TERM	DEFINITION
Average Wholesale Price (AWP)	The published suggested wholesale price of a drug. It is often used by pharmacies as a cost basis for pricing prescriptions.
Bureau of Health Services (BHSF)	The Bureau within the Department of Health and Hospitals which **Financing** administers the Medicaid Program.
Centers for Medicare and Medicaid Services (CMS)	The government agency within the Department of Health and Human Services which directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs. Formerly known as the Health Care Financing Administration (HCFA).
Department of Health and Hospitals (DHH)	The Louisiana Department of Health and Hospitals is the single state agency designated to administer the Louisiana Medicaid Program.
Drug Efficacy Study Implementation (DESI) Drugs	DESI drugs refer to those drugs that the FDA has proposed to withdraw from the market because they lack substantial evidence of effectiveness
Dispense As Written (DAW)	A prescribing directive issued by physicians to indicate that the pharmacy should not in any way alter a p rescription. Such alterations are usually done in order to substitute a generic drug for the brand-name drug ordered.
Drug Utilization Review (DUR)	The quantitative evaluation of prescription drug use, physician prescribing patterns or patient drug utilization to determine the appropriateness of drug therapy.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	The EPSDT program covers screening and diagnostic services to determine physical or mental deficiencies in recipients under age 21, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered.
Eligible	An eligible is an individual who has been determined to meet the Medicaid program's eligibility criteria and is enrolled in the program.
Estimated Acquisition Cost (EAC)	An estimate of the price generally, and currently, paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.
Federal Upper Limits (FUL)	The upper limit amount that Medicaid can reimburse for a drug product if there are three or more generic versions of the product rated therapeutically equivalent and at least three suppliers listed in the current editions of published national compendia. T hese limits are intended to assure that the federal government acts as a prudent buyer of drugs. The upper limits program seeks to achieve savings by taking advantage of current market prices.

TERM	DEFINITION
Fiscal Intermediary	A contractor that processes or pays vendor claims on behalf of a Medicaid agency. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and the Medicaid agency.
Full Benefit Dual Eligibles	The term describes a population of low-income elderly and individuals with disabilities who qualify for both Medicare and Medicaid coverage. hospital care, full benefit dual eligibles rely on Medicaid to pay Medicare premiums and cost-sharing and to cover critical benefits Medicare does not cover, such as long-term care and prescription drugs. However starting in 2006, Medicare will pay for most of the full
Intermediate Care Facility for The Mentally Retarded (ICF/MR)	The ICF/MR benefit is an optional Medicaid Benefit for States. Section 1905(d) of the Social Security Act created this benefit to fund "institutions" (4 or more beds) for people with mental retardation, and specifies that these institutions must provide health and/or rehabilitative services.
Intermediate Classification of Diseases, 9th Edition (Clinical Modification) (ICD-9-CM)	A listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide for reliable, consistent communications on claim forms.
Long Term Care	A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services such as home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.
Medicaid	A federally aided state-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who meed specified eligibility criteria. Subject to broad federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program. Also referred to as State Medical Assistance Programs.

TERM	DEFINITION
Medicaid Management Information System (MMIS)	Federally developed guidelines for a computer system designed to achieve national standardization of Medicaid claims processing, payment, review and reporting for all health care claims.
Medicare (Part A/Part B)	A U. S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).
Medicare Part D	The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) made prescription drug coverage, also known as Medicare Part D, available to all Medicare beneficiaries. Prescription drug coverage is available through private prescription drug plans (PDPs), which offer only prescription drug coverage, and Medicare Advantage Plans (MA PDs), which offer drug coverage integrated with the health coverage provided by the managed care plan. Full benefit dual eligible Medicaid recipients **no longer receive** their pharmacy benefits through the Louisiana Medicaid Pharmacy Program with the exception of some drugs excluded from the Part D benefit.
National Drug Code (NDC)	A national classification system for identification of drugs. Similar to the Universal Product Code (UPC).
National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a ten digit number mandated by the Health Insurance Portability and Accountability Act (HIPAA) for health care providers. The NPI is a single provider identifier that replaces the multiple provider identifiers currently used to bill health plans.
Over-the-Counter (OTC)	A drug product that does not require a prescription under Federal or State law.
Point of Sale System (POS)	POS claims processing provides on-line adjudication of Medicaid claims. With POS, a claim is electronically processed entirely through the claims processing cycle in real-time, and within seconds of submission, a response is returned to the pharmacy that the recipient is eligible or ineligible and the claim is either payable, duplicated or rejected.

TERM	DEFINITION
Preferred Drug List (PDL)	Drugs that do NOT require further Prior Authorization.
Prior Authorization	The process of obtaining prior approval for a service or medication before payment can be made by the program. Prior authorization does not guarantee coverage as all program criteria must be met such as recipient eligibility.
Providers	Pharmacies or physicians, which are enrolled with the state to prescribe/dispense prescriptions to Medicaid recipients.
Rebate	A monetary amount that is returned to a payor from a prescription drug manufacturer based upon utilization by a covered person or purchases by a provider.
Recipient	A recipient of Medicaid is an individual who has been determined to be eligible for Medicaid and who has used medical services covered under Medicaid.
Retrospective Review	Determination of medical necessity and/or appropriate billing practice for services already rendered.
Telecommunication Switch Vendor	A telecommunications services vendor who transfers via telephone lines, the prescription transaction from the pharmacy to the Medicaid fiscal intermediary.
Third Party Liability	Under Medicaid, third-party liability exists if there is any entity (i.e., other government programs or insurance) which is or may be liable to pay all or part of the medical cost or injury, disease, or disability of an applicant or recipient of Medicaid.
UniDUR	As part of the Point of Sale system, claims are subjected to editing for prospective drug utilization review. Molina and First Data Bank developed the software used to edit pharmacy claims. The UniDUR software is updated twice a month to reflect the most current UniDUR information available to the industry.