GLOSSARY OF MEDICARE TERMS

Aged—One of the categories used for classifying Medicare enrollees and Medicaid eligible.

Under Medicare, persons aged 65 or over are included in this category if they are: entitled to monthly SSA benefits or payments from the RRB, uninsured for SSA or RRB benefits but transitionally insured for Medicare, or not included in the previously mentioned groups, but based on meeting certain criteria, elect to purchase A and/ or B coverage by paying the appropriate monthly premium.

Persons aged 65 or over identified as having ESRD are included. Under Medicaid, persons aged 65 or over are included if, in addition to initially being age 65 or over met certain means (income and resources) criteria or incur medical expenses for health care that when deducted from income qualifies the individual for Medicaid. Also referred as Senior or Older Adult.

Allowed Charge—An individual charge determination (approved amount) made by a Medicare Administrative Contractor on a covered Part B medical service or supply.

Assigned Claim—A claim for which the physician or supplier agrees to accept the amount approved by Medicare as the total payment. Medicare pays the physician or supplier 80 percent of the Medicare-approved fee schedule (less any unmet deductible). The doctor or supplier can charge the beneficiary only for the coinsurance, which is the remaining 20 percent of the approved amount. A participating physician or supplier agrees to accept assignment on all claims.

Assignment (Medicare) – assignment is a fee schedule agreement between Medicare and a doctor. Accepting assignment means your doctor agrees to the payment terms of Medicare. Over 93% of all doctors in America accept Medicare assignment. Before Medicare eligibility, most people use networks and referrals.

Providers of Part B services that participate in the Medicare program can choose to accept the *Medicare allowed amount* as payment in full for services. That is called "accepting assignment". If they choose to participate or be a Medicare provider but **NOT** "accept assignment" they can charge up to 15% above Medicare's approved amount. The 15% is called the "excess charge".

Balance Billing—A type of cost sharing under Medicare in which a beneficiary is responsible for the difference between the physician's submitted charge and the Medicare allowed charge on unassigned claims. Currently, a non-participating physician cannot charge a Medicare beneficiary more than 115 percent of the amount listed in the Medicare fee schedule for unassigned physician claims.

Beneficiary—A person who has health care insurance through the Medicare and/or Medicaid programs.

Benefit Payments—Benefit pays providers for services rendered for covered services to Medicare enrollees under the FFS payment system and monthly premiums to Medicare Advantage plans and other Medicare Choice organizations under capitated payment systems.

Benefit Period—The unit of time for measuring the use of Part A benefits (spell of illness). A benefit period begins the first day an enrollee is furnished inpatient hospital or extended care services by a

qualified provider, and it ends when the enrollee has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days. There is no limit to the number of benefit periods an enrollee can have. The enrollee must pay the hospital insurance deductible for each new benefit period.

Buy-In—A Medicare beneficiary who is also eligible for Medicaid, and for whom Medicare Part B premiums and/or Part A premiums are paid by a State Medicaid program (refer to dual eligible, Medicare-Medicaid enrollee, QMB, QDWI, and SLMB).

Calendar Year (CY)—The 12-month period running from January 1- December 31 that is used for establishing the payment of the voluntary Part A and the Part B premiums, deductibles, and coinsurance requirements. It is used as the basis for tabulating Medicare enrollment, program utilization and cost sharing, and program payments.

Centers for Medicare & Medicaid Services (CMS)—The Federal Agency within DHHS that runs Medicare. In addition, CMS works with the States to run the Medicaid and CHIP programs. CMS also runs the federally facilitated Marketplace, called 'Connect for Health Colorado' in Colorado.

Claim—A request to a Medicare Administrative Contractor, to a State by a beneficiary, or by a provider acting on behalf of a beneficiary for payment of benefits under Medicare or Medicaid.

Coinsurance—The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, that Medicare does not cover and for which the beneficiary is responsible; or, for which Medicaid may pay in the case of certain dually entitled beneficiaries.

- Under Part A, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st-90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible.

- There is no coinsurance for the first 20 days of SNF care; from the 21st- 100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible.

- Under Part B, after the annual deductible has been met, Medicare pays 80 percent of the allowed amount for covered services and supplies; the remaining 20 percent is the coinsurance payable by the enrollee.

- There is no coinsurance for home health services, or for clinical laboratory services under Part B.

Cost Sharing—The generic term that includes copayments, coinsurance, deductibles, and out- of-pocket payments for balanced billing. Does not include monthly premium for Part-B, Part- D, voluntary Part A coverage, or Medigap insurance.

- *Copayments*—A specified dollar amount, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a prescription.

- *Coinsurance*—Medicare Part A: A specified per-day dollar amount. Medicare Part B: A percentage share of the cost of services, after deductibles.

- *Deductibles*—Specified amounts of spending which a beneficiary must incur before insurance begins to make payments. Works just like car insurance.

Covered Day of Care—A day of care, which was covered in full or in part, by Part A Medicare benefits. This excludes days of care prior to the person's entitlement to Part A benefits, and days of care after exhaustion of benefits.

Covered Services—Services and supplies for which Medicare and Medicaid will reimburse.

Creditable Coverage— Creditable coverage is a health insurance, prescription drug, or other health benefit plan that meets a minimum set of qualifications. For Medicare purposes

- *Creditable health coverage and Part B, medical insurance*: An employer's group health plan related to the current employment of the beneficiary or spouse is considered creditable for Part B, medical insurance.

- *Creditable health coverage and a Medigap policy:* A company selling Medicare supplement insurance can delay the effective date of coverage for a pre-existing condition. If an individual had at least six months of creditable coverage (without a break of more than 63 days) prior to applying for a Medigap policy, the company must shorten or eliminate the waiting period.

- *Creditable drug coverage and Part D, prescription drug plan:* This drug coverage is considered at least as good as that of the standard Medicare prescription drug plan. This means the drug plan will pay at least as much as the standard Medicare plan. Those who have creditable drug coverage can delay purchasing a Medicare Part D prescription drug plan until that coverage ends without facing a Part D Late Enrollment Penalty.

Critical Access Hospitals—A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

Current Procedural Terminology (CPT) Codes—A medical code set used for reporting medical services and procedures performed by physicians or other qualified providers.

Deductible— Specified amounts of spending which a beneficiary must incur before insurance begins to make payments. Works just like car insurance. The deductible applies to each new benefit period.

Department of Health and Human Services (DHHS)—Administers many of the social programs of the Federal Government dealing with the health and welfare of the citizens of the U.S.

Disabled—One of the categories used for classifying Medicare enrollees and Medicaid eligible. Disabled persons under age 65 receiving Social Security or RRB disability insurance benefits for 24 months are eligible for Medicare coverage. Persons under age 65 who are diagnosed with ESRD are eligible to receive

Medicare coverage without the Social Security disability insurance 24-month requirement. Under Medicaid, the disabled category refers to low- income individuals of any age who are eligible as persons meeting SSA's programmatic definition of disability.

Discharge—A formal release from a hospital (under Medicare or Medicaid), a SNF (under Medicare), or a NF (under Medicaid). Discharges include persons who died during their stay, were discharged to home, or were transferred to another facility.

Drug Tier – Many plans place drugs into different levels, called "tiers," on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost you less than a drug in a higher tier.

- *Tier 1*—lowest Copayment. Most generic prescription drugs.
- *Tier 2*—medium copayment: preferred, brand-name prescription drugs.
- *Tier 3*—higher copayment: non-preferred, brand-name prescription drugs. Specialty tier—highest copayment: very high-cost prescription drugs.

Dual Eligible—Also referred to as Medicare-Medicaid Enrollee. An individual who is entitled to Medicare Parts A and/or B and is eligible for a form of Medicaid benefits (depending on the services and limitations placed by the State), as well as payment of Medicare monthly premium, deductibles, and/or coinsurance.

Durable Medical Equipment (DME)—Medical supplies, and items used in a beneficiary's home, such as hospital beds, wheelchairs, assistive devices, oxygen, etc. These supplies need a physician's order to be covered under Part B.

Eligibility—Meeting the requirements for coverage under Medicare and/or Medicaid.

Eligible—*Medicare:* a person who *can* enroll in the Medicare program or a portion of the Medicare program. *Medicaid:* a person who *is* enrolled in the Medicaid program and eligible to receive Medicaid services.

End Stage Renal Disease (ESRD)—Permanent kidney failure. To survive, the patient must either receive a kidney transplant or periodic kidney dialysis. Individuals with ESRD are eligible for Medicare benefits under a special entitlement. Individuals who have chronic kidney disease requiring renal dialysis or a kidney transplant are considered to have ESRD.

To qualify for Medicare coverage, such individuals must be fully or currently insured under Social Security or the Railroad Retirement System or be the dependent of an insured person. Eligibility for Medicare coverage begins the first day of the fourth month of dialysis treatments; coverage may begin sooner if the patient participates in a self-care dialysis training program provided by a Medicare-approved training facility.

Also, coverage may begin on admittance to a Medicare-approved hospital to receive a kidney transplant

or to receive dialysis before the transplant if the transplant takes place in that same month or within the following 2 months.

Enrollee—A person who is eligible for coverage and is enrolled in the Medicare and/or Medicaid. Also known as a *beneficiary*.

Enrollment Periods – There are certain times you can enroll in Medicare, and each of these times has certain rules around applying and when coverage begins. See **General Enrollment Periods (GEP), Initial Enrollment Period (IEP), Medicare Advantage Open Enrollment Period (MAOEP), Open Enrollment Period (OEP) and Special Enrollment Periods (SEP).**

Extra Help (see Low Income Subsidy)**-** Under Part D, individuals eligible for both Medicare and Medicaid receive a low-income subsidy for the Medicare drug plan premium and assistance with cost sharing for prescriptions.

Fee-for-Service (FFS) Reimbursement—The payment that physicians and other providers receive for services provided, under the traditional health care payment system.

Federally Qualified Health Centers-Federally Qualified Health Centers are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.

Federally Qualified Health Centers may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing.

Formulary - List of covered prescription drugs. Most Medicare drug plans (Medicare drug plans and Medicare Advantage Plans with prescription drug coverage) have their own list of what drugs are covered, called a formulary. Plans include both brand-name prescription drugs and generic drug coverage. Many plans place drugs into different levels, called "tiers," on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost you less than a drug in a higher tier.

General Enrollment Period (GEP) - If you miss your Initial Enrollment Period or your Special Enrollment Period, you get another chance to enroll. You can sign up for Medicare Parts A & B between January 1 and March 31 each year. Your Medicare coverage would begin on July 1 of the same year. It is important to note that if you need to buy Part A, you must also enroll in Part B at this time.

Health Maintenance Organizations (HMOs) - are private plans that the federal government pays to administer Medicare benefits. Some HMOs offer additional benefits, such as vision and hearing care. Eligibility and costs basics. You must have both Parts A and B to join a Medicare HMO.

- *HMO vs PPO* - Although they generally have provider networks, Medicare Advantage PPOs let you see doctors outside the plan network. You do not have to choose a primary care provider with a Medicare PPO, but you do with an HMO. If you want to see a specialist, an HMO generally requires you to get a referral.

Healthcare Common Procedure Coding System (HCPCS)—A Medicare coding system for all services performed by a physician, other health care professional, or supplier.

Home Health Agency (HHA)—A public or private organization that provides skilled nursing services and other therapeutic services in the patient's home, under the care of physicians, and that meets certain conditions to ensure the health and safety of the individual. HHA services are furnished under an established plan and periodically reviewed by a physician. They include part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical social services; medical supplies and appliances (other than drugs and biological); home health aide services; and services of interns and residents.

Hospice—A public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to patients that are certified to be terminally ill. Medicare beneficiaries may elect to receive hospice care instead of standard Medicare benefits for terminal illnesses. Under Medicaid, beneficiaries electing hospice no longer receive Medicaid covered therapeutic services.

Initial Enrollment Period (IEP) - The Initial Enrollment Period (IEP) is the first time you can sign up for Medicare. You may join Medicare Parts A, B, C and D during this time:

- The 3 months before your 65th birthday,
- The month of your birthday, and
- The 3 months after your birthday.

Inpatient Hospital Services—Items and services furnished to an inpatient of a hospital by the hospital, including room and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services. *A beneficiary has to be formally admitted to the hospital to be considered "inpatient."*

KEPRO – Quality Improvement Organization (QIO) that manages all Medicare beneficiary complaints and quality of care reviews to ensure consistency in the review process. KEPRO also reviews discharge appeals when Medicare beneficiaries do not feel they are ready for discharge from the hospital or skilled services. KEPRO case review services are free.

Lifetime Reserve Days—In Original Medicare, a Medicare Part A enrollee has a non-renewable lifetime reserve of 60 days of inpatient hospital care to draw on if the 90 covered days per benefit period are exhausted. Patients are required to pay a daily coinsurance amount equal to one-half of the inpatient hospital deductible for each lifetime reserve day.

Long Term Care Hospitals—Certified as acute-care hospitals, but long-term care hospitals focus on patients who, on average, stay more than 25 days.

Low-Income Subsidy (LIS) — Also known as the Extra Help program, administrated by the SSA that assists with prescription drug costs for eligible individuals whose income and resources are limited. The

subsidy provides assistance with the premium, deductible, and co- payments of the program paid by the Federal government to the drug plan in which the Medicare beneficiary enrolls.

Medicare Advantage Open Enrollment Period (MAOEP) – Newly created (Jan 2019) enrolment period in which:

- If you have an existing MA plan, you can switch to another, (with or without drug coverage)
- Dis-enroll from the MA plan to go to Original Medicare, (and join a Part D drug plan)

Medicaid—The joint Federal/State entitlement program, enacted in 1965 as Title XIX of the Social Security Act, that pays for medical care on behalf of certain groups of low-income persons.

Medicare—The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End Stage Renal Disease.

Medicare Administrative Contractor (MAC)—A company under contract with the federal government to handle claims processing for Medicare services.

Medicare Advantage Prescription Drug Plan (MAPD)—A Medicare Advantage (Part C) plan that includes prescription drug coverage. These plans are offered by private companies that contract with Medicare to provide Part A, Part B, and Part D benefits, and include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee- for- Service (PFFS) plans, or Medicare Medical Savings Account (MSA) plans.

Medicare Part A or Hospital Insurance (HI)— Part A helps cover inpatient hospital care, skilled nursing facility (SNF) care, hospice care, and some home health care.

Medicare Part B or Supplementary Medical Insurance (SMI)—a voluntary insurance program that provides insurance benefits for physicians' services, outpatient care, ambulatory services, medical supplies and services, durable medical equipment, some home health care services, and preventive services to aged and disabled individuals who elect to enroll under the program in accordance with the provisions of Title XVIII of the Social Security Act.

Medicare Part C – Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are an "all in one" alternative to Original Medicare. These are plans that offer the benefits of both original Medicare and may offer benefits not covered by Original Medicare, such as dental, vision and hearing services, as well as non-medical services like free gym memberships, transportation to medical appointments and more. They are offered by private companies approved by and contracted with, Medicare and enrollees may be limited to what providers they can use.

Medicare Part D—Prescription drug coverage for Medicare beneficiaries who choose to participate. Coverage is provided through Prescription Drug Plans (PDPs) or Medicare Advantage Plans. These plans are offered by private insurance companies that have a contract to provide this service, with Medicare.

Medicare Outpatient Observation Notice – (MOON) Hospitals are required to provide a MOON to

Medicare beneficiaries (including Medicare Advantage health plan enrollees) informing them that they are *outpatients receiving observation services* and are *not inpatients of a hospital*.

Medicare Savings Programs (MSP)-- federally funded program administered by each individual state. These programs are for people with limited income and resources and help pay some or all their Medicare premiums, deductibles, copayments and coinsurance. Applications are submitted and processed at the county (of residence) Department of Human Services.

Open Enrollment Period (OEP) – The Open Enrollment Period runs from Oct 15th thru Dec 7th of each year. Coverage begins Jan 1st of following year.

Opting Out of Medicare Enrollment - Physicians and practitioners who do not wish to enroll in the Medicare program may "opt-out" of Medicare. This means that neither the physician/practitioner, nor the beneficiary submits the bill to Medicare for services rendered. Instead, the beneficiary pays the physician/practitioner out-of-pocket and neither party is reimbursed by Medicare. A private contract is signed between the physician/practitioner and the beneficiary that states, that neither one can receive payment from Medicare for the services that were performed. The physician or practitioner must submit an affidavit to Medicare expressing his/her decision to opt-out of the program.

Opt-out periods last for two years and cannot be terminated early unless the physician or practitioner is opting out for the very first time and the affidavit is terminated no later than 90 days after the effective date of the physician or practitioner's first opt out period.

Original Medicare Enrollees—Medicare beneficiaries enrolled in the traditional Medicare health care system (or Fee-for-Service).

Out of pocket (OOP) - Medicare out-of-pocket costs are the amount you are responsible to pay after Medicare pays its share of your medical benefits.

- In *Medicare Part A*, there is no out-of-pocket maximum. Most people do not pay a premium for Part A, but there are deductibles and limits to what is covered.
- In *Medicare Part B*, you pay a monthly premium and a deductible, but there is a limit beyond that to what Medicare covers. There is no limit to the out-of-pocket maximum you might pay beyond what Medicare covers.
- *Medicare Part C (Medicare Advantage)* plans are sold by private insurance companies and offer combined packages to cover your Medicare Part A, Part B, and even *Part D (prescription drug) costs.* Your monthly premiums, deductibles, coinsurance, and other payments will vary based on the plan you choose, but there is a maximum out-of-pocket limit set that all plans must adhere to.
- Medicare supplement insurance (Medigap) plans can help offset any out-of-pocket costs you may be responsible for paying.

Outpatient Hospital Services—Services furnished to outpatients by a participating hospital for diagnosis or treatment of an illness or injury. Outpatient hospital care may include emergency department services, observation services, outpatient surgery, lab tests, or X-rays.

Outpatient Services—Medical and other services provided by a hospital or other qualified facility or supplier, such as community mental health center, rural health clinic, X-ray mobile unit, or freestanding dialysis unit. Such services include outpatient physical therapy, diagnostic X-ray and laboratory tests, and X-ray and other radiation therapy.

Part B Penalty—An amount added to the monthly Part B premium for late enrollment. The monthly Part B premium may increase by 10% for each full 12-month period if a beneficiary is eligible for Part B but delays signing up. Assessed by SSA.

Parts vs Plans – *Parts:* There are four parts of Medicare: Part A, Part B, Part C, and Part D. Part A provides inpatient/hospital coverage. Part B provides outpatient/medical coverage. Part C offers an alternate way to receive your Medicare benefits.

- Plans: Original Medicare (Part A and Part B) or a Medicare Advantage Plan (Part C). Some people need to get additional coverage, like Medicare drug coverage or Medicare Supplement Insurance (Medigap).

Participating Physician or Supplier—A physician/supplier that agrees to accept assignment on all Medicare claims under the Medicare SMI program. Accepting Medicare assignment means the physician/supplier agrees to be paid directly by Medicare, to accept the payment amount Medicare approves for the services, and to bill the beneficiary for only the Medicare deductible and coinsurance amounts, if applicable. In Medicaid, participating providers agree to accept Medicaid reimbursement as payment in full.

Physician Services—Under Medicare, physicians' services are services provided by an individual licensed under State law to practice medicine or osteopathy. Services covered by hospital bills are not included.

Place of Residence—The beneficiary's place of residence classification is a mailing address, not necessarily an actual place of residence. Some beneficiaries have their checks mailed to a post office or to a representative payee in a State or county that may differ from their own residence.

Preferred Provider Organization (PPO) - A Medicare PPO Plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company. PPO Plans have network doctors, other health care providers, and hospitals. You pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. You pay more if you use doctors, hospitals, and providers outside of the network.

- *HMO vs PPO* - Although they generally have provider networks, Medicare Advantage PPOs let you see doctors outside the plan network. You do not have to choose a primary care provider with a Medicare PPO, but you do with an HMO. If you want to see a specialist, an HMO generally

requires you to get a referral.

Premium—A monthly fee that may be paid to Medicare or Medicaid. Medicare Part A enrollees who are Social Security or RRB beneficiaries and who qualify for coverage through age or disability are not required to pay premiums. Aged persons who are not eligible for automatic Part A enrollment may pay a monthly premium to obtain Part A coverage.

Part B enrollees pay a monthly premium that is updated annually to reflect changes in program costs. Under Part D, most drug plans charge a monthly fee that varies by plan.

Prescription Drug Plan (PDP)—A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare PFFS plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved and contracted by Medicare.

Primary Care—Basic or general health care, traditionally provided by family practice, pediatrics, and internal medicine.

Prospective Payment System (PPS)—A method of provider reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service.

Provider— A Medicare provider is a facility, supplier, physician, or other individual or organization that furnishes health care services. Under Medicaid, a provider is an individual, group, or agency that provides a covered Medicaid service to a Medicaid enrollee.

Psychiatric Hospitals—An institution that is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients, maintains clinical records necessary to determine the degree and intensity of the treatment provided to the mentally ill patient, and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution.

Qualified Disabled and Working Individuals (QDWI) — Part of the Medicare Savings Program. Also called a Medicare Buy-In Program.

Medicaid is required to pay Medicare Part A premiums only for certain disabled individuals who lose Medicare coverage because of work. These are individuals whose income is below 200 percent of the Federal Poverty Level, whose resources are not more than twice the value allowed under SSI, and who are not otherwise eligible for Medicaid.

Qualified Medicare Beneficiary (QMB) — Part of the Medicare Savings Program. A low-income Medicare beneficiary who qualifies for certain assistance under Medicaid. The beneficiary must have Medicare Part A and income less than or equal to 100% of the Federal Poverty Level and resources below twice the value allowed under SSI. *If qualified, the Medicaid program must pay Medicare Part A premiums (if applicable), Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare covered services depending on the Medicaid State plan.* Some of these individuals may also qualify for

full Medicaid benefits and are sometimes referred to as "QMB plus" enrollees.

Qualifying Individual (QI) — Part of the Medicare Savings Program. These individuals are entitled to Medicare Part A, have income of at least 120% but less than 135% of the Federal Poverty Level, 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.* There is an annual cap on the amount of money available, which may limit the number of individuals in the group.

Railroad Retirement Board (RRB)—Independent agency of the Federal Government charged with administering the retirement-survivor and unemployment-sickness benefit program for railroad workers and their families.

Rehabilitation Hospitals—Free-standing rehabilitation hospitals that provide an intensive rehabilitation program, and patients who are admitted must be able to tolerate three hours of intensive rehabilitation services per day.

Retiree Drug Subsidy—Enables employers and unions to continue assisting their Medicare-eligible retirees in obtaining more generous drug coverage.

Rural Health Clinics—A federally qualified health center (FQHC) that provides health care services in rural areas where there is a shortage of health care services.

Skilled Nursing Facility (SNF)—In Medicare, an institution that has a transfer agreement with one or more participating hospitals, is primarily engaged in providing skilled nursing care and rehabilitative services to inpatients and meets specific regulatory certification requirements.

Social Security Act—The Titles of the 1965 Social Security Act include: Title II—Old Age, Survivors, and Disability Insurance Benefits (OASDI); also, Social Security; Title IV-A AFDC; Title IV-B—Child Welfare; Title IV-D—Child Support; Title IV-E—Foster Care and Adoption; Title IV- F—Job Opportunities and Basic Skills Training; Title V—Maternal and Child Health Services; Title XVI—SSI; Title XVIII—Medicare; Title XIX—Medicaid; Title XX—Social Services; and Title XXI— State Children's Health Insurance Program.

Special Enrollment Period (SEP) - There are Special Enrollment Periods (SEPs) that apply when you can delay your enrollment in Medicare Parts A, B, C & D. These SEPs are only available for certain circumstances and are limited in when and how often you can enroll, change, or leave a Medicare Advantage Plan (MAPD) or prescription drug plan (Part D).

Specified Low Income Medicare Beneficiary (SLMB) — Part of the Medicare Savings Program. A low-income Medicare beneficiary who qualifies for certain assistance under Medicaid. The beneficiary must have Medicare Part A and income above 100 percent, but less than 120 percent of the Federal Poverty Level and resources below twice the value allowed under SSI. *For those who qualify, the Medicaid program pays the Medicare Part B premium.* Some of these individuals may also qualify for full Medicaid benefits and are sometimes referred to as "SLMB plus" enrollees.

Supplier—An organization that has been issued a Medicare supplier number, and which provides DME (such as wheelchair, walker, and oxygen equipment), medical devices (such as artificial limbs and

braces), or medical supplies (such as surgical dressings), except for hospital or skilled nursing facility settings.

Swing Bed Hospitals—A hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide post-hospital SNF care and meets certain requirements. The hospital can use its beds, as needed, to provide either acute or SNF care.

Total Days of Care—Any day during which inpatient hospital services were furnished to a person eligible for Part B benefits under Medicare including covered and non-covered days of care.

Utilization—A measure of the extent to which the members of a covered group use a program or obtain a service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per number of persons eligible for the services.

Waiver—An exception to the usual requirements of Medicare or the usual requirements of Medicaid granted to a State by CMS, authorized through sections of the Social Security Act or Social Security Amendments.