GLOSSARY OF TERMS

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

How To Navigate This Document: Put your curser over a specific letter of the glossary and left click with the mouse. Once you are in the document and want to return to the beginning of the document hit Back To Top using the same method stated above.

A

Accessibility - As required by the Americans with Disabilities Act, removal of barriers that would hinder a person with a disability from entering, functioning, and working within a facility. Required restructuring of the facility cannot cause undue hardship for the employer.

Accredited (Accreditation) - Means having a seal of approval. Being accredited means that a facility or health care organization has met certain quality standards. These standards are set by private, nationally recognized groups that check on the quality of care at health care facilities and organizations. Organizations that accredit Medicare Managed Care Plans include the National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and the American Accreditation HealthCare Commission/URAC.

Activities Of Daily Living (ADLs) - Self-care tasks/activities, including the ability to bathe/shower, dress/undress, eat, voluntarily control urinary and fecal discharge, transfer in and out of bed or chair, and walk, which are used to measure the Functional Impairment Level of an Applicant or a Client.

Acute Care - Care that is generally provided for a short period of time to treat a certain illness or condition. This type of care can include short-term hospital stays, doctor's visits, surgery, and X-rays.

Actual Charge - The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves. See Approved Amount; Assignment.

Acute Hospital - A hospital which provides care for persons who have a crisis, intense or severe illness or condition which requires urgent restorative care.

Acute Illness - Illness that is usually short-term and that often comes on quickly

Added Protection Upon Lapse - Also referred to as Third Party Designation or Third Party Notice. Long-term care insurance benefit that lets you name someone who the insurance company would notify if your coverage is about to end because of lack of premium payment. This can be a relative, friend, or professional, such as your lawyer.

Additional Benefits - Health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered services. Additional benefits are specified by the Medicare Advantage Organization and are offered to Medicare beneficiaries at no additional premium. Those benefits must be at least equal in value to the adjusted excess amount calculated in the Adjusted Community Rating (ACR). An excess amount is created when the average payment rate exceeds the adjusted community rate (as reduced by the actuarial value of coinsurance, copayments, and deductibles under Parts A and B of Medicare). The excess amount is then adjusted for any contributions to a stabilization fund. The remainder is the adjusted excess, which will be used to pay for services not covered by Medicare and/or will be used to reduce charges otherwise allowed for Medicare-covered services. Additional benefits can be subject to cost sharing by plan enrollees. Additional benefits can also be different for each MA plan offered to Medicare beneficiaries.

Administrative Law Judge (ALJ) - A hearings officer who presides over appeal conflicts between providers of services, or beneficiaries, and Medicare contractors.

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.

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

Affiliated Provider - A health care provider or facility that is paid by a health plan to give service to plan members.

Aging Services Access Point (ASAP) - Private, non-profit, state-designated agencies under contract with the Executive Office of Elder Affairs that provides a single-entry point for seniors to access a variety of programs and services. Formerly known as “Home Care Corporation”.

Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig’s Disease) - A progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord.

Annual Election Period - The Annual Election Period is the month each year that Medicare health plans enroll eligible beneficiaries into available health plans. This is the only time in which all Medicare Advantage Plans will be open and accepting new members. See Election Periods.

Any Willing Doctor - A doctor, hospital, or other health care provider that agrees to accept the plan's terms and conditions related to payment and that meets other requirements for coverage.

Appeal Process (Medicare) - 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 Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to you from a company that handles bills for Medicare. If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, or does not allow or stops a service that you think should be covered or provided. The Medicare managed care plan must tell you in writing how to appeal. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. See Organizational Determination.

Applicant - An individual who has applied for services. One becomes an applicant when they enter into a defined intake procedure by telephone, mail or in person, documented by staff recording initial data.

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Approved Amount - The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge". See Actual Charge; Assignment.

Assets - Anything a person owns that has a monetary value i.e. cash, real estate property, treasury notes, stocks and bonds.

Assigned Claim - A claim submitted for a service or supply by a provider who accepts Medicare assignment.

Assignment - In the Original Medicare Plan, this means a doctor agrees to accept the Medicare-approved amount as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.

Assignment Of Benefits – A policy provision that allows someone insured by long-term care insurance to have all or a portion of the benefits paid directly to care providers.

Assisted Living - A type of living arrangement in which personal care services such as meals, housekeeping, transportation, and assistance with activities of daily living are available as needed to people who still live on their own in a residential facility. In most cases, the "assisted living" residents pay a regular monthly rent. Then, they typically pay additional fees for the services they get.

Assisted Living Facility (ALF) - Also referred to as an Assisted Living Residence (ALR). The Executive Office of Elder Affairs certifies Assisted Living Facilities (ALF's). Assisted Living refers to a combination of housing and supportive services which might include laundry, housekeeping, transportation, social activities and assistance with personal care such as medication management, bathing, dressing and ambulating. Assisted Living is a residential option which stresses privacy, dignity, autonomy, and individuality. ALFs vary in size and style ranging from small apartments to larger family style units. Some serve fewer than 10 residents while others serve over 100 residents. Some ALFs are non-profit organizations, some have religious affiliations and some have units or wings to address the needs of special populations such as residents with Alzheimer's disease. While the majority of Assisted Living residents pay privately some facilities do accept Group Adult Foster Care (GAFC) payments from Medicaid.

Assisted Living Ombudsman Program - The purpose of the Assisted Living Ombudsman Program is to maintain or improve the quality of life for assisted living residents in the areas of health, safety, welfare or resident rights. The Assisted Living Ombudsman acts as a mediator and attempts to resolve problems or conflicts that arise between an assisted living facility and one or more of its residents. The Ombudsman serves as an advocate for resident rights, promoting the dignity, autonomy and respect of residents. Assisted Living residents and their families may call the Assisted Living Ombudsman Program for information and assistance, to register a complaint or to have a complaint investigated. Complaints may be brought on behalf of a specific resident or on behalf of residents as a whole.

At Risk - An elder who fails to, or is unable to provide for him/herself one or more of the necessities essential for physical and emotional well-being (food, clothing, shelter, personal care, and medical care) so that he/she is not able to safely remain in the community without intervention.

Atherosclerosis - The process of hardening or thickening of the artery walls due to fat deposits on their inner lining.

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Attachment(s) - Information, hard copy or electronic, related to a particular claim. Attachments may be structured (such as Certificates of Medical Necessity) or non-structured (such as an Operative Report). Though attachments may be submitted separately, it is common to say the attachment was "submitted with the claim."

Attending Physician - 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.

Attending Physician's Statement (APS) - Report from your doctor or a medical facility that has treated you, providing information such as medical history, medications, and diagnoses.

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.)

Automated Claim Review - Claim review and determination made using system logic (edits). Automated claim reviews never require the intervention of a human to make a claim determination.

Authorization - Document completed by a case manager that states the level of service to be provided and permission to begin providing services to a client.

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.

B

Balance Billing - A situation in which Private Fee-for-Service Plan providers (doctors or hospitals) can charge and bill you 15% more than the plan's payment amount for services.

Base Estimate - The updated estimate of the most recent historical year.

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

Bathing - Washing oneself by sponge bath, or in the bathtub or shower. One of the six Activities of Daily Living (ADLs)

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Benchmark - A benchmark is sustained superior performance by a medical care provider, which can be used as a reference to raise the mainstream of care for Medicare beneficiaries. The relative definition of superior will vary from situation to situation. In many instances an appropriate benchmark would be a provider that appears in the top 10% of all providers for more than a year.

Beneficiary - The name for a person who has health care insurance through the Medicare or Medicaid/MassHealth program.

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.

Benefit Maximum - The limit a health insurance policy will pay for a certain loss or covered service. The benefit can be expressed either as 1) 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 (Medicare) - The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received any hospital care (or skilled care in a SNF) for 60 days in a row. If you go into the hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins if you are in the Original Medicare Plan. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Benefit Triggers (Triggers) - Criteria insurance companies use to determine when you are eligible to receive benefits. The most common Benefit Triggers for long-term care insurance are: (1) needing help with two or more ADLs, or (2) having a Cognitive Impairment.

Benefits - The money or services provided by an insurance policy. In a health plan, benefits are the health care you get.

Benefits Description (Plan) - The scope, terms and/or condition(s) of coverage including any limitation(s) associated with the plan provision of the service.

Bereavement - The state of being sad or lonely due to the loss of a significant other, friend, pet, or relative by death.

Bill - A legislative proposal for general law.

Biofeedback - A technique of giving person information of physiological processes with the goal that they can gain conscious control of them.

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.

Biological Therapy - Also called Immunotherapy, this medical treatment restores or stimulates the immune system so it can fight disease and infection.

Biometric Identifier - An identifier based on some physical characteristic, such as a fingerprint.

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Blood Pressure - The pressure exerted by the blood against the walls of the blood vessels, especially the arteries. It may vary with one's age and physical and mental health.

Blood Urea Nitrogen - The term BUN refers to the substance urea, which is the major breakdown product of protein metabolism, and is ordinarily removed by the kidneys. During kidney failure, urea accumulates in proportion to the degree of kidney failure and to the amount of protein breakdown. The symptoms of uremia correspond roughly to the amount of urea in the blood stream.

Board And Care Home - Often referred to as an adult care home or a group adult home. Residence which offers housing and personal care services for 3 to 16 residents. Services (such as meals, supervision, and transportation) are usually provided by the owner or manager. May be single family home. Licensed as adult family home or adult group home.

Board Hearing - That hearing provided for in section 1878(a) of the Act (42 U.S.C. 139500(a)) and 42 CFR §405.1835.

C

Cancelable- An insurance contract that can be terminated by the company or individual at any time.

Caregiver - A caregiver of an older adult is anyone who provides physical, financial, and/or emotional support for an older adult whose daily activities are limited by diminished mental or physical function.

Caregiver Burden - The emotional, physical, and financial toll that caregiving can have on a caregiver which can increase his/her stress level.

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

CareTeam - Anyone who is providing any sort of support to the older adult and most importantly the older adult him/herself. This team includes the older adult, the caregiver(s) (primary, secondary, long distance, etc.), medical professionals, allied health professionals, lawyers, homemakers, home health aides, and anyone else who contributes to supporting the health and independence of the older adult.

CareTeam Binder - A binder in which all important information regarding the CareTeam and the caregiving process can be kept. Three essential parts of this CareTeam binder are the contact information of anyone associated with the CareTeam, a hospital log in which an in depth record is kept of the older adult's medical appointments, and a daily journal so that everyone who cares for the older adult can write down exactly what was done and how it went.

Caring Home - Program for non-Medicaid clients where the caregiver receives payments for the care they provide in the home; similar to Adult Family Care.

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, social worker or other professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources.

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Case Manager - A nurse, doctor, or social worker who arranges all services that are needed to give proper care to a consumer.

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

Centers For Medicare & Medicaid Services - The HHS agency responsible for Medicare and parts of Medicaid. Centers for Medicare & Medicaid Services has historically maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

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

Central Mass Family Caregiver Support Program (CMFCSP) - A program designed to give education, training and assistance to caregivers. This is a federally funded program.

Certificate Of Creditable Coverage - A written certificate issued by a group health plan or health insurance issuer (including an HMO) that states the period of time you were covered by your health plan.

CHAMPUS - Medical care to active duty members of the military, military retirees, and their eligible dependents. This program is now called "TRICARE".

Claim - A claim is a request for payment for services and benefits you received. Claims are also called bills for all Part A and Part B services billed through Fiscal Intermediaries. "Claim" is the word used for Part B physician/supplier services billed through the Carrier. See Carrier; Fiscal Intermediary; Medicare Part A; Medicare Part B.

Claim Adjustment Reason Codes - 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 transactions, 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.

Client/Consumer - A person who is seeking services from an organization.

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Coinsurance (Medicare Private Fee-For-Service Plan) - The percentage of the Private Fee-for-Service Plan charge for services that you may have to pay after you pay any plan deductibles. In a Private Fee-for-Service Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

Coinsurance (Outpatient Prospective Payment System) - The percentage of the Medicare payment rate or a hospital's billed charge that you have to pay after you pay the deductible for Medicare Part B services.

Commercial MCO - A Commercial MCO is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare Advantage organization; a provider sponsored organization, or any other private or public organization, which meets the requirements of §1902(w). These MCOs provide comprehensive services to commercial and/or Medicare enrollees, as well as Medicaid enrollees.

CommonHealth - Another offering from MassHealth that provides very similar coverage to MassHealth Standard. However, it is for eligible adults with a disability who have incomes and assets too high for MassHealth Standard. See MassHealth Standard

Community-Based Services - Services designed to help older people remain independent and in their own homes; can include senior centers, transportation, delivered meals or congregate meals site, visiting nurses or home health aides, adult day care, and homemaker services.

Community Care Ombudsman Program (CCO) - Assists people age 60 and over who receive home care, day care services and other community services. The CCO responds to inquiries from elders and their families; educates consumers about their rights and responsibilities; counsels consumers about concerns with their services; refers consumers to appropriate resources for help and investigates and resolves complaints through mediation.

Community Choices - A program for MassHealth recipients who have been determined nursing home eligible. In this program the individual can receive a higher level of services but the total cost of care should not exceed the amount the state would spend on nursing home placement.

Community Health Center - Also referred to as a neighborhood health center. An ambulatory health care program usually serving a catchment area which has scarce or nonexistent health services or a population with special health needs. These centers attempt to coordinate federal, state, and local resources in a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.

Community Mental Health Center - A facility that provides the following services: Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharge from inpatient treatment at a mental health facility. Services possibly offered are 24 hour a day emergency care services, day treatment, other than partial hospitalization services, or psychosocial rehabilitation services, screening for patients considered for admission to State mental health facilities to determine the appropriateness of such admission, and consultation and education services.

Community Spouse - Spouse of the person applying for or receiving Medicaid/MassHealth long-term care services

Companions - Companions provide regularly scheduled visits to frail elders providing socialization, medical escort, errands, light meal prep and respite to family caregivers.

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Comprehensive And Coordinated Service System - Program of interrelated services, including health, social and nutrition, designed within a particular Planning and Service Area to meet the needs of elder persons.

Comprehensive Health Insurance - Health insurance that is usually subject to a deductibles, it is a broad form of health insurances that provides coverage for many medical expenses with few limitations.

Comprehensive MCO - A MCO is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare Advantage organization; a provider sponsored organization or any other private or public organization, which meets the requirements of §1902(w). These MCOs provides comprehensive services to both commercial and/or Medicare, as well as Medicaid/MassHealth enrollees.

Conditional Enrollment - For persons who are not already enrolled in Medicare Part A and choose to enroll only if qualified for the State payment of deductible, they can apply for a conditional enrollment. If not qualified, enrollment will not occur. See Qualified Medicare Beneficiary, (QMB's).

Confidentiality - Is an understanding that certain information will not be disclosed to other individuals without expressed permission. This term is used in many settings i.e. medical, social services, human services, financial and legal.

COBRA – (Consolidates Omnibus Budget Reconciliation Act) - Legislation that allows specific individuals and their dependents to continue receiving coverage under an employer's group health plan coverage for a specific period of time. To be eligible the individual must have lost their job, had their work hours reduced, or left the job voluntary. Also if the employed spouse dies or the individual gets a divorce the spouse can receive COBRA.

Coordinated Care - A program to better manage long term care services provided to frail elders. The goal is being accomplished by addressing the fragmentation of services, overlapping responsibilities and duplication of effort in the Commonwealth of Massachusetts' current long-term care system. This interagency initiative more effectively manages the services purchased by both state agencies by consolidating in the two agencies the activities that involve intake, assessment, authorization and case management of both institutional and community-based long term care.

CPT - "Physicians' Current Procedural Terminology", yearly publication of the American Medical Association. 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 for Medicare payment.

Cost-Based Health Maintenance Organization - A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

Covered Benefit - A health service or item that is included in your health plan and that is paid for either partially or fully.

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Covered Charges - Services or benefits for which a health plan makes either partial or full payment.

Covered Employee - An individual who is (or was) provided coverage under a group health plan.

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.

Covered Employment - All employment and self-employment creditable for Social Security purposes. Almost every kind of employment and self-employment is covered under the program. In a few employment situations-for example, religious orders under a vow of poverty, foreign affiliates of American employers, or the employer must elect State and local governments-coverage. However, effective July 1991, coverage is mandatory for State and local employees who are not participating in a public employee retirement system. All new State and local employees have been covered since April 1986. In a few situations-for instance, ministers or self-employed members of certain religious groups-workers can opt out of coverage. Covered employment for health insurance (Medicare) includes all federal employees (whereas covered employment for OASDI includes some, but not all, federal employees).

Covered Entity - Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction.

Covered Function - Functions that make an entity a health plan, a health care provider, or a health care clearinghouse.

Covered Services - Specific services that a health plan or an organization will provide payment.

Covered Worker - A person who has earnings creditable for Social Security purposes on the basis of services for wages in covered employment and/or on the basis of income from covered self-employment. The number of health insurance (Medicare) covered workers is slightly larger than the number of Old Age Survivors and Disability Insurance (OASDI) covered workers because of different coverage status for federal employment. See Covered employment.

Creditable Prescription Drug Coverage - Prescription drug coverage (like from an employer or union), that pays out, on average, as much as or more than Medicare's standard prescription drug coverage.

Custodial Care - Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving round, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

D

Deductible (Medicare) - The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year. See Benefit Period; Medicare Part A; Medicare Part B.

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Deductible Period - Specified amount of time at the beginning of a disability during which covered services are received, but for which the policy will not pay benefits (also known as an Elimination Period or Benefit Waiting Period). A Service Day Deductible Period is satisfied by each day of the period on which you receive covered services. A Calendar Day or Disability Day Deductible Period doesn't require that you receive covered services during the entire deductible period, but only requires that you meet the policy's benefit triggers during that time period.

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.

Disability Insurance - See Old-Age, Survivors, and Disability Insurance (OASDI).

Disability Method - Method of paying long-term care insurance benefits that only requires you to meet the benefit eligibility criteria. Once you do, you receive your full daily benefit.

Disabled Enrollee - An individual under age 65 who has been entitled to disability benefits under Title II of the Social Security Act or the Railroad Retirement system for at least 2 years and who is enrolled in the SUPPLEMENTARY MEDICAL INSURANCE (PART B OF MEDICARE) program.

Drug List - A list of drugs covered by a plan. This list is also called a formulary.

Dual Eligibles - Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid/MassHealth.

Duplication Of Coverage - Coverage of the same health services by more than one health insurance policy. Expenses for the covered services are only paid for by one policy, meaning the policyholder has two (or more) policies but has only received benefits from one of them.

E

Eldercare - Public, private, formal, and informal programs and support systems, government laws, and finding ways to meet the needs of the elderly, including: housing, home care, pensions, Social Security, long-term care, health insurance, and elder law.

Election - Your decision to join or leave the Original Medicare Plan or a Medicare Advantage plan.

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Election Periods - Time when an eligible person may choose to join or leave the Original Medicare Plan or a Medicare Advantage Plan. There are four types of election periods in which you may join and leave Medicare health plans: Annual Election Period, Initial Coverage Election Period, Special Election Period, and Open Enrollment Period.

- Annual Election Period: The Annual Election Period is the month each year that Medicare health plans enroll eligible beneficiaries into available health plans. This is the only time in which all Medicare Advantage Plans will be open and accepting new members.
- Initial Coverage Election Period: The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. If you choose to join a Medicare health plan during your Initial Coverage Election Period, the plan must accept you. The only time a plan can deny your enrollment during this period is when it has reached its member limit. This limit is approved by the Centers for Medicare & Medicaid Services. The Initial Coverage Election Period is different from the Initial Enrollment Period (IEP).
- Special Election Period: A set time when you can sign up for Medicare Part B if you didn't take Medicare Part B during the Initial Enrollment Period, because you or your spouse were working and had group health plan coverage through the employer or union. You can sign up at anytime you are covered under the group plan based on current employment status. The last eight months of the Special Enrollment Period starts the month after the employment ends or the group health coverage ends, whichever comes first.
- Open Enrollment Period: A one-time-only six month period when you can buy any Medigap policy you want that is sold in your State. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can't be denied coverage or charged more due to past or present health problems.

Elimination Period - It is the number of days before any benefit will be paid. (Also known as a deductible period or a waiting period).

Emergency Aid To The Elderly, Disabled, And Children (EAEDC) - EAEDC is a cash benefit for disabled adults, caretakers, and some children who are not able to get welfare.

EMTALA (Emergency Medical Treatment And Active Labor Act) - 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.

End-Stage Renal Disease (ESRD) - Permanent kidney failure. That stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

Enhanced Benefits - Defined as Additional, Mandatory and Optional Supplemental benefits.

Enroll - To join a health plan.

Enrollee Hotlines - Toll-free telephone lines, usually staffed by the State or enrollment broker that beneficiaries may call when they encounter a problem with their MCO/PHP. The people who staff hotlines are knowledgeable about program policies and may play an "intake and triage" role or may assist in resolving the problem.

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Enrollment - Is the process by which a Medicaid eligible person becomes a member of a managed care plan. Enrollment data refer to the managed care plan's information on Medicaid eligible individuals who are plan members. The managed care plan gets its enrollment data from the Medicaid program's eligibility system.

Enrollment Fee - The amount you must pay every year to get a Medicare-approved drug discount card.

Enrollment Period - A certain period of time when you can join a health plan if it is open and accepting new members. If a health plan chooses to be open, it must allow all eligible people to join.

Entrance Age - The maximum or minimum age at which a company will sell the policy.

Excess Charges - If you are in the Original Medicare Plan, this is the difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

Exclusions (Medicare) - Items or services that Medicare does not cover, such as long-term care, and custodial care in a nursing or private home.

Explanation Of Medicare Benefits (EOMB) Form - The statement that Medicare sends the beneficiary to show what action was taken by the carrier in processing the Medicare claim. If payment is being issued to the Medicare beneficiary, a check will be attached. Most Medigap policies pay claims based on the EOMB.

F

Financial Eligibility - Assessment of an individual's available income and assets to determine if he/she meets eligibility requirements for a specific program.

Food Stamps - See SNAP

Frail Elder Waiver - For individuals who are determined clinically eligible for placement in a nursing home. This is a demonstration grant approved by the Federal government that allowed individuals 300% over the Federal poverty level in monthly income, and with a limited amount of assets, receive Mass Health benefits.

Future Purchase Option (FPO) - Form of inflation protection in a long-term care insurance policy, where the insured has the right to increase benefits periodically (for example, annually or every three years) to reflect increases in the cost of care. Increases can be elected without providing evidence of insurability as long as the insured is not receiving benefits at the time. Terms of the FPO vary from one company to another.

G

Gaps - The costs or services that are not covered under the Original Medicare Plan.

Group Insurance - A group policy is a written contract between an insurer and employer or group, which provides benefits to the insured group members who hold individual certificates of insurance. The certificates state the provisions of the coverage given to each insured individual or family.

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Group Or Network HMO - A health plan that contracts with group practices of doctors to give services in one or more places.

Guaranteed Issue Rights (Also Called "Medigap Protections") - Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company cannot deny you insurance coverage or place conditions on a policy, must cover you for all pre-existing conditions, and cannot charge you more for a policy because of past or present health problems.

Guaranteed Renewable - A right you have that requires your insurance company to automatically renew or continue your Medigap policy, unless you make untrue statements to the insurance company, commit fraud or do not pay your premiums.

H

Health Insurance Claims Number - The number assigned by the Social Security Administration to an individual identifying him/her as a Medicare beneficiary. This number is shown on the beneficiary's insurance card and is used in processing Medicare claims for that beneficiary.

Health Insurance Portability And Accountability Act (HIPAA) - The privacy provisions of the federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), apply to health information created or maintained by health care providers who engage in certain electronic transactions, health plans, and health care clearinghouses. The Department of Health and Human Services (HHS) has issued the regulation, "Standards for Privacy of Individually Identifiable Health Information," applicable to entities covered by HIPAA. The Office for Civil Rights (OCR) is the Departmental component responsible for implementing and enforcing the privacy regulation.

Health Maintenance Organizations (HMO) - A type of managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to beneficiaries for a set amount of money each month. You usually must get your care from the providers in the plan's network.

Health Plan - An entity that assumes the risk of paying for medical treatments, i.e. uninsured patient, self-insured employer, payer, or HMO.

Home And Community-Based Service Waiver Programs (HCBS) - The HCBS programs offer different choices to some people with Medicaid/MassHealth. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help older adults and individuals with disabilities. These programs give quality and low-cost services.

Hospital Coinsurance - For the 61st through 90th day of hospitalization in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-fourth of the inpatient hospital deductible; for lifetime reserve days, a daily amount for which the beneficiary is responsible, equal to one-half of the inpatient hospital deductible. See Lifetime Reserve Days.

Hospital Indemnity Insurance - This kind of insurance pays a certain cash amount for each day you are in the hospital up to a certain number of days. Indemnity insurance doesn't fill gaps in your Medicare coverage.

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Hospital Insurance - The Medicare program that covers specified inpatient hospital services, post hospital skilled nursing care, home health services, and hospice care for aged and disabled individuals who meet the eligibility requirements. Also known as Medicare Part A.

Human Resources Department - The company department charged with finding, screening, recruiting and training job applicants, as well as administering employee-benefit programs.

I

Initial Coverage Election Period - The three months immediately before you are entitled to Medicare Part A and enrolled in Part B. If you choose to join a Medicare health plan during your Initial Coverage Election Period, the plan must accept you. The only time a plan can deny your enrollment during this period is when it has reached its member limit. This limit is approved by the Centers for Medicare & Medicaid Services. The Initial Coverage Election Period is different from the Initial Enrollment Period (IEP).

Initial Enrollment Period (IEP) - The Initial Enrollment Period is the first chance you have to enroll in Medicare Part B. Your Initial Enrollment Period starts three months before you first meet all the eligibility requirements for Medicare and lasts for seven months.

Inpatient Hospital Deductible - An amount of money that is deducted from the amount payable by Medicare Part A for inpatient hospital services furnished to a beneficiary during a spell of illness.

Inpatient Hospital Services - These services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

Inpatient Psychiatric Facility - A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

Insolvency - When an organization has no money or other means to stay open.

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

Instrumental Activities Of Daily Living (IADLs) - Tasks such as ability to prepare meals, do house work, go shopping, do laundry, medication management, transportation, money management, use the telephone, get around when outside of the home.

Insulin - A hormone that controls the level of glucose in the body and helps the body use glucose for energy.

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

Insurer - An insurer of a plan is an entity that, in exchange for payment of a premium, agrees to pay for the plan's-covered services received by eligible individuals.

Internal Revenue Service/Social Security Administration/Health Care Financing Administration Data Match - A process by which information on employers and employees is provided by the IRS and SSA and is analyzed by CMS for use in contacting employers concerning possible periods of MSP. This information is used to update the CWF-Medicare Common Working File.

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J

Joint Life Policy -: A life insurance policy which covers two or more people. The benefits of the policy are paid upon the first death of those insured.

L

Lapse - Termination of an insurance policy when a renewal premium is not paid.

Large Group Health Plan - A group health plan that covers employees of either an employer or employee organization that has 100 or more employees.

Lifetime Reserve Days - In the Original Medicare Plan, 60 days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance

Lifetime Maximum - The maximum dollar amount that a policy will pay in the policy holder's lifetime.

Limited Medication Administration - A service available in assisted living facilities that allows a licensed practitioner or family member to administer medication to the individual.

Limited Policy - Type of insurance policy which only pays for specific benefits named in the policy.

Limiting Charge - In the Original Medicare Plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

Living Benefit - Also referred to as Accelerated or Advanced Benefits, it is proceeds through the life insurance policy that are paid to the policy holders while the individuals are still alive.

M

Major Hospitalization Policy Or Insurance - This insurance is usually subject to large deductibles and pays for most hospital bills up to a high limit.

Major Medical Insurance - Insurance that is usually subject to large deductibles but will pay for most major medical expenses up to a high limit.

Managed Care Payment Suspension - Suspension of Payments Includes Health Maintenance Organizations (HMO), Competitive Medical Plans (CMP), and other plans that provide health services on a prepayment basis, which is based either on cost or risk, depending on the type of contract they have with Medicare. See Suspension of Payments.

Managed Care Plan - In most managed care plans, you can only go to doctors, specialists, or hospitals on the plans list except in an emergency.

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Managed Care Plan With A Point Of Service Option (POS) - A managed care plan that lets you use doctors and hospitals outside the plan for an additional cost. See Medicare Managed Care Plan.

Managed Care System - Integrates the financing and delivery of appropriate health care services to covered individuals by means of: arrangements with selected providers to furnish a comprehensive set of health care services to members, explicit criteria for the selection of health care provides, and significant financial incentives for members to use providers and procedures associated with the plan. Managed care plans typically are labeled as HMOs (staff, group, IPA, and mixed models), PPOs, or Point of Service plans. Managed care services are reimbursed via a variety of methods including capitation, fee for service, and a combination of the two.

Mandate - A policy or program which is required by law, either federal, state or local. Mandated Services, in general, refers to services which must be provided under a federal or state law. Services which are not mandatory are considered optional or discretionary.

Mandatory Spending - Outlays for entitlement programs (Medicare and Medicaid) that are not subject to the Federal appropriations process.

Massachusetts Peer Review Organization (MASSPRO) - The organization that you should contact when you feel an older adult who is enrolled in Original Medicare or a Medicare Advantage Plan is being discharged too soon from a hospital, nursing home, or home health service. MASSPRO is also responsible for reviewing quality of care complaints when a Medicare customer has a concern about his/her individual care from a Medicare provider, rights when dealing with Medicare, benefits from his/her Medicare.

MassHealth - A public health insurance program for low- to medium-income residents of Massachusetts. The national health insurance program called Medicaid, and the Children's Health Insurance Program (CHIP) are combined in one program in Massachusetts called MassHealth.

MassHealth Spousal Waiver - Under the MassHealth Spousal Waiver Program an older adult who would be eligible for placement in a long term care facility can remain in the community with services. The income and assets of the older adult's spouse would not be counted towards his/her MassHealth eligibility.

Maximum Plan Benefit Coverage - The maximum dollar amount per period that a plan will insure. This is only applicable for service categories where there are enhanced benefits being offered by the plan, because Medicare coverage does not allow a Maximum Plan Benefit Coverage expenditure limit.

Medicaid - A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. This program is known as MassHealth in Massachusetts.

Medicaid MCO - A Medicaid Managed Care Organization (MCO) that provides comprehensive services to Medicaid beneficiaries, but not commercial or Medicare enrollees.

Medical Insurance (Part B) - Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, some medical services that aren't covered by Part A and emergency transportation.

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Medicare - The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Medicare Advantage Plan - A Medicare program that gives you more choices among health plans. Anyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.

Medicare Advantage Prescription Drug Plan - A Medicare Advantage plan that offers Medicare Prescription Drug coverage and Part A and Part B benefits in one plan.

Medicare Advocacy Project (MAP) - If the older adult needs to make an appeal, MAP is devoted to assisting people who may have been wrongfully denied Medicare.

Medicare Appeal (Reconsideration) - Procedure by which a beneficiary who disagrees with the amount of Medicare Part B reimbursement can challenge the Medicare carrier or intermediary within six months of the date of the Explanation of Medicare Benefits (EOMB).

Medicare-Approved Amount - In the Original Medicare Plan, this is the Medicare payment amount for an item or service. This is the amount a doctor or supplier is paid by Medicare and you for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the Approved Charge.

Medicare Benefits - Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system.

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 Carrier - A private company that contracts with Medicare to pay Part B bills.

Medicare Contractor - A Medicare Part A Fiscal Intermediary (institutional), a Medicare Part B Carrier (professional), or a Medicare Durable Medical Equipment Regional Carrier (DMERC).

Medicare Coordinated Care Plan - Medicare Advantage HMO or PPO Plan.

Medicare Coordination Of Benefits Contractor - A Medicare contractor who collects and manages information on other types of insurance or coverage that pay before Medicare. Some examples of other types of insurance or coverage are: Group Health Coverage, Retiree Coverage, Workers' Compensation, No-fault or Liability insurance, Veterans benefits, TRICARE, Federal Black Lung Program, and COBRA.

Medicare Costs Plans - Medicare cost plans are a type of HMO that contracts as a Medicare Health Plan. As with other HMOs, the plan only pays for services outside its service area when they are emergency or urgently needed services. However, when you are enrolled in a Medicare Cost Plan, if you get routine services outside of the plan's network without a referral, your Medicare-covered services will be paid for under Original Medicare, and you will be responsible for the Original Medicare deductibles and coinsurance.

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Medicare Coverage - Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). See Medicare Hospital Insurance; Medicare Medical Insurance.

Medicare Durable Medical Equipment Regional Carrier - A Medicare contractor responsible for administering Durable Medical Equipment (DME) benefits for a region.

Medicare Economic Index - An index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule.

Medicare Handbook - The Medicare Handbook provides information on such things as how to file a claim and what type of care is covered under the Medicare program. This handbook is given to all beneficiaries when first enrolled in the program.

Medicare Health Plan - A plan offered by a private company that contracts with Medicare to provide you with your Medicare Part A and/or Part B benefits. Medicare Health Plans include Medicare Advantage plans (including HMO, PPO, or Private Fee-for-Service Plans); Medicare Cost Plans; PACE plans; and special needs plans.

Medicare HMOs - Under Medicare HMOs (health maintenance organizations), members pay their regular monthly premiums to Medicare and Medicare pays the HMO a fixed sum of money each month to provide Medicare benefits (e.g., hospitalization, doctor's visits, and more). Medicare HMOs may provide extra benefits over and above regular Medicare benefits (such as prescription drug coverage, eyeglasses, and more). Members do not pay Medicare deductibles and co-payments; however, the HMO may require them to pay an additional monthly premium and co-payments for some services. If members use providers outside the HMO's network, they pay the entire bill themselves unless the plan has a point of service option.

Medicare Hospital Insurance (Part A) - The Medicare program that covers specified inpatient hospital services, post hospital skilled nursing care, home health services, and hospice care for older adults and individuals with a disability who meet the eligibility requirements.

Medicare Managed Care Plan - A type of Medicare Advantage Plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Medical Insurance (Part B) - Medicare medical insurance that helps pay for doctors, services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A.

Medicare Medical Savings Account Plan (MSA) - A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.

Medicare Savings Programs - There are programs that help millions of people with Medicare save money each year. States have programs for people with limited incomes and resources that pay Medicare premiums. Some programs may also pay Medicare deductibles and coinsurance. You can apply for these programs if you have Medicare Part A (Hospital Insurance), you are an individual or a couple with limited resources below a certain amount and you are an individual with a monthly income below a certain amount.

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Medicare National Coverage Determinations Manual - (Formerly the Coverage Issues Manual.) The National Coverage Determinations Manual contains implementing instructions for National Coverage Determinations. The manual includes information whether specific medical items, services, treatment procedures, or technologies are paid for under the Medicare program on a national level.

Medicare Part A - See Medicare Hospital Insurance.

Medicare Part A Fiscal Intermediary - A Medicare contractor that administers the Medicare Part A (institutional) benefits for a given region.

Medicare Part B - See Medicare Medical Insurance.

Medicare Part B Carrier - A Medicare contractor that administers the Medicare Part B (Professional) benefits for a given region.

Medicare Part B Premium Reduction Amount - Since CY 2003, MCOs are able to use their adjusted excess to reduce the Medicare Part B premium for beneficiaries. When offering this benefit, a plan cannot reduce its payment by more than 125 percent of the Medicare Part B premium. In order to calculate the Part B premium reduction amount, the PBP system must multiply the number entered in the "indicate your MCO plan payment reduction amount, per member" field by 80 percent. The resulting number is the Part B premium reduction amount for each member in that particular plan (rounded to the nearest multiple of 10 cents).

Medicare Participation Physicians And Suppliers Directory (Medpard) - Directory issued by the carrier listing all Medicare participating Part B providers.

Medicare Preferred Provider Organization (PPO) Plan - A type of Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Premium Collection Center (MPCC) - The contractor that handles all Medicare direct billing payments for direct billed beneficiaries. MPCC is located in Pittsburgh, Pennsylvania.

Medicare Prescription Drug Plan - A stand-alone drug plan, offered by insurers and other private companies to beneficiaries that receive their Medicare Part A and/or B benefits through Original Medicare; Medicare Private Fee-for-Service Plans that do not offer prescription drug coverage; and Medicare Cost Plans offering Medicare prescription drug coverage

Medicare Private Fee-For-Service Plan - A type of Medicare Advantage plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Medicare Supplemental Policy (also known as Medigap) - Type of insurance policy with coverage specifically designed to pay the major benefit gaps in Medicare (deductibles and co-payment).

Medicare Savings Programs - There are programs that help millions of people with Medicare save money each year. States have programs for people with limited incomes and resources that pay Medicare premiums. Some programs may also pay Medicare deductibles and coinsurance. You can apply for these programs if you have Medicare Part A (Hospital Insurance), you are an individual or a couple with limited resources below a certain amount and you are an individual with a monthly income below a certain amount.

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Medicare Secondary Payer - A statutory requirement that private insurers providing general health insurance coverage to Medicare beneficiaries pay beneficiary claims as primary payers.

Medicare Select - A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medicare Summary Notice (MSN) - A notice you get after the doctor or provider files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Medicare Supplement Insurance - Medicare supplement insurance is a Medigap policy. It is sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. See Gaps and Medigap.

Medicare Trust Funds - Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the health insurance (Medicare) and Supplementary Medical Insurance (Part B of Medicare).

Medication Dispensing System - A machine that signals an alert when medication is to be taken. It is connected to a Personal Emergency Response System (PERS) and a call center is notified if the medication is not taken. The machine can be preloaded up to 40 days.

Medigap - Insurance policies that supplement, or fill in the holes in, the federal Medicare program. Medigap insurance covers deductibles and co-payments elders would otherwise have to pay under the Medicare program, but generally does not provide expanded services such as long-term care protection and most routine medical services.

Medigap Policy - A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. See Gaps.

Military Pensions - Regular payments intended to provide an income to people who are no longer earning a regular military income.

Multi-Employer Group Health Plan - A group health plan that is sponsored jointly by two or more employers or by employers and employee organizations.

Multi-Employer Plan - A group health plan that is 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 are generally plans that are offered through membership in an association or a trade group.

N

National Association Of State Medicaid Directors - An association of state Medicaid directors. NASMD is affiliated with the American Public Health Human Services Association (APHSA).

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National Coverage Policy - A policy developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. It is published in CMS regulations, published in the Federal Register as a final notice, contained in a CMS ruling, or issued as a program instruction.

Non-Countable Assets - Also called exempt asset. Assets whose value is not counted in determining financial eligibility for programs.

Notice Of Non-Coverage - A Medicare beneficiary may become liable for costs of hospital care after he/she is given a written Notice of Non-Coverage. This notice of non-coverage states that in the hospital's opinion and with the attending physician's or Peer Review Organization's concurrence, the beneficiary no longer requires inpatient hospital care. Liability begins on the third day after the receipt of this notice from the hospital. Medicare beneficiaries can appeal written denials of coverage through an expedited appeal to the MASSPRO or through the usual Medicare Part A Appeals procedure.

Nursing Home Policy - Type of limited health insurance policy which generally pays indemnity benefits for medically necessary stays in nursing facilities. Also referred to as Long Term Care policies.

Nutrition Program - The Massachusetts Nutrition Program is the second largest program operated by the Executive Office of Elder Affairs. Twenty-eight (28) nutrition projects, located throughout the Commonwealth, serve millions of meals to elders each year. Meals are provided at congregate meal sites as well as to homebound elders. Additionally, the Nutrition Screening Counseling program operates a commodity foods program, a homeless elder meals program and sponsors a variety of nutrition education programs.

O

Old-Age, Survivors, And Disability Insurance - The Social Security programs that pay for (1) monthly cash benefits to retired-worker (old-age) beneficiaries, their spouses and children, and survivors of deceased insured workers (OASI); and (2) monthly cash benefits to disabled-worker beneficiaries and their spouses and children, and for providing rehabilitation services to the disabled (DI).

Open Enrollment Period - A one-time-only six month period when you can buy any Medigap policy you want that is sold in your State. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you cannot be denied coverage or charged more due to past or present health problems.

Optional Supplemental Benefits - Services not covered by Medicare that enrollees can choose to buy or reject. Enrollees that choose such benefits pay for them directly, usually in the form of premiums and/or cost sharing. Those services can be grouped or offered individually and can be different for each Medicare Advantage plan offered.

Organizational Determination - A health plan's decision on whether to pay all or part of a bill, or to give medical services, after you file an appeal. If the decision is not in your favor, the plan must give you a written notice. This notice must give a reason for the denial and a description of steps in the appeal process. See Appeal Process Medicare.

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Original Medicare Plan - A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare approved amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). See Medicare Hospital Insurance and Medicare Medical Insurance

Other Managed Care Arrangement - Other Managed Care Arrangement is used if the plan is not considered a PCCM, PHP, Comprehensive MCO, Medicaid-only MCO, or HIO.

Out Of Network Benefit - Generally, an out-of-network benefit provides a beneficiary with the option to access plan services outside of the plan's contracted network of providers. In some cases, a beneficiary's out-of-pocket costs may be higher for an out-of-network benefit.

P

Part A (Medicare) - Medicare Hospital Insurance also referred to as "HIB." Part A is the hospital insurance portion of Medicare. It was established by §1811 of Title XVIII of the Social Security Act of 1965, as amended, and covers inpatient hospital care, skilled nursing facility care, some home health agency services, and hospice care. See Medicare Hospital Insurance.

Part A Premium - A monthly premium paid by or on behalf of individuals who wish for and are entitled to voluntary enrollment in the Medicare health insurance program. These individuals are those who are aged 65 and older, are uninsured for social security or railroad retirement, and do not otherwise meet the requirements for entitlement to Part A. Individuals with a disability who have exhausted other entitlement are also qualified. These individuals are those not now entitled but who have been entitled under section 226(b) of the Act, who continue to have the disabling impairment upon which their entitlement was based, and whose entitlement ended solely because the individuals had earnings that exceeded the substantial gainful activity amount.

Part B (Medicare) Medicare Supplementary Medical Insurance also referred to as "SMI". Medicare insurance that pays for inpatient hospital stay, care in a skilled nursing facility, home health care, and hospice care. Part B is the supplementary or "physicians" insurance portion of Medicare. It was established by 1831 of the Title XVIII of the Social Security Act of 1965 as amended, and covers services of physicians/other suppliers, outpatient care, medical equipment and supplies, and other medical services not covered by the hospital insurance part of Medicare. See Medicare Medical Insurance.

Partnership Policy - Private long-term care insurance policy that allows you to protect (keep) some or all of your assets if you apply for Medicaid after using up your policy's benefits. Only a few states currently have Partnership Programs. However, the Deficit Reduction Act of 2005 allows any state that wishes to do so to establish a Partnership Program. Under a Partnership Policy, generally, the amount of Medicaid spend-down protection you receive is equal to the amount of benefits paid to you under your private Partnership policy. (State-specific program designs may vary.)

Personal Care Attendant (PCA) Program - A Medicaid/MassHealth program that helps Medicaid/MassHealth eligible members with long-term disabilities live at home by providing funds for them to hire Personal Care Attendants (PCAs) to assist them with their personal care needs.

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Personal Needs Allowance - Designated portion of monthly income that a person receiving Medicaid/MassHealth long-term care services may retain for personal needs. This amount includes food and shelter costs for persons receiving home and community-based waiver services. The amount allowed varies from state to state.

Pre-Paid Hospital Service Plan - Provides comprehensive health care for those who pay a flat fee for services, whether that be inpatient or outpatient treatment.

Preferred Provider Organization (PPO) - A managed care in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

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 Services - Health care to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots, and screening mammograms).

Premium Surcharge - The standard Medicare Part B premium will go up ten percent for each full 12-month period (beginning with the first month after the end of your Initial Enrollment Period) that you could have had Medicare Part B but didn't take it. The additional premium amount is called a premium surcharge. There will be a surcharge for Part D also.

Prescription Advantage - The nation's first state-sponsored prescription drug insurance plan for elders and younger people with disabilities. Prescription Advantage is available to all Massachusetts residents age 65 and older, as well as younger individuals with disabilities who meet income and employment guidelines.

Primary Care Physician (PCP) - A doctor who is trained to give you basic care. Your primary care physician is the doctor you see first for most health problems. He/she makes sure that you get the care that you need to keep you healthy. He/she may talk with other doctors and health care providers about your care and refer you to them. In many Medicare managed care plans, you must see your primary care physician before you see any other health care provider.

Programs Of All-Inclusive Care For The Elderly (PACE) - PACE combines medical, social, and long-term care services for frail people. PACE is available only in states that have chosen to offer it under Medicaid. To be eligible, you must:

- Be 55 years old, or older,
- Live in the service area of the PACE program,
- Be certified as eligible for nursing home care by the appropriate state agency , and
- Be able to live safely in the community.

The goal of PACE is to help people stay independent and live in their community as long as possible, while getting high quality care they need.

Q

Qualified Beneficiary - Generally, qualified beneficiaries include covered employees, their spouses and their dependent children who are covered under the group health plan. In certain cases, retired employees, their spouses and dependent children may be qualified beneficiaries.

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Qualified Medicare Beneficiary (QMB) - This is a Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.

Qualified Long-Term Care Insurance Policy - Also referred to as a Tax-Qualified Long-Term Care Insurance Policy; this is a policy that conforms to federal law and may offer federal tax advantages.

Quality of Life - Includes self perceived health status, mental status, sexual function and stress level, helps to explain an individual's general well-being.

Qualifying Individuals (1) (QI-1S) - This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, the Medicaid program pays full Medicare Part B premiums only.

Qualifying Individuals (2) (QI-2S) - This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, Medicaid pays a percentage of Medicare Part B premiums only.

R

Railroad Retirement - A federal insurance program similar to Social Security designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

Reconsideration Or Review - The first step in the Medicare Part A and Part B appeal processes. Beneficiary sends a written request to the intermediary showing his or her disagreement with the Part A or Part B payment allowed for claim and asks that the payment decision be reviewed.

Retiree For the RDS Program - An individual who is provided coverage under a group health plan after that individual has retired.

Review Of Claims - Using information on a claim or other information requested to support the services billed, to make a determination.

S

Senior Care Options (SCO) - An innovative full-service Medicare and Medicaid managed care program that is being offered to eligible Medicaid/Mass Health members age 65 and over, at all levels of need, in both the community and institutional settings. Qualified senior care organizations have been selected to contract with Medicaid/Mass Health and the Centers for Medicare and Medicaid Services (CMS), and have established large provider networks that are coordinating and delivering all acute, long-term care, and mental health and substance abuse services. Senior Care Options is based on a geriatric model of care.

Senior Medical Benefit Request - The MassHealth application for older adults or people needing long-term care.

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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. The plan may disenroll you if you move out of the plans service area.

Service Area (Private Fee-For-Service) - The area where a Medicare Private Fee-for-Service plan accepts members.

Service Category Definition - A general description of the types of services provided under the service and/or the characteristics that define the service category.

Service Plan - Also referred to as a care plan or treatment plan. Written document which outlines the types and frequency of the long-term care services that a consumer receives. It may include treatment goals for him or her for a specified time period.

Serving The Health Information Needs Of Elders Program (S.H.I.N.E.) - A program of the Executive Office of Elder Affairs which provides free, confidential and unbiased health insurance counseling. S.H.I.N.E. is a volunteer network of health benefits counselors who provide information to elders about Medigap Insurance, Medicare, HMOs, public benefits, retiree health plans, individual insurance, prescription drug charge coverage, health insurance counseling, long term care insurance and other health insurance options.

SNAP (Supplemental Nutrition Assistance Program) (Formally Known as Food Stamps) - Provides financial assistance to individuals with low or no income to buy food. Individuals use an Electronic Benefit Transfer (EBT) card to purchase food. The EBT card works like a credit or debit card.

Social Security Act - Public Law 74-271, enacted on August 14, 1935, with subsequent amendments. The Social Security Act consists of 20 titles, four of which have been repealed. The health insurance (Medicare) and Supplementary Medical Insurance (Part B of Medicare) programs are authorized by Title XVIII of the Social Security Act.

Social Security Administration - The Federal agency that, among other things, determines initial entitlement to and eligibility for Medicare benefits.

Social Security Benefits - People contribute to this fund during their working years. After you apply for benefits you may receive monthly checks if your are retired at you full retirement age, permanently disabled or a dependent of a retired or permanently disabled worker, working past age 62 but make less than the annual exemption, over 70 regardless of income, age 60 and a widow/widower of a beneficiary, a dependent of a deceased individual entitled to benefits.

Social Security Disability Insurance (SSDI) - A system of federally provided payments to eligible workers (and, in some cases, their families) when they are unable to continue working because of a disability. Benefits begin with the sixth full month of disability and continue until the individual is capable of substantial gainful activity.

Special Enrollment Period (SEP) - A set time when you can sign up for Medicare Part B if you didn't take Medicare Part B during the Initial Enrollment Period, because you or your spouse were working and had group health plan coverage through the employer or union. You can sign up at anytime you are covered under the group plan based on current employment status. The last eight months of the Special Enrollment Period starts the month after the employment ends or the group health coverage ends, whichever comes first.

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Special Needs Plan - A special type of plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid/MassHealth, who reside in a nursing home, or who have certain chronic medical conditions.

Specified Low-Income Medicare Beneficiaries (SLMB) - A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.

Spend-Down - Medicaid financial eligibility requirements are strict. Individuals may need to spend down/use up assets or if they are over income meet a deductible until they reach the eligibility level.

State Health Insurance Assistance Program - A State program that gets money from the Federal Government to give free local health insurance counseling to people with Medicare. See Serving The Health Information Needs Of Elders Program (S.H.I.N.E.).

Specified Low-Income Medicare Beneficiaries (SLMB) - A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.

Supplemental Health Insurance - See Medicare Supplemental Policy.

Supplemental Security Income (SSI) - A federal needs based program administered by the Social Security Administration which provides for a federally guaranteed minimum monthly income for certain aged, disabled and blind persons. Eligibility criteria include having limited assets.

Supplementary Medical Insurance - The Medicare program that pays for a portion of the costs of physicians' services, outpatient hospital services, and other related medical and health services for voluntarily insured aged and disabled individuals. Also known as Part B.

Suppliers That Participate In Medicare - Participating suppliers must accept assignment for all supply categories (accept Medicare's approved payment amount as payment in full). You may pay more for products and supplies from suppliers that do not accept Medicare's approved payment amount as payment in full.

Suspension Of Payments - The withholding of payment by an FI or carrier from a provider or supplier of an approved Medicare payment amount before a determination of the amount of the overpayment exists.

T

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

Taxation Of Benefits - Beginning in 1994, up to 85 percent of an individual's or a couple's OASDI benefits are potentially subject to federal income taxation under certain circumstances. The revenue derived from taxation of benefits in excess of 50 percent, up to 85 percent, is allocated to the health insurance (Medicare) trust fund.

Term Insurance - A type of insurance that is in force for a specified period of time.

Term Life Insurance - Life insurance policy that covers a person for a period of one or more years. It pays a death benefit only if you die during that term. It generally does not build cash value.

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Tiers - To have lower costs, many plans place drugs into different "tiers," which cost different amounts. Each plan can form their tiers in different ways. Here is an example of how a plan might form its tiers.

Example:

- Tier 1 - Generic drugs. Tier 1 drugs will cost you the least amount.
- Tier 2 - Preferred brand-name drugs. Tier 2 drugs will cost you more than Tier 1 drugs.
- Tier 3 - Non-preferred brand-name drugs. Tier 3 drugs will cost you more than Tier 1 and Tier 2 drugs.

TRICARE - A health care program for active duty and retired uniformed services members and their families.

TRICARE For Life (TFL) - Expanded medical coverage available to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses.

U

Universal Life Insurance - Flexible life insurance policy that lets you vary your premium payments and adjust the face amount of your coverage.

V

Veteran's Benefits - There are Veteran's pensions for eligible veterans who are permanently or totally disabled. Eligibility depends on assets and income limits. Qualifying Veterans must have war time service.

W

Waiting Period - The time between when you sign up with a Medigap insurance company or Medicare health plan and when the coverage starts.

Waiver of Premium - Long-term care insurance policy provision that suspends premium payment after a specified period of time, during which the insured is receiving benefits for long-term care services. The suspension continues until recovery, at which time premium payments resume.

Whole Life Insurance - Life insurance policies that build cash value and cover a person for as long as he or she lives, if premiums continue to be paid.

Workers' Compensation Program - State-mandated system under which employers assume the cost of medical treatment and wage losses for employees who suffer job-related illnesses or injuries, regardless of who is at fault. In return, employees are generally prohibited from suing employers, even if the disabling event was due to employer negligence. U.S. government employees, harbor workers, and railroad workers are not covered by state workers' compensation laws, but instead by various federally administered laws.

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