APPENDIX F: WYOMING MEDICAID RATE HISTORY

Table F.1 details changes to Wyoming Medicaid rates for the service areas used in the benchmarking study. Inflation updates indicated in the *SFY 2020 and Previous* column of the table are not indicated as a change for the SFY 2021 through SFY 2024 columns of the table, unless it is an inflation update based on the Medicare Economic Index (MEI).

Table F.1: Changes to Wyoming Service Area Medicaid Rates[9]

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Ambulance	• In SFY 2010, rates adjusted to 75% of Medicare's 2008 ambulance rates • Lower of the Medicaid fee schedule or the provider's usual and customary charges • Fixed fee schedule amount for transport • Mileage and disposable supplies billed separately • Separate fee schedules for basic life support (ground), advanced life support (ground), additional advanced life support (ground), and air ambulance • Rates adjusted to 90% of Medicare's 2007 ambulance rates • Ground mileage rate increased 125% from $2.50 to $5.63 per mile • Fixed wing air mileage rate decreased to $10.12 per mile and base rate increased 325% to $3,303.63 • Rotary wing air mileage rate increased to $26.95 per mile and base rate increased 627% from $528.34 to $3,840.96	Reimbursement reduced by 2.5% due to the Governor's budget cuts	No change	No change	Effective July 1, 2023, the Ground Ambulance Supplemental Payment Program, implemented supplemental payments for in-state ground ambulance providers

[9] Service area updates are obtained from the Wyoming Medicaid Annual Report.

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Ambulatory Surgery Centers (ASCs)[10]	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • Rates based on eight ASC payment groups established by Medicare. The groups are all inclusive bundled payments per procedure code • Rates are 90% of Medicare's 2007 ASC rates • Ninth payment group added for services that are not paid through the other eight groups • Group Y (ninth group) is reimbursed at 70% of billed charges • Adopted new OPPS-based methodology to better align reimbursement with those services provided in other outpatient settings • Adjusted conversion factors effective calendar year 2017 • SFY 2018 Wyoming ASC Conversion Factor: $34.94 • SFY 2019 Wyoming ASC Conversion Factor: $37.42 • SFY 2020 Wyoming ASC Conversion Factor: $40.30	Reimbursement reduced by 2.5% due to Governor's budget cuts SFY 2021 Wyoming ASC Conversion Factor: $38.55	SFY 2022 Wyoming ASC Conversion Factor: $41.25	SFY 2023 Wyoming ASC Conversion Factor: $40.91	SFY 2024 Wyoming ASC Conversion Factor: $40.81[11]
Behavioral Health	• In SFY 2010, CPT code rates decreased to 90% of Medicare's rates (effective November 1, 2009) • Lower of the Medicaid fee schedule or the provider's usual and customary charges • Separate fee schedules based on the type of provider • Legislated and funded rate increase of 24% from $70 per hour to $87 per hour • State portion of the increase effective July 1, 2007, and federal portion effective September 2007 • In SFY 2017, the reimbursement rate reduced by 3.3% • In SFY 2018, psychologists paid 100% of the fee schedule and APRN paid 90% of fee schedule as of 1/1/18	Reimbursement reduced by 2.5% due to the Governor's budget cuts	No change	No change	No change

[10] On July 1, 2014 (SFY 2015), Wyoming Medicaid implemented a new reimbursement methodology for ASC services based on Medicare's ASC reimbursement system.
[11] Wyoming Medicaid, Outpatient Prospective Payment System (OPPS) Information. Available online: https://www.wyomingmedicaid.com/portal/OPPS-Information

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Care Management Entity	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • Adopted risk-based capitated payment in SFY 2016 • In SFY 2018, rates were adjusted from SFY 2017 and 2018 Care Management Entity (CME) premium payment claims to the approved CMS rate for risk-based capitated payments • In SFY 2019, administrative services payments to CME were made under a non-risk capitated payment methodology. CME network provider payments require CME prior authorization and use the procedure code fee schedule	• Beginning 10/01/2020, the CME sends a 278 transaction to Conduent • Conduent uses the 278 files to issue PA numbers for services provided by the CME network providers who utilize the PAs 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	Reimbursement rate increase of 2.5% effective 1/1/2022	FFS Rate Development Study completed	Payment methodology and waiver renewals informed by SFY 2023 study

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Clinic/ Center	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • In SFY 2017, changed from billing as single entity to billing as a group with treating providers effective for dates of service as of 6/1/17. Became part of the Cap Limit process	Reimbursement reduced by 2.5% due to the Governor's budget cuts	No change	No change	No change
Dental	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • Adult optional dental services added (effective July 1, 2006) • SFY 2017 adult dental coverage reduced to preventive and emergency services only	Reimbursement reduced by 2.5% due to the Governor's budget cuts	No change	Reimbursement rates for dental providers were increased by 25% effective April 1, 2023	Dental expenditures for both children and adults have increased due to the legislation approved rate increase, effective 4/1/2023
Durable Medical Equipment, Prosthetics and Orthotics	• In SFY 2009, rates increased to 90% of Medicare's rates (effective January 1, 2009) • Lower of the Medicaid fee schedule, or the provider's usual and customary charges for each HCPCS code • Medicaid uses Medicare's fee schedule, which is updated annually for inflation based on the consumer price index • For procedure codes not on Medicare's list, Medicaid considers other states' rates • Certain DME, e.g., customized wheelchairs, is manually priced based on the manufacturer's invoice price, plus a 15 percent add-on, plus shipping and handling • Delivery of DME more than 50 miles roundtrip is reimbursed per mile • In SFY 2019, codes impacted by the 21st Century CURES Act were set at 100% of the lowest Medicare rate • No change occurred or the codes not impacted by the 21st Century CURES Act	Reimbursement reduced by 2.5% due to the Governor's budget cuts	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 Reimbursement method updated for new and rental rates effective September 1, 2023. DME claims will be paid the lesser of: 1. Provider's usual and customary charge for the service, or; 2. 90% of Medicare's rural or non-rural rate based on the member's primary location ZIP code	Annual rate increase based on 90% of Medicare's fee schedule

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
End Stage Renal Disease Services	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • Dialysis services reimbursed at a percentage of billed charges • Dialysis services reimbursed at 70% of billed charges (effective September 1, 2008) • Dialysis services reimbursed at 17% of billed charges (effective January 1, 2012) • Dialysis services reimbursed at 12% of billed charges (effective January 1, 2013) • Dialysis services reimbursed at 9% of billed charges (effective January 1, 2014)	Reimbursement reduced by 2.5% due to the Governor's budget cuts	No change	Reimbursement method updated for ESRD facilities effective October 1, 2023. ESRD claims will be paid the lesser of: 1. Provider's billed charges for the service, or; 2. State-developed bundled per treatment rate which is based on the average Medicare projected per treatment amount	Effective October 1, 2023, Wyoming Medicaid converted their ESRD payment methodology to use the average Medicare projected per treatment amount. Rate is adjusted annually

Federally Qualified Health Centers	• Prospective per visit payment system implemented on January 1, 2001, 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 updated annually for inflation based on the Medicare Economic Index (MEI)
	  ○ Rates increased 0.6% based on MEI
	• In SFY 2013, rates increased 0.8% based on MEI
	• In SFY 2014, rates increased 0.8% based on MEI
	• In SFY 2015, rates increased 0.8% based on MEI
	• In SFY 2016, rates increased 1.1% based on MEI
	• In SFY 2017, rates increased 1.2% based on MEI
	• In SFY 2018, rates increased 1.01% based on MEI
	• In SFY 2019, rates increase 1.015% based on MEI
	• In SFY 2020, rates increased 1.9% based on MEI
		Rates increased 1.4% based on MEI	Rates increased 2.1% based on MEI	Rates increased by 3.8% based on MEI	Rates increased by 4.6% based on MEI

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Home Health	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • Per visit rates based on Medicare's fee schedule • Prior authorization required starting March 2017 • Prior authorization suspended in March 2020	Reimbursement reduced by 2.5% due to the Governor's budget cuts	No change	No change	No change
Hospice	• In SFY 2011, rates increased 2.6% • Fees based on Medicare rates • Medicare pays a per-diem rate based on the level of care and updates fees annually based on inflation • For nursing facilities that provide hospice services, payment is 95% of the facility's Medicaid per diem rate and is made in lieu of the nursing facility reimbursement • Rates increase annually based on Medicare's inflation increases • In SFY 2013, rates increased 0.6% based on MEI • In SFY 2019, rates were adjusted per Medicare's adjustments, Medicare outcomes, and geographical location • In SFY 2020, rates were adjusted per Medicare's adjustments, Medicare outcomes, and geographical location	Reimbursement reduced by 2.5% for hospice in nursing facilities due to the Governor's budget cuts	Rates adjusted per Medicare's adjustments, Medicare outcomes, and geographical location; NH hospice reimbursement was increased by 5% for part of SFY 2022	Rates adjusted per Medicare adjustments	Rates adjusted per Medicare adjustments

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Inpatient Hospital	• Rebased the LOC system using more recent cost and claims data to better categorize service • New rates effective September 1, 2009 • In SFY 2010, approved budget reduction of $5.8 million over two years based on Governor's recommendations • Based on a budget footnote for SFY 2010, the Governor's office authorized an increase to The Children's Hospital rates after the required reductions, resulting in an increase of $1 million over a two-year period • The prospective level of care (LOC) rate per discharge was implemented on July 1, 1994, and rebased in 1998. Services paid outside of the LOC system are: ○ Transplant services, which are paid at 55 percent of billed charges • Hospitals that serve a disproportionate share of low-income patients receive disproportionate share hospital (DSH) payments • Per diem rates are made for rehabilitation with a ventilator, or a separate rate without a ventilator • Specialty services, not otherwise obtainable in Wyoming, are negotiated through letters of agreement • LOC rates are updated annually for inflation using the Medicare inpatient prospective payment (PPS) inflation rates • Qualified Rate Adjustment (QRA) program implemented on July 4, 2004 to provide supplemental payments to non-state governmental hospital • In SFY 2009, LOC rates updated for inflation • In SFY 2017, no change to LOC reimbursement. Private hospital UPL implemented • In SFY 2019, DRG was implemented 5/31/19 with an effective date of 2/1/19. The private hospital UPL program, DSH, and QRA remained in place. Rehab claims were paid outside of the DRG • In SFY 2020, second year of DRG rates implemented on February 1, 2020	Reimbursement reduced by 2.5% due to the Governor's budget cuts	No change	• Updated the DRG payment methodology for hospital inpatient services from version 33 of All Patient Refined (APR) DRG to version 40 • Updated payment parameters including policy adjustors and changing the categories of hospitals receiving separate base rates	Effective 10/1/2023, implemented version 40 of APR DRGs and shifted to three DRG base rate categories, Critical Access Hospitals (CAHs), psychiatric specialty hospitals, and all other hospitals. Removed separate capital payment for DRG claims and shifted capital funds into the DRG base rates. Implemented less-than-one-day-stay payment reduction policy

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Intermediate Care Facility for people with Intellectual Disabilities (IFCF/IID)	• Full cost reimbursement method based on previous year cost reports • Removed link with Nursing Home rates. Rates now updated annually with full cost coverage	No change	No change	No change	No change
Laboratory	• Lower of the Medicaid fee schedule or the provider's usual and customary charges • In SFY 2009, rates increased to 90% of Medicare's rates • Twelve laboratory procedure codes' rates adjusted to 80% of SFY 2007 average billed charges	Reimbursement reduced by 2.5% due to the Governor's budget cuts	No change	No change	No change

Nursing Facility[12]	• In SFY 2011, rates were updated based on analysis of Medicaid cost reports
	• Prospective per diem rate with rate components for capital cost, operational cost, and direct care costs
	• Additional reimbursement monthly for extraordinary needs determined on a per case basis
	• Rate updates in SFY 2016 based on approved NF reimbursement update.
	• Additional payments:
	  ○ Provider Assessment and Upper Payment Limit (UPL) Payment provides supplemental payments (effective April 1, 2011)
	  ○ Implemented Provider Assessment and Upper Payment Limit (UPL) Payment after Legislative and federal approval. First payment in SFY 2012.
	• Nursing Facility Gap Payment Program approved in SFY 2017; no change to rate methodology
		Reimbursement reduced by 2.5% due to the Governor's budget cuts	Reimbursement rates increased by 5% July,1 2021 through June 30, 2022	Reimbursement rates increased	Reimbursement increased by 20% for Wyoming nursing facilities effective July 1, 2023

[12] On July 1, 2015 (SFY 2016), Wyoming Medicaid implemented an acuity-based reimbursement methodology for nursing facility services.

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Outpatient Hospital	• Outpatient prospective payment system (OPPS) based on Medicare's Ambulatory Payment Classifications (APC) system • 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 • QRA program provides supplemental payments to non-state governmental hospital • SFY 2012 adjusted conversion factors: ○ General acute: $50.99 ○ Critical access: $129.74 ○ Children's: $109.95 • SFY 2013 adjusted conversion factors: ○ General acute: $48.19 ○ Critical access: $126.82 ○ Children's: $105.50 • SFY 2014 adjusted conversion factors: ○ General acute: $45.45 ○ Critical access: $118.86 ○ Children's: $100.05 • SFY 2015 adjusted conversion factors: ○ General acute: $42.34 ○ Critical access: $111.93 ○ Children's: $92.71 • SFY 2016 adjusted conversion factors due to budget cuts: ○ General acute $39.41 ○ Critical access $102.53 ○ Children's $85.41 • SFY 2017 adjusted conversion factors due to budget cuts: ○ General acute $37.94 ○ Critical access $98.80 ○ Children's $76.34 ○ ASCs $33.39 • SFY 2018 adjusted conversion factors due to budget cuts (effective calendar year 2018): ○ General acute $39.70 ○ Critical access $104.27 ○ Children's $83.92 ○ ASCs $34.94 • SFY 2019 adjusted conversion factors (effective calendar year 2019): ○ General acute $42.53 ○ Critical access $105.89	Reimbursement reduced by 2.5% due to the Governor's budget cuts	Adjusted conversion factors (effective calendar year 2022): • General acute $46.88 • Critical access $112.72 • Children's $84.54 • ASCs $41.25	Adjusted conversion factors (effective calendar year 2023): • General acute $46.49 • Critical access $111.80 • Children's $83.77 • ASCs $40.91	Adjusted conversion factors (effective calendar year 2024): • General acute: $46.37 • Critical access hospitals: $111.42 • Children's: $83.39 • ASCs $40.81

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
	○ Children's $88.45 ○ ASCs $37.42 • SFY 2020 adjusted conversion factors (effective calendar year 2020): ○ General acute $45.79 ○ Critical access $109.66 ○ Children's $83.59 ○ ASCs $40.30				
Physicians/ Practitioners[13]	• Adopted Medicare's 2009 RVUs (effective August 1, 2009) • Adjusted the conversion factors for physician services (effective August 1, 2009) • Reimbursement budget reduced by $4.8 million • 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 • Beginning January 1, 2013, the Affordable Care Act (ACA) mandated increased primary care service payment by State agencies to at least meet the Medicare rates in effect in CY 2009 for CY 2013 and 2014 • Beginning August 1, 2013, OB services transitioned to RBRVS reimbursement methodology using Calendar Year 2013 RVUs • On November 1, 2016, the conversion factor was adjusted to reflect a 3.3% reduction on all RBRVS codes	• Reimbursement reduced by 2.5% due to the Governor's budget cuts • Chiropractic services are limited to children under EPSDT and members on Medicare • Threshold limit for dietician services removed	No change	No change	No change

[13] The ACA Primary Care Service Payments ended December 31, 2014 (SFY 2015).

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Prescription Drugs	• In SFY 2011, the prescription drug list (PDL) was expanded to 80 specific drug classes • The lower of the estimated acquisition cost (EAC) of the ingredients plus the dispensing fee and the provider's usual and customary charge include: ○ The EAC, which is the Average Wholesale Price (AWP) minus 11% ○ Of note, the AWP is determined by pricing information supplied by drug manufacturers, distributors, and suppliers and is updated monthly ○ Some drugs are priced by the State Maximum Allowable Cost (SMAC) ○ The dispensing fee is $5.00 per claim • In SFY 2009, Preferred Drug List (PDL) expanded to 21 specific drug classes • In SFY 2011 - PDL expanded to 80 specific drug classes • In SFY 2012 - PDL expanded to 109 specific drug classes • In SFY 2013 - PDL expanded to 108 specific drug classes • In SFY 2014 – PDL expanded to 119 specific drug classes • In SFY 2015 – PDL expanded to 123 specific drug classes • Reimbursement structure changed on April 1, 2017, to comply with the Final Covered Outpatient Drug Rule	No change	No change	No change	No change
PRTFs	• Rates increased based on analysis of Medicaid cost reports • Per diem rate. The rate includes room and board, treatment services specified in the treatment plan, and may include an add-on rate for medical services • SFY 2014 – Rates adjusted December 1, 2014, based on analysis of Medicaid cost reports	Reimbursement reduced by 2.5% due to the Governor's budget cuts	Per diem rates increased by facility for SFY 2022	Per diem rates increased by facility for SFY 2023	• Per diem rates increased by facility for SFY 2024 • PRTF Supplemental Payment Program implemented, effective July 1, 2023

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
RHCs	• In SFY 2011, rates increased 0.4% based on Medicare Economic Index (MEI) • Prospective per encounter payment system established 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 MEI • SFY 2014 – rates increased 0.8% based on MEI • SFY 2015 – rates increased 0.8% based on MEI • SFY 2016 - rates increased 1.1% based on MEI • SFY 2017 – rates increased 1.2% based on MEI • SFY 2018 - rates increased 1.01% based on MEI • SFY 2019 – rates increased 1.015% based on MEI • SFY 2020-- rates increased 1.9% based on MEI	Rates increased 1.4% based on MEI	Rates increased 2.1% based on MEI	Rates increased 3.8% based on MEI	Rates increased 4.6% based on MEI
Vision	• Lower of the Medicaid fee schedule or the provider's usual and customary charge • 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	Reimbursement reduced by 2.5% due to the Governor's budget cuts	No change	No change	No change

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024

Waiver Services – Comprehensive & Supports	• A 6% restoration of the SFY 2010 10% rate reduction (or 96% of the SFY 2009 rates) was implemented
	• Cost-based reimbursement methodology, implemented in SFY 2009:
	  ○ The Individualized Budget Amount (IBA) is based on the historical plan of care units multiplied by the respective service rate less one-time costs, such as assessments, specialized equipment, or home modifications
	  ○ Prior to cost-based reimbursement, individualized budget amount determined by the "DOORS" funding model, which estimates individual expenditures based on specific customer characteristics
	• Reimbursement for specific residential and day habilitation services is made on a per diem basis and varies by provider and consumer
	• Consumers negotiate rates based on their budget amount
	• Rates were reduced by 1% at the beginning of SFY 14 as required by the legislature to reach a 4% overall budget reduction for the waivers
	• Participants from ABI waivers will transition to either the Comprehensive or Supports Waiver between January 1st and March 31st of 2017. On March 31st, 2017, ending the ABI waivers
	• Implemented 3.3% rate increase on February 1, 2017, applied retroactively back to July 1, 2016; Adult and Children ID/DD Waivers closed
	• Temporary provider rate increase of 12.5% for some waiver services in response to the COVID-19 public health emergency (March 1 - September 1, 2020)
		Temporary provider rate increase (February 1, 2022- March 1, 2024). Rate increases were financed through the American Rescue Plan Act of 2021 (ARPA). Providers must apply the entirety of rate increases to direct support worker compensation	A rate rebasing study was finalized in September 2021, and new provider reimbursement rates went into effect on February 1, 2022. Providers must apply the entirety of rate increases to direct support worker compensation. The reimbursement 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	Rates increased 4.6% based on MEI	12.5% temporary rate increase maintained funded through ARPA in effect until 3/31/2025

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Waiver Services – Children's Mental Health Waiver	• In SFY 2010, rates were adjusted to reflect budget neutrality • Lower of the Medicaid fee schedule or the provider's usual and customary charge • Reimbursement based on procedure code fee schedule • On July 1, 2015, the Care Management Entity began serving youth • In SFY 2018, worked with CMS for approval of SFY 2017 rates • In SFY 2019, the Care Management Entity (CME) premium payment claims made in SFY 2017 and SFY 2018 were adjusted to the approved CMS rate for risk-based capitated payments • Administrative services payments to CME were made under a non-risk capitated payment methodology • CME network provider payments require prior authorization from CME • Payments based on procedure code fee schedule	No change	No change	No change	No change[14]
Waiver Services – Community Choices [formerly: Long-Term Care and Assisted Living Facility (ALF) Waivers]	• Lower of the Medicaid fee schedule or the provider's usual and customary charge • Reimbursement limited to a monthly or yearly cap per person, according to the established care plan • Rates increased for ALF Waiver • ALF Waiver: 12% increase per rate rebasing project, effective March 1, 2016 • LTC Waiver: 8% increase per rate rebasing project, effective March 1, 2016 • ALF Waiver closed in SFY 2017, with service provided under the Community Choices Waiver	Rate increase for select direct care services in response to the COVID-19 public health emergency	Provider rate increase implemented July 1, 2021. As required by ARPA, case management and assisted living facility rates were retroactively adjusted to ensure rates were not less than the rates that were effective as of April 1, 2021	Rate increase as agency adopted an increase for hot and cold meals for recipients	12.5% temporary rate maintained, funded through ARPA in effect until 3/31/2025

[14] Rate increases were implemented for SFY 2025 on July 1, 2024.

Service Area	SFY 2020 and Previous	SFY 2021	SFY 2022	SFY 2023	SFY 2024
Waiver Services - Family Planning Waiver - Pregnant by Choice Program	• The waiver was implemented in SFY 2009 • Multiple reimbursement methodologies and fee schedules based on the service areas detailed in this table • Extended to 12/31/2019 • In SFY 2019, an extension application was submitted to CMS • Waiver extension through 12/31/2027	The Family Planning Waiver was approved 4/7/2020 to cover FPW services through 12/31/2027 CMS reimbursement will be through a PMPM amount. For CY 2021 the PMPM rate is $12.10. For CY 2022 the PMPM rate is $12.65 Any expenses beyond the PMPM are covered by Wyoming Medicaid	No change	No change	No change