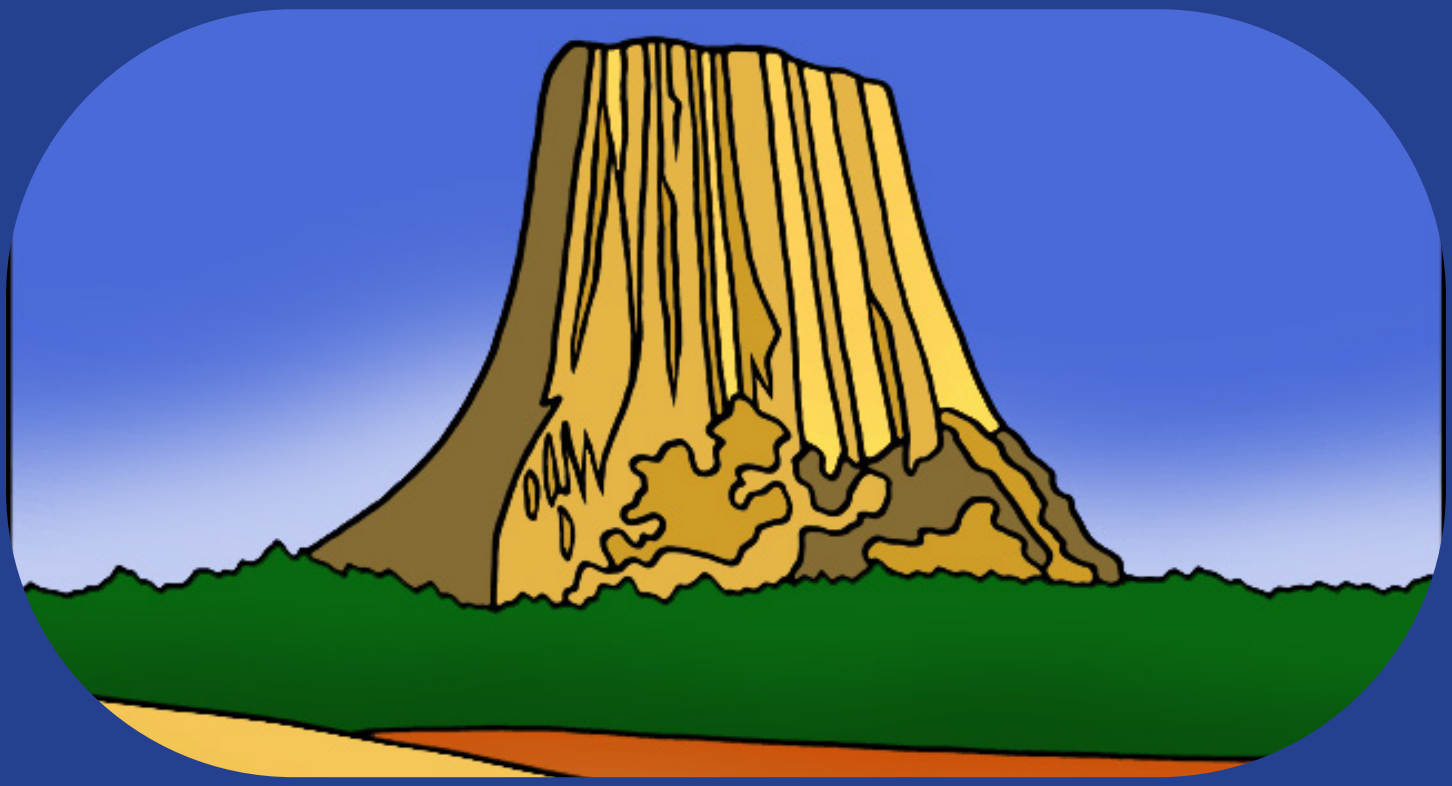

WYOMING MEDICAID ANNUAL REPORT SFY 2022

WYOMING DEPARTMENT OF HEALTH

GOVERNOR MARK GORDON
DIRECTOR STEFAN JOHANSSON
STATE MEDICAID AGENT LEE GROSSMAN

Wyoming Department of Health

401 Hathaway Building • Cheyenne, WY 82002
Phone (307) 777-7656 • 1-866-571-0944
Fax (307) 777-7439 • www.health.wyo.gov

Stefan Johansson
Director

Mark Gordon
Governor

April 14, 2023

Dear Medicaid Providers, Members, Stakeholders, and Wyoming Residents

State Fiscal Year 2022 (July 1, 2021, to June 30, 2022) was a busy and purposeful year for Wyoming Medicaid, with the primary focus of the year being Medicaid's continued support of individuals with COVID-19, immunization efforts, and planning for the unwinding of the public health emergency.

Since the end of SFY 2022 to the date of this report, a couple of major events have occurred that are worth noting. First is my appointment for the dual role of state Medicaid agent and senior administrator of the Division of Healthcare Financing effective February 6, 2023. Prior to this role, I have served in various leadership roles in the Department in the past eleven years. I look forward to our continued work together in service to Wyoming Medicaid recipients and providers. As you may recall, Jan Stall, provider and benefit management administrator, stepped up to serve in this dual role last January on an interim basis, and her leadership and comprehensive experience in Medicaid ensured a seamless interim period. Jan's dedication and service to the Division and the people of Wyoming are greatly missed since her March 3, 2023 retirement. Secondly, the Division implemented two new modules of the Medicaid Management Information System (MMIS): the new claims processing module called Benefit Management Services (BMS) on October 25, 2021, and the new electronic visit verification (EVV) module on February 15, 2022, both of which were a culmination of years of planning and work.

Additional Medicaid highlights:

- As of January 1, 2022, utilized ARPA funding to provide enhanced care coordination for children and youth with co-occurring issues who are receiving ID/DD waiver waitlist services.
- Increased CCW and DD waiver provider reimbursement rates.
- As of February 1, 2022, implemented a provider attestation process to ensure that provider rate increases are being applied to direct support worker compensation.
- The contract with Optum ended effective July 1, 2022. The new HM/UM vendor, Telligen, went live July 1, 2022.
- As of January 1, 2022, immediate postpartum Long-Acting, Reversible Contraceptive (LARC) insertion will reimburse professional services for immediate postpartum IUD or contraceptive implant insertion procedures if billed separately from the professional global obstetric procedure.
- Implemented new policy for Speech-Generating Devices
  Implemented Professional Services Supplement Payment Program (PSSP)

Many details, including expenditure and program utilization numbers, are provided for Medicaid programs in this report. Questions may be directed to the Wyoming Department of Health's Division of Healthcare Financing (307-777-7531).

Best regards,

Lee Grossman,
DHCF Senior Administrator and State Medicaid Agent

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SFY 2022 AT A GLANCE

ENROLLMENT

77,473

Average Medicaid SFY 2022 monthly enrollment
(13% increase over SFY 2021)

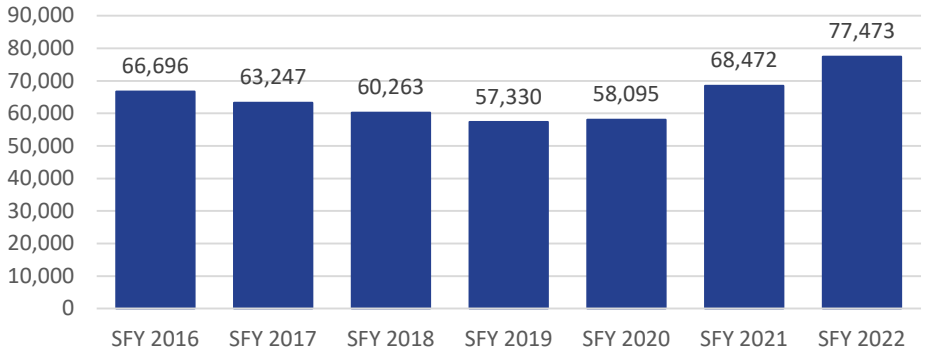


Figure 1. Enrollment History: Monthly Average

88,149

Medicaid members enrolled at any point during the SFY
(10% increase over SFY 2021)

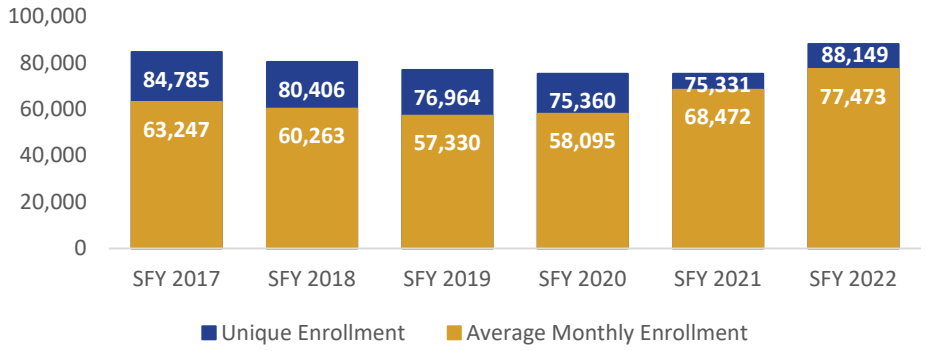


Figure 2. Enrollment History: Monthly Average and Unique Enrollment

15%

of Wyoming residents are enrolled in Medicaid

61%

of members are children under age 21

42%

of members reside in Laramie, Natrona, and Fremont counties

9.4

months of average enrollment per member

EXPENDITURES

$580.5 MILLION

paid to 3,448 providers with over 23,275 providers actively enrolled at any point during the SFY
(2.4% increase over SFY 2021)

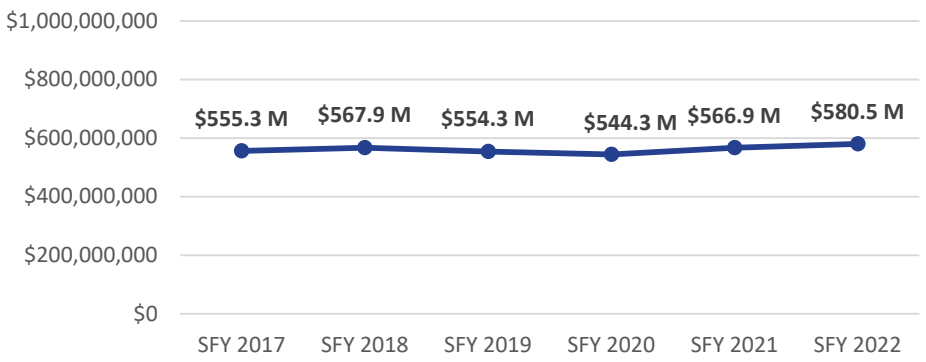
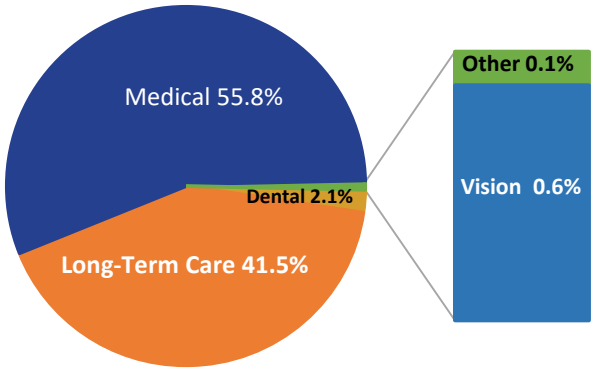


Figure 3. Medicaid Expenditure History



$628 **Per Member Per Month cost (preliminary)**

Figure 4. SFY 2022 Expenditures by Service Group

RECIPIENTS

70,930
enrolled members with claims paid

82%
had a physician claim paid

59%
had a prescription drug claim paid

65%
had a hospital claim paid

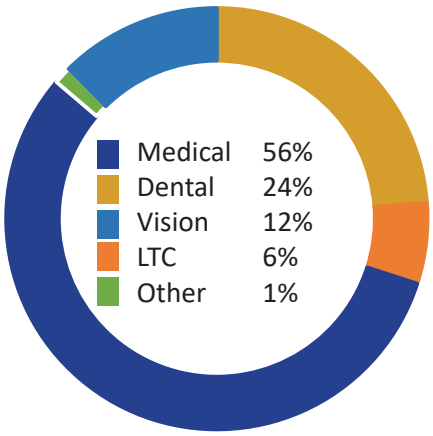


Figure 5. SFY 2022 Recipients by Service Type

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 the administration of Wyoming Medicaid. DHCF partners with the Fiscal Division for accounting and budgeting services.

Wyoming Medicaid serves four major eligibility populations: Children, Pregnant Women, Adults, and Aged, Blind, or Disabled. Wyoming has not extended optional eligibility for adults under 133% of the Federal Poverty Level (FPL).

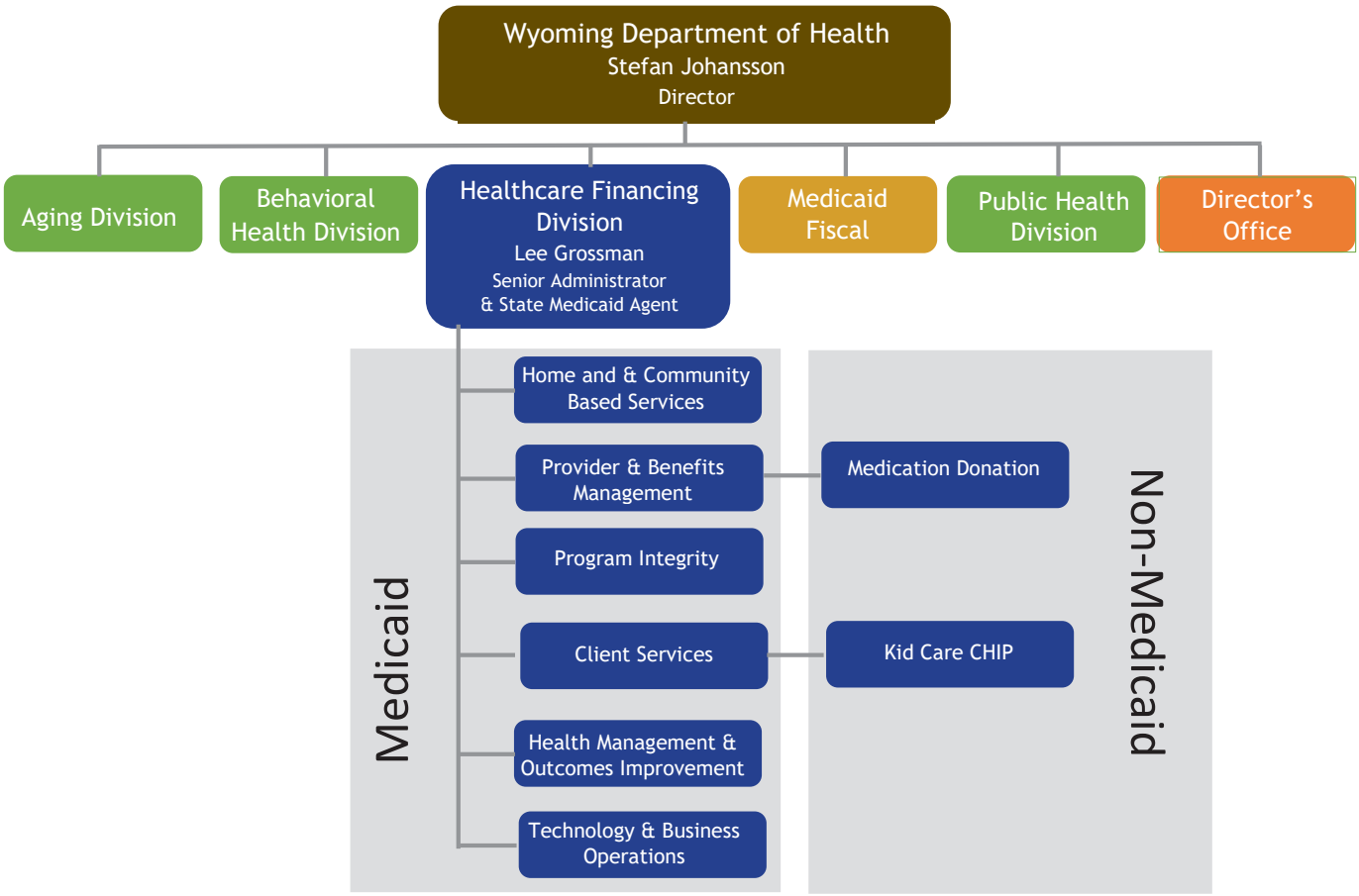


Figure 6. Wyoming Department of Health Organization Chart

FINANCIALS AND FUNDING

Enrolled providers have one year to submit claims for reimbursement. Claims are processed through the Medicaid Management Information System (MMIS). During SFY 2022, a new vendor was contracted to process claims, and began processing and paying claims as of October 25, 2021. This Annual Report focuses on the members enrolled during SFY 2022 and claims paid during SFY 2022, regardless of when service was rendered.

Table 1. Division of Healthcare Financing Expenditures for SFY 2022

Medicaid Related Expenditures (in Millions)	
Annual Report Benefit Expenditures (this report)[1]	$580.5
Medicaid Administration	$53.3
Nursing Facilities Supplemental Payments	$43.6
Hospital Supplemental Payments	$55.4
Medicare Buy-in	$24.2
Medicare Clawback (Part D)	$15.2
Medicaid One-Time Capital Expenses for New Technology Systems (Medicaid modules, HIE, Other)	$28.1
Other[2]	--
Subtotal Medicaid Expenditures	**$800.3**
Drug Rebates	($43.8)
Total Medicaid Expenditures	**$756.5**
Non-Medicaid Expenditures (in Millions)	
Children's Health Insurance Program (CHIP)[3]	$8.3
CHIP Administration[3]	$0.0
State Only Foster Care and General Fund Foster Care (Court Orders)	$0.9
Supplemental Security Income Payments	$0.8
Total Health Record (THR)[4]	$0.0
State Only Other	$1.4
Total Non-Medicaid Expenditures	**$11.4**
Total Division of Healthcare Financing Expenditures	**$767.9**

1. Includes reductions in expenditures due to recoveries processed through the MMIS.
2. Adjustment to reflect timing differences related to drug rebate and claims differences between WOLFS and MMIS.
3. The CHIP (Children's Health Insurance Program) has been administered in-house by Wyoming Medicaid since October 1, 2020. Prior to that it was administered by Blue Cross Blue Shield. Starting with SFY 2022, there are no administration costs.
4. The Total Health Record (THR) program was discontinued in SFY 2021.

HCF DIVISION EXPENDITURES AND FUNDING HISTORY

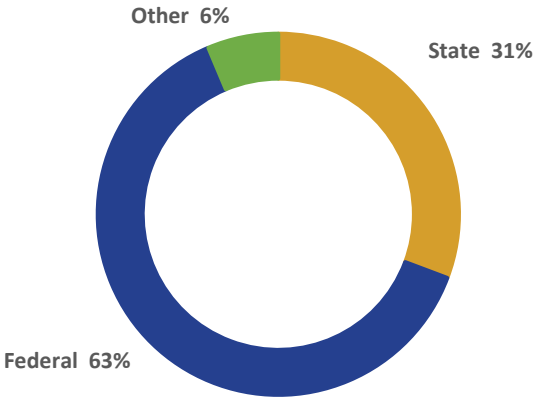


Figure 7. SFY 2022 DHCF Funding Sources

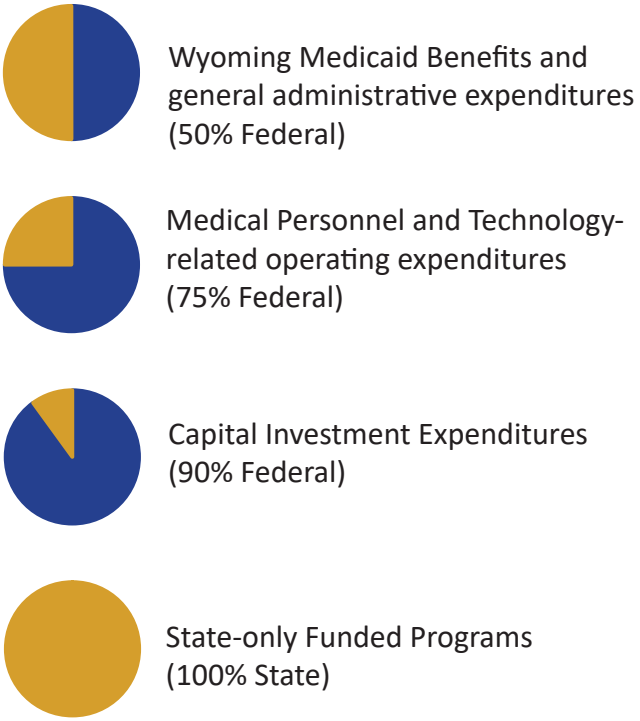


Figure 8. Medicaid Funding Breakdown

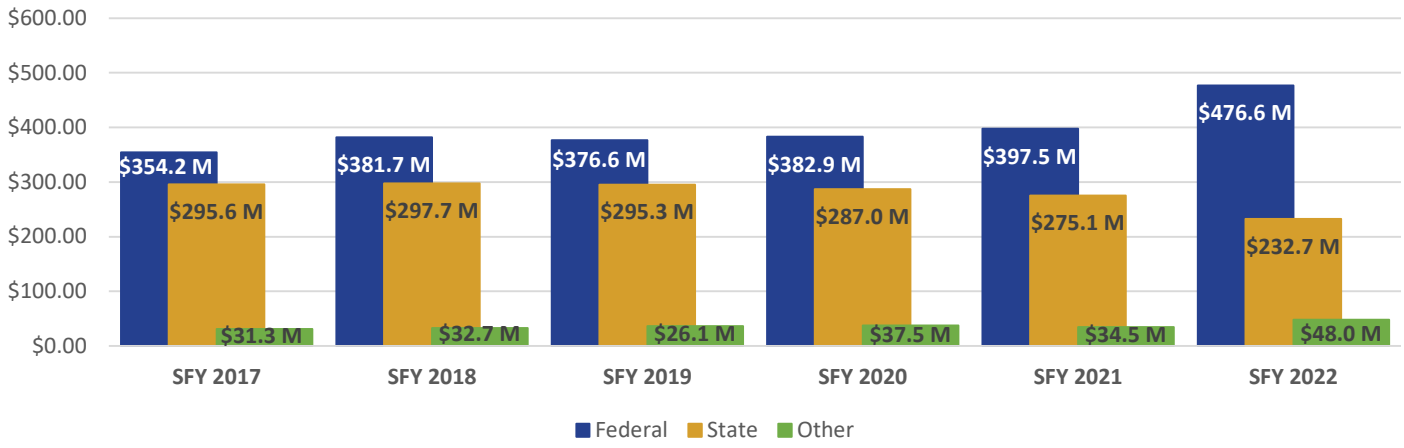


Figure 9. Division of Healthcare Funding History (in millions)

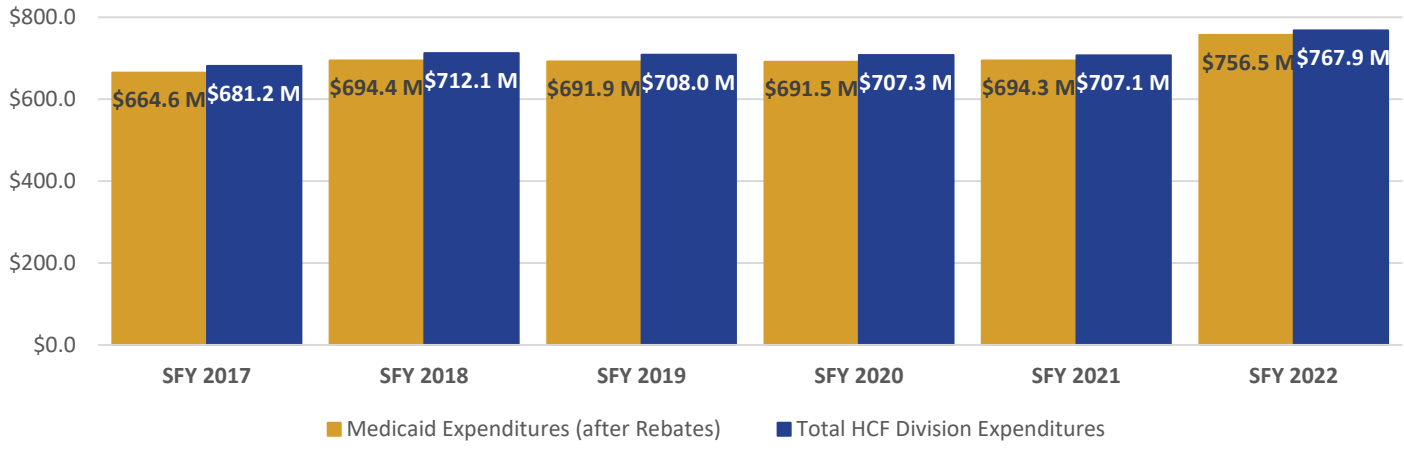


Figure 10. Division of Healthcare Expenditure History

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, CNSI.	Represents a wide range of interests, experience, dental specialties, and various areas of the state, while advising Medicaid regarding the 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, and 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 (PI) AND THIRD-PARTY LIABILITY (TPL)

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

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

To view the most current presentations of data for these two program areas, please refer to the Program Integrity HealthStat and TPL HealthStat reports.

DEMOGRAPHICS

15.2%

of Wyoming residents enrolled in Medicaid
(2% increase over SFY 2021)

22.9%

of Wyoming residents under the age of 18

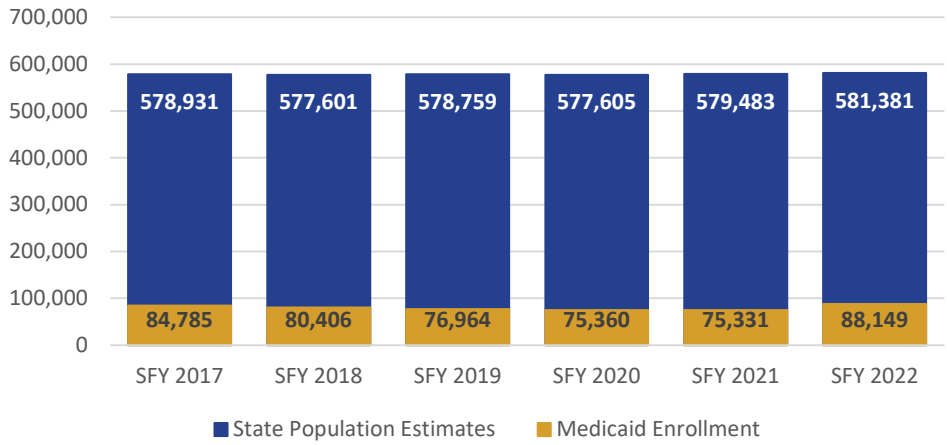


Figure 11. Medicaid enrollment and State Population History

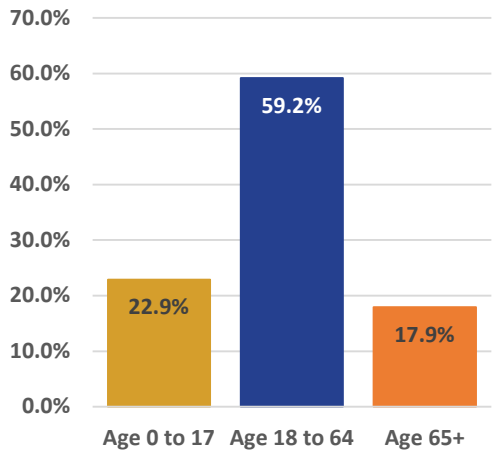


Figure 12. SFY 2022 State Population Age Percentages

0.4%

State Population[5] Increase (from 2017 to 2022)

2.5%

Increase in Medicaid Enrollment (from SFY 2017 to SFY 2022)

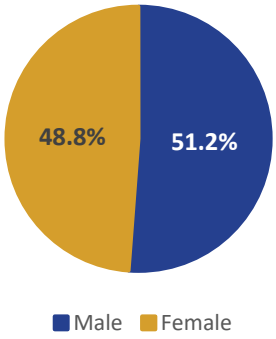


Figure 13. SFY 2022 State Population Gender Percentages

ECONOMY [6, 7, 8]

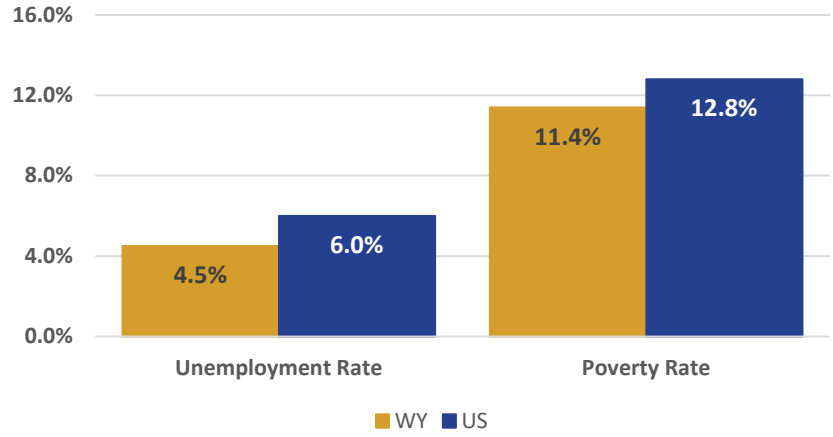


Figure 14. WY vs. US Unemployment and Poverty Rates

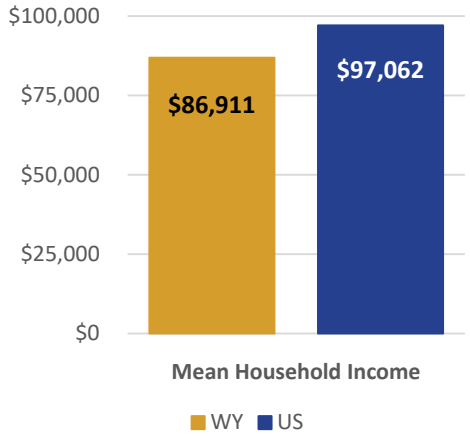


Figure 15. WY vs. US Mean Income

5. 2022 forecasted population information prepared by the Wyoming Department of Administration & Information, Economic Analysis Division (http://http://eadiv.state.wy.us/pop/st-22est.htm). Prepared July 1, 2022.
6. US Census Bureau: S2301 EMPLOYMENT STATUS TABLE. https://data.census.gov/table?q=unemployment+rate&g=0100000US&tid=ACSST1Y2021.S2301
7. US Census Bureau. S1701: POVERTY STATUS IN THE PAST 12 MONTHS table. https://data.census.gov/cedsci/table?q=S1701: POVERTY STATUS IN THE PAST12 MONTHS&t=Income Households, Families, Individuals &tid=ACSST1Y2019.S1701
8. US Census Bureau S1901: INCOME IN THE PAST 12 MONTHS (IN 2021 INFLATION-ADJUSTED DOLLARS). https://data.census.gov/table?q=S1901+Wyoming&g=0100000US

HIGHLIGHTS & INITIATIVES

MEDICAID UPDATES

SFY 2022 included several positive highlights and initiatives for Wyoming's Medicaid program.

Table 3. SFY 2022 Medicaid Highlights and Initiatives

Area/Program	Category	Highlight/Initiative
Care Management Entity (CME)	Policy	• As of January 1, 2022, utilized ARPA funding to provide enhanced care coordination for children and youth with co-occurring issues who are receiving ID/DD waiver waitlist services.
Division of Healthcare Finance (DHCF), Wyoming Integrated Next Generation System (WINGS)	Technology	• Implemented a new claims processing module called Benefit Management Services (BMS) as part of the Medicaid Management Information System (MMIS) • Implemented a new electronic visit verification module (EVV) as part of the Medicaid Management Information System (MMIS).
Home & Community-Based Services (HCBS)	Program	• Increased CCW and DD waiver provider rates. • As of July 1, 2022, implemented new service plan requirements and processes in response to the Community Choices waiver renewal that went into effect on that day. • As of February 1, 2022, implemented a provider attestation process to ensure that provider rate increases are being applied to direct support worker compensation.
Health Management Outcome Improvement (HMOI), Health Management - Utilization Management (HMUM)	Program	• The contract with Optum ended effective July 1, 2022. The new HM/UM vendor, Telligen, went live July 1, 2022.
Pharmacy Benefit Management Unit (PBMU)	Policy	• As of January 1, 2022, Immediate postpartum Long-Acting, Reversible Contraceptive (LARC) insertion will reimburse professional services for immediate postpartum IUD or contraceptive implant insertion procedures if billed separately from the professional global obstetric procedure. • Implemented a new policy for Speech-Generating Devices.
Pharmacy Benefit Management Unit (PBMU)	Legislation/ Policy	• Implemented a Professional Services Supplement Payment Program (PSSP).

WYOMING INTEGRATED NEXT GENERATION SYSTEM (WINGS)

The Wyoming Integrated Next Generation System (WINGS) project within the Division of Healthcare Finance has been, and continues to be, in the process of replacing the previous MMIS (all-in-one) system with modular units designed to work together to manage the Medicaid Program. The WINGS project will continue this modular approach, replacing modules as needed going forward, ensuring continued up-to-date technology for each Medicaid area.

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 the identification, investigation, and collection of fraud, waste, & abuse of Medicaid services by providers and clients

5 BMS & TPL

Benefit Management System processes Medicaid claims and manages benefit plans. Third-Party Liability ensures proper coordination exists between Medicaid and any other entity/individual with an 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

7 EVV

Electronic Visit Verification measures and validates service activity for personal care and home health programs, ensuring services billed are actually rendered.

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 ensure each project module functions correctly.

B

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

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

Figure 16. WINGS Project

ENROLLMENT

77,473

Average monthly enrollment
(13% increase over SFY 2021)

88,261

Unique annual enrollment
(10% increase over SFY 2021)

After steadily declining for 4 years, the average monthly and unique SFY enrollment in Medicaid began increasing in SFY 2020 (see Figures 1, 2, and 17). The SFY 2022 enrollment numbers increased by 13% and 10% over SFY 2021, respectively. The average length of enrollment (in months) decreased by 12% over SFY 2021 (see Table 4 below).

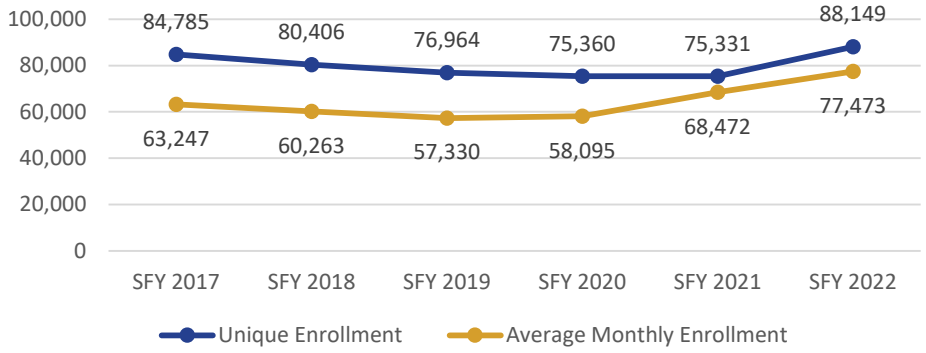


Figure 17. Unique SFY and Average Monthly Enrollment History

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

Table 4. Change in Medicaid Enrollment

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Unique Enrollment	84,785	80,406	76,964	75,360	75,331	88,149
% Change from previous SFY	-4.5	-5.2	-4.3	-2.1	-0.04	17
Average Monthly Enrollment	63,247	60,263	57,330	58,095	68,472	77,743
% Change from previous SFY	-5.2	-4.7	-4.9	1.3	17.9	13.1
Average Length of Enrollment (months)	9.2	9.3	9.3	9.3	10.7	9.4

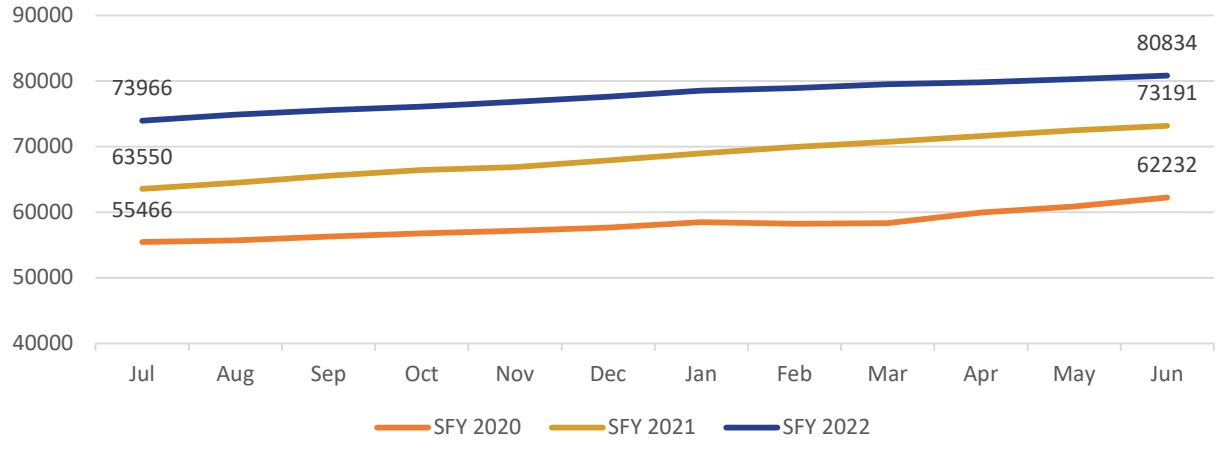


Figure 18. Monthly Medicaid Enrollment by SFY

BY COUNTY

Table 5. Medicaid Enrollment by County

County	Enrolled Members	% of Total
Albany	3,946	4.5
Big Horn	2,263	2.6
Campbell	7,218	8.2
Carbon	2,118	2.4
Converse	2,168	2.5
Crook	958	1.1
Fremont	10,206	11.6
Goshen	1,944	2.2
Hot Springs	854	1.0
Johnson	1,059	1.2
Laramie	14,605	16.6
Lincoln	2,023	2.3
Natrona	14,147	16.1
Niobrara	413	0.5
Park	4,069	4.6
Platte	1,275	1.4
Sheridan	4,262	4.8
Sublette	856	1.0
Sweetwater	6,528	7.4
Teton	1,237	1.4
Uinta	3,583	4.1
Washakie	1,298	1.5
Weston	923	1.0
Total	**87,953**	**100**

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

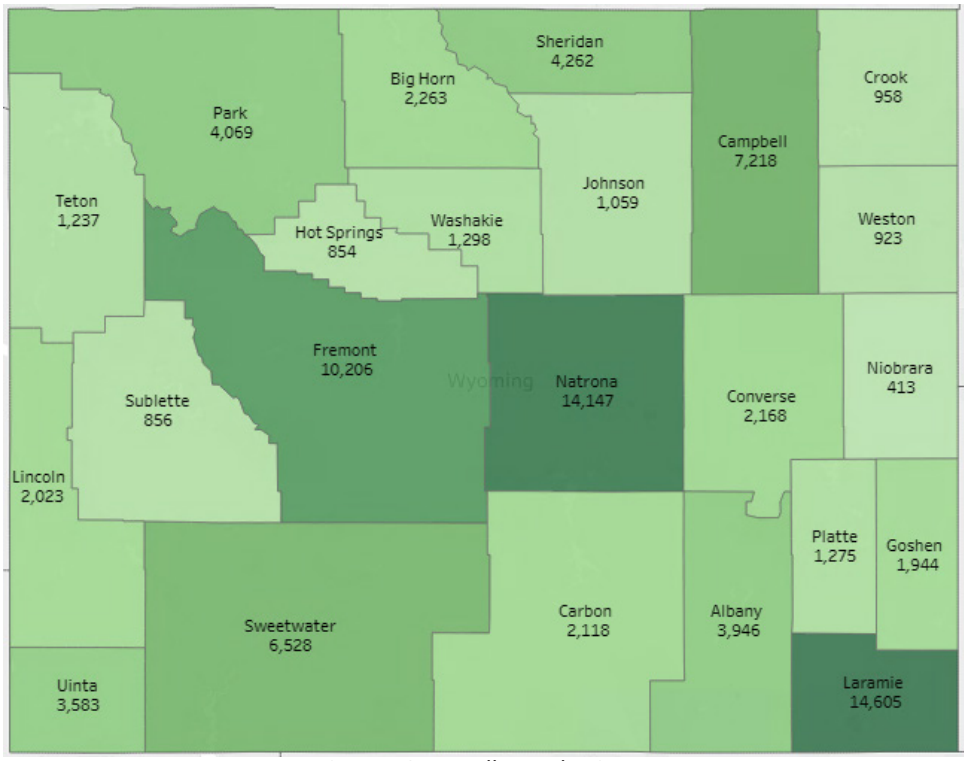


Figure 19. Enrollment by County

EXPENDITURES

$580,511,215

paid to 3,448 providers with 23,275 providers actively enrolled at any point during the SFY
(2.4 % increase over SFY 2021)

Providers have one year to submit claims to Medicaid for reimbursement; therefore, expenditures here include services rendered in both SFY 2021 & SFY 2022

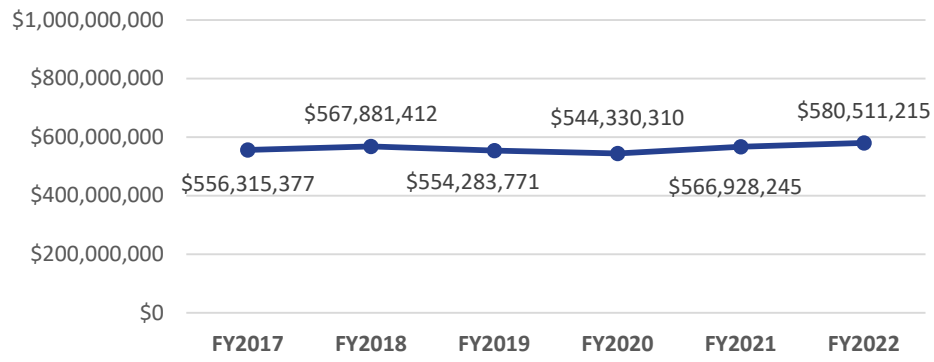


Figure 20. Expenditure History

Table 6. Expenditure History by Service Type

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Medical	$207,486,654	$310,277,087	$288,794,695	$270,422,977	$293,681,490	$324,130,654
Long Term Care	$239,788,830	$241,030,693	$249,685,762	$260,153,810	$254,093,439	$240,541,733
Dental	$14,167,617	$11,847,581	$11,304,079	$9,893,628	$11,898,535	$11,937,162
Vision	$3,850,574	$3,712,855	$3,466,069	$2,977,070	$3,526,355	$3,402,928
Other	$1,021,702	$1,013,196	$1,033,166	$862,825	$728,426	$498,738

Figure 21, below, compares expenditures for the top services ($5 million or higher) for SFY 2021 and SFY 2022. More detailed information on services is available in the Services section of this report. For each service area, the percentage shown is the % of Total Medicaid for that SFY.

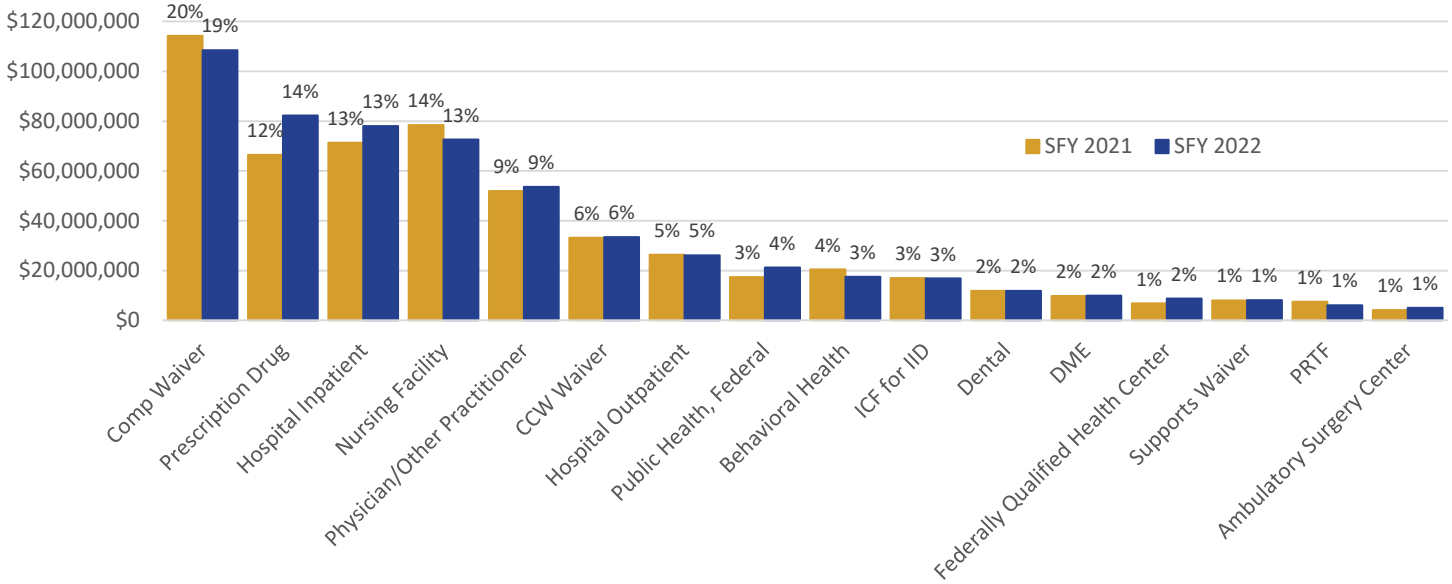


Figure 21. Comparison of Top Services' Expenditures for SFY 2021 and SFY 2022.

RECIPIENTS

70,930

enrolled members with claims paid
(6.2 % increase over SFY 2021)

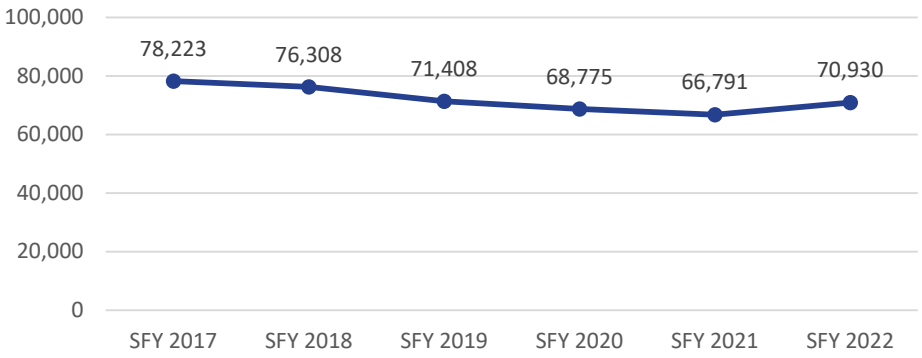


Figure 22. Recipient History

Table 7. Recipient History by Service Type

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Medical	74,629	73,286	68,230	65,460	63,016	67,482
Dental	31,483	28,789	27,524	24,732	27,609	28,561
Vision	15,921	15,821	14,790	12,680	15,016	14,895
Long Term Care	7,605	7,684	7,711	8,193	7,671	7,419
Other	3,024	3,363	3,475	3,325	2,987	1,619

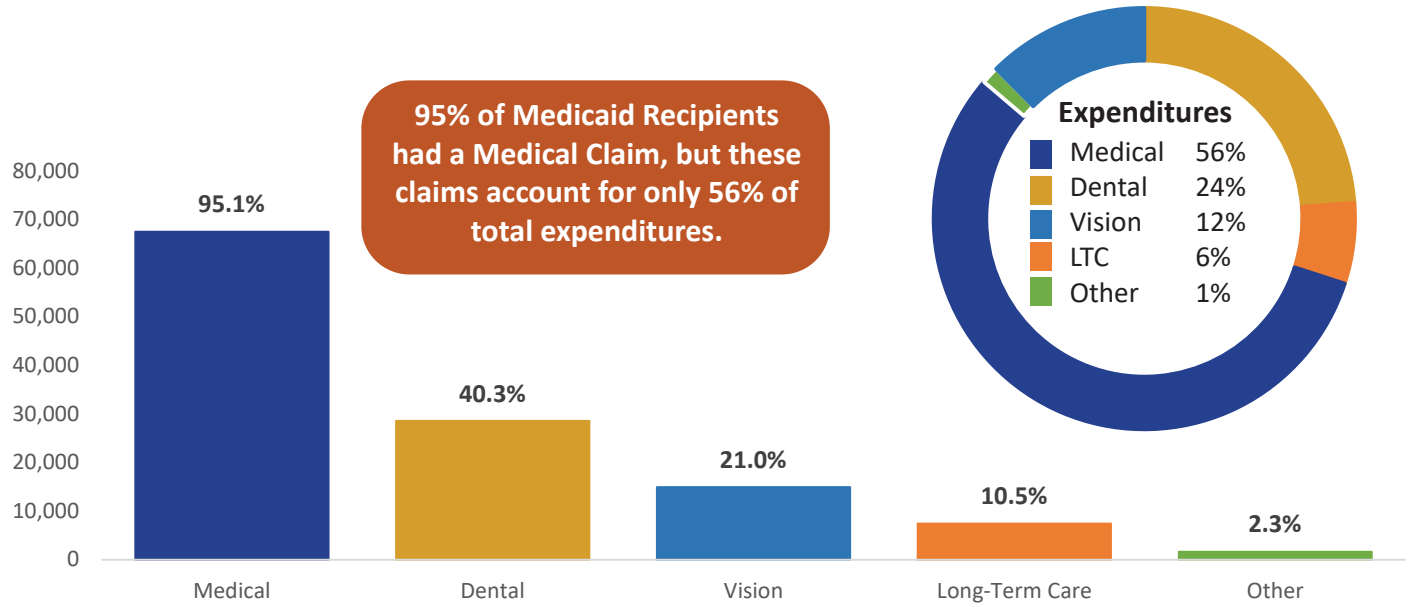


Figure 23. Recipient Utilization versus Expenditure Breakdown by Service Type

ELIGIBILITY CATEGORIES

AGED, BLIND, OR DISABLED

1. Employed Individuals with Disabilities (EID)
2. Individuals with Intellectual/ Developmental Disabilities or Acquired Brain Injury (ID/DD/ABI)
3. Institution
4. Long-Term Care (LTC)
5. Supplemental Security Income (SSI)
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.

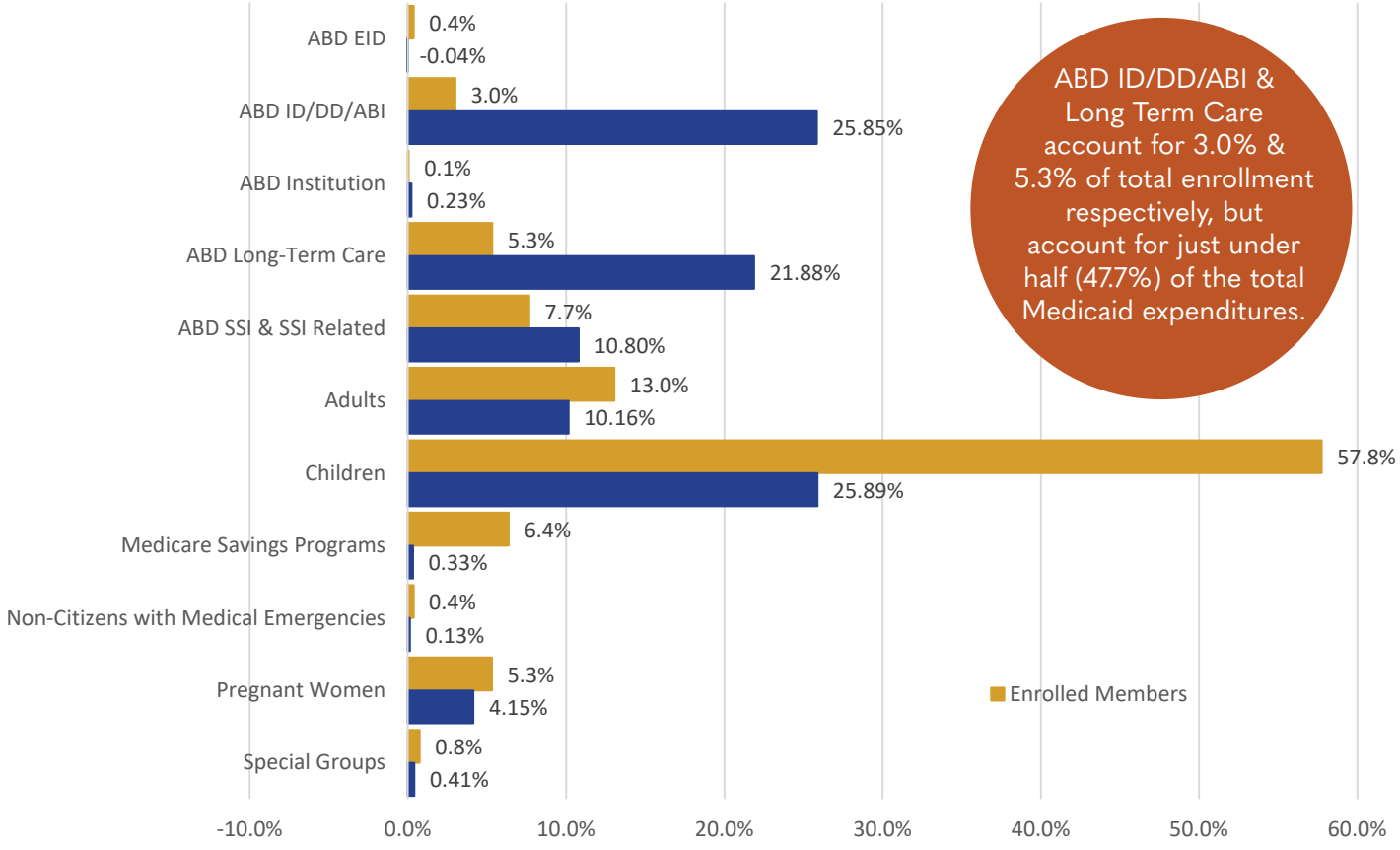


Figure 24. Enrolled members versus Expenditures by Eligibility Category

Table 8. Eligibility Category Summary

Eligibility Category	Enrolled Members	% Change from SFY 2021	Unique Recipients[9]	% Change from SFY 2021	Expenditures	% Change from SFY 2021
ABD EID	333	0.6	318	-0.6	($260,705)[10]	-108.2
ABD ID/DD/ABI	2,646	1.2	2,669	1.0	$150,075,613	-3.4
ABD Institution	51	-10.5	57	-19.7	$1,342,111	-67.6
ABD LTC	4,705	-3.7	4,977	-3.5	$127,024,117	-5.8
ABD SSI & SSI Related	6,764	5.1	5,949	2.1	$62,668,792	11.5
Adults	11,499	17.7	9,083	9.3	$58,987,396	12.9
Children	50,907	15.2	42,216	7.5	$150,272,180	11.9
Medicare Savings Program	5,615	12.4	2,687	-1.1	$1,904,049	3.9
Non-Citizens with Medical Emergencies	318	79.7	154	24.2	$781,986	18.9
Pregnant Women	4,686	25.6	4,264	13.6	$24,065,741	9.0
Special Groups	667	633.0	99	15.1	$2,391,243	5.6
Total	**88,149**	**17.0**	**70,930**	**6.2**	**$580,511,215**	**2.4**

Table 9. Screenings and Gross Adjustments Summary

	Unique Recipients[10]	% Change from SFY 2021	Expenditures[11]	% Change from SFY 2021
Screenings	853	-37.1	$485,026	-7.6
Gross Adjustments	--	--	$736,623	-197.2

Table 10. Enrollment History by Eligibility Category

Eligibility Category	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
ABD EID	496	404	365	356	331	333	-32.9
ABD ID/DD/ABI	2,640	2,603	2,550	2,618	2,614	2,646	0.23
ABD Institution	80	55	46	65	57	51	-36.3
ABD LTC	4,885	5,007	5,105	5,076	4,888	4,705	-3.7
ABD SSI & SSI Related	7,117	6,609	6,737	6,661	6,437	6,764	-5.0
Adults	11,825	10,989	9,900	9,692	9,772	11,499	-2.8
Children	51,164	47,919	45,367	44,204	44,196	50,907	-0.50
Medicare Savings Program	4,994	4,978	5,082	5,150	4,997	5,615	12.4
Non-Citizens with Medical Emergencies	292	195	167	158	177	318	8.9
Pregnant Women	4,778	4,336	4,113	3,927	3,732	4,686	-1.9
Special Groups	164	121	97	88	91	667	306.7
Total	**84,785**	**80,406**	**76,964**	**75,360**	**75,331**	**88,149**	**4.0**

9. This column 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
10. The negative expenditure number for the ABD EID (Aged, Blind, or Disabled Employed Individuals with Disabilities) is due to a large number of gross adjustments for this category meaning that the Agency received more money than it paid out.
11. Expenditures for Screenings and Gross Adjustments are included in the Total Expenditures, however, since they are not eligibility categories, they are displayed separately (Table 9). The large change in Gross Adjustments from SFY 2021 is due to a negative amount in SFY 2021, meaning that the Agency received more money than it paid out..

Table 11. Expenditure History by Eligibility Category

Eligibility Category	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
ABD EID	$4,491,523	$3,170,198	$2,201,872	$1,756,635	$3,168,949	($260,705)	-105.8
ABD ID/DD/ABI	$145,024,485	$139,120,839	$148,210,163	$152,541,587	$155,360,814	$150,075,613	3.5
ABD Institution	$2,806,554	$2,489,828	$1,683,641	$1,239,234	$4,139,118	$1,342,111	-52.2
ABD LTC	$133,820,492	$137,811,401	$136,564,759	$144,976,414	$134,892,349	$127,024,117	-5.1
ABD SSI & SSI Related	$55,141,541	$57,608,075	$55,018,028	$54,412,195	$56,186,651	$62,668,792	13.7
Adults	$40,633,756	$46,008,562	$42,819,380	$37,137,296	$52,267,090	$58,987,396	45.2
Children	$140,921,270	$149,233,800	$134,481,804	$124,888,851	$134,266,458	$150,272,180	6.6
Medicare Savings Program	$3,206, 357	$1,654,936	$1,687,004	$1,743,633	$1,831,726	$1,904,049	-40.6
Non-Citizens with Medical Emergencies	$1,040,454	$713,218	$913,315	$568,871	$657,593	$781,986	-24.8
Pregnant Women	$26,264,576	$25,247,867	$22,579,721	$21,725,470	$22,087,873	$24,065,741	-8.4
Special Groups	$1,519,979	$1,459,944	$1,623,461	$1,826,629	$2,263,994	$2,391,243	57.3
Total[11]	**$556,315,377**	**$567,881,412**	**$554,283,771**	**$544,330,310**	**$566,928,245**	**$580,511,215**	**4.3**

Table 12. Screenings and Gross Adjustments Expenditure History[12]

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Screenings	$349,832	$716,611	$505,557	$762,114	$524,863	$485,026	38.6
Gross Adjustments	$5,057,496	$2,606,576	$5,980,134	$680,047	($758,113)	$736,623	-30.3

Table 13. Unique Recipient History by Eligibility Category [13]

Eligibility Category	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
ABD EID	517	455	401	382	320	318	-38.5
ABD ID/DD/ABI	2,661	2,633	2,584	2,665	2,633	2,659	-0.08
ABD Institution	110	88	68	76	71	57	-48.2
ABD LTC	5,092	5,268	5,416	5,830	5,160	4,977	-2.3
ABD SSI & SSI Related	6,383	6,285	6,203	6,087	5,828	5,949	-6.8
Adults	10,329	9,958	8,706	8,098	8,308	9,083	-12.1
Children	45,408	44,835	41,770	39,420	39,256	42,216	-9.0
Medicare Savings Program	2,895	2,836	2,820	2,938	2,717	2,687	-7.2
Non-Citizens with Medical Emergencies	254	146	145	140	124	154	-39.4
Pregnant Women	5,346	5,146	4,386	4,336	3,753	4,264	-20.2
Special Groups	132	116	85	84	86	99	-25.0
Total	**78,223**	**76308**	**71,408**	**68,775**	**66,791**	**70,930**	**-9.3**

12 Expenditures for screenings and gross adjustments are included in the Total Expenditures. The SFY 2022 expenditures for screenings and gross adjustments are displayed in Table 9.

13. 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.

SERVICES

OVERVIEW

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.

Table 14. Covered Services

Service	Adults	Children (Under Age 21)
Ambulance	Mandatory	Mandatory
Ambulatory Surgical Center	Optional	Mandatory (EPSDT)[14]
Behavioral Health[15]	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[16]	Optional	Optional[17]
Community Choices Waiver	Optional	N/A
Dental	Optional	Mandatory (EPSDT)
Durable Medical Equipment	Optional	Mandatory (EPSDT)
End-State Renal Disease	Optional	Mandatory (EPSDT)
Federally Qualified Health Centers	Mandatory	Mandatory
Home Health	Mandatory	Mandatory
Hospice	Optional	Mandatory (EPSDT)
Hospital	Mandatory	Mandatory
Intermediate Care Facility for Individuals with Intellectual Disabilities	Optional	Optional
Laboratory/X-Ray	Mandatory	Mandatory
Nursing Facility	Mandatory	Mandatory
Pharmacy	Optional	Mandatory (EPSDT)
Physician and Other Practitioner	Optional	Mandatory (EPSDT)
Pregnant by Choice Waiver	Optional	N/A
Psychiatric Residential Treatment Facility (PRTF)	N/A	Mandatory (EPSDT)
Physical/Occupational/Speech Therapies[18]	Optional	Mandatory (EPSDT)
Public Health, Federal[19]	Optional	Mandatory (EPSDT)
Public Health or Welfare	Optional	Mandatory (EPSDT)
Rural Health Clinic	Optional	Mandatory (EPSDT)
Vision	Optional	Mandatory (EPSDT)

14. EPSDT: Early Periodic Screening Detection and Treatment program.
15. Excludes the Children's Mental Health Waiver and Psychiatric Residential Treatment Facility (PRTF).
16. ID/DD/ABI: Intellectual Disabilities/Developmental Disabilities/Acquired Brain Injury. Prior waiver programs (e.g., Acquired Brain Injury Waiver, Adult ID/DD Waiver) have been discontinued and recipients transitioned to these waivers. Additional details can be found in the detail section of this report.
17. Some Services in these waivers may be mandatory if the child is otherwise eligible for Medicaid without the waiver.
18. Physical/Occupational/Speech Therapies service detail is included in the Physician and Other Practitioner data in the detail section of this report.
19. Refers to Indian Health Services and Tribal 638 facilities.

Table 15. Service Utilization Summary

Service	Expenditures	% Change from SFY 2021	Recipient[20]	% Change from SFY 2021	Expenditures per Recipient	% Change from SFY 2021
Ambulance	$3,249,355	-5.6	3,606	5.4	$901	-10.4
Ambulatory Surgical Center	$5,117,524	22.3	3,370	24.2	$1,519	-1.5
Behavioral Health	$17,494,012	-14.5	12,048	4.7	$1,452	-18.4
Care Management Entity (CME)[21]	$3,244,965	5.2	461	-6.7	$7,039	12.8
Clinic/Center	$790,699	11.0	985	7.1	$803	3.7
Dental	$11,937,162	0.32	28,561	3.4	$418	-3.0
DME, Prosthetics/Orthodontics/Supplies	$9,940,316	1.0	8,876	8.3	$1,120	-6.8
End-Stage Renal Disease	$2,268,909	4.4	165	9.3	$13,571	-4.4
Federally Qualified Health Center	$8,752,845	28.0	8,415	13.6	$1,040	12.7
Home Health	$990,008	-0.28	246	1.2	$4,024	-1.5
Hospice	$921,529	-29.0	173	-4.4	$5,327	-25.7
Hospital Total	**$104,092,926**	**7.2**	**45,906**	**9.7**	**$2,268**	**-2.3**
Inpatient	$77,988,519	9.3	8,396	1.0	$9,289	8.2
Outpatient	$26,134,700	-1.2	37,274	12.5	$701	-12.2
Other Hospital	($30,294)	-95.8	236	-43.7	($128)	-92.5
Intermediate Care Facility (IID)	$16,842,461	-1.1	52	-1.9	$323,893	0.83
Laboratory	$1,057,050	32.6	7,751	8.3	136	22.4
Nursing Facility	$72,642,108	-7.4	2,067	-10.8	$35,144	3.8
Other	$498,738	-31.5	1,619	-45.8	$308	26.3
Physician & Other Practitioner	$53,685,571	3.5	58,335	6.9	$920	-3.2
Prescription Drug	$82,303,272	23.9	42,053	22.6	$1,957	1.0
Program for All-Inclusive Care of Elderly (PACE)[22]	--	--	--	--	--	--
PRTF	$6,101,319	-18.8	150	-25.7	$40,675	9.3
Public Health or Welfare	$356,804	-48.7	4,381	-29.8	$81	-26.8
Public Health, Federal	$21,248,347	21.7	4,432	12.7	$485	6.8
Rural Health Clinic	$3,505,312	29.4	7,232	21.2		
Vision	$3,402,928	-3.5	14,895	-0.81	$228	-2.7
Waiver Total	**$150,067,156**	**-3.5**	**5,534**	**0.18**	**$27,117**	**-3.7**
Community Choices	$33,400,970	0.77	2,943	-0.51	$11,349	1..3
Comprehensive	$108,465,328	-5.1	1,866	-1.4	$58,127	-3.8
Supports	$8,200,858	1.8	725	7.6	$11,312	-5.4
TOTAL	**$580,511,215[23]**	**2.4**	**70,930**	**6.2**	**$8,814**	**-3.6**

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 across all service areas will not equal the total recipients shown as recipients often receive multiple services throughout the SFY.
21. The Care Management Entity service includes $67,869 in expenditures paid for 11 children while enrolled in non-Medicaid state-funded institutional foster care.
22. The PACE program was discontinued in January 2021, so there were no expenditures in SFY 2022.
23. Expenditures for screenings and gross adjustments are included in the Total Expenditures. The SFY 2022 expenditures for screenings and gross adjustments are displayed in Table 9.

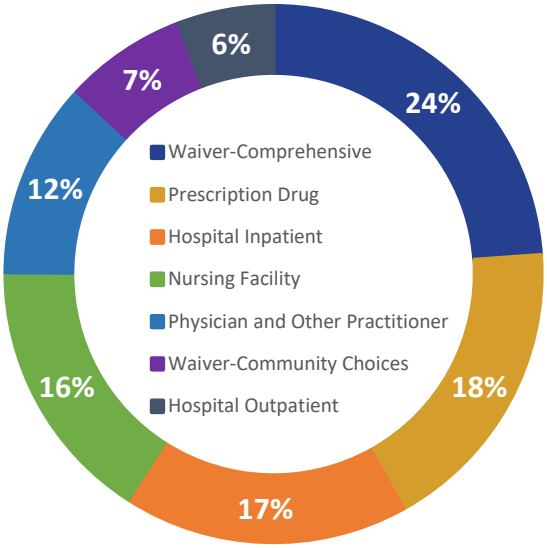


Figure 25. SFY 2022 Top Services by Expenditure

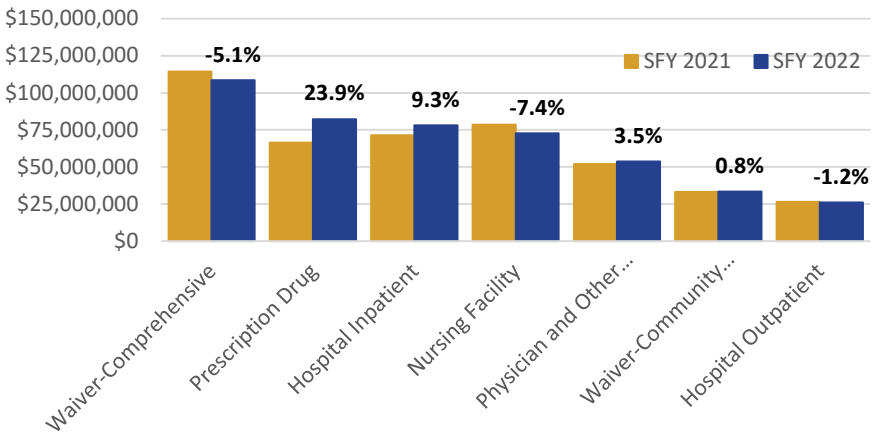


Figure 26. SFY 2022 Top Services by Expenditures versus SFY 2021 (Showing % change over SFY 2021)

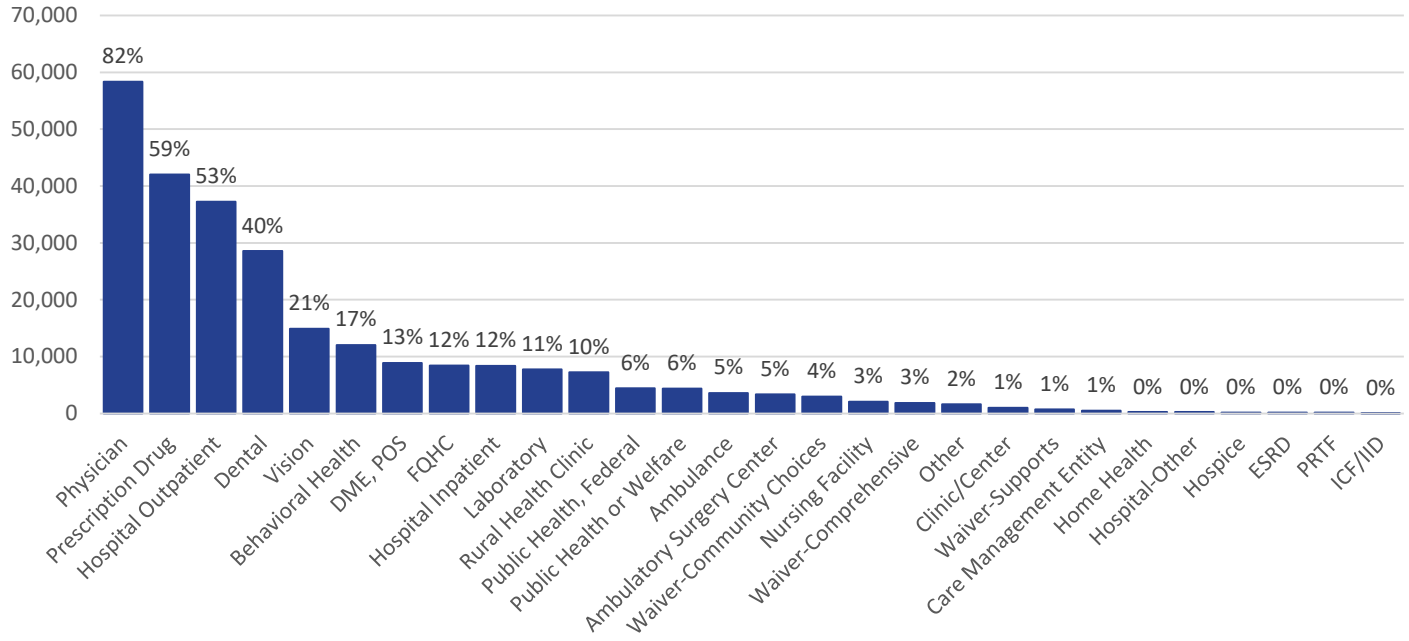


Figure 27. SFY 2022 Number of Unduplicated Recipients by Service.[24]

24. *The percentages listed above show the percent of total unduplicated recipients for each service.* the percent for the last six services, in order, are 0.35%, 0.33%, 0.24%, 0.23%, 0.21%, and 0.07%.

Table 16. Expenditure History by Service

Service	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Ambulance	$3,847,375	$2,381,969	$3,543,958	$2,869,734	$3,441,088	$3,249,355	-15.5
Ambulatory Surgical Center	$4,095,973	$3,881,705	$3,555,184	$3,170,249	$4,183,523	$5,117,524	24.9
Behavioral Health	$30,821,940	$26,738,799	$23,837,713	$22,191,112	$20,469,559	$17,494,012	-43.2
Care Management Entity (CME)[25]	$7,135,148	$7,599,455	$3,290,255	$3,928,461	$3,083,353	$3.244.965	-54.5
Clinic/Center	$1,327,800	$972,701	$815,334	$435,776	$712,388	$790,699	-40.5
Dental	$14,167,617	$11,847,581	$11,304,079	$9,893,628	$11,898,535	$11,937,162	-15.7
DME, Prosthetics/ Orthodontics/Supplies	$9,029,583	$8,390,660	$9,013,400	$9,490,752	$9,846,339	$9,940,316	10.1
End-Stage Renal Disease	$1,267,034	$1,012,427	$1,063,315	$1,595,216	$2,172,271	$2,268,909	79.1
Federally Qualified Health Center	$5,725,094	$11,418,874	$5,776,571	$6,554,011	$6,839,456	$8,752,845	52.9
Home Health	$9,596,803	$4,012,083	$570,570	$1,004,397	$992,823	$990,008	-89.7
Hospice	$1,316,838	$1,394,149	$1,190,302	$1,251,068	$1,297,041	$921,529	-30.0
Hospital Total	**$98,467,703**	**$97,086,021**	**$97,635,206**	**$87,874,110**	**$97,117,803**	**$104,092,926**	**-5.7**
Inpatient	$71,022,272	$72,073,654	$71,923,532	$63,651,012	$71,378,127	$77,988,519	9.8
Outpatient	$27,373,462	$25,021,868	$25,558,107	$23,383,212	$26,453,299	$26,134,700	-4.5
Other Hospital	$71,969	$(9,501)	$153,567	$839,885	$(713,623)	($30,294)	-142.1
Intermediate Care Facility (IID)	$19,204,867	$13,999,444	$12,901,888	$16,058,915	$17,024,561	$16,842,461	-12.3
Laboratory	$844,218	$1,020,356	$719,701	$585,977	$797,433	$1,057,050	25.2
Nursing Facility	$87,001,112	$87,304,589	$84,440,433	$89,426,962	$78,447,126	$72,642,108	-16.5
Other	$1,021,702	$1,013,196	$1,033,166	$862,825	$728,426	$498,738	-51.2
Physician & Other Practitioner	$60,013,763	$55,798,175	$50,659,864	$47,547,833	$51,893,375	$53,685,571	-10.5
Prescription Drug	$50,300,175	$57,642,641	$61,612,808	$60,473,215	$66,453,925	$82,303,272	63.6
Program for All-Inclusive Care of Elderly (PACE)[26]	$3,520,283	$3,471,255	$3,693,978	$3,586,650	$2,152,985	--	--
PRTF	$12,121,830	$12,537,788	$10,391,372	$7,334,441	$7,517,488	$6,101,319	-49.7
Public Health or Welfare	$912,684	$881,419	$917,659	$898,521	$694,880	$356,804	-60.9
Public Health, Federal	$8,718,888	$19,625,445	$12,488,676	$11,864,895	$17,453,190	$21,248,347	143.7
Rural Health Clinic	$1,540,607	$1,894,505	$2,283,377	$2,377,607	$2,708,379	$3,505,312	127.5
Vision	$3,850,574	$3,712,855	$3,466,069	$2,977,070	$3,526,355	$3,402,928	-11.6
Waiver Total	**$120,465,765**	**$132,243,321**	**$148,078,894**	**$150,076,885**	**$155,475,943**	**$150,067,156**	**24.6**
Acquired Brain Injury	$6,960,893	$4,948,202	$15,008			--	--
Adult ID/DD	$1,565					--	--
Community Choices	$20,597,605	$26,930,997	$28,957,689	$29,661,574	$33,146,033	$33,400,970	62.2
Comprehensive	$88,527,446	$94,568,471	$112,673,503	$113,532,461	$114,273,065	$108,465,328	22.5
Supports	$4,378,255	$5,795,651	$6,432,694	$6,882,850	$8,056,846	$8,200,858	87.3
TOTAL	**$556,315,377**	**$567,881,412**	**$554,283,771**	**$544,330,310**	**$566,928,245**	**$580,511,215**	**4.3**

25. The Care Management Entity service may include expenditures paid for children while enrolled in non-Medicaid, state-funded institutional foster care.
26. The PACE program was discontinued in January 2021, so there were no expenditures in SFY 2022.

Table 17. Expenditure History by Other Services [27]

Service	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Case Management	$409,938	$295,274	$188,388	$24,621	$5,940	$20,049	-95.1
Chiropractor	$280,207	$347,441	$406,862	$368,608	$337,670	$20,634	-92.6
Clinic/Center, Ambulatory Family Planning Facility	$62,853	$51,449	$51,977	$48,668	$41,326	$64,565	2.7
Clinic/Center, Radiology, Mobile	--	--		--		$158	--
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	$84,406	$29,156	$26,024	$22,394	$26,454	$30,677	-63.7
Day Training, Developmentally Disabled Services	$73,932	$73,711	$103,963	$155,484	$72,987	$94,307	27.6
Dietitian, Registered	$391	$1,803	$617	$697	$385	$2,647	577.8
Emergency Medical Technician, Basic	--	--	--	--	--	$46	--
Interpreter	$32,056	$22,119	$5,799	$9,096	$17,094	$18,652	-41.8
Lodging	$53,950	$85,915	$127,715	$108,735	$105,625	$150,329	178.6
Midwife	--	--	--	$14,782	$36,514	$43,060	--
Pharmacy, Home Infusion Therapy Pharmacy	--	--	--	--	--	$233	--
Pharmacy, Long-Term Care Pharmacy	--	--	--	--	--	$2	--
Private Vehicle	$7,329	$11,145	$18,455	$12,973	$8,702	$5,949	-18.8
Specialist		$61,574	$58,231	$60,043	$56,864	$47,341	--
Taxi	$16,674	$33,435	$45,135	$36,725	$18,864	$90	-99.5
Unclassified	$(34)	$174	--	--	--	--	--
TOTAL	**$1,021,702**	**$1,013,196**	**$1,033,166**	**$862,825**	**$728,426**	**$498,738**	**-51.2**

27. This table shows services whose criteria, as defined by the pay-to-provider taxonomy, fall outside the main list of services shown in previous tables.

Table 18. Recipient Count History by Service [28]

Service	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Ambulance	3,664	3,200	3,528	3,276	3,420	3,606	-1.58
Ambulatory Surgical Center	3,343	3,202	2,710	2,216	2,714	3,370	0.81
Behavioral Health	13,358	13,266	12,667	11,789	11,510	12,048	-9.81
Care Management Entity (CME)[29]	485	606	897	927	494	461	-4.95
Clinic/Center	1,434	1,256	1,142	860	920	985	-31.31
Dental	31,483	28,789	27,524	24,732	27,609	28,561	-9.28
DME, Prosthetics/Orthodontics/Supplies	7,476	7,367	7,497	7,712	8,197	8,876	18.73
End-Stage Renal Disease	149	158	150	171	151	165	10.74
Federally Qualified Health Center	7,052	8,927	6,340	7,421	7,408	8,415	19.33
Home Health	720	496	163	239	243	246	-65.83
Hospice	228	232	245	196	181	173	-24.12
Hospital Total	**48,040**	**47,697**	**45,161**	**45,109**	**41,864**	**45,906**	**-4.44**
Inpatient	10,262	9,281	8,810	10,736	8,312	8,396	-18.18
Outpatient	37,522	37,872	35,932	33,953	33,133	37,274	-0.66
Other Hospital	256	544	419	420	419	236	-7.81
Intermediate Care Facility (IID)	67	61	54	58	53	52	-22.39
Laboratory	8,044	8,334	6,789	5,967	7,159	7,751	-3.64
Nursing Facility	2,578	2,569	2,516	2,826	2,317	2,067	-19.82
Other	3,024	3,363	3,475	3,325	2,987	1,619	-46.46
Physician & Other Practitioner	64,070	62,674	58,644	55,463	54,573	58,335	-8.95
Prescription Drug	43,598	42,667	40,798	36,991	34,290	42,053	-3.54
Program for All-Inclusive Care of Elderly (PACE)[30]	143	178	163	186	143	--	--
PRTF	299	298	309	221	202	150	-49.83
Public Health or Welfare	7,929	8,074	7,594	7,490	6,245	4,381	-44.75
Public Health, Federal	3,530	4,138	4,135	3,696	3,934	4,432	25.55
Rural Health Clinic	4,577	5,541	6,113	5,560	5,967	7,232	58.01
Vision	15,921	15,821	14,790	12,680	15,016	14,895	-6.44
Waiver Total	**4,980**	**5,293**	**5,374**	**5,451**	**5,524**	**5,534**	**11.12**
Acquired Brain Injury	162	144	19	--	--	--	--
Adult ID/DD	1	--	--	--	--	--	--
Community Choices	2,414	2,622	2,828	2,875	2,958	2,943	21.91
Comprehensive	1,863	1,962	1,959	1,932	1,892	1,866	0.16
Supports	540	565	568	644	674	725	34.26
TOTAL	**78,223**	**76,308**	**71,408**	**68,775**	**66,791**	**70,930**	**-9.32**

28. 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 throughout the SFY.
29 The Care Management Entity service may include expenditures paid for children while enrolled in non-Medicaid, state-funded institutional foster care.
30. The PACE program was discontinued in January 2021, so there were no recipients in SFY 2022.

AMBULANCE

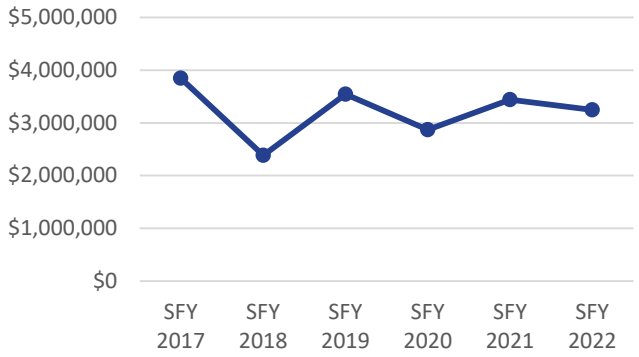
Emergency ground and air transportation and limited non-emergent ground transportation.

EXPENDITURES

$3,248,588

5.6% decrease from SFY 2021

0.6% of Total Medicaid Expenditures



RECIPIENTS

3,606

5.1% increase from SFY 2021

5.1% of Total Medicaid Recipients

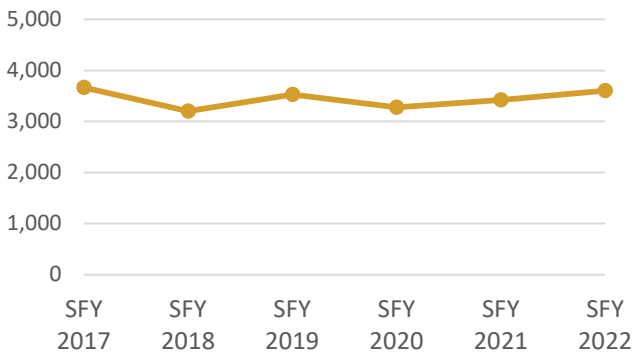


Table 19. Ambulance Services Summary

Ambulance	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Total Ambulance Services							
Expenditures	$3,847,225	$2,376,630	$3,501,735	$2,903,217	$3,437,861	$3,248,588	-15.6
Recipients	3,654	3,199	3,528	3,276	3,420	3,606	-1.3
Expenditures per Recipient	$1,053	$743	$993	$886	$1,005	$901	-14.4
Air Ambulance Services							
Expenditures	$2,444,615	$1,342,922	$2,406,019	$1,823,177	$2,340,683	$2,261,067	-7.5
Recipients	518	370	565	460	588	575	11.0
Expenditures per Recipient	$4,719	$3,630	$4,258	$3,963	$3,981	$3,932	-16.7
Ground Ambulance Services							
Expenditures	$1,402,066	$1,033,707	$1,095,716	$1,079,870	$1,097,133	$985,815	-29.7
Recipients	3,483	3,068	3,300	3,092	3,174	3,353	-3.7
Expenditures per Recipient	$403	$337	$332	$349	$346	$294	-27.0

AMBULATORY SURGICAL CENTER

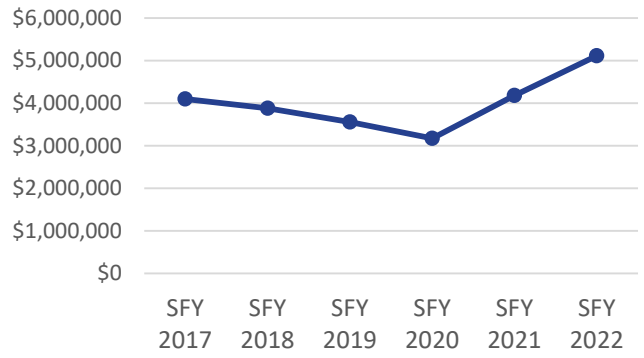
Surgical procedures that do not require overnight inpatient hospital care. Encompasses all surgical procedures covered by Medicare, as well as procedures Medicaid has approved for provision as outpatient services. Ambulatory Surgical Center (ASC) services may also be provided in an outpatient hospital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

EXPENDITURES

$5,117,524

22.3% increase from SFY 2021

0.9% of Total Medicaid Expenditures



RECIPIENTS

3,370

24.2% increase from SFY 2021

4.8% of Total Medicaid Recipients

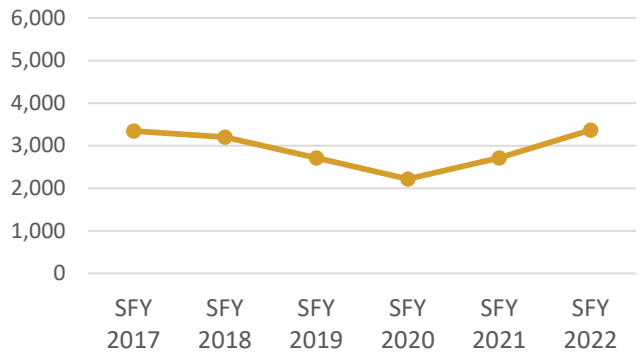


Table 20. Ambulatory Surgery Center Services Summary

Ambulatory Surgery Center Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$4,095,973	$3,881,705	$3,555,184	$3,170,249	$4,183,523	$5,117,524	24.9
Recipients	3,343	3,202	2,710	2,216	2,714	3,370	0.81
Expenditures per Recipient	$1,225	$1,212	$1,312	$1,431	$1,541	$1,519	23.9

BEHAVIORAL HEALTH

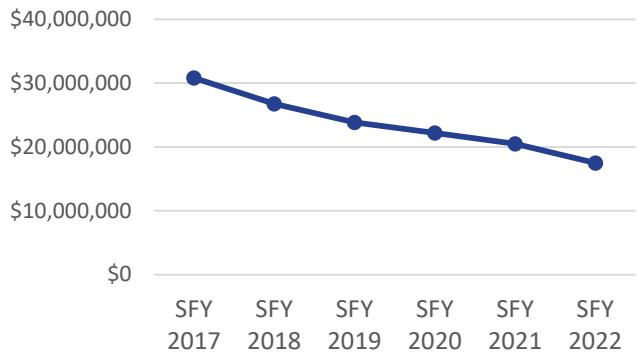
Outpatient and community-based behavioral health services for Wyoming Medicaid clients who are experiencing mental health and/or substance use symptoms.

EXPENDITURES

$17,464,012

14.5% decrease from SFY 2021

3.0% of Total Medicaid Expenditures



RECIPIENTS

12,048

4.7% increase from SFY 2021

17.0% of Total Medicaid Recipients

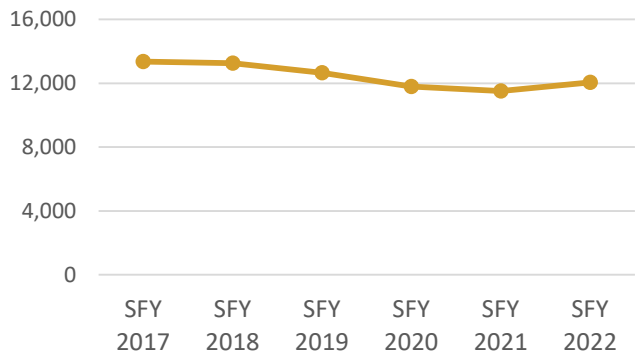


Table 21. Behavioral Health Services Summary

Behavioral Health	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Behavioral Health Services							
Expenditures	$30,821,940	$26,738,799	$23,837,713	$22,191,112	$20,469,559	$17,494,012	-43.2
Recipients	13,358	13,266	12,667	11,789	11,510	12,048	-9.8
Expenditures per Recipient	$2,307	$2,016	$1,882	$1,882	$1,778	$1,452	-37.0
Non-Behavioral Health Provider Services							
Expenditures	$3,714,493	$3,620,929	$5,410,915	$5,766,773	$7,681,712	$7,613,822	105.0
Recipients	4,907	5,778	6,342	6,596	7,239	7,522	53.3
Expenditures per Recipient	$757	$627	$853	$874	$1,061	$1,012	33.7

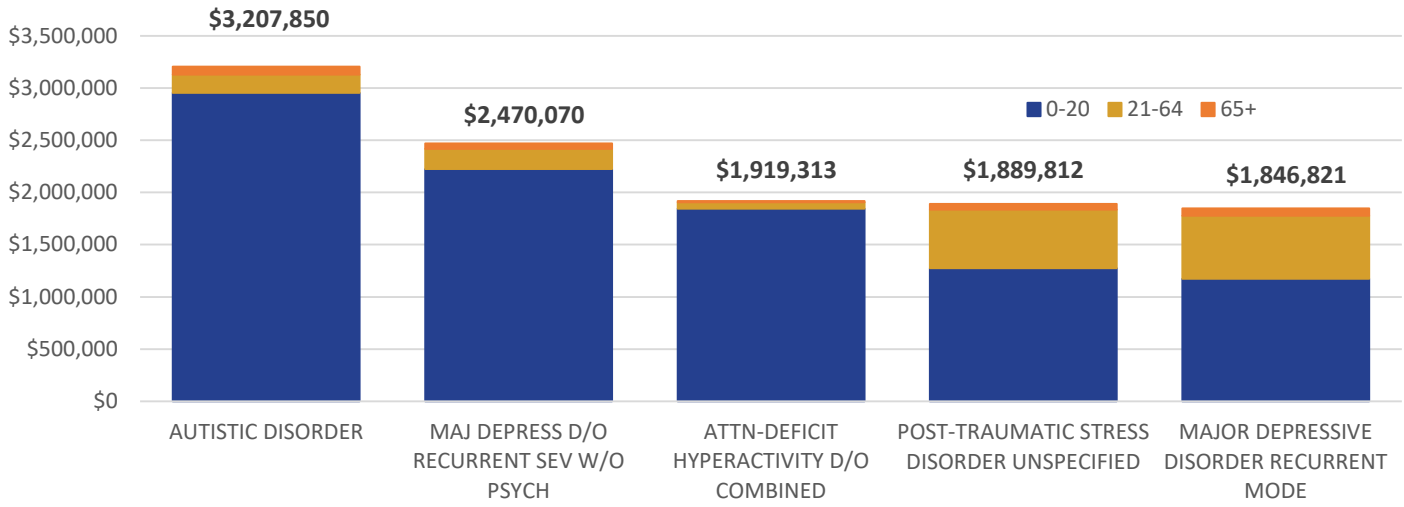


Figure 28. Top Five Behavioral Health Diagnosis Codes by Expenditures for All Provider Types, (excluding Alzheimer's and Other Types of Dementia)

Table 22. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types [31]

Diagnosis Description	Age 0-20	Age 21-64	Age 65+	Total
AUTISTIC DISORDER	$2,955,786	$175,231	$76,834	$3,207,850
MAJ DEPRESS D/O RECURRENT SEV W/O PSYCH	$2,226,630	$191,892	$51,548	$2,470,070
ATTN-DEFICIT HYPERACTIVITY D/O COMBINED	$1,846,266	$60,849	$12,199	$1,919,313
POST-TRAUMATIC STRESS DISORDER UNSPECIFIED	$1,275,210	$559,947	$54,655	$1,889,812
MAJOR DEPRESSIVE DISORDER RECURRENT MODE	$1,172,849	$605,737	$68,234	$1,846,821
	$9,476,741	**$1,593,655**	**$263,470**	**$11,333,866**

On January 1, 2017, the Centers for Medicare & Medicaid Services (CMS) required Medicaid programs to provide medically necessary diagnostic and treatment services to beneficiaries with Autism Spectrum Disorder (ASD) under the age of 21 years. Applied Behavior Analysis (ABA) treatment was implemented.

Table 23. Applied Behavior Analysis Treatment Summary

Applied Behavior Analysis Services	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Expenditures	$239,369	$888,167	$1,661,511	$1,445,297
Recipients	46	75	71	53
Expenditures per Recipient	$5,204	$11,842	$23,402	$27,270
Providers	4	7	6	7

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

CARE MANAGEMENT ENTITY

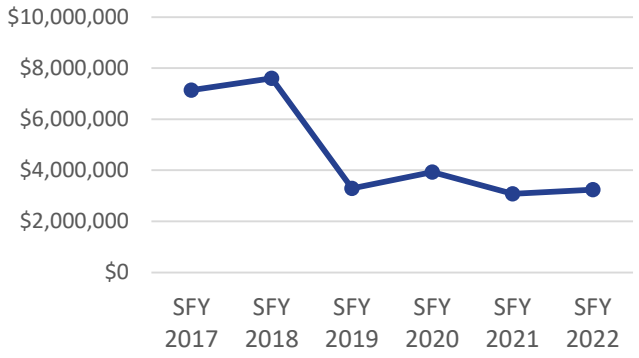
Provides intensive care coordination to children and youth with complex behavioral health conditions and their families, using a High Fidelity Wrap-around model to support their success in their homes, schools, and communities.

EXPENDITURES

$3,244,965

5.2% increase from SFY 2021

0.6% of Total Medicaid Expenditures



RECIPIENTS

461

6.7% decrease from SFY 2021

0.6% of Total Medicaid Recipients

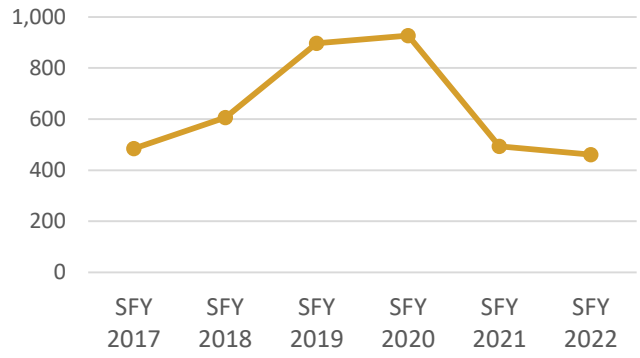


Table 24. Care Management Entity (CME) Services Summary

Care Management Entity Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$7,135,148	$7,599,455	$3,290,255	$3,928,461	$3,083,353	$3,244,965	-54.52
Recipients	485	606	897	927	494	461	-4.95
Expenditures per Recipient	$14,712	$12,540	$3,668	$4,238	$6,242	$7,039	-52.15

CLINIC / CENTER (DEVELOPMENTAL CENTERS)

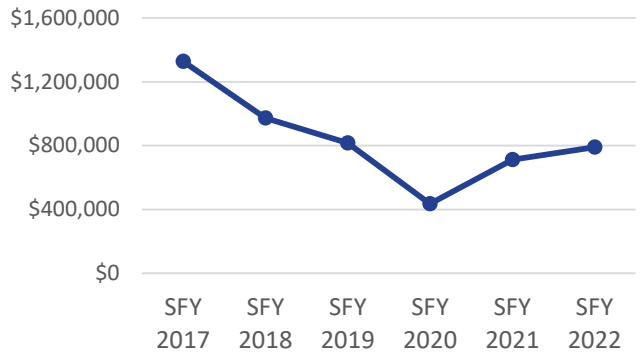
Services for clients with developmental disabilities who qualify for programs, training, care, treatment, and supervision in a structured setting, provided by state or privately funded facilities. Services include diagnostic evaluations and assessments, physical, occupational, and speech therapies, and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

EXPENDITURES

$790,699

11.0% increase from SFY 2021

0.1% of Total Medicaid Expenditures



RECIPIENTS

985

7.1% increase from SFY 2021

1.4% of Total Medicaid Recipients

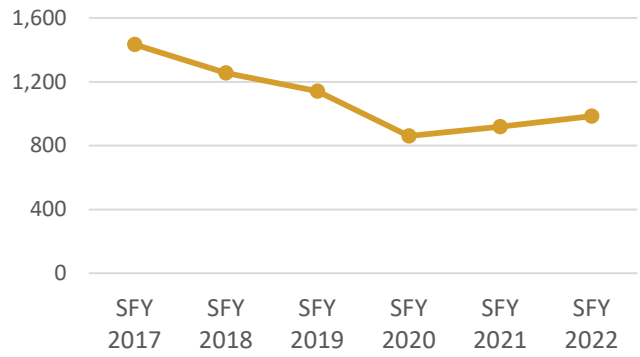


Table 25. Clinic/Center (Developmental Centers) Services Summary

Clinic/Center (Developmental Centers) Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$1,327,800	$972,701	$815,334	$435,776	$712,388	$790,699	-40.45
Recipients	1,434	1,256	1,142	860	920	985	-31.31
Expenditures per Recipient	$926	$774	$714	$507	$774	$803	-13.31

DENTAL

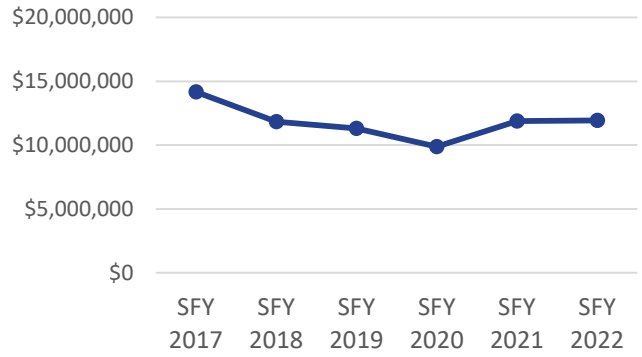
Dental services are covered based on enrolled members' age, with the goal of ensuring access to dental care so recipients may avoid emergency dental situations by receiving preventive and routine dental services for overall oral health.

EXPENDITURES

$11,937,162

0.3% increase from SFY 2021

2.1% of Total Medicaid Expenditures



RECIPIENTS

28,561

3.4% increase from SFY 2021

40.3% of Total Medicaid Recipients

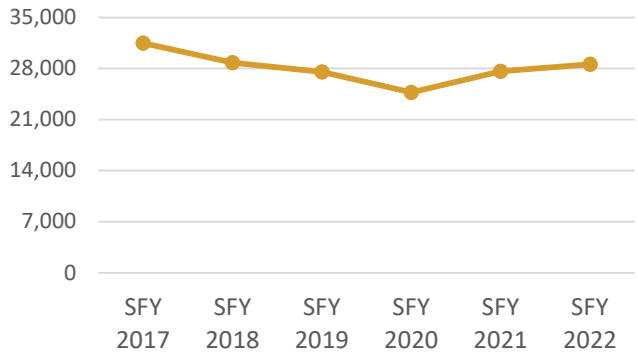


Table 26. Dental Services Summary

Dental Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$14,167,617	$11,847,581	$11,304,079	$9,893,628	$11,898,535	$11,937,162	-15.74
Recipients	31,483	28,789	27,524	24,732	27,609	28,561	-9.28
Expenditures per Recipient	$450	$412	$411	$400	$431	$418	-7.12

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, & SUPPLIES (DME)

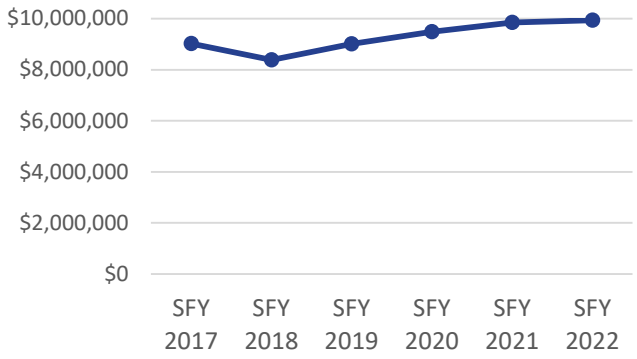
Services are covered when ordered by a physician or other licensed practitioner for home use to reduce an individual's physical disability and restore the individual to a functional level.

EXPENDITURES

$9,940,316

1.0% increase from SFY 2021

1.7% of Total Medicaid Expenditures



RECIPIENTS

8,876

8.3% increase from SFY 2021

12.5% of Total Medicaid Recipients

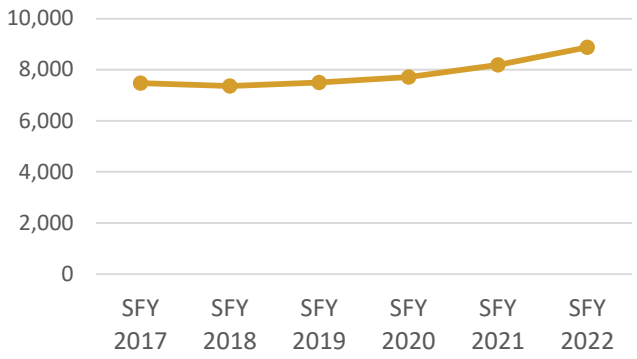


Table 27. DME Services Summary [32]

DME	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Total Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services							
Expenditures	$9,029,583	$8,390,660	$9,013,400	$9,490,752	$9,846,339	$9,940,316	10.09
Recipients	7,476	7,367	7,497	7,712	8,197	8,876	18.73
Expenditures per Recipient	$1,208	$1,139	$1,202	$1,231	$1,201	$1,120	-7.28
Durable Medical Equipment Services							
Expenditures	$8,285,291	$7,746,167	$8,437,833	$8,934,057	$9,242,980	$9,372,951	13.13
Recipients	7,069	6,973	7,170	7,356	7,876	8,376	18.49
Expenditures per Recipient	$1,172	$1,111	$1,177	$1,215	$1,174	$1,119	-4.52
Prosthetics, Orthotics, and Supplies Services							
Expenditures	$757,241	$615,641	$590,930	$541,981	$610,290	$570,717	-24.63
Recipients	665	626	576	585	547	776	16.69
Expenditures per Recipient	$1,139	$983	$1,026	$926	$1,116	$735	-35.41

32. This table displays expenditures and a unique count of recipients for each of the two DME sub-service areas, as well as the totals for all DME, Prosthetics, Orthotics, and Supplies Services. Summing expenditures or recipients of the two sub-service areas will not equal the totals for all DME services because recipients may receive services from both DME sub-service areas.

END-STAGE RENAL DISEASE

All medically necessary services related to renal disease care, including inpatient renal dialysis and outpatient services related to end-stage renal disease (ESRD) treatment, as well as treatment if Medicare denies coverage for an enrolled member on a home dialysis program. A hospital or free-standing facility must be a certified ESRD facility. Personal care attendants are not covered by this program.

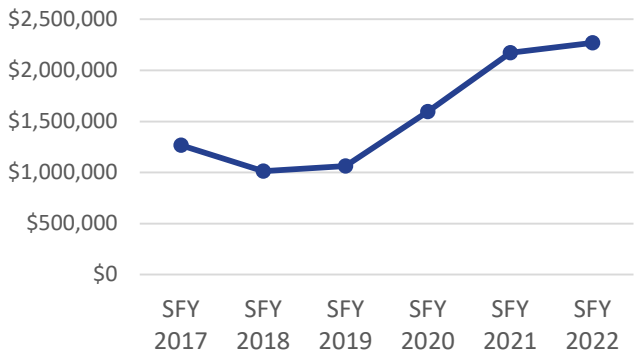
The majority of ESRD recipients are dual individuals, those enrolled in both Medicare and Medicaid. Medicare is the primary payer for End-Stage Renal Disease (ESRD) services for dual individuals, and therefore most Medicaid ESRD expenditures are for Medicaid-only individuals.

EXPENDITURES

$2,268,909

4.4% increase from SFY 2021

0.4% of Total Medicaid Expenditures



RECIPIENTS

165

9.3% increase from SFY 2021

0.2% of Total Medicaid Recipients

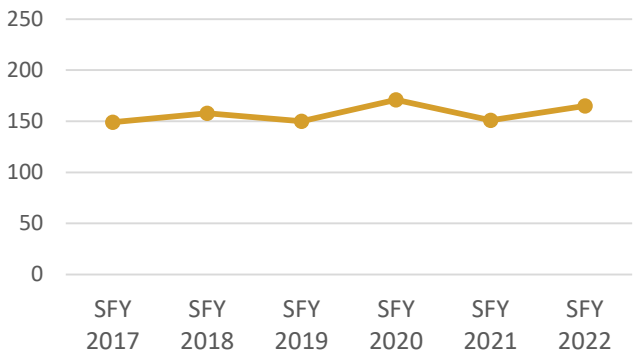


Table 28. End-Stage Renal Disease Services Summary

End-Stage Renal Disease Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$1,267,034	$1,012,427	$1,063,315	$1,595,216	$2,172,271	$2,268,909	79.07
Recipients	149	158	150	171	151	165	10.74
Expenditures per Recipient	$8,504	$6,408	$7,089	$9,329	$14,386	$13,751	61.71

FEDERALLY QUALIFIED HEALTH CENTER

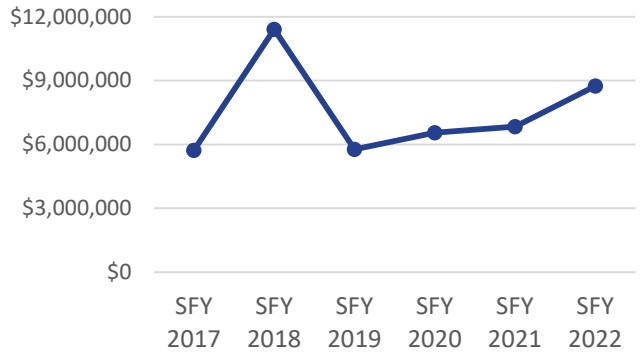
Provides preventive primary health services when medically necessary and provided by or under the direction of a physician, physician assistant, nurse practitioner, nurse midwife, dentist, orthodontist, licensed clinical psychologist, or licensed clinical social worker. The facility is designated as 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.

EXPENDITURES

$8,752,845

28.0% increase from SFY 2021

1.5% of Total Medicaid Expenditures



RECIPIENTS

8,415

13.6% increase from SFY 2021

11.9% of Total Medicaid Recipients

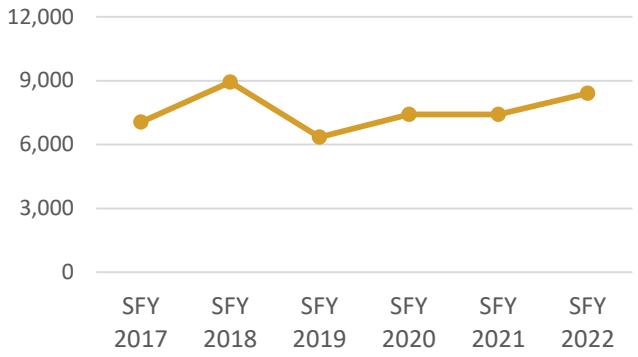


Table 29. Federally Qualified Health Center Services Summary[33]

Federally Qualified Health Center Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$5,725,094	$11,418,874	$5,776,571	$6,554,011	$6,839,456	$8,752,845	52.89
Recipients	7,052	8,927	6,340	7,421	7,408	8,415	19.33
Expenditures per Recipient	$812	$1,279	$911	$883	$923	$1,040	28.12

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

HOME HEALTH

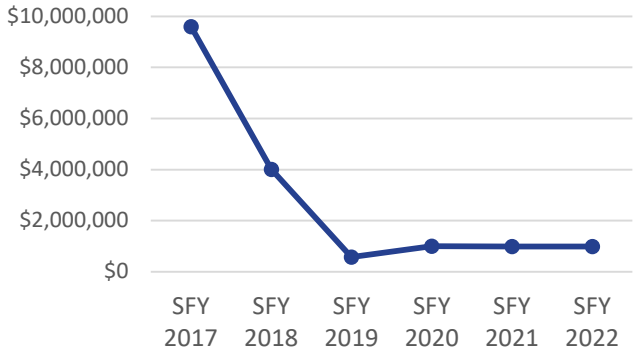
Services are intended to be a temporary transitional program to assist Members with care required after an acute health incident or an institutional stay. The services are intermittent and assist with medical support and education to the Member and any caregiver regarding the Member's new medical needs. Services must be medically necessary, ordered by a physician, and documented in a signed/dated treatment plan to be reviewed and revised as medically necessary by the attending physician at least every 60 days.

EXPENDITURES

$990,008

0.3% decrease from SFY 2021

0.2% of Total Medicaid Expenditures

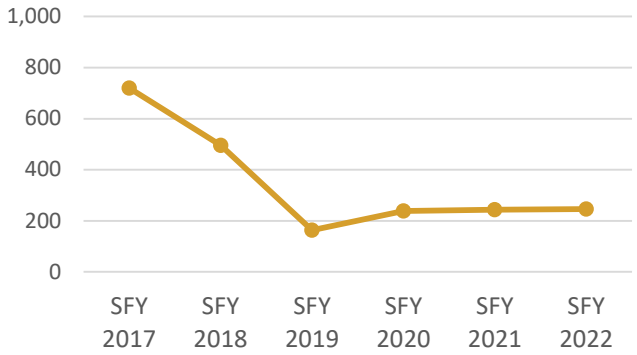


RECIPIENTS

246

1.2% increase from SFY 2021

0.3% of Total Medicaid Recipients



Home Health agencies must provide at least two of the following services to be a licensed provider in the state of Wyoming:	The following are NOT covered Home Health services:
• 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	• homemaking • respite care • Meals on Wheels or home-delivered meals • services deemed inappropriate or not cost-effective in home setting

Table 30. Home Health Services Summary

Home Health Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$9,596,803	$4,012,083	$570,570	$1,004,397	$992,823	$990,008	-89.68
Recipients	720	496	163	239	243	246	-65.83
Expenditures per Recipient	$13,329	$8,089	$3,500	$4,202	$4,086	$4,024	-69.81

HOSPICE

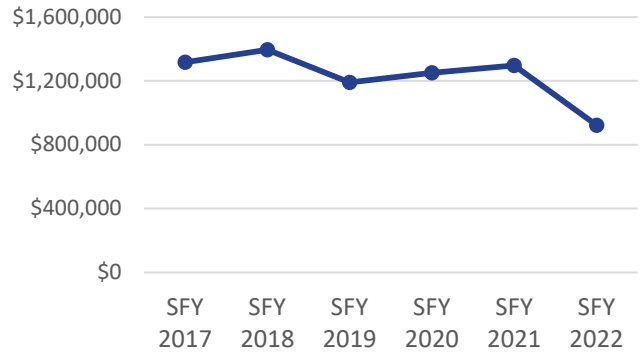
An interdisciplinary approach to caring for the psychological, social, spiritual, and physical needs of dying individuals. Hospice care is covered if the individual elects it and a physician certifies that the individual is terminally ill. Covered services include routine and continuous home care, inpatient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

EXPENDITURES

$921,529

29.0% decrease from SFY 2021

0.2% of Total Medicaid Expenditures



RECIPIENTS

173

4.4% decrease from SFY 2021

0.2% of Total Medicaid Recipients

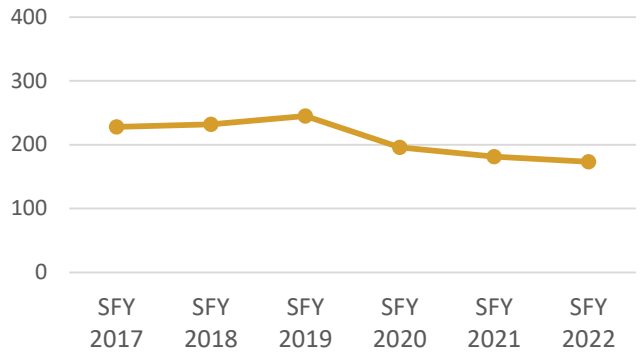


Table 31. Hospice Services Summary

Hospice Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$1,316,838	$1,394,149	$1,190,302	$1,251,068	$1,297,041	$921,529	-30.02
Recipients	228	232	245	196	181	173	-24.12
Expenditures per Recipient	$5,776	$6,009	$4,858	$6,383	$7,166	$5,327	-7.77

HOSPITAL

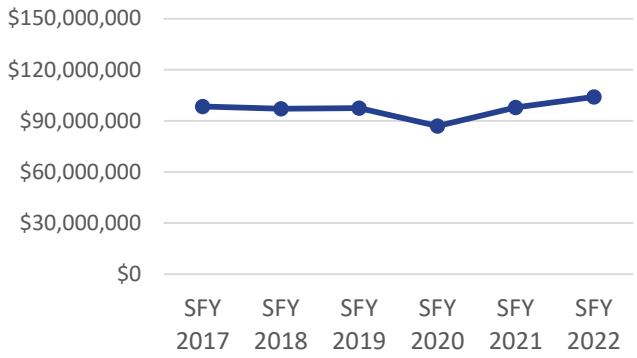
Inpatient and Outpatient hospital services.

EXPENDITURES

$104,123,220

6.4% increase from SFY 2021

17.9% of Total Medicaid Expenditures



RECIPIENTS

45,670

10.2% increase from SFY 2021

64.4% of Total Medicaid Recipients

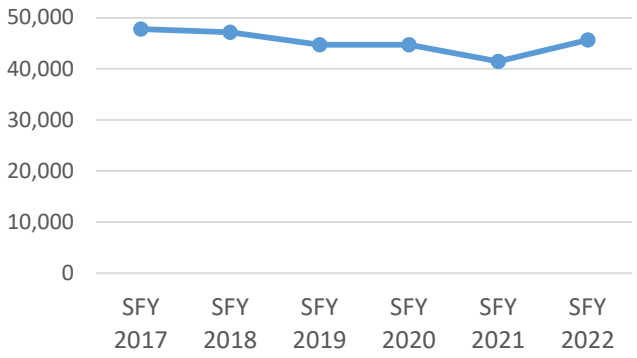


Table 32. Total Hospital Services Summary

Total Hospital Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$98,395,734	$97,095,522	$97,481,639	$87,034,224	$97,831,427	$104,123,220	5.82
Recipients	47,784	47,153	44,742	44,689	41,445	45,670	-4.42
Expenditures per Recipient	$7,650	$8,426	$8,875	$6,617	$9,386	$9,990	30.58
Supplemental Payments & Taxes[34]							
Private Hospital Tax[35]	--	--	--	--	--	$8,474,217	--
Physician & Surgical Services (PSSP)[35]	--	--	--	--	--	$20,992,651	--
Qualified Rate Adjustment (QRA[36])	$11,202,759	$12,472,416	$13,065,161	$12,073,261	$12,969,675	$25,939,349	131.54
Total Expenditures plus Supplemental Payments	$109,598,493	$109,567,938	$110,546,800	$99,107,485	$110,801,102	$159,529,437	45.56

34. See Table 33 for hospital supplemental payment and tax explanations'
35. SFY 2022 is the first year for reporting the Private Hospital tax and the PSSP in the Annual Report.
36. For QRA supplemental Payments, only the Federal portion was reported prior to SFY 2022, so the 5-year % change is greater than it would otherwise be.

Table 33. Hospital Supplemental Payment and Tax definitions

Supplemental Payment/Tax	Definition
Private Hospital Tax	Only privately owned facilities are included in this non-optional tax. These providers are reimbursed quarterly. The amount available within the Private Hospital Supplemental Payment (PHP) pool will equal the aggregate Upper Payment Limit (UPL) gap for privately owned and operated hospitals. The UPL gap is calculated to be the total of the difference between the amount that would have been paid under Medicare payment principles (cost-based) in accordance with 42 CFR 447.272 (Upper Payment Limit) and the amount paid for such services by the Medicaid agency. This is a Tax and is not optional regardless of Hospital Medicaid status.
Physician and Surgical Services (PSSP)	Non-State-Government-Owned or Operated (NGSO) Hospitals shall receive an annual lump sum supplemental payment. The PSSP amount available for each provider group owned or operated by a NSGO hospital participating in the PSSP program will equal the difference between the Medicaid payment ceiling that Wyoming commercial payers would pay under average commercial rate (ACR) principles and the amount paid for the same services by the Wyoming Department of Health. Aggregate payments to provider groups owned or operated by NSGO hospitals shall not exceed the Medicaid upper payment limit (UPL) in accordance with section 1902(a)(30(A) of the Social Security Act. The Department will perform the Medicaid UPL analysis prior to making the supplemental payments.
Qualified Rate Adjustment (QRA)	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.

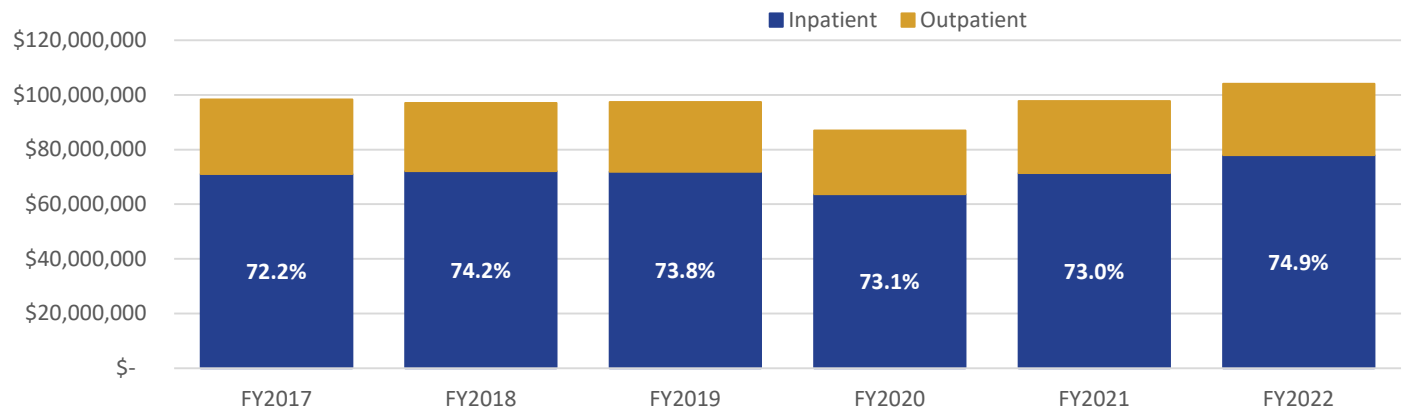


Figure 29. Hospital Inpatient and Outpatient Expenditure Breakdown History

INPATIENT HOSPITAL 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 34. Inpatient Hospital Services Summary

Inpatient Hospital Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$71,022,272	$72,073,654	$71,923,532	$63,651,012	$71,378,127	$77,988,519	9.81
Recipients	10,262	9,281	8,810	10,736	8,312	8,396	-18.18
Expenditures per Recipient	$6,921	$7,766	$8,164	$5,929	$8,587	$9,289	34.21
Inpatient Hospital Supplemental Payments[37]							
Private Hospital Tax[38]	--	--	--	--	--	$1,230,916	--
Qualified Rate Adjustment (QRA)[39]	$2,200,706	$3,010,904	$3,942,199	$4,038,693	$3,151,019	$6,322,037	187.27
Total Expenditures plus Supplemental Payments	$73,222,978	$75,084,558	$75,865,731	$72,689,705	$74,529,146	$85,481,472	16.82

OUTPATIENT HOSPITAL 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, visits for family planning, Health Check services, and emergency room.

Table 35. Outpatient Hospital Services Summary

Outpatient Hospital Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$27,373,462	$25,021,868	$25,558,107	$23,383,212	$26,453,299	$26,134,700	-4.53
Recipients	37,522	37,872	35,932	33,953	33,133	37,274	-0.66
Expenditures per Recipient	$730	$661	$711	$689	$798	$701	-3.89
Inpatient Hospital Supplemental Payments[37]							
Private Hospital Tax[38]	--	--	--	--	--	$7,243,301	--
Qualified Rate Adjustment (QRA)[39]	$9,002,053	$9,461,519	$9,122,962	$8,034,563	$9,808,656	$19,617,312	117.92
Total Expenditures plus Supplemental Payments	$36,375,515	$34,483,387	$34,681,069	$31,417,775	$36,261,955	$52,995,313	45.69

37. See Table 33 for hospital supplemental payment and tax explanations'
38. SFY 2022 is the first year for reporting the Private Hospital tax in the Annual Report.
39. For QRA supplemental Payments, only the Federal portion was reported prior to SFY 2022, so the 5-year % change is greater than it would otherwise be.

For each unit of service, reimbursement equals the scaled relative weight[34] for the Ambulatory Payment Classification (APC), multiplied by a conversion factor.[40] 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:[41] • 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

EMERGENCY ROOM SERVICES

The methodology used to identify emergency room utilization was 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 36. Emergency Room Utilization History

Emergency Room Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$15,433,747	$14,035,612	$13,619,756	$12,511,151	$12,030,079	$14,290,525	-7.41
Recipients	25,687	24,648	23,442	21,251	19,232	23,233	-9.55
Expenditures per Recipient	$531	$546	$541	$592	$610	$701	2.37
Emergency Room Visits	48,578	47,214	44,485	37,800	35,380	44,108	-9.20
% of Total Medicaid Expenditures	**2.51**	**2.31**	**2.31**	**2.11**	**2.01**	**2.44**	**-2.88**

40. 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.
41. Some services from the APC methodology are reimbursed on separate fee schedules, as follows: select DME are covered under the 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 the charges

Table 37. Emergency Room Utilization Summary by Eligibility Category

Eligibility Category	Expenditures	% Change from SFY 2021	Recipient[42]	% Change from SFY 2021	Expenditures per Recipient	% Change from SFY 2021
ABD EID	$36,480	-11.16	115	0.88	$317	0.24
ABD ID/DD/ABI	$274,611	11.48	711	11.79	$386	0.26
ABD Institution	$9,996	5.22	18	20.00	$555	0.14
ABD Long-Term Care	$556,027	7.27	1,728	11.05	$322	0.29
ABD SSI & SSI Related	$2,014,716	-2.47	2,405	5.58	$838	0.10
Adults	$3,556,459	15.12	3,767	18.31	$944	0.10
Children	$5,910,012	36.12	11,528	32.43	$513	0.21
Medicare Savings Programs	$122,501	10.17	961	8.47	$127	0.81
Non-Citizens with Medical Emergencies	$42,371	301.53	58	222.22	$731	0.21
Pregnant Women	$1,028,080	38.29	1,334	28.15	$771	0.15
Special Groups	$23,973	-53.09	22	4.76	$1,090	0.02
TOTAL	**$14,290,525**	**18.79**	**23,233**	**20.80**	**$615**	**0.16**

Table 38. 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	115	318	36.16	$36,480	$(260,705)	-13.99
ABD ID/DD/ABI	711	2,659	26.74	$274,611	$150,075,613	0.18
ABD Institution	18	57	31.58	$9,996	$1,342,111	0.74
ABD Long-Term Care	1,728	4,977	34.72	$556,027	$127,024,117	0.44
ABD SSI & SSI Related	2,405	5,949	40.43	$2,014,716	$62,668,792	3.21
Adults	3,767	9,083	41.47	$3,556,459	$58,987,396	6.03
Children	11,528	42,216	27.31	$5,910,012	$150,272,180	3.93
Medicare Savings Programs	961	2,687	35.76	$122,501	$1,904,049	6.43
Non-Citizens with Medical Emergencies	58	154	37.66	$42,371	$781,986	5.42
Pregnant Women	1,334	4,264	31.29	$1,028,080	$24,065,741	4.27
Special Groups	22	99	22.22	$23,973	$2,391,243	1.00
TOTAL	**23,233**	**70,930**	**32.75**	**$14,290,525**	**$580,511,215**	**2.46**

42. This column 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.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID)

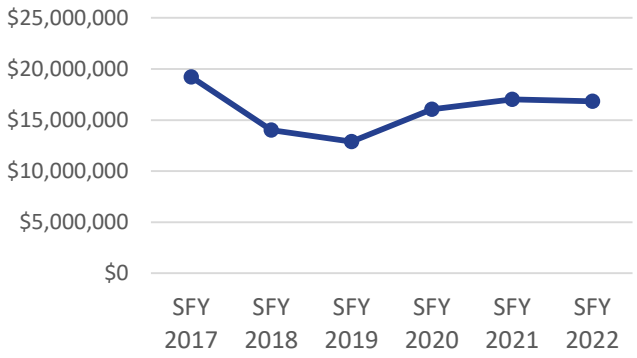
Services are covered only in a residential facility licensed and certified by the state survey agency as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The Wyoming Life Resource Center is the sole facility in the state. This service is unique to Medicaid and is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

EXPENDITURES

$16,842,461

1.1% decrease from SFY 2021

2.9% of Total Medicaid Expenditures



RECIPIENTS

52

1.9% decrease from SFY 2021

0.1% of Total Medicaid Recipients

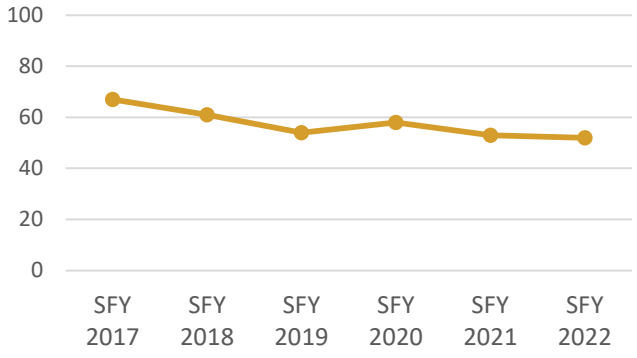


Table 39. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) Services Summary

ICF-IID Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$19,204,867	$13,999,444	$12,901,888	$16,058,915	$17,024,561	$16,842,461	-12.30
Recipients	67	61	54	58	53	52	-22.39
Expenditures per Recipient	$286,640	$229,499	$238,924	$276,878	$321,218	$323,893	13.00

LABORATORY

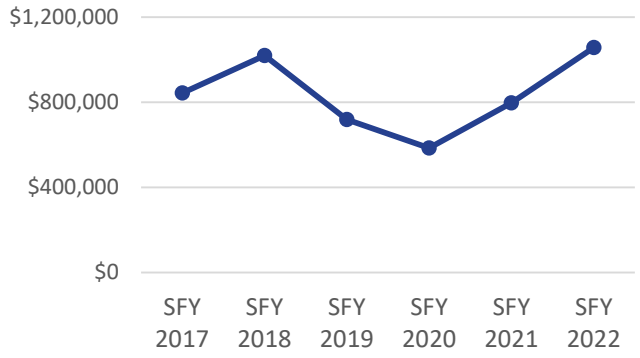
Medicaid covers professional and technical laboratory services ordered by a practitioner that is directly related to the diagnosis and treatment of the individual as specified in the treatment plan developed by the ordering practitioner.

EXPENDITURES

$1,057,050

32.6% increase from SFY 2021

0.2% of Total Medicaid Expenditures



RECIPIENTS

7,751

8.3% increase from SFY 2021

10.9% of Total Medicaid Recipients

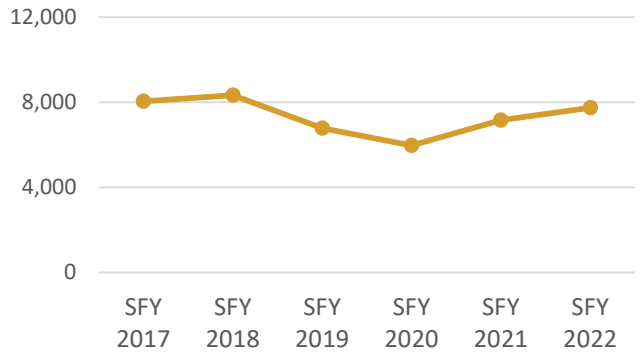


Table 40. Laboratory Services Summary

Laboratory Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$844,218	$1,020,356	$719,701	$585,977	$797,433	$1,057,050	25.21
Recipients	8,044	8,334	6,789	5,967	7,159	7,751	-3.64
Expenditures per Recipient	$105	$122	$106	$98	$111	$136	29.94

NURSING FACILITY

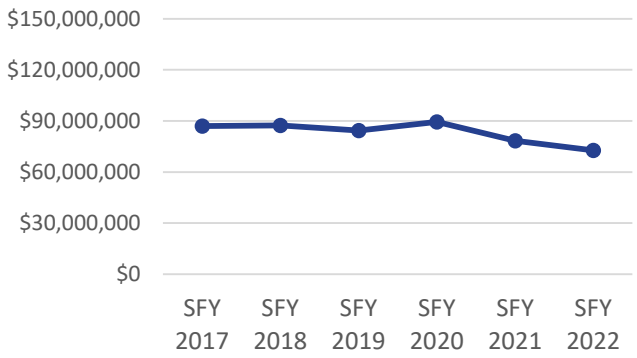
Medicaid covers nursing facility services for individuals who are no longer able to live in the community. The nursing facility is an institution, or a distinct part of an institution, which is not primarily for the care and treatment of mental diseases, and provides skilled nursing care and related 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.

EXPENDITURES

$72,642,108

7.4% decrease from SFY 2021

12.5% of Total Medicaid Expenditures



RECIPIENTS

2,067

10.8% decrease from SFY 2021

2.9% of Total Medicaid Recipients

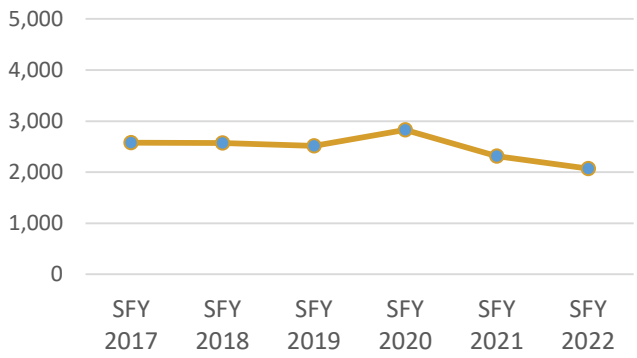


Table 41. Nursing Facility Services History [43]

Emergency Room Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$87,001,112	$87,304,589	$84,440,433	$89,426,962	$78,447,126	$72,642,108	-16.50
Recipients	2,578	2,569	2,516	2,826	2,317	2,067	-19.82
Expenditures per Recipient	$33,748	$33,984	$33,561	$31,644	$33,857	$35,144	4.14
GAP	--	--	--	--	--	$4,174,508	--
Provider Assessment/UPL (Federal Share)	$15,275,937	$16,385,303	$16,949947	$16,936,907	$5,325,748	$8,484,550	-44.46
Total Expenditures							

43 See Table 42 for definitions of extra payments to nursing facilities (GAP and Provider Assessment/UPL). GAP payment amounts are not available for SFY's prior to SFY 2022

Table 42. Nursing Facility Programs Rates and Payments

Rate/Payment	Definition
GAP	Supplemental payment for non-State-government-owned nursing facilities. The total funds available for the distribution will equal the UPL gap remaining after the UPL distributions are made under the existing authority. The undistributed balance will remain available for this distribution program. The state shall distribute the funds based on the percentage to total of each provider's calculation of the difference between what Medicaid paid and what Medicare would have paid, less the original supplemental PL payment, as calculated on the annual UPL demonstration. If this calculation results in the provider having a negative UPL gap, that provider will not qualify for the payment.
Provider Assessment and Upper Limit Payment (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.
Per Diem Rate	Based on facility-specific cost reports May not exceed the 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
Extraordinary Care Per Diem Rate	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

PHYSICIAN AND OTHER PRACTITIONER

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.

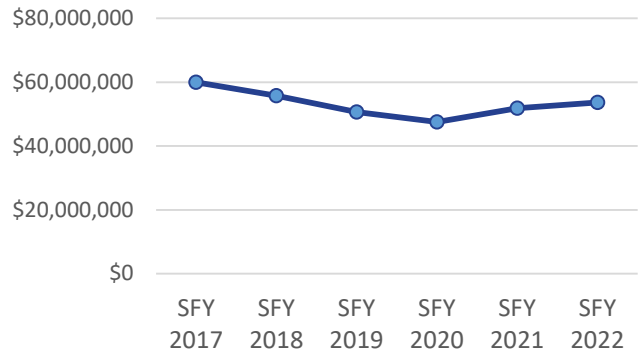
There is no limit for Medicare crossovers or children under age 21; also no limit for family planning visits, Health Check services, or emergency services.

EXPENDITURES

$53,685,571

3.5% increase from SFY 2021

9.2% of Total Medicaid Expenditures



RECIPIENTS

58,335

6.9% increase from SFY 2021

82.2% of Total Medicaid Recipients

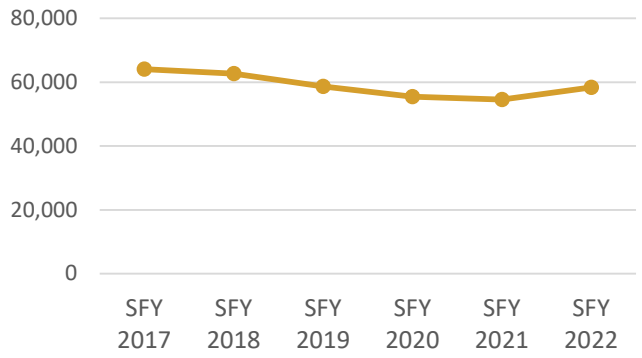


Table 43. Physician and Other Practitioner Services Summary[44]

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Total Physician and Other Practitioner Services							
Expenditures	$60,013,763	$55,798,175	$50,659,864	$47,547,833	$51,893,375	$53,685,571	-10.54
Recipients	64,070	62,674	58,644	55,463	54,573	58,335	-8.95
Expenditures per Recipient	$937	$890	$864	$857	$951	$920	-1.75
Physician Services							
Expenditures	$51,857,906	$49,001,617	$45,269,907	$42,053,713	$45,805,772	$47,006,260	-9.36
Recipients	63,358	62,133	58,029	54,642	53,716	57,276	-9.60
Expenditures per Recipient	$818	$789	$780	$770	$853	$821	0.27
Other Practitioner Services							
Expenditures	$8,155,858	$6,796,557	$5,389,957	$5,494,119	$6,087,603	$6,679,311	-18.10
Recipients	8,732	7,150	7,242	7,793	8,421	9,943	13.87
Expenditures per Recipient	$934	$951	$744	$705	$723	$672	-28.08

44. This table displays expenditures and a unique count of recipients for each of the two Physician and Other Practitioner sub-service areas, as well as the totals for all Physician and Other Practitioner Services. Summing recipients of the two sub-service areas will not equal the totals for all of the services because recipients may receive services from both sub-service areas.

Other Practitioners Include:

- 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

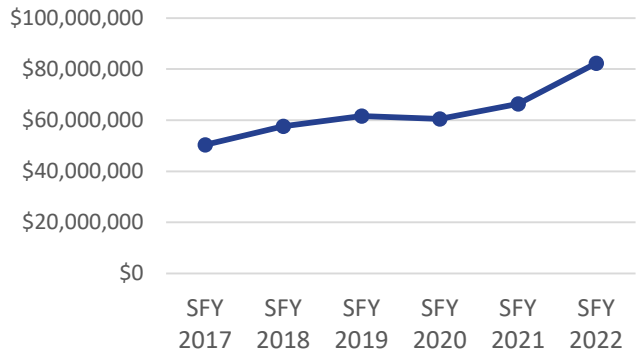
Medicaid covers most prescription drugs and specific over-the-counter drugs. A prescription and co-payment are required for all drugs for most individuals. Exceptions may apply for specific products or conditions.

EXPENDITURES

$82,303,272

23.9% increase from SFY 2021

14.2% of Total Medicaid Expenditures



RECIPIENTS

42,053

22.6% increase from SFY 2021

59.3% of Total Medicaid Recipients

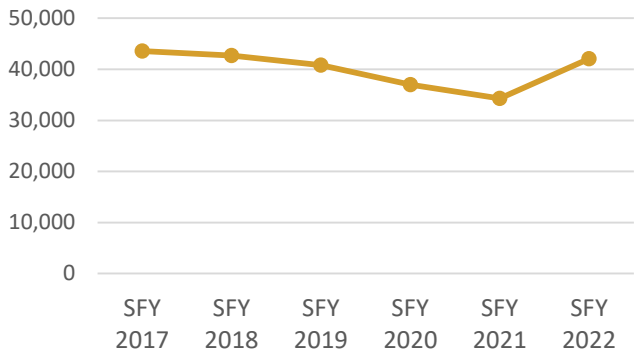


Table 44. Prescription Drug Services Summary[45]

Prescription Drug Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$50,300,175	$57,642,641	$61,612,808	$60,473,215	$66,453,925	$82,303,272	63.62
Recipients	43,598	42,667	40,798	36,991	34,290	42,053	-3.54
Expenditures per Recipient	$1,154	$1,351	$1,510	$1,635	$1,938	$1,957	69.64

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

133

specific drug classes designated as preferred drugs in SFY 2022

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

Table 45. Pharmacy Cost Avoidance - SFY 2022

Program Area	Cost Avoidance
Prior Authorization (PA) Preferred Drug List (PDL)	$13,506.785
State Maximum Allowable Cost (SMAC)	$1,577,631
Program Integrity Cost Avoidance	$1,451,583
Total	**$16,535,999**

Table 46. 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
SFY 2020	$27.2
SFY 2021	$33.5
SFY 2022	$38.6

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.

$5.2 MILLION

collected in J-Code rebates[46] from drug man manufacturers for physician-administered or injectable drugs

46. J-code rebates are mandated by the Deficit Reduction Act of 2005.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

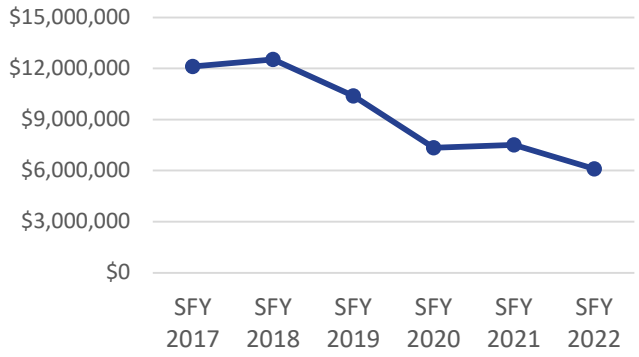
Medicaid covers psychiatric residential treatment for individuals under the age of 21 at a Psychiatric Residential Treatment Facility (PRTF), a stand-alone entity providing a range of comprehensive services to treat the psychiatric conditions of residents under the direction of a physician, with a goal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

EXPENDITURES

$6,101,319

18.8% decrease from SFY 2021

1.1% of Total Medicaid Expenditures



RECIPIENTS

150

25.7% decrease from SFY 2021

0.2% of Total Medicaid Recipients

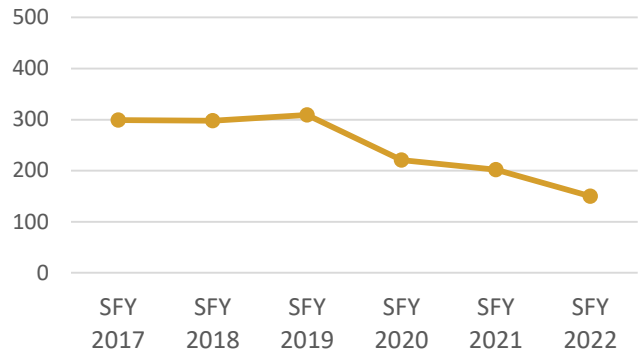


Table 47. State General Funds for the Transitional Period (Services that no longer meet medical necessity) [47]

PRTF Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$12,121,830	$12,537,788	$10,391,372	$7,334,441	$7,517,488	$6,101,319	-49.67
Recipients	299	298	309	221	202	150	-49.83
Expenditures per Recipient	$40,541	$42,073	$33,629	$33,188	$37,215	$40,675	0.33

47 State General Funds (SGF) are only used after a clinical review and determination that the PRTF placement no longer meets medical necessity. A transition period of up to thirty (30) days may be authorized permitting time for the necessary court hearings, multidisciplinary team meetings, and court orders to be updated. Upon expiration of an approved transition, no further reimbursement shall be authorized.

PUBLIC HEALTH OR WELFARE

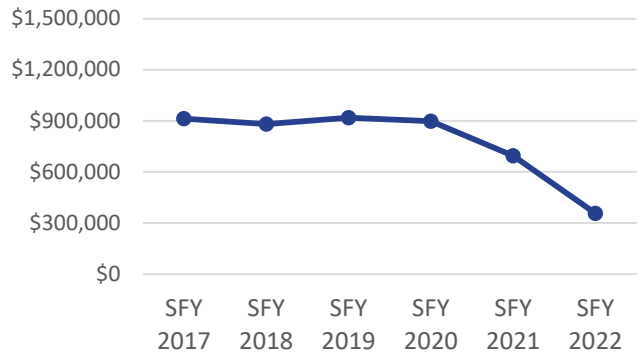
Physician and mid-level practitioner services are provided in a clinic designated by the Department of Health as a public health clinic. These services must be provided directly by a physician or a public health nurse under a physician's immediate supervision, such as when the physician has seen the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

EXPENDITURES

$356,804

48.7% decrease from SFY 2021

0.1% of Total Medicaid Expenditures



RECIPIENTS

4,381

29.8% decrease from SFY 2021

6.2% of Total Medicaid Recipients

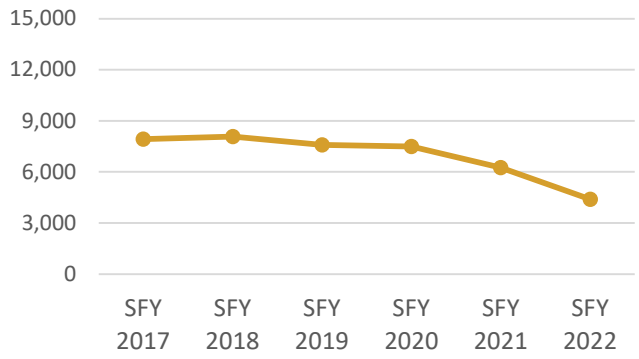


Table 48. Public Health or Welfare Services Summary

Public Health or Welfare Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$912,684	$881,419	$917,659	$898,521	$694,880	$356,804	-60.91
Recipients	7,929	8,074	7,594	7,490	6,245	4,381	-44.75
Expenditures per Recipient	$115	$109	$121	$120	$111	$81	-29.25

PUBLIC HEALTH, FEDERAL

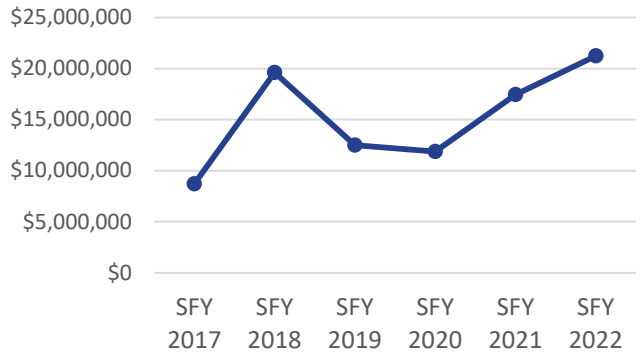
These services are provided to the American Indian/Alaskan Native population by Tribal Contract Health Centers and Indian Health Centers. Tribal Contract Health Centers are outpatient health care programs and facilities owned or operated by the Tribes or Tribal organizations. The Indian Health Service (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).

EXPENDITURES

$21,248,347

21.7% increase from SFY 2021

3.7% of Total Medicaid Expenditures



RECIPIENTS

4,432

12.7% increase from SFY 2021

6.2% of Total Medicaid Recipients

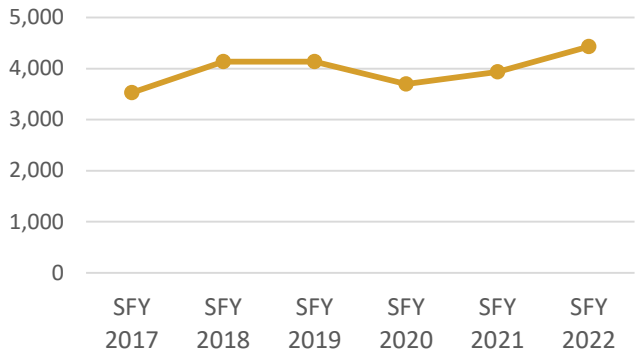


Table 49. Public Health, Federal Services Summary

Public Health, Federal Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$8,718,888	$19,625,445	$12,488,676	$11,864,895	$17,453,190	$21,248,347	8.27
Recipients	3,530	4,138	4,135	3,696	3,934	4,432	7.10
Expenditures per Recipient	$2,470	$4,743	$3,020	$3,210	$4,436	$4,794	1.09

RURAL HEALTH CLINIC

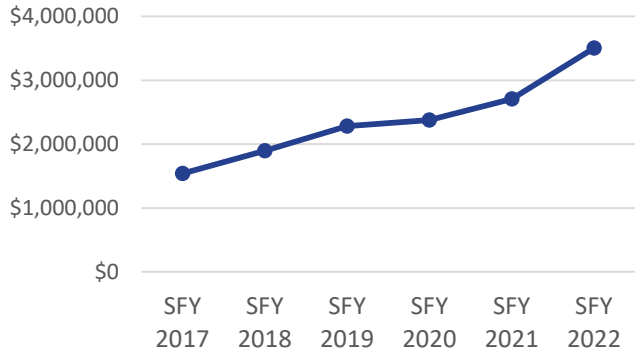
Primary care services are provided at a Rural Health Clinic, as designated by Medicare if it is located in a "shortage area", a geographic area designated by the HHS as having a shortage of personal health services or primary medical care professionals. Medicaid covers services provided by a physician,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

EXPENDITURES

$3,505,312

29.4% increase from SFY 2021

0.6% of Total Medicaid Expenditures



RECIPIENTS

7,232

21.2% increase from SFY 2021

10.2% of Total Medicaid Recipients

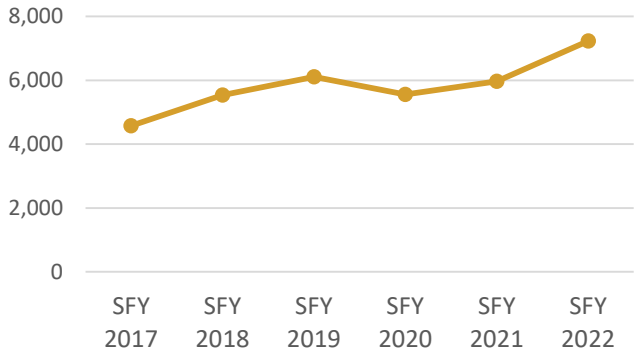


Table 50. Rural Health Clinic Services Summary

Rural Health Clinic Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$1,540,607	$1,894,505	$2,283,377	$2,377,607	$2,708,379	$3,505,312	127.53
Recipients	4,577	5,541	6,113	5,560	5,967	7,232	58.01
Expenditures per Recipient	$337	$342	$374	$428	$454	$485	44.00

VISION

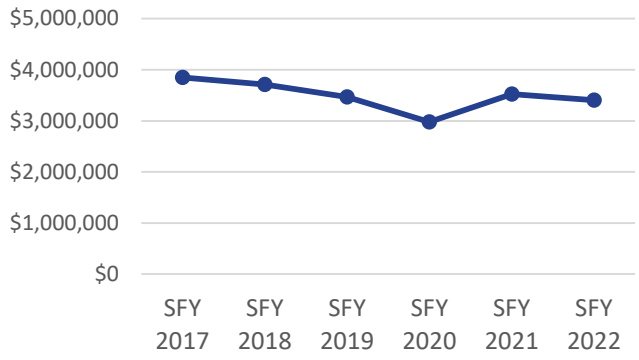
Medicaid covers vision services provided by opticians, optometrists, and ophthalmologists, with services dependent on recipient age. Children receive services to correct and maintain healthy vision, including eyeglasses (frames, frame parts, and lenses) and vision therapy based on diagnosis codes. Adults 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.

EXPENDITURES

$3,402,928

3.5% decrease from SFY 2021

0.6% of Total Medicaid Expenditures



RECIPIENTS

14,895

0.8% decrease from SFY 2021

21.0% of Total Medicaid Recipients

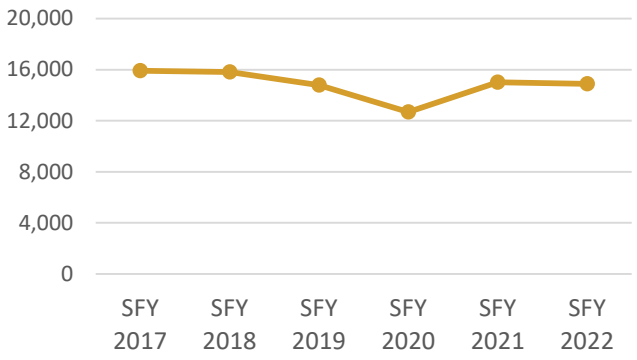


Table 51. Vision Services Summary

Vision Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$3,850,574	$3,712,855	$3,466,069	$2,977,070	$3,526,355	$3,402,928	-11.63
Recipients	15,921	15,821	14,790	12,680	15,016	14,895	-6.44
Expenditures per Recipient	$242	$235	$234	$235	$235	$228	-5.54

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 WAIVERS
Home & Community-Based Services Waivers • Community Choices • Children's Mental Health • Acquired Brain Injury • Comprehansive • Supports
Pregnant by Choice (Section 1115 waiver)

HOME & COMMUNITY-BASED SERVICES (HCBS) WAIVERS

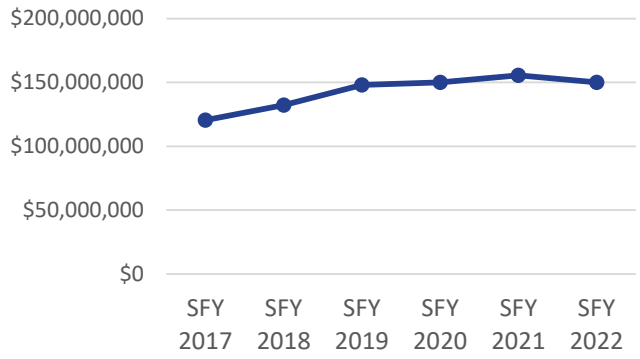
These waivers provide care in the home and community to the elderly and disabled, intellectually disabled, developmentally disabled, and certain other disabled adults enrolled in Medicaid.

EXPENDITURES

$150,067,156

3.5% decrease from SFY 2021

25.9% of Total Medicaid Expenditures



RECIPIENTS

5,534

0.2% increase from SFY 2021

7.8% of Total Medicaid Recipients

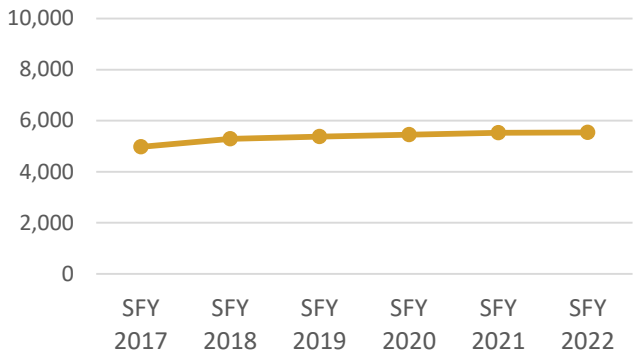


Table 52. HCBS Waiver Services Summary

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Total HCBS Waiver Services							
Expenditures	$148,399,089	$154,199,389	$164,663,475	$167,427,190	$173,460,532	$167,145,896	12.63
Recipients	5,287	5,479	5,630	5,891	5,792	5,869	11.01
Expenditures per Recipient	$28,069	$28,144	$29,248	$28,421	$29,948	$28,479	1.46
Non-Waiver Services							
Expenditures	$27,954,129	$21,956,068	$16,584,581	$17,350,305	$17,984,589	$17,078,740	-38.90
Recipients	5,133	5,306	5,418	5,697	5,596	5,600	9.10
Expenditures per Recipient	$5,446	$4,138	$3,061	$3,046	$3,214	$3,050	-44.00
Waiver Only Services							
Expenditures	$120,444,960	$132,243,321	$148,078,894	$150,076,885	$155,475,943	$150,067,156	24.59
Recipients	4,958	5,144	5,317	5,425	5,514	5,517	11.27
Expenditures per Recipient	$24,293	$25,708	$27,850	$27,664	$28,197	$27,201	11.97

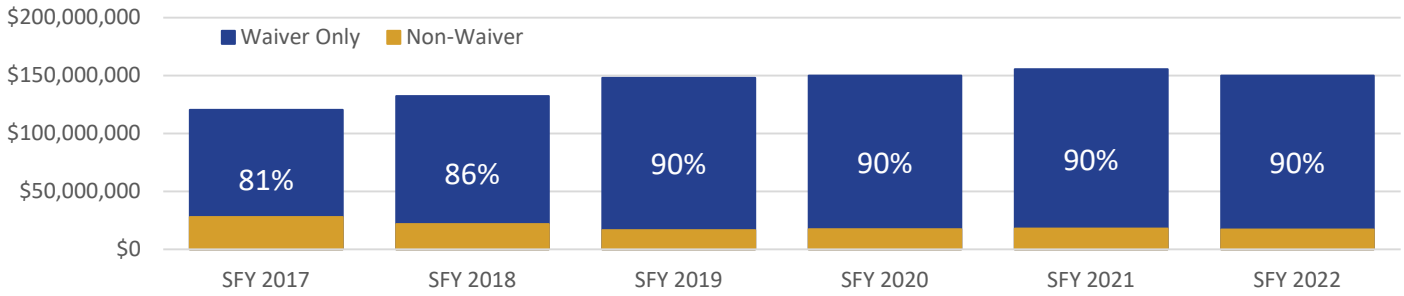


Figure 30. HCBS Waiver vs. Non-Waiver Expenditures History

Table 53. HCBS Waiver Expenditures History by Waiver

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Total HCBS Waiver Services							
ABI	$7,675,482	$5,295,577	$20,168	--	--	--	--
Adult DD	$2,600	$36	--	--	--	--	--
Child DD	($4,650)	$218	--	--	--	--	--
Child Mental Health	$451,590	$653,713	$435,708	$290,891	$502,477	$525,103	16.28
Community Choices	$30,998,469	$36,097,908	$36,588,816	$38,256,084	$41,963,082	$41,486,868	33.84
Comprehensive	$102,439,057	$103,944,569	$119,241,045	$120,016,261	$120,380,980	$114,300,864	11.58
Supports	$6,836,540	$8,207,369	$8,377,738	$8,863,953	$10,613,993	$10,833,061	58.46
Non-Waiver Services							
ABI	$714,600	$347,375	$5,160	--	--	--	--
Adult DD	$1,035	$36	--	--	--	--	--
Child DD	($4,650)	$218	--	--	--	--	--
Child Mental Health	$451,590	$653,713	$435,708	$290,891	$502,477	$525,103	16.28
Community Choices	$10,411,275	$9,166,911	$7,631,127	$8,594,510	$8,817,049	$8,085,897	-22.34
Comprehensive	$13,921,993	$9,376,098	$6,567,542	$6,483,800	$6,107,916	$5,835,536	-58.08
Supports	$2,458,285	$2,411,717	$1,945,044	$1,981,104	$2,557,147	$2,632,203	7.07
Waiver Only Services							
ABI	$6,960,882	$4,948,202	$15,008	--	--	--	--
Adult DD	$1,565	--	--	--	--	--	--
Child DD	--	--	--	--	--	--	--
Child Mental Health	--	--	--	--	--	--	--
Community Choices	$20,587,194	$26,930,997	$28,957,689	$29,661,574	$33,146,033	$33,400,970	62.24
Comprehensive	$88,517,064	$94,568,471	$112,673,503	$113,532,461	$114,273,065	$108,465,328	22.54
Supports	$4,378,255	$5,795,651	$6,432,694	$6,882,850	$8,056,846	$8,200,858	87.31

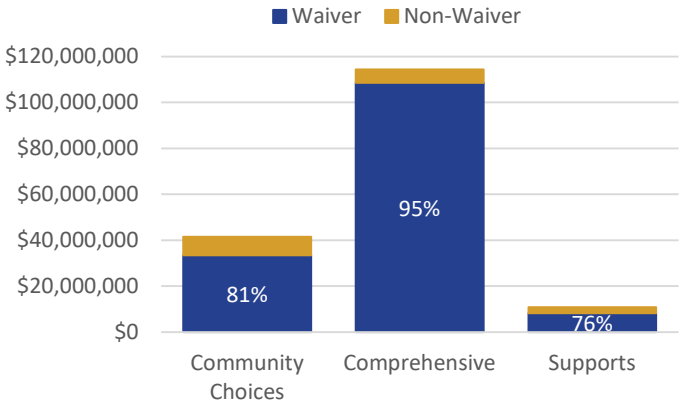


Figure 31. SFY 2022 HCBS Waiver Only vs. Non-Waiver Services

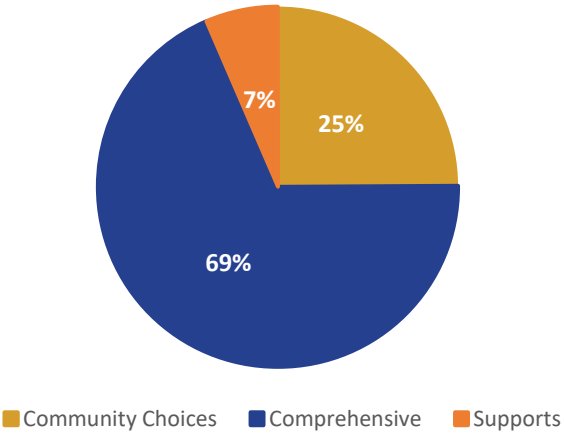
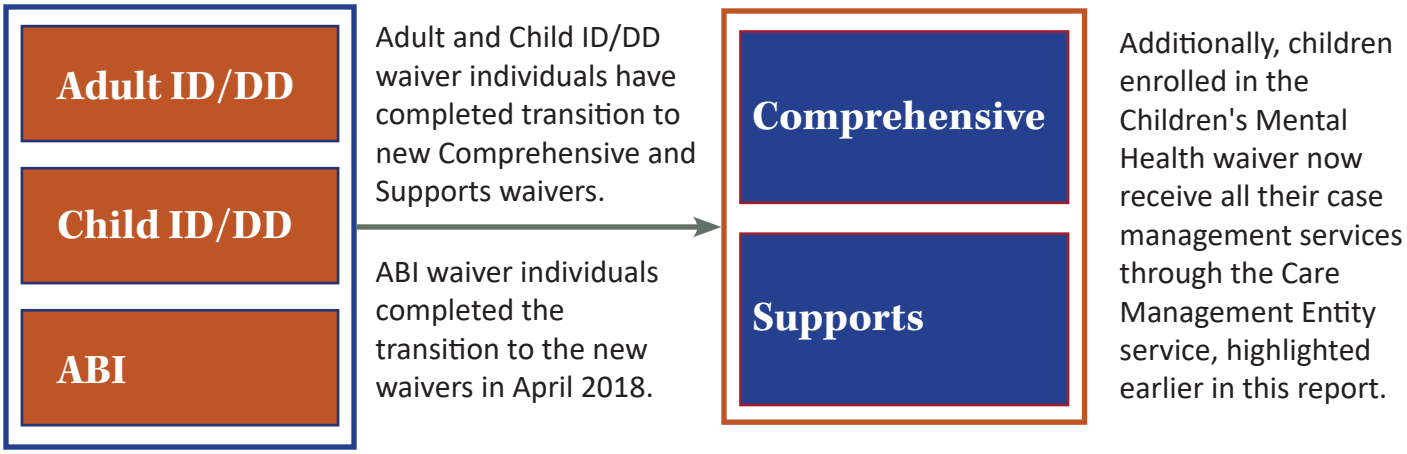


Figure 32. SFY 2022 HCBS Total Waiver Expenditures by Waiver



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

COMMUNITY CHOICES WAIVER

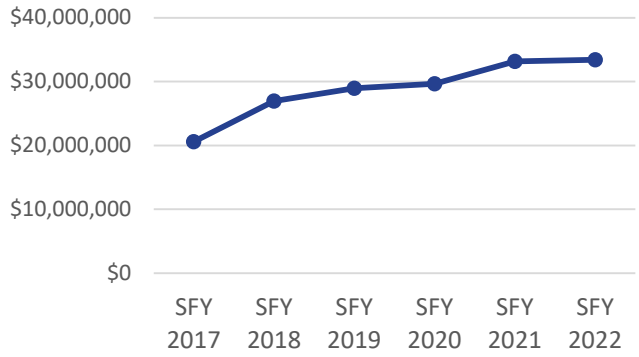
This waiver provides in-home services and assisted living services to Medicaid enrollees 19 years of age and older who are aged, blind, or disabled and require services equivalent to nursing home level of care. This waiver was formerly the Long-Term Care waiver, and starting in SFY 2017 added the assisted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

EXPENDITURES

$33,400,970

0.8% increase from SFY 2021

5.8% of Total Medicaid Expenditures



RECIPIENTS

2,943

0.5% decrease from SFY 2021

4.1% of Total Medicaid Recipients

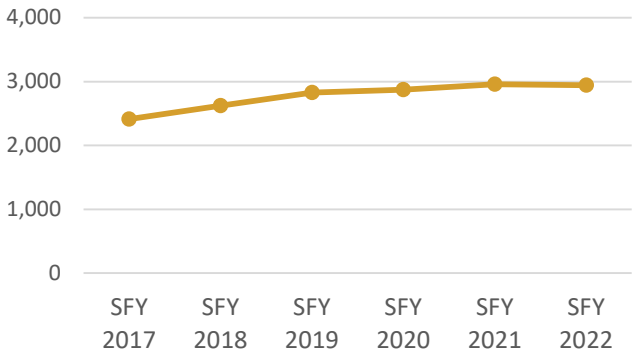


Table 54. Community Choices Waiver Services Summary

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Total Community Choices Waiver Services							
Expenditures	$30,998,469	$36,097,908	$36,588,816	$38,256,084	$41,963,082	$41,486,868	33.84
Recipients	2,602	2,807	2,993	3,200	3,112	3,141	20.71
Expenditures per Recipient	$11,913	$12,860	$12,225	$11,955	$13,484	$13,208	10.87
% Waiver Only	66.41	74.61	79.14	77.53	78.99	80.51	21.22
Community Choices Non-Waiver Services							
Expenditures	$10,411,275	$9,166,911	$7,631,127	$8,594,510	$8,817,049	$8,085,897	-22.34
Recipients	2,524	2,699	2,851	3,086	3,003	2,961	17.31
Expenditures per Recipient	$4,125	$3,396	$2,677	$2,785	$2,936	$2,731	-33.80
Community Choices Waiver-Only Services							
Expenditures	$20,587,194	$26,930,997	$28,957,689	$29,661,574	$33,146,033	$33,400,970	62.24
Recipients	2,414	2,622	2,828	2,875	2,958	2,943	21.91
Expenditures per Recipient	$8,528	$10,271	$10,240	$10,317	$11,206	$11,349	33.08

COMPREHENSIVE WAIVER

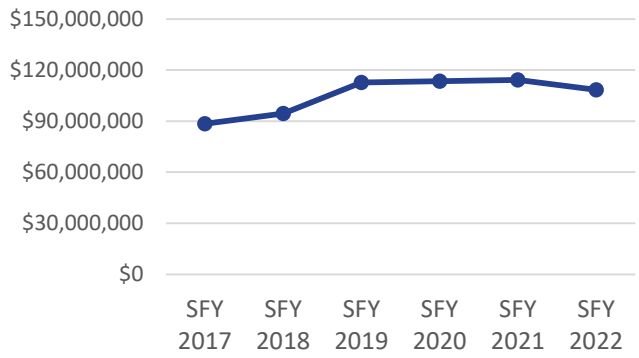
This Medicaid waiver, started in SFY 2014, funds services for individuals with intellectual or developmental disability based on assessed need, as measured by the standardized Inventory for Client and Agency Planning (ICAP) tool.

EXPENDITURES

$108,465,328

5.1% decrease from SFY 2021

18.7% of Total Medicaid Expenditures



RECIPIENTS

1,866

1.4% decrease from SFY 2021

2.6% of Total Medicaid Recipients

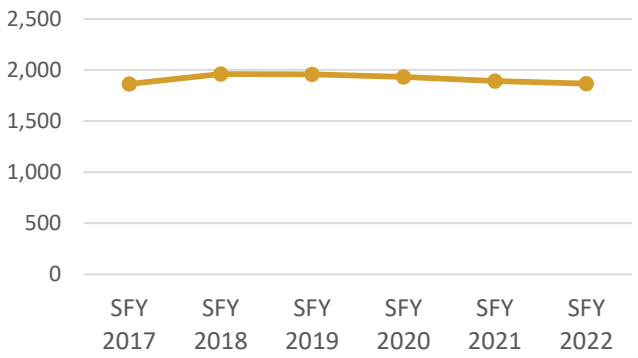


Table 55. Comprehensive Waiver Services Summary

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Total Comprehensive Waiver Services							
Expenditures	$102,439,057	$103,944,569	$119,241,045	$120,016,261	$120,380,980	$114,300,864	11.58
Recipients	1,890	1,989	1,983	1,966	1,911	1,887	-0.16
Expenditures per Recipient	$54,201	$52,260	$60,132	$61,046	$62,994	$60,573	11.76
% Waiver Only	86.41	90.98	94.49	94.60	94.93	94.89	9.82
Comprehensive Non-Waiver Services							
Expenditures	$13,921,993	$9,376,098	$6,567,542	$6,483,800	$6,107,916	$8,085,897	-41.92
Recipients	1,858	1,937	1,938	1,930	1,873	1,845	-0.70
Expenditures per Recipient	$7,493	$4,841	$3,389	$3,359	$3,261	$3,163	-57.79
Comprehensive Waiver-Only Services							
Expenditures	$88,517,064	$94,568,471	$112,673,503	$113,532,461	$114,273,065	$108,465,328	22.54
Recipients	1,863	1,962	1,959	1,932	1,892	1,866	0.16
Expenditures per Recipient	$47,513	$48,200	$57,516	$58,764	$60,398	$58,127	22.34

SUPPORTS WAIVER

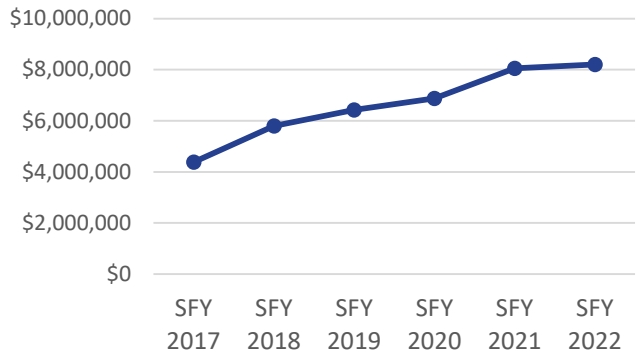
This Medicaid waiver, started in SFY 2014, provides more flexible, although capped, funding for supportive services for individuals with intellectual or developmental disability.

EXPENDITURES

$8,200,858

1.8% increase from SFY 2021

1.4% of Total Medicaid Expenditures



RECIPIENTS

725

7.6% increase from SFY 2021

1.0% of Total Medicaid Recipients

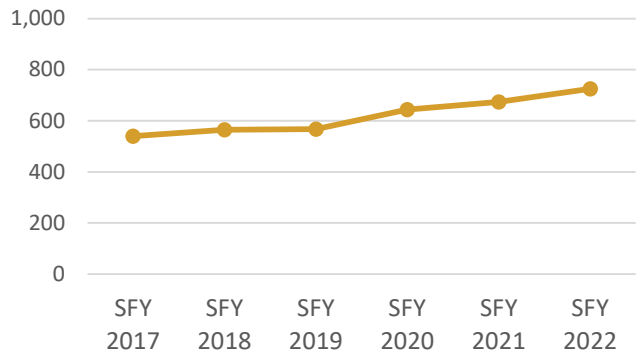


Table 56. Supports Waiver Services Summary

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Total Supports Waiver Services							
Expenditures	$6,836,540	$8,207,369	$8,377,738	$8,863,953	$10,613,993	$10,833,061	58.46
Recipients	555	581	584	658	682	739	33.15
Expenditures per Recipient	$12,318	$14,126	$14,345	$13,471	$15,563	$14,659	19.00
% Waiver Only	64.04	70.62	76.78	77.65	75.91	75.70	18.21
Supports Non-Waiver Services							
Expenditures	$2,458,285	$2,411,717	$1,945,044	$1,981,104	$2,557,147	$2,632,203	7.07
Recipients	513	552	554	610	630	692	34.89
Expenditures per Recipient	$4,792	$4,369	$3,511	$3,248	$4,059	$3,804	-20.62
Supports Waiver-Only Services							
Expenditures	$4,378,255	$5,795,651	$6,432,694	$6,882,850	$8,056,846	$8,200,858	87.31
Recipients	540	565	568	644	674	725	34.26
Expenditures per Recipient	$8,108	$10,258	$11,325	$10,688	$11,954	$11,312	39.51

PREGNANT BY CHOICE WAIVER[48]

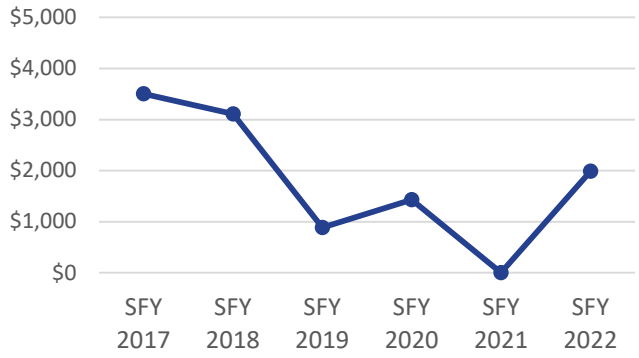
Medicaid provides pregnancy planning services through this Section 1115 waiver with the goal of reducing the incidence of closely spaced pregnancies and decreasing the number of unintended pregnancies in order to reduce health risks to women and children and achieve cost savings. These services are available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

EXPENDITURES

$1,988

increase from SFY 2021[49]

0.0003% of Total Medicaid Expenditures



RECIPIENTS

<10[50]

33.3% increase from SFY 2021

0.1% of Total Medicaid Recipients

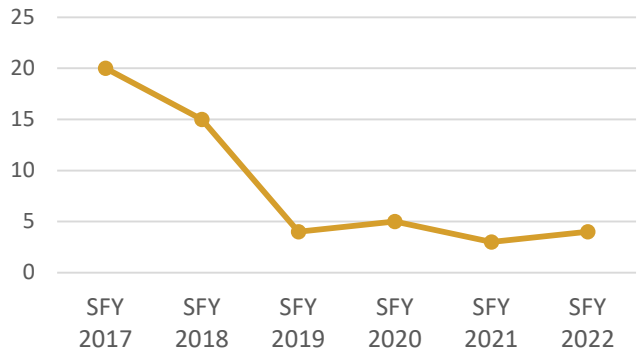


Table 57. Pregnant by Choice Services Summary

Pregnant by Choice Services	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Expenditures	$3,507	$3,113	$888	$1,428	$-	$1,988	-43.32
Recipients	20	15	<10	<10	<10	<10	-80.00
Expenditures per Recipient	$175	$208	$222	$286	$-	$497	183.40

48. Pregnant by Choice waiver services are included in the individual service sections in this report and are thus excluded from the service overview tables earlier in the report.
49. The % increase from SFY 2021 to SFY 2022 is mathematically impossible to calculate because it involves division by zero.
50. Values less than 10 are not shown in order to protect the privacy of recipients.

SUBPROGRAMS AND SPECIAL POPULATIONS

SUBPROGRAMS

DRUG UTILIZATION REVIEW

The Drug Utilization Review (DUR) program reviews the 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.

Input from Medical Committee
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.

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).

WYOMING FRONTIER INFORMATION (WYFI) HEALTH EXCHANGE

The WYFI Health Information Exchange (HIE) system enables and supports Medicaid providers in promoting a healthier Wyoming by developing a secure, connected, and coordinated statewide health IT system that supports effective and efficient healthcare. For additional information refer to the WYFI HealthStat documentation.

Table 58. WYFI Health Exchange Outcomes Summary

WYFI Outcomes								
		Desired Trend	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Facilities	Data Contributing	⬆	N/A[44]	51	54	92	189	217
	View Only		N/A	0	15	100	157	165
WYFI Users	Unique Providers	⬆	N/A	0	27	386	3,556	3,551
	Total Users		N/A	0	170	939	5,446	5,552
Covered Lives in the HIE	WY Covered Lives	⬆	N/A	N/A[*52]	N/A	210,576	357,359	452,915
	All Covered Lives		N/A	N/A*	N/A*	311,198	402,304	550,651
	Medicaid Covered Lives		N/A	N/A*	N/A*	N/A	34,171	43,145
# of Patient Encounters in the HIE		⬆	N/A[**53]	N/A**	N/A**	2,485,938	3,668,561	5,525,435
Notify Users - ADTs (Alert, Discharge, Transfer Notifications)		⬆	N/A	N/A	N/A	8	62	63

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 59. Administrative Transportation Summary

Administrative Transportation	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Expenditures	$77,953	$130,495	$191,305	$158,432	$133,191	$156,368
Recipients	272	359	410	412	297	190
Expenditures per Recipient	$287	$363	$467	$385	$448	$823

51. N/A Reporting tool was not available until SFY 2020.
52. N/A* Indicates no data since the program did not start until late SFY 2018.
53. N/A** indicates this data was not tracked prior to SFY 2021.

PATIENT-CENTERED MEDICAL HOME

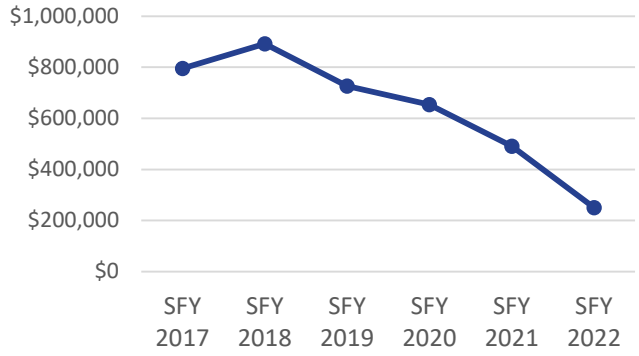
The PCMH program promotes high-value care using a value-based purchasing model in which health care is coordinated through a primary care physician/practitioner, with a focus on quality and safety. Participating providers are paid a per member per month rate based on their patient volume.

EXPENDITURES

$250,610

49.0% decrease from SFY 2021

0.04% of Total Medicaid Expenditures



RECIPIENTS

9,731

12.7% decrease from SFY 2021

13.7% of Total Medicaid Recipients

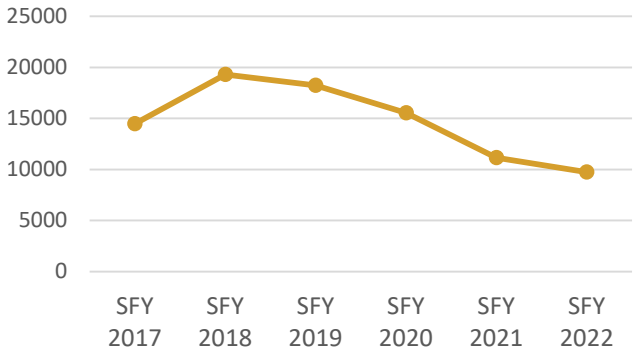


Table 60. Patient-Centered Home Summary

Patient-Centered Home	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Expenditures	$795,895	$892,319	$726,704	$654,155	$491,342	$250,610
Recipients	14,462	19,293	18,248	15,542	11,147	9,731
Expenditures per Recipient	$55	$46	$40	$42	$44	$26
Participating Practices	13	19	20	12	10	10
Practitioners in Participating Practices	130	168	167	107	114	118

HEALTH CHECK

This program provides the following services for children under the age of 21 under the 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

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, Medicare pays first for services covered by both programs, while Medicaid covers additional payments through crossover claims. Non-Medicare-covered services are entirely funded by Medicaid, up to Wyoming's payment limit. 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.

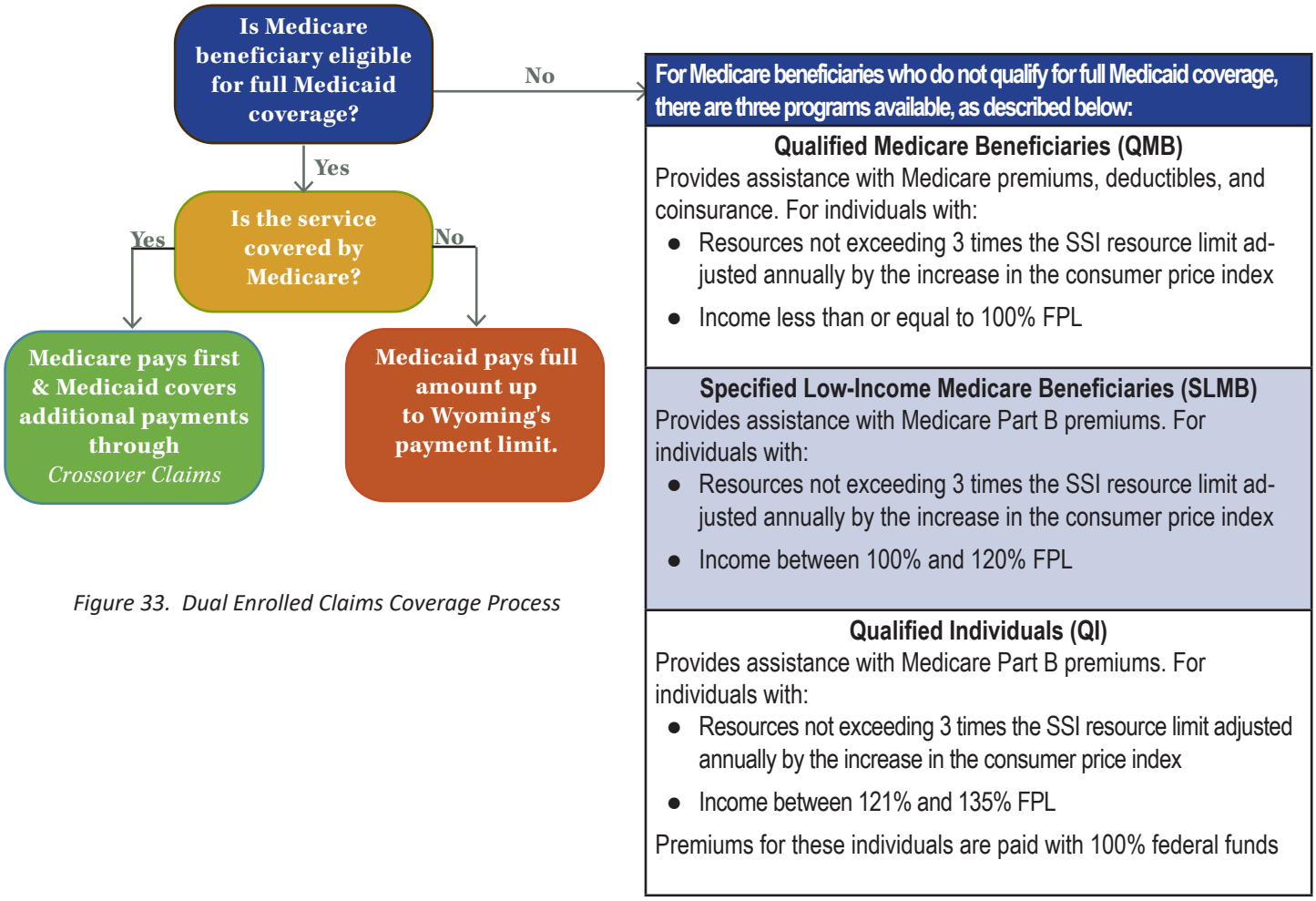


Figure 33. Dual Enrolled Claims Coverage Process

Table 61. Medicaid/Medicare Dual Enrollment Summary

Medicaid/Medicare Dual Enrollment	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Dual Enrolled Members	12,941	13,134	13,294	13,122	12,986	13,751	6.26
Expenditures	$216,807,680	$210,224,425	$209,430,025	$221,115,931	$215,140,771	$202,706,496	-6.50
Recipients (unduplicated)	10,981	11,271	11,447	11,879	11,066	10,888	-0.85
Expenditures per Recipient	$19,744	$18,652	$18,296	$18,614	$19,442	$18,617	-5.71
Crossover Claims Expenditures	$14,966,523	$7,751,187	$8,008,235	$7,996,566	$7,457,024	$8,025,391	-46.38
Crossover Claims Expenditures as Percent of Total Dual Expenditures	6.90	3.69	3.82	3.62	3.47	3.96	-42.65

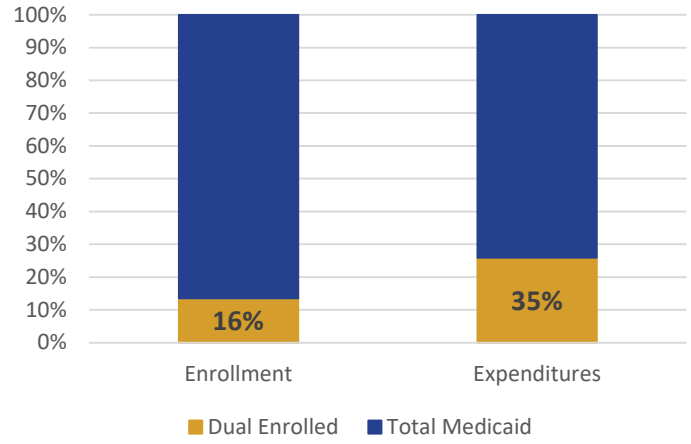


Figure 34. Dual Enrolled as Percent of Total Medicaid in SFY 2022

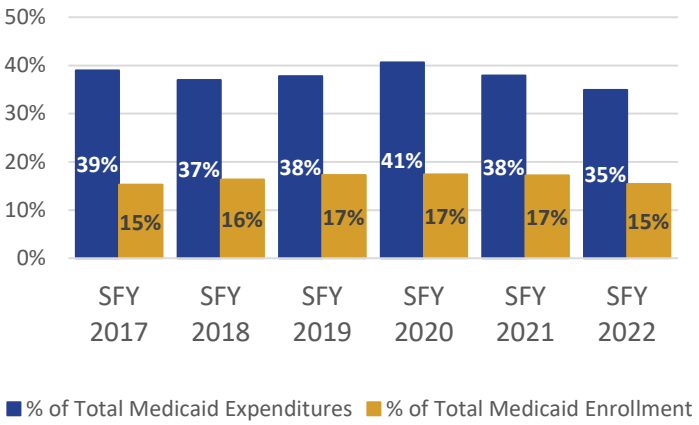


Figure 35. History of Dual Enrollment and Expenditures as Percent of Total Medicaid

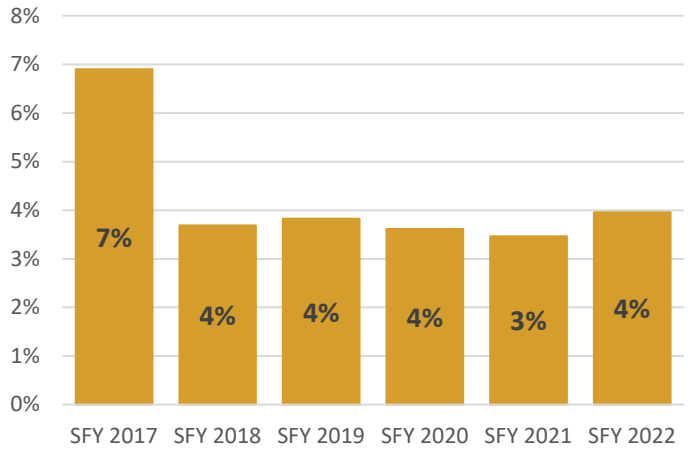


Figure 36. History of Crossover Expenditures as Percent of Total Dual Expenditures

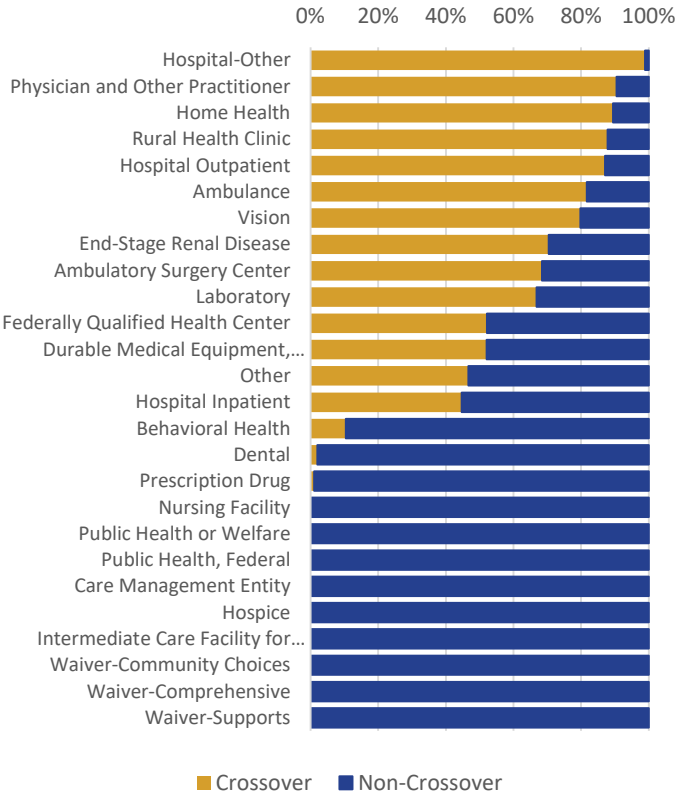


Figure 37. Crossover Expenditures as Percent of Dual Expenditures by Service Area for SFY 2022

Table 62. Dual Enrolled Member Service Utilization History [54]

Service Area	Total Dual Enrolled			Crossovers		
	Expenditures	Recipients[55]	Expenditures per Recipient	Expenditures	Recipients	Expenditures per Recipient
Ambulance	$150,376	1,565	$96	$122,828	1,542	$80
Ambulatory Surgery Center	$81,898	709	$116	$56,030	695	$81
Behavioral Health	$1,369,285	2,062	$664	$143,431	1,316	$109
Care Management Entity	$4,628	<10[456]	$4,628	--	--	--
Dental	$470,615	1,802	$261	$9,482		$2,371
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	$2,688,466	3,749	$717	$1,400,480	3,392	$413
End-Stage Renal Disease	$396,259	133	$2,979	$278,951	129	$2,162
Federally Qualified Health Center	$236,523	1,257	$188	$123,448	1,137	$109
Home Health	$126,733	81	$1,565	$113,303	75	$1,511
Hospice	$515,924	116	$4,448	--	28	
Hospital Total	$3,262,772	9,140	$357	$2,037,062	8,941	$228
Hospital Inpatient	$1,897,901	1,737	$1,093	$848,552	1,646	$516
Hospital Outpatient	$1,356,481	7,179	$189	$1,180,218	7,074	$167
Hospital-Other	$8,390	224	$37	$8,293	221	$38
Intermediate Care Facility for Individuals with Intellectual Disabilities	$13,882,358	42	$330,532	--	--	--
Laboratory	$21,127	1,584	$13	$14,123	1,554	$9
Nursing Facility	$68,934,657	1,973	$34,939	$177,267	976	$182
Other	$30,132	302	$100	$14,060	234	$60
Physician and Other Practitioner	$3,530,890	8,981	$393	$3,194,913	8,811	$363
Prescription Drug	$1,523,731	2,089	$729	$16,918	313	$54
Public Health or Welfare	$115,703	1,480	$78	$85	541	$0.16
Public Health, Federal	$486,997	169	$2,882	$151	<10	$17
Rural Health Clinic	$103,341	1,210	$85	$90,788	1,198	$76
Vision	$86,049	1,881	$46	$68,672	1,761	$39
Waiver-Community Choices	$29,283,112	2,551	$11,479	--	--	--
Waiver-Comprehensive	$72,438,498	1,155	$62,717	--	--	--
Waiver-Supports	$2,966,425	224	$13,243	--	--	--
Totals	**$202,706,496**	**10,888**	**$18,617**	**$7,861,994**	**10,139**	**$775**

54. Claims data for dual-enrolled members was included in the service area detail provided earlier in this report.
55. 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.
56. Values less than 10 are not shown in order to protect the privacy of recipients.

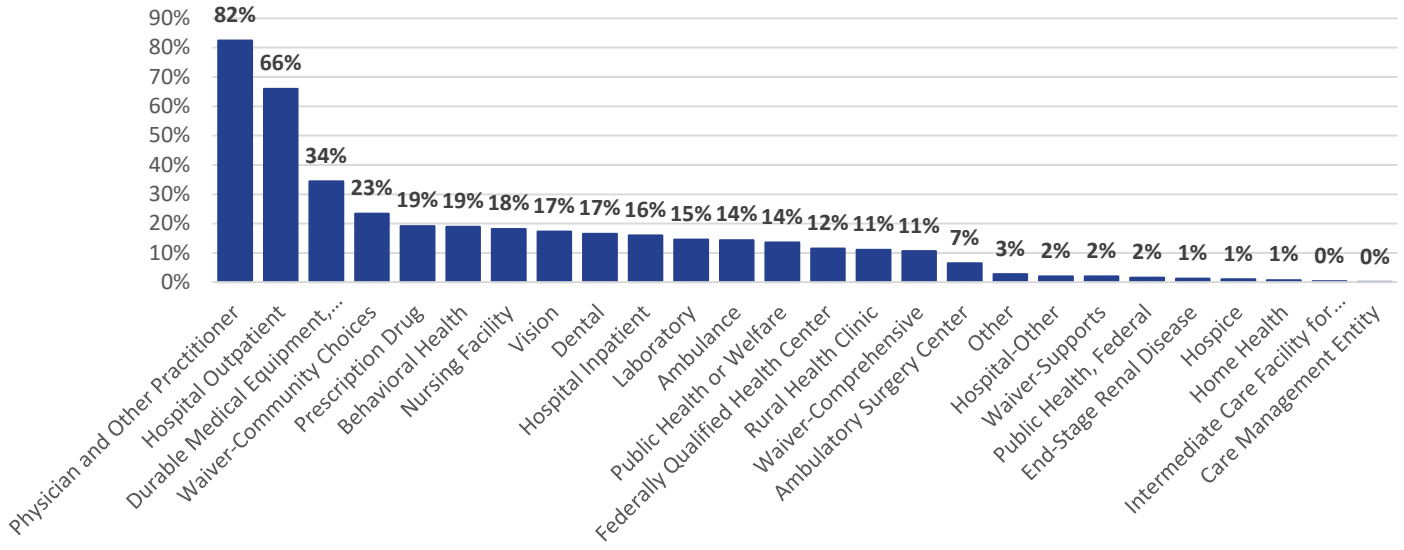


Figure 38. Percent of Total Unduplicated Dual Recipients by Service

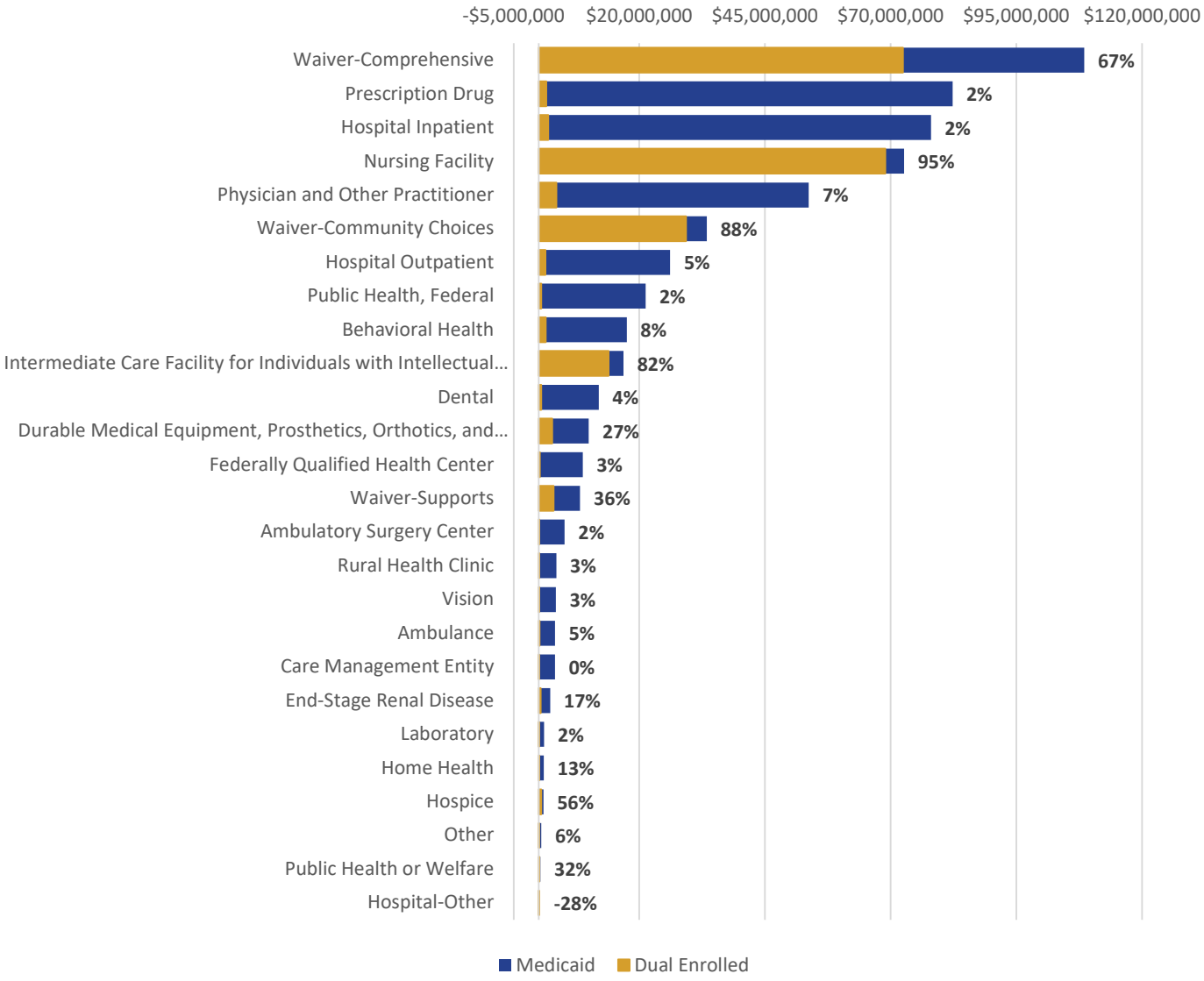


Figure 39. Dual Expenditures as Percent of Total Medicaid Expenditures by Service

FOSTER CARE

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

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

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

422 children enrolled

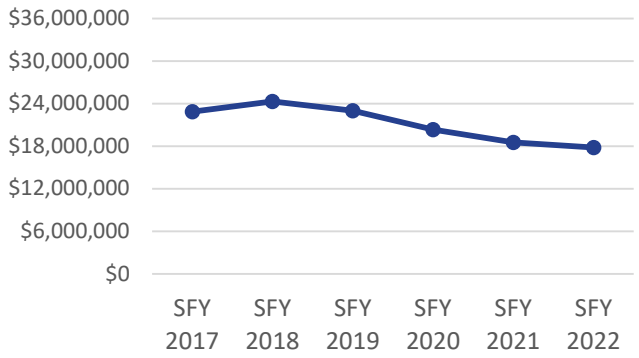
$922,914 in claims expenditures

EXPENDITURES

$17,825,737

3.9% decrease from SFY 2021

3.1% of Total Medicaid Expenditures



RECIPIENTS

3,415

0.4% increase from SFY 2021

4.8% of Total Medicaid Recipients

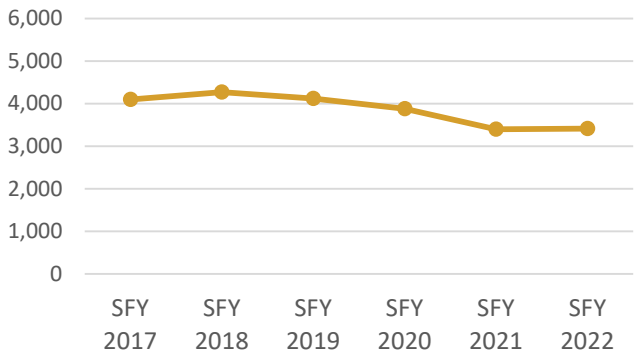


Table 63. Foster Care Summary[57]

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Medicaid Foster Cares							
Enrolled Members	4,102	4,159	3,995	3,881	3,516	3,738	-8.87
Expenditures	$21,117,610	$22,534,237	$21,259,813	$19,115,700	$17,599,763	$16,902,823	-19.96
Recipients	3,783	3,946	3,802	3,621	3,197	3,210	-15.15
Expenditures per Recipient	$5,582	$5,711	$5,592	$5,279	$5,505	$5,266	-5.67
State-Only Foster Care							
Enrolled Members	305	318	286	251	323	422	38.36
Expenditures	$1,753,782	$1,787,501	$1,736,824	$1,214,600	$944,427	$922,914	-47.38
Recipients	314	324	322	256	205	205	-34.7
Expenditures per Recipient	$5,585	$5,517	$5,394	$4,745	$4,607	$4,502	-19.40

57. 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.

Table 64. Foster Care Summary by Services - Medicaid vs. State-Only[58]

Service Area	Medicaid Foster Care			State-Only Foster Care		
	Expenditures	Recipients	Expenditures per Recipient	Expenditures	Recipients	Expenditures per Recipient
Ambulance	$98,536	94	$1,048	$2,060	<10[59]	$412
Ambulatory Surgery Center	$203,981	107	$1,906	$4,327	<10	$2,164
Behavioral Health	$3,095,534	1,351	$2,291	$397,435	155	$2,564
Care Management Entity	$179	<10	$179	--	--	--
Clinic/Center	$96,639	127	$761	--	--	--
Dental	$728,994	1,726	$422	$56,102	112	$501
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	$194,732	207	$941	$6,004	<10	$858
Federally Qualified Health Center	$363,323	324	$1,121	$3,651	<10	$456
Home Health	$1,977	<10	$494	--	--	--
Hospital Total	$3,303,300	$1,486	$2,223	$133,260	$98	$1,360
Hospital Inpatient	$2,574,945	193	$13,342	$90,301	<10	$12,900
Hospital Outpatient	$728,354	1,293	$563	$42,959	91	$472
Laboratory	$21,585	186	$116	$330	<10	$55
Other	$29,800	113	$264	$686	<10	$114
Physician and Other Practitioner	$1,919,644	2,468	$778	$58,547	130	$450
Prescription Drug	$2,586,032	2,015	$1,283	$92,915	134	$693
Psychiatric Residential Treatment Facility	$2,513,637	61	$41,207	$124,910	<10	$15,614
Public Health or Welfare	$12,276	169	$73	$1,737	43	$40
Public Health, Federal	$1,263,899	256	$4,937	$14,029	<10	$2,806
Rural Health Clinic	$190,130	374	$508	$2,988	13	$230
Vision	$278,627	1,058	$263	$23,933	80	$299
Totals	**$16,902,823**	**3,210**	**$5,266**	**$922,914**	**205**	**$4,502**

58. 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.
59. Values less than 10 are not shown in order to protect the privacy of recipients.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)[60]

The Wyoming Children's Health Insurance Program (CHIP) provides health care coverage to qualified children of uninsured, low-income families. Children who are over the income limit for Medicaid may qualify for CHIP if their family countable income is between 155% and 200% of the Federal Poverty Level (FPL) for children 0 to 5 years of age or between 134% and 200% for children 6 to 19 years of age. Beginning October 1, 2020, the CHIP program was brought in-house and is now managed within the Division of Healthcare Finance. Prior to that, it was managed by Blue Cross Blue Shield of Wyoming.

EXPENDITURES

$8,346,010

RECIPIENTS

3,394

Table 65. CHIP Summary

CHIP	SFY 2021	SFY 2022
Enrolled Members	4,111	4,171
Expenditures	$5,045,497	$8,346,010
Recipients	2,939	3,394
Expenditures per Recipient	$1,717	$2,459

Table 67. SFY 2022 CHIP Expenditure History by Service Type

CHIP	SFY 2021[53]	SFY 2022
Dental	$600,247	$862,900
Long-Term Care	$1,833	$412
Medical	$4,225,754	$7,228,215
Other	$17,258	$17,981
Vision	$200,405	$236,502

Table 68. SFY 2022 CHIP Recipient History by Service Type

CHIP	SFY 2021[53]	SFY 2022
Dental	1,801	2,102
Long-Term Care	--	<10[61]
Medical	2,368	3,025
Other	97	68
Vision	748	918

Table 66. SFY 2022 CHIP Service Utilization History

CHIP	SFY 2021	SFY 2022
Ambulance	$11,207	$24,752
Ambulatory Surgery Center	$110,986	$175,300
Behavioral Health	$381,684	$672,132
Care Management Entity	$281	--
Clinic/Center	$8,440	$28,889
Dental	$600,247	$862,900
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	$50,691	$62,391
Federally Qualified Health Center	$115,366	$270,176
Home Health	$1,833	$412
Hospice	$9,070	--
Hospital Total	$928,011	$1,555,302
Hospital Inpatient	$285,068	$1,084,966
Hospital Outpatient	$642,943	$470,335
Laboratory	$13,062	$21,594
Other	$17,258	$17,981
Physician and Other Practitioner	$758,176	$1,427,736
Prescription Drug	$1,416,890	$2,134,770
Psychiatric Residential Treatment Facility	$60,030	$26,161
Public Health or Welfare	$3,321	$9,622
Public Health, Federal	$290,885	$677,280
Rural Health Clinic	$67,654	$142,110
Vision	$200,405	$236,502
Totals	**$5,045,497**	**$8,346,010**

60. The CHIP program was brought in-house on October 1, 2020. SFY 2021 contains only nine months (October 1, 2020, through June 30, 2021) of data. Because of this, historical line graphs and, one- and five-year percentage changes are not included within this section of the annual report.
61. Values less than 10 are not shown in order to protect the privacy of recipients.

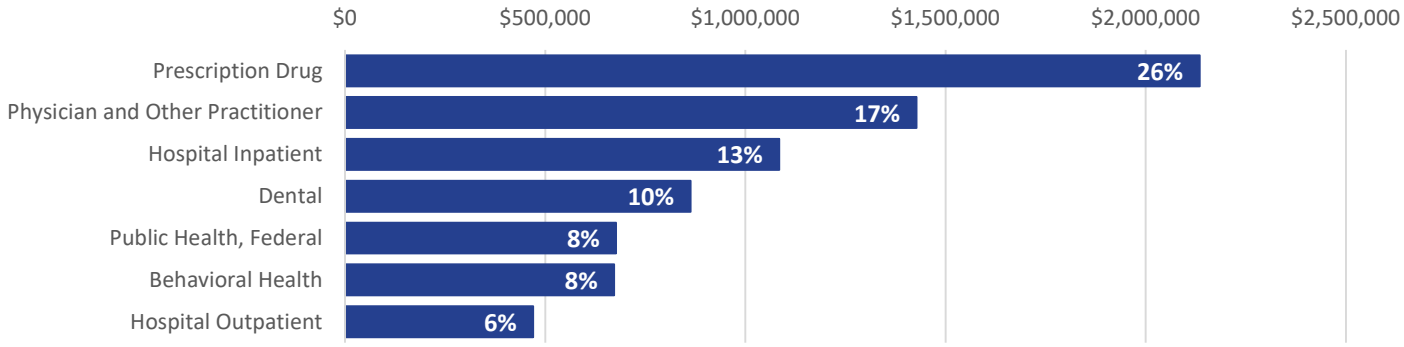


Figure 40. Top SFY 2022 CHIP Services (greater than 5% of Total CHIP Expenditures)

Table 69. SFY 2022 CHIP Recipient Utilization History

CHIP	SFY 2021	SFY 2022
Ambulance	14	30
Ambulatory Surgery Center	72	92
Behavioral Health	328	459
Care Management Entity	<10[62]	--
Clinic/Center	19	30
Dental	1,801	2,102
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	91	150
Federally Qualified Health Center	171	287
Home Health	<10	<10
Hospice	<10	--
Hospital Total	824	1,232
Hospital Inpatient	36	61
Hospital Outpatient	788	1,171
Laboratory	120	182
Other	97	68
Physician and Other Practitioner	1,883	2,470
Prescription Drug	1,244	1,884
Psychiatric Residential Treatment Facility	<10	<10
Public Health or Welfare	109	195
Public Health, Federal	120	168
Rural Health Clinic	183	334
Vision	748	918
Totals	**2,939**	**3,394**

62. Values less than 10 are not shown in order to protect the privacy of recipients.

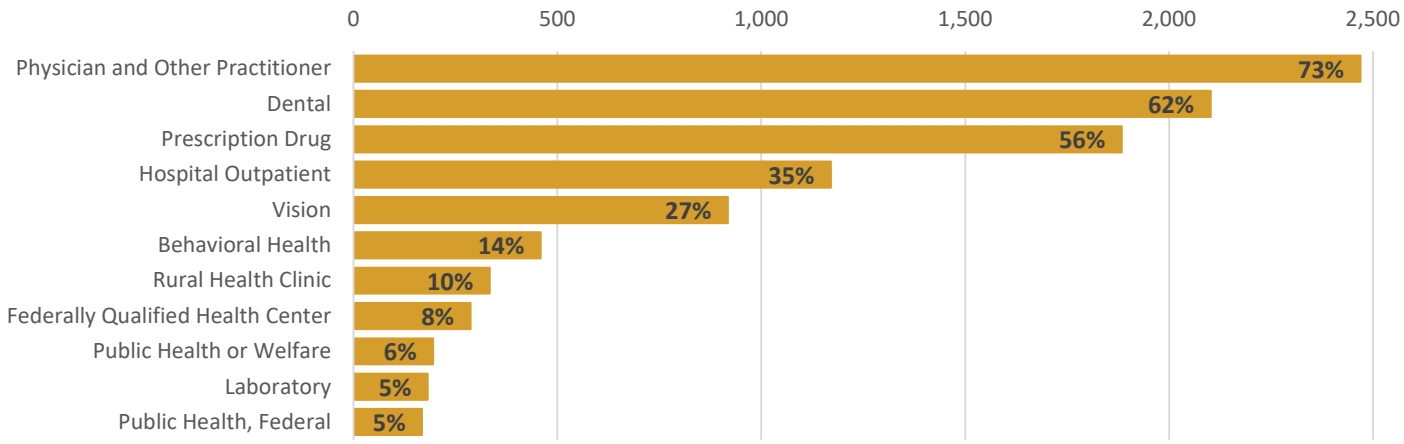


Figure 41. Top SFY 2022 CHIP Recipients (greater than 5% of Total CHIP Recipients)

APPENDICES

APPENDIX A: SUPPLEMENTAL TABLES

SERVICES

Table 70. 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: - Physician Assistants	Medically necessary psychiatric services
Advanced practice mental health nurse practitioners Independently practicing clinical psychologists 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 71. Waiver Services by Waiver

Waiver Service	Comprehensive	Supports	Community Choices	Children's Mental Health
Case Management	X	X	X	X
Functional assessments	X	X	X	X
Respite	X	X	X	X
Personal care	X	X	X	
Skilled nursing	X	X	X	
Dietitian	X	X	X[63]	
Homemaker	X	X	X	
Special family habilitation home	X			
Day habilitation	X	X		
Child habilitation	X	X		
Residential habilitation training	X	X		
Specialized equipment	X	X		
Environmental modifications	X	X		
Supported living	X	X		
Community integrated employment	X	X		
Employment supports	X	X		
Companion	X	X		
Occupational, physical, and Speech therapies	X	X		
Cognitive retraining				
Self-directed / Consumer-directed available	X	X	X	
High Fidelity Wraparound				X
Family and Youth Peer Support Services				X

BIRTHS

Table 72. Wyoming and Medicaid Birth

Calendar Year	Wyoming Births[64]	Medicaid Births	Medicaid % of Total
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	2,857	37%
2015	7,715	2,784	36%
2016	7,384	2,696	37%
2017	6,904	2,448	35%
2018	6,549	2,232	34%
2019	6,566	2,152	33%
2020	6,133	2,001	33%
2021	6,235	1,906	31%

63. Service available for Assisted Living recipients only
64. Provisional statistics for statewide births were supplied by Vital Records.

COUNTY DATA

Table 73. Medicaid County Summary

County	Enrolled Members[65]	% of Total Enrolled Members	Recipients[66]	% of Total Recipients	Expenditures	% of Total Expenditures
Albany	3,653	4.1%	3,180	4%	$22,799,742.32	3.9%
Big Horn	2,152	2.4%	1,811	3%	$14,383,133.87	2.4%
Campbell	6,874	7.8%	5,769	8%	$34,046,512.69	6.0%
Carbon	1,974	2.2%	1,685	2%	$9,088,166.98	1.6%
Converse	2,068	2.3%	1,775	2%	$11,094,329.29	2.1%
Crook	887	1.0%	752	1%	$3,874,223.34	0.7%
Fremont	9,880	11.2%	9,100	13%	$105,704,126.24	20.2%
Goshen	1,847	2.1%	1,563	2%	$12,774,013.90	1.9%
Hot Springs	821	0.9%	705	1%	$6,723,395.95	1.3%
Johnson	990	1.1%	814	1%	$5,544,244.35	0.9%
Laramie	13,965	15.8%	11,819	17%	$95,267,145.74	16.1%
Lincoln	1,891	2.1%	1,517	2%	$10,619,300.67	2.0%
Natrona	13,538	15.4%	12,022	17%	$90,849,304.02	15.7%
Niobrara	373	0.4%	292	0%	$1,692,656.62	0.2%
Other[67]	3,746	4.2%	3,788	5.3%	$10,467,102.12	2.4%
Park	3,829	4.3%	3,199	4%	$23,271,707.64	3.7%
Platte	1,228	1.4%	1,051	1%	$6,494,048.99	1.2%
Sheridan	4,059	4.6%	3,475	5%	$23,845,740.10	4.3%
Sublette	797	0.9%	628	1%	$3,016,010.61	0.7%
Sweetwater	6,252	7.1%	5,291	7%	$32,688,426.07	5.3%
Teton	1,185	1.3%	937	1%	$5,418,777.82	0.8%
Uinta	3,422	3.9%	2,977	4%	$24,251,389.98	4.2%
Washakie	1,218	1.4%	1,052	1%	$8,300,817.47	1.3%
Weston	863	1.0%	738	1%	$5,478,813.56	0.9%
Overall	**88,149**		**70,930**		**$580,511,215**	

65. Enrollment is based on Complete SFY.
66. Recipients and Expenditures are based on the 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.
67. Recipients in "Other" county have moved out of the state prior to their claim being processed.

PROVIDERS

The data in Table 74 is based on providers paid during the SFY and does not reflect the number of enrolled providers.

Table 74. SFY 2022 Provider Taxonomy Summary

Provider Taxonomy	Providers	Recipients[68]	Expenditures
Advanced Practice Midwife (367A00000X)	3	22	$30,193
Allergy & Immunology, Allergy (207KA0200X)	7	340	$130,965
Ambulance (341600000X)	72	3,606	$3,249,255
Anesthesiology (207L00000X)	55	7,009	$2,410,054
Audiologist (231H00000X)	13	470	$165,975
Behavior Analyst (103K00000X)	6	59	$1,499,933
Case Management (251B00000X)	129	2,964	$33,421,019
Chiropractor (111N00000X)	37	234	$20,634
Clinic/Center (261Q00000X)	10	985	$790,699
Clinic/Center, Ambulatory Family Planning Facility (261QA0005X)	5	242	$64,565
Clinic/Center, Ambulatory Surgical (261QA1903X)	31	3,370	$5,117,524
Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	15	165	$2,268,909
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	16	8,415	$8,752,845
Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X)	32	3,921	$2,844,818
Clinic/Center, Public Health, Federal (261QP0904X)	4	4,432	$21,248,347
Clinic/Center, Radiology, Mobile (261QR0208X)	1	<10[68]	$158
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	60	$30,677
Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X)	36	1,173	$1,953,063
Clinic/Center, Rural Health (261QR1300X)	31	7,232	$3,505,312
Clinical Medical Laboratory (291U00000X)	83	7,751	$1,057,050
Clinical Neuropsychologist (103G00000X)	1	<10	$23
Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X)	12	641	$204,114
Community/Behavioral Health (251S00000X)	40	461	$3,244,965
Counselor, Addiction (Substance Use Disorder) (101YA0400X)	2	46	$3,223
Counselor, Professional (101YP2500X)	164	3,068	$4,112,145
Day Training, Developmentally Disabled Services (251C00000X)	605	2,917	$109,621,235
Dentist (122300000X)	29	3,471	$1,225,145
Dentist, Endodontics (1223E0200X)	3	96	$65,452
Dentist, General Practice (1223G0001X)	110	11,067	$3,492,491
Dentist, Oral, and Maxillofacial Surgery (1223S0112X)	9	1,434	$1,211,377
Dentist, Orthodontics, and Dentofacial Orthopedics (1223X0400X)	13	327	$333,693
Dentist, Pediatric Dentistry (1223P0221X)	33	14,307	$5,609,003
Dermatology (207N00000X)	16	2,208	$318,659
Dietitian, Registered (133V00000X)	2	<10	$2,647

68. This table displays a unique count of recipients for each provider taxonomy. Summing the recipients across all taxonomies will not equal the total recipients shown as recipients often receive multiple services throughout the SFY.
69. Values less than 10 are not shown in order to protect the privacy of recipients

Provider Taxonomy (continued)	Providers	Recipients	Expenditures
Durable Medical Equipment & Medical Supplies (332B00000X)	215	8,298	$9,209,090
Emergency Medical Technician, Basic (146N00000X)	1	<10	$46
Emergency Medicine (207P00000X)	31	19,768	$4,323,385
Family Medicine (207Q00000X)	83	20,513	$4,666,113
General Acute Care Hospital (282N00000X)	115	32,579	$90,552,390
General Acute Care Hospital, Rural (282NR1301X)	32	9,787	$12,891,842
Hearing Aid Equipment (332S00000X)	6	141	$163,922
Home Health (251E00000X)	23	246	$990,008
Hospice Care, Community-Based (251G00000X)	14	173	$921,529
Intermediate Care Facility, Intellectually Disabled (315P00000X)	1	52	$16,842,461
Internal Medicine (207R00000X)	57	14,378	$7,139,871
Internal Medicine, Cardiovascular Disease (207RC0000X)	16	2,279	$403,466
Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X)	4	140	$20,504
Internal Medicine, Gastroenterology (207RG0100X)	7	1,859	$718,558
Internal Medicine, Geriatric Medicine (207RG0300X)	6	232	$61,393
Internal Medicine, Medical Oncology (207RX0202X)	6	16	$(1,573)
Internal Medicine, Nephrology (207RN0300X)	6	565	$94,006
Internal Medicine, Pulmonary Disease (207RP1001X)	7	368	$124,173
Internal Medicine, Rheumatology (207RR0500X)	2	163	$16,983
Interpreter (171R00000X)	2	98	$18,652
Lodging (177F00000X)	4	168	$150,329
Marriage & Family Therapist (106H00000X)	15	270	$553,964
Medical Genetics, Clinical Genetics (M.D.) (207SG0201X)	1	31	$4,923
Medicare Defined Swing Bed Unit (275N00000X)	13	49	$287,091
Midwife (176B00000X)	5	60	$43,060
Neurological Surgery (207T00000X)	10	588	$2,461,141
Nurse Anesthetist, Certified Registered (367500000X)	14	672	$144,861
Nurse Practitioner (363L00000X)	14	2,022	$506,610
Nurse Practitioner, Adult Health (363LA2200X)	1	12	$1,020
Nurse Practitioner, Family (363LF0000X)	18	2,111	$447,153
Nurse Practitioner, Pediatrics (363LP0200X)	3	274	$50,433
Obstetrics & Gynecology (207V00000X)	28	3,934	$3,990,789
Obstetrics & Gynecology, Gynecology (207VG0400X)	2	190	$91,906
Obstetrics & Gynecology, Obstetrics (207VX0000X)	3	14	$998
Occupational Therapist (225X00000X)	14	532	$1,349,513
Ophthalmology (207W00000X)	31	1,861	$640,473
Optometrist (152W00000X)	81	14,759	$3,360,475
Orthopaedic Surgery (207X00000X)	27	4,588	$1,652,443
Otolaryngology (207Y00000X)	13	2,482	$786,603
Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X)	13	2,271	$274,907
Pediatrics (208000000X)	60	11,663	$4,443,868
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	4	263	$307,005
Pharmacy (333600000X)	218	42,053	$82,303,272

Provider Taxonomy (continued)	Providers	Recipients	Expenditures
Pharmacy, Home Infusion Therapy Pharmacy (3336H0001X)	1	<10	$233
Pharmacy, Long Term Care Pharmacy (3336L0003X)	1	<10	$2
Physical Medicine & Rehabilitation (208100000X)	14	298	$145,182
Physical Therapist (225100000X)	80	3,810	$3,556,811
Physician Assistant (363A00000X)	3	125	$43,633
Physician, General Practice (208D00000X)	60	20,403	$7,318,853
Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X)	4	48	$16,575
Podiatrist (213E00000X)	13	883	$32,484
Private Vehicle (347C00000X)	1	17	$5,949
Prosthetic/Orthotic Supplier (335E00000X)	28	776	$567,304
Psychiatric Hospital (283Q00000X)	3	21	$101,841
Psychiatric Residential Treatment Facility (323P00000X)	6	150	$6,101,319
Psychiatry & Neurology, Neurology (2084N0400X)	18	1,415	$321,994
Psychiatry & Neurology, Psychiatry (2084P0800X)	20	865	$1,291,376
Psychologist, Clinical (103TC0700X)	49	2,242	$2,349,169
Public Health or Welfare (251K00000X)	25	4,381	$356,804
Radiology, Diagnostic Radiology (2085R0202X)	38	17,571	$3,300,665
Rehabilitation Hospital (283X00000X)	3	84	$546,854
Skilled Nursing Facility (314000000X)	48	2,037	$72,355,016
Social Worker, Clinical (1041C0700X)	110	2,557	$2,682,186
Specialist (174400000X)	2	299	$47,341
Speech-Language Pathologist (235Z00000X)	14	333	$394,256
Supports Brokerage (251X00000X)	1	497	$7,139,257
Surgery (208600000X)	26	1,566	$493,899
Surgery, Pediatric Surgery (2086S0120X)	4	72	$27,606
Surgery, Vascular Surgery (2086S0129X)	5	73	$18,524
Taxi (344600000X)	1	<10	$90
Technician/Technologist, Optician (156FX1800X)	6	342	$42,453
Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X)	1	11	$2,685
Urology (208800000X)	11	1,119	$235,031
Totals	**23,275**	**70,930**	**$580,511,215**

Table 75. Top 20 Provider Taxonomies by Expenditures

Provider Taxonomy	Expenditures	Percent of Total Medicaid Expenditures
Day Training, Developmentally Disabled Services (251C00000X)	$109,621,235	18.88
General Acute Care Hospital (282N00000X)	$90,552,390	15.60
Pharmacy (333600000X)	$82,303,272	14.18
Skilled Nursing Facility (314000000X)	$72,355,016	12.46
Case Management (251B00000X)	$33,421,019	5.76
Clinic/Center, Public Health, Federal (261QP0904X)	$21,248,347	3.66
Intermediate Care Facility, Intellectually Disabled (315P00000X)	$16,842,461	2.90
General Acute Care Hospital, Rural (282NR1301X)	$12,891,842	2.22
Durable Medical Equipment & Medical Supplies (332B00000X)	$9,209,090	1.59
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	$8,752,845	1.51
Physician, General Practice (208D00000X)	$7,318,853	1.26
Internal Medicine (207R00000X)	$7,139,871	1.23
Supports Brokerage (251X00000X)	$7,139,257	1.23
Psychiatric Residential Treatment Facility (323P00000X)	$6,101,319	1.05
Dentist, Pediatric Dentistry (1223P0221X)	$5,609,003	0.97
Clinic/Center, Ambulatory Surgical (261QA1903X)	$5,117,524	0.88
Family Medicine (207Q00000X)	$4,666,113	0.80
Pediatrics (208000000X)	$4,443,868	0.77
Emergency Medicine (207P00000X)	$4,323,385	0.74
Counselor, Professional (101YP2500X)	$4,112,145	0.71

Table 76. Pay-to-Provider Count History by Taxonomy

Pay-to-Provider Taxonomy	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5 Year % Change
Advanced Practice Midwife (367A00000X)	7	8	4	4	3	3	-57.14
Allergy & Immunology, Allergy (207KA0200X)	6	5	5	5	6	7	16.67
Ambulance (341600000X)	64	63	73	66	67	72	12.50
Anesthesiology (207L00000X)	73	78	73	56	56	55	-24.66
Audiologist (231H00000X)	14	12	13	12	13	13	-7.14
Behavior Analyst (103K00000X)	--	5	3	7	5	6	--
Case Management (251B00000X)	115	114	120	128	129	129	12.17
Chiropractor (111N00000X)	50	52	54	54	55	37	-26.00
Clinic/Center (261Q00000X)	14	23	12	12	11	10	-28.57
Clinic/Center, Ambulatory Family Planning Facility (261QA0005X)	9	7	7	5	5	5	-44.44
Clinic/Center, Ambulatory Surgical (261QA1903X)	28	28	31	27	30	31	10.71
Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	15	15	16	15	15	15	--
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	12	11	11	16	15	16	33.33
Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X)	27	26	26	27	27	32	18.52
Clinic/Center, Public Health, Federal (261QP0904X)	4	4	5	4	5	4	0.00

Pay-to-Provider Taxonomy (continued)	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5 Year % Change
Clinic/Center, Radiology, Mobile (261QR0208X)	--	--	--	1	--	1	--
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	1	1	1	1	1	0.00
Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X)	31	32	33	33	32	36	16.13
Clinic/Center, Rural Health (261QR1300X)	21	24	32	31	34	31	47.62
Clinical Medical Laboratory (291U00000X)	85	74	71	70	76	83	-2.35
Clinical Neuropsychologist (103G00000X)	2	4	4	5	1	1	-50.00
Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X)	14	12	9	10	10	12	-14.29
Community/Behavioral Health (251S00000X)	1	1	1	1	29	40	3,900.00
Counselor, Addiction (Substance Use Disorder) (101YA0400X)	4	3	3	3	4	2	-50.00
Counselor, Professional (101YP2500X)	123	138	145	155	154	164	33.33
Day Training, Developmentally Disabled Services (251C00000X)	629	649	657	659	623	605	-3.82
Dentist (122300000X)	29	27	29	31	31	29	0.00
Dentist, Endodontics (1223E0200X)	3	3	2	4	3	3	0.00
Dentist, General Practice (1223G0001X)	137	130	129	121	109	110	-19.71
Dentist, Oral and Maxillofacial Surgery (1223S0112X)	16	11	13	11	9	9	-43.75
Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X)	17	15	17	14	14	13	-23.53
Dentist, Pediatric Dentistry (1223P0221X)	32	34	32	33	30	33	3.13
Dermatology (207N00000X)	13	15	17	16	16	16	23.08
Dietitian, Registered (133V00000X)	1	2	2	2	2	2	100.00
Durable Medical Equipment & Medical Supplies (332B00000X)	234	231	222	202	204	215	-8.12
Emergency Medical Technician, Basic (146N00000X)	--	--	--	--	--	1	--
Emergency Medicine (207P00000X)	36	32	32	29	32	31	-13.89
Family Medicine (207Q00000X)	86	84	93	86	80	83	-3.49
General Acute Care Hospital (282N00000X)	114	114	112	103	107	115	0.88
General Acute Care Hospital, Rural (282NR1301X)	36	30	27	26	32	32	-11.11
Hearing Aid Equipment (332S00000X)	11	9	8	9	9	6	-45.45
Home Health (251E00000X)	29	25	23	23	20	23	-20.69
Hospice Care, Community-Based (251G00000X)	12	13	12	13	14	14	16.67
Intermediate Care Facility, Intellectually Disabled (315P00000X)	1	1	1	1	1	1	0.00
Internal Medicine (207R00000X)	55	57	60	57	59	57	3.64
Internal Medicine, Cardiovascular Disease (207RC0000X)	17	18	19	20	17	16	-5.88
Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X)	4	4	4	4	3	4	0.00
Internal Medicine, Gastroenterology (207RG0100X)	4	6	6	6	7	7	75.00
Internal Medicine, Geriatric Medicine (207RG0300X)	4	4	5	5	4	6	50.00
Internal Medicine, Medical Oncology (207RX0202X)	7	6	4	4	4	6	-14.29
Internal Medicine, Nephrology (207RN0300X)	6	6	7	6	6	6	0.00
Internal Medicine, Pulmonary Disease (207RP1001X)	11	9	10	8	8	7	-36.36
Internal Medicine, Rheumatology (207RR0500X)	2	2	2	2	3	2	0.00
Interpreter (171R00000X)	1	2	3	2	2	2	100.00
Lodging (177F00000X)	2	3	2	2	4	4	100.00
Marriage & Family Therapist (106H00000X)	15	13	15	10	12	15	0.00

Pay-to-Provider Taxonomy (continued)	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5 Year % Change
Medical Genetics, Clinical Genetics (M.D.) (207SG0201X)	1	1	1	1	1	1	0.00
Medicare Defined Swing Bed Unit (275N00000X)	11	15	11	12	13	13	18.18
Midwife (176B00000X)	--	--	--	3	3	5	--
Neurological Surgery (207T00000X)	12	10	10	9	11	10	-16.67
Nurse Anesthetist, Certified Registered (367500000X)	16	13	14	13	12	14	-12.50
Nurse Practitioner (363L00000X)	9	9	14	14	17	14	55.56
Nurse Practitioner, Adult Health (363LA2200X)	1	1	1	1	1	1	0.00
Nurse Practitioner, Family (363LF0000X)	15	12	16	23	23	18	20.00
Nurse Practitioner, Pediatrics (363LP0200X)	2	2	2	3	3	3	50.00
Obstetrics & Gynecology (207V00000X)	40	33	28	27	27	28	-30.00
Obstetrics & Gynecology, Gynecology (207VG0400X)	5	5	3	4	2	2	-60.00
Obstetrics & Gynecology, Obstetrics (207VX0000X)	5	5	5	4	4	3	-40.00
Occupational Therapist (225X00000X)	21	20	17	14	14	14	-33.33
Ophthalmology (207W00000X)	25	30	32	32	35	31	24.00
Optometrist (152W00000X)	93	89	80	77	83	81	-12.90
Orthopaedic Surgery (207X00000X)	36	34	32	30	29	27	-25.00
Otolaryngology (207Y00000X)	24	19	18	15	15	13	-45.83
Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X)	19	17	16	14	13	13	-31.58
Pediatrics (208000000X)	97	76	67	69	65	60	-38.14
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	5	5	3	4	5	4	-20.00
Pharmacy (333600000X)	205	208	206	205	215	218	6.34
Pharmacy, Home Infusion Therapy Pharmacy (3336H0001X)	--	--	--	--	--	1	--
Pharmacy, Long Term Care Pharmacy (3336L0003X)	--	--	--	--	--	1	--
Physical Medicine & Rehabilitation (208100000X)	14	12	15	14	12	14	0.00
Physical Therapist (225100000X)	63	62	67	66	75	80	26.98
Physician Assistant (363A00000X)	1	1	3	5	2	3	200.00
Physician, General Practice (208D00000X)	67	62	58	61	58	60	-10.45
Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X)	11	11	7	8	5	4	-63.64
Podiatrist (213E00000X)	13	11	15	14	12	13	0.00
Private Vehicle (347C00000X)	4	4	6	3	2	1	-75.00
Program of All-Inclusive Care for the Elderly (PACE) Provider Organization (251T00000X)	1	1	1	1	1	--	--
Prosthetic/Orthotic Supplier (335E00000X)	26	31	28	28	27	28	7.69
Psychiatric Hospital (283Q00000X)	3	3	3	4	3	3	0.00
Psychiatric Residential Treatment Facility (323P00000X)	14	13	16	13	14	6	-57.14
Psychiatry & Neurology, Neurology (2084N0400X)	20	19	22	21	19	18	-10.00
Psychiatry & Neurology, Psychiatry (2084P0800X)	31	26	25	21	20	20	-35.48
Psychologist, Clinical (103TC0700X)	76	69	60	59	53	49	-35.53
Public Health or Welfare (251K00000X)	24	24	24	24	25	25	4.17
Radiology, Diagnostic Radiology (2085R0202X)	46	49	46	44	41	38	-17.39
Rehabilitation Hospital (283X00000X)	2	3	3	2	3	3	50.00
Skilled Nursing Facility (314000000X)	53	52	56	56	48	48	-9.43

Pay-to-Provider Taxonomy (continued)	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5 Year % Change
Social Worker, Clinical (1041C0700X)	74	77	84	94	96	110	48.65
Specialist (174400000X)	--	7	7	4	3	2	--
Speech-Language Pathologist (235Z00000X)	9	9	10	10	13	14	55.56
Supports Brokerage (251X00000X)	2	1	1	1	1	1	-50.00
Surgery (208600000X)	33	30	30	31	32	26	-21.21
Surgery, Pediatric Surgery (2086S0120X)	5	2	2	5	5	4	-20.00
Surgery, Vascular Surgery (2086S0129X)	4	4	5	4	4	5	25.00
Taxi (344600000X)	1	1	1	1	2	1	0.00
Technician/Technologist, Optician (156FX1800X)	6	6	6	6	5	6	0.00
Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X)	3	2	2	2	1	1	-66.67
Unclassified	1	1	1	1	1	--	--
Urology (208800000X)	16	13	13	12	10	11	-31.25

Table 77. Provider Expenditure History by Taxonomy

Provider Taxonomy	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Advanced Practice Midwife (367A00000X)	$89,855	$64,608	$31,747	$27,464	$16,866	$30,193	-66.40
Allergy & Immunology, Allergy (207KA0200X)	$372,655	$396,665	$282,684	$210,462	$121,800	$130,965	-64.86
Ambulance (341600000X)	$3,847,375	$2,381,969	$3,543,958	$2,869,734	$3,441,088	$3,249,255	-15.55
Anesthesiology (207L00000X)	$2,697,539	$2,488,633	$2,449,632	$2,387,211	$2,372,652	$2,410,054	-10.66
Audiologist (231H00000X)	$158,494	$229,847	$141,981	$344,821	$175,435	$165,975	4.72
Behavior Analyst (103K00000X)	--	$167,595	$533,209	$831,883	$1,673,558	$1,499,933	--
Case Management (251B00000X)	$21,007,543	$27,226,271	$29,146,077	$29,686,195	$33,151,973	$33,421,019	59.09
Chiropractor (111N00000X)	$280,207	$347,441	$406,862	$368,608	$337,670	$20,634	-92.64
Clinic/Center (261Q00000X)	$1,327,800	$972,701	$815,334	$435,776	$712,388	$790,699	-40.45
Clinic/Center, Ambulatory Family Planning Facility (261QA0005X)	$62,853	$51,449	$51,977	$48,668	$41,326	$64,565	2.72
Clinic/Center, Ambulatory Surgical (261QA1903X)	$4,095,973	$3,881,705	$3,555,184	$3,170,249	$4,183,523	$5,117,524	24.94
Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	$1,267,034	$1,012,427	$1,063,315	$1,595,216	$2,172,271	$2,268,909	79.07
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	$5,725,094	$11,418,874	$5,776,571	$6,554,011	$6,839,456	$8,752,845	52.89
Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X)	$7,681,229	$6,196,355	$5,381,394	$3,951,005	$2,961,942	$2,844,818	-62.96
Clinic/Center, Public Health, Federal (261QP0904X)	$8,718,888	$19,625,445	$12,488,676	$11,864,895	$17,453,190	$21,248,347	143.70
Clinic/Center, Radiology, Mobile (261QR0208X)	--	--	--	--	--	$158	--
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	$84,406	$29,156	$26,024	$22,394	$26,454	$30,677	-63.66
Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X)	$2,997,914	$2,940,116	$2,793,311	$3,065,233	$2,228,012	$1,953,063	-34.85
Clinic/Center, Rural Health (261QR1300X)	$1,540,607	$1,894,505	$2,283,377	$2,377,607	$2,708,379	$3,505,312	127.53
Clinical Medical Laboratory (291U00000X)	$844,218	$1,020,356	$719,701	$585,977	$797,433	$1,057,050	25.21
Clinical Neuropsychologist (103G00000X)	$8,924	$79,582	$50,843	$37,580	$23,900	$23	-99.75
Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X)	$335,697	$363,266	$326,066	$278,963	$275,019	$204,114	-39.20
Community/Behavioral Health (251S00000X)	$7,135,148	$7,599,455	$3,290,255	$3,928,461	$3,083,353	$3,244,965	-54.52
Counselor, Addiction (Substance Use Disorder) (101YA0400X)	$235,019	$207,018	$210,373	$62,187	$15,045	$3,223	-98.63
Counselor, Professional (101YP2500X)	$5,605,555	$5,024,798	$4,176,857	$4,184,775	$4,642,838	$4,112,145	-26.64
Day Training, Developmentally Disabled Services (251C00000X)	$95,966,105	$100,815,145	$113,694,991	$114,398,383	$115,425,234	$109,621,235	14.23
Dentist (122300000X)	$1,468,732	$1,051,336	$962,164	$867,521	$1,299,378	$1,225,145	-16.58

Provider Taxonomy (continued)	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Dentist, Endodontics (1223E0200X)	$43,105	$52,582	$49,611	$52,182	$64,620	$65,452	51.84
Dentist, General Practice (1223G0001X)	$6,085,423	$4,331,962	$3,985,182	$3,089,844	$3,596,275	$3,492,491	-42.61
Dentist, Oral and Maxillofacial Surgery (1223S0112X)	$1,132,105	$1,106,227	$879,442	$873,145	$1,144,135	$1,211,377	7.00
Dentist, Orthodontics, and Dentofacial Orthopedics (1223X0400X)	$543,829	$368,831	$420,012	$261,832	$283,798	$333,693	-38.64
Dentist, Pediatric Dentistry (1223P0221X)	$4,894,424	$4,936,642	$5,007,670	$4,749,104	$5,510,329	$5,609,003	14.60
Dermatology (207N00000X)	$272,569	$300,262	$271,678	$254,356	$288,837	$318,659	16.91
Dietitian, Registered (133V00000X)	$391	$1,803	$617	$697	$385	$2,647	577.81
Durable Medical Equipment & Medical Supplies (332B00000X)	$7,360,167	$6,944,732	$7,850,643	$8,174,435	$8,742,496	$9,209,090	25.12
Emergency Medical Technician, Basic (146N00000X)	--	--	--	--	--	$46	--
Emergency Medicine (207P00000X)	$4,130,517	$4,026,740	$3,855,001	$3,400,286	$3,446,604	$4,323,385	4.67
Family Medicine (207Q00000X)	$6,805,220	$6,424,856	$5,746,907	$5,163,045	$4,727,108	$4,666,113	-31.43
General Acute Care Hospital (282N00000X)	$83,353,763	$84,380,731	$84,697,383	$75,855,320	$84,960,939	$90,552,390	8.64
General Acute Care Hospital, Rural (282NR1301X)	$14,474,403	$11,942,563	$12,195,829	$11,589,064	$11,513,676	$12,891,842	-10.93
Hearing Aid Equipment (332S00000X)	$912,176	$831,358	$567,915	$775,873	$493,176	$163,922	-82.03
Home Health (251E00000X)	$9,596,803	$4,012,083	$570,570	$1,004,397	$992,823	$990,008	-89.68
Hospice Care, Community-Based (251G00000X)	$1,316,838	$1,394,149	$1,190,302	$1,251,068	$1,297,041	$921,529	-30.02
Intermediate Care Facility, Intellectually Disabled (315P00000X)	$19,204,867	$13,999,444	$12,901,888	$16,058,915	$17,024,561	$16,842,461	-12.30
Internal Medicine (207R00000X)	$7,938,991	$7,076,336	$7,075,072	$6,517,068	$7,014,980	$7,139,871	-10.07
Internal Medicine, Cardiovascular Disease (207RC0000X)	$419,095	$291,341	$302,157	$326,970	$354,478	$403,466	-3.73
Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X)	$22,999	$18,807	$21,509	$23,002	$20,203	$20,504	-10.85
Internal Medicine, Gastroenterology (207RG0100X)	$495,528	$550,096	$479,940	$423,968	$736,866	$718,558	45.01
Internal Medicine, Geriatric Medicine (207RG0300X)	$27,816	$12,796	$43,908	$43,886	$42,598	$61,393	120.71
Internal Medicine, Medical Oncology (207RX0202X)	$2,469,020	$2,756,577	$1,914,670	$2,155,922	$647,946	($1,573)	-100.06
Internal Medicine, Nephrology (207RN0300X)	$26,828	$37,495	$64,890	$73,053	$62,204	$94,006	250.39
Internal Medicine, Pulmonary Disease (207RP1001X)	$147,096	$102,784	$121,574	$91,720	$114,401	$124,173	-15.58
Internal Medicine, Rheumatology (207RR0500X)	$18,310	$13,849	$13,841	$8,389	$18,004	$16,983	-7.25
Interpreter (171R00000X)	$32,056	$22,119	$5,799	$9,096	$17,094	$18,652	-41.81
Lodging (177F00000X)	$53,950	$85,915	$127,715	$108,735	$105,625	$150,329	178.64
Marriage & Family Therapist (106H00000X)	$298,392	$510,758	$391,014	$376,927	$512,977	$553,964	85.65
Medical Genetics, Clinical Genetics (M.D.) (207SG0201X)	$2,583	$6,455	$3,266	$3,083	$4,482	$4,923	90.58
Medicare Defined Swing Bed Unit (275N00000X)	$462,413	$620,073	$479,918	$557,037	$633,663	$287,091	-37.91

Provider Taxonomy (continued)	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Midwife (176B00000X)	--	--	--	$14,782	$36,514	$43,060	--
Neurological Surgery (207T00000X)	$251,854	$69,210	$75,191	$88,516	$3,911,236	$2,461,141	877.21
Nurse Anesthetist, Certified Registered (367500000X)	$73,627	$65,899	$78,819	$86,639	$133,402	$144,861	96.75
Nurse Practitioner (363L00000X)	$297,224	$142,851	$200,823	$277,571	$330,772	$506,610	70.45
Nurse Practitioner, Adult Health (363LA2200X)	$7	$2,582	$2,284	$2,958	$1,862	$1,020	13,820.05
Nurse Practitioner, Family (363LF0000X)	$268,262	$246,169	$251,881	$338,367	$365,288	$447,153	66.69
Nurse Practitioner, Pediatrics (363LP0200X)	$20,832	$20,745	$15,922	$16,328	$19,309	$50,433	142.10
Obstetrics & Gynecology (207V00000X)	$4,887,444	$4,563,484	$3,814,652	$3,657,589	$3,708,849	$3,990,789	-18.35
Obstetrics & Gynecology, Gynecology (207VG0400X)	$164,003	$134,985	$93,676	$94,634	$97,463	$91,906	-43.96
Obstetrics & Gynecology, Obstetrics (207VX0000X)	$655,371	$534,587	$503,347	$474,269	$253,688	$998	-99.85
Occupational Therapist (225X00000X)	$3,199,864	$2,904,323	$1,884,711	$1,630,049	$1,606,782	$1,349,513	-57.83
Ophthalmology (207W00000X)	$604,685	$584,656	$574,291	$542,002	$652,329	$640,473	5.92
Optometrist (152W00000X)	$3,782,521	$3,656,808	$3,409,020	$2,930,037	$3,477,790	$3,360,475	-11.16
Orthopaedic Surgery (207X00000X)	$1,628,003	$1,534,594	$1,222,153	$1,344,579	$1,399,881	$1,652,443	1.50
Otolaryngology (207Y00000X)	$917,671	$795,300	$679,438	$523,531	$702,197	$786,603	-14.28
Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X)	$145,815	$142,709	$83,620	$80,615	$67,961	$274,907	88.53
Pediatrics (208000000X)	$5,310,575	$4,878,853	$4,681,066	$3,931,424	$4,388,608	$4,443,868	-16.32
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	$227,825	$295,963	$208,703	$283,124	$332,879	$307,005	34.75
Pharmacy (333600000X)	$50,007,275	$57,006,524	$61,385,109	$60,432,330	$66,364,286	$82,303,272	64.58
Pharmacy, Home Infusion Therapy Pharmacy (3336H0001X)	--	--	--	--	--	$233	--
Pharmacy, Long Term Care Pharmacy (3336L0003X)	--	--	--	--	--	$2	--
Physical Medicine & Rehabilitation (208100000X)	$111,247	$119,039	$137,136	$123,650	$157,540	$145,182	30.50
Physical Therapist (225100000X)	$3,286,973	$2,653,095	$2,491,622	$2,316,327	$3,032,422	$3,556,811	8.21
Physician Assistant (363A00000X)	$86	$4,294	$21,168	$26,466	$38,811	$43,633	50683.43
Physician, General Practice (208D00000X)	$7,254,319	$7,406,209	$7,372,159	$7,102,898	$6,999,259	$7,318,853	0.89
Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X)	$85,222	$22,339	$22,049	$16,093	$9,091	$16,575	-80.55
Podiatrist (213E00000X)	$72,405	$58,482	$47,751	$42,304	$34,640	$32,484	-55.14
Private Vehicle (347C00000X)	$7,329	$11,145	$18,455	$12,973	$8,702	$5,949	-18.83
Program of All-Inclusive Care for the Elderly (PACE) Provider Organization (251T00000X)	$3,520,283	$3,471,255	$3,693,978	$3,586,650	$2,152,985	--	--
Prosthetic/Orthotic Supplier (335E00000X)	$757,241	$615,641	$598,186	$540,444	$610,680	$567,304	-25.08

Provider Taxonomy (continued)	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	5-Year % Change
Psychiatric Hospital (283Q00000X)	$75,848	$200,677	$122,776	$21,285	$75,743	$101,841	34.27
Psychiatric Residential Treatment Facility (323P00000X)	$12,121,830	$12,537,788	$10,391,372	$7,334,441	$7,517,488	$6,101,319	-49.67
Psychiatry & Neurology, Neurology (2084N0400X)	$805,683	$621,258	$468,020	$333,100	$324,947	$321,994	-60.03
Psychiatry & Neurology, Psychiatry (2084P0800X)	$2,552,807	$2,270,198	$1,813,284	$1,570,802	$1,855,312	$1,291,376	-49.41
Psychologist, Clinical (103TC0700X)	$7,892,343	$5,704,493	$5,198,374	$4,887,558	$3,590,150	$2,349,169	-70.23
Public Health or Welfare (251K00000X)	$912,684	$881,419	$917,659	$898,521	$694,880	$356,804	-60.91
Radiology, Diagnostic Radiology (2085R0202X)	$1,821,704	$1,794,304	$1,677,907	$1,538,606	$1,874,163	$3,300,665	81.19
Rehabilitation Hospital (283X00000X)	$563,688	$562,051	$619,218	$408,441	$567,445	$546,854	-2.99
Skilled Nursing Facility (314000000X)	$86,538,699	$86,684,517	$83,960,515	$88,869,925	$77,813,463	$72,355,016	-16.39
Social Worker, Clinical (1041C0700X)	$3,214,061	$3,274,619	$2,962,987	$2,944,198	$2,690,806	$2,682,186	-16.55
Specialist (174400000X)	--	$61,574	$58,231	$60,043	$56,864	$47,341	--
Speech-Language Pathologist (235Z00000X)	$688,314	$407,957	$242,416	$411,291	$370,827	$394,256	-42.72
Supports Brokerage (251X00000X)	$3,975,987	$4,570,890	$5,530,177	$6,172,411	$6,977,663	$7,139,257	79.56
Surgery (208600000X)	$740,929	$621,880	$648,362	$502,970	$588,358	$493,899	-33.34
Surgery, Pediatric Surgery (2086S0120X)	$76,375	$32,996	$30,182	$33,952	$50,641	$27,606	-63.85
Surgery, Vascular Surgery (2086S0129X)	$6,400	$23,257	$14,387	$26,205	$14,120	$18,524	189.43
Taxi (344600000X)	$16,674	$33,435	$45,135	$36,725	$18,864	$90	-99.46
Technician/Technologist, Optician (156FX1800X)	$68,054	$56,048	$57,048	$47,032	$48,565	$42,453	-37.62
Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X)	$20,262	$14,046	$27,538	$11,947	$8,685	$2,685	-86.75
Unclassified	$292,866	$635,221	$224,355	$40,885	$89,626	--	--
Urology (208800000X)	$295,664	$303,965	$268,132	$235,121	$251,901	$235,031	-20.51

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 78. Reimbursement Methodology and History by Service Area

Reimbursement Methodology and History by Service Area					
SFY 2017	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**
Ambulance — Wyoming Medicaid Administrative Rule Chapter 15; Chapter 3 • Lower of the Medicaid fee schedule or the provider's usual and customary charge • Fixed fee schedule for transport • Mileage and disposable supplies reimbursed separately • Separate fee schedules for: Basic life support (ground), Advanced life support (ground), Additional advanced life support (ground), Air ambulance					
No changes	No changes	No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No Changes
Ambulatory Surgery Center — 43 CFR 447.321 SPA 4.19B • 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.					
Adjusted conversion factors effective calendar year 2017	No changes	No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No Changes
Behavioral Health — State plan 4.19B • Lower of the Medicaid fee schedule or the provider's usual and customary charge • Separate fee schedules based on the type of provider					
Reimbursement rate reduced by 3.3%	No changes	Psychologists paid 100% of fee schedule. APRN paid 90% of fee schedule (eff. 1/1/2018)	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No Changes

Reimbursement Methodology and History by Service Area					
SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Care Management Entity 42 CFR 438.6; Annual actuarial analysis with review and approval by CMS for each SFY. ● Lower of the Medicaid fee schedule or the provider's usual and customary charge ● Reimbursement based on procedure code fee schedule					
No changes	No changes	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.	No changes	Beginning 10/01/2020, the CME sends a 278 transaction to Conduent. Conduent uses the 278 file to issue PA numbers for services provided by the CME network providers who utilize the PA's to bill the Medicaid fiscal agent directly. Magellan continues to send an 837P to Conduent for the PMPM payments but doesn't submit FFS claims on behalf of the CME network providers since the change on 10/01/2020.	Rate increase of 2.5% effective 1/1/2022.
Clinic/Center (Children's Developmental Centers) Wyoming Medicaid Administrative Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B. ● Lower of the Medicaid fee schedule or the provider's usual and customary charge					
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 changes	No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes
Dental Wyoming State Plan Attachment 4.19B ● Lower of the Medicaid fee schedule or the provider's usual and customary charge ● Adult optional dental services added (effective July 1, 2006)					
Per Governor's budget cuts, adult dental coverage reduced to preventive and emergency services only.	No changes	No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes

Reimbursement Methodology and History by Service Area					
SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies — Wyoming Medicaid Administrative Rule Chapter 11; Chapter 3; Wyoming State Plan Attachment 4.19B-12c • 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					
No changes	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 changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	Codes impacted by the 21st Century CURES Act are set at 97.5% of the lowest Medicare rate. Codes not impacted by the 21st Century CURES Act, no change
End-Stage Renal Disease — 42 CFR Part 413 Subpart H; State Plan 4.19B • Lower of the Medicaid fee schedule or the provider's usual and customary charge • Dialysis services reimbursed at a percentage of billed charges					
No changes	No changes	No changes	No changes	Due to Governor's budget reductions, reimbursement was red	No changes
Federally Qualified Health Centers — 42 CFR 405 Subchapter B; 405.2400-405.2472 Subpart X; 405.2400-405.2417; 405.2430-405.2452; 405.2460-405.2472; Wyoming Medicaid Administrative Rule Chapter 37 • 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					
Rates increased 1.2% based on MEI	Rates increased 1.01% based on MEI	Rates increased 1.015% based on MEI	Rates increased 1.9% based on MEI	Rates increased by 1.4%	Rates increase by 2.1%
Home Health — 42 CFR 484 Subpart E • Lower of the Medicaid fee schedule or the provider's usual and customary charge • Per visit rates based on Medicare's fee schedule					
Prior authorization required starting dates of service 3/1/17 and newer	No changes	No changes	Prior authorization suspended in March 2020.	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes

Reimbursement Methodology and History by Service Area					
SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Hospice 42 CFR 418; Wyoming State Statute 42-4-103(a)(xxv) ● Per diem rate based on Medicare's fee schedule ● Rates adjust annually based on Medicare's adjustments ● Rates for services provided to nursing facility residents are 95% of the nursing facility's per diem rate ● Rate for room and board in an inpatient hospice facility not to exceed 50% of the established nursing home room and board rate (effective July 1, 2013)					
Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments	Due to Governor's budget reductions, reimbursement was reduced by 2.5% for hospice in nursing home.	Rates adjusted per Medicare's adjustments, NH hospice was increased by 5% for part of SFY 2022.
Hospital (Inpatient) CFR 447 Subpart C Payment; State Plan 4.19B ● Level of Care (LOC) rate per discharge ● Per diem rates for rehabilitation with a ventilator and separate rate without a ventilator ● Transplant services are reimbursed at 55% of billed charges ● Specialty services not otherwise obtainable in Wyoming negotiated through letters of agreement ● 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					
No change to LOC reimbursement; private hospital UPL implemented	No changes	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	Second year of DRG rates implemented February 1, 2020	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes
Hospital (Outpatient) CFR 447.321; CFR 447.325; Wyoming Medicaid Administrative Rule Chapter 33 ● 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					

Reimbursement Methodology and History by Service Area					
SFY 2017	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**
Adjusted conversion factors (effective calendar year 2017): General acute $37.94 Critical access $98.80 Children's $76.34 ASCs $33.39 No change for QRA	Adjusted conversion factors (effective calendar year 2018): General acute $39.70 Critical access $104.27 Children's $83.92 ASCs $34.94 No change for QRA	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	Adjusted conversion factors (effective calendar year 2020): General acute $45.79 Critical access $109.66 Children's $83.59 ASCs $40.30	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	Adjusted conversion factors (effective calendar year 2022): General Acute $46.88 Children's Hospital $84.54 Critical Access $112.72 ASCs $41.25
Intermediate Care Facility for Individuals with Intellectual Disabilities (IFCF/IID) — Wyoming Medicaid Administrative Rule Chapter 20 • Full cost reimbursement method based on previous year cost reports.					
No changes	No changes	No changes	No changes	No changes	No changes
Laboratory — Wyoming Medicaid Administrative Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B • Lower of the Medicaid fee schedule or the provider's usual and customary charge					
No changes	No changes	No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes
Nursing Facility — W.S. 42-4-104 (c); State Plan- 4.19D; Wyoming Medicaid Administrative Rule Chapter 7 • Prospective per diem rate with rate components for capital cost, operational cost and direct care costs • Additional reimbursement 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					
Nursing Facility Gap Payment Program approved in SFY 2017; no change to rate methodology	No changes	No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	NH rates were increased by 5% for July 2021 through June 30, 2022 with a break in January.
Physician and Other Practitioners — State Plan Amendment 3.1 and 4.19B • 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.					

Reimbursement Methodology and History by Service Area					
SFY 2017	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**
Adjusted conversion factor on 11.01.16 to reflect a 3.3 reduction on all RBRVS codes	No changes	No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%. Chiro-practic services only allowed for children under EPSDT and clients on Medicare. Dietician service no longer have a threshold limit.	No changes
Prescription Drugs State Plan Amendment, Attachment 4.19B, Section 12.a., pages 1-3; Wyoming Medicaid Administrative Rule, Chapter 10, Pharmaceutical Services, Section 16 (Medicaid Allowable Payment) ● Lower of the estimated acquisition cost (EAC) of the ingredients plus the dispensing fee and the provider's usual and customary charge ● The EAC is the Average Wholesale Price (AWP) minus 11% ● The AWP is determined by pricing information supplied by drug manufacturers, distributors and suppliers and is updated monthly. Some drugs are priced by the State Maximum Allowable Cost (SMAC). ● Dispensing fee is $5.00 per claim					
Reimbursement structure changed on April 1, 2017, to be in compliance with the Final Covered Outpatient Drug Rule. New Reimbursement structure is: 1) The National Average Drug Acquisition Cost (NADAC) 2) When no NADAC is available, DHCF will substitute Wholesale Acquisition Cost (WAC) into logic in place of NADAC 3) State Maximum Allowable Cost (SMAC) 4) Federal Upper Limit (FUL) 5) Ingredient Cost Submitted 6) Gross Amount Due (GAD) 7) The 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.	No changes	No changes	No changes	No changes	No changes

Reimbursement Methodology and History by Service Area					
SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Program for All-Inclusive Care of the Elderly (PACE) State Plan Amendment 3.1-A ● 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					
Rate increased	Rate decreased for Medicaid-only; increased for dual-Medicare/Medicaid	Rates increased for Medicaid-only; decreased for dual-Medicare/Medicaid	Rate decreased	Program was discontinued January 2021 due to budget cuts.	N/A
Psychiatric Residential Treatment Facility (PRTF) Wyoming Medicaid Administrative Rule Chapter 26; Chapter 3; Wyoming State Plan Attachment 4.19B ● Per diem rate. The rate includes room and board, treatment services specified in the treatment plan, and may include an add-on rate for medical services.					
No changes	No changes	No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes
Public Health or Welfare State Plan Amendment 3.1-A ● Lower of the Medicaid fee schedule or the provider's usual and customary charge					
Adjusted conversion factor on November 1, 2016, to reflect 3.3% reduction on all RBRVS codes	No changes	No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes
Public Health, Federal Public Health Service Act, Sections 321(a) and 322(b); Public Law 83-568; Indian Health Care Improvement Act ● Indian Health Service (IHS) encounter rate set annually by IHS.					
No changes	No changes	IHS encounter increases every year based on OMB calculations	IHS encounter increases every year based on OMB calculations	IHS encounter increases every year based on OMB calculations	IHS encounter increases every year based on OMB calculations
Rural Health Center 42 CFR 405 Subchapter B; 405.2400-405.2472 Subpart X; 405.2400-405.2417; 405.2430-405.2452; 405.2460-405.2472; Wyoming Medicaid Administrative Rule Chapter 37 ● 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)					

Reimbursement Methodology and History by Service Area					
SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
Rates increased 1.2% based on MEI	Rates increased 1.01% based on MEI	Rates increased 1.015% based on MEI	Rates increased by 1.9% based on MEI	Rates increased by 1.4%	Rate increase by 2.1%

Vision

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

- 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

No changes	No changes	No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes

Waivers (Comprehensive and Supports)

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

- Implemented in SFY 2014 with reimbursement 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.

Reimbursement Methodology and History by Service Area					
SFY 2017	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**
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	In response to the COVID-19 public health emergency, provider rates for some Comprehensive Waiver Services were increased by 12.5%, beginning March 1, 2020. The temporary increase ends September 1, 2020. Services receiving the increase were as follows: Adult Day, Child Habilitation, Community Living, Community Support, Companion, Crisis Intervention, Homemaker, Individual Habilitation Training, Personal Care, Respite, Skilled Nursing, Special Family Habilitation Home. and Supported Employment. Additionally, self-directed budgets were increased by 12.5% for the month of June 2020.	Temporary increase to some services during the COVID PHE ended on September 30th. Rates returned to pre-COVID amounts. Effective February 1, 2021, all rates were decreased by 2.5% as a result of budget reductions.	A rate rebasing study was finalized in September 2021, and new provider reimbursement rates went into effect on February 1, 2022. Providers must apply the entirety of rate increases to direct support worker compensation. These rates are being paid through the enhanced funding made available through ARPA and will sunset on March 31, 2024, unless permanent funding is appropriated by the Wyoming Legislature

Waiver (Community Choices) Waiver Agreement Appendix I.2.a; Appendix K COVID-19 Addendum

- 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 rates are based on the participant's functional assessment. Per diem rate includes required personal care, 24-hour supervision, and medication assistance up to a monthly or yearly cap. Case management services are reimbursed at a separate rate. Participants pay their own room and board.

Reimbursement Methodology and History by Service Area					
SFY 2017	**SFY 2018**	**SFY 2019**	**SFY 2020**	**SFY 2021**	**SFY 2022**
No changes	No changes	No changes	Rates for select direct care services increased in response to COVID-19 public health emergency.	COVID increase continued through SFY2021.	A rate rebasing study was finalized in November 2020, and new provider reimbursement rates went into effect on July 1, 2021. Due to requirements established as part of the American Rescue Plan Act of 2021 (ARPA), case management rates and assisted living facility rates were retroactively adjusted to ensure these rates were not less than the rates that were effective as of April 1, 2021.
Waiver (Children's Mental Health) 42 CFR 438.6; Annual actuarial analysis with review and approval by CMS for each SFY. ● Lower of the Medicaid fee schedule or the provider's usual and customary charge ● Reimbursement based on procedure code fee schedule					
CMS approved the SFY17 rates. An adjustment occurred for DOS service during SFY17 and resulted in the CME contractor returning $2,571,371.49 to Medicaid.	CMS is reviewing SFY18 CME actuarial rate certification for approval. A mass adjustment for SFY18 DOS using the SFY17 approved rate is in process.	No changes	No changes	No changes	No changes
Waiver (Pregnant by Choice) 11-W-00238/8 (Demonstration Project Number). ● Lower of the Medicaid fee schedule or the provider's usual and customary charge ● Reimbursement based on procedure code fee schedule					

Reimbursement Methodology and History by Service Area					
SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
No changes	No changes	No changes	No changes	We completed an extension application for Family Planning Waiver Services that was approved 4/7/2020 to cover FPW services through 12/31/2027. CMS will reimburse by a PMPM amount that varies depending on calendar year. For SFY2021 (July 1, 2021 - June 30, 2022), the rate would be $12.10 (7/1/2021-12/31/2021) and $12.65 (1/1/2022-6/30/2022). Expenses beyond the PMPM would be covered at Wyoming Medicaid's expense. This is outlined in the most current Special Terms and Conditions Document, which has been shared with Fiscal (Chelle).	No changes

APPENDIX C: ELIGIBILITY REQUIREMENTS AND BENEFITS

Table 79. Income Limits by Eligibility Category

Eligibility Category	CY 2022
Children 0-5	154% FPL[70]
Children 6-18	133% FPL
Former Foster Care Children, age 19 to 26	No income test
Family Care Adults	Values in Table 73
Pregnant Women	154% FPL
ABD Waivers and institutions	Less than or equal to 300% SSI
SSI and SSI-Related Coverage Groups	100% SSI
Qualified Medicare Beneficiary	100% FPL
Specified Low-Income Medicare Beneficiary	120% FPL
Qualified Individual	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 80. Monthly Income Standard Values by Family Size

Income Standard	Income Limit	CY 2021				CY 2022			
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%	$1,074	$1,452	$1,830	$2,209	$1,133	$1,526	$1,919	$2,312
	133%	$1,428	$1,931	$2,434	$2,938	$1,507	$2,030	$2,553	$3,076
	154%	$1,653	$2,236	$2,819	$3,401	$1,745	$2,350	$2,956	$3,562
Supplementary Security Income (SSI)	100%	$794	$1,191	--	--	$841	$1,261	--	--
	300%	$2,382	--	--	--	$2,523	--	--	--

70. Federal Poverty Level.

Table 81. 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 18 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 spousal support	
	Former Foster Youth	Full Medicaid Coverage	Under age 26	Client has to have been in DFS (Dept of Family Services) custody and on a Federally Funded Foster Care program at age 18 or older		

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 SSA standards; or disabled by SSA 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 or SSI-related eligibility. Goldberg Kelly, 1619, Window Widowers SDX, and most DAC cases are all determined by SSA.	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 may assist 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 eligible for Medicare Part B); meet the Cancer and Chronic Disease Prevention unit 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 benefits after payment of premium (7.5 percent of gross monthly income)	Between age 16 and 64; disabled; employed	Countable personal 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. Eligibility must be determined monthly.	Meets applicable eligibility requirements under an existing eligibility group		

APPENDIX D: GLOSSARY AND ACRONYMS

GLOSSARY

Table 82. Glossary

Term	Definition
A	
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.
B	
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.
C	
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 a 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.

Term	Definition
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.
D	
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.
E	
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.
F	
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 2022 ends on September 30, 2022).
Federal Medical Assistance Percentage (FMAP)	he 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.
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.

Term	Definition
H	
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.
I	
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.
J	
Joint Commission	An organization that accredits healthcare organizations.
L	
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.
M	
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.

Term	Definition
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.
P	
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.
Q	
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.
R	
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.
S	
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.

Term	Definition
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 2022 ends on June 30, 2022).
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.
T	
Third-Party Liability (TPL)	The legal obligation of a third party to pay part or all of the expenditures for medical assistance under Medicaid.
U	
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 83. Acronyms

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

Acronym	Meaning	Acronym	Meaning
LOC	Level of Care	LTC	Long-Term Care
MAGI	Modified Adjusted Gross Income	MEI	Medicare Economic Index
MFCU	Medicaid Fraud Control Unit	MMIS	Medicaid Management Information System
MU	Meaningful Use	NAMFCU	National Association of Medicaid Fraud Control Units
NPI	National Provider Identifier	OIG	Office of Inspector General
OPPS	Outpatient Prospective Payment System	OSCR	On-Site Compliance Review
P&T	Pharmacy and Therapeutics	PA	Prior Authorization
PAB	Psychiatrist Advisory Board	PACE	Program of All-Inclusive Care for the Elderly
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
QIS	Quality Improvement Strategy	QMB	Qualified Medicare Beneficiaries
QRA	Qualified Rate Adjustment	RBRVS	Resource-Based Relative Value Scale
RHC	Rural Health Clinic	RIBN	Resource Integration into Behavioral Health Networks
SCHIP	State Children's Health Insurance Program	SFY	State Fiscal Year
SLMB	Specified Low-Income Medicare Beneficiaries	SMAC	State Maximum Allowable Cost
SSA	Social Security Administration	SSDC	Sovereign States Drug Consortium
SSI	Supplemental Security Income	TB	Tuberculosis
THR	Total Health Record	TPL	Third-Party Liability
WDH	Wyoming Department of Health	WES	Wyoming Eligibility System

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 include 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 2020 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 77 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 84. Program Codes

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

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

Medicaid Eligibility Category	Program Codes	
Aged, Blind, Disabled Long-Term Care (continued)	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
	S71	SSI Eligible < 21
Children	A02	Family Care Past 5yr Limit <21
	A04	Family Care <21
	A50	AFDC Medicaid (inactive)
	A54	2nd-6mos. Trans Mcaid Child (inactive)
	A56	Alien: 245 (IRCA) Child (inactive)
	A57	Baby <1 Yr, Mother SSI Elig (inactive)
	A59	Retro Medicaid-"Pr" Child (inactive)
	A60	4 Mo Extended Med <21
	A61	Institutional (AF-IV-E) (inactive)
	A62	Retro Medicaid-"Rm" Child (inactive)
	A63	Refugee Child (inactive)
	A64	Alien: 245 (IRCA) Child (inactive)
	A58	Child 6 Through 18 Yrs
	A65	AFDC-Up Unemployed Parent Ch (inactive)
	A67	12 Mo Extended Med <21
	A87	16+ Not In School AF HH (inactive)
	K03	Kidcare to Child Magi
	M02	Adult MAGI <21
	M03	Child MAGI
	M05	Family MAGI <21
	M10	Children's PE
	M12	Family MAGI PE <21

Medicaid Eligibility Category	Program Codes	
Children (continued)	M14	Adult MAGI PE <21
	S62	Continuous SSI Eligible <19
	A55	Child 0 Through 5 Yrs
	S65	Cont Childrens 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
	P07	CHIPRA CME
Medicare Savings Programs	S43	Qual Disabled Working Ind
	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

Medicaid Eligibility Category	Program Codes	
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
	D99	Targeted Case Management on Waitlist
	X01	Beneficiary Monitoring Program
	X02	Incarcerated Medicaid Member
Screenings & Gross Adjustments	N96	Disability Determination Only
	N99	LTC Screening Only
	W98	Single Day Waiver Assessment - Support
	W99	Single Day Waiver Assessment
	S97	CASII Screening Only
	ZZZ	Other

Table 85. Chart B Program Codes

Chart B Eligibility Category	Program Codes	
State-Funded Foster Care	A95	Pending Foster Care
	A96	Basic Foster Care
	A99	Institutional Foster Care

Table 86. CHIP Program Codes

CHIP Eligibility Category	Program Codes	
CHIP	K01	CHIP - A
	K02	CHIP - B
	K04	CHIP - C
	K05	CHIP - A PE
	K06	CHIP - B&C PE

DATA PARAMETERS

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 87. 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
Behavioral 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 Psychologist Social Worker Assistant Behavior Analyst Marriage and Family Therapist Behavior Technician RN LPN Case Worker Community Health Worker; Peer Specialist; Certified Addictions Practitioner Assistant Psychiatrist Mental Health - including Community Mental Health Center Rehabilitation, Substance Use Disorder NP, APN Psychiatric/Mental Health	G9012, T1017, H0004, H0031, H0038, H0046, Hf2101, H2014, HF2017, H2019, S9480, 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90846, 90847, 90849, 90853, 96105, 96106, 96,107, 96108, 96109, 96110, 96111, 96112, 96113, 96114, 96115, 96116, 96117, 96118, 96119, 96120, 96121, 96122, 96123, 96124, 96125, 96126, 96127, 96128, 96129, 96130, 96131, 96132, 96133, 96134, 96135, 96136, 96137, 96138, 96139, 96140, 96141, 96142, 96143, 96144, 96145, 96146, 96101, 96102, 96103, 96104, H2018, T1007, H2021, T1012, H0034, H0005, H2015, H0006, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Behavioral Health services provided by Non-BH providers	EXCLUDE Behavioral Health Provider taxonomies and 261QP0904X: Public Health, Federal		Procedure Codes: G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792, H0001-H2037, 90801-90899, 96101-96125 99201 and 99360 when paired with 90833, 90836, 90838, or 90785 on same claim with same treating provider Claim Types: EXCLUDE W (waiver)
Care Management Entity	251S00000X	CHPR CME	n/a
Clinic/Center (Developmental Centers)	261Q00000X	Clinic/Center	n/a
Dental	122300000X	Dentist	n/a
	1223D0001X	Dental Public Health	
	1223E0200X	Endodontics	
	1223G0001X	General Practice Dentist	
	1223P0221X	Pedodontics	
	1223P0300X	Periodontics	
	1223S0112X	Surgery, Oral and Maxillofacial	
	1223X0400X	Orthodontics	
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	332B00000X	DME	n/a
	332S00000X	Hearing Aid Equipment	
	335E00000X	POS	
Durable Medical Equipment Only	332B00000X	DME	n/a
	332S00000X	Hearing Aid Equipment	
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	Rehabilitation	n/a
	282N00000X	General Acute Care Hospital	
	282NR1301X	General Acute Care Hospital - Rural	
	283Q00000X	Psychiatric Hospital	
	283X00000X	Rehabilitation Hospital	

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
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 (2020 HEDIS) OR Revenue Code: 0450 through 0459 Counts: Claim Type O Expenditures: Header level amounts for all events that have both Medical and Outpatient claim (i.e. no associated inpatient admission)
International Care Facility for Individuals with Intellectual Disabilities	315P00000X	Intermediate Care Facility, Intellectual Disability	n/a
Laboratory	291U00000X	Clinical Medical Laboratory	n/a
Nursing Facility	275N00000X 314000000X	Medicare Defined Swing Bed Skilled Nursing Facility	n/a
Program for All-Inclusive Care of Elderly (PACE)	251T00000X	PACE Organization	n/a

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Physician and Other Practitioner Total	All Taxonomies starting with '20'		n/a
	363A00000X	Physician Assistant	
	225X00000X	Occupational Therapist	
	225100000X	Physical Therapist	
	213E00000X	Podiatrist	
	363L00000X	Nurse Practitioner	
	363LA2200X		
	363LF0000X		
	363LG0600X		
	363LX0001X		
	363LP0200X		
	367A00000X	Nurse Midwife	
	367500000X	Nurse Anesthetist	
	231H00000X	Audiologist	
	235Z00000X	Speech-Language Pathologist	
Physician	All Taxonomies starting with '20' EXCLUDING 2084P0800X	Psychiatrists	n/a
	363A00000X	Physician Assistant	
Other Practitioner	225X00000X	Occupational Therapist	n/a
	225100000X	Physical Therapist	
	213E00000X	Podiatrist	
	363L00000X	Nurse Practitioner	
	363LA2200X		
	363LF0000X		
	363LG0600X		
	363LX0001X		
	363LP0200X		
	367A00000X	Nurse Midwife	
	367500000X	Nurse Anesthetist	
	231H00000X	Audiologist	
	235Z00000X	Speech-Language Pathologist	
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

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Public Health or Welfare	251K00000X	Public Health or Welfare	n/a
Rural Health Clinic	261QR1300X	Rural Health Clinic	n/a
Vision	152W00000X 156FX1800X	Optometrist Optician	n/a
Waiver - HCBS Waivers - Waiver Only Services	251B00000X 251C00000X 251X00000X	Case Management Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S64, S93, S94, N98, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21, W22, W23, W24, W25, W26
Waiver - HCBS Waivers - Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X, 251C00000X, 251X00000X Recipient Program Codes: B01, B02, S60, R01, R02, R03, R04, S65, S95, S96, S22, S23, S44, S45, S59, S58, S64, S93, S94, N98, S24, S25, S46, S47, W03, W04, W08, W09, W10, W14, W15, W16, W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21, W22, W23, W24, W25, W26
Waiver - Acquired Brain Injury Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: B01, B02, S60
Waiver - Acquired Brain Injury Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: B01, B02, S60
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

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
Waiver - Adult with ID/DD Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: S22, S23, S44, S45, S59
Waiver - Child with ID/DD Waiver Only	251C00000X 251X00000X	Day Training, DD PACE PPL	Claim Type: W, G Recipient Program Codes: S58, S93, S94, S64
Waiver - Child with ID/DD Non-Waiver Services	All Taxonomies		EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X Recipient Program Codes: S58, S93, S94, S64
Waiver - Children's Mental Health Waiver Only	251B00000X	Case Management	Claim Type: W, G Recipient Program Codes: S95, S96, S65
Waiver - Children's Mental Health Non-Waiver Services	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 Non-Waiver Services	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

Service Area (Continued)	Pay-to-Provider Taxonomy		Other Parameters
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 Non-Waiver Services	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 88. Data Parameters for Subprogram and Special Populations

Subprogram / Special Population	Parameters
Crossover Claims	Claim Type: B, V, X
Foster Care - Medicaid	Recipient Program Codes: A51, A52, A85, A86, A88, A97, A98, S63
Foster Care - State Funded	Recipient Program Codes: A99


GREAT SEAL OF THE STATE OF WYOMING
EQUAL RIGHTS
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MINES
GRAIN
OIL
1869
1890