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.

All Patient Refined (APR) – Used in the context of APR-DRG (All Patient Refined Diagnosis Related Groups), a classification system that adjusts for severity of illness and risk of mortality.

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.

Benefits Improvement and Protection Act (BIPA) – A federal law that made changes to Medicare and Medicaid, including payment systems for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

Board of Cooperative Educational Services (BOCES) – Regional educational service agencies that provide shared educational programs and services to school districts, often referenced in school-based Medicaid programs.

Calendar Year (CY) – The period of 365 days (or 366 days in leap years) beginning on January 1 and ending on December 31.

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. 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.

COVID – Refers to the infectious disease caused by the SARS-CoV-2 virus, which led to the global pandemic starting in 2019.

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

Critical Access Hospital (CAH) – A designation given to eligible rural hospitals by CMS to reduce financial vulnerability and improve access to healthcare.

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 require 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.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – A comprehensive Medicaid benefit for individuals under age 21 that includes regular health screenings, diagnostic services, and treatment to correct or ameliorate health conditions.

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 section 1115 waiver that offers family planning services and birth control options to women who lose their Medicaid benefits under the Pregnant Women Program once their postpartum benefits end.

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 underserved 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 for Service (FFS) – A payment model where services are unbundled and paid for separately, as opposed to bundled or capitated payments.

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.

Individuals with Disabilities Education Act (IDEA) – A federal law ensuring services to children with disabilities throughout the nation, often referenced in the context of school-based Medicaid services.

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.

Intellectual Disability (ID) – A disability characterized by significant limitations in both intellectual functioning and adaptive behavior.

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.

Family Planning Waiver - Pregnant by Choice Program – 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.

School-Based Services (SBS) – Medicaid-covered services provided in schools to eligible students, often tied to IDEA requirements and delivered by local education agencies.

State Children's Health Insurance Program (SCHIP) – A program that provides health coverage to eligible children through both Medicaid and separate CHIP programs.

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 payments offered to providers by Medicaid, which are 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.

Supported Living Services (SLS) – Services provided to individuals with disabilities to help them live independently in the community.

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.

Upper Payment Limit (UPL) – A federal limit on the amount Medicaid programs can reimburse providers, typically not exceeding what Medicare would pay.

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.