Annual Report

SFY 2016

Wyoming Medicaid

Matthew H. Mead, Governor
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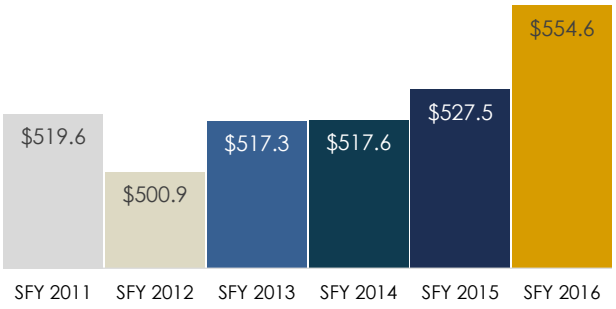
SFY 2016 Medicaid *At a glance*

EXPENDITURES

$554,583,138

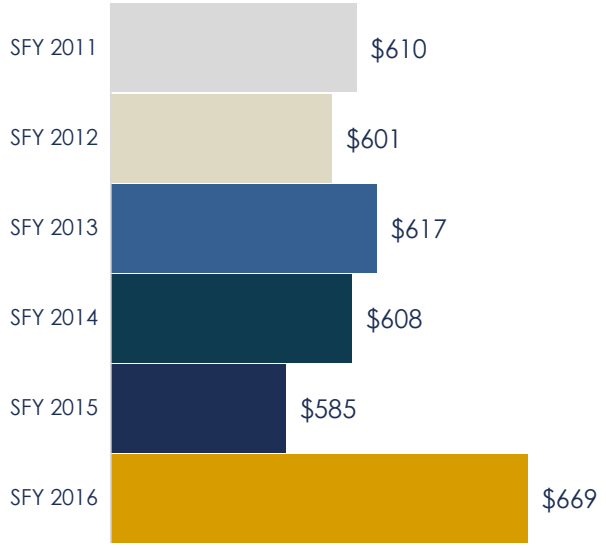
Paid in Claims during SFY 2016



PER MEMBER PER MONTH

$669

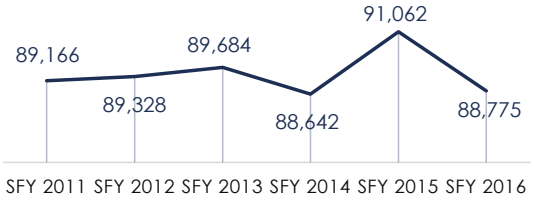
Preliminary estimate for SFY 2016



ENROLLMENT

88,775

Unique members for total SFY 2016



SERVICE UTILIZATION

Percent of Total SFY 2016 Expenditures

55% $303,594,435
MEDICAL

42% $208,759,250
LONG-TERM CARE

3% $15,450,029
DENTAL

1% $3,652,188
VISION

0.2% $894,268
OTHER

RECIPIENTS

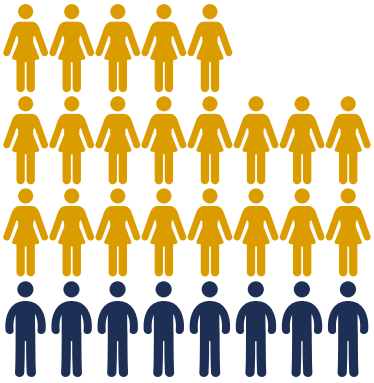
75,000

Enrolled members with claims paid in SFY 2016

58%

42%

64%
age 0–20



29%
age 21–64

7%
age 65+

WHAT SERVICES DID RECIPIENTS USE?

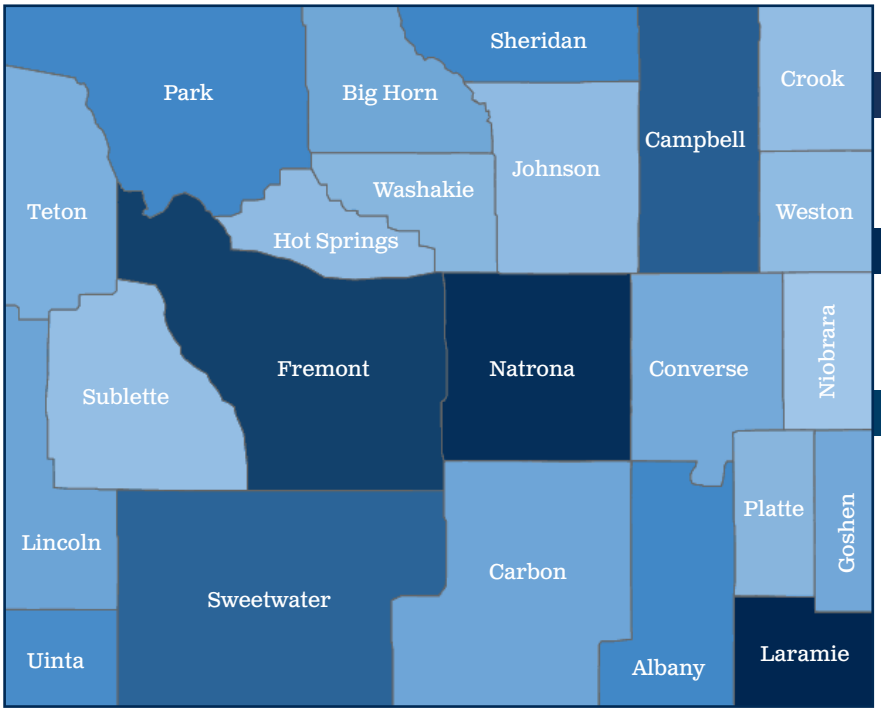
82% physician & other practitioner

59% prescription drug

55% hospital

42% dental

COUNTY ENROLLMENT



Laramie 17%
15,016

Natrona 15%
13,301

Fremont 11%
9,918

WY Medicaid Background

Wyoming Medicaid is a joint federal and state government program that pays for medical care for low income and medically needy individuals and families. The Wyoming Department of Health (WDH), Division of Healthcare Financing (DHCF) is the state-appointed entity for administration of Wyoming Medicaid. DHCF partners with the Fiscal Division for accounting and budgeting services, and with the Behavioral Health Division for the administration of waivers that serve persons with developmental disabilities or acquired brain injuries.

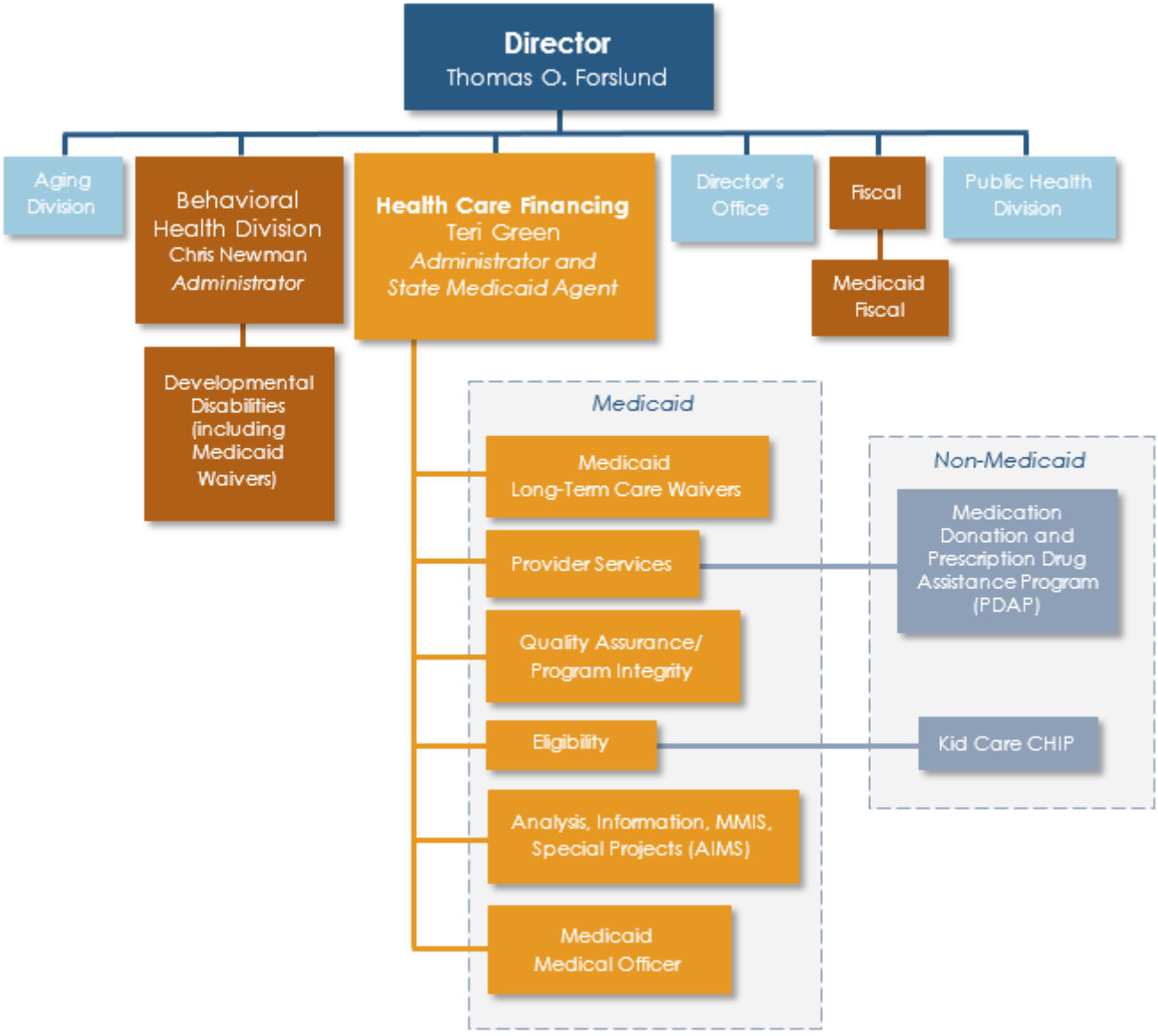


Figure 1. Wyoming Department of Health Organization Chart

This Annual Report focuses on the $554.6 million in claims expenditures for Medicaid benefits in SFY 2016 processed through the Medicaid Management Information System (MMIS). Table 1 and Figure 2 address other Healthcare Financing Division expenditures in SFY 2016, such as administrative costs, capital investment, the Kid Care CHIP program and non-Medicaid programs.

Table 1. Division of Healthcare Financing Budget

Medicaid Related Expenditures	
Expenditure Type	SFY 2016 (millions)
Annual Report Benefit Expenditures (this report)[1]	$554.6
Medicaid Administration	$40.5
Nursing Facilities Tax Assessment	$29.9
Hospital Qualified Rate Adjustment (QRA) Payments	$22.8
Medicare Buy-In	$14.9
Medicaid One-Time Capital Expenses for New Technology Systems (WES, MMIS, Other)	$16.5
Medicare Clawback (Part D)	$11.6
Physician Electronic Health Record (EHR) Incentives	$1.1
Other[2]	-$8.4
Subtotal Medicaid Expenditures	**$683.5**
Drug Rebates	-$31.4
Total Medicaid Expenditures	**$652.1**
Non-Medicaid Expenditures	
Children's Health Insurance Program (CHIP)	$9.8
CHIP Administration	$0.5
State Only Foster Care and General Fund Foster Care (Court Orders)	$2.4
Prescription Drug Assistance Program (PDAP)	$0.2
Total Health Record (Health Information Exchange (HIE))	$2.2
State Only Other	$0.6
Total Non-Medicaid Expenditures	**$15.7**
Total Division of Healthcare Financing	**$667.8**

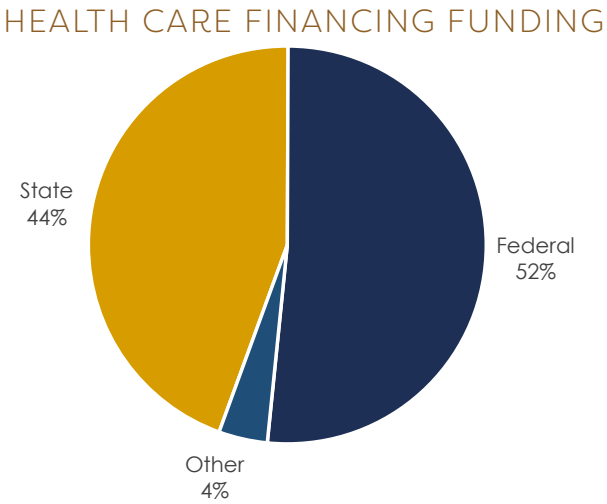


Figure 2. Health Care Financing Funding

Wyoming Medicaid benefits expenditures generally receive 50 percent Federal match (FMAP), while other expenditure types, such as administration and capital investment, may receive higher levels of funding (75 and 90 percent, respectively) from Federal sources. Some expenditures, such as Hospital QRA payments and the nursing facility tax, have no state expenditures and are funded by providers (50 percent FMAP, 50 percent Provider contribution). The Kid Care CHIP program received 65 percent enhanced FMAP, while state-only funded programs are 100 percent State General Funds.

[1] Includes reductions in expenditures due to recoveries processed through the MMIS.
[2] Adjustment to reflect timing difference related to drug rebate and claims differences between WOLFs and MMIS claims data.

Advisory groups and committees offer independent guidance and provider industry expertise to the Medicaid program.

Table 2. Wyoming Medicaid Advisory Groups and Committees

Advisory Group	Members	Description
Dental Advisory Group (DAG)	Two specialists, three general dentists, and representatives from Medicaid and its fiscal agent, Xerox.	Represents a wide range of interests, experience, dental specialties and various areas of the state, while advising Medicaid regarding administration of the dental program.
Long-Term Care Advisory Group	Nursing Home Association leadership, five nursing home providers, a home health provider, a hospice provider, an assisted living provider, a Long-Term Care waiver case manager, and an Independent Living Center representative	Focuses on issues and recommendations with institutional and community-based long-term care providers.
Medical Advisory Group (MAG)	Wyoming Hospital Association, Wyoming Medical Society, executives from hospitals throughout Wyoming, physicians, and medical practitioners	Focuses on new and upcoming issues within the healthcare industry, member concerns, and relevant presentations. Works to develop solutions to issues.
Pharmacy & Therapeutics Committee (P&T)	Six physicians, five pharmacists, one allied health professional.	Provides recommendations regarding prospective drug utilization review, retrospective drug utilization review and education activities to Medicaid

Wyoming Medicaid's Program Integrity unit is tasked with reviewing, auditing, and investigating providers for claims lacking sufficient documentation or incorrect billing. This team manages the associated administrative process, collects recoveries of State funds, as applicable, and ensures the State's compliance to the Federal standards regarding the reduction of Fraud, Waste, and Abuse. The Program Integrity unit oversees recovering funds from third party liability (TPL) and seeking other recoveries, such as Estate, drug (J-code), and credit balances.

Table 3. Medicaid Cost Avoidance and Recoveries - SFY 2016

Program Area	Description	Amount Recovered
Program Integrity	Process of reviewing, auditing, and investigating providers for claims lacking sufficient documentation or incorrect billing.	$350,571
Third Party Liability Recoveries	Funds recovered from other responsible parties which may include Medicare, health insurance companies, worker's compensation, casualty insurance companies, or a spouse/ parent court order to carry health insurance.	$2,474,959
Third Party Liability Cost Avoidance	An estimate of costs not incurred by the State when claims are denied up front due to third party liability. This figure is calculated based on billed charges, not on the final amount Medicaid would have paid -- as the claims are not fully processed once TPL is determined; therefore, this figure is only an estimate and may be inflated. As such, the program integrity team is currently reviewing and auditing their process for calculating this figure.	$15,040,686
Estate Recoveries	Funds recovered from any real or personal property a client had legal title or interest in at the time of death or when s/he took their last breath to the extent of that interest, including such assets conveyed to a survivor heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship life estate, living trust or other arrangement.	$2,582,490
Credit Balances	Moneys recovered from providers whose credits (i.e. take-backs or adjustments) exceed their debits (pay-outs or paid claims).	$131,527
Total Recovered Dollars (excluding Cost Avoidance)		**$5,539,547**
Total Recovered Dollars (including Cost Avoidance)		**$20,580,233**

WYOMING DEMOGRAPHICS & ECONOMY

From 2011 to 2015 the population estimates for Wyoming have increased 3.3 percent, while Medicaid enrollment increased by 1.4 percent. Medicaid enrollment has remained relatively stable during this time period around 15 percent of the total state population.[3]

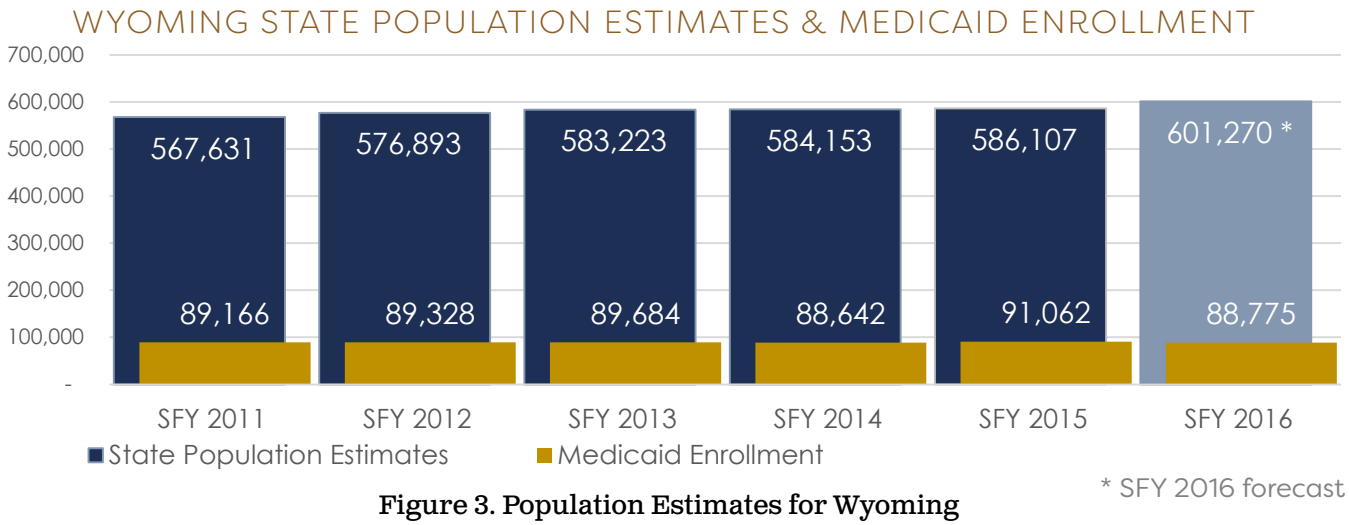


Figure 3. Population Estimates for Wyoming

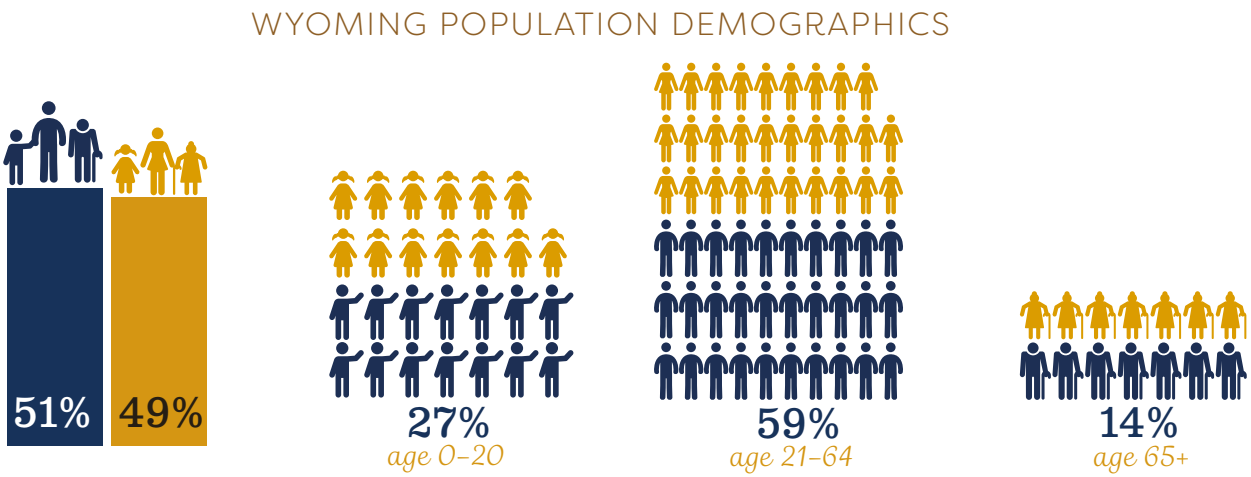


Figure 4. Wyoming Population Demographics

[3] Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2015. Source: U.S. Census Bureau, Population Division. Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2015. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2016. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2016. http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

The unemployment rate in Wyoming continues to remain below the national average, with a seasonally adjusted rate of 5.5 percent as of August 2016[4]. The poverty rate for Wyoming, as of 2015, was 9.8 percent, well below the national average of 13.5 percent[5].

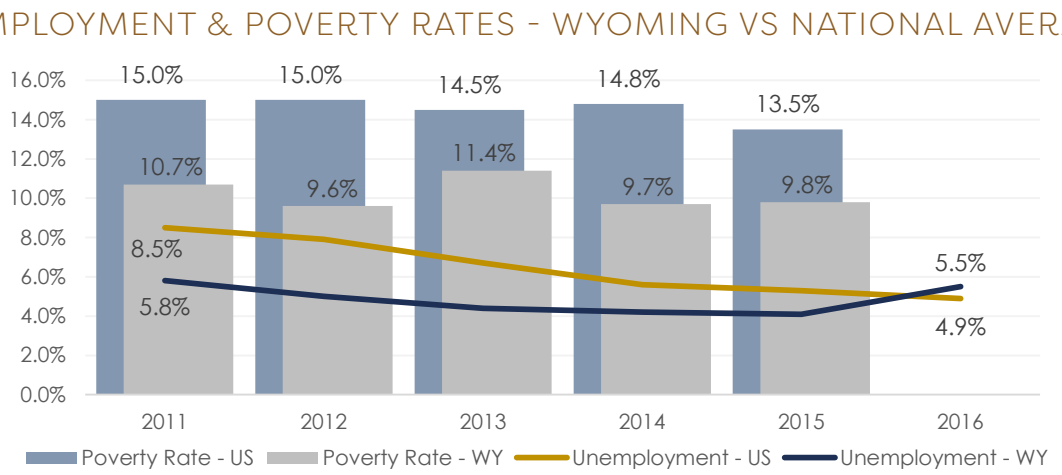


Figure 5. Unemployment and Poverty Rates - Wyoming vs. National Average

Wyoming's overall employment from 2005 to 2015 has increased an estimated 12.8 percent, far exceeding the national average rate of 5.8 percent. Healthcare Practitioners and Technical Occupations employment also out-paced the national average. Growth for Healthcare Support Workers was not as great in Wyoming as it was nationally; however, the mean hourly wage for those workers increased more than the national average during this time.[6,7]

Table 4. Employment and Mean Wages by Occupation

	Employment Total Percent Change 2005 to 2015		Wages Total Percent Change 2005 to 2015		Mean Hourly Wages 2015	
	US	WY	US	WY	US	WY
All Occupations	5.8%	12.8%	27.6%	39.1%	$23.23	$22.04
Healthcare Practitioners & Technical Occupations	22.5%	34.0%	31.5%	38.2%	$37.40	$36.79
Healthcare Support Workers	18.6%	7.0%	23.7%	33.8%	$14.19	$14.45

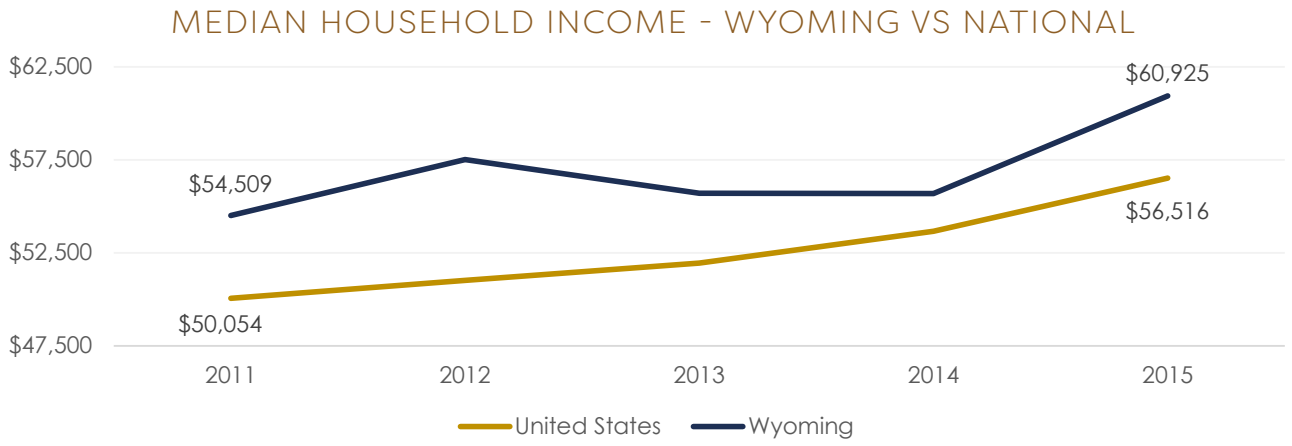


Figure 6. Median Household Income - Wyoming vs National[8]

[4] Senate Joint Economic Committee, State Economic Snapshots, September 22, 2016, http://www.jec.senate.gov/public/_cache/files/b2fb1607-cbaa-4d20-871f-c58170cbf5c0/jec-state-economic-snapshots-september-2016.pdf

[5] Historical Poverty Tables-People and Families, Tables 9, 21: http://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-people.html

[6] Bureau of Labor Statistics, May 2015 State Occupational Employment and Wage Estimates, Wyoming. http://www.bls.gov/oes/current/oes_wy.htm

[7] Bureau of Labor Statistics, May 2015 State Occupational Employment and Wage Estimates, United States. http://www.bls.gov/oes/current/oes_nat.htm

[8] US Census Bureau, Historical Income Table H-8. https://www2.census.gov/programs-surveys/cps/tables/time-series/historical-income-households/h08.xls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Highlights and Initiatives

During SFY 2016, Medicaid implemented a number of changes to meet federal or state government mandates, to meet the specific medical needs of Medicaid individuals and to improve access to care and care options.

Medicaid Reform

Tribal 1115 Waiver

Designed and submitted to CMS

Requests authority to issue facility-based uncompensated care payments

Still awaiting approval

Care Management Entity

Approved by CMS on September 1, 2015

Implemented under formal authority to serve youth between the ages of 4 and 21 with Serious Emotional Disturbance (SED)

Long-Term Care Redesign

NEW LT-101
Prepared for launch of new LT-101 medical assessment on August 1, 2016. Efforts included finalizing design of new assessment tool, modifying technology system, moving to an electronic process, and conducting extensive training statewide.

COMMUNITY CHOICES WAIVER
Submitted application and received approval to add Assisted Living Facility waiver services to the Long-Term Care waiver. Long-Term Care waiver to be renamed the Community Choices Waiver and begin July 1, 2016. Assisted Living Facility to be phased out over time.

NURSING FACILITY REIMBURSEMENT CHANGE
Implemented July 1, 2015. State plan was approved by CMS, and rates were adjusted quarterly based on acuity levels reported through the facilities' MDS data.

Technology

Wyoming Eligibility System

Deloitte

WES Operations & Maintenance

Remaining WES Development

Successfully completed procurement and contracting for new vendors for WES and Customer Service Center (CSC)

Maximus

CSC Operations

Improve CSC Efficiency using new technologies

Both contracts began transition on July 1, 2016, with hand-off complete as of October 1, 2016

Increased WES functionality with completion of State Data Exchange from the Social Security Administration

Completed transition to Electronic Document Management of all Medicaid & Kid Care CHIP eligibility cases.

Long-Term Care unit piloted an Electronic Asset Verification System. Allows staff to search for potential assets not reported by applicants/ clients. Implementing a permanent solution in 2017, as required by CMS.

Allows electronic payments for the State Supplemental Income program, eliminating the need to print and mail

3,500

checks monthly

AFFORDABLE CARE ACT *Impacts*

Medicaid agencies required to:

- Re-enroll all providers (Wyoming's deadline was December 31, 2015)
- Complete enhanced provider screening processes
- Enroll all ordering, referring, prescribing, and attending providers for purposes of validating all treating providers through the enhanced provider screening processes

LEGISLATION

Statutary Clean Up of ACA implementation and transition of Medicaid Eligibility & State Supplemental Payment Program to Wyoming Department of Health

Education services for youth placed in a Psyciatric Residential Treatment Facility through Medicaid covered by Wyoming Department of Education regardless of court-order status

Wyoming Medicaid given authority to submit state plan amendments to design & implement a provider tax assessment program for private hospitals & an IGT/QRA-like program for non-state Government owned nursing facilities

Services of an independently practicing licensed dietitian added to Title 42 for Medicaid Coverage

Quality Assurance & Program Integrity

Behavioral Health Services

- Completed a full self-assessment, as required by CMS, regarding adequacy of coverage for children with autism in need of specialized services. As a result of the review, a state plan was submitted to begin coverage of Applied Behavior Analysis services starting January 1, 2017.
- Kicked off an extensive and in-depth analysis of current behavioral health service reimbursement and cost coverage for facility-based and independent practitioner services.

Payment Error Rate Measurement

- Completed 2015 Payment Error Rate Measurement (PERM) Cycle. Due to ongoing PERM Pilots for Eligibility, implemented in 2014, the 2015 PERM Cycle reviewed claims only. Anticipate returning to the standard Eligibility and Claims PERM Cycle in 2018.

Provider Services

- Participated in the Governor's Health and Human Services (HHS) policy team's workgroup related to the youth who cross systems and receive out-of-home psychiatric services. Program performance summaries were presented at the HHS sub-cabinet's deputy director's meeting.
- Conducted, as required by new federal rule, all appropriate surveys and analyses to complete and submit Wyoming's first access review monitoring plan. Final report made public and submitted to CMS on July 1, 2016.
- Implemented ICD-10 for all providers on October 1, 2015

Program Integrity

- Working with Provider Services to meet new Federal guidelines requiring all states to implement, by June 30, 2017, a system to account for providers with High, Moderate, and Limited risk, and require fingerprint background checks of the High to Moderate risk providers. Also working closely with Division of Criminal Investigations regarding the fingerprinting processes.
- Working to improve efficiency of Fraud, Waste, and Abuse referral processes. New process to be implemented February 1, 2017.

BUDGET Update

The Division of Healthcare Financing was tasked to reduce its 2017-2018 biennium operating budget. The following efforts have been planned and implemented, as of the dates shown, to meet the requested budget reduction.

2015

- Kid Care Chip match increased to 88% — Oct 1

2016

- Service Cap Limits for Occupational/Speech/Physical Therapies
- Enhance Pharmacy Third Party Liability — Jan 1

- Across-the-board Provider Rate Cuts (phased implementation, excludes ID/DD Waivers)
- 5% Reduction Admin Costs
- End Stage Renal Facility now a Tribal Health 638 clinic
- Care Management Entity Rate Update (pending CMS approval)
- Annual LT-101 Evaluation for LTC Waiver
- Changed Financial Management Services Vendor
- J-code rebates on existing and new services (crossovers)
- Reallignment of Dental Code rates to ASCs
- Reset rates for anesthesia, clinical laboratory, radiology — Jul 1

- End Prescription Drug Assistance Program
- End State Licensed Shelter Care Coverage — Aug 1

- Patient Contribution to Swing Bed and Extraordinary Care Clients — Sep 1

- Hold Advisory Group Meetings as Webinars
- Non-payment for Nursing Facility/Swing Bed Reserve Bed Days — Oct 1

2017

- Behavioral Health Service Cap Limits & Prior Authorizations
- Update Pricing Method for Medicare Crossover Claims — Jan 1

- Editing Lines on Encounter-Priced Claims (FQHC/RHC) — Feb 1

- 100% Federal match for IHS/638 Tribal Services (pending approval)
- Home Health Services prior authorization
- J-Code Pricing standardization
- Title 25 Medicaid Coverage of non-IMD Services — Mar 1

- End Employed Individuals with Disabilities Program and Breast/Cerical Cancer Coverage over 100% FPL — Jul 1

Additionally the following measures are also being pursued with implementation dates pending:

- Transition Long-Term Care Waiver and Assisted Living Facility Waiver into new Community First Choice Waiver
- Enhance Fraud, Waste, Abuse and Third Party Liability processes through WINGS project
- Rate reductions for dental codes

WY INTEGRATED NEXT GENERATION SYSTEM

wings

Modules A, B, & C are consulting services to support the WINGS project throughout the transition to the new system

A Testing & Quality Assurance/Quality Control Services
Ensures each project module functions correctly

B Independent Verification & Validation
Certifies system meets all requirements & fulfills intended purpose

C Business Process Re-Engineering & Optimization
Assists in streamlining processes to achieve cost reductions, enhance quality of Medicaid services, and increase efficiency

Enrollment

Medicaid provides medical assistance for low-income and medically vulnerable citizens. There are currently four major categories of eligibility: Children, Pregnant Women, Adults, and Aged, Blind, or Disabled (ABD). Wyoming has not extended optional eligibility to adults under 133% of the Federal Poverty Level (FPL).

88,775
Individuals Enrolled in Medicaid in SFY 2016

↓2.5%
from SFY 2015

Medicaid eligibility is based on residency, citizenship and identity, social security eligibility as verified by social security number, family income and, to a lesser extent, resources and/or health care needs.

Since 1996, Medicaid eligibility has been separate from eligibility for economic assistance to families with dependent children. Twenty years ago, most individuals receiving Medicaid services received cash assistance. The reverse is true today. Today, the vast majority of all individuals enrolled in Medicaid are not receiving any cash assistance.

ENROLLMENT OVERVIEW

There were 88,775 unique individuals enrolled in Medicaid in SFY 2016, a 2.5 percent decrease from SFY 2015.

Individuals may gain and lose eligibility several times throughout the SFY. While some individuals may be eligible for a portion of the year, others retain eligibility throughout the year. As such, the distinct count of enrolled individuals for Medicaid for a complete SFY – regardless of how long they were enrolled – is greater than a point-in-time count of Medicaid enrollment. The table below compares the average monthly enrollment with the distinct count of enrolled members for each SFY.[9]

Table 5. Change in Medicaid Enrollment

	Monthly Average	Percent Change from Previous SFY	Complete SFY	Percent Change from Previous SFY
SFY 2011	69,784	3.5%	89,166	3.2%
SFY 2012	69,610	-0.2%	89,328	0.2%
SFY 2013	69,479	-0.2%	89,684	0.4%
SFY 2014	70,389	1.3%	88,642	-1.2%
SFY 2015	74,628	6.0%	91,062	2.7%
SFY 2016	66,696	-10.6%	88,775	-2.5%

[9] Enrolled Members "Monthly Average" provides an average of the monthly distinct count of individuals enrolled. Enrolled Members 'Complete SFY' is a distinct count of individuals for a complete SFY, July 1 through June 30.

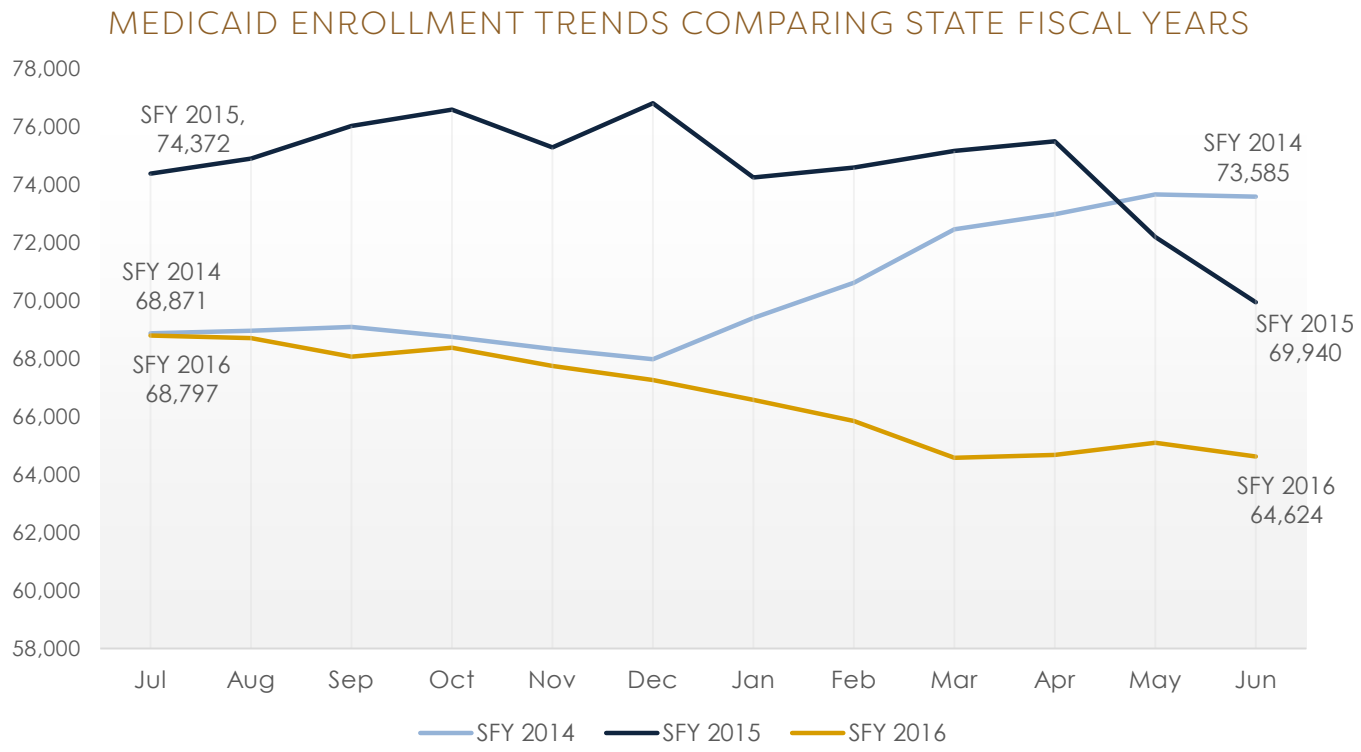


Figure 7. Medicaid Enrollment Trends Comparing State Fiscal Years

Medicaid enrolled members reside in every county in Wyoming, with more than half residing in 5 counties: Laramie (17 percent), Natrona (15 percent), Fremont (11 percent), Sweetwater and Campbell (7 percent each). County 'Other' indicates individuals who were once enrolled in Medicaid but have since moved out of state. County of residence is based on member address at the time the data is extracted.

Table 6. Medicaid Enrollment by County

County	Enrolled Members	Percent of Total	County	Enrolled Members	Percent of Total
Albany	3,859	4.3%	Natrona	13,301	15.0%
Big Horn	2,091	2.4%	Niobrara	376	0.4%
Campbell	6,471	7.3%	Other	3,111	3.5%
Carbon	2,177	2.5%	Park	3,870	4.4%
Converse	1,972	2.2%	Platte	1,264	1.4%
Crook	848	1.0%	Sheridan	3,944	4.4%
Fremont	9,918	11.2%	Sublette	763	0.9%
Goshen	2,048	2.3%	Sweetwater	6,202	7.0%
Hot Springs	897	1.0%	Teton	1,618	1.8%
Johnson	956	1.1%	Uinta	3,623	4.1%
Laramie	15,016	16.9%	Washakie	1,267	1.4%
Lincoln	2,244	2.5%	Weston	939	1.1%
			Total	**88,775**	

ELIGIBILITY CATEGORIES

Federal statutes define individuals who qualify for Medicaid coverage. For this report, these individuals are presented in 11 eligibility categories.

Eligibility is determined using Federal Poverty Level (FPL) guidelines, Supplemental Security Income (SSI) standards, or the 1996 Family Care income standard. In many instances, the guideline or standard used is determined by the federal laws that created each eligibility category. The FPL guidelines and SSI standards are based on an index that changes every year. For detailed information regarding these income requirements, see Appendix C.

Childless adults who do not fit into one of the eligibility categories described below are not currently covered, regardless of income or resources.

Table 7. Eligibility Categories

Eligibility Category	Description
Aged, Blind, or Disabled Employed Individuals with Disabilities (ABD EID)	• Employed individuals with disabilities • Must pay a premium • No Supplemental Security Income eligibility requirement • Income requirement based on SSI standards
Aged, Blind, or Disabled Intellectually Disabled / Developmentally Disabled / Acquired Brain Injury (ABD ID/DD/ABI)	• Children and adults with an intellectual/developmental disability or acquired brain injury • No SSI eligibility requirement • Income requirement based on SSI • Includes residents living in the Intermediate Care Facility for the Intellectually Disabled (ICF-ID) (State training school/WY Life Resource Center)
Aged, Blind, or Disabled Institutional (ABD Institution)	• Residents living in the hospital or WY state hospital (age 65 and older) • Resources are taken into consideration • No SSI eligibility requirement • Income requirement based on SSI

Aged, Blind, or Disabled Long-Term Care (ABD LTC)	• Includes the following clients:
	  • Adults in need of nursing facility level of care, but who have elected to receive services and supports in their home or community
	  • Residents of nursing home
	  • Adults and children receiving hospice care
	• Resources are taken into consideration
	• No SSI eligibility requirement
	• Income requirement based on SSI

Aged, Blind, or Disabled Supplemental Security Income (ABD SSI)	• Disabled individuals receiving SSI automatically qualify • SSI Related - an individual no longer receiving SSI payment may be eligible using SSI criteria
Adults	• Family-Care Adults - adult caretaker relatives with a dependent child; must cooperate with child support enforcement; income requirement based on set values • Newly Eligible Adults - Income requirement based on Federal Poverty Level (FPL) • Former Foster Care - individuals who age out of foster care when they become 18 years old. As of January 1, 2014, former foster care children remain eligible until the age of 26.
Children	• Newborns - automatically eligible if the mother is eligible for Medicaid at the time of the birth • Children - those whose caretaker is eligible for Medicaid; income requirement based on FPL and is dependent on age of the child • Foster Care children - automatically eligible when in the Department of Family Services (DFS) custody, including some children who enter subsidized adoption. The Department of Health also covers medical services for children in foster care who are not eligible for Medicaid. These expenditures are state-funded and tracked separately. • Children's Mental Health Waiver - Children with severe mental health needs

Medicare Savings Programs	• Individuals not eligible in another category and eligible for Medicare
	• Provides premium assistance and, depending on income, cost-sharing assistance
	• Qualified Medicare Beneficiaries (QMB)
	  • Resources also taken into consideration
	  • Medicaid pays for Medicare premiums, deductibles, and cost-sharing
	  • Income requirement based on FPL
	• Specified Low-Income Medicare Beneficiaries (SLMB) and Qualified Individuals
	  • Medicaid pays for Medicare premiums only
	  • Income requirement based on FPL

Eligibility Category *(continued)*	Description
Non-Citizens with Medical Emergencies	• Non-citizen who meets all eligibility factors of a Medicaid group except citizenship and social security number • Emergency services only
Pregnant Women	• Pregnant women • 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, allowing immediate, temporary Medicaid coverage for ambulatory prenatal care and prescription drugs for low income, pregnant patients, pending their formal Medicaid application. • Income requirement based on FPL

Special Groups	• Breast and Cervical Cancer Treatment program
	  • Uninsured women diagnosed with breast or cervical cancer
	  • Income requirement based on FPL
	• Tuberculosis (TB) program
	  • Individuals diagnosed with tuberculosis
	  • Resources also taken into consideration
	  • Income requirement based on SSI
	• Pregnant by Choice Waiver
	  • Family planning services for individuals who received Medicaid benefits through the Pregnant Women program

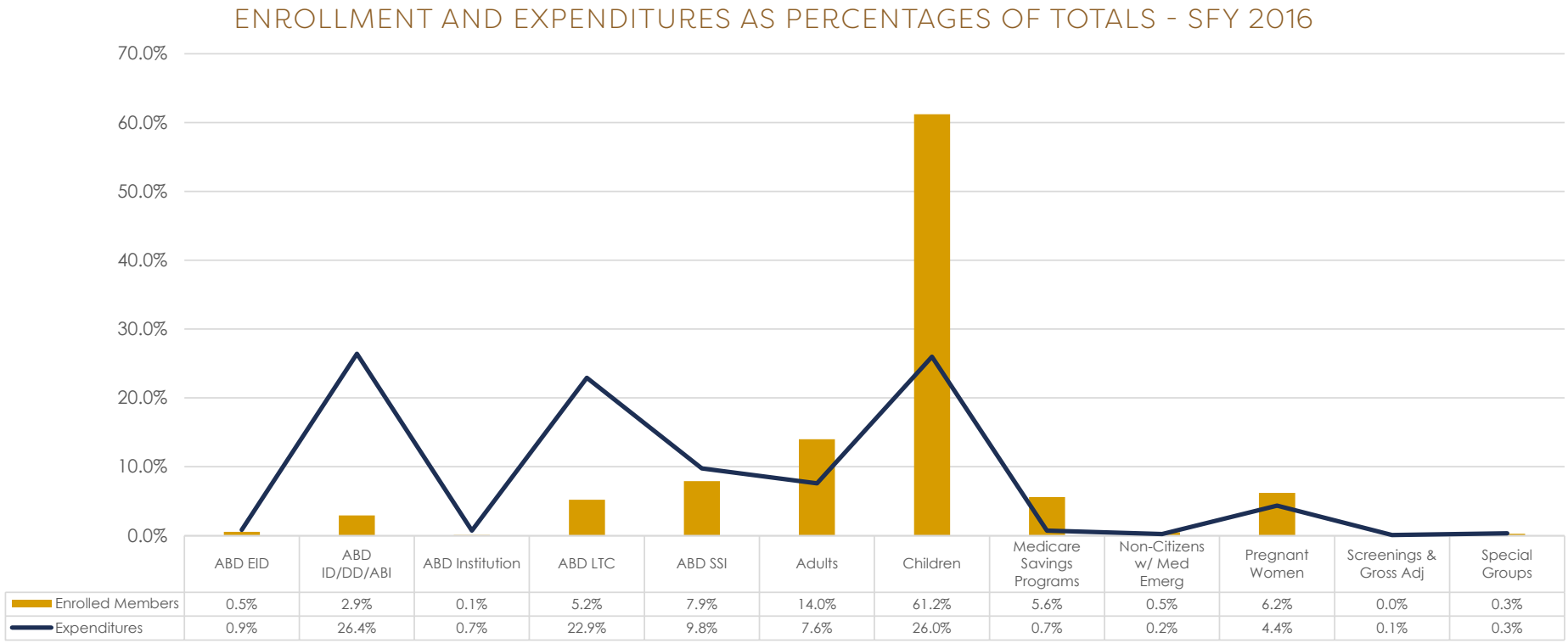
ENROLLMENT BY CATEGORY

Table 8. Enrollment History by Eligibility Category

Eligibility Category	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
ABD EID	250	309	350	341	360	479	92
ABD ID/DD/ABI	2,394	2,427	2,437	2,402	2,480	2,609	9
ABD Institution	118	78	86	71	76	77	-35
ABD LTC	4,210	4,149	4,184	4,176	4,378	4,643	10
ABD SSI	7,264	7,331	7,389	7,134	7,052	7,039	-3
Adults	8,312	8,091	7,925	8,719	10,998	12,431	50
Children	57,290	57,196	57,061	56,079	57,007	54,345	-5
Medicare Savings Programs	4,365	4,746	5,032	5,167	5,338	4,982	14
Non-Citizens with Medical Emergencies	671	776	953	949	794	432	-36
Pregnant Women	5,950	5,704	5,633	5,400	5,743	5,517	-7
Special Groups	1,408	1,524	1,451	1,120	694	250	-82
Total	**89,166**	**89,328**	**89,684**	**88,642**	**91,062**	**88,775**	**0**

RECIPIENTS AND EXPENDITURES BY ELIGIBILITY CATEGORY

The figure below illustrates the distribution of members across the eligibility categories compared to the expenditures for those categories. Note, screenings and gross adjustments are included to account for those expenditures; however, this is not an eligibility category.



	ABD EID	ABD ID/DD/ABI	ABD Institution	ABD LTC	ABD SSI	Adults	Children	Medicare Savings Programs	Non-Citizens w/ Med Emerg	Pregnant Women	Screenings & Gross Adj	Special Groups
Enrolled Members	0.5%	2.9%	0.1%	5.2%	7.9%	14.0%	61.2%	5.6%	0.5%	6.2%	0.0%	0.3%
Expenditures	0.9%	26.4%	0.7%	22.9%	9.8%	7.6%	26.0%	0.7%	0.2%	4.4%	0.1%	0.3%

Figure 8. Enrollment and Expenditures as Percentage of Totals - SFY 2016

While children represented 61 percent of all members for SFY 2016, the corresponding expenditures for children receiving services only accounted for 26 percent of total Medicaid expenditures.

On the other hand, the ABD ID/DD/ABI and ABD LTC populations accounted for less than 11 percent of all members for the SFY but 49 percent of total Medicaid expenditures.

Table 9. Eligibility Category Summary

Eligibility Category	Enrolled Members	Percent Change from SFY 2015	Recipients	Percent Change from SFY 2015	Expenditures	Percent Change from SFY 2015	Expenditures per Enrolled Member	Percent Change from SFY 2015	Expenditures per Recipient	Percent Change from SFY 2015
ABD EID	479	33	475	32	$4,730,644	25	$9,876	-6	$9,959	-6
ABD ID/DD/ABI	2609	5	2,637	7	$146,523,597	7	$56,161	2	$55,565	0
ABD Institution	77	1	97	7	$3,976,596	4	$51,644	2	$40,996	-3
ABD LTC	4643	6	4,805	6	$127,126,736	16	$27,380	9	$26,457	9
ABD SSI	7039	0	6,053	-1	$54,218,689	-6	$7,703	-6	$8,957	-5
Adults	12431	13	9,901	17	$42,070,572	7	$3,384	-5	$4,249	-8
Children	54345	-5	46,120	-3	$144,048,715	0	$2,651	5	$3,123	4
Medicare Savings Programs	4982	-7	2,914	-2	$4,098,086	-10	$823	-4	$1,406	-8
Non-Citizens with Medical Emergencies	432	-46	259	-10	$1,212,043	-2	$2,806	80	$4,680	9
Pregnant Women	5517	-4	5,472	0	$24,192,832	0	$4,385	4	$4,421	0
Screenings & Gross Adjustments	--	--	--	--	$512,743	180	--	--	--	--
Special Groups	250	-64	149	-45	$1,871,886	-27	$7,488	104	$12,563	34
Total	**88,775**	**-3**	**75,015**	**0**	**$554,583,138**	**5**	**$6,247**	**8**	**$7,393**	**6**

Table 10. Expenditures History by Eligibility Category

Eligibility Category	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
ABD EID	$2,721,026	$3,208,536	$4,589,792	$4,545,872	$3,795,205	$4,730,644	74
ABD ID/DD/ABI	$128,973,756	$131,305,592	$140,008,570	$140,255,339	$137,112,834	$146,523,597	14
ABD Institution	$7,040,563	$4,975,050	$4,836,583	$6,947,121	$3,843,309	$3,976,596	-44
ABD LTC	$113,614,225	$115,028,538	$111,411,633	$109,585,095	$109,685,023	$127,126,736	12
ABD SSI	$51,934,208	$51,345,795	$52,203,560	$53,252,515	$57,532,693	$54,218,689	4
Adults	$29,178,291	$28,827,439	$28,446,023	$28,414,259	$39,268,780	$42,070,572	44
Children	$141,159,152	$124,839,646	$133,149,744	$135,754,662	$143,624,614	$144,048,715	2
Medicare Savings Programs	$3,007,075	$3,245,880	$3,708,394	$4,086,134	$4,564,069	$4,098,086	36
Non-Citizens with Medical Emergencies	$1,960,832	$1,948,889	$1,892,640	$1,490,032	$1,236,724	$1,212,043	-38
Pregnant Women	$36,086,835	$32,051,842	$31,815,394	$28,762,228	$24,134,468	$24,192,832	-33
Screenings & Gross Adjustments	$239,567	$355,924	$378,465	$389,686	$183,197	$512,743	114
Special Groups	$3,688,749	$3,797,900	$4,816,363	$4,139,581	$2,550,692	$1,871,886	-49
Total	**$519,604,279**	**$500,931,031**	**$517,257,164**	**$517,622,524**	**$527,531,608**	**$554,583,138**	**7**

The table below displays a distinct count of recipients for each eligibility category, as well as the total distinct count of recipients. Summing the recipients for each eligibility category will not match the total recipients, because individuals may receive services under multiple eligibility categories throughout the SFY.

Table 11. Recipient Count History by Eligibility Category

Eligibility Category	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
ABD EID	253	310	342	345	360	475	88
ABD ID/DD/ABI	2,409	2,431	2,448	2,407	2,476	2,637	9
ABD Institution	166	119	100	92	91	97	-42
ABD LTC	4,563	4,433	4,401	4,386	4,525	4,805	5
ABD SSI	6,094	6,191	6,245	6,269	6,125	6,053	-1
Adults	6,936	6,590	6,683	6,907	8,467	9,901	43
Children	50,082	49,110	49,040	49,408	47,612	46,120	-8
Medicare Savings Programs	2,333	2,514	2,641	2,762	2,985	2,914	25
Non-Citizens with Medical Emergencies	419	426	414	367	287	259	-38
Pregnant Women	6,149	5,785	5,939	5,509	5,469	5,472	-11
Special Groups	683	686	622	497	271	149	-78
Total	**77,229**	**75,968**	**76,276**	**76,319**	**75,292**	**75,015**	**-3**

Table 12. Expenditures per Recipient History by Eligibility Category

Eligibility Category	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
ABD EID	$10,755	$10,350	$13,420	$13,176	$10,542	$9,959	-7
ABD ID/DD/ABI	$53,538	$54,013	$57,193	$58,270	$55,377	$55,565	4
ABD Institution	$42,413	$41,807	$48,366	$75,512	$42,234	$40,996	-3
ABD LTC	$24,899	$25,948	$25,315	$24,985	$24,240	$26,457	6
ABD SSI	$8,522	$8,294	$8,359	$8,495	$9,393	$8,957	5
Adults	$4,207	$4,374	$4,256	$4,114	$4,638	$4,249	1
Children	$2,819	$2,542	$2,715	$2,748	$3,017	$3,123	11
Medicare Savings Programs	$1,289	$1,291	$1,404	$1,479	$1,529	$1,406	9
Non-Citizens with Medical Emergencies	$4,680	$4,575	$4,572	$4,060	$4,309	$4,680	0
Pregnant Women	$5,869	$5,541	$5,357	$5,221	$4,413	$4,421	-25
Special Groups	$5,401	$5,536	$7,743	$8,329	$9,412	$12,563	133
Total	**$6,728**	**$6,594**	**$6,781**	**$6,782**	**$7,006**	**$7,393**	**10**

Table 13. Expenditures per Enrolled Member History by Eligibility Category

Eligibility Category	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
ABD EID	$10,884	$10,384	$13,114	$13,331	$10,542	$9,876	-9
ABD ID/DD/ABI	$53,874	$54,102	$57,451	$58,391	$55,287	$56,161	4
ABD Institution	$59,666	$63,783	$56,239	$97,847	$50,570	$51,644	-13
ABD LTC	$26,987	$27,724	$26,628	$26,242	$25,054	$27,380	1
ABD SSI	$7,150	$7,004	$7,065	$7,465	$8,158	$7,703	8
Adults	$3,510	$3,563	$3,589	$3,259	$3,571	$3,384	-4
Children	$2,464	$2,183	$2,333	$2,421	$2,519	$2,651	8
Medicare Savings Programs	$689	$684	$737	$791	$855	$823	19
Non-Citizens with Medical Emergencies	$2,922	$2,511	$1,986	$1,570	$1,558	$2,806	-4
Pregnant Women	$6,065	$5,619	$5,648	$5,326	$4,202	$4,385	-28
Special Groups	$2,620	$2,492	$3,319	$3,696	$3,675	$7,488	186
Total	**$5,827**	**$5,608**	**$5,768**	**$5,839**	**$5,793**	**$6,247**	**7**

Service Utilization

Medicaid provides a wide range of covered medical, behavioral and long-term care services. Some recipients receive full benefits while others receive partial or limited benefits. Medicaid covers mandatory services as required by the federal government and optional services authorized by the Wyoming Legislature. Rate information and reimbursement methodology and history are available in Appendix B.

SERVICE UTILIZATION OVERVIEW

Wyoming Medicaid covers the following mandatory[10] and optional services. These service areas are explained in further detail later in this report.

Table 14. Covered Services

Service Area	Adults	Children (Under Age 21)
Acquired Brain Injury Waiver	Optional	Optional
Ambulance	Mandatory	Mandatory
Ambulatory Surgical Center	Optional	Optional
Assisted Living Facility Waiver	Optional	N/A
Behavioral Health[11]	Optional	Mandatory (EPSDT)
Care Management Entity / Children's Mental Health Waiver	N/A	Optional
Clinic Services	Optional	Mandatory (EPSDT)
Comprehensive and Supports Waivers for Persons with ID/DD/ABI	Optional	Optional [12]
Dental	Optional	Mandatory (EPSDT)
Durable Medical Equipment	Optional	Mandatory (EPSDT)
End Stage Renal Disease	Optional	Mandatory (EPSDT)
Federally Qualified Health Centers	Mandatory	Mandatory
Home Health	Mandatory	Mandatory
Hospice	Optional	Optional
Hospital	Mandatory	Mandatory
ICF-ID	Optional	Optional
Laboratory / X-Ray	Mandatory	Mandatory
Long-Term Care Waiver	Optional	N/A
Nursing Facility	Mandatory	Mandatory
Program for All-Inclusive Care of the Elderly (PACE)	Optional	N/A
Pharmacy	Optional	Mandatory (EPSDT)
Physician and Other Practitioner	Mandatory	Mandatory
Pregnant by Choice Waiver	Optional	N/A
Psychiatric Residential Treatment Facility (PRTF)	N/A	Mandatory (EPSDT)
Physical/Occupational/Speech Therapies[13]	Optional	Mandatory (EPSDT)
Public Health, Federal[14]	Mandatory	Mandatory
Public Health or Welfare	Optional	Mandatory (EPSDT)
Rural Health Clinic	Mandatory	Mandatory
Vision	Optional	Mandatory (EPSDT)

[10] These services are required for children to comply with Early Prevention, Screening, Detection, and Treatment (EPSDT) requirements. EPSDT services are operated under the Health Check program, discussed in more detail in the Subprograms section.
[11] Excludes the Children's Mental Health Waiver and Psychiatric Residential Treatment Facility.
[12] Some services in these waivers may be mandatory if the child is otherwise eligible for Medicaid without the waiver.
[13] Physical/Occupational/Speech Therapies service detail is included in the Physician and Other Practitioner data in the detail section of this report.
[14] Refers to Indian Health Services and Tribal 638 facilities.

Table 15. Service Utilization Summary

Service Area	Expenditures	Percent Change from SFY 2015	Recipients[15]	Percent Change from SFY 2015	Expenditures per Recipient	Percent Change from SFY 2015
Ambulance	$3,571,623	-18	3,305	-6	$1,081	-13
Ambulatory Surgical Center	$5,953,159	-2	3,419	-3	$1,741	1
Behavioral Health	$34,964,154	3	12,693	3	$2,755	0
Care Management Entity (CME)[16]	$5,021,978	--	342	--	$14,684	--
Clinic/Center	$1,361,953	2	1,529	-4	$891	6
Dental	$15,450,029	7	31,869	4	$485	3
DME, Prosthetics/Orthotics/Supplies	$8,200,062	-5	7,110	-3	$1,153	-2
End Stage Renal Disease	$948,612	-14	128	20	$7,411	-28
Federally Qualified Health Center	$3,689,548	13	6,430	7	$574	5
Home Health	$9,467,835	105	732	7	$12,934	92
Hospice	$1,014,959	-12	199	11	$5,100	-21
Hospital Total	$107,692,150	3	40,958	-4	$2,629	7
Inpatient	*$78,575,068*	*7*	*10,054*	*-5*	*$7,815*	*13*
Outpatient	*$28,975,050*	*-7*	*38,751*	*-4*	*$748*	*-3*
Other Hospital	*$142,031*	*134*	*177*	*19*	*$802*	*97*
Intermediate Care Facility-ID	$18,193,221	1	70	-7	$259,903	8
Laboratory	$1,536,310	1	9,561	8	$161	-6
Nursing Facility	$82,445,811	17	2,411	3	$34,196	14
Other	$894,268	38	1,947	19	$459	16
PACE	$2,934,877	31	118	24	$24,872	5
Physician & Other Practitioner	$58,278,406	-5	61,540	-2	$947	-3
Prescription Drug	$48,597,364	1	43,932	-5	$1,106	6
PRTF	$11,797,657	-13	298	-10	$39,589	-3
Public Health or Welfare	$1,072,715	6	5,995	0	$179	6
Public Health, Federal	$8,479,944	-3	3,416	1	$2,482	-4
Rural Health Clinic	$1,413,842	-15	3,783	-16	$374	1
Vision	$3,652,188	2	15,241	2	$240	0
Waiver Total	$117,950,473	4	4,829	9	$24,425	-4
Acquired Brain Injury	*$6,748,171*	*2*	*163*	*-3*	*$41,400*	*5*
Adult ID/DD	*$1,674*	*-100*	*2*	*-100*	*$837*	*-93*
Assisted Living Facility	*$3,339,254*	*20*	*256*	*12*	*$13,044*	*8*
Child ID/DD	*$179,173*	*-98*	*148*	*-78*	*$1,211*	*-90*
Children's Mental Health	*$61,981*	*-92*	*40*	*-49*	*$1,550*	*-83*
Comprehensive	*$88,377,607*	*39*	*1,925*	*10*	*$45,910*	*26*
Long-Term Care	*$16,462,164*	*19*	*2,067*	*14*	*$7,964*	*5*
Supports	*$2,780,450*	*239*	*425*	*123*	*$6,542*	*52*
Total	**$554,583,138**	**5**	**75,015**	**0**	**$7,393**	**6**

[15] This table displays a unique count of recipients for each service area, as well as the total unique count of recipients for all of Medicaid. Summing the recipients for each year across all service areas will not equal the total recipients shown as recipients often receive multiple services through the SFY.

[16] The Care Management Entity service includes $125,519 in expenditures paid for 30 children while enrolled in non-Medicaid state-funded institutional foster care.

Total expenditures for all Medicaid services increased 5.1 percent from SFY 2015 to $554,583,138.

The top service areas based on expenditures in SFY 2016 are Waivers[17], Hospital, Nursing Facility and Physician & Other Practitioner.

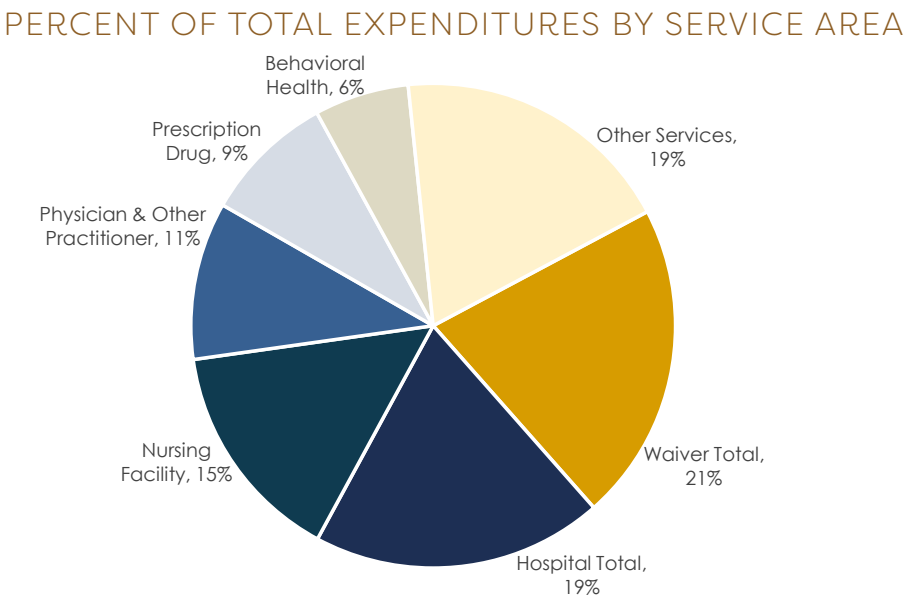


Figure 9. Percent of Total Expenditures by Service Area

Total unique recipient count for all Medicaid services remained stable, decreasing by only 0.4 percent from the previous year to 75,015 individuals.

The top service areas based on recipient count in SFY 2016 were Physician & Other Practitioner, Prescription Drug, Hospital, and Dental. The figure below shows that 82 percent of Medicaid recipients used Physician & Other Practitioner services in SFY 2016, 59 percent used prescription drug services, and so on.

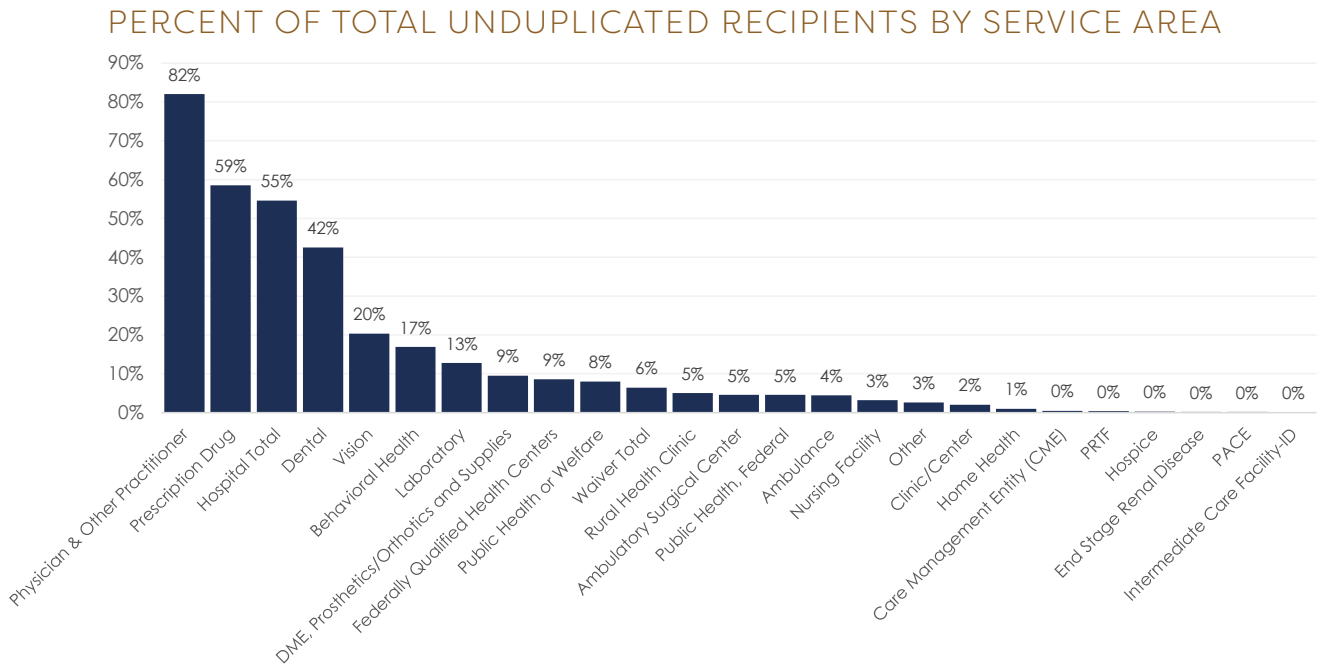


Figure 10. Percent of Total Unduplicated Recipients by Service Area

[17] Includes waiver services expenditures only, and does not account for non-waiver medical services utilized by waiver recipients.

Table 16. Expenditure History by Service Area

Service Area	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Ambulance	$3,303,240	$3,459,400	$3,606,360	$3,760,537	$4,352,067	$3,571,623	8
Ambulatory Surgical Center	$2,912,791	$2,822,957	$3,439,188	$4,039,944	$6,090,776	$5,953,159	104
Behavioral Health	$24,927,506	$26,125,428	$28,354,676	$30,602,969	$33,879,362	$34,964,154	40
Care Management Entity[19]	--	--	--	--	--	$5,021,978	n/a
Clinic/Center	$1,496,903	$1,195,547	$1,166,813	$1,295,561	$1,339,630	$1,361,953	-9
Dental	$13,616,583	$13,561,177	$13,272,110	$13,391,934	$14,473,863	$15,450,029	13
DME, Prosthetics/ Orthotics/Supplies	$7,505,683	$7,270,213	$7,730,289	$7,627,734	$8,624,246	$8,200,062	9
End Stage Renal Disease	$835,621	$1,233,755	$1,343,669	$1,071,750	$1,099,569	$948,612	14
Federally Qualified Health Center	$3,103,164	$1,550,274	$2,018,911	$2,698,283	$3,259,793	$3,689,548	19
Home Health	$2,732,905	$2,963,510	$2,897,016	$3,533,728	$4,618,885	$9,467,835	246
Hospice	$1,036,887	$983,026	$1,082,188	$1,468,295	$1,157,101	$1,014,959	-2
Hospital Total	$114,357,604	$105,798,987	$108,839,452	$101,931,277	$104,523,947	$107,692,150	-6
Inpatient	*$84,557,214*	*$77,130,425*	*$78,462,603*	*$72,932,440*	*$73,407,132*	*$78,575,068*	*-7*
Outpatient	*$29,692,078*	*$28,657,373*	*$30,189,391*	*$28,703,147*	*$31,056,066*	*$28,975,050*	*-2*
Other Hospital	*$108,312*	*$11,189*	*$187,458*	*$295,690*	*$60,748*	*$142,031*	*31*
Intermediate Care Facility-ID[17]	$11,388,412	$10,065,657	$17,942,326	$19,152,530	$18,091,427	$18,193,221	60
Laboratory	$1,171,185	$1,100,774	$1,149,473	$1,284,678	$1,516,042	$1,536,310	31
Nursing Facility	$73,180,333	$73,805,803	$73,593,462	$72,866,933	$70,354,260	$82,445,811	13
Other	$1,368,275	$838,430	$625,371	$538,127	$649,268	$894,268	-35
PACE	--	--	$168,398	$1,288,934	$2,242,570	$2,934,877	n/a
Physician & Other Practitioner	$65,226,891	$62,845,816	$62,856,989	$62,372,535	$61,249,367	$58,278,406	-11
Prescription Drug	$41,352,500	$41,914,658	$39,110,022	$41,238,663	$47,946,923	$48,597,364	18
PRTF	$15,244,613	$8,019,118	$12,080,494	$14,886,133	$13,575,847	$11,797,657	-23
Public Health or Welfare	$1,093,398	$988,455	$924,007	$962,164	$1,009,814	$1,072,715	-2
Public Health, Federal	$8,532,271	$7,240,130	$8,067,975	$7,999,556	$8,761,358	$8,479,944	-1
Rural Health Clinic	$1,940,640	$1,628,043	$1,845,491	$1,521,233	$1,668,167	$1,413,842	-27
Vision	$3,227,545	$3,192,131	$3,389,793	$3,464,394	$3,595,216	$3,652,188	13
Waiver Total	$120,049,329	$122,327,742	$121,752,688	$118,624,631	$113,452,108	$117,950,473	-2
Acquired Brain Injury	*$6,963,271*	*$6,925,596*	*$7,679,811*	*$7,371,614*	*$6,636,440*	*$6,748,171*	*-3*
Adult ID/DD	*$81,369,215*	*$84,846,084*	*$84,204,861*	*$83,501,095*	*$16,541,190*	*$1,674*	*-100*
Assisted Living Facility	*$2,757,617*	*$2,612,026*	*$2,451,875*	*$2,593,984*	*$2,773,135*	*$3,339,254*	*21*
Child ID/DD	*$14,128,741*	*$13,646,013*	*$13,301,942*	*$11,415,264*	*$8,372,841*	*$179,173*	*-99*
Children's Mental Health	*$918,455*	*$942,386*	*$688,995*	*$527,514*	*$732,257*	*$61,981*	*-93*
Comprehensive	--	--	--	*$44,982*	*$63,719,016*	*$88,377,607*	*n/a*
Long-Term Care	*$13,912,032*	*$13,355,638*	*$13,425,205*	*$13,169,724*	*$13,857,541*	*$16,462,164*	*18*
Supports	--	--	--	*$454*	*$819,690*	*$2,780,450*	*n/a*
Total	**$519,604,279**	**$500,931,031**	**$517,257,164**	**$517,622,524**	**$527,531,608**	**$554,583,138**	**7**

[18] For SFY 2011 and 2012 only Federal portion of expenditures are shown.
[19] The Care Management Entity service includes expenditures paid for non-Medicaid children in state-funded institutional foster care.

Table 17. Expenditure History by Other[20] Service Areas

Eligibility Category	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Ambulatory Family Planning Facility	$83,744	$81,564	$68,988	$71,213	$69,754	$55,497	-34
Case Management	$299,617	$219,942	$196,574	$193,913	$297,117	$254,740	-15
Chiropractor	$6,102	$7,349	$7,500	$5,661	$6,347	$99,664	1533
Day Training, Developmentally Disabled Service	$222,425	$57,158	$71,266	$79,578	$27,476	$52,304	-76
Interpreter	$54,259	$48,321	$43,529	$38,171	$56,339	$47,205	-13
Pace PPL	--	--	--	--	$0	-$80	n/a
Phlebotomy/WY Health Fair	$3,820	$5,910	$2,635	$5,870	$1,920	$575	-85
Radiology: Mobile	$217,463	$109,250	$4,081	$226	$52	$7	-100
Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	$56,646	$125,928	$121,618	$143,525	$154,682	$146,226	158
Residential Treatment Facility For Emotionally Disturbed	$424,200	$183,009	$109,220	--	$35,712	$237,904	-44
Unclassified	--	--	-$39	-$30	-$131	$225	n/a
Total	**$1,368,275**	**$838,430**	**$625,371**	**$538,127**	**$649,268**	**$894,268**	**-35**

[20] This table shows services that fall outside the criteria ranges used to define other service areas for this report, as defined by pay to provider taxonomy.

Table 18. Recipient Count[21] History by Service Area

Service Area	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Ambulance	3,613	3,604	3,433	3,517	3,513	3,305	-9
Ambulatory Surgical Center	3,151	3,088	3,259	3,392	3,540	3,419	9
Behavioral Health	10,514	10,674	11,410	11,294	12,289	12,693	21
Care Management Entity[22]	--	--	--	--	--	342	n/a
Clinic/Center	1,470	1,623	1,465	1,520	1,589	1,529	4
Dental	28,171	28,593	28,532	29,170	30,660	31,869	13
DME, Prosthetics/ Orthotics/Supplies	7,502	7,245	7,364	7,122	7,319	7,110	-5
End Stage Renal Disease	86	98	110	106	107	128	49
Federally Qualified Health Center	4,834	2,722	3,612	4,034	5,989	6,430	33
Home Health	623	582	591	590	687	732	17
Hospice	150	135	179	251	179	199	33
Hospital Total	42,525	44,107	42,667	40,033	42,480	40,958	-4
Inpatient	*11,640*	*10,890*	*10,970*	*10,293*	*10,607*	*10,054*	*-14*
Outpatient	*39,757*	*41,772*	*40,148*	*37,618*	*40,167*	*38,751*	*-3*
Other Hospital	*91*	*104*	*142*	*194*	*149*	*177*	*95*
Intermediate Care Facility-ID	84	84	81	79	75	70	-17
Laboratory	9,923	9,415	9,724	9,490	8,832	9,561	-4
Nursing Facility	2,444	2,410	2,445	2,384	2,346	2,411	-1
Other	2,426	2,422	1,857	1,642	1,643	1,947	-20
PACE	--	--	22	63	95	118	436
Physician & Other Practitioner	64,940	63,695	61,515	65,285	62,825	61,540	-5
Prescription Drug	50,118	48,222	47,607	44,464	46,031	43,932	-12
PRTF	403	274	328	338	332	298	-26
Public Health or Welfare	7,731	6,466	6,238	5,772	5,969	5,995	-22
Public Health, Federal	4,551	3,249	4,222	3,546	3,382	3,416	-25
Rural Health Clinic	5,277	4,174	5,418	4,670	4,530	3,783	-28
Vision	14,120	13,940	14,180	14,558	15,010	15,241	8
Waiver Total	4,413	4,302	4,207	4,168	4,443	4,829	9
Acquired Brain Injury	*177*	*188*	*186*	*181*	*168*	*163*	*-8*
Adult ID/DD	*1,355*	*1,380*	*1,395*	*1,409*	*1,325*	*2*	*-100*
Assisted Living Facility	*217*	*201*	*190*	*194*	*229*	*256*	*18*
Child ID/DD	*799*	*773*	*761*	*699*	*659*	*148*	*-81*
Children's Mental Health	*136*	*131*	*82*	*57*	*79*	*40*	*-71*
Comprehensive	--	--	--	*3*	*1,755*	*1,925*	*n/a*
Long-Term Care	*1,801*	*1,718*	*1,674*	*1,700*	*1,819*	*2,067*	*15*
Supports	--	--	--	*0*	*191*	*425*	*n/a*
Total	**77,229**	**75,968**	**76,276**	**76,319**	**75,292**	**75,015**	**-3**

[21] This table displays a unique count of recipients for each service area, as well as the total unique count of recipients for all of Medicaid. Summing the recipients for each year across all service areas will not equal the total recipients shown as recipients often receive multiple services through the SFY.

[22] The Care Management Entity service recipient count includes non-Medicaid children in state-funded institutional foster care.

Ambulance

Ambulance services provide emergency ground and air transportation and limited non-emergency ground transportation.

The table below shows total Ambulance services, as well as the breakdown of air and ground ambulance services.

$3,571,623
Total Expenditures

↓18%
from SFY 2015

0.6%
of Total Medicaid Expenditures

SFY 2016

Table 19. Ambulance Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Total Ambulance Services							
Expenditures	$3,303,240	$3,459,400	$3,606,360	$3,760,537	$4,352,067	$3,571,623	8
Recipients	3,613	3,604	3,433	3,517	3,513	3,305	-9
Expenditures per Recipient	$914	$960	$1,050	$1,069	$1,239	$1,081	18
Air Ambulance Services							
Expenditures	$1,888,518	$1,892,961	$2,129,324	$2,291,183	$2,931,554	$2,310,149	22
Recipients	366	396	426	505	557	480	31
Expenditures per Recipient	$5,160	$4,780	$4,998	$4,537	$5,263	$4,813	-7
Ground Ambulance Services							
Expenditures	$1,410,232	$1,562,840	$1,472,500	$1,467,922	$1,413,123	$1,250,084	-11
Recipients	3,479	3,476	3,290	3,375	3,326	3,119	-10
Expenditures per Recipient	$405	$450	$448	$435	$425	$401	-1

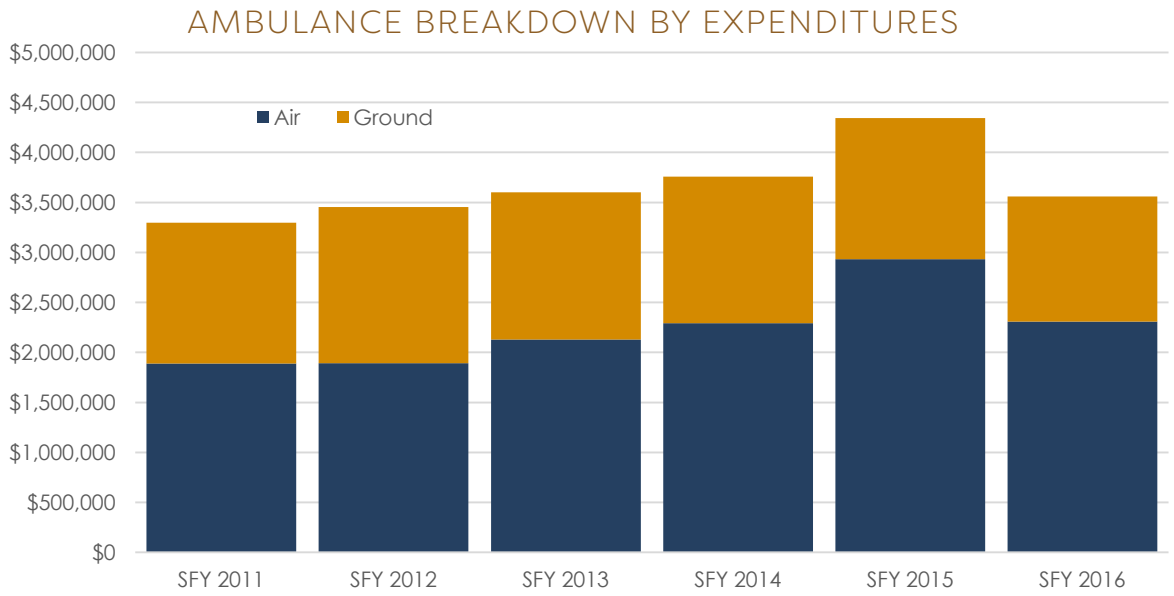


Figure 11. Ambulance Breakdown by Expenditures

Ambulatory Surgery Center

SFY 2016

$5,953,159
Total Expenditures

↓2%
from SFY 2015

1.1%
of Total Medicaid Expenditures

Ambulatory Surgery Centers (ASC) provide services that do not require overnight inpatient hospital care. These services encompass all surgical procedures covered by Medicare and additional surgical procedures that Medicaid approves for provision as outpatient services. ASC services may also be provided in an outpatient hospital setting.

Total expenditures for outpatient hospital and ASC services combined decreased by six percent from the previous state fiscal year to $34.9 million.

Table 20. Ambulatory Surgery Center Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$2,912,791	$2,822,957	$3,439,188	$4,039,944	$6,090,776	$5,953,159	104
Recipients	3,151	3,088	3,259	3,392	3,540	3,419	9
Expenditures per Recipient	$924	$914	$1,055	$1,191	$1,721	$1,741	88

Behavioral Health

SFY 2016

$34,964,154
Total Expenditures

↑3%
from SFY 2015

6.3%
of Total Medicaid Expenditures

Behavioral Health services are all services provided by Behavioral Health provider taxonomies.

The table below also provides data regarding Behavioral Health services provided by non-Behavioral Health providers as identified by procedure codes. This section does not, however, include behavioral health services provided in hospitals or under the Children's Mental Health Waiver. Information for those services is located in the Hospital and Waiver sections, respectively.

See Appendix B for additional information regarding the types of providers who provide Behavioral Health services.

Table 21. Behavioral Health Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Behavioral Health Services							
Expenditures	$24,927,506	$26,125,428	$28,354,676	$30,602,969	$33,879,362	$34,964,154	40
Recipients	10,514	10,674	11,410	11,294	12,289	12,693	21
Expenditures per Recipient	$2,371	$2,448	$2,485	$2,710	$2,757	$2,755	16
Non-Behavioral Health Provider Services							
Expenditures	$1,853,410	$1,767,941	$1,676,141	$1,783,169	$1,640,661	$1,624,461	-12
Recipients	3,594	3,757	2,981	3,834	3,856	4,319	20
Expenditures per Recipient	$422	$380	$463	$363	$328	$287	-32

Table 22. Top Five Behavioral Health Diagnosis Codes by Expenditures

Diagnosis Code & Description		Age 0-20	Age 21-64	Age 65+	Total
311	Depressive Disorder, Not elsewhere classified	$1,340,517	$974,266	$319,037	**$2,633,819**
309.81	Post-Traumatic Stress Disorder	$1,090,536	$385,216	$2,498	**$1,478,250**
296.33	Major Depressive Disorder, Recurrent EPI	$1,286,115	$112,648	$16,903	**$1,415,666**
F39	Unspecified Mood Affective Disorder	$771,279	$286,650	$80,741	**$1,138,670**
314.01	Attention Deficit Disorder of Childhood	$992,022	$63,504	$0	**$1,055,526**
Total		**$5,480,469**	**$1,822,284**	**$419,178**	**$7,721,932**

Care Management Entity

In SFY 2016, utilizing 1915(b) and 1915(c) home and community-based waivers, Medicaid procured a Care Management Entity (CME) to act as the central, accountable hub for intensive care coordination provided to children and youth who have complex behavioral health conditions and their families. Children and youth with complex behavioral health needs have historically been served in out-of-home placements at a nominal cost and with limited success when returning to the community.

SFY 2016

$5,021,978
Total Expenditures

New Program in SFY 2016

0.9%
of Total Medicaid Expenditures

The CME uses an evidence-based practice known as the High Fidelity Wrap-around model to support the success of children, youth, and their families in their homes, schools, and communities.

Table 23. Care Management Entity Services Summary

	SFY 2016
Expenditures	$5,021,978
Recipients	342
Expenditures per Recipient	$14,684

CME also provides services to children enrolled in non-Medicaid state-funded institutional foster care. The total SFY 2016 expenditures and recipient count shown in Table 23 includes includes $125,519 for those 30 children.

Clinic / Center

SFY 2016

$1,361,953
Total Expenditures

↑2%
from SFY 2015

0.2%
of Total Medicaid Expenditures

A developmental center is a state or privately funded facility, which provides services to clients with developmental disabilities who have been determined to require programs, training, care, treatment, and supervision in a structured setting.

Services include diagnostic evaluations and assessments, physical, occupational, and speech therapies, and mental health services, provided to clients 5 years of age or younger.

Table 24. Clinic/Center Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$1,496,903	$1,195,547	$1,166,813	$1,295,561	$1,339,630	$1,361,953	-9
Recipients	1,470	1,623	1,465	1,520	1,589	1,529	4
Expenditures per Recipient	$1,018	$737	$796	$852	$843	$891	-13

Dental

SFY 2016

$15,450,029
Total Expenditures

↑7%
from SFY 2015

2.8%
of Total Medicaid Expenditures

Wyoming Medicaid covers dental services based on the age of the enrolled member.

The purpose of the Medicaid Dental program is to ensure access to dental care so that recipients may receive preventive and routine dental services to support oral health and avoid emergency dental situations.

Although there are dental providers in most of Wyoming's 23 counties, dental specialists exist in only 10 (43 percent). 45 percent of dental services recipients received services from a dental specialist in SFY 2016, with 9 percent receiving such services out of state.

Table 25. Dental Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$13,616,583	$13,561,177	$13,272,110	$13,391,934	$14,473,863	$15,450,029	13
Recipients	28,171	28,593	28,532	29,170	30,660	31,869	13
Expenditures per Recipient	$483	$474	$465	$459	$472	$485	0

Durable Medical Equipment Prosthetics, Orthotics, and Supplies

Medicaid covers Durable Medical Equipment (DME), Prosthetics, Orthotics, and Supplies ordered by a physician or other licensed practitioner for home use to reduce an individual's physical disability and restore the individual to his or her functional level.

$8,200,062
Total Expenditures

↓5%
from SFY 2015

1.5%
of Total Medicaid Expenditures

SFY 2016

Medicaid covers rental of DME, and applies rental payments toward the purchase of the item when the cost of renting equals the cost of purchase, or at the end of 10 months of rental. Medicaid automatically purchases low cost items (i.e., less than $150) and caps all rental items, except oxygen concentrators and ventilators, at the purchase price. Medicaid also caps all per-day rentals at 100 days and monthly rentals at 10 months. Medicaid does not cover routine maintenance and repairs for rental equipment.

See Appendix B for more information regarding equipment and supplies included in this service area.

Table 26. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Total Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services							
Expenditures	$7,505,683	$7,270,213	$7,730,289	$7,627,734	$8,624,246	$8,200,062	9
Recipients	7,502	7,245	7,364	7,122	7,319	7,110	-5
Expenditures per Recipient	$1,000	$1,003	$1,050	$1,071	$1,178	$1,153	15
Durable Medical Equipment Services Only							
Expenditures	$6,725,808	$6,492,369	$7,062,121	$7,040,745	$7,910,490	$7,401,383	10
Recipients	7,127	6,880	8,170	6,820	6,918	6,735	-6
Expenditures per Recipient	$944	$944	$864	$1,032	$1,143	$1,099	16
Prosthetics, Orthotics, and Supplies Services Only							
Expenditures	$779,875	$778,124	$828,261	$587,006	$720,162	$798,679	2
Recipients	701	673	651	587	743	625	-11
Expenditures per Recipient	$1,113	$1,156	$1,272	$1,000	$969	$1,278	15

End Stage Renal Disease

SFY 2016

$948,612
Total Expenditures

↓14%
from SFY 2015

0.2%
of Total Medicaid Expenditures

The majority of ESRD recipients are dual individuals -- that is, individuals enrolled in both Medicare and Medicaid. For dual individuals Medicare is the primary payer for End Stage Renal Disease (ESRD) services, and therefore most Medicaid ESRD expenditures are for non-dual individuals.

Medicare ESRD coverage may begin no later than the third month after the patient begins a course of dialysis treatment. During the 90-day Medicare eligibility determination period, Medicaid reimburses ESRD services for enrolled members and will reimburse services if Medicare denies eligibility.

Medicaid covers all medically necessary services related to renal disease care, including inpatient renal dialysis and outpatient services related to ESRD treatment, as well as treatment if Medicare denies coverage for an enrolled member on a home dialysis program. Individuals must be eligible for Medicaid, and the hospital or free-standing facility must be certified as an ESRD facility. Medicaid does not cover personal care attendants for this program.

Wyoming also has a non-Medicaid state-funded ESRD program, which reimburses at Medicare rates.

Table 27. End Stage Renal Disease Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$835,621	$1,233,755	$1,343,669	$1,071,750	$1,099,569	$948,612	14
Recipients	86	98	110	106	107	128	49
Expenditures per Recipient	$9,717	$12,589	$12,215	$10,111	$10,276	$7,411	-24

Federally Qualified Health Center

$3,689,548
Total Expenditures
↑13%
from SFY 2015
0.7%
of Total Medicaid Expenditures
SFY 2016

A Federally Qualified Health Center (FQHC) provides preventive primary health services. Medicaid covers services provided if they are medically necessary and provided by or under the direction of a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, licensed clinical psychologist, or licensed clinical social worker.

Medicare designates a facility as an FQHC if it is located in an area designated as a "shortage area" -- geographic areas designated by the HHS as having either a shortage of personal health services or a shortage of primary medical care professionals. An FQHC differs from a Rural Health Clinic (RHC) based on several criteria related to location, shortage area, corporate structure, board of director requirements, and clinical staffing requirements.[23]

Table 28. Federally Qualified Health Center Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$3,103,163	$1,550,274	$2,018,911	$2,698,283	$3,259,793	$3,689,548	19
Recipients	4,834	2,722	3,612	4,034	5,989	6,430	33
Expenditures per Recipient	$642	$570	$559	$669	$544	$574	-11

Home Health

$9,467,835
Total Expenditures
↑105%
from SFY 2015
1.7%
of Total Medicaid Expenditures
SFY 2016

Medicaid covers home health services if the individual is not an inpatient of a hospital or a nursing care facility. Covered services must be intermittent, three or fewer visits per day for home health aide and/or skilled nursing services (with each visit lasting no more than four hours), medically necessary and ordered by a physician, and documented in a signed and dated plan of treatment that is reviewed and revised as medically necessary by the attending physician at least once every 60 days.

Home Health agencies must provide at least two of the covered services in order to be a licensed provider in the state of Wyoming. These services include: skilled nursing, home health aide supervised by a qualified professional, physical therapy provided by a qualified and licensed physical therapist, speech therapy provided by a qualified therapist, occupational therapy provided by a qualified, registered, or certified therapist, and medical social services provided by a qualified, licensed Master of Social Work (MSW) or a Bachelor of Social Work (BSW)-prepared person supervised by an MSW. Medicaid does not cover homemaking services, respite care, meals on wheels, or services that are inappropriate or not cost-effective when provided in the home setting.

[23] Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs, US Department of Health and Human Services Health Resources and Services Administration, Revised June 2006. http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf

Due to the recent increase in expenditures in Home Health services, Medicaid is implementing a prior authorization requirement that takes effect March 1, 2017. Additional policy updates are being reviewed to further address these increases.

Table 29. Home Health Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$2,732,905	$2,963,510	$2,897,016	$3,533,728	$4,618,885	$9,467,835	246
Recipients	623	582	591	590	687	732	17
Expenditures per Recipient	$4,387	$5,092	$4,902	$5,989	$6,723	$12,934	195

Hospice

SFY 2016

$1,014,959
Total Expenditures

↓12%
from SFY 2015

0.2%
of Total Medicaid Expenditures

Hospice care is an interdisciplinary approach to caring for the psychological, social, spiritual, and physical needs of dying individuals. Medicaid covers hospice care if the individual elects it and a physician certifies that the individual is terminally ill. Medicaid covers hospice, independent physician services, and HCBS services provided to the individual in a hospice setting. Covered services include: routine and continuous home care, inpatient respite care, and general inpatient care. Inpatient services are provided during critical periods for individuals who need a high level of care.

Table 30. Hospice Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$1,036,887	$983,026	$1,082,188	$1,468,295	$1,157,101	$1,014,959	-2
Recipients	150	135	179	251	179	199	33
Expenditures per Recipient	$6,913	$7,282	$6,046	$5,850	$6,464	$5,100	-26

Hospital

Medicaid covers both inpatient and outpatient hospital services. The table below shows total expenditures for all hospital services, with detail on inpatient and outpatient provided in following sections.

$107,692,150
Total Expenditures

↑3%
from SFY 2015

19.4%
of Total Medicaid Expenditures

SFY 2016

The Qualified Rate Adjustment (QRA) is a supplement for qualified hospital providers. Qualifying hospitals (i.e. Wyoming non-state government owned or operated hospitals with unreimbursed Medicaid costs) provide state share of the payment. Medicaid distributes corresponding Federal matching funds along with the state share to the participating hospitals. The QRA payments reported here are payments calculated using the previous SFY paid claims data and made during the current SFY.

Table 31. Total Hospital Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$114,357,604	$105,798,987	$108,839,452	$101,931,277	$104,523,947	$107,692,150	3
Recipients	42,525	44,107	42,667	40,033	42,480	40,958	-4
Expenditures per Recipient	$2,689	$2,399	$2,551	$2,546	$2,461	$2,629	7
QRA (Federal Share)	$6,828,879	$6,833,447	$8,329,770	$8,604,610	$9,441,087	$12,607,068	34
Total Expenditures w/ QRA	$121,186,483	$112,632,434	$117,169,222	$110,535,887	$113,965,034	$120,299,218	6

As shown below, 73 percent of Hospital expenditures were for Inpatient services, with 7 percent of those inpatient costs being for Neonatal Intensive Care Unit (NICU) services.

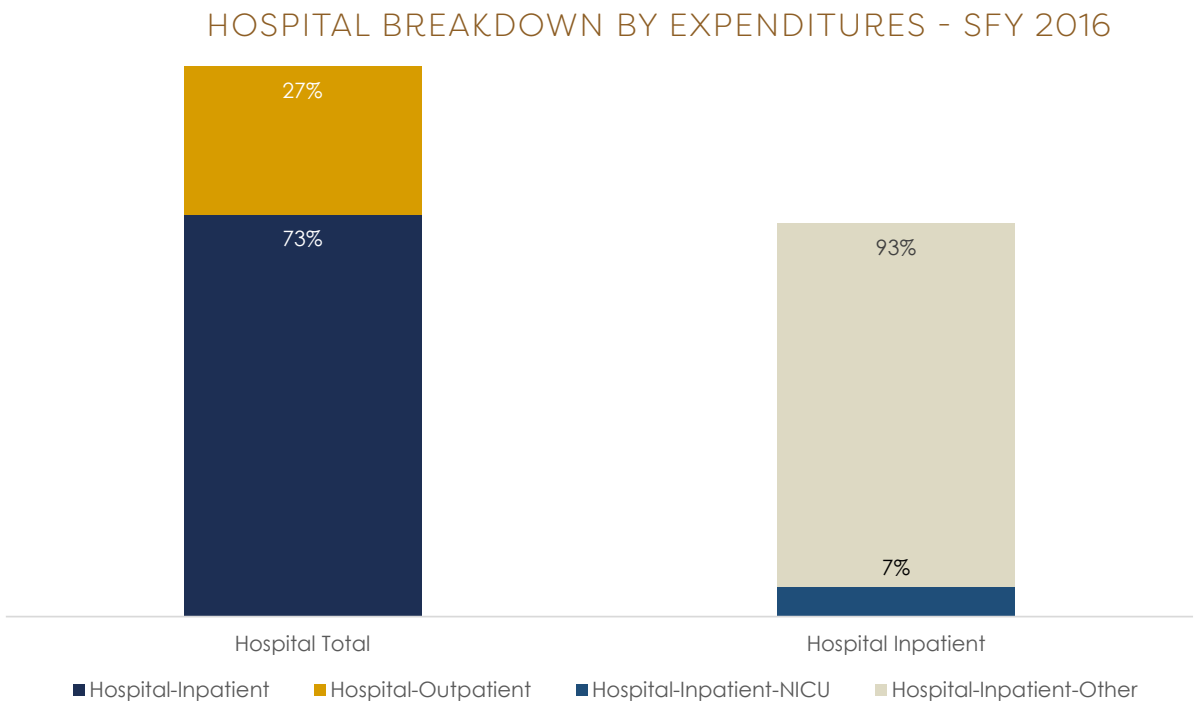


Figure 12. Hospital Breakdown by Expenditures - SFY 2016

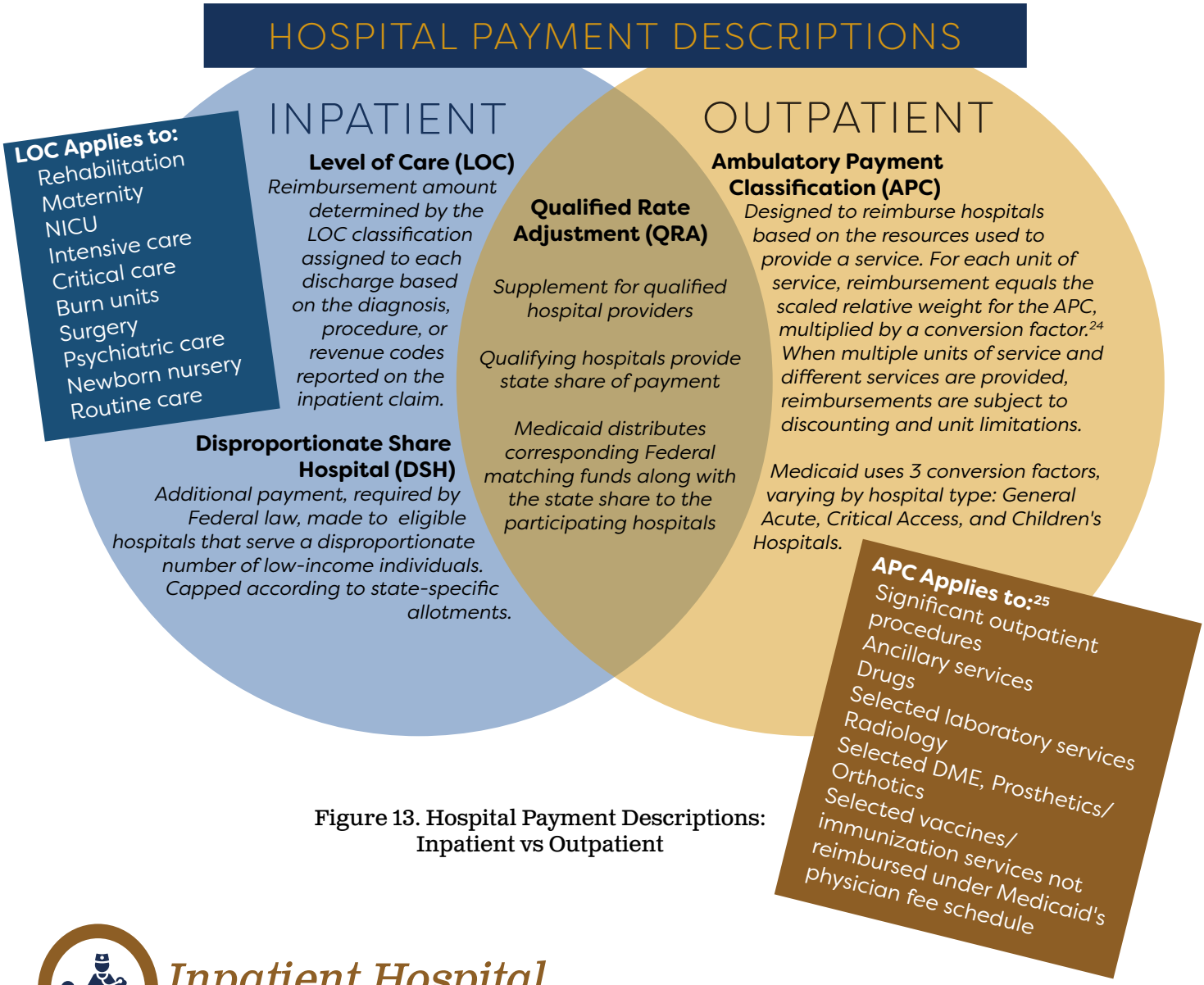


Figure 13. Hospital Payment Descriptions: Inpatient vs Outpatient

Inpatient Hospital

SFY 2016

$78,575,068
Total Expenditures

↑7%
from SFY 2015

14.2%
of Total Medicaid Expenditures

Medicaid covers inpatient hospital services,with the exception of alcohol and chemical rehabilitation services, cosmetic surgery, and experimental services. Medicaid covers only those surgical procedures that are medically necessary. Medicaid may not cover a surgery if there is a non-surgical alternative or if a provider performs the surgery only for the convenience of the individual.

Expenditure history by inpatient Level of Care codes is available in Appendix A.

[24] The scaled relative weight for an APC measures the resource requirements of the service and is based on the median cost (Medicare) of services in that APC. The conversion factor translates the scaled relative weights into dollar payment rates.

[25] Some services from the APC methodology are reimbursed on separate fee schedules, as follows: select DME are covered under DME fee schedule; select vaccines/immunizations, select radiology and mammography screening, diagnostic mammographies and therapies are covered under the Physician fee schedule; laboratory services are reimbursed on the laboratory fee schedule; and corneal tissue, dental, and bone marrow transplants, and new medical devices covered under Medicare's transitional pass-through payments are reimbursed a percent of charges

Table 32. Inpatient Hospital Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Total Inpatient Services							
Expenditures	$84,557,214	$77,130,425	$78,462,603	$72,932,440	$73,407,132	$78,575,068	-7
Recipients	11,640	10,890	10,970	10,293	10,607	10,054	-14
Expenditures per Recipient	$7,264	$7,083	$7,152	$7,086	$6,921	$7,815	8
QRA (Federal Share)	$2,379,785	$2,001,293	$2,248,251	$2,599,625	$2,667,482	$3,143,380	32
Total Expenditures w/ QRA	$86,936,999	$79,131,718	$80,710,854	$75,532,065	$76,074,614	$81,718,448	-6
NICU Services							
Expenditures	$3,567,130	$9,120,329	$6,335,289	$6,361,703	4,852,484	$5,633,758	58
Recipients	76	158	130	140	131	122	61
Expenditures per Recipient	$46,936	$57,724	$48,733	$45,441	$37,042	$46,178	-2
Other Inpatient Services							
Expenditures	$83,730,213	$75,436,885	$70,795,136	$72,100,900	$68,079,955	$67,773,375	-19
Recipients	12,243	11,558	10,831	10,896	10,225	10,586	-14
Expenditures per Recipient	$6,839	$6,527	$6.536	$6,617	$6,658	$6,402	-6

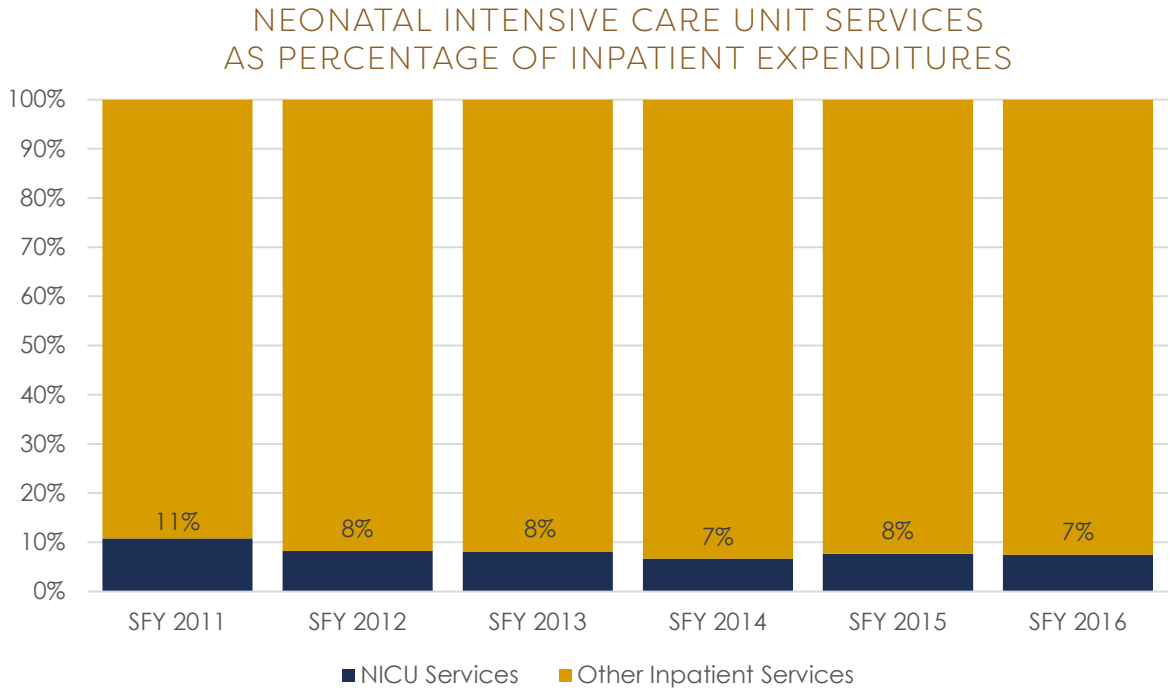


Figure 14. Neonatal Intensive Care Unit Services as Percentage of Inpatient Expenditures

Outpatient Hospital

SFY 2016

$28,975,050
Total Expenditures

↓7%
from SFY 2015

5.2%
of Total Medicaid Expenditures

Outpatient hospital services include emergency room, surgery, laboratory, radiology, and other testing services.

Medicaid limits visits to hospital outpatient departments to a maximum of 12 per calendar year for individuals over the age of 21.

There is no limit for Medicare crossovers or for individuals under age 21. Visits for family planning, Health Check services and emergency room are also unlimited.

Table 33. Outpatient Hospital Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$29,692,078	$28,657,373	$30,189,391	$28,703,147	$31,056,066	$28,975,050	-2
Recipients	39,757	41,772	40,148	37,618	40,167	38,751	-3
Expenditures per Recipient	$747	$686	$752	$763	$773	$748	0
QRA (Federal Share)	$4,449,094	$4,832,154	$6,081,517	$6,004,985	$6,773,605	$6,773,605	113
Total Expenditures w/ QRA	$34,141,172	$33,489,527	$36,270,908	$34,708,131	$37,829,671	$38,438,738	13

Emergency Room Utilization

SFY 2016

$11,411,497
Total Expenditures

↓6%
from SFY 2015

2.1%
of Total Medicaid Expenditures

The utilization of emergency room services remains a topic of high interest with questions regularly asked regarding overall cost of these services and which populations are high utilizers.

The data in this section incorporates both professional and institutional claims, using the criteria set forth by CMS in the core quality measures. Duplicate claims for each recipient on the same service date are accounted for resulting in a unique count of emergency room visits paid during the SFY.

Table 34. Emergency Room Utilization Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$10,689,120	$9,206,150	$9,831,233	$9,964,263	$12,128,641	$11,411,497	7
Recipients	27,223	26,940	26,309	24,878	26,520	27,080	-1
Expenditures per Recipient	$393	$342	$374	$401	$457	$462	18
Emergency Room Visits	57,816	56,907	55,556	52,383	57,795	51,787	-10
% of Total Medicaid Expenditures	2.1%	2.0%	1.9%	1.9%	2.3%	2.1%	

Table 35. Emergency Room Utilization by Eligibility Category

Eligibility Category	Expenditures[26]	Percent Change from SFY 2015	Recipients	Percent Change from SFY 2015	ER Visits	Percent Change from SFY 2015
ABD EID	$69,064	37	143	22	328	13
ABD ID/DD/ABI	$201,391	2	691	3	1,574	8
ABD Institution	$11,904	-7	36	29	59	79
ABD LTC	$367,414	8	1,363	2	3,411	0
ABD SSI	$1,861,534	-5	2,652	-5	8,022	-11
Adults	$2,941,947	9	4,123	10	10,529	4
Children	$5,203,349	-13	13,894	-11	23,505	-16
Medicare Savings Programs	$51,159	-15	766	-15	1,684	-21
Non-Citizens with Medical Emergencies	$27,085	-1	68	-7	96	-9
Pregnant Women	$640,305	-17	1,459	-9	2,517	-20
Special Groups	$34,079	-23	37	-36	83	-38
Total	**$11,411,497**	**-6**	**27,080**	**2**	**51,787**	**-10**

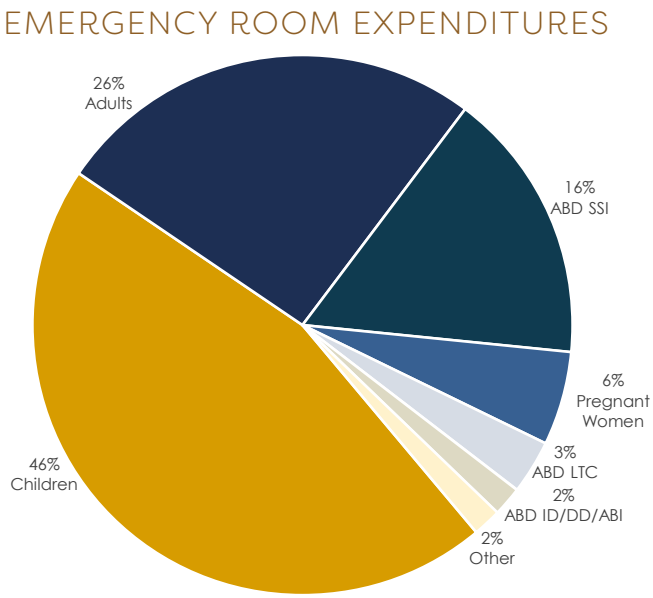


Figure 15. Emergency Room Utilization by Expenditures

Children accounted for almost one half (46 percent) of emergency room expenditures.

The bottom two percent of emergency room expenditures covered recipients in five eligibility categories: Medicare Savings Programs, ABD EID, Special Groups, Non-Citizens with Medical Emergencies, and ABD Institution. Each of these categories accounted for less than 1 percent of total emergency room expenditures.

The breakdown by number of unique visits is similar to that of expenditures, though the Medicare Savings Programs account for a greater percent of the visits (3 percent) than they do of the total expenditures, as these costs are primarily being paid by Medicare.

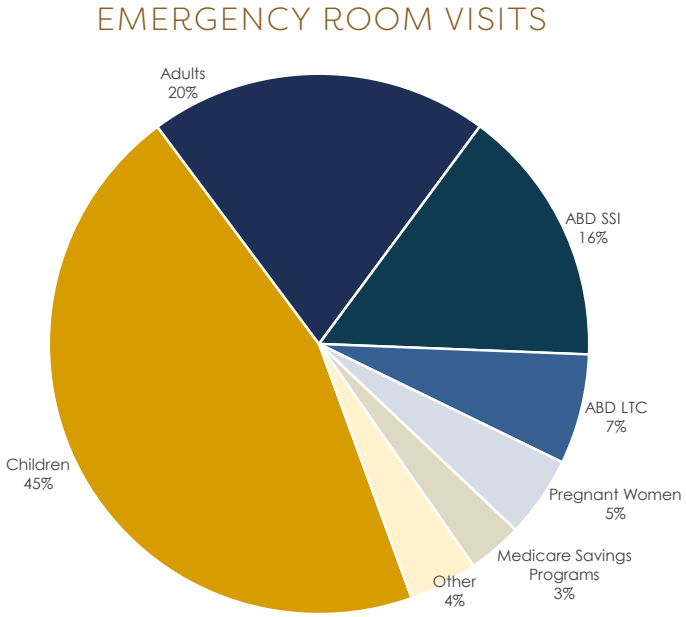


Figure 16. Emergency Room Visits

[26] Screenings and Gross Adjustments are excluded from this table; as such, summing expenditures across the eligibility categories will not match the total shown.

About one-third (33 percent) of Medicaid recipients used emergency room services in SFY 2016. The ABD SSI eligibility category had the greatest portion of recipients receiving emergency room services, with 44 percent, while Special Groups had the smallest with 23 percent.

Emergency room services accounted for 2.1 percent of total Medicaid expenditures in SFY 2016, with the Adult population having the greatest percentage (7 percent) of their total expenditures going toward emergency room services.

Table 37. Emergency Room Utilization vs Total Medicaid by Eligibility Category

Eligibility Category	ER Recipients	Total Medicaid Recipients	% Using ER Services	ER Expenditures	Total Medicaid Expenditures[27]	% Paid for ER Services
ABD EID	143	475	30%	$69,064	$4,730,644	1.5%
ABD ID/DD/ABI	691	2,637	26%	$201,391	$146,523,597	0.1%
ABD Institution	36	97	37%	$11,904	$3,976,596	0.3%
ABD LTC	1,363	4,805	28%	$367,414	$127,126,736	0.3%
ABD SSI	2,652	6,053	44%	$1,861,534	$54,218,689	3.4%
Adults	4,123	9,901	42%	$2,941,947	$42,070,572	7.0%
Children	13,894	46,120	30%	$5,203,349	$144,048,715	3.6%
Medicare Savings Programs	766	2,914	26%	$51,159	$4,098,086	1.2%
Non-Citizens with Medical Emergencies	68	259	26%	$27,085	$1,212,043	2.2%
Pregnant Women	1,459	5,472	27%	$640,305	$24,192,832	2.6%
Special Groups	37	149	25%	$34,079	$1,871,886	1.8%
Total	**24,706**	**75,015**	**33%**	**$11,411,497**	**$554,583,138**	**2.1%**

Intermediate Care Facility - Intellectually Disabled

SFY 2016

$18,193,221
Total Expenditures

↑1%
from SFY 2015

3.3%
of Total Medicaid Expenditures

Medicaid coverage of Intermediate Care Facilities for individuals with intellectual disabilities (ICF-ID) services is available only in a residential facility licensed and certified by the state survey agency as an ICF-ID. In Wyoming the sole facility is the Wyoming Life Resource Center. ICF-ID is a service unique to Medicaid and is not commonly covered by other payers.

Table 36. Intermediate Care Facility - Intellectually Disabled Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$11,388,412	$10,065,657	$17,942,326	$19,152,530	$18,091,427	$18,193,221	60
Recipients	84	84	81	79	75	70	-17
Expenditures per Recipient	$135,576	$119,829	$221,510	$242,437	$241,219	$259,903	92

[27] Screenings and Gross Adjustments are excluded from this table; as such, summing expenditures across the eligibility categories will not match the total shown.

Laboratory

Medicaid covers professional and technical laboratory services ordered by a practitioner that are directly related to the diagnosis and treatment of the individual as specified in the treatment plan developed by the ordering practitioner.

$1,536,310
Total Expenditures

↑1%
from SFY 2015

0.3%
of Total Medicaid Expenditures

SFY 2016

Table 38. Laboratory Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$1,171,185	$1,100,774	$1,149,473	$1,284,678	$1,516,042	$1,536,310	31
Recipients	9,923	9,415	9,724	9,490	8,832	9,561	-4
Expenditures per Recipient	$118	$117	$118	$135	$172	$161	36

Nursing Facility

Medicaid covers nursing facility services for individuals who are no longer able to live in the community. Medicaid also provides long-term care services to individuals on select waivers. This section focuses on nursing facility services. A pay rate change was approved and implemented July 1, 2015.

$82,445,811
Total Expenditures

↑17%
from SFY 2015

14.9%
of Total Medicaid Expenditures

SFY 2016

A nursing facility is an institution (or a distinct part of an institution), which is not primarily for the care and treatment of mental diseases, and provides skilled nursing care and related services to residents who require medical or nursing care, rehabilitation services for injured, disabled or sick individuals, and health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which is available to them only through institutional facilities.

NURSING FACILITY PAYMENT DESCRIPTIONS

Per Diem Rate

Based on facility-specific cost reports
May not exceed maximum rate established by Medicaid

Includes:
Limited reserve bed days
Routine services (room, dietary, laundry, nursing, minor medical surgical supplies, non-legend pharmaceutical items, use of equipment & facilities)

Excludes:
physician visits, hospitalizations, laboratory, x-rays, and prescription drugs which are reimbursed separately.

Provider Assessment and Upper Payment Limit (UPL)

Supplemental payment for qualified nursing facilities

Based on calculations from most recent cost reports & comparisons to what would have been paid for Medicaid services under Medicare's payment principles

Assessment collected on all non-Medicare days & UPL payment paid on Medicaid days once corresponding federal matching dollars are obtained.

Extraordinary Care Per Diem Rates

Paid for services provided to a resident with extraordinary needs

Medicaid determines per case rates for extraordinary care based on relevant cost and a review of medical records.

Enhanced Adult Psychiatric Reimbursement

Provided to encourage nursing facilities to accept adults who require individualized psychiatric care

Figure 17. Nursing Facility Payment Descriptions

Program of All-Inclusive Care for the Elderly

SFY 2016

$2,934,877
Total Expenditures

↑31%
from SFY 2015

0.5%
of Total Medicaid Expenditures

The Program of All-Inclusive Care for the Elderly (PACE) is available in Laramie County to qualified individuals ages 55 and older as an alternative to nursing home care. Each participant has a plan of care developed by a team of healthcare professionals to improve and maintain the participant's overall health. The participant works with the team to develop and update their plan of care.

Services available under PACE include primary care, specialty medical care, dental, social work counseling, meals, nutritional counseling, laboratory, radiology, prescription drug, hospital, emergency, nursing home, home care, adult day care, personal care, physical therapy, occupational therapy, recreational therapy, and transportation.

Table 39. Program of All-Inclusive Care for the Elderly Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	3 Year Percent Change
Expenditures	-	-	$168,398	$1,288,934	$2,242,570	$2,934,877	1,643
Recipients	-	-	22	63	95	118	436
Expenditures per Recipient	-	-	$7,654	$20,459	$23,606	$24,872	225

Physician and Other Practitioner

SFY 2016

$58,278,406
Total Expenditures

↓5%
from SFY 2015

10.5%
of Total Medicaid Expenditures

Medicaid places the following limits on physician and other practitioner services:

- Hospital outpatient departments, physician offices, and optometrist offices - 12 visit max per calendar year for individuals over age 21
- Physical, occupational, and speech therapy - 20 visit max *each* per calendar year for individuals over age 21
- No limit for Medicare crossovers or individuals under age 21
- No limit for family planning visits, Health Check services or emergency services

Medical services provided by physicians, physician assistants, physical and occupational therapists, ophthalmologists and nurse practitioners are reimbursed based on the resource-based relative value scale (RBRVS) methodology. This methodology is based on estimates of the costs of resources required to provide physician services and includes a relative value unit (RVU) and a conversion factor. Each RVU reflects the resources used by a physician to deliver a service, compared to resources used for other physicians' services, considering the time and intensity of the physician's effort in providing a service, the physician's practice expense and malpractice expenses. The RVU is multiplied by a conversion factor (the average cost for all procedures) to determine the rate for the fee schedule.

Services provided by anesthesiologists are reimbursed based on RVUs developed and published

by the American Society of Anesthesiologists.

Family health, family practice and general practice physician represent 26 percent of total physician and other practitioner expenditures.

Table 40. Physician and Other Practitioner Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Total Physician and Other Practitioner Services							
Expenditures	$65,226,891	$62,845,816	$62,856,989	$62,372,535	$61,249,367	$58,278,406	-11
Recipients	64,940	63,695	61,515	65,285	62,825	61,540	-5
Expenditures per Recipient	$1,004	$987	$1,022	$955	$975	$947	-6
Physician Only Services							
Expenditures	$59,880,382	$57,483,815	$57,459,450	$56,694,139	$54,142,991	$50,015,210	-16
Recipients	64,307	63,158	60,830	64,721	62,117	60,777	-5
Expenditures per Recipient	$931	$910	$945	$876	$872	$823	-12
Other Practitioner Services							
Expenditures	$5,346,509	$5,362,001	$5,397,540	$5,678,397	$7,106,377	$8,263,196	55
Recipients	8,295	7,713	8,034	7,778	9,210	9,108	10
Expenditures per Recipient	$645	$695	$672	$730	$772	$907	41

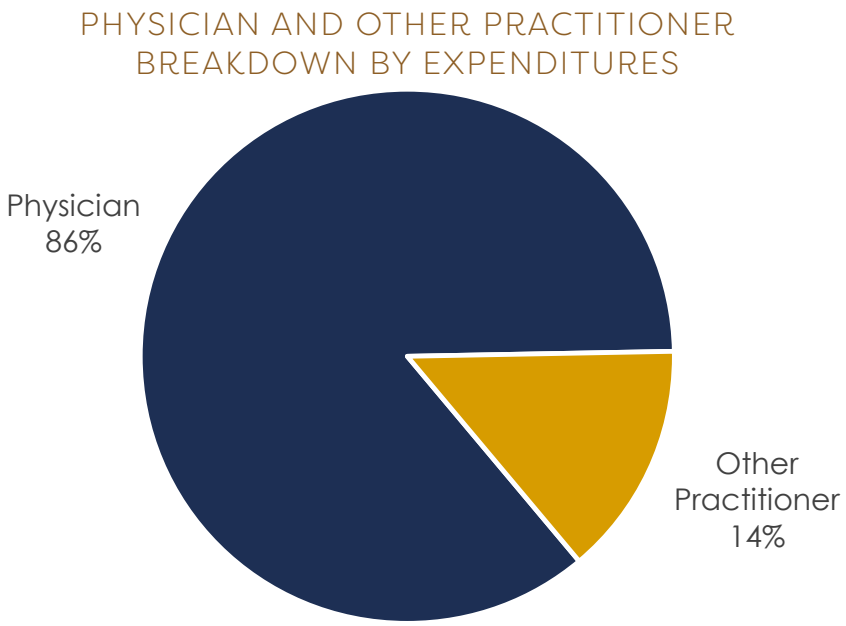


Figure 18. Physician and Other Practitioner Breakdown by Expenditures

Prescription Drug

SFY 2016

$48,597,364
Total Expenditures

↑1%
from SFY 2015

8.8%
of Total Medicaid Expenditures

Medicaid covers most prescription drugs and specific over-the-counter drugs. A prescription and co-payment are required for all drugs for most individuals. Exceptions may apply for specific products or conditions.

In SFY 2016, Medicaid designated preferred drugs in 123 specific drug classes.

Table 41. Prescription Drug Services Summary [28]

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$41,352,500	$41,914,658	$39,110,022	$41,238,663	$47,946,923	$48,597,364	18
Recipients	50,118	48,222	47,607	44,464	46,031	43,932	-12
Expenditures per Recipient	$825	$869	$822	$927	$1,042	$1,106	34

Medicaid has a Drug Utilization Review (DUR) program to ensure individuals are receiving appropriate, medically necessary medications. More information regarding DUR is available in the Subprograms section of this report.

The Medicaid Drug Rebate Program was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) and requires that drug manufacturers have a national rebate agreement with the HHS Secretary. Medicaid refers to these rebates as OBRA rebates. In order for Medicaid to cover a prescription drug, Medicaid must receive an OBRA rebate on that prescription drug. This federal mandate provides Medicaid the opportunity to receive greatly discounted prices, similar to those offered by drug manufacturers to large purchasers in the marketplace. Medicaid is a member of the Sovereign States Drug Consortium (SSDC) which is a collaborative of state Medicaid programs that negotiate and acquire rebates from drug manufacturers, supplemental to the Medicaid Drug Rebate Program. Supplemental rebates augment the Medicaid Drug Rebate Program savings that the SSDC states realize because of OBRA.

Table 42. Pharmacy Cost Avoidance - SFY 2016 [29]

Program Area	Cost Avoidance
Prior Authorization (PA) Preferred Drug List (PDL)	$9,821,265
State Maximum Allowable Cost (SMAC)	$17,045,765
Total	**$26,867,030**

Table 43. Prescription Drug Rebates History

	Rebate (millions)
SFY 2011	$17.8
SFY 2012	$19.3
SFY 2013	$19.4
SFY 2014	$21.4
SFY 2015	$20.1
SFY 2016	$31.4

In addition to the Drug rebates in Table 43, Medicaid collects J-Code rebates from drug manufacturers for physician-administered drugs or injectable drugs. Collection for physician-administered drugs is mandated by the Deficit Reduction Act of 2005. In SFY 2016, J-Code Rebates totaled $1,930,282.

[28] Data includes expenditures for pharmacies only and does not take into account rebate amounts.
[29] Total Cost Avoidance dollars are from both Medicaid and the Prescription Drug Assistance Program (PDAP). The PDAP contributes a lesser amount of the total dollars and is a non-Medicaid state funded program.

Psychiatric Residential Treatment Facility

Medicaid covers psychiatric residential treatment for individuals under age 21 in a Psychiatric Residential Treatment Facility (PRTF). A PRTF is a stand-alone entity providing a range of comprehensive services to treat the psychiatric conditions of residents on an inpatient basis under the direction of a physician, with the goal of improving the resident's condition or preventing further regression so services will no longer be needed. PRTFs are nationally accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation of Services for Families and Children (COA).

SFY 2016

$11,797,657
Total Expenditures

↓13%
from SFY 2015

2.1%
of Total Medicaid Expenditures

Table 44. Psychiatric Residential Treatment Facility Services Summary [30]

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$15,244,613	$8,019,118	$12,080,494	$14,886,133	$13,575,847	$11,797,657	-23
Recipients	403	274	328	338	332	298	-26
Expenditures per Recipient	$37,828	$29,267	$36,831	$44,042	$40,891	$39,589	5

Each PRTF resident has an individualized plan of care developed by a team of physicians and behavioral health specialists employed by or providing services at the PRTF. This plan confirms the need for residential psychiatric care and is designed to achieve the resident's discharge from the inpatient status at the earliest possible time. The team of specialists reviews this plan at least every 7 days (will vary by resident and their level of need) and documents responses to treatment and any plan revisions. The plan assists in determining the medical necessity of a continued stay, or documenting progress towards goals to assist with discharge planning.

Medicaid continues to review rate recommendations developed by our actuarial consultants based on an analysis of Medicaid cost reports, and make appropriate changes.

Medicaid continues to collaborate with its enrolled PRTFs, CMS, and other state agencies and stakeholders to ensure compliance with federal guidelines and make changes, as appropriate. Medicaid cannot receive, per CMS guidelines, the Federal Medical Assistance Percentage (FMAP) for PRTF services that are court ordered. Court orders cannot reference a facility name or a specific level of care, as only a physician should be ordering a client into a PRTF based upon medical necessity.

As of July 1, 2013, court ordered PRTF services with incorrect language in the court order or court ordered services that no longer meet PRTF medical necessity are no longer being reimbursed with 100 percent state funds. As such, SFY 2014 saw a significant decrease in non-Medicaid payments made for such PRTF court ordered recipients.

[30] Due to court-ordered placements not complying with CMS rules, SFY 2012 and SFY 2013 had decreases in Medicaid PRTF placements as these placement orders did not qualify for federal matching funds. This led to significant increases in State General Fund only placements (expenses paid for by DHCF but not included in the Medicaid budget).

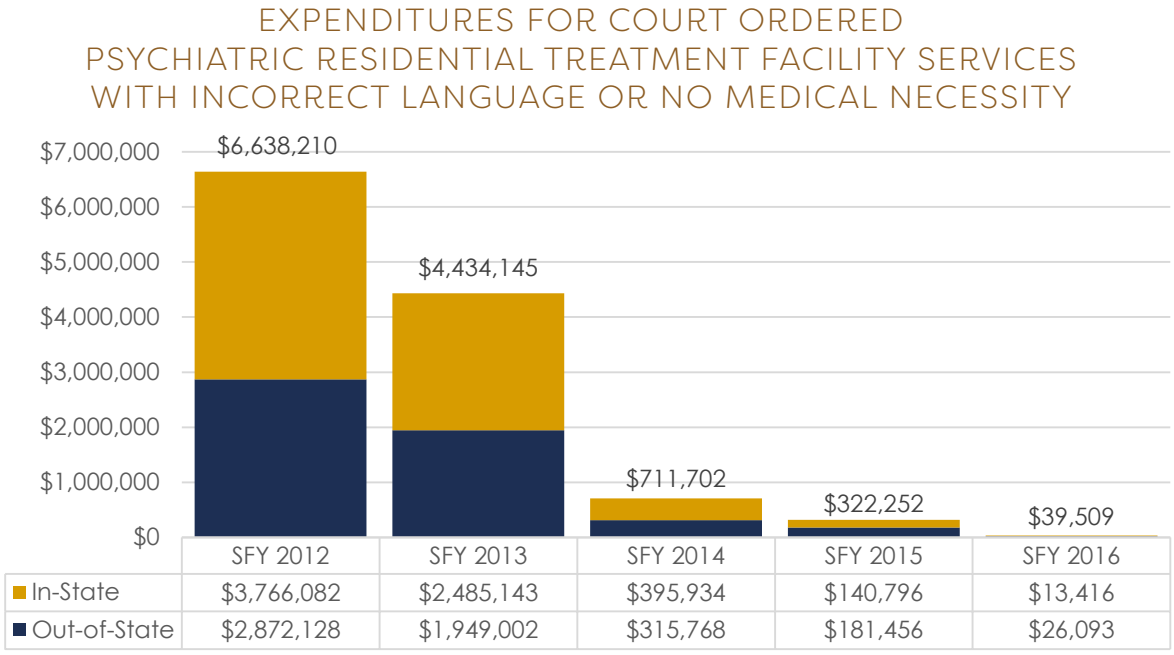


Figure 19. Expenditures for Court Ordered Psychiatric Residential Treatment Facility Services with Incorrect Language or No Medical Necessity

Continuing efforts by Medicaid and the DFS to ensure language submitted on court orders follow federal guidelines has significantly reduced overall general fund expenditures by allowing Medicaid to receive the FMAP.

Public Health or Welfare

SFY 2016

$1,072,715
Total Expenditures

↑6%
from SFY 2015

0.2%
of Total Medicaid Expenditures

Public health clinic services are physician and mid-level practitioner services provided in a clinic designated by the Department of Health as a public health clinic. Services must be provided directly by a physician or a public health nurse under a physician's immediate supervision (i.e. the physician has seen the client and ordered the service).

Table 45. Public Health or Welfare Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$1,093,398	$988,455	$924,007	$962,164	$1,009,814	$1,072,715	-2
Recipients	7,731	6,466	6,238	5,772	5,969	5,995	-22
Expenditures per Recipient	$141	$153	$148	$167	$169	$179	27

Public Health, Federal

Public Health, Federal services are provided to the American Indian and Alaskan Native population by Tribal Contract Health Centers and Indian Health Centers. The Tribal Contract Health Centers are outpatient health care programs and facilities owned or operated by the Tribes or Tribal organizations. Indian Health Centers are FQHCs designated to provide comprehensive primary care and related services to the American Indian and Alaskan Native population. Services provide by these facilities are claimed by the state at 100% Federal Financial Participation (FFP).

SFY 2016

$8,479,944
Total Expenditures

↓3%
from SFY 2015

1.5%
of Total Medicaid Expenditures

Table 46. Public Health, Federal Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$8,532,271	$7,240,130	$8,067,975	$7,999,556	$8,761,358	$8,479,944	-1
Recipients	4,551	3,249	4,222	3,546	3,382	3,416	-25
Expenditures per Recipient	$1,875	$2,228	$1,911	$2,256	$2,591	$2,482	32

Rural Health Clinic

A Rural Health Clinic (RHC) provides primary care services. Medicaid covers services provided by a physician, nurse practitioner, certified nurse midwife, visiting nurse, clinical psychologist, certified social worker, and physician assistant, as well as services and supplies incident to a physician's service.

SFY 2016

$1,413,842
Total Expenditures

↓3%
from SFY 2015

0.3%
of Total Medicaid Expenditures

Medicare designates a health clinic as an RHC if it is located in an area designated as a "shortage area." Shortage areas are defined geographic areas designated by the HHS as having either a shortage of personal health services or a shortage of primary medical care professionals. An RHC differs from a FQHC based on several criteria related to location, shortage area, corporate structure, requirements for a board of directors and clinical staffing requirements.[31] Since RHCs are reimbursed through an encounter rate, it is expected that as recipients increase, expenditures would also increase. Reimbursement rate includes the office visit, as well as any ancillary services provided (x-rays, etc.). Adjustments may be made to rates if a provider requests a review of its rate based on a change in its scope of service.

Table 47. Rural Health Clinic Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$1,940,640	$1,628,043	$1,845,491	$1,521,233	$1,668,167	$1,413,842	-27
Recipients	5,277	4,174	5,418	4,670	4,530	3,783	-28
Expenditures per Recipient	$368	$390	$341	$326	$368	$374	2

[31] Comparison of the Rural Health Clinic and Federally Qualified Health Center Programs, US Department of Health and Human Services Health Resources and Services Administration, Revised June 2006. Available online: http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf

Vision

SFY 2016

$3,652,188
Total Expenditures

↑2%
from SFY 2015

1.2%
of Total Medicaid Expenditures

Medicaid covers vision services provided by opticians, optometrists, and ophthalmologists. These services vary depending on recipient age. Children receive vision services to correct and maintain healthy vision, and adults may receive services to treat an eye injury or eye disease. Vision services provided by ophthalmologists are included in the Physician and Other Practitioners section of this report.

Medicaid covers eyeglasses for children and vision therapy based on diagnosis codes. Medicaid reimburses the dispensing of eyeglasses, as well as the dispensing of frames, frame parts, or lenses. Adults who have an eye injury or eye disease may be seen for treatment of the injury or disease, but are not eligible to receive corrective eye wear.

Table 48. Vision Services Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$3,227,545	$3,192,131	$3,389,793	$3,464,394	$3,595,216	$3,652,188	13
Recipients	14,120	13,940	14,180	14,558	15,010	15,241	8
Expenditures per Recipient	$229	$229	$239	$238	$240	$240	5

Waivers

Medicaid offers various waivers with approval from the federal government to selectively "waive" one or more Medicaid requirements and subsequently allow for greater flexibility in the Medicaid program. These waivers include eight Home and Community Based Services (HCBS) Waivers and one Section 1115 Waiver. Medicaid manages three of the HCBS waivers and the Section 1115 waiver, while the Behavioral Health Division (BHD) manages the remaining HCBS Waivers. This breakdown is shown below.

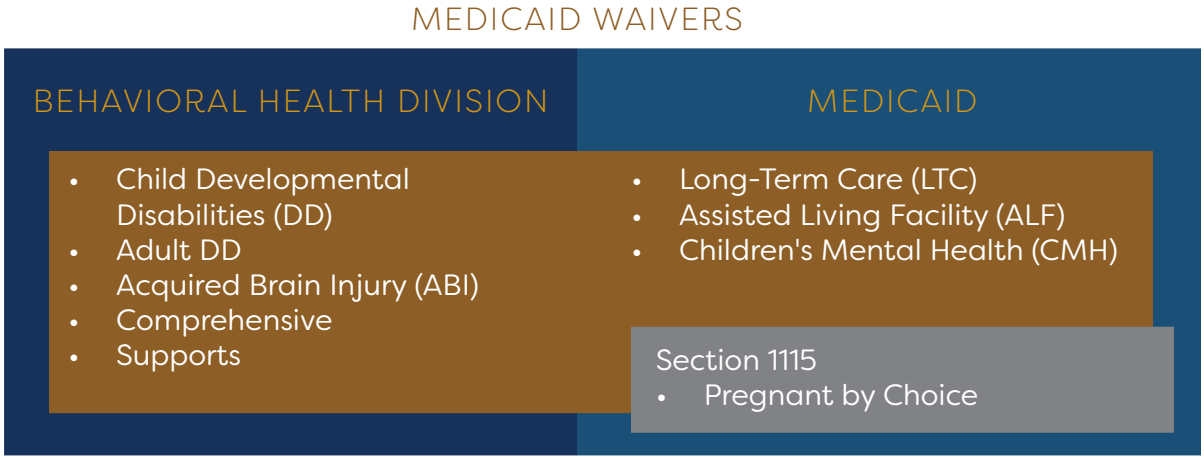
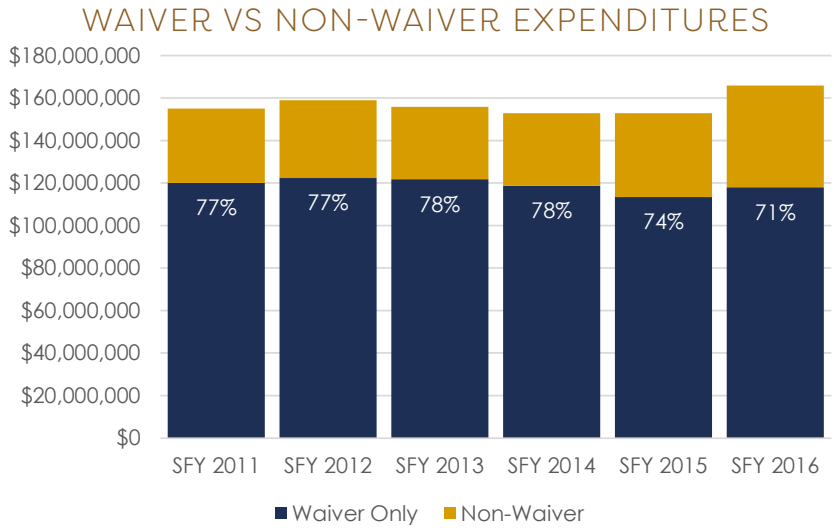


Figure 20. Medicaid Waivers

HCBS Waiver participants receive specific waiver services, as well as the standard Medicaid package of benefits, referred to in this report as "non-waiver" services. Pregnant by Choice Waiver individuals only receive waiver services.

Home & Community Based Services Waivers



$117,950,473
Waiver Only Expenditures

↑4%
from SFY 2015

21.3%
of Total Medicaid Expenditures

SFY 2016

Figure 21. Waiver vs Non-Waiver Expenditures

Table 49. Home and Community Based Services Waiver Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Waiver Only Services							
Expenditures	$120,049,329	$122,327,742	$121,752,688	$118,624,631	$113,452,108	$117,950,473	-2
Recipients	4,413	4,302	4,207	4,168	4,443	4,829	9
Expenditures per Recipient	$27,204	$28,435	$28,941	$28,461	$25,535	$24,425	-10
% Waiver-Only of Total Waivers	77%	77%	78%	78%	74%	71%	
Non-Waiver Services							
Expenditures	$34,967,575	$36,678,558	$34,089,088	$34,172,122	$39,359,014	$47,958,177	37
Recipients	4,605	4,491	4,391	4,352	4,528	4,924	7
Expenditures per Recipient	$7,593	$8,167	$7,763	$7,852	$8,692	$9,740	28
Total Waiver							
Expenditures	$155,016,904	$159,006,300	$155,841,776	$152,796,753	$152,811,123	$165,908,650	7
Recipients	4,709	4,590	4,504	4,462	4,667	5,090	8
Expenditures per Recipient	$32,919	$34,642	$34,601	$34,244	$32,743	$32,595	-1

As shown in the figures below, in SFY 2016 Total Comprehensive waiver expenditures accounted for over two-thirds of all HCBS Expenditures, with 77 percent of its expenditures for waiver-only services.

By contrast, the Children's Mental Health waiver expenditures accounted for less than one percent of all HCBS Expenditures, with only seven percent of its expenditures for waiver-only services.

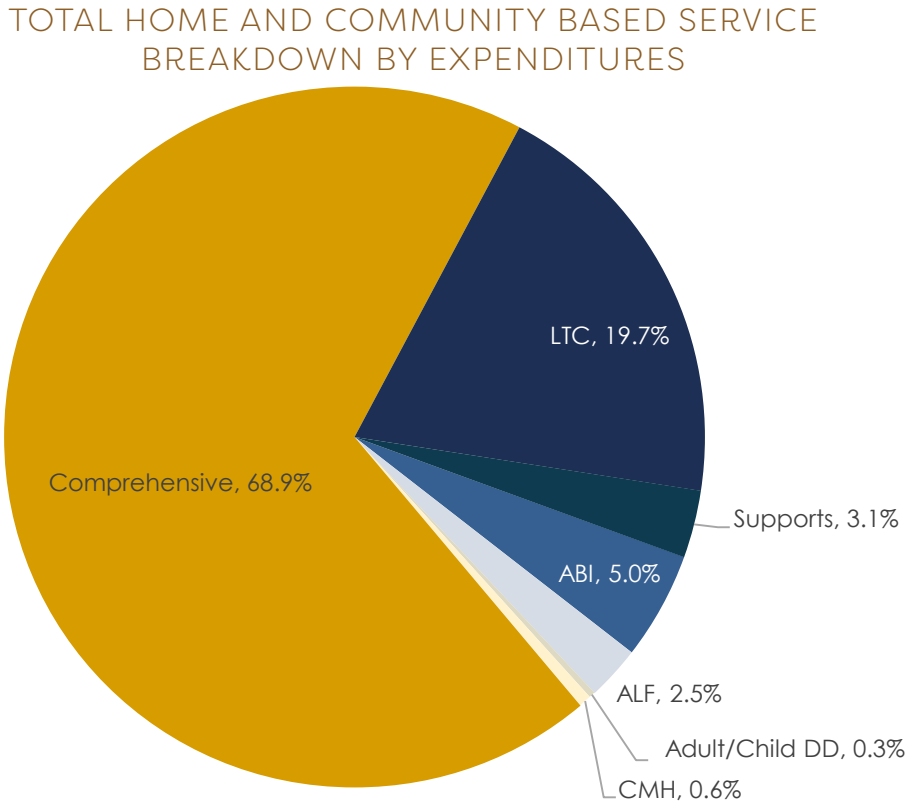
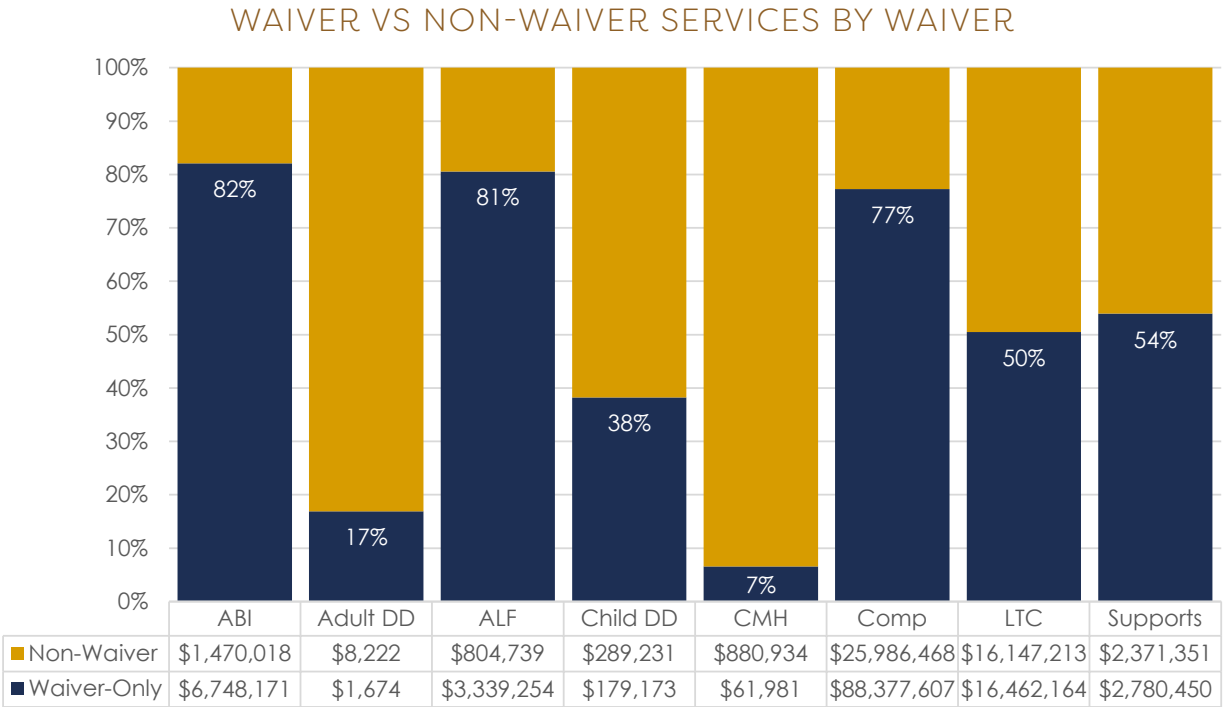


Figure 23. Total Home and Community Based Service Breakdown by Expenditures



	ABI	Adult DD	ALF	Child DD	CMH	Comp	LTC	Supports
Non-Waiver	$1,470,018	$8,222	$804,739	$289,231	$880,934	$25,986,468	$16,147,213	$2,371,351
Waiver-Only	$6,748,171	$1,674	$3,339,254	$179,173	$61,981	$88,377,607	$16,462,164	$2,780,450

Figure 22. Waiver vs Non-Waiver Services by Waiver

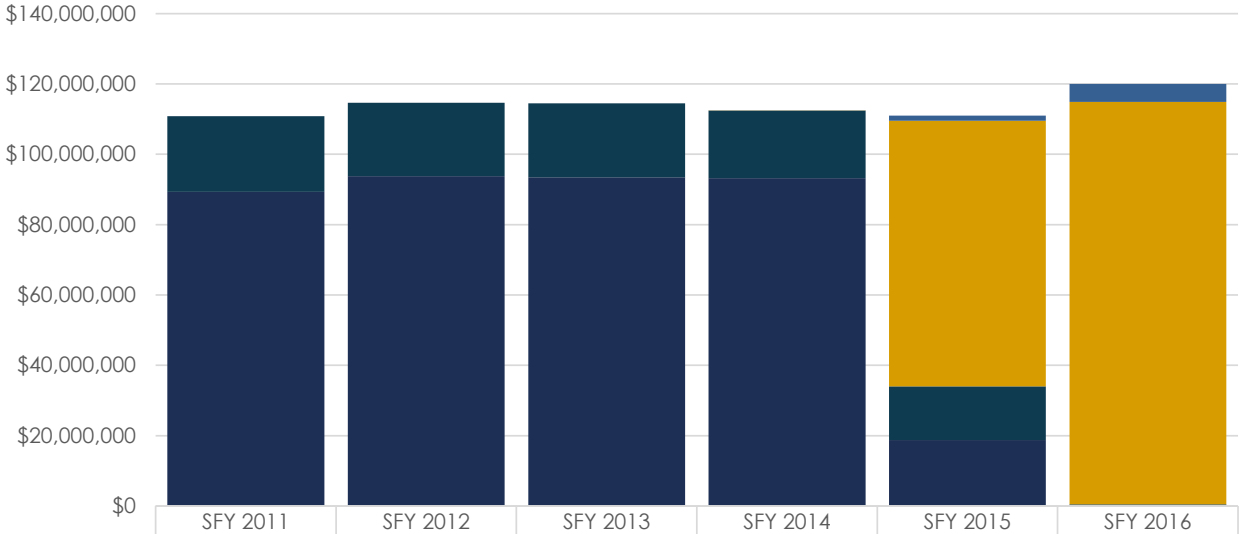
Medicaid partnered with the Wyoming Behavioral Health Division to provide an array of services to adults and children with developmental disabilities (DD) using these two waivers, which were designed to assist adults and children with DD in receiving training and support that would allow them to remain in their home communities and avoid institutionalization.

In SFY 2015 members of these waivers were transitioned to the new Comprehensive and Supports Waivers, with that transition being complete as of September 30, 2014 for adults and June 30, 2015 for children. The figure below shows the change in expenditures as this transition was implemented.

SFY 2016

	Adult DD	Child DD
Waiver Only Expenditures	$1,674	$179,173
from SFY 2015	↓100%	↓98%
of Total Medicaid Expenditures	0%	0.03%

EXPENDITURE HISTORY FOR TRANSITION FROM ADULT/CHILD DD WAIVERS TO COMPREHENSIVE AND SUPPORTS WAIVERS



	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Supports	$0	$0	$0	$568	$1,395,616	$5,151,800
Comprehensive	$0	$0	$0	$61,132	$75,532,821	$114,364,075
Child DD	$21,535,672	$20,897,302	$21,053,459	$19,119,880	$15,278,837	$468,404
Adult DD	$89,288,685	$93,731,860	$93,426,901	$93,224,222	$18,739,515	$9,897

Figure 24. Expenditure History for Transition from Adult/Child DD Waivers to Comprehensive and Supports Waivers

Table 50. Adult Developmental Disabilities Waiver Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Waiver Only Services							
Expenditures	$81,369,215	$84,846,084	$84,204,861	$83,501,095	$16,541,190	$1,674	-100
Recipients	1,355	1,380	1,395	1,409	1,325	2	-100
Expenditures per Recipient	$60,051	$61,483	$60,362	$59,263	$12,484	$837	-99
% Waiver-Only of Total Waivers	91%	91%	90%	90%	88%	17%	
Non-Waiver Services							
Expenditures	7,919,471	8,885,776	9,222,040	9,723,128	2,198,325	8,222	-100
Recipients	1,367	1,394	1,407	1,426	1,276	67	-95
Expenditures per Recipient	$5,793	$6,374	$6,554	$6,818	$1,723	$123	-98
Total Waiver							
Expenditures	$89,288,685	$93,731,860	$93,426,901	$93,224,222	$18,739,515	$9,897	-100
Recipients	1,394	1,423	1,444	1,455	1,385	69	-95
Expenditures per Recipient	$64,052	$65,869	$64,700	$64,072	$13,530	$143	-100

Table 51. Child Developmental Disabilities Waiver Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Waiver Only Services							
Expenditures	$14,128,741	$13,646,013	$13,301,942	$11,415,264	$8,372,841	$179,173	-99
Recipients	799	773	761	699	659	148	-81
Expenditures per Recipient	$17,683	$17,653	$17,480	$16,331	$12,705	$1,211	-93
% Waiver-Only of Total Waivers	66%	65%	63%	60%	55%	38%	
Non-Waiver Services							
Expenditures	$7,406,932	$7,251,289	$7,751,518	$7,704,616	$6,905,996	$289,231	-96
Recipients	800	782	769	715	651	226	-72
Expenditures per Recipient	$9,259	$9,273	$10,080	$10,776	$10,608	$1,280	-86
Total Waiver							
Expenditures	$21,535,672	$20,897,302	$21,053,459	$19,119,880	$15,278,837	$468,404	-98
Recipients	830	810	799	743	679	282	-66
Expenditures per Recipient	$25,947	$25,799	$26,350	$25,733	$22,502	$1,661	-94

Medicaid and the BHD also work together to provide services to adults with acquired brain injury (ABI). The waiver was developed to assist adults -- ages 21 to 65 -- with an ABI in receiving training and support so they may remain in their home communities and avoid institutionalization. Individuals on the waiver may remain on the waiver without aging off.

This waiver is in the process of closing, with enrolled members currently being transitioned to the Comprehensive and Supports waivers. Expected completion of this transition is during SFY 2017.

$6,748,171
Waiver Only Expenditures

↑2%
from SFY 2015

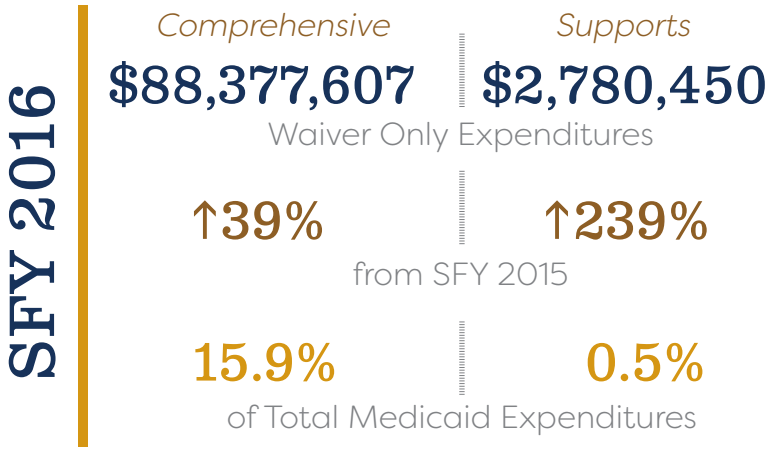
1.2%
of Total Medicaid Expenditures

SFY 2016

Table 52. Acquired Brain Injury Waiver Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Waiver Only Services							
Expenditures	$6,963,271	$6,925,596	$7,679,811	$7,371,614	$6,636,440	$6,748,171	-3
Recipients	177	188	186	181	168	163	-8
Expenditures per Recipient	$39,341	$36,838	$41,289	$40,727	$39,503	$41,400	5
% Waiver-Only of Total Waivers	82%	84%	85%	86%	83%	82%	
Non-Waiver Services							
Expenditures	$1,565,807	$1,325,676	$1,331,294	$1,211,369	$1,351,962	$1,470,018	-6
Recipients	180	191	192	178	169	165	-8
Expenditures per Recipient	$8,699	$6,941	$6,934	$6,805	$8,000	$8,909	2
Total Waiver							
Expenditures	$8,529,077	$8,251,272	$9,011,104	$8,582,983	$7,988,402	$8,218,189	-4
Recipients	186	199	196	184	171	167	-10
Expenditures per Recipient	$45,855	$41,464	$45,975	$46,647	$46,716	$49,211	7

Comprehensive and Supports Waivers



The Comprehensive and Supports Waivers were designed to meet the requirements of SEA82.

The Comprehensive Waiver funds services based on assessed need, as measured by the standardized Inventory for Client and Agency Planning (ICAP) tool.

The Supports Waiver provides more flexible, although capped, funding for supportive services.

Both waivers went into effect on April 1, 2014. Individuals enrolled in the Adult DD or Child DD waivers were allowed to transfer to one of these two new waivers, with those transitions being complete in SFY 2015 and SFY 2016 respectively.

Table 53. Comprehensive and Supports Waivers Summary

	Comprehensive Waiver			Supports Waiver		
	SFY 2014	SFY 2015	SFY 2016	SFY 2014	SFY 2015	SFY 2016
Waiver Only Services						
Expenditures	$44,982	$63,719,016	$88,377,607	$454	$819,690	$2,780,450
Recipients	3	1,755	1,925	0	191	425
Expenditures per Recipient	$14,994	$36,307	$45,910	--	$4,292	$6,542
% Waiver-Only of Total Waivers	74%	84%	77%	80%	59%	54%
Non-Waiver Services						
Expenditures	$16,150	$11,813,805	$25,986,468	$114	$575,926	$2,371,351
Recipients	29	1,728	1,902	3	179	406
Expenditures per Recipient	$557	$6,837	$13,663	$38	$3,217	$5,841
Total Waiver						
Expenditures	$61,132	$75,532,821	$114,364,075	$568	$1,395,616	$5,151,800
Recipients	31	1,836	1,949	3	203	443
Expenditures per Recipient	$1,972	$41,140	$58,678	$189	$6,875	$11,629

Long-Term Care Waiver

Medicaid provides long-term care services through the Long-Term Care (LTC) Waiver. This waiver provides in-home services to participants ages 19 and older who require services equivalent to a nursing facility level of care. Medicaid requires a functional assessment to determine eligibility for the LTC Waiver and will not cover services for an individual who has not met the level of care assessment criteria.

$16,462,164
Waiver Only Expenditures

↑19%
from SFY 2015

3%
of Total Medicaid Expenditures

SFY 2016

The LTC Waiver includes a Consumer-Directed Care option for participants who are capable of directing their own care. This option allows participants to recruit, hire, train, schedule, evaluate and terminate their own personal care assistants. Medicaid continues to strengthen the quality assurance component of the waiver program by increasing provider accountability and developing internal processes to gather data to evaluate strengths and weaknesses.

Table 54. Long-Term Care Waiver Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Waiver Only Services							
Expenditures	$13,912,032	$13,355,638	$13,425,205	$13,169,724	$13,857,541	$16,462,164	18
Recipients	1,801	1,718	1,674	1,700	1,819	2,067	15
Expenditures per Recipient	$7,725	$7,774	$8,020	$7,747	$7,618	$7,964	3
% Waiver-Only of Total Waivers	48%	44%	48%	48%	49%	50%	
Non-Waiver Services							
Expenditures	$15,372,652	$17,100,473	$14,469,542	$14,025,261	$14,700,371	$16,147,213	5
Recipients	1,943	1,845	1,821	1,825	1,921	2,149	11
Expenditures per Recipient	$7,912	$9,269	$7,946	$7,685	$7,652	$7,514	-5
Total Waiver							
Expenditures	$29,284,684	$30,456,111	$27,894,747	$27,194,984	$28,557,911	$32,609,378	11
Recipients	1,983	1,884	1,860	1,877	1,967	2,219	12
Expenditures per Recipient	$14,768	$16,166	$14,997	$14,489	$14,519	$14,696	0

Assisted Living Facility Waiver

SFY 2016

$3,339,254
Waiver Only Expenditures

↑20%
from SFY 2015

0.6%
of Total Medicaid Expenditures

Medicaid provides long-term care services through the Assisted Living Facility (ALF) Waiver. The ALF Waiver allows participants ages 19 and older who require services equivalent to a nursing facility level of care to receive services in an ALF. Each ALF Waiver participant has a plan of care prepared by a case manager. Medicaid requires a functional assessment to determine eligibility for the ALF Waiver. Medicaid will not cover services for an individual who has not met the level of care assessment criteria.

Medicaid continues to strengthen the quality assurance component of the waiver program by increasing provider accountability and developing internal processes to gather data to validate strengths and weaknesses.

There are 15 ALFs in Wyoming providing ALF Waiver services. This has allowed access and choice for waiver participants.

Table 55. Assisted Living Facility Waiver Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Waiver Only Services							
Expenditures	$2,757,617	$2,612,026	$2,451,875	$2,593,984	$2,773,135	$3,339,254	21
Recipients	217	201	190	194	229	256	18
Expenditures per Recipient	$12,708	$12,995	$12,905	$13,371	$12,110	$13,044	3
% Waiver-Only of Total Waivers	104%	71%	70%	80%	91%	101%	
Non-Waiver Services							
Expenditures	$739,815	$622,186	$579,859	$697,390	$803,350	$804,739	9
Recipients	244	218	203	214	235	257	5
Expenditures per Recipient	$3,032	$2,854	$2,856	$3,259	$3,419	$3,131	3
Total Waiver							
Expenditures	$2,652,809	$3,670,483	$3,497,432	$3,234,213	$3,031,734	$3,291,373	24
Recipients	253	231	216	222	256	278	10
Expenditures per Recipient	$10,485	$15,890	$16,192	$14,569	$11,843	$11,839	13

The CMH Waiver was developed to allow youth with serious emotional disturbance who need mental health treatment to remain in their home communities. Waiver participants must be between the ages of 4 and 20, have needs that meet the definition of serious emotional disturbance, be financially eligible for Medicaid based on the child's income, qualify based on a standardized assessment, and meet specific inpatient clinical criteria.

The program offers a High Fidelity Wraparound community based service as an alternative to institutionalization.

$61,981
Waiver Only Expenditures

↓92%
from SFY 2015

0.01%
of Total Medicaid Expenditures

SFY 2016

Each participant has an individualized plan of care developed by a team of providers and the participant's family. Waiver participants receive non-clinical services as outlined in their plan of care, including family care coordination, youth and family training and support, and respite.

Table 56. Children's Mental Health Waiver Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Waiver Only Services							
Expenditures	$918,455	$942,386	$688,995	$527,514	$732,257	$61,981	-93
Recipients	136	131	82	57	79	40	-71
Expenditures per Recipient	$6,753	$7,194	$8,402	$9,255	$9,269	$1,550	-77
% Waiver-Only of Total Waivers	32%	39%	48%	40%	42%	7%	
Non-Waiver Services							
Expenditures	$1,962,899	$1,493,157	$734,835	$794,094	$1,009,279	$880,934	-55
Recipients	171	164	112	82	86	92	-46
Expenditures per Recipient	$11,479	$9,105	$6,561	$9,684	$11,736	$9,575	-17
Total Waiver							
Expenditures	$2,881,354	$2,435,543	$1,423,830	$1,321,609	$1,741,535	$942,915	-67
Recipients	173	165	116	85	91	93	-46
Expenditures per Recipient	$16,655	$14,761	$12,274	$15,548	$19,138	$10,139	-39

Pregnant by Choice Waiver

SFY 2016

$8,356
Waiver Only Expenditures

↓72%
from SFY 2015

0%
of Total Medicaid Expenditures

Medicaid provides pregnancy planning services through a Section 1115 waiver called Pregnant by Choice. The Pregnant by Choice Waiver is a five year demonstration project that was effective from October 1, 2008 through September 30, 2013. The CMS granted an extension to the project, which is currently effective through December 31, 2017.

The waiver provides family planning services and birth control options to women who have received Medicaid benefits under the Pregnant Women program and who would otherwise lose Medicaid eligibility 60 days after giving birth. The goal of the waiver is to reduce the incidence of closely spaced pregnancies and decrease the number of unintended pregnancies. The intent is to reduce health risks to women and children and achieve cost savings.

The Pregnant by Choice Waiver services are included in the individual service sections in this Report, and thus are excluded from the service overview tables.

Table 57. Pregnant by Choice Waiver Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$106,300	$111,105	$123,985	$76,481	$30,272	$8,356	-92
Recipients	424	407	372	280	107	31	-93
Expenditures per Recipient	$251	$273	$333	$273	$283	$270	8

Waiver services are provided by family planning clinics, primary care physicians (MDs and DOs) in public and private practice, certified nurse midwives, nurse practitioners, physician assistants, pharmacies, laboratories, outpatient departments of hospitals, federally qualified health centers, rural health clinics, and Indian health services.

Medicaid implemented the waiver on January 1, 2009; therefore, expenditures for SFY 2009 represent six months of activity. The Pregnant by Choice Waiver is currently effective through December 31, 2017.

Subprograms and Special Populations

SUBPROGRAMS

Medicaid has implemented subprograms to meet federal or state government mandates, to meet the specific medical needs of Medicaid individuals and to give individuals better access to care or more care options. While these subprograms are carried out in conjunction with the service areas described in the preceding sections, there are specific features of these subprograms that warrant separate discussion.

Administrative Transportation

Medicaid covers the cost of transportation to and from medical appointments if all three criteria below are met:

1. The medical appointment must be medically necessary.
2. Transportation must be approved at least three business days in advance by the Department.[32]
3. The least costly mode of transportation must be selected.

Medicaid chooses the appropriate mode of transportation based on expense and reasonable availability, which includes public transportation, private automobile, taxi, bus, shuttle service and airline.

In addition to the cost of transportation, per diem expenses are reimbursable to the family or legal guardian if the individual is under age 21 (considered a child) and the services to be received are expanded services. Reimbursement for per diem expenses is limited to $25 per day if the child receives inpatient services and $50 per day if the child receives outpatient services. The per diem payment is to be used for meals and commercial lodging.

[32] Retrospective transportation reimbursement is allowed if the request is made within 30 days of travel and all required documentation is provided.

Drug Utilization Review Program

Medicaid established a Drug Utilization Review (DUR) program in 1992 in response to requirements outlined in OBRA 90 and defined in the Code of Federal Regulations (42 CFR 456 Subpart K). The program reviews utilization of outpatient prescription drugs to ensure individuals are receiving appropriate, medically necessary medications which are not likely to result in adverse effects. Medicaid has contracted with the University of Wyoming to administer the program. The program includes a number of activities, as described in the following sections.

Pharmacy & Therapeutics (P&T) Committee

The P&T Committee is comprised of six physicians, five pharmacists, and one allied health professional, all actively practicing in the state of Wyoming, as well as ad hoc members, including the Medicaid Medical Director, Pharmacy Program Manager, Pharmacist Consultant, and a drug information specialist from the University of Wyoming, School of Pharmacy.

The P&T Committee meets four times per year to provide recommendations regarding prospective drug utilization review, retrospective drug utilization review and education activities to Medicaid.

Prospective DUR

Required review of prescription claims for appropriateness prior to dispensing at the pharmacy.

This review takes prior authorization policies into consideration while identifying potential issues, including, but not limited to, therapeutic duplication, drug-disease contraindications, drug-drug interactions, potential adverse effects.

Education

Quarterly newsletters are sent to all Wyoming providers. Targeted education letters regarding duplicate benzodiazepine utilization, long and short acting opiate utilization, and high dose opiate utilization were also sent.

Retrospective DUR

Ongoing review of aggregate claims data to uncover trends and review individual patient profiles to aid in monitoring for therapeutic appropriateness, over- and underutilization, therapeutic duplication, drug-disease contraindications, drug-drug interactions and others issues.

The review of aggregate claims data can lead to recommendations for prospective DUR policy, including prior authorizations, to encourage appropriate utilization at the program level.

Reviewing individual patient profiles may result in educational letters to the prescriber when the reviewing Committee members determine the issue to be clinically significant to a specific patient.

Review of Clinical Evidence

The P&T Committee is responsible for reviewing evidence regarding the comparative safety and efficacy of medications. The Committee makes recommendations to Medicaid regarding the comparative safety and efficacy of each reviewed class, and provides input on clinical considerations that are included in the creation of the Medicaid PDL.

Input from the Medical Community

The DUR Program actively solicits feedback about PA policies from prescribers in Wyoming through direct mailings. The letters are sent to all specialists in the affected area as well as a random sample of fifty general practitioners. The P&T Committee reviews all comments that are received prior to giving final approval of the policy. This is an important step in the DUR process which allows providers an opportunity to participate in the decision-making process.

Providers are encouraged to submit comments and concerns to the P&T Committee for review through the public comment forms available on the DUR website. Providers may use this method to comment on existing policy as well as new policy.

Health Check

Health Check is a program for children under age 21 that provides the following services under Early, Periodic Screening Detection and Treatment (EPSDT) authority:

- Physical exams
- Immunizations
- Lab tests (blood tests and lead screening)
- Growth and developmental check
- Nutrition check
- Eye exam
- Hearing screening
- Dental screening
- Health information
- Behavioral health assessment
- Other healthcare prescribed by a physician and approved by Medicaid
- Teenage health education
- Transportation (ambulance and administrative)

Medicaid will reimburse all Health Check screening exams and authorized follow-up care and treatment as long as the child is eligible for Medicaid.

Health Information Technology

Wyoming Department of Health Health Information Technology (HIT) systems enable and support Medicaid providers achieve Meaningful Use and allow for clinical data interoperability among providers in Wyoming with the ultimate goal of improving the quality of healthcare.

Total Health Record Gateway

The Total Health Record (THR) Gateway is a Medicaid Health Information Exchange (HIE) that is currently connected to the Immunization, Cancer, Laboratory, and Early Hearing Detection Indicator (EHDI) registries. The gateway provides a single interface connection to Wyoming providers for Public Health Reporting as required to meet Meaningful Use (MU). Access to the THR Gateway requires a certified Electronic Health Record (EHR).

During SFY 2016, 67 new connections were established with providers.

THR EHR

305 Users

33 Locations

90 Providers

98,000 Patient Records

Total Health Record Electronic Health Record

Wyoming offers the THR EHR to Wyoming Medicaid providers at no cost. The THR EHR is an ONC Stage 2 Certified electronic health record and is currently used in 33 clinical settings. This enables them to meet the eligibility requirements for the EHR Incentive Program and promotes connectivity across the state.

Continuity of Care Document

The THR Gateway also provides a Continuity of Care Document (CCD) that gives providers medical information on Medicaid recipients. This information is collected through a combination of claims and providers via the Electronic Health Record (EHR). Alerts are then generated to enable providers the ability to follow-up as needed with their Medicaid recipients.

Electronic Health Record Incentive Program

Medicaid established an EHR Incentive Program under the American Recovery and Reinvestment Act (ARRA) of 2009. This program provides incentive payments to eligible professionals and hospitals for the adoption, implementation, upgrading, and meaningful use of an EHR. Payments for this program are paid with 100 percent federal funds.

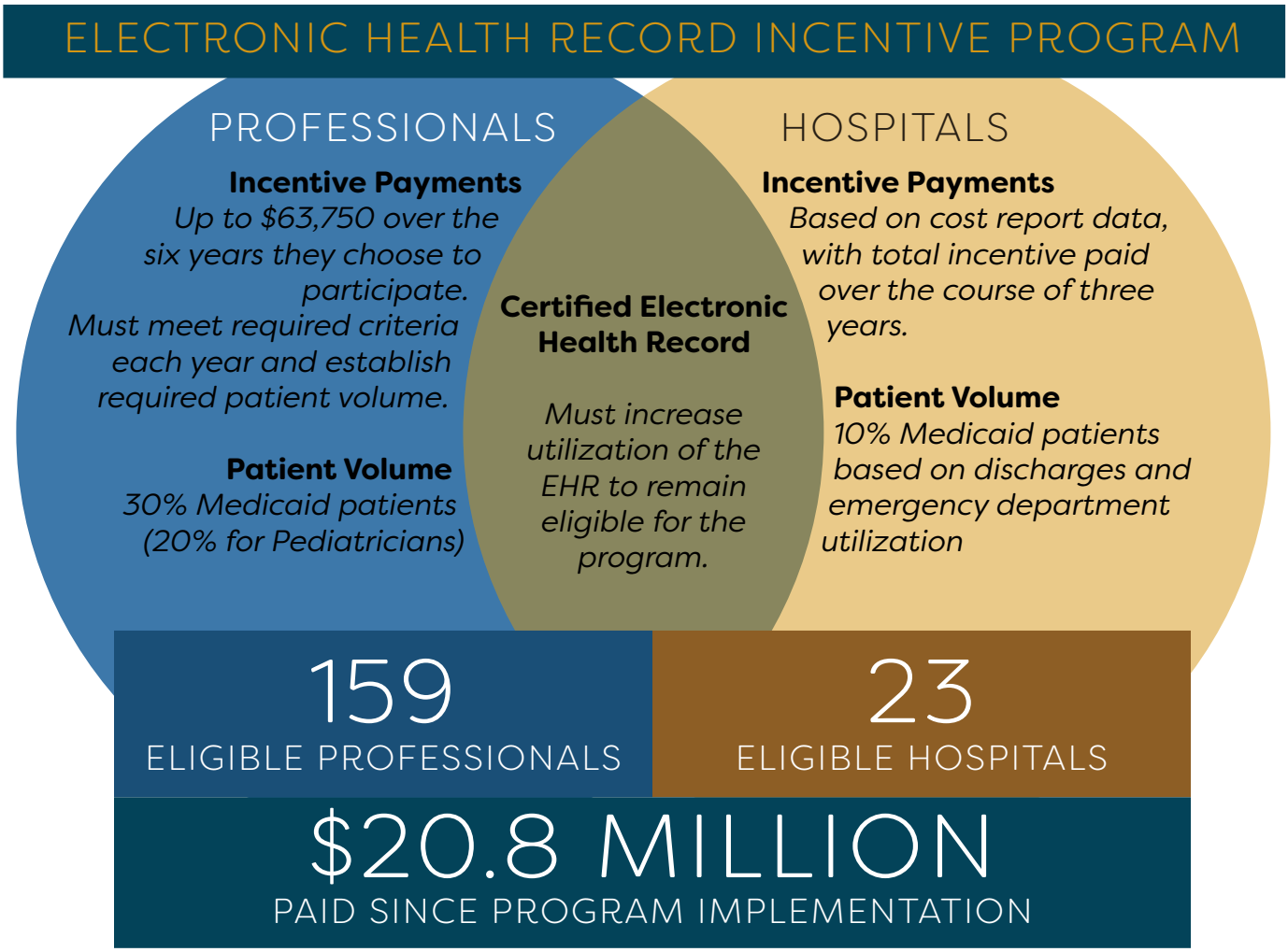


Figure 25. Electronic Health Record Incentive Program

State Level Repository

The State Level Repository (SLR) system is used by Wyoming providers to attest for the Medicaid EHR Incentive Program. This has been expanded to also accept Clinical Quality Measures (CQM) submissions for the Patient Centered Medical Home (PCMH) Program through both manual and electronic upload of HL7 Quality Reporting Document Architecture (QRDA). This information can then be viewed by state staff to set benchmarks and measure improvement.

Data Repository

A data repository is used to collect data from both the THR Gateway and the SLR. This is then used to generate reports for Medicaid program managers to assist with identifying program gaps and tracking patient outcomes in an effort to reduce overall Medicaid costs.

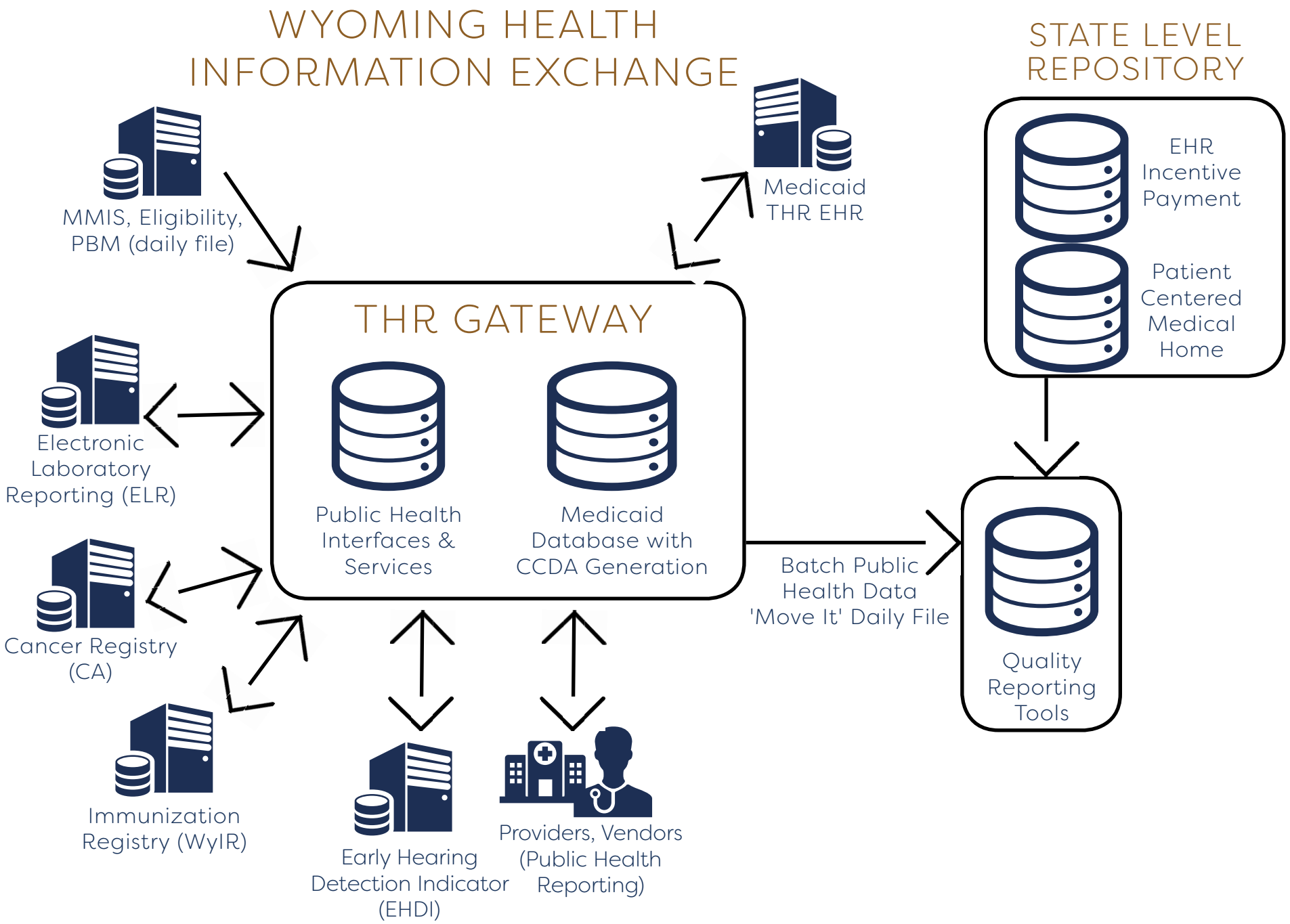


Figure 26. Wyoming Health Information Exchange and Medicaid

Project Out

Project Out is a temporary, short-term intervention and assistance program helping participants overcome the barriers to living independently in the community. The program covers non-Medicaid services that allow an individual to divert nursing facility care or to transition out of a nursing home and back to the community.

In SFY 2016 the program, which is 100% state-funded, served 238 recipients for a total of $100,638.

Diversion
an individual, who is at risk of needing nursing facility care or who has been in the nursing home for less than 3 months, is able to remain in or return to the community

Transition
an individual, who has resided in a nursing facility or long-term care institution for at least 3 months, returns to the community.

The program provides targeted case management that works with the participant's healthcare provider and/or discharge planner to create a transition or diversion plan, identifying the services and supports necessary for independent living. Limited financial resources to assist with the diversion or transition are also provided to cover such expenses as moving/storage, rental/utility deposits, furniture, household items, home modifications (i.e. grab bars and assistive devices), and limited transportation. Participants are also linked to community services and long-term care programs that provide ongoing support.

Patient Centered Medical Home

The Patient Centered Medical Home (PCMH) program is a value-based purchasing model that is patient-centered, comprehensive, team-based, coordinated, and accessible with a focus on quality and safety, promoting improved primary care processes and health outcomes so care meets national standards while avoiding preventable events. Patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.

In SFY 2016 the PCMH program had 46 rendering physicians and nurse practitioners across 6 practices participating with over 14,000 Medicaid Recipients reached.

SPECIAL POPULATIONS

This section provides greater detail on two Medicaid populations of interest: Medicaid/ Medicare Dual Enrolled Members and Foster Care.

Medicaid/Medicare Dual Enrollment

Individuals with Medicare coverage, depending on income, may also be eligible for Medicaid services. These individuals are referred to as dual enrolled. For dual enrolled members, Medicare pays first for services covered by both programs, while Medicaid covers additional payments through crossover claims. Non-Medicare-covered services are entirely funded by Medicaid, up to Wyoming's payment limit.

Limited medical benefits are available to pay out-of-pocket Medicare cost-sharing expenses, for those Medicare beneficiaries who do not qualify for full Medicaid coverage. These benefits are provided through the programs, described here:

Qualified Medicare Beneficiaries (QMB)

Provides assistance with Medicare premiums, deductibles, and coinsurance to individuals whose resources do not exceed three times the SSI resource limit adjusted annually by the increase in the consumer price index and income less than or equal to 100 percent of the FPL receive assistance.

Specified Low-Income Medicare Beneficiaries (SLMB)

Provides assistance with Medicare Part B premiums to individuals whose resources do not exceed three times the SSI resource limit adjusted annually by the increase in the consumer price index and income exceeding the QMB level, income more than the 100 percent of the FPL, but less than 120 percent of the FPL.

Qualified Individuals (QI)

Provides assistance with Medicare Part B premiums to individuals who are not otherwise eligible for full Medicaid benefits, whose resources do not exceed three times the SSI resource limit adjusted annually by the increase in the consumer price index, with income between 120 percent and 135 percent of the FPL. Premiums for this group are paid with 100 percent federal funds.

This section includes information on both crossover claims services and those services funded entirely by Medicaid. Premium assistance payments for QMB, SLMB-1, and QI members are not included as these are considered administrative expenditures.

SFY 2016

$210,495,628
Total Dual Expenditures

↑9%
from SFY 2015

38%
of Total Medicaid Expenditures

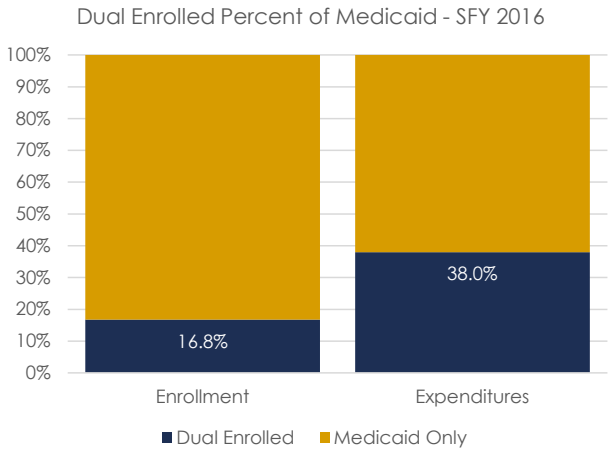


Figure 27. Dual Enrolled as Percent of Medicaid SFY 2016

As shown in Figure 27, nearly 17 percent of Medicaid enrolled members were also enrolled in Medicare while their expenditures, including crossover claims, accounted for over one-third, 38 percent, of total Medicaid expenditures.

Table 58. Medicaid/Medicare Dual Enrollment Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures	$180,891,512	$181,766,090	$189,787,625	$193,531,089	$192,301,496	$210,495,628	16
Dual Enrolled Members	11,567	11,987	12,340	12,542	15,115	14,887	29
Recipients (unduplicated)	9,592	9,751	9,942	10,127	10,439	10,341	8
Expenditures per Dual Enrolled Member	$15,639	$15,164	$15,380	$15,431	$12,723	$14,140	-10
Expenditures per Recipient	$18,859	$18,641	$19,089	$19,110	$18,421	$20,355	8
Crossover Claims Expenditures	$14,786,603	$15,401,922	$16,853,247	$16,951,537	$18,058,494	$17,547,805	-3
Crossover Claims Expenditures as Percent of Total Dual Expenditures	8.2	8.5	8.9	8.8	9.4	8.3	-

In SFY 2016, crossover claims expenditures accounted for just over 8 percent of all expenditures for dual enrolled members. The figure below shows how the crossover claims to non-crossover claims compared by service area.

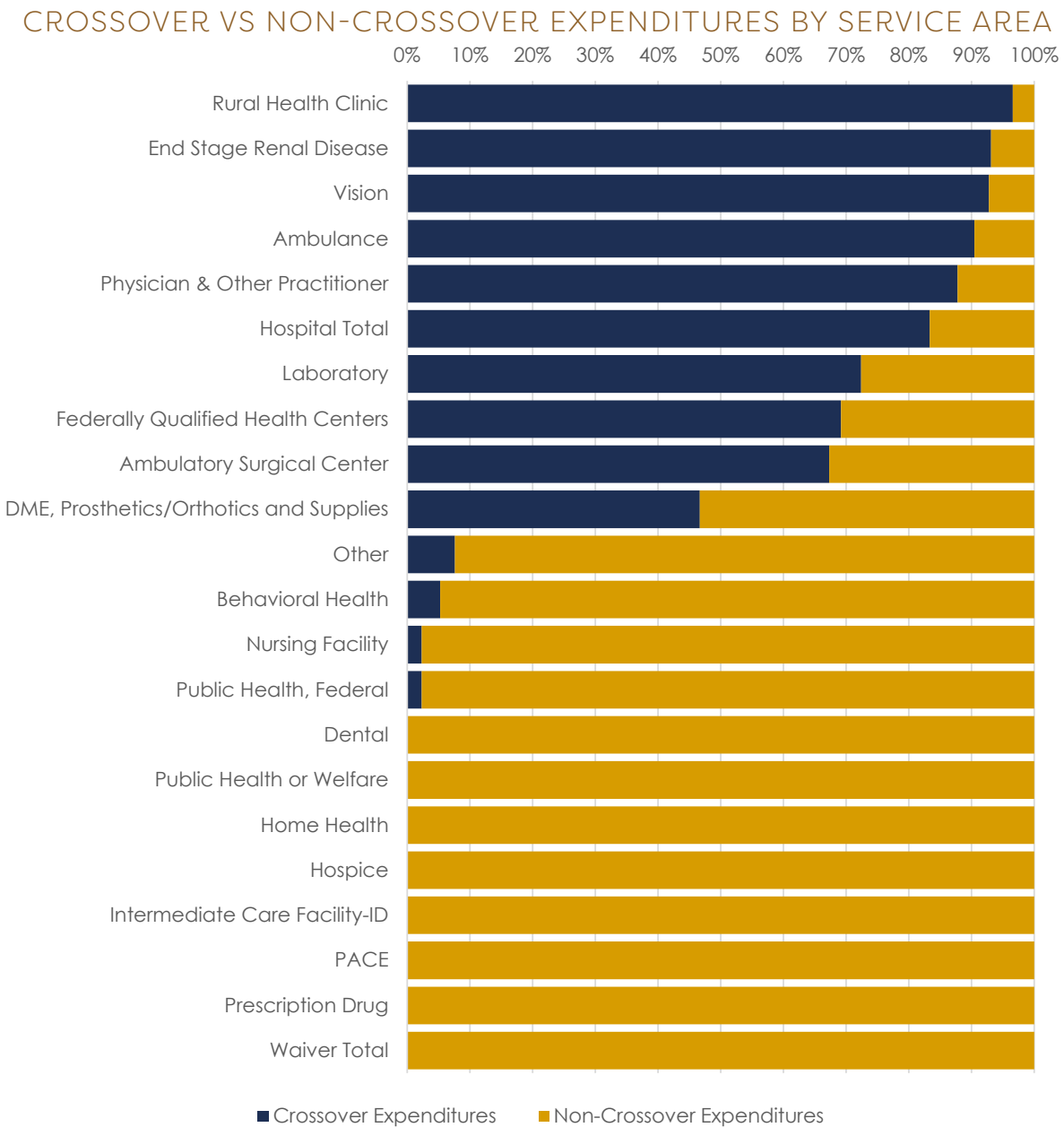


Figure 28. Crossover vs Non-Crossover Expenditures by Service Area

Table 59. Dual Enrolled Member Service Utilization Summary

Service Area	Expenditures	Recipients[33]	Expenditures per Recipient
Ambulance	$571,696	1,247	$458
Ambulatory Surgical Center	$198,810	643	$309
Behavioral Health	$6,971,606	2,381	$2,928
Dental	$1,170,221	2,161	$542
DME, Prosthetics/Orthotics/Supplies	$2,626,271	3,133	$838
End Stage Renal Disease	$553,255	105	$5,269
Federally Qualified Health Center	$224,795	1,189	$189
Home Health	$6,623,577	351	$18,871
Hospice	$623,318	144	$4,329
Hospital Total	$9,908,669	6,959	$1,424
Inpatient	*$4,341,597*	*1,889*	*$2,298*
Outpatient	*$3,195*	*140*	*$23*
Other Hospital	*$5,563,877*	*6,792*	*$819*
Intermediate Care Facility-ID	$14,457,432	57	$253,639
Laboratory	$50,541	2,077	$24
Nursing Facility	$77,157,490	2,234	$34,538
Other	$200,624	344	$583
PACE	$2,695,434	112	$24,066
Physician & Other Practitioner	$4,890,920	8,299	$589
Prescription Drug	$1,249,069	2,072	$603
Public Health or Welfare	$595,628	2,943	$202
Public Health, Federal	$422,788	261	$1,620
Rural Health Clinic	$113,249	600	$189
Vision	$116,194	1,828	$64
Waiver Total	$79,074,040	3,109	$25,434
Acquired Brain Injury	*$5,346,429*	*131*	*$40,812*
Adult ID/DD	*$1,868*	*1*	*$1,868*
Assissted Living Facility	*$3,149,724*	*233*	*$13,518*
Child ID/DD	*$23,569*	*8*	*$2,946*
Children's Mental Health	*$330*	*1*	*$330*
Comprehensive	*$55,622,187*	*956*	*$58,182*
Long-Term Care	*$13,704,406*	*1,695*	*$8,085*
Supports	*$1,225,527*	*134*	*$9,146*
Total	**$210,495,628**	**10,341**	**$20,355**

Claims data for dual enrolled members was included in the service area detail provided earlier in this report.

[33] This table displays a unique count of recipients for each service area, as well as the total unique count of all dual enrolled recipients. Summing the recipients for each year across all service areas will not equal the total recipients shown as recipients often receive multiple services through the SFY.

Dual enrolled recipients most commonly utilized Physician and Other Practitioner and Hospital services, with 80 percent and 67 percent of unique recipients receiving those services respectively.

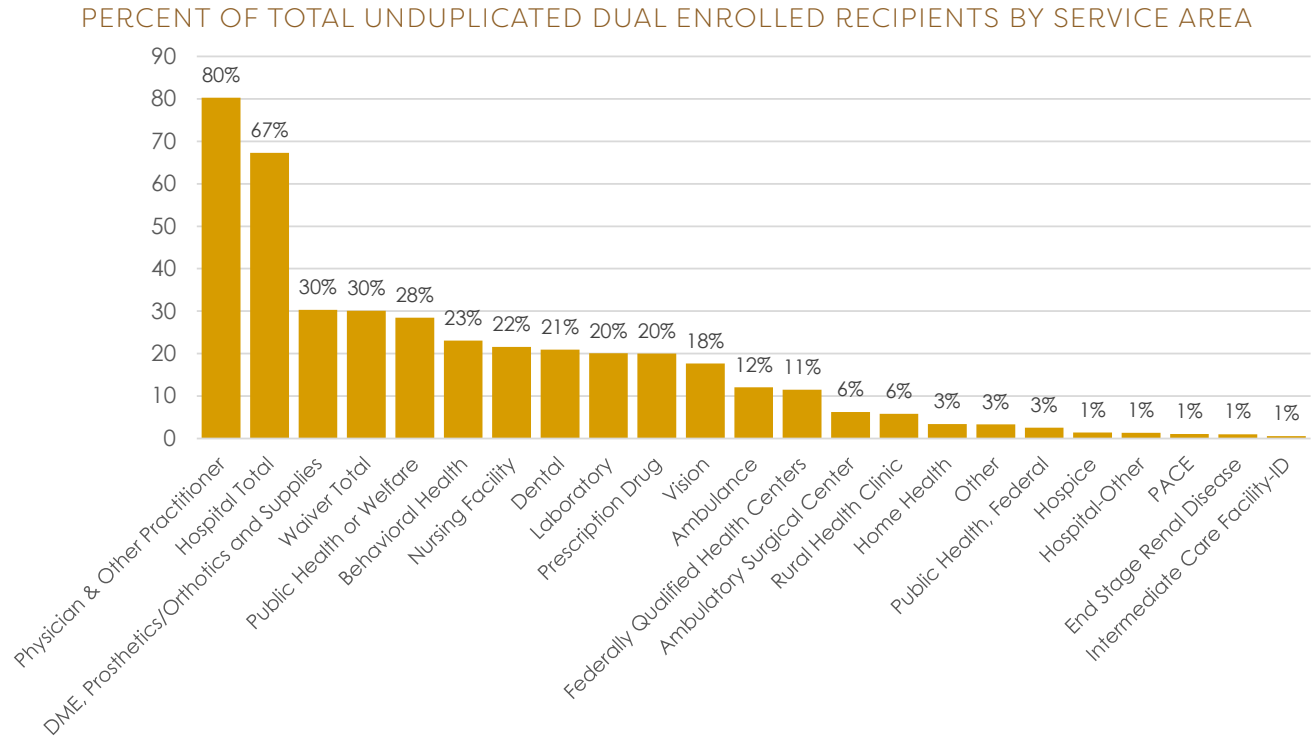


Figure 29. Percent of Total Unduplicated Dual Enrolled Recipients by Service Area

However, Physician and Other Practitioner services only accounted for 2.3 percent of dual enrolled expenditures due to the majority (88 percent) being from crossover claims. Waiver and Nursing Facility expenditures comprised the largest portion of dual enrolled expenditures, with 38 percent and 37 percent, respectively, as most of these claims are funded exclusively by Medicaid.

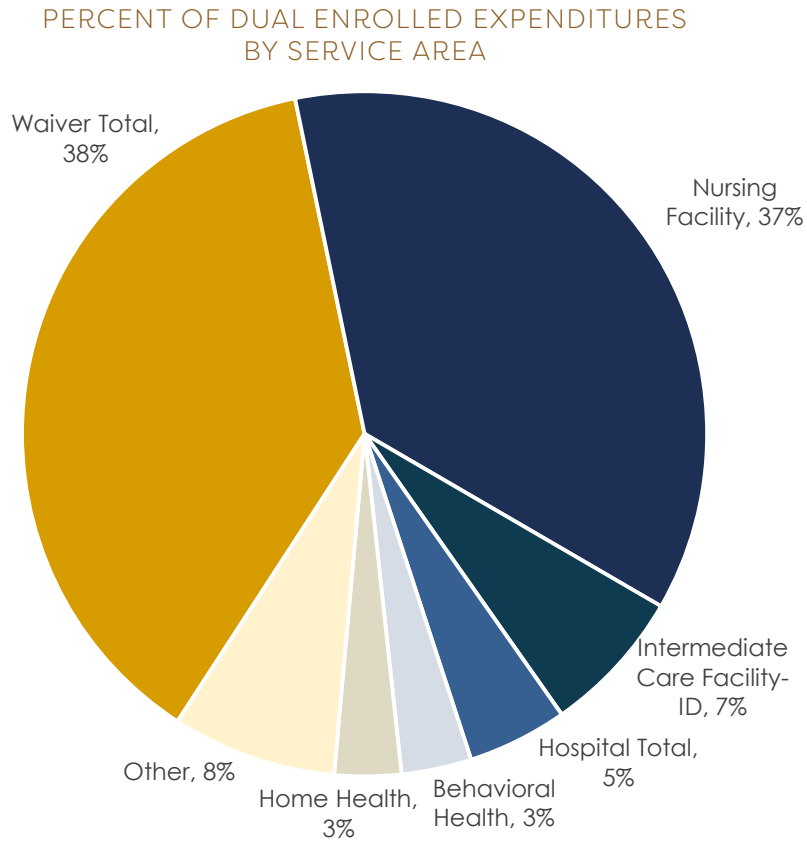


Figure 30. Percent of Dual Enrolled Expenditures by Service Area

Foster Care

The foster care program is administered through the Department of Family Services (DFS), providing for a child until a more permanent plan for the child's well-being can be implemented. Medical coverage under foster care is intended to provide for the medical needs of the children while in DFS custody.

Two types of medical coverage are available:

Medicaid Foster Care

For children eligible for Medicaid. Foster children covered under Title IV-E of the Social Security Act and some children receiving federally reimbursed adoption subsidies must be covered by Medicaid.

Wyoming also uses existing Medicaid eligibility groups to extend coverage to non-Title IV-E eligible foster children and adopted children supported by state-funded subsidies.

State Foster Care

For children ineligible for Medicaid. Includes children awaiting eligibility determination, those who do not meet income requirements or are institutionalized.

SFY 2016

4,431
Total Enrollment

↓7.4%
from SFY 2015

95%
of Foster Care Children enrolled in Medicaid

Table 60. Foster Care Summary

	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Medicaid Foster Care							
Enrolled Members	3,622	3,706	3,836	4,096	4,253	4,228	17
Expenditures	$22,957,008	$17,534,383	$20,934,667	$24,197,999	$22,627,859	$21,473,583	-6
Recipients	3,341	3,303	3,442	3,643	3,629	3,634	9
	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Expenditures per Recipient	$6,871	$5,309	$6,082	$6,642	$6,235	$5,909	-14
State Only Foster Care							
Enrolled Members	213	183	179	173	211	203	-5
Expenditures	$1,599,409	$1,517,769	$2,768,409	$2,697,681	$2,852,108	$2,310,733	44
Recipients	328	282	326	376	318	327	0
Expenditures per Recipient	$4,876	$5,382	$8,492	$7,175	$8,969	$7,066	45

FOSTER CARE TOP SERVICE UTILIZATION AS PERCENT OF EXPENDITURES

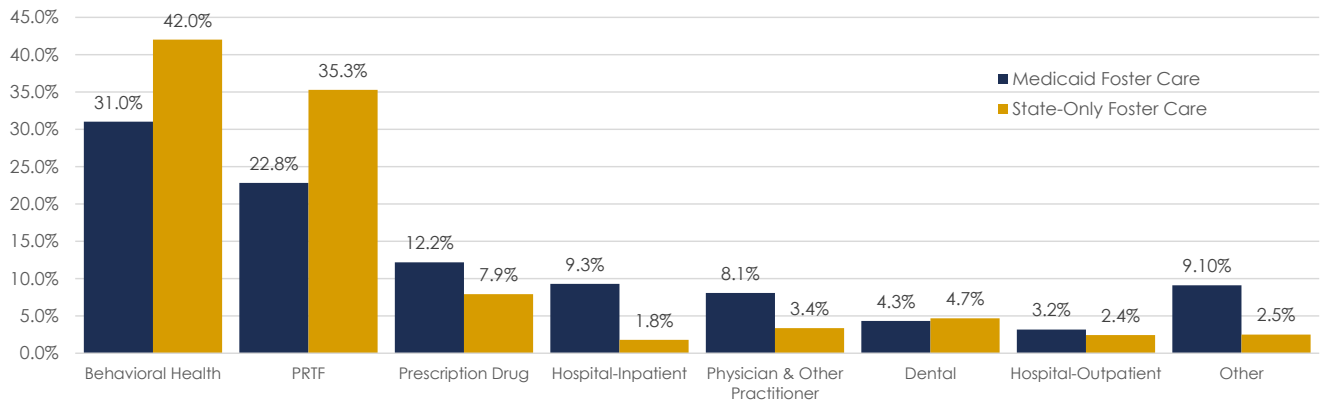


Figure 31. Foster Care Top Service Utilization as Percent of Expenditures


GREAT SEAL OF THE STATE OF WYOMING
EQUAL RIGHTS
1869
1890

Appendix A Supplemental TABLES

This section provides additional detail on select programs within Medicaid, as well as supplemental tables regarding demographics, counties, providers, and births.

SERVICES

Table 61. Behavioral Health Services by Provider Type

Provider	Services Provided
Behavioral Health Providers	
Mental health and substance abuse treatment professionals through Community Mental Health Centers (CMHCs) and Substance Abuse Treatment Centers (SACs)	• Mental health assessments • Individual group therapy • Rehabilitation services • Peer specialists services • Targeted case management
Physicians, including psychiatrists, or other behavioral health practitioners who work under a physician, including: - Masters level counselors (e.g. Licensed Addictions Therapists (LATs), Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), or Licensed Clinical Social Workers (LCSWs)) - Physician Assistants	• Medically necessary psychiatric services
Advanced practice mental health nurse practitioners Independently practicing clinical psychologists Mental health practitioners who work under a clinical psychologist Masters level counselors (e.g. Licensed Addictions Therapists (LATs), Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), or Licensed Clinical Social Workers (LCSWs))	• Behavioral health services
Non-Behavioral Health Providers	
Psychiatric Residential Treatment Facility	• Psychiatric residential treatment for individuals under age 21
Wyoming State Hospital	• Admits patients considered to be a danger to themselves or others pursuant to Wyoming Statue on involuntary hospitalization • Patients who are psychiatrically and medically fragile • Persons whom the legal system placed in the hospital after classifying them as not competent to stand trial or who were found guilty of committing crimes due to mental illness
Wyoming Behavioral Institute	• Behavioral health services

Table 62. Waiver Services by Waiver

Waiver Service	ABI	Adult ID/DD	Child ID/DD	Comp	Supports	LTC	ALF	CMH
Case Management	✓	✓	✓	✓	✓	✓	✓	✓
Functional assessments	✓	✓	✓	✓	✓	✓	✓	✓
Respite	✓	✓	✓	✓	✓	✓		✓
Personal care	✓	✓	✓	✓	✓	✓	✓	
Skilled nursing	✓	✓	✓	✓	✓	✓	✓	
Dietician	✓	✓	✓	✓	✓		✓	
Homemaker		✓	✓	✓	✓	✓		
Special family habilitation home			✓	✓				
Day habilitation	✓	✓		✓	✓			
Child habilitation			✓	✓	✓			
Residential habilitation training			✓	✓	✓			
Specialized equipment	✓	✓	✓	✓	✓			
Environmental modifications	✓	✓	✓	✓	✓			
Supported living	✓	✓	✓	✓	✓			
Community integrated employment	✓	✓	✓	✓	✓			
Employment supports	✓	✓	✓	✓	✓			
Companion	✓	✓	✓	✓	✓			
Occupational, physical, and Speech therapies	✓	✓		✓	✓			
Cognitive retraining	✓							
Self-directed / Consumer-directed available	✓	✓	✓	✓	✓	✓		
High Fidelity Wraparound								✓
Family and Youth Peer Support Services								✓

Table 63. Inpatient Hospital Levels of Care Summary - SFY 2016

Inpatient Levels of Care	Expenditures	Recipients	Claims
07 - Kidney Transplant	$104,399	1	1
10 - Bone Transplant	$1,397,922	4	4
31 - Rehab W/O Vent As Of 090109	$542,230	34	38
32 - Maternity-Surg As Of 090109	$8,881,461	1,627	1,631
33 - Maternity-Med As Of 090109	$4,795,577	1,284	1,367
34 - NICU As Of 090109	$5,850,531	130	131
35 - ICU-CCU-Burn As Of 090109	$19,657,426	509	640
36 - Surgery As Of 090109	$10,010,704	542	619
37 - Psychiatric As Of 090109	$3,784,842	447	586
38 - Newborn Nursery As Of 090109	$8,312,124	2,919	3,002
39 - Routine Discharge As Of 090109	$12,351,127	1,411	1,867

Table 64. Inpatient Hospital Expenditures History by Levels of Care

Inpatient Level of Care	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
07 - Kidney Transplant	--	$237,169	$177,177	-$98,381	$258,328	$104,399
08 - Heart Transplant	--	$214,453	--	--	--	--
09 - Liver Transplant	$750,049	--	$500,557	$223,942	--	--
10 - Bone Transplant	$910,635	$152,845	$2,634,285	$976,412	$733,295	$1,397,922
12 - Extended Psychiatric	$184	--	--	--	--	--
16 - Lung Transplant	--	--	$647,237	--	--	--
20 - Maternity-Surg As Of 010198	$3,882	--	--	--	--	--
21 - Maternity-Med As Of 010198	$2,605	--	--	--	--	--
22 - ICU CCU Burn As Of 010198	$158,897	--	--	--	--	--
23 - Major Surgery As Of 010198	-$79,960	--	--	--	--	--
24 - Psychiatric As Of 010198	$5,714	--	--	--	--	--
25 - Rehabilitation As Of 010198	-$17,522	--	--	--	--	--
26 - Normal Newborn As Of 010198	$86,565	$1,536	$1,841	--	--	--
28 - Routine Care As Of 010198	$137,159	$339,409	--	--	--	--
31 - Rehab W/O Vent As Of 090109	$721,399	$739,310	$804,938	$489,079	$531,720	$542,230
32 - Maternity-Surg As Of 090109	$6,078,069	$5,775,706	$5,691,247	$5,854,738	$5,187,948	$8,881,461
33 - Maternity-Med As Of 090109	$8,986,441	$8,222,824	$7,878,460	$7,568,221	$7,538,977	$4,795,577
34 - NICU As Of 090109	$9,120,329	$6,335,289	$6,361,703	$4,852,484	$5,633,758	$5,850,531
35 - ICU-CCU-Burn As Of 090109	$18,272,165	$16,927,608	$16,420,469	$17,237,870	$17,477,140	$19,657,426
36 - Surgery As Of 090109	$10,876,254	$10,735,807	$9,270,316	$8,634,138	$8,408,699	$10,010,704
37 - Psychiatric As Of 090109	$3,797,481	$4,128,997	$4,392,193	$3,878,870	$4,198,515	$3,784,842
38 - Newborn Nursery As Of 090109	$7,378,726	$6,830,888	$7,124,918	$7,050,485	$7,333,486	$8,312,124
39 - Routine Discharge As Of 090109	$14,660,516	$13,675,922	$13,632,077	$13,395,349	$13,061,157	$12,351,127

BIRTHS

Table 65. Wyoming Medicaid Births[34]

Year	Wyoming Births	Medicaid Births	Medicaid % of Total
1996	6,286	2,880	46%
1997	6,361	2,606	41%
1998	6,248	2,412	39%
1999	6,122	2,352	38%
2000	6,247	2,366	38%
2001	6,110	2,766	45%
2002	6,545	3,037	46%
2003	6,549	2,991	46%
2004	6,800	3,105	46%
2005	7,231	3,410	47%
2006	7,640	3,452	45%
2007	7,823	3,454	44%
2008	8,015	3,353	42%
2009	7,841	3,401	43%
2010	7,541	3,395	45%
2011	7,339	3,166	43%
2012	7,576	3,071	41%
2013	7,617	3,026	40%
2014	7,693	2,850	37%
2015	7,715	2,757	36%

[34] Medicaid statistics starting with 2006 is based on a calendar year. The data prior to 2006 was based on SFY. Provisional statistics for statewide births was supplied by Vital Records.

Table 66. County Summary

County	Enrolled Members[35]	Percent of Total Enrolled Members	Recipients[36]	Percent of Total Recipients	Expenditures	Percent of Total Expenditures
Albany	3,859	4	3,450	5	$25,820,364	5
Big Horn	2,091	2	1,900	3	$15,783,890	3
Campbell	6,471	7	5,758	8	$32,014,864	6
Carbon	2,177	2	1,931	3	$12,097,344	2
Converse	1,972	2	1,767	2	$11,565,182	2
Crook	848	1	731	1	$3,851,975	1
Fremont	9,918	11	9,058	12	$80,537,890	15
Goshen	2,048	2	1,806	2	$13,782,644	2
Hot Springs	897	1	855	1	$7,879,112	1
Johnson	956	1	841	1	$5,165,165	1
Laramie	15,016	17	13,170	18	$98,012,159	18
Lincoln	2,244	3	1,924	3	$10,341,871	2
Natrona	13,301	15	11,907	16	$85,116,008	15
Niobrara	376	0	347	0	$2,671,528	0
Other	3,111	4	1,142	2	$12,648,900	2
Park	3,870	4	3,452	5	$26,205,476	5
Platte	1,264	1	1,181	2	$6,411,122	1
Sheridan	3,944	4	3,579	5	$24,169,533	4
Sublette	763	1	631	1	$3,720,980	1
Sweetwater	6,202	7	5,446	7	$29,528,900	5
Teton	1,618	2	1,435	2	$6,745,537	1
Uinta	3,623	4	3,271	4	$27,075,065	5
Washakie	1,267	1	1,173	2	$7,631,179	1
Weston	939	1	795	1	$5,806,448	1
Overall	**88,775**		**75,015**		**$554,583,138**	

[35] Enrollment is based on Complete SFY.

[36] Recipients and Expenditures are based on recipient county of residence on file at the time the claim was processed in the MMIS. As recipients may move between counties, summing the county totals will not match the total recipient count shown. Recipients in "Other" county have moved out of the state prior to their claim being processed.

PROVIDERS

The data in this section is based on claims paid and does not reflect the number of active and enrolled providers, but only those providers paid during the SFY.

Table 67. Provider Summary by Taxonomy

Provider Taxonomy	Providers	Recipients	Expenditures
Addiction Therapist/Practitioner (101YA0400X)	4	95	$112,463
Adult Health (363LA2200X)	1	15	$1,789
Advance Practice Nurse (364SP0808X)	11	649	$286,789
Allergy And Immunology, Allergy (207KA0200X)	9	821	$444,553
Ambulance (341600000X)	67	3,305	$3,571,623
Ambulatory Family Planning Facility (261QA0005X)	9	454	$55,497
Ambulatory Surgical (261QA1903X)	33	3,419	$5,953,159
Anesthesiology (207L00000X)	86	7,153	$2,568,307
Audiologist (231H00000X)	15	407	$123,718
Case Management (251B00000X)	100	2,392	$20,056,159
Chiropractor (111N00000X)	34	540	$99,664
Chpr Cme (251S00000X)	1	5	$5,021,978
Clinic/Center (261Q00000X)	12	1,529	$1,361,953
Clinical Medical Laboratory (291U00000X)	90	9,561	$1,536,310
Clinical Neuropsychologist (103G00000X)	2	2	$642
Clinical Psychologist (103TC0700X)	94	3,973	$13,790,956
Day Training, Developmentally Disabled Service (251C00000X)	601	2,696	$93,766,911
Dentist (122300000X)	25	3,512	$1,445,036
Dentist, General Practice (1223G0001X)	146	16,579	$7,171,071
Dermatology (207N00000X)	15	1,985	$253,755
Diagnostic Radiology (2085R0202X)	45	19,509	$2,018,120
Durable Medical Equipment And Medical Supplies (332B00000X)	244	6,503	$6,610,828
Emergency Medicine (207P00000X)	39	15,890	$3,198,766
End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	14	128	$948,612
Endodontics (1223E0200X)	5	73	$51,569
Family Health (363LF0000X)	16	1,614	$311,405
Family Practice (207Q00000X)	88	22,304	$6,384,974
Federally Qualified Health Center (261QF0400X)	9	6,430	$3,689,548
General Acute Care Hospital (282N00000X)	181	33,868	$91,167,750
General Acute Care Hospital - Rural (282NR1301X)	42	9,899	$15,380,672
Hearing Aid Equipment (332S00000X)	12	311	$790,555
Home Health (251E00000X)	30	732	$9,467,835
Hospice Care, Community Based (251G00000X)	11	199	$1,014,959
Intermediate Care Facility, Mentally Retarded (315P00000X)	1	70	$18,193,221
Internal Medicine (207R00000X)	67	13,714	$6,899,612
Internal Medicine, Cardiovascular Disease (207RC0000X)	26	3,100	$388,767
Internal Medicine, Endocrinology Diabetes And Metabolic (207RE0101X)	8	101	$19,270
Internal Medicine, Gastroenterology (207RG0100X)	9	1,007	$442,390
Internal Medicine, Geriatric Medicine (207RG0300X)	2	126	$20,590
Internal Medicine, Medical Oncology (207RX0202X)	11	389	$1,632,500

Provider Taxonomy (continued)	Providers	Recipients	Expenditures
Internal Medicine, Nephrology (207RN0300X)	9	135	$51,808
Internal Medicine, Pulmonary Disease (207RP1001X)	11	274	$77,414
Internal Medicine, Rheumatology (207RR0500X)	4	128	$15,778
Interpreter (171R00000X)	1	347	$47,205
Licensed Clinic/Certified Social Worker (1041C0700X)	59	1,139	$2,284,684
Licensed Marriage & Family Therapist (106H00000X)	10	139	$280,470
Medicare Defined Swing Bed Unit (275N00000X)	9	40	$775,338
Mental Health-Including Community Mental Health (261QM0801X)	27	5,366	$7,930,515
Midwife, Certified Nurse (367A00000X)	9	58	$51,381
Neurological Surgery (207T00000X)	16	1,189	$536,628
Nurse Anesthetist, Certified Registered (367500000X)	20	895	$189,955
Nurse Practitioner (363L00000X)	10	2,551	$336,366
Obstetrics And Gynecology (207V00000X)	48	5,581	$5,733,312
Obstetrics And Gynecology (363LX0001X)	1	28	$7,023
Obstetrics And Gynecology, Gynecology (207VG0400X)	6	204	$80,997
Obstetrics And Gynecology, Obstetrics (207VX0000X)	5	440	$417,994
Occupational Therapist (225X00000X)	20	434	$3,053,289
Ophthalmology (207W00000X)	34	2,372	$606,722
Optician (156FX1800X)	9	555	$80,235
Optometrist (152W00000X)	98	15,001	$3,571,953
Orthodontics (1223X0400X)	16	562	$547,443
Orthopedic Surgery (207X00000X)	37	4,385	$1,404,323
Otolaryngology (207Y00000X)	27	3,210	$895,930
PACE Organization (251T00000X)	1	118	$2,934,877
PACE PPL (251X00000X)	1	346	$4,434,368
Pathology (207ZP0105X)	22	2,494	$164,404
Pediatrics (208000000X)	73	14,531	$5,455,184
Pediatrics (363LP0200X)	2	59	$12,213
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	5	83	$248,989
Pedodontics (1223P0221X)	34	12,377	$5,008,474
Periodontics (1223P0300X)	1	4	$480
Pharmacy (333600000X)	205	43,931	$48,325,155
Phlebotomy/WY Health Fair (246RP1900X)	1	9	$575
Physical Medicine And Rehabilitation (208100000X)	17	297	$128,026
Physical Therapist (225100000X)	59	2,856	$3,382,286
Physician Assistant (363A00000X)	1	4	$577
Physician, General Practice (208D00000X)	78	22,059	$7,598,341
Plastic Surgery (2082S0099X)	10	180	$90,174
Podiatrist (213E00000X)	16	1,137	$79,404
Professional Counselor (101YP2500X)	97	1,705	$3,676,332
Prosthetic/Orthotic Supplier (335E00000X)	26	625	$798,679
Psychiatric Hospital (283Q00000X)	2	25	$127,648
Psychiatric Residential Treatment Facility (323P00000X)	16	298	$11,797,657
Psychiatry And Neurology, Psychiatry (2084P0800X)	32	2,328	$2,705,413
Psychiatry And Neurology: Neurology (2084N0400X)	26	1,823	$959,006
Public Health Or Welfare (251K00000X)	24	5,995	$1,072,715
Public Health, Federal (261QP0904X)	4	3,416	$8,479,944
Radiology: Mobile (261QR0208X)	1	1	$7
Rehabilitation Hospital (283X00000X)	3	112	$1,016,080
Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	135	$146,226

Provider Taxonomy (continued)	Providers	Recipients	Expenditures
Rehabilitation, Substance Use Disorder (261QR0405X)	31	1,447	$3,895,890
Residential Treatment Facility For Emotionally Disturbed (322D00000X)	3	3	$237,904
Rural Health (261QR1300X)	23	3,783	$1,413,842
Skilled Nursing Facillity (314000000X)	52	2,383	$81,670,473
Speech-Language Pathologist (235Z00000X)	9	174	$714,369
Surgery, Oral & Maxillofacial (1223S0112X)	14	1,309	$1,225,956
Surgery, Pediatric (2086S0120X)	3	79	$57,200
Surgery, Vascular (2086S0129X)	6	52	$32,393
Surgery: General Surgery (208600000X)	43	1,729	$713,150
Thoracic Surgery (208G00000X)	5	36	$34,078
Urology (208800000X)	17	2,009	$441,176
Unclassified	1	15	$272,435
Total	**3,605**	**75,015**	**$554,583,138**

Table 68. Top 20 Provider Taxonomies by Expenditures

Provider Taxonomy	Expenditures	Percent of Total Medicaid Expenditures
Day Training, Developmentally Disabled Service (251C00000X)	$93,766,911	17%
General Acute Care Hospital (282N00000X)	$91,167,750	16%
Skilled Nursing Facillity (314000000X)	$81,670,473	15%
Pharmacy (333600000X)	$48,325,155	9%
Case Management (251B00000X)	$20,056,159	4%
Intermediate Care Facility, Mentally Retarded (315P00000X)	$18,193,221	3%
General Acute Care Hospital - Rural (282NR1301X)	$15,380,672	3%
Clinical Psychologist (103TC0700X)	$13,790,956	2%
Psychiatric Residential Treatment Facility (323P00000X)	$11,797,657	2%
Home Health (251E00000X)	$9,467,835	2%
Public Health, Federal (261QP0904X)	$8,479,944	2%
Mental Health-Including Community Mental Health (261QM0801X)	$7,930,515	1%
Physician, General Practice (208D00000X)	$7,598,341	1%
Dentist, General Practice (1223G0001X)	$7,171,071	1%
Internal Medicine (207R00000X)	$6,899,612	1%
Durable Medical Equipment And Medical Supplies (332B00000X)	$6,610,828	1%
Family Practice (207Q00000X)	$6,384,974	1%
Ambulatory Surgical (261QA1903X)	$5,953,159	1%
Obstetrics And Gynecology (207V00000X)	$5,733,312	1%
Pediatrics (208000000X)	$5,455,184	1%
Top 20 Providers Combined	**$471,833,726**	**85%**

Table 69. Provider Count History by Taxonomy

Provider Taxonomy	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Addiction Therapist/Practitioner (101YA0400X)	-	-	-	-	2	4	-
Adult Health (363LA2200X)	-	-	1	1	1	1	-
Advance Practice Nurse (364SP0808X)	5	6	7	9	9	11	120
Allergy And Immunology, Allergy (207KA0200X)	6	6	7	7	10	9	50
Ambulance (341600000X)	67	69	66	64	72	67	0
Ambulatory Family Planning Facility (261QA0005X)	10	10	10	10	9	9	-10
Ambulatory Surgical (261QA1903X)	36	38	38	39	34	33	-8
Anesthesiology (207L00000X)	77	82	79	84	80	86	12
Audiologist (231H00000X)	15	14	17	19	17	15	0
Case Management (251B00000X)	106	108	102	103	100	100	-6
Chiropractor (111N00000X)	14	16	18	20	13	34	143
CHPR CME (251S00000X)	-	-	-	-	-	1	-
Clinic/Center (261Q00000X)	13	12	13	13	12	12	-8
Clinical Genetics (M.D.) (207SG0201X)	-	-	-	1	-	-	-
Clinical Medical Laboratory (291U00000X)	71	69	79	87	84	90	27
Clinical Neuropsychologist (103G00000X)	-	-	-	-	2	2	-
Clinical Psychologist (103TC0700X)	67	70	78	106	122	94	40
Day Training, Developmentally Disabled Service (251C00000X)	885	879	801	777	645	601	-32
Dental Public Health (1223D0001X)	1	-	-	-	-	-	-
Dentist (122300000X)	22	20	23	31	35	25	14
Dentist, General Practice (1223G0001X)	146	153	155	149	154	146	0
Dermatology (207N00000X)	16	16	19	18	17	15	-6
Diagnostic Radiology (2085R0202X)	56	56	50	53	48	45	-20
Durable Medical Equipment And Medical Supplies (332B00000X)	235	223	245	247	252	244	4
Emergency Medicine (207P00000X)	24	26	23	26	38	39	63
End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	11	11	14	15	13	14	27
Endodontics (1223E0200X)	4	4	5	5	5	5	25
Family Health (363LF0000X)	10	10	13	12	17	16	60
Family Practice (207Q00000X)	93	89	97	100	97	88	-5
Federally Qualified Health Center (261QF0400X)	7	5	9	7	10	9	29
General Acute Care Hospital (282N00000X)	201	189	207	201	192	181	-10
General Acute Care Hospital - Rural (282NR1301X)	31	32	38	46	36	42	35
Hearing Aid Equipment (332S00000X)	19	20	20	19	16	12	-37
Home Health (251E00000X)	29	28	30	31	32	30	3
Hospice Care, Community Based (251G00000X)	14	13	14	12	13	11	-21
Intermediate Care Facility, Mentally Retarded (315P00000X)	1	1	1	1	1	1	0
Internal Medicine (207R00000X)	63	59	73	80	59	67	6
Internal Medicine, Cardiovascular Disease (207RC0000X)	20	16	19	17	17	26	30
Internal Medicine, Endocrinology Diabetes And Metabolic (207RE0101X)	10	9	7	6	7	8	-20
Internal Medicine, Gastroenterology (207RG0100X)	12	10	10	9	6	9	-25
Internal Medicine, Geriatric Medicine (207RG0300X)	1	1	1	2	2	2	100

Provider Taxonomy (continued)	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Internal Medicine, Medical Oncology (207RX0202X)	19	18	15	15	12	11	-42
Internal Medicine, Nephrology (207RN0300X)	8	8	9	8	9	9	13
Internal Medicine, Pulmonary Disease (207RP1001X)	15	11	11	14	13	11	-
Internal Medicine, Rheumatology (207RR0500X)	4	4	4	4	4	4	0
Interpreter (171R00000X)	4	2	2	1	1	1	-75
Licensed Clinic/Certified Social Worker (1041C0700X)	-	-	1	2	43	59	-
Licensed Marriage & Family Therapist (106H00000X)	-	-	-	-	8	10	-
Medicare Defined Swing Bed Unit (275N00000X)	17	17	16	10	9	9	-
Mental Health-Including Community Mental Health (261QM0801X)	25	27	52	36	27	27	8
Midwife, Certified Nurse (367A00000X)	4	6	6	6	5	9	125
Neurological Surgery (207T00000X)	17	18	18	20	14	16	-6
Neuromusculoskeletal Medicine And Omm (204D00000X)	1	1	1	-	-	-	-
Nurse Anesthetist, Certified Registered (367500000X)	23	23	21	24	22	20	-13
Nurse Practitioner (363L00000X)	7	6	6	9	10	10	43
Obstetrics And Gynecology (207V00000X)	55	52	54	54	46	48	-13
Obstetrics And Gynecology (363LX0001X)	4	5	5	6	2	1	-75
Obstetrics And Gynecology, Gynecology (207VG0400X)	4	3	2	3	5	6	50
Obstetrics And Gynecology, Obstetrics (207VX0000X)	2	2	3	2	2	5	150
Occupational Therapist (225X00000X)	9	13	13	15	18	20	122
Ophthalmology (207W00000X)	40	35	36	36	36	34	-15
Optician (156FX1800X)	10	11	11	11	11	9	-10
Optometrist (152W00000X)	98	94	97	96	102	98	0
Orthodontics (1223X0400X)	7	17	17	15	14	16	129
Orthopedic Surgery (207X00000X)	53	50	44	44	35	37	-30
Otolaryngology (207Y00000X)	31	30	29	29	26	27	-13
PACE Organization (251T00000X)	-	-	-	1	1	1	-
PACE PPL (251X00000X)	-	-	-	-	1	1	-
Pathology (207ZP0105X)	20	20	20	22	21	22	10
Pediatrics (208000000X)	74	70	70	71	72	73	-1
Pediatrics (363LP0200X)	1	1	1	1	1	2	100
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	10	8	9	9	8	5	-50
Pedodontics (1223P0221X)	24	26	28	32	31	34	42
Periodontics (1223P0300X)	1	1	-	1	1	1	-
Pharmacy (333600000X)	208	205	199	198	204	205	-1
Phlebotomy/WY Health Fair (246RP1900X)	1	1	1	1	1	1	0
Physical Medicine And Rehabilitation (208100000X)	11	12	14	16	14	17	55
Physical Therapist (225100000X)	56	54	58	56	61	59	5
Physician Assistant (363A00000X)	-	-	-	-	1	1	-
Physician, General Practice (208D00000X)	86	96	93	86	74	78	-9
Plastic Surgery (2082S0099X)	17	18	17	17	15	10	-41
Podiatrist (213E00000X)	14	18	15	17	17	16	14
Professional Counselor (101YP2500X)	5	8	7	5	64	97	1,840
Prosthetic/Orthotic Supplier (335E00000X)	26	25	25	26	30	26	0
Psychiatric Hospital (283Q00000X)	2	2	1	4	4	2	0

Provider Taxonomy (continued)	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Psychiatric Residential Treatment Facility (323P00000X)	22	22	15	19	20	16	-27
Psychiatry And Neurology, Psychiatry (2084P0800X)	38	38	38	43	35	32	-
Psychiatry And Neurology: Neurology (2084N0400X)	31	23	26	27	27	26	-16
Public Health Or Welfare (251K00000X)	24	25	25	24	24	24	0
Public Health, Federal (261QP0904X)	1	2	2	2	2	4	300
Radiology: Mobile (261QR0208X)	5	4	3	2	1	1	-
Rehabilitation Hospital (283X00000X)	4	3	3	3	4	3	-25
Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	1	1	1	1	1	0
Rehabilitation, Substance Use Disorder (261QR0405X)	23	27	52	30	32	31	-
Residential Treatment Facility For Emotionally Disturbed (322D00000X)	26	9	4	2	1	3	-88
Rural Health (261QR1300X)	20	21	19	20	22	23	15
Skilled Nursing Facillity (314000000X)	43	43	40	45	50	52	21
Speech-Language Pathologist (235Z00000X)	6	8	8	5	13	9	50
Surgery, Oral & Maxillofacial (1223S0112X)	15	16	16	17	17	14	-7
Surgery, Pediatric (2086S0120X)	3	2	2	2	2	3	-
Surgery, Vascular (2086S0129X)	7	6	6	5	5	6	-14
Surgery: General Surgery (208600000X)	50	39	45	48	37	43	-14
Thoracic Surgery (208G00000X)	4	3	5	3	4	5	25
Urology (208800000X)	22	20	22	21	18	17	-23
Unclassified	1	1	1	1	1	1	0
Total	**3,699**	**3,752**	**3,763**	**3,603**	**3,651**	**3,605**	**-3**

Table 70. Provider Expenditures History by Taxonomy

Eligibility Category	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Addiction Therapist/Practitioner (101YA0400X)	-	-	-	-	$10,121	$112,463	-
Adult Health (363LA2200X)	-	-	$208	$181	$1,791	$1,789	-
Advance Practice Nurse (364SP0808X)	$194,737	$203,063	$185,079	$217,012	$319,007	$286,789	47
Allergy And Immunology, Allergy (207KA0200X)	$420,255	$457,860	$462,979	$412,870	$473,744	$444,553	6
Ambulance (341600000X)	$3,807,538	$3,303,240	$3,459,400	$3,606,360	$4,352,067	$3,571,623	-6
Ambulatory Family Planning Facility (261QA0005X)	$103,949	$83,744	$81,564	$68,988	$69,754	$55,497	-47
Ambulatory Surgical (261QA1903X)	$3,315,928	$2,912,791	$2,822,957	$3,439,188	$6,090,776	$5,953,159	80
Anesthesiology (207L00000X)	$2,873,295	$2,688,531	$2,660,467	$2,569,464	$2,519,148	$2,568,307	-11
Audiologist (231H00000X)	$55,615	$53,035	$113,056	$124,025	$134,326	$123,718	122
Case Management (251B00000X)	$16,814,987	$16,969,265	$16,187,605	$16,073,653	$16,927,792	$20,056,159	19
Chiropractor (111N00000X)	$5,874	$6,102	$7,349	$7,500	$6,347	$99,664	1,597
CHPR CME (251S00000X)	-	-	-	-	-	$5,021,978	-
Clinic/Center (261Q00000X)	$1,327,399	$1,496,903	$1,195,547	$1,166,813	$1,339,630	$1,361,953	3
Clinical Genetics (M.D.) (207SG0201X)	-	-	-	$1,345	-	-	-
Clinical Medical Laboratory (291U00000X)	$1,121,964	$1,171,185	$1,100,774	$1,149,473	$1,284,678	$1,536,310	37
Clinical Neuropsychologist (103G00000X)	-	-	-	-	$2,071	$642	-
Clinical Psychologist (103TC0700X)	$6,752,837	$7,780,854	$9,025,018	$11,432,476	$14,027,227	$13,790,956	-
Day Training, Developmentally Disabled Service (251C00000X)	$96,906,907	$103,602,106	$106,417,236	$105,946,874	$94,141,526	$93,766,911	-3
Dental Public Health (1223D0001X)	$220,085	-	-	-	-	-	-
Dentist (122300000X)	$1,177,716	$1,307,247	$1,304,083	$1,299,057	$1,345,202	$1,445,036	23
Dentist, General Practice (1223G0001X)	$6,667,264	$6,985,175	$6,567,492	$6,223,175	$6,400,779	$7,171,071	8
Dermatology (207N00000X)	$278,029	$306,992	$346,181	$301,872	$276,343	$253,755	-9
Diagnostic Radiology (2085R0202X)	$2,401,544	$2,557,894	$2,698,857	$2,766,607	$2,218,816	$2,018,120	-16
Durable Medical Equipment And Medical Supplie (332B00000X)	$5,417,606	$5,988,070	$5,803,375	$6,501,225	$6,970,432	$6,610,828	22
Emergency Medicine (207P00000X)	$3,740,215	$3,800,063	$3,662,836	$3,587,560	$3,862,924	$3,198,766	-14
End-Stage Renal Disease (Esrd) Treatment (261QE0700X)	$1,160,798	$835,621	$1,233,755	$1,343,669	$1,099,569	$948,612	-18
Endodontics (1223E0200X)	$114,460	$154,897	$145,175	$176,754	$125,417	$51,569	-55
Family Health (363LF0000X)	$240,460	$308,796	$307,731	$312,321	$368,970	$311,405	30
Family Practice (207Q00000X)	$6,571,534	$6,601,112	$6,408,005	$7,194,712	$5,824,202	$6,384,974	-3
Federally Qualified Health Center (261QF0400X)	$2,864,956	$3,103,164	$1,550,274	$2,018,911	$3,259,793	$3,689,548	29
General Acute Care Hospital (282N00000X)	$97,112,122	$96,670,956	$89,158,045	$90,818,612	$86,971,143	$91,167,750	-6
General Acute Care Hospital - Rural (282NR1301X)	$14,087,353	$16,907,624	$15,538,331	$16,826,942	$16,389,825	$15,380,672	9

Eligibility Category (Continued)	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Hearing Aid Equipment (332S00000X)	$542,768	$737,738	$688,994	$560,896	$940,058	$790,555	46
Home Health (251E00000X)	$1,941,097	$2,732,905	$2,963,510	$2,897,016	$4,618,885	$9,467,835	388
Hospice Care, Community Based (251G00000X)	$1,432,471	$1,036,887	$983,026	$1,082,188	$1,157,101	$1,014,959	-29
Intermediate Care Facility, Mentally Retarded (315P00000X)	$10,651,941	$11,388,412	$10,065,657	$17,942,326	$18,091,427	$18,193,221	71
Internal Medicine (207R00000X)	$2,677,104	$3,681,658	$4,165,557	$4,488,138	$4,966,149	$6,899,612	158
Internal Medicine, Cardiovascular Disease (207RC0000X)	$591,191	$538,377	$447,730	$419,713	$437,224	$388,767	-34
Internal Medicine, Endocrinology Diabetes And Metaboli (207RE0101X)	$28,542	$29,855	$31,333	$30,547	$37,657	$19,270	-32
Internal Medicine, Gastroenterology (207RG0100X)	$293,075	$209,512	$253,524	$201,831	$377,353	$442,390	51
Internal Medicine, Geriatric Medicine (207RG0300X)	$15,894	$14,477	$189	$1,187	$17,669	$20,590	30
Internal Medicine, Medical Oncology (207RX0202X)	$1,727,358	$1,792,761	$2,090,706	$3,029,644	$2,493,943	$1,632,500	-5
Internal Medicine, Nephrology (207RN0300X)	$42,389	$34,141	$57,824	$47,826	$54,404	$51,808	22
Internal Medicine, Pulmonary Disease (207RP1001X)	$48,942	$59,557	$73,916	$119,064	$83,584	$77,414	58
Internal Medicine, Rheumatology (207RR0500X)	$46,899	$50,926	$53,116	$41,963	$49,969	$15,778	-66
Interpreter (171R00000X)	$47,837	$54,259	$48,321	$43,529	$56,339	$47,205	-1
Lic Clinic/Cert Social Worker (1041C0700X)	-	-	$2,564	$5,966	$907,851	$2,284,684	-
Lic Marriage & Fam Therapist (106H00000X)	-	-	-	-	$161,044	$280,470	-
Medicare Defined Swing Bed Unit (275N00000X)	$879,546	$866,458	$1,072,703	$887,666	$833,841	$775,338	-12
Mental Health-Including Community Mental Health (261QM0801X)	$10,274,257	$9,911,967	$9,581,854	$9,640,599	$8,668,925	$7,930,515	-23
Midwife, Certified Nurse (367A00000X)	$16,873	$16,281	$35,068	$18,485	$19,041	$51,381	205
Neurological Surgery (207T00000X)	$1,245,000	$1,177,850	$1,063,118	$890,226	$955,405	$536,628	-57
Neuromusculoskeletal Medicine And Omm (204D00000X)	$24,238	$853	$0	-	-	-	-
Nurse Anesthetist, Certified Registered (367500000X)	$524,777	$491,532	$378,968	$426,998	$227,083	$189,955	-64
Nurse Practitioner (363L00000X)	$168,666	$118,770	$205,988	$279,449	$336,154	$336,366	99
Obstetrics And Gynecology (207V00000X)	$11,210,316	$10,784,741	$9,603,368	$8,906,934	$6,832,110	$5,733,312	-49
Obstetrics And Gynecology (363LX0001X)	$420,486	$735,818	$668,453	$356,682	$6,019	$7,023	-98
Obstetrics And Gynecology, Gynecology (207VG0400X)	$90,214	$12,646	$14,134	$8,385	$11,932	$80,997	-10
Obstetrics And Gynecology, Obstetrics (207VX0000X)	$10,594	$8,899	$6,188	$4,232	$10,974	$417,994	3,846
Occupational Therapist (225X00000X)	$335,576	$519,915	$777,572	$667,385	$2,260,765	$3,053,289	810
Ophthalmology (207W00000X)	$698,593	$700,218	$709,763	$693,621	$690,214	$606,722	-13
Optician (156FX1800X)	$140,095	$123,831	$101,728	$94,212	$74,200	$80,235	-43
Optometrist (152W00000X)	$3,046,630	$3,103,713	$3,090,404	$3,295,581	$3,521,016	$3,571,953	17
Orthodontics (1223X0400X)	$229,986	$314,684	$456,310	$415,802	$406,253	$547,443	138

Eligibility Category (Continued)	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Orthopedic Surgery (207X00000X)	$1,836,993	$1,657,652	$1,679,389	$1,480,296	$1,422,229	$1,404,323	-24
Otolaryngology (207Y00000X)	$1,000,269	$1,097,720	$982,135	$882,361	$957,868	$895,930	-10
PACE Organization (251T00000X)	-	-	-	$168,398	$2,242,570	$2,934,877	-
PACE PPL (251X00000X)	-	-	-	-	$2,707,383	$4,434,368	-
Pathology (207ZP0105X)	$333,627	$414,608	$413,824	$365,084	$170,879	$164,404	-51
Pediatrics (208000000X)	$8,425,254	$7,408,393	$6,332,565	$5,954,804	$5,662,679	$5,455,184	-35
Pediatrics (363LP0200X)	$32,367	$22,194	$10,525	$10,696	$10,995	$12,213	-62
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	$1,217,266	$802,591	$761,916	$812,471	$452,942	$248,989	-80
Pedodontics (1223P0221X)	$3,588,181	$3,923,576	$4,109,557	$4,374,460	$5,148,703	$5,008,474	40
Periodontics (1223P0300X)	$2,766	$60	-	$1,385	$2,341	$480	-83
Pharmacy (333600000X)	$38,750,658	$41,330,767	$41,918,402	$38,919,301	$47,785,528	$48,325,155	25
Phlebotomy/WY Health Fair (246RP1900X)	$3,520	$3,820	$5,910	$2,635	$1,920	$575	-84
Physical Medicine And Rehabilitation (208100000X)	$164,875	$135,880	$106,951	$143,519	$191,749	$128,026	-22
Physical Therapist (225100000X)	$2,415,165	$2,776,082	$2,673,200	$2,799,403	$2,917,423	$3,382,286	40
Physician Assistant (363A00000X)	-	-	-	-	$589	$577	-
Physician, General Practice (208D00000X)	$9,907,834	$10,068,544	$9,845,606	$9,598,191	$10,113,348	$7,598,341	-23
Plastic Surgery (2082S0099X)	$238,432	$154,444	$142,040	$133,343	$116,240	$90,174	-62
Podiatrist (213E00000X)	$48,861	$76,857	$73,605	$65,795	$78,388	$79,404	63
Professional Counselor (101YP2500X)	$32,630	$40,195	$43,384	$24,104	$2,338,814	$3,676,332	11,167
Prosthetic/Orthotic Supplier (335E00000X)	$645,342	$779,875	$778,124	$828,261	$720,162	$798,679	24
Psychiatric Hospital (283Q00000X)	$1,132,834	$1,284	$17,594	$106,009	$275,227	$127,648	-89
Psychiatric Residential Treatment Facility (323P00000X)	$14,658,731	$15,244,613	$8,019,118	$12,080,494	$13,575,847	$11,797,657	-20
Psychiatry And Neurology, Psychiatry (2084P0800X)	$4,085,344	$4,818,845	$4,695,322	$3,682,231	$2,650,594	$2,705,413	-34
Psychiatry And Neurology: Neurology (2084N0400X)	$837,067	$781,629	$672,232	$661,311	$1,354,679	$959,006	15
Public Health Or Welfare (251K00000X)	$1,081,591	$1,093,398	$988,455	$924,007	$1,009,814	$1,072,715	-1
Public Health, Federal (261QP0904X)	$7,700,047	$8,532,271	$7,240,130	$8,067,975	$8,761,358	$8,479,944	10
Radiology: Mobile (261QR0208X)	$222,281	$217,463	$109,250	$4,081	$52	$7	-100
Rehabilitation Hospital (283X00000X)	$1,308,965	$777,740	$1,085,017	$1,087,890	$887,751	$1,016,080	-22
Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	$36,757	$56,646	$125,928	$121,618	$154,682	$146,226	298
Rehabilitation, Substance Use Disorder (261QR0405X)	$1,545,165	$2,172,581	$2,592,208	$3,352,288	$4,793,708	$3,895,890	152
Residential Treatment Facility For Emotionally Disturbed (322D00000X)	$8,757,612	$424,200	$183,009	$109,220	$35,712	$237,904	-97
Rural Health (261QR1300X)	$1,710,855	$1,940,640	$1,628,043	$1,845,491	$1,668,167	$1,413,842	-17

Eligibility Category (Continued)	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	5 Year Percent Change
Skilled Nursing Facillity (314000000X)	$74,555,265	$72,313,876	$72,733,100	$72,705,796	$69,520,419	$81,670,473	10
Speech-Language Pathologist (235Z00000X)	$144,868	$227,230	$117,626	$336,118	$745,421	$714,369	393
Surgery, Oral & Maxillofacial (1223S0112X)	$863,849	$930,943	$978,561	$781,478	$1,045,169	$1,225,956	42
Surgery, Pediatric (2086S0120X)	$80,818	$48,896	$90,962	$63,361	$80,089	$57,200	-29
Surgery, Vascular (2086S0129X)	$47,597	$48,526	$38,008	$32,715	$18,527	$32,393	-32
Surgery: General Surgery (208600000X)	$935,283	$853,509	$796,756	$765,767	$635,372	$713,150	-24
Thoracic Surgery (208G00000X)	$15,186	$12,002	$11,995	$13,475	$31,776	$34,078	124
Urology (208800000X)	$886,191	$887,064	$799,645	$835,010	$740,261	$441,176	-50
Unclassified	$120,195	$21,733	-$4,024	$30,590	$154,857	$272,435	127
Total	**$514,529,323**	**$519,604,279**	**$500,931,031**	**$517,257,164**	**$527,531,608**	**$554,583,138**	**8**

Appendix B Reimbursement Methodology

This section provides a brief overview and recent history of the reimbursement methodology for the service areas discussed in this report.

Table 71. Reimbursement Methodology and History by Service Area

Ambulance

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Fixed fee schedule for transport
Mileage and disposable supplies reimbursed separately
Separate fee schedules for: Basic life support (ground), Advanced life support (ground), Additional advanced life support (ground), Air ambulance

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	No change

Wyoming State Rule Chapter 15; Chapter 3

Ambulatory Surgery Center

Based on Medicaid's Outpatient Prospective Payment System (OPPS). Uses Medicare's relative weights and the Wyoming Medicaid payment method for each service (OPPS status indicator) for each procedure code. Medicaid adopted Medicare's OPPS status indicators for most services, with some adjustments for Medicaid policies.

Services are paid based on one of the following (by status indicator): 1) Ambulatory Payment Classification (APC) fee schedule, 2) separate Medicaid fee schedule, or 3) percentage of charges.

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	Adopted new OPPS-based methodology to better align reimbursement with those services provided in other outpatient settings	No change

43 CFR 447.321 SPA 4.19B

Behavioral Health

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Separate fee schedules based on the type of provider

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	No change

State plan 4.19B

Care Management Entity

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Reimbursement based on procedure code fee schedule

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
N/A	N/A	N/A	N/A	N/A	Beginning of service

42 CFR 438.6; Annual actuarial analysis with review and approval by CMS for each SFY.

Clinic/Center

Lower of the Medicaid fee schedule or the provider's usual and customary charge

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	No change

Wyoming State Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B

Dental

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Adult optional dental services added (effective July 1, 2006)

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	No change

Wyoming State Plan Attachment 4.19B

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

Lower of the Medicaid fee schedule, or the provider's usual and customary charge
Rates based on Medicare's fee schedule which is updated annually for inflation based on the consumer price index
For procedure codes not on Medicare's fee schedule, Medicaid considers other states' rates
Certain DME is manually priced based on the manufacturer's invoice price, plus a 15% add-on, plus shipping and handling
Delivery of DME more than 50 miles roundtrip is reimbursed per mile

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	No change

Wyoming State Rule Chapter 11; Chapter 3; Wyoming State Plan Attachment 4.19B-12c

End Stage Renal Disease

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Dialysis services reimbursed at a percentage of billed charges

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Dialysis services reimbursed at 24% of billed charges (effective September 1, 2010)	Dialysis services reimbursed at 17% of billed charges (effective January 1, 2012)	Dialysis services reimbursed at 12% of billed charges (effective January 1, 2013)	Dialysis services reimbursed at 9% of billed charges (Effective January 1, 2014)	No change	No change

42 CFR Part 413 Subpart H; State Plan 4.19B

Federally Qualified Health Centers

Prospective per encounter payment system as required by the Benefits Improvement and Protection Act (BIPA) of 2000.
Based on 100% of a facility's average costs during SFYs 1999 and 2000.
Rates increase annually for inflation based on Medicare Economic Index (MEI) charges

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Rates increased 0.4% based on MEI	Rates increased 0.6% based on MEI	Rates increased 0.8% based on MEI	Rates increased 0.8% based on MEI	Rates increased 0.8% based on MEI	Rates increased 1.1% based on MEI

42 CFR 405 Supchapter B; 405.2400-405.2472 Subpart X; 405.2400-405.2417; 405.2430-405.2452; 405.2460-405.2472; Chapter 37 Rule

Home Health

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Per visit rates based on Medicare's fee schedule

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	No change

42 CFR 484 Subpart E

Hospice

Per diem rate based on Medicare's fee schedule
Rates adjust annually based on Medicare's adjustments
Rates for services provided to nursing facility residents are 95% of the nursing facility's per diem rate
Rate for room and board in an inpatient hospice facility not to exceed 50% of the established nursing home room and board rate (effective July 1, 2013)

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments

42 CFR 418; Wyoming State Statute 42-4-103(a)(xxv)

Hospital Inpatient

Level of Care (LOC) rate per discharge
Per diem rates for rehabilitation with a ventilator and separate rate without a ventilator
Transplant services are reimbursed at 55% of billed charges
Specialty services not otherwise obtainable in Wyoming negotiated through letters of agreement

Additional payments:
Inpatient hospitals that serve a disproportionate share of low-income individuals receive disproportionate share hospital (DSH) payments
Qualified Rate Adjustment (QRA) program provides supplemental payments to non-state governmental hospital

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	No change

CFR 447 Subpart C Payment; State Plan 4.19B

Hospital Outpatient

Outpatient prospective payment system (OPPS) based on Medicare's Ambulatory Payment Classifications (APC) system
Three conversion factors based on hospital type: General acute; Critical access; Children's
Separate fee schedules for: Select DME; Select vaccines, therapies immunizations, radiology, mammography screening and diagnostic mammographies; Laboratory; Corneal tissue, dental and bone marrow transplant services, new medical devices

Additional payments:
Qualified Rate Adjustment (QRA) program provides supplemental payments to non-state governmental hospital

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Adjusted conversion factors to support budget neutrality in the aggregate (effective calendar year 2011): General acute $48.65 Critical access $129.22 Children's $105.62	Adjusted conversion factors to support budget neutrality in the aggregate (effective calendar year 2012): General acute $50.99 Critical access $129.74 Children's $109.95	Adjusted conversion factors to support budget neutrality in the aggregate (effective calendar year 2013): General acute $48.19 Critical access $126.82 Children's $105.50	Adjusted conversion factors to support budget neutrality in the aggregate (effective calendar year 2014): General acute $45.45 Critical access $118.86 Children's $100.05	Adjusted conversion factors to support budget neutrality in the aggregate (effective calendar year 2015): General acute $42.34 Critical access $111.93 Children's $92.71	Adjusted conversion factors due to budget cuts (effective November 1, 2016): General acute $39.41 Critical access $102.53 Children's $85.41 ASCs $34.68
No change for QRA	No change for QRA	No change for QRA	No change for QRA	No change for QRA	No change for QRA

CFR 447.321; CFR 447.325; Chapter 33 Rule

Intermediate Care Facility for people with Intellectual Disabilities (ICF-ID)

Full cost reimbursement method based on previous year cost reports.

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	Removed link with Nursing Home rates. Rates now updated annually with full cost coverage.

Wyoming State Rule Chapter 20

Laboratory

Lower of the Medicaid fee schedule or the provider's usual and customary charge

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	No change

Wyoming State Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B

Nursing Facility

Prospective per diem rate with rate components for capital cost, operational cost and direct care costs
Additional reimbursement on a monthly basis for extraordinary needs determined on a per case basis

Additional payments:
Provider Assessment and Upper Payment Limit (UPL) Payment provides supplemental payments (effective April 1, 2011)

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change to rates Implemented Provider Assessment and Upper Payment Limit (UPL) Payment after Legislative and federal approval. First payment in SFY 2012.	No change	No change	No change	Rate updates effective SFY16 pending SPA approval- based on approved NH Rate Reimbursement update	No change

W.S. 42-4-104 (c); State Plan- 4.19D; Chapter 7 Rule

Physicians and Other Practitioners

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Resource-Based Relative Value Scale (RBRVS) reimbursement methodology based on Medicare's RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rates.

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	Beginning January 1, 2013 The Affordable Care Act (ACA)mandated increased primary care service payment by State Agencies of least the Medicare rates in effect in CY 2009 for CY 2013 and 2014. This only effected Evaluation and Management procedure codes 99201-99499 and Vaccine codes 90460, 90471, 90472, 90743 and 90474. This was only applicable to Physicians that completed a self-attestation to having a specialty in Family, Internal or Pediatric Medicine.	The ACA Primary Care Service Payments officially ended December 31, 2014.	No change	No change

State Plan Amendment 3.1 and 4.19B

Prescription Drugs

Lower of the estimated acquisition cost (EAC) of the ingredients plus the dispensing fee and the provider's usual and customary charge. The EAC is the Average Wholesale Price (AWP) minus 11% The AWP is determined by pricing information supplied by drug manufacturers, distributors and suppliers and is updated monthly. Some drugs are priced by the State Maximum Allowable Cost (SMAC). Dispensing fee is $5.00 per claim

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
PDL expanded to 80 specific drug classes	PDL expanded to 109 specific drug classes	PDL adjusted to 108 specific drug classes	PDL expanded to 119 specific drug classes	PDL expanded to 123 specific drug classes	No change

State Plan Amendment, Attachment 4.19B, Section 12.a., pages 1-3; Wyoming Medicaid Rules, Chapter 10, Pharmaceutical Services, Section 16 (Medicaid Allowable Payment)

Program for All-Inclusive Care of the Elderly (PACE)

Capitation rate of no less than 90% of the fee for service equivalent cost, including department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all services were provided on a fee for service basis.

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	No change

Wyoming Medicaid Rules, Chapter 27; Wyoming Statute 42-4-121d(ii); CFR 460.90 Subpart F

Psychiatric Residential Treatment Facility

Per diem rate. The rate includes room and board, treatment services specified in the treatment plan, and may include an add-on rate for medical services.

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
Rates increased based on analysis of Medicaid cost reports	No change	No change	Rates adjusted 12/1/14 based on analysis of Medicaid cost reports	No change	No change

W.S. 42-4-103 (a)(xvi); 42 CFR Part 483 Subpart G; 42 CFR Part 441 Subpart D; State Plan- Attachment 4.19A, pg. 1; Attachment 3.1A, pg. 7; Chapter 40 Rule

Public Health or Welfare

Lower of the Medicaid fee schedule or the provider's usual and customary charge

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	No change

Wyoming State Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B

Public Health, Federal

Indian Health Service (IHS) encounter rate set annually by IHS.

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	No change

Public Health Service Act, Sections 321(a) and 322(b); Public Law 83-568; Indian Health Care Improvement Act

Rural Health Center

Prospective per encounter payment system as required by the Benefits Improvement and Protection Act (BIPA) of 2000
Based on 100% of a facility's average costs during SFYs 1999 and 2000
Rates increased annually for inflation based on Medicare Economic Index (MEI)

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	Rates increased 0.8% based on MEI	Rates increased 0.8% based on MEI	Rates increased 1.1% based on MEI

42 CFR 405 Subchapter B; 405.2400-405.2472 Subpart X; 405.2400-405.2417; 405.2430-405.2452; 405.2460-405.2472; Chapter 37 Rule

Vision

Lower of the Medicaid fee schedule or the provider's usual and customary charge. The most recent update was in SFY 2006 when the rate for standard frames was increased.
Ophthalmologists and optometrists are reimbursed under the Resource-Based Relative Value Scale (RBRVS) reimbursement methodology based on Medicare's RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rates.
Optician reimbursement based on a procedure code fee schedule

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	No change

State Plan 3.1-A; State Plan 4.19B/6.b

Waivers - Acquired Brain Injury / Adult ID-DD / Child ID-DD

Cost based reimbursement methodology, implemented in SFY 2009. The Individualized Budget Amount (IBA) is based on the historical plan of care units multiplied by the respective service rate less one-time costs, such as assessments, specialized equipment or home modifications. Reimbursement for specific residential and day habilitation services is made on a per diem basis and varies by provider and consumer. Consumers negotiate rates based on their budget amount. For extraordinary care needs, the Extraordinary Care Committee (ECC) reviews the full service and support structure of a participant, including non-waiver services and supports, to determine the appropriate service(s) and funding to meet the participant's assessed needs. The ECC will also review requests for IBA adjustments due to a change in client needs or emergencies.

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
A 6% restoration of the SFY 2010 10% rate reduction (or 96% of the SFY 2009 rates) was implemented	No change	No change	Rates were reduced by 1% at the beginning of FY 14 as required by the legislature to reach a 4% overall budget reduction for the waivers.	No change	Participants will transition to either the Comprehensive or Supports Waiver between January 1st and March 31st of 2017. On March 31st, 2017, this waiver will be closed. No rate changes.

Required to rebase the rates and conduct rate studies every 2 -4 years per Wyoming Statute Wyo. Stat. § 42-4-120(g)

Waivers - Comprehensive and Supports

Implemented in SFY 2014 with reimbursment based on the cost based reimbursement methodology implemented in SFY 2009, but with the reductions made in SFY 2011 and SFY 2014 applied. The Individualized Budget Amount (IBA) is based on the historical plan of care units multiplied by the respective service rate less one-time costs, such as assessments, specialized equipment or home modifications. Reimbursement for specific residential and day habilitation services is made on a per diem basis and varies by provider and consumer. Consumers negotiate rates based on their budget amount. For extraordinary care needs, the Extraordinary Care Committee (ECC) reviews the full service and support structure of a participant, including non-waiver services and supports, to determine the appropriate service(s) and funding to meet the participant's assessed needs. The ECC will also review requests for IBA adjustments due to a change in client needs or emergencies.

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
N/A	N/A	N/A	Waivers implemented with reimbursement based on SFY 2009 methodology with SFY '11 and '14 reductions included	No change	3.3% across-the-board rate increase and 3.3% increase to each IBA to be implemented 1/1/17

Required to rebase the rates and conduct rate studies every 2 -4 years per Wyoming Statute Wyo. Stat. § 42-4-120(g)

Waiver - Children's Mental Health

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Reimbursement based on procedure code fee schedule

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	Care Management Entity began serving youth July 1, 2015

42 CFR 438.6; Annual actuarial analysis with review and approval by CMS for each SFY.

Waiver - Assisted Living Facility

Reimbursement made on a per diem rate, based on an all-inclusive payment methodology. Per diem ratesare based on the participant's functional assessment. Per diem rate includes required personal care, 24-hour supervision and medication assistance up to a monthly or yearly cap.
Case management services are reimbursed a separate rate.
Participants pay their own room and board.

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	12% increase per rate rebasing project, effective March 1, 2016.

Waiver agreement

Waiver - Long-Term Care

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Reimbursement limited to a monthly or yearly cap per person, according to the established care plan

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	No change	No change	8% increase per rate rebasing project, effective March 1, 2016.

Waiver agreement

Waiver - Pregnant by Choice

The waiver was implemented in SFY 2009 Multiple reimbursement methodologies and fee schedules based on the service areas detailed in this appendix

SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016
No change	No change	No change	Extended to December 31, 2017	No change	No change

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Appendix C Eligibility Requirements and Benefits

Table 72. Income Limits by Eligibility Category

Eligibility Category	CY 2015-2016
Children 0-5	154% FPL, no resource limits
Children 6-18	133% FPL, no resource limits
Former Foster Care Children, age 19 to 26	Eligible, no resource limits
Family Care Adults	Values in Table 73, no resource limits
Pregnant Women	154% FPL, no resource limits
ABD Waivers and institutions	Less than or equal to 300% SSI
ABD with Eligibility Determined by Social Security Administration	100% SSI
Qualified Medicare Beneficiary	100% FPL
Specified Low-Income Medicare Beneficiary	Less than or equal to 120% FPL
Qualified Individual	121 to 135% FPL
Breast & Cervical Cancer	Less than or equal to 250% FPL
Tuberculosis	100% SSI
Employed individuals with disabilities	Less than or equal to 300% SSI
Non-Citizens with Medical Emergencies	Depends on eligibility group qualified under

Table 73. Monthly Income Standard Values by Family Size

Income Standard	Income Limit	CY 2015				CY 2016			
Family Size		1	2	3	4	1	2	3	4
Family Care Adults		$529	$737	$873	$999	$529	$737	$873	$999
Federal Poverty Level (FPL)	100%	$973	$1,311	$1,649	$1,988	$990	$1,335	$1,680	$2,025
	133%	$1,294	$1,744	$2,194	$2,644	$1,317	$1,776	$2,235	$2,694
	154%	$1,498	$2,019	$2,540	$3,061	$1,525	$2,056	$2,588	$3,119
Supplementary Security Income (SSI)	100%	$733	$1,100	--	--	$733	$1,100	--	--
	300%	$2,199	$3,300	--	--	$2,199	$3,300	--	--

Table 74. Eligibility Requirements

Category Group	Eligibility Category	Benefits	Eligibility Requirement	Countable Income	Income Level	Resource Limits
Children	Newborn	Full Medicaid Coverage	Newborns up to age one, with Medicaid eligible mothers	N/A; eligibility determined by mother's Medicaid eligibility		
	Children Age 0-5	Full Medicaid Coverage	Under age six	Countable family income	Less than or equal to 154 percent of FPL	
	Children Age 6-18	Full Medicaid Coverage	Under age 19	Countable family income	Less than or equal to 133 percent of FPL	
	Foster Care	Full Medicaid Coverage	Under age 21, in DFS custody	Requirements vary by type of foster care coverage or subsidized adoption		
	Subsidized Adoption	Full Medicaid Coverage	Under age 18; under age 21 for children with special needs	Requirements vary by type of foster care coverage or subsidized adoption		
Pregnant Women	Pregnant Women	Full Medicaid Coverage	Pregnant	Countable family income	Less than or equal to 154 percent of FPL	
	Presumptive Eligibility for Pregnant Women	Outpatient services for a limited time	Pregnant	Countable family income	Less than or equal to 154 percent of FPL	
Family Care	Family Care	Full Medicaid Coverage	Adult with eligible child under age 19 living in the household	Countable family income	Less than or equal to Family Care Income Standard	
	Family Care 4 and 12 month (extended medical)	Full Medicaid Coverage	Adult with eligible child under age 19 living in the household; Family unit must have received family care benefits for at least three of the previous 6 months	Countable family income	Exceeds the family care income standard due to increased income due to increased employment, increased salary, parent returning to work, or child support	
	Aging-Out Foster Care Program	Full Medicaid Coverage	Under age 26	Requirements vary by the type of foster care coverage or subsidized adoption		
Aged, Blind, or Disabled (ABD)	ABD Individuals in Institutions	Full Medicaid Coverage	Age 65 or older; or blind by SSI standards; or disabled by SSI standards; and in an institutional setting, such as nursing home, IMD, hospice care, inpatient hospital, or ICF-ID	Countable personal income	Less than or equal to 300 percent of the SSI payment standard for a single individual	yes
	Categories with eligibility determined by Social Security Administration (SSA)	Full Medicaid Coverage	SSI eligibility	Countable personal and spousal income	Eligibility determined by SSA; automatically eligible for Medicaid Monthly SSI Payment Standard	yes
	SSI related categories with eligibility determined by DFS	Full Medicaid Coverage	Lost SSI due to increase or receipt of Social Security benefits; disregard increase or SSA benefit amount	Countable personal income	Countable income less than or equal to Monthly SSI Payment Standard	yes

Category Group	Eligibility Category	Benefits	Eligibility Requirement	Countable Income	Income Level	Resource Limits
Medicare Savings Program	Qualified Medicare Beneficiary (QMB)	Medicaid covers Medicare Part A/B premiums CMS assists with Medicare Part D premiums Medical deductible and coinsurance payments	Entitled to Medicare Part A or Part B	Countable personal and spousal income	Less than or equal to 100 percent of FPL	yes
	Specified Low-Income Medicare Beneficiary (SLMB)	Medicaid pays Medicare Part B premiums	Entitled to Medicare Part B	Countable personal and spousal income	Less than or equal to 120 percent of FPL	yes
	Qualified Individuals (QI	Medicaid pays Medicare Part B premiums (100% federal funds)	Entitled to Medicare Part B	Countable personal and spousal income	Between 121 and 135 percent of FPL	yes
Special Groups	Breast and Cervical Cancer	Full Medicaid Coverage	Between age 18 and 65 (if over 65, must not be eligibile for Medicare Part B); meet Preventative Health and Safety Division criteria; no insurance coverage paying for cancer screening or treatment (including Medicaid and Medicare Part B)	Countable personal income	Less than or equal to 250 percent of FPL	
	Tuberculosis	Partial benefits related to tuberculosis	Verification of tuberculosis	Countable personal income	Based on twice SSI Payment Standard, plus $85 per month	yes
Medicaid Buy-In	Employed Individuals with Disabilities	Full Medicaid benefics after payment of premium (7.5 percent of gross monthly income)	Between age 16 and 64; disabled; employed	Countable personal and spousal income	Unearned income less than or equal to 300 percent of the SSI standard for a single individual	
Non-Citizens	Non-Citizens with Medical Emergencies	Benefits limited to services provided from the time treatment was given for a condition until that same condition is no longer considered an emergency	Illegal immigrants or qualified immigrants who do not meet citizenship criteria	Meets applicable eligibility requirements under an existing eligibility group		


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Appendix D Glossary & Acronyms

GLOSSARY

Acquired Brain Injury (ABI) – Damage to the brain that occurs after birth and is not related to a congenital or degenerative disorder.

Affordable Care Act (ACA) – The Patient Protection and Affordable Care Act as well as the Healthcare and Education Reconciliation Act was signed into law in March 2010. These laws are collectively known as the Affordable Care Act legislation and represent a significant overhaul to the healthcare system.

Ambulatory Surgical Center (ASC) – A free-standing facility, other than a physician's office or a hospital, where surgical and diagnostic services are provided on an ambulatory basis. The facility operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours.

Ambulatory Payment Classifications (APC) – A group to which an outpatient service is assigned in Medicare's prospective payment system for outpatient hospital services. The healthcare common procedure coding system, including certain current procedural terminology codes and descriptors are used to identify and group the services within each APC group. Services within an APC group are comparable clinically and with respect to resource use. A payment rate is established for each APC group.

American Recovery and Reinvestment Act of 2009 (ARRA) – Legislation signed into law in February 2009 in response to the economic crisis. The Act specified funding for a wide range of federal programs, including certain benefits under Medicaid.

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

Basic Life Support – A level of medical care, usually provided by emergency medical service professionals, provided to patients of life-threatening illnesses or injuries until they can be given full medical care. Basic life support consists of essential non-invasive life-saving procedures including CPR, bleeding control, splinting broken bones, artificial ventilation, and basic airway management.

Benefits Improvement and Protection Act of 2000 (BIPA) – Legislation signed into law in December 2000 that affects several aspects of Medicare and Medicaid.

Centers for Medicare and Medicaid Services (CMS) – The government agency within the Department of Health and Human Services that administers the Medicare program, and works with states to administer Medicaid. In addition to Medicare and Medicaid, CMS oversees the Children's Health Insurance Program.

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

Cognos – The reporting tool used to extract data from the Medicaid Management Information System (MMIS).

Commission on Accreditation of Rehabilitation Facilities (CARF) – An organization that accredits rehabilitation facilities.

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

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that provides coordinated, comprehensive outpatient rehabilitation services under the supervision of a physician. At minimum, a CORF must provide physician supervision and physical therapy and social or psychological services to be certified as a CORF.

Co-payment – A fixed amount of money paid by the enrolled member at the time of service. Council on Accreditation – An organization that accredits healthcare organizations.

Crossover Claim – Services for Medicaid and Medicare dual individuals in which Medicare is the primary payer and forwards the claim to Medicaid for additional payments.

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

Deficit Reduction Act of 2005 (DRA) – Legislation signed into law in February 2006 that affects several aspects of Medicare and Medicaid.

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

Disproportionate Share Hospital (DSH) – Hospitals that serve a significantly disproportionate number of low-income individuals. Eligible hospitals can receive an adjustment payment under Medicaid.

Drug Utilization Review (DUR) – A review utilization of outpatient prescription drugs to determine if recipients are receiving appropriate, medically necessary medications which are not likely to result in adverse effects.

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

Dual Individual – For the purposes of this Report, an individual enrolled in Medicare and Medicaid who is eligible to receive Medicaid services.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – The comprehensive and preventive child health component of Medicaid for individuals under age 21. Medicaid's EPSDT services are operated under the Health Check program. All medically necessary diagnostic and treatment services within the federal definition of Medicaid medical assistance must be covered, regardless of whether or not such services are otherwise covered under the state Medicaid plan for adults ages 21 and older.

Eligibility – Criteria that establish an individual as qualified to enroll in Medicaid. The federal government establishes minimum eligibility standards and requires states to cover certain population groups. States have the flexibility to cover other population groups within federal guidelines.

Enrollment – A unique count of members enrolled in Medicaid. Enrollment may be reported at a point in time (e.g., as of June 30) or over a time frame (e.g., SFY 2015).

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

Estimated Acquisition Cost (EAC) – The estimated cost to the pharmacy of acquiring a prescription drug. Federal regulations require that each State's reimbursement for Medicaid prescription drugs not exceed the lower of (1) its estimated acquisition cost plus a dispensing fee, or (2) the provider's usual and customary charge to the public for the drug.

Expenditure – Funds or money spent to liquidate an expense regardless of when the service was provided or the expense was incurred.

Explanation of Benefits (EOB) – An itemized statement of services from an insurance company detailing what services were paid for on the behalf of an individual. The EOB informs an individual what portion of a claim was paid to the healthcare provider and what portion of the payment, if any, the individual is responsible for.

Federal Fiscal Year (FFY) – The 12 month accounting period, for which the federal government plans its budget, usually running from October 1 through September 30. The FFY is named for the end date of the year (e.g., FFY 2009 ends on September 30 2009).

Federal Medical Assistance Percentage (FMAP) – The percentage rates used to determine the federal matching funds allocated to the Medicaid program. The FMAP is the portion of the Medicaid program that is paid by the federal government.

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

Federally Qualified Health Center (FQHC) – A designated health center in a medically under-served area that is eligible to receive cost-based Medicare and Medicaid reimbursement.

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

Fee Schedule – A complete listing of fees used by health plans to pay medical care professionals.

Healthcare Common Procedure Coding System (HCPCS) – A standardized coding system used to report procedures, specific items, equipment, supplies, and services provided in the delivery of healthcare. There are two principal subsystems, Level I and Level II. Level I codes are comprised of CPT codes which are identified by five numeric digits. Level II codes are used primarily to identify equipment, supplies and services not included in the CPT code set. Level II codes are alphanumeric codes.

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

HCBS Acquired Brain Injury (ABI) Waiver – A HCBS waiver developed to assist adults from ages 21 to 65 with acquired brain injuries to receive training and support that will allow them to remain in their home communities and avoid institutionalization. Being replaced by the Comprehensive and Supports Waiver starting in SFY 2016.

HCBS Adult Developmental Disabilities (DD) Waiver – A HCBS waiver developed to assist adults with developmental disabilities to receive training and support that will allow them to remain in their home communities and avoid institutionalization. Replaced by the Comprehensive and Supports Waiver starting in April 2014.

HCBS Assisted Living Facility (ALF) Waiver – A HCBS waiver that allows participants ages 19 and older who require services equivalent to a nursing facility level of care to receive services in an ALF.

HCBS Child Developmental Disabilities (DD) Waiver – A HCBS waiver developed to assist children under age 21 with developmental disabilities to receive training and support that will allow them to remain in their home communities and avoid institutionalization. Replaced by the Comprehensive and Supports Waiver starting in April 2014.

HCBS Children's Mental Health (CMH) Waiver – A HCBS waiver developed to allow youth with serious emotional disturbances who need mental health treatment to remain in their home communities.

HCBS Comprehensive Waiver – A HCBS waiver developed to replace the former DD waivers for with people with a developmental disability.

HCBS Long-Term Care (LTC) Waiver – A HCBS waiver that provides in-home services to participants ages 19 and older who require services equivalent to a nursing facility level of care.

HCBS Supports Waiver - A HCBS waiver developed to replace the former DD waivers for with people with a developmental disability. Provides more flexible service than the Comprehensive Waiver, but with a lower cap on benefits.

Health Professional Shortage Area (HPSA) – A geographic, demographic or institutional designation by the Health Resources and Services Administration as having shortages of primary medical care, dental or mental health providers.

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

Individualized Budget Amount (IBA) – In the developmental disability and acquired brain injury waiver programs, the amount of funding allocated to each participant based on individual characteristics and his or her service utilization.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) – An organization that accredits healthcare organizations.

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

Medicaid – A joint federal-state program authorized by Title XIX of the Social Security Act that provides medical coverage for certain low-income and other categorically related individuals who meet eligibility requirements. A portion of the Medicaid program is funded by the federal government using the Federal Medical Assistance Percentage.

Medicaid Management Information System (MMIS) – An integrated group of procedures and computer processing operations (subsystems) that supports the Medicaid program operations. The functional areas of the MMIS include recipients, providers, claims processing, reference files, surveillance and utilization review, management and administration reporting, and third party liability. The MMIS is certified by the Centers for Medicare and Medicaid Services.

Medicare – A federal program, authorized by Title XVIII of the Social Security Act, that provides medical coverage for individuals age 65 or older, individuals under age 65 with certain disabilities, and individuals of all ages with end stage renal disease.

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

Member – An individual enrolled in Medicaid and eligible to receive services.

Modified Adjusted Gross Income (MAGI) — A new income methodology implemented in SFY 2013.

Per Member per Month – The monthly average cost for each enrolled member.

Pharmacy Benefit Management (or Manager) (PBM) – Third party administrator of prescription drug programs.

Preferred Drug List (PDL) – A list of clinically sound and cost effective prescription drugs covered by Medicaid that do not require prior authorization.

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

Prescription Drug Assistance Program (PDAP) – A state-funded program administered by the Healthcare Financing Division providing up to three prescriptions per month to Wyoming residents with income at or below 100 percent of the FPL.

Prior Authorization (PA) – The requirement of a prescriber to obtain permission to prescribe a medication prior to prescribing it. In the context of a PBM plan, a program that requires physicians to obtain certification of medical necessity prior to drug dispensing.

Procedure Code – A HCPCS Level I or Level II code used to report the delivery of healthcare for reimbursement purposes.

Psychiatric Residential Treatment Facility (PRTF) – A facility that provides services to individuals who require extended care beyond acute psychiatric stabilization or extended psychiatric services. These services address long-standing behavioral disturbances, which are not usually responsive to shorter-term care.

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

Recipient – For the purposes of this Report, an individual enrolled in Medicaid who received Medicaid services.

Resource Based Relative Value Scale (RBRVS) – Established as part of the Omnibus Reconciliation Act of 1989, Medicare's payment principles for physician services were adjusted by establishing an RBRVS fee schedule. This payment methodology has three components: a relative value for each procedure, a geographic adjustment factor and a conversion factor. Procedures are assigned a relative value which is adjusted by geographic region. This value is then multiplied by a conversion factor to determine the amount of payment.

Rural Health Clinic (RHC) – A designated health clinic in a medically underserved area that is non-urbanized as defined by the U.S. Bureau of Census and that is eligible to receive cost-based Medicare and Medicaid reimbursement.

Section 1115 Waiver – An experimental, pilot or demonstration project authorized by Section 1115 of the Social Security Act. Section 1115 projects allow states the flexibility to test new or existing approaches to financing and delivering the Medicaid program.

Social Security Act – The legislation, signed in 1965 that authorized Medicare under Title XVIII, and Medicaid under Title XIX.

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

State Funds – For the purposes of this Report, funds that do not receive any Medicaid Federal Medical Assistance Percentage.

State Maximum Allowable Cost (SMAC) – The maximum price pharmacies receive as reimbursement for equivalent groups of multiple-source generic prescription drugs. Medicaid may include more drugs than what are covered under the federal upper limit program as well as set reimbursement rates that are lower than federal upper limit rates.

Supplemental Security Income (SSI) – A federal income supplement program administered by the Social Security Administration. It is designed to assist the aged, blind, or disabled individuals who have little or no income and provides cash to meet basic needs for food, clothing and shelter.

Third Party Liability (TPL) – The legal obligation of a third party to pay part or all of the expenditures for medical assistance under Medicaid.

Usual and Customary Charge – The fee that is most consistently charged by a healthcare provider for a particular procedure. The actual price that pharmacies charge cash-paying customers for prescription drugs.

Table 75. Acronyms

Acronym	Meaning
ACA	Affordable Care Act
ARRA	American Recovery and Reinvestment Act of 2009
ABD	Aged, Blind, or Disabled
ABI	Acquired Brain Injury
ALF	Assisted Living Facility
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgery Center
AWP	Average Wholesale Price
BHD	Behavioral Health Division
BIPA	Benefits Improvement and Protection Act of 2000
CARF	Commission on Accreditation of Rehabilitation Facilities
CCD	Continuity of Care Document
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CME	Care Management Entity
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
COA	Council on Accreditation of Services for Families and Children
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT	Current Procedural Terminology
CQM	Clinical Quality Measures
DD	Developmental Disabilities
DFS	Department of Family Services
DME	Durable Medical Equipment
DRA	Deficit Reduction Act
DSH	Disproportionate Share Hospital
DUR	Drug Utilization Review
EAC	Estimated Acquisition Cost
EHR	Electronic Health Record
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ESRD	End Stage Renal Disease
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FUL	Federal Upper Limit
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HIE	Health Information Exchange
HIT	Health Information Technology
HPSA	Health Professional Shortage Area
IBA	Individualized Budget Amount
ICF-ID	Intermediate Care Facility for the Intellectually Disabled
I/OCE	Integrated Outpatient Code Editor
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LEP	Limited English Proficiency

Acronyms (continued)	Meaning
LOC	Level of Care
LTC	Long-Term Care
MAGI	Modified Adjusted Gross Income
MEI	Medicare Economic Index
MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
MU	Meaningful Use
NAMFCU	National Association of Medicaid Fraud Control Units
NPI	National Provider Identifier
OIG	Office of Inspector General
OPPS	Outpatient Prospective Payment System
OSCR	On-Site Compliance Review
PACE	Program of All-Inclusive Care for the Elderly
P&T	Pharmacy and Therapeutics
PA	Prior Authorization
PAB	Psychiatrist Advisory Board
PBM	Pharmacy Benefit Management (or Manager)
PCMH	Patient Centered Medical Home
PDAP	Prescription Drug Assistance Program
PDL	Preferred Drug List
PMPM	Per Member Per Month
POS	Prosthetics, Orthotics and Supplies
PPS	Prospective Payment System
PRTF	Psychiatric Residential Treatment Facility
QMB	Qualified Medicare Beneficiaries
QIS	Quality Improvement Strategy
QRA	Qualified Rate Adjustment
RIBN	Resource Integration into Behavioral Health Networks
RBRVS	Resource Based Relative Value Scale
RHC	Rural Health Clinic
SCHIP	State Children's Health Insurance Program
SFY	State Fiscal Year
SLMB	Specified Low-Income Medicare Beneficiaries
SLR	State Level Repository
SMAC	State Maximum Allowable Cost
SSA	Social Security Administration
SSDC	Sovereign States Drug Consortium
SSI	Supplemental Security Income
TB	Tuberculosis
THR	Total Health Record
TPL	Third Party Liability
WDH	Wyoming Department of Health
WES	Wyoming Eligibility System

Appendix E Data Methodology

The following provides some notes on how data was gathered for this report.

Enrollment and Members

Enrollment data is a distinct (or unduplicated) count of members enrolled in Medicaid based on their Medicaid ID number.

The monthly average is calculated using the distinct count of members as of the last day of each month.

The total SFY enrollment is a distinct count of all members enrolled at any time during the SFY.

Enrolled members are enrolled in an eligibility program code. These program codes define the eligibility categories, as shown in Medicaid Chart A and Non-Medicaid Chart B, tables 76 and 77, respectively. The appropriate program codes are used to extract the desired data from the Cognos tool.

Recipients

A Recipient as an enrolled member who has received services and had a Medicaid claim processed and paid during the SFY.

For this report, distinct counts of recipients is calculated based on original claims, never voided or adjusted, and final adjustment claims only and excludes the following eligibility program codes:

- N96 Disability Determination
- N99 Long-Term Care Screening
- S97 CASII screening
- ZZZ Gross Adjustments

Since the distinct count of recipients is based on claims paid during the SFY, this count may exceed enrollment as some recipients may not have maintained enrollment in the SFY, though they were enrolled when the service was rendered.

Expenditures

Expenditures represent claim payments and include original claims (never voided/adjusted), final adjustment claims, as well as the adjusted and re-adjusted claims.

Unlike recipient counts, total expenditures include claims with the N96, N99, S97, and ZZZ eligibility program codes.

Third-party payments, co-payments, DSH payments, and history-only adjustments are excluded from totals, as are premium and cost-sharing assistance for Medicare individuals.

Service Utilization

Service areas are defined by the pay-to-provider taxonomy codes, unless otherwise specified, on claims paid during the SFY.

Per Member Per Month

The Per Member Per Month represents the monthly average cost for each enrolled member. This calculation is equal to expenditures divided by member months, with expenditures based on first service dates on original and final adjusted claims only and member months being the total number of months individuals are enrolled in Medicaid. A preliminary PMPM figure is provided in this report, with final data expected in the Medicaid Per Member Per Month report to be released separately.

Table 76. Medicaid Chart A Eligibility Program Codes

Eligibility Category	Program Codes	
Aged, Blind, Disabled Employed Individuals with Disabilities	S56	Emp Ind w/ Disabilities > 21
	S57	Emp Ind w/ Disabilities < 21
	S61	Continuous EID <19
Aged, Blind, Disabled Intellectual/ Developmental Disabilities and Acquired Brain Injury	B01	Acq Brain Injury Wvr SSI
	B02	Acq Brain Injury Wvr 300%
	S60	Acq Brain Injury Wvr w/ EID <65
	S22	DD Waiver SSI > 65 (inactive)
	S23	DD Waiver 300% Cap > 65 (inactive)
	S44	DD Wvr SSI Between 21 & 65 Yrs (inactive)
	S45	DD Wvr 300% Between 21 & 65 Yrs (inactive)
	S59	DD Waiver w/ EID > 21 (inactive)
	S58	DD Waiver w/ EID < 21 (inactive)
	S65	Continuous DD < 19 (inactive)
	S93	DD Waiver SSI <21 (inactive)
	S94	DD Waiver 300% Cap <21 (inactive)
	W03	EID Comp Waiver Adult > 21
	W08	SSI Comp Waiver Adult > 21
	W10	SSI Comp Waiver Aged > 65
	W14	300% Comp Waiver Adult > 21
	W16	300% Comp Waiver Aged > 65
	W04	EID Comp Waiver Child < 21
	W09	SSI Comp Waiver Child < 21
	W15	300% Comp Waiver Child < 21
	W22	EID Comp ABI Waiver Adult > 21
	W23	SSI Comp ABI Waiver Adult > 21
	W24	SSI Comp ABI Waiver Aged > 65
	W25	300% Comp ABI Waiver Adult > 21
	W26	300% Comp ABI Waiver Aged > 65
	S03	ICF-MR SSI > 65
	S04	ICF-MR 300% Cap > 65
	S05	ICF-MR SSI < 65
	S06	ICF-MR 300% Cap < 65
	W01	EID Support Waiver Adult > 21
	W05	SSI Support Waiver Adult > 21
	W07	SSI Support Waiver Aged > 65
	W11	300% Support Waiver Adult > 21
	W13	300% Support Waiver Aged > 65
	W02	EID Support Waiver Child < 21
	W06	SSI Support Waiver Child < 21
	W12	300% Support Waiver Child < 21
	W17	EID Support ABI Waiver Adult > 21
	W18	SSI Support ABI Waiver Adult > 21
	W19	SSI Support ABI Waiver Aged > 65
	W20	300% Support ABI Waiver Adult > 21
	W21	300% Support ABI Waiver Aged > 65
Aged, Blind, Disabled Institution	S14	Institutional (Hosp) Aged - Inactive
	S15	Inpatient Hospital 300% Cap > 65
	S34	Inatitutional (Hosp) Disabled - Inactive
	S35	Inpatient Hospital 300% Cap < 65
	S13	Inpat-Psych > 65

Eligibility Category (Continued)	Program Codes	
Aged, Blind, Disabled Long-Term Care	R01	Asst Living Fac Wvr SSI < 65
	R02	Asst Living Fac Wvr 300% < 65
	R03	Asst Living Fac Wvr SSI > 65
	R04	Asst Living Fac Wvr 300% > 65
	S50	Hospice Care > 65
	S51	Hospice Care < 65
	N98	WLTC Temp Services
	S24	LTC Waiver SSI > 65
	S25	LTC Waiver 300% Cap > 65
	S46	LTC Waiver SSI < 65
	S47	LTC Waiver 300% Cap < 65
	N97	NH Temp Services
	S01	NH-SSI & Ssa Blend >65
	S02	NH-SSI & Ssa Blend <65
	S10	Nursing Home SSI >65
	S11	Nursing Home 300% Cap >65
	S17	Retro Medicaid-"Pr" Aged (inactive)
	S18	Retro Medicaid-"Rm" Aged (inactive)
	S30	Retro Medicaid-"Pr" Disabled (inactive)
	S32	Nursing Home SSI <65
	S33	Nursing Home 300% Cap <65
	S54	Medicaid Only-No Rm & Brd >65
	S55	Medicaid Only-No Rm & Brd <65
	S90	Retro Medicaid-"Rm" Disabled
	P11	PACE < 65
	P12	PCMR < 65
	P13	PACE SSI Disabled < 65
	P14	PACE Mcare SSI Disabled < 65
	P15	PACE NF < 65
	P16	PACE NF SSI Disabled < 65
	P17	PACE NF Mcare Disabled < 65
	P18	PACE NF Mcare SSI Disable < 65
	P21	PACE > 65
	P22	PCMR > 65
	P23	PACE SSI Aged > 65
	P24	PACE Mcare SSI Aged > 65
	P25	PACE NF > 65
	P26	PACE NF SSI Aged > 65
	P27	PACE NF Mcare Aged > 65
	P28	PACE NF Mcare SSI Aged > 65
Aged, Blind, Disabled SSI & SSI Related	S12	SSI Eligible >65
	S20	Blind SSI - Receiving Payment
	S21	Blind SSI - Not Receiving Pymt
	S31	SSI Eligible <65
	S36	Disabled Adult Child (DAC)
	S37	Goldberg-Kelly
	S39	1619 Disabled
	S40	Aptd Essent. Person Med Only -I
	S48	Zebley >21
	S49	Zebley <21
	S92	Widow-Widowers SDX

Eligibility Category (Continued)	Program Codes	
Aged, Blind, Disabled SSI & SSI Related (Continued)	S98	Pseudo SSI Aged (inactive)
	S99	Pseudo SSI Disabled (inactive)
	S09	SSI-Disabled Child Definition
	S16	Pickle >65
	S38	Pickle <65
	S42	Widow-Widowers
	S43	Qual Disabled Working Ind
Adults	A01	Family Care Past 5yr Limit >21 (inactive)
	A03	Family Care >21
	A68	12 Mo Extended Med >21
	A69	2nd-6mos. Trans Mcaid Adult (inactive)
	A75	Institutional (AFDC) Adult (inactive)
	A77	AFDC-Up Unemployed Parent Ad (inactive)
	A79	Retro Medicaid-"Rm" Adult (inactive)
	M11	Family MAGI PE >21
	A80	Refugee Adult (inactive)
	A82	Alien: 245 (IRCA) Adult (inactive)
	A83	Alien: 210 (IRCA) Adult (inactive)
	A70	AFDC Medicaid - Adult (inactive)
	A76	4 Mo Extended Med >21
	A78	Retro Medicaid-"Pr" Adult (inactive)
	M04	Family MAGI >21
	M08	Former Foster Youth > 21
	M18	Former Foster Youth PE > 21
	M01	Adult MAGI > 21
	M13	Adult MAGI PE > 21
Children	A02	Family Care Past 5yr Limit <21
	A04	Family Care <21
	A50	AFDC Medicaid (inactive)
	A54	2nd-6mos. Trans Mcaid Child (inactive)
	A56	Alien: 245 (IRCA) Child (inactive)
	A57	Baby <1 Yr, Mother SSI Elig (inactive)
	A59	Retro Medicaid-"Pr" Child (inactive)
	A60	4 Mo Extended Med <21
	A61	Institutional (AF-IV-E) (inactive)
	A62	Retro Medicaid-"Rm" Child (inactive)
	A63	Refugee Child (inactive)
	A64	Alien: 245 (IRCA) Child (inactive)
	A58	Child 6 Through 18 Yrs
	A65	AFDC-Up Unemployed Parent Ch (inactive)
	A67	12 Mo Extended Med <21
	A87	16+ Not In School AF HH (inactive)
	K03	Kidcare to Child Magi
	M02	Adult MAGI <21
	M03	Child MAGI
	M05	Family MAGI <21
	M10	Children's PE
	M12	Family MAGI PE <21
	M14	Adult MAGI PE <21
	S62	Continuous SSI Eligible <19
	A55	Child 0 Through 5 Yrs
	S65	Cont Childrns Ment Health Wvr < 19

Eligibility Category (Continued)	Program Codes	
Children (Continued)	S95	Childrens Ment Hlth Wvr SSI < 21
	S96	Childrens Ment Hlth Wvr 300% <21
	A51	IV-E Foster Care
	A52	IV-E Adoption
	A85	Foster Care Title 19
	A86	Subsidized Adoption Title 19
	A88	Aging Out Foster Care
	A97	Foster Care 0 Through 5
	A98	Foster Care 6 Through 18
	M09	Former Foster Youth <21
	M17	Former Foster Youth PE <21
	S63	Continuous Foster Care <19
	A53	Newborn
Medicare Savings Programs	Q17	QMB > 65
	Q41	QMB < 65
	Q94	SLMB 2 > 65
	Q95	SLMB 2 < 65
	Q96	SLMB 1 > 65
	Q97	SLMB 1 < 65
	Q98	Part B-Partial Aged (Inactive)
	Q99	Part B-Partial Disabled (Inactive)
Non-Citizens with Medical Emergencies	A81	Emergency Svc < 21
	A84	Emergency Svc > 21
Pregnant Women	A71	Pregnant Woman < 21
	A72	Pregnant Woman > 21
	A73	Qualified Pregnant Woman > 21
	A74	Qualified Pregnant Woman < 21
	M06	Pregnancy MAGI > 21
	M07	Pregnancy MAGI < 21
	A19	Presumptive Eligibility
Special Groups	B03	Breast & Cervical > 21
	B04	Breast & Cervical < 21
	M15	Breast & Cervical PE > 21
	M16	Breast & Cervical PE < 21
	S52	Tuberculosis (Tb) > 65
	S53	Tuberculosis (Tb) < 65
	A20	Pregnant By Choice
Screenings & Gross Adjustments	N96	Disability Determination Only
	N99	LTC Screening Only
	S97	CASII Screening Only
	ZZZ	Other
	P07	CHIPRA CME

Table 77. Medicaid Chart B Eligibility Program Codes

Eligibility Category	Program Codes	
State Funded Foster Care	A95	Pending Foster Care
	A96	Basic Foster Care
	A99	Institutional Foster Care
Project Out	P05	Project Out Transitional Coverage

DATA PARAMETERS

Table 78, below, provides the parameters used for extracting data for each service area included in this report. As stated in the previous section, Expenditures are calculated using all Medicaid Chart A recipient program codes and all claim adjustments except history-only adjustments. Counts exclude several program codes and only include original and final claims.

Table 78. Data Parameters by Service Area

Service Area	Pay-to-Provider Taxonomy		Other Parameters
Ambulance - Total	341600000X	Ambulance	n/a
Ambulance - Air	341600000X	Ambulance	Procedure Codes: A0030, A0430, A0431, A0435, A0436, A0382, A0398, A0422, A0433, A0434, A0998
Ambulance - Ground	341600000X	Ambulance	Procedure Codes: A0221, A0360, A0362, A0368, A0370, A0380, A0390, A0425, A0426, A0427, A0428, A0429, A0382, A0398, A0422, A0433, A0434, A0998
Ambulatory Surgery Center	261QA1903X	Ambulatory Surgery Center	n/a
Behavorial Health	101Y00000X 101YA0400X 101YP2500X 103G00000X 103TC0700X 1041C0700X 106H00000X 163W00000X 164W00000X 171M00000X 172V00000X 2084P0800X 261QM0801X 261QR0405X 364SP0808X	Professional Counselor; Certified Mental Health Worker Addictions Therapist/Practitioner Professional Counselor Neuropsychologist Clinical Pscyhologist Social Worker Marriage and Family Therapist RN LPN Case Worker Community Health Worker; Peer Specialist; Certified Addictions Practitioner Asisstant Psychiatrist Mental Health - including Community Mental Health Center Rehabilitation, Substance Use Disorder NP, APN Psychiatric/Mental Health	n/a
Behavioral Health services provided by Non BH providers	EXCLUDE Behavioral Health Provider taxonomies and 261QP0904X: Public Health, Federal		Procedure Codes: G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792, H0001-H2037, 90801-90899, 96101-96125 99201 and 99360 when paired with 90833, 90836, 90838, or 90785 on same claim with same treating provider Claim Types: EXCLUDE W (waiver)
Care Management Entity	251S00000X	CHPR CME	n/a
Clinic/Center	261Q00000X	Clinic/Center	n/a
Dental	122300000X 1223D0001X 1223E0200X 1223G0001X 1223P0221X 1223P0300X 1223S0112X 1223X0400X	Dentist Dental Public Health Endodontics General Practice Dentist Pedodontics Periodontics Surgery, Oral and Maxillofacial Orthodontics	n/a

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	332B00000X 332S00000X 335E00000X	DME Hearing Aid Equipment POS	n/a
Durable Medical Equipment Only	332B00000X 332S00000X	DME Hearing Aid Equipment	n/a
Prosthetics, Orthotics, and Supplies Only	335E00000X	POS	n/a
End-Stage Renal Disease	261QE0700X	End-Stage Renal Disease	n/a
Federally Qualified Health Center	261QF0400X	Federally Qualified Health Center	n/a
Home Health	251E00000X	Home Health	n/a
Hospice	251G00000X	Hospice Care, Community Based	n/a
Hospital Total	261QR0400X 282N00000X 282NR1301X 283Q00000X 283X00000X	Rehabilitation General Acute Care Hospital General Acute Care Hospital - Rural Psychiatric Hospital Rehabilitation Hospital	n/a
Hospital Inpatient	282N00000X 282NR1301X 283Q00000X 283X00000X	General Acute Care Hospital General Acute Care Hospital - Rural Psychiatric Hospital Rehabilitation Hospital	Claim Type: I, X
Hospital Outpatient	261QR0400X 282N00000X 282NR1301X 283X00000X	Rehabilitation General Acute Care Hospital General Acute Care Hospital - Rural Rehabilitation Hospital	Claim Type: O, V
Hospital Emergency Room	All Taxonomies		Procedure Codes: 99281 thru 99285 OR Place of Service: 23 AND Procedure Codes in Emergency Department Procedure Code Value Set (Table 80) OR Revenue Code: 0450 through 0459
Laboratory	291U00000X	Clinical Medical Laboratory	n/a
Nursing Facility	275N00000X 314000000X	Medicare Defined Swing Bed Skilled Nursing Facility	n/a
Program for All-Inclusive Care of Elderly (PACE)	251T00000X	PACE Organization	n/a
Physician and Other Practitioner Total	All Taxonomies starting with '20' EXCLUDING 2084P0800X 363A00000X 225X00000X 225100000X 213E00000X 363L00000X 363LA2200X 363LF0000X 363LG0600X 363LX0001X 363LP0200X 367A00000X 367500000X 231H00000X 235Z00000X	Psychiatrists Physician Assistant Occupational Therapist Physical Therapist Podiatrist Nurse Practitioner Nurse Midwife Nurse Anesthetist Audiologist Speech-Language Pathologist	n/a
Physician	All Taxonomies starting with '20' EXCLUDING 2084P0800X 363A00000X	Psychiatrists Physician Assistant	n/a

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Other Practitioner	225X00000X 225100000X 213E00000X 363L00000X 363LA2200X 363LF0000X 363LG0600X 363LX0001X 363LP0200X 367A00000X 367500000X 231H00000X 235Z00000X	Occupational Therapist Physical Therapist Podiatrist Nurse Practitioner Nurse Midwife Nurse Anesthetist Audiologist Speech-Language Pathologist	n/a
Prescription Drug	333600000X	Pharmacy	Claim Type: P
Psychiatric Residential Treatment Facility	323P00000X	Psychiatric Residential Treatment Facility	Claim Types: I, X
Public Health, Federal	261QP0904X	Public Health, Federal	n/a
Public Health or Welfare	251K00000X	Public Health or Welfare	n/a
Rural Health Clinic	261QR1300X	Rural Health Clinic	n/a
Vision	152W00000X 156FX1800X	Optometrist Optician	n/a
Waiver - HCBS Waivers - Waiver Only Services	251B00000X 251C00000X 251X00000X	Case Management Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S64, S93, S94, N98, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21, W22, W23, W24, W25, W26
Waiver - HCBS Waivers - Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X, 251C00000X, 251X00000X Recipient Program Codes: B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S64, S93, S94, N98, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21, W22, W23, W24, W25, W26
Waiver - Acquired Brain Injury Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: B01, B02, S60
Waiver - Acquired Brain Injury Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: B01, B02, S60

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Waiver - Adult with ID/ DD Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: S22, S23, S44, S45, S59
Waiver - Adult with ID/ DD Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: S22, S23, S44, S45, S59
Waiver - Assisted Living Facility Waiver Only	251B00000X	Case Management	Claim Type: W, G Recipient Program Codes: R01, R02, R03, R04
Waiver - Assisted Living Facility Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X Recipient Program Codes: R01, R02, R03, R04
Waiver - Child with ID/DD Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: S58, S93, S94, S64
Waiver - Child with ID/DD Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: S58, S93, S94, S64
Waiver - Children's Mental Health Waiver Only	251B00000X	Case Management	Claim Type: W, G Recipient Program Codes: S95, S96, S65
Waiver - Children's Mental Health Waiver Only	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X Recipient Program Codes: S95, S96, S65
Waiver Comprehensive Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: W03, W04, W08, W09, W10, W14, W15, W16, W22, W23, W24, W25, W26
Waiver Comprehensive Waiver Only	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: W03, W04, W08, W09, W10, W14, W15, W16, W22, W23, W24, W25, W26

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Waiver - Long-Term Care Waiver Only	251B00000X	Case Management	Claim Type: W, G Recipient Program Codes: S24, S25, S46, S47, N98
Waiver - Long-Term Care Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X Recipient Program Codes: S24, S25, S46, S47, N98
Waiver - Pregnant by Choice	All Taxonomies		Recipient Program Code: A20
Waiver - Supports Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21
Waiver - Supports Waiver Only	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21

Table 79. Data Parameters for Subprogram and Special Populations

Subprogram / Special Population	Parameters
Crossover Claims	Claim Type: B, V, X
Medicare / Medicaid Dual Enrolled	Medicaid Recipients with a Medicare ID in the 13 months prior to the SFY
Foster Care - Medicaid	Recipient Program Codes: A51, A52, A85, A86, A88, A97, A98, S63
Foster Care - State Funded	Recipient Program Codes: A95, A96, A99
Project Out	Recipient Program Code: P05

Table 80. Emergency Department Procedure Code Value Set

Emergency Department Procedure Codes													
10040	10060	10061	10080	10081	10120	10121	10140	10160	10180	11000	11001	11004	11005
11006	11008	11010	11011	11012	11042	11043	11044	11045	11046	11047	11055	11056	11057
11100	11101	11200	11201	11300	11301	11302	11303	11305	11306	11307	11308	11310	11311
11312	11313	11400	11401	11402	11403	11404	11406	11420	11421	11422	11423	11424	11426
11440	11441	11442	11443	11444	11446	11450	11451	11462	11463	11470	11471	11600	11601
11602	11603	11604	11606	11620	11621	11622	11623	11624	11626	11640	11641	11642	11643
11644	11646	11719	11720	11721	11730	11732	11740	11750	11752	11755	11760	11762	11765
11770	11771	11772	11900	11901	11920	11921	11922	11950	11951	11952	11954	11960	11970
11971	11976	11980	11981	11982	11983	12001	12002	12004	12005	12006	12007	12011	12013
12014	12015	12016	12017	12018	12020	12021	12031	12032	12034	12035	12036	12037	12041
12042	12044	12045	12046	12047	12051	12052	12053	12054	12055	12056	12057	13100	13101
13102	13120	13121	13122	13131	13132	13133	13150	13151	13152	13153	13160	14000	14001
14020	14021	14040	14041	14060	14061	14301	14302	14350	15002	15003	15004	15005	15040
15050	15100	15101	15110	15111	15115	15116	15120	15121	15130	15131	15135	15136	15150
15151	15152	15155	15156	15157	15200	15201	15220	15221	15240	15241	15260	15261	15271
15272	15273	15274	15275	15276	15277	15278	15570	15572	15574	15576	15600	15610	15620
15630	15650	15731	15732	15734	15736	15738	15740	15750	15756	15757	15758	15760	15770
15775	15776	15777	15780	15781	15782	15783	15786	15787	15788	15789	15792	15793	15819
15820	15821	15822	15823	15824	15825	15826	15828	15829	15830	15832	15833	15834	15835
15836	15837	15838	15839	15840	15841	15842	15845	15847	15850	15851	15852	15860	15876
15877	15878	15879	15920	15922	15931	15933	15934	15935	15936	15937	15940	15941	15944
15945	15946	15950	15951	15952	15953	15956	15958	15999	16000	16020	16025	16030	16035
16036	17000	17003	17004	17106	17107	17108	17110	17111	17250	17260	17261	17262	17263
17264	17266	17270	17271	17272	17273	17274	17276	17280	17281	17282	17283	17284	17286
17311	17312	17313	17314	17315	17340	17360	17380	17999	19000	19001	19020	19030	19100
19101	19102	19103	19105	19110	19112	19120	19125	19126	19260	19271	19272	19290	19291
19295	19296	19297	19298	19300	19301	19302	19303	19304	19305	19306	19307	19316	19318
19324	19325	19328	19330	19340	19342	19350	19355	19357	19361	19364	19366	19367	19368
19369	19370	19371	19380	19396	19499	20005	20100	20101	20102	20103	20150	20200	20205
20206	20220	20225	20240	20245	20250	20251	20500	20501	20520	20525	20526	20527	20550
20551	20552	20553	20555	20600	20605	20610	20612	20615	20650	20660	20661	20662	20663
20664	20665	20670	20680	20690	20692	20693	20694	20696	20697	20802	20805	20808	20816
20822	20824	20827	20838	20900	20902	20910	20912	20920	20922	20924	20926	20930	20931
20936	20937	20938	20950	20955	20956	20957	20962	20969	20970	20972	20973	20974	20975

Emergency Department Procedure Codes (Continued)													
20979	20982	20985	20999	21010	21011	21012	21013	21014	21015	21016	21025	21026	21029
21030	21031	21032	21034	21040	21044	21045	21046	21047	21048	21049	21050	21060	21070
21073	21076	21077	21079	21080	21081	21082	21083	21084	21085	21086	21087	21088	21089
21100	21110	21116	21120	21121	21122	21123	21125	21127	21137	21138	21139	21141	21142
21143	21145	21146	21147	21150	21151	21154	21155	21159	21160	21172	21175	21179	21180
21181	21182	21183	21184	21188	21193	21194	21195	21196	21198	21199	21206	21208	21209
21210	21215	21230	21235	21240	21242	21243	21244	21245	21246	21247	21248	21249	21255
21256	21260	21261	21263	21267	21268	21270	21275	21280	21282	21295	21296	21299	21310
21315	21320	21325	21330	21335	21336	21337	21338	21339	21340	21343	21344	21345	21346
21347	21348	21355	21356	21360	21365	21366	21385	21386	21387	21390	21395	21400	21401
21406	21407	21408	21421	21422	21423	21431	21432	21433	21435	21436	21440	21445	21450
21451	21452	21453	21454	21461	21462	21465	21470	21480	21485	21490	21495	21497	21499
21501	21502	21510	21550	21552	21554	21555	21556	21557	21558	21600	21610	21615	21616
21620	21627	21630	21632	21685	21700	21705	21720	21725	21740	21742	21743	21750	21800
21805	21810	21820	21825	21899	21920	21925	21930	21931	21932	21933	21935	21936	22010
22015	22100	22101	22102	22103	22110	22112	22114	22116	22206	22207	22208	22210	22212
22214	22216	22220	22222	22224	22226	22305	22310	22315	22318	22319	22325	22326	22327
22328	22505	22520	22521	22522	22523	22524	22525	22526	22527	22532	22533	22534	22548
22551	22552	22554	22556	22558	22585	22586	22590	22595	22600	22610	22612	22614	22630
22632	22633	22634	22800	22802	22804	22808	22810	22812	22818	22819	22830	22840	22841
22842	22843	22844	22845	22846	22847	22848	22849	22850	22851	22852	22855	22856	22857
22861	22862	22864	22865	22899	22900	22901	22902	22903	22904	22905	22999	23000	23020
23030	23031	23035	23040	23044	23065	23066	23071	23073	23075	23076	23077	23078	23100
23101	23105	23106	23107	23120	23125	23130	23140	23145	23146	23150	23155	23156	23170
23172	23174	23180	23182	23184	23190	23195	23200	23210	23220	23330	23331	23332	23350
23395	23397	23400	23405	23406	23410	23412	23415	23420	23430	23440	23450	23455	23460
23462	23465	23466	23470	23472	23473	23474	23480	23485	23490	23491	23500	23505	23515
23520	23525	23530	23532	23540	23545	23550	23552	23570	23575	23585	23600	23605	23615
23616	23620	23625	23630	23650	23655	23660	23665	23670	23675	23680	23700	23800	23802
23900	23920	23921	23929	23930	23931	23935	24000	24006	24065	24066	24071	24073	24075
24076	24077	24079	24100	24101	24102	24105	24110	24115	24116	24120	24125	24126	24130
24134	24136	24138	24140	24145	24147	24149	24150	24152	24155	24160	24164	24200	24201
24220	24300	24301	24305	24310	24320	24330	24331	24332	24340	24341	24342	24343	24344
24345	24346	24357	24358	24359	24360	24361	24362	24363	24365	24366	24370	24371	24400
24410	24420	24430	24435	24470	24495	24498	24500	24505	24515	24516	24530	24535	24538

Emergency Department Procedure Codes (Continued)													
24545	24546	24560	24565	24566	24575	24576	24577	24579	24582	24586	24587	24600	24605
24615	24620	24635	24640	24650	24655	24665	24666	24670	24675	24685	24800	24802	24900
24920	24925	24930	24931	24935	24940	24999	25000	25001	25020	25023	25024	25025	25028
25031	25035	25040	25065	25066	25071	25073	25075	25076	25077	25078	25085	25100	25101
25105	25107	25109	25110	25111	25112	25115	25116	25118	25119	25120	25125	25126	25130
25135	25136	25145	25150	25151	25170	25210	25215	25230	25240	25246	25248	25250	25251
25259	25260	25263	25265	25270	25272	25274	25275	25280	25290	25295	25300	25301	25310
25312	25315	25316	25320	25332	25335	25337	25350	25355	25360	25365	25370	25375	25390
25391	25392	25393	25394	25400	25405	25415	25420	25425	25426	25430	25431	25440	25441
25442	25443	25444	25445	25446	25447								