MEDICAID OPTIONS STUDY REPORT ONE

JUNE 1, 2012

Wyoming Department of Health

MEDICAID OPTIONS STUDY REPORT ONE

(Preliminary Report, 1 of 3 reports)

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Prepared by

Medicaid Options Study Internal Work Group

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PART ONE: INTRODUCTION AND OVERVIEW

Rising Cost of Medicaid in Wyoming and Nationally

One of the most challenging policy dilemmas facing the nation is the persistent need to balance the demand for excellent health care with a limited ability to fund such care. Continuous increases in the cost of healthcare are not only concerning, but problematic for payers, providers, and consumers. As the largest payer of healthcare for the low-income population, Medicaid is directly impacted by the rising cost of healthcare.

While many states are beginning to see signs of economic improvement, most continue to struggle with the lingering effects of the recent recession. Wyoming weathered the recession fairly well; however, it now faces a potential extended period of possible depressed revenue due to the state's heavy reliance on mineral taxes. The increasing cost of healthcare, and specifically Medicaid, combined with a potential for depressed revenue, has highlighted the need to evaluate Wyoming's Medicaid system.

The Wyoming Department of Health (WDH) is committed to scrutinizing its Medicaid system to ensure it administers a consistently high value, cost efficient healthcare system. The pages that follow represent the beginning of this examination.

Medicaid Options Study

During the Sixty-First Legislature of the State of Wyoming 2012 Budget Session, the Wyoming Legislature passed Original Senate File No. 0034, Enrolled Act No. 58, Senate (hereinafter SEA0058 or the Medicaid Options Study legislation) requiring the WDH to conduct a study into the Medicaid system. This legislation requires the WDH to:

> analyze the cost drivers and identify other areas within the Medicaid program that may benefit from redesign, to evaluate potential redesign of current Medicaid programs and to evaluate the design of Medicaid programs mandated by the Patient Protection and Affordable Care Act, P.L. 111-148, and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, hereinafter referred to collectively as 'the health care reform acts.' *See SEA0058.*

SEA0058 requires the WDH to present preliminary reports to the Joint Labor, Health and Social Services Interim Committee on June 1, 2012 and October 1, 2012. The study and a final report documenting its findings are due by December 1, 2012. The Legislature appropriated $200,000 to the WDH to complete this study.

In order to meet the requirements set out by SEA0058, the WDH created an in-house team to work with stakeholders, experts, and consultants to conduct this study.

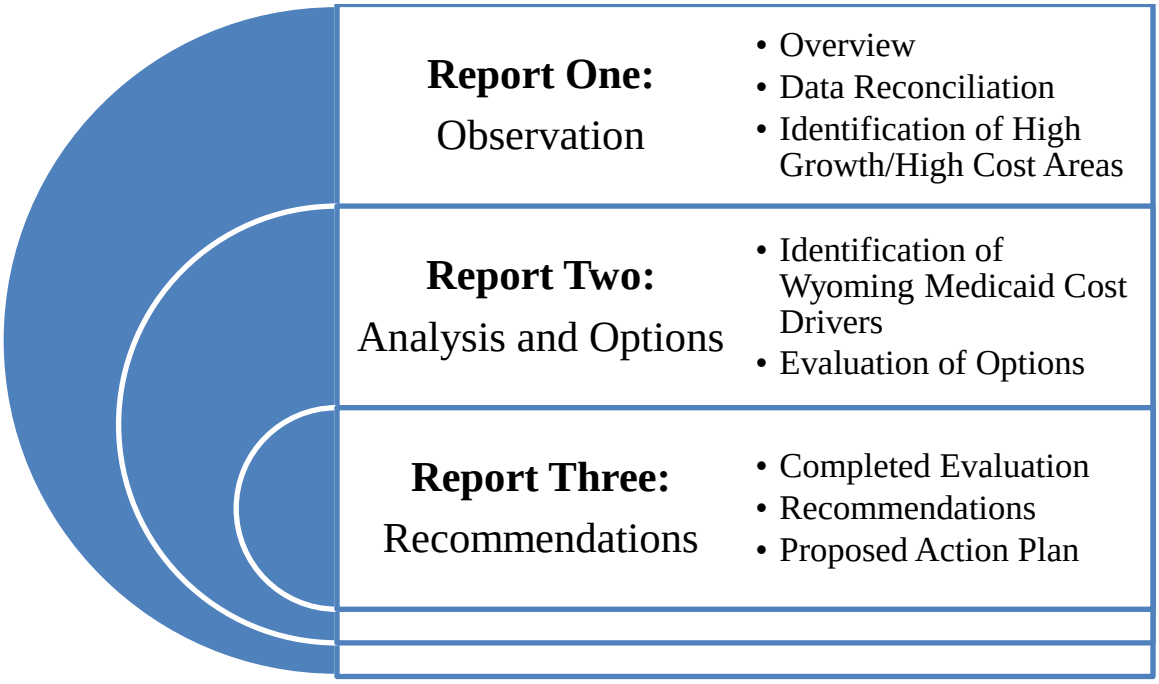
Structure and Charge of the Medicaid Options Study Internal Work Group

The WDH created an internal team made up of Medicaid staff, fiscal staff, policy staff, and senior administrators to study the Medicaid system, identify cost drivers, and generally identify areas in need of improvement and potential impacts of the federal health care reform acts to Wyoming Medicaid. This team became known as the Medicaid Options Study Internal Work Group (Work Group; see Appendix H for a complete listing of members).

Separate subcommittees were created by the Work Group to ensure a timely and valuable study could be conducted. Subcommittees were created in the following areas: the examination of options for provision of health care services, options for waiver design or redesign, Medicaid and fiscal data, eligibility and expansion population, and to seek stakeholder input and involvement. Significant work has been, and continues to be done through these subcommittees.

The Work Group determined that the best strategy to completing a quality study would be to dissect the study into three phases, each resulting in a report.

Overview of Report Phases



Report One is focused on presenting general observations about the Medicaid system. It begins with a brief description of the current Medicaid system, including specifics about Wyoming Medicaid. The next part of the report begins the discussion on overall Medicaid system costs, along with potential contributing factors. The report will then provide results of significant

research into specific Wyoming Medicaid data. Before concluding, this report will summarize current cost containment efforts implemented by Wyoming Medicaid.

Report Two, due October 1, 2012, will focus on analyses of Medicaid system costs and begin the discussion and evaluation of potential redesign or design options. In Report Two, the WDH expects to identify specific "cost drivers" in Wyoming Medicaid. During this second phase, robust outside stakeholder input will be gathered, summarized, and analyzed.

The first two reports will focus on identifying and analyzing/evaluating data and options so that WDH can, in the final report, present well informed proposals for moving forward. In the final report, Report Three, due December 1, 2012, the WDH will present its recommended options for modification or redesign of the Wyoming Medicaid system. This report will also propose a plan of action for the options that are recommended.

It is the goal of the WDH to utilize this study process to identify the best possible approaches to operating a Medicaid system. The WDH looks forward to legislative, executive and other stakeholder input throughout the completion of this study.

Report One Roadmap

Part One:	Introduction and Overview
Part Two:	Medicaid in Wyoming
Part Three:	General Framework of Medicaid System Cost
Part Four:	How Wyoming Medicaid Compares
Part Five:	Presentation of Wyoming Medicaid Data, Identifying High Cost/High Growth Areas
Part Six:	Current Cost Containment in Wyoming Medicaid
Part Seven:	Conclusion and Future Reports

After the introduction, Part Two of this report will provide an overview of the Medicaid system and specifically, a discussion about Wyoming Medicaid, including: explanations of current eligibility, current waivers, and current services covered.

Part Three of this report will provide a framework for understanding overall Medicaid system costs, explaining that overall cost increases occur within the Medicaid system because of two major causes: 1) the number of people enrolled increases and/or 2) the cost per person to Medicaid increases. However, these two major causes are influenced by a number of contributing factors. These factors are introduced and explained in Part Three.

In Part Four, the report will begin to analyze Wyoming Medicaid as compared to other Medicaid systems in the surrounding states and as compared to the national Medicaid system. These

comparisons provide an important reference point as Wyoming Medicaid data is analyzed and presented in the next part of the report.

In Part Five, Wyoming Medicaid data is presented to lay a foundation for the identification of cost drivers in Wyoming Medicaid, as required by SEA0058. This part will present the first phase of analysis into Wyoming Medicaid data necessary to focus the efforts of the Medicaid Options Study to areas most likely to be driving cost increases. Specific cost drivers of Wyoming Medicaid will not be identified in this report, but the analysis done for this report will allow the identification of cost drivers to occur in Report Two.

To clearly identify the cost drivers of Wyoming Medicaid, it was essential to establish an agreed upon definition of "cost driver." This is much easier said than done. As the Work Group discovered the term "cost driver" meant something different to each of its members. In the end, the Work Group determined that the following general definition of "cost driver" would be appropriate:

- Cost Driver: A factor that can cause a change in the cost of an activity.
  This may include:
  - The price of services being delivered/consumed.
  - The number of people consuming services.
  - The quantity of services being delivered/consumed.
  - The construct of the delivery system.

Using this definition, the Work Group assigned considerable data research responsibilities to its data subcommittee. As is detailed in Part Five of this report, the data subcommittee spent significant amounts of time reconciling data among data sources, refining data queries, running data queries, interpreting data, and finding ways to present sophisticated analyses in the most simple manner possible. It is through these efforts that the Work Group was able to narrow its focus to high growth or high cost areas, which are the areas that most likely contain or influence actionable cost drivers.

The final substantive section of this report, Current Cost Containment in Wyoming Medicaid, Part Six, provides a summary of current efforts and activities being implemented by Wyoming Medicaid and its partners to continually manage and reduce costs. It is important to understand what Wyoming Medicaid is already doing to control its costs, so that readers of this report, along with the WDH, can look for additional changes or adjustments that do not duplicate, but supplement, current efforts. A comprehensive discussion of cost containment in Wyoming Medicaid is included in Appendix A.

PART TWO: MEDICAID IN WYOMING

Medicaid Overview

Medicaid was established in 1965, at the same time as Medicare, under Title XIX of the Social Security Act. Wyoming began participation in Medicaid in 1967. Since that time, Medicaid has grown from a healthcare coverage program for welfare recipients into a healthcare coverage program for the low-income population as well as the predominant long-term care program for the elderly and individuals with disabilities.

Medicaid is an "entitlement" program, which means it is a government program that provides benefits to an indefinite number of potential enrollees who have a legal right (enforceable in court, if necessary) to those benefits whenever they meet eligibility conditions that are specified by the standing law that authorizes the program. However, Medicaid does not provide payments directly to recipients. Rather, it pays to reimburse healthcare and other providers for the services they supply to recipients. Medicaid is jointly funded by the federal and state governments. Currently, the federal match rate, technically called the Federal Medical Assistance Percentage (FMAP), is at 50% in Wyoming.[1]

Wyoming Medicaid Overview

Population Served

Wyoming Medicaid plays an important role in the health and well-being of many low-income children, families and adults. In SFY 2011, nearly 90,000 Wyoming residents were enrolled in Wyoming Medicaid at some time during the year, and approximately 77,000 of these residents received services.[2] Almost two-thirds of the individuals eligible for Medicaid were children. Individuals eligible for Medicaid reside in every county in Wyoming.

When states choose to participate in Medicaid, the Federal Government mandates states provide Medicaid coverage for specific groups, but states are also given the option to cover additional groups. There are four primary categories of Medicaid eligibility in Wyoming: Children, Pregnant Women, Family Care Adults, and individuals who are Aged, Blind or Disabled (ABD).

In addition to these four major categories, Wyoming extends Medicaid eligibility to "other groups" for individuals in the Medicare Savings Program, individuals with breast or cervical cancer, individuals with tuberculosis, employed individuals with disabilities, and non-citizens

[1] This is the lowest match rate allowed. In other words, Wyoming is currently reimbursed at the lowest rate possible by the Federal Government.

[2] Throughout this report, the terms "enrollee" and "recipient" will be used. For the purposes of this report, "enrollee" means an individual who is enrolled in Medicaid and eligible to receive services, however, the individual may not have received services during the time stated. "Recipient" means an individual that has received services during the time period stated.

with medical emergencies. Also, as is discussed later in this report, Wyoming has six Home and Community-Based Services Waivers that were implemented at the option of the state. Finally, it should be noted that childless adults who do not fit into one of these eligibility categories are not covered, regardless of income or assets under the current Wyoming Medicaid.

The following table offers a summary of the primary eligibility categories for Wyoming Medicaid. A detailed matrix of eligibility is included as Appendix B. For an explanation of income eligibility standards in 2012 dollars, please see Appendix C.

Medicaid Eligibility Categories	
Eligibility Category	**Groups that are Eligible**
Children	• A newborn is automatically eligible if his or her mother was eligible for Medicaid at the time of the birth. • Low-income children are eligible if family income is less than or equal to 100% of the Federal Poverty Level (FPL)[3] or 133% of the FPL, depending on age of the child. • Family Care children are eligible when a caretaker is determined eligible (i.e., family income is less than or equal to the 1996 Family Care Standard). • Foster care children in Department of Family Services (DFS) custody are eligible, including some children who enter subsidized adoption or who age out of foster care when they become 18 years old. The Department of Health covers medical services for children in foster care who are not eligible for Medicaid using 100% state general funds. Expenditures for these children are tracked separately.
Pregnant Women	• Pregnant women are eligible if family income is less than or equal to 133% FPL. Women with income below the 1996 Family Care Standard must cooperate in establishing paternity for the baby so Medicaid can pursue medical support. • Presumptive eligibility allows for coverage of outpatient services for up to 60 days pending Medicaid eligibility determination.

[3] The Federal Poverty Level (FPL) is a guideline created by the Federal Government to assist government agencies with determining eligibility for public assistance programs.

Family Care Adults	Family Care adults (caretaker relatives with a dependent child) are eligible if the family income is less than or equal to the 1996 Family Care Standard.
Aged, Blind, or Disabled (ABD)	• Institutionalization – Residents of the following institutional categories are eligible if income is less than or equal to 300% of the SSI Standard. Individuals do not have to be eligible for SSI. o Nursing Home o Inpatient Hospital o Hospice o ICF/MR (Wyoming Life Resource Center) o WY State Hospital – Age 65 and older • Home & Community-Based Services (HCBS) Waivers – Individuals in the State's six waiver programs are eligible if income is less than or equal to 300% of the Supplemental Security Income (SSI) Standard. Individuals do not have to be eligible for SSI. o Adult Developmental Disabilities (Adult DD) o Child Developmental Disabilities (Child DD) o Long Term Care (LTC) o Assisted Living Facility (ALF) o Children's Mental Health (CMH) o Acquired Brain Injury (ABI) • Employed Individuals with Disabilities (EID) – these individuals must be disabled, working and pay a premium for their Medicaid coverage. Individuals must also have earned income less than or equal to 300% of the SSI Standard. • Supplemental Security Income (SSI) & SSI Related o A person receiving SSI automatically qualifies for Medicaid. o SSI-related – A person no longer receiving SSI payments may be eligible using SSI criteria.

Medicare Savings Programs	Savings programs.
	• Individuals in Medicare Savings Programs
	  ○ Qualified Medicare Beneficiary – income less than or equal to 100% of FPL
	  ▪ Medicaid pays Medicare premiums, deductibles and cost sharing
	  ○ Specified Low-Income Medicare Beneficiary 1 – income between 101-120% of FPL
	  ▪ Medicaid pays for Medicare premiums only
	  ○ Specified Low-Income Medicare Beneficiary 2 – income between 121-135% of FPL
	  ▪ The Federal Government pays for 100% of the Medicare premiums

Special Groups	• Special Groups
	  ○ 1115 Family Planning Waiver (Pregnant by Choice)
	  ○ Breast and Cervical Cancer Treatment Program (BCCT)
	  ○ Tuberculosis Program (TB)
	
	• Non-citizens
	  ○ Emergency Services (ES) is for emergency medical treatment, including labor and delivery.
	  ▪ Payment of ES claims is based on diagnosis and procedure codes.
	  ○ Non-citizens who have lived in the U.S. for at least five years and have 40 or more quarters of qualified work may apply for regular Medicaid.

Services Covered under Wyoming Medicaid

The Federal Government mandates that states participating in Medicaid provide coverage for certain services. Other services can be provided at the option of the state. The following table details the services that are Mandatory vs. Optional in Wyoming.

Federally Mandated Covered Services	Optional Services[4] as Selected by Wyoming Legislature
• Administrative transportation • Durable medical equipment (DME) • Early and Periodic Screening, Diagnosis and Treatment (EPSDT) • Emergency transportation • Family planning services • Federally Qualified Health Center (FQHC) • Home health care • Indian Health Service Clinic (IHS) • Inpatient hospital • Laboratory and Radiology • Nursing facility services • Nurse practitioner services, includes nurse midwife and Certified Registered Nurse Anesthetist (CRNA) • Outpatient hospital • Physician services • Rural Health Clinic (RHC)	• Ambulatory Surgical Center • Audiologist and hearing aids • Comprehensive Outpatient Rehab Facility • Dental • End Stage Renal Disease Clinic (ESRD) • Hospice • Independent psychologist • Institution for Mental Diseases (IMD) >65 • Intermediate Care Facility for Intellectually Disabled - ICF-ID (Wyoming Life Resource Center) • Mental Health and Substance Abuse Rehabilitative Services • Nursing facility services under age 21 • Occupational therapist • Optometrist services • Physical therapy (independent) • Prescription drugs • Prosthetics and orthotics • Targeted case management • Transplants (kidney, liver and bone marrow) • Waiver Services[5]

Wyoming Medicaid Waivers

Medicaid also allows states to waive certain Medicaid requirements in order to serve a specific population through what is called a Medicaid Waiver. Wyoming currently has six 1915(c) Home and Community-Based Services Waiver Programs (Adult DD, Child DD, Acquired Brain Injury, Children's Mental Health, Long Term Care, and Assisted Living Facility). These waivers were

[4] Optional Services are at the discretion of each state. Wyoming has legislated coverage of the above optional services for adults. All states cover prescription drugs. Transportation services are not a mandatory service, but states are required to ensure necessary transportation to providers.

[5] Wyoming Legislature has authorized six Medicaid Waivers to selectively "waive" one or more federal requirements and allow for greater flexibility in the Medicaid system. These waiver programs can be used to fund services not authorized by federal Medicaid statute such as respite care, home modifications and non-medical transportation and can be used to provide optional Medicaid services such as case-management and personal assistance services. These are 1915 (c) home and community-based services waivers: DD Adult, DD Child, Acquired Brain Injury (ABI), Elderly and Physically Disabled (LTC), Assisted Living Facility (ALF), and Children's Mental Health Waiver (CMHW).

approved under section 1915(c) of the Social Security Act which, upon CMS approval, permits a state to waive certain Medicaid requirements in order to furnish home and community-based services that promote community living for Medicaid enrollees and, thereby, avoid institutionalization. Each of these waivers is implemented at the option of the state.

Waiver services complement and/or supplement the services that are available through the Medicaid State Plan. Common waiver services include: case management, homemaker, personal care, adult day care, habilitation (both day and residential), and respite.

There is no limit to the number of Home and Community-Based Services (HCBS) Waivers a state can operate. However, within each waiver, states are expected to design a strategy to assure health and welfare of participants, manage the waiver in a way that promotes cost-effective delivery of home and community-based services, link the delivery of services to other state and local programs, ensure the program meets essential federal statutory assurances, and continuously improve the effectiveness of the waiver. States have flexibility in designing waiver programs. This flexibility allows the state to decide: the target group(s) served through the waiver, the services furnished, the opportunity for participant direction of services, and the qualifications of providers.

HCBS waiver participants must meet both clinical and financial eligibility (re-determined on a periodic basis) to receive benefits. The number of participants served on a waiver is set by the State based on legislative funding, as well as the cost of individual plans of care as approved by CMS. There is currently a waiting list for each one of the six Wyoming HCBS waivers. The following table offers additional information on each waiver.

Wyoming Medicaid Waivers		
Waiver Type	**Waiver Description**	
Adult Developmental Disabilities	**Eligibility Criteria**	
		The Adult Developmental Disabilities Waiver is targeted toward individuals age 21 and older with a developmental disability or mental disability and provides community-based services for individuals who meet the clinical criteria for an ICF/MR.
	Services	
		Services include case management, community integrated employment, day habilitation, homemaker, personal care, residential habilitation, respite, supported living, occupational therapy, physical therapy, speech therapy, companion services, dietician services, environmental modifications, skilled nursing, and specialized equipment.

	Participant Directed Services	
		Participant directed service delivery option services include agency with choice, independent support broker, individually-directed goods and services, and unpaid caregiver training and education.
	Expires	
		June 30, 2014
Child Developmental Disabilities	**Eligibility Criteria**	
		The Child Developmental Disabilities Waiver is targeted toward individuals age 20 and under with a developmental disability or mental disability and provides community-based services for individuals who meet the clinical criteria for an ICF/MR.
	Services	
		Services include case management, community integrated employment, homemaker, personal care, residential habilitation, residential habilitation training, respite, special family habilitation home, child habilitation services, companion services, dietician services, environmental modifications, skilled nursing, specialized equipment, and supported living.
	Participant Directed Services	
		Participant directed service delivery option services include agency with choice, independent support broker, individually-directed goods and services, and unpaid caregiver training and education.
	Expires	
		June 30, 2015
Acquired Brain Injury	**Eligibility Criteria**	
		The Acquired Brain Injury Waiver is targeted toward individuals age 21 and over with an acquired brain injury and provides community-based services for individuals who meet the clinical criteria for an ICF/MR.
	Services	

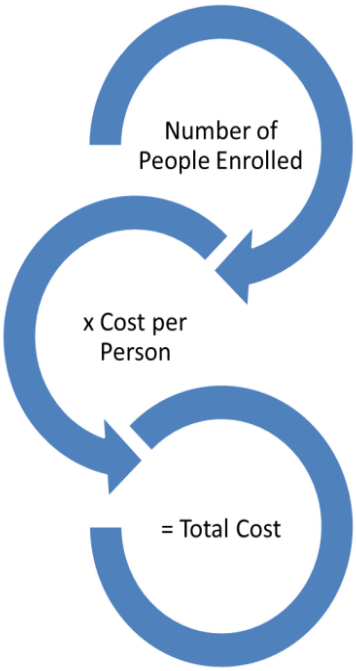
		Services include case management, community integrated employment, day habilitation, homemaker, personal care, residential habilitation, respite, supportive living, occupational therapy, physical therapy, speech therapy, cognitive retraining, companion services, dietician services, environmental modifications, skilled nursing, and specialized equipment.
	Participant Directed Services	
		Participant directed service delivery option services include agency with choice, independent support broker, individually-directed goods and services, and unpaid caregiver training and education.
	Expires	
		June 30, 2014
Children's Mental Health	**Eligibility Criteria**	
		The Children's Mental Health Waiver is targeted toward individuals age 20 and under with serious emotional disturbance and provides community-based services to individuals who meet the clinical criteria for inpatient psychiatric care.
	Services	
		Services include family care coordination, youth and family training and support, and respite.
	Participant Directed Services	
		N/A
	Expires	
		June 30, 2014
Long Term Care HCBS	**Eligibility Criteria**	
		The Long Term Care HCBS Waiver Program is targeted toward elderly and physically disabled individuals age 19 and older and provides in-home services for individuals who meet the clinical criteria for nursing home care.
	Services	

		Services include case management, personal care attendant, respite, skilled nursing, adult day care, home delivered meals, non-medical transportation, and personal emergency response system.
	Participant Directed Services	
		Participant directed service delivery option services include self help assistant (which replaces the personal care attendant), care coordination (which replaces case management), and fiscal management.
	Expires	
		June 30, 2016
Assisted Living Facility HCBS	**Eligibility Criteria**	
		The Assisted Living Facility HCBS Waiver Program is targeted toward elderly and physically disabled individuals age 19 and older and provides services in an Assisted Living Facility for individuals who meet the clinical criteria for nursing home care. Because an assisted living facility is considered a home and community-based setting, Medicaid can not pay for the room and board.
	Services	
		Services include case management and one of three levels of direct care services based on the level of need identified on the functional assessment.
	Participant Directed Services	
		N/A
	Expires	
		June 30, 2014

PART THREE: GENERAL FRAMEWORK OF MEDICAID SYSTEM COST

Overview of Factors that Impact Cost

The simple understanding that costs are increasing is not always enough information to develop an appropriate plan to decelerate expenses. Acting with only this base knowledge could lead to ineffective directions being taken and improper decisions being made. The WDH recognizes that in order for the agency to recommend options to control its cost drivers, it must understand exactly what is causing its costs to increase.



Overall cost increases occur within the Medicaid system because of two major causes: 1) the number of people enrolled increases and/or 2) the cost per person increases.

These two major causes of overall system cost increase are influenced by a number of contributing factors. The level of impact that each contributing factor may have on a high growth or high cost area varies, and thus necessitates examination. Additionally, certain contributing factors can be controlled or influenced by Medicaid, whereas others cannot. Contributing factors necessary to the understanding of overall system cost are set out below, followed by a more comprehensive discussion.

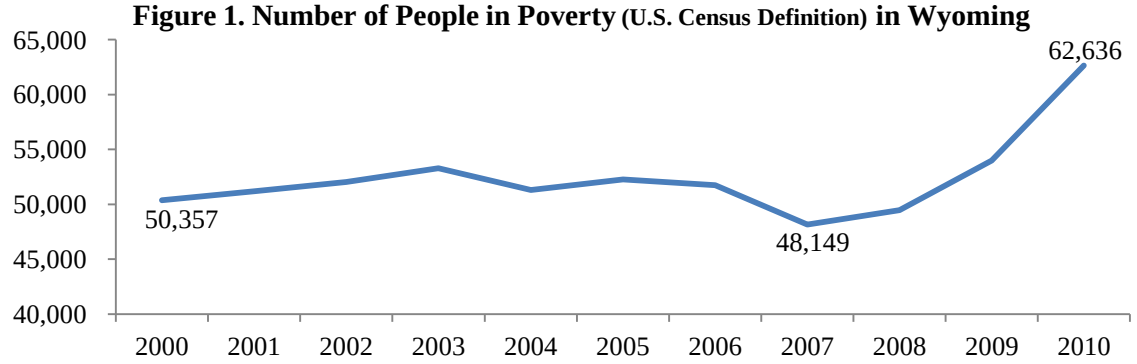
Contributing Factors: # of People Enrolled	Contributing Factors: Cost per Person
□ Economy and Population Growth	□ Recipient Mix
□ Eligibility Design	□ Service Utilization
□ Enrollment Practices	□ Healthcare Inflation
	□ Provider Payment Rates
	□ Services Offered
	□ Medicaid System/Program Design

Contributing Factors- Number of People Enrolled

Economy and Population Growth

Wyoming's population growth over the past decade, from 2000 to 2010, exceeded the national average (14.1% compared to 9.7%).[i] As the Wyoming population grew by one of the largest percentage increases in the country, the number of people in poverty grew even more, by 24.4%[ii] from 2000 to 2010, primarily due to the impact of the recession. All of the growth in the number of people in poverty in Wyoming occurred between 2007 and 2010, for a 30.1% increase in the number of people in poverty in Wyoming in only three years.

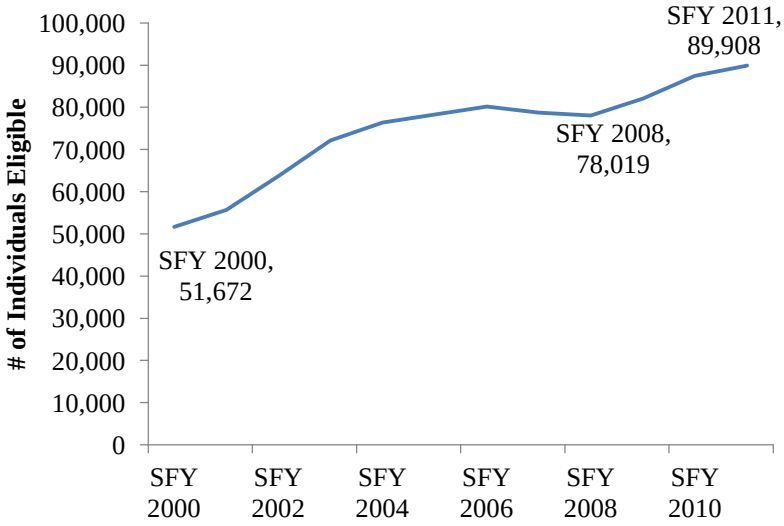
Figure 1. Number of People in Poverty (U.S. Census Definition) in Wyoming



During the recession (from December 2007 to December 2009) the nation saw a 13.6% increase in Medicaid enrollment. Wyoming during this same time period had a 15.1% increase in enrollment.[iii]

The enrollment in Wyoming Medicaid has grown significantly over the last decade, as shown in Figure 2[6]. While poverty is a factor in this growth, not all people that are eligible for Wyoming Medicaid are in poverty. For example, individuals in the state's six waiver programs are eligible for Medicaid up to 300% of the SSI Standard. On average 87% of individuals from 2000-2011 that were eligible used services in any given year.[iv]

Figure 2. Wyoming Medicaid Eligibility Count



It is also interesting to note that economic factors may cause other changes that directly impact Medicaid beyond loss of employment and income. One such example is that of employers eliminating health insurance coverage. The percentage of the population under age 65 in

[6] Data Source for Wyoming Medicaid Eligibility chart: Wyoming Medicaid Data, Medicaid Management Information System, Run Date: May 16, 2012

Wyoming with employer provided insurance declined from 65.8% in 2000-2001 to 63.2% in 2008-2009.[v]

Eligibility Design

While the Federal Government requires states that participate in Medicaid to provide services to certain groups, it also allows states to expand Medicaid eligibility to non-mandatory groups. The number of people eligible to receive Medicaid services increases when a state chooses to expand its eligibility for Medicaid to cover groups outside those that are mandatory.

Federal Medicaid Mandatory Populations[7]

- Children below federal minimum income levels
- Adults in families with children with incomes less than or equal to the state's July 1996 welfare levels
- Pregnant women with income less than or equal to 133% of the federal poverty level
- Disabled Supplemental Security Income (SSI) recipients
- Certain working people with disabilities
- Elderly SSI recipients/eligibles
- Medicare Buy-in groups

Federal Medicaid Optional Populations

- Children above federal minimum income levels
- Adults in families with children above the minimum level
- Pregnant women with income above 133% of federal poverty level
- Disabled with income above SSI levels
- Disabled under a Home and Community-Based Service (HCBS) waiver
- Certain working disabled with income above SSI Standards
- Elderly with income above SSI Standards; State Supplementary Payment (SSP)
- Elderly nursing home residents with income above SSI Standards
- Medically needy

For a more detailed explanation of Eligibility Design, please see Appendix B. For reference to the dollar amounts of income standards for 2012, please see Appendix C.

Enrollment Practices

Enrollment practices are the policies and procedures related to an individual trying to apply for, enroll in, or renew Medicaid coverage. Modernizing and simplifying enrollment practices often reduces paperwork and allows greater efficiency and effectiveness in administering Medicaid.

Modernization or simplification practices could increase and/or decrease overall Medicaid costs. Possible cost increase could occur because a more efficient system would allow those eligible to start using services sooner resulting in longer periods of use. However, it is also possible that modernization/simplification practices will decrease costs as those who are ineligible would be identified in a timely manner. Additionally, decrease in cost could occur because there would be fewer processing errors and less staff time necessary to administer eligibility.

[7] Listing for mandatory and optional eligibility adapted based on multiple sources.

Contributing Factors- Cost per Person

Recipient Mix

There are four primary categories of Medicaid eligibility in Wyoming: Children, Pregnant Women, Family Care Adults and individuals who are Aged, Blind or Disabled. On average, it is more expensive to serve recipients in certain categories than in others; therefore, recipient mix (the number of recipients in each eligibility category) has an impact on overall system cost.

Based on Wyoming Medicaid data to be presented later in this report, in SFY 2011 the cost per recipient in each of the four major categories were, from highest to lowest: individuals who are Aged, Blind or Disabled ($23,454 per recipient); Pregnant Women ($5,893 per recipient); Family Care Adults ($4,191 per recipient); and Children ($2,764 per recipient). The average cost per recipient for all Wyoming Medicaid recipients was $6,720.

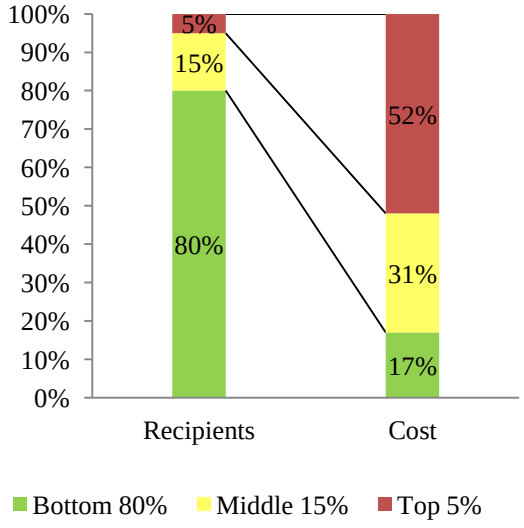
Wyoming's recipient mix has a greater percentage of children than other groups, which tends to lower the average cost per recipient for Wyoming Medicaid because children are significantly less expensive to serve than any other Wyoming Medicaid group. While children made up 64.7% of the Wyoming Medicaid population in SFY 2011, children only represented 26.6% of expenditures. Additionally, for SFY 2011 a recipient in the eligibility category of Individuals who are Aged, Blind, or Disabled cost as much as approximately 8.5 children, a Pregnant Woman cost the same as approximately 2.1 children, and a Family Care Adult costs the same as approximately 1.5 children.

Service Utilization

The types of services utilized, along with the number of services utilized, can have a big impact on overall spending, as not all services are created equal in terms of cost. A simplified example would be one premature baby that requires $500,000 of services over many months is equal to 5,000 primary care visits costing $100.

Spending in Medicaid includes a wide range of services such as preventive services, clinician visits, inpatient hospital visits, outpatient services, as well as a variety of long-term care services. The location of care, type of facility and the length of stay can have a great impact on healthcare costs. For example, if a recipient allows a condition to become more severe before seeking care, and then seeks care in an emergency room setting, the services required will be more costly than the services that could have been provided through primary care or prevention to control the condition before it worsened.

Figure 3. Top 5% Analysis: Medicaid Recipients SFY11



Finally, it is important to note that a small percentage of individuals are the largest users of

services and/or account for significant portions of overall cost (see Figure 3 and Section 5 of this report). High service utilization and cost primarily result from severe events and/or chronic conditions. In Wyoming Medicaid in SFY 2011, for example, 5% of the Medicaid recipients utilized 52% of the cost. The next 15% of recipients utilized 31% of cost.

General Inflation and Healthcare Inflation

Inflation is a rise in the prices of goods and services in an economy over a period of time. With inflation, the same amount of money buys fewer goods and services over time.

The general inflation rate describes the rise of inflation overall, and is normally described by the Consumer Price Index (CPI). The medical care inflation rate describes the rise of costs for healthcare goods and services specifically, and is a subset of the CPI. Between January 2002 and January 2012, national average prices for all goods and services rose 28% and national medical care prices rose 46%.[vi] A dollar in 2012 now only buys 68.5% of the amount of medical care that the same dollar purchased in 2002.

While the per capita spending for healthcare continues to increase, the annual growth rate (how fast it grows each year) has slowed in recent years. The average annual growth rate for personal healthcare spending per capita nationally was 6.4% from 1998 to 2004, but fell to 4.7% between 2004 and 2009.[vii] In Wyoming, the average annual growth rate for personal healthcare spending per capita was 7.5% from 1998 to 2004, which slowed to 5.8% from 2004 to 2009.

The average growth rate in spending, per enrollee, for Medicaid, nationally, was 3.3% per year from 1998 to 2004.[viii] This rate slowed to 2.3% per year from 2004 to 2009. In Wyoming, the growth rate in spending, per enrollee, for Wyoming Medicaid was 2% per year from 1998 to 2004, but actually accelerated to 4.9% per year between 2004 and 2009.[ix]

Even with this slight acceleration, however, the average annual growth rate in spending, per enrollee, for Wyoming Medicaid was less than the growth rate in spending for overall healthcare, per capita, in Wyoming from 1998 to 2009. [x] In 1998, per capita personal healthcare spending in Wyoming was $3,451. That same year, Wyoming Medicaid per enrollee expenditures were $5,661 or $2,210 more than Wyoming's per capita personal healthcare spending. By 2009, however, per capita personal healthcare spending in Wyoming was $7,040 and Wyoming Medicaid per enrollee expenditures were $8,079 or $1,039 more than Wyoming per capita personal healthcare spending.[8]

Provider Payment Rates and Provider Costs

Provider payment rates are the rates that medical providers are paid for each type and instance of service provided to Medicaid recipients. Provider payment rates are set by Medicaid and are generally set using a percentage of Medicare rates. The Medicaid provider payment rates (also referred to as reimbursement rates) can differ significantly from what the medical providers would be paid by a private entity for the same service.

[8] It should be noted that Medicaid offers services that are not commonly offered by private health insurance plans. These services include dental coverage, vision coverage and transportation to medical services.

Provider costs have increased with medical inflation and with national and local competition among firms for skilled medical staff. Lowering provider payment rates below a level that providers believe is necessary to recoup their costs may lead to unintended effects such as providers refusing to serve Medicaid recipients or generating a greater number of billable services per recipient to maintain or increase revenue.

Services Offered

Some services must be offered by all Medicaid plans, while other services are optional. The selection of services offered and the quantity of each service that participants are allowed to use under a Medicaid plan can have a great deal of impact on costs. Some states have chosen to offer or not offer certain optional services due to cost considerations or have capped the number of service events a participant can use per year.

The list of Mandatory/Optional services provided by Wyoming Medicaid can be seen in Part Two of this report.

Medicaid System/Program Design Attributes

The Federal Government mandates certain design attributes and management practices. However, states have a great deal of latitude in how they design their Medicaid systems' breadth, generosity, and eligibility. State design choices can include waiver design, program design, and whether programs are designed as a component of Medicaid (with federal matching) or are funded instead solely or primarily with state general fund dollars.

While there is no Medicaid design silver bullet, there are a number of designs and models being implemented or piloted with promises of reducing costs while increasing quality of care. Examples of these designs include medical homes and accountable care organizations.

Conclusion

These contributing factors provide a foundation of knowledge for understanding overall Medicaid system costs. When identifying cost drivers within a healthcare system, it is important to recognize as many these components as possible that may be influencing overall cost increases. It is through this recognition of contributing factors that valid solutions to cost drivers will be found.

PART FOUR: HOW WYOMING MEDICAID COMPARES

To begin the examination into cost drivers and areas that may benefit from redesign, as required by SEA0058, the WDH looked at how Wyoming Medicaid compares to other states and to the nation as a whole. Finding direct comparison data for Medicaid systems is a difficult task. States have flexibility to create and administer a system that fits the needs of their state, and thus, no two Medicaid systems are alike. However, there are sources that compile available data to compare state Medicaid systems. It is important to note, however, that in some cases the cost categories created do not necessarily represent the same services or same programs across states or the nation.

This section uses national data[9] compiled by the Kaiser Family Foundation to demonstrate Medicaid enrollment, total expenditures, and payments per enrollee from federal fiscal year (FFY) 2009 to make comparisons among Wyoming, its surrounding region, and the nation. This data is grouped into four major enrollee categories: aged, disabled, adults, and children. For this report, the Mountain region was defined as Colorado, Montana, Nebraska, North Dakota, South Dakota, Utah and Wyoming, and all regional averages are based on this group of states.

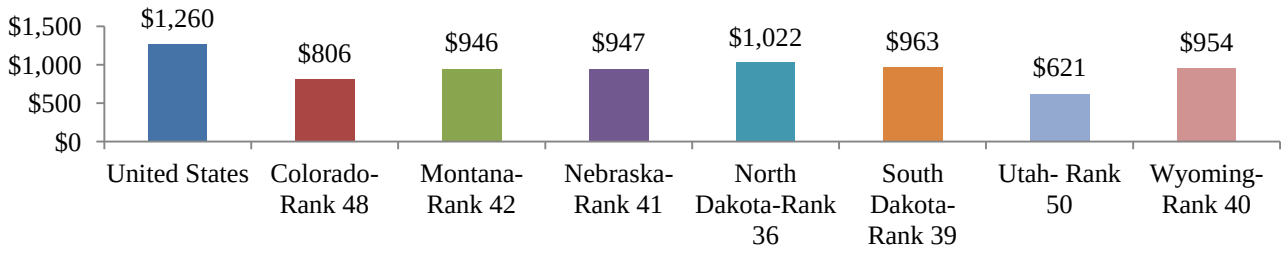
What you will see is that Wyoming Medicaid's average cost per capita is comparable to surrounding states (cost to each state resident, calculated as total cost of state Medicaid system divided by US Census population). Also, you will see that Wyoming's percentage of total state population on Medicaid is lower than the national average and higher than other states in the region.

Wyoming has a higher percentage of children in its Medicaid population than the national average, which lowers its average cost per enrollee. Costs per child are similar to the average of states in the region. Costs per enrollee are substantially higher than both the nation and region for elderly, disabled and adult enrollees.

9 This section utilizes national data for Medicaid enrollment, total expenditures, and payments per enrollee from federal fiscal year (FFY) 2009 to make comparisons among Wyoming, its surrounding region, and the nation. All expenditures are standardized as per enrollee or as ratios to enable effective comparisons between states of different populations. Sources are fully cited in the endnotes.

Wyoming Medicaid has a per capita cost (cost to each state resident) of $954 which is similar to the region and less than the national average. [xi]

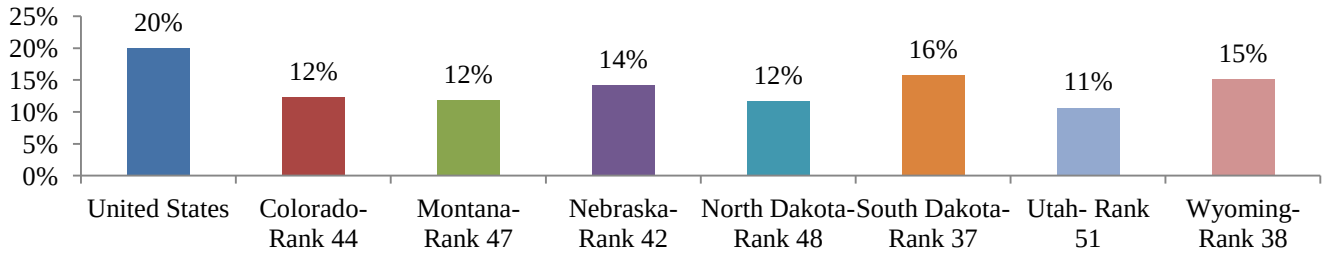
Figure 4. Total Per Capita Medicaid Spending FFY 2010 & U.S. Census 2010
(for rankings, 1 is most spending per capita, 51 is least)



To better understand per capita cost, as shown in the above figure, it is necessary to examine Medicaid enrollment, as the Medicaid per capita cost and percentage of total population receiving Medicaid are highly related.

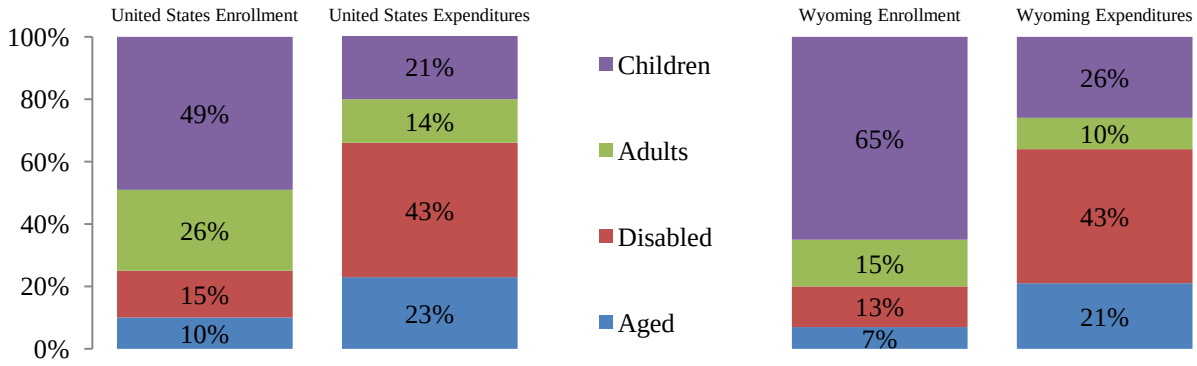
Medicaid serves less of Wyoming's total population than the national average, but a greater percentage of Wyoming's total population than all but one Medicaid system in the region. The percentage of the total population on Medicaid in Wyoming was 15% in FFY 2009 which was the 38th highest in the country. More of Wyoming's total population is enrolled in Medicaid than most of the states in the comparison region. However, it is important to note that the comparison region/Mountain region (Colorado, Montana, Nebraska, North Dakota, South Dakota, Utah and Wyoming) as a group has significantly less of its population on Medicaid than the national average.[xii]

Figure 5. Medicaid Enrollment as Percent of Total Population- FFY 2009
(for rankings, 1 is highest percent of total population on Medicaid, 51 is least)



Wyoming's recipient mix has a greater percentage of children, and a lower percentage of other groups than the national average. While children make up 65% of the Wyoming Medicaid population in FFY 2009, they only represented 26% of expenditures.

Figure 6. Share of Medicaid Enrollment and Total Expenditures FFY 2009

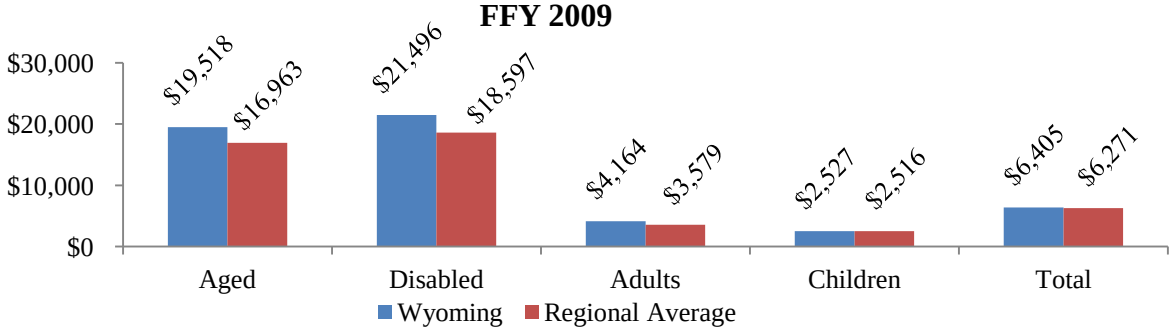


Compared to all states plus Washington D.C., Wyoming ranked 17th overall in expenditures per enrollee in FFY 2009[10], with first being most expensive per enrollee. Wyoming was in the top ten states for per enrollee spending for aged and disabled enrollees.

	Aged	Disabled	Adult	Children	Overall
Wyoming Rank	10th	9th	13th	22nd	17th

The comparison region (Colorado, Montana, Nebraska, North Dakota, South Dakota, Utah, and Wyoming) on average spent significantly more (13.3%) than the national average per enrollee on Medicaid. The spending per type of enrollee can vary significantly but in each category Wyoming spent more per enrollee than the regional average.

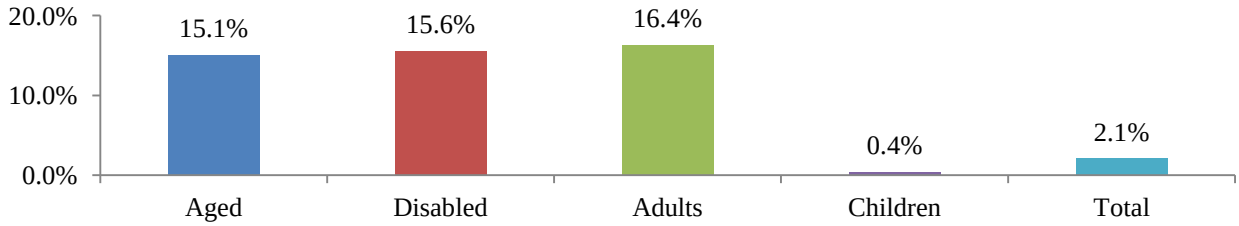
Figure 7. Medicaid Spending Per Enrollee FFY 2009



[10] Per enrollee costs are the costs per Medicaid enrollee overall and sub-divided into four different major groups- children, adults, aged and disabled.

As can be seen in Figure 8, Wyoming spending per enrollee was at least 15% more than the regional average for aged, disabled, and adult enrollees but less than one percent more than the regional average for children.

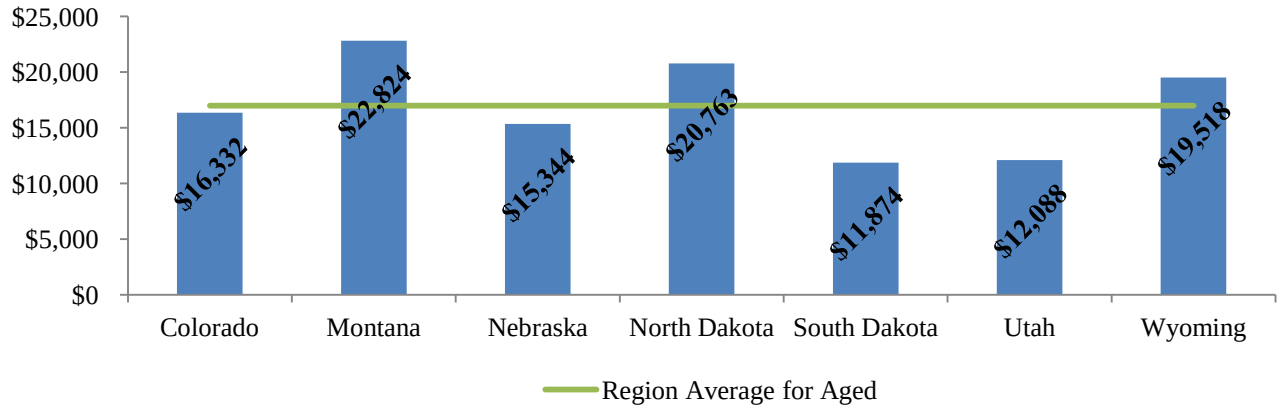
Figure 8. Wyoming Spending Per Enrollee Above Regional Average FFY 2009



Spending per aged enrollee was 15.1% above the regional average, or $2,555 more than the regional average in FFY 2009 (see Figure 9).

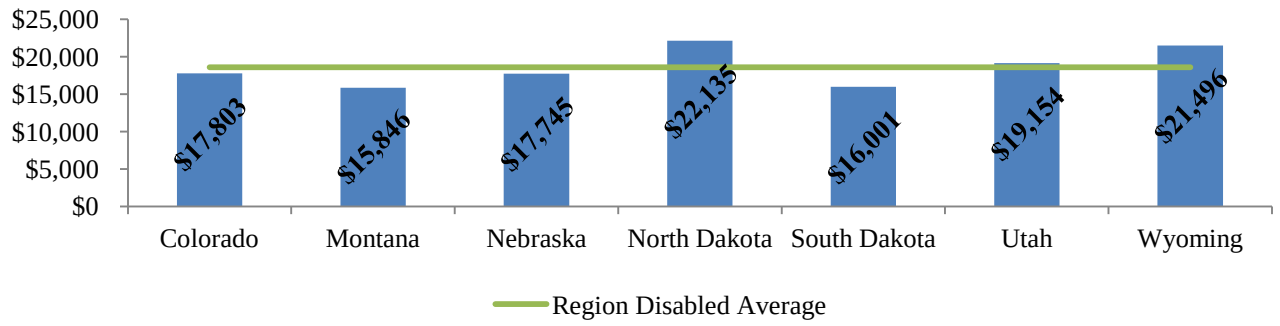
Figure 9. Spending Per Enrollee: Aged- FFY 2009

Regional Average=$16,963



Spending on disabled enrollees was 15.6% above the regional average, or $2,899 more than the regional average in FFY 2009 (see Figure 10).

Figure 10. Spending Per Enrollee: Disabled- FFY 2009
Regional Average= $18,597



Spending per enrollee for other groups was also above the regional average. Spending per adult enrollee was 16.4% above the regional average, or $585 more than the regional average in FFY 2009. Spending per child was 0.4% above the regional average, or $11 more than the regional average in FFY 2009. Overall spending per enrollee was 2.1% above the regional average, or $134 per enrollee more than the regional average.

The variation among the costs of different groups of enrollees is significant, and a percentage change will not yield the same dollar amount of savings in all groups.

Conclusion

Understanding how Wyoming Medicaid compares to the nation and to our comparison region allows for a basic reference point when considering the cost of Wyoming Medicaid and its components. How Wyoming compares should be considered when identifying cost drivers and solutions to cost drivers.

Comparisons among national and regional Medicaid systems, however, are only the beginning of this analysis.[11] Wyoming-specific data must be inspected to identify areas wherein cost drivers lie. It is through the analysis of Wyoming data that the cost drivers of Wyoming Medicaid will be uncovered and ultimately addressed.

[11] It is important to note that Part Four uses national data for enrollees using a federal fiscal year (FFY). Part Five uses Wyoming Medicaid data for recipients using a state fiscal year (SFY).

PART FIVE: PRESENTATION OF WYOMING MEDICAID DATA, IDENTIFYING HIGH COST/HIGH GROWTH AREAS

Examination of Current Medicaid Plan

SEA0058 requires that Wyoming Department of Health (WDH) gather and analyze a variety of data in the pursuit of identifying cost drivers for the Wyoming Medicaid system. These cost drivers are expected to inform the in-depth study of options that are likely to be successful for Medicaid in Wyoming, which will be presented in the final report.

Specifically, the study is to examine the current Wyoming Medicaid plan and determine the annual cost of benefits in each program (e.g., Children, Pregnant Women, etc.), as well as define how much of these costs were paid by the state, by the federal match, by clients, and how much was dedicated to administrative costs (see Tables 1-6 and Appendix E). In addition, the study is to examine the costs within broad categories of health benefits provided by Medicaid, such as physical health and mental health care, over time and within the programs (see Tables 6-10 and Appendix F). Finally, the study is to analyze this data to find cost drivers, as defined by the WDH, for the Wyoming Medicaid program (see Table 12). While the information in the following sections is dense, it serves the essential function of informing the data-driven decision making that must be used for this study to be successful.

Methodology

The current study was informed by the most current and complete data available to the WDH. The Medicaid Management Information System (MMIS) database (maintained by Xerox, a Medicaid contractor) was queried to provide all claims data through SFY 2011 (the most recently available data; providers have up to 1 year following service delivery to bill for that service in the MMIS, which means that aggregate figures may change over time). The WOLFS financial management system was queried to provide financial data through SFY 2011. The data tables presented below were produced in a systematic and stepwise fashion, from most general to more specific representations of data.

A significant period of the time spent prior to this report's deadline was dedicated to reconciling the data between the available data sources, as well as to refining the data query[12] methods used to develop meaningful demonstrations of the data from very complex databases. At this time, the MMIS and the WOLFS financial system do not 'talk' to one another without a significant amount of manual work on the part of staff. It was a priority to ensure that the information contained in the MMIS matched information found in WOLFS for the purposes of this study. All data methodology and analytics underwent multiple reviews by Medicaid program senior management and WDH Fiscal staff in order to appear in this report.

The end goal of examining the data presented in this section (as well as the more detailed data that will be presented in future reports) is to identify "cost drivers" for Wyoming Medicaid.

[12] Here, "query" describes the use of computer programming language to ask the data a specific question.

While there are any number of possible definitions that could be used, it was determined that a general definition of "cost drivers" would be ideal. This definition gives direction to the examination of the data, while still allowing the flexibility to ask a variety of questions of the data as more information is learned throughout the coming months. The data presented in the current report does examine each of the factors (price, number, quantity, and construct) listed below at a high level.

- **Cost Driver:** A factor that can cause a change in the cost of an activity.
  This may include:
  - The **price** of services being delivered/consumed.
  - The **number** of people consuming services.
  - The **quantity** of services being delivered/consumed.
  - The **construct** of the delivery system.

A few points related to the interpretation of the data tables presented below are worthy of note. First, data is presented only for Medicaid recipients; that is, people who were eligible for Wyoming Medicaid and received services during the time period in question. For example, while nearly 90,000 people were eligible to receive services in SFY 2011, approximately 77,000 received one or more services in SFY 2011. Second, the data is presented according to Medicaid "Programs," as required by the legislation. For the purposes of this report, a "Program" is defined as the large categories of Medicaid eligibility groups, of which there are ten (10). These include: Children, Pregnant Women, Family Care, AB&D – SSI & SSI Related, AB&D – Institution, AB&D – Home and Community Based Waivers, and Other (including AB&D – EID, Special Groups, Medicare Savings Programs, and Non-Citizens).

Third, the data tables are complex, containing a variety of groupings, years, and subtotals. To assist the reader, footnotes, endnotes, and appendices have been provided where additional explanation may be useful. It should be noted that 'grand totals' in the tables do not exactly match one another, depending on the topic being examined. This is due to a variety of financial or claims adjustments that are not consistent across the data, depending on how the question is asked. Calculations were completed for each table using the best available methodology and data, and so each table should be interpreted individually unless otherwise noted.

Finally, in addition to presenting the foundational data upon which the rest of this ongoing study's work will be conducted, the tables begin to lay the groundwork to define "cost drivers" for Wyoming Medicaid. High cost/high growth areas will be identified in Table 12, and further explored in the narrative following that table. Specific cost drivers, such as a particular service that might be over-utilized by a particular program, will be identified and explored alongside explicit options for Wyoming Medicaid in Report Two. This multi-phase methodology has been used by other states (e.g., South Dakota, Georgia, etc.) as they examined cost drivers and options for their respective Medicaid programs.

Total Annual Costs of Benefits

SEA0058 first requires that the WDH examine the total annual costs of benefits. The total annual cost of benefits per Medicaid recipient was first examined using the last full year of available data (SFY 2011). These costs are presented in Table 1 according to state share and federal share[13], total expenditures by program, and the number of recipients and cost per recipient. Client share (co-pays) and administrative costs are presented separately[14], as this information is more useful if examined for the entire Wyoming Medicaid system.

TABLE 1: Medicaid Programs in SFY11 by State and Federal Share

Medicaid Programs	Total Expenditures[4]	State Share %	Federal Share %	# of Recipients[1]	Cost Per Recipient	% of Total Expenditures
Aged, Blind, & Disabled[2]	$ 304,200,528	49.4%	50.6%	12,970	$ 23,454	58.6%
AB&D - HCBS	154,929,180	49.9%	50.1%	4,722	32,810	29.9%
AB&D - Institution	97,492,649	49.0%	51.0%	2,843	34,292	18.8%
AB&D - SSI & SSI Related	51,778,699	48.3%	51.7%	6,099	8,490	10.0%
Children	138,125,451	48.5%	51.5%	49,966	2,764	26.6%
Pregnant Women	36,079,605	47.9%	52.1%	6,122	5,893	7.0%
Family Care Adults	29,097,326	46.3%	53.7%	6,942	4,191	5.6%
Other[3]	11,365,176	44.7%	55.3%	3,676	3,092	2.2%
Grand Total	**$ 518,868,086**	**48.8%**	**51.2%**	**77,207**	**$ 6,720**	**100.0%**

[1]Recipients are presented as unduplicated counts for each program. A client may be in more than one program in a given year; therefore, the subtotals should not be added together by hand. They will not equal the Grand Total.

[2]The Aged, Blind, & Disabled total expenditures is the sum of the AB&D-SSI, AB&D-Institution, and AB&D HCBS lines.

[3]The Other Subtotal line is the sum of the Special Groups, AB&D-EID, Medicare Savings Programs, and Non Citizens groups.

[4]The Expenditures in this table will not match those in the Service Area tables, due to the fact that only Chart A Programs were used. The non-eligibility categories not represented here accounted for $238,591 in SFY11.

Interpretation of Table 1. The information in Table 1 paints a relatively clear picture of which Medicaid programs cost the most in SFY 2011, which programs contained the greatest number of recipients, and which programs show the greatest cost per recipient. It is also easy to see the state and federal share distribution within each of the programs.

[13] The American Recovery and Reinvestment Act (ARRA) temporary enhanced matching funds have been removed from this analysis because they do not represent sustained funding.

[14] *Client Share and Administrative Costs.* Clients enrolled in Medicaid do not have to pay deductibles in the same way that a traditional health plan might require, and only a few services do require small co-pays. These co-pays are not tracked by providers in a way that can be accessed for the whole state program, so we cannot know exactly how much is paid by Medicaid recipients in a given year. However, the table presented in Appendix D provides an overall picture of what is expected according to the services delivered. Administrative costs for Wyoming Medicaid have remained relatively constant over the past four state fiscal years that were examined for this report (SFY 2008 through SFY 2011). In SFY08, administrative costs amounted to 5.6% of the overall Medicaid budget, jumping to 5.8% in SFY 2009, and down again to 5.7% in SFY 2010. In SFY 2011, administrative costs fell to just 5% of the overall budget, resulting in an average 4-year administrative cost of 5.5%.

Top 5 Programs in Rank Order					
% of Total Expenditures		# of Recipients		Cost Per Recipient	
Rank		*Rank*		*Rank*	
1	AB&D - HCBW	1	Children	1	AB&D - Institution
2	Children	2	Family Care	2	AB&D - HCBW
3	AB&D - Institution	3	Pregnant Women	3	AB&D - EID
4	AB&D - SSI	4	AB&D - SSI	4	AB&D - SSI
5	Pregnant Women	5	AB&D - HCBW	5	Pregnant Women

While Table 1 is helpful in a basic sense, it could be more helpful to rank-order the programs in the three primary areas of concern: percent of total expenditures, number of recipients, and the cost per recipient. The top five (5) programs in each of those categories are represented above, with 1 being the highest and 5 being the lowest (of the top 5) in each category. Only one of the four programs in the "Other" category ranked in the top 5 (AB&D – EID, in the Cost Per Recipient column).

As can be seen above, the Aged, Blind, and Disabled (AB&D) programs are well represented in the top five, regardless of how the data is examined. It is important to examine all three of these categories (% of total expenditures, # of recipients, and cost per recipient) in combination with one another, since examining just one can be misleading. For example, if only the percent of total expenditures is considered, it appears that Children are very expensive (ranked 2nd). This might encourage this group to be named a "cost driver," particularly because they also represent the greatest number of Medicaid recipients (ranked 1st). However, Children are actually ranked 9th (of 10) on cost per recipient, indicating that this program should not automatically be considered a cost driver for the purposes of this study.

The rankings presented above indicate that programs appearing in the "Top 5" of at least 2 of the three categories (expenditures, recipients, and cost/recipient) should be examined in greater detail. The goal is to determine how they drive cost, and whether there might be some sub-groups within each larger program that drive cost more than others. The sub-groups within each larger Medicaid Program will be reviewed in Table 6.

Costs, Recipients, and Cost per Recipient Over Time

In order to better understand the costs and recipients that impact Wyoming Medicaid, the data were examined by Medicaid Program across four years (SFY 2008 through SFY 2011). A single year of data can be very useful, but patterns of use can only be seen over time. These patterns might help to pinpoint particular groups that seem to be growing or declining, and this information allows for better decisions about where to focus efforts related to developing options for Wyoming Medicaid. Tables 2, 3, 4, and 5 only show the beginning (SFY 2008) and ending (SFY 2011) years of data for simplicity in the body of the report. The smaller programs have also

been combined into a section called 'Other' (as defined in the table footnote). Expanded versions of these tables (showing detail for all four years and for the 'Other' categories) can be found in Appendix E.

TABLE 2: Medicaid Program Expenditures from SFY2008 - SFY2011

Medicaid Programs	SFY 2008 Total Cost	SFY 2011 Total Cost	% Change 2008 to 2011
Aged, Blind, & Disabled[2]	$ 273,275,975	$ 304,200,528	11.3%
AB&D - SSI & SSI Related	39,972,290	51,778,699	29.5%
AB&D - Institution	92,829,101	97,492,649	5.0%
AB&D - HCBS	140,474,585	154,929,180	10.3%
Children	125,791,334	138,125,451	9.8%
Pregnant Women	31,734,766	36,079,605	13.7%
Family Care Adults	23,729,222	29,097,326	22.6%
Other[3]	6,922,610	11,365,176	64.2%
Grand Total	**$ 461,453,908**	**$ 518,868,086**	12.4%

[2]The AB&D Subtotal line is the sum of the AB&D-SSI, AB&D-Institution, and AB&D HCBS lines.

[3]The Other Subtotal line is the sum of the Special Groups, AB&D-EID, Medicare Savings Programs, and Non Citizens lines (available in the Appendix).

TABLE 3: Medicaid Program Recipients[1] from SFY2008 - SFY2011

Medicaid Programs	SFY 2008 # of Recipients	SFY 2011 # of Recipients	% Change 2008-2011
Aged, Blind, & Disabled[2]	12,034	12,970	7.8%
AB&D - SSI & SSI Related	5,628	6,099	8.4%
AB&D - Institution	3,187	2,843	-10.8%
AB&D - HCBS	4,269	4,722	10.6%
Children	43,791	49,966	14.1%
Pregnant Women	6,766	6,122	-9.5%
Family Care Adults	6,407	6,942	8.4%
Other[3]	2,788	3,676	31.9%
Grand Total	**69,343**	**77,207**	11.3%

[1]Recipients are presented as unduplicated counts for each program. A client may be in more than one program in a given year; the subtotals should not be added together by hand. They do not equal the Grand Total.

[2]The AB&D Subtotal line is unduplicated calculation of AB&D-SSI, AB&D-Institution, and AB&D HCBS lines.

[3]The Other Subtotal line is the unduplicated calculation of Special Groups, AB&D-EID, Medicare Savings Programs, and Non Citizens lines (available in the Appendix).

TABLE 4: Medicaid Program Cost Per Recipient from SFY2008 - SFY2011

Medicaid Programs	SFY 2008 Cost per Recipient	SFY 2011 Cost per Recipient	% Change 2008-2011
Aged, Blind, & Disabled[2]	$ 22,709	$ 23,454	3.3%
AB&D - SSI & SSI Related	7,102	8,490	19.5%
AB&D - Institution	29,127	34,292	17.7%
AB&D - HCBS	32,906	32,810	-0.3%
Children	2,873	2,764	-3.8%
Pregnant Women	4,690	5,893	25.7%
Family Care Adults	3,704	4,191	13.2%
Other[3]	2,483	3,092	24.5%
Grand Total	**$ 6,655**	**$ 6,720**	1.0%

2The AB&D Subtotal line is the overall calculation of AB&D-SSI, AB&D-Institution, and AB&D HCBS lines.
[3]The Other Subtotal line is the overall calculation of Special Groups, AB&D-EID, Medicare Savings Programs, and Non Citizens lines (available in the Appendix).

Interpretation of Tables 2 through 5. The most important information from Tables 2, 3, and 4 is summarized in Table 5 (below). The number of people receiving Medicaid services has increased by about 11%, with a parallel increase in overall costs by about 12%. However, the cost per recipient has increased by only 1% in four years. It is clear that there are a few programs which appear to be growing steadily if only the total expenditures and recipient counts are considered (e.g., the Other category, Family Care Adults, etc.). However, the final column (% of Total Expenditures) indicates that these groups together only made up approximately 8% of the total expenditures for SFY 2011, which would lead to the conclusion that a focus here would not result in the definition of significant cost drivers for Wyoming Medicaid.

TABLE 5: Percent Change From SFY2008 - SFY2011

Medicaid Programs	Expenditures 2008-2011	Recipients 2008 -2011	Cost/Recipient 2008-2011	% of Total Expenditures
Aged, Blind, & Disabled[2]	11.3%	7.8%	3.3%	58.6%
AB&D - SSI & SSI Related	29.5%	8.4%	19.5%	10.0%
AB&D - Institution	5.0%	-10.8%	17.7%	18.8%
AB&D - HCBS	10.3%	10.6%	-0.3%	29.9%
Children	9.8%	14.1%	-3.8%	26.6%
Pregnant Women	13.7%	-9.5%	25.7%	7.0%
Family Care Adults	22.6%	8.4%	13.2%	5.6%
Other[3]	64.2%	31.9%	24.5%	2.2%
Grand Total	**12.4%**	**11.3%**	**1.0%**	**100.0%**

2The AB&D Subtotal line represents the overall calculation of AB&D-SSI, AB&D-Institution, and AB&D HCBS lines.
[3]The Other Subtotal line represents the overall calculation of Special Groups, AB&D-EID, Medicare Savings Programs, and Non Citizens lines (available in the Appendix).

In order to flush out some of the trends that can be seen in Tables 2, 3, 4, and 5, the sub-groups that make up each Medicaid Program were examined next.

Sub-groups Analysis. The 10 primary Medicaid Programs are composed of a variety of Sub-groups. For instance, within the Children's program, there are four Sub-groups (i.e., Newborn, Low Income Children, Foster Care, and Children) that may evidence differing patterns of change over time in expenditures, recipients, and cost per recipient. These Sub-groups were analyzed to determine whether the cost, recipient, and use patterns further illuminate the general patterns that were observed in Tables 2 through 5. Table 6 presents the percent change in expenditures, number of recipients, and cost per recipient for the Medicaid Sub-groups between SFY 2008 and SFY 2011. Detailed Sub-groups tables can be found in Appendix F.

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Table 6: Medicaid Program Sub-Groups Change in Cost, Recipients, and Cost Per Recipients 2008-2011

Primary Medicaid Programs	Sub-Groups[1]	Expenditures 2008-2011	Recipients 2008 -2011	Cost per Recipient 2008-2011	SFY11 % of Total Expenditures
	Aged, Blind, & Disabled				
AB&D - SSI	SSI	30.0%	8.5%	19.8%	10.0%
	SSI Related	-50.0%	-11.3%	-43.7%	0.0%
AB&D - SSI		**29.5%**	**8.4%**	**19.5%**	**10.0%**
AB&D - Institution	Hospice	72.6%	142.1%	-28.7%	0.1%
	Hospital	-13.3%	7.7%	-19.6%	1.4%
	ICF MR (WY Life Resource Center)[2]	15.9%	-10.7%	29.8%	1.9%
	IMD (WY State Hospital - Age 65 & Over)	-63.1%	0.0%	-63.1%	0.0%
	Nursing Home	5.6%	-13.1%	21.5%	15.5%
AB&D - Institution Total		**5.0%**	**-10.8%**	**17.7%**	**18.8%**
AB&D - HCBS	Acquired Brain Injury (ABI)	21.4%	1.1%	20.1%	1.6%
	Assisted Living Facility (ALF)	7.4%	8.1%	-0.6%	0.7%
	Children's Mental Health	*n/a*	*n/a*	*n/a*	*0.6%*
	DD Adult	2.4%	3.3%	-0.8%	17.2%
	DD Child	6.7%	0.5%	6.2%	4.1%
	Long Term Care (LTC)	29.0%	11.8%	15.4%	5.6%
AB&D - HCBS Total		**10.3%**	**10.6%**	**-0.3%**	**29.9%**
Children	Children	12.6%	2.9%	9.4%	3.3%
	Foster Care	-23.2%	-1.0%	-22.4%	4.4%
	Low Income Children (Ages 0-18)	33.7%	20.9%	10.6%	12.9%
	Newborn	1.4%	-5.8%	7.6%	6.0%
Children Total		**9.8%**	**14.1%**	**-3.8%**	**26.6%**
Pregnant Women	Pregnant Women	13.6%	-7.6%	22.9%	6.9%
	Presumptive Eligibility	33.8%	38.4%	-3.4%	0.0%
Pregnant Women Total		**13.7%**	**-9.5%**	**25.7%**	**7.0%**
Family Care Adults	Presumptive Eligibility	22.6%	8.4%	13.2%	5.6%
Family Care Adults Total		**22.6%**	**8.4%**	**13.2%**	**5.6%**
	Other Programs				
Special Groups	Breast and Cervical	97.8%	16.7%	69.4%	0.7%
	Family Planning Waiver	*n/a*	*n/a*	*n/a*	*0.0%*
	Tuberculosis	*n/a*	*n/a*	*n/a*	*0.0%*
Special Groups Total		**102.8%**	**202.6%**	**-33.0%**	**0.7%**
AB&D - EID	EID	110.8%	129.1%	-8.0%	0.5%
AB&D - EID Total		**110.8%**	**129.1%**	**-8.0%**	**0.5%**
Medicare Savings Programs	Part B - Partial AMB	-25.0%	-33.3%	12.5%	0.0%
	Qualified Medicare Beneficiary	54.4%	25.6%	22.9%	0.6%
	Specified Low Income Medicare Beneficiary	83.0%	20.0%	52.5%	0.0%
Medicare Savings Programs Total		**54.6%**	**25.1%**	**23.5%**	**0.6%**
Non Citizens	Non Citizens	4.6%	-30.1%	49.7%	0.4%
Non Citizens Total		**4.6%**	**-30.1%**	**49.7%**	**0.4%**
Grand Total		**12.4%**	**11.3%**	**1.0%**	**100.0%**

N/A: Change between SFY08 and SFY11 could not be calculated because these programs began before or after SFY08.

[1]Sub-group definitions can be found in the Medicaid Eligibility Matrix Appendix.

[2]The expenditures shown for the Life Resource Center only represent the federal portion of the total expenditures, and the SGF portion is accounted for in the Life Resource Center's budget. Effective July 1, 2012 (SFY 2013) this will no longer be an issue as the entire expenditure will be processed through the Medicaid budget.

Interpretation of Table 6. The information in Table 6 illuminates some interesting patterns for Sub-groups that could not be seen by examining only the larger Medicaid Programs. Once again, it is essential that all four categories (columns) of information be examined in combination with

each other. If change in expenditures were the only factor used to identify cost drivers, attention might be given to Programs and Sub-groups that only account for a minute percentage of the overall Medicaid budget (e.g., Specified Low Income Medicaid Beneficiary, Breast and Cervical, etc.).

The first step toward identifying potential cost drivers in the Sub-groups was to rank order each one according to its overall budgetary impact on Wyoming Medicaid. Relative rankings on each of the categories represented in Table 6 can be found below. The top five Sub-groups, according to overall budgetary impact, are: DD Adult Waiver, Nursing Homes, Low Income Children (ages 0-18), AB&D-SSI, and Pregnant Women. Compared to some other Sub-groups, these groups did not generally experience exceptional changes over the four years that were examined; however, small changes within these Sub-groups could have a larger budgetary impact than some of the other, smaller Sub-groups (e.g., AB&D-EID, Breast and Cervical).

To illustrate the drastically different impact that increased utilization by various Sub-groups can cause, compare the DD Adult Waiver Sub-group to the Low Income Children Sub-group. Both of these Sub-Groups are represented in the Top 5 ranking table below, which could lead to the conclusion that they deserve heightened attention. However, a 10-person increase in the Adult DD Waiver Sub-group recipient count could result in a system impact of $641,170 in just one year's time, whereas an increase of the same magnitude (10 people) in the Low Income Children Sub-group could cost just $18,150 in one year.

Similarly, one might conclude that the Aged, Blind, or Disabled – Employed Individuals with Disabilities (AB&D – EID) Sub-Group should receive a great deal of additional investigation, seeing as how this Sub-group appears twice in the rankings below. Upon further examination, however, this Sub-Group accounted for only 0.5% of SFY2011 Medicaid annual expenditures, leading to the conclusion that perhaps this Sub-group should not be a large focus in this ongoing study. This stepwise process of doing an initial examination of the data, followed by a much more detailed analysis, will continue throughout the course of this study.

Top 5 Sub-Groups in Rank Order

Change in Expenditures		% of Total Expenditures		Change in # of Recipients		Change in Cost Per Recipient	
Rank		*Rank*		*Rank*		*Rank*	
1	AB&D - EID	1	DD Adult Waiver	1	Hospice	1	Breast and Cervical
2	Breast & Cervical	2	Nursing Homes	2	AB&D - EID	2	Specified Low Income Medicare Beneficiary
3	Specified Low Income Medicare Beneficiary	3	Low Income Children	3	Pregnant Women - Presumptive Eligibility	3	Non Citizens
4	Pregnant Women - Presumptive Eligibility	4	AB&D - SSI	4	Qualified Medicare Beneficiary	4	ICF-MR (Training School)
5	Low Income Children	5	Pregnant Women	5	Low Income Children	5	Qualified Medicare Beneficiary

Costs by Medicaid Service Areas

In addition to examining costs, recipients, cost per recipient, and change in these numbers over time for the Medicaid Programs and Sub-groups, broad service categories were also examined. These categories were chosen to represent the types of services offered in Wyoming Medicaid (and also to align with the Medicaid Annual Report). Tables 7, 8, 9, and 10 (below) show the SFY2008 and SFY2011 expenditures, recipients, cost per recipient, and finally the overall percentage change for each of those three categories. For simplicity, an "Other" category was created.[15]

It is important to note that a Medicaid health plan offers a variety of services that would not normally be covered by a traditional health benefit plan. For instance, waiver services are unique to Medicaid, and unlike other Medicaid benefits (e.g., basic medical coverage), are fully under the control of the state in which the waivers are operating. As well, the rapid growth depicted for the Children's Mental Health Waiver is expected, since this program was in its infancy in SFY2008 and only began running at full capacity in SFY2010. These factors should be kept in mind as the following tables are reviewed.

TABLE 7: Medicaid Service Areas and Expenditures SFY2008-SFY2011

Service Areas	SFY 2008 Expenditures	SFY 2011 Expenditures	% Change 2008-2011
HCBS Waiver Services[1]	$112,069,126	$120,052,789	7.1%
Adult DD Waiver	80,211,858	81,368,423	1.4%
Child DD Waiver	12,879,475	14,131,328	9.7%
LTC Waiver	10,255,289	13,912,443	35.7%
ABI Waiver	5,891,037	6,964,560	18.2%
ALF Waiver	2,822,362	2,757,459	-2.3%
Children's Mental Health Waiver	9,104	918,577	9989.8%
Hospital	$94,312,212	$114,353,216	21.2%
Inpatient Hospital	73,959,742	84,557,214	14.3%
Outpatient Hospital	20,066,679	29,687,689	47.9%
Nursing Facilities	69,274,181	73,180,333	5.6%
Physician and Other Practitioners	58,099,555	65,165,045	12.2%
Prescription Drugs	34,904,721	40,864,150	17.1%
Behavioral Health	17,447,670	24,917,152	42.8%
PRTF	8,387,267	15,244,613	81.8%
Dental	10,806,128	13,616,583	26.0%
Other[2]	55,900,347	51,712,797	-8.1%
Grand Total	**$461,201,208**	**$519,106,677**	**11.2%**

[1]The Waiver Services category and sub-groups represent only Waiver costs. These do not include Medical costs incurred by recipients on a Waiver.

[2]The Other category represents 10% of overall expenditures in SFY2011. A detailed list of items included in the Other category can be found in the footnotes.

[15] The Other Category includes: Intermediate Care for the Mentally Retarded (ICFMR; 100% Federal Funds), Public Health, Federal, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Ambulance, Vision, Federally Qualified Health Center (FQHC), Ambulatory Surgical Center (ASC), Home Health, Rural Health Clinic (RHC), Clinic/Center, Laboratory, Public Health or Welfare, Hospice, End Stage Renal Disease (ESRD), Residential Treatment Facility (RTF; Emotionally Disturbed Children), Case Management, Day Training/DD Service, Mobile Radiology, Ambulatory Family Planning Facility, Comprehensive Outpatient Rehabilitation Facilities (CORF), Interpreter Services, Chiropractor, Phlebotomy/WY Health Fair, and Unknown.

TABLE 8: Medicaid Service Areas and Recipients SFY2008-SFY2011			
Service Areas	**SFY 2008 Recipients**	**SFY 2011 Recipients**	**% Change 2008-2011**
HCBS Waiver Services[1]	4,031	4,445	10.3%
Adult DD Waiver	1,300	1,356	4.3%
Child DD Waiver	799	802	0.4%
LTC Waiver	1,626	1,828	12.4%
ABI Waiver	180	178	-1.1%
ALF Waiver	206	217	5.3%
Children's Mental Health Waiver	7	137	1857.1%
Hospital	38,601	42,109	9.1%
Inpatient Hospital	12,092	11,452	-5.3%
Outpatient Hospital	35,811	39,486	10.3%
Nursing Facilities	2,420	2,388	-1.3%
Physician and Other Practitioners	57,994	64,580	11.4%
Prescription Drugs	45,160	50,273	11.3%
Behavioral Health	8,488	10,572	24.6%
PRTF	256	408	59.4%
Dental	21,566	28,160	30.6%
Other[2]	n/a	n/a	n/a

[1]The Waiver Services category and sub-groups represent only Waiver costs. These do not include Medical costs incurred by recipients on a Waiver.

[2]Recipient counts were not calculated for the Other category. A detailed list of items included in the Other category can be found in the footnotes.

TABLE 9: Medicaid Service Areas and Cost Per Recipient SFY2008-SFY2011			
Service Areas	**SFY 2008 Cost/Recipient**	**SFY 2011 Cost/Recipient**	**% Change 2008-2011**
HCBS Waiver Services[1]	$27,802	$27,009	-2.9%
Adult DD Waiver	61,701	60,006	-2.7%
Child DD Waiver	16,119	17,620	9.3%
LTC Waiver	6,307	7,611	20.7%
ABI Waiver	32,728	39,127	19.6%
ALF Waiver	13,701	12,707	-7.3%
Children's Mental Health Waiver	1,301	6,705	415.5%
Hospital	$2,443	$2,716	11.1%
Inpatient Hospital	6,116	7,384	20.7%
Outpatient Hospital	560	752	34.2%
Nursing Facilities	28,626	30,645	7.1%
Physician and Other Practitioners	1,002	1,009	0.7%
Prescription Drugs	773	813	5.2%
Behavioral Health	2,056	2,357	14.7%
PRTF	32,763	37,364	14.0%
Dental	501	484	-3.5%
Other[2]	n/a	n/a	n/a

[1]The Waiver Services category and sub-groups represent only Waiver costs. These do not include Medical costs incurred

[2]Recipient counts were not calculated for the Other category. A detailed list of items included in the Other category can be found in the footnotes.

TABLE 10: Medicaid Service Areas Percent Change from SFY2008-SFY2011				
Service Areas	Expenditures 2008-2011	Recipient Change 2008 -2011	Cost per Recipient 2008-2011	SFY11 % of Total Expenditures
HCBS Waiver Services[1]	7.1%	10.3%	-2.9%	*23.1%*
Adult DD Waiver	1.4%	4.3%	-2.7%	15.7%
Child DD Waiver	9.7%	0.4%	9.3%	2.7%
LTC Waiver	35.7%	12.4%	20.7%	2.7%
ABI Waiver	18.2%	-1.1%	19.6%	1.3%
ALF Waiver	-2.3%	5.3%	-7.3%	0.5%
Children's Mental Health Waiver	9989.8%	1857.1%	415.5%	0.2%
Hospital	21.2%	9.1%	11.1%	*22.0%*
Inpatient Hospital	14.3%	-5.3%	20.7%	16.3%
Outpatient Hospital	47.9%	10.3%	34.2%	5.7%
Nursing Facilities	5.6%	-1.3%	7.1%	14.1%
Physician and Other Practitioners	12.2%	11.4%	0.7%	12.6%
Prescription Drugs	17.1%	11.3%	5.2%	7.9%
Behavioral Health	42.8%	24.6%	14.7%	4.8%
PRTF	81.8%	59.4%	14.0%	2.9%
Dental	26.0%	30.6%	-3.5%	2.6%
Other[2]	-8.1%	n/a	n/a	10.0%

[1]The Waiver Services category and sub-groups represent only Waiver costs. These do not include Medical costs incurred by recipients on a Waiver.

[2]Recipient counts were not calculated for the Other category. A detailed list of items included in the Other category can be found in the footnotes.

Interpretation of Tables 7 through 10. The Service Areas tables were examined in the same fashion as the Medicaid Program tables. Looking first to the percent of total expenditures that each line comprises, it is clear that the majority of dollars are spent in the Inpatient Hospital, Adult DD Waiver, Nursing Facilities, and Physicians and Other Practitioners service areas. Although other Service Areas show greater growth across time (e.g., Behavioral Health, Outpatient Hospital, etc.), these areas account for less of the overall budget than do the four mentioned above. While growth that occurs at a rapid rate deserves note and is worthy of monitoring by Wyoming Medicaid, growth in raw expenditures or recipients within these (relatively) smaller Service Areas may not have as great a budgetary impact.

Outlier Analysis: The Top 5 Percent

In an effort to further explore each of the six (6) most costly Medicaid Programs (AB&D – HCBS Waivers, AB&D – Institution, AB&D – SSI, Children, Pregnant Women, and Family Care Adults) an analysis that separated the most expensive 5% of recipients within each Program from the other, less expensive 95% was performed. It has been commonly noted in health research that extremely high-need or high-use recipients can skew an average calculation (these people are typically referred to as "outliers" because they lie outside the usual distribution of data). This "law of averages" means that if only group averages are used, important information that would be useful for decision making may be overlooked.

Figure 11 represents the entire Wyoming Medicaid system in SFY 2011, and is followed by six (6) additional figures that represent the largest primary Medicaid Programs (the "Other" category was removed from this analysis due to the fact that these programs account for only 2% of overall expenditures). From left-to-right, the first bar represents the top 5%, middle 15%, and bottom 80% costliest recipients for each group in SFY 2011. The second bar (to the right)

indicates what percentage of the SFY 2011 expenditures are affiliated with those 5%, 15%, or 80% categories. Next to the bars, the cost per recipient is represented in gray boxes. Below the bars, the actual number of unduplicated recipients and the actual cost for each category is presented.

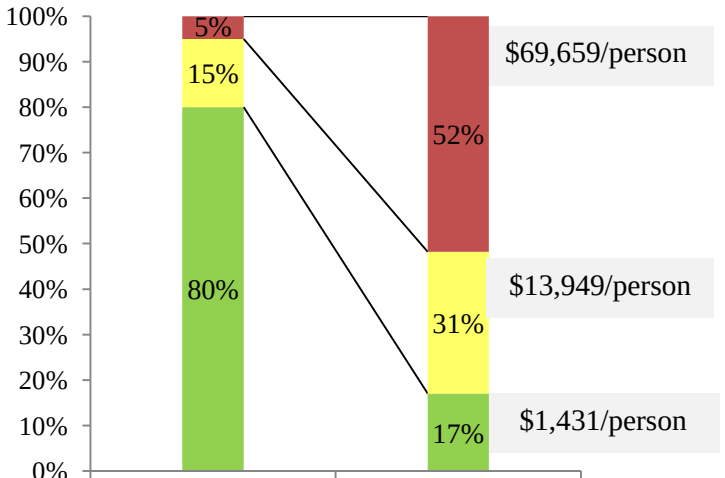
For example, the two bars in Figure 11 should be examined together, such that the top 5% of Medicaid recipients consumed 52% of the dollars within the system. The next-highest 15% consumed 31% of the dollars, and the remaining lowest 80% consumed 17% of the dollars.

It is common to see the top 5% (highest cost and/or highest utilization of services) of recipients in a given group of similar people represent significantly higher cost than those recipients in the lower categories. In all of the programs, the top 5% in a given program accounted for over 20% of the expenditures in SFY 2011. In three of the six programs, the top 5% of recipients account for at least 40% of the cost (AB&D – Institution, Children, and Family Care Adults).

The top 5% of recipients in all of these programs deserve additional attention as this study moves forward. The next 15% of recipients will also be examined in depth, as this group of recipients could be viewed as trending toward becoming members of that top 5% most costly group.

To illustrate the important differences between the three groups, Figure 12 depicts the HCBS Waiver programs. The Top 5% of Recipients (N=236) have an average cost of $148,113 per person, whereas the bottom 80% have an average cost of $16,875 per person. This wide discrepancy indicates that a closer look at the Top 5% is needed.

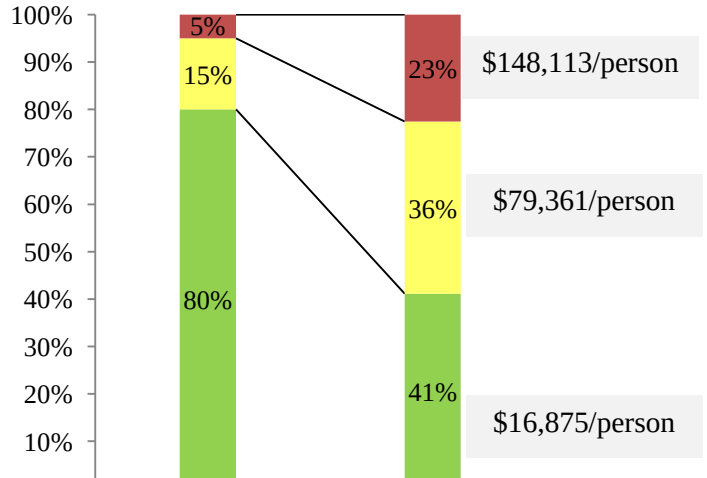
Figure 11. Top 5% Analysis: Medicaid Recipients SFY2011



	Recipients	Cost
Top 5%	3,860	$268,907,077
Middle 15%	11,581	$161,549,584
Bottom 80%	61,766	$88,411,425

Bottom 80% Middle 15% Top 5%

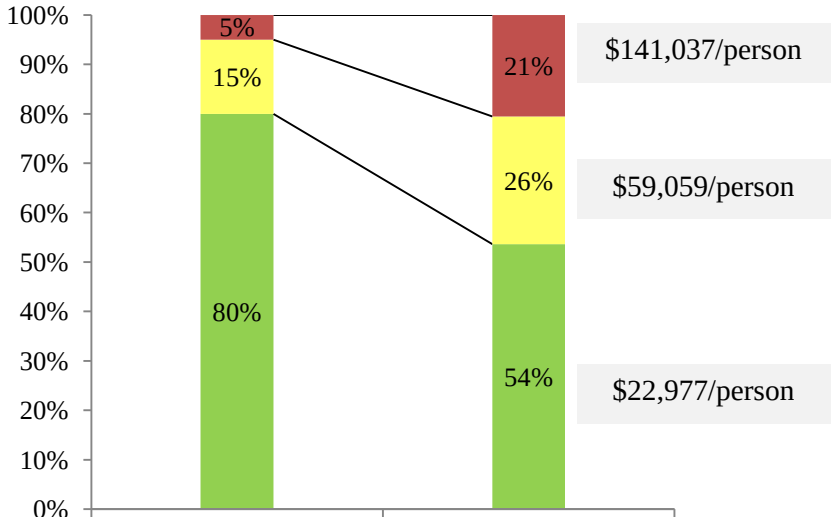
Figure 12. Top 5% Analysis: AB&D - HCBS Waivers SFY2011



	Recipients	Cost
Top 5%	236	$34,969,496
Middle 15%	708	$56,211,077
Bottom 80%	3,778	$63,748,607

Bottom 80% Middle 15% Top 5%

Figure 13. Top 5% Analysis: AB&D - Institution SFY2011



	Recipients	Cost
Top 5%	142	$20,048,469
Middle 15%	426	$25,185,605
Bottom 80%	2,274	$52,258,575

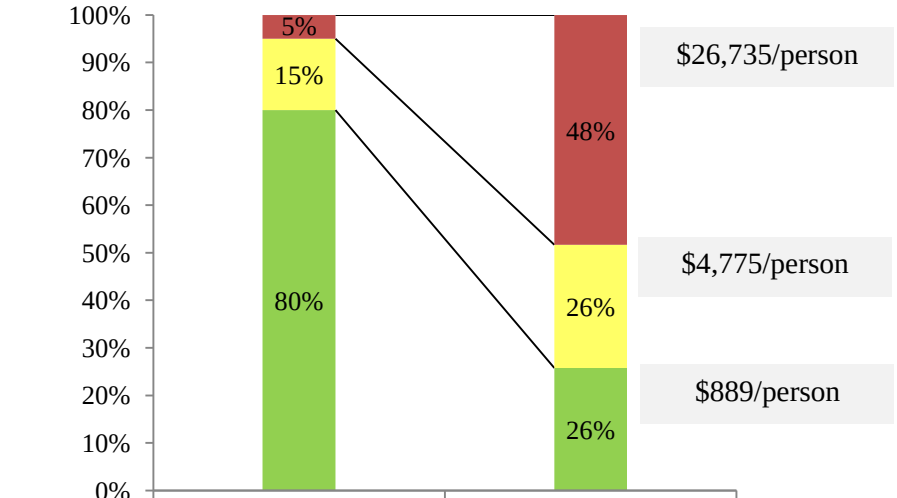
Bottom 80% Middle 15% Top 5%

Figure 14. Top 5% Analysis: AB&D - SSI SFY2011

	Recipients	Cost
Top 5%	305	$22,454,175
Middle 15%	915	$17,173,848
Bottom 80%	4,879	$12,150,676

Bottom 80% Middle 15% Top 5%

Figure 15. Top 5% Analysis: Children
SFY2011



	Recipients	Cost
Top 5%	2,498	$66,792,480
Middle 15%	7,495	$35,789,576
Bottom 80%	39,973	$35,543,395

Bottom 80% Middle 15% Top 5%

Figure 16. Top 5% Analysis: Pregnant Women
SFY2011

	Recipients	Cost
Top 5%	306	$6,824,312
Middle 15%	918	$11,712,517
Bottom 80%	4,898	$17,542,776

Bottom 80% Middle 15% Top 5%

Figure 17. Top 5% Analysis: Family Care Adults SFY2011

	Recipients	Cost
Top 5%	347	$11,383,478
Middle 15%	1,041	$9,967,262
Bottom 80%	5,554	$7,746,586

Bottom 80% Middle 15% Top 5%

Next Steps: Medicaid Programs by Service Area

After examining the Medicaid Programs and the Service Areas individually, the next level of analysis cross-tabulated both types of information. This means that each type of information (i.e., Programs and Service Areas) would be cross-referenced to look for patterns that might have been missed by only examining the information separately. A portion of Table 11 is available here; the full table can be seen in Appendix G.

A useful way to interpret this table is to first examine the columns (Programs) and then examine the rows (Service Areas). For each Program, it is easy to see the types of services that are used, and compare how much each area costs for each Program. It is also easy to see what Service Areas are accessed by which Programs (e.g., Waiver Services only show up in AB&D – HCBS column, as would be expected). In Report Two, any patterns of utilization or spending that give cause for concern will be examined.

Table 11. SFY 2011 Expenditures: Medicaid Programs by Service Area*

Service Areas	AB&D - SSI & SSI Related	AB&D - Institution	AB&D - HCBS
HCBS Waiver Services			$ 120,052,789
Adult DD Waiver			$ 81,368,423
Child DD Waiver			$ 14,131,328
LTC Waiver			$ 13,912,443
ABI Waiver			$ 6,964,560
ALF Waiver			$ 2,757,459
Children's MH Waiver			$ 918,577
Hospital	$ 19,711,674	$ 8,496,417	$ 8,475,538
Inpatient	$ 14,509,423	$ 7,855,843	$ 5,536,156
Outpatient	$ 5,152,982	$ 626,935	$ 2,937,129
Nursing Facilities	$ 74,887	$ 72,893,016	$ 234,375
Physician and Other Practitioners	$ 7,693,727	$ 1,472,266	$ 4,865,223
Prescription Drugs	$ 10,770,743	$ 779,161	$ 7,626,360
Behavioral Health	$ 4,053,033	$ 292,271	$ 4,243,317
PRTF	$ 1,685,821	$ -	$ 734,521
Dental	$ 1,038,882	$ 189,620	$ 794,784
Other	$ 6,749,931	$ 13,695,099	$ 7,902,272
GRAND TOTAL	**$ 51,778,699**	**$ 97,817,849**	**$ 154,929,180**

Identifying Interest Areas for Future Examination

The data presented in this report led to the identification of some high-level factors in Wyoming Medicaid that deserve further examination. These factors will be refined and investigated in depth prior to the next report, which will include the results of this deeper investigation and specific options to accompany each factor that is determined to be a "cost driver."

At this stage in the analysis, the areas that appear to be the most worthy of deeper examination include (but are not limited to):

Table 12. Interest Areas for Future Examination

INTEREST AREA	RATIONALE
Top 5% and 15% Recipients	• These recipients represent over 80% of the total annual expenditures in Wyoming Medicaid. • The number of recipients in these categories is small compared to all Medicaid recipients, so identifying opportunities for change may be greater.
Aged, Blind, or Disabled Programs	• These programs (including the Institutions, the Waivers, and SSI Sub-groups) represent nearly 60% of all annual expenditures in Wyoming Medicaid, yet they serve only 17% of the Medicaid recipient population. • Some of these programs and sub-groups have seen consistent growth in the past four years in expenditures, recipients, and/or cost per recipient. • The state has relatively more control over how some of these programs (e.g., Waivers) are administered than other areas of the Medicaid system.
Pregnant Women's Programs	• This program has seen growth of 23% in expenditures and 13% in cost per recipient over the past four years, although the number of people served has decreased. It also represents 7% of the overall Medicaid budget.
Children's Programs	• While Children overall do not appear to be driving costs (showing a 4% decrease in cost per recipient over the past four years), there appear to be sub-groups that bear additional scrutiny.
Service Areas	• Service areas and specific services will be examined based on recipient growth, cost per recipient growth, and overall cost growth.

The areas identified above are based on large, categorical factors that were easily visible in the data that is presented in this report. These areas do not represent a final list of cost drivers, but rather an initial look at the large areas in Wyoming Medicaid that deserve dedicated research and directed data analysis. This ongoing analysis will involve examining each Program and/or Sub-group from the highest, aggregate level (all recipients grouped together) down to the individual recipient level. In Report Two, individual providers, services, and geographic patterns of service utilization and cost will be examined in more detail. There will also be a focus on the top 5% and the next 15% costliest recipients in each area of interest.

PART SIX: CURRENT COST CONTAINMENT IN WYOMING MEDICAID

Prior to concluding Report One of the Medicaid Options Study, it is necessary to make clear that the WDH takes the stewardship of state funds for the healthcare of its program recipients seriously. As was discussed in the introduction of this report, WDH is committed to scrutinizing its Medicaid system to ensure the administration of a high value healthcare system.

However, it is important to differentiate between proper management of the Medicaid system, and overall growth of expenditures. An efficiently and effectively run Medicaid system will still experience cost growth over time due primarily to guaranteed eligibility and overall medical cost inflation. While Wyoming Medicaid includes multiple layers of protection from the misuse of funds, fraud, abuse and inappropriate payments, it is still constantly looking for ways to better manage its costs, control fraud and abuse and limit inappropriate use and payments.

This Part summarizes the current cost containment efforts in Wyoming Medicaid, and where possible quantifies the money saved by these efforts.[16] A complete discussion of cost containment efforts and activities, along with further explanation of costs saved or avoided has been included as Appendix A. The major areas of cost containment effort are:

- **Health management participation and savings**: Due primarily to disease management efforts, the system saved an estimated $48,622,145 for calendar year 2011.

- **Claims processing savings**: This layer of defense disallows claims due to multiple filters and edits.

- **Program integrity**: Recovered $1,016,929 in claim payments for SFY 2011 and serves as future deterrent to fraud.

- **Utilization management**: Utilization management avoided $1,154,498 in costs in calendar year 2011. Utilization reviews help control improper utilization and helps indicate whether other processes related to controlling utilization are working effectively.

- **Third party liability and estate recovery**: Total cost avoidance and recoveries for all third-party liability and estate recovery functions was $17,382,105 for SFY2011.

- **Prescription Drug Management Program**: The documentable savings from Medicaid's prescription drug management program generated an estimated savings of approximately $24,136,166 per year (FFY 2010/SFY 2011).

[16] Challenges include the combining information for State Fiscal Year, calendar year, and Federal Fiscal Year. Also, some programs are run internally, externally from private contractors and/or in cooperation with the federal government. Some savings for 2011 are estimated based on previous years.

- **Other efforts**: $8,231,433 was attributable to certain rate changes, the Pregnancy by Choice waiver, and adopting national methodology for certain medications. Other rate changes, system changes and decisions could not be quantified but may have led to further savings for the system.

2011 Cost Containment Summary

Cost containment efforts that could be quantified for 2011 equaled approximately $100,197,993.

PART SEVEN: CONCLUSION AND FUTURE REPORTS

Conclusion

As the cost of healthcare continues to rise, the need to understand the array of options available for healthcare system design becomes more urgent. In order to identify a design option that will benefit the system, however, it is important to understand the components of that system. Before the WDH recommends a new design or redesign within Wyoming Medicaid, it must understand Wyoming Medicaid data, and more specifically, what is driving costs in Wyoming Medicaid.

In this report, the WDH has identified areas within Wyoming Medicaid that deserve further examination. These areas include, but are not limited to: the top 5% and 15% recipients, the Aged, Blind or Disabled programs, the Pregnant Women program, the Children's program, and the high cost/high growth Service Areas. For the many reasons discussed in Part Five of this report, these areas will be examined in greater depth over the coming months.

The next phase of this study will include the analysis of providers, procedures, client sub-groups, conditions/treatments, and utilization rates. Ultimately, the aim of this intensive work is the identification of specific cost drivers that can be reasonably addressed by Wyoming Medicaid. The results of this analysis, along with an evaluation of potential options for design or redesign, will be presented in the Report Two (due October 1, 2012).

The continued goal of the WDH is to identify the best possible approaches to operating a high quality Medicaid system in the most cost efficient manner. To attain this goal, it is imperative that stakeholder input is sought and considered. Therefore, a robust plan for obtaining and analyzing stakeholder input will be executed throughout the next two phases of this study.

The efforts made in the first two phases of this study (resulting in Reports One and Two) are necessary so that the WDH, in Report Three, may present its recommended options and suggested action plan for modification or redesign of Wyoming Medicaid.

APPENDIX A: CURRENT COST CONTAINMENT IN WYOMING MEDICAID

It is important to differentiate between proper management of the Medicaid system, and overall growth of expenditures. An efficiently and effectively run Medicaid system will still experience cost growth over time due primarily to the guaranteed eligibility nature of the program and overall medical cost inflation. However, the Wyoming Department of Health takes its stewardship of state funds for the health care of clients very seriously and manages the system as sustainably as possible. In addition, Wyoming Medicaid includes multiple layers of protection from the misuse of funds, fraud, abuse and inappropriate payments. This section explains the current cost containment efforts in Wyoming Medicaid, and where possible quantifies the money saved by these efforts.[17] The major areas of effort are:

- **Health management participation and savings**: Due primarily to disease management efforts, the system saved an estimated $48,622,145 for calendar year 2011.

- **Claims processing savings**: This layer of defense disallows claims due to multiple filters and edits.

- **Program integrity**: Recovered $1,016,929 in claim payments for SFY 2011 and serves as future deterrent to fraud.

- **Utilization management**: Utilization management avoided $1,154,498 in costs in calendar year 2011. Utilization reviews help control improper utilization and helps indicate whether other processes related to controlling utilization are working effectively.

- **Third party liability and estate recovery**: Total cost avoidance and recoveries for all third-party liability and estate recovery functions was $17,382,105 for SFY2011.

- **Prescription Drug Management Program**: The documentable savings from Medicaid's prescription drug management program generated an estimated savings of approximately $24,136,166 per year (FFY 2010/SFY 2011).

- **Other efforts**: $8,231,433 was attributable to certain rate changes, the Pregnancy by Choice waiver, and adopting national methodology for certain medications. Other rate changes, system changes and decisions could not be quantified but may have led to further savings for the system.

[17] Challenges include the combining information for State Fiscal Year, calendar year, and Federal Fiscal Year. Also, some programs are run internally, externally from private contractors and/or in cooperation with the federal government. Some savings for 2011 are estimated based on previous years.

2011 Cost Containment Summary

Cost containment efforts that could be quantified for 2011 equaled approximately $100,197,993.

Health Management

In July 2004, Wyoming Medicaid began an effort to provide a health management program to the state's entire Medicaid enrollee population. This program promotes compliance with treatment plans, healthy lifestyle choices and modifications, education and social support to equip clients with the decision making tools they need to improve their quality of life and health.

Health management promotes cost containment in two components:

1. Chronic disease and catastrophic illness component.
    a. Provides direct and immediate savings by assuring that medical treatment is appropriate, timely and cost-effective.
2. Wellness and prevention component.
    a. Education and culture change to promote the role of personal responsibility, self-management, and lifestyle choices in maintaining good health.
    b. Long-term savings from clients that will be less costly over their lifetimes due to healthier choices and greater independence.

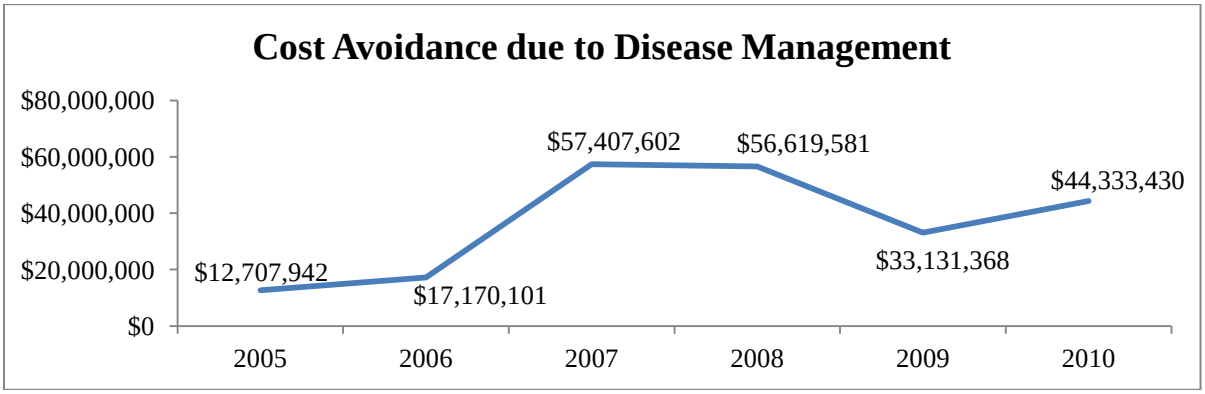
The chronic disease and catastrophic illness component assists clients to develop the personal and social skills required to make positive health behavior choices. Nurse counseling reinforces information from the clients' healthcare providers and assist clients in incorporating behavior changes into their daily healthcare and lifestyle decisions. Clinical interventions are also continuously reinforced through printed, web-based and verbal education and support.

In a rural state like Wyoming, it is sometimes a difficult task to provide access and appropriate care due to geography and limited health care access. The health management program provides support to all Medicaid clients in the form of a telephone-based care manager or a health coach.

The chronic disease and catastrophic illness component identifies clients that are appropriate for the program, identifies the highest risk patients using claims data, and develops health plans to support clinical interventions. Additional services include one-on-one health coaching, a 24/7 toll-free line with access to a nurse, and remote health management and vital sign monitoring via a telephone line. These methods are supported with general and illness-specific education materials, and resource support to eliminate obstacles outside of healthcare such as transportation. Complex care management is used for specific conditions, including cancer, trauma, congenital disease, multiple sclerosis, behavioral health, psychosocial needs and other conditions which require more intensive management by nurses.

The chronic disease and catastrophic illness component generates quantifiable savings primarily from disease management, and inpatient cost avoidance.

Disease management seeks to reduce the cost per member per month in the disease management program. For instance, in 2010 the per member per month cost with disease management was $390 less than would be expected without disease management based on comparison to a baseline per member per month trend established before the beginning of the program. This savings per month multiplied times 113,440 member months equals total savings in calendar year 2010 of $44,333,430. The chart below shows the increase of savings since the program started in 2005. Savings for calendar year 2011 were not yet available and were estimated for this use based on the average of 2008-2010 actual savings.



Inpatient cost avoidance is based on reducing the rate of inpatient admissions per member month. Based on this measure, the program avoided 463 inpatient admissions in 2011 at a cost per inpatient admission of $8,489 for a total savings in 2011 of $3,927,352.

2011 Savings

Disease Management*	$ 44,694,793
Inpatient Cost Avoidance (2011 Actual)	$ 3,927,352
Total Savings Calculated for 2011	$ 48,622,145

**3 year actual average 2008-2010, used for 2011 estimate.*

The wellness and prevention component also provides wellness and prevention education and activities for the entire Medicaid population, such as healthy diet, smoking cessation and increased physical activity. The goals of wellness and prevention activities are:

1. Encouraging individuals to practice habits that support ongoing health and vitality.
2. Improving clients' effectiveness in self-management of their health problems to reduce unnecessary or avoidable use of emergency services.
3. Promoting wellness and prevention education to prevent or delay chronic diseases and disabling conditions.

Claims Processing

Medicaid claims must be paid to enrolled providers on behalf of eligible clients for services provided to Medicaid clients covered by the program. The Medicaid Management Information System (MMIS) claims processing system performs functions for claims entry, payment, payment denial, editing and auditing, recipient eligibility, provider eligibility, exception control review, pricing, Third Party Liability, Medicare Coordination of Benefits, prior authorization, utilization review, suspension for claims review, duplicate services verification, reimbursement determination, quality control and verification of required attachments.

The Wyoming MMIS has filters that prevent billing of inappropriate claims and ineligible transactions. This is a strong first layer that eliminates the majority of most problem claims. It restricts certain procedure codes from being billed with other procedures codes or with certain diagnosis codes. Wyoming Medicaid recently added National Correct Coding Initiative filtering as well. This added more than a million additional "code-to-code" combinations that are not paid if billed together. The system also has several claims sorting functions which identify patterns and trends for accepted claims and eliminate more claims that do not meet Medicaid criteria.

In addition, there is a separate system for prescription drug claims processing. The Pharmacy Benefits Management System (PBM) provides real time claims adjudication or denial to the pharmacy, as well as prior authorizations.

Program Integrity

In SFY 2011, the Program Integrity Unit opened 365 cases, reviewed $8.8 million in claims, and recovered $1,016,929 in claims from providers. This is the highest number of claim reviews ever completed. These reviews send a message to the provider community that Wyoming Medicaid is serious about looking for fraud and abuse. This message translates to future cost containment by deterring fraudulent billings.

The Program Integrity Unit uses numerous reports and models to assist in cost containment to detect sudden increases or decreases in provider or client payment activity, and common billing problems and schemes. Program Integrity takes complaints and referrals from clients, providers and state personnel regarding any possible issues. These issues often lead to recoveries or system changes that help contain costs.

The Enterprise Fraud and Abuse Detection System gives the Unit the ability to run claims data to look for suspicious patterns. Wyoming Medicaid also monitors national illegal billings schemes to see if the same billing schemes are happening in Wyoming. Wyoming coordinates with surrounding states on fraud prevention efforts and to identify providers that may have fraud and abuse issues in other states.

The Program Integrity Unit requires current licensing/certification, ownership verification and checks against multiple databases before any provider can be enrolled to ensure Wyoming Medicaid is not enrolling sanctioned or otherwise unqualified providers.

The Centers for Medicare and Medicaid Services also has federal programs that assist Wyoming Medicaid in looking for fraud. The Federal Payment Error Rate Measurement (PERM) program reviews approximately 500 claims in detail for documentation and billing errors every three years, and does follow-up reviews with providers for additional documentation if issues are noted. The Medicaid Integrity Contractors program uses third-party contractors to audit Wyoming claims data on a more regular basis and has audited nine providers in Wyoming to date. Wyoming Medicaid will soon begin services with a Recovery Audit Contractor, which is another audit program that seeks to recover fraudulent payments identified through audits.

The Wyoming Department of Family Services is responsible for reviewing and pursuing potential client eligibility fraud.

Utilization Management Reviews

Utilization management review is a federal requirement for participation in Medicaid and is closely monitored by the Centers for Medicare and Medicaid Services. The goal of utilization management review is to reduce inappropriate utilization of services while allowing the individual to obtain services which best meet their health care needs. Utilization management review activities are conducted both by a contractor and internally by Wyoming Medicaid staff.

In reviewing admissions, procedures and services, utilization management review evaluates:

- Medical necessity of an admission, continued stay or course of treatment or service.
- Adequacy of the discharge plan in relation to a client's capabilities and resources.
- Efficiency of the use of health care services, procedures and facilities under the provisions of the Wyoming Medicaid State Plan and Statutes.

Federal regulations require Medicaid programs to review any service (admission or procedure) where it is anticipated or known that the service could either be over or underutilized, or otherwise abused by providers or clients. Utilization management focuses on services that could easily result in excessive Medicaid costs if left uncontrolled.

Contracted utilization management focuses on managing the length of stay in psychiatric residential treatment facilities (PRTFs) as this care is occurring. The average stay was reduced from 80.3 days in 2010 to 71.5 in 2011. This average length of stay change translates into 3,597 fewer days spent in PRTF facilities overall, which at $321 per day equals a savings of $1,154,498.

Wyoming Medicaid also conducts utilization reviews with internal staff. In SFY 2011, a sample of 408 provider claims was reviewed. In total, $2,065,218 worth of claims was reviewed, with $0 identified as recoveries, and $0 recovered. This tends to indicate that other processes such as preapproval reviews and coding filtering are working as intended.

Third Party Liability and Estate Recovery

The Wyoming Medicaid Third Party Liability and Estate Recovery Unit functions to keep Medicaid as the payer of last resort, taking all reasonable measures to determine the obligation of other liable parties responsible for claims payment before Medicaid. Examples of liable third-parties are health insurance companies, absent parents, court-ordered restitution cases, casualty carriers, recipients and workers' compensation.

During SFY 2011 third-party liability efforts led to costs avoided of $13,016,102, health insurance and Medicare recoveries of $1,237,439, third-party subrogation/casualty recoveries of $1,589,474, and estate recoveries of $1,539,091.

Total cost avoidance and recoveries for all third-party liability and estate recovery functions were $17,382,105 in SFY2011.

Medicaid, in cooperation with its fiscal agent and the Wyoming Attorney Generals Office, continue to strive to improve the effectiveness and efficiency of cost avoidance, third party recovery, and estate recovery. In recent years, the unit has been strengthening its working relationships with other Wyoming State agencies both as potential third-party payers and as sources of information. Collaborations with outside entities such as casualty carriers, attorneys, County Clerks Offices, and major health insurance companies have also been successful. By fostering and further developing these relationships, Medicaid achieves greater success with third-party recovery and cost avoidance.

When these collaborative and voluntary methods are not effective, the Attorney General's Office may become involved to pursue civil judgments. Wyoming Medicaid also is currently using a collection agency to recover overpayments from five providers.

Prescription Drug Management Program

The total documentable savings from Medicaid's Prescription Drug Management program were approximately $23,790,823 in SFY 2011/FFY 2010.

The implementation of Prior Authorization in 2002 and the Preferred Drug List in 2004 led to $5,115,660 in cost-avoidance for SFY 2011.

The prescription drug management program recovers drug rebates for certain physician administered drugs from drug manufacturers. In January 2008, Wyoming joined the Sovereign States Drug Consortium, a syndicate of seven states working together to negotiate additional rebates to enhance the savings Wyoming realizes in addition to federal rebates. For SFY 2011, $1,332,259 of federal drug manufacturer rebates were collected, and an additional $1,373,012 was collected through the Sovereign States Consortium.

State Maximum Allowable Cost pricing sets reimbursement amounts for therapeutically equivalent drug products, based on actual product cost. The use of State Maximum Allowable Cost pricing contributed $4,417,554 to overall cost-avoidance for SFY 2011.

The Mandatory Generic Program began November 1, 2005 and requires the use of generic drugs over a brand name drug, when appropriate. The overall generic substitution rate increased from 56% in SFY 2007 to 72% in SFY 2010 for all paid pharmacy claims. The generic use rate for all paid pharmacy claims in SFY 2011 was 74%.

The Drug Utilization Review program reviews utilization of outpatient prescription drugs to ensure Wyoming Medicaid recipients are receiving appropriate, medically necessary medications that are not likely to result in adverse effects. A Pharmacy & Therapeutics Committee reviews evidence regarding the comparative safety and efficacy of specific classes of medications. This committee provides critical clinical input when creating and expanding the Preferred Drug List. Wyoming also has a Psychiatrist Advisory Board who continually provides focused recommendations regarding utilization of psychiatric medications for all Wyoming Medicaid recipients.

For FFY 2010, prospective drug utilization review at the point of sale resulted in cost avoidance of more than $11.4 million.

In FFY 2010, through the review of aggregated claims data, 523 letters were mailed to medical providers regarding 381 individual patient cases to alert providers to potential prescription drug utilization issues. The letters notified providers of possible drug-disease interactions (40%), potential drug-drug interactions (38%), and drug overutilization (16%). This intervention realized $152,338 in cost-avoidance.

Pharmacy program integrity efforts have included the pharmacy lock-in program which supports appropriate use of narcotic pain medications and pharmacy-specific fraud and abuse detection. The pharmacy lock-in program is intended to prevent Medicaid recipients from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

In January 2011, the 2nd Opinion Contract with the University of Washington went into place. This contract allows for medication review by a child psychiatrist when prescribed medications exceed the parameters referred to as “Too Much, Too Many, Too Young”.

Other Initiatives Implemented For Reducing Costs

- End-Stage Renal Disease methodology changed to reflect a "Medicare-like" payment, reducing payments from 70% of billed charges to 24% of billed charges.

- Inpatient reimbursement was rebased to better distribute payments among in-state providers by reducing out of state outliers. Outliers were modified to reduce outlier payments. New levels of care were created to establish set payments for more defined services (Neonatal Intensive Care Unit, Rehabilitation)

- Preadmission screening and resident reviews for psychosocial patients were changed to a flat fee instead of per time unit.

- Outpatient payment rates have been held budget neutral since 2009.

- Nursing home rates have not changed since 2009.

- Added prior authorization requirements to all durable medical equipment/prosthetics/orthotics codes with a reimbursement of $1,000 and up.

- All medically unnecessary, non-emergency ambulance codes were closed.

- Assisted with updating Psychiatric Residential Treatment Facilities criteria to comply with federal policy and guidelines, as well as ensuring only medically necessary admissions into psychiatric residential treatment facilities in 2011.

- Dis-enrolled all residential treatment centers that had been receiving a Medicaid per diem rate, to comply with Federal inpatient psychiatric facility policy and guidelines.

- Reviewing all specialized, high-cost equipment internally, rather than sending and paying for peer review.

- Reduced the Ambulatory Surgical Center reimbursement from 80% to 70%.

- Medicare Relative Value Units (RVUs) were implemented through Resource-Based Relative Value Scale (RBRVS) August 1, 2009. This resulted in a reduction of $4.8 million dollars for SFY 2010.

- Family Planning Waiver saves the State approximately $2,780,993 annually.

- Implemented a requirement for providers to bill Medicare before Medicaid.

- Placed approximately 20 dental procedure codes on a review process that allows the dental manager to review and approve or deny the service and to obtain an agreement for the services at an acceptable rate.

- Placed over 200 additional procedures on prior authorization for medical necessity.

- Implemented the American Academy of Pediatrics criteria for the proper and effective use of Synagis in infants for the prevention of Respiratory Syncytial Virus with the following results:

Year	# of Prescriptions	Dollars Spent
2010	967	$ 1,815,607
2011	719	$ 1,439,291
2012	587	$ 1,165,167

  From 2010 to 2012, the number of prescriptions for Synagis dropped from 967 to 587, for a savings in 2012 of $650,440 as compared to 2010.

- Strengthened criteria for utilization management of developmental disability requests for enhanced staffing, often requiring second opinions.

APPENDIX B: MEDICAID ELIGIBILITY MATRIX

Wyoming Medicaid and Selected State Programs

The following table provides an overview of the Wyoming Medicaid and selected state programs. It includes information on basic eligibility requirements, income limits, Resource limits, and also special provisions that must be considered. It should be noted that Citizenship, Identity, Residency and Social Security Number (SSN) are basic eligibility requirements for Medicaid for most programs. If you have specific questions on these items please refer to the Eligibility Online Manual at http://ecom.health.wyo.gov or contact a member of the Medicaid Eligibility Unit.

Group	Mandatory Optional or State	Benefits	MMIS Code	EPICS Code	Description	Basic Requirements			Special Provision
						Basic Eligibility Requirement	Income Limit	Resource Limit	
Children									
Newborn									
Newborns	M	Full Medicaid coverage	A53	TY	Newborn	Mother eligible for Medicaid at time baby is born			Up to 13 months of coverage
Low Income Children									
Low Income Children Ages 0-5	M	Full Medicaid coverage	A55	BA	Baby 0 through 5 yrs	Ages 0-5	133% FPL	No Resource Test	12 months continuous coverage
Low Income Children Ages 6 - 18	M	Full Medicaid coverage	A58	CI	Child 6 through 18 yrs	Ages 6-18	100% FPL	No Resource Test	12 months continuous coverage
Family Care									
Family Care Child	M	Full Medicaid coverage	A04	MD	Family Care < 21	Child under age 19 w/ eligible adult	Family Care Standard 1996	No Resource Test	12 months continuous coverage
Family Care Child - 4 Month Extended Medical	M	Full Medicaid coverage	A60	4M	4 Month Extended Medical < 21	Child under age 19 w/ eligible adult	Child support increase exceeds Family Care Standard in 1996	No Resource Test	Additional 4 months coverage
Family Care Child - 12 Month Extended Medical	M	Full Medicaid coverage	A67	12	12 Month Extended Medical < 21	Child under age 19 w/ eligible adult	Earned income increase exceeds Family Care Standard in 1996	No Resource Test	Child receives additional 12 months continuous coverage
Foster Care									
IV-E Foster Care	M	Full Medicaid coverage	A51	FC	IV-E Foster Care	DFS Custody under Age 18	Family Care Standard	No Resource Test	Must be in DFS Custody. Initially the family income and Resources count
IV-E Subsidized Adoption	M	Full Medicaid coverage	A52	IV	IV-E Adoption	IV-E Subsidized Adoption under age 21		No Resource Test	
State Foster Care	O	Full Medicaid coverage	A85	RC	Foster Care	DFS Custody under age 21	No income limit	No Resource Test	Must be in DFS Custody can not be in parents home
State Subsidized Adoption	O	Full Medicaid coverage	A86	RA	Subsidized Adoption	Subsidized Adoption under age 21	No income limit	No Resource Test	
Foster Care Zero Through the Age of Five	M	Full Medicaid coverage	A97	FA	Foster Care 0 through 5 yrs	DFS Custody under age 6	133% FPL	No Resource Test	If in parent home count family income must be in DFS custody
Foster Care Six Through the Age of 18	M	Full Medicaid coverage	A98	FI	Foster Care 6 through 18 yrs	DFS Custody age 6 - 18	100% FPL	No Resource Test	If in parent home count family income must be in DFS custody
Continuous Foster Care	O	Full Medicaid coverage	S63	CF	Continuous Foster Care <19	Child who loses Foster Care but remains eligible for the 12 Continuous Months Period			
Foster Care Aging Out	O	Full Medicaid coverage	A88	FE	Aging Out Foster Care	Aged out of foster care 18-20	Children 0-5 133% FPL	No Resource Test	Must be in DFS custody on 18th Birthday
Basic Foster Care	State	Full Medicaid coverage	A96	FR	Basic Foster Care	Under age 21	Children 0-5 133% FPL	No Resource Test	Must be in DFS Custody
Institutional Foster Care	State	Full Medicaid coverage	A99	FT	Institutional Foster Care	Under age 21	No income limit	No Resource Test	Must be in DFS Custody
Pending Foster Care	State	Full Medicaid coverage	A95	FM	Pending Foster Care	Under age 21	No income limit	No Resource Test	Must be in DFS Custody

Pregnant Women

Pregnant Woman

Poverty Level Pregnant Women	M	Full Medicaid Coverage	A71 A72	PW PW	Pregnant Woman <21 Pregnant Woman >21	Pregnancy self declared	133% FPL	No Resource Test	Coverage limited to pregnancy plus 60 days postpartum - unborn child included in determining family size
Qualified Pregnant Women	M	Full Medicaid Coverage	A73 A74	PQ PQ	Qualified PW >21 Qualified PW <21	Pregnancy self declared - requires mother to cooperate with child support after birth of child	Family Care Standard set in 1996 -current estimate 36% FPL	No Resource Test	Coverage is limited to pregnancy plus 60 days postpartum - unborn child included in determining family size

Presumptive Eligibility

Presumptive Eligibility	O	Outpatient services pending Medicaid eligibility determination	A19	No EPICS Code	Presumptive Eligibility	Pregnancy self declared	133% FPL	No Resource Test	Up to 61 days of coverage - limited to US Citizens

Family Care Adult

Adult

Family Care Adult	M	Full Medicaid coverage	A03	MD	Family Care > 21	Child under 19 living in the HH	Family Care Standard set in 1996 $560/ Family of 3	No Resource Test	
Family Care Adult - 4 Month Extended Medical	M	Full Medicaid coverage	A76	4M	4 Month Extended Medical > 21	Child under 19 living in the HH	Family Care Standard set in 1996 $560/ Family of 3	No Resource Test	Additional 4 months coverage
Family Care Adult - 12 Month Extended Medical	M	Full Medicaid coverage	A68	12	12 Month Extended Medical > 21	Child under 19 living in the HH	Family Care Standard set in 1996 $560/ Family of 3	No Resource Test	Over 185% FPL 6 months coverage for adult - child receives 12 months; Under 185% FPL 12 months coverage for child and adult

Aged, Blind and Disabled - Institution

SSI

SSI	M	Full Medicaid Coverage	S12 S20 S21 S31 S36 S37 S39 S48 S49 S92	SI BC BN SI DA GK 69 ZB ZB WS	SSI Eligible > 65 Blind Receiving SSI Payment Blind Not Receiving SSI Payment SSI Eligible < 65 Disabled Adult Child (DAC) Goldberg-Kelly 1619 Zebley > 21 Zebley < 21 Widow - Widowers SDX	Eligibility determined by SSA	SSI Payment Standard $698/mo single $1,048/mo couple	Individual $2,000 Married $3,000	Eligibility determined by SSA
Continuous SSI/IPH	O	Full Medicaid coverage	S62	CS	Continuous SSI/IPH <19	Child who loses SSI but remains eligible for the 12 Continuous Months Period			

SSI Related

SSI Related	M	Full Medicaid Coverage	S09 S16 S38 S42	SD PP PP WW	SSI-Disabled Child Definition PICKLE > 65 PICKLE < 65 Widow-Widowers	Must have lost SSI	SSI Payment Standard $698/mo single $1,048/mo couple	Individual $2,000 Married $3,000	Eligibility determined by DFS

Nursing Home

Nursing Home	O O M M O O	Full Medicaid Coverage	S01 S02 S10 S32 S11 S33	NC NC NM NM N3 N3	Full Med + NH services Full Med + NH services Nursing Home SSI > 65 Nursing Home SSI < 65 Nursing Home 300% CAP > 65 Nursing Home 300% CAP < 65	Must meet medical necessity	300% SSI Payment Standard $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance	Requires patient contribution
Nursing Home	M	Medicaid Services Only No Room and Board	S54 S55	NO NO	Med Only transfer penalty >65 Med Only transfer penalty < 65	Must meet medical necessity	300% SSI Payment Standard $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance $113,640	Requires patient to private pay.

SLSC									
Nursing Home	State	Covers NH Room and Board Only	S26 S27	NS NS	State Licensed Shelter Care > 65 State Licensed Shelter Care < 65	Must meet medical necessity	Income Above 300% SSI Payment Standard $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance	Requires patient contribution - must be in process of setting up Income Trust
Hospital									
Inpatient Hospital	O	Full Medicaid Coverage	S14 S15 S34 S35	II H3 II H3	Institutional - Hosp > 65 Inpatient Hospital 300% > 65 Institutional - Hosp < 65 Inpatient Hospital 300% < 65	Must meet 30 days of Acute Hospital Care	300% SSI Payment Standard $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance $113,640	Requires patient contribution
Hospice									
Hospice	O	Covers Hospice, Waiver and Physician Services	S50 S51	HO HO	Hospice Care >65 Hospice Care < 65	Must meet medical necessity	300% SSI Payment Standard $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance	
ICF MR									
ICF MR	M O M O	Full Medicaid Coverage	S03 S04 S05 S06	NT NW NT NW	ICF-MR SSI > 65 ICF-MR 300% CAP > 65 ICF-MR SSI < 65 ICF-MR 300% CAP < 65	Must meet medical necessity	300% SSI Payment Standard $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance	Requires patient contribution. Resides in State Training School.
IMD 65+									
IMD 65+	O	Full Medicaid Coverage	S13	IP	Inpatient - Psych > 65		300% SSI Payment Standard $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance $113,640	Resides in State Training School.
Aged, Blind and Disabled - Home and Community Based Waivers									
DD Child									
Developmental Disabilities Children's Waiver	O	Full Medicaid Coverage + Waiver Services	S93 S94	DC DK	DD Waiver SSI < 21 DD Waiver 300% CAP <21	Must meet medical necessity - birth through 20 years of age	300% SSI Payment Standard $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance	
Continuous Developmental Disabilities Children's Waiver	O	Full Medicaid coverage	S64	CD	Continuous Developmental Disabilities Children's Waiver <19	Child who loses Developmental Disabilities Children's Waiver but remains eligible for the 12 Continuous Months Period			
DD Adult									
Developmental Disabilities Adult Waiver	O	Full Medicaid Coverage + Waiver Services	S22 S23 S44 S45	NI ND NI ND	DD Waiver SSI > 65 DD Waiver 300% CAP > 65 DD Waiver SSI 21 - 65 DD waiver 300% CAP 21 - 65	Must meet medical necessity - 21 years of age or older	300% SSI Payment Standard $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance $113,640	

ABI									
Acquired Brain Injury Waiver (ABI)	O	Full Medicaid Coverage + Waiver Services	B01 B02	BI B3	ABI Waiver SSI ABI Waiver 300% CAP	Must meet medical necessity - 21 years of age or older	300% SSI Payment Standard $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance $113,640	
ALF									
Assisted Living Facilities Waiver (ALF)	O	Full Medicaid Coverage + Waiver Services	R01 R02 R03 R04	RL R3 RL R3	ALF Waiver SSI < 65 ALF Waiver 300% CAP < 65 ALF Waiver SSI > 65 ALF Waiver 300% CAP > 65	Must meet medical necessity	300% SSI Payment Standard $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance $113,640	Must be able to pay room and board
Long Term Care									
Long Term Care Waiver	O	Full Medicaid Coverage + Waiver Services	S24 S25 S46 S47	NE NA NE NA	LTC Waiver SSI > 65 LTC Waiver 300% CAP > 65 LTC Waiver SSI < 65 LTC Waiver 300% CAP <65	Must meet medical necessity. Over 19 years of age	300% SSI $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance $113,640	
Children's Mental Health									
Children's Mental Health Waiver	O	Full Medicaid Coverage + Waiver Services	S95 S96	MC MK	Children's Mental Health Waiver < 21 Children's Mental Health Waiver 300% CAP < 21	Must meet medical necessity - ages 4 through 20	300% SSI Payment Standard $2,094/mo	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance	
Continuous Children's Mental Health Waiver	O	Full Medicaid Coverage	S65	CM	Continuous Children's Mental Health Waiver <19	Child who loses Children's Mental Health Waiver but remains eligible for the 12 Continuous Months Period			
Special Groups									
Breast and Cervical									
Breast and Cervical	O	Full Medicaid Coverage	B03 B04	TA TA	Breast and Cervical > 21 Breast and Cervical < 21	No creditable insurance coverage - screened and diagnosed under WY BCC/EDP	250% FPL	No Resource Test	
Tuberculosis									
Tuberculosis	O	Full Medicaid coverage except Inpatient Services	S52 S53	TB TB	Tuberculosis (TB) > 65 Tuberculosis (TB) < 65	Verify diagnosis of TB	$698/mo single $1,048/mo couple	Individual $2,000 Married $3,000 (on initial, if both are applying use most beneficial) Spousal Allowance $113,640	

EID									
Employed Individuals with Disabilities (EID) (AKA Medicaid Buy In)	O	Full Medicaid coverage	S56 S57 S58 S59 S60	TW TW T2 T3 T4	EID > 21 EID < 21 DD Waiver w/ EID < 21 DD Waiver w/ EID > 21 ABI Waiver w/ EID < 65	Person with a disability (SSA Guidelines) who is employed - ages 16 through 64	300% SSI Payment Standard $2,094/mo (unearned income)	No Resource Test	Requires payment of premium of 7.5% of earned and unearned income per month $50 disregard
Continuous Employed Individuals with Disabilities (EID) (AKA Medicaid Buy In)	O	Full Medicaid coverage	S61	CE	Continuous EID <19	Child who loses EID eligibility but remains eligible for the 12 Continuous Months Period.			
Pregnant By Choice									
Pregnant By Choice	O	Services Limited to Family Planning	A20	FP	Pregnant By Choice	Must be between the ages of 19 and 44	133% FPL	No Resource Test	Must apply during 60 day post partum period - cannot be eligible for another Medicaid program or have other health insurance
Medicare Savings Programs									
Qualified Medicare Beneficiary									
Qualified Medicare Beneficiary (QMB)	M	Payment of Medicare premiums, deductibles and coinsurance	Q17 Q41	QM QM	QMB > 65 QMB < 65	Must be entitled to Medicare Part A and Part B	100% FPL 1- $908 2- $1,226	Single $6,940 Couple $10,410	
Specified Low Income Beneficiary									
Specified Low Income Beneficiary (SLMB)	M	Payment of Medicare Part B Premium	Q94 Q95 Q96 Q97	QT QT QS QS	SLMB 2 > 65 SLMB 2 < 65 SLMB 1 > 65 SLMB 1 < 65	Must be entitled to Medicare Part A and Part B	QT 121-135% FPL 1- $1,225 2- $1,665 QS 101-120% FPL 1- $1,225 2- $1,665	Single $6,940 Couple $10,410	
Non Citizens with Medical Emergencies									
Non Citizens									
Non Citizen	M	Emergency Services Only; Includes labor and delivery	A81 A84	ES ES	Emergency Svc < 21 Emergency Svc > 21	Must meet all eligibility factors under a Medicaid group, except for Citizenship, Identity and SSN			
Prescription Drug Assistance Program									
PDAP									
Prescription Drug Assistance Program	State	3 Prescriptions per month	A90 A91	MP MP	State only PDAP > 21 State only PDAP < 21	WY Resident	100% FPL 1- $931 2- $1,261	Resources $2,500	Must be screened for other Medicaid programs. No insurance coverage for Prescriptions.

FPL - Monthly Income Chart – May be Revised in April 2012			Family Care Standard - 1996	
Family Size	100% FPL	133% FPL	Family Size	
1	931	1239	1	362
2	1261	1677	2	512
3	1591	2116	3	590
4	1921	2555	4	659

SSI Standard is updated in January of each year.

revised 12/5/2011

APPENDIX C: 2012 INCOME LIMITS IN DOLLARS PER YEAR

This income table was created for the purpose of this report only to illustrate income in dollar amounts per year. Income is shown for up to a family of four for the sake of presentation, income limits generally continue to increase with family size. Certain programs may have specific additional income disregards, in-kind contribution exclusions and limits, resource limits and spousal resource exclusions and limits that are not shown here for the sake of clarity. More details on specific eligibility can be seen in the Medicaid Eligibility Matrix, and specific program eligibility rules are available from Wyoming Medicaid on request.

Department of Health and Human Services

2012 Federal Poverty Guideline Income Limit Per Year

Family Size	1	2	3	4
100% Federal Poverty Level	$ 11,170	$ 15,130	$ 19,090	$ 23,050
120% Federal Poverty Level	$ 13,404	$ 18,156	N/A	N/A
133% Federal Poverty Level	$ 14,856	$ 20,123	$ 25,390	$ 30,657
135% Federal Poverty Level	$ 15,080	$ 20,426	N/A	N/A
185% Federal Poverty Level	$ 20,665	$ 27,991	$ 35,317	$ 42,643
250% Federal Poverty Level	$ 27,925	$ 37,825	$ 47,725	$ 57,625

http://aspe.hhs.gov/poverty/12poverty.shtml

Family Care Income Standard- (AFDC/1931)

Wyoming Income Limit Per Year based on Wyoming's July 1996 AFDC/1931 eligibility levels

Family Size	1	2	3	4
Unemployed	$ 4,344	$ 6,144	$ 7,080	$ 7,908
Employed w/ $200 per month disregard	$ 6,744	$ 8,544	$ 9,480	$ 10,308
Employed w/ $400 per month disregard	$ 9,144	$ 10,944	$ 11,880	$ 12,708

The dollar amounts of this income standard have not changed since 1996, except for the earned income disregard. The earned income disregard is based on household composition and marital status.

Supplemental Security Income (SSI) Program Rates

	Single	Couple
100% SSI	$ 8,376	$ 12,576
300% SSI	$ 25,128	$ 37,728

http://www.ssa.gov/policy/docs/quickfacts/prog_highlights/RatesLimits2012.pdf
http://www.ssa.gov/policy/docs/quickfacts/prog_highlights/index.html

APPENDIX D: WYOMING MEDICAID CO-PAYMENTS

Type of Service	Co-Payment Amount	Exceptions
• Office Visits Procedure codes: 99201-99215 (The $2.00 co-payment only applies to these office visit codes when the place of service code is 11) • Home Visits Procedure codes: 99341-99350 • Eye Examinations Procedure codes: 92002, 92004, 92014 • Medical psychotherapy Procedure codes: 90804-90815 (The $2.00 co-payment only applies to these medical psychotherapy codes when the place of service code is 11) • Rural Health Clinic Encounters Procedure code: T1015 and Revenue code: 0521 • Federally Qualified Health Center Encounters Procedure code: T1015 and Revenue code: 0520	$2.00	Co-payment requirements do not apply to: • Recipients under age 21 • Nursing Facility Residents • Pregnant Women • Family Planning Services • Emergency Services • Hospice Services • Medicare Crossovers
Outpatient Hospital Visits (non-emergency) Revenue Codes: 450-459 and 510-519	$3.40	
Prescription Drugs	Generics (multisource medications) $1.00 All brand-name medications $3.00	Co-payment requirements do not apply to: • Recipients under age 21 • Nursing Facility Residents • Pregnant Women • Family Planning Services • Emergency Services • Hospice Services
Prescription Drug Assistance Program (PDAP) – State Funded	Generic Brand $10.00 Brand Name $25.00	

APPENDIX E: EXPANDED DATA TABLES 2, 3, 4, AND 5

EXPANDED TABLE 2: Medicaid Program Expenditures from SFY2008 - SFY2011

Medicaid Programs	SFY 2008 Total Cost	SFY 2009 Total Cost	SFY 2010 Total Cost	SFY 2011 Total Cost	% Change 2008 to 2011
Aged, Blind, & Disabled[2]	*273,275,975*	*286,595,762*	*294,955,422*	*304,200,528*	*11.3%*
AB&D - SSI & SSI Related	39,972,290	47,176,829	49,752,880	51,778,699	29.5%
AB&D - Institution	92,829,101	93,465,666	99,262,201	97,492,649	5.0%
AB&D - HCBS	140,474,585	145,953,267	145,940,342	154,929,180	10.3%
Children	125,791,334	$ 141,944,877	$ 144,436,791	$ 138,125,451	9.8%
Pregnant Women	31,734,766	32,434,251	36,184,905	36,079,605	13.7%
Family Care	23,729,222	26,869,319	28,237,011	29,097,326	22.6%
Other[3]	*6,922,610*	*8,579,964*	*10,006,378*	*11,365,176*	*64.2%*
Special Groups	1,813,034	1,989,091	2,435,092	3,677,006	102.8%
AB&D - EID	1,290,343	1,963,343	2,805,685	2,720,263	110.8%
Medicare Savings Programs	1,945,317	2,447,998	2,562,625	3,007,075	54.6%
Non Citizens	1,873,916	2,179,533	2,202,976	1,960,832	4.6%
Grand Total	**$ 461,453,908**	**$ 496,424,173**	**$ 513,820,507**	**$ 518,868,086**	12.4%

2The AB&D Subtotal line is the sum of the AB&D-SSI, AB&D-Institution, and AB&D HCBS lines.

[3]The Other Subtotal line is the sum of the Special Groups, AB&D-EID, Medicare Savings Programs, and Non Citizens lines.

EXPANDED TABLE 3: Medicaid Program Recipients[1] from SFY2008 - SFY2011

Medicaid Programs	SFY 2008 # of Recipients	SFY 2009 # of Recipients	SFY 2010 # of Recipients	SFY 2011 # of Recipients	% Change 2008-2011
Aged, Blind, & Disabled[2]	*12,034*	*13,272*	*13,493*	*12,970*	*7.8%*
AB&D - SSI & SSI Related	5,628	5,789	5,935	6,099	8.4%
AB&D - Institution	3,187	3,086	2,914	2,843	-10.8%
AB&D - HCBS	4,269	4,397	4,644	4,722	10.6%
Children	43,791	45,366	48,300	49,966	14.1%
Pregnant Women	6,766	6,694	6,388	6,122	-9.5%
Family Care	6,407	6,535	6,622	6,942	8.4%
Other[3]	*2,788*	*3,150*	*3,426*	*3,676*	*31.9%*
Special Groups	228	296	570	690	202.6%
AB&D - EID	110	187	223	252	129.1%
Medicare Savings Programs	1,857	2,098	2,154	2,324	25.1%
Non Citizens	598	569	479	418	-30.1%
Grand Total	**69,343**	**75,017**	**78,229**	**77,207**	11.3%

[1]Recipients are presented as unduplicated counts for each program. A client may be in more than one program in a given year; therefore, the subtotals should not be added together by hand. They will not equal the Grand Total.

2The AB&D Subtotal line is unduplicated calculation of AB&D-SSI, AB&D-Institution, and AB&D HCBS lines.

[3]The Other Subtotal line is the unduplicated calculation of Special Groups, AB&D-EID, Medicare Savings Programs, and Non Citizens lines.

EXPANDED TABLE 4: Medicaid Program Cost Per Recipient from SFY2008 - SFY2011

Medicaid Programs	SFY 2008 Cost per Recipient	SFY 2009 Cost per Recipient	SFY 2010 Cost per Recipient	SFY 2011 Cost per Recipient	% Change 2008-2011
Aged, Blind, & Disabled[2]	*22,709*	*21,594*	*21,860*	*23,454*	*3.3%*
AB&D - SSI & SSI Related	7,102	8,149	8,383	8,490	19.5%
AB&D - Institution	29,127	30,287	34,064	34,292	17.7%
AB&D - HCBS	32,906	33,194	31,426	32,810	-0.3%
Children	$ 2,873	3,129	2,990	$ 2,764	-3.8%
Pregnant Women	4,690	4,845	5,665	5,893	25.7%
Family Care	3,704	4,112	4,264	4,191	13.2%
Other[3]	*2,483*	*2,724*	*2,921*	*3,092*	*24.5%*
Special Groups	7,952	6,720	4,272	5,329	-33.0%
AB&D - EID	11,730	10,499	12,582	10,795	-8.0%
Medicare Savings Programs	1,048	1,167	1,190	1,294	23.5%
Non Citizens	3,134	3,830	4,599	4,691	49.7%
Grand Total	**$ 6,655**	**$ 6,617**	**$ 6,568**	**$ 6,720**	1.0%

2The AB&D Subtotal line is the overall calculation of AB&D-SSI, AB&D-Institution, and AB&D HCBS lines.

[3]The Other Subtotal line is the overall calculation of Special Groups, AB&D-EID, Medicare Savings Programs, and Non Citizens lines.

EXPANDED TABLE 5: Percent Change from SFY2008 - SFY2011

Medicaid Programs	Expenditures 2008-2011	Recipients 2008 -2011	Cost per Recipient 2008-2011	% of Total Expenditures
Aged, Blind, & Disabled[2]	*11.3%*	*7.8%*	*3.3%*	*58.6%*
AB&D - SSI & SSI Related	29.5%	8.4%	19.5%	10.0%
AB&D - Institution	5.0%	-10.8%	17.7%	18.8%
AB&D - HCBS	10.3%	10.6%	-0.3%	29.9%
Children	9.8%	14.1%	-3.8%	26.6%
Pregnant Women	13.7%	-9.5%	25.7%	7.0%
Family Care	22.6%	8.4%	13.2%	5.6%
Other[3]	*64.2%*	*31.9%*	*24.5%*	*2.2%*
Special Groups	102.8%	202.6%	-33.0%	0.7%
AB&D - EID	110.8%	129.1%	-8.0%	0.5%
Medicare Savings Programs	54.6%	25.1%	23.5%	0.6%
Non Citizens	4.6%	-30.1%	49.7%	0.4%
Grand Total	**12.4%**	**11.3%**	**1.0%**	**100.0%**

2The AB&D Subtotal line represents the overall calculation of AB&D-SSI, AB&D-Institution, and AB&D HCBS lines.

[3]The Other Subtotal line represents the overall calculation of Special Groups, AB&D-EID, Medicare Savings Programs, and Non Citizens lines.

APPENDIX F: MEDICAID PROGRAM SUB-GROUPS DETAIL TABLE

Medicaid Program Sub-Groups Details: SFY2008-2011

Primary Medicaid Programs	Sub-Groups	SFY 2008 Total Cost	SFY 2011 Total Cost	SFY 2008 # of Recipients	SFY 2011 # of Recipients	SFY 2008 Cost per Recipient	SFY 2011 Cost per Recipient	SFY11 % of Total Expenditures
		Aged, Blind, & Disabled						
AB&D - SSI	SSI	$ 39,730,317	$ 51,657,770	5,576	6,052	$ 7,125	$ 8,536	10.0%
	SSI Related	241,972	120,929	62	55	3,903	2,199	0.0%
AB&D - SSI		**$ 39,972,290**	**$ 51,778,699**	**5,628**	**6,099**	**$ 7,102**	**$ 8,490**	**10.0%**
AB&D - Institution	Hospice	191,512	330,490	19	46	10,080	7,185	0.1%
	Hospital	8,124,236	7,040,443	155	167	52,414	42,158	1.4%
	ICF MR (WY Life Resource Center)	8,302,233	9,620,321	84	75	98,836	128,271	1.9%
	IMD (WY State Hospital - Age 65 & Over)	325	120	1	1	325	120	0.0%
	Nursing Home	76,210,794	80,501,275	3,004	2,611	25,370	30,832	15.5%
AB&D - Institution Total		**$ 92,829,101**	**$ 97,492,649**	**3,187**	**2,843**	**$ 29,127**	**$ 34,292**	**18.8%**
AB&D - HCBS	Acquired Brain Injury (ABI)	7,023,426	8,523,960	184	186	38,171	45,828	1.6%
	Assisted Living Facility (ALF)	3,255,179	3,497,432	236	255	13,793	13,715	0.7%
	Children's Mental Health	194,797	2,880,820	13	175	14,984	16,462	0.6%
	DD Adult	87,154,078	89,250,838	1,348	1,392	64,654	64,117	17.2%
	DD Child	20,164,385	21,511,828	827	831	24,383	25,887	4.1%
	Long Term Care (LTC)	22,682,721	29,264,302	1,783	1,993	12,722	14,684	5.6%
AB&D - HCBS Total		**$ 140,474,585**	**$ 154,929,180**	**4,269**	**4,722**	**$ 32,906**	**$ 32,810**	**29.9%**
Children	Children	15,184,352	17,093,676	9,580	9,862	1,585	1,733	3.3%
	Foster Care	29,853,256	22,927,263	3,381	3,346	8,830	6,852	4.4%
	Low Income Children (Ages 0-18)	50,197,027	67,132,166	29,998	36,261	1,673	1,851	12.9%
	Newborn	30,556,699	30,972,346	7,518	7,082	4,064	4,373	6.0%
Children Total		**$ 125,791,334**	**$ 138,125,451**	**43,791**	**49,966**	**$ 2,873**	**$ 2,764**	**26.6%**
Pregnant Women	Pregnant Women	31,576,973	35,868,513	6,504	6,011	4,855	5,967	6.9%
	Presumptive Eligibility	157,794	211,092	505	699	312	302	0.0%
Pregnant Women Total		**$ 31,734,766**	**$ 36,079,605**	**6,766**	**6,122**	**$ 4,690**	**$ 5,893**	**7.0%**
Family Care Adults	Presumptive Eligibility	23,729,222	29,097,326	6,407	6,942	3,704	4,191	5.6%
Family Care Adults Total		**$ 23,729,222**	**$ 29,097,326**	**6,407**	**6,942**	**$ 3,704**	**$ 4,191**	**5.6%**
		Other Programs						
Special Groups	Breast and Cervical	1,805,619	3,571,513	227	265	7,954	13,477	0.7%
	Family Planning Waiver	n/a	105,492	n/a	427	n/a	247	0.0%
	Tuberculosis	7,415	n/a	1	0	7,415	n/a	0.0%
Special Groups Total		**$ 1,813,034**	**$ 3,677,006**	**228**	**690**	**$ 7,952**	**$ 5,329**	**0.7%**
AB&D - EID	EID	1,290,343	2,720,263	110	252	11,730	10,795	0.5%
AB&D - EID Total		**$ 1,290,343**	**$ 2,720,263**	**110**	**252**	**$ 11,730**	**$ 10,795**	**0.5%**
Medicare Savings Programs	Part B - Partial AMB	320	240	3	2	107	120	0.0%
	Qualified Medicare Beneficiary	1,930,932	2,981,091	1,722	2,163	1,121	1,378	0.6%
	Specified Low Income Medicare Beneficiary	14,065	25,745	135	162	104	159	0.0%
Medicare Savings Programs Total		**$ 1,945,317**	**$ 3,007,075**	**1,857**	**2,324**	**$ 1,048**	**$ 1,294**	**0.6%**
Non Citizens	Non Citizens	1,873,916	1,960,832	598	418	3,134	4,691	0.4%
Non Citizens Total		**$ 1,873,916**	**$ 1,960,832**	**598**	**418**	**$ 3,134**	**$ 4,691**	**0.4%**
Grand Total		**$ 461,453,908**	**$ 518,868,086**	**69,343**	**77,207**	**$ 6,655**	**$ 6,720**	**100.0%**

N/A: Change between SFY08 and SFY11 could not be calculated because these programs began (or ended) after SFY08.

APPENDIX G: MEDICAID PROGRAMS BY SERVICE AREA

Table 11. SFY 2011 Expenditures: Medicaid Programs by Service Area*

Service Areas	AB&D - SSI & SSI Related	AB&D - Institution	AB&D - HCBS	Children	Pregnant Women	Family Care
HCBS Waiver Services			$ 120,052,789			
Adult DD Waiver			$ 81,368,423			
Child DD Waiver			$ 14,131,328			
LTC Waiver			$ 13,912,443			
ABI Waiver			$ 6,964,560			
ALF Waiver			$ 2,757,459			
Children's MH Waiver			$ 918,577			
Hospital	$ 19,711,674	$ 8,496,417	$ 8,475,538	$ 42,983,084	$ 16,693,230	$ 12,289,928
Inpatient	$ 14,509,423	$ 7,855,843	$ 5,536,156	$ 32,492,700	$ 13,897,860	$ 6,881,145
Outpatient	$ 5,152,982	$ 626,935	$ 2,937,129	$ 10,478,466	$ 2,793,969	$ 5,419,615
Nursing Facilities	$ 74,887	$ 72,893,016	$ 234,375	$ 179	$ -	$ -
Physician and Other Practitioners	$ 7,693,727	$ 1,472,266	$ 4,865,223	$ 25,793,962	$ 15,493,938	$ 6,561,615
Prescription Drugs	$ 10,770,743	$ 779,161	$ 7,626,360	$ 15,961,115	$ 788,872	$ 3,937,970
Behavioral Health	$ 4,053,033	$ 292,271	$ 4,243,317	$ 14,506,956	$ 275,197	$ 1,337,961
PRTF	$ 1,685,821	$ -	$ 734,521	$ 12,987,125	$ -	$ -
Dental	$ 1,038,882	$ 189,620	$ 794,784	$ 9,717,651	$ 510,815	$ 1,298,189
Other	$ 6,749,931	$ 13,695,099	$ 7,902,272	$ 16,175,379	$ 2,317,553	$ 3,671,663
GRAND TOTAL	**$ 51,778,699**	**$ 97,817,849**	**$ 154,929,180**	**$ 138,125,451**	**$ 36,079,605**	**$ 29,097,326**

Service Areas	Special Groups	AB&D - EID	Medicare Savings Programs	Non- Citizens	*Gross Adjustment*	Total
HCBS Waiver Services						***$ 120,052,789***
Adult DD Waiver						$ 81,368,423
Child DD Waiver						$ 14,131,328
LTC Waiver						$ 13,912,443
ABI Waiver						$ 6,964,560
ALF Waiver						$ 2,757,459
Children's MH Waiver						$ 918,577
Hospital	$ 1,708,513	$ 1,185,561	$ 1,504,187	$ 1,263,672	$ 41,411	$ 114,353,216
Inpatient	$ 789,253	$ 834,481	$ 561,559	$ 1,198,795	$ -	$ 84,557,214
Outpatient	$ 919,261	$ 350,500	$ 943,955	$ 64,877	$ -	$ 29,687,689
Nursing Facilities	$ -	$ -	$ 68,810	$ -	*$ (90,935)*	$ 73,180,333
Physician and Other Practitioners	$ 1,283,611	$ 499,470	$ 848,893	$ 663,655	*$ (11,314)*	$ 65,165,045
Prescription Drugs	$ 403,564	$ 682,872		$ -	*$ (86,508)*	$ 40,864,150
Behavioral Health	$ 31,851	$ 100,569	$ 81,227	$ -	*$ (5,230)*	$ 24,917,152
PRTF	$ -	$ -	$ -	$ -	*$ (162,855)*	$ 15,244,613
Dental	$ 30,034	$ 36,051	$ 107		*$ 449*	$ 13,616,583
Other	$ 219,433	$ 215,740	$ 503,850	$ 33,504	*$ 228,373*	$ 51,712,797
GRAND TOTAL	**$ 3,677,006**	**$ 2,720,263**	**$ 3,007,075**	**$ 1,960,832**	***$ (86,609)***	**$ 519,106,677**

**The Grand Total represented in this table will not match the totals in other tables due to the use of a different data path.*

The information is accurate based on the best available methodology and data.

APPENDIX H: MEDICAID OPTIONS STUDY INTERNAL WORK GROUP MEMBERS

Name	Position	Division
Thomas O. Forslund	Director	Director's Office
Lee Clabots	Deputy Director	Director's Office
Teri Green	Senior Administrator and State Medicaid Agent	Healthcare Financing
Chris Newman	Senior Administrator	Behavioral Health
Dr. Wendy E. Braund	Senior Administrator and State Health Officer	Public Health
April Getchius	Senior Administrator	Aging
Bob Peck	Chief Financial Officer	Director's Office, Fiscal
Meredith Asay	Administrator, Director's Unit for Policy, Research and Evaluation (DUPRE)	Director's Office, DUPRE
Dr. Mindy Dahl Chai	Senior Research Scientist	Director's Office, DUPRE
Jesse Springer	Policy Advisor	Director's Office, DUPRE
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Jan Stall	Eligibility and Operations Administrator	Healthcare Financing
Kim Latta	Waivers and Program Coordinator	Healthcare Financing
Susie Scott	KidCare CHIP Manager	Healthcare Financing

END NOTES

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