

SNP Alliance Glossary of Relevant Terms November 2018

Please note: many of these are not legal definitions; please consult directly with CMS regulations and guidance when referring to programs or products with specific definitions in law.

Advance Beneficiary Notice of Noncoverage (ABN)

In Original Medicare, a notice that a doctor, supplier, or provider gives a person with Medicare before furnishing an item or service if the doctor, supplier, or provider believes that Medicare may deny payment. In this situation, if a beneficiary **isn't** given an ABN before they get the item or service, and Medicare denies payment, then they may not have to pay for it. If they **are** given an ABN, and it is signed, the beneficiary probably has to pay for the item or service if Medicare denies payment.

Advance coverage decision

A notice from a Medicare Advantage Plan letting a beneficiary know in advance whether the plan will cover a particular service.

Advance directive

A written document stating how a beneficiary would want medical decisions to be made if they lose the ability to make them for themselves. It may include a living will and a durable power of attorney for health care.

Alternative Payment Models (APMs)

An alternative payment model (APM) is a payment approach that rewards providers for delivering high-quality and cost-efficient care. Advanced APMs are a subset of APMs that let practices earn more rewards in exchange for taking on risk related to patient outcomes; A new approach to paying for medical care that incentivizes quality and value.

Medicare APMs include:

- CMS Innovation Center models,
- The Medicare Shared Savings Program,
- Demonstrations under the Health Quality Demonstration Program, and
- Other demonstrations initiated by Federal law.

Annual Coordinated Election Period (ACEP)

Annual coordinated election period (ACEP) or annual election period refers to the period of time between October 15 and December 7 during which changes can be made to Medicare prescription drug coverage or Medicare Advantage plan coverage (including switching from Original Medicare to a Medicare Advantage plan).

Annual Wellness Visit (AWV)

The Annual Wellness Visit is a yearly appointment with a Medicare beneficiary's primary care provider (PCP) to create or update a personalized prevention plan. This plan may help prevent illness based on current health and risk factors. The AWV is not a head-to-toe physical. Also, this service is similar to but separate from the one-time Welcome to Medicare preventive visit. Medicare Part B covers the Annual Wellness Visit if: 1) A patient has had Part B for over 12 months, and 2) they have not received an AWV in the past 12 months. Additionally, beneficiaries cannot receive an AWV within the same year as their Welcome to Medicare preventive visit. Medicare Advantage plans frequently cover as supplemental benefits annual physicals beyond what is covered under Original Medicare.

Appeal from a decision by a Medicare health plan or a Medicare Prescription Drug Plan

An appeal is the action a beneficiary can take if they disagree with an adverse coverage or payment decision made by a Medicare health plan or a Medicare Prescription Drug Plan. An appeal of a coverage or payment decision is distinguishable from a grievance, as defined below.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)

A type of QIO (an organization of doctors and other health care experts under contract with Medicare) that uses doctors and other health care experts to review complaints and quality of care from persons enrolled in Medicare health plans. The BFCC-QIO makes sure there is consistency in the case review process while taking into consideration local factors and local needs, including general quality of care and medical necessity. The BFCC-QIO also has a role in Medicare health plan member appeals in hospital, skilled nursing facility, and home health settings.

Benefits Coordination & Recovery Center (BCRC)

The company that acts on behalf of Medicare to collect and manage information on other types of insurance or coverage that a person with Medicare may have and determine whether the coverage pays before or after Medicare. This company also acts on behalf of Medicare to obtain repayment when Medicare makes a conditional payment, and the other payer is determined to be primary.

Coverage determination (Part D)

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

- Whether a particular drug is covered
- Whether a beneficiary has met all the requirements for getting a requested drug
- How much a beneficiary is required to pay for a drug

- Whether to make an exception to a plan rule when requested

Coverage gap (Medicare prescription drug coverage)

A period of time in which beneficiaries pay higher cost sharing for prescription drugs until they spend enough to qualify for catastrophic coverage. The coverage gap (also called the “donut hole”) starts when a plan has paid a set dollar amount for prescription drugs during that year.

Creditable prescription drug coverage

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

Chronic Condition Special Needs Plans (C-SNP)

Chronic Condition Special Needs Plans (C-SNPs) restrict enrollment to special needs individuals with specific severe or disabling chronic conditions. C-SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum. CMS currently has approved 15 SNP-specific chronic conditions for which C-SNPs can target enrollment. Under the Bipartisan Budget Act, CMS will establish by January 1, 2022 a new set of conditions that meets certain requirements identified in the law.

Demonstrations

Special projects, sometimes called "pilot programs" or "research studies," that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time, for a specific group of people, and in specific areas. The laws that allow for demonstrations generally permit CMS to waive specified Medicare and/or Medicaid requirements.

Dual-Eligible Special Needs Plan (D-SNP)

Dual Eligible Special Needs Plans (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. Under regulations propose in November 2018 all D-SNPs would need to meet one of three requirements: qualify as a Fully Integrated Dual Eligible Special Needs Plan; a Highly Integrated Dual Special Needs Plan; or meet certain other requirements related to data sharing with the State Medicaid agency.

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)

Fully Integrated Dual Eligible (FIDE) SNPs were created by Congress in section 3205 of the Affordable Care Act (ACA). Designed to promote the full integration and coordination of Medicare and Medicare benefits for dual eligible beneficiaries by a single managed care organization, FIDE-SNPs are described in section 1853(a)(1)(B)(iv) of the Social Security Act and at 42 CFR §422.2.

FIDE SNPs must meet the following five elements:

- Enroll special needs individuals entitled to medical assistance under a Medicaid State Plan, as defined in Section 1859(b)(6)(B)(ii) of the Act and 42 CFR Section 422.2 and described in detail in Section 40.5.3 of this chapter
- Provide dually-eligible beneficiaries access to Medicare and Medicaid benefits under a single managed care organization;
- Have a CMS approved MIPPA compliant contract with a State Medicaid Agency that includes coverage of specified primary, acute, and long-term care benefits and services, consistent with State policy, under risk-based financing;
- Coordinate the delivery of covered Medicare and Medicaid health and long-term care services, using aligned care management and specialty care network methods for high-risk beneficiaries; and
- Employ policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality improvement.

In November 2018, CMS proposed revisions to the FIDE SNP definition to conform to new requirements added by the BBA.

Grievance

A complaint about the way a Medicare health plan or Medicare drug plan is giving care. For example, a beneficiary may file a grievance if they have a problem calling the plan or if they're unhappy with the way a staff person at the plan has behaved. However, if there is a complaint about a plan's refusal to cover a service, supply, or prescription, an *appeal* is appropriate.

Group health plan

In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families and/or retirees.

Guaranteed issue rights (also called "Medigap protections")

Rights that beneficiaries have in certain situations when insurance companies are required by law to sell or offer a Medigap policy. In these situations, an insurance company can't deny a Medigap policy, or place conditions on a Medigap policy, like exclusions for pre-existing conditions, and can't charge more for a Medigap policy because of a past or present health problem.

Guaranteed renewable policy

An insurance policy that can't be terminated by the insurance company unless a beneficiary is found to have made untrue statements to the insurance company, committed fraud, or failed to pay premiums. All Medigap policies issued since 1992 are guaranteed renewable.

Healthcare C-Suite

CXO - The chief experience officer is responsible for the overall experience of a healthcare organization's products and services. The CXO is charged with bringing a holistic experience design to the boardroom, and making it an intrinsic part of the organization's strategy and culture.

CLO - Chief learning officers are responsible for the learning initiatives in a healthcare setting. They provide direct training, education and development programs to ensure the effectiveness of their staffs.

CI(N)O - A chief innovation officer is primarily responsible for managing the process of innovation and change management, and in some cases is the person who not only originates new ideas but recognizes the innovative ideas generated by others. The CINO also manages technological change, sometimes under the name of chief technology innovation officer, or CTIO.

CTO - Chief transformation officers drive the organization forward and hold accountable those responsible for the hundreds of daily actions and initiatives that underlie typical programs. Effective CTOs act as role models for the sort of behaviors needed to encourage change.

CSO - A chief strategy officer is responsible for assisting the CEO with developing, communicating and executing corporate strategic initiatives. Part consultant, part leader and part doer, CSOs are often executives who have worn many hats for many companies.

CIO - A chief integration officer is in charge of ensuring the coordination of all the interacting systems within the enterprise. This can involve information systems, people, ideas or processes -- or all of the above.

CCO - Chief compliance officers are responsible for all of the hospital's compliance activities, which can include planning, implementing and monitoring a hospital of private practice compliance plan.

CMIO - The chief medical information officer ensures that IT is used correctly and effectively in medical settings, and while they don't necessarily practice medicine, many do in addition to providing that medical IT support.

CMO - Chief Marketing Officer; Chief Medical Officer

CQO - The chief quality officer is a manager responsible for the quality of a hospital or system's products and services. They set goals for quality measures, set methodologies for supporting quality and follow up on key quality performance indicators.

CPO - The chief privacy officer helps to keep personal information safe, as well as medical data and financial information. They are also responsible for ensuring data is secure from unauthorized users.

Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS) is the patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS is to gather valid, reliable, and clinically meaningful health status data from the Medicare Advantage (MA) program to use in quality

improvement activities, pay for performance, program oversight, public reporting, and to improve health. All managed care organizations with Medicare contracts must participate.

Highly Integrated Dual Special Needs Plan (HIDE SNP)

In November 2018, MS proposes to define a HIDE SNP as a type of D-SNP offered by an MA organization that has – or whose parent organization or another entity that is owned and controlled by its parent organization has – a capitated contract with the Medicaid agency in the state in which the D-SNP operates that includes coverage of LTSS, behavioral health services, or both, consistent with state policy. All the requirements of a D-SNP would also apply to a HIDE SNP, such as the obligation to provide, as applicable, and coordinate Medicare and Medicaid benefits. In contrast to a FIDE SNP, a D-SNP could satisfy the requirements of a HIDE SNP if its parent organization offered a companion Medicaid product that covered only LTSS or behavioral health services, or both, under a capitated contract.

Home health care

Health care services and supplies a doctor decides that a beneficiary may get in the home under a plan of care established by a physician. Medicare only covers home health care on a limited basis, as ordered by a doctor.

Hospice

A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver. Medicare health members may remain in the health plan if they elect hospice but the payment rate is reduced because the range of services to which the Medicare health plan is responsible for is reduced.

Health Plan Management System (HPMS)

A web-enabled information system that serves a critical role in the ongoing operations of the Medicare Advantage (MA) and Part D programs.

HPMS services the MA and Part D programs in two central ways. First, HPMS functionality facilitates the numerous data collection and reporting activities mandated for these entities by legislation. Second, HPMS provides support for the ongoing operations of the plan enrollment and plan compliance business functions as well as for longer-term strategic planning and program analysis.

Specifically, HPMS supports the following business processes for all private health and drug plans participating in the MA and Part D programs:

- Contract and plan enumeration and management
- Application submission and review
- Formulary submission and review
- Bid and benefit package submission and review
- Electronic contracting and certifications
- Marketing material submission and review

- Audit and assessment of plan performance
- Plan payment reconciliation data reporting

Independent reviewer

An organization (sometimes called an Independent Review Entity or IRE) that has no connection to a given Medicare health plan or Medicare Prescription Drug Plan. Medicare contracts with the IRE to review cases if a beneficiary has appealed their plan's payment or coverage reconsideration decision, or if the plan doesn't make a timely appeals decision.

Institutional Special Needs Plans (I-SNP)

Institutional Special Needs plans restrict enrollment to Medicare Advantage (MA) eligible individuals who, for 90 days or longer, require or are expected to need the level of services provided in an institutional skilled nursing facility (SNF), a nursing facility (NF), a SNF/NF, an intermediate care facility (ICF) for the developmentally disabled (ICF/MR), or a n inpatient psychiatric facility. I-SNPs may also enroll MA eligible individuals living in the community, but requiring an institutional level of care, known as Institutional Equivalent SNPs. When an I-SNP opts to enroll individuals prior to having at least 90 days of institutional level care, a CMS-approved needs-assessment must be conducted. Results of the assessment must demonstrate that the individual's condition makes it likely that either the length of stay or the need for an institutional level-of-care will be at least 90 days.

Lifetime reserve days

In Original Medicare, these are additional days that Medicare will pay for when a beneficiary in a hospital for more than 90 days. They have a total of 60 reserve days that can be used during their lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Limiting charge

In Original Medicare, the highest amount of money a beneficiary can be charged for a covered service by doctors and other health care suppliers who don't 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. When applicable, amounts charged to a Medicare health plan for covered services furnished by non-network providers is subject to the limiting charge provision.

Long Term Services and Supports

Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living, like 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 don't pay for long-term care.

Long-term care hospital

Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Long-term care ombudsman

An independent advocate (supporter) for nursing home and assisted living facility residents who works to solve problems of residents of nursing homes, assisted living facilities, or similar facilities. They may be able to provide information about home health agencies in their area.

Medicaid-certified provider

A health care provider (like a home health agency, hospital, nursing home, or dialysis facility) that's been approved by Medicaid. Providers are approved or "certified" if they've passed an inspection conducted by a state government agency. The term provider in this context is much narrower than the commonly used health care term which refers to a person or entity that furnishes health services to an enrollee.

Medical Loss Ratio (MLR)

Many insurance companies spend a substantial portion of consumers' premium dollars on administrative costs and profits, including executive salaries, overhead, and marketing.

The Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement to total revenue, also known as the Medical Loss Ratio (MLR). It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards. The Affordable Care Act requires insurance companies to spend at least 80% or 85% of premium dollars on medical care, with the rate review provisions imposing tighter limits on health insurance rate increases. If an issuer fails to meet the applicable MLR standard in any given year, as of 2012, the issuer is required to provide a rebate to its customers. Under the Medicare Advantage program, Medicare health plans that have an MLR of less than 85% must return the difference to CMS.

Medically necessary

Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medical underwriting

The process that an insurance company uses to decide, based on a patient's medical history, whether to take their application for insurance, whether to add a waiting period for pre-existing conditions (if the state law allows it), and how much to charge for that insurance. Medicare health plans generally may not engage in medical underwriting except if the beneficiary has been medically determined to have end-stage renal disease. SNPs are permitted to engage in medical underwriting for purposes of ascertaining if an applicant qualifies to enroll in the SNP.

Medicare Advantage Plan (Part C)

A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all Part A and Part B benefits. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Advantage Plans include:

- Health Maintenance Organizations, which may include a point-of-service option
- Preferred Provider Organizations (regional and local)
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

If enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Medicare services aren't paid for by Original Medicare

Medicare Cost Plan

A type of Medicare health plan available in some areas. In a Medicare Cost Plan, if services are provided outside of the plan's network without a referral, the Medicare-covered services will be paid for under Original Medicare (the Cost Plan pays for non-network emergency services or urgently needed services).

Medicare Advantage Health Maintenance Organization (HMO) Plan

A type of Medicare Advantage Plan (Part C) available in some areas of the country. In most HMOs, beneficiaries can only go to doctors, specialists, or hospitals on the plan's list except in an emergency or urgently needed situations. Medicare Advantage HMOs may include a point-of-service benefit that allows for coverage of some out-of-network services. Many HMOs also require a referral from the primary care physician for some services.

Medicare health plan

Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans. PACE plans can be offered by public or private companies and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare Advantage Medical Savings Account (MSA) Plan

MSA Plans combine a high deductible Medicare Advantage Plan and a bank account. The plan deposits money from Medicare into the account. The money in this account can be used to pay for health care costs, but only Medicare-covered expenses count toward a beneficiary's deductible. The amount

deposited is usually less than the deductible amount so, generally, the enrollee will have to pay out-of-pocket before their coverage begins.

Medicare Part A (Hospital Insurance)

Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)

Part B covers principally certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Advantage Preferred Provider Organization (PPO) Plan

A type of Medicare Advantage Plan (Part C) available in some areas of the country in which enrollees pay less if they use doctors, hospitals, and other health care providers that belong to the plan's network. Enrollees can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare prescription drug coverage (Part D)

Optional benefits for prescription drugs available to all people with Medicare for an additional charge. This coverage is offered by insurance companies and other private companies approved by Medicare. This coverage is either through enrollment in a Medicare health plan or enrolled in a Medicare prescription drug plan.

Medicare Prescription Drug Plan (Part D)

Part D adds prescription drug coverage to:

- Original Medicare
- Some Medicare Cost Plans
- Some Medicare Private-Fee-for-Service Plans
- Medicare Medical Savings Account Plans

These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Medicare Advantage Private Fee-For-Service (PFFS) Plan

A type of Medicare Advantage Plan (Part C) in which beneficiaries can generally go to any doctor or hospital they could go to with Original Medicare, if the doctor or hospital agrees to treatment. The plan determines how much it will pay doctors and hospitals, and how much beneficiaries must pay when they get care.

A Private Fee-For-Service Plan is very different than Original Medicare, and beneficiaries must follow the plan rules carefully when they go for health care services.

Medicare Advantage Regional Plan

MA regional plan means a coordinated care plan structured as a preferred provider organization (PPO) that serves one or more entire regions. An MA regional plan must have a network of contracting providers that have agreed to a specific reimbursement for the plan's covered services and must pay for all covered services whether provided in or out of the network.

Medicare Savings Program

A Medicaid program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance.

Medicare SELECT

A type of Medigap policy that may provide incentives for beneficiaries to use network hospitals and, in some cases, doctors within its network to be eligible for full benefits.

Medicare Special Needs Plan (SNP)

A special type of Medicare Advantage Plan (Part C) that provides more focused and specialized health care for specific groups of people, like those who have both Medicare and Medicaid, who live in a nursing home, or have certain chronic medical conditions.

Medicare Summary Notice (MSN)

A notice sent after the doctor, other health care provider, or supplier files a claim for Part A or Part B services in Original Medicare. It explains what the doctor, other health care provider, or supplier billed for, the Medicare-approved amount, how much Medicare paid, and what the beneficiary must pay.

Partial Duals

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

- Qualified Medicare Beneficiaries without other Medicaid (QMB only)

These individuals are entitled to Medicare Part A, have income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers.

- Specified Low-Income Medicare Beneficiaries without other Medicaid (SLMB-only)

These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

- Qualified Disabled and Working Individuals (QDWI)

These individuals lost their Medicare Part A benefits due to their return to work. They are eligible to purchase Medicare Part A benefits, have income of 200% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.

- Qualifying Individuals (QI)

There is an annual cap on the amount of money available, which may limit the number of individuals in the group. These individuals are entitled to Medicare Part A, have income of at least 120% FPL, but less than 135% FPL, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only.

Programs of All-inclusive Care for the Elderly (PACE)

A special type of health plan that provides all the care and services covered by Medicare and Medicaid as well as additional medically necessary care and services based on unique needs as determined by an interdisciplinary team. PACE serves frail older adults who need nursing home services but are capable of living in the community. PACE combines medical, social, and long-term care services and prescription drug coverage.

Risk-Adjusted Data Validation (RADV)

Payments to Medicare Advantage plans are adjusted based on health risk of enrollees. The goal of risk adjustment is to ensure beneficiaries, including those with chronic conditions, are enrolled in plans that are appropriately reimbursed to meet their individual health needs. Diagnosis codes submitted by Medicare Advantage plans for their enrollees' medical conditions are used by the Centers for Medicare & Medicaid Services (CMS) to determine enrollee risk scores. The Agency performs risk adjustment data validation (RADV) audits to confirm these diagnoses are supported in beneficiary medical records and meet other CMS requirements.

Special Election Periods (SEPs)

Special election periods are times, outside of the annual election period when an individual may discontinue the election of an MA plan and change his or her election. CMS has a list of circumstances in which SEPs are allowed, including in many circumstances when an individual has or loses dual eligible status. Similar SEPs are available for persons who may want to change Part D coverage.

Special Enrollment Periods

A period of time outside the Open Enrollment Periods (OEP) for beneficiaries to enroll in Medicare. The length of the Special Enrollment Period and the effective date of new coverage vary depending on the circumstances that trigger a given SEP. The Medicare Enrollment period is distinct from the special election period, which is a Medicare Advantage concept.

Statistical Enrollment Data System (SEDS)

Statistical Enrollment Data System – States submit quarterly and annual CHIP statistical data to CMS through the SEDS automated reporting system (U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, 2010, p. 47). Using forms provided by CMS, states report unduplicated counts of the number of children under age 19 who are enrolled in separate CHIPs and Medicaid expansion CHIPs. SEDS is a web-based system maintained by CMS since 2000 that collects new and total Medicaid and CHIP enrollment data from states on a quarterly basis. States must submit quarterly enrollment data within 30 days after the end of the fiscal quarter and aggregate annual data within 30 days after the end of the fourth quarter.⁴⁶ This analysis uses quarterly and annual total enrollment data from three of the SEDS reporting forms and, to our knowledge, is the first analysis to do so.

State Health Access Data Assistance Center (SHADAC)

SHADAC is a multidisciplinary health policy research center with a focus on state policy. Our staff members represent a broad range of expertise, ranging from economics, statistics and evaluation to sociology and journalism. We are passionate about the importance of using sound data to inform policy decisions, and work collaboratively with our clients to achieve results. SHADAC strives to produce rigorous, policy-driven analyses. We translate complex findings into actionable information that is accessible to a broad audience. Thanks to our long history of working with state agencies and foundations, we've developed a deep understanding of the unique challenges and opportunities states face.

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.

State Health Insurance Assistance Program (SHIP)

A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State Insurance Department

A state agency that regulates insurance and can provide information about Medigap policies and other private health insurance. Some states have different names for the agency that performs this function.

State Medical Assistance (Medicaid) office

A state or local agency that can give information about, and help with applications for, Medicaid programs that help pay medical bills for people with limited income and resources.

State Pharmaceutical Assistance Program (SPAP)

A state program that provides help paying for drug coverage based on financial need, age, or medical condition. This assistance is typically for needy people who do not qualify for Medicaid coverage.

State Survey Agency

A state agency that oversees health care facilities that participate in the Medicare and/or Medicaid programs by, for example, inspecting health care facilities and investigating complaints to ensure that health and safety standards are met. Test

Step therapy for prescription drugs

A coverage rule used by some Medicare Prescription Drug Plans that requires a beneficiary to try one or more similar, lower cost drugs to treat their condition before the plan will cover the prescribed drug.

Telemedicine

Medical or other health services given to a patient using a communications system (like a computer, phone, or television) by a practitioner who is not in the same physical space as the patient. Original Medicare covers telemedicine that is offered in certain rural areas where certain additional services are met. Medicare Advantage plans are allowed to supplement telemedicine services in other settings.