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# Affordable Care Act Provisions Relating to the Care of Dually Eligible Medicare and Medicaid Beneficiaries

There are 9 million Medicaid beneficiaries who are "dual eligibles"—low-income seniors and younger persons with disabilities who are enrolled in both the Medicaid and Medicare programs. The Affordable Care Act (ACA) includes a number of provisions aimed at improving care and streamlining service delivery for dually eligible Medicaid and Medicare beneficiaries. Dual eligibles are among the sickest and poorest individuals covered by either the Medicaid or Medicare programs; they comprise only 15 percent of total Medicaid enrollment yet represent 39 percent of annual Medicaid expenditures. Similarly for Medicare, duals represent 21 percent of Medicare enrollees but 36 percent of Medicare expenditures. Dual eligibles' care needs are served through both the Medicare and Medicaid programs. Medicare primarily pays for acute and hospital care, and prescription drugs, while Medicaid generally helps to pay for Medicare premiums, cost sharing and long-term care, as well as other non-medical services.

The ACA presents an array of new and enhanced options to improve care for dual eligibles: through better care integration, improved quality measures, and increased access to home and community-based long term services and supports. This brief identifies major provisions in the ACA that relate to the care of dual eligibles, highlighted below.

### Coordination of Care

The ACA establishes two new federal entities—The Federal Coordinated Health Care Office (FCHCO or Duals Office) and the Center for Medicare and Medicaid Innovation (CMMI or Innovation Center)—that will be involved in efforts to study and improve care for dual eligibles. The Duals Office will be responsible for ensuring that dual eligibles have full access to the benefits to which they are entitled under the Medicare and Medicaid programs. Additionally, this office is charged with providing states, Medicare Advantage special needs plans, physicians, and other relevant entities with tools and education to necessary for developing programs to align benefits for duals under the Medicaid and Medicare programs. In comparison, the role of the Innovation Center (CMMI) will be to test innovative payment and delivery models to lower costs and improve quality for dual eligible beneficiaries.

### Prescription Drugs and Medicare Advantage Plans

The ACA eliminates cost sharing in Medicare Part D plans for some dual eligibles. The law states that all Medicare Part D cost-sharing will be waived for full benefit duals who would be institutionalized but for the provision of home and community-based services, effective January 1, 2012. The law also strengthens quality requirements for Medicare Advantage Special Needs Plans that exclusively serve duals.

### Long-Term Care and Chronic Illness

There is also new option within Medicaid to provide health homes for beneficiaries with multiple chronic conditions, at a 90 percent federal matching rate. Establishing a medical home could be a first step toward more integrated care for duals, a key goal of the ACA. Furthermore, the law increases federal support for state efforts to expand home and community-based services and supports for long-term care. Duals, with their complex health care needs often rely on these services to enable them to remain in the community.

## Affordable Care Act Provisions Relating to the Care of Dually Eligible Medicare and Medicaid Beneficiaries: Overview

**New Entities**

- New Federal Coordinated Health Care Office to improve coordination of care for dual eligibles (FCHCO or Duals Office)
- Innovative models involving dual eligibles may be tested by the Center for Medicare and Medicaid Innovation (CMMI or Innovation Center)

**Coordination of Care**

- Independence at home Medicare demonstration project for beneficiaries with chronic illness
- Medicaid option to provide health homes for beneficiaries with chronic conditions
- Medicaid waivers involving dual eligibles may last 5 years

**Preventive Benefits (provisions not exclusive to dual eligibles)**

- New Medicare annual wellness benefit
- Medicare and Medicaid preventive services

**Medicare Part D Prescription Drug Plans**

- Improved calculation of Low-Income Subsidy (LIS) benchmark premium
- Voluntary de minimus policy for LIS individuals
- Continued eligibility for LIS surviving spouses
- Plan information LIS individuals who are reassigned to another plan
- Elimination of cost-sharing for certain full benefit dual eligible individuals
- Dispensing techniques for medicines prescribed for long-term care facility residents
- Inspector General studies of Part D plan formularies
- Medication therapy management programs (MTMP) for at-risk enrollees

**Medicare Advantage Plans**

- Extends the authority for MA plans for special needs individuals (SNP)
- Permanently authorized the senior housing facility demonstration
- Hold harmless for PACE programs

**Long-Term Care (provisions not exclusive to dual eligibles)**

- Medicaid Community First Choice Option
- Money Follows the Person demonstration extended
- Temporary spousal impoverishment protection
- Community Living Assistance Services and Supports (CLASS) Program

**Advisory Bodies**

- MACPAC to study the interaction of Medicaid and Medicare policies
- IPAB to take into account the unique needs of dual eligibles

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| **NEW ENTITIES** | |
| New Federal Coordinated Health Care Office to improve coordination of care for dual eligibles<br>(FCHCO or Duals Office)<br><br>Section: §2602 | Federal Coordinated Health Care Office established within the Centers for Medicare and Medicaid Services (CMS) in 2010 to more effectively integrate Medicare and Medicaid benefits for dual eligibles and to improve coordination between CMS and the states to ensure that dual eligibles receive full access to benefits under both programs. Annual reports required, containing recommendations for improving care coordination and benefits for dual eligibles.<br><br>CMS Notice Establishing FCHCO:<br>http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2010_register&docid=fr30de10-77.pdf |
| Innovative models involving dual eligibles may be tested by the Center for Medicare and Medicaid Innovation (CMMI or Innovation Center)<br><br>Section: §3021 | A Center for Medicare and Medicaid Innovation established within CMS in 2010 will test innovative payment and service delivery models designed to reduce program expenditures while maintaining or improving quality of care.<br><br>Among the 20 models identified in the law as those that might be tested by the Center are two involving state flexibility and dual eligible individuals. One model would allow states to test and evaluate fully integrating care for dual eligible individuals in the state, including the management and oversight of all Medicare and Medicaid funds. The second would allow states to test and evaluate all payer payment reform for all state residents, including dual eligibles. The Center may test models other than those suggested in the law.<br><br>CMS Notice Establishing CMMI:<br>http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2010_register&docid=fr17no10-105.pdf |
| **COORDINATION OF CARE** | |
| Independence at home Medicare demonstration project for beneficiaries with chronic illness<br><br>Section: §3024 | Demonstration project to test home-based primary care delivery model and coordination of care across treatment settings for Medicare beneficiaries with at least 2 chronic conditions, at least 2 functional dependencies and a nonelective hospital stay within the past year. Could involve up to 10,000 beneficiaries treated by qualifying primary care practices directed by physicians or nurse practitioners. Project to begin by January 1, 2012. |
| Medicaid option to provide health homes for beneficiaries with chronic conditions<br><br>Section: §2703 | A new state option to permit certain Medicaid beneficiaries to designate a provider as a health home. To qualify, a beneficiary must have at least two chronic conditions; one condition and at risk of developing another, or at least one serious and persistent mental health condition. States electing this option receive a 90% federal matching rate for these services for two years. Effective January 1, 2011.<br><br>Guidance issued 11/2010: http://www.cms.gov/smdl/downloads/SMD10024.pdf |

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| **COORDINATION OF CARE (CONTINUED)** | |
| Medicaid waivers involving dual eligibles may last 5 years<br><br>Section: §2601 | Medicaid waivers under §1915 or §1115 involving dual eligibles may be conducted for 5 years and states may request a 5-year extension unless conditions of the waiver not met or it would no longer be cost-effective to continue the waiver. |
| **PREVENTIVE BENEFITS (PROVISIONS NOT EXCLUSIVE TO DUAL ELIGIBLES)** | |
| New Medicare annual wellness benefit<br><br>Section: §4103 | New Medicare coverage for an annual wellness visit including development, or updating, of a personalized prevention plan. Effective January 1, 2011. |
| Medicare and Medicaid preventive services<br><br>Section: §4104 and §4106 | Medicare and Medicaid coverage is provided for certain preventive services recommended by the US Preventive Services Task Force and for recommended immunizations. In Medicare, beneficiary cost sharing for these services is eliminated. For states that provide Medicaid coverage for and remove cost-sharing for these preventive services, the federal matching rate for these services is increased by one percentage point. Effective January 1, 2011. |
| **MEDICARE PART D PRESCRIPTION DRUG PLANS** | |
| Improved calculation of low-income subsidy (LIS) benchmark premium<br><br>Section: §3302 | Rebate and bonus payments to Part D plans are excluded in calculating the LIS benchmark premium. This should result in a greater number of fully subsidized or $0 premium Part D plans for LIS enrollees. Effective for plans years beginning with 2011. |
| Voluntary de minimis policy for LIS individuals<br><br>Section: §3303 | A Part D plan that submits a bid that is slightly higher (a de minimis amount) than the LIS benchmark established by CMS may absorb the cost of that de minimis difference in order to qualify as a LIS plan. This should also result in a greater number of fully subsidized or $0 premium Part D plans for LIS enrollees. Effective for plans years beginning with 2011. |
| Continued eligibility for LIS for surviving spouses<br><br>Section: §3304 | The death of a spouse automatically triggers a redetermination of the eligibility of the surviving spouse for continued eligibility for the low-income subsidy. This provision delays that redetermination, and continues the eligibility previously established for that surviving spouse for one year. Effective January 1, 2011. |
| Plan information for LIS individuals who are reassigned to another plan<br><br>Section: §3305 | For LIS individuals who are reassigned to another Part D plan, CMS must provide within 30 days of reassignment information on the differences under the new plan formulary as well as information on the new plan's grievance and appeals rights. Effective January 1, 2011. |

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| **MEDICARE PART D PRESCRIPTION DRUG PLANS (CONTINUED)** | |
| Elimination of cost-sharing for certain full benefit dual eligible individuals<br><br>Section: §3309 | In the case of full-benefit dual eligible individuals who would be institutionalized but for the provision of home and community-based service care, all cost-sharing under a Part D plan is waived. Effective January 1, 2012. |
| Dispensing techniques for medicines prescribed for long-term care facility residents<br><br>Section: §3310 | Part D plans must use specific, uniform dispensing techniques for residents of long-term care facilities. Effective January 1, 2012, the Secretary will require 7-day prescriptions for most brand name medicines. The Secretary may impose a similar 7-day prescription requirement for generic drugs in future rulemaking. |
| Inspector General studies of Part D plan formularies<br><br>Section: §3313 | The Inspector General of the Department of Health and Human Services will submit annual reports to Congress on whether and to what extent Part D plan formularies include medicines commonly used by full-benefit dual eligible beneficiaries to determine the access to those medicines under Part D plans. The first report is due July 1, 2011. |
| Medication therapy management programs (MTMP) for at risk enrollees<br><br>Section: §10328 | Part D plans must perform quarterly assessments of all at risk enrollees who are not enrolled in an MTMP, including enrollees undergoing a transition in care. Plans must offer MTMPs to enrollees with high Part D medicine costs for treatment of multiple chronic conditions. The MTMPs must include annual comprehensive medication review, conducted in person or by telehealth, and quarterly medication review thereafter.<br><br>Plans must also establish automatic enrollment in MTMPs of these enrollees with an opportunity to opt out.<br><br>The Secretary proposes to require monthly medication review for residents of long-term care facilities. Effective January 1, 2013. |
| **MEDICARE ADVANTAGE PLANS** | |
| Extends the authority for MA plans for special needs individuals (SNP)<br><br>Section: §3205 | The authority for SNPs to restrict enrollment to special needs individuals is extended through 2013.<br>Provides authority to the Secretary to apply a frailty adjustment to payments for dual eligible SNPs that are fully integrated. A fully integrated dual eligible SNP (DE SNP) must provide dual eligible enrollees access to all Medicare and Medicaid benefits, including long-term care, under a single managed care organization and must coordinate delivery of those benefits using aligned care management and provide specialty care networks for high-risk enrollees. Enrollment, communications, grievance and appeals, quality assurance and other member materials must be coordinated and integrated.<br><br>New DE SNP plans must have a contract in place with State Medicaid agencies; existing DE SNP plans may continue to operate without that contract through 2012.<br><br>Beginning 2012, all SNPs must be approved by the National Committee for Quality Assurance. |

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| **MEDICARE ADVANTAGE PLANS (CONTINUED)** | |
| Permanently authorizes the senior housing facility demonstration<br><br>Section: §3208 | Creates a Medicare Advantage senior housing facility plan that restricts enrollment in the plan to residents of a continuing care retirement community, provides primary care on site and transportation to other settings, and operated under a continuing care retirement community demonstration project for at least one year. Effective March 23, 2010. |
| Hold harmless for PACE programs<br><br>Section: §1102 of HCERA | The Program of All-inclusive Care for the Elderly (PACE) is exempted from the new Medicare Advantage blended benchmark payment methodology recognizing the unique nature of PACE programs and scope of health care benefits provided to the frail, elderly PACE enrollees under PACE programs. |
| **LONG-TERM CARE (PROVISIONS NOT EXCLUSIVE TO DUAL ELIGIBLES)** | |
| Medicaid Community First Choice Option<br><br>Section: §2401 | A state may provide home and community-based attendant supports and services to individuals who require an institutional level of care and who have incomes up to 150% of the federal poverty level, or, if higher, up to the income level at which the state provides eligibility for institutional care.<br><br>Guidance issued 2/2011: http://edocket.access.gpo.gov/2011/pdf/2011-3946.pdf |
| Medicaid HCBS option<br><br>Section: §2402 | The home and community based services (HCBS) option available to states is changed to expand the scope of services that a state may cover, allow states to provide the benefit without doing so statewide and otherwise target the benefit to specific populations, and to eliminate the ability of states to place a cap on the number of enrollees receiving the benefit.<br><br>In addition, a state may extend full Medicaid benefits to individuals with incomes up to 300% of SSI that meet the state's criteria HCBS benefit criteria. Effective 4/1/2010. |
| Money follows the person demonstration extended<br><br>Section: §2403 | This demonstration, which provides states with additional federal payments for beneficiaries transitioned from institutional care to the community, is extended for five years, through 2016. |
| Temporary spousal impoverishment protection<br><br>Section: §2404 | Protections currently provided to prevent the impoverishment of community-based spouses of Medicaid beneficiaries who are nursing home residents will be extended to spouses of individuals being served in Medicaid's HCBS programs. Applies from January 1, 2014 through December 31, 2019. |
| Community Living Assistance Services and Supports (CLASS) Program<br><br>Section: Title VIII | The CLASS Program will allow individuals to make voluntary payroll deductions and after five years become eligible for services and supports to maintain independence in the community if they have functional limitations expected to last at least 90 days that require help with daily living activities and meet other program eligibility requirements. Premiums to be set to cover future expenditures. Cash benefits provided to cover nonmedical services and supports including home modifications, assistive technologies, home care aides, and personal assistance. No deadline for implementation is specified but benefits must be established by September 1, 2012. |

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| **ADVISORY BODIES** | |
| MACPAC to study the interaction of Medicaid and Medicare policies<br><br>Section: §2801 | The Medicaid and CHIP Payment and Access Commission (in consultation with the Medicare Payment Advisory Commission) is required to review and assess the interaction of Medicaid and Medicare policies. It is also directed to coordinate its recommendations with the new Coordinated Health Care Office created under §2602. |
| IPAB to take into account the unique needs of dual eligibles<br><br>Section: §3403 | A new 15-member Presidentially-appointed Independent Payment Advisory Board is established and given authority to recommend proposals to limit Medicare spending growth. If projected per capita Medicare spending exceeds target growth rates, the Board is required to recommend proposals to reduce Medicare spending by specified amounts, and these recommendations become law unless the Congress enacts an alternative. The first set of recommendations is due in 2014 for implementation in 2015.<br><br>In developing and submitting each proposal, the IPAB is required, among other things, to consider the unique needs of beneficiaries who are dually eligible for Medicare and Medicaid. |

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