GLOSSARY

I. PURPOSE

This document defines commonly used terms from the State Resource Center (SRC) and Special Needs Plan (SNP) Frequently Asked Questions (FAQs).

II. DEFINITIONS

Annual Notice of Change (ANOC): Medicare plans and Medicare Prescription Drug Plans (PDPs)/Part D sponsors will send an "Annual Notice of Change" each year to beneficiaries. The ANOC includes any changes in coverage, costs, or service area that will be effective in January.

Capitated Payment: Payment for services based on the number of patients covered over a specified period of time rather than payment for the specific services or treatment a patient receives as under the fee-for-service (FFS) model. These payments are agreed upon in a capitated contract by a managed care organization and a healthcare provider, delineating a pre-arranged monthly payment received by a physician, clinic or hospital per patient enrolled in a managed care organization.

Further, Medicare Advantage (MA) organizations in a capitated arrangement receive advance monthly payments from the Centers for Medicare and Medicaid Services (CMS) for each enrollee in an MA plan for coverage of original Medicare benefits in an MA payment area for a month. In the case of an enrollee in an MA Prescription Drug (MA-PD) plan, the MA organization also receives payment for coverage of Part D prescription drug benefits, including direct and reinsurance subsidy payments for qualified prescription drug coverage, reimbursement for the beneficiary drug premium, and the cost sharing reductions applicable to low-income individuals enrolled in the plan.

Chronic Care Improvement Program (CCIP): Section 721 of the Medicare Modernization Act of 2003 (MMA) authorized development and testing of voluntary chronic care improvement programs, now called Medicare Health Support, to improve the quality of care and life for people living with multiple chronic illnesses. The programs were overseen by CMS and operated by health care organizations chosen through a competitive selection process. Phase I program operations began between August 2005 and January 2006. Phase I ended on August 31, 2008 and CMS is assessing the results of this program.

Coordinated Care Plan (CCP): A plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by CMS.CCPs include plans offered by health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), regional or local preferred provider organizations (PPOs), and other network plans, with the exception of private fee-for-service (PFFS) plans.

Cost sharing: Costs shared by both the participant and the participant's primary insurer or between the State Medicaid Agency (SMA) and the plan. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but generally does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services which are costs primarily paid by the participant.

Evidence of Coverage (EOC): Medicare plans and Medicare Prescription Drugs Plans will send an "Evidence of Coverage" each year to beneficiaries. The EOC provides details about what the plan covers, how much individuals pay, and other updates regarding plan coverage.

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Fee-For-Service (FFS): A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Financial Alignment Demonstration (Demonstration): A demonstration designed to better align the financial incentives of Medicare and Medicaid to provide Medicare-Medicaid enrollees with a better care experience. Through the demonstration, CMS's Medicare-Medicaid Coordination Office (MMCO) will partner with States to test two models, a capitated and a managed FFS model, for effectiveness in accomplishing these goals.

Health Plan Management System (HPMS): The CMS HPMS manages the following plan enrollment processes for the MA and MA-PD programs: application, bid and formulary submissions, marketing material reviews, plan oversight, complaints tracking, operational data feeds for enrollment and payment, and data support for the Medicare & You handbook and www.medicare.gov. HPMS supports these processes for all plans and ensures that there is a single mechanism by which plans and CMS can communicate electronically in a secure and efficient manner.

Long Term Care (LTC): Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans do not cover LTC services.

Managed Care Organization (MCO): A group of doctors and other health care providers who work together to provide health care for their members. Enrollees select a primary care provider to perform regular check-ups, deliver basic care and provide referrals to specialists approved by the enrollee's MCO as necessary.

Medicare Improvements for Patients and Providers Act of 2008 (MIPPA): An act that amended titles XVIII and XIX of the Social Security Act to extend expiring provisions under the Medicare to, i) improve beneficiary access to preventive and mental health services, ii) enhance low-income benefit programs, and iii) maintain access to care in rural areas, including pharmacy access.

All D-SNP contracts between a State and an MA organization must include how the plan will meet the eight MIPPA elements found below:

1. MA organization's responsibilities, including financial obligations, to provide or arrange for Medicaid benefits;
2. Category or categories of eligibility for dual eligible beneficiaries to be enrolled under the SNP, including the targeting of specific subsets;
3. Medicaid benefits covered under the SNP;
4. Cost-sharing protections covered under the SNP;
5. Identification and sharing of information on Medicaid provider participation;
6. Verification process of an enrollee's eligibility for both Medicare and Medicaid;
7. Service area covered under the SNP; and
8. Contracting period.

Medicare Managed Care Manual (MMCM): Policies and procedures for MA and MA-PD organizations consisting of 17 active chapters.

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Model of Care (MOC): MOCs are required for all SNP plans. The MOC contains clinical and non-clinical standards upon which scoring criteria are based for the National Committee for Quality Assurance (NCQA) approval process of SNPs.

National Committee for Quality Assurance (NCQA): The NCQA is a private, not-for-profit organization dedicated to improving health care quality. The NCQA accredits and certifies health care organizations to ensure adherence to health care quality.

Online Enrollment Center (OEC): CMS provides an on-line enrollment center for beneficiaries through the www.medicare.gov web site and the 1-800-Medicare call center for enrollment into all Medicare plans.

Out-of-Pocket Maximum/Limit: The maximum amount of money a beneficiary will pay during a policy period (usually a year) before the plan begins to pay 100% of the allowed amount. The out-of-pocket maximum/limit does not include costs such as the beneficiary's premium, balance-billed charges, or non-covered services. In addition, some plans do not count copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward the out-of-pocket maximum/limit.

Plan Benefit Package (PBP): A set of benefits for a defined MA or PDP service area. The PBP is submitted by MA organizations and PDP sponsors to CMS for benefit analysis, marketing and beneficiary communication purposes.

Program of All-inclusive Care for the Elderly (PACE): PACE is a unique capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. PACE features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

Quality Improvement Projects (QIP): QIPs are initiatives that focus on one or more clinical or non-clinical area(s) with the aim of improving health outcomes and beneficiary satisfaction. MA organizations must conduct at least one QIP for all non-special needs coordinated care plans offered under a contract. However, MA organizations must identify a unique QIP for each SNP offered, including multiple SNPs of the same subtype. MA organizations must submit the QIPs to CMS and report progress annually for review.

Remuneration: The law prohibits individuals from knowingly and willfully offering, paying, soliciting, or receiving anything of value (generally referred to as a "remuneration") to influence the referral of items or services reimbursable by a Federal health care program.

Skilled Nursing Facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Special Enrollment Period (SEP): Beneficiaries can make changes to their MA and Medicare prescription drug coverage when certain events happen, such as a change in residence or loss of other insurance coverage. Such opportunities to make changes are called Special Enrollment Periods (SEPs) and are in addition to the regular enrollment periods that happen each year. Rules about when beneficiaries can make changes and the type of changes that can be made are different for each SEP.

Special Needs Individual: An MA-eligible individual who is institutionalized, entitled to receive Medicaid benefits, or has a severe or disabling chronic condition and would benefit from enrollment in a specialized MA plan.

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Specialized MA Plan: An MA CCP that exclusively enrolls, or enrolls a disproportionate percentage, of special needs individuals, provides Part D benefits and has been designated by CMS as meeting the requirements of an SNP. Meeting the requirements of an SNP is determined on a case-by-case basis using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population.

Summary of Benefits: Provides a comparison of costs and coverage between health plans. Beneficiaries can compare options based on price, benefits, and other features specific to beneficiaries' needs.

D-SNPs are required to provide prospective enrollees, prior to enrollment, with a summary of benefits using a standardized content and format that describe the benefits and cost-sharing protections to which the individual is entitled under the State Medicaid program that are covered by the D-SNP.

MIPPA's intent is to limit D-SNPs from imposing cost sharing on dual eligible beneficiaries that would exceed the amounts permitted under the State Medicaid plan if the individual were not enrolled in the D-SNP.

The Social Security Act: Provides for the general welfare by i) establishing a system of Federal elderly benefits, and ii) enabling States to make more adequate provisions for the elderly, blind, dependent and disabled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws.

Title XVIII (Medicare): Title XVIII of the Social Security Act, designated "Health Insurance for the Aged and Disabled" and commonly known as Medicare. As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for the elderly to complement the retirement, survivors, and disability insurance benefits under Title II of the Social Security Act.

Title XIX (Medicaid): Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist States in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people.

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