Wyoming Department of Health

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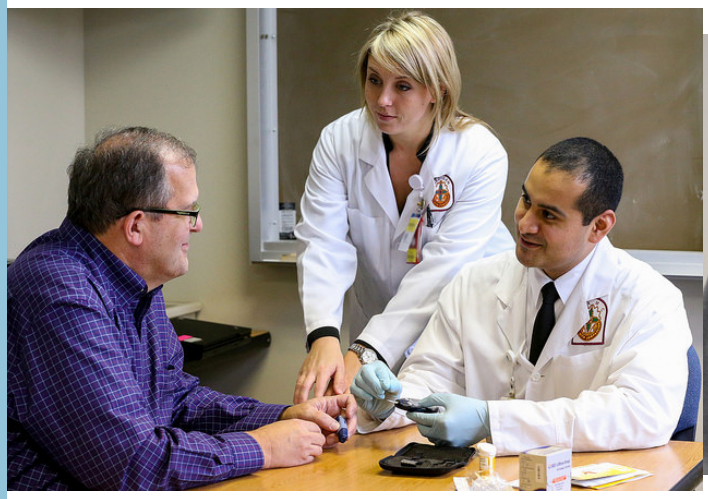
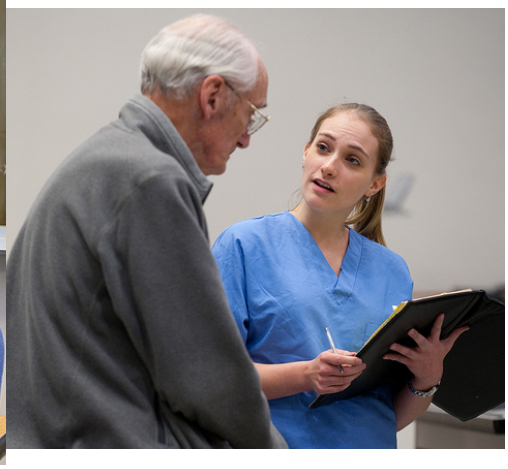
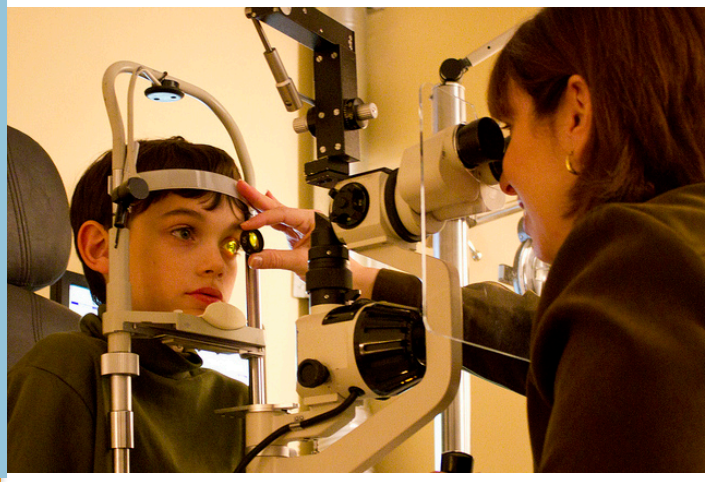
MEDICAID ANNUAL REPORT

STATE FISCAL YEAR 2014







Matt Mead, Governor

Thomas O. Forslund, Director

Teri Green, State Medicaid Agent

Thomas O. Forslund, Director **Governor Matthew H. Mead**

Dear Wyoming Citizen:

It is my pleasure to present the Wyoming Medicaid State Fiscal Year (SFY) 2014 Annual Report which provides insight into Wyoming's Medicaid program, our ongoing efforts, and the multiple activities and accomplishments from the past year. This report offers an extensive look at Medicaid in our state by including the specific services covered, by identifying those who depend on these services, and by disclosing what those services cost.

A new addition to the report this year is an "At A Glance" section, a two-page summary highlighting key points from the past year and presenting essential information about the Wyoming Medicaid program. Also included this year is a section on the background of Wyoming Medicaid which describes the mission, organizational structure and budgetary outline. The report provides information on enrollment, service utilization and Per Member Per Month (PMPM) costs, to enable cost comparisons to other programs and private insurance. This report also includes a section on Wyoming's economy and demographics that helps place the program in the context of the larger Wyoming environment.

In SFY 2014 Wyoming Medicaid covered 86,188 enrollees, or approximately 1 in 7 individuals in the overall Wyoming population, with 63% of the enrollees being children. Overall claims expenditures for Medicaid recipients totaled over $517 million, while our PMPM cost for all enrollees was $608, or $7,296 per year. This PMPM ranges from $249 for children[1] to $4,721 for individuals in an institution, such as a nursing home or Intermediate Care Facility-ID. Based on enrollment figures, the Wyoming Medicaid program may now be slightly larger than the state's Medicare program (84,076[2]).

This past fiscal year saw a number of operational changes to the Wyoming Medicaid program, with a focus on the eligibility function and technology. These major changes include the launch of the our new Wyoming Eligibility System (WES), the opening of a centralized customer service center, expansion of Medicaid to an additional mandatory population of low income children, the addition of currently eligible but not enrolled people, and the implementation of the 2013 Medicaid Reform legislation. Added to this slate of activities were cost reduction adjustments necessary for us to meet the mandated SFY 2014 state general fund budget reductions.

The Affordable Care Act (ACA) continued to require changes to the Wyoming Medicaid program in SFY 2014. Major changes implemented during SFY 2014 included:

- expanding income eligibility for children,
- transitioning children from Kid Care CHIP to Medicaid,
- implementing the Modified Adjusted Gross Income (MAGI) eligibility for children, pregnant women and family care adults,
- expanding the availability of Medicaid benefits to former foster care children until age 26, and

[1] Including all children from the children, newborns and foster care children sub-groups.
[2] http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/ , 2012 is most recent data available.

- continuing enhanced payments to primary care physician and for mental health parity until December 2014.

The launch of the Health Insurance Marketplace (healthcare.gov) in October 2013 and corresponding marketing efforts raised the awareness of the need for healthcare coverage and each open enrollment has led to increased referrals to Medicaid from that portal.

Further activity in the Wyoming Department of Health focused on changes driven by the Medicaid Reform bill passed by the Wyoming Legislature during the 2013 session. The Department implemented reforms to medical services and behavioral health services, and completed extensive redesigns of both long-term care services/supports and waivers for persons with intellectual disabilities. An independent study of managed and coordinated care models that was part of the legislation concluded that Wyoming should not pursue full-risk capitated managed care at this time, and suggested other coordinated care models may have greater health and cost benefits for Wyoming's healthcare system.

During SFY 2014, Medicaid pursued a number of operational and technological improvements including a kick-off to the replacement of our Medicaid Management Information System (MMIS) enterprise technology system. The MMIS replacement project will span several years and will transform Medicaid administration operations. We continue to explore opportunities and initiatives that will improve healthcare for members while saving tax dollars. In the course of these significant projects we remain committed to collaboration with our stakeholders to ensure access to and delivery of quality healthcare services for our members.

Thank you for your interest in Wyoming Medicaid. I hope you find this report informative and useful, and I welcome your questions and comments.

Sincerely,

Teri Green
State Medicaid Agent and Division Administrator
Division of Healthcare Financing
Wyoming Department of Health

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Medicaid SFY 2014 – At a Glance

In SFY 2014 Wyoming Medicaid had a two percent decrease in enrollment from the previous year, while total claims expenditures[3] and unduplicated recipient counts remained steady, with a one-tenth percent increase in both. Per Member Per Month expenditures decreased by 1.4 percent.

86,188
Eligible Individuals

$517,622,524
Total Claims Expenditures

76,341
Unique Recipients

$608
Per Member Per Month

Table 1: Medicaid Overview

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year % Change
Expenditures	$498,325,166	$514,529,323	$519,604,279	$500,931,031	$517,257,164	$517,622,524	4
Eligible Individuals[4]	80,277	85,416	88,059	88,134	87,946	86,188	7
Recipients (Unduplicated)	71,584	74,871	77,229	75,969	76,285	76,341	7
Expenditures per Eligible	$6,208	$6,024	$5,901	$5,684	$5,882	$6,006	-3
Expenditures per Recipient	$6,961	$6,872	$6,728	$6,594	$6,781	$6,780	-3
Per Member Per Month	$666	$626	$610	$600	$617	$608	-9

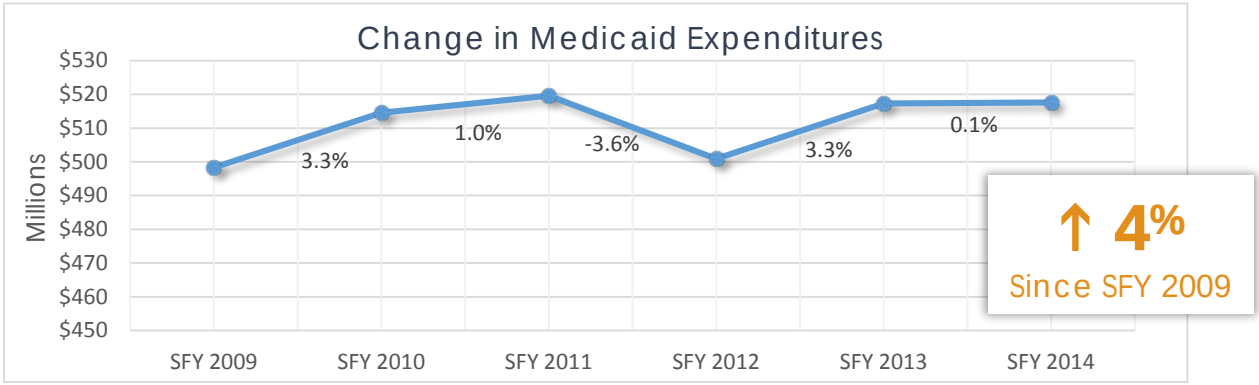

Figure 1: Change in Medicaid Expenditures

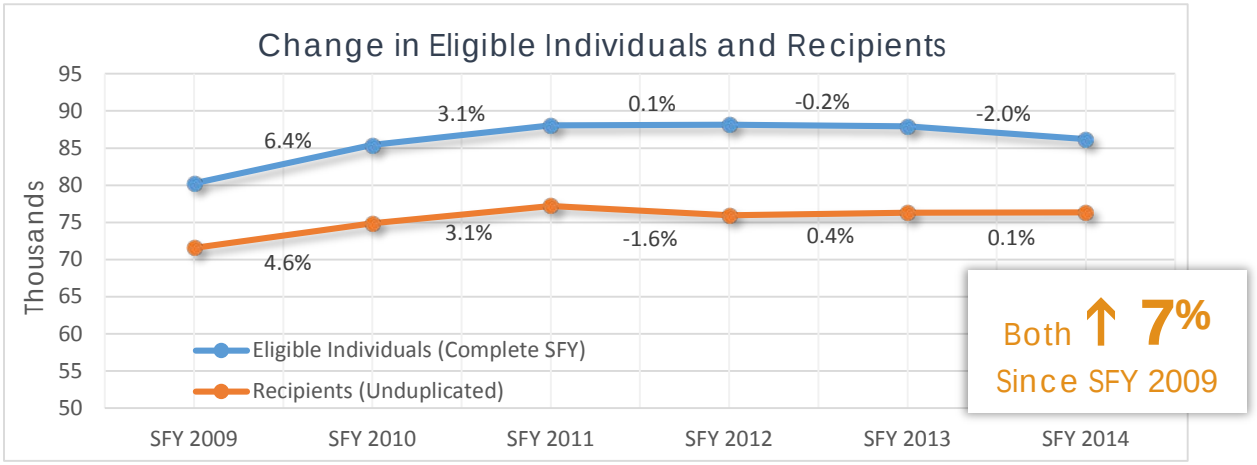

Figure 2: Change in Eligible Individuals and Recipients

[3] Expenditures reported in this annual report are benefit expenditures only based on claims data.
[4] Eligible individuals is a distinct count of individuals for a complete SFY, July 1 through June 30.

Table 2: Medicaid Eligibility Category Summary

Eligibility Category	Eligible Individuals	Recipients	Expenditures	Per Member Per Month
ABD EID	287	345	$4,545,872	$1,507
ABD HCBS Waiver	4,162	4,510	$154,077,818	$3,297
ABD Institution	2,229	2,661	$104,031,345	$4,721
ABD SSI	6,508	6,270	$53,252,515	$734
Children	54,417	49,362	$134,433,053	$249
Family Care	7,908	6,908	$28,414,259	$456
Medicare Savings Programs	4,881	2,762	$4,086,134	$81
Non-Citizens with Medical Emergencies	877	367	$1,490,032	$218
Pregnant Women	3,973	5,509	$28,762,228	$908
Screenings & Gross Adjustments	--	--	$389,686	--
Special Groups	946	497	$4,139,581	$429
Total	**86,188**	**76,341**	**$517,622,524**	**$608**

More than two-thirds (67 percent) of all recipients were youth under age 21. Over half of recipients (57 percent) were female.

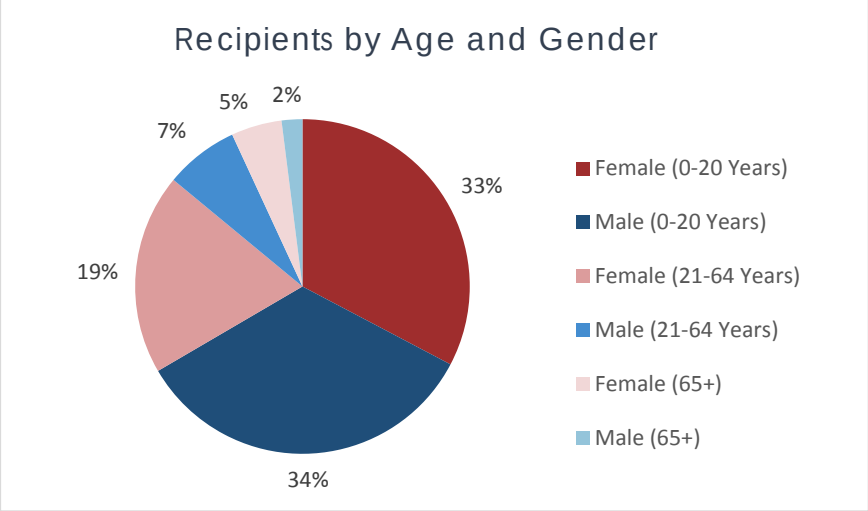

Figure 3: Recipients by Age and Gender

While the majority of eligible individuals were children and youth (under age 21), making up 63 percent of the total enrolled, their claims expenditures accounted for only 26 percent of all Medicaid claims. By comparison, the ABD HCBS Waiver accounted for only five percent of total enrolled, but 30 percent of total claims expenditures.

63% of eligible individuals were Children → **26%** of total Medicaid claims expenditures

5% of eligible individuals were ABD HCBS Waiver → **30%** of total Medicaid claims expenditures

Wyoming 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.

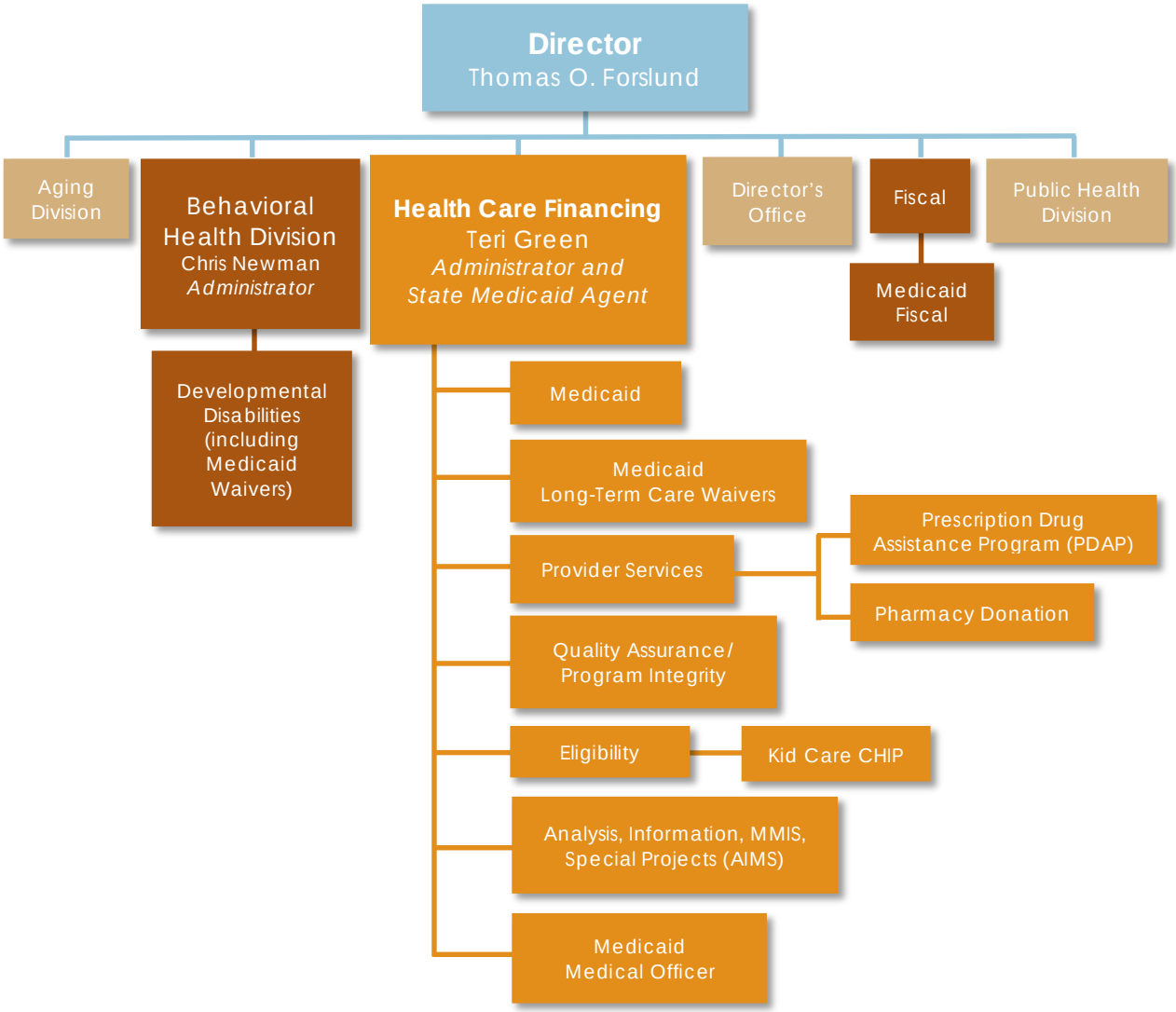

Figure 4: Wyoming Department of Health Organization Chart

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

Table 3: 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.
Hospital Advisory Group (HAG)	Wyoming Hospital Association and six executives from hospitals throughout Wyoming.	Focuses on new and upcoming issues within the healthcare industry, member concerns and presentations relevant to the hospital industry.
Nursing Home Advisory Group (NAG)	Nursing facility administrator, directors of nursing, and both nursing home associations.	Discusses issues important to nursing facilities and works to develop solutions to issues.
Physician Advisory Group (PAG)	Physicians, medical practitioners and the Wyoming Medical Society.	Discusses issues important to physicians and medical practitioners. 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

This Annual Report focuses on the $517.6 million in claims expenditures for Medicaid benefits in SFY 2014 processed through the Medicaid Management Information System (MMIS). Table 4 and Figure 5 address other Healthcare Financing Division expenditures in SFY 2014, such as administrative costs, capital investment, the Kid Care CHIP program and non-Medicaid programs.

Table 4: Division of Healthcare Financing Budget

Medicaid Related Expenditures	
Expenditure Type	**SFY 2014 (in millions)**
Annual Report Benefit Expenditures (this report)[5]	$517.6
Medicaid Administration	$43.4
Nursing Facilities Tax Assessment	$30.0
Hospital Qualified Rate Adjustment (QRA) Payments	$17.2
Medicare Buy-In	$14.1
Medicare Clawback (Part D)	$12.0
Medicaid One-Time Capital Expenses for New Technology Systems (WES, MMIS, Other)	$10.2
Physician Electronic Health Record (EHR) Incentives	$4.1
Other	$0.4
Subtotal Medicaid Expenditures	**$649.1**
Drug Rebates[6]	($25.3)
Total Medicaid Expenditures	**$623.7**
Non-Medicaid Expenditures	
State Children's Health Insurance Program (SCHIP)	$14.5
SCHIP Administration	$0.5
State Only Foster Care	$2.7
GF Fund Foster Care (Court Orders)	$0.8
Prescription Drug Assistance Program (PDAP)	$1.2
State Only Other	$0.3
Total Non-Medicaid Expenditures	**$20.1**
Total Division of Healthcare Financing	**$643.9**

[5] Includes reductions in expenditures due to recoveries processed through the MMIS.
[6] Includes $21.4 million from the Medicaid Drug Rebate Program created under Omnibus Budget Reconciliation Act of 1990

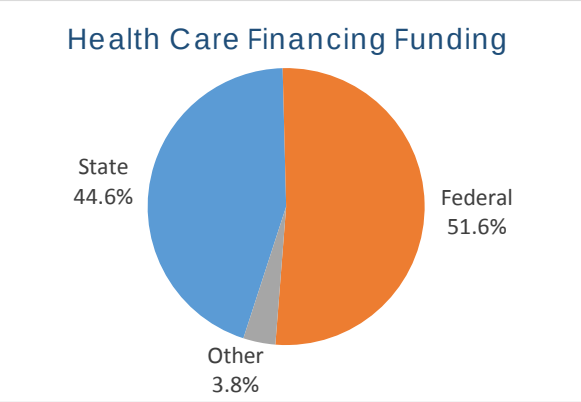

Figure 5: Health Care Financing Funding

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.

Medicaid is responsible, through a coordinated process of education, reviews, audits and appropriate corrective action plans, for ensuring the integrity and accountability of all payments made for healthcare services on behalf of an individual.

Table 5: Medicaid Quality Assurance Activities

Program Area	Description
Program Integrity	Collects recoveries from providers for claims that do not have sufficient documentation or that were billed incorrectly
Global Settlements	Receives settlements as a result of legal agreements to address or compromise both civil claims and criminal charges against a corporation or other large entity.
Third Party Liability and Other Recovery	Assists in keeping Medicaid as the payer of last resort through cost avoidance and benefit recovery by identifying legally obligated parties. Includes recoveries collected from: • health insurance companies • Medicare • personal injury and subrogation • estates • drug rebates (J-Code rebates) for certain physician administered drugs from drug manufacturers

Table 6: Medicaid Cost Avoidance and Recoveries

Program Area	Amount Collected
Program Integrity	$595,454
Program Integrity – Pharmacy	$239,247
Global Settlements	$564,357
Third Party Liability Cost Avoidance	$12,749,398
Third Party Liability Cost Avoidance - Pharmacy	$2,969,273
Third Party Liability Recoveries	$2,433,598
Estate Recoveries	$2,433,666
J-Code Rebate Recovery	$1,629,162
Total	**$23,614,155**


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During SFY 2014, 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

Medical & Coordinated Care Reforms

- Implemented incentives for clients & providers
- Initiated Primary Care Medical Home (PCMH) project
- Focused program changes on decreased emergency room use
- Enhanced health management for foster care children
- SBIRT

Long-Term Care Redesign

- Designed an updated, quality-controlled and tested assessment to replace the current LT-101
- Designed a new nursing facility rate system that incorporates acuity, Medicaid occupancy and regional economic factors
- Removed enrollment waiting list from both Long-Term Care and Assisted Living Facility waivers

HCBS Waiver Redesign

- Created two new waivers: Comprehensive and Supports, replace current Adult Developmentally Disabled (DD), Child DD and Acquired Brain Injury (ABI) waivers
  - Currently enrolled adults and children can select which waiver best meets their needs
  - Began transitioning adults from Adult DD waiver in SFY 2014. Completed September 30, 2014
  - Began transitioning children from the Child DD Waiver and adults from the ABI waiver to be completed June 30, 2015.
  - Transferred the Child Mental Health (CMH) Waiver from Behavioral Health division to Medicaid Finance
  - Reduced number of individuals on waiting lists
- Began conflict-free case management and Home Community Based Service Waiver Transition process

Managed Care Study

- Conducted during SFY 2014
- Released early SFY 2015
- Recommended Wyoming focus on completing current initiatives and not pursue managed care at this time

Mental Health & Substance Abuse Modernization Project

PHASE 1 (completed during SFY 2014) – Identified Challenges with Current System:

- Contract inflation and access
- Geographic gaps
- Service gaps

PHASE 2 (initiated during SFY 2014) – Focused on:

- Maximizing Medicaid reimbursement for state general fund block grant providers
- Redrafting division contracts
- Studying potential improvements to the involuntary hospitalization and emergency detention process

Affordable Care Act Impacts

Enhanced Primary Care Payments

100% Federally funded

Continued from SFY 2013
Ended in December 2014

Mandatory Medicaid Expansion for Children

Ages 6-18 income eligibility raised to 133% FPL

Shifted children from Kid Care CHIP to Medicaid

Effective January 1, 2014

MAGI Income Methodology

Applies to children, pregnant women & family care adults

Effective January 1, 2014

Former Foster Care Children

Former foster care children allowed to remain on Medicaid until Age 26

Effective January 1, 2014

Major Technology Projects

Wyoming Eligibility System (WES)

Developed and launched new eligibility system, featuring:

- New central eligibility unit focused on disability and long-term care
- Centralized call center

MMIS Replacement Project Kick-Off

Project will replace:

- Pharmacy Benefit Management (PBM) System
- Waiver System
- Data Warehouse and Business Intelligence
- MMIS Core

Healthcare Information Technology

Wyoming Total Health Record (THR)

- Began development of on-boarding process to Immunization Registry for Electronic Health Record (EHR) Incentive Program Public Health Reporting Measure for Meaningful Use
- Obtained Stage 2 Certification for THR EHR

enabling providers using the system to continue participation in the WY Medicaid EHR Incentive Program

State Level Registry

- Leveraged current system's specific capabilities to support the Patient Centered Medical Home (PCMH) Model
- Incorporated tools to display Clinical Quality Measures used for attestations in PCMH model

Budget Actions

Due to budget reductions in SFY 2014:

- Some provider rates reduced
- Service levels and offerings for some Medicaid members adjusted

Changes from the 2014 Legislative Budget Session

SEA 41, 2014

2015-16 Biennium Budget

- Added ongoing funding to address the costs of mandatory Medicaid expansion and the expected "woodwork effect" among eligible adults and administration of this population
- Added ongoing funding to reduce waiting lists for persons with developmental disabilities (DD) or acquired brain injuries (ABI)
  - $9.7 million for Adult DD
  - $6.0 million for Child DD
  - $4.6 million for ABI
  - Focused on individuals waiting 18 months or more as of September 30, 2013
- Added ongoing funding to transfer positions from Department of Family Services to Department of Health to create the Medicaid Long-Term Care eligibility unit and to operate and maintain WES
- Added significant one-time capital funding for the MMIS replacement project to replace the primary Medicaid technology system and related components - $18.5 million with the remainder of $75 million to be requested for 2017-2018
- Budget footnotes pertaining to Medicaid or Medicaid waivers:
  - Section 338. Negotiation of Medicaid expansion demonstration waiver
  - Section 48. Item 3 - Hospital Cost Shift Study; Item 5 – Medicaid Enrollment Report; Item 6 – Nursing facility rate freeze until legislative authorization; Item 17 – WDH host a training conference for developmental disability Medicaid waiver benefits

HEA 38, 2014

- Mandated a study of the impact of diabetes on the state, including the Medicaid program

SEA 49, 2014

- Addition of Licensed Mental Health Professionals as Medicaid Providers, allowing licensed professional counselors, licensed marriage and family therapists, licensed addictions therapists and licensed clinical social workers to bill Medicaid directly

HEA 4, 2014

- Mandated insurance and Medicaid coverage of treatments necessary for persons with inherited enzymatic disorders

HEA 53, 2014

- This "Employment First" bill focuses on improving employment options for persons with disabilities

HEA 58, 2014

- This bill directed the Department of Health to allow greater transition time and to apply for waivers from some federal requirements, if necessary

Quality Assurance & Program Integrity

- **Passed a new type of nontestamentary transfer on death deed.**
  While this legislation was not put forth by the Department of Health, Division of Healthcare Financing, we worked with the Legislative Services Office, as well as provided testimony at legislative committee meetings to ensure Wyoming Medicaid's interests were protected regarding estate recovery.

- **Statute 42-4-111(e) – update to statute, effective July 1, 2014**
  It is unlawful for a person to knowingly fail to maintain records in accordance with Medicaid program rules as necessary to disclose fully the nature of the goods, services, items, facilities, or accommodations for which a claim was submitted for payment was received under the Medicaid program. Any person who violates this subsection is guilty of a misdemeanor.

- **Implemented a screening and monitoring process on May 1, 2014.**
  The ACA established requirements for new provider screening, enrollment and monitoring for all participating Medicaid providers. Every provider must be screened upon enrollment and reenrollment at least every five years and monitored for compliance on a monthly basis.


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Eligibility

Medicaid provides medical assistance for low-income and medically vulnerable citizens. There are currently four major categories of eligibility: Children, Pregnant Women, Family Care Adults, and Aged, Blind and Disabled (ABD).

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 healthcare 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.

86,188

Individuals eligible for Medicaid in SFY 2014

↓ 2%

from last year

Eligibility Overview

There were 86,188 individuals eligible for Medicaid in SFY 2014, a two percent decrease from SFY 2013.

Individuals eligible for Medicaid 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 individuals eligible for Medicaid for a complete SFY – regardless of how long they were eligible – is greater than a point-in-time count of individuals eligible for Medicaid.

Eligibility data in this section is based on eligible individuals for the complete SFY.

Table 7: Change in Eligible Individuals[7]

	As of June 30	Percent Change From Previous SFY	Complete SFY	Percent Change From Previous SFY
SFY 2009	62,698	9.7	80,277	4.2
SFY 2010	67,088	7.0	85,416	6.4
SFY 2011	67,811	1.1	88,059	3.1
SFY 2012	67,291	-0.8	88,134	0.1
SFY 2013	66,321	-1.4	87,946	-0.2
SFY 2014	**68,320**	**3.0**	**86,188**	**-2.0**

[7] Eligible Individuals 'As of June 30' is a distinct count of individuals at a point in time. Eligible Individuals 'Complete SFY' is a distinct count of individuals for a complete SFY, July 1 through June 30.

Individuals eligible for Medicaid 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).

Table 8: Eligible Individuals by County

County	Eligible Individuals	Percent of Total	County	Eligible Individuals	Percent of Total
Albany	3,929	4.6	Natrona	12,878	14.9
Big Horn	2,050	2.4	Niobrara	462	0.5
Campbell	6,318	7.3	Other	1,620	1.9
Carbon	2,330	2.7	Park	3,811	4.4
Converse	1,931	2.2	Platte	1,344	1.6
Crook	841	1.0	Sheridan	3,823	4.4
Fremont	9,762	11.3	Sublette	786	0.9
Goshen	2,250	2.6	Sweetwater	5,874	6.8
Hot Springs	931	1.1	Teton	1,724	2.0
Johnson	933	1.1	Uinta	3,548	4.1
Laramie	14,704	17.1	Washakie	1,301	1.5
Lincoln	2,142	2.5	Weston	896	1.0
			Total	**86,188**	**100**

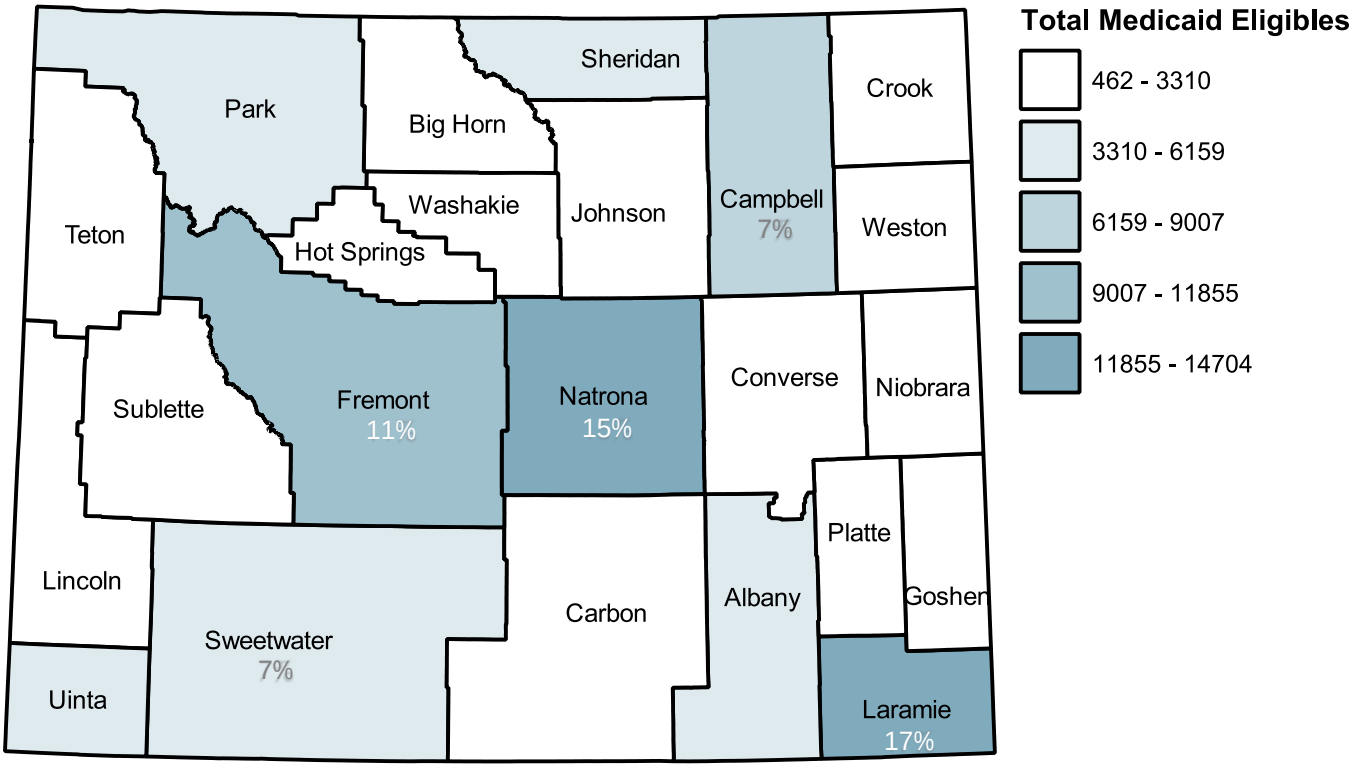


Figure 6: Eligible Individuals by County

Eligibility Categories

Federal statutes define individuals who may qualify for Medicaid coverage. For this report, these individuals are presented in 10 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 D.

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

Table 9: Eligibility Categories

Eligibility Category	Description
Aged, Blind and Disabled Employed Individuals with Disabilities (ABD EID)	• Employed individuals with disabilities • Must pay a premium • Individuals do not have to be eligible for Supplemental Security Income (SSI) • Income requirement based on SSI standards
Aged, Blind and Disabled Home & Community Based Services Waivers (ABD HCBS Waiver)	• Children and adults with a developmental disability or acquired brain injury • Adults in need of nursing facility level of care, but have elected to receive services and supports in their home or community • Children with severe mental health needs • Resources are taken into consideration • Individuals do not have to be eligible for SSI • Income requirement based on SSI
Aged, Blind and Disabled Institutional (ABD Institution)	• Residents living in the following types of institution: o Nursing Home o Hospital o Hospice o Intermediate Care Facility for the Intellectually Disabled (ICF-ID) (State training School/Wyoming Life Resource Center) o WY State Hospital – Age 65 and older • Resources are taken into consideration • Individuals do not have to be eligible for SSI • Income requirement based on SSI
Aged, Blind and 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
Children	• Newborns – automatically eligible if the mother is eligible for Medicaid at the time of the birth • Low-Income children – income requirement based on Federal Poverty Level (FPL), and is dependent on age of the child • Family Care children – when the caretaker is eligible • Foster Care children – automatically eligible when in the Department of Family Services (DFS) custody, including some children who enter subsidized adoption or 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. 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.
Family Care	• Adult caretaker relatives with a dependent child • Must cooperate with child support enforcement • Income requirement based on FPL

Eligibility Category	Description

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)
	  o Resources also taken into consideration
	  o Medicaid pays for Medicare premiums, deductibles and cost-sharing
	  o Income requirement based on FPL
	• Specified Low-Income Medicare Beneficiaries (SLMB)
	  o Medicaid pays for Medicare premiums only
	  o Income requirement based on FPL

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.[8] • Income requirement based on FPL

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

Eligible Individuals by Category

Almost two-thirds (63 percent) of the individuals eligible for Medicaid were children.

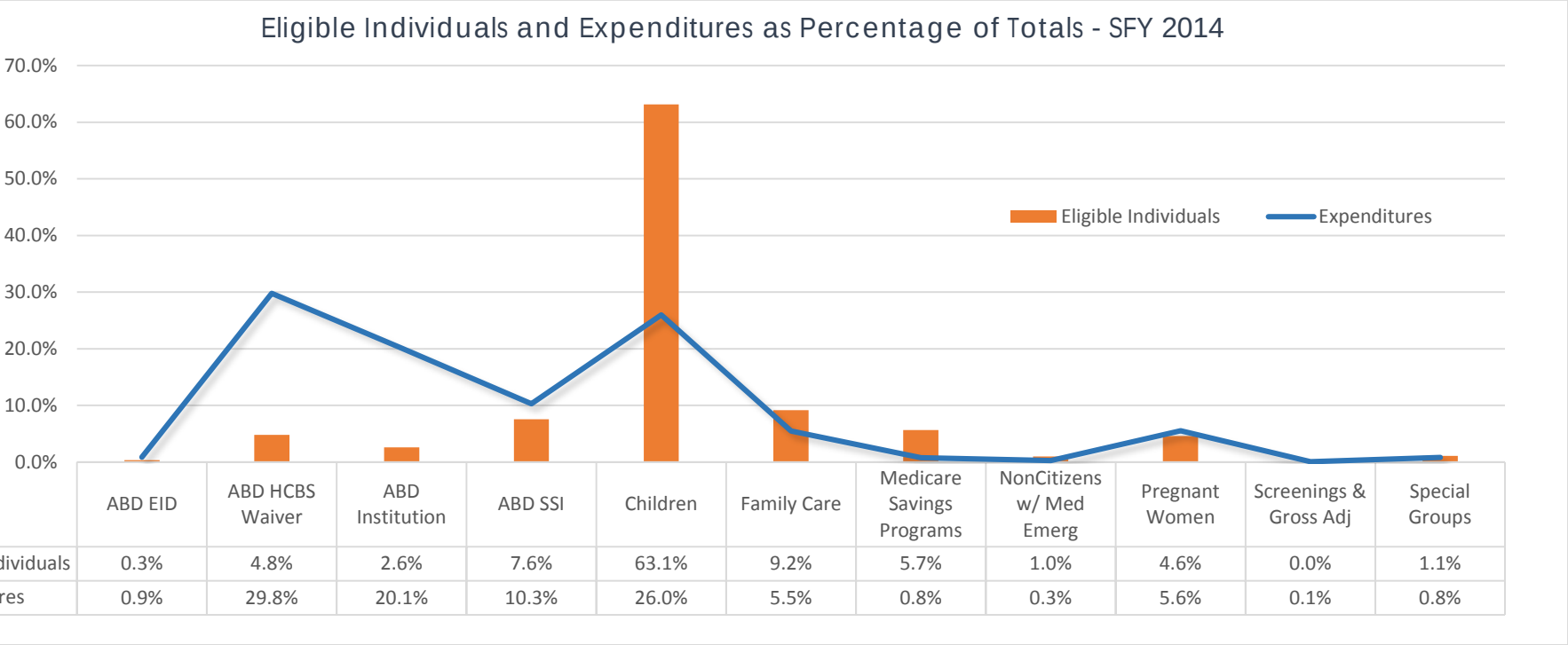
Table 10: Change in Eligible Individuals – Complete SFY

Eligibility Category	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
ABD EID	155	188	228	280	307	287	85
ABD HCBS Waiver	4,070	4,271	4,233	4,184	4,123	4,162	2
ABD Institution	2,315	2,383	2,308	2,309	2,327	2,229	-4
ABD SSI	6,057	6,199	6,497	6,650	6,793	6,508	7
Children	51,014	54,674	56,226	56,115	55,849	54,417	7
Family Care	6,841	7,303	7,516	7,320	7,144	7,908	16
Medicare Savings Programs	3,359	3,730	4,161	4,500	4,794	4,881	45
Non-Citizens with Medical Emergencies	1,128	1,115	1,065	1,060	1,001	877	-22
Pregnant Women	4,914	4,622	4,542	4,362	4,359	3,973	-19
Special Groups	424	931	1,283	1,354	1,249	946	123
Total	**80,277**	**85,416**	**88,059**	**88,134**	**87,946**	**86,188**	**7**

[8] Presumptive eligibility for pregnant women allows immediate, temporary Medicaid coverage for ambulatory prenatal care and prescription drugs for low income, pregnant patients, pending their formal Medicaid application.

Recipients and Expenditures by Eligibility Category

The figure below illustrates the distribution of eligible individuals across the eligibility categories[9] compared to the expenditures for those categories.



	ABD EID	ABD HCBS Waiver	ABD Institution	ABD SSI	Children	Family Care	Medicare Savings Programs	NonCitizens w/ Med Emerg	Pregnant Women	Screenings & Gross Adj	Special Groups
Eligible Individuals	0.3%	4.8%	2.6%	7.6%	63.1%	9.2%	5.7%	1.0%	4.6%	0.0%	1.1%
Expenditures	0.9%	29.8%	20.1%	10.3%	26.0%	5.5%	0.8%	0.3%	5.6%	0.1%	0.8%

Figure 7: Eligible Individuals and Expenditures as Percentage of Totals - SFY 2014

While children represented 63% of all eligible individuals for SFY 2014, the corresponding expenditures for children receiving services only accounted for 26% of total Medicaid expenditures.

On the other hand, the ABD HCBS Waiver population accounted for only 4.8% of all eligible individuals for the SFY, but nearly 30% of total Medicaid expenditures.

[9] Screenings and gross adjustments are included to account for expenditures; however, this is not an eligibility category.

Table 11: Eligibility Category Summary

Eligibility Category	Eligible Individuals	Percent Change from SFY2013	Recipients	Percent Change from SFY2013	Expenditures	Percent Change from SFY2013	Expenditures per Eligible	Percent Change from SFY2013	Expenditures per Recipient	Percent Change from SFY2013
ABD EID	287	-6.5	345	0.9	$4,545,872	-1.0	$15,839	5.9	$13,176	-1.8
ABD HCBS Waiver	4,162	0.9	4,510	0.0	$154,077,818	-1.2	$37,020	-2.2	$34,164	-1.2
ABD Institution	2,229	-4.2	2,661	-2.7	$104,031,345	2.3	$46,672	6.8	$39,095	5.2
ABD SSI	6,508	-4.2	6,270	0.4	$53,252,515	2.0	$8,183	6.5	$8,493	1.6
Children	54,417	-2.6	49,362	0.8	$134,433,053	2.1	$2,470	4.7	$2,723	1.2
Family Care	7,908	10.7	6,908	3.4	$28,414,259	-0.1	$3,593	-9.8	$4,113	-3.4
Medicare Savings Programs	4,881	1.8	2,762	4.6	$4,086,134	10.2	$837	8.2	$1,479	5.4
Non-Citizens with Medical Emergencies	877	-12.4	367	-11.4	$1,490,032	-21.3	$1,699	-10.1	$4,060	-11.2
Pregnant Women	3,973	-8.9	5,509	-7.2	$28,762,228	-9.6	$7,239	-0.8	$5,221	-2.5
Screenings & Gross Adjustments	--	--	--	--	$389,686	3.0	--	--	--	--
Special Groups	946	-24.3	497	-20.1	$4,139,581	-14.1	$4,376	13.5	$8,329	7.6
Total	**86,188**	**-2.0**	**76,341**	**0.1**	**$517,622,524**	**0.1**	**$6,006**	**2.1**	**$6,780**	**0.0**

Table 12: Change in Expenditures by Eligibility Category

Eligibility Category	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
ABD EID	$1,967,005	$2,807,582	$2,721,026	$3,208,536	$4,589,792	$4,545,872	131
ABD HCBS Waiver	$146,260,548	$146,381,081	$155,016,904	$159,006,300	$156,010,329	$154,077,818	5
ABD Institution	$93,233,194	$98,980,787	$97,492,993	$94,738,423	$101,670,287	$104,031,345	12
ABD SSI	$47,255,068	$50,065,766	$51,934,208	$51,345,795	$52,203,560	$53,252,515	13
Children	$141,946,704	$144,479,541	$138,277,799	$122,404,103	$131,725,914	$134,433,053	-5
Family Care	$26,870,044	$28,237,358	$29,178,291	$28,827,439	$28,446,023	$28,414,259	6
Medicare Savings Programs	$2,447,998	$2,562,625	$3,007,075	$3,245,880	$3,708,394	$4,086,134	67
Non-Citizens with Medical Emergencies	$2,179,533	$2,202,976	$1,960,832	$1,948,889	$1,892,640	$1,490,032	-32
Pregnant Women	$32,434,376	$36,184,628	$36,086,835	$32,051,842	$31,815,394	$28,762,228	-11
Screenings & Gross Adjustments	$1,727,733	$182,034	$239,567	$355,924	$378,465	$389,686	-77
Special Groups	$2,002,965	$2,444,944	$3,688,749	$3,797,900	$4,816,363	$4,139,581	107
Total	**$498,325,166**	**$514,529,323**	**$519,604,279**	**$500,931,031**	**$517,257,164**	**$517,622,524**	**4**

Table 13: Change in Recipients[10] by Eligibility Category

Eligibility Category	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
ABD EID	187	223	253	310	342	345	84
ABD HCBS Waiver	4,397	4,644	4,709	4,590	4,510	4,510	3
ABD Institution	3,099	2,924	2,835	2,768	2,736	2,661	-14
ABD SSI	5,789	5,934	6,094	6,191	6,245	6,270	8
Children	45,364	48,297	49,964	48,979	48,952	49,362	9
Family Care	6,535	6,622	6,936	6,590	6,683	6,908	6
Medicare Savings Programs	2,098	2,153	2,333	2,514	2,641	2,762	32
Non-Citizens with Medical Emergencies	569	479	419	426	414	367	-36
Pregnant Women	6,694	6,388	6,149	5,785	5,939	5,509	-18
Special Groups	296	570	683	686	622	497	68
Total	**71,584**	**74,871**	**77,229**	**75,969**	**76,285**	**76,341**	**7**

Table 14: Change in Expenditures per Recipient by Eligibility Category

Eligibility Category	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
ABD EID	$10,519	$12,590	$10,755	$10,350	$13,420	$13,176	25
ABD HCBS Waiver	$33,264	$31,520	$32,919	$34,642	$34,592	$34,164	3
ABD Institution	$30,085	$33,851	$34,389	$34,226	$37,160	$39,095	30
ABD SSI	$8,163	$8,437	$8,522	$8,294	$8,359	$8,493	4
Children	$3,129	$2,991	$2,768	$2,499	$2,691	$2,723	-13
Family Care	$4,112	$4,264	$4,207	$4,374	$4,256	$4,113	0
Medicare Savings Programs	$1,167	$1,190	$1,289	$1,291	$1,404	$1,479	27
Non-Citizens with Medical Emergencies	$3,830	$4,599	$4,680	$4,575	$4,572	$4,060	6
Pregnant Women	$4,845	$5,664	$5,869	$5,541	$5,357	$5,221	8
Special Groups	$6,767	$4,289	$5,401	$5,536	$7,743	$8,329	23
Total	**$6,961**	**$6,872**	**$6,728**	**$6,594**	**$6,781**	**$6,780**	**-3**

[10] The table 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 15: Change in Expenditures per Eligible Individual by Eligibility Category

Eligibility Category	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
ABD EID	$12,690	$14,934	$11,934	$11,459	$14,950	$15,839	25
ABD HCBS Waiver	$35,936	$34,273	$36,621	$38,003	$37,839	$37,020	3
ABD Institution	$40,274	$41,536	$42,241	$41,030	$43,692	$46,672	16
ABD SSI	$7,802	$8,076	$7,994	$7,721	$7,685	$8,183	5
Children	$2,783	$2,643	$2,459	$2,181	$2,359	$2,470	-11
Family Care	$3,928	$3,867	$3,882	$3,938	$3,982	$3,593	-9
Medicare Savings Programs	$729	$687	$723	$721	$774	$837	15
Non-Citizens with Medical Emergencies	$1,932	$1,976	$1,841	$1,839	$1,891	$1,699	-12
Pregnant Women	$6,600	$7,829	$7,945	$7,348	$7,299	$7,239	10
Special Groups	$4,724	$2,626	$2,875	$2,805	$3,856	$4,376	-7
Total	**$6,208**	**$6,024**	**$5,901**	**$5,684**	**$5,882**	**$6,006**	**-3**

Per Member Per Month

The Per Member Per Month (PMPM) cost is the average cost for each eligible individual per month of enrollment. The PMPM calculation considers expenditures based on dates of service, as well as the number of eligible individuals enrolled in that month. All reporting of expenditures within this section is based on dates of service, and as such expenditures in this section may not match those reported elsewhere in the report, which are based on paid date. This section provides PMPM data for each eligibility category defined in the previous section.

PMPM Overview

From SFY 2009 and SFY 2014, Medicaid expenditures, based on date of services, increased a total of 5%, while member months increased a total of 15%.

Over this same time period, PMPM has decreased a total of 9%, with a PMPM cost of $608 in SFY 2014.

$608 *PMPM for SFY 2014*

↓ 1.4% *from last year*

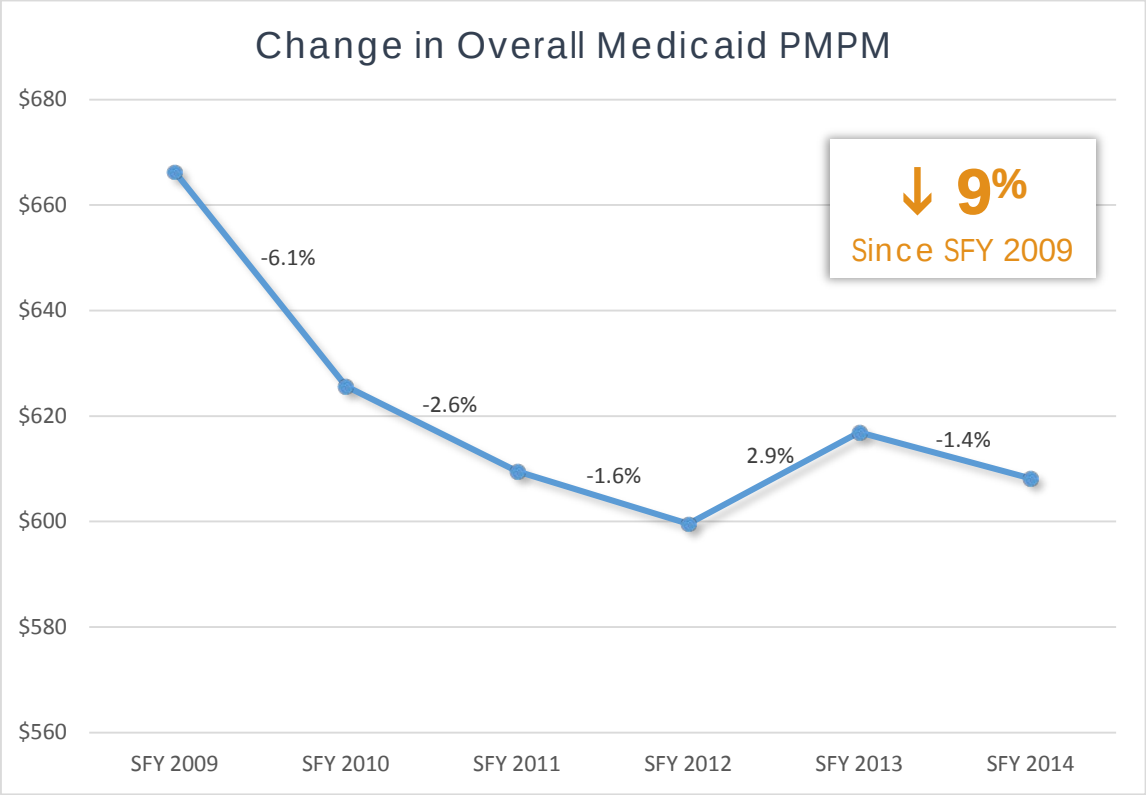


Figure 8: Change in Medicaid PMPM

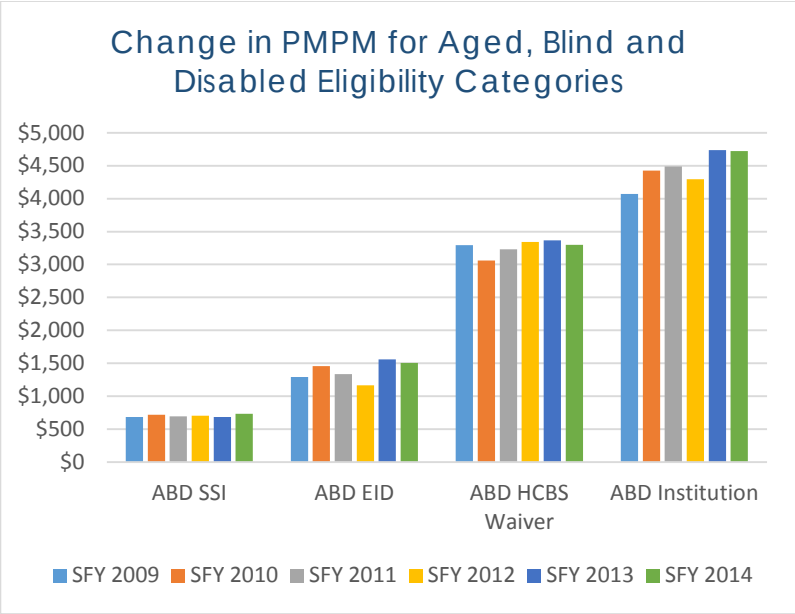


Figure 9: Change in PMPM for Aged, Blind and Disabled Eligibility Categories

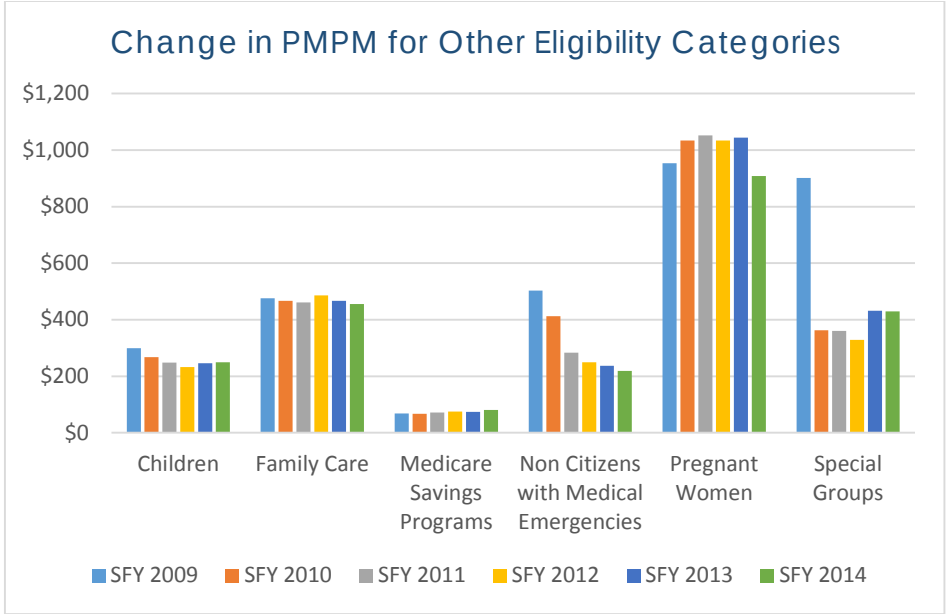


Figure 10: Change in PMPM for Other Eligibility Categories

Table 16: Change in PMPM by Eligibility Category

Eligibility Category	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
ABD EID	$1,291	$1,456	$1,336	$1,165	$1,560	$1,507	17
ABD HCBS Waiver	$3,292	$3,061	$3,233	$3,344	$3,365	$3,297	0
ABD Institution	$4,071	$4,424	$4,489	$4,293	$4,737	$4,721	16
ABD SSI	$682	$719	$696	$705	$686	$734	8
Children	$299	$267	$248	$232	$246	$249	-16
Family Care	$476	$467	$462	$486	$466	$456	-4
Medicare Savings Programs	$69	$67	$72	$74	$74	$81	18
Non-Citizens with Medical Emergencies	$503	$412	$283	$249	$237	$218	-57
Pregnant Women	$953	$1,034	$1,052	$1,033	$1,044	$908	-5
Special Groups	$901	$363	$360	$329	$432	$429	-52
Total	**$666**	**$626**	**$610**	**$600**	**$617**	**$608**	**-9**

Aged, Blind and Disabled – Employed Individuals with Disabilities (ABD EID)

The ABD EID PMPM cost was $1,507 in SFY 2014, a decrease of 3.4 percent from SFY 2013.

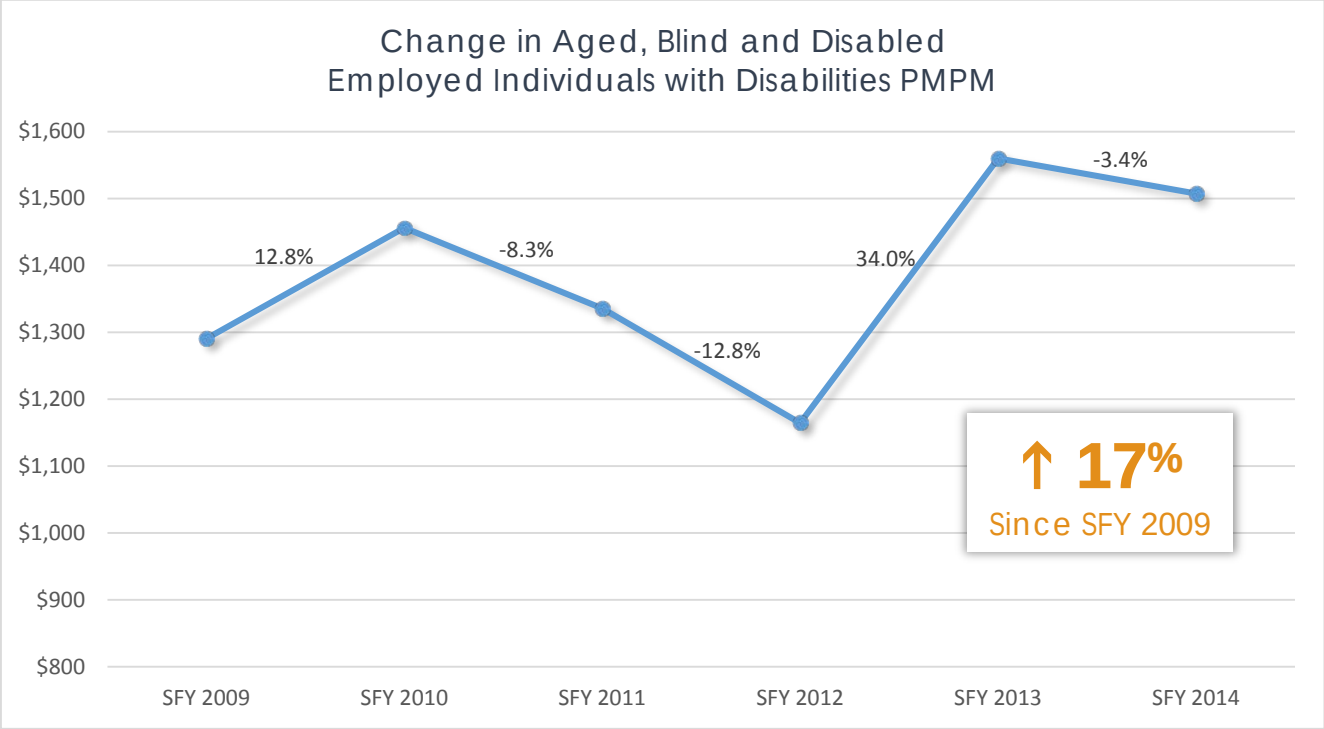


Figure 11: Change in Aged, Blind and Disabled Employed Individuals with Disabilities PMPM

Table 17: Change in Aged, Blind and Disabled Employed Individuals with Disabilities PMPM

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$1,882,216	$2,718,766	$2,942,697	$3,115,090	$4,819,890	$4,663,828	148
Enrollment	155	188	228	280	307	287	85
Member Months	1,458	1,867	2,203	2,675	3,089	3,094	112
PMPM	**$1,291**	**$1,456**	**$1,336**	**$1,165**	**$1,560**	**$1,507**	**17**

Table 18: Change in Aged, Blind and Disabled Employed Individuals with Disabilities PMPM by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$4.50	$17.29	$4.60	$10.51	$11.39	$12.76	184
Ambulatory Surgery Center	$4.25	$6.30	$6.68	$6.21	$4.47	$3.71	-13
Behavioral Health	$57.47	$90.40	$48.35	$60.41	$69.51	$64.79	13
CORF	--	$0.10	$0.17	$0.92	$1.13	$0.47	360
Dental	$12.59	$16.34	$15.12	$14.84	$22.34	$17.31	37
DMEPOS	$50.92	$47.21	$43.59	$42.38	$38.07	$38.37	-25
ESRD	--	$1.28	$2.89	$6.42	$6.64	$8.72	581
FQHC	$17.05	$15.13	$16.33	$8.14	$8.86	$5.82	-66
Home Health	$14.56	$6.53	$5.82	$8.28	$5.68	$12.21	-16
Hospice	$7.77	$0.91	$6.08	$10.30	$2.58	$12.13	56
Hospital Total	$521.92	$673.30	$617.11	$433.65	$668.45	$570.65	9
Hospital-Inpatient	*$307.07*	*$487.24*	*$416.66*	*$292.51*	*$471.79*	*$396.03*	*29*
Hospital-Other	*$0.00*	*-$1.09*	*-$7.57*	*-$0.85*	--	*$0.02*	--
Hospital-Outpatient	*$214.86*	*$187.15*	*$208.02*	*$141.98*	*$196.65*	*$174.60*	*-19*
Interpreter	--	--	--	--	--	--	--
Laboratory	$3.99	$4.72	$2.23	$2.29	$6.91	$3.95	-1
Nursing Facility	$0.75	$0.00	$0.00	$3.74	--	$0.43	-42
Other	$3.31	$2.50	$2.64	$1.08	$0.79	$1.62	-51
Physician & Other Practitioner	$230.52	$295.70	$242.62	$180.02	$385.16	$489.29	112
Prescription Drug	$355.12	$269.73	$313.04	$371.74	$323.77	$261.82	-26
PRTF	--	--	--	--	--	--	--
Radiology-Mobile	$0.91	$4.61	$5.86	$0.73	--	--	--
Rural Health Clinic	$2.98	$2.36	$1.67	$1.54	$3.09	$1.72	-42
Vision	$2.38	$1.81	$0.99	$1.32	$1.51	$1.61	-32
Total	**$1,291**	**$1,456**	**$1,336**	**$1,165**	**$1,560**	**$1,507**	**17**

Aged, Blind and Disabled – Home & Community Based Services Waiver

Individuals in the ABD Home & Community Based Services (HCBS) Waiver eligibility category can receive other Medicaid services in addition to waiver services. These services are discussed as "non-waiver" services.

The ABD HCBS Waiver PMPM cost was $3,297 in SFY 2014, a decrease of 2 percent from SFY 2013.

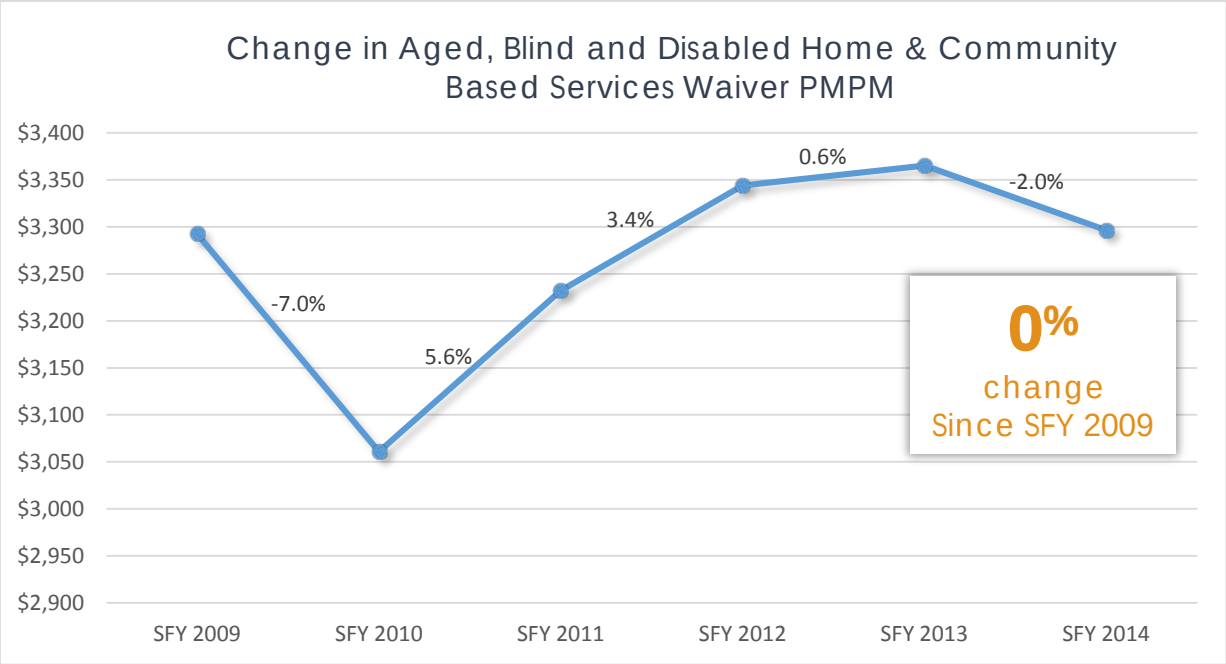


Figure 12: Change in Aged, Blind and Disabled Home & Community Based Services Waiver PMPM

Table 19: Change in Aged, Blind and Disabled Home & Community Based Services Waiver PMPM

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$145,528,526	$144,302,611	$154,123,380	$158,939,352	$156,196,030	$152,622,024	5
Waiver	*$116,152,567*	*$111,656,357*	*$120,362,699*	*$122,203,952*	*$122,194,192*	*$117,592,767*	*1*
Non-Waiver	*$29,375,959*	*$32,646,254*	*$33,760,681*	*$36,735,400*	*$34,001,839*	*$35,029,257*	*19*
Enrollment	4,070	4,271	4,233	4,184	4,123	4,162	2
Member Months	44,201	47,143	47,678	47,529	46,417	46,298	5
PMPM	**$3,292**	**$3,061**	**$3,233**	**$3,344**	**$3,365**	**$3,297**	**0**
Waiver	*$2,628*	*$2,368*	*$2,524*	*$2,571*	*$2,633*	*$2,540*	*-3*
Non-Waiver	*$665*	*$692*	*$708*	*$773*	*$733*	*$757*	*14*

Table 20: Change in Aged, Blind and Disabled Home & Community Based Services Waiver PMPM by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$6.47	$5.80	$6.62	$6.81	$8.83	$7.72	19
Ambulatory Surgery Center	$3.35	$3.76	$3.12	$3.40	$4.85	$5.43	62
Behavioral Health	$79.87	$84.61	$90.40	$98.05	$98.97	$109.45	37
CORF	$0.10	$0.10	$0.35	$0.58	$0.53	$0.28	175
Dental	$14.08	$15.62	$16.31	$17.01	$15.61	$14.98	6
DMEPOS	$62.21	$59.40	$64.33	$65.94	$75.09	$70.43	13
ESRD	$3.15	$3.01	$3.18	$4.50	$8.19	$6.15	95
FQHC	$2.90	$4.23	$4.51	$1.83	$1.85	$2.17	-25
Home Health	$29.76	$34.28	$47.04	$55.03	$53.43	$61.28	106
Hospice	$3.50	$2.84	$1.14	$0.51	$3.19	$4.63	32
Hospital Total	$161.87	$182.17	$170.92	$194.10	$169.89	$153.13	-5
Hospital-Inpatient	*$115.02*	*$132.80*	*$111.87*	*$134.49*	*$109.45*	*$93.77*	*-18*
Hospital-Other	*$-2.25*	*$-3.13*	*$-0.82*	*$-0.10*	*$-0.24*	*$-0.01*	*-99*
Hospital-Outpatient	*$49.10*	*$52.49*	*$59.87*	*$59.71*	*$60.67*	*$59.38*	*21*
Interpreter	$0.03	$0.10	$0.06	$0.03	$0.02	$0.02	-32
Laboratory	$0.88	$1.01	$1.19	$1.16	$1.06	$0.78	-11
Nursing Facility	$5.56	$5.45	$4.87	$5.26	$7.66	$6.70	20
Other	$37.92	$29.70	$19.03	$18.10	$20.69	$41.70	10
Physician & Other Practitioner	$79.81	$91.83	$97.53	$103.55	$104.27	$111.45	40
Prescription Drug	$166.54	$147.62	$161.98	$179.88	$145.68	$142.66	-14
PRTF	$1.77	$15.88	$10.27	$12.53	$8.41	$13.61	667
Radiology-Mobile	$0.33	$0.55	$0.41	$0.19	$0.00	$0.00	-99
Rural Health Clinic	$1.58	$1.56	$1.80	$1.70	$1.55	$1.41	-11
Vision	$2.91	$2.96	$3.03	$2.74	$2.73	$2.60	-10
Waiver Total	$2,627.83	$2,368.46	$2,524.49	$2,571.15	$2,632.53	$2,539.91	-3
Waiver-ABI	*$135.64*	*$130.50*	*$146.33*	*$145.09*	*$166.61*	*$157.72*	*16*
Waiver-Adult DD	*$1,843.43*	*$1,589.56*	*$1,717.70*	*$1,786.69*	*$1,829.58*	*$1,777.28*	*-4*
Waiver-ALF	*$56.94*	*$55.52*	*$56.26*	*$52.33*	*$51.46*	*$56.04*	*-2*
Waiver-Child DD	*$327.98*	*$302.60*	*$298.15*	*$284.36*	*$285.77*	*$244.34*	*-26*
Waiver-Child Mental Health	*$2.19*	*$9.41*	*$21.65*	*$18.44*	*$13.31*	*$12.43*	*466*
Waiver-Comprehensive	--	--	*$-0.08*	*$-0.01*	--	*$4.48*	--
Waiver-LTC	*$261.65*	*$280.87*	*$284.47*	*$284.24*	*$285.81*	*$287.57*	*10*
Waiver-Supports	--	--	--	--	--	*$0.05*	--
Total	**$3,292**	**$3,061**	**$3,232**	**$3,344**	**$3,365**	**$3,297**	**0**

Aged, Blind and Disabled – Institution

The ABD Institution PMPM cost was $4,721 in SFY 2014, a decrease of 0.4 percent from SFY 2013.

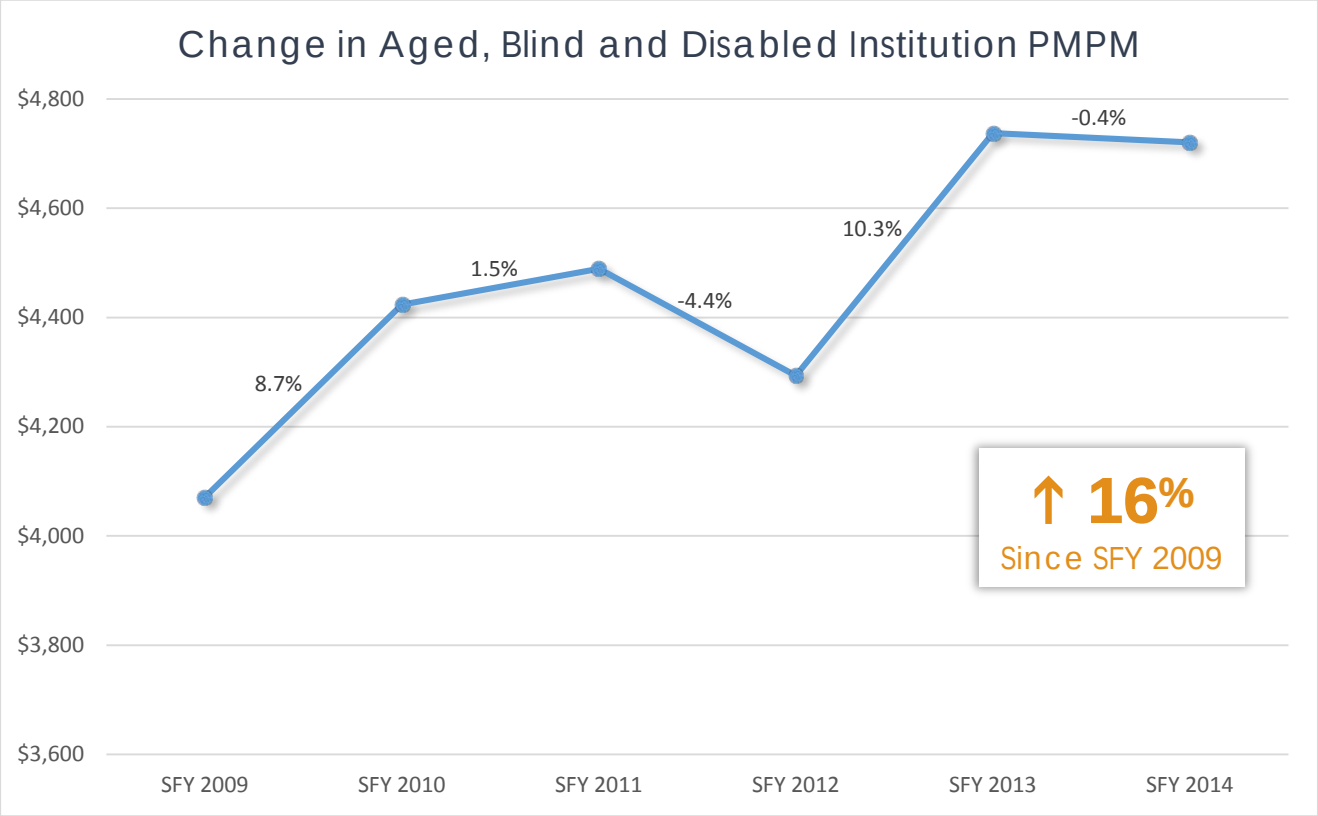


Figure 13: Change in Aged, Blind and Disabled Institution PMPM

Table 21: Change in Aged, Blind and Disabled Institution PMPM

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$93,233,194	$98,980,787	$97,492,993	$94,738,423	$101,670,287	$104,031,345	12
Enrollment	2,315	2,383	2,308	2,309	2,327	2,229	-4
Member Months	22,252	22,062	21,600	21,766	21,506	21,435	0
PMPM	**$4,071**	**$4,424**	**$4,489**	**$4,293**	**$4,737**	**$4,721**	**16**

Table 22: Change in Aged, Blind and Disabled Institution by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$10.40	$12.03	$8.21	$6.25	$8.15	$10.48	1
Ambulatory Surgery Center	$0.55	$0.32	$0.32	$0.38	$0.35	$0.41	-25
Behavioral Health	$13.03	$13.60	$15.51	$14.57	$14.00	$14.55	12
CORF	--	--	$0.00	--	$0.02	--	--
Dental	$7.04	$5.19	$8.60	$8.00	$8.47	$8.18	16
DMEPOS	$17.18	$10.11	$17.34	$11.79	$10.34	$18.59	8
ESRD	$7.02	$4.35	$2.79	$2.79	$2.85	$2.41	-66
FQHC	$3.30	$2.35	$1.88	$0.24	$0.17	$0.22	-93
Home Health	$0.20	$0.38	$1.19	$0.58	$0.51	$0.82	299
Hospice	$30.36	$56.69	$34.10	$37.90	$40.88	$36.85	21
Hospital Total	$281.59	$386.46	$412.20	$256.40	$368.70	$311.28	11
Hospital-Inpatient	*$257.30*	*$361.03*	*$379.16*	*$225.23*	*$336.23*	*$279.11*	*8*
Hospital-Other	*-$1.37*	*-$1.75*	*-$1.16*	*-$0.62*	*-$0.09*	*$0.01*	*-101*
Hospital-Outpatient	*$25.65*	*$27.18*	*$34.21*	*$31.79*	*$32.56*	*$32.16*	*25*
Interpreter	--	--	--	--	--	--	--
Laboratory	$0.57	$0.67	$0.46	$0.26	$0.63	$0.56	-2
Nursing Facility	$3,183.72	$3,327.26	$3,344.05	$3,360.90	$3,340.33	$3,330.14	5
Other	$428.90	$504.16	$539.89	$505.69	$848.29	$898.05	109
Physician & Other Practitioner	$49.58	$62.08	$62.65	$46.07	$57.92	$57.95	17
Prescription Drug	$30.04	$35.00	$36.43	$38.36	$32.74	$27.21	-9
PRTF	$3.85	--	--	--	--	--	--
Radiology-Mobile	$0.36	$0.45	$0.45	$0.13	$0.00	$0.00	-100
Rural Health Clinic	$2.28	$2.02	$2.30	$2.44	$2.52	$2.32	2
Vision	$0.59	$0.69	$0.74	$0.67	$0.60	$0.61	4
Total	**$4,071**	**$4,424**	**$4,489**	**$4,293**	**$4,737**	**$4,721**	16

Aged, Blind and Disabled –Supplemental Security Income (ABD SSI)

The ABD SSI PMPM cost was $734 in SFY 2014, an increase of 6.9 percent from SFY 2013.

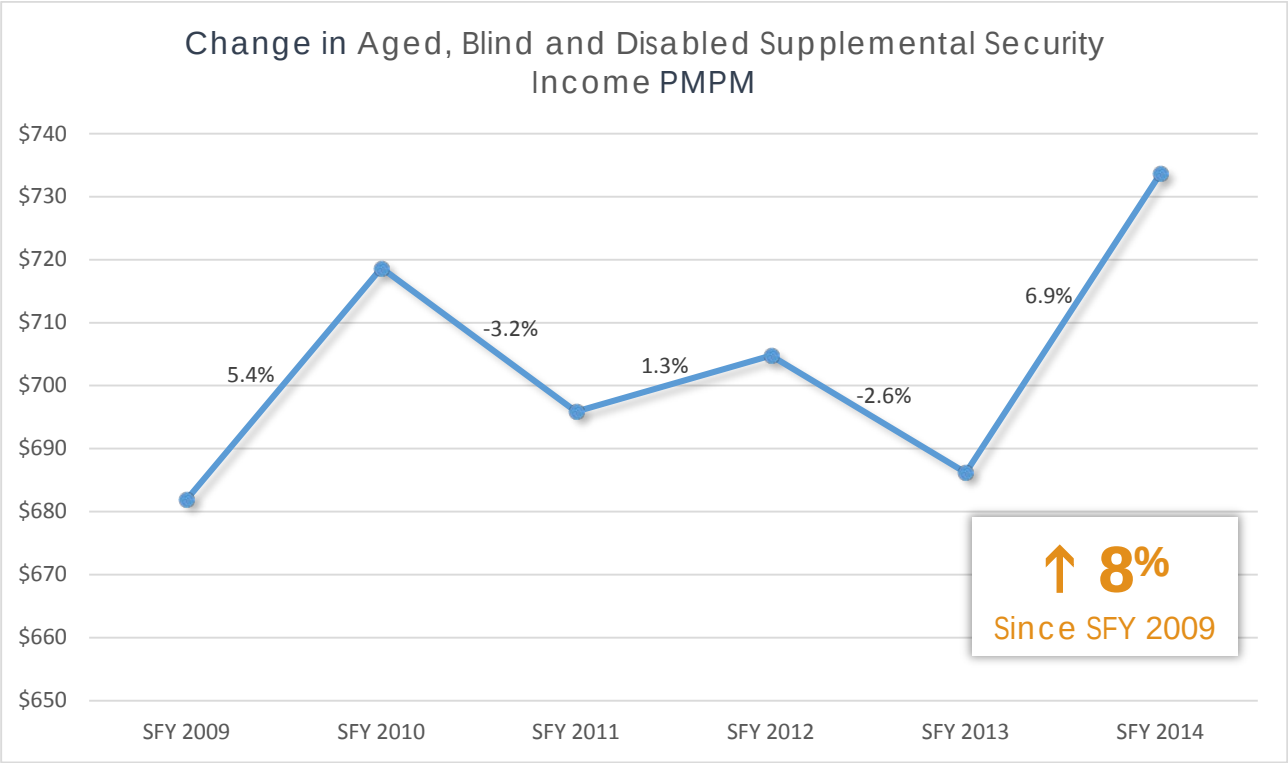


Figure 14: Change in Aged, Blind and Disabled Supplemental Security Income PMPM

Table 23: Change in Aged, Blind and Disabled Supplemental Security Income PMPM

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$46,045,530	$50,600,412	$50,434,153	$52,373,945	$51,392,543	$53,717,482	17
Enrollment	6,057	6,199	6,497	6,650	6,793	6,508	7
Member Months	67,524	70,408	72,474	74,314	74,897	73,214	8
PMPM	**$682**	**$719**	**$696**	**$705**	**$686**	**$734**	**8**

Table 24: Change in Aged, Blind and Disabled Supplemental Security Income PMPM by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$8.75	$8.76	$8.83	$9.29	$9.64	$11.46	31
Ambulatory Surgery Center	$3.60	$3.31	$3.38	$3.09	$3.54	$4.28	19
Behavioral Health	$59.73	$61.80	$57.46	$66.03	$64.94	$66.38	11
CORF	$0.26	$0.16	$0.24	$0.36	$0.27	$0.53	102
Dental	$11.44	$12.91	$14.46	$13.52	$13.17	$13.56	19
DMEPOS	$25.81	$27.14	$28.05	$28.67	$26.86	$26.83	4
ESRD	$13.45	$10.26	$7.20	$9.50	$9.45	$6.23	-54
FQHC	$6.38	$6.45	$6.74	$3.84	$4.10	$5.48	-14
Home Health	$2.92	$2.89	$2.54	$3.13	$4.46	$5.49	88
Hospice	$0.85	$0.93	$0.68	$2.96	$1.73	$2.26	166
Hospital Total	$229.62	$283.72	$257.53	$271.74	$252.72	$257.93	12
Hospital-Inpatient	*$173.79*	*$222.14*	*$188.25*	*$199.92*	*$181.66*	*$179.30*	*3*
Hospital-Other	*-$0.74*	*-$0.92*	*-$0.23*	*-$0.15*	*-$0.05*	*$0.01*	*-101*
Hospital-Outpatient	*$56.56*	*$62.50*	*$69.50*	*$71.97*	*$71.12*	*$78.62*	*39*
Interpreter	--	$0.15	$0.00	$0.00	$0.00	$0.00	--
Laboratory	$1.91	$2.33	$2.16	$2.79	$2.77	$2.95	55
Nursing Facility	$1.02	$0.63	$1.44	$0.59	$0.99	$1.07	5
Other	$48.72	$34.21	$22.50	$21.54	$24.22	$23.52	-52
Physician & Other Practitioner	$104.48	$102.12	$102.78	$99.50	$97.20	$107.94	3
Prescription Drug	$150.61	$139.55	$152.18	$153.79	$150.23	$170.10	13
PRTF	$7.13	$16.17	$22.68	$9.93	$15.48	$23.70	233
Radiology-Mobile	$0.67	$0.72	$0.58	$0.37	$0.00	$0.00	-100
Rural Health Clinic	$2.51	$2.50	$2.59	$2.18	$2.25	$1.99	-21
Vision	$2.07	$1.98	$1.87	$1.95	$2.15	$1.99	-4
Total	**$682**	**$719**	**$696**	**$705**	**$686**	**$734**	**8**

Children

The Children PMPM cost was $249 in SFY 2014, an increase of 1.3 percent from SFY 2013.

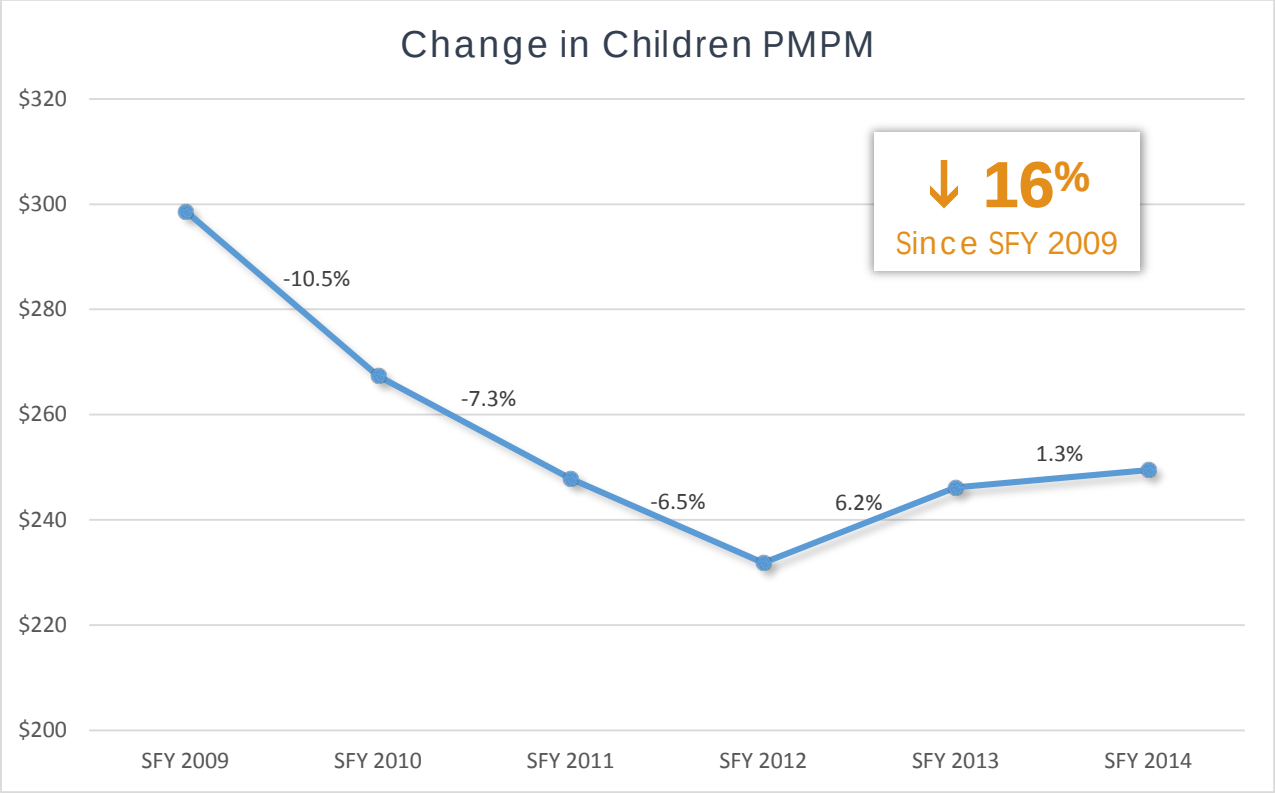


Figure 15: Change in Children PMPM

Table 25: Change in Children PMPM

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$139,791,781	$140,022,343	$133,693,710	$124,115,388	$130,944,627	$133,632,655	-4
Enrollment	51,014	54,674	56,226	56,115	55,849	54,417	7
Member Months	467,952	523,733	539,448	535,345	531,898	535,663	14
PMPM	**$299**	**$267**	**$248**	**$232**	**$246**	**$249**	**-16**

Table 26: Change in Children PMPM by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$4.09	$2.65	$2.34	$2.50	$2.39	$2.42	-41
Ambulatory Surgery Center	$5.74	$4.97	$4.14	$4.05	$5.15	$6.04	5
Behavioral Health	$25.21	$26.69	$27.84	$30.41	$32.39	$35.18	40
CORF	$0.03	$0.02	$0.04	$0.05	$0.04	$0.11	235
Dental	$19.32	$17.76	$17.98	$18.31	$18.25	$18.61	-4
DMEPOS	$1.55	$1.85	$1.73	$1.71	$2.07	$1.84	19
ESRD	--	$0.00	$0.06	$0.14	$0.11	$0.02	--
FQHC	$2.80	$2.58	$2.40	$1.52	$1.72	$1.96	-30
Home Health	$0.51	$0.26	$0.15	$0.19	$0.15	$0.22	-57
Hospice	--	$0.00	--	--	--	--	--
Hospital Total	$91.02	$79.04	$76.35	$71.42	$73.70	$68.12	-25
Hospital-Inpatient	*$74.52*	*$60.67*	*$57.48*	*$52.71*	*$54.78*	*$50.91*	*-32*
Hospital-Other	*-$0.34*	*-$0.23*	*-$0.12*	*-$0.04*	*$0.05*	*-$0.02*	*-95*
Hospital-Outpatient	*$16.84*	*$18.61*	*$18.99*	*$18.76*	*$18.87*	*$17.22*	*2*
Interpreter	$0.08	$0.07	$0.09	$0.08	$0.08	$0.07	-12
Laboratory	$0.43	$0.44	$0.48	$0.40	$0.40	$0.33	-24
Nursing Facility	--	--	$0.00	--	--	$0.00	--
Other	$42.31	$19.55	$9.25	$8.43	$8.79	$9.73	-77
Physician & Other Practitioner	$49.75	$47.65	$45.54	$45.04	$45.80	$45.07	-9
Prescription Drug	$32.45	$29.58	$29.79	$27.18	$26.79	$28.69	-12
PRTF	$16.03	$26.54	$21.89	$12.97	$20.56	$23.30	45
Radiology-Mobile	$0.08	$0.09	$0.08	$0.04	--	--	--
Rural Health Clinic	$2.03	$2.24	$2.41	$2.13	$2.20	$2.04	0
Vision	$5.28	$5.36	$5.27	$5.29	$5.60	$5.69	8
Total	**$299**	**$267**	**$248**	**$232**	**$246**	**$249**	**-16**

Family Care

The Family Care PMPM cost was $456 in SFY 2014, a decrease of 2.3 percent from SFY 2013.

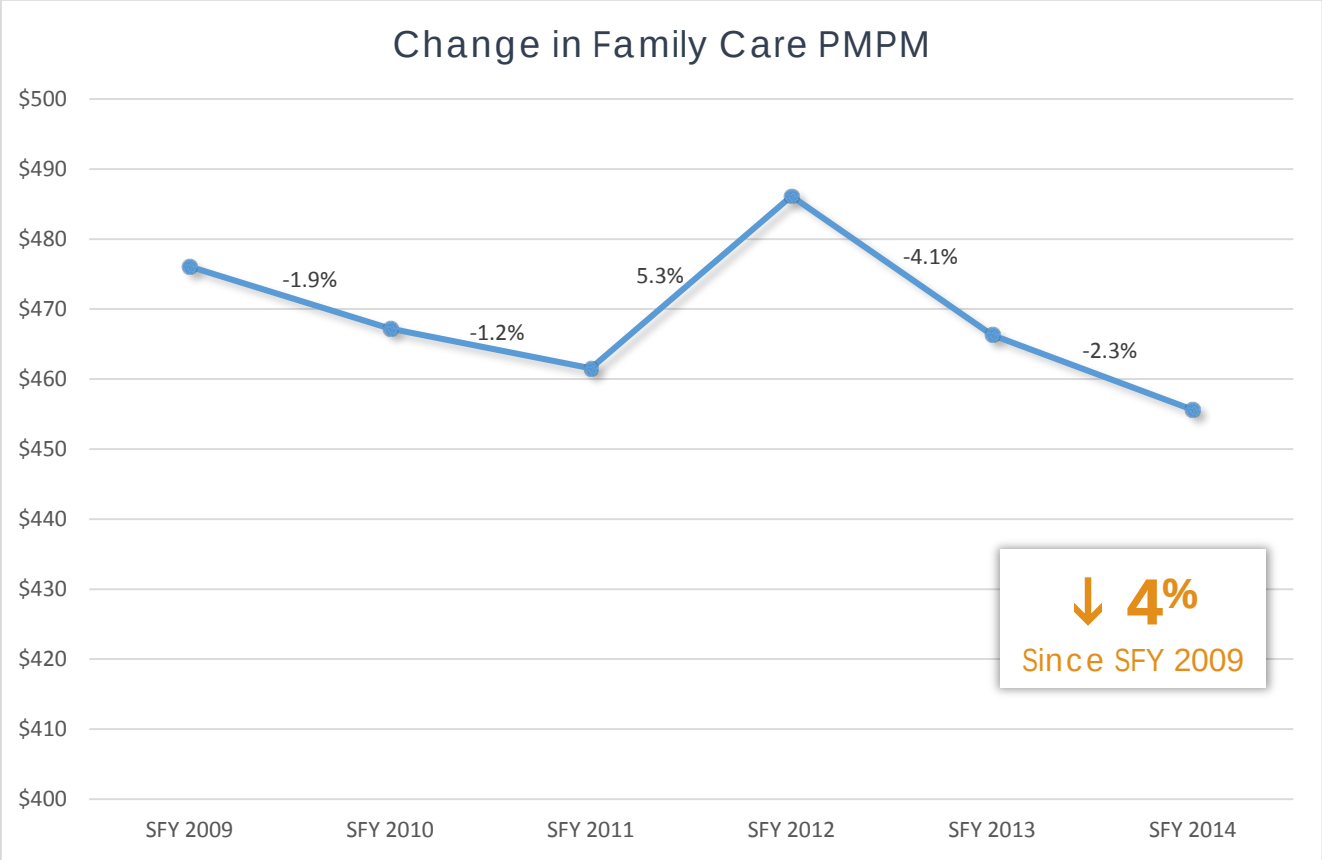


Figure 16: Change in Family Care PMPM

Table 27: Change in Family Care PMPM

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$25,863,961	$28,038,717	$28,924,529	$29,518,721	$27,447,400	$29,074,619	12
Enrollment	6,841	7,303	7,516	7,320	7,144	7,908	16
Member Months	54,329	60,011	62,669	60,722	58,861	63,814	17
PMPM	**$476**	**$467**	**$462**	**$486**	**$466**	**$456**	**-4**

Table 28: Change in Family Care PMPM by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$6.17	$4.88	$3.83	$5.78	$5.63	$5.91	-4
Ambulatory Surgery Center	$3.56	$3.25	$2.80	$3.16	$2.82	$2.99	-16
Behavioral Health	$20.53	$23.62	$21.57	$24.98	$28.52	$26.26	28
CORF	$0.32	$0.08	$0.31	$0.24	$0.59	$0.38	19
Dental	$17.84	$18.45	$20.44	$18.09	$19.34	$17.58	-1
DMEPOS	$5.67	$5.06	$6.32	$7.11	$8.65	$7.54	33
ESRD	$0.13	$3.50	$0.04	$0.42	$0.68	$1.55	1072
FQHC	$5.77	$5.80	$5.50	$3.59	$4.96	$5.66	-2
Home Health	$0.37	$0.42	$0.37	$0.37	$0.84	$0.61	68
Hospice	$0.15	$0.01	$0.13	$0.05	$0.10	$0.15	-1
Hospital Total	$195.19	$189.46	$198.36	$205.98	$186.54	$181.31	-7
Hospital-Inpatient	*$125.55*	*$109.14*	*$114.02*	*$119.61*	*$101.51*	*$99.32*	-21
Hospital-Other	*-$0.60*	*-$0.46*	*-$0.41*	*-$0.35*	*-$0.11*	*-$0.01*	-98
Hospital-Outpatient	*$70.24*	*$80.78*	*$84.75*	*$86.71*	*$85.14*	*$82.00*	17
Interpreter	--	--	--	--	--	--	--
Laboratory	$2.34	$3.48	$3.44	$4.10	$3.91	$4.22	80
Nursing Facility	--	--	--	--	--	--	--
Other	$29.27	$31.02	$27.85	$24.91	$26.41	$24.82	-15
Physician & Other Practitioner	$111.32	$108.55	$101.39	$110.54	$105.73	$102.87	-8
Prescription Drug	$72.65	$64.81	$64.37	$72.68	$67.90	$70.48	-3
PRTF	--	--	--	--	--	--	--
Radiology-Mobile	$0.67	$0.85	$0.95	$0.46	--	--	--
Rural Health Clinic	$3.20	$3.12	$3.09	$2.82	$2.93	$2.37	-26
Vision	$0.92	$0.87	$0.78	$0.84	$0.75	$0.91	-1
Total	**$476**	**$467**	**$462**	**$486**	**$466**	**$456**	**-4**

Medicare Savings Programs

The Medicare Savings Programs PMPM cost was $81 in SFY 2014, an increase of 9.5 percent from SFY 2013. This does not include the premium to buy individuals onto Medicare, a total of $14.1 million for SFY 2014.

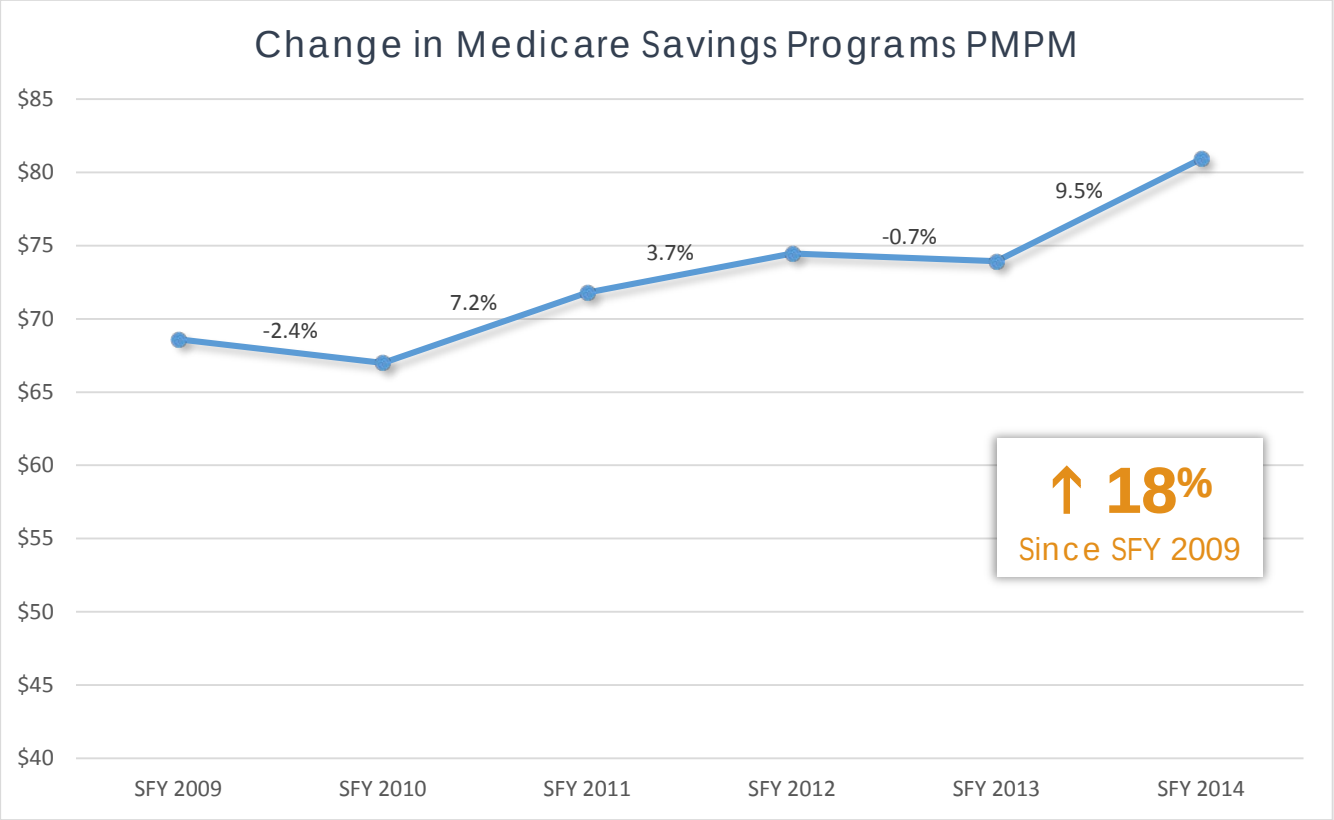


Figure 17: Change in Medicare Savings Programs PMPM

Table 29: Change in Medicare Savings Programs PMPM

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$2,388,285	$2,495,617	$3,006,118	$3,397,000	$3,570,722	$4,208,167	76
Enrollment	6,841	7,303	7,516	7,320	7,144	7,908	16
Member Months	34,811	37,253	41,873	45,623	48,297	52,004	49
PMPM	**$69**	**$67**	**$72**	**$74**	**$74**	**$81**	**18**

Table 30: Change in Medicare Savings Programs PMPM by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 year % change
Ambulance	$0.79	$1.01	$1.01	$1.18	$1.15	$2.42	206
Ambulatory Surgery Center	$1.06	$0.76	$1.04	$1.18	$0.98	$1.14	7
Behavioral Health	$1.88	$1.91	$2.28	$2.09	$2.27	$2.05	9
CORF	$0.02	$0.03	$0.08	$0.13	$0.11	$0.10	421
Dental	--	--	$0.00	--	--	--	--
DMEPOS	$5.83	$5.44	$5.19	$5.35	$4.79	$4.84	-17
ESRD	$0.86	$1.16	$1.30	$1.55	$1.48	$1.69	96
FQHC	$0.41	$0.53	$0.62	$0.28	$0.43	$0.44	6
Home Health	--	$0.00	$0.00	--	--	--	--
Hospice	$0.00	--	$0.00	$0.00	$0.00	$0.00	--
Hospital Total	$33.57	$33.71	$35.91	$37.00	$38.28	$41.97	25
Hospital-Inpatient	*$15.17*	*$13.70*	*$13.64*	*$13.54*	*$12.55*	*$14.37*	*-5*
Hospital-Other	*-$0.53*	*-$0.32*	*-$0.22*	*-$0.08*	*-$0.13*	*-$0.01*	*-98*
Hospital-Outpatient	*$18.92*	*$20.32*	*$22.49*	*$23.54*	*$25.86*	*$27.61*	*46*
Interpreter	--	--	--	--	--	--	--
Laboratory	$0.15	$0.12	$0.17	$0.21	$0.10	$0.13	-11
Nursing Facility	$2.33	$1.02	$1.68	$2.60	$1.54	$1.90	-19
Other	$1.28	$1.41	$1.38	$1.29	$1.12	$1.08	-16
Physician & Other Practitioner	$19.04	$18.69	$19.90	$20.38	$20.62	$22.22	17
Prescription Drug	--	--	--	--	--	--	--
PRTF	--	--	--	--	--	--	--
Radiology-Mobile	$0.16	$0.13	$0.14	$0.16	$0.00	$0.00	--
Rural Health Clinic	$0.76	$0.66	$0.69	$0.65	$0.67	$0.51	-34
Vision	$0.44	$0.40	$0.40	$0.41	$0.39	$0.44	0
Total	**$69**	**$67**	**$72**	**$74**	**$74**	**$81**	**18**

Non-Citizens with Medical Emergencies

The Non-Citizens with Medical Emergencies PMPM cost was $218 in SFY 2014, a decrease of 7.8 percent from SFY 2013.

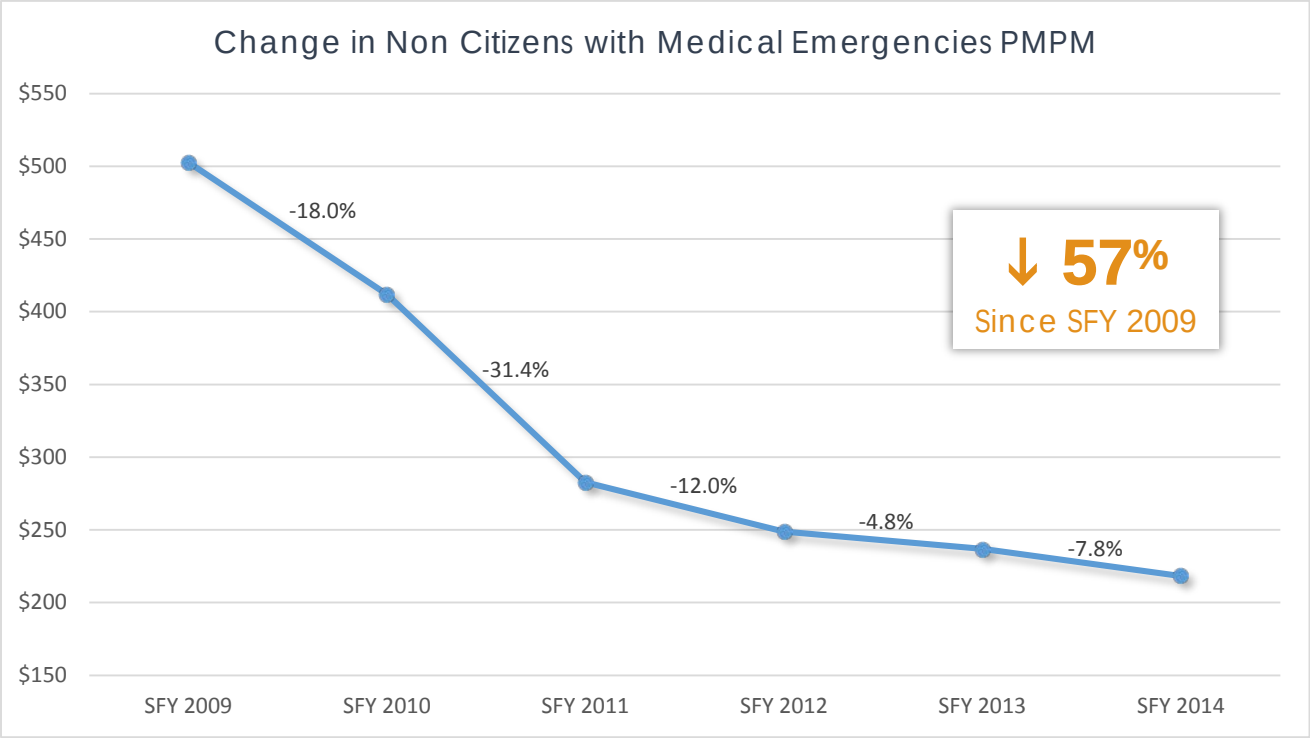


Figure 18: Change in Non-Citizens with Medical Emergencies PMPM

Table 31: Change in Non-Citizens with Medical Emergencies PMPM

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$2,123,533	$2,206,717	$1,906,178	$1,994,024	$1,825,694	$1,480,837	-30
Enrollment	1,128	1,115	1,065	1,060	1,001	877	-22
Member Months	4,225	5,357	6,742	8,012	7,706	6,782	61
PMPM	**$503**	**$412**	**$283**	**$249**	**$237**	**$218**	**-57**

Table 32: Change in Non-Citizens with Medical Emergencies by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$10.79	$4.10	$7.19	$2.84	$5.66	$8.91	-17
Ambulatory Surgery Center	$0.20	--	$0.10	$0.08	--	$0.04	-78
Behavioral Health	--	--	--	--	--	--	--
CORF	--	--	--	--	--	--	--
Dental	--	--	--	--	--	--	--
DMEPOS	--	--	--	--	--	--	--
ESRD	--	--	--	--	--	--	--
FQHC	--	$0.06	$0.06	--	$0.06	--	--
Home Health	--	--	--	--	--	--	--
Hospice	--	--	--	--	--	--	--
Hospital Total	$302.42	$271.26	$180.52	$165.94	$159.50	$160.15	-47
Hospital-Inpatient	*$290.79*	*$264.17*	*$171.12*	*$156.60*	*$149.65*	*$153.43*	*-47*
Hospital-Other	*--*	*-$2.53*	*--*	*--*	*--*	*--*	*--*
Hospital-Outpatient	*$11.63*	*$9.62*	*$9.40*	*$9.34*	*$9.85*	*$6.72*	*-42*
Interpreter	$0.08	--	--	$0.01	--	--	--
Laboratory	$0.45	$0.12	$0.23	$0.64	$0.69	$0.02	-95
Nursing Facility	--	--	--	--	--	--	--
Other	$0.14	$0.02	$0.02	$0.01	--	--	--
Physician & Other Practitioner	$188.49	$136.23	$94.47	$79.31	$70.97	$49.19	-74
Prescription Drug	--	--	--	--	--	--	--
PRTF	--	--	--	--	--	--	--
Radiology-Mobile	--	--	--	--	--	--	--
Rural Health Clinic	$0.04	$0.14	$0.15	$0.04	$0.03	$0.04	15
Vision	--	--	--	--	--	--	--
Total	**$503**	**$412**	**$283**	**$249**	**$237**	**$218**	**-57**

Pregnant Women

The Pregnant Women PMPM cost was $908 in SFY 2014, a decrease of 13.1 percent from SFY 2013.

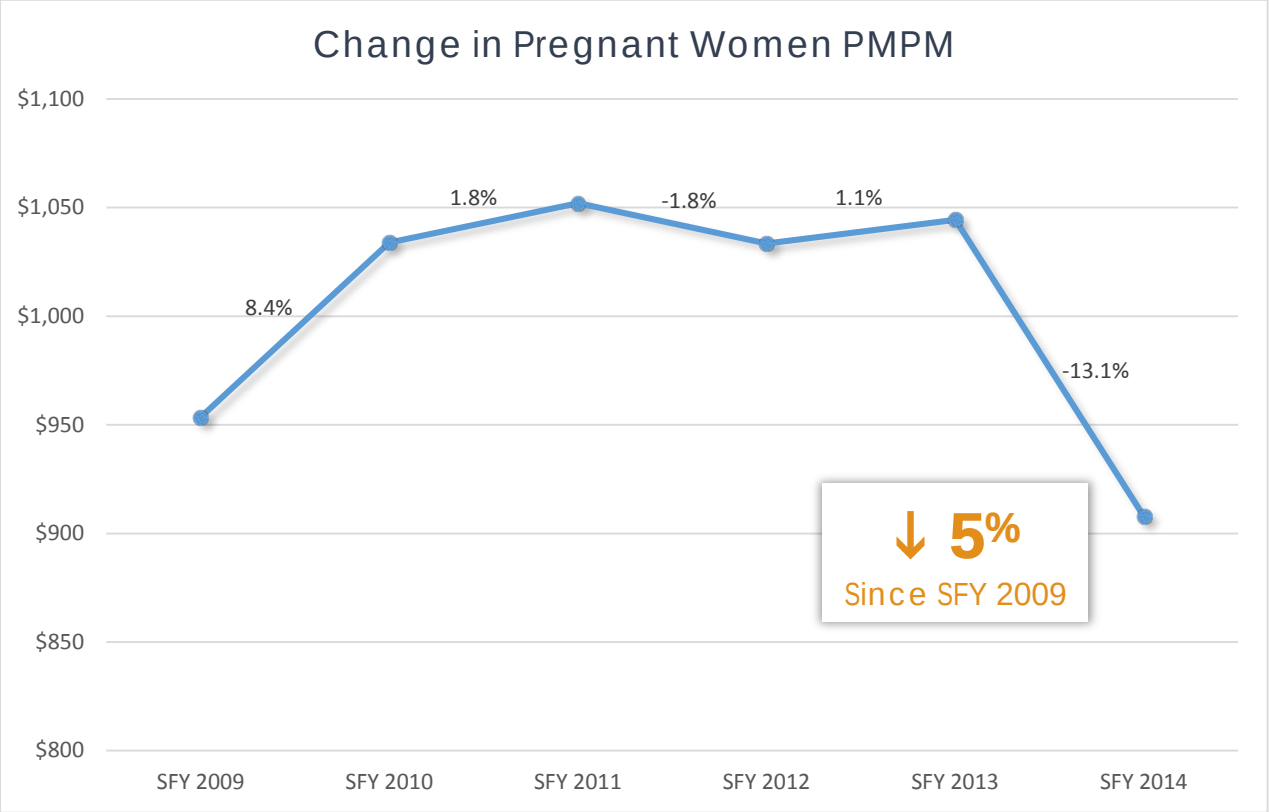


Figure 19: Change in Pregnant Women PMPM

Table 33: Change in Pregnant Women PMPM

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$31,586,015	$35,942,177	$35,524,089	$32,056,858	$31,599,652	$27,541,779	-13
Enrollment	4,914	4,622	4,542	4,362	4,359	3,973	-19
Member Months	33,128	34,763	33,767	31,018	30,255	30,338	-8
PMPM	**$953**	**$1,034**	**$1,052**	**$1,033**	**$1,044**	**$908**	**-5**

Table 34: Change in Pregnant Women PMPM by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$24.24	$17.16	$16.37	$18.47	$18.16	$13.44	-45
Ambulatory Surgery Center	$0.79	$0.60	$0.70	$0.66	$0.43	$0.65	-18
Behavioral Health	$9.15	$7.89	$7.98	$10.21	$9.56	$11.20	22
CORF	$0.01	$0.06	$0.04	$0.01	$0.02	$0.11	695
Dental	$11.29	$13.26	$14.97	$12.86	$14.24	$12.57	11
DMEPOS	$0.70	$2.16	$1.33	$1.97	$1.43	$1.98	182
ESRD	--	--	--	--	--	--	--
FQHC	$14.49	$12.47	$11.74	$4.60	$12.67	$18.89	30
Home Health	$0.82	$0.50	$0.54	$0.46	$0.73	$0.38	-54
Hospice	--	--	--	--	--	--	--
Hospital Total	$410.39	$475.54	$491.46	$491.62	$494.60	$450.08	10
Hospital-Inpatient	*$329.08*	*$397.53*	*$410.24*	*$409.77*	*$408.36*	*$375.89*	*14*
Hospital-Other	*-$0.28*	*-$0.09*	*-$0.21*	*-$0.68*	*-$0.69*	*-$0.10*	*-64*
Hospital-Outpatient	*$81.59*	*$78.10*	*$81.43*	*$82.53*	*$86.94*	*$74.29*	*-9*
Interpreter	$0.01	$0.00	--	--	--	$0.04	328
Laboratory	$8.79	$11.00	$10.87	$11.10	$12.52	$13.82	57
Nursing Facility	$0.01	--	--	--	--	--	--
Other	$12.79	$17.14	$20.11	$21.32	$19.92	$24.44	91
Physician & Other Practitioner	$430.50	$444.57	$449.64	$432.22	$430.74	$329.34	-23
Prescription Drug	$26.56	$28.51	$23.56	$25.43	$26.69	$27.61	4
PRTF	--	--	--	--	--	--	--
Radiology-Mobile	$0.22	$0.17	$0.15	$0.07	--	--	--
Rural Health Clinic	$0.99	$0.88	$1.06	$0.97	$1.21	$1.85	87
Vision	$1.69	$2.00	$1.51	$1.53	$1.53	$1.43	-15
Total	**$953**	**$1,034**	**$1,052**	**$1,033**	**$1,044**	**$908**	**-5**

Special Groups

The Special Groups PMPM cost was $429 in SFY 2014, a decrease of 13.1 percent from SFY 2013.

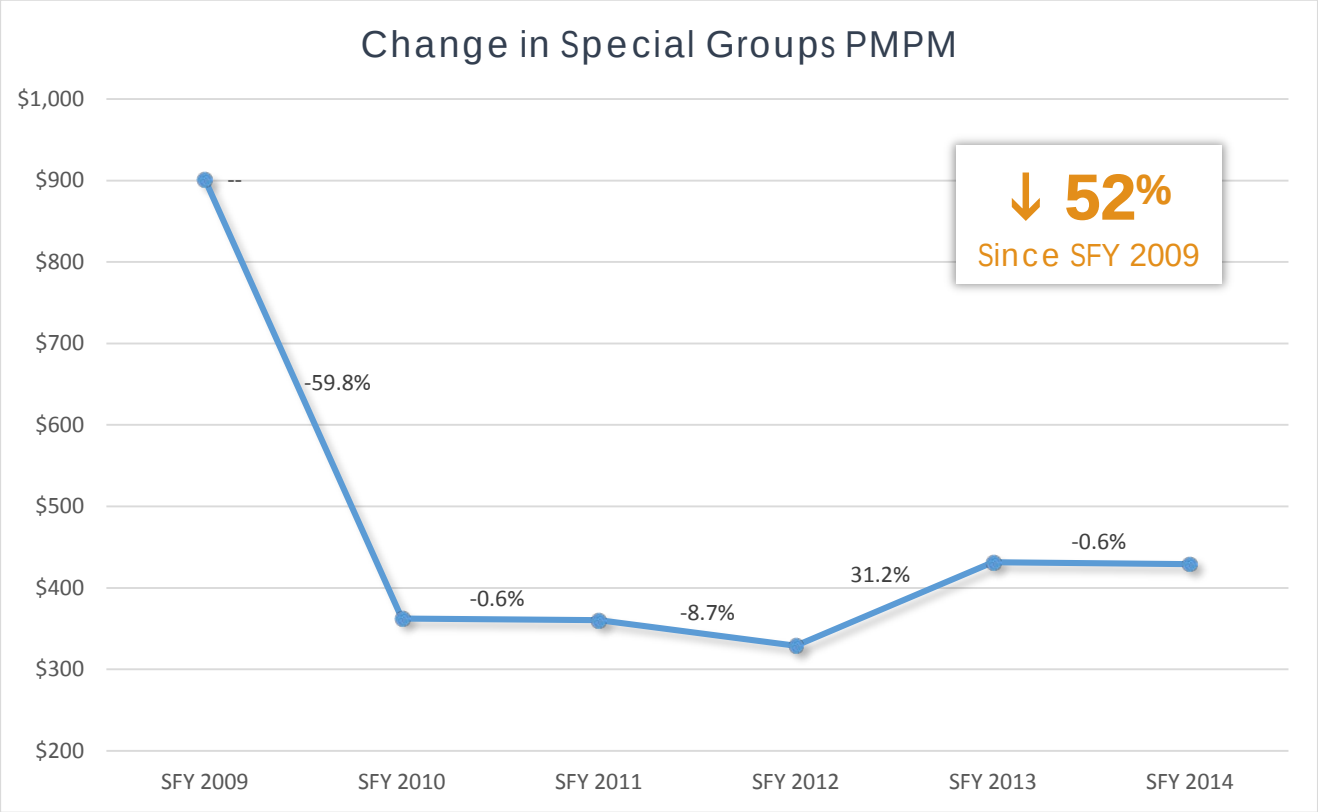


Figure 20: Change in Special Groups PMPM

Table 35: Change in Special Groups PMPM

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$2,010,134	$2,475,418	$3,722,978	$3,795,041	$4,709,710	$4,088,679	103
Enrollment	424	931	1,283	1,354	1,249	946	123
Member Months	2,230	6,828	10,333	11,539	10,911	9,527	327
PMPM	**$901**	**$363**	**$360**	**$329**	**$432**	**$429**	**-52**

Table 36: Change in Special Groups PMPM by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$3.63	$1.44	$0.82	$1.40	$1.19	$4.40	21
Ambulatory Surgery Center	$7.07	$1.19	$2.01	$1.47	$0.72	$1.44	-80
Behavioral Health	$9.03	$2.91	$3.34	$4.87	$6.20	$4.44	-51
CORF	--	--	$0.12	$0.00	--	$0.15	--
Dental	$9.42	$3.16	$3.10	$5.91	$2.77	$2.69	-71
DMEPOS	$12.47	$2.43	$2.31	$2.44	$2.86	$4.14	-67
ESRD	--	--	--	--	--	--	--
FQHC	$9.33	$2.45	$2.02	$1.11	$1.49	$1.42	-85
Home Health	$2.18	$0.61	$0.31	$0.35	$0.97	$1.06	-51
Hospice	--	$0.97	$1.46	$1.92	$3.05	$4.96	--
Hospital Total	$267.45	$142.02	$170.00	$121.99	$203.82	$173.05	-35
Hospital-Inpatient	*$142.07*	*$67.15*	*$77.71*	*$60.65*	*$80.73*	*$65.45*	*-54*
Hospital-Other	*-$4.07*	*-$0.01*	*-$1.87*	*-$0.15*	*$0.16*	*$0.45*	*-111*
Hospital-Outpatient	*$129.45*	*$74.88*	*$94.16*	*$61.49*	*$122.93*	*$107.16*	*-17*
Interpreter	--	--	--	--	--	--	--
Laboratory	$4.92	$5.81	$5.09	$5.24	$4.12	$4.19	-15
Nursing Facility	--	--	--	--	--	--	--
Other	$14.90	$7.67	$5.83	$6.26	$6.71	$9.59	-36
Physician & Other Practitioner	$395.14	$137.68	$122.51	$139.29	$156.13	$172.63	-56
Prescription Drug	$153.14	$50.14	$39.70	$35.19	$41.04	$44.34	-71
PRTF	--	--	--	--	--	--	--
Radiology-Mobile	$9.22	$2.99	$0.91	$0.70	--	--	--
Rural Health Clinic	$2.14	$0.89	$0.54	$0.41	$0.29	$0.39	-82
Vision	$1.35	$0.17	$0.23	$0.34	$0.28	$0.28	-79
Total	**$901**	**$363**	**$360**	**$329**	**$432**	**$429**	**-52**

Service Areas

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 C.

Service Areas – Overview

Wyoming Medicaid covers the following mandatory and optional services.

Table 37: Mandatory and Optional Services

Mandatory Services	Optional Services
Certified pediatric nurse practitioner or family nurse practitioner	Dental[11]
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)[12]	Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
Family planning and supplies	End Stage Renal Disease (ESRD)
Federally Qualified Health Center (FQHC)	Intermediate Care Facility for the Intellectually Disabled (ICF-ID)
Home health	Interpreter
Inpatient and outpatient hospital	Mental health and substance abuse
Laboratory and x-ray	Prescription Drug
Nurse-midwife	Psychiatric Residential Treatment Facility (PRTF)
Nursing facility	Targeted case management
Physician	Vision[13]
Rural Health Clinic	Waivers
Transportation[14]	

Provider types and procedure codes have been used to define the following 22 service areas to be explained in further detail in this report.

Table 38: Service Areas

Service Areas		
Ambulance	Ambulatory Surgery Center (ASC)	Behavioral Health[15]
Comprehensive Outpatient Rehabilitation Facility (CORF)	Dental	Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS)
End Stage Renal Disease (ESRD)	Federally Qualified Health Centers (FQHC)	Home Health
Hospice	Hospital	Interpreter
Laboratory	Nursing Facility[16]	Other[17]
Physician & Other Practitioner	Prescription Drug	Psychiatric Residential Treatment Facility (PRTF)
Radiology-Mobile	Rural Health Clinic	Vision
Waivers[18]		

[11] Dental services are mandatory for children under age 21, but optional for adults.
[12] Medicaid's EPSDT services are operated under the Health Check program.
[13] Vision services are mandatory for children under age 21, but optional for adults.
[14] Transportation services are not a mandatory service, but states are required to ensure necessary transportation to providers.
[15] Excludes the Children's Mental Health Waiver and Psychiatric Residential Treatment Facility.
[16] Excludes the Long-Term Care and Assisted Living Facility Waivers.
[17] The Other service area is comprised of services that fall outside the criteria ranges used for this report
[18] Excludes the Pregnant by Choice Waiver.

Table 39: Service Area Summary

Service Area	Expenditures	Percent Change from SFY2013	Recipients[19]	Percent Change from SFY2013	Expenditures per Recipient	Percent Change from SFY2013	Per Member Per Month (PMPM)	Percent Change from SFY2013
Ambulance	$3,760,537	4.3	3,531	2.8	$1,065	1.4	$4.48	6.4
ASC	$4,039,944	17.5	3,400	4.3	$1,188	12.6	$4.88	19.9
Behavioral Health	$31,995,615	7.6	13,838	5.6	$2,312	1.9	$37.34	9.8
CORF	$143,525	18.0	225	0.0	$638	18.0	$0.18	20.4
Dental	$13,391,934	0.9	29,185	2.3	$459	-1.3	$15.93	3.0
DMEPOS	$7,627,734	-1.3	7,138	-3.1	$1,069	1.8	$8.98	0.7
ESRD	$1,071,750	-20.2	108	-1.8	$9,924	-18.8	$1.21	-18.6
FQHC	$2,698,283	33.7	4,038	11.8	$668	19.6	$3.02	36.4
Home Health	$3,533,728	22.0	590	-0.2	$5,989	22.2	$4.12	24.5
Hospice	$1,468,295	35.7	252	40.8	$5,827	-3.6	$1.50	38.4
Hospital Total	$101,931,277	-6.3	40,120	-6.0	$2,541	-0.4	$119.98	-4.4
Hospital-Inpatient	*$72,932,440*	*-7.0*	*10,324*	*-5.9*	*$7,064*	*-1.2*	*$85.61*	*-5.2*
Hospital-Other	*$295,690*	*57.7*	*194*	*36.6*	*$1,524*	*15.5*	*($0.01)*	*61.0*
Hospital-Outpatient	*$28,703,147*	*-4.9*	*37,704*	*-6.1*	*$761*	*1.3*	*$34.38*	*-3.0*
Interpreter	$38,171	-12.3	389	0.0	$98	-12.3	$0.05	-10.5
Laboratory	$1,284,678	11.8	9,507	-2.3	$135	14.3	$1.41	14.0
Nursing Facility	$72,866,933	-1.0	2,400	-1.9	$30,361	1.0	$85.34	1.0
Other	$30,911,249	8.0	11,421	-9.5	$2,707	19.3	$36.33	10.2
Physician & Other Practitioner	$61,053,011	-0.8	65,224	6.3	$936	-6.7	$70.83	1.2
Prescription Drug	$41,238,663	5.4	44,467	-6.6	$927	12.9	$49.37	7.6
PRTF	$14,906,432	23.7	335	6.0	$44,497	16.7	$17.63	26.2
Radiology-Mobile	$226	-94.5	20	-45.9	$11	-89.8	$0.00	-94.4
RHC	$1,521,233	-17.6	4,676	-13.7	$325	-4.5	$1.90	-15.9
Vision	$3,514,674	2.3	15,123	2.9	$232	-0.6	$4.11	4.4
Waiver Total	$118,624,631	-2.6	4,168	-0.9	$28,461	-1.7	$139.63	-0.6
Waiver-ABI	*$7,371,614*	*-4.0*	*181*	*-2.7*	*$40,727*	*-1.4*	*$8.67*	*-2.1*
Waiver-Adult DD	*$83,501,095*	*-0.8*	*1,409*	*1.0*	*$59,263*	*-1.8*	*$97.71*	*1.2*
Waiver-ALF	*$2,593,984*	*5.8*	*194*	*2.1*	*$13,371*	*3.6*	*$3.08*	*8.0*
Waiver-Child DD	*$11,415,264*	*-14.2*	*699*	*-8.1*	*$16,331*	*-6.6*	*$13.43*	*-12.4*
Waiver-Child Mental Health	*$527,514*	*-23.4*	*57*	*-30.5*	*$9,255*	*10.1*	*$0.68*	*-21.9*
Waiver-Comprehensive	*$44,982*	*--*	*3*	*--*	*--*	*--*	*$0.25*	*--*
Waiver-LTC	*$13,169,724*	*-1.9*	*1,700*	*1.6*	*$7,747*	*-3.4*	*$15.81*	*0.1*
Waiver-Supports	*$454*	*--*	*0*	*--*	*--*	*--*	*$0.00*	*--*
Total	**$517,622,524**	**0.1**	**76,341**	**0.1**	**$6,780**	**0.0**	**$608**	**2.1**

[19] The table displays a distinct count of recipients for each service area, as well as the total distinct count of recipients. Summing the recipients for each service area will not match the total recipients, because individuals may receive services from multiple service areas.

Total expenditures for all Medicaid services increased four percent from SFY 2013 to $517,622,524.

The top service areas based on expenditures in SFY2014 are Waivers, Hospital, Nursing Facility and Physician & Other Practitioner.

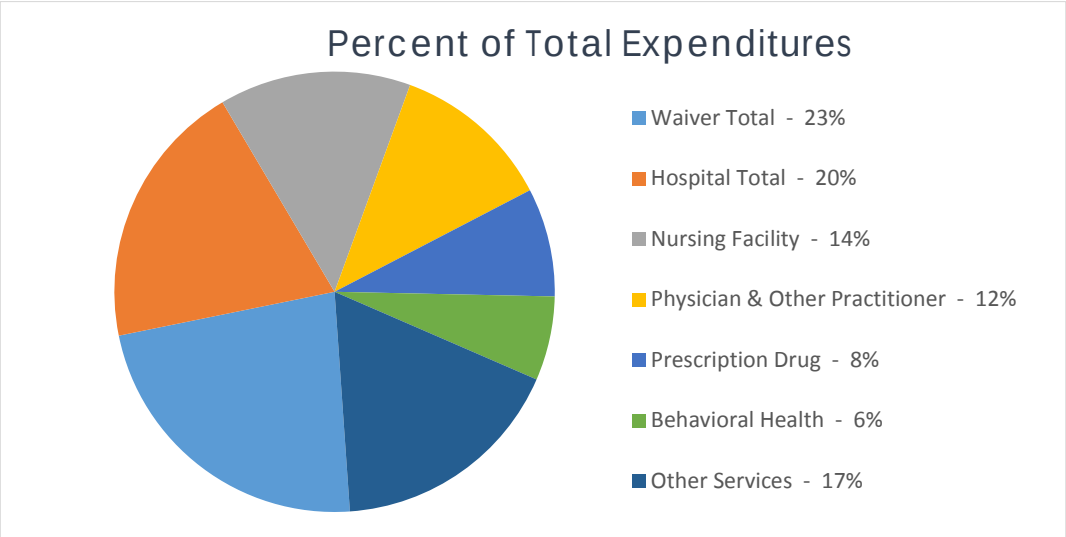


Figure 21: Percent of Total Expenditures by Service Area

Total unique recipient count for all Medicaid services remained relatively stable, increasing by 0.1 percent from the previous year to 76,341 individuals.

The top service areas based on recipient count in SFY 2014 were Physician & Other Practitioner, Prescription Drug, Hospital and Dental.

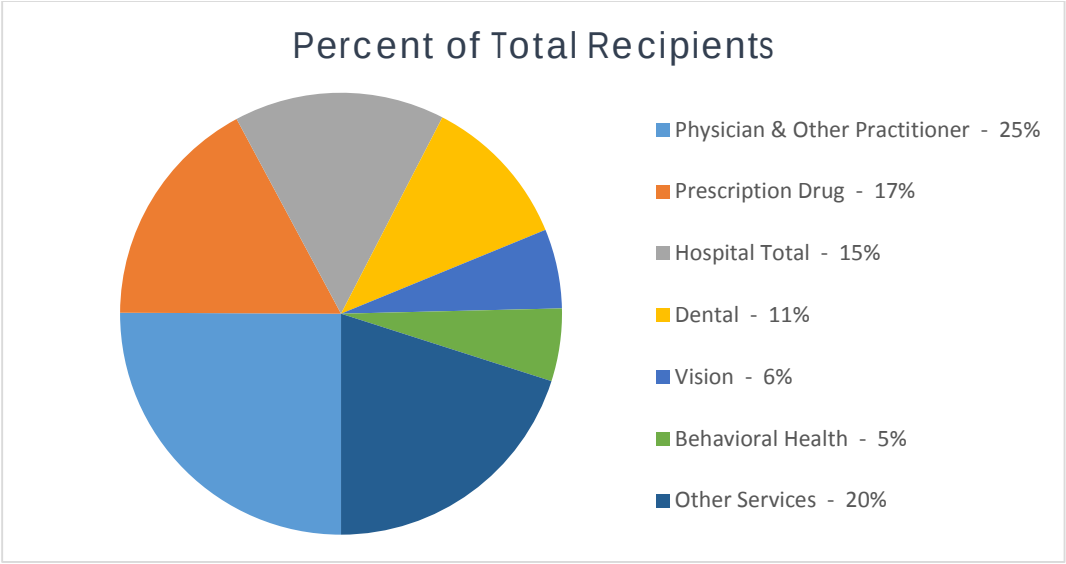


Figure 22: Percent of Total Recipients[20] by Service Area

[20] Total recipients for this chart includes duplicates across services to account for those recipients who received multiple services during the SFY.

Table 40: Change in Expenditures by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$4,327,795	$3,807,538	$3,303,240	$3,459,400	$3,606,360	$3,760,537	-13
ASC	$3,497,383	$3,315,928	$2,912,791	$2,822,957	$3,439,188	$4,039,944	16
Behavioral Health	$21,088,922	$24,579,989	$26,444,878	$27,553,867	$29,734,932	$31,995,615	52
CORF	$59,613	$36,757	$56,646	$125,928	$121,618	$143,525	141
Dental	$12,062,946	$12,864,308	$13,616,583	$13,561,177	$13,272,110	$13,391,934	11
DMEPOS	$6,358,280	$6,605,716	$7,505,683	$7,270,213	$7,730,289	$7,627,734	20
ESRD	$1,347,305	$1,160,798	$835,621	$1,233,755	$1,343,669	$1,071,750	-20
FQHC	$4,113,634	$2,864,956	$3,103,164	$1,550,274	$2,018,911	$2,698,283	-34
Home Health	$1,998,695	$1,941,097	$2,732,905	$2,963,510	$2,897,016	$3,533,728	77
Hospice	$939,603	$1,432,471	$1,036,887	$983,026	$1,082,188	$1,468,295	56
Hospital Total	$102,369,413	$113,636,933	$114,358,067	$105,798,987	$108,839,452	$101,931,277	0
Hospital-Inpatient	*$79,509,583*	*$87,297,343*	*$84,557,214*	*$77,130,425*	*$78,462,603*	*$72,932,440*	*-8*
Hospital-Other	*$-93,803*	*$79,286*	*$108,775*	*$11,189*	*$187,458*	*$295,690*	*-415*
Hospital-Outpatient	*$22,953,633*	*$26,260,304*	*$29,692,078*	*$28,657,373*	*$30,189,391*	*$28,703,147*	*25*
Interpreter	$49,399	$47,837	$54,259	$48,321	$43,529	$38,171	-23
Laboratory	$852,797	$1,121,964	$1,171,185	$1,100,774	$1,149,473	$1,284,678	51
Nursing Facility	$73,188,663	$75,434,811	$73,180,333	$73,805,803	$73,593,462	$72,866,933	0
Other	$37,163,264	$29,351,508	$23,158,723	$19,883,226	$28,622,127	$30,911,249	-17
Physician & Other Practitioner	$60,027,144	$64,036,069	$63,918,782	$61,576,270	$61,564,892	$61,053,011	2
Prescription Drug	$39,302,672	$38,870,852	$41,352,500	$41,914,658	$39,110,022	$41,238,663	5
PRTF	$8,297,310	$14,928,300	$15,384,914	$7,984,857	$12,050,809	$14,906,432	80
Radiology-Mobile	$191,239	$222,281	$217,463	$109,250	$4,081	$226	-100
RHC	$1,515,936	$1,710,855	$1,940,640	$1,628,043	$1,845,491	$1,521,233	0
Vision	$2,925,372	$3,233,037	$3,269,685	$3,228,994	$3,434,854	$3,514,674	20
Waiver Total	$116,647,784	$113,325,317	$120,049,329	$122,327,742	$121,752,688	$118,624,631	2
Waiver-ABI	*$6,058,440*	*$6,243,946*	*$6,963,271*	*$6,925,596*	*$7,679,811*	*$7,371,614*	*22*
Waiver-Adult DD	*$81,815,516*	*$75,746,359*	*$81,369,215*	*$84,846,084*	*$84,204,861*	*$83,501,095*	*2*
Waiver-ALF	*$2,156,841*	*$3,058,800*	*$2,757,617*	*$2,612,026*	*$2,451,875*	*$2,593,984*	*20*
Waiver-Child DD	*$14,451,370*	*$14,460,017*	*$14,128,741*	*$13,646,013*	*$13,301,942*	*$11,415,264*	*-21*
Waiver-Child Mental Health	*$76,778*	*$391,862*	*$918,455*	*$942,386*	*$688,995*	*$527,514*	*587*
Waiver-Comprehensive	--	--	--	--	--	*$44,982*	--
Waiver-LTC	*$12,088,839*	*$13,424,332*	*$13,912,032*	*$13,355,638*	*$13,425,205*	*$13,169,724*	*9*
Waiver-Supports	--	--	--	--	--	*$454*	--
Total	**$498,325,166**	**$514,529,323**	**$519,604,279**	**$500,931,031**	**$517,257,164**	**$517,622,524**	**4**

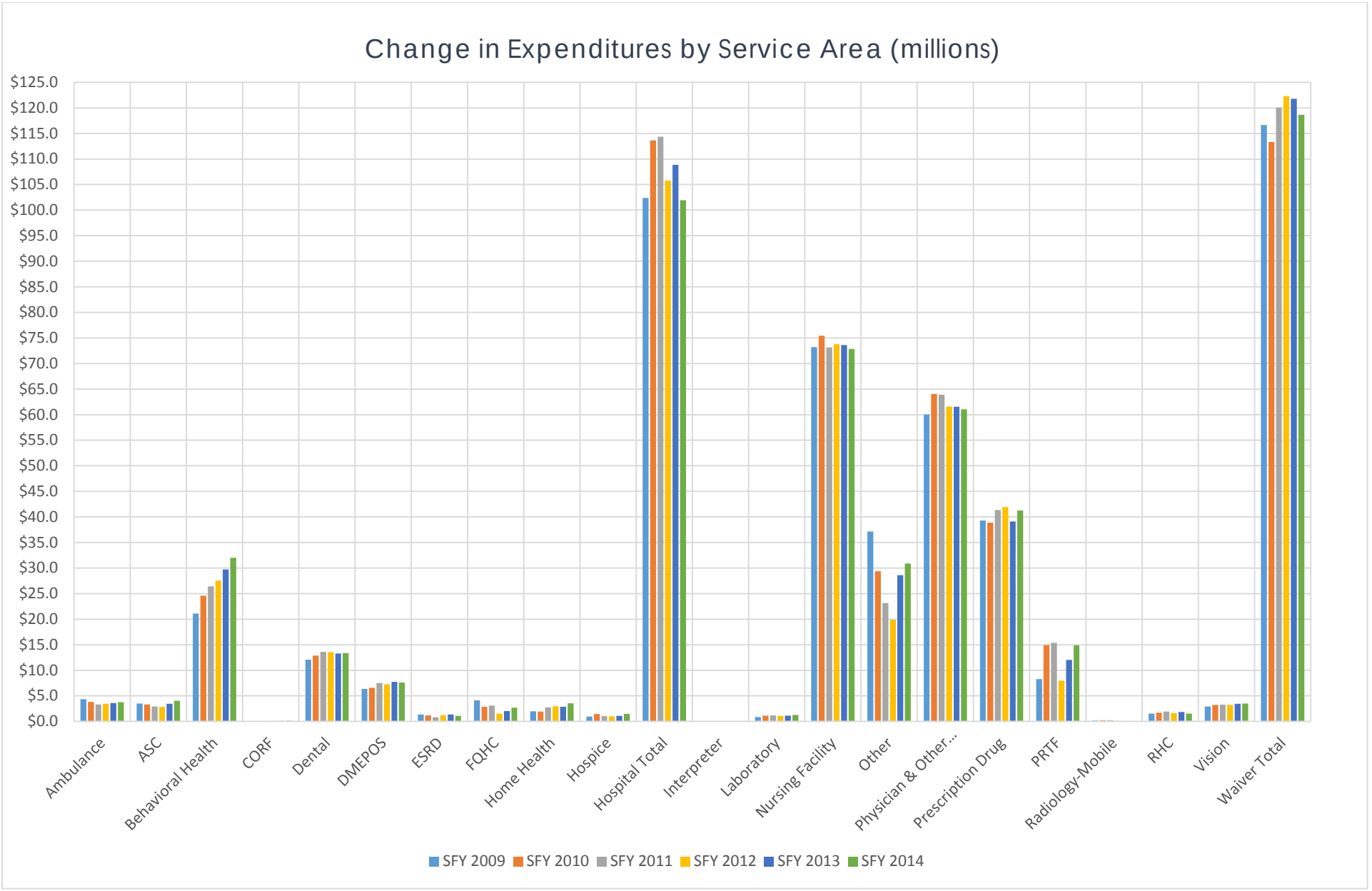


Figure 23: Change in Expenditures by Service Area (millions)

Table 41: Change in Expenditures by Other[21] Service Areas

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulatory Family Planning Facility	$100,239	$103,949	$83,744	$81,564	$68,988	$71,213	-29.0
Case Management	$161,428	$331,855	$299,617	$219,942	$196,574	$109,200	-32.4
Chiropractor	$6,746	$5,874	$6,102	$7,349	$7,500	$5,661	-16.1
Clinic/Center	$1,018,213	$1,319,195	$1,478,958	$1,171,841	$1,152,753	$1,263,963	24.1
Day Training, Developmentally Disabled Service	$45,196	$64,723	$222,425	$54,478	$61,326	$72,487	60.4
Intermediate Care Facility, Mentally Retarded[22]	$9,159,786	$10,651,941	$11,388,412	$10,065,657	$17,942,326	$19,152,530	109.1
Non-Medicaid Provider (Mail Only)	$1,938	--	--	--	--	--	--
PACE Organization	--	--	--	--	$168,398	$1,288,934	--
Phlebotomy/WY Health Fair	$21,915	$3,520	$3,820	$5,910	$2,635	$5,870	-73.2
Psychiatric Residential Treatment Facility (PRTF)	$28,004	-$269,570	-$140,302	$34,260	$29,684	-$20,299	-172.5
Public Health or Welfare	$1,005,083	$1,081,591	$1,093,398	$988,455	$924,007	$962,164	-4.3
Public Health, Federal	$6,861,407	$7,700,047	$8,532,271	$7,240,130	$8,067,975	$7,999,556	16.6
Residential Treatment Facility for Emotionally	$18,753,308	$8,358,382	$190,279	$13,640	--	--	--
Unknown	--	--	--	--	-$39	-$30	--
Total	**$37,163,264**	**$29,351,508**	**$23,158,723**	**$19,883,226**	**$28,622,127**	**$30,911,249**	**-16.8**

[21] This table shows services that fall outside the criteria ranges used to define other service areas for this report. These are defined by provider taxonomy.
[22] The increase for Intermediate Care Facility, Mentally Retarded over this five-year span is partially due to a change in the way the federal funds are reported.

Table 42: Change in Recipient Count[23] by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	3,522	3,351	3,613	3,604	3,435	3,531	0
ASC	3,217	3,075	3,151	3,088	3,259	3,400	6
Behavioral Health	10,488	12,022	12,842	12,946	13,101	13,838	32
CORF	83	81	146	222	225	225	171
Dental	23,341	26,482	28,173	28,594	28,535	29,185	25
DMEPOS	6,716	7,443	7,502	7,245	7,366	7,138	6
ESRD	72	83	86	98	110	108	50
FQHC	4,532	4,109	4,834	2,722	3,613	4,038	-11
Home Health	552	587	623	582	591	590	7
Hospice	115	147	150	135	179	252	119
Hospital Total	42,721	43,681	42,525	44,108	42,675	40,120	-6
Hospital-Inpatient	*12,041*	*12,277*	*11,640*	*10,891*	*10,972*	*10,324*	*-14*
Hospital-Other	*217*	*213*	*91*	*104*	*142*	*194*	*-11*
Hospital-Outpatient	*40,159*	*40,823*	*39,757*	*41,773*	*40,156*	*37,704*	*-6*
Interpreter	407	384	420	406	389	389	-4
Laboratory	9,278	9,852	9,923	9,415	9,726	9,507	2
Nursing Facility	2,478	2,609	2,444	2,410	2,447	2,400	-3
Other	13,076	12,733	14,474	12,107	12,619	11,421	-13
Physician & Other Practitioner	60,096	63,451	64,739	63,494	61,359	65,224	9
Prescription Drug	45,465	49,041	50,118	48,223	47,610	44,467	-2
PRTF	210	423	391	264	316	335	60
Radiology-Mobile	485	505	555	486	37	20	-96
RHC	4,400	4,670	5,277	4,174	5,420	4,676	6
Vision	12,911	14,324	14,676	14,428	14,694	15,123	17
Waiver Total	4,066	4,382	4,413	4,302	4,207	4,168	3
Waiver-ABI	*161*	*192*	*177*	*188*	*186*	*181*	*12*
Waiver-Adult DD	*1,301*	*1,336*	*1,355*	*1,380*	*1,395*	*1,409*	*8*
Waiver-ALF	*210*	*236*	*217*	*201*	*190*	*194*	*-8*
Waiver-Child DD	*755*	*804*	*799*	*773*	*761*	*699*	*-7*
Waiver-Child Mental Health	*26*	*77*	*136*	*131*	*82*	*57*	*119*
Waiver-Comprehensive	*--*	*--*	*--*	*--*	*--*	*3*	*--*
Waiver-LTC	*1,682*	*1,820*	*1,801*	*1,718*	*1,674*	*1,700*	*1*
Waiver-Supports	*--*	*--*	*--*	*--*	*--*	*0*	*--*
Total	**71,584**	**74,871**	**77,229**	**75,969**	**76,285**	**76,341**	**7**

[23] The table displays a unique count of recipients for each service area, as well as the total unique count of recipients. Summing the recipients for each year across all service areas will not match the total recipients as shown due to recipients receiving services in multiple service areas.

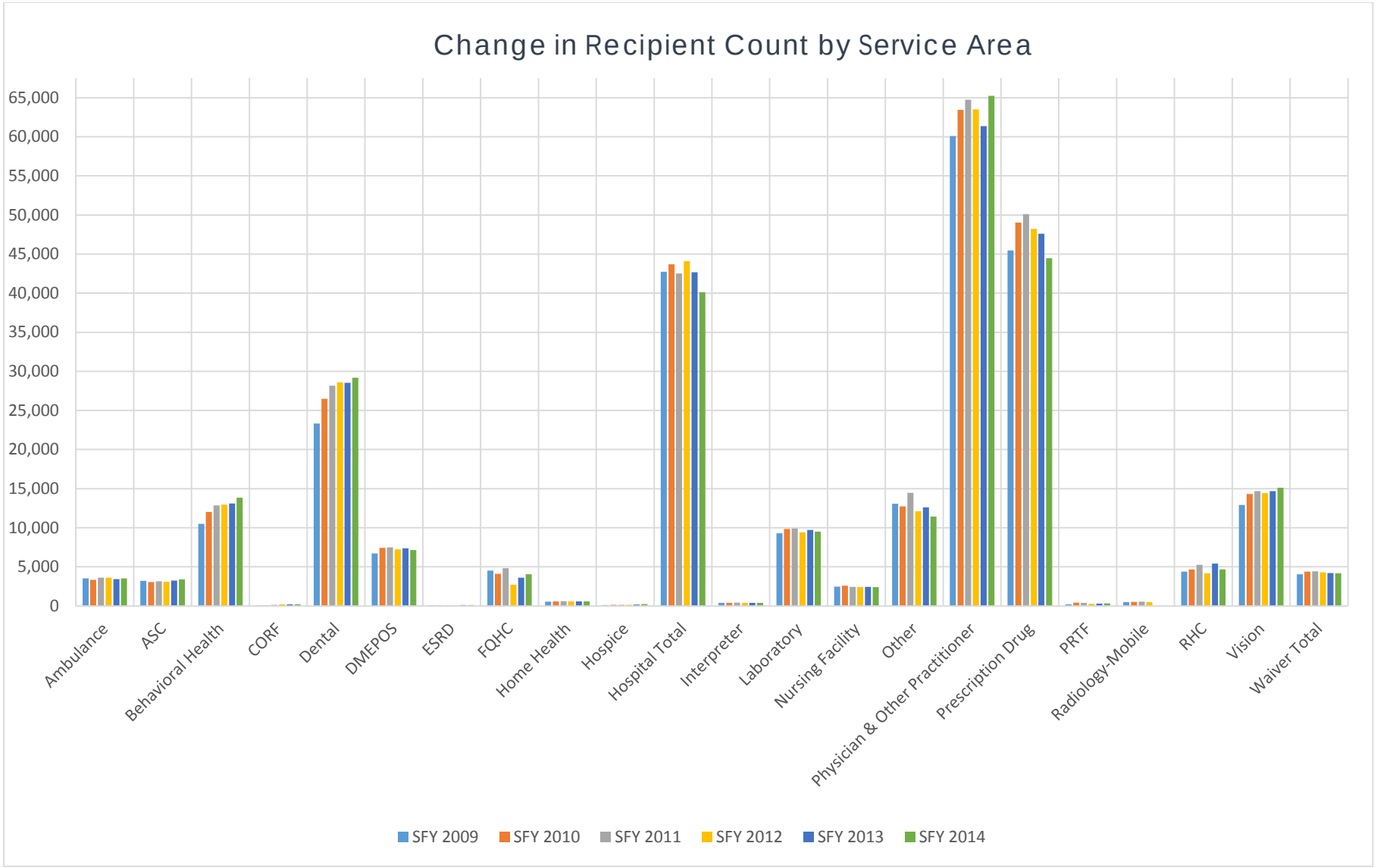


Figure 24: Change in Recipient Count by Service Area

Table 43: Change in Expenditures per Recipient by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$1,229	$1,136	$914	$960	$1,050	$1,065	-13.3
ASC	$1,087	$1,078	$924	$914	$1,055	$1,188	9.3
Behavioral Health	$2,011	$2,045	$2,059	$2,128	$2,270	$2,312	15.0
CORF	$718	$454	$388	$567	$541	$638	-11.2
Dental	$517	$486	$483	$474	$465	$459	-11.2
DMEPOS	$947	$888	$1,000	$1,003	$1,049	$1,069	12.9
ESRD	$18,713	$13,986	$9,717	$12,589	$12,215	$9,924	-47.0
FQHC	$908	$697	$642	$570	$559	$668	-26.4
Home Health	$3,621	$3,307	$4,387	$5,092	$4,902	$5,989	65.4
Hospice	$8,170	$9,745	$6,913	$7,282	$6,046	$5,827	-28.7
Hospital Total	$2,396	$2,602	$2,689	$2,399	$2,550	$2,541	6.0
Hospital-Inpatient	*$6,603*	*$7,111*	*$7,264*	*$7,082*	*$7,151*	*$7,064*	*7.0*
Hospital-Other	*-$432*	*$372*	*$1,195*	*$108*	*$1,320*	*$1,524*	*-452.6*
Hospital-Outpatient	*$572*	*$643*	*$747*	*$686*	*$752*	*$761*	*33.2*
Interpreter	$121	$125	$129	$119	$112	$98	-19.2
Laboratory	$92	$114	$118	$117	$118	$135	47.0
Nursing Facility	$29,535	$28,913	$29,943	$30,625	$30,075	$30,361	2.8
Other	$2,842	$2,305	$1,600	$1,642	$2,268	$2,707	-4.8
Physician & Other Practitioner	$999	$1,009	$987	$970	$1,003	$936	-6.3
Prescription Drug	$864	$793	$825	$869	$821	$927	7.3
PRTF	$39,511	$35,291	$39,348	$30,246	$38,135	$44,497	12.6
Radiology-Mobile	$394	$440	$392	$225	$110	$11	-97.1
RHC	$345	$366	$368	$390	$340	$325	-5.6
Vision	$227	$226	$223	$224	$234	$232	2.6
Waiver Total	$28,689	$25,862	$27,204	$28,435	$28,941	$28,461	-0.8
Waiver-ABI	*$37,630*	*$32,521*	*$39,341*	*$36,838*	*$41,289*	*$40,727*	*8.2*
Waiver-Adult DD	*$62,887*	*$56,696*	*$60,051*	*$61,483*	*$60,362*	*$59,263*	*-5.8*
Waiver-ALF	*$10,271*	*$12,961*	*$12,708*	*$12,995*	*$12,905*	*$13,371*	*30.2*
Waiver-Child DD	*$19,141*	*$17,985*	*$17,683*	*$17,653*	*$17,480*	*$16,331*	*-14.7*
Waiver-Child Mental Health	*$2,953*	*$5,089*	*$6,753*	*$7,194*	*$8,402*	*$9,255*	*213.4*
Waiver-Comprehensive	--	--	--	--	--	--	--
Waiver-LTC	*$7,187*	*$7,376*	*$7,725*	*$7,774*	*$8,020*	*$7,747*	*7.8*
Waiver-Supports	--	--	--	--	--	--	--
Total	**$6,961**	**$6,872**	**$6,728**	**$6,594**	**$6,781**	**$6,780**	**-2.6**

Table 44: Change in Per Member Per Month by Service Area

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$5.80	$4.37	$3.93	$4.21	$4.33	$4.48	-23
ASC	$4.60	$4.06	$3.47	$3.42	$4.18	$4.88	6
Behavioral Health	$29.01	$30.36	$30.62	$33.76	$35.20	$37.34	29
CORF	$0.08	$0.05	$0.10	$0.12	$0.13	$0.18	128
Dental	$16.36	$15.66	$16.17	$15.97	$15.92	$15.93	-3
DMEPOS	$8.52	$8.14	$8.57	$8.72	$9.30	$8.98	5
ESRD	$1.69	$1.51	$0.99	$1.40	$1.61	$1.21	-29
FQHC	$3.82	$3.59	$3.41	$1.90	$2.46	$3.02	-21
Home Health	$2.50	$2.50	$3.09	$3.61	$3.60	$4.12	65
Hospice	$1.24	$1.80	$1.05	$1.34	$1.44	$1.50	21
Hospital Total	$135.94	$137.54	$133.25	$127.10	$128.63	$119.98	-12
Hospital-Inpatient	*$106.08*	*$105.39*	*$98.50*	*$92.65*	*$92.92*	*$85.61*	*-19*
Hospital-Other	*($0.56)*	*($0.53)*	*($0.27)*	*($0.12)*	*($0.03)*	*($0.01)*	*-98*
Hospital-Outpatient	*$30.42*	*$32.68*	*$35.02*	*$34.56*	*$35.73*	*$34.38*	*13*
Interpreter	$0.06	$0.07	$0.06	$0.06	$0.05	$0.05	-12
Laboratory	$1.13	$1.36	$1.35	$1.38	$1.40	$1.41	25
Nursing Facility	$97.31	$91.11	$86.60	$87.74	$86.76	$85.34	-12
Other	$49.73	$34.27	$25.92	$24.19	$33.55	$36.33	-27
Physician & Other Practitioner	$79.16	$77.50	$74.90	$72.99	$73.65	$70.83	-11
Prescription Drug	$53.37	$47.90	$49.52	$50.04	$47.04	$49.37	-7
PRTF	$11.13	$19.50	$16.62	$9.87	$14.97	$17.63	58
Radiology-Mobile	$0.24	$0.27	$0.25	$0.13	$0.00	$0.00	-100
RHC	$2.03	$2.13	$2.25	$2.00	$2.06	$1.90	-6
Vision	$3.93	$4.01	$3.89	$3.87	$4.07	$4.11	5
Waiver Total	$158.65	$137.95	$143.50	$145.73	$146.54	$139.63	-12
Waiver-ABI	*$8.19*	*$7.60*	*$8.32*	*$8.22*	*$9.27*	*$8.67*	*6*
Waiver-Adult DD	*$111.30*	*$92.58*	*$97.64*	*$101.27*	*$101.85*	*$97.71*	*-12*
Waiver-ALF	*$3.44*	*$3.23*	*$3.20*	*$2.97*	*$2.86*	*$3.08*	*-10*
Waiver-Child DD	*$19.80*	*$17.62*	*$16.95*	*$16.12*	*$15.91*	*$13.43*	*-32*
Waiver-Child Mental Health	*$0.13*	*$0.55*	*$1.23*	*$1.05*	*$0.74*	*$0.68*	*416*
Waiver-Comprehensive	*--*	*--*	*--*	*--*	*--*	*$0.25*	*--*
Waiver-LTC	*$15.80*	*$16.36*	*$16.17*	*$16.11*	*$15.91*	*$15.81*	*0*
Waiver-Supports	*--*	*--*	*--*	*--*	*--*	*$0.00*	*--*
Total	**$666**	**$626**	**$610**	**$600**	**$617**	**$608**	**-9**

Ambulance Services

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

In SFY 2014, total ambulance expenditures were less than one percent of total Medicaid expenditures and increased four percent from the previous year to $3,760,537.

Table 45: Total Ambulance Services[24] Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$4,327,795	$3,807,538	$3,303,240	$3,459,400	$3,606,360	$3,760,537	-13
Recipients	3,522	3,351	3,613	3,604	3,435	3,531	0
Expenditures per Recipient	$1,229	$1,136	$914	$960	$1,050	$1,065	-13
Per Member Per Month	$5.80	$4.37	$3.93	$4.21	$4.33	$4.48	-23

Table 46: Air Ambulance Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$2,764,883	$2,374,667	$1,888,518	$1,892,961	$2,129,324	$2,291,183	-17
Recipients	397	401	366	396	426	505	27
Expenditures per Recipient	$6,964	$5,922	$5,160	$4,780	$4,998	$4,537	-35

Table 47: Ground Ambulance Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$1,531,866	$1,426,764	$1,410,232	$1,562,840	$1,472,500	$1,467,922	-4
Recipients	3,336	3,224	3,479	3,476	3,292	3,389	2
Expenditures per Recipient	$459	$443	$405	$450	$447	$433	-6

[24] Total ambulance expenditures include unspecified ambulance services that could not be determined to be ground or air ambulance. Summing the expenditures from the ground and air ambulance breakdowns will not match the total ambulance expenditures in this table.

Ambulatory Surgery Center

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.

ASC services increased 17.5 percent from the previous year to total $4,039,944. However, total expenditures for outpatient hospital and ASC services combined declined 2.6 percent from the previous year to $32.7 million.

A new reimbursement methodology for ASC services will be in effect in SFY 2015 to better align its reimbursement with those identical services provided in other outpatient settings.

ASC services accounted for less than one percent of total Medicaid expenditures.

Table 48: Ambulatory Surgery Center Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$3,497,383	$3,315,928	$2,912,791	$2,822,957	$3,439,188	$4,039,944	16
Recipients	3,217	3,075	3,151	3,088	3,259	3,400	6
Expenditures per Recipient	$1,087	$1,078	$924	$914	$1,055	$1,188	9
Per Member Per Month	$4.60	$4.06	$3.47	$3.42	$4.18	$4.88	6

Behavioral Health

Behavioral Health services include all services provided by Behavioral Health providers as well as Behavioral Health procedures provided by non-Behavioral Health providers as identified by procedure codes. These services have been excluded from other service areas in this report.

The following are considered Behavioral Health providers:

Table 49: Services Provided by Types of Behavioral Health Providers

Provider	Services Provided
Mental health and substance abuse treatment professionals through Community Mental Health Centers (CMHCs) and Substance Abuse Treatment Centers (SACs)	Mental health assessments Individual and 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 and psychiatric mental health nurse practitioners Independently practicing clinical psychologists Mental health practitioners who work under a clinical psychologist Starting late SFY 2014 due to Wyoming legislation, 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)) were able to enroll independently	Behavioral health services

The following are included under non-behavioral health providers providing behavioral health services:

Table 50: Behavioral Health Services Provided by Non-Behavioral Health Providers

Provider	Services Provided
Psychiatric Residential Treatment Facility (PRTF)	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 Statute 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[25]
Wyoming Behavioral Institute	Behavioral health services

[25] W.S. 25-10-101(a)(ii)

This section does not include behavioral health services provided in hospitals or under the Children's Mental Health Waiver (CMHW). For more information regarding these services, refer to the Hospital section and the Waiver section.

In SFY 2014, total behavioral health expenditures were six percent of total Medicaid expenditures and increased eight percent from the previous year to $31,995,615.

Table 51: Total Behavioral Health Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$21,088,922	$24,579,989	$26,444,878	$27,553,867	$29,734,932	$31,995,615	52
Recipients	10,488	12,022	12,842	12,946	13,101	13,838	32
Expenditures per Recipient	$2,011	$2,045	$2,059	$2,128	$2,270	$2,312	15
Per Member Per Month	$29.01	$30.36	$30.62	$33.76	$35.20	$37.34	29

Table 52: Behavioral Health Provider Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$18,938,708	$22,884,970	$24,927,506	$26,125,428	$28,354,676	$30,602,969	62
Recipients	9,061	9,795	10,514	10,674	11,410	11,301	25
Expenditures per Recipient	$2,090	$2,336	$2,371	$2,448	$2,485	$2,708	30

Table 53: Non-Behavioral Health Providers Providing Behavioral Health Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$2,150,214	$1,695,019	$1,517,372	$1,428,438	$1,380,256	$1,392,647	-35
Recipients	2,616	3,423	3,594	3,757	2,983	3,855	47
Expenditures per Recipient	$822	$495	$422	$380	$463	$361	-56

Table 54: 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 class	$3,583,490	$1,681,426	$942,749	**$6,207,666**
309.81	Post-Traumatic Stress Disorder	$2,822,564	$873,244	$42,742	**$3,738,550**
296.90	Unspecified Affective Psychosis	$2,793,035	$457,466	$28,580	**$3,279,080**
314.01	Attention Deficit Disorder of Childhood	$2,591,453	$138,323	$172	**$2,729,948**
296.32	Major Depressive Disorder, Recurrent EPI	$2,170,350	$529,396	$22,988	**$2,722,734**
Total		**$13,960,892**	**$3,679,855**	**$1,037,230**	**$18,677,978**

Table 55: Behavioral Health Services by Provider Type

Provider Taxonomy & Description		Providers	Recipients	Expenditures
364SP0808X	Advance Practice Nurse	9	677	$272,949
207L00000X	Anesthesiology	2	38	$1,668
251B00000X	Case Management	2	134	$84,713
261Q00000X	Clinic/Center	3	60	$31,599
103TC0700X	Clinical Psychologist	126	4,947	$13,859,094
251C00000X	Day Training, Developmentally Disabled Service	2	31	$7,091
207P00000X	Emergency Medicine	1	11	$24,935
363LF0000X	Family Health	1	20	$2,520
207Q00000X	Family Practice	15	497	$651,304
207R00000X	Internal Medicine	4	163	$80,691
1041C0700X	Licensed Clinic/Cert Social Worker	2	3	$1,124
261QM0801X	Mental Health - Including Community Mental Health	27	5,128	$9,097,476
207T00000X	Neurological Surgery	1	35	$4,538
363L00000X	Nurse Practitioner	1	12	$1,591
207V00000X	Obstetrics and Gynecology	1	4	$96
363LX0001X	Obstetrics and Gynecology	1	1	$11
152W00000X	Optometrist	7	85	$13,803
208000000X	Pediatrics	14	1,637	$63,470
363LP0200X	Pediatrics	1	18	$7,004
2080N0001X	Pediatrics, Neonatal-Perinatal Medicine	1	14	$6,599
208100000X	Physical Medicine and Rehabilitation	1	11	$370
208D00000X	Physician, General Practice	16	1,036	$349,483
101YP2500X	Professional Counselor	3	33	$26,127
2084P0800X	Psychiatry and Neurology, Psychiatry	40	2,248	$3,177,882
2084N0400X	Psychiatry and Neurology: Neurology	3	150	$60,407
261QR0405X	Rehabilitation, Substance Use Disorder	28	1,287	$4,168,317
208600000X	Surgery: General Surgery	1	1	$755
Total		**313**	**13,838**	**$31,995,615**

Comprehensive Outpatient Rehabilitation Facility

A Comprehensive Outpatient Rehabilitation Facility (CORF) provides coordinated, comprehensive outpatient rehabilitation services under the supervision of a physician.

To be certified as a CORF the facility must provide, at a minimum:

- Physician supervision
- Physical therapy
- Social or psychological services

A CORF may also provide the following:

- Drugs and biologicals which cannot be self-administered
- Occupational therapy
- Speech therapy
- Orthotics and prosthetics
- Medical supplies and equipment
- Nursing services

Services provided by a CORF are intended to restore the individual to safe, functional independence. Maintenance or general conditionings are not considered appropriate in a CORF setting.

The Gottsche Center in Thermopolis is the only CORF in Wyoming.

In SFY2014, CORF expenditures accounted for less than one percent of total Medicaid expenditures and increased 18 percent from the previous year to $143,525.

Table 56: Comprehensive Outpatient Rehabilitation Facility Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$59,613	$36,757	$56,646	$125,928	$121,618	$143,525	141
Recipients	83	81	146	222	225	225	171
Expenditures per Recipient	$718	$454	$388	$567	$541	$638	-11
Per Member Per Month	$0.08	$0.05	$0.10	$0.12	$0.13	$0.18	128

Dental

Wyoming Medicaid covers the following dental services based on age of the eligible individual:

Table 57: Covered Dental Services by Age

Age Range	Services
Under 21	Comprehensive dental
12 to 18	Comprehensive dental + Orthodontic severe malocclusions which impact speech, mastication or breathing
21+	Diagnostic and preventive services, basic restorative care, removable prosthesis and emergency tooth extraction

Dental shortages exist throughout the United States, and Wyoming's shortage is exacerbated by Wyoming's rural and frontier nature. Thirteen Wyoming counties are designated Dental Health Professional Shortage Areas (HPSA).[26] The aging of the professional population may also affect the supply of dental services in the future, as half of Wyoming's dentists will reach retirement age by 2017.[27]

In SFY 2014, there were 190 active dental providers in Wyoming providing services to 93 percent of recipients who received dental services. The remaining recipients received dental services from out of state dental providers. Each county had at least one dental provider except for Niobrara County.

Although there are dental providers in most counties in Wyoming, dental specialists exist in only 10, or 43 percent, of Wyoming's 23 counties. 45 percent of recipients of dental services received services from a dental specialist in SFY 2014, with four percent receiving such services out of state.

In SFY 2014, dental expenditures were three percent of total Medicaid expenditures, increasing one percent from the previous year to $13,391,934. The top 20 procedure codes (based on expenditures), account for 67 percent of all dental expenditures, while the top 5 providers (based on expenditures), represent 28 percent of total dental expenditures.

Table 58: Dental Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$12,062,946	$12,864,308	$13,616,583	$13,561,177	$13,272,110	$13,391,934	11
Recipients	23,341	26,482	28,173	28,594	28,535	29,185	25
Expenditures per Recipient	$517	$486	$483	$474	$465	$459	-11
Per Member Per Month	$16.36	$15.66	$16.17	$15.97	$15.92	$15.93	-3

[26] The Health Resource and Services Administration Health Professional Shortage areas are available by state and county online: http://hpsafind.hrsa.gov.

[27] The 2010 Wyoming Oral Health Initiative Report states "Wyoming currently has 263 active dentists. Over 56 percent of these dentists are over the age of 51. Available online: http://health.wyo.gov/familyhealth/dental/index.html

Table 59: Top 20 Dental Procedures by Expenditures

Procedure Code and Description	Expenditures
D2930 - Prefabricated Crown	$822,168
D2392 - Resin-based Composite 2 Surfaces	$786,204
D0120 - Periodic Oral Evaluation	$757,076
D1120 - Prophylaxis, Child	$730,500
D1206 - Topical Fluoride Varnish	$609,141
D7140 - Extraction Erupted Tooth	$595,887
D2391 - Resin-based Composite 1 Surface	$580,694
D1110 - Prophylaxis, Adult	$477,205
D2150 - Amalgam	$463,231
D1351 - Sealant	$439,908
D7210 - Surgical Extraction	$357,669
D0330 - Panoramic Image	$306,779
D0140 - Limited Oral Evaluation	$287,738
D2140 - Amalgam	$284,834
D3220 - Therapeutic Pulpotomy	$267,872
D0150 - Oral Evaluation	$267,574
D0272 - Dental Bitewings Two Images	$257,089
D2330 - Resin, Once Surface, Anterior	$243,325
D2331 - Resin, Two Surfaces, Anterior	$242,643
D7240 - Removal Impacted Tooth	$242,063
Total	**$9,019,598**

Table 60: Top 20 Dental Procedures by Units of Service

Procedure Code and Description	Units of Service	Expenditures
D0120 - Periodic Oral Evaluation	24,510	$757,076
D1120 - Prophylaxis, Child	21,439	$730,500
D1206 - Topical Fluoride Varnish	18,588	$609,141
D1351 - Sealant	16,200	$439,908
D0272 - Dental Bitewings Two Images	11,032	$257,089
D1110 - Prophylaxis, Adult	9,891	$477,205
D0220 - Intraoral Periapical First	9,166	$134,795
D7140 - Extraction Erupted Tooth	8,858	$595,887
D2392 - Resin-based Composite 2 Surfaces	8,576	$786,204
D2391 - Resin-based Composite 1 Surface	7,791	$580,694
D0150 - Oral Evaluation	7,788	$267,574
D0230 - Intraoral Periapical EA Add	7,639	$101,195
D0140 - Limited Oral Evaluation	6,487	$287,738
D2930 - Prefabricated Crown	6,213	$822,168
D0274 - Bitewings Four Images	6,008	$203,128
D0330 - Panoramic Image	5,260	$306,779
D1208 - Topical App Fluoride Ex Varnish	5,173	$99,521
D2150 - Amalgam	5,078	$463,231
D2140 - Amalgam	3,808	$284,834
D3220 - Therapeutic Pulpotomy	3,211	$267,872
Total		**$8,472,538**

Table 61: Top 5 Dental Providers by Expenditures

Provider	Expenditures
Provider 1	1,328,977
Provider 2	944,949
Provider 3	578,721
Provider 4	550,148
Provider 5	411,325
Total	**3,814,120**

Table 62: Dental Providers by Wyoming County

County	Providers	Recipients	Expenditures
Albany	4	374	$144,136
Big Horn	3	326	$84,652
Campbell	11	891	$264,371
Carbon	4	277	$89,293
Converse	3	355	$103,718
Crook	1	33	$7,102
Fremont	14	2,616	$1,243,240
Goshen	2	90	$18,368
Hot Springs	1	260	$125,273
Johnson	3	458	$147,782
Laramie	27	8,182	$3,407,048
Lincoln	10	947	$353,530
Natrona	39	4,794	$2,559,105
Niobrara	0	0	0
Park	9	1,413	$563,272
Platte	2	344	$163,136
Sheridan	13	1,758	$866,096
Sublette	3	172	$54,486
Sweetwater	14	1,780	$849,765
Teton	9	695	$296,502
Uinta	12	1,574	$655,754
Washakie	2	960	$335,495
Weston	4	483	$180,619
Total	**190**	**27,970**	**$12,512,744**

Table 63: Dental Specialists by Wyoming County

Provider Type	County	Providers	Recipients	Expenditures
Endodontics	Laramie	1	58	$54,607
	Natrona	2	53	$38,546
	Sheridan	1	12	$12,106
Endodontics – Total		**4**	**123**	**$105,259**
Orthodontics	Laramie	3	149	$139,175
	Lincoln	1	4	$4,050
	Natrona	6	155	$87,060
	Park	1	182	$99,481
	Sheridan	1	18	$19,725
	Sweetwater	1	41	$26,115
	Teton	1	27	$21,793
	Uinta	1	6	$6,975
Orthodontics – Total		**15**	**582**	**$404,374**
Pedodontics	Campbell	2	361	$100,480
	Fremont	1	229	$198,253
	Laramie	2	6,551	$2,275,126
	Natrona	2	1,641	$833,275
	Sheridan	1	1,003	$550,148
	Sweetwater	2	878	$411,827
Pedodontics – Total		**10**	**10,618**	**$4,369,108**
Periodontics	Sweetwater	1	8	$527
Periodontics – Total		**1**	**8**	**$527**
Surgery, Oral & Maxillofacial	Laramie	1	219	$164,593
	Natrona	1	411	$388,721
	Teton	1	113	$102,325
Surgery, Oral & Maxillofacial – Total		**3**	**743**	**$655,640**
Total		**33**	**11,776**	**$5,534,907**

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.

Table 64: Durable Medical Equipment, Prosthetics, Orthotics and Supplies Service Description

Service	Description
Durable Medical Equipment (DME)	Supplies and/or equipment that: -- withstand repeated use (equipment) -- Serve a medical purpose -- Are generally not useful to a person in the absence of illness or injury -- Appropriate for use in the home -- Will not be used by any other member of the household (e.g. wheelchairs, crutches, beds and other home medical equipment)
Prosthetics	Items that replace missing parts of the body
Orthotics	Items employed for correction or prevention of skeletal deformities
Supplies	Include: -- Diabetic supplies (not including insulin and syringes billed through prescription drug providers) -- Syringes and needles -- Urinary care supplies -- Stocking and elastic supports -- Respiratory care accessories and related devices

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.

In SFY 2014 total expenditures for DME, Prosthetics, Orthotics and Supplies services were approximately 1.5 percent of total Medicaid expenditures, decreasing one percent from the previous year to $7,627,734.

Table 65: Total Durable Medical Equipment, Prosthetics, Orthotics and Supplies Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$6,358,280	$6,605,716	$7,505,683	$7,270,213	$7,730,289	$7,627,734	20
Recipients	6,716	7,443	7,502	7,245	7,366	7,138	6
Expenditures per Recipient	$947	$888	$1,000	$1,003	$1,049	$1,069	13
Per Member Per Month	$8.52	$8.14	$8.57	$8.72	$9.30	$8.98	5

Table 66: Durable Medical Equipment Only Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$5,344,231	$5,960,375	$6,725,808	$6,492,089	$6,902,029	$7,040,728	32
Recipients	6,338	7,094	7,127	6,880	7,014	6,835	8
Expenditures per Recipient	$843	$840	$944	$944	$984	$1,030	22

Table 67: Prosthetics, Orthotics and Supplies Only Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$1,014,048	$645,342	$779,875	$778,124	$828,261	$587,006	-42
Recipients	691	641	701	673	651	590	-15
Expenditures per Recipient	$1,468	$1,007	$1,113	$1,156	$1,272	$995	-32

End Stage Renal Disease

Medicare is the primary payer of End Stage Renal Disease (ESRD) services. Medicare ESRD coverage may begin no later than the third month after the month in which the patient begins a course of dialysis treatment. During the 90-day Medicare eligibility determination period, Medicaid will reimburse ESRD services for eligible individuals and will reimburse services if Medicare denies eligibility.

Medicaid covers the following:

- All medically necessary services related to renal disease care, including inpatient renal dialysis, and outpatient services related to ESRD treatment.
- Treatment if Medicare denies coverage for an eligible individual 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. This program reimburses at Medicare rates. While the majority of ESRD recipients are dual individuals, most ESRD expenditures are for non-dual individuals since Medicare is the primary payer of ESRD services for dual individuals.

In SFY 2014 ESRD expenditures were less than one percent of total Medicaid expenditures, decreasing by 20 percent from the previous year to $1,071,750.

Table 68: End Stage Renal Disease Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$1,347,305	$1,160,798	$835,621	$1,233,755	$1,343,669	$1,071,750	-20
Recipients	72	83	86	98	110	108	50
Expenditures per Recipient	$18,713	$13,986	$9,717	$12,589	$12,215	$9,924	-47
Per Member Per Month	$1.69	$1.51	$0.99	$1.40	$1.61	$1.21	-29

Federally Qualified Health Center

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 mid-wife, 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, requirements for a board of director and clinical staffing requirements.[28]

In SFY 2014 FQHC expenditures were less than one percent of total Medicaid expenditures, increasing by 34 percent from the previous year to $2,698,283.

Table 69: Federally Qualified Health Center Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$4,113,634	$2,864,956	$3,103,164	$1,550,274	$2,018,911	$2,698,283	-34
Recipients	4,532	4,109	4,834	2,722	3,613	4,038	-11
Expenditures per Recipient	$908	$697	$642	$570	$559	$668	-26
Per Member Per Month	$3.82	$3.59	$3.41	$1.90	$2.46	$3.02	-21

[28] 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

Home Health

Medicaid covers home health services if the individual is not an inpatient of a hospital or nursing care facility. Covered services must meet the following:

- Intermittent
- Three or fewer visits a day for home health aide and/or skilled nursing services, where each visit does not last more than four hours
- Medically necessary and ordered by a physician
- 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. Covered services include:

- Skilled nursing services
- Home health aide services supervised by a qualified professional
- Physical therapy services provided by a qualified, licensed physical therapist
- Speech therapy provided by a qualified therapist
- Occupational therapy provided by a qualified, registered or certified therapist
- Medical social services provided by a qualified, licensed Master of Social Work (MSW) or Bachelor of Social Work (BSW)-prepared person supervised by an MSW

Medicaid does not cover homemaker services, respite care, meals on wheels or services that are inappropriate or not cost effective when provided in the home setting.

In SFY 2014, Home health expenditures were less than one percent of total Medicaid expenditures, increasing 22 percent from the previous year to $3,533,728.

Table 70: Home Health Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$1,998,695	$1,941,097	$2,732,905	$2,963,510	$2,897,016	$3,533,728	77
Recipients	552	587	623	582	591	590	7
Expenditures per Recipient	$3,621	$3,307	$4,387	$5,092	$4,902	$5,989	65
Per Member Per Month	$2.50	$2.50	$3.09	$3.61	$3.60	$4.12	65

Hospice

Hospice care is an interdisciplinary approach to caring for the psychological, social, spiritual and physical needs of dying individuals. Medicaid covers hospice care if a physician certifies that the individual is terminally ill and the individual elects to receive hospice care.

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.

In SFY 2014 hospice expenditures were less than one percent of total Medicaid expenditures, increasing 36 percent from the previous year to $1,468,295.

Table 71: Hospice Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$939,603	$1,432,471	$1,036,887	$983,026	$1,082,188	$1,468,295	56
Recipients	115	147	150	135	179	252	119
Expenditures per Recipient	$8,170	$9,745	$6,913	$7,282	$6,046	$5,827	-29
Per Member Per Month	$1.24	$1.80	$1.05	$1.34	$1.44	$1.50	21

Hospital

Medicaid covers both inpatient and outpatient hospital services.

In SFY 2014 total hospital expenditures were 20 percent of total Medicaid expenditures, decreasing by six percent from the previous year to $101,931,277.

Table 72: Total Hospital Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$102,369,413	$113,636,933	$114,358,067	$105,798,987	$108,839,452	$101,931,277	0
Recipients	42,721	43,681	42,525	44,108	42,675	40,120	-6
Expenditures per Recipient	$2,396	$2,602	$2,689	$2,399	$2,550	$2,541	6
Per Member Per Month	$135.94	$137.54	$133.25	$127.10	$128.63	$119.98	-12
QRA Payments (Federal Share)	$6,634,910	$8,797,380	$6,828,879	$6,833,447	$8,329,769	$8,604,611	30
Total Expenditures with QRA	$109,004,323	$122,434,313	$121,186,946	$112,632,434	$117,169,221	$110,535,888	1

The Wyoming Legislature rate freeze for inpatient and outpatient hospital services remained in effect during SFY 2014.

Hospital – Inpatient

Medicaid covers inpatient hospital services, with the following exceptions:

- alcohol and chemical rehabilitation services
- cosmetic surgery
- experimental services.

In addition, 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.

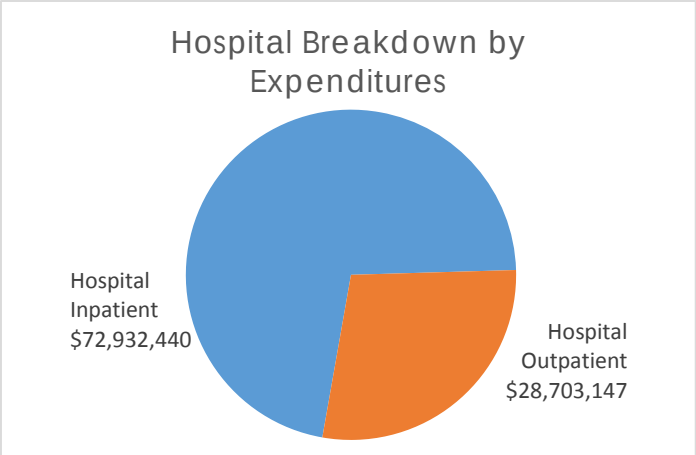


Figure 25: Hospital Breakdown by Expenditures

Table 73: Hospital Inpatient Payment Descriptions

Payment Type	Description
Level of Care (LOC)	Medicaid reimburses a prospective payment amount per discharge. Each discharge is classified into a LOC based on the diagnosis, procedure or revenue codes the hospitals report on the inpatient claim. LOCs are: - Rehabilitation with ventilator - Rehabilitation - Maternity (medical) - Maternity (surgical) - Neonatal intensive care unit (NICU) - Intensive care, critical care and burn units - Surgery - Psychiatric care - Newborn nursery - Routine care Includes: - All in-state hospitals enrolled as Medicaid providers - Out-of-state hospitals enrolled as Medicaid providers that received a specified level of Medicaid reimbursement
Disproportionate Share Hospital (DSH)	Additional payment made to eligible hospitals that serve a disproportionate number of low-income individuals. Required by Federal law and capped according to state-specific allotments. Medicaid determines amount of payment to each qualifying hospital based on unreimbursed Medicaid costs (i.e., the Medicaid payment deficit). As part of the ACA, DSH allotments are expected to start decreasing in 2014. This section of the ACA will not affect the mechanism Medicaid uses to distribute the DSH dollars; it will only adjust the federal allotment.
Qualified Rate Adjustment (QRA)	Supplement for qualified inpatient hospital providers Qualifying hospitals (i.e., Wyoming non-state government owned or operated hospitals with unreimbursed Medicaid costs) provide state share of payment Medicaid distributes corresponding Federal matching funds along with the state share to the participating hospitals.

In SFY 2014, Inpatient hospital expenditures accounted for 72 percent of total hospital expenditures and 14 percent of total Medicaid expenditures, decreasing by eight percent from the previous year to $72,932,440.

Medicaid paid 19 hospitals a total of $5.2 million in inpatient hospital QRA payments in SFY 2014 (federal and state share).[29]

Table 74: Inpatient Hospital Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$79,509,583	$87,297,343	$84,557,214	$77,130,425	$78,462,603	$72,932,440	-8
Recipients	12,041	12,277	11,640	10,891	10,972	10,324	-14
Expenditures per Recipient	$6,603	$7,111	$7,264	$7,082	$7,151	$7,064	7
Per Member Per Month	$106.08	$105.39	$98.50	$92.65	$92.92	$85.61	-19
QRA Payments (Federal Share)	$3,369,460	$4,047,431	$2,379,785	$2,001,293	$2,248,248	$2,599,622	-23
Total Expenditures with QRA	$82,879,043	$91,344,773	$86,936,999	$79,131,718	$80,710,851	$75,532,061	-9

Hospital-Outpatient

Outpatient hospital services include emergency room, surgery, laboratory, radiology and other testing services. Medicaid limits visits as follows:

- Hospital outpatient departments, physician offices and optometrist offices – maximum of 12 per calendar year for individuals over the age of 21
- No limit for Medicare crossovers or for individuals under the age of 21
- No limit for family planning visits, Health Check services and emergency services for all individuals

[29] The QRA payments reported are payments calculated using the prior SFY paid claims data and made during the current SFY.

Table 75: Hospital Outpatient Payment Descriptions

Payment Type	Description
Ambulatory Payment Classification (APC)	Designed to reimburse hospitals based on the resources used to provide a service. For each unit of service, reimbursement equals the scaled relative weight for the APC, multiplied by a conversion factor.[30] When multiple units of services and different services are provided, reimbursements are subject to discounting and unit limitations. Medicaid uses 3 conversion factors, varying by hospital type: General Acute, Critical Access, or Children's Hospitals. Services are grouped for payment the same way as Medicare, using many of Medicare's APC payment principles, adjusted to reflect the Medicaid population. Medicaid reimburses the following services under this methodology: - Significant outpatient procedures[31] - Ancillary services - Drugs - Selected laboratory services - Radiology - Selected durable medical equipment, prosthetics and orthotics - Selected vaccines and immunization services not reimbursed under Medicaid's physician fee schedule Select services from the APC methodology are reimbursed on separate fee schedules: - Selected DME – DME fee schedule - Selected vaccines and immunizations, selected radiology and mammography screening and diagnostic mammographies and therapies – Physician fee schedule - Laboratory services – Laboratory fee schedule - Corneal tissue, dental and bone marrow transplant services; and new medical devices covered under Medicare's transitional pass-through payments – Percent of charges
Qualified Rate Adjustment (QRA)	Supplement for qualified outpatient hospital providers Qualifying hospitals (i.e., Wyoming non-state government owned or operated hospitals with unreimbursed Medicaid costs) provide state share of payment Medicaid distributes corresponding Federal matching funds along with the state share to the participating hospitals.

In SFY 2014 outpatient hospital expenditures accounted for 28 percent of total hospital expenditures and six percent of total Medicaid expenditures, decreasing by five percent from the previous year to $28,703,147.

Medicaid paid 20 hospitals a total of $12 million in outpatient hospital QRA payments in SFY 2014 (federal and state share).[32]

Table 76: Outpatient Hospital Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$22,953,633	$26,260,304	$29,692,078	$28,657,373	$30,189,391	$28,703,147	25
Recipients	40,159	40,823	39,757	41,773	40,156	37,704	-6
Expenditures per Recipient	$572	$643	$747	$686	$752	$761	33
Per Member Per Month	$30.42	$32.68	$35.02	$34.56	$35.73	$34.38	13
QRA Payments (Federal Share)	$3,265,450	$4,749,950	$4,449,094	$4,832,154	$6,081,521	$6,004,989	84
Total Expenditures with QRA	$26,219,083	$31,010,253	$34,141,172	$33,489,526	$36,270,912	$34,708,136	32

[30] 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.
[31] A procedure that establishes the primary reason for the visit.
[32] The QRA payments reported are payments calculated using the prior SFY paid claims data and made during the current SFY.

Interpreter

Medicaid covers interpreter services for individuals who have Limited English Proficiency (LEP) or are deaf or hearing impaired. Hearing impaired is defined as "limited hearing which prevents an individual from hearing well enough to interact effectively with healthcare providers." The purpose of providing these services is to assist the individual in communicating effectively about health and medical issues. Medicaid offers interpretation services in over 90 languages.

Medicaid does not cover interpreter services in conjunction with the following services:

- Inpatient or outpatient hospital
- Intermediate care facility for the intellectually disabled
- Nursing facility
- Ambulance by public providers
- Psychiatric residential treatment facility
- Comprehensive inpatient or outpatient rehabilitation facility
- Other agencies or organizations receiving direct federal funding
- Interpreter services provided by family members or by a volunteer, associate or friend
- Interpreter services provided for the same individual on the same day more than once if provided in conjunction with Medicaid healthcare services delivered by different providers.

Interpreter expenditures were less than one percent of total Medicaid expenditures in SFY 2014.

Table 77: Interpreter Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$49,399	$47,837	$54,259	$48,321	$43,529	$38,171	-23
Recipients	407	384	420	406	389	389	-4
Expenditures per Recipient	$121	$125	$129	$119	$112	$98	-19
Per Member Per Month	$0.06	$0.07	$0.06	$0.06	$0.05	$0.05	-12

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.

Laboratory expenditures were less than one percent of total Medicaid expenditures in SFY 2014.

Table 78: Laboratory Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$852,797	$1,121,964	$1,171,185	$1,100,774	$1,149,473	$1,284,678	51
Recipients	9,278	9,852	9,923	9,415	9,726	9,507	2
Expenditures per Recipient	$92	$114	$118	$117	$118	$135	47
Per Member Per Month	$1.13	$1.36	$1.35	$1.38	$1.40	$1.41	25

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. The waivers are discussed in the Waiver sections.

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 the rehabilitation of injured, disabled or sick individuals
- 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

The Wyoming legislative rate freeze for nursing facility services remained in effect during SFY 2014.

Table 79: Nursing Facility Payment Descriptions

Payment Type	Description
Per Diem Rate	Medicaid reimburses nursing facilities at a per diem rate based on facility specific cost reports. A facility's per diem rate may not exceed the maximum rate established by Medicaid. The most recent update was effective October 1, 2009 when rates were adjusted based on an analysis of Medicaid cost reports. This rate includes: - Limited reserve bed days – may be reimbursed during a resident's temporary absence, based on nursing facility occupancy levels - Routine services, including: room, dietary, laundry, nursing, minor medical surgical supplies, non-legend pharmaceutical items (including over-the-counter drugs and products, insulin and diabetic supplies), and use of equipment and facilities This rate *excludes* the following, which are reimbursed separately: - Physician visits - Hospitalizations - Laboratory - X-rays - Prescription drugs
Provider Assessment and Upper Payment Limit (UPL)	Supplemental payment for qualified nursing facilities Based on calculations from the most recent cost reports and comparisons to what would have been paid for Medicaid services under Medicare's payment principles. Assessment is collected on all non-Medicare days and UPL payment is paid on Medicaid days once corresponding federal matching dollars are obtained. Assessment is based on paid claims data from the Federal Fiscal Year (FFY), October through September, and remits quarterly payments the following FFY.
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 that require individualized psychiatric care.

In SFY 2014 nursing facility expenditures accounted for 14 percent of total Medicaid, decreasing by one percent from the previous year to $72,866,933.

Table 80: Nursing Facility Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$73,188,663	$75,434,811	$73,180,333	$73,805,803	$73,593,462	$72,866,933	0
Recipients	2,478	2,609	2,444	2,410	2,447	2,400	-3
Expenditures per Recipient	$29,535	$28,913	$29,943	$30,625	$30,075	$30,361	3
Per Member Per Month	$97.31	$91.11	$86.60	$87.74	$86.76	$85.34	-12
Provider Assessment (Federal Share)	-	-	-	$12,748,232	$14,299,645	$15,537,040	22[33]
Total Expenditures with Provider Assessment	$73,188,663	$75,434,811	$73,180,333	$86,554,035	$87,893,107	$88,403,973	21

Physician and Other Practitioner

Medicaid limits visits as follows:

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

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.

The most recent update was effective August 2013 when obstetric procedure codes transitioned from a percent of billed charge reimbursement to a RBRVS reimbursement methodology using 2013 relative value units (RVUs) and a new obstetric conversion factor.

Physician services reported in this section exclude services provided by psychiatrists and routine vision services provided by ophthalmologists. These services are reported in the Behavioral Health and Vision sections, respectively. Also excluded are procedure codes associated with behavioral health services that

[33] Percent change since SFY 2012.

are reported in the Behavioral Health Services section. For more information, please refer to Appendix E.

In SFY 2014, physician and other practitioner services accounted for 12 percent of total Medicaid expenditures, with a decrease of one percent from the previous year to $61,053,011.

Table 81: Physician and Other Practitioner Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$60,027,144	$64,036,069	$63,918,782	$61,576,270	$61,564,892	$61,053,011	2
Recipients	60,096	63,451	64,739	63,494	61,359	65,224	9
Expenditures per Recipient	$999	$1,009	$987	$970	$1,003	$936	-6
Per Member Per Month	$79.16	$77.50	$74.90	$72.99	$73.65	$70.83	-11

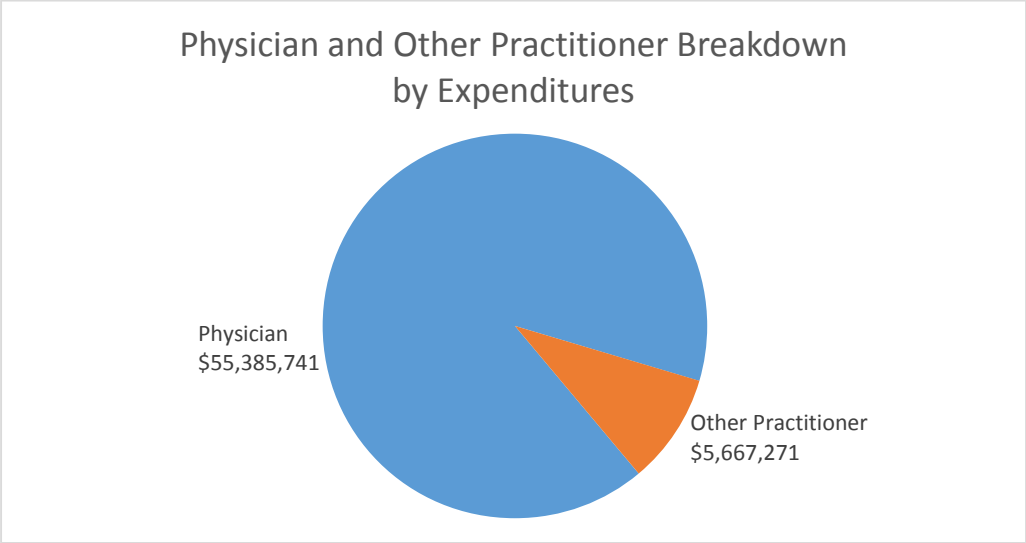


Figure 26: Physician and Other Practitioner Breakdown by Expenditures

Table 82: Physician Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$56,790,736	$59,663,936	$58,604,229	$56,228,007	$56,179,579	$55,385,741	-2
Recipients	59,663	62,962	64,105	62,951	60,665	64,656	8
Expenditures per Recipient	$952	$948	$914	$893	$926	$857	-10

Table 83: Other Practitioner Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$3,236,407	$4,372,134	$5,314,552	$5,348,263	$5,385,313	$5,667,271	75
Recipients	6,415	7,147	8,249	7,695	8,022	7,767	21
Expenditures per Recipient	$505	$612	$644	$695	$671	$730	45

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

Table 84: Physician and Other Practitioner Services by Provider Type

Provider Taxonomy & Description	Providers	Recipients	Expenditures
207KA0200X - Allergy and Immunology, Allergy	8	808	$470,077
207L00000X - Anesthesiology	82	6,740	$2,458,271
231H00000X - Audiologist	16	460	$114,987
207N00000X - Dermatology	16	2,227	$277,674
2085R0202X - Diagnostic Radiology	50	20,460	$2,699,798
207P00000X - Emergency Medicine	29	17,658	$3,434,644
363LF0000X - Family Health	16	1,605	$296,922
207Q00000X - Family Practice	95	22,515	$6,033,262
207R00000X - Internal Medicine	67	12,073	$4,832,858
207RC0000X - Internal Medicine, Cardiovascular Disease	19	3,007	$474,579
207RE0101X - Internal Medicine, Endocrinology Diabetes and Metabolic	5	133	$29,923
207RG0100X - Internal Medicine, Gastroenterology	8	802	$348,782
207RG0300X - Internal Medicine, Geriatric Medicine	2	91	$18,321
207RX0202X - Internal Medicine, Medical Oncology	15	477	$3,230,629
207RN0300X - Internal Medicine, Nephrology	8	112	$43,608
207RP1001X - Internal Medicine, Pulmonary Disease	15	227	$91,813
207RR0500X - Internal Medicine, Rheumatology	4	264	$43,863
367A00000X - Midwife, Certified Nurse	5	33	$19,024
207T00000X - Neurological Surgery	18	1,726	$960,299
367500000X - Nurse Anesthetist, Certified Registered	22	1,396	$376,138
363L00000X - Nurse Practitioner	11	904	$138,191
207V00000X - Obstetrics and Gynecology	48	6,471	$7,505,831
363LX0001X - Obstetrics and Gynecology	6	87	$18,738
207VG0400X - Obstetrics and Gynecology, Gynecology	4	20	$3,609
207VX0000X - Obstetrics and Gynecology, Obstetrics	2	4	$3,204
225X00000X - Occupational Therapist	16	282	$1,206,851
207W00000X - Ophthalmology	34	2,464	$587,288
207X00000X - Orthopedic Surgery	37	4,245	$1,262,261
207Y00000X - Otolaryngology	25	3,178	$893,581
207ZP0105X - Pathology	22	2,685	$329,317
208000000X - Pediatrics	67	16,135	$6,319,027
2080N0001X - Pediatrics, Neonatal-Perinatal Medicine	8	1,444	$747,018
208100000X - Physical Medicine and Rehabilitation	15	391	$170,136
225100000X - Physical Therapist	56	2,397	$2,695,796
208D00000X - Physician, General Practice	75	21,623	$9,495,247
2082S0099X - Plastic Surgery	16	247	$130,775
213E00000X - Podiatrist	14	1,161	$77,507
2084N0400X - Psychiatry and Neurology: Neurology	25	1,945	$908,314
235Z00000X - Speech-Language Pathologist	9	162	$723,116
2086S0120X - Surgery, Pediatric	2	97	$67,096
2086S0129X - Surgery, Vascular	5	70	$35,650
208600000X - Surgery: General Surgery	39	1,632	$684,089
208G00000X - Thoracic Surgery	2	9	$16,468
208800000X - Urology	22	2,930	$778,430
Total	**1,060**	**65,224**	**$61,053,011**

Prescription Drug

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 2014, Medicaid designated preferred drugs in 119 specific drug classes. Prescription drug expenditures were eight percent of total Medicaid expenditures, increasing five percent from the previous year to $41,238,663.

Table 85: Prescription Drug Services Summary[34]

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	39,302,672	38,870,852	41,352,500	41,914,658	39,110,022	41,238,663	5
Recipients	45,465	49,041	50,118	48,223	47,610	44,467	-2
Expenditures per Recipient	864	793	825	869	821	927	7
Per Member Per Month	$53.37	$47.90	$49.52	$50.04	$47.04	$49.37	-7

Medicaid has a Drug Utilization Review (DUR) program to ensure individuals are receiving appropriate, medically necessary medications. More information regarding DUR is available in Appendix A.

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 collected $21.4 million in OBRA rebates in SFY 2014.

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 the SSDC states realize because of OBRA. Goold Health Systems was selected to manage the program for the SSDC. With the continued expansion of the PDL, Medicaid has collected $1.8 million in supplemental rebates in SFY 2014.

Table 86: Pharmacy Cost Avoidance -- SFY 2014[35]

Program Area	Cost Avoidance
Prior Authorization (PA) Preferred Drug List (PDL)	$7,844,047
State Maximum Allowable Cost (SMAC)	$14,359,484
Total	**$22,203,531**

Table 87: Prescription Drug Rebates

Year	Rebate (in millions)
SFY 2009	$12.5
SFY 2010	$13.6
SFY 2011	$17.8
SFY 2012	$19.3
SFY 2013	$19.4
SFY 2014	$21.4

[34] Data includes expenditures for pharmacies only and does not take into account rebate amounts.
[35] 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).

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.

In SFY 2014, PRTF services accounted for three percent of total Medicaid expenditures, with an increase of 24 percent from the previous year to $14,906,432.

Table 88: Psychiatric Residential Treatment Facility Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$8,297,310	$14,928,300	$15,384,914	$7,984,857*	$12,050,809*	$14,906,432	80
Recipients	210	423	391	264	316	335	60
Expenditures per Recipient	$39,511	$35,291	$39,348	$30,246	$38,135	$44,497	13
Per Member Per Month	$11.13	$19.50	$16.62	$9.87	$14.97	$17.63	58

*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).

Medicaid continues to review rate recommendations developed by Navigant Consulting 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 appropriate changes.

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.

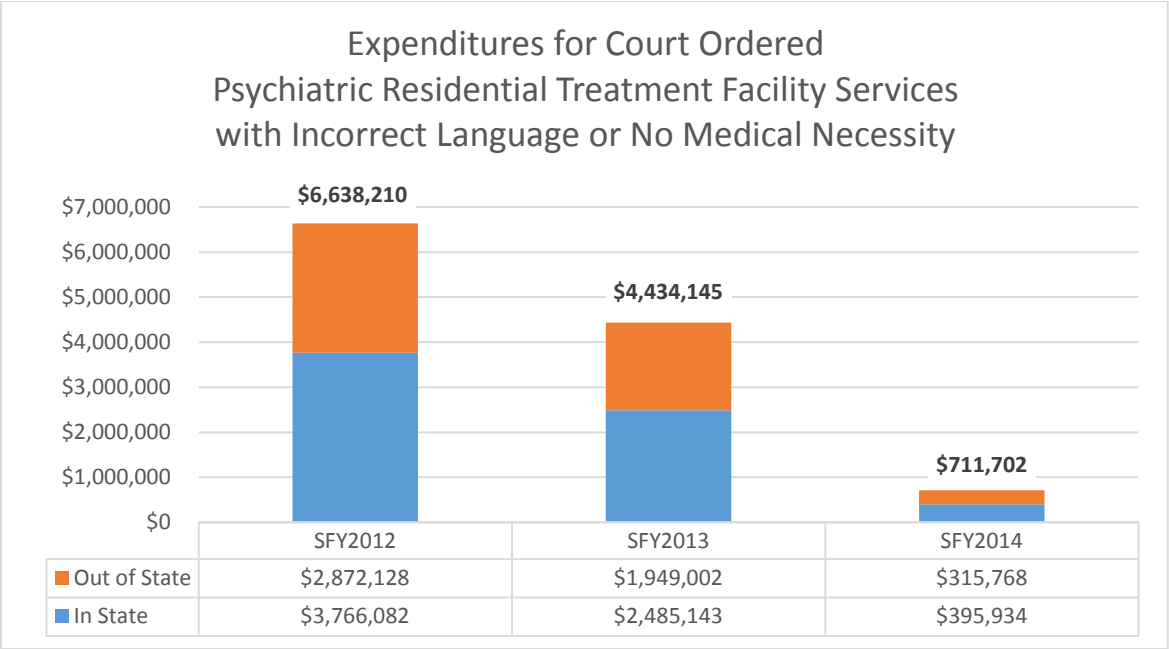


Figure 27: Expenditures for Court Ordered Psychiatric Residential Treatment Facility Services with Incorrect Language or No Medical Necessity

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.

Radiology

Medicaid covers radiology services including x-ray, screening mammography, ultrasound, radiation therapy and nuclear medicine services, if ordered by a physician or a nurse practitioner.

This section discusses two types of radiology: mobile radiology and physician radiology. Physician radiology is the professional component of radiology services provided by a physician or other practitioner. Mobile radiology services are unique to this section, while physician radiology services are also included in the individual service sections in this Report. For this reason, the physician radiology services are excluded from the tables by service area.

In SFY 2014, mobile radiology services decreased by 94 percent from the previous year to $226, while physician radiology services increased less than one percent from the previous year to $4,762,361.

Table 89: Mobile Radiology Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$191,239	$222,281	$217,463	$109,250	$4,081	$226	-100
Recipients	485	505	555	486	37	20	-96
Expenditures per Recipient	$394	$440	$392	$225	$110	$11	-97
Per Member Per Month	$0.24	$0.27	$0.25	$0.13	$0.00	$0.00	-100

Table 90: Physician Radiology Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$4,650,857	$4,958,377	$5,304,938	$4,711,603	$4,747,822	$4,762,361	2
Recipients	25,335	26,663	26,609	26,161	25,656	25,404	0
Expenditures per Recipient	$184	$186	$199	$180	$185	$187	2

Medicaid established rates for both professional services (e.g., the radiologist or the radiation oncologist) and technical services (e.g., the hospital).

The professional component is based on a Relative Value Unit (RVU) that comprises physician work, practice expense and malpractice cost. The technical component is based on a RVU that comprises facility practice expense and facility malpractice cost. Each component's RVU is multiplied by a conversion factor to determine the rate. These two components might be reimbursed separately (if the procedure was performed in a hospital or another facility not owned by the physician) or together as one "global" rate (if the physician is on staff at the hospital or owns the facility).

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 services, and physician assistant, as well as services and supplies incident to a physician's service.

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. A RHC differs from a FQHC based on several criteria related to location, shortage area, corporate structure, requirements for a board of director and clinical staffing requirements.[36]

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.

In SFY 2014, RHC services accounted for less than one percent of total Medicaid expenditures, with a decrease of 18 percent from the previous year to $1,521,233.

Table 91: Rural Health Clinic Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$1,515,936	$1,710,855	$1,940,640	$1,628,043	$1,845,491	$1,521,233	0
Recipients	4,400	4,670	5,277	4,174	5,420	4,676	6
Expenditures per Recipient	$345	$366	$368	$390	$340	$325	-6
Per Member Per Month	$2.03	$2.13	$2.25	$2.00	$2.06	$1.90	-6

[36] 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

Medicaid provides vision services based on age.

Table 92: Vision Services by Age Group

Age Group	Services Provided
Under age 21	- Routine eye examinations, including determination of refractive state - Office exams, as medically necessary for the treatment of eye disease or eye injury - One pair of eyeglasses, replacement pairs when medically necessary and repairs when no longer under warranty - One pair of standard frames per 12 month period - Corrective lenses - Contact lenses for the correction of pathological conditions when useful vision cannot be obtained with regular lenses - Vision therapy
21 and over	- Treatment of eye disease or eye injury - Payment of deductible and/or coinsurance due on Medicare crossover claims for post-surgical contact lenses and/or eyeglasses - Vision therapy for individuals receiving services through the ABI Waiver with qualifying medical diagnosis

Vision therapy services are provided by opticians, optometrists and ophthalmologists and are covered services under the ABI Waiver. For more information regarding the ABI Waiver, refer to the ABI Waiver section.

Vision therapy services are identified by diagnoses codes and are limited to a maximum of 32 visits per calendar year. Medicaid considers additional visits or exceptions to the identified diagnosis codes on a per case basis.

Medicaid reimburses the dispensing of eyeglasses as well as the dispensing of frames, frame parts or lenses; however, Medicaid will not reimburse the dispensing of frames, frame parts or lenses in addition to the eyeglass dispensing fee.

In SFY 2014, total vision services accounted for less than one percent of total Medicaid expenditures, and increased two percent from the previous year to $3,514,674.

Table 93: Total Vision Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$2,925,372	$3,233,037	$3,269,685	$3,228,994	$3,434,854	$3,514,674	20
Recipients	12,911	14,324	14,676	14,428	14,694	15,123	17
Expenditures per Recipient	$227	$226	$223	$224	$234	$232	3
Per Member Per Month	$3.93	$4.01	$3.89	$3.87	$4.07	$4.11	5

Waivers

Medicaid offers the following 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:

Home and Community Based Service (HCBS) Waivers

- Child Developmental Disabilities (DD) Waiver
- Adult Developmental Disabilities (DD) Waiver
- Acquired Brain Injury (ABI) Waiver
- Comprehensive Waiver
- Supports Waiver
- Long-Term Care (LTC) Waiver
- Assisted Living Facility (ALF) Waiver
- Children's Mental Health (CMH) Waiver

Section 1115 Waiver

- Pregnant by Choice Waiver (implemented in October 2008)

Medicaid and the Behavioral Health Division (BHD) manage the various waiver programs.

- The BHD manages five of the HCBS waivers: Child DD, Adult DD, ABI, Comprehensive and Supports.
- Medicaid manages three HCBS waivers: Long Term Care, Assisted Living Facility and Children's Mental Health
- Medicaid also manages the limited benefit Pregnant by Choice 1115 Waiver.

Descriptions of each waiver are detailed in the sections that follow.

In SFY 2014, the enrollment caps were removed for the LTC and ALF waivers, and significant waiting list funding was added during the budget process. Although the Wyoming Legislature has not placed limits on the number of individuals who can enroll, they approve funding for any expansion of these waiver programs.

Each waiver provides specific services as shown in the following table.

Table 94: Waiver Services Provided

	Child Developmental Disabilities (DD) Waiver	Adult DD Waiver	Acquired Brain Injury (ABI) Waiver	Comprehensive Waiver	Supports Waiver	Long-Term Care (LTC) Waiver	Assisted Living Facility (ALF) Waiver	Children's Mental Health (CMH) Waiver
Case management	✓	✓	✓	✓	✓	✓	✓	✓
Functional assessments	✓	✓	✓	✓	✓	✓	✓	✓
Respite	✓	✓	✓	✓	✓	✓		✓
Personal care	✓	✓	✓	✓	✓	✓	✓	
Skilled nursing	✓	✓	✓	✓	✓	✓	✓	
Dietician	✓	✓	✓	✓	✓		✓	
Homemaker	✓	✓		✓	✓	✓		
Special family habilitation home	✓			✓				
Day habilitation		✓	✓	✓	✓			
Child habilitation	✓			✓	✓			
Residential habilitation training	✓			✓	✓			
Residential habilitation		✓	✓	✓				
Specialized equipment	✓	✓	✓	✓	✓			
Environmental modifications	✓	✓	✓	✓	✓			
Supported living	✓	✓	✓	✓	✓			
Community integrated employment	✓	✓	✓	✓	✓			
Employment supports	✓	✓	✓	✓	✓			
Companion	✓	✓	✓	✓	✓			
Occupational, physical and speech therapies		✓	✓	✓	✓			
Cognitive retraining			✓					
Self-directed / Consumer-directed option available	✓	✓	✓	✓	✓	✓		
High Fidelity Wraparound								✓
Family and Youth Peer Support Services								✓

In addition to waiver services, individuals participating in the waivers can receive the standard Medicaid package of benefits. These services are identified as “non-waiver” services, and are also included in the

individual service sections in this Report. This does not apply to Pregnant by Choice Waiver individuals who only receive waiver services.

In SFY 2014, total expenditures for individuals on HCBS waivers, including both waiver only and non-waiver services, represented 30 percent of total Medicaid expenditures, decreasing one percent from the previous year to $154,077,818.

Table 95: Total Home & Community Based Service Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$146,260,548	$146,381,081	$155,016,904	$159,006,300	$156,010,329	$154,077,818	5
Recipients	4,397	4,644	4,709	4,590	4,510	4,510	3
Expenditures per Recipient	$33,264	$31,520	$32,919	$34,642	$34,592	$34,164	3
Per Member Per Month	$158.65	$137.95	$143.50	$145.73	$146.54	$139.63	-12

Waiver only expenditures were 23 percent of total Medicaid expenditures, with a decrease of three percent from the previous year to $118,624,631. Waiver only services accounted for 77 percent of total HCBS Waiver Service expenditures.

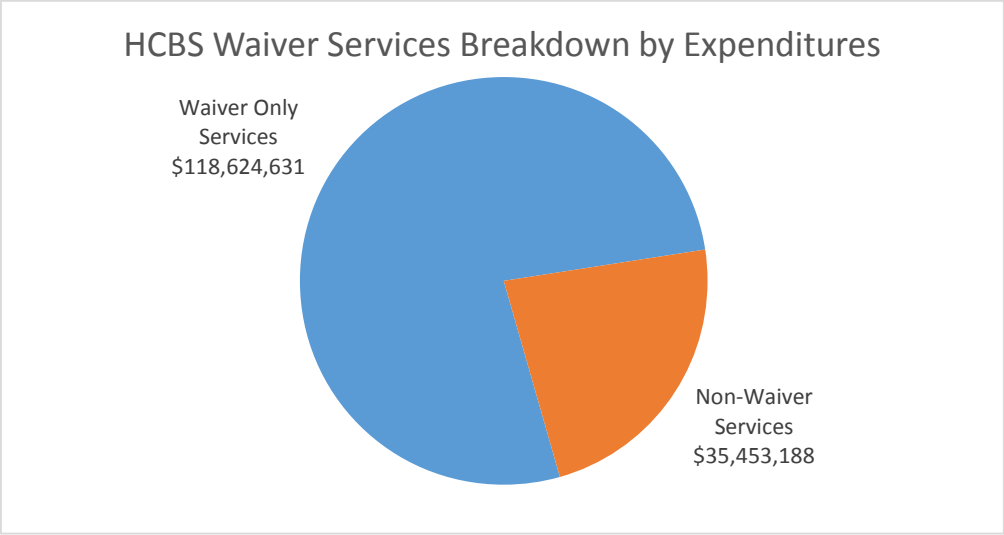


Figure 28: Home & Community Based Service Waiver Services Breakdown by Expenditures

Table 96: Home & Community Based Service Waiver Only Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$116,647,784	$113,325,317	$120,049,329	$122,327,742	$121,752,688	$118,624,631	2
Recipients	4,066	4,382	4,413	4,302	4,207	4,168	3
Expenditures per Recipient	$28,689	$25,862	$27,204	$28,435	$28,941	$28,461	-1

Table 97: Home & Community Based Service Non-Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$29,612,764	$33,055,764	$34,967,575	$36,678,558	$34,257,642	$35,453,188	20
Recipients	4,305	4,544	4,605	4,491	4,397	4,404	2
Expenditures per Recipient	$6,879	$7,275	$7,593	$8,167	$7,791	$8,050	17

The ratio of waiver only services to non-waiver services has remained relatively unchanged since SFY 2009.

Table 98: Home & Community Based Service Waiver Only versus Non-Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Waiver Only Services	$116,647,784	$113,325,317	$120,049,329	$122,327,742	$121,752,688	$118,624,631
Non-Waiver Services	$29,612,764	$33,055,764	$34,967,575	$36,678,558	$34,257,642	$35,453,188
Total Waiver Expenditures	$146,260,548	$146,381,081	$155,016,904	$159,006,300	$156,010,329	$154,077,818
% Waiver-Only of Total Waivers	80%	77%	77%	77%	78%	77%

Total Adult Developmental Disability waiver expenditures accounted for 61 percent of all HCBS Expenditures, with 90 percent of its expenditures for waiver-only services (see Figure 32).

In contrast, Children's Mental Health waiver expenditures accounted for one percent of all HCBS Expenditures, with less than half (40 percent) of its expenditures for waiver-only services.

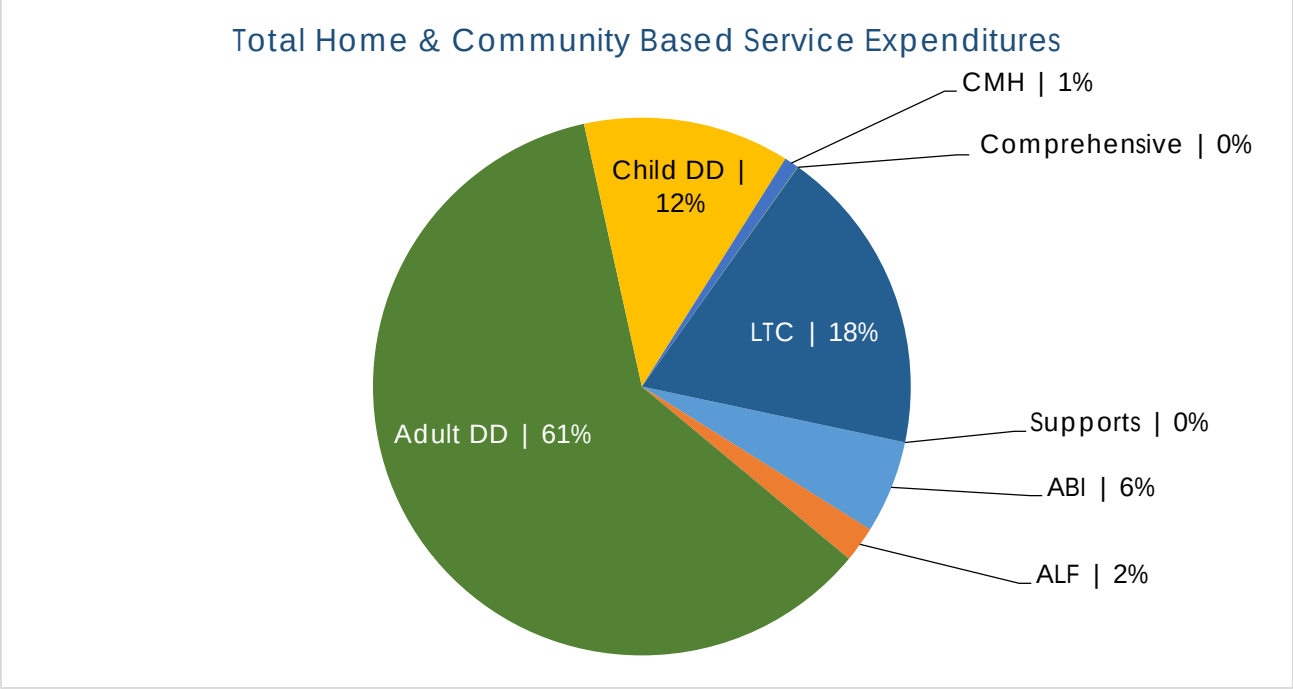
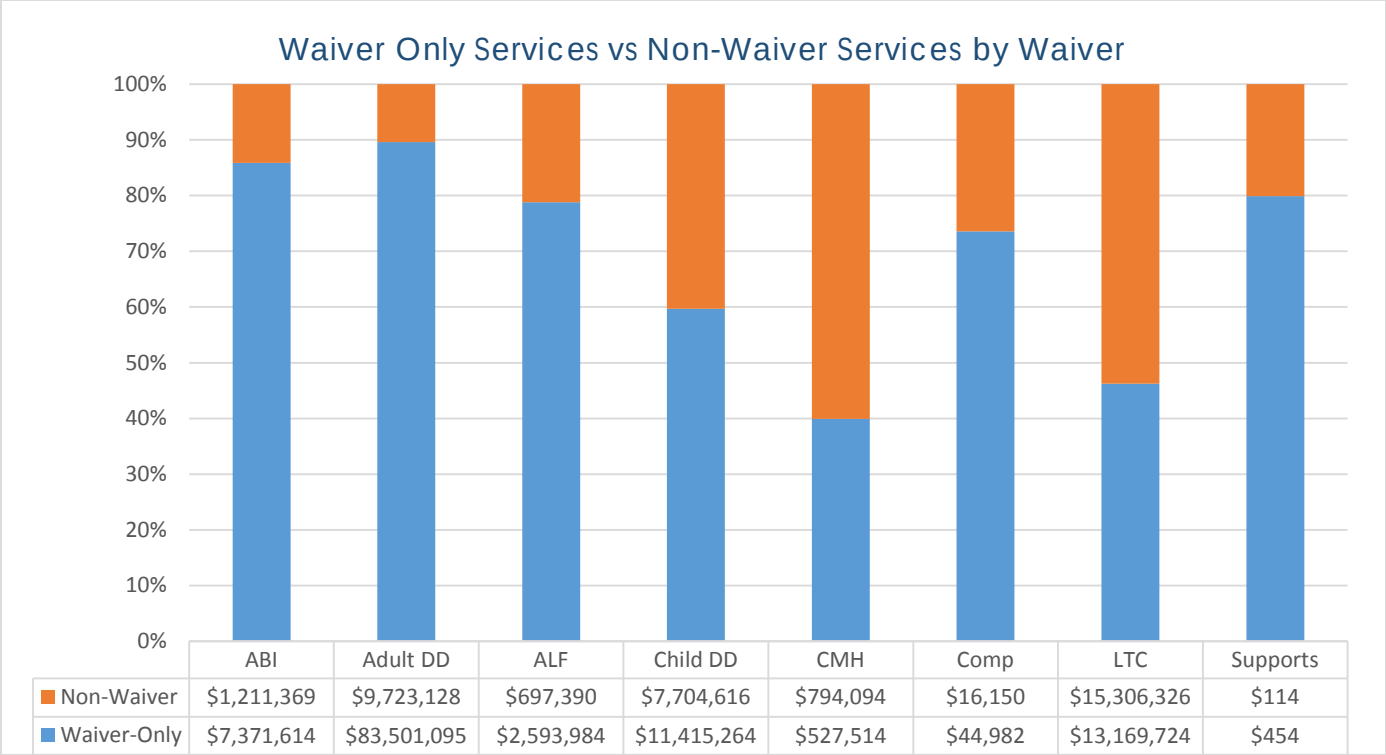


Figure 29: Total Home & Community Based Service Expenditures by Waiver



	ABI	Adult DD	ALF	Child DD	CMH	Comp	LTC	Supports
Non-Waiver	$1,211,369	$9,723,128	$697,390	$7,704,616	$794,094	$16,150	$15,306,326	$114
Waiver-Only	$7,371,614	$83,501,095	$2,593,984	$11,415,264	$527,514	$44,982	$13,169,724	$454

Figure 30: Waiver Only vs Non-Waiver Services by Waiver

Child Developmental Disabilities (DD) Waiver

Medicaid in partnership with the Behavioral Health Division provides an array of services to children with developmental or intellectual disabilities. The waiver was developed to enable children under age 21 to receive training and support that will allow them to remain in their home communities and avoid institutionalization.

Participants may choose to self-direct waiver services from one of two Financial Management Service options, either a Fiscal Employer Agent or an Agency with Choice. For those choosing to self-direct services, the waiver also provides:

- Agency with Choice
- Support Brokerage
- Goods and Services
- Unpaid Caregiver Training and Education

Habilitation services assist individuals with DD to improve self-help and socialization skills, and skills related to activities of daily living. The majority of services provided under this waiver are respite services.

The BHD recognizes that there are workforce shortages in several areas of the State, which limit the ability of providers to accept more clients. One factor contributing to the workforce shortages is competition for staff with the energy extraction industries. Additionally, some of

the more rural communities lack providers. The BHD promotes access and choice by encouraging eligible family members and neighbors to become certified waiver service providers.

In SFY 2014, total expenditures for the Child DD Waiver, including waiver and non-waiver services, accounted for 12 percent of total waiver expenditures and four percent of total Medicaid expenditures, with a decrease of nine percent from the previous year to $19,119,880.

Table 99: Total Child Developmental Disabilities Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$21,885,597	$22,644,643	$21,535,672	$20,897,302	$21,053,459	$19,119,880	-13
Recipients	814	834	830	810	799	743	-9
Expenditures per Recipient	$26,886	$27,152	$25,947	$25,799	$26,350	$25,733	-4
Per Member Per Month	$19.80	$17.62	$16.95	$16.12	$15.91	$13.43	-32

Child DD waiver only services accounted for 60 percent of total Child DD waiver expenditures and two percent of total Medicaid expenditures in SFY2014.

Table 100: Child Developmental Disabilities Waiver Only Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$14,451,370	$14,460,017	$14,128,741	$13,646,013	$13,301,942	$11,415,264	-21
Recipients	755	804	799	773	761	699	-7
Expenditures per Recipient	$19,141	$17,985	$17,683	$17,653	$17,480	$16,331	-15

Table 101: Child Developmental Disabilities Non-Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$7,434,227	$8,184,626	$7,406,932	$7,251,289	$7,751,518	$7,704,616	4
Recipients	4,305	4,544	4,605	4,491	4,397	4,404	2
Expenditures per Recipient	$1,727	$1,801	$1,608	$1,615	$1,763	$1,749	1

Adult Developmental Disabilities (DD) Waiver

Similar to the Child DD Waiver, the BHD and Medicaid provide an array of services to adults with DD. The waiver was developed to assist adults with DD to receive training and support that will allow them to remain in their home communities and avoid institutionalization.

Participants may choose to self-direct services as discussed in the Child DD Waiver section. The largest volumes of services that are provided under the Adult DD Waiver are residential habilitation and day habilitation services.

In SFY 2014, total expenditures for the Adult DD Waiver, including waiver and non-waiver services, accounted for 61 percent of total waiver expenditures and 18 percent of total Medicaid expenditures, decreasing less than half a percent from the previous year to $93,224,222.

Table 102: Total Adult Developmental Disabilities Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$89,525,581	$83,183,518	$89,288,685	$93,731,860	$93,426,901	$93,224,222	4
Recipients	1,352	1,375	1,394	1,423	1,444	1,455	8
Expenditures per Recipient	$66,217	$60,497	$64,052	$65,869	$64,700	$64,072	-3
Per Member Per Month	$111.30	$92.58	$97.64	$101.27	$101.85	$97.71	-12

Adult DD waiver only services accounted for 90 percent of total Adult DD waiver expenditures and 16 percent of total Medicaid expenditures in SFY2014.

Table 103: Adult Developmental Disabilities Waiver Only Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$81,815,516	$75,746,359	$81,369,215	$84,846,084	$84,204,861	$83,501,095	2
Recipients	1,301	1,336	1,355	1,380	1,395	1,409	8
Expenditures per Recipient	$62,887	$56,696	$60,051	$61,483	$60,362	$59,263	-6

Table 104: Adult Developmental Disabilities Non-Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$7,710,065	$7,437,159	$7,919,471	$8,885,776	$9,222,040	$9,723,128	26
Recipients	1,321	1,336	1,367	1,394	1,407	1,426	8
Expenditures per Recipient	$5,837	$5,567	$5,793	$6,374	$6,554	$6,818	17

Acquired Brain Injury (ABI) Waiver

The BHD and Medicaid provide an array of services to adults with an acquired brain injury (ABI). The waiver was developed to assist adults from ages 21 to 65 with ABI to receive training and support that will allow them to remain in their home communities and avoid institutionalization. Individuals on the waiver may remain on the waiver without aging off.

Participants may choose to self-direct services as discussed in the Child DD Waiver section.

In SFY 2014, total expenditures for the ABI Waiver, including waiver and non-waiver services, accounted for six percent of total waiver expenditures and two percent of total Medicaid expenditures, decreasing five percent from the previous year to $8,582,983.

Table 105: Total Acquired Brain Injury Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$7,265,159	$7,679,186	$8,529,077	$8,251,272	$9,011,104	$8,582,983	18
Recipients	177	201	186	199	196	184	4
Expenditures per Recipient	$41,046	$38,205	$45,855	$41,464	$45,975	$46,647	14
Per Member Per Month	$8.19	$7.60	$8.32	$8.22	$9.27	$8.67	6

ABI waiver only services accounted for 86 percent of total ABI waiver expenditures and one percent of total Medicaid expenditures in SFY2014.

Table 106: Acquired Brain Injury Waiver Only Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$6,058,440	$6,243,946	$6,963,271	$6,925,596	$7,679,811	$7,371,614	22
Recipients	161	192	177	188	186	181	12
Expenditures per Recipient	$37,630	$32,521	$39,341	$36,838	$41,289	$40,727	8

Table 107: Acquired Brain Injury Non-Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$1,206,719	$1,435,240	$1,565,807	$1,325,676	$1,331,294	$1,211,369	0
Recipients	170	198	180	191	192	178	5
Expenditures per Recipient	$7,098	$7,249	$8,699	$6,941	$6,934	$6,805	-4

Comprehensive Waiver

The Comprehensive Waiver was designed to meet the requirements of SEA82 as discussed in the Initiatives section of this Report. The Waiver came into effect on April 1, 2014, and is reserved for current waiver recipients grandfathered onto this waiver from the Adult DD and Child DD Waivers, unless they choose to receive services under the newly established Supports Waiver. New individuals will be funded in a priority order by highest level of assessed need as openings and funding are available.

Current Child DD Waiver participants will transition to the Comprehensive Waiver by June 30, 2015.

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

In SFY 2014, the Comprehensive Waiver had 48 eligible individuals enrolled. Expenditures totaled $61,132, serving 31 recipients.

Supports Waiver

The Supports Waiver was designed to meet the requirements of SEA82 as discussed in the Initiatives section of this Report. The Supports Waiver came into effect on April 1, 2014, providing more flexible, but capped, funding for supportive services to eligible individuals currently on the waitlist, as funding allows. Individuals currently served on the Adult DD and Child DD Waivers may choose to go on the Supports Waiver instead of the Comprehensive Waiver.

In SFY 2014, supports waiver had five eligible individuals enrolled. Expenditures totaled $568, serving three recipients.

Long-Term Care (LTC) Waiver

Medicaid provides long-term care services through the Long-Term Care (LTC) Waiver. The LTC 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. Medicaid will not cover services for an individual who has not met the level of care assessment criteria.

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.

In SFY 2014, total expenditures for the LTC Waiver, including waiver and non-waiver services, accounted for 18 percent of total waiver expenditures and six percent of total Medicaid expenditures, increasing one percent from the previous year to $28,476,050.

Table 108: Total Long-Term Care Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$24,219,716	$27,670,091	$29,284,684	$30,456,111	$28,063,301	$28,476,050	18
Recipients	1,873	1,974	1,983	1,884	1,866	1,925	3
Expenditures per Recipient	$12,931	$14,017	$14,768	$16,166	$15,039	$14,793	14
Per Member Per Month	$15.80	$16.36	$16.17	$16.11	$15.91	$15.81	0

LTC waiver only services accounted for 79 percent of total LTC waiver expenditures and one percent of total Medicaid expenditures in SFY2014.

Table 109: Long-Term Care Waiver Only Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$12,088,839	$13,424,332	$13,912,032	$13,355,638	$13,425,205	$13,169,724	9
Recipients	1,682	1,820	1,801	1,718	1,674	1,700	1
Expenditures per Recipient	$7,187	$7,376	$7,725	$7,774	$8,020	$7,747	8

Table 110: Long-Term Care Non-Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$12,130,878	$14,245,758	$15,372,652	$17,100,473	$14,638,096	$15,306,326	26
Recipients	1,841	1,947	1,943	1,845	1,827	1,877	2
Expenditures per Recipient	$6,589	$7,317	$7,912	$9,269	$8,012	$8,155	24

Assisted Living Facility (ALF) Waiver

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.

In SFY 2014, total expenditures for the ALF Waiver, including waiver and non-waiver services, accounted for two percent of total waiver expenditures and one percent of total Medicaid expenditures, increasing nine percent from the previous year to $3,291,373.

Table 111: Total Assisted Living Facility Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$2,652,809	$3,670,483	$3,497,432	$3,234,213	$3,031,734	$3,291,373	24
Recipients	243	263	253	231	216	222	-9
Expenditures per Recipient	$10,917	$13,956	$13,824	$14,001	$14,036	$14,826	36
Per Member Per Month	$3.44	$3.23	$3.20	$2.97	$2.86	$3.08	-10

ALF waiver only services accounted for 79 percent of total ALF waiver expenditures and one percent of total Medicaid expenditures in SFY2014.

Table 112: Assisted Living Facility Waiver Only Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$2,156,841	$3,058,800	$2,757,617	$2,612,026	$2,451,875	$2,593,984	20
Recipients	210	236	217	201	190	194	-8
Expenditures per Recipient	$10,271	$12,961	$12,708	$12,995	$12,905	$13,371	30

Table 113: Assisted Living Facility Non-Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$495,967	$611,682	$739,815	$622,186	$579,859	$697,390	41
Recipients	240	253	244	218	203	214	-11
Expenditures per Recipient	$2,067	$2,418	$3,032	$2,854	$2,856	$3,259	58

Children's Mental Health (CMH) Waiver

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, and meet specific inpatient clinical criteria.

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

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.

In SFY 2014, total expenditures for the CMH Waiver, including waiver and non-waiver services, accounted for one percent of total waiver expenditures and less than half of one percent of total Medicaid expenditures, decreasing seven percent from the previous year to $1,321,609.

Table 114: Total Children's Mental Health Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$711,685	$1,533,159	$2,881,354	$2,435,543	$1,423,830	$1,321,609	86
Recipients	45	111	173	165	116	86	91
Expenditures per Recipient	$15,815	$13,812	$16,655	$14,761	$12,274	$15,368	-3
Per Member Per Month	$0.13	$0.55	$1.23	$1.05	$0.74	$0.68	416

CMH waiver only services accounted for 40 percent of total CMH waiver expenditures and less than half of one percent of total Medicaid expenditures in SFY2014.

Table 115: Children's Mental Health Waiver Only Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$76,778	$391,862	$918,455	$942,386	$688,995	$527,514	587
Recipients	26	77	136	131	82	57	119
Expenditures per Recipient	$2,953	$5,089	$6,753	$7,194	$8,402	$9,255	213

Table 116: Children's Mental Health Non-Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$634,908	$1,141,297	$1,962,899	$1,493,157	$734,835	$794,094	25
Recipients	45	111	171	164	112	83	84
Expenditures per Recipient	$14,109	$10,282	$11,479	$9,105	$6,561	$9,567	-32

Pregnant by Choice Waiver

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 also included in the individual service sections in this Report. For this reason, the Pregnant by Choice Waiver services are excluded from the tables by service area.

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 (as appropriate)
- FQHCs
- RHCs
- 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.

The Pregnant by Choice Waiver expenditures were less than one percent of total Medicaid expenditures in SFY 2014, with a decrease of 38 percent from the previous year to $76,481.

Table 117: Pregnant by Choice Waiver Services Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$11,987	$74,633	$106,300	$111,105	$123,985	$76,481	538
Recipients	66	310	424	407	372	280	324
Expenditures per Recipient	$182	$241	$251	$273	$333	$273	50

To strategically plan for the future direction of the Medicaid program, the Division must consider Medicaid's service delivery system, reimbursement methodologies, expenditures and number of eligible individuals in the context of broader economic and demographic trends. The Medicaid program is subject to external influences. Federal legislation, the economy, demographics and other factors nationally and in the State affect growth of Medicaid expenditures and eligibility.

Wyoming's economy impacts the number of Medicaid eligible individuals, with more individuals becoming eligible as the economy slows. Economic forces not only affect the demand for Medicaid services, but they also have an impact on providers. Decreasing unemployment, for example, may increase the growth of healthcare labor costs (wages and benefits) as competition for employees with other industries increases.

In recent years, the Wyoming and national economies have begun to recover from the recession. Since one year ago, total employment for the State increased by 1.6 percent, representing an additional 4,670 jobs as of the third quarter of 2014, which is the fastest growth rate since the second quarter of 2012. Wyoming's recovery is due in part to the rebound of the energy industry where oil drilling in the State continued to expand.

Furthermore, demographics influence healthcare costs significantly. Average medical spending for adults generally increases with age, so an older population will result in higher than average spending. Total health spending made up approximately 17 percent of the Gross Domestic Product (GDP) in 2012 and is projected to increase to 19 percent of GDP by 2022.[37] However, if the recovering economy brings younger, healthier workers into the State, then healthcare spending for those populations may be less.

Impact of Federal Legislation

The Affordable Care Act (ACA) includes provisions to expand Medicaid and private health insurance coverage and reduce the number of uninsured; the ACA has had a major effect on Medicaid financing, eligibility and the numbers of eligible individuals. Based on the Supreme Court's ruling, states are not required to expand Medicaid for low-income adults. States have the option to expand Medicaid coverage to all non-disabled individuals with income less than or equal to 133 percent of the FPL with a five percent disregard. In Wyoming, the optional Medicaid expansion would cover an estimated 17,600 adults. States that expand Medicaid eligibility will receive 100 percent federal funding from 2014 through 2016 to cover costs of the expansion group. This Federal funding will gradually decrease to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019 and 90 percent for 2020 and subsequent years.[38]

Wyoming had not expanded Medicaid coverage to optional low-income adults as of June 30, 2014.[39] Medicaid eligibility for non-disabled adults is limited to care-taker adults with incomes below 56 percent of the FPL. The expansion rejection also causes a coverage gap for adults without dependent children with incomes under the FPL, and for parents with incomes between 56 and 100 percent of the FPL.[40]

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[37] Medicare Payment Advisory Committee, *A Data Book: Healthcare Spending and the Medicare Program* (June 2014). Available online: http://medpac.gov/documents/publications/jun14databookentirereport.pdf

[38] Kaiser Family Foundation, *Summary of New Health Reform Law* (April 2013). Available online: http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf

[39] Medicaid.gov., *Wyoming Medicaid-Marketplace Overview.* Available online: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/wyoming.html

[40] Kaiser Commission on Medicaid and the Uninsured, *How Will the Uninsured in Wyoming Fare Under the Affordable Care Act?* (January 2013). Available online: http://kff.org/health-reform/fact-sheet/state-profiles-uninsured-under-aca-wyoming/

One provision of the ACA provides for the creation and operation of Health Insurance Marketplaces by January 2014. Marketplaces allow individuals to apply for healthcare coverage. Through this application process, the Marketplace will determine if they qualify for Medicaid, CHIP, Advance Premium Tax Credits, or they may purchase private coverage. Advance Premium Tax Credits are available in states that have not expanded Medicaid at incomes above 100% of the Federal Poverty Level. Individuals below 100% do not qualify for Advance Premium Tax Credits and fall into a coverage gap. In the Federally-Facilitated Marketplace, HHS is responsible for performing all marketplace functions and Wyoming residents apply for and enroll in healthcare coverage at healthcare.gov.[41] In 2014, more than 11,000 Wyoming residents enrolled in healthcare using healthcare.gov.[42]

Medicaid and the Economy

Medicaid is instrumental in providing health insurance coverage to some individuals and families with low incomes or who are medically needy. While the persistent effects of the recession have kept national Medicaid enrollment high – with a growth rate peaking at 7.8 percent from SFY 2008 to SFY 2009 – initial economic improvements have resulted in slowed growth. As of June 2013, 55 million individuals were enrolled in Medicaid and nearly three-quarters were non-disabled, non-elderly individuals. Compared to one year earlier, enrollment grew by 814,200 or 1.5 percent – the slowest rate since the start of the Great Recession. For states expanding their Medicaid coverage, enrollment increased by 1.7 percent from 2012 to 2013, while enrollment for states not participating in Medicaid expansion experienced an increase of 1.2 percent.[43]

Wyoming has seen growth patterns related to Medicaid eligibility similar to those experienced nationally. From SFY 2008 to SFY 2013, Wyoming Medicaid experienced an average growth rate of 3.1 percent, with ranges from -1.4 percent to 9.7 percent. From SFY 2011 to SFY 2013, Wyoming Medicaid experienced a slight decline in the number of new Medicaid eligible individuals. In 2014, as a result of the implementation of the ACA, Wyoming Medicaid increased its enrollment by 3.4 percent as compared to 17.5 percent nationally.[4]

Table 118: Annual Growth Rate in Medicaid Enrollees for US and Wyoming[44]

SFY	US	Wyoming
2007	-0.5%	-3.5%
2008	3.1%	-0.7%
2009	7.8%	9.7%
2010	7.2%	7.0%
2011	4.4%	1.1%
2012	3.2%	-0.8%
2013	2.8%	-1.4%
2014	17.5%	3.4%

[41] State Health Insurance Marketplace Types, 2015. Available online: http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/

[42] Wyoming health insurance exchange. Available online: http://www.healthinsurance.org/wyoming-state-health-insurance-exchange

[43] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment: June 2013 Data Snapshot* (January 2014). Available online: https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8050-07-medicaid-enrollment-june-2013-data-snapshot1.pdf

[44] Centers for Medicare & Medicaid Services, *Medicaid & CHIP: November 2014 Monthly Applications, Eligibility Determinations and Enrollment Report* (February 2015). Available online: http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-november-2014-application-eligibility-and-enrollment-report.pdf

Population Trends

From 2010 to 2014, Wyoming's population growth exceeded the national average (3.6 percent compared to 3.3 percent).[45] Wyoming ranked 25th among states for population growth from 2010 to 2014, but remains the least populated state in the nation.[46]

The Wyoming median age has increased from 36.2 in 2000 to 36.6 in 2013 at a rate that is slower than national figures.[47, 48] Wyoming has one of the lowest median age in the nation because labor-intensive job opportunities from the energy boom attract young workers to Wyoming. However, baby boomers (those born in the 1950s and 1960s) make up a large percentage of Wyoming's population. Those baby boomers will soon retire, and there are fewer middle-aged workers to take their places.[49] In 2010, the U.S. Census Bureau found that Wyoming's percentage of residents 65 and older was relatively the same as nationally (12.4 percent compared to 13 percent, respectively). However, the Administration on Aging estimates that Wyoming's aging population that are 65 and over will be 26.5 percent of the State's population compared to 19.7 percent nationally by 2030.[50]

Wyoming had a higher percentage of high school graduates in 2013 (92.4 percent), compared to the national average of 86 percent. However, Wyoming has a lower percentage of individuals with a Bachelor's degree or higher (24.7 percent) compared to the national average of 28.8 percent. Median household income of $57,406 in 2013 was higher than the national average of $53,046.[51]

Wyoming Employment Conditions

Wyoming's unemployment rate has historically been lower than the national average, including during the economic downturn. The unemployment rate in Wyoming was 4.2 percent in December 2014, down from its high of 7.3 percent in 2009.[52]

Table 119: Unemployment Rates - U.S. and Wyoming

Year	US	Wyoming
2008	6.1%	3.3%
2009	9.7%	7.3%
2010	9.6%	6.8%
2011	8.5%	5.8%
2012	7.9%	5.0%
2013	6.7%	4.4%
2014	5.6%	4.2%

[45] U.S. Census Bureau, *State and County Quick Facts*. Available online: http://quickfacts.census.gov/qfd/states/56000.html
[46] U.S. Census Bureau, *Table 2. Cumulative Estimates of Resident Population Change for the United States, Regions, States, and Puerto Rico and Region and State Rankings: April 1, 2010 to July 1, 2014*. Available online: https://www.census.gov/popest/data/state/totals/2014/tables/NST-EST2014-02.xls
[47] Based on U.S. Census Bureau's 2013 American Community Survey 1-Year Estimates. Available online: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_1YR_S0101&prodType=table
[48] U.S. Census Bureau, *Profile of General Population and Housing Characteristics:* (2010). Available online: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
[49]The Washington Post. *The Age of Modern America, in 6 Maps*. Available online: http://www.washingtonpost.com/blogs/govbeat/wp/2014/06/26/the-age-of-modern-america-in-6-maps/
[50] U.S. Census Bureau, *Population Division, Interim State Population Projections, 2005.*
Administration on Aging. *Projected Future Growth of the Older Population, By State: 2005 – 2030, Percent of Persons 65 and Over.* Available online: http://www.aoa.acl.gov/Aging_Statistics/future_growth/DOCS/State-percent_65-age-projections-2005-2030.xls
[51] U.S. Census Bureau, *State and County Quick Facts*. Available online: http://quickfacts.census.gov/qfd/states/56000.html
[52] Joint Economic Committee, United States Congress, *Economic Overview and Outlook: Wyoming* (January 2015). Available online: http://www.jec.senate.gov/public//index.cfm?a=Files.Serve&File_id=6a217471-8918-42a9-807e-8eae7d23be41

There were 13,000 unemployed Wyoming residents during December 2014.[53] From the last quarter of 2013 compared to the last quarter of 2014, unemployment declined by 0.2 percent, with the greatest employment increases in the trade, transportation, and utilities.

Wyoming's job growth overall from 2003 to 2013 is estimated at 15.8 percent, which is considerably higher than the national average rate of 3.9 percent.[54]

- Nearly all industry sectors saw increases in job growth during the third quarter of 2014, with the largest increases in construction, mining and logging. From the third quarter of 2013 to the third quarter of 2014, the State added 1,270 construction jobs and 640 mining and logging jobs.[55]
- The mining, oil, and gas extraction industry continues to dominate Wyoming's economy as the oil drilling in the state continues to expand. In 2013, the mining industry comprised approximately 9.2 percent of Wyoming's total employment and 37.2 percent of the State's Gross Domestic Product.[56, 57]

Wyoming Healthcare Industry

According to the Bureau of Labor Statistics, as of May 2013, the mean hourly wage for a Wyoming worker was $21.05, or $43,770 per year. The mean Healthcare Practitioner and Technical Occupation Wage was $35.55 per hour, or $73,950 per year and Healthcare Support jobs averaged $14.18 per hour, or $29,500 per year.[58] The average Healthcare Practitioner and Technical Occupation wage fell below the national average, while wages for Healthcare Support jobs were slightly higher than the national average.[59] Overall average wage growth in Wyoming for all occupations from 2003 to 2013 outpaced national wage growth.[60]

Table 3 compares the percent change in employment and wages for healthcare occupations and all occupations at both the state and national level, from 2003 to 2013. Wyoming exceeded national averages in wage increases for all occupations and healthcare occupations. Additionally, Wyoming exceeded national averages for employment growth for all occupations and healthcare practitioners and technical occupations.[61] Employment in the healthcare sector continued to increase faster than overall employment growth during the same period, both nationally and in Wyoming.

[53] Joint Economic Committee, United States Congress, *Economic Overview and Outlook: Wyoming* (January 2015). Available online: http://www.jec.senate.gov/public//index.cfm?a=Files.Serve&File_id=6a217471-8918-42a9-807e-8eae7d23be41
[54] Bureau of Labor Statistics, *May 2013 State Occupational Employment and Wage Estimates, Wyoming.* http://www.bls.gov/oes/current/oes_wy.htm National Occupational Employment and Wage Estimates United States: http://www.bls.gov/oes/current/oes_nat.htm
[55] Wyoming Economic Analysis Division, *Economic Summary: 3Q14* December 2014). Available online: http://eadiv.state.wy.us/wef/Economic_Summary3Q14.pdf
[56] Wyoming Labor Market Information, *Wyoming Nonagricultural Wage and Salary Employment. Preliminary Benchmark 2013.* Available online: http://doe.state.wy.us/lmi/ces/naanav9002.htm
[57] U.S. Department of Commerce, Bureau of Economic Analysis, *Gross Domestic Product by State.* Available online: http://www.bea.gov/iTable/iTable.cfm?ReqID=70&step=1&isuri=1&acrdn=1
[58] Bureau of Labor Statistics, *May 2013 State Occupational Employment and Wage Estimates, Wyoming.* http://www.bls.gov/oes/current/oes_wy.htm
[59] Bureau of Labor Statistics, *May 2013 State Occupational Employment and Wage Estimates, United States.* http://www.bls.gov/oes/current/oes_nat.htm
[60] Bureau of Labor Statistics, *May 2013 State Occupational Employment and Wage Estimates, Wyoming.* http://www.bls.gov/oes/current/oes_wy.htm
[61] Bureau of Labor Statistics, *May 2013 State Occupational Employment and Wage Estimates, Wyoming.* http://www.bls.gov/oes/current/oes_wy.htm

Table 120: Percent Employment and Wage Increases, U.S. and WY, 2003 to 2013

	Employment Total Percent Increase from 2003 to 2013		Wages Total Percent Increase from 2003 to 2013	
	US	WY	US	WY
All Occupations	3.9%	15.8%	28.3%	40.3%
Healthcare Practitioners and Technical Occupations	25.6%	29.0%	35.0%	46.0%
Healthcare Support Workers	22.3%	25.0%	24.4%	44.3%

Conclusion

Wyoming has a history of strong state budget performance. Due to the revenue generated from Wyoming's mineral resources, combined with the State's restrained spending, Wyoming ended SFY 2012 with a budget surplus. Additionally, Wyoming is one of 11 states with the top credit rating from Standard & Poor's, which recognized the State for its "conservative budgeting and forecasting practices."[62] Per Standard & Poor's December 23, 2014 Report, Wyoming will continue to receive an AAA rating with a stable outlook and financial management practices rated as "Good."[63]

[62] Bloomberg, *Wyoming Boosted to Highest Credit Rating by S&P to Join 11 States at AAA* (May 2011). Available at: http://www.bloomberg.com/news/2011-05-03/wyoming-s-issuer-credit-rating-is-raised-to-aaa-by-s-p-with-stable-outlook.html

[63] *Standard & Poor's* Ratings Direct*, Wyoming; General Obligation* (December 23, 2014). Available at: http://treasurer.state.wy.us/pdf/SPCreditRatingDec2014.pdf

Appendix A: Subprograms and Special Populations

This section provides further detail on select programs and special populations within Medicaid.

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:

- The medical appointment must be medically necessary.
- Transportation must be approved at least three business days in advance by the Department.[64]
- 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.

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 members are actively practicing in the state of Wyoming. Ad hoc members include the Medicaid Medical Director, Pharmacy Program Manager, Pharmacist Consultant, and two drug information specialists from the University of Wyoming, School of Pharmacy. The P&T

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

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

The DUR program is required to review prescription claims for appropriateness prior to dispensing at the pharmacy. The PA policies are also taken into consideration. This review identifies potential issues such as therapeutic duplication, drug-disease contraindications, drug-drug interactions, potential adverse effects and others.

Retrospective DUR

Retrospective DUR is the ongoing review of utilization to monitor for therapeutic appropriateness, over- and underutilization, therapeutic duplication, drug-disease contraindications, drug-drug interactions and others. This review takes place through examination of aggregate claims data to uncover trends, as well as review of individual patient profiles. Review of aggregate claims data can lead to recommendations for prospective DUR policy, including PA, to encourage appropriate utilization at the program level. Review of 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.

Education

The DUR program sends quarterly newsletters to all Wyoming providers. In addition, the program sent targeted education letters regarding:

- Appropriate medication utilization for diabetic patients
- Narcotic utilization during pregnancy

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 receives input from the Wyoming Medical Community in several ways:

- 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

Medicaid's EPSDT services are operated under the Health Check program. Health Check is a program for children under age 21 that provides the following services:

- 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.

Medicaid Electronic Health Record Incentive Program

The Medicaid Electronic Health Record (EHR) Incentive Program was established under the American Recovery and Reinvestment Act of 2009 (ARRA) and provides incentive payments to eligible professionals and hospitals to adopt, implement, upgrade, and use EHR in a meaningful way. Payments for this program are paid with 100 percent federal funds.

For professionals to be eligible, they must have a certified EHR and a 30 percent Medicaid patient volume (20 percent for pediatricians). Over the six years that they choose to participate, professionals can receive up to $63,750 in incentive payments after meeting required criteria each year and establishing patient volume.

For hospitals to be eligible, they must have a certified EHR and a 10 percent Medicaid patient volume (discharges and ER visits). Incentive payments are based on cost report data and the total incentive is paid over the course of three years.

To remain eligible for the program, professionals and hospitals are required to increase the utilization of their EHR and meet the required Medicaid patient volume.

Since the implementation of the program in December 2011, Wyoming has paid 132 professionals and 23 hospitals $16.3 million.

The Wyoming Total Health Record (THR) EHR is a basic EHR offered to Wyoming Medicaid providers at no cost. This enables them to meet the eligibility requirements for the EHR Incentive Program and promotes connectivity across the state. As of SFY 2014, the THR is used at 27 locations by 78 total providers with 324 users (primarily ancillary staff) and contains approximately 83,000 patient records.

Project Out

Project Out is a temporary short-term Medicaid and non-Medicaid state funded intervention and assistance program that helps participants overcome the barriers to living independently in the community. The program provides targeted case management and limited financial resources to assist with some of the costs of transitioning out of or diverting from a nursing home. Costs might include moving or storage expenses, rental or utility deposits, household items, furniture, personal emergency response system, grab bars or other assistive devices, as well as limited transportation services during the transition or diversion process. Project Out links the participant to community services and long-term care programs that may provide the ongoing support needed to live independently.

To be considered for Project Out services, an individual must be a Wyoming resident, age 18 and older, and Medicaid eligible. During the transition or diversion process, Medicaid eligibility must be determined. Until the participant is Medicaid eligible, the assistance is state funded.

Each Project Out participant collaborates with a Project Out case manager, his or her healthcare provider and/or discharge planner to create a transition or diversion plan, which includes services and supports that are necessary to facilitate independent living.

Wyoming defines a diversion as an individual at risk of needing nursing facility care being able to remain in the community, or an individual who has resided in a nursing facility for three months or less and is able to return to the community to live. Wyoming defines a transition as an individual currently residing in a nursing facility or long-term care institution for a minimum of three months.

Project Out is a fee-for-service program, providing services for 148 Medicaid eligible recipients, with expenditures totaling $111,437 in SFY 2014. The average amount spent per recipient during this period was $753.

The Project Out program continues to strive to increase awareness of the program within every Wyoming community. Identifying nursing home residents who want to return to the community through Minimum Data Set (MDS) collected by the nursing homes, and increased education and outreach have resulted in individuals being educated earlier about their long-term care options. Remaining in the community or returning earlier to the community is generally more desirable for the individual and is the least costly for Wyoming.

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

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
- Transportation

In SFY 2014, the program provided service for 63 recipients, with expenditures totaling $1,281,485, a 660 percent increase from the previous year.

Special Populations

Medicaid provides services to some populations of high interest, for which greater detail is desired. This section provides background information and data regarding two select populations: Medicaid and Medicare Dual Eligible Individuals and Foster Care.

Medicaid and Medicare Dual Eligible Individuals

Individuals with Medicare coverage, may also be eligible for Medicaid services, dependent upon income. These individuals are referred to as dual eligible. For dual eligible individuals, Medicare pays first for services covered by both programs, with Medicaid covering 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. For example:

- Qualified Medicare Beneficiaries (QMB), 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 with Medicare premiums, deductibles and coinsurance.
- Specified Low-Income Medicare Beneficiaries (SLMB-1), 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, receive assistance with Medicare Part B premiums.
- SLMB-2, 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, receive assistance with Medicare Part B premiums if their income exceeds 120 percent of the

FPL, but is less than or equal to 135 percent of the FPL. Premiums for this group are paid with 100 percent federal funds.

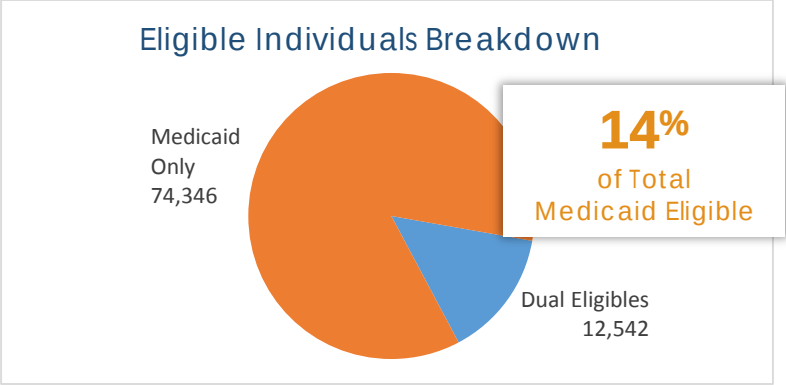

Figure 31: Eligible Individuals Breakdown

The data for dual eligible individuals includes expenditures for both crossover claim services and services funded entirely through Medicaid, and excludes premium assistance for QMB, SLMB-1 and SLMB-2 individuals because these expenditures are considered administrative expenditures.

Dual eligible individual data is also included in the individual service sections in this Report.

In SFY 2014, the number of dual eligible individuals increased by two percent from the previous year to 12,542, accounting for 14 percent of all Medicaid enrollment. Total expenditures for dual eligible individuals, including crossover claims, totaled $193.5 million, an increase of two percent from the previous year.

Table 121: Medicaid/Medicare Dual Eligible Individuals Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Expenditures	$172,596,285	$175,811,864	$180,891,512	$181,766,090	$189,787,625	$193,531,089	12
Dual Eligible Individuals	10,655	11,195	11,567	11,987	12,340	12,542	18
Recipients (unduplicated)	9,120	9,364	9,592	9,751	9,942	10,127	11
Expenditure per Dual Individual	$16,199	$15,704	$15,639	$15,164	$15,380	$15,431	-5
Expenditures per Recipient	$18,925	$18,775	$18,859	$18,641	$19,089	$19,110	1

In SFY 2014, crossover claims accounted for nine percent of total expenditures for dual eligible individuals, with a total of $17 million, an increase of one percent from the previous year.

Waiver and nursing facility services accounted for 76 percent of total dual eligible individual expenditures.

Table 122: Medicaid/Medicare Dual Eligible Individual Service Area Summary

Service Area	Expenditures	Recipients	Expenditures per Recipient
Ambulance	$518,010	1,228	$422
Ambulatory Surgery Center	$204,115	729	$280
Behavioral Health	$5,109,884	2,408	$2,122
CORF	$22,432	81	$277
Dental	$930,537	1,915	$486
DMEPOS	$2,314,924	3,208	$722
ESRD	$506,679	96	$5,278
FQHC	$176,343	695	$254
Home Health	$2,176,323	217	$10,029
Hospice	$822,566	186	$4,422
Hospital Total	$9,335,230	6,884	$1,356
Hospital-Inpatient	*$3,779,806*	*1,943*	*$1,945*
Hospital-Other	*-$39,844*	*105*	*-$379*
Hospital-Outpatient	*$5,595,269*	*6,727*	*$832*
Laboratory	$45,524	2,163	$21
Nursing Facility	$68,749,889	2,277	$30,193
Other	$17,696,578	2,967	$5,964
Physician & Other Practitioner	$4,941,876	8,359	$591
Prescription Drug	$1,468,751	2,193	$670
PRTF	$87,550	1	$87,550
Radiology-Mobile	$226	19	$12
Rural Health Clinic	$136,749	780	$175
Vision	$94,731	1,620	$58
Waiver Total	$78,192,171	2,689	$29,079
Waiver-ABI	*$5,746,123*	*140*	*$41,044*
Waiver-Adult DD	*$58,616,016*	*959*	*$61,122*
Waiver-ALF	*$2,504,448*	*186*	*$13,465*
Waiver-Child DD	*$223,790*	*14*	*$15,985*
Waiver-Comprehensive	*$30,473*	*1*	
Waiver-Child Mental Health	-	-	-
Waiver-LTC	*$11,070,868*	*1,418*	*$7,807*
Waiver-Supports	*$454*	-	
Total	**$193,531,089**	**10,127**	**$19,110**

Children in Foster Care

The foster care program is administered through the DFS. Foster care provides for the 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 foster children while in the custody of DFS. There are two types of medical coverage for foster care children:

- Medicaid coverage provides medical care to foster care children who are eligible for Medicaid. According to Section 1902(a)(10)(A)(i)(I) of the Social Security Act, 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 other existing Medicaid coverage groups to extend coverage to non-Title IV-E eligible foster children and adopted children supported by state funded subsidies.
- State funded coverage provides medical care to foster care children who are not eligible for Medicaid. Children in this eligibility category include those awaiting eligibility determination, those who are not income eligible for Medicaid and those who are institutionalized.

The majority of children eligible for foster care are eligible to receive services that are paid by Medicaid. In SFY 2014 95 percent of all foster care children were eligible for Medicaid, with a total of 3,602, while state only foster care children totaled 203.

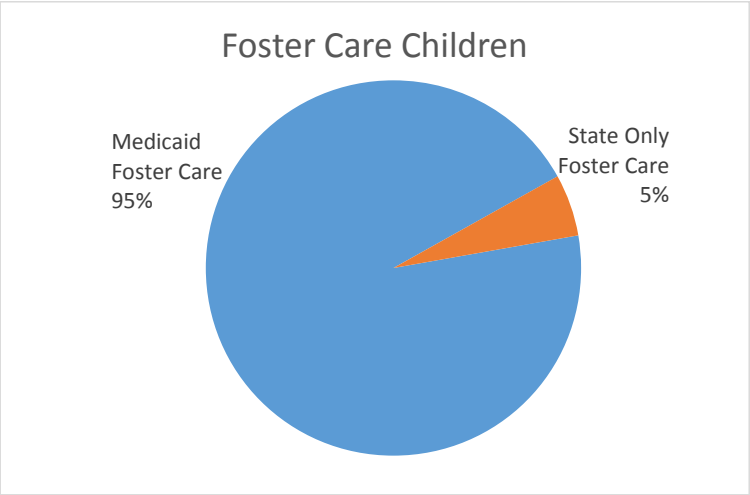

Figure 32: Foster Care Children

Table 123: Foster Care Eligibility History

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Medicaid Foster Care Eligible Individuals	3,237	3,111	3,148	3,248	3,369	3,602	11
State Only Foster Care Eligible Individuals	213	183	179	173	211	203	-5
Total Foster Care Eligible Individuals	**3,450**	**3,294**	**3,327**	**3,421**	**3,580**	**3,805**	**10**

Medicaid Foster Care Children

In SFY 2014, the number of children eligible for Medicaid foster care increased by seven percent from the previous year to 3,602, while the number of unduplicated Medicaid foster care recipients increased six percent and expenditures increased 16 percent during that same time.

Table 124: Medicaid Foster Care Children Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Eligible Individuals	3,237	3,111	3,148	3,248	3,369	3,602	11
Expenditures	$31,778,236	$28,858,199	$22,957,008	$17,534,383	$20,934,667	$24,197,999	-24
Recipients	3,501	3,266	3,341	3,303	3,444	3,645	4

State Funded Foster Care Children

In SFY 2014, the number of children eligible for state funded foster care decreased by four percent from the previous year to 203, while the number of unduplicated recipients increased by 15 percent and expenditures decreased by 3 percent during that same time.

Table 125: State Funded Foster Care Children Summary

	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Eligible Individuals	213	183	179	173	211	203	-5
Expenditures	$2,239,829	$2,052,536	$1,599,409	$1,517,769	$2,768,409	$2,697,681	20
Recipients	409	343	328	282	326	376	-8

Medicaid Foster Care

In SFY 2014 expenditures for Medicaid foster care totaled $24.2 million, accounting for five percent of total Medicaid expenditures. The top five service areas based on expenditures for Medicaid foster care were behavioral health, PRTF, prescription drugs, physician or other practitioner, and inpatient hospital.

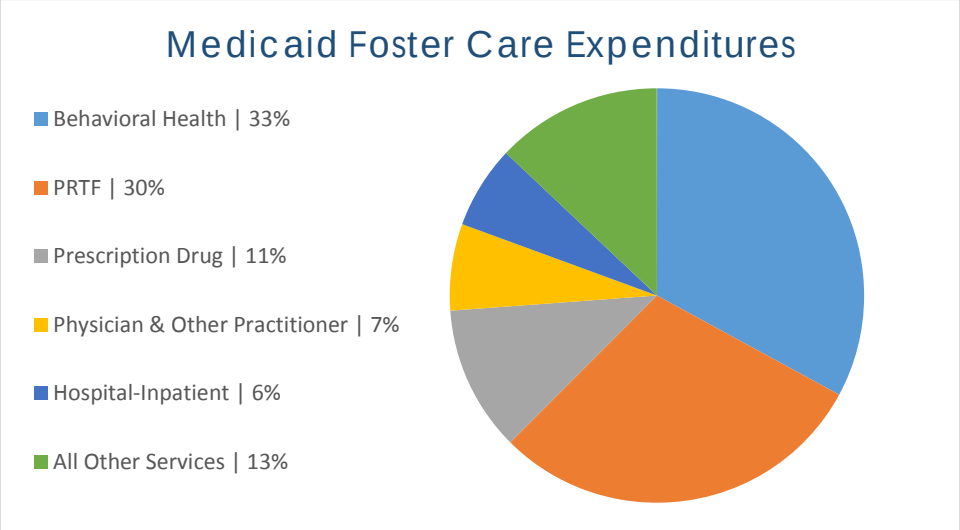

Figure 33: Medicaid Foster Care Expenditures

Table 126: Medicaid Foster Care Service Area Summary

Service Area	Expenditures	Recipients	Expenditures per Recipient
Ambulance	$98,607	112	$880
Ambulatory Surgery Center	$193,894	134	$1,447
Behavioral Health	$7,969,305	1,892	$4,212
CORF	$2,936	7	$419
Dental	$796,279	1,882	$423
DMEPOS	$124,084	144	$862
ESRD	$12,823	1	$12,823
FQHC	$107,959	166	$650
Home Health	$13,959	10	$1,396
Hospital Total	$2,406,952	1,484	$1,622
Hospital-Inpatient	*$1,558,593*	*173*	*$9,009*
Hospital-Other	*$63*	*1*	*$63*
Hospital-Outpatient	*$848,296*	*1,449*	*$585*
Interpreter	$90	1	$90
Laboratory	$28,355	322	$88
Other	$485,418	597	$813
Physician & Other Practitioner	$1,635,365	2,883	$567
Prescription Drug	$2,742,599	2,332	$1,176
PRTF	$7,153,744	149	$48,012
Radiology-Mobile	--	--	--
Rural Health Clinic	$87,935	302	$291
Vision	$337,696	1,244	$271
Total	**$24,197,999**	**3,645**	**$6,639**

Table 127: Change in Medicaid Foster Care Expenditures

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$133,932	$97,941	$83,516	$102,741	$122,303	$98,607	-26
Ambulatory Surgery Center	$166,343	$107,999	$109,855	$115,041	$154,125	$193,894	17
Behavioral Health	$4,500,794	$5,651,685	$6,438,697	$6,695,733	$7,670,908	$7,969,305	77
CORF	$4,151	$1,812	$7,191	$1,560	$3,245	$2,936	-29
Dental	$973,666	$782,598	$775,467	$804,203	$756,376	$796,279	-18
DMEPOS	$115,495	$76,482	$116,301	$116,201	$116,937	$124,084	7
ESRD	--	--	$18,132	$81,257	$65,216	$12,823	-29
FQHC	$128,982	$100,969	$98,434	$51,372	$73,787	$107,959	-16
Home Health	$2,282	$25,641	$2,366	$6,929	$5,577	$13,959	512
Hospital Total	$2,516,282	$2,567,341	$2,002,228	$1,883,261	$2,157,106	$2,406,952	-4
Hospital-Inpatient	*$1,912,920*	*$1,893,692*	*$1,368,399*	*$1,168,762*	*$1,382,914*	*$1,558,593*	*-19*
Hospital-Other	*-$16,450*	*-$5*	*-$207*	*$1,001*	*$4,129*	*$63*	*-100*
Hospital-Outpatient	*$619,812*	*$673,653*	*$634,036*	*$713,498*	*$770,063*	*$848,296*	*37*
Interpreter	$45	--	--	--	$23	$90	100
Laboratory	$35,249	$31,948	$27,294	$20,792	$24,492	$28,355	-20
Other	$13,588,600	$5,779,092	$562,503	$402,269	$452,765	$485,418	-96
Physician & Other Practitioner	$1,554,257	$1,476,481	$1,440,348	$1,317,214	$1,402,920	$1,635,365	5
Prescription Drug	$3,153,214	$3,004,818	$3,164,049	$2,591,551	$2,368,756	$2,742,599	-13
PRTF	$4,527,209	$8,769,574	$7,703,572	$2,959,843	$5,133,529	$7,153,744	58
Radiology-Mobile	$2,603	$6,304	$3,177	$943	--	--	-100
Rural Health Clinic	$74,610	$81,159	$100,547	$80,023	$83,810	$87,935	18
Vision	$300,524	$296,356	$303,334	$303,449	$342,793	$337,696	12
Total	**$31,778,236**	**$28,858,199**	**$22,957,008**	**$17,534,383**	**$20,934,667**	**$24,197,999**	**-24**

Table 128: Change in Medicaid Foster Care Recipient Count

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	129	109	106	112	104	112	-13
Ambulatory Surgery Center	135	103	105	114	120	134	-1
Behavioral Health	1,814	1,753	1,748	1,724	1,838	1,892	4
CORF	3	4	9	4	4	7	133
Dental	1,784	1,677	1,716	1,759	1,799	1,882	5
DMEPOS	135	157	149	135	146	144	7
ESRD	--	--	1	1	1	1	0
FQHC	241	192	180	72	161	166	-31
Home Health	3	6	4	8	10	10	233
Hospital Total	1,702	1,518	1,379	1,503	1,482	1,484	-13
Hospital-Inpatient	*202*	*183*	*157*	*139*	*163*	*173*	*-14*
Hospital-Other	*6*	*2*	*4*	*3*	*3*	*1*	*-83*
Hospital-Outpatient	*1,652*	*1,463*	*1,339*	*1,469*	*1,451*	*1,449*	*-12*
Interpreter	1	--	--	--	1	1	0
Laboratory	386	317	294	222	297	322	-17
Other	830	713	687	611	693	597	-28
Physician & Other Practitioner	2,675	2,495	2,499	2,514	2,448	2,883	8
Prescription Drug	2,366	2,225	2,252	2,174	2,287	2,332	-1
PRTF	103	239	194	92	133	149	45
Radiology-Mobile	9	11	8	9	--	--	-100
Rural Health Clinic	220	216	248	196	288	302	37
Vision	1,143	1,123	1,165	1,155	1,208	1,244	9
Total	**3,501**	**3,266**	**3,341**	**3,303**	**3,444**	**3,645**	**4**

State Funded Foster Care

In SFY 2014 expenditures for state funded foster care totaled $2.7 million, accounting for one half of one percent of total Medicaid expenditures. Over half (57 percent) of state funded foster care expenditures were for behavioral health services.

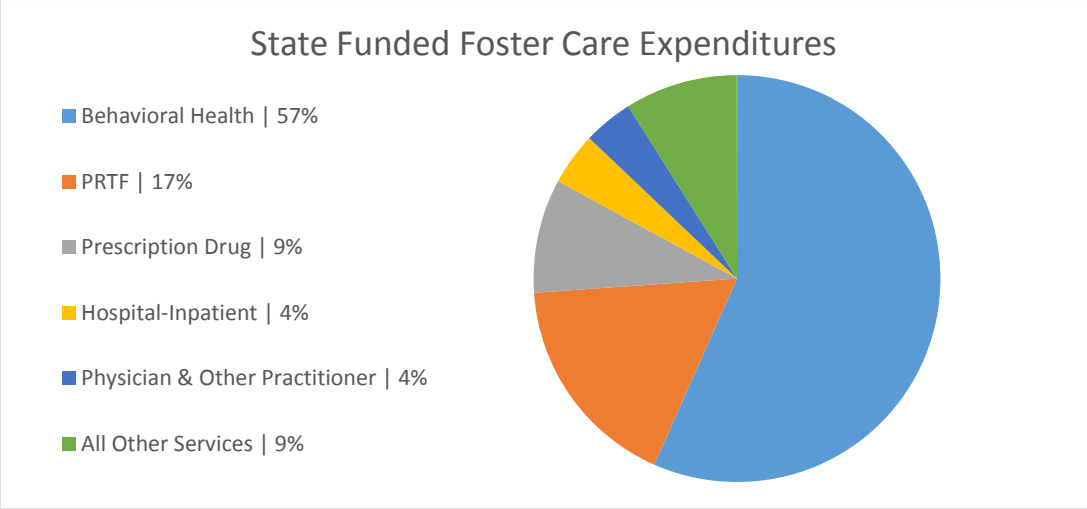

Figure 34: State Funded Foster Care Expenditures

Table 129: State Funded Foster Care Summary

Service Area	Expenditures	Recipients	Expenditures per Recipient
Ambulance	$8,550	11	$777
Ambulatory Surgery Center	--	--	--
Behavioral Health	$1,528,744	296	$5,165
CORF	$2,320	4	$580
Dental	$99,629	196	$508
DMEPOS	$4,544	10	$454
FQHC	$2,657	11	$242
Home Health	$600	1	$600
Hospital Total	$192,106	150	$1,281
Hospital-Inpatient	*$112,644*	*15*	*$7,510*
Hospital-Other	--	--	--
Hospital-Outpatient	*$79,462*	*143*	*$556*
Interpreter	--	--	--
Laboratory	$2,208	37	$60
Other	$6,065	85	$71
Physician & Other Practitioner	$105,887	248	$427
Prescription Drug	$243,728	259	$941
PRTF	$464,695	15	$30,980
Radiology-Mobile	--	--	--
Rural Health Clinic	$3,018	8	$377
Vision	$32,930	117	$281
Total	**$2,697,681**	**376**	**$7,175**

Table 130: Change in State Funded Foster Care Expenditures

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	$16,271	$1,343	$1,764	$2,680	$2,344	$8,550	-47
Ambulatory Surgery Center	$3,355	$2,391	--	$689	$1,046	--	-100
Behavioral Health	$886,154	$1,031,905	$974,848	$937,245	$1,838,682	$1,528,744	73
CORF	--	$395	--	--	$2,894	$2,320	488
Dental	$114,887	$119,490	$92,269	$82,656	$73,403	$99,629	-13
DMEPOS	$3,746	$916	$358	$3,958	$2,262	$4,544	21
FQHC	-$104	$5,685	$1,621	$1,062	$594	$2,657	-2658
Home Health	$338	--	--	--	$2,090	$600	78
Hospital Total	$243,356	$111,714	$136,786	$104,690	$182,416	$192,106	-21
Hospital-Inpatient	*$205,781*	*$70,682*	*$97,779*	*$72,987*	*$123,170*	*$112,644*	*-45*
Hospital-Other	*-$1,206*	*$1,199*	--	--	--	--	*-100*
Hospital-Outpatient	*$38,781*	*$39,832*	*$39,007*	*$31,702*	*$59,246*	*$79,462*	*105*
Interpreter	$23	--	--	$11	--	--	-100
Laboratory	$1,877	$1,558	$1,988	$1,454	$1,381	$2,208	18
Other	$493,381	$172,030	$9,847	$6,444	$5,892	$6,065	-99
Physician & Other Practitioner	$95,661	$61,557	$58,210	$65,307	$85,930	$105,887	11
Prescription Drug	$190,680	$144,671	$168,718	$155,382	$165,175	$243,728	28
PRTF	$155,720	$369,249	$123,507	$129,730	$368,351	$464,695	198
Radiology-Mobile	--	--	--	$176	--	--	-100
Rural Health Clinic	$3,707	$1,700	$1,131	$1,976	$1,272	$3,018	-19
Vision	$30,778	$27,933	$28,362	$24,308	$34,676	$32,930	7
Total	**$2,239,829**	**$2,052,536**	**$1,599,409**	**$1,517,769**	**$2,768,409**	**$2,697,681**	**20**

Table 131: Change in State Funded Foster Care Recipient Count

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulance	8	4	7	8	9	11	38
Ambulatory Surgery Center	4	2	--	1	2	--	-100
Behavioral Health	314	292	278	225	282	296	-6
CORF	--	3	--	--	2	4	33
Dental	184	194	158	155	168	196	7
DMEPOS	7	4	4	6	9	10	43
FQHC	3	8	8	3	2	11	267
Home Health	1	--	--	--	1	1	0
Hospital Total	151	124	102	106	127	150	-1
Hospital-Inpatient	*13*	*10*	*10*	*11*	*9*	*15*	*15*
Hospital-Other	*1*	*2*	--	--	--	--	*-100*
Hospital-Outpatient	*147*	*118*	*97*	*103*	*124*	*143*	*-3*
Interpreter	1	--	--	1	--	--	-100
Laboratory	14	18	18	10	21	37	164
Other	81	96	63	89	73	85	5
Physician & Other Practitioner	216	187	149	158	166	248	15
Prescription Drug	263	227	198	198	216	259	-2
PRTF	7	13	7	10	10	15	114
Radiology-Mobile	--	--	--	1	--	--	-100
Rural Health Clinic	16	6	8	5	10	8	-50
Vision	108	116	104	96	120	117	8
Total	**409**	**343**	**328**	**282**	**326**	**376**	**-8**


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Appendix B: Supplementary Tables

This section provides further detail on select programs within Medicaid, as well as additional tables with information related to demographics, counties, providers and births.

Demographics

Table 132: Medicaid Recipients by Age and Gender

Age Group	Female	Male	Total
0-20 Years	24,971	25,856	**50,827**
21-64 Years	14,819	5,426	**20,245**
65+	3,739	1,527	**5,266**
Total	**43,529**	**32,809**	**76,338**

Table 133: Medicaid Recipients by Race

Age Group	Black	Hispanic	Native American	White	Other	Total
0-20 Years	1,359	7,111	4,038	34,646	3,673	**50,827**
21-64 Years	410	1,522	1,388	15,843	1,082	**20,245**
65+	40	294	199	4,540	193	**5,266**
Total	**1,809**	**8,927**	**5,625**	**55,029**	**4,948**	**76,338**

Births

Table 134: Wyoming Medicaid Births[65]

Year	Wyoming Births	Medicaid Births	% 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%

[65] 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.

County

Table 135: County Summary[66]

County	Eligible Individuals[67]	Percent of Total Eligible Individuals	Recipients[68]	Expenditures	Percent of Total Expenditures
Albany	3,929	5	5,593	$23,917,791	5
Big Horn	2,050	2	1,765	$8,913,894	2
Campbell	6,318	7	6,551	$23,814,202	5
Carbon	2,330	3	2,115	$8,082,272	2
Converse	1,931	2	2,907	$7,630,526	1
Crook	841	1	583	$1,325,924	0
Fremont	9,762	11	9,822	$62,725,136	12
Goshen	2,250	3	2,118	$13,196,226	3
Hot Springs	931	1	1,491	$7,992,268	2
Johnson	933	1	1,288	$2,946,305	1
Laramie	14,704	17	18,934	$74,923,047	14
Lincoln	2,142	2	2,388	$8,538,953	2
Natrona	12,878	15	17,926	$84,342,887	16
Niobrara	462	1	382	$915,928	0
Other	1,620	2	21,658	$76,661,460	15
Park	3,811	4	5,027	$23,344,414	5
Platte	1,344	2	1,598	$4,077,961	1
Sheridan	3,823	4	4,838	$25,845,112	5
Sublette	786	1	994	$1,418,782	0
Sweetwater	5,874	7	5,803	$17,554,220	3
Teton	1,724	2	2,505	$5,888,936	1
Uinta	3,548	4	4,622	$25,285,264	5
Washakie	1,301	2	4,287	$5,531,982	1
Weston	896	1	1,023	$2,749,033	1
Total	**86,188**	**100**	**76,341**	**$517,622,524**	**100**

[66] Recipients and expenditures by county are based on county in which services were received determined by pay to provider location. Eligible individuals by county are based on individual's county of residence. For this reason the count of recipients in a particular county may exceed the number of eligible individuals within that same county.
[67] Eligibility is shown for Complete SFY.
[68] This table shows unduplicated recipient counts per county; however, because individuals may receive services in multiple counties, summing the counts for all counties will not match the total number of recipients shown.

Providers

Table 136: Provider Summary by Taxonomy

Provider Taxonomy and Description	Providers	Recipients	Expenditures
364SP0808X - Advance Practice Nurse	9	677	$272,949
207KA0200X - Allergy And Immunology, Allergy	8	808	$470,077
341600000X - Ambulance	68	3,530	$3,760,537
261QA0005X - Ambulatory Family Planning Facility	10	535	$71,213
261QA1903X - Ambulatory Surgical	37	3,400	$4,039,944
207L00000X - Anesthesiology	82	6,740	$2,459,938
231H00000X - Audiologist	16	460	$114,987
251B00000X - Case Management	103	1,961	$15,957,620
111N00000X - Chiropractor	16	71	$5,661
261Q00000X - Clinic/Center	13	1,520	$1,295,561
291U00000X - Clinical Medical Laboratory	81	9,505	$1,284,678
103TC0700X - Clinical Psychologist	126	4,946	$13,859,094
251C00000X - Day Training, Developmentally Disabled Service	691	2,437	$102,940,502
122300000X - Dentist	30	3,219	$1,242,847
207N00000X - Dermatology	16	2,227	$277,674
2085R0202X - Diagnostic Radiology	50	20,457	$2,699,798
332B00000X - Durable Medical Equipment And Medical Supplies	259	6,635	$6,427,307
207P00000X - Emergency Medicine	29	17,663	$3,459,580
261QE0700X - End-Stage Renal Disease (ESRD) Treatment	16	108	$1,071,750
1223E0200X - Endodontics	6	146	$116,279
363LF0000X - Family Health	16	1,611	$299,442
207Q00000X - Family Practice	99	22,742	$6,684,566
261QF0400X - Federally Qualified Health Center	8	4,038	$2,698,283
282N00000X - General Acute Care Hospital	192	32,898	$85,099,651
282NR1301X - General Acute Care Hospital - Rural	38	9,781	$15,639,679
1223G0001X - General Practice	149	15,301	$6,128,204
332S00000X - Hearing Aid Equipment	17	287	$613,437
251E00000X - Home Health	32	590	$3,533,728
251G00000X - Hospice Care, Community Based	14	252	$1,468,295
315P00000X - Intermediate Care Facility, Mentally Retarded	1	79	$19,152,530
207R00000X - Internal Medicine	67	12,090	$4,913,549
207RC0000X - Internal Medicine, Cardiovascular Disease	19	3,007	$474,579
207RE0101X - Internal Medicine, Endocrinology Diabetes And Metabolic	5	133	$29,923
207RG0100X - Internal Medicine, Gastroenterology	8	802	$348,782
207RG0300X - Internal Medicine, Geriatric Medicine	2	91	$18,321
207RX0202X - Internal Medicine, Medical Oncology	15	477	$3,230,629
207RN0300X - Internal Medicine, Nephrology	8	112	$43,608
207RP1001X - Internal Medicine, Pulmonary Disease	15	227	$91,813
207RR0500X - Internal Medicine, Rheumatology	4	264	$43,863
171R00000X - Interpreter	1	389	$38,171
1041C0700X - Licensed Clinic/Cert Social Worker	2	3	$1,124
275N00000X - Medicare Defined Swing Bed Unit	9	46	$796,835

Provider Taxonomy and Description	Providers	Recipients	Expenditures
261QM0801X - Mental Health-Including Community Mental Health	27	5,128	$9,097,476
367A00000X - Midwife, Certified Nurse	5	33	$19,024
207T00000X - Neurological Surgery	18	1,727	$964,837
367500000X - Nurse Anesthetist, Certified Registered	22	1,396	$376,138
363L00000X - Nurse Practitioner	11	907	$139,782
207V00000X - Obstetrics And Gynecology	48	6,472	$7,505,927
363LX0001X - Obstetrics And Gynecology	6	87	$18,749
207VG0400X - Obstetrics And Gynecology, Gynecology	4	20	$3,609
207VX0000X - Obstetrics And Gynecology, Obstetrics	2	4	$3,204
225X00000X - Occupational Therapist	16	282	$1,206,851
207W00000X - Ophthalmology	34	2,759	$651,370
156FX1800X - Optician	10	724	$97,813
152W00000X - Optometrist	92	14,237	$3,366,582
1223X0400X - Orthodontics	16	590	$406,649
207X00000X - Orthopedic Surgery	37	4,245	$1,262,261
207Y00000X - Otolaryngology	25	3,178	$893,581
251T00000X – PACE Organization	1	63	$1,288,934
207ZP0105X - Pathology	22	2,685	$329,317
208000000X - Pediatrics	67	16,145	$6,382,497
363LP0200X - Pediatrics	1	18	$7,004
2080N0001X - Pediatrics, Neonatal-Perinatal Medicine	9	1,458	$753,617
1223P0221X - Pedodontics	30	11,248	$4,706,746
1223P0300X - Periodontics	1	8	$527
333600000X - Pharmacy	198	44,467	$41,151,323
246RP1900X - Phlebotomy/WY Health Fair	1	57	$5,870
208100000X - Physical Medicine And Rehabilitation	15	391	$170,506
225100000X - Physical Therapist	56	2,397	$2,695,796
208D00000X - Physician, General Practice	76	21,876	$9,844,730
2082S0099X - Plastic Surgery	16	247	$130,775
213E00000X - Podiatrist	14	1,160	$77,507
101YP2500X - Professional Counseler	3	33	$26,127
335E00000X - Prosthetic/Orthotic Supplier	23	589	$587,006
283Q00000X - Psychiatric Hospital	4	42	$203,859
323P00000X - Psychiatric Residential Treatment Facility	21	339	$14,886,133
2084P0800X - Psychiatry And Neurology, Psychiatry	40	2,248	$3,177,882
2084N0400X - Psychiatry And Neurology: Neurology	26	2,003	$968,721
251K00000X - Public Health Or Welfare	24	5,779	$962,164
261QP0904X - Public Health, Federal	2	3,549	$7,999,556
261QR0208X - Radiology: Mobile	2	20	$226
283X00000X - Rehabilitation Hospital	4	75	$988,087
261QR0401X - Rehabilitation, Comprehensive Outpatient rehabilitation Facility (CORF)	1	225	$143,525
261QR0405X - Rehabilitation, Substance Use Disorder	28	1,287	$4,168,317
261QR1300X - Rural Health	20	4,676	$1,521,233
314000000X - Skilled Nursing Facility	50	2,365	$72,070,098

Provider Taxonomy and Description	Providers	Recipients	Expenditures
235Z00000X - Speech-Language Pathologist	9	162	$723,116
1223S0112X - Surgery, Oral & Maxillofacial	13	918	$790,683
2086S0120X - Surgery, Pediatric	2	97	$67,096
2086S0129X - Surgery, Vascular	5	70	$35,650
208600000X - Surgery: General Surgery	39	1,632	$684,844
208G00000X - Thoracic Surgery	2	9	$16,468
Unclassified	1	17	$87,293
208800000X - Urology	22	2,930	$778,430
Total	**3,603**	**76,336**	**$517,622,524**

Table 137: Top 20 Provider Types by Expenditures

Provider Taxonomy and Description	Expenditures	Expenditures Percent of Total
251C00000X - Day Training, Developmentally Disabled Service	$102,940,502	20%
282N00000X - General Acute Care Hospital	$85,099,651	16%
314000000X - Skilled Nursing Facility	$72,070,098	14%
333600000X - Pharmacy	$41,151,323	8%
315P00000X - Intermediate Care Facility, Mentally Retarded	$19,152,530	4%
251B00000X - Case Management	$15,957,620	3%
282NR1301X - General Acute Care Hospital - Rural	$15,639,679	3%
323P00000X - Psychiatric Residential Treatment Facility	$14,886,133	3%
103TC0700X - Clinical Psychologist	$13,859,094	3%
208D00000X - Physician, General Practice	$9,844,730	2%
261QM0801X - Mental Health-Including Community Mental Health	$9,097,476	2%
261QP0904X - Public Health, Federal	$7,999,556	2%
207V00000X - Obstetrics And Gynecology	$7,505,927	1%
207Q00000X - Family Practice	$6,684,566	1%
332B00000X - Durable Medical Equipment And Medical Supplies	$6,427,307	1%
208000000X - Pediatrics	$6,382,497	1%
1223G0001X - General Practice	$6,128,204	1%
207R00000X - Internal Medicine	$4,913,549	1%
1223P0221X - Pedodontics	$4,706,746	1%
261QR0405X - Rehabilitation, Substance Use Disorder	$4,168,317	1%
Total	**$454,615,505**	**88%**

Table 138: Provider Count History[69]

Provider Taxonomy and Description	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	5 Year Percent Change
363LA2200X - Adult Health	-	-	-	1	1	9	-
364SP0808X - Advance Practice Nurse	3	5	6	7	9	9	200
207KA0200X - Allergy And Immunology, Allergy	5	6	6	7	7	8	60
341600000X - Ambulance	67	67	69	66	64	68	1
261QA0005X - Ambulatory Family Planning Facility	10	10	10	10	10	10	0
261QA1903X - Ambulatory Surgical	36	36	38	38	39	37	3
207L00000X - Anesthesiology	82	77	82	79	84	82	0
231H00000X - Audiologist	19	15	14	17	19	16	-16
251B00000X - Case Management	98	106	108	102	103	103	5
111N00000X - Chiropractor	14	14	16	18	20	16	14
261Q00000X - Clinic/Center	14	13	12	13	13	13	-7
207SG0201X - Clinical Genetics (M.D.)	-	-	-	-	1	-	-
291U00000X - Clinical Medical Laboratory	65	71	69	79	87	81	25
103TC0700X - Clinical Psychologist	67	67	70	78	106	126	88
251C00000X - Day Training, Developmentally Disabled Service	859	885	879	801	777	691	-20
1223D0001X - Dental Public Health	1	1	-	-	-	-	-
122300000X - Dentist	21	22	20	23	31	30	43
207N00000X - Dermatology	15	16	16	19	18	16	7
2085R0202X - Diagnostic Radiology	53	56	56	50	53	50	-6
332B00000X - Durable Medical Equipment And Medical Supplies	232	235	223	245	247	259	12
207P00000X - Emergency Medicine	25	24	26	23	26	29	16
261QE0700X - End-Stage Renal Disease (ESRD) Treatment	13	11	11	14	15	16	23
1223E0200X - Endodontics	2	4	4	5	5	6	200
363LF0000X - Family Health	10	10	10	13	12	16	60
207Q00000X - Family Practice	109	93	89	97	100	99	-9
261QF0400X - Federally Qualified Health Center	8	7	5	9	7	8	0
282N00000X - General Acute Care Hospital	190	201	189	207	201	192	1
282NR1301X - General Acute Care Hospital - Rural	28	31	32	38	46	38	36
1223G0001X - General Practice	157	146	153	155	149	149	-5
332S00000X - Hearing Aid Equipment	18	19	20	20	19	17	-6
251E00000X - Home Health	29	29	28	30	31	32	10
251G00000X - Hospice Care, Community Based	19	14	13	14	12	14	-26
315P00000X - Intermediate Care Facility, Mentally Retarded	3	1	1	1	1	1	-67
207R00000X - Internal Medicine	65	63	59	73	80	67	3
207RC0000X - Internal Medicine, Cardiovascular Disease	22	20	16	19	17	19	-14
207RE0101X - Internal Medicine, Endocrinology Diabetes And Metabolic	9	10	9	7	6	5	-44
207RG0100X - Internal Medicine, Gastroenterology	9	12	10	10	9	8	-11

[69] Provider counts are based on claims data and do not indicate the number of providers enrolled with Medicaid, only those who have billed claims during the SFY shown.

Provider Taxonomy and Description	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	5 Year Percent Change
207RG0300X - Internal Medicine, Geriatric Medicine	1	1	1	1	2	2	100
207RX0202X - Internal Medicine, Medical Oncology	19	19	18	15	15	15	-21
207RN0300X - Internal Medicine, Nephrology	10	8	8	9	8	8	-20
207RP1001X - Internal Medicine, Pulmonary Disease	16	15	11	11	14	15	-6
207RR0500X - Internal Medicine, Rheumatology	6	4	4	4	4	4	-33
171R00000X - Interpreter	1	4	2	2	1	1	0
1041C0700X - Licensed Clinic/Cert Social Worker	-	-	-	1	2	2	-
275N00000X - Medicare Defined Swing Bed Unit	15	17	17	16	10	9	-40
261QM0801X - Mental Health-Including Community Mental Health	26	25	27	52	36	27	4
367A00000X - Midwife, Certified Nurse	3	4	6	6	6	5	67
207T00000X - Neurological Surgery	18	17	18	18	20	18	0
204D00000X - Neuromusculoskeletal Medicine And Omm	1	1	1	1	-	-	-
367500000X - Nurse Anesthetist, Certified Registered	20	23	23	21	24	22	10
363L00000X - Nurse Practitioner	7	7	6	6	9	11	57
207V00000X - Obstetrics And Gynecology	62	55	52	54	54	48	-23
363LX0001X - Obstetrics And Gynecology	4	4	5	5	6	6	50
207VG0400X - Obstetrics And Gynecology, Gynecology	3	4	3	2	3	4	33
207VX0000X - Obstetrics And Gynecology, Obstetrics	2	2	2	3	2	2	0
225X00000X - Occupational Therapist	9	9	13	13	15	16	78
207W00000X - Ophthalmology	44	40	35	36	36	34	-23
156FX1800X - Optician	9	10	11	11	11	10	11
152W00000X - Optometrist	100	98	94	97	96	92	-8
1223X0400X - Orthodontics	7	7	17	17	15	16	129
207X00000X - Orthopedic Surgery	56	53	50	44	44	37	-34
207Y00000X - Otolaryngology	36	31	30	29	29	25	-31
251T00000X - PACE Organization	-	-	-	-	1	1	-
207ZP0105X - Pathology	21	20	20	20	22	22	5
208000000X - Pediatrics	74	74	70	70	71	67	-9
363LP0200X - Pediatrics	1	1	1	1	1	1	0
2080N0001X - Pediatrics, Neonatal-Perinatal Medicine	11	10	8	9	9	9	-18
1223P0221X - Pedodontics	24	24	26	28	32	30	25
1223P0300X - Periodontics	2	1	1	-	1	1	-50
333600000X - Pharmacy	212	208	205	199	198	198	-7
246RP1900X - Phlebotomy/WY Health Fair	1	1	1	1	1	1	0
208100000X - Physical Medicine And Rehabilitation	10	11	12	14	16	15	50
225100000X - Physical Therapist	54	56	54	58	56	56	4
363A00000X - Physician Assistant	1	-	-	-	-	-	-
208D00000X - Physician, General Practice	92	86	96	93	86	76	-17
2082S0099X - Plastic Surgery	18	17	18	17	17	16	-11
213E00000X - Podiatrist	14	14	18	15	17	14	0

Provider Taxonomy and Description	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	5 Year Percent Change
101YP2500X - Professional Counselor	6	5	8	7	5	3	-50
335E00000X - Prosthetic/Orthotic Supplier	28	26	25	25	26	23	-18
283Q00000X - Psychiatric Hospital	2	2	2	1	4	4	100
323P00000X - Psychiatric Residential Treatment Facility	16	22	22	15	19	21	31
2084P0800X - Psychiatry And Neurology, Psychiatry	33	38	38	38	43	40	21
2084N0400X - Psychiatry And Neurology: Neurology	30	31	23	26	27	26	-13
251K00000X - Public Health Or Welfare	24	24	25	25	24	24	0
261QP0904X - Public Health, Federal	1	1	2	2	2	2	100
261QR0208X - Radiology: Mobile	5	5	4	3	2	2	-60
261QR0400X - Rehabilitation	1	0	-	-	-	-	-
283X00000X - Rehabilitation Hospital	4	4	3	3	3	4	0
261QR0401X - Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	1	1	1	1	1	1	0
261QR0405X - Rehabilitation, Substance Use Disorder	22	23	27	52	30	28	27
322D00000X - Residential Treatment Facility For Emotionally Challenged Children	25	26	9	4	2	-	-
261QR1300X - Rural Health	22	20	21	19	20	20	-9
314000000X - Skilled Nursing Facility	38	43	43	40	45	50	32
235Z00000X - Speech-Language Pathologist	-	6	8	8	5	9	-
1223S0112X - Surgery, Oral & Maxillofacial	12	15	16	16	17	13	8
2086S0120X - Surgery, Pediatric	3	3	2	2	2	2	-33
2086S0129X - Surgery, Vascular	7	7	6	6	5	5	-29
208600000X - Surgery: General Surgery	50	50	39	45	48	39	-22
208G00000X - Thoracic Surgery	2	4	3	5	3	2	0
Unclassified	-	1	1	1	1	1	-
208800000X - Urology	25	22	20	22	21	22	-12
Total	**3,742**	**3,755**	**3,699**	**3,752**	**3,763**	**3,603**	**-4**

Table 139: Provider History by Expenditures

Provider Taxonomy and Description	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	5 Year Percent Change
363LA2200X - Adult Health	-	-	-	$208	$181	-	-
364SP0808X - Advance Practice Nurse	$155,260	$194,737	$203,063	$185,079	$217,012	$272,949	76
207KA0200X - Allergy And Immunology, Allergy	$341,077	$420,255	$457,860	$462,979	$412,870	$470,077	38
341600000X - Ambulance	$4,327,795	$3,807,538	$3,303,240	$3,459,400	$3,606,360	$3,760,537	-13
261QA0005X - Ambulatory Family Planning Facility	$100,239	$103,949	$83,744	$81,564	$68,988	$71,213	-29
261QA1903X - Ambulatory Surgical	$3,497,383	$3,315,928	$2,912,791	$2,822,957	$3,439,188	$4,039,944	16
207L00000X - Anesthesiology	$3,200,397	$2,873,295	$2,688,531	$2,660,467	$2,569,464	$2,459,938	-23
231H00000X - Audiologist	$54,644	$55,615	$53,035	$113,056	$124,025	$114,987	110
251B00000X - Case Management	$14,407,109	$16,814,987	$16,969,265	$16,187,605	$16,073,653	$15,957,620	11
111N00000X - Chiropractor	$6,746	$5,874	$6,102	$7,349	$7,500	$5,661	-16
261Q00000X - Clinic/Center	$1,022,376	$1,327,399	$1,496,903	$1,195,547	$1,166,813	$1,295,561	27
207SG0201X - Clinical Genetics (M.D.)	-	-	-	-	$1,345	-	-
291U00000X - Clinical Medical Laboratory	$852,797	$1,121,964	$1,171,185	$1,100,774	$1,149,473	$1,284,678	51
103TC0700X - Clinical Psychologist	$5,516,132	$6,752,837	$7,780,854	$9,025,018	$11,432,476	$13,859,094	151
251C00000X - Day Training, Developmentally Disabled Service	$102,447,300	$96,906,907	$103,602,106	$106,417,236	$105,946,874	$102,940,502	0
1223D0001X - Dental Public Health	$830,140	$220,085	-	-	-	-	-
122300000X - Dentist	$921,677	$1,177,716	$1,307,247	$1,304,083	$1,299,057	$1,242,847	35
207N00000X - Dermatology	$242,682	$278,029	$306,992	$346,181	$301,872	$277,674	14
2085R0202X - Diagnostic Radiology	$2,344,973	$2,401,544	$2,557,894	$2,698,857	$2,766,607	$2,699,798	15
332B00000X - Durable Medical Equipment And Medical Supplies	$4,790,456	$5,417,606	$5,988,070	$5,803,375	$6,501,225	$6,427,307	34
207P00000X - Emergency Medicine	$3,484,047	$3,740,215	$3,800,063	$3,662,836	$3,587,560	$3,459,580	-1
261QE0700X - End-Stage Renal Disease (ESRD) Treatment	$1,347,305	$1,160,798	$835,621	$1,233,755	$1,343,669	$1,071,750	-20
1223E0200X - Endodontics	$84,246	$114,460	$154,897	$145,175	$176,754	$116,279	38
363LF0000X - Family Health	$178,227	$240,460	$308,796	$307,731	$312,321	$299,442	68
207Q00000X - Family Practice	$6,740,124	$6,571,534	$6,601,112	$6,408,005	$7,194,712	$6,684,566	-1
261QF0400X - Federally Qualified Health Center	$4,113,634	$2,864,956	$3,103,164	$1,550,274	$2,018,911	$2,698,283	-34
282N00000X - General Acute Care Hospital	$84,906,412	$97,112,122	$96,670,956	$89,158,045	$90,818,612	$85,099,651	0
282NR1301X - General Acute Care Hospital - Rural	$12,758,988	$14,087,353	$16,907,624	$15,538,331	$16,826,942	$15,639,679	23

Provider Taxonomy and Description	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	5 Year Percent Change
1223G0001X - General Practice	$5,929,594	$6,667,264	$6,985,175	$6,567,492	$6,223,175	$6,128,204	3
332S00000X - Hearing Aid Equipment	$553,776	$542,768	$737,738	$688,994	$560,896	$613,437	11
251E00000X - Home Health	$1,998,695	$1,941,097	$2,732,905	$2,963,510	$2,897,016	$3,533,728	77
251G00000X - Hospice Care, Community Based	$939,603	$1,432,471	$1,036,887	$983,026	$1,082,188	$1,468,295	56
315P00000X - Intermediate Care Facility, Mentally Retarded	$9,159,786	$10,651,941	$11,388,412	$10,065,657	$17,942,326	$19,152,530	109
207R00000X - Internal Medicine	$2,603,182	$2,677,104	$3,681,658	$4,165,557	$4,488,138	$4,913,549	89
207RC0000X - Internal Medicine, Cardiovascular Disease	$405,660	$591,191	$538,377	$447,730	$419,713	$474,579	17
207RE0101X - Internal Medicine, Endocrinology Diabetes And Metabolic	$38,309	$28,542	$29,855	$31,333	$30,547	$29,923	-22
207RG0100X - Internal Medicine, Gastroenterology	$218,798	$293,075	$209,512	$253,524	$201,831	$348,782	59
207RG0300X - Internal Medicine, Geriatric Medicine	$2,391	$15,894	$14,477	$189	$1,187	$18,321	666
207RX0202X - Internal Medicine, Medical Oncology	$1,221,165	$1,727,358	$1,792,761	$2,090,706	$3,029,644	$3,230,629	165
207RN0300X - Internal Medicine, Nephrology	$53,850	$42,389	$34,141	$57,824	$47,826	$43,608	-19
207RP1001X - Internal Medicine, Pulmonary Disease	$176,125	$48,942	$59,557	$73,916	$119,064	$91,813	-48
207RR0500X - Internal Medicine, Rheumatology	$33,008	$46,899	$50,926	$53,116	$41,963	$43,863	33
171R00000X - Interpreter	$49,399	$47,837	$54,259	$48,321	$43,529	$38,171	-23
1041C0700X - Licensed Clinic/Cert Social Worker	-	-	-	$2,564	$5,966	$1,124	-
275N00000X - Medicare Defined Swing Bed Unit	$780,041	$879,546	$866,458	$1,072,703	$887,666	$796,835	2
261QM0801X - Mental Health-Including Community Mental Health	$8,662,327	$10,274,257	$9,911,967	$9,581,854	$9,640,599	$9,097,476	5
367A00000X - Midwife, Certified Nurse	$28,355	$16,873	$16,281	$35,068	$18,485	$19,024	-33
207T00000X - Neurological Surgery	$1,229,804	$1,245,000	$1,177,850	$1,063,118	$890,226	$964,837	-22
204D00000X - Neuromusculoskeletal Medicine And Omm	$59,204	$24,238	$853	$0	-	-	-
367500000X - Nurse Anesthetist, Certified Registered	$417,921	$524,777	$491,532	$378,968	$426,998	$376,138	-10
363L00000X - Nurse Practitioner	$88,516	$168,666	$118,770	$205,988	$279,449	$139,782	58
207V00000X - Obstetrics And Gynecology	$10,681,327	$11,210,316	$10,784,741	$9,603,368	$8,906,934	$7,505,927	-30
363LX0001X - Obstetrics And Gynecology	$392,250	$420,486	$735,818	$668,453	$356,682	$18,749	-95
207VG0400X - Obstetrics And Gynecology, Gynecology	$105,730	$90,214	$12,646	$14,134	$8,385	$3,609	-97
207VX0000X - Obstetrics And Gynecology, Obstetrics	$13,624	$10,594	$8,899	$6,188	$4,232	$3,204	-76
225X00000X - Occupational Therapist	$371,252	$335,576	$519,915	$777,572	$667,385	$1,206,851	225
207W00000X - Ophthalmology	$653,248	$698,593	$700,218	$709,763	$693,621	$651,370	0
156FX1800X - Optician	$123,729	$140,095	$123,831	$101,728	$94,212	$97,813	-21

Provider Taxonomy and Description	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	5 Year Percent Change
152W00000X - Optometrist	$2,762,647	$3,046,630	$3,103,713	$3,090,404	$3,295,581	$3,366,582	22
1223X0400X - Orthodontics	$218,399	$229,986	$314,684	$456,310	$415,802	$406,649	86
207X00000X - Orthopedic Surgery	$1,820,454	$1,836,993	$1,657,652	$1,679,389	$1,480,296	$1,262,261	-31
207Y00000X - Otolaryngology	$1,062,191	$1,000,269	$1,097,720	$982,135	$882,361	$893,581	-16
251T00000X - PACE Organization	-	-	-	-	$168,398	$1,288,934	-
207ZP0105X - Pathology	$355,054	$333,627	$414,608	$413,824	$365,084	$329,317	-7
208000000X - Pediatrics	$7,627,451	$8,425,254	$7,408,393	$6,332,565	$5,954,804	$6,382,497	-16
363LP0200X - Pediatrics	$22,294	$32,367	$22,194	$10,525	$10,696	$7,004	-69
2080N0001X - Pediatrics, Neonatal-Perinatal Medicine	$1,245,886	$1,217,266	$802,591	$761,916	$812,471	$753,617	-40
1223P0221X - Pedodontics	$3,307,266	$3,588,181	$3,923,576	$4,109,557	$4,374,460	$4,706,746	42
1223P0300X - Periodontics	$6,204	$2,766	$60	-	$1,385	$527	-92
333600000X - Pharmacy	$39,302,672	$38,750,658	$41,330,767	$41,918,402	$38,919,301	$41,151,323	5
246RP1900X - Phlebotomy/WY Health Fair	$21,915	$3,520	$3,820	$5,910	$2,635	$5,870	-73
208100000X - Physical Medicine And Rehabilitation	$124,590	$164,875	$135,880	$106,951	$143,519	$170,506	37
225100000X - Physical Therapist	$1,642,817	$2,415,165	$2,776,082	$2,673,200	$2,799,403	$2,695,796	64
363A00000X - Physician Assistant	$93	-	-	-	-	-	-
208D00000X - Physician, General Practice	$9,424,001	$9,907,834	$10,068,544	$9,845,606	$9,598,191	$9,844,730	4
2082S0099X - Plastic Surgery	$191,938	$238,432	$154,444	$142,040	$133,343	$130,775	-32
213E00000X - Podiatrist	$50,213	$48,861	$76,857	$73,605	$65,795	$77,507	54
101YP2500X - Professional Counselor	$58,380	$32,630	$40,195	$43,384	$24,104	$26,127	-55
335E00000X - Prosthetic/Orthotic Supplier	$1,014,048	$645,342	$779,875	$778,124	$828,261	$587,006	-42
283Q00000X - Psychiatric Hospital	$2,957,631	$1,132,834	$1,284	$17,594	$106,009	$203,859	-93
323P00000X - Psychiatric Residential Treatment Facility	$8,345,259	$14,658,731	$15,244,613	$8,019,118	$12,080,494	$14,886,133	78
2084P0800X - Psychiatry And Neurology, Psychiatry	$3,721,374	$4,085,344	$4,818,845	$4,695,322	$3,682,231	$3,177,882	-15
2084N0400X - Psychiatry And Neurology: Neurology	$942,694	$837,067	$781,629	$672,232	$661,311	$968,721	3
251K00000X - Public Health Or Welfare	$1,005,563	$1,081,591	$1,093,398	$988,455	$924,007	$962,164	-4
261QP0904X - Public Health, Federal	$6,861,407	$7,700,047	$8,532,271	$7,240,130	$8,067,975	$7,999,556	17
261QR0208X - Radiology: Mobile	$191,239	$222,281	$217,463	$109,250	$4,081	$226	-100
261QR0400X - Rehabilitation	$19,509	$0	-	-	-	-	-
283X00000X - Rehabilitation Hospital	$1,734,938	$1,308,965	$777,740	$1,085,017	$1,087,890	$988,087	-43

Provider Taxonomy and Description	SFY2009	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	5 Year Percent Change
261QR0401X - Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	$59,613	$36,757	$56,646	$125,928	$121,618	$143,525	141
261QR0405X - Rehabilitation, Substance Use Disorder	$825,236	$1,545,165	$2,172,581	$2,592,208	$3,352,288	$4,168,317	405
322D00000X - Residential Treatment Facility For Emotionally Challenged Children	$19,175,557	$8,757,612	$424,200	$183,009	$109,220	-	-
261QR1300X - Rural Health	$1,515,936	$1,710,855	$1,940,640	$1,628,043	$1,845,491	$1,521,233	0
314000000X - Skilled Nursing Facility	$72,408,622	$74,555,265	$72,313,876	$72,733,100	$72,705,796	$72,070,098	0
235Z00000X - Speech-Language Pathologist	-	$144,868	$227,230	$117,626	$336,118	$723,116	-
1223S0112X - Surgery, Oral & Maxillofacial	$765,419	$863,849	$930,943	$978,561	$781,478	$790,683	3
2086S0120X - Surgery, Pediatric	$116,323	$80,818	$48,896	$90,962	$63,361	$67,096	-42
2086S0129X - Surgery, Vascular	$28,746	$47,597	$48,526	$38,008	$32,715	$35,650	24
208600000X - Surgery: General Surgery	$942,605	$935,283	$853,509	$796,756	$765,767	$684,844	-27
208G00000X - Thoracic Surgery	$22,170	$15,186	$12,002	$11,995	$13,475	$16,468	-26
Unclassified	-	$120,195	$21,733	-$4,024	$30,590	$87,293	-
208800000X - Urology	$762,040	$886,191	$887,064	$799,645	$835,010	$778,430	2
Total	**$498,325,166**	**$514,529,323**	**$519,604,279**	**$500,931,031**	**$517,257,164**	**$517,622,524**	**4**

Table 140: Ambulatory Surgical Center (ASC) SFY 2014 Expenditures and Rates by ASC Grouping[70]

ASC Grouping	Expenditures	Percent of Total ASC Expenditures	Calendar Year 2014 Rates
Group 1	$130,701	3	300
Group 2	$291,741	7	401
Group 3	$197,402	5	459
Group 4	$420,183	10	567
Group 5	$49,370	1	645
Group 6	$927	0	743
Group 7	$58,691	1	896
Group 8	$66,602	2	876
Group Y	$2,821,868	70	70% of billed charges
Group Z	$260	0	
Unknown	$2,600	0	

[70] The ASC Groupings exclude gross adjustments. Summing the expenditures for the ASC Grouping will not match the total ASC expenditures. The expenditures in group Y represent expenditures for procedure codes that do not fall into ASC groups 1 through 8. Medicaid reviews these procedure codes and pays them at a percentage of billed charges. Procedure code 41899 represents 100 percent of group Y expenditures.

Table 141: Reimbursement History by Service Area

Service Area	Reimbursement Description	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	Rate Method Authority for SFY 2014
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	No Change	Rates adjusted to 75% of Medicare's 2008 ambulance rates	No Change	No Change	No Change	No Change	Wyoming State Rule Chapter 15; Chapter 3
Ambulatory Surgery Center	Lower of the Medicaid fee schedule or the provider's usual and customary charge Rates based on eight ASC payment groups established by Medicare. The groups are all inclusive bundled payment per procedure code. Ninth payment group rate is 70% of billed charges Rates are 90% of Medicare's 2007 ASC rates	No Change	No Change	No Change	No Change	No Change	No Change	43 CFR 447.321 State Plan Amendment 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	No Change	CPT code rates decreased to 90% of Medicare's rates (effective November 1, 2009)	No Change	No Change	No Change	No Change	42 CFR 440.130 42 CFR 440.40b 42 CFR 440.169 State Plan Amendment 3.1d and 4.19b

Service Area	Reimbursement Description	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	Rate Method Authority for SFY 2014
Comprehensive Outpatient Rehabilitation Facility	Lower of the Medicaid fee schedule or the provider's usual and customary charge	Payment methodology changed from a revenue code to a procedure code fee schedule.	No Change	No Change	No Change	No Change	No change	42 CFR 414.1105; State Plan 3.1A, 13d. Rehab Services; Attachment 4.19B 13d. Rehab Services
Dental	Lower of the Medicaid fee schedule or the provider's usual and customary charge Adult optional dental services added (effective July 1, 2006)	No Change	No Change	No Change	No Change	No Change	No Change	State Plan Amendment 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	Rates increased to 90% of Medicare's rates (effective January 1, 2009)	No Change	No Change	No Change	No Change	No Change	Wyoming State Rule Chapter 11; Chapter 3; Wyoming State Plan Attachment 4.19B-12c

Service Area	Reimbursement Description	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	Rate Method Authority for SFY 2014
End State Renal Dialysis	Lower of the Medicaid fee schedule or the provider's usual and customary charge Dialysis services reimbursed at a percentage of billed charges	Dialysis services reimbursed at 70% of billed charges (effective September 1, 2008)	No Change	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)	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)	Rates increased 1.6% based on MEI	Rates increased 1.2% based on MEI	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	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	No Change	No Change	No Change	No Change	No Change	No Change	
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)	Rates adjusted per Medicare's adjustments	Rates adjusted per Medicare's adjustments	Rates adjusted per Medicare's adjustments	Rates adjusted per Medicare's adjustments	Rates adjusted per Medicare's adjustments	Rates adjusted per Medicare's adjustments	42 CFR 418 Wyoming State Statute 42-4-103(a)(xxv)

Service Area	Reimbursement Description	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	Rate Method Authority for SFY 2014
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	LOC rates increased 3.1% for inflation No change for QRA	Rebased the LOC system using more recent cost and claims data to better categorize services. New rates effective September 1, 2009 Legislated approved budget reduction of $5.8 million over two years based on Governor's recommendations Based on a budget footnote, the Governor's office authorized an increase to The Children's Hospital rates after the required reductions, resulting in an increase of $1 million over a two year period Based on meetings with Senior Management of Wyoming Department of Health and Wyoming Behavioral Institute, increased Wyoming Behavioral Institute's rates after the required reductions, resulting in an	No change	No change	No change	No change	CFR 447 Subpart C Payment; State Plan 4.19B

Service Area	Reimbursement Description	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	Rate Method Authority for SFY 2014
			increase of $2 million over a two year period Between the budget footnote and the Senior Management meetings above, the overall reduction to inpatient hospital rates is expected to reflect $2.8 million instead of $5.8 million No change for QRA					
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	Increased conversion factors (effective January 1, 2009): General acute $49.54 Critical access $129.48 Children's $112.96 No change for QRA	No change	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 No change for QRA	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 No change for QRA	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 No change for QRA	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 No change for QRA	CFR 447.321; CFR 447.325; Chapter 33 Rule

Service Area	Reimbursement Description	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	Rate Method Authority for SFY 2014
	non-state governmental hospital							
Interpreter	Lower of the Medicaid fee schedule or the provider's usual and customary charge	No change	No change	No change	No change	No change	No change	Wyoming State Rule Chapter 3
Lab	Lower of the Medicaid fee schedule or the provider's usual and customary charge	Rates increased to 90% of Medicare's rates	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)	Rates adjusted based on analysis of Medicaid cost reports	Rates adjusted based on analysis of Medicaid cost reports	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	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.	No change	Adopted Medicare's 2009 RVUs (effective August 1, 2009) Adjusted the conversion factors for physician services (effective August 1, 2009) Reimbursement budget reduced by $4.8 million	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 affected Evaluation and Management procedure codes	The ACA Primary Care Service Payments officially ended December 31, 2014.	State Plan Amendment 3.1 and 4.19B

Service Area	Reimbursement Description	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	Rate Method Authority for SFY 2014
						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.		
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	Preferred Drug List (PDL) expanded to 21 specific drug classes	PDL expanded to 32 specific drug classes	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	**State Plan Amendment**, Attachment 4.19B, Section 12.a., pages 1-3; **Wyoming Medicaid Rules**, Chapter 10, Pharmaceutical Services, Section 16 (Medicaid Allowable Payment)
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.	No change	Rates increased based on analysis of Medicaid cost reports	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	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

Service Area	Reimbursement Description	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	Rate Method Authority for SFY 2014
Radiology	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.	Rates increased to 90% of Medicare's non-facility rates	No change	No change	No change	No change	No change	Wyoming State Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B
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)	No change	No change	No change	No change	No change	Rates increased 0.8% 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 reimbursement under the Resource-Based Relative Value Scale (RBRVS) methodology based on Medicare's RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rates. Optician reimbursement based on a procedure code fee schedule	No change	No change	No change	No change	No change	No Change	State Plan 3.1-A State Plan 4.19B/6.b

Service Area	Reimbursement Description	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	Rate Method Authority for SFY 2014
Waiver (Acquired Brain Injury, Adults with Developmental Disabilities and Children with Developmental Disabilities)	Cost based reimbursement methodology, implemented in SFY 2009. The Individualized Budget Amount (IBA) is based on the historical plan of care units multiplied by the respective service rate less one-time costs, such as assessments, specialized equipment or home modifications. Prior to cost based reimbursement Individualized budget amount determined by the "DOORS" funding model, which estimates individual expenditures based on specific customer characteristics. Reimbursement for specific residential and day habilitation services is made on a per diem basis and varies by provider and consumer. Consumers negotiate rates based on their budget amount. 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	New cost based reimbursement methodology implemented July 1, 2008	Rates decreased 10% due to budget reduction	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.	Medicaid is required by statute to rebase the rates and conduct the rate studies every 2 -4 years as stated in Wyoming Statute Wyo. Stat. § 42-4-120(g) for the Acquired Brain Injury, Comprehensive, and Supports Medicaid Waiver programs administered by the Behavioral Health Division of the Agency.

Service Area	Reimbursement Description	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	Rate Method Authority for SFY 2014
	change in client needs or emergencies.							
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	No change	Rates adjusted to reflect budget neutrality	No change	No change	No change	No Change	1915(c)
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	No change	No change	No change	No change	No change	No change	Waiver agreement
Waiver (Assisted Living Facility)	Reimbursement made on a per diem rate, based on an all-inclusive payment methodology. Per diem rates are 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.	No change	No change	No change	No change	No change	No change	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 table	Implemented Waiver	No change	No change	No change	No change	Extended to 12.31.17	11-W-00238/8

Service Area	Reimbursement Description	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	Rate Method Authority for SFY 2014
Waiver (Comprehensive)	The waiver was implemented in SFY 2014	n/a	n/a	n/a	n/a	n/a	Rates were based on the methodology from FY09 but with the reductions made in FY11 and FY 14. The rates for new services were also based on these methodologies and reductions.	Medicaid is required by statute to rebase the rates and conduct the rate studies every 2 -4 years as stated in Wyoming Statute Wyo. Stat. § 42-4-120(g) for the Acquired Brain Injury, Comprehensive, and Supports Medicaid Waiver programs administered by the Behavioral Health Division of the Agency.
Waiver (Supports)	The waiver was implemented in SFY 2014	n/a	n/a	n/a	n/a	n/a	Rates were based on the methodology from FY09 but with the reductions made in FY11 and FY 14. The rates for new services were also based on these methodologies and reductions.	Medicaid is required by statute to rebase the rates and conduct the rate studies every 2 -4 years as stated in Wyoming Statute Wyo. Stat. § 42-4-120(g) for the Acquired Brain Injury, Comprehensive, and Supports Medicaid Waiver programs administered by the Behavioral Health Division of the Agency.

Appendix D: Eligibility Requirements and Benefits

On January 1, 2014 Wyoming changed to MAGI-based income eligibility due to the ACA. This impacted how income is calculated for the children, family care adults, and pregnant women groups. In addition, due to the ACA, income eligibility for children ages 6-18 was expanded from 100% to 133% of the Federal Poverty Level. Also due to the ACA, former foster care children may remain on Medicaid until their 26th birthday.

The following table provides the income limits for calendar years 2013 and 2014.

Table 142: Income Limits by Eligibility Category

Eligibility Category	CY 2013	CY 2014
Children 0-6	133% FPL, no resource limits	154% FPL, no resource limits
Children 6-18	100% FPL, no resource limits	133% FPL, no resource limits
Former Foster Care Children, over age 21 to age 26	Not Eligible	Eligible, no resource limits
Family Care Adults	56% FPL, no resource limits	56% FPL, no resource limits
Pregnant Women	133% FPL, no resource limits	154% FPL, no resource limits
ABD Waivers and institutions	Less than or equal to 300% SSI	Less than or equal to 300% SSI
ABD with Eligibility Determined by Social Security Administration	100% SSI	100% SSI
ABD with Eligibility Determined by DFS	100% SSI	100% SSI
Qualified Medicare Beneficiary	100% FPL	100% FPL
Specified Low-Income Medicare Beneficiary	135% FPL	135% FPL
Breast & Cervical Cancer	Less than or equal to 250% FPL	Less than or equal to 250% FPL
Tuberculosis	100% SSI	100% SSI
Employed individuals with disabilities	Less than or equal to 300% SSI	Less than or equal to 300% SSI
Non-Citizens with Medical Emergencies	n/a	n/a

Table 143: Monthly Income Standard Values by Family Size

Income Standard	Income Limit	CY 2013				CY 2014			
Family Size		1	2	3	4	1	2	3	4
Federal Poverty Level (FPL)	56%	$536	$724	$912	$1,099	$545	$734	$923	$1,113
	100%	$958	$1,293	$1,628	$1,963	$973	$1,311	$1,649	$1,988
	133%	$1,274	$1,720	$2,165	$2,611	$1,294	$1,744	$2,193	$2,644
	154%	$1,475	$1,991	$2,507	$3,023	$1,498	$2,019	$2,539	$3,062
Supplementary Security Income (SSI)	100%	$710	$1,066	--	--	$721	$1,082	--	--
	300%	$2,130	$3,198	--	--	$2,163	$3,246	--	--

Table 142, below, summarizes Medicaid eligibility by category and indicates the basic requirements for each, along with the associated Medicaid benefit levels, type of income, and whether income resource limits apply[71]. Note this table does not include information for the waiver programs, which are covered in detail in the Service Areas section of this Report.

There are numerous mandatory and optional Medicaid eligibility categories defined by federal law. For ease of presentation, we present an overview of these categories here; each row in the table may represent several different federal eligibility categories.

After summarizing the eligibility categories for Medicaid, we further organized similar categories into four major groups: Children, Pregnant Women, Family Care (adults) and Aged, Blind and Disabled (ABD). There are also four different categories of Other Groups. A comparison of these major groups shows that there are some notable differences in eligibility criteria, for example:

- Individuals in the Children and Pregnant Women eligibility categories are not subject to resource limits, unlike the individuals who are eligible under the ABD categories or selected Special Groups categories.
- For those categories that are subject to resource limits based on the SSI standard, the amounts of such limits will vary depending on the eligibility category.
- Individuals in most Medicaid eligibility groups receive full Medicaid benefits, except for individuals in the Medicare Savings Program, who receive assistance related to Medicare premium payments. Some individuals also receive further assistance with Medicare coinsurance and deductibles.

[71] For details regarding Medicaid eligibility, refer to the Wyoming Medicaid Online Eligibility Manual available at http://ecom.health.wyo.gov.

Table 144: Eligibility Requirements

Major 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 133 percent of FPL in 2013 Less than or equal to 154 percent of FPL in 2014	
	Children - Age 6-18	Full Medicaid Coverage	Under age 19	Countable family income	Less than or equal to 100 percent of FPL in 2013 Less than or equal to 133 percent of FPL in 2014	
	Children in Foster Care	Full Medicaid Coverage	Up to age 19, in DFS custody	Requirements vary by the type of foster care coverage or subsidized adoption		
	Aging-out Foster Care Program	Full Medicaid Coverage	Up to age 21 in 2013 Up to age 26 in 2014	Requirements vary by the type of foster care coverage or subsidized adoption		
	Subsidized Adoption	Full Medicaid Coverage	Under age 18; under age 21, if child over 18 meets special needs	Requirements vary by the type of foster care coverage or subsidized adoption		
Pregnant Women	Pregnant Women	Full Medicaid Coverage	Pregnant	Countable family income	Less than or equal to 133 percent of FPL in 2013 Less than or equal to 154 percent of FPL in 2014	
	Presumptive Eligibility for Pregnant Women	Outpatient services, for a limited time	Pregnant	Countable family income	Less than or equal to 133 percent of FPL in 2013 Less than or equal to 154 percent of FPL in 2014	
Family Care	Family Care	Full Medicaid Coverage	Adult must have an 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 must have an eligible child, under age 19, living in the household Family unit must have received Family Care benefits for at least three of the previous six 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	

Major Category Group	Eligibility Category	Benefits	Eligibility Requirement	Countable Income	Income Level	Resource Limits
Aged, Blind and Disabled (ABD)	Aged, Blind and individuals in Institutions	Full Medicaid Coverage	Meets one or more of the following: - Age 65 or older - Blind by SSI standards - Individual with disability by SSI standards In institutional setting (i.e. 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	✓
	Categories with Eligibility Determined by Social Security Administration (SSA)	Full Medicaid Coverage	N/A; eligibility determined by eligibility for SSI	Countable personal income and spousal income	Eligibility determined by SSA; automatically eligible for Medicaid Monthly SSI Payment Standard	✓
	SSI Related Categories with Eligibility Determined by DFS	Full Medicaid Coverage	Must have lost SSI due to an increase or receipt of Social Security benefits Must disregard increase or SSA benefit amount	Countable personal income	Countable income less than or equal to the Monthly SSI Payment Standard	✓
Medicare Savings Program	Qualified Medicare Beneficiary (QMB)	Medicaid will pay Medicare Part A and B premiums CMS assists with Medicare Part D premium payments Receive medical deductible and coinsurance payment	Must be entitled to Part A and Part B of Medicare insurance	Countable personal income and spousal income	Less than or equal to 100 percent of FPL	✓
	Specified Low-Income Medicare Beneficiary (SLMB)	Medicaid will pay Medicare Part B premium	Must be entitled to Part B of Medicare insurance	Countable personal income and spousal income	Less than or equal to 135 percent of FPL	✓
Special Groups	Breast and Cervical Cancer Treatment Program	Full Medicaid Coverage	Between Age 18 and 65 (if 65 or older must not be Medicare Part B eligible) Meet the 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	
	Wyoming Tuberculosis Program	Partial benefits related to tuberculosis	Provide verification of Tuberculosis	Countable personal income	Based on twice SSI Payment Standard, plus $85 per month	✓
Medicaid Buy-in	Employed individuals with Disabilities	Full Medicaid benefits after payment of premium (7.5 percent of gross monthly income)	Age 16 through 64 Disabled and employed	Countable personal income and spousal income	Unearned income less than or equal to 300 percent of the SSI standard for a single individual	

Major Category Group	Eligibility Category	Benefits	Eligibility Requirement	Countable Income	Income Level	Resource Limits
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 E: Methodology and Data Sources

Annual Report Overview

Prior SFY data represented in this Report may not match the data in prior SFY Annual Reports, because the data criteria may have changed and are re-extracted for this Report to be consistent for comparison purposes.

- Recipient counts have changed due to adjustments.
- The eligible individual counts have changed due to extracting the eligibility data from system generated reports. The dual individual count was extracted using the Cognos tool.
- Overall, total expenditures have not changed from the prior SFY Annual Report; however the distribution of expenditures in the service areas may have changed due to improved report extraction.

For most services, data is identified by taxonomy using paid claims data from Medicaid's claims processing system. Tables 147 and 148 detail the data parameters used to extract data through the Cognos tool. For all data extracts for the service areas, except behavioral health and the waivers, the behavioral health procedure code lines are excluded.

For all data extracts for the service areas, third-party payments, co-payments and DSH payments, as well as history-only adjustments, are excluded. Data extracts do not include expenditures for premium or cost-sharing assistance for Medicare individuals.

Counts may be calculated in one of two ways, "count" or "distinct count". A "count" returns the number of individuals. A "distinct count" returns the number of unique individuals. A distinct count provides an unduplicated count. For the purposes of this Report, distinct count has been used.

If comparing recipient count to eligible count, recipient count may be higher than eligible count, because claims may be paid on recipients who are no longer eligible but were eligible at the time of service.

State funded foster care is a non-Medicaid program and is excluded from the Medicaid data; however, it is discussed separately in Appendix A of the Annual Report.

Dual eligible individual data is included in the Medicaid data and is also discussed separately in Appendix A.

Eligibility

An individual is considered eligible if the individual was enrolled in Medicaid and eligible to receive services at any point in time during the SFY.

Eligibility data by eligibility category is extracted from monthly and annual MMIS generated reports.

The dual eligibility data is extracted using the Cognos tool. First, individuals who were eligible for Medicare are identified. This requires using data up to 13 months prior to the beginning of the SFY to

allow for a lag in submission of claims. This data is then matched to Medicaid eligibility data. These results represent the population of dual individuals.

Eligibility data by age, gender and race is extracted from FFY quarter 4 federal MMIS generated report.

A count of eligible individuals is a count of the number of unique eligible individuals at the program code level. This distinct count provides an unduplicated count at the program code level.

Program Codes

Eligibility program codes are captured at the claim header level, and are then used to exclude or include program codes as needed for data extracts.

To exclude or include appropriate program codes in our Medicaid data extracts, the Wyoming Eligibility Program Groups Medicaid Chart A, version 18 (Table 145) is utilized.

To exclude or include appropriate program codes in the state funded foster care and Project Out data extracts, the Wyoming Eligibility Program Groups Non-Medicaid Chart B, version 18 (Table 146) is utilized.

Table 145: Eligibility Program Codes

Eligibility Category	Eligibility Program Codes and Descriptions[72]			
Children	A02	Family Care Past 5yr Limit <21	A65	AFDC-Up Unemployed Parent Ch -I
	A04	Family Care <21	A67	12 Mo Extended Med <21
	A50	AFDC Medicaid -I	A87	16+ Not In School AF HH -I
	A54	2nd-6mos. Trans Mcaid Child -I	K03	Kidcare to Child Magi
	A56	Alien: 245 (IRCA) Child -I	M02	Adult MAGI <21
	A57	Baby <1 Yr, Mother SSI Elig -I	M03	Child MAGI
	A59	Retro Medicaid-"Pr" Child -I	M05	Family MAGI <21
	A60	4 Mo Extended Med <21	M10	Children's PE
	A61	Institutional (AF-IV-E) -I	M12	Family MAGI PE <21
	A62	Retro Medicaid-"Rm" Child -I	M14	Adult MAGI PE <21
	A63	Refugee Child -I	S62	Continuous SSI Eligible <19
	A64	Alien: 245 (IRCA) Child -I		
	A51	IV-E Foster Care	A97	Foster Care 0 Through 5
	A52	IV-E Adoption	A98	Foster Care 6 Through 18
	A85	Foster Care Title 19	M09	Former Foster Youth <21
	A86	Subsidized Adoption Title 19	M17	Former Foster Youth PE <21
	A88	Aging Out Foster Care	S63	Continuous Foster Care <19
	A55	Child 0 Through 5 Yrs	A58	Child 6 Through 18 Yrs
	A53	Newborn		
Pregnant Women	A71	Pregnant Woman <21	A74	Qualified Pregnant Woman <21
	A72	Pregnant Woman >21	M06	Pregnancy MAGI >21
	A73	Qualified Pregnant Woman >21	M07	Pregnancy MAGI <21
	A19	Presumptive-Eligibility		
Family Care	A01	Family Care Past 5yr Limit >21	A80	Refugee Adult -I

[72] "-I" indicates an inactive program code

Eligibility Category	Eligibility Program Codes and Descriptions[72]			
	A03	Family Care >21	A82	Alien: 245 (IRCA) Adult -I
	A68	12 Mo Extended Med >21	A83	Alien: 210 (IRCA) Adult -I
	A69	2nd-6mos. Trans Medicaid Adult -I	M01	Adult MAGI >21
	A70	AFDC Medicaid - Adult -I	M04	Family MAGI >21
	A75	Institutional (AFDC) Adult -I	M08	Former Foster Youth >21
	A76	4 Mo Extended Med >21	M11	Family MAGI PE >21
	A77	AFDC-Up Unemployed Parent Ad -I	M13	Adult MAGI PE >21
	A78	Retro Medicaid-"Pr" Adult-I	M18	Former Foster Youth PE >21
	A79	Retro Medicaid-"Rm" Adult -I		
Special Groups	B03	Breast & Cervical >21	M15	Breast & Cervical PE >21
	B04	Breast & Cervical <21	M16	Breast & Cervical PE <21
	S52	Tuberculosis (Tb) >65	S53	Tuberculosis (TB) <65
	A20	Pregnant By Choice		
ABD - SSI & SSI Related	S09	SSI-Disabled Child Definition	S42	Widow-Widowers
	S16	Pickle >65	S43	Qualified Disabled Working Individual
	S38	Pickle <65		
	S12	SSI Eligible >65	S40	Aptd Essent. Person Med Only -I
	S20	Blind SSI - Receiving Payment	S48	Zebley >21
	S21	Blind SSI - Not Receiving Pymt	S49	Zebley <21
	S31	SSI Eligible <65	S92	Widow-Widowers SDX
	S36	Disabled Adult Child (DAC)	S98	Pseudo SSI Aged -I
	S37	Goldberg-Kelly	S99	Pseudo SSI Disabled -I
	S39	1619 Disabled		
ABD - Institution	S50	Hospice Care >65	S51	Hospice Care <65
	S14	Institutional (Hosp) Aged -I	S34	Institutional (Hosp) Disabled -I
	S15	Inpatient Hospital 300% Cap>65	S35	Inpatient Hospital 300% Cap<65
	S03	ICF-MR SSI >65	S05	ICF-MR SSI <65
	S04	ICF-MR 300% Cap >65	S06	ICF-MR 300% Cap <65
	S13	Inpatient-Psych >65		
	N97	NH Temp Services	S10	Nursing Home SSI >65
	P15	PACE NF < 65	S11	Nursing Home 300% Cap >65
	P16	PACE NF SSI Disabled < 65	S17	Retro Medicaid-"Pr" Aged -I
	P17	PACE NF Medicare Disabled < 65	S18	Retro Medicaid-"Rm" Aged -I
	P18	PACE NF Medicare SSI Disable < 65	S30	Retro Medicaid-"Pr" Disabled -I
	P25	PACE NF > 65	S32	Nursing Home SSI <65
	P26	PACE NF SSI Aged > 65	S33	Nursing Home 300% Cap <65
	P27	PACE NF Medicare Aged > 65	S54	Medicaid Only-No Rm & Brd >65
	P28	PACE NF Medicare SSI Aged > 65	S55	Medicaid Only-No Rm & Brd <65
	S01	NH-SSI & SSA Blend >65	S90	Retro Medicaid-"Rm" Disabled
	S02	NH-SSI & SSA Blend <65		
ABD - Home & Community Based Waivers	B01	Acq Brain Injury Wvr SSI	S60	Acq Brain Injury Wvr W/EID <65
	B02	Acq Brain Injury Wvr 300%		
	R01	Asst Living Fac Wvr SSI <65	R03	Asst Living Fac Wvr SSI >65
	R02	Asst Living Fac Wvr 300% <65	R04	Asst Living Fac Wvr 300% >65
	S65	Cont Chldrns Ment Hlth Wvr <19	S96	Chldns Ment Hlth Wvr 300% <21

Eligibility Category	Eligibility Program Codes and Descriptions[72]			
	S95	Chldns Ment Hlth Wvr SSI <21		
	S22	DD Waiver SSI >65	S45	DD Wvr 300% Between 21&65 Yrs
	S23	DD Waiver 300% Cap >65	S59	DD Waiver W/EID >21
	S44	DD Wvr SSI Between 21&65 Yrs		
	S58	DD Waiver W/EID <21	S93	DD Waiver SSI <21
	S64	Continuous DD <19	S94	DD Waiver 300% Cap <21
	N98	WLTC Temp Services	P23	PACE SSI Aged > 65
	P11	PACE < 65	P24	PACE Mcare SSI Aged > 65
	P12	PCMR < 65	S24	LTC Waiver SSI >65
	P13	PACE SSI Disabled < 65	S25	LTC Waiver 300% Cap >65
	P14	PACE Mcare SSI Disabled < 65	S46	LTC Waiver SSI <65
	P21	PACE > 65	S47	LTC Waiver 300% Cap <65
	P22	PCMR > 65		
	W03	EID Comp Waiver Adult >21	W10	SSI Comp Waiver Aged >65
	W04	EID Comp Waiver Child <21	W14	300% Comp Waiver Adult >21
	W08	SSI Comp Waiver Adult >21	W15	300% Comp Waiver Child <21
	W09	SSI Comp Waiver Child <21	W16	300% Comp Waiver Aged > 65
	W01	EID Support Waiver Adult >21	W07	SSI Support Waiver Aged >65
	W02	EID Support Waiver Childt <21	W11	300% Support Waiver Adult >21
	W05	SSI Support Waiver Adult >21	W12	300% Support Waiver Child<21
	W06	SSI Support Waiver Child <21	W13	300% Support Waiver Aged >65
ABD - Employed Individuals with Disabilities	S56	Emp Ind/W Disabilities >21	S61	Continuous EID <19
	S57	Emp Ind/W Disabilities <21		
Medicare Savings Programs	Q17	QMB >65	Q41	QMB <65
	Q94	SLMB 2 >65	Q96	SLMB 1 >65
	Q95	SLMB 2 <65	Q97	SLMB 1 <65
	Q98	Part B-Partial Aged -I	Q99	Part B-Partial Disabled -I
Non Citizens with Medical Emergencies	A81	Emergency Svc <21	A84	Emergency Svc >21
Screenings and Gross Adjustments	N96	Disability Determination Only	N99	LTC Screening Only
	S97	CASII Screening Only	ZZZ	Other
	P07	CHIPRA CME		

Table 146: Non-Medicaid Program Codes Included in Analysis

Eligibility Category	Program Code and Description			
State Funded Foster Care	A95	Pending Foster Care	A96	Basic Foster Care
	A99	Institutional Foster Care		
Project Out Services	P05	Project Out Transitional Cvrg		

Per Member Per Month

The Per Member Per Month (PMPM) represents the monthly average cost for each eligible individual.

The PMPM calculation is equal to expenditures divided by the member months. Expenditures are extracted based on claim first service date and the original and final adjusted claims. Member months count the number of months an eligible individual was enrolled in Medicaid.

Expenditures

Expenditures represent claim payments. Expenditure data for this report include:

- Original claims never voided/adjusted
- Original claims voided/adjusted
- Void/adjustment re-adjusted claims
- Final adjustment claims

For crossover claims, dual individuals, and all service areas except waivers, all eligibility program codes from Medicaid Chart A version 18 are included, as well as:

- N96 - disability determination
- N99 - long-term care screening
- S97 - CASII screening
- ZZZ - gross adjustments
- P07 - CHIPRA CME.

The N96, N99, S97, ZZZ and P07 program codes are included in the expenditure data as these expenditures are Medicaid expenditures.

The appropriate waiver eligibility program codes are extracted for the individual waivers.

Recipients

A recipient represents an eligible individual who received Medicaid services. Recipient data for this report includes original claims never voided/adjusted and final adjustment claims only.

For crossover claims, dual individuals, and all service areas except waivers, all eligibility program codes from Medicaid Chart A version 18 are used, excluding N96 (disability determination), N99 (long-term care screening), S97 (CASII screening), ZZZ (gross adjustments) and P07 (CHIPRA CME). These are excluded from the eligible and recipient data as these individuals may not be Medicaid eligible.

Additional Data or Calculations

For some service areas it is necessary to adjust data to accurately represent expenditures and recipients.

Service Area Claims Allocation

Behavioral health procedure codes billed by non behavioral health providers are excluded from the individual service areas and allocated in the behavioral health service area. These include

Evaluation and Management (EM) procedure codes when billed with certain Behavioral Health procedure codes and performed by the same treating provider.

The following steps are used to allocate expenditures and recipients data appropriately to service areas:

1) Identify all claims for the particular service areas. (claim set A)
2) Identify all claims with behavioral health procedure codes that are provided by non behavioral health providers (claim set B)
3) Claim set B is removed from claim set A. (claim set C)
4) Identify individual claim lines from claim set B that should be included in behavioral health or another particular service area. This involves identifying which EM procedure code lines should be allocated to behavioral health using the following steps:
    a) Identify all claims with EM procedure codes that are provided by non behavioral health providers (claim set D)
    b) Isolate the lines from claim set D that have the EM procedure codes to ignore non-EM procedure codes on these claims (claim set E)
    c) Compare claim set D to claim set E and return only claims which have the same treating provider for both the EM procedure code and behavioral health procedure codes. (claim set F)
    d) Identify final claims for a particular service area by merging claim set C with only those claim lines from claim set B of the particular service area. For behavioral health services, this includes identifying lines in claim set B that have the EM procedure code and a claim TCN found in claim set F.
5) The resulting data represents the claims and claim lines for that particular service area.

Ambulance

We allocated expenditures and recipients between air and ground services based on the procedure code associated with each claim line. Most procedure codes apply only to either air or ground service, but procedure codes A0382, A0398, A0422, A0433, A0434 and A0998 are shared between both air and ground service.

To identify the appropriate claims to allocate expenditures and recipients to air and ground ambulance services:

1) For Air Ambulance:
    a) Identify all claims with air procedure codes (claim set A). Count recipients on this claim set.
    b) Isolate claims from claim set A that only have air procedure codes (claim set B). Claim set B represents claims that are strictly air ambulance. Extract expenditure data for air ambulance from claim set B.
2) For Ground Ambulance:
    a) Identified all claims with ground procedure codes (claim set C). Count recipients on this claim set.

b) Isolate claims from claim set C that only have ground procedure codes (claim set D). Claim set D represents claims that are strictly ground ambulance. Extract expenditure data for ground ambulance from claim set D.

3) Identify claims that contain both air and ground procedure codes (claim set E). Identify each line in claim set E as air, ground, or shared based on their procedure code.
4) Calculate total expenditures for each service:
   a) Add air line expenditures from claim set E to the total claims expenditures from claim set B.
   b) Add ground line expenditures from claim set E to the total claims expenditures from claim set D.

Calculations

A recipient or provider count is an unduplicated count of the number of unique recipients or providers.

Expenditures per recipient are equal to the expenditures divided by the recipient count.

Expenditures per eligible individual are equal to the expenditures divided by the eligible count.

Percentage change shows the increase or decrease from one SFY to another SFY.

Table 147: Data Parameters by Service Area[73]

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Ambulance – Total	341600000X: Ambulance Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider	Expenditures – Chart A Counts – Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Ambulance – Air	341600000X: Ambulance Procedure Codes: A0030, A0430, A0431, A0435, A0436, A0382, A0398, A0422, A0433, A0434, A0998	Expenditures – Chart A Counts – Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Medical
Ambulance – Ground	341600000X: Ambulance Procedure Codes: A0221, A0360, A0362, A0368, A0370, A0380, A0390, A0425, A0426, A0427, A0428, A0429, A0382, A0398, A0422, A0433, A0434, A0998	Expenditures – Chart A Counts – Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Medical
Ambulatory Surgery Center	261QA1903X: Ambulatory Surgery Center Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider	Expenditures – Chart A Counts – Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical

[73] All services areas, except behavioral health, exclude behavioral health procedure code lines.
[74] Chart A is defined as Chart A version 18

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Behavioral Health – Total	Behavioral Health Providers: 101Y00000X: Professional Counselor; Certified Mental Health Worker 101YA0400X: Addictions Therapist/Practitioner 101YP2500X: Professional Counselor 103G00000X: Neuropsychologist 103TC0700X: Clinical Psychologist 1041C0700X: Social Worker 106H00000X: Marriage and Family Therapist 163W00000X: RN 164W00000X: LPN 171M00000X: Case Worker 172V00000X: Community Health Worker; Peer Specialist; Certified Addictions Practitioner Assistant 2084P0800X: Psychiatrist 261QM0801X: Mental Health - including Community Mental Health Center 261QR0405X: Rehabilitation, Substance Use Disorder 364SP0808X: NP, APN Psychiatric/Mental Health AND Behavioral Health Services provided by non-behavioral health providers: Exclude behavioral health providers: 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103TC0700X, 1041C0700X, 106H00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 2084P0800X, 261QM0801X, 261QR0405X, 364SP0808X Exclude federal public health: 261QP0904X Procedure Codes: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider	Expenditures – Chart A Counts – Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude W on non-behavioral health providers	All Paid and All Medical

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Behavioral Health – Behavioral Health Providers	101Y00000X: Professional Counselor; Certified Mental Health Worker 101YA0400X: Addictions Therapist/Practitioner 101YP2500X: Professional Counselor 103G00000X: Neuropsychologist 103TC0700X: Clinical Psychologist 1041C0700X: Social Worker 106H00000X: Marriage and Family Therapist 163W00000X: RN 164W00000X: LPN 171M00000X: Case Worker 172V00000X: Community Health Worker; Peer Specialist; Certified Addictions Practitioner Assistant 2084P0800X: Psychiatrist 261QM0801X: Mental Health - including Community Mental Health Center 261QR0405X: Rehabilitation, Substance Use Disorder 364SP0808X: NP, APN Psychiatric/Mental Health	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P06	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Behavioral Health – Non-Behavioral Health Providers	Exclude behavioral health providers: 101Y00000X, 101YA0400X, 101YP2500X, 103G00000X, 103TC0700X, 1041C0700X, 106H00000X, 163W00000X, 164W00000X, 171M00000X, 172V00000X, 2084P0800X, 261QM0801X, 261QR0405X, 364SP0808X Exclude federal public health: 261QP0904X Procedure Codes: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P06	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude W	All Medical

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
CORF	261QR0401X: Rehabilitation, Comprehensive Outpatient Rehabilitation Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P06	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Dental	122300000X: Dentist 1223D0001X: Dental Public Health 1223E0200X: Endodontics 1223G0001X: General Practice 1223P0221X: Pedodontics 1223P0300X: Periodontics 1223S0112X: Surgery, Oral and Maxillofacial 1223X0400X: Orthodontics Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P06	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical[75]
DMEPOS – Total	332B00000X: DME 332S00000X: Hearing Aid Equipment 335E00000X: POS Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P06	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude P	All Paid and All Medical

[75] Dental path in Cognos is also used in the Annual Report for determining top 5 dental procedures.

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
DME Only	332B00000X: DME Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P06	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude P	All Paid and All Medical
POS Only	335E00000X: POS Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P06	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude P	All Paid and All Medical
End-Stage Renal Disease	261QE0700X: End-Stage Renal Disease Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P06	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Federally Qualified Health Center	261QF0400X: Federally Qualified Health Center Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Home Health	251E00000X: Home Health Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Hospice	251G00000X: Hospice Care, Community Based Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Hospital – Total	261QR0400X: Rehabilitation 282N00000X: General Acute Care Hospital 282NR1301X: General Acute Care Hospital - Rural 283Q00000X: Psychiatric Hospital 283X00000X: Rehabilitation Hospital Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P06	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Hospital – Inpatient	282N00000X: General Acute Care Hospital 282NR1301X: General Acute Care Hospital - Rural 283Q00000X: Psychiatric Hospital 283X00000X: Rehabilitation Hospital Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P06	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	I,X	All Paid and All Medical

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Hospital – Outpatient	261QR0400X: Rehabilitation 282N00000X: General Acute Care Hospital 282NR1301X: General Acute Care Hospital - Rural 283X00000X: Rehabilitation Hospital Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P06	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	O, V	All Paid and All Medical
Interpreter	171R00000X: Interpreter Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Laboratory	291U00000X: Clinical Medical Laboratory Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Nursing Facility	275N00000X: Medicare Defined Swing Bed 314000000X: Skilled Nursing Facility Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Physician and Other Practitioner – Total	207W00000X: Ophthalmologist, excluding diagnosis V72.0 (routine vision services) All taxonomies starting with '20', except 2084P0800X: Psychiatrists 363A00000X: Physician Assistant 225X00000X: Occupational Therapist 225100000X: Physical Therapist 213E00000X: Podiatrist 363L00000X, 363LA2200X, 363LF0000X, 363LG0600X, 363LX0001X, 363LP0200X: Nurse Practitioner 367A00000X: Nurse Midwife 367500000X: Nurse Anesthetist 231H00000X: Audiologist 235Z00000X: Speech-Language Pathologist Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Physician	207W00000X: Ophthalmologist, excluding diagnosis V72.0 (routine vision services) All taxonomies starting with '20', except 2084P0800X: Psychiatrists 363A00000X: Physician Assistant Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Other Practitioner	225X00000X: Occupational Therapist 225100000X: Physical Therapist 213E00000X: Podiatrist 363L00000X, 363LA2200X, 363LF0000X, 363LG0600X, 363LX0001X, 363LP0200X: Nurse Practitioner 367A00000X: Nurse Midwife 367500000X: Nurse Anesthetist 231H00000X: Audiologist 235Z00000X: Speech-Language Pathologist Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Prescription Drug	333600000X: Pharmacy Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	P	All Paid and All Medical
PRTF	323P00000X: Psychiatric Residential Treatment Facility Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	I, X	All Paid and All Medical
Radiology - Mobile	261QR0208X: Mobile Radiology Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Radiology - Physician	Exclude 261QR0208X (Mobile Radiology) Procedure Codes: 70000 through 79999	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Medical

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Rural Health Clinic	261QR1300X: Rural Health Clinic Exclude Behavioral Health Procedures: G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 H0001 through H2037 90801 through 90899 96101 through 96125 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Vision – Total	152W00000X: Optometrist 156FX1800X: Optician 207W00000X: Ophthalmologist with diagnosis code V72.0 (routine vision) only Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Vision – Ophthalmologist	207W00000X: Ophthalmologist Diagnosis Code: V72.0 (routine vision) Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Vision – Optometrist	152W00000X: Optometrist Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Vision – Optician	156FX1800X: Optician Exclude Behavioral Health Procedures: • G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792 • H0001 through H2037 • 90801 through 90899 • 96101 through 96125 • 99201 and 99360 when paired with 90833, 90836, 90838, 90785 on same claim with same treating provider90836, 90838, 90785 on same claim with same treating provider	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Waiver – All HCBS – Total	All	B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S65, S93, S94, N98, P11, P1, P13, P14, P21, P22, P23, P24, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Waiver – All HCBS – Waiver Only	251B00000X: Case Management 251C00000X: Day Training, DD 251X00000X: PACE PPL	B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S65, S93, S94, N98, P11, P1, P13, P14, P21, P22, P23, P24, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid
Waiver – All HCBS – Non-Waiver Services	All	B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S65, S93, S94, N98, P11, P1, P13, P14, P21, P22, P23, P24, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude W, G for 251B00000X, 251C00000X, 251X00000X	All Paid
Waiver – HCBS Acquired Brain Injury (ABI) – Total	All	B01, B02, S60	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid
ABI – Waiver Only	251C00000X: Day Training, DD	B01, B02, S60	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	W, G	All Paid
ABI – Non-Waiver Services	All	B01, B02, S60	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude W, G for 251C00000X	All Paid
Waiver – HCBS Adult with Developmental Disabilities (DD) – Total	All	S22, S23, S44, S45, S59	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid
Adult DD – Waiver Only	251C00000X: Day Training, DD 251X00000X: PACE PPL	S22, S23, S44, S45, S59	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	W, G	All Paid
Adult DD – Non-Waiver Services	All	S22, S23, S44, S45, S59	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude W, G for 251C00000X, 251X00000X	All Paid
Waiver – HCBS Assisted Living Facility (ALF) – Total	All	R01, R02, R03, R04	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid
ALF – Waiver Only	251B00000X: Case Management	R01, R02, R03, R04	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	W, G	All Paid
ALF – Non-Waiver Services	All	R01, R02, R03, R04	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude W, G for 251B00000X	All Paid
Waiver – HCBS Child with Developmental Disabilities (DD) – Total	All	S58, S93, S94, S64	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code[74]	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Child DD – Waiver Only	251C00000X: Day Training, DD 251X00000X: PACE PPL	S58, S93, S94, S64	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	W, G	All Paid
Child DD – Non-Waiver Services	All	S58, S93, S94, S64	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude W, G for 251C00000X, 251X00000X	All Paid
Waiver – HCBS Children's Mental Health (CMH) – Total	All	S95, S96, S65	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid
CMH – Waiver Only	251B00000X: Case Management	S95, S96, S65	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	W, G	All Paid
CMH – Non-Waiver Services	All	S95, S96, S65	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude W, G for 251B00000X	All Paid
Waiver – HCBS Comprehensive – Total	All	W03, W04, W08, W09, W10, W14, W15, W16	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid
Comprehensive – Waiver Only	251B00000X: Case Management 251C00000X: Day Training, DD 251X00000X: PACE PPL	W03, W04, W08, W09, W10, W14, W15, W16	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	W, G	All Paid
Comprehensive – Non-Waiver Services	All	W03, W04, W08, W09, W10, W14, W15, W16	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude W, G for 251B00000X, 251C00000X, 251X00000X	All Paid
Waiver – HCBS Long-Term Care (LTC) – Total	All	S24, S25, S46, S47, P11, P12, P13, P14, P21, P22, P23, P24, N98	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid
LTC – Waiver Only	251B00000X: Case Management	S24, S25, S46, S47, P11, P12, P13, P14, P21, P22, P23, P24, N98	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	W, G	All Paid
LTC – Non-Waiver Services	All	S24, S25, S46, S47, P11, P12, P13, P14, P21, P22, P23, P24, N98	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude W, G for 251B00000X	All Paid
Waiver – Pregnant By Choice	All	A20	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid
Waiver – HCBS Supports – Total	All	W01, W02, W05, W06, W07, W11, W12, W13	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid
Supports – Waiver Only	251B00000X: Case Management 251C00000X: Day Training, DD 251X00000X: PACE PPL	W01, W02, W05, W06, W07, W11, W12, W13	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	W, G	All Paid
Supports – Non-Waiver Services	All	W01, W02, W05, W06, W07, W11, W12, W13	Expenditures – ALL Counts – 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	Exclude W, G for 251B00000X, 251C00000X, 251X00000X	All Paid

Table 148: Data Parameters for Subprograms and Special Populations

Subprograms and Special Populations	Provider Taxonomy and Procedure Codes	Recipient Program Code	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Crossover Claims	All	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures - ALL Counts - 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Dual Eligible Individuals	All	Expenditures - Chart A Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures - ALL Counts - 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Foster Care - Medicaid	All	A51, A52, A85, A86, A88, A97, A98, S63	Expenditures - ALL Counts - 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Foster Care - State Funded[76]	All	A95, A96, A99	Expenditures - ALL Counts - 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
PACE	All	P11, P12, P13, P14, P15, P16, P17, P18, P21, P22, P23, P24, P25, P26, P27, P28	Expenditures - ALL Counts - 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid
Project Out[77]	All	P05	Expenditures - ALL Counts - 0, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid

[76] State-Funded Foster Care is a non-Medicaid program.
[77] Project Out is a non-Medicaid program.


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Appendix F: Glossary and 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 eligible individual 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, Prosthetics, Orthotics and Supplies (DMEPOS) – 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.

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

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

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

Expenditure – 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 underserved 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 beginning SFY 2015.

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. Being replaced by the Comprehensive and Supports Waiver beginning SFY 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. Being replaced by the Comprehensive and Supports Waiver beginning SFY 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 current waivers for developmentally disabled and those with acquired brain injury.

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 current waivers for developmentally disabled and those with acquired brain injury. 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 the Intellectually Disabled (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.

Limited English Proficiency (LEP) – The limited ability to write, speak, read or understand the English language at a level that permits an individual to communicate effectively with healthcare providers.

Median – The median, or 50th percentile, is the middle value of a set of numbers. The median divides the set of numbers into two equal parts.

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 – For the purposes of this Report as related to per member per month, an individual enrolled in Medicaid who is eligible to receive services. A member is an eligible individual.

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

Percentile – A value on a scale that indicates the percent of a distribution that is equal to it or below it. For example, a score at the 50th percentile is equal to or higher than 50 percent of the scores. The 50th percentile is also called the median value.

Per Member per Month – The monthly average cost for each eligible individual.

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.

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, and 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.

Acronyms

Table 149: 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
CHIP	Children's Health Insurance Program
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
DD	Developmental Disabilities
DFS	Department of Family Services
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
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
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
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
NAMFCU	National Association of Medicaid Fraud Control Units
OIG	Office of Inspector General
OPPS	Outpatient Prospective Payment System
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)
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
SMAC	State Maximum Allowable Cost
SSA	Social Security Administration
SSDC	Sovereign States Drug Consortium
SSI	Supplemental Security Income
TB	Tuberculosis
TPL	Third Party Liability
WES	Wyoming Eligibility System