Rural Health Transformation
in Wyoming

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an application

submitted to the

Centers for Medicare and Medicaid Services

pursuant to

P.L. 119-21 §71401

Wyoming Department of Health

November 5th, 2025

 YOMING is a small town with unusually long streets.

—former Governor Mike Sullivan

Contents

1 Project summary

Wyoming's proposal for Rural Health Transformation, as developed and submitted by the Department of Health (WDH) and the Governor's Office, is intended to directly address the health care priorities of our rural communities.

We collected those priorities in a series of eleven (11) town hall meetings, and had them ranked by 1,316 Wyomingites in an online survey. The priorities that came out on top aren't extravagant. Most center on access to the basics: hospitals that can effectively treat emergencies, ambulances that show up quickly when you dial 911, and primary care that treats the whole person.

When combined with the federal objectives articulated in the One Big Beautiful Bill Act, these priorities informed the four (4) major goals of our proposal. With supporting components listed under each, these are:

1. To increase sustainable access to right-sized and coordinated rural medical care.

- Encouraging smaller Critical Access Hospitals to focus on doing the basics well, and creating incentives for small ambulance services to consolidate around sustainable regional funding bases;
- Expansion of primary care that integrates behavioral health and preventative medicine;
- Building an affordable major medical plan for people priced out of health insurance.

2. To build a durable workforce pipeline.

- Individual education support for people looking to become nurses, primary care providers, behavioral health clinicians and emergency medical technicians;
- Grants for institutions to build career pipelines in these fields, starting in high school; and,
- Loosening scope of practice for physician assistants, dental hygienists, and pharmacists.

3. To improve metabolic, cardiovascular, and behavioral health outcomes.

- Exercise and diet promotion;
- Restricting the use of SNAP/food stamps to buy unhealthy food; and,
- Statewide telepsychiatry and crisis intervention services.

4. To use technology and payment models to improve chronic disease management and bring care closer to home.

- Clinically-integrated care coordination for people at high risk of chronic disease; and,
- Non-emergency transportation coordination.

We were requested to assume a hypothetical $200,000,000 total budget for this proposal. Depending on the amount Wyoming actually receives, 48% of the funding will support access to emergency medical care, 25% will increase rural workforce supply, 16% is targeted at improving health outcomes, 10% will help providers acquire innovative new technology, and less than 1% will cover State administrative costs.

Although this funding is time-limited, all of our initiatives are intentionally built for the long-term. Rural Health Transformation is a once-in-a-generation opportunity to strengthen how care is delivered in Wyoming, and we will not let it go to waste.

2 Rural health needs and target population

2.1 Wyoming's rural and frontier geography

With an estimated 587,618 people[1] spread over 97,813 square miles, Wyoming is the most sparsely-populated state in the lower 48.

This doesn't mean that 6 people are spread out over every square mile, exactly. As Figure 8 in the Supplemental Materials section shows, our population clusters into a loose network of small cities and towns. Only two cities (Cheyenne and Casper) have more than 50,000 inhabitants, and only the next three (Gillette, Laramie, and Rock Springs) have more than 20,000 people.[2] In this respect, Wyoming resembles a large archipelago spread out over a vast sea of sagebrush, split up by ranges of forested mountains.

For the purposes of this application, we categorize the State into three major geographic areas, which are visualized on Figure 9 in the Supplemental Materials:

- **Urban** areas, which are those Census Tracts that are *not* classified as "rural" in the latest iteration of the Federal Office of Rural Health Policy (FORHP) rural area data file.[3]
- **Rural** areas, which are those Census Tracts designated as rural by FORHP, but do *not* meet USDA Frontier and Remote (FAR) Level 2 standards.
- **Frontier** areas, which are all those 2020 Census Blocks that fall into a rural Tract designated by FORHP and *also* meet USDA FAR Level 2 standards.[4]

[1] 2024 annual population estimate; Division of Economic Analysis, Department of Administration and Information. http://eadiv.state.wy.us/pop/st-24est.htm

[2] http://eadiv.state.wy.us/pop/Place-24EST.htm

[3] https://www.hrsa.gov/rural-health/about-us/what-is-rural/data-files. Note: this classification basically includes the urban areas of Cheyenne and Casper, though one Census Tract southeast of Cheyenne encompasses an "urban" area which is clearly quite sparsely populated, per the population density map in Figure 8.

[4] See: https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes/documentation. We applied this methodology to 2020 Census Block geographies using driving distance matrices calculated with Open Source Routing Machine / Open Street Map data. We "rolled our own" methodology here because USPS ZIP codes are collections of post offices and routes, change from year to year, and are not intended to be areal. Equivalent Census ZCTAs thus have significant holes across the State. 2020 Census Blocks, by contrast, cover the State entirely and can be mapped neatly to the latest Decennial Census population counts.

2.2 Rural demographics

Wyoming's frontier areas are its largest, in terms of both area and population. Approximately 253,000 people, or ~ 44% of the State's population, live in these cities and towns, followed by ~ 171,000 people (~ 30%) in rural areas, and ~ 153,000 (~26%) in the urban cores of Cheyenne and Casper.

2.2.1 Age distribution

Figure 7 in the Supplemental Materials shows the distribution of 5-year age groups by these geographic areas.[5] The pane on the right shows absolute counts (thousands) in urban (green), rural (dark blue) and frontier (light blue) areas. The pane on the left translates those counts into the percentage of each area's total population.

The pane on the left shows the most salient geographic differences:

- Frontier areas have a disproportionately older population, which is most evident in the 55-80 year age groups. There are also comparatively fewer younger working-age adults (20-40), compared with urban and adjacent rural areas.
- Urban areas also have higher percentages of the 'oldest old', likely due to the more acute medical and long-term care needs of this population.

2.2.2 Educational attainment, employment, and income

Wyoming prides itself on the uniformity and equality of its education system, principles which are deeply rooted in our State Constitution. And, as Figure 17 in the Supplemental Materials shows, there are little meaningful differences in educational attainment by geography.[6]

Employment figures are similarly uniform across geography. Likely due to age differences, there is a slightly higher percentage of people who are not in the labor force in rural and frontier areas, as shown in

[5] Data comes from 2020 Decennial Census data aggregated and cleaned by IPUMS (IPUMS USA, University of Minnesota, www.ipums.org), with block groups categorized per Figure 9.

[6] These data are from 2023 ACS estimates downloaded from data.census.gov. Because these tables are only available at the Census Tract level, we cannot distinguish between rural and frontier here.

Table 25 in the Supplemental Materials.[7] Some intuitive geographic differences show up in the industry breakdown shown in Table 26 in the Supplemental Materials: more people in rural/frontier areas work in agriculture, forestry, fishing, and mining than those in urban areas, who tend to work slightly more in retail and public administration.

As shown on Figure 18 in the Supplemental Materials, Wyoming's rural and frontier areas have a slightly higher household income than urban areas. This is likely due to being older, on average, per Figure 7 in the Supplemental Materials.

2.2.3 Health insurance coverage

Table 24 in the Supplemental Materials shows how our estimate[8] of *primary* health insurance coverage varies across geography.

Of note:

- Frontier areas tend to have more Medicare and Indian Health Service coverage, due to the older demographics and the location of the Wind River Reservation, as noted on Figure 9.
- The rural areas around urban cores have lower Medicaid and Medicare penetration, and higher employer sponsored insurance (ESI) coverage.
- Warren Air Force Base and the associated military retiree community in Cheyenne increases the urban percentage of VA and TRICARE.
- Directly-purchased insurance on the federally-facilitated marketplace has increased significantly from ~ 25,000 to 45,000 with the expansion of Advanced Premium Tax Credits under ARPA. It is likely that Marketplace enrollment would fall back to previous levels if the APTC expansion is not extended.

[7] As with the educational attainment data, employment information comes from 2023 Census estimates aggregated at the Tract level, so breaking out frontier from rural is also not possible.

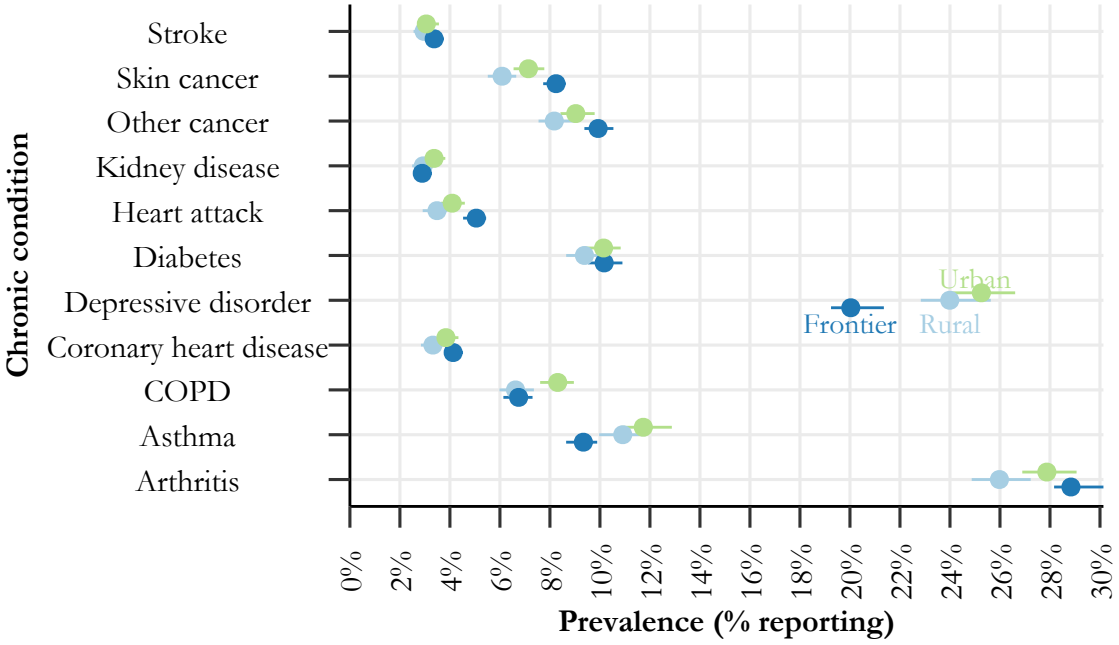
[8] This comes from Bayesian models applied to ten years of pooled restricted American Community Survey microdata. We undertook this effort in partnership with the US Census Bureau and its Rocky Mountain Federal Statistical Research Data Center. The associated project number is 2909; estimates by age-group, sex, race/ethnicity, and Census Block Group cleared disclosure review and were publicly released in December of 2024 (CBDRB-FY25-0096). We combined these estimates with 2020 Decennial Census data from IPUMS to produce this post-stratified table.

2.3 Health outcomes

2.3.1 Chronic conditions

Figure 1 shows the current (2024) estimated burden of 11 self-reported chronic conditions by the same rural/frontier/urban divide.[9]

Figure 1: Chronic conditions - reported prevalence (2024 est.)



While Wyoming's burden of chronic disease is comparable to the national average, there are some disparities that seem to be largely driven by age: note the increase in cancer, heart attack, stroke, and arthritis conditions among the largely older frontier populations, but lower reported depression and asthma.

Socioeconomic status also affects risk. In addition to the figure showing individual chronic conditions, we include two maps in the Supplemental Materials section:

- Figure 11 shows **metabolic disease risk**[10] across the Census Block Groups of Wyoming; and,

[9] These estimates come from pooled 2021-2024 Behavioral Risk Factor Surveillance System (BRFSS) microdata, which was then used to build a set of hierarchical Generalized Additive Models to predict reported prevalence based on demographic factors and geographic location (population-weighted ZIP centroids). We applied these models to the same 2020 Decennial Census population model to estimate reported prevalence across Census Blocks, which we then aggregated into the frontier/rural/urban areas shown on Figure 9.

[10] We represent this on an ordinal scale that comes from adding up reported BRFSS dummy variables for obesity, diabetes,

- Figure 12 shows **cardiovascular disease risk**[11] over the same areas.

Importantly, on the metabolic risk map, the wealthier areas of the State in the northwest corner (Teton, northern Lincoln, Sublette and upper Fremont counties) have significantly lower risk than the central areas.

2.3.2 Behavioral health outcomes

Wyoming stands out from the rest of the United States on one major concern: our **suicide rate** is one of the highest in the nation, with an age-adjusted 26.3 deaths per 100,000 people.[12] Two other major behavioral health concerns include:

- **Overconsumption of alcohol**, with 19.8% of adults reporting binge drinking within the last 30 days, making Wyoming the 13th highest state on this measure in 2022.[13]
- Wyoming's **drug overdose** rate is lower than the national average (23.7 deaths per 100,000), but still unacceptably high.[14]

2.3.3 Maternal and child health outcomes

The Department of Health's most recent Maternal and Child Health Needs Assessment[15] revealed both bright spots and deficits when it comes to maternal and child health.

One bright spot is preventive care. More mothers, for example, received early prenatal (80%) and post-partum (95%) checkups than the national average (77% and 91%, respectively). More Wyoming children (84%) also received a preventive dental visit than the national average (79%).

Unfortunately, Adverse Childhood Experiences (ACEs) are a significant deficit: More children under 17 (24%) have experienced 2 or more ACEs than the national average (18%), and more Wyoming adolescents

and kidney disease.

[11] Another ordinal scale, adding up angina/CHD, stroke, and heart attack.

[12] CDC WONDER - 2023; https://www.cdc.gov/suicide/facts/rates-by-state.html

[13] CDC BRFSS - https://www.cdc.gov/alcohol/excessive-drinking-data/index.html

[14] CDC WONDER - https://www.cdc.gov/nchs/state-stats/deaths/drug-overdose.html

[15] https://health.wyo.gov/publichealth/mch/mch-needs-assessment-2025/

report being bullied (47%) or bullying others (21%), compared with the national average (33% and 12%, respectively).

2.4 Healthcare access challenges

Our geography and population density make access to care difficult. Health care facilities, as shown in Table 23 in the Supplemental Materials section,[16] tend to cluster in the larger cities and towns within each county.

People therefore expect to drive some distance to reach medical care. As an example, Table 1, below, uses SFY24 Wyoming Medicaid claims data to estimate median travel times[17] (in minutes) to various provider types. As you would expect, people in frontier areas have much longer distances to travel to care than those in rural or urban areas. Access is obviously more difficult for people who can't drive; in Wyoming, there is effectively no public transportation outside the "urban" centers of Cheyenne and Casper.

Table 1: Median travel times (minutes) - Wyoming Medicaid

	Geography		
Provider Type	**Frontier**	**Rural**	**Urban**
Dental	34.8	57.1	9.5
FQHC/RHC	6.9	7.3	7.0
Family Medicine	26.0	10.2	7.4
Hospital	27.4	9.2	7.3
Obstetrics & Gynecology	98.6	10.3	8.9
Pediatrics	44.2	10.9	7.7
Pharmacy	7.2	7.3	6.5

Critically, however, our biggest challenge lies in **access to basic medical care.** These include:

- The availability of **ground ambulance** services to respond to 911 calls;

[16] We omit smaller provider types like Boarding Homes and ICF/IDs for brevity.

[17] Weighted by each member-provider pairing for Wyoming Medicaid's population for all paid claims where geocoded address data was available for both member and provider. Driving distances were calculated using the Open Source Routing Machine on Open Street Map data for Wyoming and surrounding states.

- The viability of **small, rural hospitals** capable of the basics: e.g., "stabilize and ship" to higher levels of care in case of emergency;
- Access to **labor and delivery services** so mothers can have babies safely; and,
- Low and variable access to **primary care** and **behavioral health providers**.

2.4.1 Ambulance service availability

Most people expect an ambulance to show up quickly when they dial 911. In Wyoming, we can't take this for granted. Figure 10 in the Supplemental Materials, for example, shows which areas of the State have ground EMS responses under 9 minutes, between 9 and 30 minutes, and over 30 minutes.

When we add up the people living in those areas and categorize by urban, rural, and frontier status, we end up with Table 2, which intuitively shows that significantly more people in frontier areas live in areas with longer EMS response times.

Table 2: Percent of people living within response time areas

	Response time (minutes)		
Geography	**< 9**	**9-30**	**30 +**
Frontier	39%	51%	9.8%
Rural	61%	35%	4.6%
Urban	88%	11%	0.9%

This, of course, is the current situation, which is constantly at risk of degrading. Many smaller EMS services are operated by volunteers, and volunteerism is declining. Due to the gravity of the situation, the Department of Health conducted a thorough analysis of ground EMS around Wyoming earlier this year.[18] Key findings from this report include:

- 44 EMS providers in Wyoming respond to ~ 77,500 calls per year. Of these calls, around 37,300 are 911 responses and 12,300 are inter-facility[19] transports.[20]

[18] https://health.wyo.gov/wp-content/uploads/2025/06/WDH-Ground-EMS-primer-6.4.2025.pdf

[19] E.g. hospital to hospital.

[20] These are reimbursable calls, meaning EMS services can be paid for them by most public and private health insurers. The remaining ~ 34% of calls are *not* reimbursable by most payers. Most of these are "lift assists," where ambulance personnel help

- The costs of EMS are fixed, because they are based around a need for readiness. Statewide, we estimate that between 71 (off-peak) to 113 (peak) ambulances are required to be on call at any given moment, at a cost of **~ $66.5 million** dollars per year. EMS revenue, however, is variable. Where the largest services can expect to get paid for 9,000 - 10,000 calls per year, many smaller services see fewer than 100 calls annually. We estimate that, if all visits were billed, the EMS system could collect **~$36.7 million** in revenue. This leaves a significant gap that is filled by existing subsidies like volunteer labor, local tax revenue, and Critical Access Hospital (CAH) reimbursement.
- As shown on Figure 19 in the Supplemental Materials, only the three (3) largest services have utilization[21] greater than the 30% benchmark that most EMS services need to be sustainable based on volume alone.

2.4.2 Rural facility financial health

While Wyoming is fortunate to not have had any hospitals close in recent memory, we have seen reduction in services due to financial strain, particularly in labor and delivery.[22]

Small rural hospital finances remain shaky. The Provider Financial Trends section of the Supplemental Materials shows how (e.g., in Table 30) various health and human service providers compare with each other on basic financial metrics, averaged over the last five years.

For Critical Access Hospitals in particular, while financial health did improve after COVID due to federal subsidies (e.g. CARES and ARPA), it has begun to degrade again, as shown in the Critical Access Hospital tables in the Supplemental Materials.[23] The root causes of these trends are explored in the relevant Goals section.

someone who has fallen but cannot get up.

[21] I.e., the percent of time the ambulance is actually responding to calls.

[22] This is discussed in detail in a subsequent section.

[23] Unfortunately, the timelines for processing cost report data mean that more recent financial health metrics are not available.

2.4.3 Labor and delivery: maternity deserts

The precarious position of hospital finances has manifested itself most clearly in the increasing spread of maternity deserts in Wyoming. Here, we define a "maternity desert" as a county that simply does not have a hospital where babies can be delivered routinely and safely: we do not even consider the absence of higher-level care,[24] which is a separate concern entirely.

In addition to showing hospitals with labor and delivery units as red dots, Figure 20 in the Supplemental Materials shows our current assessment of three different categories of maternity desert:

- **Longstanding** deserts are counties that have never had a hospital with this capability. Mothers who live in these areas have always had to drive somewhere else for care.
- **New** deserts are the most concerning. Over the past five years, hospitals in Riverton (2018), Rawlins (2022), Kemmerer (2022), Evanston (2024) and Wheatland (2025) have shut down labor and delivery services. In almost all cases, the hospitals have cited financial stress and the relative unprofitability of these services as a rationale.
- **Warning** areas are where we see declining births[25] and counts of OB/GYN providers. While the situation in Gillette appears stable, Lander has shown a precipitous decline.[26]

The degradation in labor and delivery services has had an observable impact on new mothers. Figure 2 shows how the *median* drive time from mothers' residences to their birthing hospital[27] has significantly increased for the frontier areas of Wyoming. Rural and urban drive times have only increased slightly over the same period.

Limited access and longer distances to maternity care are associated with a range of poorer outcomes, to include maternal and infant mortality, severe maternal morbidity, births in hospitals without obstetrics

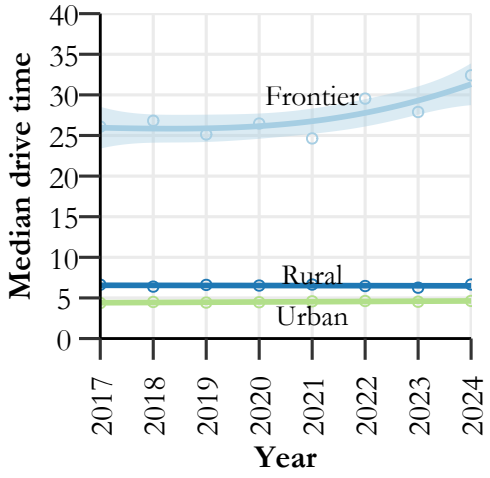
[24] E.g. Wyoming does not have a Level III NICU.

[25] Figure 21 in the Supplemental Materials shows the trends in births by hospital over time. While Wyoming's birth rate has been declining generally due to demographic shifts, charts like this do give us some indication of where new maternity deserts may emerge.

[26] Note, however, that Wheatland, which stopped L&D services last month, was not previously identified as a warning county; decisions of corporate owners or hospital boards to reduce maternity services can occur very unexpectedly, and more Wyoming facilities may be at risk of reducing maternity services than may be identifiable from this analysis.

[27] Locations taken from Wyoming Vital Statistic Services for all Wyoming births.

Figure 2: Median drive times for mothers



units, preterm and low-birthweight infants, and NICU admissions.[28]

2.4.4 Low and variable medical provider density

The difficulty hospitals have in maintaining a group of obstetric providers who can deliver babies[29] is one reason for the growth in maternity deserts. But low provider density generally is a major rural health care challenge in and of itself. Wyoming has one of the lowest provider-to-population ratios in the nation. This ratio is also highly variable *within* the State itself.

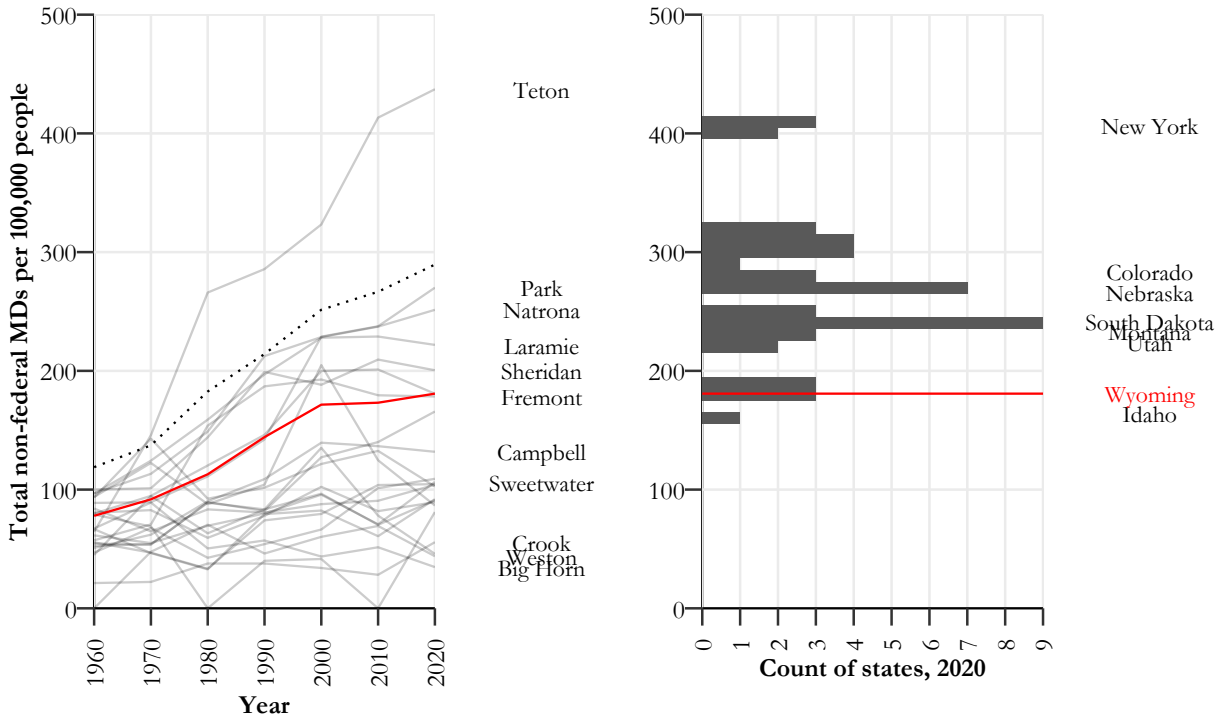
Figure 3 on the next page, for example, shows trends in active MDs per capita by county since 1960.[30] The right pane of the figure shows a histogram for all US states in 2020. Note that Wyoming is the second-lowest state, after Idaho, on MDs per capita in the nation, but also that disparities inside Wyoming are widening. Where counties like Teton have more MDs per capita now than New York State today, other counties like Big Horn, Weston and Crook have the same or fewer MDs per capita than they did in 1960.

[28] E.g., Nesbitt TS, Larson EH, Rosenblatt RA, and Hart LG. Access to maternity care in rural Washington: its effect on neonatal outcomes and resource use. Department of Family Practice, University of California-Davis, Sacramento 95817, USA. American Journal of Public Health 87, no. 1 (January 1, 1997): pp. 85-90. https://doi.org/10.2105/AJPH.87.1.85

[29] Most hospitals need at least three in order to mitigate the strain of being on-call.

[30] Data is from HRSA Area Health Resource Files aggregated from 2014 to 2024. MDs are not the only provider out there, but the count appears to be one of the consistently tracked provider types over this long time period. It's unclear if "active" MDs means practicing in-State physically, or merely having an active medical license, but we trust that the HRSA definition has remained consistent across time and space.

Figure 3: Comparative trends in MDs per capita



MD physicians, of course, are not the only providers of interest. Table 27 in the Supplemental Materials gives a more comprehensive look at current primary care provider to population ratios across Wyoming counties today (2022 being the most recent date in the 2024 Area Health Resources File). When allied health professionals like Physician Assistants (PAs) and Nurse Practitioners (NPs) are included, Teton's primary care to population ratio is not nearly as disproportionately high as it is for MDs, but frontier counties like Big Horn, Niobrara, Sublette, and Crook are still quite low.

2.5 Target population and geographic area

The target population for all the initiatives in this program are the ~ 424K Wyomingites who live in the rural and frontier parts of the State, where the fundamental access to care problems articulated in the previous section are most acute. All providers, however, including the larger hospitals in our two "urban" cores, serve this population, so we see Rural Health Transformation as a Statewide effort.

3 Goals and strategy

Rural Health Transformation would be pointless, even harmful, if it did not address the priorities of Wyoming's rural communities.

How do we know what these priorities are? We asked, and we listened. As described in the Stakeholder Engagement section, we undertook a *significant* effort to gather feedback from the public during the short application window. After 11 town-hall style meetings and a large (over 1,300 complete responses) online survey, we arrived at a ranked list of what we call "Community Rural Health Priorities." The full list is shown in that later section, but the top ten (10) are listed in Table 3 below:

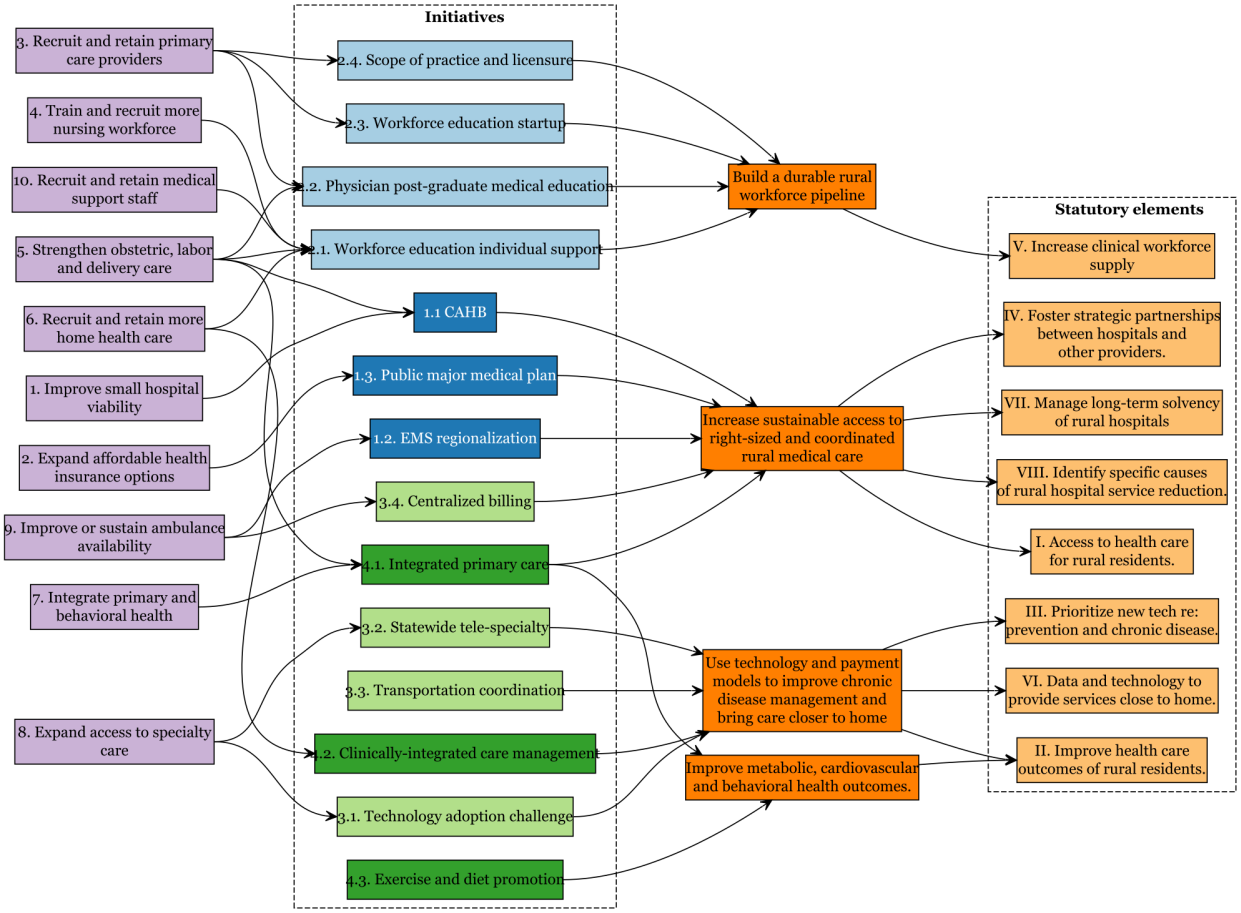
Table 3: Top 10 Community Rural Health Priorities

Rank	Priority
1	Improve the financial viability of small, rural hospitals to provide basic services to their communities.
2	Expand affordable health insurance options.
3	Recruit and retain primary care physicians, in order to improve access and build longer relationships with patients.
4	Train and recruit more nurses and related direct care workforce (e.g. nursing assistants) in order to improve staffing at hospitals and long-term care facilities.
5	Strengthen obstetric/gynecological, labor/delivery and related services so women can deliver babies safely.
6	Recruit and retain more home health aides, and invest in home- and community-based alternatives to nursing home care.
7	Expand the integration of behavioral health and primary care, in order to better treat the whole person.
8	Improve access to specialty medical care in local communities (e.g., orthopedics, pediatrics, geriatrics).
9	Improve or sustain ambulance availability to ensure timely responses to emergencies.
10	Recruit and retain more medical support staff for the health care industry (e.g. radiology, laboratory, therapies, medical assistants).

Figure 4 gives an overview of how these Priorities (light purple) directly influenced the development of our initiative components (colored by overall initiative), which in turn link to our four Goals (orange) that address the elements listed in statute (peach).

For example, Wyoming's top Community Rural Health Priority relates to improving the viability of smaller hospitals. That informed the first initiative's Critical Access Hospital - Basic (CAHB) component, which directly supports our Goal of sustainable access to medical care for rural residents, and is tied to statutory elements I., IV., VII., and VIII..

Figure 4: Strategic framework



3.1 Summary

As shown on Figure 4, we have four primary goals (orange) for Rural Health Transformation:

- **Increasing sustainable access to right-sized and coordinated rural medical care.** As we will illustrate, right-sizing and coordination is key to sustainability for rural hospitals, EMS agencies, and primary care practices.

- **Building a durable rural workforce pipeline**. This goal gets at increasing supply over a long period of time, by focusing on: (1) growing our own workforce, starting with young people, not poaching existing nurses and physicians from other states, and (2) building clear pipelines or career ladders within larger domains (e.g., nursing), so people starting off in lower-level occupations can visualize a longer-term career trajectory.
- **Improving metabolic, cardiovascular, and behavioral health**. These are some of our most pressing health issues as a State, and we believe sustained focus on them over time can make a dent in what are currently unacceptably-high metrics.
- **Using technology and payment models to improve chronic disease management and bring care closer to home**. Technology and innovative payment models are means, not ends-in-themselves. This objective ties the use of innovation to two clear and complementary purposes that directly benefit people's medical care.

Each of these goals is tagged in the sections below with the relevant statutory element as Roman numerals.

3.2 Increase sustainable access to right-sized and coordinated rural medical care (I., IV., VII., VIII.)

Because sustainable access to care requires providers to be financially viable, we begin with a digression on the causes of, and potential solutions to, rural provider financial distress.

3.2.1 Causes of rural provider financial distress (VIII)

The epigraph in this application —former Governor Mike Sullivan's quote about Wyoming being a "small town with unusually long streets" —gets at the fundamental reason why access to basic care is so difficult here: we require significant **fixed health care capacity** to provide service over our "long streets", but don't have the **patient volume** (i.e., the "small town") to pay for it.

In some ways, the existing multi-payer system makes things worse by creating perverse incentives:

- Small rural hospitals, for example, need to maintain emergency department capacity, along with some ancillary services like stroke- and trauma-related imaging, in order to fulfill basic community needs. Patient volume, however, is rarely sufficient to pay for these services alone, so many have to rely on strategies like encouraging elective surgeries —and associated additional cost structures — to pay the bills. It is well documented, however, that the overall cost is lower and quality is higher in higher-volume settings,[31] so this incentive, while logical, is not helpful.
- Similarly, in the case of EMS, interfacility transports are both more predictable and often reimburse more than 911 responses, but they also take resources out of service for long periods of time.

Some of the biggest initiatives in this proposal are therefore aimed at countering these existing effects, using targeted incentives to pay for the fixed cost structure that is so essential to provide, while encouraging regionalization and right-sizing. We believe these "big bets", if sustained, can lead to *true* system transformation in addressing the problems with current payment models.

3.2.1.1 Cause: High fixed costs and low patient volume. The section on ambulance availability noted the significant mismatch between fixed costs and patient volume. This also bedevils small hospitals. Table 28 in the Supplemental Materials, for example, shows our current list of Critical Access Hospital (CAH) and larger Prospective Payment System (PPS) hospitals, with some indicators on size, patient volume, and occupancy.[32]

Note on the table that even the largest PPS hospitals only have occupancy between 40-60%. The smaller CAHs are usually below 30%. And yet, the essential services they provide, whether it's the Emergency Department or the ambulance service, still have to be paid for, regardless of volume.

3.2.1.2 Cause: Staffing shortages and increasing labor costs. Where the "high fixed cost, low volume" problem has always been an issue in Wyoming, a second major issue for rural health care facilities

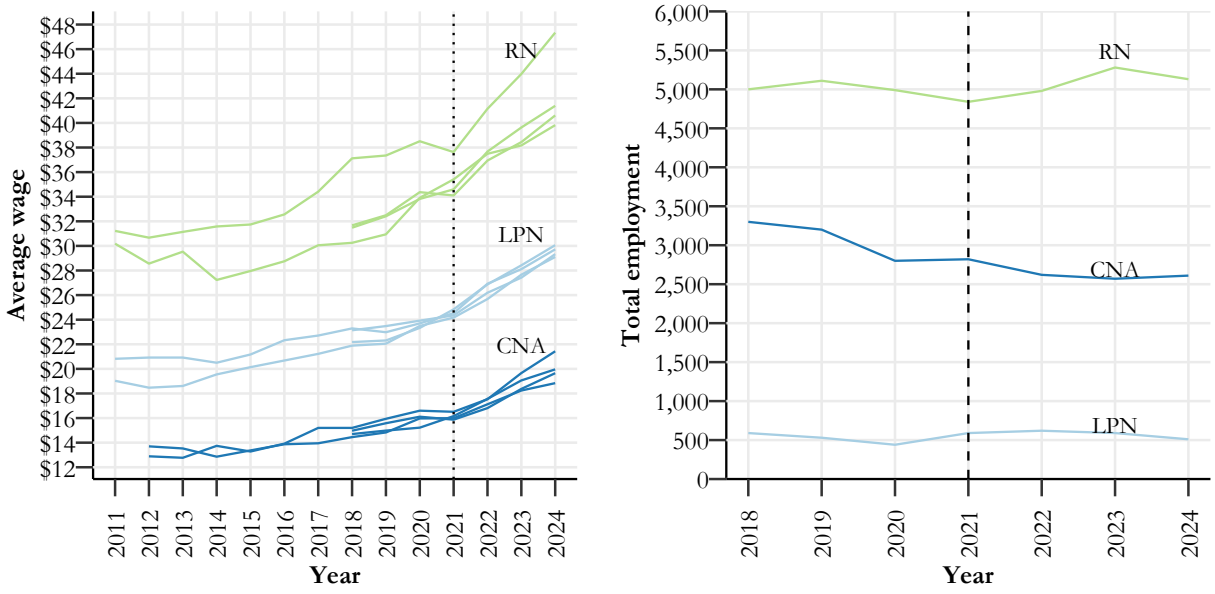
[31] E.g.: https://www.sciencedirect.com/science/article/pii/S0883540325002529 or https://pubmed.ncbi.nlm.nih.gov/39254644/ or https://pmc.ncbi.nlm.nih.gov/articles/PMC10753440/. Generally speaking for surgeons, higher volume contributes to economies of scale and fewer complications.

[32] HCRIS. Note that this data is from FY 2023. Evanston and Sweetwater Memorial have transitioned to Critical Access Hospital designation in the last year. We also have two new hospitals (Saratoga and Pinedale) that are seeking Critical Access Hospital designation, and a new community hospital under construction in Riverton.

is more recent: since the pandemic, the nurse labor market has tightened significantly. Even though it's been five years since COVID-19, many facilities are still relying on exorbitant contracts with traveling nurse agencies in order to cover care requirements.

Figure 5 shows trends in both labor supply (right pane) and average hourly wages (left pane) for nurses (green), Certified Nursing Assistants (CNAs, in dark blue) and Licensed Practical Nurses (LPNs, in light blue).[33]

Figure 5: Nursing-related workforce trends



Note the dramatic inflection in average wage growth for the nursing sector as a whole since the peak of the pandemic (dotted line), while at the same time employment has remained stable, or, in the case of CNAs, shrunk. Because nurses make up the vast majority of hospital workforce, this escalation in labor cost puts additional strain on hospital finances.

3.2.1.3 Cause: Medicare revenue has not kept up with costs for PPS hospitals. With an aging population,[34] Medicare volume will become more and more critical to hospital viability.

[33] Data on average wages taken from Bureau of Labor Statistics Occupational Employment and Wage Statistics. The multiple lines shown for each occupation are trends in the four major MSA and non-MSA regions in Wyoming.

[34] E.g., see the Department of Health's 2023 report on aging and long-term care trends that complements our most recent (pending) Aging in Wyoming 1115 waiver: https://health.wyo.gov/wp-content/uploads/2023/10/Aging-in-Wyoming-Part-I-Primer.pdf

Unfortunately, Medicare revenue for PPS hospitals is not keeping up with Medicare-allowable costs. Figure 22 in the Supplemental Materials shows three facets of this problem:

- On the left pane, it's clear that total hospital costs[35] have steadily increased over time, and that CAH costs are approximately half that of the PPS hospitals.
- On the middle pane, there is a clear increase in the Medicare-related costs per discharge, for both hospital types since the COVID-19 pandemic, but most significantly for CAHs.
- The right pane shows how Medicare cost coverage[36] has improved slightly for the CAHs (due to cost-based reimbursement), but has degraded from ~ 90% to ~ 85% for the PPS system since the pandemic.

Anecdotally, we have also received reports from hospitals of the difficulty in receiving timely and adequate payment from **Medicare Advantage** (MA) plans. Many such plans lean on prior authorization, claims denials, and other administrative hassles to cut their payables.[37] MA penetration has increased in Wyoming from 3% in 2020 to 17% in 2024,[38] and as it continues to grow, it will likely create additional strain on rural providers.

3.2.2 Long-term solvency through right-sizing and partnerships (VII., IV.)

We noted that Figure 22 shows how Medicare cost coverage has remained stable, even increased, for Critical Access Hospitals. This fact points to the central thrust of our goal: consolidate and right-size Wyoming's rural hospital and EMS system around sustainable payer sources, such that, by the end of the funding period:

- The smallest rural hospitals can **focus on doing the basics well** (e.g., emergency services, stroke

[35] i.e., Worksheet A totals, HCRIS.

[36] Medicare revenue as a share of allowable Medicare costs, aggregated across Wyoming hospitals.

[37] E.g., this article from ProPublica illustrates some of the more recent practices in this regard: https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims. And this article explores the interaction of MA with rural hospitals in South Dakota: https://kffhealthnews.org/news/article/rural-hospitals-private-medicare-advantage-contracts-reimbursements/

[38] https://www.kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population-by-plan-type/?currentTimeframe=0

and trauma, EMS, and labor and delivery), leveraging Medicare CAH reimbursement and swing bed occupancy to stay viable, while cutting extraneous cost centers;[39]

- Elective procedures are funneled to larger (likely PPS) hospitals, to increase their viability by **increasing service volume** —and thus improve economies of scale and quality of care;[40]
- EMS agencies are **interoperable on a regional basis**, centered around entities like CAHs and fire departments that have existing bases of funding to support the fixed costs of readiness, and using regional medical dispatch to coordinate resources like Community EMS and interfacility transfers;[41] and,
- People have options for **affordable health benefits** that can cover emergency medical episodes.[42]

More detail of *how* these components are designed to accomplish this endstate are described in detail in their respective Initiatives sub-sections.

3.2.3 Cross-cutting initiatives that will also increase access to care:

While our first initiative focuses on emergency medicine, we have several other initiatives that will similarly improve access to the basics:

1. **Access to integrated primary and behavioral health care**[43] will improve by the expansion of FQHCs through existing primary care and hospital spaces. FQHCs, like CAHs, are another example where sustainability is already greatly assisted by federal revenue.
2. **Access to maternity care**[44] in particular is strengthened by the workforce supply initiative:
   - The increased supply of Family Medicine and other physicians with 5-year service obligations through the post-graduate medical education slots component will add more providers with both primary care and obstetric experience to work in rural communities;

[39] Initiative 1.1.
[40] Initiative 1.1.
[41] Initiative 1.2.
[42] Initiative 1.3.
[43] Community Priority 3 and 7
[44] Community Priority 5

- The increased supply of nurse labor from the individual workforce education support component will help hospitals staff labor and delivery units; and,
- The integrated primary care component has the potential to decrease medical malpractice costs for obstetrics using the Federal Tort Claims Act protection that comes with Federally-Qualified Health Centers.

3. **Access to specialty care**[45] is increased through components like the Statewide tele-specialty and behavioral crisis stabilization pilot, the technology adoption challenge program, and, for people who can't drive, the non-emergency transportation coordination platform.

3.2.4 Key performance objectives

Our KPO for this goal relates to **maternity deserts**. As discussed above, these are a problem caused by the intersection of hospital viability, EMS integration, and rural workforce.

- **KPO 1:** Decrease the number of counties without a hospital providing labor and delivery services (in one or more county subdivisions) from 10 to 8 by the end of the five-year funding period.

3.2.5 State policy actions

The State has already implemented two policy actions relating to increasing access to care:

1. **Short-term limited duration insurance plans (E.3.)** The State does not currently restrict these plans beyond federal guidance.
2. **Certificate of need (C.3.)** Wyoming should receive the highest score on this policy measure.

3.3 Build a durable rural workforce pipeline (V)

As we've shown, access to care also depends on workforce. The endstate of this goal is for Wyoming to have an *increased* and *steady* flow of new graduates from clinical education programs in nursing, EMS, family medicine, and behavioral health. We will accomplish this objective through a combination of:

[45] Community Priority 8

- **Time-limited capacity grants** for Wyoming educational institutions to hire faculty, develop career pipelines (beginning in high school), and otherwise re-tool their operations.
- **Individual workforce education awards** that will assist people in participating in clinical workforce training programs, in exchange for a five (5) year service commitment. As detailed in our Sustainability Plan, these awards would be sustained in **perpetuity**. This not only will increase workforce supply permanently for the State, but the revenue from these awards will sustain educational programs who deliver this training capacity.
- **Physician Post-Graduate Medical Education slots**. Post-graduate medical education is a significant bottleneck in the supply of new practicing physicians. This component would aim to add more slots to our existing accredited programs, likely in new sites, aligned with the Rural Training Track (RTT) model.

3.3.1 State policy actions

In addition to these workforce education initiatives, the Executive Branch will commit to exploring two State policy actions with our Legislature, both of which should increase supply through deregulation:

1. **Licensure compacts (D.2.)**. Wyoming should receive full credit for physician, nurse, EMS, and psychology areas, as we participate in the Medical Licensure Compact,[46] the Nurse Licensure Compact,[47] the EMS Compact,[48] and the Psychology Interjurisdictional Compact (PSYPACT).[49] One area where the State will engage with the Legislature is the **Physician Assistant licensure compact**.[50]
2. **Scope of practice (D.3.)** While Wyoming scores fairly highly on this measure already, with full marks on the PA and NP Cicero measures, there are two areas that we will raise during the upcoming Legislative interim (beginning in April of 2026):

[46] https://imlcc.com/
[47] https://www.nursecompact.com/
[48] https://emscompact.gov/
[49] https://psypact.gov/page/psypactmap
[50] https://www.pacompact.org/#compact

- **Pharmacist scope of practice**. Currently, pharmacists can only prescribe and administer vaccines, epinephrine, and opioid antagonists.[51]
- **Dental hygienist scope of practice**. Wyoming presently allows 2 of 8 task categories.[52] In order to score full points on this measure, we need to allow at least four additional.

3.3.2 Key performance objectives

We have two primary KPOs for the end of the 5-year program period:

- **KPO 2:** Increase the annual number of new providers with 5-year service commitments from zero to 150.
- **KPO 3:** Reduce the rolling 2-year average wage increase for RNs from 9.9% to 4%.

3.4 Improve metabolic, cardiovascular, and behavioral health outcomes (II)

Shifting gears, this Goal is focused on improving population health. We specifically target three primary health care outcomes through a combination of initiatives and State policy actions: (1) metabolic disease, (2) cardiovascular health, and (3) behavioral health.

Our primary strategy to improve these health outcomes is the exercise and diet promotion component of the Make Wyoming Healthy Again initiative.

3.4.1 Cross-cutting initiatives that will support healthier outcomes

Three additional components, however, also support this goal:

1. Improving the integration of primary care with dental, behavioral health, and preventive medicine by funding the expansion of FQHCs into existing clinical spaces. This will improve the quality of primary care rendered to many low-income rural Wyoming residents.

[51] The policy score rewards states that allow prescribing without reliance on statewide protocols or formularies and administering any drug by class. Additionally, the policy score rewards states that allow pharmacists to be able to order and perform any lab test based on clinical judgment.

[52] Excluding the following: (1) diagnosis of oral conditions, (2) prescriptive authority, (3) supervision of dental assistants, (4) direct Medicaid reimbursement, (5) dental hygiene treatment planning, and (6) provision of sealants.

2. The statewide tele-speciality program will begin with tele-psychiatry and crisis stabilization services, which may prove effective for people with high behavioral health needs.

3. Rural workforce initiatives will broadly increase the supply and thus access to primary care and behavioral health workforce.

3.4.2 State policy actions

In addition to these initiatives, three State policy measures are directly connected at improving diet and exercise:

1. **Presidential Fitness Test (B.2.)** The Wyoming State Superintendent of Public Instruction has committed to implementing this in its primary and secondary schools. If successful, this should help increase fitness levels and thus metabolic and cardiovascular health in children.

2. **SNAP waiver (B.3.)** Wyoming has committed to submitting a SNAP Healthy Choice Waiver.[53] If successfully implemented, the federal government will cease subsidizing unhealthy food choices for lower-income Wyoming residents, which should decrease the incidence of metabolic disease.

3. **Nutrition continuing medical education (CME) requirements for physicians (B.4.)** The Department of Health will commit to raising this issue with the Board of Medicine, and possibly with the Legislature during the interim, after the 2026 Budget Session.[54] Successful implementation of this initiative should help providers and patients discuss healthier diet options.

3.4.3 Key performance objectives

We have two primary KPOs for the end of the 5-year program period:

[53] The Department of Family Services (DFS) has collaborated with the Governor's Office, the First Lady's Office, and various community partners to develop the waiver aimed at restricting candy and soft drinks. A bill (26LSO-0140 SNAP benefits-waiver request) has been drafted and passed by the Joint Labor, Health and Social Services Committee meeting on October 16, 2025, and will be received for introduction in the 2026 Budget Session in early February. See https://wyoleg.gov/InterimCommittee/2025/10-20251016 26LSO-0140v0.4.pdf. Additionally, the Governor has issued Executive Order 2025-07, which directs DFS to submit the SNAP waiver. See https://drive.google.com/file/d/12MFHWtNcTy6E25uXAEknaSQW0iSGoqse/view

[54] Current Wyoming CME requirements for physicians are set forth in the Board of Medicine's Rules, Chapter 3, Section 7, and do not currently require nutrition education.

- **KPO 4:** Reduce the prevalence of reported diabetes from a 10.1% baseline to 9%.
- **KPO 5:** Reduce Wyoming's age-adjusted suicide rate from 26.3 to 20.7 (e.g., 2014 levels).

On the last objective, while the exact causal connections between suicide and behavioral health are unclear, reducing this measure is so critical to the State that it must be prioritized. There are numerous existing suicide prevention programs that have been expanded in Wyoming over the past five years; the RHTP initiatives described would complement these activities, not supplant them.

3.5 Use technology and payment models to improve chronic disease management and bring care closer to home (III and VI)

This goal frames technology and payment models as a means to an end: improving how medical care is delivered to rural Wyomingites by giving providers the *right tools* and the *right incentives*. Innovation for innovation's sake is not the goal, and we need to be careful to avoid wasting taxpayer dollars on shiny objects.

Accordingly, our health technology adoption challenge stresses the importance of building responsible procurement guardrails into the process, such as requiring skin in the game for applicants (the "challenge") in order to substantiate their beliefs in the technology's utility, as well as requiring applicants to apply in groups, in order to promote interoperability but also build confidence that technology has been vetted by multiple entities.

Similarly, in our clinically-integrated care coordination pilot project, we will rely on gold-standard techniques (randomized controlled trials) to assess likely success or failure of pilot projects in managing chronic disease.

In sum, we propose to approach this goal cautiously and with clear eyes on what we know and what we don't, iterating our way towards solutions that work best for patients in rural Wyoming.

3.5.1 State policy actions

We do note one correction here:

1. **Medicaid telehealth and remote monitoring reimbursement (F.1.)** The cited report from CMS *incorrectly* labels Wyoming as not reimbursing remote monitoring.[55]

3.5.2 Key performance objectives

These KPOs reflect our conservative approach with technology adoption:

- **KPO 6:** Number of successful[56] shared savings chronic disease management programs.
- **KPO 7:** Percent of tele-specialist costs covered by generated revenue.

3.6 Other required information (A.2. and A.7.)

This section doesn't fit logically or neatly in the goals section, but was requested in the Notice of Funding.

- **Certified Community Behavioral Health Centers (A.2.)** The State has no CCBHCs.
- **Medicaid Disproportionate Share Hospitals (A.7.)** Five (5) hospitals in Wyoming received a grand total of $648,279 in DSH payments in SFY24. Table 4, below, is the list:

Table 4: SFY24 Disproportionate Share Hospital payments

Provider No.	Hospital	City	County	SFY24 DSH
531307	Community Hospital	Torrington	Goshen	$326,016
531304	Hot Springs County Memorial Hosp	Thermopolis	Hot Springs	$96,310
531308	Johnson County Healthcare Center	Buffalo	Johnson	$79,875
531302	Memorial Hospital of Converse County	Douglas	Converse	$62,323
530008	SageWest Healthcare - Riverton	Riverton/Lander	Fremont	$83,755

[55] Wyoming Medicaid reimburses the following codes: 99453, 99454, 99457, 99458, and our Medicaid HCBS Waivers also allow for the following remote monitoring service codes to be delivered via remote monitoring: T2017, T2017UN, T2017UP, T2031, T2016, and T2016U7 (all CLS basic through Level 4).

[56] Demonstrating reductions in PMPM and ED with some confidence in the RCT.

4 Proposed initiatives and use of funds

To achieve these transformative goals, we have developed a series of distinct ideas ("components") grouped into four major initiatives. These components are shown in the dotted box on Figure 4, and link to both the Community Rural Health Priorities (purple) they derive from and the Goals (orange) they support.

After describing each initiative, we also include tables describing the strategic objectives the initiative aligns with, the technical score factors that are impacted, key stakeholders, outcomes metrics, and estimated required funding.

That estimated required funding across our entire proposal is summarized in Table 5, below.

Table 5: Initiatives

Initiative	Initial budget	Percent
Access to emergency medical care	$96,000,000	48.0%
Rural workforce supply	$50,274,504	25.1%
Health technology transformation	$20,500,000	10.3%
Make Wyoming Healthy Again	$31,584,525	15.8%
State administrative expenditures	$1,640,971	0.8%
Total	**$200,000,000**	

In developing these proposed initiatives, we were guided by four major principles:

1. **Needs before wants**. Many of the Community Priorities reflected modest expectations of the basic standard of care: an ambulance that shows up when you dial 911 and can take you to a local ED. A primary care provider who has a real relationship with you and can treat you holistically. None of the priorities are luxuries or frivolities, nor are any of our initiatives.

2. **Initiatives should be voluntary**. There are no "sticks" in this list of proposals, only "carrots." While we often ask for changes that can be difficult, no provider will be forced to work with the State in implementation.

3. **Execution should be decentralized and easily manageable**. Even if we had the interest to do so, government does not have the ability to micromanage change from Cheyenne. All the initiatives proposed here use incentive-based structures to naturally encourage providers to work together to improve systems of care.

4. **Initiatives must be sustainable**. As described in the Sustainability Plan, there are significant risks with injecting a large amount of funding into Wyoming's economy over a short period. All initiatives we propose are either designed to accomplish their purpose within a five year period, or be sustained in perpetuity through program income.

4.1 Initiative: Access to emergency medical care

The purpose of this initiative is to shore up rural Wyoming's access to basic medical infrastructure, to include (1) ambulance services, (2) emergency department and (3) labor and delivery services.

Most Wyomingites consider all three of these **fundamental requirements** for families living anywhere in the State —in the same category as water, sewer, and electrical infrastructure. Failure of these services can effectively condemn a small rural community. As discussed previously, all three are also under stress from the mismatch between the high fixed costs of the infrastructure and the low patient volumes needed to pay for it.

The first two components of this initiative seek to address this mismatch, while aligning provider incentives to improve the efficiency and effectiveness of the emergency medical system by increasing provider partnerships and 'right-sizing' resources across geography. Both complement the existing multi-payer system and allow it to work better for Wyoming.

The remaining component seeks to address *financial* access to emergency services. It does so by setting up a public health benefit plan that offers an affordable alternative to modern comprehensive health insurance by bringing the concept back to its roots: the "major medical" plans of the 1950s that were intended to *protect people against the financial ruin caused by serious disease or injury, but not pay for routine medical services*.

4.1.1 Establishment of the "Critical Access Hospital - Basic" (CAHB) incentive program

The first idea is to give small CAHs an incentive for them to offer essential community services, but not much more. If a CAH elects to participate this program and become a "CAHB," it would be required to:

- Provide a staffed, 24/7 **Emergency Department**, with stroke and trauma imaging capability;
- Own and operate the only **ground ambulance** service within 35 miles;
- Offer **basic labor and delivery** services for new moms, if total annual births from that county exceed a designated threshold; and,
- Use the existing **Statewide Health Information Exchange (HIE)** to share data electronically.

CAHBs would also be strongly encouraged, in contract, to **limit or reduce** provision of **elective surgeries** or **ancillary services**. Those CAHB that do so would need to maintain an agreement with one or more larger hospitals —including a revenue-sharing arrangement —to provide those elective services for area residents.

Depending on the level of commitment from the applicant in bucking the existing fee-for-service incentive structure, the CAHB would receive from the State a set of tiered incentives:

- A **101% cost-based** Medicaid reimbursement rate for all services;[57]
- A one-time **swing-bed conversion grant** to improve the CAHB's financial sustainability, as they allow the CAHB to claim cost-based reimbursement, while being able to flex nursing staff across the hospital.
- A one-time **long-term liability forgiveness grant**, in exchange for writing off all medical debt owed to the facility by Wyoming residents.
- A $1,000,000 per year **perpetual incentive payment** (See the Sustainability Plan) to cover a portion of fixed costs. As shown on Table 28 in the Supplemental Materials, this would represent ~ 2.5% - 10% of a smaller CAH's total annual operating expenses.

[57] Note: this would not be paid for by RHTP funds, but would be a State policy shift associated with RHTP.

4.1.2 EMS regionalization

The second component of this initiative would provide a similar set of incentives to small ambulance services in exchange for transforming their operations to be more efficient and effective through regionalization.

Eligibility for this component would be restricted to groups of two (2) or more smaller ground EMS providers in a contiguous rural and frontier geographic region. These providers must outline a regionalization plan that will:

- **Maximize revenue sources** like Critical Access Hospital (CAH) cost-based Medicare billing or a local fire department tax base;
- Demonstrate how **regionalized medical dispatch** will be integrated with existing Public Safety Answering Points (PSAP);
- Demonstrate the use of **interoperable equipment** and technology across the new, consolidated, service area;
- Demonstrate how **administrative overhead will be cut**; and,
- Commit to the establishment and active use of **community EMS**, where ambulance staff can provide care to community members through scheduled visits between emergency responses, as well as **tele-crisis stabilization** services for people with high behavioral health needs.

In exchange for these commitments, the new EMS region would receive:

- A **perpetual incentive payment** (again, see the Sustainability Plan) of $250,000 per low-volume ambulance in order to subsidize the fixed costs of availability in smaller locations.[58] Regionalization may economize on overhead cost, but the cost of readiness in smaller areas is not reduced.
- A one-time **regionalization equipment grant** that would cover costs for new ambulances, other interoperability equipment, and implementation of medical regional dispatch.

[58] This would cover around half the annual cost of a Basic Life Support ambulance.

4.1.3 Establishment of the "BearCare" public major medical plan

Where the previous two components focus on maintaining *physical* access to care throughout rural Wyoming, this final component covers *financial* access, particularly to emergency services.

As was clear from our public engagement prior to this application, many people in Wyoming find the cost of health insurance to be unaffordable.[59] This is due in part to the high unit prices insurers pay for medical care in Wyoming, but also due to the inclusion of the ten Essential Health Benefits (EHBs) under the Affordable Care Act —many of which go unused by generally healthy people.

This component would give individuals and small employer groups the option of buying-in, at cost, to a State-operated public benefit plan[60] that only covers emergent episodes of care.[61]

This plan could be offered at a significantly lower price point than comprehensive health insurance,[62] even without subsidies, for three reasons:

- Plan benefits[63] would be limited to necessary medical services in an episode of care beginning with an **emergency anchor event**. If benefits are used, coverage would end with the next health insurance open enrollment period. At that point, members would be told that, if they have ongoing medical needs as a result of the original emergency, they need to enroll in a comprehensive health insurance plan.[64]
- Because the plan would only cover unforseeable episodes, the risk of **moral hazard** from allowing individuals to buy-in would be reduced. In other words, the plan would generally select for risk-averse but otherwise generally healthy people.

[59] See Table 29. Expanding affordable health insurance options is number 2. It is no coincidence that the average annual family employer-sponsored premium rose to $27,000 this year (https://www.kff.org/affordable-care-act/annual-family-premiums-for-employer-coverage-rise-6-in-2025-nearing-27000-with-workers-paying-6850-toward-premiums-out-of-their-paychecks/).

[60] Note: *not* an insurance product, so it would not be subject to ACA or ERISA regulation as such. It would also not qualify as insurance for the purpose of the employer or individual mandates.

[61] E.g., being attacked by a bear. In this way, it brings the idea of health coverage back to its roots.

[62] Note, even today's "catastrophic" plans are required to provide the 10 EHBs and otherwise comply with the ACA.

[63] I.e., the "bear necessities"

[64] People with pre-existing conditions would similarly be screened out, and directed to purchase comprehensive health insurance.

- **Medical rates** paid to providers could be set in a public and transparent process to a percentage of of Medicare (e.g., 120%) in order to balance premium cost for individuals against provider income without the administrative overhead of negotiating individual provider rates.

This idea would therefore offer small employers and individuals an affordable benefit plan that is closer in spirit to auto insurance: it covers collisions, but won't pay for oil changes. Members would then have the opportunity to buy other medical services (e.g., prescribed drugs, primary care) on a cash basis, without effectively 'double-paying' for it in their health insurance premium. As a consequence, this would **allows market forces** to work more effectively for elective service delivery, as well as allowing room for innovations like the direct primary care model.

While initial start-up costs[65] would be paid by RHTP funding, the plan would ultimately be **self-funded** from individual monthly enrollment fees. The more liquid portions of the corpus of the Wyoming Rural Health Transformation Perpetuity[66] could be used as an initial reserve.

4.1.4 Strategic alignment, score factors, outcomes, stakeholders, and funding

Table 6: Strategic alignment

Component	Community priority	Elements	Strategic goals
Critical Access Hospital - Basic	1, 5, 13	I., IV., VII., VIII.	Sustainable access
EMS regionalization	9	I., IV., VII.	Sustainable access
Public major medical plan	2	I., VII.	Sustainable access

Table 7: Technical score factors and use of funds

Component	Technical score factors	Use of funding
Critical Access Hospital - Basic	C.1., C.2., F.2.	G, J, K
EMS regionalization	B.1., C.2., F.2.	G, K
Public major medical plan	E.3.	I

[65] Benefit design, actuarial pricing and reserving services, marketing and premium collection.
[66] See the Sustainability Plan.

Table 8: Access to emergency medical care outcomes

Outcome	Exp. years for change	Baseline	Target
Number of CAH-B conversions	2	0	4
Percent of EMS response times under 9 minutes	2	52.4%	60%
Number of smaller EMS agencies that have consolidated	2	0	5
BearCare premium (25 year olds)	2	$589	< $200

- **Key stakeholders**: Wyoming Hospital Association, County governments, Wyoming EMS Association.
- **Impacted counties**: All Wyoming counties.
- **Estimated required funding**: $96,000,000 out of $200,000,000 (48%)

4.2 Initiative: Rural workforce supply

The purpose of this initiative is to **grow the supply** of essential health care workers in Wyoming using a combination of individual education support awards, educational capacity grants, and the 5-year required service periods.

4.2.1 Workforce education individual support

In this component, the State would fund, in perpetuity[67] an annual number of awards to cover educational costs for individuals interested in joining one of four clinical pipelines:

- **Nursing** (CNA, LPN, RN, APRN)
- **Emergency Medical Services** (ED tech, EMR/EMT, Paramedic)
- **Behavioral Health** (clinical)
- **Physician** (i.e., medical school for undergraduates).

Awards would follow the person, who would have the option of enrolling in a list of pre-approved programs. This would allow the State to maximize its options, allow choice for individuals, and encourage

[67] See Sustainability Plan.

competition across educational providers.

After completing their program, graduates would be required to work for Wyoming health care providers for a minimum of 5 years.

4.2.2 Physician post-graduate medical education slots

Similar to the previous component, we would establish, on a perpetual basis, new **post-graduate medical education** (GME) slots that would allow the State to produce more family medicine[68] physicians at sites like the existing Rural Training Track (RTT) residency program in Thermopolis, or otherwise get more exposure to obstetrics and other high-demand specialities. Graduates from these programs would incur a 5-year service commitment for underserved counties.[69]

4.2.3 Workforce education start-up

While the previous two components provide funding to individuals, this component provides time-limited and competitive funding to educational *institutions* so that they can build up their workforce training programs.

Workforce education providers who apply would need to commit to establishing a set number of slots for future nurses, EMS personnel, physicians, and clinical behavioral health providers. In the RFA criteria, we would emphasize:

- Focusing on the **basics**; e.g., widening the base of entry-level professions into healthcare vs. adding higher-level practitioners;
- Development of **integrated pipelines** for workforce; e.g., the career ladder from CNA to RN to APRN; and,
- **Outreach** into primary and secondary education in order to develop interest in health care professions (and a clear picture of career development) at early ages.

[68] We focus on Family Medicine here because it is both a primary care specialty but also includes obstetric training, which will help improve access to maternity care.

[69] We define underserved counties as those that have fewer active MDs per capita than the national average.

4.2.4 Scope of practice and licensure

This last component is made up of the two State Policy actions detailed previously in the Goals section. In the interest of brevity, we won't repeat ourselves on what they involve.

- **Licensure compacts (D.2.)**
- **Scope of practice (D.3.)**

4.2.5 Strategic alignment, score factors, outcomes, stakeholders, and funding

Table 9: Strategic alignment

Component	Community priority	Elements	Strategic goals
Workforce education individual support	4, 5, 6	V., VII., VIII.	Workforce development
Physician post-graduate education	3, 5	V., VII.	Workforce development
Workforce education startup	3, 4	V.	Workforce development
Scope of practice and licensure	3, 10	V.	Workforce development

Table 10: Technical score factors and use of funds

Component	Technical score factors	Use of funding
Workforce education individual support	D.1.	E
Physician post-graduate education	D.1.	E
Workforce education startup	D.1.	E
Scope of practice and licensure	D.2., D.3.	

Table 11: Rural workforce supply outcomes

Outcome	Exp. years for change	Baseline	Target
Number of new annual Family Medicine physicians with service obligations	3	0	3
Number of new annual RNs graduating with RHTP service obligations	2	0	50
Number of new annual behavioral health clinicians with RHTP service obligations	2	0	25
Primary care provider to population ratio by county	3	334	340

- **Key stakeholders**: University of Wyoming, Wyoming Community College Commission, Wyoming Center for Nursing, Wyoming Medical Society
- **Impacted counties**: All Wyoming counties.
- **Estimated required funding**: $50,274,504 out of $200,000,000 (25.1%)

4.3 Initiative: Health technology transformation

The purpose of this initiative is to leverage sensible technology investments that can reasonably be expected to help groups of rural health providers in their ability to:

- Care for people closer to home;
- Better manage chronic diseases and improve treatment outcomes;
- Increase access to clinical consults;
- Deepen the patient-provider relationship; and,
- Improve efficiency and effectiveness of healthcare through collaboration;

There are four components to this initiative. The first is a general purpose challenge program for technology adoption, and the last three are centralized platforms for specialized services that can start small but also be expanded and scaled as need demands.

4.3.1 Technology adoption challenge

This component is a competitive grant process for technology procurement that promises to improve care delivery closer to home, build interoperability across providers, and cut wasteful administrative activity.

Because government is in a uniquely poor position to assess the feasibility or effectiveness of any one technology, we have structured this component with some guardrails that are intended to provide some assurances that technology will be effectively used:

- The grant would be open to **groups** of two (2) or more providers applying together. The larger the group of providers applying, the more favorably the application would be received. Providers would have to demonstrate how the technology would improve either interoperabilty or coordi-

nation between them.

- Applicants must have skin in the game, in the form of **challenge funds**: the State would only contribute part of the purchase price. Revealed preference, in terms of money on the table, communicates to the State that applicants have thoroughly researched the technology and believe any return on investment is credible.
- Applicants must demonstrate how continued operations and maintenance costs after the initial purchase will be **sustainable** (e.g., paid for from projected revenue) past 2031.
- Applicants must also demonstrate how any technology project aligns with the **rightsizing** and 'back-to-basics' effort of the first initiative, particularly for smaller hospitals.

Technology projects the State will specifically emphasize in its RFA process include:

- **Home dialysis**, with nephrologist support provided via telehealth, potentially through the Statewide tele-specialty network;
- **Remote patient monitoring** programs for chronic disease management;
- **Diabetes prevention and management** programs that improve patient engagement and self-efficacy;
- Enhancing **patient-provider interaction**, e.g. by eliminating communication barriers and deepening the provider-patient relationship; and,
- Consolidation of back office functions and **meaningful reduction of administrative work.**

4.3.2 Statewide tele-specialist platform

Providing MD-level specialist care to patients across Wyoming's geography has been a struggle. While the patients who need it require significant support, volume is low and sporadic, and resources are expensive. Because of this, it often makes little sense to try and recruit a specialist to a physical location.

This component would procure a centralized tele-specialty hub that could schedule and deliver consults to various provider types around the State. Initially, we would focus on procuring psychiatry and other

behavioral health services, to include a crisis stabilization telehealth capacity for emergencies. Target providers include:

- Emergency departments;
- Law enforcement and jails;
- Psychiatric residential treatment facilities;
- Residential treatment centers, group homes;
- Long-term care facilities; and,
- Primary care providers.

Centralizing this service would create **economies of scale** for the State as a whole, which potentially could be funded sustainably through a subscription model (e.g., flat monthly fee for participating providers) once it gets off the ground and value can be demonstrated.

The State has already piloted the telepsych project with a hub in Casper and proven the concept in conjunction with the Laramie County Detention Center in Cheyenne.

4.3.3 Non-emergency transportation coordination platform

A second area where centralized procurement could pay dividends is in the scheduling, coordination, and billing of non-emergency transportation. Getting to medical appointments has long been a concern for seniors and people with disabilities. The problem is bad enough in Wyoming's "urban" cities, but it is even more concerning in our rural and frontier cities and towns.

This component would bridge the gap between people who need rides (who also may not have smartphones or be technologically savvy) and people who can give rides (ranging from established transit services to ride-share drivers), using technology to glue together existing resources like Senior Centers, 211, and ride-sharing platforms. Important requirements in this procurement include:

- Integrating local ride-sharing with established transit services in a seamless user experience that gives people choices on convenience and cost.
- Capability of third parties (e.g. Senior Centers or 2-1-1) to schedule rides on people's behalf across

the region or State.

- Payment to the ride provider from the person or that third party. Having local entities like Senior Centers responsible for the initial payment could create incentives to provide oversight over the quantity and necessity of the rides provided, as well as encourage revenue collection on a sliding fee scale. It also reduces moral hazard compared with directly subsidizing the rides from a ride-sharing application.
- Reimbursement invoice generation for payers like Medicaid and Title III OAA.

4.3.4 Centralized billing capacity

This component begins with small EMS agencies. While most already bill, the overhead involved can be a significant lift. The idea here is to explore the use of a competitively-procured billing contractor(s) who would use *existing data* in the Wyoming Ambulance Trip Reporting System (WATRS) to generate health insurance claims, submit them to payers, collect on the bills, and then remit revenue back to voluntarily-participating EMS agencies. If successful, this would:

- **Cut administrative costs** by de-duplicating work of EMS agencies reporting to WATRS and then having to generate bills;
- **Obtain more competitive pricing** for billing services through volume, compared with smaller services trying to procure this themselves;
- **Lower barriers to entry** for entities like fire departments that do not currently bill for services (or even have this administrative overhead); and,
- **Improve the data quality** of WATRS. Since complete and accurate information will be necessary to bill, there are strong incentives for participating entities to be thorough in their WATRS reports.

Once established, this model may be able to be scaled to hospitals or other participating providers, particularly if they are in distress. Being able to quickly take over revenue cycle management in the case of an imminent closure or financial emergency would assist greatly in stabilizing a chaotic situation.

4.3.5 Strategic alignment, score factors, stakeholders, outcomes, and funding

Table 12: Strategic alignment

Component	Community priority	Elements	Strategic goals
Technology adoption challenge	8, 15, 23, 31	III., VI.	Tech innovation
Statewide tele-specialty consult network	8,12, 20, 23	I., IV., VI.	Tech innovation
Nonemergency transportation coordination	15, 19	I., VI.	Sustainable access
Centralized billing capability	9, 17	I., IV., VII.	Sustainable access

Table 13: Technical score factors and use of funds

Component	Technical score factors	Use of funding
Technology adoption challenge	B1., F.1., F.2.	C, D, F
Statewide tele-specialty consult network	F.1.	F
Nonemergency transportation coordination	B.1., C.1., F.2.	F, K
Centralized billing capability	B.1., C.2., F.2.	F, K

Table 14: Health technology transformation outcomes

Outcome	Exp. years for change	Baseline	Target
Number of counties with hospital or other provider offering home dialysis	3	N/A	4
County jails and law enforcement agencies participating in telepsych and crisis stabilization services	1	1	7
Number of hospitals adopting common technology platforms for backend functions	2	0	5
Number of EMS agencies participating in centralized billing	2	0	10

- **Key stakeholders**: Wyoming Hospital Association, Wyoming Medical Society, Wyoming EMS Association.
- **Impacted counties**: All Wyoming counties.
- **Estimated required funding**: $20,500,000 out of $200,000,000 (10.25%)

4.4 Initiative: Make Wyoming Healthy Again

As noted in the Goals section, this initiative is focused on improving people's metabolic, behavioral, and cardiovascular health through a set of clinical and non-clinical interventions.

4.4.1 Integrated primary care expansion

This component would expand the number and geographical reach of Federally Qualified Health Centers (FQHCs) around the State, with a focus on improving the integration of primary care with behavioral health, obstetric and gynecological care, as well as dental and preventive health services.

FQHCs have several baseline advantages as primary care providers:

- **Sustainable operational financing** through grants, 340B pharmacy revenue, and relatively high Medicare and Medicaid encounter rates;
- A focus on **serving lower-income and high-needs people** based on their ability to pay; and,
- Federal Tort Claims Act (FTCA) **malpractice coverage** which can lower the cost of doing business for primary care and obstetric providers.

In this component, we would competitively fund FQHCs costs in converting existing clinical spaces and practices to an integrated primary care model. Applicants would be required to demonstrate:

- How behavioral health care, dental care, and preventive medicine (e.g., to include teaching kitchens for patient nutrition education) would be provided and coordinated in the new locations;
- How physicians and other providers who deliver babies will be coordinated to assist local hospitals in maintaining labor and delivery services under FTCA malpractice protection; and,
- How they will coordinate with the workforce development, chronic care coordination, and technology initiatives in this application.

4.4.2 Clinically-integrated care coordination for chronic disease

This component aims to improve the clinical coordination of care for dual Medicare/Medicaid eligibles who are at high risk of chronic disease.

We would initially open a competitive Request for Applications to hospitals, providers, and other rural health facilities for care coordination initiatives in each Wyoming county. Each provider model might vary —the intent is to 'let a hundred flowers bloom' —but each successful bidder for that particular county or counties would submit a proposal illustrating their coordination model and the causal logic on how it will effectively manage chronic disease in a high-risk population.

In its RFA, the State will prioritize applications that:

- Leverage the use of Community Health Workers, Community EMS, and other lower-level health professionals to coordinate care;
- Demonstrate cooperation with other providers; and,
- Use technology like remote patient monitoring and home dialysis that will help patients receive care closer to home.

Once successful bidders are established, the State would use its Medicaid claims data to:

- Identify a list high-risk dual eligibles with unmanaged chronic conditions;
- Randomize that list;
- Provide the 'treatment group' to the successful bidder for that county;
- Track outcomes for the 'control group', who would *not* be given to any bidder; and,
- Compare outcomes from claims data (e.g. ED visits, inpatient stays, overall Medicare + Medicaid PMPM costs) to evaluate success or failure of each model.[70]

The State would then pay, using RHTP funds:

- A capped amount of **start-up costs** for each program;

[70] We will use Bayesian methods to wring as much information from this design as possible, while communicating parameter uncertainty, recognizing that panels in some counties may not be sufficiently powered to detect small effects.

- A **per-member per-month** fee for care coordination of designated individuals; and,
- A share of identified[71] **annual savings**.

Results from the pilot would be communicated to CMS, so Medicare might make its own decision to continue funding the pilot after five years based on its results.

4.4.3 Exercise and healthy diet promotion

This component is designed to encourage people to eat better, exercise, and take advantage of one of Wyoming's greatest resources —the outdoors. As with many of these initiatives, this would be an annual competitive Requests for Applications process, open to any Wyoming-based entity, with the goal of demonstrating quantifiable increases in people engaging in healthy behavior.

Examples might include partnerships with:

- Local non-profits to defray their operational costs for organizing runs, walks, hikes, and other evidence-based activities in their communities.
- The Wyoming Department of Transportation to extend its Transportation Alternatives Program and help rural towns become more walkable and connected through the development, repair, and connection of sidewalks, pathways, and pedestrian routes to improve accessibility and promote physical activity in rural and frontier areas.
- Department of Family Services to continue funding for its Cent$ible Nutrition program, which offers cooking classes and nutrition education.
- Wyoming's extractive and transportation industries to improve the diet and exercise of its workforce.

This component also contains three State Policy Actions previously detailed in the Goals section:

- **The Presidential Fitness Test (B.2.)**

[71] I.e., within some uncertainty tolerance, the difference in PMPM costs between the applicant's treatment list and the Statewide control group, times the number of member-months in the panel, times the sharing percentage.

- **The SNAP waiver (B.3.)**
- **Nutrition Continuing Medical Education (B.4.)**

4.4.4 Strategic alignment, score factors, outcomes, stakeholders, and funding

Table 15: Strategic alignment

Component	Community priority	Elements	Strategic goals
Integrated primary care expansion	3, 5, 7	I., II.	Make rural America healthy
Clinically-integrated care management	6, 15	II., III., VI.	Innovative care
Exercise and diet promotion	29	II.	Make rural America healthy

Table 16: Technical score factors and use of funds

Component	Technical score factors	Use of funding
Integrated primary care expansion	B.1., F.2.	A, H, J
Clinically-integrated care management	B.1., E.1., E.2., F.1., F.3.	A, I
Exercise and diet promotion	B.2., B.3.,	A

Table 17: Make Wyoming Healthy Again outcomes

Outcome	Exp. years for change	Baseline	Target
Duals with chronic conditions - average difference in ED visits per 100,000 MM - treatment vs control group	2	N/A	TBD
Duals with chronic conditions - average difference in Medicare allowable PMPM costs - treatment vs control group	2	N/A	TBD
Percent of population with obesity - by county	4	33.3%	30%
Number of FQHCs with integrated behavioral health on-site	3	N/A	TBD

- **Key stakeholders**: Wyoming-based non-profit philanthropic organizations, Wyoming counties and local governments, industry partners.
- **Impacted counties**: All Wyoming counties.
- **Estimated required funding**: $31,584,525 out of $200,000,000 (15.8%)

5 Implementation plan

5.1 Initiative timelines

You'll note that virtually all of our initiatives are based around various procurement activities (i.e., RFAs and RFPs). Because these are standardized under State rules and policies, the timelines look similar. The key milestones include: (1) development and issuance of the RFA, (2) awarding the RFAs; and (3) ongoing monitoring and reporting. We expect all initiatives to be set up within two years, with ongoing annual RFA/RFP renewals issued in subsequent years. Figures 13, 14, 15, and 16 in the Supplemental Materials are the detailed Gantt charts for our four initiatives.

5.2 State policy timelines

We described these in the narrative of the Goals section, but Table 18 summarizes these below. As with RHTP as a whole, many of these will require statutory changes made by our State Legislature. Milestones are thus related to when we begin engagement with the Legislature (before the 2026 Budget Session, in most cases), and when we expect any final policy enactment.

Table 18: State policy timeline

Factor	Component	Requirement	Actor	Engagement start	Est. enactment
B.2	Presidential Fitness Test	Policy	Dept. of Education	Jan 26	Dec 26
B.3	SNAP Waiver	Statute	Legislature	Oct 25	Jul 26
B.4	Nutrition CME	Rules	Board of Medicine	Jan 26	Jul 27
D.2	Compacts (PA)	Statute	Legislature	Jan 26	Jul 27
D.3.a	Scope (pharmacist)	Statute	Legislature	Jan 26	Jul 27
D.3.b	Scope (dental hygenist)	Statute	Legislature	Jan 26	Jul 27

5.3 Governance and project management structure

The Wyoming Department of Health (WDH) will serve as the lead agency for the Rural Health Transformation Program (RHTP) implementation, under the direct oversight of its Director. The WDH is a "superagency" with almost 1,400 employees in four operating divisions —Aging, Behavioral Health,

Healthcare Financing (Medicaid/CHIP), and Public Health —and thus is well-equipped and staffed to handle this additional responsibility.

5.3.1 Interagency team

The Interagency Team will serve as the steering committee for RHTP implementation and will include the Director (executive oversight), Deputy Director and Business Operations Administrator (program coordinators), Healthcare Financing Senior Administrator and State Medicaid Agent (Medicaid initiatives), Medicaid Medical Director (clinical oversight), Medicaid Chief Policy Officer (policy development), Public Health Division Senior Administrator (public health initiatives), and Governor Gordon's Senior Policy Advisor on Health (gubernatorial coordination).

5.3.2 Iterative management

Members of the Interagency Team will meet, monitor progress, and address issues on a quarterly basis. Prior to each quarterly meeting, coordinators and staff will prepare and distribute an overall Rural Health Transformation performance report, summarizing trends in objective metrics and KPOs across the various initiatives, as well as providing status updates on milestones, and any feedback received from stakeholders.

Similar to the Department's existing HealthStat performance management process,[72] the Interagency Team will use the report to focus on analyzing program deficits and proposing corrective actions to ensure initiatives remain on track. Corrective actions may include providing technical assistance to RFA grantees, re-allocating staff effort to lagging initiatives, refining RFA and other procurement guidelines for the next funding cycle, and highlighting any remaining barriers that require Director or cabinet-level attention. All major decisions, such as significant changes to initiatives or budget re-allocations between initiatives, will be raised with CMS program staff for prior approval, in accordance with the cooperative agreement terms.

[72] See the 2024 Final Report here: https://health.wyo.gov/wp-content/uploads/2025/02/2024-HealthStat-Final-Report.pdf

5.3.3 Key personnel

The Business Operations Administrator and Deputy Director will serve as the Program Coordinators and manage day-to-day Rural Health Transformation activities.

The Healthcare Financing Senior Administrator/State Medicaid Agent and Public Health Division Senior Administrator will oversee implementation within their respective divisions. Existing staff from Healthcare Financing and Public Health will provide day-to-day program management, to include RFA development and awards. Director's Office staff will provide overall contracting and data support.

The 15 new FTE at-will employment contractors required for administering the RHTP initiatives are outlined in the budget narrative; we will not utilize outside project management for overall program administration.

5.3.4 Outside stakeholder advisory committee

A Rural Health Transformation Advisory Committee will be established with semi-annual meetings to provide input and guidance on program implementation. Membership will include representation from the following stakeholder groups: hospitals, EMS, FQHCs, behavioral health, public health, long-term care, Tribal governments, county governments, higher education. Patient and community voices will be added by drawing on community volunteers already serving on Community Services Block Grant (CSBG) tripartite boards around the State.

The Advisory Committee will provide any formal written recommendations to the Interagency Team, timed to inform the Team's quarterly performance reviews. The Team will then be required to review all committee recommendations and provide a documented response that details which recommendations are being adopted, which are not and why, and any resulting actions. This will ensure that stakeholder feedback is addressed in a transparent fashion.

6 Stakeholder engagement

Despite the short timeline to develop this application, we made a significant commitment to gather public input on both rural health priorities and potential solutions.

6.1 Community rural health priorities

This began in mid September with a series of eight in-person and three virtual meetings around the State, shown in Table 19.

Table 19: Rural Health Transformation - Public Meetings

City	Date	Participants
Newcastle	9/12/2025	24
Wheatland	9/12/2025	16
Buffalo	9/18/2025	20
Powell	9/18/2025	40
Virtual meeting	9/23/2025	74
Virtual meeting	9/25/2025	99
Evanston	9/30/2025	17
Lander	9/30/2025	32
Saratoga	10/1/2025	31
Laramie	10/2/2025	62
Virtual meeting	10/9/2025	24
Total		**439**

After an initial briefing on the Rural Health Transformation Program, we began each meeting with structured exercises asking attendees to consider broad health policy questions. After the structured exercises (results are in the Supplemental Materials), we prioritized most of the meeting time for qualitative feedback from the audience.

We recorded and transcribed each meeting, then generated a list of summarized bullet points along each of these themes.[73] After the last public meeting, we consolidated all the feedback we heard into 33 distinct

[73] Summaries are available at https://health.wyo.gov/admin/rural-health-transformation-program/

priorities. We then set up an online survey to ask the public to rank these priorities over a week (10/8/25 to 10/15/25).

In total, we received 1,316 unique responses from this survey. The results of the pair-ranking exercise are shown in Table 29, in the Supplemental Materials. As demonstrated in the Goals section, these community priorities have driven virtually all the initiatives we propose in this application.

6.2 Stakeholder meetings and idea solicitation

In parallel with the community meetings, we sent a letter out to Wyoming's health associations and other stakeholders on 9/9/25, asking them to submit ideas for this application no later than 10/10/25. The Department received a total of 34 proposal from stakeholders, which we ranked using a rubric grading: (1) the clarity of the idea, (2) how well the idea nested within the strategic priorities and Community Rural Health Priorities, and (3) if the proposals included ideas for sustainability moving forward. Many of these ideas informed our initiatives, as well as providing cost estimates for our budget narrative.

We also held various stakeholder meetings, shown in Table 20, to walk through our understanding of the program and help stakeholders brainstorm and refine ideas.

Table 20: Rural Health Transformation - Stakeholder Meetings

Stakeholder group	Location	Date
Hospital CEOs	Virtual meeting	9/16/2025
Long-term care facilities	Virtual meeting	9/23/2025
Eastern Shoshone and Northern Arapaho Tribes	Riverton	9/30/2025
Hospital CEOs	Casper	10/8/2025
EMS agencies	Virtual meeting	10/7/2025
EMS agencies	Virtual meeting	10/9/2025

The State intends to continue this rigorous process of public and stakeholder engagement after the award, through the project governance committees as discussed in the previous section.

7 Metrics and evaluation plan

7.1 Key performance objectives

Table 21, below, shows the consolidated list of key performance objectives from the Goals section. We do not duplicate the baseline and target information, but show the data source and a column indicating whether or not sub-state (e.g. county) data will be reported.

Table 21: Key performance objectives

KPO	Source	Substate
Counties without a hospital providing labor and delivery services to a large county subdivision	WDH	Yes
Annual number of new providers with 5-year service commitments	Program data	No
2-year average RN wage growth	BLS OEWS	No
Prevalence of diagnosed diabetes	BRFSS	Yes
Age-adjusted suicide rate	CDC WONDER	No
Number of successful shared-savings chronic disease management programs	Program data	Yes
Percent of tele-specialist costs covered by generated revenue	Program data	No

7.2 Outcomes

Similarly, Table 22, below, shows the consolidated list of metrics from the Initiatives section.

Table 22: Initiative outcomes metrics

Outcome	Source	Substate
Number of CAH-B conversions	Program data	Yes
Percent of EMS response times under 9 minutes	WDH Office of EMS	Yes
Number of smaller EMS agencies that have consolidated	Program data	Yes
BearCare premium (25 year olds)	TPA	No
Number of new annual Family Medicine physicians with service obligations	Program data	No
Number of new annual RNs graduating with RHTP service obligations	Program data	No

Number of new annual behavioral health clinicians with RHTP service obligations	Program data	No
Primary care provider to population ratio by county	AHRF	Yes
Number of counties with hospital or other provider offering home dialysis	Program data	Yes
County jails and law enforcement agencies participating in telepsych and crisis stabilization services	Program data	Yes
Number of hospitals adopting common technology platforms for backend functions	Program data	Yes
Number of EMS agencies participating in centralized billing	Program data	Yes
Duals with chronic conditions - average difference in ED visits per 100,000 MM - treatment vs control group	Medicaid claims data	Yes
Duals with chronic conditions - average difference in Medicare allowable PMPM costs - treatment vs control group	Medicaid claims data	Yes
Percent of population with obesity - by county	BRFSS	Yes
Number of FQHCs with integrated behavioral health on-site	Program data	Yes

7.3 Formal evaluation

We confirm we will cooperate with any CMS-led evaluation or monitoring.

In addition, because of its randomized design, Wyoming Medicaid, with support from the Director's Office, will conduct a formal evaluation by the end of each year (i.e., based on the RFA award dates) on the success or failure of the chronic disease management program in order to distribute any demonstrated shared savings. As noted previously, this evaluation will compare ED visits and Medicare allowable PMPM across the randomized treatment and control dual-eligibles. We are happy to share results from this evaluation with CMS in order to inform any continuation of these programs by Medicare after the award period.

8 Sustainability plan

Sustainability is more than a buzzword: being able to spread the benefits of Rural Health Transformation over a longer time horizon is central to our proposal.

8.1 The problem: risks of "spending it all in one place"

Rural Health Transformation represents significant opportunity, but responsibly spending almost a billion dollars over a short period of time will be a challenge. We will need to avoid multiple pitfalls:

- **Waste or revert**. The pressure to rapidly expend this magnitude of funds in a small State will put us in the horns of a dilemma: either risk wasting funds on ill-conceived projects in a rush to "get the money out the door," or risk reverting funds if a thorough vetting of a limited pool of proposals reduces what can be spent.
- **Maintenance of effort expectations**. As experience with limited provider rate increases using ARPA funds demonstrated, even when the "one-time" nature of funding is made clear, it can create pressure to maintain those expenditures with State General Funds.
- **Inflationary effects**. While ARPA and CARES helped the health sector recover after the COVID-19 pandemic, they also likely induced significant inflation, particularly in the nurse labor market, as is evident in Figure 5, but also clear in the construction industry.[74] Expending a similar magnitude of funds, even if every dollar is spent wisely, may induce a similar effect.

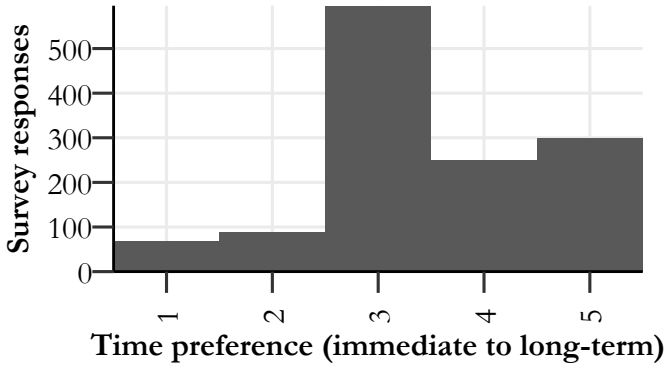
8.2 The public recognizes these risks

The importance of spreading the benefits of Rural Health Transformation over time came up over and over again during our public meetings. And in the final online survey, we specifically asked people to rate their temporal preference: if they'd prefer funding to focus on more immediate needs, they chose a 1 out of 5. If they preferred funding to be spread out over time, they'd chose a 5 out of 5. While the average

[74] For example, the Non-residential construction producer price index for the West Census region exploded after the federal pandemic response: https://fred.stlouisfed.org/series/PCU236400236400I4

was around 3.5, the distribution, shown in Figure 6, shows a mixture of people who thought a balanced approach (3) was best, and a group of people heavily skewed towards longer-term approaches.

Figure 6: Online survey results - time preference



8.3 Sustainability is critical to effective system transformation

In addition to mitigating these risks, sustainability will improve the odds of achieving federal objectives for **true system transformation.** Consider:

- Given the necessary ramp-up, two to three years of turning out new nurses or clinical behavioral health workers is just not enough time in order to truly make a difference with workforce supply. Similarly, the one-time investments we're making in educational capacity depend on future revenue from these individual awards being sustainable.
- In order to take risks in transforming their business models, health care providers like hospitals need certainty: clear and unambiguous signals that the new rules of the game will stick around for longer than five years. This is particularly important when facing the headwinds of existing incentives —like the use of elective procedures to pay the bills in small hospitals —which won't be going away any time soon.

We simply can't expect the system to right-size, or payment models to improve how care is delivered, unless the incentives in this proposal are made durable.

8.4 Primary: The Wyoming Rural Health Transformation Perpetuity

The answer to these challenges, and the core of our sustainability plan, is the establishment of a dedicated, purpose-driven, and actively-managed Wyoming Health Transformation Perpetuity. This vehicle would:

- **Harness the power of the American economy** to generate returns from a variety of investments, using a fixed 3-5% annual withdrawal rate[75] to fund specific health transformation initiatives in perpetuity, while re-investing any surplus back into the perpetuity corpus. This allows us to continue the work of health transformation without additional debt-financed federal outlays.
- **Be irrevocably established for designated purposes**, with an ironclad guarantee that federal expenditures would accomplish statutory purposes and strategic priorities;
- Be managed by the Wyoming State Treasurer,[76] leveraging Wyoming's unique sovereign wealth management expertise at **low administrative cost.**

8.4.1 Purpose-dedicated shares

Once established in law, we would expend Rural Health Transformation funds to purchase certain quantities of *purpose-dedicated* shares that would support each initiative over a long time horizon. We propose four major share types to support these initiatives:

- **Healthcare Workforce - Perpetual Award Shares**
  - Cost: $1,000,000 per share
  - Product: 1 ×$50,000 award for nursing-related, EMS, physician, or behavioral health workforce training costs. Due to cost, some (e.g., medical school) may require more than one share per person per year. Others may require fractional shares.
- **Physician Post-Graduate Medical Education - Perpetual Award Shares**
  - Cost: $5,000,000 per share

[75] With options to either to adjust dedicated share returns for inflation (e.g., increasing the annual nurse scholarship from $50,000 to $55,000), or to expand the number of shares (e.g. adding another nurse scholarship slot). The objective is to ensure incentive payments and individual awards remain predictable over time.

[76] The Wyoming Department of Health would be responsible for tracking funding allocated to specific purposes, and would provide the Treasurer recommendations on required liquidity, risk, and return.

  - Product: 1 ×$250,000 annual slot.
- **Critical Access Hospital - Basic (CAHB) - Perpetual Incentive Payment Shares**
  - Cost: $20,000,000 per share
  - Return: 1 ×$1,000,000 annual incentive payment per CAHB for fixed cost coverage.
- **EMS Regionalization - Perpetual Incentive Payment Shares**
  - Cost: $5,000,000 per share
  - Return: 1 ×$250,000 annual incentive payment per low-volume ambulance.

As noted previously, growth in the perpetuity's returns over time would allow these to be either adjusted for inflation or multiplied into additional slots. The Department of Health would be responsible for continuing to fund these awards and incentive payments past the five-year program period.

8.4.2 Ensuring a future stream of benefits

Consider something that would be a holy grail in long-term care: a **direct care robot** that could autonomously assist people to age in their homes. This technology, of course, does not yet exist. But if did, it would fit perfectly within the RHTP framework and **would almost certainly be approved** by CMS as an appropriate and sustainable use of funds.

The Wyoming Rural Health Transformation Perpetuity is a similar instrument: a significant capital investment that will provide a dedicated stream of purpose-driven benefits well into the future.[77]

In many ways, it is a superior instrument. It will not depreciate or require maintenance. It will not charge expensive subscription fees or require bloated software updates. It mitigates the risk of buying the wrong brand of robot. Importantly, it also allows the State and federal governments to address future healthcare needs: it hedges risk across time, even giving future generations the ability to invest in solutions to solve new problems that arise.

[77] Note that the dedicated nature of the proposed instrument ensures that it will **not** "earn or keep any profit", per 2 CFR 200.400 (g), for the State. All program income from these investments will directly fund approved RHT initiatives. The State is willing to work with CMS to ensure any statutory language establishing the Perpetuity reflects this guarantee.

8.5 Secondary: Procedural safeguards to ensure sustainability

While the Perpetuity is the central vehicle for sustaining transformational change over time, we also take pains to ensure that benefits from the time-limited components are not dissipated after five years.

Some of these are structured in the RFAs:

- We require multiple providers to apply together, in order to build credibility in the proposal and to ensure interoperability.
- We will require a demonstrated plan on how provider revenue will fund future O&M costs.
- In the case of educational capacity, initial investments in new faculty and secondary school outreach are intended to be funded with individual education award revenue.

In other areas where centralized services are set up (e.g., tele-specialty, non-emergency transportation), we will find ways to use program income or payer revenue to sustain them moving forward.

Finally, in the case of the chronic disease care management pilot, we will share results of success or failure with CMS, in case Medicare is interested in funding promising chronic disease care coordination models.

8.6 Tertiary: Policy changes that will help sustain program impacts

This last example, working with Medicare to sustain any successful chronic disease management models, is a hypothetical policy change that could sustain or expand any observed benefits.

Others, like our implementation of the SNAP waiver and Presidential Fitness Test, will likely remain in place and provide sustainable benefits as long as there is a similar federal commitment to do so.

8.7 Maps, figures and tables

Figure 7: Population pyramid by geography

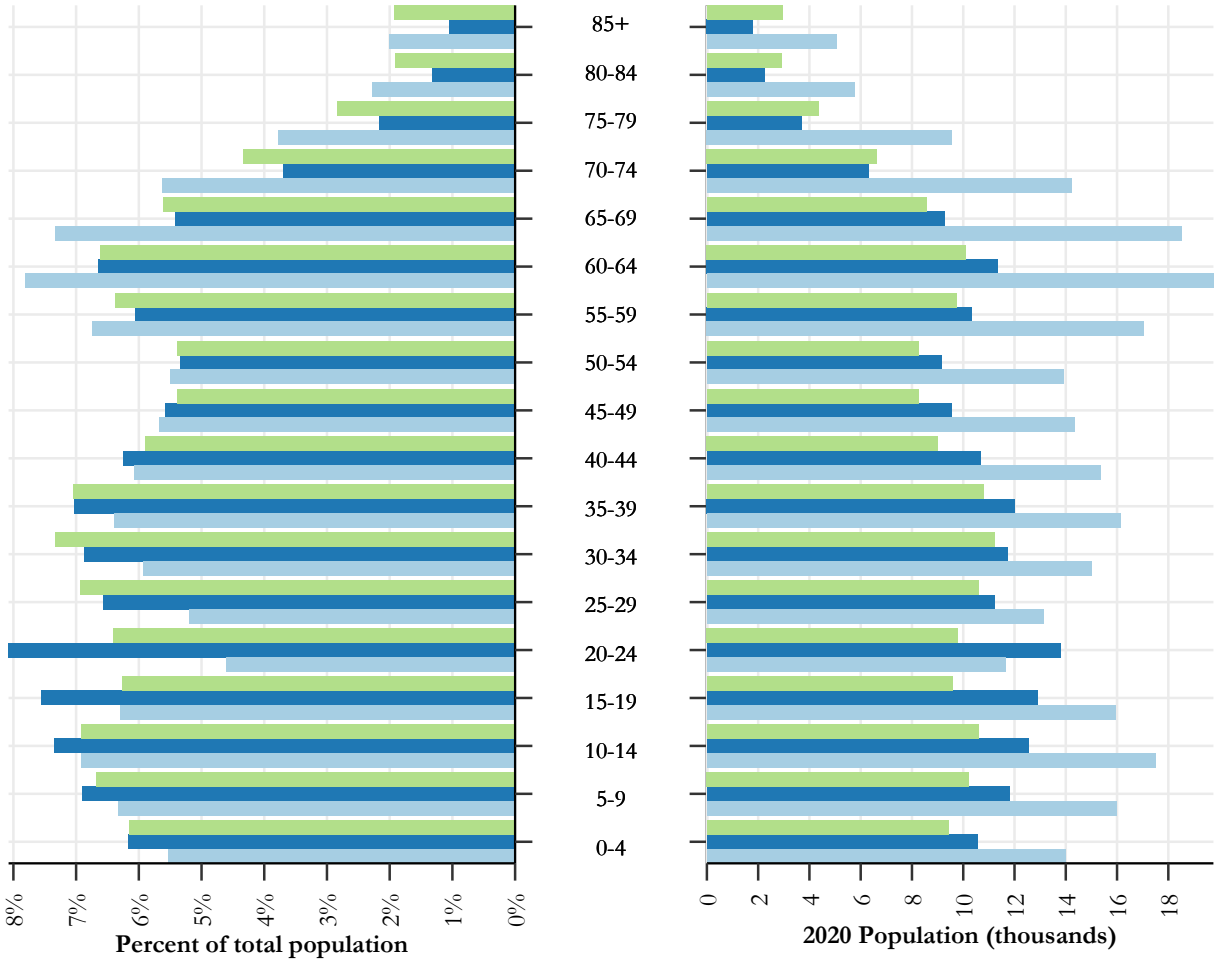


Table 23: Health facility counts by county

County	ALF	ASC	CAH	ESRD	FQHC	HHA	HOSP	HSPC	NH	PRTF	RHC
Albany	1	1		1	1	4	1	1	1		
Big Horn			2		1			1	2		3
Campbell	1	4		1		5	1	2	1		
Carbon			2			1			1		1
Converse	1		1						1		2
Crook	1		1						1		3
Fremont	2	2		2	4	6	1	2	4		1
Goshen	1		1						1	1	1
Hot Springs	1		1			1			1		2
Johnson	3		1			2		1	2		
Laramie	5	4		2	3	8	1	4	3		1
Lincoln	1		2			3		1	2		1
Natrona	5	4		1	4	8	2	3	3	1	
Niobrara			1								1
Park	2	1	2	1	4	3		1	2		1
Platte	1		1						1		3
Sheridan	1	1		1	1	4	1	1	3		
Sublette							1		1		
Sweetwater	2	2	1	1	1	3	1	2	2		2
Teton		1				3	1	1	1		
Uinta	2	1	1	1	1	4		2	1		4
Washakie			1		1	1			1		1
Weston	1		1			1			1		2
Total	31	21	19	11	21	57	10	22	36	2	29

The facilities in columns include: Assisted Living Facilities (ALF), Ambulatory Surgical Centers (ASC), Critical Access Hospitals (CAH), End-Stage Renal Dialysis (ESRD), Federally-Qualified Health Centers (FQHC), Home Health Agencies (HHA), PPS hospitals (HOSP), hospice (HSPC), nursing homes (NH), Psychiatric Residential Treatment Facilities (PRTF) and Rural Health Clinics (RHCs).

Figure 8: Wyoming population density (2020)

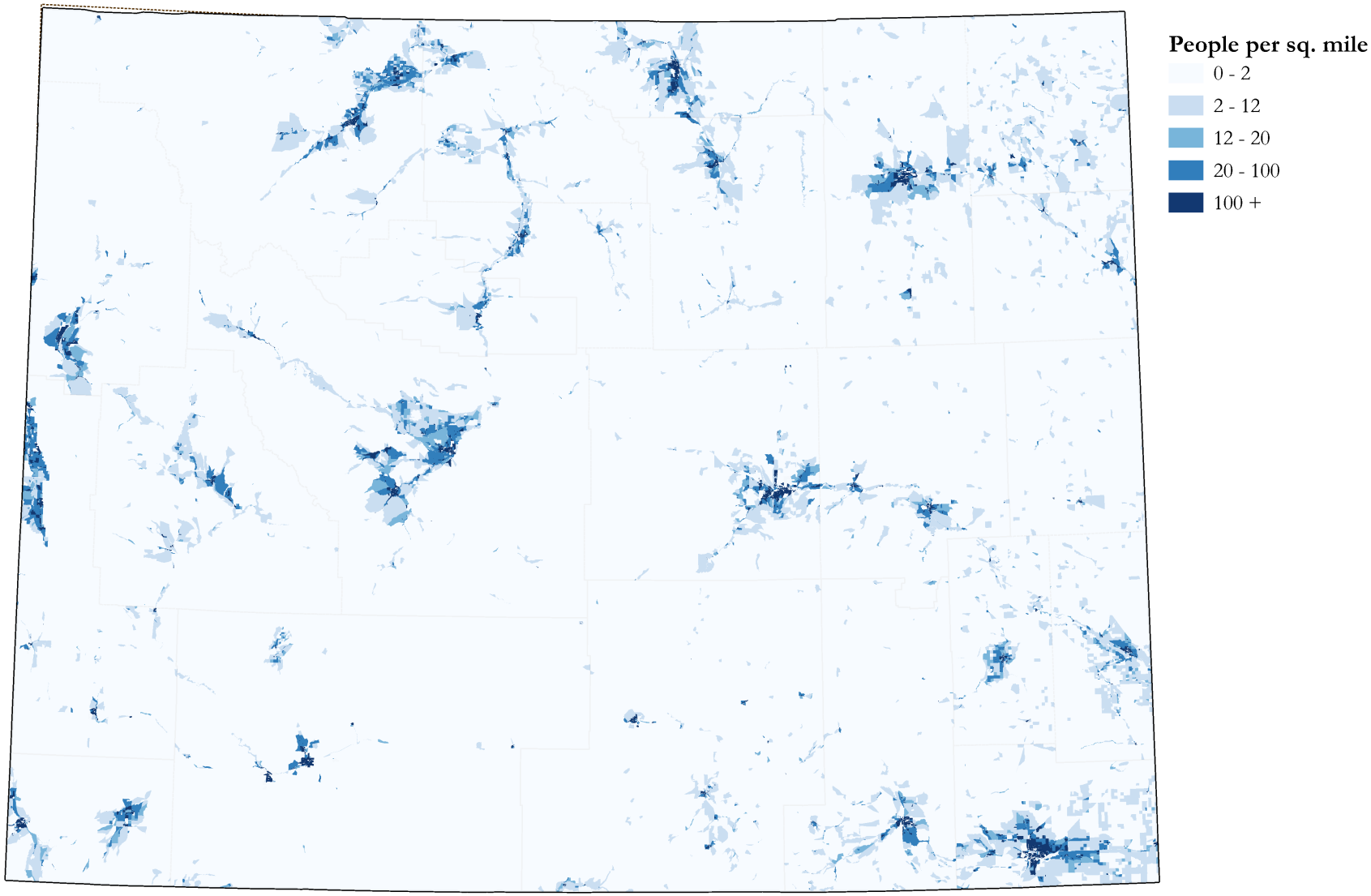


Figure 9: Rural/frontier/urban definition

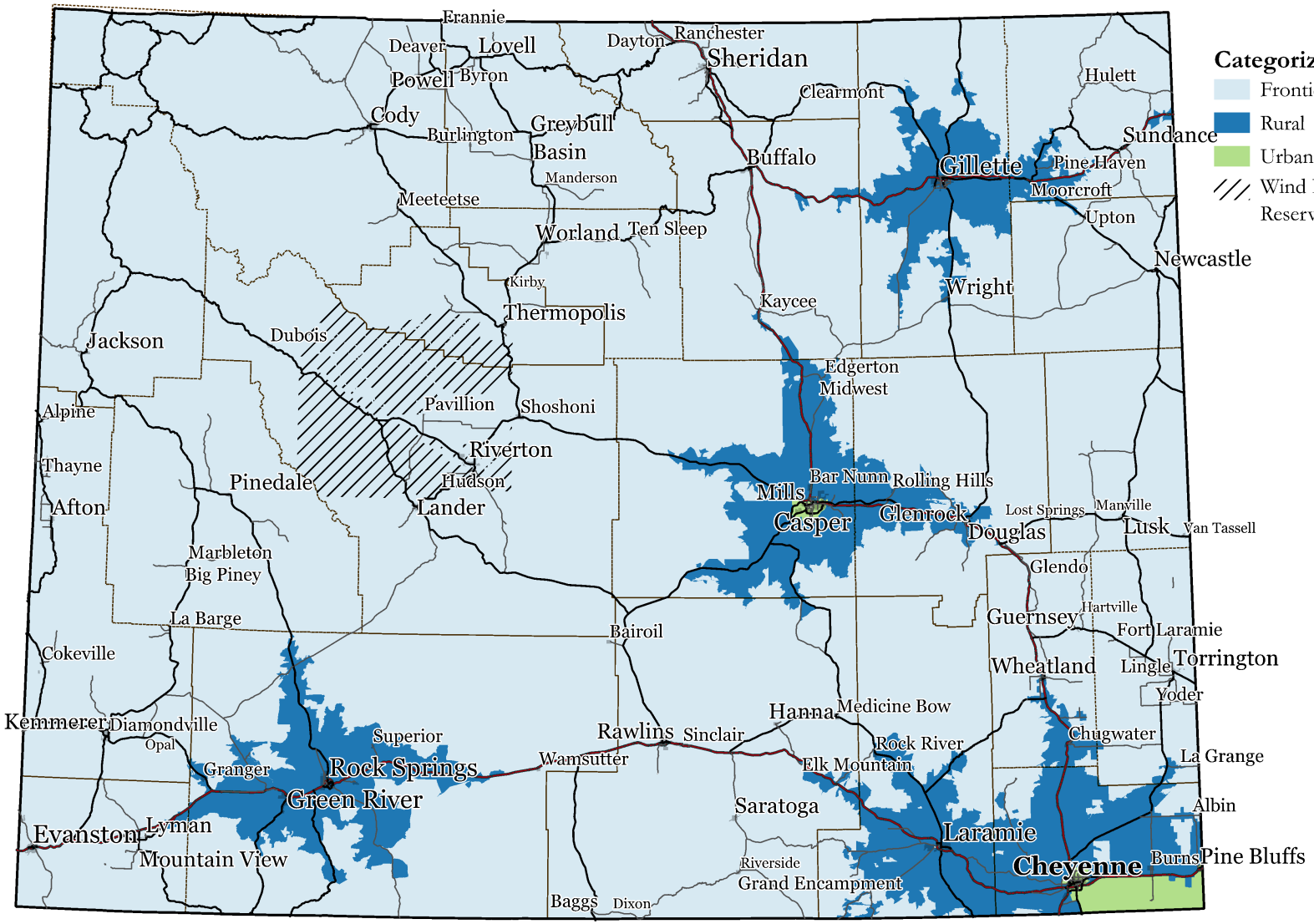


Figure 10: Emergency Medical Services (EMS) response times

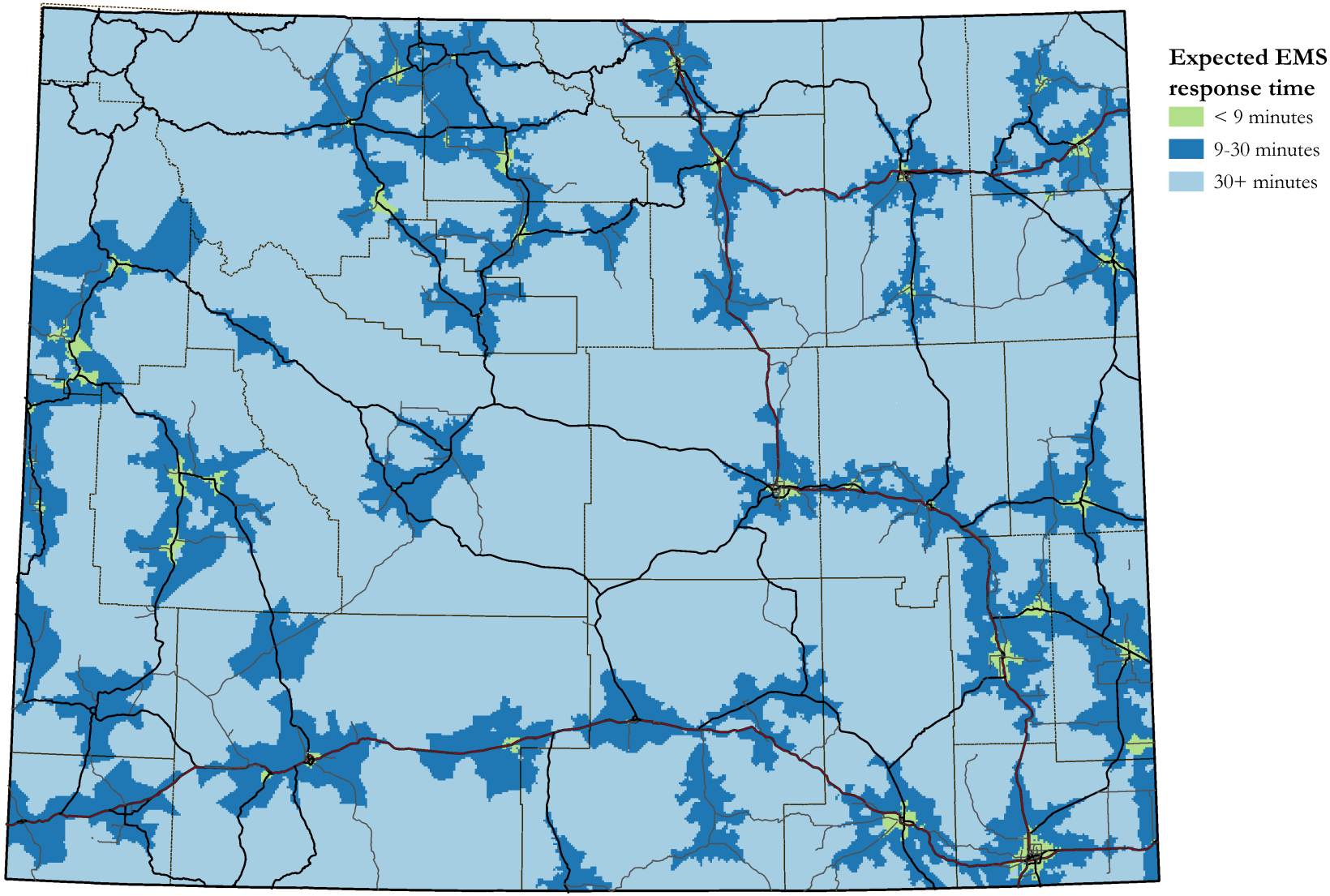


Figure 11: Metabolic disease risk map

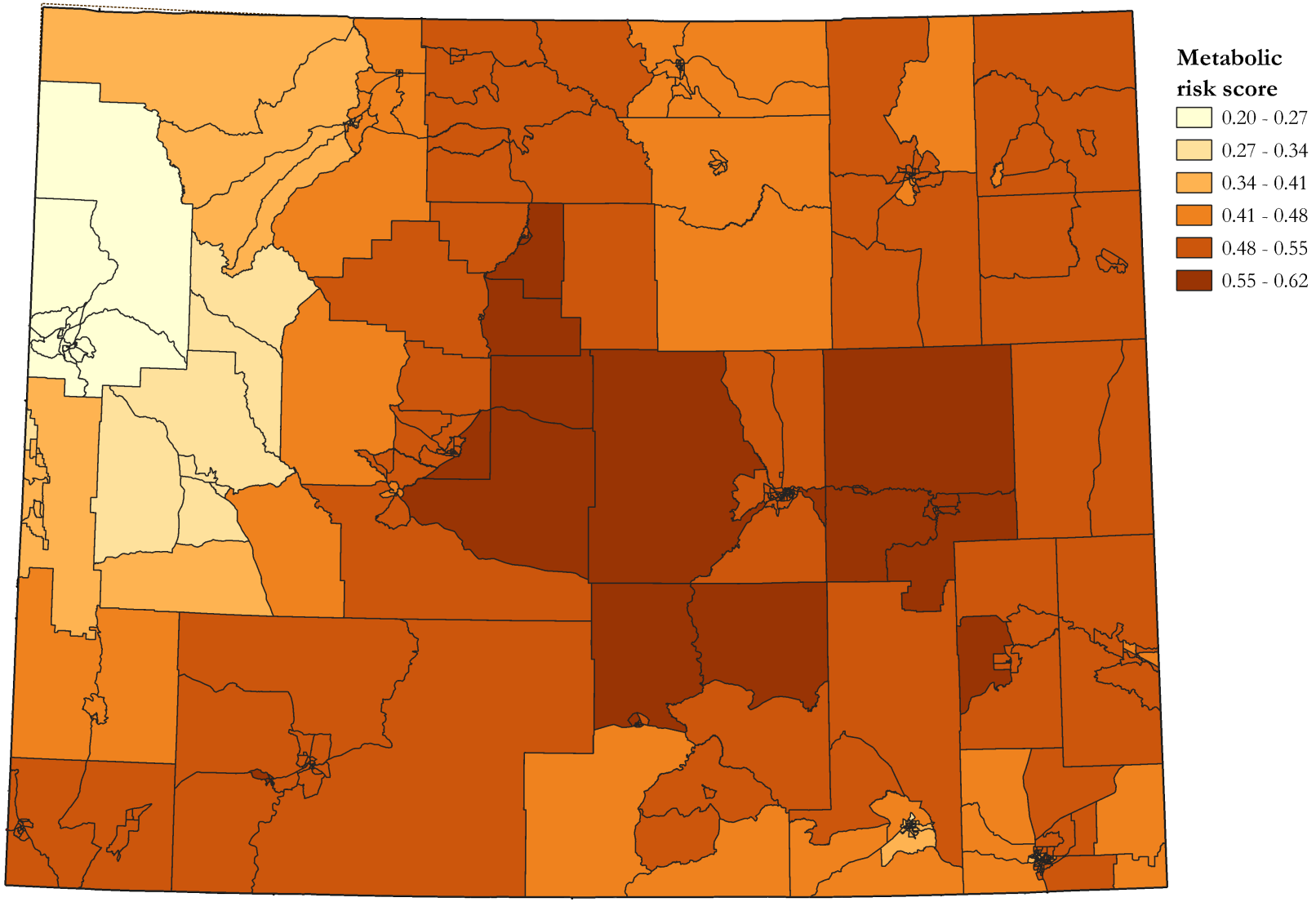


Figure 12: Cardiovascular disease risk map

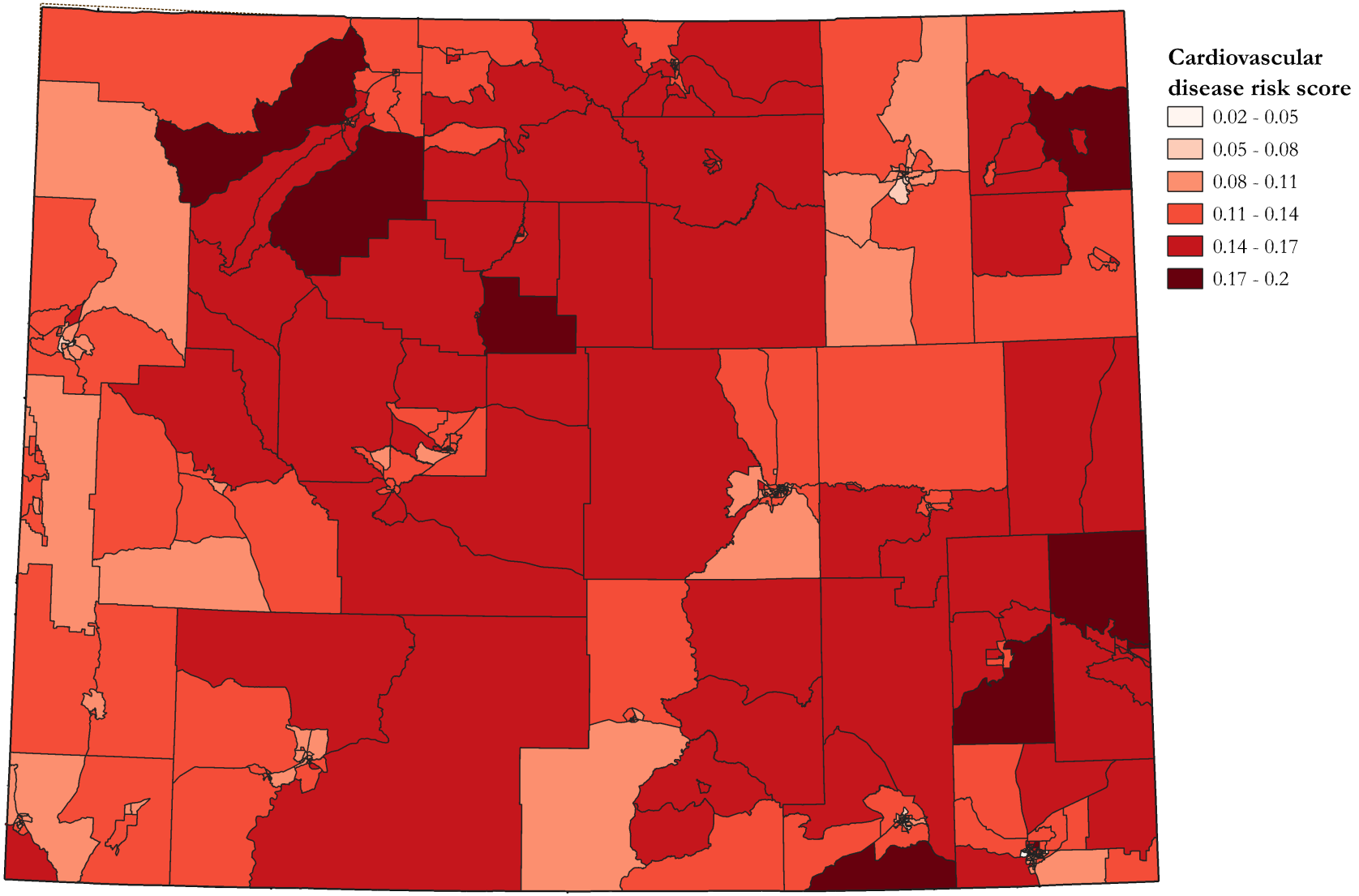


Figure 13: Access to emergency medical care initiative timeline

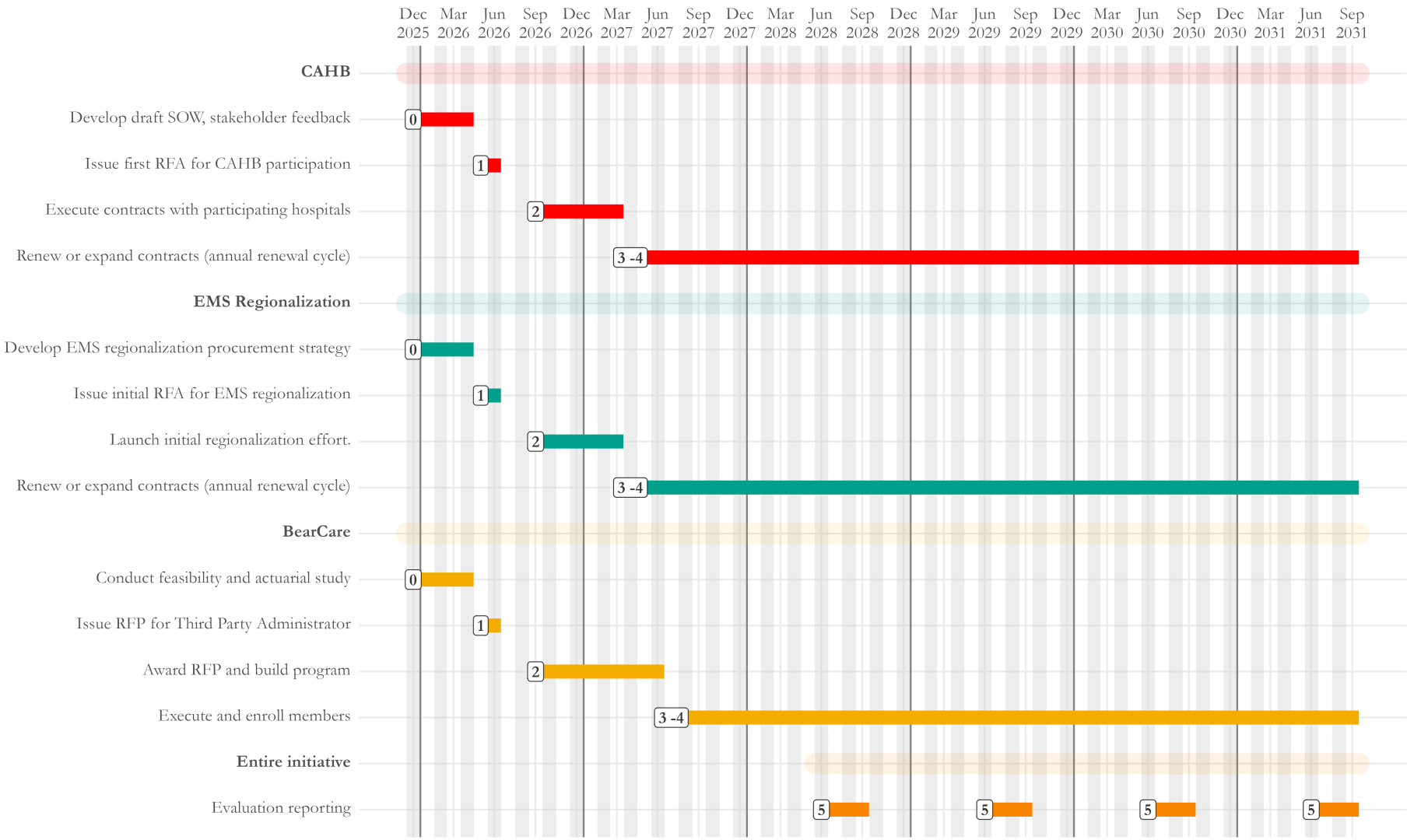


Figure 14: Rural workforce supply initiative timeline

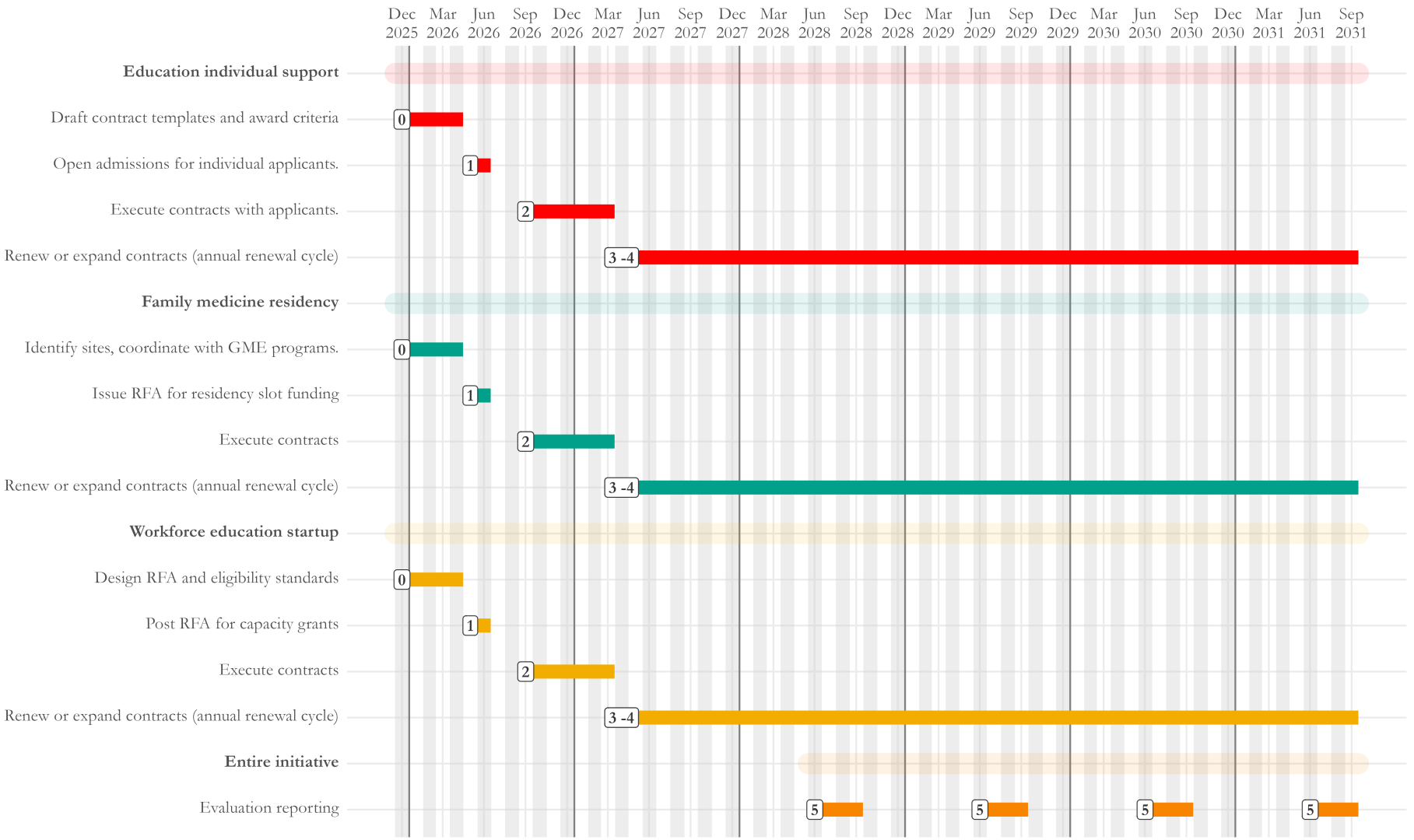


Figure 15: Health technology transformation timeline

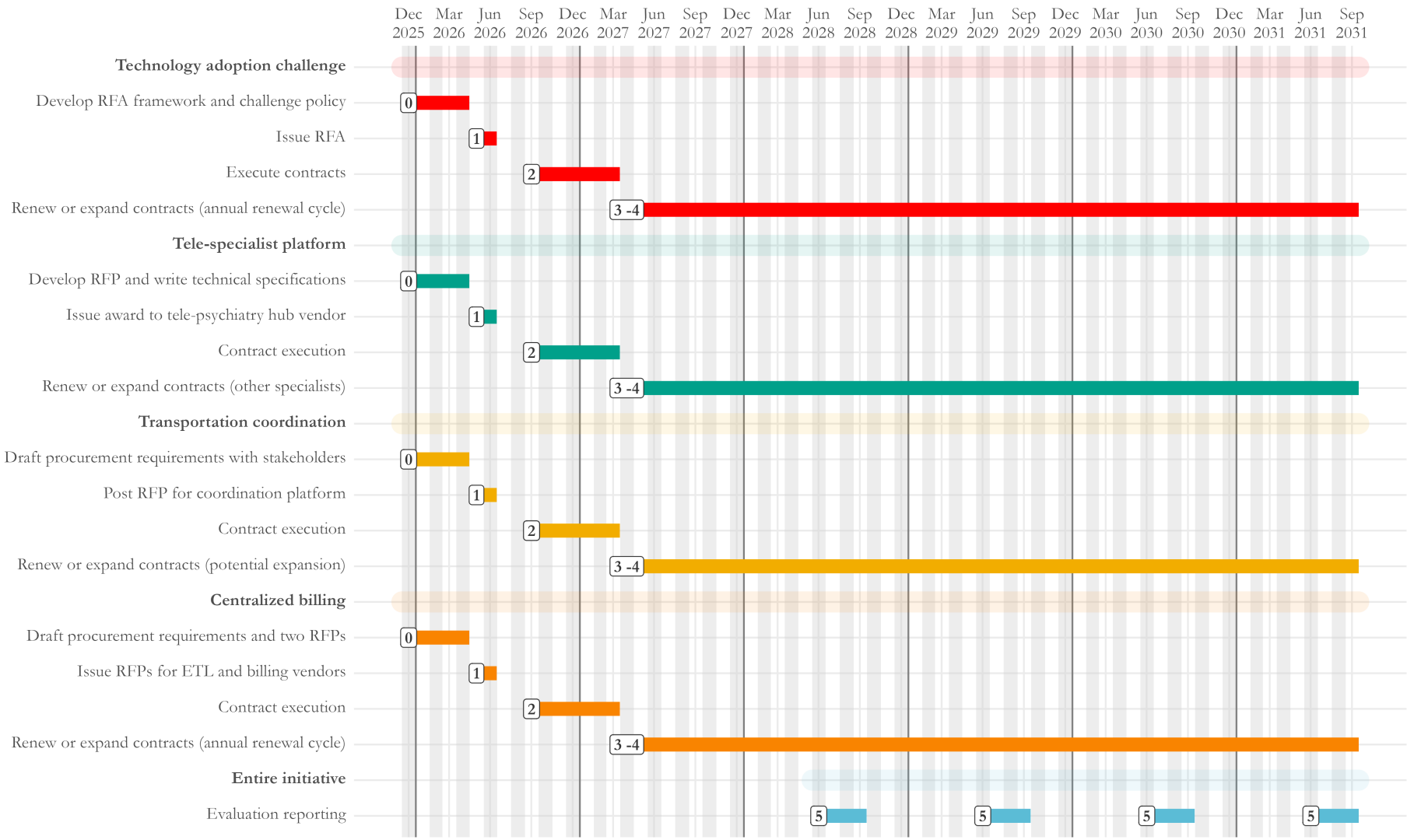


Figure 16: Make Wyoming Healthy Again initiative timeline

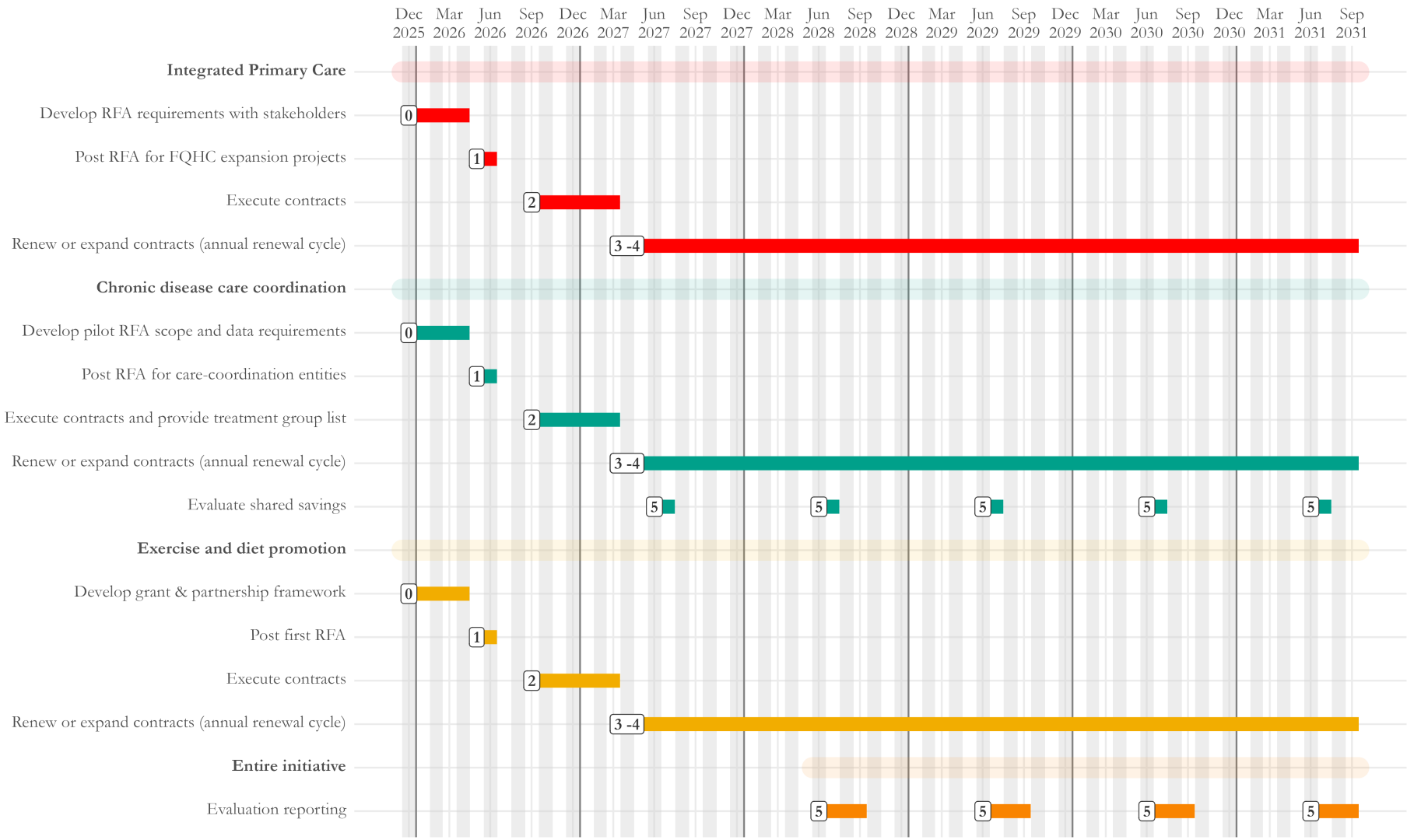


Table 24: Primary health insurance coverage

	Geography		
Insurance	**Frontier**	**Rural**	**Urban**
Directly purchased	9.0% (8.4% - 9.5%)	7.5% (6.9% - 8.0%)	5.8% (5.4% - 6.4%)
Dual	2.2% (2.1% - 2.4%)	1.7% (1.5% - 2.0%)	2.7% (2.4% - 2.9%)
Employer sponsored	43.4% (42.5% - 44.3%)	55.2% (54.3% - 56.5%)	45.2% (44.3% - 46.2%)
Indian Health Services	1.5% (1.3% - 1.6%)	0.4% (0.3% - 0.6%)	0.3% (0.1% - 0.4%)
Medicaid	10.8% (10.2% - 11.1%)	8.6% (8.0% - 9.4%)	11.1% (10.6% - 11.7%)
Medicare	21.2% (21.0% - 21.4%)	14.1% (13.9% - 14.3%)	17.0% (16.8% - 17.2%)
TRICARE & VA	2.1% (1.9% - 2.3%)	4.0% (3.6% - 4.3%)	8.5% (8.1% - 9.1%)
Uninsured (low income)	4.5% (4.2% - 4.8%)	4.3% (4.0% - 4.6%)	4.2% (3.9% - 4.6%)
Uninsured (higher income)	5.4% (5.2% - 6.1%)	4.2% (3.8% - 4.5%)	5.1% (4.6% - 5.5%)

Figure 17: Educational attainment by geography

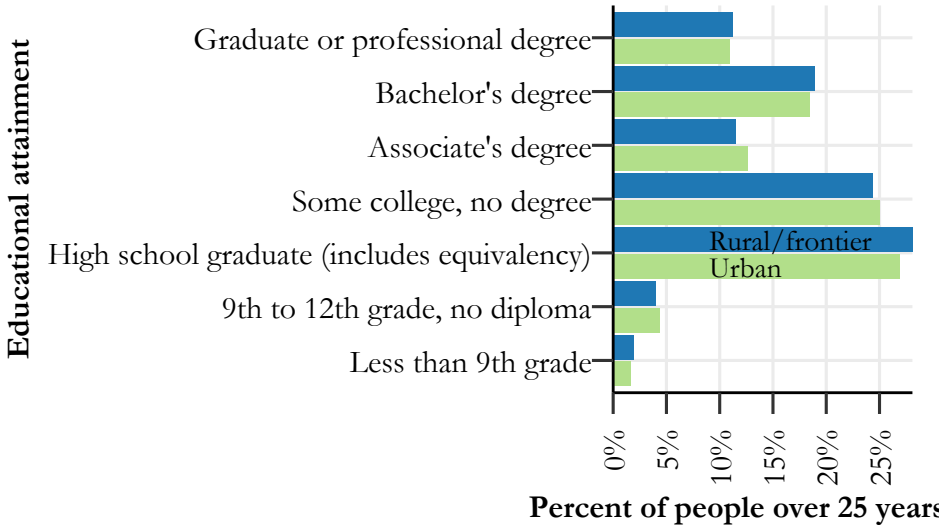


Table 25: Employment status by geography

	Geography	
Employment status	**Rural**	**Urban**
Employed	61.8%	61.9%
Armed Forces	0.2%	2.2%
Unemployed	2.4%	2.3%
Not in labor force	35.5%	33.6%

Table 26: Industry by geography

Industry	Geography	
	Rural	Urban
Information	1.5%	1.5%
Wholesale trade	1.5%	2.1%
Finance and insurance, and real estate and rental and leasing	4.4%	5.5%
Manufacturing	4.5%	4.1%
Other services, except public administration	4.9%	4.6%
Public administration	5.9%	8.0%
Transportation and warehousing, and utilities	6.1%	6.3%
Professional, scientific, and management, and administrative and waste management services	7.1%	8.0%
Construction	8.9%	8.1%
Arts, entertainment, and recreation, and accommodation and food services	9.3%	9.0%
Retail trade	9.9%	13.6%
Agriculture, forestry, fishing and hunting, and mining	11.3%	4.5%
Educational services, and health care and social assistance	24.8%	24.5%

Figure 18: Household income by geography

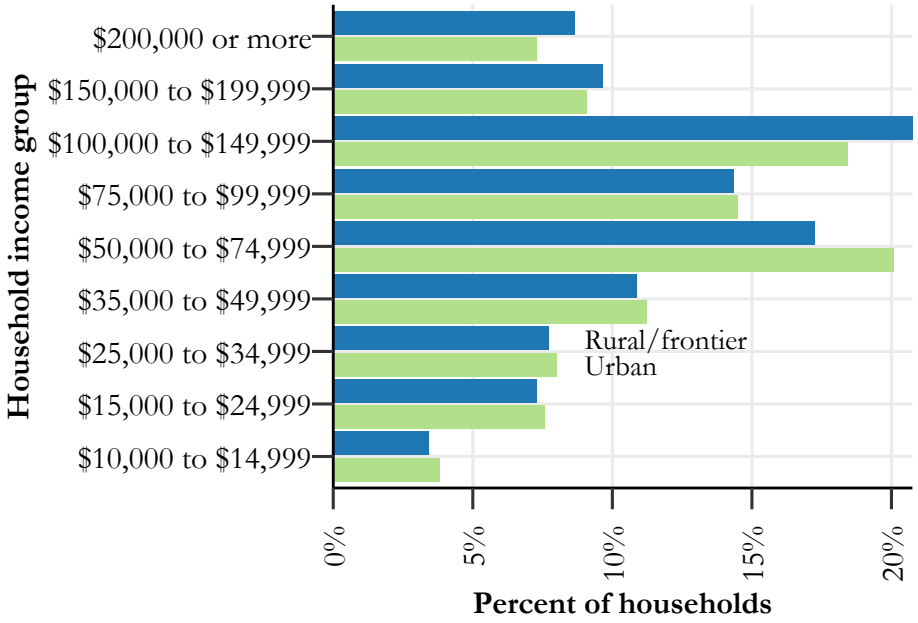


Figure 19: Est. EMS utilization by service

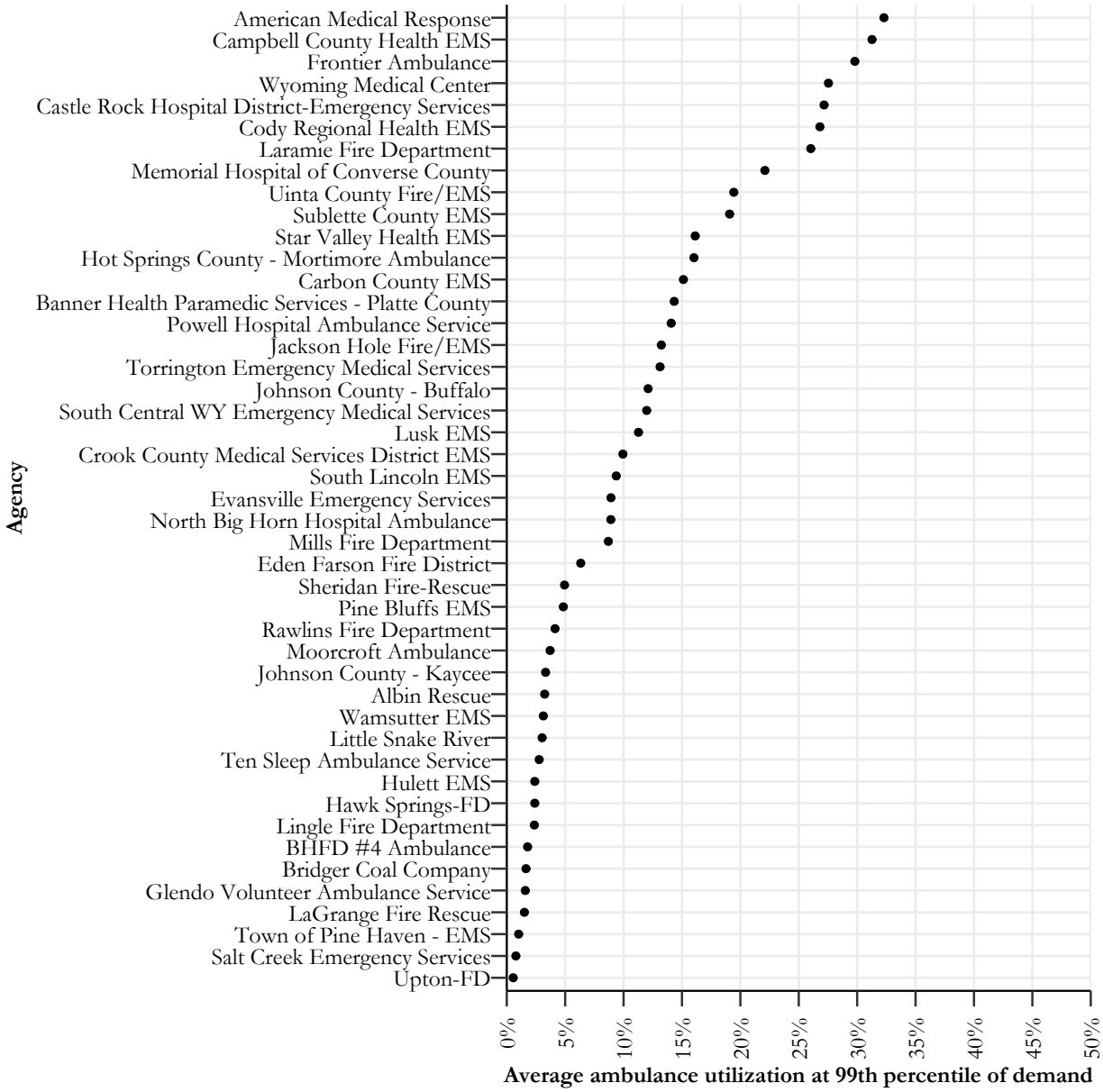


Figure 20: Current maternity deserts

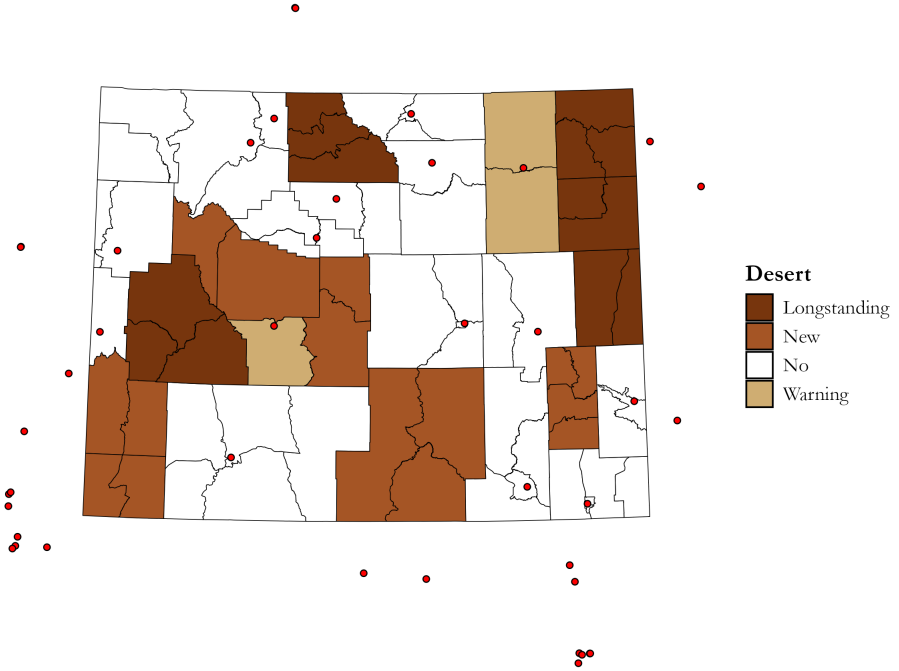


Figure 21: Hospital delivery trends

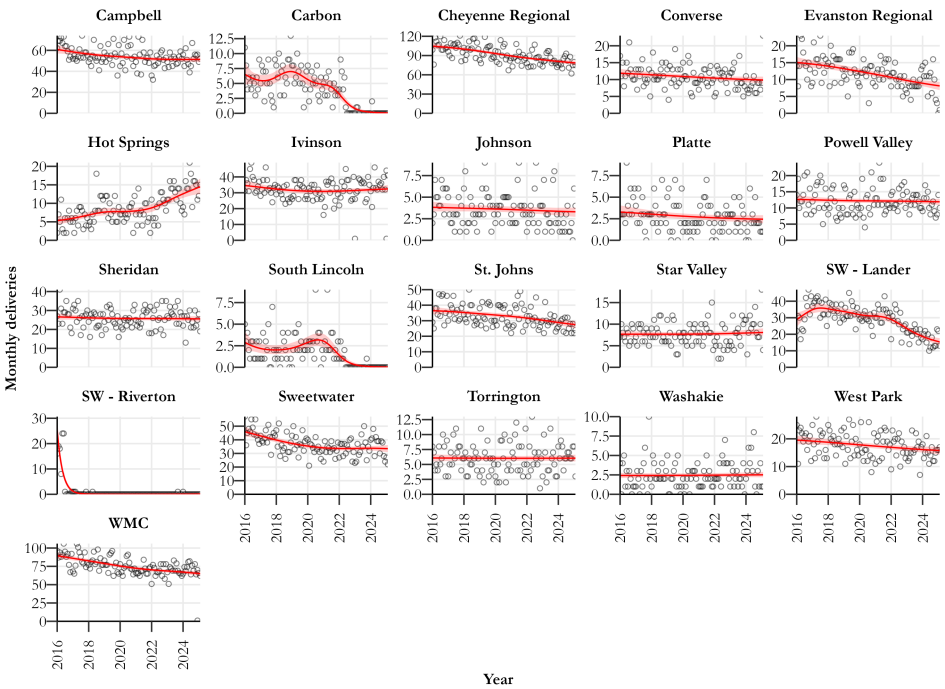


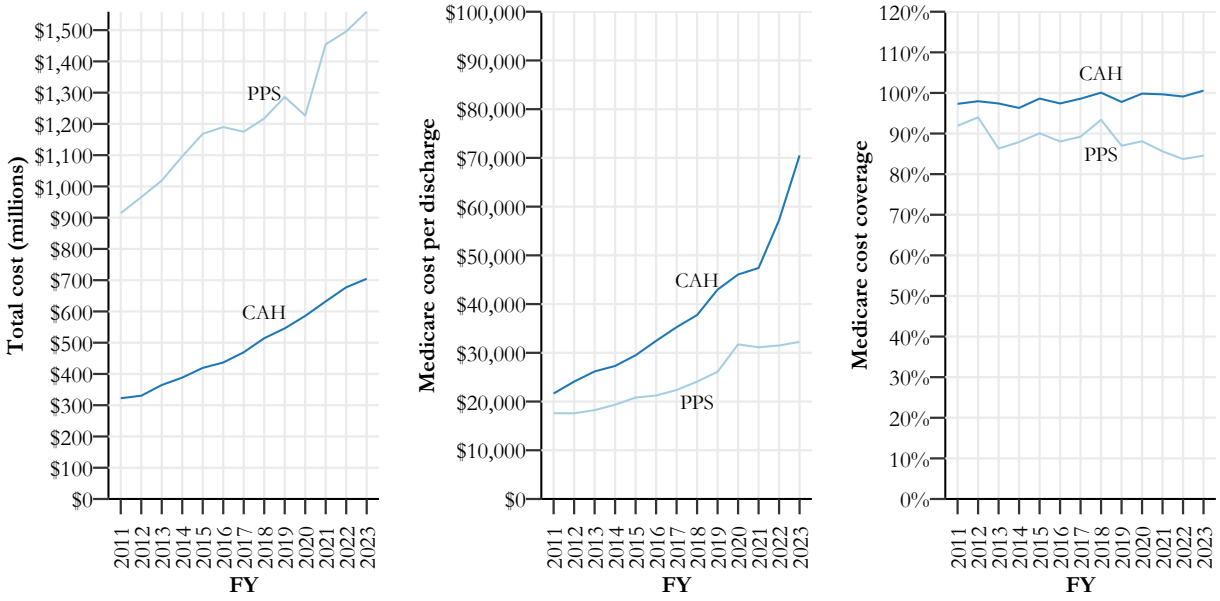
Table 27: Primary care providers (2022)

County	PCP MD/DO	PA/APRN/NP	Total PCP	Providers per 100,000
Albany	29	127	156	410.2
Big Horn	4	11	15	126.5
Campbell	28	99	127	269.9
Carbon	8	22	30	206.3
Converse	8	34	42	304.7
Crook	3	11	14	188.0
Fremont	31	103	134	339.5
Goshen	10	23	33	262.7
Hot Springs	6	8	14	305.1
Johnson	12	11	23	263.5
Laramie	70	338	408	405.1
Lincoln	12	35	47	227.5
Natrona	59	267	326	409.5
Niobrara	2	2	4	168.1
Park	38	96	134	439.1
Platte	4	10	14	161.9
Sheridan	21	102	123	383.2
Sublette	3	9	12	136.9
Sweetwater	15	71	86	208.0
Teton	23	88	111	476.7
Uinta	13	39	52	251.1
Washakie	8	16	24	310.9
Weston	2	14	16	233.2

Table 28: Current Wyoming hospital volume (HCRIS - FY 2023)

Type	City	Beds	Patient days	Occupancy	Total cost (M)
CAH	Basin	10	526	14%	$11.28
CAH	Newcastle	12	1,746	40%	$27.16
CAH	Lovell	14	1,854	36%	$26.93
CAH	Kemmerer	14	668	13%	$24.59
CAH	Thermopolis	15	1,514	28%	$38.60
CAH	Sundance	16	1,014	17%	$14.57
CAH	Worland	18	1,539	23%	$29.94
CAH	Buffalo	20	2,187	26%	$32.98
CAH	Afton	22	1,889	23%	$96.19
CAH	Lusk	24	6,413	73%	$10.01
CAH	Douglas	25	2,519	28%	$80.69
CAH	Wheatland	25	1,837	20%	$28.32
CAH	Torrington	25	3,141	34%	$42.17
CAH	Powell	25	2,066	23%	$79.36
CAH	Cody	25	4,192	46%	$122.35
CAH	Rawlins	25	1,373	15%	$39.31
PPS	Casper	16	91	3%	$14.21
PPS	Evanston	32	1,238	11%	$33.03
PPS	Jackson	48	6,824	39%	$195.19
PPS	Rock Springs	58	5,734	27%	$125.71
PPS	Gillette	66	9,155	38%	$231.68
PPS	Laramie	76	6,107	22%	$122.44
PPS	Sheridan	88	12,169	38%	$143.30
PPS	Riverton	133	6,693	14%	$74.98
PPS	Cheyenne	159	33,112	57%	$369.30
PPS	Casper	249	36,868	41%	$249.05

Figure 22: Hospital costs and Medicare cost coverage



8.8 Public engagement - quantitative results

8.8.1 Public meeting structured exercises

On the first question —asking participants to allocate 100 points across the access-cost-quality tradeoff —our adjusted[78] model-based estimate of the resulting priorities put them in the following order:

- **Cost:** 40% [34 - 46%]
- **Access:** 32% [24 - 40%]
- **Quality:** 28% [22 - 35%]

On the second question, we used a similar model-based estimate to arrive at the following ranking of "brick and mortar" providers: (1) Emergency room, (2) Primary care provider, (3) Ambulance, (4) Hospital inpatient, (5) Pharmacy, (6) Labor and delivery, (7) Mental health / substance abuse treatment, (8) Specialty physicians, (9) Dental, (10) Long-term care / home health, (11) PT/ST/OT (therapies), (12) Vision.

8.8.2 Online survey

Table 29: Ranked Community Rural Health Priorities

Rank	Score	Priority
1	0.25	Improve the financial viability of small, rural hospitals to provide basic services to their communities.
2	0.21	Expand affordable health insurance options.
3	0.00	Recruit and retain primary care physicians, in order to improve access and build longer relationships with patients.
4	-0.14	Train and recruit more nurses and related direct care workforce (e.g. nursing assistants) in order to improve staffing at hospitals and long-term care facilities.

[78] Recognizing that meeting participation was certainly not random or representative of Wyoming's population, we did try to adjust results to match Wyoming's age distribution, the 'not a medical provider' category, and included varying effects for meeting location and respondent city.

5	-0.23	Strengthen obstetric/gynecological, labor/delivery and related services so women can deliver babies safely.
6	-0.24	Recruit and retain more home health aides, and invest in home- and community-based alternatives to nursing home care.
7	-0.30	Expand the integration of behavioral health and primary care, in order to better treat the whole person.
8	-0.36	Improve access to specialty medical care in local communities (e.g., orthopedics, pediatrics, geriatrics).
9	-0.41	Improve or sustain ambulance availability to ensure timely responses to emergencies.
10	-0.42	Recruit and retain more medical support staff for the health care industry (e.g. radiology, laboratory, therapies, medical assistants).
11	-0.49	Improve nursing home quality and sustainability, and increase capacity for people with higher needs (e.g., locked dementia units).
12	-0.50	Expand inpatient behavioral health care, to include crisis stabilization, psychiatric facilities, residential addiction, and recovery services.
13	-0.61	Improve hospital accountability to cities and counties so they provide services reflecting the needs of their communities.
14	-0.62	Build out mobile health care units to bring basic primary and preventive care to where people live.
15	-0.69	Improve the coordination and referral of existing community services for patients and people in need of assistance.
16	-0.80	Expand options for behavioral health care for high-needs children, so they can be safely served closer to home.
17	-0.81	Streamline paperwork and administrative burdens on healthcare providers in order to improve their focus on patient care.
18	-0.86	Expand licensure reciprocity and scope of practice across-the-board in order to increase access to different levels of providers and telehealth.
19	-0.96	Add transportation options so people can get to and from medical appointments, senior centers, and other activities.
20	-1.02	Assist county jails and hospitals in stabilizing and managing people with high behavioral health needs.
21	-1.06	Invest in suicide prevention activities.
22	-1.16	Keep more medical care in-State, as opposed to it 'leaking' out-of-State.
23	-1.21	Improve physician access to consults with specialists via telemedicine.
24	-1.24	Improve palliative and hospice care for people at the end of life.
25	-1.26	Increase Emergency Medical Services (EMS) training in order to improve quality of care in ambulances.
26	-1.40	Improve diabetes care by increasing access to dialysis, nutrition, podiatry, and other specialty services.
27	-1.60	Improve prescription drug / pharmacy availability.
28	-1.61	Improve access to healthy foods and nutrition education.

29	-1.64	Encourage exercise, access to physical activity, and healthy lifestyle choices.
30	-1.84	Recruit and retain more dentists and hygienists in order to improve access to dental care.
31	-1.88	Assist people with technology so they can better use telehealth options.
32	-1.98	Reduce [State] regulations on healthcare providers, particularly in long-term care settings.
33	-2.53	Limit federal money and associated regulations in Wyoming's healthcare system.

8.9 Provider financial trends

Table 30: Cross-sector financial benchmarks (WY, 2018-2023)

Sector	Margin	Current ratio	Days cash	Debt ratio
Behavioral Health Center	5.3%	5.6	115.6	0.10
Critical Access Hospital	3.7%	3.4	105.9	0.15
Early Intervention	1.5%	6.4	100.2	0.08
Intellectual/Developmental Disability	4.6%	4.8	138.2	0.12
Nursing Home	5.0%	2.3	33.1	0.18
Prospective Payment System Hospital	5.7%	2.4	58.1	0.05
Senior Center	5.9%	14.5	163.8	0.04

Table 31: Cross-sector financial benchmarks (WY, 2018-2023)

Sector	Age of plant	Net capital	Employees
Behavioral Health Center	13.0	$3,752,890	85
Critical Access Hospital	12.4	$19,862,183	179
Early Intervention	12.3	$2,147,805	124
Intellectual/Developmental Disability	17.1	$2,603,146	202
Nursing Home	5.7	$1,745,456	64
Prospective Payment System Hospital	13.1	$95,987,669	645
Senior Center	15.9	$489,671	28

8.9.1 Critical Access Hospitals

Table 32: State and regional financial benchmarks (CAH)

	Margin		Current ratio		Days cash		Debt ratio	
Year	**WY**	**Region**	**WY**	**Region**	**WY**	**Region**	**WY**	**Region**
2013	6.2%	4.2%	4.1	2.9	105.0	82.0	0.1	0.2
2014	3.7%	4.0%	4.3	3.1	110.2	83.1	0.2	0.2
2015	6.9%	5.6%	4.2	3.0	105.5	91.8	0.2	0.2
2016	4.1%	3.6%	2.9	3.0	78.2	90.5	0.2	0.2
2017	1.5%	4.3%	3.2	2.8	81.1	88.5	0.2	0.2
2018	0.6%	3.4%	3.8	3.0	80.1	96.9	0.2	0.2
2019	1.0%	4.9%	3.5	2.4	88.9	83.4	0.2	0.2
2020	2.6%	7.4%	2.1	1.8	141.1	165.0	0.2	0.2
2021	12.5%	17.7%	2.8	2.1	129.9	169.2	0.1	0.2
2022	3.0%	3.2%	3.9	2.3	111.6	123.4	0.1	0.2
2023	2.4%	4.6%	4.2	3.4	83.7	105.6	0.2	0.2

Table 33: State and regional size benchmarks (CAH)

	Employees		Capital		Age of plant	
Year	**WY**	**Region**	**WY**	**Region**	**WY**	**Region**
2013	152.2	108.4	$13,279,225	$9,774,520	9.0	9.1
2014	155.8	109.7	$13,354,159	$10,276,734	9.4	9.2
2015	154.0	110.4	$15,398,915	$11,202,617	9.5	9.2
2016	160.3	112.5	$19,472,041	$11,536,111	8.5	9.6
2017	159.2	116.5	$19,821,469	$12,081,512	9.1	10.3
2018	169.5	120.3	$19,352,331	$12,521,015	9.8	11.3
2019	171.2	127.5	$18,588,933	$13,168,793	12.0	11.6
2020	176.6	125.6	$18,703,634	$13,416,706	12.8	11.5
2021	180.4	124.2	$20,382,598	$14,911,946	13.7	11.8
2022	185.4	124.8	$20,470,645	$15,367,075	13.7	11.5
2023	193.0	128.4	$21,674,957	$16,238,825	12.6	11.8

8.9.2 Prospective Payment System Hospitals

Table 34: State and regional financial benchmarks (PPS)

	Margin		Current ratio		Days cash		Debt ratio	
Year	**WY**	**Region**	**WY**	**Region**	**WY**	**Region**	**WY**	**Region**
2013	10.1%	8.0%	2.8	2.8	67.7	40.1	0.1	0.2
2014	8.4%	10.9%	3.0	2.9	67.3	63.3	0.1	0.2
2015	7.3%	10.9%	3.3	3.0	70.2	35.0	0.1	0.2
2016	5.4%	9.5%	3.7	2.4	88.1	38.2	0.1	0.2
2017	-4.6%	10.0%	3.8	2.7	73.8	36.7	0.1	0.2
2018	3.6%	10.8%	3.5	3.0	59.6	42.9	0.1	0.2
2019	6.2%	11.8%	2.9	3.2	47.3	48.2	0.1	0.2
2020	6.0%	11.1%	2.0	2.3	91.1	74.9	0.0	0.2
2021	15.3%	18.6%	1.7	2.0	62.1	59.4	0.0	0.2
2022	-0.9%	2.0%	2.3	2.5	50.8	43.2	0.1	0.2
2023	3.8%	8.0%	2.0	2.3	38.0	50.7	0.0	0.2

Table 35: State and regional size benchmarks (PPS)

	Employees		Capital		Age of plant	
Year	**WY**	**Region**	**WY**	**Region**	**WY**	**Region**
2013	559.1	1121.0	$66,658,274	$106,855,759	12.1	12.4
2014	612.3	1187.1	$83,384,468	$118,168,719	10.9	13.8
2015	621.6	1228.1	$86,496,395	$126,024,361	11.2	14.2
2016	652.1	1226.4	$87,228,577	$131,854,268	11.6	15.8
2017	614.5	1317.4	$79,329,725	$143,503,827	11.0	14.7
2018	751.6	1333.4	$100,357,388	$149,205,794	14.2	16.0
2019	667.6	1318.5	$91,334,555	$158,400,266	12.7	16.8
2020	667.2	1279.3	$92,750,091	$159,329,191	12.6	17.2
2021	610.2	1262.1	$92,611,071	$160,187,334	11.4	18.1
2022	558.2	1280.7	$94,517,239	$172,771,695	13.5	18.0
2023	617.4	1277.6	$104,355,668	$179,466,893	14.1	20.9

8.10 Financial health definitions

$$\text{Total Margin} = \frac{\text{Net income}}{\text{Total expenditures}}$$

$$\text{Current ratio} = \frac{\text{Current assets}}{\text{Current liabilities}}$$

$$\text{Days cash on hand} = \frac{365 \times \text{Cash on hand}}{\text{Total expenditures} - \text{Depreciation expense}}$$

$$\text{Debt ratio} = \frac{\text{Financial debt}}{\text{Financial debt} + \text{Total assets}}$$

$$\text{Age of plant} = \frac{\text{Accumulated depreciation}}{\text{Depreciation expense}}$$

$$\text{Net capital} = \text{Fixed assets (gross)} - \text{Accumulated depreciation}$$

$$\text{Employees FTE (hospitals)} = \text{Interns and residents FTE} + \text{Employees FTE} + \text{Unpaid employees FTE}$$