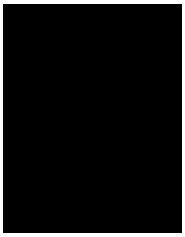

Glossary of Terms Related to Dual-Eligible Beneficiaries of Medicare and Medicaid

accountable care organizations: Groups of doctors, hospitals, and other health care providers who join together to provide coordinated care to a set of patients and who agree to be held accountable for the quality and total cost of those patients' care. The Centers for Medicare & Medicaid Services is encouraging the development of accountable care organizations by offering to share savings with those groups if they can demonstrate that they have met certain quality standards and savings benchmarks for their Medicare patients.

acute care: Medical care provided by physicians' offices, short-term acute care hospitals, and outpatient care facilities. Services such as prescription drugs and dental care are also considered to be acute care.

aged, blind, or disabled (ABD) Medicaid beneficiaries: People who are eligible for and receive Medicaid benefits because of age, blindness, or disability in addition to the amount of their income and assets. The dual-eligible population is a subset of those beneficiaries.

behavioral health care: Treatment of mental health and substance abuse problems.

capitated payment: A single payment, made on a per-enrollee basis, that covers all care within a specified set of benefits. Medicare and Medicaid make capitated payments to managed care organizations, which then pay health care providers for a specific set of benefits for people enrolled in a managed care plan. The recipient of a capitated payment keeps the difference between its costs and the amount of the payment if costs are below the payment, but it is responsible for paying any costs that exceed the capitated payment.

cost plan: A type of Medicare Advantage plan in which payments to plans are based on submitted claims rather than being capitated. Fewer than 2 percent of dual-eligible beneficiaries enrolled in a Medicare Advantage plan are enrolled in a cost plan. Such plans typically do not cover all of an enrollee's use of services; the remaining claims for those enrollees are covered by traditional fee-for-service Medicare.

dual-eligible beneficiaries: People who are jointly enrolled in Medicare and Medicaid and who are eligible to receive benefits from both programs. All dual-eligible beneficiaries qualify for full Medicare benefits, which cover their acute and postacute care. Dual-eligible beneficiaries vary, however, in the amount of Medicaid benefits for which they qualify. The dual-eligible population can be divided into "full duals" and "partial duals" on the basis of the Medicaid benefits that people are eligible to receive. At a minimum, all dual-eligible beneficiaries qualify to have the Medicaid program pay their premiums for Part B of Medicare (and for Part A, if applicable).

fee for service (FFS): A payment system in which a health care program or plan pays providers a fee for each covered service performed for its enrollees.

full duals: Dual-eligible beneficiaries who qualify for full benefits from Medicaid as well as from Medicare. Thus, Medicaid pays for their premiums for Part B of Medicare (and for Part A, if applicable) and covers various health care services that Medicare does not cover, such as most types of long-term services and supports (as well as dental care and other services in some states). In addition, some states' Medicaid programs cover the entire cost-sharing amounts that full duals incur under Medicare, whereas other states cover only a portion of those amounts.

health home: A type of medical home that serves Medicaid beneficiaries who have a particular set of chronic conditions. Health homes are intended to address those beneficiaries' needs for behavioral and physical health care as well as for institutional or community-based long-term care. The Affordable Care Act created an optional program in which states can receive a 90 percent federal matching rate for up to two years for providing this type of service.

long-term services and supports (LTSS): A category that encompasses a variety of supportive services provided to people who have limits on their ability to perform daily activities, such as bathing or dressing. LTSS typically excludes medical services that are needed to manage underlying health conditions. LTSS can be provided in nursing homes or other institutions, in people's homes, or in community-based settings (such as adult day care centers). Medicaid is the primary government payer for most of those types of services. The exceptions are skilled nursing facility services, hospice care, and home health care services, which are provided by Medicare in some circumstances.

managed FFS: A model in which providers are paid on a fee-for-service basis while beneficiaries are enrolled in care management programs designed to improve the quality of, and promote the appropriate use of, health care services.

managed LTSS: Long-term services and supports provided to Medicaid beneficiaries through managed care programs. The number of state Medicaid programs offering managed LTSS is growing rapidly.

medical home: A model for delivering health care—increasingly being used by state Medicaid programs—in which a team of health care professionals, led by a primary care provider, coordinates the care given to an individual or family.

Medicare Advantage: Medicare's managed care program, known formally as Medicare Part C. Most Medicare Advantage plans receive a capitated payment from Medicare in exchange for providing beneficiaries with all of the services covered by Parts A and B of Medicare. (A small number of plans, called cost plans, are paid on a claim-by-claim basis rather than with a capitated payment and do not necessarily cover all of those services.) Roughly 20 percent of dual-eligible beneficiaries are enrolled in Medicare Advantage plans.

nondual: A term used to describe Medicare beneficiaries who are not enrolled in Medicaid or Medicaid beneficiaries who are not enrolled in Medicare.

partial duals: Dual-eligible beneficiaries who qualify to have Medicaid pay some of the expenses they incur under Medicare. For all partial duals, Medicaid pays the premiums for Part B of Medicare (and for Part A, if applicable). For some partial duals (depending on the state they live in and their income and assets), Medicaid also pays part or all of the cost-sharing amounts they owe under Medicare.

Parts A, B, C, and D: The Medicare program has three components: Hospital Insurance (Part A), Medical Insurance (Part B), and prescription drug coverage (Part D). Medicare Part C (known as Medicare Advantage) specifies the rules under which private health care plans can assume responsibility for, and be compensated for, providing benefits covered under Parts A, B, and D.

postacute care: Recuperation and rehabilitation services provided to patients recovering after a stay in a hospital for acute care. Postacute care is provided by skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities, among others.

Program of All-Inclusive Care for the Elderly (PACE): A health care program that receives capitated payments in exchange for offering specialized services to Medicare and Medicaid beneficiaries who are age 55 or older and who need the degree of care usually provided in nursing facilities. PACE provides beneficiaries with community-based long-term services and supports that are intended to help them remain outside institutions. Notably, PACE programs may use their Medicare and Medicaid payments for any services that would enable a beneficiary to continue to live at home, including physical improvements to make the home more accessible. In addition, PACE programs have their own facilities—which provide services such as adult day care and visits by physicians—and offer transportation between a beneficiary's home and those facilities.

risk-based managed care: A system in which a health care program contracts with health plans, most of which are privately run, to provide a set of covered benefits for a fixed amount per beneficiary. Those amounts may be adjusted to reflect the health risks of beneficiaries.

special-needs plan (SNP): A type of Medicare Advantage plan that is designed to provide targeted services to Medicare beneficiaries who are in institutions, are dual-eligible beneficiaries, or have a severe or disabling chronic condition.