SUMMARY OF THE CASE AND REQUEST FOR ORAL ARGUMENT

On January 29, 2003, Teresa Mae Kai and Stacy Noller, on behalf of themselves and a class of approximately 10,000 single working mothers and other caretaker relatives, filed this lawsuit in the United States District Court for the District of Nebraska against Ron Ross, as the Director of the Nebraska Department of Heath and Human Services challenging the department's refusal to provide them the transitional medical assistance benefits described in section 1925 of the Social Security Act, 42 U.S.C. § 1396r-6. Along with the Complaint, Ms. Kai and Ms. Noller filed a motion for class certification and a motion for a preliminary injunction.

On March 4, 2003, the district court entered an Order certifying the class but denying the requested preliminary injunction. On March 17, 2003, Ms. Kai and Ms. Noller filed this interlocutory appeal challenging the denial of the preliminary injunction. On April 4, 2003, this Court issued an Order granting the class members' request for expedited review of their appeal.

The Appellants request 20 minutes for oral argument in this case because of the importance of this appeal to the lives and ongoing well-being of the class members.

JURISDICTIONAL STATEMENT

Teresa Kai and Stacey Noller, on behalf of themselves and all others similarly situated, brought this action in the United States District Court for the District of Nebraska under the Supremacy Clause of the U.S. Constitution and 28 U.S.C. §§ 1983 and 2202, seeking to declare unlawful and preliminarily and then permanently enjoin the refusal of Nebraska Health and Human Services officials to provide the transitional medical assistance (TMA) benefits described in 42 U.S.C. § 1396r-6(a) to people who had received Medicaid in Nebraska for at least three of the six months before losing their ongoing Medicaid eligibility because of the amount of their earned income, as determined by the Defendant's new method of counting that income. The Plaintiffs invoked the jurisdiction of the district court pursuant to 28 U.S.C. § 1331.

Following a hearing on Plaintiffs' motion for a preliminary injunction held on February 13, 2003, the district court on March 4, 2003, entered an Order granting the Plaintiffs' motion for class certification and denying their motion for preliminary relief. The court determined that the class would suffer irreparable injury as the result of losing medical coverage and that the balance of hardships weighed in favor of the class, notwithstanding the fiscal difficulties of the state. But the court concluded that the class was unlikely

to prevail on the merits of its claim and that therefore the public interest did not lie in granting an injunction.

On March 12, 2003, the class filed the instant appeal of the denial of the preliminary injunction. This Court has jurisdiction of the appeal pursuant to 28 U.S.C. § 1292(a). On March 19, 2003, the class moved for expedited review of its appeal, which was granted by an Order of this Court dated April 3, 2003.

STATEMENT OF THE ISSUES

I. Did the district court err in finding that the appellant class of single working mothers and other caretaker relatives was not covered by the language of 42 U.S.C. § 1396u-1(b) that instructs that they be "treated as receiving" Aid to Families with Dependent Children (AFDC), thereby entitling them to transitional medical assistance (TMA) upon the loss of their ongoing Medicaid benefits due to the amount of their earned income?

42 U.S.C. § 1396r-6(a); 42 U.S.C. § 1396u-1(b); 42 U.S.C. § 1396b(f); 42 C.F.R. § 435.1007; Neb. Rev. Stat. § 68-1020(2)(c); 468 Neb. Admin. Code § 4-010 and Appendix 468-000-204.

II. Assuming the class members are among those described in 42 U.S.C. § 1396u-1(b)(A)(i), are they entitled to transitional medical assistance (TMA) when they are determined by the state to have too much earned income to qualify for Medicaid, not because of an actual increase in their earned income but rather because of a change in the way that the state counts that earned income?

42 U.S.C. § 1396r-6(a); 42 U.S.C. § 1396u-1(b) and (c); and *Phillips v. Noot*, 728 F.2d 1175 (8th Cir. 1984).

STATEMENT OF THE CASE

On January 29, 2003, Teresa Mae Kai and Stacy Noller, on behalf of themselves and a class of approximately 10,000 single working mothers and other caretaker relatives, filed this lawsuit against Ron Ross, as the Director of the Nebraska Department of Heath and Human Services, challenging the department's refusal to provide them the transitional medical assistance benefits described in section 1925 of the Social Security Act, 42 U.S.C. § 1396r-6.[1] The Plaintiffs contended that they are entitled to those benefits by virtue of being among those that 42 U.S.C. § 1396u-1 dictates be "treated as receiving" Aid to Families with Dependent Children benefits, the loss of which under the circumstances of this case triggers transitional medical assistance coverage. Along with the Complaint, Ms. Kai and Ms. Noller filed a motion for class certification and a motion for a preliminary injunction.

[1] By its terms, section 1396r-6 was due to sunset as of September 30, 2002, but it has been extended by Congress through June 30, 2003. P. L. 108-7 2003, Omnibus FY2003 Appropriations Bill, H.J. Res. 2, DIVISION N– EMERGENCY RELIEF AND OFFSETS, SEC. 401. All expectations are that Congress will extend the effect of section 1396r-6 at least through the end of this fiscal year. Should that not happen, 42 U.S.C. § 1396a(e)(1) would automatically become effective upon the expiration of section 1396r-6.

A hearing was held on February 13, 2003, and on March 4, 2003, the district court issued an order granting the Plaintiffs' motion for class certification but denying their motion for a preliminary injunction. The district court found that while the class members were likely to suffer irreparable harm and that the balance of the hardships favored granting the injunction, the class was not likely to succeed on the merits.[2] (A-88.) On March 17, 2003, the class members filed this appeal challenging the lower court's denial of preliminary injunctive relief. On April 3, 2003, this Court granted the class' subsequent motion for expedited review.

[2] The lower court also ruled that the public interest did not support an injunction in this case, but that part of its opinion was premised entirely upon the court's belief that the class was unlikely to prevail upon the merits. (A-88.)

STATEMENT OF THE FACTS

Effective October 15, 2002, Nebraska changed the way in which it determines the financial eligibility of caretaker relatives for the medically needy component of its Medicaid program. (Ex. 13 ¶ 5.) Nebraska's new way of determining financial eligibility resulted in each of the class members being found to have too much income to qualify for Medicaid any longer, despite the fact that their actual incomes had not changed in any material way. (Ex. 13 ¶ 6.) Consequently, the working mothers or other caretaker relatives who comprise the class have had or soon will have their desperately needed Medicaid benefits terminated. (*Id.*)

The class representatives are Teresa Kai and Stacey Noller, each of whom is the single mother of a young daughter. Both Ms. Noller and Ms. Kai, like the other class members, received Medicaid for at least three of the six months before the month in which their ongoing Medicaid benefits were terminated. (A-33, A-36.)

Teresa Kai suffers from type II diabetes, high blood pressure, asthma, severe allergies and, perhaps not surprisingly given her other ailments, depression. Ms. Kai relies upon several expensive prescription medications that enable her to cope with these conditions and continue working to

support her daughter Laura. The restaurant in Pender, Nebraska, where Ms. Kai works does not offer its employees health insurance. (A-33.)

Stacey Noller suffers from both schizophrenia and bipolar disorder. (A-37.) Before losing her Medicaid coverage, she attended therapy once a week and took four costly prescription medications to maintain her ability to work and function normally. With this treatment, Ms. Noller has held a job as a secretary/bookkeeper for an air conditioning company in Kearney, Nebraska, since 1997. (A-36.) Her employer does not offer its employees health insurance. Ms. Noller lives with and is the primary support for her daughter, Brenna, age five. (*Id*.)

Following the termination of their Medicaid benefits, Ms. Kai and Ms. Noller filed this action. They did not challenge Nebraska's right to change the way in which it determines eligibility for ongoing Medicaid benefits. Rather, they alleged that under the circumstances of this case, they are entitled to receive transitional medical assistance (TMA) for up to one year pursuant to 42 U.S.C. § 1396r-6, but that Nebraska refuses to afford them that assistance. When the district court denied their request for a preliminary injunction, they filed this appeal.

SUMMARY OF ARGUMENT

This appeal is brought on behalf of a certified class of approximately 10,000 single working mothers and other caretaker relatives who recently lost their ongoing Medicaid benefits when Nebraska changed the manner in which it calculated their income eligibility for that program. The class contends that they are now eligible for the transitional medical assistance (TMA) benefits described in section 1925 of the Social Security Act, 42 U.S.C. § 1396r-6, which provides up to one year of transitional medical coverage to working caretakers who lose Medicaid because of the amount of their earned income.

As the district court recognized, the issue in this case is a purely legal one of statutory interpretation, *i.e.*, whether the class members fall within the ambit of section 1931 of the Social Security Act, 42 U.S.C. § 1396u-1, thereby entitling them to TMA now that they have lost their ongoing Medicaid benefits. Unfortunately, as the appellants will demonstrate, in attempting to answer this question the district court committed several critical errors of law that led it to reach the wrong conclusion. First, the court applied the wrong income counting system, or methodology, in determining if the class members had countable incomes low enough to bring them within the language of section 1396u-1. While the court

purported to quote section 1396u-1(b), it inexplicably failed to include, and therefore consider, a critical part of that section of the statute that supports the Appellants' position that the relevant income methodology to be used in this case is the less restrictive medically needy caretaker relative methodology actually employed by Nebraska in determining the class members' eligibility for Medicaid.

This error was further compounded by the district court failing even to mention the Nebraska statute that authorized and described Nebraska's methodology for determining the class members' financial eligibility for Medicaid, the elimination of which gave rise to this case. Neb. Rev. Stat. § 68-1020 (2)(c) (2001) (amended by 2002 Special Session, LB 8 (2002)). Had the court considered this statute, it could not have found that the amount of income attributed to each class member in this case "meant nothing by itself." (A-85.)

Finally, the lower court applied the wrong income eligibility limit in determining if the class members fall within section 1396u-1. The court concluded that Nebraska had expanded financial eligibility for its medically needy Medicaid category not by disregarding greater amounts of the gross income of the caretaker relative, but rather by raising the "maximum income" limit that the caretaker relative's family had to meet. (A-84.) In

reaching this conclusion, however, the court both relied upon a Nebraska regulation that does not support its decision and ignored federal law that prohibits Nebraska from doing precisely what the court concluded it had done. Cumulatively, these errors led the district court to reach a result that is wholly inconsistent with the controlling federal statutes and regulations, as well as with the views of relevant employees of the Centers for Medicare and Medicaid Services (CMS), the federal agency charged with oversight of the Medicaid program.

When all of the relevant statutes and regulations are considered, it is clear that the district court erred as a matter of law and that the class members are indeed encompassed by the language of section 1396u-1. As such, they are entitled to receive TMA benefits now that they have lost their ongoing Medicaid benefits because of the new way in which Nebraska has chosen to count their gross earnings. This has been the law of this Circuit since its 1984 decision in *Phillips v. Noot*, 728 F.2d 1175, and subsequent action by Congress has clarified that it is indeed the law of the land. The class members are therefore likely to prevail on their claim for the TMA benefits that they seek in this case.

ARGUMENT

Introduction

This case involves the relationship between the financial eligibility requirements for Nebraska's current Medicaid program and its former Aid to Families with Dependent Children (AFDC) program. Each of those programs is or was need based, which means that people can have too much income to qualify for benefits even if they appear otherwise eligible. (Tr. 22:10-18.) The maximum amount of income that a family of a given size can have and still qualify for assistance is known as the income eligibility limit, or, in the language of the statute at issue here, the "income standard." 42 U.S.C. § 1396u-1(b)(1)(A)(i). Medicaid and AFDC have different income eligibility standards.

In determining whether or not a person's income is below the relevant income limit, net rather than gross income is considered. That net income is often referred to as countable income. *Phillips v. Noot*, 728 F.2d 1 175**,** 1177 (8th Cir. 1984). The process for determining how much of an applicant's gross income to count (or conversely, disregard) is known as an "income methodology." *See* 42 U.S.C. §§ 1396a(r)(2) and 1396u-1(b)(2)(C). Medicaid and AFDC also employ different income methodologies.

In order to reach a proper resolution in this case, section 1396u-1 requires one to identify and compare the relevant Medicaid and AFDC income limits employed by Nebraska. In addition, because TMA benefits under the Medicaid program are at issue here, one must look to the Medicaid, not the AFDC, income methodology in determining the amount of a person's countable income to be measured against the relevant income standard. As will be demonstrated, the district court misapprehended both of these concepts and therefore incorrectly concluded that the class members are not among those made eligible for TMA by the language of section 1396u-1(b)(1).

Medicaid and the Process for Determining Eligibility

As the court below noted, Medicaid is a jointly funded state and federal program that provides medical services to certain low-income people pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, *et seq.* State participation in the Medicaid program is optional, but a state that chooses to participate, and thereby receive federal matching funds for its Medicaid program expenditures, must comply with the requirements of the federal Medicaid Act and its implementing regulations. *See Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1982); *Missouri Child Care Ass'n v. Cross*, 294 F.3d 1034, 1036 (8th Cir. 2002) (finding state obligated to comply with

analogous requirements of the Child Welfare Act). Nebraska has chosen to participate in the Medicaid program and accepts federal matching funds for its program expenditures. (A-82.)

There is, and may be, only one Medicaid program in a state, although for administrative purposes Nebraska has subdivided its program into different categories of assistance. (Tr. 62:14-15; 63:1-2.) Medicaid is only available to financially needy children, their parents or caretaker relatives, pregnant women, the elderly, or the blind or disabled. *Children's Healthcare Is a Legal Duty, Inc. v. De Parle*, 212 F.3d 1084 (8th Cir. 2000). The administrative subdivisions of Nebraska's Medicaid program correspond to these different types of recipients. However, a person or family may qualify under more than one Medicaid category. 42 C.F.R. § 435.404. This is a fact that, prior to this litigation at least, Nebraska readily admitted. *See* Ex. 12 (response of George Kahlandt to question from one of Appellants' counsel).

Financially eligible individuals are further divided by the Medicaid Act into groups that Nebraska must cover, called the mandatory categories, and those that the state may choose to cover, called the optional categories. Among those that Nebraska must cover are children and their parents or caretaker relatives who "receive" AFDC. 42 U.S.C. § 1396a(a)(10)(A)(i)(I).

Phillips, 728 F.2d at 1176.[3] Among the people that a state may choose to cover are parents and other caretaker relatives of children who would be eligible to receive AFDC if they were sufficiently poor. 42 U.S.C. §§ 1396d(a)(ii) and 1396a(a)(10)(C). Nebraska has chosen to cover this group of people, and refers to them as "medically needy caretaker relatives." It is the Appellants' contention that because Nebraska set its Medicaid eligibility limit for this group at a level that is lower than the eligibility limit that Nebraska used in its AFDC program in 1996, the enactment of section 1396u-1(b) caused the class members to be eligible for Medicaid under both the medically needy category described in section 1396d(a)(ii) and the mandatory category described in section 1396a(a)(10)(A)(i)(I).

Federal law affords Nebraska considerable latitude in choosing where to set the Medicaid income eligibility limit, or standard, for people seeking assistance as medically needy caretaker relatives. That eligibility limit is

[3] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 actually repealed the AFDC program and replaced it with a program known as Temporary Assistance to Needy Families (TANF). However, Congress wanted to make certain that families similar to those receiving AFDC in 1996 continued to receive Medicaid. Thus, at the same time it enacted TANF, Congress amended the Medicaid Act to treat certain people as recipients of AFDC, and therefore, mandatory recipients of Medicaid under section 1396a(a)(10)(A)(i)(I), despite the fact that the AFDC program no longer exists. 42 U.S.C. § 1396u-1(b)(1)(A). (A-80.) Whether or not the class members are among the people described in section 1396u-1(b) is the issue on appeal.

called the Medically Needy Income Level (MNIL). *See* 468 Neb. Admin. Code § 4-010. However, Nebraska's latitude in setting the MNIL is not unlimited. Rather, the federal Medicaid law contains a maximum income eligibility level that Nebraska may use for such applicants, if the state wishes to have the federal government pay its share of the cost of providing coverage.

For the class members in this case, the maximum income eligibility limit that Nebraska may employ is an amount, rounded to the nearest $100, that equals "133 1/3 percent of the highest money payment most frequently made under the State's AFDC plan" to an individual or family of the same size "without income and resources." 42 C.F.R. § 435.1007(b) and (d) (the latter subsection allows states like Nebraska to use the two-person AFDC payment amount to calculate its one-person medically needy income limit). That amount in Nebraska translates to $392.00 per month, which is in fact where Nebraska set its medically needy income eligibility limit for medically needy caretaker relatives.[4] (Ex. 13 ¶ 2.) The maximum income eligibility standard that a state establishes for medically needy Medicaid

[4] *See* Exhibit 4, chart in the upper left-hand corner. Line 2 under the column marked "ADC Pay Max" (*i.e.*, AFDC Payment Maximum) lists the AFDC payment maximum for a family of two as $293.00 per month. That amount multiplied by 1.333 equals $390.57.

applicants must be reported in writing to the federal government, 42 C.F.R. section 435.814, and Nebraska complied with this requirement. (Ex. 11.)

In deciding this case, the other relevant income eligibility limit that must be identified is Nebraska's 1996 AFDC limit. For the class members to be eligible for TMA benefits, they must have been determined to have countable income at or below the AFDC income eligibility limit. At all times relevant to this case, the AFDC income eligibility limit in Nebraska for an individual was set at $411.00 per month.[5] (Ex. 7.)

The Medicaid Act also affords Nebraska a great deal of latitude in deciding the methodology it will employ to determine exactly what income to count or disregard in determining an applicant's eligibility for Medicaid. Here too, however, the state's discretion is not unlimited. Rather, the methodology that it uses for deciding how much of a person's gross income to count in determining Medicaid financial eligibility cannot be any more restrictive than the methodology the state uses in its cash assistance programs (AFDC or Supplemental Security Income) for similarly situated people. 42 U.S.C. § 1396a(r)(2)(A) and § 1396u-1(b)(1)(B). On the other hand, the income methodology used in Medicaid may be "less restrictive"

[5] Because of the way it analyzed the case, the district court believed that the relevant AFDC income standard was that for a family of two, which it concluded was $542.00 per month. (A-85.)

(*i.e.*, more generous) than those used in the cash assistance programs. 42 U.S.C. § 1396a(r)(2)(A) and (B) and § 1396u-1(b)(2)(C).

When the proper income methodology and income limits are applied in this case, it becomes clear that the class members are eligible for the TMA benefits they are seeking by virtue of being among those that section 1396u-1(b) treats as "receiving" AFDC, and that the district court's decision not to grant the preliminary injunction should accordingly be overturned.

I. THE DISTRICT COURT ERRED AS A MATTER OF LAW IN CONCLUDING THAT THE CLASS MEMBERS ARE NOT ENTITLED TO TMA BECAUSE THEY DO NOT FALL WITHIN THE AMBIT OF 42 U.S.C. § 1396u-1.

A. The Class Members Fall Within the Plain Language of 42 U.S.C. § 1396u-1.

The issue in this appeal is a purely legal one: whether the single mothers and other caretaker relatives now before this Court are among those that 42 U.S.C. § 1396u-1(b)(1)(A) says "shall be treated as receiving" AFDC.[6] If so, that status renders them eligible for up to one year of transitional medical assistance (TMA) when, as in this case, they lose their ongoing Medicaid eligibility because of the amount of their countable

[6] Where the sole issue on appeal is one of law, this Court has exercised *de novo* review when, as here, considering the denial of a preliminary injunction by a district court. *See, e.g., Bank One v. Guttau*, 190 F.3d 844, 847-48 (8th Cir. 1999).

earned income. 42 U.S.C. § 1396r-6(a). In attempting to resolve this question, the district court recognized that the appropriate starting point for the inquiry is section 1396u-1 itself. As is relevant to this case, section 1396u-1(a) and (b) provide that:

> (a) REFERENCES TO TITLE IV-A ARE REFERENCES TO PRE-WELFARE-REFORM PROVISIONS.– Subject to the succeeding provisions of this section, . . . any reference in this title . . . to a provision of part A of title IV, or a State plan under such part . . ., including income and resource standards and income and resource methodologies under such part or plan, shall be considered a reference to such a provision or plan as in effect as of July 16, 1996, with respect to the State.
>
> (b) APPLICATION OF PRE-WELFARE-REFORM ELIGIBILITY CRITERIA.–
>
> (1) IN GENERAL. – For purposes of this title, *subject to paragraphs (2) and (3)*, in determining eligibility for medical assistance –
>
> (A) an individual shall be treated as receiving aid or assistance under a State plan approved under part A of title IV [AFDC] only if the individual meets –
> (i) the income and resource standards for determining eligibility under such plan, and
> (ii) the eligibility requirements of such plan under subsections (a) through (c) of section 406 and section 407(a),
> as in effect as of July 16, 1996; and
>
> (B) the income and resource methodologies under such plan as of such date shall be used in the determination of whether any individual meets income and resource standards under such plan.
>
> (2) STATE OPTION. – For purposes of applying this section, a State –

> (A) may lower its income standards applicable with respect to part A of title IV, but not below the income standards applicable . . . on May 1, 1988;
>
> (B) may increase income and resource standards under the State plan referred to in paragraph (1) . . . by a percentage that does not exceed the percentage increase in the Consumer Price Index . . .; and
>
> (C) may use income and resource methodologies that are less restrictive than the methodologies used under the State plan under such part as of July 16, 1996.

42 U.S.C. § 1396u-1.

This section of the Medicaid Act is used to determine if a person "shall be treated as receiving" AFDC. Those who are "treated as receiving" AFDC are eligible for Medicaid under 42 U.S.C. § 1396a(a)(10)(A)(i)(I), which used to cover actual recipients of AFDC when that program still existed. Now people receiving Medicaid under that category are referred to as the "1931 group." (Tr. 38:2-6.)

The statute clearly sets out the rules for discerning whether someone falls within its parameters. As is relevant to this case, the first step in determining if a person shall be treated as receiving AFDC is to ascertain if the person meets the income limit of the state's AFDC program as it existed on July 16, 1996. 42 U.S.C. § 1396u-1(b)(1)(A). Nebraska's income limit at that time for one person was $411.00 per month. (Ex. 7.) Therefore, this

part of the statute as applied to Nebraska indicates that any individual with *countable* income below $411.00 "shall be treated as receiving" AFDC.

The next step in determining if a person's countable income is under $411.00 is to decide how much of her gross income to count. The choices available to the state in this regard are set forth in sections 1396u-1(b)(1)(B) and (b)(2)(C). The former, if read in a vacuum, suggests that the state must use the same methodology for determining countable income as it used in its AFDC program on July 16, 1996. However, this provision turns out to be not a mandate, but rather an option, when it is read in conjunction with paragraph (b)(2), as paragraph (b)(1) says it must be.

Paragraph 2(b)(2)(C) specifically allows the state to use a less restrictive methodology for determining countable income in its Medicaid program than it used in its 1996 AFDC program. A methodology is considered less restrictive by the Medicaid Act when, using that methodology, additional people are rendered eligible for medical assistance and no people who would otherwise be eligible are made ineligible. 42 U.S.C. § 1396a(r)(2)(B).

Each class member in this case was determined eligible for Medicaid as a medically needy caretaker relative using the less restrictive Medicaid methodology described in Neb. Rev. Stat. § 68-1020 (2)(c) (2001), before it

was amended last year by 2002 Spec. Sess., LB 8 (2002). (Ex. 13.) According to Nebraska's own regulations, neither an individual nor a family of two can be found eligible in the medically needy category unless their countable income is equal to or less than the medically needy income level (MNIL) of $392.00 per month. 468 Neb. Admin. Code § 4-010 and Appendix 468-000-204. (Ex. 6.) Thus, when using the methodology that it abandoned last year, Nebraska by definition determined that each class member had countable income that was less than its 1996 AFDC income eligibility limit of $411.00 per month.[7] That is all that is required for the

[7] The class contends that Nebraska's medically needy income methodology, as enacted by the Nebraska Legislature, *infra* at 31**,** resulted in each class member being treated as a medically needy family of one, with her child(ren) in a separate poverty level category of Medicaid. At the hearing below, Nebraska was less than forthcoming about the exact nature of its practice, which is perhaps what led the district court astray. Mike Harris, the state's only witness, testified first that Ms. Noller and her daughter were both in the medically needy category, (Tr. 45:15-17), but later that Ms. Kai and her daughter were in separate Medicaid categories. (Tr. 46:22-24.) In either event, the relevant MNIL is $392.00 per month. Further, for a family of any given size, the MNIL is always lower than the 1996 AFDC income eligibility standard for a family of that same size. (Ex. 6 & 7.) Thus, however the Appellee categorized them, the fact that the class members were found eligible in the medically needy category defined in 468 Neb. Admin. Code section 4-010 and Appendix 468-000-204 means their *countable* income, as determined by the state, had to be below the 1996 AFDC income eligibility limit. As such, they qualified for Medicaid both in the medically needy and the "section 1931" categories. The TMA that they seek in this action follows from their inclusion in the latter group.

class to be "treated as receiving" AFDC under the terms of section 1396u-1.

As the class will now demonstrate, the district court probably reached its legally incorrect conclusion because it failed to consider section 1396u-1(b)(2) when reviewing that statute. Whatever the reason, however, it is clear that in attempting to ascertain whether the class is covered by the language of section 1396u-1, the district court looked to both the wrong income methodology and the wrong income limit in its analysis.

B. The District Court Applied the Wrong Income Methodology In Determining Whether the Class Falls Within the Ambit of 42 U.S.C. § 1396u-1(b).

As previously noted, in arriving at an amount of countable income to compare to the 1996 AFDC financial eligibility limit, one must first decide what methodology will be used to determine how much of a person's gross income to count or, conversely, disregard. The state may use a methodology that is the same as the one it used in its AFDC program on July 16, 1996. 42 U.S.C. § 1396u-1(b)(1)(B). Or, pursuant to 42 U.S.C. § 1396u-1(b)(2)(C), it may use a less restrictive methodology, *i.e.*, one that determines countable income by disregarding more of a person's gross income than did the 1996 AFDC methodology. *See* 42 U.S.C. § 1396a(r)(2)(B).

Unfortunately, when the court below quoted what it considered to be the relevant parts of section 1396u-1, it inexplicably included only subsections (a) and (b)(1), not subsection (b)(2). (A-80 to 81.) However, as subsection (b)(1) clearly states, its provisions are "subject to paragraphs (2) and (3) . . . ." Apparently because it never considered subsection (b)(2)(C), the district court believed that it "must apply the income methodologies that were used by the State in July 1996." (A-83.) It further concluded that, in order to qualify for TMA, class members had to demonstrate that they would have "qualified for AFDC under the standards and income methodologies employed by the State of Nebraska in July 1996." (A-85.) Both of these conclusions, to the extent they import the 1996 AFDC income methodology into Nebraska's Medicaid eligibility determination process, are demonstrably wrong.[8]

[8] What the district court intended with its references to the "income methodologies employed by the State of Nebraska in July 1996" is not entirely clear. In July, 1996, Nebraska was already using the less restrictive methodology that the Appellee has dubbed "stacking." (Ex. 13 ¶ 3.) The class contends that it is their countable income as determined using that methodology that must be measured against the 1996 AFDC income limit of $411.00 per month for a single individual. It appears from the lower court's discussion that its reference to the 1996 methodologies must mean the 1996 AFDC income methodology, for otherwise it is difficult to discern how the court reached its conclusion that the class members' net, not gross, income exceeded the 1996 AFDC income eligibility standard. (A-86.)

First, as noted, section 1396u-1(b)(2)(C) specifically authorizes Nebraska to use a less restrictive income methodology for determining the Medicaid eligibility of caretaker relatives than was used by the state in its AFDC program in 1996. Thus, the 1996 AFDC income methodology would only be correctly applied if Nebraska had not opted to use a less restrictive income methodology when determining eligibility for Medicaid. But in fact the Nebraska Legislature did adopt a less restrictive income methodology with the passage of Neb. Rev. Stat. section 68-1020(2)(c) (2001). (Ex. 5.) Using that methodology, each class member was determined eligible for Medicaid as a medically needy caretaker relative. (Ex. 13 ¶ 5.)

As a result of Nebraska's repeal of that methodology last year, the class members were determined to be no longer eligible for Medicaid, even though there had been no other material change in their circumstances. (Ex. 13 ¶ 7.) This result exactly reflects the Medicaid Act's definition of a less restrictive methodology. 42 U.S.C. § 1396a(r)(2)(B). Because Nebraska chose to use a less restrictive methodology when determining the class members' eligibility for Medicaid, it is the amount of their countable income as calculated by that methodology that must be employed in deciding whether the class members also were eligible to receive the "medical

assistance" described in section 1396u-1(b) because they had countable incomes below the 1996 AFDC income eligibility limit.

Nonetheless, despite the fact that Neb. Rev. Stat. section 68-1020(2)(c) deals directly with the Medicaid income eligibility of the caretaker relatives now before this Court, the district court never cited that provision. That it should have focused on this Medicaid-specific methodology is borne out not only by the language of section 1396u-1(b)(2)(C), but also by two opinions from employees of the federal Health Care Financing Administration (HCFA), which is the agency directly responsible for oversight of state Medicaid programs.[9] One of those opinions was solicited by Nebraska and the other by the Appellants.

On July 28, 2000, Nebraska sought the opinion of Judy Rhoades at HCFA concerning the eligibility for TMA of "an ADC unit [*i.e.*, children or caretaker relatives] that was eligible under a State's Medically Needy plan." (Ex. 14, 8:24 a.m. email from George Kahlandt.) Ms. Rhoades responded by first stating what she deemed to be obvious, that TMA is only available to people who fall within the ambit of section 1931 of the Social Security Act, *i.e.*, 42 U.S.C. § 1396u-1. But in exploring whether or not some medically

[9] HCFA has now changed its name to the Centers for Medicare & Medicaid Services and goes by the initials CMS.

needy recipients in Nebraska might also fall within section 1931, she contemplates exactly the situation before this Court by asking: "Do you have any children or caretaker relatives in your medically needy group whose countable income and resources (after the section 1931 [*i.e.*, Medicaid, not AFDC] methodologies are used) are below the section 1931 standards?" (Ex. 14, 8:04 a.m. email from George Kahlandt.)

This response from HCFA confirms both that caretaker relatives categorized as medically needy by Nebraska can nonetheless simultaneously be covered by section 1931, and that it is the Medicaid, not AFDC, income methodology that must be used in determining whether their countable income falls below the "1931 standards," *i.e.*, the 1996 AFDC income limit.

Any remaining doubt in this regard is dispelled by the Declaration of Timothy Westmoreland, who, along with being Ms. Rhoades' ultimate supervisor, was the federal government's chief Medicaid officer at the time of the email correspondence between Mr. Kahlandt and Ms. Rhoades. (Ex. 15.) In that Declaration, addressing Nebraska's contention that the emails from Ms. Rhoades somehow constituted federal permission for its conduct, Mr. Westmoreland states:

> 4. I do not believe from my review that the emails from Ms. Rhoades can be taken as permission for Nebraska to deny . . . TMA benefits to the plaintiffs in the circumstances of this case. . . .

> 5. In any event, if the emails in question could be read as approving what Nebraska is doing in this case, *i.e.*, denying TMA to caretaker relatives whose countable income, as determined by Nebraska using its medically needy methodology, was below the state's AFDC eligibility limit, then Ms. Rhoades was simply wrong to do so.

(Ex. 15.)

Thus, the language of section 1396u-1(b)(2)(C) in conjunction with Neb. Rev. Stat. section 68-1020(2)(c), and the relevant guidance from those in the federal agency with responsibility for the Medicaid program all demonstrate that the district court erred as a matter of law when it evaluated the class member's earned income using the 1996 AFDC income methodology. Rather, the correct methodology to be employed is the Medicaid methodology actually used by the Appellee in determining the class member's financial eligibility for Medicaid. That methodology resulted in each class member being found financially eligible for Medicaid as a medically needy caretaker relative. As the class will now demonstrate, that determination by Nebraska, as a matter of law, meant that each class member was found to have countable income of $392.00 or less per month. As that amount of income is below the 1996 AFDC income eligibility limit of $411.00 per month, the class is indeed entitled to receive the TMA benefits that they seek in this case.

C. The District Court Applied the Wrong Income Eligibility Limit In Determining Whether the Class Falls Within the Ambit of 42 U.S.C. § 1396u-1(b).

The district court also erred as matter of law when it concluded that the relevant income eligibility limit that the class members had to meet in order to qualify for Medicaid as medically needy caretaker relatives was not $392.00 per month. Rather, the court decided that this $392.00 per month figure was merely a "component" of a larger family income eligibility limit established by the Appellee. (A-84 to 86.) The court reached this result by concluding that Nebraska's less restrictive Medicaid income methodology was not a methodology for calculating countable income at all, but rather a mechanism for raising the applicable eligibility limit for a medically needy family of any given size. This conclusion is not only inconsistent with the state regulation that the lower court cited in support of its position, but also ignores the state statute that created the Medicaid methodology in question and, if true, would mean that Nebraska since 1996 has been ineligible for the federal matching funds it has received for everyone in its medically needy category of Medicaid assistance.

The district court determined that under the methodology used by Nebraska to determine the income eligibility of medically needy caretaker relatives, only total family income mattered, and therefore the amount of

income attributed to the caretaker relative "meant nothing by itself." (A-85 to 86.) Rather, according to the court, a family of two consisting of an adult and an infant child had an income eligibility limit of $1499.00. (A-84.) The court purported to find this increased income eligibility limit in 468 Neb. Admin. Code section 4-010. (*Id.*) Far from supporting the court's conclusion, however, this section of the Nebraska code flatly contradicts it. Section 4-010 is entitled "Medically Needy Income Level." Its last four sentences provide that:

> The parent may decide who is included in the unit. For the MNIL, see 468-000-204. The net income is compared to the appropriate MNIL to determine eligibility for MA only or MA with excess income. If the net income is equal to or less than the MNIL, the unit may be eligible for MA only; if the net income is more than the MNIL, the unit may be eligible for MA with excess.

468 Neb. Admin. Code § 4-010.

Appendix 468-000-204, referenced in section 4-010, provides a chart of the MNIL for a family of any given size.[10] Nowhere on that chart, or anywhere else in Nebraska's published regulations, does the $1499.00 eligibility limit for a family of two discerned by the district court appear. Rather, the income limit for a family of two (and also for one) is listed as

[10] Section 4-010 and Appendix 468-000-204 are both presented in their entirely in Exhibit 6.

$392.00 per month. This is the medically needy income limit that Nebraska has reported to the federal government, as it is required to do by 42 C.F.R. section 435.814. (Ex. 11.)

According to section 4-010, a person can be eligible as "MA only" medically needy only if her net income is "equal to or less than the MNIL." As each of the class members in this case was found eligible as a "MA only" medically needy caretaker relative using the methodology in question, (Ex. 13 ¶ 4), it is clear that Nebraska must have determined that each family of two, to use the lower court's example, had a net (*i.e.*, countable) income of $392.00 or less per month.

The district court's decision also fails to mention Neb. Rev. Stat. section 68-1020(2)(c) (2001), which authorized and described Nebraska's medically needy caretaker relative Medicaid category. Had the court considered this statute, it could not have concluded that Nebraska's medically needy income eligibility methodology worked by raising the eligibility limits for families of any given size, rather than by allocating certain amounts of the caretaker relative's gross income to her child(ren) and then attributing only any remaining income to her.

Prior to its amendment by 2002 Spec. Sess., LB 8 (2002) in October of last year, Neb. Rev. Stat. section 68-1020 (2)(c) (2001) provided in relevant part:

> The Director of Finance and Support shall adopt and promulgate rules and regulations governing provision of such medical assistance benefits to qualified individuals: . . . (d) who are medically needy caretaker relatives . . . and who have children with allocated income as follows: (i) At or below one hundred fifty percent of the Office of Management and Budget poverty line with eligible children one year of age or younger; (ii) At or below one hundred thirty-three percent of the Office of Management and Budget poverty line with eligible children over one year of age and under six years of age; or (iii) at or below one hundred percent of the Office of Management and Budget poverty line with eligible children six years of age or more and under fifteen years of age.

From the above language, it can be seen that the Nebraska Legislature mandated that the Appellee provide Medicaid benefits to qualified "individuals" who are "medically needy caretaker relatives," not to the entire family unit, as the district court believed. It is certainly true that one must have at least one dependent child in the home to qualify as a caretaker relative. But the Nebraska Legislature addressed this reality not by establishing increased income eligibility standards for family units of various sizes, but rather by creating the concept of "children with allocated income" in detailed amounts that vary with the age of the child and exactly

reflect federal requirements for the children's poverty level Medicaid categories. *See* 42 U.S.C. § 1396a(1).

Thus, the less restrictive methodology envisioned by the Nebraska Legislature for its medically needy caretaker relative category did not, as the district court incorrectly concluded, depend on raising the eligibility limits for that category above those that are listed in the Nebraska regulations and have been reported to the federal government. Rather, it eased the task of meeting the existing eligibility limits for caretaker relatives by disregarding income allocated to their child(ren) in amounts precisely calculated to allow the child(ren) to qualify for Medicaid under the various federal poverty level categories. Only following that allocation of income was the eligibility of the "individuals" who were "caretaker relatives" to be determined based upon any remaining income. Thus, the language of Neb. Rev. Stat. section 68-1020(2)(c) (2001) belies the district court's conclusion. Indeed, that statute squarely supports the contention of the class members that they were determined eligible for Medicaid as medically needy caretaker relatives because their incomes, after disregarding those amounts allocated to their child(ren), fell below the MNIL of $392.00 per month listed in Nebraska's published regulations.

Finally, unless Nebraska has been accepting Medicaid federal matching funds to which it was not entitled for its medically needy category of assistance since at least 1996, the district court's categorization of Nebraska's income eligibility methodology cannot possibly be correct. If, as the lower court concluded, Nebraska was determining the class members to be eligible as medically needy caretaker relatives by raising the eligibility limit for that program to accommodate their greater incomes, then the state would not have qualified for federal matching funds under the terms of the Medicaid Act, 42 U.S.C. § 1396b(f), and its implementing regulation, 42 C.F.R. section 435.1007.

Section 1396b(f)(1) delineates the parameters within which federal financial participation (FFP) is available to states for their Medicaid expenditures. As is relevant to this case, it provides:

> (A) . . . payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance . . . for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.
>
> (B) (i) . . . the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133 1/3 percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act [*i.e.*, AFDC].

42 U.S.C. § 1396b(f)(1).

As discussed earlier, 133 1/3 percent of the Nebraska AFDC grant for two is almost exactly the $392.00 per month medically needy income eligibility limit listed in Nebraska's Medicaid regulations. Thus, if the district court were correct that Nebraska's medically needy category accommodated, *e.g.*, a family of two with greater income by raising the eligibility limit for that family to an amount greater than $392.00 per month, Nebraska would not be eligible to receive federal matching funds for any medical assistance provided to that family. Clearly, this was not the case.

Nonetheless, Nebraska can provide Medicaid to individuals whose gross incomes are above the limit set forth in section 1396b(f) of the Act. It just cannot do so in the way that the district court suggested, by raising its Medicaid income eligibility standards above the prescribed levels. Rather, as 42 C.F.R. section 435.1007 makes clear, the state must disregard sufficient amounts of gross income to bring the individual or family below the federally established maximum eligibility limits. After parroting the eligibility limits contained in the Medicaid Act, section 435.1007 provides that:

> (e) FFP is not available in expenditures for services provided to categorically needy and medically needy recipients subject to the FFP limits if their annual income, after the cash assistance income deductions and any income disregards in the State plan

> authorized under section 1902(r)(2) of the Act [42 U.S.C. § 1396a(r)(2)] are applied, exceeds the 133 1/3 percent limitation described under paragraphs (b), (c), and (d) of this section.
>
> (f) A State may use the less restrictive income methodologies included under its State plan as authorized under § 435.601 in determining whether a family's income exceeds the limitation described in paragraph (b) of this section.

42 C.F.R. § 435.1007.

This language could not be clearer. It specifically authorizes the use of less restrictive income methodologies that disregard more income in order to accomplish the goal of providing Medicaid to individuals and families with higher amounts of gross income. It does not authorize, and indeed prohibits federal payments for, systems that accomplish that goal by raising the applicable income eligibility standard. The district court misunderstood this basic concept of Medicaid budgeting, but the Nebraska Legislature did not. The latter, understandably interested in assuring federal matching funds for its expenditures, did not raise the income eligibility limits for its medically needy caretaker relative program above those authorized by the Medicaid Act. Rather, it established a system in which fixed amounts of income were allocated to the minor child(ren) in a family and then disregarded when determining the caretaker relative's countable income for purposes of determining her eligibility for Medicaid.

Under the system created by the Nebraska Legislature, each of the class members before this Court was determined eligible for Medicaid as a medically needy caretaker relative. Given Nebraska's published medically needy income levels listed in 468 Neb. Admin. Code section 4-010 and Appendix 468-000-204, each class member was thus determined by the state to have countable income that was below the corresponding AFDC income eligibility limit for a family of its size. As such, 42 U.S.C. § 1396u-1(b)(1)(A) requires that the class members "be treated as receiving" AFDC, the import of which is that they are eligible under 42 U.S.C. § 1396r-6(a) for TMA now that they have lost their ongoing Medicaid benefits due to the amount of their earned income.

II. CHANGES IN THE METHODOLOGY USED TO CALCULATE INCOME ELIGIBILITY CAN RESULT IN A PERSON BECOMING INELIGIBLE FOR MEDICAID DUE TO HOURS OF, OR INCOME FROM EMPLOYMENT.

As all the parties to this litigation agree, TMA benefits are only available to people who are "treated as receiving" AFDC by section 1396u-1. The provision of TMA to such people is mandated by 42 U.S.C. § 1396r-6(a)(1), which states in relevant part:

> Notwithstanding any other provision of this subchapter, each [Medicaid] state plan approved under this subchapter must provide that each family which was…[treated as receiving AFDC] in at least 3 of the 6 months immediately preceding the month in which such family becomes ineligible for such aid,

> because of hours of, or income from, employment of the caretaker relative…shall…remain eligible for [Medicaid]…during the immediately succeeding 6-month period in accordance with this subsection.

42 U.S.C. § 1396r-6(a)(1).

Each of the class members before this Court received Medicaid in at least three of the six months prior to her Medicaid being terminated due to the change in Nebraska's income methodology. (A-78.) Each also lost her Medicaid when application of that new income methodology resulted in a determination by Nebraska that she had too much income from employment to qualify for ongoing Medicaid. (*Id*.)

When Nebraska determined that the class members no longer qualified for Medicaid because of its new way of counting their income, it triggered a responsibility to provide the class with TMA benefits. This exact issue was decided by this Court in *Phillips v. Noot*, 728 F.2d 1175 (8th Cir. 1984). In *Phillips*, the Court was called upon to decide whether certain families were entitled to extended Medicaid coverage under 42 U.S.C. § 1396a(e)(1), the predecessor statute to § 1396r-6. The language of section 1396a(e) varies from that of section 1396r-6. It provides that TMA must be afforded to any family that has received AFDC benefits for three of the six months before the month in which the family "became ineligible for such aid

because of *increased* hours of, or *increased* income from, employment . . . ." 42 U.S.C. § 1396a(e)(1) (emphasis added).

As in the current case, the families losing benefits in *Phillips* had not experienced an actual increase in their gross income from employment. Rather, the manner in which the state measured income for the program had changed, so that the families experienced an increase in their countable income from employment.

The state in *Phillips* argued that TMA need not be provided in that situation. The court disagreed, finding that one intent of Congress in enacting this provision was to protect Medicaid recipients from a precipitous loss of medical coverage due to their employment earnings. It concluded that providing TMA when those earnings, although unchanged, suddenly rendered a family ineligible for ongoing Medicaid was the outcome most consistent with Congressional intent. *Phillips*, 728 F.2d at 1177-1178.

The case currently before this Court is much easier than *Phillips.* Congress, in enacting first section 1396r-6 and then section 1396u-1(c)(2), eliminated any doubt that the *Phillips* court had correctly discerned its intent. This was done by deleting the requirement of section 1396a(e)(1) that the loss of eligibility that triggers TMA be the result of an *increase* in earnings from employment. Now, under both section 1396r-6(a)(1) and

section 1396u-1(c)(2), TMA is triggered simply if the loss of eligibility for benefits is because of "earnings from employment."

This change in language must be viewed as an intentional, affirmative action by Congress. A district court in Missouri recently determined as much in granting first a preliminary injunction and then final relief that required the state to provide TMA benefits to a class of recipients with earned income who lost their Medicaid when the state lowered the program's income eligibility standard. *White v. Martin,* Civ. No. 02-4154-CV-C-NKL, Preliminary Injunction Decision and Order of 10/03/02, at 13, and Final Judgment of 3/25/03 (W.D. Mo.) (attached to this brief in the Addendum).

The decision of the court in *White* was consistent with the holding of the Supreme Court in a unanimous decision in *Brown v. Gardner*, 513 U.S. 115, 120 (1994) (citing *Russello v. United States*, 464 U.S. 16 (1983)). The Court there stated:

> Where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.

Brown, 513 U.S. at 120.

Nebraska has adopted a new income methodology to calculate the Medicaid eligibility of medically needy caretaker relatives. The result of

this change is that the class members have now been determined to have too much money to qualify for Medicaid "because of . . . income from employment." That is all that is required by sections 1396u-1(c)(2) and 1396r-6(a)(1) to trigger eligibility for TMA, and the class members are therefore entitled to receive that desperately needed protection.

CONCLUSION

For the reasons set forth above, this Court should reverse the decision of the district court and order the Appellee forthwith to provide the class with transitional medical assistance as set forth in 42 U.S.C. § 1396r-6(a).

TERESA KAI and STACY NOLLER, on behalf of themselves and all others similarly situated, Plaintiffs-Appellants

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CERTIFICATION

The foregoing brief was prepared using Microsoft Word 2002. The undersigned hereby certifies that the Appellant's Brief complies with the typeface and volume limitations imposed by Fed. R. App. P. 32(a)(5) and 32(a)(7); that, according to an electronic word count of those sections designated in Fed. R. App. P. 32(a)(7)(B)(iii), there are 9,071 words in the brief; and that the enclosed diskette containing a copy of the brief has been scanned for viruses and is virus free.

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