APPENDIX E: SUMMARY OF HEALTH CARE INFLATION INDICES

There is not one single source that can be used to estimate cost increases for all providers across all types of services. There are, however, measures of inflation and cost data that other health care programs use to evaluate providers' cost increases and develop inflation factors for purposes of annual rate updates. The Centers for Medicaid and Medicare Services (CMS) uses forecasted market baskets and other inflation indices to update various types of Medicare payments.[1]

CMS Market Baskets

A market basket is "a fixed-weight index… [that] answers the question of how much more or less it would cost, at a later time, to purchase the same mix of goods and services that was purchased in a base period."[2] The CMS market baskets include the quantity, intensity and prices of inputs that comprise a service. Only the prices are updated; the other factors are held constant. Thus, the market baskets provide a good measure of the changes in input prices faced by health care providers.

The CMS market baskets consist of updates to the various data components (e.g., wages and benefits, utilities, prescription drugs) that make up an individual health care service. Each component may have a different data source used to calculate its update factor; ultimately, these factors are aggregated to produce one composite factor. The market baskets, including their individual component data sources, are available to the public on the CMS website. The main sources include the:

- *Producer Price Index (PPI):* Measures the average change of the selling prices that producers receive for their goods and services. The PPI includes thousands of indices, including indices for industry prices, commodity prices, and "stage-of-processing" indices (finished goods, intermediate materials, supplies and components and crude materials).[3]

  The PPI indices are preferred over many other indices when measuring expected health care service costs because they measure actual input costs rather than a final selling price for a good or service.[4] PPI is the preferred index to consumer price index (CPI) since providers are typically wholesale consumers rather than retail consumers.

[1] The CMS market basket forecasts are developed by an economic forecasting firm contracted by CMS and are released quarterly.
[2] Centers for Medicare and Medicaid Services, *Market Basket Definitions and General Information*. Available online: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/info.pdf
[3] Bureau of Labor Statistics, Producer Price Index. Available online: http://www.bls.gov/ppi/
[4] Centers for Medicare and Medicaid Services, *Market Basket Definitions and General Information*. Available online: http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/info.pdf

- *Consumer Price Index (CPI):* Measures the average change in prices paid by urban consumers for certain goods and services. The CPI is *consumer-based*, as opposed to the *producer-based* PPI.[5] If the expenditure made by a health care provider is retail, rather than wholesale, then the CPI may be an appropriate index to consider. In addition, if there is not an existing PPI for a specific service, the CPI may be the preferable index.

- *Employment Cost Index (ECI):* Measures quarterly changes in labor costs such as wages, salaries, benefits, and total compensation. The ECI details these costs by industry, occupation, and other factors.[6]

Each type of service is comprised of different inputs. For example, facility-based services may require components such as capital, utilities, and food, which are not required for other services. Thus, CMS develops a separate market basket for each of the following types of service:

- Hospital – inpatient and outpatient
- Hospital capital
- Skilled nursing facility
- Home health agency
- Inpatient rehabilitation facility
- Long-term care hospital, inpatient rehabilitation facility and inpatient psychiatric facility
- Physician

Table E.1 displays the annual increases in the CMS market baskets from State Fiscal Year (SFY) 2016 to SFY 2021.

[5] Bureau of Labor Statistics, Consumer Price Index. Available online: http://www.bls.gov/cpi/home.htm
[6] Bureau of Labor Statistics, Employment Cost Index Summary. Available online: http://www.bls.gov/ncs/summary.htm#ect

Table E.1: Six-Year History of Medicare Input Price Indices, SFY 2016 to SFY 2021[7,8]

Service	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	Average SFY 2016 - 2021
Hospital – Inpatient	1.8	2.6	2.5	2.4	2.0	3.0	2.4
Hospital Capital – Inpatient	1.0	1.0	1.1	1.3	1.2	1.0	1.1
Skilled Nursing Facility	2.0	2.5	2.6	2.4	2.1	3.6	2.5
Home Health Agency	1.8	2.3	2.6	2.7	2.3	3.3	2.5
Long Term Care Hospital	1.8	2.4	2.4	2.3	2.0	2.8	2.3
Inpatient Rehabilitation Facility	1.8	2.4	2.3	2.3	2.1	2.7	2.3
Inpatient Psychiatric Facility	1.9	2.4	2.6	2.5	2.2	2.9	2.4
Medicare Economic Index (Physician Services)	1.2	1.4	1.8	1.7	1.6	2.5	1.7

Consumer Price Index

CMS uses the CPI to update Medicare reimbursement for several services that are not updated using the CMS market baskets: ambulance, clinical laboratories and durable medical equipment, prosthetics, and orthotics (DMEPOS). Table E.2 details the percent changes in the CPI (all items) from June 2016 to June 2021.

Table E.2: Twelve-Month Change in CPI, 2016 to 2021[9]

	Twelve Month Change From Prior Year (percent)
June 2016	1.0
June 2017	1.6
June 2018	2.9
June 2019	1.6
June 2020	0.6
June 2021	5.4

[7] All SFY data is using Quarter 3 of the Calendar Year 4 Quarter Rolling Average, because this corresponds to the SFY. The figures in Table E.1 represent the actual market basket data; the Medicare updates were based on the most recent forecast available at the time (March 2022) and may include other factors (e.g., a volume adjustment for physician services) and therefore may not correspond to the figures in Table F.1.
[8] Centers for Medicare and Medicaid Services, Market Basket Data. Accessed April 21, 2022. Available online: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html
[9] Bureau of Labor Statistics, Consumer Price Index – All Urban Consumers. Avalable online : http://www.bls.gov/data/

Appendix F: Wyoming Medicaid Rate History

Table F.1 details changes to Wyoming Medicaid rates for the service areas used in the benchmarking study. Inflation updates indicated in the *SFY 2017 and Previous* column of the table are not indicated as a change for the SFY 2018 through SFY 2021 columns of the table, unless it is an inflation update based on the Medicare Economic Index (MEI).

Table F.1: Changes to Wyoming Service Area Medicaid Rates[10]

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Ambulance	• In SFY 2010, Rates adjusted to 75% of Medicare's 2008 ambulance rates • Lower of the Medicaid fee schedule or the provider's usual and customary charges • Fixed fee schedule amount for transport • Mileage and disposable supplies billed separately • Separate fee schedules for basic life support (ground); advanced life support (ground); additional advanced life support (ground) and air ambulance • Rates adjusted to 90% of Medicare's 2007 ambulance rates • Ground mileage rate increased 125% from $2.50 to $5.63 per mile • Fixed wing air mileage rate decreased to $10.12 per mile and base rate increased 325% to $3,303.63 • Rotary wing air mileage rate increased to $26.95 per mile and base rate increased 627% from $528.34 to $3,840.96	No change	No change	No change	Reimbursement reduced by 2.5% due to Governor's budget cuts

[10] Service areas updates obtained from Wyoming Medicaid Annual Report.

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Ambulatory Surgery Centers (ASCs)[11]	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • Rates based on eight ASC payment groups established by Medicare. The groups are all inclusive bundled payment per procedure code • Rates are 90% of Medicare's 2007 ASC rates • Ninth payment group added for services that are not paid through the other eight groups • Group Y (ninth group) reimbursed at 70% of billed charges • Adopted new OPPS-based methodology to better align reimbursement with those services provided in other outpatient settings • Adjusted conversion factors effective calendar year 2017	ASC OPPS rate: $34.94	ASC OPPS rate: $37.42	ASC OPPS rate: $40.30	Reimbursement reduced by 2.5% due to Governor's budget cuts
Behavioral Health	• In SFY 2010, CPT code rates decreased to 90% of Medicare's rates (effective November 1, 2009) • Lower of the Medicaid fee schedule or the provider's usual and customary charges • Separate fee schedules based on the type of provider • Legislated and funded rate increase of 24% from $70 per hour to $87 per hour • State portion of the increase effective July 1, 2007 and federal portion effective September, 2007 • In SFY 2017 reimbursement rate reduced by 3.3%	Psychologists paid 100% of fee schedule APRN paid 90% of fee schedule as of 1/1/18	No change	No change	Reimbursement reduced by 2.5% due to Governor's budget cuts

[11] On July 1, 2014 (SFY 2015), Wyoming Medicaid implemented a new reimbursement methodology for ASC services based on Medicare's ASC reimbursement system.

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Care Management Entity	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • Adopted risk-based capitated payment in SFY 2016	Adjusted SFY 2017 and 2018 Care Management Entity (CME) premium payment claims to the approved CMS rate for risk-based capitated payments	Administrative services payments to CME are made under a non-risk capitated payment methodology CME network providers payments require CME prior authorization and use the procedure code fee schedule	No change	No change
Clinic/Center	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • SFY 2017 Changed from billing as single entity to billing as a group with treating providers effective for dates of service as of 6/1/17. Became part of the Cap Limit process.	No change	No change	No change	Reimbursement reduced by 2.5% due to Governor's budget cuts
Dental	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • Adult optional dental services added (effective July 1, 2006) • SFY 2017 Adult dental coverage reduced to preventive and emergency services only	No change	No change	No change	Reimbursement reduced by 2.5% due to Governor's budget cuts
Durable Medical Equipment, Prosthetics and Orthotics	• In SFY 2009, Rates increased to 90% of Medicare's rates (effective January 1, 2009) • Lower of the Medicaid fee schedule, or the provider's usual and customary charges for each HCPCS code. Medicaid uses Medicare's fee schedule, which is updated annually for inflation based on the consumer price index. For procedure codes not on Medicare's list, Medicaid considers other states' rates. • Certain DME, e.g., customized wheelchairs, is manually priced based on the manufacturer's invoice price, plus a 15 percent add-on, plus shipping and handling • Delivery of DME more than 50 miles roundtrip is reimbursed per mile	Codes impacted by the 21st Century CURES Act are set at 100% of the lowest Medicare rate No change for codes not impacted by the 21st Century CURES Act	No change	No change	Reimbursement reduced by 2.5% due to Governor's budget cuts

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021
End Stage Renal Disease Services	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • Dialysis services reimbursed at a percentage of billed charges • Dialysis services reimbursed at 70% of billed charges (effective September 1, 2008) • Dialysis services reimbursed at 17% of billed charges (effective January 1, 2012) • Dialysis services reimbursed at 12% of billed charges (effective January 1, 2013) • Dialysis services reimbursed at 9% of billed charges (effective January 1, 2014)	No change	No change	No change	Reimbursement reduced by 2.5% due to Governor's budget cuts
Federally Qualified Health Centers	• Prospective per visit payment system implemented on January 1, 2001 as required by the Benefits Improvement and Protection Act (BIPA) of 2000 ○ Based on 100%of a facility's average costs during SFYs 1999 and 2000. Rates updated annually for inflation based on the Medicare Economic Index (MEI) ○ Rates increased 0.6% based on MEI • In SFY 2013, rates increased 0.8% based on MEI • In SFY 2014, rates increased 0.8% based on MEI • In SFY 2015, rates increased 0.8% based on MEI • In SFY 2016, rates increased 1.1% based on MEI • In SFY 2017, rates increased 1.2% based on MEI	Rates increased 1.01% based on MEI	Rates increased 1.015% based on MEI	Rates increased 1.9% based on MEI	Rates increased 1.4% based on MEI
Home Health	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • Per visit rates based on Medicare's fee schedule • Prior authorization required starting March 2017	No change	No change	Prior Authorization suspended in March 2020	Reimbursement reduced by 2.5% due to Governor's budget cuts

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Hospice	• In SFY 2011, rates increased 2.6% • Fees based on Medicare rates. Medicare pays a per-diem rate based on level of care and updates fees annually based on inflation • For nursing facilities that provide hospice services, payment is 95% of the facility's Medicaid per diem rate and is made to the hospice in lieu of the nursing facility reimbursement • Rates increase annually based on Medicare's inflation increases • In SFY 2013, rates increased 0.6% based on MEI	Rates adjusted per Medicare's adjustments	Rates adjusted per Medicare's adjustments	Rates adjusted per Medicare's adjustments	Reimbursement reduced by 2.5% for hospice in nursing homes due to Governor's budget cuts

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Inpatient Hospital	• Rebased the LOC system using more recent cost and claims data to better categorize services. New rates effective September 1, 2009 • In SFY 2010, approved budget reduction of $5.8 million over two years based on Governor's recommendations • Based on a budget footnote for SFY 2010, the Governor's office authorized an increase to The Children's Hospital rates after the required reductions, resulting in an increase of $1 million over a two-year period • Prospective level of care (LOC) rate per discharge implemented on July 1, 1994 and rebased in 1998. Services paid outside of the LOC system are: ○ Transplant services are paid at 55 percent of billed charges • Hospitals that serve a disproportionate share of low-income patients receive disproportionate share hospital (DSH) payments • Per diem rates are for rehabilitation with a ventilator and separate rate without a ventilator • Specialty services not otherwise obtainable in Wyoming negotiated through letters of agreement • LOC rates updated annually for inflation using the Medicare inpatient prospective payment (PPS) inflation rates • Qualified Rate Adjustment (QRA) program implemented on July 4, 2004 to provide supplemental payments to non-state governmental hospital • In SFY 2009, LOC rates updated for inflation • In SFY 2017, No change to LOC reimbursement. Private hospital UPL implemented	No change	DRG implemented 5/31/19 with an effective date of 2/1/19 Private hospital UPL program, DSH, and QRA remain in place Rehab claims paid outside of the DRG	Second year of DRG rates implemented on February 1, 2020	Reimbursement reduced by 2.5% due to Governor's budget cuts
Intermediate Care Facility for people with Intellectual Disabilities (ICD-ID)	• Full cost reimbursement method based on previous year cost reports • Removed link with Nursing Home rates. Rates now updated annually with full cost coverage	No change	No change	No change	No change

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Laboratory	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • In SFY 2009, Rates increased to 90% of Medicare's rates • Twelve laboratory procedure codes' rates adjusted to 80% of SFY 2007 average billed charges	No change	No change	No change	Reimbursement reduced by 2.5% due to Governor's budget cuts

Nursing Facility[12]	• In SFY 2011, Rates were updated based on analysis of Medicaid cost reports
	• Prospective per diem rate with rate components for capital cost, operational cost, and direct care costs
	• Additional reimbursement monthly for extraordinary needs determined on a per case basis
	• Rate updates in SFY 2016 based on approved NF reimbursement update.
	• Additional payments:
	  • Provider Assessment and Upper Payment Limit (UPL) Payment provides supplemental payments (effective April 1, 2011)
	  • Implemented Provider Assessment and Upper Payment Limit (UPL) Payment after Legislative and federal approval. First payment in SFY 2012.
	• Nursing Facility Gap Payment Program approved in SFY 2017; no change to rate methodology
		No change	No change	No change	Reimbursement reduced by 2.5% due to Governor's budget cuts

[12] On July 1, 2015 (SFY 2016), Wyoming Medicaid implemented an acuity-based reimbursement methodology for nursing facility services.

Outpatient Hospital	• Outpatient prospective payment system (OPPS) based on Medicare's Ambulatory Payment Classifications (APC) system
	• Separate fee schedules for:
	  ○ Select DME
	  ○ Select vaccines, therapies immunizations, radiology, mammography screening and diagnostic mammography
	  ○ Laboratory
	  ○ Corneal tissue, dental and bone marrow transplant services, new medical devices
	• QRA program provides supplemental payments to non-state governmental hospital
	• SFY 2012 adjusted conversion factors:
	  ○ General acute: $50.99
	  ○ Critical access: $129.74
	  ○ Children's: $109.95
	• SFY 2013 adjusted conversion factors:
	  ○ General acute: $48.19
	  ○ Critical access: $126.82
	  ○ Children's: $105.50
	  ○ No change to QRA
	• SFY 2014 adjusted conversion factors:
	  ○ General acute: $45.45
	  ○ Critical access: $118.86
	  ○ Children's: $100.05
	  ○ No change to QRA
	• SFY 2015 adjusted conversion factors:
	  ○ General acute: $42.34
	  ○ Critical access: $111.93
	  ○ Children's: $92.71
	  ○ No change to QRA
	• SFY 2016 adjusted conversion factors: Adjusted conversion factors due to budget cuts
	  ○ General acute $39.41
	  ○ Critical access $102.53
	  ○ Children's $85.41
	  ○ No change to QRA
		• Adjusted conversion factors due to budget cuts (effective calendar year 2018):
		  ○ General acute $39.70
		  ○ Critical access $104.27
		  ○ Children's $83.92
		  ○ ASCs $34.94
		• No change to QRA
			• Adjusted conversion factors (effective calendar year 2019):
			  ○ General acute $42.53
			  ○ Critical access $105.89
			  ○ Children's $88.45
			  ○ ASCs $37.42
			• No change for QRA
				• Adjusted conversion factors (effective calendar year 2020):
				  ○ General acute $45.79
				  ○ Critical access $109.66
				  ○ Children's $83.59
				  ○ ASCs $40.30
				• No change for QRA
					Reimbursement reduced by 2.5% due to Governor's budget cuts

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021
	• SFY 2017 adjusted conversion factors due to budget cuts ○ General acute $37.94 ○ Critical access $98.80 ○ Children's $76.34 ○ ASCs $33.39 ○ No change to QRA				
Physicians/ Practitioners[13]	• Adopted Medicare's 2009 RVUs (effective August 1, 2009) • Adjusted the conversion factors for physician services (effective August 1, 2009) • Reimbursement budget reduced by $4.8 million • Resource-Based Relative Value Scale (RBRVS) reimbursement methodology based on Medicare's RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rates. • Beginning January 1, 2013, the Affordable Care Act (ACA) mandated increased primary care service payment by State Agencies of at least the Medicare rates in effect in CY 2009 for CY 2013 and 2014 • Beginning August 1, 2013, transitioned OB services to RBRVS reimbursement methodology using Calendar Year 2013 RVUs • Adjusted conversion factor on November 1, 2016 to reflect a 3.3% reduction on all RBRVS codes	No change	No change	No change	Reimbursement reduced by 2.5% due to Governor's budget cuts Chiropractic services limited to children under EPSDT and members on Medicare. Threshold limit for dietician services removed.

[13] The ACA Primary Care Service Payments ended December 31, 2014 (SFY 2015).

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021

Prescription Drugs	• In SFY 2011, Prescription Drug List prescription drug list (PDL) expanded to 80 specific drug classes
	• Lower of the estimated acquisition cost (EAC) of the ingredients plus the dispensing fee and the provider's usual and customary charge
	  ○ The EAC is the Average Wholesale Price (AWP) minus 11%
	  ○ The AWP is determined by pricing information supplied by drug manufacturers, distributors and suppliers and is updated monthly. Some drugs are priced by the State Maximum Allowable Cost (SMAC)
	• Dispensing fee is $5.00 per claim
	• In SFY 2009, Preferred Drug List (PDL) expanded to 21 specific drug classes
	• SFY 2011 - PDL expanded to 80 specific drug classes
	• SFY 2012 - PDL expanded to 109 specific drug classes
	• SFY 2013 - PDL expanded to 108 specific drug classes
	• SFY 2014 – PDL expanded to 119 specific drug classes
	• SFY 2015 – PDL expanded to 123 specific drug classes
	• Reimbursement structure changed on April 1, 2017 to comply with the Final Covered Outpatient Drug Rule
		No change	No change	No change	No change

PRTFs	• Rates increased based on analysis of Medicaid cost reports • Per diem rate. The rate includes room and board, treatment services specified in the treatment plan, and may include an add-on rate for medical services • SFY 2014 – Rates adjusted December 1, 2014 based on analysis of Medicaid cost reports	No change	No change	No change	Reimbursement reduced by 2.5% due to Governor's budget cuts

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021
RHCs	• In SFY 2011, Rates increased 0.4% based on MEI • Prospective per encounter payment system as required by the Benefits Improvement and Protection Act (BIPA) of 2000 ○ Based on 100% of a facility's average costs during SFYs 1999 and 2000 • Rates increased annually for inflation based on Medicare Economic Index (MEI) • SFY 2014 – rates increased 0.8% based on MEI • SFY 2015 – rates increased 0.8% based on MEI • SFY 2016 - rates increased 1.1% based on MEI • SFY 2017 – rates increased 1.2% based on MEI	Rates increased 1.01% based on MEI	Rates increased 1.015% based on MEI	Rates increased 1.9% based on MEI	Rates increased 1.4% based on MEI
Vision	• Lower of the Medicaid fee schedule or the provider's usual and customary charge • Ophthalmologists and optometrists are reimbursed under the Resource-Based Relative Value Scale (RBRVS) reimbursement methodology based on Medicare's RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rates • Optician reimbursement based on a procedure code fee schedule	No change	No change	No change	Reimbursement reduced by 2.5% due to Governor's budget cuts

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021

Waiver Services – Comprehensive, Supports and Acquired Brain Injury (ABI) Waivers	• A 6% restoration of the SFY 2010 10% rate reduction (or 96% of the SFY 2009 rates) was implemented
	• Cost-based reimbursement methodology, implemented in SFY 2009
	  ○ The Individualized Budget Amount (IBA) is based on the historical plan of care units multiplied by the respective service rate less one-time costs, such as assessments, specialized equipment, or home modifications
	  ○ Prior to cost-based reimbursement, individualized budget amount determined by the "DOORS" funding model, which estimates individual expenditures based on specific customer characteristics
	• Reimbursement for specific residential and day habilitation services is made on a per diem basis and varies by provider and consumer
	• Consumers negotiate rates based on their budget amount
	• Rates were reduced by 1% at the beginning of FY 14 as required by the legislature to reach a 4% overall budget reduction for the waivers
	• Participants from ABI waivers will transition to either the Comprehensive or Supports Waiver between January 1st and March 31st of 2017. On March 31st, 2017, ending the ABI waivers
		Implemented 3.3% rate increase on February 1, 2017, applied retroactively back to July 1, 2016; Adult and Children ID/DD Waivers closed	No change	Rate increase 4.2% for all services[14]	Temporary provider rate increase of 12.5% for some waiver services in response to the COVID-19 public health emergency (March 1 - September 1, 2020)

[14] The Acquired Brain Injury Waiver was closed in April 2018, with enrolled members being transitioned into the Comprehensive and Supports Waivers.

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Waiver Services – Children's Mental Health Waiver	• In SFY 2010, Rates were adjusted to reflect budget neutrality • Lower of the Medicaid fee schedule or the provider's usual and customary charge • Reimbursement based on procedure code fee schedule • July 1, 2015: Care Management Entity began serving youth	Working with CMS for approval of SFY 2017 rates	Adjusted SFY 2017 and 2018 Care Management Entity (CME) premium payment claims to the approved CMS rate for risk-based capitated payments	Administrative services payments to CME made under a non-risk capitated payment methodology CME network providers payments require prior authorization from CME. Payments based on procedure code fee schedule	No change
Waiver Services – Community Choices [formerly: Long-Term Care and Assisted Living Facility (ALF) Waivers]	• Lower of the Medicaid fee schedule or the provider's usual and customary charge • Reimbursement limited to a monthly or yearly cap per person, according to the established care plan • Rates increased for ALF Waiver • ALF Waiver: 12% increase per rate rebasing project, effective March 1, 2016 • LTC Waiver: 8% increase per rate rebasing project, effective March 1, 2016	ALF Waiver closed in SFY 2017, with service provided under the Community Choices Waiver	No change	No change	Rate increase for select direct care services in response to the COVID-19 public health emergency

Service Area	SFY 2017 and Previous	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Waiver Services - Pregnant by Choice Waiver	• The waiver was implemented in SFY 2009 • Multiple reimbursement methodologies and fee schedules based on the service areas detailed in this table • Extended to 12/31/2019	No change	Extension application submitted to CMS	Extended to 12/31/2027	Family Planning Waiver Services waiver approved 4/7/2020 to cover FPW services through 12/31/2027. CMS reimbursing by a PMPM amount. For CY 2021 the PMPM rate is $12.10. For CY 2022 the PMPM rate is $12.65. Any expenses beyond the PMPM are covered by Wyoming Medicaid.

APPENDIX G: GLOSSARY

Ambulatory Surgical Center (ASC) – A location other than a physician's office or a hospital that performs outpatient surgery and diagnostic services. At an ambulatory (in and out) surgery center, a patient might stay for only a few hours or for one night.

Ambulatory Payment Classifications (APC) – Medicare's prospective payment system for outpatient hospital services. All services paid are grouped into APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC.

Average Manufacturer Price (AMP) – The average price paid to manufacturers by wholesalers for drugs distributed to a retail pharmacy.

Average Sale Price (ASP) – The volume-weighted average manufacturer sales price for a pharmaceutical drug net of all rebates, discounts, and other price concessions.

Average Wholesale Price (AWP) – The published price for drug products charged by wholesalers to pharmacies.

Centers for Medicare and Medicaid Services (CMS) – The government agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs as well as research to support these programs.

Children's Health Insurance Program (CHIP) – A federal-state partnership program to provide free or low-cost health insurance for uninsured children under age 19. The CHIP is intended for uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage.

Community Choices Waiver (CCW) - A home- and community-based services waiver that provides long-term care services for individuals who require a nursing home level of care but wish to remain in their community. These services include personal care assistance, adult day care, respite care and meal delivery.

Community Mental Health Center (CMHC) – A community-based healthcare facility that provides comprehensive mental health services to individuals residing or employed in the facility service area. These services are mostly ambulatory based.

Comprehensive Waiver - A home- and community-based services waiver developed for children and adults with developmental disabilities to assist them in receiving training and support that will allow them to remain in their home communities and not require institutionalization.

Consumer Price Index (CPI) – An inflationary indicator developed by the U.S. Bureau of Labor Statistics that measures the change in the cost of a fixed basket of products and services.

Copayment – A fixed amount of money paid by the Medicaid enrollee at the time of service.

Crossover Claim – Services for Medicare and Medicaid dual eligible beneficiaries where Medicare is the primary payer and Medicaid provides additional payments.

Current Procedural Terminology (CPT) – A code set developed by the American Medical Association for standardizing the terminology and coding used to report medical procedures and services. CPT codes are Level I of the HCPCS code set.

Department of Health and Human Services (HHS) – The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Diagnosis-Related Groups (DRG) – Medicare's prospective payment system (PPS) for inpatient hospital services reimburses a pre-determined rate for each Medicare admission based on each patients' clinical information.

Disproportionate Share Hospitals (DSH) – Hospitals that serve high volumes of low-income patients receive a payment adjustment under Medicare's prospective payment system or under Medicaid.

Drug Rebate Program – Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA'90), the Medicaid Drug Rebate program requiring brand and generic pharmaceutical manufacturers to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) for states to receive federal funding for outpatient drugs dispensed to Medicaid patients.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) – Medical equipment and other supplies that are intended to reduce a patient's physical disability and restore the patient to his or her functional level.

Dual Eligible – A low-income individual who qualifies for both Medicaid and Medicare.

Eligibility – Refers to the process whereby an individual is determined to be eligible for healthcare coverage through the Medicaid program. The State determines eligibility.

Eligible Individual – For purposes of this Report, an individual enrolled in the Wyoming Medicaid program who is eligible to receive services during the SFY. An eligible individual might or might not receive services.

End-Stage Renal Disease (ESRD) – The complete, or almost complete, failure of the kidneys to function. The only treatments for ESRD are dialysis or kidney transplantation.

Estimated Acquisition Cost (EAC) – The estimated cost to the pharmacy of acquiring a prescription drug. Federal regulations require that each State's reimbursement for Medicaid prescription drugs not exceed the lower of (1) its estimated acquisition cost plus

a dispensing fee, or (2) the provider's usual and customary charge to the public for the drug.

Expenditure – The issuance of checks, disbursement of cash, or electronic transfer of funds made to liquidate an expense regardless of the fiscal year the service was provided, or the expense was incurred.

Family Planning Waiver – A Wyoming Medicaid program that provides family planning services and birth control options through a Section 1115 Medicaid waiver to women who have received Medicaid benefits through the Pregnant Women program and who would otherwise lose eligibility 60 days after giving birth.

Federal Fiscal Year (FFY) – The 12-month accounting period for which the federal government plans its budget, usually running from October 1 through September 30. The SFY is named for the end date of the year, e.g., FFY 2012 ends on September 30, 2012.

Federal Poverty Level (FPL) – The amount of income determined by the U.S. Department of Health and Human Services to provide a minimum for living necessities.

Federally Qualified Health Center (FQHC) – A health center in a medically under-served area that is eligible to receive cost-based Medicare and Medicaid reimbursement and provide direct reimbursement to nurse practitioners, physician assistants and certified nurse midwives.

Fee Schedule – A complete listing of fees used by health plans to pay doctors or other providers.

Federal Upper Limit (FUL) – The maximum price pharmacies receive as reimbursement for providing multiple-source generic prescription drugs to Medicaid recipients. The FUL is established by CMS to achieve savings by taking advantage of current market pricing. Not all drugs have FULs and states may establish reimbursement limits for non-FUL drugs using other pricing methodologies.

Healthcare Common Procedure Coding System (HCPCS) – A medical code set that identifies healthcare procedures, equipment and supplies for claim submission purposes. There are two principal subsystems, Level I and Level II. Level I codes are comprised of CPT codes which are identified by five numeric digits. Level II codes are used primarily to identify equipment, supplies and services not included in the CPT code set. Level II codes are alphanumeric codes.

Home- and Community-Based Services (HCBS) – Care provided in the home and community to Medicaid eligibles. HCBS programs help the elderly and disabled, intellectually disabled, developmentally disabled, and certain other disabled adults.

HCBS Waiver for Adults with Acquired Brain Injury – A home- and community-based services waiver developed for adults from ages 21 to 65 with acquired brain injuries to

assist them in receiving training and support that will allow them to remain in their home communities and not require institutionalization.

HCBS Waiver for Assisted Living Facilities – A home- and community-based services waiver that provides assisted living facility services for recipients 19 years of age and older who require services equivalent to a nursing home facility level of care.

HCBS Waiver for Children's Mental Health – A home- and community-based services waiver that provides treatment for youth with serious emotional disturbances that allows them to stay in their communities.

HCBS Waiver for Long-Term Care – A home- and community-based services waiver that provides in-home services for recipients 19 year of age and older who require services equivalent to a nursing home facility level of care.

Home Health – For the purposes of this Report, defines a category of services that are limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies and other services.

Hospice – For the purposes of this Report, defines a category of services that are for people who are terminally ill. This care includes physical care and counseling.

Inpatient – For the purposes of this Report, defines a category of services that are provided to a patient admitted for overnight stay in a hospital or health service facility receiving diagnostic treatment.

Intermediate Care Facility for the Intellectually Disabled (ICF-ID) – A facility that primarily provides comprehensive and individualized health care and rehabilitation services above the level of custodial care to intellectually disabled individuals but does not provide the level of care available in a hospital or skilled nursing facility.

Level of Care (LOC) – Under Wyoming Medicaid's prospective payment system for inpatient hospital services, Wyoming Medicaid pays an amount per discharge. Each discharge is classified into a LOC based on the diagnosis, procedures, and revenue codes that hospitals report on the inpatient claim.

Medicaid – A joint federal-state program, authorized by Title XIX of the Social Security Act, that provides medical benefits for certain low-income persons in need of health and medical care.

Medicaid State Plan – The document that defines how each state will operate its Medicaid program. The state plan addresses the areas of state program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement.

Medicaid Waiver – States have the option of applying for certain waivers to operate their Medicaid programs outside of typical State Plan restrictions.

Medicare – A federal program, authorized by Title XVIII of the Social Security Act, that provides medical benefits for people age 65 or older, under age 65 with certain disabilities, and any age with End-Stage Renal Disease (ESRD).

Medicare Cost Report – Medicare-certified institutional providers are required to submit an annual cost report to a Fiscal Intermediary (FI). The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data.

Medicare Economic Index (MEI) – An index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule. Wyoming Medicaid uses the index as an update factor for FQHC and RHC reimbursement rates.

National Average Drug Acquisition Cost (NADAC) – CMS calculated pricing file, intended to provide state Medicaid agencies with covered outpatient drug prices by averaging survey invoice prices from retail community pharmacies across the United States.

Outpatient – For the purposes of this Report, defines a category of services that are medical or surgical in nature and do not include an overnight hospital stay. These services are often provided within one day (24 hours) at a hospital outpatient department or community mental health center.

Outpatient Prospective Payment System (OPPS) – A method of reimbursement used by Medicare and some state Medicaid programs in which payments for designated hospital outpatient services are made based on a predetermined, fixed amount. The amount is derived based on the classification of that service.

Participating Provider – A participating provider is defined as all hospitals within Wyoming that are providers, and all out-of- state hospitals that were paid $250,000 or more by Wyoming Medicaid during the period from July 1, 1994, through December 31, 1996. Participating providers also include all rehabilitation facilities and psychiatric hospitals that received Wyoming Medicaid funds during the period from July 1, 1994, through December 31, 1996.

Pregnant by Choice Waiver – A Section 1115 waiver that provides family planning services and birth control options to women who have received Medicaid benefits under the Pregnant Women program and who would otherwise lose Medicaid eligibility 60 days after giving birth.

Procedure Code – A HCPCS Level I or Level II code or CPT code used to report the delivery of a health care service for reimbursement purposes.

Psychiatric Residential Treatment Facility (PRTF) – A facility that provides services to individuals who require extended care beyond acute psychiatric stabilization or extended

psychiatric services. These services address long-standing behavioral disturbances, which are not usually responsive to shorter-term care.

Qualified Rate Adjustment (QRA) – Wyoming Medicaid's annual lump sum supplemental payment equal to a portion of the difference between a qualifying hospital's Medicaid allowable costs for the payment period and its pre-QRA Wyoming Medicaid payments for the same period, minus amounts payable by other third parties and beneficiaries. QRA payments are only available to in-state hospitals for inpatient and outpatient services.

Relative Value Unit (RVU) – A standardized dollar amount assigned to physician services and used in the Medicare fee schedule to account for the resources used to provide a service, including the physician's work, practice expenses and professional liability insurance.

Resource Based Relative Value Scale (RBRVS) – Established as part of the Omnibus Reconciliation Act of 1989, Medicare payment rules for physician services were altered by establishing an RBRVS fee schedule. This payment methodology has three components: a relative value for each procedure, a geographic adjustment factor and a dollar conversion factor.

Rural Health Clinic (RHC) – An outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the U.S. Bureau of Census.

Skilled Nursing Facility (SNF) – A type of nursing facility recognized by Medicare and Medicaid as meeting the long-term health care needs for patients. These institutions provide round-the-clock skilled nursing and rehabilitative services.

State Fiscal Year (SFY) – The 12-month accounting period for which the state plans its budget, usually running from July 1 through June 30. The SFY is named for the end date of the year, e.g., SFY 2009 ends on June 30, 2009.

State Maximum Allowable Cost (SMAC) – The maximum price pharmacies receive as reimbursement for equivalent groups of multiple-source generic drug products established by the Office of Pharmacy Services (OPS). The OPS may include more drugs than are covered under the FUL program as well as set reimbursement rates that are lower than FUL rates.

Supplemental Payment Program (SPP) – Supplemental payment offered to providers by Medicaid, which is broken down into two categories: DSH payments and Upper payment limit (UPL) supplemental payments. DSH payments are intended to offset hospital uncompensated care costs, and UPL payments are intended to compensate for the difference in fee-for-service payments and the amount that Medicare would have paid for the same service.

Supports Waiver – An HCBS waiver developed for children and adults with developmental disabilities and for adults ages 21 and older with brain injury to assist them in receiving training and support that will allow them to remain in their home communities and not require institutionalization.

Usual and Customary Charge – The actual price that pharmacies charge cash-paying customers for prescription drugs.

Wholesale Acquisition Cost (WAC) – An estimate of the manufacturer's list price for a drug to wholesalers or other direct purchasers, not including discounts or rebates. This price is defined by federal law.

APPENDIX H: ACRONYMS

Acronym	Term
ABD	Aged, Blind, and Disabled
ABI	Acquired Brain Injury
ACA	Patient Protection and Affordable Care Act of 2010
ACO	Accountable Care Organization
AIF	Ambulance Inflation Factor
AIR	All-Inclusive Rate
ALF	Assisted Living Facility
AMP	Average Manufacturer Price
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgical Center
ASP	Average Sale Price
AWP	Average Wholesale Price
BMI	Body Mass Index
BPCI	Bundled Payments for Care Improvement
CHIP	Children's Health Insurance Program
CMHC	Community Mental Health Center
CBSA	Core Based Statistical Area
CLFS	Clinical Laboratory Fee Schedule
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CPI	Consumer Price Index
DD	Developmental Disabilities
DMEPOS	Durable Medical Equipment, Prosthetic, Orthotic, and Supply
DRG	Diagnosis-Related Group

Acronym	Term
DSH	Disproportionate Share Hospital
EAC	Estimated Acquisition Cost
ESRD	End Stage Renal Disease
FFY	Federal Fiscal Year
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FUL	Federal Upper Limit
GAF	Geographic Adjustment Factor
GPCI	Geographic Practice Cost Indices
HAC	Hospital Acquired Condition
HCBS	Home- and Community- Based Services
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHS	Department of Health and Human Services
ICF-ID	Intermediate Care Facilities for the Intellectually Disabled
IPPS	Inpatient Prospective Payment System
LOC	Level of Care
MACRA	Medicare and CHIP Reauthorization Act of 2015
MEI	Medicare Economic Index
MFP	Multifactor Productivity
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMA	Medicare Prescription Drug, Improvement and Modernization Act of 2003
MS-DRG	Medicare Severity Diagnosis Related Group
MU	Meaningful Use
NADAC	National Average Drug Acquisition Cost

Acronym	Term
OPPS	Outpatient Prospective Payment System
PACE	Programs of All-inclusive Care for the Elderly
PFS	Physician Fee Schedule
PPS	Prospective Payment System
PRTF	Psychiatric Residential Treatment Center
PQRS	Physician Quality Reporting System
QPP	Quality Payment Program
QRA	Qualified Rate Adjustment Payments
RBRVS	Resource Based Relative Value Scale
RHC	Rural Health Clinic
RUG	Resource Utilization Group
RVU	Relative Value Unit
SCH	Sole Community Hospital
SFY	State Fiscal Year
SMAC	State Maximum Allowable Cost
SNF	Skilled Nursing Facility
SPP	Supplemental Payment Program
SSI	Supplemental Security Income
VBP	Value-Based Purchasing
WAC	Wholesale Acquisition Cost