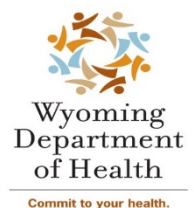


Wyoming Medicaid SFY 2015 Annual Report



Matt Mead, Governor
Thomas O. Forslund, Director
Teri Green, State Medicaid Agent





Thomas O. Forslund, DirectorGovernor Matthew H. Mead

Dear Wyoming Citizen:

It is my pleasure to present the Wyoming Medicaid State Fiscal Year (SFY) 2015 Annual Report. SFY 2015 covers the period from July 1, 2014 to June 30, 2015. This Annual Report provides insight into Wyoming's Medicaid program, our ongoing efforts, and the activities and accomplishments from the past year. Included in this report you will find a detailed look at services covered by Medicaid in Wyoming, information regarding those who depend on these services, and what the services cost.

In SFY 2015 Wyoming Medicaid covered 89,252 enrollees, or approximately 1 in 7 individuals in the overall Wyoming population, with 62% of the enrollees being children. Claims expenditures for Medicaid recipients totaled over \$527 million. Based on enrollment figures, the Wyoming Medicaid program may now be slightly larger than the state's Medicare program (84,076¹).

Several significant initiatives were launched this year to promote cost containment, improved healthcare outcomes, and compliance with Federal mandates.

- To better coordinate care and reward primary care providers for improving quality, the State launched a monthly capitated payment for Patient Center Medical Home.
- Comprehensive technical system changes were made to accommodate the nationwide transition from ICD-9 to ICD-10 diagnosis coding. A major outreach campaign was planned and accomplished to educate Wyoming providers, ensure they were prepared for the change and continued to receive timely reimbursement.
- Ongoing communication and support has been extended to providers in order to assist them in meeting a new federal requirement to "re-enroll" and be rescreened by the Division prior to December 31, 2015
- A new vendor for the Care Management Entity for children with serious emotional disturbance was procured and these services were launched statewide on July 1, 2015.
- A Tribal Advisory Group was created in order to improve communications with the Northern Arapaho and Eastern Shoshone Tribes.

For the Intellectual Disability waivers coordinated by the Behavioral Health Division a number of changes were implemented.

- The transition of adults from the Adult with Developmental Disabilities to new Comprehensive and Support waivers was completed September 30, 2014. A transition of children from the Children with Developmental Disabilities waiver to the Comprehensive and Support waivers was completed June 30, 2015.
- The Behavioral Health Division finalized implementation of conflict-free case management.
- A budget appropriation in SFY 2015 allowed many clients needing services to move from waitlists to receiving waiver services.

¹ <http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/> , 2012 is most recent data available.

Further activity focused on changes driven by legislation in the 2014 and 2015 sessions including the addition of licensed mental health professionals, chiropractors and provisional Mental Health professionals as direct Medicaid providers. "Employment First" was passed to promote employment options for persons with disabilities. Budget appropriations provided funding to support the implementation of new acuity-based nursing home rates and a rate increase for persons with higher level of care needs on the ID/DD waivers. In addition, funding was added for Wyoming to pursue a Tribal Uncompensated Care 1115 waiver.

Operational projects and technological improvements for the year included the continuation of the replacement of our Medicaid Management Information System (MMIS). The 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. These include further development and maturation of the Wyoming Eligibility System, State Level Registry for quality and outcome information, Health Information Exchange, telehealth, and electronic health record initiatives. 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.

The "At A Glance" section provides a two-page summary highlighting key points of the report and presents essential information about the Wyoming Medicaid program, including a description of the mission, organizational structure and budgetary outline. This section also includes information on Wyoming's economy and demographics that helps to place the program in the context of the larger Wyoming environment.

Per Member Per Month (PMPM) information will be available in a separate report to be issued in early 2016 and will allow service date information to be more current. This change also provides the opportunity to issue the Annual Report in the Fall of each year.

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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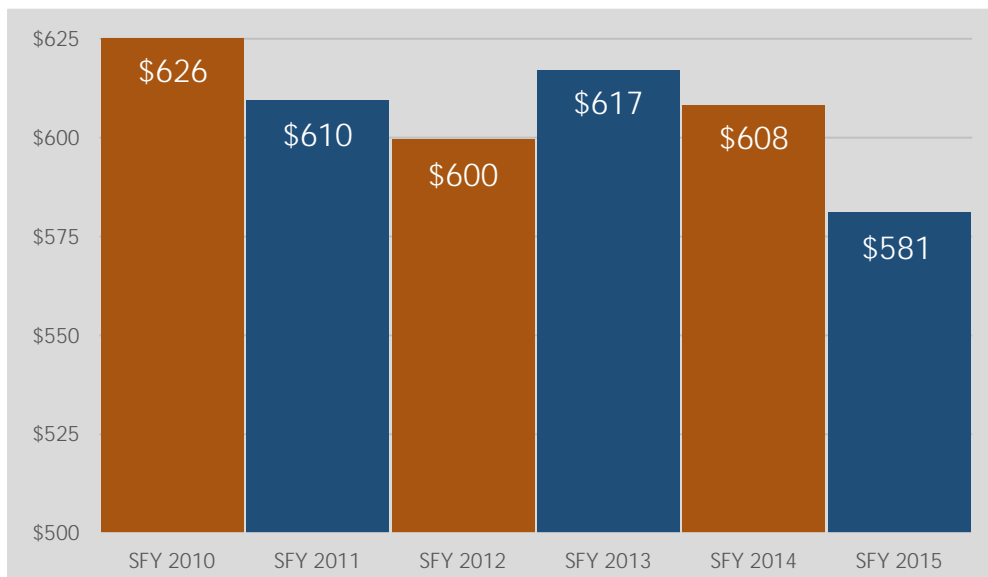
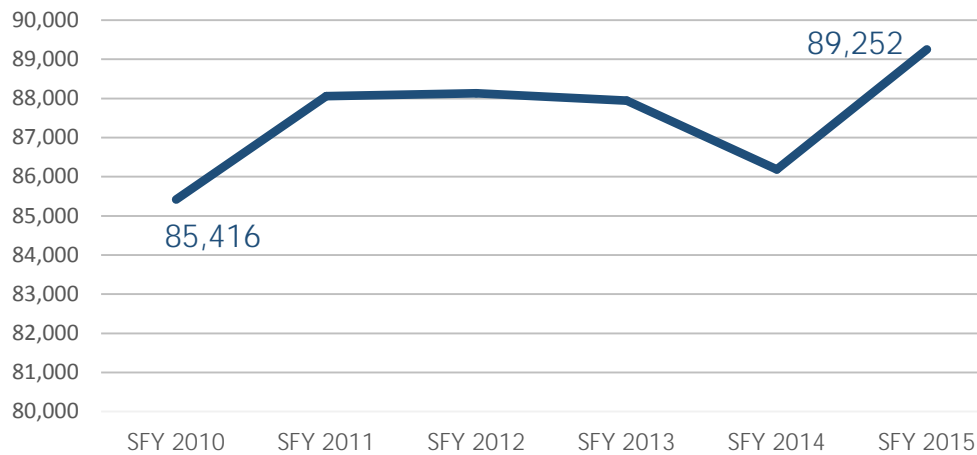
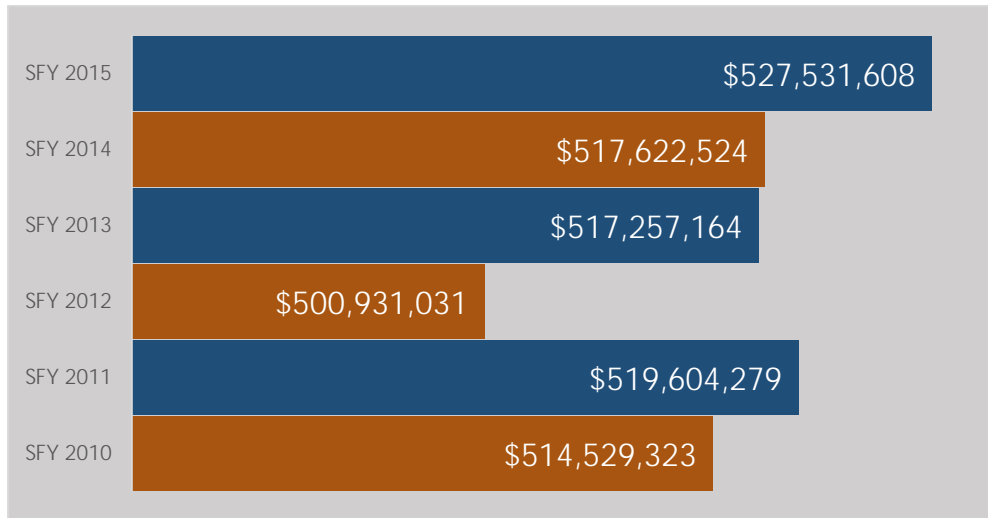
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Medicaid SFY 2015 – At a Glance

In SFY 2015 Wyoming Medicaid had a 3.6 percent increase in enrollment² from the previous year, while total claims expenditures³ increased by nearly 2 percent.



EXPENDITURES

\$527,531,608

(by Claim Paid Date)

ENROLLMENT

89,252

(unique count,
complete SFY)

PER MEMBER PER MONTH

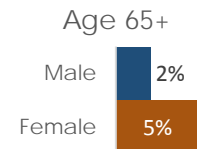
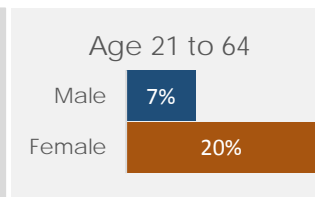
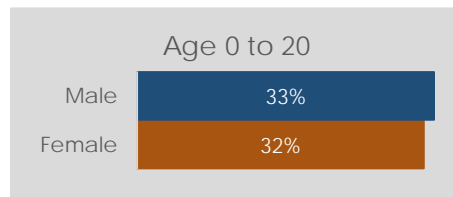
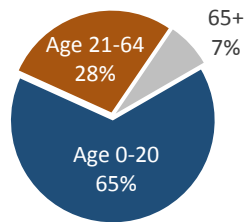
\$581*

² Medicaid enrollment is a distinct count of individuals for a complete state fiscal year, July 1 through June 30.

³ Expenditures reported in this annual report are benefit expenditures only based on claims data.

* Per Member Per Month as of October 27, 2015. Final PMPM cost will be available in the SFY 2015 Per Member Per Month report

RECIPIENT DEMOGRAPHICS



COUNTY ENROLLMENT

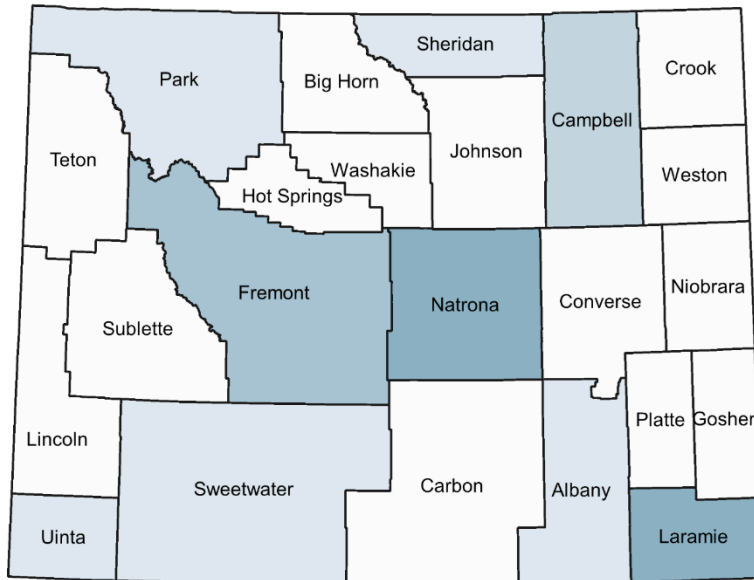
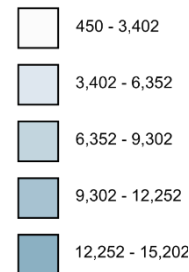


Figure 1: Medicaid Enrollment by County

Table 1: Top Five Counties by Enrollment

County	Enrollment	% of Total Medicaid
Laramie	15,202	17%
Natrona	13,193	15%
Fremont	9,942	11%
Campbell	6,536	7%
Sweetwater	6,091	7%



SERVICE UTILIZATION

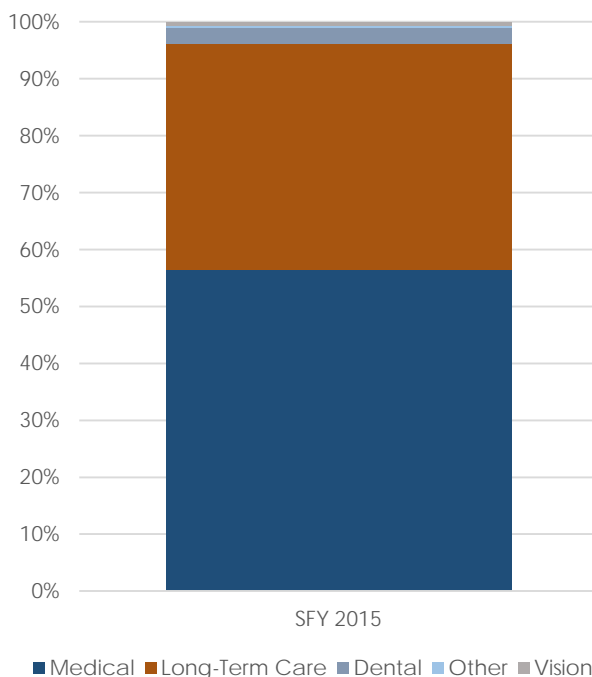


Figure 2: Service Utilization - SFY 2015

In SFY 2015 the majority of Medicaid claims expenditures covered medical services, totaling 56 percent of the total.

Table 2: Service Utilization by Expenditures

Service Area	Expenditures	Percent of Total
Medical	\$297,898,340	56%
Long-Term Care	\$208,759,250	40%
Dental	\$14,473,863	3%
Other	\$2,772,090	1%
Vision	\$3,628,064	1%

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.

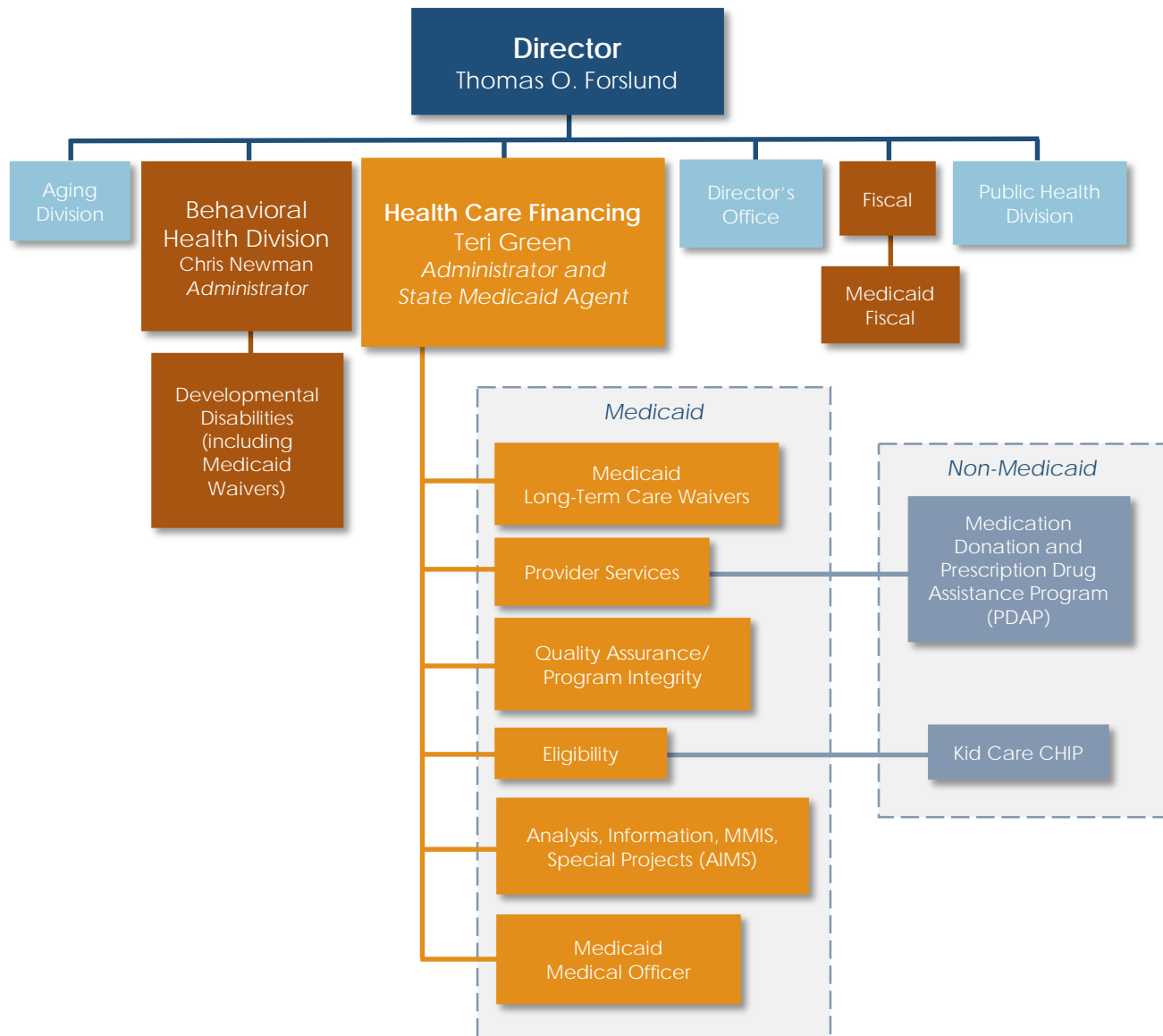


Figure 3: Wyoming Department of Health Organization Chart

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.
Long-Term Care Advisory Group	Nursing Home Association leadership, five nursing home providers, a home health provider, a hospice provider, an assisted living provider, a Long-Term Care waiver case manager, and an Independent Living Center representative	Focuses on issues and recommendations with institutional and community-based long-term care providers.
Medical Advisory Group (MAG)	Wyoming Hospital Association, Wyoming Medical Society, executives from hospitals throughout Wyoming, physicians, and medical practitioners	Focuses on new and upcoming issues within the healthcare industry, member concerns, and relevant presentations. Works to develop solutions to issues.
Pharmacy & Therapeutics Committee (P&T)	Six physicians, five pharmacists, one allied health professional.	Provides recommendations regarding prospective drug utilization review, retrospective drug utilization review and education activities to Medicaid

This Annual Report focuses on the \$527.5 million in claims expenditures for Medicaid benefits in SFY 2015 processed through the Medicaid Management Information System (MMIS). Table 4 and Figure 5 address other Healthcare Financing Division expenditures in SFY 2015, 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 2015 (in millions)
Annual Report Benefit Expenditures (this report) ⁴	\$527.5
Medicaid Administration	\$38.3
Nursing Facilities Tax Assessment	\$30.8
Hospital Qualified Rate Adjustment (QRA) Payments	\$18.9
Medicare Buy-In	\$14.5
Medicaid One-Time Capital Expenses for New Technology Systems (WES, MMIS, Other)	\$13.9
Medicare Clawback (Part D)	\$11.1
Physician Electronic Health Record (EHR) Incentives	\$4.1
Subtotal Medicaid Expenditures	\$659.1
Drug Rebates ⁵	-\$24.6
Total Medicaid Expenditures	\$634.5
Non-Medicaid Expenditures	
Children's Health Insurance Program (CHIP)	\$9.8
CHIP Administration	\$0.8
State Only Foster Care	\$2.1
GF Fund Foster Care (Court Orders)	\$0.3
Prescription Drug Assistance Program (PDAP)	\$0.5
Total Health Record (Health Information Exchange (HIE))	\$2.0
State Only Other	\$0.5
Total Non-Medicaid Expenditures	\$16.7
Total Division of Healthcare Financing	\$650.6

⁴ Includes reductions in expenditures due to recoveries processed through the MMIS.

⁵ Includes \$21.4 million from the Medicaid Drug Rebate Program created under Omnibus Budget Reconciliation Act of 1990

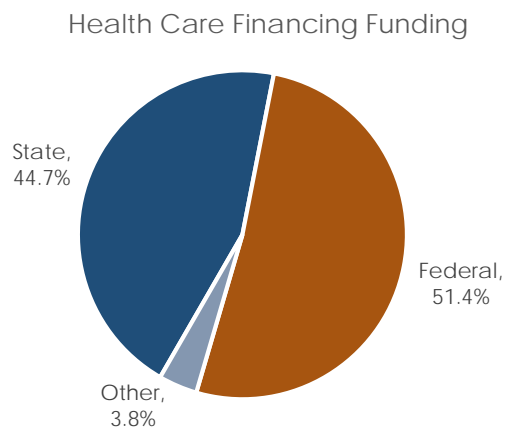


Figure 4: Health Care Financing Funding

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.

WYOMING DEMOGRAPHICS and ECONOMY

From 2010 to 2014 the population estimates for Wyoming have increased 3.5 percent, while Medicaid enrollment has increased by less than 1 percent. Medicaid enrollment has remained relatively stable during this time period around 15 percent of the total state population. ⁶

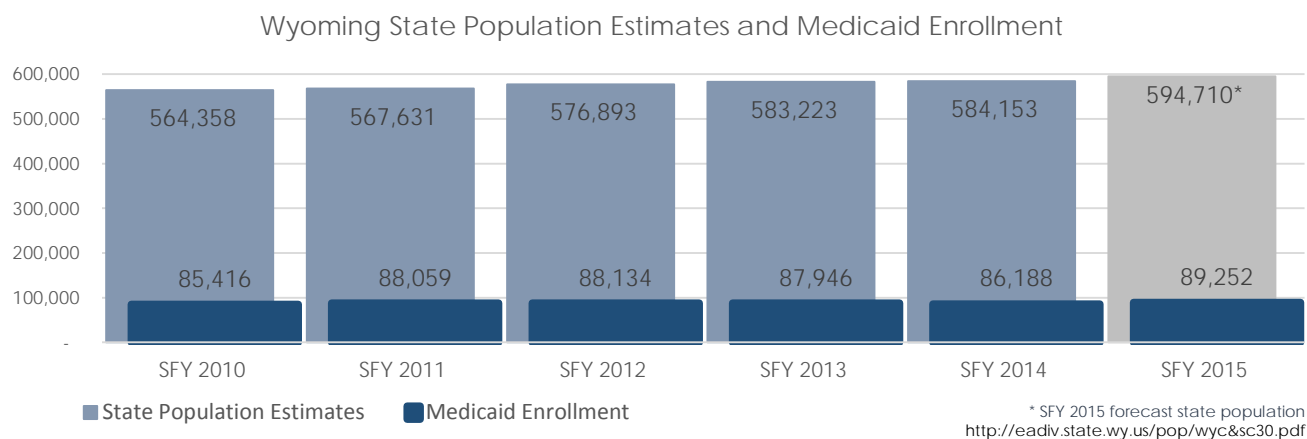


Figure 5: Population Estimates for Wyoming

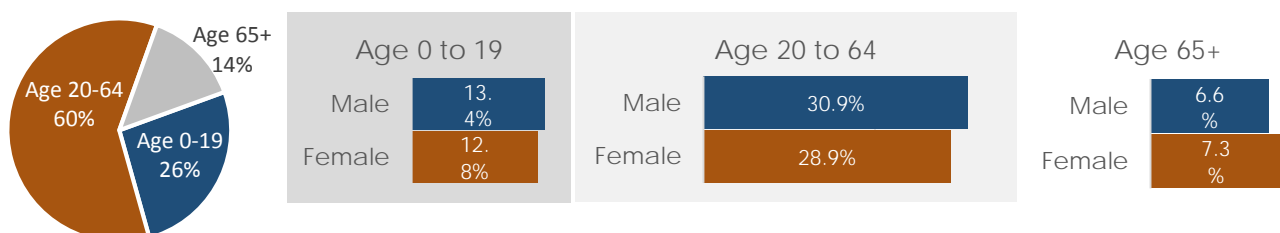


Figure 6: Wyoming Population by Age and Gender

⁶ Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014. Source: U.S. Census Bureau, Population Division. Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015. <http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>

The unemployment rate in Wyoming continues to remain below the national average, with a seasonally adjusted rate of 4.1 percent as of June 2015⁷. The poverty rate for Wyoming, as of 2014, was 9.7 percent, well below the national average of 14.8 percent.

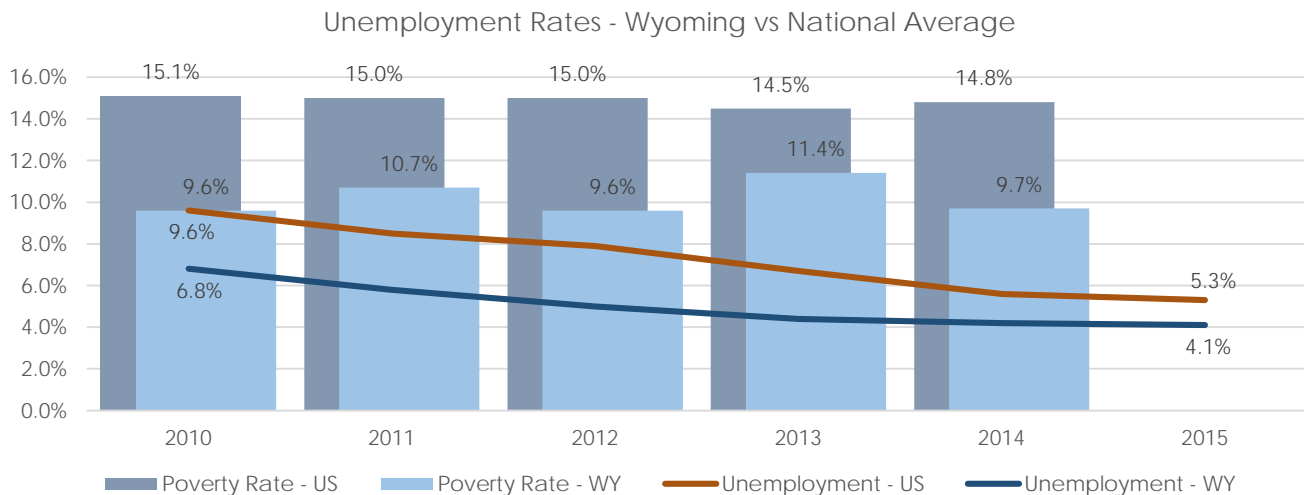


Figure 7: Unemployment and Poverty Rates - Wyoming vs National Average

Wyoming's overall employment from 2004 to 2014 has increased an estimated 15.4 percent, far exceeding the national average rate of 5.5 percent. Healthcare Practitioners and Technical Occupations employment also out-paced the national average. Growth for Healthcare Support Workers was not as great in Wyoming as it was nationally; however, the mean hourly wage for those workers increased more than the national average during this time.^{8,9}

Table 5: Employment and Mean Wages by Occupation

	Employment Total Percent Increase 2004 to 2014		Wages Total Percent Increase 2004 to 2014		Mean Hourly Wages 2014	
	US	WY	US	WY	US	WY
All Occupations	5.5%	15.4%	27.6%	39.6%	\$22.71	\$21.60
Healthcare Practitioners and Technical Occupations	23.5%	32.5%	32.6%	32.3%	\$36.54	\$35.20
Healthcare Support Workers	20.5%	1.8%	24.1%	39.9%	\$13.86	\$14.44

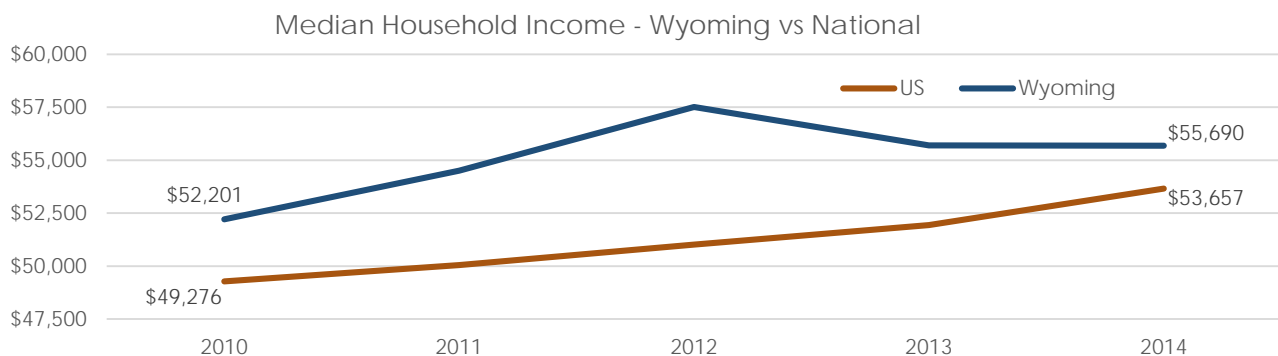


Figure 8: Median Household Income - Wyoming vs National¹⁰

⁷ Historical Poverty Tables- People, Tables 9 and 21: <http://www.census.gov/hhes/www/poverty/data/historical/people.html>

⁸ Bureau of Labor Statistics, *May 2014 State Occupational Employment and Wage Estimates, Wyoming*. http://www.bls.gov/oes/current/oes_wy.htm

⁹ Bureau of Labor Statistics, *May 2014 State Occupational Employment and Wage Estimates, United States*. http://www.bls.gov/oes/current/oes_nat.htm

¹⁰ US Census Bureau, Historical Income Table H-8. <https://www.census.gov/hhes/www/income/data/historical/household/2014/h08.xls>

Highlights and Initiatives

During SFY 2015, 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



Long-Term Care

- Continued to develop and test a revised LT-101 form and process. Additional testing needed in SFY 2016 prior to roll-out in SFY 2017.
- New nursing home rate system funded by legislature with implementation date of July 1, 2015.

Medical and Coordinated Care



- Wyoming accepted to National Governors Association Policy Academy focused on high-cost, high-need individuals (super-utilizers). Wyoming will use this assistance to help develop a super-utilizer focused program or procurement.
- Magellan Healthcare Inc. procured as the new Care Management Entity. Expanded services developed under the existing CHIPRA grant, and moved the program from a seven-county pilot to a statewide service offering. Magellan also took over administration and oversight of services delivered under the Children's Mental Health Waiver. Start-up contract executed April 1, 2015 with launch services July 1, 2015.
- Patient Centered Medical Home launched with year one of the program on January 1, 2015.
- Development of a health risk assessment screening tool and research on how to integrate the tool into application and renewal processes.

Home & Community Based Waiver Redesign



- Transition to the new Comprehensive and Supports Waivers:
 - Adult Developmentally Disabled (DD) complete as of September 30, 2014.
 - Child DD complete as of June 30, 2015.
- Began planning transition of individuals with Acquired Brain Injury (ABI) – to be completed in September 2016.
- Completed implementation of conflict-free case management.
- Completed assessment of the current system to meet CMS requirements and proposed a transition plan.

Dental Nursing Home Pilot



- Conducted pilot in 3 nursing facilities to evaluate the unmet needs of residents and their barriers to care.
- Based on findings, addressed these barriers by incentivizing providers and clients to provide better dental care in facilities.
- Anticipated pilot evaluation report due December 2015.

Wyoming Eligibility System

- Incremental releases of additional functionality and defect resolution on a monthly basis.
- New Presumptive Eligibility groups to be added to WES with training and performance measures for providers.
- Additional staff added to Customer Service Center to improve customer service to Wyoming residents and other organizations.
- Began planning for reprourement of WES and the Customer Service Center.



MMIS Replacement Project



- MITA 3.0 System assessment completed on current status, to-be planned and procurement plan completed.
- Pharmacy Benefit Management Procurement developed and released.

Technology Projects

Health Information Technology

Wyoming Total Health Record (THR) Gateway

- Currently connected to Immunization and Cancer registries.
- Laboratory registry to be available by February 2016.
- Provides a Continuity of Care Document (CCD) with medical information on Medicaid clients collected via claims and providers using the THR Electronic Health Record (EHR).
- Generates alerts to enable providers to follow-up as needed for Medicaid clients.



State Level Repository (SLR)

- Expanded to accept Clinical Quality Measures submissions for the Patient Centered Medical Home (PCMH) Program for upload of HL7 Quality Reporting Document Architecture (QRDA).

ICD-10

- Division level ICD-10 preparation activities re-initiated in September 2014.
- Additional policy remediation efforts completed December 2014.
- Provider outreach activities initiated in February 2015.
- The State began provider end-to-end testing on April 1, 2015 and conducted system testing with providers through August 21, 2015.
- A new billing policy requiring all providers to submit electronic claims to Medicaid was implemented July 1, 2015.
- National launch of ICD-10 October 1, 2015.

Affordable Care Act Impacts

Mandatory Enrollment of Ordering and Rendering Providers

42 CFR 455.410 mandates all ordering physicians or other eligible professionals providing services under the state plan or under a waiver of the plan be enrolled as a participating provider and submit to screening and monitoring.

42 CFR 455.440 requires all claims for the payment for items and services ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered, referred, or prescribed items or services.

Wyoming Medicaid will begin enrolling these providers on September 1, 2015.

Budget Actions

- **Rate Increase / New Model Nursing Homes**
Budget appropriation increase of \$8.4 million allowed implementation of new acuity based model. A separate footnote increased funding for stand-alone hospice rates.
- **Rate Increase / Waiver Rates for Developmental Disability Waiver Services**
Rate Increases targeted at persons with level of need 4 thru 6.
- **Tribal Uncompensated Care Waiver**
Directed the Wyoming Department of Health to apply for and appropriated funds for an uncompensated care waiver for Tribal facilities. Funded at 100% Federal funds for uncompensated care supplemental payments to facilities and 50% Federal / 50% Tribal for administration which consists of one full-time state employee to develop and implement the waiver.
- **Psychiatric Residential Treatment Facility (PRTF) Rates**
Re-based PRTF rates, removing the ancillary service allowance. Implemented October 2014.
- **Mental Health and Substance Abuse / Payer of Last Resort**
State required to make block grant funding payer of last resort to Medicaid and all

Quality Assurance & Program Integrity

The ACA established provider screening, enrollment, and monitoring for all participating Medicaid providers. Providers are screened prior to executing a provider agreement and on a monthly basis thereafter to ensure continued compliance with Federal and state requirements. All provider types are required to revalidate every five years. As of June 30, 2015, 60% of all Medicaid providers have completed the re-enrollment process.

Provider Re-Enrollment

Wyoming Legislation



- **SEA 21 2015 – Medical Billing Provisional Providers**

Allowed provisional licensed mental health professionals to bill under the supervision of qualified, fully licensed mental health professionals.

- **SEA 70 2015 – Medicaid Chiropractic Services**

Extended a chiropractic benefit to all Medicaid beneficiaries. No appropriation. Wyoming Department of Health noted a likely cost of \$1 to 2 million.

- **HEA 103 – Insurance Coverage- Early Refills of Prescription Eye Drops**

Earlier refill of eyedrops and an allowance for a spare bottle for daycare or school. Programming was put into place in the pharmacy point-of-sale system to allow eye drop refills when 75% of the previous prescription is used. Additionally, overrides will be allowed for an extra bottle to be dispensed every quarter. All programming live on July 1, 2015.

Medicaid Program Improvement

- **On-Site Compliance Review (OSCR) – Launched May 1, 2015**

On-site reviews are conducted for all Medicaid-enrolled PRTFs serving Wyoming youth, with the goal of assessing facility compliance with State and Federal law, assessing program improvement and developing a provider ranking system based on survey results that is available to all stakeholders, placement agencies, and referral sources.

- **Health Help**

Implemented a full peer-to-peer educational consult and utilization review (UR) program through Health Help. Provides consults and URs for radiology, cardiology, and radiation oncology services funded through Medicaid.

- **Tribal Advisory Group**

WDH Director approved a policy formally establishing the Tribal Leadership Advisory Council including Tribal leadership, Indian Health Services and the WDH. The advisory group meets quarterly and seeks to create a consistent and collaborative process for engaging Tribal leadership and Indian Health Services in ongoing agency programs, policies, and barriers as well as providing WDH with a thorough understanding and evaluation of impacts and benefits to the American Indian/Alaskan Native population in Wyoming.

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

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

89,252
Individuals enrolled
in Medicaid in SFY
2015

↑ 3.6%
from SFY 2014

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

Enrollment Overview

There were 89,252 unique individuals enrolled in Medicaid in SFY 2015, a 3.6 percent increase from SFY 2014.

Individuals may gain and lose eligibility several times throughout the SFY. While some individuals may be eligible for a portion of the year, others retain eligibility throughout the year. As such, the distinct count of enrolled individuals for Medicaid for a complete SFY – regardless of how long they were enrolled – is greater than a point-in-time count of Medicaid enrollment.

Table 6: Change in Medicaid Enrollment¹¹

	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
SFY 2015	66,532	-2.6	89,252	3.6

For the purpose of this Annual Report, enrollment data for the complete SFY is used.

¹¹ Enrolled Members 'As of June 30' is a distinct count of individuals at a point in time. Enrolled Members 'Complete SFY' is a distinct count of individuals for a complete SFY, July 1 through June 30.

Medicaid Enrollment Trends Comparing State Fiscal Year

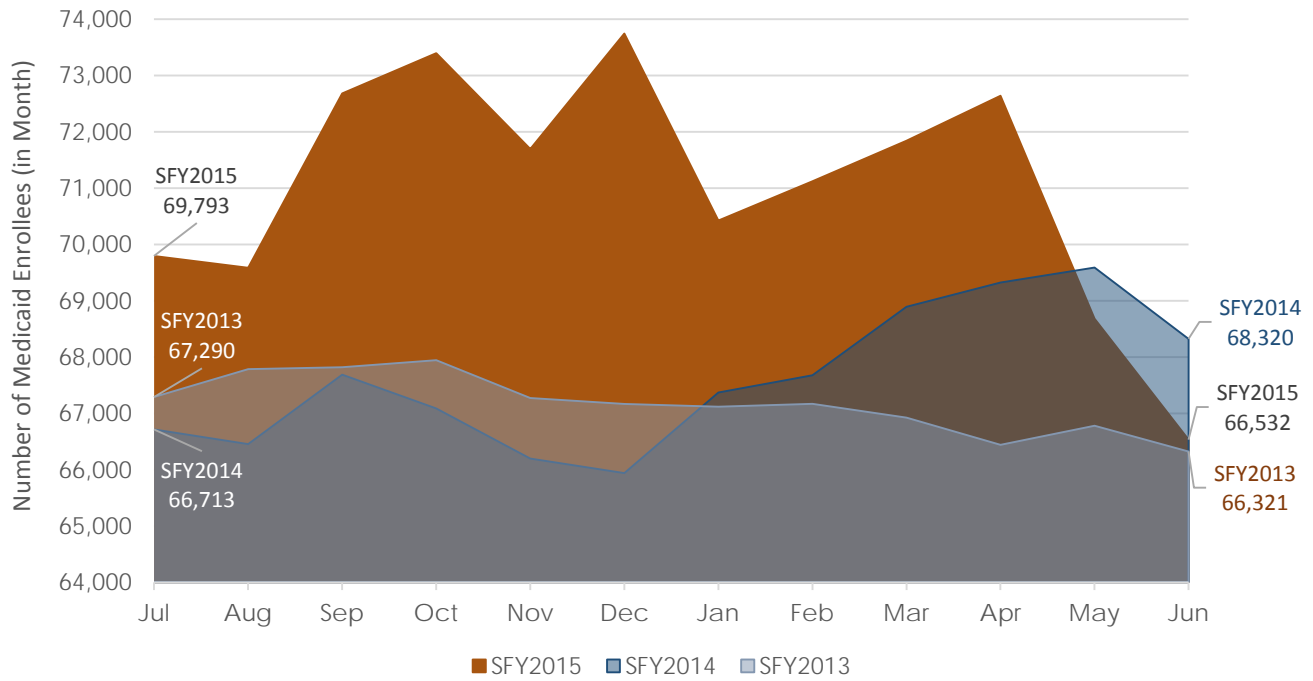


Figure 9: Medicaid Enrollment Trends Comparing State Fiscal Years

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 7: Enrolled Members by County

County	Enrolled Members	Percent of Total	County	Enrolled Members	Percent of Total
Albany	4,019	4.5	Natrona	13,193	14.8
Big Horn	2,052	2.3	Niobrara	452	0.5
Campbell	6,536	7.3	Other	2,320	2.6
Carbon	2,342	2.6	Park	3,928	4.4
Converse	1,967	2.2	Platte	1,382	1.6
Crook	904	1.0	Sheridan	4,064	4.6
Fremont	9,942	11.1	Sublette	806	0.9
Goshen	2,211	2.5	Sweetwater	6,091	6.8
Hot Springs	941	1.1	Teton	1,797	2.0
Johnson	973	1.1	Uinta	3,678	4.1
Laramie	15,202	17.0	Washakie	1,272	1.4
Lincoln	2,237	2.5	Weston	943	1.0
Total			89,252	100	

Eligibility Categories

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

Eligibility is determined using Federal Poverty Level (FPL) guidelines, Supplemental Security Income (SSI) standards, or the 1996 Family Care income standard. In many instances, the guideline or standard used is determined by the federal laws that created each eligibility category. The FPL guidelines and SSI standards are based on an index that changes every year. For detailed information regarding these income requirements, see Appendix 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 8: Eligibility Categories

Eligibility Category	Description
Aged, Blind, or Disabled Employed Individuals with Disabilities (ABD EID)	<ul style="list-style-type: none"> • 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, or Disabled Intellectually Disabled/Developmentally Disabled/Acquired Brain Injury (ABD ID/DD/ABI)	<ul style="list-style-type: none"> • Children and adults with a developmental disability or acquired brain injury • Individuals do not have to be eligible for SSI • Income requirement based on SSI • Includes residents living in the Intermediate Care Facility for the Intellectually Disabled (ICF-ID) (State training School/Wyoming Life Resource Center)
Aged, Blind, or Disabled Institutional (ABD Institution)	<ul style="list-style-type: none"> • Residents living in the following types of institution: <ul style="list-style-type: none"> ◦ Hospital ◦ 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, or Disabled Supplemental Security Income (ABD SSI)	<ul style="list-style-type: none"> • Disabled individuals receiving SSI automatically qualify • SSI Related – An individual no longer receiving SSI payment may be eligible using SSI criteria
Children	<ul style="list-style-type: none"> • Newborns – automatically eligible if the mother is eligible for Medicaid at the time of the birth • Children – includes children whose caretaker is eligible for Medicaid, income requirement based on Federal Poverty Level (FPL), and is dependent on age of the child • Foster Care children – automatically eligible when in the Department of Family Services (DFS) custody, including some children who enter subsidized adoption 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. • Children's Mental Health Waiver – Children with severe mental health needs
Adults	<ul style="list-style-type: none"> • Family-Care Adults – Adult caretaker relatives with a dependent child; Must cooperate with child support enforcement; Income requirement based on set values • Newly Eligible Adults – Income requirement based on FPL • Former Foster Care – covers individuals who age out of the foster care when they become 18 years old. As of January 1, 2014, former foster care children remain eligible until the age of 26.

Eligibility Category	Description
Medicare Savings Programs	<ul style="list-style-type: none"> • Individuals not eligible in another category and eligible for Medicare • Provides premium assistance and, depending on income, cost-sharing assistance • Qualified Medicare Beneficiaries (QMB) <ul style="list-style-type: none"> ◦ Resources also taken into consideration ◦ Medicaid pays for Medicare premiums, deductibles and cost-sharing ◦ Income requirement based on FPL • Specified Low-Income Medicare Beneficiaries (SLMB) <ul style="list-style-type: none"> ◦ Medicaid pays for Medicare premiums only ◦ Income requirement based on FPL
Non-Citizens with Medical Emergencies	<ul style="list-style-type: none"> • Non-citizen who meets all eligibility factors of a Medicaid group except citizenship and social security number • Emergency services only
Pregnant Women	<ul style="list-style-type: none"> • 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.¹² • Income requirement based on FPL
Special Groups	<ul style="list-style-type: none"> • Breast and Cervical Cancer Treatment Program <ul style="list-style-type: none"> ◦ Uninsured women diagnosed with breast or cervical cancer ◦ Income requirement based on FPL • Tuberculosis (TB) Program <ul style="list-style-type: none"> ◦ Individuals diagnosed with tuberculosis ◦ Resources also taken into consideration ◦ Income requirement based on SSI • Pregnant by Choice Waiver <ul style="list-style-type: none"> ◦ Family planning services for individuals who received Medicaid benefits through the Pregnant Women program

Enrollment by Category

Almost two-thirds (63 percent) of Medicaid members were children.

Table 9: Change in Enrollment by Eligibility Category

Eligibility Category	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
ABD EID	188	228	280	307	287	297	58
ABD ID/DD/ABI	2,373	2,359	2,408	2,406	2,364	2,423	2
ABD Institution	44	37	23	25	14	18	-59
ABD Long-Term Care (Elderly/Physically Disabled)	4,119	3,995	3,943	3,950	3,953	4,183	2
ABD SSI	6,199	6,497	6,650	6,793	6,508	6,503	5
Adults	7,303	7,516	7,320	7,144	7,908	10,274	41
Children	54,792	56,375	56,234	55,918	54,477	55,589	1
Medicare Savings Programs	3,730	4,161	4,500	4,794	4,881	4,918	32
Non-Citizens with Medical Emergencies	1,115	1,065	1,060	1,001	877	724	-35
Pregnant Women	4,622	4,542	4,362	4,359	3,973	3,795	-18
Special Groups	931	1,283	1,354	1,249	946	528	-43
Total	85,416	88,058	88,134	87,946	86,188	89,252	4

¹² 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 members across the eligibility categories¹³ compared to the expenditures for those categories.

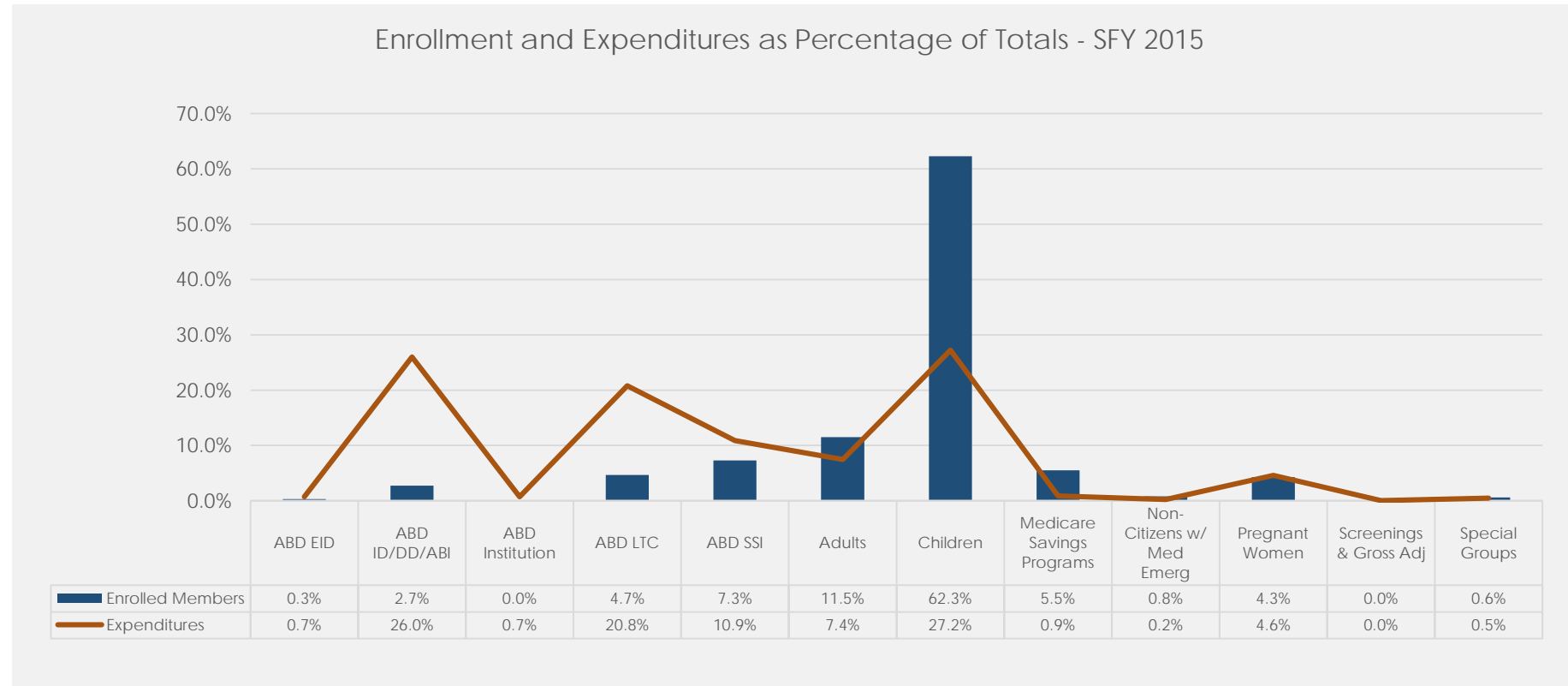


Figure 10: Enrollment and Expenditures as Percentage of Totals - SFY 2015

While children represented 62 percent of all members for SFY 2015, the corresponding expenditures for children receiving services only accounted for 27 percent of total Medicaid expenditures.

On the other hand, the ABD – ID/DD/ABI and ABD – LTC populations accounted for only 7.4 percent of all members for the SFY but nearly 46.8 percent of total Medicaid expenditures.

• ¹³ Screenings and gross adjustments are included to account for expenditures; however, this is not an eligibility category.

Table 10: Eligibility Category Summary

Eligibility Category	Enrolled Members	Percent Change from SFY 2014	Recipients	Percent Change from SFY 2014	Expenditures	Percent Change from SFY 2014	Expenditures per Enrolled Member	Percent Change from SFY 2014	Expenditures per Recipient	Percent Change from SFY 2014
ABD EID	297	3.5	360	4.3	\$3,795,205	-16.5	\$12,778	-19.3	\$10,542	-20.0
ABD ID/DD/ABI	2,423	2.5	2,476	2.9	\$137,112,834	-2.2	\$56,588	-4.6	\$55,377	-5.0
ABD Institution	18	28.6	91	-1.1	\$3,843,309	-44.7	\$213,517	-57.0	\$42,234	-44.1
ABD Long-Term Care (Elderly/Physically Disabled)	4,183	5.8	4,533	3.4	\$109,685,023	0.1	\$26,222	-5.4	\$24,197	-3.2
ABD SSI	6,503	-0.1	6,126	-2.3	\$57,532,693	8.0	\$8,847	8.1	\$9,392	10.6
Adults	10,274	29.9	8,468	22.6	\$39,268,780	38.2	\$3,822	6.4	\$4,637	12.7
Children	55,589	2.0	47,633	-3.6	\$143,624,614	5.8	\$2,584	3.7	\$3,015	9.7
Medicare Savings Programs	4,918	0.8	2,985	8.1	\$4,564,069	11.7	\$928	10.9	\$1,529	3.4
Non-Citizens with Medical Emergencies	724	-17.4	287	-21.8	\$1,236,724	-17.0	\$1,708	0.5	\$4,309	6.1
Pregnant Women	3,795	-4.5	5,473	-0.7	\$24,134,468	-16.1	\$6,360	-12.2	\$4,410	-15.5
Screenings & Gross Adjustments	-	-	-	-	\$183,197	-53.0	-	-	-	-
Special Groups	528	-44.2	271	-45.5	\$2,550,692	-38.4	\$4,831	10.4	\$9,412	13.0
Total	89,252	3.6	75,325	-1.3	\$527,531,608	1.9	\$5,911	-1.6	\$7,003	3.3

Table 11: Change in Expenditures by Eligibility Category

Eligibility Category	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
ABD EID	\$2,807,582	\$2,721,026	\$3,208,536	\$4,589,792	\$4,545,872	\$3,795,205	35
ABD ID/DD/ABI	\$122,490,695	\$128,973,756	\$131,305,592	\$140,008,570	\$140,255,339	\$137,112,834	12
ABD Institution	\$7,616,076	\$7,040,563	\$4,975,050	\$4,836,583	\$6,947,121	\$3,843,309	-50
ABD Long-Term Care (Elderly/Physically Disabled)	\$113,721,938	\$113,614,225	\$115,028,538	\$111,411,633	\$109,585,095	\$109,685,023	-4
ABD SSI	\$50,065,766	\$51,934,208	\$51,345,795	\$52,203,560	\$53,252,515	\$57,532,693	15
Adults	\$28,237,358	\$29,178,291	\$28,827,439	\$28,446,023	\$28,414,259	\$39,268,780	39
Children	\$146,012,700	\$141,159,152	\$124,839,646	\$133,149,744	\$135,754,662	\$143,624,614	-2
Medicare Savings Programs	\$2,562,625	\$3,007,075	\$3,245,880	\$3,708,394	\$4,086,134	\$4,564,069	78
Non-Citizens with Medical Emergencies	\$2,202,976	\$1,960,832	\$1,948,889	\$1,892,640	\$1,490,032	\$1,236,724	-44
Pregnant Women	\$36,184,628	\$36,086,835	\$32,051,842	\$31,815,394	\$28,762,228	\$24,134,468	-33
Screenings & Gross Adjustments	\$182,034	\$239,567	\$355,924	\$378,465	\$389,686	\$183,197	1
Special Groups	\$2,444,944	\$3,688,749	\$3,797,900	\$4,816,363	\$4,139,581	\$2,550,692	4
Total	\$514,529,323	\$519,604,279	\$500,931,031	\$517,257,164	\$517,622,524	\$527,531,608	3

Table 12: Change in Recipients¹⁴ by Eligibility Category

Eligibility Category	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
ABD EID	223	253	310	342	345	360	61
ABD ID/DD/ABI	2,422	2,409	2,431	2,448	2,407	2,476	2
ABD Institution	190	166	119	100	92	91	-52
ABD Long-Term Care (Elderly/Physically Disabled)	4,616	4,563	4,433	4,401	4,386	4,533	-2
ABD SSI	5,934	6,094	6,191	6,245	6,269	6,126	3
Adults	6,622	6,936	6,590	6,683	6,907	8,468	28
Children	48,368	50,082	49,110	49,042	49,410	47,633	-2
Medicare Savings Programs	2,153	2,333	2,514	2,641	2,762	2,985	39
Non-Citizens with Medical Emergencies	479	419	426	414	367	287	-40
Pregnant Women	6,388	6,149	5,785	5,939	5,509	5,473	-14
Special Groups	570	683	686	622	497	271	-52
Total	74,871	77,229	75,968	76,278	76,321	75,325	1

Table 13: Change in Expenditures per Recipient by Eligibility Category

Eligibility Category	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
ABD EID	\$12,590	\$10,755	\$10,350	\$13,420	\$13,176	\$10,542	-16
ABD ID/DD/ABI	\$50,574	\$53,538	\$54,013	\$57,193	\$58,270	\$55,377	9
ABD Institution	\$40,085	\$42,413	\$41,807	\$48,366	\$75,512	\$42,234	5
ABD Long-Term Care (Elderly/Physically Disabled)	\$24,636	\$24,899	\$25,948	\$25,315	\$24,985	\$24,197	-2
ABD SSI	\$8,437	\$8,522	\$8,294	\$8,359	\$8,495	\$9,392	11
Adults	\$4,264	\$4,207	\$4,374	\$4,256	\$4,114	\$4,637	9
Children	\$3,019	\$2,819	\$2,542	\$2,715	\$2,748	\$3,015	0
Medicare Savings Programs	\$1,190	\$1,289	\$1,291	\$1,404	\$1,479	\$1,529	28
Non-Citizens with Medical Emergencies	\$4,599	\$4,680	\$4,575	\$4,572	\$4,060	\$4,309	-6
Pregnant Women	\$5,664	\$5,869	\$5,541	\$5,357	\$5,221	\$4,410	-22
Special Groups	\$4,289	\$5,401	\$5,536	\$7,743	\$8,329	\$9,412	119
Total	\$6,872	\$6,728	\$6,594	\$6,781	\$6,782	\$7,003	2

¹⁴ 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 14: Change in Expenditures per Enrolled Member by Eligibility Category

Eligibility Category	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
ABD EID	\$14,934	\$11,934	\$11,459	\$14,950	\$15,839	\$12,778	-14
ABD ID/DD/ABI	\$51,618	\$54,673	\$54,529	\$58,191	\$59,330	\$56,588	10
ABD Institution	\$173,093	\$190,285	\$216,307	\$193,463	\$496,223	\$213,517	23
ABD Long-Term Care (Elderly/Physically Disabled)	\$27,609	\$28,439	\$29,173	\$28,205	\$27,722	\$26,222	-5
ABD SSI	\$8,076	\$7,994	\$7,721	\$7,685	\$8,183	\$8,847	10
Adults	\$3,867	\$3,882	\$3,938	\$3,982	\$3,593	\$3,822	-1
Children	\$2,665	\$2,504	\$2,220	\$2,381	\$2,492	\$2,584	-3
Medicare Savings Programs	\$687	\$723	\$721	\$774	\$837	\$928	35
Non-Citizens with Medical Emergencies	\$1,976	\$1,841	\$1,839	\$1,891	\$1,699	\$1,708	-14
Pregnant Women	\$7,829	\$7,945	\$7,348	\$7,299	\$7,239	\$6,360	-19
Special Groups	\$2,626	\$2,875	\$2,805	\$3,856	\$4,376	\$4,831	84
Total	\$6,024	\$5,901	\$5,684	\$5,882	\$6,006	\$5,911	-2

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 Utilization – Overview

Wyoming Medicaid covers the following mandatory and optional services.

Table 15: Mandatory and Optional Services

Mandatory Services	Optional Services
Certified pediatric nurse practitioner or family nurse practitioner	Dental (for adults 21 and older)
Dental (for children under age 21)	Durable Medical Equipment (DME), Prosthetics, Orthotics and Supplies
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) ¹⁵	End Stage Renal Disease
Family planning and supplies	Intermediate Care Facility for the Intellectually Disabled (ICF-ID)
Federally Qualified Health Center (FQHC)	Interpreter
Home health	Mental health and substance abuse
Inpatient and outpatient hospital	Prescription Drug
Laboratory and x-ray	Psychiatric Residential Treatment Facility (PRTF)
Nurse-midwife	Targeted case management
Nursing facility	Vision (for adults 21 and older)
Physician	Waivers
Rural Health Clinic	
Transportation ¹⁶	
Vision (for children under age 21)	

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 16: Service Areas

Service Areas		
Ambulance	Ambulatory Surgery Center (ASC)	Behavioral Health ¹⁷
Dental	Durable Medical Equipment (DME), Prosthetics/Orthotics, and Supplies	End Stage Renal Disease
Federally Qualified Health Centers	Home Health	Hospice
Hospital	Intermediate Care Facility-ID	Laboratory
Nursing Facility ¹⁸	Other ¹⁹	PACE
Physician & Other Practitioner	Prescription Drug	Psychiatric Residential Treatment Facility (PRTF)
Public Health, Federal	Rural Health Clinic	Vision
Waivers ²⁰		

¹⁵ Medicaid's EPSDT services are operated under the Health Check program, which is discussed in more detail in Appendix A.

¹⁶ Transportation services are not a mandatory service, but states are required to ensure necessary transportation to providers.

¹⁷ Excludes the Children's Mental Health Waiver and Psychiatric Residential Treatment Facility.

¹⁸ Excludes the Long-Term Care and Assisted Living Facility Waivers.

¹⁹ The Other service area is comprised of services that fall outside the criteria ranges used for this report

²⁰ Excludes the Pregnant by Choice Waiver.

Table 17: Service Utilization Summary

Service Area	Expenditures	Percent Change from SFY2014	Recipients ²¹	Percent Change from SFY2014	Expenditures per Recipient	Percent Change from SFY2014
Ambulance	\$4,352,067	15.7	3,546	0.7	\$1,227	14.9
Ambulatory Surgical Center	\$6,090,776	50.8	3,547	4.6	\$1,717	44.2
Behavioral Health	\$35,143,911	9.8	14,700	6.4	\$2,391	3.3
Dental	\$14,473,863	8.1	30,679	5.2	\$472	2.8
DME, Prosthetics/Orthotics/Supplies	\$8,624,246	13.1	7,328	2.9	\$1,177	9.9
End Stage Renal Disease	\$1,099,569	2.6	107	0.0	\$10,276	2.6
Federally Qualified Health Center	\$3,259,793	20.8	5,995	48.6	\$544	-18.7
Home Health	\$4,618,885	30.7	688	16.6	\$6,713	12.1
Hospice	\$1,157,101	-21.2	182	-27.8	\$6,358	9.1
Hospital Total	\$104,523,947	2.5	42,562	6.3	\$2,456	-3.5
<i>Hospital-Inpatient</i>	<i>\$73,407,132</i>	<i>0.7</i>	<i>10,649</i>	<i>3.4</i>	<i>\$6,893</i>	<i>-2.7</i>
<i>Hospital-Other</i>	<i>\$60,748</i>	<i>-79.5</i>	<i>149</i>	<i>-23.2</i>	<i>\$408</i>	<i>-73.3</i>
<i>Hospital-Outpatient</i>	<i>\$31,056,066</i>	<i>8.2</i>	<i>40,252</i>	<i>7.0</i>	<i>\$772</i>	<i>1.1</i>
Intermediate Care Facility-ID	\$18,091,427	-5.5	75	-5.1	\$241,219	-0.5
Laboratory	\$1,516,042	18.0	8,852	-6.7	\$171	26.5
Nursing Facility	\$70,354,260	-3.4	2,357	-1.3	\$29,849	-2.2
Other	\$2,772,090	4.5	8,581	2.1	\$323	2.4
PACE	\$2,242,570	74.0	95	50.8	\$23,606	15.4
Physician & Other Practitioner	\$60,174,203	-1.4	62,783	-3.7	\$958	2.3
Prescription Drug	\$47,946,923	16.3	46,031	3.5	\$1,042	12.3
PRTF	\$13,580,238	-8.9	334	0.0	\$40,659	-8.9
Public Health, Federal	\$8,761,358	9.5	3,384	-4.6	\$2,589	14.8
Rural Health Clinic	\$1,668,167	9.7	4,532	-3.0	\$368	13.0
Vision	\$3,628,064	3.2	15,391	1.9	\$236	1.3
Waiver Total	\$113,452,108	-4.4	4,446	6.7	\$25,518	-10.3
<i>Waiver-ABI</i>	<i>\$6,636,440</i>	<i>-10.0</i>	<i>168</i>	<i>-7.2</i>	<i>\$39,503</i>	<i>-3.0</i>
<i>Waiver-Adult DD</i>	<i>\$16,541,190</i>	<i>-80.2</i>	<i>1,325</i>	<i>-6.0</i>	<i>\$12,484</i>	<i>-78.9</i>
<i>Waiver-ALF</i>	<i>\$2,773,135</i>	<i>6.9</i>	<i>230</i>	<i>18.6</i>	<i>\$12,057</i>	<i>-9.8</i>
<i>Waiver-Child DD</i>	<i>\$8,372,841</i>	<i>-26.7</i>	<i>659</i>	<i>-5.7</i>	<i>--</i>	<i>--</i>
<i>Waiver-Child Mental Health</i>	<i>\$732,257</i>	<i>38.8</i>	<i>79</i>	<i>38.6</i>	<i>\$9,269</i>	<i>0.2</i>
<i>Waiver-Comprehensive</i>	<i>\$63,719,016</i>	<i>141,553.8</i>	<i>1,755</i>	<i>58,400.0</i>	<i>--</i>	<i>--</i>
<i>Waiver-LTC</i>	<i>\$13,857,541</i>	<i>5.2</i>	<i>1,821</i>	<i>7.1</i>	<i>\$7,610</i>	<i>-1.8</i>
<i>Waiver-Supports</i>	<i>\$819,690</i>	<i>180,448.4</i>	<i>191</i>	<i>--</i>	<i>\$4,292</i>	<i>--</i>
Total	\$527,531,608	1.9	75,325	-1.3	\$7,003	3.3

²¹ 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 1.9 percent from SFY 2014 to \$527,531,608.

The top service areas based on expenditures in SFY2015 are Waivers²², Hospital, Nursing Facility and Physician & Other Practitioner.

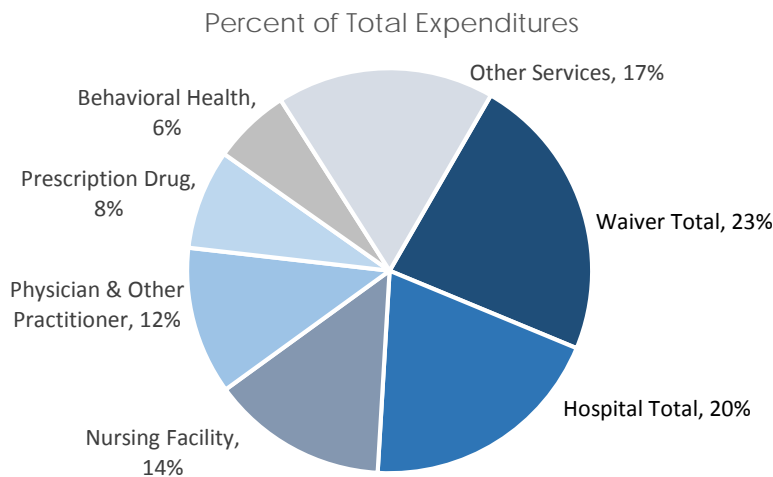


Figure 11: Percent of Total Expenditures by Service Area

Total unique recipient count for all Medicaid services remained relatively stable, decreasing by 1.3 percent from the previous year to 75,325 individuals.

The top service areas based on recipient count in SFY 2015 were Physician & Other Practitioner, Prescription Drug, Hospital, and Dental. The figure below shows that 83 percent of Medicaid recipients used Physician & Other Practitioner services in SFY 2015, 61 percent used prescription drug services, and so on.

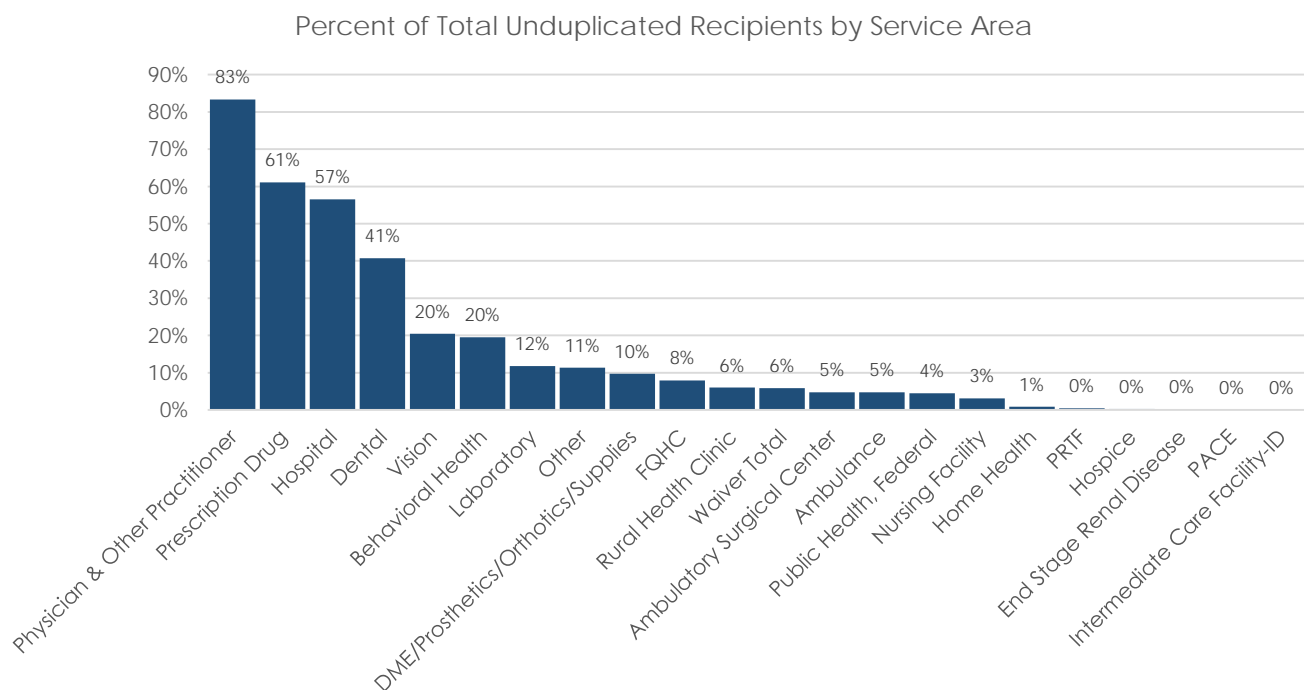


Figure 12: Percent of Total Unduplicated Recipients by Service Area

²² Includes waiver services expenditures only, and does not account for non-waiver medical services utilized by waiver recipients.

Table 18: Change in Expenditures by Service Area

Service Area	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Ambulance	\$3,807,538	\$3,303,240	\$3,459,400	\$3,606,360	\$3,760,537	\$4,352,067	14.3
Ambulatory Surgical Center	\$3,315,928	\$2,912,791	\$2,822,957	\$3,439,188	\$4,039,944	\$6,090,776	83.7
Behavioral Health	\$24,579,989	\$26,444,878	\$27,553,867	\$29,734,932	\$31,995,615	\$35,143,911	43.0
Dental	\$12,864,308	\$13,616,583	\$13,561,177	\$13,272,110	\$13,391,934	\$14,473,863	12.5
DME, Prosthetics/Orthotics/Supplies	\$6,605,716	\$7,505,683	\$7,270,213	\$7,730,289	\$7,627,734	\$8,624,246	30.6
End Stage Renal Disease	\$1,160,798	\$835,621	\$1,233,755	\$1,343,669	\$1,071,750	\$1,099,569	-5.3
Federally Qualified Health Center	\$2,864,956	\$3,103,164	\$1,550,274	\$2,018,911	\$2,698,283	\$3,259,793	13.8
Home Health	\$1,941,097	\$2,732,905	\$2,963,510	\$2,897,016	\$3,533,728	\$4,618,885	138.0
Hospice	\$1,432,471	\$1,036,887	\$983,026	\$1,082,188	\$1,468,295	\$1,157,101	-19.2
Hospital Total	\$113,636,933	\$114,358,067	\$105,798,987	\$108,839,452	\$101,931,277	\$104,523,947	-8.0
<i>Hospital-Inpatient</i>	<i>\$87,297,343</i>	<i>\$84,557,214</i>	<i>\$77,130,425</i>	<i>\$78,462,603</i>	<i>\$72,932,440</i>	<i>\$73,407,132</i>	<i>-15.9</i>
<i>Hospital-Other</i>	<i>\$79,286</i>	<i>\$108,775</i>	<i>\$11,189</i>	<i>\$187,458</i>	<i>\$295,690</i>	<i>\$60,748</i>	<i>-23.4</i>
<i>Hospital-Outpatient</i>	<i>\$26,260,304</i>	<i>\$29,692,078</i>	<i>\$28,657,373</i>	<i>\$30,189,391</i>	<i>\$28,703,147</i>	<i>\$31,056,066</i>	<i>18.3</i>
Intermediate Care Facility-ID ²³	\$10,651,941	\$11,388,412	\$10,065,657	\$17,942,326	\$19,152,530	\$18,091,427	69.8
Laboratory	\$1,121,964	\$1,171,185	\$1,100,774	\$1,149,473	\$1,284,678	\$1,516,042	35.1
Nursing Facility	\$75,434,811	\$73,180,333	\$73,805,803	\$73,593,462	\$72,866,933	\$70,354,260	-6.7
Other	\$11,306,396	\$3,566,409	\$2,860,936	\$2,612,656	\$2,652,151	\$2,772,090	-75.5
PACE	--	--	--	\$168,398	\$1,288,934	\$2,242,570	--
Physician & Other Practitioner	\$64,036,069	\$63,918,782	\$61,576,270	\$61,564,892	\$61,053,011	\$60,174,203	-6.0
Prescription Drug	\$38,870,852	\$41,352,500	\$41,914,658	\$39,110,022	\$41,238,663	\$47,946,923	23.3
PRTF	\$14,928,300	\$15,384,914	\$7,984,857	\$12,050,809	\$14,906,432	\$13,580,238	-9.0
Public Health, Federal	\$7,700,047	\$8,532,271	\$7,240,130	\$8,067,975	\$7,999,556	\$8,761,358	13.8
Rural Health Clinic	\$1,710,855	\$1,940,640	\$1,628,043	\$1,845,491	\$1,521,233	\$1,668,167	-2.5
Vision	\$3,233,037	\$3,269,685	\$3,228,994	\$3,434,854	\$3,514,674	\$3,628,064	12.2
Waiver Total	\$113,325,317	\$120,049,329	\$122,327,742	\$121,752,688	\$118,624,631	\$113,452,108	0.1
<i>Waiver-ABI</i>	<i>\$6,243,946</i>	<i>\$6,963,271</i>	<i>\$6,925,596</i>	<i>\$7,679,811</i>	<i>\$7,371,614</i>	<i>\$6,636,440</i>	<i>6.3</i>
<i>Waiver-Adult DD</i>	<i>\$75,746,359</i>	<i>\$81,369,215</i>	<i>\$84,846,084</i>	<i>\$84,204,861</i>	<i>\$83,501,095</i>	<i>\$16,541,190</i>	<i>-78.2</i>
<i>Waiver-ALF</i>	<i>\$3,058,800</i>	<i>\$2,757,617</i>	<i>\$2,612,026</i>	<i>\$2,451,875</i>	<i>\$2,593,984</i>	<i>\$2,773,135</i>	<i>-9.3</i>
<i>Waiver-Child DD</i>	<i>\$14,460,017</i>	<i>\$14,128,741</i>	<i>\$13,646,013</i>	<i>\$13,301,942</i>	<i>\$11,415,264</i>	<i>\$8,372,841</i>	<i>--</i>
<i>Waiver-Child Mental Health</i>	<i>\$391,862</i>	<i>\$918,455</i>	<i>\$942,386</i>	<i>\$688,995</i>	<i>\$527,514</i>	<i>\$732,257</i>	<i>86.9</i>
<i>Waiver-Comprehensive</i>	<i>--</i>	<i>--</i>	<i>--</i>	<i>--</i>	<i>\$44,982</i>	<i>\$63,719,016</i>	<i>--</i>
<i>Waiver-LTC</i>	<i>\$13,424,332</i>	<i>\$13,912,032</i>	<i>\$13,355,638</i>	<i>\$13,425,205</i>	<i>\$13,169,724</i>	<i>\$13,857,541</i>	<i>3.2</i>
<i>Waiver-Supports</i>	<i>--</i>	<i>--</i>	<i>--</i>	<i>--</i>	<i>\$454</i>	<i>\$819,690</i>	<i>--</i>
Total	\$514,529,323	\$519,604,279	\$500,931,031	\$517,257,164	\$517,622,524	\$527,531,608	2.5

²³ Federal portion only shown for SFY 2010 thru 2012.

Change in Expenditures by Service Area

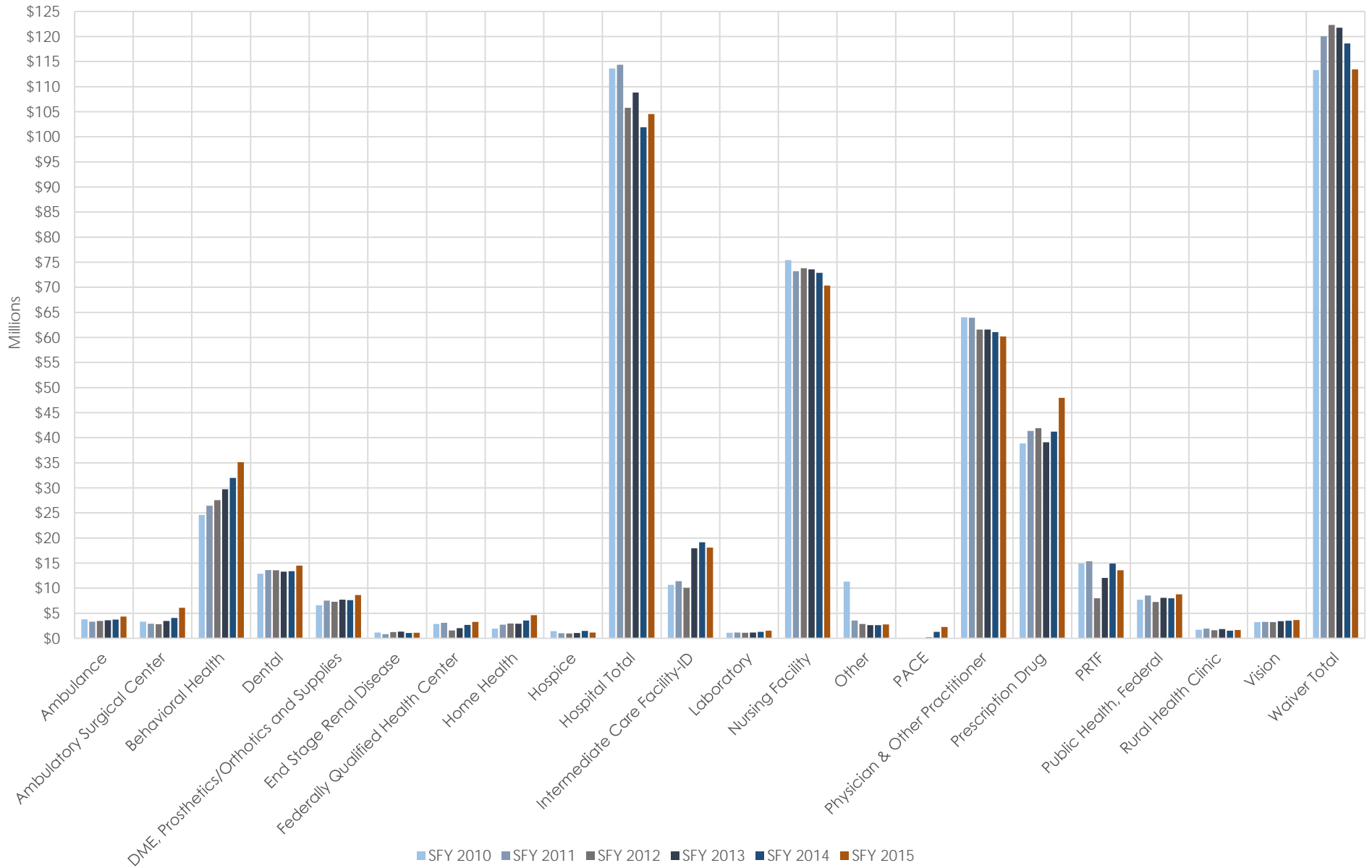


Figure 13: Change in Expenditures by Service Area (millions)

Table 19: Change in Expenditures by Other²⁴ Service Areas

Service Area	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5 Year Percent Change
Ambulatory Family Planning Facility	\$103,949	\$83,744	\$81,564	\$68,988	\$71,213	\$69,754	-33
Case Management	\$331,855	\$299,617	\$219,942	\$196,574	\$109,200	\$107,554	-68
Chiropractor	\$5,874	\$6,102	\$7,349	\$7,500	\$5,661	\$6,347	8
Clinic/Center	\$1,319,195	\$1,478,958	\$1,171,841	\$1,152,753	\$1,263,963	\$1,311,732	-1
Comprehensive Outpatient Rehabilitation Facility (CORF)	\$36,757	\$56,646	\$125,928	\$121,618	\$143,525	\$154,682	321
Day Training, Developmentally Disabled Service	\$64,723	\$222,425	\$54,478	\$61,326	\$72,487	\$26,209	-60
Interpreter	\$47,837	\$54,259	\$48,321	\$43,529	\$38,171	\$56,339	18
Phlebotomy/WY Health Fair	\$3,520	\$3,820	\$5,910	\$2,635	\$5,870	\$1,920	-45
Psychiatric Residential Treatment Facility	-\$269,570	-\$140,302	\$34,260	\$29,684	-\$20,299	-\$4,391	-98
Public Health Or Welfare	\$1,081,591	\$1,093,398	\$988,455	\$924,007	\$962,164	\$1,006,310	-7
Radiology: Mobile	\$222,281	\$217,463	\$109,250	\$4,081	\$226	\$52	-100
Residential Treatment Facility For Emotionally Disturbed	\$8,358,382	\$190,279	\$13,640	--	--	\$35,712	-100
Unknown	--	--	--	-\$39	-\$30	-\$131	--
Total	\$11,306,396	\$3,566,409	\$2,860,936	\$2,612,656	\$2,652,151	\$2,772,090	-75

²⁴ 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.

Table 20: Change in Recipient Count²⁵ by Service Area

Service Area	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Ambulance	3,351	3,613	3,604	3,433	3,520	3,546	5.8
Ambulatory Surgical Center	3,075	3,151	3,088	3,259	3,392	3,547	15.3
Behavioral Health	12,022	12,842	12,946	13,100	13,820	14,700	22.3
Dental	26,482	28,171	28,594	28,534	29,175	30,679	15.8
DME, Prosthetics/Orthotics/Supplies	7,443	7,502	7,245	7,364	7,124	7,328	-1.5
End Stage Renal Disease	83	86	98	110	107	107	28.9
Federally Qualified Health Center	4,109	4,834	2,722	3,612	4,034	5,995	45.9
Home Health	587	623	582	591	590	688	17.2
Hospice	147	150	135	179	252	182	23.8
Hospital Total	43,681	42,525	44,107	42,667	40,045	42,562	-2.6
<i>Hospital-Inpatient</i>	<i>12,277</i>	<i>11,640</i>	<i>10,890</i>	<i>10,970</i>	<i>10,299</i>	<i>10,649</i>	<i>-13.3</i>
<i>Hospital-Other</i>	<i>213</i>	<i>91</i>	<i>104</i>	<i>142</i>	<i>194</i>	<i>149</i>	<i>-30.0</i>
<i>Hospital-Outpatient</i>	<i>40,823</i>	<i>39,757</i>	<i>41,772</i>	<i>40,148</i>	<i>37,628</i>	<i>40,252</i>	<i>-1.4</i>
Intermediate Care Facility-ID	91	84	84	81	79	75	-17.6
Laboratory	9,852	9,923	9,415	9,724	9,490	8,852	-10.2
Nursing Facility	2,609	2,444	2,410	2,445	2,387	2,357	-9.7
Other	9,920	10,905	9,821	8,998	8,406	8,581	-13.5
PACE	--	--	--	22	63	95	--
Physician & Other Practitioner	63,451	64,739	63,493	61,352	65,176	62,783	-1.1
Prescription Drug	49,041	50,118	48,222	47,608	44,464	46,031	-6.1
PRTF	423	391	264	316	334	334	-21.0
Public Health, Federal	3,656	4,551	3,249	4,222	3,546	3,384	-7.4
Rural Health Clinic	4,670	5,277	4,174	5,418	4,670	4,532	-3.0
Vision	14,324	14,676	14,428	14,691	15,111	15,391	7.4
Waiver Total	4,382	4,413	4,302	4,207	4,168	4,446	1.5
<i>Waiver-ABI</i>	<i>192</i>	<i>177</i>	<i>188</i>	<i>186</i>	<i>181</i>	<i>168</i>	<i>-12.5</i>
<i>Waiver-Adult DD</i>	<i>1,336</i>	<i>1,355</i>	<i>1,380</i>	<i>1,395</i>	<i>1,409</i>	<i>1,325</i>	<i>-0.8</i>
<i>Waiver-ALF</i>	<i>236</i>	<i>217</i>	<i>201</i>	<i>190</i>	<i>194</i>	<i>230</i>	<i>-2.5</i>
<i>Waiver-Child DD</i>	<i>804</i>	<i>799</i>	<i>773</i>	<i>761</i>	<i>699</i>	<i>659</i>	<i>--</i>
<i>Waiver-Child Mental Health</i>	<i>77</i>	<i>136</i>	<i>131</i>	<i>82</i>	<i>57</i>	<i>79</i>	<i>2.6</i>
<i>Waiver-Comprehensive</i>	<i>--</i>	<i>--</i>	<i>--</i>	<i>--</i>	<i>3</i>	<i>1,755</i>	<i>--</i>
<i>Waiver-LTC</i>	<i>1,820</i>	<i>1,801</i>	<i>1,718</i>	<i>1,674</i>	<i>1,700</i>	<i>1,821</i>	<i>0.1</i>
<i>Waiver-Supports</i>	<i>--</i>	<i>--</i>	<i>--</i>	<i>--</i>	<i>0</i>	<i>191</i>	<i>--</i>
Total	74,871	77,229	75,968	76,278	76,321	75,325	0.6

²⁵ 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.

Change in Recipient Counts by Service Area

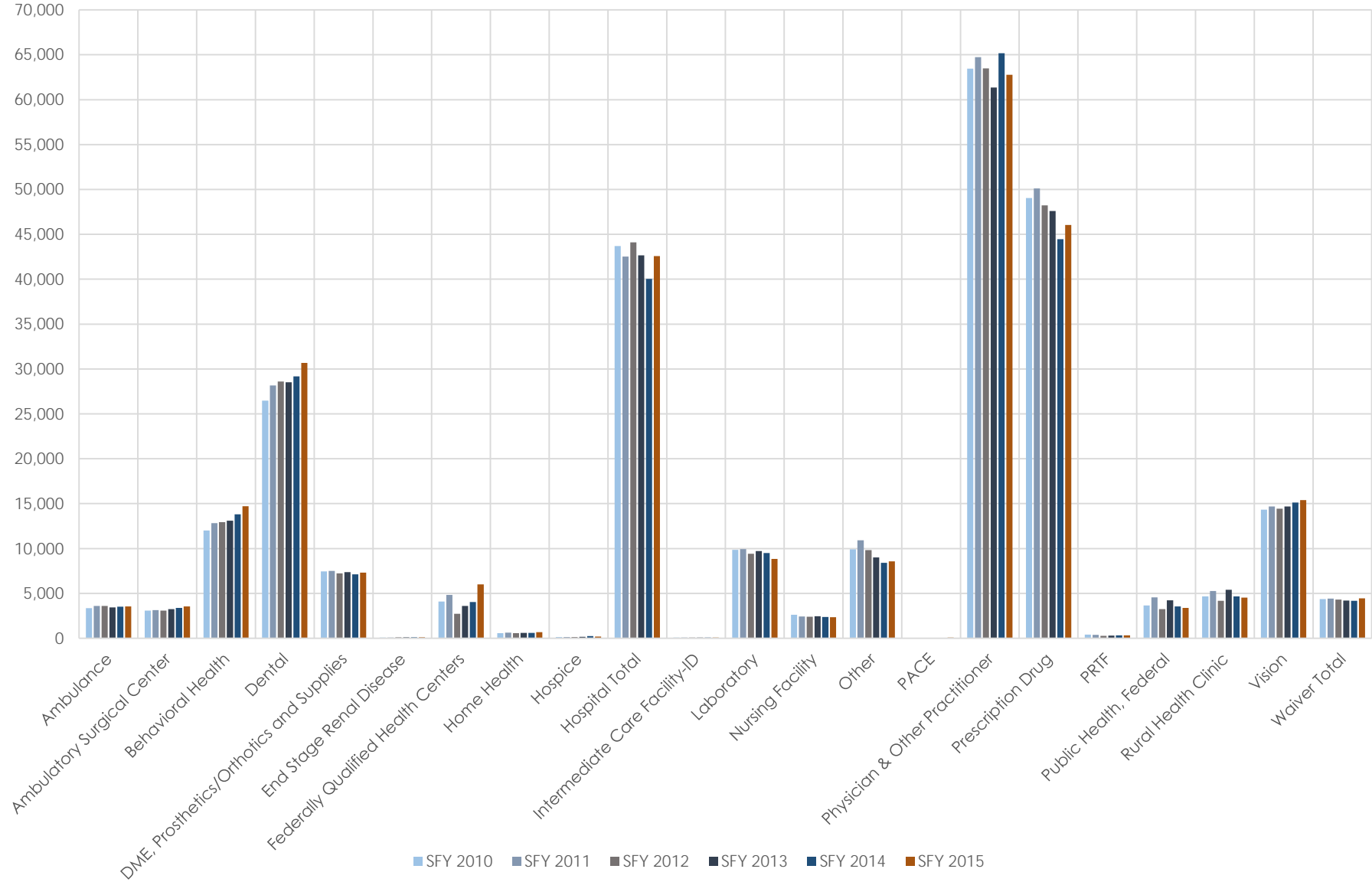


Figure 14: Change in Recipient Count by Service Area

Table 21: Change in Expenditures per Recipient by Service Area

Service Area	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Ambulance	\$1,136	\$914	\$960	\$1,050	\$1,068	\$1,227	8.0
Ambulatory Surgical Center	\$1,078	\$924	\$914	\$1,055	\$1,191	\$1,717	59.2
Behavioral Health	\$2,045	\$2,059	\$2,128	\$2,270	\$2,315	\$2,391	16.9
Dental	\$486	\$483	\$474	\$465	\$459	\$472	-2.9
DME, Prosthetics/Orthotics/Supplies	\$888	\$1,000	\$1,003	\$1,050	\$1,071	\$1,177	32.6
End Stage Renal Disease	\$13,986	\$9,717	\$12,589	\$12,215	\$10,016	\$10,276	-26.5
Federally Qualified Health Center	\$697	\$642	\$570	\$559	\$669	\$544	-22.0
Home Health	\$3,307	\$4,387	\$5,092	\$4,902	\$5,989	\$6,713	103.0
Hospice	\$9,745	\$6,913	\$7,282	\$6,046	\$5,827	\$6,358	-34.8
Hospital Total	\$2,602	\$2,689	\$2,399	\$2,551	\$2,545	\$2,456	-5.6
<i>Hospital-Inpatient</i>	<i>\$7,111</i>	<i>\$7,264</i>	<i>\$7,083</i>	<i>\$7,152</i>	<i>\$7,082</i>	<i>\$6,893</i>	<i>-3.1</i>
<i>Hospital-Other</i>	<i>\$372</i>	<i>\$1,195</i>	<i>\$108</i>	<i>\$1,320</i>	<i>\$1,524</i>	<i>\$408</i>	<i>9.5</i>
<i>Hospital-Outpatient</i>	<i>\$643</i>	<i>\$747</i>	<i>\$686</i>	<i>\$752</i>	<i>\$763</i>	<i>\$772</i>	<i>19.9</i>
Intermediate Care Facility-ID	\$117,054	\$135,576	\$119,829	\$221,510	\$242,437	\$241,219	106.1
Laboratory	\$114	\$118	\$117	\$118	\$135	\$171	50.4
Nursing Facility	\$28,913	\$29,943	\$30,625	\$30,100	\$30,527	\$29,849	3.2
Other	\$1,140	\$327	\$291	\$290	\$316	\$323	-71.7
PACE	--	--	--	\$7,654	\$20,459	\$23,606	--
Physician & Other Practitioner	\$1,009	\$987	\$970	\$1,003	\$937	\$958	-5.0
Prescription Drug	\$793	\$825	\$869	\$822	\$927	\$1,042	31.4
PRTF	\$35,291	\$39,348	\$30,246	\$38,135	\$44,630	\$40,659	15.2
Public Health, Federal	\$2,106	\$1,875	\$2,228	\$1,911	\$2,256	\$2,589	22.9
Rural Health Clinic	\$366	\$368	\$390	\$341	\$326	\$368	0.5
Vision	\$226	\$223	\$224	\$234	\$233	\$236	4.4
Waiver Total	\$25,862	\$27,204	\$28,435	\$28,941	\$28,461	\$25,518	-1.3
<i>Waiver-ABI</i>	<i>\$32,521</i>	<i>\$39,341</i>	<i>\$36,838</i>	<i>\$41,289</i>	<i>\$40,727</i>	<i>\$39,503</i>	<i>21.5</i>
<i>Waiver-Adult DD</i>	<i>\$56,696</i>	<i>\$60,051</i>	<i>\$61,483</i>	<i>\$60,362</i>	<i>\$59,263</i>	<i>\$12,484</i>	<i>-78.0</i>
<i>Waiver-ALF</i>	<i>\$12,961</i>	<i>\$12,708</i>	<i>\$12,995</i>	<i>\$12,905</i>	<i>\$13,371</i>	<i>\$12,057</i>	<i>-7.0</i>
<i>Waiver-Child DD</i>	--	--	--	--	--	--	--
<i>Waiver-Child Mental Health</i>	<i>\$5,089</i>	<i>\$6,753</i>	<i>\$7,194</i>	<i>\$8,402</i>	<i>\$9,255</i>	<i>\$9,269</i>	<i>82.1</i>
<i>Waiver-Comprehensive</i>	--	--	--	--	--	--	--
<i>Waiver-LTC</i>	<i>\$7,376</i>	<i>\$7,725</i>	<i>\$7,774</i>	<i>\$8,020</i>	<i>\$7,747</i>	<i>\$7,610</i>	<i>3.2</i>
<i>Waiver-Supports</i>	--	--	--	--	--	<i>\$4,292</i>	--
Total	\$6,872	\$6,728	\$6,594	\$6,781	\$6,782	\$7,003	1.9

Service Areas – Detail

Ambulance Services

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

\$4,352,067

Total Expenditures SFY 2015

↑ 15.7%

from SFY 2014

Less than 1% of Total Medicaid Expenditures

Table 22: Ambulance Services²⁶ Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Total Ambulance Services							
Expenditures	\$3,807,538	\$3,303,240	\$3,459,400	\$3,606,360	\$3,760,537	\$4,352,067	14
Recipients	3,351	3,613	3,604	3,433	3,520	3,546	6
Expenditures per Recipient	\$1,136	\$914	\$960	\$1,050	\$1,068	\$1,227	8
Air Ambulance Services							
Expenditures	\$2,374,667	\$1,888,518	\$1,892,961	\$2,129,324	\$2,291,183	\$2,931,554	23
Recipients	401	366	396	426	505	562	40
Expenditures per Recipient	\$5,922	\$5,160	\$4,780	\$4,998	\$4,537	\$5,216	-12
Ground Ambulance Services							
Expenditures	\$1,426,764	\$1,410,232	\$1,562,840	\$1,472,500	\$1,467,922	\$1,413,123	-1
Recipients	3,224	3,479	3,476	3,290	3,378	3,358	4
Expenditures per Recipient	\$443	\$405	\$450	\$448	\$435	\$421	-5

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. A new reimbursement methodology for ASC services was implemented in SFY 2015 to better align reimbursement with identical services provided in other outpatient settings.

\$6,090,776

Total Expenditures SFY 2015

↑ 50.8%

from SFY 2014

1.2% of Total Medicaid Expenditures

Total expenditures for outpatient hospital and ASC services combined increased by 13.4 percent from the previous year to \$37.1 million.

Table 23: Ambulatory Surgery Center Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$3,315,928	\$2,912,791	\$2,822,957	\$3,439,188	\$4,039,944	\$6,090,776	84
Recipients	3,075	3,151	3,088	3,259	3,392	3,547	15
Expenditures per Recipient	\$1,078	\$924	\$914	\$1,055	\$1,191	\$1,717	59

²⁶ 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.

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.

\$35,143,911
Total Expenditures SFY 2015

↑ 9.8%
from SFY 2014

6.7% of Total Medicaid Expenditures

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

Table 24: Total Behavioral Health Services²⁷ Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Total Behavioral Health Services							
Expenditures	\$24,579,989	\$26,444,878	\$27,553,867	\$29,734,932	\$31,995,615	\$35,143,911	43
Recipients	12,022	12,842	12,946	13,100	13,820	14,700	22
Expenditures per Recipient	\$2,045	\$2,059	\$2,128	\$2,270	\$2,315	\$2,391	17
Behavioral Health Provider Services							
Expenditures	\$22,884,970	\$24,927,506	\$26,125,428	\$28,354,676	\$30,602,969	\$33,879,362	48
Recipients	9,795	10,514	10,674	11,410	11,295	12,304	26
Expenditures per Recipient	\$2,336	\$2,371	\$2,448	\$2,485	\$2,709	\$2,754	18
Non-Behavioral Health Provider Services							
Expenditures	\$1,695,019	\$1,517,372	\$1,428,438	\$1,380,256	\$1,392,647	\$1,264,549	-25
Recipients	3,423	3,594	3,757	2,981	3,834	3,859	13
Expenditures per Recipient	\$495	\$422	\$380	\$463	\$363	\$328	-34

Table 25: Top Five Behavioral Health Diagnosis Codes by Expenditures

Diagnosis Code & Description		Age 0 - 20	Age 21 - 64	Age 65+	Total
311	Depressive Disorder, Not elsewhere classified	\$4,487,764	\$2,194,212	\$702,537	\$7,384,513
309.81	Post-Traumatic Stress Disorder	\$2,974,719	\$1,032,350	\$10,689	\$4,017,758
314.01	Attention Deficit Disorder of Childhood	\$3,056,746	\$149,078	\$131	\$3,205,955
296.33	Major Depressive Disorder, Recurrent EPI	\$2,681,236	\$387,837	\$25,310	\$3,094,382
296.32	Major Depressive Disorder, Recurrent EPI	\$2,378,294	\$550,837	\$69,749	\$2,998,880
Total		\$15,578,759	\$4,314,314	\$808,416	\$20,701,489

²⁷ 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.

Dental

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

\$14,473,863
Total Expenditures SFY 2015

↑ 8.1%
from SFY 2014

2.7% of Total Medicaid Expenditures

Table 26: Dental Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$12,864,308	\$13,616,583	\$13,561,177	\$13,272,110	\$13,391,934	\$14,473,863	13
Recipients	26,482	28,171	28,594	28,534	29,175	30,679	16
Expenditures per Recipient	\$486	\$483	\$474	\$465	\$459	\$472	-3

Table 27: Dental Services by Age Group

Age Group	Services Provided
Under age 21	<ul style="list-style-type: none"> - Comprehensive dental coverage - Orthodontics for malocclusions that impact function
21 and over	<ul style="list-style-type: none"> - Diagnostic and preventive services - Basic restorative care - Removable prosthesis - 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).²⁸ 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 2017.²⁹

Although there are dental providers in most counties in Wyoming, dental specialists exist in only 10, or 43 percent, of Wyoming's 23 counties. 46 percent of recipients of dental services received services from a dental specialist in SFY 2015, with five percent receiving such services out of state.

²⁸ The Health Resource and Services Administration Health Professional Shortage areas are available by state and county online: <http://hpsafind.hrsa.gov>.

²⁹ 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>

*Durable Medical Equipment,
Prosthetics, Orthotics,
and Supplies*

\$8,624,246
Total Expenditures SFY 2015

↑ 13.1%
from SFY 2014

1.6% of Total Medicaid Expenditures

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 28: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Total Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services							
Expenditures	\$6,605,716	\$7,505,683	\$7,270,213	\$7,730,289	\$7,627,734	\$8,624,246	31
Recipients	7,443	7,502	7,245	7,364	7,124	7,328	-2
Expenditures per Recipient	\$888	\$1,000	\$1,003	\$1,050	\$1,071	\$1,177	33
DME Only							
Expenditures	\$5,960,375	\$6,725,808	\$6,492,089	\$6,902,029	\$7,040,728	\$7,904,083	33
Recipients	7,094	7,127	6,880	7,012	6,821	6,916	-3
Expenditures per Recipient	\$840	\$944	\$944	\$984	\$1,032	\$1,143	36
Prosthetics, Orthotics, and Supplies Only							
Expenditures	\$645,342	\$779,875	\$778,124	\$828,261	\$587,006	\$720,162	12
Recipients	641	701	673	651	589	744	16
Expenditures per Recipient	\$1,007	\$1,113	\$1,156	\$1,272	\$997	\$968	-4

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.

Table 29: 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

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 enrolled members and will reimburse services if Medicare denies eligibility.

\$1,099,569

Total Expenditures SFY 2015

↑ 2.6%

from SFY 2014

0.2% of Total Medicaid Expenditures

Table 30: End Stage Renal Disease Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$1,160,798	\$835,621	\$1,233,755	\$1,343,669	\$1,071,750	\$1,099,569	-5
Recipients	83	86	98	110	107	107	29
Expenditures per Recipient	\$13,986	\$9,717	\$12,589	\$12,215	\$10,016	\$10,276	-27

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

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

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.

\$3,259,793

Total Expenditures SFY 2015

↑ 20.8%

from SFY 2014

0.2% of Total Medicaid Expenditures

Table 31: Federally Qualified Health Center Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$2,864,956	\$3,103,164	\$1,550,274	\$2,018,911	\$2,698,283	\$3,259,793	14
Recipients	4,109	4,834	2,722	3,612	4,034	5,995	46
Expenditures per Recipient	\$697	\$642	\$570	\$559	\$669	\$544	-22

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 directors and clinical staffing requirements.³⁰

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 criteria:

- 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

Table 32: Home Health Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$1,941,097	\$2,732,905	\$2,963,510	\$2,897,016	\$3,533,728	\$4,618,885	138
Recipients	587	623	582	591	590	688	17
Expenditures per Recipient	\$3,307	\$4,387	\$5,092	\$4,902	\$5,989	\$6,713	103

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.

³⁰ 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>

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.

Table 33: Hospice Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$1,432,471	\$1,036,887	\$983,026	\$1,082,188	\$1,468,295	\$1,157,101	-19
Recipients	147	150	135	179	252	182	24
Expenditures per Recipient	\$9,745	\$6,913	\$7,282	\$6,046	\$5,827	\$6,358	-35

Hospital

Medicaid covers both inpatient and outpatient hospital services. Rates for both inpatient and outpatient hospitals have remained unchanged in SFY 2015.

\$104,523,947

Total Expenditures SFY 2015

↑ 2.5%

from SFY 2014

19.8% of Total Medicaid Expenditures

Table 34: Total Hospital Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$113,636,933	\$114,358,067	\$105,798,987	\$108,839,452	\$101,931,277	\$104,523,947	-8
Recipients	43,681	42,525	44,107	42,667	40,045	42,562	-3
Expenditures per Recipient	\$2,602	\$2,689	\$2,399	\$2,551	\$2,545	\$2,456	-6
QRA Payments (Federal Share) ³¹	\$8,797,380	\$6,828,879	\$6,833,447	\$8,329,770	\$8,604,610	\$9,441,087	7
Total Expenditures with QRA	\$122,434,313	\$121,186,946	\$112,632,434	\$117,169,222	\$110,535,887	\$113,965,034	-7

Hospital Breakdown by Expenditures

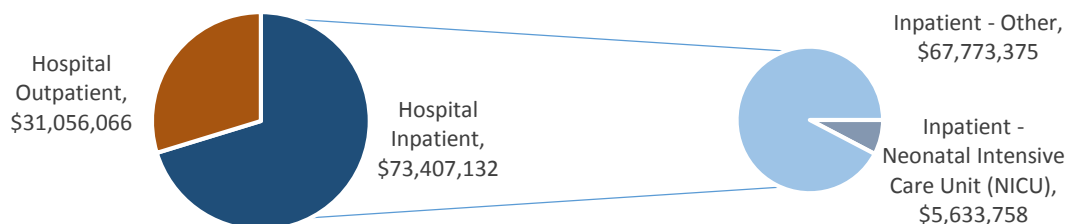


Figure 15: Hospital Breakdown by Expenditures

³¹ The QRA payments reported are payments calculated using the prior SFY paid claims data and made during the current SFY.

Hospital – Inpatient

Medicaid covers inpatient hospital services, with the exception of alcohol and chemical rehabilitation

services, cosmetic surgery,

and experimental services. Medicaid covers only those surgical procedures that are medically necessary. Medicaid may not cover a surgery if there is a non-surgical alternative or if a provider performs the surgery only for the convenience of the individual.

\$73,407,132

Total Expenditures SFY 2015

↑ 0.7%

from SFY 2014

13.9% of Total Medicaid Expenditures

Table 35: Inpatient Hospital Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
TOTAL Inpatient Services							
Expenditures	\$87,297,343	\$84,557,214	\$77,130,425	\$78,462,603	\$72,932,440	\$73,407,132	-16
Recipients	12,277	11,640	10,890	10,970	10,299	10,649	-13
Expenditures per Recipient	\$7,111	\$7,264	\$7,083	\$7,152	\$7,082	\$6,893	-3
QRA Payments (Federal Share)	\$4,047,431	\$2,379,785	\$2,001,293	\$2,248,251	\$2,599,625	\$2,667,482	-34
Total Expenditures with QRA	\$91,344,774	\$86,936,999	\$79,131,718	\$80,710,854	\$75,532,065	\$76,074,614	-17
NICU Services							
Expenditures	\$3,567,130	\$9,120,329	\$6,335,289	\$6,361,703	\$4,852,484	\$5,633,758	58
Recipients	76	158	130	140	131	122	61
Expenditures per Recipient	\$46,936	\$57,724	\$48,733	\$45,441	\$37,042	\$46,178	-2
Other Inpatient Services							
Expenditures	\$83,730,213	\$75,436,885	\$70,795,136	\$72,100,900	\$68,079,955	\$67,773,375	-19
Recipients	12,243	11,558	10,831	10,896	10,225	10,586	-14
Expenditures per Recipient	\$6,839	\$6,527	\$6,536	\$6,617	\$6,658	\$6,402	-6

Neonatal Intensive Care Unit Services as Percentage of Inpatient Expenditures

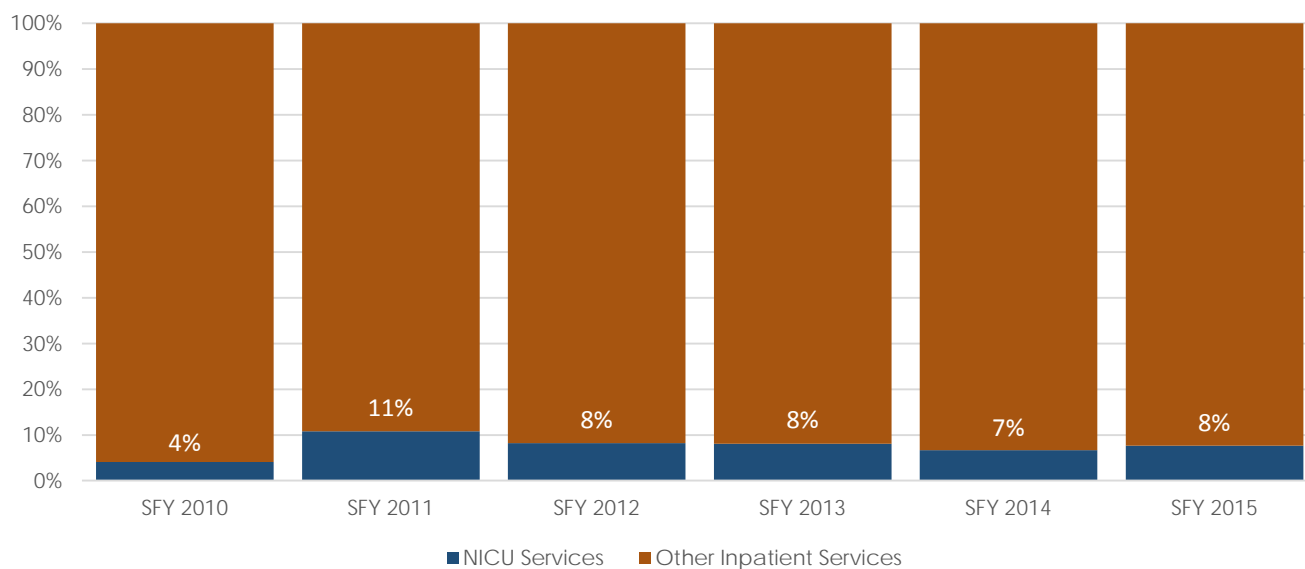


Figure 16: Neonatal Intensive Care Unit Services as Percentage of Inpatient Expenditures

Table 36: Hospital Inpatient Payment Descriptions

Payment Type	Description
Level of Care (LOC)	<p>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.</p> <ul style="list-style-type: none"> - Rehabilitation with ventilator - Rehabilitation - Maternity (medical) - Maternity (surgical) - NICU - Intensive care, critical care and burn units - Surgery - Psychiatric care - Newborn nursery - Routine care <p>Includes all enrolled in-state hospitals and enrolled out-of-state hospitals that received a special level of Medicaid reimbursement</p>
Disproportionate Share Hospital (DSH)	<p>Additional payment made to eligible hospitals that serve a disproportionate number of low-income individuals.</p> <p>Required by Federal law and capped according to state-specific allotments.</p> <p>Medicaid determines amount of payment to each qualifying hospital based on unreimbursed Medicaid costs (i.e., the Medicaid payment deficit).</p> <p>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.</p>
Qualified Rate Adjustment (QRA)	<p>Supplement for qualified inpatient hospital providers</p> <p>Qualifying hospitals (i.e., Wyoming non-state government owned or operated hospitals with unreimbursed Medicaid costs) provide state share of payment</p> <p>Medicaid distributes corresponding Federal matching funds along with the state share to the participating hospitals.</p>

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

Emergency room utilization is covered in more detail in Appendix A.

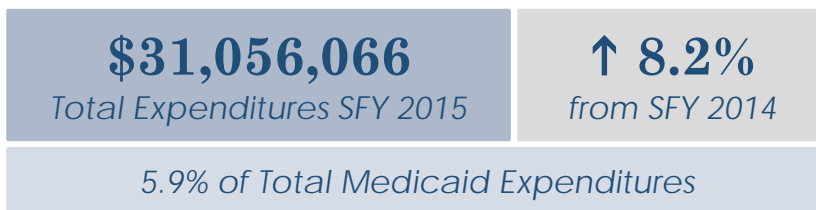


Table 37: Outpatient Hospital Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$26,260,304	\$29,692,078	\$28,657,373	\$30,189,391	\$28,703,147	\$31,056,066	18
Recipients	40,823	39,757	41,772	40,148	37,628	40,252	-1
Expenditures per Recipient	\$643	\$747	\$686	\$752	\$763	\$772	20
QRA Payments (Federal Share)	\$4,749,950	\$4,449,094	\$4,832,154	\$6,081,517	\$6,004,985	\$6,773,605	43
Total Expenditures with QRA	\$31,010,254	\$34,141,172	\$33,489,527	\$36,270,908	\$34,708,132	\$37,829,671	22

Table 38: Hospital Outpatient Payment Descriptions

Payment Type	Description
	<p>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.³² 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.</p> <p>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:</p> <ul style="list-style-type: none"> - Significant outpatient procedures³³ - 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 <p>Select services from the APC methodology are reimbursed on separate fee schedules:</p> <ul style="list-style-type: none"> - 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
Ambulatory Payment Classification (APC)	
Qualified Rate Adjustment (QRA)	<p>Supplement for qualified outpatient hospital providers</p> <p>Qualifying hospitals (i.e., Wyoming non-state government owned or operated hospitals with unreimbursed Medicaid costs) provide state share of payment</p> <p>Medicaid distributes corresponding Federal matching funds along with the state share to the participating hospitals.</p>

³² 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.

³³ A procedure that establishes the primary reason for the visit.

Intermediate Care Facility- Intellectually Disabled

Medicaid coverage of Intermediate Care Facilities for individuals with intellectual disabilities (ICF-ID) services is available only in a

residential facility licensed and certified by the state survey agency as an ICF-ID. In Wyoming the sole facility is the Wyoming Life Resource Center. ICF-ID is a service unique to Medicaid and is not commonly covered by other payers.

\$18,091,427

Total Expenditures SFY 2015

↓ 5.5%

from SFY 2014

3.4% of Total Medicaid Expenditures

Table 39: Intermediate Care Facility - Intellectually Disabled Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$10,651,941	\$11,388,412	\$10,065,657	\$17,942,326	\$19,152,530	\$18,091,427	70
Recipients	91	84	84	81	79	75	-18
Expenditures per Recipient	\$117,054	\$135,576	\$119,829	\$221,510	\$242,437	\$241,219	106

Laboratory

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

\$1,516,042

Total Expenditures SFY 2015

↑ 18.0%

from SFY 2014

0.3% of Total Medicaid Expenditures

Table 40: Laboratory Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$1,121,964	\$1,171,185	\$1,100,774	\$1,149,473	\$1,284,678	\$1,516,042	35
Recipients	9,852	9,923	9,415	9,724	9,490	8,852	-10
Expenditures per Recipient	\$114	\$118	\$117	\$118	\$135	\$171	50

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.

\$70,354,260

Total Expenditures SFY 2015

↓ 3.4%

from SFY 2014

13.3% of Total Medicaid Expenditures

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

Table 41: Nursing Facility Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$75,434,811	\$73,180,333	\$73,805,803	\$73,593,462	\$72,866,933	\$70,354,260	-7
Recipients	2,609	2,444	2,410	2,445	2,387	2,357	-10
Expenditures per Recipient	\$28,913	\$29,943	\$30,625	\$30,100	\$30,527	\$29,849	3
Provider Assessment (Federal Share)	-	-	\$12,748,232	\$14,299,645	\$15,537,040	\$15,219,087	19 ³⁴
Total Expenditures with Provider Assessment	\$75,434,811	\$73,180,333	\$86,554,035	\$87,893,107	\$88,403,973	\$85,573,347	13

The Wyoming legislative rate freeze for nursing facility services remained in effect during SFY 2015; however, a pay rate change was approved and implemented July 1, 2015.

Table 42: Nursing Facility Payment Descriptions

Payment Type	Description
Per Diem Rate	<p>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.</p> <p>This rate includes:</p> <ul style="list-style-type: none"> - 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 <p>This rate <i>excludes</i> physician visits, hospitalizations, laboratory, x-rays, and prescription drugs, which are reimbursed separately.</p>
Provider Assessment and Upper Payment Limit (UPL)	<p>Supplemental payment for qualified nursing facilities</p> <p>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.</p> <p>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.</p>
Extraordinary Care per diem rates	<p>Paid for services provided to a resident with extraordinary needs.</p> <p>Medicaid determines per case rates for extraordinary care based on relevant cost and a review of medical records.</p>
Enhanced adult psychiatric reimbursement	<p>Provided to encourage nursing facilities to accept adults that require individualized psychiatric care.</p>

³⁴ Percent change since SFY 2012.

*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.

\$2,242,070

Total Expenditures SFY 2015

↑ 75.0%

from SFY 2014

0.4% of Total Medicaid Expenditures

Table 43: Program of All-Inclusive Care for the Elderly Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	3 Year Percent Change
Expenditures	-	-	-	\$168,554	\$1,281,485	\$2,242,070	1,230
Recipients	-	-	-	23	63	97	322
Expenditures per Recipient	-	-	-	\$7,328	\$20,341	\$23,114	215

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

*Physician and Other
Practitioner*

Medicaid limits physician and other practitioner services as follows:

\$60,174,203

Total Expenditures SFY 2015

↓ 1.4%

from SFY 2014

11.4% of Total Medicaid Expenditures

- Hospital outpatient departments, physician offices and optometrist offices – maximum of 12 visits per calendar year for individuals over the age of 21
- Physical, occupational and speech therapy visits – maximum of 20 each 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

Table 44: Physician and Other Practitioner Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Total Physician and Other Practitioner Services							
Expenditures	\$64,036,069	\$63,918,782	\$61,576,270	\$61,564,892	\$61,053,011	\$60,174,203	-6
Recipients	63,451	64,739	63,493	61,352	65,176	62,783	-1
Expenditures per Recipient	\$1,009	\$987	\$970	\$1,003	\$937	\$958	-5
Physician Only Services							
Expenditures	\$59,663,936	\$58,604,229	\$56,228,007	\$56,179,579	\$55,385,741	\$53,100,087	-11
Recipients	62,962	64,105	62,950	60,658	64,610	62,077	-1
Expenditures per Recipient	\$948	\$914	\$893	\$926	\$857	\$855	-10
Other Practitioner Services							
Expenditures	\$4,372,134	\$5,314,552	\$5,348,263	\$5,385,313	\$5,667,271	\$7,074,116	62
Recipients	7,147	8,249	7,695	8,021	7,753	9,157	28
Expenditures per Recipient	\$612	\$644	\$695	\$671	\$731	\$773	26

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.

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

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

Physician and Other Practitioner Breakdown by Expenditures

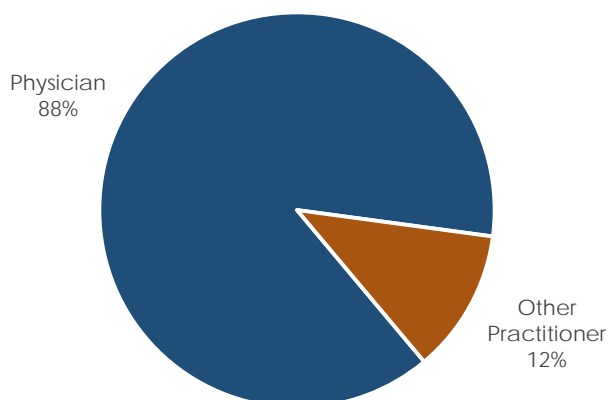


Figure 17: Physician and Other Practitioner Breakdown by Expenditures

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.

\$47,946,923
Total Expenditures SFY 2015

↑ 16.3%
from SFY 2014

9.1% of Total Medicaid Expenditures

In SFY 2015, Medicaid designated preferred drugs in 123 specific drug classes.

Table 45: Prescription Drug Services Summary³⁵

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$38,870,852	\$41,352,500	\$41,914,658	\$39,110,022	\$41,238,663	\$47,946,923	23
Recipients	49,041	50,118	48,222	47,608	44,464	46,031	-6
Expenditures per Recipient	\$793	\$825	\$869	\$822	\$927	\$1,042	31

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 \$20.1 million in OBRA rebates in SFY 2015.

Medicaid is a member of the Sovereign States Drug Consortium (SSDC) which is a collaborative of state Medicaid programs that negotiate and acquire rebates from drug manufacturers, supplemental to the Medicaid Drug Rebate Program. Supplemental rebates augment the Medicaid Drug Rebate Program savings that the SSDC states realize because of OBRA. With the continued expansion of the PDL, Medicaid has collected \$1.4 million in supplemental rebates in SFY 2015.

Table 46: Pharmacy Cost Avoidance -- SFY 2015³⁶

Program Area	Cost Avoidance
Prior Authorization (PA)	
Preferred Drug List (PDL)	\$8,894,753
State Maximum Allowable Cost (SMAC)	\$15,085,685
Total	\$23,980,438

Table 47: Prescription Drug Rebates

Year	Rebate (in millions)
SFY 2010	\$13.6
SFY 2011	\$17.8
SFY 2012	\$19.3
SFY 2013	\$19.4
SFY 2014	\$21.4
SFY 2015	\$20.1

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

³⁶ 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.

\$13,575,847
Total Expenditures SFY 2015

↓ 8.8%
from SFY 2014

2.6% of Total Medicaid Expenditures

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).

Table 48: Psychiatric Residential Treatment Facility Services Summary³⁷

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$14,658,731	\$15,244,613	\$8,019,118	\$12,080,494	\$14,886,133	\$13,575,847	-7
Recipients	438	403	274	328	338	334	-24
Expenditures per Recipient	\$33,467	\$37,828	\$29,267	\$36,831	\$44,042	\$40,646	21

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

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

Medicaid continues to collaborate with its enrolled PRTFs, CMS, and other state agencies and stakeholders to ensure compliance with federal guidelines and make changes, as appropriate.

Medicaid cannot receive, per CMS guidelines, the Federal Medical Assistance Percentage (FMAP) for PRTF services that are court ordered. Court orders cannot reference a facility name or a specific level of care, as only a physician should be ordering a client into a PRTF based upon medical necessity.

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

³⁷ Due to court-ordered placements not complying with CMS rules, SFY 2012 and SFY 2013 had decreases in Medicaid PRTF placements as these placement orders did not qualify for federal matching funds. This led to significant increases in State General Fund only placements (expenses paid for by DHCF but not included in the Medicaid budget).

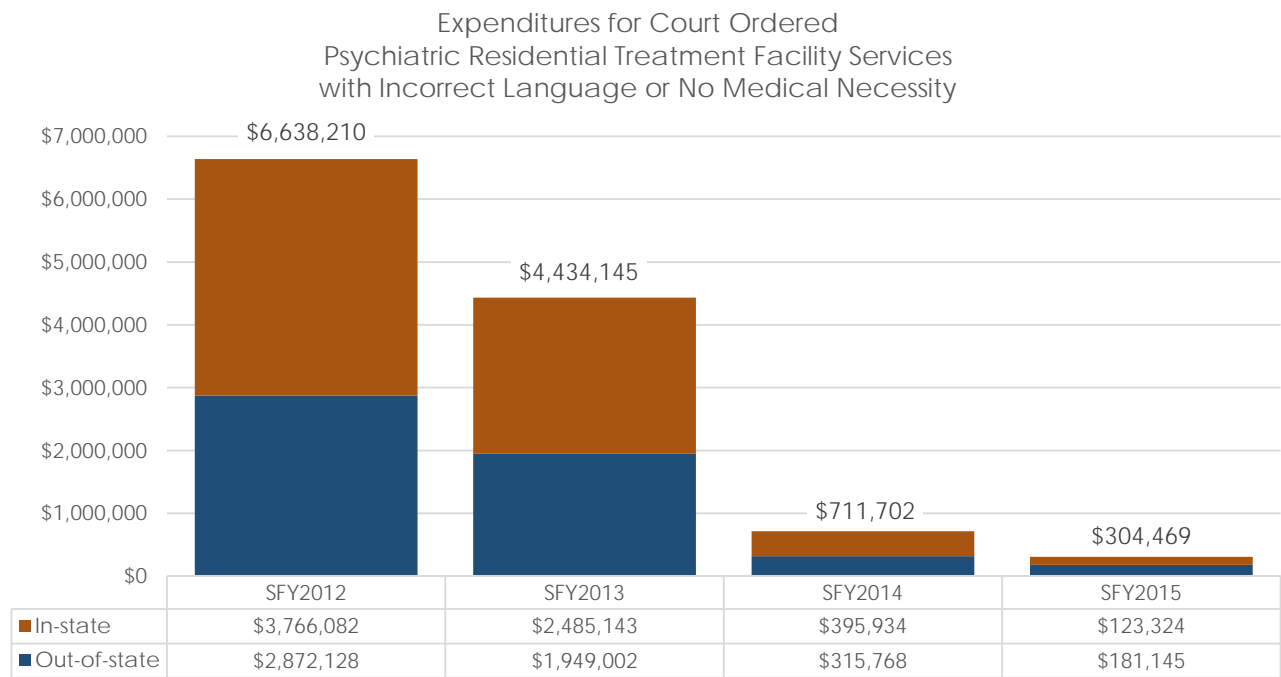


Figure 18: Expenditures for Court Ordered Psychiatric Residential Treatment Facility Services with Incorrect Language or No Medical Necessity

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

Public Health, Federal

Public Health, Federal services are provided to the American Indian and Alaskan Native population by Tribal Contract Health Centers and Indian Health Centers. The Tribal Contract

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

\$8,761,358 <i>Total Expenditures SFY 2015</i>	↑ 9.5% <i>from SFY 2014</i>
<i>1.7% of Total Medicaid Expenditures</i>	

Table 49: Public Health, Federal Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$7,700,047	\$8,532,271	\$7,240,130	\$8,067,975	\$7,999,556	\$8,761,358	14
Recipients	3,656	4,551	3,249	4,222	3,546	3,384	-7
Expenditures per Recipient	\$2,106	\$1,875	\$2,228	\$1,911	\$2,256	\$2,589	23

Rural Health Clinic

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

\$1,668,167
Total Expenditures SFY 2015

↑ 9.7%
from SFY 2014

0.3% of Total Medicaid Expenditures

Table 50: Rural Health Clinic Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$1,710,855	\$1,940,640	\$1,628,043	\$1,845,491	\$1,521,233	\$1,668,167	-2
Recipients	4,670	5,277	4,174	5,418	4,670	4,532	-3
Expenditures per Recipient	\$366	\$368	\$390	\$341	\$326	\$368	0

Medicare designates a health clinic as an RHC if it is located in an area designated as a “shortage area.” Shortage areas are defined geographic areas designated by the HHS as having either a shortage of personal health services or a shortage of primary medical care professionals. An RHC differs from a FQHC based on several criteria related to location, shortage area, corporate structure, requirements for a board of directors and clinical staffing requirements.³⁸

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.

³⁸ 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 covers vision services provided by opticians, optometrists, and ophthalmologists. These services vary depending on recipient age, as shown below.

\$3,628,064

Total Expenditures SFY 2015

↑ 3.2%

from SFY 2014

0.7% of Total Medicaid Expenditures

Table 51: Total Vision Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$3,233,037	\$3,269,685	\$3,228,994	\$3,434,854	\$3,514,674	\$3,628,064	12
Recipients	14,324	14,676	14,428	14,691	15,111	15,391	7
Expenditures per Recipient	\$226	\$223	\$224	\$234	\$233	\$236	4

Table 52: Vision Services by Age Group

Age Group	Services Provided
Under age 21	<ul style="list-style-type: none"> - 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	<ul style="list-style-type: none"> - 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 identified by diagnosis code 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 does not reimburse the dispensing of frames, frame parts or lenses in addition to the eyeglass dispensing fee.

Waivers

Medicaid offers various waivers with approval from the federal government to selectively “waive” one or more Medicaid requirements and subsequently allow for greater flexibility in the Medicaid program. These waivers include eight Home

and Community Based Services (HCBS) Waivers and one Section 1115 Waiver. Medicaid manages three of the HCBS waivers and the Section 1115 waiver, while the Behavioral Health Division (BHD) manages the remaining HCBS Waivers. This breakdown is shown below.

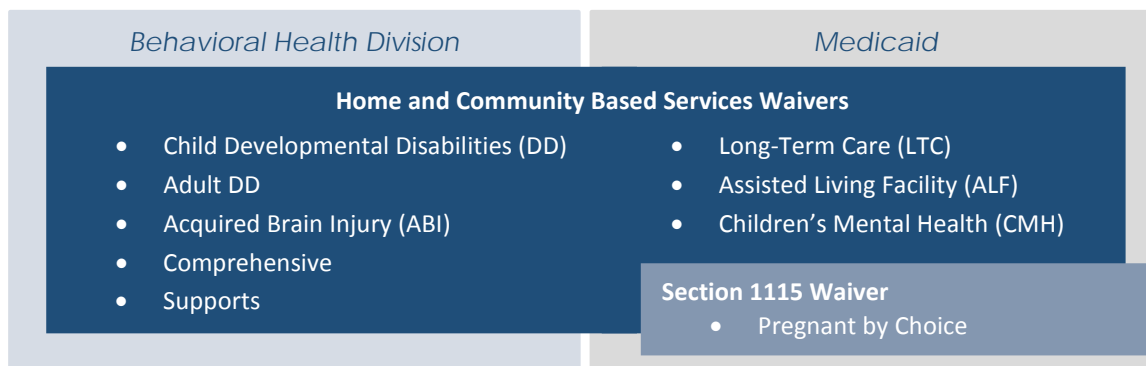


Figure 19: Medicaid Waivers

Each waiver provides specific services as outlined in Table 76 in Appendix B. Individuals participating in the waivers can also receive the standard Medicaid package of benefits. These services are identified as “non-waiver” services. This does not apply to Pregnant by Choice Waiver individuals who only receive waiver services.

Table 53: Home and Community Based Service Waiver Services Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Total Waiver Services							
Expenditures	\$146,381,081	\$155,016,904	\$159,006,300	\$155,841,776	\$152,796,753	\$152,811,123	4
Recipients	4,644	4,709	4,590	4,504	4,463	4,668	1
Expenditures per Recipient	\$31,520	\$32,919	\$34,642	\$34,601	\$34,236	\$32,736	4
Waiver-Only Services							
Expenditures	\$113,325,317	\$120,049,329	\$122,327,742	\$121,752,688	\$118,624,631	\$113,452,108	0
Recipients	4,382	4,413	4,302	4,207	4,168	4,446	1
Expenditures per Recipient	\$25,862	\$27,204	\$28,435	\$28,941	\$28,461	\$25,518	-1
% Waiver-Only of Total Waivers	77%	77%	77%	78%	77%	74%	
Non-Waiver Services							
Expenditures	\$33,055,764	\$34,967,575	\$36,678,558	\$34,089,088	\$34,172,122	\$39,359,014	19
Recipients	4,544	4,605	4,491	4,391	4,353	4,528	0
Expenditures per Recipient	\$7,275	\$7,593	\$8,167	\$7,763	\$7,850	\$8,692	19

In SFY 2015, Total Comprehensive waiver expenditures accounted for half of all HCBS Expenditures, with 84 percent of its expenditures for waiver-only services (see Figure 21).

In contrast, both the Children’s Mental Health waiver expenditures accounted for one percent of all HCBS Expenditures, with less than half (42 percent) of its expenditures for waiver-only services.

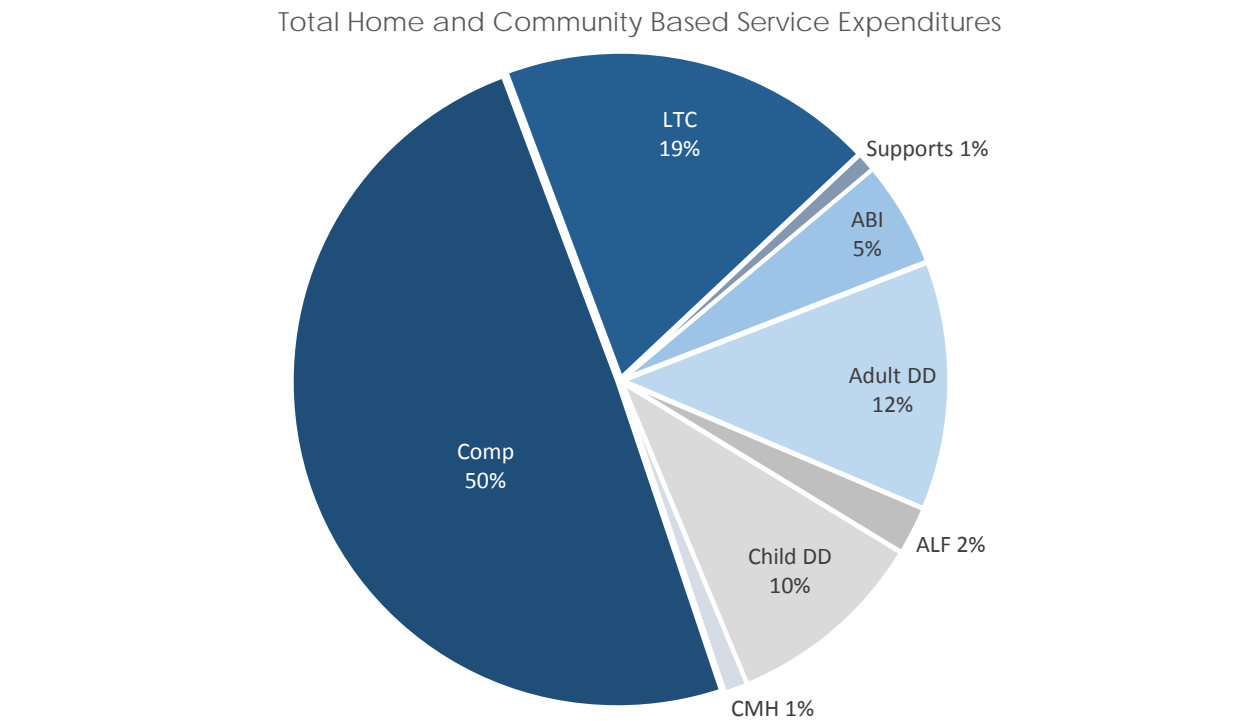


Figure 20: Total Home and Community Based Service Expenditures by Waiver

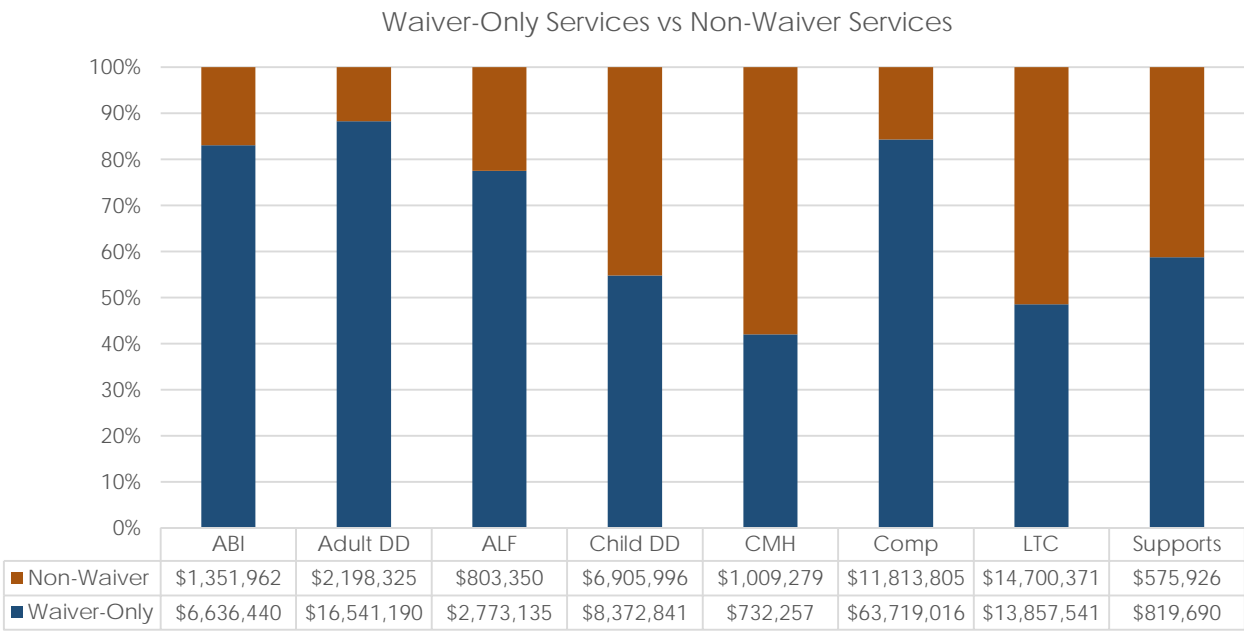


Figure 21: Waiver-Only vs Non-Waiver Services

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.

\$15,278,837

Total Expenditures SFY 2015

↓ 20%

from SFY 2014

2.9% of Total Medicaid Expenditures

Enrolled members of this waiver were transitioned to the new Comprehensive and Supports waivers, with that transition complete as of June 30, 2015.

Table 54: Child Developmental Disabilities Waiver Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Total Waiver Services							
Expenditures	\$22,644,643	\$21,535,672	\$20,897,302	\$21,053,459	\$19,119,880	\$15,278,837	-33
Recipients	834	830	810	799	743	679	-19
Expenditures per Recipient	\$27,152	\$25,947	\$25,799	\$26,350	\$25,733	\$22,502	-17
Waiver-Only Services							
Expenditures	\$14,460,017	\$14,128,741	\$13,646,013	\$13,301,942	\$11,415,264	\$8,372,841	-42
Recipients	804	799	773	761	699	659	-18
Expenditures per Recipient	\$17,985	\$17,683	\$17,653	\$17,480	\$16,331	\$12,705	-29
% Waiver-Only of Total Waivers	64%	66%	65%	63%	60%	55%	
Non-Waiver Services							
Expenditures	\$8,184,626	\$7,406,932	\$7,251,289	\$7,751,518	\$7,704,616	\$6,905,996	-16
Recipients	802	800	782	769	715	651	-19
Expenditures per Recipient	\$10,205	\$9,259	\$9,273	\$10,080	\$10,776	\$10,608	4

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.

\$18,739,515

Total Expenditures SFY 2015

↓ 80%

from SFY 2014

3.6% of Total Medicaid Expenditures

Enrolled members of this waiver were transitioned to the new Comprehensive and Supports waivers, with that transition complete as of September 30, 2014. This transition explains the sharp decline in expenditures shown below.

Table 55: Adult Developmental Disabilities Waiver Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Total Waiver Services							
Expenditures	\$83,183,518	\$89,288,685	\$93,731,860	\$93,426,901	\$93,224,222	\$18,739,515	-77
Recipients	1,375	1,394	1,423	1,444	1,455	1,385	1
Expenditures per Recipient	\$60,497	\$64,052	\$65,869	\$64,700	\$64,072	\$13,530	-78
Waiver-Only Services							
Expenditures	\$75,746,359	\$81,369,215	\$84,846,084	\$84,204,861	\$83,501,095	\$16,541,190	-78
Recipients	1,336	1,355	1,380	1,395	1,409	1,325	-1
Expenditures per Recipient	\$56,696	\$60,051	\$61,483	\$60,362	\$59,263	\$12,484	-78
% Waiver-Only of Total Waivers	91%	91%	91%	90%	90%	88%	
Non-Waiver Services							
Expenditures	\$7,437,159	\$7,919,471	\$8,885,776	\$9,222,040	\$9,723,128	\$2,198,325	-70
Recipients	1,336	1,367	1,394	1,407	1,426	1,276	-4
Expenditures per Recipient	\$5,567	\$5,793	\$6,374	\$6,554	\$6,818	\$1,723	-69

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.

Enrolled members of this waiver are being transitioned to the new Comprehensive and Supports waivers, with expected completion of this transition in SFY 2016.

\$7,988,402

Total Expenditures SFY 2015

↓ 7%

from SFY 2014

1.5% of Total Medicaid Expenditures

Table 56: Total Acquired Brain Injury Waiver Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Total Waiver Services							
Expenditures	\$7,679,186	\$8,529,077	\$8,251,272	\$9,011,104	\$8,582,983	\$7,988,402	4
Recipients	201	186	199	196	184	171	-15
Expenditures per Recipient	\$38,205	\$45,855	\$41,464	\$45,975	\$46,647	\$46,716	22
Waiver-Only Services							
Expenditures	\$6,243,946	\$6,963,271	\$6,925,596	\$7,679,811	\$7,371,614	\$6,636,440	6
Recipients	192	177	188	186	181	168	-13
Expenditures per Recipient	\$32,521	\$39,341	\$36,838	\$41,289	\$40,727	\$39,503	21
% Waiver-Only of Total Waivers	81%	82%	84%	85%	86%	83%	
Non-Waiver Services							
Expenditures	\$1,435,240	\$1,565,807	\$1,325,676	\$1,331,294	\$1,211,369	\$1,351,962	-6
Recipients	198	180	191	192	178	169	-15
Expenditures per Recipient	\$7,249	\$8,699	\$6,941	\$6,934	\$6,805	\$8,000	10

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 currently serves waiver recipients transferring to this waiver from the Adult DD and Child DD, as those waivers end, 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.

\$75,532,821
Total Expenditures SFY 2015

14.3% of Total Medicaid Expenditures

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

Table 57: Total Comprehensive Waiver Summary

	SFY 2014	SFY 2015
Total Waiver Services		
Expenditures	\$61,132	\$75,532,821
Recipients	31	1,836
Expenditures per Recipient	\$1,972	\$41,140
Waiver-Only Services		
Expenditures	\$44,982	\$63,719,016
Recipients	3	1,755
Expenditures per Recipient	\$14,994	\$36,307
% Waiver-Only of Total Waivers	74%	84%
Non-Waiver Services		
Expenditures	\$16,150	\$11,813,805
Recipients	29	1,728
Expenditures per Recipient	\$557	\$6,837

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 enrolled members 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.

\$1,395,616

Total Expenditures SFY 2015

0.3% of Total Medicaid Expenditures

Table 58: Total Supports Waiver Summary

	SFY 2014	SFY 2015
Total Waiver Services		
Expenditures	\$568	\$1,395,616
Recipients	3	203
Expenditures per Recipient	\$189	\$6,875
Waiver-Only Services		
Expenditures	\$454	\$819,690
Recipients	0	191
Expenditures per Recipient	--	\$4,292
% Waiver-Only of Total Waivers	80%	59%
Non-Waiver Services		
Expenditures	\$114	\$575,926
Recipients	3	179
Expenditures per Recipient	\$38	\$3,217

Long-Term Care (LTC) Waiver

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

\$28,557,911

Total Expenditures SFY 2015

↑ 5%

from SFY 2014

5.4% of Total Medicaid Expenditures

Table 59: Total Long-Term Care Waiver Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Total Waiver Services							
Expenditures	\$27,670,091	\$29,284,684	\$30,456,111	\$27,894,747	\$27,194,984	\$28,557,911	3
Recipients	1,974	1,983	1,884	1,860	1,877	1,968	0
Expenditures per Recipient	\$14,017	\$14,768	\$16,166	\$14,997	\$14,489	\$14,511	4
Waiver-Only Services							
Expenditures	\$13,424,332	\$13,912,032	\$13,355,638	\$13,425,205	\$13,169,724	\$13,857,541	3
Recipients	1,820	1,801	1,718	1,674	1,700	1,821	0
Expenditures per Recipient	\$7,376	\$7,725	\$7,774	\$8,020	\$7,747	\$7,610	3
% Waiver-Only of Total Waivers	49%	48%	44%	48%	48%	49%	
Non-Waiver Services							
Expenditures	\$14,245,758	\$15,372,652	\$17,100,473	\$14,469,542	\$14,025,261	\$14,700,371	3
Recipients	1,947	1,943	1,845	1,821	1,825	1,921	-1
Expenditures per Recipient	\$7,317	\$7,912	\$9,269	\$7,946	\$7,685	\$7,652	5

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.

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.

\$3,576,484

Total Expenditures SFY 2015

↑ 9%

from SFY 2014

0.7% of Total Medicaid Expenditures

Table 60: Total Assisted Living Facility Waiver Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Total Waiver Services							
Expenditures	\$3,670,483	\$3,497,432	\$3,234,213	\$3,031,734	\$3,291,373	\$3,576,484	-3
Recipients	263	253	231	216	222	256	-3
Expenditures per Recipient	\$13,956	\$13,824	\$14,001	\$14,036	\$14,826	\$13,971	0
Waiver-Only Services							
Expenditures	\$3,058,800	\$2,757,617	\$2,612,026	\$2,451,875	\$2,593,984	\$2,773,135	-9
Recipients	236	217	201	190	194	230	-3
Expenditures per Recipient	\$12,961	\$12,708	\$12,995	\$12,905	\$13,371	\$12,057	-7
% Waiver-Only of Total Waivers	83%	79%	81%	81%	79%	78%	
Non-Waiver Services							
Expenditures	\$611,682	\$739,815	\$622,186	\$579,859	\$697,390	\$803,350	31
Recipients	253	244	218	203	214	235	-7
Expenditures per Recipient	\$2,418	\$3,032	\$2,854	\$2,856	\$3,259	\$3,419	41

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.

The CMH Waiver was developed to allow youth with serious emotional disturbance who need mental health treatment to remain in their home communities.

Waiver participants must be between the ages of 4 and 20, have needs that meet the definition of serious emotional disturbance, be financially eligible for Medicaid based on the child's income, qualify based on a standardized assessment, and meet specific inpatient clinical criteria.

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

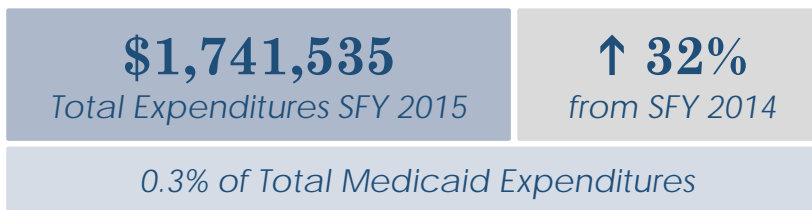


Table 61: Total Children's Mental Health Waiver Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Total Waiver Services							
Expenditures	\$1,533,159	\$2,881,354	\$2,435,543	\$1,423,830	\$1,321,609	\$1,741,535	14
Recipients	111	173	165	116	86	91	-18
Expenditures per Recipient	\$13,812	\$16,655	\$14,761	\$12,274	\$15,368	\$19,138	39
Waiver-Only Services							
Expenditures	\$391,862	\$918,455	\$942,386	\$688,995	\$527,514	\$732,257	87
Recipients	77	136	131	82	57	79	3
Expenditures per Recipient	\$5,089	\$6,753	\$7,194	\$8,402	\$9,255	\$9,269	82
% Waiver-Only of Total Waivers	26%	32%	39%	48%	40%	42%	
Non-Waiver Services							
Expenditures	\$1,141,297	\$1,962,899	\$1,493,157	\$734,835	\$794,094	\$1,009,279	-12
Recipients	111	171	164	112	83	86	-23
Expenditures per Recipient	\$10,282	\$11,479	\$9,105	\$6,561	\$9,567	\$11,736	14

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.

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.

\$30,272

Total Expenditures SFY 2015

↓ 59%

from SFY 2014

0.01% of Total Medicaid Expenditures

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

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

Table 62: Pregnant by Choice Waiver Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$74,633	\$106,300	\$111,105	\$123,985	\$76,481	\$30,272	-59
Recipients	310	424	407	372	280	107	-65
Expenditures per Recipient	\$241	\$251	\$273	\$333	\$273	\$283	18

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

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



Appendix A: Subprograms and Special Populations

Subprograms

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

Administrative Transportation

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

- The medical appointment must be medically necessary.
- Transportation must be approved at least three business days in advance by the Department.³⁹
- 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 Committee meets four times per year to provide recommendations regarding prospective

³⁹ Retrospective transportation reimbursement is allowed if the request is made within 30 days of travel and all required documentation is provided.

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

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

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

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

Health Information Technology (HIT)

Total Health Record Gateway and Electronic Health Record

The Total Health Record (THR) Gateway is a Medicaid Health Information Exchange (HIE) that is currently connected to the Immunization and Cancer registries, with plans to connect to the Laboratory registry by February 2016. The Gateway provides a single interface connection to Wyoming providers for Public Health Reporting as required to meet Meaningful Use (MU).

WY Total Health Record EHR		
27 <i>Locations</i>	78 <i>Providers</i>	324 <i>Users</i>
83,000 <i>Patient Records</i>		

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

The EHR is an ONC Stage 2 Certified electronic health record, used in 27 clinical settings and is 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.

Electronic Health Record Incentive Program

The Medicaid 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.

Since Program Implementation December 2011

149

Professionals

23

Hospitals

\$19.7

Paid (millions)

Electronic Health Record Incentive Program Eligibility

Professionals

- Certified EHR
- 30 percent Medicaid patient volume (20 percent for pediatricians)

Hospitals

- Certified EHR
- 10 percent Medicaid patient volume (discharges and ER visits)

Figure 22: Electronic Health Record Incentive Program Eligibility

Professionals can receive up to \$63,750 in incentive payments – over the six years that they choose to participate – after meeting required criteria each year and establishing patient volume. Hospitals receive incentive payments based on cost report data, with the total incentive 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.

State Level Repository

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

Data Repository

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

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 188 recipients, with expenditures totaling \$92,918 in SFY 2015. The average amount spent per recipient during this period was \$494.

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.

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 three such populations: Emergency Room Utilization, Medicaid/Medicare Dual Enrolled Members, and Foster Care.

Emergency Room Utilization

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

\$12,128,641 <i>Total Expenditures SFY 2015</i>	↑ 22% <i>from SFY 2014</i>
<i>2.3% of Total Medicaid Expenditures</i>	

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

Table 63: Emergency Room Utilization Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$10,162,899	\$10,689,120	\$9,986,857	\$9,831,233	\$9,964,263	\$12,128,641	19
Recipients	27,744	27,670	28,555	26,726	25,264	27,080	-2
Expenditures per Recipient	\$366	\$386	\$350	\$368	\$394	\$448	22
ER Visits	60,482	60,215	63,668	57,713	54,339	60,752	0
% of Total Medicaid Expenditures	1.98%	2.06%	1.99%	1.90%	1.93%	2.30%	

Table 64: Emergency Room Utilization by Eligibility Category

Eligibility Category	Expenditures	Percent Change from SFY 2014	Recipients	Percent Change from SFY 2014	ER Visits	Percent Change from SFY 2014
ABD EID	\$50,588	-26	117	-11	327	-8
ABD ID/DD/ABI	\$198,190	21	671	13	1,477	17
ABD Institution	\$12,795	48	28	8	44	-6
ABD Long-Term Care (Elderly/Physically Disabled)	\$341,722	41	1,339	14	3,779	23
ABD SSI	\$1,955,812	19	2,808	5	9,451	10
Adults	\$2,696,402	41	3,762	27	10,869	30
Children	\$5,973,966	17	15,705	4	28,292	7
Medicare Savings Programs	\$59,984	26	903	16	2,242	22
Non-Citizens with Medical Emergencies	\$27,468	27	73	-6	108	0
Pregnant Women	\$767,731	5	1,616	-4	4,017	1
Special Groups	\$43,983	15	58	-18	146	-8
Total	\$12,128,641	22	27,080	7	60,752	12

Emergency Room Utilization Breakdown by Expenditures

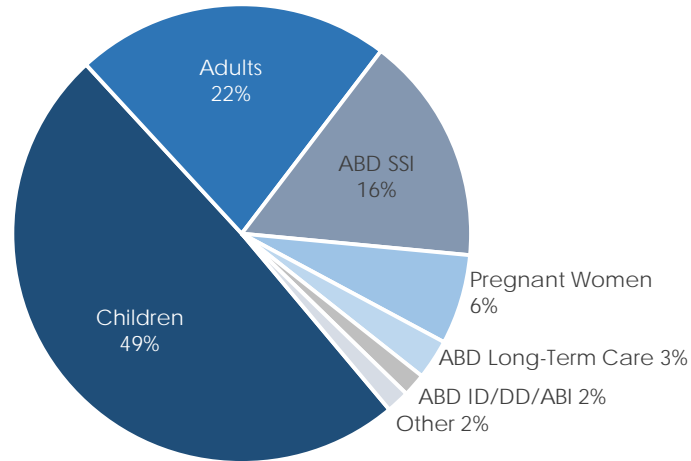


Figure 23: Emergency Room Utilization Breakdown by Expenditures

Children accounted for nearly half (49 percent) of emergency room expenditures. The bottom two percent of emergency room expenditures covered recipients in five eligibility categories: Medicare Savings Programs, ABD EID, Special Groups, Non-Citizens with Medical Emergencies, and ABD Institution. Each of these categories accounted for less than 1 percent of total emergency room expenditures.

The breakdown by number of unique visits is similar to that of expenditures, though the Medicare Savings Programs account for a greater percent of the visits (4 percent) than they do of the total expenditures, as these costs are primarily being paid by Medicare.

Emergency Room Utilization Breakdown by Unique Visits

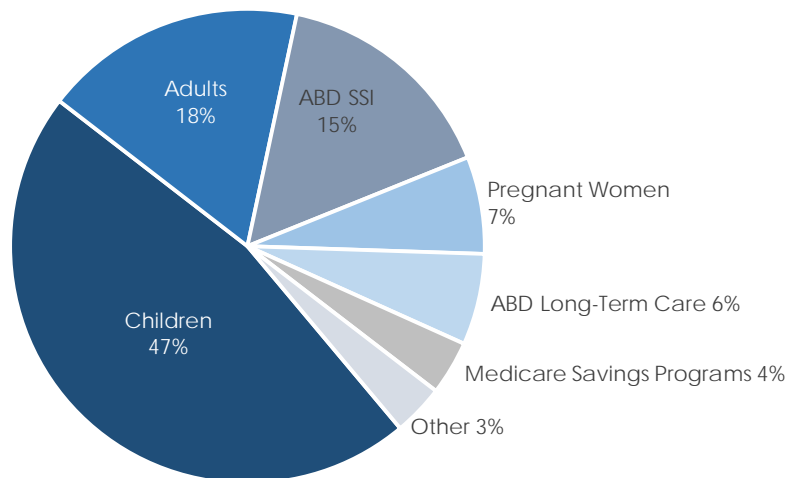


Figure 24: Emergency Room Utilization Breakdown by Unique Visits

Over one-third (36 percent) of Medicaid recipients used emergency room services in SFY 2015. The ABD SSI eligibility category had the greatest portion of recipients receiving emergency room services, with 46 percent.

Emergency room services accounted for 2.3 percent of total Medicaid expenditures in SFY 2015, with the Adult population having the greatest percentage (6.9 percent) of their total expenditures going toward emergency room services.

Table 65: Emergency Room Services vs Total Medicaid by Eligibility Category

Eligibility Category	ER Recipients	Total Medicaid Recipients	Percent Using ER Services	ER Expenditures	Total Medicaid Expenditures ⁴⁰	Percent of Total Medicaid Expenditures
ABD EID	117	360	33%	\$50,588	\$3,795,205	1.3%
ABD ID/DD/ABI	671	2,476	27%	\$198,190	\$137,112,834	0.1%
ABD Institution	28	91	31%	\$12,795	\$3,843,309	0.3%
ABD Long-Term Care (Elderly/Physically Disabled)	1,339	4,533	30%	\$341,722	\$109,685,023	0.3%
ABD SSI	2,808	6,126	46%	\$1,955,812	\$57,532,693	3.4%
Adults	3,762	8,468	44%	\$2,696,402	\$39,268,780	6.9%
Children	15,705	47,633	33%	\$5,973,966	\$143,624,614	4.2%
Medicare Savings Programs	903	2,985	30%	\$59,984	\$4,564,069	1.3%
Non-Citizens with Medical Emergencies	73	287	25%	\$27,468	\$1,236,724	2.2%
Pregnant Women	1,616	5,473	30%	\$767,731	\$24,134,468	3.2%
Special Groups	58	271	21%	\$43,983	\$2,550,692	1.7%
Total	27,080	75,325	36%	\$12,128,641	\$527,531,608	2.3%

Emergency Room Services as Percent of Total Medicaid Recipients and Expenditures by Eligibility Category

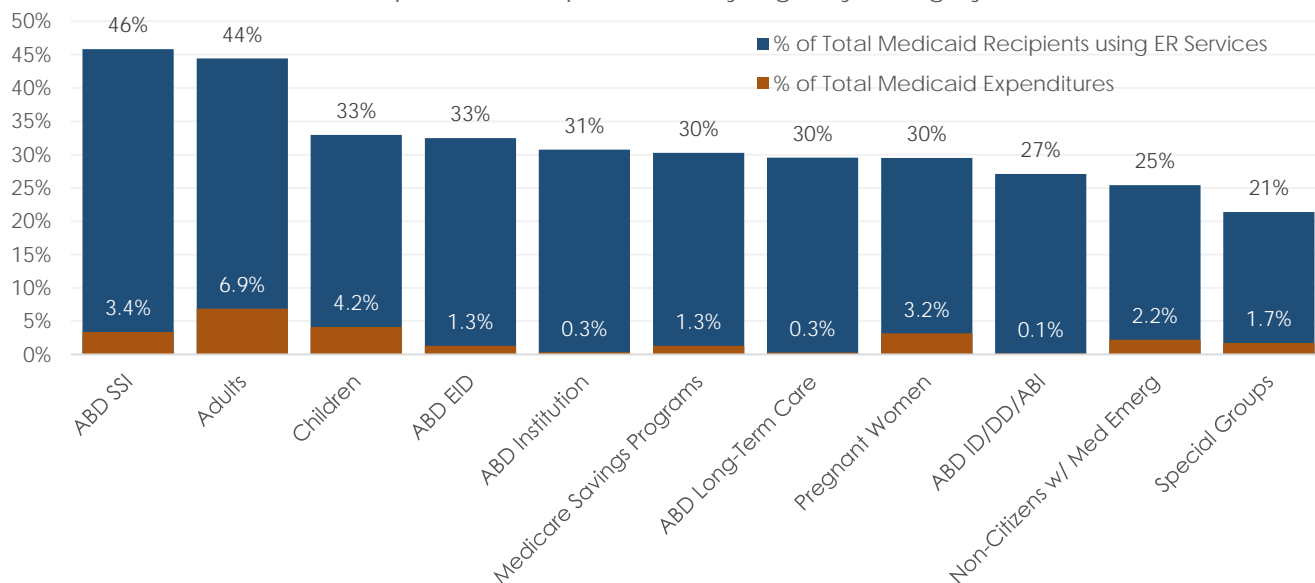


Figure 25: Emergency Room Services as Percent of Total Medicaid

⁴⁰ Expenditures for Screenings and Gross Adjustments are not shown in this table. As such, the eligibility category expenditures will not sum to the total shown.

Medicaid and Medicare Dual Enrollment

Individuals with Medicare coverage, may also be eligible for Medicaid services, dependent upon income. These individuals are referred to as dual eligible. For dual enrolled members, 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.

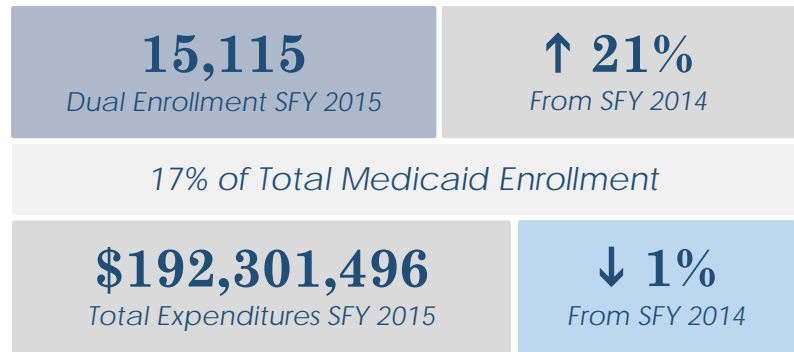


Table 66: Medicaid/Medicare Dual Enrollment Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Expenditures	\$175,811,864	\$180,891,512	\$181,766,090	\$189,787,625	\$193,531,089	\$192,301,496	9
Dual Enrolled Members	11,195	11,567	11,987	12,340	12,542	15,115	35
Recipients (unduplicated)	9,364	9,592	9,751	9,942	10,127	10,439	11
Expenditures per Dual Enrolled Member	\$15,704	\$15,639	\$15,164	\$15,380	\$15,431	\$12,723	-19
Expenditures per Recipient	\$18,775	\$18,859	\$18,641	\$19,089	\$19,110	\$18,421	-2
Crossover Claims Expenditures	\$13,616,250	\$14,786,603	\$15,401,922	\$16,853,247	\$16,951,537	\$18,058,494	7

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.

The data for dual enrolled members 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 enrollment data is also included in the individual service sections in this Report.

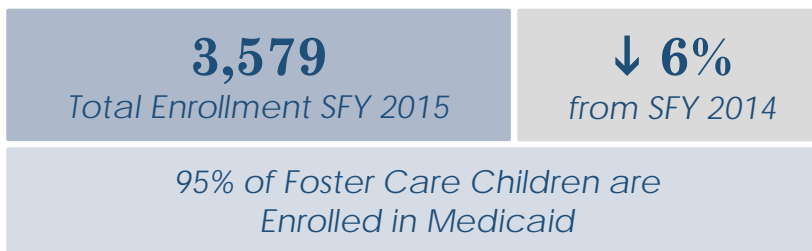
Waiver and nursing facility services accounted for 74 percent of total expenditures for dual enrolled members.

Table 67: Medicaid/Medicare Dual Enrollment Service Utilization

Service Area	Expenditures	Recipients	Expenditures per Recipient
Ambulance	\$624,598	1,260	\$496
Ambulatory Surgical Center	\$254,483	691	\$368
Behavioral Health	\$6,258,673	2,545	\$2,459
Dental	\$1,125,062	2,043	\$551
DME, Prosthetics/Orthotics/Supplies	\$2,789,981	3,353	\$832
End Stage Renal Disease	\$554,566	90	\$6,162
Federally Qualified Health Center	\$177,294	1,136	\$156
Home Health	\$2,695,304	290	\$9,294
Hospice	\$835,139	132	\$6,327
Hospital Total	\$9,840,491	7,140	\$1,378
<i>Hospital-Inpatient</i>	<i>\$4,126,575</i>	<i>1,980</i>	<i>\$2,084</i>
<i>Hospital-Other</i>	<i>\$2,761</i>	<i>87</i>	<i>\$32</i>
<i>Hospital-Outpatient</i>	<i>\$5,711,155</i>	<i>6,993</i>	<i>\$817</i>
Intermediate Care Facility-ID	\$14,715,654	62	\$237,349
Laboratory	\$36,825	2,273	\$16
Nursing Facility	\$66,151,819	2,225	\$29,731
Other	\$709,664	2,849	\$249
PACE	\$2,081,735	91	\$22,876
Physician & Other Practitioner	\$5,383,279	8,605	\$626
Prescription Drug	\$1,507,130	2,216	\$680
PRTF	\$168,300	1	\$168,300
Public Health, Federal	\$280,644	269	\$1,043
Rural Health Clinic	\$144,014	735	\$196
Vision	\$101,410	1,695	\$60
Waiver Total	\$75,865,430	2,899	\$26,170
<i>Waiver-ABI</i>	<i>\$5,274,909</i>	<i>135</i>	<i>\$39,073</i>
<i>Waiver-Adult DD</i>	<i>\$11,879,106</i>	<i>931</i>	<i>\$12,760</i>
<i>Waiver-ALF</i>	<i>\$2,600,051</i>	<i>218</i>	<i>\$11,927</i>
<i>Waiver-Child DD</i>	<i>\$362,190</i>	<i>23</i>	<i>\$15,747</i>
<i>Waiver-Child Mental Health</i>	<i>\$5,606</i>	<i>1</i>	<i>\$5,606</i>
<i>Waiver-Comprehensive</i>	<i>\$43,711,573</i>	<i>952</i>	<i>\$45,916</i>
<i>Waiver-LTC</i>	<i>\$11,571,812</i>	<i>1,528</i>	<i>\$7,573</i>
<i>Waiver-Supports</i>	<i>\$460,184</i>	<i>77</i>	<i>\$5,976</i>
Total	\$192,301,496	10,439	\$18,421

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 care 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.

Table 68: Foster Care Summary

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	5 Year Percent Change
Medicaid Foster Care							
Enrolled Members	3,111	3,148	3,248	3,369	3,602	3,390	9
Expenditures	\$28,858,199	\$22,957,008	\$17,534,383	\$20,934,667	\$24,197,999	\$22,627,859	-22
Recipients	3,266	3,341	3,303	3,443	3,643	3,631	11
State Foster Care							
Enrolled Members	183	179	173	211	203	189	3
Expenditures	\$2,052,536	\$1,599,409	\$1,517,769	\$2,768,409	\$2,697,681	\$2,852,108	39
Recipients	343	328	282	326	376	318	-7

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.

Table 69: Foster Care Service Utilization Summary⁴¹

Service Area	Medicaid Foster Care			State Foster Care		
	Expenditures	Recipients	Expenditures per Recipient	Expenditures	Recipients	Expenditures per Recipient
Ambulance	\$126,637	109	\$1,162	\$9,396	*	*
Ambulatory Surgical Center	\$201,583	108	\$1,867	\$15,112	*	*
Behavioral Health	\$7,231,780	1,917	\$3,772	\$1,448,568	270	\$5,365
Dental	\$781,144	1,920	\$407	\$121,950	194	\$629
DME, Prosthetics/Orthotics and Supplies	\$98,077	150	\$654	\$4,603	*	*
End Stage Renal Disease	\$10,520	*	*	--	--	--
Federally Qualified Health Centers	\$84,543	188	\$450	\$1,077	*	*
Home Health	\$37,118	*	*	--	--	--
Hospital Total	\$2,702,386	1,581	\$1,709	\$82,200	140	\$587
<i>Hospital-Inpatient</i>	\$1,965,666	185	\$10,625	\$31,296	*	*
<i>Hospital-Other</i>	\$3,129	*	*	--	--	--
<i>Hospital-Outpatient</i>	\$733,591	1,543	\$475	\$50,904	140	\$364
Laboratory	\$56,422	291	\$194	\$7,852	*	*
Other	\$190,803	408	\$468	\$6,316	*	*
Physician & Other Practitioner	\$1,608,317	2,667	\$603	\$84,260	185	\$455
Prescription Drug	\$2,906,312	2,291	\$1,269	\$297,253	213	\$1,396
PRTF	\$5,782,994	130	\$44,485	\$742,670	*	*
Public Health, Federal	\$401,172	222	\$1,807	\$3,468	*	*
Rural Health Clinic	\$98,203	305	\$322	\$1,075	*	*
Vision	\$309,847	1153	\$269	\$26,307	*	*
Total	\$22,627,859	3,631	\$6,232	\$2,852,108	318	\$8,969

Foster Care Top Service Utilization as Percent of Expenditures

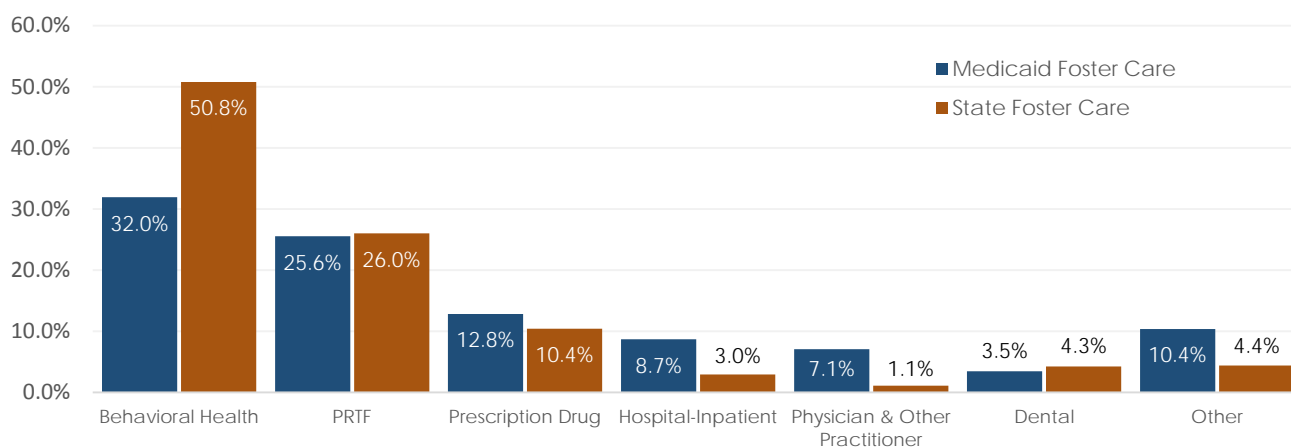


Figure 26: Foster Care Top Service Utilization as Percent of Expenditures

⁴¹ Data for services with fewer than 100 recipients has been omitted to secure Protected Health Information (PHI).

Appendix B: Supplemental 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 70: Medicaid Recipients by Age and Gender

Age Group	Female	Male	Total
0-20 Years	24,074	24,954	49,028
21-64 Years	15,336	5,546	20,882
65+	3,818	1,571	5,389
Total	43,228	32,071	75,299

Table 71: Medicaid Recipients by Race

Age Group	Black	Hispanic	Native American	White	Other	Total
0-20 Years	1,001	5,867	3,707	28,965	9,488	49,028
21-64 Years	356	1,403	1,419	15,044	2,660	20,882
65+	38	290	201	4,154	706	5,389
Total	1,395	7,560	5,327	48,163	12,854	75,299

Births

Table 72: Wyoming Medicaid Births⁴²

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

⁴² Medicaid statistics starting with 2006 is based on a calendar year. The data prior to 2006 was based on SFY. Provisional statistics for statewide births was supplied by Vital Records.

Table 73: County Summary⁴³

County	Enrolled Members ⁴⁴	Percent of Total Enrolled Members	Recipients ⁴⁵	Expenditures	Percent of Total Expenditures
Albany	4,019	5	5,512	\$23,504,169	4
Big Horn	2,052	2	1,789	\$8,774,379	2
Campbell	6,536	7	6,309	\$24,485,635	5
Carbon	2,342	3	1,992	\$7,650,171	1
Converse	1,967	2	2,970	\$7,852,678	1
Crook	904	1	572	\$1,779,566	0
Fremont	9,942	11	9,577	\$63,761,625	12
Goshen	2,211	2	2,049	\$12,483,394	2
Hot Springs	941	1	1,590	\$7,448,276	1
Johnson	973	1	1,328	\$3,244,089	1
Laramie	15,202	17	19,644	\$80,577,449	15
Lincoln	2,237	3	2,482	\$9,781,691	2
Natrona	13,193	15	18,034	\$85,962,176	16
Niobrara	452	1	388	\$881,215	0
Other	2,320	3	21,957	\$78,044,746	15
Park	3,928	4	4,986	\$24,671,559	5
Platte	1,382	2	1,463	\$3,860,248	1
Sheridan	4,064	5	4,870	\$23,919,356	5
Sublette	806	1	622	\$1,584,028	0
Sweetwater	6,091	7	5,963	\$18,520,784	4
Teton	1,797	2	2,534	\$6,569,014	1
Uinta	3,678	4	4,615	\$23,416,110	4
Washakie	1,272	1	3,856	\$5,558,979	1
Weston	943	1	1,148	\$3,200,270	1
Total	89,252	100	75,325	\$527,531,608	100

⁴³ Recipients and expenditures by county are based on county in which services were received determined by pay to provider location. Enrolled members by county are based on individuals' county of residence. For this reason the count of recipients in a particular county may exceed the number of enrolled members within that same county.

⁴⁴ Eligibility is shown for Complete SFY.

⁴⁵ 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.

Table 74: 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	Behavioral health services
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	

Table 75: 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 ⁴⁶
Wyoming Behavioral Institute	Behavioral health services

⁴⁶ W.S. 25-10-101(a)(ii)

Table 76: Waiver Services Provided by Waiver

Waiver Service	ABI	Adult DD	Child DD	Comp	Supports	LTC	ALF	CMH
Case management	✓	✓	✓	✓	✓	✓	✓	✓
Functional assessments	✓	✓	✓	✓	✓	✓	✓	✓
Respite	✓	✓	✓	✓	✓	✓		✓
Personal care	✓	✓	✓	✓	✓	✓	✓	
Skilled nursing	✓	✓	✓	✓	✓	✓	✓	
Dietician	✓	✓	✓	✓	✓		✓	
Homemaker		✓	✓	✓	✓	✓		
Special family habilitation home			✓	✓				
Day habilitation	✓	✓		✓	✓			
Child habilitation			✓	✓	✓			
Residential habilitation training			✓	✓	✓			
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 available	✓	✓	✓	✓	✓	✓		
High Fidelity Wraparound								✓
Family and Youth Peer Support Services								✓

Table 77: Hospital – Inpatient Summary by Levels of Care – SFY 2015

Inpatient Levels of Care	Expenditures	Recipients	Claims
07 - Kidney Transplant	\$258,328	3	3
10 - Bone Transplant	\$733,295	2	2
31 - Rehab w/o Vent As Of 090109	\$531,720	24	25
32 - Maternity-Surgery As Of 090109	\$5,187,948	962	965
33 - Maternity-Med As Of 090109	\$7,538,977	2,154	2,287
34 - NICU As Of 090109	\$5,633,758	122	122
35 - ICU-CCU-Burn As Of 090109	\$17,477,140	542	669
36 - Surgery As Of 090109	\$8,408,699	550	617
37 - Psychiatric As Of 090109	\$4,198,515	500	649
38 - Newborn Nursery As Of 090109	\$7,333,486	2,963	3,018
39 - Routine Discharge As Of 090109	\$13,061,157	1,694	2,204
Total Inpatient Expenditures	\$73,407,132	10,649	13,667

Table 78: Hospital – Inpatient Expenditures History by Levels of Care

Inpatient Levels of Care	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
07 - Kidney Transplant	--	--	\$237,169	\$177,177	-\$98,381	\$258,328
08 - Heart Transplant	--	--	\$214,453	--	--	--
09 - Liver Transplant	\$162,415	\$750,049	--	\$500,557	\$223,942	--
10 - Bone Transplant	--	\$910,635	\$152,845	\$2,634,285	\$976,412	\$733,295
12 - Extended Psychiatric	\$814,512	\$184	--	--	--	--
15 - Contract Rehab	\$417,143	--	--	--	--	--
16 - Lung Transplant	--	--	--	\$647,237	--	--
20 - Maternity-Surgery As Of 010198	\$1,640,253	\$3,882	--	--	--	--
21 - Maternity-Med As Of 010198	\$1,704,386	\$2,605	--	--	--	--
22 - ICU CCU Burn As Of 010198	\$8,322,137	\$158,897	--	--	--	--
23 - Major Surgery As Of 010198	\$2,991,483	-\$79,960	--	--	--	--
24 - Psychiatric As Of 010198	\$736,801	\$5,714	--	--	--	--
25 - Rehabilitation As Of 010198	\$179,285	-\$17,522	--	--	--	--
26 - Normal Newborn As Of 010198	\$4,943,827	\$86,565	\$1,536	\$1,841	--	--
27 - Newborn Re-Admit As Of 010198	\$57,801	--	--	--	--	--
28 - Routine Care As Of 010198	\$4,122,603	\$137,159	\$339,409	--	--	--
31 - Rehab w/o Vent As Of 090109	\$695,631	\$721,399	\$739,310	\$804,938	\$489,079	\$531,720
32 - Maternity-Surgery As Of 090109	\$4,665,957	\$6,078,069	\$5,775,706	\$5,691,247	\$5,854,738	\$5,187,948
33 - Maternity-Med As Of 090109	\$7,315,076	\$8,986,441	\$8,222,824	\$7,878,460	\$7,568,221	\$7,538,977
34 - NICU As Of 090109	\$3,567,130	\$9,120,329	\$6,335,289	\$6,361,703	\$4,852,484	\$5,633,758
35 - ICU-CCU-Burn As Of 090109	\$14,570,683	\$18,272,165	\$16,927,608	\$16,420,469	\$17,237,870	\$17,477,140
36 - Surgery As Of 090109	\$7,896,890	\$10,876,254	\$10,735,807	\$9,270,316	\$8,634,138	\$8,408,699
37 - Psychiatric As Of 090109	\$2,864,678	\$3,797,481	\$4,128,997	\$4,392,193	\$3,878,870	\$4,198,515
38 - Newborn Nursery As Of 090109	\$5,121,809	\$7,378,726	\$6,830,888	\$7,124,918	\$7,050,485	\$7,333,486
39 - Routine Discharge As Of 090109	\$11,795,775	\$14,660,516	\$13,675,922	\$13,632,077	\$13,395,349	\$13,061,157
Total Inpatient Expenditures	\$87,297,343	\$84,557,214	\$77,130,425	\$78,462,603	\$72,932,440	\$73,407,132

Table 79: Provider Summary by Taxonomy

Provider Taxonomy and Description	Providers	Recipients	Expenditures
101YA0400X - Addiction Therapist/Practitioner	2	37	\$10,121
363LA2200X - Adult Health	1	21	\$1,791
364SP0808X - Advance Practice Nurse	9	654	\$319,007
207KA0200X - Allergy And Immunology, Allergy	10	858	\$473,744
341600000X - Ambulance	72	3,546	\$4,352,067
261QA0005X - Ambulatory Family Planning Facility	9	545	\$69,754
261QA1903X - Ambulatory Surgical	34	3,547	\$6,090,776
207L00000X - Anesthesiology	80	7,035	\$2,519,148
231H00000X - Audiologist	17	454	\$134,326
251B00000X - Case Management	100	2,123	\$16,927,792
111N00000X - Chiropractor	13	69	\$6,347
261Q00000X - Clinic/Center	12	1,589	\$1,339,630
291U00000X - Clinical Medical Laboratory	84	8,852	\$1,516,042
103G00000X - Clinical Neuropsychologist	2	2	\$2,071
103TC0700X - Clinical Psychologist	122	4,671	\$14,027,227
251C00000X - Day Training, Developmentally Disabled Service	645	2,516	\$94,141,526
122300000X - Dentist	35	3,727	\$1,345,202
207N00000X - Dermatology	17	2,157	\$276,343
2085R0202X - Diagnostic Radiology	48	21,292	\$2,218,816
332B00000X - Durable Medical Equipment And Medical Supplies	252	6,686	\$6,970,432
207P00000X - Emergency Medicine	38	18,278	\$3,862,924
261QE0700X - End-Stage Renal Disease (ESRD) Treatment	13	107	\$1,099,569
1223E0200X - Endodontics	5	145	\$125,417
363LF0000X - Family Health	17	1,719	\$368,970
207Q00000X - Family Practice	97	21,005	\$5,824,202
261QF0400X - Federally Qualified Health Center	10	5,995	\$3,259,793
282N00000X - General Acute Care Hospital	192	35,147	\$86,971,143
282NR1301X - General Acute Care Hospital - Rural	36	10,314	\$16,389,825
1223G0001X - General Practice Dentist	154	15,733	\$6,400,779
332S00000X - Hearing Aid Equipment	16	342	\$940,058
251E00000X - Home Health	32	688	\$4,618,885
251G00000X - Hospice Care, Community Based	13	182	\$1,157,101
315P00000X - Intermediate Care Facility, Mentally Retarded	1	75	\$18,091,427
207R00000X - Internal Medicine	59	12,358	\$4,966,149
207RC0000X - Internal Medicine, Cardiovascular Disease	17	3,131	\$437,224
207RE0101X - Internal Medicine, Endocrinology Diabetes And Metabolic	7	155	\$37,657
207RG0100X - Internal Medicine, Gastroenterology	6	843	\$377,353
207RG0300X - Internal Medicine, Geriatric Medicine	2	98	\$17,669
207RX0202X - Internal Medicine, Medical Oncology	12	471	\$2,493,943
207RN0300X - Internal Medicine, Nephrology	9	137	\$54,404
207RP1001X - Internal Medicine, Pulmonary Disease	13	261	\$83,584
207RR0500X - Internal Medicine, Rheumatology	4	277	\$49,969
171R00000X - Interpreter	1	449	\$56,339

Provider Taxonomy and Description	Providers	Recipients	Expenditures
1041C0700X - Licensed Clinic/Cert Social Worker	43	661	\$907,851
106H00000X - Licensed Marriage & Family Therapist	8	104	\$161,044
275N00000X - Medicare Defined Swing Bed Unit	9	59	\$833,841
261QM0801X - Mental Health-Including Community Mental Health	27	5,437	\$8,668,925
367A00000X - Midwife, Certified Nurse	5	27	\$19,041
207T00000X - Neurological Surgery	14	1,554	\$955,405
367500000X - Nurse Anesthetist, Certified Registered	22	1,058	\$227,083
363L00000X - Nurse Practitioner	10	2,497	\$336,154
207V00000X - Obstetrics And Gynecology	46	6,363	\$6,832,110
363LX0001X - Obstetrics And Gynecology	2	50	\$6,019
207VG0400X - Obstetrics And Gynecology, Gynecology	5	40	\$11,932
207VX0000X - Obstetrics And Gynecology, Obstetrics	2	9	\$10,974
225X00000X - Occupational Therapist	18	384	\$2,260,765
207W00000X - Ophthalmology	36	2,691	\$690,214
156FX1800X - Optician	11	512	\$74,200
152W00000X - Optometrist	102	14,794	\$3,521,016
1223X0400X - Orthodontics	14	650	\$406,253
207X00000X - Orthopedic Surgery	35	4,383	\$1,422,229
207Y00000X - Otolaryngology	26	3,413	\$957,868
251T00000X - Pace Organization	1	95	\$2,242,570
251X00000X - Pace PPL	1	318	\$2,707,383
207ZP0105X - Pathology	21	2,382	\$170,879
208000000X - Pediatrics	72	14,234	\$5,662,679
363LP0200X - Pediatrics	1	18	\$10,995
2080N0001X - Pediatrics, Neonatal-Perinatal Medicine	8	1,000	\$452,942
1223P0221X - Pedodontics	31	12,221	\$5,148,703
1223P0300X - Periodontics	1	6	\$2,341
333600000X - Pharmacy	204	46,026	\$47,785,528
246RP1900X - Phlebotomy/WY Health Fair	1	24	\$1,920
208100000X - Physical Medicine And Rehabilitation	14	410	\$191,749
225100000X - Physical Therapist	61	2,728	\$2,917,423
363A00000X - Physician Assistant	1	7	\$589
208D00000X - Physician, General Practice	74	22,850	\$10,113,348
2082S0099X - Plastic Surgery	15	211	\$116,240
213E00000X - Podiatrist	17	1,195	\$78,388
101YP2500X - Professional Counselor	64	1,093	\$2,338,814
335E00000X - Prosthetic/Orthotic Supplier	30	744	\$720,162
283Q00000X - Psychiatric Hospital	4	51	\$275,227
323P00000X - Psychiatric Residential Treatment Facility	20	334	\$13,575,847
2084P0800X - Psychiatry And Neurology, Psychiatry	35	2,333	\$2,650,594
2084N0400X - Psychiatry And Neurology: Neurology	27	1,983	\$1,354,679
251K00000X - Public Health Or Welfare	24	5,977	\$1,009,814
261QP0904X - Public Health, Federal	2	3,384	\$8,761,358
261QR0208X - Radiology: Mobile	1	10	\$52
283X00000X - Rehabilitation Hospital	4	95	\$887,751
261QR0401X - Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	1	209	\$154,682

Appendix B: Supplemental Tables

Provider Taxonomy and Description	Providers	Recipients	Expenditures
261QR0405X - Rehabilitation, Substance Use Disorder	32	1,414	\$4,793,708
322D00000X - Residential Treatment Facility For Emotionally Disturbed	1	1	\$35,712
261QR1300X - Rural Health	22	4,532	\$1,668,167
314000000X - Skilled Nursing Facility	50	2,329	\$69,520,419
235Z00000X - Speech-Language Pathologist	13	176	\$745,421
1223S0112X - Surgery, Oral & Maxillofacial	17	1,226	\$1,045,169
2086S0120X - Surgery, Pediatric	2	94	\$80,089
2086S0129X - Surgery, Vascular	5	78	\$18,527
208600000X - Surgery: General Surgery	37	1,682	\$635,372
208G00000X - Thoracic Surgery	4	23	\$31,776
208800000X - Urology	18	2,526	\$740,261
Unclassified Taxonomy	1	25	\$154,857
Total	3,651	75,325	\$527,531,608

Table 80: Top 20 Provider Types by Expenditures

Provider Taxonomy and Description	Expenditures	Percent of Total Medicaid Expenditures
251C00000X - Day Training, Developmentally Disabled Service	\$94,141,526	18%
282N00000X - General Acute Care Hospital	\$86,971,143	16%
314000000X - Skilled Nursing Facility	\$69,520,419	13%
333600000X - Pharmacy	\$47,785,528	9%
315P00000X - Intermediate Care Facility, Mentally Retarded	\$18,091,427	3%
251B00000X - Case Management	\$16,927,792	3%
282NR1301X - General Acute Care Hospital - Rural	\$16,389,825	3%
103TC0700X - Clinical Psychologist	\$14,027,227	3%
323P00000X - Psychiatric Residential Treatment Facility	\$13,575,847	3%
208D00000X - Physician, General Practice	\$10,113,348	2%
261QP0904X - Public Health, Federal	\$8,761,358	2%
261QM0801X - Mental Health-Including Community Mental Health	\$8,668,925	2%
332B00000X - Durable Medical Equipment And Medical Supplies	\$6,970,432	1%
207V00000X - Obstetrics And Gynecology	\$6,832,110	1%
1223G0001X - General Practice Dentist	\$6,400,779	1%
261QA1903X - Ambulatory Surgical	\$6,090,776	1%
207Q00000X - Family Practice	\$5,824,202	1%
208000000X - Pediatrics	\$5,662,679	1%
1223P0221X - Pedodontics	\$5,148,703	1%
207R00000X - Internal Medicine	\$4,966,149	1%
Total	\$452,870,198	86%

Table 81: Provider Count History⁴⁷

Provider Taxonomy and Description	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015	5 Year Percent Change
101YA0400X - Addiction Therapist/Practitioner	-	-	-	-	-	2	-
363LA2200X - Adult Health	-	-	-	1	1	1	-
364SP0808X - Advance Practice Nurse	3	5	6	7	9	9	200
207KA0200X - Allergy And Immunology, Allergy	5	6	6	7	7	10	100
341600000X - Ambulance	67	67	69	66	64	72	7
261QA0005X - Ambulatory Family Planning Facility	10	10	10	10	10	9	-10
261QA1903X - Ambulatory Surgical	36	36	38	38	39	34	-6
207L00000X - Anesthesiology	82	77	82	79	84	80	-2
231H00000X - Audiologist	19	15	14	17	19	17	-11
251B00000X - Case Management	98	106	108	102	103	100	2
111N00000X - Chiropractor	14	14	16	18	20	13	-7
261Q00000X - Clinic/Center	14	13	12	13	13	12	-14
207SG0201X - Clinical Genetics (M.D.)	-	-	-	-	1	-	-
291U00000X - Clinical Medical Laboratory	65	71	69	79	87	84	29
103G00000X - Clinical Neuropsychologist	-	-	-	-	-	2	-
103TC0700X - Clinical Psychologist	67	67	70	78	106	122	82
251C00000X - Day Training, Developmentally Disabled Service	859	885	879	801	777	645	-25
1223D0001X - Dental Public Health	1	1	-	-	-	-	-
122300000X - Dentist	21	22	20	23	31	35	67
207N00000X - Dermatology	15	16	16	19	18	17	13
2085R0202X - Diagnostic Radiology	53	56	56	50	53	48	-9
332B00000X - Durable Medical Equipment & Medical Supplies	232	235	223	245	247	252	9
207P00000X - Emergency Medicine	25	24	26	23	26	38	52
261QE0700X - End-Stage Renal Disease (ESRD) Treatment	13	11	11	14	15	13	0
1223E0200X - Endodontics	2	4	4	5	5	5	150
363LF0000X - Family Health	10	10	10	13	12	17	70
207Q00000X - Family Practice	109	93	89	97	100	97	-11
261QF0400X - Federally Qualified Health Center	8	7	5	9	7	10	25
282N00000X - General Acute Care Hospital	190	201	189	207	201	192	1
282NR1301X - General Acute Care Hospital - Rural	28	31	32	38	46	36	29
1223G0001X - General Practice Dentist	157	146	153	155	149	154	-2
332S00000X - Hearing Aid Equipment	18	19	20	20	19	16	-11
251E00000X - Home Health	29	29	28	30	31	32	10
251G00000X - Hospice Care, Community Based	19	14	13	14	12	13	-32
315P00000X - Intermediate Care Facility, Mentally Retarded	3	1	1	1	1	1	-67
207R00000X - Internal Medicine	65	63	59	73	80	59	-9
207RC0000X - Internal Medicine, Cardiovascular Disease	22	20	16	19	17	17	-23
207RE0101X - Internal Medicine, Endocrinology Diabetes And Metabolism	9	10	9	7	6	7	-22
207RG0100X - Internal Medicine, Gastroenterology	9	12	10	10	9	6	-33

⁴⁷ 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	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015	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	12	-37
207RN0300X - Internal Medicine, Nephrology	10	8	8	9	8	9	-10
207RP1001X - Internal Medicine, Pulmonary Disease	16	15	11	11	14	13	-19
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	43	-
106H00000X - Licensed Marriage & Family Therapist	-	-	-	-	-	8	-
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	14	-22
204D00000X - Neuromusculoskeletal Medicine & 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	10	43
207V00000X - Obstetrics And Gynecology	62	55	52	54	54	46	-26
363LX0001X - Obstetrics And Gynecology	4	4	5	5	6	2	-50
207VG0400X - Obstetrics And Gynecology, Gynecology	3	4	3	2	3	5	67
207VX0000X - Obstetrics And Gynecology, Obstetrics	2	2	2	3	2	2	0
225X00000X - Occupational Therapist	9	9	13	13	15	18	100
207W00000X - Ophthalmology	44	40	35	36	36	36	-18
156FX1800X - Optician	9	10	11	11	11	11	22
152W00000X - Optometrist	100	98	94	97	96	102	2
1223X0400X - Orthodontics	7	7	17	17	15	14	100
207X00000X - Orthopedic Surgery	56	53	50	44	44	35	-38
207Y00000X - Otolaryngology	36	31	30	29	29	26	-28
251T00000X - Pace Organization	-	-	-	-	1	1	-
251X00000X - Pace PPL	-	-	-	-	-	1	-
207ZP0105X - Pathology	21	20	20	20	22	21	0
208000000X - Pediatrics	74	74	70	70	71	72	-3
363LP0200X - Pediatrics	1	1	1	1	1	1	0
2080N0001X - Pediatrics, Neonatal-Perinatal Medicine	11	10	8	9	9	8	-27
1223P0221X - Pedodontics	24	24	26	28	32	31	29
1223P0300X - Periodontics	2	1	1	-	1	1	-50
333600000X - Pharmacy	212	208	205	199	198	204	-4
246RP1900X - Phlebotomy/WY Health Fair	1	1	1	1	1	1	0
208100000X - Physical Medicine And Rehabilitation	10	11	12	14	16	14	40
225100000X - Physical Therapist	54	56	54	58	56	61	13
363A00000X - Physician Assistant	1	-	-	-	-	1	-
208D00000X - Physician, General Practice	92	86	96	93	86	74	-20
2082S0099X - Plastic Surgery	18	17	18	17	17	15	-17

Provider Taxonomy and Description	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015	5 Year Percent Change
213E00000X - Podiatrist	14	14	18	15	17	17	21
101YP2500X - Professional Counselor	6	5	8	7	5	64	967
335E00000X - Prosthetic/Orthotic Supplier	28	26	25	25	26	30	7
283Q00000X - Psychiatric Hospital	2	2	2	1	4	4	100
323P00000X - Psychiatric Residential Treatment Facility	16	22	22	15	19	20	25
2084P0800X - Psychiatry And Neurology, Psychiatry	33	38	38	38	43	35	6
2084N0400X - Psychiatry And Neurology: Neurology	30	31	23	26	27	27	-10
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	1	-80
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	32	45
322D00000X - Residential Treatment Facility for Emotionally Disturbed Children	25	26	9	4	2	1	-
261QR1300X - Rural Health	22	20	21	19	20	22	0
314000000X - Skilled Nursing Facility	38	43	43	40	45	50	32
235Z00000X - Speech-Language Pathologist	-	6	8	8	5	13	-
1223S0112X - Surgery, Oral & Maxillofacial	12	15	16	16	17	17	42
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	37	-26
208G00000X - Thoracic Surgery	2	4	3	5	3	4	100
208800000X - Urology	25	22	20	22	21	18	-28
Unknown	-	1	1	1	1	1	-
Total	3,755	3,699	3,752	3,763	3,603	3,651	-3

Table 82: Provider History by Expenditures

Provider Taxonomy and Description	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015	5 Year Percent Change
101YA0400X - Addiction Therapist/Practitioner	-	-	-	-	-	\$10,121	-
363LA2200X - Adult Health	-	-	-	\$208	\$181	\$1,791	-
364SP0808X - Advance Practice Nurse	\$155,260	\$194,737	\$203,063	\$185,079	\$217,012	\$319,007	105
207KA0200X - Allergy And Immunology, Allergy	\$341,077	\$420,255	\$457,860	\$462,979	\$412,870	\$473,744	39
341600000X – Ambulance	\$4,327,795	\$3,807,538	\$3,303,240	\$3,459,400	\$3,606,360	\$4,352,067	1
261QA0005X - Ambulatory Family Planning Facility	\$100,239	\$103,949	\$83,744	\$81,564	\$68,988	\$69,754	-30
261QA1903X - Ambulatory Surgical	\$3,497,383	\$3,315,928	\$2,912,791	\$2,822,957	\$3,439,188	\$6,090,776	74
207L00000X – Anesthesiology	\$3,200,397	\$2,873,295	\$2,688,531	\$2,660,467	\$2,569,464	\$2,519,148	-21
231H00000X – Audiologist	\$54,644	\$55,615	\$53,035	\$113,056	\$124,025	\$134,326	146
251B00000X - Case Management	\$14,407,109	\$16,814,987	\$16,969,265	\$16,187,605	\$16,073,653	\$16,927,792	17
111N00000X – Chiropractor	\$6,746	\$5,874	\$6,102	\$7,349	\$7,500	\$6,347	-6
261Q00000X - Clinic/Center	\$1,022,376	\$1,327,399	\$1,496,903	\$1,195,547	\$1,166,813	\$1,339,630	31
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
103G00000X - Clinical Neuropsychologist	-	-	-	-	-	\$2,071	-
103TC0700X - Clinical Psychologist	\$5,516,132	\$6,752,837	\$7,780,854	\$9,025,018	\$11,432,476	\$14,027,227	154
251C00000X - Day Training, Developmentally Disabled Service	\$102,447,300	\$96,906,907	\$103,602,106	\$106,417,236	\$105,946,874	\$94,141,526	-8
1223D0001X - Dental Public Health	\$830,140	\$220,085	-	-	-	-	-
122300000X – Dentist	\$921,677	\$1,177,716	\$1,307,247	\$1,304,083	\$1,299,057	\$1,345,202	46
207N00000X – Dermatology	\$242,682	\$278,029	\$306,992	\$346,181	\$301,872	\$276,343	14
2085R0202X - Diagnostic Radiology	\$2,344,973	\$2,401,544	\$2,557,894	\$2,698,857	\$2,766,607	\$2,218,816	-5
332B00000X - Durable Medical Equipment & Medical Supplies	\$4,790,456	\$5,417,606	\$5,988,070	\$5,803,375	\$6,501,225	\$6,970,432	46
207P00000X - Emergency Medicine	\$3,484,047	\$3,740,215	\$3,800,063	\$3,662,836	\$3,587,560	\$3,862,924	11
261QE0700X - End-Stage Renal Disease (ESRD) Treatment	\$1,347,305	\$1,160,798	\$835,621	\$1,233,755	\$1,343,669	\$1,099,569	-18
1223E0200X - Endodontics	\$84,246	\$114,460	\$154,897	\$145,175	\$176,754	\$125,417	49
363LF0000X - Family Health	\$178,227	\$240,460	\$308,796	\$307,731	\$312,321	\$368,970	107
207Q00000X - Family Practice	\$6,740,124	\$6,571,534	\$6,601,112	\$6,408,005	\$7,194,712	\$5,824,202	-14
261QF0400X - Federally Qualified Health Center	\$4,113,634	\$2,864,956	\$3,103,164	\$1,550,274	\$2,018,911	\$3,259,793	-21
282N00000X - General Acute Care Hospital	\$84,906,412	\$97,112,122	\$96,670,956	\$89,158,045	\$90,818,612	\$86,971,143	2
282NR1301X - General Acute Care Hospital - Rural	\$12,758,988	\$14,087,353	\$16,907,624	\$15,538,331	\$16,826,942	\$16,389,825	28

Provider Taxonomy and Description	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015	5 Year Percent Change
1223G0001X - General Practice Dentist	\$5,929,594	\$6,667,264	\$6,985,175	\$6,567,492	\$6,223,175	\$6,400,779	8
332S00000X - Hearing Aid Equipment	\$553,776	\$542,768	\$737,738	\$688,994	\$560,896	\$940,058	70
251E00000X - Home Health	\$1,998,695	\$1,941,097	\$2,732,905	\$2,963,510	\$2,897,016	\$4,618,885	131
251G00000X - Hospice Care, Community Based	\$939,603	\$1,432,471	\$1,036,887	\$983,026	\$1,082,188	\$1,157,101	23
315P00000X - Intermediate Care Facility, Mentally Retarded	\$9,159,786	\$10,651,941	\$11,388,412	\$10,065,657	\$17,942,326	\$18,091,427	98
207R00000X - Internal Medicine	\$2,603,182	\$2,677,104	\$3,681,658	\$4,165,557	\$4,488,138	\$4,966,149	91
207RC0000X - Internal Medicine, Cardiovascular Disease	\$405,660	\$591,191	\$538,377	\$447,730	\$419,713	\$437,224	8
207RE0101X - Internal Medicine, Endocrinology Diabetes & Metabolism	\$38,309	\$28,542	\$29,855	\$31,333	\$30,547	\$37,657	-2
207RG0100X - Internal Medicine, Gastroenterology	\$218,798	\$293,075	\$209,512	\$253,524	\$201,831	\$377,353	72
207RG0300X - Internal Medicine, Geriatric Medicine	\$2,391	\$15,894	\$14,477	\$189	\$1,187	\$17,669	639
207RX0202X - Internal Medicine, Medical Oncology	\$1,221,165	\$1,727,358	\$1,792,761	\$2,090,706	\$3,029,644	\$2,493,943	104
207RN0300X - Internal Medicine, Nephrology	\$53,850	\$42,389	\$34,141	\$57,824	\$47,826	\$54,404	1
207RP1001X - Internal Medicine, Pulmonary Disease	\$176,125	\$48,942	\$59,557	\$73,916	\$119,064	\$83,584	-53
207RR0500X - Internal Medicine, Rheumatology	\$33,008	\$46,899	\$50,926	\$53,116	\$41,963	\$49,969	51
171R00000X - Interpreter	\$49,399	\$47,837	\$54,259	\$48,321	\$43,529	\$56,339	14
1041C0700X - Licensed Clinic/Cert Social Worker	-	-	-	\$2,564	\$5,966	\$907,851	-
106H00000X - Licensed Marriage & Family Therapist	-	-	-	-	-	\$161,044	-
275N00000X - Medicare Defined Swing Bed Unit	\$780,041	\$879,546	\$866,458	\$1,072,703	\$887,666	\$833,841	7
261QM0801X - Mental Health-Including Community Mental Health	\$8,662,327	\$10,274,257	\$9,911,967	\$9,581,854	\$9,640,599	\$8,668,925	0
367A00000X - Midwife, Certified Nurse	\$28,355	\$16,873	\$16,281	\$35,068	\$18,485	\$19,041	-33
207T00000X - Neurological Surgery	\$1,229,804	\$1,245,000	\$1,177,850	\$1,063,118	\$890,226	\$955,405	-22
204D00000X - Neuromusculoskeletal Medicine & OMM	\$59,204	\$24,238	\$853	\$0	-	-	-
367500000X - Nurse Anesthetist, Certified Registered	\$417,921	\$524,777	\$491,532	\$378,968	\$426,998	\$227,083	-46
363L00000X - Nurse Practitioner	\$88,516	\$168,666	\$118,770	\$205,988	\$279,449	\$336,154	280
207V00000X - Obstetrics And Gynecology	\$10,681,327	\$11,210,316	\$10,784,741	\$9,603,368	\$8,906,934	\$6,832,110	-36
363LX0001X - Obstetrics And Gynecology	\$392,250	\$420,486	\$735,818	\$668,453	\$356,682	\$6,019	-98
207VG0400X - Obstetrics And Gynecology, Gynecology	\$105,730	\$90,214	\$12,646	\$14,134	\$8,385	\$11,932	-89
207VX0000X - Obstetrics And Gynecology, Obstetrics	\$13,624	\$10,594	\$8,899	\$6,188	\$4,232	\$10,974	-19
225X00000X - Occupational Therapist	\$371,252	\$335,576	\$519,915	\$777,572	\$667,385	\$2,260,765	509
207W00000X - Ophthalmology	\$653,248	\$698,593	\$700,218	\$709,763	\$693,621	\$690,214	6
156FX1800X - Optician	\$123,729	\$140,095	\$123,831	\$101,728	\$94,212	\$74,200	-40

Appendix B: Supplemental Tables

Provider Taxonomy and Description	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015	5 Year Percent Change
152W00000X - Optometrist	\$2,762,647	\$3,046,630	\$3,103,713	\$3,090,404	\$3,295,581	\$3,521,016	27
1223X0400X - Orthodontics	\$218,399	\$229,986	\$314,684	\$456,310	\$415,802	\$406,253	86
207X00000X - Orthopedic Surgery	\$1,820,454	\$1,836,993	\$1,657,652	\$1,679,389	\$1,480,296	\$1,422,229	-22
207Y00000X - Otolaryngology	\$1,062,191	\$1,000,269	\$1,097,720	\$982,135	\$882,361	\$957,868	-10
251T00000X - Pace Organization	-	-	-	-	\$168,398	\$2,242,570	-
251X00000X - Pace PPL	-	-	-	-	-	\$2,707,383	-
207ZP0105X - Pathology	\$355,054	\$333,627	\$414,608	\$413,824	\$365,084	\$170,879	-52
208000000X - Pediatrics	\$7,627,451	\$8,425,254	\$7,408,393	\$6,332,565	\$5,954,804	\$5,662,679	-26
363LP0200X - Pediatrics	\$22,294	\$32,367	\$22,194	\$10,525	\$10,696	\$10,995	-51
2080N0001X - Pediatrics, Neonatal-Perinatal Medicine	\$1,245,886	\$1,217,266	\$802,591	\$761,916	\$812,471	\$452,942	-64
1223P0221X - Pedodontics	\$3,307,266	\$3,588,181	\$3,923,576	\$4,109,557	\$4,374,460	\$5,148,703	56
1223P0300X - Periodontics	\$6,204	\$2,766	\$60	-	\$1,385	\$2,341	-62
333600000X - Pharmacy	\$39,302,672	\$38,750,658	\$41,330,767	\$41,918,402	\$38,919,301	\$47,785,528	22
246RP1900X - Phlebotomy/WY Health Fair	\$21,915	\$3,520	\$3,820	\$5,910	\$2,635	\$1,920	-91
208100000X - Physical Medicine And Rehabilitation	\$124,590	\$164,875	\$135,880	\$106,951	\$143,519	\$191,749	54
225100000X - Physical Therapist	\$1,642,817	\$2,415,165	\$2,776,082	\$2,673,200	\$2,799,403	\$2,917,423	78
363A00000X - Physician Assistant	\$93	-	-	-	-	\$589	-
208D00000X - Physician, General Practice	\$9,424,001	\$9,907,834	\$10,068,544	\$9,845,606	\$9,598,191	\$10,113,348	7
2082S0099X - Plastic Surgery	\$191,938	\$238,432	\$154,444	\$142,040	\$133,343	\$116,240	-39
213E00000X - Podiatrist	\$50,213	\$48,861	\$76,857	\$73,605	\$65,795	\$78,388	56
101YP2500X - Professional Counselor	\$58,380	\$32,630	\$40,195	\$43,384	\$24,104	\$2,338,814	3,906
335E00000X - Prosthetic/Orthotic Supplier	\$1,014,048	\$645,342	\$779,875	\$778,124	\$828,261	\$720,162	-29
283Q00000X - Psychiatric Hospital	\$2,957,631	\$1,132,834	\$1,284	\$17,594	\$106,009	\$275,227	-91
323P00000X - Psychiatric Residential Treatment Facility	\$8,345,259	\$14,658,731	\$15,244,613	\$8,019,118	\$12,080,494	\$13,575,847	63
2084P0800X - Psychiatry And Neurology, Psychiatry	\$3,721,374	\$4,085,344	\$4,818,845	\$4,695,322	\$3,682,231	\$2,650,594	-29
2084N0400X - Psychiatry And Neurology: Neurology	\$942,694	\$837,067	\$781,629	\$672,232	\$661,311	\$1,354,679	44
251K00000X - Public Health Or Welfare	\$1,005,563	\$1,081,591	\$1,093,398	\$988,455	\$924,007	\$1,009,814	0
261QP0904X - Public Health, Federal	\$6,861,407	\$7,700,047	\$8,532,271	\$7,240,130	\$8,067,975	\$8,761,358	28
261QR0208X - Radiology: Mobile	\$191,239	\$222,281	\$217,463	\$109,250	\$4,081	\$52	-100
261QR0400X - Rehabilitation	\$19,509	\$0	-	-	-	-	-
283X00000X - Rehabilitation Hospital	\$1,734,938	\$1,308,965	\$777,740	\$1,085,017	\$1,087,890	\$887,751	-49

Appendix B: Supplemental Tables

Provider Taxonomy and Description	SFY2010	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015	5 Year Percent Change
261QR0401X - Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	\$59,613	\$36,757	\$56,646	\$125,928	\$121,618	\$154,682	159
261QR0405X - Rehabilitation, Substance Use Disorder	\$825,236	\$1,545,165	\$2,172,581	\$2,592,208	\$3,352,288	\$4,793,708	481
322D00000X - Residential Treatment Facility For Emotionally Disturbed Children	\$19,175,557	\$8,757,612	\$424,200	\$183,009	\$109,220	\$35,712	-
261QR1300X - Rural Health	\$1,515,936	\$1,710,855	\$1,940,640	\$1,628,043	\$1,845,491	\$1,668,167	10
314000000X - Skilled Nursing Facility	\$72,408,622	\$74,555,265	\$72,313,876	\$72,733,100	\$72,705,796	\$69,520,419	-4
235Z00000X - Speech-Language Pathologist	-	\$144,868	\$227,230	\$117,626	\$336,118	\$745,421	-
1223S0112X - Surgery, Oral & Maxillofacial	\$765,419	\$863,849	\$930,943	\$978,561	\$781,478	\$1,045,169	37
2086S0120X - Surgery, Pediatric	\$116,323	\$80,818	\$48,896	\$90,962	\$63,361	\$80,089	-31
2086S0129X - Surgery, Vascular	\$28,746	\$47,597	\$48,526	\$38,008	\$32,715	\$18,527	-36
208600000X - Surgery: General Surgery	\$942,605	\$935,283	\$853,509	\$796,756	\$765,767	\$635,372	-33
208G00000X - Thoracic Surgery	\$22,170	\$15,186	\$12,002	\$11,995	\$13,475	\$31,776	43
208800000X - Urology	\$762,040	\$886,191	\$887,064	\$799,645	\$835,010	\$740,261	-3
Unclassified Taxonomy	-	\$120,195	\$21,733	-\$4,024	\$30,590	\$154,857	-
Total	\$498,325,166	\$514,529,323	\$519,604,279	\$500,931,031	\$517,257,164	\$527,531,608	6





Appendix C: Rates and Reimbursement Methodology

Table 83: Reimbursement History by Service Area

Service Area	Reimbursement Description	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	Rate Method Authority for SFY 2015
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	Rates adjusted to 75% of Medicare's 2008 ambulance rates	No Change	No Change	No Change	No Change	No Change	Wyoming State Rule Chapter 15; Chapter 3
	Separate fee schedules for Basic life support (ground)							
	Advanced life support (ground)							
Ambulatory Surgery Center	Additional advanced life support (ground)							
	Air ambulance							
	Based on Medicaid's Outpatient Prospective Payment System (OPPS). Uses Medicare's relative weights and the Wyoming Medicaid payment method for each service (OPPS status indicator) for each procedure code. Medicaid adopted Medicare's OPPS status indicators for most services, with some adjustments for Medicaid policies.	Lower of the Medicaid fee schedule or the provider's usual and customary charge with rates based on eight ASC payment groups established by Medicare. The groups are all inclusive bundled payment per procedure code.	No Change	No Change	No Change	No Change	Adopted new OPPS-based methodology to better align reimbursement with those services provided in other outpatient settings.	43 CFR 447.321
	Services are paid based on one of the following (by status indicator): 1) Ambulatory Payment Classification (APC) fee schedule, 2) separate Medicaid fee schedule, or 3) percentage of charges.	Ninth payment group rate is 70% of billed charges						State Plan Amendment 4.19B
		Rates are 90% of Medicare's 2007 ASC rates						

Service Area	Reimbursement Description	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	Rate Method Authority for SFY 2015
Behavioral Health	Lower of the Medicaid fee schedule or the provider's usual and customary charge	CPT code rates decreased to 90% of Medicare's rates (effective November 1, 2009)	No Change	No Change	No Change	No Change	No Change	42 CFR 440.130 42 CFR 440.40b 42 CFR 440.169
	Separate fee schedules based on the type of provider							SEA 21 2015
Comprehensive Outpatient Rehabilitation Facility	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	State Plan Amendment 3.1d and 4.19b 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	No Change	No Change	No Change	No Change	No Change	Additional services added for vulnerable adult population By report fee schedule revised	State Plan Amendment 3.1A and 4.19B
	Adult optional dental services added (effective July 1, 2006)							
Durable Medical Equipment, Prosthetics, Orthotics and Supplies	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 11; Chapter 3; Wyoming State Plan Attachment 4.19B-12c
	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							

Service Area	Reimbursement Description	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	Rate Method Authority for SFY 2015
End State Renal Dialysis	Lower of the Medicaid fee schedule or the provider's usual and customary charge	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)	No Change	42 CFR Part 413 Subpart H; State Plan 4.19B
	Dialysis services reimbursed at a percentage of billed charges							
Federally Qualified Health Centers	Prospective per encounter payment system as required by the Benefits Improvement and Protection Act (BIPA) of 2000.	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	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
	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)							
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	42 CFR 484, Subpart E
Hospice	Per diem rate based on Medicare's fee schedule	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)
	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)							

Service Area	Reimbursement Description	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	Rate Method Authority for SFY 2015
Hospital (Inpatient)		- 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 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						CFR 447 Subpart C Payment; State Plan 4.19B
	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		No change	No change	No change	No change	No change	
	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							

Service Area	Reimbursement Description	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	Rate Method Authority for SFY 2015
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		Adjusted conversion factors to support budget neutrality in the aggregate	Adjusted conversion factors to support budget neutrality in the aggregate	Adjusted conversion factors to support budget neutrality in the aggregate	Adjusted conversion factors to support budget neutrality in the aggregate	Adjusted conversion factors to support budget neutrality in the aggregate	
	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	No change	(effective calendar year 2011): General acute \$48.65 Critical access \$129.22 Children's \$105.62	(effective calendar year 2012): General acute \$50.99 Critical access \$129.74 Children's \$109.95	(effective calendar year 2013): General acute \$48.19 Critical access \$126.82 Children's \$105.50	(effective calendar year 2014): General acute \$45.45 Critical access \$118.86 Children's \$100.05	(effective calendar year 2015): General acute \$42.34 Critical access \$111.93 Children's \$92.71	CFR 447.321; CFR 447.325; Chapter 33 Rule
	Additional payments: Qualified Rate Adjustment (QRA) program provides supplemental payments to non-state governmental hospital		No change for QRA	No change for QRA	No change for QRA	No change for QRA	No change for QRA	
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	No change	No change	No change	No change	No change	No change	Wyoming State Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B

Service Area	Reimbursement Description	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	Rate Method Authority for SFY 2015
Nursing Facility	Prospective per diem rate with rate components for capital cost, operational cost and direct care costs		No change to rates					
	Additional reimbursement on a monthly basis for extraordinary needs determined on a per case basis	Rates adjusted based on analysis of Medicaid cost reports	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	No change	W.S. 42-4-104(c); State Plan- 4.19D; Chapter 7 Rule
	Additional payments: Provider Assessment and Upper Payment Limit (UPL) Payment provides supplemental payments (effective April 1, 2011)							
Physicians and Other Practitioners	Lower of the Medicaid fee schedule or the provider's usual and customary charge	Adopted Medicare's 2009 RVUs (effective August 1, 2009)			Beginning January 1, 2013 the Affordable Care Act (ACA) mandated State Agencies to increase primary care service payments equivalent to the Medicare rates in effect in CY 2009 for CY 2013 and 2014. This only affected Evaluation and Management procedure codes 99201-99499 and Vaccine codes 90460, 90471, 90472, 90743 and 90474. This was only applicable to Physicians that completed a self-attestation to having a specialty in Family, Internal or Pediatric Medicine.			
	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.	Adjusted the conversion factors for physician services (effective August 1, 2009) Reimbursement budget reduced by \$4.8 million	No change	No change	The ACA Primary Care Service Payments officially ended December 31, 2014.	No change		State Plan Amendment 3.1 and 4.19B

Service Area	Reimbursement Description	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	Rate Method Authority for SFY 2015
Prescription Drugs	Lower of the estimated acquisition cost (EAC) of the ingredients plus the dispensing fee and the provider's usual and customary charge							State Plan Amendment, Attachment 4.19B, Section 12.a., pages 1-3; Wyoming Medicaid Rules, Chapter 10, Pharmaceutical Services, Section 16 (Medicaid Allowable Payment)
	The EAC is the Average Wholesale Price (AWP) minus 11%	Preferred Drug List (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	PDL expanded to 123 specific drug classes	
	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							
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.	Rates increased based on analysis of Medicaid cost reports	Rates increased based on analysis of Medicaid cost reports	No change	No change	No change	Rates adjusted December 1, 2014 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
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.	No change	No change	No change	No change	No change	No change	Wyoming State Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B

Service Area	Reimbursement Description	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	Rate Method Authority for SFY 2015
Rural Health Center	Prospective per encounter payment system as required by the Benefits Improvement and Protection Act (BIPA) of 2000							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
	Based on 100% of a facility's average costs during SFYs 1999 and 2000	No change	No change	No change	No change	Rates increased 0.8% based on MEI	Rates increased 0.8% based on MEI	
	Rates increased annually for inflation based on Medicare Economic Index (MEI)							
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.							State Plan 3.1-A State Plan 4.19B/6.b
	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.	No change	No change	No change	No change	No change	No Change	
	Optician reimbursement based on a procedure code fee schedule							

Service Area	Reimbursement Description	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	Rate Method Authority for SFY 2015
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.	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.	No change	Medicaid is required by statute to rebase the rates and conduct the rate studies every 2 -4 years as stated in 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.
	Consumers negotiate rates based on their budget amount.							
	For extraordinary care needs, the Extraordinary Care Committee (ECC) reviews the full service and support structure of a participant, including non-waiver services and supports, to determine the appropriate service(s) and funding to meet the participant's assessed needs. The ECC will also review requests for IBA adjustments due to a change in client needs or emergencies.							

Service Area	Reimbursement Description	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	Rate Method Authority for SFY 2015
Waiver (Children's Mental Health)	Lower of the Medicaid fee schedule or the provider's usual and customary charge	Rates adjusted to reflect budget neutrality	No change	No change	No change	No Change	No Change	1915(c)
	Reimbursement based on procedure code fee schedule							
Waiver (Long-Term Care)	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	Waiver agreement
	Reimbursement limited to a monthly or yearly cap per person, according to the established care plan							
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.	No change	No change	No change	No change	No change	No change	Waiver agreement
	Case management services are reimbursed a separate rate.							
	Participants pay their own room and board.							
Waiver (Pregnant by Choice)	The waiver was implemented in SFY 2009 and extended until December 31, 2017.	No change	No change	No change	No change	No change	No change	11-W-00238/8
	Multiple reimbursement methodologies and fee schedules based on the service areas detailed in this table							

Service Area	Reimbursement Description	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	Rate Method Authority for SFY 2015
Waiver (Comprehensive)	The waiver was implemented in SFY 2014	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.	No change	Medicaid is required by statute to rebase the rates and conduct the rate studies every 2 -4 years as stated in 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	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.	No change	Medicaid is required by statute to rebase the rates and conduct the rate studies every 2 -4 years as stated in 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

The following table provides the income limits for calendar years 2014 and 2015.

Table 84: Income Limits by Eligibility Category

Eligibility Category	CY 2014-2015
Children 0-6	154% FPL, no resource limits
Children 6-18	133% FPL, no resource limits
Former Foster Care Children, over age 21 to age 26	Eligible, no resource limits
Family Care Adults	Values in Table 85, no resource limits
Pregnant Women	154% FPL, no resource limits
ABD Waivers and institutions	Less than or equal to 300% SSI
ABD with Eligibility Determined by Social Security Administration	100% SSI
ABD with Eligibility Determined by Wyoming Department of Health assessment	100% SSI
Qualified Medicare Beneficiary	100% FPL
Specified Low-Income Medicare Beneficiary	135% FPL
Breast & Cervical Cancer	Less than or equal to 250% FPL
Tuberculosis	100% SSI
Employed individuals with disabilities	Less than or equal to 300% SSI
Non-Citizens with Medical Emergencies	Depends on eligibility group qualified under

Table 85: Monthly Income Standard Values by Family Size

Income Standard		Income Limit	CY 2014				CY 2015			
<i>Family Size</i>			1	2	3	4	1	2	3	4
Family Care Adults			\$529	\$737	\$873	\$999	\$529	\$737	\$873	\$999
Federal Poverty Level (FPL)	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	\$2,194	\$2,644
	154%		\$1,475	\$1,991	\$2,507	\$3,023	\$1,498	\$2,019	\$2,540	\$3,061
Supplementary Security Income (SSI)	100%		\$710	\$1,066	--	--	\$721	\$1,082	--	--
	300%		\$2,130	\$3,198	--	--	\$2,163	\$3,246	--	--

Table 86, 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 apply⁴⁸. 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, or 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.

⁴⁸ For details regarding Medicaid eligibility, refer to the Wyoming Medicaid Online Eligibility Manual available at <http://ecom.health.wyo.gov>.

Table 86: 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		
	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	
	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		

Major Category Group	Eligibility Category	Benefits	Eligibility Requirement	Countable Income	Income Level	Resource Limits
Aged, Blind, or Disabled (ABD)	Aged, Blind, or Disabled 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		





Appendix E: 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 enrolled member at the time of service.

Council on Accreditation – An organization that accredits healthcare organizations.

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

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

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

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

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

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

Durable Medical Equipment, 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.

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

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

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

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

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

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

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

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

Federally Qualified Health Center (FQHC) – A designated health center in a medically 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 starting in SFY 2016.

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

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

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

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

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

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

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

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

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

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

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

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

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

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 enrolled member.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 87: Acronyms

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

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





Appendix F: 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 enrolled member 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 89 and 90 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 enrollment count, recipient count may be higher than enrollment count, because claims may be paid on recipients who are no longer enrolled in this State Fiscal Year but were enrolled 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 enrollment data is included in the Medicaid data and is also discussed separately in Appendix A.

Enrollment / Members

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

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

The dual enrollment data is extracted using the Cognos tool. First, individuals enrolled in 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 enrollment data. These results represent the population of dual individuals.

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

A count of members is a count of the number of unique members 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 20 (Table 88) 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 20 (Table 89) is utilized.

Table 88: Eligibility Program Codes

Eligibility Category	Eligibility Program Codes and Descriptions	
Children	A02	Family Care Past 5yr Limit <21
	A04	Family Care <21
	A50	AFDC Medicaid -I
	A54	2nd-6mos. Trans Mcaid Child -I
	A56	Alien: 245 (IRCA) Child -I
	A57	Baby <1 Yr, Mother SSI Elig -I
	A59	Retro Medicaid-"Pr" Child -I
	A60	4 Mo Extended Med <21
	A61	Institutional (AF-IV-E) -I
	A62	Retro Medicaid-"Rm" Child -I
	A63	Refugee Child -I
	A64	Alien: 245 (IRCA) Child -I
	A51	IV-E Foster Care
	A52	IV-E Adoption
	A85	Foster Care Title 19
	A86	Subsidized Adoption Title 19
	A88	Aging Out Foster Care
	A55	Child 0 Through 5 Yrs
	A53	Newborn
	S65	Cont Chldrns Ment Hlth Wvr <19
	S95	Chldns Ment Hlth Wvr SSI <21
Pregnant Women	A71	Pregnant Woman <21
	A72	Pregnant Woman >21
	A73	Qualified Pregnant Woman >21
	A19	Presumptive-Eligibility
Family Care	A01	Family Care Past 5yr Limit >21
	A03	Family Care >21
	A68	12 Mo Extended Med >21
	A69	2nd-6mos. Trans Mcaid Adult -I
	A70	AFDC Medicaid - Adult -I
	A65	AFDC-Up Unemployed Parent Ch -I
	A67	12 Mo Extended Med <21
	A87	16+ Not In School AF HH -I
	K03	Kidcare to Child Magi
	M02	Adult MAGI <21
	M03	Child MAGI
	M05	Family MAGI <21
	M10	Children's PE
	M12	Family MAGI PE <21
	M14	Adult MAGI PE <21
	S62	Continuous SSI Eligible <19
	A97	Foster Care 0 Through 5
	A98	Foster Care 6 Through 18
	M09	Former Foster Youth <21
	M17	Former Foster Youth PE <21
	S63	Continuous Foster Care <19
	A58	Child 6 Through 18 Yrs
	S96	Chldns Ment Hlth Wvr 300% <21
	A74	Qualified Pregnant Woman <21
	M06	Pregnancy MAGI >21
	M07	Pregnancy MAGI <21
	A80	Refugee Adult -I
	A82	Alien: 245 (IRCA) Adult -I
	A83	Alien: 210 (IRCA) Adult -I
	M01	Adult MAGI >21
	M04	Family MAGI >21

Eligibility Category	Eligibility Program Codes and Descriptions			
	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	Qual Disabled Working Ind
	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	S14	Institutional (Hosp) Aged -I	S34	Institutional (Hosp) Disabled -I
	S15	Inpatient Hospital 300% Cap>65	S35	Inpatient Hospital 300% Cap<65
	S13	Inpat-Psych >65		
ABD - Long-Term Care (Elderly/Physically Disabled)	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
	S50	Hospice Care >65	S51	Hospice Care <65
	N98	WLTC Temp Services	S46	LTC Waiver SSI <65
	S24	LTC Waiver SSI >65	S47	LTC Waiver 300% Cap <65
	S25	LTC Waiver 300% Cap >65		
	N97	NH Temp Services	S30	Retro Medicaid-"Pr" Disabled -I
	S01	NH-SSI & Ssa Blend >65	S32	Nursing Home SSI <65
	S02	NH-SSI & Ssa Blend <65	S33	Nursing Home 300% Cap <65
	S10	Nursing Home SSI >65	S54	Medicaid Only-No Rm & Brd >65
	S11	Nursing Home 300% Cap >65	S55	Medicaid Only-No Rm & Brd <65
	S17	Retro Medicaid-"Pr" Aged -I	S90	Retro Medicaid-"Rm" Disabled
	S18	Retro Medicaid-"Rm" Aged -I		
	P11	PACE < 65	P21	PACE > 65
	P12	PCMR < 65	P22	PCMR > 65
	P13	PACE SSI Disabled < 65	P23	PACE SSI Aged > 65
	P14	PACE Mcare SSI Disabled < 65	P24	PACE Mcare SSI Aged > 65
	P15	PACE NF < 65	P25	PACE NF > 65
	P16	PACE NF SSI Disabled < 65	P26	PACE NF SSI Aged > 65
	P17	PACE NF Mcare Disabled < 65	P27	PACE NF Mcare Aged > 65
	P18	PACE NF Mcare SSI Disable < 65	P28	PACE NF Mcare SSI Aged > 65
	B01	Acq Brain Injury Wvr SSI	S60	Acq Brain Injury Wvr W/EID <65
	B02	Acq Brain Injury Wvr 300%		
	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		
ABD - ID/DD/ABI	S58	DD Waiver W/EID <21	S93	DD Waiver SSI <21
	S64	Continuous DD <19	S94	DD Waiver 300% Cap <21
	W03	EID Comp Waiver Adult >21	W16	300% Comp Waiver Aged > 65
	W04	EID Comp Waiver Child <21	W22	EID Comp ABI Waiver Adult >21

Eligibility Category	Eligibility Program Codes and Descriptions			
	W08	SSI Comp Waiver Adult >21	W23	SSI Comp ABI Waiver Adult >21
	W09	SSI Comp Waiver Child <21	W24	SSI Comp ABI Waiver Aged >65
	W10	SSI Comp Waiver Aged >65	W25	300% Comp ABI Waiver Adult >21
	W14	300% Comp Waiver Adult >21	W26	300% Comp ABI Waiver Aged >65
	W15	300% Comp Waiver Child <21		
	S03	ICF-MR SSI >65	S05	ICF-MR SSI <65
	S04	ICF-MR 300% Cap >65	S06	ICF-MR 300% Cap <65
	W01	EID Support Waiver Adult >21	W13	300% Support Waiver Aged >65
	W02	EID Support Waiver Child <21	W17	EID Support ABI Waiver Adult >21
	W05	SSI Support Waiver Adult >21	W18	SSI Support ABI Waiver Adult >21
	W06	SSI Support Waiver Child <21	W19	SSI Support ABI Waiver Aged >65
	W07	SSI Support Waiver Aged >65	W20	300% Support Waiver Adult >21
ABD - Employed Individuals with Disabilities	W11	300% Support Waiver Adult >21	W21	300% Support Waiver Adult >65
	W12	300% Support Waiver Child <21		
Medicare Savings Programs	S56	Emp Ind/W Disabilities >21	S61	Continuous EID <19
	S57	Emp Ind/W Disabilities <21		
	Q17	QMB >65	Q41	QMB <65
	Q94	SLMB 2 >65	Q96	SLMB 1 >65
Non Citizens with Medical Emergencies	Q95	SLMB 2 <65	Q97	SLMB 1 <65
	Q98	Part B-Partial Aged -I	Q99	Part B-Partial Disabled -I
	A81	Emergency Svc <21	A84	Emergency Svc >21

Table 89: 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 Coverage		

Per Member Per Month

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

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 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 20 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 a member 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 20 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.

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

Data Parameters

Table 90: Data Parameters by Service Area⁴⁹

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code ⁵⁰	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Ambulance – Total	341600000X: Ambulance					
	Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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

⁴⁹ All services areas, except behavioral health, exclude behavioral health procedure code lines.

⁵⁰ Chart A is defined as Chart A version 18

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code ⁵⁰	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
	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					
Behavioral Health – Total	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: <ul style="list-style-type: none"> 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 ⁵⁰	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	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: <ul style="list-style-type: none"> 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	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 ⁵⁰	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Dental	122300000X: Dentist 1223D0001X: Dental Public Health 1223E0200X: Endodontics 1223G0001X: General Practice Dentist 1223P0221X: Pedodontics 1223P0300X: Periodontics 1223S0112X: Surgery, Oral and Maxillofacial 1223X0400X: Orthodontics	Expenditures - Chart A				
	Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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 	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 ⁵¹
DME, Prosthetics/Orthotics and Supplies – Total	332B00000X: DME 332S00000X: Hearing Aid Equipment 335E00000X: POS					
	Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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
DME Only	332B00000X: DME Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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

⁵¹ 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 ⁵⁰	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Prosthetics/Orthotics and Supplies Only	335E0000X: POS					
	Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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
Federally Qualified Health Center	261QF0400X: Federally Qualified Health Center					
	Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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 ⁵⁰	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Home Health	251E00000X: Home Health					
	Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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
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: <ul style="list-style-type: none"> 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 ⁵⁰	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Hospital – Inpatient	282N00000X: General Acute Care Hospital 282NR1301X: General Acute Care Hospital - Rural 283Q00000X: Psychiatric Hospital 283X00000X: Rehabilitation Hospital					
	Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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
Hospital – Outpatient	261QR0400X: Rehabilitation 282N00000X: General Acute Care Hospital 282NR1301X: General Acute Care Hospital - Rural 283X00000X: Rehabilitation Hospital					
	Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code ⁵⁰	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Hospital – Emergency Room	261QR0400X: Rehabilitation 282N00000X: General Acute Care Hospital 282NR1301X: General Acute Care Hospital - Rural 283X00000X: Rehabilitation Hospital Revenue Codes: 0450 through 0459 Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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 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	O, V	All Paid and All Medical
	291U00000X: Clinical Medical Laboratory Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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 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
Nursing Facility	275N00000X: Medicare Defined Swing Bed 314000000X: Skilled Nursing Facility Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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 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

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code ⁵⁰	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
PACE	251T00000X: PACE Organization					
	Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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 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
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	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
	Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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 90836, 90838, 90785 on same claim with same treating provider 					

Service Area	Provider Taxonomy and Procedure Codes	Recipient Program Code ⁵⁰	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Physician	<p>207W00000X: Ophthalmologist, excluding diagnosis V72.0 (routine vision services)</p> <p>All taxonomies starting with '20', except</p> <p>2084P0800X: Psychiatrists 363A00000X: Physician Assistant</p> <p>Exclude Behavioral Health Procedures:</p> <ul style="list-style-type: none"> 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 	<p>Expenditures - Chart A</p> <p>Counts - Chart A, excluding N96, N99, S97, ZZZ, P07</p>	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	<p>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</p> <p>Exclude Behavioral Health Procedures:</p> <ul style="list-style-type: none"> 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 	<p>Expenditures - Chart A</p> <p>Counts - Chart A, excluding N96, N99, S97, ZZZ, P07</p>	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 ⁵⁰	Claim Adjustment Status Code	Claim Accounting Code	Claim Type	Cognos Claims Path
Prescription Drug	333600000X: Pharmacy					
	Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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
Public Health, Federal	261QP0904X: Public Health, Federal					
	Exclude Behavioral Health Procedures: <ul style="list-style-type: none"> 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 ⁵⁰	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: <ul style="list-style-type: none"> 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
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 ⁵⁰	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 251X00000X: PACE PPL	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 ⁵⁰	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 91: 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 - O, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Dual Enrolled Members	All	Expenditures - Chart A				
		Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures - ALL Counts - O, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Emergency Room Services	99281 thru 99285					
	OR					
	Place of Service: 23 AND Procedure Codes in Emergency Department Procedure Code Value Set (Table 92)	Expenditures - Chart A				
	OR	Counts - Chart A, excluding N96, N99, S97, ZZZ, P07	Expenditures - ALL Counts - O, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Medical and Outpatient w/ Line Items
	Revenue Code: 0450, 0451, 0452, 0456, 0459, 0981					
Foster Care - Medicaid	All	A51, A52, A85, A86, A88, A97, A98, S63	Expenditures - ALL Counts - O, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid and All Medical
Foster Care - State Funded⁵²	All	A95, A96, A99	Expenditures - ALL Counts - O, 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 - O, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid
Project Out⁵³	All	P05	Expenditures - ALL Counts - O, F only	Exclude History: 1, 6, 7, G, H, I, J, K, L	All	All Paid

⁵² State-Funded Foster Care is a non-Medicaid program.⁵³ Project Out is a non-Medicaid program.

Table 92: Emergency Department Procedure Code Value Set

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

Emergency Department Procedure Code Value Set													
20936	20937	20938	20950	20955	20956	20957	20962	20969	20970	20972	20973	20974	20975
20979	20982	20985	20999	21010	21011	21012	21013	21014	21015	21016	21025	21026	21029
21030	21031	21032	21034	21040	21044	21045	21046	21047	21048	21049	21050	21060	21070
21073	21076	21077	21079	21080	21081	21082	21083	21084	21085	21086	21087	21088	21089
21100	21110	21116	21120	21121	21122	21123	21125	21127	21137	21138	21139	21141	21142
21143	21145	21146	21147	21150	21151	21154	21155	21159	21160	21172	21175	21179	21180
21181	21182	21183	21184	21188	21193	21194	21195	21196	21198	21199	21206	21208	21209
21210	21215	21230	21235	21240	21242	21243	21244	21245	21246	21247	21248	21249	21255
21256	21260	21261	21263	21267	21268	21270	21275	21280	21282	21295	21296	21299	21310
21315	21320	21325	21330	21335	21336	21337	21338	21339	21340	21343	21344	21345	21346
21347	21348	21355	21356	21360	21365	21366	21385	21386	21387	21390	21395	21400	21401
21406	21407	21408	21421	21422	21423	21431	21432	21433	21435	21436	21440	21445	21450
21451	21452	21453	21454	21461	21462	21465	21470	21480	21485	21490	21495	21497	21499
21501	21502	21510	21550	21552	21554	21555	21556	21557	21558	21600	21610	21615	21616
21620	21627	21630	21632	21685	21700	21705	21720	21725	21740	21742	21743	21750	21800
21805	21810	21820	21825	21899	21920	21925	21930	21931	21932	21933	21935	21936	22010
22015	22100	22101	22102	22103	22110	22112	22114	22116	22206	22207	22208	22210	22212
22214	22216	22220	22222	22224	22226	22305	22310	22315	22318	22319	22325	22326	22327
22328	22505	22520	22521	22522	22523	22524	22525	22526	22527	22532	22533	22534	22548
22551	22552	22554	22556	22558	22585	22586	22590	22595	22600	22610	22612	22614	22630
22632	22633	22634	22800	22802	22804	22808	22810	22812	22818	22819	22830	22840	22841
22842	22843	22844	22845	22846	22847	22848	22849	22850	22851	22852	22855	22856	22857
22861	22862	22864	22865	22899	22900	22901	22902	22903	22904	22905	22999	23000	23020
23030	23031	23035	23040	23044	23065	23066	23071	23073	23075	23076	23077	23078	23100
23101	23105	23106	23107	23120	23125	23130	23140	23145	23146	23150	23155	23156	23170
23172	23174	23180	23182	23184	23190	23195	23200	23210	23220	23330	23331	23332	23350
23395	23397	23400	23405	23406	23410	23412	23415	23420	23430	23440	23450	23455	23460
23462	23465	23466	23470	23472	23473	23474	23480	23485	23490	23491	23500	23505	23515
23520	23525	23530	23532	23540	23545	23550	23552	23570	23575	23585	23600	23605	23615
23616	23620	23625	23630	23650	23655	23660	23665	23670	23675	23680	23700	23800	23802
23900	23920	23921	23929	23930	23931	23935	24000	24006	24065	24066	24071	24073	24075
24076	24077	24079	24100	24101	24102	24105	24110	24115	24116	24120	24125	24126	24130
24134	24136	24138	24140	24145	24147	24149	24150	24152	24155	24160	24164	24200	24201
24220	24300	24301	24305	24310	24320	24330	24331	24332	24340	24341	24342	24343	24344

Emergency Department Procedure Code Value Set													
24345	24346	24357	24358	24359	24360	24361	24362	24363	24365	24366	24370	24371	24400
24410	24420	24430	24435	24470	24495	24498	24500	24505	24515	24516	24530	24535	24538
24545	24546	24560	24565	24566	24575	24576	24577	24579	24582	24586	24587	24600	24605
24615	24620	24635	24640	24650	24655	24665	24666	24670	24675	24685	24800	24802	24900
24920	24925	24930	24931	24935	24940	24999	25000	25001	25020	25023	25024	25025	25028
25031	25035	25040	25065	25066	25071	25073	25075	25076	25077	25078	25085	25100	25101
25105	25107	25109	25110	25111	25112	25115	25116	25118	25119	25120	25125	25126	25130
25135	25136	25145	25150	25151	25170	25210	25215	25230	25240	25246	25248	25250	25251
25259	25260	25263	25265	25270	25272	25274	25275	25280	25290	25295	25300	25301	25310
25312	25315	25316	25320	25332	25335	25337	25350	25355	25360	25365	25370	25375	25390
25391	25392	25393	25394	25400	25405	25415	25420	25425	25426	25430	25431	25440	25441
25442	25443	25444	25445	25446	25447								