WYOMING MEDICAID

ANNUAL REPORT

2·0·1·8

Wyoming
Department
of Health

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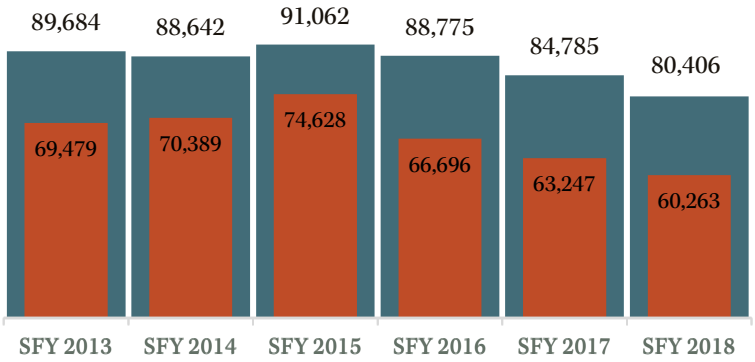
80,406

members enrolled at any point during the SFY with 60,263 enrolled each month on average



9.3 months of average enrollment per member

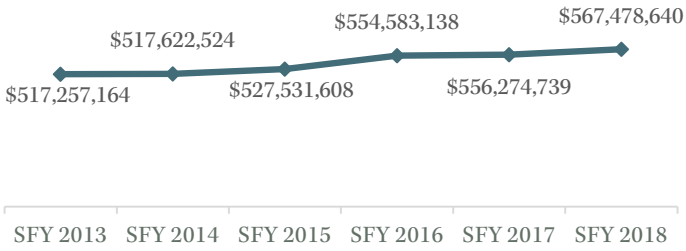
13.6% of Wyoming residents are enrolled in Medicaid

60% of members are children under age 21

44% of members reside in 3 counties: Laramie, Natrona, and Fremont

$567,478,640

total paid to providers



55% medical

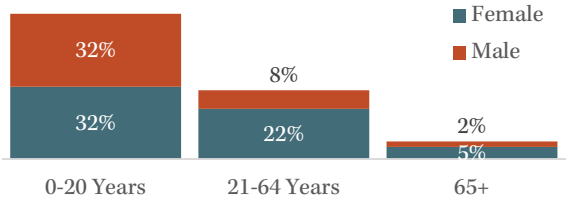
42% long-term care

3% dental / vision / other

3,456 providers paid with over 18,600 providers actively enrolled at any point during the SFY

74,056

enrolled members with claims paid



$726 preliminary Per Member Per Month

84% had physician & other practitioner claims

57% had prescription drug claims

53% had hospital claims


GREAT SEAL OF THE STATE OF WYOMING
EQUAL RIGHTS
1869
1890

WYOMING MEDICAID BACKGROUND

WHAT IS WYOMING MEDICAID?

Wyoming Medicaid is a joint federal and state government program that pays for medical care for low income individuals and families. 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.

The Division of Healthcare Financing (DHCF) within the Wyoming Department of Health (WDH) is the state-appointed entity for administration of Wyoming Medicaid. DHCF partners with the Fiscal Division for accounting and budgeting services and with the Behavioral Health Division for the administration of waivers that serve persons with developmental disabilities or acquired brain injuries.

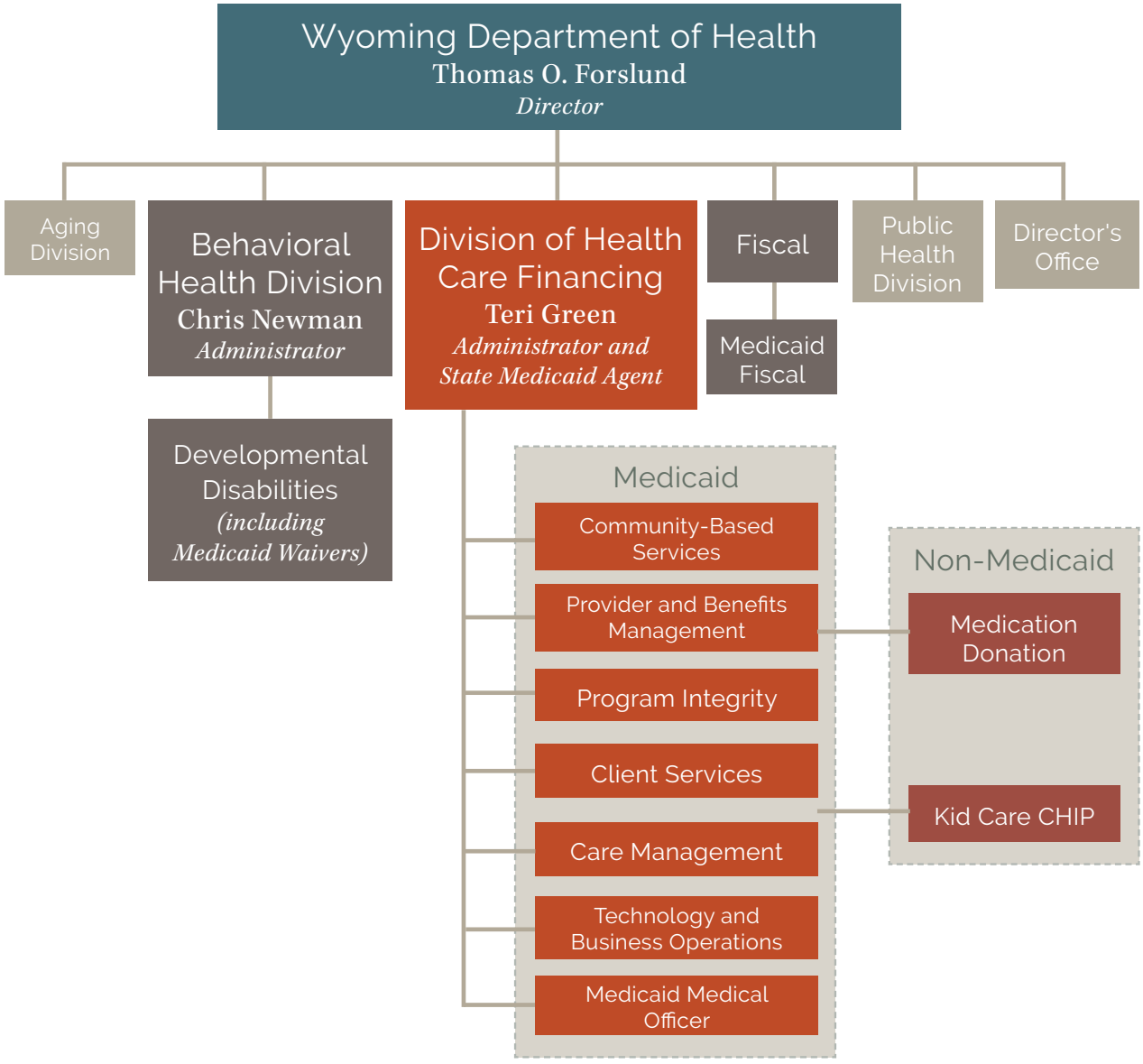


Figure 1. Wyoming Department of Health Organization Chart

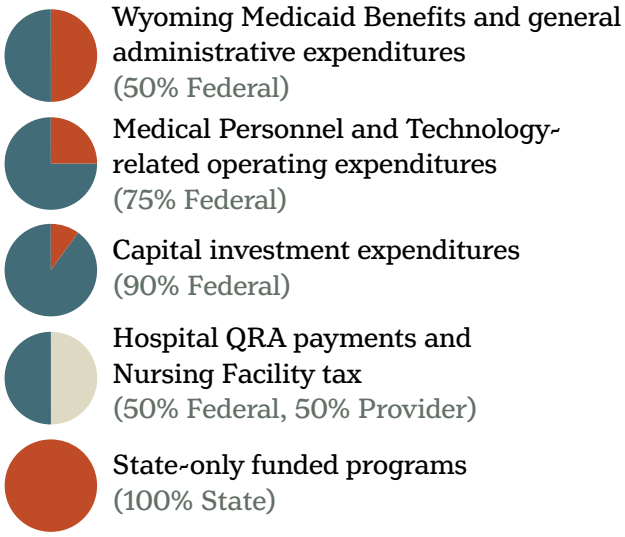
Enrolled providers must submit claims to Medicaid for reimbursement within one year of the date of service. These claims are processed through the Medicaid Management Information System (MMIS). This Annual Report focuses on the members enrolled during SFY 2017 and claims paid during SFY 2017, regardless of when service was rendered.

Table 1 below addresses the other DHCF expenditures in SFY 2017, such as administrative costs, capital investment, the Kid Care CHIP program, and non-Medicaid programs.

Table 1. Division of Health Care Financing Budget

Medicaid Related Expenditures	
Expenditure Type	SFY 2018 (millions)
Annual Report Benefit Expenditures (this report)[1]	$567.5
Medicaid Administration	$47.3
Nursing Facilities Tax Assessment	$33.4
Hospital Qualified Rate Adjustment (QRA) Payments	$30.9
Medicare Buy-In	$18.5
Medicaid One-Time Capital Expenses for New Technology Systems (WES, MMIS, Other)	$15.9
Medicare Clawback (Part D)	$24.4
Physician Electronic Health Record (EHR) Incentives	$0.3
Other[2]	-$7.0
Subtotal Medicaid Expenditures	$731.2
Drug Rebates	-$36.8
Total Medicaid Expenditures	$694.4
Non-Medicaid Expenditures	
Children's Health Insurance Program (CHIP)	$10.8
CHIP Administration	$0.9
State Only Foster Care and General Fund Foster Care (Court Orders)	$1.8
Supplemental Security Income (SSI) Payments	$1.1
Total Health Record (Health Information Exchange (HIE))	$2.0
State Only Other	$1.1
Total Non-Medicaid Expenditures	$17.7
Total Division of Healthcare Financing	$712.1

WYOMING MEDICAID FUNDING



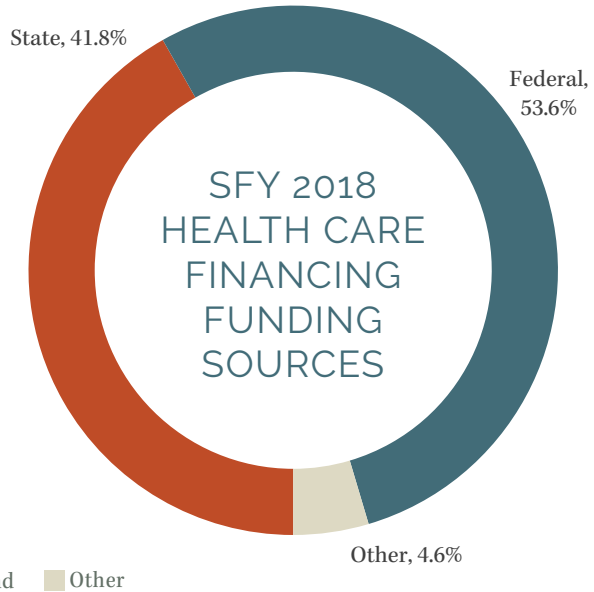
Wyoming Medicaid Benefits and general administrative expenditures (50% Federal)

Medical Personnel and Technology-related operating expenditures (75% Federal)

Capital investment expenditures (90% Federal)

Hospital QRA payments and Nursing Facility tax (50% Federal, 50% Provider)

State-only funded programs (100% State)



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

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

Table 2. Wyoming Medicaid Advisory Groups and Committees

Advisory Group	Members	Description
Dental Advisory Group (DAG)	Two specialists, three general dentists, and representatives from Medicaid and its fiscal agent, Conduent.	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.
Tribal Leadership Advisory Group	Tribal Business Council members, leadership and executives from tribal health clinics and Indian Health Services, long-term care providers, and representatives from all Wyoming Department of Health divisions	Focuses on new and upcoming issues within the healthcare industry, consultation with the Tribal leaders, updates from facilities, and work to develop solutions and programs to decrease barriers for this group.

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

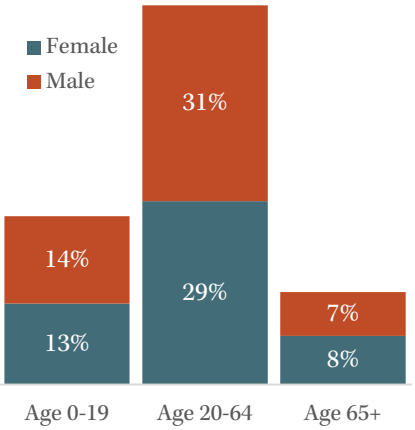
Table 3. Medicaid Cost Avoidance and Recoveries - SFY 2018

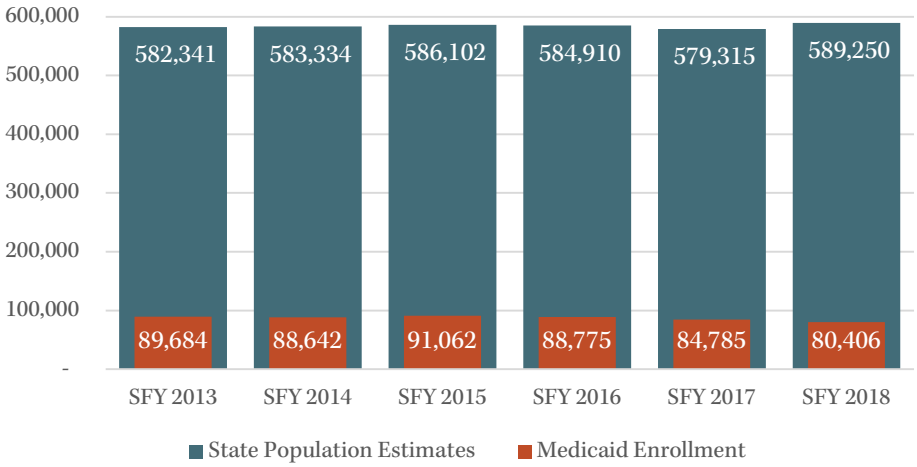
Program Area	Description	Amount Recovered
Program Integrity	Process of reviewing, auditing, and investigating providers for claims lacking sufficient documentation or incorrect billing.	$1,332,499
Third Party Liability Recoveries	Funds recovered from other responsible parties which may include Medicare, health insurance companies, worker's compensation, casualty insurance companies, or a spouse/parent court order to carry health insurance.	$5,205,642
Third Party Liability Cost Avoidance	An estimate of costs not incurred by the State when claims are denied up front due to third party liability. This figure is calculated based on billed charges, not on the final amount Medicaid would have paid -- as the claims are not fully processed once TPL is determined; therefore, this figure is only an estimate and may be inflated. As such, the program integrity team is currently reviewing and auditing their process for calculating this figure.	$11,412,314
Estate Recoveries	Funds recovered from any real or personal property a client had legal title or interest in at the time of death, including such assets conveyed to a survivor heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship life estate, living trust or other arrangement.	$3,603,406
Credit Balances	Moneys recovered from providers whose credits (i.e. take-backs or adjustments) exceed their debits (pay-outs or paid claims).	$76,684
Total Recovered Dollars (excluding Cost Avoidance)		$10,218,231
Total Recovered Dollars (including Cost Avoidance)		$21,630,545

WYOMING DEMOGRAPHICS & ECONOMY

13.6%
of Wyoming residents enrolled in Medicaid

27%
of residents under age 20





State Population[3] *increased* by

1.7%

from 2013 to 2018

Medicaid enrollment *decreased* by

5.1%

from SFY 2013 to SFY 2018

HOW WYOMING COMPARES

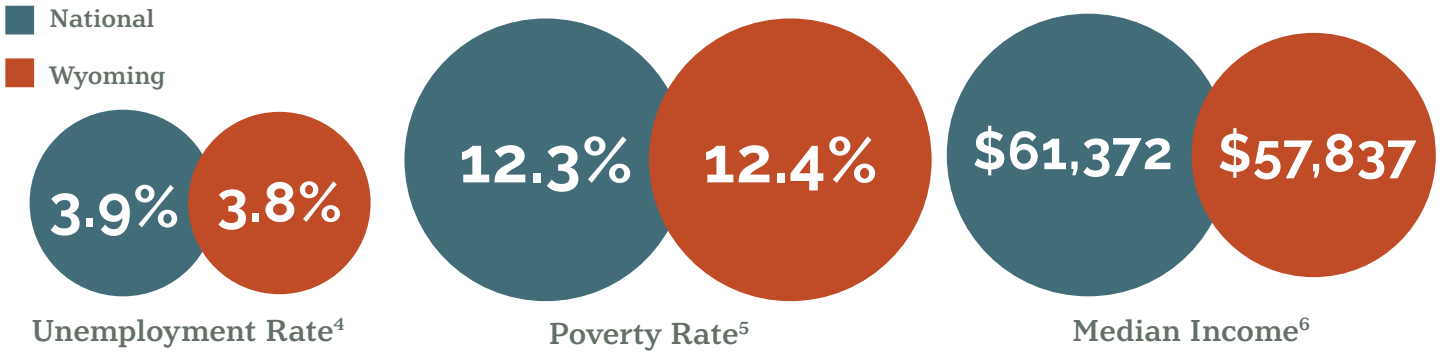


Table 4. Employment and Mean Wages by Occupation[7,8]

	Employment Total Percent Change 2007 to 2017		Wages Total Percent Change 2007 to 2017		Mean Hourly Wages 2017	
	US	WY	US	WY	US	WY
All Occupations	6.1%	-1.9%	29.2%	32.0%	$24.34	$22.91
Healthcare Practitioners & Technical Occupations	23.7%	25.0%	24.2%	32.9%	$38.83	$38.82
Healthcare Support Workers	13.5%	9.4%	22.3%	30.3%	$15.05	$15.23

[3] 2017 forecast population prepared by Wyoming Department of Administration & Information, Economic Analysis Division (http://eadiv.state.wy.us), August 2017

[4] Senate Joint Economic Committee, Wyoming Employment Report, August 2018, https://www.jec.senate.gov/public/_cache/files/df4f4d70-a0af-4f32-9e77-d83910535e47/wyoming-employment-update.pdf

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

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

[6] Bureau of Labor Statistics, May 2017 State Occupational Employment and Wage Estimates, Wyoming. http://www.bls.gov/oes/current/oes_wy.htm

[7] Bureau of Labor Statistics, May 2017 State Occupational Employment and Wage Estimates, United States. http://www.bls.gov/oes/current/oes_nat.htm

HIGHLIGHTS & INITIATIVES

Third Party Liability program manager moved to client services, allowing for additional support of TPL services, as well as cross-training with Benefit Coordination Unit.

Pharmacy Benefit Management System (PBMS) went live on July 23, 2017

This contract and new system brought new capabilities including:
1) consolidating all rebate activities into a single vendor,
2) medication therapy management,
3) enhanced Third Party Liability capabilities,
4) enhanced reporting and other technical capabilities,
5) online enrollment application for pharmacy providers,
6) processing and editing of IHS pharmacy claims in the Pharmacy point of sale system

The project continued operations and prepared for Federal certification (November 2018).

Implemented additional interfaces with WES for increased electronic of social security data.

Implemented New Medicare Card initiative

Implemented T-MSIS file sharing process with CMS

Moved tribal pharmacy claims to processing through Pharmacy Benefit Management System (PBMS)

Asset Verification System

Implemented cloud-based program to verify assets of individuals on or applying for Aged, Blind, or Disabled programs

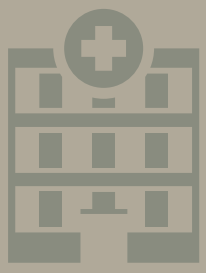
WINGS Project Procurements and Start-Ups

- Fraud, Waste, and Abuse (FWA) contract awarded to Deloitte Transactions and Business Analytics LLP
- Third Party Lability & Buy-In Solution (TPL) released in March 2018. Received no vendor responses. TPL scope of work moved to Beneftis Management System and Services module with the Buy-In scope moved under the WES program.
- Data Warehouse with Business Intelligence Tools & Reporting (DW/BI-R) contract with Deloitte Consulting LLP, fully executed in March 2018
- System Integrator/Enterprise Service Bus (SI/ESB) contract with Deloitte Consulting LLP, executed in Fall 2017.

Launched POSSE interface within WES to allow for increased referrals to POSSE for Medicaid adults required to cooperate with Child Support Enforcement.

Will be adding increased functionality in SFY 2019 to improve coordination.

Entered into a contract to allow Tribal Eligibility Workers to process application for Medicaid MAGI programs within WES



BUDGET

$54,438,246 required reduction in State General Funds for 2017-18 biennium → **$28,104,512** corresponding reduction in Federal Funds

In total, State General Fund Reduced by 9.01%

Total budget (State, Federal, Other funds) reduced by 5.6%

Reductions primarily concentrated on Medicaid; however, reductions were also made to Kid Care CHIP program, state general fund budget, and other non-Medicaid programs. Some major reductions included:

- Eliminated State Licensed Shelter Care Program allowing for 50/50 FMAP for a program previously covered by 100% state general fund
- Reduced provider reimbursement rates by 3.3%
- Eliminated coverage of nursing facility reserve bed days
- Revised reimbursement methodology for processing Medicare crossover claims
- Reduced coverage of adult dental services

Adjusted SFY 2017 Care Management Entity (CME) premium payment claims to the newly approved CMS rate and SFY 2018 adjustments are currently underway.

Rate changes associated with the adjustments have reduced PMPM payments by 65% for dates of service during state fiscal years 2017 and 2018

Physical, Occupational, and Speech therapy services began requiring a prior authorization above the threshold of 20 visits per calendar year for all ages of clients, November 1, 2017

Behavioral health services began requiring a prior authorization for those services above the threshold of 20 visits per calendar year for adults 21 and older, November 1, 2017

WYOMING INTEGRATED NEXT GENERATION SYSTEM

Modules 5 and 7 will be issued as one proucrement.

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

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

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

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

2·0·1·8 A CLOSER LOOK

This section provides more detail on the performance of Wyoming Medicaid in SFY 2018, comparing enrollment, expenditures, and recipient counts across the past six years.

ENROLLMENT

SFY 2018 saw a decrease in enrollment of 5.2 percent from the previous SFY, with 80,406 unique individuals enrolled at any time during the SFY.

80,406

members enrolled at any point during the SFY with 60,263 members enrolled on average each month

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

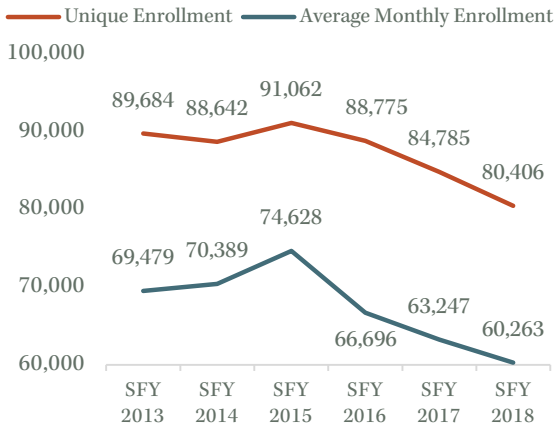


Figure 2. Enrollment History: Unique and Monthly Average

Table 5. Change in Medicaid Enrollment

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Unique Enrollment	89,684	88,642	91,062	88,775	84,785	80,406
% Change from Previous SFY	--	-1.2%	2.7%	-2.5%	-4.5%	-5.2%
Average Monthly Enrollment	69,479	70,389	74,628	66,696	63,247	60,263
% Change from Previous SFY	--	1.3%	6.0%	-10.6%	-5.2%	-4.7%
Average Length of Enrollment (months)	9.2	9.5	9.8	9.2	9.2	9.3

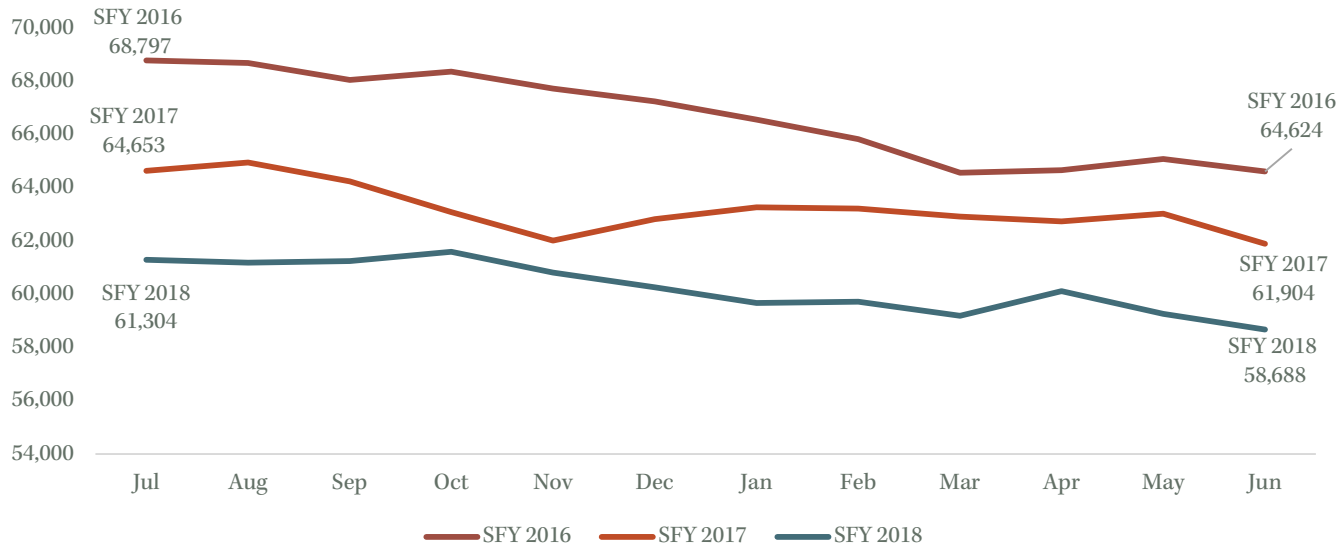


Figure 3. Monthly Medicaid Enrollment by State Fiscal Year

Medicaid enrolled members reside in every county in Wyoming, with more than half residing in 5 counties: Laramie (17 percent), Natrona (16 percent), Fremont (12 percent), Campbell (8 percent), and Sweetwater (7 percent).

County 'Other' indicates individuals who were at one time enrolled in Medicaid, but have moved out of state. Member county of residence is based on the address on file at the time the data is extracted.

Table 6. Medicaid Enrollment by County

County	Enrolled Members	Percent of Total
Albany	3,492	4.3%
Big Horn	2,048	2.5%
Campbell	6,002	7.5%
Carbon	1,940	2.4%
Converse	1,886	2.3%
Crook	784	1.0%
Fremont	9,598	11.9%
Goshen	1,794	2.2%
Hot Springs	800	1.0%
Johnson	890	1.1%
Laramie	13,709	17.0%
Lincoln	1,758	2.2%
Natrona	12,472	15.5%
Niobrara	307	0.4%
Other	1,743	2.2%
Park	3,520	4.4%
Platte	1,140	1.4%
Sheridan	3,657	4.5%
Sublette	706	0.9%
Sweetwater	5,639	7.0%
Teton	1,296	1.6%
Uinta	3,269	4.1%
Washakie	1,102	1.4%
Weston	854	1.1%
Total	80,406	

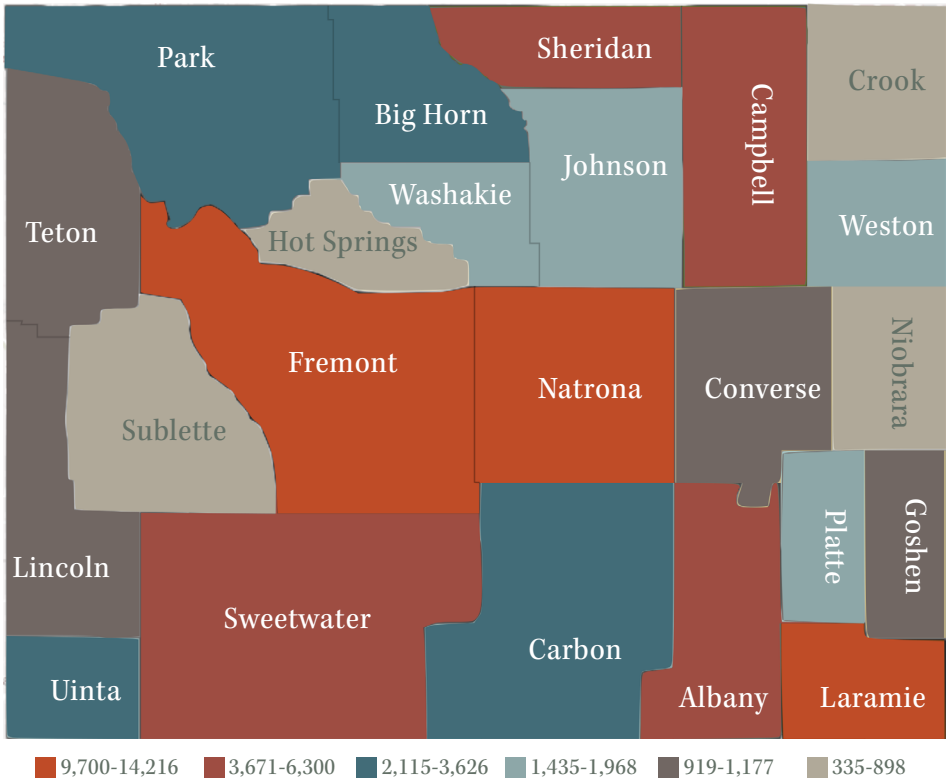


Figure 4. Wyoming County Map by Medicaid Enrollment

EXPENDITURES

In SFY 2018, the amount paid to providers remained relatively stable with a slight increase of 2 percent from SFY 2017.

$567,478,640
total paid to providers

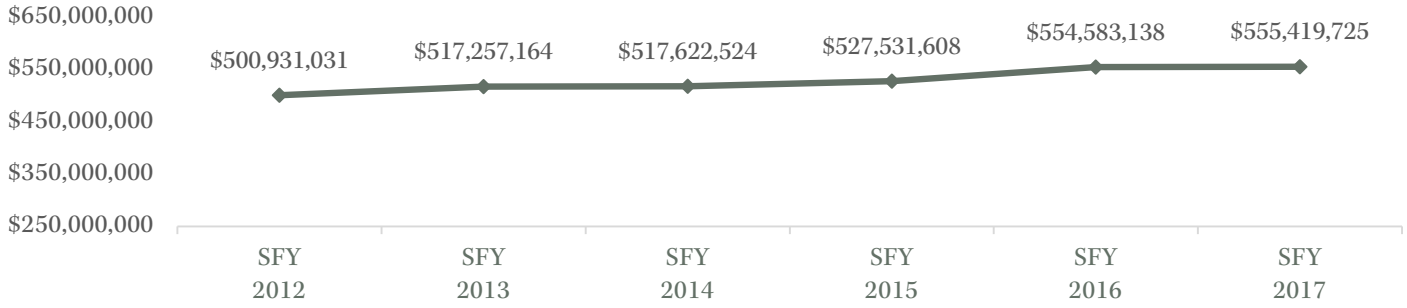


Figure 5. Expenditure History

As providers have up to one year from the date of service to submit claims to Medicaid for reimbursement, these expenditures include payments for services rendered prior to the start of SFY 2017.

Table 7. Expenditure History by Service Type

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Medical	$283,615,999	$284,761,312	$300,054,010	$303,594,435	$297,461,585	$309,898,364
Long-Term Care	$216,353,891	$215,466,756	$208,759,250	$230,992,217	$239,788,830	$241,030,693
Dental	$13,272,110	$13,391,934	$14,473,863	$15,450,029	$14,167,617	$11,847,581
Vision	$3,389,793	$3,464,394	$3,595,216	$3,652,188	$3,850,574	$3,712,855
Other	$625,371	$538,127	$649,268	$894,268	$1,006,132	$989,147

Figure 6, below, shows how SFY 2018 paid expenditures compared to SFY 2017 for top services. Only services with over $5 million in expenditures in either SFY have been included in the figure. More detailed information on services is available in the Services section of this report.

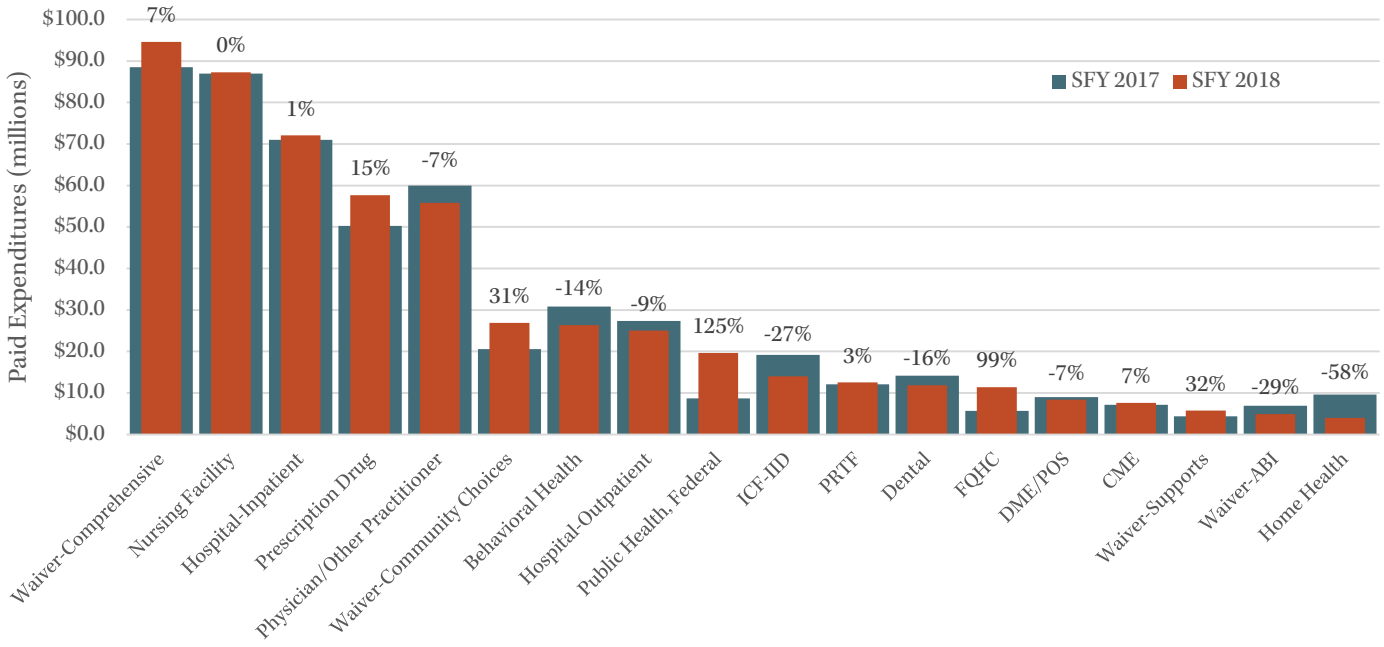


Figure 6. Change in Expenditures from SFY 2017 to SFY 2018 for Top Services

RECIPIENTS

In SFY 2018, the number of enrolled members who had claims paid during the year increased minimally by 0.1 percent from the previous SFY. Figure 7, below, shows the comparison between service utilization and expenditures; while 95 percent of recipients used Medical services, these only accounted for 53 percent of total Medicaid expenditures.

74,056
enrolled members with claims paid

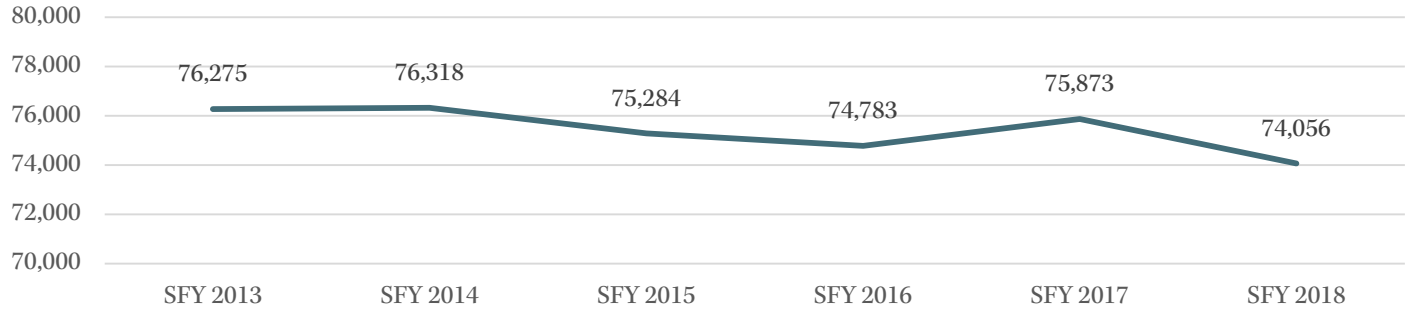


Figure 7. Recipient History

Table 8. Recipient History by Service Type

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Medical	72,851	73,122	71,794	70,687	72,143	70,960
Long-Term Care	6,771	6,688	6,967	7,317	7,532	7,638
Dental	28,530	29,169	30,635	31,843	31,405	28,732
Vision	14,180	14,558	15,010	15,227	15,612	15,804
Other	1,857	1,642	1,643	1,945	2,913	3,183

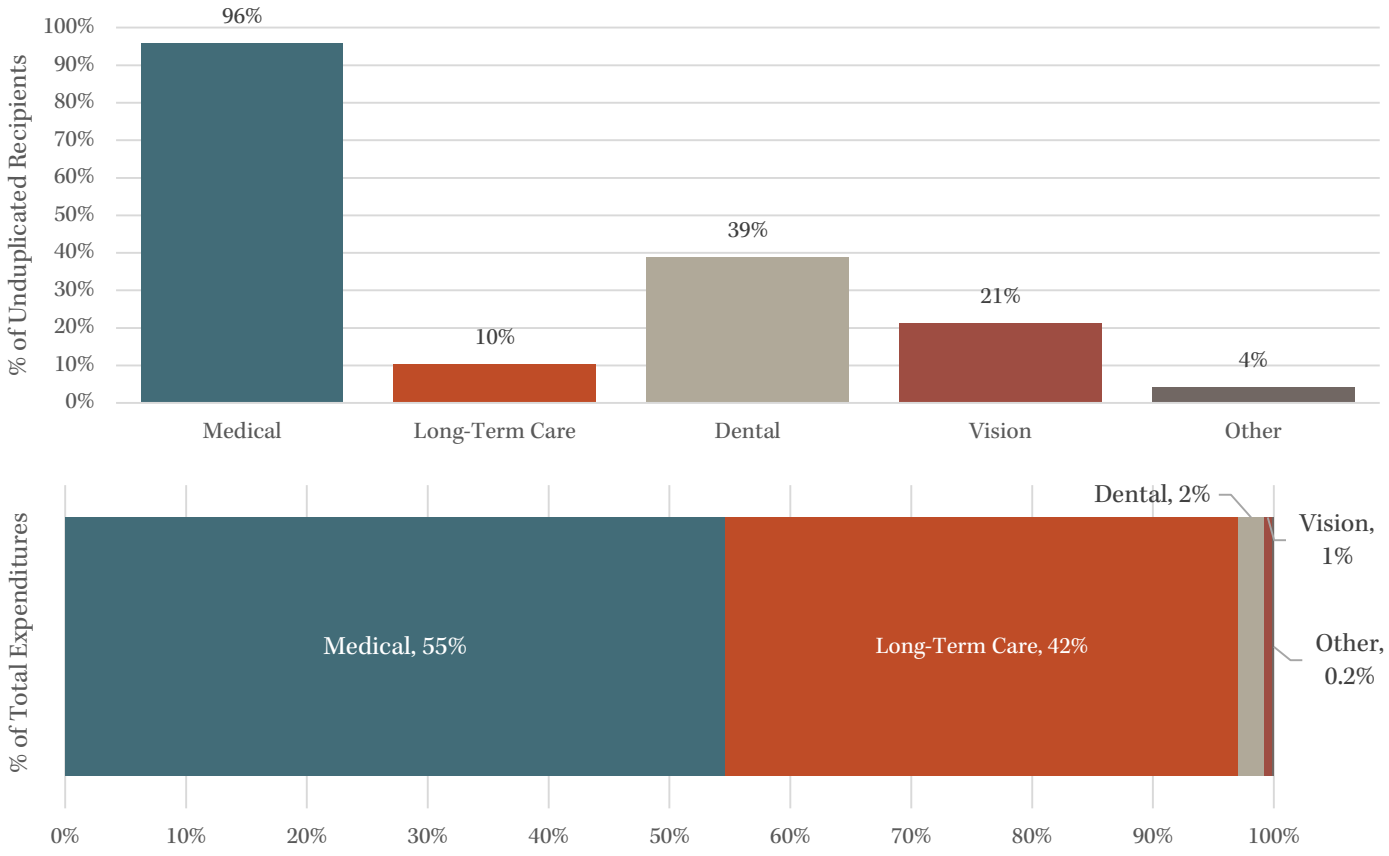


Figure 8. Recipient Utilization versus Expenditure Breakdown by Service Type

ELIGIBILITY CATEGORIES

Federal statutes define individuals who qualify for Medicaid coverage, with eligibility determined using Federal Poverty Level (FPL) guidelines, Supplemental Security Income (SSI) standards, or the 1996 Family Care income standard. The FPL guidelines and SSI standards are based on an index that changes each year. See Appendix C for more information. For this report, Medicaid enrolled members are presented in 11 eligibility categories, as shown below:

AGED, BLIND, OR DISABLED

Employed Individuals with Disabilities (EID)
- Premium payments required
- No SSI eligibliity requirement
- Income standard: SSI

Institution
- Residents of a hospital or the WY state hospital (Age 65+)
- Resources taken into consideration / No SSI eligibility requirement
- Income standard: SSI

Individuals with Intellectual/Developmental Disabilities or Acquired Brain Injury (ID/DD/ABI)
- Individuals with intellectual/developmental disabilities or acquired brain injury or residents of Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) (WY Life Resource Center)
- No SSI eligibility requirement / Income standard: SSI

Long-Term Care (LTC)
- Residents of Nursing Facilities / Individuals receiving hospice care / Individuals needing nursing facility level of care who choose to receive services at home or in the community
- Resources taken into consideration / No SSI eligibility requirement
- Income standard: SSI

Supplemental Security Income (SSI)
- Individuals receiving SSI qualify
- Individuals no longer receiving SSI may still be eligible

Adults
- Adult caretaker relatives with a dependent child; must cooperate with child support enforcement; Income standard: set values
- Former foster care; aged out of foster care at 18 years old; As of January 1, 2014, remain eligible until age 26
- Presumptive eligibilty available for immediate/temporary coverage

Children
- Newborns; automatically eligible if mother is eligible for Medicaid at time of birth
- Children; Household income standard: FPL and dependent on child's age
- Children with severe mental health needs
- Foster care; automatically eligible when in Department of Family Services (DFS) custody, including some who enter subsidized adoption; WDH covers medical services for children in foster care who are not eligible for Medicaid, using state funds (tracked separately)
- Presumptive eligibility available for immediate/temporary coverage

Non-Citizens with Medical Emergencies
- Individuals who meet all Medicaid eligibility factors except citizenship and social security number
- Covers only emergency services, including labor and delivery

Medicare Savings
- Medicare individuals not eligible for other Medicaid programs
- Qualified Medicare Beneficiary (QMB) has resources taken into consideration; Covers premiums, deductibles, and cost sharing
- Specified Low-Income Medicare Beneficiaries (SLMB) and Qualified Individuals (QI); Covers premiums only
- Income standard: FPL

Pregnant Women
- Pregnant women
- Income standard: FPL based on household size
- May be required to cooperate in establishing paternity for the baby
- Presumptive eligibility available for immediate/temporary coverage

Special Groups
- Breast and Cervical Cancer Treatment Program for uninsured women with breast or cervical cancer; income standard: FPL; presumptive eligibility available for immediate/temporary coverage
- Pregnant by Choice Waiver for individuals who received Medicaid benefits through the pregnant women program and no longer qualify for other Medicaid programs; covers family planning services only
- Tuberculosis program for individuals with tuberculosis; resources taken into consideration; income standard: SSI

Table 9. Eligibility Category Summary

Eligibility Category	Enrolled Members	% Change from SFY 2017	Unique Recipients	% Change from SFY 2017	Expenditures	% Change from SFY 2017
ABD EID	404	-19	450	-12	$3,170,198	-29
ABD ID/DD/ABI	2,603	-1	2,631	-1	$139,120,839	-4
ABD Institution	55	-31	89	-18	$2,489,828	-11
ABD LTC	5,007	2	5,198	3	$137,811,401	3
ABD SSI	6,609	-7	6,255	-1	$57,608,075	4
Adults	10,989	-7	9,914	-3	$46,008,562	13
Children	47,919	-6	44,760	-3	$149,233,800	6
Medicare Savings Programs	4,978	0	2,816	-2	$1,654,936	-48
Non-Citizens with Medical Emergencies	195	-33	147	-41	$713,218	-31
Pregnant Women	4,336	-9	5,115	-3	$25,247,867	-4
Screenings & Gross Adjustments	--	--	--	--	$2,959,972	111
Special Groups	121	-26	115	-13	$1,459,944	-4
Total	80,406	-5	74,056	-2	$567,478,640	2

The figure below illustrates the distribution of members across the eligibility categories compared to the expenditures for those categories. While children represented 60% of all enrolled members for SFY 2017, the expenditures for children receiving services only accounted for 26% of total Medicaid expenditures. The ABD ID/DD/ABI and ABD LTC populations accounted for 9% of all enrolled members for the SFY but 49% of total Medicaid expenditures.

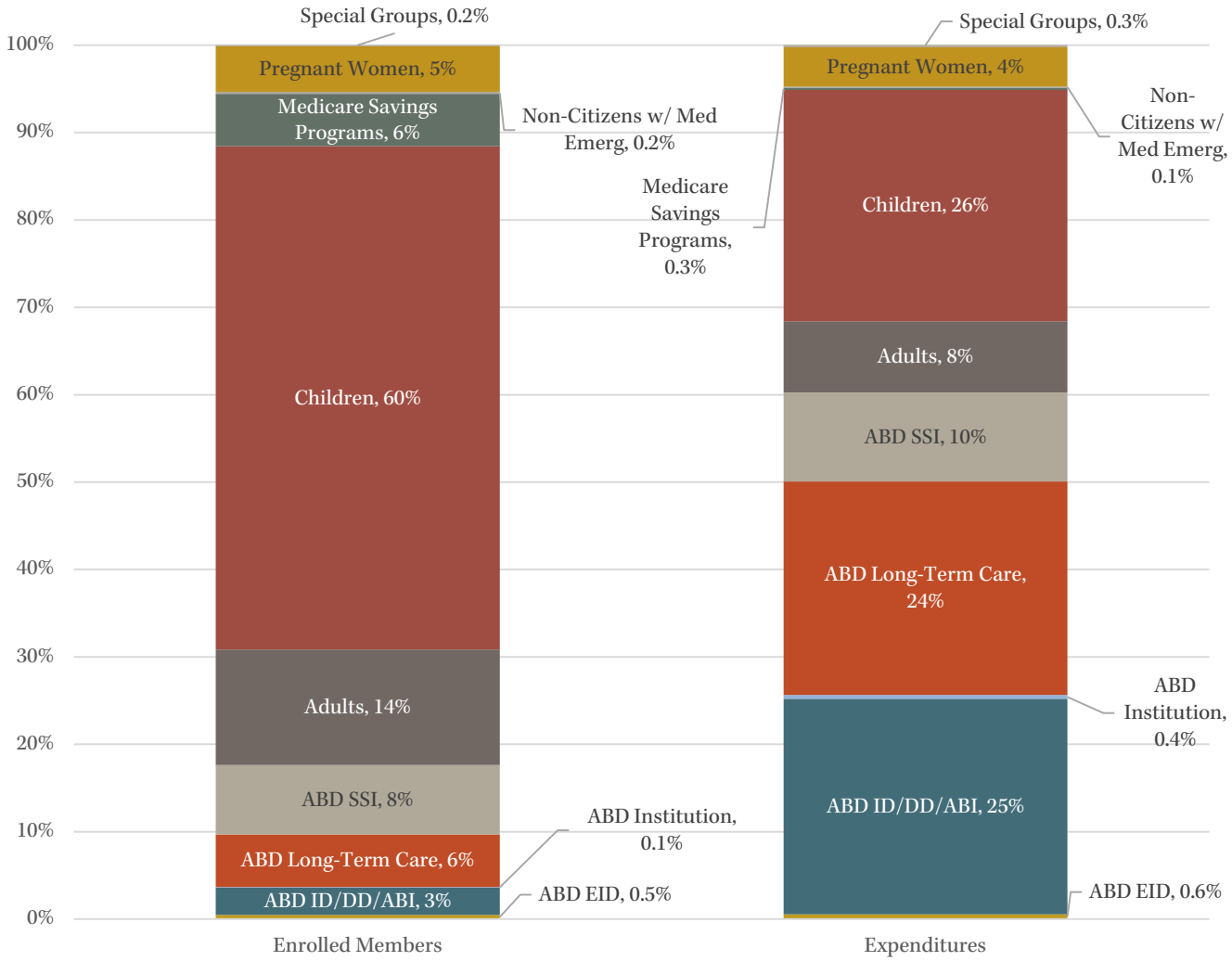


Figure 9. Enrolled Members versus Expenditures by Eligibility Category

Table 10. Enrollment History by Eligibility Category

Eligibility Category	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
ABD EID	350	341	360	479	496	404	15
ABD ID/DD/ABI	2,437	2,402	2,480	2,609	2,640	2,603	7
ABD Institution	86	71	76	77	80	55	-36
ABD LTC	4,184	4,176	4,378	4,643	4,885	5,007	20
ABD SSI	7,389	7,134	7,052	7,039	7,117	6,609	-11
Adults	7,925	8,719	10,998	12,431	11,825	10,989	39
Children	57,061	56,079	57,007	54,345	51,164	47,919	-16
Medicare Savings Programs	5,032	5,167	5,338	4,982	4,994	4,978	-1
Non-Citizens with Medical Emergencies	953	949	794	432	292	195	-80
Pregnant Women	5,633	5,400	5,743	5,517	4,778	4,336	-23
Special Groups	1,451	1,120	694	250	164	121	-92
Total	89,684	88,642	91,062	88,775	84,785	80,406	-10

Figure 10, below, shows how the breakdown of enrollment by eligibility category has changed over time. Most eligibility categories have maintained a steady percentage of the Medicaid population, however, Adults and Children have seen broader shifts, from 9% and 64%, respectively in SFY 2013 to 14% and 60% in SFY 2018.

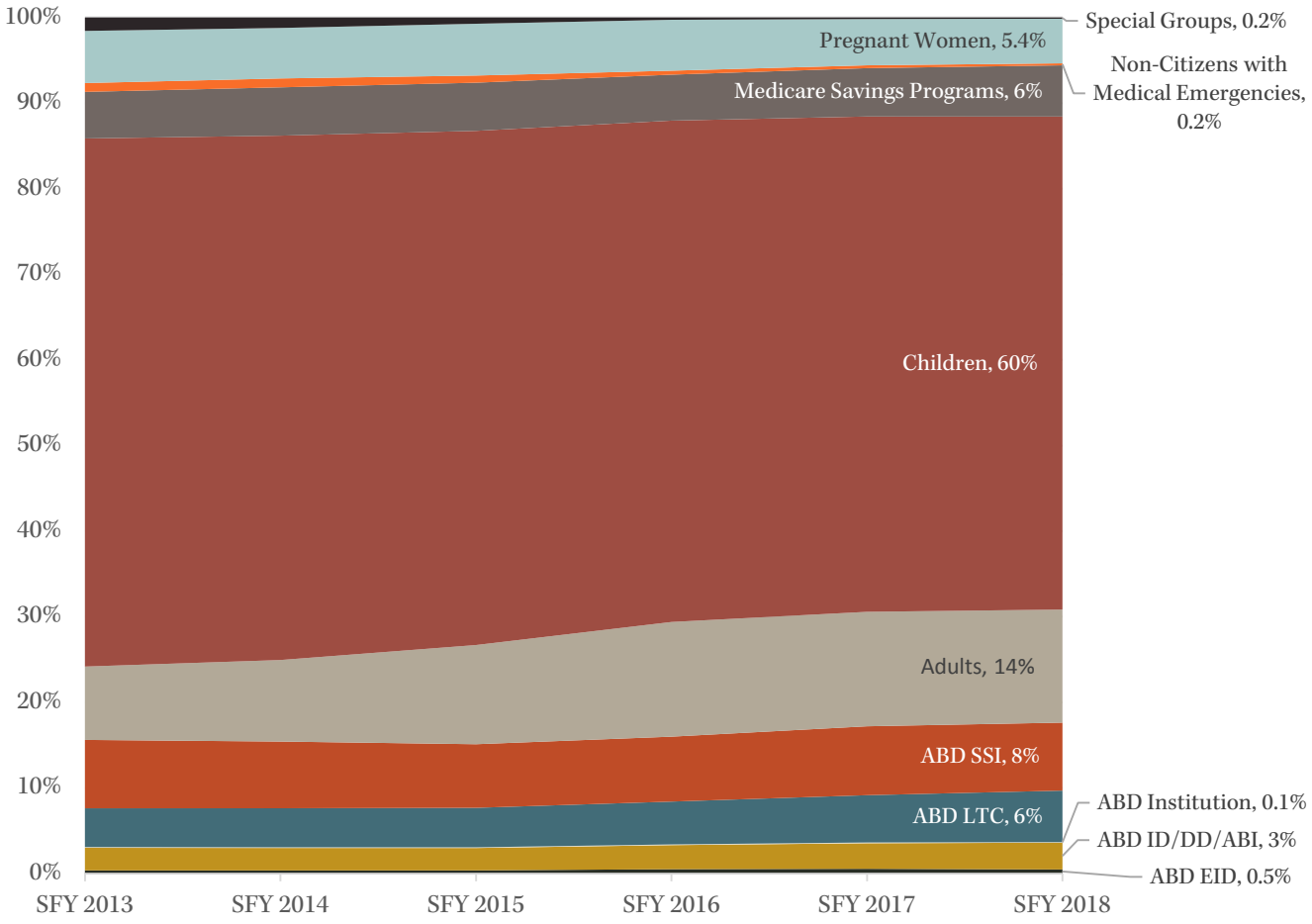


Figure 10. Enrollment History by Eligibility Category

Table 11. Expenditures History by Eligibility Category

Eligibility Category	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
ABD EID	$4,589,792	$4,545,872	$3,795,205	$4,730,644	$4,491,523	$3,170,198	-31
ABD ID/DD/ABI	$140,008,570	$140,255,339	$137,112,834	$146,523,597	$145,024,485	$139,120,839	-1
ABD Institution	$4,836,583	$6,947,121	$3,843,309	$3,976,596	$2,806,554	$2,489,828	-49
ABD LTC	$111,411,633	$109,585,095	$109,685,023	$127,126,736	$133,820,492	$137,811,401	24
ABD SSI	$52,203,560	$53,252,515	$57,532,693	$54,218,689	$55,141,541	$57,608,075	10
Adults	$28,446,023	$28,414,259	$39,268,780	$42,070,572	$40,633,756	$46,008,562	62
Children	$133,149,744	$135,754,662	$143,624,614	$144,048,715	$140,921,270	$149,233,800	12
Medicare Savings Programs	$3,708,394	$4,086,134	$4,564,069	$4,098,086	$3,206,357	$1,654,936	-55
Non-Citizens with Medical Emergencies	$1,892,640	$1,490,032	$1,236,724	$1,212,043	$1,040,454	$713,218	-62
Pregnant Women	$31,815,394	$28,762,228	$24,134,468	$24,192,832	$26,264,576	$25,247,867	-21
Screenings & Gross Adjustments	$378,465	$389,686	$183,197	$512,743	$1,403,752	$2,959,972	682
Special Groups	$4,816,363	$4,139,581	$2,550,692	$1,871,886	$1,519,979	$1,459,944	-70
Total	$517,257,164	$517,622,524	$527,531,608	$554,583,138	$556,274,739	$567,478,640	10

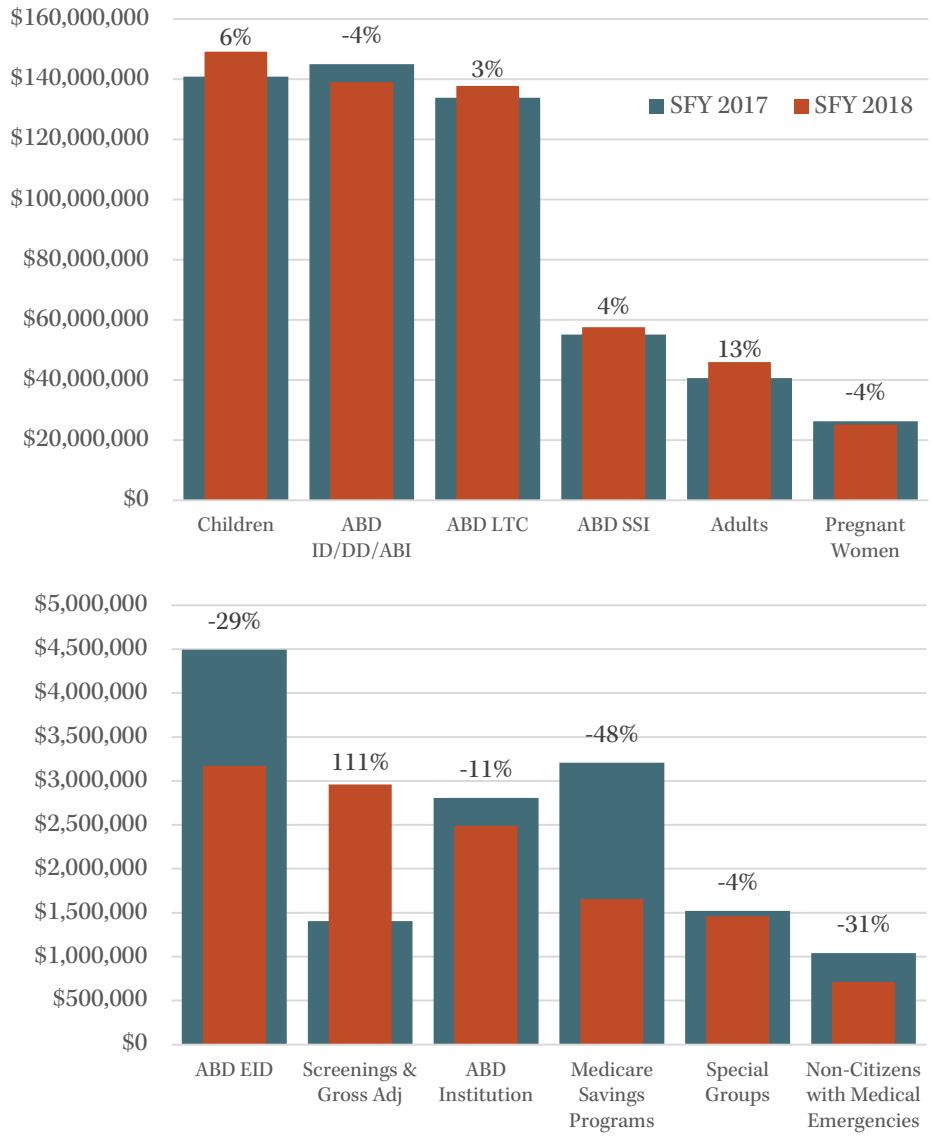


Figure 11. Change in Expenditures from SFY 2017 to SFY 2018 by Eligibility Category

Figure 11 shows how expenditures have changed from the previous SFY for each eligibility category.

While most populations experienced a decrease in expenditures, increases occurred for Children, Long-Term Care, SSI, Adults, and Screenings and Gross Adjustments, with the increase for the latter being primarily due to gross adjustments.

Figure 12, on the next page, shows how the changes in Expenditures compares to the change in Recipients from SFY 2017 to SFY 2018. Note, an increase in recipients served does not necessarily involve an increase in spending.

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

Table 12. Unique Recipient History by Eligibility Category

Eligibility Category	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
ABD EID	342	345	360	475	512	450	32
ABD ID/DD/ABI	2,448	2,407	2,476	2,636	2,660	2,631	7
ABD Institution	100	92	91	97	108	89	-11
ABD LTC	4,401	4,386	4,523	4,787	5,056	5,198	18
ABD SSI	6,245	6,269	6,125	6,048	6,341	6,255	0
Adults	6,683	6,907	8,466	9,867	10,273	9,914	48
Children	49,039	49,407	47,608	45,984	46,243	44,760	-9
Medicare Savings Programs	2,641	2,762	2,984	2,907	2,872	2,816	7
Non-Citizens with Medical Emergencies	414	367	287	248	251	147	-64
Pregnant Women	5,939	5,509	5,469	5,442	5,286	5,115	-14
Special Groups	686	622	497	271	148	132	-82
Total	76,275	76,318	75,284	74,783	75,873	74,056	-3

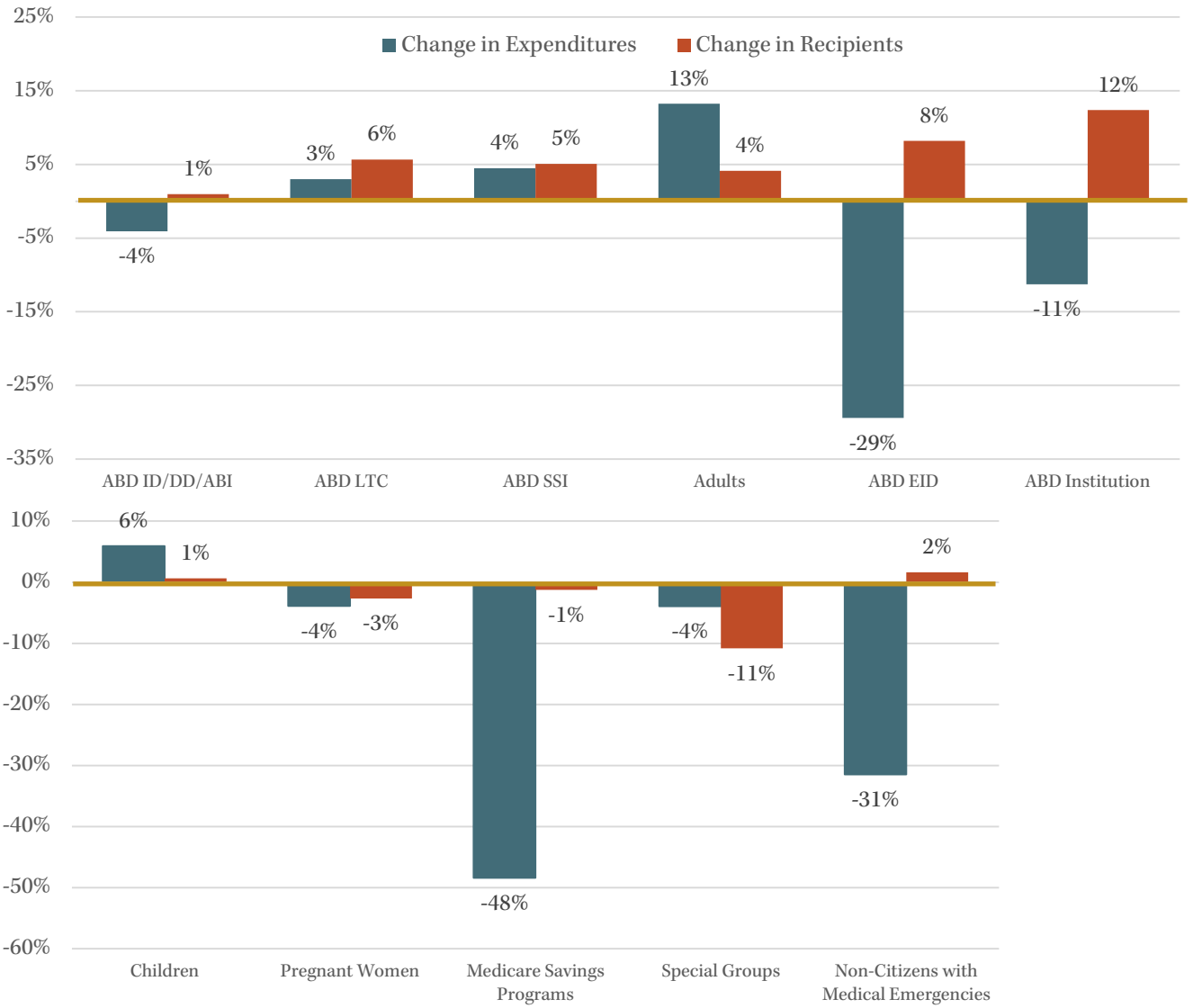


Figure 12. Change in Expenditures and Recipients from SFY 2017 to SFY 2018 by Eligibility Category


GREAT SEAL OF THE STATE OF WYOMING
EQUAL RIGHTS
1869
1890

SERVICES

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

OVERVIEW

Wyoming Medicaid covers the following mandatory[9] and optional services. These service areas are explained in further detail later in this report.

Table 13. Covered Services

Service	Adults	Children (Under Age 21)
Acquired Brain Injury Waiver	Optional	Optional
Ambulance	Mandatory	Mandatory
Ambulatory Surgical Center	Optional	Optional
Behavioral Health[10]	Optional	Mandatory (EPSDT)
Care Management Entity / Children's Mental Health Waiver	N/A	Optional
Clinic Services	Optional	Mandatory (EPSDT)
Comprehensive and Supports Waivers for Persons with ID/DD/ABI	Optional	Optional [11]
Community Choices Waiver	Optional	N/A
Dental	Optional	Mandatory (EPSDT)
Durable Medical Equipment	Optional	Mandatory (EPSDT)
End Stage Renal Disease	Optional	Mandatory (EPSDT)
Federally Qualified Health Centers	Mandatory	Mandatory
Home Health	Mandatory	Mandatory
Hospice	Optional	Optional
Hospital	Mandatory	Mandatory
Intermediate Care Facility for Individuals with Intellectual Disabilities	Optional	Optional
Laboratory / X-Ray	Mandatory	Mandatory
Nursing Facility	Mandatory	Mandatory
Program for All-Inclusive Care of the Elderly (PACE)	Optional	N/A
Pharmacy	Optional	Mandatory (EPSDT)
Physician and Other Practitioner	Mandatory	Mandatory
Pregnant by Choice Waiver	Optional	N/A
Psychiatric Residential Treatment Facility (PRTF)	N/A	Mandatory (EPSDT)
Physical/Occupational/Speech Therapies[12]	Optional	Mandatory (EPSDT)
Public Health, Federal[13]	Mandatory	Mandatory
Public Health or Welfare	Optional	Mandatory (EPSDT)
Rural Health Clinic	Mandatory	Mandatory
Vision	Optional	Mandatory (EPSDT)

[9] These services are required for children to comply with Early Prevention, Screening, Detection, and Treatment (EPSDT) requirements. EPSDT services are operated under the Health Check program, discussed in more detail in the Subprograms section.

[10] Excludes the Children's Mental Health Waiver and Psychiatric Residential Treatment Facility.

[11] Some services in these waivers may be mandatory if the child is otherwise eligible for Medicaid without the waiver.

[12] Physical/Occupational/Speech Therapies service detail is included in the Physician and Other Practitioner data in the detail section of this report.

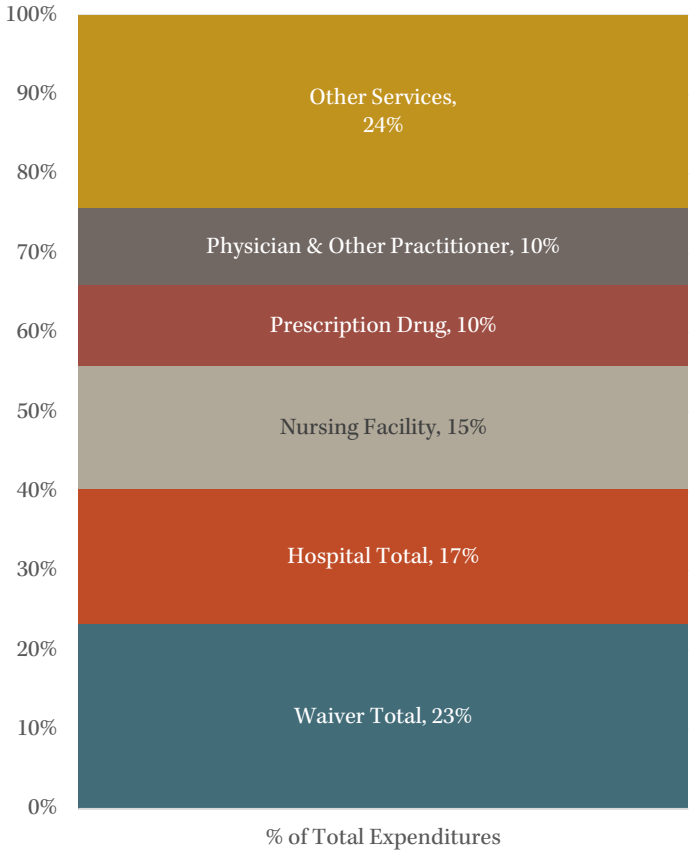
[13] Refers to Indian Health Services and Tribal 638 facilities.

Table 14. Service Utilization Summary

Service	Expenditures	% Change from SFY 2017	Recipients[15]	% Change from SFY 2017	Expenditures per Recipient	% Change from SFY 2017
Ambulance	$2,381,969	-38	3,157	-12	$755	-30
Ambulatory Surgical Center	$3,881,705	-5	2,728	-12	$1,423	7
Behavioral Health	$26,370,315	-14	12,768	-3	$2,065	-12
Care Management Entity (CME)[16]	$7,599,455	7	522	73	$14,558	-39
Clinic/Center	$972,701	-27	1,254	-12	$776	-16
Dental	$11,847,581	-16	28,732	-9	$412	-9
DME, Prosthetics/Orthotics/Supplies	$8,390,660	-7	7,290	-1	$1,151	-6
End Stage Renal Disease	$1,012,427	-20	147	3	$6,887	-22
Federally Qualified Health Center	$11,418,874	99	8,915	91	$1,281	4
Home Health	$4,012,083	-58	491	-31	$8,171	-39
Hospice	$1,394,149	6	194	-12	$7,186	20
Hospital Total	$97,086,021	-1	39,484	0	$2,459	-1
Inpatient	*$72,073,654*	*1*	*9,186*	*-9*	*$7,846*	*12*
Outpatient	*$25,021,868*	*-9*	*37,604*	*1*	*$665*	*-10*
Other Hospital	*-$9,501*	*-113*	*455*	*97*	*-$21*	*-107*
Intermediate Care Facility-IID	$13,999,444	-27	60	-9	$233,324	-20
Laboratory	$1,020,356	21	8,286	4	$123	16
Nursing Facility	$87,304,589	0	2,508	1	$34,810	-1
Other	$989,147	-2	3,183	9	$311	-10
PACE	$3,471,255	-1	178	26	$19,501	-22
Physician & Other Practitioner	$55,788,175	-7	62,488	-2	$893	-5
Prescription Drug	$57,642,641	15	42,002	-2	$1,372	17
PRTF	$12,537,788	3	296	0	$42,357	3
Public Health or Welfare	$881,179	-3	5,783	2	$152	-6
Public Health, Federal	$19,625,445	125	4,065	17	$4,828	93
Rural Health Clinic	$1,894,505	23	5,523	22	$343	1
Vision	$3,712,855	-4	15,804	1	$235	-5
Waiver Total	$132,243,321	10	5,139	4	$25,733	6
Acquired Brain Injury	*$4,948,202*	*-29*	*144*	*-11*	*$34,363*	*-21*
Community Choices	*$26,930,997*	*31*	*2,617*	*9*	*$10,291*	*20*
Comprehensive	*$94,568,471*	*7*	*1,961*	*5*	*$48,225*	*1*
Supports	*$5,795,651*	*32*	*565*	*5*	*$10,258*	*27*
Total	$567,478,640	2	74,056	-2	$7,663	5

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

[15] The Care Management Entity service includes $86,043 in expenditures paid for 15 children while enrolled in non-Medicaid state-funded institutional foster care.



Total expenditures for all Medicaid services remained steady with a minimal 2% increase from SFY 2017 for a total of $567,478,640.

The top services based on expenditures in SFY 2018 are Waivers[16], Hospital, Nursing Facility and Physician & Other Practitioner.

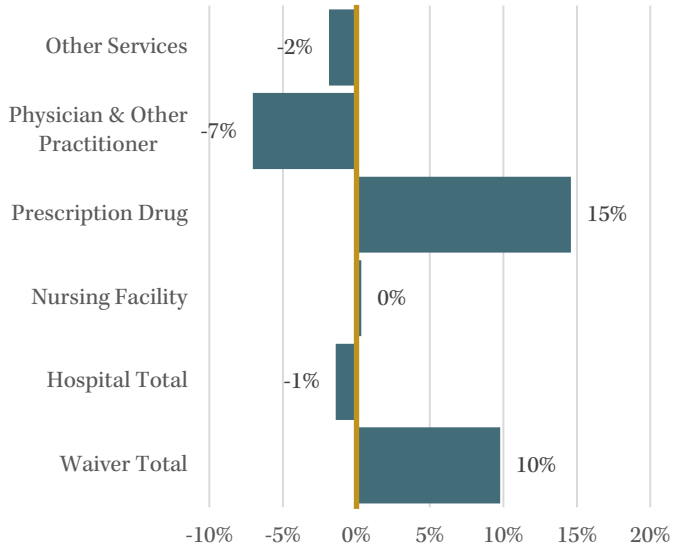


Figure 14. Change in Expenditures for Top Services

The total unique recipient count for all Medicaid services decreased by 2% from the previous year to 74,056 individuals, with Physician and Other Practitioner, Prescription Drug, and Hospital as the top services.

The figure below shows the percentage of unduplicated Medicaid recipients using each service. In SFY 2017 84% of Medicaid recipients had claims for Physician & Other Practitioner services, 57% had prescription drug claims, and so on.

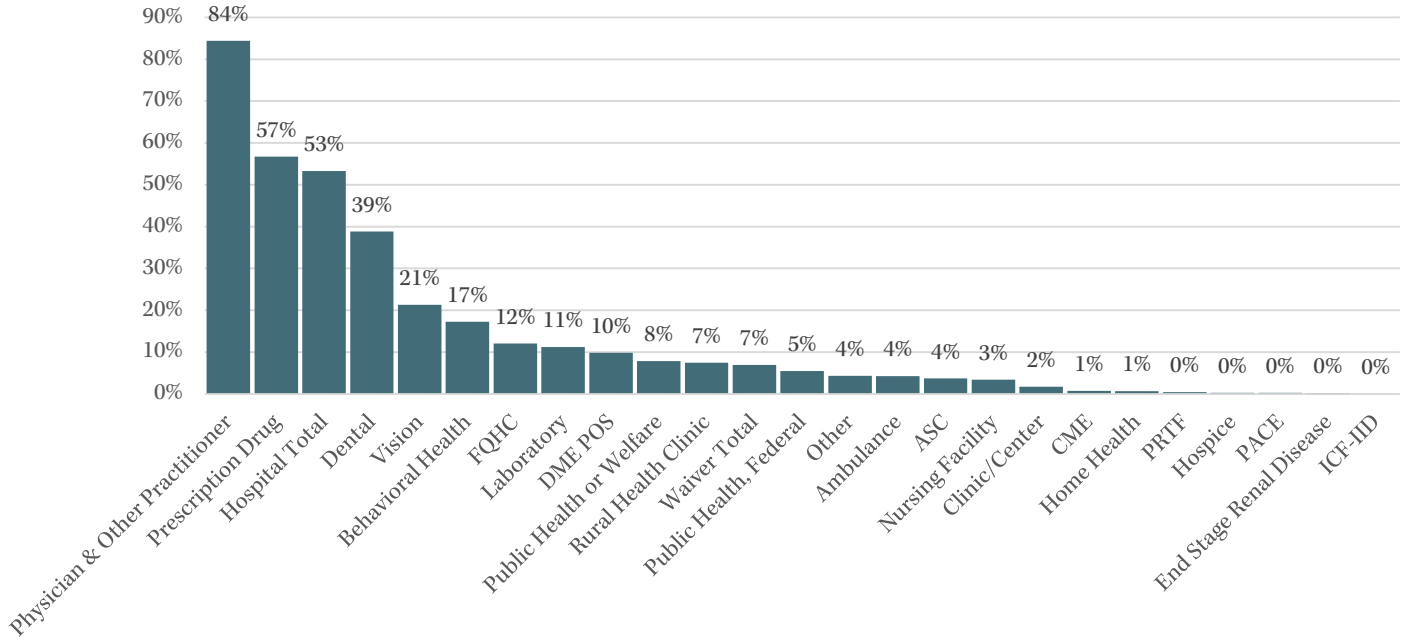


Figure 13. Percent of Total Unduplicated Recipients by Service

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

Table 15. Expenditure History by Service

Service	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Ambulance	$3,606,360	$3,760,537	$4,352,067	$3,571,623	$3,847,375	$2,381,969	-34
Ambulatory Surgical Center	$3,439,188	$4,039,944	$6,090,776	$5,953,159	$4,095,973	$3,881,705	13
Behavioral Health	$28,354,676	$30,602,969	$33,879,362	$34,964,154	$30,797,112	$26,370,315	-7
Care Management Entity[17]	--	--	--	$5,021,978	$7,135,148	$7,599,455	n/a
Clinic/Center	$1,166,813	$1,295,561	$1,339,630	$1,361,953	$1,327,800	$972,701	-17
Dental	$13,272,110	$13,391,934	$14,473,863	$15,450,029	$14,167,617	$11,847,581	-11
DME, Prosthetics/ Orthotics/Supplies	$7,730,289	$7,627,734	$8,624,246	$8,200,062	$9,029,583	$8,390,660	9
End Stage Renal Disease	$1,343,669	$1,071,750	$1,099,569	$948,612	$1,267,034	$1,012,427	-25
Federally Qualified Health Center	$2,018,911	$2,698,283	$3,259,793	$3,689,548	$5,725,094	$11,418,874	466
Home Health	$2,897,016	$3,533,728	$4,618,885	$9,467,835	$9,596,803	$4,012,083	38
Hospice	$1,082,188	$1,468,295	$1,157,101	$1,014,959	$1,316,838	$1,394,149	29
Hospital Total	$108,839,452	$101,931,277	$104,523,947	$107,692,150	$98,467,703	$97,086,021	-11
Inpatient	*$78,462,603*	*$72,932,440*	*$73,407,132*	*$78,575,068*	*$71,022,272*	*$72,073,654*	*-8*
Outpatient	*$30,189,391*	*$28,703,147*	*$31,056,066*	*$28,975,050*	*$27,373,462*	*$25,021,868*	*-17*
Other Hospital	*$187,458*	*$295,690*	*$60,748*	*$142,031*	*$71,969*	*-$9,501*	*-105*
Intermediate Care Facility-IID	$17,942,326	$19,152,530	$18,091,427	$18,193,221	$19,204,867	$13,999,444	-22
Laboratory	$1,149,473	$1,284,678	$1,516,042	$1,536,310	$844,218	$1,020,356	-11
Nursing Facility	$73,593,462	$72,866,933	$70,354,260	$82,445,811	$87,001,112	$87,304,589	19
Other	$625,371	$538,127	$649,268	$894,268	$1,006,132	$989,147	58
PACE	$168,398	$1,288,934	$2,242,570	$2,934,877	$3,520,283	$3,471,255	1,961
Physician & Other Practitioner	$62,856,989	$62,372,535	$61,249,367	$58,278,406	$60,013,763	$55,788,175	-11
Prescription Drug	$39,110,022	$41,238,663	$47,946,923	$48,597,364	$50,300,175	$57,642,641	47
PRTF	$12,080,494	$14,886,133	$13,575,847	$11,797,657	$12,121,830	$12,537,788	4
Public Health or Welfare	$924,007	$962,164	$1,009,814	$1,072,715	$912,444	$881,179	-5
Public Health, Federal	$8,067,975	$7,999,556	$8,761,358	$8,479,944	$8,718,888	$19,625,445	143
Rural Health Clinic	$1,845,491	$1,521,233	$1,668,167	$1,413,842	$1,540,607	$1,894,505	3
Vision	$3,389,793	$3,464,394	$3,595,216	$3,652,188	$3,850,574	$3,712,855	10
Waiver Total	$121,752,688	$118,624,631	$113,452,108	$117,950,473	$120,465,765	$132,243,321	9
Acquired Brain Injury	*$7,679,811*	*$7,371,614*	*$6,636,440*	*$6,748,171*	*$6,960,893*	*$4,948,202*	*-36*
Adult ID/DD	*$84,204,861*	*$83,501,095*	*$16,541,190*	*$1,674*	*$1,565*	--	*-100*
Child ID/DD	*$13,301,942*	*$11,415,264*	*$8,372,841*	*$179,173*	--	--	*-100*
Children's Mental Health	*$688,995*	*$527,514*	*$732,257*	*$61,981*	--	--	*-100*
Community Choices	*$15,877,079*	*$15,763,707*	*$16,630,675*	*$19,801,419*	*$20,597,605*	*$26,930,997*	*70*
Comprehensive	--	*$44,982*	*$63,719,016*	*$88,377,607*	*$88,527,446*	*$94,568,471*	*n/a*
Supports	--	*$454*	*$819,690*	*$2,780,450*	*$4,378,255*	*$5,795,651*	*n/a*
Total	$517,257,164	$517,622,524	$527,531,608	$554,583,138	$556,274,739	$567,478,640	10

[17] The Care Management Entity service includes expenditures paid for non-Medicaid children in state-funded institutional foster care.

Table 16. Expenditure History by Other[18] Service

Service	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Ambulatory Family Planning Facility	$68,988	$71,213	$69,754	$55,497	$62,853	$51,449	-25
Case Management	$196,574	$193,913	$297,117	$254,740	$409,938	$295,274	50
Chiropractor	$7,500	$5,661	$6,347	$99,664	$280,207	$347,441	4533
Day Training, Developmentally Disabled Service	$71,266	$79,578	$27,476	$52,304	$58,362	$49,662	-30
Dietitian, Registered	--	--	--	--	$391	$1,803	n/a
ECSII & CASII Evaluator	--	--	--	--	--	$61,574	n/a
Interpreter	$43,529	$38,171	$56,339	$47,205	$32,056	$22,119	-49
Lodging	--	--	--	--	$53,950	$85,915	n/a
Pace PPL	--	--	$0	-$80	$0	$0	n/a
Phlebotomy/WY Health Fair	$2,635	$5,870	$1,920	$575	--	--	n/a
Radiology: Mobile	$4,081	$226	$52	$7	--	--	n/a
Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	$121,618	$143,525	$154,682	$146,226	$84,406	$29,156	-76
Residential Treatment Facility For Emotionally Disturbed	$109,220	--	$35,712	$237,904	--	--	n/a
Taxi	--	--	--	--	$16,674	$33,435	n/a
Transportation Service	--	--	--	--	$7,329	$11,145	n/a
Unclassified	-$39	-$30	-$131	$225	-$34	$174	-546
Total	$625,371	$538,127	$649,268	$894,268	$1,006,132	$989,147	58

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

Table 17. Recipient Count[19] History by Service

Service	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Ambulance	3,433	3,517	3,506	3,275	3,584	3,157	-8
Ambulatory Surgical Center	3,259	3,392	3,537	3,408	3,090	2,728	-16
Behavioral Health	11,410	11,294	12,285	12,682	13,136	12,768	12
Care Management Entity[20]	--	--	--	342	301	522	n/a
Clinic/Center	1,465	1,520	1,589	1,529	1,431	1,254	-14
Dental	28,530	29,169	30,635	31,843	31,405	28,732	1
DME, Prosthetics/Orthotics/ Supplies	7,364	7,122	7,319	7,075	7,393	7,290	-1
End Stage Renal Disease	110	106	107	127	143	147	34
Federally Qualified Health Center	3,612	4,034	5,987	3,436	4,662	8,915	147
Home Health	591	590	686	730	713	491	-17
Hospice	179	251	179	197	220	194	8
Hospital Total	42,666	40,033	42,464	40,789	39,618	39,484	-7
Inpatient	*10,970*	*10,293*	*10,599*	*9,559*	*10,100*	*9,186*	*-16*
Outpatient	*40,147*	*37,618*	*40,150*	*38,654*	*37,151*	*37,604*	*-6*
Other Hospital	*142*	*194*	*148*	*176*	*231*	*455*	*220*
Intermediate Care Facility-IID	81	79	75	70	66	60	-26
Laboratory	9,724	9,490	8,830	9,535	7,983	8,286	-15
Nursing Facility	2,445	2,384	2,342	2,387	2,474	2,508	3
Other	1,857	1,642	1,643	1,945	2,913	3,183	71
PACE	22	63	95	117	141	178	709
Physician & Other Practitioner	61,515	65,284	62,816	61,442	63,747	62,488	2
Prescription Drug	47,607	44,464	46,031	43,926	42,990	42,002	-12
PRTF	328	338	332	298	296	296	-10
Public Health or Welfare	6,238	5,772	5,967	5,986	5,650	5,783	-7
Public Health, Federal	4,222	3,546	3,382	3,414	3,489	4,065	-4
Rural Health Clinic	5,418	4,670	4,530	3,663	4,535	5,523	2
Vision	14,180	14,558	15,010	15,227	15,612	15,804	11
Waiver Total	4,207	4,168	4,443	4,818	4,944	5,139	22
Acquired Brain Injury	*186*	*181*	*168*	*163*	*161*	*144*	*-23*
Adult ID/DD	*1,395*	*1,409*	*1,325*	*2*	*1*	*--*	*-100*
Child ID/DD	*761*	*699*	*659*	*148*	*--*	*--*	*-100*
Children's Mental Health	*82*	*57*	*79*	*40*	*--*	*--*	*-100*
Community Choices	*1,841*	*1,870*	*2,034*	*2,282*	*2,401*	*2,617*	*42*
Comprehensive	*--*	*3*	*1,755*	*1,925*	*1,863*	*1,961*	*n/a*
Supports	*--*	*0*	*191*	*425*	*540*	*565*	*n/a*
Total	76,275	76,318	75,284	74,783	75,873	74,056	-3

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

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

SERVICE DETAILS

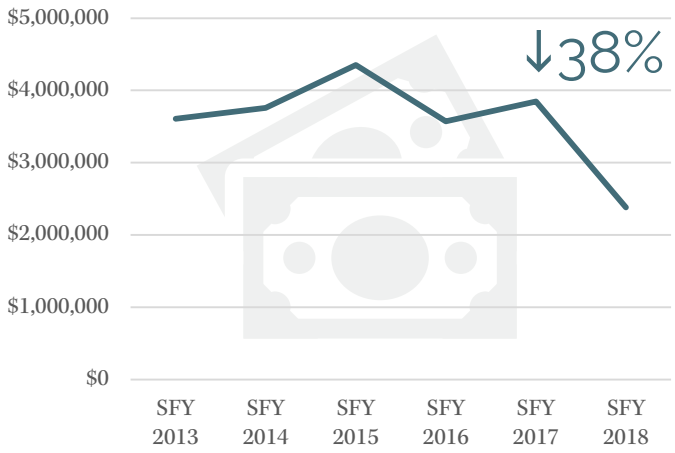
This section provides a detailed view of the services presented in the overview. Services are defined by the taxonomy of the provider paid for the service.

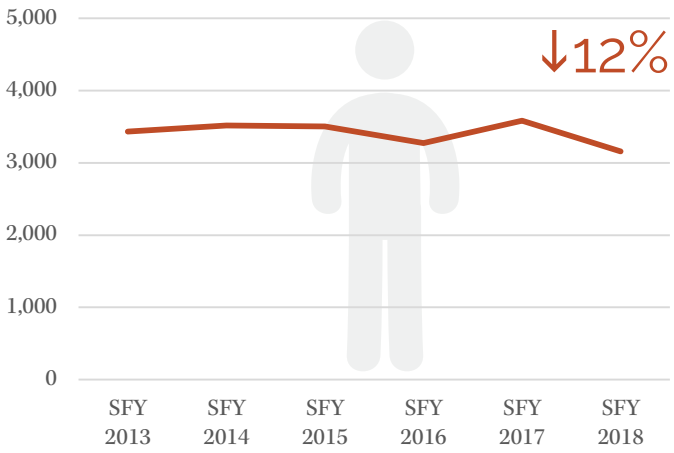
AMBULANCE

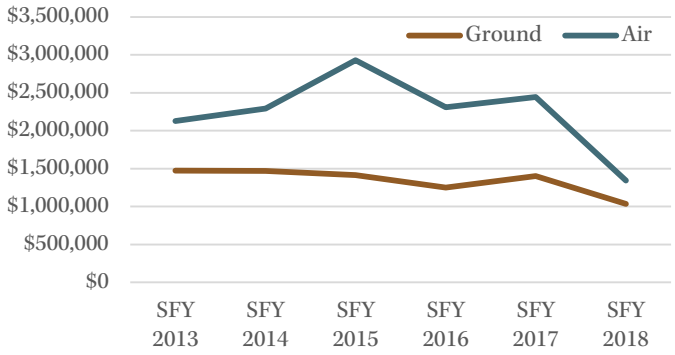
Emergency ground and air transportation and limited non-emergency ground transportation

$2,381,969 0.4% OF MEDICAID EXPENDITURES

3,157 4% OF MEDICAID RECIPIENTS







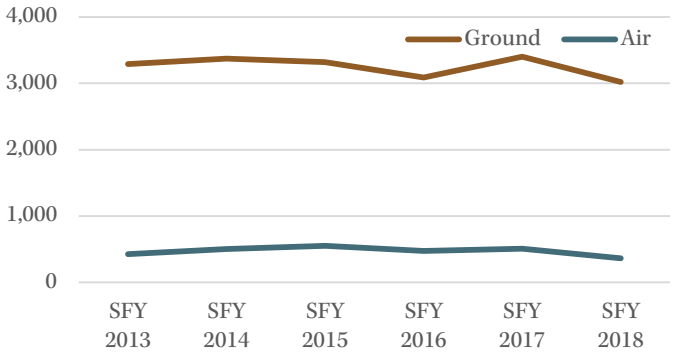


Table 18. Ambulance Services Summary

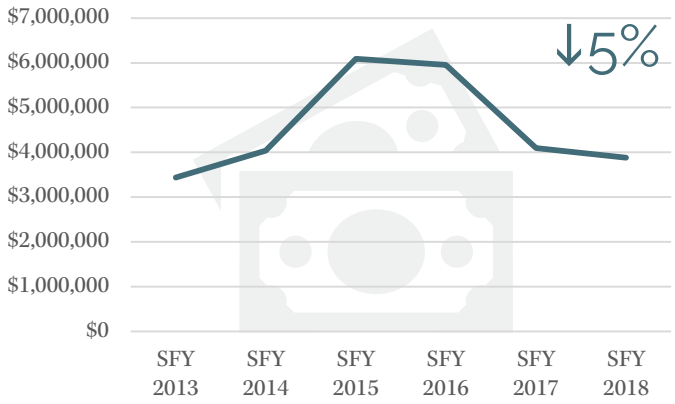
Total Ambulance Services	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$3,606,360	$3,760,537	$4,352,067	$3,571,623	$3,847,375	$2,381,969	-34
Recipients	3,433	3,517	3,506	3,275	3,584	3,157	-8
Expenditures per Recipient	$1,050	$1,069	$1,241	$1,091	$1,073	$755	-28
Air Ambulance Services							
Expenditures	$2,129,324	$2,291,183	$2,931,554	$2,310,149	$2,444,615	$1,342,922	-37
Recipients	426	505	553	476	506	363	-15
Expenditures per Recipient	$4,998	$4,537	$5,301	$4,853	$4,831	$3,700	-26
Ground Ambulance Services							
Expenditures	$1,472,500	$1,467,922	$1,413,123	$1,250,084	$1,401,636	$1,033,707	-30
Recipients	3,290	3,375	3,322	3,090	3,402	3,023	-8
Expenditures per Recipient	$448	$435	$425	$405	$412	$342	-24

AMBULATORY SURGERY CENTERS

Surgical procedures that do not require overnight inpatient hospital care. Encompasses all surgical procedures covered by Medicare, as well as procedures Medicaid has approved for provision as outpatient services. ASC services may also be provided in an outpatient hospital setting.

$3,881,705 0.7% OF MEDICAID EXPENDITURES

2,728 4% OF MEDICAID RECIPIENTS



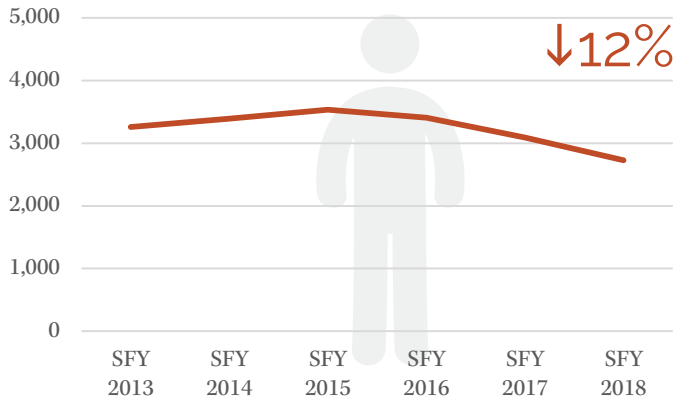


Table 19. Ambulatory Surgery Center Services Summary

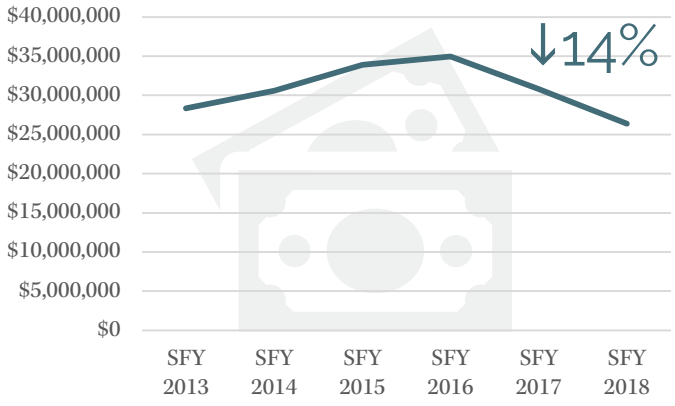
	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$3,439,188	$4,039,944	$6,090,776	$5,953,159	$4,095,973	$3,881,705	13
Recipients	3,259	3,392	3,537	3,408	3,090	2,728	-16
Expenditures per Recipient	$1,055	$1,191	$1,722	$1,747	$1,326	$1,423	35

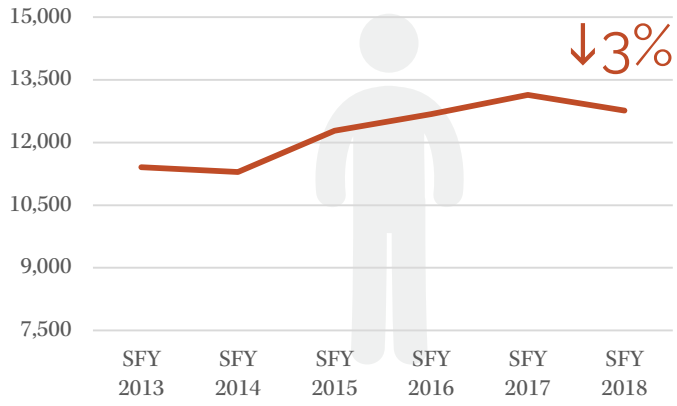
BEHAVIORAL HEALTH

All services provided by Behavioral Health provider taxonomies

$26,370,315 5% OF MEDICAID EXPENDITURES

12,768 17% OF MEDICAID RECIPIENTS





BEHAVIORAL HEALTH SERVICES FROM NON-BEHAVIORAL HEALTH PROVIDERS

Additionally, non-behavioral health providers may provide behavioral health services, which are not included in the figures above. In SFY 2018, behavioral health expenditures paid to non-behavioral health providers decreased by 27% to $925,691, while the number of behavioral health recipients who received behavioral health services from these providers increased by 8% to 4,898.

Table 20. Behavioral Health Services Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Behavioral Health Services							
Expenditures	$28,354,676	$30,602,969	$33,879,362	$34,964,154	$30,797,112	$26,370,315	-7
Recipients	11,410	11,294	12,285	12,682	13,136	12,768	12
Expenditures per Recipient	$2,485	$2,710	$2,758	$2,757	$2,344	$2,065	-17
Non-Behavioral Health Provider Services[21]							
Expenditures	$1,380,256	$1,392,647	$1,264,549	$1,241,688	$1,265,657	$925,691	-33
Recipients	2,981	3,834	3,854	4,275	4,560	4,898	64
Expenditures per Recipient	$463	$363	$328	$290	$278	$189	-59

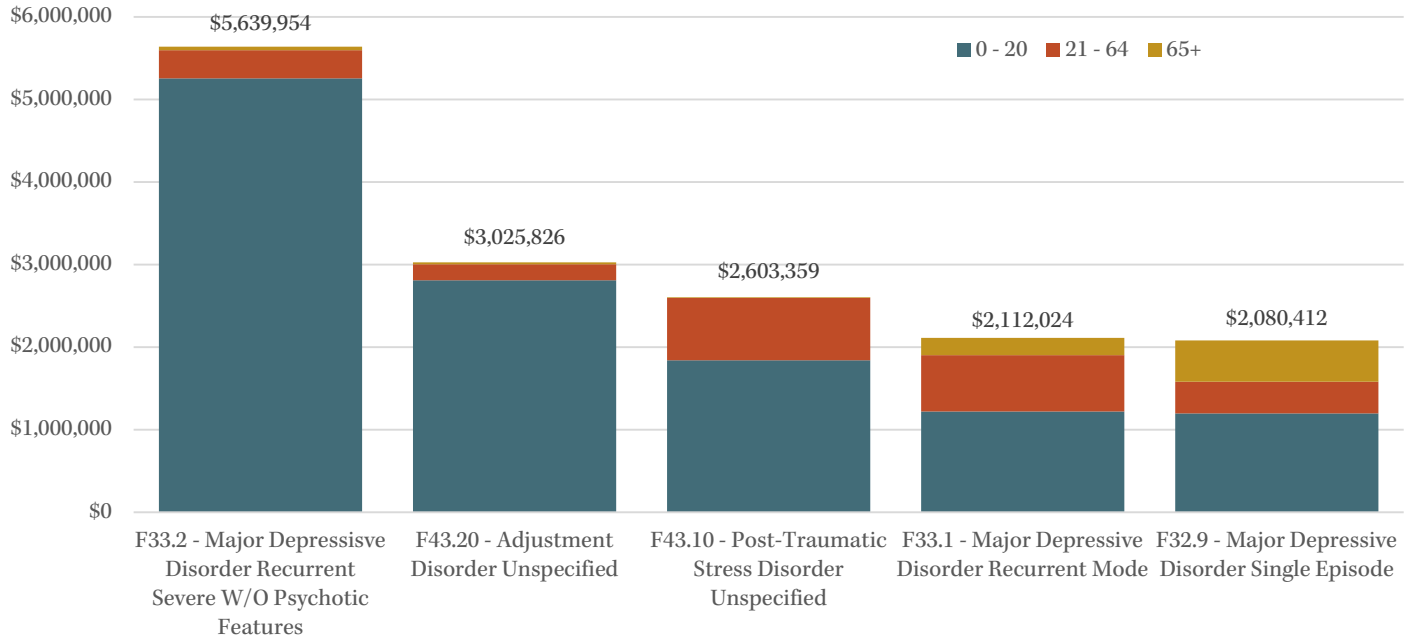


Figure 15. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types (excluding Dementia and Alzheimers)

Table 21. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types

Diagnosis Code and Description	Age 0-20	Age 21-64	Age 65+	Total
F33.2 - Major Depressive Disorder Recurrent Severe w/o Psychotic Features	$5,256,894	$338,601	$44,459	$5,639,954
F43.20 - Adjustment Disorder Unspecified	$2,807,266	$194,480	$24,079	$3,025,826
F43.10 - Post-Traumatic Stress Disorder Unspecified	$1,841,357	$754,463	$7,539	$2,603,359
F32.9 - Major Depressive Disorder Single Episode	$1,218,698	$685,129	$208,197	$2,112,024
F33.1 - Major Depressive Disorder Recurrent Mode	$1,196,138	$382,159	$502,114	$2,080,412
Total	$12,320,354	$2,354,833	$786,389	$15,461,575

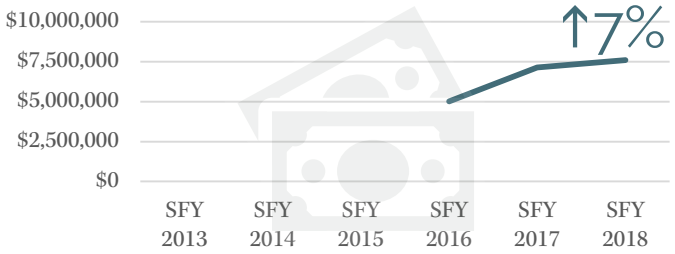
[21] See Appendix B for additional information regarding the types of providers who provide Behavioral Health services.

CARE MANAGEMENT ENTITY

Provides intensive care coordination to children and youth with complex behavioral health conditions and their families, using a High Fidelity Wrap-around model to support their success in their homes, schools, and communities. Started in SFY 2016.

$7,599,455

1% OF MEDICAID EXPENDITURES



522

1% OF MEDICAID RECIPIENTS

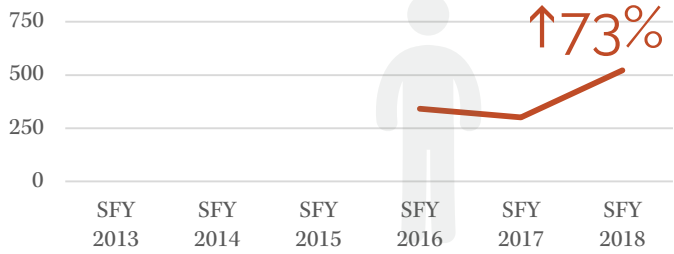


Table 22. Care Management Entity Services Summary

	SFY 2016	SFY 2017	SFY 2018
Expenditures	$5,021,978	$7,135,148	$7,599,455
Recipients	342	301	522
Expenditures per Recipient	$14,684	$23,705	$14,558

NOTE

The expenditures reported here for Care Management Entity are for amounts paid to the provider during the state fiscal years. These figures do not take into account the retroactive adjustments processed due to recent rate changes.

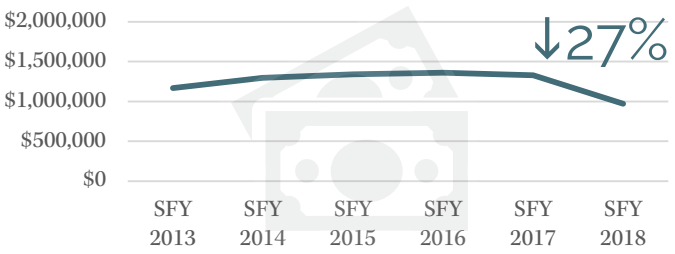
CME also provides services to children enrolled in non-Medicaid state-funded institutional foster care. The total SFY 2018 expenditures and recipient count shown in Table 22 includes $86,043 for those 15 children.

CLINIC/CENTER

Services for clients with developmental disabilities who qualify for programs, training, care, treatment, and supervision in a structured setting, provided by state or privately funded facilities. Services include diagnostic evaluations and assessments, physical, occupational, and speech therapies, and mental health services for clients age 5 and younger.

$972,701

0.2% OF MEDICAID EXPENDITURES



1,254

2% OF MEDICAID RECIPIENTS

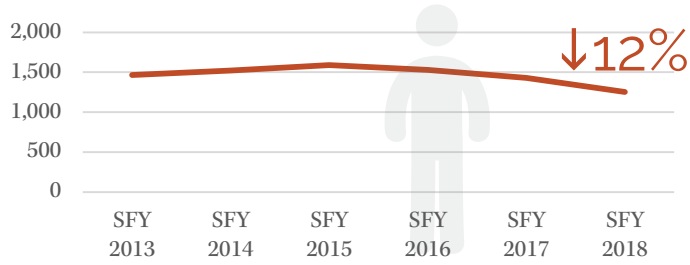


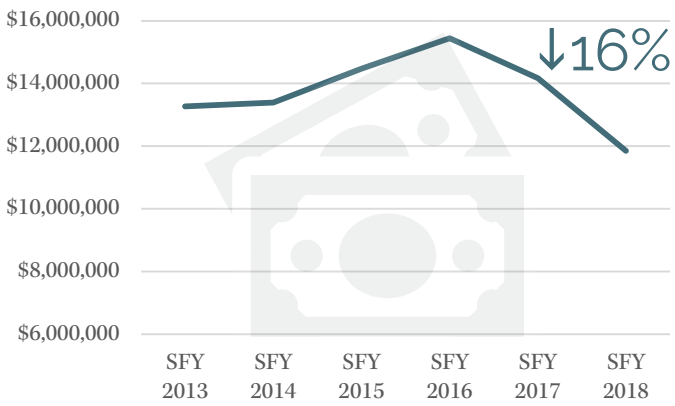
Table 23. Clinic/Center Services Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$1,166,813	$1,295,561	$1,339,630	$1,361,953	$1,327,800	$972,701	-17
Recipients	1,465	1,520	1,589	1,529	1,431	1,254	-14
Expenditures per Recipient	$796	$852	$843	$891	$928	$776	-3

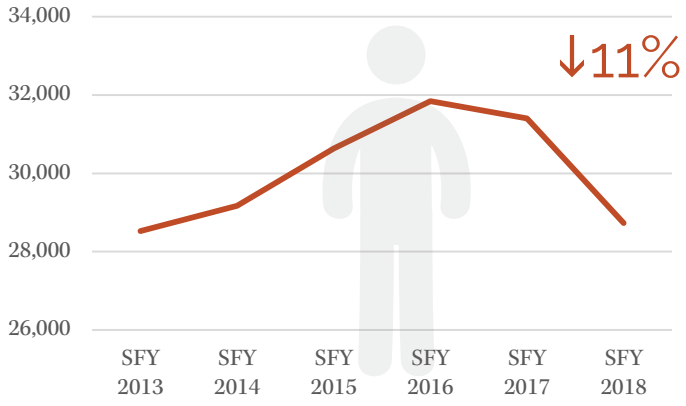
DENTAL

Dental services are covered based on enrolled member's age, with the goal of ensuring access to dental care so recipients may avoid emergency dental situations by receiving preventive and routine dental services for overall oral health.

$11,847,581 2% OF MEDICAID EXPENDITURES



28,732 39% OF MEDICAID RECIPIENTS



Although there are dental providers in most of Wyoming's 23 counties, dental specialists exist in only 9 (39%). In SFY 2018, 48% of dental recipients received services from a dental specialist, with 9% of those clients receiving such services out of state.

Table 24. Dental Services Summary

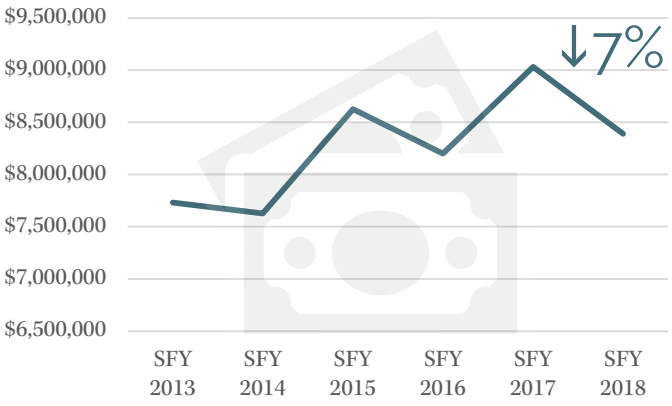
	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$13,272,110	$13,391,934	$14,473,863	$15,450,029	$14,167,617	$11,847,581	-11
Recipients	28,530	29,169	30,635	31,843	31,405	28,732	1
Expenditures per Recipient	$465	$459	$472	$485	$451	$412	-11

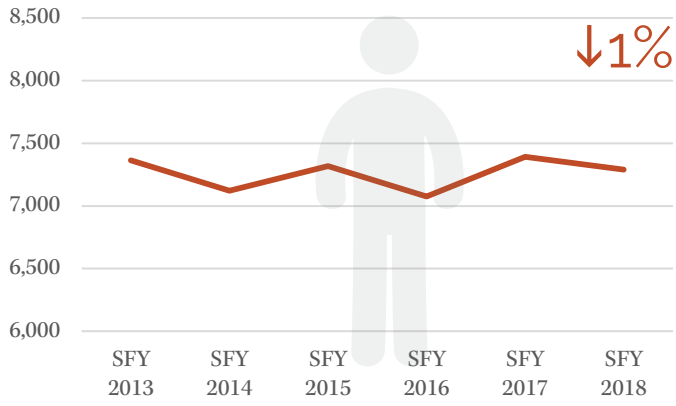
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES

Services covered when ordered by a physician or other licensed practitioner for home use to reduce an individual's physical disability and restore the individual to a functional level.

$8,390,660 2% OF MEDICAID EXPENDITURES

7,290 10% OF MEDICAID RECIPIENTS





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

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

Table 25. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services Summary

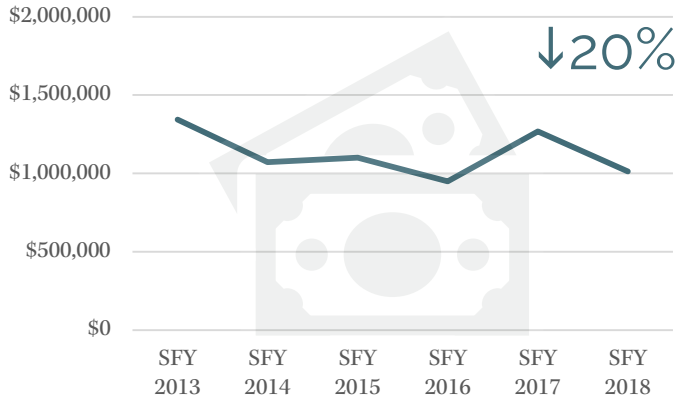
	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Total Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services							
Expenditures	$7,890,382	$7,627,751	$8,630,652	$8,200,062	$9,029,583	$8,391,731	6
Recipients	8,508	7,122	7,328	7,075	7,393	7,290	-14
Expenditures per Recipient	$927	$1,071	$1,178	$1,159	$1,221	$1,151	24
Durable Medical Equipment Services Only							
Expenditures	$7,062,121	$7,040,745	$7,910,490	$7,401,382	$8,272,343	$7,776,090	10
Recipients	8,170	6,820	6,918	6,701	6,991	6,902	-16
Expenditures per Recipient	$864	$1,032	$1,143	$1,105	$1,183	$1,127	30
Prosthetics, Orthotics, and Supplies Services Only							
Expenditures	$828,261	$587,006	$720,162	$798,679	$757,241	$615,641	-26
Recipients	651	587	743	624	664	623	-4
Expenditures per Recipient	$1,272	$1,000	$969	$1,280	$1,140	$988	-22

END STAGE RENAL DISEASE

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. Hospital or free-standing facility must be a certified ESRD facility. Personal care attendants are not covered for this program.

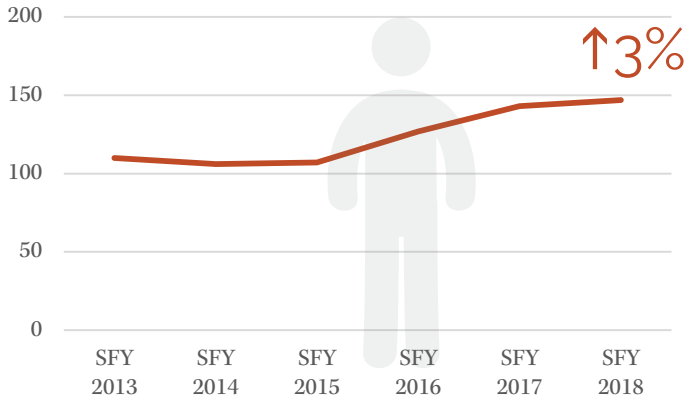
$1,012,427

0.2% OF MEDICAID EXPENDITURES



147

0.2% OF MEDICAID RECIPIENTS



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

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

Table 26. End Stage Renal Disease Services Summary

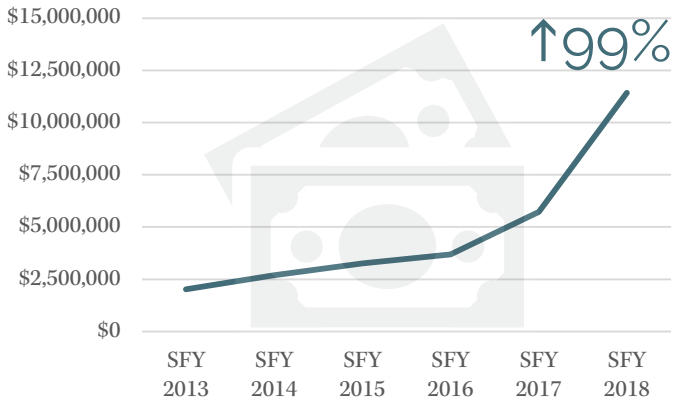
	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$1,343,669	$1,071,750	$1,099,569	$948,612	$1,267,034	$1,012,427	-25
Recipients	110	106	107	127	143	147	34
Expenditures per Recipient	$12,215	$10,111	$10,276	$7,469	$8,860	$6,887	-44

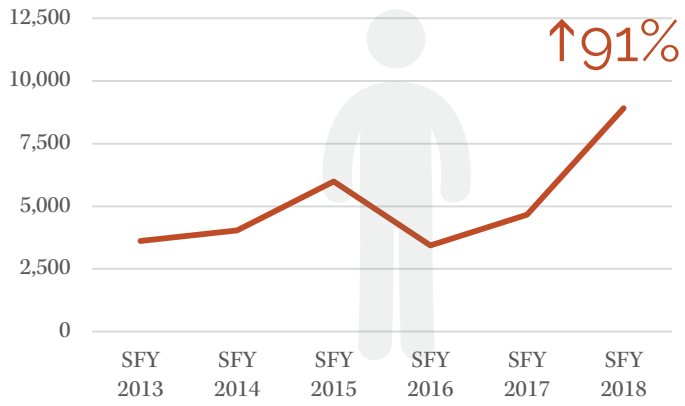
FEDERALLY QUALIFIED HEALTH CENTER

Provides preventive primary health services when medically necessary and provided by or under the direction of a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, licensed clinical psychologist, or licensed clinical social worker. Facility is designated as an FQHC by Medicare if it is located in an area designated as a "shortage area", a geographic area designated by HHS as having either a shortage of personal health services or of primary medical care professionals.

$11,418,874 2% OF MEDICAID EXPENDITURES

8,915 12% OF MEDICAID RECIPIENTS





An FQHC differs from a Rural Health Clinic (RHC) based on several criteria related to location, shortage area, corporate structure, board of director requirements, and clinical staffing requirements.[22]

Table 27. Federally Qualified Health Center Services Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$2,018,911	$2,698,283	$3,259,793	$3,689,548	$5,725,094	$11,418,874	466
Recipients	3,612	4,034	5,987	3,436	4,662	8,915	147
Expenditures per Recipient	$559	$669	$544	$1,074	$1,228	$1,281	129

A rate increase for FQHC services was applied retroactively, resulting in past claims being re-processed during SFY 2018. This explains the increase in both expenditures and recipient counts seen above.

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

HOME HEALTH

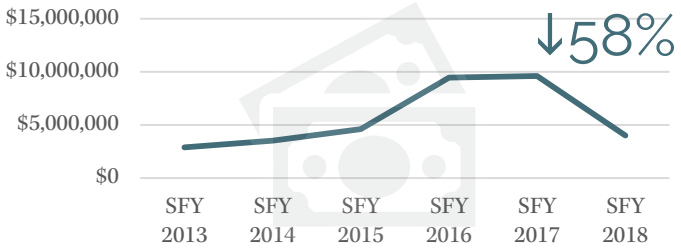
Services for individuals not admitted to the hospital or a nursing care facility. Must be intermittent, three or fewer visits per day for home health aide and/or skilled nursing, with each visit lasting no more than four hours. Services must be medically necessary, ordered by a physician, and documented in a signed/dated treatment plan to be reviewed and revised as medically necessary by the attending physician at least every 60 days.

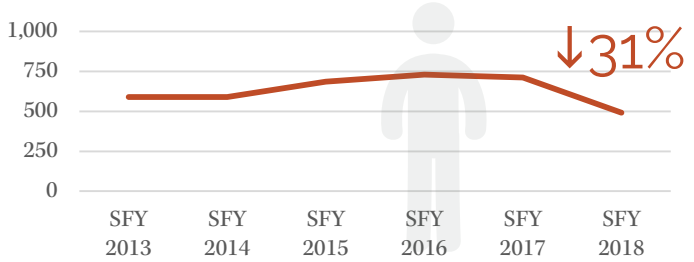
$4,012,083

0.7% OF MEDICAID EXPENDITURES

491

0.7% OF MEDICAID RECIPIENTS





Home Health agencies must provide at least two of the following services to be a licensed provider in the state of Wyoming:

- skilled nursing
- home health aide supervised by a qualified professional
- physical therapy provided by a qualified and licensed physical therapist
- speech therapy provided by a qualified therapist
- occupational therapy provided by a qualified, registered, or certified therapist
- medical social services provided by a qualified and licensed Master of Social Work (MSW) or a Bachelor of Social Work (BSW)-prepared person supervised by an MSW

The following are NOT covered Home Health services:

- homemaking
- respite care
- Meals on Wheels or home-delivered meals
- services deemed inappropriate or not cost-effective in home setting

Table 28. Home Health Services Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$2,897,016	$3,533,728	$4,618,885	$9,467,835	$9,596,803	$4,012,083	38
Recipients	591	590	686	730	713	491	-17
Expenditures per Recipient	$4,902	$5,989	$6,733	$12,970	$13,460	$8,171	67

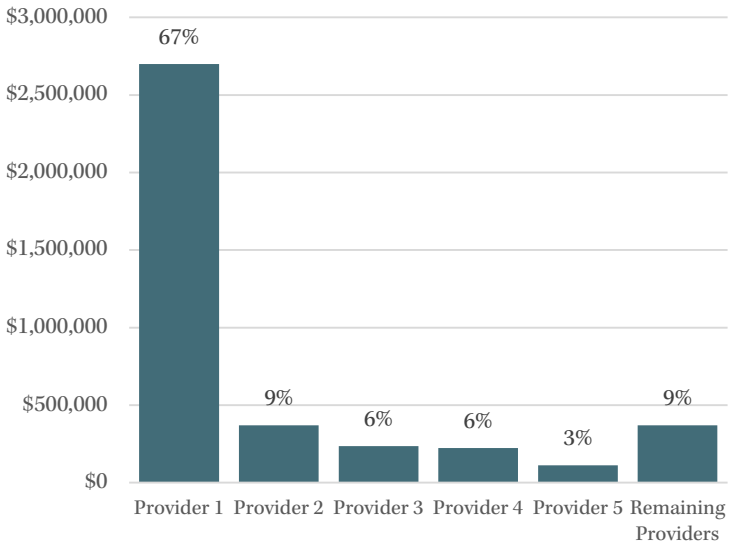


Figure 16. Top 5 Home Health Providers by Expenditures in SFY 2018

Medicaid implemented a prior authorization requirement effective March 1, 2017, to address the recent increase in expenditures. The effects of this policy change can be observed in the data for SFY 2018.

Table 29. Top 5 Home Health Providers by Expenditures in SFY 2018

	Expenditures	% of Total Home Health Expenditures
Provider 1	$2,699,338	67%
Provider 2	$369,930	9%
Provider 3	$235,612	6%
Provider 4	$224,647	6%
Provider 5	$112,639	3%

HOSPICE

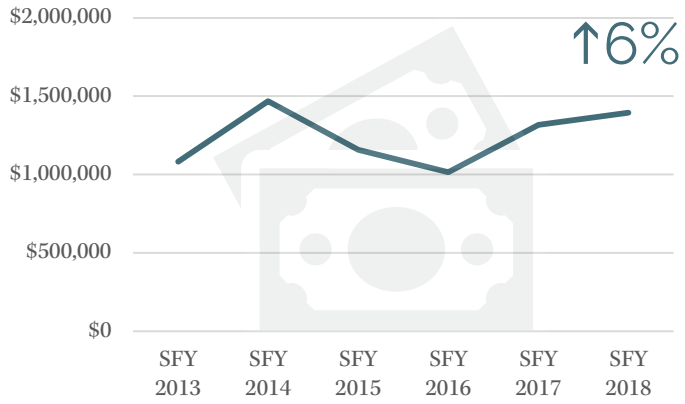
An interdisciplinary approach to caring for the psychological, social, spiritual, and physical needs of dying individuals. Hospice care is covered if the individual elects it and a physician certifies that the individual is terminally ill. Covered services include routine and continuous home care, inpatient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

$1,394,149

0.2% OF MEDICAID EXPENDITURES

194

0.3% OF MEDICAID RECIPIENTS



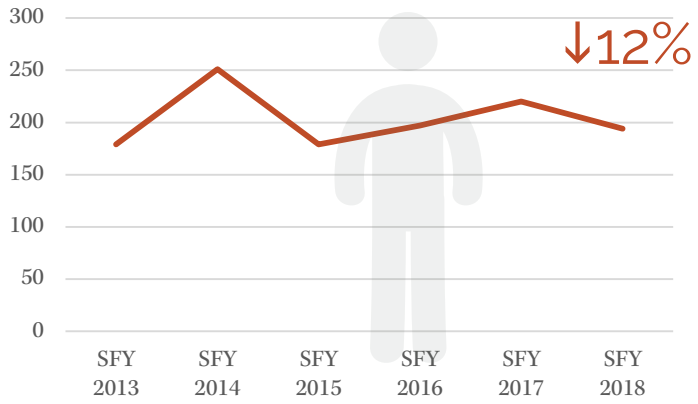


Table 30. Hospice Services Summary

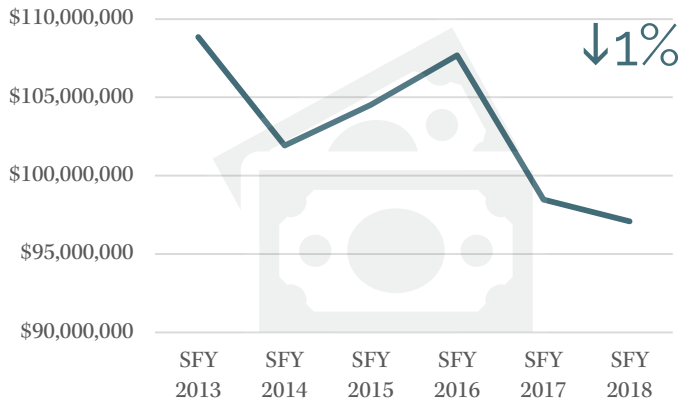
	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$1,082,188	$1,468,295	$1,157,101	$1,014,959	$1,316,838	$1,394,149	29
Recipients	179	251	179	197	220	194	8
Expenditures per Recipient	$6,046	$5,850	$6,464	$5,152	$5,986	$7,186	19

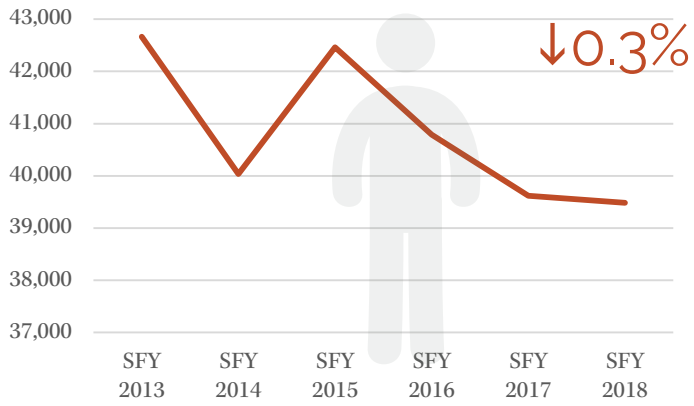
HOSPITAL

Inpatient and Outpatient hospital services

$97,086,021 17% OF MEDICAID EXPENDITURES

39,484 53% OF MEDICAID RECIPIENTS





QUALIFIED RATE ADJUSTMENT

The Qualified Rate Adjustment (QRA) is a supplement for qualified hospital providers. Qualifying hospitals provided state share of the payment, and Medicaid distributes corresponding Federal matching funds, along with the state share, to the participating hospitals. QRA payments are calculated using the previous SFY paid claims data.

Table 31. Total Hospital Services Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$108,839,452	$101,931,277	$104,523,947	$107,692,150	$98,467,703	$97,086,021	-11
Recipients	42,666	40,033	42,464	40,789	39,618	39,487	-7
Expenditures per Recipient	$2,551	$2,546	$2,461	$2,640	$2,485	$2,459	-4
QRA (Federal Share)	$8,329,770	$8,604,610	$9,441,087	$12,607,068	$11,202,759	$12,472,415	50
Total Expenditures w/ QRA	$117,169,222	$110,535,887	$113,965,034	$120,299,218	$109,670,462	$109,558,436	-6

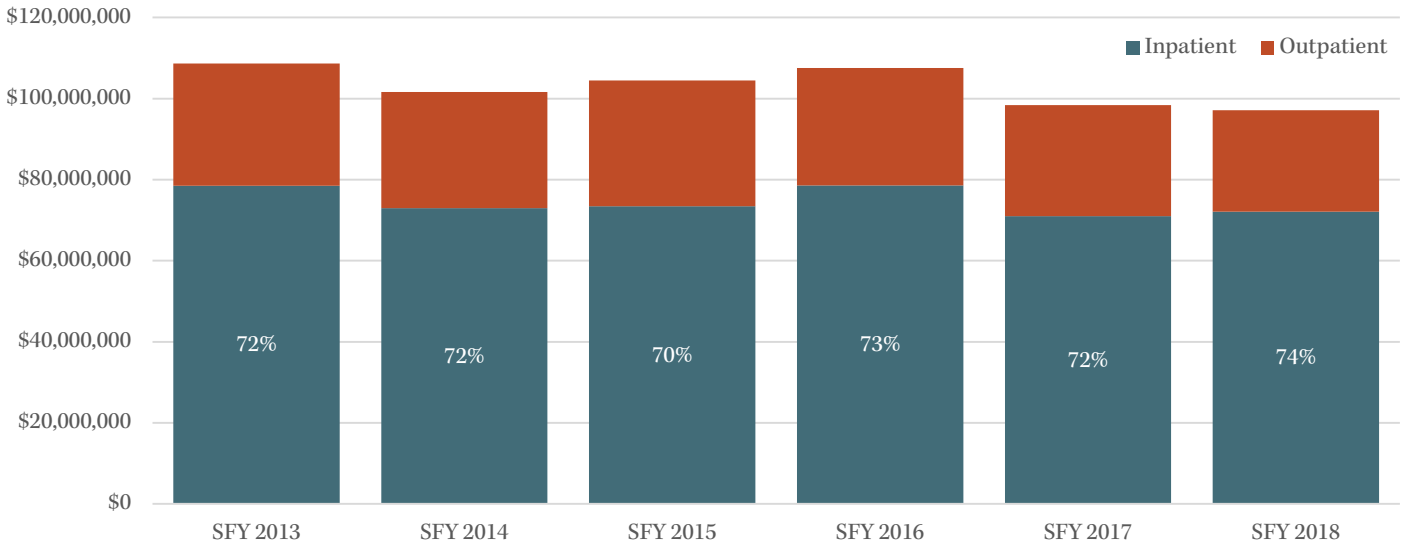
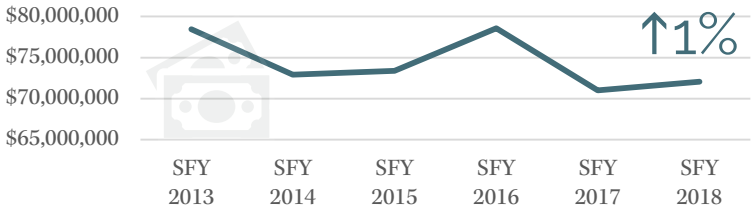


Figure 17. Hospital Inpatient-Outpatient Breakdown History by Expenditures

INPATIENT SERVICES

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



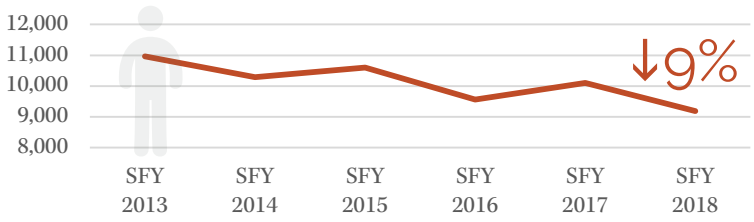


Table 32. Inpatient Hospital Services Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$78,462,603	$72,932,440	$73,407,132	$78,575,068	$71,022,272	$72,073,654	-8
Recipients	10,970	10,293	10,599	9,559	10,100	9,186	-16
Expenditures per Recipient	$7,152	$7,086	$6,926	$8,220	$7,032	$7,846	10
QRA (Federal Share)	$2,248,251	$2,599,625	$2,667,482	$3,143,380	$2,200,706	$3,010,897	34
Total Expenditures w/ QRA	$80,710,854	$75,532,065	$76,074,614	$81,718,448	$73,222,978	$75,084,551	-7

Inpatient services reimbursement is determined by the **Level of Care (LOC)** classification assigned to each discharge based on the diagnosis, procedure, or revenue codes reported on the inpatient claim.

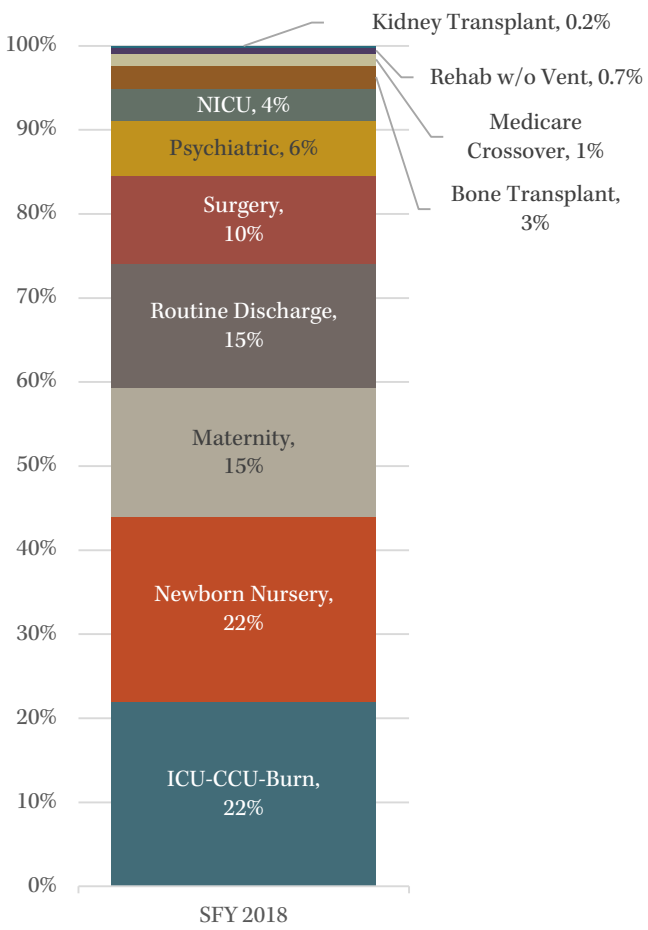


Figure 18. Percent of Hospital Inpatient Expenditures by Level of Care

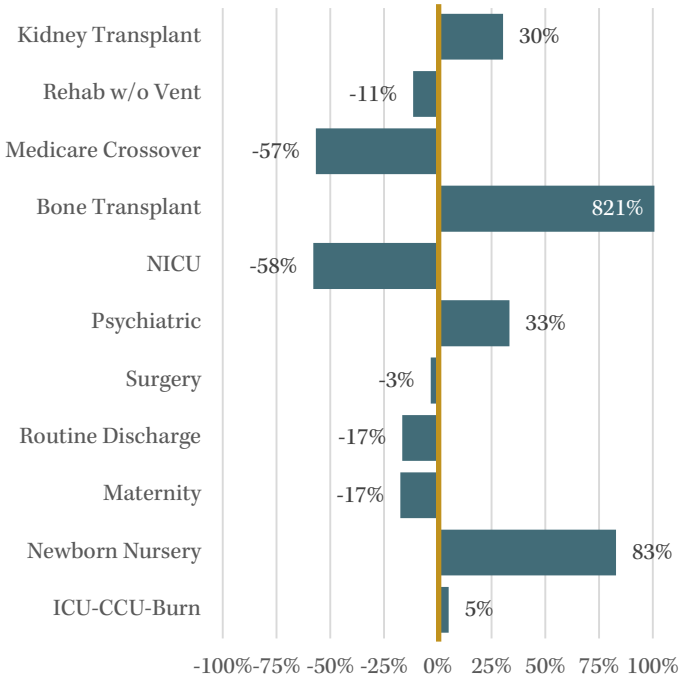


Figure 19. Change in Hospital Inpatient Expenditures by Level of Care

Eligible hospitals who serve a disproportionate number of low-income individuals also receive **Disproportionate Share Hospital (DSH)** payments as required by Federal law. These payments are capped according to state-specific allotments. DSH payments are approximately $250K per year for all Wyoming hospitals due to Wyoming's low historical allottment from this Federal program.

OUTPATIENT SERVICES

Medicaid covers outpatient hospital services, including emergency room, surgery, laboratory, radiology, and other testing services. For individuals over age 21, visits to hospital outpatient departments are limited to a maximum of 12 per calendar year. There are no limits for Medicare crossovers, children under age 21, or for visits for family planning, Health Check services, and emergency room.

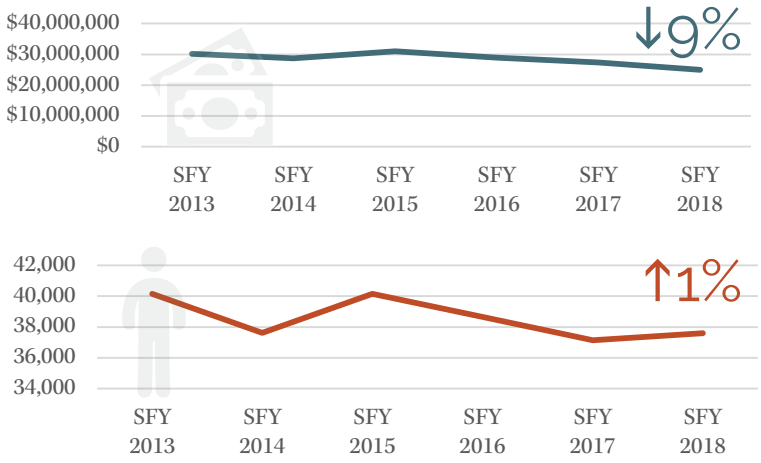


Table 33. Outpatient Hospital Services Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$30,189,391	$28,703,147	$31,056,066	$28,975,050	$27,373,462	$25,021,868	-17
Recipients	40,147	37,618	40,150	38,654	37,151	37,608	-6
Expenditures per Recipient	$752	$763	$774	$750	$737	$665	-12
QRA (Federal Share)	$6,081,517	$6,004,985	$6,773,605	$9,463,689	$9,002,053	$9,461,519	56
Total Expenditures w/ QRA	$36,270,908	$34,708,132	$37,829,671	$38,438,739	$36,375,515	$34,483,386	-5

For each unit of service, reimbursement equals the scaled relative weight for the **Ambulatory Payment Classification (APC)**, multiplied by a conversion factor.[23] When multiple units of service and different services are provided, reimbursements are subject to discounting and unit limitations. This is designed to reimburse hospitals based on the resources used to provide services. Medicaid uses 3 conversion factors by hospital type: General Acute, Critical Access, and Children's Hospitals.

APC APPLIES TO[24]:

- Significant outpatient procedures
- Ancillary services
- Drugs
- Select laboratory services
- Radiology
- Select DME, Prosthetics/Orthotics
- Select Vaccines/Immunization not reimbursed under Medicaid's physician fee schedule

[23] 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.

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

EMERGENCY ROOM UTILIZATION

The methodology used to identify emergency room utilization has been updated in SFY 2017. This data excludes those visits that result in an inpatient admission for both visit count and expenditures. Total ER expenditures include the total amount paid on claims with a line indicating treatment in the ER. This change was made to include the cost of laboratory, radiology, and other tests that may not be performed in the ER setting, but are still associated with the ER visit.

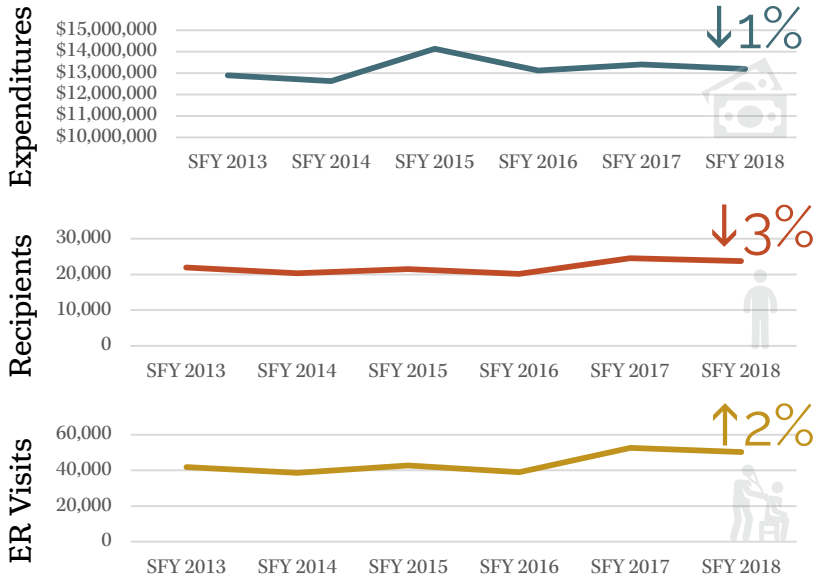


Table 34. Emergency Room Utilization Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$12,896,119	$12,626,625	$14,135,281	$13,112,661	$13,392,689	$13,193,860	2
Recipients	21,957	20,330	21,541	20,213	24,573	23,761	8
Expenditures per Recipient	$587	$621	$656	$649	$545	$555	-5
Emergency Room Visits	41,788	38,687	42,759	39,048	52,518	50,246	20
% of Total Medicaid Expenditures	2.5%	2.4%	2.7%	2.4%	2.4%	2.3%	

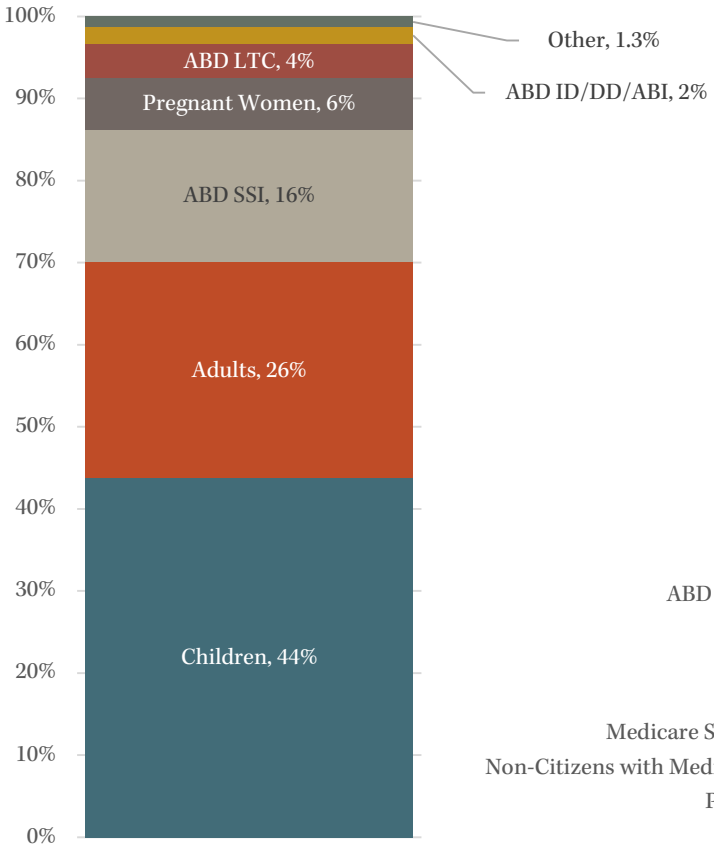


Figure 20. Emergency Room Expenditures by Eligibility Category

As shown to the left, 44% of emergency room expenditures were spent on Children. The 1.3% allotted to "Other" includes the ABD EID, Medicare Savings Program, Non-Citizens with Medical Emergencies, Special Groups, and Institution eligibility categories.

The chart below shows the average annual growth rate for each eligibility category's emergency room expenditures from SFY 2013 to SFY 2018.

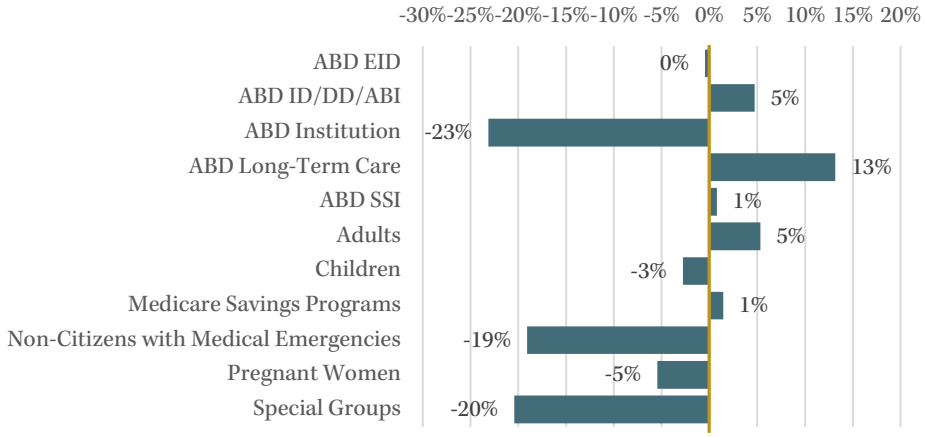


Figure 21. Average Yearly Growth Rate of Emergency Room Expenditures by Eligibility Category

Table 35. Emergency Room Utilization by Eligibility Category

Eligibility Category	Expenditures[25]	% Change from SFY 2017	Recipients	% Change from SFY 2017	ER Visits	% Change from SFY 2017
ABD EID	$64,170	-42	122	-18	274	-19
ABD ID/DD/ABI	$263,415	7	753	-2	1,729	6
ABD Institution	$3,322	-41	16	-45	18	-45
ABD LTC	$560,319	19	1,551	7	4,178	17
ABD SSI	$2,138,182	-4	2,605	-1	7,523	-5
Adults	$3,465,428	-3	3,823	-7	9,169	-10
Children	$5,775,363	0	12,646	-5	21,221	-6
Medicare Savings Program	$57,474	3	847	5	1,797	2
Non-Citizens with Medical Emergencies	$19,829	-53	26	-42	51	-37
Pregnant Women	$820,130	-5	1,287	-4	2,311	-10
Special Groups	$26,606	-10	20	-46	68	-1
Total	$13,193,860	-1	23,761	-3	50,246	-4

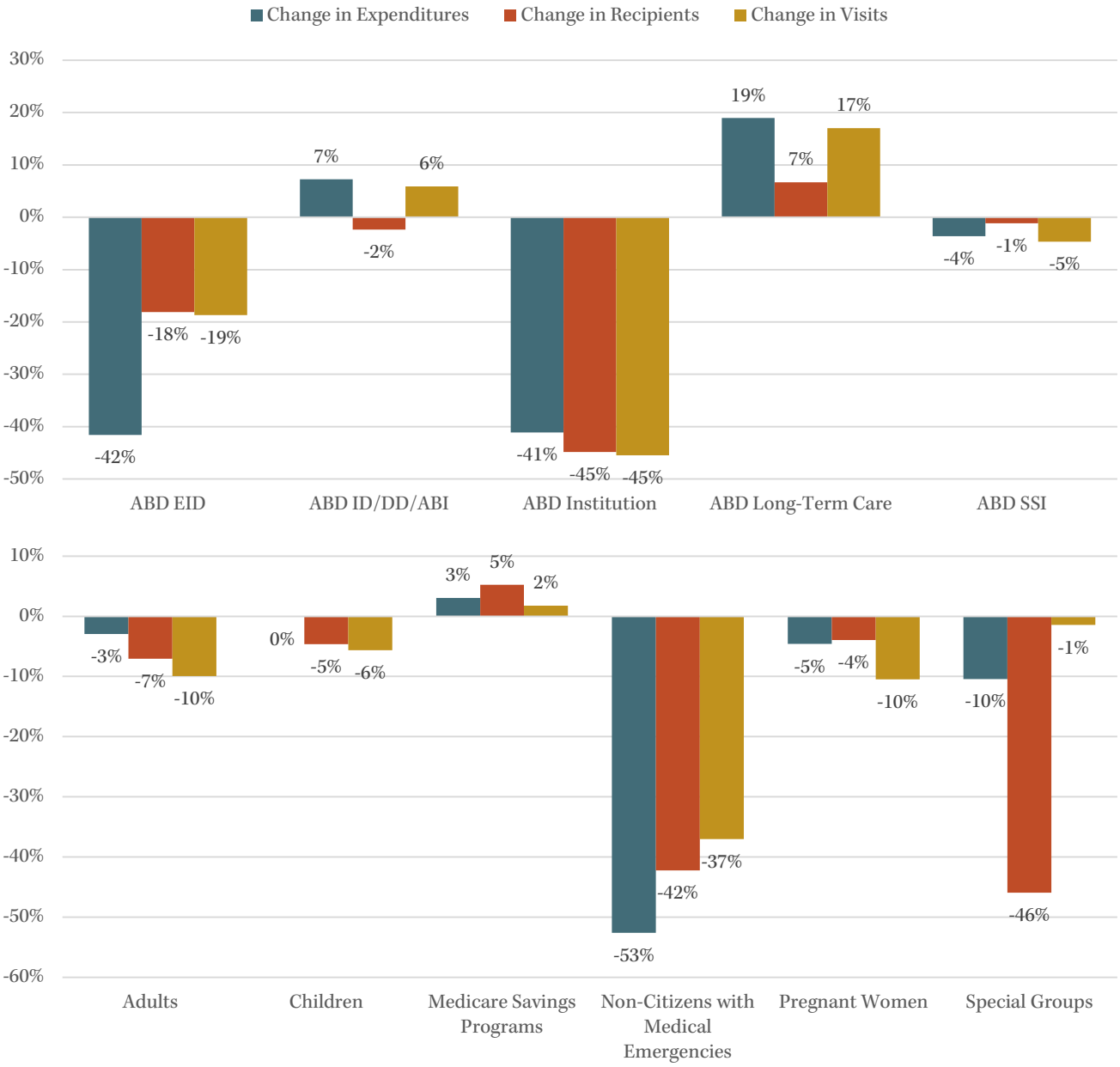


Figure 22. Change in Emergency Room Utilization from SFY 2017 to SFY 2018 by Eligibility Category

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

Nearly one-third (32%) of Medicaid recipients used emergency room services in SFY 2018. ABD SSI had the greatest portion of recipients receiving emergency room services, with 42%, while Special Groups had the fewest percentage, with 17%.

Emergency room services accounted for 2.3% of total Medicaid expenditures in SFY 2018, with the Adult population having the greatest percentage (7.5%) of their total expenditures going toward emergency room services.

Emergency room expenditures for Non-citizens with Medical Emergencies only account for 2.8% of their total expenditures due to emergency room utilization excluding any Emergency Room visit that results in an inpatient admission.

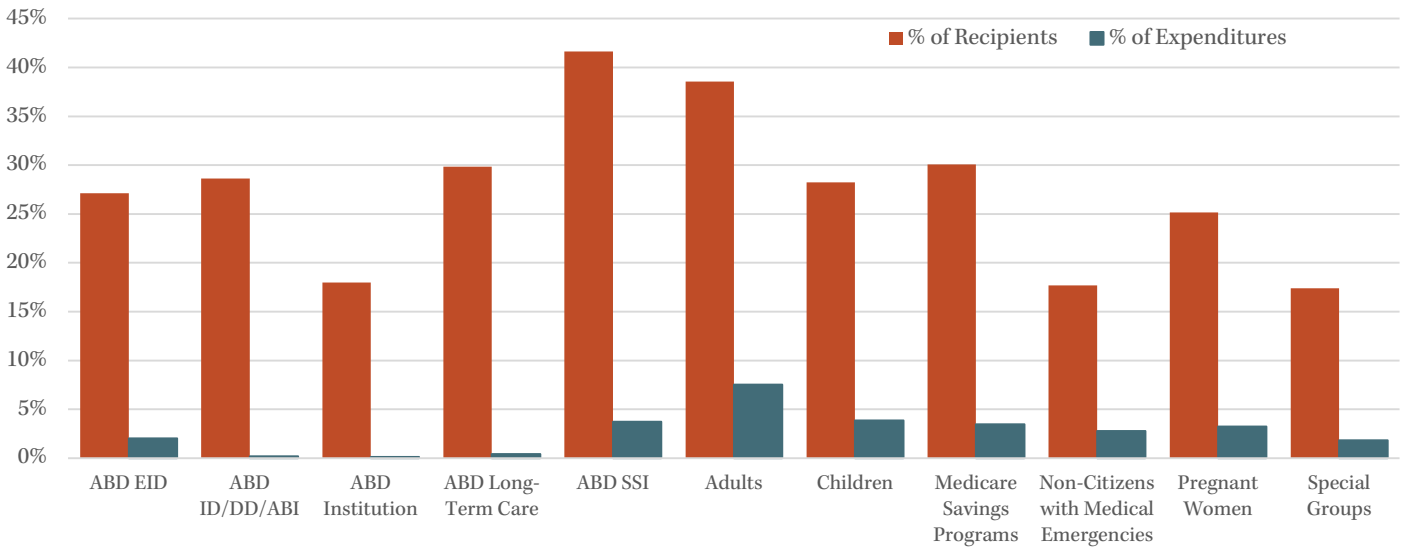


Figure 23. Emergency Room Utilization vs Total Medicaid by Eligibility Category

Table 36. Emergency Room Utilization vs Total Medicaid by Eligibility Category

Eligibility Category	ER Recipients	Total Medicaid Recipients	% Using ER Services	ER Expenditures	Total Medicaid Expenditures[26]	% Paid for ER Services
ABD EID	122	450	27%	$64,170	$3,170,198	2.0%
ABD ID/DD/ABI	753	2,631	29%	$263,415	$139,120,839	0.2%
ABD Institution	16	89	18%	$3,322	$2,489,828	0.1%
ABD LTC	1,551	5,198	30%	$560,319	$137,811,401	0.4%
ABD SSI	2,605	6,255	42%	$2,138,182	$57,608,075	3.7%
Adults	3,823	9,914	39%	$3,465,428	$46,008,562	7.5%
Children	12,646	44,760	28%	$5,775,363	$149,233,800	3.9%
Medicare Savings Program	847	2,816	30%	$57,474	$1,654,936	3.5%
Non-Citizens with Medical Emergencies	26	147	18%	$19,829	$713,218	2.8%
Pregnant Women	1,287	5,115	25%	$820,130	$25,247,867	3.2%
Special Groups	20	115	17%	$26,606	$1,459,944	1.8%
Total	23,761	74,056	32%	$13,193,860	$567,478,640	2.3%

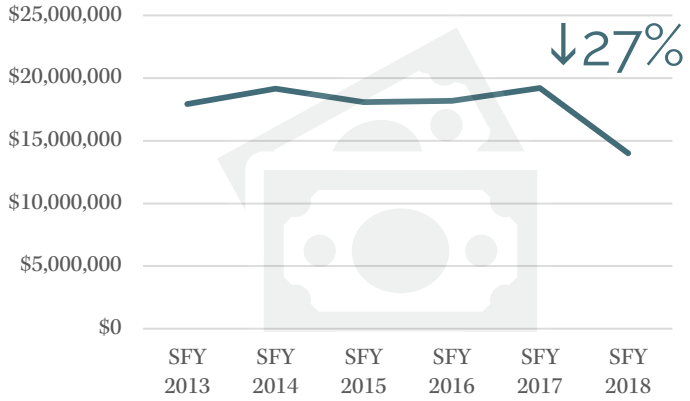
[26] Screenings and Gross Adjustments are excluded from this table; as such, summing expenditures across the eligibility categories will not match the total shown.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABLITIES

Services covered only in a residential facility licensed and certified by the state survey agency as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The Wyoming Life Resource Center is the sole facility in the state. This service is unique to Medicaid and is not commonly covered by other payers.

$13,999,444
3% OF MEDICAID EXPENDITURES

60
0.1% OF MEDICAID RECIPIENTS



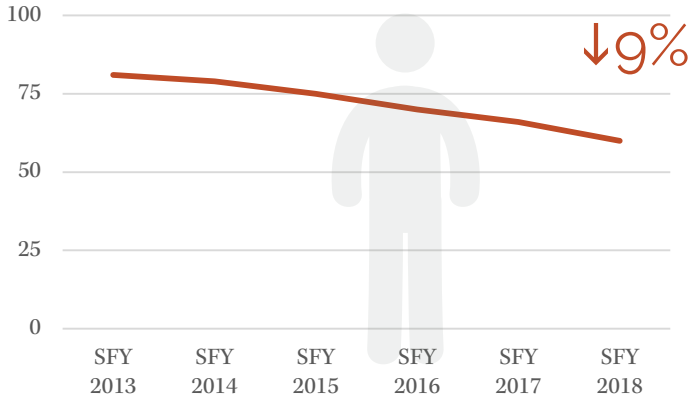


Table 37. Intermediate Care Facility for Individuals with Intellectual Disabilities Services Summary

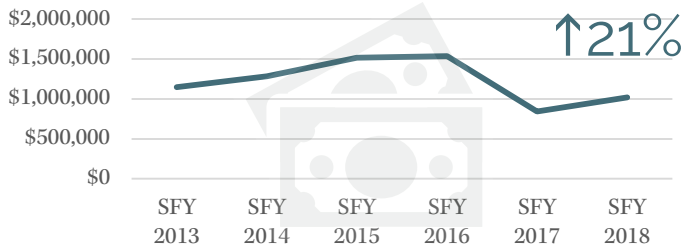
	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$17,942,326	$19,152,530	$18,091,427	$18,193,221	$19,204,867	$13,999,444	-22
Recipients	81	79	75	70	66	60	-26
Expenditures per Recipient	$221,510	$242,437	$241,219	$259,903	$290,983	$233,324	5

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.

$1,020,356
0.2% OF MEDICAID EXPENDITURES

8,286
11% OF MEDICAID RECIPIENTS



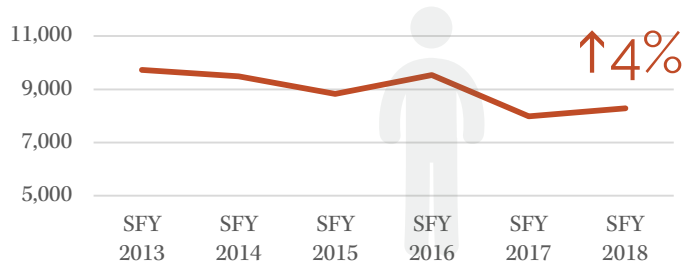


Table 38. Laboratory Services Summary

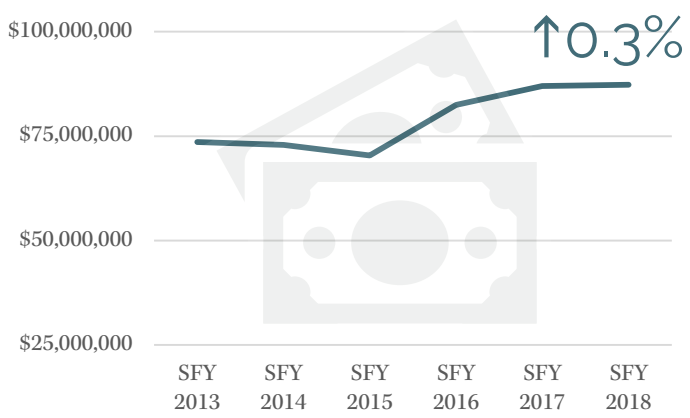
	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$1,149,473	$1,284,678	$1,516,042	$1,536,310	$844,218	$1,020,356	-11
Recipients	9,724	9,490	8,830	9,535	7,983	8,286	-15
Expenditures per Recipient	$118	$135	$172	$161	$106	$123	4

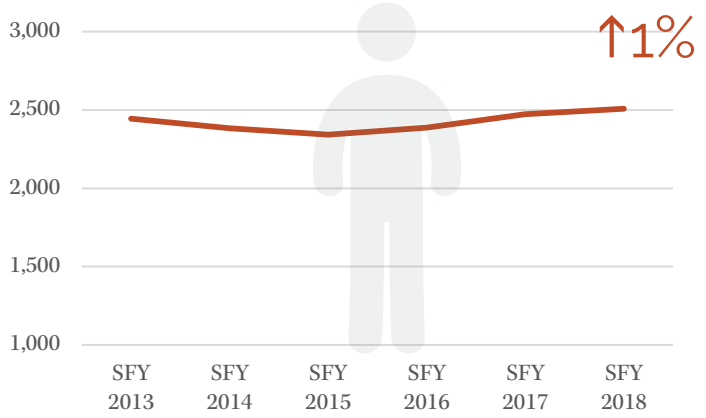
NURSING FACILITY

Medicaid covers nursing facility services for individuals who are no longer able to live in the community. The nursing facility is an institution, or a distinct part of an institution, which is not primarily for the care and treatment of mental diseases, and provides skilled nursing care and related services to residents who require medical or nursing care, rehabilitation services for injured, disabled or sick individuals, and health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which is available to them only through institutional facilities.

$87,304,589 15% OF MEDICAID EXPENDITURES

2,508 3% OF MEDICAID RECIPIENTS





NURSING FACILITY PAYMENT DESCRIPTIONS

Per Diem Rate

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

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

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

Provider Assessment and Upper Payment Limit (UPL)

Supplemental payment for qualified nursing facilities

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

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

Extraordinary Care Per Diem Rates

Paid for services provided to a resident with extraordinary needs

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

Enhanced Adult Psychiatric Reimbursement

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

Figure 24. Nursing Facility Payment Descriptions

Table 39. Nursing Facility Services Summary

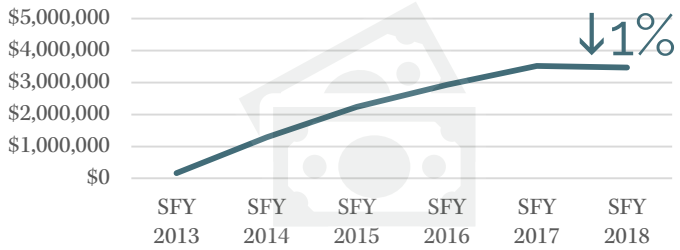
	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$73,593,462	$72,866,933	$70,354,260	$82,445,811	$87,001,112	$87,304,589	19
Recipients	2,445	2,384	2,342	2,387	2,474	2,508	3
Expenditures per Recipient	$30,100	$30,565	$30,040	$34,540	$35,166	$34,810	16
Provider Assessment (Federal Share)	$14,299,645	$15,537,040	$15,219,087	$14,689,893	$15,275,937	$16,385,303	15
Total Expenditures with Provider Assessment	$87,893,107	$88,403,973	$85,573,347	$97,135,704	$102,277,049	$103,689,892	18

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

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.

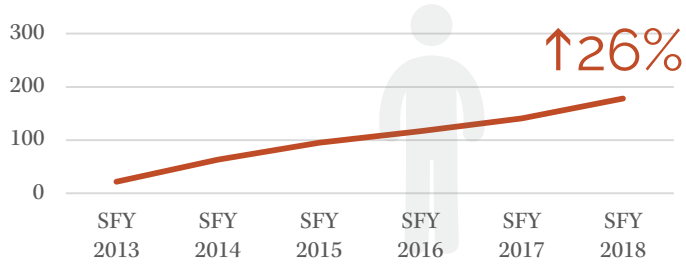
$3,471,255

0.6% OF MEDICAID EXPENDITURES



178

0.2% OF MEDICAID RECIPIENTS



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

Table 40. Program of All-Inclusive Care for the Elderly Services Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$168,554	$1,281,485	$2,242,070	$2,949,312	$3,525,507	$3,485,761	1,968
Recipients	23	63	97	120	142	179	678
Expenditures per Recipient	$7,328	$20,341	$23,114	$24,578	$24,828	$19,474	166

PHYSICIANS AND OTHER PRACTITIONERS

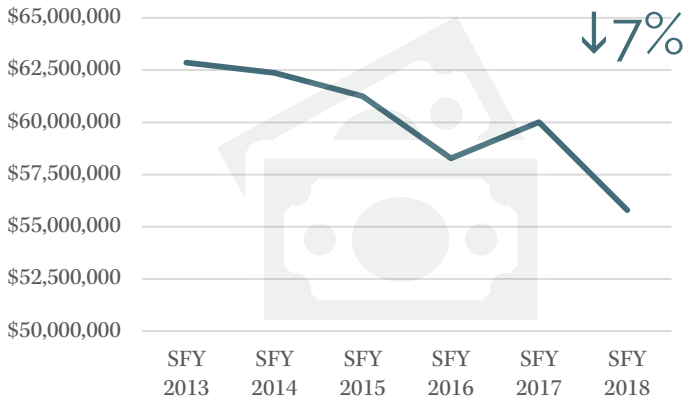
Services provided by physicians and other practitioners, with the following limits:

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

There is no limit for Medicare crossovers or children under age 21; also no limit for family planning visits, Health Check services, or emergency services.

$55,788,175

10% OF MEDICAID EXPENDITURES



62,488

84% OF MEDICAID RECIPIENTS

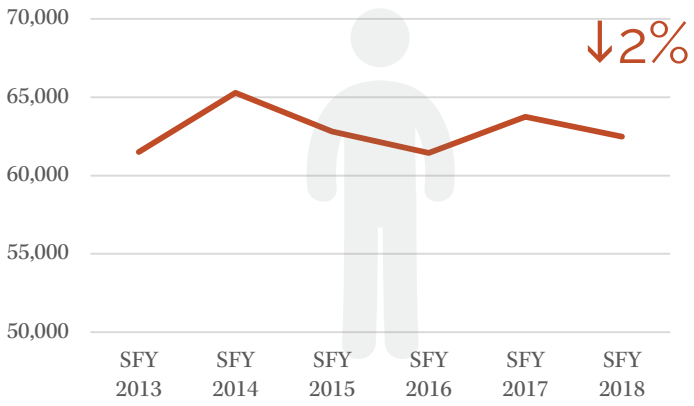


Table 41. Physician and Other Practitioner Services Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Total Physician and Other Practitioner Services							
Expenditures	$62,856,989	$62,372,535	$61,249,367	$58,278,406	$60,013,763	$55,788,175	-11
Recipients	61,515	65,284	62,816	61,442	63,747	62,489	2
Expenditures per Recipient	$1,022	$955	$975	$949	$941	$893	-13
Physician Only Services							
Expenditures	$57,459,450	$56,694,139	$54,142,991	$50,015,210	$51,857,906	$48,991,617	-15
Recipients	60,830	64,720	62,108	60,679	63,045	61,955	2
Expenditures per Recipient	$945	$876	$872	$824	$823	$791	-16
Other Practitioner Services							
Expenditures	$5,397,540	$5,678,397	$7,106,377	$8,263,196	$8,155,858	$6,796,557	26
Recipients	8,034	7,778	9,208	9,075	8,622	7,097	-12
Expenditures per Recipient	$672	$730	$772	$911	$946	$958	43

The majority of Medicaid expenditures for these services is paid to physicians; however, Figure 25 to the right shows that the ABD ID/DD/ABI eligibility category spends a greater percentage for other practitioners than for physicians.

Other Practitioners

Physical Therapists
Occupational Therapists
Speech-Language Pathologists
Podiatrists
Nurse Practitioners
Nurse Midwives
Nurse Anesthetists
Audiologists

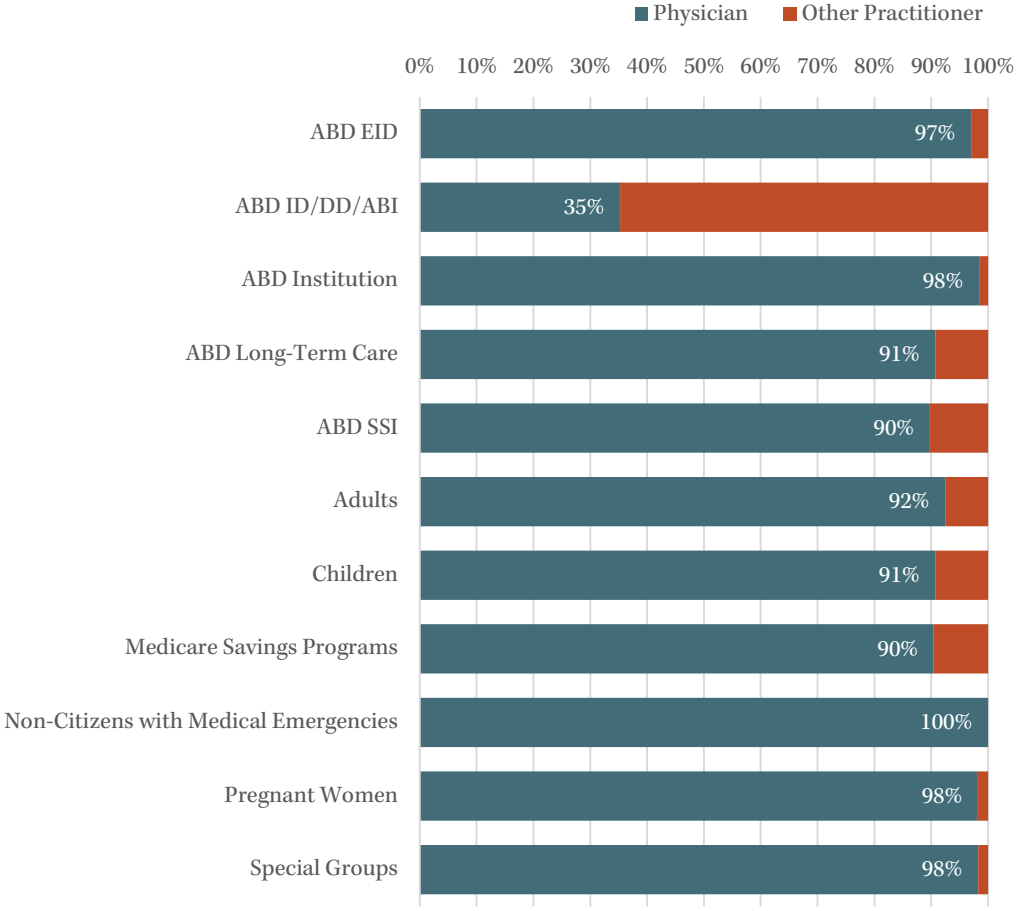


Figure 25. Physician and Other Practitioner Expenditure Breakdown by Eligibility Category

RESOURCE-BASED RELATIVE VALUE SCALE

Used to reimburse medical services provided by physicians, physician assistants, physical and occupational therapists, ophthalmologists, and nurse practitioners. Based on estimates of the costs of resources required to provide physician services using a relative value unit (RVU) and conversion factor.

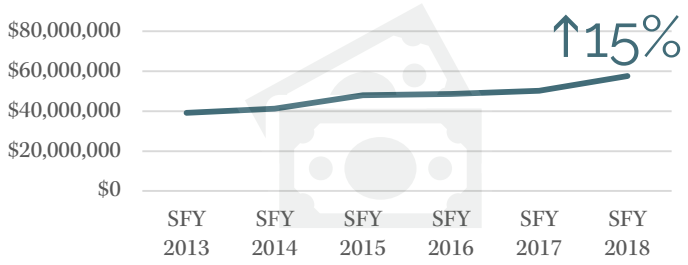
RVU x Conversion Factor = fee schedule rate

RVU reflects the resources used by a physician to deliver a service, compared to resources used for other physicians' services, taking into consideration the time and intensity of the physician's effort, and the physician's practice and malpractice expenses. Services provided by anesthesiologists are reimbursed using RVUs developed and published by the American Society of Anesthesiologists.

PRESCRIPTION DRUGS

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.

$57,642,641
10% OF MEDICAID EXPENDITURES



42,002
57% OF MEDICAID RECIPIENTS

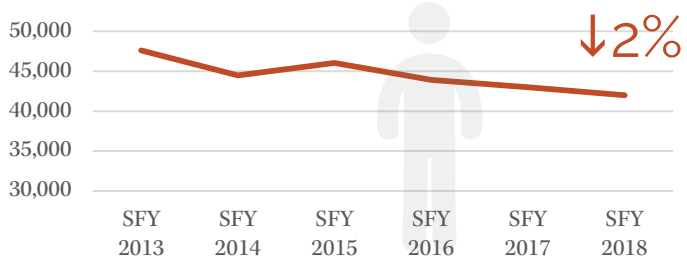


Table 42. Prescription Drug Services Summary [27]

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$39,110,022	$41,238,663	$47,946,923	$48,597,364	$50,300,175	$57,642,641	47
Recipients	47,607	44,464	46,031	43,926	42,990	42,002	-12
Expenditures per Recipient	$822	$927	$1,042	$1,106	$1,170	$1,372	67

128
specific drug classes designated as preferred drugs in SFY 2018

Drug Utilization Review (DUR) program ensures individuals receive appropriate, medically necessary medications. More information is available in the Subprograms section of this report.

Drug Rebate Program

Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). Requires drug manufacturers have national rebate agreement with HHS Secretary. For a prescription drug to be covered, Medicaid must receive an OBRA rebate for it. This federal mandate provides Medicaid the opportunity to receive greatly discounted products, similar to those offered to large purchases in the marketplace.

Medicaid is a member of the Sovereign States Drug Consortium (SSDC), 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.

$5.75 million
collected in J-Code rebates[28] from drug manufacturers for physician-administered or injectable drugs

Table 43. Pharmacy Cost Avoidance - SFY 2018

Program Area	Cost Avoidance
Prior Authorization (PA) Preferred Drug List (PDL)	$10,756,339
State Maximum Allowable Cost (SMAC)	$900,210
Program Integrity Cost Avoidance	$1,092,461
Total	$12,749,010

Table 44. Prescription Drug Rebates History

	Rebate (millions)
SFY 2012	$19.3
SFY 2013	$19.4
SFY 2014	$21.4
SFY 2015	$20.1
SFY 2016	$31.4
SFY 2017	$27.7
SFY 2018	$30.4

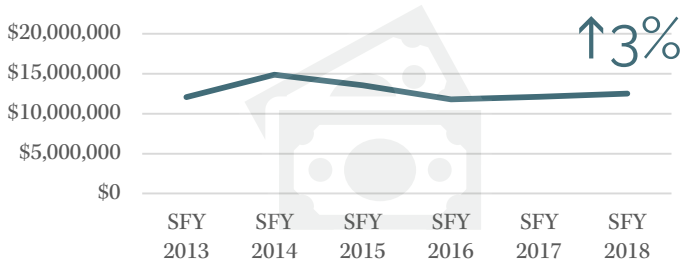
[27] Data includes expenditures for pharmacies only and does not take into account rebate amounts.
[28] J-code rebates are mandated by the Deficit Reduction Act of 2005

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

Medicaid covers psychiatric residential treatment for individuals under age 21 at a Psychiatric Residential Treatment Facility (PRTF), a stand-alone entity providing a range of comprehensive services to treat the psychiatric conditions of residents under the direction of a physician, with a goal of improving the resident's condition or preventing further regression so services will no longer be needed.

$12,537,788 2% OF MEDICAID EXPENDITURES

296 0.4% OF MEDICAID RECIPIENTS



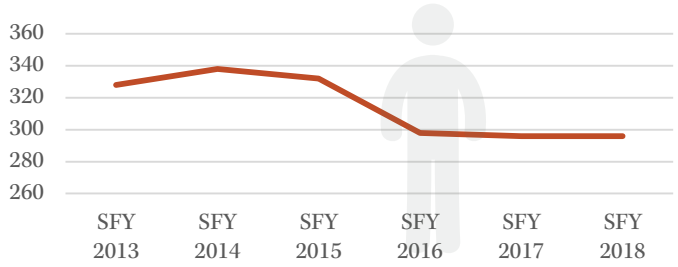


Table 45. Psychiatric Residential Treatment Facility Services Summary [29]

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$12,080,494	$14,886,133	$13,575,847	$11,797,657	$12,121,830	$12,537,788	4
Recipients	328	338	332	298	296	296	-10
Expenditures per Recipient	$36,831	$44,042	$40,891	$39,589	$40,952	$42,357	15

Per CMS guidelines, Medicaid cannot receive the Federal Medical Assistance Percentage (FMAP) for court-ordered PRTF services. 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. 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.

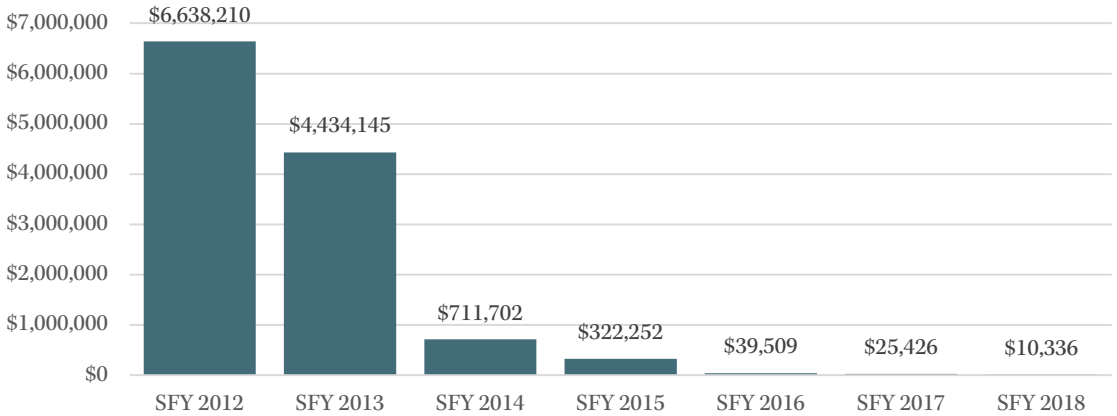


Figure 26. Expenditures for Court Ordered Psychiatric Residential Treatment Facility Services with Incorrect Language or No Medical Necessity

[29] 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).

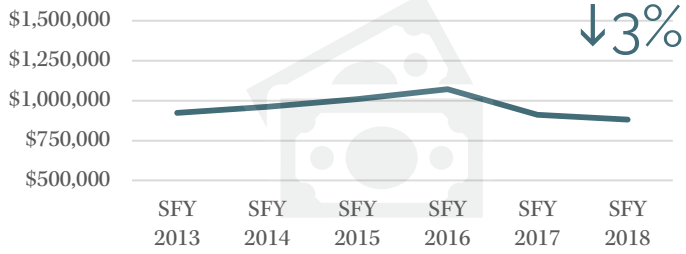
PUBLIC HEALTH OR WELFARE

Physician and mid-level practitioner services provided in a clinic designated by the Department of Health as a public health clinic. These services must be provided directly by a physician or a public health nurse under a physician's immediate supervision, such as when the physician has seen the client and ordered the service.

$881,179

0.2% OF MEDICAID EXPENDITURES

↓3%



5,783

8% OF MEDICAID RECIPIENTS

↑2%

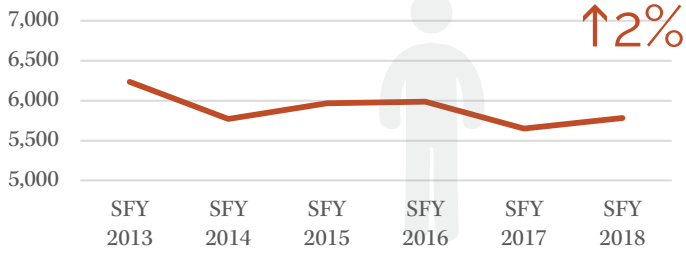


Table 46. Public Health or Welfare Services Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$924,007	$962,164	$1,009,814	$1,072,715	$912,444	$881,179	-5
Recipients	6,238	5,772	5,967	5,986	5,650	5,783	-7
Expenditures per Recipient	$148	$167	$169	$179	$161	$152	3

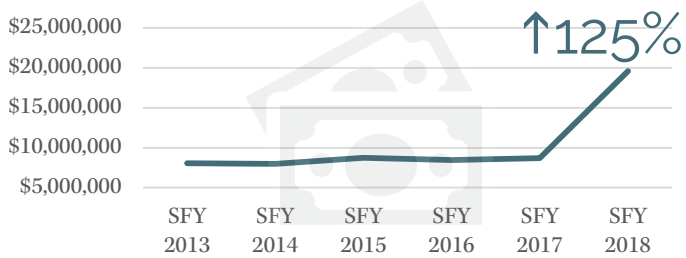
PUBLIC HEALTH FEDERAL

These services are provided to the American Indian/Alaskan Native population by Tribal Contract Health Centers and Indian Health Centers. Tribal Contract Health Centers are outpatient health care programs and facilities owned or operated by the Tribes or Tribal organizations. The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing comprehensive primary care and related services to the American Indian/Alaska Native Population. Services provided by these facilities are claimed by the state at 100% Federal Financial Participation (FFP).

$19,625,445

4% OF MEDICAID EXPENDITURES

↑125%



5,783

8% OF MEDICAID RECIPIENTS

↑2%

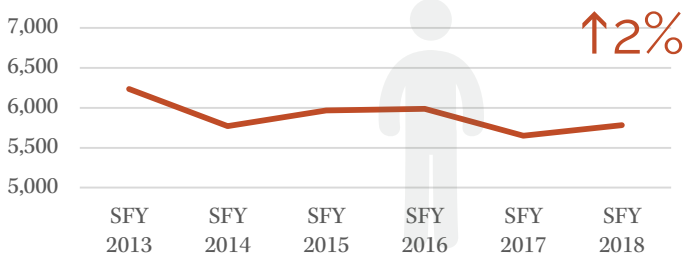


Table 47. Public Health, Federal Services Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$8,067,975	$7,999,556	$8,761,358	$8,479,944	$8,718,888	$19,625,445	143
Recipients	4,222	3,546	3,382	3,414	3,489	4,065	-4
Expenditures per Recipient	$1,911	$2,256	$2,591	$2,484	$2,499	$4,828	153

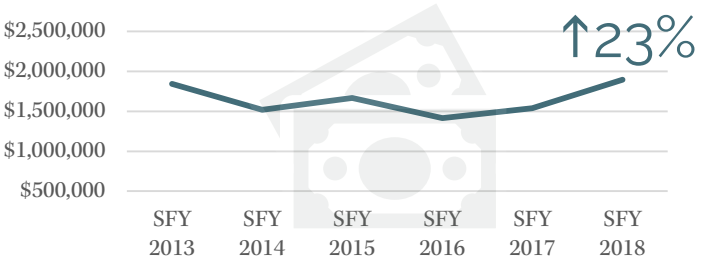
A policy change increased the reimbursement rate and number of encounters that could be billed by IHS/638 Facilities, thus driving the increases in this service area. These are 100% Federally Funded.

RURAL HEALTH CLINIC

Primary care services provided at a Rural Health Clinic, as designated by Medicare if it is located in a "shortage area", a geographic area designated by the HHS as having a shortage of personal health services or primary medical care professionals. Medicaid covers services provided by a physician, nurse practitioner, certified nurse midwife, visiting nurse, clinical psychologist, certified social worker, and physician assistent, as well as services and supplies incident to a physician's service.

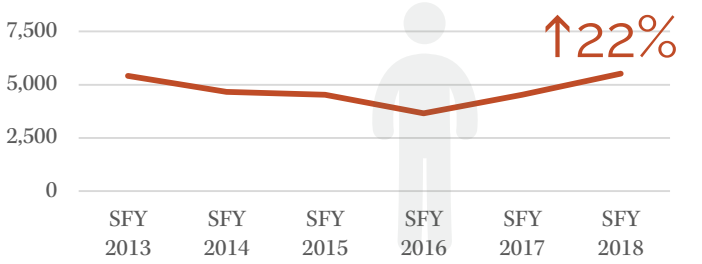
$1,894,505

0.3% OF MEDICAID EXPENDITURES



5,523

7% OF MEDICAID RECIPIENTS



RHCs are reimbursed through an encounter rate; therefore, it is expected that as recipients increase, expenditures would also increase. The reimbursement rate includes the office visit, as well as any ancillary services provided (x-rays, etc.). Adjustments may be made to rates if a provider requests a review of its rate based on a change in its scope of service.

Table 48. Rural Health Clinic Services Summary

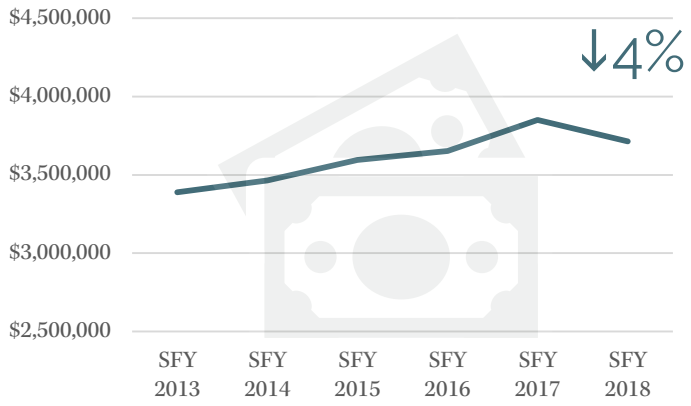
	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$1,845,491	$1,521,233	$1,668,167	$1,413,842	$1,540,607	$1,894,505	3
Recipients	5,418	4,670	4,530	3,663	4,535	5,523	2
Expenditures per Recipient	$341	$326	$368	$386	$340	$343	1

VISION

Medicaid covers vision services provided by opticians, optometrists, and ophthalmologists, with services dependent on recipient age. Children receive services to correct and maintain healthy vision, including eyeglasses (frames, frame parts, and lenses) and vision therapy based on diagnosis codes. Adults may receive services to treat an eye injury or eye disease. Vision services provided by ophthalmologists are included in the Physician and Other Practitioners section of this report.

$3,712,855

0.7% OF MEDICAID EXPENDITURES



15,804

21% OF MEDICAID RECIPIENTS

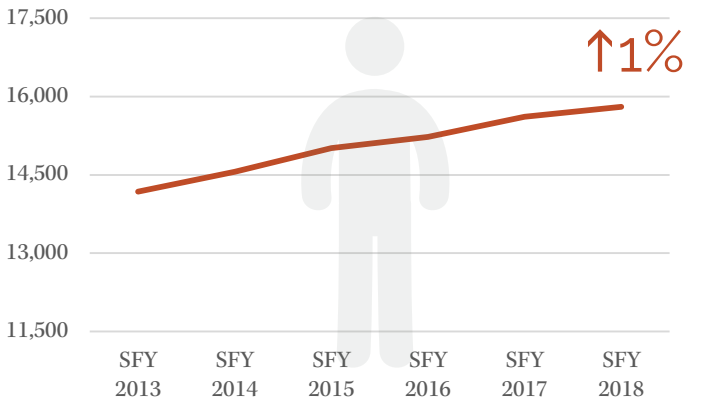


Table 49. Vision Services Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$3,389,793	$3,464,394	$3,595,216	$3,652,188	$3,850,574	$3,712,855	10
Recipients	14,180	14,558	15,010	15,227	15,612	15,804	11
Expenditures per Recipient	$239	$238	$240	$240	$247	$235	-2

WAIVERS

Medicaid offers various waivers with approval from CMS to selectively "waive" one or more Medicaid requirements to allow greater flexibility in the Medicaid program.

Medicaid offers four Home and Community Based Services (HCBS) waivers and one Section 1115 waiver, as shown in Figure 31.

HCBS Waiver participants receive specific waiver services, as well as the standard Medicaid package of benefits. Pregnant by Choice Waiver individuals only receive waiver services.

This section provides data on both the waiver-only services and the additional Medicaid services, referred to in this report as "non-waiver" services. The non-waiver service data is incorporated into the totals for the individual services defined in this report.

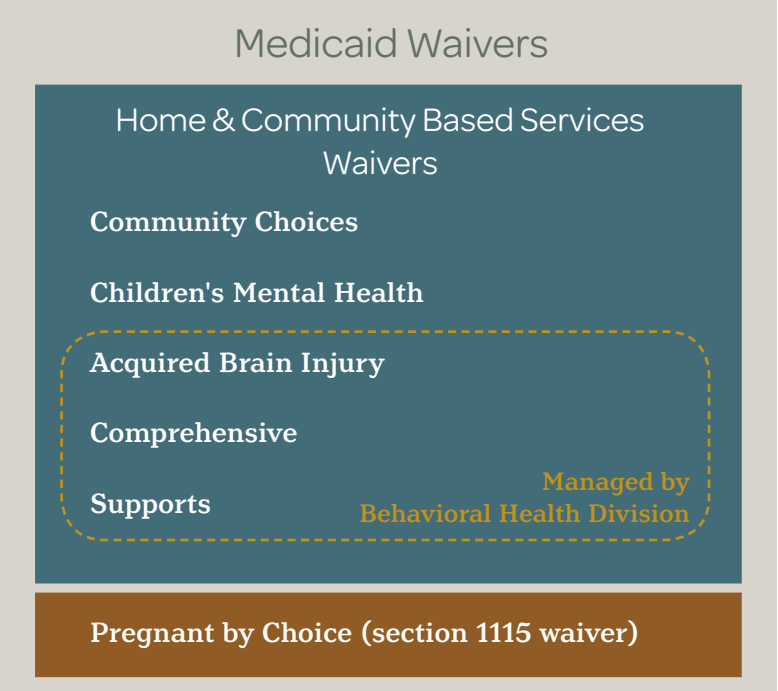


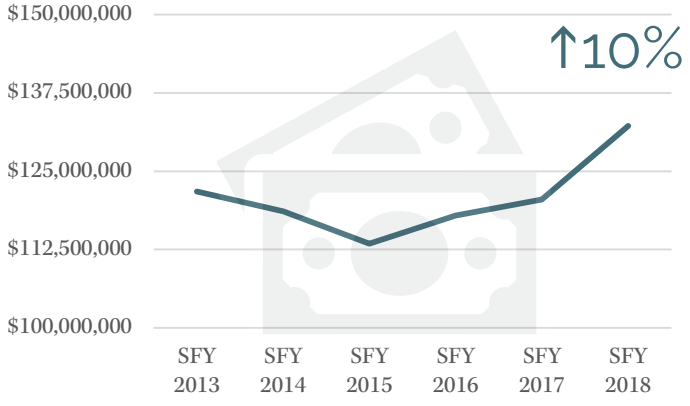
Figure 27. Medicaid Waivers

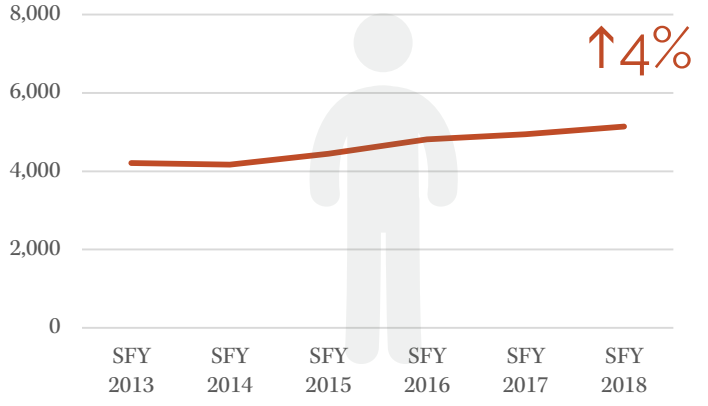
HOME AND COMMUNITY BASED SERVICES WAIVERS

These waivers provide care in the home and community to the elderly and disabled, intellectually disabled, developmentally disabled and certain other disabled adults enrolled in Medicaid.

$132,243,321 — 23% OF MEDICAID EXPENDITURES

5,139 — 7% OF MEDICAID RECIPIENTS





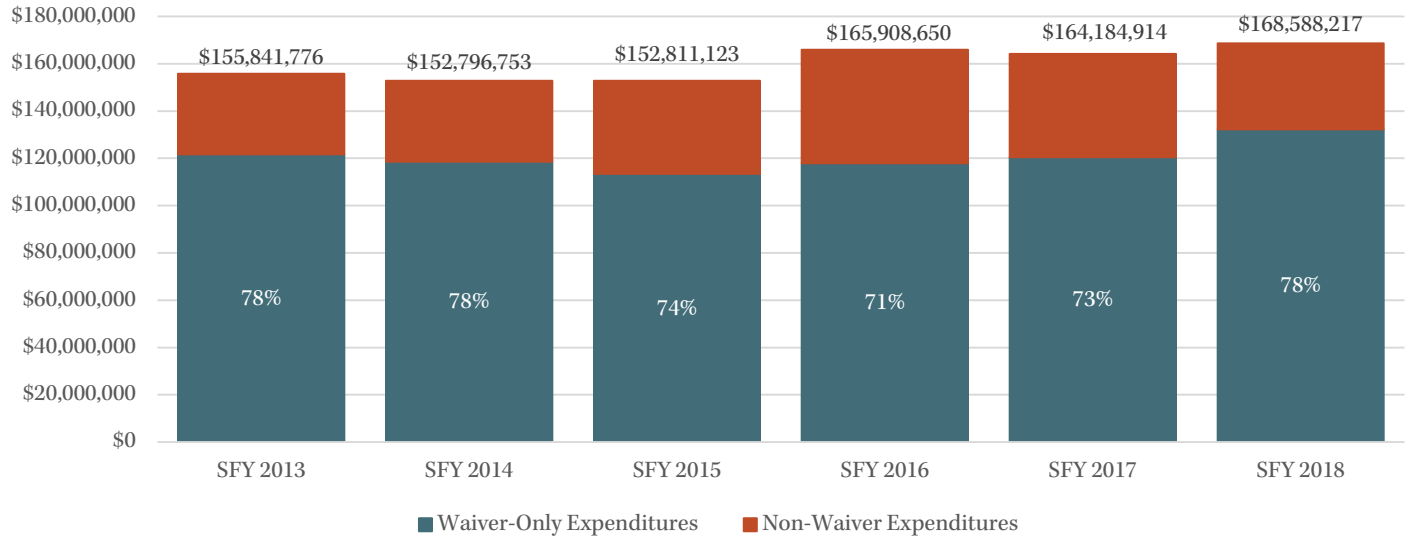
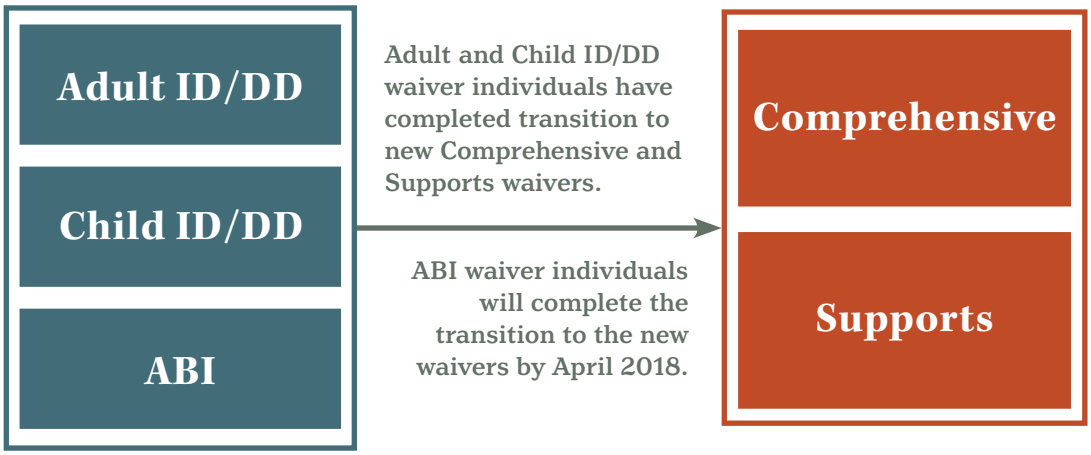


Figure 28. Waiver vs Non-Waiver Expenditures History

Table 50. Home and Community Based Services Waiver Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Waiver Only Services							
Expenditures	$121,752,688	$118,624,631	$113,452,108	$117,950,473	$120,465,765	$132,243,321	9
Recipients	4,207	4,168	4,443	4,818	4,944	5,139	22
Expenditures per Recipient	$28,941	$28,461	$25,535	$24,481	$24,366	$25,733	-11
% Waiver-Only of Total Waivers	78%	78%	74%	71%	73%	78%	
Non-Waiver Services							
Expenditures	$34,089,088	$34,172,122	$39,359,014	$47,958,177	$43,719,149	$36,344,896	7
Recipients	4,391	4,352	4,528	4,919	5,114	5,279	20
Expenditures per Recipient	$7,763	$7,852	$8,692	$9,750	$8,549	$6,885	-11
Total Waiver							
Expenditures	$155,841,776	$152,796,753	$152,811,123	$165,908,650	$164,184,914	$168,588,217	8
Recipients	4,504	4,462	4,667	5,085	5,271	5,459	21
Expenditures per Recipient	$34,601	$34,244	$32,743	$32,627	$31,149	$30,883	-11



Additionally children enrolled in the Children's Mental Health waiver now receive all their case management services through the Care Management Entity service, highlighted earlier in this report.

Due to the above changes, the Adult ID/DD, Child ID/DD, and Children's Mental Health waivers are included in Table 51 to show their historical trends; however, these waivers will not be reported in further detail in this section.

Figures 29 and 30 show the historical change in expenditures as the transition to Comprehensive and Supports waivers have been implemented. From SFY 2013 to SFY 2018, total expenditures for these populations have increased 1.3%, with non-waiver expenditures increasing by 8%.

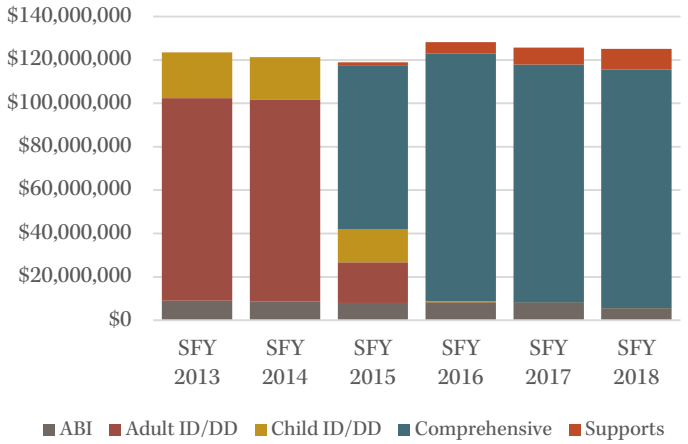


Figure 29. Total Expenditure History for Transition from Adult and Child ID/DD Waivers to Comprehensive and Supports Waivers

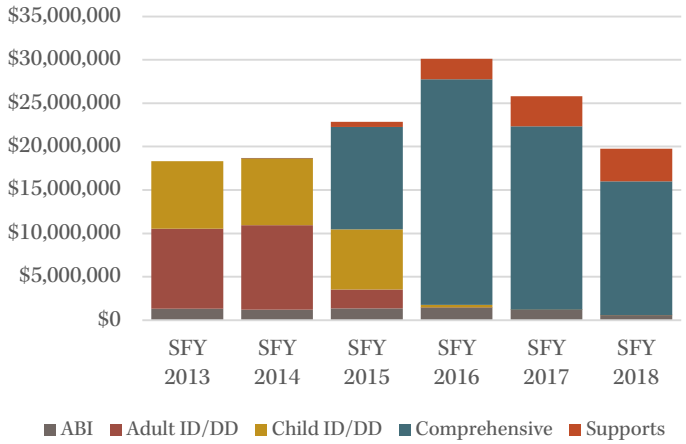


Figure 30. Non-Waiver Services Expenditure History for Transition from Adult and Child ID/DD Waivers to Comprehensive and Supports Waivers

Table 51. Home and Community Based Services Waiver Expenditures History by Waiver

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Waiver Only Services						
ABI	$7,679,811	$7,371,614	$6,636,440	$6,748,171	$6,960,893	$4,948,202
Adult ID/DD	$84,204,861	$83,501,095	$16,541,190	$1,674	$1,565	--
Child ID/DD	$13,301,942	$11,415,264	$8,372,841	$179,173	--	--
Children's Mental Health	$688,995	$527,514	$732,257	$61,981	--	--
Community Choices	$15,877,079	$15,763,707	$16,630,675	$19,801,419	$20,597,605	$26,930,997
Comprehensive	--	$44,982	$63,719,016	$88,377,607	$88,527,446	$94,568,471
Supports	--	$454	$819,690	$2,780,450	$4,378,255	$5,795,651
Non-Waiver Services						
ABI	$1,331,294	$1,211,369	$1,351,962	$1,470,018	$1,211,223	$575,512
Adult ID/DD	$9,222,040	$9,723,128	$2,198,325	$8,222	$1,035	$36
Child ID/DD	$7,751,518	$7,704,616	$6,905,996	$289,231	$8,476	$218
Children's Mental Health	$734,835	$794,094	$1,009,279	$880,934	$675,081	$814,392
Community Choices	$15,049,401	$14,722,651	$15,503,721	$16,951,952	$17,240,246	$15,753,166
Comprehensive	--	$16,150	$11,813,805	$25,986,468	$21,106,234	$15,405,710
Supports	--	$114	$575,926	$2,371,351	$3,476,854	$3,795,863
Total Waiver						
ABI	$9,011,104	$8,582,983	$7,988,402	$8,218,189	$8,172,117	$5,523,714
Adult ID/DD	$93,426,901	$93,224,222	$18,739,515	$9,897	$2,600	$36
Child ID/DD	$21,053,459	$19,119,880	$15,278,837	$468,404	$8,476	$218
Children's Mental Health	$1,423,830	$1,321,609	$1,741,535	$942,915	$675,081	$814,392
Community Choices	$30,926,481	$30,486,358	$32,134,396	$36,753,371	$37,837,852	$42,684,163
Comprehensive	--	$61,132	$75,532,821	$114,364,075	$109,633,679	$109,974,181
Supports	--	$568	$1,395,616	$5,151,800	$7,855,109	$9,591,514

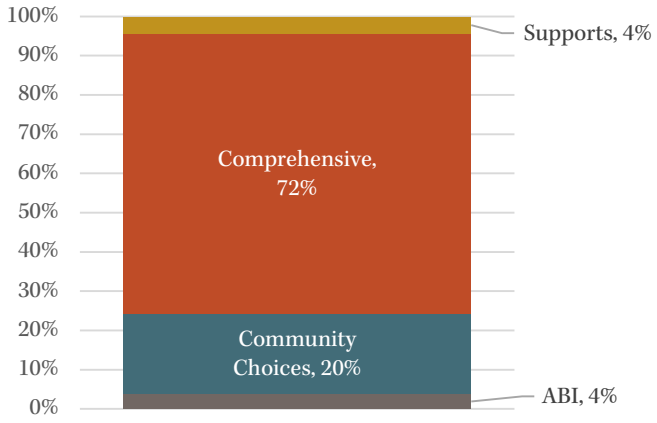


Figure 32. SFY 2018 Total Waiver Expenditure Breakdown by Waiver

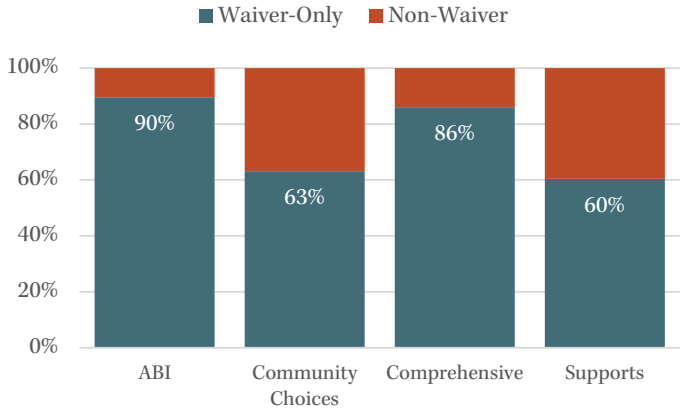


Figure 31. SFY 2018 Waiver-Only versus Non-Waiver Services by Waiver

ACQUIRED BRAIN INJURY

This Medicaid waiver is managed by the Behavioral Health Division (BHD) to provide services to adults with acquired brain injury (ABI). Assists adults, ages 21 to 65, with an ABI in receiving training and support so they may remain in their home communities and avoid institutionalization.

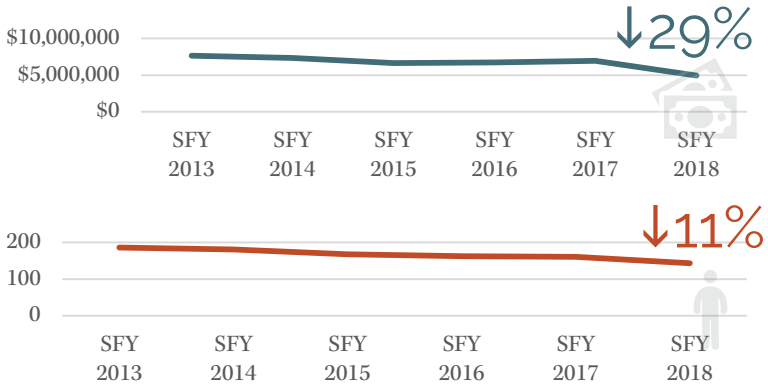


Table 52. Acquired Brain Injury Waiver Summary

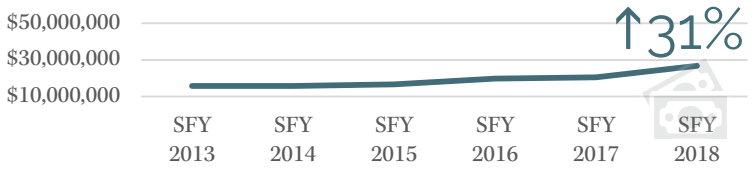
	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Waiver Only Services							
Expenditures	$7,679,811	$7,371,614	$6,636,440	$6,748,171	$6,960,893	$4,948,202	-36
Recipients	186	181	168	163	161	144	-23
Expenditures per Recipient	$41,289	$40,727	$39,503	$41,400	$43,235	$34,363	-17
% Waiver-Only of Total Waivers	85%	86%	83%	82%	85%	90%	
Non-Waiver Services							
Expenditures	$1,331,294	$1,211,369	$1,351,962	$1,470,018	$1,211,223	$575,512	-57
Recipients	192	178	169	165	160	146	-24
Expenditures per Recipient	$6,934	$6,805	$8,000	$8,909	$7,570	$3,942	-43
Total Waiver							
Expenditures	$9,011,104	$8,582,983	$7,988,402	$8,218,189	$8,172,117	$5,523,714	-39
Recipients	196	184	171	167	163	150	-23
Expenditures per Recipient	$45,975	$46,647	$46,716	$49,211	$50,136	$36,825	-20

The Acquired Brain Injury Waiver is in the process of closing, with enrolled members being transitioned to the Comprehensive and Supports Waivers.

Estimated completion of this transition is April 2018.

COMMUNITY CHOICES

This waiver provides in-home services and assisted living services to Medicaid enrollees 19 years of age and older who are aged, blind, or disabled and require services equivalent to nursing home level of care. This waiver was formerly the Long-Term Care waiver, and starting in SFY 2017 added the assisted living services to replace the Assisted Living Facility waiver.



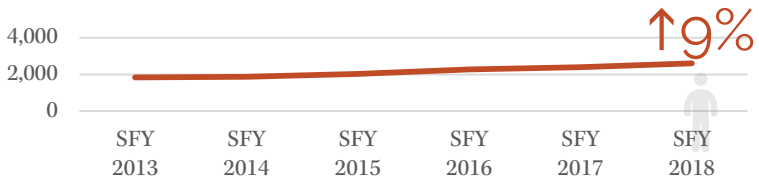
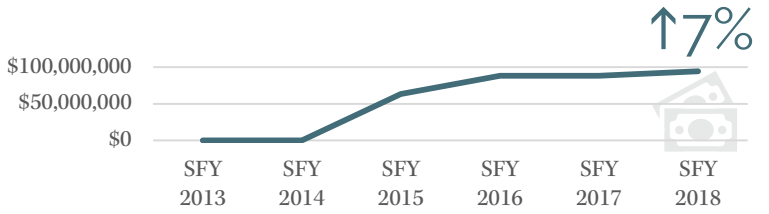


Table 53. Community Choices Waiver Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Waiver Only Services							
Expenditures	$15,877,079	$15,763,707	$16,630,675	$19,801,419	$20,597,605	$26,930,997	20
Recipients	1,841	1,870	2,034	2,282	2,401	2,617	42
Expenditures per Recipient	$8,624	$8,430	$8,176	$8,677	$8,579	$10,291	19
% Waiver-Only of Total Waivers	51%	52%	52%	54%	54%	63%	
Non-Waiver Services							
Expenditures	$15,049,401	$14,722,651	$15,503,721	$16,951,952	$17,240,246	$15,753,166	5
Recipients	1,995	2,013	2,135	2,370	2,511	2,675	34
Expenditures per Recipient	$7,544	$7,314	$7,262	$7,153	$6,866	$5,889	-22
Total Waiver							
Expenditures	$30,926,481	$30,486,358	$32,134,396	$36,753,371	$37,837,852	$42,684,163	38
Recipients	2,091	2,042	2,066	2,200	2,456	2,590	24
Expenditures per Recipient	$16,112	$15,145	$14,756	$14,607	$14,965	$14,579	-10

COMPREHENSIVE

This Medicaid waiver, managed by the BHD and started in SFY 2014, funds services for individuals with intellectual or developmental disability based on assessed need, as measured by the standardized Inventory for Client and Agency Planning (ICAP) tool. This waiver was designed, along with the Supports Waiver, to meet the requirements of SEA82, 2013.



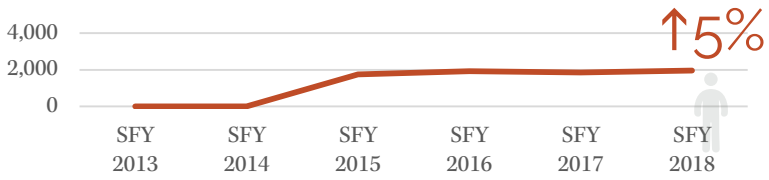
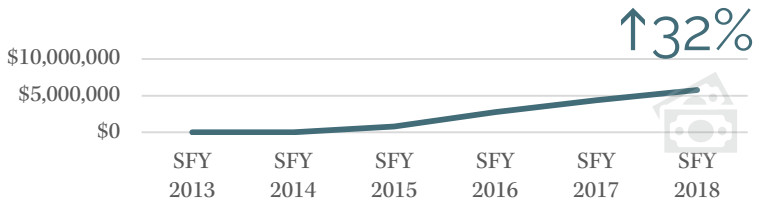


Table 54. Comprehensive Waiver Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Waiver Only Services					
Expenditures	$44,982	$63,719,016	$88,377,607	$88,527,446	$94,568,471
Recipients	3	1,755	1,925	1,863	1,961
Expenditures per Recipient	$14,994	$36,307	$45,910	$47,519	$48,225
% Waiver-Only of Total Waivers	74%	84%	77%	81%	86%
Non-Waiver Services					
Expenditures	$16,150	$11,813,805	$25,986,468	$21,106,234	$15,405,710
Recipients	29	1,728	1,901	1,853	1,935
Expenditures per Recipient	$557	$6,837	$13,670	$11,390	$7,962
Total Waiver					
Expenditures	$61,132	$75,532,821	$114,364,075	$109,633,679	$109,974,181
Recipients	31	1,836	1,949	1,890	1,987
Expenditures per Recipient	$1,972	$41,140	$58,678	$58,007	$55,347

SUPPORTS

This Medicaid waiver, managed by the BHD and started in SFY 2014, provides more flexible, although capped, funding for supportive services for individuals with intellectual or developmental disability. This waiver was designed, along with the Comprehensive Waiver, to meet the requirements of SEA82, 2013.



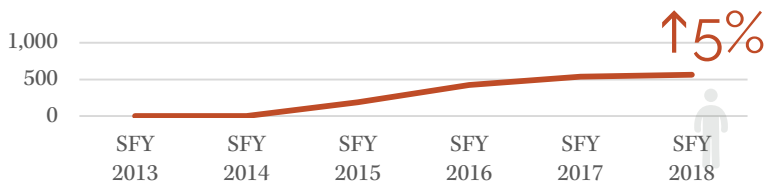
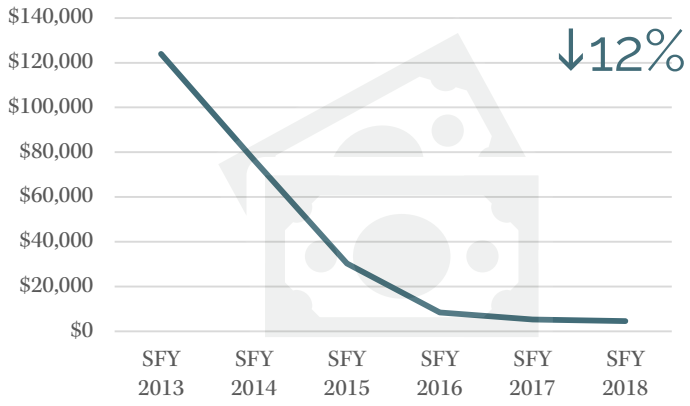


Table 55. Supports Waiver Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Waiver Only Services					
Expenditures	$454	$819,690	$2,780,450	$4,378,255	$5,795,651
Recipients	0	191	425	540	565
Expenditures per Recipient	--	$4,292	$6,542	$8,108	$10,258
% Waiver-Only of Total Waivers	80%	59%	54%	56%	60%
Non-Waiver Services					
Expenditures	$114	$575,926	$2,371,351	$3,476,854	$3,795,863
Recipients	3	179	406	511	551
Expenditures per Recipient	$38	$3,217	$5,841	$6,804	$6,889
Total Waiver					
Expenditures	$568	$1,395,616	$5,151,800	$7,855,109	$9,591,514
Recipients	3	203	443	555	580
Expenditures per Recipient	$189	$6,875	$11,629	$14,153	$16,537

PREGNANT BY CHOICE WAIVER

Medicaid provides pregnancy planning services through this Section 1115 waiver with the goal of reducing the incidence of closely spaced pregnancies and decrease the number of unintended pregnancies in order to reduce health risks to women and children and achieve cost savings. These services are available to women who have received Medicaid benefits under the Pregnant Women eligibility program and would otherwise lose Medicaid eligibility 60 days postpartum.



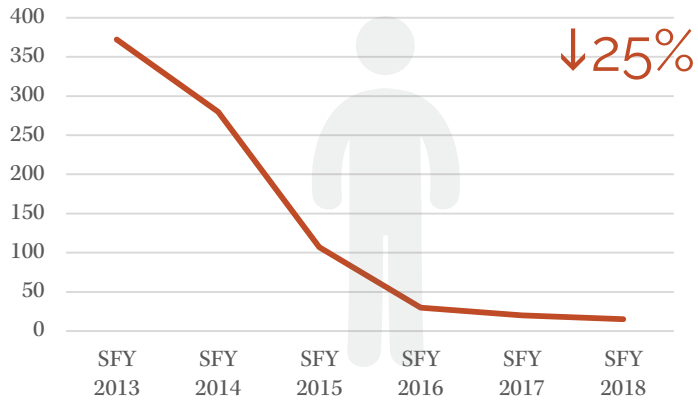


Table 56. Pregnant by Choice Waiver Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$123,985	$76,481	$30,272	$8,356	$5,197	$4,597	-96
Recipients	372	280	107	30	20	15	-96
Expenditures per Recipient	$333	$273	$283	$279	$260	$306	-8

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 earlier in this report. 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.

The Pregnant by Choice Waiver is currently effective through December 31, 2018.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EQUAL RIGHTS
1869
1890

SUBPROGRAMS & 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.

DRUG UTILIZATION REVIEW

The Drug Utilization Review (DUR) 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. The program was established in 1992 in response to requirements outlined in OBRA 90 and defined in the Code of Federal Regulations (42 CFR 456 Subpart K). Medicaid has contracted with the University of Wyoming to administer the program, which includes a number of activities, as described below.

Pharmacy & Therapeutics (P&T) Committee

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

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

Prospective DUR

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

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

Education

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

Retrospective DUR

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

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

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

Review of Clinical Evidence

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

Input from the Medical Community

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

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

HEALTH INFORMATION TECHNOLOGY

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

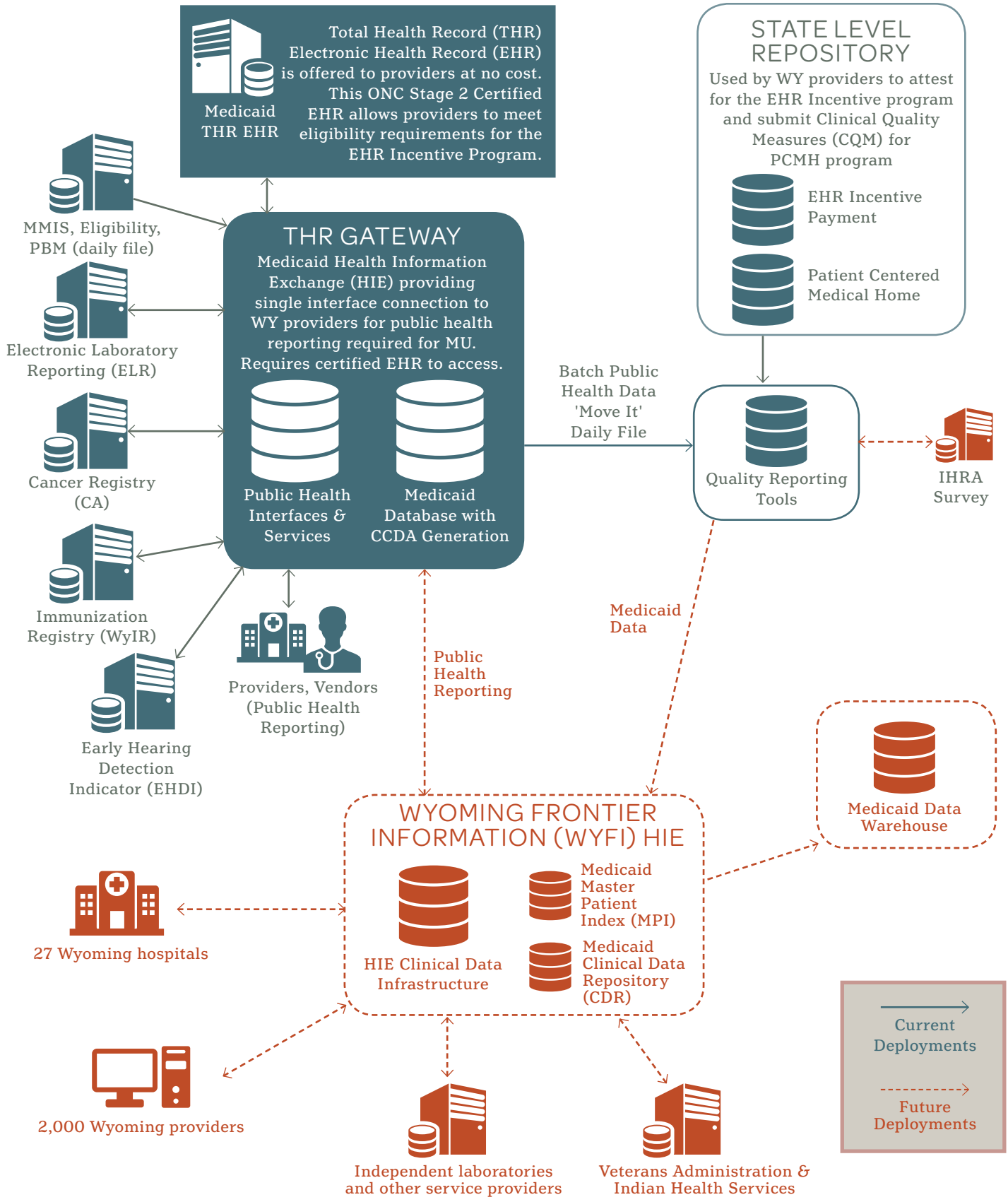


Figure 33. Wyoming Health Information Exchange and Medicaid

The Wyoming Frontier Information (WYFI) Health Information Exchange (HIE) serves to promote a healthier Wyoming through the development of a statewide secure, connected, and coordinated health IT system that supports effective and efficient healthcare.

The WYFI HIE will be a centralized repository of clinical data of participating patients. Providers, through their electronic health record system (EHR) and also via a web browser, will have the ability to download clinical information to support better care and treatment of patients. All of the HIE data is encrypted and secured, and access to the data is logged and audited.

The Wyoming Department of Health, along with CMS have funded the design, development, and implementation of WYFI so Wyoming providers will be able to share patient information electronically and provide patient and care coordination across different care settings in Wyoming.

The WYFI will not cost providers a fee to participate through 2021 and will provide access to data immediately upon provider participation.

Phase 1 is initially planned to have 27 hospitals.

Electronic Health Record Incentive Program

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

195 eligible professionals participated

Must have 30% Medicaid patients (20% for pediatricians) and increase utilization of the EHR to become and remain eligible

Receive up to $63,750 over the 6 years they choose to participate

24 eligible hospitals participated

Must have 10% Medicaid patients and increase utilization of the EHR to become and remain eligible

Total incentive paid over the course of three years

$22.2 Million

paid out since program implementation from 100% Federal funds

ADMINISTRATIVE TRANSPORTATION

Cost of transportation to and from medical appointments is covered if:

- the appoinment is medically necessary
- it is approved by WDH at least 3 business days in advance; and,
- the least costly mode of transportation is selected

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

Medicaid chooses the appropirate transportation based on expense and reasonable availbility. May include: public transit, private automobile, taxi, bus, shuttle service, and airline.

Per diem expenses are reimbursable to family/legal guardian for recipients under age 21 if the services to be received are expanded services.

Per diem reimbursement covers meals and commercial lodging.

$25/day (inpatient)
$50/day (outpatient)

$130,495 paid for lodging, taxi, and other transportation services in SFY 2018

$81,238 paid to providers

serving **245** individuals

Project Out provides targeted case management to create a transition or diversion plan, identifying the services and supports necessary for independent living.

PROJECT OUT

A temporary, short-term intervention and assistance program aimed at helping participants overcome barriers to living independently in the community through diversion or transition.

Limited financial resources may be provided to cover the expense of moving/storage, rental/utility deposits, furniture, house hold items, home modifications and limited transportation.

Participants are also linked to community services and long-term care programs that provide ongoing support.

Diversion
for those at risk of needing nursing facility care or in a nursing home for less than 3 months

Transition
for those in a nursing facility care or long-term care institution for at least 3 months

PATIENT CENTERED MEDICAL HOME

The PCMH program promotes high-value care using a value-based purchasing model in which health care is coordinated through a primary care physician/ practitioner, with a focus on quality and safety.

Participating providers are paid a Per Member Per Month rate based on their patient volume, with **$784,530** paid to providers in SFY 2018.

SFY 2018
147 practitioners
18 practices
19,000 Medicaid Recipients

Medicaid reimburses all Health Check screening exams and authorized follow-up care and treatment as long as the child is enrolled in Medicaid.

HEALTH CHECK

This program is for children under age 21 and provides the following services under Early Periodic Screening Detection and Treatment (EPSDT) authority:

- Physical exams
- Immunizations
- Lab tests
- Growth/development check
- Nutrition check
- Vision / Hearing / Dental screenings
- Behavioral health assessment
- Health information
- Teenage health education
- Transportation (ambulance and administrative)
- Other healthcare prescribed by a physician and approved by Medicaid

SPECIAL POPULATIONS

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

MEDICAID/MEDICARE DUAL ENROLLED

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

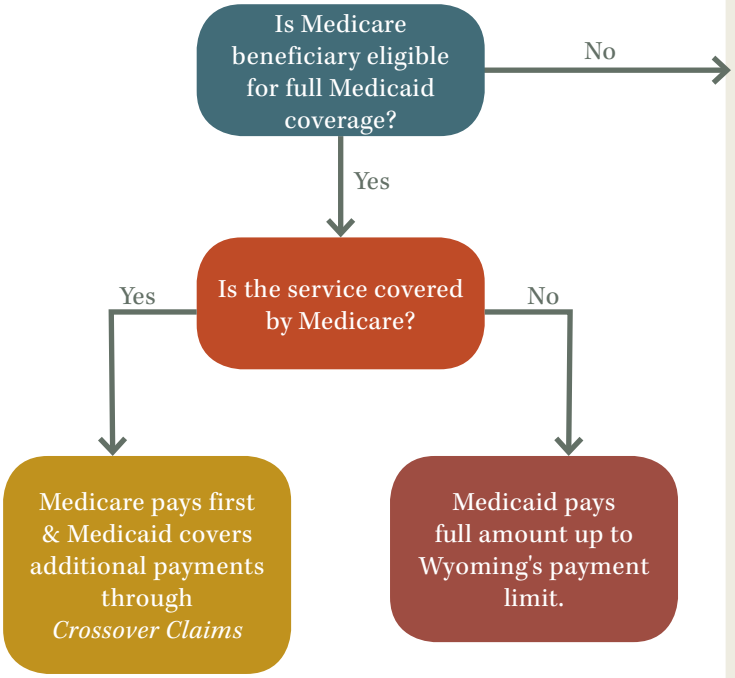


Figure 34. Dual Enrolled Claims Coverage Process

This section includes information on both crossover claims services and those services funded entirely by Medicaid. Premium assistance for QMB, SLMB, and QI enrollees is excluded, as these are considered administrative costs.

For Medicare beneficiaries who do not qualify for full Medicaid coverage, there are three programs available, as described below:

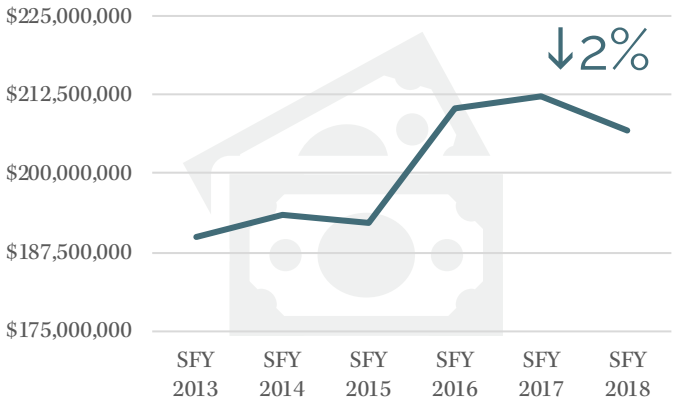
Qualified Medicare Beneficiaries (QMB)
Provides assistance with Medicare premiums, deductibles, and coinsurance.
For individuals with:
- Resources not exceeding 3 times the SSI resource limit adjusted annually by the increase in the consumer price index
- Income less than or equal to 100% FPL

Specified Low-Income Medicare Beneficiaries (SLMB)
Provides assistance with Medicare Part B premiums
For individuals with:
- Resources not exceeding 3 times the SSI resource limit adjusted annually by the increase in the consumer price index
- Income between 100% and 120% FPL

Qualified Individuals (QI)
Provides assistance with Medicare Part B premiums
For individuals with:
- Resources not exceeding 3 times the SSI resource limit adjusted annually by the increase in the consumer price index
- Income between 120% and 135% FPL

Premiums for these individuals are paid with 100% federal funds

$206,944,190
36% OF MEDICAID EXPENDITURES



11,031
15% OF MEDICAID RECIPIENTS

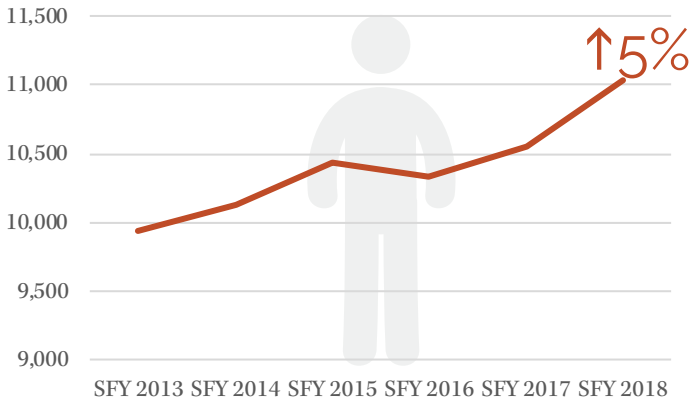


Table 57. Medicaid/Medicare Dual Enrollment Summary

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$189,787,625	$193,531,089	$192,301,496	$210,495,628	$212,135,354	$206,944,190	9
Dual Enrolled Members	12,340	12,542	15,115	14,887	14,671	15,091	22
Recipients (unduplicated)	9,942	10,127	10,439	10,341	10,547	11,031	11
Expenditures per Dual Enrolled Member	$15,380	$15,431	$12,723	$14,140	$14,460	$13,713	-11
Expenditures per Recipient	$19,089	$19,110	$18,421	$20,355	$20,113	$18,760	-2
Crossover Claims Expenditures	$16,853,247	$16,951,537	$18,058,494	$17,547,805	$14,966,523	$7,751,187	-54
Crossover Claims Expenditures as Percent of Total Dual Expenditures	9%	9%	9%	8%	7%	4%	-

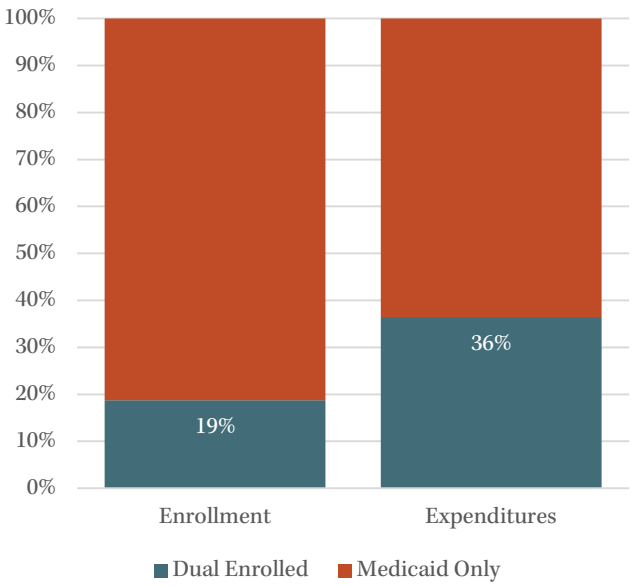


Figure 35. Dual Enrolled as Percent of Total Medicaid in SFY 2018

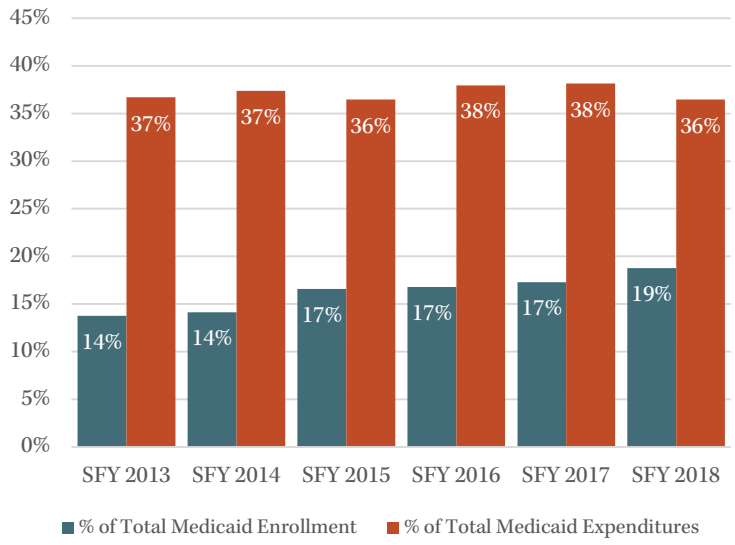


Figure 36. History of Dual Enrollment and Expenditures as Percent of Total Medicaid

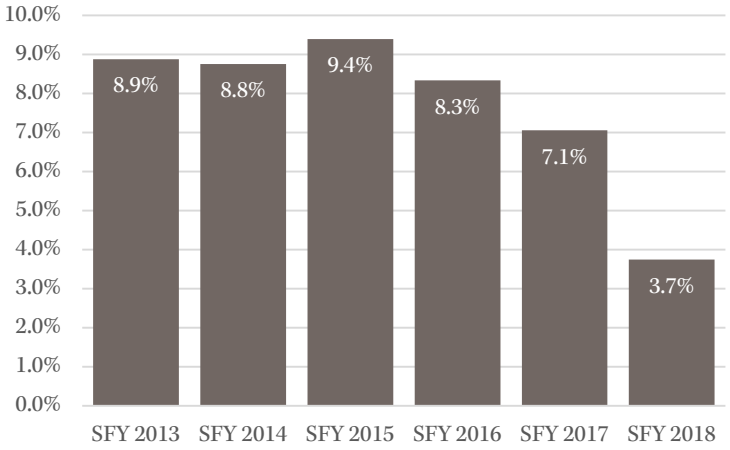


Figure 37. History of Crossover Expenditures as Percent of Total Dual Expenditures

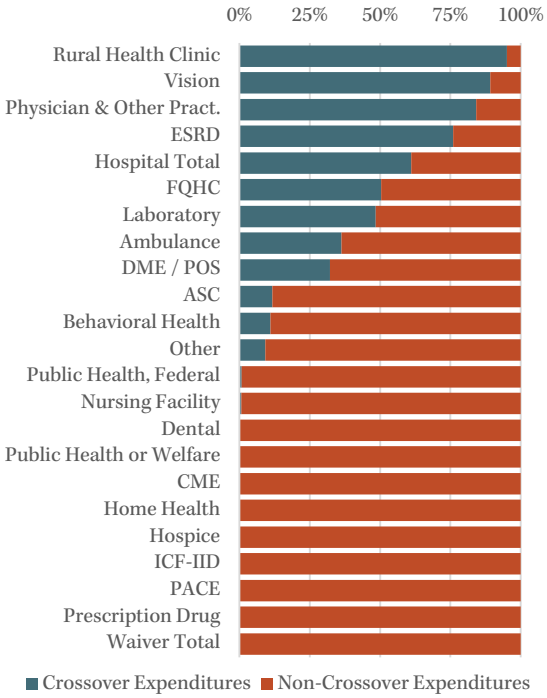


Figure 38. Crossover Expenditures as Percent of Dual Expenditures by Service Area

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

Table 58. Dual Enrolled Member Service Utilization Summary

Service Area	Expenditures	Recipients[30]	Expenditures per Recipient	Crossover Expenditures	Crossover Recipients	% Crossover Expenditures
Ambulance	$105,407	1,220	$86	$38,237	1,173	36%
Ambulatory Surgical Center	$46,596	139	$335	$5,444	115	12%
Behavioral Health	$2,207,191	2,243	$984	$242,233	1,640	11%
Care Management Entity	$5,149	1	$5,149	-	-	-
Dental	$440,969	1,867	$236	$133	4	0%
DME, Prosthetics/Orthotics/Supplies	$2,299,127	3,335	$689	$739,753	2,928	32%
End Stage Renal Disease	$232,815	125	$1,863	$176,796	126	76%
Federally Qualified Health Center	$395,855	1,388	$285	$199,397	1,284	50%
Home Health	$2,506,130	246	$10,188	-	-	-
Hospice	$658,581	122	$5,398	-	-	-
Hospital Total	$2,960,218	7,415	$399	$1,807,918	7,383	61%
Inpatient	*$1,927,608*	*1,915*	*$1,007*	*1,011,228*	*1,903*	*52%*
Outpatient	*$1,091,681*	*7,218*	*$151*	*755,278*	*7,177*	*69%*
Intermediate Care Facility-IID	$11,515,023	50	$230,300	-	-	-
Laboratory	$16,816	1,639	$10	$8,139	1,588	48%
Nursing Facility	$82,130,541	2,346	$35,009	$559,414	1,030	1%
Other	$267,863	542	$494	$24,715	211	9%
PACE	$3,311,798	170	$19,481	-	-	-
Physician & Other Practitioner	$4,375,646	8,749	$500	$3,683,352	8,727	84%
Prescription Drug	$1,616,846	2,259	$716	-	-	-
Public Health or Welfare	$468,345	2,784	$168	$68	38	0%
Public Health, Federal	$1,903,272	241	$7,897	$15,141	198	1%
Rural Health Clinic	$176,877	1,017	$174	$168,277	1,022	95%
Vision	$92,130	2,062	$45	$82,172	2,009	89%
Waiver Total	$89,210,994	3,447	$25,881	-	-	-
Acquired Brain Injury	*$4,039,816*	*122*	*$33,113*	-	-	-
Community Choices	*$23,011,811*	*2,192*	*$10,498*	-	-	-
Comprehensive	*$59,849,939*	*1,061*	*$56,409*	-	-	-
Supports	*$2,309,428*	*191*	*$12,091*	-	-	-
Total	$206,944,190	11,031	$18,760	$7,751,187	9673	4%

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

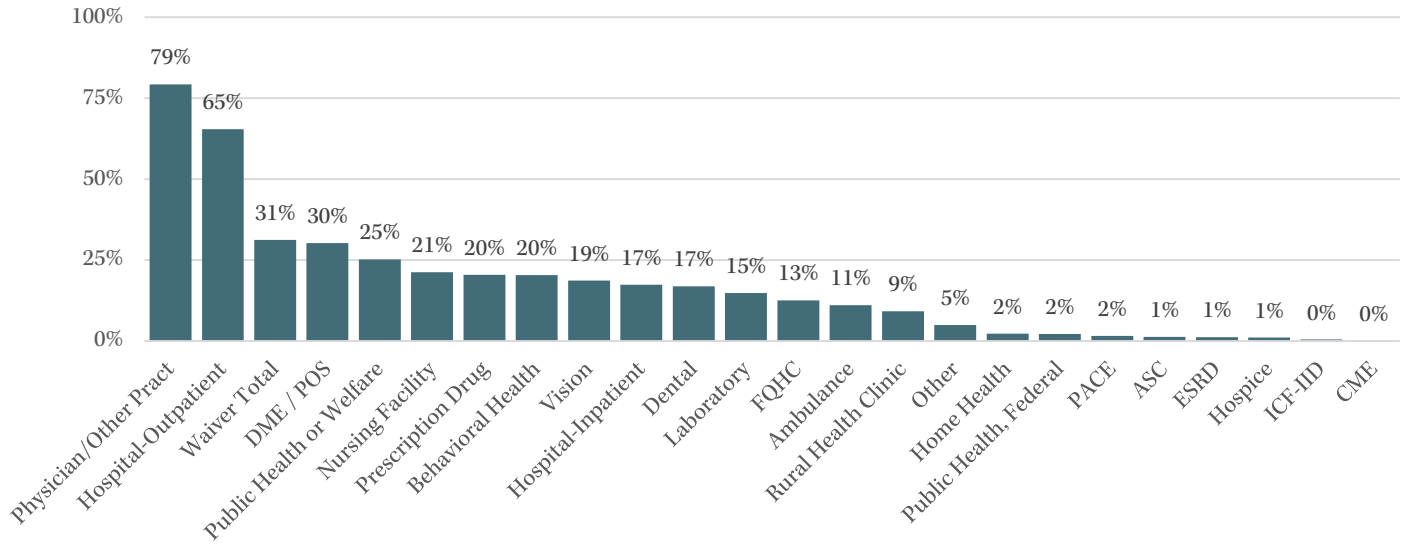


Figure 40. Percent of Total Unduplicated Dual Recipients by Service

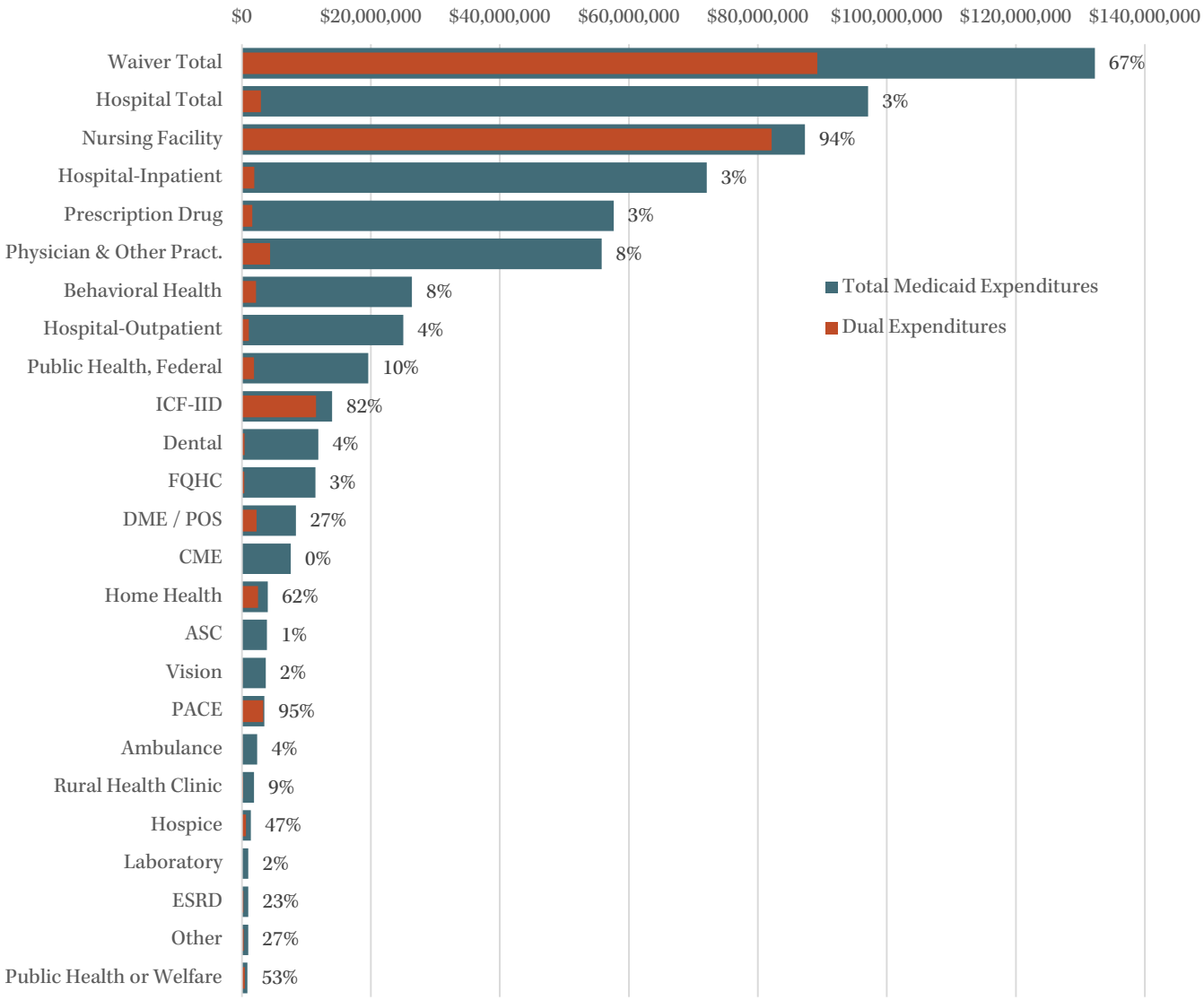


Figure 39. Dual Expenditures as Percent of Total Medicaid Expenditures by Service

FOSTER CARE

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

Two types of medical coverage are available:

Medicaid Foster Care

For children eligible for Medicaid. Foster children covered under Title IV-E of the Social Security Act and some children receiving federally reimbursed adoption subsidies must be covered by Medicaid. Wyoming also uses existing Medicaid eligibility groups to extend coverage to non-Title IV-E eligible foster children and adopted children supported by state-funded subsidies.

State Foster Care

For children ineligible for Medicaid. Includes children who do not meet income or citizenship requirements or are institutionalized.

327 children enrolled

$1,791,834 in claims expenditures

93% of foster care children are enrolled in Medicaid

$22,534,237

4% OF MEDICAID EXPENDITURES

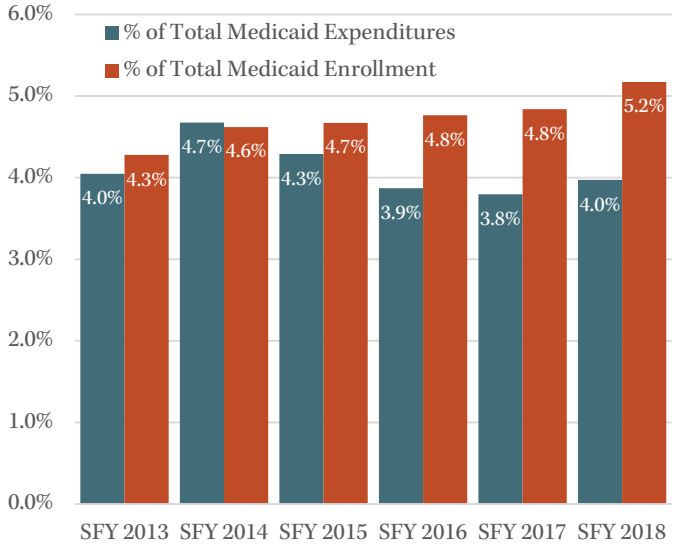


Figure 41. Medicaid Foster Care as Percent of Total Medicaid Expenditures and Enrollment

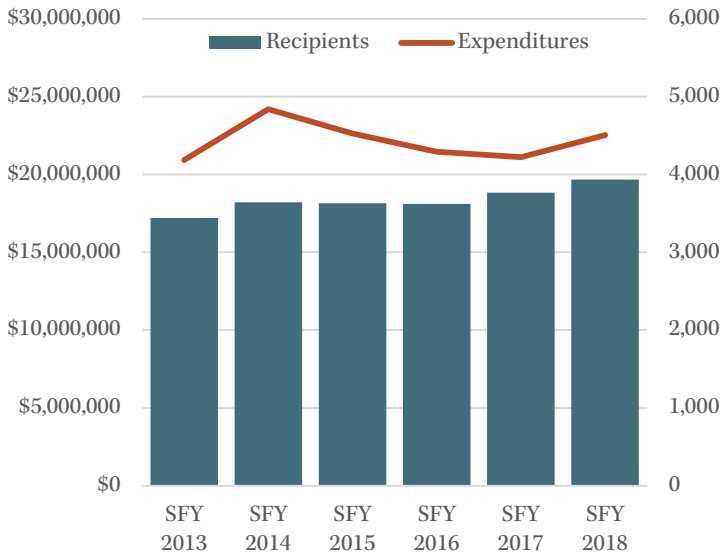


Figure 42. Medicaid Foster Care Recipient and Expenditures History

Table 59. Foster Care Summary[31]

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Medicaid Foster Care							
Enrolled Members	3,836	4,096	4,253	4,228	4,102	4,159	8
Expenditures	$20,934,667	$24,197,999	$22,627,859	$21,473,583	$21,117,610	$22,534,237	8
Recipients	3,442	3,643	3,629	3,621	3,766	3,933	14
Expenditures per Recipient	$6,082	$6,642	$6,235	$5,930	$5,607	$5,730	-6
State-Only Foster Care							
Enrolled Members	179	173	211	203	310	316	77
Expenditures	$2,768,409	$2,697,681	$2,852,108	$2,310,733	$1,776,060	$1,791,834	-35
Recipients	326	376	318	327	318	327	0
Expenditures per Recipient	$8,492	$7,175	$8,969	$7,066	$5,585	$5,480	-35

[31] As claims data shown is based on paid date, not service date, the number of recipients may exceed the count of enrolled members as individuals may have claims paid up to one year after services are rendered, at which time they may no longer be enrolled in the program.

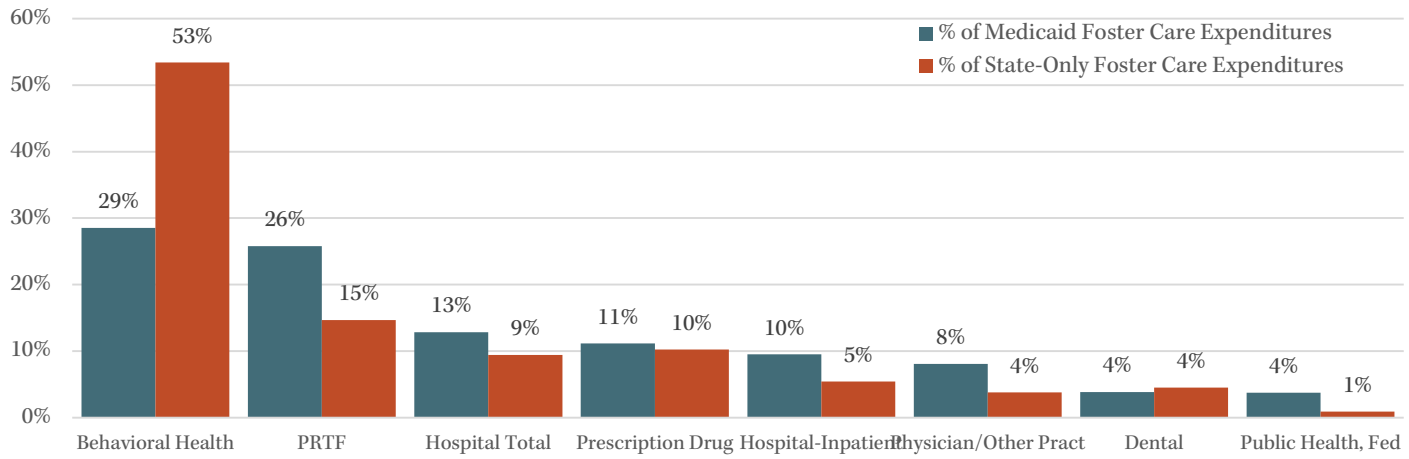


Figure 43. Percent of Foster Care Expenditures by Service - Medicaid versus State-Only

Table 60. Foster Care Summary by Services - Medicaid versus State-Only

	Medicaid Foster Care			State-Only Foster Care		
Service Area	Expenditures	Recipients[32]	Expenditures per Recipient	Expenditures	Recipients[32]	Expenditures per Recipient
Ambulance	$78,212	90	$869	$6,861	4	$1,715
Ambulatory Surgical Center	$213,670	130	$1,644	$1,899	2	$949
Behavioral Health	$6,429,867	1,830	$3,514	$956,702	281	$3,405
Care Management Entity (CME)	$0	1	$0	-	-	-
Clinic/Center	$130,993	174	$753	-	-	-
Dental	$857,994	2,063	$416	$80,539	172	$468
DME, Prosthetics/Orthotics/Supplies	$129,383	137	$944	$1,207	7	$172
Federally Qualified Health Center	$302,466	356	$850	$10,123	21	$482
Home Health	$761	2	$380	-	-	-
Hospital Total	$2,895,373	1,548	$1,870	$168,416	141	$1,194
Inpatient	*$2,140,891*	*192*	*$11,150*	*$97,229*	*13*	*$7,479*
Outpatient	*$754,482*	*1,506*	*$501*	*$71,188*	*138*	*$516*
Laboratory	$22,235	181	$123	$615	9	$68
Other	$39,098	179	$218	$3,036	25	$121
Physician & Other Practitioner	$1,814,954	3,041	$597	$67,507	144	$469
Prescription Drug	$2,510,009	2,295	$1,094	$183,008	190	$963
PRTF	$5,813,500	136	$42,746	$262,268	15	$17,485
Public Health or Welfare	$6,799	154	$44	$866	16	$54
Public Health, Federal	$844,356	302	$2,796	$16,323	8	$2,040
Rural Health Clinic	$91,383	294	$311	$2,081	12	$173
Vision	$353,184	1,290	$274	$30,383	102	$298
Total	$22,534,237	3,933	$5,730	$1,791,834	327	$5,480

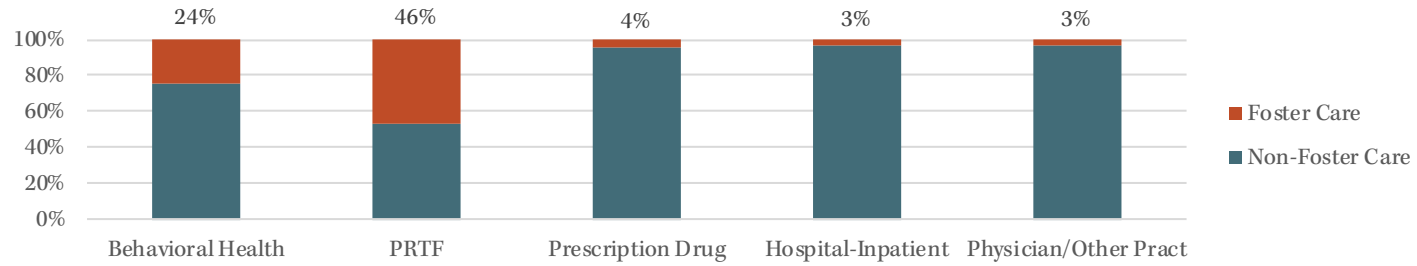


Figure 44. Medicaid Foster Care as Percent of Total Medicaid Expenditures for Top Foster Care Services

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

APPENDIX A: SUPPLEMENTAL TABLES

SERVICES

Table 61. Behavioral Health Services by Provider Type

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

Table 62. Waiver Services by Waiver

Waiver Service	Acquired Brain Injury	Comprehensive	Supports	Community Choices	Children's Mental Health
Case Management	✓	✓	✓	✓	✓
Functional assessments	✓	✓	✓	✓	✓
Respite	✓	✓	✓	✓	✓
Personal care	✓	✓	✓	✓	
Skilled nursing	✓	✓	✓	✓	
Dietitian	✓	✓	✓	✓*	
Homemaker		✓	✓	✓	
Special family habilitation home		✓			
Day habilitation	✓	✓	✓		
Child habilitation		✓	✓		
Residential habilitation training		✓	✓		
Specialized equipment	✓	✓	✓		
Environmental modifications	✓	✓	✓		
Supported living	✓	✓	✓		
Community integrated employment	✓	✓	✓		
Employment supports	✓	✓	✓		
Companion	✓	✓	✓		
Occupational, physical, and Speech therapies	✓	✓	✓		
Cognitive retraining	✓				
Self-directed / Consumer-directed available	✓	✓	✓	✓	
High Fidelity Wraparound					✓
Family and Youth Peer Support Services					✓

* Service available for Assisted Living recipients only

Table 63. Inpatient Hospital Levels of Care Summary - SFY 2018

Inpatient Levels of Care	Expenditures	Recipients	Claims
07 - Kidney Transplant	$146,057	1	1
10 - Bone Transplant	$2,013,420	2	2
31 - Rehab W/O Vent As Of 090109	$524,785	21	40
32 - Maternity-Surg As Of 090109	$5,951,347	1,075	1,084
33 - Maternity-Med As Of 090109	$5,122,127	1,309	1,394
34 - NICU As Of 090109	$2,770,661	62	67
35 - ICU-CCU-Burn As Of 090109	$15,871,237	498	613
36 - Surgery As Of 090109	$7,556,785	522	562
37 - Psychiatric As Of 090109	$4,672,769	592	752
38 - Newborn Nursery As Of 090109	$15,793,516	2,515	2,611
39 - Routine Discharge As Of 090109	$10,639,723	1,232	1,598

Table 64. Inpatient Hospital Expenditures History by Levels of Care

Inpatient Level of Care	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
07 - Kidney Transplant	$177,177	-$98,381	$258,328	$104,399	$111,981	$146,057
09 - Liver Transplant	$500,557	$223,942	-	-	-	-
10 - Bone Transplant	$2,634,285	$976,412	$733,295	$1,397,922	$218,663	$2,013,420
16 - Lung Transplant	$647,237	-	-	-	-	-
26 - Normal Newborn As Of 010198	$1,841	-	-	-	-	-
31 - Rehab W/O Vent As Of 090109	$804,938	$489,079	$531,720	$542,230	$592,420	$524,785
32 - Maternity-Surg As Of 090109	$5,691,247	$5,854,738	$5,187,948	$8,881,461	$12,333,057	$5,951,347
33 - Maternity-Med As Of 090109	$7,878,460	$7,568,221	$7,538,977	$4,795,577	$1,077,195	$5,122,127
34 - NICU As Of 090109	$6,361,703	$4,852,484	$5,633,758	$5,850,531	$6,571,395	$2,770,661
35 - ICU-CCU-Burn As Of 090109	$16,420,469	$17,237,870	$17,477,140	$19,657,426	$15,094,830	$15,871,237
36 - Surgery As Of 090109	$9,270,316	$8,634,138	$8,408,699	$10,010,704	$7,810,089	$7,556,785
37 - Psychiatric As Of 090109	$4,392,193	$3,878,870	$4,198,515	$3,784,842	$3,502,035	$4,672,769
38 - Newborn Nursery As Of 090109	$7,124,918	$7,050,485	$7,333,486	$8,312,124	$8,631,054	$15,793,516
39 - Routine Discharge As Of 090109	$13,632,077	$13,395,349	$13,061,157	$12,351,127	$12,745,156	$10,639,723

Table 65. Inpatient Hospital Recipient History by Levels of Care

Inpatient Level of Care	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
07 - Kidney Transplant	1	0	3	1	1	1
09 - Liver Transplant	3	2	-	-	-	-
10 - Bone Transplant	6	2	2	4	1	2
16 - Lung Transplant	0	1	-	-	-	-
26 - Normal Newborn As Of 010198	1	-	-	-	-	-
31 - Rehab W/O Vent As Of 090109	34	27	24	32	31	21
32 - Maternity-Surg As Of 090109	1,074	989	956	1,547	2,378	1,075
33 - Maternity-Med As Of 090109	2,153	2,078	2,141	921	653	1,309
34 - NICU As Of 090109	140	131	121	128	132	62
35 - ICU-CCU-Burn As Of 090109	488	482	538	504	465	498
36 - Surgery As Of 090109	646	582	546	508	613	522
37 - Psychiatric As Of 090109	472	452	499	447	437	592
38 - Newborn Nursery As Of 090109	3,050	2,901	2,959	2,916	2,692	2,515
39 - Routine Discharge As Of 090109	1,810	1,483	1,684	1,387	1,476	1,232

BIRTHS

Table 66. Wyoming Medicaid Births[33]

Calendar Year	Wyoming Births	Medicaid Births	Medicaid % of Total
2007	7,823	3,454	44%
2008	8,015	3,353	42%
2009	7,841	3,401	43%
2010	7,541	3,395	45%
2011	7,339	3,166	43%
2012	7,576	3,071	41%
2013	7,617	3,026	40%
2014	7,693	2,850	37%
2015	7,715	2,757	36%
2016	7,384	2,704	37%
2017	6,904	2,439	35%

COUNTY DATA

Table 67. County Summary

County	Enrolled Members[34]	% of Total Enrolled Members	Recipients[35]	% of Total Recipients	Expenditures	% of Total Expenditures
Albany	3,475	4.3%	3,297	4.5%	$25,080,451	4.4%
Big Horn	2,090	2.6%	1,897	2.6%	$15,327,246	2.7%
Campbell	6,032	7.4%	5,539	7.5%	$35,070,940	6.2%
Carbon	1,928	2.4%	1,804	2.4%	$9,905,203	1.7%
Converse	1,894	2.3%	1,724	2.3%	$11,435,437	2.0%
Crook	793	1.0%	742	1.0%	$3,428,515	0.6%
Fremont	9,663	11.9%	9,346	12.6%	$94,094,710	16.6%
Goshen	1,793	2.2%	1,714	2.3%	$13,680,329	2.4%
Hot Springs	814	1.0%	784	1.1%	$8,094,398	1.4%
Johnson	888	1.1%	790	1.1%	$5,804,921	1.0%
Laramie	13,809	17.0%	13,577	18.3%	$91,757,032	16.2%
Lincoln	1,776	2.2%	1,565	2.1%	$10,071,072	1.8%
Natrona	12,613	15.5%	12,351	16.7%	$91,115,716	16.1%
Niobrara	317	0.4%	295	0.4%	$1,850,734	0.3%
Other	2,040	2.5%	1,408	1.9%	$13,068,981	2.3%
Park	3,533	4.4%	3,318	4.5%	$23,889,622	4.2%
Platte	1,139	1.4%	1,036	1.4%	$9,157,844	1.6%
Sheridan	3,673	4.5%	3,400	4.6%	$23,137,157	4.1%
Sublette	710	0.9%	613	0.8%	$3,889,312	0.7%
Sweetwater	5,676	7.0%	5,184	7.0%	$31,688,733	5.6%
Teton	1,299	1.6%	1,199	1.6%	$5,923,066	1.0%
Uinta	3,296	4.1%	3,078	4.2%	$25,961,532	4.6%
Washakie	1,109	1.4%	1,048	1.4%	$7,036,928	1.2%
Weston	848	1.0%	776	1.0%	$7,008,761	1.2%
Overall	81,208		74,056		$567,478,640	

[33] Provisional statistics for statewide births was supplied by Vital Records.

[34] Enrollment is based on Complete SFY.

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

PROVIDERS

The data in this section is based on providers paid during the SFY and does not reflect the number of enrolled providers.

Table 68. Provider Summary by Taxonomy - SFY 2018

Provider Taxonomy	Providers	Recipients	Expenditures
Addiction Therapist/Practitioner(101YA0400X)	3	199	$207,018
Adult Health(363LA2200X)	1	23	$2,582
Advance Practice Nurse(364SP0808X)	12	1,087	$363,266
Allergy And Immunology, Allergy(207KA0200X)	5	750	$396,665
Ambulance(341600000X)	63	3,159	$2,381,969
Ambulatory Family Planning Facility(261QA0005X)	7	346	$51,449
Ambulatory Surgical(261QA1903X)	27	2,728	$3,881,705
Anesthesiology(207L00000X)	77	7,157	$2,488,633
Audiologist(231H00000X)	12	503	$229,847
Behavior Analyst(103K00000X)	5	35	$167,595
Case Management(251B00000X)	113	2,727	$27,226,271
Chiropractor(111N00000X)	52	1,536	$347,441
Chpr Cme(251S00000X)	1	522	$7,599,455
Clinic/Center(261Q00000X)	23	1,254	$972,701
Clinical Genetics (M.D.)(207SG0201X)	1	36	$6,455
Clinical Medical Laboratory(291U00000X)	73	8,286	$1,020,356
Clinical Neuropsychologist(103G00000X)	4	34	$24,628
Clinical Psychologist(103TC0700X)	69	3,010	$5,398,489
Day Training, Developmentally Disabled Service(251C00000X)	643	2,686	$100,791,096
Dentist(122300000X)	27	3,304	$1,051,336
Dentist, General Practice(1223G0001X)	127	13,187	$4,331,962
Dermatology(207N00000X)	15	2,118	$300,262
Diagnostic Radiology(2085R0202X)	48	19,408	$1,794,304
Dietitian, Registered(133V00000X)	2	7	$1,803
Durable Medical Equipment And Medical Supplies (332B00000X)	230	6,695	$6,944,732
Ecsii & Casii Evaluator(174400000X)	7	296	$61,574
Emergency Medicine(207P00000X)	31	18,493	$4,026,740
End-Stage Renal Disease (Esrd) Treatment(261QE0700X)	15	147	$1,012,427
Endodontics(1223E0200X)	3	65	$52,582
Family Health(363LF0000X)	12	1,226	$246,169
Family Practice(207Q00000X)	83	23,887	$6,424,856
Federally Qualified Health Center(261QF0400X)	11	8,915	$11,418,874
General Acute Care Hospital(282N00000X)	105	32,900	$84,380,731
General Acute Care Hospital - Rural(282NR1301X)	30	9,302	$11,942,563
Hearing Aid Equipment(332S00000X)	9	284	$831,358
Home Health(251E00000X)	25	491	$4,012,083
Hospice Care, Community Based(251G00000X)	13	194	$1,394,149
Intermediate Care Facility, Intellectual Disability(315P00000X)	1	60	$13,999,444
Internal Medicine(207R00000X)	56	16,553	$7,076,336
Internal Medicine, Cardiovascular Disease(207RC0000X)	18	2,223	$291,341
Internal Medicine, Endocrinology Diabetes And Metaboli(207RE0101X)	4	126	$18,807
Internal Medicine, Gastroenterology(207RG0100X)	6	1,281	$550,096
Internal Medicine, Geriatric Medicine(207RG0300X)	4	74	$12,796

Provider Taxonomy (continued)	Providers	Recipients	Expenditures
Internal Medicine, Medical Oncology(207RX0202X)	6	430	$2,756,577
Internal Medicine, Nephrology(207RN0300X)	6	98	$37,495
Internal Medicine, Pulmonary Disease(207RP1001X)	9	382	$102,784
Internal Medicine, Rheumatology(207RR0500X)	2	119	$13,849
Interpreter(171R00000X)	2	193	$22,119
Lic Clinic/Cert Social Worker(1041C0700X)	77	1,748	$3,274,619
Lic Marriage & Fam Therapist(106H00000X)	13	183	$510,758
Lodging(177F00000X)	3	165	$85,915
Medicare Defined Swing Bed Unit(275N00000X)	14	50	$620,073
Mental Health-Including Community Mental Health(261QM0801X)	26	5,233	$6,188,978
Midwife, Certified Nurse(367A00000X)	4	27	$64,608
Neurological Surgery(207T00000X)	10	140	$69,210
Nurse Anesthetist, Certified Registered(367500000X)	13	361	$65,899
Nurse Practitioner(363L00000X)	9	703	$142,851
Obstetrics And Gynecology(207V00000X)	33	4,190	$4,563,484
Obstetrics And Gynecology, Gynecology(207VG0400X)	4	251	$134,985
Obstetrics And Gynecology, Obstetrics(207VX0000X)	5	550	$534,587
Occupational Therapist(225X00000X)	20	534	$2,904,323
Ophthalmology(207W00000X)	30	2,002	$584,656
Optician(156FX1800X)	6	414	$56,048
Optometrist(152W00000X)	89	15,675	$3,656,808
Orthodontics(1223X0400X)	15	370	$368,831
Orthopedic Surgery(207X00000X)	33	4,990	$1,534,594
Otolaryngology(207Y00000X)	19	2,886	$795,300
Pace Organization(251T00000X)	1	178	$3,471,255
Pace Ppl(251X00000X)	1	346	$4,570,890
Pathology(207ZP0105X)	17	2,443	$142,709
Pediatrics(208000000X)	76	13,452	$4,878,853
Pediatrics(363LP0200X)	2	102	$20,745
Pediatrics, Neonatal-Perinatal Medicine(2080N0001X)	5	87	$295,963
Pedodontics(1223P0221X)	34	12,567	$4,936,642
Pharmacy(333600000X)	204	41,982	$57,006,524
Physical Medicine And Rehabilitation(208100000X)	12	347	$119,039
Physical Therapist(225100000X)	62	3,086	$2,653,095
Physician Assistant(363A00000X)	1	39	$4,294
Physician, General Practice(208D00000X)	59	21,759	$7,406,209
Plastic Surgery(2082S0099X)	11	58	$22,339
Podiatrist(213E00000X)	11	1,054	$58,482
Professional Counselor(101YP2500X)	138	2,459	$5,024,798
Prosthetic/Orthotic Supplier(335E00000X)	31	623	$615,641
Psychiatric Hospital(283Q00000X)	3	38	$200,677
Psychiatric Residential Treatment Facility(323P00000X)	13	296	$12,537,788
Psychiatry And Neurology, Psychiatry(2084P0800X)	26	1,257	$2,270,198
Psychiatry And Neurology: Neurology(2084N0400X)	19	2,014	$611,258
Public Health Or Welfare(251K00000X)	24	5,783	$881,179
Public Health, Federal(261QP0904X)	4	4,065	$19,625,445
Rehabilitation Hospital(283X00000X)	3	102	$562,051
Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (Corf)(261QR0401X)	1	61	$29,156
Rehabilitation, Substance Use Disorder(261QR0405X)	31	1,507	$2,939,968

Provider Taxonomy (continued)	Providers	Recipients	Expenditures
Rural Health(261QR1300X)	23	5,523	$1,894,505
Skilled Nursing Facillity(314000000X)	49	2,478	$86,684,517
Speech-Language Pathologist(235Z00000X)	9	180	$407,957
Surgery, Oral & Maxillofacial(1223S0112X)	11	1,289	$1,106,227
Surgery, Pediatric(2086S0120X)	2	57	$32,996
Surgery, Vascular(2086S0129X)	4	51	$23,257
Surgery: General Surgery(208600000X)	30	1,792	$621,880
Taxi(344600000X)	1	135	$33,435
Thoracic Surgery(208G00000X)	2	14	$14,046
Transportation Service(347C00000X)	3	53	$11,145
Urology(208800000X)	13	1,315	$303,965
Unclassified	1	371	$635,221
Total	3,456	74,056	$567,478,640

Table 69. Top 20 Provider Taxonomies by Expenditures

Provider Taxonomy	Expenditures	Percent of Total Medicaid Expenditures
Day Training, Developmentally Disabled Service(251C00000X)	$100,791,096	18%
Skilled Nursing Facillity(314000000X)	$86,684,517	15%
General Acute Care Hospital(282N00000X)	$84,380,731	15%
Pharmacy(333600000X)	$57,006,524	10%
Case Management(251B00000X)	$27,226,271	5%
Public Health, Federal(261QP0904X)	$19,625,445	3%
Intermediate Care Facility, Intellectual Disability(315P00000X)	$13,999,444	2%
Psychiatric Residential Treatment Facility(323P00000X)	$12,537,788	2%
General Acute Care Hospital - Rural(282NR1301X)	$11,942,563	2%
Federally Qualified Health Center(261QF0400X)	$11,418,874	2%
Chpr Cme(251S00000X)	$7,599,455	1%
Physician, General Practice(208D00000X)	$7,406,209	1%
Internal Medicine(207R00000X)	$7,076,336	1%
Durable Medical Equipment And Medical Supplies (332B00000X)	$6,944,732	1%
Family Practice(207Q00000X)	$6,424,856	1%
Mental Health-Including Community Mental Health(261QM0801X)	$6,188,978	1%
Clinical Psychologist(103TC0700X)	$5,398,489	1%
Professional Counselor(101YP2500X)	$5,024,798	1%
Pedodontics(1223P0221X)	$4,936,642	1%
Pediatrics(208000000X)	$4,878,853	1%
Top 20 Providers Combined	$487,492,599	86%

Table 70. Provider Count History by Taxonomy

Provider Taxonomy	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Addiction Therapist/Practitioner (101YA0400X)	-	-	2	4	4	3	-
Adult Health (363LA2200X)	1	1	1	1	1	1	0
Advance Practice Nurse (364SP0808X)	7	9	9	11	14	12	71
Allergy And Immunology, Allergy (207KA0200X)	7	7	10	9	6	5	-29
Ambulance (341600000X)	66	64	72	67	63	63	-5
Ambulatory Family Planning Facility (261QA0005X)	10	10	9	9	9	7	-30
Ambulatory Surgical (261QA1903X)	38	39	34	33	28	27	-29
Anesthesiology (207L00000X)	79	84	80	86	73	77	-3
Audiologist (231H00000X)	17	19	17	15	14	12	-29
Behavior Analyst (103K00000X)	-	-	-	-	-	5	-
Case Management (251B00000X)	102	103	100	100	113	113	11
Chiropractor (111N00000X)	18	20	13	34	50	52	189
CHPR CME (251S00000X)	-	-	-	1	1	1	-
Clinic/Center (261Q00000X)	13	13	12	12	14	23	77
Clinical Genetics (M.D.) (207SG0201X)	-	1	-	-	1	1	-
Clinical Medical Laboratory (291U00000X)	79	87	84	90	84	73	-8
Clinical Neuropsychologist (103G00000X)	-	-	2	2	1	4	-
Clinical Psychologist (103TC0700X)	78	106	122	94	73	69	-12
Day Training, Developmentally Disabled Service (251C00000X)	801	777	645	601	618	643	-20
Dentist (122300000X)	23	31	35	25	29	27	17
Dentist, General Practice (1223G0001X)	155	149	154	146	137	127	-18
Dermatology (207N00000X)	19	18	17	15	13	15	-21
Diagnostic Radiology (2085R0202X)	50	53	48	45	46	48	-4
Dietitian, Registered (133V00000X)	-	-	-	-	-	2	-
Durable Medical Equipment And Medical Supplies (332B00000X)	245	247	252	244	233	230	-6
ECSII & CASII Evaluator (174400000X)	-	-	-	-	-	7	-
Emergency Medicine (207P00000X)	23	26	38	39	36	31	35
End-Stage Renal Disease (Esrd) Treatment (261QE0700X)	14	15	13	14	14	15	7
Endodontics (1223E0200X)	5	5	5	5	3	3	-40
Family Health (363LF0000X)	13	12	17	16	14	12	-8
Family Practice (207Q00000X)	97	100	97	88	84	83	-14
Federally Qualified Health Center (261QF0400X)	9	7	10	9	12	11	22
General Acute Care Hospital (282N00000X)	207	201	192	181	109	105	-49
General Acute Care Hospital - Rural (282NR1301X)	38	46	36	42	36	30	-21
Hearing Aid Equipment (332S00000X)	20	19	16	12	11	9	-55
Home Health (251E00000X)	30	31	32	30	29	25	-17
Hospice Care, Community Based (251G00000X)	14	12	13	11	12	13	-7
Intermediate Care Facility, Intellectual Disability (315P00000X)	1	1	1	1	1	1	0
Internal Medicine (207R00000X)	73	80	59	67	54	56	-23
Internal Medicine, Cardiovascular Disease (207RC0000X)	19	17	17	26	17	18	-5
Internal Medicine, Endocrinology Diabetes And Metabolic (207RE0101X)	7	6	7	8	4	4	-43
Internal Medicine, Gastroenterology (207RG0100X)	10	9	6	9	4	6	-40

Provider Taxonomy (continued)	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Internal Medicine, Geriatric Medicine (207RG0300X)	1	2	2	2	4	4	300
Internal Medicine, Medical Oncology (207RX0202X)	15	15	12	11	7	6	-60
Internal Medicine, Nephrology (207RN0300X)	9	8	9	9	6	6	-33
Internal Medicine, Pulmonary Disease (207RP1001X)	11	14	13	11	10	9	-18
Internal Medicine, Rheumatology (207RR0500X)	4	4	4	4	2	2	-50
Interpreter (171R00000X)	2	1	1	1	1	2	0
Licensed Clinic/Cert Social Worker (1041C0700X)	1	2	43	59	74	77	7,600
Licensed Marriage & Family Therapist (106H00000X)	-	-	8	10	15	13	-
Lodging (177F00000X)	-	-	-	-	2	3	-
Medicare Defined Swing Bed Unit (275N00000X)	16	10	9	9	10	14	-13
Mental Health-Including Community Mental Health (261QM0801X)	52	36	27	27	27	26	-50
Midwife, Certified Nurse (367A00000X)	6	6	5	9	7	4	-33
Neurological Surgery (207T00000X)	18	20	14	16	11	10	-44
Neuromusculoskeletal Medicine And Omm (204D00000X)	1	-	-	-	-	-	-
Nurse Anesthetist, Certified Registered (367500000X)	21	24	22	20	14	13	-38
Nurse Practitioner (363L00000X)	6	9	10	10	9	9	50
Obstetrics And Gynecology (207V00000X)	54	54	46	48	39	33	-39
Obstetrics And Gynecology (363LX0001X)	5	6	2	1	-	-	-
Obstetrics And Gynecology, Gynecology (207VG0400X)	2	3	5	6	5	4	100
Obstetrics And Gynecology, Obstetrics (207VX0000X)	3	2	2	5	5	5	67
Occupational Therapist (225X00000X)	13	15	18	20	21	20	54
Ophthalmology (207W00000X)	36	36	36	34	25	30	-17
Optician (156FX1800X)	11	11	11	9	6	6	-45
Optometrist (152W00000X)	97	96	102	98	92	89	-8
Orthodontics (1223X0400X)	17	15	14	16	17	15	-12
Orthopedic Surgery (207X00000X)	44	44	35	37	34	33	-25
Otolaryngology (207Y00000X)	29	29	26	27	24	19	-34
PACE Organization (251T00000X)	-	1	1	1	1	1	-
PACE PPL (251X00000X)	-	-	1	1	2	1	-
Pathology (207ZP0105X)	20	22	21	22	19	17	-15
Pediatrics (208000000X)	70	71	72	73	97	76	9
Pediatrics (363LP0200X)	1	1	1	2	2	2	100
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	9	9	8	5	5	5	-44
Pedodontics (1223P0221X)	28	32	31	34	31	34	21
Periodontics (1223P0300X)	-	1	1	1	-	-	-
Pharmacy (333600000X)	199	198	204	205	205	204	3
Phlebotomy/WY Health Fair (246RP1900X)	1	1	1	1	-	-	-
Physical Medicine And Rehabilitation (208100000X)	14	16	14	17	13	12	-14
Physical Therapist (225100000X)	58	56	61	59	63	62	7
Physician Assistant (363A00000X)	-	-	1	1	1	1	-
Physician, General Practice (208D00000X)	93	86	74	78	62	59	-37
Plastic Surgery (2082S0099X)	17	17	15	10	11	11	-35
Podiatrist (213E00000X)	15	17	17	16	13	11	-27

Provider Taxonomy (continued)	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Professional Counselor (101YP2500X)	7	5	64	97	123	138	1,871
Prosthetic/Orthotic Supplier (335E00000X)	25	26	30	26	24	31	24
Psychiatric Hospital (283Q00000X)	1	4	4	2	3	3	200
Psychiatric Residential Treatment Facility (323P00000X)	15	19	20	16	14	13	-13
Psychiatry And Neurology, Psychiatry (2084P0800X)	38	43	35	32	30	26	-32
Psychiatry And Neurology: Neurology (2084N0400X)	26	27	27	26	20	19	-27
Public Health Or Welfare (251K00000X)	25	24	24	24	24	24	-4
Public Health, Federal (261QP0904X)	2	2	2	4	4	4	100
Radiology: Mobile (261QR0208X)	3	2	1	1	-	-	-
Rehabilitation Hospital (283X00000X)	3	3	4	3	2	3	0
Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	1	1	1	1	1	0
Rehabilitation, Substance Use Disorder (261QR0405X)	52	30	32	31	31	31	-40
Residential Treatment Facility For Emotionally Disturbed (322D00000X)	4	2	1	3	-	-	-
Rural Health (261QR1300X)	19	20	22	23	21	23	21
Skilled Nursing Facility (314000000X)	40	45	50	52	50	49	23
Speech-Language Pathologist (235Z00000X)	8	5	13	9	9	9	13
Surgery, Oral & Maxillofacial (1223S0112X)	16	17	17	14	16	11	-31
Surgery, Pediatric (2086S0120X)	2	2	2	3	5	2	0
Surgery, Vascular (2086S0129X)	6	5	5	6	3	4	-33
Surgery: General Surgery (208600000X)	45	48	37	43	33	30	-33
Taxi (344600000X)	-	-	-	-	1	1	-
Thoracic Surgery (208G00000X)	5	3	4	5	3	2	-60
Transportation Service (347C00000X)	-	-	-	-	4	3	-
Urology (208800000X)	22	21	18	17	15	13	-41
Unclassified	1	1	1	1	1	1	0
Total	3,763	3,603	3,651	3,605	3,492	3,456	-8

Table 71. Provider Expenditures History by Taxonomy

Eligibility Category	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Addiction Therapist/Practitioner (101YA0400X)	-	-	$10,121	$112,463	$235,019	$207,018	-
Adult Health (363LA2200X)	$208	$181	$1,791	$1,789	$7	$2,582	1,142
Advance Practice Nurse (364SP0808X)	$185,079	$217,012	$319,007	$286,789	$335,697	$363,266	96
Allergy And Immunology, Allergy (207KA0200X)	$462,979	$412,870	$473,744	$444,553	$372,655	$396,665	-14
Ambulance (341600000X)	$3,459,400	$3,606,360	$4,352,067	$3,571,623	$3,847,375	$2,381,969	-31
Ambulatory Family Planning Facility (261QA0005X)	$81,564	$68,988	$69,754	$55,497	$62,853	$51,449	-37
Ambulatory Surgical (261QA1903X)	$2,822,957	$3,439,188	$6,090,776	$5,953,159	$4,095,973	$3,881,705	38
Anesthesiology (207L00000X)	$2,660,467	$2,569,464	$2,519,148	$2,568,307	$2,697,539	$2,488,633	-6
Audiologist (231H00000X)	$113,056	$124,025	$134,326	$123,718	$158,494	$229,847	103
Behavior Analyst (103K00000X)						$167,595	-
Case Management (251B00000X)	$16,187,605	$16,073,653	$16,927,792	$20,056,159	$21,007,543	$27,226,271	68
Chiropractor (111N00000X)	$7,349	$7,500	$6,347	$99,664	$280,207	$347,441	4,628
CHPR CME (251S00000X)	-	-	-	$5,021,978	$7,135,148	$7,599,455	-
Clinic/Center (261Q00000X)	$1,195,547	$1,166,813	$1,339,630	$1,361,953	$1,327,800	$972,701	-19
Clinical Genetics (M.D.) (207SG0201X)	-	$1,345	-	-	$2,583	$6,455	-
Clinical Medical Laboratory (291U00000X)	$1,100,774	$1,149,473	$1,284,678	$1,536,310	$844,218	$1,020,356	-7
Clinical Neuropsychologist (103G00000X)	-	-	$2,071	$642	$6,824	$24,628	-
Clinical Psychologist (103TC0700X)	$9,025,018	$11,432,476	$14,027,227	$13,790,956	$7,869,869	$5,398,489	-40
Day Training, Developmentally Disabled Service (251C00000X)	$106,417,236	$105,946,874	$94,141,526	$93,766,911	$95,950,535	$100,791,096	-5
Dentist (122300000X)	$1,304,083	$1,299,057	$1,345,202	$1,445,036	$1,468,732	$1,051,336	-19
Dentist, General Practice (1223G0001X)	$6,567,492	$6,223,175	$6,400,779	$7,171,071	$6,085,423	$4,331,962	-34
Dermatology (207N00000X)	$346,181	$301,872	$276,343	$253,755	$272,569	$300,262	-13
Diagnostic Radiology (2085R0202X)	$2,698,857	$2,766,607	$2,218,816	$2,018,120	$1,821,704	$1,794,304	-34
Dietitian, Registered (133V00000X)						$1,803	-
Durable Medical Equipment And Medical Supplie (332B00000X)	$5,803,375	$6,501,225	$6,970,432	$6,610,828	$7,360,167	$6,944,732	20
ECSII & CASII Evaluator (174400000X)						$61,574	-
Emergency Medicine (207P00000X)	$3,662,836	$3,587,560	$3,862,924	$3,198,766	$4,130,517	$4,026,740	10
End-Stage Renal Disease (Esrd) Treatment (261QE0700X)	$1,233,755	$1,343,669	$1,099,569	$948,612	$1,267,034	$1,012,427	-18
Endodontics (1223E0200X)	$145,175	$176,754	$125,417	$51,569	$43,105	$52,582	-64
Family Health (363LF0000X)	$307,731	$312,321	$368,970	$311,405	$268,262	$246,169	-20
Family Practice (207Q00000X)	$6,408,005	$7,194,712	$5,824,202	$6,384,974	$6,805,220	$6,424,856	0
Federally Qualified Health Center (261QF0400X)	$1,550,274	$2,018,911	$3,259,793	$3,689,548	$5,725,094	$11,418,874	637
General Acute Care Hospital (282N00000X)	$89,158,045	$90,818,612	$86,971,143	$91,167,750	$83,353,763	$84,380,731	-5

Eligibility Category (Continued)	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
General Acute Care Hospital - Rural (282NR1301X)	$15,538,331	$16,826,942	$16,389,825	$15,380,672	$14,474,403	$11,942,563	-23
Hearing Aid Equipment (332S00000X)	$688,994	$560,896	$940,058	$790,555	$912,176	$831,358	21
Home Health (251E00000X)	$2,963,510	$2,897,016	$4,618,885	$9,467,835	$9,596,803	$4,012,083	35
Hospice Care, Community Based (251G00000X)	$983,026	$1,082,188	$1,157,101	$1,014,959	$1,316,838	$1,394,149	42
Intermediate Care Facilities, Intellectual Disability (315P00000X)	$10,065,657	$17,942,326	$18,091,427	$18,193,221	$19,204,867	$13,999,444	39
Internal Medicine (207R00000X)	$4,165,557	$4,488,138	$4,966,149	$6,899,612	$7,938,991	$7,076,336	70
Internal Medicine, Cardiovascular Disease (207RC0000X)	$447,730	$419,713	$437,224	$388,767	$419,095	$291,341	-35
Internal Medicine, Endocrinology Diabetes And Metabolic (207RE0101X)	$31,333	$30,547	$37,657	$19,270	$22,999	$18,807	-40
Internal Medicine, Gastroenterology (207RG0100X)	$253,524	$201,831	$377,353	$442,390	$495,528	$550,096	117
Internal Medicine, Geriatric Medicine (207RG0300X)	$189	$1,187	$17,669	$20,590	$27,816	$12,796	6,670
Internal Medicine, Medical Oncology (207RX0202X)	$2,090,706	$3,029,644	$2,493,943	$1,632,500	$2,469,020	$2,756,577	32
Internal Medicine, Nephrology (207RN0300X)	$57,824	$47,826	$54,404	$51,808	$26,828	$37,495	-35
Internal Medicine, Pulmonary Disease (207RP1001X)	$73,916	$119,064	$83,584	$77,414	$147,096	$102,784	39
Internal Medicine, Rheumatology (207RR0500X)	$53,116	$41,963	$49,969	$15,778	$18,310	$13,849	-74
Interpreter (171R00000X)	$48,321	$43,529	$56,339	$47,205	$32,056	$22,119	-54
Lic Clinic/Cert Social Worker (1041C0700X)	$2,564	$5,966	$907,851	$2,284,684	$3,213,974	$3,274,619	127,615
Licensed Marriage & Family Therapist (106H00000X)	-	-	$161,044	$280,470	$298,392	$510,758	-
Lodging (177F00000X)	-	-	-	-	$53,950	$85,915	-
Medicare Defined Swing Bed Unit (275N00000X)	$1,072,703	$887,666	$833,841	$775,338	$462,413	$620,073	-42
Mental Health-Including Community Mental Health (261QM0801X)	$9,581,854	$9,640,599	$8,668,925	$7,930,515	$7,681,061	$6,188,978	-35
Midwife, Certified Nurse (367A00000X)	$35,068	$18,485	$19,041	$51,381	$89,855	$64,608	84
Neurological Surgery (207T00000X)	$1,063,118	$890,226	$955,405	$536,628	$251,854	$69,210	-93
Neuromusculoskeletal Medicine And Omm (204D00000X)	$0	-	-	-	-	-	-
Nurse Anesthetist, Certified Registered (367500000X)	$378,968	$426,998	$227,083	$189,955	$73,627	$65,899	-83
Nurse Practitioner (363L00000X)	$205,988	$279,449	$336,154	$336,366	$297,224	$142,851	-31
Obstetrics And Gynecology (207V00000X)	$9,603,368	$8,906,934	$6,832,110	$5,733,312	$4,887,444	$4,563,484	-52
Obstetrics And Gynecology (363LX0001X)	$668,453	$356,682	$6,019	$7,023	-	-	-
Obstetrics And Gynecology, Gynecology (207VG0400X)	$14,134	$8,385	$11,932	$80,997	$164,003	$134,985	855
Obstetrics And Gynecology, Obstetrics (207VX0000X)	$6,188	$4,232	$10,974	$417,994	$655,371	$534,587	8,539
Occupational Therapist (225X00000X)	$777,572	$667,385	$2,260,765	$3,053,289	$3,199,864	$2,904,323	274
Ophthalmology (207W00000X)	$709,763	$693,621	$690,214	$606,722	$604,685	$584,656	-18
Optician (156FX1800X)	$101,728	$94,212	$74,200	$80,235	$68,054	$56,048	-45
Optometrist (152W00000X)	$3,090,404	$3,295,581	$3,521,016	$3,571,953	$3,782,521	$3,656,808	18
Orthodontics (1223X0400X)	$456,310	$415,802	$406,253	$547,443	$543,829	$368,831	-19

Eligibility Category (Continued)	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Orthopedic Surgery (207X00000X)	$1,679,389	$1,480,296	$1,422,229	$1,404,323	$1,628,003	$1,534,594	-9
Otolaryngology (207Y00000X)	$982,135	$882,361	$957,868	$895,930	$917,671	$795,300	-19
PACE Organization (251T00000X)	-	$168,398	$2,242,570	$2,934,877	$3,520,283	$3,471,255	-
PACE PPL (251X00000X)	-	-	$2,707,383	$4,434,368	$3,975,987	$4,570,890	-
Pathology (207ZP0105X)	$413,824	$365,084	$170,879	$164,404	$145,815	$142,709	-66
Pediatrics (208000000X)	$6,332,565	$5,954,804	$5,662,679	$5,455,184	$5,310,575	$4,878,853	-23
Pediatrics (363LP0200X)	$10,525	$10,696	$10,995	$12,213	$20,832	$20,745	97
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	$761,916	$812,471	$452,942	$248,989	$227,825	$295,963	-61
Pedodontics (1223P0221X)	$4,109,557	$4,374,460	$5,148,703	$5,008,474	$4,894,424	$4,936,642	20
Periodontics (1223P0300X)	-	$1,385	$2,341	$480	-	-	-
Pharmacy (333600000X)	$41,918,402	$38,919,301	$47,785,528	$48,325,155	$49,158,887	$57,006,524	36
Phlebotomy/WY Health Fair (246RP1900X)	$5,910	$2,635	$1,920	$575	-	-	-
Physical Medicine And Rehabilitation (208100000X)	$106,951	$143,519	$191,749	$128,026	$111,247	$119,039	11
Physical Therapist (225100000X)	$2,673,200	$2,799,403	$2,917,423	$3,382,286	$3,286,973	$2,653,095	-1
Physician Assistant (363A00000X)	-	-	$589	$577	$86	$4,294	-
Physician, General Practice (208D00000X)	$9,845,606	$9,598,191	$10,113,348	$7,598,341	$7,254,319	$7,406,209	-25
Plastic Surgery (2082S0099X)	$142,040	$133,343	$116,240	$90,174	$85,222	$22,339	-84
Podiatrist (213E00000X)	$73,605	$65,795	$78,388	$79,404	$72,405	$58,482	-21
Professional Counselor (101YP2500X)	$43,384	$24,104	$2,338,814	$3,676,332	$5,605,555	$5,024,798	11,482
Prosthetic/Orthotic Supplier (335E00000X)	$778,124	$828,261	$720,162	$798,679	$757,241	$615,641	-21
Psychiatric Hospital (283Q00000X)	$17,594	$106,009	$275,227	$127,648	$75,848	$200,677	1,041
Psychiatric Residential Treatment Facility (323P00000X)	$8,019,118	$12,080,494	$13,575,847	$11,797,657	$12,121,830	$12,537,788	56
Psychiatry And Neurology, Psychiatry (2084P0800X)	$4,695,322	$3,682,231	$2,650,594	$2,705,413	$2,552,807	$2,270,198	-52
Psychiatry And Neurology: Neurology (2084N0400X)	$672,232	$661,311	$1,354,679	$959,006	$805,683	$611,258	-9
Public Health Or Welfare (251K00000X)	$988,455	$924,007	$1,009,814	$1,072,715	$912,444	$881,179	-11
Public Health, Federal (261QP0904X)	$7,240,130	$8,067,975	$8,761,358	$8,479,944	$8,718,888	$19,625,445	171
Radiology: Mobile (261QR0208X)	$109,250	$4,081	$52	$7	-	-	-
Rehabilitation Hospital (283X00000X)	$1,085,017	$1,087,890	$887,751	$1,016,080	$563,688	$562,051	-48
Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	$125,928	$121,618	$154,682	$146,226	$84,406	$29,156	-77
Rehabilitation, Substance Use Disorder (261QR0405X)	$2,592,208	$3,352,288	$4,793,708	$3,895,890	$2,997,914	$2,939,968	13
Residential Treatment Facility For Emotionally Disturbed (322D00000X)	$183,009	$109,220	$35,712	$237,904	-	-	-
Rural Health (261QR1300X)	$1,628,043	$1,845,491	$1,668,167	$1,413,842	$1,540,607	$1,894,505	16
Skilled Nursing Facility (314000000X)	$72,733,100	$72,705,796	$69,520,419	$81,670,473	$86,538,699	$86,684,517	19

Eligibility Category (Continued)	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Speech-Language Pathologist (235Z00000X)	$117,626	$336,118	$745,421	$714,369	$688,314	$407,957	247
Surgery, Oral & Maxillofacial (1223S0112X)	$978,561	$781,478	$1,045,169	$1,225,956	$1,132,105	$1,106,227	13
Surgery, Pediatric (2086S0120X)	$90,962	$63,361	$80,089	$57,200	$76,375	$32,996	-64
Surgery, Vascular (2086S0129X)	$38,008	$32,715	$18,527	$32,393	$6,400	$23,257	-39
Surgery: General Surgery (208600000X)	$796,756	$765,767	$635,372	$713,150	$740,929	$621,880	-22
Taxi (344600000X)	-	-	-	-	$16,674	$33,435	-
Thoracic Surgery (208G00000X)	$11,995	$13,475	$31,776	$34,078	$20,262	$14,046	17
Transportation Service (347C00000X)	-	-	-	-	$7,329	$11,145	-
Urology (208800000X)	$799,645	$835,010	$740,261	$441,176	$295,664	$303,965	-62
Unclassified	($4,024)	$30,590	$154,857	$272,435	$286,240	$635,221	-15,886
Total	$500,931,031	$517,257,164	$527,531,608	$554,583,138	$555,419,725	$567,478,640	13

APPENDIX B: REIMBURSEMENT METHODOLOGY

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

Table 72. Reimbursement Methodology and History by Service Area

Ambulance

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	No change	No change	No change

Wyoming State Rule Chapter 15; Chapter 3

Ambulatory Surgery Center

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

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	Adopted new OPPS-based methodology to better align reimbursement with those services provided in other outpatient settings	No change	Adjusted conversion factors effective calendar year 2017	No change

43 CFR 447.321 SPA 4.19B

Behavioral Health

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	No change	Reimbursement rate reduced by 3.3%	No change

State plan 4.19B

Care Management Entity

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
N/A	N/A	N/A	Beginning of service	No change	

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

Clinic/Center

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	No change	Changed from billing as single entity to billing as a group with treating providers effective for dates of service as of 6/1/17. Also became part of the Cap Limit process, effective the same date.	No change

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

Dental

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	No change	Per Governor's budget cuts, adult dental coverage reduced to preventive and emergency services only.	No change

Wyoming State Plan Attachment 4.19B

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	No change	No change	Codes impacted by the 21st Century CURES Act are set at 100% of the lowest Medicare rate. Codes not impacted by the 21st Century CURES Act, no change

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

End Stage Renal Disease

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Dialysis services reimbursed at 17% of billed charges (effective January 1, 2012)	Dialysis services reimbursed at 12% of billed charges (effective January 1, 2013)	Dialysis services reimbursed at 9% of billed charges (Effective January 1, 2014)	No change	No change	No change

42 CFR Part 413 Subpart H; State Plan 4.19B

Federally Qualified Health Centers

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Rates increased 0.8% based on MEI	Rates increased 0.8% based on MEI	Rates increased 0.8% based on MEI	Rates increased 1.1% based on MEI	Rates increased 1.2% based on MEI	Rates increased 1.01% 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

Home Health

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	No change	Prior authorization required starting dates of service 3/1/17 and newer	No change

42 CFR 484 Subpart E

Hospice

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments

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

Hospital Inpatient

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

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	No change	No change to LOC reimbursement; private hospital UPL implemented	No change

CFR 447 Subpart C Payment; State Plan 4.19B

Hospital Outpatient

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

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Adjusted conversion factors to support budget neutrality in the aggregate (effective calendar year 2012): General acute $50.99 Critical access $129.74 Children's $109.95	Adjusted conversion factors to support budget neutrality in the aggregate (effective calendar year 2013): General acute $48.19 Critical access $126.82 Children's $105.50	Adjusted conversion factors to support budget neutrality in the aggregate (effective calendar year 2014): General acute $45.45 Critical access $118.86 Children's $100.05	Adjusted conversion factors to support budget neutrality in the aggregate (effective calendar year 2015): General acute $42.34 Critical access $111.93 Children's $92.71	Adjusted conversion factors due to budget cuts (effective calendar year 2017): General acute $37.94 Critical access $98.80 Children's $76.34 ASCs $33.39	Adjusted conversion factors due to budget cuts (effective calendar year 2018): General acute $39.70 Critical access $104.27 Children's $83.92 ASCs $34.94
No change for QRA	No change for QRA	No change for QRA	No change for QRA	No change for QRA	No change for QRA

CFR 447.321; CFR 447.325; Chapter 33 Rule

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)

Full cost reimbursement method based on previous year cost reports.

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	Removed link with Nursing Home rates. Rates now updated annually with full cost coverage.	No change	No change

Wyoming State Rule Chapter 20

Laboratory

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	No change	No change	No change

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

Nursing Facility

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

Additional payments:
Provider Assessment and Upper Payment Limit (UPL) Payment provides supplemental payments (effective April 1, 2011)
Nursing Facility Gap Payment Program approved in SFY 2017 as a supplemental payment program

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	Rate updates effective SFY16 pending SPA approval- based on approved NH Rate Reimbursement update	No change	Nursing Facility Gap Payment Program approved in SFY 2017; no change to rate methodology	No change

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

Physicians and Other Practitioners

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Beginning January 1, 2013 The Affordable Care Act (ACA) mandated increased primary care service payment by State Agencies of least the Medicare rates in effect in CY 2009 for CY 2013 and 2014. This only effected Evaluation and Management procedure codes 99201-99499 and Vaccine codes 90460, 90471, 90472, 90743 and 90474. This was only applicable to Physicians that completed a self-attestation to having a specialty in Family, Internal or Pediatric Medicine.	The ACA Primary Care Service Payments officially ended December 31, 2014.	No change	No change	Adjusted conversion factor on November 1, 2016 to reflect a 3.3% reduction on all RBRVS codes	No change

State Plan Amendment 3.1 and 4.19B

Prescription Drugs

New rate structure implemented on April 1, 2017, pays lower of:
1) The National Average Drug Acquisition Cost (NADAC)
2) When no NADAC is available, DHCF substitutes Wholesale Acquisition Cost (WAC) into logic
3) State Maximum Allowable Cost (SMAC)
4) Federal Upper Limit (FUL)
5) Ingredient Cost Submitted
6) Gross Amount Due (GAD)
7) Provider's usual and customary (U&C) charge to the public

Reimbursement for claims that pay at GAD or U&C will not include a dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim. Dispensing fee is $10.65 per claim

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
PDL adjusted to 108 specific drug classes	PDL expanded to 119 specific drug classes	PDL expanded to 123 specific drug classes	No change	Reimbursement structure changed on April 1, 2017 to be in compliance with the Final Covered Outpatient Drug Rule.	No change

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

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

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Beginning of Service	No change	No change	Rate increased	Rate decreased	Rate decreased for Medicaid-only; increased for dual-Medicare/Medicaid

State Plan Amendment 3.1-A

Psychiatric Residential Treatment Facility

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	Rates adjusted 12/1/14 based on analysis of Medicaid cost reports	No change	No change	No change	No change

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

Public Health or Welfare

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	No change	Adjusted conversion factor on November 1, 2016 to reflect 3.3% reduction on all RBRVS codes	No change

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

Public Health, Federal

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	No change	No change	No change

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

Rural Health Center

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	Rates increased 0.8% based on MEI	Rates increased 0.8% based on MEI	Rates increased 1.1% based on MEI	Rates increased 1.2% based on MEI	Rates increased 1.01% based on MEI

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

Vision

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	No change	No change	No change

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

Waivers - Acquired Brain Injury

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
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	No change	On February 1, 2017 this waiver received an across the board rate increase of 3.3% that was made retroactive back to July 1, 2016. Adult and Children ID/DD Waivers closed	Rate increase of 4.2% for all services

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

Waivers - Comprehensive and Supports

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
N/A	Waivers implemented with reimbursement based on SFY 2009 methodology with SFY '11 and '14 reductions included	No change	3.3% across-the-board rate increase and 3.3% increase to each IBA to be implemented 1/1/17	February 1, 2017, implemented 3.3% rate increase applied retroactively back to July 1, 2016.	Rate increase of 4.2% for all services

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

Waiver - Children's Mental Health

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	Care Management Entity began serving youth July 1, 2015	Continue to work with CMS for approval of SFY 2017 rates	CMS is reviewing SFY18 CME actuarial rate certification for approval. A mass adjustment for SFY18 DOS using the SFY17 approved rate is in process.

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

Waiver - Community Choices

Long-Term Care services are paid lower of the Medicaid fee schedule or the provider's usual and customary (U&C) charge with reimbursement limited to a monthly or yearly cap per person, according to their established care plan.
For Assisted Living services, reimbursement made on a per diem rate, based on an all-inclusive payment methodology. Per diem ratesare based on the participant's functional assessment. Per diem rate includes required personal care, 24-hour supervision and medication assistance up to a monthly or yearly cap. Case management services are reimbursed a separate rate. Participants pay their own room and board.

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	No change	No change	12% increase per rate rebasing project, effective March 1, 2016.	No change	No change

Waiver agreement

Waiver - Pregnant by Choice

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

SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
No change	Extended to December 31, 2017	No change	No change	No change	No change

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APPENDIX C: ELIGIBILITY REQUIREMENTS & BENEFITS

Table 73. Income Limits by Eligibility Category

Eligibility Category	CY 2017-2018
Children 0-5	154% FPL, no resource limits
Children 6-18	133% FPL, no resource limits
Former Foster Care Children, age 19 to 26	Eligible, no resource limits
Family Care Adults	Values in Table 74, no resource limits
Pregnant Women	154% FPL, no resource limits
ABD Waivers and institutions	Less than or equal to 300% SSI
ABD with Eligibility Determined by Social Security Administration	100% SSI
Qualified Medicare Beneficiary	100% FPL
Specified Low-Income Medicare Beneficiary	Less than or equal to 120% FPL
Qualified Individual	121 to 135% FPL
Breast & Cervical Cancer	Less than or equal to 250% FPL
Tuberculosis	100% SSI
Employed individuals with disabilities	Less than or equal to 300% SSI
Non-Citizens with Medical Emergencies	Depends on eligibility group qualified under

Table 74. Monthly Income Standard Values by Family Size

Income Standard	Income Limit	CY 2017				CY 2018			
Family Size		1	2	3	4	1	2	3	4
Family Care Adults		$529	$737	$873	$999	$529	$737	$873	$999
Federal Poverty Level (FPL)	100%	$1,005	$1,354	$1,702	$2,050	$1,012	$1,372	$1,732	$2,092
	133%	$1,337	$1,800	$2,264	$2,727	$1,346	$1,825	$2,304	$2,782
	154%	$1,548	$2,085	$2,621	$3,157	$1,558	$2,113	$2,667	$3,222
Supplementary Security Income (SSI)	100%	$735	$1,103	--	--	$750	$1,125	--	--
	300%	$2,205	$3,309	--	--	$2,250	$3,375	--	--

Table 75. Eligibility Requirements

Category Group	Eligibility Category	Benefits	Eligibility Requirement	Countable Income	Income Level	Resource Limits
Children	Newborn	Full Medicaid Coverage	Newborns up to age one, with Medicaid eligible mothers	N/A; eligibility determined by mother's Medicaid eligibility		
	Children Age 0-5	Full Medicaid Coverage	Under age six	Countable family income	Less than or equal to 154 percent of FPL	
	Children Age 6-18	Full Medicaid Coverage	Under age 19	Countable family income	Less than or equal to 133 percent of FPL	
	Foster Care	Full Medicaid Coverage	Under age 21, in DFS custody	Requirements vary by type of foster care coverage		
	Subsidized Adoption	Full Medicaid Coverage	Under age 18; under age 21 for children with special needs	Requirements vary by type of subsidized adoption		
Pregnant Women	Pregnant Women	Full Medicaid Coverage	Pregnant	Countable family income	Less than or equal to 154 percent of FPL	
	Presumptive Eligibility for Pregnant Women	Outpatient services for a limited time	Pregnant	Countable family income	Less than or equal to 154 percent of FPL	
Family Care	Family Care	Full Medicaid Coverage	Adult with eligible child under age 19 living in the household	Countable family income	Less than or equal to Family Care Income Standard	
	Family Care 4 and 12 month (extended medical)	Full Medicaid Coverage	Adult with eligible child under age 19 living in the household; Family unit must have received family care benefits for at least three of the previous 6 months	Countable family income	Exceeds the family care income standard due to increased income due to increased employment, increased earnings, parent returning to work, or child support	
	Aging-Out Foster Care Program	Full Medicaid Coverage	Under age 26	Requirements vary by the type of foster care coverage		

Category Group	Eligibility Category	Benefits	Eligibility Requirement	Countable Income	Income Level	Resource Limits
Aged, Blind, or Disabled (ABD)	ABD Individuals in Institutions	Full Medicaid Coverage	Age 65 or older; or blind by SSI standards; or disabled by SSI standards; and in an institutional setting, such as nursing home, IMD, hospice care, inpatient hospital, or ICF-IID	Countable personal income	Less than or equal to 300 percent of the SSI payment standard for a single individual	yes
	Categories with eligibility determined by Social Security Administration (SSA)	Full Medicaid Coverage	SSI eligibility	Countable personal and spousal income	Eligibility determined by SSA; automatically eligible for Medicaid Monthly SSI Payment Standard	yes
	SSI related categories with eligibility determined by WDH	Full Medicaid Coverage	Lost SSI due to increase or receipt of Social Security benefits; disregard increase or SSA benefit amount	Countable personal income	Countable income less than or equal to Monthly SSI Payment Standard	yes
Medicare Savings Program	Qualified Medicare Beneficiary (QMB)	• Medicaid covers Medicare Part A/B premiums • CMS assists with Medicare Part D premiums • Medical deductible and coinsurance payments	Entitled to Medicare Part A or Part B	Countable personal and spousal income	Less than or equal to 100 percent of FPL	yes
	Specified Low-Income Medicare Beneficiary (SLMB)	Medicaid pays Medicare Part B premiums	Entitled to Medicare Part B	Countable personal and spousal income	Between 101 and 120 percent of FPL	yes
	Qualified Individuals (QI	Medicaid pays Medicare Part B premiums (100% federal funds)	Entitled to Medicare Part B	Countable personal and spousal income	Between 121 and 135 percent of FPL	yes
Special Groups	Breast and Cervical Cancer	Full Medicaid Coverage	Between age 18 and 65 (if over 65, must not be eligibile for Medicare Part B); meet Preventative Health and Safety Division criteria; no insurance coverage paying for cancer screening or treatment (including Medicaid and Medicare Part B)	Countable personal income	Less than or equal to 250 percent of FPL	
	Tuberculosis	Partial benefits related to tuberculosis	Verification of tuberculosis	Countable personal income	SSI Payment Standard	yes

Category Group	Eligibility Category	Benefits	Eligibility Requirement	Countable Income	Income Level	Resource Limits
Medicaid Buy-In	Employed Individuals with Disabilities	Full Medicaid benefics after payment of premium (7.5 percent of gross monthly income)	Between age 16 and 64; disabled; employed	Countable personal and spousal income	Unearned income less than or equal to 300 percent of the SSI standard for a single individual, no limit on earned income	
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 D: 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 (DME), Prosthetics, Orthotics and Supplies – Medical equipment and other supplies that are intended to reduce an individual's physical disability and restore the individual to his or her functional level.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HCBS 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. This waiver closed in SFY 2017, with service now provided under the Community Choices Waiver.

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 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 Community Choices (CC) Waiver – A HCBS waiver allowing participants age 19 and older who require services equivalent to a nursing facility level of care to receive services in an assisted living facility or in their home.

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. Replaced by the Community Choices Waiver in SFY 2017.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rural Health Clinic (RHC) – A designated health clinic in a medically under-served 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.

ACRONYMS

Table 76. Acronyms

Acronym	Meaning	Acronym	Meaning
ACA	Affordable Care Act	JCAHO	Joint Commission on Accreditation of Healthcare Organizations
ARRA	American Recovery and Reinvestment Act of 2009	LEP	Limited English Proficiency
ABD	Aged, Blind, or Disabled	LOC	Level of Care
ABI	Acquired Brain Injury	LTC	Long-Term Care
ALF	Assisted Living Facility	MAGI	Modified Adjusted Gross Income
APC	Ambulatory Payment Classification	MEI	Medicare Economic Index
ASC	Ambulatory Surgery Center	MFCU	Medicaid Fraud Control Unit
AWP	Average Wholesale Price	MMIS	Medicaid Management Information System
BHD	Behavioral Health Division	MU	Meaningful Use
BIPA	Benefits Improvement and Protection Act of 2000	NAMFCU	National Association of Medicaid Fraud Control Units
CARF	Commission on Accreditation of Rehabilitation Facilities	NPI	National Provider Identifier
CCD	Continuity of Care Document	OIG	Office of Inspector General
CHIP	Children's Health Insurance Program	OPPS	Outpatient Prospective Payment System
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009	OSCR	On-Site Compliance Review
CME	Care Management Entity	PACE	Program of All-Inclusive Care for the Elderly
CMHC	Community Mental Health Center	P&T	Pharmacy and Therapeutics
CMS	Centers for Medicare and Medicaid Services	PA	Prior Authorization
COA	Council on Accreditation of Services for Families and Children	PAB	Psychiatrist Advisory Board
CORF	Comprehensive Outpatient Rehabilitation Facility	PBM	Pharmacy Benefit Management (or Manager)
CPT	Current Procedural Terminology	PCMH	Patient Centered Medical Home
CQM	Clinical Quality Measures	PDAP	Prescription Drug Assistance Program
DD	Developmental Disabilities	PDL	Preferred Drug List
DFS	Department of Family Services	PMPM	Per Member Per Month
DME	Durable Medical Equipment	POS	Prosthetics, Orthotics and Supplies
DRA	Deficit Reduction Act	PPS	Prospective Payment System
DSH	Disproportionate Share Hospital	PRTF	Psychiatric Residential Treatment Facility
DUR	Drug Utilization Review	QMB	Qualified Medicare Beneficiaries
EAC	Estimated Acquisition Cost	QIS	Quality Improvement Strategy
EHR	Electronic Health Record	QRA	Qualified Rate Adjustment
EOB	Explanation of Benefits	RIBN	Resource Integration into Behavioral Health Networks
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment	RBRVS	Resource Based Relative Value Scale
ESRD	End Stage Renal Disease	RHC	Rural Health Clinic
FFY	Federal Fiscal Year	SCHIP	State Children's Health Insurance Program
FMAP	Federal Medical Assistance Percentage	SFY	State Fiscal Year
FPL	Federal Poverty Level	SLMB	Specified Low-Income Medicare Beneficiaries
FQHC	Federally Qualified Health Center	SLR	State Level Repository
FUL	Federal Upper Limit	SMAC	State Maximum Allowable Cost
HCBS	Home and Community Based Services	SSA	Social Security Administration
HCPCS	Healthcare Common Procedure Coding System	SSDC	Sovereign States Drug Consortium
HHS	Department of Health and Human Services	SSI	Supplemental Security Income
HIE	Health Information Exchange	TB	Tuberculosis
HIT	Health Information Technology	THR	Total Health Record
HPSA	Health Professional Shortage Area	TPL	Third Party Liability
IBA	Individualized Budget Amount	WDH	Wyoming Department of Health
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities	WES	Wyoming Eligibility System

APPENDIX E: DATA METHODOLOGY

OVERVIEW

Members are enrolled in an eligibility program code. These program codes define the eligibility categories.

See tables 77 & 78 for the eligibility category breakdown by program codes

ENROLLMENT AND MEMBERS

A member is any individual enrolled in Medicaid identified by a Medicaid ID number.

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

Monthly average of enrollment is calculated using the distinct count of members as of the last day of each month.

Total SFY Enrollment is a distinct count of all members enrolled at any time during the SFY, regardless of the duration of their enrollment span.

RECIPIENTS

Any enrolled member who has received services and had a Medicaid claim processed and paid during the SFY.

For this report, distinct counts of recipients is calculated based on original claims, never voided or adjusted, and final adjustment claims only. Eligibility program codes for disability determination, screenings, and gross adjustments are excluded, as well.

Since the distinct count of recipients is based on claims paid during the SFY, this count may exceed enrollment as some recipients may not have maintained enrollment in the SFY in which their claim paid.

EXPENDITURES

Expenditures represent claim payments made to providers during the SFY.

For this report, expenditures includes all paid claims, including those that were adjusted and re-adjusted during the SFY. Unlike recipient counts, total expenditures also includes claims for disability determination, screenings, and gross adjustments.

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

The PMPM value in this report is a preliminary value only.

The final SFY 2017 PMPM value will be available in the separate *Wyoming Medicaid Per Member Per Month report*.

PER MEMBER PER MONTH

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

This calculation is equal to expenditures divided by member months in which expenditures are based on original and final adjusted claims by first service dates and member months is the sum of the number of months individuals are enrolled in Medicaid.

SERVICES

Most service areas are defined using pay-to-provider taxonomy codes on claims paid during the SFY.

Other services may use claim types or the recipient's eligibility program code in addition to the pay-to-provider tax code.

See table 79 for the parameters used for each service and special population in this report.

Table 77. Medicaid Chart A Eligibility Program Codes

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

Eligibility Category (Continued)	Program Codes	
Aged, Blind, Disabled Institution	S14	Institutional (Hosp) Aged - Inactive
	S15	Inpatient Hospital 300% Cap > 65
	S34	Inatitutional (Hosp) Disabled - Inactive
	S35	Inpatient Hospital 300% Cap < 65
	S13	Inpat-Psych > 65
Aged, Blind, Disabled Long-Term Care	R01	Asst Living Fac Wvr SSI < 65
	R02	Asst Living Fac Wvr 300% < 65
	R03	Asst Living Fac Wvr SSI > 65
	R04	Asst Living Fac Wvr 300% > 65
	S50	Hospice Care > 65
	S51	Hospice Care < 65
	N98	WLTC Temp Services
	S24	LTC Waiver SSI > 65
	S25	LTC Waiver 300% Cap > 65
	S46	LTC Waiver SSI < 65
	S47	LTC Waiver 300% Cap < 65
	N97	NH Temp Services
	S01	NH-SSI & Ssa Blend >65
	S02	NH-SSI & Ssa Blend <65
	S10	Nursing Home SSI >65
	S11	Nursing Home 300% Cap >65
	S17	Retro Medicaid-"Pr" Aged (inactive)
	S18	Retro Medicaid-"Rm" Aged (inactive)
	S30	Retro Medicaid-"Pr" Disabled (inactive)
	S32	Nursing Home SSI <65
	S33	Nursing Home 300% Cap <65
	S54	Medicaid Only-No Rm & Brd >65
	S55	Medicaid Only-No Rm & Brd <65
	S90	Retro Medicaid-"Rm" Disabled
	P11	PACE < 65
	P12	PCMR < 65
	P13	PACE SSI Disabled < 65
	P14	PACE Mcare SSI Disabled < 65
	P15	PACE NF < 65
	P16	PACE NF SSI Disabled < 65
	P17	PACE NF Mcare Disabled < 65
	P18	PACE NF Mcare SSI Disable < 65
	P21	PACE > 65
	P22	PCMR > 65
	P23	PACE SSI Aged > 65
	P24	PACE Mcare SSI Aged > 65
	P25	PACE NF > 65
	P26	PACE NF SSI Aged > 65
	P27	PACE NF Mcare Aged > 65
	P28	PACE NF Mcare SSI Aged > 65

Eligibility Category (Continued)	Program Codes	
Aged, Blind, Disabled SSI & SSI Related	S12	SSI Eligible >65
	S20	Blind SSI - Receiving Payment
	S21	Blind SSI - Not Receiving Pymt
	S31	SSI Eligible <65
	S36	Disabled Adult Child (DAC)
	S37	Goldberg-Kelly
	S39	1619 Disabled
	S40	Aptd Essent. Person Med Only -I
	S48	Zebley >21
	S49	Zebley <21
	S92	Widow-Widowers SDX
	S98	Pseudo SSI Aged (inactive)
	S99	Pseudo SSI Disabled (inactive)
	S09	SSI-Disabled Child Definition
	S16	Pickle >65
	S38	Pickle <65
	S42	Widow-Widowers
	S43	Qual Disabled Working Ind
Adults	A01	Family Care Past 5yr Limit >21 (inactive)
	A03	Family Care >21
	A68	12 Mo Extended Med >21
	A69	2nd-6mos. Trans Mcaid Adult (inactive)
	A75	Institutional (AFDC) Adult (inactive)
	A77	AFDC-Up Unemployed Parent Ad (inactive)
	A79	Retro Medicaid-"Rm" Adult (inactive)
	M11	Family MAGI PE >21
	A80	Refugee Adult (inactive)
	A82	Alien: 245 (IRCA) Adult (inactive)
	A83	Alien: 210 (IRCA) Adult (inactive)
	A70	AFDC Medicaid - Adult (inactive)
	A76	4 Mo Extended Med >21
	A78	Retro Medicaid-"Pr" Adult (inactive)
	M04	Family MAGI >21
	M08	Former Foster Youth > 21
	M18	Former Foster Youth PE > 21
	M01	Adult MAGI > 21
	M13	Adult MAGI PE > 21

Eligibility Category (Continued)	Program Codes	
Children	A02	Family Care Past 5yr Limit <21
	A04	Family Care <21
	A50	AFDC Medicaid (inactive)
	A54	2nd-6mos. Trans Mcaid Child (inactive)
	A56	Alien: 245 (IRCA) Child (inactive)
	A57	Baby <1 Yr, Mother SSI Elig (inactive)
	A59	Retro Medicaid-"Pr" Child (inactive)
	A60	4 Mo Extended Med <21
	A61	Institutional (AF-IV-E) (inactive)
	A62	Retro Medicaid-"Rm" Child (inactive)
	A63	Refugee Child (inactive)
	A64	Alien: 245 (IRCA) Child (inactive)
	A58	Child 6 Through 18 Yrs
	A65	AFDC-Up Unemployed Parent Ch (inactive)
	A67	12 Mo Extended Med <21
	A87	16+ Not In School AF HH (inactive)
	K03	Kidcare to Child Magi
	M02	Adult MAGI <21
	M03	Child MAGI
	M05	Family MAGI <21
	M10	Children's PE
	M12	Family MAGI PE <21
	M14	Adult MAGI PE <21
	S62	Continuous SSI Eligible <19
	A55	Child 0 Through 5 Yrs
	S65	Cont Childrns Ment Health Wvr < 19
	S95	Childrens Ment Hlth Wvr SSI < 21
	S96	Childrens Ment Hlth Wvr 300% <21
	A51	IV-E Foster Care
	A52	IV-E Adoption
	A85	Foster Care Title 19
	A86	Subsidized Adoption Title 19
	A88	Aging Out Foster Care
	A97	Foster Care 0 Through 5
	A98	Foster Care 6 Through 18
	M09	Former Foster Youth <21
	M17	Former Foster Youth PE <21
	S63	Continuous Foster Care <19
	A53	Newborn

Eligibility Category (Continued)	Program Codes	
Medicare Savings Programs	Q17	QMB > 65
	Q41	QMB < 65
	Q94	SLMB 2 > 65
	Q95	SLMB 2 < 65
	Q96	SLMB 1 > 65
	Q97	SLMB 1 < 65
	Q98	Part B-Partial Aged (Inactive)
	Q99	Part B-Partial Disabled (Inactive)
Non-Citizens with Medical Emergencies	A81	Emergency Svc < 21
	A84	Emergency Svc > 21
Pregnant Women	A71	Pregnant Woman < 21
	A72	Pregnant Woman > 21
	A73	Qualified Pregnant Woman > 21
	A74	Qualified Pregnant Woman < 21
	M06	Pregnancy MAGI > 21
	M07	Pregnancy MAGI < 21
	A19	Presumptive Eligibility
Special Groups	B03	Breast & Cervical > 21
	B04	Breast & Cervical < 21
	M15	Breast & Cervical PE > 21
	M16	Breast & Cervical PE < 21
	S52	Tuberculosis (Tb) > 65
	S53	Tuberculosis (Tb) < 65
	A20	Pregnant By Choice
Screenings & Gross Adjustments	N96	Disability Determination Only
	N99	LTC Screening Only
	S97	CASII Screening Only
	ZZZ	Other
	P07	CHIPRA CME

Table 78. Medicaid Chart B Eligibility Program Codes

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

DATA PARAMETERS

Table 79, below, provides the parameters used for extracting data for each service area included in this report. As stated in the previous section, Expenditures are calculated using all Medicaid Chart A recipient program codes and all claim adjustments except history-only adjustments. Counts exclude several program codes and only include original and final claims.

Table 79. Data Parameters by Service Area

Service Area	Pay-to-Provider Taxonomy		Other Parameters
Ambulance - Total	341600000X	Ambulance	n/a
Ambulance - Air	341600000X	Ambulance	Procedure Codes: A0030, A0430, A0431, A0435, A0436, A0382, A0398, A0422, A0433, A0434, A0998
Ambulance - Ground	341600000X	Ambulance	Procedure Codes: A0221, A0360, A0362, A0368, A0370, A0380, A0390, A0425, A0426, A0427, A0428, A0429, A0382, A0398, A0422, A0433, A0434, A0998
Ambulatory Surgery Center	261QA1903X	Ambulatory Surgery Center	n/a
Behavorial Health	101Y00000X 101YA0400X 101YP2500X 103G00000X 103K00000X 103TC0700X 1041C0700X 106E00000X 106H00000X 106S00000X 163W00000X 164W00000X 171M00000X 172V00000X 2084P0800X 261QM0801X 261QR0405X 364SP0808X	Professional Counselor; Certified Mental Health Worker Addictions Therapist/Practitioner Professional Counselor Neuropsychologist Behavior Analyst Clinical Pscyhologist Social Worker Assistant Behavior Analyst Marriage and Family Therapist Behavior Technician RN LPN Case Worker Community Health Worker; Peer Specialist; Certified Addictions Practitioner Asisstant Psychiatrist Mental Health - including Community Mental Health Center Rehabilitation, Substance Use Disorder NP, APN Psychiatric/Mental Health	n/a
Behavioral Health services provided by Non BH providers	EXCLUDE Behavioral Health Provider taxonomies and 261QP0904X: Public Health, Federal		Procedure Codes: G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792, H0001-H2037, 90801-90899, 96101-96125 99201 and 99360 when paired with 90833, 90836, 90838, or 90785 on same claim with same treating provider Claim Types: EXCLUDE W (waiver)
Care Management Entity	251S00000X	CHPR CME	n/a
Clinic/Center	261Q00000X	Clinic/Center	n/a

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Dental	122300000X 1223D0001X 1223E0200X 1223G0001X 1223P0221X 1223P0300X 1223S0112X 1223X0400X	Dentist Dental Public Health Endodontics General Practice Dentist Pedodontics Periodontics Surgery, Oral and Maxillofacial Orthodontics	n/a
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	332B00000X 332S00000X 335E00000X	DME Hearing Aid Equipment POS	n/a
Durable Medical Equipment Only	332B00000X 332S00000X	DME Hearing Aid Equipment	n/a
Prosthetics, Orthotics, and Supplies Only	335E00000X	POS	n/a
End-Stage Renal Disease	261QE0700X	End-Stage Renal Disease	n/a
Federally Qualified Health Center	261QF0400X	Federally Qualified Health Center	n/a
Home Health	251E00000X	Home Health	n/a
Hospice	251G00000X	Hospice Care, Community Based	n/a
Hospital Total	261QR0400X 282N00000X 282NR1301X 283Q00000X 283X00000X	Rehabilitation General Acute Care Hospital General Acute Care Hospital - Rural Psychiatric Hospital Rehabilitation Hospital	n/a
Hospital Inpatient	282N00000X 282NR1301X 283Q00000X 283X00000X	General Acute Care Hospital General Acute Care Hospital - Rural Psychiatric Hospital Rehabilitation Hospital	Claim Type: I, X
Hospital Outpatient	261QR0400X 282N00000X 282NR1301X 283X00000X	Rehabilitation General Acute Care Hospital General Acute Care Hospital - Rural Rehabilitation Hospital	Claim Type: O, V
Hospital Emergency Room	All Taxonomies		Procedure Codes: 99281 thru 99285 OR Place of Service: 23 AND Procedure Codes in Emergency Department Procedure Code Value Set (2017 HEDIS) OR Revenue Code: 0450 through 0459 Counts: Claim Type O Expenditures: Header level amounts for all events that have both Medical and Outpatient claim (i.e. no associated inpatient admission)
International Care Facility for Individuals with Intellectual Disabilities	315P00000X	Intermediate Care Facility, Intellectual Disability	n/a
Laboratory	291U00000X	Clinical Medical Laboratory	n/a
Nursing Facility	275N00000X 314000000X	Medicare Defined Swing Bed Skilled Nursing Facility	n/a
Program for All-Inclusive Care of Elderly (PACE)	251T00000X	PACE Organization	n/a

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Physician and Other Practitioner Total	All Taxonomies starting with '20' EXCLUDING 2084P0800X 363A00000X 225X00000X 225100000X 213E00000X 363L00000X 363LA2200X 363LF0000X 363LG0600X 363LX0001X 363LP0200X 367A00000X 367500000X 231H00000X 235Z00000X	Psychiatrists Physician Assistant Occupational Therapist Physical Therapist Podiatrist Nurse Practitioner Nurse Midwife Nurse Anesthetist Audiologist Speech-Language Pathologist	n/a
Physician	All Taxonomies starting with '20' EXCLUDING 2084P0800X 363A00000X	Psychiatrists Physician Assistant	n/a
Other Practitioner	225X00000X 225100000X 213E00000X 363L00000X 363LA2200X 363LF0000X 363LG0600X 363LX0001X 363LP0200X 367A00000X 367500000X 231H00000X 235Z00000X	Occupational Therapist Physical Therapist Podiatrist Nurse Practitioner Nurse Midwife Nurse Anesthetist Audiologist Speech-Language Pathologist	n/a
Prescription Drug	333600000X	Pharmacy	Claim Type: P
Psychiatric Residential Treatment Facility	323P00000X	Psychiatric Residential Treatment Facility	Claim Types: I, X
Public Health, Federal	261QP0904X	Public Health, Federal	n/a
Public Health or Welfare	251K00000X	Public Health or Welfare	n/a
Rural Health Clinic	261QR1300X	Rural Health Clinic	n/a
Vision	152W00000X 156FX1800X	Optometrist Optician	n/a
Waiver - HCBS Waivers - Waiver Only Services	251B00000X 251C00000X 251X00000X	Case Management Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S64, S93, S94, N98, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21, W22, W23, W24, W25, W26

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Waiver - HCBS Waivers - Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X, 251C00000X, 251X00000X Recipient Program Codes: B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S64, S93, S94, N98, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21, W22, W23, W24, W25, W26
Waiver - Acquired Brain Injury Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: B01, B02, S60
Waiver - Acquired Brain Injury Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: B01, B02, S60
Waiver - Adult with ID/DD Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: S22, S23, S44, S45, S59
Waiver - Adult with ID/DD Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: S22, S23, S44, S45, S59
Waiver - Child with ID/DD Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: S58, S93, S94, S64
Waiver - Child with ID/DD Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: S58, S93, S94, S64
Waiver - Children's Mental Health Waiver Only	251B00000X	Case Management	Claim Type: W, G Recipient Program Codes: S95, S96, S65
Waiver - Children's Mental Health Waiver Only	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X Recipient Program Codes: S95, S96, S65

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
			Claim Type: W, G
Waiver Comprehensive Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Recipient Program Codes: W03, W04, W08, W09, W10, W14, W15, W16, W22, W23, W24, W25, W26
Waiver Comprehensive Waiver Only	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: W03, W04, W08, W09, W10, W14, W15, W16, W22, W23, W24, W25, W26
Waiver - Community Choices Waiver Only	251B00000X	Case Management	Claim Type: W, G Recipient Program Codes: S24, S25, S46, S47, N98, R01, R02, R03, R04
Waiver - Community Choices Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X Recipient Program Codes: S24, S25, S46, S47, N98, R01, R02, R03, R04
Waiver - Pregnant by Choice	All Taxonomies		Recipient Program Code: A20
Waiver - Supports Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21
Waiver - Supports Waiver Only	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21

Table 80. Data Parameters for Subprogram and Special Populations

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