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 often referred to as "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. 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. Enrollees may not have out-of-pocket costs (Medicaid typically covers Medicare cost-sharing). Keep in mind that standard D-SNPs do not directly cover Medicaid-only services, including dental, long-term care, or transportation (see question 5 for more on long-term care).

This project was supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $150,000 with 100 percent funding by ACL/HHS. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS or the U.S. Government.

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 unless they are also enrolled in the Qualified Medicare Beneficiary (QMB) Medicare Savings Program (MSP).

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 integrated coverage options for dually eligible individuals aim to provide a more coordinated experience and may cover 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 may have the following coverage options, depending on their state:

- 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)

This project was supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $150,000 with 100 percent funding by ACL/HHS. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS or the U.S. Government.

- Managed long-term services and supports (MLTSS) plans

Some options combine Medicare and Medicaid coverage. For other options, Medicare and Medicaid coverage are separate and pay one after the other for covered care. 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 coverage for 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, behavioral health care, **and** long-term care services
    - Cover Medicare cost-sharing for both dually eligible individuals who also have the Qualified Medicare Beneficiary (QMB) MSP and for dually eligible enrollees who do not have QMB
    - And, have exclusively aligned enrollment*

*Aligned enrollment refers to when a dually eligible individual enrolled in a D-SNP also receives coverage of Medicaid benefits from the D-SNP or from a Medicaid Managed Care Organization (MCO) where that MCO is either offered by the same organization as the Medicare Advantage organization offering the D-SNP, its parent organization, or an entity that is owned and controlled by the D-SNP's parent organization. Plans are considered to have exclusively aligned enrollment when state policy limits a D-SNP's membership to individuals with aligned enrollment.

This project was supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $150,000 with 100 percent funding by ACL/HHS. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS or the U.S. Government.

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.

This project was supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $150,000 with 100 percent funding by ACL/HHS. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS or the U.S. Government.

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

Medicare-Medicaid Plans (MMPs, also known as "duals demos") are plans 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 all 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.

All MMPs are set to end December 31, 2025. After an MMP ends, former enrollees need to find alternative coverage that meets their needs and suits their preferences. Ombuds programs associated with the MMP should have more information about replacement plans and other options.

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 those benefits from a stand-alone MLTSS plan in some states. 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., Medicaid health benefits and 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 could impact 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.

This project was supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $150,000 with 100 percent funding by ACL/HHS. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS or the U.S. Government.

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, Medicaid or a Medicaid Managed Care plan 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.

- **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.

- **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

This project was supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $150,000 with 100 percent funding by ACL/HHS. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS or the U.S. Government.

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.

This project was supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $150,000 with 100 percent funding by ACL/HHS. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS or the U.S. Government.

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. It can be difficult to tell plans apart or understand the differences in what each plan covers. Plan Finder does not use terms like HIDE SNP or FIDE SNP, so different plans can look the same in Plan Finder.

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/plan-compare/#/pace

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/medicaid-chip/medicare-coordination/financial-alignment

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.

This project was supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $150,000 with 100 percent funding by ACL/HHS. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS or the U.S. Government.

Using My Care, My Choice

Beneficiaries living in the state of California, Illinois, Michigan, or Ohio 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, Illinois, Michigan, and Ohio 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
- State's long-term care ombudsman
  - Visit www.theconsumervoice.org/get_help
- State Health Insurance Assistance Program (SHIP)
  - Visit www.shiptacenter.org or call 877-839-2675
- 1-800-MEDICARE (1-800-633-4227)

This project was supported by the Administration for Community Living (ACL), U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $150,000 with 100 percent funding by ACL/HHS. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement, by ACL/HHS or the U.S. Government.