A primer on integrated care options for people with Medicare and Medicaid

Medicare beneficiaries who also qualify for Medicaid have a range of options to receive coverage. This primer reviews the current national landscape of coverage options for dually eligible individuals (people with both Medicare and Medicaid) and provides an explanation of important changes to coverage options relevant to these beneficiaries and the professionals who serve them.

1. Coverage options for people with Medicare and Medicaid

A. Landscape at a glance

Dually eligible individuals have several options for how they receive their Medicare and Medicaid coverage:

- Original Medicare and fee-for-service (FFS) Medicaid
- Medicare Advantage (MA) Plan and FFS Medicaid
- Dual-eligible Special Needs Plans (D-SNPS)
- Highly Integrated Dual-Eligible (HIDE) SNPs
- Fully Integrated Dual-Eligible (FIDE) SNPs
- Program of All-Inclusive Care for the Elderly (PACE)
- Medicare-Medicaid Plans (MMP)

Dually eligible individuals have the choice of enrolling in Original Medicare or choosing a Medicare Advantage Plan to cover their Medicare benefits. In addition to Medicare, dually eligible individuals also have Medicaid coverage. Medicaid coverage may provide secondary insurance, cost assistance, and coverage for services that Medicare does not cover.

Dually eligible individuals who require long-term services and supports may choose to receive their benefits from a stand-alone long-term care plan. Managed long-term services and supports (MLTSS) plans (sometimes known as managed long-term care plans) are responsible for administering certain benefits (e.g., Medicaid long-term care) but not all benefits (e.g., Medicare-covered services).

Having a stand-alone MLTSS plan does not affect an individual's Medicare coverage. This means that Original Medicare or a Medicare Advantage Plan remains the individual's primary payer, paying first for the care they get from hospitals,

primary care doctors, and specialists. The individual's Medicare prescription drug coverage also remains unchanged. Beneficiaries should contact their local Medicaid office to learn whether enrollment in an MLTSS plan affects their other Medicaid benefits.

An MLTSS plan may be a good option for individuals who like their Original Medicare or Medicare Advantage coverage and are looking for greater flexibility in choosing providers. Keep in mind that those enrolled in stand-alone MLTSS will need to navigate multiple insurances: Original Medicare or Medicare Advantage, Part D, and an MLTSS plan.

Options for dually eligible individuals defined		Enrollment criteria	MLTSS	*BH
Medicare & FFS Medicaid				
+stand-alone MLTSS program	Medicaid plan that covers variety of long-term care services and supports	Full duals	Y	N/A
PACE	Program that provides Medicare, Medicaid, and long-term care services under one plan	Full duals	Y	Y
Medicare Advantage Special Needs Plans				
D-SNP	Type of Medicare Advantage Plan for dually eligible individuals	Varies by plan	N	N
D-SNP + MLTSS program	D-SNP and a separate plan to covered long-term care services and supports	Full duals	Y	N
HIDE SNP	D-SNP that provides Medicare, Medicaid, and either long-term care or behavioral health services under one plan	Full duals	Varies	Varies
FIDE SNP	D-SNP that provides Medicare, Medicaid, and long-term care services under one plan (may provide behavioral health services)	Full duals	Y	Varies
Financial Alignment Initiatives				
MMPs	Plans that contract with state and CMS to provide Medicare and Medicaid services	Full duals	Y	Y

*Behavioral health

Note: Beneficiaries should contact 1-800-MEDICARE or visit https://www.shiptacenter.org to find out what plans are available in their area. Not all of the coverage options above are available in all states or counties

B. Dual-eligible Special Needs Plans (D-SNPs)

D-SNPs are types of Medicare Advantage Plans for individuals enrolled in Medicare and Medicaid (dually eligible individuals). Like other Medicare Advantage Plans, D-SNPs typically require use of an in-network provider for Medicare services. These providers should also accept Medicaid. Cost-sharing varies from plan to plan, and some plans offer zero cost-sharing for enrollees.

D-SNP enrollment is voluntary. Some D-SNPs only serve beneficiaries with Medicare and full Medicaid benefits, while others serve those with partial Medicaid benefits, such as individuals enrolled in certain Medicare Savings Programs (MSPs). However, it may be difficult to identify these plans without contacting the plan directly (see the FAQ for more information on how to find plans in a given area).

D-SNPs normally are only responsible for furnishing Medicare benefits. However, there are also two types of D-SNPs that are paid to furnish both Medicare and Medicaid benefits. These plans are designed to provide a more coordinated experience for dually eligible individuals:

- **Highly Integrated Dual-Eligible (HIDE) SNPs:** HIDE SNPs must provide Medicare, Medicaid, and either long-term care or behavioral health services.
- **Fully Integrated Dual-Eligible (FIDE) SNPs:** FIDE SNPs must provide Medicare, Medicaid, and long-term care services. FIDE SNPs may also be required to provide behavioral health services in certain states.

The basic distinction between HIDE and FIDE SNPs is that FIDE SNPs typically cover a more comprehensive set of services. However, coverage requirements will vary from state to state.

Generally, HIDE and FIDE SNPs may be good options for individuals who want to receive their care through a single plan. Both options offer the possibility of greater care coordination, and an individual may find these models preferable if they are accustomed to managed care and provider networks.

Exclusively aligned enrollment

While enrollees in HIDE and FIDE SNPs should receive their Medicare and Medicaid services through one plan, other types of plans may not be operated by a single entity. Some beneficiaries may enroll in Medicare SNPs where their Medicaid, long-term care, or other benefits are furnished by a separate Medicaid managed care plan.

HIDE and FIDE SNPs where a single entity is responsible for managing the Medicare, Medicaid, and applicable behavioral health or LTC benefits for all enrollees are referred to as plans with exclusively aligned enrollment. This typically means that the beneficiary is enrolled in a D-SNP and an affiliated Medicaid

managed care plan. Often both plans are operated by the same managed care organization. HIDE and FIDE SNPs with exclusively aligned enrollment are also required to have a unified grievance and appeals process (see section 2B). (HIDE and FIDE SNPs may not cover hospice benefits. A beneficiary in need of hospice care is covered through Original Medicare.)

C. Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-inclusive Care for the Elderly is a program that provides Medicare, Medicaid, and long-term care services under one plan. PACE is not available everywhere; not every state has PACE and it may be limited to specific areas. Enrollees receive their care at PACE centers, which are responsible for arranging all primary care, inpatient hospital care, and long-term care.

PACE enrollment is voluntary, and individuals are eligible to enroll in PACE if they meet the following criteria:

- Are 55 years or older
- Require long-term care for more than 120 days
- Live in the service area of a PACE center
- Are able to live safely in their community

PACE plans are meant to provide more patient-centered care coordination and may encourage better communication among providers, caregivers, and patients. Once enrolled, beneficiaries in PACE should be assigned an interdisciplinary team whose purpose is to help make sure they get needed care. The interdisciplinary team may include the enrollee's primary care physician, social worker, aides, and other providers.

Generally, PACE may be a good option for individuals who want to receive their care through a single plan. PACE offers the possibility of greater care coordination at a Center in their community.

D. Medicare-Medicaid Plans (MMPs)/Duals demonstrations

MMPs (also known as "duals demos") are designed to provide dually eligible individuals with improved care coordination and to better align Medicare and Medicaid benefits. Through the Financial Alignment Initiative (FAI), a state, the Centers for Medicare & Medicaid Services (CMS), and a health plan may enter into a three-way contract, and the plan will be responsible for providing all Medicare and Medicaid services (including long-term care and behavioral health services).

MMPs are not available in all states or counties. Generally, MMPs may be a good option for individuals who want to receive their care through a single plan. However, beneficiaries should be aware that the way MMPs operate may vary from state to state, despite the requirement that they provide comprehensive coverage.

A list of all states with MMPs is available at:

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination

2. New integration requirements

A. Minimum criteria for Medicare and Medicaid integration

All D-SNPs are required to do at least one of the following:

- Cover Medicaid long-term services and supports and/or behavioral health care services (meaning the plan is either a HIDE SNP or FIDE SNP)
- Notify the state Medicaid agency of hospital and skilled nursing facility admissions for at least one group of high-risk dually eligible beneficiaries, as determined by the state agency

D-SNPs will also be required to perform additional Medicaid care coordination activities, such as:

- Verifying an enrollee's eligibility for long-term care supports and services or behavioral health services under Medicaid or determining how an enrollee receives such services (such as through Medicaid managed care or fee-for-service Medicaid)
- Helping beneficiaries with Medicaid grievances or appeals, including assistance filling out forms or obtaining documentation

B. Unified grievance and appeals processes

A grievance is a formal complaint that a beneficiary files with their plan if they are dissatisfied with the plan. An appeal is a formal request for review of a coverage decision made the beneficiary's MA Plan. If a beneficiary is denied coverage for a health care service or item, they may appeal the decision.

Medicare and Medicaid have separate processes for handling appeals and grievances, with different deadlines for filing and reviewers at subsequent levels. This makes it harder for D-SNP enrollees to understand how and where to file a grievance or appeal, resulting in delayed or denied access to needed services.

By 2021, HIDE SNPs and FIDE SNPs with exclusively aligned enrollment (see section 1B) are required to have a unified process at the plan level for grievances and appeals.

A unified process for grievances and appeals means that beneficiaries will use a single process to receive plan coverage determinations and grievance responses for Medicare and Medicaid. Plans must also have one timeline for filing, responding to, and resolving the appeal or grievance, rather than different timelines depending on whether Medicare or Medicaid is handling the grievance or appeal. Beneficiaries should also receive one notice when appealing or filing a grievance, rather than multiple notices from the MA Plan and the state Medicaid agency.

The unified appeal and grievance processes apply to services covered by both Medicare Part A or Part B and Medicaid. Grievances and appeals will only be unified at the plan level, however. This means that if a beneficiary escalates their appeal to levels that involve outside entities, they will have to file their appeal with either Medicare, Medicaid, or both, depending on the service being denied.

This project was supported in part by grant 90MINC0001-01-00 from the U.S. Administration for Community Living, Department of Health and Human Services. Points of view or opinions do not necessarily represent official ACL policy.