction on the treatment of couples, its legislative history supports the above methodology. /18/ One court, however, arrived at a different conclusion, holding that the couple's total countable income must be measured against the poverty standard for two people. /19/

A related question arises when an individual applicant meets the non-financial criteria and has a family. The statute states that the income level must not exceed 100 percent of the official poverty line "applicable to a family of the size involved." /20/ This suggests that although only one member of the family is applying to become a QMB, the family's income should be measured against the standard for the total number of people in the family. Apparently, states are measuring an individual's income against the standard for a family of one, regardless of the
family's size. No written federal guidance exists on the interpretation of this phrase. A QMB applicant in Nevada, denied benefits based on the application of the one-person family standard, has challenged his state's denial, relying on the above statutory language to support his eligibility claim. /21/

2. Outreach

Since the program came into effect in January 1989, outreach has been seriously deficient. Without an explicit statutory requirement, federal and state governments have not been zealous in any efforts to affirmatively identify eligible individuals. In 1989, responding to pressure from advocates, the federal Health Care Financing Administration (HCFA) mailed notices about the QMB program to 14 million low-income Title II (Social Security) recipients who were potentially eligible for QMB benefits. HCFA was not satisfied with the results of that mailing, and has since refused to send additional notices.

Families USA, an advocacy organization, estimates that several million people entitled to QMB benefits are not receiving them. In two reports, (published in 1991 and 1992), Families USA presented state-by-state breakdowns of numbers of people likely to be eligible for QMB coverage. /22/ Advocates in a number of states have used the reported figures to pressure their states to undertake more aggressive outreach. /23/ The reports included a number of proposals to expand program awareness, including requiring the federal government to provide QMB information to Medicare beneficiaries at least once a year (when they are informed of premium and deductible increases), and requiring physicians and hospitals to provide information about the QMB program to patients. The reports also propose requiring Social Security offices to take QMB applications. Currently, applications are taken only through each state's welfare system. Legislation has been introduced in the 102nd Congress to implement the above ideas. However, the likelihood of its passage is slim.

3. Enrollment of Individuals in Part A

Although automatic Medicare Part A entitlement is related to the receipt of Social Security retirement or disability benefits, individuals for whom Social Security taxes had not been paid during their years of employment may also receive Part A by paying a monthly premium. These individuals include domestic workers, seasonal employees and migrant workers (many who are immigrants), as well as federal, state and local government employees. Individuals who purchase Part A may be eligible for QMB benefits in the same manner as those who receive Part A without charge. However, Part A premiums are extremely expensive ($192 per month for 1992), and thus beyond the reach of people likely to be eligible as QMBs. /24/ States should pay the Part A premium for people who would be eligible as QMBs. /25/ States' failure to undertake outreach, coupled with their failure to enroll identifiable individuals who may be eligible, leave hundreds of thousands of QMB-entitled individuals in this category without the benefits.

Potential QMBs not entitled to Part A at no charge may be enrolled in Part A in one of two ways. In 33 states and the District of Columbia, they are enrolled through the state's buy-in
agreement with HCFA. /26/ Through this system, if an individual is determined to meet the other criteria for QMB eligibility, his or her name is entered into the system that HCFA uses to bill the state for Part A premiums. For individuals enrolled through a buy-in agreement, there is no penalty for late enrollment, and enrollment may occur at any time during the year.

Despite the above administratively simple process, states have failed to enroll even those potential QMBs who are already in their Medicaid systems. /27/ Each month, HCFA identifies for each state the number of individuals for whom the state is paying Part B premiums under its Medicaid program, and who are not insured for Part A. Advocates should demand that their states evaluate for QMB eligibility each person not insured for Part A, for whom the state is paying Part B premiums.

In the remaining 17 states that do not have buy-in agreements, enrollment in Part A is limited to the first three months of each year, and a penalty applies for late enrollment. Medicare coverage does not begin until the month of July following enrollment. In these states, individuals who need to purchase Part A are denied the possibility of QMB benefits for at least 12 months if they fail to enroll before March 31st. /28/ Advocates should pressure these states to enter into buy-in agreements. They should argue that by not having such an agreement, the state is unlawfully denying individuals benefits to which they are entitled. /29/

4. Cost-Sharing

The statute seems to require clearly that states pay full Medicare cost-sharing for all QMBs. /30/ Cost-sharing must be paid even for services not covered by a state's Medicaid plan. /31/

HCFA has advised the states, in apparent contradiction to the plain language of the statute, that they need only pay cost-sharing up to the Medicaid rate (for services covered by Medicaid). /32/ For example, if the Medicare rate for a physician's service is $100, Medicare will pay $80 and the individual (or the state, in the case of QMBs), should pay $20. According to HCFA's view, however, the state would pay nothing in this example if its Medicaid rate for the same service was $70. The Second Circuit has held, contrary to the HCFA view, that full cost-sharing, at 100 percent of the Medicare rate, is required by the statute. /33/

The level of cost-sharing affects the value of QMB benefits to individuals. More providers may participate in the Medicare program than in Medicaid because payments under Medicare are often more generous than those under Medicaid. A large number of states currently do not pay cost-sharing at 100 percent of Medicare.

5. Retroactivity

Entitlement to QMB benefits begins in the month after the month of eligibility determination. The statute appears to preclude retroactive benefits (or at least, federal payment of retroactive benefits) that are otherwise available to Medicaid recipients. /34/ By regulation, the Medicaid agency has 45 days to process an application. /35/ Thus, entitlement can be delayed until three months after application. Since many people may learn of the QMB program only as they
actually incur medical bills, delayed entitlement can cause significant hardship. Advocates have been successful in getting states to bear the full cost of retroactive benefits in some situations. /36/

**D. Practical Difficulties in Obtaining or Using QMB Benefits**

Advocates report serious difficulties in getting their clients into the system once they have been determined to be eligible. For at least several months after an eligibility determination, Part B premiums continue to be deducted from a client's Social Security checks. Delays occur in the state welfare office, at HCFA, or at Social Security. /37/ National advocacy organizations are investigating this problem and seeking possible solutions.

Other problems include provider unwillingness to treat individuals as QMBs because it must do so on an assignment-related basis, /38/ and terminations without notice from the QMB program.

**III. Section 303(e) and Its Effect in Section 209(b) States**

Section 303(e) was enacted as part of the MCCA, and by its language restricts states' options regarding the use of restrictive income and resource methodologies. It also authorizes states to use rules more generous than those of the related cash assistance programs. The federal government, through HCFA, has construed the provision narrowly, and thus far, the statutory change has not resulted in increased Medicaid eligibility for the elderly. /39/

This part of the article describes the provision, its historical development, and its interpretation through the courts. Although portions of the provision apply to all states, this discussion will focus on its application to states known as Section 209(b) states: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma and Virginia. Unlike most states which grant Medicaid "categorical" eligibility to all persons who receive SSI, Section 209(b) states use rules more restrictive than those used for SSI eligibility determinations.

**A. Background of Section 209(b)**

In 1973, Congress enacted legislation establishing the SSI program /40/ --legislation designed to federalize three of four needs-based, cash assistance programs administered by the states. /41/ Under the programs, receipt of benefits resulted in automatic Medicaid eligibility. The new federal SSI eligibility criteria, however, were more generous than some of the criteria previously established by some states, creating a situation in which more persons in those states were automatically eligible for Medicaid.

Fearing that states faced with an increased financial burden through participation in Medicaid would drop out of the program entirely, Congress permitted states to use in their Medicaid
programs guidelines that are more restrictive than those used in SSI, as long as the restrictive guidelines had been in effect in January 1972. /42/ Congress mandated states adopting this option to allow people to spend-down their income /43/ in order to fit within the more restrictive (lower) eligibility standard. /44/ Under the spend-down, people with too much income to qualify initially can qualify for Medicaid once they have spent some of their income on necessary medical costs. /45/

The foregoing provision, known as the Section 209(b) option (in reference to its public law section number), /46/ has, since 1974, allowed states choosing the option to use eligibility criteria for Medicaid that are more restrictive than those used in the SSI program. The option has been the subject of considerable litigation, and has been restricted to a degree over the years. /47/ Most recently, with the passage of Section 303(e) of the MCCA, the option was apparently cut back substantially. /48/

**B. Section 303(e)**

Under Section 303(e), now codified at 42. U.S.C. Sec. 1396a(r)(2), methodologies used in determining Medicaid eligibility are to be "no more restrictive than" the methodologies used in the related cash assistance programs. Also, states are authorized by Section 303(e) to use more liberal income and resource eligibility criteria than those used in SSI. /49/ And finally, the new statutory language extends the provision's applicability to eligibility determination for virtually all non-cash assistance Medicaid recipients. /50/

The actual language of Section 303(e) states that "the methodology to be employed in determining income and resource eligibility for individuals [in Section 209(b) states] may be less restrictive, and shall be no more restrictive than the methodology [used in the SSI program]." /51/ The language is cumbersome--not atypical for a Medicaid provision. But it is also straightforward. Section 209(b) states are directed to refrain from using more restrictive income and resource methodologies in determining Medicaid eligibility. Despite this mandate, Section 209(b) states have continued to use their more restrictive income and resource methodologies. Moreover, HCFA and at least one court of appeals /52/ have found this to be permissible.

The proper interpretation of Section 303(e) was the subject of litigation in federal court in Virginia, discussed below. Although the district court upheld the literal language of the statute, paring back the Section 209(b) option for a statewide class of Medicaid beneficiaries, the Fourth Circuit reversed. /53/

**C. Mowbray v. Kozlowski**

In Mowbray v. Kozlowski, /54/ plaintiffs alleged that Virginia's restrictive resource rule limiting the homestead exemption, as well as other restrictive Medicaid eligibility methodologies, violated Section 303(e) of the MCCA.
In a lengthy and well-reasoned opinion, the district court certified a statewide class, and ruled in favor of the plaintiffs on all grounds. The court granted a permanent injunction prohibiting the defendants from using, for Medicaid eligibility determinations, any income or resource methodology more restrictive than those used under SSI. /55/

The Fourth Circuit reversed, finding that "Congress has not spoken with the clarity" required under Pennhurst State School v. Halderman, /56/ before the federal government can "change the terms of its Medicaid 'contract' with the states." /57/ The court found an apparent "tension" between Section 209(b) and Section 303(e), and deferred to the restrictive federal agency interpretation of the statute.

The Fourth Circuit's extension of the Pennhurst doctrine to the Medicaid program is novel. Although the case was decided by the Supreme Court more than a decade ago, the doctrine had never been applied in such a context. /58/ It remains to be seen whether other circuits will follow suit; there have been no reported cases since the Fourth Circuit's decision. /59/

Advocates in Section 209(b) states may want to examine their state Medicaid plans for income and resource methodologies that are more restrictive than those used in the SSI program, and thus, violate Section 303(e), illegally denying Medicaid to certain individuals. Clients who receive SSI, but were denied Medicaid, may have been subject to these illegal policies, and advocates outside the Fourth Circuit may consider bringing claims based on Section 303(e). /60/

IV. Conclusion

Provisions enacted in the MCCA significantly affect the elderly poor. The mandatory QMB program requires states to provide full Medicare cost-sharing for persons at the poverty level. More outreach and advocacy are necessary, however, before the benefits are fully enjoyed by the intended beneficiaries. Although MCCA apparently limits states' use of restrictive eligibility rules, HCFA and the courts have interpreted the statute otherwise.

Footnotes


2. Id. at Sec. 301.

3. Id. at Sec. 303(e).


5. MCCA, supra note 1 at Sec. 303(a).

6. Id. at Sec. 303(b).

7. Sixth Omnibus Budget Reconciliation Act (SOBRA), Pub. L. No. 99-509. The provision is currently codified at 42 U.S.C. Secs. 1396a(a)(10)(E)(i), 1396d(p). Prior to 1986, states were permitted to pay the Medicare Part B premiums for their categorically eligible Medicaid recipients who were also receiving Medicare. These individuals are referred to as "dual-eligibles." States received federal matching funds for those payments. In addition, some states paid the Medicare premiums for their medically needy Medicaid recipients, although they received no federal matching funds. States could also receive federal matching funds for other Medicare cost-sharing (such as deductibles and co-insurance amounts) for their dual-eligibles, thus giving those individuals greater access to services that might not be covered by the state Medicaid plan. The 1986 option allowed the states to pay the Medicare out-of-pocket costs for a group of people who were not otherwise eligible for Medicaid, but whose incomes fell below the federal poverty line. Such individuals were called Qualified Medicare Beneficiaries.

8. Medicare beneficiary cost-sharing is considerable. In 1992, Part B (physician and related services) beneficiaries pay the following: $31.80 premium per month; $100 deductible per year; and 20 percent of charges Medicare determines to be reasonable. Part A (hospitalization and skilled nursing facility services) beneficiaries pay the following: $652 deductible per benefit period; $163 in coinsurance, for each day after the 60th day of hospitalization; $81.50 for each skilled nursing facility day after the 20th day of care. For the relatively few who must purchase Part A, the premium is $192 per month.

9. The Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388, added a more limited buy-in for individuals with slightly higher incomes. Beginning in 1993, states must pay Medicare Part B premiums only for people with income up to 110 percent of the poverty level. Beginning in 1995, the poverty ceiling increases to 120 percent. HCFA refers to this group as Specified Low-Income Medicare Beneficiaries (SLMBs). See Transmittal No. 57, STATE MEDICAID MANUAL, Part 3--Eligibility, (July 1991) [hereinafter Transmittal No. 57].

10. In 1992, the poverty amount for an individual is $568 per month in the continental United States, $709 in Alaska, and $653 in Hawaii. For a couple, the poverty amount is $766 per month in the continental United States, $957 in Alaska, and $881 in Hawaii.

11. 42 U.S.C. Sec. 1396d(p). The SSI resource level is $2,000 for an individual and $3,000 for a couple. Thus, the QMB levels are $4,000 and $6,000, respectively.


15. 42 U.S.C. Sec. 1396a(m)(4)(B); Transmittal No. 57, supra note 9.


17. 42 U.S.C. Sec. 1396d(p)(2)(D).


22. See FAMILIES USA, THE SECRET BENEFIT: THE FAILURE TO PROVIDE THE MEDICARE BUY-IN TO POOR SENIORS (1991) and FAMILIES USA, THE MEDICARE BUY-IN: STILL A GOVERNMENT SECRET (Mar. 1992). The release of these reports generated much publicity, and prompted many individuals to call Social Security or their state Medicaid agencies to inquire about QMB benefits. According to reports from advocates, too often, the individuals were told that the program did not exist, or were given other incorrect information.

23. For example, advocates in Tennessee organized a QMB coalition consisting of nearly all organizations that have an interest in the program. Members include representatives from the Social Security Administration, State Human Services agency, Medicare Part B carrier, Commission on Aging, State Department of Agriculture, a university extension program, senior service centers, American Association of Retired Persons, the Association for the Mentally Ill, U.S. Senator James Sasser, Social Action Group on Aging, legal services programs and others. The coalition has recruited a public relations firm to provide free advice. The state Department of Agriculture has begun a pilot program to screen for QMB eligibility at commodities distribution sites. Tennessee uses a single page QMB application that can be sent by mail to the applicant, and mailed back to the Medicaid agency. Advocates in other states have developed fliers to inform people about the QMB program. The National Senior Citizens Law Center (NCSLC) has copies of such materials.

24. Moreover, if individuals do not sign up for Part A when they are first eligible to apply (at age 65), they can enroll only between January and March of each year thereafter. Additionally, they must pay a 10 percent penalty with each month's premium for a limited time.
25. 42 U.S.C. Sec. 1396d(p) defines a QMB as someone entitled to Medicare Part A either automatically, or through the payment of the monthly premium. HCFA has implied that states must enroll individuals in Part A to make them QMB-eligible. See, e.g., Transmittal No. 57, supra note 9.


27. Medicare Part A can be valuable even to an individual entitled to full Medicaid benefits. About 22 states limit Medicaid hospitalization, either by the number of days for which the state will pay, or by requiring prior authorization for hospitalization. Moreover, many states--probably illegally--limit coverage for therapies in nursing facilities.

28. The mechanics of enrollment are cumbersome, as well. Individuals must first go to their local Social Security office and ask to be enrolled in Medicare Part A if their state pays the premium. (HCFA refers to this process as conditional enrollment.) They must then go to their Medicaid office to apply for QMB status. Often, individuals are unaware of the last requirement, and think that they have completed the process at the Social Security office.

29. See supra note 24.

30. 42 U.S.C. Sec. 1396d(p)(3).

31. Id.

32. See, e.g., Transmittal No. 31, STATE MEDICAID MANUAL, Part 3--Eligibility (December 1988); Transmittal No. 57, supra note 9.


34. 42 U.S.C. Sec. 1396d(a).

35. 42 C.F.R. Sec. 435.911.

36. Elliot Legow, an attorney with the Northeast Ohio Legal Services reports success in obtaining retroactive QMB benefits for people who had applied for some other benefit since January 1, 1989, when QMB became effective. The theory is that eligibility for QMB benefits should have been determined at the same time. Elliot Legow has obtained premium refunds for periods exceeding two years. Letter from Elliot Legow to NSCLC (May 7, 1992) (on file with NSCLC).

37. One advocate reports that an individual employed by the Department of Health and Human Services in Baltimore was able to override the computer manually to accrete (i.e. identify in its records as a QMB) a person outside the normal process. This occurred after the advocate
persuaded someone in her local Social Security office that the client was the victim of unconscionable delays. Letter from Judith Allonby, Rhode Island Legal Services, Inc. to Patricia Nemore, NSCLC (May 28, 1992) (on file with the NSCLC), and a subsequent telephone conversation on June 29, 1992.

38. 42 U.S.C. Sec. 1395w-4(g)(3). See also 42 C.F.R. Sec. 447.15 (Medicaid payment-in-full regulation).

39. See also Mowbray v. Kozlowski, 914 F. 2d 593 (4th Cir. 1990).

40. 42 U.S.C. Sec. 1381 et seq.

41. The four original programs were as follows: Old Age Assistance, 42 U.S.C. Sec. 301 et seq.; Aid to Families with Dependent Children, 42 U.S.C. Sec. 601 et seq.; Aid to the Blind, 42 U.S.C. Sec. 1201 et seq.; and Aid to the Blind and Permanently and Totally Disabled, 42 U.S.C. Sec. 1351 et seq. All of these programs, except AFDC, have since been consolidated under the SSI program.


43. Arguably, a resource spend-down is also required by the statute.


45. Id.


47. See, e.g., Darling v. Bowen, 685 F. Supp. 125 (W.D. Mo. 1988), aff'd. 878 F.2d 1069 (8th Cir. 1989) (Clearinghouse No. 42,592), cert. denied, Stangler v. Darling, 110 S. Ct. 1782 (1990) (Section 209(b) states required to give Medicaid benefits to certain disabled widows and widowers); Coleman v. Barry, 1989-2 Medicare & Medicaid Guide (CCH) Para. 37,905 (S.D. Ohio 1989) (Clearinghouse No. 44,388) (Section 209(b) states required to apply higher resource standard to QMBs); Winter v. Miller, 676 F.2d 276, 280 (7th Cir. 1982); Norman v. St. Clair, 610 F.2d 1228, 1235 (5th Cir. 1980) (Clearinghouse No. 21,479), cert. denied, Schweiker v. Norman, 453 U.S. 922 (1981) (restrictive criteria must have been legal restrictions, and in effect in 1972). See also Turner v. Heckler, 573 F. Supp. 874-75 (S.D. Ohio 1986), rev'd on other grounds, 783 F.2d 657 (6th Cir. 1986) (burden on HHS to prove rule was in effect in 1972).

48. To fully understand Section 303(e), it is necessary to review its historical development in the context of previous legislative enactments and administrative responses. In 1982, Congress amended the Medicaid statute, as a part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), directing states to apply SSI methodologies for "SSI type" medically needy applicants, and AFDC methodologies for "AFDC type" medically needy applicants, in determining eligibility for the medically needy. 42 U.S.C. Sec. 1396a(a)(10)(c)(i)(III) (as
amended by Pub. L. No. 97-248, Sec. 137(a)(8)). HCFA interpreted this provision too literally, and rejected all state plan amendments which proposed to use more flexible income or resource methodologies for the medically needy than were used in the cash assistance programs.

In response, Congress added a technical amendment in the Deficit Reduction Act of 1984 (DEFRA), prohibiting the agency from sanctioning any state that used less restrictive rules in its medically needy program. Pub. L. No. 98-369, Sec. 2373(c), 98 Stat. 1111 (July 18, 1984). This "moratorium" was scheduled to expire 18 months after the Secretary of HHS submitted a report to Congress. HCFA interpreted the moratorium as applying only to more flexible rules that were already incorporated in a State's approved plan of operation as of the passage of DEFRA--once again, an overly restrictive interpretation of the statute. Congress "clarified" its more expansive position in the Medicare and Medicaid Program Protection Act of 1987, Pub. L. No. 100-93, Sec. 9, 101 Stat. 695 (August 18, 1987). Significantly, under the statutory clarification, the moratorium explicitly applied also in Section 209(b) states, and in the determination of eligibility for Medicaid nursing home coverage under the optional categorically needy program. In other words, the 1987 legislation extended the prohibition against HHS from penalizing States with more flexible income and resources rules beyond the medically needy program, so that States could apply more liberal eligibility rules to Medicaid nursing home residents, and to Section 209(b) "spenddowners." HHS submitted the report required by DEFRA to Congress on August 17, 1987. The moratorium was thus scheduled to expire 18 months later, on February 17, 1989.

In MCCA, Congress did not extend or amend the moratorium language. Instead, it made the moratorium a permanent part of the statute, and rewrote the statute, eliminating the "same methodology" language which had created, in 1982, the alleged ambiguity. The MCCA provision was made effective retroactive to October 1, 1982, the date of TEFRA's enactment.

49. HCFA has stringently construed States' use of more liberal criteria, insisting that statutory provisions concerning limits on federal financial participation cap the use of many such criteria. See, e.g. 56 Fed. Reg. 24822, 24823 (May 31, 1991) (HCFA disapproval of Georgia's liberal methodology that has the potential for exceeding the federal financial participation limits).

50. It specifically refers to individuals receiving assistance under 42 U.S.C. Sec. 1396a(a)(10)(A)(i)(III) (pregnant women and children five years old and below who are not on AFDC, but have income and resources at or below the AFDC limits); Sec. 1396a(a)(10)(A)(i)(IV) (pregnant women and infants with income below 100 percent of poverty); Sec. 1396a(a)(10)(A)(ii) (optionally categorically needy, including nursing home recipients); Sec. 1396a(a)(10)(C)(i)(III) (medically needy); and Sec. 1396a(f) (elderly, blind and disabled in Section 209(b) states).

Moreover, in the Family Support Act, Congress amended Section 303(e) of the MCCA further to include QMBs as an additional non-cash assistance group. Family Support Act of 1988, Pub. L. No. 100-485, Sec. 608 (d)(16)(C) (amending MCCA Sec. 303(e)). The Omnibus Budget Reconciliation Act of 1989 amended Sec. 209(b) itself, thereby adding a final non-cash assistance group, the "qualified disabled and working individuals," to whom more liberal income and resource methodologies may apply. Omnibus Budget Reconciliation Act of 1989 (OBRA'89), Pub. L. No. 101-239, Sec. 6408(d)(4)(C).

52. Mowbray v. Kozlowski, 914 F.2d 593 (4th Cir. 1990) (Clearinghouse No. 45,170).


54. The case was filed originally as Hottinger v. Kozlowski.

55. Mowbray, 724 F. Supp. at 420. The court also held that the state could not use criteria more restrictive than those used under SSI for determining benefits for QMBs, and ruled in plaintiffs' favor on a beneficiary's right to present arguments in the state administrative proceeding. The issue relating to QMBs has since been resolved through legislation which clarified the original language of the MCCA.


57. Mowbray, 914 F.2d at 600.

58. The Pennhurst doctrine has been used previously to determine whether the chosen statutory language is evidence of Congressional intent to impose financial obligations on states, or merely congressional "encouragement" of the state programs. Pennhurst, 451 U.S. at 17 (Clearinghouse No. 12,902). The mandatory nature of the Medicaid state plan requirements is not in question. But see Suter v. Artist M, 112 S. Ct. 1360 (1992) (Clearinghouse No. 48,036), discussing state plan requirements in the foster care context.

59. Advocates in other Section 209(b) states have used the Mowbray district court's reasoning to contest restrictive income and resource methodologies in their jurisdictions. In Indiana, a preliminary injunction was issued on June 7, 1990 on behalf of a statewide class, restraining Indiana from imposing its more restrictive resource rules to persons with spouses who entered nursing facilities prior to September 30, 1989, the effective date of the spousal impoverishment provisions enacted in MCCA. Cherry v. Magnant, No. 1P 90-1348-C (D. Ind. June 7, 1990) (Clearinghouse No. 45,808). Cross-motions for summary judgement are pending. In New Hampshire, advocates challenged the state's refusal to recognize the SSI income exclusion for Plans to Achieve Self Support (PASS) for working, disabled individuals. Through a settlement agreement, the PASS program rules were changed. Moyer v. Morgan, No. 90-286-S, Consent Decree (D.N.H. filed June 20, 1991). In Illinois, relief for individual clients has been negotiated. North Dakota's restrictive rules were challenged, but the court decided the case on other grounds. Luithle v. Burleigh County Soc. Servs., No. 40809, 1992-1 Medicare & Medicaid Guide (CCH) Para. 39,552 (N.D. S. Ct. 1991) (Clearinghouse No. 46,078).

60. Even under the most liberal view, Section 209(b) states may still employ income and resource standards that are more restrictive than those used in the SSI program; they are prohibited only from using more restrictive income and resource methodologies.