

## MEDICARE MODERNIZATION ACT GLOSSARY AND ACRONYMS

**ACS:** Affiliated Computer Services, Inc. (previously Consultec, Inc.)

**AMDD:** Addictive and Mental Disorders Division of DPHHS

**CAHRD:** Child and Adult Health Resources Division of DPHHS (now Health Resources Division)

**CFSD:** Child and Family Services Division of DPHHS

**Clawback:** The mechanism through which states will help finance the new Medicare drug benefit (the statutory term is "phased-down State contribution"). In brief, the clawback is a monthly payment made by each state to the federal Medicare program beginning in January 2006.

**CMS:** Centers for Medicare and Medicaid Services (formerly HCFA), the part of the federal Department of Health and Human Services having oversight responsibilities for Medicare and Medicaid.

**Coinsurance:** The percent of the Medicare-approved amount that a beneficiary pays after paying the deductible for Part A and or Part B.

**Copayment:** The amount a beneficiary pays for each service, usually a set amount.

**CY:** Calendar year, January 1 through December 31

**Deductible:** The amount a beneficiary pays for health care, before Medicare begins to pay. These amounts can change every year.

**DPHHS:** Department of Public Health and Human Services, Montana's state agency that manages Medicaid.

**DRAMS:** Drug Rebate Analysis and Management System

**DRG:** Diagnosis Related Group

**DSD:** Disability Services Division of DPHHS

**Fallback PDP:** Fallback prescription drug plan, in which the federal government would assume responsibility for the provision of prescription drugs in any region of the country where there is an insufficient number of private plans.

**Federal match:** The percentage of a program's cost provided by the federal government.

**FFP:** Federal Financial Participation. Costs are shared by the federal government.

**FFS:** Fee-for-service, payments made through direct agreements with providers.

**FFY:** Federal fiscal year, October 1 through September 30

**FMAP:** Federal Medical Assistance Percentage, the federal reimbursement percentage for approved medical services

**Formulary:** List of preferred medicines.

**FPL:** Federal Poverty Level

**FQHC:** Federally Qualified Health Center, public or not for profit, consumer-directed health care corporation that provides cost-effective and comprehensive primary and preventive care to medically underserved and uninsured people.

**FTE:** Full time equivalent position, or the equivalent of one person working full time for the entire year.

**Full-benefit dual eligible:** An individual who meets the criteria for enrollment under both Medicaid and Medicare Part D.

**FY:** Fiscal Year (state FY is July 1 through June 30, federal FY is October 1 through September 30)

**HCFA:** Health Care Financing Administration (now Centers for Medicare and Medicaid Services – CMS)

**HCBS:** Home and Community Based Services

**HCPI:** Health Care Price Index

**HCSD:** Human and Community Services Division of DPHHS

**HIPAA:** Health Insurance Portability and Accountability Act, passed in 1996, to help people buy and keep health insurance, and to ensure patient confidentiality.

**HMO:** Health Maintenance Organization, a type of health insurance plan. HMOs usually limit coverage to care from providers who work for or contract with the HMO.

**HRD:** Health Resources Division of DPHHS (formerly Child and Adult Health Resources Division)

**ICFMR:** Intermediate Care Facility for Mental Retardation

**IHS:** Indian Health Services

**IMD:** Intermediate Care Facility for Mental Disease

**Insurance risk:** For a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a state. Does not include payment variations or elements within the control of the pharmacy.

**LTC:** Long term care

**M+C:** Medicare+Choice, now Medicare Advantage.

**MA:** Medicare Advantage, the program authorized under Part C of Title XVIII. Formerly called Medicare+Choice (M+C)

**MA-PD:** An MA (Medicare Advantage) Prescription Drug plan that provides qualified prescription drug coverage.

**MCO:** Managed Care Organization, a type of health insurance plan. Like an HMO, managed care plans can limit coverage to health care provided by providers who work for or contract with them.

**Medicaid:** A program providing comprehensive health insurance coverage and other assistance to certain low-income residents. Funding is shared by the state and federal governments. All states have Medicaid programs, though eligibility levels and covered benefits vary.

**Medically needy:** Medically needy is an optional Medicaid eligibility category that includes children, elderly and disabled individuals, many of whom reside in nursing homes. Medically needy individuals have incomes exceeding the Medicaid eligibility standard, but also have high enough medical expenses that they meet the Medicaid income standard after deducting the medical expenses that they incur (“spend down”).

**Medicare:** A federal program that pays for certain health care expenses for people aged 65 or older and certain disabled persons. Part A covers hospital bills, Part B covers doctor bills, Part C provides the option to choose from a package of health care plans, and Part D provides prescription drug coverage.

**Medicare-approved amount:** Sometimes called the “approved charge.” This is the Medicare payment amount for an item or service, to a provider or supplier.

**Medicare prescription drug account:** The account created within the Federal Supplemental Medical Insurance Trust Fund for purposes of Medicare Part D.

**MMA:** Medicare Modernization Act of 2003.

**MMIS:** Medicaid Management Information System, for claims payment, information management, and decision support.

**MSH:** Montana State Hospital (IMD)

**MSIS:** Medicare Statistical Information System

**MSP:** Medicare Savings Program

**NDC:** National Drug Code

**NH:** Nursing Home

**NHE:** National Health Expenditure—inflation factor

**OBRA:** Omnibus Budget Reconciliation Act

**Part A:** Medicare’s hospital plan

**Part B:** Medicare's doctor plan

**Part C:** Medicare's health plan choice option, Medicare Advantage

**Part D:** Medicare's prescription drug plan

**Part D eligible individual:** An individual who is entitled to or enrolled in Medicare benefits under Part A and or Part B.

**PDL:** Preferred Drug List

**PDP:** Prescription Drug Plan. Prescription drug coverage that is offered under a policy, contract, or approved plan and offered by a PDP sponsor that has a contract with CMS.

**PDP sponsor:** A nongovernmental entity certified as meeting the appropriate requirements and standards.

**PMPM:** Per member per month.

**POS:** Point of service. A Medicare Managed Care Plan option that lets a beneficiary use providers outside the plan for an additional cost.

**PPO:** Preferred Provider Organization. A type of Medicare Advantage Plan in which a beneficiary uses providers that belong to a network. Providers outside the network can be accessed for an additional cost.

**Premium:** The periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.

**PCP:** Primary Care Provider. A provider trained to give basic care. In many Medicare Managed Care Plans, a beneficiary must see the PCP before seeing any other health care provider.

**QAD:** Quality Assurance Division of DPHHS

**QDWI:** Qualified Disabled Working Individual, a plan for a person who had Social Security and Medicare because of a disability, but lost Social Security benefits and free Medicare Part A because they returned to work and their earnings exceed the limit allowed. QDWI pays the Part A premium, but not the Part B premium.

**QI-1:** Qualified Individual program, for an individual with income too high for QMB or SLMB. QI-1 pays the Medicare Part B premium.

**QI-2:** Qualified Individual 2 program, for an individual with income too high for QMB or SLMB, and higher than QI-1. QI-2 pays a small portion of the Medicare Part B premium.

**QMB:** Qualified Medicare Beneficiary program: Pays for Medicare's premiums, deductibles and coinsurance

**RBRVS:** Resource-Based Relative Value Scale

**RHC:** Rural Health Clinic

**RVU:** Relative Value Unit

**SDMI:** Severe and Disabling Mental Illness (adults)

**SED:** Serious Emotional Disturbance (children and adolescents)

**SFY:** State Fiscal Year (July 1 through June 30)

**SHIP:** State Health Insurance Assistance Program. A state program funded by the federal government to give free local health insurance counseling to people with Medicare.

**SLMB:** Specified Low-income Medicare Beneficiary program: Pays for Medicare's Part B Premium

**SLTC:** Senior and Long Term Care Division of DPHHS

**SNP:** Special Needs Plans, specialized Medicare Advantage plans for individuals with special needs.

**SPAP:** State Pharmacy Assistance Program

**Spend down:** See Medically Needy

**SSA:** Social Security Administration

**SSI:** Supplemental Security Income

**TPL:** Third party liability

**TrOOP:** True Out Of Pocket, cost coordination to track spending and sources of drug claims payments.

**Wrap around:** The Medicaid wrap-around refers to how Medicare and Medicaid work together for individuals who are dually eligible for both programs. Specifically, Medicare serves as the primary payer, and Medicaid "wraps around" that coverage to fill in gaps in Medicare coverage. It also picks up most or all Medicare co-payments.