GLOSSARY

Abuse – When providers supply services or products that are not medically necessary and/or do not meet professional standards.

Accessibility of Services – The ability to get medical care and services when needed.

Accountable Care Organization (ACO) – A group of health care providers who agree to work together with Medicare to provide coordinated service and care to patients.

Accreditation – A seal of approval from a private independent group. Being accredited means that certain quality standards have been met.

Achieving a Better Life Experience (ABLE) Program -The New York Achieving a Better Life Experience **(NY ABLE)** Program - encourages and assists individuals and families to save private funds in accounts in the program to support individuals with disabilities to maintain health, independence and quality of life. Is intended to supplement, but not supplant, benefits provided through Medicaid, SSI, SSDI, private insurance and other sources.

Activities of Daily Living (ADL) **–** Activities you usually do during a normal day. Although definitions differ, activities usually considered to be everyday activities include walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. See: Custodial Care.

Actual Charge – The amount a physician or other health care provider bills a patient for a particular medical service or procedure. The actual charge may differ from the Medicare-approved amount or amount approved by other insurance programs.

Actuarial Value - The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy

Acute Care – Medical care designed to treat or cure disease or injury, usually within a limited time period. Acute care usually refers to physician and/or hospital services of less than three (3) months in length.

Acute Illness –A severe rapidly occurring condition that can be cured with proper treatment, i.e. broken bone or pneumonia

ADAP Plus Insurance Continuations (APIC) - This program is one of the services offered by the New York State Uninsured Care Programs. The purpose of the APIC program is to pay health insurance premiums on behalf of ADAP eligible participants. Can assist with COBRA, direct pay and Medicare Part D (see Aids Drug Assistance Program, ADAP)

Adjusted Average Per Capita Cost (AAPCC)- An estimate of how much Medicare will spend in a year for an average beneficiary. (See Risk Adjustment.)

Adjusted Gross Income (AGI) - Your total (or "gross") income for the tax year, minus certain adjustments you're allowed to take. Adjustments include deductions for conventional IRA contributions, student loan interest, and more. Adjusted gross income appears on IRS Form 1040, line 11.

To report expected income on your Marketplace health insurance application, you can start with your most recent year's adjusted gross income and update it based on income and household changes you expect for the coverage year.

The Marketplace uses a different figure, called modified adjusted gross income (MAGI), to determine eligibility for savings. MAGI is not a line on your tax return.

Administration for Community Living (ACL) – The ACL was established in 2012 and brought together the Administration on Aging, the Office on Disability, and the Administration on Developmental Disabilities for the purpose of reducing the fragmentation in federal programs; enhancing access to quality health care and long- term services and supports; and complementing existing community infrastructure for both the aging and disability populations. **Administrative Costs-** A general term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. CMS administrative costs are the costs of operating CMS (e.g., salaries and expenses, facilities, equipment, rent and utilities, etc.). These costs are reflected in the Program Management account. **Administrative Law Judge (ALJ) –** A hearing officer who presides over appeal conflicts between providers of service or beneficiaries, and Medicare contractors.

Administrative Simplification Compliance Act- Signed into law on December 27, 2001, as Public Law 107-105, this Act provides a one-year extension to HIPAA "covered entities" (except small health plans, which already have until October 16, 2003) to meet HIPAA electronic and code set transaction requirements. Also, allows the Secretary of HHS to exclude providers from Medicare if they are not compliant with the HIPAA electronic and code set transaction requirements and to prohibit Medicare payment of paper claims received after October 16, 2003, except under certain situations.

Admission Date- The date the patient was admitted for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits.

Admitting Diagnosis Code- Code indicating patient's diagnosis at admission.

Adult Day Care – A daytime community-based program for functionally impaired adults that provides a variety of health, social, and related support services in a protective setting.

Adult Care Facility – Facilities that provide temporary or long-term, non-medical residential care services to adults who are substantially unable to live independently. The facilities are licensed and supervised through the New York State Department of Health. **Advance Beneficiary Notice of Non-coverage (ABN) –** A notice that a doctor or supplier should give a person with Medicare to sign if it is believed that Medicare does not consider the service medically necessary, and Medicare will not pay for it. If you do not get an ABN to sign before you get the service from your provider of service (doctor), and Medicare does not pay for that service, then you do not have to pay for the service. If your doctor does give you an ABN to sign and Medicare does not pay for it, you will be responsible to pay for the service. (This form could also be given by a home health agency or skilled nursing facility.)

Advance Coverage Decision – A determination that a Private Fee-for-Service Plan makes on whether or not it will pay for a certain service.

Advance Determination of Medicare Coverage (ADMC) – A voluntary program that allows Suppliers and Beneficiaries to request prior approval of "eligible" items before delivery of the items to the beneficiary. At this time, only customized wheelchairs (manual and power) are eligible for ADMC.

Advance Directive – A legal document that outlines how you want medical decisions made if you can no longer communicate your wishes. A health care directive may include a health care proxy and a living will. Completed while a person has decision making capacity, a health care proxy names someone who is designated as the health care agent authorized to make medically related decisions if, in the future, the person completing the document lacks capacity. A living will outlines the types of treatments that the person would or would not want if seriously ill and not expected to recover. See Health Care Proxy.

Advance Premium Tax Credit (APTC) – A tax credit you can take in advance that can help you afford health coverage through the Health Insurance Marketplace. When you apply for coverage in the Health Insurance Marketplace, you estimate your expected income for the year. If at the end of the year you've taken more premium tax credit in advance than you're due based on your final income, you'll have to pay back the excess when you file your federal tax return. If you have taken less than you qualify for, you will get the difference back.

Advisory Council on Social Security- Prior to the enactment of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103-296) on August 15, 1994, the Social Security Act required the appointment of an Advisory Council every 4 years to study and review the financial status of the OASDI and Medicare programs. The most recent Advisory Council was appointed on June 9, 1994, and its report on the financial status of the OASDI program was submitted on January 6, 1997. Under the provisions of Public Law 103-296, this is the last Advisory Council to be appointed.

Advocate – A person who gives you support or protects your rights.

Affiliated Contractor- A Medicare carrier, FI, or other contractor such as a Durable Medical Equipment Regional Carrier (DMERC), which shares some or all of the PSC's jurisdiction in which the affiliated contractor performs non-PSC Medicare functions such as claims processing or education.

Affiliated Provider – A health care provider (physician) or facility that is paid by a health plan to give services to plan members.

Affordable Care Act (ACA) – The Patient Protection and Affordable Care Act (PPACA), informally known as Obamacare, and was signed into law on March 23, 2010. The Health Care and Education Reconciliation Act amended the Affordable Care Act and was signed on March 30, 2010. This legislation comprises an extensive list of health care reform programs, provisions and initiatives.

Affordable Coverage - A job-based health plan covering only the employee that costs 9.61% or less of the employee's household income. If a job-based plan is "affordable," and meets the "minimum value" standard, you're not eligible for a premium tax credit if you buy a Marketplace insurance plan instead.

- The plan used to define affordability is the lowest priced "self-only" plan the employer offers — meaning a plan covering only the employee, not dependents. This is true even if you're enrolled in a plan that costs more or covers dependents.

- The cost is the amount the employee would pay for the insurance, not the plan's total premium.

- The employee's total household income is used. Total household income includes income from everybody in the household who's required to file a tax return.

Aged Enrollee- An individual aged 65 or over, who is enrolled in the SMI program.

Aid to the Permanently and Totally Disabled (APTD) - Cash assistance for individuals who are between the ages of 18 and 64 and who are physically or mentally disabled and meet certain requirements.

AIDS Drug Assistance Program (ADAP) – A program established by the NYS Department of Health's AIDS Institute that provides free medications for treatment of HIV/AIDS and opportunistic infections. ADAP can help people with partial insurance and those who have a Medicaid spenddown requirement.

Allowed Charge- Individual charge determined by a carrier for a covered SMI medical service or supply.

Ambulance (Air or Water) - An air or water vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured.

Ambulance (Land) - A land vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured.

Ambulatory Care – Health services that do not require an overnight hospital stay.

Ambulatory Care Sensitive Conditions (ACSC)- ACSC stands for Ambulatory Care Sensitive Conditions. ACSC conditions are medical conditions for which physicians broadly concur that a substantial proportion of cases should not advance to the point where hospitalization is needed if they are treated in a timely fashion with adequate primary care and managed properly on an outpatient basis.

Ambulatory Payment Classifications (APC) – APCs are used to determine the amount that Medicare reimburses hospitals for outpatient services. It is part of the Outpatient Prospective Payment System (OPPS). The hospital is paid a fixed amount based on the APC code for the patient.

Ambulatory Surgical Center (ASC) – A separate part of a hospital that does outpatient surgery where patients are not expected to need more than 24 hours of care.

American Association for Homecare- An industry association for the home care industry, including home IV therapy, home medical services and manufacturers, and home health providers. AAHomecare was created through the merger of the Health Industry Distributors Association's Home Care Division (HIDA Home Care), the Home Health Services and Staffing Association (HHSSA), and the National Association for Medical Equipment Services (NAMES).

American Dental Association (ADA)- A professional organization for dentists. The ADA maintains a hardcopy dental claim form and the associated claim submission specifications, and also maintains the Current Dental Terminology (CDT ....) medical code set. The ADA and the Dental Content Committee (DeCC), which it hosts, have formal consultative roles under HIPAA.

American Health Information Management Association- An association of health information management professionals. AHIMA sponsors some HIPAA educational seminars.

American Health Care Act (AHCA) – A United States Congressional bill to repeal the Patient Protection and Affordable Care Act (ACA). The bill was withdrawn on March 24, 2017, after it failed to gain sufficient House Republican support to pass it.

American Hospital Association (AHA)- A health care industry association that represents the concerns of institutional providers. The AHA hosts the NUBC, which has a formal consultative role under HIPAA.

American Medical Association (AMA)- A professional organization for physicians. The AMA is the secretariat of the NUCC, which has a formal consultative role under HIPAA. The AMA also maintains the Current Procedural Terminology (CPT ....) medical code set.

American Medical Informatics Association- A professional organization that promotes the development and use of medical informatics for patient care, teaching, research, and health care administration.

American Society for Testing and Materials (ASTM)- A standards group that has published general guidelines for the development of standards, including those for health care identifiers. ASTM Committee E31 on Healthcare Informatics develops standards on information used within healthcare.

Americans with Disabilities Act of 1990 (ADA) – A civil rights law that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places that are open to the general public.

Amyotrophic Lateral Sclerosis, also known as Lou Gehrig's disease (ALS) – People with *ALS* automatically get Medicare Part A and Part B the month the disability benefits start.

Ancillary Services – Professional services by a hospital or other inpatient health program. These may include X-ray, drug, laboratory, or other services.

Annual Coordinated Election Period (ACEP) – See: Annual Open Enrollment Period.

Annual Election Period (AEP) – See: Annual Open Enrollment Period.

Annual Notice of Change (ANOC) – Notice you receive from your Medicare Advantage or Part D plan in September which provides a summary of any changes in the plan's cost and coverage that will take effect January 1st of the next year.

Annual Open Enrollment Period – From October 15 through December 7 each year, the time when you can make changes in the way you receive Medicare – Original Medicare or a Medicare Advantage Plan – and/or your Medicare drug plan (Part D). The plan changes will be effective January 1st of the following year. [Also known as Annual Election Period (AEP) and Annual Coordinated Election Period (ACEP).]

Annual Wellness Visit (**AWV) -** Once a year visit covered by Medicare in which you can meet with your doctor to develop a prevention plan based on your needs, update your medical history, and list your current medications, healthcare providers and suppliers.

Appeal – People with Medicare have the right to request a review of a denied claim, and if not satisfied with the review, to appeal to a higher-level review. See: Medicare Appeal.

Appeals Process - The process you use if you disagree with any decision about your health care services. If Medicare does not pay for an item or service, you have been given, or if you are not given an item or service you think you should get, you can have the initial Medicare decision reviewed again. If you are in the Original Medicare Plan, your appeal rights are on the back of the Medicare Summary Notice (MSN). If you are in a Medicare managed care plan, see your plan's membership materials or contact your plan for details about your Medicare appeal rights. See: Medicare Appeal.

Approved Amount – The maximum fee that Medicare or other insurers will use in reimbursing a provider for a given service or piece of equipment. The Medicare "approved" charge may be lower than the actual billed amount and is based upon the Medicare Fee Schedule.

Area Agencies on Aging (AAA) – State and local government agencies which grant or contract with public and private organizations to provide services that help older adults remain independent in their home and community.

Assessment- The gathering of information to rate or evaluate your health and needs, such as in a nursing home.

Asset Protection – This refers to the protection from Medicaid "spend-down" requirements available under the Medicaid extended coverage feature of the New York State Partnership for Long-Term Care.

Assignment – In the Original Medicare Plan, doctors and other providers who accept assignment accept the amount Medicare approves for a particular service or supply as payment in full. (The person with Medicare is still responsible for any deductible and coinsurance amount.) **Not accepting assignment** means the provider does not accept Medicare's approved amount as payment in full. A provider cannot, however, charge whatever he/she chooses to people with Medicare. Federal and New York State laws may limit how much a provider may charge in excess of Medicare's approved amount.

Assignment of Benefits (AOB) – An arrangement by which a patient requests that their health benefit payments be made directly to a designated person or facility, such as a physician or hospital.

Assisted Living Facility (ALF) – A residential living arrangement that provides individual personal care and health services for people requiring assistance with ADLs.

Attending Physician- Number of the licensed physician who would normally be expected to certify and recertify the medical necessity of the number of services rendered and/or who has primary responsibility for the patient's medical care and treatment.

Authoritative Approval- Method or type of approval that requires a determination that the service is likely to have a diagnostic or therapeutic benefit for patients for whom it is intended.

Authoritative Evidence- Written medical or scientific conclusions demonstrating the medical effectiveness of a service produced by the following:

- Controlled clinical trials, published in peer-reviewed medical or scientific journals.

- Controlled clinical trials completed and accepted for publication in peer-reviewed medical or scientific journals.
- Assessments initiated by CMS.
- Evaluations or studies initiated by Medicare contractors.
- Case studies published in peer-reviewed medical or scientific journals that present treatment protocols.

Authorization- MCO approval necessary prior to the receipt of care. (Generally, this is different from a referral in that, an authorization can be a verbal or written approval from the MCO whereas a referral is generally a written document that must be received by a doctor before giving care to the beneficiary.)

Authorized Representative – Someone who you choose to act on your behalf like a family member or other trusted person. Some authorized representatives may have legal authority to act on your behalf.

Automatic Enrollment – Individuals who are receiving monthly Social Security benefits or Railroad Retirement Board (RRB) benefits prior to attainment of age 65 are automatically enrolled in Medicare Part A and Part B when they attain age 65. Individuals of any age who have been receiving Social Security disability benefits for 24 months are automatically enrolled in Medicare in their 25th month.

Baby Boom – The period from the end of World War II through the mid-1960s marked by unusually high birth rates.

Balance Billing (Medicare) – A method of billing that allows doctors to bill the patient the difference between their charges and the Medicare-allowed amount. New York State Law limits the amount that non-participating providers may charge to no more than 5% above the Medicare approved amount for most physician services. The term "Balance Billing" is also sometimes used to refer to billing for the Medicare cost-sharing – deductibles and coinsurance.

Balance Billing (Surprise Billing)- When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. This happens most often when you see an out-of-network provider (non-preferred provider). These balance bill costs are in addition to what you pay out-of-pocket for out-of-network services according to your health plan coverage. An in-network provider (preferred provider) may not balance bill you for covered services.

Balanced Budget Act of 1997 (BBA) – an Act to balance the federal budget by 2002 and included cuts in Medicare and hospital inpatient and outpatient payments.

Basic Benefits- Basic Benefits includes both Medicare-covered benefits (except hospice services) and additional benefits.

Basic Benefits (Medigap Policy)- Benefits provided in Medigap Plan A. They are also included in all other standardized Medigap policies. (See Medigap Policy.)

Benchmark – The maximum monthly amount that the Low-Income Subsidy, or Extra Help, will pay toward the Medicare Part D monthly premium. Some Basic Part D plans are referred to as benchmark plans due to premiums at or below the benchmark. See: Extra Help.

Beneficiary – Any person who receives benefits (also referred to as a person with Medicare).

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) – A type of QIO, an organization of doctors and other health care experts under contract with Medicare, that uses doctors and other health care experts to review complaints and quality of care for people with Medicare.

Beneficiary Encrypted File- A restricted public use file. An Agreement for Release of the Centers for Medicare & Medicaid (CMS) Beneficiary Encrypted Files (PDF, 13KB) data use agreement is required.

Beneficiary Notification Letter- A letter that is required with CMS Administrator's signature when Medicare beneficiaries will be contacted to participate in a research project.

Beneficiary Notices Initiative (BNI) – An initiative that identifies the financial liability and appeal rights and protections of both Medicare beneficiaries and providers and requires such information be communicated to beneficiaries through notices given by providers.

Benefit Maximum – The limit a health insurance policy will pay for a certain loss or covered service. The benefit can be expressed either as l) a length of time (for example, 60 days), or 2) a dollar amount (for example, $350 for a specific procedure or illness), or 3) a percentage of the Medicare approved amount. The benefits may be paid to the policyholder or to a third party. This may refer to specific illness, time frame, or the life of the policy.

Benefit Payments- The amounts disbursed for covered services to beneficiaries after the deductible and coinsurance amounts have been deducted.

Benefit Period – The period of time for which payments for benefits covered by an insurance policy are available. The availability of certain benefits may be limited over a specified time period.

Benefit Period (Medicare) – A Medicare Part A benefit period begins upon entry into a hospital and ends when the patient has been out of a hospital and not receiving Medicare benefits in a skilled nursing facility for 60 consecutive days, including the day of discharge.

Benefit Triggers – Term used by insurance companies to describe when to pay benefits. Long-term care policies may use functional impairment, limitations in cognitive impairment, medical necessity, and/or a physician's certification to trigger benefits.

Benefits – The health care items, or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicare and Medicaid, covered benefits and excluded services are defined in state and federal law.

Benefits Coordination & Recovery Center (**BCRC**) – The company that acts on behalf of Medicare to collect and manage information on other types of insurance or coverage that a person with Medicare may have.

Benefits Improvement and Protection Act of 2000 (BIPA) – Includes changes to Medicare coverage, payment mechanism and appeals procedures. Expands Medicaid programs, including the State Children's Health Insurance Program (SCHIP)

Biologicals- Usually a drug or vaccine made from a live product and used medically to diagnose, prevent, or treat a medical condition. For example, a flu or pneumonia shot.

Birthing Center- A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.

Blue Cross and Blue Shield Association- An association that represents the common interests of Blue Cross and Blue Shield health plans. The BCBSA serves as the administrator for the Health Care Code Maintenance Committee and also helps maintain the HCPCS Level II codes.

Board and Care Home- A type of group living arrangement designed to meet the needs of people who cannot live on their own. These homes offer help with some personal care services.

Board of Trustees- A Board established by the Social Security Act to oversee the financial operations of the Federal Supplementary Medical Insurance Trust Fund. The Board is composed of six members, four of whom serve automatically by virtue of their positions in the federal government: the Secretary of the Treasury, who is the Managing Trustee; the Secretary of Labor; the Secretary of Health and Human Services; and the Commissioner of Social Security. The other two members are appointed by the President and confirmed by the Senate to serve as public representatives. John L. Palmer and Thomas R. Saving began serving their 4-year terms on October 28, 2000. The Administrator of CMS serves as Secretary of the Board of Trustees.

Board Certified- This means a doctor has special training in a certain area of medicine and has passed an advanced exam in that area of medicine. Both primary care doctors and specialists may be board-certified.

Bonus- Means a payment a physician or entity receives beyond any salary, fee-for-service payments, capitation or returned withhold. Bonuses and other compensation that are not based on referral or utilization levels (such as bonuses based solely on quality of care, patient satisfaction or physician participation on a committee) are not considered in the calculation of substantial financial risk.

Brand Name Drug – A drug that has a trade name and is protected by a patent. Brand name drugs may be available by prescription or over the counter. See: Generic Drug.

Brokers - Licensed professionals that have been certified by the Marketplace to provide enrollment assistance to individuals and small businesses about the health insurance options available through the Marketplace. Brokers may also be involved with Medicare Advantage.

Budgeting – The process which is used to determine the value of a client's income and as appropriate, resources and whether or not they are below the allowable exemption levels.

Bundled Payment – The reimbursement of health care providers such as hospitals and physicians on the basis of expected costs for clinically-defined episodes of care.

Calendar Year – January 1 through December 31.

Capitated - Relationship between a managed care organization (MCO) and primary care physician (PCP), where there is a payment arrangement for health care service providers such as physicians or nurse practitioners. It pays a physician or group of physicians a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care. Under capitation, physicians are given incentive to consider the cost of treatment. Also See: Fully Capitated and Partially Capitated.

Capped Rental Item- Durable medical equipment (like nebulizers or manual wheelchairs) that costs more than $150, and the supplier rents it to people with Medicare more than 25 percent of the time.

Coronavirus Aid, Relief, and Economic Security Act (CARES Act)- The Coronavirus Aid, Relief, and Economic Security Act, also known as the CARES Act, is a $2.2 trillion economic stimulus bill passed by the 116th U.S. Congress and signed into law by President Donald Trump on March 27, 2020, in response to the economic fallout of the COVID-19 pandemic in the United States.

Care Plan – A written plan for your care. It tells what services you will need to reach and keep your best physical, mental and social well-being.

Caregiver- A person who helps care for someone who is ill, disabled, or aged. Some caregivers are relatives or friends who volunteer their help. Some people provide caregiving services for a cost.

Carrier- A private company that has a contract with Medicare to pay your Medicare Part B bills. (See Medicare Part B.)

Case Management – A process used by a doctor, nurse or other health professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources**.**

Case Mix- Is the distribution of patients into categories reflecting differences in severity of illness or resource consumption.

Case Mix Index- The average DRG relative weight for all Medicare admissions.

Cash Basis- The costs of the service when payment was made rather than when the service was performed.

Catastrophic Coverage – The Medicare Part D prescription drug coverage you will receive until the end of the calendar year after you reach a certain amount in out-of-pocket costs for covered drugs. (The amount is subject to yearly change.)

Catastrophic Illness – A very serious and costly health problem that could be life-threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause financial hardship.

Catastrophic Limit- The highest amount of money you have to pay out of your pocket during a certain period of time for certain covered charges. Setting a maximum amount you will have to pay protects you.

Center for Healthcare Information Management- A health information technology industry association.

Centers for Disease Control and Prevention- An organization that maintains several code sets included in the HIPAA standards, including the ICD-9-CM codes.

Centers for Medicare & Medicaid Services (CMS) – A branch of the Department of Health and Human Services. This federal agency is responsible for administering the Medicare, Medicaid, and Child Health Insurance Programs.

Centers for Medicare & Medicaid Services Data Center User Form- A form that is required for access to the CMS data center.

Certificate of Medical Necessity (CMN) – The order, prescription or certificate signed by your Medicare-enrolled provider that explains why you need medical equipment or supplies. Medicare requires this documentation before it will cover certain Durable Medical Equipment (DME).

Certified (certification) - See "Medicare-certified provider."

Certified Application Counselor (CAC) – An individual who is trained to provide enrollment assistance to individuals applying for coverage through the Marketplace. CACs may work for entities such as hospitals, clinics, providers or health plans.

Certified Home Health Agency (CHHA) – Provides nursing services, home health aide services, medical supplies, equipment and appliances and at least one of the following services: physical therapy, speech/language pathology, occupational therapy, social work services and nutritional services.

Certified Nursing Assistant (CNA)- CNAs are trained and certified to help nurses by providing non-medical assistance to patients, such as help with bathing, dressing, and using the bathroom.

Chain of Trust- A term used in the HIPAA Security NPRM for a pattern of agreements that extend protection of health care data by requiring that each covered entity that shares health care data with another entity require that that entity provide protections comparable to those provided by the covered entity, and that that entity, in turn, require that any other entities with which it shares the data satisfy the same requirements.

Chain of Trust Agreement- Contract needed to extend the responsibility to protect health care data across a series of sub-contractual relationships.

Charges – Prices assigned to units of medical service, such as a visit to a physician or a day in the hospital. Charges for services may not be related to the actual costs of providing the services. Further, the methods by which charges are related to costs vary substantially from service to service and from institution to institution.

Cherry Picking – The managed care practice of seeking only healthy customers.

Chronic (Illness) – A lasting, lingering or prolonged illness.

Chronic Maintenance Dialysis- Dialysis that is regularly furnished to an ESRD patient in a hospital based independent (non-hospital based), or home setting.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) – Relating to auxiliary medical services for active/retired military and their dependents. See: TRICARE.

Claim – A bill requesting that medical services be paid by Medicare or by some other insurance.

Claim Adjustment Reason Code- A national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This code set is used in the X12 835 Claim Payment & Remittance Advice and the X12 837 Claim transactions and is maintained by the Health Care Code Maintenance Committee.

Claim Attachment- Any of a variety of hardcopy forms or electronic records needed to process a claim in addition to the claim itself.

Claim Status Category Codes- A national administrative code set that indicates the general category of the status of health care claims. This code set is used in the X12 277 Claim Status Notification transaction and is maintained by the Health Care Code Maintenance Committee.

Claim Status Codes- A national administrative code set that identifies the status of health care claims. This code set is used in the X12N 277 Claim Status Inquiry and Response transaction and is maintained by the Health Care Code Maintenance Committee.

Clinical Breast Exam - An exam by your doctor or other health care provider to check for breast cancer by feeling and looking at your breasts. This exam isn't the same as a mammogram and is usually done in the doctor's office during your Pap test and pelvic exam.

Clinical Performance Measure- This is a method or instrument to estimate or monitor the extent to which the actions of a health care practitioner or provider conform to practice guidelines, medical review criteria, or standards of quality.

Clinical Practice Guidelines- Reports written by experts who have carefully studied whether a treatment works, and which patients are most likely to be helped by it.

Clinical Trails- Clinical trials are one of the final stages of a long and careful research process to help patients live longer, healthier lives. They help doctors and researchers find better ways to prevent, diagnose, or treat diseases. Clinical trials test new types of medical care, like how well a new cancer drug works. The trials help doctors and researchers see if the new care works and if it is safe. They may also be used to compare different treatments for the same condition to see which treatment is better, or to test new uses for treatments already in use.

CMS Agent- Any individual or organization, public or private, with whom CMS has a contractual arrangement to contribute to or participate in the Medicare survey and certification process. The State survey agency is the most common example of a "CMS" agent as established through the partnership role of the State agency (SA) plays in the survey process under the provisions of §1864 of the Act. A private physician serving a contractual consultant role with the SA or CMS regional office as part of a survey and certification activity is another example of a "CMS agent".

CMS Directed Improvement Process- A CMS directed improvement project is any project where CMS specifies the subject, size, pace, data source, analytic techniques, educational intervention techniques, or impact measurement model. These projects may be developed by CMS in consultation with Networks, the health care community, and other interested people.

CMS National Training Program - Provides support for partners and stakeholders, not-for-profit professionals and volunteers who work with seniors and people with disabilities, and others who help people make informed health care decisions.

CMS-1450- The uniform institutional claim form.

CMS-1500- The uniform professional claim form.

Cognitive Impairment – A breakdown in a person's mental state that may affect a person's moods, fears, anxieties, and ability to think clearly.

Coinsurance – A percentage amount that you pay for a medical service after you have paid any deductibles that apply. In Medicare Part B, the percentage of the approved amount (usually 20 percent), that you are responsible for after you have met the annual Part B deductible.

Community Based Long-Term Care Services (CBLTCS) – A requirement of eligibility for enrollment in a Managed Long Term Care plan. These services include Nursing Services in the home, Home Health Care Personal Care Services in the home, Adult Day Health Care, Private Duty Nursing; and Consumer Directed Personal Assistance Services.

Community-Based Organization (CBO) – Community-based service provider.

Community-Based Services – Those services that are designed to help older people remain independent and in their own homes; can include senior centers, transportation, delivered meals or congregate meal sites, visiting nurses or home health aides, contingent upon certain specified conditions.

Community Mental Health Center- A place where Medicare patients can go to receive partial hospitalization services.

Community Rating – A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.

Competitive Bidding (for **D**urable **M**edical **E**quipment) - Open bidding for Medicare contracts between suppliers that compete for the contract by providing the best bid. Competitive bidding program awards Medicare contracts solely based on who offers the lowest bid.

Compliance Date- Under HIPAA, this is the date by which a covered entity must comply with a standard, an implementation specification, or a modification. This is usually 24 months after the effective date of the associated final rule for most entities, but 36 months after the effective data for small health plans. For future changes in the standards, the compliance date would be at least 180 days after the effective data but can be longer for small health plans and for complex changes.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that provides outpatient rehabilitation for the treatment of Medicare beneficiaries who are injured, disabled, or recovering from an illness. **Conditional Payment** – A payment Medicare makes for services another payer may be responsible for.

Confidentiality – Your right to talk with your health care provider without anyone else finding out what you have discussed.

Conflict Free Evaluation and Enrollment Center (CFEEC) – Currently run by Maximus, NY Medicaid Choice, the state's contractor. An assessment is done by a nurse in the client's home or nursing home and makes a simple determination of whether the individual needs long-term care services so they may enroll in an MLTC plan.

Conservatorship – Legal procedure by which one person, the conservator, is given power over the living arrangements, property and/or finances, of another person, the conservatee. Conservatorships are established with legal safeguards for a person in need.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – A federal law that requires most employers to provide continuing health insurance coverage to employees and their dependents who are no longer eligible for the company's health insurance program. You have to pay both your share and the employer's share of the premium. COBRA does not protect you from Part B late enrollment penalties.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) – CMS sponsored surveys used to report Medicare beneficiaries' experience with, among other topics, fee-for-service care plans. The results are shared with Medicare beneficiaries and the public.

Consumer Directed Personal Assistance Program (CDPAP) – A Medicaid funded Personal Care program that empowers self-directing seniors, people with disabilities or their designated representatives to recruit, hire, train, supervise and terminate their choice of personal assistant home care worker including family and friends. Generally, spouses are excluded from being eligible to act as paid caregivers.

Continuing Care Retirement Communities (CCRC) – Offer housing and a range of health care, social, and other services for substantial initial costs plus monthly fees. Can provide care for different stages of aging at one facility without having to move.

Continuum of Care – A comprehensive set of services including preventive, acute, long-term, and rehabilitative services, or the set of providers offering those services.

Coordinated Care Plans – Medicare Advantage plans or Medicare Health plans that offer health care through an established provider network that is approved by the Centers for Medicare and Medicaid Services.

Coordination of Benefits (COB) – A clause in an insurance policy stating the policy will not pay the costs of a covered expense when another insurer pays it or that each insurer will pay part of the costs of the covered service, not to exceed the total actual cost. It is used to prevent the policyholder from receiving duplicate payments for a covered service when he or she is insured by more than one policy.

Coordination Period- A period of time when your employer group health plan will pay first on your health care bills and Medicare will pay second. If your employer group health plan doesn't pay 100% of your health care bills during the coordination period, Medicare may pay the remaining costs.

Copayment (also known as co-pay) **–** A specified dollar amount you pay for a medical service after satisfying any deductible. For example: A Medicare Advantage Plan may have a $10 copayment for each primary care physician office visit.

Coronavirus Aid, Relief, and Economic Security (CARES) Act – Act signed into law on March 27, 2020, to protect the public from the health and economic impacts of COVID-19.

Coronavirus Disease (also known as COVID-19 or 2019 novel coronavirus) – A respiratory disease caused by a coronavirus. First appeared in Wuhan, China in December 2019 and subsequently spread across the world.

Costs – Expenses incurred in the provision of services or goods. Charges billed to an individual or third party may not necessarily be the same.

Cost Sharing – The cost for medical care that you pay yourself, including copayment, coinsurance, or deductible.

Coverage Determination – The first decision made by your Medicare drug plan (not the pharmacy) about your drug benefits, including:

- Whether a particular drug is covered
- Whether you have met all the requirements for getting a requested drug
- How much you're required to pay for a drug
- Whether to make an exception to a plan rule when you request it

The drug plan must give you a prompt decision (72 hours for standard requests, 24 hours for expedited requests). If you disagree with the plan's coverage determination, the next step is an appeal.

Coverage Gap (also known as the donut hole) – The phase of Part D coverage after your initial coverage period. You enter the coverage gap when your total drug costs, including what you and your plan have paid for your drugs, reach a certain limit.

Coverage Restrictions (also known as Utilization Management Tools or Formulary Restrictions*)* – Restriction's drug plans may place on certain covered services to restrict their usage. See: prior authorization, quantity limits, and step therapy.

Covered Services – Medicare law permits payment only for services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury." Therefore, Medicare can pay for services only as long as they are medically necessary.

Creditable coverage (Medigap) - Previous health insurance coverage that can be used to shorten a pre-existing condition waiting period under a Medigap policy.

Creditable coverage (prescription drug coverage) - Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Critical Access Hospital (**CAH**) – A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.

Crossover – A billing arrangement between your Medicare supplemental insurance and Original Medicare whereby your supplemental plan is automatically billed for its share of the cost of your health care services after Medicare claims have been processed.

Current Dental Terminology- A medical code set of dental procedures, maintained and copyrighted by the American Dental Association (ADA), and adopted by the Secretary of HHS as the standard for reporting dental services on standard transactions.

Current Procedural Terminology (CPT) – A listing of the descriptive terms and the numeric identifying codes and modifiers for describing and reporting medical services and procedures performed by physicians. These codes are required on claims submitted to Medicare and are shown on the person with Medicare's MSN.

Currently Working – Considered as currently working if you have employment rights at your company even if on sick leave, not working on a regular basis or laid off temporarily. Those with COBRA are not considered to be currently working.

Custodial Care – Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. (These may also be referred to as Activities of Daily Living or ADLs.) Medicare generally does not cover custodial care.

Daily Benefit – The amount of insurance benefit in dollars a person chooses to buy for long-term care expenses.

Data Matching Issue (Inconsistency) – A difference between information you supplied on your health insurance application (ex. Marketplace health insurance application) and information gained from other sources. (ex. Social Security Administration).

Deductible - An initial amount of medical expense for which the person with Medicare is responsible before Medicare or an insurance policy will pay.

Delivery System Reform Incentive Payment Program (DSRIP) – Is a part of New York's Medicaid Redesign Team (MRT) Waiver Amendment whose purpose is to restructure the health care delivery system by reinvesting in the Medicaid program.

Demand Bill – A demand that a provider continue to bill Medicare for the given services even though the provider does not think that Medicare will cover them. In order to demand bill, you must sign the ABN and agree to pay for the services in full if Medicare denies coverage.

Demonstration Projects - Special projects, sometimes called "pilot programs" or "research studies," that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time, for a specific group of people, and in specific areas.

Denial of Coverage – A decision by Medicare or another insurance that your claim for benefits will not be approved and paid. Common reasons for a denial: the service is not an approved service; the service is not being provided in an appropriate setting; the service is not provided by an approved participating provider; or the service is not medically necessary.

Department of Health and Human Services (DHHS)- DHHS administers many of the "social" programs at the Federal level dealing with the health and welfare of the citizens of the United States. (It is the "parent" of CMS.)

Detailed Notice of Discharge (DND) – This notice explains in writing why your hospital care is ending and lists any Medicare coverage rules related to your case given to you by a hospital after you have requested a Quality Improvement Organization (QIO) review of the hospital's decision that you be discharged. Once you request QIO review of a discharge decision, the hospital must provide you this notice in all cases (whether you in are in Original Medicare or in a Medicare Advantage Plan).

Diagnosis Code- The first of these codes is the ICD-9-CM diagnosis code describing the principal diagnosis (i.e., The condition established after study to be chiefly responsible for causing this hospitalization). The remaining codes are the ICD-9-CM diagnosis codes corresponding to additional conditions that coexisted at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay.

Diagnosis Related Groups (DRGs) – DRGs are used to determine the amount that Medicare reimburses hospitals for inpatient services. They are part of the Prospective Payment System Categories of illnesses, one of which is assigned to a Medicare patient who is being admitted to a hospital. The hospital is reimbursed a fixed amount based on the DRG code for the patient.

Disability- For Social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months. Special rules apply for workers aged 55 or older whose disability is based on blindness. The law generally requires that a person be disabled continuously for 5 months before he or she can qualify for a disabled worker cash benefit. An additional 24 months is necessary to qualify under Medicare

Discharge Plan – A coordinated plan for post-hospitalization/skilled nursing facility care intended to identify an individual's need for medical and social services and resources available to help prevent re-hospitalization.

Disclosure History- Under HIPAA this is a list of any entities that have received personally identifiable health care information for uses unrelated to treatment and payment.

Disenroll – To end one's health coverage with a health plan.

Donut Hole – See: Coverage Gap.

Drug Class – Group of drugs that treat the same symptoms or have similar effects on the body. For example, people with Medicare often use statin class drugs, which are used for reducing cholesterol. Drugs in this class include (but are not limited to) Lipitor, Zocor, Pravachol, Zetia, and Vytorin.

Drug List – A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. (Also known as a formulary)

Drug Tier- Drug tiers are definable by the plan. The option "tier" was introduced in the PBP to allow plans the ability to group different drug types together (i.e., Generic, Brand, Preferred Brand). In this regard, tiers could be used to describe drug groups that are based on classes of drugs. If the "tier" option is utilized, plans should provide further clarification on the drug type(s) covered under the tier in the

PBP notes section(s). This option was designed to afford users additional flexibility in defining the prescription drug benefit.

Dual Eligibles – People who have both Medicare and full Medicaid. People with Medicaid with a spenddown are not considered Dual Eligible UNLESS they meet their spenddown.

Dually Certified Nursing Facility – A nursing facility having dual certification as a skilled nursing facility and a nursing facility and can admit Medicare or Medicaid patients to either their skilled nursing facility or nursing facility.

Duplication of Coverage – Coverage of the same health services by more than one health insurance policy.

Durable Medical Equipment (DME) – Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, oxygen equipment, or hospital beds. DME is paid for under Medicare Part B, and the person with Medicare pays 20 percent coinsurance in Original Medicare.

Durable Medical Equipment Medicare Administrative Contractor (DME MAC) - A private insurance company that contracts with Medicare to process durable medical equipment (DME) claims. Noridian is the DME MAC for New York State.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) – See: Durable Medical Equipment (DME)

DMEPOS Competitive Bidding – A program that changes the amount Medicare pays suppliers for certain types of durable medical equipment and supplies and makes changes to who can supply these items. (See: Competitive Bidding for up-to-date information.)

Durable Power of Attorney – A legal document that lets a person appoint an agent/another person(s) to make decisions on their personal affairs, such as finances, health insurance and other legal decisions, on their behalf should they become sick or incapacitated.

Duration of Benefits – Time period or maximum amount of dollars for which an insurance policy will pay benefits.

Earned Income Disregards (EID) – Earned income disregards are the allowable deductions and exclusions subtracted from the gross earnings. The resulting amount, or net income, is applied against the household's need. EIDs vary in amount and type, depending on the category of the applicant and the program applied for.

Effective Date of Coverage – The starting date of insurance coverage which can be any of the following: 1) Date of the application, 2) Date of the insurance company's approval, 3) Date the policy is issued.

Elderly Pharmaceutical Insurance Coverage (EPIC) – The State Prescription Assistance Program (SPAP) in New York State. EPIC's annual income eligibility limit is $75,000 for singles and $100,000 for married couples.

Election – A person's decision to join or leave the Original Medicare Plan or a Medicare Advantage and/or Part D plan.

Electronic Health Records (EHRs) – Computerized confidential records about a person's health care or treatments kept by doctors, other health care providers, medical office staff, or hospital.

Eligibility/ Medicare Part A – People with Medicare are eligible for premium-free Medicare Part A (hospital insurance) if: they are 65 or older and receiving Social Security or Railroad Retirement Board benefits, under 65 and have received Social Security disability benefits for 24 months, under 65 and have End-Stage Renal Disease or receiving Social Security disability benefits due to Amyotrophic Lateral Sclerosis (ALS**),** commonly known as Lou Gehrig's Disease.

Eligibility/ Medicare Part B – Automatically eligible for Part B if you are eligible for Part A, also eligible for Part B if not eligible for Part A premium-free but are age 65 or older and a resident or citizen or lawful alien admitted for permanent residency. And you must have lived in the United States continuously for at least five years to be eligible for Medicare.

Elimination Period – An amount of time that applies to "hospital indemnity," long-term care, or other "indemnity" type policies. It is the number of days before any benefit will be paid. (Also known as a deductible or waiting period.)

Emergency Care – Care given for a medical emergency when you believe that your health is in serious danger.

Emergency Medication Treatment and Active Labor Act (EMTALA) - The Emergency Medical Treatment and Active Labor Act, codified at 42 U.S.C. § 1395dd. EMTALA requires any Medicare-participating hospital that operates a hospital emergency department to provide an appropriate medical screening examination to any patient that requests such an examination. If the hospital determines that the patient has an emergency medical condition, it must either stabilize the patient's condition or arrange for a transfer; however, the hospital may only transfer the patient if the medical benefits of the transfer outweigh the risks or if the patient requests the transfer. CMS regulations at 42 C.F.R. §§ 489.24(b) and 413.65(g) further clarify the statutory language.

Employer Group Health Plan (EGHP) – A health plan that gives health coverage to employees, former employees and their families.

End Stage Renal Disease (ESRD) – Medical condition in which a person's kidneys no longer function, requiring the individual to receive dialysis or a kidney transplant to sustain his or her life.

Enrollment – The procedure by which eligible persons can sign up for the Medicare program and receive Medicare (Part A and Part B) coverage. It is handled by the Social Security Administration. This may also refer to the process of joining a Medicare Advantage or Medicare prescription drug plan.

Enrollment Period (EP) – Period during which individuals may enroll in an insurance policy, Medicare Part A and Part B, Part D drug plan or Medicare Advantage plan. See: Fall Open Enrollment Period; Annual Coordinated Election Period; Medicare Advantage Open Enrollment Period; General Enrollment Period; Initial Enrollment Period; and Special Enrollment Period.

Episode of Care (EOC) – The health care services given during a certain period of time, during a hospital stay or home health service.

Evidence of Coverage (EOC) – A resource that explains your plan (Medicare Advantage Plan, Part D Plan) benefits, premiums, and cost-sharing; conditions and limitations of coverage; and plan rules. The EOC is typically mailed with the plan's Annual Notice of Change (ANOC), which is a notice informing you of plan changes that will take effect the following year.

Exception – A formal written request submitted to a Medicare Part D plan by your prescriber to ask that a non-formulary drug be covered; to request that a coverage rule (such as prior authorization) be waived; or to request that the tier level of your drug be changed to lower the cost.

Excess Charges – A limited amount above the Medicare-approved amount charged by doctors and other health care providers who do not accept assignment.

Exclusion – An expense or condition that the policy does not cover and toward which it will not pay. Common exclusions may include pre-existing conditions, such as heart disease, diabetes, or hypertension. For Medicare supplement insurance, plans may exclude coverage for pre-existing conditions only for a maximum of six months after coverage begins.

Expedited Appeal – A fast appeal of a Medicare private health plan or drug plan's denial of coverage in which a beneficiary must receive a decision within 72 hours.

Explanation of Benefits (EOB) – An Explanation of Benefits is sent to you to describe what benefits were paid or not paid by your employer-sponsored retiree plan or by your Medigap or other private health insurance. Usually, the reasons for claim denial are listed on the EOB.

External Review – A review of a plan's decision to deny coverage for or payment of a service by an independent third-party not related to the plan.

Extra Help (Also known as the Low-Income Subsidy (LIS) – A Medicare program that helps people with low income and resources pay Medicare Part D Prescription Drug plan costs, such as premiums, deductibles and coinsurance.

Facility Fee – a charge you may have to pay (in addition to any other charges for the visit) when you see a doctor at a clinic that is not owned by the doctor.

Fair Hearing (FH) – Fair Hearing means a formal procedure provided by the Office of Administrative Hearings, upon a request made by an applicant or recipient, to determine whether an action taken or failure to act by a local district was correct.

False Claims Act (FCA) – an Act that imposes liability on any person who submits a claim to the federal government, such as CMS, that he or she knows (or should know) is false.

Federal Coordinated Health Care Office (FCHCO) – The Office established under the Affordable Care Act to improve services for individuals dually eligible for Medicaid and Medicare.

Federal Employees Health Benefit (FEHB) Program – Health Insurance for full-time permanent civilian employees and retirees of the United States Government, offered through private health plans.

Federal Poverty Level (FPL) - The federally set level of income that an individual or family can earn below which it is recognized that they cannot afford necessary services. The FPL is used to determine

eligibility for Extra Help and the Medicare Savings Programs. The FPL changes every year and varies depending on the number of people in a household.

Federal Insurance Contribution Act Payroll Tax- Medicare's share of FICA is used to fund the HI Trust Fund.

Federally Qualified Health Center (FQHC) – Health centers that have been approved by the government for a program to give low-cost health care. FQHCs include community health centers, Tribal health clinics, migrant health services, and health centers for homeless individuals.

Fee-for-Service (FFS) – Method of charging whereby a physician or other practitioner bills for each encounter or service rendered. This is the method of billing by providers in Original Medicare.

Fee Schedule – A listing of accepted charges or established allowances for specified medical, dental, or other procedures or services. It usually represents either a physician or third party's standard or maximum charges for the listed procedures.

Fiscal Year (FY) – The Federal Government's budget (or fiscal) year runs from October 1 to September 30 of the following calendar year.

Flexible Spending Account (FSA) – A tax-advantaged financial account set up by an employer in which an employee can set aside a portion of earnings to pay for qualifying expenses – often medical expenses. There is no carry-over of FSA funds. This means that FSA funds you don't spend by the end of the plan year can't be used for expenses in the next year.

Food & Drug Administration (FDA) – Responsible for protecting and promoting public health through the regulation and supervision of food safety, tobacco products, dietary supplements, prescription and over-the-counter drugs, vaccines, biopharmaceuticals, blood transfusions, and medical devices.

Formulary – A list of covered drugs. In Medicare health and drug plans, doctors may have to order or use only drugs listed on the health plan's formulary.

Formulary Exception - A type of coverage determination request whereby a Medicare plan member asks the plan to cover a non-formulary drug or amend the plan's usage management restrictions that are placed on the drug.

Formulary Restrictions – See: coverage restrictions

Fraud – To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the actual service provided

Fraud Enforcement and Recovery Act (FERA) – The primary civil enforcement tool used by the federal government (including CMS) to combat healthcare fraud which made significant changes to the Fraud Claims Act.

Free Look (Medigap) – A period of time (usually 30 days) when you can try out a Medigap policy. During this time, if you change your mind about keeping the policy, it can be cancelled.

Freedom of Information Act (FOIA) – provides the public the right to request access to records from any federal agency. It is often described as the law that keeps citizens in the know about their government. Federal agencies are required to disclose any information requested under the FOIA unless it falls under one of nine exemptions which protect interests such as personal privacy, national security, and law enforcement.

Fully Capitated – Plan is given a set amount which includes all reimbursement for all long term care services as well as medical services such as doctor office visits, hospital care, pharmacy and other health related services

Fully Integrated Dual Advantage (FIDA) plan – A type of managed care plan for dual eligible individuals that will cover not only Medicaid long-term care services, but also, all other medical care covered by Medicare and Medicaid. As of December 31, 2019, the Fully Integrated Dual Advantage (FIDA) program is no longer available in the State of New York.

Fully Integrated Dual Eligible (FIDE) plan – A Medicaid Advantage Plus (MAP) plan which combines a Medicare Advantage Dual-SNP with an MLTC plan and adds all other Medicaid services into one fully capitated plan. May also be referred to as Fully Integrated Dual Eligible SNP (FIDE SNP)

Gag Rule Laws – Special laws that make sure that health plans let doctors tell their patients complete health care information. This includes information about treatments not covered by the health plan. These laws make it illegal to include "gag" clauses in doctor contracts, which limit a doctor's ability to give information to patients about treatment choices for a health problem.

Gaps in Coverage – The costs or services that are not covered under the Original Medicare Plan such as deductibles and coinsurances, and dental and vision care.

Gatekeeper – In a managed care plan, this is another name for the primary care physician (PCP). This doctor gives you basic medical services and coordinates proper medical care and referral.

General Enrollment Period (GEP) - January 1 to March 31 of each year in which eligible persons can sign up for Medicare Part B and/or premium Part A. Coverage begins the first of the month after the month of enrollment.

Generic Drug – A copy of a brand name drug that is regulated by the Food & Drug Administration to be identical in dosage, safety, strength, how it is taken, quality, performance and intended use *(Definition from the U.S. Food & Drug Administration)*. Generics generally work just as well as the brand-name version but are less expensive because they are not patented. See: Brand name drug.

Grace Period – A specified period after a premium payment is due on an insurance policy, in which the policyholder may make such payment, and during which the provisions of the policy continue.

Grandfathered – As used in connection with the Affordable Care Act: exempt from certain provisions of this law

Grievance – A formal complaint about your Medicare Advantage/Part D plan, including a complaint about their customer service. A grievance is not the same as an appeal. See: Medicare Appeal.

Group Health Plan (GHP) – A health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Group Insurance – A written contract between an insurer and a "middleman," usually an employer or group, which provides benefits to the insured persons holding individual certificates of insurance stating the provisions of the coverage given to each insured individual or family.

Guaranteed Issue Rights – rights you have when insurance companies are required by law to sell you a Medicare Supplement (Medigap) policy.

Guaranteed Renewable – The insurance company agrees to continue to insure the policyholder for as long as the premium is paid. The premiums cannot be raised for a policyholder because of the benefits received, but premiums can be raised for all policyholders. Medigap plans are guaranteed renewable.

Health and Human Services, Department of (HHS) – An executive department of the federal government that has the ultimate authority for the Medicare and Medicaid programs.

Health Benefit Exchange – See: Health Insurance Exchange.

Health Care Fraud Prevention and Enforcement Action Team (**HEAT)** – A joint initiative between the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), and the U.S. Department of Justice (DOJ), that plays a critical role in the fight against health care fraud.

Health Care Provider – A person who is trained and licensed to give health care. Also, a place that is licensed to give health care.

Health Care Proxy – This legal document designates and authorizes a person (the "proxy") to make decisions regarding medical treatment for another only when that person becomes temporarily or permanently incapable of communicating their own care or treatment wishes. The Health Care Proxy document can be revoked at any time. See: Advance Directive; Power of Attorney.

Health Care Quality Improvement Program (HCQIP) – A program which supports the mission of CMS to assure health care security for beneficiaries.

Health Home – A care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. (Also known as Medicaid Health Home.)

Health Insurance Claim Number (HICN) – The unique alphanumeric Medicare entitlement number assigned to a person with Medicare, and which formerly was used on the Medicare card. This SSN-based number has been replaced by the Medicare Beneficiary Identifier (MBI) that now appears on the new Medicare cards.

Health Insurance Exchange – A set of government-regulated and standardized health care plans, from which individuals may purchase health insurance eligible for federal subsidies. New York State established a state-based exchange called the New York State of Health. (Also known as Marketplace, Health Insurance Exchange.)

Health Insurance Information, Counseling and Assistance Program (HIICAP) – A statewide program developed to enable New York Medicare beneficiaries to become educated health care consumers. HIICAP is part of the national SHIP (State Health Insurance Assistance Program).

Health Insurance Information, Counseling and Assistance Program (HIICAP) Consortium – A group of private and public organizations that coordinate resources to educate people with Medicare and their families about Medicare and other health insurance.

Health Insurance Marketplace – A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. (Also known as Marketplace, Health Insurance Exchange.)

Health Insurance Portability and Accountability Act (HIPAA) – Federal health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits. HIPAA also provides rules for disclosure of medical record information.

Health Maintenance Organization (HMO) – An organization that, for a prepaid fee, provides a comprehensive range of health maintenance and treatment services (including hospitalization, preventive care, and nursing). Medicare HMOs are a common type of Medicare Advantage plan.

Health Reimbursement Account (HRA) – Employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year.

Health Savings Account (HSA) – A savings account used in conjunction with a high-deductible health insurance policy that allows users to save money tax-free against other expenses, including medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if you don't spend them.

Hearing – a procedure that gives a dissatisfied claimant an opportunity to present reasons for the dissatisfaction and to receive a new determination based on the record developed at the hearing.

HMO with a Point of Service Option (HMO-POS) – A Managed Care Plan, generally less restrictive than an HMO. A person with this type of plan may have additional coverage for certain types of services outside of the plan network for an additional cost.

Home and Community-Based Services (HCBS) – Services and support provided by state Medicaid programs in your home or community that give help with such daily tasks as bathing and dressing.

Home and Community-Based Waiver Services - Services provided pursuant to a waiver under Section 1915(c) of the Social Security Act. New York has obtained several such waivers: Long Term Home Health Care Program; Home and Community Based Services (HCBS) Waiver; Nursing Home Transition and Diversion (NHTD) Waiver; Office of Mental Health (OMH) Home and Community Based Services Waiver (HCBS) For Children and Adolescents with Serious Emotional Disturbance (SED); and Traumatic Brain Injury (TBI) Waiver. Under these waivers, specialized services may be provided, in addition to the regular State Plan services. The general intent is to avoid institutionalization.

Hold Harmless (HH) – A provision of the Social Security Act that ensures that Social Security checks will not decline from one year to the next because of increases in Medicare Part B premiums. The hold harmless rule applies to most, but not all, Social Security recipients.

Homebound – Normally unable to leave home. Leaving home takes considerable and taxing effort. You may leave home for medical treatment or short, infrequent absences for non-medical reasons, like a trip to the barber or church service. A doctor must certify this condition.

Home Health Advance Beneficiary Notice (HHABN) – A notice that informs the beneficiary of the potential of non-coverage by Medicare.

Home Health Agency (HHA) – A home health agency is a public or private agency that specializes in giving skilled nursing services, home health aides, and other therapeutic services, such as physical therapy, in the home.

Home Health Care – Health care services provided in the home on a part time basis for the treatment of an illness or injury. Medicare pays for home care only if the type of care needed is skilled and required on an intermittent basis.

Hospice – Comprehensive care for people who are terminally ill that includes pain management, counseling, respite care, prescription drugs, inpatient care and outpatient care, and bereavement services for the terminally ill person's family. (Also known as Hospice Care.)

Hospital Coinsurance – For the 61st through the 90th day of inpatient hospitalization in a benefit period, a daily amount for which the beneficiary is responsible. Coinsurance would also apply from day 91 through 150 if Lifetime Reserve days are used.

Hospital Insurance – See: Medicare Part A.

Hospital Indemnity Insurance – Supplemental insurance that pays a fixed cash amount for each day a person is in the hospital up to a certain amount of days. Some policies may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount.

Hospital Readmissions - A situation where you were discharged from the hospital and wind up going back in for the same or related care within 30, 60 or 90 days. The number of hospital readmissions is often used in part to measure the quality of hospital care, since it can mean that your follow-up care wasn't properly organized, or that you weren't fully treated before discharge.

Important Message from Medicare (IM) – A standard notice that must be delivered to all Medicare inpatients within two days of admission and when you are going to be discharged. It explains your rights as a patient and tells you how to ask for an expedited review of the discharge decision by the BFCC-QIO.

Income-Related Monthly Adjustment Amount (IRMAA) – Amount paid in addition to Medicare Part B and/or Medicare Part D premium when a beneficiary's modified adjusted gross income is greater than the specified threshold amounts.

Indemnity Policy – Type of insurance policy, which pays a fixed amount per day for covered services received, generally a fixed amount per day of covered hospitalization.

Independent Consumer Advocacy Network (ICAN) - The New York State Ombudsman Program for people with Medicaid long-term care services.

Independent Review Entity (IRE) – An independent entity with which Medicare contracts to handle the second level of appeals of a denial of coverage (except for hospital care) if you are in a Medicare Advantage Plan or a Medicare Part D Prescription Drug Plan.

Individual Health Insurance – An individual policy of insurance is a written contract between an insurance company and an insured person. It is separate from Medicare.

Individual Insurance Policy – The individual copy of the master contract that contains a policy number assigned only to the subscriber. That policy number should be used when contacting the insurance company for information.

Inflation Protection – A policy option that provides a percentage or dollar amount increase in benefit levels to adjust for inflation or allows the policyholder to purchase additional units of coverage to keep up with inflation

In-Home Supportive Services (IHSS) – Personal care services and non-medical services to help functionally impaired persons of all ages, with limited resources, stay at home. Title XX of the Social Security Act authorizes payment to those individuals who qualify for IHSS.

Initial Coverage Election Period – The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. You may choose a Medicare Advantage plan during your Initial Coverage Election Period.

Initial Coverage Limit – The initial period of Part D insurance coverage after a beneficiary has met any deductible requirement and before expenditures reach the coverage gap.

Initial Enrollment Period (IEP) – Your IEP starts three months before you first meet all the eligibility requirements for Medicare and lasts for seven months. This IEP is the first chance a person has to enroll in Part B if they do not get it automatically, without paying a penalty.

Initial Preventive Physical Exam (IPPE) – See: "Welcome to Medicare" Preventive Visit

In-Network – Part of a managed care plan's network of providers. If you use doctors, hospitals, pharmacies, home health agencies, skilled nursing facilities and equipment suppliers that are in your private health plans or Medicare private drug plan's network, you will generally pay less than if you use out-of-network providers.

Inpatient – A person who has been admitted at least overnight to a hospital or other health facility for the purpose of receiving a diagnosis, treatment, or other health services. Must have doctor's written order of admittance.

Inpatient Hospital Deductible – an amount deducted from the amount payable by Medicare Part A for beneficiary inpatient hospital services.

Institutionalization – Admission of an individual to an institution, such as a nursing home, where he or she will reside indefinitely or for an extended period of time.

Institutionalized Spouse - A person who is: (a) in a medical institution or nursing facility and is expected to remain in such a medical institution or nursing facility for at least 30 consecutive days; or (b) in receipt of home and community-based waiver services, and expected to receive such services for at least 30

consecutive days; or (c) receiving institutional or non-institutional services under a Program of All-Inclusive Care for the Elderly (PACE); or (d) in a medical institution/nursing facility or in receipt of home and community-based waiver services, and expected to receive a combination of institutional services and home and community-based waiver services for at least 30 consecutive days; **and** (e) is married to a person who is not described in items (a) through (d).

Insurance Contract – The master copy of a policy which is submitted to the State Department of Financial Services (DFS) for approval. It is assigned a form number, which is listed in the bottom left corner of the cover. This number should be used when seeking information from DFS.

Insured – The individual or organization protected in case of loss or covered service under the terms of an insurance policy.

Insurer – A company which, for a set premium, agrees to reimburse the insured for a loss covered by an insurance policy.

Interdisciplinary Care Teams (ICTs) – Important component of integrated care programs for Medicare-Medicaid enrollees and include the enrollee, providers, other support professionals, and family members/caregivers.

Intermediate Care Facility for Individuals with Mental Retardation or Developmental Disabilities (ICF/MRDD) – An optional Medicaid benefit that provides comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence.

IRMAA – See: Medicare Income-Related Monthly Adjustment Amount.

Large Group Health Plan (LGHP) – In general, a group health plan that covers employees of an employer that has 100 or more employees.

Length of Stay – The time a patient stays in a hospital or other health facility.

Lifetime Maximum – The Affordable Care Act prohibits health plans from putting a lifetime dollar limit on most benefits you receive. The law also restricts and phases out the annual dollar limits a health plan can place on most of your benefits — and does away with these limits entirely in 2014.

Lifetime Reserve Days – When you are in the hospital for more than 90 days in a single benefit period, Medicare pays for 60 additional reserve days that you can only use once in your lifetime. They are not renewable once you use them. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Limited Benefits Policy – Type of insurance policy, which only pays benefits for a specific type of illness or health care services, named in the policy.

Limited Income Newly Eligible Transition (LINET) – Medicare's program that provides temporary (and retroactive) Part D prescription drug coverage for low-income Medicare beneficiaries not already enrolled in a Medicare Part D plan.

Limiting Charge – The maximum amount doctors and other health care providers who don't accept assignment can charge for a covered service. The Federal limit is 15 percent over Medicare's approved

payment amount. New York State's limit is 5 percent for physician services, except for home and office visits, where the 15 percent Federal limit applies.

Living Will (also known as a medical or advance directive) – A written legal document that shows what type of treatments you want or don't want in case you can't speak for yourself.

Long-Term Care (LTC) – The medical and social care given to individuals who have severe chronic impairments over a long period of time. Long-term care can consist of care in the home, by family members assisted with voluntary or employed help (such as provided by home health care agencies), adult day health care, or care in institutions.

Long-Term Care Hospital – Acute care hospital that provides treatment for patients who stay, on average, more than 25 days.

Long-Term Care Insurance (LTCI) – A policy designed to help alleviate some of the costs associated with long-term care. Often, benefits are paid in the form of a fixed dollar amount (per day or per visit) for covered long-term care expenses and may exclude or limit certain conditions from coverage.

Long-Term Care Ombudsman – An independent advocate for nursing home and assisted living facility residents who provides information about how to find a facility and how to get quality care and addresses complaints and advocates for improvements in the long-term care system.

Loss – The basis for a claim under an insurance policy. In health insurance, loss refers to expenses incurred resulting from an illness or injury.

Loss/Benefit Ratio – The percentage of premiums collected that is returned in benefits to the policyholder by an insurer. See: Medical Loss Ratio.

Low Income Subsidy (LIS) – See: Extra Help.

Mammogram – A special X-ray of the breasts. Medicare covers the cost of a screening mammogram once a year for women over 40 who are enrolled in Medicare.

Managed Care Organization (MCO) – A health care provider or a group or organization of medical service providers who offers managed care health plans.

Managed Care Plan– A health care plan that involves a group of doctors, hospitals and other health care providers who have agreed to provide care to people with Medicare in exchange for a fixed amount of money every month.

Managed Long Term Care Program (MLTC) - Provides health and long-term care services to adults with chronic illness or disabilities to better address their needs and to prevent or delay nursing home placement.

Marketing Fraud- When Medicare private plans deceive you—through marketing materials or through a person misrepresenting the plan—about what the plan offers and how much it costs.

Marketplace – Shorthand for the "Health Insurance Marketplace," a shopping and enrollment service for medical insurance created by the Affordable Care Act in 2010. (AKA Health Insurance Exchange.)

Maximum Out-of-Pocket (MOOP) – Medicare Advantage plans limit how much beneficiaries pay out- of- pocket for all Part A and Part B (hospital and medical) covered services. MOOP does NOT include the Part D costs and monthly premiums.

MAXIMUS – A national organization that serves as the Qualified Independent Contractor (QIC) for Medicare Parts A, B, C, and D appeals. MAXIMUS provides Medicare and Medicaid beneficiaries and providers with independent reviews of health insurance denials.

Medicaid – Federally assisted, state-administered program to finance health care services for low-income persons of all ages.

Medicaid Buy-In Program for Working People with Disabilities - A state-run Medicaid program that allows people with disabilities under the age of 65 to work and still get the comprehensive benefits of Medicaid. The program allows people who are not eligible for traditional Medicaid—because their income or assets are too high—to "buy in" to the program for a small percentage of their income.

Medicaid Choice - New York Medicaid Choice is the managed care enrollment program of the New York State Department of Health. NY DOH has contracted with MAXIMUS to oversee this program.

Medicaid Managed Care – Type of Medicaid health coverage that offers enrollees the opportunity to choose a Medicaid health plan. Enrollees can only see the doctors and other health providers in their plan's network and must follow the plans rules for accessing care. In addition, they will be assigned a primary care provider and must go to this provider in order to get a referral for specialty care and prior authorizations for non-emergency hospitalizations and many other services.

Medicaid Managed Long-Term Care (MMLTC) - an arrangement in which the state Medicaid program makes a single managed care plan responsible for a range of long-term care services and pays the plan a set monthly fee, called capitation, regardless of the amount of care delivered. (Sometimes known as MLTC.)

Medicaid Spend-Down (also known as Medicaid Excess Income or Surplus Income Program) – A state-run Medicaid program for people whose income is higher than would normally qualify them for Medicaid, but who have high medical expenses that reduce their incomes to the Medicaid eligibility level. In New York State you must be under age 21, age 65 or older, certified blind or certified disabled, pregnant or a parent of a child under age 21 to become eligible for Medicaid Spend-Down.

Medicaid Waiver programs – Programs that help provide services to people who would otherwise be in an institution, nursing home or hospital to receive long-term care in the community. The approval of Federal Medicaid Waiver programs allows states to provide services to consumers in their homes and in their communities.

Medical Insurance (MI) – See: Medicare Part B.

Medical Loss Ratio (MLR) – As required by the Affordable Care Act, certain health insurers must provide rebates to their customers for each year that the insurers do not meet a set financial target called a medical loss ratio (MLR). A MLR measures the share of a health care premium dollar spent on health care quality improvement, as opposed to administrative costs. The ACA sets the minimum required MLR at 80% for the individual and small group markets and 85% for the large group market.

Medical Necessity – Accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Medicare normally covers services deemed medically necessary.

Medical Nutrition Therapy (MNT) - Nutrition counseling provided by a registered dietitian. This preventive benefit is currently offered through Medicare, only for people with renal disease or diabetes.

Medical Underwriting – The process that an insurance company uses to decide whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions and how much to charge you for that insurance.

Medically Necessary – Procedures, services or equipment that meets medical standards and is necessary for the diagnosis and treatment of a medical condition. Medical necessity must be established (via diagnostic and/or other information presented on the claim under consideration) before the insurer will make payment.

Medicare – Title XVIII of the Social Security Act, federal health insurance program for people 65 and older and some under 65 who are disabled. Medicare has two parts. Part A is Hospital Insurance and primarily provides coverage for inpatient care. Part B is Medical Insurance and provides limited coverage for physician services and supplies for the diagnosis and treatment of illness or injury. You can receive Medicare health insurance coverage directly through the federal government (See: Original Medicare) or administered through a private company. (See: Medicare Advantage)

Medicare Advantage Plan (also known as Part C or health plan) – Medicare program developed as a result of the Balanced Budget Act of 1997, which provides people with Medicare with many different health insurance options. Plans must cover all Medicare Part A and Part B services and may include prescription drug coverage. Plans may also cover extras, like dental care, eyeglasses or hearing aids.

Medicare Appeal – Procedure in which a person with Medicare who disagrees with the denial of payment for a claim by Medicare can challenge the decision made. See: Appeals Process.

Medicare Approved Amount – See: Approved Amount.

Medicare-Approved Supplier - A company, person, or agency that's been certified by Medicare to give you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility.

Medicare Administrative Contractor (MAC) – A private company that contracts with CMS to process both Medicare Part A and Part B claims and makes payments to providers on behalf of Medicare**.** The MAC replaced Medicare Part A intermediaries and Part B carriers.

Medicare Advantage Disenrollment Period (MADP) – Replaced with the Medicare Advantage Open Enrollment Period beginning in 2019.

Medicare Advantage Open Enrollment Period (OEP) - Beginning 2019, during the OEP (January 1 – March 31), beneficiaries enrolled in a Medicare Advantage plan (with or without prescription drug coverage) have one opportunity to switch to Original Medicare or another Medicare Advantage plan.

Medicare Benefits Notice- A notice you get after your doctor files a claim for Part A services in the Original Medicare Plan. It says what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay. You might also get an Explanation of Medicare Benefits

(EOMB) for Part B services or a Medicare Summary Notice (MSN). (See Explanation of Medicare Benefits; Medicare Summary Notice.)

Medicare Beneficiary Identifier (MBI) – CMS removed Social Security Number (SSN)-based Health Insurance Claim Numbers (HICNs) from Medicare cards and is now using Medicare Beneficiary Identifiers (MBIs) for Medicare transactions like billing, eligibility status, and claim status. Use of the Social Security based numbers ended 12/31/19.

Medicare-Certified Provider - A health care provider (like a home health agency, hospital, nursing home, or dialysis facility) that's been approved by Medicare. Providers are approved or "certified" by Medicare if they've passed an inspection conducted by a state government agency. Medicare only covers care given by providers who are certified or accredited. Being certified is not the same as being accredited.

Medicare Coordination of Benefits Contractor – A Medicare contractor who collects and manages information on other types of insurance or coverage that pay before Medicare. See: Coordination of Benefits (COB).

Medicare Cost Plan – A type of Health Maintenance Organization (HMO) that works in much the same way as a Medicare Advantage Plan if you use in-network providers. But if you go to an out-of-network provider, the services are actually covered under Original Medicare.

Medicare Fraud and Abuse – Medicare fraud is defined as making false statements or representation of material facts to obtain benefit or payment for which no Medicare entitlement exists. Medicare abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced.

Medicare Hospital Insurance Tax – A tax under the Federal Insurance Contributions Act (FICA) that is a United States payroll tax imposed by the Federal government on both employees and Employers to fund Medicare.

Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 – States, territories, and the District of Columbia received funding to help Medicare beneficiaries apply for the Medicare Part D Extra Help/Low-Income Subsidy (LIS) and the Medicare Savings Programs (MSPs).

Medicare Income-Related Monthly Adjustment Amount (IRMAA) – Is the amount paid ***in addition*** to the Medicare Part B and/or Part D premiums if income reported two years ago was above a specified income threshold.

Medicare Insurance Premium Payment (MIPP) Process -Medicaid recipients newly in receipt of Medicare will have their Medicare Part B premiums reimbursed by DOH through the Medicare Insurance Premium Payment (MIPP) process.

Medicare Medical Savings Account (MSA) Plan – Combines a high deductible Medicare Advantage plan with a Medical Savings Account for medical expenses. MSA plans do not include Part D.

Medicare Outpatient Observation Notice (MOON) – A standardized notice to inform Medicare beneficiaries (including health plan enrollees) that they are outpatients receiving observation services and are not inpatients of a hospital or critical access hospital (CAH).

Medicare Part A (Hospital Insurance) – Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, home health care, and hospice care.

Medicare Part B (Medical Insurance) – Medical insurance that helps pay for doctors' services, outpatient hospital care, and other medical services.

Medicare Part C – (Also known as health plan.) See: Medicare Advantage Plan.

Medicare Part D (Medicare Prescription Drug Coverage) – Coverage for prescription drugs which is available through private stand-alone plans for people on Original Medicare or through Medicare Advantage plans for their members.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also called the Medicare Modernization Act or MMA) – The federal law establishing Part D prescription drug coverage and other changes.

Medicare Savings Programs (MSP) also known as "Medicare Buy-In" programs – Helps pay your Medicare premiums and sometimes also coinsurance and deductibles. There are three main Medicare Savings Programs, with different eligibility limits: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI) program.

Medicare Secondary Payer (MSP) – Medicare may pay second on a claim for medical care, after an employer group health plan has paid, for example.

Medicare Select – A type of Medigap/Medicare Supplement plan that may require you to use doctors and hospitals within its network to be eligible for benefits

Medicare Summary Notice (MSN) – A notice mailed to beneficiaries on Original Medicare that lists services received from doctors, hospitals or other health care providers. It details what the provider billed Medicare, Medicare's approved amount for the service, the amount Medicare paid, and what the beneficiary is responsible to pay. An MSN is not a bill.

Medicare Supplement Insurance – See: Medigap.

Medicare Trust Funds – Federal treasury accounts established by the Social Security Act (SSA) for the receipt of revenues, maintenance of reserves, and distribution of payments for Hospital Insurance HI (Medicare Part A) and Supplementary Medical Insurance SMI (Medicare Part B).

Medication Therapy Management Program (MTMP) – The application of a distinct CMS approved service or group of services that optimizes drug therapy with the intent of improved therapeutic outcomes for individual patients.

Medigap (Medicare Supplement) – Type of insurance policy with coverage specifically designed to fill the major benefit gaps in Medicare Part A and Part B (deductibles and coinsurance). Medigap policies only work with Original Medicare.

Mental Health Services – Services that may be provided by a psychiatrist (MD), clinical psychologist (PhD) or clinical social worker (LCSW/LMSW).

Minimum Essential Coverage (MEC) – Any insurance that met the Affordable Care Act requirement for having health coverage

Modified Adjusted Gross Income (MAGI) – The figure used to determine eligibility for lower costs in the Marketplace and for Medicaid and Child Health Insurance Program (CHIP). Generally, modified adjusted gross income is your adjusted gross income plus any tax-exempt Social Security, interest, or foreign income you have.

Multi-Employer Plan – A group health plan that's sponsored jointly by two or more employers or by employers and unions.

Multiple Employer Plan – A health plan sponsored by two or more employers. These plans are generally offered through membership in an association or a trade group.

National Association of Insurance Commissioners (NAIC) – The organization that prepares model provisions and guidelines for insurance companies and state legislatures.

National Committee for Quality Assurance (NCQA) – A non-profit organization that accredits and measures the quality of care in Medicare health plans. NCQA does this by using the Health Employer Data and Information Sets (HEDIS) data reporting system**.**

National Coverage Determination (NCD) – A decision about particular treatments that Medicare will or will not cover for particular conditions. Medicare contractors are required to follow NCDs.

National Provider Identifier (NPI) – A unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).

Navigators – Navigators are individuals trained and certified to educate and provide enrollment assistance to individuals and small businesses about the health insurance options available to them through the Marketplace.

Network – A group of doctors, hospitals, pharmacies and other health care experts hired by a health plan to take care of its members.

New York State of Health – See: Health Insurance Exchange.

New York State Partnership for Long-Term Care (NYSPLTC) – Long-term care insurance policies which are approved under the Partnership program by the New York State Insurance Department. (Department of Financial Services) The NYSPLTC program combines private long-term care insurance and Medicaid Extended Coverage to assist New Yorkers in covering the cost of long-term care.

Non-covered service – A service that does not meet the requirements of a Medicare benefit category, is statutorily excluded from coverage, or is not reasonable and necessary.

Nonforfeiture Benefits – A policy feature that returns at least part of the premiums if the policyholder cancels or lets the policy lapse. For example, the "Reduced Paid-Up Benefit" provides reduced benefits for the original term of the policy, and the "Shortened Benefit Period" provides full benefits for a reduced period of time.

Non-formulary drugs – drugs not on a plan-approved list.

Non-Participating Provider – In Original Medicare, this is a provider that does not always accept assignment. Non-participating providers may charge up to 15 percent of Medicare's approved amount for the service or item on top of the Medicare coinsurance. In addition, the provider can request full payment up front and will then submit the bill to Medicare for patient reimbursement. New York State's limit is 5 percent for physician services, except for home and office visits, where the 15 percent Federal limit applies.

Notice – An official form of communication that informs individuals about the status of their applications, their eligibility for programs, or other important information.

Notice of Medicare Non-Coverage (NOMNC) – A notice that tells you when care you are receiving from a home health agency (HHA), skilled nursing facility (SNF) or comprehensive outpatient rehabilitation facility (CORF) is ending and how you can contact a Quality Improvement Organization (QIO) to appeal.

Notice of Observation Treatment and Implications for Care Eligibility (NOTICE) Act of 2015 – Requires hospitals to inform patients orally and in writing that they are in observation status not inpatients and the consequences of that status.

Nursing Home – Also referred to as a long-term care facility or skilled nursing facility. A residence for persons who need some level of medical assistance and/or assistance with activities of daily living. If certain health criteria are met, Medicare covers a limited stay in a Medicare-certified skilled nursing facility for rehabilitation therapies. Not all nursing homes are Medicare approved/certified facilities.

Nursing Home Policy (sometimes referred to as Long-Term Care policies) **–** Type of limited health insurance policy, which generally pays indemnity benefits for medically necessary stays in nursing facilities. See: Long-Term Care Insurance.

Obamacare – An informal name sometimes used to refer to the Affordable Care Act and health coverage plans available through the Health Insurance Marketplace.

Observation Status – A well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether a patient requires further treatment as a hospital inpatient (Medicare Part A applies) or if they are to be treated on an outpatient basis (Medicare Part B applies).

Occupational Therapy (OT) – Activities designed to improve the useful functioning of physically and/or mentally disabled persons.

Off-Label Use – The practice of prescribing pharmaceuticals for a reason other than the use approved by the U.S. Food and Drug Administration (FDA). See: Food and Drug Administration.

Ombudsman – A "citizens' representative" who protects a person's rights through advocacy, providing information and encouraging institutions or agencies to respect citizens' rights.

Omicron- The Omicron variant is a variant of SARS-CoV-2 that was first reported to the World Health Organization from South Africa on 24 November 2021.

Opt-Out – Doctors can "opt-out" of Medicare by notifying the Medicare Administrative Contractor that they will not accept Medicare payments and informing their patients in writing before providing

services. Doctors who have "opted-out" can charge as much as they want, and their patients have to pay the entire bill themselves.

Original Medicare (Traditional Medicare) – The pay-per-visit federal health insurance program created in 1965 that provides coverage for medically necessary services from any doctor, hospital, or other health care provider who accepts Medicare regardless of location. Persons with Original Medicare share costs by paying deductibles and coinsurances. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance)

Out-of-Area – Services provided to enrollees by providers that have no contractual or other relationship with a Medicare Advantage Plan (also known as Medicare Part C or health plan).

Out-of-Network – Not part of a managed care plan's network of health care providers. If you get services from an out-of-network doctor, hospital or pharmacy, you will likely have to pay higher out of pocket for the services you received.

Out-of-Pocket Costs – Health care costs that you must pay because Medicare or other health insurance does not cover them.

Outlier Case – Outlier cases are atypical cases which involve longer hospital stays or higher treatment costs.

Outpatient – A patient who receives care outside of a facility or at a hospital or other health facility without being admitted to the facility.

Outpatient Hospital Services – Medical or surgical care that Medicare Part B helps pay for and does not include an overnight hospital stay. This includes blood transfusions, certain drugs, hospital billed laboratory tests, mental health care, medical supplies such as splints and casts, emergency services or outpatient clinics, including same day surgery and X-rays or other radiation services.

Outpatient Prospective Payment System (OPPS) – The way that Medicare pays for most outpatient services at hospitals or community mental health centers.

Outpatient Rehabilitation Therapy – Services covered if a doctor prescribes therapy and it is received either in a doctor's office or as an outpatient of a Medicare-approved hospital, home health agency, clinic, rehabilitation or public health agency, or from an independent Medicare-certified physical or occupational therapist in his or her office or in a person's home.

Over the Counter (OTC) Drug – A drug that you can buy without a prescription, at your local pharmacy or drug store. These drugs are not covered by Medicare Part D.

Palliative Care – A multidisciplinary area of healthcare that focuses on relieving and preventing the suffering of patients and is appropriate for patients in all disease stages, including those undergoing treatment for curable illnesses and those living with chronic diseases, as well as patients who are nearing the end of life.

Pandemic – When a disease has rapidly spread across a large international area or worldwide affecting a large number of people. On March 11, 2020, the World Health Organization (WHO) declared Coronavirus Disease (COVID-19) a pandemic.

Partially Capitated – Plan receives a set amount for Medicaid services only. See: Capitated

Participating Facility – Health care facility, which participates in the Medicare program and accepts Medicare payment for services received in the facility.

Participating Physician/Supplier Agreement – An agreement, by an individual physician or supplier, to always accept assignment on claims for Medicare-covered items and services.

Participating Provider – (Medicare) A health care provider who agrees to always take assignment.

Patient Advocate- A hospital employee whose job is to speak on a patient's behalf and help patients get any information or services they need.

Patient Assistant Program- A program offered by a pharmaceutical manufacturer that offers lower-cost or free prescriptions to people with low incomes.

Patient Centered Medical Home – A model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care.

Patient Protection and Affordable Care Act (PPACA) – See: Affordable Care Act.

Patient Representative – A member of the hospital staff who serves as a link between patient, family, physicians and other hospital staff. The representative should be available to answer questions about hospital procedures, help with special needs or concerns and help solve problems (i.e., explaining hospital notices, etc.). There is no charge for services provided by the patient representative.

Patients' Activation Measurement Tool – used by DSRIP to assess a patient's level of understanding of their health self-management abilities.

Penalty – An amount added to your monthly Medicare Part B or Medicare Part D drug plan if you don't join when you're first eligible. You pay this higher premium amount as long as you have Medicare. There are some exceptions.

Period of Care (Hospice) – A set period of time that hospice services are provided. Additional periods of care are possible if the patient is evaluated and still found to be hospice appropriate. Hospice has unlimited periods of care.

Personal Care – Assistance with bathing, cooking, dressing, eating, grooming, or personal hygiene. Medicare only covers personal care if you are homebound and receiving skilled care.

Personal Comfort Items – For inpatients in a hospital, such items as a television, telephone, etc.

Personal Health Information (PHI) – aka **protected health information** and generally refers to demographic information, medical history, test and laboratory results, insurance information and other data that a healthcare professional collects to identify an individual and determine appropriate care.

Physical Therapy (PT) – Services provided by specially trained and licensed physical therapists in order to relieve pain, maintain function, and prevent disability, injury or loss of body part. Note: A beneficiary's lack of restorative potential alone cannot serve as a reason to deny a Medicare claim for therapy. See: Skilled Nursing Care.

Pilot Programs – See Demonstration Projects.

Plan Benefit Package (PBP) – A set of benefits for a defined Medicare Advantage (MA) or Prescription Drug Plan (PDP) service area. The PBP is submitted by PDP sponsors and MA organizations to the Center for Medicare and Medicaid Services (CMS) for benefit analysis, marketing and beneficiary communication purposes.

Plan of Care – Your doctor's written plan saying what kind of services and care you need for your health problem.

Point of Service Option (POS) – Gives managed care plan members the right to partial coverage for certain services they get outside of the managed care plan network.

Power of Attorney – A legal document which gives a person (usually a spouse, relative, or friend) the power to act on behalf of another. A power of attorney primarily authorizes the person you designate to make financial decisions for you. In New York State, it cannot be used to make health care decisions. See: Health Care Proxy.

Pre-Authorization (AKA pre-approval) – An approval that must be requested from a managed care plan or primary care doctor for care, treatment, or other medical services needed. See: Prior Authorization.

Pre-existing Condition – Health conditions or problems that were identified and treated before health insurance was purchased. There is a maximum six-month waiting period for Medigap policies.

Preferred Provider Organization (PPO) – Type of Medicare Advantage plan under which you can get coverage for providers both in **and** out of network.

Premium – Dollar amount paid periodically (monthly, quarterly, or yearly) by an insured person or policyholder in exchange for a designated amount of insurance coverage.

Premium Penalty – An amount that you must pay in addition to the regular monthly premium for late enrollment in Part B or Part D.

Premium Tax Credit – A tax credit that can help you afford health coverage through the Health Insurance Marketplace.

Prescription Drug Plan (PDP) – Stand-alone drug plan offered by private companies (contracted with Medicare) available to beneficiaries on Original Medicare or enrolled in a Medicare Private Fee-for-Service (or Medicare Medical Savings Account (MSA)) plan without Part D.

Preventive Services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, colorectal cancer screenings, yearly mammograms, annual wellness visits, and flu shots). Medicare covers most preventive services at 100%.

Primary Care Physician (PCP) – A doctor who is trained to give you basic care. This includes being the first one to check on health problems and coordinating your health care with other doctors, specialists and therapists. In some Medicare managed care plans, you may have to see your primary care doctor for a referral to see a specialist.

Primary Payer – The insurance company that pays first on a claim. This could be Medicare or other insurance.

Prior Authorization – Also called pre-authorization or pre-approval. Approval may be required before a medical service is provided under a Medicare Advantage plan or a prescription drug is covered under a Part D plan. For a service or medication to be covered a provider must get special permission from the plan. When prior authorization is required, an insurer can deny coverage for services already provided or for proposed services that are deemed not to be medically necessary.

Private Fee-For-Service Plan (PFFS) – A type of managed care plan that allows a Medicare beneficiary to receive services from any Medicare participating doctor or hospital regardless of location as long as that provider accepts the plan's terms and conditions. The insurance plan, rather than the Medicare program, determines how much the person with Medicare pays for services.

Programs of All-Inclusive Care for the Elderly (PACE) – Serves individuals who are age 55 or older who are certified by their state to need nursing home care to be able to live safely in the community at the time of enrollment and who live in a PACE service area.

Prospective Payment System (PPS) – A standardized payment system to help manage health care reimbursement whereby the incentive for hospitals to deliver unnecessary care is eliminated. Under PPS, hospitals are paid fixed amounts based on the principal diagnosis for each hospital stay. In special cases, the hospital may receive additional payment for unusually high costs. Also see "Outlier Cases."

Provider – A doctor, hospital, other health care professional or health care facility.

Qualified Disabled Working Individual (QDWI) – A less common Medicare Savings Program (MSP) administered by each state's Medicaid program. It pays the Medicare Part A premium for people who are under 65, have a disabling impairment, continue to work, and are not otherwise eligible for Medicaid.

Qualified Health Plan (QHP) – A health insurance plan sold in the Marketplace that covers Essential Health Benefits.

Qualified Independent Contractor (QIC) – An independent entity with which Medicare contracts to handle the reconsideration level of an Original Medicare (Part A or Part B) appeal.

Qualified Medicare Beneficiaries (QMB) – A Medicaid program that pays the Medicare Part A premium, Part B premium, and eliminates Medicare deductibles and coinsurance for individuals who are entitled to or eligible for Medicare Part A and have a low monthly income.

Qualifying Individual (QI) – A Medicaid program that pays the Medicare Part B premium for individuals who have Medicare Part A, and a low monthly income, but who are not otherwise eligible for Medicaid.

Qualifying Life Event – A change in your life that can make you eligible for a Special Enrollment Period to enroll in health insurance coverage.

Quality Improvement Organization (QIO) – Groups of health care professionals paid by the federal government to monitor the care given to Medicare patients. They are responsible for reviewing complaints and grievances from people with Medicare about the quality of care provided by hospitals,

skilled nursing facilities; home health agencies; Medicare Advantage plans and ambulatory surgical centers. Livanta is the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) in New York State.

Quantity Limit – A restriction used by private health plans and Medicare Part D plans that limit coverage of a particular drug to a specific quantity (such as 30 pills a month).

Quarter of Coverage (QC) – (Also known as Social Security Credit or Work Credit.) Quarter of coverage is the basic unit for determining whether a worker is insured under the Social Security program. A quarter of coverage will be credited for each $1,470 of an individual's total wages and self-employment income for calendar year 2021 (up to a maximum of 4 quarters of coverage for the year). An individual must have 40 quarters of coverage in order to qualify for "premium-free Part A. "

Railroad Retirement – Persons who worked for a railroad company are entitled to their benefits at retirement (including Medicare). Railroad Retirement benefits are similar to Social Security benefits.

Reasonable and Necessary Care – The amount and type of health services generally accepted by the health community as being required for the treatment of a specific disease or illness.

Reconsideration – The second level in the Medicare Part A and Part B appeals process.

Redetermination – The first level in the Medicare Part A and Part B appeals process that occurs when a person with Medicare receives a Medicare Summary Notice (MSN) with a denial of coverage and appeals that decision.

Referral – A written authorization from your primary care doctor for you to see a specialist or get certain services. In some Medicare managed care plans, this is a necessary step.

Rehabilitation Services – health care services that help keep you get back or improve skills and functioning for daily living. Includes: Physical Therapy, Occupational Therapy, Speech and Language Pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Religious Nonmedical Health Care Institution – A facility that provides nonmedical health care, items and services to people who need hospital or skilled nursing facility care, but for whom that care would be inconsistent with their religious beliefs.

Reserve Days – See: Lifetime Reserve Days

Residential Health Care Facility (RHCF) – A nursing home.

Respite Care – Short-term care given to a hospice patient by another caregiver, so that the usual caregiver can rest. A volunteer, an institution, or an adult day care center may provide the care.

Retiree Insurance – Health insurance provided by employers to former employees who have retired. Retiree insurance is usually always secondary to Medicare.

Retroactive Disenrollment- A way to discontinue enrollment in a Medicare Advantage or Medicare Part D Prescription Drug Plan that you mistakenly joined or joined due to marketing fraud, effective back to the date you joined. A person with Medicare will be disenrolled from the Medicare private health or drug plan as if they had never joined it.

Rider – A legal document which modifies the protection of an insurance policy, either extending or decreasing its benefits, or which adds or excludes certain conditions from the policy's coverage.

Sanctions- Administrative remedies and actions (e.g., exclusion, Civil Monetary Penalties, etc.) available to the OIG to deal with questionable, improper, or abusive behaviors of providers under the Medicare, Medicaid, or any State health programs.

Second Opinion – When another doctor gives his or her view about a patient's diagnosis and treatment.

Secondary Payer – A payer of health benefits whose payments cannot be made until another primary party has processed the claim and issued a claim determination.

Self-pay – Consumers pay for all of their own health care costs.

Senior Medicare Patrol (SMP) – A federally funded nation-wide, long-term initiative to fight fraud, waste, error and abuse in Medicare and Medicaid.

Service Area – The area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided.

Service Benefits – Type of benefits in a health insurance policy, which pays the costs of the services, covered by the policy rather than a fixed dollar amount per day to cover any services received.

Skilled Nursing/Therapy Care – Care that can only be provided by or under the supervision of licensed nursing personnel or professional therapists under the general direction of a physician. If a home health aide (someone who provides help with activities of daily living) or other person can perform the service, it is not considered skilled care.

Skilled Nursing Facility (SNF) – A Medicare approved facility which is staffed and equipped to furnish skilled nursing care and skilled rehabilitation services for which Medicare pays benefits.

Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) – A notice issued by SNFs before providing a Part A item or service to a fee for service beneficiary that is usually paid by Medicare but may not be paid in this particular instance because it is not.

Skilled Nursing Facility Coinsurance – For the 21st through the 100th day of extended care, services in a benefit period, a daily amount for which the beneficiary is responsible

Small Business Health Options Program (SHOP) – A program within the Marketplace, where small businesses and their employees can search for and purchase health insurance.

Social Security Act – Legislation passed in 1935, with subsequent amendments establishing Hospital Insurance HI (Medicare Part A) and Supplementary Medical Insurance SMI (Medicare Part B) under Title XVIII.

Social Security Administration (SSA) – The federal agency responsible for determining Medicare eligibility and handling the Medicare enrollment process.

Social Security Disability Insurance (SSDI) – A monthly benefit provided through the Social Security Administration for people who lose their ability to work because of a severe medical impairment.

Special Enrollment Period (SEP) – A period of time when a person with Medicare can enroll in or switch their Part D plan outside of the Annual Coordinated Election Period (October 15 – December 7) due to special circumstances. The term is also used in the context of enrolling in Medicare Part B following the end of a beneficiary's coverage through their own or their spouse's current employment.

Special Needs Plan (SNP) – Type of Medicare Advantage plan that provides specialized care for specific groups of people with Medicare, such as those with both Medicare and Medicaid, institutionalized beneficiaries or with certain chronic conditions.

Specific Disease Policy – Type of limited health insurance policy which only covers the expenses incurred for the specific disease named in the policy. The most common type is cancer insurance.

Specified Low-Income Medicare Beneficiary (SLMB) – A Medicaid program that pays the Medicare Part B premium for individuals who have Medicare Part A and a low monthly income.

Speech/Language Pathology (SLP) – The study, examination, and therapeutic treatment of defects and diseases of the voice, speech, spoken and written language.

Spend-down – The use of medical expenses to reduce available net income and as appropriate, resources in excess of the medically needy income/resource levels.

Spousal Impoverishment Protection Law – Law which allows the at-home spouse of a Medicaid-eligible nursing home resident to keep a minimum amount of joint income and assets.

Star Ratings (Medicare Advantage and Part D Plans) – The star ratings system began in 2007 as a way for CMS and Medicare beneficiaries to assess MA health and Part D plans. Medicare gives star ratings for health plan quality, with the top rating being five stars. The measures target a broad array of clinical quality, customer satisfaction and other beneficiary experience areas.

State Health Insurance Assistance Program (SHIP) – Federally funded program to train volunteers to provide counseling on the insurance needs of Medicare beneficiaries. In New York State, the SHIP program is known as HIICAP.

State Pharmaceutical Assistance Program (SPAP) – A state program that provides help paying for drug coverage. SPAP coverage varies by state. In New York State, the SPAP is EPIC.

State Insurance Department – A state agency that regulates and can provide information about Medicare Supplement (Medigap) policies and other private health insurance.

Step Therapy – A utilization management restriction in which a Medicare Part D plan requires a member to try less expensive drugs for the same condition before they will pay for a particular formulary drug.

Stop-Loss – A policy that takes effect after a certain amount has been paid in claims. Companies providing health insurance for their employees through a self-insured plan often subscribe to stop-loss policies in order to protect themselves against catastrophic claims.

Subsidized Senior Housing- A type of program, available through the Federal Department of Housing and Urban Development and some States, to help people with low or moderate incomes pay for housing.

Supplemental Insurance – Fills gaps in Original Medicare coverage by helping to pay for the portion of health care expenses that Original Medicare does not pay for, such as deductibles and coinsurances. Supplemental insurance includes Medigap plans and retiree insurance from a former employer and may offer additional benefits that Medicare does not cover.

Supplemental Security Income (SSI) – A federal program that pays monthly checks to people in need who are 65 years or older and to people at any age who are blind or disabled and in need. The purpose of the program is to provide sufficient resources so that these individuals can have a basic monthly income. Eligibility is based on income and assets.

Supplementary Medical Insurance (SMI) – See: Medicare Part B.

Suppliers – Persons or organizations, other than physicians or health care facilities that furnish durable medical equipment, prosthetics, orthotics or medical supplies. See: Durable Medical Equipment (DME).

Swing Beds – A unit of beds in a hospital designated for the Medicare program for both traditional hospital acute care and long-term care and rehabilitation.

Tax-Qualified Long-Term Care Insurance Policy – A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

Telemedicine – The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and health education, using interactive audio, video, or data communications.

Temporary First Fill – See: Transition Policy.

Third-Party Administrator – An independent entity that administers health plan benefits, claims, utilization review, etc. for a self-insured plan. The TPA does not assume any risk.

Third-Party Liability – A party, other than a person with Medicare, who is responsible for payment of all or part of a specific Medicare claim. Ex - Medicare Supplement Insurance (Medigap) coverage.

Third-Party Notice – A benefit that lets you name someone who the insurance company would notify if your coverage is about to end due to lack of premium payment.

Tiers – Different levels of drug coverage within the same Medicare Part D plan. Plans may have tiers for generic, preferred brand name, non-preferred brand name and specialty drugs.

Tier Exception – A type of coverage determination used when a brand name medication is on a plan's formulary but is placed in a nonpreferred **tier** that has a higher co-pay or co-insurance.

Title XVIII – That portion of the Social Security Act, which clearly defines the provisions of Medicare.

Title XIX – That portion of the Social Security Act that clearly defines the provisions of Medicaid.

Transition Policy or Temporary First-Fill - Allows new members of Medicare private drug plans (Part D) to get temporary coverage of drugs they were taking before they joined if those medications are not covered by their new plan (or covered with restrictions).

TRICARE (formerly known as CHAMPUS) **–** TRICARE is the health care program for members of the military, eligible dependents and military retirees.

TRICARE for Life – Health insurance benefits for military retirees who have served honorably for at least 20 years. They must have Part B to receive these benefits. It is secondary to Medicare.

Twisting – The insurance sales practice of replacing an existing health insurance policy with a new one from a different company in order to receive the high first year sales commission.

Unassigned Claim – A claim on which the doctor or supplier refuses to accept Medicare's approved charge as payment in full.

Underwriting – Process by which an insurer establishes and assumes risks according to insurability.

Unearned Income – Income from sources other than current employment.

Urgent Care – Immediate medical attention for a sudden illness or injury that is not life threatening.

Usual, Customary, Reasonable (UCR) Charges – In "insurance language," this is the maximum amount a company will pay on a claim as determined by their guidelines. See: Approved Amount.

Utilization Management Tools – See: Coverage Restrictions.

Utilization Review Committee – Committee in health care facility that evaluates necessity, appropriateness, and efficiency of use of medical services, procedures, and facilities.

Viatical Settlement – Lump sum payments to life insurance policy holders with catastrophic or life-threatening illnesses in return for having the policy's death benefit assigned to that company**.**

Veterans Administration (VA) benefits – Benefits, including health care benefits, provided by the federal government to people who have been in "active service" in the military.

Visit – An encounter between a patient and health care professional which requires either the patient to travel from his home to the professional's usual place of practice (an office visit), or for the doctor or other health care provider to see the patient in the hospital, skilled nursing facility, or in patient's home.

Waiting Period – The period of time that must pass after becoming insured before the policy will begin to pay benefits for a pre-existing condition.

Waiver of Liability – See: Advance Beneficiary Notice of Non-Coverage.

"**Welcome to Medicare" Preventive Visit** - An introductory visit within the first 12 months you have Medicare Part B. This visit includes a review of your medical and social history related to your health, counseling about preventive services, and referrals for other care, if needed. See: Annual Wellness Visit.

Work Credit – (Also known as Social Security Credit or Quarter of Coverage.) Work credits are the basic unit for determining whether a worker is insured under the Social Security program. A quarter of coverage is credited for each $1,470 of an individual's total wages and self-employment income for calendar year 2021 (up to a maximum of 4 quarters of coverage for the year).

Worker's Compensation – Insurance that employers are required to have to cover employees who get sick or injured on the job.

World Health Organization (WHO) - The World Health Organization is a specialized agency of the United Nations responsible for international public health.