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Changes in OBRA-90 Affecting Medicaid Eligibility and Services for the Elderly and Disabled

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The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) /1/ contained numerous provisions affecting Medicaid eligibility and services for elderly and disabled people. This article will discuss the most significant of those provisions, primarily for noninstitutionalized Medicaid beneficiaries.

I. Buy-In Provisions

A. Mandatory Buy-in of Medicare Cost-Sharing for Low-Income Medicare Beneficiaries

The Medicare Catastrophic Coverage Act of 1988 (MCCA) required states to pay Medicare premiums, deductibles, and coinsurance for elderly and disabled people with incomes of up to 100 percent of federal poverty guidelines, and with resources of up to 200 percent of the SSI resource limit for one person. /2/ The mandate was to be phased in over a period of four years, reaching 100 percent of poverty on January 1, 1992. However, because of substantial increases in Medicare cost-sharing contained in OBRA-90 that have a disproportionately adverse impact on low-income people, the new law accelerates the phase-in of these provisions to include people with incomes of up to 100 percent of poverty effective January 1, 1991. Five 209(b) states (Hawaii, Illinois, North Carolina, Ohio, and Utah) with slower phase-in periods must cover people with incomes of up to 95 percent of poverty in 1991, and up to 100 percent of poverty in 1992. /3/

Unresolved issues from the original buy-in mandate continue to limit its effectiveness for eligible clients. The new law, like the original, has no specific outreach provisions. Moreover, the Health Care Financing Administration (HCFA) continues to hold the view that states need not pay cost-sharing of the entire Medicare payment if their state Medicaid payment for the same service is less than that amount. /4/ The effect of such a policy is to limit access to services instead of making the Medicare benefit available to low-income people on the same terms as it is available to the rest of the population. HCFA's interpretation is challengeable under provisions of the law defining "cost-sharing." /5/

In addition to accelerated phase-in, OBRA-90 requires states to pay Medicare premiums only (not other cost-sharing) for individuals with incomes of up to 110 percent of poverty beginning in 1993 and 120 percent of poverty in 1995 and thereafter. /6/

In determining eligibility for Qualified Medicare Beneficiary (QMB) status, as well as for the payment of Medicare premiums only, states must disregard the amount of social security retirement or disability benefit cost-of-living adjustments (COLAs) through March of each year. /7/ This provision protects people who might be temporarily found ineligible due to the fact that COLAs are in effect beginning January of each year, while the poverty index changes are not published until mid-February.

B. Mandatory Medicaid Payments for Cost-Sharing Under Group Health Plans

The law requires states to pay premiums and cost-sharing for Medicaid beneficiaries to be enrolled in group health plans for which they are eligible, if to do so is cost-effective. /8/ Once the state has determined cost-effectiveness, the beneficiary must enroll in the plan. Federal match is available for all cost-sharing for items and services covered in the state plan. If, however, non-Medicaid-eligible family members must be enrolled in the group, federal match is available only for the payment of the premium for those ineligible individuals. The legislative history emphasizes that by enrolling in a group health plan, a Medicaid beneficiary does not waive the law's protections against all but nominal cost-sharing. Thus, the burden is on the Medicaid program itself to pay the health plan's cost-sharing. /9/ The provision was effective January 1, 1991, unless a state is required by its own laws to enact legislation to make changes in its state plan.

C. Optional Payment for Premiums for COBRA Continuation Benefits

States may pay premiums for people exercising their rights under COBRA to purchase health benefits formerly paid by an employer /10/ after their loss of entitlement to such benefits, if the state determines that the savings to Medicaid will exceed the cost of the premiums. /11/ Individuals (or families) with income of up to 100 percent of poverty and with resources of not more than twice the SSI resource limit (which is $2,000 for an individual) are eligible. Income and resources are determined using SSI rules; states cannot consider incurred medical expenses in determining eligibility--i.e., they cannot be allowed a spend down. This provision was effective January 1, 1991.

II. Spousal Impoverishment

A. Clarification Concerning Attribution of Income

OBRA-90 amends the attribution of income section of the spousal protections provisions to clarify that those rules apply only to the posteligibility income determination that is used to determine a Medicaid beneficiary's share of cost to the nursing home. /12/ The provision is most significant in community property states that have an absolute dollar cap on income eligibility (the 300 percent rule). In those states, married individuals may be determined to be

eligible (under the income cap) if income ownership is defined by community property principles, ignoring the "name on the check" rule. Once they are determined to be eligible, attribution of income by the "name on the check" rule is less harmful, because of the spousal and family allowances that must be deducted in determining the share of cost. The provision is effective as if included in MCCA.

HCFA's interpretation that states could use community property rules for eligibility determinations but not redeterminations may have resulted in some clients' being found ineligible for Medicaid since September 1990. /13/ Advocates in the affected states should make efforts to identify these clients and have the state redetermine their eligibility.

B. Clarification of Period for Computing Total Spousal Resources

Under the original spousal provisions, a theoretical division of resources occurred at the beginning of a continuous period of institutionalization. This was done through the concept of a snapshot of all of the couple's nonexempt resources at that time. The purpose was to identify the amount to be protected for the spouse at home, so that this amount was not spent prior to the application for Medicaid. The law had no specific provision for the occurrence of more than one continuous period of institutionalization, such as in the case in which an individual was institutionalized for more than 30 days, returned home for a period of time, then was institutionalized for another period of more than 30 days. HCFA's interpretation was that a division of the couple's resources occurred each time. The effect of such a policy is that the amount initially protected for the spouse at home is divided in half upon the second institutionalization, if the other spouse has already spent his or her share on nursing home care. This was clearly not the purpose of the resource protections.

The OBRA-90 amendment /14/ clarifies the rules for treatment of resources to provide that a computation of the total resources is done only at the beginning of the first continuous period of institutionalization of the institutionalized spouse. This amendment is effective as if included in the original law. Again, advocates should review cases to ensure that eligible clients are not being forced to use their spouses' protected resources to pay for nursing home care.

C. Notice to Nursing Home Residents of Rights to Have Income and Resources Protected

The law amends nursing home reform provisions, 42 U.S.C. Sec. 1396(c)(1)(B)(ii), to include a requirement that facilities provide a state-prepared notice of Medicaid rights, including the rights of spouses of nursing home residents, upon reasonable request of the resident. /15/ The original spousal provisions in MCCA included a requirement that nursing facilities inform residents at the time of admission of the requirements for Medicaid eligibility, including the right to request an assessment of spousal resources. /16/ Advocates should be aware that this original requirement, which was not repealed, does not appear in the 1990 Supplement to West's United States Code Annotated. It is probably more important than the OBRA-90 requirement, because it does not depend on the resident's asking for the information, and because it is beneficial for the couple to have the assessment done as close to admission as

possible. It would be helpful if the state-prepared notice of Medicaid rights /17/ were distributed to the resident at the time of admission instead of merely at the resident's request, as the OBRA-90 amendment requires.

III. Other Coverage Provisions

A. Optional Provision of Home- and Community-Based Services

OBRA-90 provides for a modest optional program /18/ for home and community care for functionally disabled older people. /19/ It lists eight specific types of service that can be included /20/ and one catchall category, i.e., "such other . . . services, other than room and board, as the Secretary may approve." Functional disability is defined in the law. /21/ States electing this option must provide for a specific assessment and care plan for each eligible individual. States must also have an appeal procedure for individuals adversely affected by the contents of their assessment. Providers of care must meet all requirements relating to individuals' rights and quality of care; states must certify providers /22/ and establish an enforcement system that includes, at minimum, civil monetary penalties. If a state that is currently providing these services under a waiver eliminates the waiver in favor of the option, it can continue to serve those waiver-program beneficiaries who would, but for income or resources, /23/ meet the definition for the optional service. States need not provide the services statewide. The Secretary must publish a proposed regulation concerning care requirements by December 1991 and final requirements by October 1992. The provision is effective July 1, 1991.

B. Optional Provision of Community-Supported Living Arrangement Services

Community-supported living arrangement services /24/ are authorized for between two and eight states for the first five years. /25/ The law permits the provision of certain services /26/ to help developmentally disabled people to live in the community. Eligible individuals must live with family or in housing with no more than three other people receiving similar services and in a neighborhood populated primarily by people without developmental disabilities. Covered services do not include room and board (for the individual) or the cost of prevocational, vocational, and supported employment services. Participating states must maintain current levels of spending for such services, which are currently provided primarily through home- and community-based waiver programs.

The Secretary can waive certain Medicaid requirements, including comparability of amount, duration, and scope of services; statewideness; and freedom of choice of provider. Individuals receiving services need not be at risk of institutionalization, as under the current waiver program. The Secretary must publish interim regulations setting forth requirements for care by July 1, 1991, and final regulations by October 1, 1992. The provision is effective July 1, 1991.

C. Inclusion of Personal Care Services in Definition of Home Health Care Services

The law amends the definition of home health services to include personal care services prescribed by a physician, provided by a qualified individual not a member of the beneficiary's family, supervised by an RN, and provided in the patient's home or other location that is not a nursing facility. /27/ This provision is effective October 1, 1994.

D. Clarification of Effect of Electing Hospice Care

The law seeks to clarify that a Medicaid beneficiary electing hospice care under the plan waives payment for services that might otherwise be available under Medicare. /28/

E. Codification of Coverage of Rehabilitative Services

OBRA-90 amends the statutory definition of rehabilitative services to include the regulatory language that such services are for "the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." /29/

F. Coverage of Alcoholism and Drug Dependency Treatment Services

The law amends the definition of medical assistance, 42 U.S.C. Sec. 1396d(a), to add that no service shall be excluded from the definition solely because it is for treatment of alcoholism or drug dependency. /30/

IV. Other Eligibility and Posteligibility Provisions

A. Codification of Medically Needy Income Level for Certain One-Member Families

The law amends provisions relating to payments to the states to allow states to use a two-person household standard for setting the medically needy income limit for a one-person household, if this standard was included in the state's plan as of June 1, 1989. /31/ The new provision is effective for payments made "before, on, or after" the date of enactment and codifies a long-standing regulatory provision that recognized that the two-person standard most typically was applied to one child and one adult, thus coming closer to meeting the needs of the one-adult household rather than the one-person standard that was developed to apply most typically to one child. HCFA sought to eliminate the regulatory provision in a proposed rule issued in late 1989. The rule has not yet been published in final form.

B. Authority for States to Use Alternative Spend Down Provision

OBRA-90 permits states to offer individuals eligible for Medicaid as medically needy the option of paying the amount of their spend down to the state, rather than incurring the same amount in medical expenses. /32/

C. Authority for States to Make Disability Determinations

States are permitted to make independent determinations of disability for Medicaid purposes pending final determinations by the Social Security Administration (SSA). /33/ However, states must use the Social Security Act's definitions of disability in making their determinations. This provision may respond in part to final regulations issued by HCFA in late 1989 that provided that, in most cases, SSA disability determinations are binding on Medicaid. /34/ Subsequent interpretations of those regulations clarified that a Medicaid recipient's eligibility would be continued pending the outcome of the highest administrative appeal to which the individual was entitled. The OBRA-90 provision appears to apply a similar protection to applicants for Medicaid. It may permit states to avoid the regulation that precludes them from finding a Medicaid applicant disabled when he or she has been found not disabled by SSA. /35/

D. Disregard of German Reparations in Posteligibility Determinations

The law requires states to disregard reparations paid by the Federal Republic of Germany in determining how much income an individual receiving institutional care or home care under a waiver must pay to the provider. /36/

V. Demonstration Projects and Home- and Community-Based Waivers

A. Home- and Community-Based Waivers

The law amends the waiver program's prohibition on payment for room and board by authorizing such payments for unrelated caregivers without whose care the individual would require institutional care. /37/

B. Expansion of Frail Elderly Demonstration Project Waivers

The 1986 authorization of waiver of Medicaid requirements for 10 demonstration projects providing services to frail elderly people at risk of institutionalization is expanded to cover 15 projects. Projects granted initial waivers on or after October 1, 1990, need not provide Medicare services on a per capita basis for the first two years. /38/

C. Study of Extending Medicaid to Low-Income Individuals Not Otherwise Eligible

The Secretary is required to enter into agreements with three or four states to conduct demonstrations to study "the effect on access to, and costs of, health care of eliminating the categorical eligibility requirement for Medicaid benefits for certain low-income individuals." The law contains detailed requirements for Secretarial approval and permissible restrictions, limits on benefits, and other features of the demonstration projects. /39/

VI. Miscellaneous Provisions

A. Continuation of Moratorium on Voluntary Contributions Regulations

The moratorium imposed in 1988 on new regulations affecting the treatment of voluntary contributions as part of a state's Medicaid match is continued through December 31, 1991. The Secretary is prohibited from denying payments to states that finance their Medicaid share through the taxation of provider institutions. Such providers may not, however, include such taxes in their cost basis for Medicaid reimbursement. /40/

B. Requirements Concerning Advance Directives

The law requires Medicaid institutional and home care providers to have policies and procedures with respect to adult beneficiaries concerning the use of advance directives. /41/ The policies and procedures must include giving information about the individual's rights under state law, documenting whether the individual has such a directive, ensuring compliance with state law respecting advance directives, and providing for education of the staff and the community on issues concerning the use of advance directives. The provision of care cannot be conditioned on the existence of a directive.

The Secretary is required to develop a national campaign to inform the public about advance directives and about a patient's right to participate and direct health care decisions.

C. Improvement in Quality of Physician Services

The Secretary must establish a system for a unique physician identifier, which is necessary for payment, for each Medicaid physician provider. Foreign medical graduates must meet certain qualifications to be issued a physician identifier, and physicians providing services to pregnant women and children must meet certain qualifications. States must include in their reports of formal proceedings against health care practitioners actions by peer review organizations or private accreditation entities. /42/

D. Notice to State Licensing Board When Adverse Actions Are Taken

State Medicaid agencies are required to report sanctions taken against physicians to state licensing boards. /43/ This provision was effective January 7, 1991.

E. Clarification of Coverage of Inpatient Psychiatric Hospital Services

The Secretary is authorized to develop regulations for coverage of psychiatric hospital services in inpatient settings other than psychiatric hospitals. /44/ This provision is effective as if included in the Deficit Reduction Act of 1984.

F. Intermediate Sanctions for Psychiatric Hospitals

States must establish the intermediate sanction of denying payment for admissions after a finding of noncompliance with program requirements by a psychiatric hospital and must use that sanction in certain circumstances. /45/

G. State Utilization Review Systems

The law establishes a moratorium on federal regulations requiring state Medicaid plans to include coverage for ambulatory surgery, preadmission testing, or same-day surgery. /46/ The moratorium will be extended by 180 days after the Secretary submits to Congress a report on the appropriateness of such services and their effects on access, quality, and cost. This report must be submitted no later than January 1, 1993.

FOOTNOTES

1. Omnibus Budget Reconciliation Act of 1990 (OBRA-90), Pub. L. No. 101-508, 104 Stat. 1388, signed November 8, 1990 [hereinafter OBRA-90]. This article is not an exhaustive recitation of all of the Medicaid provisions of OBRA-90 that might have some effect on older people. It covers few of the law's provisions contained in the "Payments" section (sections 4702 et seq.) or the "Health Maintenance Organizations" section (sections 4731-4734), and it does not cover the nursing home reform amendments or the provisions that affect only one state. It also does not discuss the required drug rebate agreements that form a major basis for the reductions in Medicaid spending contained in the law.

2. OBRA-90, supra note 1, at Sec. 4501(a).

3. Advocates in all section 209(b) states should be aware of the OBRA-89 amendment clarifying that the mandated QMB income methodology and the resource standard of 200

percent of SSI are applicable in their states. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2270. See also OBRA-90, supra note 1, at Sec. 6411(a)(1).

4. HCFA Transmittal No. 31, Sec. 3490, 14-A-1, 2 (Dec. 1988).

5. 42 U.S.C. Sec. 1396d(p)(3), as amended by Sec. 301(d) of the Medicare Catastrophic Coverage Act of 1988 and Sec. 608(d)(14) of the Family Support Act.

6. OBRA-90, supra note 1, at Sec. 4501(b).

7. Id. at Sec. 4501(e).

8. Id. at Sec. 4402.

9. Omnibus Budget Reconciliation Act of 1990, Report of the House Comm. on the Budget to accompany H.R. 5835, H.R. REP. NO. 101-881, 101st Cong., 2d Sess. 100 (Oct. 16, 1990).

10. This benefit is limited to continuation benefits from employers of 75 or more employees. Id. at Sec. 4713(a)(2), adding a new subsection 42 U.S.C. Sec. 1396a(u)(1)-(4).

11. OBRA-90, supra note 1, at Sec. 4713.

12. Id. at Sec. 4717(a).

13. Since the spousal protections and the attribution of income rules became effective September 30, 1989, most clients were not scheduled for redeterminations of eligibility until one year later. However, states are permitted to use a six-month eligibility period for nursing home residents, so people may have been found ineligible for Medicaid benefits on this ground as far back as March 1990.

14. OBRA-90, supra note 1, at Sec. 4714(c).

15. Id. at Sec. 4801(e)(10).

16. 42 U.S.C. Sec. 1396r(c)(1)(B)(i).

17. This notice is required by 42 U.S.C. Sec. 1396r(e)(6).

18. OBRA-90, supra note 1, at Sec. 4711, creating a new section 1929 of the Social Security Act. No U.S. Code designation appears in the Congressional Record version of OBRA-90. The optional program is in addition to the current section 1915 waiver programs. States electing the option do not have to demonstrate budget neutrality as they do for the waiver.

19. This program is capped at $580 million over a five-year period. It provides $40 million for FY 1991; $70 million for FY 1992; $130 million for FY 1993; $160 million for FY 1994; and $180 million for FY 1995.

20. The eight categories are (1) homemaker/home health aide service; (2) chore service and personal care service; (3) nursing care service provided by, or under the supervision of, a registered nurse; (4) respite care; (5) training for family members in managing the individual; (6) adult day care, and, in the case of an individual with chronic mental illness, day treatment or partial hospitalization; (7) psychosocial rehabilitation service; and (8) clinic service.

21. The definition is in two parts. To be eligible, an individual must either (1) be unable to perform, without substantial assistance, at least two of the three activities of daily living (ADLs) (toileting, transferring, and eating); or (2) have a primary or secondary diagnosis of Alzheimer's disease and either require substantial assistance with two of five listed ADLs or be cognitively impaired so as to require substantial supervision. The definition does not include the waiver requirement that the individual is at risk of institutionalization.

22. In addition to at-home care, the law identifies and defines "small" and "large" "community care settings," both of which may be residential or nonresidential.

23. Waiver programs can use the same income and resource eligibility criteria that are used for nursing home services. These more liberal criteria are not available under the optional program.

24. OBRA-90, supra note 1, at Sec. 4712.

25. This program is also capped, but at a much lower amount than the home- and community-based services program. The total authorization is $70 million over five years: $5 million for FY 1991; $10 million for FY 1992; $20 million for FY 1993; $30 million for FY 1994; and $35 million for FY 1995.

26. The services are (1) personal assistance, training, and habilitation services that are necessary to assist the individual in achieving increased integration, independence, and productivity; 24-hour emergency assistance; assistive technology; adaptive equipment; support services to aid the individual to participate in community activities; and other services as approved by the Secretary.

27. OBRA-90, supra note 1, at Sec. 4721.

28. Id. at Sec. 4717.

29. Id. at Sec. 4719.

30. Id. at Sec. 4722.

31. Id. at Sec. 4718.

32. Id. at Sec. 4723.

33. Id. at Sec. 4724.

34. 54 Fed. Reg. 50755 (Dec. 11, 1989).

35. In a case recently argued in the Ninth Circuit, a legal services attorney maintained that the OBRA-90 provision required states to do independent disability determinations. See Hays v. Concannon, No. 89-35702 (9th Cir., argued Nov. 8, 1990).

36. OBRA-90, supra note 1, at Sec. 4715. A 1984 Ninth Circuit decision, Grunfeder v. Heckler, 748 F.2d 503 (9th Cir. 1984) (en banc), had the result that reparations that were being paid to Holocaust survivors by the West German government were excluded from SSI eligibility determinations, and therefore from most Medicaid determinations. HCFA regulations, however, require, apparently without statutory authority, that all income disregarded in the eligibility process be included in the posteligibility process. See, e.g., 42 C.F.R. Sec. 435.725.

37. OBRA-90, supra note 1, at Sec. 4741.

38. Id. at Sec. 4744.

39. Id. at Sec. 4745.

40. Id. at Sec. 4701. Voluntary contributions or provider-specific taxes used to meet the state match requirement for Medicaid have been utilized creatively by states and advocates to fund Medicaid expansion.

41. Id. at Sec. 4751.

42. Id. at Sec. 4752.

43. Id. at Sec. 4754.

44. Id. at Sec. 4755(a)(1).

45. Id. at Sec. 4755(a)(2).

46. Id. at Sec. 4755(b).