

## Coverage options for people with Medicare and Medicaid: Frequently Asked Questions

The following are some common questions asked related to the different coverage options for individuals who are enrolled in Medicare and Medicaid.

### 1. How do Medicare and Medicaid work together?

All states offer a variety of Medicaid programs, with eligibility and coverage specifics varying by state. If an individual with Medicare qualifies for Medicaid, it may help pay for costs and services that Medicare does not cover.

Beneficiaries with both Medicare and Medicaid are dually eligible individuals.

### 2. What is a Dual-eligible Special Needs Plan (D-SNP)?

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 also serve those with partial Medicaid benefits, such as individuals enrolled in certain Medicare Savings Programs (MSPs).

### 3. What should an individual consider when deciding whether to enroll in a D-SNP?

A D-SNP could be a good option for individuals interested in consolidating their Medicare and Medicaid coverage. D-SNPs offer networks of providers and facilities that take both Medicare and Medicaid coverage. Most individuals who enroll in a D-SNP should find out if that Medicaid covers their Medicare cost-sharing, such as deductibles and copayments. Keep in mind that standard D-SNPs do not offer long-term care coverage (see question 5).

Some dually eligible individuals may prefer Original Medicare coverage because it does not have networks and provides greater flexibility in choosing providers. An individual with Original Medicare and Medicaid should make sure that their providers accept both Medicare and Medicaid. If the provider accepts Original

Medicare but not Medicaid, then individuals may be responsible for paying out-of-pocket costs for their care.

#### **4. What are behavioral health services?**

Behavioral health services include mental health care and substance use disorder treatment. According to the National Alliance on Mental Illness (NAMI), “a mental illness is a condition that affects a person’s thinking, feeling, or mood.” Examples of mental health conditions include depression, anxiety, and schizophrenia. Substance use disorders and addiction do not fall under this definition of mental health condition, but they are included under behavioral health conditions.

While Medicare and Medicaid both provide coverage for behavioral health care services, many of the coverage options for dually eligible individuals are designed to provide a more coordinated experience and may offer a more comprehensive set of behavioral health services.

#### **5. What is long-term care?**

Long-term care encompasses a range of services and supports to help individuals perform everyday activities. Services can include but are not limited to help with activities of daily living (routine activities that individuals tend to do each day, such as eating, bathing, and dressing), adult day care, and care in an assisted living facility or nursing home.

Dually eligible individuals with long-term care needs have the following coverage options:

- Some Highly Integrated Dual-Eligible (HIDE) SNPs\*
- Fully Integrated Dual-Eligible (FIDE) SNPs
- Program of All-Inclusive Care for the Elderly (PACE)
- Medicare-Medicaid Plans (MMPs)
- Managed long-term services and supports (MLTSS) plans

Some options combine Medicare and Medicaid coverage. For other options, Medicare and Medicaid are separate. Depending on an individual’s situation, some coverage options may meet their health care needs better than others. Please note that plan availability, eligibility requirements, and coverage will vary from state to state and by locality.

\*HIDE SNPs must provide either long-term care or behavioral health services (see question 6).

## 6. What are Highly Integrated Dual-Eligible Special Needs Plans and Fully Integrated Dual-Eligible Special Needs Plans?

HIDE and FIDE SNPs are 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:

- HIDE SNPs must provide Medicare, Medicaid, and **either** long-term care or behavioral health services.
- 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.

## 7. What is PACE?

The Program of All-inclusive Care for the Elderly (PACE) 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 (see question 12). 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.

## **8. What are Medicare-Medicaid Plans (MMPs)?**

Medicare-Medicaid Plans (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 (see question 12). Generally, MMPs may be a good option for individuals who want to receive their care through a single plan. 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>

## **9. What is a managed long-term services and supports (MLTSS) plan?**

Dually eligible individuals who require long-term services and supports may choose to receive their benefits from a stand-alone MLTSS plan. 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 received 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 types of insurance: Original Medicare or Medicare Advantage, Medicare Part D, and an MLTSS plan.

#### **10. What should an individual consider when deciding among HIDE SNPs, FIDE SNPs, PACE, MMPs, and MLTSS plans?**

Keep in mind that plan availability (see question 12), eligibility requirements, and coverage will vary from state to state. Beneficiaries should always start by finding out what options are available and, when possible, compare the plans using detailed information about their specific benefits to make decisions. Even if they are the same kind of product, plans may differ from one insurer to the next.

- **HIDE SNPs** coordinate Medicare and Medicaid services, which may provide a better experience for enrollees. However, HIDE SNPs have provider networks, which means a beneficiary has less flexibility in choosing their providers. In addition, HIDE SNPs are not required to meet the more stringent requirements of FIDE SNPs. Keep in mind that the basic distinction between HIDE and FIDE SNPs is that FIDE SNPs typically cover a more comprehensive set of services. This means that in states that have both, HIDE SNPs may provide a less integrated experience or cover fewer services. However, keep in mind that services covered by HIDE and FIDE SNPs may vary by state. Beneficiaries may find that HIDE SNPs cover services that FIDE SNPs in their state do not.
- **PACE, FIDE SNPs, and MMPs** may provide greater care coordination than other options because they are often responsible for providing all benefits (Medicare, Medicaid, and long-term care and/or behavioral health care). Enrollees may have a care manager or interdisciplinary team responsible for coordinating access to needed care. However, in addition to having less flexibility in choosing providers:
  - **PACE** enrollees are required to use their PACE center for almost all services. Beneficiaries more used to Original Medicare may prefer an option with greater provider flexibility.
  - **FIDE SNP** enrollees may find it difficult to access services that are not covered by their plan. For example, individuals enrolled in FIDE SNPs that do not cover behavioral health services may have to access those services through fee-for-service Medicaid (Medicaid

benefits administered by a state plan, rather than Medicaid through a managed care plan). Their plan may not be well-versed in requirements for such services, so beneficiaries who prefer managed care may still experience some fragmentation in their benefits.

- **MLTSS plan** enrollees will likely have greater provider choice and flexibility if they remain in Original Medicare, but they may also find it difficult to navigate multiple kinds of insurance. MLTSS plans only cover long-term care benefits. Although MLTSS plans may provide care managers, these care managers are typically only responsible for helping enrollees navigate their long-term care benefits. These beneficiaries will often have the lowest cost-sharing when seeing providers who take their Medicare and Medicaid insurance; however, they may find it difficult to find providers who accept both.

## **11. What should an individual consider when switching from one kind of coverage to another?**

Many dually eligible individuals may already have Original Medicare or Medicare Advantage, or they may have one of the managed care options above before learning that they are eligible for other options in their state.

An important factor for many beneficiaries when switching among options is whether the new plan covers their current providers, facilities, and pharmacies. It can be a good idea before making any changes for individuals to create a list of their preferred providers, facilities, and pharmacies and find out if those providers contract with the plan.

Switching plans could also mean switching Medicare Part D drug coverage. There is no guarantee that previously covered drugs will be covered by the new plan. It can be a good idea for the individuals to create a list of their medications—including names, dosages, and frequency taken—and to use this list to search for plans with minimal or no differences in drug coverage.

Those considering switching from managed care to Original Medicare and fee-for-service Medicaid will likely have more provider choice but may face challenges coordinating several different types of coverage, including a Part D plan.

## 12. How can individuals find out which plans are available in their states?

It can be difficult to learn about which types of plans are available in each state and locality. It may be necessary to use multiple resources to narrow down the available options. It is also best practice to call plans and confirm any information found online about the plan and its coverage rules.

### Using Medicare Plan Finder

[Medicare Plan Finder](#) can be used as a starting point when searching for D-SNPs, but there are some limitations, and all information should be double-checked by contacting plans directly.

First, an individual should go through the steps to complete a search for Medicare Advantage Plans. Once they are on the results page, Plan Finder has an option to add Special Needs Plans to the search results. At the top of the results page, the individual should click on the link that says “Add Special Needs Plans” and then check the box for “Plans for people who have both Medicare and Medicaid” to add D-SNPs. Individuals in need of long-term care can also check the box for “Plans for people who need long-term care in a facility or at home.”

When searching for D-SNPs, an individual should look for plans identified as “SNP Type: Dual Eligible.” Plan Finder also identifies plans that cover Medicaid benefits, however these plans are not necessarily HIDE or FIDE SNPs.

There are three issues someone may encounter when using Plan Finder.

1. Plan Finder provides a limited ability to filter. This means that search results may include several plans that are other types of SNPs or are D-SNPs that do not include long-term care.
2. It can be difficult to tell the plans apart or understand the differences in what each plan covers. Plan Finder does not use terms like HIDE SNP or MLTSS, so very different plans can look the same in Plan Finder.
3. Plan Finder does not include plan eligibility requirements.

Again, Plan Finder can be helpful for learning about available D-SNPs in a particular service area, but an individual should be sure to contact the plan directly to confirm all information found online.

To use Plan Finder, visit <https://www.medicare.gov/plan-compare/>.

## **Finding FIDE SNPs, HIDE SNPs, and MLTSS plans**

Individuals searching for these types of plans should start by contacting their local Medicaid office or state long-term care ombudsman program, if applicable. Be aware that that these types of plans may be named differently depending on the state.

## **Finding PACE plans**

Medicare has a portal to search for PACE plans: <https://www.medicare.gov/find-a-plan/questions/pace-home.aspx>

The tool lists all PACE plans available in a particular state. An individual should contact plans directly to learn whether they are eligible to enroll in the plan and for more information about coverage. They should also contact their state long-term care ombudsman program, if applicable.

## **Finding MMPs**

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>

The information provided on the Centers for Medicare & Medicaid Services (CMS) website is technical, but most demonstrations have information and fact sheets for beneficiary audiences or links to MMP ombudsman programs. The name of each MMP is also provided, so an individual can use the plan name to search for more information.

## **Using My Care, My Choice**

Beneficiaries living in the state of California who want to learn more about their coverage options can visit <https://www.mycaremychoice.org/>.

This tool helps beneficiaries learn what plans they may be eligible for and has helpful resources related to the coverage options in California for beneficiaries and advisors.



### 13. Who can an individual contact if they have additional questions?

Individuals experiencing problems with their coverage or in need of help navigating their options may want to try contacting the following for assistance:

- Local Medicaid office
  - Visit [www.medicaid.gov/about-us/contact-us/index.html](http://www.medicaid.gov/about-us/contact-us/index.html)
- State's long-term care ombudsman
  - Visit [www.theconsumervoicework.org/get\\_help](http://www.theconsumervoicework.org/get_help)
- State Health Insurance Assistance Program (SHIP)
  - Visit [www.shiptacenter.org](http://www.shiptacenter.org) or call 877-839-2675
- 1-800-MEDICARE (1-800-633-4227)

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