

The Healthcare Reform Law: Improving Coordination of Benefits & Care for Dual Eligibles

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“Dual eligibles,” the nine million individuals who qualify for both Medicare and Medicaid, face a number of problems with access to appropriate and timely care. For these individuals, more than half of whom have mental illnesses or cognitive impairments,¹ Medicare largely covers acute care services and prescription drugs, and Medicaid pays for Medicare premiums and cost-sharing, as well as long-term care and other services not covered by Medicare. This division of benefits can cause confusion, both for dual eligibles and the mental health and other providers who serve them, because Medicare and Medicaid have different rules and financing incentives.

In response, the **Patient Protection and Affordable Care Act**, the comprehensive healthcare reform law enacted on March 23, 2010, **includes several provisions that seek to improve coordination of benefits and care for dual eligibles**. Summaries of these provisions—which will become increasingly important as Medicaid eligibility expands under the law and the number of dual eligibles increases—appear below.

The National Council strongly supports these provisions and seeks to ensure that their implementation meets the needs of individuals with mental illnesses and substance use disorders.

Changes to Medicare Special Needs Plans (SNPs)

The healthcare reform law revises a number of policies related to SNPs, which are Medicare Advantage coordinated care plans focused on one or more of three types of special needs individuals: dual eligibles, institutionalized beneficiaries, and beneficiaries with severe or disabling chronic illnesses. Under the law, which extends authority for SNPs through 2013, the Department of Health and Human Services after 2010 can apply a frailty payment adjustment to fully integrated dual-eligible SNPs that have contracts with states to provide long-term care and other Medicaid services, as well as similar average levels of frailty. The law also requires dual-eligible SNPs to contract with states to provide Medicaid services by 2013.

In addition, in 2012 and subsequent years, the law requires all SNPs to obtain approval from the National Committee for Quality Assurance, based on standards established by HHS. The law also mandates that Medicare beneficiaries who are enrolled in SNPs but do not qualify for these plans must transition from these plans by 2013.

Medicare Part D Cost-Sharing

The healthcare reform law requires CMS on or after January 1, 2012, to eliminate Medicare Part D cost-sharing for full-benefit dual eligibles who receive home- or community-based care under a Medicaid waiver or state plan amendment but otherwise would receive institutional care. The law also requires the HHS Office of Inspector General to begin a study of the extent to which formularies used by Medicare prescription drug plans and MA plans under Part D include medications commonly used by full-benefit dual eligibles and, in 2011 and subsequent years, submit by July 1 a report to Congress on the results of the study with any relevant recommendations.

Extension of Medicaid Waivers

The healthcare reform law extends to five years the time period for new Medicaid waivers that involve dual eligibles and allows HHS, at the request of states, to approve an extension of these waivers for an additional five years.

Office on Coordination of Benefits

Under the healthcare reform law, the Centers for Medicare and Medicaid Services as of March 1, 2010, must establish a Federal Coordinated Health Care Office, which will seek to improve integration of benefits for dual eligibles and increase coordination between the federal government and states in regard to these individuals. Among other responsibilities, this office will:

- Provide states, providers, and other relevant entities or individuals with the information and tools needed to develop programs that coordinate benefits under Medicare and Medicaid for dual eligibles;
- Support state efforts to coordinate acute and long-term care services for dual eligibles with other benefits provided under Medicare;
- Support coordination of contracting and oversight by states and CMS for Medicare and Medicaid in regard to integration of benefits for dual eligibles;
- Consult and coordinate with the Medicare Payment Advisory Commission and the Medicaid and Children's Health Insurance Program Payment and Access Commission in regard to policies related to access and provision of benefits for dual eligibles; and
- Study the provision of prescription drug benefits for new full-benefit dual eligibles, as well as monitor and report annual total expenditures, health outcomes, and access to benefits for dual eligibles.

This office also will submit to Congress an annual report that includes recommendations for legislation that would improve coordination of benefits and care for dual eligibles.

Assessments of Adult Services

The healthcare reform law requires CMS to use \$11 million appropriated in fiscal year 2010 to expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services for dual eligibles and other beneficiaries.

For additional information on these provisions, please visit the links below:

<http://www.kff.org/medicaid/upload/7957.pdf>

http://www.nhpg.org/media/10477/keysnp_mapaymentprovisions.pdf

http://www.nslc.org/areas/medicare-part-d/health-reform-duals/at_download/attachment

<http://www.medicarerights.org/pdf/Health-Reform-Implementation-Timeline.pdf>

Other National Council resources on healthcare reform are available at:

http://www.thenationalcouncil.org/cs/healthcare_reform

For more information on the provisions in the healthcare reform law related to dual eligibles, please contact Chuck Ingoglia, MSW, Vice President of Public Policy, National Council for Community Behavioral Healthcare, at chucki@thenationalcouncil.org or 202-684-7457 ext. 249.

1. Kaiser Family Foundation, "Health Care Reform Opportunities: Improving Policy for Dual Eligibles," Aug. 2009