Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Participant Handbook* with their definitions. The terms are listed in alphabetical order. If you can’t find a term you’re looking for or if you need more information than a definition includes, contact Participant Services.

[The plan should insert definitions as appropriate to the plan type described in the Participant Handbook. The plan may insert definitions not included in this model.]

[If revisions to terminology affect glossary terms, the plan should rename the term and alphabetize it correctly within the glossary.]

[The plan should refer Participants to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, “refer to Chapter 9, Section A, page 1.” An instruction [plan may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

# Activities of daily living (ADLs): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, walking, or brushing the teeth.

# Aid paid pending: You can continue getting your services or items that are the subject of your appeal while you are waiting for a decision on a Level 1, 2, or 3 Appeal. This continued coverage is called “aid paid pending” or “continuing benefits.” All other services and items automatically continue at approved levels during your appeal.

# Appeal: A way for you to challenge a coverage decision if you think it is wrong. You can ask us to change a coverage decision by filing an appeal. Chapter 9 [plan may insert reference, as applicable] explains appeals, including how to make an appeal.

# Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same active ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

# Care Manager: One main person who works with you, with the FIDA-IDD Plan, with your care providers, and with your Interdisciplinary Team (IDT) to make sure you get the care you need.

# Centers for Medicare & Medicaid Services (CMS**):** The federal agency in charge of Medicare and Medicaid. Chapter 2 [plan may insert reference, as applicable] explains how to contact CMS.

# Comprehensive Assessment or Comprehensive Service Planning Assessment: A review of your medical, behavioral health, Community-based and Facility-based long-term services and supports (LTSS), developmental disability services, and social needs. It is used by you and your Interdisciplinary Team (IDT) to develop your Life Plan. The term refers to the initial comprehensive assessment you will have when you first join <plan name>. The comprehensive assessment will be conducted by your Care Manager in your home, which may include the hospital, nursing facility, or any other place you live at the time the assessment occurs.

# Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

# Comprehensive Re-assessment: A subsequent comprehensive re-assessment you will have at least once annually but more frequently if necessary due to changes in your needs. The comprehensive re-assessments will be conducted by a licensed professional in your home, which may include the hospital, intermediate care facility, or any other place you live at the time the re-assessment occurs.

# Continuing benefits: Refer to “aid paid pending.”

# Coverage decision: A decision made by your IDT, <plan name>, or another authorized provider about whether <plan name> will cover a service for you. This includes decisions about covered services, items, and drugs. Chapter 9 [plan may insert reference, as applicable] explains how to ask us for a coverage decision.

# Covered drugs: The term we use to mean all of the prescription and other drugs covered by <plan name>.

# Covered services and items: The general term we use to mean all of the health care, LTSS, developmental disability services, supplies, prescription and OTC drugs, equipment, and other services covered by <plan name>. Covered services and items are individually listed in Chapter 4 [plan may insert reference, as applicable].

# Cultural Competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

# Disenrollment: The process of ending your participation in <plan name>. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

# Drug tier: A group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs). Every drug on the *List of Covered Drugs* (Drug List) is in one of [insert number of tiers] tiers.

# Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

# Emergency: A medical emergency is when you, or any other person with average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function [insert as applicable: (and if you are a pregnant woman, loss of an unborn child)]. The medical symptoms may be a serious injury or severe pain.

# Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency. The plan covers emergency care from out-of-network providers.

# Enrollment Broker: The independent entity (New York Medicaid Choice) that handles FIDA-IDD Plan enrollments and disenrollments for the State of New York.

# Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

# *Explanation of Benefits* (EOB): A summary of the drugs you got during a certain month. It also shows the total payments made by <plan name> and Medicare for you since January 1.

# Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drugs costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

# Fair hearing: A chance for you to tell your problem in New York State court and show that a decision we made about your Medicaid or FIDA-IDD Program eligibility is wrong.

# Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Plan: A managed care organization under contract with Medicare and Medicaid to provide eligible individuals with all services available through both programs as well as new services. The plan is made up of doctors, hospitals, developmental disability providers, pharmacies, providers of long-term services, and other providers. It also has Care Managers to help you manage all your providers and services. They all work together to provide the care you need.

# Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Program: A demonstration program jointly run by New York State and the federal government to provide better health care for people who have both Medicare and Medicaid and who have intellectual and developmental disabilities. Under this demonstration, the State and federal government are testing new ways to improve how you get your Medicare and Medicaid health care services.

# Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

# Grievance: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies.

# Health Insurance Information, Counseling and Assistance Program (HIICAP): HIICAP is the State Health Insurance Assistance Program for New York. HIICAP gives free health insurance counseling to people with Medicare. HIICAP is not connected with any insurance company, managed care plan, or FIDA-IDD Plan.

# Home and Community-Based Services: Services developed by the Office for People With Developmental Disabilities (OPWDD) under home and community-based waivers to meet the needs of individuals with intellectual and/or developmental disabilities (I/DD) who prefer to get long-term care services and supports (LTSS) in their home or community, rather than in an institutional setting.

OPWDD waivered services include day habilitation, live-in caregiver, prevocational employment, supported employment, residential habilitation, respite, fiscal intermediary, individual directed goods and services, support brokerage, assistive technology-adaptive devices, community habilitation, community transition, environmental modifications (home accessibility), vehicle modifications, intensive behavioral supports, and pathways to employment.

# Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

* A Participant who has a terminal prognosis has the right to elect hospice.
* A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
* <Plan name> must give you a list of hospice providers in your geographic area.

# Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan’s cost sharing amount for services. Show your <plan name> Participant ID Card when you get any services or prescriptions. Call Participant Services if you get any bills you do not understand.

Because <plan name> pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

# Independent Consumer Advocacy Network (ICAN): An office that helps you if you are having problems with <plan name>. ICAN’s services are free. Refer to Chapter 2 [plan may insert reference, as applicable] for information about how to contact ICAN.

# Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

# Integrated Administrative Hearing: A meeting before the Integrated Administrative Hearing Office during which you can explain why you think <plan name> or your Interdisciplinary Team (IDT) made the wrong decision.

# Integrated Administrative Hearing Office (IAHO): A unit within the New York State Office of Temporary and Disability Assistance that conducts many of the Level 2 Appeals as described in Chapter 9 [plan may insert reference, as applicable].

# Interdisciplinary Team (IDT): Your IDT will include your Care Manager, your primary provider(s) of developmental disability services, and other health professionals who are there to help you get the care you need. Your IDT will also help you make a Life Plan and coverage decisions.

# Life Plan: A plan for what services and items you will get, how you will get them, and your goals of care. Your Life Plan is developed by you and your Interdisciplinary Team (IDT).

# *List of Covered Drugs* (Drug List): A list of prescription drugs covered by <plan name>. <Plan name> chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a “formulary.”

# Long-term services and supports (LTSS): LTSS are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS are sometimes also referred to as long-term care, long-term supports and services, or home and community-based services.

# Medicaid (or Medical Assistance): A program run by the federal government and the State that helps people with limited incomes and resources pay for health care, long-term services and supports, and medical costs.

* It covers extra services and drugs not covered by Medicare.
* Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
* Refer to Chapter 2 [plan may insert reference, as applicable] for information about how to contact Medicaid in your state.

# Medically necessary: Those services and items necessary to prevent, diagnose, correct, or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant handicap. <Plan name> will provide coverage in accordance with the more favorable of the current Medicare and New York State Department of Health (NYSDOH) coverage rules, as outlined in NYSDOH and federal rules and coverage guidelines.

# Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (ESRD) (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan.

# Medicare Advantage Plan: A Medicare program, also known as “Medicare Part C” or “MA Plans,” that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

# Medicare Appeals Council (MAC): The entity that conducts Level 3 Appeals, as described in Chapter 9 [plan may insert reference, as applicable].

# Medicare-covered services and items: Services and items covered by Medicare Part A and Part B. All Medicare health plans, including <plan name>, must cover all of the services and items that are covered by Medicare Part A and Part B.

# Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care.

# Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

# Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

# Medicare Part D: The Medicare prescription drug benefit program. (We call this program “Part D” for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. <Plan name> includes Medicare Part D.

# Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

# Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for <plan name> Participants. We call them “network pharmacies” because they have agreed to work with <plan name>. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

# Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, developmental disability services and long-term services and supports (LTSS).

* They are licensed or certified by Medicare and by the State to provide health care services.
* We call them “network providers” when they agree to work with the health plan and accept our payment and not charge our Participants an extra amount.
* While you are a Participant of <plan name>, you must use network providers to get covered services and items, unless under certain conditions such as in cases of an emergency or urgently needed care. Network providers are also called “plan providers.”

# Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

# Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. The ombudsman for individuals enrolled in the FIDA-IDD Plan is ICAN. You can find more information about ICAN in Chapters 2 [plan may insert reference, as applicable] and 9 [plan may insert reference, as applicable] of this handbook.

# Organization determination: <Plan name> has made an organization determination when it, or one of its providers, makes a decision about whether services and items are covered or how much you have to pay for covered services and items. Organization determinations are called “coverage decisions” in this handbook. Chapter 9 [plan may insert reference, as applicable] explains how to ask us for a coverage decision.

# Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the federal government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers in amounts that are set by Congress.

* You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
* Original Medicare is available everywhere in the United States.
* If you do not want to be in <plan name>, you can choose Original Medicare.

# Out-of-network pharmacy: A pharmacy that has not agreed to work with <plan name> to coordinate or provide covered drugs to Participants of <plan name>. Most drugs you get from out‑of‑network pharmacies are not covered by <plan name> unless certain conditions apply.

# Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by <plan name> and is not under contract to provide covered services and items to Participants of <plan name>. Chapter 3 [plan may insert reference, as applicable] explains out-of-network providers or facilities.

# Over-the-counter (OTC) drugs: OTC drugs refers to any drug or medicine that a person can buy without a prescription from a healthcare professional.

# Part A: Refer to “Medicare Part A.”

# Part B: Refer to “Medicare Part B.”

# Part C: Refer to “Medicare Part C.”

# Part D: Refer to “Medicare Part D.”

# Part D drugs: Refer to “Medicare Part D drugs.”

# Participant (Participant of our plan, or plan Participants): A person with Medicare and Medicaid who qualifies to get covered services and items through the FIDA-IDD Program, who has enrolled in <plan name>, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the State.

# *Participant Handbook* and Disclosure Information: This document, along with your enrollment form and any other attachments, or riders, which explains your coverage, what we must do, your rights, and what you must do as a Participant of <plan name>.

# Participant Services: A department within <plan name> responsible for answering your questions about your participation, benefits, grievances, and appeals. Refer to Chapter 2 [plan may insert reference, as applicable] for information about how to contact Participant Services.

# Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to <plan name>’s Notice of Privacy Practices for more information about how <plan name> protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

# Primary Care Provider (PCP): Your main doctor or other provider who is responsible for providing many of your preventive and primary care services and items. Your PCP will be a part of your Interdisciplinary Team (IDT).

* Your PCP will participate in developing your Life Plan, making coverage determinations about services and items you asked for, and approving authorizations for services and items that will be part of your Life Plan.
* Your PCP may be a primary care physician, a nurse practitioner, or a physician assistant.
* For more information, refer to Chapter 3 [plan may insert reference, as applicable].

# Prior authorization (PA): [The plan may delete applicable words or sentences if it does not require PA for any medical services or any drugs.] An approval from <plan name> you must get before you can get a specific service or drug or use an out-of-network provider. <Plan name> may not cover the service or drug if you don’t get approval.

Some services, items, and drugs are covered only if <plan name>, your IDT, or another specific provider authorizes them for you.

* Covered services and items that need our plan’s PA are marked in the Covered Items and Services Chart in Chapter 4 [plan may insert reference, as applicable].

Some drugs are covered only if you get PA from <plan name>.

* Covered drugs that need PA are marked in the *List of Covered Drugs* (Drug List).

# Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to Participants. Refer to Chapter 2 [plan may insert reference, as applicable] for information about how to contact the QIO for your state.

# Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

# Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

# Service area: A geographic area where a health plan accepts Participants. For a plan that limits which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get <plan name>. For more information about the FIDA-IDD Plan’s service area, refer to Chapter 1 [plan may insert reference, as applicable].

# 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.

# Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

# Specialist: A doctor who provides health care for a specific disease or part of the body.

# State Medicaid agency: The New York State Medicaid Agency is the New York State Department of Health (NYSDOH), Office of Health Insurance Programs (OHIP).

# Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

# Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

[The plan may add a back cover to the Participant Handbook that contains contact information for Participant Services. Below is an example the plan may use. Plan also may add a logo and/or photographs, as long as these elements do not make it difficult for Participants to find and read the contact information.]

**<Plan name> Participant Services**

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| --- | --- |
| **CALL** | [Insert phone number(s).]  Calls to this number are free. [Insert days and hours of operation, including information on the use of alternative technologies.]  Participant Services also has free language interpreter services available for non-English speakers. |
| **TTY** | [Insert number.]  [Insert if plan uses a direct TTY number: This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.]  Calls to this number are free. [Insert days and hours of operation.] |
| **FAX** | [Optional: Insert fax number.] |
| **WRITE** | [Insert address.]  [**Note:**Plan may add email addresses here.] |
| **WEBSITE** | [Insert URL.] |