Glossary of Terms Related to Integrated Care for Dually Eligible Individuals

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 aligned. In general, in "integrated care" systems, Medicare and Medicaid services are coordinated and 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.

Basic Programs and Services for Dually Eligible Individuals

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, hospital insurance (e.g., inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care); Part B, medical insurance (e.g., certain doctors' services, outpatient care, medical supplies, and preventive services); and Part D, prescription drug insurance.
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, elderly adults, and individuals with disabilities, although eligibility requirements vary depending on the state.
Medicaid Managed Care	Managed care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides 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.[1]
Medicare Advantage (MA) Plans	Medicare Advantage plans (also called "Part C" plans) are managed care plans 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, but may have different cost-sharing 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.[2]

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.[3]
Appeals	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[4] include denial of a service, denial of payment for a service, a failure to provide a service or to provide a service in a timely manner,[5] and other circumstances.[6] In Medicare, an appeal includes any of the procedures that deal with the review of adverse organization determinations made by an organization on the health care services an enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services, or disputes on any amounts the enrollee must pay for a service.[7,8]
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.[9] In Medicare, a grievance is any complaint or dispute expressing dissatisfaction with any aspect of a Medicare Advantage organization's provider's operations, activities, or behavior, regardless of whether remedial action is requested.[10]
Durable Medical Equipment (DME)	Durable medical equipment is an item of repeatedly used medical equipment designed to support a better quality of life. 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). [11, 12]
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.[13]
Skilled Nursing Facility (SNF)	A skilled nursing facility 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).[14]
Nursing Facility (NF)	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, or (3) long term services and supports, 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 NF services are available only when other payment options are unavailable, and the individual is eligible for the Medicaid program.[15] Nursing facilities must obtain Medicaid certification to provide these services, and may also be certified as Medicare skilled nursing facilities.

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/or people with physical disabilities, intellectual or developmental disabilities, and/or mental illness.[16] 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 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;[17] and can include such services as nursing facility care, adult day care programs, home health aide services, personal care services, transportation, and supported employment, as well as assistance provided by a family caregiver.[18] Medicaid is the primary payer of LTSS in the United States.[19]
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: • Deductible: Amount the enrollee must pay before the plan pays. • Coinsurance: A fixed percentage of the total amount paid for a health care service that can be charged to an enrollee on a per-service basis. • Copayment: A fixed dollar amount that can be charged to a plan enrollee on a per-service basis.[20] Medicaid covers Medicare cost sharing for Qualified Medicare Beneficiaries (QMBs) and other Full Benefit Dual Eligible Individuals (FBDE individuals).

Dually Eligible Individuals

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.[21] Dually eligible individuals may be designated as Full Benefit Dually Eligible Individuals or Partial Benefit Dually Eligible Individuals depending on the Medicare Savings Program for which they qualify.[22]
Medicare Savings Programs (MSPs)	Medicare Savings Programs are Medicaid programs that assist beneficiaries in paying Medicare premiums and/or cost-sharing, but that do not provide full (comprehensive) Medicaid benefits. (However, Medicare Savings Program enrollees may also qualify for full Medicaid benefits. Individuals who qualify for both Medicare Savings Program 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.[23]
Qualified Medicare Beneficiary (QMB) Program	Qualified Medicare Beneficiaries receive coverage for Medicare Part A and Part B premiums and cost-sharing (deductibles, co-insurance, and co-payments). To qualify as a QMB, an individual must be enrolled in Medicare Part A (or have filed a conditional application for Part A coverage) and meet specific income and asset criteria. The federal government sets a "floor" for these criteria, but states can choose to implement criteria that are more generous than the federal ones.[24] QMBs who also qualify for full Medicaid benefits are known as QMB+ and are considered Full Benefit Dually Eligible Individuals.
Specified Low-Income Medicare Beneficiary (SLMB) Program	Specified Low-Income Medicare Beneficiaries receive coverage for Medicare Part B premiums only through the SLMB program. To qualify for SLMB benefits, beneficiaries must be enrolled in Medicare Part A and meet specific income and asset criteria. The federal government sets a "floor" for these criteria, but states can choose to implement criteria that are more generous than the federal ones.[25] SLMBs who also qualify for full Medicaid benefits are known as SLMB+, and are considered Full Benefit Dually Eligible Individuals. States may choose to cover Medicare cost sharing for SLMB+ under their Medicaid state plan.[26]
Qualifying Individual (QI) Program	Qualifying Individuals receive coverage for Medicare Part B premiums only. To qualify for QI benefits, beneficiaries must not qualify for full Medicaid benefits, must be enrolled in Medicare Part A and meet specific income and asset requirements, and must reapply annually. States receive a designated annual allotment to pay QI benefits, and beneficiary applications are granted on a first-come, first-served basis, with priority given to people who got QI benefits the previous year. As with QMB and SLMB benefits, the federal government sets a "floor" for these criteria, but states can choose to implement criteria that are more generous than the federal ones.[27]
Qualified Disabled Working Individual (QDWI) Program	Qualified Disabled Working Individuals receive coverage for Part A premiums. The QDWI program covers certain beneficiaries with disabilities who have lost access to premium-free Part A because they returned to work. To qualify for QDWI benefits, beneficiaries must meet specific income and asset criteria.[28]
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 QMB benefits and full Medicaid benefits (known as "QMB+"), individuals who have SLMB benefits and full Medicaid benefits (known as "SLMB+"), and individuals who have full Medicaid benefits, but no Medicare Savings Program benefits (known as "other FBDE individuals").[29]

Partial Benefit Dually Eligible Individuals	Partial Benefit Dually Eligible individuals are enrolled in Medicare Part A and/or B and MSP benefits, but do not receive full (comprehensive) Medicaid benefits. They are known as "QMB only," "SLMB only," "QI" or "QDWI" beneficiaries, based on the Medicare Savings Program they are enrolled in.[30]

Medicare and Medicaid Integrated Care

Dual Eligible Special Needs Plans (D-SNPs)	Dual Eligible Special Needs Plans are Medicare Advantage plans that only enroll, and are specifically designed to serve, dually eligible individuals.[31] To operate in a state, a D-SNP must:
	• Coordinate the delivery of Medicare and Medicaid services;
	• May provide coverage of Medicaid services, including long-term services and supports and behavioral health services;
	• hold a contract with the state Medicaid agency that meets certain minimum requirements as outlined in 42 CFR 422.107,[32]
	• D-SNPs must either:
	  ○ Meet the additional requirement of notifying, or arranging another entity(ies) to notify, the state Medicaid agency, individuals, or entities designated by the state Medicaid agency, or both, of hospital and skilled nursing admissions for at least one group of high-risk FBDE individuals, identified by the state Medicaid agency. The state Medicaid agency must establish the timeline(s) and method(s) by which notice is provided, and the D-SNP must retain responsibility for complying with the requirement;[33]
	  ○ Meet the requirements of a HIDE SNP; or
	  ○ Meet the requirements of a FIDE SNP. [34]

State Medicaid Agency Contract (SMAC)	State Medicaid Agency Contracts (SMACs) are contracts between Medicare Advantage Organizations that offer D-SNPs and the state Medicaid agencies in 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. 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. 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.[35] 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.[36]
Model of Care (MOC)	A Model of Care (MOC) is a D-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 D-SNP is required to have a Model of Care approved by the National Committee for Quality Assurance (NCQA).[37]
Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)	Fully Integrated Dual Eligible Special Needs Plans are Medicare Advantage plans that provide 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) 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 primary care, acute care, and long-term services and supports (including coverage of nursing facility services for a period of at least 180 days during the plan year), [38] with permissible carve outs of behavioral health services and limited carve-outs of long-term services and supports consistent with state policy;[39] and

	• coordinate the delivery of Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries, 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. Starting in 2025, FIDE SNPs must also: • cover additional Medicaid benefits: Medicare cost sharing; behavioral health services; home health services; and medical supplies, equipment, and appliances, and • operate with exclusively aligned enrollment and hold a capitated contract with the State Medicaid Agency that covers the entire service area of the D-SNP. [40]
Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs)	Highly Integrated Dual Eligible Special Needs Plans are Medicare Advantage plans that provide coverage of Medicaid benefit under a capitated contract between the State Medicaid agency and: • The Medicare Advantage organization; or • The Medicare Advantage organization's parent organization (or an affiliated plan). HIDE SNPs must provide coverage of: • 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,[41] with allowable carve outs of behavioral health services and limited carve-outs of LTSS consistent with state policy.[42] Starting in 2025, a HIDE SNP's capitated contract with the state Medicaid agency must cover the entire service area of the D-SNP.[43]
Parent Organization	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 MA organization, directly or through a subsidiary or subsidiaries, and which is not itself a subsidiary of any other legal entity.[44]
Affiliated Plans	Affiliated plans (or entities) are 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. Regular (non-D-SNP) Medicare Advantage plans and Medicaid managed care plans owned by the same parent organization may be affiliated but are not considered integrated.[45]
Aligned Enrollment	Aligned enrollment occurs when a dually eligible individual is enrolled in a Medicare Advantage D-SNP for both Medicare and Medicaid benefits, or when a dually eligible individual is enrolled in a D-SNP and a Medicaid managed care plan offered by the same parent organization in the same geographic area (affiliated plans). When a beneficiary is enrolled in an affiliated plan, one entity is substantially responsible for all Medicare and Medicaid benefits, and therefore has a financial stake in ensuring that enrollees receive high quality, cost-effective care and avoid unnecessary hospitalization and institutionalization. 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 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.[46]

Exclusively Aligned Enrollment	Exclusively aligned enrollment occurs when the state's contract with the 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.[47]
Applicable Integrated Plans (AIPs)	Applicable Integrated Plans (AIP)s are: • FIDE SNPs or HIDE SNPs operating with exclusively aligned enrollment that cover (through the D-SNP or through an affiliated Medicaid managed care plan) Medicaid benefits for the D-SNP enrollees; or • CO-D-SNPs with exclusively aligned enrollment that cover (through the D-SNP or through the 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.[48] These plans must comply with integrated appeal and grievance processes required at 42 CFR §422.629 - §422.634, as well as conforming Medicaid managed care rules at 42 CFR §438.210, §438.400, and §438.402.[49]
Financial Alignment Initiative	The Financial Alignment Initiative and related work is designed to provide 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, CMS is working 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."[50] • **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 work together to improve the beneficiary experience in health plans that maintain contracts with both CMS and D-SNPs and with the state to deliver Medicaid services.[51]
Program of All-Inclusive Care for the Elderly (PACE)	The Program of All-Inclusive Care for the Elderly 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.[52]

Managed Long-Term Services and Supports (MLTSS)	Managed long-term services and supports is the delivery of LTSS through capitated Medicaid managed care programs. A growing number of states are implementing MLTSS programs, in which 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.[53,54]
Default Enrollment	Default enrollment is a process that allows a Medicare Advantage organization, following approval by the state and CMS, to enroll—unless the member chooses otherwise—a member of an affiliated Medicaid managed care organization into its Medicare Advantage D-SNP when that member becomes eligible for Medicare. This process is only permissible in circumstances in which 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 Advantage (that is, has Medicare Parts A and B for the first time).[55]
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.[56] States may also passively enroll dually eligible individuals into D-SNPs in certain circumstances. 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 CMS or the state will be ending. To receive passive enrollments, a D-SNP must: (1) qualify as a FIDE SNP or 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).[57]

[1] Centers for Medicare & Medicaid Services. "Managed Care." Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available at https://www.medicaid.gov/medicaid/managed-care/index.html.

[2] Centers for Medicare & Medicaid Services. "Medicare & You 2024". Baltimore, MD: Centers for Medicare & Medicaid Services, 2024. Available at https://www.medicare.gov/publications/10050-Medicare-and-You.pdf.

[3] Centers for Medicare & Medicaid Services. "About the Medicare-Medicaid Coordination Office." Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.

[4] 42 CFR 438.400(b)(1), "Statutory Basis, Definitions, and Applicability," as amended by 84 FR 15844; published April 16, 2019, effective January 1, 2021.

[5] Services obtained under any other provider outlined in 42 CFR 438.52(b)(2)(ii), "Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM Entities."

[6] 42 CFR 438.400, "Statutory Basis, Definitions, and Applicability," as amended by 84 FR 15844; published April 16, 2019, effective January 1, 2021.

[7] Defined under 42 CFR 422.566(b), "Organizations," as amended by 84 FR 15834; published April 16, 2019, effective January 1, 2021.

[8] 42 CFR 422.561, "Definitions," as amended by 84 FR 26579; published June 7, 2019, effective January 1, 2020.

[9] 42 CFR 438.400, "Statutory Basis, Definitions, and Applicability," as amended by 84 FR 15844 published April 16, 2019, effective January 1, 2021.

[10] 42 CFR 422.561, "Definitions," as amended by 84 FR 26579; published June 7, 2019, effective January 1, 2020.

[11] 42 CFR § 410.38, "Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS): Scope and conditions," as amended at 57 FR 57688, Nov 8, 2019.

[12] Centers for Medicare & Medicaid Services. "CMCS Informational Bulletin: Strategies to Support Dually Eligible Individuals' Access to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies." Baltimore, MD. Jan 4, 2019. Available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib010419.pdf.

[13] Integrated Care Resource Center. "Working with Medicare: Coordination of Medicare and Medicaid Behavioral Health Benefits." Washington, DC: Integrated Care Resource Center, 2019. Available at https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_WWM_BH_Benefits_10-09-18_FINAL_FOR%20508.pdf.

[14] Centers for Medicare & Medicaid Services. "Dual Skilled Nursing Facility (SNF) Care." Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available at https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care.

[15] Centers for Medicare & Medicaid Services. "Nursing Facilities." (2019) Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available at https://www.medicaid.gov/medicaid/ltss/institutional/nursing/index.html.

[16] Centers for Medicare & Medicaid Services. "Home & Community Based Services." Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available at https://www.medicaid.gov/medicaid/hcbs/index.html.

[17] Centers for Medicare & Medicaid Services. "LTSS Overview." Baltimore, MD: Centers for Medicare & Medicaid Services, 2016. Available at https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/ltss-overview.html.

[18]Kaiser Family Foundation. "Medicaid and Long-Term Services and Supports: A Primer." San Francisco, California: Kaiser Family Foundation, 2019. Available at https://www.kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

[19] Centers for Medicare & Medicaid Services. "Long Term Services & Supports." Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available at https://www.medicaid.gov/medicaid/ltss/index.html.

[20] 42 CFR § 422.2, "Definitions," as amended at 65 FR 40314; updated May 23, 2019.

[21] Centers for Medicare & Medicaid Services. "Dual Eligible Beneficiaries Under Medicare and Medicaid." Baltimore, MD: Centers for Medicare & Medicaid Services, 2018. Available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.

[22] For more details on the definitions of the categories of dually eligible individuals, see the MMCO definitions: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf.

[23] Centers for Medicare & Medicaid Services. "Medicare Savings Program." Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available at https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs#collapse-2624.

[24] Centers for Medicare & Medicaid Services. "Dually Eligible Individuals – Categories." Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf.

[25] Ibid.

[26] Centers for Medicare & Medicaid Services. "Dually Eligible Individuals – Categories." Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf.

[27] Ibid.

[28] Centers for Medicare & Medicaid Services. "Dual Eligible Beneficiaries Under Medicare and Medicaid." Baltimore, MD: Centers for Medicare & Medicaid Services, 2018. Available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.

[29] Centers for Medicare & Medicaid Services. "Dually Eligible Individuals – Categories." Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf.

[30] Centers for Medicare & Medicaid Services. "Medicare Savings Program." Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available at https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs#collapse-2624.

[31] Centers for Medicare & Medicaid Services. "Dual Eligible Special Needs Plans (D-SNPs)." Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available at https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/D-SNPs.html.

[32] 42 CFR 422.2. "Definitions," as amended by 84 FR 23879, effective May 23, 2019.

[33] 42 CFR 422.107(c) and (d). "Requirements for dual eligible special needs plans," as amended by 84 FR 26579, effective April 16, 2019.

[34] 42 CFR 422.2. "Definitions," as amended by 84 FR 23879, effective May 23, 2019.

[35] Integrated Care Resource Center. "State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options." Washington, DC: Integrated Care Resource Center, 2016. Available at https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_DSNP_Issues__Options.pdf.

[36] Centers for Medicare & Medicaid Services. "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021." *Federal Register*, vol. 84, no. 73, April 16, 2019. Available at https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

[37] Section 20.2, "Medicare Managed Care Manual Chapter 5 - Quality Assessment," Revised August 8, 2014. Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c05.pdf.

[38] 42 CFR 422.2. "Definitions," as amended by 87 FR 27893, effective June 28, 2022.

[39] 42 CFR 422.107(g) and (h). "Requirements for dual eligible special needs plans," as amended by 87 FR 27894, effective Jun. 28, 2022.

[40] 42 CFR 422.2. "Definitions," as amended by 87 FR 27893, effective June 28, 2022.

[41] Ibid.

[42] 42 CFR 422.107(g) and (h). "Requirements for dual eligible special needs plans," as amended by 87 FR 27894, effective Jun. 28, 2022.

[43] 42 CFR 422.2. "Definitions," as amended by 87 FR 27893, effective June 28, 2022.

[44] 42.CFR 422.2. "Definitions," as amended by 87 FR 278894, effective May 9, 2022.

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