W·Y·O·M·I·N·G MEDICAID

SFY 2019

annual report

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Wyoming Department of Health

contents

list of figures

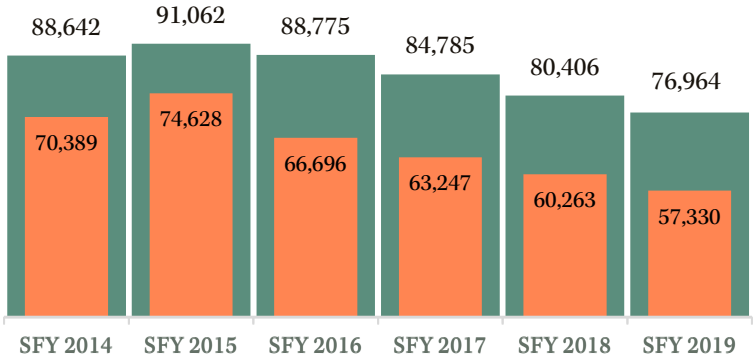
list of tables

SFY 2019 at a glance

enrollment

76,964

members enrolled at any point during the SFY with 57,330 enrolled each month on average



9.3 months of average enrollment per member

13.6% of Wyoming residents are enrolled in Medicaid

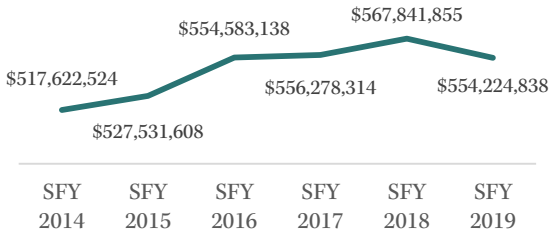
62% of members are children under age 21

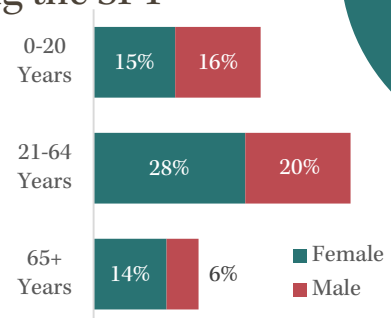
45% of members reside in 3 counties: Laramie, Natrona, and Fremont

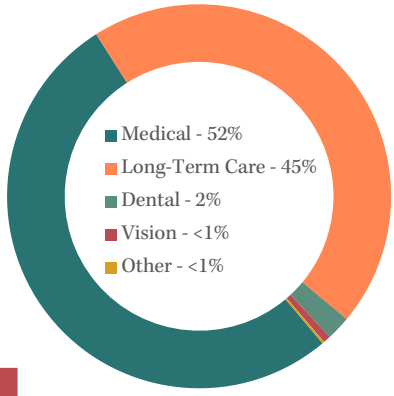
expenditures

$554 million

paid to 3,468 providers with over 18,600 providers actively enrolled at any point during the SFY







$726 preliminary Per Member Per Month cost

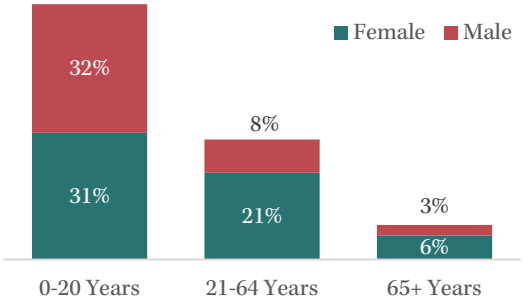
recipients

71,324 enrolled members with claims paid

84% had physician claims

57% had prescription drug claims

53% had hospital claims




GREAT SEAL OF THE STATE OF WYOMING

background

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

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.

4
MAJOR ELIGIBILITY CATEGORIES

Children
Pregnant Women
Adults
Aged, Blind, or Disabled (ABD)

Wyoming has not extended optional eligibility to adults under 133% of the Federal Poverty Level (FPL).

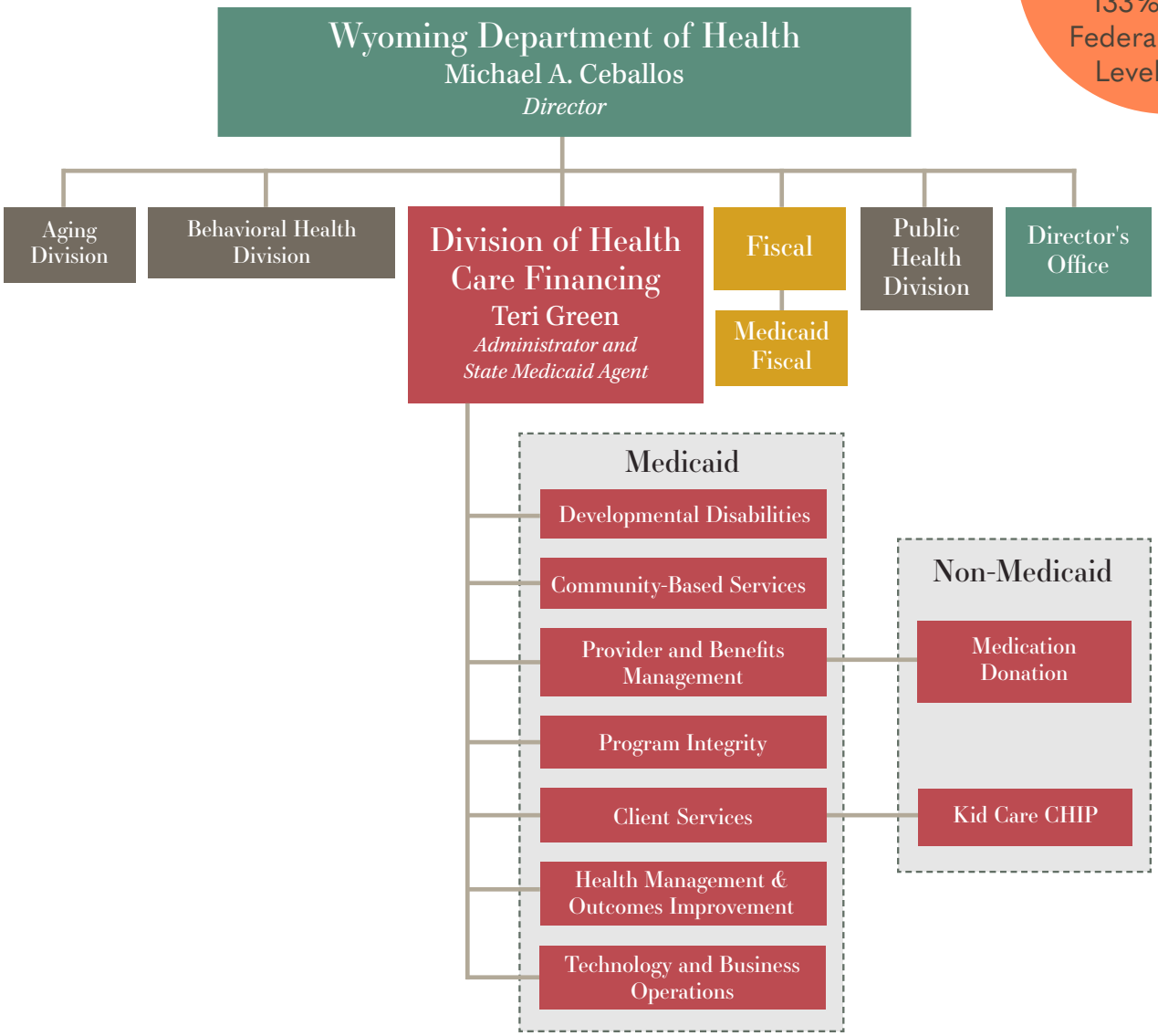


Figure 1. Wyoming Department of Health Organization Chart

financials

Enrolled providers have one year to submit claims for reimbursement. Claims are processed through the Medicaid Management Information System (MMIS). This Annual Report focuses on the members enrolled during SFY 2019 and claims paid during SFY 2019, regardless of when service was rendered.

Table 1. Division of Health Care Financing Expenditures for SFY 2019

Medicaid Related Expenditures (in millions)	
Annual Report Benefit Expenditures (this report)[1]	$553.1
Medicaid Administration	$42.6
Nursing Facilities Tax Assessment	$37.8
Hospital Qualified Rate Adjustment (QRA) Payments	$34.3
Medicare Buy-In	$19.1
Medicaid One-Time Capital Expenses for New Technology Systems (WES, MMIS, Other)	$27.7
Medicare Clawback (Part D)	$17.5
Physician Electronic Health Record (EHR) Incentives	$0.1
Other[2]	-$5.3
Subtotal Medicaid Expenditures	$726.9
Drug Rebates	-$35.0
Total Medicaid Expenditures	$691.9
Non-Medicaid Expenditures (in millions)	
Children's Health Insurance Program (CHIP)	$11.7
CHIP Administration	$0.8
State Only Foster Care and General Fund Foster Care (Court Orders)	$1.9
Supplemental Security Income (SSI) Payments	$1.1
Total Health Record (Health Information Exchange (HIE))	$0.6
Total Non-Medicaid Expenditures	$16.1
Total Division of Healthcare Financing	$708.0

funding

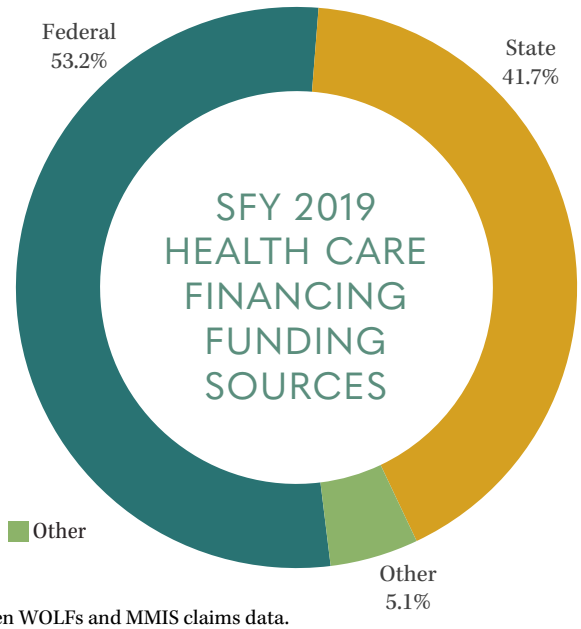
Wyoming Medicaid Benefits and general administrative expenditures
(50% Federal)

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

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.

program integrity

Wyoming Medicaid reviews, audits, and investigates providers for claims lacking sufficient documentation or incorrect billing.

Funds are recovered from third party liabitility, estates, drugs, and credit balances.

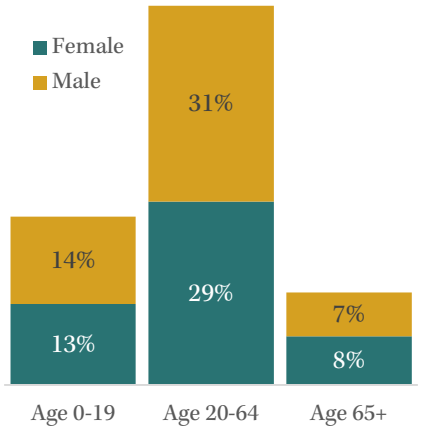
Table 3. Medicaid Cost Avoidance and Recoveries - SFY 2019

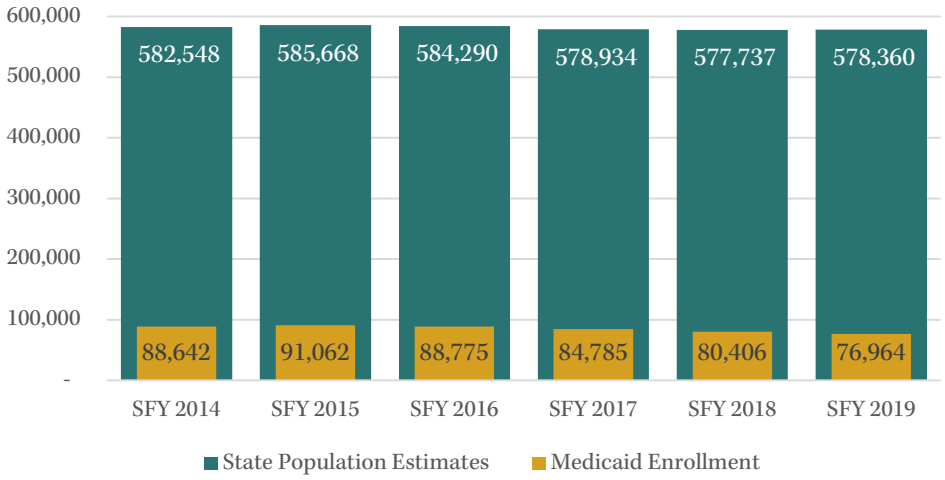
Program Area	Description	Amount Recovered
Program Integrity	Process of reviewing, auditing, and investigating providers for claims lacking sufficient documentation or incorrect billing.	$517,116
Third Party Liability Recoveries	Funds recovered from other responsible parties which may include Medicare, health insurance companies, worker's compensation, casualty insurance companies, or a spouse/parent court order to carry health insurance.	$2,184,827
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.	$9,985,850
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.	$3,853,730
Credit Balances	Moneys recovered from providers whose credits (i.e. take-backs or adjustments) exceed their debits (pay-outs or paid claims).	$31,625
Total Recovered Dollars (excluding Cost Avoidance)		$6,070,182
Total Recovered Dollars (including Cost Avoidance)		$16,056,032

demographics

13%
of Wyoming residents enrolled in Medicaid

27%
of residents under age 20





State Population[3] *increased* by

1.7%

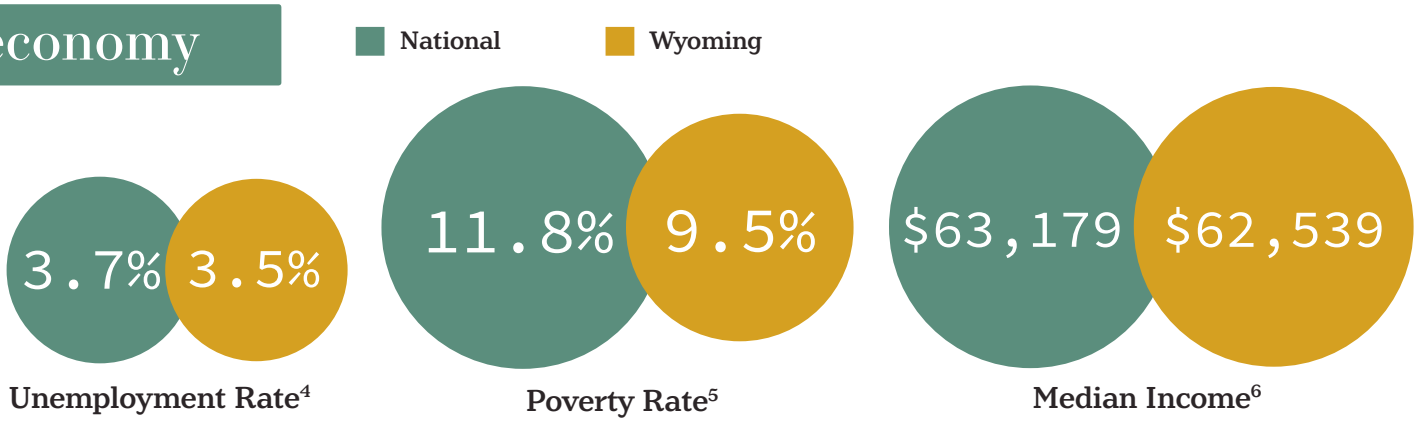
from 2014 to 2019

Medicaid enrollment *decreased* by

0.7%

from SFY 2014 to SFY 2019

economy



Unemployment Rate[4]

Poverty Rate[5]

Median Income[6]

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

	Employment Total Percent Change 2008 to 2018		Wages Total Percent Change 2008 to 2018		Mean Hourly Wages 2018	
	US	WY	US	WY	US	WY
All Occupations	7.1%	-5.2%	22.9%	27.4%	$24.98	$23.38
Healthcare Practitioners & Technical Occupations	22.2%	22.4%	20.8%	29.0%	$39.42	$38.67
Healthcare Support Workers	8.9%	-2.4%	23.0%	29.0%	$15.57	$15.83

3 2019 forecast population prepared by Wyoming Department of Administration & Information, Economic Analysis Division (http://eadiv.state.wy.us), August 2018

4 Senate Joint Economic Committee, Wyoming Employment Report, July 2019, https://www.jec.senate.gov/public/_cache/files/812bd4d0-203a-4586-9235-a5dd2630fdf3/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

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

7 Bureau of Labor Statistics, May 2018 State Occupational Employment and Wage Estimates, Wyoming. http://www.bls.gov/oes/current/oes_wy.htm

8 Bureau of Labor Statistics, May 2018 State Occupational Employment and Wage Estimates, United States. http://www.bls.gov/oes/current/oes_nat.htm

highlights & initiatives

More details regarding SFY 2019 Highlights & Initiatives can be found in Table 64 in Appendix A.

legislation

- Birth Cost Recovery implemented
- Certified Midwives approved as providers
- Reimbursement for School-Based Services
- Allowed to enter contracts with certified clubhouse providers for psychosocial services
- Physician UPL

policy

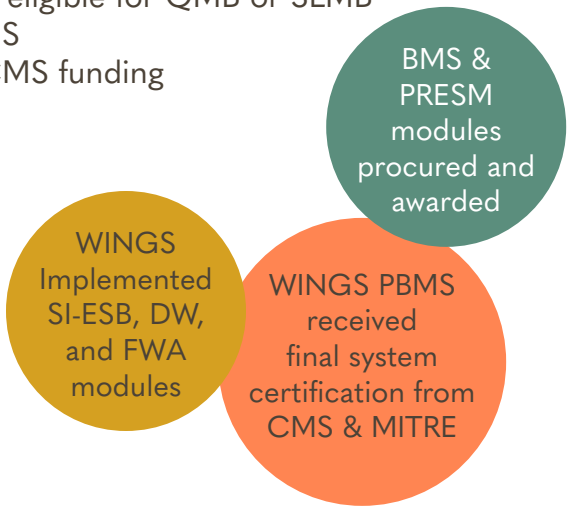
- Restrict access to MMIS online adds to limit errors
- Limit enrollment for individuals out of state more than 120 days
- New provider enrollment agreement

administration

- Access Review Monitoring Plan
- CME Payment Methodology change
- Drafted procedures for TPL processes
- IHS Workers contracted to process enrollment applications

technology

- Launched Triple A for Better Health
- Launched POSSE enhancement within WES
- Developed & deployed an Electronic Document Management System for use by DFS programs
- Implemented APR-DRG for inpatient hospitals
- Implemented Buy-In Changes in WES and MMIS for those eligible for QMB or SLMB
- Launched Bendex Interface between SSA and WDH in WES
- Electronic Visit Verification System approved for federal CMS funding



wyoming integrated next generation system

The Wyoming Integrated Next Generation System (WINGS) is replacing the current Medicaid Management Information System (MMIS) through the procurement of separate modules over two to three years.

Modules A, B, & C are consulting services to support the WINGS project

1 PBMS

Pharmacy Benefit Management System processes pharmacy point-of-sale claims and handles pharmacy related prior authorizations

2 SI-ESB

System Integrator with Enterprise Service Bus connects all modules together into an enterprise system

3 DW-BI

Data Warehouse with Business Intelligence Tools serves as data storage for all other modules with tools used to compile reports and analyze the Medicaid program

4 FWA

Fraud, Waste, Abuse Analytics and Case Tracking supports identification, investigation, and collection of fraud, waste, & abuse of Medicaid services by providers and clients

5 TPL

Third Party Liability ensures proper coordination exists between Medicaid and any other entity/ individual with obligation to provide financial support for Medicaid services

6 PRESM

Provider Enrollment Screening and Monitoring supports provider enrollment through an electronic self-service solution, verifies provider licensing, and reviews/maintains all provider enrollments

Modules 5 & 7 were issued in a single procurement

7 BMS

Benefit Management System processes Medicaid claims and manages benefit plans

8 CCMS

Care and Case Management System develops & monitors plans of care, captures & monitors assessments, screenings, treatment plans, and authorizes services

A

Testing & Quality Assurance Quality Control Services ensures each project module functions correctly

B

Independent Verification & Validation certifies system meets all requirements and fulfills intended purpose

C

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

enrollment

4.3%

76,964 members enrolled at any point during the SFY with 57,330 enrolled each month on average

Individuals may gain and lose eligibility throughout the SFY. As such, the unique enrollment for a complete SFY is greater than a point-in time unique count

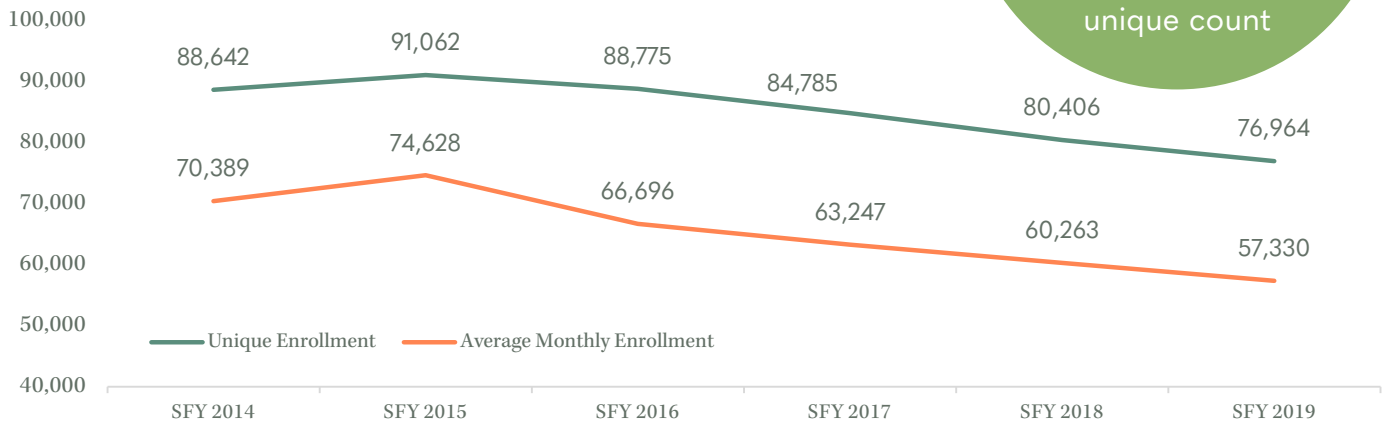


Figure 2. Enrollment History: Unique and Monthly Average

Table 5. Change in Medicaid Enrollment

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Unique Enrollment	88,642	91,062	88,775	84,785	80,604	76,964
% Change from Previous SFY	-	2.7%	-2.5%	-4.5%	-5.2%	-4.3%
Average Monthly Enrollment	70,389	74,628	66,696	63,247	60,263	57,330
% Change from Previous SFY	-	6.0%	-10.6%	-5.2%	-4.7%	-4.9%
Average Length of Enrollment (months)	9.4	9.8	9.2	9.2	9.3	9.3

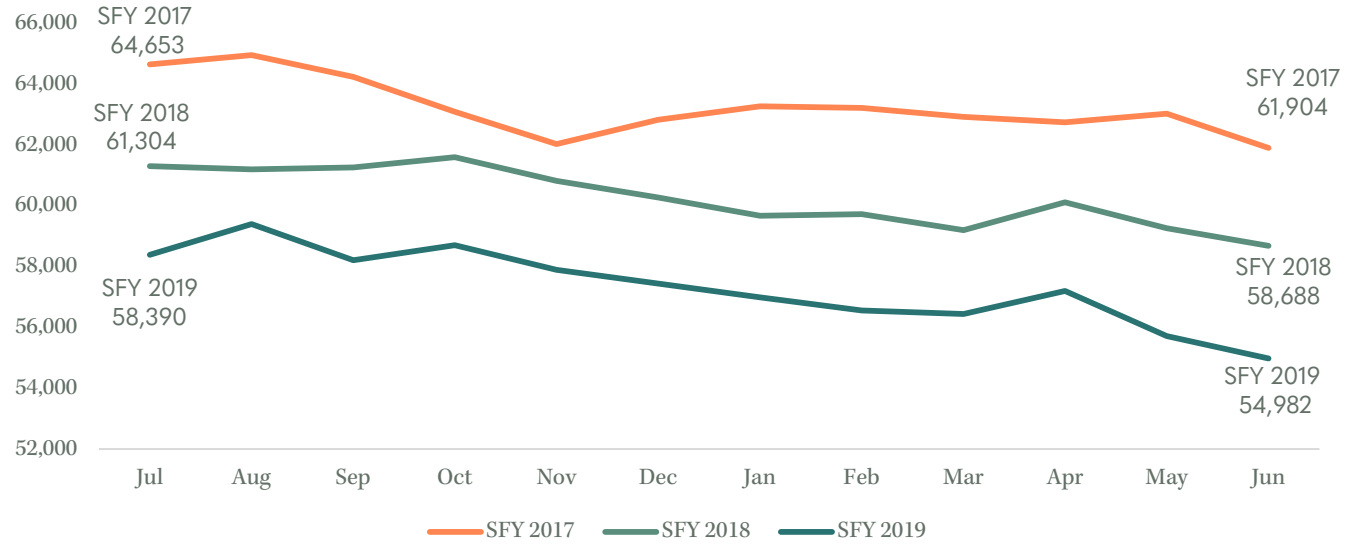


Figure 3. Monthly Medicaid Enrollment by State Fiscal Year

by county

More than half of Medicaid members reside in 5 counties: Laramie, Natrona, Fremont, Campbell, and Sweetwater.

Table 6. Medicaid Enrollment by County

County	Enrolled Members	Percent of Total
Albany	3,291	4.3%
Big Horn	1,947	2.5%
Campbell	5,660	7.4%
Carbon	1,821	2.4%
Converse	1,700	2.2%
Crook	781	1.0%
Fremont	9,307	12.1%
Goshen	1,689	2.2%
Hot Springs	759	1.0%
Johnson	837	1.1%
Laramie	13,286	17.3%
Lincoln	1,668	2.2%
Natrona	12,085	15.7%
Niobrara	277	0.4%
Other[9]	1,634	2.1%
Park	3,428	4.5%
Platte	1,097	1.4%
Sheridan	3,644	4.7%
Sublette	635	0.8%
Sweetwater	5,297	6.9%
Teton	1,133	1.5%
Uinta	3,080	4.0%
Washakie	1,073	1.4%
Weston	835	1.1%
Total	76,964	

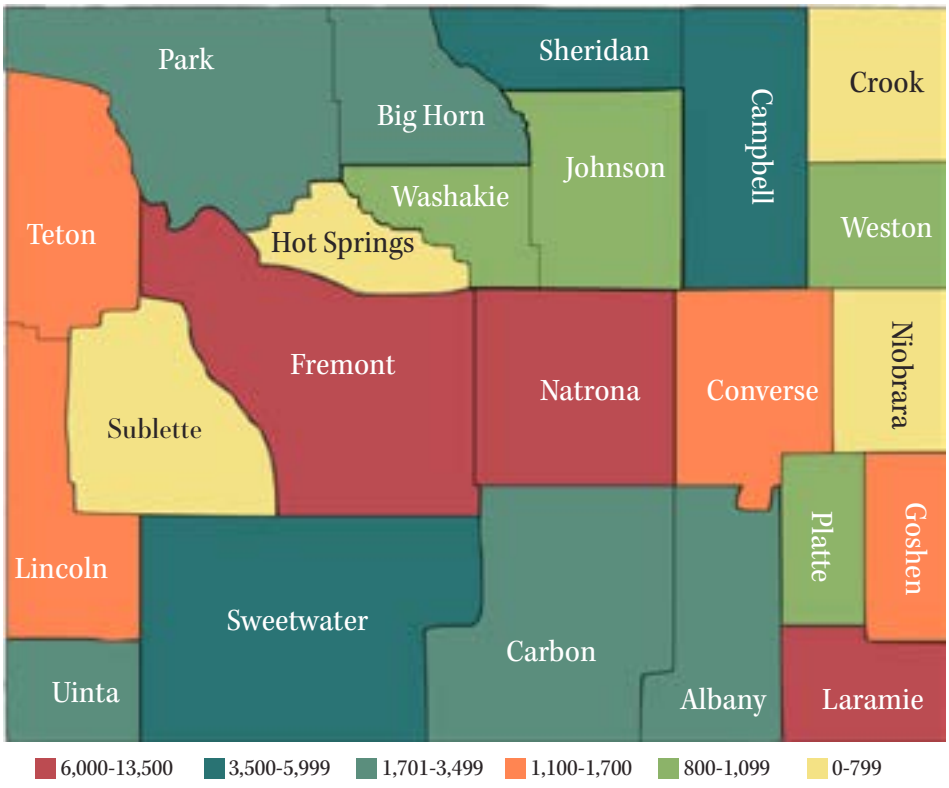


Figure 4. Wyoming County Map by Medicaid Enrollment

9 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.

expenditures

2.4%

$554,224,838 paid to 3,468 providers with over 18,600 providers actively enrolled at any point during the SFY

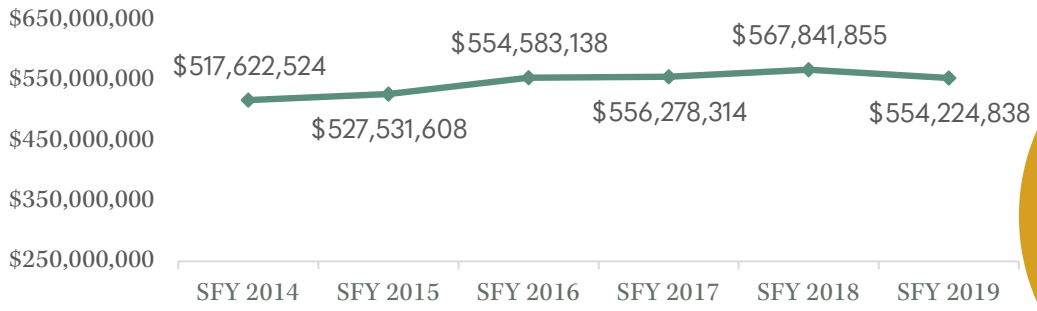


Figure 5. Expenditure History

Providers have one year to submit claims to Medicaid for reimbursement; therefore, expenditures here include services rendered in both SFY 2018 & SFY 2019

Table 7. Expenditure History by Service Type

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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 2019 paid expenditures compared to SFY 2018 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.

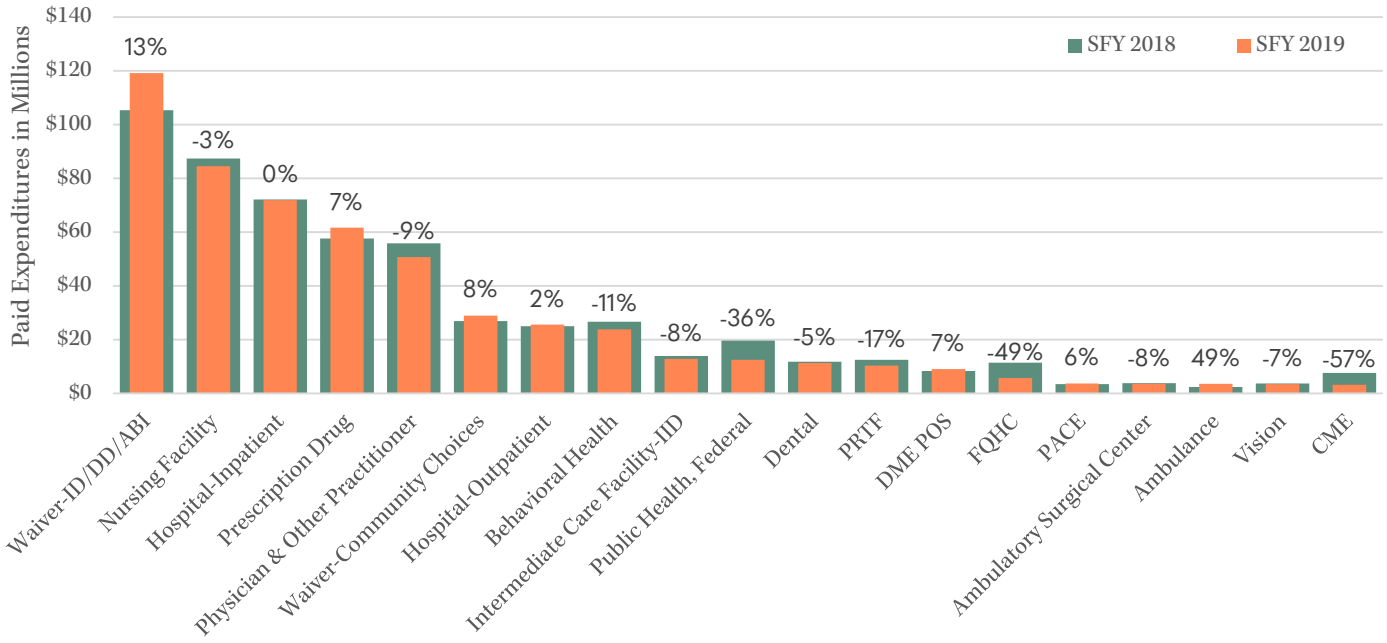


Figure 6. Change in Expenditures from SFY 2017 to SFY 2018 for Top Services

recipients

6.1%

69,497

enrolled members with claims paid

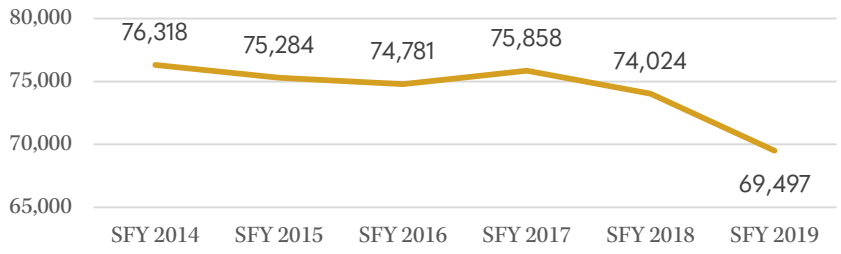


Figure 7. Recipient History

Table 8. Recipient History by Service Type

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Medical	73,122	71,794	70,685	72,123	70,919	66,262
Long-Term Care	6,688	6,967	7,317	7,528	7,614	7,691
Dental	29,169	30,635	31,840	31,395	28,700	27,468
Vision	14,558	15,010	15,227	15,608	15,795	14,762
Other	1,642	1,643	1,945	2,913	3,178	3,238

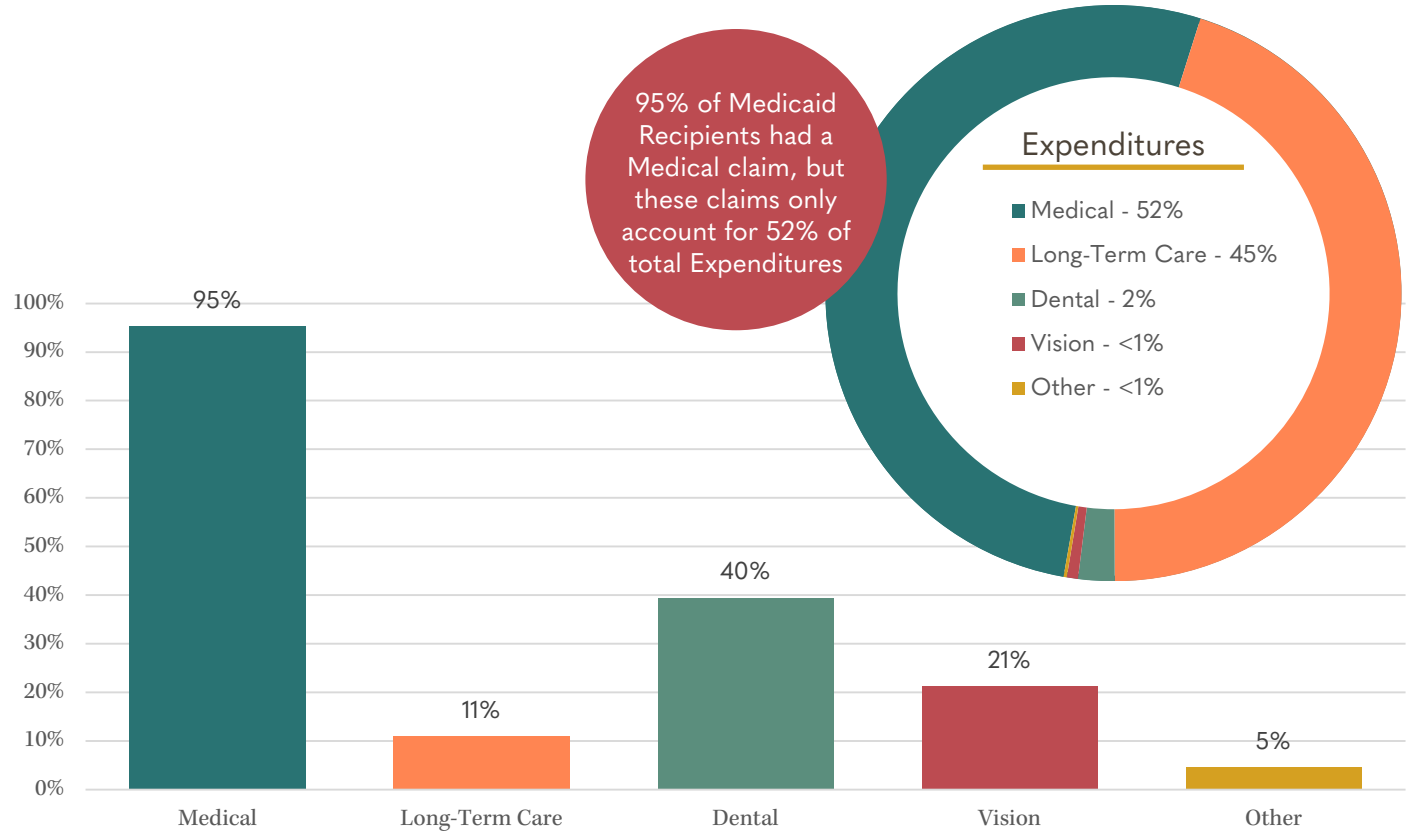


Figure 8. Recipient Utilization versus Expenditure Breakdown by Service Type

eligibility categories

For this report, Medicaid enrolled members are presented in 11 eligibility categories.

aged, blind, or disabled

1. Employed Individuals with Disabilities
2. Individuals with Intellectual/ Developmental Disabilities or Acquired Brain Injury
3. Institution
4. Long-Term Care
5. Supplemental Security Income

6. Adults
7. Children
8. Medicare Savings
9. Non-Citizens with Medical Emergencies
10. Pregnant Women
11. Special Groups

Per Federal statutes, individuals qualify for Medicaid coverage based on Federal Poverty Level guidelines, Supplemental Security Income standards, or the 1996 Family Care income standard.

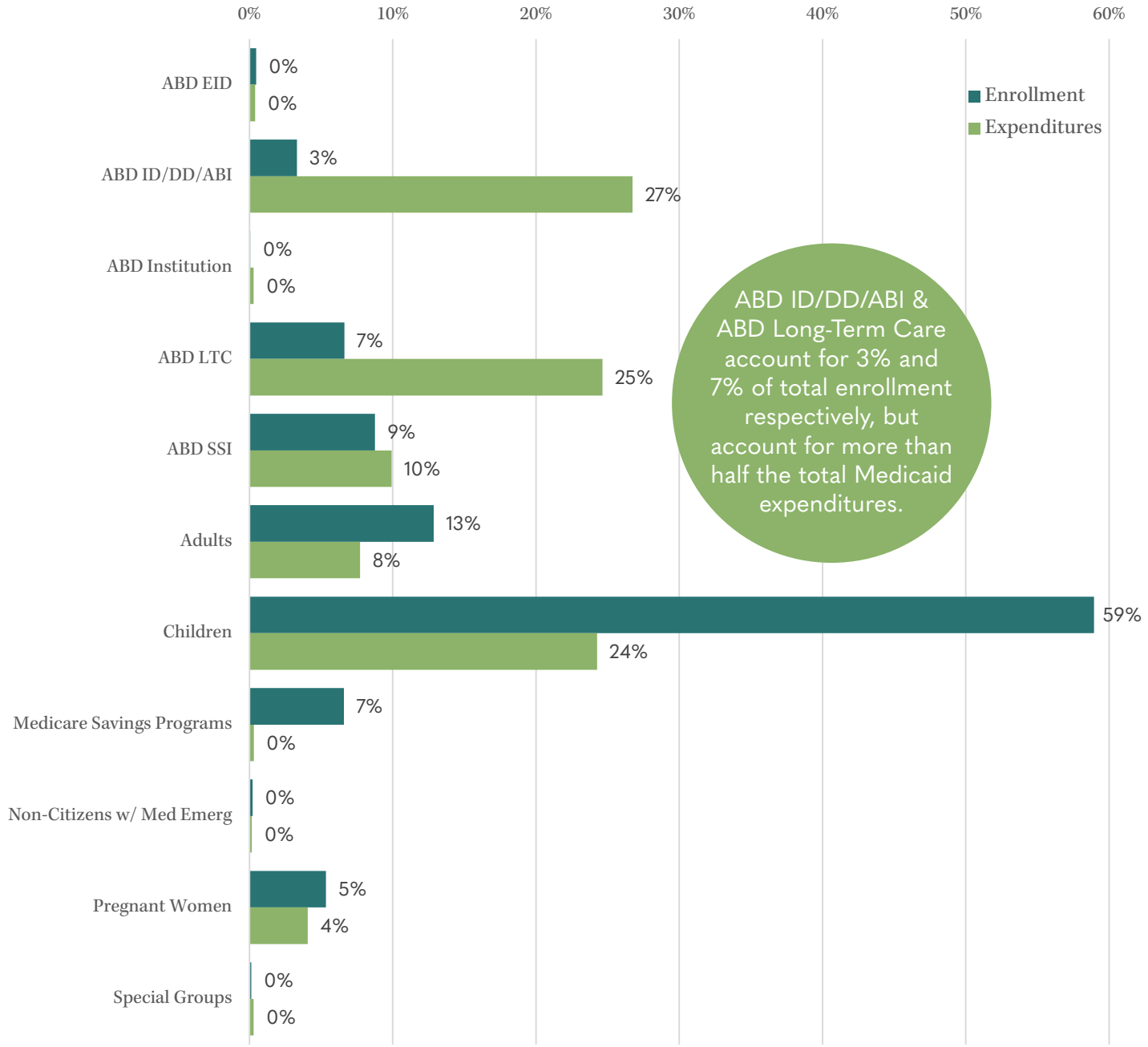


Figure 9. Enrolled Members versus Expenditures by Eligibility Category - SFY 2019

Table 9. Eligibility Category Summary

Eligibility Category	Enrolled Members	% Change from SFY 2018	Unique Recipients	% Change from SFY 2018	Expenditures	% Change from SFY 2018
ABD EID	365	-10	402	-11	$2,201,872	-31
ABD ID/DD/ABI	2,550	-2	2,585	-2	$148,210,163	7
ABD Institution	46	-16	68	-23	$1,638,641	-34
ABD LTC	5,105	2	5,389	4	$136,564,759	-1
ABD SSI	6,737	2	6,166	-1	$55,018,028	-4
Adults	9,900	-10	8,667	-13	$42,819,380	-7
Children	45,367	-5	41,678	-7	$139,771,403	-6
Medicare Savings Programs	5,082	2	2,815	0	$1,687,004	2
Non-Citizens with Medical Emergencies	167	-14	145	-1	$913,315	28
Pregnant Women	4,113	-5	4,363	-15	$22,579,721	-11
Screenings & Gross Adjustments	--	--	--	--	$1,197,091	-64
Special Groups	97	-20	86	-25	$1,623,461	11
Total	76,964	-4	69,497	-6	$554,224,838	-2

Table 10. Enrollment History by Eligibility Category

Eligibility Category	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
ABD EID	341	360	479	496	404	365	7
ABD ID/DD/ABI	2,402	2,480	2,609	2,640	2,603	2,550	6
ABD Institution	71	76	77	80	55	46	-35
ABD LTC	4,176	4,378	4,643	4,885	5,007	5,105	22
ABD SSI	7,134	7,052	7,039	7,117	6,609	6,737	-6
Adults	8,719	10,998	12,431	11,825	10,989	9,900	14
Children	56,079	57,007	54,345	51,164	47,919	45,367	-19
Medicare Savings Programs	5,167	5,338	4,982	4,994	4,978	5,082	-2
Non-Citizens with Medical Emergencies	949	794	432	292	195	167	-82
Pregnant Women	5,400	5,743	5,517	4,778	4,336	4,113	-24
Special Groups	1,120	694	250	164	121	97	-91
Total	88,642	91,062	88,775	84,785	80,406	76,964	-13

Table 11. Expenditures History by Eligibility Category[10]

Eligibility Category	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
ABD EID	$4,545,872	$3,795,205	$4,730,644	$4,491,523	$3,170,198	$2,201,872	-52
ABD ID/DD/ABI	$140,255,339	$137,112,834	$146,523,597	$145,024,485	$139,120,839	$148,210,163	6
ABD Institution	$6,947,121	$3,843,309	$3,976,596	$2,806,554	$2,489,828	$1,638,641	-76
ABD LTC	$109,585,095	$109,685,023	$127,126,736	$133,820,492	$137,811,401	$136,564,759	25
ABD SSI	$53,252,515	$57,532,693	$54,218,689	$55,141,541	$57,608,075	$55,018,028	3
Adults	$28,414,259	$39,268,780	$42,070,572	$40,633,756	$46,008,562	$42,819,380	51
Children	$135,754,662	$143,624,614	$144,048,715	$140,921,270	$149,233,800	$139,771,403	3
Medicare Savings Programs	$4,086,134	$4,564,069	$4,098,086	$3,206,357	$1,654,936	$1,687,004	-59
Non-Citizens with Medical Emergencies	$1,490,032	$1,236,724	$1,212,043	$1,040,454	$713,218	$913,315	-39
Pregnant Women	$28,762,228	$24,134,468	$24,192,832	$26,264,576	$25,247,867	$22,579,721	-21
Screenings & Gross Adjustments	$389,686	$183,197	$512,743	$1,407,327	$3,323,187	$1,197,091	207
Special Groups	$4,139,581	$2,550,692	$1,871,886	$1,519,979	$1,459,944	$1,623,461	-61
Total	$517,622,524	$527,531,608	$554,583,138	$556,278,314	$567,841,855	$554,224,838	7

Table 12. Unique Recipient History by Eligibility Category[11]

Eligibility Category	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
ABD EID	345	360	476	517	455	402	17
ABD ID/DD/ABI	2,410	2,479	2,639	2,661	2,633	2,585	7
ABD Institution	94	92	99	110	89	68	-28
ABD LTC	4,428	4,553	4,832	5,093	5,245	5,420	22
ABD SSI	6,293	6,140	6,094	6,383	6,286	6,205	-1
Adults	6,941	8,509	9,935	10,329	9,959	8,706	25
Children	49,515	47,754	46,289	46,413	44,848	41,780	-16
Medicare Savings Programs	2,771	2,992	2,930	2,895	2,836	2,820	2
Non-Citizens with Medical Emergencies	368	289	261	254	148	145	-61
Pregnant Women	5,538	5,504	5,504	5,348	5,159	4,392	-21
Special Groups	500	280	149	132	116	86	-83
Total	78,376	77,482	77,321	78,167	76,271	71,324	-9

10 Expenditures for Children for SFY 2019 include a gross adjustment for the Care Management Entity (CME) service rate adjustment which affected claims over multiple years. While this amount was a gross adjustment and would normally be reported under the Screenings & Gross Adjustments category, we have included those in the Children category for this report, as these services are strictly for children.

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


GREAT SEAL OF THE STATE OF WYOMING

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

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[12]	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 [13]
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[14]	Optional	Mandatory (EPSDT)
Public Health, Federal[15]	Mandatory	Mandatory
Public Health or Welfare	Optional	Mandatory (EPSDT)
Rural Health Clinic	Mandatory	Mandatory
Vision	Optional	Mandatory (EPSDT)

12 Excludes the Children's Mental Health Waiver and Psychiatric Residential Treatment Facility.
13 Some services in these waivers may be mandatory if the child is otherwise eligible for Medicaid without the waiver.
14 Physical/Occupational/Speech Therapies service detail is included in the Physician and Other Practitioner data in the detail section of this report.
15 Refers to Indian Health Services and Tribal 638 facilities.

Table 14. Service Utilization Summary

Service	Expenditures	% Change from SFY 2018	Recipients[16]	% Change from SFY 2018	Expenditures per Recipient	% Change from SFY 2018
Ambulance	$3,543,958	49	3,528	10	$1,005	35
Ambulatory Surgical Center	$3,555,184	-8	2,710	-15	$1,312	8
Behavioral Health	$23,818,379	-11	12,627	-5	$1,886	-7
Care Management Entity (CME)[17]	$3,290,255	-57	897	48	$3,668	-71
Clinic/Center	$815,334	-16	1,142	-9	$714	-8
Dental	$11,304,079	-5	27,526	-4	$411	0
DME, Prosthetics/Orthotics/ Supplies	$9,013,400	7	7,499	2	$1,202	6
End Stage Renal Disease	$1,063,315	5	150	-5	$7,089	11
Federally Qualified Health Center	$5,776,571	-49	6,341	-29	$911	-29
Home Health	$570,570	-86	163	-67	$3,500	-57
Hospice	$1,190,302	-15	245	6	$4,858	-19
Hospital Total	$97,635,206	1	37,812	-5	$2,582	6
Inpatient	$71,923,532	0	8,810	-5	$8,164	5
Outpatient	$25,558,107	1	35,941	-5	$711	8
Other Hospital	$153,567	-1,716	419	-23	$367	-2,198
Intermediate Care Facility-IID	$12,901,888	-8	54	-11	$238,924	4
Laboratory	$719,701	-29	6,791	-19	$106	-13
Nursing Facility	$84,440,433	-3	2,516	-2	$33,561	-1
Other	$995,134	1	3,336	3	$298	-2
PACE	$3,693,978	6	163	-8	$22,662	16
Physician & Other Practitioner	$50,658,777	-9	58,657	-6	$864	-3
Prescription Drug	$61,612,808	7	40,807	-4	$1,510	12
PRTF	$10,391,372	-17	309	4	$33,629	-20
Public Health or Welfare	$917,179	4	7,592	-6	$121	11
Public Health, Federal	$12,488,676	-36	4,135	0	$3,020	-36
Rural Health Clinic	$2,283,377	21	6,114	10	$373	9
Vision	$3,466,069	-7	14,790	-7	$234	0
Waiver Total	$148,078,894	12	5,320	3	$27,834	8
Acquired Brain Injury	$15,008	-100	19	-87	$790	-98
Community Choices	$28,957,689	8	2,830	8	$10,232	0
Comprehensive	$112,673,503	19	1,959	0	$57,516	19
Supports	$6,432,694	11	569	1	$11,305	10
Total	$554,224,838	-2	71,324	-6	$7,771	4

16 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.

17 The Care Management Entity service includes $66,200 in expenditures paid for 19 children while enrolled in non-Medicaid state-funded institutional foster care.

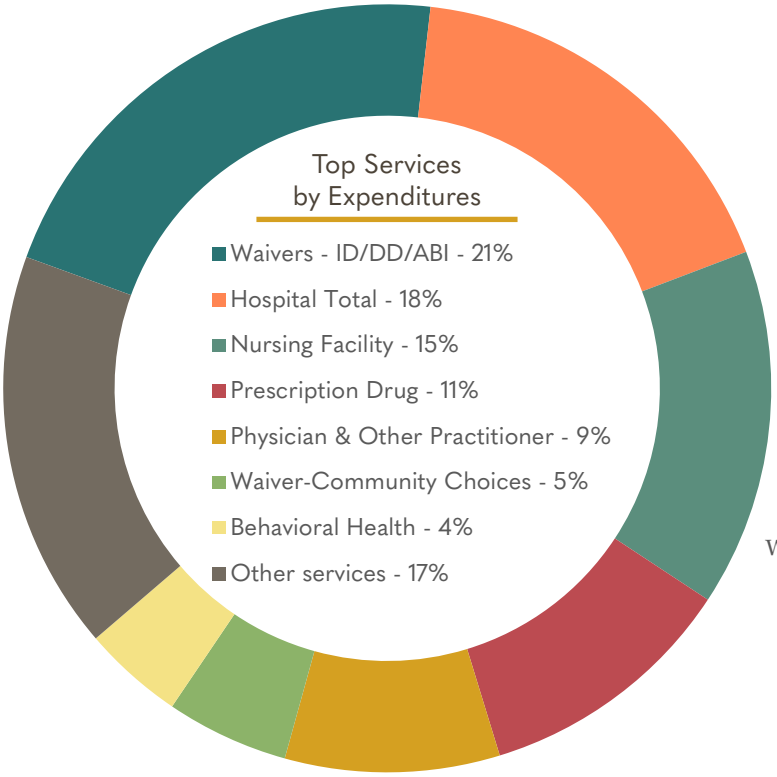


Figure 10. SFY 2019 Top Services by Expenditures

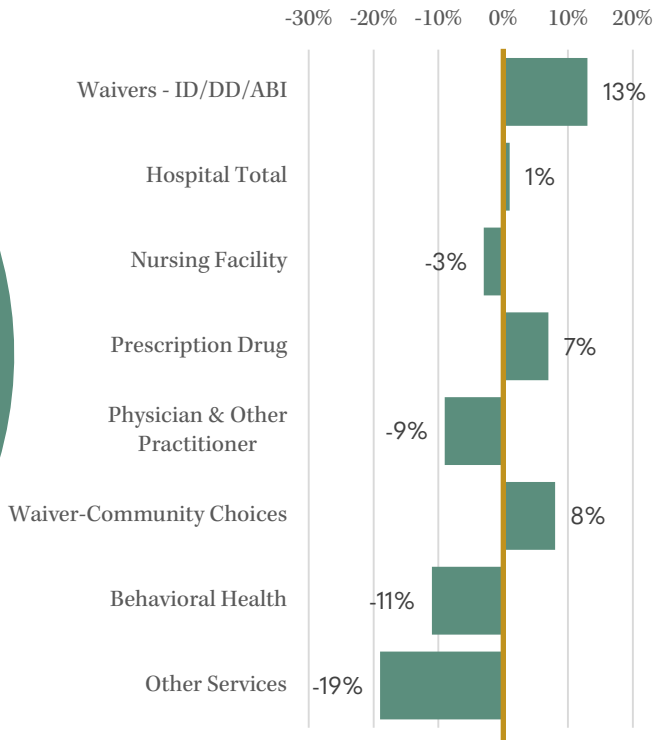


Figure 11. One-Year Change in Expenditures for Top Services

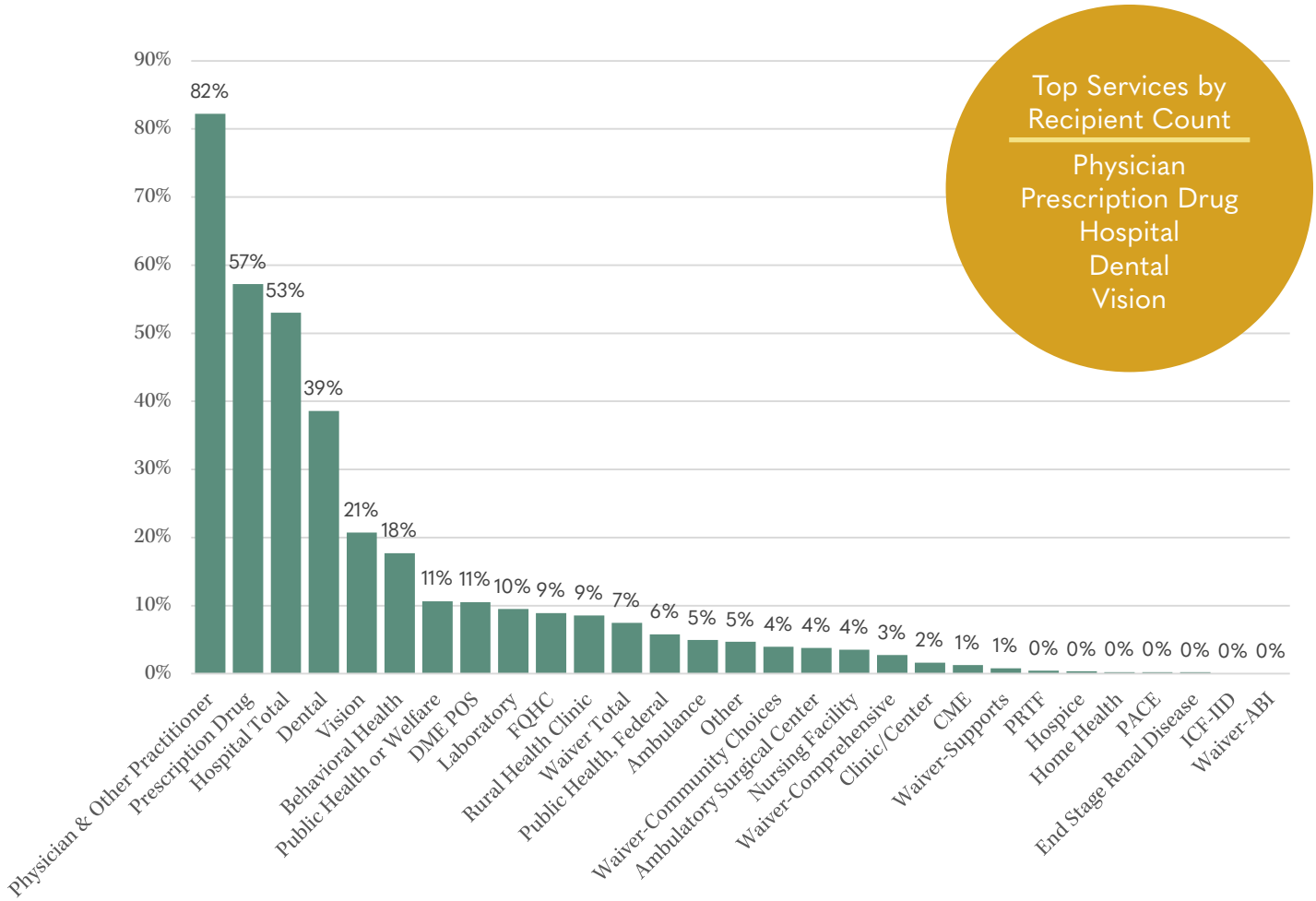


Figure 12. Percent of Unduplicated Recipients by Service

Table 15. Expenditure History by Service

Service	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Ambulance	$3,760,537	$4,352,067	$3,571,623	$3,847,375	$2,381,969	$3,543,958	-6
Ambulatory Surgical Center	$4,039,944	$6,090,776	$5,953,159	$4,095,973	$3,881,705	$3,555,184	-12
Behavioral Health	$30,602,969	$33,879,362	$34,964,154	$30,800,687	$26,723,530	$23,818,379	-22
Care Management Entity[18]	--	--	$5,021,978	$7,135,148	$7,599,455	$3,290,255	n/a
Clinic/Center	$1,295,561	$1,339,630	$1,361,953	$1,327,800	$972,701	$815,334	-37
Dental	$13,391,934	$14,473,863	$15,450,029	$14,167,617	$11,847,581	$11,304,079	-16
DME, Prosthetics/ Orthotics/Supplies	$7,627,734	$8,624,246	$8,200,062	$9,029,583	$8,390,660	$9,013,400	18
End Stage Renal Disease	$1,071,750	$1,099,569	$948,612	$1,267,034	$1,012,427	$1,063,315	-1
Federally Qualified Health Center	$2,698,283	$3,259,793	$3,689,548	$5,725,094	$11,418,874	$5,776,571	114
Home Health	$3,533,728	$4,618,885	$9,467,835	$9,596,803	$4,012,083	$570,570	-84
Hospice	$1,468,295	$1,157,101	$1,014,959	$1,316,838	$1,394,149	$1,190,302	-19
Hospital Total	$101,931,277	$104,523,947	$107,692,150	$98,467,703	$97,086,021	$97,635,206	-4
Inpatient	$72,932,440	$73,407,132	$78,575,068	$71,022,272	$72,073,654	$71,923,532	-1
Outpatient	$28,703,147	$31,056,066	$28,975,050	$27,373,462	$25,021,868	$25,558,107	-11
Other Hospital	$295,690	$60,748	$142,031	$71,969	-$9,501	$153,567	-48
Intermediate Care Facility-IID	$19,152,530	$18,091,427	$18,193,221	$19,204,867	$13,999,444	$12,901,888	-33
Laboratory	$1,284,678	$1,516,042	$1,536,310	$844,218	$1,020,356	$719,701	-44
Nursing Facility	$72,866,933	$70,354,260	$82,445,811	$87,001,112	$87,304,589	$84,440,433	16
Other	$538,127	$649,268	$894,268	$1,006,132	$989,147	$995,134	85
PACE	$1,288,934	$2,242,570	$2,934,877	$3,520,283	$3,471,255	$3,693,978	187
Physician & Other Practitioner	$62,372,535	$61,249,367	$58,278,406	$60,013,763	$55,798,175	$50,658,777	-19
Prescription Drug	$41,238,663	$47,946,923	$48,597,364	$50,300,175	$57,642,641	$61,612,808	49
PRTF	$14,886,133	$13,575,847	$11,797,657	$12,121,830	$12,537,788	$10,391,372	-30
Public Health or Welfare	$962,164	$1,009,814	$1,072,715	$912,444	$881,179	$917,179	-5
Public Health, Federal	$7,999,556	$8,761,358	$8,479,944	$8,718,888	$19,625,445	$12,488,676	56
Rural Health Clinic	$1,521,233	$1,668,167	$1,413,842	$1,540,607	$1,894,505	$2,283,377	50
Vision	$3,464,394	$3,595,216	$3,652,188	$3,850,574	$3,712,855	$3,466,069	0
Waiver Total	$118,624,631	$113,452,108	$117,950,473	$120,465,765	$132,243,321	$148,078,894	25
Acquired Brain Injury	$7,371,614	$6,636,440	$6,748,171	$6,960,893	$4,948,202	$15,008	-100
Adult ID/DD	$83,501,095	$16,541,190	$1,674	$1,565	--	--	n/a
Child ID/DD	$11,415,264	$8,372,841	$179,173	--	--	--	n/a
Children's Mental Health	$527,514	$732,257	$61,981	--	--	--	n/a
Community Choices	$15,763,707	$16,630,675	$19,801,419	$20,597,605	$26,930,997	$28,957,689	84
Comprehensive	$44,982	$63,719,016	$88,377,607	$88,527,446	$94,568,471	$112,673,503	250,384
Supports	$454	$819,690	$2,780,450	$4,378,255	$5,795,651	$6,432,694	1,416,793
Total	$517,622,524	$527,531,608	$554,583,138	$556,278,314	$567,841,855	$554,224,838	7

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

Table 16. Expenditure History by Other[19] Service

Service	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Ambulatory Family Planning Facility	$71,213	$69,754	$55,497	$62,853	$51,449	$51,977	-27
Case Management	$193,913	$297,117	$254,740	$409,938	$295,274	$188,388	-3
Chiropractor	$5,661	$6,347	$99,664	$280,207	$347,441	$406,862	7,088
Day Training, Developmentally Disabled Service	$79,578	$27,476	$52,304	$58,362	$49,662	$65,931	-17
Dietitian, Registered	--	--	--	$391	$1,803	$617	n/a
ECSII & CASII Evaluator	--	--	--	--	$61,574	$58,231	n/a
Interpreter	$38,171	$56,339	$47,205	$32,056	$22,119	$5,799	-85
Lodging	--	--	--	$53,950	$85,915	$127,715	n/a
PACE FMS	--	$0	-$80	$0	$0	--	-100
Phlebotomy/WY Health Fair	$5,870	$1,920	$575	--	--	--	-100
Radiology: Mobile	$226	$52	$7	--	--	--	-100
Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	$143,525	$154,682	$146,226	$84,406	$29,156	$26,024	-82
Residential Treatment Facility For Emotionally Disturbed	--	$35,712	$237,904	--	--	--	-100
Taxi	--	--	--	$16,674	$33,435	$45,135	n/a
Transportation Service	--	--	--	$7,329	$11,145	$18,455	n/a
Unclassified	-$30	-$131	$225	-$34	$174	--	n/a
Total	$538,127	$649,268	$894,268	$1,006,132	$989,147	$995,134	85

19 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[20] History by Service

Service	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Ambulance	3,628	3,595	3,356	3,664	3,200	3,528	-3
Ambulatory Surgical Center	3,417	3,565	3,431	3,343	3,202	2,710	-21
Behavioral Health	11,367	12,366	12,819	13,323	13,239	12,627	11
Care Management Entity[21]	--	--	342	485	606	897	n/a
Clinic/Center	1,525	1,593	1,533	1,434	1,256	1,142	-25
Dental	29,249	30,755	32,050	31,483	28,789	27,526	-6
DME, Prosthetics/Orthotics/ Supplies	7,163	7,367	7,159	7,477	7,367	7,499	5
End Stage Renal Disease	110	107	131	149	158	150	36
Federally Qualified Health Center	4,047	6,014	6,451	7,053	8,929	6,341	57
Home Health	598	692	738	720	496	163	-73
Hospice	256	185	202	228	232	245	-4
Hospital Total	40,484	42,791	41,208	39,989	39,771	37,812	-7
Inpatient	10,514	10,751	10,205	10,262	9,281	8,810	-16
Outpatient	38,103	40,506	39,003	37,525	37,882	35,941	-6
Other Hospital	195	152	178	256	544	419	115
Intermediate Care Facility-IID	80	75	71	67	61	54	-33
Laboratory	9,573	8,899	9,602	8,046	8,335	6,791	-29
Nursing Facility	2,464	2,388	2,433	2,579	2,570	2,516	2
Other	1,669	1,654	1,976	2,938	3,251	3,336	100
PACE	63	95	119	143	178	163	159
Physician & Other Practitioner	65,603	63,117	61,769	64,075	62,699	58,657	-11
Prescription Drug	44,963	46,673	44,547	43,602	42,676	40,807	-9
PRTF	341	336	301	299	298	309	-9
Public Health or Welfare	7,878	8,168	8,226	7,929	8,073	7,592	-4
Public Health, Federal	3,557	3,391	3,433	3,531	4,138	4,135	16
Rural Health Clinic	4,690	4,552	3,835	4,577	5,542	6,114	30
Vision	14,624	15,063	15,371	15,921	15,821	14,790	1
Waiver Total	4,172	4,450	4,833	4,958	5,145	5,320	28
Acquired Brain Injury	181	168	163	162	144	19	-90
Adult ID/DD	1,409	1,328	2	1	--	--	n/a
Child ID/DD	699	659	148	--	--	--	n/a
Children's Mental Health	57	79	40	--	--	--	n/a
Community Choices	1,874	2,040	2,296	2,414	2,623	2,830	51
Comprehensive	24	1,756	1,927	1,863	1,962	1,959	8,063
Supports	1	191	425	540	565	569	56,800
Total	78,376	77,482	77,321	78,167	76,271	71,324	-9

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

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

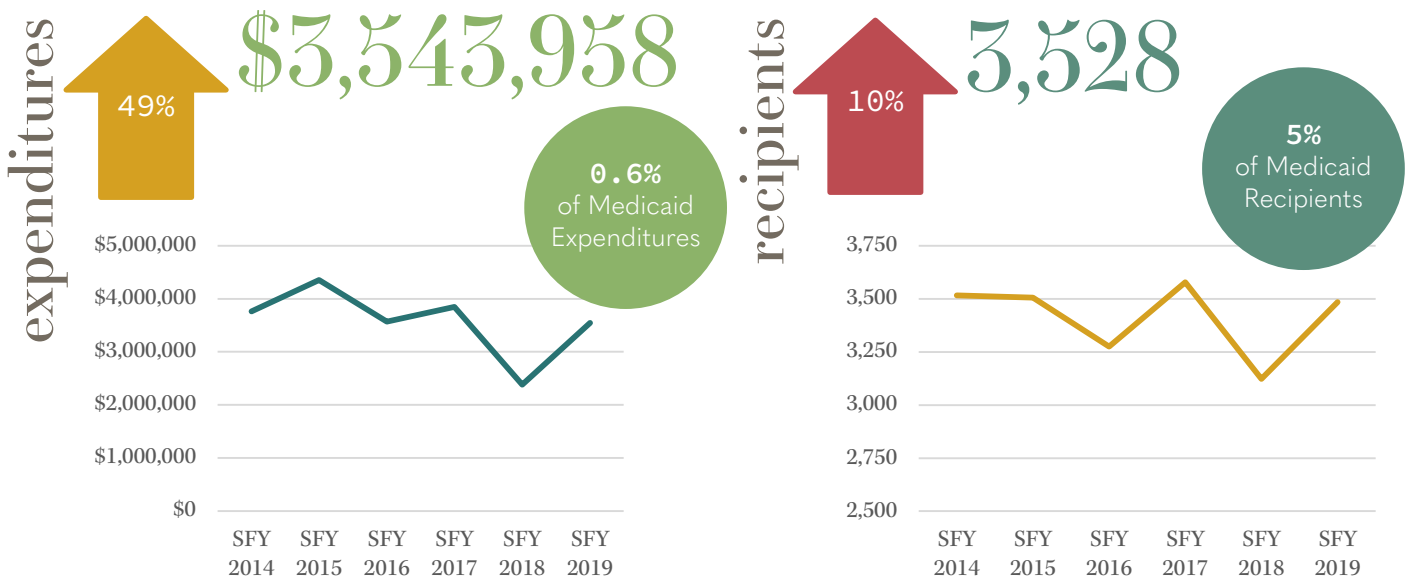


Table 18. Ambulance Services Summary[22]

Total Ambulance Services	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$3,760,537	$4,352,067	$3,571,623	$3,847,375	$2,381,969	$3,543,958	-6
Recipients	3,628	3,595	3,356	3,664	3,200	3,528	-3
Expenditures per Recipient	$1,037	$1,211	$1,064	$1,050	$744	$1,005	-3
Air Ambulance Services							
Expenditures	$2,292,657	$2,932,801	$2,311,809	$2,446,175	$1,343,584	$2,406,665	5
Recipients	519	570	490	518	370	565	9
Expenditures per Recipient	$4,417	$5,145	$4,718	$4,722	$3,631	$4,260	-4
Ground Ambulance Services							
Expenditures	$1,478,409	$1,422,083	$1,256,808	$1,406,743	$1,038,728	$1,099,712	-26
Recipients	3,479	3,399	3,168	3,477	3,061	3,298	-5
Expenditures per Recipient	$425	$418	$397	$405	$339	$333	-22

22 Total Ambulance service expenditures include gross adjustments which are not included in the Air and Ground breakdowns; therefore, these will not match the total expenditures when summed.

ambulatory surgery center

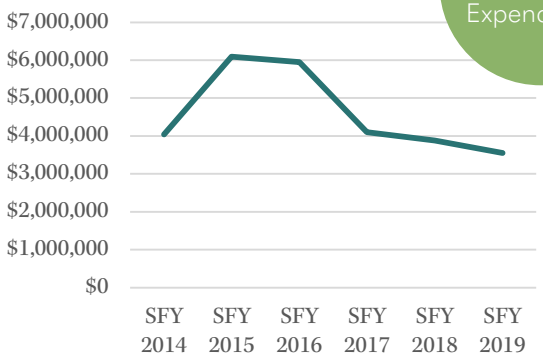
Surgical procedures that do not require overnight inpatient hospital care. Encompasses all surgical procedures covered by Medicare, as well as procedures Medicaid has approved for provision as outpatient services. ASC services may also be provided in an outpatient hospital setting.

expenditures

8%

$3,555,184

0.6% of Medicaid Expenditures



recipients

15%

2,710

4% of Medicaid Recipients

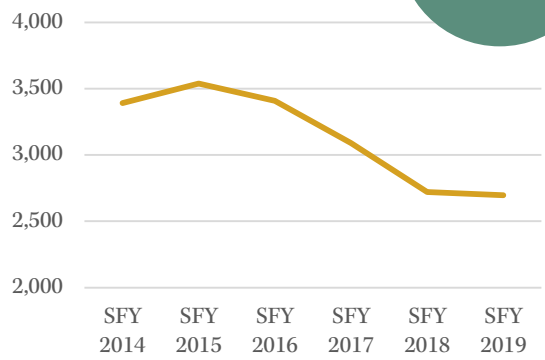


Table 19. Ambulatory Surgery Center Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$4,039,944	$6,090,776	$5,953,159	$4,095,973	$3,881,705	$3,555,184	-12
Recipients	3,417	3,565	3,431	3,343	3,202	2,710	-21
Expenditures per Recipient	$1,182	$1,708	$1,735	$1,225	$1,212	$1,312	11

behavioral health

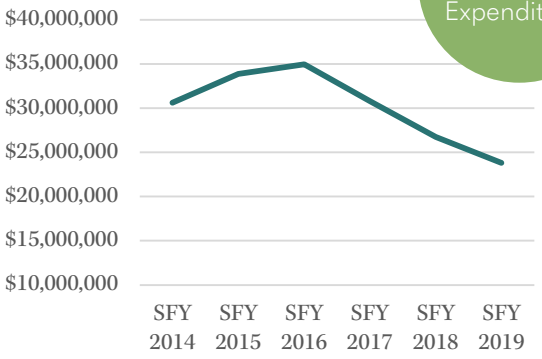
All services provided by Behavioral Health provider taxonomies

expenditures

11%

23,818,379

9% of Medicaid Expenditures

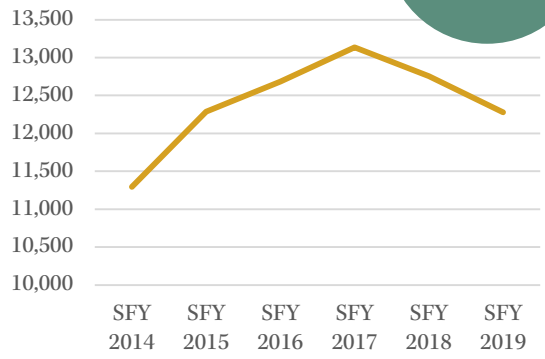


recipients

5%

12,627

18% of Medicaid Recipients



Non-behavioral health providers may provide behavioral health services. These are not included in the summary figures on the previous page.

These expenditures paid to non-behavioral health taxonomies decreased by 27% in SFY 2019 from the previous SFY, while the number of recipients receiving services from these providers increased by 7%.

More details are provided in Table 20.

Table 20. Behavioral Health Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Behavioral Health Services							
Expenditures	$30,602,969	$33,879,362	$34,964,154	$30,800,687	$26,723,530	$23,818,379	-22
Recipients	11,367	12,366	12,819	13,323	13,239	12,627	11
Expenditures per Recipient	$2,692	$2,740	$2,728	$2,312	$2,019	$1,886	-30
Non-Behavioral Health Provider Services[23]							
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

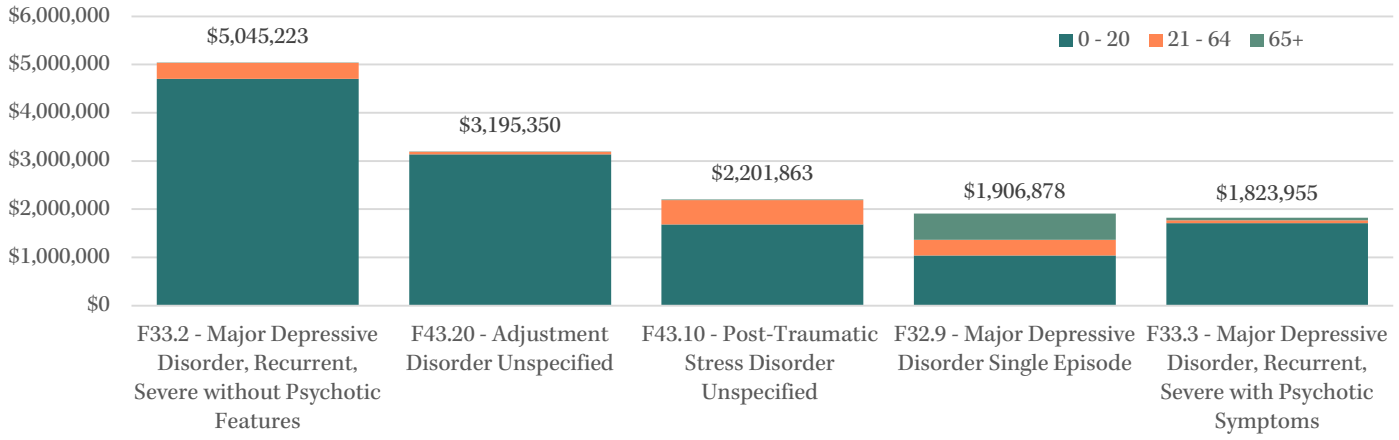


Figure 13. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types (excluding Dementia and Alzheimers)

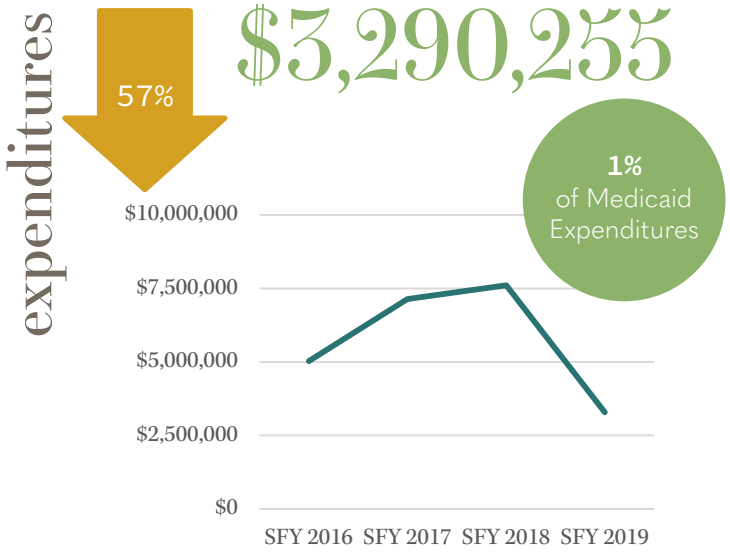
Table 21. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types

Diagnosis Code and Description	Age 0-20	Age 21-64	Age 65+	Total
F33.2 - Major Depressive Disorder, Recurrent, Severe w/o Psychotic Features	$4,701,437	$337,326	$6,460	$5,045,223
F43.20 - Adjustment Disorder Unspecified	$3,134,755	$52,424	$8,172	$3,195,350
F43.10 - Post-Traumatic Stress Disorder Unspecified	$1,681,756	$507,756	$12,351	$2,201,863
F32.9 - Major Depressive Disorder Single Episode	$1,043,332	$322,692	$540,854	$1,906,878
F33.3 - Major Depressive Disorder, Recurrent, Severe w/ Psychotic Symptoms	$1,712,427	$57,827	$53,701	$1,823,955
Total	$12,273,707	$1,278,025	$621,537	$14,173,269

23 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.



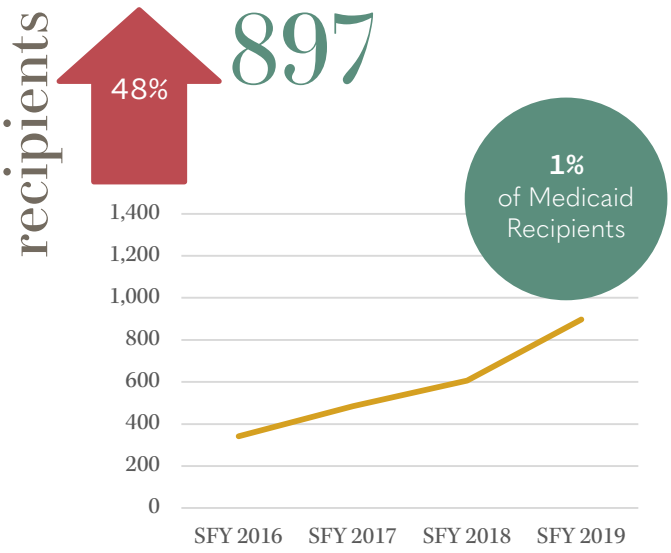


Table 22. Care Management Entity Services Summary

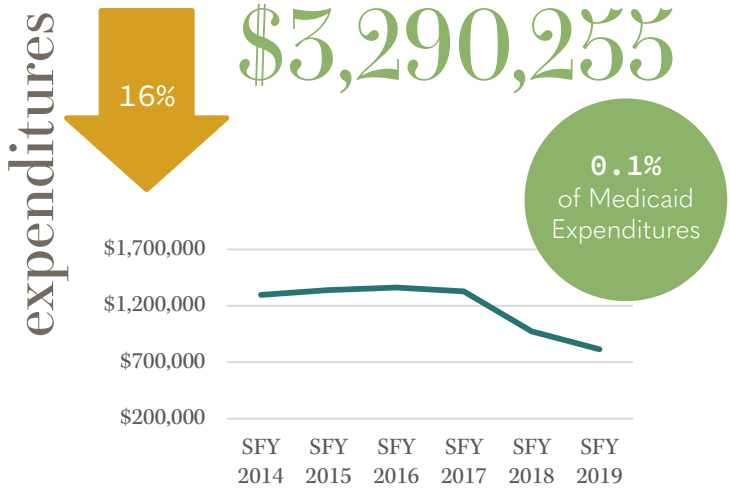
	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Expenditures	$5,021,978	$7,135,148	$7,599,455	$3,290,255
Recipients	342	485	606	897
Expenditures per Recipient	$14,684	$14,712	$12,540	$3,668

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.



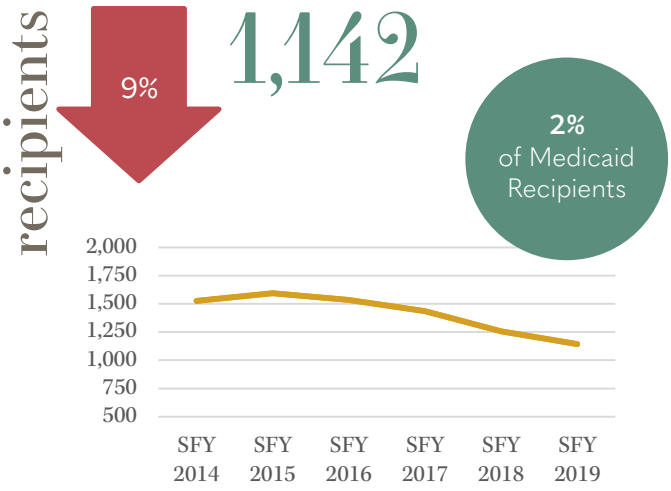
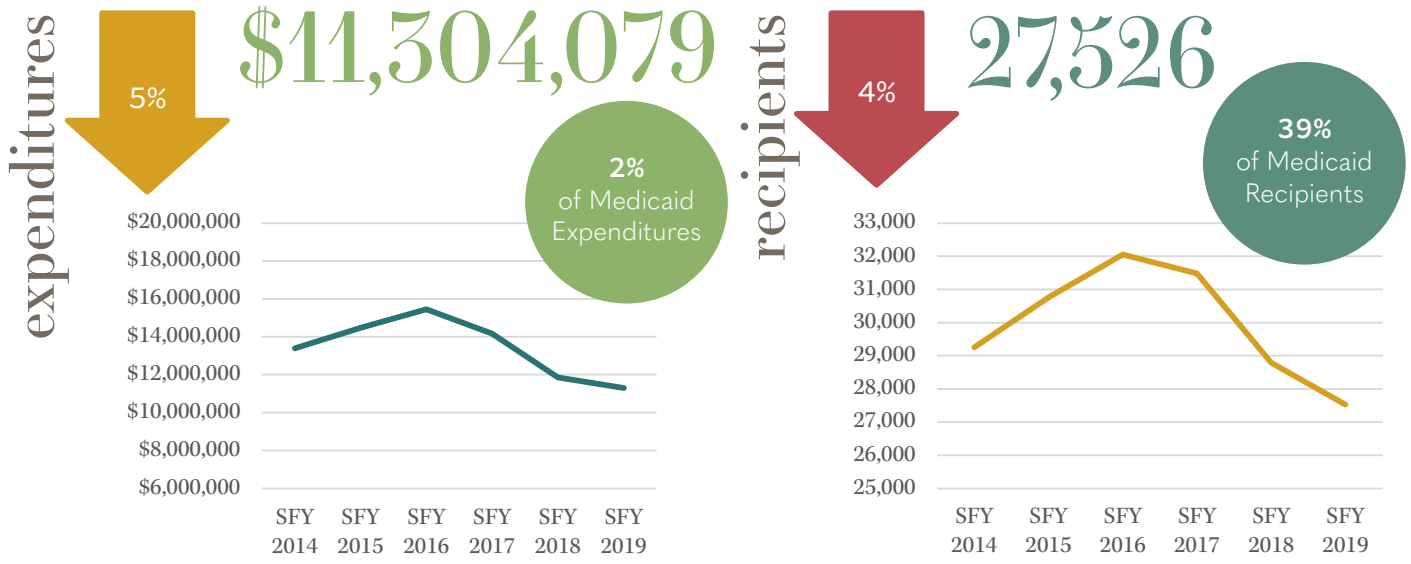


Table 23. Clinic/Center Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$1,295,561	$1,339,630	$1,361,953	$1,327,800	$972,701	$815,334	-16
Recipients	1,525	1,593	1,533	1,434	1,256	1,142	-25
Expenditures per Recipient	$850	$841	$888	$926	$774	$714	-16

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.



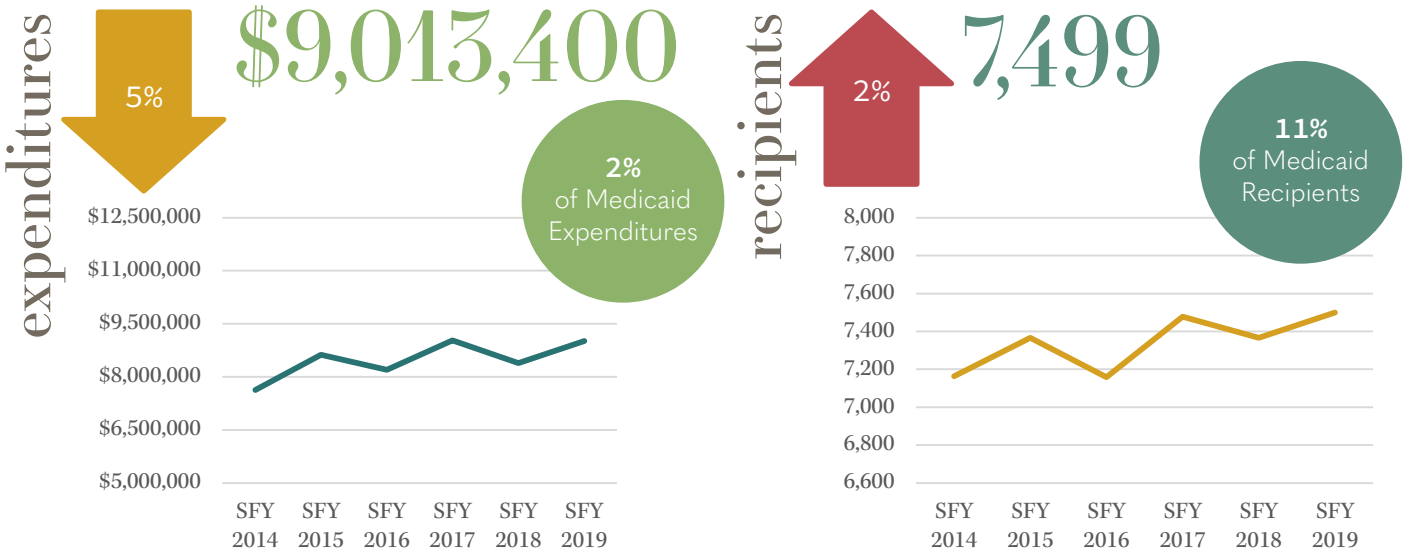
Although there are dental providers in most of Wyoming's 23 counties, dental specialists exist in only 9 (39%). In SFY 2018, 48% of dental recipients received services from a dental specialist, with 9% of those clients receiving such services out of state.

Table 24. Dental Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$13,391,934	$14,473,863	$15,450,029	$14,167,617	$11,847,581	$11,304,079	-5
Recipients	29,249	30,755	32,050	31,483	28,789	27,526	-6
Expenditures per Recipient	$458	$471	$482	$450	$412	$411	-10

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.



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.

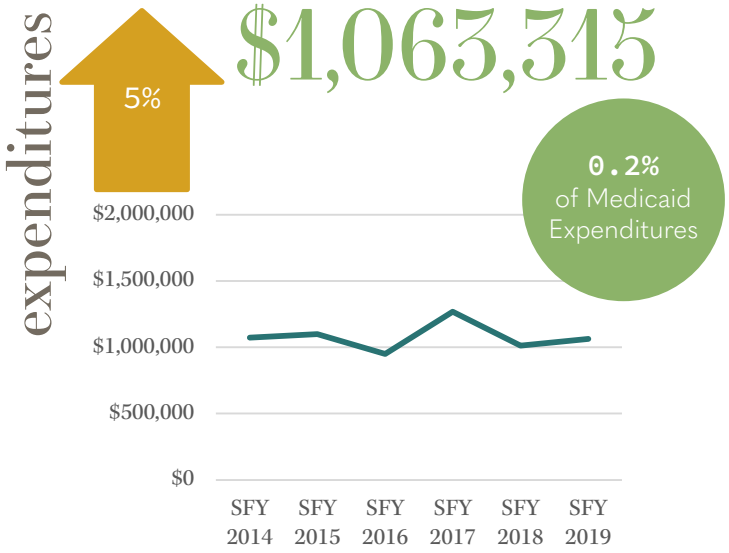
See Appendix B for more information regarding equipment and supplies included in this service area.

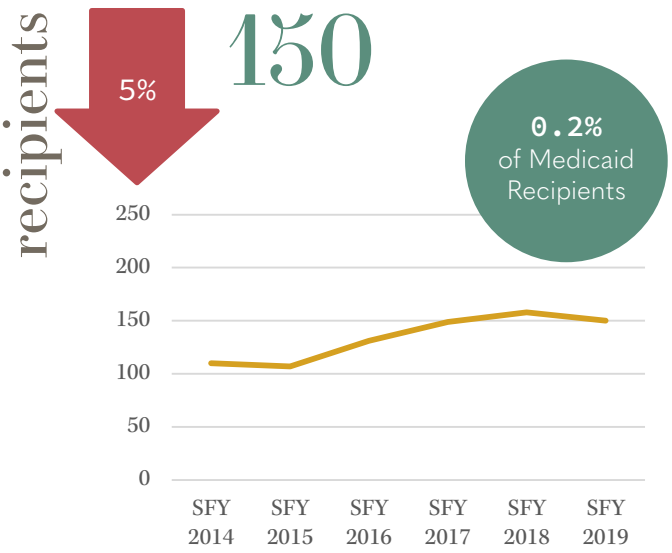
Table 25. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Total Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services							
Expenditures	$7,627,734	$8,624,246	$8,200,062	$9,029,583	$8,390,660	$9,013,400	18
Recipients	7,163	7,367	7,159	7,477	7,367	7,499	5
Expenditures per Recipient	$1,065	$1,171	$1,145	$1,208	$1,139	$1,202	13
Durable Medical Equipment Services Only							
Expenditures	$7,040,745	$7,910,490	$7,401,383	$8,272,343	$7,776,090	$8,418,558	20
Recipients	6,857	6,967	6,784	7,077	6,980	7,172	5
Expenditures per Recipient	$1,027	$1,135	$1,091	$1,169	$1,114	$1,174	14
Prosthetics, Orthotics, and Supplies Services Only							
Expenditures	$587,006	$720,162	$798,679	$757,241	$615,641	$598,186	2
Recipients	597	749	629	666	626	576	-4
Expenditures per Recipient	$983	$961	$1,270	$1,137	$983	$1,039	6

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.





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.

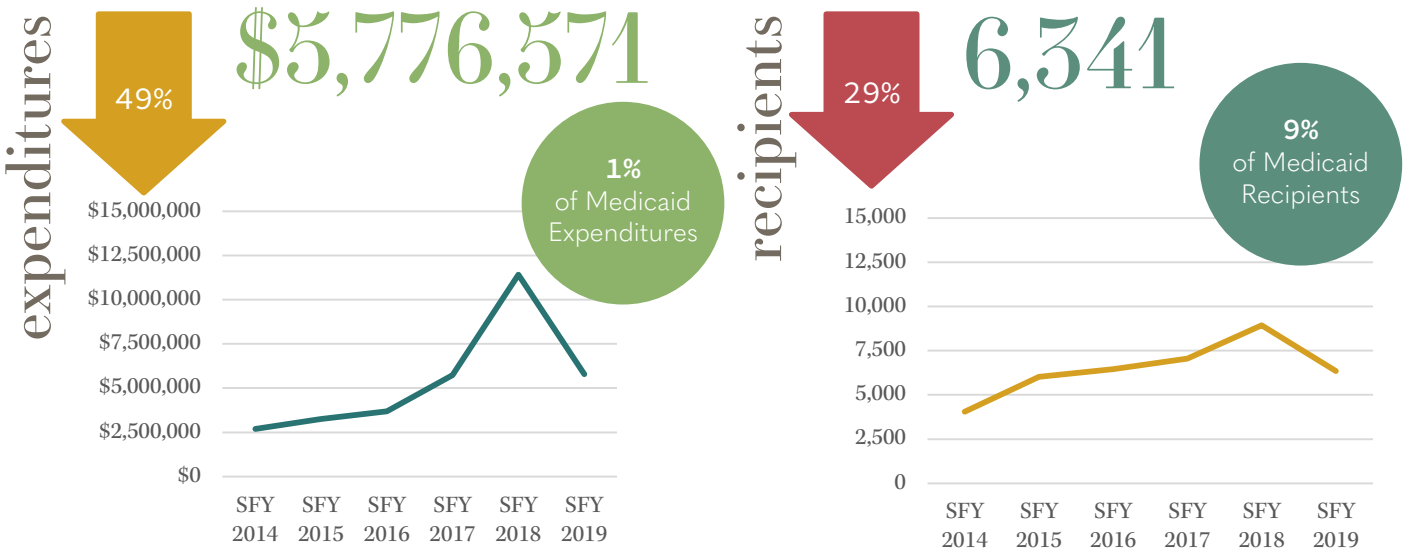
Medicare ESRD coverage may begin no later than the third month after the patient begins a course of dialysis treatment. During the 90-day Medicare eligibility determination period, Medicaid reimburses ESRD services for enrolled members and will reimburse services if Medicare denies eligibility.

Table 26. End Stage Renal Disease Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$1,071,750	$1,099,569	$948,612	$1,267,034	$1,012,427	$1,063,315	-1
Recipients	110	107	131	149	158	150	36
Expenditures per Recipient	$9,743	$10,276	$7,241	$8,504	$6,408	$7,089	-27

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, 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.



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.[24]

Table 27. Federally Qualified Health Center Services Summary

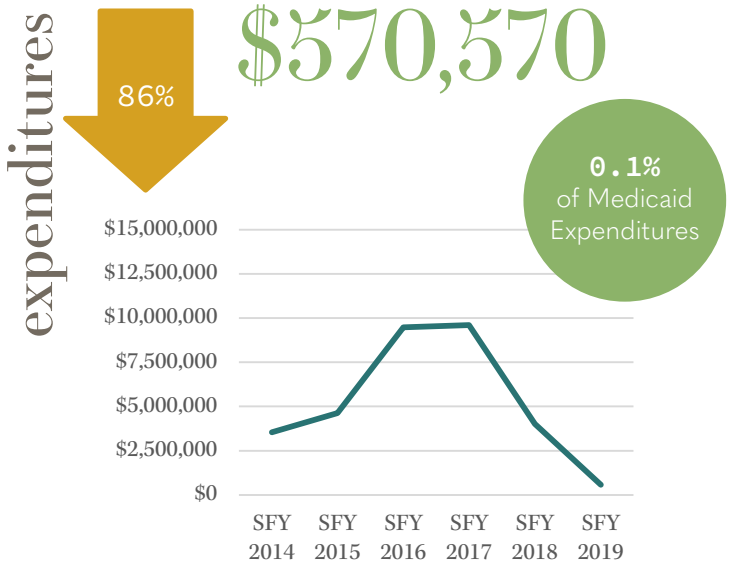
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$2,698,283	$3,259,793	$3,689,548	$5,725,094	$11,418,874	$5,776,571	114
Recipients	4,047	6,014	6,451	7,053	8,929	6,341	57
Expenditures per Recipient	$667	$542	$572	$812	$1,279	$911	37

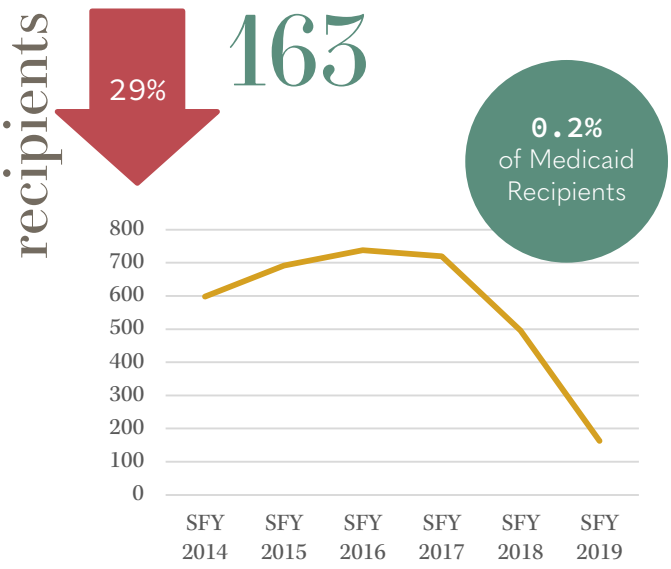
A rate increase for FQHC services was applied retroactively, resulting in past claims being re-processed during SFY 2018. This explains the increase in both expenditures and recipient counts seen for that year above.

24 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 fe visits per day for home health aide and/or skilled nursing, with each visit lasting no more than four hours. Ser 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.





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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$3,533,728	$4,618,885	$9,467,835	$9,596,803	$4,012,083	$570,570	-84
Recipients	598	692	738	720	496	163	-73
Expenditures per Recipient	$5,909	$6,675	$12,829	$13,329	$8,089	$3,500	-41

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.

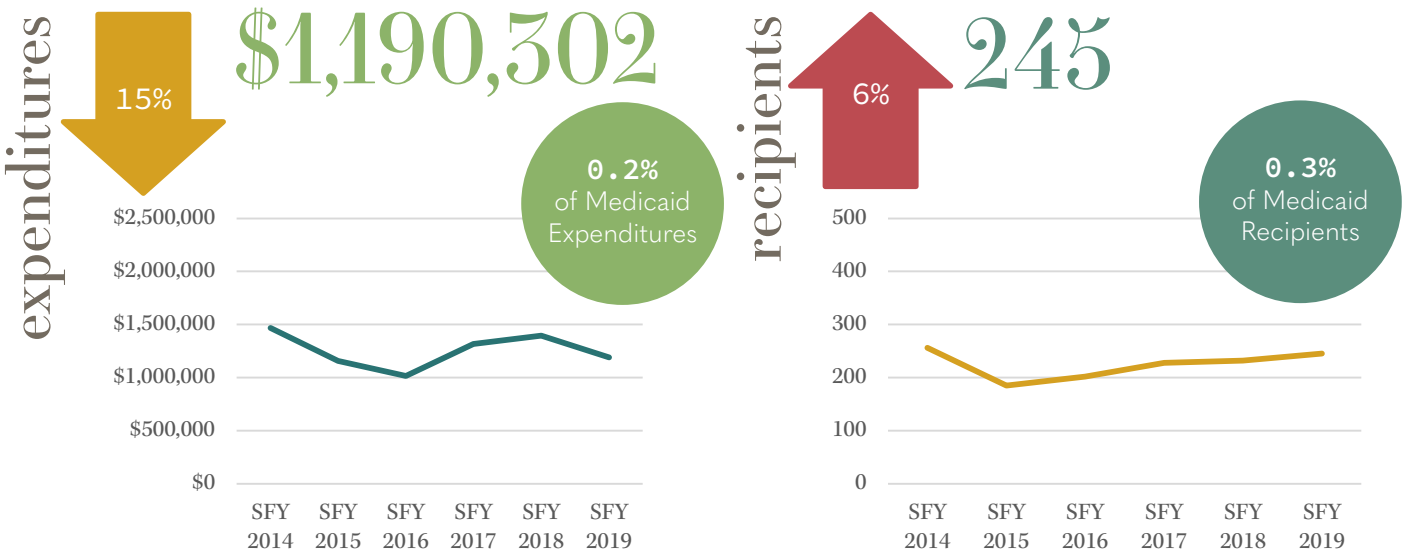


Table 29. Hospice Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$1,468,295	$1,157,101	$1,014,959	$1,316,838	$1,394,149	$1,190,302	-19
Recipients	256	185	202	228	232	245	-4
Expenditures per Recipient	$5,909	$6,675	$12,829	$13,329	$8,089	$3,500	-41

hospital

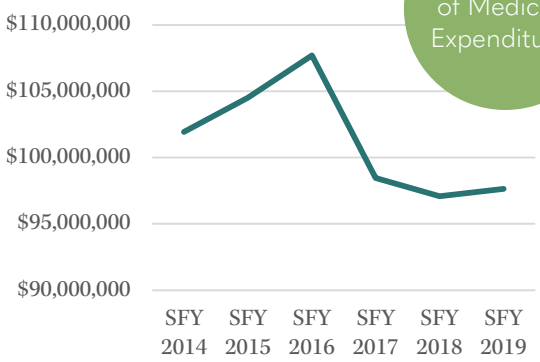
Inpatient and Outpatient hospital services

expenditures

1%

$97,635,206

18% of Medicaid Expenditures

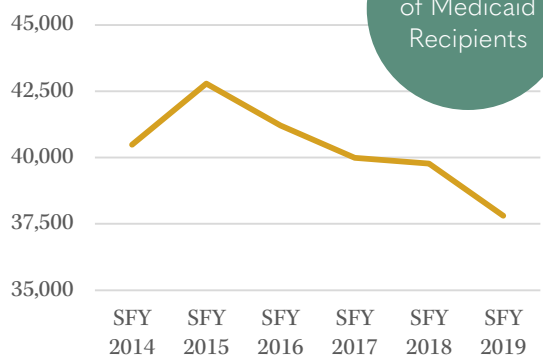


recipients

5%

37,812

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 30. Total Hospital Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$101,931,277	$104,523,947	$107,692,150	$98,467,703	$97,086,021	$97,635,206	-4
Recipients	40,484	42,791	41,208	39,989	39,771	37,812	-7
Expenditures per Recipient	$2,518	$2,443	$2,613	$2,462	$2,441	$2,582	3
QRA (Federal Share)	$8,604,610	$9,441,087	$12,607,068	$11,202,759	$12,472,415	$13,065,161	52
Total Expenditures w/ QRA	$110,535,887	$113,965,034	$120,299,218	$109,670,462	$109,558,436	$110,700,367	0

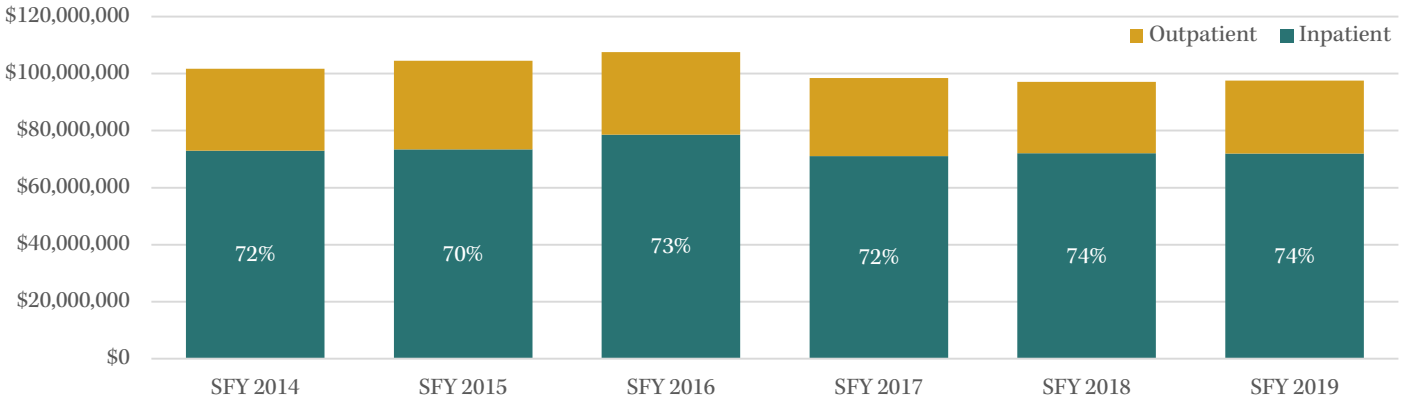


Figure 14. Hospital Inpatient-Outpatient Breakdown History by Expenditures

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.

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 31. Inpatient Hospital Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	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)	$2,599,625	$2,667,482	$3,143,380	$2,200,706	$3,010,897	$3,942,199	52
Total Expenditures w/ QRA	$75,532,065	$76,074,614	$81,718,448	$73,222,978	$75,084,551	$75,865,731	0

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 32. Outpatient Hospital Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	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)	$6,004,985	$6,773,605	$9,463,689	$9,002,053	$9,461,519	$9,122,962	52
Total Expenditures w/ QRA	$34,708,132	$37,829,671	$38,438,739	$36,375,515	$34,483,387	$34,681,069	0

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

25 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.

26 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 services

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 33. Emergency Room Utilization Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$14,397,808	$16,147,280	$15,110,117	$14,597,247	$13,416,829	$13,118,606	-9
Recipients	26,112	27,754	25,963	25,758	24,857	23,501	-10
Expenditures per Recipient	$551	$582	$582	$567	$540	$558	1
Emergency Room Visits	56,437	62,063	55,950	56,173	53,574	50,425	-11
% of Total Medicaid Expenditures	2.8%	3.1%	2.7%	2.6%	2.4%	2.4%	

Table 34. Emergency Room Utilization by Eligibility Category

Eligibility Category	Expenditures	% Change from SFY 2018	Recipients	% Change from SFY 2018	ER Visits	% Change from SFY 2018
ABD EID	$64,041	-7	148	-6	305	-18
ABD ID/DD/ABI	$322,946	16	808	-5	2,184	8
ABD Institution	$5,599	223	19	-24	22	-29
ABD LTC	$667,030	6	2,146	6	5,673	3
ABD SSI	$2,403,043	9	2,910	0	8,872	1
Adults	$3,248,197	-6	3,575	-9	8,497	-12
Children	$5,431,894	-6	11,911	-8	19,773	-11
Medicare Savings Program	$135,650	8	1,122	0	2,734	7
Non-Citizens with Medical Emergencies	$19,053	-4	28	-7	39	-32
Pregnant Women	$796,091	-3	1,205	-10	2,287	-5
Screenings & Gross Adjustments	$2,858	342	5	67	11	267
Special Groups	$22,203	-17	21	-9	44	-42
Total	$13,118,606	-2	23,501	-5	50,425	-6

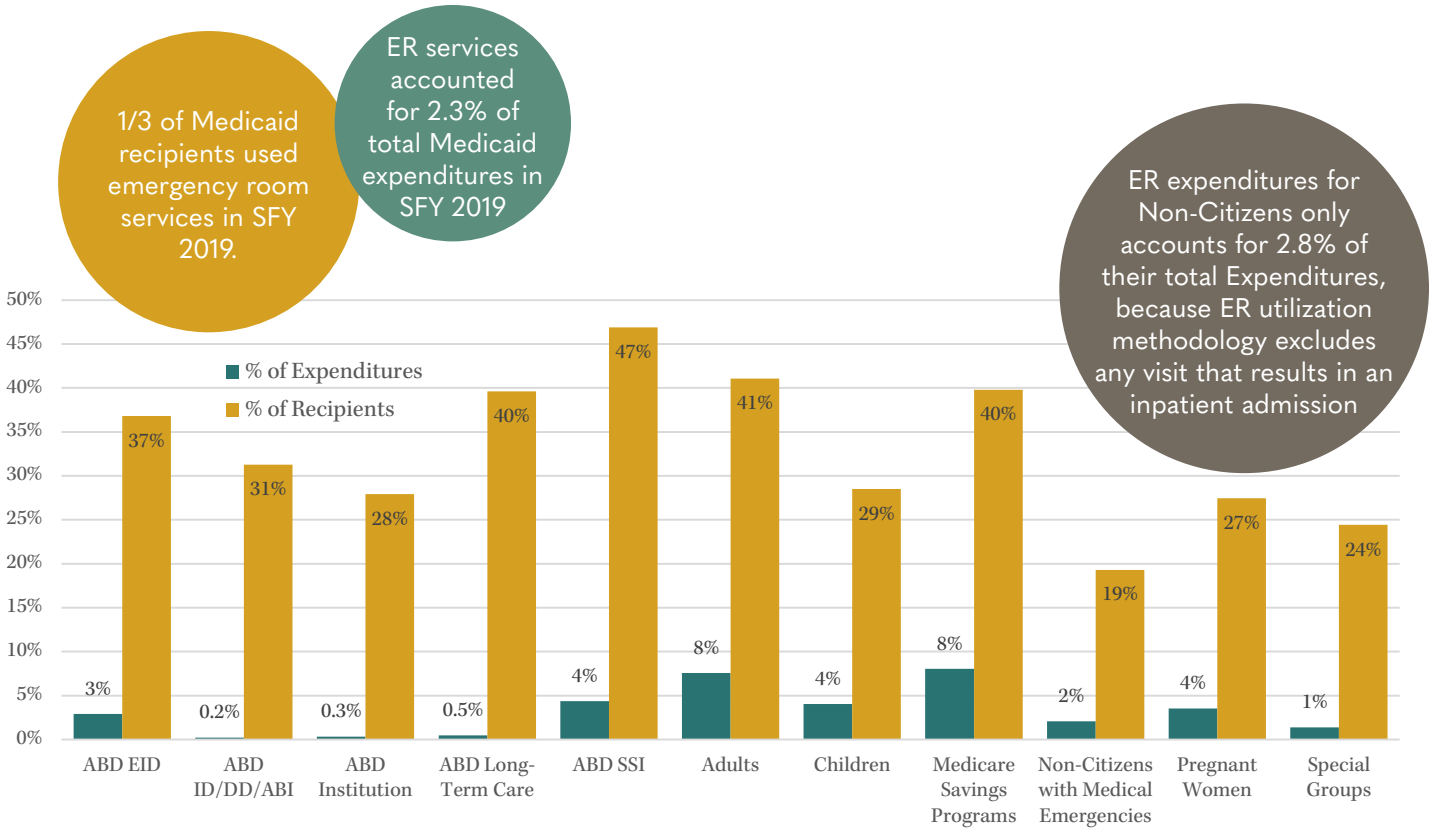


Figure 15. Emergency Room Utilization vs Total Medicaid by Eligibility Category

Table 35. Emergency Room Utilization vs Total Medicaid by Eligibility Category

Eligibility Category	ER Recipients	Total Medicaid Recipients	% Using ER Services	ER Expenditures	Total Medicaid Expenditures	% Paid for ER Services
ABD EID	148	402	37%	$64,041	$2,201,872	3%
ABD ID/DD/ABI	808	2,585	31%	$322,946	$148,210,163	0.2%
ABD Institution	19	68	28%	$5,599	$1,638,641	0.3%
ABD LTC	2,146	5,420	40%	$667,030	$136,564,759	0.5%
ABD SSI	2,910	6,205	47%	$2,403,043	$55,018,028	4%
Adults	3,575	8,706	41%	$3,248,197	$42,819,380	8%
Children	11,911	41,780	29%	$5,431,894	$134,481,804	4%
Medicare Savings Program	1,122	2,820	40%	$135,650	$1,687,004	8%
Non-Citizens with Medical Emergencies	28	145	19%	$19,053	$913,315	2%
Pregnant Women	1,205	4,392	27%	$796,091	$22,579,721	4%
Screenings & Gross Adjustments	5	2,857	0%	$2,858	$6,486,690	0.04%
Special Groups	21	86	24%	$22,203	$1,623,461	1%
Total	23,501	71,324	33%	$13,118,606	$554,224,838	2%

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.

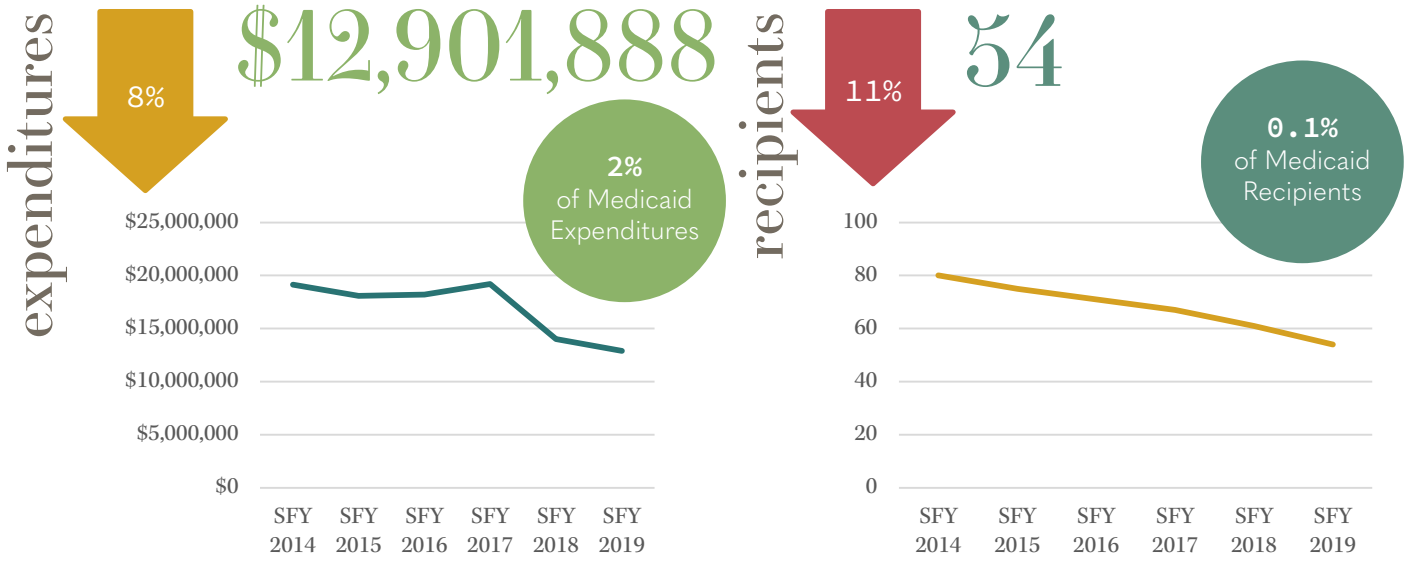


Table 36. Intermediate Care Facility for Individuals with Intellectual Disabilities Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$19,152,530	$18,091,427	$18,193,221	$19,204,867	$13,999,444	$12,901,888	-33
Recipients	80	75	71	67	61	54	-33
Expenditures per Recipient	$239,407	$241,219	$256,243	$286,640	$229,499	$238,924	0

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.

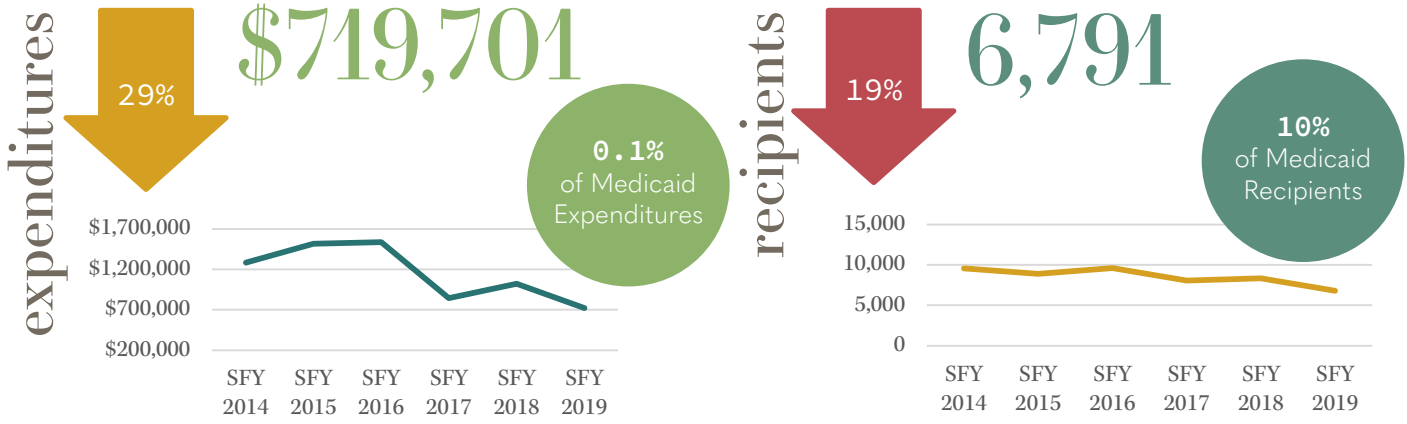


Table 37. Laboratory Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$1,284,678	$1,516,042	$1,536,310	$844,218	$1,020,356	$719,701	-44
Recipients	9,573	8,899	9,602	8,046	8,335	6,791	-29
Expenditures per Recipient	$134	$170	$160	$105	$122	$106	-21

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.

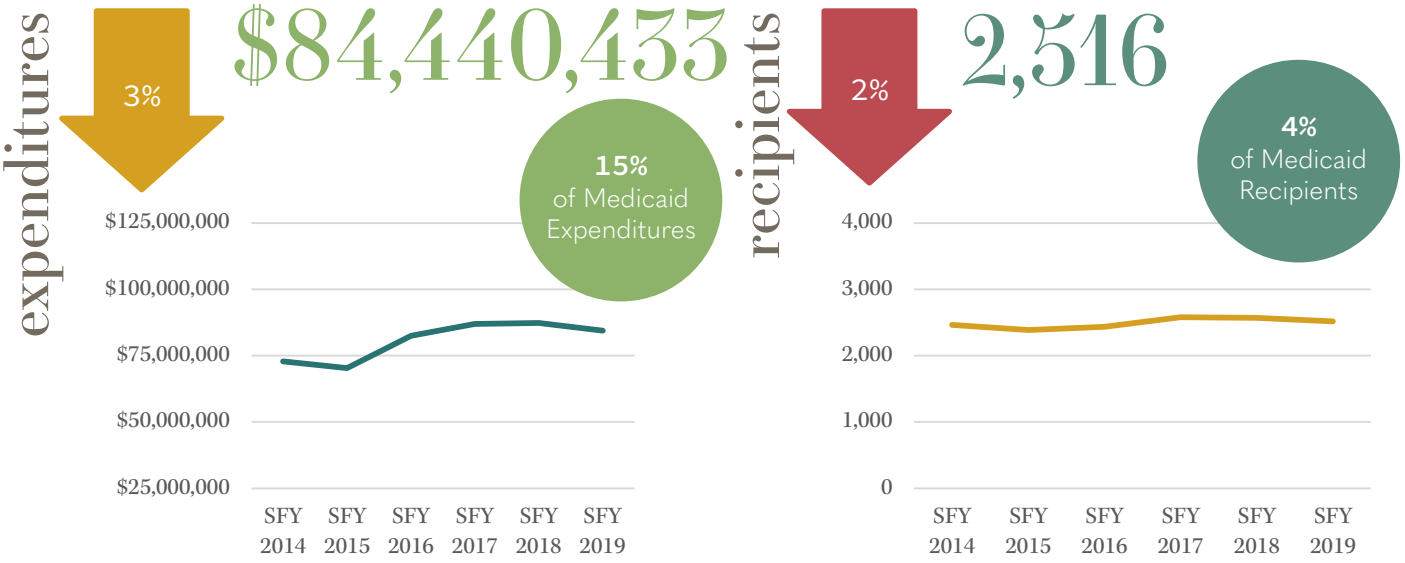


Table 38. Nursing Facility Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$72,866,933	$70,354,260	$82,445,811	$87,001,112	$87,304,589	$84,440,433	16
Recipients	2,464	2,388	2,433	2,579	2,570	2,516	2
Expenditures per Recipient	$29,573	$29,462	$33,886	$33,734	$33,971	$33,561	13
Provider Assessment (Federal Share)	$15,537,040	$15,219,087	$14,689,893	$15,275,937	$16,385,303	$16,982,657	9
Total Expenditures with Provider Assessment	$88,403,973	$85,573,347	$97,135,704	$102,277,049	$103,689,892	$101,423,090	15

Per Diem Rate

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

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

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

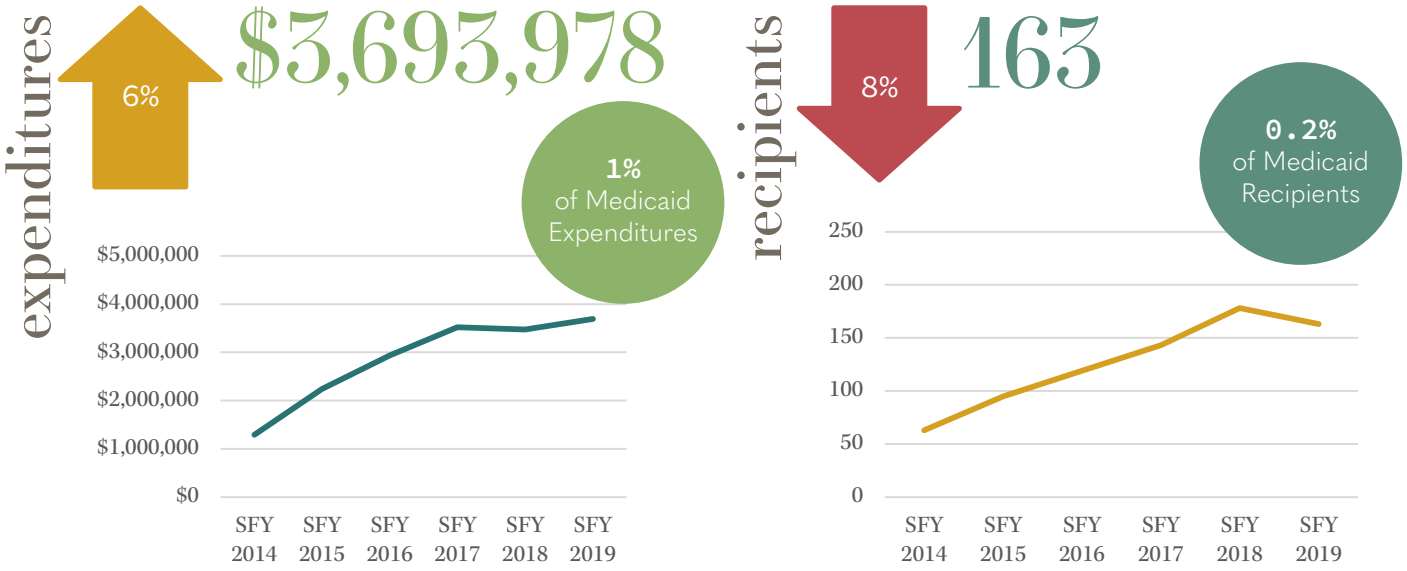
Medicaid determines per case rates for extraordinary care based on relevant cost and a review of medical records.

Enhanced Adult Psychiatric Reimbursement

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

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.



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

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$1,288,934	$2,242,570	$2,934,877	$3,520,283	$3,471,255	$3,693,978	187
Recipients	63	95	119	143	178	163	159
Expenditures per Recipient	$20,459	$23,606	$24,663	$24,617	$19,501	$22,662	11

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, with additional visits approved after review for medical necessity

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.

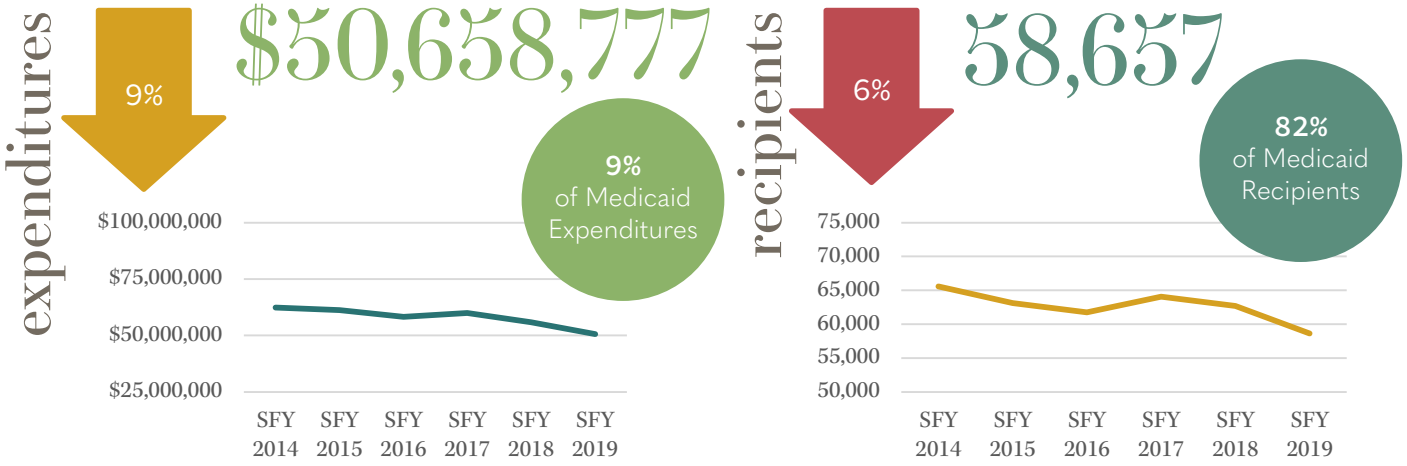


Table 40. Physician and Other Practitioner Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Total Physician and Other Practitioner Services							
Expenditures	$62,372,535	$61,249,367	$58,278,406	$60,013,763	$55,798,175	$50,658,777	-19
Recipients	65,603	63,117	61,769	64,075	62,699	58,657	-11
Expenditures per Recipient	$951	$970	$943	$937	$890	$864	-9
Physician Only Services							
Expenditures	$56,694,139	$54,142,991	$50,015,210	$51,857,906	$49,001,617	$45,268,820	-20
Recipients	65,038	62,412	61,012	63,363	62,157	58,041	-11
Expenditures per Recipient	$872	$868	$820	$818	$788	$780	-11
Other Practitioner Services							
Expenditures	$5,678,397	$7,106,377	$8,263,196	$8,155,858	$6,796,557	$5,389,957	-5
Recipients	7,840	9,252	9,130	8,732	7,151	7,244	-8
Expenditures per Recipient	$724	$768	$905	$934	$950	$744	3

OTHER PRACTITIONERS
Physical therapists
Occupational therapists
Speech-language pathologists
Podiatrists
Nurse practitioners
Nurse Midwives
Nurse Anesthetists
Audiologists

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.

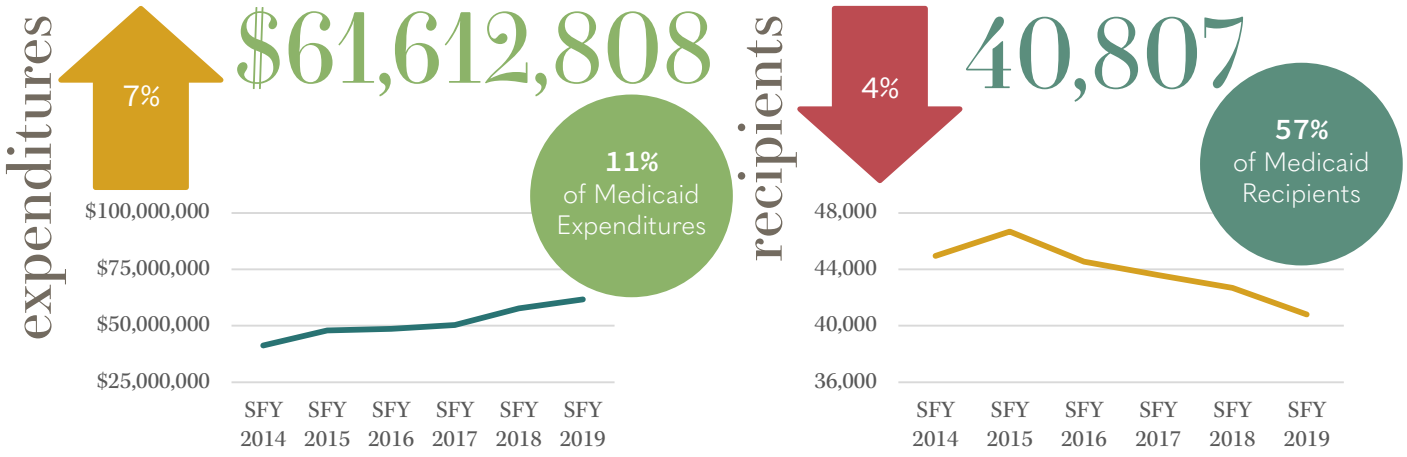


Table 41. Prescription Drug Services Summary [27]

	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	5 Year % Change
Expenditures	$41,238,663	$47,946,923	$48,597,364	$50,300,175	$57,642,641	$61,612,808	49
Recipients	44,963	46,673	44,547	43,602	42,676	40,807	-9
Expenditures per Recipient	$917	$1,027	$1,091	$1,154	$1,351	$1,510	65

128
specific drug classes designated as preferred drugs in SFY 2019

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.

$5.73 million

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

Table 42. Pharmacy Cost Avoidance - SFY 2019

Program Area	Cost Avoidance
Prior Authorization (PA) Preferred Drug List (PDL)	$10,562,232
State Maximum Allowable Cost (SMAC)	$900,210
Program Integrity Cost Avoidance	$1,638,099
Total	$13,100,541

Table 43. 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
SFY 2019	$29.3

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.

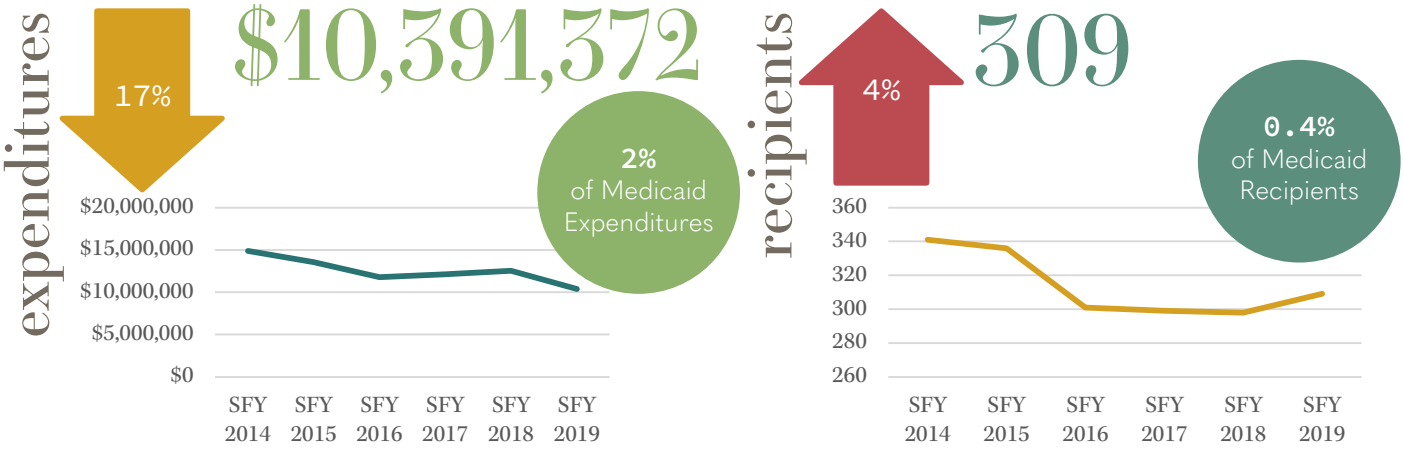


Table 44. Psychiatric Residential Treatment Facility Services Summary [29]

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$14,886,133	$13,575,847	$11,797,657	$12,121,830	$12,537,788	$10,391,372	-30
Recipients	341	336	301	299	298	309	-9
Expenditures per Recipient	$43,654	$40,404	$39,195	$40,541	$42,073	$33,629	-23

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.

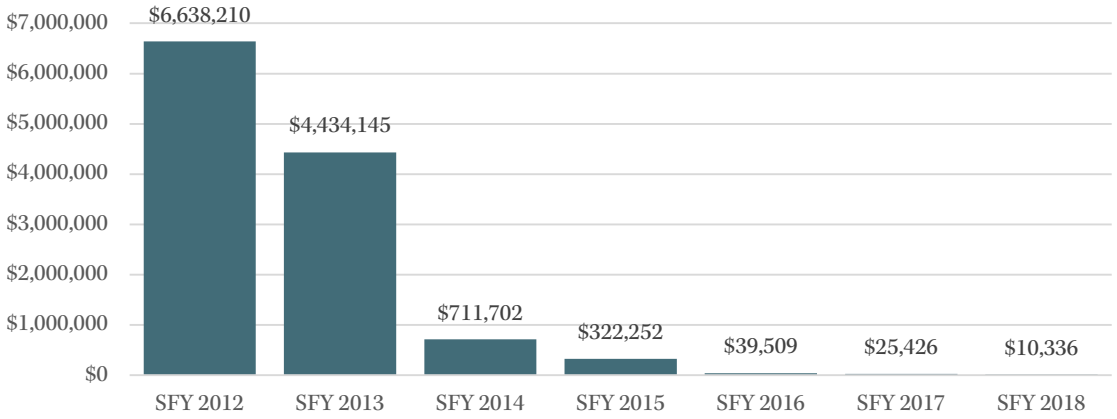


Figure 16. Expenditures for Court Ordered Psychiatric Residential Treatment Facility Services with Incorrect Language or No Medical Necessity

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.

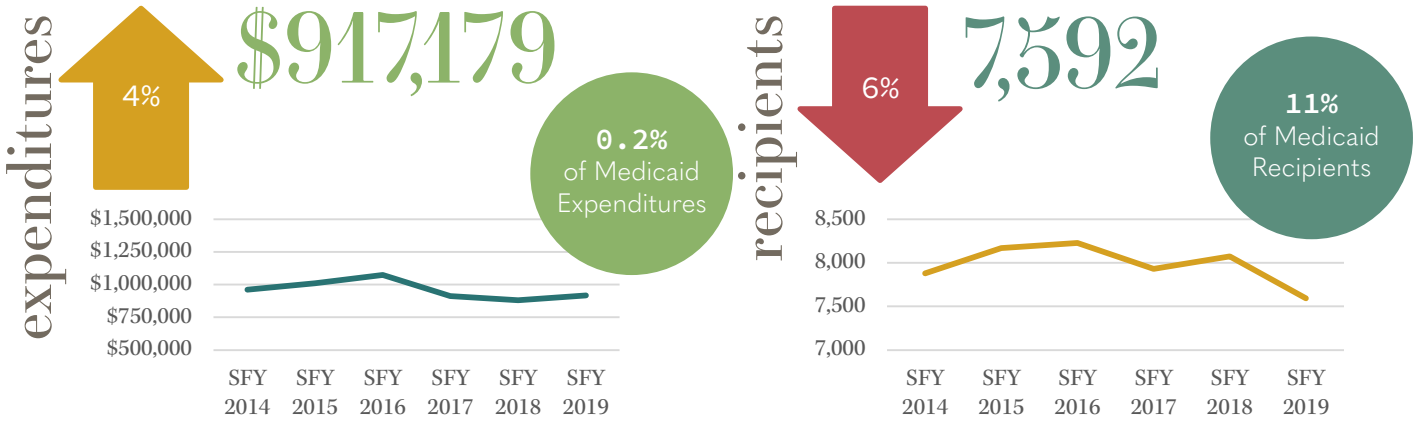


Table 45. Public Health or Welfare Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$962,164	$1,009,814	$1,072,715	$912,444	$881,179	$917,179	-5
Recipients	7,878	8,168	8,226	7,929	8,073	7,592	-4
Expenditures per Recipient	$122	$124	$130	$115	$109	$121	-1

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).

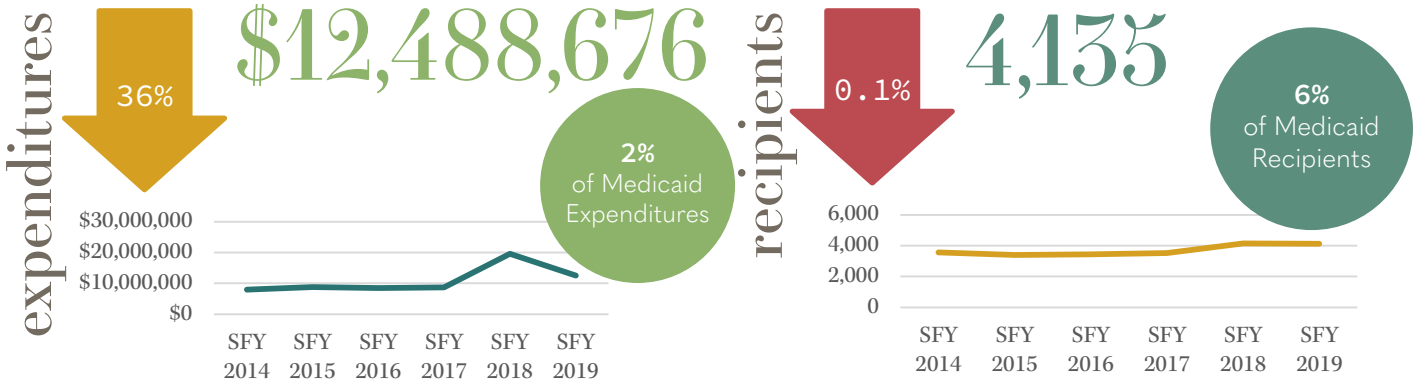


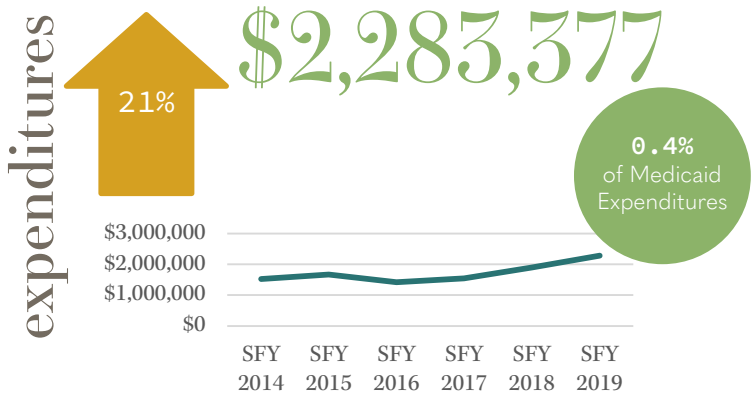
Table 46. Public Health, Federal Services Summary

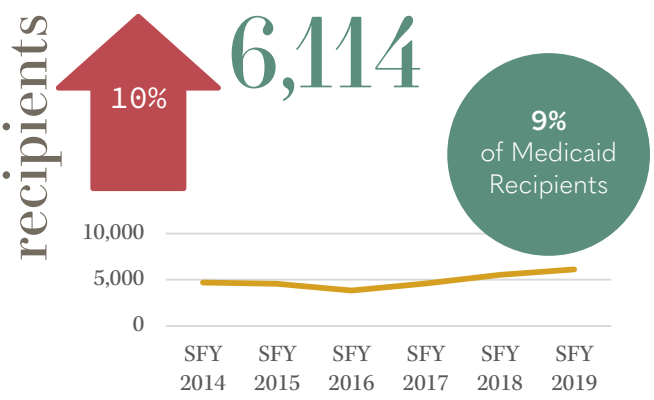
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$7,999,556	$8,761,358	$8,479,944	$8,718,888	$19,625,445	$12,488,676	56
Recipients	3,557	3,391	3,433	3,531	4,138	4,135	16
Expenditures per Recipient	$2,249	$2,584	$2,470	$2,469	$4,743	$3,020	34

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 in SFY 2018. 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, clinical psychologist, certified social worker, and physician assistent, as well as services and supplies incident to a physician's service.





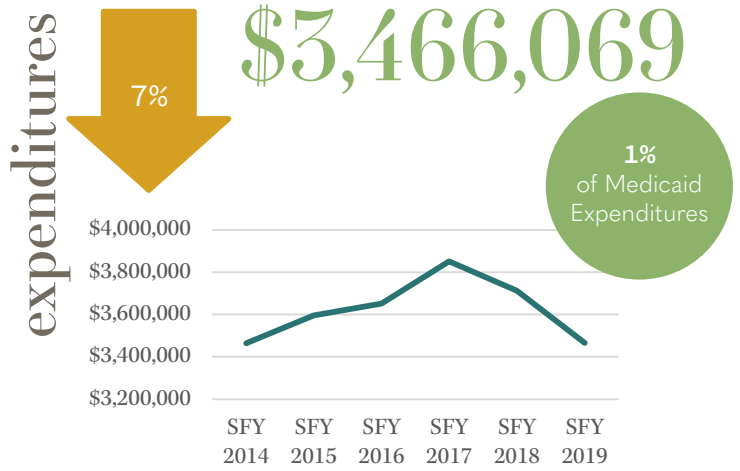
RHCs are reimbursed through an encounter rate; therefore, it is expected that as recipients increase, expenditures would also increase. The reimbursement rate includes the office visit, as well as any ancillary services provided (x-rays, etc.). Adjustments may be made to rates if a provider requests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

Table 47. Rural Health Clinic Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$1,521,233	$1,668,167	$1,413,842	$1,540,607	$1,894,505	$2,283,377	50
Recipients	4,690	4,552	3,835	4,577	5,542	6,114	30
Expenditures per Recipient	$324	$366	$369	$337	$342	$373	15

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.



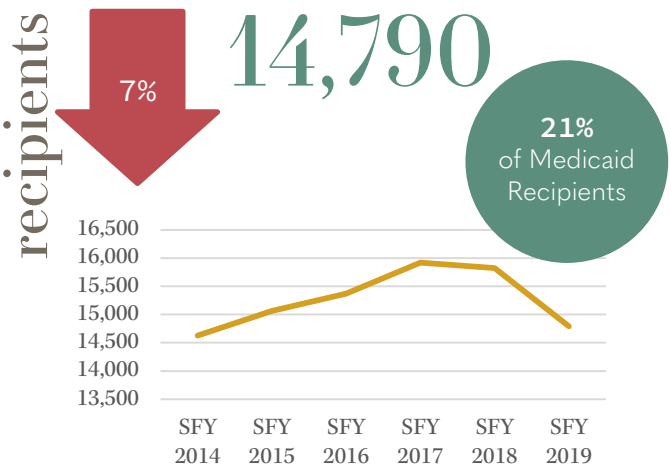


Table 48. Vision Services Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$3,464,394	$3,595,216	$3,652,188	$3,850,574	$3,712,855	$3,466,069	0
Recipients	14,624	15,063	15,371	15,921	15,821	14,790	1
Expenditures per Recipient	$237	$239	$238	$242	$235	$234	-1

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 to the right.

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.

MEDICAID WAIVERS

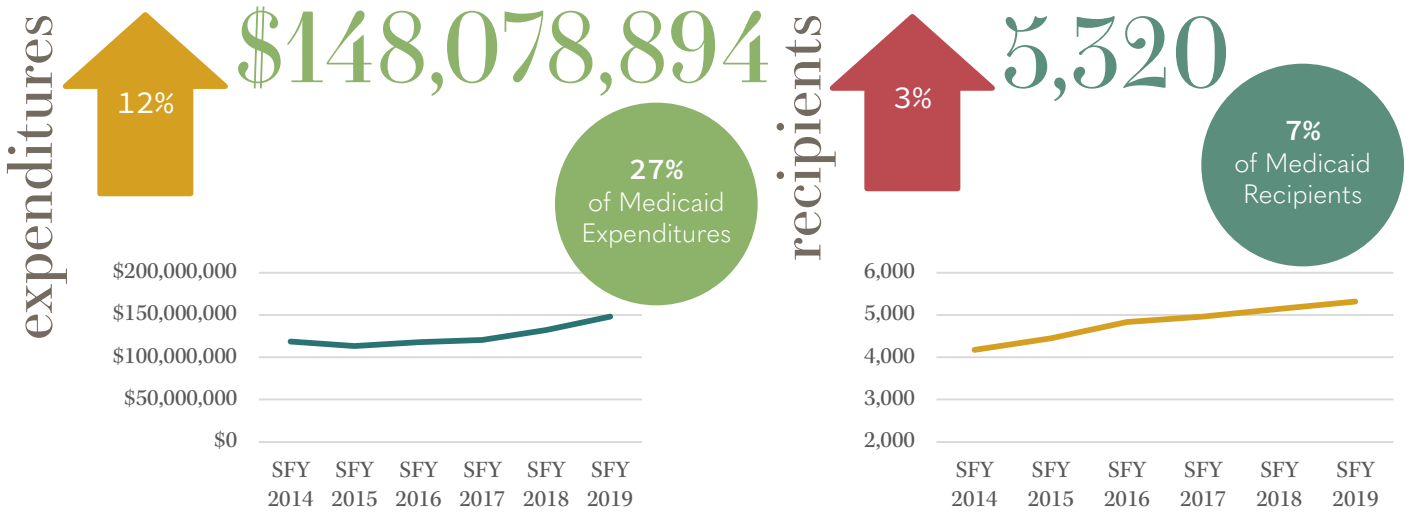
HOME & COMMUNITY BASED SERVICES WAIVERS

- Community Choices
- Children's Mental Health
- Acquired Brain Injury
- Comprehensive
- Supports

Pregnant by Choice (section 1115 waiver)

home and community based waiver services

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.



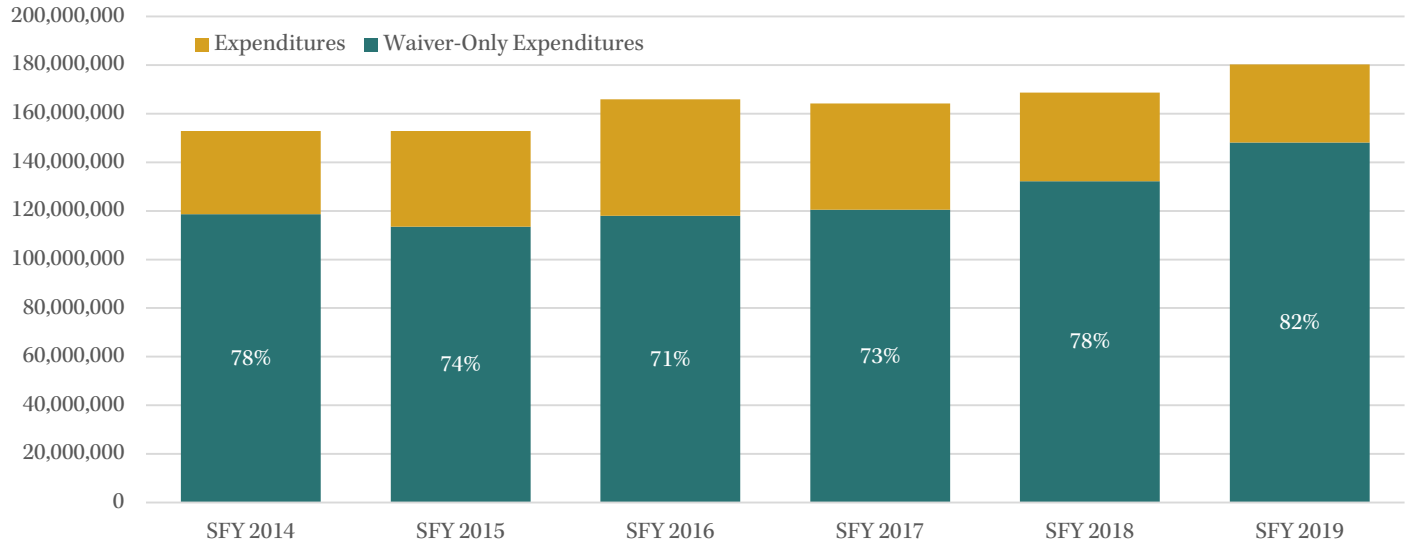
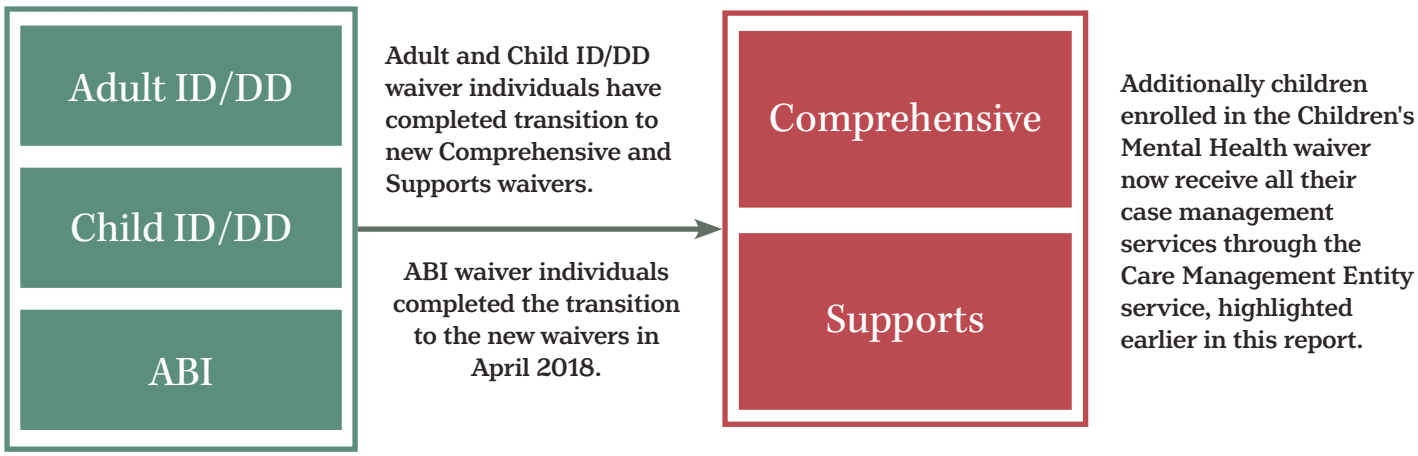


Figure 17. Waiver vs Non-Waiver Expenditures History

Table 49. Home and Community Based Services Waiver Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Waiver Only Services							
Expenditures	$118,624,631	$113,452,108	$117,950,473	$120,465,765	$132,243,321	$148,078,894	25
Recipients	4,172	4,450	4,833	4,958	5,145	5,320	28
Expenditures per Recipient	$28,434	$25,495	$24,405	$24,297	$25,703	$27,834	-2
% Waiver-Only of Total Waivers	78%	74%	71%	73%	78%	82%	
Non-Waiver Services							
Expenditures	$34,172,122	$39,359,014	$47,958,177	$43,719,149	$36,344,896	$32,159,952	-6
Recipients	4,375	4,538	4,938	5,137	5,307	5,420	24
Expenditures per Recipient	$7,811	$8,673	$9,712	$8,511	$6,848	$5,934	-24
Total Waiver							
Expenditures	$152,796,753	$152,811,123	$165,908,650	$164,184,914	$168,588,217	$180,238,846	18
Recipients	4,484	4,678	5,102	5,291	5,480	5,633	26
Expenditures per Recipient	$34,076	$32,666	$32,518	$31,031	$30,764	$31,997	-6



Due to the above changes, the Adult ID/DD, Child ID/DD, and Children's Mental Health waivers are included in Table 50 to show their historical trends; however, these waivers will not be reported in further detail in this section.

Figures 18 and 19 show the historical change in expenditures as the transition to Comprehensive and Supports waivers have been implemented. From SFY 2014 to SFY 2019, total expenditures for these populations have increased 12%, with non-waiver expenditures decreasing by 14%.

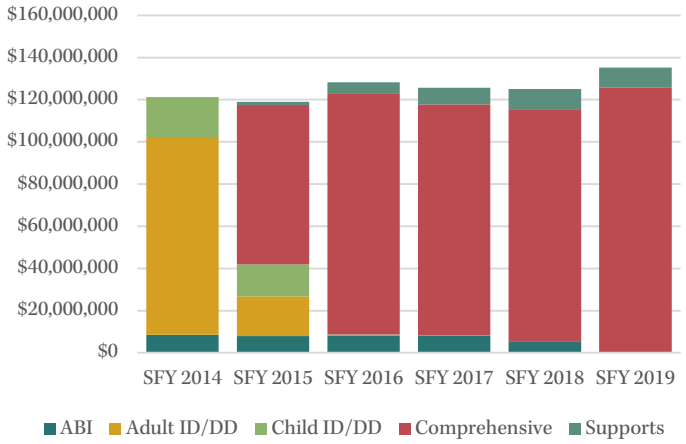


Figure 18. Total Expenditure History for Transition from Adult and Child ID/DD Waivers to Comprehensive and Supports Waivers

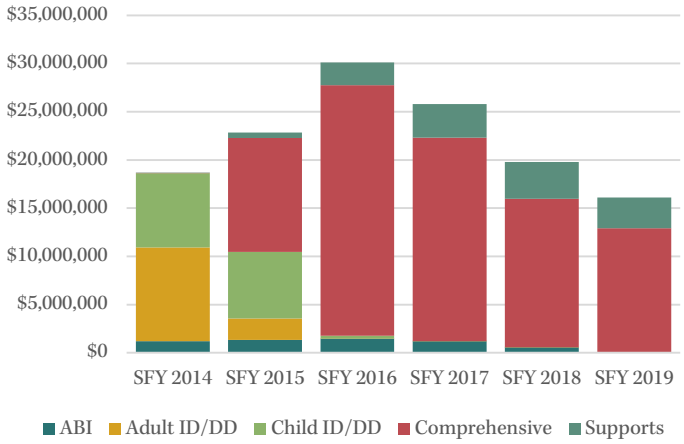


Figure 19. Non-Waiver Services Expenditure History for Transition from Adult and Child ID/DD Waivers to Comprehensive and Supports Waivers

Table 50. Home and Community Based Services Waiver Expenditures History by Waiver

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Waiver Only Services						
ABI	$7,371,614	$6,636,440	$6,748,171	$6,960,893	$4,948,202	$15,008
Adult ID/DD	$83,501,095	$16,541,190	$1,674	$1,565	--	--
Child ID/DD	$11,415,264	$8,372,841	$179,173	--	--	--
Children's Mental Health	$527,514	$732,257	$61,981	--	--	--
Community Choices	$15,763,707	$16,630,675	$19,801,419	$20,597,605	$26,930,997	$28,957,689
Comprehensive	$44,982	$63,719,016	$88,377,607	$88,527,446	$94,568,471	$112,673,503
Supports	$454	$819,690	$2,780,450	$4,378,255	$5,795,651	$6,432,694
Non-Waiver Services						
ABI	$1,211,369	$1,351,962	$1,470,018	$1,211,223	$575,512	$6,476
Adult ID/DD	$9,723,128	$2,198,325	$8,222	$1,035	$36	--
Child ID/DD	$7,704,616	$6,905,996	$289,231	$8,476	$218	--
Children's Mental Health	$794,094	$1,009,279	$880,934	$675,081	$814,392	$517,327
Community Choices	$14,722,651	$15,503,721	$16,951,952	$17,240,246	$15,753,166	$15,541,576
Comprehensive	$16,150	$11,813,805	$25,986,468	$21,106,234	$15,405,710	$12,909,462
Supports	$114	$575,926	$2,371,351	$3,476,854	$3,795,863	$3,185,111
Total Waiver						
ABI	$8,582,983	$7,988,402	$8,218,189	$8,172,117	$5,523,714	$21,484
Adult ID/DD	$93,224,222	$18,739,515	$9,897	$2,600	$36	--
Child ID/DD	$19,119,880	$15,278,837	$468,404	$8,476	$218	--
Children's Mental Health	$1,321,609	$1,741,535	$942,915	$675,081	$814,392	$517,327
Community Choices	$30,486,358	$32,134,396	$36,753,371	$37,837,852	$42,684,163	$44,499,265
Comprehensive	$61,132	$75,532,821	$114,364,075	$109,633,679	$109,974,181	$125,582,965
Supports	$568	$1,395,616	$5,151,800	$7,855,109	$9,591,514	$9,617,805

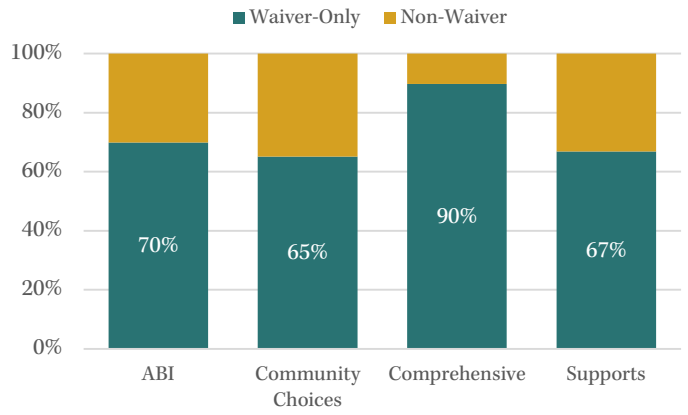


Figure 20. SFY 2019 Waiver-Only versus Non-Waiver Services by Waiver

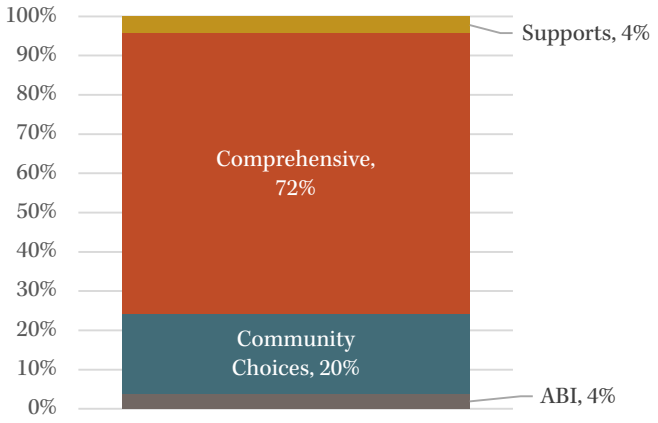


Figure 21. SFY 2019 Total Waiver Expenditure Breakdown by Waiver

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. This waiver completed transition to the Comprehensive and Supports waivers in SFY 2018; however, due to claim lag, claims continued to be paid through SFY 2019.

Table 51. Acquired Brain Injury Waiver Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Waiver Only Services							
Expenditures	$7,371,614	$6,636,440	$6,748,171	$6,960,893	$4,948,202	$15,008	-100
Recipients	181	168	163	162	144	19	-90
Expenditures per Recipient	$40,727	$39,503	$41,400	$42,968	$34,363	$790	-98
% Waiver-Only	86%	83%	82%	85%	90%	70%	
Non-Waiver Services							
Expenditures	$1,211,369	$1,351,962	$1,470,018	$1,211,223	$575,512	$6,476	-99
Recipients	178	170	165	160	146	44	-75
Expenditures per Recipient	$6,805	$7,953	$8,909	$7,570	$3,942	$147	-98
Total Waiver							
Expenditures	$8,582,983	$7,988,402	$8,218,189	$8,172,117	$5,523,714	$21,484	-100
Recipients	184	172	167	164	150	57	-69
Expenditures per Recipient	$46,647	$46,444	$49,211	$49,830	$36,825	$377	-99

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 52. Community Choices Waiver Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Waiver Only Services							
Expenditures	$15,763,707	$16,630,675	$19,801,419	$20,597,605	$26,930,997	$28,957,689	84
Recipients	1,874	2,040	2,296	2,414	2,623	2,830	51
Expenditures per Recipient	$8,412	$8,152	$8,624	$8,533	$10,267	$10,232	22
% Waiver-Only	52%	52%	54%	54%	63%	65%	
Non-Waiver Services							
Expenditures	$14,722,651	$15,503,721	$16,951,952	$17,240,246	$15,753,166	$15,541,576	6
Recipients	2,031	2,142	2,385	2,526	2,700	2,852	40
Expenditures per Recipient	$7,249	$7,238	$7,108	$6,825	$5,835	$5,449	-25
Total Waiver							
Expenditures	$30,486,358	$32,134,396	$36,753,371	$37,837,852	$42,684,163	$44,499,265	46
Recipients	2,084	2,208	2,468	2,604	2,808	2,995	44
Expenditures per Recipient	$14,629	$14,554	$14,892	$14,531	$15,201	$14,858	2

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.

Table 53. Comprehensive Waiver Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Waiver Only Services						
Expenditures	$44,982	$63,719,016	$88,377,607	$88,527,446	$94,568,471	$112,673,503
Recipients	24	1,756	1,927	1,863	1,962	1,959
Expenditures per Recipient	$1,874	$36,286	$45,863	$47,519	$48,200	$57,516
% Waiver-Only	74%	84%	77%	81%	86%	90%
Non-Waiver Services						
Expenditures	$16,150	$11,813,805	$25,986,468	$21,106,234	$15,405,710	$12,909,462
Recipients	29	1,732	1,903	1,858	1,937	1,938
Expenditures per Recipient	$557	$6,821	$13,656	$11,360	$7,953	$6,661
Total Waiver						
Expenditures	$61,132	$75,532,821	$114,364,075	$109,633,679	$109,974,181	$125,582,965
Recipients	38	1,836	1,950	1,890	1,989	1,983
Expenditures per Recipient	$1,609	$41,140	$58,648	$58,007	$55,291	$63,330

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.

Table 54. Supports Waiver Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Waiver Only Services						
Expenditures	$454	$819,690	$2,780,450	$4,378,255	$5,795,651	$6,432,694
Recipients	1	191	425	540	565	569
Expenditures per Recipient	$454	$4,292	$6,542	$8,108	$10,258	$11,305
% Waiver-Only	80%	59%	54%	56%	60%	67%
Non-Waiver Services						
Expenditures	$114	$575,926	$2,371,351	$3,476,854	$3,795,863	$3,185,111
Recipients	3	180	406	514	552	555
Expenditures per Recipient	$38	$3,200	$5,841	$6,764	$6,877	$5,739
Total Waiver						
Expenditures	$568	$1,395,616	$5,151,800	$7,855,109	$9,591,514	$9,617,805
Recipients	3	204	443	555	581	585
Expenditures per Recipient	$189	$6,841	$11,629	$14,153	$16,509	$16,441

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. This waiver currently expires on December 31, 2019; however, a five-year extension is being requested for January 1, 2020 through December 31, 2024.

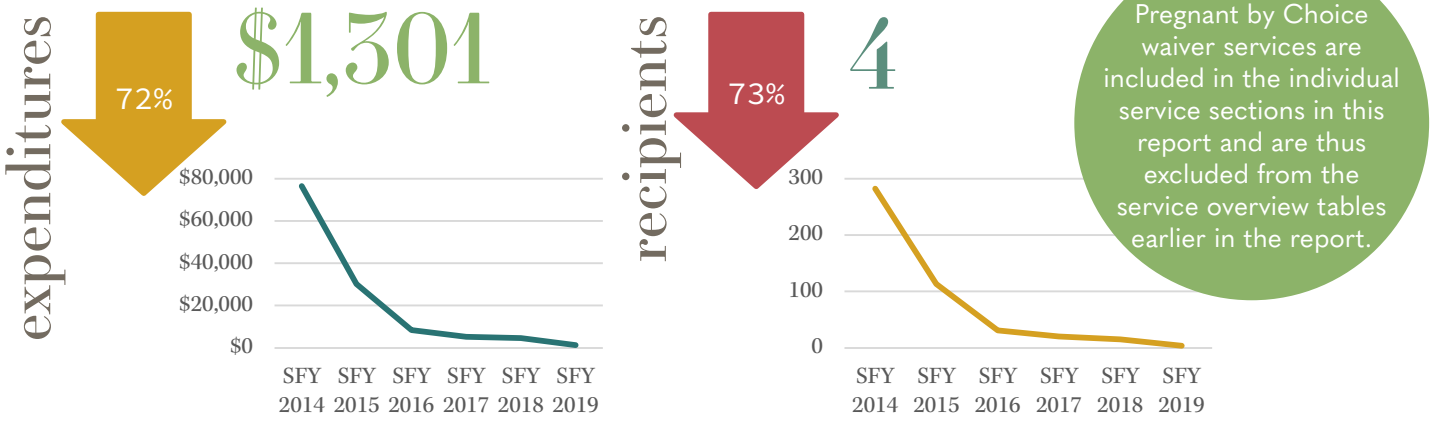


Table 55. Pregnant by Choice Waiver Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$76,481	$30,272	$8,356	$5,197	$4,597	$1,301	-98
Recipients	282	113	31	20	15	4	-99
Expenditures per Recipient	$271	$268	$270	$260	$306	$325	20

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 Committee

Six physicians, five pharmacists, and one allied health professional along with the Medicaid Medical Director, Pharmacy Program Manager, Pharmacist Consultant, and a drug information specialist from the University of Wyoming School of Pharmacy. Meets quarterly 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 when identifying potential issues, including, but not limited to, therapeutic duplication, drug-disease contraindications, drug-drug interactions, and potential adverse effects.

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 under-utilization, therapeutic duplication, drug-disease contraindications, drug-drug interactions, and other issues. This 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.

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 are also sent.

Review Clinical Evidence

The P&T Committee reviews evidence regarding the comparative safety and efficacy of medications, making recommendations to Medicaid for each reviewed class and providing input on clinical considerations included in the creation of the Medicaid Preferred Drug List (PDL).

Input from Medical Community

Actively solicits feedback about prior authorization policies from prescribers in Wyoming through direct mailings. Letters are sent to all specialists in affected areas, 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 allows providers an opportunity to participate in the decision-making process. Providers are encouraged to submit comments and concerns to the committee for review through public comment forms available on the DUR website. Providers may use this method to comment on both existing and 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.

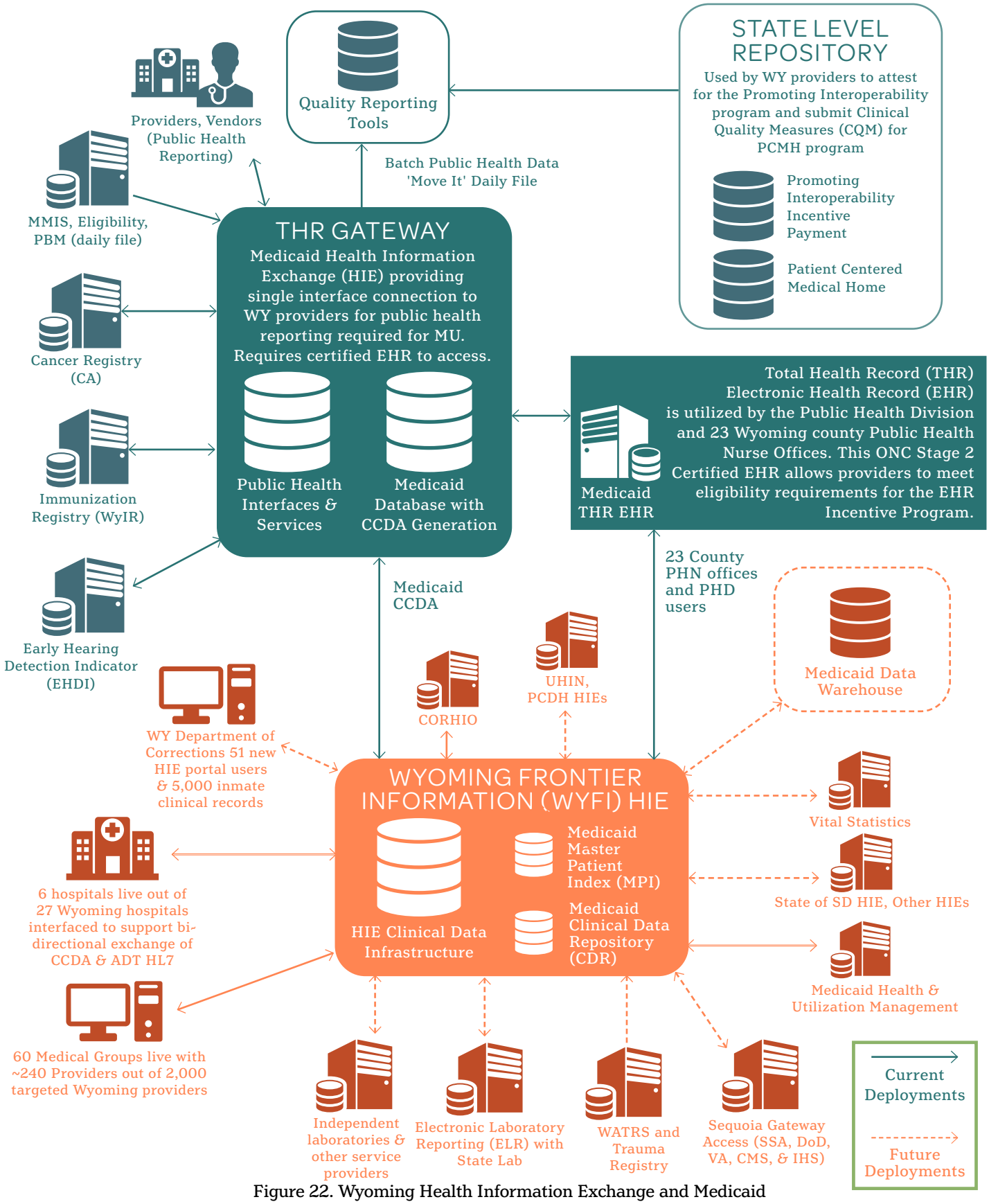


Figure 22. Wyoming Health Information Exchange and Medicaid

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.

promoting interoperability program

Medicaid established the Promoting Interoperability 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 Electronic Health Record system. Payments for this program are paid with 100% Federal Funds.

195 eligible professionals participated

24 eligible hospitals participated

$22.4 Million paid out since program implementation from 100% Federal funds

Professionals must have 30% Medicaid patients (20% for pediatricians) and increase utilization of the EHR to become and remain eligible to receive up to $63,750 over the 6 years they choose to participate.

Hospitals must have 10% Medicaid patients and increase utilization of the EHR to become and remain eligible, with the total incentive paid over the course of three years.

administrative transportation

Medicaid covers the cost of transportation to and from medical appointments if the appointment 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. Per diem expenses are reimbursable to family/legal guardian for recipients under age 21 for expanded services. This covers meals and commercial lodging at $25/day for inpatient and $50/day for outpatient.

Table 56. Administrative Transportation Summary

	SFY 2017	SFY 2018	SFY 2019
Expenditures	$77,953	$130,495	$191,305
Recipients	272	359	410
Expenditures per Recipient	$287	$363	$467

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

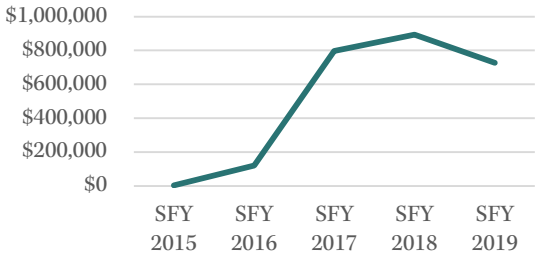
patient centered medical home

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.

expenditures

19%

$726,797



recipients

5%

18,247

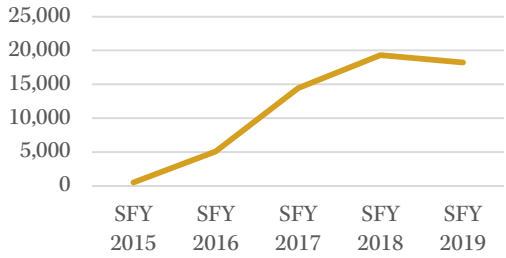


Table 57. Patient Centered Medical Home Summary

	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Expenditures	$3,839	$119,777	$796,389	$892,709	$726,797
Recipients	490	5,102	14,458	19,292	18,247
Expenditures per Recipient	$8	$23	$55	$46	$40
Participating Practices	3	7	13	19	21
Practitioners in Participating Practices	20	41	130	168	144

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

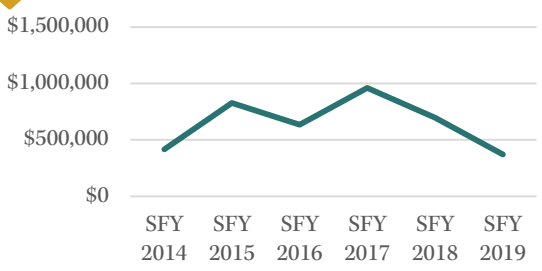
DIVERSION
for those at risk of needing nursing facility care or on ia nursing home for less than three months

TRANSITION
for those in a nursing facility or long-term care institution for at least three months

expenditures

47%

$370,667



recipients

21%

366

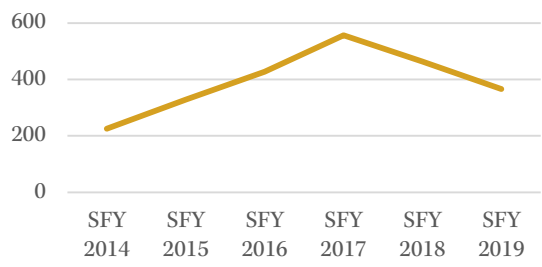


Table 58. Project Out Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Expenditures	$416,875	$826,482	$634,025	$960,164	$696,577	$370,667	-11%
Recipients	225	329	427	557	463	366	63%
Expenditures per Recipient	$1,853	$2,512	$1,485	$1,724	$1,504	$1,013	-45%

health check

This program provides the following services for children under age 21 under authority of Early Periodic Screening Detection and Treatment (EPSDT). Medicaid reimburses all Health Check screening exams and authorized follow-up care and treatment as long as the child is enrolled in Medicaid.

- Physical exams
- Immunizations
- Lab tests
- Growth/development check
- Nutrition check
- Vision/Hearing/Dental screenings
- Behavioral health assessment
- Health information
- Teen health education
- Transportation (ambulance & 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 may also be eligible for Medicaid services, dependent on income. These individuals are referred to as dual enrolled. For these members, Medicae 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.

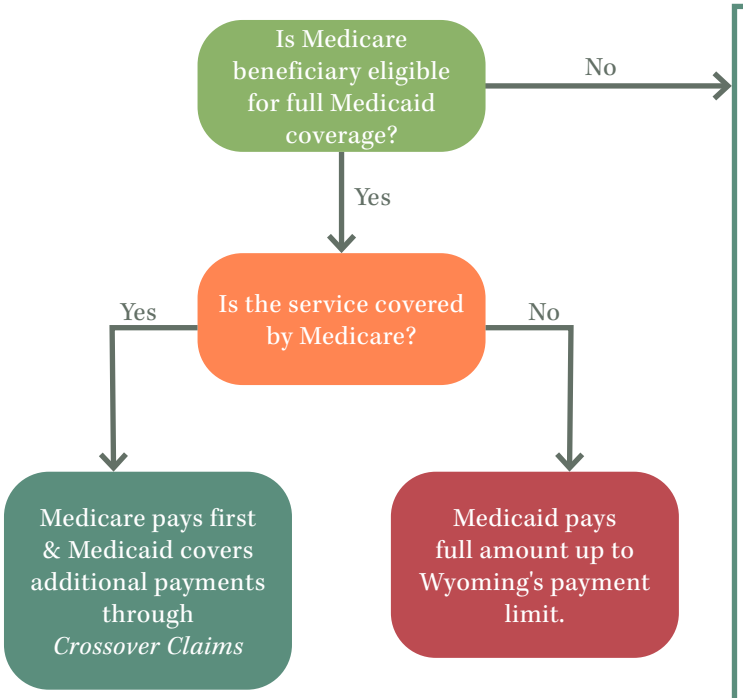


Figure 23. Dual Enrolled Claims Coverage Process

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

Table 59. Medicaid/Medicare Dual Enrollment Summary

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Dual Enrolled Members	11,246	12,496	12,679	12,941	13,134	13,294	18
Expenditures	$161,691,512	$184,462,807	$209,667,170	$212,314,487	$204,958,745	$203,596,896	26
Recipients (unduplicated)	8,646	9,872	10,508	10,810	10,983	11,085	28
Expenditures per Recipient	$18,701	$18,685	$19,953	$19,641	$18,661	$18,367	-2
Crossover Claims Expenditures	$16,951,537	$18,058,494	$17,547,805	$14,966,523	$7,751,187	$8,008,235	-53
Crossover Claims Expenditures as Percent of Total Dual Expenditures	10%	10%	8%	7%	4%	4%	-

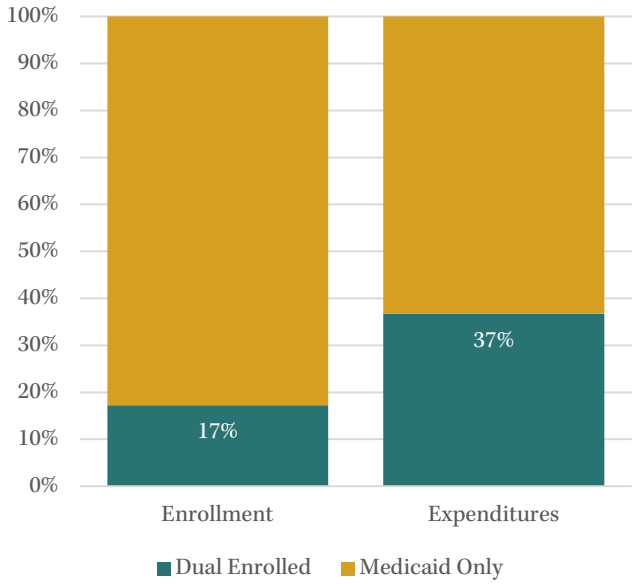


Figure 24. Dual Enrolled as Percent of Total Medicaid in SFY 2019

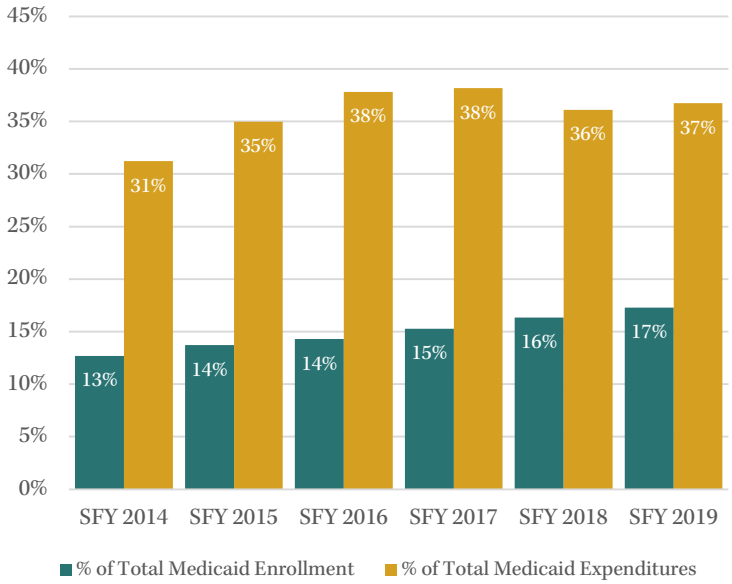


Figure 25. History of Dual Enrollment and Expenditures as Percent of Total Medicaid

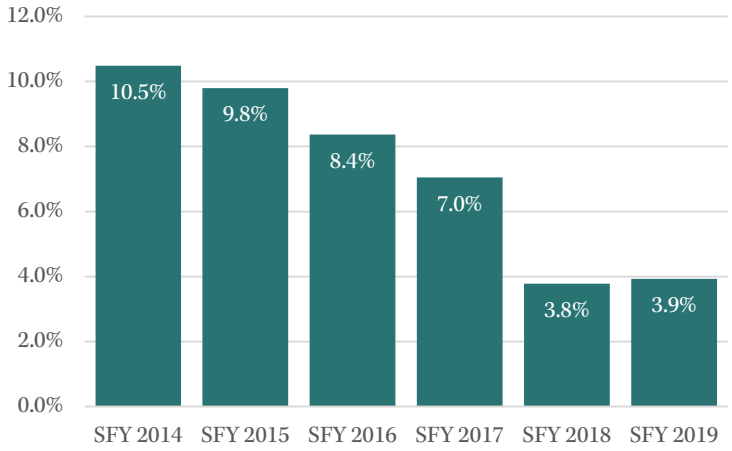


Figure 26. History of Crossover Expenditures as Percent of Total Dual Expenditures

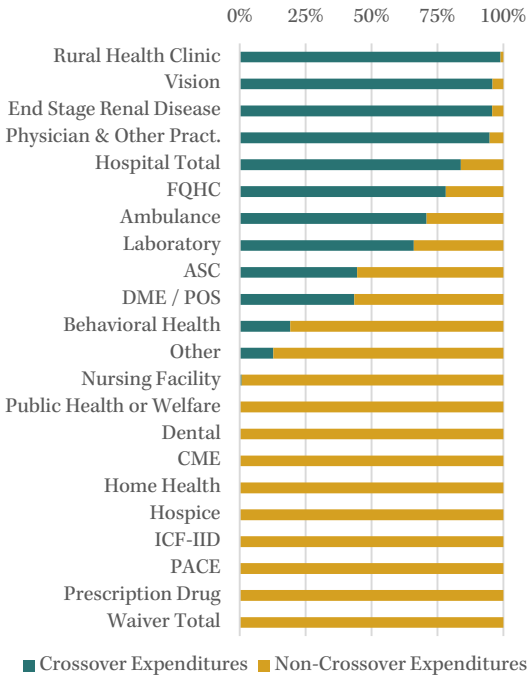


Figure 27. Crossover Expenditures as Percent of Dual Expenditures by Service Area

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

Table 60. Dual Enrolled Member Service Utilization Summary

Service Area	Expenditures	Recipients[30]	Expenditures per Recipient	Crossover Expenditures	Crossover Recipients	Crossover Expenditures per Recipient
Ambulance	$34,983	1,369	$26	$24,817	1,359	$18
Ambulatory Surgical Center	$48,801	290	$168	$21,760	281	$77
Behavioral Health	$1,297,209	2,268	$572	$248,262	1,690	$147
Care Management Entity	-$7,412	1	-$7,412	--	--	--
Dental	$432,714	1,869	$232	$5	1	$5
DME, Prosthetics/Orthotics/ Supplies	$2,176,304	3,441	$632	$946,462	3,071	$308
End Stage Renal Disease	$196,658	125	$1,573	$188,521	124	$1,520
Federally Qualified Health Center	$267,861	1,312	$204	$209,396	1,269	$165
Home Health	$39,813	22	$1,810	--	--	--
Hospice	$766,167	184	$4,164	--	--	--
Hospital Total	$2,214,552	7,627	$290	$1,857,168	7,658	$243
Inpatient	$1,086,650	2,017	$539	$801,330	2,026	$396
Outpatient	$1,095,087	7,403	$148	$1,022,848	7,425	$138
Intermediate Care Facility-IID	$11,344,885	47	$241,381	--	--	--
Laboratory	$10,556	1,599	$7	$6,974	1,586	$4
Nursing Facility	$78,208,064	2,334	$33,508	$500,007	1,036	$483
Other	$223,841	555	$403	$28,538	230	$124
PACE	$3,485,601	154	$22,634	--	--	--
Physician & Other Practitioner	$3,811,852	8,785	$434	$3,616,941	8,807	$411
Prescription Drug	$1,217,374	2,439	$499	--	--	--
Public Health or Welfare	$382,428	2,840	$135	$10	47	$0
Public Health, Federal	-$1,287,136	267	-$4,821	$15,299	144	$106
Rural Health Clinic	$263,781	1,191	$221	$261,068	1,197	$218
Vision	$86,526	1,982	$44	$83,005	1,967	$42
Waiver Total	$98,171,554	3,676	$26,706	--	--	--
Acquired Brain Injury	$11,675	14	$834	--	--	--
Community Choices	$24,884,337	2,404	$10,351	--	--	--
Comprehensive	$70,855,056	1,096	$64,649	--	--	--
Supports	$2,420,485	189	$12,807	--	--	--
Total	$203,596,896	11,085	$18,367	$8,008,235	9,949	$805

[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.

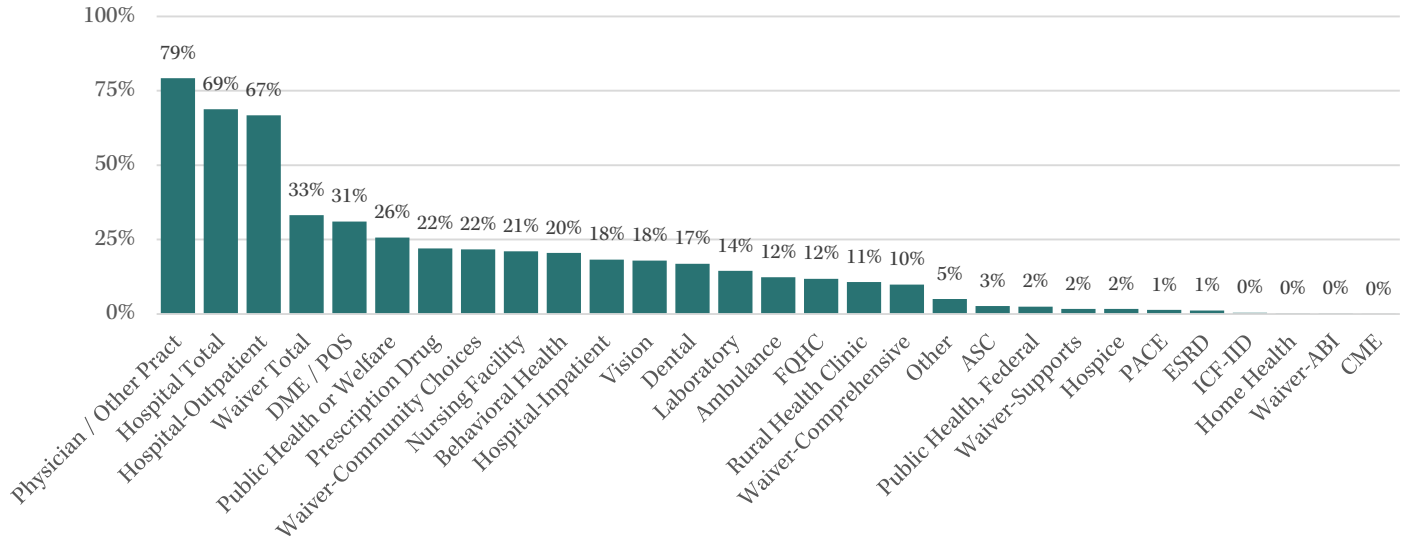


Figure 28. Percent of Total Unduplicated Dual Recipients by Service

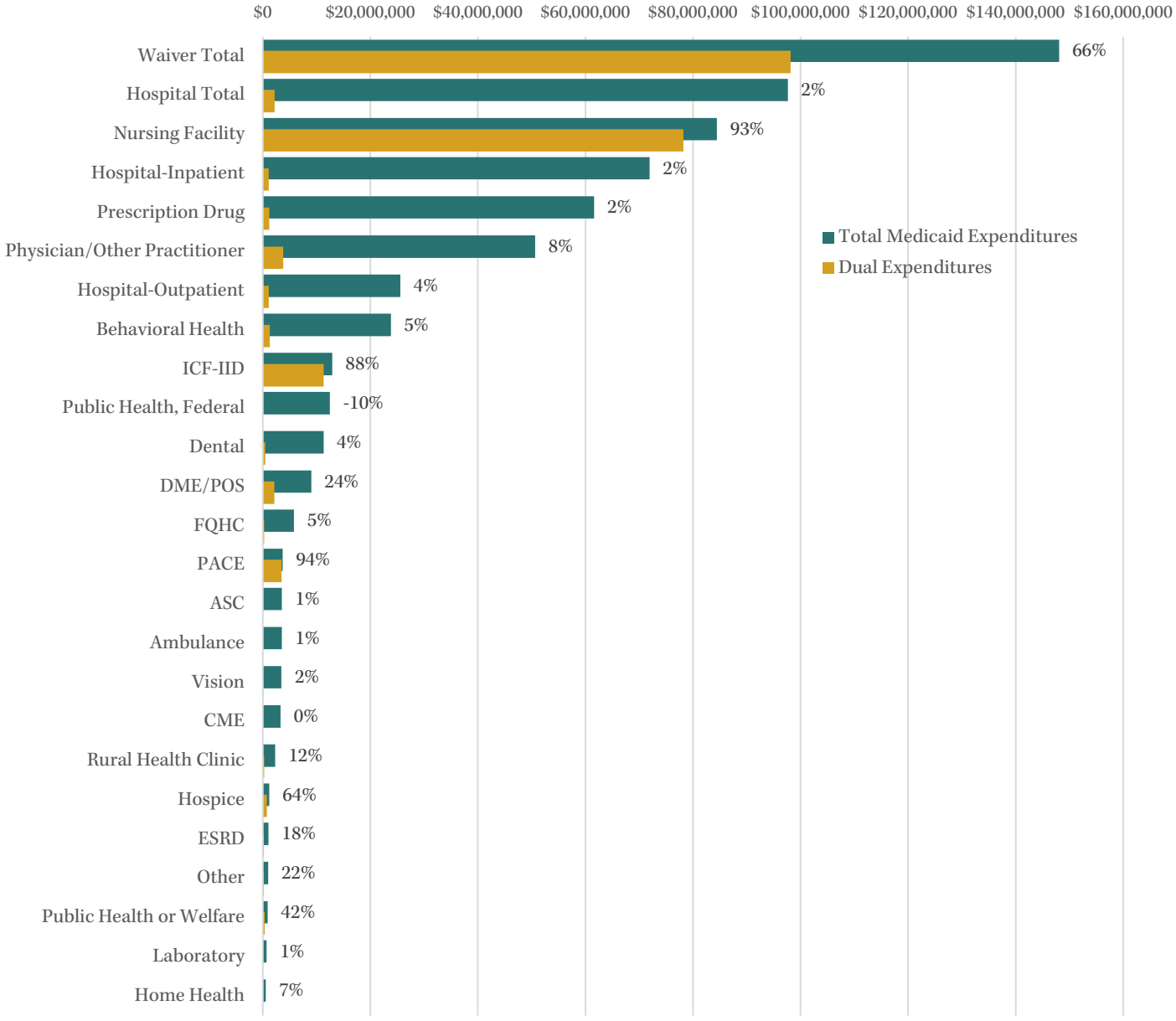


Figure 29. Dual Expenditures as Percent of Total Medicaid Expenditures by Service

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

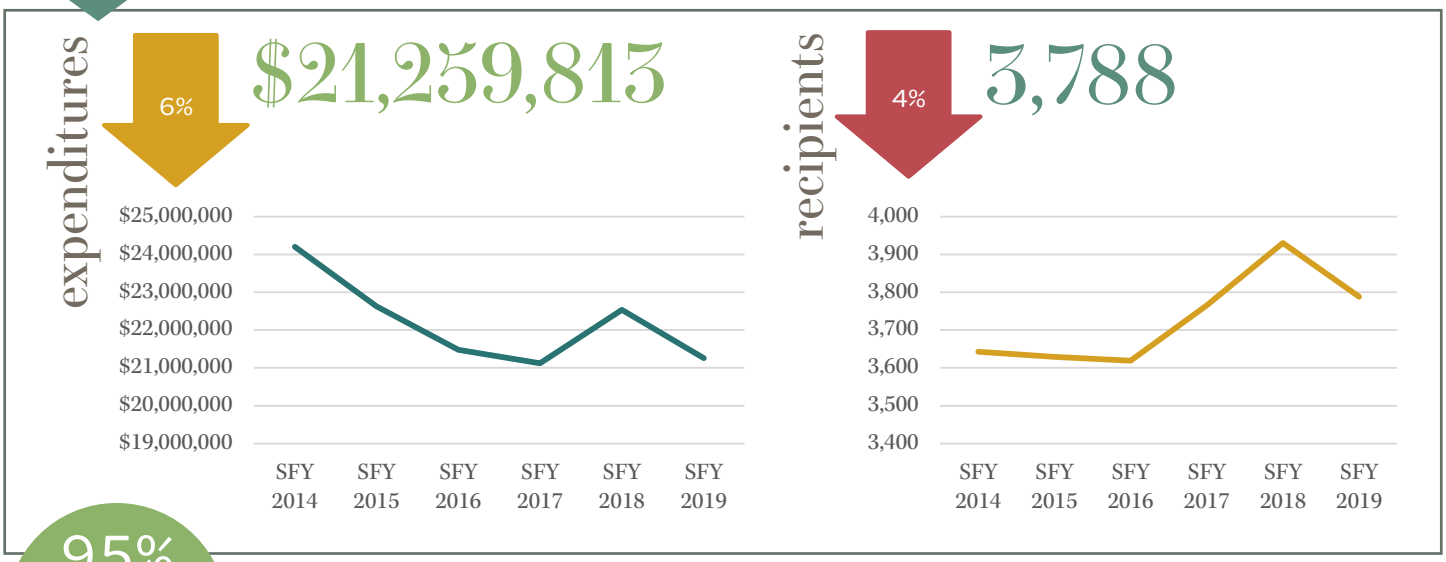
For children eligible for Medicaid. Foster children covered under Title IV-E of the Social Security Act and some children receiving federally reimbursed adoption subsidies must be covered by Medicaid. Wyoming also uses existing Medicaid eligibility groups to extend coverage to non-Title IV-E eligible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

282 children enrolled

$1,742,596 in claims expenditures



95% of foster care children are enrolled in Medicaid

Table 61. Foster Care Summary[31]

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Medicaid Foster Care							
Enrolled Members	4,096	4,253	4,228	4,102	4,159	3,995	-2
Expenditures	$24,197,999	$22,627,859	$21,473,583	$21,117,610	$22,534,237	$21,259,813	-12
Recipients	3,643	3,629	3,619	3,765	3,930	3,788	4
Expenditures per Recipient	$6,642	$6,235	$5,934	$5,609	$5,734	$5,612	-16
State-Only Foster Care							
Enrolled Members	173	211	203	310	316	282	63
Expenditures	$2,697,681	$2,852,108	$2,310,733	$1,776,060	$1,791,834	$1,742,596	-35
Recipients	385	319	328	318	328	326	-15
Expenditures per Recipient	$7,007	$8,941	$7,045	$5,585	$5,463	$5,345	-24

[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.

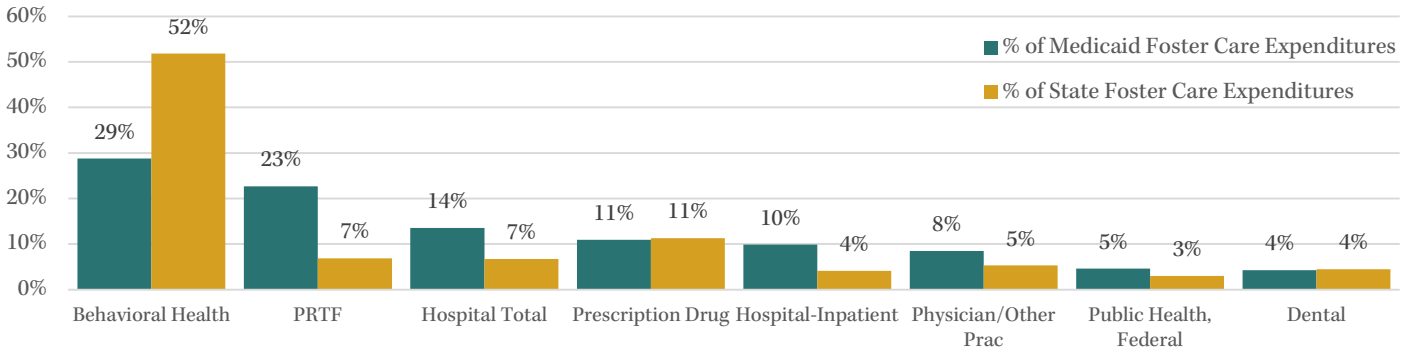


Figure 30. Percent of Foster Care Expenditures by Service - Medicaid versus State-Only

Table 62. 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	$140,446	106	$1,325	$14,777	5	$2,955
Ambulatory Surgical Center	$204,109	115	$1,775	$3,622	3	$1,207
Behavioral Health	$6,124,045	1,818	$3,369	$902,744	272	$3,319
Care Management Entity (CME)	$0	1	$0	--	--	--
Clinic/Center	$126,916	169	$751	--	--	--
Dental	$911,914	2,084	$438	$78,150	176	$444
DME, Prosthetics/Orthotics/ Supplies	$187,167	165	$1,134	$7,920	4	$1,980
Federally Qualified Health Center	$230,196	240	$959	$1,537	5	$307
Home Health	$423	1	$423	--	--	--
Hospital Total	$2,872,321	1,544	$1,860	$117,705	131	$899
Inpatient	$2,098,798	225	$9,328	$71,667	8	$8,958
Outpatient	$773,523	1,493	$518	$46,038	129	$357
Laboratory	$16,948	161	$105	$1,360	14	$97
Other	$47,616	208	$229	$3,827	32	$120
Physician & Other Practitioner	$1,802,139	2,984	$604	$92,183	198	$466
Prescription Drug	$2,322,951	2,371	$980	$196,297	213	$922
PRTF	$4,821,659	144	$33,484	$119,478	8	$14,935
Public Health or Welfare	$12,437	129	$96	$2,827	48	$59
Public Health, Federal	$982,956	299	$3,287	$52,046	10	$5,205
Rural Health Clinic	$123,506	340	$363	$1,554	7	$222
Vision	$332,067	1,256	$264	$38,588	136	$284
Total	$21,259,813	3,788	$5,612	$1,742,596	326	$5,345

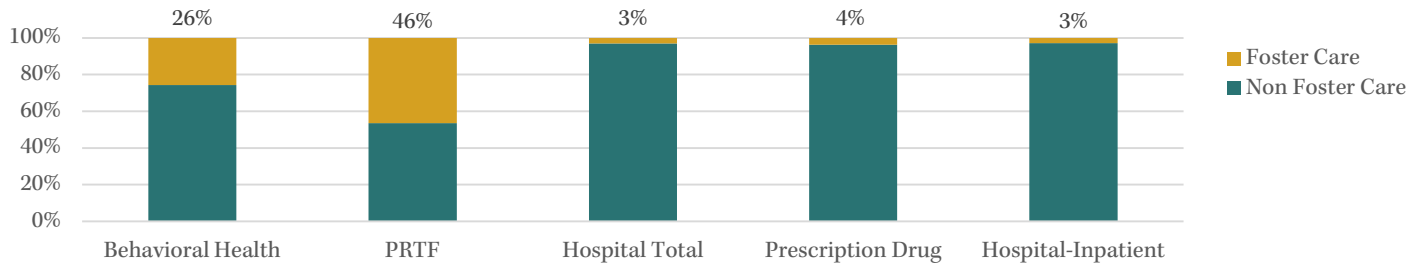


Figure 31. Medicaid Foster Care as Percent of Total Medicaid Expenditures for Top Foster Care Services

[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

Table 63. SFY 2019 Highlights and Initiatives Details

Highlight	Information
Legislation	
Medicaid Fairness	Implemented Birth Cost Recovery as required by the Medicaid Fairness Legislation
Certified Midwives	State Legislation and a State Plan Amendment now allows Certified Midwives to be Medicaid providers
Clubhouse-based psychosocial services	HB0257 directs the reimbursement for clubhouse services within the Medicaid program and allows Medicaid to enter into contracts with certified clubhouse providers for services. Prior to September 1, 2019, the department reported to the joint labor, health, and social services interim committee on information, findings, and recommendations related to clubhouse rehabilitation services including information to facilitate implementation of Medicaid contracts
School-based Services	State legislation authorized review and implementation for Medicaid reimbursement for school-based services
Physician UPL Program	Resulting from the 2019 General Session, WY Medicaid has been directed to design and implement a Physician UPL program, targeted at "physician and other professional service providers affiliated with a hospital". We envision this to be a broad-based provider tax program for eligible services/provider types.
Administration	
Access Review Monitoring Plan	As required by new federal rule to be completed every 3 years, conducted all appropriate surveys and analyses to complete and submit Wyoming's Access Review Monitoring Plan
CME Payment Methodology change	The concurrent 1915(b) and (c) waivers and the CME contract were amended to change the payment methodology from a risk-based capitated payment to fee-for-service payments for state plan and waiver services delivered by CME network providers and a per diem payment to the CME for administrative services provided.
Third Party Liability Processes & Procedures	Drafted procedures for TPL processes to include trust, estate recovery, hardship, and TPL. Removes some of the gray from the processes.
Tribal Eligibility	Entered into a contract to allow IHS workers to process application for Medicaid MAGI programs within WES. Training of IHS staff began in September 2019.
Policy	
Restricted Access to Online Adds in MMIS	Policy change to restrict access to the MMIS online adds so fewer people can make additions. This has decreased the number of incorrect online adds in the MMIS.
Temporary Residents	Updated policy to limit the amount of time a person can maintain Wyoming Medicaid when out of the state for more than 120 days.
Provider Enrollment Agreement	New provider enrollment agreement went into effect on April 1, 2019 to combine provider agreements from multiple WDH programs.

Highlight	Information
Technology	
Triple A for Better Health	Launched a new client assessment within WES. Assessment sent by email to clients when case is approved or at renewal. Referrals are sent to other agencies based on results. Have seen an increase in the number of assessments being completed and number of referrals being made.
Access to NEICE	WDH Coordinated with DFS to implement the National Electronic Interstate Compact Enterprise (NEICE) project. This allows WDH to access NEICE to verify ICPC children and provide Medicaid benefits faster.
WES POSSE Interface Enhancements	Launched POSSE enhancements within WES to improve the referral process for Child Support Enforcement.
Launched Bendex Interface in WES	Launched the Bendex Interface between SSA and WDH in WES
Buy-In Changes in WES and MMIS	Implemented changes to allow us to issue more than one program when a person is eligible for QMB or SLMB. This allows us to claim federal match on a larger number of clients.
DFS EDMS within WES	Leveraged WES to develop and deploy an Electronic Document Management System for use by DFS programs. Was able to use some 90/10 funding for the architecture changes needed to accomodate their program.
WINGS Pharmacy Benefit Management System	Final system certification letter received from CMS and MITRE.
WINGS System Integrator Implementation and Initial Go-Live	The System Integrator - Enterprise Service Bus (SI-ESB) was implemented as of November 2018.
WINGS Data Warehouse Implementation and Initial Go-Live	The Data Warehouse (DW) was implemented as of November 2018.
WINGS Fraud, Waste and Abuse Implementation and Initial Go-Live	The Fraud, Waste, and Abuse (FWA) solution was implemented as of May 2019.
WINGS Benefit Management System Procurement Completed	The Benefit Management System (BMS) was procured and awarded July 2019. Contract start is estimated for December 2019. The new BMS will include the provision of a TPL system and services.
WINGS Provider Enrollment, Screening and Monitoring (PRESM) Procurement Completed	The Provider Enrollment, Screening, and Monitoring (PRESM) module was procured and awarded February 2019. Contract start is expected August 2019.
MMIS Implementation of APR-DRG for Inpatient Hospitals	Implementation of APR-DRG effective February 1, 2019.
EVV Budget Approval	The Electronic Visit Verification System (EVV) was approved for federal CMS funding March 2019.

Table 64. 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 65. Waiver Services by Waiver

Waiver Service	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

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%
2018	6,549	2,206	34%

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

Table 67. County Summary

County	Enrolled Members[34]	% of Total Enrolled Members	Recipients[35]	% of Total Recipients	Expenditures	% of Total Expenditures
Albany	3,291	4.3%	3,103	4.4%	$22,612,229	4.1%
Big Horn	1,947	2.5%	1,817	2.5%	$14,248,154	2.6%
Campbell	5,660	7.4%	5,157	7.2%	$32,450,437	5.9%
Carbon	1,821	2.4%	1,671	2.3%	$8,734,187	1.6%
Converse	1,700	2.2%	1,634	2.3%	$11,308,831	2.0%
Crook	781	1.0%	727	1.0%	$3,536,530	0.6%
Fremont	9,307	12.1%	9,098	12.8%	$94,237,928	17.0%
Goshen	1,689	2.2%	1,591	2.2%	$14,658,747	2.6%
Hot Springs	759	1.0%	762	1.1%	$7,825,110	1.4%
Johnson	837	1.1%	791	1.1%	$5,373,082	1.0%
Laramie	13,286	17.3%	12,872	18.0%	$91,863,209	16.6%
Lincoln	1,668	2.2%	1,494	2.1%	$10,644,775	1.9%
Natrona	12,085	15.7%	11,558	16.2%	$89,158,517	16.1%
Niobrara	277	0.4%	263	0.4%	$1,713,893	0.3%
Other	1,634	2.1%	2,539	3.6%	$17,194,440	3.1%
Park	3,428	4.5%	3,229	4.5%	$22,364,156	4.0%
Platte	1,097	1.4%	1,033	1.4%	$7,103,658	1.3%
Sheridan	3,644	4.7%	3,376	4.7%	$22,558,261	4.1%
Sublette	635	0.8%	556	0.8%	$3,168,385	0.6%
Sweetwater	5,297	6.9%	4,925	6.9%	$30,440,422	5.5%
Teton	1,133	1.5%	1,041	1.5%	$5,567,434	1.0%
Uinta	3,080	4.0%	2,930	4.1%	$23,883,387	4.3%
Washakie	1,073	1.4%	1,017	1.4%	$7,807,387	1.4%
Weston	835	1.1%	778	1.1%	$5,771,678	1.0%
Overall	76,964		71,324		$554,224,838	

[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 2019

Provider Taxonomy	Providers	Recipients	Expenditures
Addiction Therapist/Practitioner (101YA0400X)	3	160	$210,373
Adult Health (363LA2200X)	1	21	$2,284
Advance Practice Nurse (364SP0808X)	9	1,023	$326,066
Allergy And Immunology, Allergy (207KA0200X)	5	629	$282,684
Ambulance (341600000X)	73	3,528	$3,543,958
Ambulatory Family Planning Facility (261QA0005X)	7	227	$51,977
Ambulatory Surgical (261QA1903X)	31	2,710	$3,555,184
Anesthesiology (207L00000X)	73	6,929	$2,449,632
Audiologist (231H00000X)	13	524	$141,981
Behavior Analyst (103K00000X)	3	55	$533,209
Case Management (251B00000X)	120	2,941	$29,146,077
Chiropractor (111N00000X)	54	1,815	$406,862
CHPR CME (251S00000X)	1	897	$3,290,255
Clinic/Center (261Q00000X)	12	1,142	$815,334
Clinical Genetics (M.D.) (207SG0201X)	1	22	$3,266
Clinical Medical Laboratory (291U00000X)	71	6,791	$719,701
Clinical Neuropsychologist (103G00000X)	4	55	$50,843
Clinical Psychologist (103TC0700X)	60	2,898	$5,179,123
Day Training, Developmentally Disabled Service (251C00000X)	656	2,710	$113,656,959
Dentist (122300000X)	29	3,079	$962,164
Dentist, General Practice (1223G0001X)	129	12,122	$3,985,182
Dermatology (207N00000X)	17	2,003	$271,678
Diagnostic Radiology (2085R0202X)	46	18,286	$1,677,907
Dietitian, Registered (133V00000X)	2	4	$617
Durable Medical Equipment And Medical Supplies (332B00000X)	222	6,995	$7,850,643
ECSII & CASII Evaluator (174400000X)	7	356	$58,231
Emergency Medicine (207P00000X)	32	17,861	$3,855,001
End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	16	150	$1,063,315
Endodontics (1223E0200X)	2	70	$49,611
Family Health (363LF0000X)	16	1,165	$251,881
Family Practice (207Q00000X)	93	21,640	$5,746,636
Federally Qualified Health Center (261QF0400X)	11	6,341	$5,776,571
General Acute Care Hospital (282N00000X)	112	31,427	$84,697,383
General Acute Care Hospital - Rural (282NR1301X)	27	9,043	$12,195,829
Hearing Aid Equipment (332S00000X)	8	251	$567,915
Home Health (251E00000X)	23	163	$570,570
Hospice Care, Community Based (251G00000X)	12	245	$1,190,302
Intermediate Care Facility, Intellectual Disabilities (315P00000X)	1	54	$12,901,888

Provider Taxonomy (continued)	Providers	Recipients	Expenditures
Internal Medicine (207R00000X)	60	15,185	$7,075,071
Internal Medicine, Cardiovascular Disease (207RC0000X)	19	2,166	$302,157
Internal Medicine, Endocrinology Diabetes And Metabolism (207RE0101X)	4	136	$21,509
Internal Medicine, Gastroenterology (207RG0100X)	6	1,239	$479,940
Internal Medicine, Geriatric Medicine (207RG0300X)	5	215	$43,908
Internal Medicine, Medical Oncology (207RX0202X)	4	418	$1,914,670
Internal Medicine, Nephrology (207RN0300X)	7	281	$64,890
Internal Medicine, Pulmonary Disease (207RP1001X)	10	351	$121,574
Internal Medicine, Rheumatology (207RR0500X)	2	121	$13,841
Interpreter (171R00000X)	3	62	$5,799
Licensed Clinic/Cert Social Worker (1041C0700X)	84	1,947	$2,962,987
Licensed Marriage & Family Therapist (106H00000X)	15	203	$391,014
Lodging (177F00000X)	2	156	$127,715
Medicare Defined Swing Bed Unit (275N00000X)	11	45	$479,918
Mental Health-Including Community Mental Health (261QM0801X)	26	5,025	$5,381,311
Midwife, Certified Nurse (367A00000X)	4	37	$31,747
Neurological Surgery (207T00000X)	10	114	$75,191
Nurse Anesthetist, Certified Registered (367500000X)	14	430	$78,819
Nurse Practitioner (363L00000X)	14	976	$200,823
Obstetrics And Gynecology (207V00000X)	28	3,353	$3,814,652
Obstetrics And Gynecology, Gynecology (207VG0400X)	3	197	$93,676
Obstetrics And Gynecology, Obstetrics (207VX0000X)	5	502	$503,347
Occupational Therapist (225X00000X)	17	535	$1,884,711
Ophthalmology (207W00000X)	32	1,992	$574,291
Optician (156FX1800X)	6	441	$57,048
Optometrist (152W00000X)	80	14,612	$3,409,020
Orthodontics (1223X0400X)	17	354	$420,012
Orthopedic Surgery (207X00000X)	32	4,165	$1,222,153
Otolaryngology (207Y00000X)	18	2,297	$679,438
PACE FMS - Waiver Provider (251X00000X)	1	409	$5,530,177
PACE Organization (251T00000X)	1	163	$3,693,978
Pathology (207ZP0105X)	16	1,878	$83,620
Pediatrics (363LP0200X)	2	88	$15,922
Pediatrics (208000000X)	67	12,683	$4,681,066
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	3	59	$208,703
Pedodontics (1223P0221X)	32	12,593	$5,007,670
Pharmacy (333600000X)	206	40,807	$61,385,109
Physical Medicine And Rehabilitation (208100000X)	15	340	$137,136
Physical Therapist (225100000X)	67	3,081	$2,491,622
Physician Assistant (363A00000X)	3	138	$21,168
Physician, General Practice (208D00000X)	58	21,300	$7,372,159
Plastic Surgery (2082S0099X)	7	35	$22,049
Podiatrist (213E00000X)	15	1,005	$47,751

Provider Taxonomy (continued)	Providers	Recipients	Expenditures
Professional Counselor (101YP2500X)	145	2,478	$4,176,857
Prosthetic/Orthotic Supplier (335E00000X)	28	576	$598,186
Psychiatric Hospital (283Q00000X)	3	22	$122,776
Psychiatric Residential Treatment Facility (323P00000X)	16	309	$10,391,372
Psychiatry And Neurology, Psychiatry (2084P0800X)	25	1,018	$1,813,284
Psychiatry And Neurology: Neurology (2084N0400X)	22	1,948	$467,204
Public Health Or Welfare (251K00000X)	24	7,592	$917,179
Public Health, Federal (261QP0904X)	5	4,135	$12,488,675
Rehabilitation Hospital (283X00000X)	3	111	$619,218
Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	59	$26,024
Rehabilitation, Substance Use Disorder (261QR0405X)	33	1,435	$2,793,311
Rural Health (261QR1300X)	32	6,114	$2,283,377
Skilled Nursing Facillity (314000000X)	56	2,492	$83,960,515
Speech-Language Pathologist (235Z00000X)	10	162	$242,416
Surgery, Oral & Maxillofacial (1223S0112X)	13	1,203	$879,442
Surgery, Pediatric (2086S0120X)	2	53	$30,182
Surgery, Vascular (2086S0129X)	5	60	$14,387
Surgery: General Surgery (208600000X)	30	1,640	$648,362
Taxi (344600000X)	1	177	$45,135
Thoracic Surgery (208G00000X)	2	15	$27,538
Transportation Service (347C00000X)	6	78	$18,455
Urology (208800000X)	13	1,191	$268,132
Unclassified	3	27	$224,355
Total	3,506	71,324	$554,224,838

Table 69. Top 20 Provider Taxonomies by Expenditures

Provider Taxonomy	Expenditures	Percent of Total Medicaid Expenditures
Day Training, Developmentally Disabled Service (251C00000X)	$113,656,959	21%
General Acute Care Hospital (282N00000X)	$84,697,383	15%
Skilled Nursing Facillity (314000000X)	$83,960,515	15%
Pharmacy (333600000X)	$61,385,109	11%
Case Management (251B00000X)	$29,146,077	5%
Intermediate Care Facility, Intellectual Disabilities (315P00000X)	$12,901,888	2%
Public Health, Federal (261QP0904X)	$12,488,675	2%
General Acute Care Hospital - Rural (282NR1301X)	$12,195,829	2%
Psychiatric Residential Treatment Facility (323P00000X)	$10,391,372	2%
Durable Medical Equipment And Medical Supplies (332B00000X)	$7,850,643	1%
Physician, General Practice (208D00000X)	$7,372,159	1%
Internal Medicine (207R00000X)	$7,075,071	1%
Federally Qualified Health Center (261QF0400X)	$5,776,571	1%
Family Practice (207Q00000X)	$5,746,636	1%
PACE FMS - Waiver Provider (251X00000X)	$5,530,177	1%
Mental Health-Including Community Mental Health (261QM0801X)	$5,381,311	1%
Clinical Psychologist (103TC0700X)	$5,179,123	1%
Pedodontics (1223P0221X)	$5,007,670	1%
Pediatrics (208000000X)	$4,681,066	1%
Professional Counselor (101YP2500X)	$4,176,857	1%
Total for Top 20 Providers	$484,601,091	87%

Table 70. Provider Count History by Taxonomy

Provider Taxonomy	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Addiction Therapist/Practitioner (101YA0400X)	--	2	4	4	3	3	--
Adult Health (363LA2200X)	--	1	1	1	1	1	--
Advance Practice Nurse (364SP0808X)	9	9	12	14	12	9	0
Allergy And Immunology, Allergy (207KA0200X)	8	10	9	6	5	5	-38
Ambulance (341600000X)	69	72	68	64	63	73	6
Ambulatory Family Planning Facility (261QA0005X)	10	9	9	9	7	7	-30
Ambulatory Surgical (261QA1903X)	37	34	33	28	28	31	-16
Anesthesiology (207L00000X)	83	81	87	73	78	73	-12
Audiologist (231H00000X)	16	17	15	14	12	13	-19
Behavior Analyst (103K00000X)	--	--	--	--	5	3	--
Case Management (251B00000X)	104	101	101	115	114	120	15
Chiropractor (111N00000X)	17	13	34	50	52	54	218
CHPR CME (251S00000X)	--	--	1	1	1	1	--
Clinic/Center (261Q00000X)	13	12	12	14	23	12	-8
Clinical Genetics (M.D.) (207SG0201X)	--	--	--	1	1	1	--

Provider Taxonomy (continued)	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Clinical Medical Laboratory (291U00000X)	81	84	90	85	74	71	-12
Clinical Neuropsychologist (103G00000X)	--	2	2	2	4	4	--
Clinical Psychologist (103TC0700X)	126	122	96	76	69	60	-52
Day Training, Developmentally Disabled Service (251C00000X)	713	665	614	629	649	656	-8
Dentist (122300000X)	31	35	28	29	27	29	-6
Dentist, General Practice (1223G0001X)	149	154	149	137	130	129	-13
Dermatology (207N00000X)	16	17	15	13	15	17	6
Diagnostic Radiology (2085R0202X)	51	49	45	46	49	46	-10
Dietitian, Registered (133V00000X)	--	--	--	1	2	2	--
Durable Medical Equipment And Medical Supplies (332B00000X)	262	255	246	234	231	222	-15
ECSII & CASII Evaluator (174400000X)	--	--	--	--	7	7	--
Emergency Medicine (207P00000X)	29	38	39	36	32	32	10
End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	16	13	14	15	15	16	0
Endodontics (1223E0200X)	6	5	5	3	3	2	-67
Family Health (363LF0000X)	16	17	16	15	12	16	0
Family Practice (207Q00000X)	102	99	88	86	84	93	-9
Federally Qualified Health Center (261QF0400X)	8	10	9	12	11	11	38
General Acute Care Hospital (282N00000X)	196	193	190	114	114	112	-43
General Acute Care Hospital - Rural (282NR1301X)	39	36	42	36	30	27	-31
Hearing Aid Equipment (332S00000X)	17	16	12	11	9	8	-53
Home Health (251E00000X)	32	33	30	29	25	23	-28
Hospice Care, Community Based (251G00000X)	15	14	11	12	13	12	-20
Intermediate Care Facility, Intellectual Disabilities (315P00000X)	1	1	1	1	1	1	0
Internal Medicine (207R00000X)	68	60	68	55	57	60	-12
Internal Medicine, Cardiovascular Disease (207RC0000X)	19	17	26	17	18	19	0
Internal Medicine, Endocrinology Diabetes And Metabolism (207RE0101X)	6	7	8	4	4	4	-33
Internal Medicine, Gastroenterology (207RG0100X)	8	6	9	4	6	6	-25
Internal Medicine, Geriatric Medicine (207RG0300X)	2	2	2	4	4	5	150
Internal Medicine, Medical Oncology (207RX0202X)	15	12	11	7	6	4	-73
Internal Medicine, Nephrology (207RN0300X)	9	9	9	6	6	7	-22
Internal Medicine, Pulmonary Disease (207RP1001X)	15	13	12	11	9	10	-33
Internal Medicine, Rheumatology (207RR0500X)	4	4	4	2	2	2	-50
Interpreter (171R00000X)	1	1	1	1	2	3	200
Licensed Clinic/Cert Social Worker (1041C0700X)	2	43	60	74	77	84	4,100

Provider Taxonomy (continued)	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Licensed Marriage & Family Therapist (106H00000X)	--	8	10	15	13	15	--
Lodging (177F00000X)	--	--	--	2	3	2	--
Medicare Defined Swing Bed Unit (275N00000X)	9	9	10	11	15	11	22
Mental Health-Including Community Mental Health (261QM0801X)	30	27	27	27	26	26	-13
Midwife, Certified Nurse (367A00000X)	5	5	9	7	8	4	-20
Neurological Surgery (207T00000X)	18	14	16	12	10	10	-44
Nurse Anesthetist, Certified Registered (367500000X)	22	23	21	16	13	14	-36
Nurse Practitioner (363L00000X)	11	10	10	9	9	14	27
Obstetrics And Gynecology (207V00000X)	49	48	48	40	33	28	-43
(363LX0001X)	6	2	1	--	--	--	-100
Obstetrics And Gynecology, Gynecology (207VG0400X)	4	5	6	5	5	3	-25
Obstetrics And Gynecology, Obstetrics (207VX0000X)	2	2	5	5	5	5	150
Occupational Therapist (225X00000X)	17	18	20	21	20	17	0
Ophthalmology (207W00000X)	34	36	34	25	30	32	-6
Optician (156FX1800X)	10	11	9	6	6	6	-40
Optometrist (152W00000X)	92	102	98	93	89	80	-13
Orthodontics (1223X0400X)	17	14	16	17	15	17	0
Orthopedic Surgery (207X00000X)	40	35	37	36	34	32	-20
Otolaryngology (207Y00000X)	26	26	27	24	19	18	-31
PACE FMS - Waiver Provider (251X00000X)	--	1	1	2	1	1	--
PACE Organization (251T00000X)	1	1	1	1	1	1	0
Pathology (207ZP0105X)	22	22	22	19	17	16	-27
Pediatrics (208000000X)	68	72	73	97	76	67	-1
Pediatrics (363LP0200X)	1	1	2	2	2	2	100
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	9	8	6	5	5	3	-67
Pedodontics (1223P0221X)	31	33	34	32	34	32	3
Periodontics (1223P0300X)	1	1	1	--	--	--	-100
Pharmacy (333600000X)	200	206	207	205	208	206	3
Phlebotomy/WY Health Fair (246RP1900X)	1	1	1	--	--	--	-100
Physical Medicine And Rehabilitation (208100000X)	15	14	17	14	12	15	0
Physical Therapist (225100000X)	56	61	60	63	62	67	20
Physician Assistant (363A00000X)	--	1	1	1	1	3	--
Physician, General Practice (208D00000X)	77	74	81	67	62	58	-25
Plastic Surgery (2082S0099X)	16	15	10	11	11	7	-56
Podiatrist (213E00000X)	14	17	16	13	11	15	7
Professional Counselor (101YP2500X)	3	64	97	123	138	145	4,733
Prosthetic/Orthotic Supplier (335E00000X)	24	31	27	26	31	28	17

Provider Taxonomy (continued)	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Psychiatric Hospital (283Q00000X)	4	4	2	3	3	3	-25
Psychiatric Residential Treatment Facility (323P00000X)	21	20	17	14	13	16	-24
Psychiatry And Neurology, Psychiatry (2084P0800X)	41	35	32	31	26	25	-39
Psychiatry And Neurology: Neurology (2084N0400X)	26	27	26	20	19	22	-15
Public Health Or Welfare (251K00000X)	24	24	24	24	24	24	0
Public Health, Federal (261QP0904X)	2	2	4	4	4	5	150
Radiology: Mobile (261QR0208X)	2	1	2	--	--	--	-100
Rehabilitation Hospital (283X00000X)	4	4	3	2	3	3	-25
Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	1	1	1	1	1	0
Rehabilitation, Substance Use Disorder (261QR0405X)	28	32	32	31	32	33	18
Residential Treatment Facility For Emotionally Disturbed (322D00000X)	--	1	3	--	--	--	--
Rural Health (261QR1300X)	21	22	23	21	24	32	52
Skilled Nursing Facillity (314000000X)	50	51	53	53	52	56	12
Speech-Language Pathologist (235Z00000X)	9	13	10	9	9	10	11
Surgery, Oral & Maxillofacial (1223S0112X)	13	17	14	16	11	13	0
Surgery, Pediatric (2086S0120X)	2	2	3	5	2	2	0
Surgery, Vascular (2086S0129X)	5	5	6	4	4	5	0
Surgery: General Surgery (208600000X)	39	38	43	33	30	30	-23
Taxi (344600000X)	--	--	--	1	1	1	--
Thoracic Surgery (208G00000X)	2	4	5	3	2	2	0
Transportation Service (347C00000X)	--	--	--	4	4	6	--
Urology (208800000X)	22	18	17	16	13	13	-41
Unclassified	1	1	1	1	1	1	0
Total	3,662	3,694	3,654	3,531	3,502	3,506	-4

Table 71. Provider Expenditures History by Taxonomy

Eligibility Category	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Addiction Therapist/Practitioner (101YA0400X)	--	$10,121	$112,463	$235,019	$207,018	$210,373	--
Adult Health (363LA2200X)	--	$1,791	$1,789	$7	$2,582	$2,284	--
Advance Practice Nurse (364SP0808X)	$272,949	$319,007	$286,789	$335,697	$363,266	$326,066	19
Allergy And Immunology, Allergy (207KA0200X)	$470,077	$473,744	$444,553	$372,655	$396,665	$282,684	-40
Ambulance (341600000X)	$3,760,537	$4,352,067	$3,571,623	$3,847,375	$2,381,969	$3,543,958	-6
Ambulatory Family Planning Facility (261QA0005X)	$71,213	$69,754	$55,497	$62,853	$51,449	$51,977	-27
Ambulatory Surgical (261QA1903X)	$4,039,944	$6,090,776	$5,953,159	$4,095,973	$3,881,705	$3,555,184	-12
Anesthesiology (207L00000X)	$2,459,938	$2,519,148	$2,568,307	$2,697,539	$2,488,633	$2,449,632	0
Audiologist (231H00000X)	$114,987	$134,326	$123,718	$158,494	$229,847	$141,981	23
Behavior Analyst (103K00000X)	--	--	--	--	$167,595	$533,209	--
Case Management (251B00000X)	$15,957,620	$16,927,792	$20,056,159	$21,007,543	$27,226,271	$29,146,077	83
Chiropractor (111N00000X)	$5,661	$6,347	$99,664	$280,207	$347,441	$406,862	7088
CHPR CME (251S00000X)	--	--	$5,021,978	$7,135,148	$7,599,455	$3,290,255	--
Clinic/Center (261Q00000X)	$1,295,561	$1,339,630	$1,361,953	$1,327,800	$972,701	$815,334	-37
Clinical Genetics (M.D.) (207SG0201X)	--	--	--	$2,583	$6,455	$3,266	--
Clinical Medical Laboratory (291U00000X)	$1,284,678	$1,516,042	$1,536,310	$844,218	$1,020,356	$719,701	-44
Clinical Neuropsychologist (103G00000X)	--	$2,071	$642	$8,924	$78,578	$50,843	--
Clinical Psychologist (103TC0700X)	$13,859,094	$14,027,227	$13,790,956	$7,871,344	$5,690,754	$5,179,123	-63
Day Training, Developmentally Disabled Service (251C00000X)	$102,940,502	$94,141,526	$93,766,911	$95,950,535	$100,791,096	$113,656,959	10
Dentist (122300000X)	$1,242,847	$1,345,202	$1,445,036	$1,468,732	$1,051,336	$962,164	-23
Dentist, General Practice (1223G0001X)	$6,128,204	$6,400,779	$7,171,071	$6,085,423	$4,331,962	$3,985,182	-35
Dermatology (207N00000X)	$277,674	$276,343	$253,755	$272,569	$300,262	$271,678	-2
Diagnostic Radiology (2085R0202X)	$2,699,798	$2,218,816	$2,018,120	$1,821,704	$1,794,304	$1,677,907	-38
Dietitian, Registered (133V00000X)	--	--	--	$391	$1,803	$617	--
Durable Medical Equipment And Medical Supplies (332B00000X)	$6,427,307	$6,970,432	$6,610,828	$7,360,167	$6,944,732	$7,850,643	22
Ecsii & Casii Evaluator (174400000X)	--	--	--	--	$61,574	$58,231	--
Emergency Medicine (207P00000X)	$3,459,580	$3,862,924	$3,198,766	$4,130,517	$4,026,740	$3,855,001	11

Eligibility Category (Continued)	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	$1,071,750	$1,099,569	$948,612	$1,267,034	$1,012,427	$1,063,315	-1
Endodontics (1223E0200X)	$116,279	$125,417	$51,569	$43,105	$52,582	$49,611	-57
Family Health (363LF0000X)	$299,442	$368,970	$311,405	$268,262	$246,169	$251,881	-16
Family Practice (207Q00000X)	$6,684,566	$5,824,202	$6,384,974	$6,805,220	$6,424,856	$5,746,636	-14
Federally Qualified Health Center (261QF0400X)	$2,698,283	$3,259,793	$3,689,548	$5,725,094	$11,418,874	$5,776,571	114
General Acute Care Hospital (282N00000X)	$85,099,651	$86,971,143	$91,167,750	$83,353,763	$84,380,731	$84,697,383	0
General Acute Care Hospital - Rural (282NR1301X)	$15,639,679	$16,389,825	$15,380,672	$14,474,403	$11,942,562	$12,195,829	-22
Hearing Aid Equipment (332S00000X)	$613,437	$940,058	$790,555	$912,176	$831,358	$567,915	-7
Home Health (251E00000X)	$3,533,728	$4,618,885	$9,467,835	$9,596,803	$4,012,083	$570,570	-84
Hospice Care, Community Based (251G00000X)	$1,468,295	$1,157,101	$1,014,959	$1,316,838	$1,394,149	$1,190,302	-19
Intermediate Care Facility, Intellectual Disabilities (315P00000X)	$19,152,530	$18,091,427	$18,193,221	$19,204,867	$13,999,444	$12,901,888	-33
Internal Medicine (207R00000X)	$4,913,549	$4,966,149	$6,899,612	$7,938,991	$7,076,336	$7,075,072	44
Internal Medicine, Cardiovascular Disease (207RC0000X)	$474,579	$437,224	$388,767	$419,095	$291,341	$302,157	-36
Internal Medicine, Endocrinology Diabetes And Metabolism (207RE0101X)	$29,923	$37,657	$19,270	$22,999	$18,807	$21,509	-28
Internal Medicine, Gastroenterology (207RG0100X)	$348,782	$377,353	$442,390	$495,528	$550,096	$479,940	38
Internal Medicine, Geriatric Medicine (207RG0300X)	$18,321	$17,669	$20,590	$27,816	$12,796	$43,908	140
Internal Medicine, Medical Oncology (207RX0202X)	$3,230,629	$2,493,943	$1,632,500	$2,469,020	$2,756,577	$1,914,670	-41
Internal Medicine, Nephrology (207RN0300X)	$43,608	$54,404	$51,808	$26,828	$37,495	$64,890	49
Internal Medicine, Pulmonary Disease (207RP1001X)	$91,813	$83,584	$77,414	$147,096	$102,784	$121,574	32
Internal Medicine, Rheumatology (207RR0500X)	$43,863	$49,969	$15,778	$18,310	$13,849	$13,841	-68
Interpreter (171R00000X)	$38,171	$56,339	$47,205	$32,056	$22,119	$5,799	-85
Licensed Clinic/Cert Social Worker (1041C0700X)	$1,124	$907,851	$2,284,684	$3,213,974	$3,274,619	$2,962,987	263,527
Licensed Marriage & Family Therapist (106H00000X)	--	$161,044	$280,470	$298,392	$510,758	$391,014	--
Lodging (177F00000X)	--	--	--	$53,950	$85,915	$127,715	--
Medicare Defined Swing Bed Unit (275N00000X)	$796,835	$833,841	$775,338	$462,413	$620,073	$479,918	-40
Mental Health-Including Community Mental Health (261QM0801X)	$9,097,476	$8,668,925	$7,930,515	$7,681,061	$6,195,978	$5,381,311	-41
Midwife, Certified Nurse (367A00000X)	$19,024	$19,041	$51,381	$89,855	$64,608	$31,747	67
Neurological Surgery (207T00000X)	$964,837	$955,405	$536,628	$251,854	$69,210	$75,191	-92
Nurse Anesthetist, Certified Registered (367500000X)	$376,138	$227,083	$189,955	$73,627	$65,899	$78,819	-79

Eligibility Category (Continued)	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Nurse Practitioner (363L00000X)	$139,782	$336,154	$336,366	$297,224	$142,851	$200,823	44
Obstetrics And Gynecology (207V00000X)	$7,505,927	$6,832,110	$5,733,312	$4,887,444	$4,563,484	$3,814,652	-49
(363LX0001X)	$18,749	$6,019	$7,023	--	--	--	-100
Obstetrics And Gynecology, Gynecology (207VG0400X)	$3,609	$11,932	$80,997	$164,003	$134,985	$93,676	2495
Obstetrics And Gynecology, Obstetrics (207VX0000X)	$3,204	$10,974	$417,994	$655,371	$534,587	$503,347	15611
Occupational Therapist (225X00000X)	$1,206,851	$2,260,765	$3,053,289	$3,199,864	$2,904,323	$1,884,711	56
Ophthalmology (207W00000X)	$651,370	$690,214	$606,722	$604,685	$584,656	$574,291	-12
Optician (156FX1800X)	$97,813	$74,200	$80,235	$68,054	$56,048	$57,048	-42
Optometrist (152W00000X)	$3,366,582	$3,521,016	$3,571,953	$3,782,521	$3,656,808	$3,409,020	1
Orthodontics (1223X0400X)	$406,649	$406,253	$547,443	$543,829	$368,831	$420,012	3
Orthopedic Surgery (207X00000X)	$1,262,261	$1,422,229	$1,404,323	$1,628,003	$1,534,594	$1,222,153	-3
Otolaryngology (207Y00000X)	$893,581	$957,868	$895,930	$917,671	$795,300	$679,438	-24
PACE FMS - Waiver Provider (251X00000X)	--	$2,707,383	$4,434,368	$3,975,987	$4,570,890	$5,530,177	--
PACE Organization (251T00000X)	$1,288,934	$2,242,570	$2,934,877	$3,520,283	$3,471,255	$3,693,978	187
Pathology (207ZP0105X)	$329,317	$170,879	$164,404	$145,815	$142,709	$83,620	-75
Pediatrics (208000000X)	$6,382,497	$5,662,679	$5,455,184	$5,310,575	$4,878,853	$4,681,066	-27
Pediatrics (363LP0200X)	$7,004	$10,995	$12,213	$20,832	$20,745	$15,922	127
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	$753,617	$452,942	$248,989	$227,825	$295,963	$208,703	-72
Pedodontics (1223P0221X)	$4,706,746	$5,148,703	$5,008,474	$4,894,424	$4,936,642	$5,007,670	6
Periodontics (1223P0300X)	$527	$2,341	$480	--	--	--	-100
Pharmacy (333600000X)	$41,151,323	$47,785,528	$48,325,155	$50,007,275	$57,006,524	$61,385,109	49
Phlebotomy/WY Health Fair (246RP1900X)	$5,870	$1,920	$575	--	--	--	-100
Physical Medicine And Rehabilitation (208100000X)	$170,506	$191,749	$128,026	$111,247	$119,039	$137,136	-20
Physical Therapist (225100000X)	$2,695,796	$2,917,423	$3,382,286	$3,286,973	$2,653,095	$2,491,622	-8
Physician Assistant (363A00000X)	--	$589	$577	$86	$4,294	$21,168	--
Physician, General Practice (208D00000X)	$9,844,730	$10,113,348	$7,598,341	$7,254,319	$7,406,209	$7,372,159	-25
Plastic Surgery (2082S0099X)	$130,775	$116,240	$90,174	$85,222	$22,339	$22,049	-83
Podiatrist (213E00000X)	$77,507	$78,388	$79,404	$72,405	$58,482	$47,751	-38
Professional Counselor (101YP2500X)	$26,127	$2,338,814	$3,676,332	$5,605,555	$5,024,798	$4,176,857	15,887
Prosthetic/Orthotic Supplier (335E00000X)	$587,006	$720,162	$798,679	$757,241	$615,641	$598,186	2

Eligibility Category (Continued)	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	5 Year % Change
Psychiatric Hospital (283Q00000X)	$203,859	$275,227	$127,648	$75,848	$200,677	$122,776	-40
Psychiatric Residential Treatment Facility (323P00000X)	$14,886,133	$13,575,847	$11,797,657	$12,121,830	$12,537,788	$10,391,372	-30
Psychiatry And Neurology, Psychiatry (2084P0800X)	$3,177,882	$2,650,594	$2,705,413	$2,552,807	$2,270,198	$1,813,284	-43
Psychiatry And Neurology: Neurology (2084N0400X)	$968,721	$1,354,679	$959,006	$805,683	$621,258	$467,204	-52
Public Health Or Welfare (251K00000X)	$962,164	$1,009,814	$1,072,715	$912,444	$881,179	$917,179	-5
Public Health, Federal (261QP0904X)	$7,999,556	$8,761,358	$8,479,944	$8,718,888	$19,625,445	$12,488,675	56
Radiology: Mobile (261QR0208X)	$226	$52	$7	--	--	--	-100
Rehabilitation Hospital (283X00000X)	$988,087	$887,751	$1,016,080	$563,688	$562,051	$619,218	-37
Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	$143,525	$154,682	$146,226	$84,406	$29,156	$26,024	-82
Rehabilitation, Substance Use Disorder (261QR0405X)	$4,168,317	$4,793,708	$3,895,890	$2,997,914	$2,939,968	$2,793,311	-33
Residential Treatment Facility For Emotionally Disturbed (322D00000X)	--	$35,712	$237,904	--	--	--	--
Rural Health (261QR1300X)	$1,521,233	$1,668,167	$1,413,842	$1,540,607	$1,894,505	$2,283,377	50
Skilled Nursing Facillity (314000000X)	$72,070,098	$69,520,419	$81,670,473	$86,538,699	$86,684,517	$83,960,515	16
Speech-Language Pathologist (235Z00000X)	$723,116	$745,421	$714,369	$688,314	$407,957	$242,416	-66
Surgery, Oral & Maxillofacial (1223S0112X)	$790,683	$1,045,169	$1,225,956	$1,132,105	$1,106,227	$879,442	11
Surgery, Pediatric (2086S0120X)	$67,096	$80,089	$57,200	$76,375	$32,996	$30,182	-55
Surgery, Vascular (2086S0129X)	$35,650	$18,527	$32,393	$6,400	$23,257	$14,387	-60
Surgery: General Surgery (208600000X)	$684,844	$635,372	$713,150	$740,929	$621,880	$648,362	-5
Taxi (344600000X)	--	--	--	$16,674	$33,435	$45,135	--
Thoracic Surgery (208G00000X)	$16,468	$31,776	$34,078	$20,262	$14,046	$27,538	67
Transportation Service (347C00000X)	--	--	--	$7,329	$11,145	$18,455	--
Urology (208800000X)	$778,430	$740,261	$441,176	$295,664	$303,965	$268,132	-66
Unclassified	$87,293	$154,857	$272,435	$292,866	$635,221	$224,355	157
Total	$517,622,524	$527,531,608	$554,583,138	$556,278,314	$567,841,855	$554,224,838	7

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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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	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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
No change	No change	No change	Reimbursement rate reduced by 3.3%	No change	Psychologists paid 100% of fee schedule. APRN paid 90% of fee schedule (eff. 1/1/2018)

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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
N/A	N/A	Beginning of service	No change	No change	Payment is made to the CME under a non-risk capitated payment methodology for administrative services. Payment is made to the CME network providers based on a procedure code fee schedule after prior authorization from the CME.

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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2019	SFY 2019
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	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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
No change	No change	No change	Per Governor's budget cuts, adult dental coverage reduced to preventive and emergency services only.	No change	No change

Wyoming State Plan Attachment 4.19B

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

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

SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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	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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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	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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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	Rates increased 1.015% 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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
No change	No change	No change	Prior authorization required starting dates of service 3/1/17 and newer	No change	No change

42 CFR 484 Subpart E

Hospice

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

SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
No change	No change	No change	No change to LOC reimbursement; private hospital UPL implemented	No change	DRG implemented 5/31/19 with an effective date 2/1/19. Private hospital UPL program, DSH, QRA still in place. Rehab claims will be paid outside of DRG

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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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	Adjusted conversion factors (effective calendar year 2019): General acute $42.53 Critical access $105.89 Children's $88.45 ASCs $37.42
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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
No change	No change	Removed link with Nursing Home rates. Rates now updated annually with full cost coverage.	No change	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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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	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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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	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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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	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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
No change	No change	Rate increased	Rate decreased	Rate decreased for Medicaid-only; increased for dual-Medicare/Medicaid	Rates increased for Medicaid-only; decreased 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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Rates adjusted 12/1/14 based on analysis of Medicaid cost reports	No change	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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
No change	No change	No change	Adjusted conversion factor on November 1, 2016 to reflect 3.3% reduction on all RBRVS codes	No change	No change

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

Public Health, Federal

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

SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
No change	No change	No change	No change	No change	IHS encounter increases every year based on OMB calculations

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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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	Rates increased 1.015% 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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
No change	No change	No change	No change	No change	No change

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

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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
No change	No change	Care Management Entity began serving youth July 1, 2015	CMS approved SFY 2017 rates, and SFY2017 claims were adjusted	CMS approved SFY 2018 rates, and SFY2018 claims were adjusted	Changed to non-risk based capitated payment to the CME for administrative services and fee for service payments to the network providers.

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 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
No change	No change	12% increase per rate rebasing project, effective March 1, 2016.	No change	No change	No change

Waiver agreement

Waiver - Pregnant by Choice

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

SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
Extended to December 31, 2017	No change	No change	No change	No change	Extension application submitted to CMS

11-W-00238/8

appendix c: eligibility requirements & benefits

Table 73. Income Limits by Eligibility Category

Eligibility Category	CY 2018-2019
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 2018				CY 2019			
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%	$1,012	$1,372	$1,732	$2,092	$1,041	$1,410	$1,778	$2,146
	133%	$1,346	$1,825	$2,304	$2,782	$1,385	$1,875	$2,365	$2,854
	154%	$1,558	$2,113	$2,667	$3,222	$1,603	$2,171	$2,738	$3,305
Supplementary Security Income (SSI)	100%	$750	$1,125	--	--	$771	$1,157	--	--
	300%	$2,250	$3,375	--	--	$2,313	$3,471	--	--

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

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

appendix e: data methodology

enrollment

- A member is any individual enrolled in Medicaid, identified by a Medicaid ID number
- Enrollment is a distinct count of Medicaid members based on ID number
- Members are enrolled in an eligibility program code, which define the eligibility categories
- See tables for the eligibility category breakdown by program codes
- 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

- A recipient is any enrolled member who has received services and had a Medicaid claim processed and paid during the SFY
- 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.
- 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

per member per month

- The Per Member Per Month (PMPM) represents the monthly average cost for each enrolled member.
- The 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.
- The PMPM value in this report is a preliminary value only.
- The final SFY 2019 PMPM value will be available in the separate Wyoming Medicaid Per Member Per Month report.

services

- Most service areas are defined using pay-to provider taxonomy codes on claims paid during the SFY. See table 79 for the parameters used for each service and special population in this report.
- Other services may use claim types or the recipient's eligibility program code in addition to the pay-to-provider tax code.

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

Eligibility Category (Continued)	Program Codes	
Aged, Blind, Disabled Intellectual/ Developmental Disabilities and Acquired Brain Injury (continued)	W18	SSI Support ABI Waiver Adult > 21
	W19	SSI Support ABI Waiver Aged > 65
	W20	300% Support ABI Waiver Adult > 21
	W21	300% Support ABI Waiver Aged > 65
Aged, Blind, Disabled Institution	S14	Institutional (Hosp) Aged - Inactive
	S15	Inpatient Hospital 300% Cap > 65
	S34	Inatitutional (Hosp) Disabled - Inactive
	S35	Inpatient Hospital 300% Cap < 65
	S13	Inpat-Psych > 65
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

Eligibility Category (Continued)	Program Codes	
Aged, Blind, Disabled Long-Term Care (continued)	P23	PACE SSI Aged > 65
	P24	PACE Mcare SSI Aged > 65
	P25	PACE NF > 65
	P26	PACE NF SSI Aged > 65
	P27	PACE NF Mcare Aged > 65
	P28	PACE NF Mcare SSI Aged > 65
Aged, Blind, Disabled SSI & SSI Related	S12	SSI Eligible >65
	S20	Blind SSI - Receiving Payment
	S21	Blind SSI - Not Receiving Pymt
	S31	SSI Eligible <65
	S36	Disabled Adult Child (DAC)
	S37	Goldberg-Kelly
	S39	1619 Disabled
	S40	Aptd Essent. Person Med Only -I
	S48	Zebley >21
	S49	Zebley <21
	S92	Widow-Widowers SDX
	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
	Q66	QMB Dual with Full Medicaid
	Q94	SLMB 2 > 65
	Q95	SLMB 2 < 65
	Q96	SLMB 1 > 65
	Q97	SLMB 1 < 65
	Q67	SLMB Dual with Full Medicaid
	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
	W99	Single Day Waiver Assessment
	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

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Clinic/Center	261Q00000X	Clinic/Center	n/a
Dental	122300000X 1223D0001X 1223E0200X 1223G0001X 1223P0221X 1223P0300X 1223S0112X 1223X0400X	Dentist Dental Public Health Endodontics General Practice Dentist Pedodontics Periodontics Surgery, Oral and Maxillofacial Orthodontics	n/a
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 (2019 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

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Nursing Facility	275N00000X 314000000X	Medicare Defined Swing Bed Skilled Nursing Facility	n/a
Program for All-Inclusive Care of Elderly (PACE)	251T00000X	PACE Organization	n/a
Physician and Other Practitioner Total	All Taxonomies starting with '20' EXCLUDING 2084P0800X 363A00000X 225X00000X 225100000X 213E00000X 363L00000X 363LA2200X 363LF0000X 363LG0600X 363LX0001X 363LP0200X 367A00000X 367500000X 231H00000X 235Z00000X	 Psychiatrists Physician Assistant Occupational Therapist Physical Therapist Podiatrist Nurse Practitioner Nurse Midwife Nurse Anesthetist Audiologist Speech-Language Pathologist	n/a
Physician	All Taxonomies starting with '20' EXCLUDING 2084P0800X 363A00000X	 Psychiatrists Physician Assistant	n/a
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

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

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Waiver - Children's Mental Health Waiver Only	251B00000X	Case Management	Claim Type: W, G Recipient Program Codes: S95, S96, S65
Waiver - Children's Mental Health Waiver Only	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X Recipient Program Codes: S95, S96, S65
Waiver Comprehensive Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: W03, W04, W08, W09, W10, W14, W15, W16, W22, W23, W24, W25, W26
Waiver Comprehensive Waiver Only	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: W03, W04, W08, W09, W10, W14, W15, W16, W22, W23, W24, W25, W26
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	Procedure Codes S5165, T2038, T1017, S9986 and Pay to Provider Taxonomy 251B00000X