SFY 2024

WYOMING MEDICAID

Annual Report

Wyoming Department of Health

MARK GORDON *Governor*
STEFAN JOHANSSON *Director*
LEE GROSSMAN *State Medicaid Agent*


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Stefan Johansson
Director

Mark Gordon
Governor

February 5, 2025

Dear Medicaid Providers, Members, Stakeholders, and Wyoming Residents:

I am proud to present to you the latest edition of the Wyoming Medicaid Annual Report for State Fiscal Year 2024 (SFY 2024) that covers expenditures and enrollment occurring July 1, 2023 to June 30, 2024. SFY 2024 was a pivotal year for Wyoming Medicaid. Our agency was focused on transitioning back to business as usual from the COVID-19 pandemic while implementing several key legislative directives.

With the expiration of the federal public health emergency declared in response to the COVID-19 pandemic, Wyoming Medicaid focused on resuming eligibility renewals for all Medicaid members beginning in March 2023 for the first time in approximately three years. This has been a historically large task for our Client Services team and a host of our agency's partners. Together, we have been laser focused on our common goal of ensuring Wyoming Medicaid continues to serve Wyomingites who remain eligible. This undertaking was completed in April 2024 after our agency completed eligibility renewals for nearly 70,000 Wyomingites.

Additional Medicaid highlights:

- Extending postpartum coverage for pregnant women from 60 days to 12 months, effective July 1, 2023
- Increasing reimbursement rates for nursing facilities by $22 million, effective July 1, 2023
- Adding podiatry as a covered benefit available to all Wyoming Medicaid members, effective July 1, 2023
- Multiple reimbursement rate increases for providers of home and community based services for Medicaid members with intellectual and developmental disabilities, totaling $18.9 million
- $15 million in increased funding to decrease waitlists for home and community based services for Medicaid members with intellectual and developmental disabilities, effective July 1, 2023

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,
State Medicaid Agent

TABLE OF CONTENTS

SFY 2024 MEDICAID AT A GLANCE

EXPENDITURES

$684,759,086

paid to **3,464** providers with over **25,265** providers actively enrolled at any point during SFY 2024

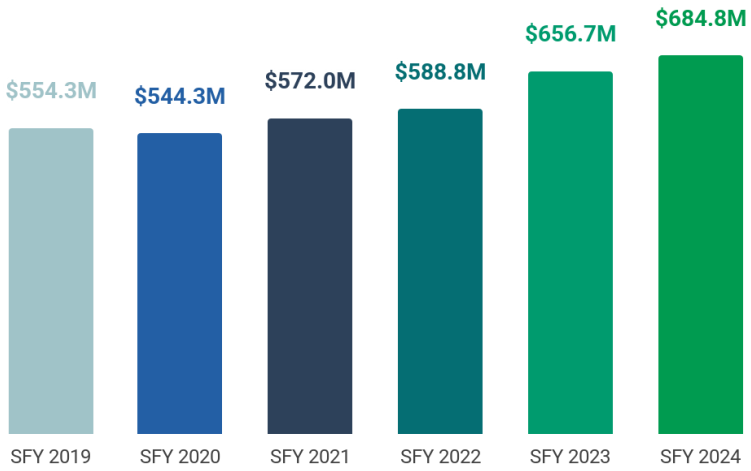


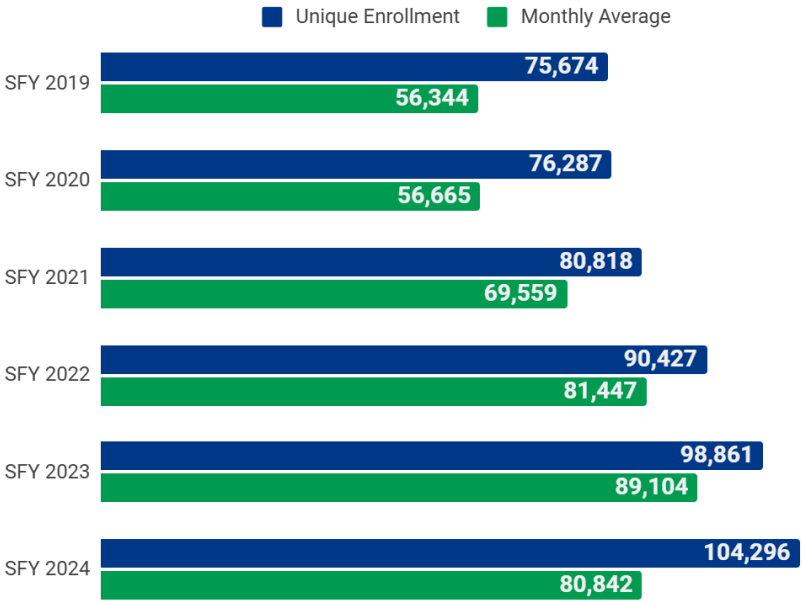
Figure 1. Medicaid Expenditure History

17.9%
Wyoming residents enrolled in Medicaid

Months of average enrollment per member:
10.7

50%
of Members reside in Laramie, Natrona, Fremont, and Campbell counties

% of members that are children under age 21:
61.2%



ENROLLMENT

104,296

Medicaid members enrolled at any point during the SFY with **80,842** enrolled each month on average

Figure 2. Medicaid Enrollment History: Monthly Average and Unique Enrollment

80% had a physician claim paid

56% had a prescription drug claim paid

55% had an outpatient hospital claim paid

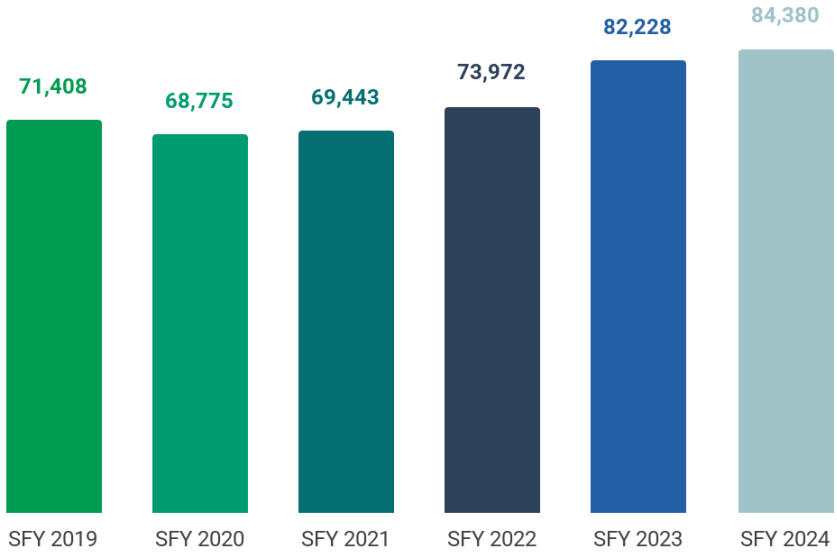


Figure 3. Medicaid Recipient History

PMPM

$700

preliminary estimate for SFY 2024

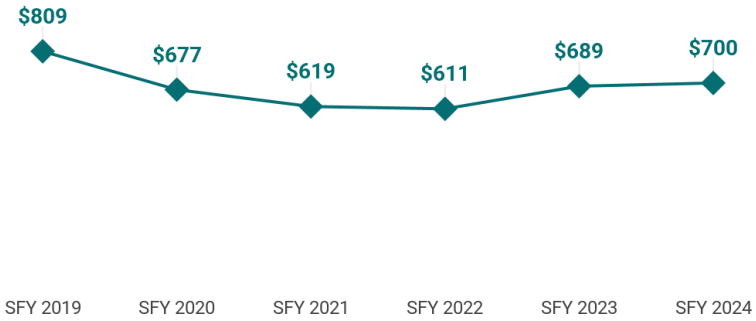


Figure 4. Medicaid PMPM History

RECIPIENTS

84,358

Medicaid members enrolled with paid claims during SFY 2024

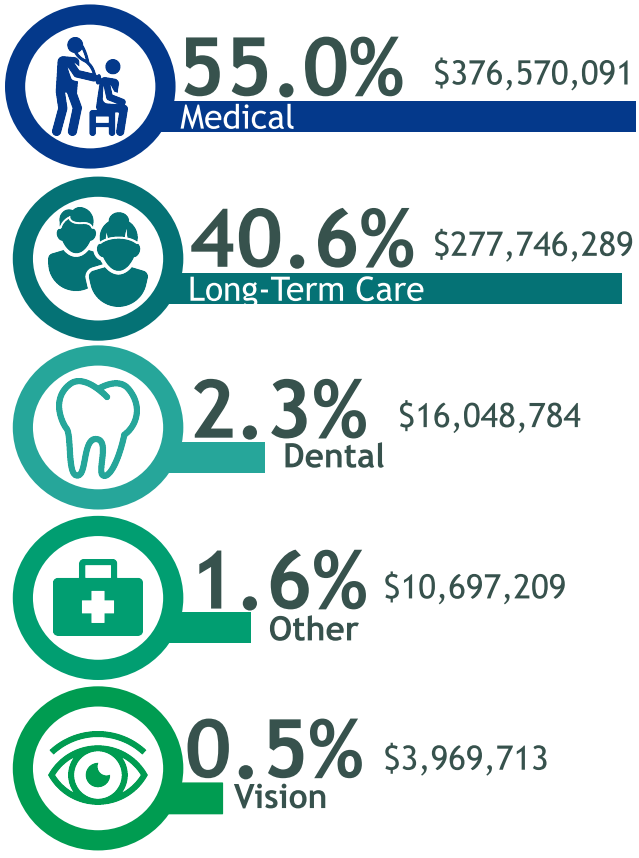


Figure 5. Percent of Total Expenditures by Type

WY MEDICAID 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 health status, age, 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.

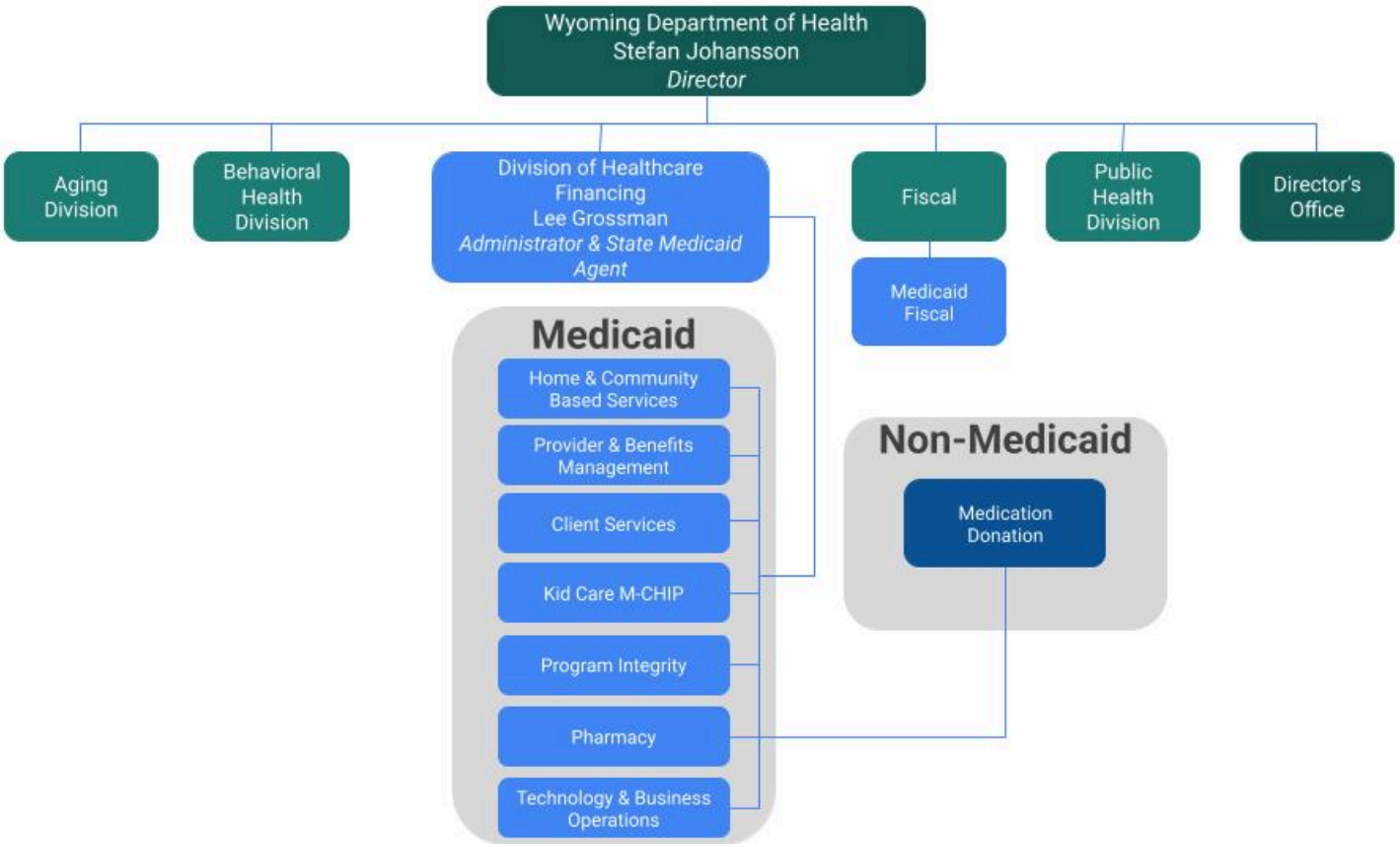


Figure 6. Wyoming Department of Health Organization Chart

FINANCIALS & FUNDING

Enrolled providers have one year from date of service to submit claims for reimbursement. Claims are processed through the Medicaid Management Information System (MMIS), which includes a pharmacy claims point of sale processing system and a separate system for all other claim types. This Annual Report focuses on the members enrolled during SFY 2024 and claims paid during SFY 2024, regardless of when service was rendered.

Table 1. Division of Healthcare Financing Expenditures for SFY 2024

Medicaid Expenditures (in Millions)	
Annual Report Benefit Expenditures (this report)	$684.8
Medicaid Administration	$55.4
Nursing Facilities Supplemental Payments	$33.4
Hospital Supplemental Payments	$82.9
Medicare Buy-In	$26.6
Medicare Clawback (Part D)	$19.2
Medicaid One-Time Capital Expenses for New Technology Systems (Medicaid Modules, HIE, Other)	$11.2
Other	-$5.6
Subtotal Medicaid Expenditures	$907.9
Drug Rebates	-$45.3
Total Medicaid Expenditures	$862.6
Non-Medicaid Expenditures (in Millions)	
State Only Foster Care & General Fund Foster Care (Court Orders)	$1.3
Supplemental Security Income Payments	$0.8
State Only Other	$0.6
Total Non-Medicaid Expenditures	$2.7
Total Division of Healthcare Financing Expenditures	$865.3

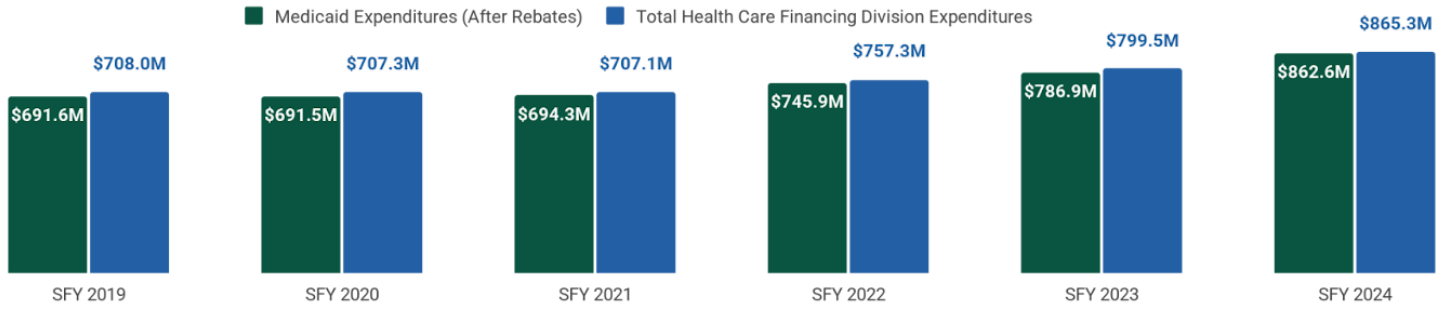
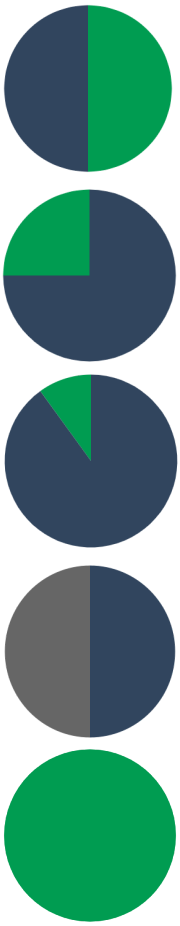


Figure 7. Health Care Financing Expenditure History

WYOMING MEDICAID FUNDING



Wyoming Medicaid Benefits & general administrative expenditures
(50% Federal, 50% State)

Medicaid Personnel & Technology related operating expenditures
(75% Federal, 25% State)

Capital Investment expenditures
(90% Federal, 10% State)

Hospital QRA Payments & Nursing Facility Tax
(50% Federal, 50% Provider)

State-only funded programs
(100% State)

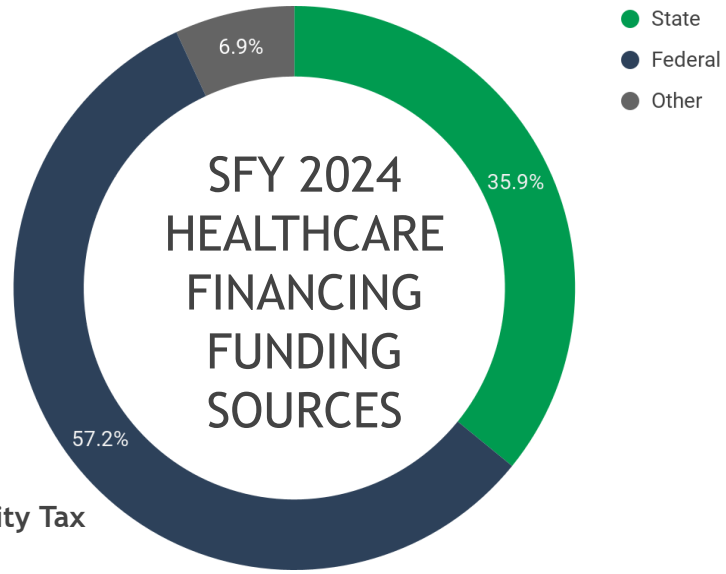


Figure 8. SFY 2024 DHCF Funding Sources

Figure 9. Medicaid Funding Breakdown

Figure 10. Division of Healthcare Financing Funding History (in millions)

ADVISORY GROUPS

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

Table 2. Wyoming Medicaid Advisory Groups and Committees

Advisory Group	Members	Description
Dental Advisory Group (DAG)	Two specialists, three general dentists, and representatives from Medicaid and its fiscal agent, Acentra.	Represents a wide range of interests, experience, dental specialties and various areas of the state, while advising Medicaid regarding administration of the dental program.
Developmental Disability Advisory Council (DDAC)	Self advocates, legally authorized representatives, providers, case managers, Wyoming Provider Association representation, members from the Governor's Council on DD, Department of Education, Department of Vocational Rehabilitation, WIND, Department of Family Services, Protection and Advocacy	The DDAC advises the Department on rules, policies and procedures related to waiver programs and the statewide service delivery system for people with developmental disabilities and acquired brain injuries.
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 Community Choices waiver case manager, and an Independent Living Center representative	Focuses on issues and recommendations with institutional and community-based long-term care providers.
Medical Advisory Group (MAG)	Wyoming Hospital Association, Wyoming Medical Society, executives from hospitals throughout Wyoming, physicians, and medical practitioners.	Focuses on new and upcoming issues within the healthcare industry, member concerns, and relevant presentations. Works to develop solutions to issues.
Pharmacy & Therapeutics Committee (P&T)	Six physicians, five pharmacists, one allied health professional.	Provides recommendations regarding prospective drug utilization review, retrospective drug utilization review and education activities to Medicaid.
Tribal Leadership Advisory Group	Tribal Business Council members, leadership and executives from tribal health clinics and Indian Health Services, long-term care providers, and representatives from all Wyoming Department of Health divisions	Focuses on new and upcoming issues within the healthcare industry, consultation with the Tribal leaders, updates from facilities, and work to develop solutions and programs to decrease barriers for this group.

PROGRAM INTEGRITY & THIRD-PARTY LIABILITY

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. Funds are recovered from third-party liability, estates, drugs, and credit balances. This unit also performs client fraud investigations.

WY DEMOGRAPHICS & ECONOMY[1]

17.9%
of Wyoming residents enrolled in Medicaid (5.5% increase over SFY 2023)

27.5%
of Wyoming residents under the age of 18

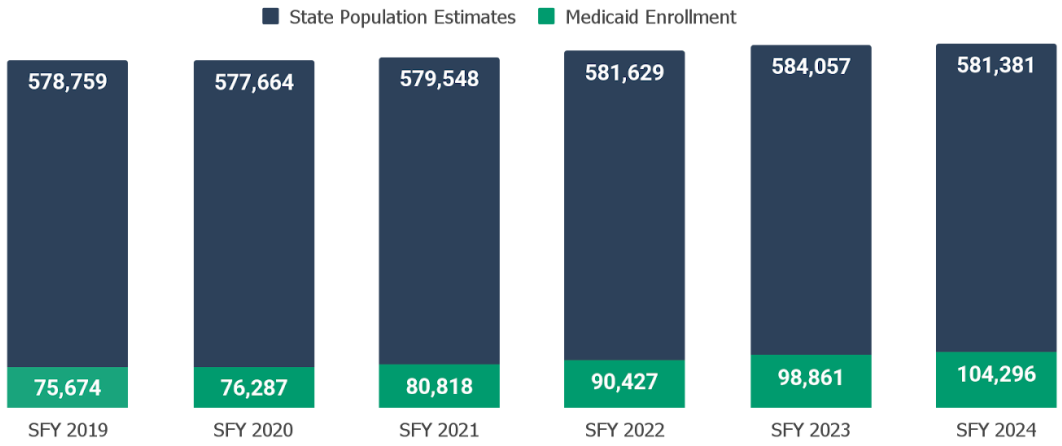


Figure 11. Medicaid Enrollment and State Population[2] History

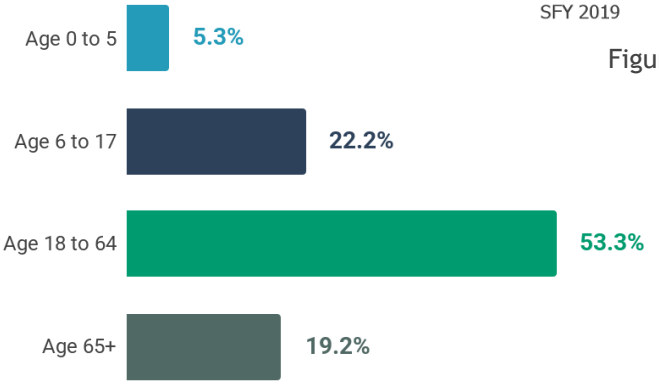


Figure 12. SFY 2024 State Population Age Percentages

37.8%
Medicaid Enrollment Increase (from 2019 to 2024)

0.5%
Increase in State Population (from SFY 2019 to SFY 2024)

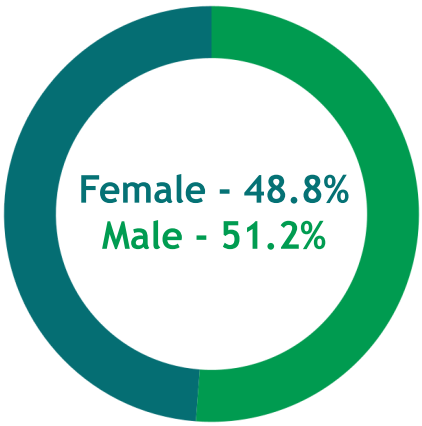


Figure 13. SFY 2024 State Population Gender Percentages

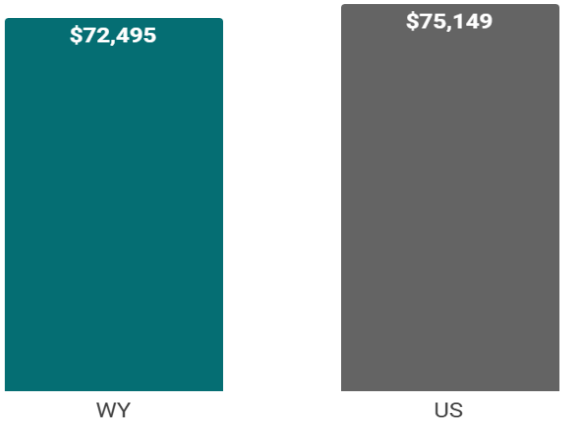


Figure 14. WY vs. US Median Income

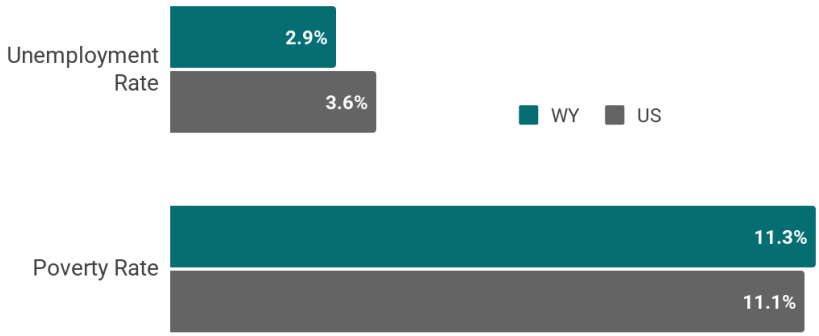


Figure 15. WY vs. US Unemployment and Poverty Rates

[1] US Census Bureau: https://doe.state.wy.us/lmi/news.htm, https://www.census.gov/quickfacts/fact/table/WY,US#
[2] 2024 forecasted population information prepared by the Wyoming Department of Administration & Information, Economic Analysis Division

HIGHLIGHTS & INITIATIVES

POLICY

- As of July 2023, Wyoming Medicaid has added coverage of Cologuard, At Home Colon Cancer Screening Test for Adults aged 45 plus, CPT code: 81528. Wyoming Medicaid has opted to backdate the effective date of this code to October 1, 2022.
- As of January 1, 2024, Wyoming Medicaid extended dental coverage with an increased age limit of professional fluoride application from age fourteen to age twenty, as recommended by the American Dental Association (ADA).
- As of January 1, 2024, Wyoming Medicaid has extended coverage of Transitional Care Management Codes to facilitate prompt follow-up with a primary care provider after a hospital admission to reassess a patient's condition and treatment plan. Follow-up visits under CPT codes 99495 and 99496 are covered under this policy change and may be provided via Telehealth.

PROGRAM

- As of April 1, 2024, provider manual and educational material updated to better communicate availability of postpartum services and to encourage more medically appropriate postpartum visits. Covered postpartum visit limits have been removed and additional coverage has been extended to cover a prenatal visit with a pediatrician.

TECHNOLOGY

- As of December 18, 2023, the Electronic Visit Verification (EVV) system went live for Home Health Services. EVV is required for all Home Health Services with a service date on or after January 1, 2024.
- Interoperability for Wyoming Medicaid went live on December 18, 2023 with patient access, provider network, and other Fast Healthcare Interoperability Resources (FHIR) API infrastructure for future possibilities. Efforts are ongoing to recruit applications to connect with Wyoming Medicaid's infrastructure.

WYOMING INTEGRATED GENERATION SYSTEM (WINGS)

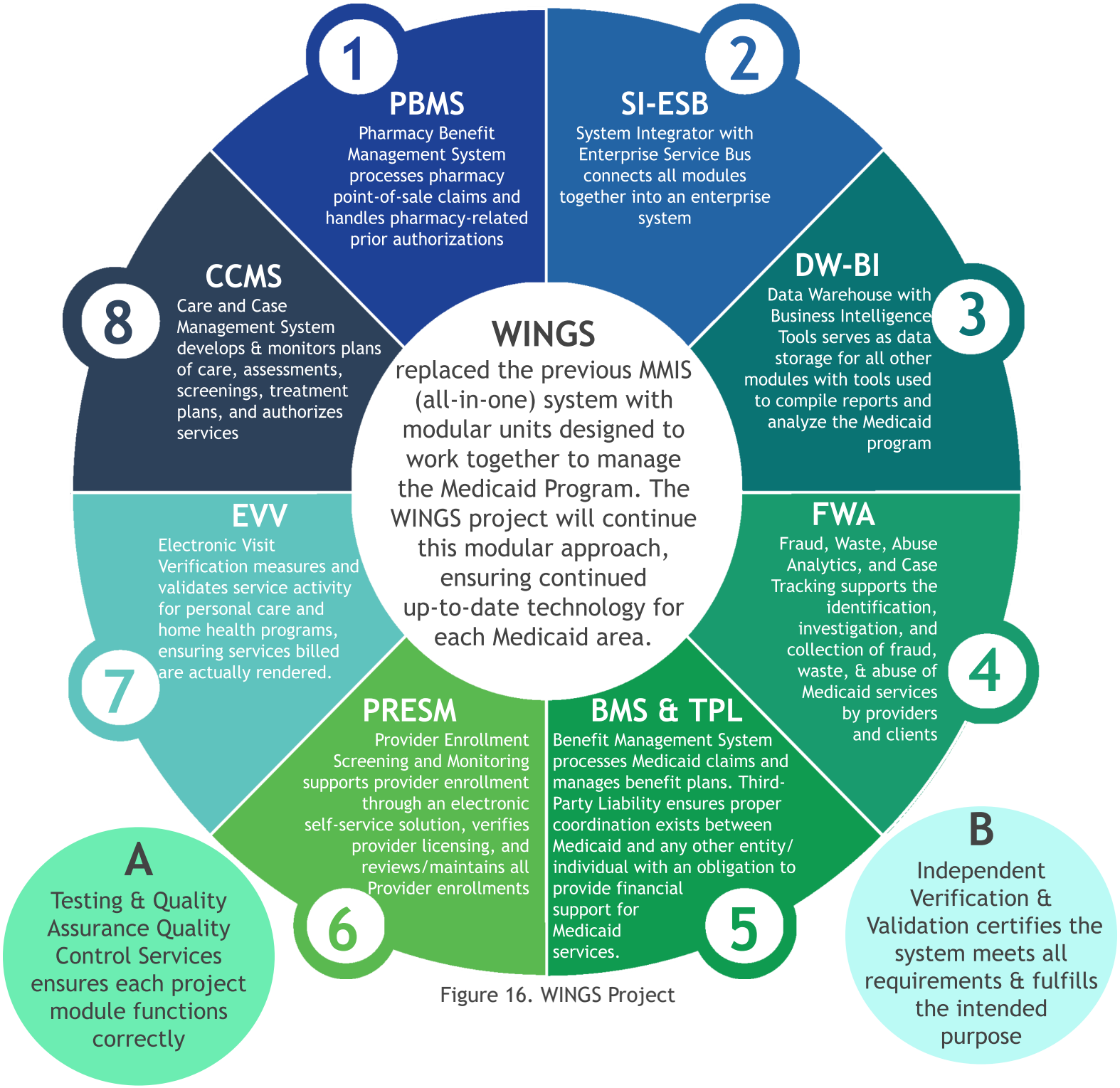


Figure 16. WINGS Project

ELIGIBILITY CATEGORIES

For this report, Medicaid enrolled members are presented in 13 eligibility categories. Per Code of Federal Regulations, individuals qualify for Medicaid coverage based on Federal Poverty Level guidelines, Supplemental Security Income standards, or the 1996 Family Care income standard. This report does not constitute billing or coverage advice for members or providers. For comprehensive program information, please refer to the Provider Manual[3] and the Member Handbook.[4]

• Employed Individuals with Disabilities (EID) • Individuals with Intellectual/ Developmental Disabilities or Acquired Brain Injury (ID/DD/ABI)	• Institution • Long-Term Care (LTC) • Supplemental Security Income (SSI) • Adults • Children	• Medicare Savings • Non-Citizens with Medical Emergencies • Pregnant Women • Screenings • Special Groups • State-Only Developmental Disability Program

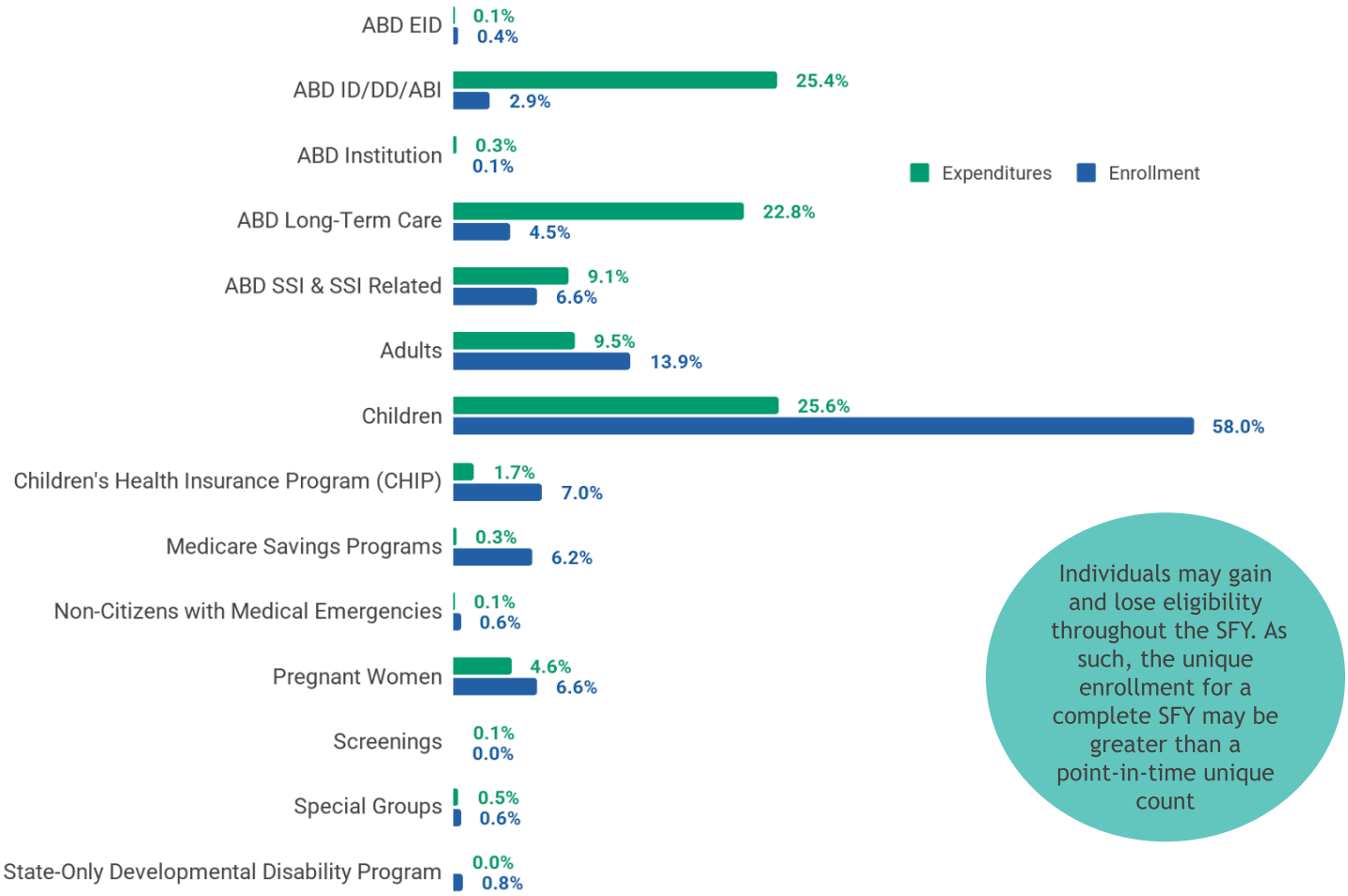


Figure 17. Enrolled members versus Expenditures by Eligibility Category

[3] Provider Manual: https://www.wyomingmedicaid.com/portal/Provider-Manuals-and-Bulletins
[4] Member Handbook: https://www.wyomingmedicaid.com/portal/Medicaid_Handbook

Table 3. Eligibility Category Summary

Eligibility Category	2024 Enrolled Members	% Change from SFY 2023	SFY 2024 Unique Recipients[5]	% Change from SFY 2023	SFY 2024 Expenditures	% Change from SFY 2023
ABD EID	422	15.9	413	15.4	$826,565	-28.5
ABD ID/DD/ABI	3,034	12.4	3,078	12.5	$173,805,589	6.6
ABD Institution	59	11.3	69	21.1	$2,079,554	-11.8
ABD Long-Term Care	4,668	0.9	5,572	5.1	$156,185,361	12.6
ABD SSI & SSI Related	6,906	-1.6	6,435	1.4	$62,092,349	-4.0
Adults	14,530	13.3	11,454	10.1	$65,364,828	-6.9
Children	60,519	6.9	48,672	2.7	$174,963,147	1.5
Children's Health Insurance Program (CHIP)	7,304	67.4	5,197	45.3	$11,500,200	15.6
Medicare Savings Programs	6,488	14.3	3,345	9.3	$1,860,701	-17.2
Non-Citizens with Medical Emergencies	632	35.0	230	-1.7	$978,974	24.3
Pregnant Women	6,892	23.6	5,972	16.8	$31,323,517	15.0
Screenings	2	100.0	698	-27.8	$613,079	-21.6
Special Groups	637	15.6	129	4.0	$3,114,167	-0.1
State-Only Developmental Disability Program	832	23.8	184	17.9	$51,056	15.3
Total	**104,296**	**5.5**	**84,358**	**2.6**	**$684,759,086**	**4.3**

Table 4. Enrollment History by Eligibility Category

Eligibility Category	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
ABD EID	331	330	328	338	364	422	27.5
ABD ID/DD/ABI	2,393	2,509	2,556	2,639	2,699	3,034	26.8
ABD Institution	35	44	39	45	53	59	68.6
ABD Long-Term Care	4,804	4,812	4,774	4,704	4,627	4,668	-2.8
ABD SSI & SSI Related	6,542	6,532	6,478	6,838	7,015	6,906	5.6
Adults	9,699	9,490	10,037	11,503	12,825	14,530	49.8
Children	42,185	41,844	44,665	50,895	56,638	60,519	43.5
Children's Health Insurance Program (CHIP)	3,027	3,809	3,932	4,095	4,362	7,304	141.3
Medicare Savings Programs	4,728	4,831	4,974	5,419	5,675	6,488	37.2
Non-Citizens with Medical Emergencies	171	156	189	319	468	632	269.6
Pregnant Women	3,763	3,230	3,508	4,618	5,577	6,892	83.2
Screenings	--	--	--	--	1	2	--
Special Groups	205	274	404	488	551	637	210.7
State-Only Developmental Disability Program	336	397	377	455	672	832	147.6
Total	**75,674**	**76,287**	**80,818**	**90,427**	**98,861**	**104,296**	**37.8**

[5] 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.

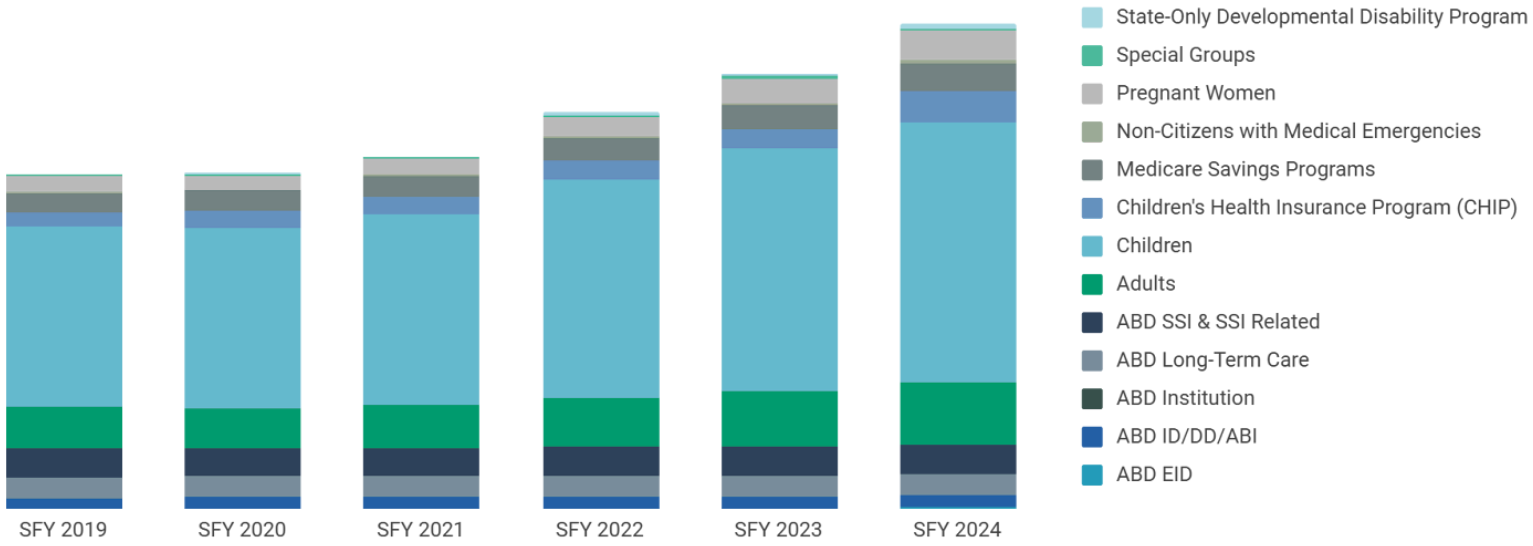


Figure 18. Enrollment History by Eligibility Category

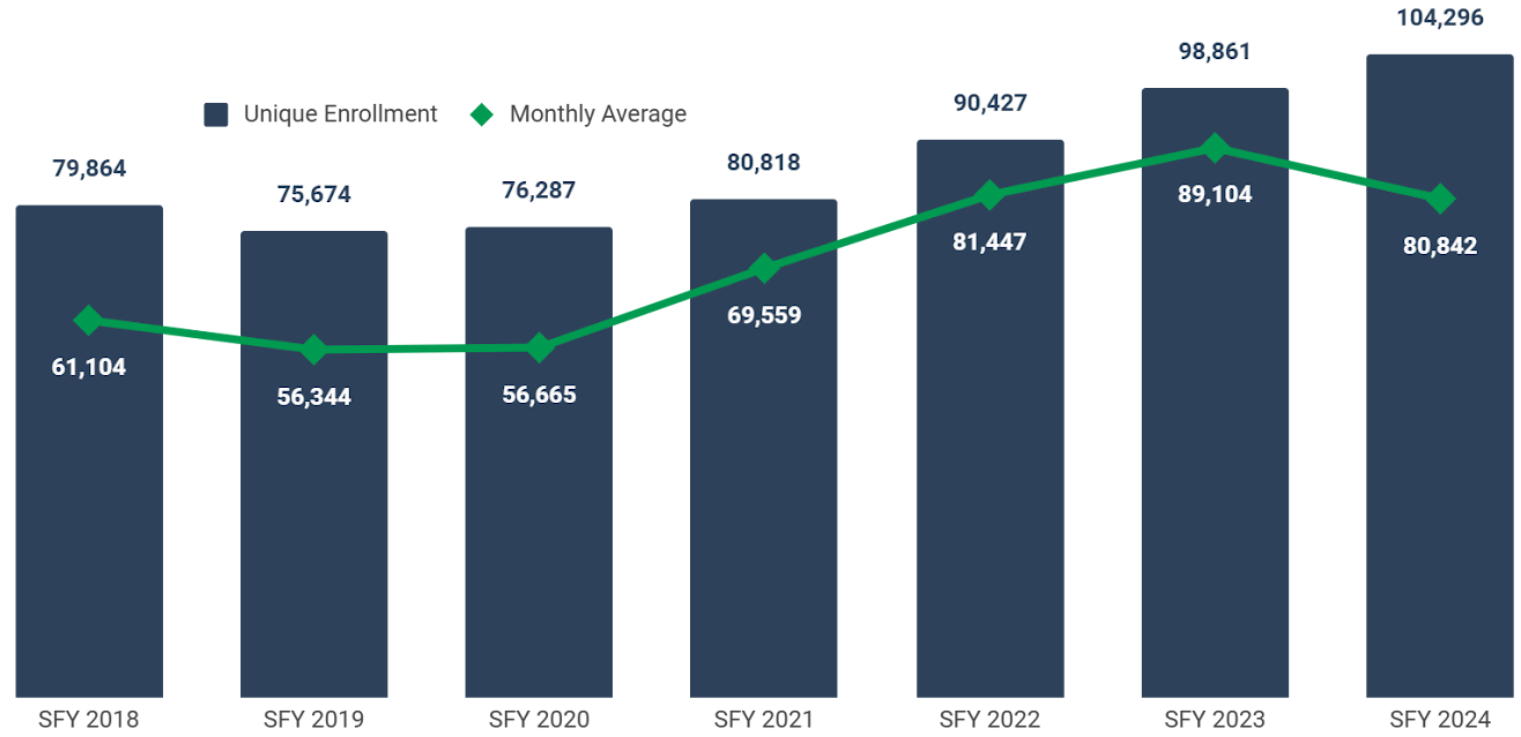


Figure 19. Medicaid Unique Enrollment and Monthly Average by SFY

Table 5. Change in Medicaid Enrollment

	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Unique Enrollment	75,674	76,287	80,818	90,427	98,861	104,296
% Change from Previous SFY	-5.2	0.8	5.9	11.9	9.3	5.5
Monthly Average Enrollment	56,344	56,665	69,559	81,447	89,104	80,842
% Change from Previous SFY	-7.8	0.6	22.8	17.1	9.4	-9.3
Average Length in Enrollment (months)	11.5	11.7	9.7	9.2	9.2	10.7

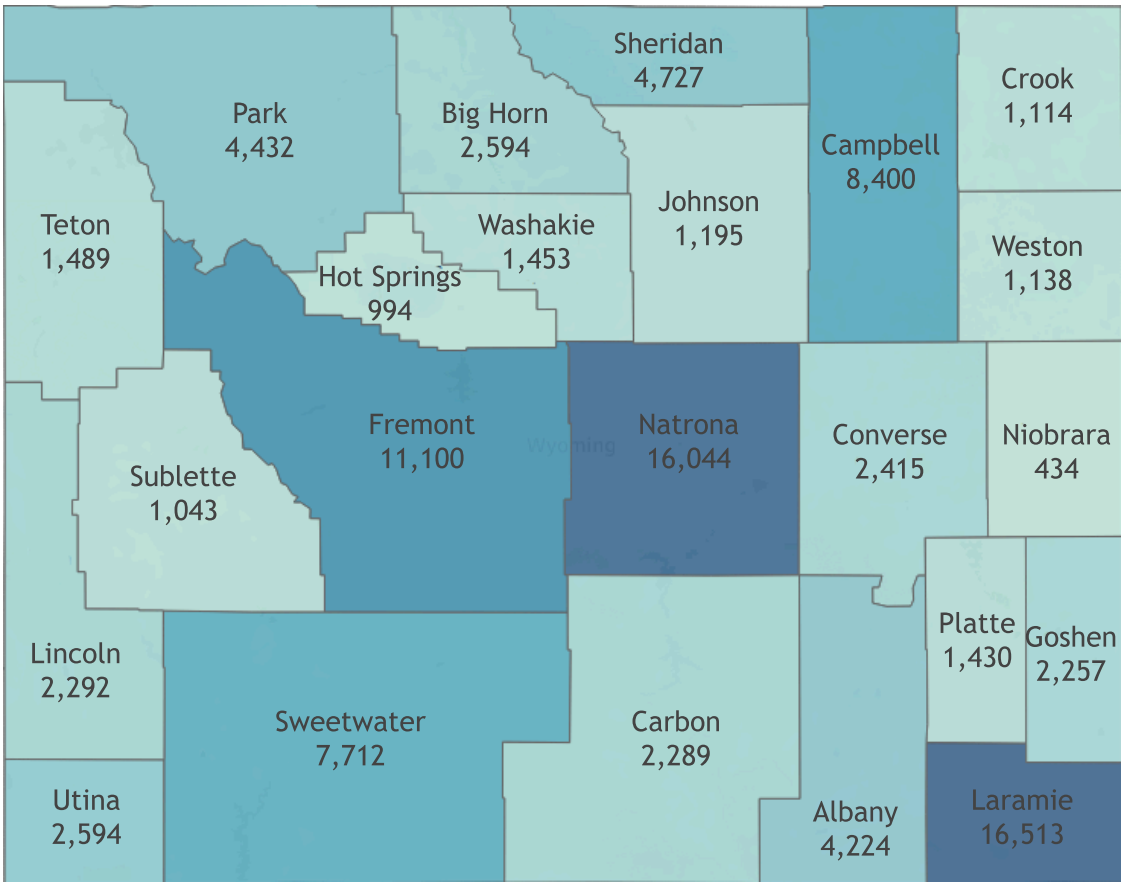


Figure 20. Medicaid Enrollment by County

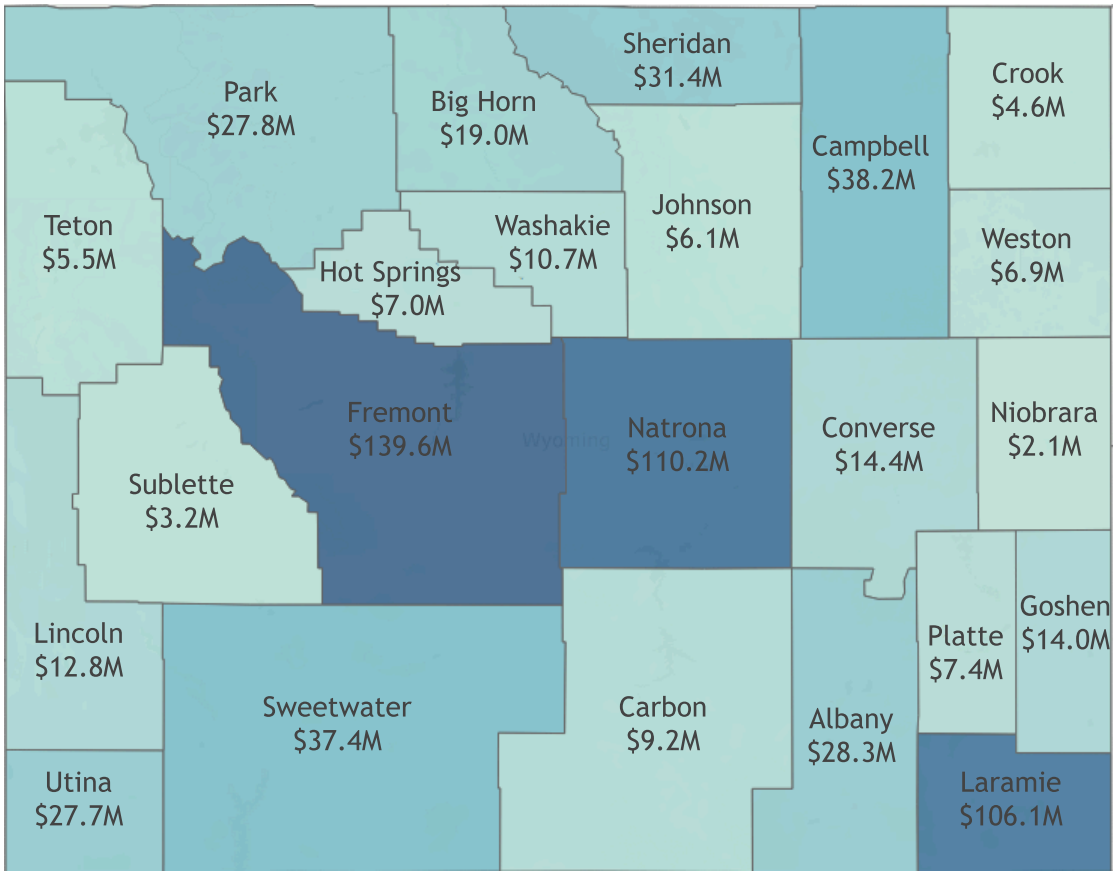


Figure 21. Medicaid Expenditures by County

EXPENDITURES

Table 6. Expenditure History by Eligibility Category

Eligibility Category	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
ABD EID	$2,201,872	$1,756,635	$3,168,949	($261,818)[6]	$1,155,239	$826,565	-62.5
ABD ID/DD/ABI	$148,210,163	$152,541,587	$155,360,814	$150,075,613	$163,097,648	$173,805,589	17.3
ABD Institution	$1,638,641	$1,239,234	$4,139,118	$1,342,101	$2,358,667	$2,079,554	26.9
ABD Long-Term Care	$136,564,759	$144,976,414	$134,892,349	$127,016,422	$138,732,339	$156,185,361	14.4
ABD SSI & SSI Related	$55,018,028	$54,412,195	$56,186,651	$62,657,716	$64,664,701	$62,092,349	12.9
Adults	$42,819,380	$37,137,296	$52,267,090	$58,987,335	$70,185,525	$65,364,828	52.7
Children	$134,481,804	$124,888,851	$134,266,458	$150,272,444	$172,332,818	$174,963,147	30.1
Children's Health Insurance Program (CHIP)	--	--	$5,045,497	$8,345,854	$9,946,248	$11,500,200	--
Gross Adjustments	$5,980,134	$680,047	($758,113)	$736,623	--	--	--
Medicare Savings Programs	$1,687,004	$1,743,633	$1,831,726	$1,894,439	$2,248,566	$1,860,701	10.3
Non-Citizens with Medical Emergencies	$913,315	$586,871	$657,593	$781,986	$787,663	$978,974	7.2
Pregnant Women	$22,579,721	$21,725,470	$22,087,873	$24,065,741	$27,244,487	$31,323,517	38.7
Screenings	$506,557	$762,114	$524,863	$485,026	$782,407	$613,079	21.0
Special Groups	$1,623,461	$1,826,629	$2,263,994	$2,391,243	$3,118,346	$3,114,167	91.8
State-Only Developmental Disability Program	$58,933	$53,333	$38,880	$37,043	$44,292	$51,056	-13.4
Total	**$554,283,771**	**$544,330,310**	**$571,973,741**	**$588,827,770**	**$656,698,947**	**$684,759,086**	**23.5**

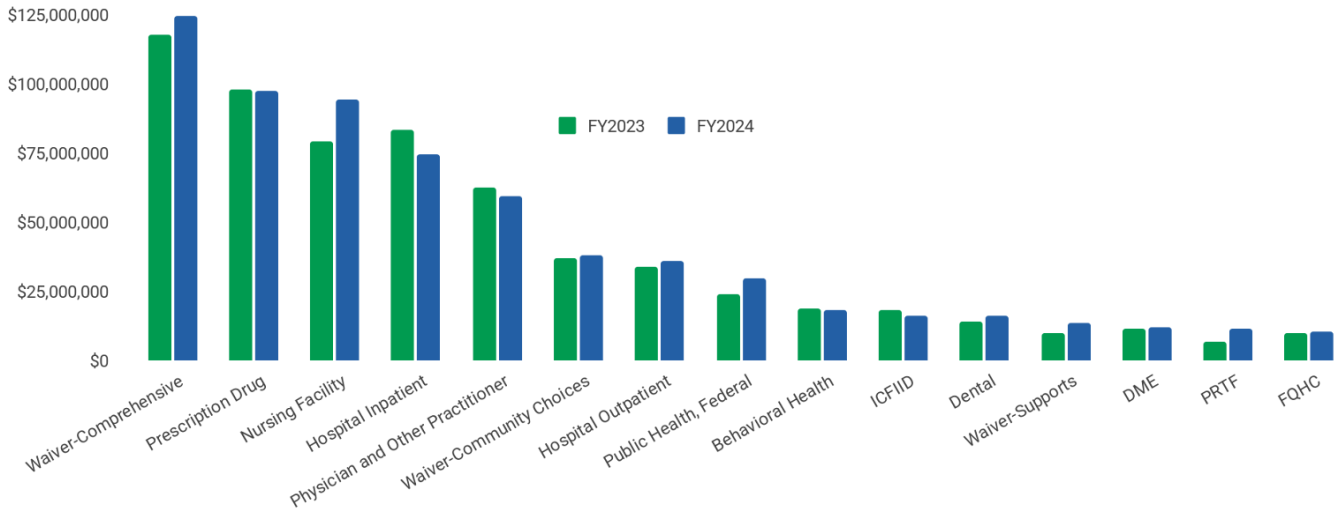


Figure 22. Comparison of Top Medicaid Services' Expenditures for SFY 2023 and SFY 2024

[6] 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.

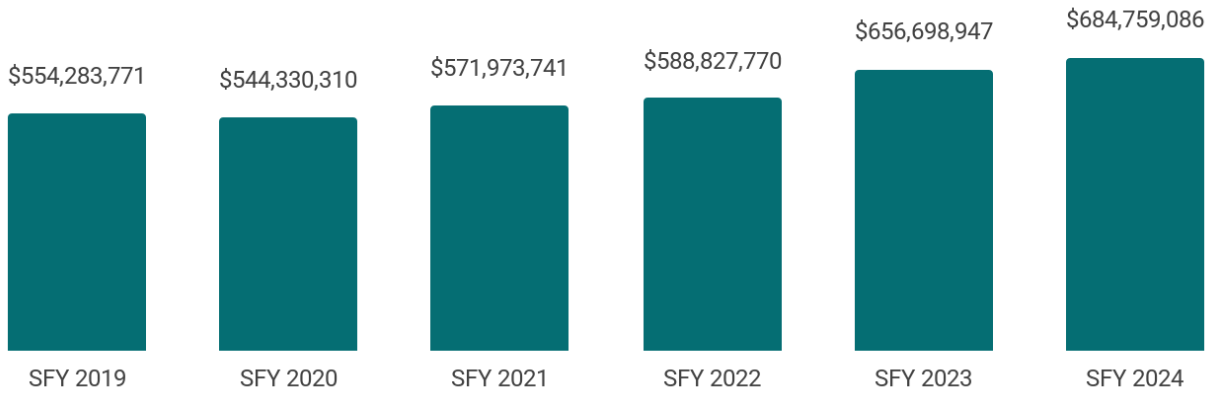


Figure 23. Medicaid Expenditures Benefit History

Table 7. Medicaid Expenditure History by Service Type

Service Area	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Medical	$288,794,695	$270,442,977	$300,907,243	$331,331,202	$374,617,609	$376,570,091	30.4
Long-Term Care	$249,685,762	$260,153,810	$254,095,272	$240,540,358	$258,470,161	$277,746,289	11.2
Dental	$11,304,079	$9,893,628	$12,498,782	$12,800,061	$14,279,555	$16,048,784	42.0
Other	$1,033,166	$862,825	$745,684	$516,719	$5,450,249	$10,697,209	935.4
Vision	$3,466,069	$2,977,070	$3,726,760	$3,639,429	$3,881,375	$3,696,713	6.7

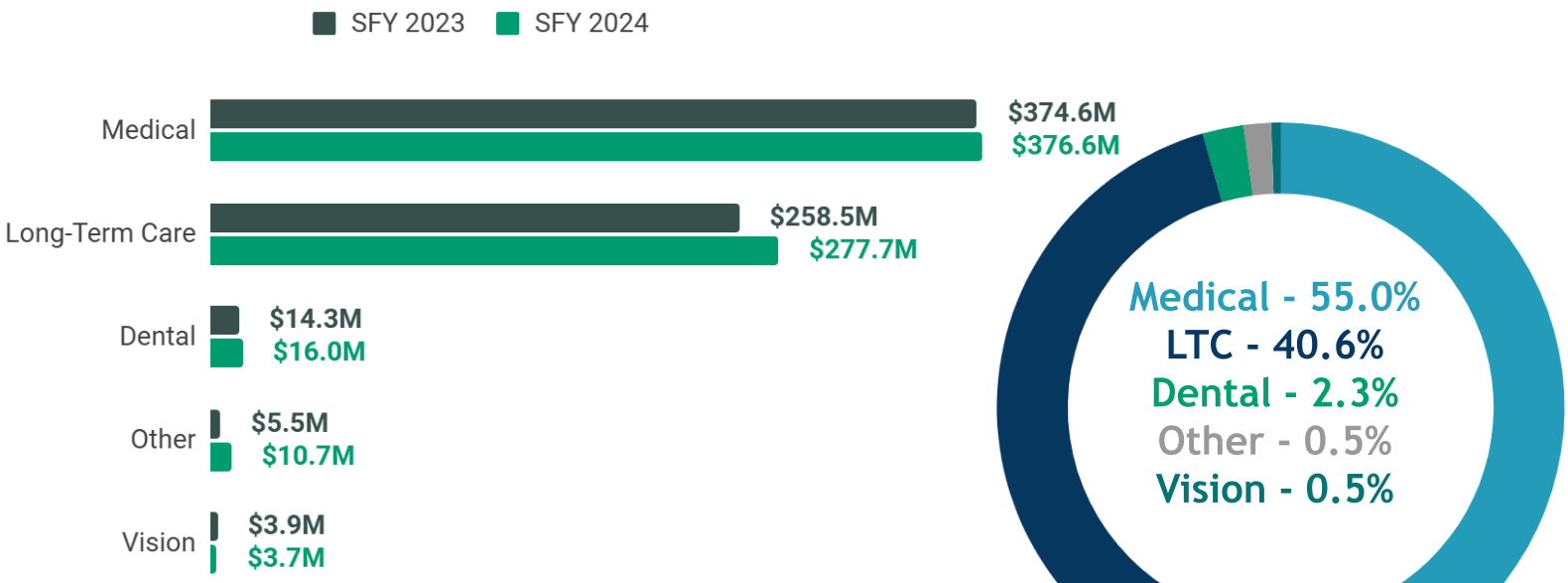


Figure 24. Comparison of Expenditures by Service Type for SFY 2023 and SFY 2024

Figure 25. SFY 2024 Expenditures by Service Type

RECIPIENTS

Table 8. Unique Recipient History by Eligibility Category[7]

Eligibility Category	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
ABD EID	401	382	320	318	358	413	3.0
ABD ID/DD/ABI	2,584	2,655	2,633	2,659	2,736	3,078	19.1
ABD Institution	68	76	71	57	57	69	1.5
ABD Long-Term Care	5,416	5,830	5,160	4,977	5,300	5,572	2.9
ABD SSI & SSI Related	6,203	6,087	5,828	5,949	6,348	6,435	3.7
Adults	8,706	8,098	8,308	9,083	10,406	11,454	31.6
Children	41,770	39,420	39,256	42,216	47,415	48,672	16.5
Children's Health Insurance Program (CHIP)	--	--	2,939	3,394	3,576	5,197	--
Gross Adjustments	373	277	93	44	--	--	--
Medicare Savings Programs	2,820	2,938	2,717	2,687	3,061	3,345	18.6
Non-Citizens with Medical Emergencies	145	140	124	154	234	230	58.6
Pregnant Women	4,386	4,336	3,753	4,264	5,111	5,972	36.2
Screenings	2,488	2,622	1,357	853	967	698	-71.9
Special Groups	85	84	86	99	124	129	51.8
State-Only Developmental Disability Program	171	204	169	165	156	184	7.6
Total	**71,408**	**68,775**	**69,443**	**73,972**	**82,228**	**84,358**	**18.1**

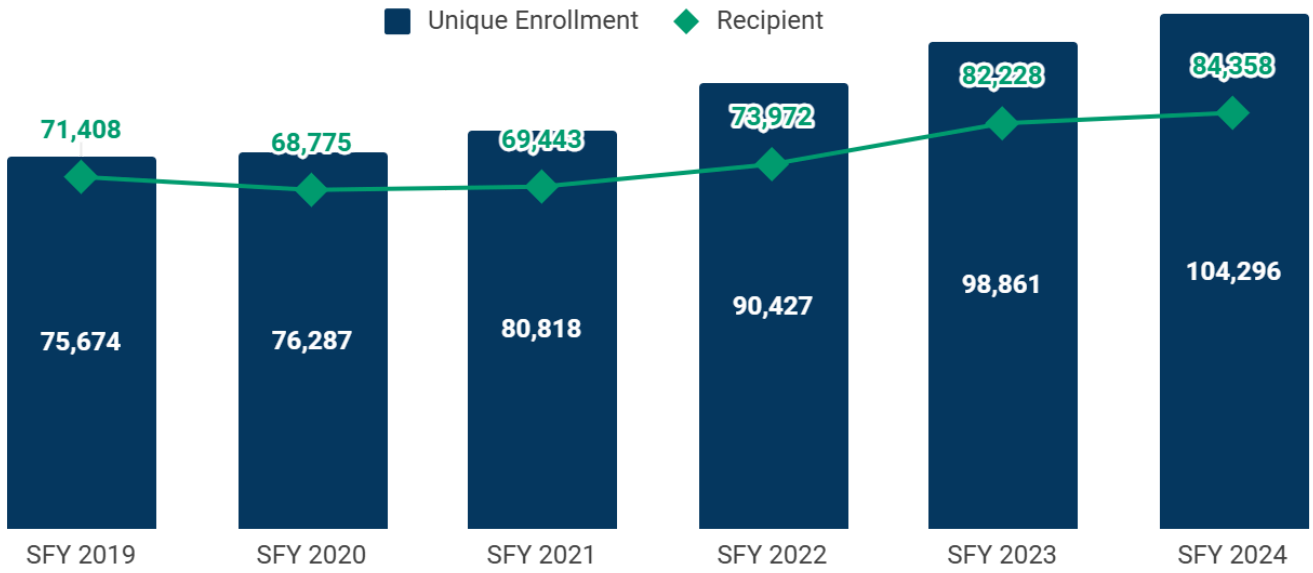
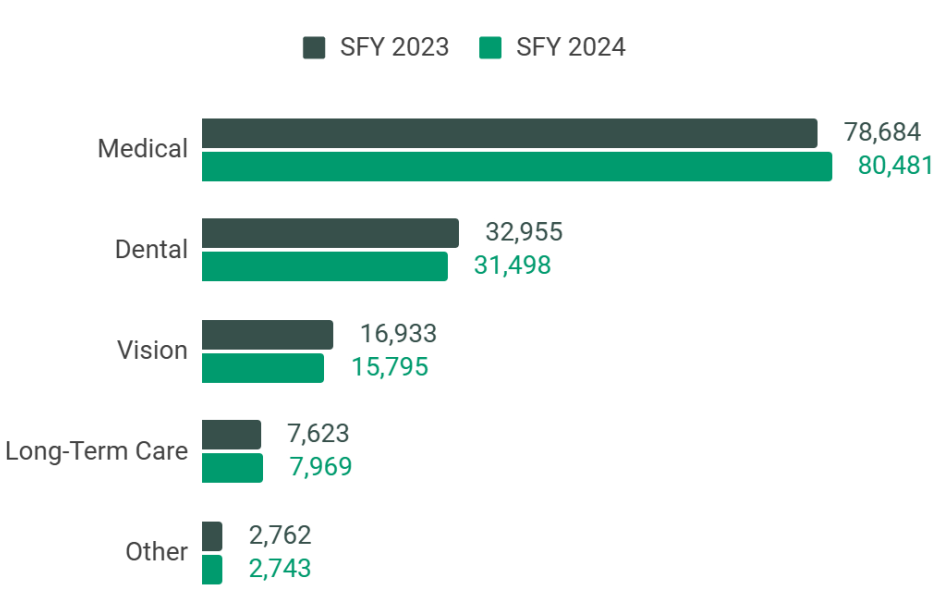


Figure 26. Historical Medicaid Enrollment vs. Medicaid Recipients by SFY

[7] 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 category will not match the total recipients as individuals may receive services under multiple eligibility categories throughout the SFY.

Table 9. Medicaid Recipient History by Service Type

Service Area	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Medical	68,230	65,460	65,168	70,214	78,684	80,481	18.0
Dental	27,524	24,732	29,329	30,566	32,955	31,498	14.4
Vision	14,790	12,680	15,761	15,808	16,933	15,795	6.8
Long-Term Care	7,711	8,193	7,672	7,420	7,623	7,969	3.3
Other	3,475	3,325	3,081	1,683	2,762	2,743	-21.1



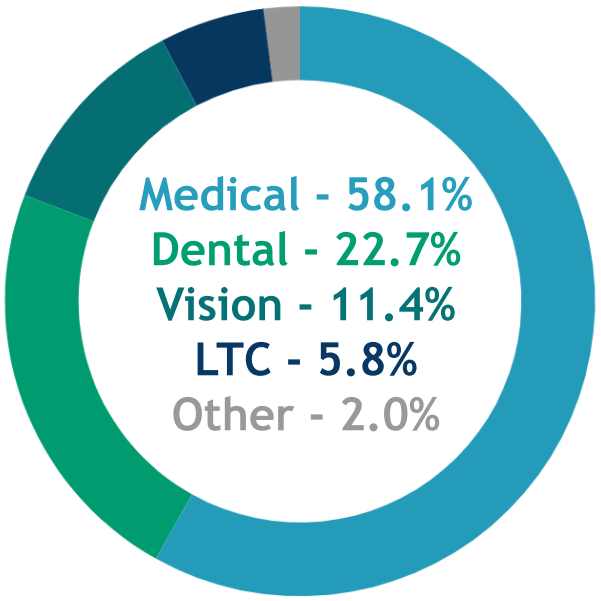


Figure 27. Comparison of Expenditures by Service Type for SFY 2023 and SFY 2024

Figure 28. SFY 2024 Expenditures by Service Type

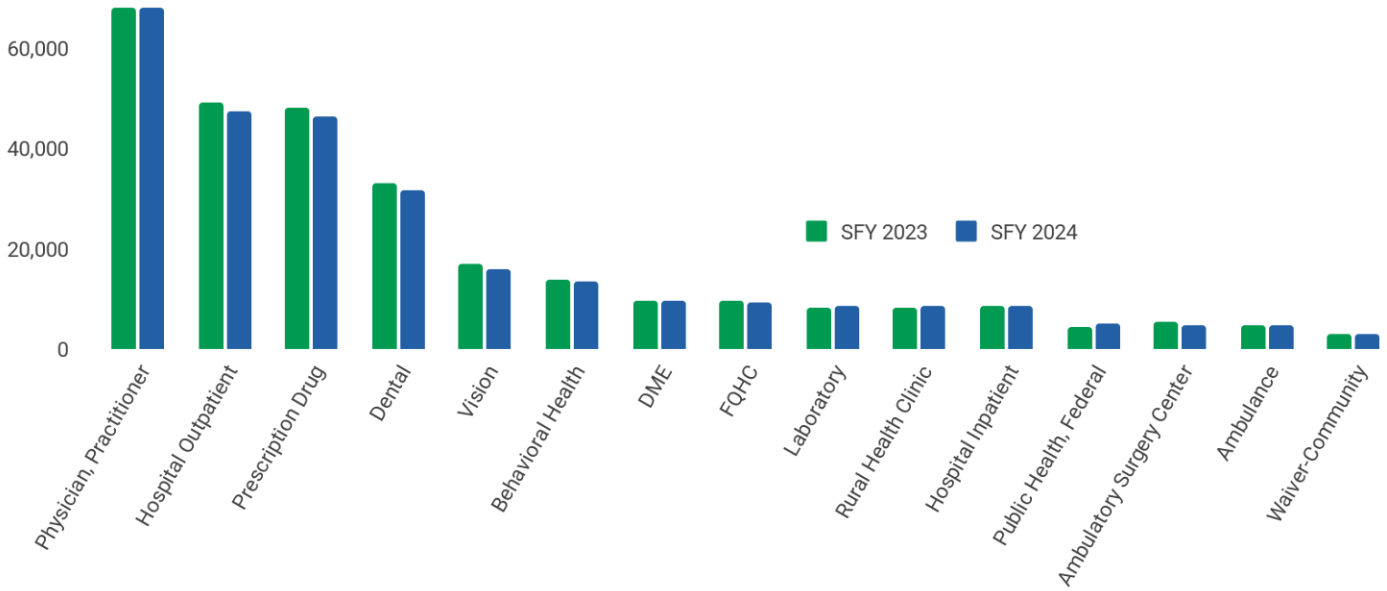


Figure 29. Comparison of Top Medicaid Services' Recipients for SFY 2023 and SFY 2024

SERVICES

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

Table 10. Covered Services

Service	Adult	Children
Ambulance	Mandatory	Mandatory
Ambulatory Surgical Center	Optional	Mandatory (EPSDT)[8]
Behavioral Health[9]	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[10]	Optional	Optional
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[11]	Optional	Mandatory (EPSDT)
Public Health, Federal[12]	Optional	Mandatory (EPSDT)
Public Health or Welfare	Optional	Mandatory (EPSDT)
Rural Health Clinic	Optional	Mandatory (EPSDT)
Vision	Optional	Mandatory (EPSDT)

[8] EPSDT: Early Periodic Screening Detection & Treatment program.
[9] Excludes the Children's Mental Health Waiver & Psychiatric Residential Treatment Facility (PRTF).
[10] ID/DD/ABI: Intellectual Disabilities/Developmental/Acquired Brain Injury.
[11] Physical/Occupational/Speech Therapies service details are included in the Physician and Other Practitioner data in the detail section of this report.
[12] Refers to Indian Health Services and Tribal 638 facilities.

Table 11. Medicaid Service Utilization Summary

Member Core ID	Expenditures	% Change from SFY 2023	Recipients[13]	% Change from SFY 2023	Expend per Recip SFY 2024	% Change from SFY 2023
Ambulance	$5,062,622	10.6	4,725	-0.5	$1,071	11.1
Ambulatory Surgery Center	$6,547,398	-2.8	4,797	-10.0	$1,365	7.9
Behavioral Health	$18,578,363	-1.1	13,633	-1.5	$1,363	0.4
Care Management Entity	$3,135,717	-20.5	650	9.4	$4,824	-27.3
Clinic/Center	$1,037,884	-3.4	1,321	7.3	$786	-10.0
Dental	$16,048,784	12.4	31,498	-4.4	$510	17.6
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	$12,074,484	2.6	9,590	-1.6	$1,259	4.3
End-Stage Renal Disease	$1,597,664	-19.1	160	1.9	$9,985	-20.6
Federally Qualified Health Center	$10,655,469	7.2	9,171	-5.1	$1,162	13.0
Home Health	$564,449	9.6	323	21.0	$1,748	-9.4
Hospice	$2,151,504	49.2	271	-3.6	$7,939	54.7
Hospital Total	**$110,717,880**	-5.8	56,314	-3.4	$1,966	-2.4
Hospital Inpatient	$74,590,572	-10.5	8,517	-2.5	$8,758	-8.2
Hospital Outpatient	$36,106,502	5.8	47,413	-3.3	$762	9.4
Hospital-Other	$20,806	-64.4	384	-31.3	$54	-48.1
Intermediate Care Facility for Individuals with Intellectual Disabilities	$16,366,887	-10.7	36	-26.5	$454,636	21.6
Laboratory	$1,970,386	8.4	8,735	6.9	$226	1.4
Nursing Facility	$94,375,923	19.0	2,262	-0.1	$41,722	19.2
Other	$685,549	3.6	2,127	-3.9	$322	7.8
Physician and Other Practitioner	$59,415,593	-5.0	67,806	-0.1	$876	-4.9
Prescription Drug	$97,610,755	-0.5	46,173	-4.0	$2,114	3.6
Psychiatric Residential Treatment Facility	$11,522,485	72.4	204	3.6	$56,483	66.4
Public Health or Welfare	$170,983	-26.2	2,846	-11.6	$60	-16.6
Public Health, Federal	$29,847,495	24.3	5,205	14.1	$5,734	8.9
Rural Health Clinic	$4,473,408	29.7	8,652	6.0	$517	22.4
Vision	$3,696,713	-4.8	15,795	-6.7	$234	2.1
Waiver Total	**$176,450,690**	6.9	5,924	5.6	$29,786	1.2
Waiver-Community Choices	$38,195,429	2.6	2,972	0.4	$12,852	2.1
Waiver-Comprehensive	$124,600,967	5.7	1,804	-2.0	$69,069	7.8
Waiver-Supports	$13,654,293	36.1	1,148	41.9	$11,894	-4.1
Total	**$684,759,086[14]**	4.3	84,360	2.6	$8,117	1.6

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

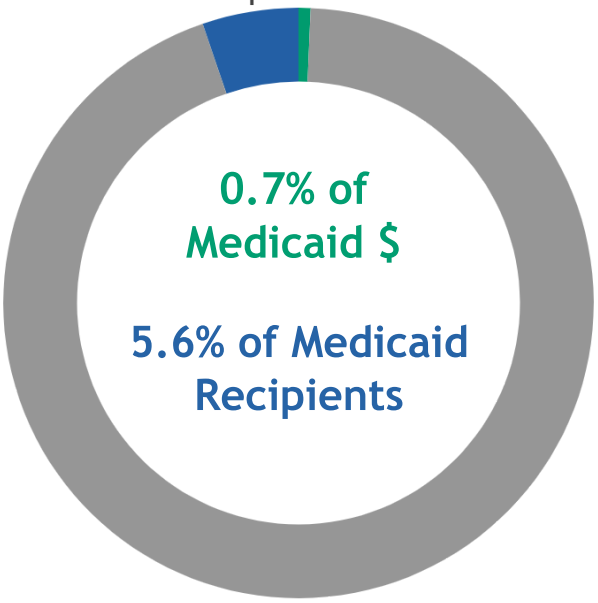
[14] Expenditures for screenings and gross adjustments are included in the Total Expenditures. The SFY 2024 expenditures for screenings and gross adjustments are displayed in Table 6.

AMBULANCE

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

from SFY23 -0.5%

RECIPIENTS 4,725



EXPENDITURES $5,062,622

10.6% from SFY23

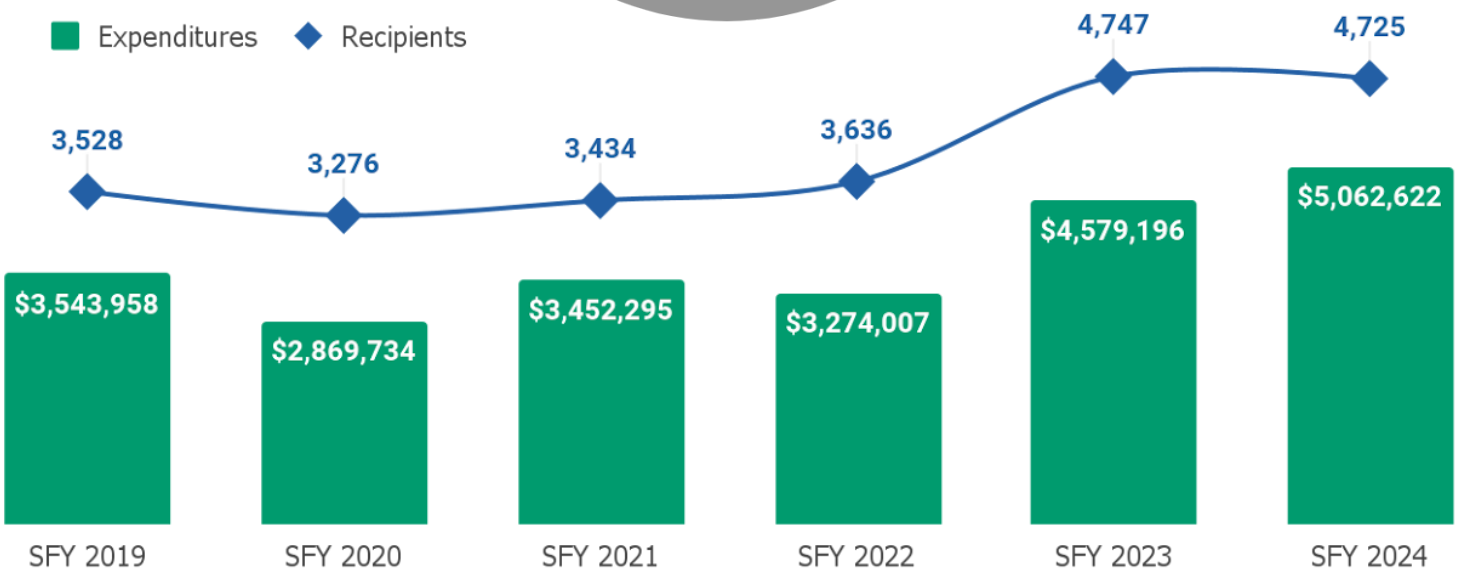


Table 12. Ambulance Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$3,543,958	$2,869,734	$3,452,295	$3,274,007	$4,579,196	$5,062,622	42.9
Recipients	3,528	3,276	3,434	3,636	4,747	4,725	33.9
Expenditures per Recipient	$1,005	$876	$1,005	$900	$965	$1,071	6.7

AMBULATORY SURGICAL CENTER

Surgical procedures that do not require overnight inpatient hospital care. It 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.

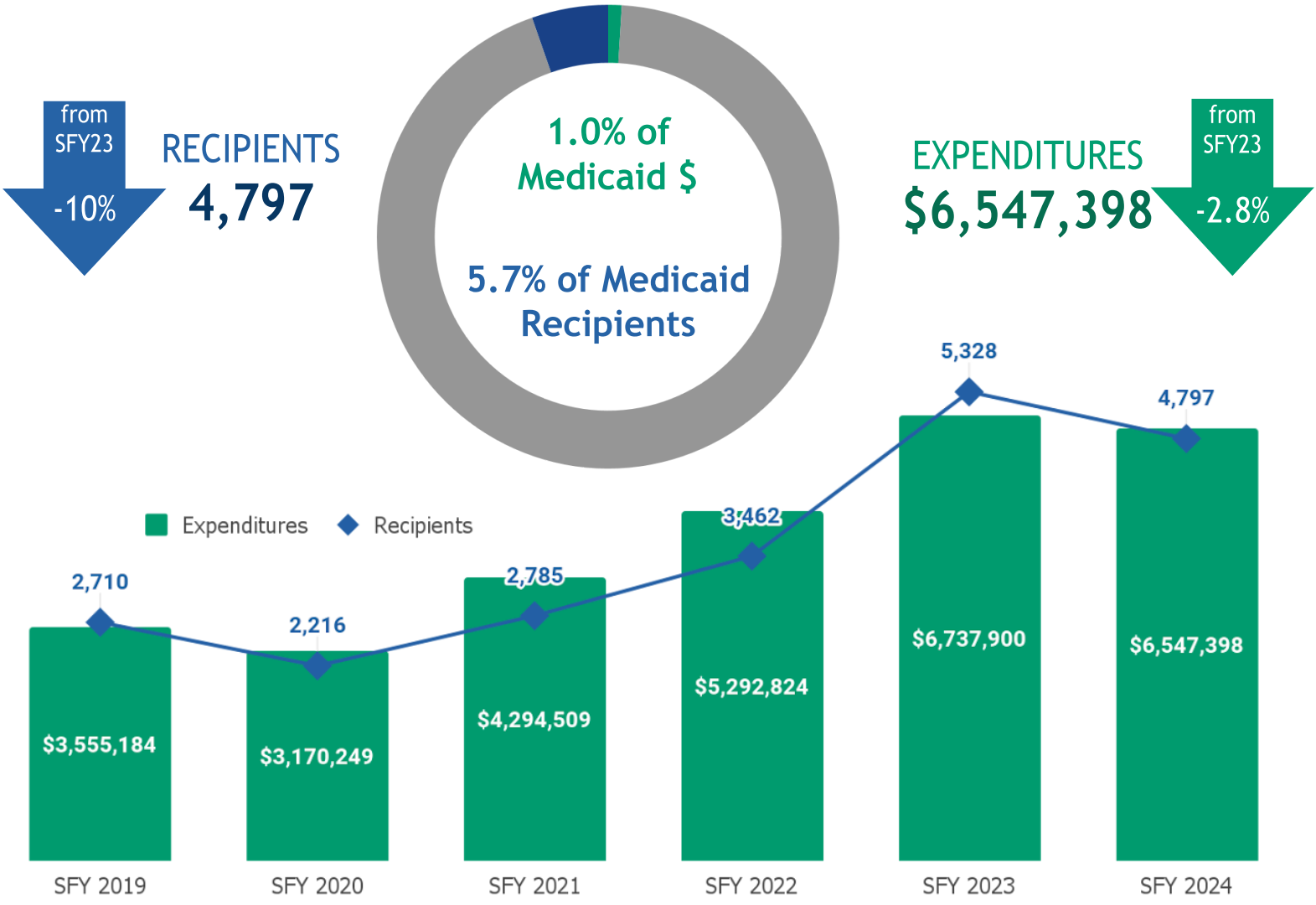
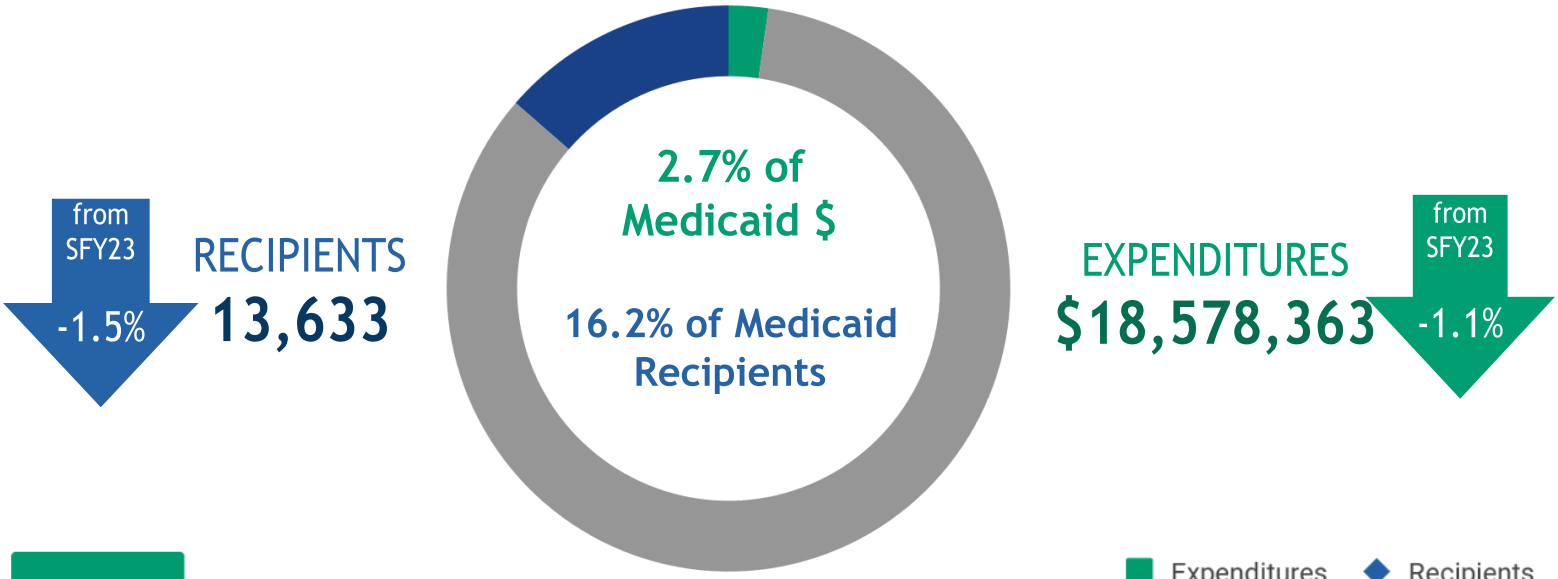


Table 13. Ambulatory Surgical Center Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$10,391,372	$7,334,441	$7,577,518	$6,127,480	$6,685,351	$11,522,485	10.9
Recipients	309	221	204	150	197	204	-34.0
Expenditures Per Recipient	$33,629	$33,188	$37,145	$40,850	$33,936	$56,483	68.0

BEHAVIORAL HEALTH

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



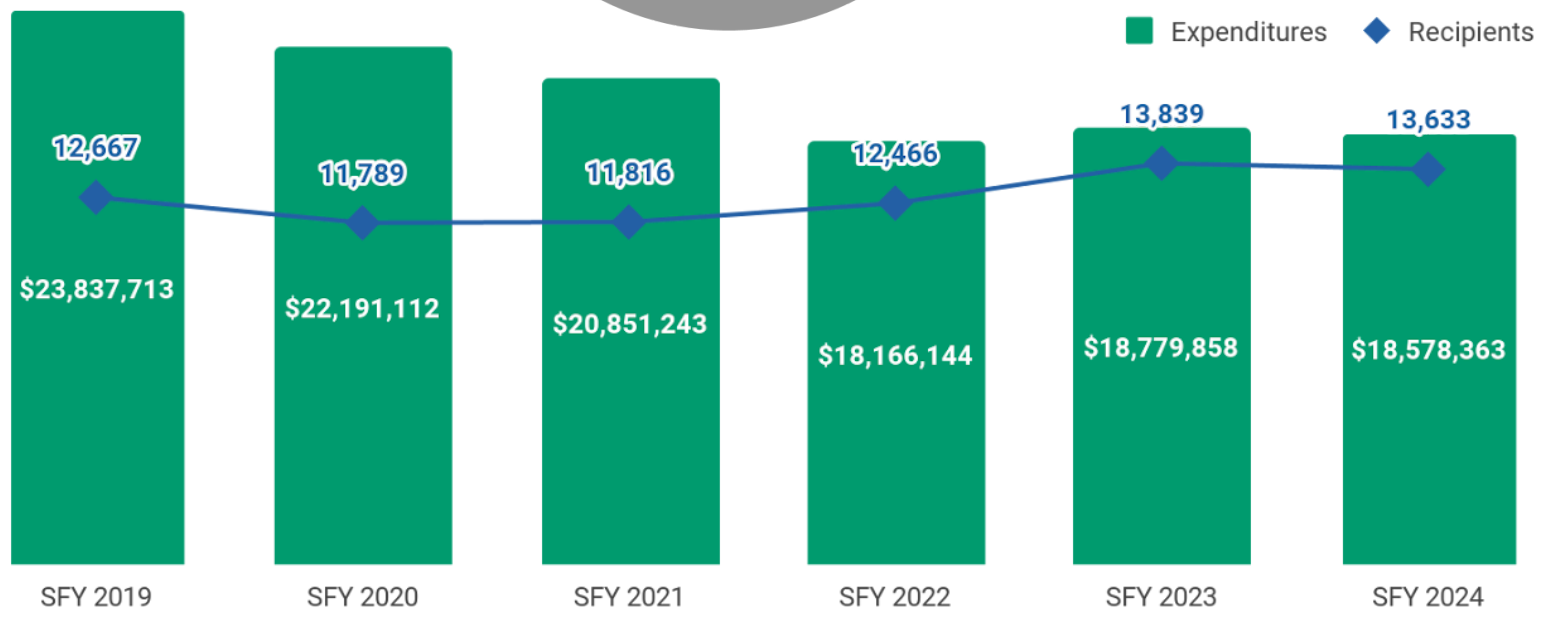


Table 14. Behavioral Health Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$23,837,713	$22,191,112	$20,851,243	$18,166,144	$18,779,858	$18,578,363	-22.1
Recipients	12,667	11,789	11,816	12,466	13,839	13,633	7.6
Expenditures Per Recipient	$1,882	$1,882	$1,765	$1,457	$1,357	$1,363	-27.6

Figure 30. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types (excluding Alzheimer's and Other Types of Dementia)

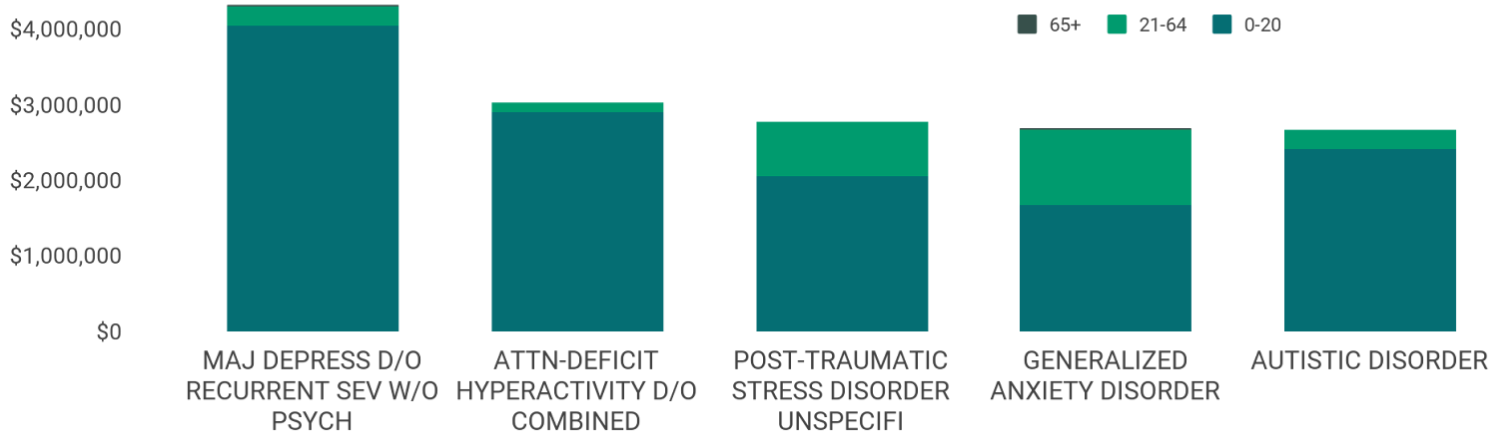


Table 15. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types[15] (excluding Alzheimer's and Other Types of Dementia)

Diagnosis Description	Age 0-20	Age 21-64	Age 65+	Total
MAJ DEPRESS D/O RECURRENT SEV W/O PSYCH	$4,055,718	$262,527	$5,475	$4,323,720
ATTN-DEFICIT HYPERACTIVITY D/O COMBINED	$2,916,460	$118,391	$1,272	$3,036,123
POST-TRAUMATIC STRESS DISORDER UNSPECIFIED	$2,056,521	$729,169	$8,697	$2,794,386
GENERALIZED ANXIETY DISORDER	$1,682,045	$994,787	$31,005	$2,707,837
AUTISTIC DISORDER	$2,427,101	$250,366	$183	$2,677,650
Total	**$13,137,844**	**$2,355,241**	**$46,631**	**$15,539,716**

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 16. Applied Behavioral Analysis Service Utilization History

Applied Behavioral Analysis	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$239,369	$888,168	$1,661,511	$1,503,425	$594,031	$968,768	304.7
Recipients	46	75	71	56	50	89	93.5
Expenditures per Recipients	$5,204	$11,842	$23,402	$26,847	$11,881	$10,885	109.2
Providers	4	7	6	7	8	11	175.0

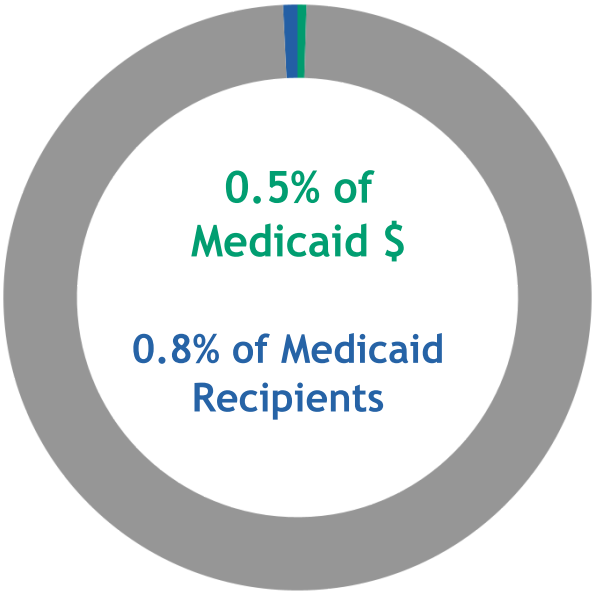
[15] See Appendix B for additional information regarding the types of providers who provide Behavioral Health services.

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.

9.4% from SFY23

RECIPIENTS
650



EXPENDITURES
$3,135,717

from SFY23 -20.5%

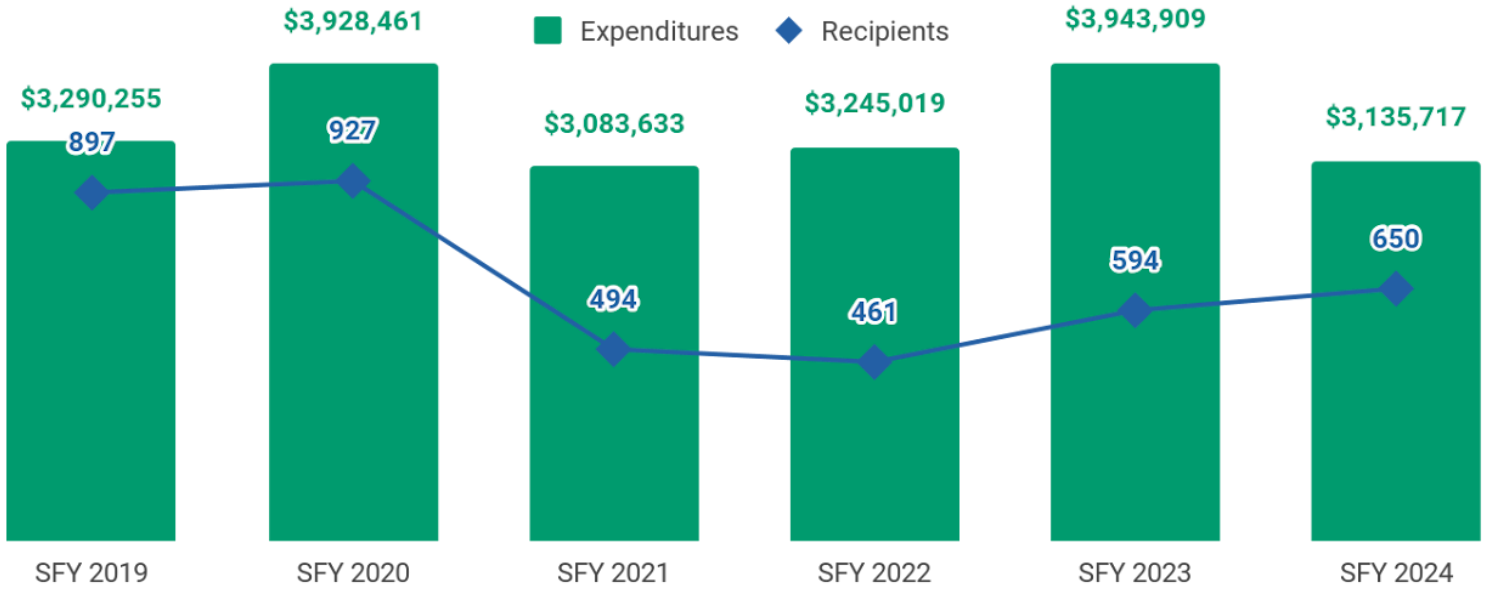


Table 17. Care Management Entity Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$3,290,255	$3,928,461	$3,083,633	$3,245,019	$3,943,909	$3,135,717	-4.7
Recipients	897	927	494	461	594	650	-27.5
Expenditures Per Recipient	$3,668	$4,238	$6,242	$7,039	$6,640	$4,824	31.5

CLINIC/CENTER (DEVELOPMENTAL CENTERS)

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

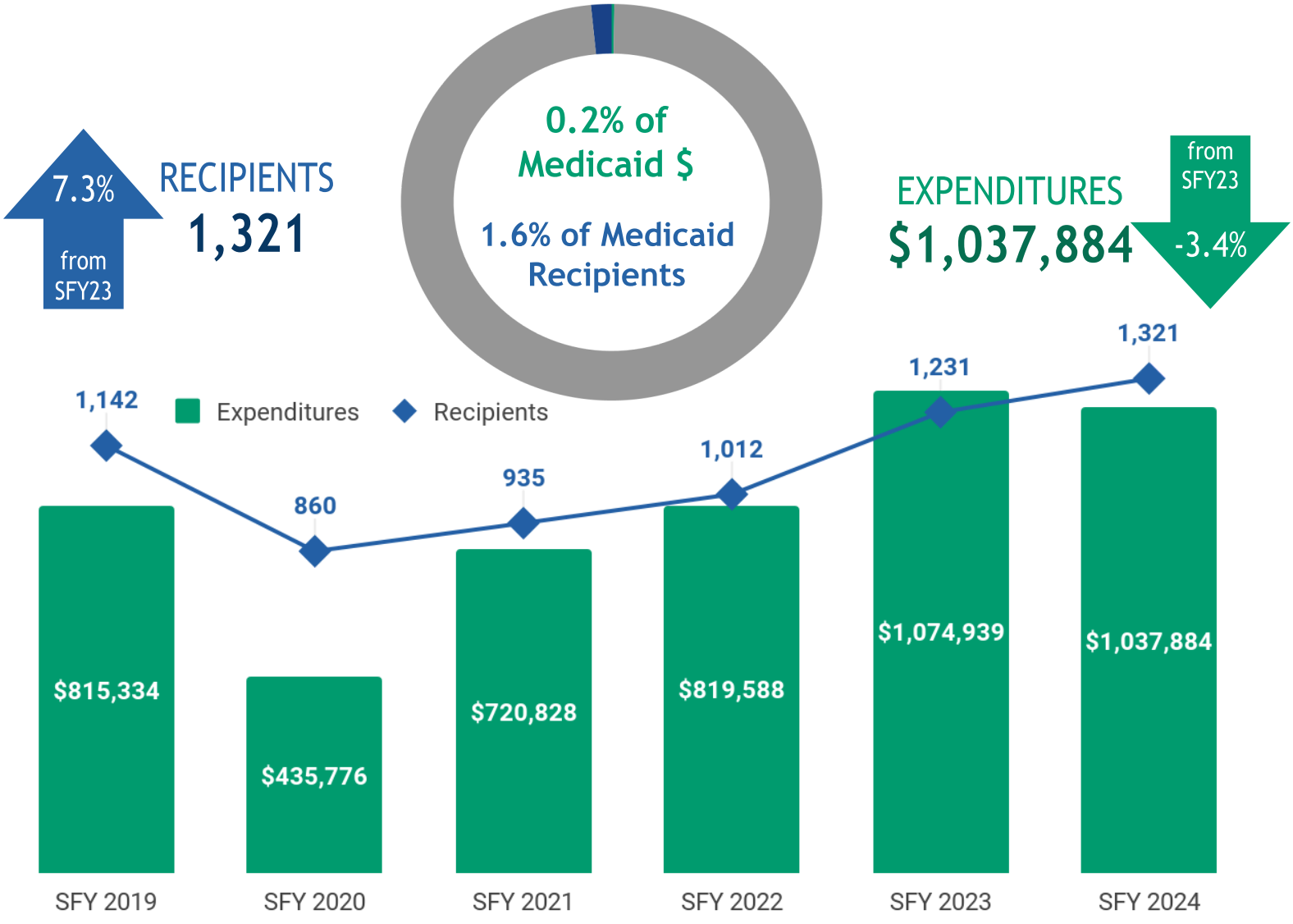
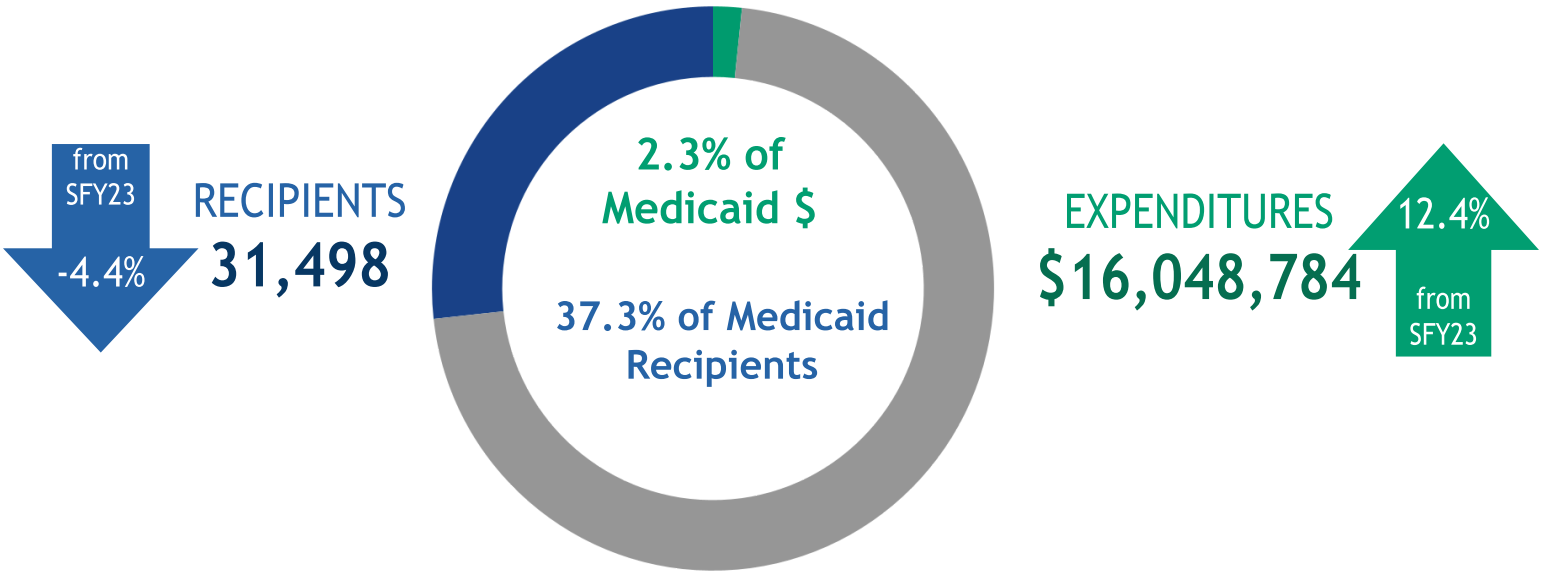


Table 18. Clinic / Center Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$815,334	$435,776	$720,828	$819,588	$1,074,939	$1,037,884	27.3
Recipients	1,142	860	935	1,012	1,231	1,321	15.7
Expenditures Per Recipient	$714	$507	$771	$810	$873	$786	10.0

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.



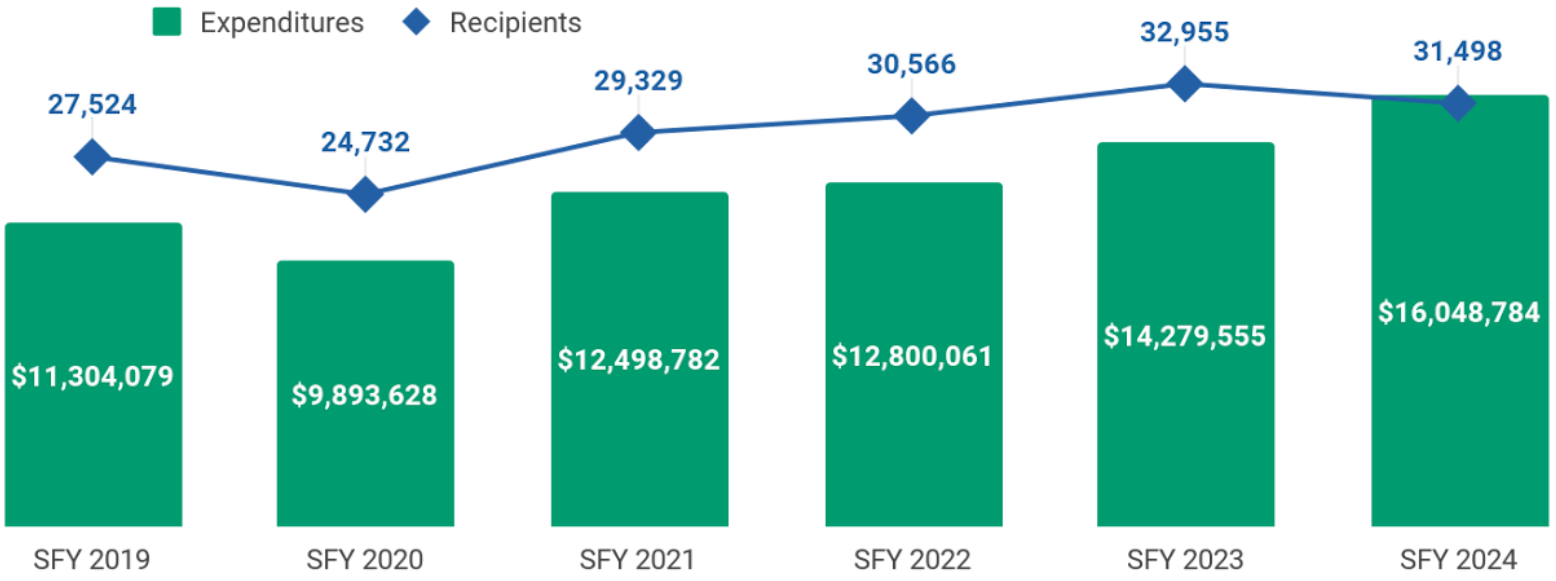


Table 19. Dental Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$11,304,079	$9,893,628	$12,498,782	$12,800,061	$14,279,555	$16,048,784	42.0
Recipients	27,524	24,732	29,329	30,566	32,955	31,498	14.4
Expenditures Per Recipient	$411	$400	$426	$419	$433	$510	24.1

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 for an injury and chronic health issue.

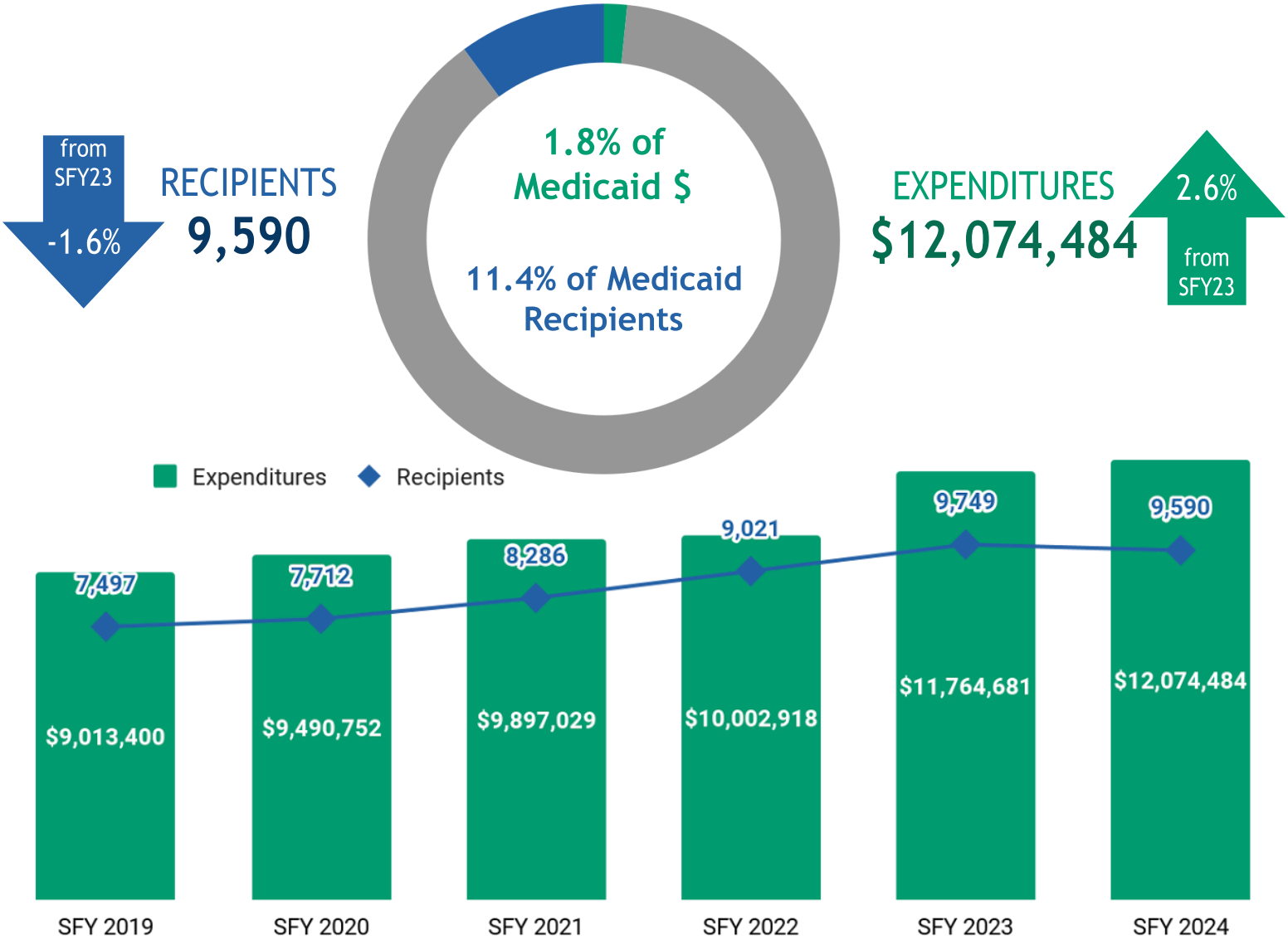


Table 20. DME Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$9,013,400	$9,490,752	$9,897,029	$10,002,918	$11,764,681	$12,074,484	34.0
Recipients	7,497	7,712	8,286	9,021	9,749	9,590	27.9
Expenditures Per Recipient	$1,202	$1,231	$1,194	$1,109	$1,207	$1,259	4.7

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.

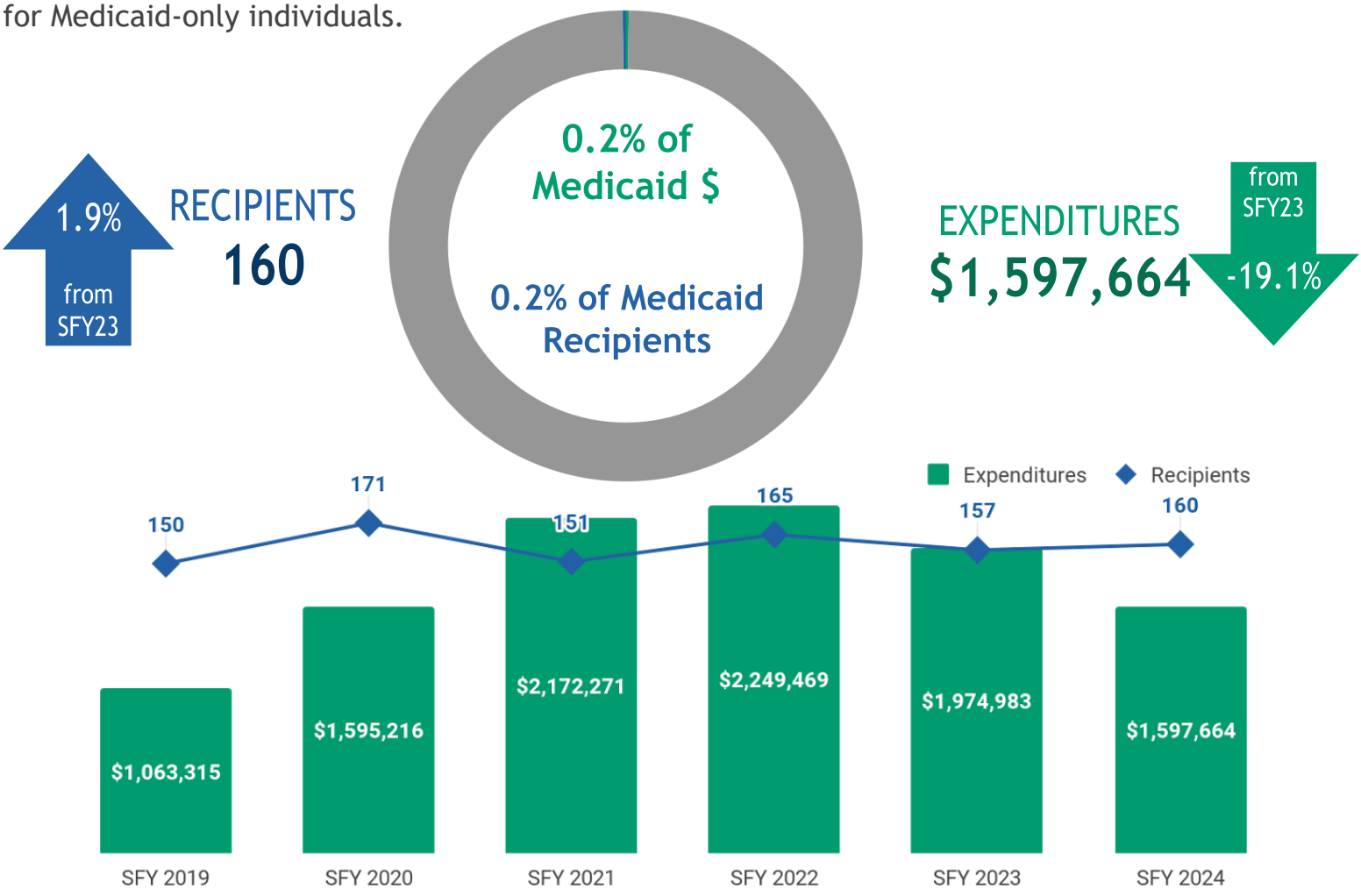


Table 21. End-Stage Renal Service Utilization History.

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$1,063,315	$1,595,216	$2,172,271	$2,249,469	$1,974,983	$1,597,664	50.3
Recipients	150	171	151	165	157	160	6.7
Expenditures Per Recipient	$7,089	$9,329	$14,386	$13,633	$12,580	$9,985	40.9

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.

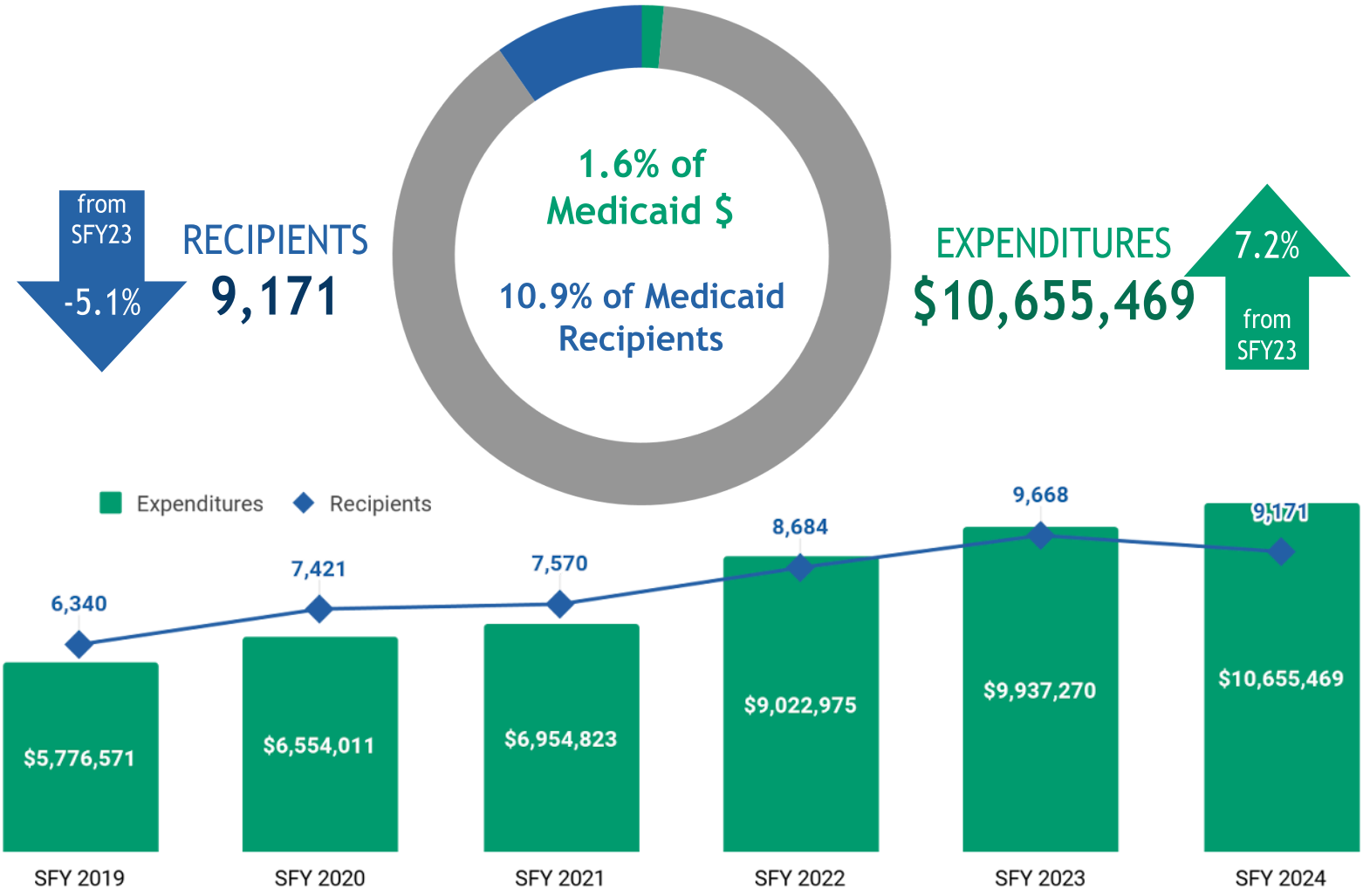


Table 22. Federally Qualified Health Center Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$5,776,571	$6,554,011	$6,954,823	$9,022,975	$9,937,270	$10,655,469	84.5
Recipients	6,340	7,421	7,570	8,684	9,668	9,171	44.7
Expenditures Per Recipient	$911	$883	$919	$1,039	$1,028	$1,162	27.5

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.

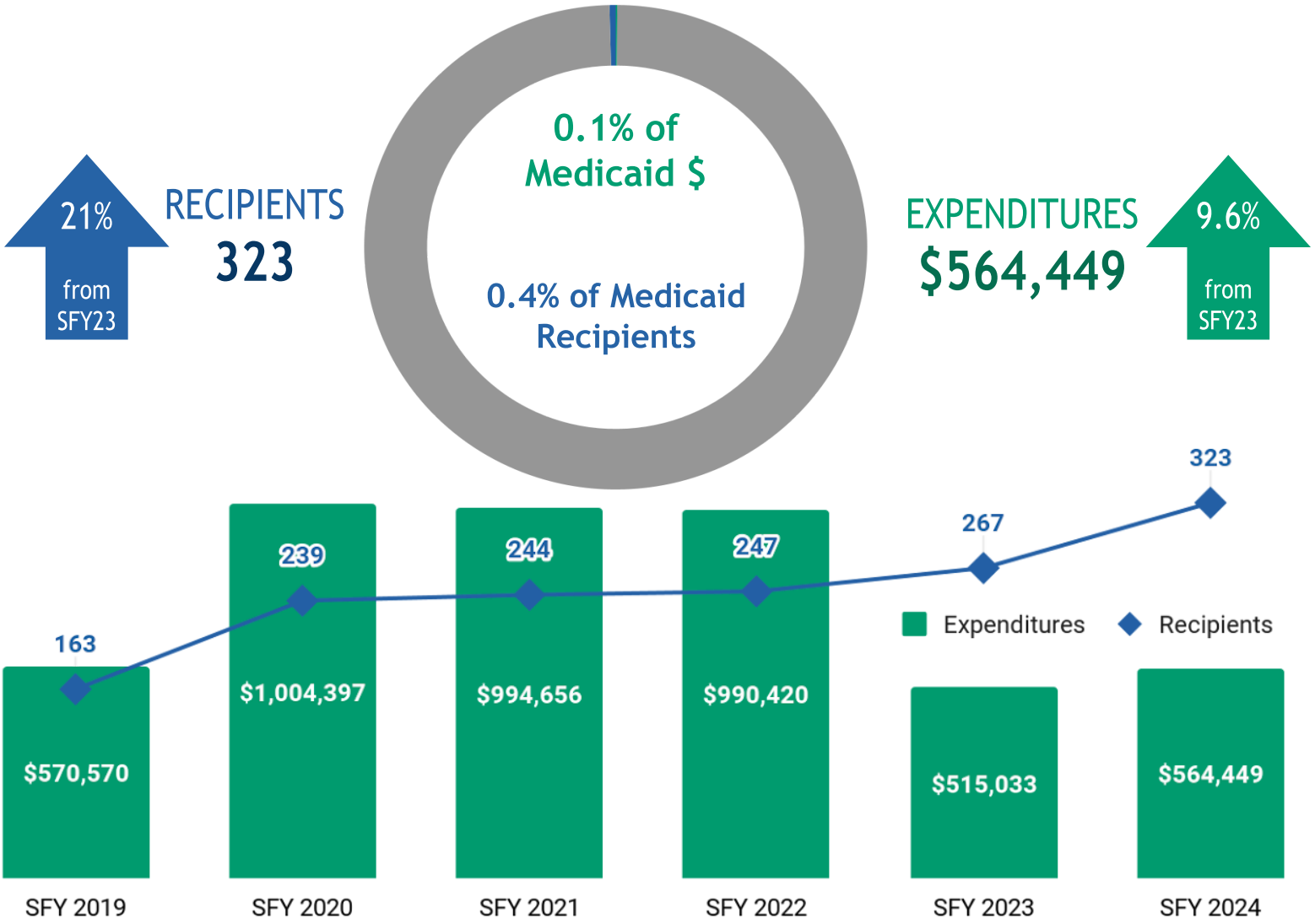


Table 23. Home Health Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$570,570	$1,004,397	$994,656	$990,420	$515,033	$564,449	-1.1
Recipients	163	239	244	247	267	323	98.2
Expenditures Per Recipient	$3,500	$4,202	$4,076	$4,010	$1,929	$1,748	-50.1

HOSPICE

Hospice care is covered if the individual elects palliative care 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. Hospice care is available to eligible Members of any age and may be provided in a home setting, nursing facility and freestanding hospice facility.

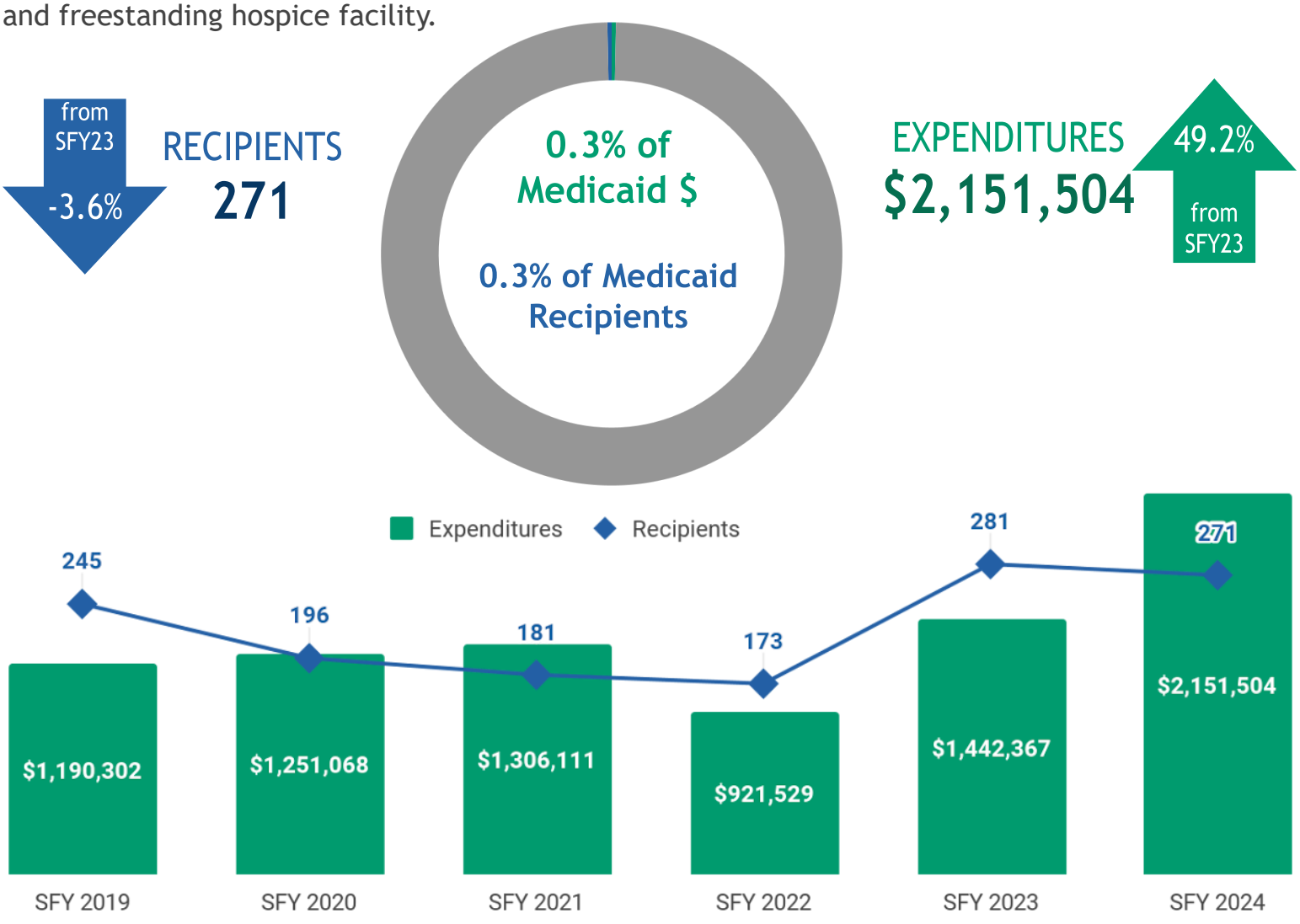
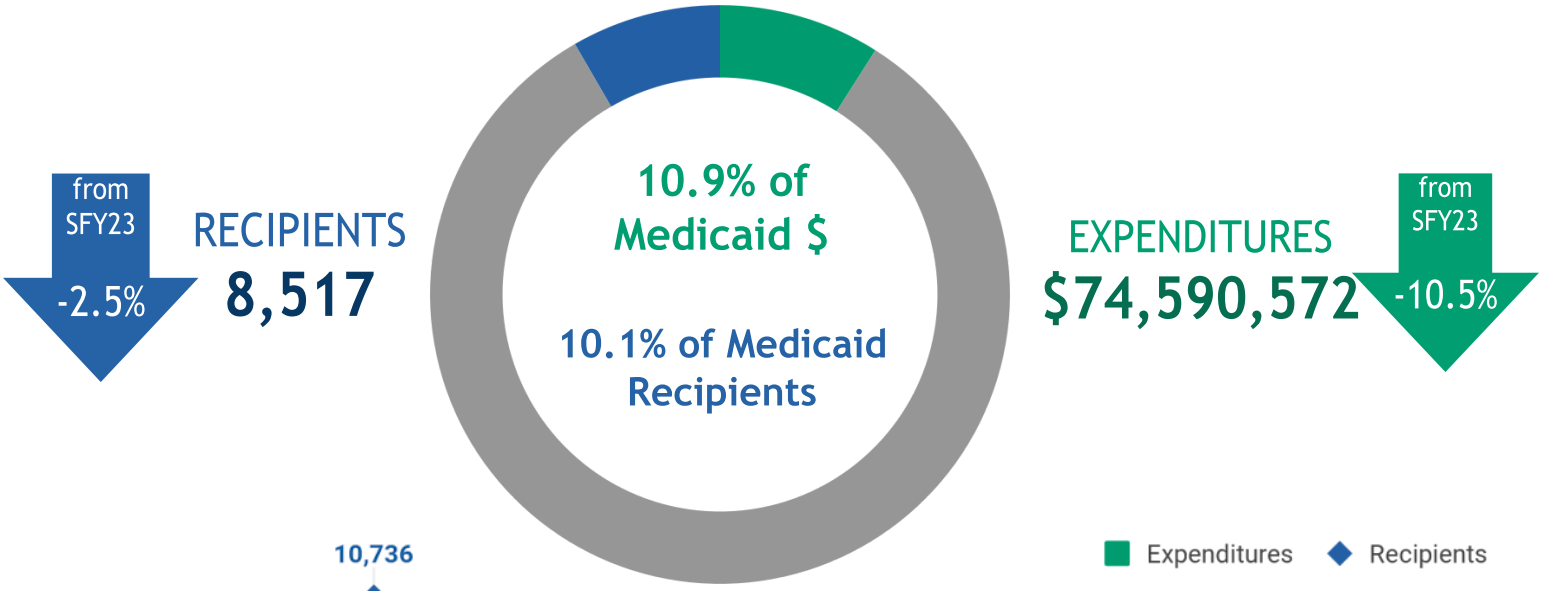


Table 24. Hospice Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$1,190,302	$1,251,068	$1,306,111	$921,529	$1,442,367	$2,151,504	80.8
Recipients	245	196	181	173	281	271	10.6
Expenditures Per Recipient	$4,858	$6,383	$7,216	$5,327	$5,133	$7,939	63.4

HOSPITAL - INPATIENT

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.



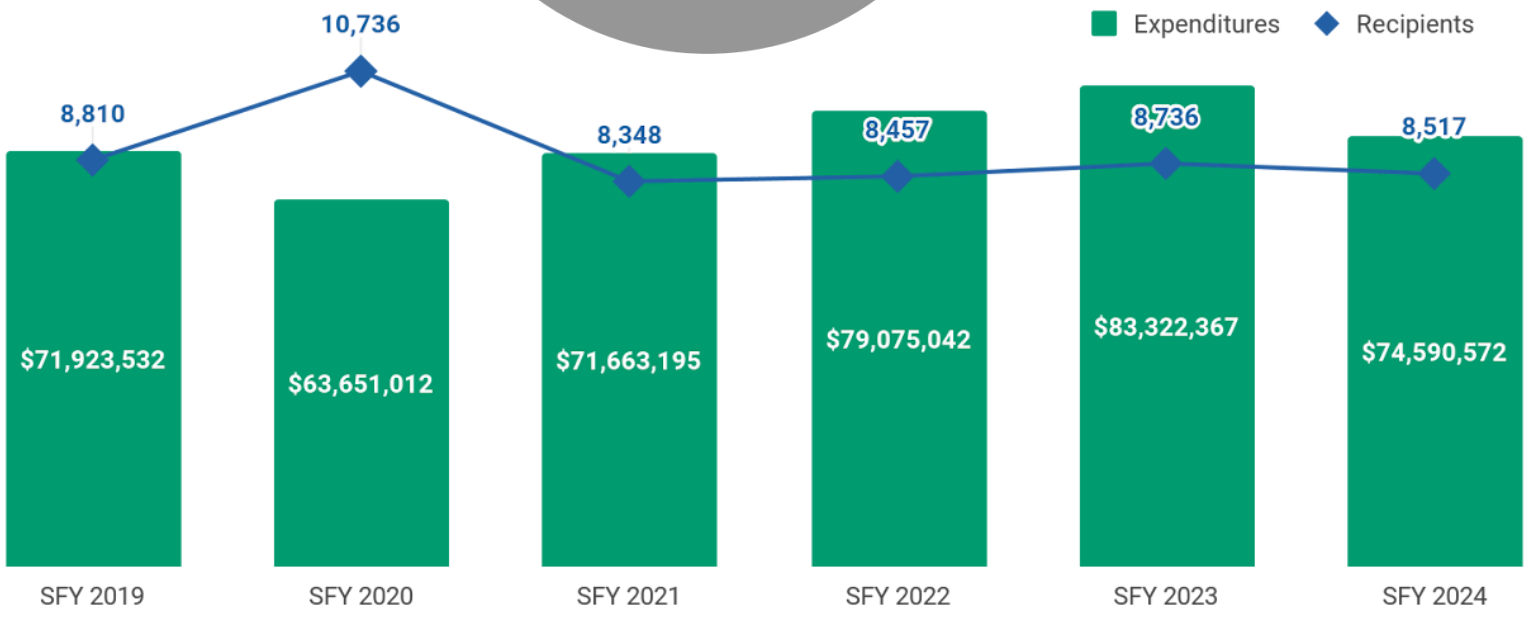


Table 25. Hospital Inpatient Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$71,923,532	$63,651,012	$71,663,195	$79,075,042	$83,322,367	$74,590,572	3.7
Recipients	8,810	10,736	8,348	8,457	8,736	8,517	-3.3
Expenditures Per Recipient	$8,164	$5,929	$8,584	$9,350	$9,538	$8,758	7.3

HOSPITAL - OUTPATIENT

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.

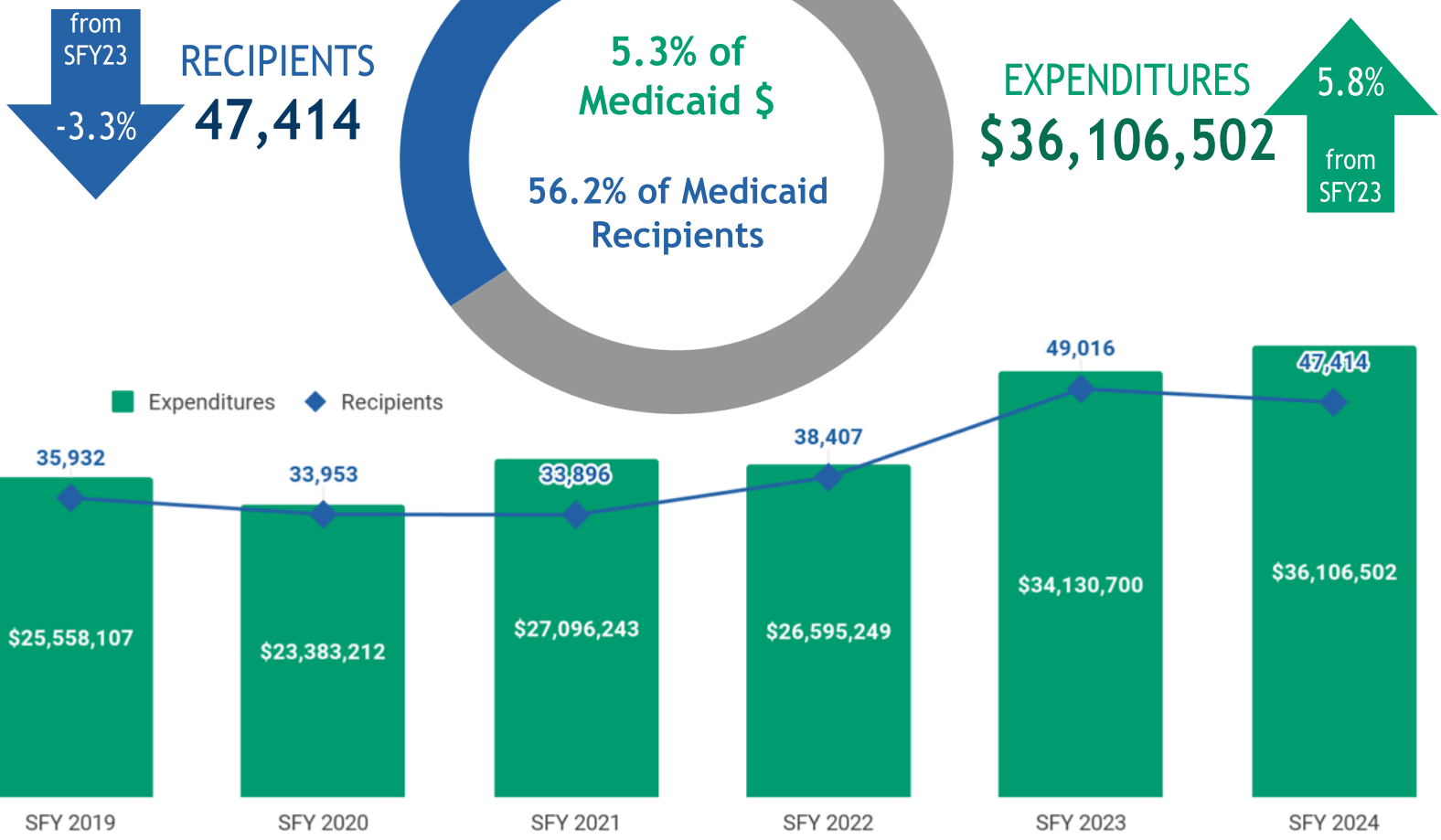


Table 26. Hospital Outpatient Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$25,558,107	$23,383,212	$27,096,243	$26,595,249	$34,130,700	$36,106,502	41.3
Recipients	35,932	33,953	33,896	38,407	49,016	47,414	32.0
Expenditures Per Recipient	$711	$689	$799	$692	$696	$762	7.1

EMERGENCY ROOM SERVICES

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.

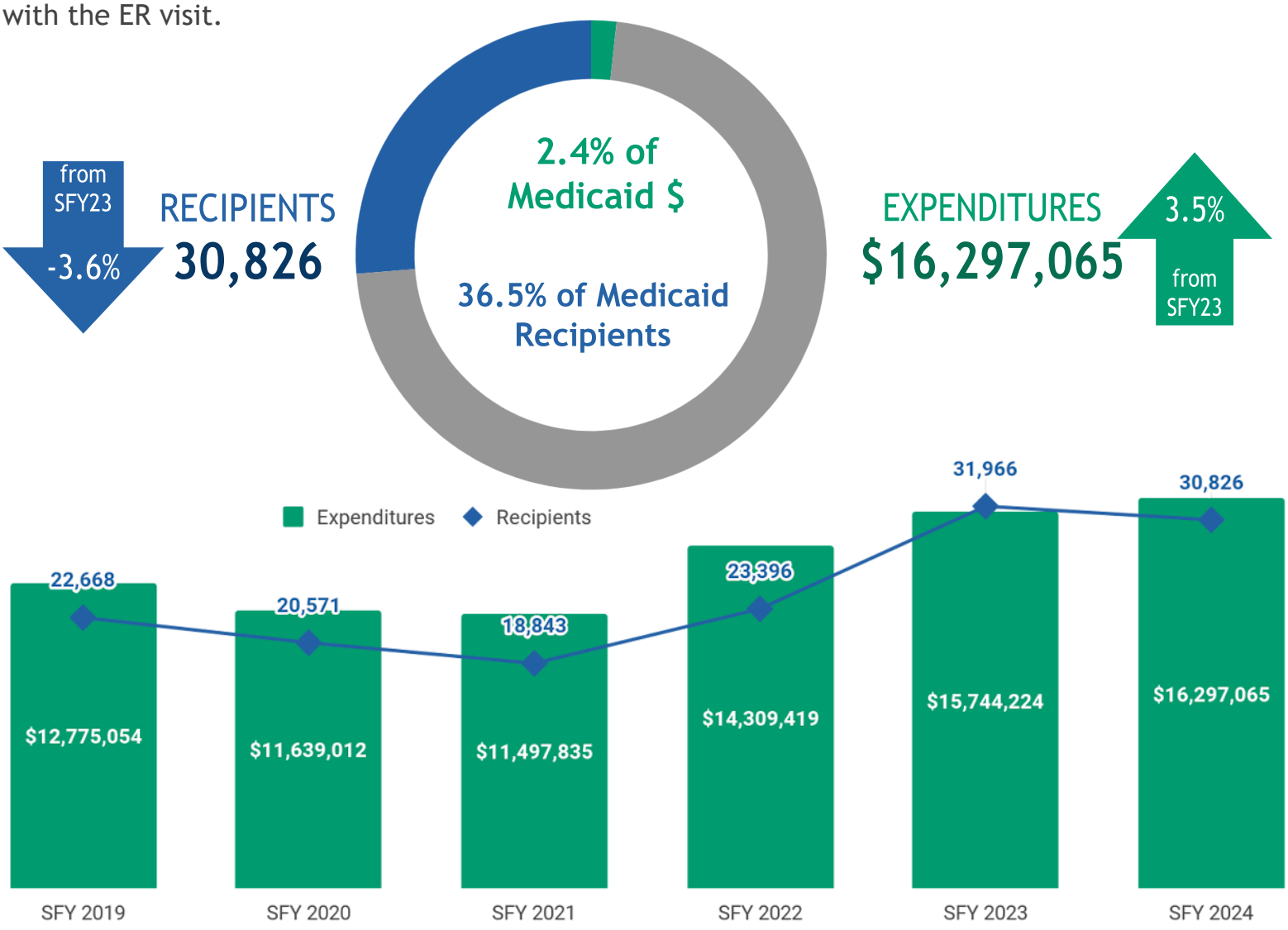


Table 27. Emergency Room Service Utilization History

Claim Paid Date	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$12,775,054	$11,639,012	$11,497,835	$14,309,419	$15,744,224	$16,297,065	27.6
Recipients	22,668	20,571	18,843	23,396	31,966	30,826	36.0
Expenditures per Recipients	$564	$566	$610	$612	$493	$529	-6.2

Table 28. Emergency Room Utilization by Eligibility Category

Eligibility Category	Expenditures	% Change from SFY 2023	Recipients[16]	% Change from SFY 2023	Expenditures per Recipient	% Change from SFY 2023
ABD EID	$34,372	-49.2	160	1.9	$215	-50.2
ABD ID/DD/ABI	$394,217	54.0	984	12.3	$401	37.1
ABD Institution	$5,546	470.6	20	25.0	$277	356.5
ABD Long-Term Care	$727,524	17.5	2,415	8.8	$301	7.9
ABD SSI & SSI Related	$2,326,596	9.9	3,132	1.2	$743	8.6
Adults	$3,795,029	-3.6	5,088	-1.0	$746	-2.6
Children	$6,985,728	2.5	15,269	-7.7	$458	11.1
Children's Health Insurance Program	$430,021	21.3	1,028	6.1	$418	14.4
Medicare Savings Programs	$123,183	0.7	1,354	7.5	$91	-6.3
Non-Citizens with Medical Emergencies	$47,517	21.1	94	13.3	$506	6.9
Pregnant Women	$1,396,654	2.7	2,159	3.1	$647	-0.4
Special Groups	$30,635	-40.6	43	4.9	$712	-43.3
Totals	**$16,297,022**	**3.5**	**31,746**	**-2.3**	**$513**	**6.0**

[16] 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.

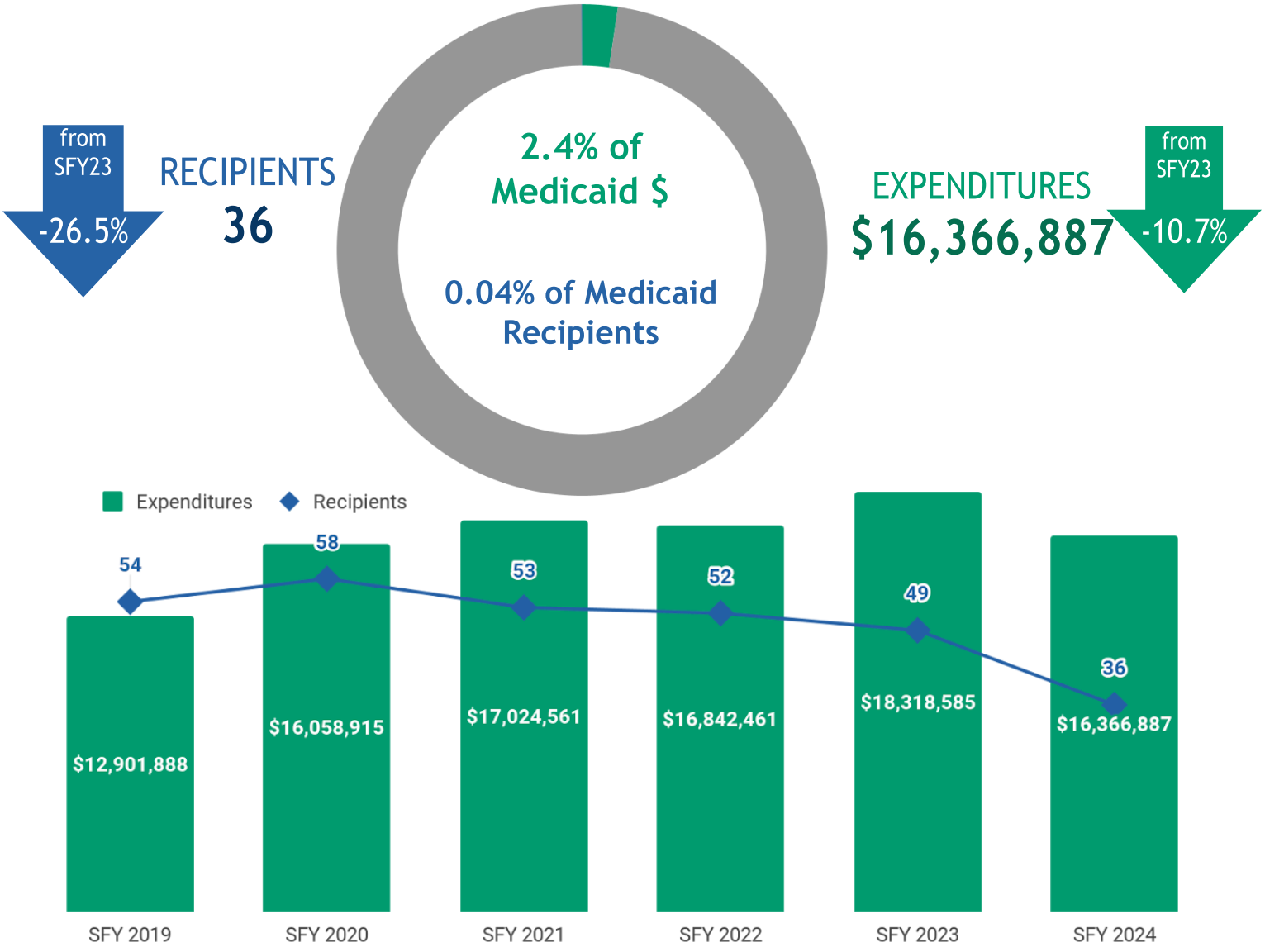
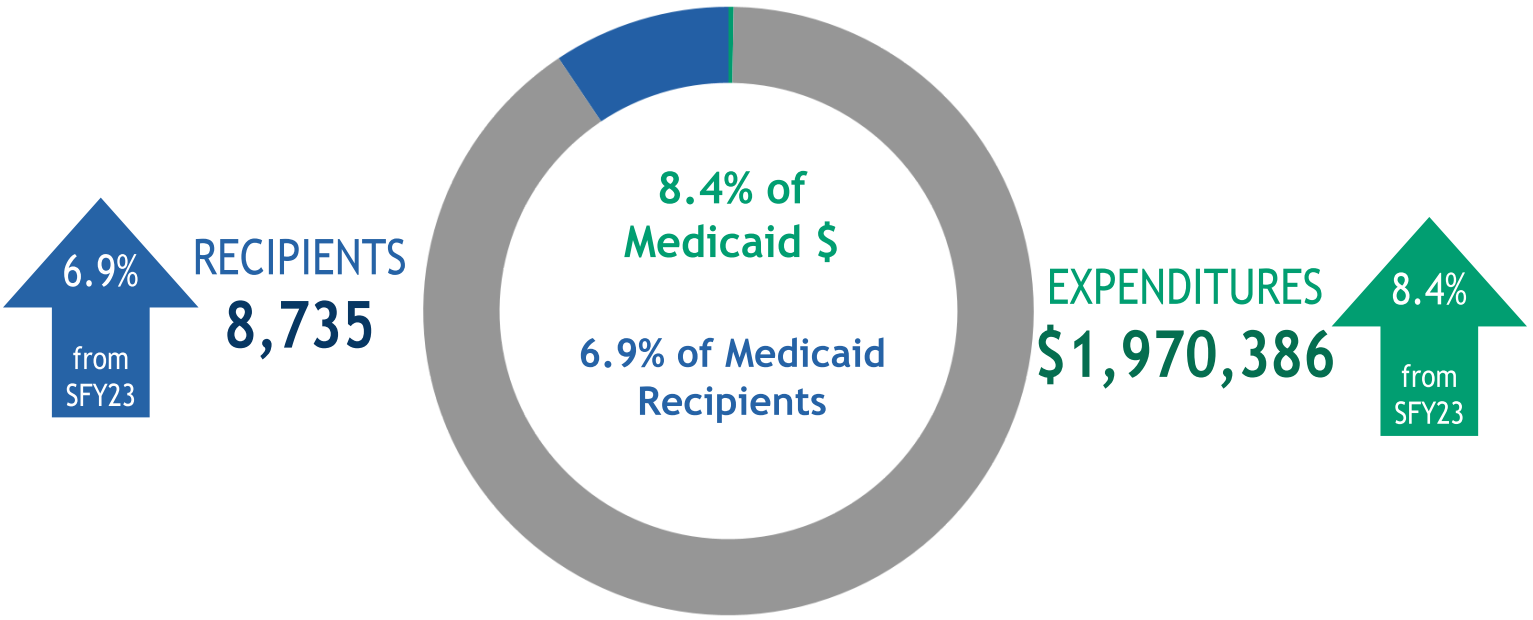


Table 29. ICF-IID Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$12,901,888	$16,058,915	$17,024,561	$16,842,461	$18,318,585	$16,366,887	26.9
Recipients	54	58	53	52	49	36	-33.3
Expenditures Per Recipient	$238,924	$276,878	$321,218	$323,893	$373,849	$454,636	90.3

LABORATORY

Medicaid covers professional and technical laboratory services ordered by a practitioner that are directly related to the diagnosis and its treatment.



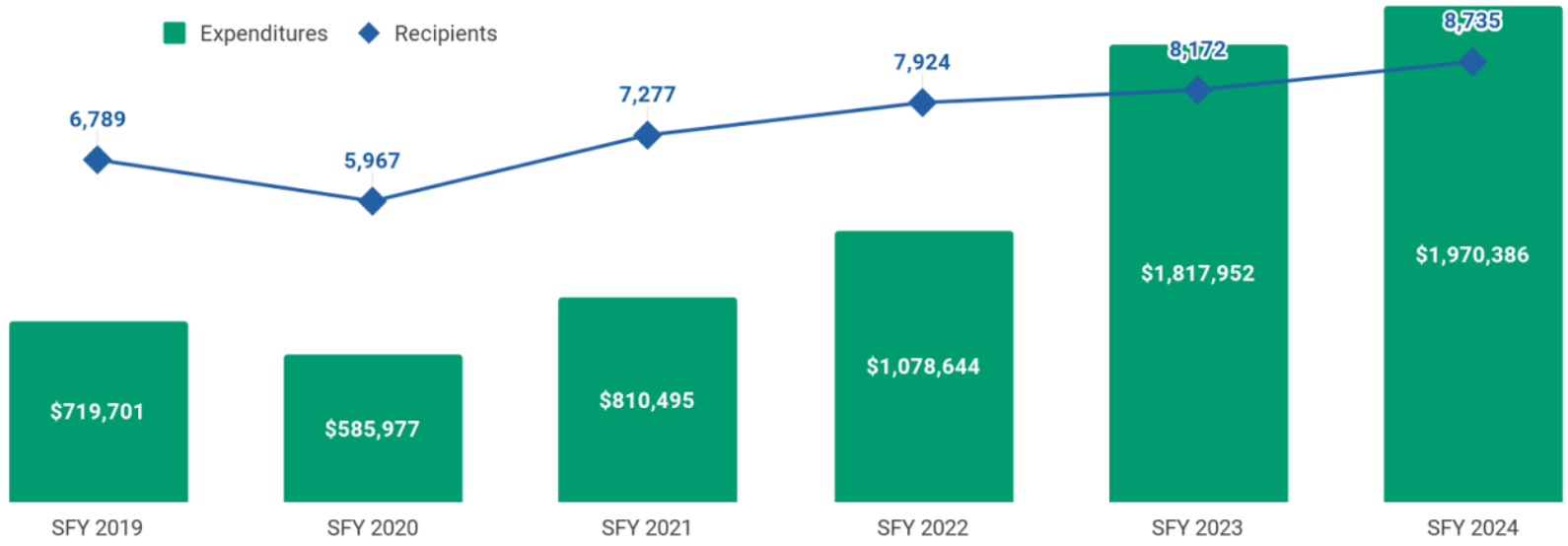


Table 30. Laboratory Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$719,701	$585,977	$810,495	$1,078,644	$1,817,952	$1,970,386	173.8
Recipients	6,789	5,967	7,277	7,924	8,172	8,735	28.7
Expenditures Per Recipient	$106	$98	$111	$136	$222	$226	112.8

NURSING FACILITY

Skilled Nursing Facilities (SNF) provide long term care to Members who are unable to live independently safely, including room and board, dietary needs, laundry services, nursing services, minor medical services, surgical supplies, over the counter medications, and the use of the equipment and facilities. Swing Bed services are those long-term care services provided in the hospital setting in place of transferring the Member to the skilled nursing facility, and are subject to the same policy as those services provided in the skilled nursing facilities.

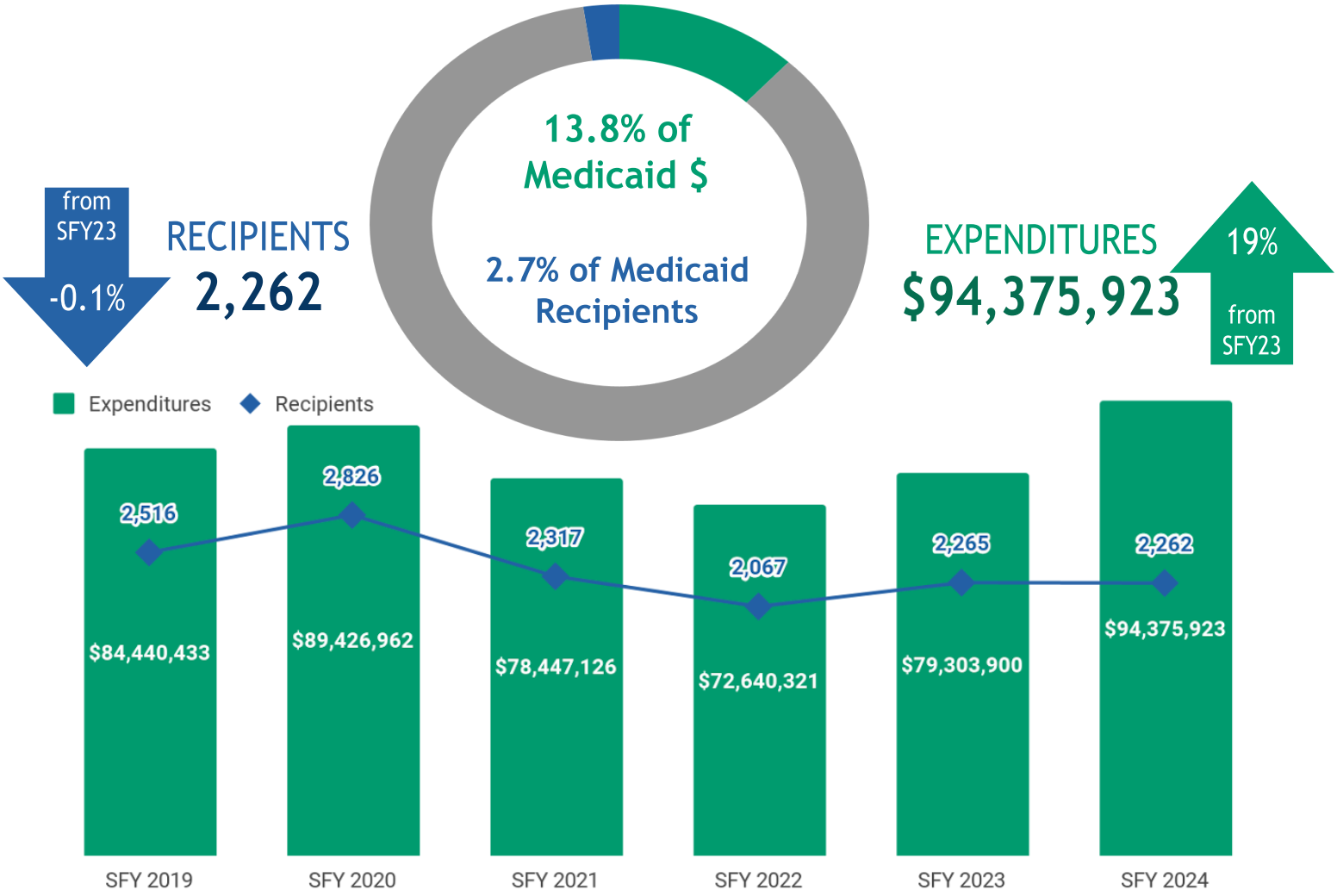


Table 31. Nursing Facilities Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$84,440,433	$89,426,962	$78,447,126	$72,640,321	$79,303,900	$94,375,923	11.8
Recipients	2,516	2,826	2,317	2,067	2,265	2,262	-10.1
Expenditures Per Recipient	$33,561	$31,644	$33,857	$35,143	$35,013	$41,722	24.3

Table 32. Nursing Facility Program 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 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 & 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 • Provided to encourage nursing facilities to accept adults who require individualized psychiatric care

PHYSICIAN & OTHER PRACTITIONER

Services provided by physicians and other practitioners, with limits:

- Hospital outpatient departments, physician offices, and optometrist offices - maximum of 12 visits per calendar year for individuals over age 21. Additional visits can be approved after referral to care management programs and review for medical necessity.
- Physical, occupational, and speech therapy - maximum of 20 visits each per calendar year for individuals over age 21, with additional visits approved after review for medical necessity.

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

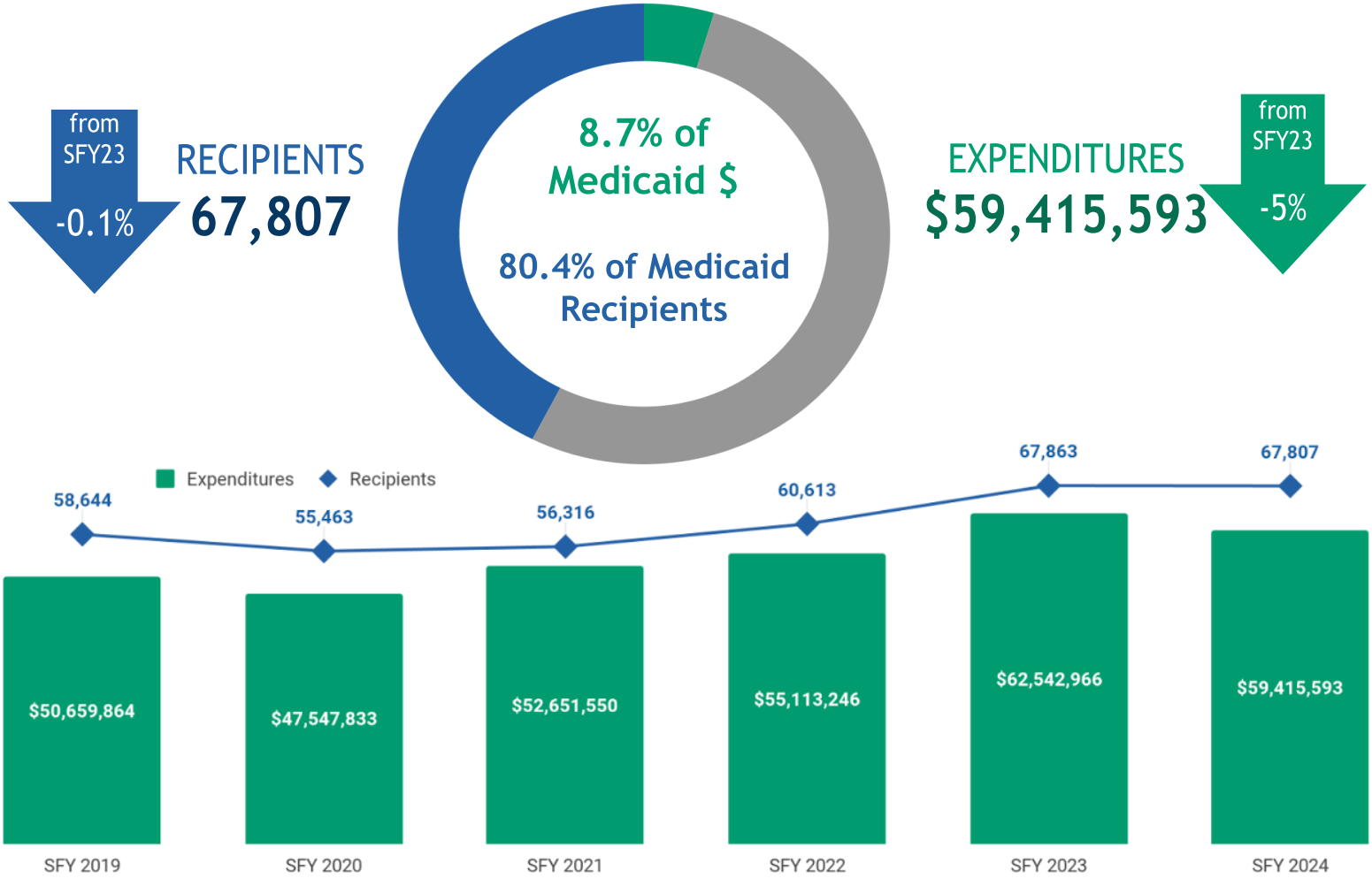


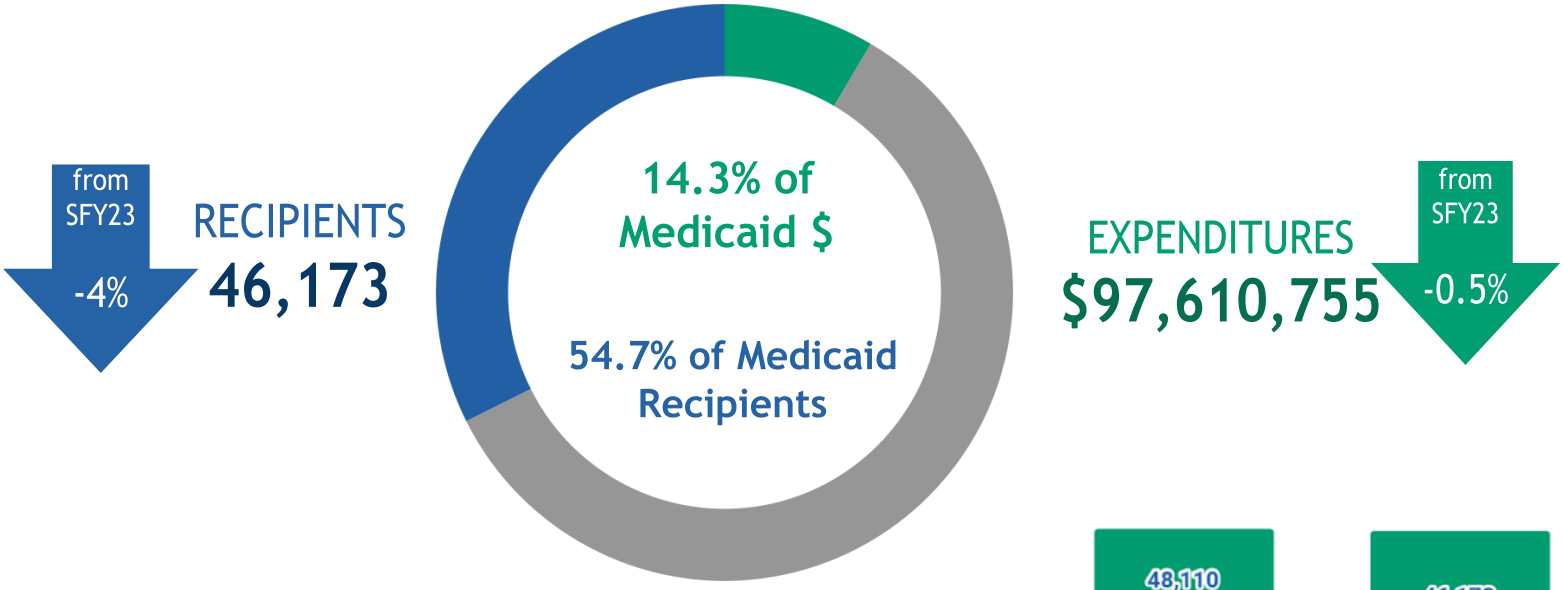
Table 33. Physician and Other Practitioner Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$50,659,864	$47,547,833	$52,651,550	$55,113,246	$62,542,966	$59,415,593	17.3
Recipients	58,644	55,463	56,316	60,613	67,863	67,807	15.6
Expenditures Per Recipient	$864	$857	$935	$909	$922	$876	1.4

Other Practitioners Include:	Resource-based Relative Value Scale
• Physical Therapists • Occupational Therapists • Speech-Language Pathologists • Podiatrists • Nurse Practitioners • Nurse Midwives • Nurse Anesthetists • Audiologists • Chiropractors	• 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 is required for all drugs for most individuals. Exceptions may apply for specific products or conditions.



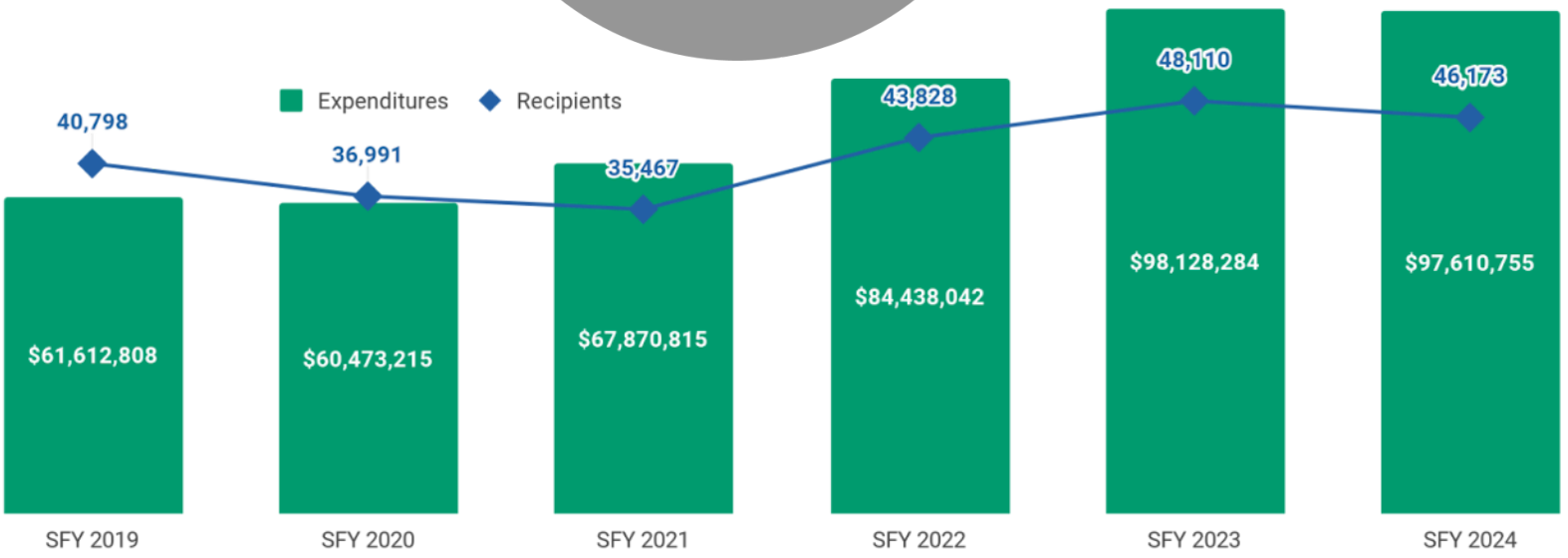


Table 34. Prescription Drugs Service Utilization History[17]

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$61,612,808	$60,473,215	$67,870,815	$84,438,042	$98,128,284	$97,610,755	58.4
Recipients	40,798	36,991	35,467	43,828	48,110	46,173	13.2
Expenditures Per Recipient	$1,510	$1,635	$1,914	$1,927	$2,040	$2,114	40.0

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

Table 35. Pharmacy Cost Avoidance ~ SFY 2024

Program Area	Cost Avoidance
Prior Authorization (PA) Preferred Drug List (PDL)	$14,059,808
% of Pharmacy Claims paid at State Maximum Allowable Cost Rate	67%
Program Integrity Cost Avoidance	n/a

140

Specific drug classes designated as preferred drugs in SFY 2024

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

DRUG REBATE PROGRAM

Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). Requires drug manufacturers have national rebate agreement with HHS Secretary. For a prescription drug to be covered, Medicaid must receive an OBRA rebate for it. This federal mandate provides Medicaid the opportunity to receive greatly discounted products, similar to those offered to large purchases in the marketplace. Medicaid is a member of the Sovereign States Drug Consortium (SSDC), a collaborative of state Medicaid programs that negotiate and acquire rebates from drug manufacturers, supplemental to the Medicaid Drug Rebate Program. Supplemental rebates augment the Medicaid Drug Rebate Program savings that the SSDC states realize because of OBRA.

Table 36. Prescription Drug - Rebates History[18]

Claim Paid Date SFY	Outpatient Drug Rebate (millions)
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
SFY 2023	$43.5
SFY 2024	$40.5

TOTAL DRUG REBATES

$4.8m + $40.5m = $45.3 million

of J-code rebates for physician-administered or injectable drugs

of outpatient drug rebates

[18] J code rebates are mandated by the Deficit Reduction Act of 2005.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

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.

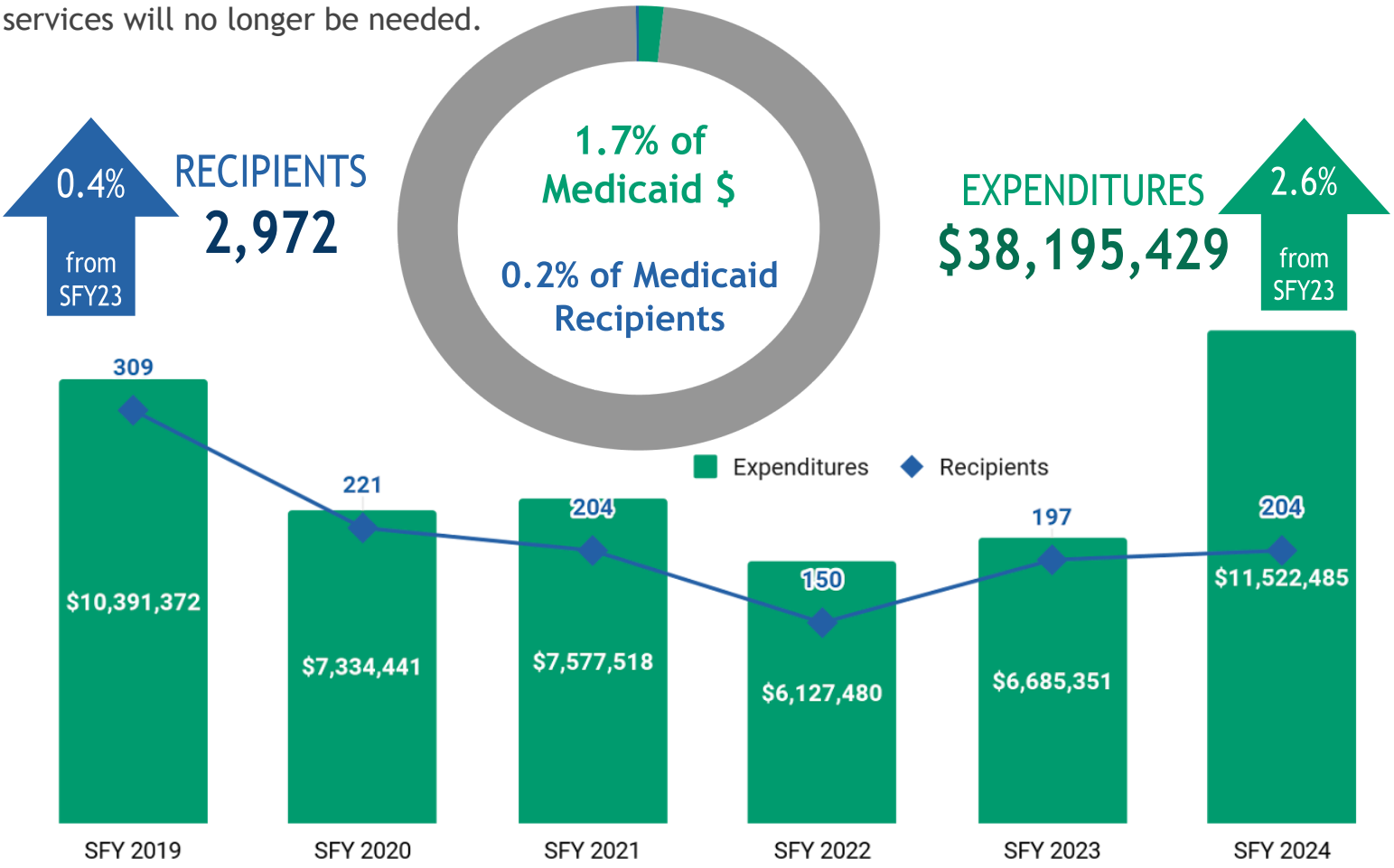


Table 37. PRTF Service Utilization History[19]

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$10,391,372	$7,334,441	$7,577,518	$6,127,480	$6,685,351	$11,522,485	10.9
Recipients	309	221	204	150	197	204	-34.0
Expenditures Per Recipient	$33,629	$33,188	$37,145	$40,850	$33,936	$56,483	68.0

[19] Most PRTF placements qualify for federal Medicaid match. However, 100% State General Funds (SGF) are used if a PRTF placement is determined to no longer meet medical necessity, after a clinical review and determination. A transition period of up to thirty 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 (Public Health Nurses) services are provided in a clinic designated by the Department of Health as a public health clinic.

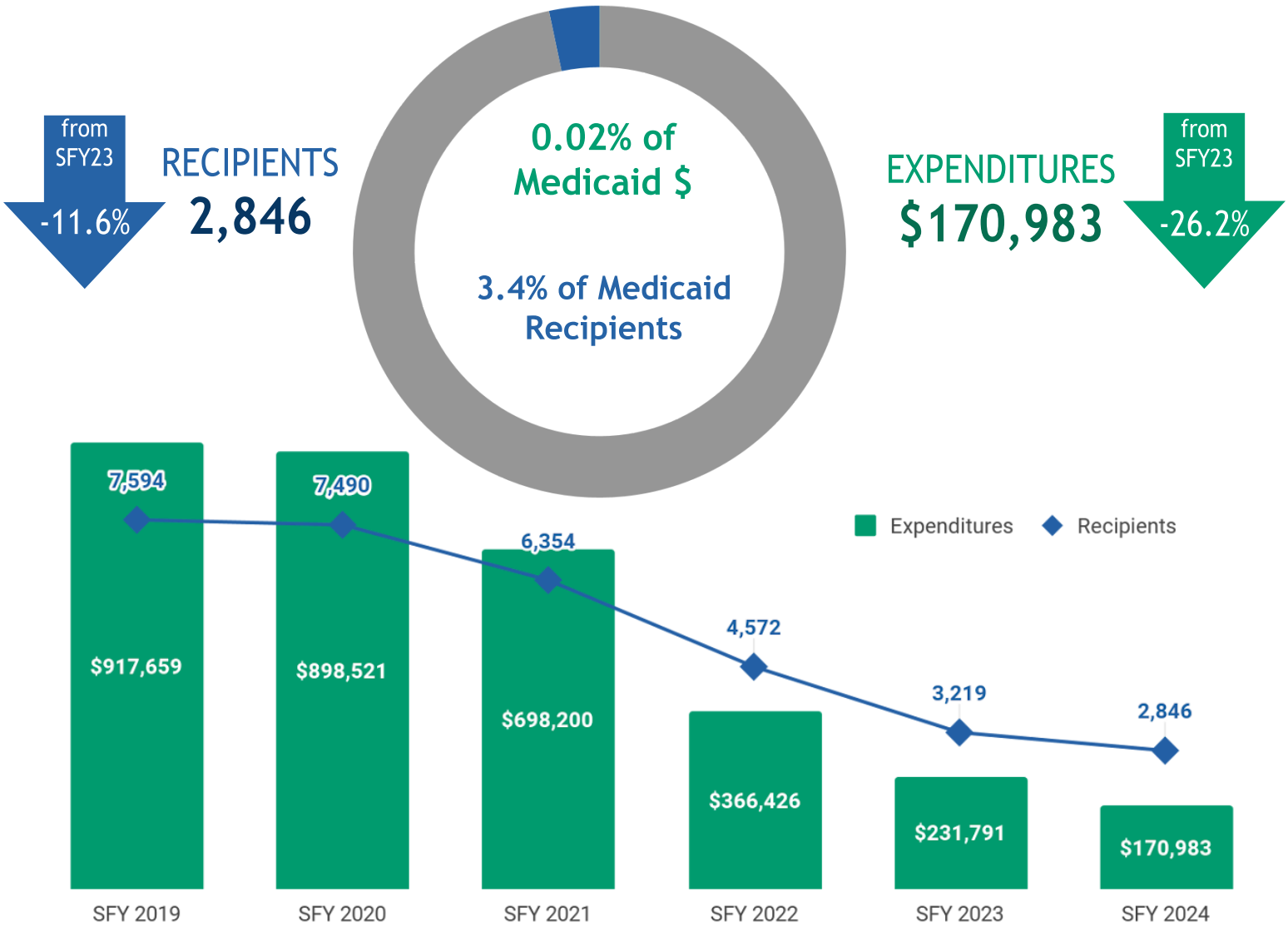


Table 38. Public Health or Welfare Service Utilization History[20]

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$917,659	$898,521	$698,200	$366,426	$231,791	$170,983	-81.4
Recipients	7,594	7,490	6,354	4,572	3,219	2,846	-62.5
Expenditures Per Recipient	$121	$120	$110	$80	$72	$60	-50.3

[20] LT-101 Level of Care Assessments shifted from a claim based process to an administrative (invoice) process in July of 2021, resulting in a decline of expenditures and recipients for subsequent state fiscal years.

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 those who are of the American Indian/Alaska Native Population. Services provided by these facilities are claimed by the state at 100% Federal Financial Participation (FFP).

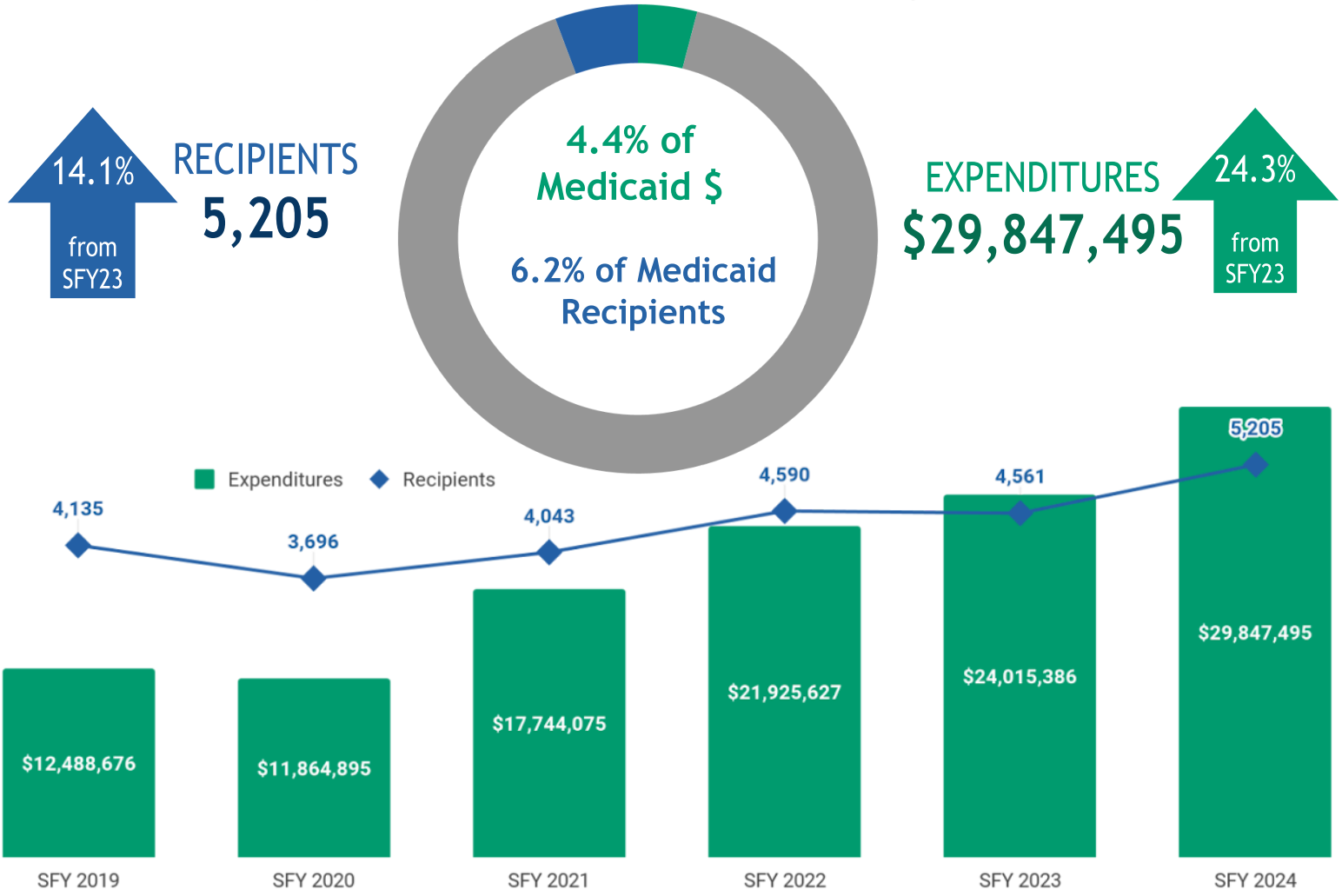


Table 39. Public Health Federal Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$12,488,676	$11,864,895	$17,744,075	$21,925,627	$24,015,386	$29,847,495	139.0
Recipients	4,135	3,696	4,043	4,590	4,561	5,205	25.9
Expenditures Per Recipient	$3,020	$3,210	$4,389	$4,777	$5,265	$5,734	89.9

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.

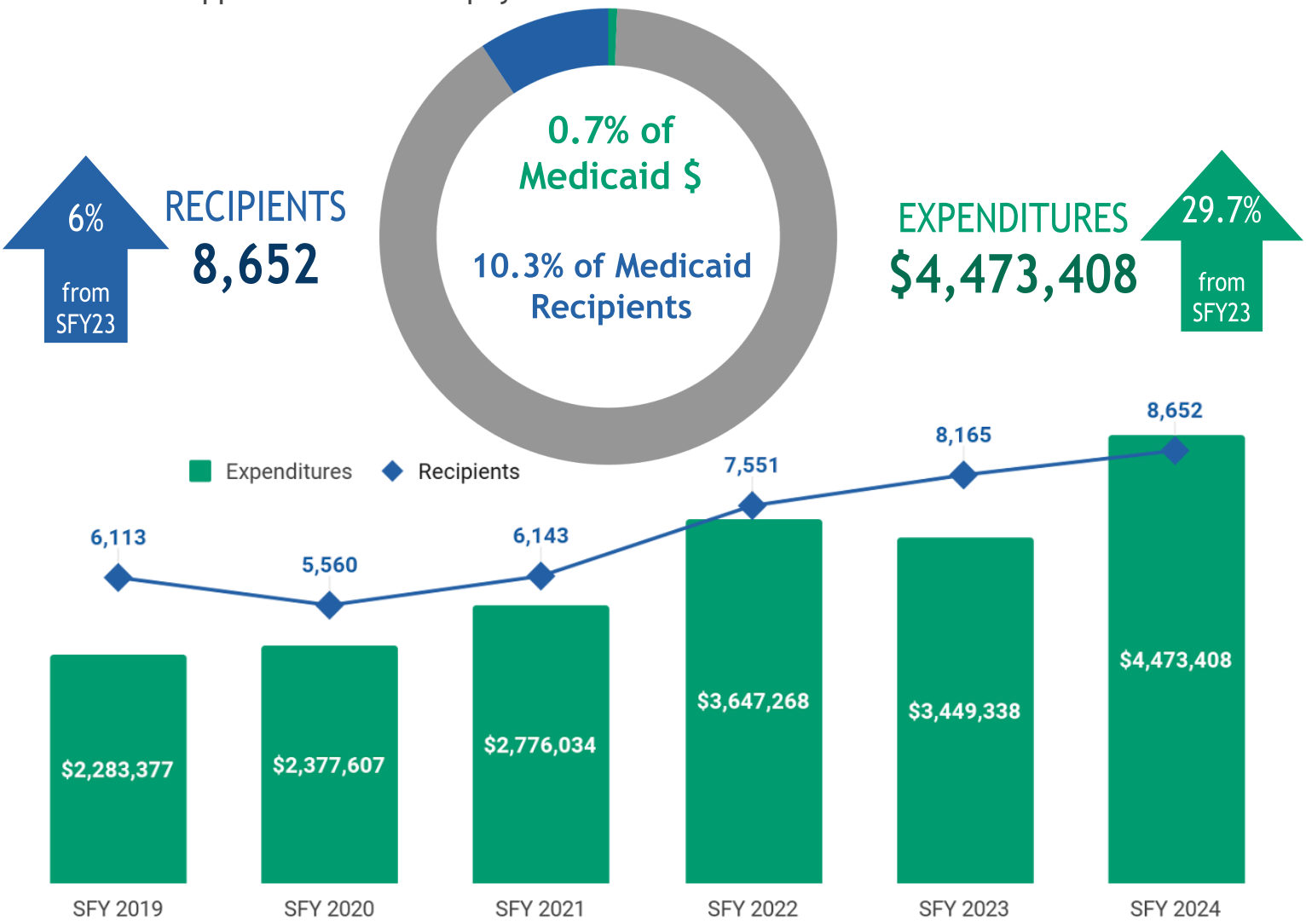


Table 40. Rural Health Clinic Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$2,283,377	$2,377,607	$2,776,034	$3,647,268	$3,449,338	$4,473,408	95.9
Recipients	6,113	5,560	6,143	7,551	8,165	8,652	41.5
Expenditures Per Recipient	$374	$428	$452	$483	$422	$517	38.4

VISION

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

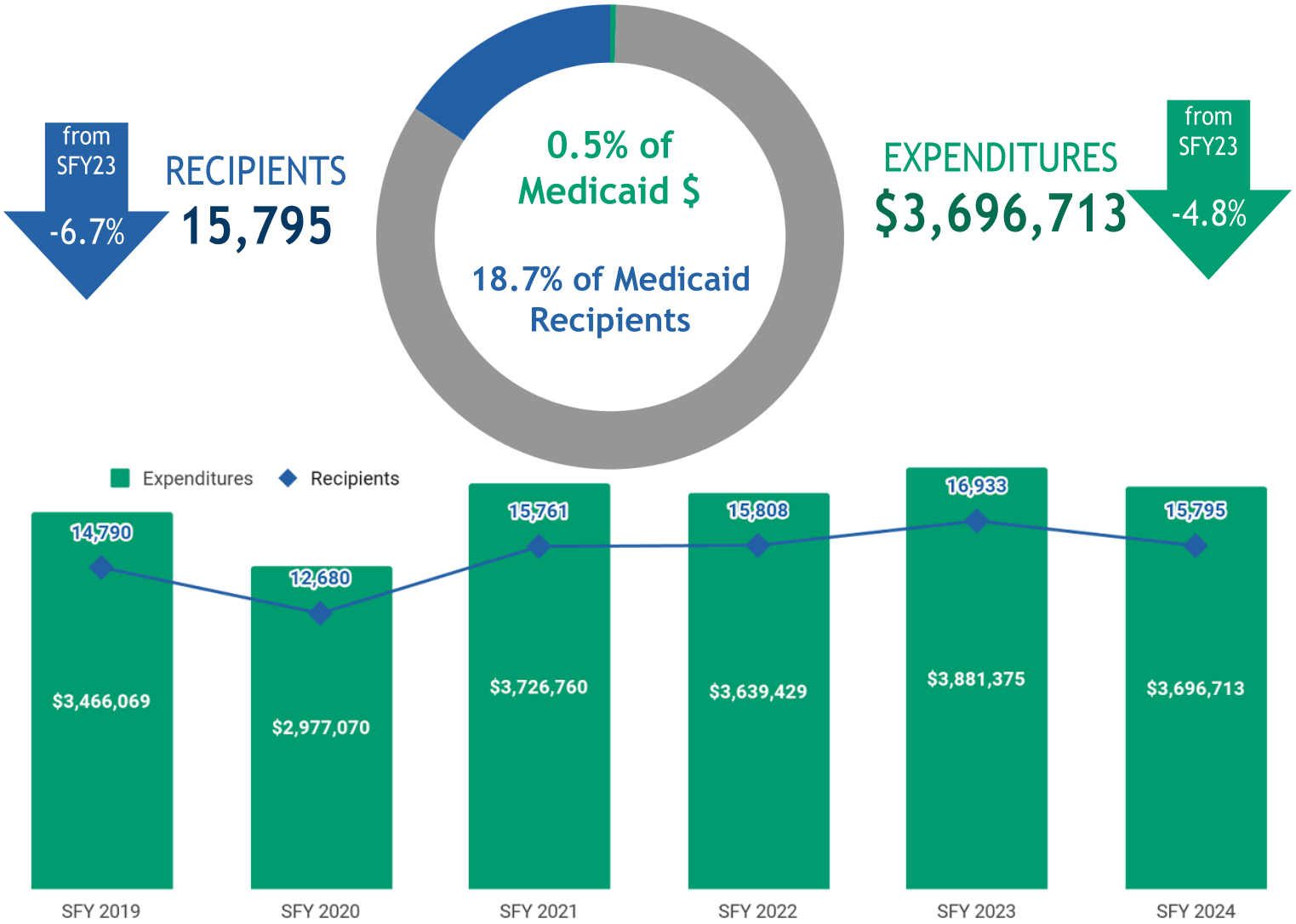
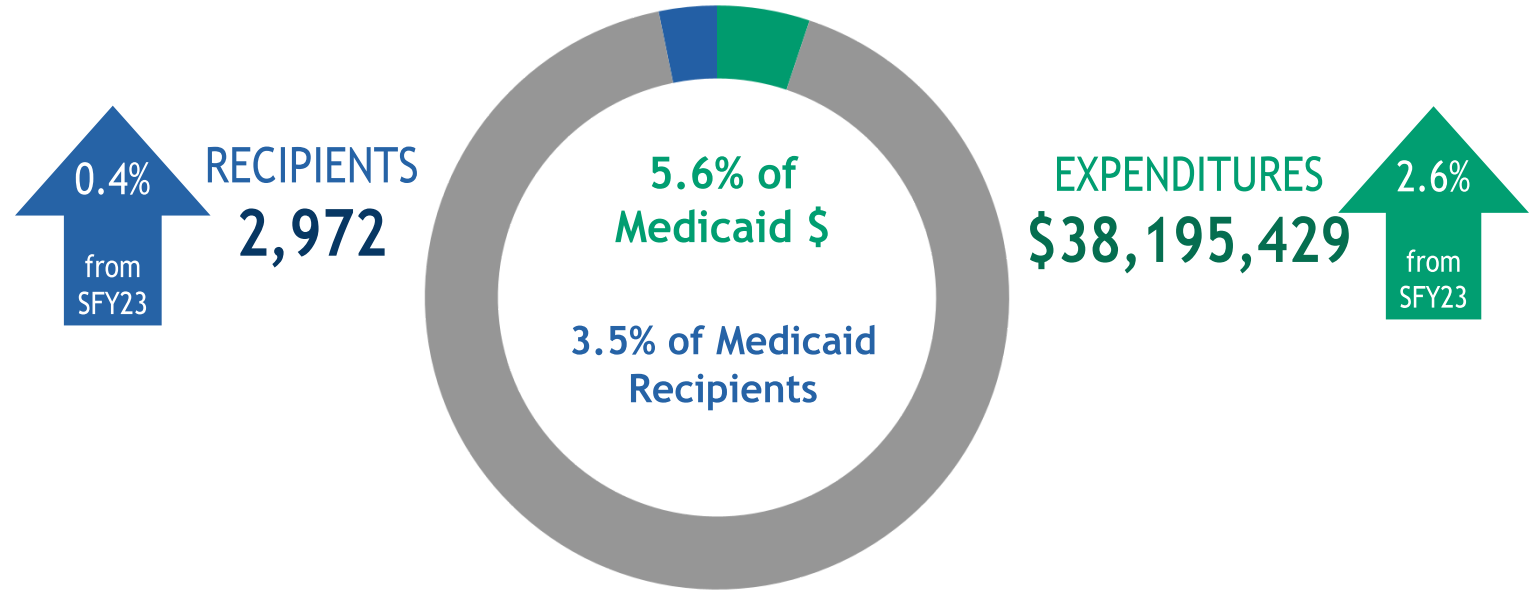


Table 41. Vision Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$3,466,069	$2,977,070	$3,726,760	$3,639,429	$3,881,375	$3,696,713	6.7
Recipients	14,790	12,680	15,761	15,808	16,933	15,795	6.8
Expenditures Per Recipient	$234	$235	$236	$230	$229	$234	-0.1

WAIVERS - COMMUNITY CHOICES

This waiver provides in-home services and assisted living services to Medicaid enrollees 19 - 64 years of age who are aged, blind, or disabled or 65 years of age or older and require services equivalent to nursing home level of care.



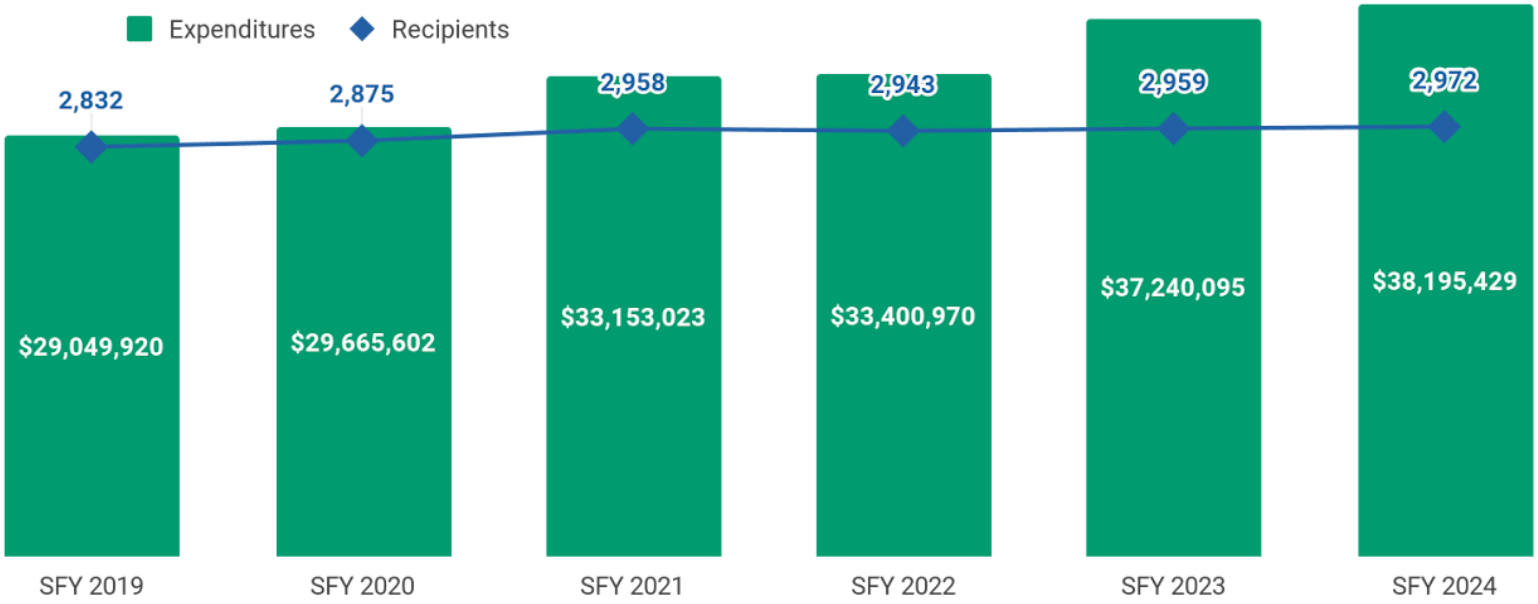


Table 42. Waivers - Community Service Center Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$29,049,920	$29,665,602	$33,153,023	$33,400,970	$37,240,095	$38,195,429	31.5
Recipients	2,832	2,875	2,958	2,943	2,959	2,972	4.9
Expenditures Per Recipient	$10,258	$10,318	$11,208	$11,349	$12,585	$12,852	25.3

WAIVERS - COMPREHENSIVE

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. The Comprehensive Waiver provides services to qualifying people of all ages who have an intellectual disability, or an acquired brain injury. However, individuals must meet additional emergency criteria to receive services under this waiver.

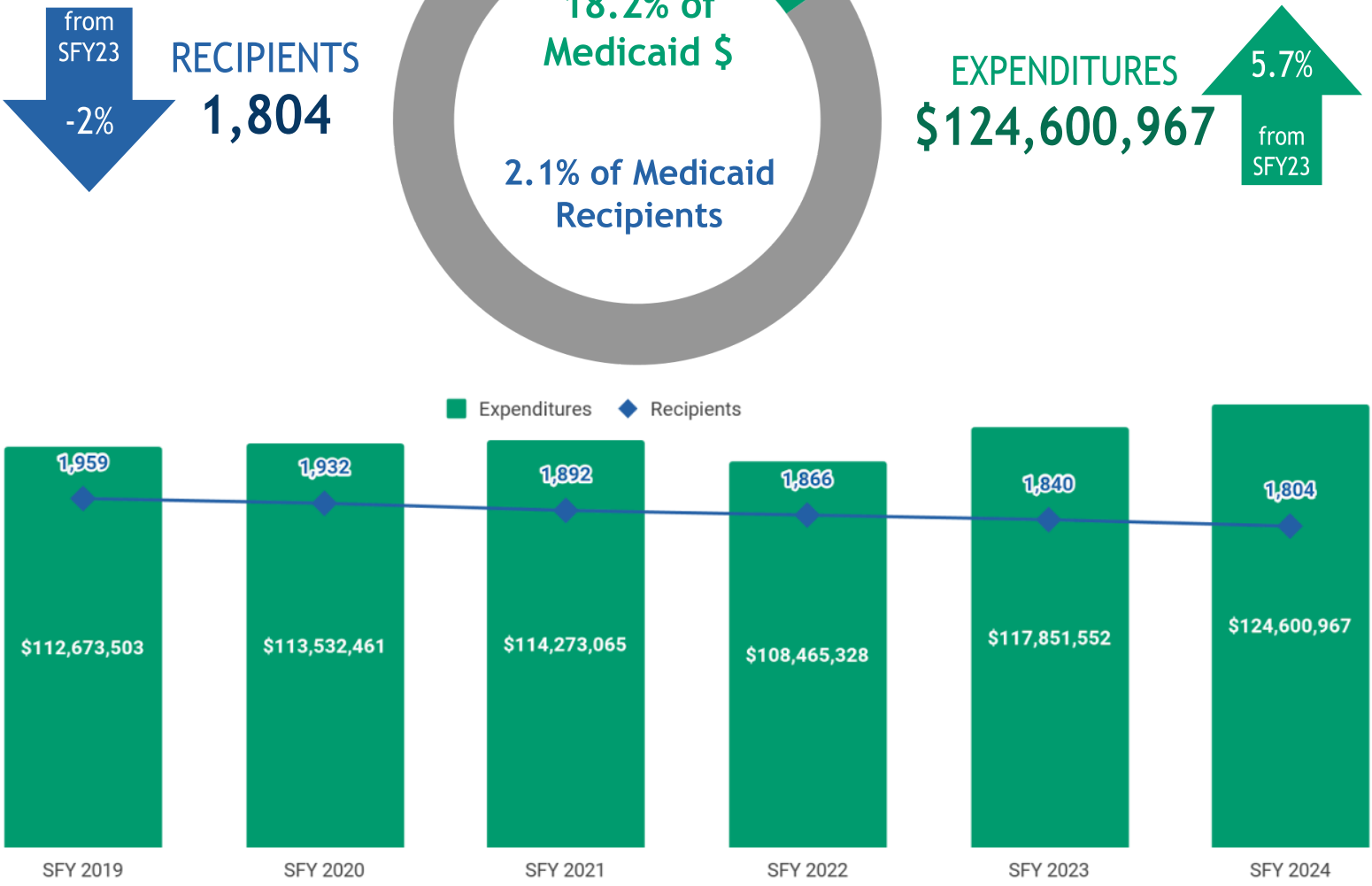


Table 43. Comprehensive Waivers Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$112,673,503	$113,532,461	$114,273,065	$108,465,328	$117,851,552	$124,600,967	10.6
Recipients	1,959	1,932	1,892	1,866	1,840	1,804	-7.9
Expenditures Per Recipient	$57,516	$58,764	$60,398	$58,127	$64,050	$69,069	20.1

WAIVERS - SUPPORT

The Supports Waiver helps people of all ages who have an intellectual disability or ages 21-64 with an acquired brain injury. It offers a limited budget for purchasing personalized services.

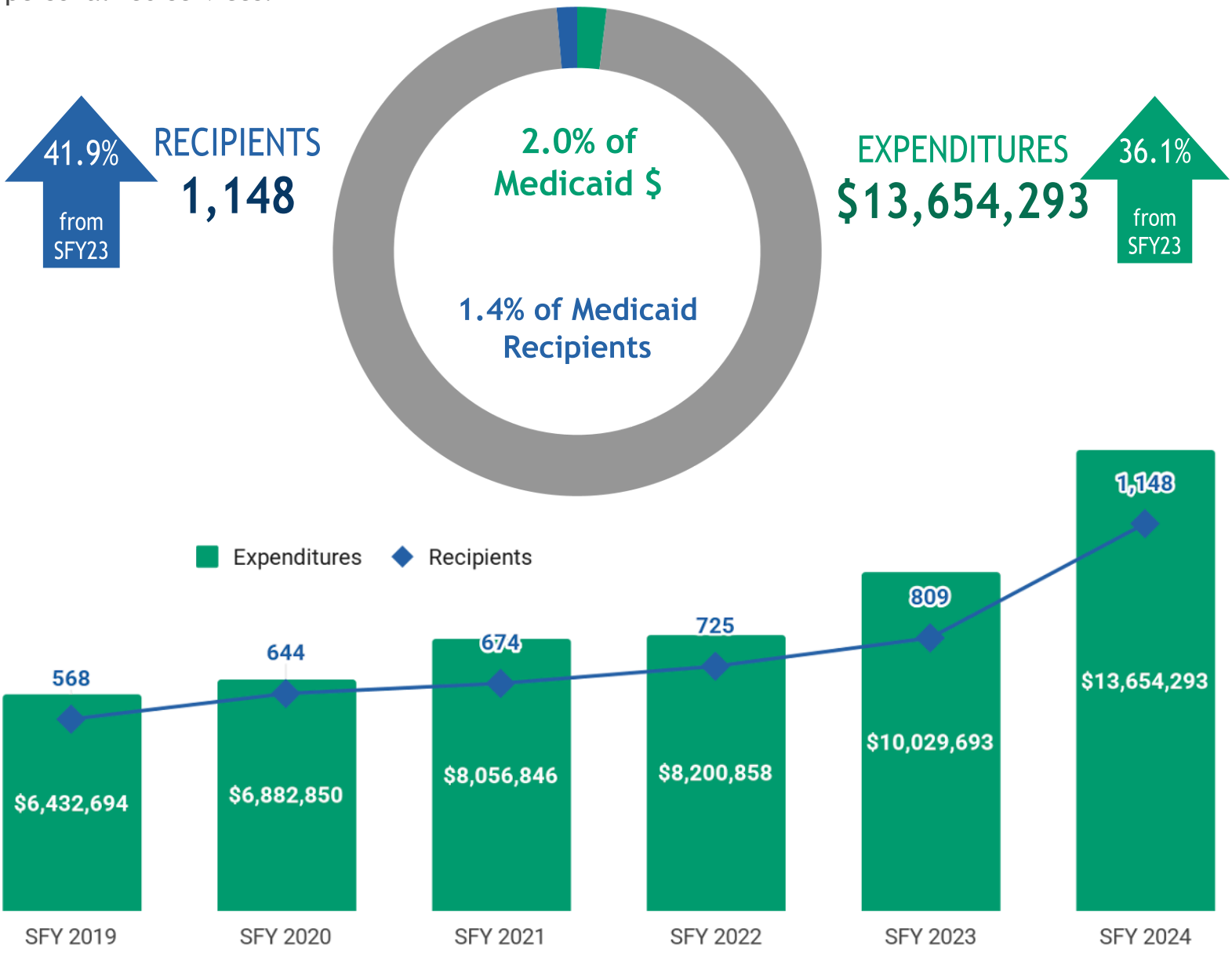


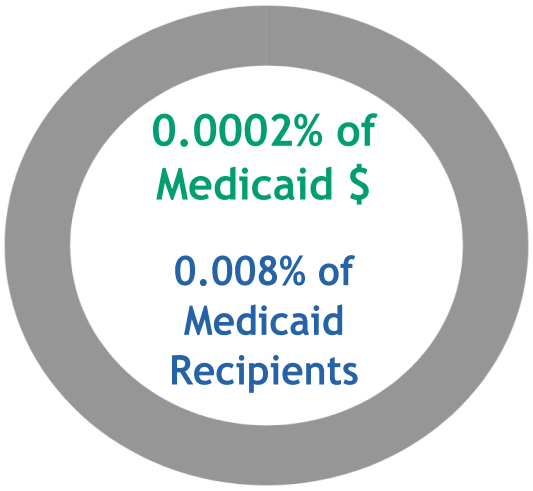
Table 44. Supports Waiver Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$6,432,694	$6,882,850	$8,056,846	$8,200,858	$10,029,693	$13,654,293	112.3
Recipients	568	644	674	725	809	1,148	102.1
Expenditures Per Recipient	$11,325	$10,688	$11,954	$11,312	$12,398	$11,894	5.0

WAIVERS - PREGNANT BY CHOICE

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 12 months postpartum.

Recipient Counts < 10 are redacted to protect the privacy of Wyoming Medicaid clients.



EXPENDITURES
$1,053
from SFY23
-38%

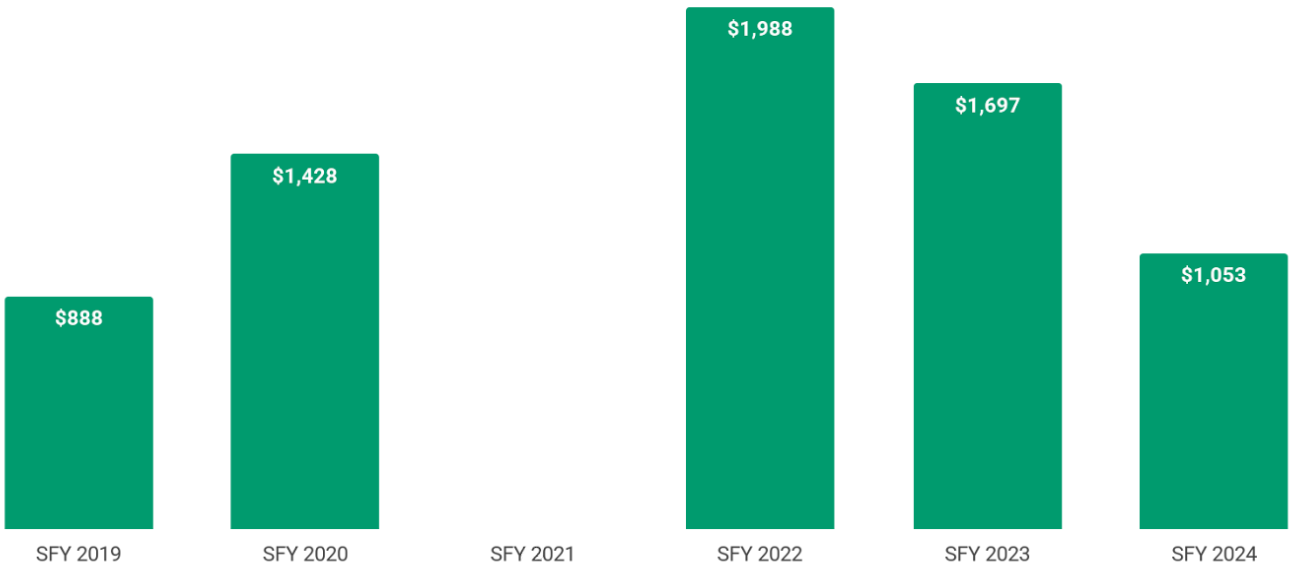


Table 45. Family Planning Waiver Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures[21]	$888	$1,428	$0	$1,988	$1,697	$1,053	18.6
Recipients	< 10	< 10	< 10	< 10	< 10	< 10	--

[21] 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.

SUBPROGRAMS & SPECIAL POPULATIONS

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 (WYFI) INFORMATION 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 46. WYFI HealthStat Outcomes

Outcomes	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Facilities - Data Contributing	54	92	189	217	227	284
Facilities - View Only	15	100	157	165	123	133
Unique Providers	27	386	3,556	3,551	3,486	244
Total WYFI Users	170	939	5,446	5,552	5,555	739
WY Covered Lives in the HIE	N/A[22]	210,576	357,359	452,915	556,602	643,107
All Covered Lives in the HIE	N/A	311,198	402,304	550,651	678,739	777,566
Medicaid Covered Lives in the HIE	N/A	N/A	34,171	43,145	62,013	72,325
# of Patient Encounters in the HIE	N/A	2,485,938	3,668,561	5,525,435	7,927,907	10,712,507
Notify Users - ADTs (Alert, Discharge, Transfer Notifications)	0	8	62	63	69	43

[22] N/A - reporting tool was not yet available until SFY 2019, no data as the program did not start until late SFY 2018, or that the data was not tracked prior to SFY 2019.

ADMINISTRATIVE TRANSPORTATION

Medicaid covers the cost of transportation to and from medical appointments if the appointment is medically necessary, it is approved by WDH 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[23].

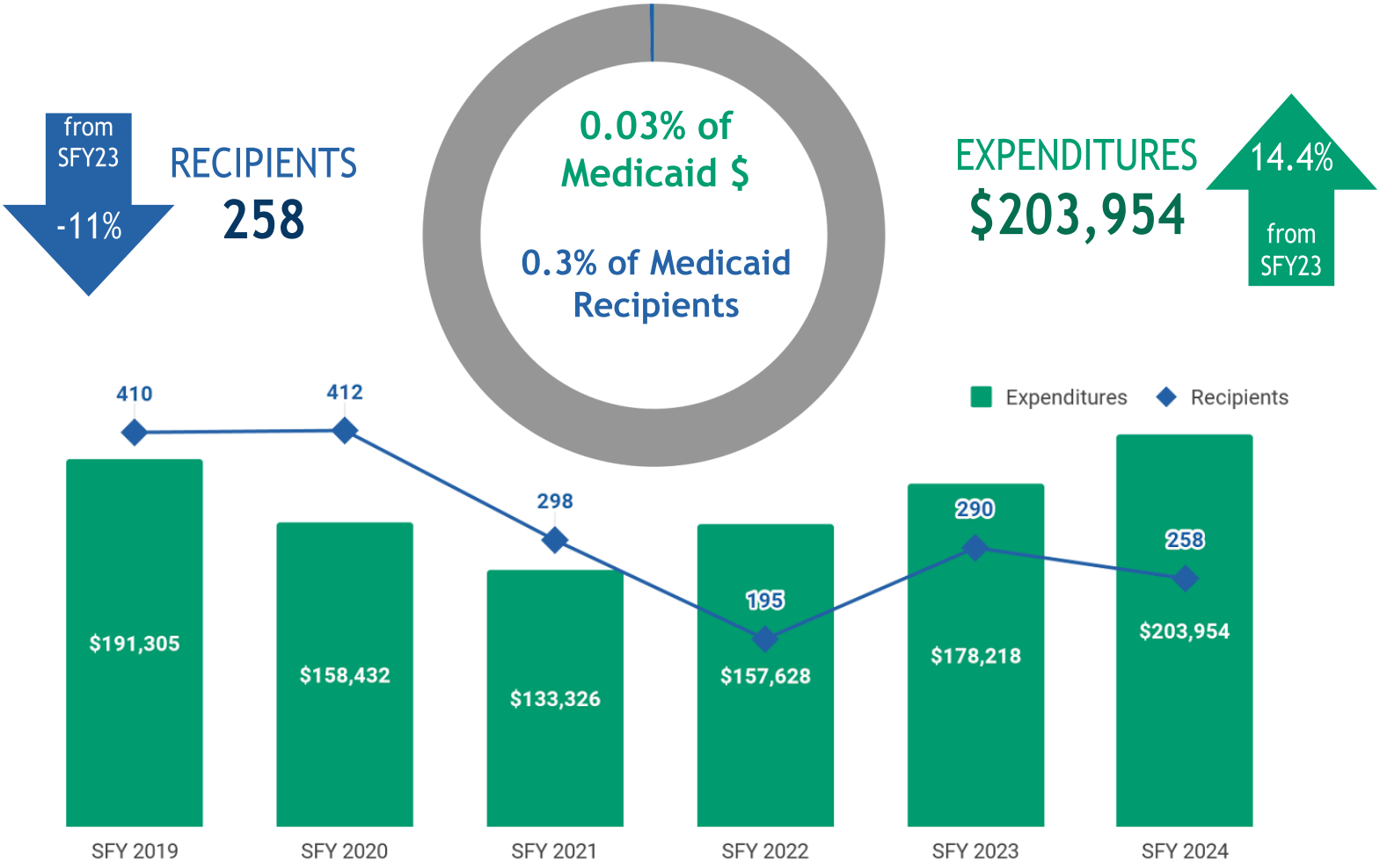


Table 47. Administrative Transportation Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	191,304.78	158,432.34	133,326	157,627.77	178,217.62	203,954.29	6.6
Recipients	410	412	298	195	290	258	-37.1
Expenditures Per Recipient	$467	$385	$447	$808	$615	$791	69.4

[23] Additional details for other scenarios are available at https://www.wyomingmedicaid.com/portal/Travel_Assistance_Manual.

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.

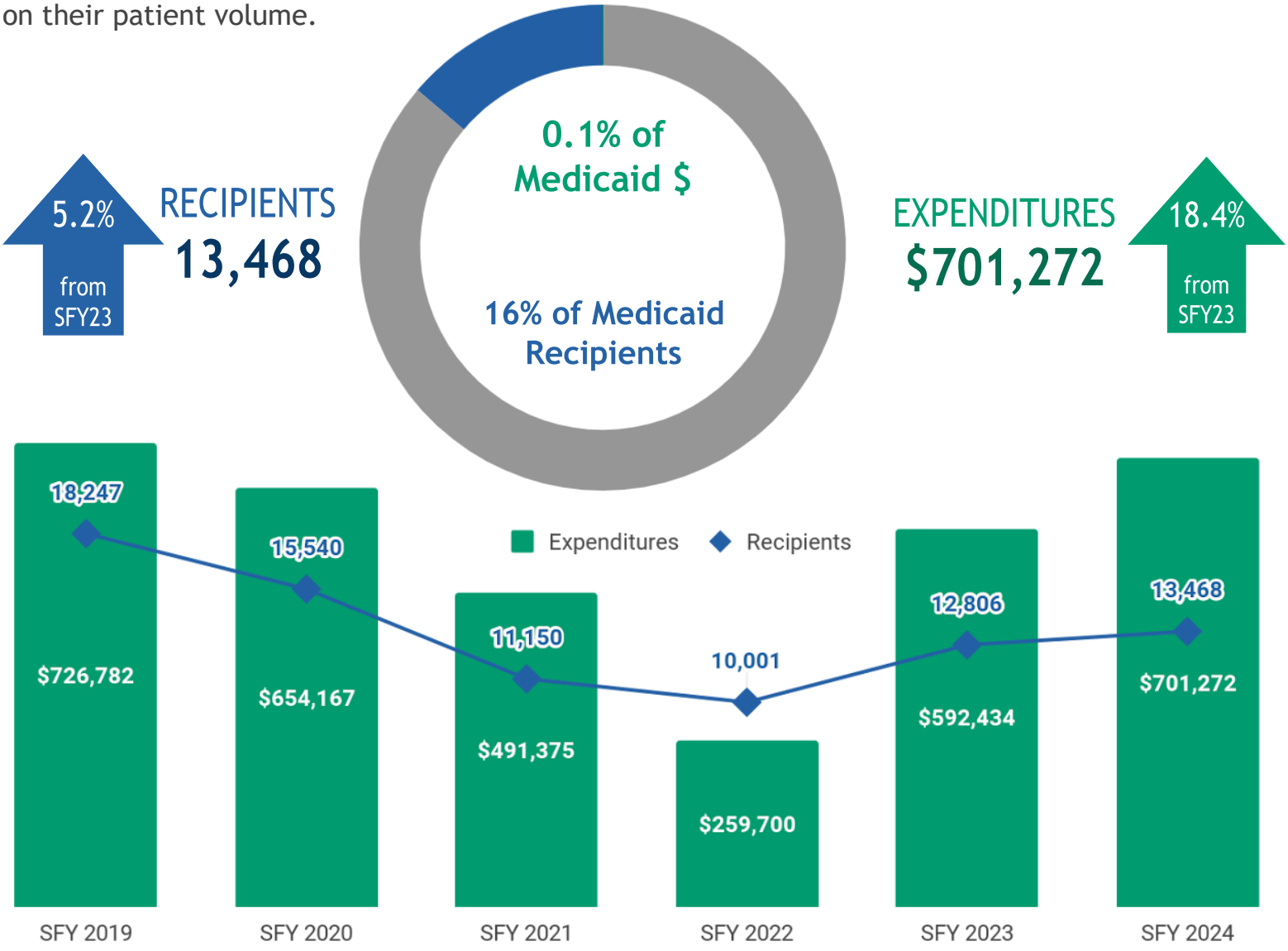


Table 48. PCMH Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Expenditures	$726,782	$654,167	$491,375	$259,700	$592,434	$701,272	-3.5
Recipients	18,247	15,540	11,150	10,001	12,806	13,468	-26.2
Expenditures Per Recipient	$40	$42	$44	$26	$46	$52	30.7

WELL CHILD CHECKS (WCC)

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

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

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

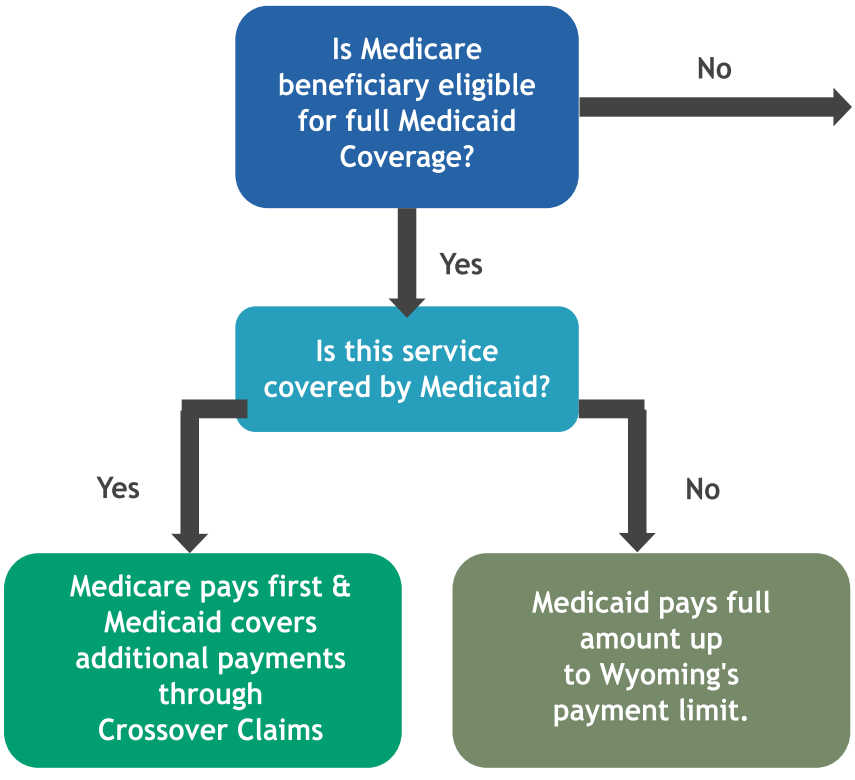
Table 49. FFY 2024 Wyoming Medicaid and CHIP Medical and Dental Periodicity Schedules based on Bright Futures[24]

	Age Group < 1	Age Group 1 - 2	Age Group 3 - 5	Age Group 6 - 9	Age Group 10 - 14	Age Group 15 - 18	Age Group 19 - 20
Number of Years in Age Range	1	2	3	4	5	4	2
Medical State Periodicity Schedule (Prevenative)	7	5	3	4	5	4	2
Dental State Periodicity Scheduled (Prevenative, 2 per year)	1	4	6	8	10	8	4

[24] Bright Futures, Release 4 periodicity schedule: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

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 when appropriate. 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.



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

Qualified Medicare Beneficiaries (QMB)

Provides assistance with Medicare premiums, deductibles, and coinsurance. For individuals with:

- Resources not exceeding 3 times the SSI resource limit
- adjusted annually by the increase in the consumer price index
- Income less than or equal to 100% FPL

Specified Low-Income Medicare Beneficiaries (SLMB)

Provides assistance with Medicare Part B premiums. For individuals with:

- Resources not exceeding 3 times the SSI resource limit
- adjusted annually by the increase in the consumer price index
- Income between 100% and 120% FPL

Qualified Individuals (QI)

Provides assistance with Medicare Part B premiums. For individuals with:

- Resources not exceeding 3 times the SSI resource limit adjusted annually by the increase in the consumer price index
- Income between 121% and 135% FPL
- Premiums for these individuals are paid with 100% federal funds

Table 50. Dual Enrolled Members and Crossover Service Utilization History

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Dual Enrolled Members	12,578	12,680	12,980	13,453	13,650	14,195	12.9
Expenditures	$194,737,467	$204,580,744	$200,239,398	$190,577,836	$206,128,562	$227,077,318	16.6
Recipients (unduplicated)	10,451	10,517	10,421	10,345	11,080	11,103	6.2
Expenditures per Recipient	$18,633	$19,452	$19,215	$18,422	$18,604	$20,452	9.8
Crossover Claim Expenditures	$7,145,856	$7,236,322	$6,822,316	$7,264,063	$9,242,035	$8,888,748	24.4
Crossover Claims - Expenditures as a % of Total Dual Expenditures	3.7%	3.5%	3.4%	3.8%	4.5%	3.9%	6.7

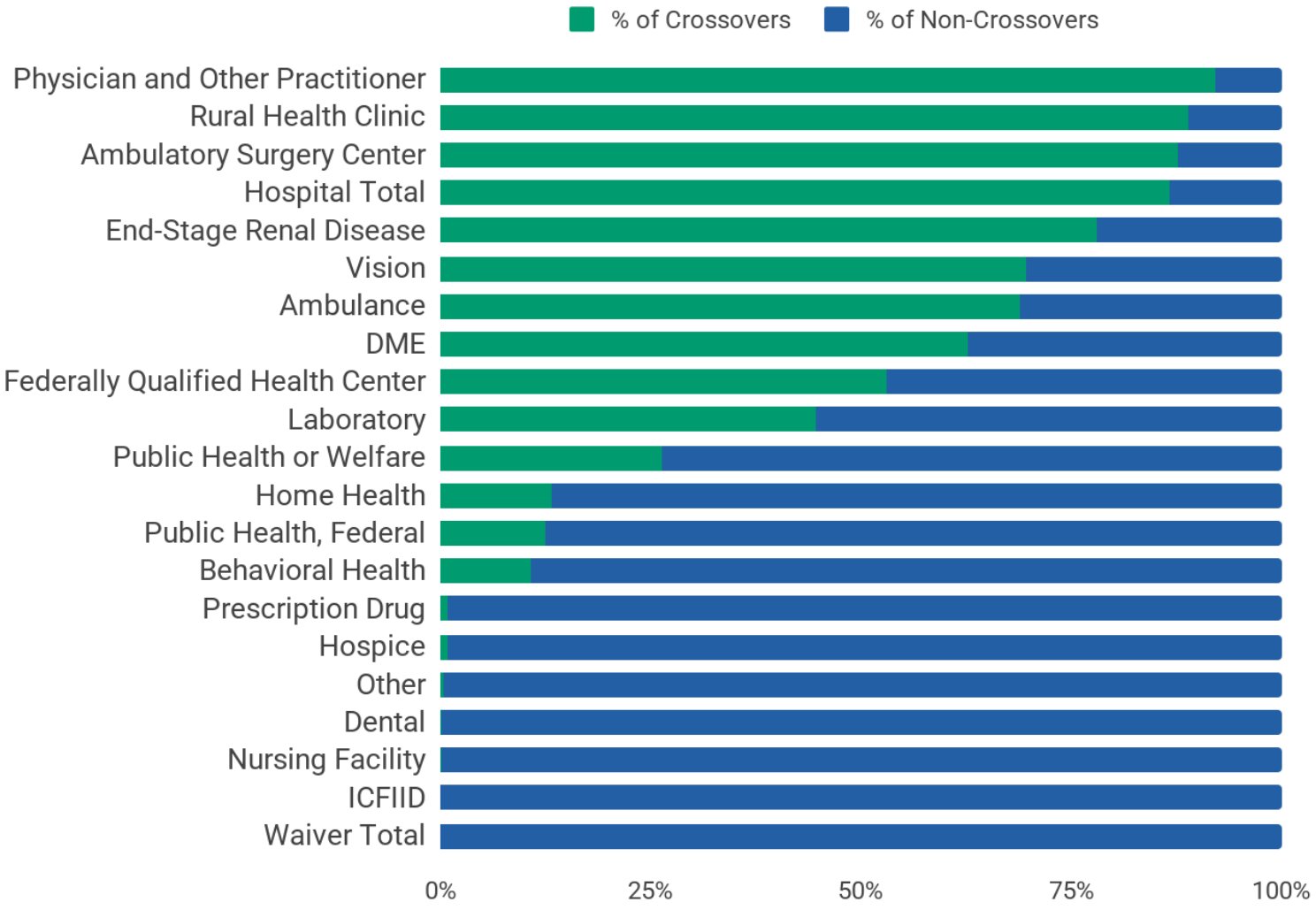


Figure 31. Crossover Expenditures as Percent of Dual Expenditures by Service Area for SFY 2024

Table 51. Dual Enrolled Member Service Utilization History[25]

Service Area	Total Dual Enrolled			Crossovers		
	Expenditures	Recipients	Expenditures per Recipient	Expenditures	Recipients	Expenditures per Recipient
Ambulance	$49,674	1,380	$36	$34,225	1,362	$25
Ambulatory Surgery Center	$169,614	853	$199	$148,616	836	$178
Behavioral Health	$1,392,226	1,849	$753	$149,821	1,268	$118
Dental	$527,076	1,715	$307	$193	2	$96
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	$3,277,441	3,680	$891	$2,051,099	3,331	$616
End-Stage Renal Disease	$277,651	102	$2,722	$216,613	99	$2,188
Federally Qualified Health Center	$193,471	1,103	$175	$102,699	1,012	$101
Home Health	$60,561	124	$488	$8,046	107	$75
Hospice	$994,192	111	$8,957	$9,021	65	$139
Hospital - Inpatient	$1,076,781	1,617	$666	$823,228	1,596	$516
Hospital - Outpatient	$1,892,213	7,904	$239	$1,750,265	7,802	$224
Hospital - Other	$17,802	347	$51	$17,916	346	$52
Hospital Total	$2,986,795	9,868	$303	$2,591,409	9,744	$266
Intermediate Care Facility for Individuals with Intellectual Disabilities	$11,931,889	23	$518,778	--	--	--
Laboratory	$12,671	1,268	$10	$5,651	1,240	$5
Nursing Facility	$79,931,903	1,717	$46,553	$22,328	898	$25
Other	$8,179,865	882	$9,274	$38,930	304	$128
Physician and Other Practitioner	$3,580,663	9,015	$397	$3,301,693	8,878	$372
Prescription Drug	$1,632,379	1,627	$1,003	$15,051	190	$79
Public Health or Welfare	$2,284	218	$10	$604	141	$4
Public Health, Federal	$120,117	252	$477	$15,128	222	$68
Rural Health Clinic	$121,916	1,262	$97	$108,310	1,251	$87
Vision	$99,607	1,718	$58	$69,315	1,447	$48
Waiver-Community Choices	$23,693,434	2,415	$9,811	--	--	--
Waiver-Comprehensive	$83,417,729	1,120	$74,480	--	--	--
Waiver-Supports	$4,424,160	293	$15,100	--	--	--
Total	**$227,077,318**	**11,103**	**$20,452**	**$8,888,748**	**10,381**	**$856**

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

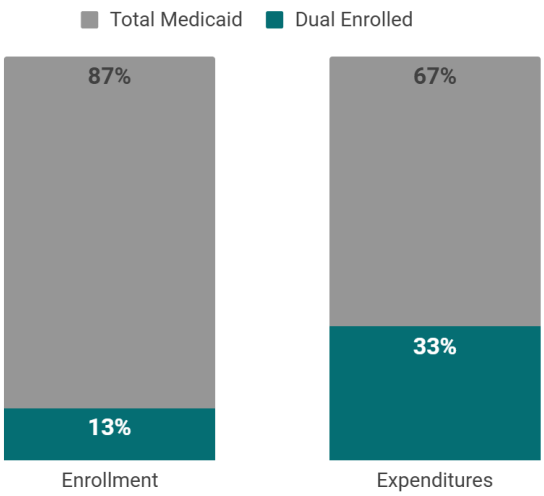


Figure 32. Dual Enrolled as Percent of Total Medicaid in SFY 2024

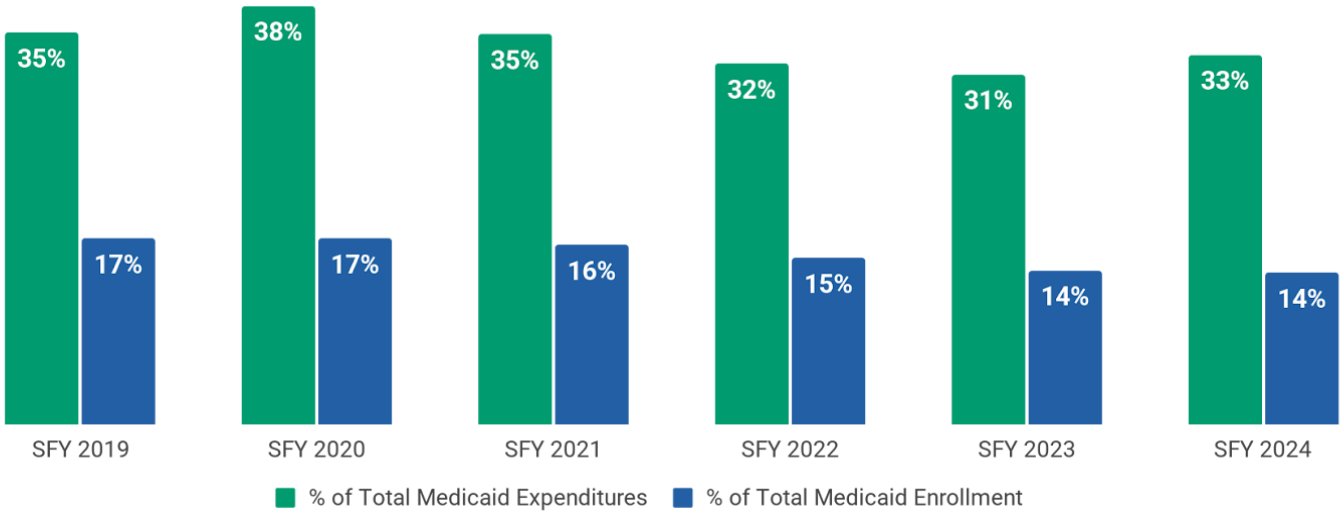


Figure 33. History of Dual Enrollment and Expenditures as Percent of Total Medicaid

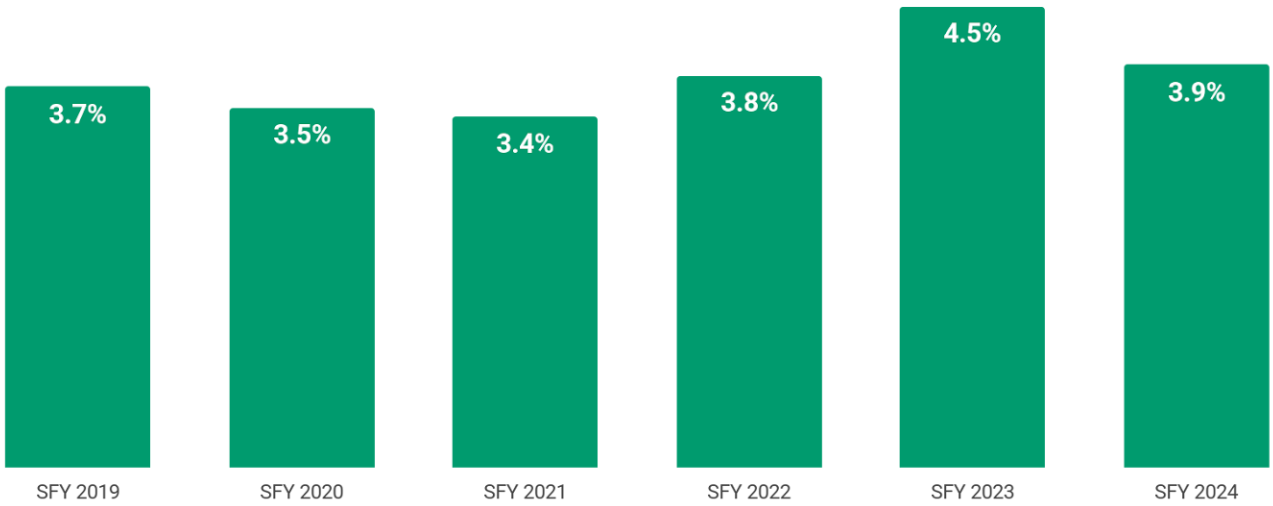


Figure 34. SFY 2024 Percentage of Crossover Claims of Total Dual Expenditures

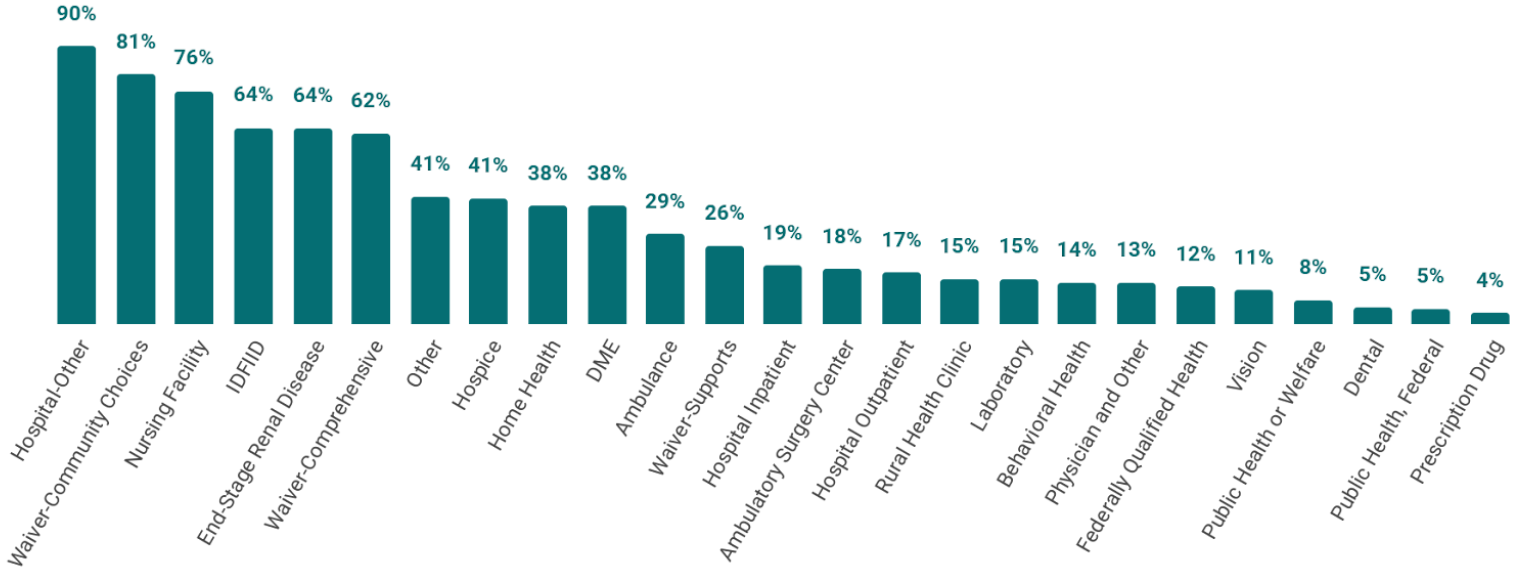


Figure 35. SFY 2024 Percent of Total Unduplicated Dual Recipients by Service

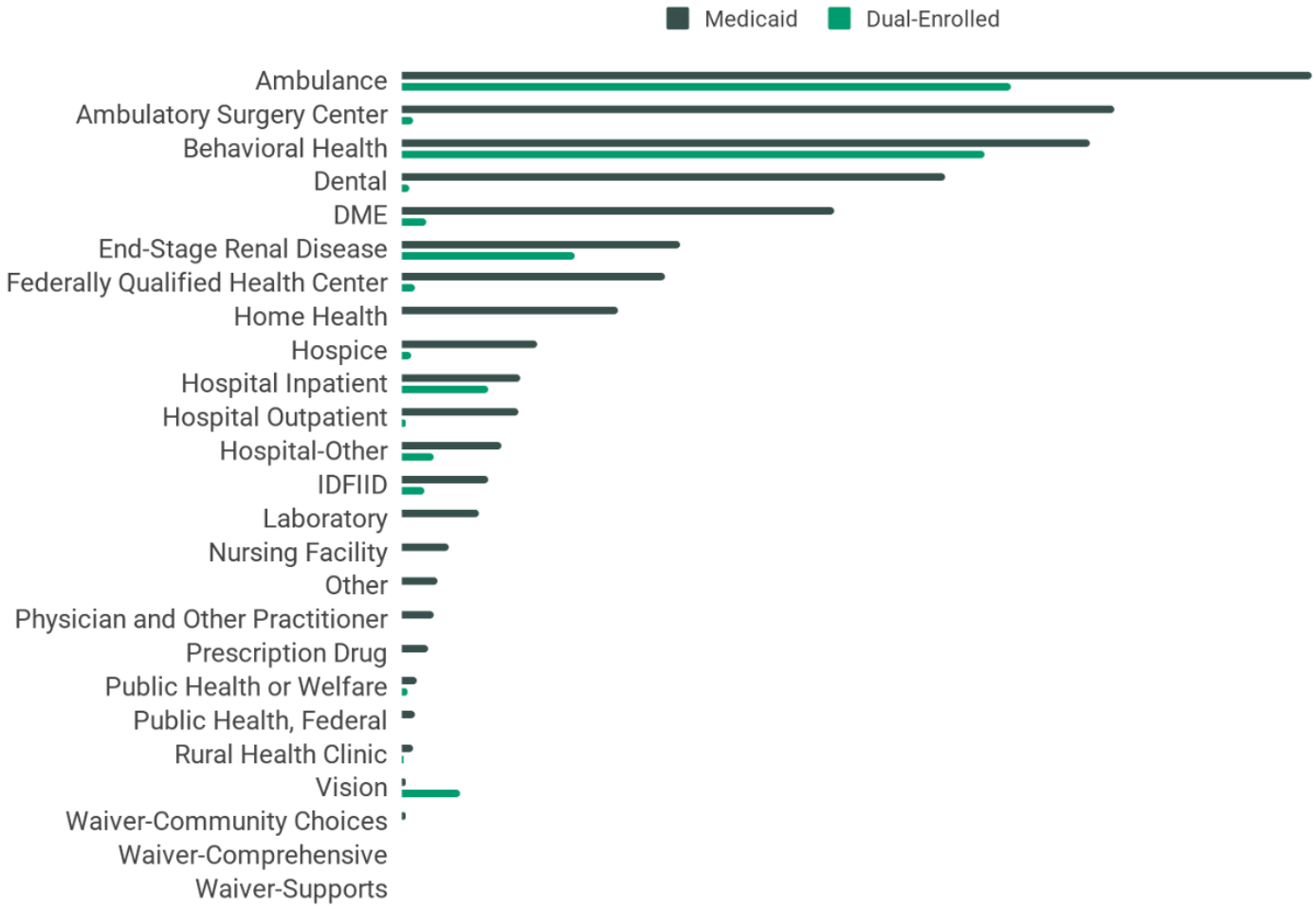


Figure 36. Dual Expenditures as Percent of Total Medicaid Expenditures by Service

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 at the Boys' or Girls' School operated by the Department of Family Services.

240
Children Enrolled

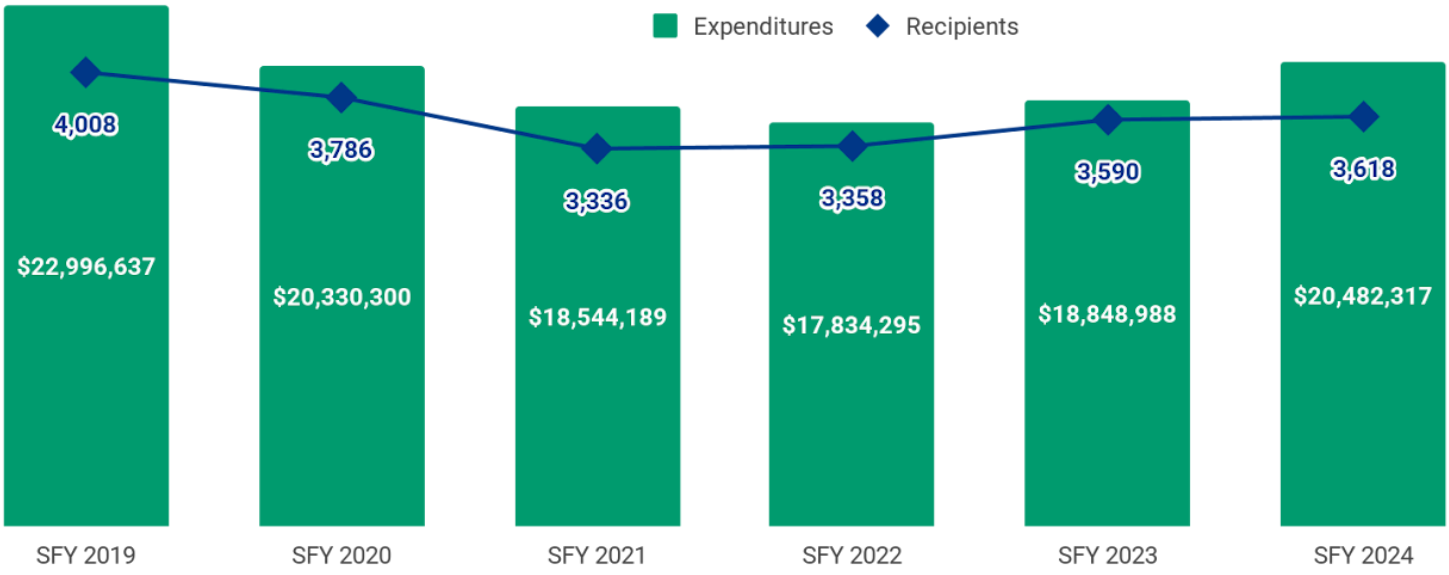
$1,312,665
In Claim Expenditures

0.8% from SFY23

RECIPIENTS
3,618

EXPENDITURES
$20,482,317

8% from SFY23



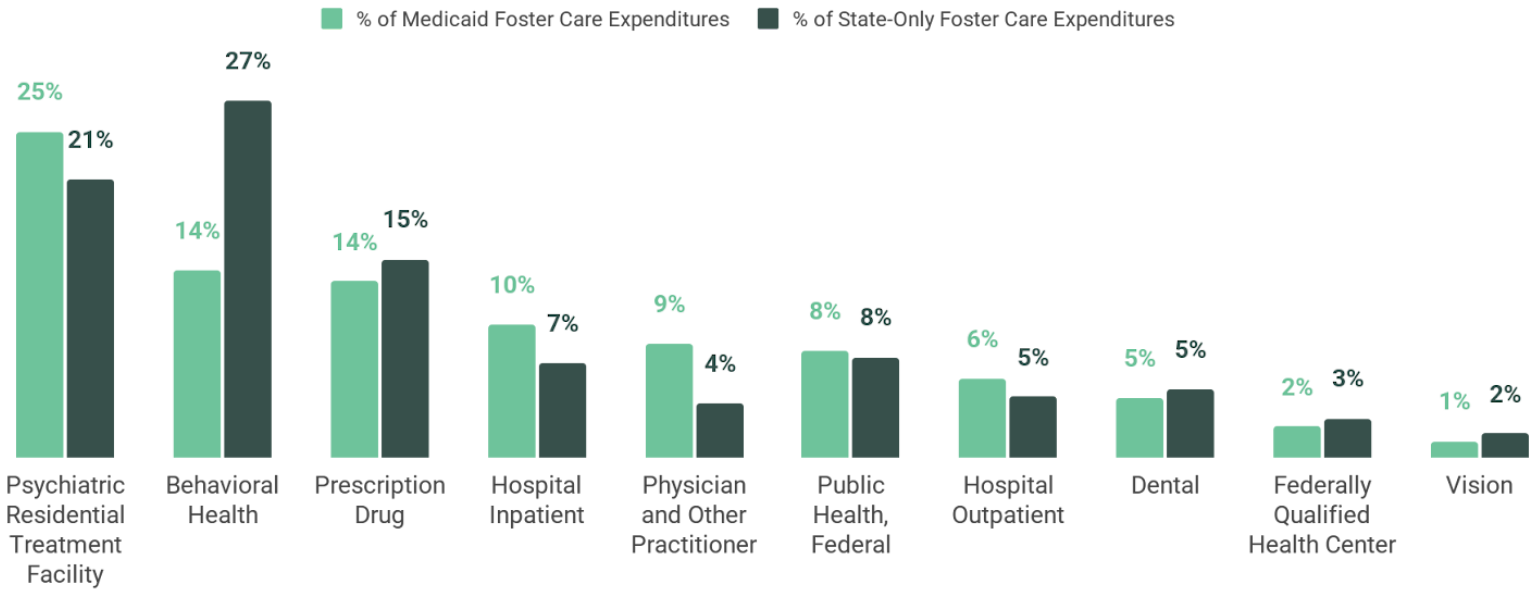


Figure 37. Percent of Foster Care Expenditures by Service ~ Medicaid vs. State-Only

Table 52. Foster Care Service Utilization History[26]

Claim Paid Date SFY	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	5 Year % Change
Medicaid Foster Care							
Enrolled Members	2,975	2,910	2,954	3,477	3,739	3,730	25.4
Expenditures	$21,259,813	$19,115,700	$17,599,763	$16,902,823	$17,826,034	$19,169,652	-9.8
Recipients	3,802	3,621	3,197	3,210	3,432	3,470	-8.7
Expenditures per Recipient	$5,592	$5,279	$5,505	$5,266	$5,194	$5,524	-1.2
State-Only Foster Care							
Enrolled Members	204	154	158	200	245	240	17.6
Expenditures	$1,736,824	$1,214,600	$944,427	$931,472	$1,022,954	$1,312,665	-24.4
Recipients	322	256	205	205	240	256	-20.5
Expenditures per Recipient	$5,394	$4,745	$4,607	$4,544	$4,262	$5,128	-4.9

[26] 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 53. Foster Care Summary by Services - Medicaid vs. State-Only

Service Area	Medicaid Foster Care			State-Only Foster Care		
	Expenditures	Recipients	Expenditures per Recipients	Expenditures	Recipients	Expenditures per Recipients
Ambulance	$219,808	146	$1,506	$10,463	10	$1,046
Ambulatory Surgery Center	$224,052	131	$1,710	$0	< 10[27]	--
Behavioral Health	$2,762,911	1,362	$2,029	$359,400	180	$1,997
Clinic/Center	$88,994	123	$724	--	--	--
Dental	$888,354	1,673	$531	$69,697	102	$683
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	$223,432	191	$1,170	$4,480	< 10	--
Federally Qualified Health Center	$466,206	427	$1,092	$40,211	65	$619
Hospice	$3,795	< 10	--	--	--	--
Hospital Inpatient	$1,961,971	225	$8,720	$95,928	14	$6,852
Hospital Outpatient	$1,169,439	1,561	$749	$61,458	128	$480
Laboratory	$44,090	233	$189	$1,997	< 10	--
Nursing Facility	$0	< 10	--	--	--	--
Other	$36,331	141	$258	$1,119	13	$86
Physician and Other Practitioner	$1,681,097	2,540	$662	$55,500	136	$408
Prescription Drug	$2,596,066	2,048	$1,268	$200,170	151	$1,326
Psychiatric Residential Treatment Facility	$4,795,254	78	$61,478	$280,173	< 10	--
Public Health or Welfare	$6,012	147	$41	$1,020	27	$38
Public Health, Federal	$1,572,321	312	$5,039	$101,428	14	$7,245
Rural Health Clinic	$175,985	378	$466	$4,711	< 10	--
Vision	$253,533	1,026	$247	$24,908	97	$257
Total	**$19,169,652**	**3,470**	**$5,524**	**$1,312,665**	**256**	**$5,128**

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

APPENDICES

APPENDIX A: SUPPLEMENTAL TABLES

SERVICES

Provider	Services Provided
Outpatient 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
Inpatient 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 54. Waiver Services by Waiver

Waiver Services	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	
Homemaker	X	X	X	
Special Family Habilitation Home	X	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	X	
Companion	X	X		
Occupational, Physical, & Speech Therapies[28]	X	X		
Cognitive Retraining				
Self-Directed / Consumer-Directed Available[29]	X	X	X	
High Fidelity Wraparound				X
Family & Youth Peer Support Services				X

[28] These services are separate from and complementary to state plan Physical and Occupational Therapies.
[29] Self-Directed services are not a specific standalone service, but a different way other services can be managed.

BIRTHS

Table 55. Wyoming and Medicaid Births[30]

Calendar Year	Wyoming Births[31]	Medicaid Births	Medicaid % of Total
2008	8,028	3,353	42%
2009	7,875	3,401	43%
2010	7,541	3,395	45%
2011	7,341	3,166	43%
2012	7,573	3,071	41%
2013	7,614	3,026	40%
2014	7,679	2,857	37%
2015	7,724	2,784	36%
2016	7,386	2,918	40%
2017	6,904	2,683	39%
2018	6,563	2,526	38%
2019	6,568	2,423	37%
2020	6,132	2,258	37%
2021	6,238	2,210	35%
2022	6,050	2,108	35%
2023	5,991	2,082	35%

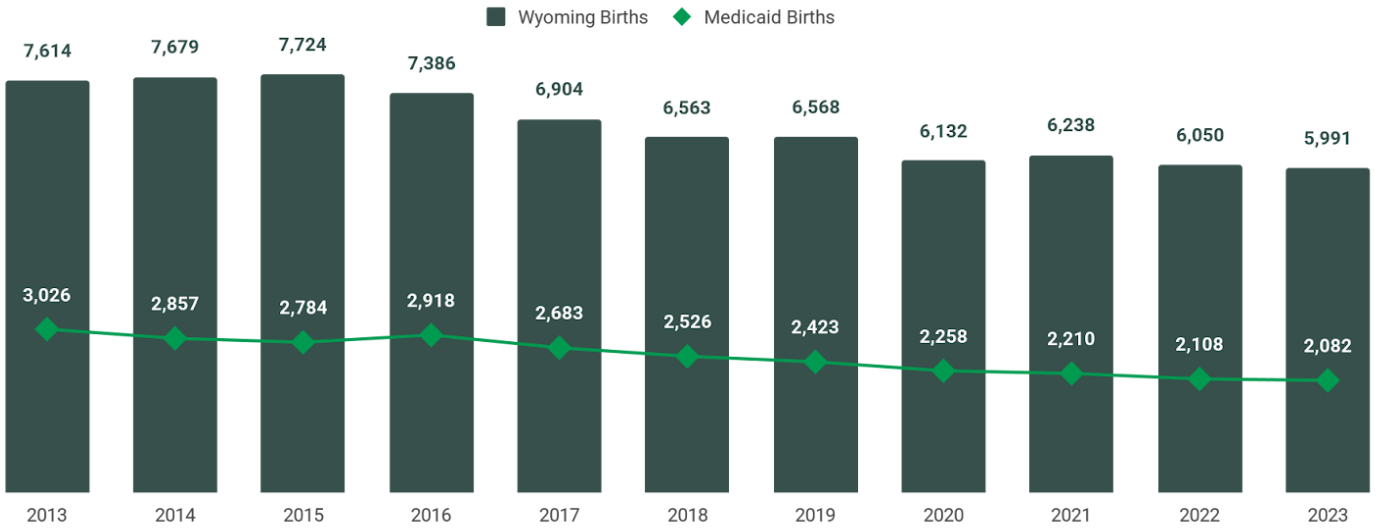


Figure 38. CY 2013 - 2023 Wyoming and Medicaid Births

[30] Service available for Assisted Living recipients only.
[31] Provisional statistics for statewide births were supplied by Vital Records.

COUNTY DATA

Table 56. Medicaid County Summary

County	Enrolled Members[32]	% of Total Enrolled Members	Recipients[33]	% of Total Recipients	Expenditures	% of Total Expenditures
Albany County	4,224	4.1%	3,642	4.3%	$28,263,885	4.1%
Big Horn County	2,594	2.5%	2,319	2.7%	$19,008,272	2.8%
Campbell County	8,400	8.1%	7,117	8.4%	$38,249,737	5.6%
Carbon County	2,415	2.3%	2,005	2.4%	$9,240,519	1.3%
Converse County	2,446	2.3%	2,215	2.6%	$14,370,748	2.1%
Crook County	1,114	1.1%	968	1.1%	$4,618,436	0.7%
Fremont County	11,100	10.6%	10,391	12.3%	$139,566,665	20.4%
Goshen County	2,257	2.2%	1,954	2.3%	$14,045,325	2.1%
Hot Springs County	944	0.9%	901	1.1%	$6,954,083	1.0%
Johnson County	1,195	1.1%	1,004	1.2%	$6,149,250	0.9%
Laramie County	16,513	15.8%	14,077	16.7%	$106,138,213	15.5%
Lincoln County	2,292	2.2%	1,811	2.1%	$12,829,390	1.9%
Natrona County	16,044	15.4%	14,400	17.1%	$110,202,281	16.1%
Niobrara County	434	0.4%	410	0.5%	$2,082,669	0.3%
Other[34]	3,640	3.5%	1,404	1.7%	$14,863,642	2.2%
Park County	4,432	4.2%	3,936	4.7%	$27,829,738	4.1%
Platte County	1,430	1.4%	1,279	1.5%	$7,396,685	1.1%
Sheridan County	4,727	4.5%	4,273	5.1%	$31,449,645	4.6%
Sublette County	1,043	1.0%	802	1.0%	$3,172,283	0.5%
Sweetwater County	7,712	7.4%	6,483	7.7%	$37,427,425	5.5%
Teton County	1,489	1.4%	1,158	1.4%	$5,532,612	0.8%
Uinta County	4,074	3.9%	3,494	4.1%	$27,715,716	4.0%
Washakie County	1,453	1.4%	1,325	1.6%	$10,748,310	1.6%
Weston County	1,138	1.1%	941	1.1%	$6,903,557	1.0%
Overall	104,296		84,358		$684,759,086	

[32] Enrollment is based on Complete SFY.
[33] 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.
[34] Recipients in "Other" county have moved out of state prior to their claim being processed.

PROVIDERS

Table 57. SFY 2024 Provider Taxonomy Summary

Provider Taxonomy	Providers	Recipients[35]	Expenditures
Advanced Practice Midwife (367A00000X)	2	43	$54,926
Allergy & Immunology, Allergy (207KA0200X)	6	367	$137,741
Ambulance (341600000X)	67	4,725	$5,062,622
Anesthesiology (207L00000X)	46	7,003	$2,276,500
Audiologist (231H00000X)	10	414	$171,471
Behavior Analyst (103K00000X)	9	121	$1,048,366
Case Management (251B00000X)	123	2,986	$28,196,671
Chiropractor (111N00000X)	25	335	$61,544
Clinic/Center (261Q00000X)	11	1,321	$1,037,884
Clinic/Center, Ambulatory Family Planning Facility (261QA0005X)	6	345	$109,241
Clinic/Center, Ambulatory Surgical (261QA1903X)	36	4,797	$6,547,398
Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	16	160	$1,597,664
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	21	9,171	$10,655,469
Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X)	29	3,285	$2,428,900
Clinic/Center, Public Health, Federal (261QP0904X)	5	5,205	$29,847,495
Clinic/Center, Radiology, Mobile (261QR0208X)	1	1	$0
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	88	$42,095
Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X)	34	2,222	$2,522,678
Clinic/Center, Rural Health (261QR1300X)	35	8,652	$4,473,408
Clinical Medical Laboratory (291U00000X)	78	8,735	$1,970,386
Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X)	16	1,131	$408,428
Community/Behavioral Health (251S00000X)	33	650	$3,135,717
Counselor, Addiction (Substance Use Disorder) (101YA0400X)	2	20	$12,517
Counselor, Professional (101YP2500X)	170	4,220	$5,489,566
Day Training, Developmentally Disabled Services (251C00000X)	556	3,204	$128,768,958
Dentist (122300000X)	32	3,850	$1,867,693
Dentist, Endodontics (1223E0200X)	3	53	$54,714
Dentist, General Practice (1223G0001X)	99	11,404	$4,574,239
Dentist, Oral and Maxillofacial Surgery (1223S0112X)	10	1,664	$1,606,228
Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X)	10	416	$367,382
Dentist, Pediatric Dentistry (1223P0221X)	35	16,476	$7,578,528

[35] 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.

Provider Taxonomy	Providers	Recipients	Expenditures
Dermatology (207N00000X)	14	2,734	$448,511
Dietitian, Registered (133V00000X)	3	23	$5,337
Durable Medical Equipment & Medical Supplies (332B00000X)	224	8,846	$11,325,201
Emergency Medicine (207P00000X)	35	21,357	$5,079,169
Family Medicine (207Q00000X)	83	26,053	$6,429,657
General Acute Care Hospital (282N00000X)	142	40,827	$95,377,887
General Acute Care Hospital, Rural (282NR1301X)	35	12,372	$14,997,405
Hearing Aid Equipment (332S00000X)	1	68	$105,956
Home Health (251E00000X)	29	323	$564,449
Hospice Care, Community Based (251G00000X)	16	271	$2,151,504
Intermediate Care Facility, Intellectually Disabled (315P00000X)	1	36	$16,366,887
Internal Medicine (207R00000X)	61	16,821	$7,615,972
Internal Medicine, Cardiovascular Disease (207RC0000X)	14	2,529	$477,772
Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X)	4	132	$15,402
Internal Medicine, Gastroenterology (207RG0100X)	9	1,838	$636,120
Internal Medicine, Geriatric Medicine (207RG0300X)	4	514	$101,690
Internal Medicine, Medical Oncology (207RX0202X)	5	24	($5,791)
Internal Medicine, Nephrology (207RN0300X)	6	512	$59,506
Internal Medicine, Pulmonary Disease (207RP1001X)	7	361	$104,186
Internal Medicine, Rheumatology (207RR0500X)	2	166	$19,533
Interpreter (171R00000X)	4	28	$1,623
Local Education Agency (LEA) (251300000X)	1	42	$20,788
Lodging (177F00000X)	3	236	$198,146
Marriage & Family Therapist (106H00000X)	16	309	$491,319
Medical Genetics, Clinical Genetics (M.D.) (207SG0201X)	1	28	$6,283
Medicare Defined Swing Bed Unit (275N00000X)	14	107	$931,680
Midwife (176B00000X)	4	27	$30,377
Neurological Surgery (207T00000X)	9	498	$2,403,059
Nurse Anesthetist, Certified Registered (367500000X)	14	732	$124,704
Nurse Practitioner (363L00000X)	22	1,989	$444,246
Nurse Practitioner, Adult Health (363LA2200X)	2	101	$143,821
Nurse Practitioner, Family (363LF0000X)	26	2,357	$453,114
Nurse Practitioner, Pediatrics (363LP0200X)	2	162	$24,836

Provider Taxonomy	Providers	Recipients	Expenditures
Obstetrics & Gynecology (207V00000X)	30	4,243	$4,087,196
Obstetrics & Gynecology, Gynecology (207VG0400X)	2	135	$36,452
Obstetrics & Gynecology, Obstetrics (207VX0000X)	3	24	$16,946
Occupational Therapist (225X00000X)	16	789	$1,659,457
Ophthalmology (207W00000X)	26	1,753	$482,121
Optometrist (152W00000X)	78	15,724	$3,680,502
Orthopedic Surgery (207X00000X)	26	4,816	$1,547,623
Otolaryngology (207Y00000X)	13	2,903	$875,317
Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X)	14	1,653	$211,313
Pediatrics (208000000X)	76	12,597	$4,416,080
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	8	706	$460,736
Pharmacy (333600000X)	210	46,173	$97,610,755
Pharmacy, Community/Retail Pharmacy (3336C0003X)	3	60	$12,448
Pharmacy, Home Infusion Therapy Pharmacy (3336H0001X)	1	2	$1,142
Pharmacy, Long Term Care Pharmacy (3336L0003X)	1	32	$0
Physical Medicine & Rehabilitation (208100000X)	16	271	$201,559
Physical Therapist (225100000X)	89	4,632	$4,284,931
Physician Assistant (363A00000X)	2	62	$18,360
Physician, General Practice (208D00000X)	67	21,892	$8,313,278
Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X)	2	55	$18,975
Podiatrist (213E00000X)	11	1,123	$84,390
Private Vehicle (347C00000X)	1	22	$5,808
Prosthetic/Orthotic Supplier (335E00000X)	28	998	$643,326
Psychiatric Hospital (283Q00000X)	4	23	$54,291
Psychiatric Residential Treatment Facility (323P00000X)	9	204	$11,522,485
Psychiatry & Neurology, Neurology (2084N0400X)	19	1,448	$334,873
Psychiatry & Neurology, Psychiatry (2084P0800X)	22	1,029	$1,385,644
Psychologist, Clinical (103TC0700X)	41	1,819	$1,906,104
Public Health or Welfare (251K00000X)	22	2,846	$170,983
Radiology, Diagnostic Radiology (2085R0202X)	48	18,648	$3,798,932
Rehabilitation Hospital (283X00000X)	5	90	$288,297
Skilled Nursing Facility (314000000X)	49	2,183	$93,444,243
Social Worker, Clinical (1041C0700X)	108	2,677	$2,884,841
Specialist (174400000X)	2	404	$63,395
Speech-Language Pathologist (235Z00000X)	16	477	$532,960

Provider Taxonomy	Providers	Recipients	Expenditures
Supports Brokerage (251X00000X)	2	1,194	$19,618,667
Surgery (208600000X)	27	1,431	$510,747
Surgery, Pediatric Surgery (2086S0120X)	4	77	$42,926
Surgery, Vascular Surgery (2086S0129X)	5	52	$25,791
Technician/Technologist, Optician (156FX1800X)	6	92	$16,211
Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X)	1	12	$1,859
Urology (208800000X)	11	1,131	$230,343
Total	**3,464**	**401,989**	**$684,759,086**

Table 58. SFY 2024 Top 20 Provider Taxonomies by Expenditures

Provider Taxonomy	Expenditures	Percent of Total Medicaid Expenditures
Day Training, Developmentally Disabled Services (251C00000X)	$128,768,958	19%
Pharmacy (333600000X)	$97,610,755	14%
General Acute Care Hospital (282N00000X)	$95,377,887	14%
Skilled Nursing Facility (314000000X)	$93,444,243	14%
Clinic/Center, Public Health, Federal (261QP0904X)	$29,847,495	4%
Case Management (251B00000X)	$28,196,671	4%
Supports Brokerage (251X00000X)	$19,618,667	3%
Intermediate Care Facility, Intellectually Disabled (315P00000X)	$16,366,887	2%
General Acute Care Hospital, Rural (282NR1301X)	$14,997,405	2%
Psychiatric Residential Treatment Facility (323P00000X)	$11,522,485	2%
Durable Medical Equipment & Medical Supplies (332B00000X)	$11,325,201	2%
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	$10,655,469	2%
Physician, General Practice (208D00000X)	$8,313,278	1%
Internal Medicine (207R00000X)	$7,615,972	1%
Dentist, Pediatric Dentistry (1223P0221X)	$7,578,528	1%
Clinic/Center, Ambulatory Surgical (261QA1903X)	$6,547,398	1%
Family Medicine (207Q00000X)	$6,429,657	1%
Counselor, Professional (101YP2500X)	$5,489,566	1%
Emergency Medicine (207P00000X)	$5,079,169	1%
Ambulance (341600000X)	$5,062,622	1%

Table 59. Pay-to-Provider Count History by Taxonomy

Pay To Provider ID	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Advanced Practice Midwife (367A00000X)	4	4	3	3	3	2
Allergy & Immunology, Allergy (207KA0200X)	5	5	6	7	6	6
Ambulance (341600000X)	73	66	67	72	67	67
Anesthesiology (207L00000X)	73	56	56	55	51	46
Audiologist (231H00000X)	13	12	13	13	12	10
Behavior Analyst (103K00000X)	3	7	5	6	8	9
Case Management (251B00000X)	120	128	129	129	124	123
Chiropractor (111N00000X)	54	54	55	37	30	25
Clinic/Center (261Q00000X)	12	12	11	10	11	11
Clinic/Center, Ambulatory Family Planning Facility (261QA0005X)	7	5	5	5	6	6
Clinic/Center, Ambulatory Surgical (261QA1903X)	31	27	30	31	37	36
Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	16	15	15	15	15	16
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	11	16	15	16	23	21
Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X)	26	27	27	32	33	29
Clinic/Center, Public Health, Federal (261QP0904X)	5	4	5	4	4	5
Clinic/Center, Radiology, Mobile (261QR0208X)		1		1	1	1
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	1	1	1	1	1	1
Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X)	33	33	32	36	41	34
Clinic/Center, Rural Health (261QR1300X)	32	31	34	31	31	35
Clinical Medical Laboratory (291U00000X)	71	70	76	83	88	78
Clinical Neuropsychologist (103G00000X)	4	5	1	1	--	--
Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X)	9	10	10	12	15	16

Table 59. Pay-to-Provider Count History by Taxonomy (Cont.)

Pay To Provider ID	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Community/Behavioral Health (251S00000X)	1	1	29	40	39	33
Counselor, Addiction (Substance Use Disorder) (101YA0400X)	3	3	4	2	4	2
Counselor, Professional (101YP2500X)	145	155	154	164	171	170
Day Training, Developmentally Disabled Services (251C00000X)	657	659	623	605	566	556
Dentist (122300000X)	29	31	31	29	30	32
Dentist, Endodontics (1223E0200X)	2	4	3	3	3	3
Dentist, General Practice (1223G0001X)	129	121	109	110	104	99
Dentist, Oral and Maxillofacial Surgery (1223S0112X)	13	11	9	9	12	10
Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X)	17	14	14	13	10	10
Dentist, Pediatric Dentistry (1223P0221X)	32	33	30	33	33	35
Dermatology (207N00000X)	17	16	16	16	15	14
Dietitian, Registered (133V00000X)	2	2	2	2	3	3
Durable Medical Equipment & Medical Supplies (332B00000X)	222	202	204	215	219	224
Emergency Medical Technician, Basic (146N00000X)	--	--	--	1	--	--
Emergency Medicine (207P00000X)	32	29	32	31	30	35
Family Medicine (207Q00000X)	93	86	80	83	85	83
General Acute Care Hospital (282N00000X)	112	103	108	117	126	142
General Acute Care Hospital, Rural (282NR1301X)	27	26	32	32	40	35
Hearing Aid Equipment (332S00000X)	8	9	9	6	2	1
Home Health (251E00000X)	23	23	20	23	24	29
Hospice Care, Community Based (251G00000X)	12	13	14	14	15	16
Intermediate Care Facility, Intellectually Disabled (315P00000X)	1	1	1	1	1	1
Internal Medicine (207R00000X)	60	57	59	57	62	61
Internal Medicine, Cardiovascular Disease (207RC0000X)	19	20	17	16	14	14

Table 59. Pay-to-Provider Count History by Taxonomy (Cont.)

Pay To Provider ID	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X)	4	4	3	4	4	4
Internal Medicine, Gastroenterology (207RG0100X)	6	6	7	7	7	9
Internal Medicine, Geriatric Medicine (207RG0300X)	5	5	4	6	6	4
Internal Medicine, Medical Oncology (207RX0202X)	4	4	4	6	6	5
Internal Medicine, Nephrology (207RN0300X)	7	6	6	6	8	6
Internal Medicine, Pulmonary Disease (207RP1001X)	10	8	8	7	7	7
Internal Medicine, Rheumatology (207RR0500X)	2	2	3	2	2	2
Interpreter (171R00000X)	3	2	2	2	3	4
Local Education Agency (LEA) (251300000X)	--	--	--	--	1	1
Lodging (177F00000X)	2	2	4	4	4	3
Marriage & Family Therapist (106H00000X)	15	10	12	15	15	16
Medical Genetics, Clinical Genetics (M.D.) (207SG0201X)	1	1	1	1	1	1
Medicare Defined Swing Bed Unit (275N00000X)	11	12	13	13	12	14
Midwife (176B00000X)	--	3	3	5	5	4
Neurological Surgery (207T00000X)	10	9	11	10	9	9
Nurse Anesthetist, Certified Registered (367500000X)	14	13	12	14	15	14
Nurse Practitioner (363L00000X)	14	14	17	14	18	22
Nurse Practitioner, Adult Health (363LA2200X)	1	1	1	1	2	2
Nurse Practitioner, Family (363LF0000X)	16	23	23	18	22	26
Nurse Practitioner, Pediatrics (363LP0200X)	2	3	3	3	3	2
Obstetrics & Gynecology (207V00000X)	28	27	27	28	28	30
Obstetrics & Gynecology, Gynecology (207VG0400X)	3	4	2	2	2	2
Obstetrics & Gynecology, Obstetrics (207VX0000X)	5	4	4	3	3	3
Occupational Therapist (225X00000X)	17	14	14	14	17	16

Table 59. Pay-to-Provider Count History by Taxonomy (Cont.)

Pay To Provider ID	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Ophthalmology (207W00000X)	32	32	35	31	30	26
Optometrist (152W00000X)	80	77	83	81	77	78
Orthopedic Surgery (207X00000X)	32	30	29	27	25	26
Otolaryngology (207Y00000X)	18	15	15	13	16	13
Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X)	16	14	13	13	12	14
Pediatrics (208000000X)	67	69	65	63	73	76
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	3	4	5	4	7	8
Pharmacy (333600000X)	206	205	215	218	211	210
Pharmacy, Community/Retail Pharmacy (3336C0003X)	--	--	--	--	4	3
Pharmacy, Home Infusion Therapy Pharmacy (3336H0001X)	--	--	--	1	2	1
Pharmacy, Long Term Care Pharmacy (3336L0003X)	--	--	--	1	1	1
Physical Medicine & Rehabilitation (208100000X)	15	14	12	14	15	16
Physical Therapist (225100000X)	67	66	75	80	84	89
Physician Assistant (363A00000X)	3	5	2	3	2	2
Physician, General Practice (208D00000X)	58	61	58	60	68	67
Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X)	7	8	5	4	4	2
Podiatrist (213E00000X)	15	14	12	13	11	11
Preventive Medicine, Public Health & General Preventive Medicine (2083P0901X)	--	--	--	--	1	--
Private Vehicle (347C00000X)	6	3	2	1	2	1
Program of All-Inclusive Care for the Elderly (PACE) Provider Organization (251T00000X)	1	1	1	--	--	--
Prosthetic/Orthotic Supplier (335E00000X)	28	28	27	29	29	28
Psychiatric Hospital (283Q00000X)	3	4	3	3	6	4
Psychiatric Residential Treatment Facility (323P00000X)	16	13	14	6	8	9

Table 59. Pay-to-Provider Count History by Taxonomy (Cont.)

Pay To Provider ID	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Psychiatry & Neurology, Neurology (2084N0400X)	22	21	19	18	20	19
Psychiatry & Neurology, Psychiatry (2084P0800X)	25	21	20	20	21	22
Psychologist, Clinical (103TC0700X)	60	59	53	49	48	41
Public Health or Welfare (251K00000X)	24	24	25	25	22	22
Radiology, Diagnostic Radiology (2085R0202X)	46	44	41	38	46	48
Rehabilitation Hospital (283X00000X)	3	2	3	3	2	5
Skilled Nursing Facility (314000000X)	56	56	48	48	47	49
Social Worker, Clinical (1041C0700X)	84	94	96	110	110	108
Specialist (174400000X)	7	4	3	2	2	2
Speech-Language Pathologist (235Z00000X)	10	10	13	14	14	16
Supports Brokerage (251X00000X)	1	1	1	1	2	2
Surgery (208600000X)	30	31	32	26	26	27
Surgery, Pediatric Surgery (2086S0120X)	2	5	5	4	4	4
Surgery, Vascular Surgery (2086S0129X)	5	4	4	5	5	5
Taxi (344600000X)	1	1	2	1	--	--
Technician/Technologist, Optician (156FX1800X)	6	6	5	6	6	6
Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X)	2	2	1	1	2	1
Unclassified	1	1	1	--	--	--
Urology (208800000X)	13	12	10	11	11	11

Table 60. Pay-to-Provider Expenditure History by Taxonomy

Pay-To-Provider Taxonomy	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Advanced Practice Midwife (367A00000X)	$31,747	$27,464	$16,866	$30,193	$40,106	$54,926
Allergy & Immunology, Allergy (207KA0200X)	$282,684	$210,462	$126,285	$141,790	$144,159	$137,741
Ambulance (341600000X)	$3,543,958	$2,869,734	$3,452,295	$3,274,007	$4,579,196	$5,062,622
Anesthesiology (207L00000X)	$2,449,632	$2,387,211	$2,402,861	$2,460,240	$2,269,071	$2,276,500
Audiologist (231H00000X)	$141,981	$344,821	$176,061	$166,964	$260,255	$171,471
Behavior Analyst (103K00000X)	$533,209	$831,883	$1,673,558	$1,597,739	$605,070	$1,048,366
Case Management (251B00000X)	$29,146,077	$29,686,195	$33,151,973	$33,421,019	$32,473,528	$28,196,671
Chiropractor (111N00000X)	$406,862	$368,608	$343,860	$22,007	$56,585	$61,544
Clinic/Center (261Q00000X)	$815,334	$435,776	$720,828	$819,588	$1,074,939	$1,037,884
Clinic/Center, Ambulatory Family Planning Facility (261QA0005X)	$51,977	$48,668	$44,687	$67,307	$71,788	$109,241
Clinic/Center, Ambulatory Surgical (261QA1903X)	$3,555,184	$3,170,249	$4,294,509	$5,292,824	$6,737,900	$6,547,398
Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X)	$1,063,315	$1,595,216	$2,172,271	$2,249,469	$1,974,983	$1,597,664
Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X)	$5,776,571	$6,554,011	$6,954,823	$9,022,975	$9,937,270	$10,655,469
Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X)	$5,381,394	$3,951,005	$2,998,132	$2,894,688	$3,150,732	$2,428,900
Clinic/Center, Public Health, Federal (261QP0904X)	$12,488,676	$11,864,895	$17,744,075	$21,925,627	$24,015,386	$29,847,495
Clinic/Center, Radiology, Mobile (261QR0208X)	--	--	--	$158	$164	--
Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X)	$26,024	$22,394	$28,662	$34,668	$24,867	$42,095
Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X)	$2,793,311	$3,065,233	$2,268,259	$2,003,447	$2,244,489	$2,522,678
Clinic/Center, Rural Health (261QR1300X)	$2,283,377	$2,377,607	$2,776,034	$3,647,268	$3,449,338	$4,473,408
Clinical Medical Laboratory (291U00000X)	$719,701	$585,977	$810,495	$1,078,644	$1,817,952	$1,970,386
Clinical Neuropsychologist (103G00000X)	$50,843	$37,580	$23,900	$23	--	--
Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X)	$326,066	$278,963	$277,798	$207,439	$262,784	$408,428

Table 60. Pay-to-Provider Expenditure History by Taxonomy (Cont.)

Pay-To-Provider Taxonomy	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Community/Behavioral Health (251S00000X)	$3,290,255	$3,928,461	$3,083,633	$3,245,019	$3,943,909	$3,135,717
Counselor, Addiction (Substance Use Disorder) (101YA0400X)	$210,373	$62,187	$15,045	$3,223	$14,498	$12,517
Counselor, Professional (101YP2500X)	$4,176,857	$4,184,775	$4,762,208	$4,292,523	$5,061,940	$5,489,566
Day Training, Developmentally Disabled Services (251C00000X)	$113,694,991	$114,398,383	$115,427,114	$109,625,371	$119,599,245	$128,768,958
Dentist (122300000X)	$962,164	$867,521	$1,366,618	$1,316,876	$1,409,479	$1,867,693
Dentist, Endodontics (1223E0200X)	$49,611	$52,182	$69,098	$73,178	$87,025	$54,714
Dentist, General Practice (1223G0001X)	$3,985,182	$3,089,844	$3,769,032	$3,726,737	$4,429,335	$4,574,239
Dentist, Oral and Maxillofacial Surgery (1223S0112X)	$879,442	$873,145	$1,195,512	$1,297,572	$1,294,614	$1,606,228
Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X)	$420,012	$261,832	$294,792	$368,657	$329,983	$367,382
Dentist, Pediatric Dentistry (1223P0221X)	$5,007,670	$4,749,104	$5,803,729	$6,017,041	$6,729,118	$7,578,528
Dermatology (207N00000X)	$271,678	$254,356	$301,765	$337,052	$416,717	$448,511
Dietitian, Registered (133V00000X)	$617	$697	$385	$2,647	$4,062	$5,337
Durable Medical Equipment & Medical Supplies (332B00000X)	$7,850,643	$8,174,435	$8,783,787	$9,254,405	$11,019,987	$11,325,201
Emergency Medical Technician, Basic (146N00000X)	--	--	--	$46	--	--
Emergency Medicine (207P00000X)	$3,855,001	$3,400,286	$3,502,145	$4,426,478	$4,933,542	$5,079,169
Family Medicine (207Q00000X)	$5,746,907	$5,163,045	$4,800,003	$4,811,423	$6,060,799	$6,429,657
General Acute Care Hospital (282N00000X)	$84,697,383	$75,855,320	$85,729,887	$91,841,923	$99,677,358	$95,377,887
General Acute Care Hospital, Rural (282NR1301X)	$12,195,829	$11,589,064	$11,672,738	$13,149,379	$16,866,583	$14,997,405
Hearing Aid Equipment (332S00000X)	$567,915	$775,873	$499,189	$164,389	$127,341	$105,956
Home Health (251E00000X)	$570,570	$1,004,397	$994,656	$990,420	$515,033	$564,449
Hospice Care, Community Based (251G00000X)	$1,190,302	$1,251,068	$1,306,111	$921,529	$1,442,367	$2,151,504
Intermediate Care Facility, Intellectually Disabled (315P00000X)	$12,901,888	$16,058,915	$17,024,561	$16,842,461	$18,318,585	$16,366,887
Internal Medicine (207R00000X)	$7,075,072	$6,517,068	$7,098,299	$7,281,881	$8,039,515	$7,615,972
Internal Medicine, Cardiovascular Disease (207RC0000X)	$302,157	$326,970	$355,553	$406,376	$478,654	$477,772

Table 60. Pay-to-Provider Expenditure History by Taxonomy (Cont.)

Pay-To-Provider Taxonomy	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X)	$21,509	$23,002	$20,706	$21,034	$19,134	$15,402
Internal Medicine, Gastroenterology (207RG0100X)	$479,940	$423,968	$741,026	$726,845	$722,332	$636,120
Internal Medicine, Geriatric Medicine (207RG0300X)	$43,908	$43,886	$42,598	$62,352	$89,000	$101,690
Internal Medicine, Medical Oncology (207RX0202X)	$1,914,670	$2,155,922	$647,946	-$1,573	$2,402	-$5,791
Internal Medicine, Nephrology (207RN0300X)	$64,890	$73,053	$62,204	$94,006	$77,501	$59,506
Internal Medicine, Pulmonary Disease (207RP1001X)	$121,574	$91,720	$114,401	$125,623	$137,298	$104,186
Internal Medicine, Rheumatology (207RR0500X)	$13,841	$8,389	$18,004	$17,537	$19,945	$19,533
Interpreter (171R00000X)	$5,799	$9,096	$19,514	$21,284	$21,846	$1,623
Local Education Agency (LEA) (251300000X)	--	--	--	--	$40,310	$20,788
Lodging (177F00000X)	$127,715	$108,735	$105,760	$151,589	$170,522	$198,146
Marriage & Family Therapist (106H00000X)	$391,014	$376,927	$519,535	$560,234	$533,288	$491,319
Medical Genetics, Clinical Genetics (M.D.) (207SG0201X)	$3,266	$3,083	$4,610	$5,141	$3,890	$6,283
Medicare Defined Swing Bed Unit (275N00000X)	$479,918	$557,037	$633,663	$287,091	$959,118	$931,680
Midwife (176B00000X)		$14,782	$36,514	$44,161	$32,686	$30,377
Neurological Surgery (207T00000X)	$75,191	$88,516	$3,913,244	$2,464,651	$2,915,224	$2,403,059
Nurse Anesthetist, Certified Registered (367500000X)	$78,819	$86,639	$136,749	$149,739	$126,512	$124,704
Nurse Practitioner (363L00000X)	$200,823	$277,571	$340,401	$523,985	$647,628	$444,246
Nurse Practitioner, Adult Health (363LA2200X)	$2,284	$2,958	$1,973	$1,146	$35,680	$143,821
Nurse Practitioner, Family (363LF0000X)	$251,881	$338,367	$371,188	$460,522	$530,811	$453,114
Nurse Practitioner, Pediatrics (363LP0200X)	$15,922	$16,328	$20,493	$53,009	$53,301	$24,836
Obstetrics & Gynecology (207V00000X)	$3,814,652	$3,657,589	$3,731,175	$4,023,250	$4,217,686	$4,087,196
Obstetrics & Gynecology, Gynecology (207VG0400X)	$93,676	$94,634	$99,103	$95,881	$85,228	$36,452
Obstetrics & Gynecology, Obstetrics (207VX0000X)	$503,347	$474,269	$253,841	$998	$53,591	$16,946
Occupational Therapist (225X00000X)	$1,884,711	$1,630,049	$1,623,882	$1,387,546	$1,449,895	$1,659,457

Table 60. Pay-to-Provider Expenditure History by Taxonomy (Cont.)

Pay-To-Provider Taxonomy	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Ophthalmology (207W00000X)	$574,291	$542,002	$664,898	$651,842	$644,860	$482,121
Optometrist (152W00000X)	$3,409,020	$2,930,037	$3,675,630	$3,594,187	$3,853,367	$3,680,502
Orthopedic Surgery (207X00000X)	$1,222,153	$1,344,579	$1,434,339	$1,702,363	$1,690,165	$1,547,623
Otolaryngology (207Y00000X)	$679,438	$523,531	$726,418	$814,430	$829,657	$875,317
Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X)	$83,620	$80,615	$68,216	$276,534	$333,253	$211,313
Pediatrics (208000000X)	$4,681,066	$3,931,424	$4,533,536	$4,707,928	$5,024,836	$4,416,080
Pediatrics, Neonatal-Perinatal Medicine (2080N0001X)	$208,703	$283,124	$333,584	$319,887	$290,420	$460,736
Pharmacy (333600000X)	$61,385,109	$60,432,330	$67,781,176	$84,438,042	$98,128,284	$97,610,755
Pharmacy, Community/Retail Pharmacy (3336C0003X)	--	--	--	--	$26,952	$12,448
Pharmacy, Home Infusion Therapy Pharmacy (3336H0001X)	--	--	--	$233	$263	$1,142
Pharmacy, Long Term Care Pharmacy (3336L0003X)	--	--	--	$2	--	--
Physical Medicine & Rehabilitation (208100000X)	$137,136	$123,650	$157,851	$145,182	$250,182	$201,559
Physical Therapist (225100000X)	$2,491,622	$2,316,327	$3,100,810	$3,689,457	$3,882,805	$4,284,931
Physician Assistant (363A00000X)	$21,168	$26,466	$38,811	$44,103	$20,347	$18,360
Physician, General Practice (208D00000X)	$7,372,159	$7,102,898	$7,106,319	$7,507,309	$8,973,306	$8,313,278
Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X)	$22,049	$16,093	$9,524	$16,575	$15,619	$18,975
Podiatrist (213E00000X)	$47,751	$42,304	$34,640	$32,484	$39,972	$84,390
Preventive Medicine, Public Health & General Preventive Medicine (2083P0901X)	--	--	--	--	$69	--
Private Vehicle (347C00000X)	$18,455	$12,973	$8,702	$5,949	$7,696	$5,808
Program of All-Inclusive Care for the Elderly (PACE) Provider Organization (251T00000X)	$3,693,978	$3,586,650	$2,152,985	--	--	--
Prosthetic/Orthotic Supplier (335E00000X)	$598,186	$540,444	$614,067	$584,124	$617,354	$643,326
Psychiatric Hospital (283Q00000X)	$122,776	$21,285	$75,743	$101,841	$255,834	$54,291
Psychiatric Residential Treatment Facility (323P00000X)	$10,391,372	$7,334,441	$7,577,518	$6,127,480	$6,685,351	$11,522,485

Table 60. Pay-to-Provider Expenditure History by Taxonomy (Cont.)

Pay-To-Provider Taxonomy	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Psychiatry & Neurology, Neurology (2084N0400X)	$468,020	$333,100	$329,532	$327,801	$484,029	$334,873
Psychiatry & Neurology, Psychiatry (2084P0800X)	$1,813,284	$1,570,802	$1,893,488	$1,327,071	$1,307,887	$1,385,644
Psychologist, Clinical (103TC0700X)	$5,198,374	$4,887,558	$3,668,549	$2,472,285	$2,333,625	$1,906,104
Public Health or Welfare (251K00000X)	$917,659	$898,521	$698,200	$366,426	$231,791	$170,983
Radiology, Diagnostic Radiology (2085R0202X)	$1,677,907	$1,538,606	$1,889,630	$3,352,644	$4,730,533	$3,798,932
Rehabilitation Hospital (283X00000X)	$619,218	$408,441	$567,445	$546,854	$711,661	$288,297
Skilled Nursing Facility (314000000X)	$83,960,515	$88,869,925	$77,813,463	$72,353,230	$78,344,782	$93,444,243
Social Worker, Clinical (1041C0700X)	$2,962,987	$2,944,198	$2,750,770	$2,807,472	$3,265,545	$2,884,841
Specialist (174400000X)	$58,231	$60,043	$57,929	$48,087	$67,950	$63,395
Speech-Language Pathologist (235Z00000X)	$242,416	$411,291	$376,895	$408,640	$483,875	$532,960
Supports Brokerage (251X00000X)	$5,530,177	$6,172,411	$6,977,663	$7,139,257	$13,184,427	$19,618,667
Surgery (208600000X)	$648,362	$502,970	$593,464	$554,557	$644,695	$510,747
Surgery, Pediatric Surgery (2086S0120X)	$30,182	$33,952	$51,964	$27,761	$52,504	$42,926
Surgery, Vascular Surgery (2086S0129X)	$14,387	$26,205	$14,120	$18,524	$40,915	$25,791
Taxi (344600000X)	$45,135	$36,725	$18,864	$90	--	--
Technician/Technologist, Optician (156FX1800X)	$57,048	$47,032	$51,130	$45,242	$28,008	$16,211
Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X)	$27,538	$11,947	$8,685	$2,685	$3,792	$1,859
Unclassified	$224,355	$40,885	$89,626		--	--
Urology (208800000X)	$268,132	$235,121	$254,932	$238,451	$277,257	$230,343

APPENDIX B: REIMBURSEMENT METHODOLOGY SERVICES

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

Table 61. Reimbursement Methodology and History by Service Area

Reimbursement Methodology and History by Service Area					
SFY 2019	**SFY 2020**	**SFY 2021**	**SFY 2022**	**SFY 2023**	**SFY 2024**
Ambulance - Wyoming Medicaid Administrative Rule Chapter 15, Chapter 3h - 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	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes
Ambulatory Surgical Center - 43 CFR 447.321 SPA 4.1.19B - 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.					
No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes

Table 61. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
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					
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	No changes	No changes
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					
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.	FFS Rate Development Study completed.	Payment methodology and waiver renewals informed by SFY 2023 study.
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					
No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes
- 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 1.015% based on MEI	Rates increased 1.9% based on MEI	Rates increased by 1.4%	Rates increased by 2.1%	Rate changes based upon fee schedule	No changes

Table 61. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
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)					
No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	Provider manual update to version 5.0	Dental expenditures for both children and adults have increased due to the legislation approved rate increase, effective 4/1/2023.
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 90% of Medicare's fee schedule which is updated annually in July 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 12.3% add-on, plus shipping and handling - Delivery of DME more than 50 miles roundtrip is reimbursed per mile					
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	Rate increase due to agency adoption of rural and non-rural methods	Annual rate increase based on 90% of Medicare's fee schedule
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	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	Rate changes based upon fee schedule	Updated in 10/2023 to an all-inclusive rate per encounter

Table 61. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
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 1.015% based on MEI	Rates increased 1.9% based on MEI	Rates increased by 1.4%	Rates increased by 2.1%	Rate changes based upon fee schedule	No changes
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					
No changes	Prior authorization suspended in March 2020	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes
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	Due to Governor's budget reductions, reimbursement was reduced by 2.5% for hospice in NH.	Rates adjusted per Medicare's adjustments, NH hospice was increased by 5% for part of SFY 2022.	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments

Table 61. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
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					
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	No changes	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 mammography; - 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					
Adjusted conversion factors (effective CY 2019): General acute $42.53 Critical access $105.89 Children's $88.45 ASCs $37.42 No change for QRA	Adjusted conversion factors (effective CY 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	No changes	No changes
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

Table 61. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
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	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	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					
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	Rate increase	No changes
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 rate					
No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%. Chiropractic services only allowed for children under EPSDT and clients on Medicare. Dietician service no longer has a threshold limit.	No changes	No changes	No changes

Table 61. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
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 - Effective 04/01/2017, Payment for covered outpatient legend and non-legend drugs will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of: a) The National Average Drug Acquisition Cost (NADAC) of the drug; b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%; c) The Federal Upper Limit (FUL); d) The State Maximum Allowable Cost (SMAC); e) The Ingredient Cost submitted; f) The Gross Amount Due (GAD); or g) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge. - Reimbursement for claims that pay at GAD or U&C will not include a $10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.					
No changes	No changes	No changes	No changes	No changes	No changes
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 for Medicaid-Only; decreased for dual-Medicare/Medicaid	Rate decreased	Program was discontinued January 2021 due to budget cuts	No changes	No changes	No changes
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	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	Rate increase
Public Health or Welfare - Wyoming State Plan Attachment 3.1-A - Lower of the Medicaid fee schedule or the provider's usual and customary charge - LT-101 Level of Care Assessments shifted from a claim based process to an administrative (invoice) process in July of 2021.					
No changes	No changes	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes

Table 61. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
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	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	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)					
Rates increased 1.015% based on MEI	Rates increased 1.9% based on MEI	Rates increased by 1.4%	Rates increased by 2.1%	Rate changes based upon fee schedule	No changes
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	Due to Governor's budget reductions, reimbursement was reduced by 2.5%	No changes	No changes	No changes

Table 61. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Waivers (Comprehensive & 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 services is made on a daily or 15-minute unit, with costs determined by a rate buildup based on Wyoming and national service and expenditure data. - 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 funding to meet the participant's assessed needs.					
Rate rebasing study was finalized. The State of Wyoming Legislature funded the "High Needs Model" of the rate study, which increased rates for some of the high-tier level services.	In response to the COVID-19 public health emergency, provider rates for most Comprehensive and Supports Waiver Services were increased, beginning March 1, 2020. The temporary increase ends September 1, 2020.	Effective February 1, 2021, all rates were decreased by 2.5% as a result of budget reductions.	As a result of the American Rescue Plan act, new provider reimbursement rates went into effect on February 1, 2022. This total fully funded the previous rate study, focusing on those services that were excluded from previous legislative action. 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. Additional increases were passed specifically for costs associated with agency providers.	12.5% temporary rate increase funded through ARPA in effect until 3/31/2025.	12.5% temporary rate increase maintained funded through ARPA in effect until 3/31/2025.

Table 61. Reimbursement Methodology and History by Service Area (Cont.)

SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Waivers (Community Choices) - Waiver Agreement Appendix I.2.a; Appendix K COVID-19 Addendum - Long-Term Care services are paid lower than 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 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.					
No changes	Rates for select direct care services increased in response to COVID-19 public health emergency	COVID rates increased continued through SFY 2021	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.	Rate increase as agency adopted an increase and hot and cold meals for recipients	12.5% temporary rate maintained, funded through ARPA in effect until 3/31/2025
Waivers (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					
No changes	No changes	No changes	No changes	No changes	No changes
Waivers (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					
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 (07/01/2021 - 06/30/2022), 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.	No changes	No changes	No changes

APPENDIX C: ELIGIBILITY REQUIREMENTS & BENEFITS

Table 62. Income Limits by Eligibility Category

Eligibility Category	CY 2023
Children 0-5	154% FPL
Children 6-18	133% FPL
CHIP	200% 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 63. Monthly Income Standard Values by Family Size

Income Standard	Income Limit	2024			
Family Size		1	2	3	4
CHIP	200%	$2,510	$3,407	$4,304	$5,200
Family Care Adults	-	$529	$737	$873	$999
Federal Poverty Level (FPL)	100%	$1,255	$1,703	$2,152	$2,600
	133%	$1,669	$2,265	$2,862	$3,458
	154%	$1,933	$2,623	$3,314	$4,004
Supplementary Security Income (SSI)	100%	$943	$1,415	—	—
	300%	$3,765	—	—	—

Table 64. Eligibility Requirements

Category Group	Eligibility Category	Benefits	Eligibility Requirements	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 foster care coverage		-
Pregnant Women	Pregnant Women	Full Medicaid Coverage	Pregnant	Countable family income	Less than or equal to 154 percent of FPL	-
	Presumptive Eligibility	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 18 living in the household	Countable family income	Less than or equal to Family Care Income Standard	-
	Family Care 4 & 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 Care	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 age 18 or older		-

Category Group	Eligibility Category	Benefits	Eligibility Requirements	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 w/ 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 w/ 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	-

Category Group	Eligibility Category	Benefits	Eligibility Requirements	Countable Income	Income Level	Resource Limits
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
Medicare Buy-In	Employed Individuals w/ 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 & ACRONYMS

GLOSSARY

Table 65. 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 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.
APR DRG	All Patient Refined Diagnosis Related Groups is a classification system used to group hospitalized patients based on their 1) Reason for Admission: the primary diagnosis that led to hospitalization, 2) Severity of illness: factors such as complications, co-morbidities, and procedures, and 3) Risk of Mortality: the likelihood of the patient dying during their hospital stay.
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.
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 2024 ends on September 30, 2024).
Federal Medical Assistance Percentage (FMAP)	The percentage rates used to determine the federal matching funds allocated to the Medicaid program. The FMAP is the portion of the Medicaid program that is paid by the federal government.
Federal Poverty Level (FPL)	The amount of income determined by the Department of Health and Human Services that is needed to provide a minimum for living necessities.
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.
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, intellectually disabled, developmentally disabled, and certain other disabled adults.
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	HCBS Waiver that serves individuals throughout the lifespan with ID, DD, and ABI.
HCBS Supports Waiver	A HCBS waiver developed to replace the former DD waivers for people with a developmental disability. Provides more flexible service than the Comprehensive Waiver, but with a lower cap on benefits.

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. For the Comprehensive and Supports Waivers, the amount of funding allocated to an individual.
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. This model ended in 2019.
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.
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	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.
Psychiatric Residential Treatment Facility (PRTF)	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.
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)	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.
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.
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 2024 ends on June 30, 2024).
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 66. 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
DRG	Diagnosis Related Groups	DUR	Drug Utilization Review
EAC	Estimated Acquisition Cost	EHR	Electronic Health Record
EHR	Electronic Health Record	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 Exchange	HPSA	Health Professional Shortage Area
IBA	Individualized Budget Amount	LEP	Limited English Proficiency
IBA	Individualized Budget Amount		

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
SLMB	Specified Low-Income Medicare Beneficiaries	SFY	State Fiscal Year
SSA	Social Security Administration	SMAC	State Maximum Allowable Cost
SSI	Supplemental Security Income	SSDC	Sovereign States Drug Consortium
THR	Total Health Record	TB	Tuberculosis
WDH	Wyoming Department of Health	TPL	Third-Party Liability
WES	Wyoming Eligibility System		

APPENDIX E: DATA METHODOLOGY

ENROLLMENT

ENROLLMENTS

- 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 defines 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 2024 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 69 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 67. Medicaid Program Codes

Medicaid Eligibility Chart	Program Codes	
Aged, Blind, Disabled Intellectual/ Developmental Disabilities, and Acquired Brain Injury	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	Inpatient - 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

Medicaid Eligibility Chart	Program Codes	
Aged, Blind, Disabled Long-Term Care	P14	PACE Medicare SSI Disabled < 65
	P15	PACE NF < 65
	P16	PACE NF SSI Disabled < 65
	P17	PACE NF Medicare Disabled < 65
	P18	PACE NF Medicare SSI Disable < 65
	P21	PACE > 65
	P22	PCMR > 65
	P23	PACE SSI Aged > 65
	P24	PACE Medicare SSI Aged > 65
	P25	PACE NF > 65
	P26	PACE NF SSI Aged > 65
	P27	PACE NF Mcare Aged > 65
Aged, Blind, Disabled SSI & SSI Related	P28	PACE NF Mcare SSI Aged > 65
	S12	SSI Eligible >65
	S20	Blind SSI - Receiving Payment
	S21	Blind SSI - Not Receiving Payment
	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)

Medicaid Eligibility Chart	Program Codes	
Children	A59	Retro Medicaid-"Pr" Child (inactive)
	A60	4 Mo Extended Med <21
	A61	Institutional (AF-IV-E) (inactive)
	A62	Retro Medicaid-"Rm" Child (inactive)
	A63	Refugee Child (inactive)
	A64	Alien: 245 (IRCA) Child (inactive)
	A58	Child 6 Through 18 Yrs
	A65	AFDC-Up Unemployed Parent Ch (inactive)
	A67	12 Mo Extended Med <21
	A87	16+ Not In School AF HH (inactive)
	K03	Kidcare to Child Magi
	M02	Adult MAGI <21
	M03	Child MAGI
	M05	Family MAGI <21
	M10	Children's PE
	M12	Family MAGI PE <21
	M14	Adult MAGI PE <21
	S62	Continuous SSI Eligible <19
	A55	Child 0 Through 5 Yrs
	S65	Cont 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

Medicaid Eligibility Chart	Program Codes	
Medicare Savings Programs	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 Service < 21
	A84	Emergency Service > 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
	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
Screenings & Gross Adjustments	X02	Incarcerated Medicaid Member
	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 68. Chart B Program Codes

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

Table 69. CHIP Program Codes

CHIP Eligibility Chart		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 70. 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	Professional Counselor; Certified Mental Health Worker	Procedure Codes: 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
	101YA0400X	Addictions Therapist/Practitioner	
	101YP2500X	Professional Counselor	
	103G00000X	Neuropsychologist	
	103K00000X	Behavior Analyst	
	103TC0700X	Clinical Psychologist	
	1041C0700X	Social Worker	
	106E00000X	Assistant Behavior Analyst	
	106H00000X	Marriage and Family Therapist	
	106S00000X	Behavior Technician	
	163W00000X	RN	
	164W00000X	LPN	
	171M00000X	Case Worker	
	172V00000X	Community Health Worker; Peer Specialist; Certified	
	2084P0800X	Psychiatrist	
	261QM0801X	Mental Health - including Community Mental Health Center	
	261QR0405X	Rehabilitation, Substance Use Disorder	
	364SP0808X	NP, APN Psychiatric/Mental Health	

Service Area	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
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	Pay-to-Provider Taxonomy		Other Parameters
Hospital Inpatient	282N00000X	General Acute Care Hospital	Claim Type: I, X
	282NR1301X	General Acute Care Hospital - Rural	
	283Q00000X	Psychiatric Hospital	
	283X00000X	Rehabilitation Hospital	
Hospital Outpatient	261QR0400X	Rehabilitation	Claim Type: O, V
	282N00000X	General Acute Care Hospital	
	282NR1301X	General Acute Care Hospital - Rural	
	283X00000X	Rehabilitation Hospital	
Hotel Emergency Room	All Taxonomies		Procedure Codes: 99281 - 99285 OR Place of Service: 23 AND Procedure Codes in Emergency Department Procedure Code Value Set (2020 HEDIS) OR Revenue Code: 0450 - 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	Medicare Defined Swing Bed	n/a
	314000000X	Skilled Nursing Facility	
Program for All-Inclusive Care of Elderly (PACE)	251T00000X	PACE Organization	n/a
Physician and Other Practitioner Total	All Taxonomies starting with '20'		n/a
	363A00000X	Physician Assistant	
	225X00000X	Occupational Therapist	
	225100000X	Physical Therapist	
	213E00000X	Podiatrist	

Service Area	Pay-to-Provider Taxonomy		Other Parameters
Physician and Other Practitioner Total	363L00000X	Nurse Practitioner	n/a
	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
Public Health or Welfare	251K00000X	Public Health or Welfare	n/a
Rural Health Clinic	261QR1300X	Rural Health Clinic	n/a

Service Area	Pay-to-Provider Taxonomy		Other Parameters
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
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: S58, S93, S94, S64
Waiver - Children's Mental Health Waiver Only	251S00000X	CHPR CME	Claim Type: W, G Recipient Program Codes: S95, S96, S65

Service Area	Pay-to-Provider Taxonomy		Other Parameters
Waiver - Children's Mental Health Non-Waiver Services	251S00000X	Community / Behavioral Health	Recipient Program Codes: S95, S96, S65
Waiver Comprehensive Waiver Only	251C00000X	Day Training, DD	Claim Type: W, G Recipient Program Codes: W03, W04, W08, W09, W10, W14, W15, W16, W22, W23, W24, W25, W26
	251X00000X	PACE PPL	
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
Waiver - Supports Waiver Only	251C00000X	Day Training, DD	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 71. Data Parameters for Subprograms 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, A96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