Government and Health Policy Acronyms

- ACA – Affordable Care Act
- AHRQ – Agency for Healthcare Research and Quality
- APM – Alternative Payment Model
- CBO – Congressional Budget Office
- CDC – Centers for Disease Control and Prevention
- CHIP – Children's Health Insurance Program
- CMS – Centers for Medicare & Medicaid Services
- CRS – Congressional Research Service
- E&C – Energy and Commerce (House Committee)
- ERISA – Employee Retirement Income Security Act
- FDA – Food and Drug Administration
- FFS – Fee-for-Service
- FMLA – Family and Medical Leave Act
- FMAP – Federal Medical Assistance Percentage
- FPL - Federal Poverty Level. This is determined each year and sets the baseline for income for Medicaid and Extra Help qualification.
- GAO – Government Accountability Office
- HELP – Health, Education, Labor, and Pensions (Senate Committee)
- HHS – U.S. Department of Health and Human Services
- HIE – Health Information Exchange
- HIPAA – Health Insurance Portability and Accountability Act
- HRSA – Health Resources and Services Administration
- IHS – Indian Health Service

- IRA – Inflation Reduction Act of 2022. Law that made some significant changes to Medicare drug coverage. It reduced the catastrophic level to $2,000 and introduced the Medicare Prescription Payment Program (M3P), among other things.

- MACRA – Medicare Access and CHIP Reauthorization Act

- MEI – Medicare Economic Index

- MIPS – Merit-Based Incentive Payment System

- NIH – National Institutes of Health

- OMB – Office of Management and Budget

- RUC – RVS Update Committee. When Medicare transitioned to a physician payment system based on the resource-based relative value scale (RBRVS) in 1992, the American Medical Association formulated a multispecialty committee, known as the AMA/Specialty Society RVS Update Committee (RUC), to provide medicine a voice in shaping Medicare relative values. The RUC is a unique multispecialty committee dedicated to describing the resources required to provide physician services which the Centers for Medicare & Medicaid Services (CMS) considers in developing Relative Value Units (RVUs). Although the RUC provides recommendations, CMS makes all final decisions about what Medicare payments will be.

- SFC – Senate Finance Committee

- W&M – Ways and Means (House Committee)

Health Insurance Acronyms and Abbreviations

- ACO – Accountable Care Organization

- AEP – Annual Enrollment Period, October 15th to December 7th. This is the only time you can change your Part D drug plan or enroll into a Medicare Advantage plan. The plan effective date is January 1st.

- ANOC – Annual Notice Of Changes. This is information sent to patients from their current Part D or Part C plan every year in September. The ANOC states any changes to the benefits for the next year, including premiums.

- EHB – Essential Health Benefits

- EHR – Electronic Health Record

- IEP – Initial Enrollment Period. This refers to the 7 months surrounding a patient's 65th birthday when they can sign up for Medicare Part A & B. It is

the 3 months before their birth month, their birth month and 3 months after their birth month. Part A & B will start the first of their birth month (unless they are born on the 1st, then it begins the month before). If a patient signs up in their birth month or the 3 months after, their Part A will backdate to the first of their birth month and their Part B will be effective the 1st of the next month.

- LIS – Low Income Subsidy. Also known as Extra Help, this is financial help for those with limited income/assets and reduces the cost of prescriptions. The income and asset limit is higher than for Medicaid. Patients apply for this through Social Security.

- M3P – Medicare Prescription Payment Plan. This is an opt-in program where patients can spread the costs of medication over the remaining months of the year. They pay nothing at the pharmacy and their drug plan bills monthly for the cost of the medication.

- MA – Medicare Advantage

- MA-OEP – Medicare Advantage Open Enrollment Period. January 1st to March 31st. During this period, if a patient has Part C, they can make one change to another Part C, or go back to Original Medicare and enroll in a Part D drug plan. The effective date is the 1st of the next month.

- MAPD – Medicare Advantage-Prescription Drug, also known as Part C. Alternative to Original Medicare where patients get Medicare coverage completely from private insurance. There are also MA-Only plans that do not include drug coverage. Typically, these work if a patient has Veterans Administration (VA) coverage. The plans are network-based and are HMOs or PPOs.

- PA – Prior Authorization. This is a limiting mechanism for drug coverage and means a drug needs approval by the patient's insurance company before the prescription can be filled. The doctor will need to call the patient's plan for approval and request authorization before the plan will cover the drug. The doctor must show the plan that the drug is medically necessary for it to be covered. This approval is not guaranteed as the patient must meet the requirements set by the insurance company. A PA for a medical service refers to the requirement of the plan to approve a treatment/test/surgery before they will pay for it. Any service that requires a PA and does not get one prior to treatment may not be covered.

- QHP – Qualified Health Plan

- QMB – Qualified Medicare Beneficiary. This is the designation for full Dual-Eligible Medicare-Medicaid; those with limited income and assets that receive the highest level of Medicaid and will pay the Part B premium and all their

Medicare deductibles and co-insurance. Eligible patients' income and assets are 100% or less of the FPL. They apply with their state Medicaid office.

- SLMB – Specified Low-income Medicare Beneficiary. This is the designation for partial Dual-Eligible Medicare-Medicaid. This level of Medicaid only pays a patient's Part B premium. Eligible patients' income and assets are between 100-120% of FPL. They apply with their state Medicaid office.

- ST – Step Therapy. A limiting mechanism for drug coverage where a patient will need to have tried one or more lower-cost drugs before the costlier drugs are covered. The doctor will need to call their plan for approval. The doctor will detail what other medications they have taken and why they are not effective for the patient. This approval is not guaranteed.