# Glossary of Terms Related to Integrated Care for Dually Eligible Individuals

## Introduction

The Integrated Care Resource Center (ICRC) uses a variety of terms related to integrated care for dually eligible individuals in our written products and webinars. ICRC broadly uses the term "integrated care" to describe systems in which Medicare and Medicaid program administrative requirements, financing, benefits, and/or care delivery are coordinated. In general, in "integrated care" systems, Medicare and Medicaid services may be covered through a single entity or coordinating entities, such as through health plans, medical systems, and/or providers.

In this glossary, ICRC highlights key terms related to dually eligible individuals and the Medicare and Medicaid integrated care programs that serve them. In many instances, we have paraphrased definitions from federal regulatory language and simplified them for ease of use and understanding. Therefore, the definitions offered in this document may vary slightly from the precise legal definitions issued in statute, regulation, or sub-regulatory guidance.

Key terms are organized alphabetically. Use the links below to navigate to a section of this tool:


- Key Terms: A-B
- Key Terms: C-D
- Key Terms: E-G
- Key Terms: H-L
- Key Terms: M
- Key Terms: N-P
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## Key Terms: A-B

**Affiliated Plans:** Affiliated plans (or entities) are dual eligible special needs plans (D-SNPs) and Medicaid managed care plans (or entities) that are owned and controlled by the same parent organization and operate in the same geographic area.[1]

**Aligned Enrollment:** Aligned enrollment occurs when a dually eligible individual is enrolled in (1) a Dual eligible special needs plan (D-SNP) for both Medicare and Medicaid benefits or (2) a D-SNP and

a Medicaid managed care plan offered by the same parent organization in the same geographic area (affiliated plans). In these instances, a single entity is responsible for covering both Medicare and Medicaid benefits. An aligned enrollment model can also be simpler for beneficiaries and providers to navigate because service payments are administered by a single payer, and plan communications can be integrated, making them easier for beneficiaries and providers to understand. Care coordination also has greater potential in aligned enrollment models because information about inpatient stays, care transitions, and service needs can be shared more efficiently and effectively when all benefits are administered by the same entity.[2]

**Annual Notice of Change (ANOC):** An annual notice of change (ANOC) is a standardized marketing material through which a Medicare Advantage organization must provide information concerning its intention to change its rules for a Medicare Advantage plan. Organizations must send the ANOC for enrollee receipt no later than September 30 each year. Enrollees with October 1, November 1, or December 1 effective dates must receive the ANOC within 10 calendar days of the plan's receipt of confirmation of enrollment from the Centers for Medicare & Medicaid Services (CMS) or by the last day of the month prior to the effective date, whichever is later.[3]

**Appeal:** In Medicaid, an appeal takes place when a beneficiary files a request for review or reconsideration of an adverse benefit determination. Examples of an adverse benefit determination include denial or limited authorization for a requested service; reduction, suspension, or termination of a previously authorized service; denial of payment for a service, a failure to provide a service or to provide a service in a timely manner, and other circumstances.[4]

In Medicare, an appeal includes any of the procedures that deal with the review of adverse organization determinations made by an organization about a health care service an enrollee believes he or she is entitled to receive, including delays in providing, arranging for, or approving health care services (such that a delay would adversely affect the health of the enrollee), as well as disputes on any amounts the enrollee must pay for a service.[5,6]

**Applicable Integrated Plans (AIPs):** Applicable Integrated Plans (AIPs) are:

- Fully or Highly Integrated dual eligible special needs plans (FIDE SNPs or HIDE SNPs) operating with exclusively aligned enrollment; or
- Coordination-Only (CO) Dual Eligible Special Needs Plans (D-SNPs) with exclusively aligned enrollment that cover (through the D-SNP or through an affiliated Medicaid managed care plan) Medicaid primary and acute care benefits, Medicare cost sharing, and at least one of the following additional Medicaid benefits: home health services; medical supplies, equipment and appliances, or nursing facility services.[7]

AIPs must comply with integrated appeal and grievance processes required at 42 CFR §422.629 - §422.634, as well as Medicaid managed care rules at 42 CFR §438.210, §438.400, and §438.402.[8]

**Behavioral Health Services:** Behavioral health services support the emotional, psychological, and social well-being of an individual and may be used to treat mental health conditions (such as anxiety,

depression, and schizophrenia) or substance use disorders (such as opioid or alcohol addiction). Many dually eligible individuals have coexisting behavioral and physical health needs.[9]

## Key Terms: C-D

**Coinsurance:** Coinsurance is a fixed percentage of the total amount paid for a health care service that can be charged to a health plan enrollee on a per-service basis.

**Coordination-Only Dual Eligible Special Needs Plan (CO D-SNP):** A coordination-only dual eligible special needs plan is a Medicare Advantage dual eligible special needs plan (D-SNP) that meets minimum CMS requirements but does not qualify as a fully integrated dual eligible special needs plan (FIDE SNP) or a highly integrated dual eligible special needs plan (HIDE SNP). CO D-SNPs must: (1) hold a contract with the state Medicaid agency in each state of operation that meets the requirements described at 42 CFR 422.107; (2) coordinate the delivery of Medicare and Medicaid services for its enrollees; and (3) meet the information-sharing requirements described at 42 CFR 422.107(d).[10]

**Copayment:** A copayment is a fixed dollar amount that can be charged to a health plan enrollee on a per-service basis.[11]

**Cost Sharing:** Cost sharing is the share of costs covered by health insurance that an enrollee must pay out of their own pocket. Enrollee cost sharing includes deductibles, coinsurance, and copayments.

Medicaid covers Medicare cost sharing for Qualified Medicare Beneficiaries. In some states, Medicaid may also cover Medicare cost sharing for other Full-Benefit Dually Eligible (FBDE) Individuals.

**Crosswalks and Crosswalk Exceptions:** A plan crosswalk is the movement of enrollees from one Medicare Advantage (MA) plan benefit package (PBP) to another MA PBP under a contract between the Medicare Advantage organization (MAO) and the Centers for Medicare & Medicaid Services (CMS).

Crosswalks are prohibited between different contracts or different plan types (for example, from a Health Maintenance Organization (HMO) to a Preferred Provider Organization (PPO)). Unless otherwise articulated in federal regulations, crosswalks are also prohibited between different MA contracts.

MA dual eligible special needs plans (D-SNPs) may only conduct a crosswalk using the CMS crosswalk exception process. CMS reviews crosswalk exception requests and may permit a crosswalk exception in various circumstances, including when:

- Medicare Advantage contracts offered by two different Medicare Advantage organizations that share the same parent organization are consolidated under one surviving contract. When this occurs, the enrollees from the consolidating contracts may be crosswalked to a Medicare Advantage plan under the surviving contract(s).
- A renewing D-SNP with a multi-state service area reduces its service area (or, in the case of a D-SNP in a Medicare Advantage regional plan contract, non-renews and creates state-specific local PPO plans in its place to accommodate state contracting efforts in the service area). In

these instances, enrollees who are no longer in the service area may be moved into new or renewing D-SNPs offered under the same parent organization (even if the D-SNPs are offered by two different Medicare Advantage organizations), as CMS determines is necessary to accommodate changes to the contracts between the state and D-SNP.

- A renewing D-SNP has another new or renewing D-SNP, and the two D-SNPs are offered to different populations. In these instances, enrollees who are no longer eligible for their current D-SNP may be moved into the other new or renewing D-SNP offered by the same Medicare Advantage organization if they meet the eligibility criteria for that D-SNP and CMS determines it is in the best interest of the enrollees to move to the new or renewing D-SNP to promote access to and continuity of care for enrollees relative to the absence of a crosswalk exception. For this crosswalk exception, CMS does not permit enrollees to be moved between different contracts.
- A Medicare Advantage organization creates a new Medicare Advantage contract when required by a State Medicaid agency to operate D-SNPs within a D-SNP only contract. In this circumstance, enrollees may be moved from the existing D-SNP that is non-renewing, reducing its service area, or has its eligible population newly restricted by the State, to a D-SNP offered under the D-SNP-only contract, which must be of the same plan type operated by the same parent organization. CMS permits enrollees to be moved between different contracts for this crosswalk exception.

Additionally, beginning in contract year 2027, CMS will permit crosswalks when one or more Medicare Advantage organizations that share a parent organization seek to consolidate D-SNPs in the same service area down to a single D-SNP under one Medicare Advantage contract to comply with requirements at 42 CFR §§422.514(h) and 422.504(a)(20). CMS will permit enrollees to be moved between different contracts for this exception.[12]

**Deductible:** A deductible is the amount a health plan enrollee must pay before the plan pays.

**Default Enrollment:** Default enrollment is a process that allows approved Medicare Advantage organizations (MAOs) to enroll—unless the member chooses otherwise—a member of an affiliated Medicaid managed care organization into the MAO's dual eligible special needs plan (D-SNP) when that member becomes eligible for Medicare. Prior to conducting default enrollment, MAOs must meet the requirements described at 42 CFR §422.66(c)(2) and receive approval from both the Centers for Medicare & Medicaid Services (CMS) and the state Medicaid agency for the state in which the D-SNP operates. Default enrollment is only permissible when the member will remain enrolled with the Medicaid managed care organization after becoming eligible for Medicare. The only default enrollment effective date possible is the date an individual is initially eligible for Medicare (that is, has Medicare Parts A and B for the first time).[13]

**Dual Eligible Special Needs Plans (D-SNPs):** Dual eligible special needs plans (D-SNPs) are Medicare Advantage plans that only enroll, and are specifically designed to serve, dually eligible individuals.[14] To operate in a state, a D-SNP must at least coordinate the delivery of Medicare and Medicaid services

and hold a contract with the state Medicaid agency that meets the minimum requirements outlined in 42 CFR 422.107(c)-(d).[15]

D-SNPs must also (1) use approved Models of Care to describe how they will meet the needs of their dually eligible enrollees,[16] (2) conduct comprehensive health risk assessments that includes questions to screen for housing, food security, and transportation needs,[17] and (3) use enrollee advisory committees to obtain enrollee feedback on designated topics.[18]

**Dually Eligible Individuals:** Dually eligible individuals are eligible for both Medicare and Medicaid. To be considered dually eligible, individuals must be: (1) eligible for Medicare Part A and/or Part B; and (2) receiving full Medicaid benefits and/or Medicare Savings Program assistance.[19] Dually eligible individuals may be designated as Full-Benefit Dually Eligible Individuals or Partial-Benefit Dually Eligible Individuals depending on whether they qualify for full Medicaid benefits or for Medicare Savings Program assistance only.[20]

**Durable Medical Equipment (DME):** Durable medical equipment (DME) are medical devices intended for repeated use and designed to support individuals with disabilities, injuries, and/or chronic health conditions. DME includes, but is not limited to, ventilators, oxygen equipment, wheelchairs, hospital beds, prosthetics, some medical supplies, and crutches. Both Medicare and Medicaid cover DME, but coverage under each program varies. Medicaid covers most DME under the mandatory home health benefit category and covers prosthetics separately as an optional benefit. This benefit is often referred to as Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS).[21,22]

**D-SNP-Only Contract:** A D-SNP-only contract occurs when a state uses its state Medicaid agency contract (SMAC) to require that dual eligible special needs plans (D-SNPs) with exclusively aligned enrollment (a) establish contracts with the Centers for Medicare & Medicaid Services (CMS) that only include one or more D-SNPs within a state, and (b) use versions of certain materials that integrate Medicare and Medicaid content (including, at a minimum, the Summary of Benefits, List of Covered Drugs/Formulary, and combined Provider and Pharmacy Directory).[23]

Because CMS and affected Medicare Advantage organizations must take certain steps to establish D-SNP-only contracts, a state that wishes to implement such contracts should formally notify CMS of the state's interest to require D-SNP-only contracts by August 15th of the year that is two years prior to the state's planned implementation.[24]

## Key Terms: E-G

**Evidence of Coverage:** The evidence of coverage (EOC) is a standardized communication material provided by a Medicare Advantage organization to its enrollees that contains information about the beneficiary's Medicare Advantage plan concerning the plan's:

- Service area;
- Benefits offered under the plan, including premiums, cost sharing, and any other conditions associated with receipt or use of benefits;

- Provider network and out-of-area coverage provided under the plan;
- Emergency coverage;
- Supplemental benefits;
- Prior authorization and review rules;
- Grievance and appeal procedures;
- Quality improvement program;
- Disenrollment rights and responsibilities; and
- Catastrophic caps and single deductible.

The EOC must be provided to current enrollees by October 15, prior to the year that the EOC applies and to new enrollees within 10 calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever is later.[25]

**Exclusively Aligned Enrollment:** Exclusively aligned enrollment occurs when a state's contract with a dual eligible special needs plan (D-SNP) limits D-SNP enrollment to only full-benefit dually eligible individuals and state policy limits D-SNP enrollment only to those with aligned enrollment. This includes those who receive their Medicaid benefits from the D-SNP or from an affiliated Medicaid managed care plan offered by the same parent organization as the D-SNP.[26,27]

**Financial Alignment Initiative:** The Financial Alignment Initiative (which ends on December 31, 2025) was designed to provide full-benefit dually eligible individuals with a better care experience and to better align the financial incentives of the Medicare and Medicaid programs. In demonstrations through this initiative, the Centers for Medicare & Medicaid Services (CMS) has worked with states to test two models to integrate primary, acute, behavioral health, and long-term services and supports for dually eligible individuals and better align the financing of the Medicare and Medicaid programs:

- **Capitated model:** A state, CMS, and health plans (known as "Medicare-Medicaid Plans," or "MMPs") enter into a three-way contract, and the plans receive a prospective, blended payment to provide comprehensive, coordinated Medicare and Medicaid benefits to their enrollees.
- **Managed fee-for-service model:** A state and CMS enter into an agreement through which the state is eligible to benefit from savings resulting from initiatives designed to improve quality of care for dually eligible individuals and reduce costs for both Medicare and Medicaid.[28]
- **Minnesota Administrative Alignment Demonstration:** A partnership between CMS and Minnesota to test new ways of improving care for dually eligible individuals. Building on the state's Minnesota Senior Health Options (MSHO) program, CMS and Minnesota have worked together to improve the beneficiary experience in health plans that maintain contracts with both CMS and the state to deliver integrated Medicare and Medicaid benefits.[29]

**Full-Benefit Dually Eligible (FBDE) Individuals:** Full-benefit dually eligible (FBDE) individuals are eligible for Medicare and are also categorically eligible for full (comprehensive) Medicaid benefits. FBDE individuals include individuals who have Qualified Medicare Beneficiary (QMB) benefits (known as "QMB+" individuals), individuals who have Specified Low-Income Medicare Beneficiary (SLMB) benefits (known as "SLMB+" individuals), and individuals who have full Medicaid benefits, but no Medicare Savings Program benefits (known as "other FBDE" individuals).[30]

**Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs):** Fully integrated dual eligible special needs plans (FIDE SNPs) are Medicare Advantage dual eligible special needs plans (D-SNPs) that provide full-benefit dually eligible individuals access to Medicare and Medicaid benefits under a single legal entity that holds both: (1) a Medicare Advantage contract with the Centers for Medicare & Medicaid Services (CMS) and (2) a Medicaid managed care contract with the state Medicaid agency that meets the requirements of a managed care organization as defined in section 1903(m) of the Social Security Act.

FIDE SNPs have capitated contracts with the state Medicaid agency(ies) in the state(s) in which they operate. FIDE SNPs must:

- Provide coverage of several types of Medicaid benefits (primary and acute care; Medicare cost sharing; behavioral health services; home health services; medical supplies, equipment, and appliances; and long-term services and supports, including coverage of nursing facility services for a period of at least 180 days during the plan year) under a single entity that holds both a Medicare Advantage contract with CMS and a Medicaid managed care organization contract (as defined in section 1903(m) of the Social Security Act) with the applicable State;[31]
- Hold a capitated Medicaid managed care contract with the applicable state Medicaid agency that covers the entire service area of the dual eligible special needs plan (D-SNP);[32]
- Operate with exclusively aligned enrollment;
- Coordinate the delivery of Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries;[33] and
- Employ policies and procedures approved by CMS and the state to coordinate or integrate beneficiary communication materials, enrollment, communications, grievances and appeals, and quality improvement.[34]

**Grievances:** In Medicaid, a grievance is an expression of dissatisfaction with any matter other than an adverse benefit determination. Grievances may include, but are not limited to, complaints about the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect an enrollee's rights, regardless of whether remedial action is requested.[35]

In Medicare, a grievance is any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of a Medicare Advantage organization's provider's operations, activities, or behavior, regardless of whether remedial action is requested.[36]

# Key Terms: H-L

**Health Maintenance Organization (HMO):** A health maintenance organization (HMO) is a type of Medicare Advantage plan that contracts with medical providers to create a network of participating providers and restricts the providers from which an enrollee can receive non-urgent/emergent covered services to the providers that are within that network. HMOs furnish only in-network services.[37,38]

**Health Maintenance Organization Point of Service (HMOPOS) Benefit Option:** A health maintenance organization (HMO) may offer a point of service (POS) benefit option (HMOPOS) to ease restrictions on access to out-of-network providers. An HMOPOS allows enrollees the option of receiving specified services outside of the plan's provider network. Medicare Advantage plans offering HMOPOS options may apply higher cost sharing for services received from out-of-network providers, limit out-of-network coverage to specific services, and limit the dollar amount of coverage provided. The HMOPOS option may be offered as either a mandatory or optional supplemental benefit.[39]

**Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs):** Highly integrated dual eligible special needs plans (HIDE SNPs) are Medicare Advantage dual eligible special needs plans (D-SNPs) that provide coverage of Medicaid benefits under a capitated contract between the State Medicaid agency and:

- The Medicare Advantage organization; or
- The Medicare Advantage organization's parent organization.

The capitated contract with the state Medicaid agency must cover the entire service area of the D-SNP and include coverage for:

- Long-term services and supports (including community-based long-term services and supports and some days of coverage of nursing facility services during the plan year); and/or
- Behavioral health services.[40]

**Home and Community Based Services (HCBS):** Home and community based services (HCBS) are long-term services and supports that Medicaid beneficiaries may receive while remaining in their homes or communities (instead of moving into a nursing facility or other institutional setting). HCBS programs are generally geared toward older adults and people with physical disabilities, intellectual or developmental disabilities, mental illness and/or substance use disorders.[41] Covered services can include respite care, home health aides, adult day services, case management, and personal care services.

**Long-Term Services and Supports (LTSS):** Long-term services and supports (LTSS) include a broad range of paid and unpaid medical and personal care services that people need—for several weeks, months, or years—when they have trouble with self-care tasks as a result of aging, chronic illness, or disability. LTSS provide assistance with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping). LTSS can be provided in the home, in community-based settings, or in facilities; and

can include such services as nursing facility care, adult day care programs, home health aide services, personal care services, and supported employment, as well as assistance provided by a family caregiver.[42] Medicaid is the primary payer of LTSS in the United States.[43]

## Key Terms: M

**Managed Long-Term Services and Supports (MLTSS):** Managed long-term services and supports (MLTSS) is the delivery of long-term services and supports (LTSS) through capitated Medicaid managed care programs. In Medicaid MLTSS programs, states contract with managed care plans and pay them a fixed monthly rate per member to provide a broad array of LTSS to Medicaid recipients who need assistance to perform activities of daily living and instrumental activities of daily living.[44]

**Maximum Out of Pocket (MOOP) Limit:** Each Medicare Advantage plan must have an enrollee in-network maximum out-of-pocket (MOOP) limit for basic benefits that can be no greater than a limit set annually by the Centers for Medicare & Medicaid Services (CMS). For Medicare Advantage plans that include coverage for services provided by out-of-network providers, CMS also annually sets a MOOP limit for in-network-services and out-of-network services combined. Medicare Advantage organizations are responsible for tracking out-of-pocket spending accrued by an enrollee and must alert enrollees and contracted providers when the plan's in-network MOOP limit or combined MOOP limit is reached.[45]

**Medicaid:** Medicaid is a state-operated health insurance program partially funded by the federal government. All states must abide by certain federal guidelines and regulations, but each state operates its own Medicaid program in its own way. Medicaid provides coverage to eligible low-income adults, children, pregnant women, parents, older adults, and individuals with disabilities. Eligibility requirements vary by state (in other words, income and resource requirements may be different in different states), and states may have different Medicaid program names.

**Medicaid Managed Care Programs:** Medicaid managed care programs are health care delivery systems operated by states as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act. These programs are organized to manage cost, utilization, and quality of care and provide for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care plans that accept a set per-member per-month (capitation) payment for these services.[46,47]

**Medicare:** Medicare is a health insurance program for people who: (1) are age 65 and older; (2) are younger than age 65 and have disabilities; or (3) have end-stage renal disease at any age. The original Medicare program has three parts:

- Part A, which provides hospital insurance (coverage for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care);
- Part B, which provides medical insurance (coverage for certain doctors' services, outpatient care, medical supplies, and preventive services); and
- Part D, which provides prescription drug insurance.

**Medicare Advantage (MA) Local Plan:** A Medicare Advantage local plan is a Medicare Advantage plan that is not a Medicare Advantage regional plan.[48]

**Medicare Advantage Organization:** A Medicare Advantage organization is a public or private entity that is (1) organized and licensed by a state as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) and (2) certified by the Centers for Medicare & Medicaid Services (CMS) as meeting the Medicare Advantage contract requirements.[49,50]

**Medicare Advantage Plans**: Medicare Advantage plans (also called "Part C" plans) are Medicare-approved managed care plans offered by private companies that provide Medicare Part A and B benefits—and often Medicare Part D benefits—through a single benefit package. Medicare Advantage plans may also offer supplemental benefits that are not covered by Original Medicare, such as routine vision services, routine dental services, hearing exams, chiropractic services, telemedicine services, and wellness programs, among others. Medicare Advantage plans must cover all Medicare benefits except hospice (which is covered by Original Medicare for Medicare Advantage plan enrollees), but these plans may have different out of pocket costs than Original Medicare, may require enrollees to follow provider network requirements, and may implement restrictions to manage utilization, such as prior authorization or step therapy.[51]

**Medicare Advantage Regional Plan:** A Medicare Advantage regional plan is a coordinated care plan structured as a preferred provider organization (PPO) that serves one or more entire regions. A Medicare Advantage regional plan must have a network of contracting providers that have agreed to a specific reimbursement for the plan's covered services and must pay for all covered services whether provided in or out of the network.[52]

**Medicare Savings Programs (MSPs):** Medicare Savings Programs (MSPs) are Medicaid programs that assist beneficiaries in paying Medicare premiums and/or cost-sharing. These programs do not provide full (comprehensive) Medicaid benefits. However, MSP enrollees may also qualify for full Medicaid benefits. Individuals who qualify for both MSP benefits and full Medicaid benefits are Full-Benefit Dually Eligible Individuals. The four MSPs are the Qualified Medicare Beneficiary (QMB) Program, the Specified Low-Income Medicare Beneficiary (SLMB) Program, the Qualifying Individual (QI) Program, and the Qualified Disabled Working Individual (QDWI) Program.[53]

**Medicare-Medicaid Coordination Office (MMCO):** The Medicare-Medicaid Coordination Office, formally known as the Federal Coordinated Health Care Office, is a division of the Centers for Medicare & Medicaid Services (CMS) that works with the Medicare and Medicaid programs, federal agencies, states, and stakeholders to better coordinate care for dually eligible individuals.[54]

**Model of Care (MOC):** A Model of Care (MOC) is a Special Needs Plan (SNP)'s description of its enrollees' unique characteristics and needs, the plan's care coordination and management processes; health risk assessment processes; individualized care plan, interdisciplinary team, and care transition protocols; and other topics. Every SNP is required to have a Model of Care approved by the National Committee for Quality Assurance (NCQA).[55]

# Key Terms: N-P

**Nursing Facility:** A nursing facility may provide one or more of three types of services: (1) skilled nursing or medical care and related services, (2) rehabilitation needed due to injury, disability, or illness, and/or (3) long term services and supports, which are services needed on an ongoing basis because of an individual's mental, physical, and/or functional condition.

Medicare only covers skilled nursing and rehabilitative services provided in nursing facilities; Medicare does not cover nursing facility care for long term services and supports. Medicaid nursing facility coverage is available only when other payment options are unavailable and the individual is eligible for the Medicaid program.[56] Medicaid covers long-term services and supports in nursing facilities when a Medicaid beneficiary qualifies for such services. Nursing facilities must obtain Medicaid certification to provide Medicaid-covered services. Similarly, to receive Medicare payment, a nursing facility must be certified as a Medicare skilled nursing facility.

**Parent Organization:** A parent organization is the legal entity that exercises a controlling interest (through the ownership of shares, the power to appoint voting board members, or other means) in a Part D sponsor or Medicare Advantage Organization, directly or through a subsidiary or subsidiaries, and which is not itself a subsidiary of any other legal entity.[57]

**Partial-Benefit Dually Eligible Individuals:** Partial-benefit dually eligible individuals receive Medicare and benefits through one of the following Medicare Savings Programs: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), or Qualified Disabled Working Individual (QDWI).

These individuals do not receive full (comprehensive) Medicaid benefits. They are known as "QMB only," "SLMB only," "QI" or "QDWI" individuals, based on the Medicare Savings Program they are enrolled in.[58]

**Passive Enrollment:** Passive enrollment is a process through which beneficiaries are automatically enrolled in health plans, with the option to opt out. Rules for passive enrollment of beneficiaries into Medicaid managed care plans are described at 42 CFR §438.54.

In several states' Financial Alignment Initiative demonstrations, dually eligible individuals may be passively enrolled in a Medicare-Medicaid Plan and have the opportunity to opt-out at any time if they prefer another plan or coverage arrangement.[59]

States may also passively enroll dually eligible individuals into dual eligible special needs plans (D-SNPs) in certain circumstances.[60] Specifically, passive enrollment into a D-SNP is only used to "promote integrated care and continuity of care" for full-benefit dually eligible individuals who are enrolled in integrated D-SNPs whose contracts with the Centers for Medicare & Medicaid Services (CMS) and the state will be ending. To receive passive enrollments, a D-SNP must: (1) qualify as a Fully Integrated D-SNP (FIDE SNP) or a Highly Integrated D-SNP (HIDE SNP), (2) have "substantially similar provider and facility networks and Medicare- and Medicaid-covered benefits as the plan (or plans) from which the beneficiaries are passively enrolled," (3) have a Medicare quality rating of at least three stars (or be a low enrollment contract or a new Medicare Advantage plan as defined in 42 CFR

§422.252, (4) "not have any prohibition on new enrollment imposed by CMS," (5) "have limits on premiums and cost-sharing appropriate to" full-benefit dually eligible individuals, and (6) "have the operational capacity to passively enroll beneficiaries and agree to receive the enrollments." Beneficiary notice requirements, including the beneficiary's opportunity to opt-out of the passive enrollment, are described at 42 CFR §422.60(g)(4).[61]

**Plan Benefit Package (PBP):** A Medicare Advantage plan benefit package (PBP) is a specific set of health benefits offered at a uniform premium and uniform level of cost sharing to all eligible Medicare beneficiaries residing in a specified service area. PBPs are submitted by Medicare Advantage organizations and Medicare Part D plan sponsors to the Centers for Medicare & Medicaid Services (CMS) for benefit analysis, marketing, and beneficiary communication purposes.[62,63]

Medicare Advantage organizations may include multiple PBPs under a single contract.

**Preferred Provider Organization (PPO):** A preferred provider organization (PPO) is a type of Medicare Advantage plan that contracts with medical providers to create a network of participating providers but provides reimbursement for all covered benefits regardless of whether the benefits are provided within the plan's network of providers.[64] PPOs must furnish all services covered by traditional (fee-for-service) Medicare but may charge higher cost sharing for plan-covered services obtained out-of-network. PPO plans that offer an optional supplemental benefit must offer the same benefit in-network and out-of-network.[65]

**Program of All-Inclusive Care for the Elderly (PACE):** The Program of All-Inclusive Care for the Elderly (PACE) is an integrated care model that provides medical and long-term services and supports to individuals age 55 and older who meet the criteria for needing a nursing facility level of care, most of whom are dually eligible individuals. PACE services are provided by an interdisciplinary team of professionals that includes a primary care physician, nurse, social worker, physical therapist, and dietitian, among others.[66]

## Key Terms: Q-S

**Qualified Disabled Working Individual (QDWI) Program:** The Qualified Disabled Working Individual (QDWI) program covers Part A premiums for certain individuals with disabilities who have lost access to premium-free Medicare Part A after returning to work. To qualify for QDWI benefits, beneficiaries must meet specific income and asset criteria.[67]

**Qualified Medicare Beneficiary (QMB) Program:** The Qualified Medicare Beneficiary (QMB) program covers Medicare Part A and Part B premiums and cost-sharing (deductibles, co-insurance, and co-payments). To qualify for QMB benefits, an individual must (1) be entitled to premium-free Medicare Part A, entitled to premium Part A for individuals age 65 and over, or, enrolled in Part B coverage of immunosuppressive drugs;[68] and (2) meet specific income and asset criteria. The federal government sets a "floor" for QMB income and asset eligibility criteria, but states can choose to use criteria that are more generous, including eliminating the asset limit.[69]

People with QMB benefits who also qualify for full Medicaid benefits are known as "QMB+" individuals and are considered full-benefit dually eligible individuals. People with QMB benefits who do not qualify for full Medicaid benefits are known as "QMB only" individuals and are considered partial-benefit dually eligible individuals.

**Qualifying Individual (QI) Program:** The Qualifying Individual (QI) program covers Medicare Part B premiums. To qualify for QI benefits, an individual must (1) not qualify for full Medicaid benefits, (2) be enrolled in Medicare Part A, (3) meet specific income and asset requirements, and (4) reapply annually. The federal government sets a "floor" for QI income and asset eligibility criteria, but states can choose to use criteria that are more generous, including eliminating the asset limit.[70]

States receive a designated annual allotment to pay QI benefits, and benefits are granted on a first-come, first-served basis, with priority given to people who received QI benefits the previous year.[71]

**Segment:** A segment is a specific geographic area or market segment within a plan benefit package (PBP), identified by a unique identifier. Segments consist of at least a full county in which benefits, premiums, cost sharing, and supplemental benefits are uniformly offered to all enrollees residing in that distinct portion of the PBP, and for which the Medicare Advantage plan bid submission information specified in §422.254 is separately submitted to CMS.[72] Within a single PBP with multiple segments, Medicare Advantage organizations may vary premiums, cost sharing, and benefits (including supplemental benefits) by segment.[73]

**Skilled Nursing Facility (SNF):** A skilled nursing facility (SNF) is a temporary residence that provides inpatient rehabilitation services, including those provided by nurses, speech pathologists, and occupational and physical therapists. Medicare covers skilled nursing care provided in a SNF only on a short-term basis (up to 100 days of care in a benefit period).[74]

**Special Needs Plans (SNPs):** Special needs plans (SNPs) – also referred to in federal statute and regulations as "specialized Medicare Advantage (MA) plans for special needs individuals" – are MA plans that only enroll, and are specifically designed to serve, individuals with certain designated needs or circumstances.[75] SNPs may be any type of MA plan, including a preferred provider organization (PPO) plan, a health maintenance organization (HMO) plan, or an HMO Point-of-Service (HMO-POS) plan.[76] There are three separate types of SNPs, each designed to serve enrollees with a different category of special needs.

- **Chronic condition SNPs (C-SNPs)** restrict enrollment to special needs individuals with specific severe or disabling chronic conditions.[77]
- **Dual Eligible SNPs (D-SNPs)** restrict enrollment to dually eligible individuals. A more complete definition of these plans can be found earlier in this document.
- **Institutional SNPs (I-SNPs)** restrict enrollment to Medicare Advantage eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility.[78]

**Specified Low-Income Beneficiary (SLMB) Program:** The Specified Low-Income Medicare Beneficiary (SLMB) program covers Medicare Part B premiums. To qualify for SLMB benefits, an individual must be enrolled in Medicare Part A and meet specific income and asset criteria. The federal government sets a "floor" for SLMB income and asset eligibility criteria, but states can choose to use criteria that are more generous, including eliminating the asset limit.[79]

People with SLMB benefits who also qualify for full Medicaid benefits are known as "SLMB+" individuals and are considered Full Benefit Dually Eligible Individuals. States may choose to cover Medicare cost sharing for SLMB+ individuals under their Medicaid state plan.[80] People with SLMB benefits who do not qualify for full Medicaid benefits are known as "SLMB only" individuals and are considered Partial Benefit Dually Eligible Individuals.

**State Medicaid Agency Contract (SMAC):** State Medicaid Agency Contracts (SMACs) are contracts between Medicare Advantage Organizations that offer dual eligible special needs plans (D-SNPs) and the states where the D-SNPs operate. These contracts must describe how the D-SNP will facilitate coordination of Medicare and Medicaid services for their enrollees and meet other minimum requirements outlined in 42 CFR 422.107(c)-(d).[81] SMACs are often referred to as "MIPPA" contracts, since they were originally required by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.[82] D-SNPs must enter into a SMAC with the state Medicaid agency in order to operate in that state, but states can choose whether to enter into such contracts with D-SNPs.[83]

As of 2021, SMACs must include eight minimum elements specified by MIPPA, as well as new elements required by the Bipartisan Budget Act (BBA) of 2018 to increase the level of Medicare and Medicaid coordination provided.[84]

**Summary of Benefits (SB):** A summary of benefits (SB) is a model marketing material for prospective Medicare Advantage plan enrollees that contains a summary of highly utilized benefits and associated cost sharing. The SB must be provided with an enrollment form and must include certain required information concerning a Medicare Advantage plan's covered medical benefits, premium, deductible, out-of-pocket limits, and prescription drug expenses.[85]

There are additional requirements for SBs for dual eligible special needs plans (D-SNPs), and those requirements vary by the type of D-SNP.

- All D-SNP SBs must identify or describe the relevant Medicaid benefits for prospective enrollees.
- SBs for D-SNPs that enroll dually eligible individuals with differing levels of cost sharing must state how cost sharing and benefits differ depending on the prospective enrollee's level of Medicaid eligibility, and describe the Medicaid benefits, if any, provided by the plan.
- D-SNPs that qualify as Applicable Integrated Plans (AIPs) have the option to display information about Medicare and Medicaid benefits in an integrated version of the SB.[86]

**Supplemental Benefits:** Supplemental Benefits are primarily health related benefits not covered by traditional fee-for-service Medicare that a Medicare Advantage organization chooses to offer as part of a Medicare Advantage plan benefit package (PBP). The Medicare Advantage organization must

incur a non-zero direct medical cost in providing the benefit. These benefits must be used directly by plan enrollees and must be directly related to enrollees' individual health care needs. A Medicare Advantage plan may offer two types of supplemental benefits: mandatory or optional.[87]

- **Mandatory supplemental benefits** are services that are made available to all of a Medicare Advantage plan's enrollees in addition to Medicare-covered services. CMS approves mandatory benefits if the benefits are designed in accordance with CMS guidelines and requirements. Mandatory supplemental benefits are provided by the Medicare Advantage plan either at no cost to the enrollee or as part of the plan premium paid by the enrollee.
- **Optional supplemental benefits** are services that a Medicare Advantage organization may offer its enrollees that are not included in the basic benefits or any mandatory supplemental benefits. If offered at all, optional supplemental benefits must be offered to all enrollees in the applicable Medicare Advantage plan. Optional supplemental benefits may be purchased at the election of enrollees.

With approval from CMS, fully and highly integrated dual eligible special needs plans (FIDE SNPs and HIDE SNPs) that meet minimum performance and quality-based standards may also offer additional supplemental benefits if CMS finds that the offering of such benefits could better integrate care for the dually eligible population. These additional supplemental benefits must comply with all of the rules for supplemental benefits at 42 CFR §422.102, as well as specialized rules at 42 CFR §422.102(e).

In addition, Medicare Advantage plans may offer Special Supplemental Benefits for the Chronically Ill (SSBCI).[88] SSBCI includes supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill enrollees. The benefits must meet the legal threshold of having a reasonable expectation of improving or maintaining the health or overall function of chronically ill enrollees and otherwise meet requirements described at 42 CFR §422.102(f).[89] A "chronically ill" enrollee is one who has one or more comorbid and medically complex chronic conditions that meet all of the following: (1) is life threatening or significantly limits the overall health or function of the enrollee; (2) has a high risk of hospitalization or other adverse health outcomes; and (3) requires intensive care coordination.[90]

## About ICRC

### ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the Integrated Care Resource Center are coordinated by Mathematica and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

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[3] 42 CFR § 422.2267

[4] 42 CFR §438.400(b)

[5] CFR §422.561

[6] 42 CFR §422.566(b)

[7] 42 CFR §422.561

[8] 42 CFR §422.107(c)(9)

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[11] 42 CFR §422.2

[12] 42 CFR §422.530

[13] 42 CFR §422.66(c)(2)

[14] 42 CFR §422.2, Section 1859(b)(6)(B)(ii) of the Social Security Act

[15] Sections 1859(f)(3)(D) and 1859(f)(8) of the Social Security Act

[16] 42 CFR §422.101(f)

[17] 42 CFR §422.101(f)(1)(i)

[18] 42 CFR §422.107(f)

[19] CMS Medicare Learning Network (MLN). "Beneficiaries Dually Eligible for Medicare and Medicaid." Baltimore, MD: CMS, June 2024. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

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[21] 42 CFR §410.38

[22] CMS. "CMCS Informational Bulletin: Strategies to Support Dually Eligible Individuals' Access to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." Baltimore, MD. Jan 4, 2019. https://www.medicaid.gov/federal-policy-guidance/downloads/cib010419.pdf

[23] 42 CFR §422.107(e)

[24] CMS. "Guidance for States Seeking to Leverage New Opportunities for Integrated Care Programs." CMS Medicare-Medicaid Coordination Office Letter to State Medicaid Agencies, August 25, 2022, https://www.cms.gov/files/document/stateoppsintegratedcareprogs.pdf

[25] 42 CFR §422.2267(e)(1)

[26] 42 CFR §422.2

[27] For more information about exclusively aligned enrollment, see ICRC's resources at https://integratedcareresourcecenter.com/resources-by-topic/exclusively-aligned-enrollment

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[31] 42 CFR §422.2; permissible carve-outs for coverage of behavioral health and long-term services and supports described at 42 CFR §422.107(g)-(h)

[32] 42 CFR §422.2

[33] 42 CFR §422.2

[34] 42 CFR §422.2

[35] 42 CFR §438.400

[36] 42 CFR §422.561

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[46] 42 CFR §438.2

[47] Centers for Medicare & Medicaid Services (CMS). "Managed Care." Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. https://www.medicaid.gov/medicaid/managed-care/index.html

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[81] Sections 1859(f)(3)(D) and 1859(f)(8) of the Social Security Act

[82] Public Law (P.L.) 110-275

[83] Section 164(c)(4) of P.L. 110-275. (Note that the numbering of sub-section (c) of section 164 of P.L. 110-275 appears to contain an error, as the numbering counts from 1-4, then re-starts with number 2 again. This reference is to the second use of number (4) within sub-section 164(c) of P.L. 110-275, which states *"NO REQUIREMENT FOR CONTRACT.—Nothing in the provisions of, or amendments made by, this subsection shall require a State to enter into a contract with a Medicare Advantage organization with respect to a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(B)(ii)), as amended by this section."*

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[85] 42 CFR §422.2267(e)(5)

[86] 42 CFR §422.2267(e)(5)(ii)(D)-(F)

[87] 42 CFR §422.102

[88] 42 CFR §422.102(f)

[89] Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024—Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE), 89 Fed. Reg. 30450 (April 23, 2024) (amending 42 CFR § 422.101(f)). https://www.federalregister.gov/d/2024-07105/p-33

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