DUAL-ELIGIBILE HEADQUARTERS

Strategic Business Development XTRAGLOBEX

NEW YORK

DUAL-ELIGIBLE HQ STATE REPORT

UPDATED APRIL 2025

New York's Dual-Eligible Program provides integrated healthcare coverage for individuals who qualify for both Medicare and Medicaid. Through the program, New York ensures coordinated care, including medical services, long-term supports, and prescription drug coverage for approximately 1 million full-benefit dual-eligible individuals.

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MEDICAID PROGRAM OVERVIEW

As of February 2025, New York's Medicaid program provides comprehensive health coverage to approximately 7 million New Yorkers, 58% of which reside in New York City. Statewide, just shy of 35% of the state is enrolled in Medicaid.

The program is for low-income persons whose income and/or resources are below certain levels. Eligible populations include children, pregnant women, single individuals, families and individuals certified blind or certified disabled.

Through Medicaid, consumers can obtain comprehensive benefits and services such as hospital care, physician services, preventative screenings, prescription drugs, as well as the delivery of long-term services to people who are chronically ill or disabled and who wish to stay in their homes and communities through the Managed Long-Term Care plan (MLTC).

Medicaid FFS

New York has been working to transition members over to managed care, but there are still some individuals who receive care through a Medicaid Fee-for-Service (FFS) system.

Available statewide, in the fee-for-service model, the State pays the provider directly for medical services.

Medicaid Managed Care

There are many different types of managed care plans in New York, with most managed care plans certified by the New York State Department of Health.

The different managed care programs are available statewide, but plans vary based on geographic location.

As of February 2025, there were 6,912,571 individuals enrolled in Medicaid. 4,932,631 of those individuals were enrolled in Managed Care.

STATE MEDICAID OVERVIEW

PROGRAM DIFFERENCES

New York offers a variety of managed care programs to provide coordinated care for Medicaid enrollees. The state pays the MCOs a capitated monthly rate (like a premium for each member), and the MCOs coordinate the health care needs for their members. There are three unique programs that cater to different target populations. These include:

MAINSTREAM MEDICAID MANAGED CARE (MMMC)

MMMC is the primary Medicaid delivery system for for most low-income children, parents, pregnant individuals, and adults without disabilities. Enrollees select from a range of state-contracted health plans that provide comprehensive services.

Target Population: This program is designed for those eligible for Medicaid under the Modified Adjusted Gross Income (MAGI) rules and typically includes children, pregnant individuals, low-income parents, and adults.

MANAGED LONG-TERM CARE (MLTC)

MLTC is a plan that streamlines the delivery of long-term services to people who are chronically ill or disabled and who wish to stay in their homes and communities. They help provide community based long-term services and supports (CBLTSS). Duals receive physical health services through FFS.

Target Population: MLTC is a managed care plan specifically designed for individuals who need over 120 days of HCBS like help with activities of daily living, nursing home care. Duals needing over 120 days of LTSS are required to enroll.

HEALTH & RECOVERY PLANS (HARP)

HARPs are specialized plans that serve individuals with significant behavioral health needs, such as SMI or SUD. HARPs provide Medicaid physical and behavioral health benefits, plus access to Behavioral Health Home and Community-Based Services (BH HCBS).

Target Population: HARPs are specifically designed for individuals 21 years of age or older with serious mental illness or substance use disorders. An individual must be eligible for Mainstream Medicaid managed care.

Enrollment as of February 2025

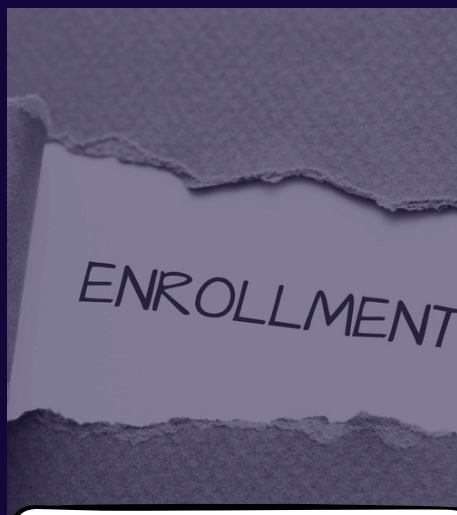
4,470,439	309,153	153,039

STATE MEDICAID OVERVIEW

ELIGIBILITY & PLAN AVAILABILITY

Eligibility for each program is as follows:

- **MMMC:** Must be a NYS resident and qualify under Modified Adjusted Gross Income (MAGI) rules linked to the federal poverty level (FPL), and not be in an exempt group.
- **MLTC:** Must be enrolled in Medicaid, be determined eligible by a Local Departments of Social Services (DSS), be determined eligible by the NY Independent Assessor Program using the Community Health Assessment, be able to live safely in the community, AND be expected to require at least one service covered by the plan for more than 120 days.
- **HARP:** Voluntary program, to be eligible an individual **m**ust be enrolled in MMMC, 21+ years, and meet the NYS behavioral health high-risk criteria.



Questions? Reach out!

HEALTH AND RECOVERY PLAN (12 HEALTH PLANS)
Capital District Physicians Health Plan, Fidelis Care, MVP Health Plan, United Healthcare, Highmark Western and Northeastern New York Inc., Molina Healthcare of New York, Excellus Health Plan, Anthem Blue Cross and Blue Shield, Independent Health Association, Healthfirst PHSP, HIP of Greater New York, MetroPlus Health Plan

These programs all have different MCOs that deliver services based on geographic region.

MANAGED LONG TERM CARE (14 HEALTH PLANS)
Aetna, Anthem Blue Cross and Blue Shield, Centers Plan, Elderplan, Elderserve, Fidelis Care, Hamaspik Choice, Healthfirst PHSP, iCircle Care, MetroPlus Health Plan, Senior Whole Health, Village Care, VNA Homecare Options, VNS Choice

MAINSTREAM MEDICAID MANAGED CARE (15 HEALTH PLANS)
Amida Care SN, Anthem Blue Cross and Blue Shield, Fidelis Care, Healthfirst PHSP, HIP of Greater New York, MetroPlus Health Plan, MetroPlus SN, Molina Healthcare of New York, United Healthcare, VNS Choice SNP, Capital District Physicians Health Plan, MVP Health Plan, Highmark Western and Northeastern New York Inc., Excellus Health Plan, Independent Health Association

DUAL-ELIGIBLE OVERVIEW

DUAL-ELIGIBLE PROGRAM OVERVIEW

QUICK FACTS

Design

New York delivers service to dual-eligibles through specialty health plans. These specialty plans are required to have a care coordination program designed for each population's needs.

Eligibility

Dual-eligibles requiring 120 days or more of community-based LTSS are required to enroll in managed care. Those not requiring LTSS s can choose between managed care, FFS, PACE, or a D-SNP.

Services

Medicare covers most acute medical services, while Medicaid, the payer of last resort, covers long-term services and supports and non-physician behavioral health services.

Launch

In 2011, under the Medicaid Redesign Team (MRT), NY began phasing in mandatory MLTC enrollment for dual-eligible individuals who need community-based long-term care.

Admin

MMC and MLTC are administered by a variety of health plans that are available on a county-by-county basis. **The New York State Department of Health (NYSDOH) oversees them.**

VBP

There are several VBP mechanisms built into the MCO contracts, including having **80% of reimbursements in Level 1 (upside-only), and 35-40% in Level 2 (up and downside risk).**

Enrollment

As of March 2024 there were 1,011,867 full-benefit dual-eligibles in New York. Total dual-eligibles in the state was 1,161,931.

DUAL-ELIGIBLE OVERVIEW

MMMC & HARP SERVICES

For dual-eligible individuals on the Mainstream Medicaid Managed Care and Health and Recovery Plans, services are delivered through a combination of Medicare and Medicaid.

MMMC SERVICES OFFERED

The following services are available through a combination of Medicare and MMMC, though they must be medically or clinically necessary and provided or referred by a PCP:

- Regular Medical Care
  - Primary care visits
  - Referrals to specialists
  - Eye/hearing exams
  - Lab tests and x-rays
- Preventative Care
  - Regular checkups
  - Immunizations
  - Smoking cessation counseling
  - HIV education & risk reduction
- Maternity Care
- Home Health Care (when medically necessary)
- Personal Care/CDPAS (medically necessary)
  - Help with bathing, dressing, and feeding
  - Meal prep and housekeeping
  - Home health aide and nursing tasks
- Personal Emergency Response System
- Adult Day Health Care Services
- Hospice Care
- Dental Care
- Vision Care
- Hospital Care
- Emergency Care
- Specialty Care
- Physical and Occupational Therapy
- Speech Therapy
- Behavioral Health Care

Under MMMC, an MCO's care management team is responsible for coordinating care, and members with higher needs are assigned a dedicated care manager.

HARP SERVICES AVAILABLE

Because HARP is a plan offered under Mainstream Medicaid Managed Care, it provides the same benefits as MMMC plans, including: doctor visits, specialty care, hospital stays, dental care, and eye care.

However, HARP also offers extra benefits and specialized support, including:

- Psychosocial rehabilitation
- Community psychiatric support and treatment
- Habilitation-skill development
- Non-medical transportation for needed community services
- Education support services
- Pre-vocational services
- Transitional employment
- Intensive support employment
- Ongoing supported employment
- Peer supports
- Family support and training

These enhanced services are designed specifically for those with SMI or SUDs and are available only to HARP plan enrollees. HARP enrollees will also have access to Care Management through a Health Home.

DUAL-ELIGIBLE OVERVIEW

MANAGED LONG-TERM CARE PLAN SERVICES

MLTC streamlines the delivery of community based long term services and supports (CBLTSS) to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services are provided through MLTC plans that are approved by the New York State Department of Health (NYSDOH).

COVERED SERVICES

The covered services provided by MLTC Plans must comply with all standards of the New York State Medicaid Plan established pursuant to Social Services Law (SSL) § 363. As medically necessary, these services include:

- Care Management
  - Home Delivered or Congregate Meals
  - Social Day Care
  - Social and Environmental Supports
- Nursing Home Care
- Home Care: Nursing, Home Health Aide, Physical Therapy (PT), Occupational Therapy (OT), Speech Pathology (SP), & Medical Social Services
- Adult Day Health Care
- Personal Care
- Durable Medical Equipment (DME)
- Personal Emergency Response System
- Non-emergent Transportation
- Podiatry
- Dentistry
- Optometry / Eyeglasses
- PT, OT, SP or other therapies provided in a setting other than a home
- Audiology / Hearing Aids
- Respiratory Therapy
- Nutrition
- Private Duty Nursing
- Consumer Directed Personal Assistance Services
- Mental Health
- Alcohol and Substance Abuse Services

EXCLUDED SERVICES

There are additional services excluded from capitation that can still be provided and billed FFS or to Medicare for dual-eligibles, including:

- Inpatient Hospital Services
- Outpatient Hospital Services
- Physician Services including services provided in an office setting, a clinic, a facility, or in the home
- Laboratory Services
- Radiology and Radioisotope Services
- Emergency Transportation
- Rural Health Clinic Services
- Chronic Renal Dialysis
- OPWDD Services
- Family Planning Services
- Prescription and Non-Prescription Drugs, Compounded Prescriptions
- Assisted Living Program
- Other services listed in Title XIX State Plan

CARE COORDINATION

In MLTC, care coordination is a core feature. Each enrollee gets assigned a dedicated Care Manager who conducts assessments, builds a personalized care plan, coordinates all services, and ensures that care is delivered appropriately and consistently. For duals, the Care Manager helps coordinate with Medicare providers, but MLTC plans do not directly manage medical services unless the member is in a MAP, D-SNP or PACE plan.

DUAL-ELIGIBLE OVERVIEW

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

The New York State Office for People With Developmental Disabilities (OPWDD) coordinates services for New Yorkers with developmental disabilities, including intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, and other neurological impairments. This is typically done through the Comprehensive Home and Community-Based Services Waiver (1915-c HCBS).

Questions?
Reach out!

ELIGIBILITY

To be able to access the majority of OPWDD services, most individuals will need to: (1) Provide evidence that they have a developmental disability through documentation and assessments, (2) Enroll in Medicaid, and (3) Enroll in the OPWDD Home and Community Based Services waiver.

In order for a person to be eligible for OPWDD services, New York State Mental Hygiene Law requires:

1. Presence of a developmental disability described by certain qualifying diagnoses or conditions,
2. The disability occurred before the person reached age 22,
3. The disability can be expected to continue indefinitely or permanently, and
4. The disability causes a substantial handicap to a person's ability to function normally in society

SERVICES PROVIDED

OPWDD services and supports can help individuals live in a home of their choosing, find employment and other meaningful activities, build relationships in the community, and support good health. Supports and services offered include:

- Help to live independently in the community with rent subsidies, community habilitation, etc.
- Help for family to support individuals in the family home with respite and family support
- Help with employment training and support, volunteer opportunities and other types of community activities you choose,
- Intensive residential and day services, if needed, and
- Care Management provided by Care Coordination Organizations.

Services are provided through a network of approximately 500 nonprofit service providing agencies, with about 80% provided by the private nonprofits and 20% by state-run services.

PROGRAM ADMINISTRATION

The New York State Office for People With Developmental Disabilities (OPWDD) oversees the Home and Community Based Services programs for the IDD community. For some services, individuals care hire a a self-directed employee (SDE), which can include family members.

DUAL-ELIGIBLE OVERVIEW

BEHAVIORAL HEALTH

For individuals who are dually eligible for both Medicare and Medicaid, coverage of behavioral health services is coordinated between the two programs to ensure comprehensive care.

Medicare Coverage	Medicaid Coverage
Outpatient Mental Health Services Medicare Part B covers services such as individual and group therapy, psychiatric evaluations, medication management, and certain preventive services like depression screenings.	**Supplemental Behavioral Health Services** Medicaid may cover additional behavioral health services not fully covered by Medicare, including certain counseling services, case management, and community-based mental health services.
Inpatient Psychiatric Care Medicare Part A covers inpatient psychiatric hospital stays, subject to specific limitations.	**Long-Term Services and Supports (LTSS)** For those requiring long-term support, Medicaid can cover services like personal care assistance and other community-based supports.

INTEGRATION OF BEHAVIORAL HEALTH SERVICES

Behavioral health services for dual-eligible individuals in New York are delivered through a combination of Medicare, Medicaid, and managed care plans, depending on the individual's enrollment and level of need. The system is complex and varies based on whether the person is in fee-for-service, a D-SNP, MAP, PACE, or a HARP.

Typically, Medicare is the primary payer that covers acute and outpatient mental health and substance use services. Medicaid is typically the secondary payer that fills in the gaps left by Medicare, including services not covered by Medicare like HCBS for behavioral health, peer supports, transportation to appointments, etc.

- **Fee-For-Service:** Behavioral health is often split, with fragmented services and little care coordination.
- **Medicaid Advantage Plus:** Fully-integrated and aligned D-SNPs where all behavioral health services are coordinated by a single plan.
- **PACE:** Program fully integrates all Medicare and Medicaid services, including behavioral health.
- **Health and Recovery Plans:** Fully-integrated and aligned D-SNPs for people with significant behavioral health needs that includes enhanced behavioral health HCBS like psychosocial rehab, supported employment, education support, and peer support services.

Depending on the type of plan/progra, a care manager or health home is assigned to coordinate care for enrollees.

DUAL-ELIGIBLE DELIVERY SYSTEM

In New York, individuals who are dually eligible for both Medicare and Medicaid receive coordinated healthcare coverage through a combination of services from both programs.

	MMMC/MLTC	PACE	D-SNP
What Is It?	New York's Medicaid managed care program.	An alternative for dual-eligible seniors (55+) who need a high level of care.	A Medicare Advantage plan that coordinates Medicare & Medicaid benefits for dual-eligibles.
Who Must Enroll?	Dual-eligibles requiring 120 days or more of community-based LTSS are required to enroll in managed care.	Optional for dual-eligibles (55+) who need nursing home-level care.	Participants can but are not required to enroll.
Medicare's Role	Pays for acute medical services like hospital, doctor, and drug coverage.	Medicare & Medicaid funding combined into one program. Providers receive a capitated payment from Medicare and Medicaid and must cover all necessary care.	Manages Medicare benefits for dual-eligibles to enhance care coordination.
Medicaid's Role	Secondary payor for LTSS and non-physician behavioral health services.		Coordinates with Medicaid.
Plan Availability	Statewide	10 agencies operate PACE.	Offered by multiple health plans.

DUAL-ELIGIBLE DELIVERY SYSTEM

DUAL-ELIGIBLE SPECIAL NEEDS PLANS (D-SNPs)

Dual-Eligible Special Needs Plans are specialized Medicare Advantage plans designed for dual-eligibles, that provide integrated care combining Medicare and Medicaid benefits, including behavioral health services. These plans can provide additional benefits beyond standard Medicare coverage, like care coordination, which can be particularly beneficial for managing complex health needs.

About 57% of full-benefit dual-eligibles in New York are enrolled in a D-SNP.

BACKGROUND

D-SNPs are plans run by private insurance companies who contract with CMS to provide Medicare (and sometimes Medicaid) benefits through managed care. All D-SNPs are required to coordinate an enrollee's Medicare benefits with their Medicaid benefits to some level. A Fully Integrated Dual-Eligible Special Needs Plan (FIDE SNP) is a special kind of Medicare managed care plan that coordinates all covered Medicare and Medicaid benefits in one health plan.

ELIGIBILITY & ENROLLMENT REQUIREMENTS

To enroll in a D-SNP, individuals must be eligible for Medicare, and be eligible for full New York Medicaid coverage. In a D-SNP, enrollees are not required to enroll with the same insurance company (D-SNP) that they have for their Medicaid coverage, however, in certain programs in NY, including IB-DUAL and MAP (more on these on the next page), they are required to fully-align Medicare and Medicaid health plans.

Dually eligible individuals are not required to enroll in a D-SNP or FIDE SNP and can choose between Traditional FFS Medicare, Medicare Advantage health plans, and PACE. The decision to join a D-SNP is an individual one based on a person's health care needs and provider preferences, the D-SNP's network of contracted providers, prescription drug availability, etc. One key difference between Traditional Medicare and a D-SNP is that enrollees are required to see providers that are contracted with the health plan or agree to accept payment from the plan. The D-SNP provider directory will include the list of providers members can see for their care.

PLAN AVAILABILITY

In New York, several health plans operated D-SNPs in NY. Plans are region-specific, so availability depends on an individuals county of residence.

SERVICES

Medicaid Services not covered by Medicare are required to be provided through D-SNPs, including but not limited to, dental, vision and hearing. Most D-SNPs and FIDE SNPS have no co-payments, premiums or deductibles. The additional benefit of a FIDE SNP is that one health plan coordinates all Medicare and Medicaid benefits and individuals have a team of doctors and case managers working together to deliver the best care.

DUAL-ELIGIBLE DELIVERY SYSTEM

INTEGRATED CARE PLANS & D-SNPS IN NY

Integrated Care Plans, plans that provide both Medicaid and Medicare services from the same health plan, are designed to help dual-eligible beneficiaries in NY meet their health care needs within their own community. There are different types of Integrated Care Plans in New York based upon care needs, including Medicaid Advantage Plus and Integrated Benefits for Dually-Eligible Enrollees Program (IB-DUAL).

IB-DUAL PROGRAM

The Integrated Benefits for Dually-Eligible Enrollees (IB-DUAL) Program is a new initiative launched in 2022 that is designed to offer a more complete set of benefits and services by providing Medicaid and Medicare covered services through the same health plan.

IB-Dual allows members who are Medicare eligible to remain in their Mainstream Medicaid Managed Care health plan, rather than being moved into Medicaid fee-for-service when they gain Medicare. Upon becoming Medicare eligible, they must enroll in the Medicare D-SNP (Dual-Eligible Special Needs Plan) through the same health plan that is providing their Medicaid services to join the IB-Dual program.

IB-DUAL ELIGIBILITY

IB-DUAL program is for full-benefit dual-eligible beneficiaries who do not require long term services and supports, and that are already enrolled in MMC or HARP. Duals in need of LTSS will be enrolled in MAP through the default enrollment process.

IB-DUAL BENEFITS

IB-DUAL allows for better coordination of care with a single point of contact. It also allows for improved continuity of care and smoother transitions into Medicare due to no disruption to their existing Medicaid plan.

MEDICAID ADVANTAGE PLUS

Medicaid Advantage Plus (MAP) is for duals in need of LTSS. These plans will pay for Medicare health services at little to no additional cost to members. MAP provides Medicaid benefits including LTSS and Medicare benefits through the same health plan. When individuals join Medicaid Advantage Plus, they must also enroll in the plan's Medicare Advantage Dual Special Needs Plan (D-SNP) product. The plan will take care of all their LTSS needs and other health services. They must choose one of the doctors from the plan to be your Primary Care Provider (PCP). Not all areas of NY have a MAP plan available.

MAP ELIGIBILITY

To enroll in the MAP plan, an individual must be 18 years or older, have full Medicaid and be eligible for Medicare Parts A and B. In addition, they must need at least 120 days or more of LTSS The MAP plan allows you to remain in the community in your own home while receiving your Medicaid and Medicare services.

MAP BENEFITS

MAP covers all Medicaid and Medicare services under one health plan in a D-SNP, which improves coordination of care and reduces fragmentation. It also covers health services at home, personal care, adult day health care, and other benefits.

DUAL-ELIGIBLE ENROLLMENT

DUAL-ELIGIBLE ENROLLMENT

According to CMS, as of March 2024, total full dual-eligible enrollment was 1,011,867.

Enrollment in NYS Integrated Plans has increased between 2022 and 2024.

Dual-eligibles requiring 120 days or more of community-based LTSS are required to enroll in managed care. Those not requiring LTSS s can choose between managed care, FFS, PACE, or a D-SNP.

Dual Status Codes	Count of Dual Enrollees (as of March 2024)
Qualified Medicare Beneficiaries (QMB)-only	94,924
QMB plus Full Medicaid Benefits	748,254
Specified Low-income Medicare Beneficiaries (SLMB)-only	11,096
SLMB plus Full Medicaid Benefits	12,780
Qualified Disabled and Working Individuals (QDWI)	0
Qualifying Individuals (QI)	44,043
Other Dual Full Medicaid Benefit	250,833

Questions? Reach out!

Total dual-eligible enrollment including partial duals, as of March 2024 was 1,161,931.

MORE INFORMATION

DualEligibleHQ.com (DEHQ) is a comprehensive resource designed to provide up-to-date information, research, and insights on dual-eligible individuals. Our platform offers in-depth STATE REPORTs, policy updates, program analyses, and industry trends, helping stakeholders understand the complexities of dual eligibility. Whether you're a healthcare provider, policy analyst, or consumer, DEHQ serves as a go-to destination for data-driven insights and expert perspectives.

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Founder

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If you're looking for more information on dual-eligible programs, state-specific policies, or the latest developments in Medicare-Medicaid integration, contact us today. Our team is ready to provide tailored insights and guidance to help you navigate the evolving landscape of dual eligibility.

OUR CONTACT

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GLOSSARY OF TERMS

We've provided a glossary to help readers understand key terms and acronyms related to dual-eligibility, Medicaid, Medicare, and managed care. You can find a full glossary with clear definitions on our website at https://www.dualeligiblehq.com/.

TERM	ABBRV.	DEFINITION
Accountable Care Organization	ACO	A network of doctors, hospitals, and healthcare providers that collaborate to improve care coordination, enhance quality, and reduce costs for Medicare beneficiaries. ACOs share in savings or losses based on their performance in value-based care models like the MSSP.
Capitation		A payment model where healthcare providers or Managed Care Organizations (MCOs) receive a fixed amount per enrollee for a defined period, regardless of the services provided.
Capitated Rate		A fixed per-member-per-month (PMPM) payment made to a Managed Care Organization (MCO) or healthcare provider to cover a defined set of services for enrolled individuals, regardless of the actual number of services used.
Dual-Eligible		Individuals who qualify for both Medicare and Medicaid benefits, often due to age, disability, and low income.
Dual-Eligible Special Needs Plans	D-SNPs	A type of Medicare Advantage plan tailored for dual-eligible individuals, integrating Medicare and Medicaid services to provide coordinated care.
Federal Poverty Level	FPL	The Federal Poverty Level (FPL) is an income measure set by HHS to determine eligibility for Medicaid, Medicare Savings Programs (MSPs), and other assistance. It varies by household size and state, with many dual-eligible programs requiring income below a certain FPL percentage.
Fee-For-Service	FFS	A traditional healthcare payment model where providers are reimbursed for each service rendered, such as tests or procedures.

GLOSSARY OF TERMS

TERM	ABBRV.	DEFINITION
Full Dual-Eligible		A full dual-eligible individual qualifies for both Medicare and full Medicaid benefits. Medicaid covers Medicare premiums, deductibles, and cost-sharing, as well as additional services that Medicare does not, such as long-term services and supports (LTSS), home and community-based services (HCBS), and certain behavioral health benefits. Full dual-eligibles may also qualify for Medicare Part D Extra Help, which reduces prescription drug costs.
Full-Benefit Dual-Eligible Medicaid Recipients		These individuals are entitled to Medicare Part A and/or entitled to Part B, and qualify for full Medicaid benefits, but not the QMB or SLMB groups. Full-benefit Medicaid coverage refers to the package of services, beyond coverage for Medicare premiums and cost-sharing, that certain individuals are entitled to under 42 CFR 440.210 and 440.330. For Medicaid-covered services (i.e., services furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover), a full-benefit Medicaid beneficiary pays no more than the Medicaid coinsurance3 (if applicable). For Medicare-only covered services (i.e., services covered by Medicare, but not Medicaid), these individuals pay the Medicare cost-sharing unless the state chooses to cover Medicare cost-sharing for all Medicarecovered services for this eligibility group.
Home and Community-Based Services	**HCBS**	Medicaid services that assist individuals with daily activities, enabling them to live independently in their communities rather than in institutional settings.
Integrated Care		A healthcare approach that combines services from multiple providers to offer seamless and coordinated care, particularly beneficial for individuals with complex health needs.

GLOSSARY OF TERMS

TERM	ABBRV.	DEFINITION
Intellectual and Developmental Disability	**IDD**	An Intellectual and Developmental Disability is a lifelong condition that affects a person's cognitive, adaptive, or social functioning. IDDs include conditions such as Down syndrome, autism spectrum disorder, cerebral palsy, and intellectual disabilities diagnosed before adulthood. Individuals with IDD may require specialized healthcare, supportive services, assistive technology, and HCBS to promote independence and quality of life.
Long-Term Services and Supports	**LTSS**	A range of medical and personal care services assisting individuals with chronic illnesses or disabilities in performing daily activities over an extended period.
Managed Care		A healthcare delivery system where organizations manage cost, utilization, and quality by providing a network of contracted providers and services.
Managed Care Organization	**MCO**	Entities that deliver managed care services by contracting with healthcare providers to offer a comprehensive set of services to enrolled members.
Medicaid		A joint federal and state program offering health coverage to eligible low-income individuals, including children, pregnant women, seniors, and people with disabilities.
Medical Assistance	**MA**	Pennsylvania's Medicaid program that provides healthcare coverage to low-income individuals, including children, pregnant women, seniors, and individuals with disabilities. It is administered by the Pennsylvania Department of Human Services (DHS), providing comprehensive benefits like hospital care, physician services, prescription drugs, and long-term care.
Medicare		A federal health insurance program primarily for individuals aged 65 and older, as well as some younger individuals with disabilities. Coverage has four parts, Part A, B, C, and D.

GLOSSARY OF TERMS

TERM	ABBRV.	DEFINITION
Medicare Advantage	MA	Medicare Advantage plans are approved by Medicare but are run by private companies. These companies provide Medicare Part A and Part B covered services and may include Medicare drug coverage too. Medicare Advantage plans are sometimes called “Part C” or “MA” plans. MA plans are not supplemental insurance.
Medicare Advantage Organization	MAO	A private insurance company that contracts with the federal government to offer Medicare Advantage (Part C) plans. These plans cover all Medicare Part A and Part B benefits, and many include additional services like prescription drug coverage, dental, vision, and hearing. MAOs receive a capitated payment from Medicare to manage and deliver care and are responsible for coordinating services to improve quality, efficiency, and member satisfaction.
Medicare Part A	Part A	Medicare Part A is the hospital insurance portion of Medicare. It covers inpatient care in hospitals, skilled nursing facility care, hospice care, and some home health services. Most people do not pay a premium for Part A if they or their spouse paid Medicare taxes while working.
Medicare Part B	Part B	Medicare Part B is the medical insurance portion of Medicare. It covers outpatient services such as doctor visits, preventive care, lab tests, mental health services, durable medical equipment, and some home health care. Beneficiaries typically pay a monthly premium and are responsible for deductibles and coinsurance.
Medicare Part C	Part C	Medicare Part C, also known as Medicare Advantage, is an alternative to Original Medicare (Parts A and B) offered by private insurance companies approved by Medicare. These plans often include additional benefits such as vision, dental, hearing, and prescription drug coverage, and may feature care coordination services.

GLOSSARY OF TERMS

TERM	ABBRV.	DEFINITION
Medicare Part D	Part C	Medicare Part D provides prescription drug coverage. It is offered through standalone drug plans or included in some Medicare Advantage (Part C) plans. Part D helps cover the cost of medications, and individuals with limited income may qualify for Extra Help to reduce their out-of-pocket costs.
Medicare Savings Programs	MSP	MSPs help low-income Medicare beneficiaries by covering Medicare premiums, deductibles, and cost-sharing. There are four MSP categories: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled and Working Individual (QDWI). Eligibility is based on income and asset limits, with Medicaid administering the benefits.
Medicare Shared Savings Program	MSSP	The Medicare Shared Savings Program (MSSP) is a value-based initiative where Accountable Care Organizations (ACOs) coordinate care to improve quality and reduce costs for Medicare. ACOs share in savings or losses based on performance.
Partial Dual-Eligible		A partial dual-eligible individual qualifies for Medicare and receives limited Medicaid assistance through a Medicare Savings Program (MSP). Medicaid helps pay for some or all of their Medicare premiums, deductibles, and coinsurance but does not provide full Medicaid benefits. Partial dual-eligibles do not receive coverage for services like long-term care or HCBS unless they qualify under another program.
Program of All-Inclusive Care for the Elderly	PACE	A Medicare and Medicaid program that helps people meet their health care needs in the community instead of going to a nursing home or other care facility. KSCE covers all Medicare- and Medicaid-covered care and services, and anything else the health care professionals in your KSCE team decide you need to improve and maintain your health. This includes prescription drugs and any medically necessary care.

GLOSSARY OF TERMS

TERM	ABBR V.	DEFINITION
Qualified Disabled and Working Individuals	QDWI	QDWI individuals) became eligible for premium-free Part A by virtue of qualifying for Social Security Disability Insurance (SSDI) benefits, but lost those benefits, and subsequently premium-free Medicare Part A, after returning to work. QDWIs have income that does not exceed 200 percent of the FPL, have resources that do not exceed two times the SSI resource standard and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.
Qualifying Individuals	QI	QIs are entitled to Part A and have income of at least 120 but less than 135 percent of the FPL, resources that do not exceed three times the limit for SSI eligibility with adjustments for inflation and are not eligible for any other eligibility group under the state plan. QIs receive coverage for their Medicare Part B premiums, to the extent their state Medicaid programs have available slots. The federal government makes annual allotments to states to fund the Part B premiums. Individuals in the limited Part B-ID benefit may also qualify for the QI eligibility group with coverage limited to the Part B-ID premium and/or cost sharing.
Qualified Medicare Beneficiaries Only	QMB-Only	QMB-Only are entitled to Medicare Part A, have income up to 100 percent of the FPL and resources that do not exceed three times the limit for SSI eligibility with adjustments for inflation and are not otherwise eligible for full-benefit Medicaid coverage. Medicaid pays their Medicare Part A premiums, if any, and Medicare Part B premiums. Medicare providers may not bill QMBs for Medicare Parts A and B cost-sharing amounts, including deductibles, coinsurance, and copays. 1 Providers can bill Medicaid programs for these amounts, but states have the option to reduce or eliminate the state's Medicare cost-sharing payments by adopting policies that limit payment to the lesser of (a) the Medicare cost-sharing amount, or (b) the difference between the Medicare payment and the Medicaid rate for the service. Individuals in the limited Part B Immunosuppressive Drug (Part B-ID) benefit may also qualify for the QMB eligibility group with coverage limited to the Part B-ID premium and/or cost-sharing, a status known as QMB-Part B-ID.

GLOSSARY OF TERMS

TERM	ABBRV.	DEFINITION
Qualified Medicare Beneficiaries with full-benefit Medicaid	QMB-Plus	QMB-Plus individuals meet the QMB-related eligibility requirements described above and the eligibility requirements for a separate categorical Medicaid eligibility group covered under the state plan. In addition to the coverage for Medicare premiums and Medicare cost-sharing described above, QMB-plus individuals receive the full range of Medicaid benefits applicable to the separate eligibility group for which they qualify. Medicaid pays their Medicare Part A premiums, if any, and Medicare Part B premiums. Medicare providers may not bill QMBs for Medicare Parts A and B cost-sharing amounts, including deductibles, coinsurance, and copays. Providers can bill Medicaid programs for these amounts, but states have the option to reduce or eliminate the state's Medicare costs haring payments by adopting policies that limit payment to the lesser of (a) the Medicare cost sharing amount, or (b) the difference between the Medicare payment and the Medicaid rate for the service.
Serious Mental Illness	SMI	Refers to chronic and severe mental health conditions that significantly impair daily life and functioning. Examples include schizophrenia, bipolar disorder, major depressive disorder, and severe anxiety disorders. Individuals with SMI may require long-term treatment, crisis intervention, case management, and community-based services to manage their condition. Medicaid often provides additional behavioral health services for individuals with SMI beyond what Medicare covers.
Specified Low-Income Medicare Beneficiaries without other Medicaid	SLMB-Only	Entitled to Part A and have income between 100 and 120 percent of the FPL, and resources that do not exceed three times the limit for supplementary security income (SSI) eligibility with adjustments for inflation. Medicaid pays only the Medicare Part B premiums for this group. Individuals in the limited Part B-ID benefit may also qualify for the SLMB eligibility group with coverage limited to the Part B-ID premium and/or cost-sharing, a status known as SLMB-Part B-ID.

GLOSSARY OF TERMS

TERM	ABBRV.	DEFINITION
Specified Low-Income Medicare Beneficiaries with full-benefit Medicaid	**SLMB-Plus**	Individuals that meet the SLMB-related eligibility requirements described above, and the eligibility requirements for a separate categorical Medicaid eligibility group covered under the state plan. In addition to coverage for Medicare Part B premiums, these individuals receive full-benefit Medicaid coverage (i.e., the package of benefits provided to the separate Medicaid eligibility group for which they qualify). For Medicaid-covered services (i.e., services furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover), an SLMB-Plus beneficiary pays no more than a nominal Medicaid copay2 (if applicable).
Value-Based Care	**VBC**	Value-based care is a term that Medicare, doctors and other health care professionals sometimes use to describe health care that is designed to focus on quality of care, provider performance and the patient experience. The “value” in value-based care refers to what an individual values most. In value-based care, doctors and other health care providers work together to manage a person’s overall health, while considering an individual’s personal health goals.
Value-Based Payment	**VBP**	Under value-based payment (VBP) models, payments to healthcare providers are tied to quality, efficiency, and positive patient experience. The purpose of value-based programs is to improve care for individuals and lower healthcare costs simultaneously. With this delivery model, doctors, hospitals, and other health care providers are compensated based on the quality of care provided and patient outcomes.
Whole-Person Care		Whole person care is a healthcare approach that considers a patient's physical, mental, social, and spiritual health. It aims to improve health and well-being by addressing multiple factors that affect a person's health.