WYOMING DEPARTMENT OF HEALTH

# WYOMING MEDICAID SFY 2020

# ANNUAL REPORT


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GREAT SEAL OF THE STATE OF WYOMING

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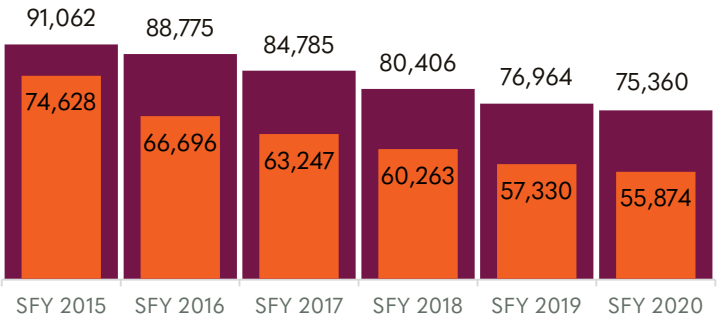
# SFY 2020 AT A GLANCE

## ENROLLMENT

**75,360**

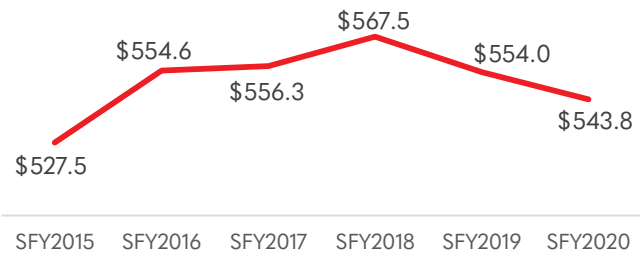
members enrolled at any point during the SFY with 55,874 enrolled each month on average

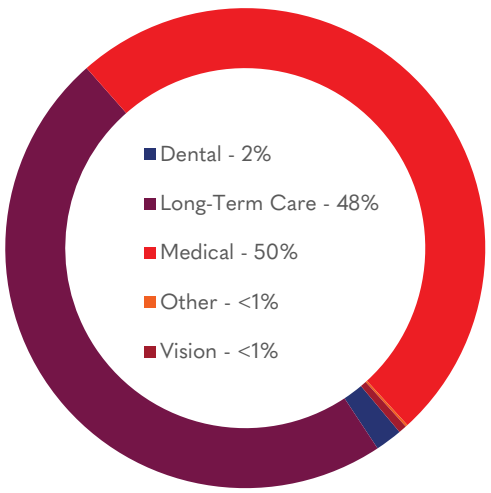



## EXPENDITURES

**$544 million**

paid to 3,445 providers with over 15,500 providers accurately enrolled at any point during the SFY




**$765** preliminary Per Member Per Month Cost

**13%** Wyoming residents enrolled in Medicaid

**62%** of members are children under age 21

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

**9.3** months of average enrollment per member

## RECIPIENTS

**68,673** enrolled members with claims paid

**81%** had a physician claim paid

**54%** had a prescription drug claim paid

**49%** had an outpatient hospital claim paid


GREAT SEAL OF THE STATE OF WYOMING

# BACKGROUND

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

Medicaid eligibility is based on residency, citizenship and identity, social security eligibility as verified by social security number, family income and, to a lesser extent, resources and/or health care needs.

The Division of Healthcare Financing (DHCF) within the Wyoming Department of Health (WDH) is the state-appointed entity for administration of Wyoming Medicaid. DHCF partners with the Fiscal Division for accounting and budgeting services.

**4**
**Major Eligibility Categories**

*Children*
*Pregnant Women*
*Adults*
*Aged, Blind, or Disabled*

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

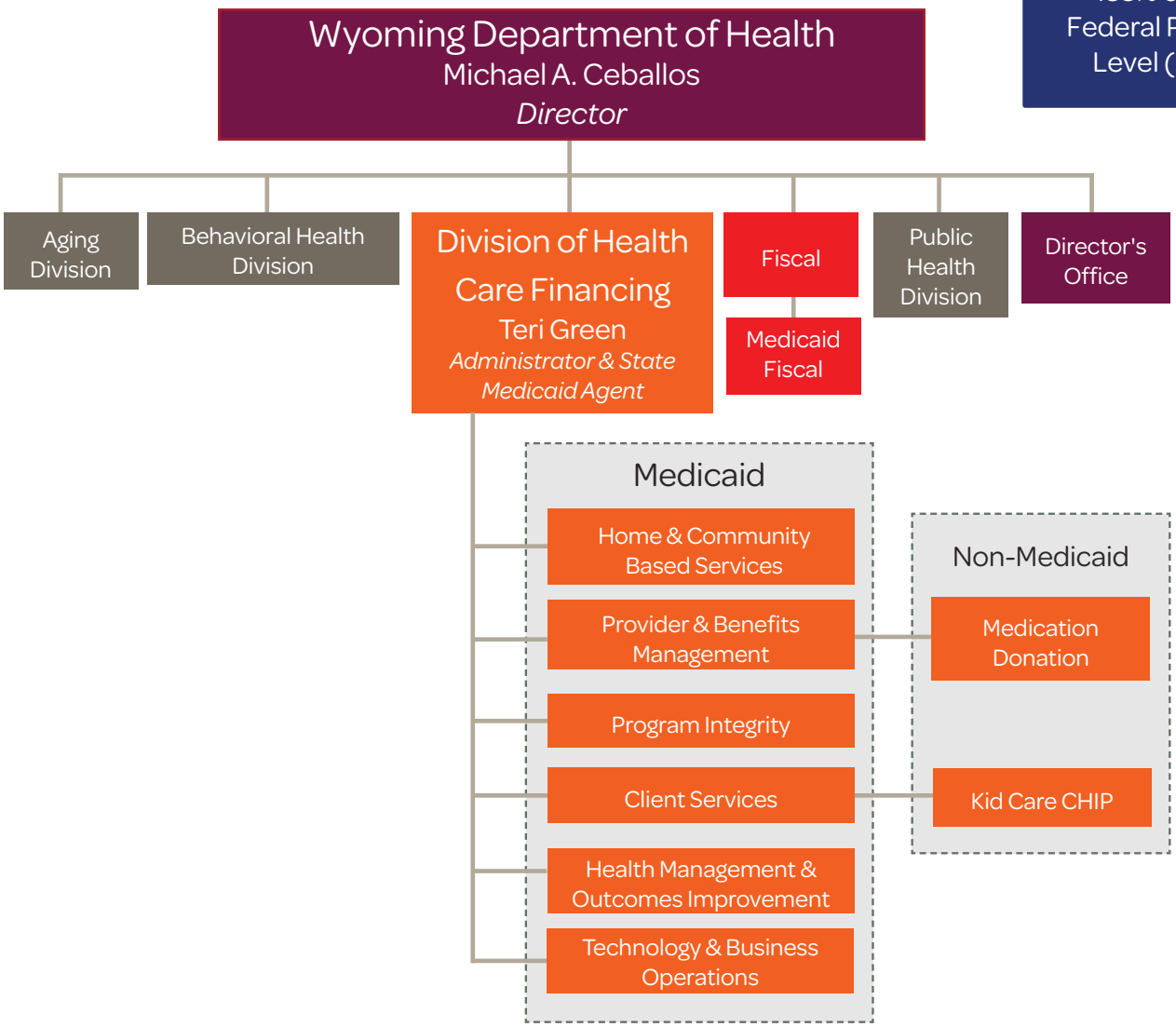



Figure 1. Wyoming Department of Health Organization Chart

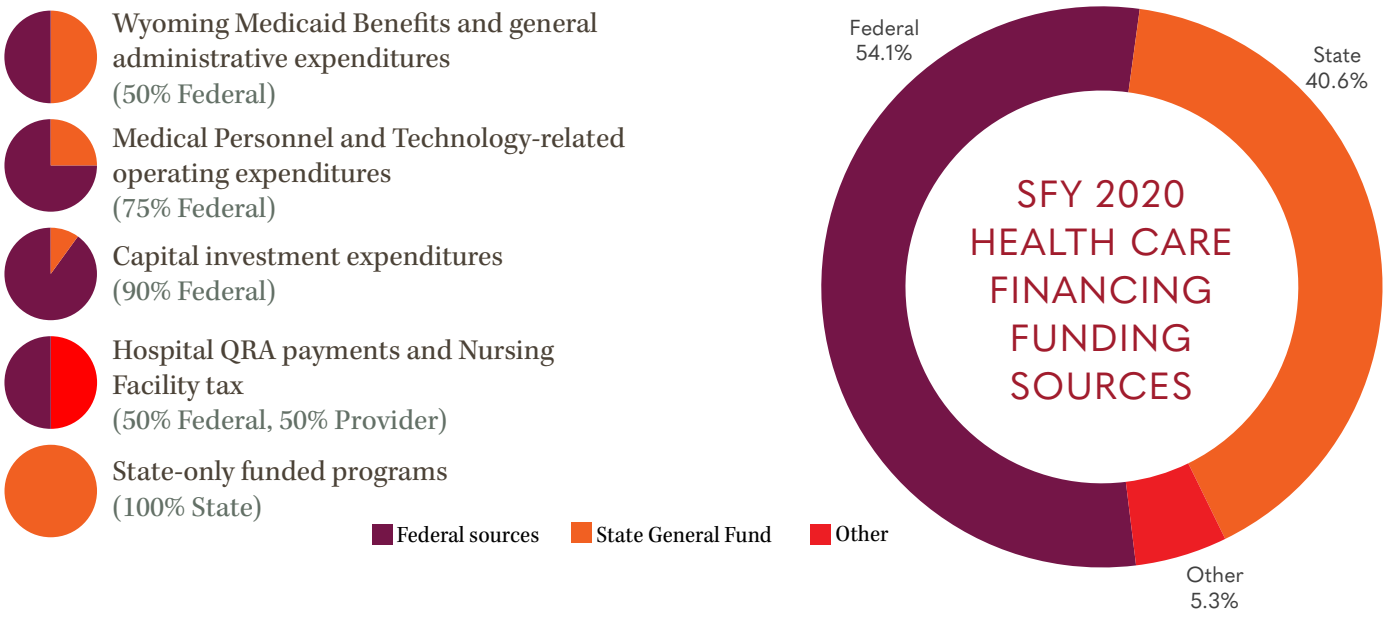
# FINANCIALS & FUNDING

Enrolled providers have one year to submit claims for reimbursement. Claims are processed through the Medicaid Management Information System (MMIS). This Annual Report focuses on the members enrolled during SFY 2020 and claims paid during SFY 2020, regardless of when service was rendered.

Table 1. Division of Health Care Financing Expenditures for SFY 2020

| Medicaid Related Expenditures (in millions) | |
|---|---|
| Annual Report Benefit Expenditures (this report)[1] | $544.3 |
| Medicaid Administration | $50.4 |
| Nursing Facilities Tax Assessment | $38.4 |
| Hospital Qualified Rate Adjustment (QRA) Payments | $34.6 |
| Medicare Buy-In | $19.9 |
| Medicaid One-Time Capital Expenses for New Technology Systems (WES, MMIS, Other) | $26.2 |
| Medicare Clawback (Part D) | $16.5 |
| Physician Electronic Health Record (EHR) Incentives | $0.1 |
| Other[2] | -$6.3 |
| Subtotal Medicaid Expenditures | $724.1 |
| Drug Rebates | -$32.5 |
| Total Medicaid Expenditures | $691.6 |
| Non-Medicaid Expenditures (in millions) | |
| Children's Health Insurance Program (CHIP) | $11.0 |
| CHIP Administration | $0.7 |
| State Only Foster Care and General Fund Foster Care (Court Orders) | $1.5 |
| Supplemental Security Income (SSI) Payments | $1.1 |
| Total Health Record (Health Information Exchange (HIE)) | $0.3 |
| State Only Other | $1.2 |
| Total Non-Medicaid Expenditures | $15.8 |
| Total Division of Health Care Financing | $707.4 |

1 Includes reductions in expenditures due to recoveries processed through the MMIS.
2 Adjustment to reflect timing difference related to drug rebate and claims differences between WOLFS and MMIS claims data.



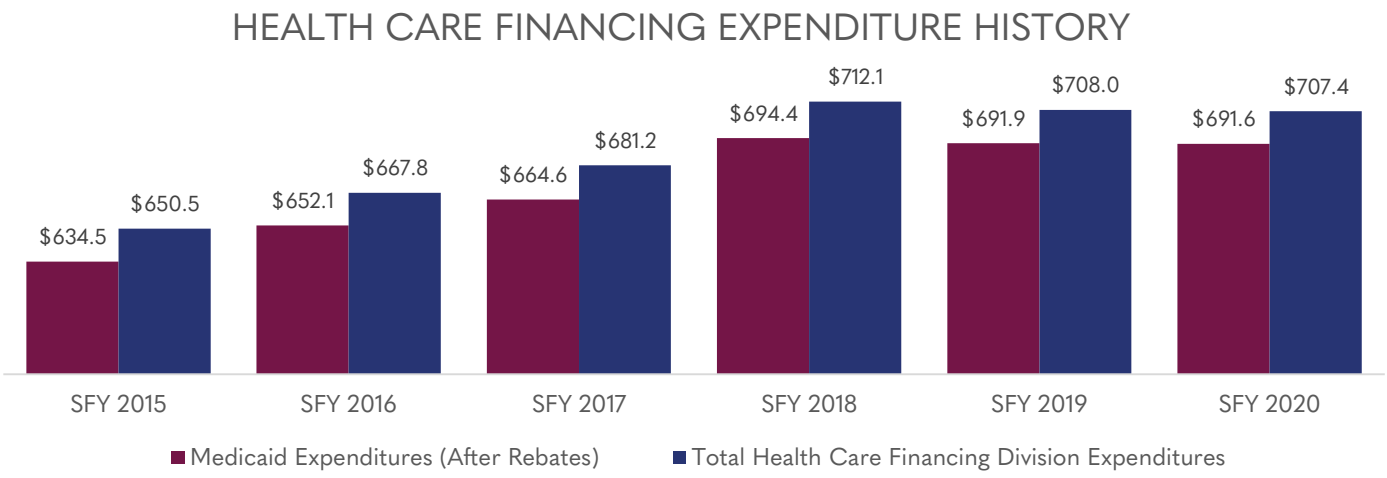




Figure 2. Health Care Financing Expenditure History

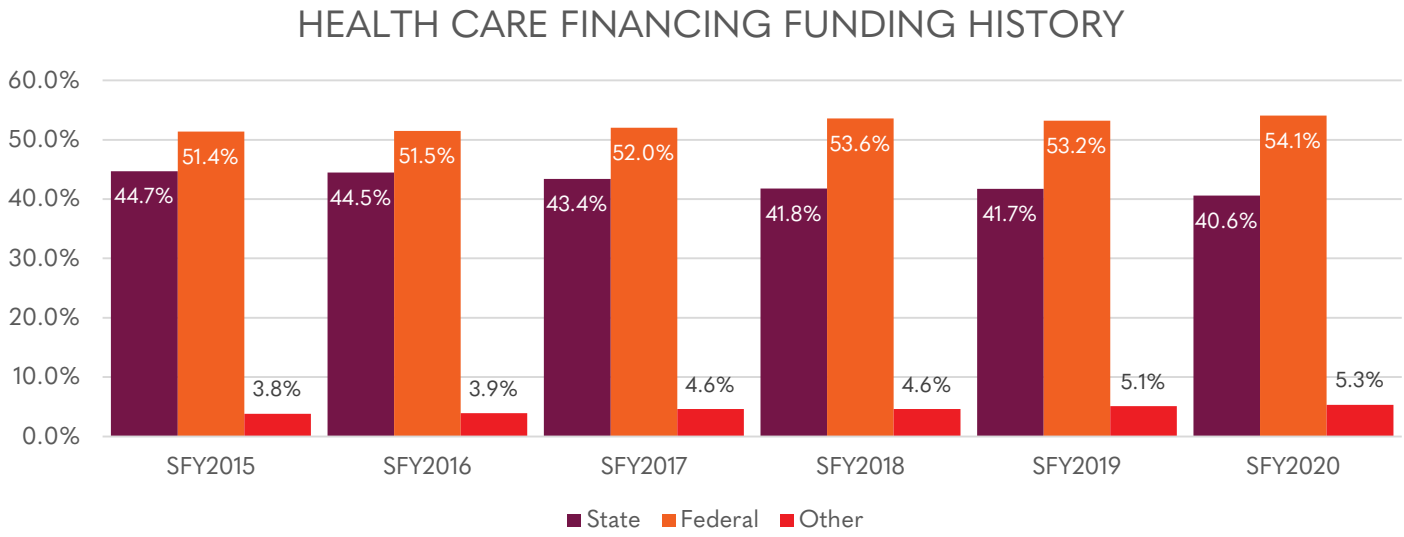



Figure 3. Health Care Financing Funding History

# ADVISORY GROUPS

Table 2. Wyoming Medicaid Advisory Groups and Committees

| Advisory Group | Members | Description |
|---|---|---|
| Dental Advisory Group (DAG) | Two specialists, three general dentists, and representatives from Medicaid and its fiscal agent, Conduent. | Represents a wide range of interests, experience, dental specialties and various areas of the state, while advising Medicaid regarding administration of the dental program. |
| Long-Term Care Advisory Group | Nursing Home Association leadership, five nursing home providers, a home health provider, a hospice provider, an assisted living provider, a Long-Term Care waiver case manager, and an Independent Living Center representative | Focuses on issues and recommendations with institutional and community-based long-term care providers. |
| Medical Advisory Group (MAG) | Wyoming Hospital Association, Wyoming Medical Society, executives from hospitals throughout Wyoming, physicians, and medical practitioners | Focuses on new and upcoming issues within the healthcare industry, member concerns, and relevant presentations. Works to develop solutions to issues. |
| Pharmacy & Therapeutics Committee (P&T) | Six physicians, five pharmacists, one allied health professional. | Provides recommendations regarding prospective drug utilization review, retrospective drug utilization review and education activities to Medicaid. |
| Tribal Leadership Advisory Group | Tribal Business Council members, leadership and executives from tribal health clinics and Indian Health Services, long-term care providers, and representatives from all Wyoming Department of Health divisions | Focuses on new and upcoming issues within the healthcare industry, consultation with the Tribal leaders, updates from facilities, and work to develop solutions and programs to decrease barriers for this group. |

# PROGRAM INTEGRITY

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

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

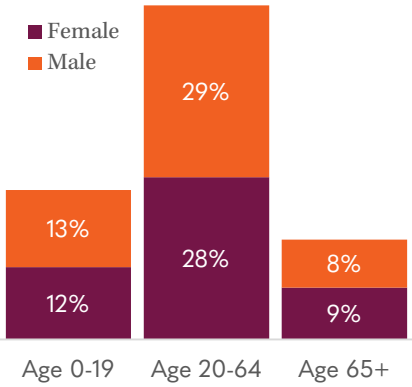
Table 3. Medicaid Cost Avoidance and Recoveries - SFY 2020

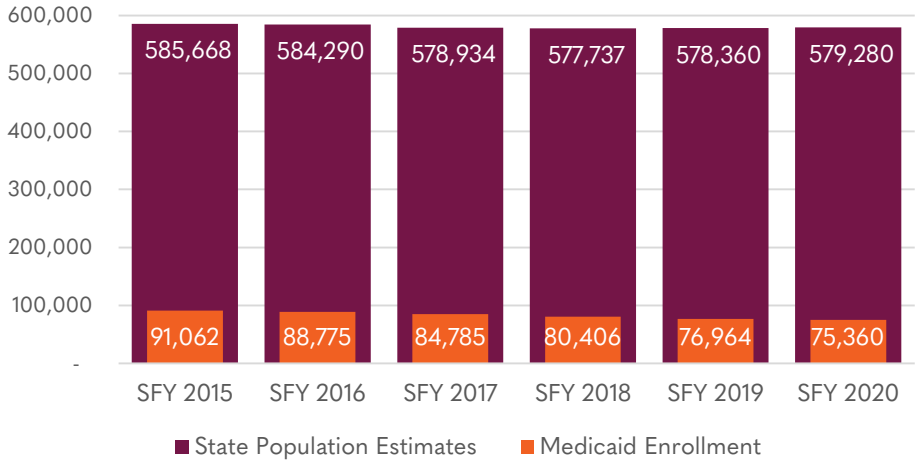
| Program Area | Description | Amount Identified or Recovered |
|---|---|---|
| Program Integrity | Process of reviewing, auditing, and investigating providers for claims lacking sufficient documentation or incorrect billing. | $394,564 |
| Third Party Liability Recoveries | Funds recovered from other responsible parties which may include Medicare, health insurance companies, worker's compensation, casualty insurance companies, or a spouse/parent court order to carry health insurance. | $1,022,535 |
| Third Party Liability Cost Avoidance | An estimate of costs not incurred by the State when claims are denied up front due to third party liability. This figure is calculated based on billed charges, not on the final amount Medicaid would have paid -- as the claims are not fully processed once TPL is determined; therefore, this figure is only an estimate and may be inflated. As such, the program integrity team is currently reviewing and auditing their process for calculating this figure. | $10,158,983 |
| Estate Recoveries | Funds recovered from any real or personal property a client had legal title or interest in at the time of death, including such assets conveyed to a survivor heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship life estate, living trust or other arrangement. | $5,295,675 |
| Credit Balances | Moneys recovered from providers whose credits (i.e. take-backs or adjustments) exceed their debits (pay-outs or paid claims). | $947,436 |
| Total Recovered Dollars (excluding Cost Avoidance) | | $7,660,210 |
| Total Recovered Dollars (including Cost Avoidance) | | $17,819,193 |

# DEMOGRAPHICS

**13%**
of Wyoming residents enrolled in Medicaid

**26%**
of residents under age 20




State Population[3] *decreased* by

**1.1%**

from 2015 to 2020

Medicaid enrollment *decreased* by

**17.2%**

from SFY 2015 to SFY 2020

# ECONOMY

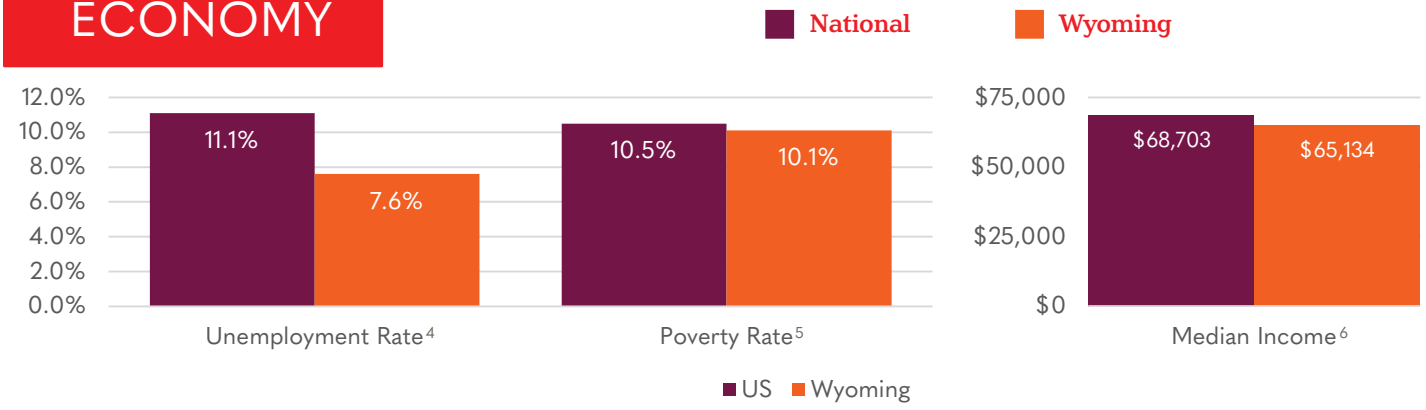



Table 4. Employment and Mean Wages by Occupation[7,8]

| | Employment Total Percent Change 2009 to 2019 | | Wages Total Percent Change 2009 to 2019 | | Mean Hourly Wages 2019 | |
|---|---|---|---|---|---|---|
| | US | WY | US | WY | US | WY |
| All Occupations | 12.4% | -3.7% | 61.3% | 47.7% | $25.72 | $23.92 |
| Healthcare Practitioners & Technical Occupations | 20.4% | 12.7% | 45.0% | 50.8% | $40.21 | $39.85 |
| Healthcare Support Workers | 67.8% | 45.1% | 25.4% | 24.1% | $14.91 | $15.52 |

3 2020 forecast population prepared by Wyoming Department of Administration & Information, Economic Analysis Division (http://eadiv.state.wy.us), August 2019

4 Senate Joint Economic Committee, Wyoming Employment Report, July 2020, https://www.jec.senate.gov/public/_cache/files/812bd4d0-203a-4586-9235-a5dd2630fdf3/wyoming-employment-update.pdf

5 Historical Poverty Tables-People and Families, Tables 9, 21: http://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-people.html

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

7 Bureau of Labor Statistics, May 2019 State Occupational Employment and Wage Estimates, Wyoming. http://www.bls.gov/oes/current/oes_wy.htm

8 Bureau of Labor Statistics, May 2019 State Occupational Employment and Wage Estimates, United States. http://www.bls.gov/oes/current/oes_nat.htm

# HIGHLIGHTS & INITIATIVES

## CORONAVIRUS RESPONSE

- Temporary rate increases in some areas including nursing home and waivers
- Temporary policy changes in some areas, including removal of prior authorization, changes to provider enrollment and renewal, and changes to member renewal periods
- Changes needed to support emergency, rate, and policy updates including system changes and report development
- Temporary policy changes to allow all ambulance providers to perform services similar to those enrolled as Community Emergency Medical Services (treat and release). Also allow transport by ambulance to medically necessary appointments, such as dialysis
- Change to policy to allow telehealth services for the following services: Indian Health Services (IHS), Federally Qualified Health Centers (FQHCs), Rural Health Clinics, (RHCs), behavioral health peer specialists, group therapy sessions, and other clinically appropriate services

## POLICY

- Completed Gap Analysis of PASRR process, updated manuals, and completed diagnosis code updates
- Speech therapy and behavioral health services (for adults age 21 and older) requiring a prior authorization for those services above the threshold of 30 visits per calendar year, effective January 1, 2020

## TECHNOLOGY

- Implementation of the second year APR-DRG effective February 1, 2020

## TRIBAL HEALTH

- Entered into contract to allow IHS workers to process application for Medicaid MAGI programs within the Wyoming Eligibility System (WES).
- Training of IHS staff began in September 2019

# WYOMING INTEGRATED NEXT GENERATION SYSTEM

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

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

## 1 PBMS

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

## 2 SI-ESB

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

## 3 DW-BI

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

## 4 FWA

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

## 5 TPL & BMS

Third Party Liability ensures proper coordination exists between Medicaid and any other entity/ individual with obligation to provide financial support for Medicaid services. Benefit Management System processes Medicaid claims and manages benefit plans

## 6 PRESM

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

## 7 EVV

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

## 8 CCMS

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

## A

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

## B

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

# ENROLLMENT

2.1%

**75,360** members enrolled at any point during the SFY with 55,874 enrolled each month on average

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

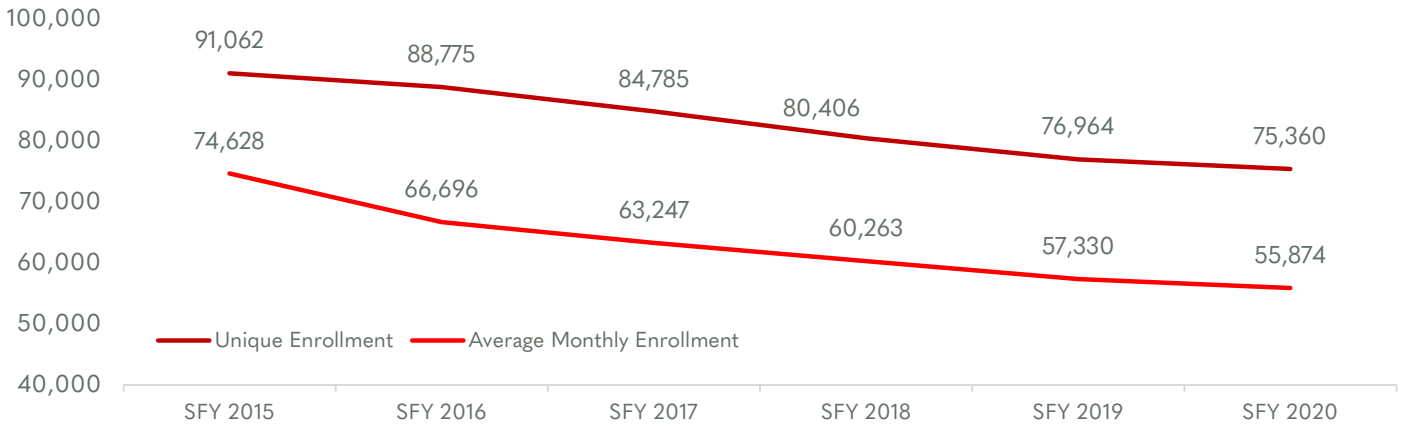



Figure 4. Enrollment History: Unique and Monthly Average

Table 5. Change in Medicaid Enrollment

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|---|
| Unique Enrollment | 91,062 | 88,775 | 84,785 | 80,604 | 76,964 | 75,360 |
| % Change from Previous SFY | - | -2.5% | -4.5% | -5.2% | -4.3% | -2.1% |
| Average Monthly Enrollment | 74,628 | 66,696 | 63,247 | 60,263 | 57,330 | 55,874 |
| % Change from Previous SFY | - | -10.6% | -5.2% | -4.7% | -4.9% | -2.5% |
| Average Length of Enrollment (months) | 9.8 | 9.2 | 9.2 | 9.3 | 9.3 | 9.3 |

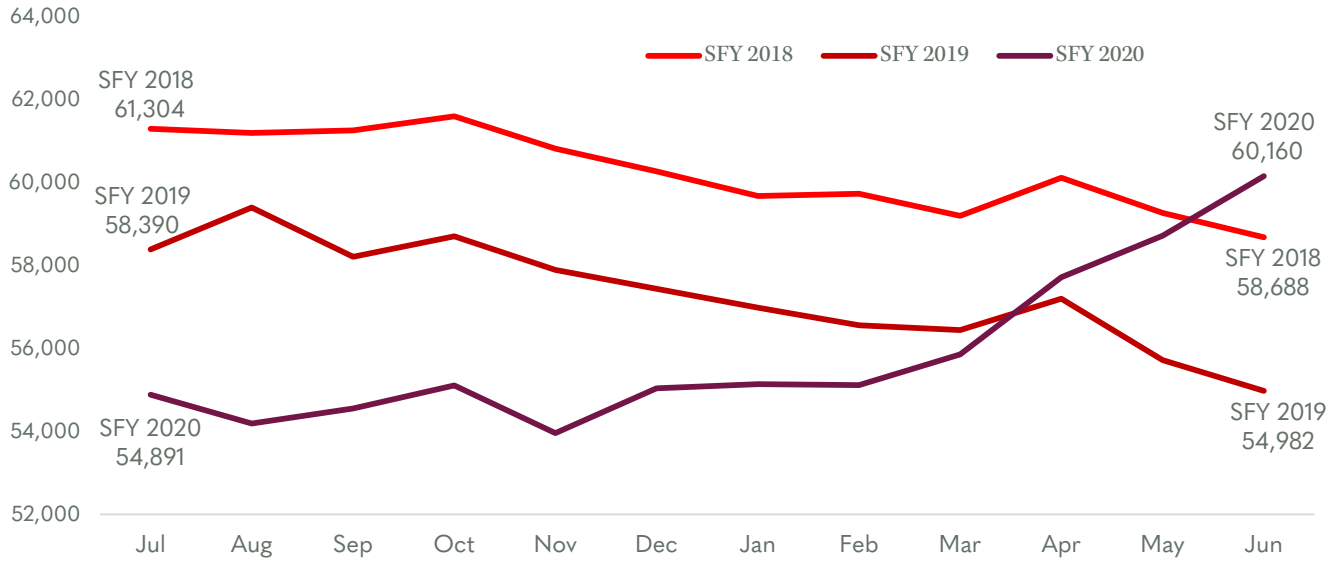



Figure 5. Monthly Medicaid Enrollment by State Fiscal Year

# BY COUNTY

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

Table 6. Medicaid Enrollment by County

| County | Enrolled Members | Percent of Total |
|---|---|---|
| Albany | 3,311 | 4.4% |
| Big Horn | 1,983 | 2.6% |
| Campbell | 5,626 | 7.5% |
| Carbon | 1,801 | 2.4% |
| Converse | 1,723 | 2.3% |
| Crook | 775 | 1.0% |
| Fremont | 9,173 | 12.2% |
| Goshen | 1,672 | 2.2% |
| Hot Springs | 724 | 1.0% |
| Johnson | 889 | 1.2% |
| Laramie | 12,909 | 17.1% |
| Lincoln | 1,609 | 2.1% |
| Natrona | 12,063 | 16.0% |
| Niobrara | 289 | 0.4% |
| Other[9] | 1,479 | 2.0% |
| Park | 3,412 | 4.5% |
| Platte | 1,108 | 1.5% |
| Sheridan | 3,593 | 4.8% |
| Sublette | 657 | 0.9% |
| Sweetwater | 5,465 | 7.3% |
| Teton | 1,055 | 1.4% |
| Uinta | 3,041 | 4.0% |
| Washakie | 1,096 | 1.5% |
| Weston | 770 | 1.0% |
| Total | 75,360 | |

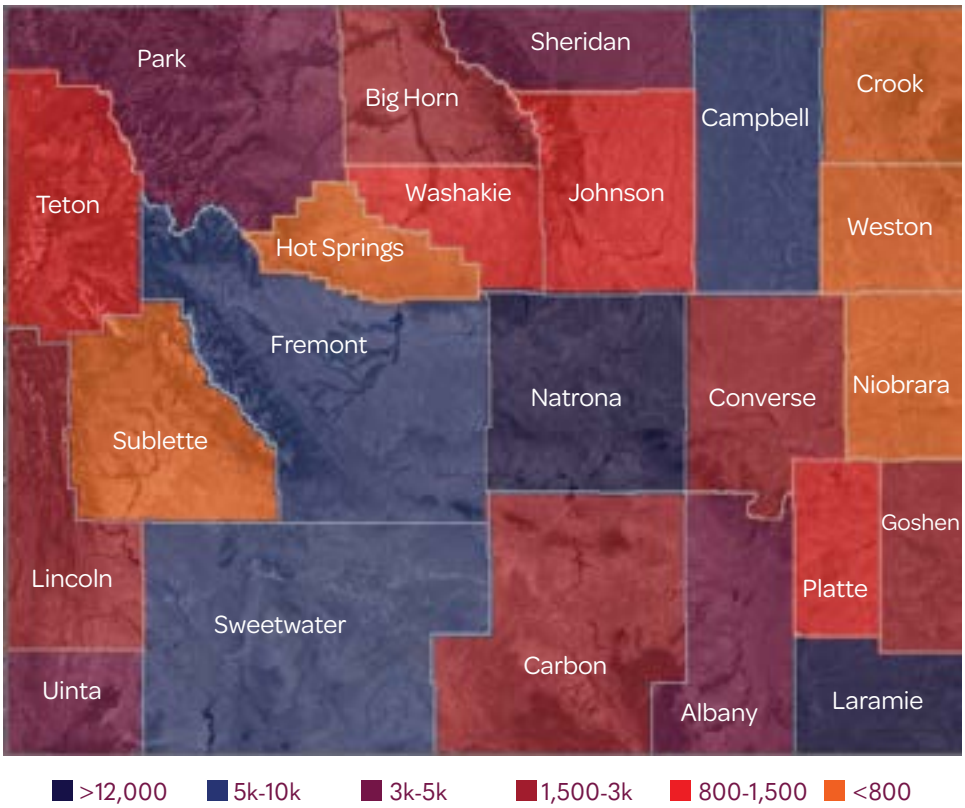



Figure 6. Wyoming County Map by Medicaid Enrollment

9 County 'Other' indicates individuals who were at one time enrolled in Medicaid, but have moved out of state. Member county of residence is based on the address on file at the time the data is extracted.

# EXPENDITURES

1.9%

**$543,792,374** paid to 3,445 providers with over 19,964 providers actively enrolled at any point during the SFY


Providers have one year to submit claims to Medicaid for reimbursement; therefore, expenditures here include services rendered in both SFY 2019 & SFY 2020

Figure 7. Expenditure History

Table 7. Expenditure History by Service Type

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|---|
| Medical | $283,615,999 | $284,761,312 | $300,054,010 | $303,594,435 | $297,461,585 | $309,898,364 |
| Long-Term Care | $216,353,891 | $215,466,756 | $208,759,250 | $230,992,217 | $239,788,830 | $241,030,693 |
| Dental | $13,272,110 | $13,391,934 | $14,473,863 | $15,450,029 | $14,167,617 | $11,847,581 |
| Vision | $3,389,793 | $3,464,394 | $3,595,216 | $3,652,188 | $3,850,574 | $3,712,855 |
| Other | $625,371 | $538,127 | $649,268 | $894,268 | $1,006,132 | $989,147 |

Figure 8, below, shows how SFY 2020 paid expenditures compared to SFY 2019 for top services. Only services with over $5 million in expenditures in either SFY have been included in the figure. More detailed information on services is available in the Services section of this report. Percentages shown are the % of Total Medicaid Expenditures for each service area.

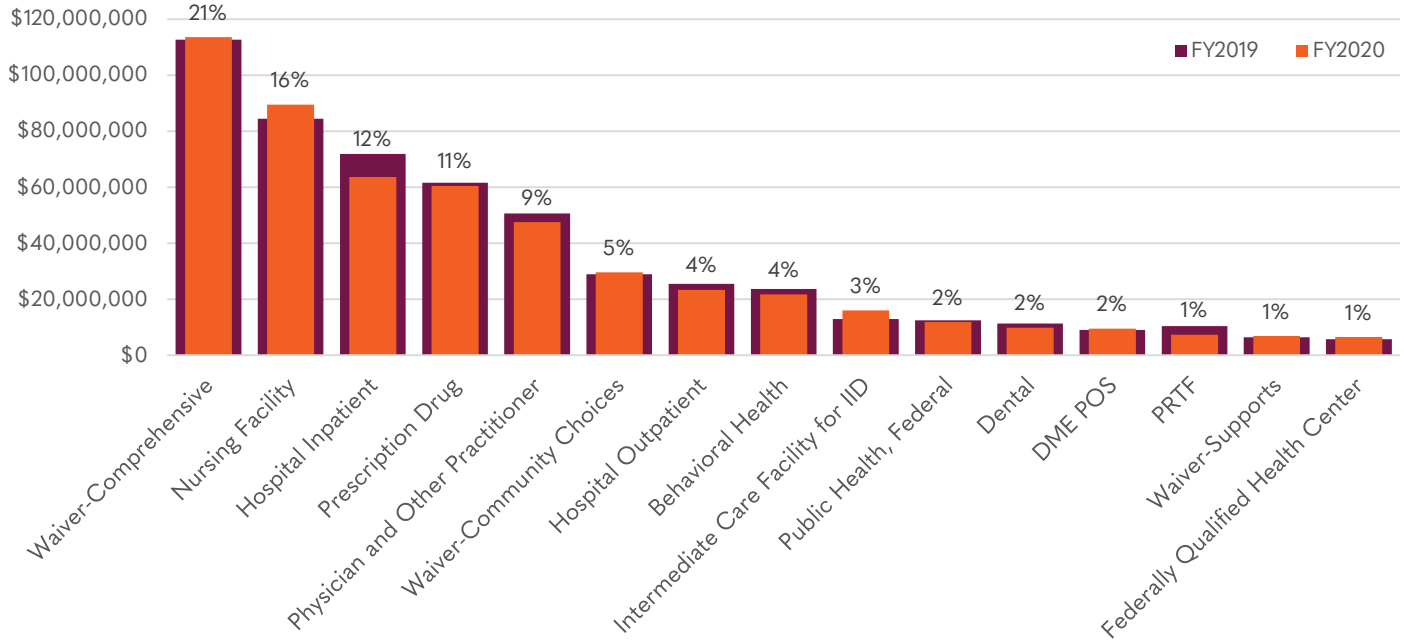



Figure 8. Top Services Expenditures as % of Total Medicaid Expenditures SFY 2020 vs SFY 2019

# RECIPIENTS

3.7%

**68,673**

enrolled members with claims paid


Figure 9. Recipient History

Table 8. Recipient History by Service Type

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|---|
| Medical | 74,075 | 73,338 | 74,597 | 73,230 | 68,170 | 65,378 |
| Long-Term Care | 7,019 | 7,368 | 7,605 | 7,684 | 7,711 | 8,193 |
| Dental | 30,754 | 32,046 | 31,483 | 28,789 | 27,525 | 24,733 |
| Vision | 15,063 | 15,369 | 15,921 | 15,821 | 14,790 | 12,680 |
| Other | 1,654 | 1,977 | 2,938 | 3,251 | 3,336 | 3,157 |

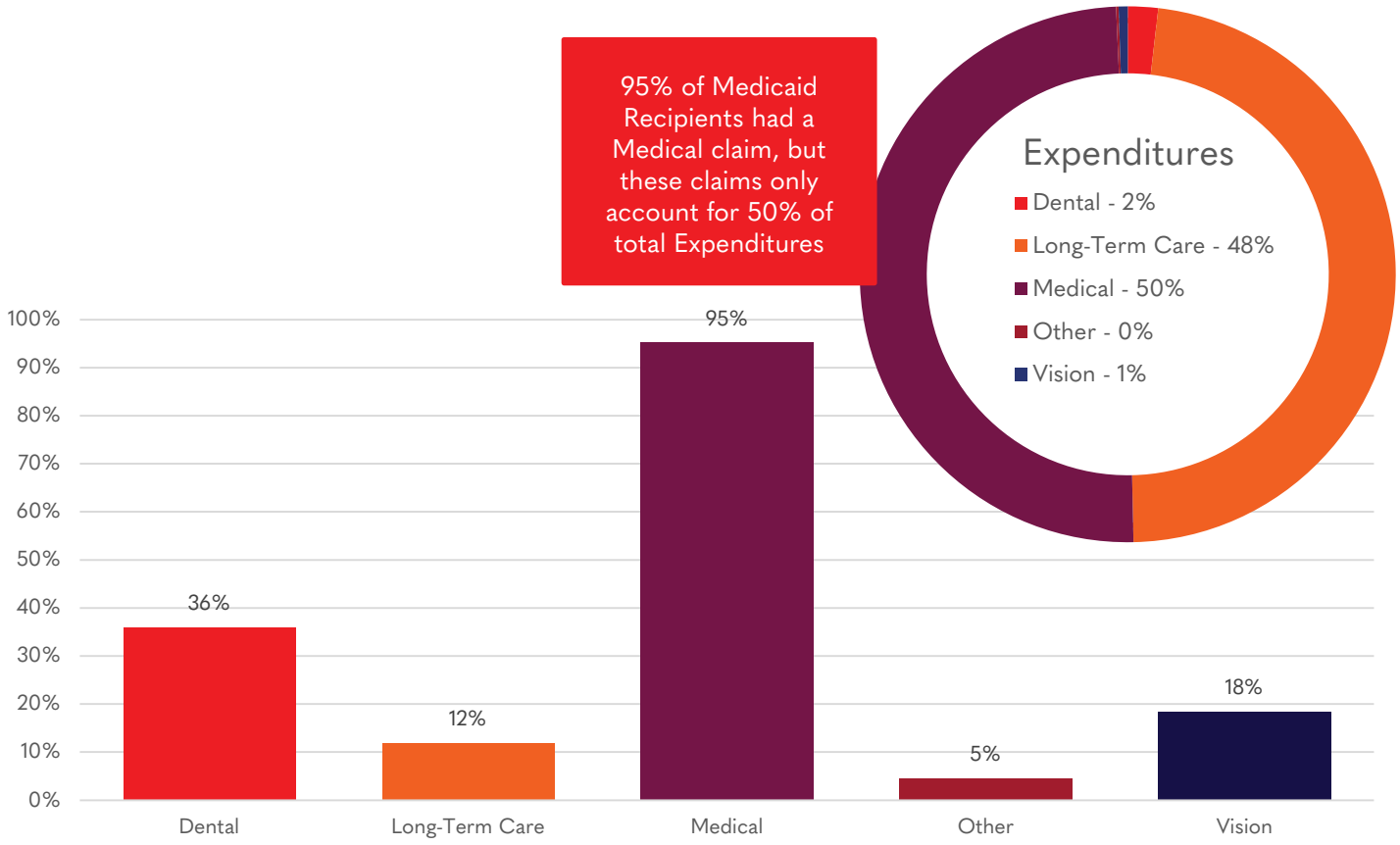



Figure 10. Recipient Utilization versus Expenditure Breakdown by Service Type

# ELIGIBILITY CATEGORIES

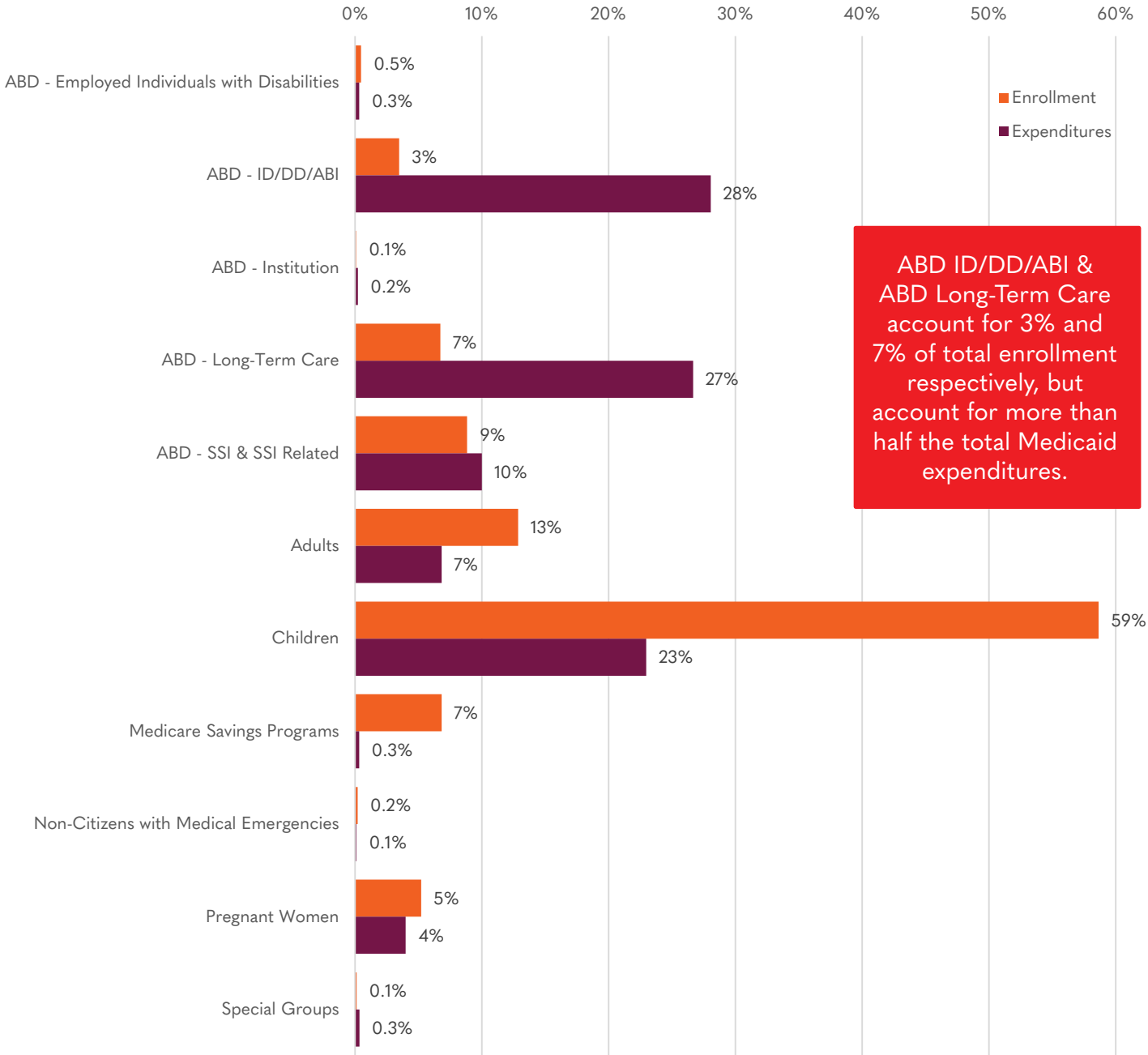
For this report, Medicaid enrolled members are presented in 11 eligibility categories.

aged, blind, or disabled

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

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

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




ABD ID/DD/ABI & ABD Long-Term Care account for 3% and 7% of total enrollment respectively, but account for more than half the total Medicaid expenditures.

Figure 11. Enrolled Members versus Expenditures by Eligibility Category - SFY 2020

Table 9. Eligibility Category Summary

| Eligibility Category | Enrolled Members | % Change from SFY 2019 | Unique Recipients | % Change from SFY 2019 | Expenditures | % Change from SFY 2019 |
|---|---|---|---|---|---|---|
| ABD EID | 356 | 6 | 382 | -5 | $1,756,635 | -20 |
| ABD ID/DD/ABI | 2,618 | 7 | 2,655 | 3 | $152,541,587 | 3 |
| ABD Institution | 65 | -17 | 76 | 12 | $1,239,234 | -24 |
| ABD LTC | 5,076 | 28 | 5,830 | 8 | $144,976,414 | 6 |
| ABD SSI | 6,661 | -1 | 6,087 | -2 | $54,412,195 | -1 |
| Adults | 9,692 | -5 | 8,098 | -7 | $37,137,296 | -13 |
| Children | 44,204 | -17 | 39,428 | -6 | $124,888,851 | -7 |
| Medicare Savings Programs | 5,150 | -2 | 2,934 | 4 | $1,687,004 | 3 |
| Non-Citizens with Medical Emergencies | 158 | -52 | 140 | -3 | $913,315 | -36 |
| Pregnant Women | 3,927 | -21 | 4,342 | -1 | $22,579,721 | -4 |
| Screenings & Gross Adjustments | -- | -- | -- | -- | $957,842 | -85 |
| Special Groups | 88 | -70 | 84 | -1 | $1,826,629 | 13 |
| Total | 75,360 | -11 | 68,673 | -4 | $543,792,374 | -2 |

Table 10. Enrollment History by Eligibility Category

| Eligibility Category | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| ABD EID | 360 | 479 | 496 | 404 | 365 | 356 | -1 |
| ABD ID/DD/ABI | 2,480 | 2,609 | 2,640 | 2,603 | 2,550 | 2,618 | 6 |
| ABD Institution | 76 | 77 | 80 | 55 | 46 | 65 | -14 |
| ABD LTC | 4,378 | 4,643 | 4,885 | 5,007 | 5,105 | 5,076 | 16 |
| ABD SSI | 7,052 | 7,039 | 7,117 | 6,609 | 6,737 | 6,661 | -6 |
| Adults | 10,998 | 12,431 | 11,825 | 10,989 | 9,900 | 9,692 | -12 |
| Children | 57,007 | 54,345 | 51,164 | 47,919 | 45,367 | 44,204 | -22 |
| Medicare Savings Programs | 5,338 | 4,982 | 4,994 | 4,978 | 5,082 | 5,150 | -4 |
| Non-Citizens with Medical Emergencies | 794 | 432 | 292 | 195 | 167 | 158 | -80 |
| Pregnant Women | 5,743 | 5,517 | 4,778 | 4,336 | 4,113 | 3,927 | -32 |
| Special Groups | 694 | 250 | 164 | 121 | 97 | 88 | -87 |
| Total | 91,062 | 88,775 | 84,785 | 80,406 | 76,964 | 75,360 | -17 |

Table 11. Expenditures History by Eligibility Category

| Eligibility Category | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| ABD EID | $3,795,205 | $4,730,644 | $4,491,523 | $3,170,198 | $2,201,872 | $1,756,635 | -54 |
| ABD ID/DD/ABI | $137,112,834 | $146,523,597 | $145,024,485 | $139,120,839 | $148,210,163 | $152,541,587 | 11 |
| ABD Institution | $3,843,309 | $3,976,596 | $2,806,554 | $2,489,828 | $1,638,641 | $1,239,234 | -68 |
| ABD LTC | $109,685,023 | $127,126,736 | $133,820,492 | $137,811,401 | $136,564,759 | $144,976,414 | 32 |
| ABD SSI | $57,532,693 | $54,218,689 | $55,141,541 | $57,608,075 | $55,018,028 | $54,412,195 | -5 |
| Adults | $39,268,780 | $42,070,572 | $40,633,756 | $46,008,562 | $42,819,380 | $37,137,296 | -5 |
| Children | $143,624,614 | $144,048,715 | $140,921,270 | $149,233,800 | $139,771,403 | $124,888,851 | -13 |
| Medicare Savings Programs | $4,564,069 | $4,098,086 | $3,206,357 | $1,654,936 | $1,687,004 | $1,743,350 | -62 |
| Non-Citizens with Medical Emergencies | $1,236,724 | $1,212,043 | $1,040,454 | $713,218 | $913,315 | $586,871 | -53 |
| Pregnant Women | $24,134,468 | $24,192,832 | $26,264,576 | $25,247,867 | $22,579,721 | $21,725,470 | -10 |
| Screenings & Gross Adjustments | $183,197 | $512,743 | $1,403,752 | $2,959,972 | $1,197,091 | $957,842 | 423 |
| Special Groups | $2,550,692 | $1,871,886 | $1,519,979 | $1,459,944 | $1,623,461 | $1,826,629 | -28 |
| Total | $527,531,608 | $554,583,138 | $556,274,739 | $567,478,640 | $554,032,539 | $543,792,374 | 3 |

Table 12. Unique Recipient History by Eligibility Category[10]

| Eligibility Category | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| ABD EID | 360 | 472 | 517 | 455 | 401 | 382 | 6 |
| ABD ID/DD/ABI | 2,478 | 2,636 | 2,661 | 2,633 | 2,584 | 2,655 | 7 |
| ABD Institution | 92 | 99 | 110 | 88 | 68 | 76 | -17 |
| ABD LTC | 4,552 | 4,827 | 5,092 | 5,238 | 5,416 | 5,830 | 28 |
| ABD SSI | 6,139 | 6,092 | 6,383 | 6,285 | 6,203 | 6,087 | -1 |
| Adults | 8,508 | 9,930 | 10,329 | 9,958 | 8,706 | 8,098 | -5 |
| Children | 47,745 | 46,259 | 46,410 | 44,840 | 41,776 | 39,428 | -17 |
| Medicare Savings Programs | 2,992 | 2,929 | 2,895 | 2,836 | 2,820 | 2,934 | -2 |
| Non-Citizens with Medical Emergencies | 289 | 258 | 254 | 146 | 145 | 140 | -52 |
| Pregnant Women | 5,497 | 5,491 | 5,346 | 5,149 | 4,389 | 4,342 | -21 |
| Special Groups | 280 | 149 | 132 | 116 | 85 | 84 | -70 |
| Total | 77,462 | 77,246 | 78,165 | 76,255 | 71,300 | 68,673 | -11 |

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

# SERVICES

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

## OVERVIEW

Table 13. Covered Services

| Service | Adults | Children (Under Age 21) |
|---|---|---|
| Acquired Brain Injury Waiver | Optional | Optional |
| Ambulance | Mandatory | Mandatory |
| Ambulatory Surgical Center | Optional | Optional |
| Behavioral Health[12] | Optional | Mandatory (EPSDT) |
| Care Management Entity / Children's Mental Health Waiver | N/A | Optional |
| Clinic Services | Optional | Mandatory (EPSDT) |
| Comprehensive and Supports Waivers for Persons with ID/DD/ABI | Optional | Optional [13] |
| Community Choices Waiver | Optional | N/A |
| Dental | Optional | Mandatory (EPSDT) |
| Durable Medical Equipment | Optional | Mandatory (EPSDT) |
| End Stage Renal Disease | Optional | Mandatory (EPSDT) |
| Federally Qualified Health Centers | Mandatory | Mandatory |
| Home Health | Mandatory | Mandatory |
| Hospice | Optional | Optional |
| Hospital | Mandatory | Mandatory |
| Intermediate Care Facility for Individuals with Intellectual Disabilities | Optional | Optional |
| Laboratory / X-Ray | Mandatory | Mandatory |
| Nursing Facility | Mandatory | Mandatory |
| Program for All-Inclusive Care of the Elderly (PACE) | Optional | N/A |
| Pharmacy | Optional | Mandatory (EPSDT) |
| Physician and Other Practitioner | Mandatory | Mandatory |
| Pregnant by Choice Waiver | Optional | N/A |
| Psychiatric Residential Treatment Facility (PRTF) | N/A | Mandatory (EPSDT) |
| Physical/Occupational/Speech Therapies[14] | Optional | Mandatory (EPSDT) |
| Public Health, Federal[15] | Mandatory | Mandatory |
| Public Health or Welfare | Optional | Mandatory (EPSDT) |
| Rural Health Clinic | Mandatory | Mandatory |
| Vision | Optional | Mandatory (EPSDT) |

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

Table 14. Service Utilization Summary

| Service | Expenditures | % Change from SFY 2019 | Recipients[15] | % Change from SFY 2019 | Expenditures per Recipient | % Change from SFY 2019 |
|---|---|---|---|---|---|---|
| Ambulance | $2,869,734 | -19 | 3,276 | -7 | $876 | -13 |
| Ambulatory Surgical Center | $3,170,249 | -11 | 2,216 | -18 | $1,431 | 9 |
| Behavioral Health | $21,705,529 | -8 | 11,395 | -8 | $1,905 | 0 |
| Care Management Entity (CME)[16] | $3,928,461 | 19 | 927 | 3 | $4,238 | 16 |
| Clinic/Center | $435,776 | -47 | 860 | -25 | $507 | -29 |
| Dental | $9,893,628 | -12 | 24,733 | -10 | $400 | -3 |
| DME, Prosthetics/Orthotics/ Supplies | $9,490,750 | 5 | 7,712 | 3 | $1,231 | 2 |
| End Stage Renal Disease | $1,595,216 | 50 | 171 | 14 | $9,329 | 32 |
| Federally Qualified Health Center | $6,554,011 | 13 | 7,422 | 17 | $883 | -3 |
| Home Health | $1,004,397 | 76 | 239 | 47 | $4,202 | 20 |
| Hospice | $1,251,068 | 5 | 196 | -20 | $6,383 | 31 |
| Hospital Total | $87,874,110 | -10 | 36,741 | -3 | $2,392 | -7 |
| Inpatient | $63,651,012 | -12 | 10,736 | 22 | $5,929 | -27 |
| Outpatient | $23,383,212 | -9 | 33,955 | -6 | $689 | -3 |
| Other Hospital | $839,885 | 447 | 420 | 0 | $2,000 | 446 |
| Intermediate Care Facility-IID | $16,058,915 | 24 | 58 | 7 | $276,878 | 16 |
| Laboratory | $585,977 | -19 | 5,967 | -12 | $98 | -7 |
| Nursing Facility | $89,426,962 | 6 | 2,826 | 12 | $31,644 | -6 |
| Other | $816,378 | -18 | 3,157 | -5 | $259 | -13 |
| PACE | $47,546,368 | -6 | 55,470 | -5 | $857 | -1 |
| Physician & Other Practitioner | $60,473,215 | -2 | 36,997 | -9 | $1,635 | 8 |
| Prescription Drug | $3,586,650 | -3 | 186 | 14 | $19,283 | -15 |
| PRTF | $7,334,441 | -29 | 221 | -28 | $33,188 | -1 |
| Public Health or Welfare | $894,081 | -3 | 7,465 | -2 | $120 | -1 |
| Public Health, Federal | $11,864,895 | -5 | 3,696 | -11 | $3,210 | 6 |
| Rural Health Clinic | $2,377,607 | 4 | 5,562 | -9 | $427 | 14 |
| Vision | $2,977,070 | -14 | 12,680 | -14 | $235 | 0 |
| Waiver Total | $150,076,885 | 1 | 5,425 | 2 | $27,664 | -1 |
| Community Choices | $29,661,574 | 2 | 2,875 | 2 | $10,317 | 1 |
| Comprehensive | $113,532,461 | 1 | 1,932 | -1 | $58,764 | 2 |
| Supports | $6,882,850 | 7 | 644 | 13 | $10,688 | -6 |
| Total | $543,792,374 | -2 | 68,673 | -4 | $7,919 | 2 |

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

16 The Care Management Entity service includes $36,766 in expenditures paid for 31 children while enrolled in non-Medicaid state-funded institutional foster care.

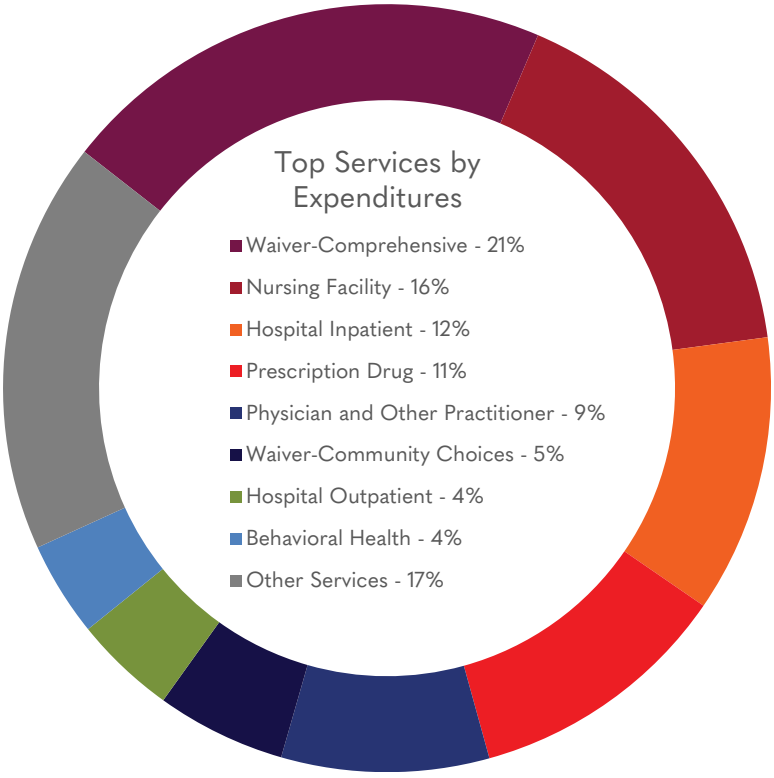



Figure 12. SFY 2020 Top Services by Expenditures

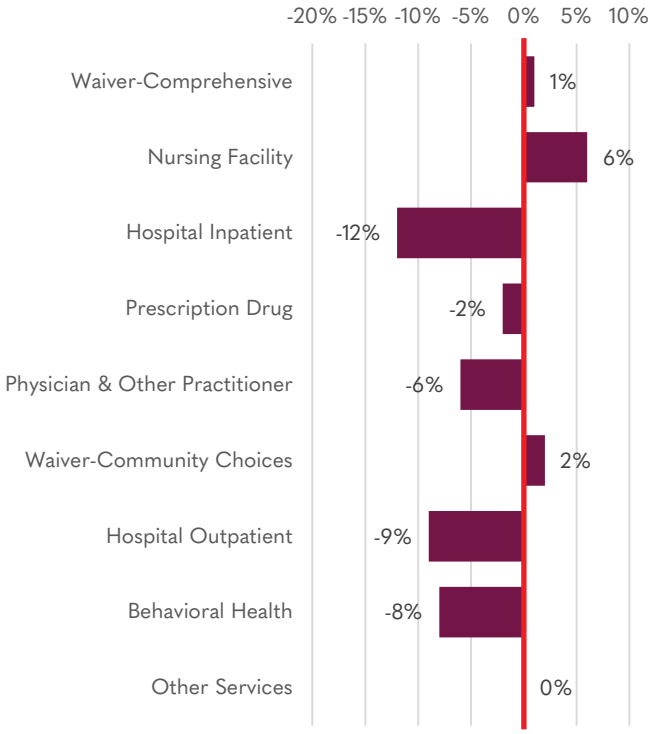



Figure 13. One-Year Change in Expenditures for Top Services

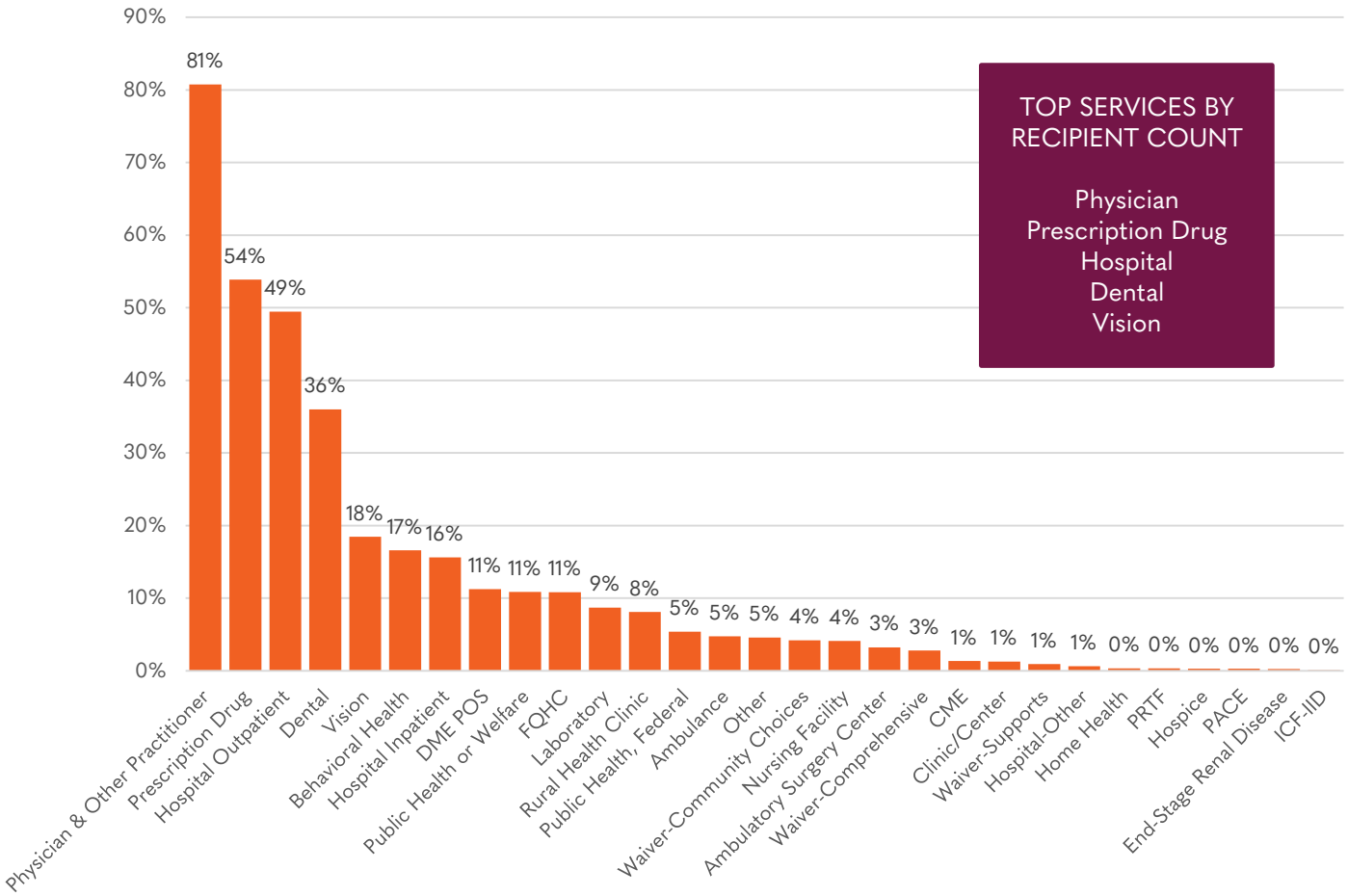



Figure 14. Percent of Unduplicated Recipients by Service

Table 15. Expenditure History by Service

| Service | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Ambulance | $4,352,067 | $3,571,623 | $3,847,375 | $2,381,969 | $3,543,958 | $2,869,734 | -34 |
| Ambulatory Surgical Center | $6,090,776 | $5,953,159 | $4,095,973 | $3,881,705 | $3,555,184 | $3,170,249 | -48 |
| Behavioral Health | $33,879,362 | $34,964,154 | $30,797,112 | $26,370,315 | $23,634,879 | $21,705,529 | -36 |
| Care Management Entity[17] | -- | $5,021,978 | $7,135,148 | $7,599,455 | $3,290,255 | $3,928,461 | n/a |
| Clinic/Center | $1,339,630 | $1,361,953 | $1,327,800 | $972,701 | $815,334 | $435,776 | -67 |
| Dental | $14,473,863 | $15,450,029 | $14,167,617 | $11,847,581 | $11,304,079 | $9,893,628 | -32 |
| DME, Prosthetics/ Orthotics/Supplies | $8,624,246 | $8,200,062 | $9,029,583 | $8,390,660 | $9,013,400 | $9,490,750 | 10 |
| End Stage Renal Disease | $1,099,569 | $948,612 | $1,267,034 | $1,012,427 | $1,063,315 | $1,595,216 | 45 |
| Federally Qualified Health Center | $3,259,793 | $3,689,548 | $5,725,094 | $11,418,874 | $5,776,571 | $6,554,011 | 101 |
| Home Health | $4,618,885 | $9,467,835 | $9,596,803 | $4,012,083 | $570,570 | $1,004,397 | -78 |
| Hospice | $1,157,101 | $1,014,959 | $1,316,838 | $1,394,149 | $1,190,302 | $1,251,068 | 8 |
| Hospital Total | $104,523,947 | $107,692,150 | $98,467,703 | $97,086,021 | $97,635,206 | $87,874,110 | -16 |
| Inpatient | $73,407,132 | $78,575,068 | $71,022,272 | $72,073,654 | $71,923,532 | $63,651,012 | -13 |
| Outpatient | $31,056,066 | $28,975,050 | $27,373,462 | $25,021,868 | $25,558,107 | $23,383,212 | -25 |
| Other Hospital | $60,748 | $142,031 | $71,969 | -$9,501 | $153,567 | $839,885 | 1,283 |
| Intermediate Care Facility-IID | $18,091,427 | $18,193,221 | $19,204,867 | $13,999,444 | $12,901,888 | $16,058,915 | -11 |
| Laboratory | $1,516,042 | $1,536,310 | $844,218 | $1,020,356 | $719,701 | $585,977 | -61 |
| Nursing Facility | $70,354,260 | $82,445,811 | $87,001,112 | $87,304,589 | $84,440,433 | $89,426,962 | 27 |
| Other | $649,268 | $894,389 | $1,006,132 | $989,147 | $995,134 | $816,378 | 26 |
| PACE | $2,242,570 | $2,934,877 | $3,520,283 | $3,471,255 | $3,693,978 | $3,586,650 | 60 |
| Physician & Other Practitioner | $61,249,367 | $58,278,406 | $60,013,763 | $55,788,175 | $50,649,977 | $47,546,368 | -22 |
| Prescription Drug | $47,946,923 | $48,597,364 | $50,300,175 | $57,642,641 | $61,612,808 | $60,473,215 | 26 |
| PRTF | $13,575,847 | $11,797,657 | $12,121,830 | $12,537,788 | $10,391,372 | $7,334,441 | -46 |
| Public Health or Welfare | $1,009,814 | $1,072,715 | $912,444 | $881,179 | $917,179 | $894,081 | -11 |
| Public Health, Federal | $8,761,358 | $8,479,944 | $8,718,888 | $19,625,445 | $12,488,676 | $11,864,895 | 35 |
| Rural Health Clinic | $1,668,167 | $1,413,842 | $1,540,607 | $1,894,505 | $2,283,377 | $2,377,607 | 43 |
| Vision | $3,595,216 | $3,652,188 | $3,850,574 | $3,712,855 | $3,466,069 | $2,977,070 | -17 |
| Waiver Total | $113,452,108 | $117,950,352 | $120,465,765 | $132,243,321 | $148,078,894 | $150,076,885 | 32 |
| Acquired Brain Injury | $6,636,440 | $6,748,171 | $6,960,893 | $4,948,202 | $15,008 | -- | -100 |
| Adult ID/DD | $16,541,190 | $1,674 | $1,565 | -- | -- | -- | -100 |
| Child ID/DD | $8,372,841 | $179,173 | -- | -- | -- | -- | -100 |
| Children's Mental Health | $732,257 | $61,981 | -- | -- | -- | -- | -100 |
| Community Choices | $16,630,675 | $19,801,298 | $20,597,605 | $26,930,997 | $28,957,689 | $29,661,574 | 78 |
| Comprehensive | $63,719,016 | $88,377,607 | $88,527,446 | $94,568,471 | $112,673,503 | $113,532,461 | 78 |
| Supports | $819,690 | $2,780,450 | $4,378,255 | $5,795,651 | $6,432,694 | $6,882,850 | 740 |
| Total | $527,531,608 | $554,583,138 | $556,274,739 | $567,478,640 | $554,032,539 | $543,792,374 | 3 |

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

Table 16. Expenditure History by Other[18] Service

| Service | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Case Management | $297,117 | $254,740 | $409,938 | $295,274 | $188,388 | $24,621 | -92 |
| Chiropractor | $6,347 | $99,664 | $280,207 | $347,441 | $406,862 | $368,608 | 5,707 |
| Clinic/Center, Ambulatory Family Planning Facility | $69,754 | $55,497 | $62,853 | $51,449 | $51,977 | $48,668 | -30 |
| Clinic/Center, Radiology, Mobile | $52 | $7 | -- | -- | -- | $0 | -100 |
| Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) | $154,682 | $146,226 | $84,406 | $29,156 | $26,024 | $22,394 | -86 |
| Day Training, Developmentally Disabled Services | $27,476 | $52,304 | $58,362 | $49,662 | $65,931 | $109,037 | 297 |
| Dietitian, Registered | -- | -- | $391 | $1,803 | $617 | $697 | n/a |
| Interpreter | $56,339 | $47,205 | $32,056 | $22,119 | $5,799 | $9,096 | -84 |
| Lodging | -- | -- | $53,950 | $85,915 | $127,715 | $108,735 | n/a |
| Midwife | -- | -- | -- | -- |  | $14,782 | n/a |
| Private Vehicle | -- | -- | $7,329 | $11,145 | $18,455 | $12,973 | n/a |
| Residential Treatment Facility, Emotionally Disturbed Children | $35,712 | $237,904 | -- | -- | -- | -- | -100 |
| Specialist | -- | -- | -- | $61,574 | $58,231 | $60,043 | n/a |
| Supports Brokerage | $0 | -$80 | $0 | $0 | -- | -- | n/a |
| Taxi | -- | -- | $16,674 | $33,435 | $45,135 | $36,725 | n/a |
| Technician, Pathology, Phlebotomy | $1,920 | $575 | -- | -- | -- | -- | -100 |
| Unclassified | -$131 | $346 | -$34 | $174 | -- | -- | -100 |
| Total | $649,268 | $894,389 | $1,006,132 | $989,147 | $995,134 | $816,378 | 26 |

18 This table shows services that fall outside the criteria ranges used to define other service areas for this report, as defined by pay to provider taxonomy.

Table 17. Recipient Count[19] History by Service

| Service | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Ambulance | 3,595 | 3,356 | 3,664 | 3,200 | 3,528 | 3,276 | -9 |
| Ambulatory Surgical Center | 3,565 | 3,431 | 3,343 | 3,202 | 2,710 | 2,216 | -38 |
| Behavioral Health | 12,365 | 12,813 | 13,317 | 12,949 | 12,448 | 11,395 | -8 |
| Care Management Entity[20] | 1,593 | 342 | 485 | 606 | 897 | 927 | -42 |
| Clinic/Center | 1,593 | 1,533 | 1,434 | 1,256 | 1,142 | 860 | -46 |
| Dental | 30,754 | 32,046 | 31,483 | 28,789 | 27,525 | 24,733 | -20 |
| DME, Prosthetics/Orthotics/ Supplies | 7,366 | 7,158 | 7,476 | 7,367 | 7,497 | 7,712 | 5 |
| End Stage Renal Disease | 107 | 131 | 149 | 158 | 150 | 171 | 60 |
| Federally Qualified Health Center | 6,014 | 6,450 | 7,052 | 8,927 | 6,340 | 7,422 | 23 |
| Home Health | 692 | 738 | 720 | 496 | 163 | 239 | -65 |
| Hospice | 185 | 202 | 228 | 232 | 245 | 196 | 6 |
| Hospital Total | 42,755 | 41,176 | 39,960 | 39,730 | 37,774 | 36,741 | -14 |
| Inpatient | 10,751 | 10,203 | 10,262 | 9,281 | 8,810 | 10,736 | 0 |
| Outpatient | 40,501 | 38,990 | 37,523 | 37,875 | 35,935 | 33,955 | -16 |
| Other Hospital | 152 | 178 | 256 | 544 | 419 | 420 | 176 |
| Intermediate Care Facility-IID | 75 | 71 | 67 | 61 | 54 | 58 | -23 |
| Laboratory | 8,899 | 9,601 | 8,045 | 8,334 | 6,790 | 5,967 | -33 |
| Nursing Facility | 2,388 | 2,432 | 2,578 | 2,569 | 2,516 | 2,826 | 18 |
| Other | 1,654 | 1,977 | 2,938 | 3,251 | 3,336 | 3,157 | 91 |
| PACE | 95 | 119 | 143 | 178 | 163 | 186 | 96 |
| Physician & Other Practitioner | 63,105 | 61,722 | 64,072 | 62,680 | 58,646 | 55,470 | -12 |
| Prescription Drug | 46,667 | 44,522 | 43,599 | 42,669 | 40,801 | 36,997 | -21 |
| PRTF | 336 | 301 | 299 | 298 | 309 | 221 | -34 |
| Public Health or Welfare | 8,166 | 8,222 | 7,928 | 8,072 | 7,590 | 7,465 | -9 |
| Public Health, Federal | 3,390 | 3,433 | 3,531 | 4,138 | 4,135 | 3,696 | 9 |
| Rural Health Clinic | 4,552 | 3,835 | 4,577 | 5,541 | 6,113 | 5,562 | 22 |
| Vision | 15,063 | 15,369 | 15,921 | 15,821 | 14,790 | 12,680 | -16 |
| Waiver Total | 4,670 | 5,070 | 5,286 | 5,479 | 5,630 | 5,891 | 26 |
| Acquired Brain Injury | 168 | 163 | 162 | 144 | 19 | -- | -100 |
| Adult ID/DD | 1,328 | 2 | 1 | -- | -- | -- | -100 |
| Child ID/DD | 659 | 148 | -- | -- | -- | -- | -100 |
| Children's Mental Health | 79 | 40 | -- | -- | -- | -- | -100 |
| Community Choices | 2,040 | 2,295 | 2,414 | 2,622 | 2,828 | 2,875 | 41 |
| Comprehensive | 1,756 | 1,927 | 1,863 | 1,962 | 1,959 | 1,932 | 10 |
| Supports | 191 | 424 | 540 | 565 | 568 | 644 | 237 |
| Total | 77,462 | 77,246 | 78,165 | 76,255 | 71,300 | 68,673 | -11 |

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

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

# DETAILS

This section provides a detailed view of the services presented in the overview. Services are defined by the taxonomy of the provider paid for the service.

## AMBULANCE

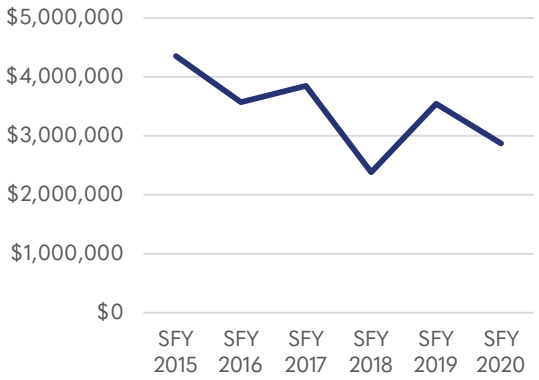
Emergency ground and air transportation and limited non-emergency ground transportation

### EXPENDITURES

19%

$2,869,734

0.5% of Medicaid Expenditures




### RECIPIENTS

7%

3,276

4.7% of Medicaid Recipients

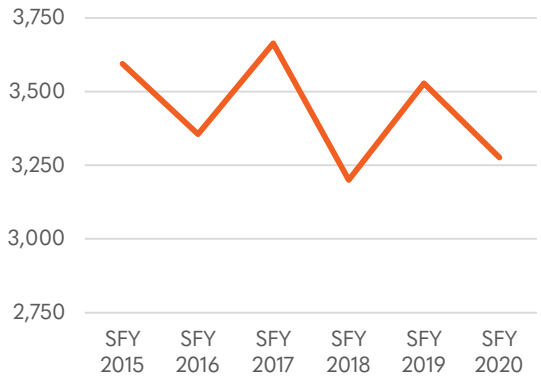



Table 18. Ambulance Services Summary[21]

| Total Ambulance Services | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $4,352,067 | $3,571,623 | $3,847,375 | $2,381,969 | $3,543,958 | $2,869,734 | -34 |
| Recipients | 3,595 | 3,356 | 3,664 | 3,200 | 3,528 | 3,276 | -9 |
| Expenditures per Recipient | $1,211 | $1,064 | $1,050 | $744 | $1,005 | $876 | -28 |
| **Air Ambulance Services** | | | | | | | |
| Expenditures | $2,931,554 | $2,310,149 | $2,444,615 | $1,342,922 | $2,406,019 | $1,823,177 | -38 |
| Recipients | 570 | 490 | 518 | 370 | 565 | 460 | -19 |
| Expenditures per Recipient | $5,143 | $4,715 | $4,719 | $3,630 | $4,258 | $3,963 | -23 |
| **Ground Ambulance Services** | | | | | | | |
| Expenditures | $1,414,413 | $1,250,134 | $1,402,066 | $1,033,707 | $1,095,716 | $1,079,870 | -24 |
| Recipients | 3407 | 3174 | 3483 | 3068 | 3300 | 3092 | -9 |
| Expenditures per Recipient | $415 | $394 | $403 | $337 | $332 | $349 | -16 |

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

# AMBULATORY SURGERY CENTER

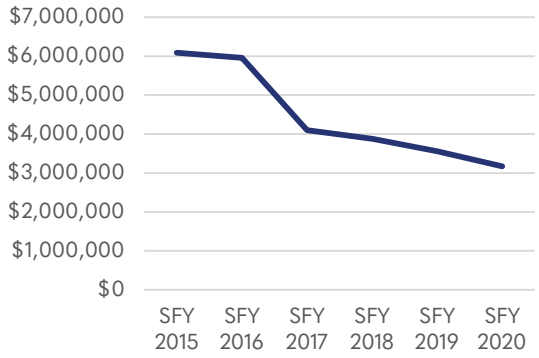
Surgical procedures that do not require overnight inpatient hospital care. Encompasses all surgical procedures covered by Medicare, as well as procedures Medicaid has approved for provision as outpatient services. ASC services may also be provided in an outpatient hospital setting.

## EXPENDITURES

11%

$3,170,249

0.6% of Medicaid Expenditures




## RECIPIENTS

18%

2,216

3.2% of Medicaid Recipients

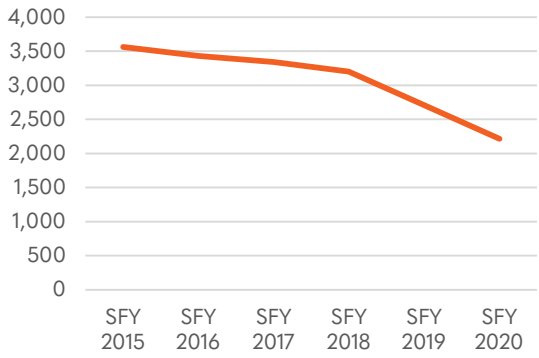



Table 19. Ambulatory Surgery Center Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $6,090,776 | $5,953,159 | $4,095,973 | $3,881,705 | $3,555,184 | $3,170,249 | -48 |
| Recipients | 3,565 | 3,431 | 3,343 | 3,202 | 2,710 | 2,216 | -38 |
| Expenditures per Recipient | $1,708 | $1,735 | $1,225 | $1,212 | $1,312 | $1,431 | -16 |

# BEHAVIORAL HEALTH

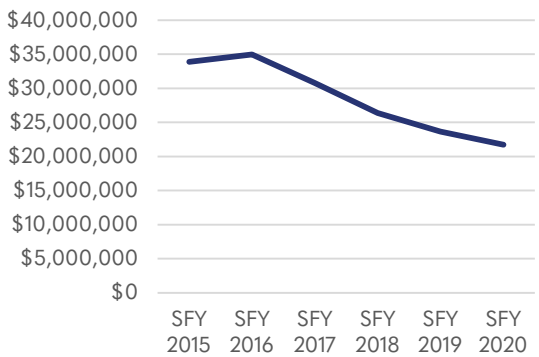
All services provided by Behavioral Health provider taxonomies

## EXPENDITURES

8%

$21,705,529

4% of Medicaid Expenditures

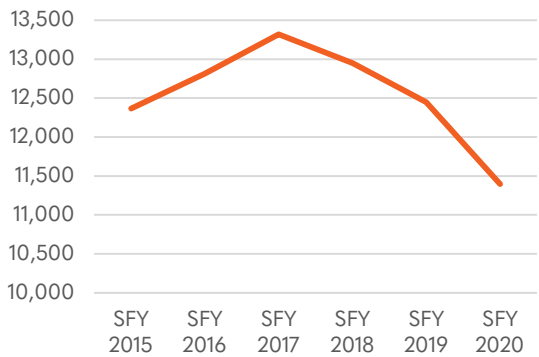



## RECIPIENTS

8%

11,395

17% of Medicaid Recipients



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

These expenditures paid to non-behavioral health taxonomies increased by 9% in SFY 2020 from the previous SFY, while the number of recipients receiving services from these providers increased by 3%.

More details are provided in Table 20.

Table 20. Behavioral Health Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| **Behavioral Health Services** | | | | | | | |
| Expenditures | $33,879,362 | $34,964,154 | $30,797,112 | $26,370,315 | $23,634,879 | $21,705,529 | -36 |
| Recipients | 12,365 | 12,813 | 13,317 | 12,949 | 12,448 | 11,395 | -8 |
| Expenditures per Recipient | $2,740 | $2,729 | $2,313 | $2,036 | $1,899 | $1,905 | -30 |
| **Non-Behavioral Health Provider Services**[22] | | | | | | | |
| Expenditures | $2,866,931 | $2,420,235 | $2,561,964 | $1,914,675 | $3,299,796 | $3,589,347 | 25 |
| Recipients | 3,638 | 4,120 | 4,452 | 4,841 | 5,347 | 5,487 | 51 |
| Expenditures per Recipient | $788 | $587 | $575 | $396 | $617 | $654 | -17 |

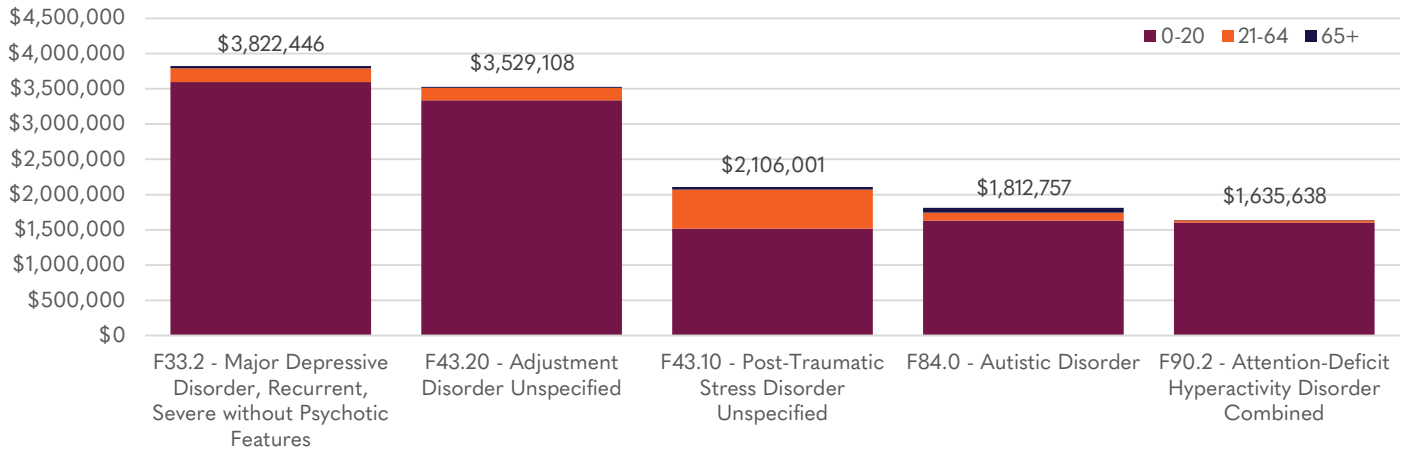



Figure 15. Top Five Behavioral Health Diagnosis Codes by Expenditures for all Provider Types (excluding Dementia and Alzheimers)

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

| Diagnosis Code and Description | Age 0-20 | Age 21-64 | Age 65+ | Total |
|---|---|---|---|---|
| F33.2 - Major Depressive Disorder, Recurrent, Severe w/o Psychotic Features | $3,594,166 | $194,330 | $33,950 | $3,822,446 |
| F43.20 - Adjustment Disorder Unspecified | $3,337,495 | $176,682 | $14,932 | $3,529,108 |
| F43.10 - Post-Traumatic Stress Disorder Unspecified | $1,516,467 | $554,666 | $34,868 | $2,106,001 |
| F84.0 - Autistic Disorder | $1,629,081 | $116,524 | $67,151 | $1,812,757 |
| F90.2 - Attention-Deficit Hyperactivity Disorder Combined | $1,604,337 | $31,270 | $30 | $1,635,638 |
| **Total** | **$11,681,546** | **$1,073,473** | **$150,931** | **$12,905,950** |

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

# CARE MANAGEMENT ENTITY

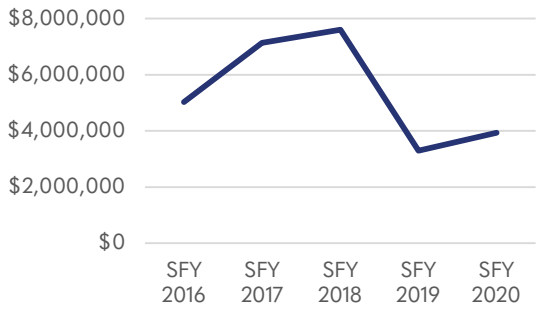
Provides intensive care coordination to children and youth with complex behavioral health conditions and their families, using a High Fidelity Wrap-around model to support their success in their homes, schools, and communities. Started in SFY 2016.

## EXPENDITURES

19%

$3,928,461

0.7% of Medicaid Expenditures




## RECIPIENTS

3%

11,395

1.3% of Medicaid Recipients

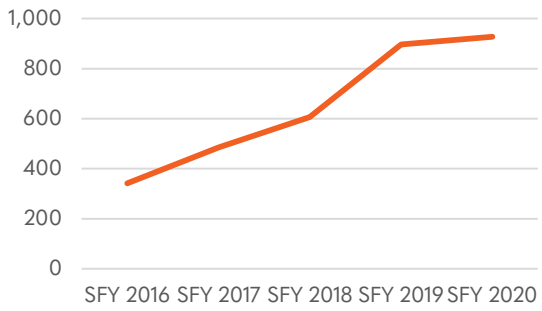



Table 22. Care Management Entity Services Summary

| | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| Expenditures | $5,021,978 | $7,135,148 | $7,599,455 | $3,290,255 | $3,928,461 |
| Recipients | 342 | 485 | 606 | 897 | 927 |
| Expenditures per Recipient | $14,684 | $14,712 | $12,540 | $3,668 | $4,238 |

The expenditures reported here are for amounts paid to the provider during the state fiscal years. These figures do not take into account the retroactive adjustments processed due to recent rate changes.

CME also provides services to children enrolled in non-Medicaid state-funded institutional foster care. The total SFY 2020 expenditures and recipient count shown in Table 22 includes $36,766 for those 31 children.

# CLINIC / CENTER

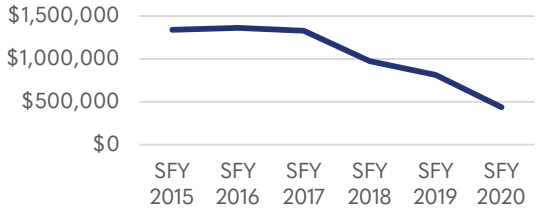
Services for clients with developmental disabilities who qualify for programs, training, care, treatment, and supervision in a structured setting, provided by state or privately funded facilities. Services include diagnostic evaluations and assessments, physical, occupational, and speech therapies, and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

## EXPENDITURES

47%

$435,776

0.1% of Medicaid Expenditures




## RECIPIENTS

25%

860

1.3% of Medicaid Recipients

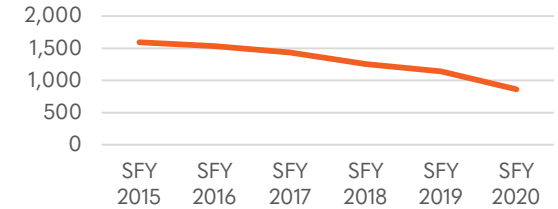


Table 23. Clinic/Center Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $1,339,630 | $1,361,953 | $1,327,800 | $972,701 | $815,334 | $435,776 | -67 |
| Recipients | 1,593 | 1,533 | 1,434 | 1,256 | 1,142 | 860 | -46 |
| Expenditures per Recipient | $841 | $888 | $926 | $774 | $714 | $507 | -40 |

# DENTAL

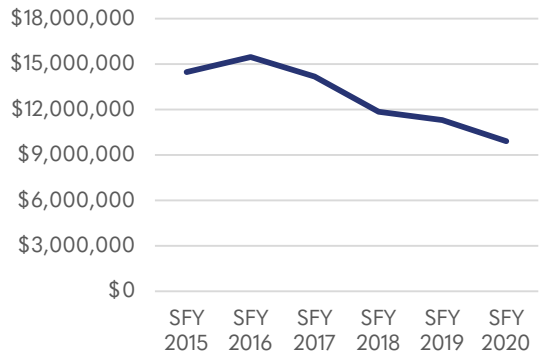
Dental services are covered based on enrolled member's age, with the goal of ensuring access to dental care so recipients may avoid emergency dental situations by receiving preventive and routine dental services for overall oral health.

## EXPENDITURES

12%

$9,893,628

1.8% of Medicaid Expenditures




## RECIPIENTS

10%

24,733

36% of Medicaid Recipients

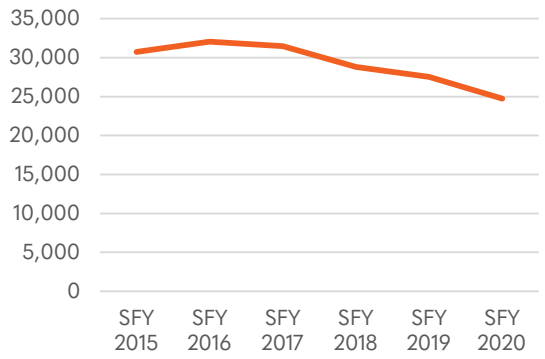



Table 24. Dental Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $14,473,863 | $15,450,029 | $14,167,617 | $11,847,581 | $11,304,079 | $9,893,628 | -32 |
| Recipients | 30,754 | 32,046 | 31,483 | 28,789 | 27,525 | 24,733 | -20 |
| Expenditures per Recipient | $471 | $482 | $450 | $412 | $411 | $400 | -15 |

# DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, & SUPPLIES

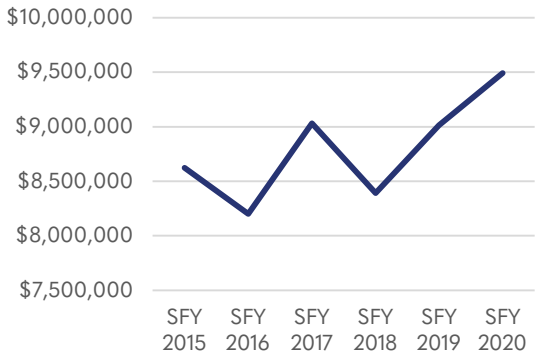
Services covered when ordered by a physician or other licensed practitioner for home use to reduce an individual's physical disability and restore the individual to a functional level.

## EXPENDITURES

5%

$9,490,750

1.7% of Medicaid Expenditures

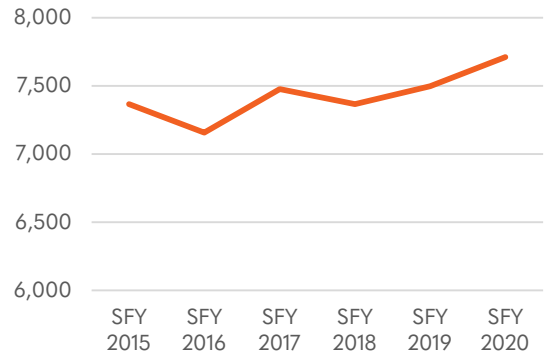



## RECIPIENTS

3%

7,712

11% of Medicaid Recipients




Medicaid covers rental of DME, and applies rental payments toward the purchase of the item when the cost of renting equals the cost of purchase, or at the end of 10 months of rental. Medicaid automatically purchases low cost items (i.e., less than $150) and caps all rental items, except oxygen concentrators and ventilators, at the purchase price. Medicaid also caps all per-day rentals at 100 days and monthly rentals at 10 months. Medicaid does not cover routine maintenance and repairs for rental equipment.

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

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

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| **Total Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Services** | | | | | | | |
| Expenditures | $8,624,246 | $8,200,062 | $9,029,583 | $8,390,660 | $9,013,400 | $9,490,750 | 10 |
| Recipients | 7,366 | 7,158 | 7,476 | 7,367 | 7,497 | 7,712 | 5 |
| Expenditures per Recipient | $1,171 | $1,146 | $1,208 | $1,139 | $1,202 | $1,231 | 5 |
| **Durable Medical Equipment Services Only** | | | | | | | |
| Expenditures | $7,907,539 | $7,391,087 | $8,285,291 | $7,746,167 | $8,437,833 | $8,934,056 | 13 |
| Recipients | 6,961 | 6,767 | 7,069 | 6,948 | 7,156 | 7,352 | 6 |
| Expenditures per Recipient | $1,136 | $1,092 | $1,172 | $1,115 | $1,179 | $1,215 | 7 |
| **Prosthetics, Orthotics, and Supplies Services Only** | | | | | | | |
| Expenditures | $719,348 | $797,996 | $757,241 | $615,641 | $590,930 | $541,981 | -25 |
| Recipients | 747 | 628 | 665 | 625 | 575 | 584 | -22 |
| Expenditures per Recipient | $963 | $1,271 | $1,139 | $985 | $1,028 | $928 | -4 |

# END STAGE RENAL DISEASE

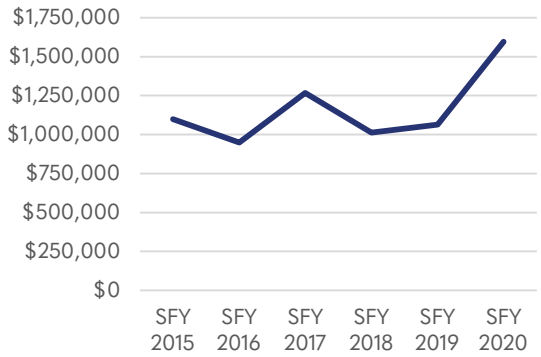
All medically necessary services related to renal disease care, including inpatient renal dialysis and outpatient services related to ESRD treatment, as well as treatment if Medicare denies coverage for an enrolled member on a home dialysis program. Hospital or free-standing facility must be a certified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

## EXPENDITURES

50%

$1,595,216

0.3% of Medicaid Expenditures

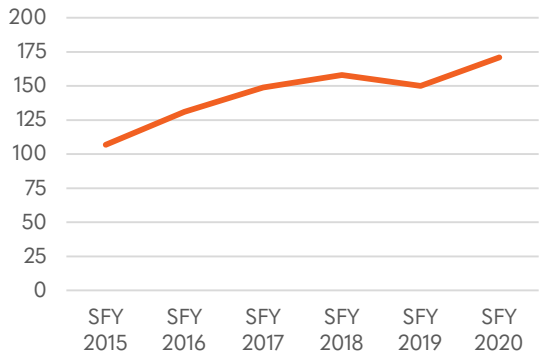



## RECIPIENTS

14%

171

0.2% of Medicaid Recipients




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

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

Table 26. End Stage Renal Disease Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $1,099,569 | $948,612 | $1,267,034 | $1,012,427 | $1,063,315 | $1,595,216 | 45 |
| Recipients | 107 | 131 | 149 | 158 | 150 | 171 | 60 |
| Expenditures per Recipient | $10,276 | $7,241 | $8,504 | $6,408 | $7,089 | $9,329 | -9 |

# FEDERALLY QUALIFIED HEALTH CENTER

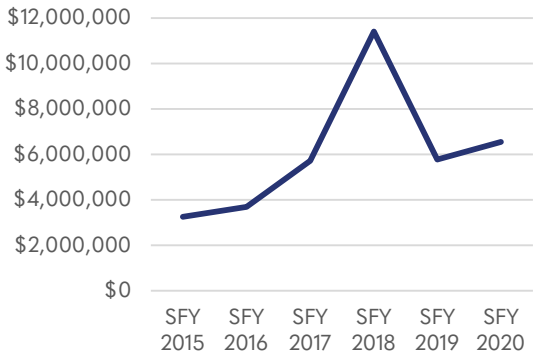
Provides preventive primary health services when medically necessary and provided by or under the direction of a physician, physician assistant, nurse practitioner, nurse midwife, dentist, orthodontist, licensed clinical psychologist, or licensed clinical social worker. Facility is designated as an FQHC by Medicare if it is located in an area designated as a "shortage area", a geographic area designated by HHS as having either a shortage of personal health services or of primary medical care professionals.

## EXPENDITURES

13%

$6,554,011

1.2% of Medicaid Expenditures

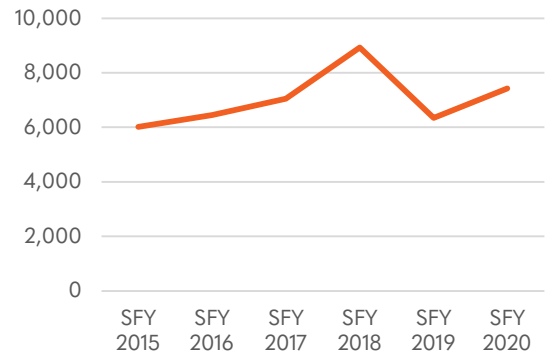



## RECIPIENTS

17%

7,422

11% of Medicaid Recipients




An FQHC differs from a Rural Health Clinic (RHC) based on several criteria related to location, shortage area, corporate structure, board of director requirements, and clinical staffing requirements.[23]

Table 27. Federally Qualified Health Center Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $3,259,793 | $3,689,548 | $5,725,094 | $11,418,874 | $5,776,571 | $6,554,011 | 101 |
| Recipients | 6,014 | 6,450 | 7,052 | 8,927 | 6,340 | 7,422 | 23 |
| Expenditures per Recipient | $542 | $572 | $812 | $1,279 | $911 | $883 | 63 |

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

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

# HOME HEALTH

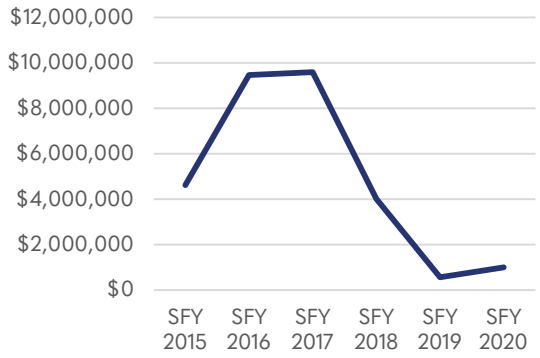
Services for individuals not admitted to the hospital or a nursing care facility. Must be intermittent, three or visits per day for home health aide and/or skilled nursing, with each visit lasting no more than four hours. S must be medically necessary, ordered by a physician, and documented in a signed/dated treatment plan to reviewed and revised as medically necessary by the attending physician at least every 60 days.

## EXPENDITURES

76%

$1,004,397

0.2% of Medicaid Expenditures

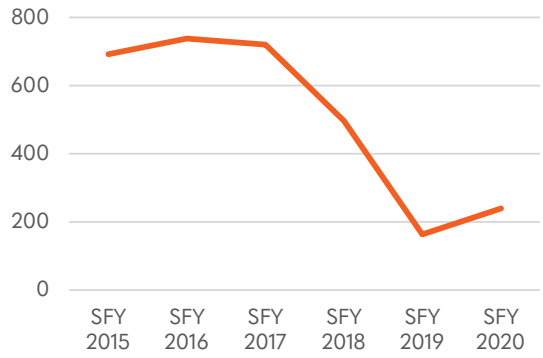



## RECIPIENTS

47%

239

0.3% of Medicaid Recipients




Home Health agencies must provide at least two of the following services to be a licensed provider in the state of Wyoming:

- skilled nursing
- home health aide supervised by a qualified professional
- physical therapy provided by a qualified and licensed physical therapist
- speech therapy provided by a qualified therapist
- occupational therapy provided by a qualified, registered, or certified therapist
- medical social services provided by a qualified and licensed Master of Social Work (MSW) or a Bachelor of Social Work (BSW)-prepared person supervised by an MSW

The following are NOT covered Home Health services:

- homemaking
- respite care
- Meals on Wheels or home-delivered meals
- services deemed inappropriate or not cost-effective in home setting

Table 28. Home Health Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $4,618,885 | $9,467,835 | $9,596,803 | $4,012,083 | $570,570 | $1,004,397 | -78 |
| Recipients | 692 | 738 | 720 | 496 | 163 | 239 | -65 |
| Expenditures per Recipient | $6,675 | $12,829 | $13,329 | $8,089 | $3,500 | $4,202 | -37 |

# HOSPICE

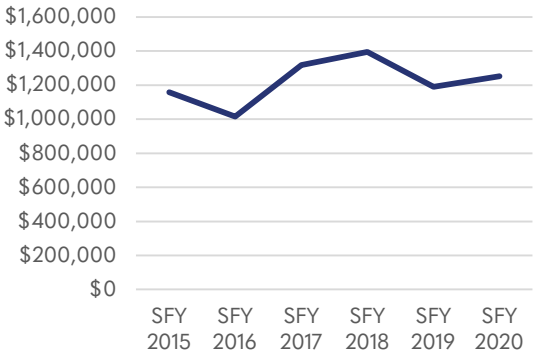
An interdisciplinary approach to caring for the psychological, social, spiritual, and physical needs of dying individuals. Hospice care is covered if the individual elects it and a physician certifies that the individual is terminally ill. Covered services include routine and continuous home care, inpatient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

## EXPENDITURES

5%

$1,251,068

0.2% of Medicaid Expenditures




## RECIPIENTS

20%

196

0.3% of Medicaid Recipients

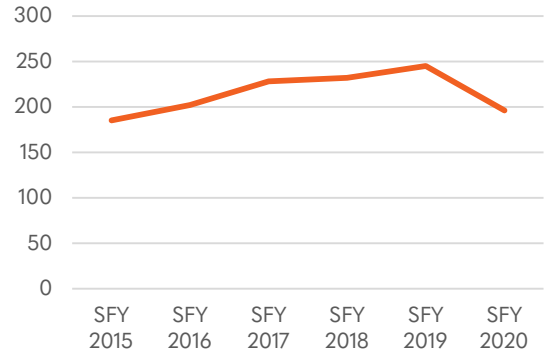



Table 29. Hospice Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $1,157,101 | $1,014,959 | $1,316,838 | $1,394,149 | $1,190,302 | $1,251,068 | 8 |
| Recipients | 185 | 202 | 228 | 232 | 245 | 196 | 6 |
| Expenditures per Recipient | $6,255 | $5,025 | $5,776 | $6,009 | $4,858 | $6,383 | 2 |

# HOSPITAL

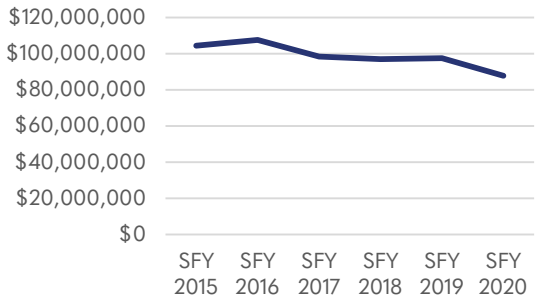
Inpatient and Outpatient hospital services

## EXPENDITURES

10%

$65,796,915

12% of Medicaid Expenditures

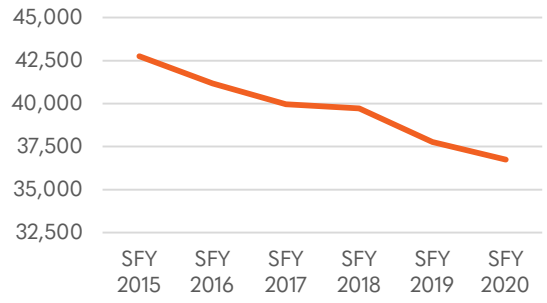



## RECIPIENTS

3%

36,754

54% of Medicaid Recipients




## QUALIFIED RATE ADJUSTMENT

The Qualified Rate Adjustment (QRA) is a supplement for qualified hospital providers. Qualifying hospitals provided state share of the payment, and Medicaid distributes corresponding Federal matching funds, along with the state share, to the participating hospitals. QRA payments are calculated using the previous SFY paid claims data.

Table 30. Total Hospital Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $104,523,947 | $107,692,150 | $98,467,703 | $97,086,021 | $97,635,206 | $87,874,110 | -16 |
| Recipients | 42,785 | 41,190 | 39,986 | 39,762 | 37,806 | 36,754 | -14 |
| Expenditures per Recipient | $2,443 | $2,615 | $2,463 | $2,442 | $2,583 | $2,391 | -2 |
| QRA (Federal Share) | $9,441,087 | $12,607,069 | $11,202,759 | $12,472,416 | $13,065,161 | $12,073,261 | 28 |
| Total Expenditures w/ QRA | $113,965,034 | $120,299,219 | $109,670,462 | $109,558,437 | $110,700,367 | $99,947,371 | -12 |

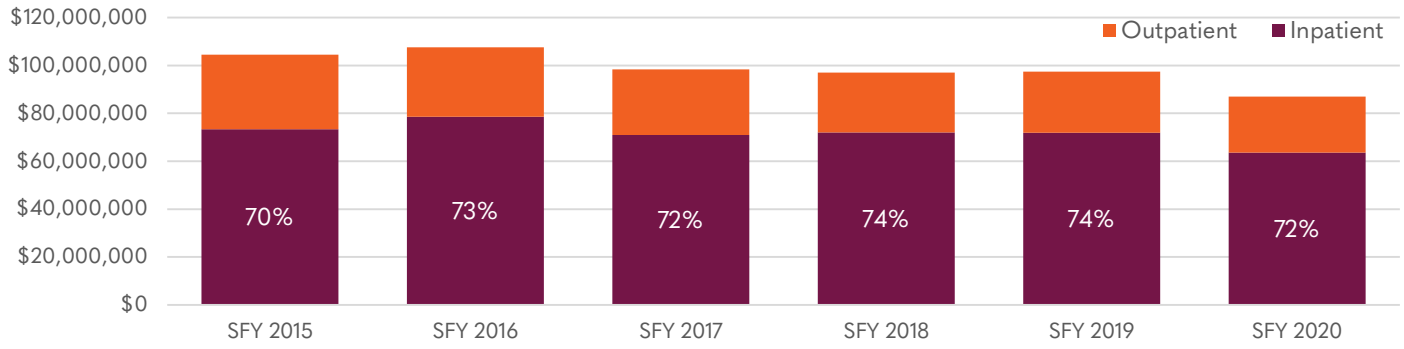



Figure 16. Hospital Inpatient-Outpatient Breakdown History by Expenditures

Eligible hospitals who serve a disproportionate number of low-income individuals also receive **Disproportionate Share Hospital (DSH)** payments as required by Federal law. These payments are capped according to state-specific allotments. DSH payments are approximately $240K per year for all Wyoming hospitals due to Wyoming's low historical allottment from this Federal program.

# INPATIENT SERVICES

Medicaid covers inpatient hospital services with the exception of alcohol and chemical rehabilitation services, cosmetic surgery, and experimental services. Surgical procedures must be medically necessary, and may not be covered if there is a non-surgical alternative or if a provider performs the surgery only for the convenience of the individual.

Table 31. Inpatient Hospital Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $73,407,132 | $78,575,068 | $71,022,272 | $72,073,654 | $71,923,532 | $63,651,012 | -13 |
| Recipients | 10,751 | 10,203 | 10,262 | 9,281 | 8,810 | 10,736 | 0 |
| Expenditures per Recipient | $6,828 | $7,701 | $6,921 | $7,766 | $8,164 | $5,929 | -13 |
| QRA (Federal Share) | $2,667,482 | $3,143,380 | $2,200,706 | $3,010,897 | $3,942,199 | $4,038,698 | 51 |
| Total Expenditures w/ QRA | $76,074,614 | $81,718,448 | $73,222,978 | $75,084,551 | $75,865,731 | $67,689,710 | -11 |

# OUTPATIENT SERVICES

Medicaid covers outpatient hospital services, including emergency room, surgery, laboratory, radiology, and other testing services. For individuals over age 21, visits to hospital outpatient departments are limited to a maximum of 12 per calendar year. There are no limits for Medicare crossovers, children under age 21, or for visits for family planning, Health Check services, and emergency room.

Table 32. Outpatient Hospital Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $31,056,066 | $28,975,050 | $27,373,462 | $25,021,868 | $25,558,107 | $23,383,212 | -25 |
| Recipients | 40,501 | 38,990 | 37,523 | 37,875 | 35,935 | 33,955 | -16 |
| Expenditures per Recipient | $767 | $743 | $730 | $661 | $711 | $689 | -10 |
| QRA (Federal Share) | $6,773,605 | $9,463,689 | $9,002,053 | $9,461,519 | $9,122,962 | $8,034,563 | 19 |
| Total Expenditures w/ QRA | $37,829,671 | $38,438,739 | $36,375,515 | $34,483,387 | $34,681,069 | $31,417,775 | -17 |

For each unit of service, reimbursement equals the scaled relative weight for the **Ambulatory Payment Classification (APC)**, multiplied by a conversion factor.[24] When multiple units of service and different services are provided, reimbursements are subject to discounting and unit limitations. This is designed to reimburse hospitals based on the resources used to provide services. Medicaid uses 3 conversion factors by hospital type: General Acute, Critical Access, and Children's Hospitals.

APC APPLIES TO[25]:

- Significant outpatient procedures
- Ancillary services
- Drugs
- Select laboratory services
- Radiology
- Select DME, Prosthetics/Orthotics
- Select Vaccines/Immunization not reimbursed under Medicaid's physician fee schedule

24 The scaled relative weight for an APC measures the resource requirements of the service and is based on the median cost (Medicare) of services in that APC. The conversion factor translates the scaled relative weights into dollar payment rates.

25 Some services from the APC methodology are reimbursed on separate fee schedules, as follows: select DME are covered under DME fee schedule; select vaccines/immunizations, select radiology and mammography screening, diagnostic mammographies and therapies are covered under the Physician fee schedule; laboratory services are reimbursed on the laboratory fee schedule; and corneal tissue, dental, and bone marrow transplants, and new medical devices covered under Medicare's transitional pass-through payments are reimbursed a percent of charges

# EMERGENCY ROOM SERVICES

The methodology used to identify emergency room utilization has been updated in SFY 2017. This data excludes those visits that result in an inpatient admission for both visit count and expenditures. Total ER expenditures include the total amount paid on claims with a line indicating treatment in the ER. This change was made to include the cost of laboratory, radiology, and other tests that may not be performed in the ER setting, but are still associated with the ER visit.

Table 33. Emergency Room Utilization Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $16,122,304 | $14,897,552 | $14,423,134 | $13,198,247 | $12,832,844 | $11,893,916 | -26 |
| Recipients | 26,773 | 24,948 | 24,651 | 23,631 | 22,372 | 20,423 | -24 |
| Expenditures per Recipient | $602 | $597 | $585 | $559 | $574 | $582 | -3 |
| Emergency Room Visits | 57,539 | 51,525 | 51,660 | 48,581 | 45,828 | 41,574 | -28 |
| % of Total Medicaid Expenditures | 3.1% | 2.7% | 2.6% | 2.3% | 2.3% | 2.2% | |

Table 34. Emergency Room Utilization by Eligibility Category

| Eligibility Category | Expenditures | % Change from SFY 2019 | Recipients | % Change from SFY 2019 | ER Visits | % Change from SFY 2019 |
|---|---|---|---|---|---|---|
| ABD EID | $70,533 | 12 | 145 | 8 | 359 | 38 |
| ABD ID/DD/ABI | $299,602 | -4 | 780 | 4 | 1,853 | -3 |
| ABD Institution | $9,512 | 70 | 19 | 19 | 21 | 24 |
| ABD LTC | $660,879 | 10 | 1,945 | 12 | 4,981 | 18 |
| ABD SSI | $2,274,622 | -2 | 2,686 | -1 | 7,609 | -4 |
| Adults | $2,855,519 | -12 | 3,060 | -13 | 6,724 | -17 |
| Children | $4,798,625 | -10 | 9,963 | -14 | 15,637 | -17 |
| Medicare Savings Program | $158,012 | 26 | 1,050 | 6 | 2,403 | 6 |
| Non-Citizens with Medical Emergencies | $13,755 | -24 | 23 | -12 | 31 | -11 |
| Pregnant Women | $718,485 | -10 | 1,100 | -8 | 1,916 | -14 |
| Screenings & Gross Adjustments | $354 | -88 | 2 | -60 | 2 | -82 |
| Special Groups | $34,017 | 52 | 27 | 29 | 51 | 19 |
| Total | $11,893,916 | -7 | 20,423 | -9 | 41,574 | -9 |

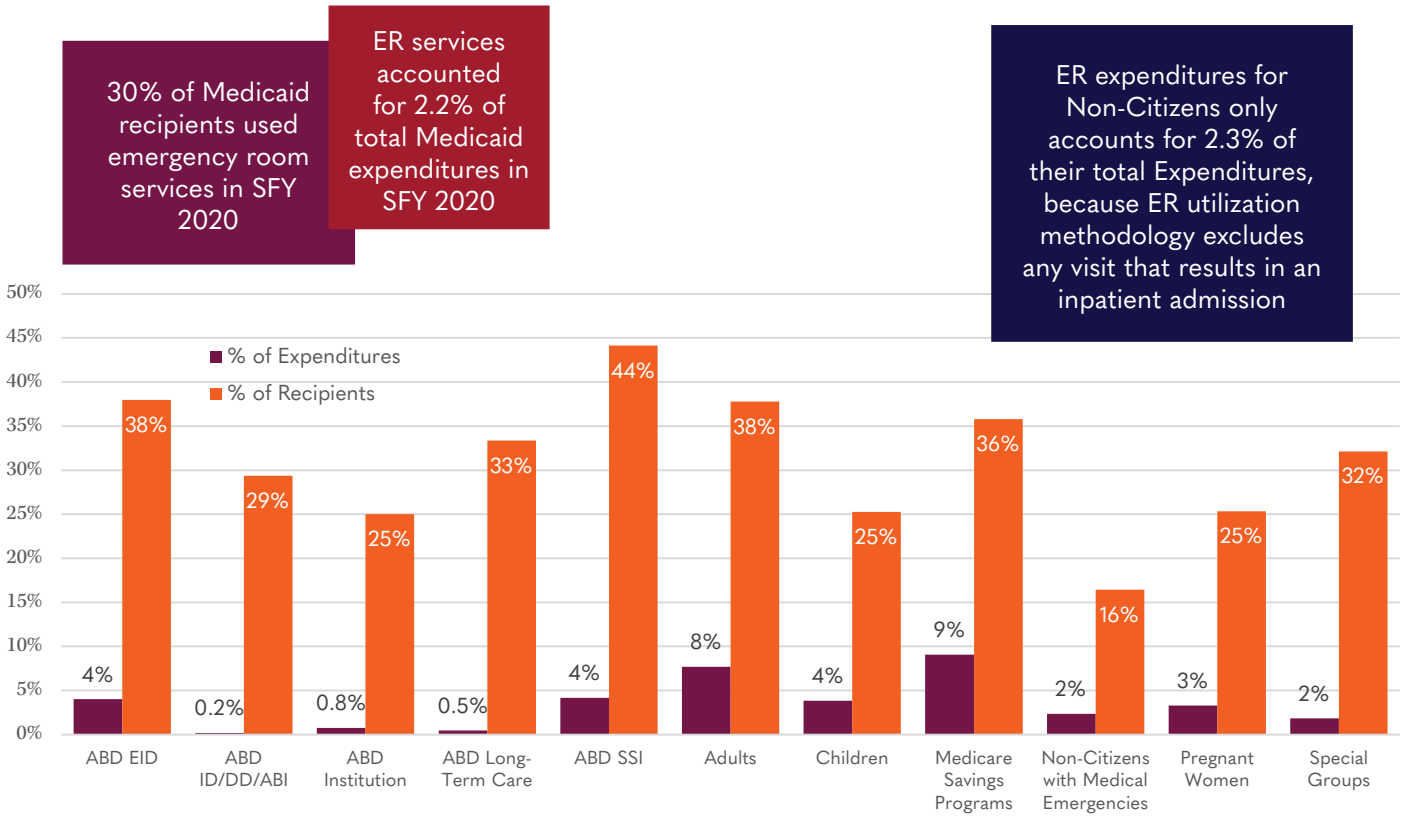



Figure 17. Emergency Room Utilization vs Total Medicaid by Eligibility Category

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

| Eligibility Category | ER Recipients | Total Medicaid Recipients | % Using ER Services | ER Expenditures | Total Medicaid Expenditures | % Paid for ER Services |
|---|---|---|---|---|---|---|
| ABD EID | 145 | 382 | 38% | $70,533 | $1,756,635 | 4% |
| ABD ID/DD/ABI | 780 | 2,655 | 29% | $299,602 | $152,541,587 | 0.2% |
| ABD Institution | 19 | 76 | 25% | $9,512 | $1,239,234 | 0.8% |
| ABD LTC | 1,945 | 5,830 | 33% | $660,879 | $144,976,414 | 0.5% |
| ABD SSI | 2,686 | 6,087 | 44% | $2,274,622 | $54,412,195 | 4% |
| Adults | 3,060 | 8,098 | 38% | $2,855,519 | $37,137,296 | 8% |
| Children | 9,963 | 39,428 | 25% | $4,798,625 | $124,888,851 | 4% |
| Medicare Savings Program | 1,050 | 2,934 | 36% | $158,012 | $1,743,350 | 9% |
| Non-Citizens with Medical Emergencies | 23 | 140 | 16% | $13,755 | $586,871 | 2% |
| Pregnant Women | 1,100 | 4,342 | 25% | $718,485 | $21,725,470 | 3% |
| Screenings & Gross Adjustments | 2 | 2,307 | 0% | $354 | $5,293,268 | 0.01% |
| Special Groups | 27 | 84 | 32% | $34,017 | $1,826,629 | 2% |
| Total | 20,423 | 68,673 | 30% | $11,893,916 | $543,792,374 | 2% |

# INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

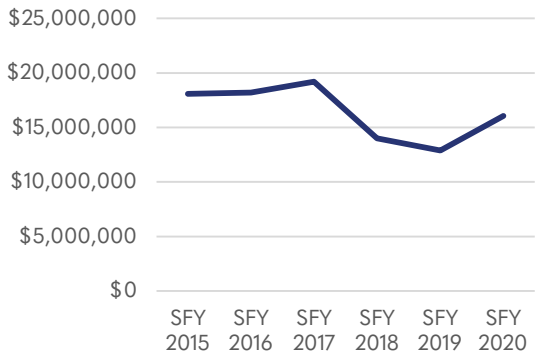
Services covered only in a residential facility licensed and certified by the state survey agency as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). The Wyoming Life Resource Center is the sole facility in the state. This service is unique to Medicaid and is not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

## EXPENDITURES

24%

$16,058,915

3% of Medicaid Expenditures




## RECIPIENTS

7%

58

0.1% of Medicaid Recipients

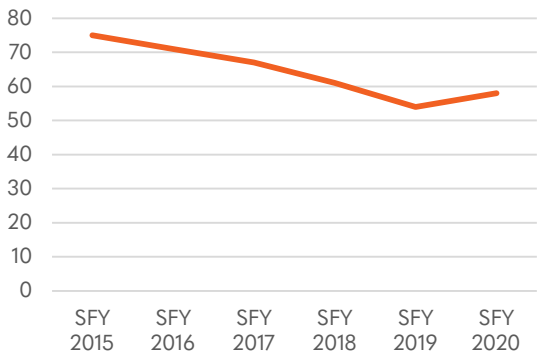



Table 36. Intermediate Care Facility for Individuals with Intellectual Disabilities Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $18,091,427 | $18,193,221 | $19,204,867 | $13,999,444 | $12,901,888 | $16,058,915 | -11 |
| Recipients | 75 | 71 | 67 | 61 | 54 | 58 | -23 |
| Expenditures per Recipient | $241,219 | $256,243 | $286,640 | $229,499 | $238,924 | $276,878 | 15 |

# LABORATORY

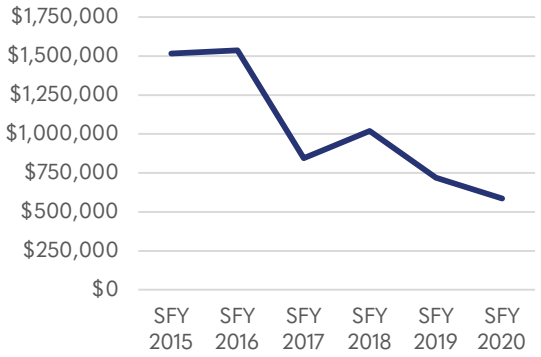
Medicaid covers professional and technical laboratory services ordered by a practitioner that are directly related to the diagnosis and treatment of the individual as specified in the treatment plan developed by the ordering practitioner.

## EXPENDITURES

19%

$585,977

0.1% of Medicaid Expenditures




## RECIPIENTS

12%

5,967

9% of Medicaid Recipients

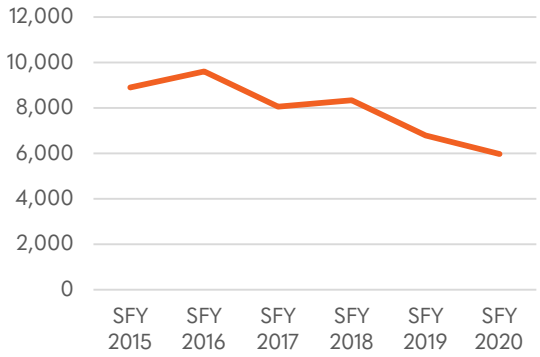



Table 37. Laboratory Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $1,516,042 | $1,536,310 | $844,218 | $1,020,356 | $719,701 | $585,977 | -61 |
| Recipients | 8,899 | 9,601 | 8,045 | 8,334 | 6,790 | 5,967 | -33 |
| Expenditures per Recipient | $170 | $160 | $105 | $122 | $106 | $98 | -42 |

# NURSING FACILITY

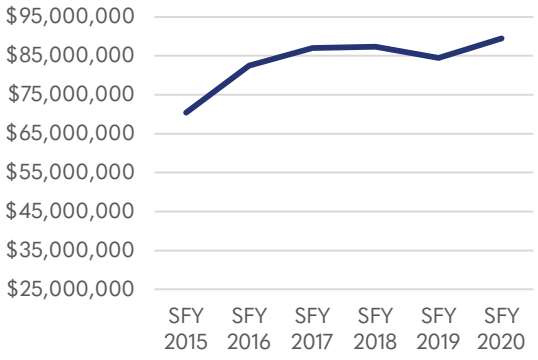
Medicaid covers nursing facility services for individuals who are no longer able to live in the community. The nursing facility is an institution, or a distinct part of an institution, which is not primarily for the care and treatment of mental diseases, and provides skilled nursing care and related services to residents who require medical or nursing care, rehabilitation services for injured, disabled or sick individuals, and health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which is available to them only through institutional facilities.

## EXPENDITURES

6%

$89,426,962

16% of Medicaid Expenditures




## RECIPIENTS

12%

2,826

4% of Medicaid Recipients

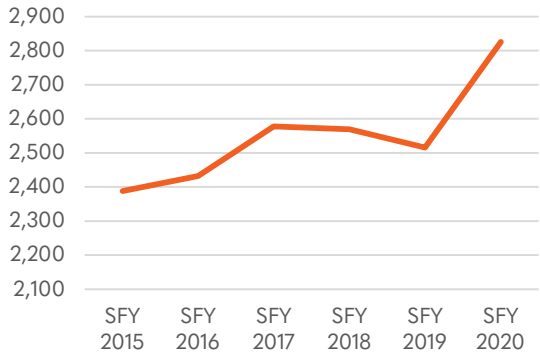



Table 38. Nursing Facility Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $70,354,260 | $82,445,811 | $87,001,112 | $87,304,589 | $84,440,433 | $89,426,962 | 27 |
| Recipients | 2,388 | 2,432 | 2,578 | 2,569 | 2,516 | 2,826 | 18 |
| Expenditures per Recipient | $29,462 | $33,900 | $33,748 | $33,984 | $33,561 | $31,644 | 7 |
| Provider Assessment (Federal Share) | $15,219,087 | $14,689,893 | $15,275,937 | $16,385,303 | $16,949,947 | $16,936,907 | 11 |
| Total Expenditures with Provider Assessment | $85,573,347 | $97,135,704 | $102,277,049 | $103,689,892 | $101,390,380 | $106,363,869 | 24 |

**Per Diem Rate**

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

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

Excludes:
physician visits, hospitalizations, laboratory, x-rays, and prescription drugs which are reimbursed separately.

**Provider Assessment and Upper Payment Limit (UPL)**

Supplemental payment for qualified nursing facilities

Based on calculations from most recent cost reports & comparisons to what would have been paid for Medicaid services under Medicare's payment principles

Assessment collected on all non-Medicare days & UPL payment paid on Medicaid days once corresponding federal matching dollars are obtained.

**Extraordinary Care Per Diem Rates**

Paid for services provided to a resident with extraordinary needs

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

**Enhanced Adult Psychiatric Reimbursement**

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

# PROGRAM FOR ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

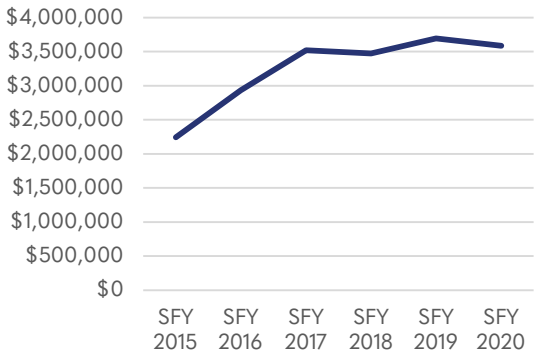
Available in Laramie County to qualified individuals ages 55 and older as an alternative to nursing home care. Each participant has a plan of care developed by a team of healthcare professionals to improve and maintain the participant's overall health. The participant works with the team to develop and update their plan of care.

## EXPENDITURES

3%

$3,586,650

0.7% of Medicaid Expenditures

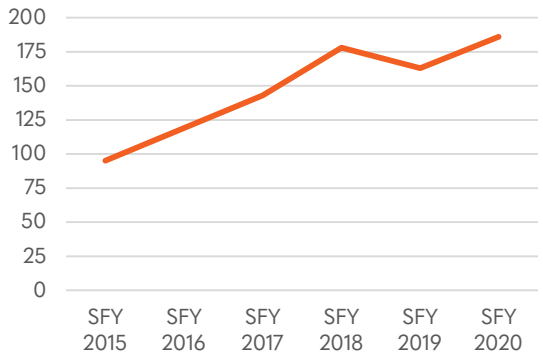



## RECIPIENTS

14%

186

0.3% of Medicaid Recipients




Services provided include: primary care, specialty medical care, dental, social work counseling, meals, nutritional counseling, laboratory, radiology, prescription drug, hospital, emergency, nursing home, home care, adult day care, personal care, physical therapy, occupational therapy, recreational therapy, and transportation.

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

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $2,242,570 | $2,934,877 | $3,520,283 | $3,471,255 | $3,693,978 | $3,586,650 | 60 |
| Recipients | 95 | 119 | 143 | 178 | 163 | 186 | 96 |
| Expenditures per Recipient | $23,606 | $24,663 | $24,617 | $19,501 | $22,662 | $19,283 | -18 |

# PHYSICIAN & OTHER PRACTITIONER

Services provided by physicians and other practitioners, with the following limits:

- Hospital outpatient departments, physician offices, and optometrist offices - maximum of 12 visits per calendar year for individuals over age 21
- Physical, occupational, and speech therapy - maximum of 20 visits each per calendar year for individual over age 21, with additional visits approved after review for medical necessity

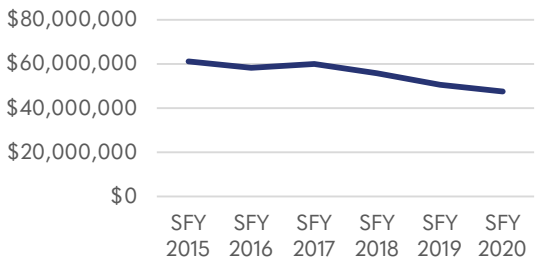
There is no limit for Medicare crossovers or children under age 21; also no limit for family planning visits, Health Check services, or emergency services.

## EXPENDITURES

6%

$47,546,368

9% of Medicaid Expenditures




## RECIPIENTS

5%

55,470

81% of Medicaid Recipients

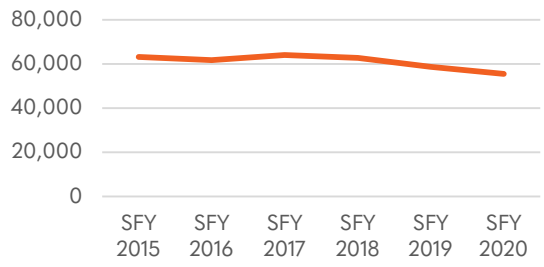



Table 40. Physician and Other Practitioner Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| **Total Physician and Other Practitioner Services** | | | | | | | |
| Expenditures | $61,249,367 | $58,278,406 | $60,013,763 | $55,788,175 | $50,649,977 | $47,546,368 | -22 |
| Recipients | 63,105 | 61,722 | 64,072 | 62,680 | 58,646 | 55,470 | -12 |
| Expenditures per Recipient | $971 | $944 | $937 | $890 | $864 | $857 | -12 |
| **Physician Only Services** | | | | | | | |
| Expenditures | $54,072,664 | $49,990,999 | $51,841,176 | $48,980,679 | $45,240,345 | $42,042,704 | -22 |
| Recipients | 62,359 | 60,905 | 63,302 | 62,068 | 58,004 | 54,634 | -12 |
| Expenditures per Recipient | $867 | $821 | $819 | $789 | $780 | $770 | -11 |
| **Other Practitioner Services** | | | | | | | |
| Expenditures | $7,103,044 | $8,252,454 | $8,155,221 | $6,797,644 | $5,392,166 | $5,494,535 | -23 |
| Recipients | 9,250 | 9,128 | 8,732 | 7,144 | 7,235 | 7,792 | -16 |
| Expenditures per Recipient | $768 | $904 | $934 | $952 | $745 | $705 | -8 |

OTHER PRACTITIONERS INCLUDE:

Physical Therapists
Occupational Therapists
Speech-Language Pathologists
Podiatrists
Nurse Practitioners
Nurse Midwives
Nurse Anesthetists
Audiologists

## RESOURCE-BASED RELATIVE VALUE SCALE

Used to reimburse medical services provided by physicians, physician assistants, physical and occupational therapists, ophthalmologists, and nurse practitioners. Based on estimates of the costs of resources required to provide physician services using a relative value unit (RVU) and conversion factor.

RVU x Conversion Factor = fee schedule rate

RVU reflects the resources used by a physician to deliver a service, compared to resources used for other physicians' services, taking into consideration the time and intensity of the physician's effort, and the physician's practice and malpractice expenses. Services provided by anesthesiologists are reimbursed using RVUs developed and published by the American Society of Anesthesiologists.

# PRESCRIPTION DRUGS

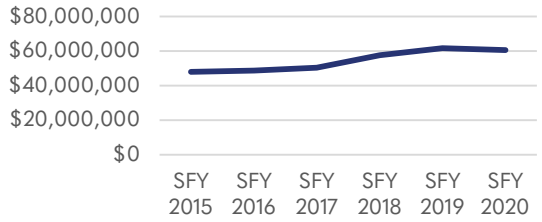
Medicaid covers most prescription drugs and specific over-the-counter drugs. A prescription and co-payment are required for all drugs for most individuals. Exceptions may apply for specific products or conditions.

## EXPENDITURES

2%

$60,473,215

11% of Medicaid Expenditures




## RECIPIENTS

9%

36,997

54% of Medicaid Recipients

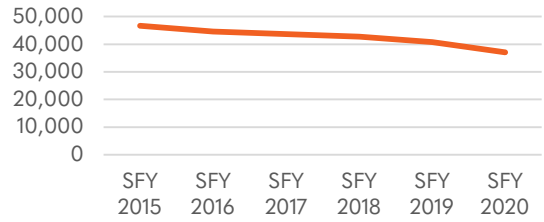



Table 41. Prescription Drug Services Summary [26]

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $47,946,923 | $48,597,364 | $50,300,175 | $57,642,641 | $61,612,808 | $60,473,215 | 26 |
| Recipients | 46,667 | 44,522 | 43,599 | 42,669 | 40,801 | 36,997 | -21 |
| Expenditures per Recipient | $1,027 | $1,092 | $1,154 | $1,351 | $1,510 | $1,635 | 59 |

**128**

specific drug classes designated as preferred drugs in SFY 2020

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

## DRUG REBATE PROGRAM

Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). Requires drug manufacturers have national rebate agreement with HHS Secretary. For a prescription drug to be covered, Medicaid must receive an OBRA rebate for it. This federal mandate provides Medicaid the opportunity to receive greatly discounted products, similar to those offered to large purchases in the marketplace.

Medicaid is a member of the Sovereign States Drug Consortium (SSDC), a collaborative of state Medicaid programs that negotiate and acquire rebates from drug manufacturers, supplemental to the Medicaid Drug Rebate Program. Supplemental rebates augment the Medicaid Drug Rebate Program savings that the SSDC states realize because of OBRA.

**$5.36 million**

collected in J-Code rebates[27] from drug manufacturers for physician-administered or injectable drugs

Table 42. Pharmacy Cost Avoidance - SFY 2020

| Program Area | Cost Avoidance |
|---|---|
| Prior Authorization (PA) Preferred Drug List (PDL) | $10,444,793 |
| State Maximum Allowable Cost (SMAC) | $1,137,119 |
| Program Integrity Cost Avoidance | $2,126,803 |
| Total | $13,708,715 |

Table 43. Prescription Drug Rebates History

| | Rebate (millions) |
|---|---|
| SFY 2012 | $19.3 |
| SFY 2013 | $19.4 |
| SFY 2014 | $21.4 |
| SFY 2015 | $20.1 |
| SFY 2016 | $31.4 |
| SFY 2017 | $27.7 |
| SFY 2018 | $30.4 |
| SFY 2019 | $29.3 |
| SFY 2020 | $27.2 |

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

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

# PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

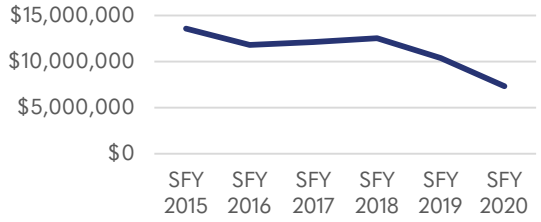
Medicaid covers psychiatric residential treatment for individuals under age 21 at a Psychiatric Residential Treatment Facility (PRTF), a stand-alone entity providing a range of comprehensive services to treat the psychiatric conditions of residents under the direction of a physician, with a goal of improving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

## EXPENDITURES

29%

$7,334,441

1.3% of Medicaid Expenditures




## RECIPIENTS

28%

221

0.3% of Medicaid Recipients

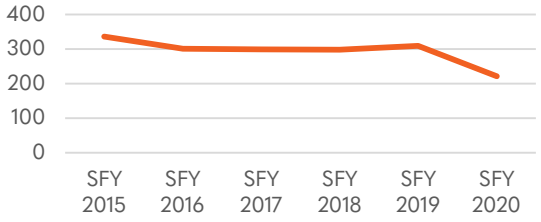



Table 44. Psychiatric Residential Treatment Facility Services Summary [28]

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $13,575,847 | $11,797,657 | $12,121,830 | $12,537,788 | $10,391,372 | $7,334,441 | -46 |
| Recipients | 336 | 301 | 299 | 298 | 309 | 221 | -34 |
| Expenditures per Recipient | $40,404 | $39,195 | $40,541 | $42,073 | $33,629 | $33,188 | -18 |

Per CMS guidelines, Medicaid cannot receive the Federal Medical Assistance Percentage (FMAP) for court-ordered PRTF services. Court orders cannot reference a facility name or a specific level of care, as only a physician should be ordering a client into a PRTF based upon medical necessity. Continuing efforts by Medicaid and the Department of Family Services (DFS) to ensure language submitted on court orders follows federal guidelines has significantly reduced overall general fund expenditures by allowing Medicaid to receive the FMAP.

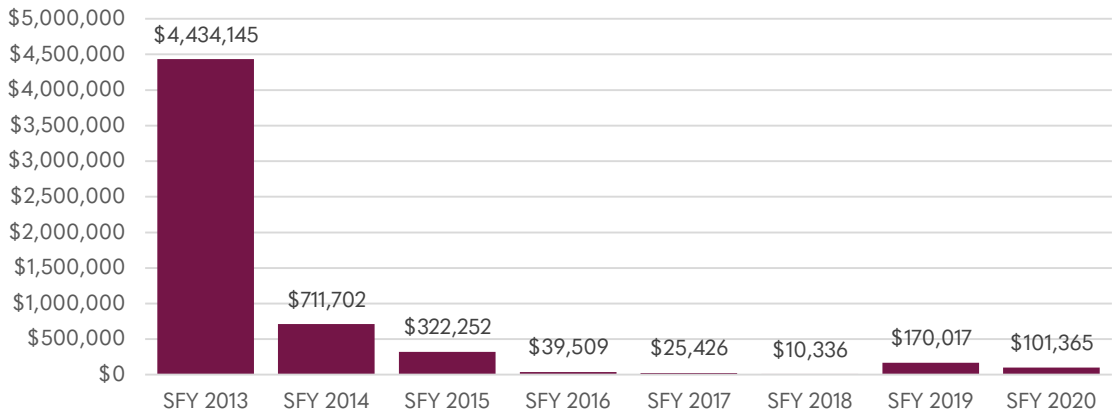



Figure 18. Expenditures for Court Ordered Psychiatric Residential Treatment Facility Services with Incorrect Language or No Medical Necessity

28 Due to court-ordered placements not complying with CMS rules, SFY 2013 had decreases in Medicaid PRTF placements as these placement orders did not qualify for federal matching funds. This led to significant increases in State General Fund only placements (expenses paid for by DHCF but not included in the Medicaid budget).

# PUBLIC HEALTH OR WELFARE

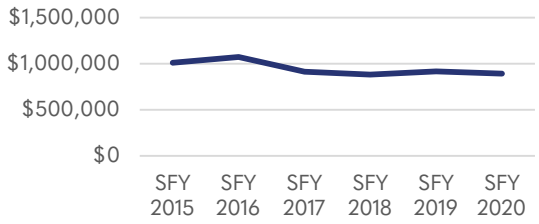
Physician and mid-level practitioner services provided in a clinic designated by the Department of Health as a public health clinic. These services must be provided directly by a physician or a public health nurse under a physician's immediate supervision, such as when the physician has seen the client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

## EXPENDITURES

3%

$894,081

0.2% of Medicaid Expenditures




## RECIPIENTS

2%

7,465

11% of Medicaid Recipients

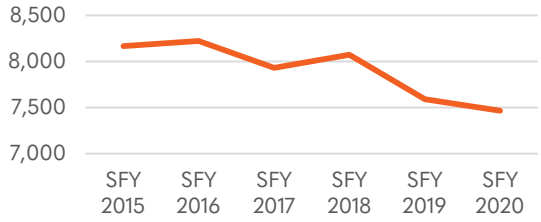



Table 45. Public Health or Welfare Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $1,009,814 | $1,072,715 | $912,444 | $881,179 | $917,179 | $894,081 | -11 |
| Recipients | 8,166 | 8,222 | 7,928 | 8,072 | 7,590 | 7,465 | -9 |
| Expenditures per Recipient | $124 | $130 | $115 | $109 | $121 | $120 | -3 |

# PUBLIC HEALTH, FEDERAL

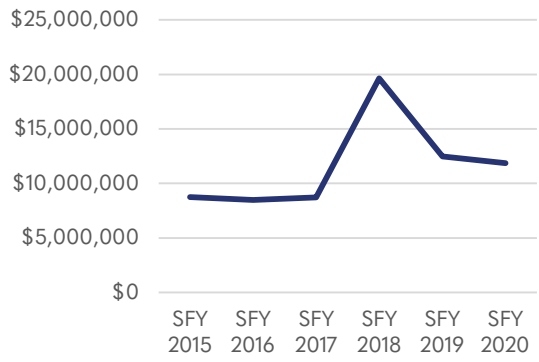
These services are provided to the American Indian/Alaskan Native population by Tribal Contract Health Centers and Indian Health Centers. Tribal Contract Health Centers are outpatient health care programs and facilities owned or operated by the Tribes or Tribal organizations. The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing comprehensive primary care and related services to the American Indian/Alaska Native Population. Services provided by these facilities are claimed by the state at 100% Federal Financial Participation (FFP).

## EXPENDITURES

5%

$11,864,895

2% of Medicaid Expenditures




## RECIPIENTS

11%

3,696

5% of Medicaid Recipients

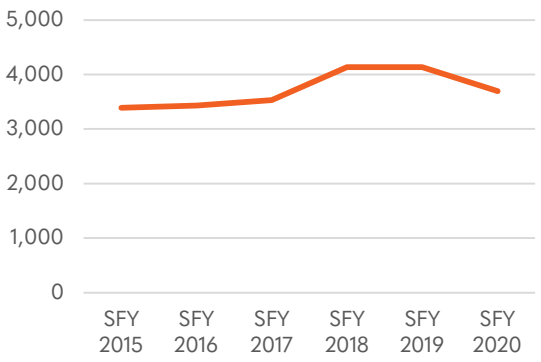


Table 47. Public Health, Federal Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $8,761,358 | $8,479,944 | $8,718,888 | $19,625,445 | $12,488,676 | $11,864,895 | 35 |
| Recipients | 3,390 | 3,433 | 3,531 | 4,138 | 4,135 | 3,696 | 9 |
| Expenditures per Recipient | $2,584 | $2,470 | $2,469 | $4,743 | $3,020 | $3,210 | 24 |

A policy change increased the reimbursement rate and number of encounters that could be billed by IHS/638 Facilities, thus driving the increases in this service area in SFY 2018. These were 100% Federally Funded.

## RURAL HEALTH CLINIC

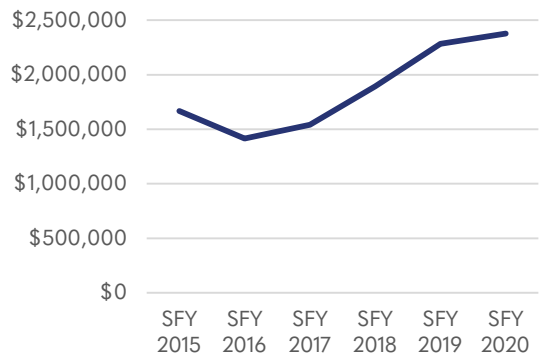
Primary care services provided at a Rural Health Clinic, as designated by Medicare if it is located in a "shortage area", a geographic area designated by the HHS as having a shortage of personal health services or primary medical care professionals. Medicaid covers services provided by a physician, nurse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

### EXPENDITURES

4%

$2,377,607

0.4% of Medicaid Expenditures

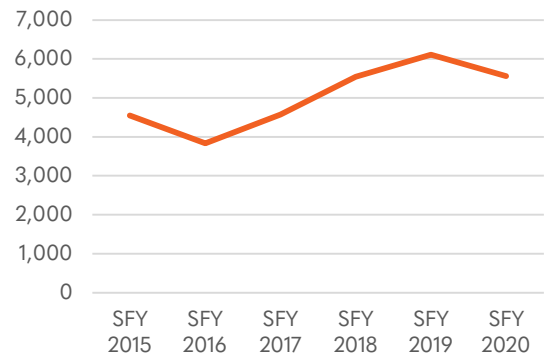



### RECIPIENTS

9%

5,562

8% of Medicaid Recipients




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

Table 46. Rural Health Clinic Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $1,668,167 | $1,413,842 | $1,540,607 | $1,894,505 | $2,283,377 | $2,377,607 | 43 |
| Recipients | 4,552 | 3,835 | 4,577 | 5,541 | 6,113 | 5,562 | 22 |
| Expenditures per Recipient | $366 | $369 | $337 | $342 | $374 | $427 | 17 |

# VISION

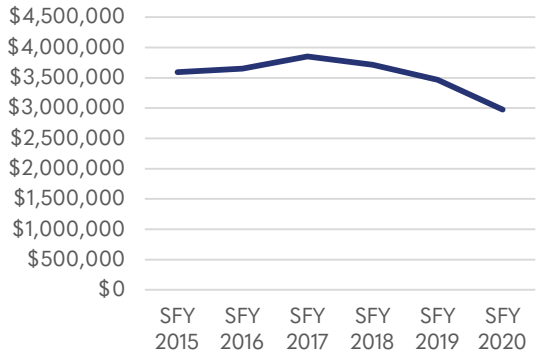
Medicaid covers vision services provided by opticians, optometrists, and ophthalmologists, with services dependent on recipient age. Children receive services to correct and maintain healthy vision, including eyeglasses ( frames, frame parts, and lenses) and vision therapy based on diagnosis codes. Adults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

## EXPENDITURES

14%

$2,977,070

0.5% of Medicaid Expenditures




## RECIPIENTS

14%

12,680

19% of Medicaid Recipients

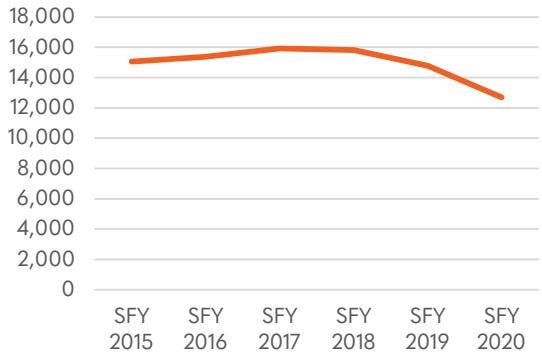



Table 48. Vision Services Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $3,595,216 | $3,652,188 | $3,850,574 | $3,712,855 | $3,466,069 | $2,977,070 | -17 |
| Recipients | 15,063 | 15,369 | 15,921 | 15,821 | 14,790 | 12,680 | -16 |
| Expenditures per Recipient | $239 | $238 | $242 | $235 | $234 | $235 | -2 |

# WAIVERS

Medicaid offers various waivers with approval from CMS to selectively "waive" one or more Medicaid requirements to allow greater flexibility in the Medicaid program.

Medicaid offers four Home and Community Based Services (HCBS) waivers and one Section 1115 waiver, as shown to the right.

HCBS Waiver participants receive specific waiver services, as well as the standard Medicaid package of benefits. Pregnant by Choice Waiver individuals only receive waiver services.

This section provides data on both the waiver-only services and the additional Medicaid services, referred to in this report as "non-waiver" services. The non-waiver service data is incorporated into the totals for the individual services defined in this report.

## MEDICAID WAIVERS

### HOME & COMMUNITY BASED SERVICES WAIVERS

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

**Pregnant by Choice (section 1115 waiver)**

# HOME & COMMUNITY BASED SERVICES WAIVERS

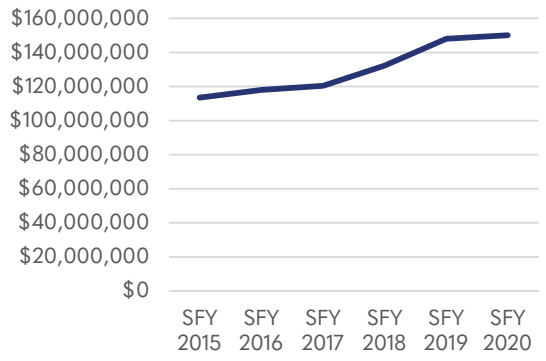
These waivers provide care in the home and community to the elderly and disabled, intellectually disabled, developmentally disabled and certain other disabled adults enrolled in Medicaid.

## EXPENDITURES

1%

$150,076,885

28% of Medicaid Expenditures

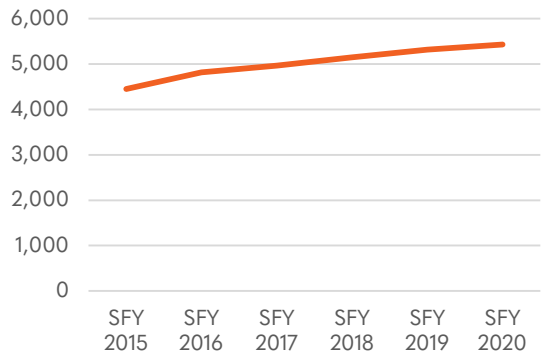



## RECIPIENTS

2%

5,425

8% of Medicaid Recipients



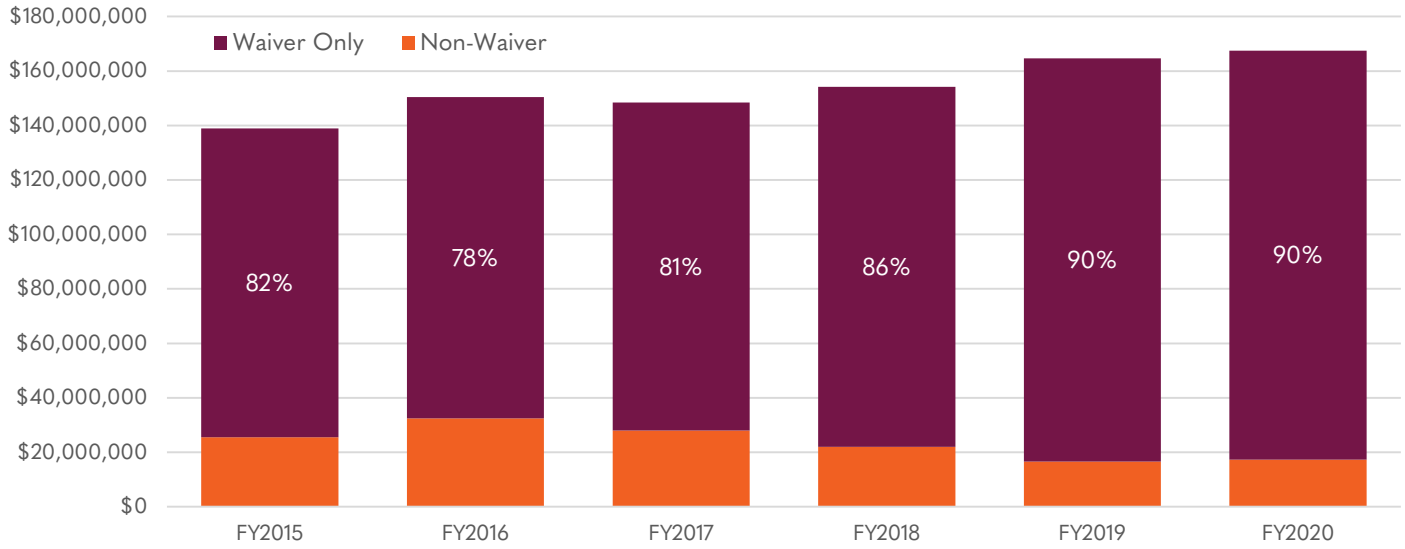
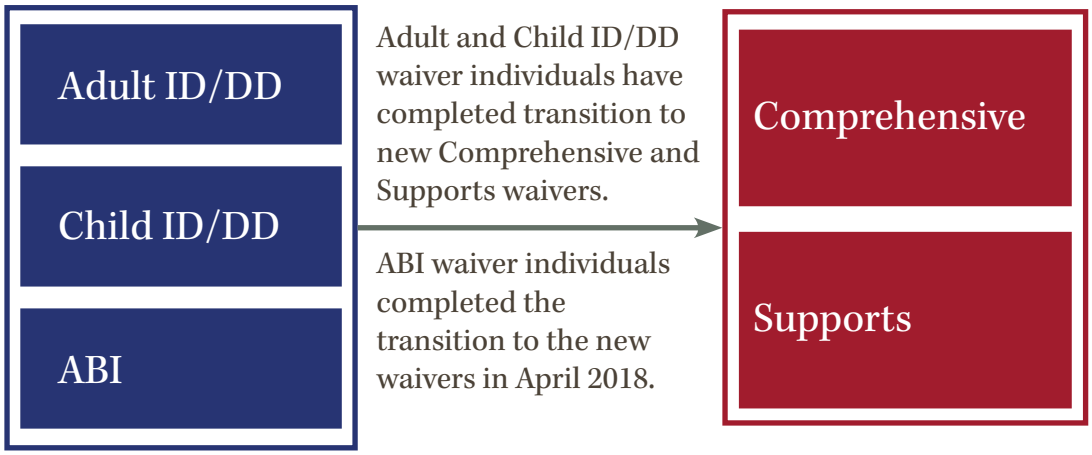



Figure 19. Waiver vs Non-Waiver Expenditures History

Table 49. Home and Community Based Services Waiver Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| **Waiver Only Services** | | | | | | | |
| Expenditures | $113,470,920 | $117,955,631 | $120,444,960 | $132,243,321 | $148,078,894 | $150,076,885 | 32 |
| Recipients | 4,448 | 4,817 | 4,958 | 5,144 | 5,317 | 5,425 | 22 |
| Expenditures per Recipient | $25,511 | $24,487 | $24,293 | $25,708 | $27,850 | $27,664 | 8 |
| % Waiver-Only of Total Waivers | 82% | 78% | 81% | 86% | 90% | 90% | |
| **Non-Waiver Services** | | | | | | | |
| Expenditures | $25,493,495 | $32,471,001 | $27,954,381 | $21,956,278 | $16,584,581 | $17,350,327 | -32 |
| Recipients | 4,532 | 4,919 | 5,132 | 5,306 | 5,418 | 5,697 | 26 |
| Expenditures per Recipient | $5,625 | $6,601 | $5,447 | $4,138 | $3,061 | $3,046 | -46 |
| **Total Waiver** | | | | | | | |
| Expenditures | $138,964,415 | $150,426,752 | $148,399,341 | $154,199,599 | $164,663,475 | $167,427,212 | 20 |
| Recipients | 4,670 | 5,070 | 5,286 | 5,479 | 5,630 | 5,891 | 26 |
| Expenditures per Recipient | $29,757 | $29,670 | $28,074 | $28,144 | $29,248 | $28,421 | -4 |




Additionally children enrolled in the Children's Mental Health waiver now receive all their case management services through the Care Management Entity service, highlighted earlier in this report.

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

Figures 20 and 21 show the historical change in expenditures as the transition to Comprehensive and Supports waivers have been implemented. From SFY 2015 to SFY 2020, total expenditures for these populations have increased 15%, with non-waiver expenditures decreasing by 46%.

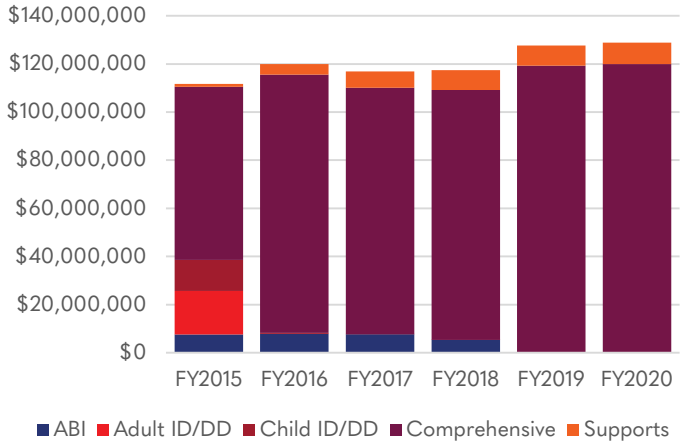



Figure 20. Total Expenditure History for Transition from Adult and Child ID/DD Waivers to Comprehensive and Supports Waivers

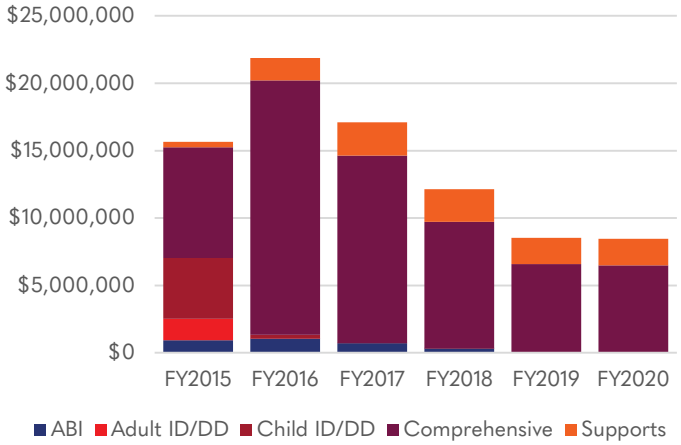



Figure 21. Non-Waiver Services Expenditure History for Transition from Adult and Child ID/DD Waivers to Comprehensive and Supports Waivers

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

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|---|
| **Waiver Only Services** | | | | | | |
| ABI | $6,637,048 | $6,748,171 | $6,960,882 | $4,948,202 | $15,008 | -- |
| Adult ID/DD | $16,545,619 | $1,868 | $1,565 | -- | -- | -- |
| Child ID/DD | $8,386,457 | $179,173 | -- | -- | -- | -- |
| Children's Mental Health | $732,257 | $61,981 | -- | -- | -- | -- |
| Community Choices | $16,627,806 | $19,806,505 | $20,587,194 | $26,930,997 | $28,957,689 | $29,661,574 |
| Comprehensive | $63,722,044 | $88,377,484 | $88,517,064 | $94,568,471 | $112,673,503 | $113,532,461 |
| Supports | $819,690 | $2,780,450 | $4,378,255 | $5,795,651 | $6,432,694 | $6,882,850 |
| **Non-Waiver Services** | | | | | | |
| ABI | $922,916 | $1,045,596 | $714,600 | $347,375 | $5,160 | $0 |
| Adult ID/DD | $1,587,052 | $9,953 | $1,035 | $36 | -- | -- |
| Child ID/DD | $4,521,679 | $268,404 | -$4,650 | $218 | -- | -- |
| Children's Mental Health | $659,139 | $636,077 | $451,590 | $653,713 | $435,708 | $290,891 |
| Community Choices | $9,170,313 | $9,947,820 | $10,411,527 | $9,167,122 | $7,631,127 | $8,594,532 |
| Comprehensive | $8,224,563 | $18,883,901 | $13,921,993 | $9,376,098 | $6,567,542 | $6,483,800 |
| Supports | $407,833 | $1,679,251 | $2,458,285 | $2,411,717 | $1,945,044 | $1,981,104 |
| **Total Waiver** | | | | | | |
| ABI | $7,559,964 | $7,793,766 | $7,675,482 | $5,295,577 | $20,168 | $0 |
| Adult ID/DD | $18,132,671 | $11,820 | $2,600 | $36 | -- | -- |
| Child ID/DD | $12,908,136 | $447,577 | -$4,650 | $218 | -- | -- |
| Children's Mental Health | $1,391,396 | $698,058 | $451,590 | $653,713 | $435,708 | $290,891 |
| Community Choices | $25,798,118 | $29,754,446 | $30,998,721 | $36,098,118 | $36,588,816 | $38,256,106 |
| Comprehensive | $71,946,607 | $107,261,385 | $102,439,057 | $103,944,569 | $119,241,045 | $120,016,261 |
| Supports | $1,227,523 | $4,459,700 | $6,836,540 | $8,207,369 | $8,377,738 | $8,863,953 |

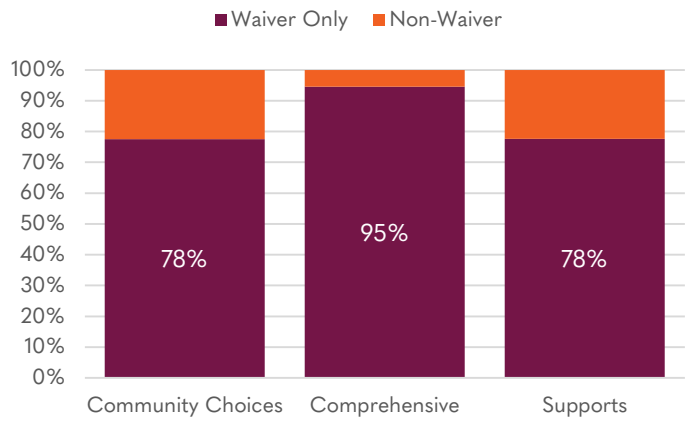



Figure 22. SFY 2020 Waiver-Only versus Non-Waiver Services by Waiver

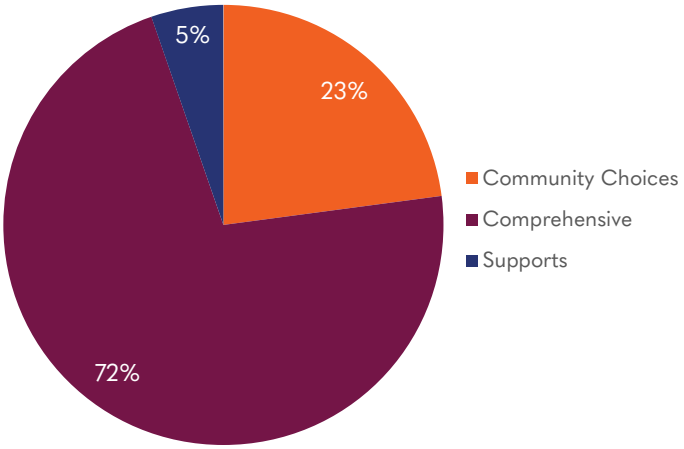



Figure 23. SFY 2020 Total Waiver Expenditure Breakdown by Waiver

## COMMUNITY CHOICES WAIVER

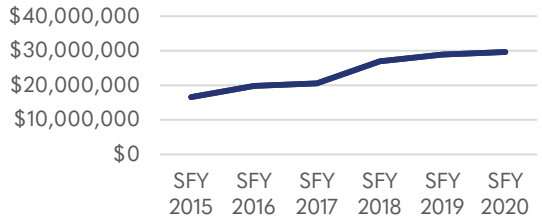
This waiver provides in-home services and assisted living services to Medicaid enrollees 19 years of age and older who are aged, blind, or disabled and require services equivalent to nursing home level of care. This waiver was formerly the Long-Term Care waiver, and starting in SFY 2017 added the assisted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

### EXPENDITURES

2%

$29,661,574

6% of Medicaid Expenditures




### RECIPIENTS

2%

2,875

4% of Medicaid Recipients

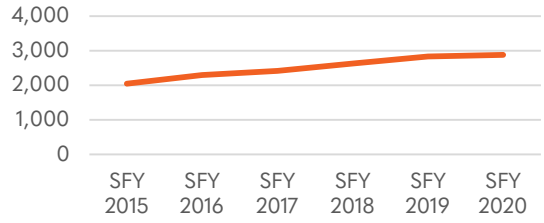



Table 51. Community Choices Waiver Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| **Waiver Only Services** | | | | | | | |
| Expenditures | $16,630,675 | $19,801,298 | $20,597,605 | $26,930,997 | $28,957,689 | $29,661,574 | 78 |
| Recipients | 2,040 | 2,295 | 2,414 | 2,622 | 2,828 | 2,875 | 41 |
| Expenditures per Recipient | $8,152 | $8,628 | $8,533 | $10,271 | $10,240 | $10,317 | 27 |
| % Waiver-Only | 64% | 67% | 66% | 75% | 79% | 78% | |
| **Non-Waiver Services** | | | | | | | |
| Expenditures | $9,170,313 | $9,947,820 | $10,411,275 | $9,166,911 | $7,631,127 | $8,594,510 | -6 |
| Recipients | 2,137 | 2,373 | 2,524 | 2,699 | 2,851 | 3,086 | 44 |
| Expenditures per Recipient | $4,291 | $4,192 | $4,125 | $3,396 | $2,677 | $2,785 | -35 |
| **Total Waiver** | | | | | | | |
| Expenditures | $25,798,118 | $29,754,446 | $30,998,469 | $36,097,908 | $36,588,816 | $38,256,084 | 48 |
| Recipients | 2,203 | 2,444 | 2,602 | 2,807 | 2,993 | 3,200 | 45 |
| Expenditures per Recipient | $11,710 | $12,174 | $11,913 | $12,860 | $12,225 | $11,955 | 2 |

## COMPREHENSIVE WAIVER

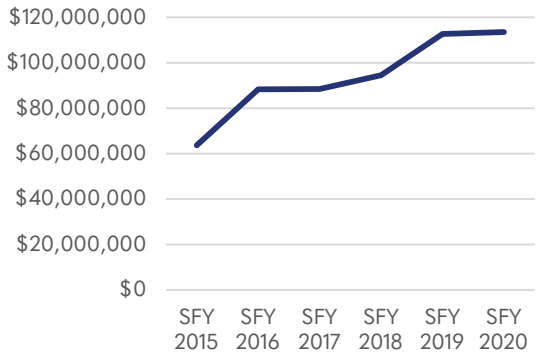
This Medicaid waiver, started in SFY 2014, funds services for individuals with intellectual or developmental disability based on assessed need, as measured by the standardized Inventory for Client and Agency Planning (ICAP) tool.

### EXPENDITURES

1%

$113,532,461

21% of Medicaid Expenditures




### RECIPIENTS

1%

1,932

3% of Medicaid Recipients

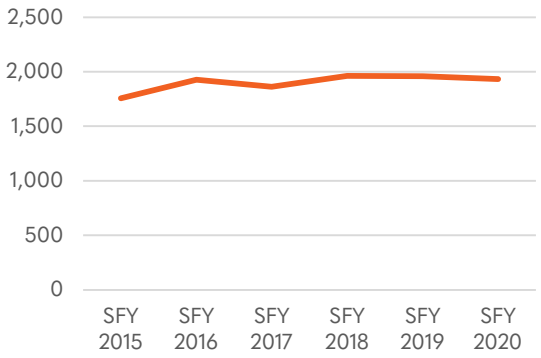



Table 52. Comprehensive Waiver Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| **Waiver Only Services** | | | | | | | |
| Expenditures | $63,719,016 | $88,377,607 | $88,527,446 | $94,568,471 | $112,673,503 | $113,532,461 | 78 |
| Recipients | 1,756 | 1,927 | 1,863 | 1,962 | 1,959 | 1,932 | 10 |
| Expenditures per Recipient | $36,286 | $45,863 | $47,519 | $48,200 | $57,516 | $58,764 | 62 |
| % Waiver-Only | 89% | 82% | 86% | 91% | 94% | 95% | |
| **Non-Waiver Services** | | | | | | | |
| Expenditures | $8,224,563 | $18,883,901 | $13,921,993 | $9,376,098 | $6,567,542 | $6,483,800 | -21 |
| Recipients | 1,731 | 1,902 | 1,858 | 1,937 | 1,938 | 1,930 | 11 |
| Expenditures per Recipient | $4,751 | $9,928 | $7,493 | $4,841 | $3,389 | $3,359 | -29 |
| **Total Waiver** | | | | | | | |
| Expenditures | $71,946,607 | $107,261,385 | $102,439,057 | $103,944,569 | $119,241,045 | $120,016,261 | 67 |
| Recipients | 1,835 | 1,949 | 1,890 | 1,989 | 1,983 | 1,966 | 7 |
| Expenditures per Recipient | $39,208 | $55,034 | $54,201 | $52,260 | $60,132 | $61,046 | 56 |

## SUPPORTS WAIVER

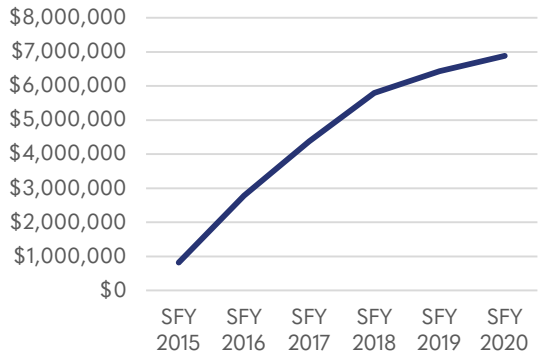
This Medicaid waiver, started in SFY 2014, provides more flexible, although capped, funding for supportive services for individuals with intellectual or developmental disability.

### EXPENDITURES

2%

$29,661,574

6% of Medicaid Expenditures




### RECIPIENTS

2%

2,875

4% of Medicaid Recipients

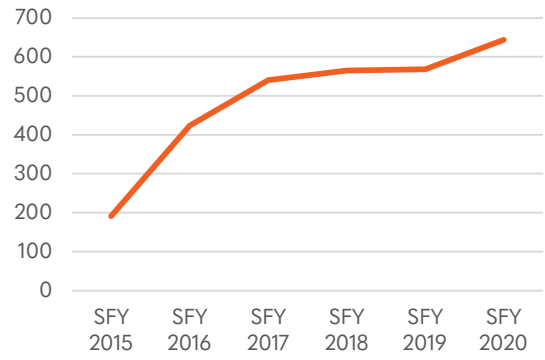



Table 53. Supports Waiver Summary

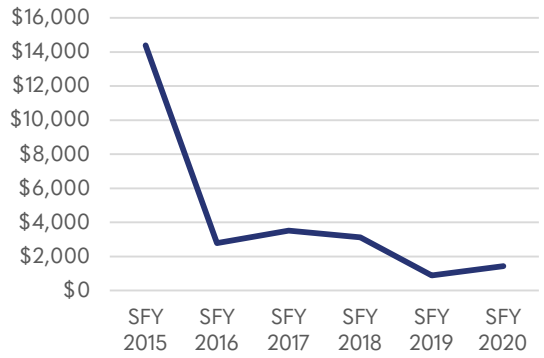
| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| **Waiver Only Services** | | | | | | | |
| Expenditures | $819,690 | $2,780,450 | $4,378,255 | $5,795,651 | $6,432,694 | $6,882,850 | 740 |
| Recipients | 191 | 424 | 540 | 565 | 568 | 644 | 237 |
| Expenditures per Recipient | $4,292 | $6,558 | $8,108 | $10,258 | $11,325 | $10,688 | 149 |
| % Waiver-Only | 67% | 62% | 64% | 71% | 77% | 78% | |
| **Non-Waiver Services** | | | | | | | |
| Expenditures | $407,833 | $1,679,251 | $2,458,285 | $2,411,717 | $1,945,044 | $1,981,104 | 386 |
| Recipients | 179 | 403 | 513 | 552 | 554 | 610 | 241 |
| Expenditures per Recipient | $2,278 | $4,167 | $4,792 | $4,369 | $3,511 | $3,248 | 43 |
| **Total Waiver** | | | | | | | |
| Expenditures | $1,227,523 | $4,459,700 | $6,836,540 | $8,207,369 | $8,377,738 | $8,863,953 | 622 |
| Recipients | 203 | 440 | 555 | 581 | 584 | 658 | 224 |
| Expenditures per Recipient | $6,047 | $10,136 | $12,318 | $14,126 | $14,345 | $13,471 | 123 |

# PREGNANT BY CHOICE WAIVER

Medicaid provides pregnancy planning services through this Section 1115 waiver with the goal of reducing the incidence of closely spaced pregnancies and decrease the number of unintended pregnancies in order to reduce health risks to women and children and achieve cost savings. These services are available to women who have received Medicaid benefits under the Pregnant Women eligibility program and would otherwise lose Medicaid eligibility 60 days postpartum. This waiver currently expires on December 31, 2019; however, a five-year extension was requested for January 1, 2020 through December 31, 2024.

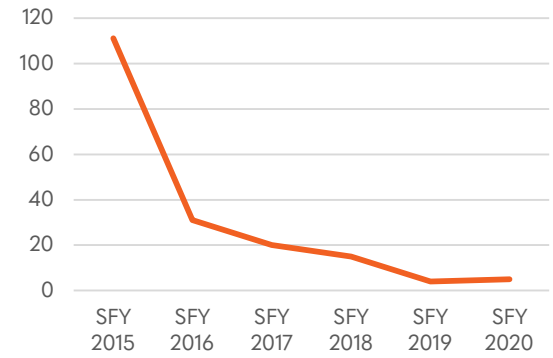
## EXPENDITURES

61% $1,428




## RECIPIENTS

25% 5




Pregnant by Choice waiver services are included in the individual service sections in this report and are thus excluded from the service overview tables iearlier in the report.

Table 54. Pregnant by Choice Waiver Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $14,383 | $2,790 | $3,507 | $3,113 | $888 | $1,428 | -90 |
| Recipients | 111 | 31 | 20 | 15 | 4 | 5 | -95 |
| Expenditures per Recipient | $130 | $90 | $175 | $208 | $222 | $286 | 120 |


GREAT SEAL OF THE STATE OF WYOMING

# SUBPROGRAMS & SPECIAL POPULATIONS

## SUBPROGRAMS

Medicaid has implemented subprograms to meet federal or state government mandates, to meet the specific medical needs of Medicaid individuals and to give individuals better access to care or more care options. While these subprograms are carried out in conjunction with the service areas described in the preceding sections, there are specific features of these subprograms that warrant separate discussion.

## DRUG UTILIZATION REVIEW

The Drug Utilization Review (DUR) program reviews utilization of outpatient prescription drugs to ensure individuals are receiving appropriate, medically necessary medications which are not likely to result in adverse effects. The program was established in 1992 in response to requirements outlined in OBRA 90 and defined in the Code of Federal Regulations (42 CFR 456 Subpart K). Medicaid has contracted with the University of Wyoming to administer the program, which includes a number of activities, as described below.

### Pharmacy & Therapeutics Committee

Six physicians, five pharmacists, and one allied health professional along with the Medicaid Medical Director, Pharmacy Program Manager, Pharmacist Consultant, and a drug information specialist from the University of Wyoming School of Pharmacy. Meets quarterly to provide recommendations regarding prospective drug utilization review, retrospective drug utilization review, and education activities to Medicaid.

### Prospective DUR

Required review of prescription claims for appropriateness prior to dispensing at the pharmacy. This review takes prior authorization policies into consideration when identifying potential issues, including, but not limited to, therapeutic duplication, drug-disease contraindications, drug-drug interactions, and potential adverse effects.

### Retrospective DUR

Ongoing review of aggregate claims data to uncover trends and review individual patient profiles to aid in monitoring for therapeutic appropriateness, over-and under-utilization, therapeutic duplication, drug-disease contraindications, drug-drug interactions, and other issues. This can lead to recommendations for prospective DUR policy, including prior authorizations, to encourage appropriate utilization at the program level. Reviewing individual patient profiles may result in educational letters to the prescriber when the reviewing Committee members determine the issue to be clinically significant to a specific patient.

### Input from Medical Community

Actively solicits feedback about prior authorization policies from prescribers in Wyoming through direct mailings. Letters are sent to all specialists in affected areas, as well as a random sample of fifty general practitioners. The P&T Committee reviews all comments that are received prior to giving final approval of the policy. This allows providers an opportunity to participate in the decision-making process. Providers are encouraged to submit comments and concerns to the committee for review through public comment forms available on the DUR website. Providers may use this method to comment on both existing and new policy.

### Education

Quarterly newsletters are sent to all Wyoming providers. Targeted education letters regarding duplicate benzodiazepine utilization, long and short acting opiate utilization, and high dose opiate utilization are also sent.

### Review Clinical Evidence

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

## HEALTH INFORMATION TECHNOLOGY

The Health Information Technology (HIT) systems enable and support Medicaid providers in achieving Meaningful Use while allowing for clinical data interoperability among Wyoming providers with the ultimate goal of improving healthcare quality.

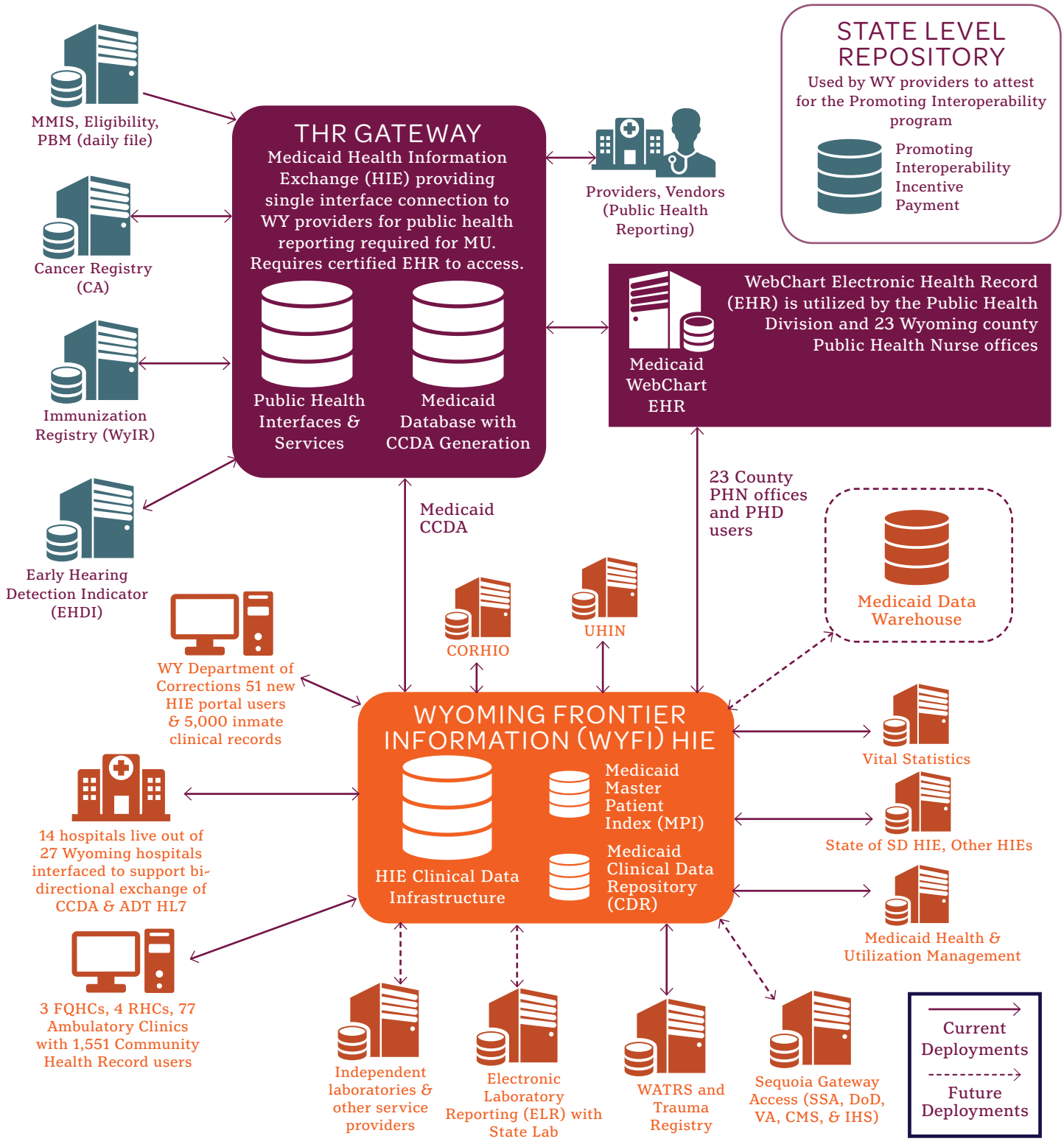



Figure 24. Wyoming Health Information Exchange and Medicaid

The Wyoming Frontier Information (WYFI) Health Information Exchange (HIE) serves to promote a healthier Wyoming through the development of a statewide secure, connected, and coordinated health IT system that supports effective and efficient healthcare.

The WYFI HIE is a centralized repository of clinical data provided by participating patients. Providers with connections from their electronic health record systems (EHRs) to WYFI send real time electronic patient data. Providers who are not connected to WYFI can access and download clinical patient data through the Community Health Record (CHR). The CHR is a secure online portal that can be accessed via a web browser. WYFI clinical data is available to all Wyoming healthcare providers to support patient care and coordination. All of the HIE data is encrypted and secured, and user access is logged and audited.

WYFI participation will be provided at no cost to healthcare participants through 2021. Access to data is available immediately upon provider participation.

## PROMOTING INTEROPERABILITY PROGRAM

Medicaid established the Promoting Interoperability Program under the American Recovery and Reinvestment Act (ARRA) of 2009 to provide incentive payments to eligible professionals and hospitals for the adoption, implementation, upgrading, and meaningful use of an Electronic Health Record system. Payments for this program are paid with 100% Federal Funds.

**195** eligible professionals participated

**24** eligible hospitals participated

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

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

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

## ADMINISTRATIVE TRANSPORTATION

Medicaid covers the cost of transportation to and from medical appointments if the appointment is medically necessary, it is approved by WDH at least 3 business days in advance, and the least costly mode of transportation is selected. Retrospective transportation reimbursement is allowed if the request is made within 30 days of travel and all required documentation is provided. Per diem expenses are reimbursable to family/legal guardian for recipients under age 21 for expanded services. This covers meals and commercial lodging at $25/day for inpatient and $50/day for outpatient.

Table 55. Administrative Transportation Summary

| | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|
| Expenditures | $77,953 | $130,495 | $191,305 | $158,432 |
| Recipients | 272 | 359 | 410 | 412 |
| Expenditures per Recipient | $287 | $363 | $467 | $385 |

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

## PATIENT CENTERED MEDICAL HOME

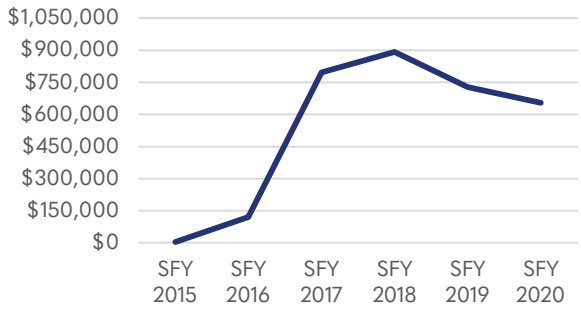
The PCMH program promotes high-value care using a value-based purchasing model in which health care is coordinated through a primary care physician/practitioner, with a focus on quality and safety. Participating providers are paid a per member per month rate based on their patient volume.

### EXPENDITURES

10%

$654,167

0.1% of Medicaid Expenditures




### RECIPIENTS

15%

15,540

19% of Medicaid Recipients

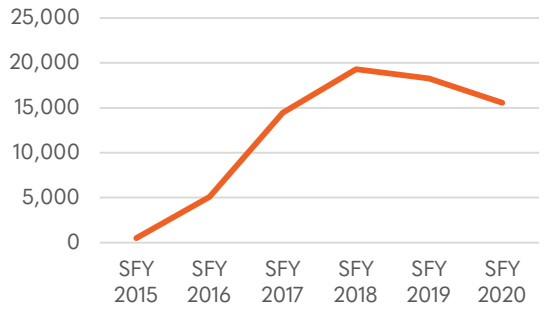



Table 56. Patient Centered Medical Home Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|---|
| Expenditures | $3,839 | $119,777 | $796,389 | $892,709 | $726,782 | $654,167 |
| Recipients | 490 | 5,102 | 14,458 | 19,292 | 18,247 | 15,540 |
| Expenditures per Recipient | $8 | $23 | $55 | $46 | $40 | $42 |
| Participating Practices | 3 | 7 | 13 | 19 | 20 | 12 |
| Practitioners in Participating Practices | 20 | 41 | 130 | 168 | 167 | 107 |

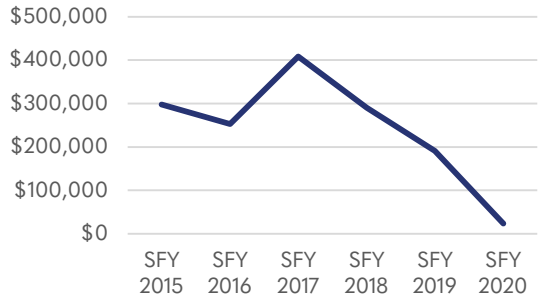
## PROJECT OUT

A temporary, short-term intervention and assistance program aimed at helping participants overcome barriers to living independently in the community through diversion or transition. Limited financial resources may be provided to cover the expense of moving/storage, rental/utility deposits, furniture, house hold items, home modifications, and limited transportation. Participants are also linked to community services and long-term care programs that provide ongoing support. Project Out provides targeted case management to create a transition/diversion plan, identifying the services and supports necessary for independent living.

### EXPENDITURES

88%

$23,623




### RECIPIENTS

85%

33

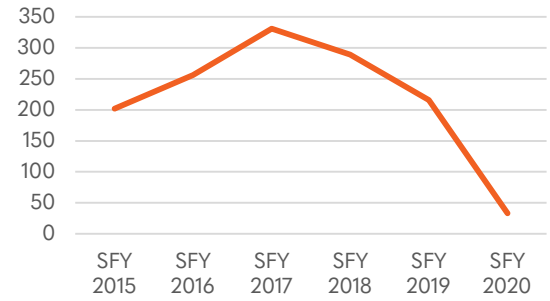



Table 57. Project Out Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Expenditures | $297,574 | $252,897 | $408,022 | $290,661 | $190,781 | $23,623 | -92 |
| Recipients | 202 | 256 | 331 | 289 | 216 | 33 | -84 |
| Expenditures per Recipient | $1,473 | $988 | $1,233 | $1,006 | $883 | $716 | -51 |

## HEALTH CHECK

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

- Physical exams
- Immunizations
- Lab tests
- Growth/development check
- Nutrition check
- Vision/Hearing/Dental screenings
- Behavioral health assessment
- Health information
- Teen health education
- Transportation (ambulance & administrative)
- Other healthcare prescribed by a physician and approved by Medicaid

# SPECIAL POPULATIONS

This section provides greater detail on two Medicaid populations of interest: Medicaid/Medicare Dual Enrolled Members and Foster Care.

## MEDICAID/MEDICARE DUAL ENROLLED

Individuals with Medicare coverage may also be eligible for Medicaid services, dependent on income. These individuals are referred to as dual enrolled. For these members, Medicare pays first for services covered by both programs, while Medicaid covers additional payments through crossover claims. Non-Medicare-covered services are entirely funded by Medicaid, up to Wyoming's payment limit.

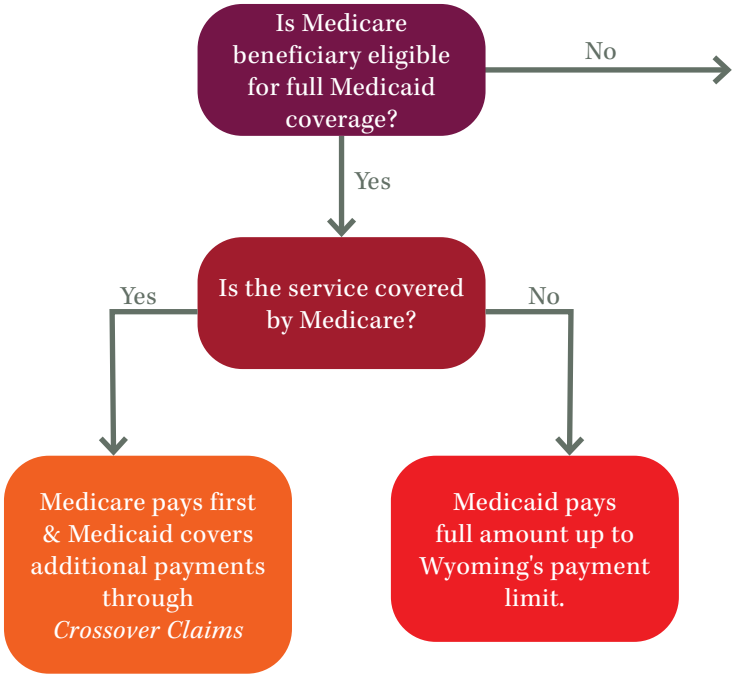



Figure 25. Dual Enrolled Claims Coverage Process

This section includes information on both crossover claims services and those services funded entirely by Medicaid. Premium assistance for QMB, SLMB, and QI enrollees is excluded, as these are considered administrative costs.

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

**Qualified Medicare Beneficiaries (QMB)**
Provides assistance with Medicare premiums, deductibles, and coinsurance. For individuals with:
- Resources not exceeding 3 times the SSI resource limit adjusted annually by the increase in the consumer price index
- Income less than or equal to 100% FPL

**Specified Low-Income Medicare Beneficiaries (SLMB)** Provides assistance with Medicare Part B premiums. For individuals with:
- Resources not exceeding 3 times the SSI resource limit adjusted annually by the increase in the consumer price index
- Income between 100% and 120% FPL

**Qualified Individuals (QI)**
Provides assistance with Medicare Part B premiums. For individuals with:
- Resources not exceeding 3 times the SSI resource limit adjusted annually by the increase in the consumer price index
- Income between 121% and 135% FPL

Premiums for these individuals are paid with 100% federal funds

Table 58. Medicaid/Medicare Dual Enrollment Summary

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Dual Enrolled Members | 12,496 | 12,679 | 12,941 | 13,134 | 13,294 | 13,122 | 5 |
| Expenditures | $181,749,483 | $211,902,937 | $214,631,258 | $206,893,220 | $205,837,780 | $217,855,671 | 20 |
| Recipients (unduplicated) | 9,604 | 10,502 | 10,901 | 11,137 | 11,268 | 11,665 | 21 |
| Expenditures per Recipient | $18,924 | $20,177 | $19,689 | $18,577 | $18,267 | $18,735 | -1 |
| Crossover Claims Expenditures | $18,058,494 | $17,547,805 | $14,966,523 | $7,751,187 | $8,008,235 | $7,996,523 | -56 |
| Crossover Claims Expenditures as Percent of Total Dual Expenditures | 10% | 8% | 7% | 4% | 4% | 4% | |

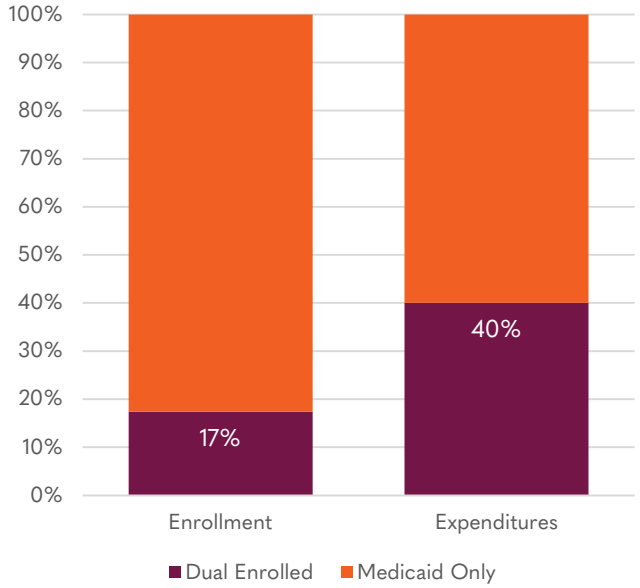



Figure 26. Dual Enrolled as Percent of Total Medicaid in SFY 2020

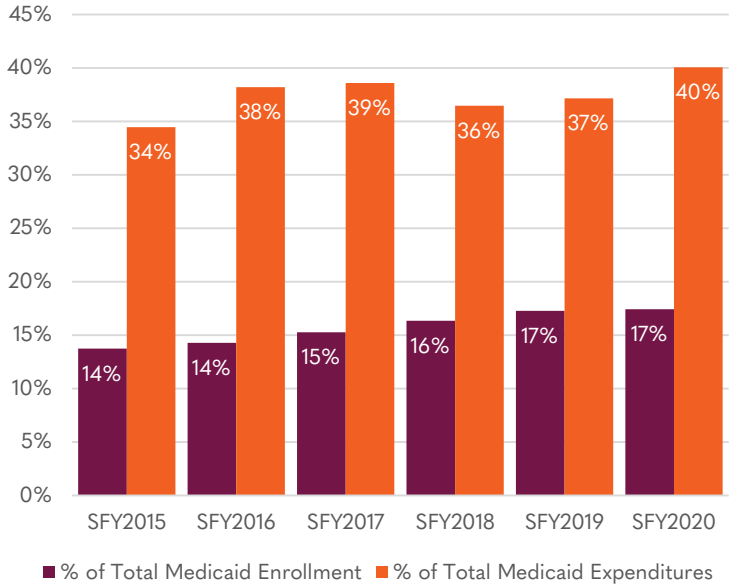



Figure 27. History of Dual Enrollment and Expenditures as Percent of Total Medicaid

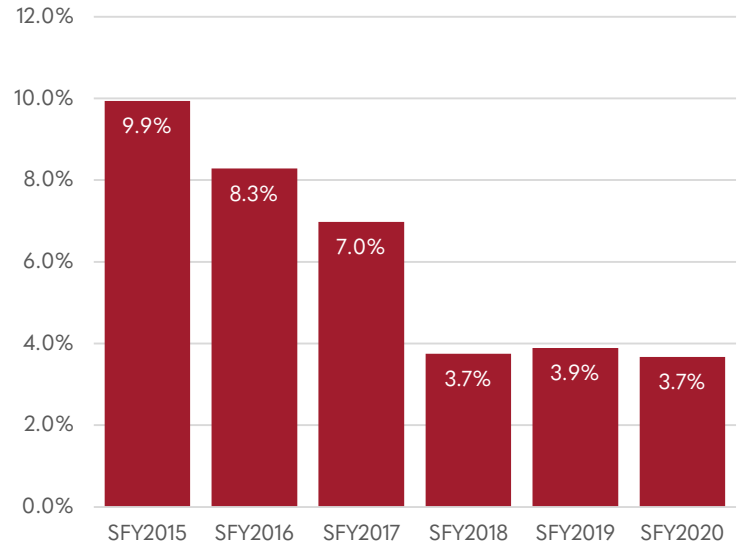



Figure 28. History of Crossover Expenditures as Percent of Total Dual Expenditures

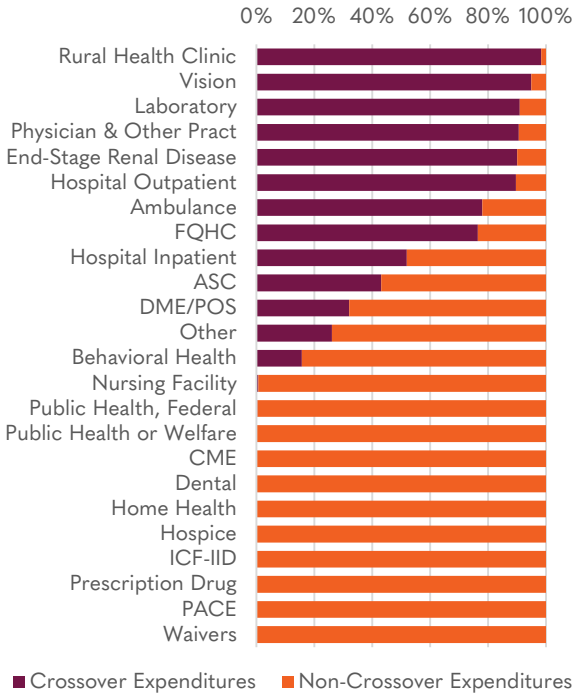



Figure 29. Crossover Expenditures as Percent of Dual Expenditures by Service Area for SFY 2020

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

Table 59. Dual Enrolled Member Service Utilization Summary

| Service Area | Expenditures | Recipients[29] | Expenditures per Recipient | Crossover Expenditures | Crossover Recipients | Crossover Expenditures per Recipient |
|---|---|---|---|---|---|---|
| Ambulance | $27,339 | 1,241 | $22 | $21,328 | 1,225 | $17 |
| Ambulatory Surgical Center | $58,405 | 183 | $319 | $25,132 | 168 | $150 |
| Behavioral Health | $1,409,560 | 2,104 | $670 | $220,352 | 1,547 | $142 |
| Care Management Entity | $116 | 1 | $116 | -- | -- | -- |
| Dental | $387,326 | 1,691 | $229 | -- | -- | -- |
| DME, Prosthetics/Orthotics/ Supplies | $2,958,534 | 3,578 | $827 | $946,501 | 3,079 | $307 |
| End Stage Renal Disease | $240,902 | 144 | $1,673 | $216,748 | 144 | $1,505 |
| Federally Qualified Health Center | $208,822 | 1,440 | $145 | $159,549 | 1,378 | $116 |
| Home Health | $38,231 | 33 | $1,159 | -- | -- | -- |
| Hospice | $792,697 | 146 | $5,429 | $0 | 49 | $0 |
| Hospital Total | $2,916,509 | 8,133 | $359 | $2,061,306 | 8,078 | $255 |
| Inpatient | $1,426,185 | 2,483 | $574 | $740,417 | 2,440 | $303 |
| Outpatient | $1,457,691 | 7,850 | $186 | $1,306,018 | 7,799 | $167 |
| Intermediate Care Facility-IID | $14,101,638 | 51 | $276,503 | -- | -- | -- |
| Laboratory | $5,816 | 1,490 | $4 | $5,286 | 1,477 | $4 |
| Nursing Facility | $85,554,407 | 2,673 | $32,007 | $528,383 | 1,137 | $465 |
| Other | $92,312 | 420 | $220 | $24,089 | 245 | $98 |
| PACE | $3,458,490 | 181 | $19,108 | -- | -- | -- |
| Physician & Other Practitioner | $3,890,429 | 8,709 | $447 | $3,522,914 | 8,605 | $409 |
| Prescription Drug | $1,008,457 | 2,103 | $480 | -- | -- | -- |
| Public Health or Welfare | $458,549 | 3,261 | $141 | $61 | 47 | $1 |
| Public Health, Federal | $198,196 | 129 | $1,536 | $584 | 29 | $20 |
| Rural Health Clinic | $190,778 | 1,164 | $164 | $187,454 | 1,157 | $162 |
| Vision | $66,539 | 1,701 | $39 | $63,100 | 1,674 | $38 |
| Waiver Total | $99,791,618 | 3,759 | $26,547 | -- | -- | -- |
| Community Choices | $25,778,424 | 2,471 | $10,432 | -- | -- | -- |
| Comprehensive | $71,455,352 | 1,100 | $64,959 | -- | -- | -- |
| Supports | $2,557,843 | 196 | $13,050 | -- | -- | -- |
| Total | $217,855,671 | 11,665 | $18,676 | $7,996,523 | 10,238 | $781 |

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

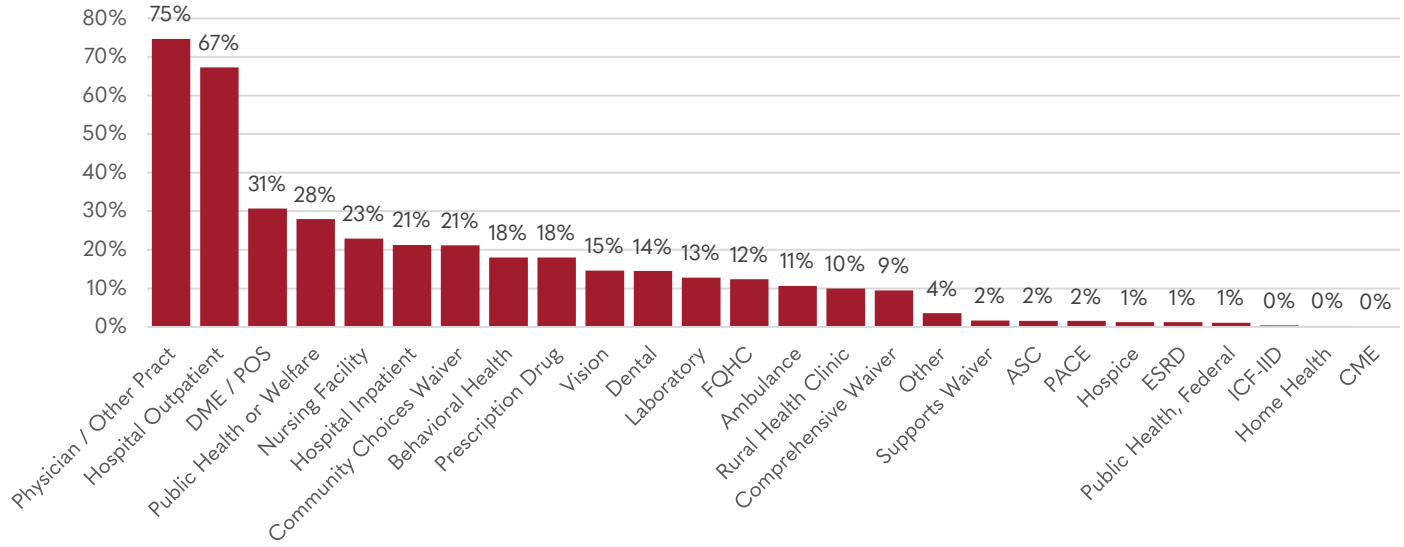



Figure 30. Percent of Total Unduplicated Dual Recipients by Service

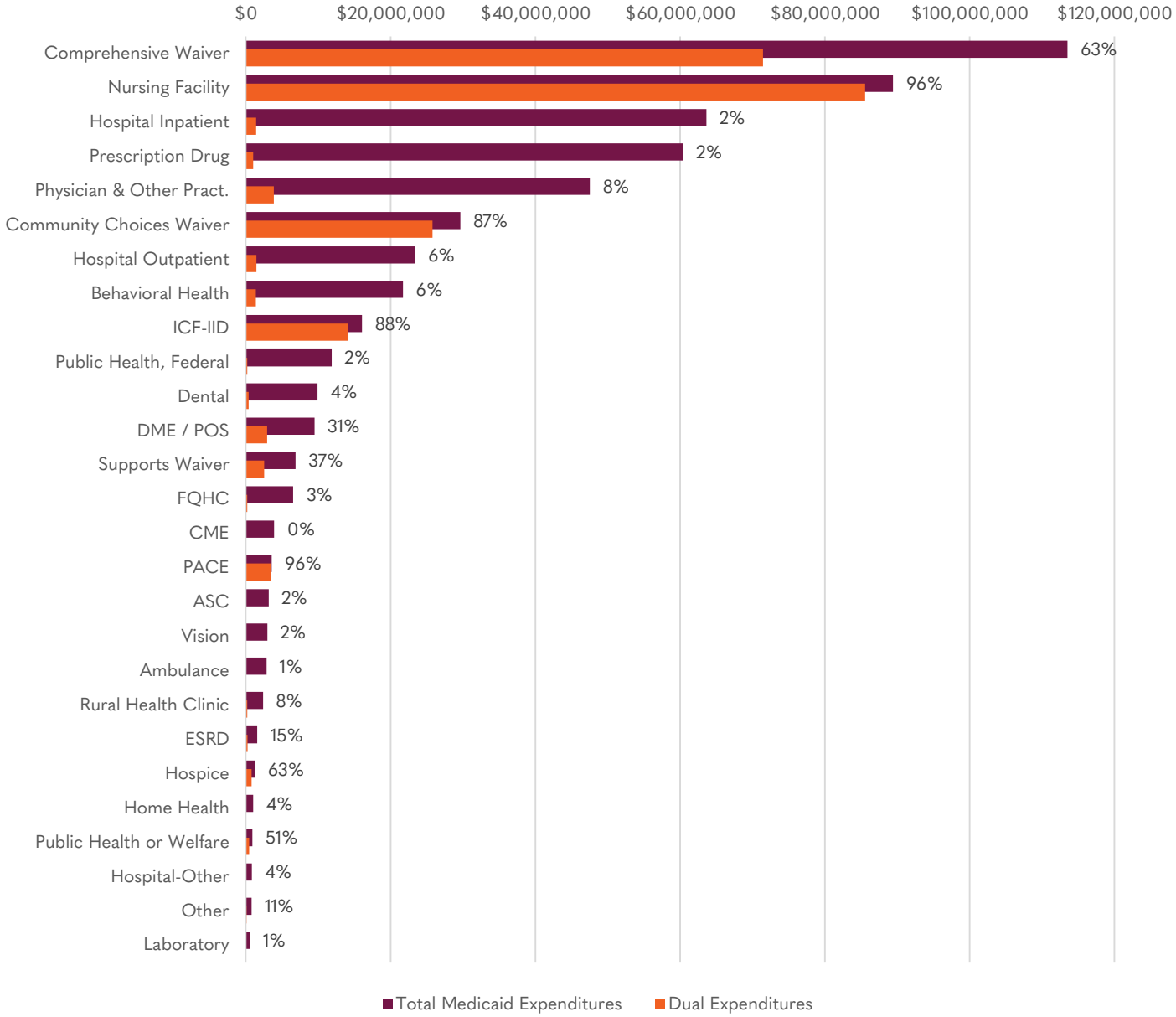



Figure 31. Dual Expenditures as Percent of Total Medicaid Expenditures by Service

## FOSTER CARE

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

**Medicaid Foster Care**

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

**State Foster Care**

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

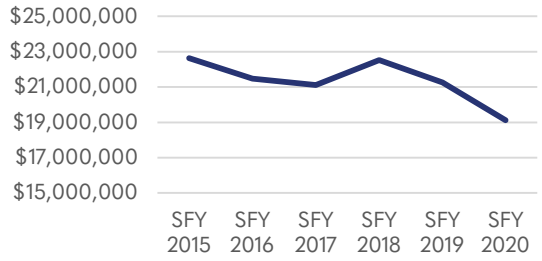
**243** children enrolled

**$1,214,600** in claims expenditures

EXPENDITURES

10%

$19,115,700




RECIPIENTS

5%

3,621

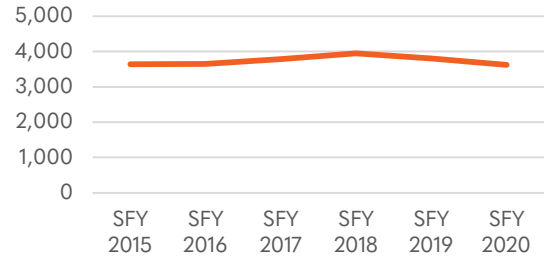



Table 60. Foster Care Summary[30]

| | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| **Medicaid Foster Care** | | | | | | | |
| Enrolled Members | 4,253 | 4,228 | 4,102 | 4,159 | 3,995 | 3,881 | -9 |
| Expenditures | $22,627,859 | $21,473,583 | $21,117,610 | $22,534,237 | $21,259,813 | $19,115,700 | -16 |
| Recipients | 3,635 | 3,649 | 3,783 | 3,946 | 3,802 | 3,621 | 0 |
| Expenditures per Recipient | $6,225 | $5,885 | $5,582 | $5,711 | $5,592 | $5,279 | -15 |
| **State-Only Foster Care** | | | | | | | |
| Enrolled Members | 211 | 203 | 310 | 316 | 282 | 243 | 15 |
| Expenditures | $2,809,733 | $2,281,501 | $1,753,782 | $1,787,501 | $1,736,824 | $1,214,600 | -57 |
| Recipients | 306 | 321 | 314 | 324 | 322 | 256 | -16 |
| Expenditures per Recipient | $9,182 | $7,107 | $5,585 | $5,517 | $5,394 | $4,745 | -48 |

[30] As claims data shown is based on paid date, not service date, the number of recipients may exceed the count of enrolled members as individuals may have claims paid up to one year after services are rendered, at which time they may no longer be enrolled in the program.

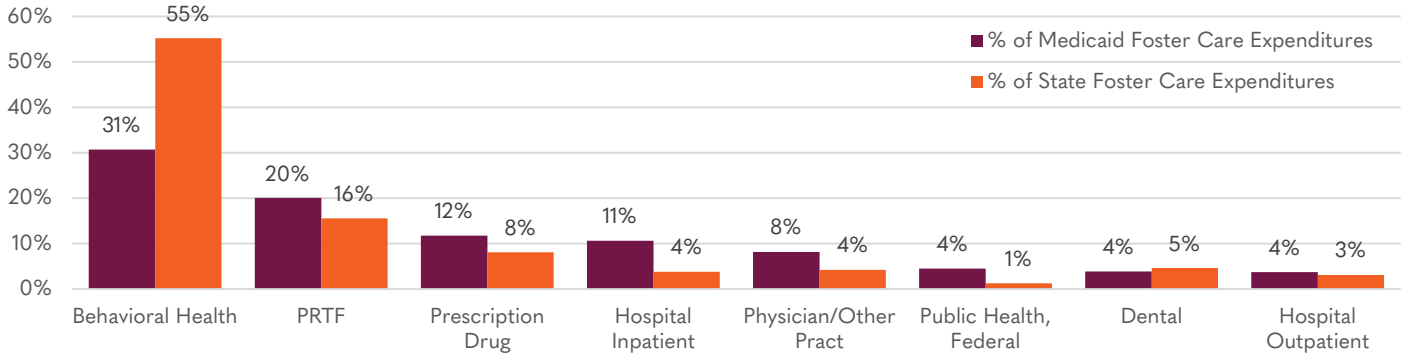



Figure 32. Percent of Foster Care Expenditures by Service - Medicaid versus State-Only

Table 61. Foster Care Summary by Services - Medicaid versus State-Only

| | Medicaid Foster Care | | | State-Only Foster Care | | |
|---|---|---|---|---|---|---|
| Service Area | Expenditures | Recipients[31] | Expenditures per Recipient | Expenditures | Recipients[31] | Expenditures per Recipient |
| Ambulance | $128,387 | 106 | $1,211 | $8,352 | 7 | $1,193 |
| Ambulatory Surgical Center | $138,351 | 85 | $1,628 | $5,301 | 2 | $2,651 |
| Behavioral Health | $5,859,713 | 1,724 | $3,399 | $670,611 | 217 | $3,090 |
| Care Management Entity (CME) | $0 | 1 | $0 | -- | -- | -- |
| Clinic/Center | $67,211 | 143 | $470 | -- | -- | -- |
| Dental | $735,148 | 1,838 | $400 | $55,956 | 141 | $397 |
| DME, Prosthetics/Orthotics/ Supplies | $133,612 | 168 | $795 | $996 | 6 | $166 |
| Federally Qualified Health Center | $304,345 | 304 | $1,001 | $8,098 | 8 | $1,012 |
| Home Health | $868 | 2 | $434 | -- | -- | -- |
| Hospital Total | $2,740,772 | 1469 | $1,866 | $83,762 | 93 | $901 |
| **Inpatient** | **$2,025,707** | **262** | **$7,732** | **$46,252** | **7** | **$6,607** |
| **Outpatient** | **$715,064** | **1,386** | **$516** | **$37,509** | **89** | **$421** |
| Laboratory | $17,532 | 146 | $120 | $1,091 | 17 | $64 |
| Other | $47,862 | 235 | $204 | $1,577 | 16 | $99 |
| Physician & Other Practitioner | $1,562,571 | 2,860 | $546 | $51,294 | 149 | $344 |
| Prescription Drug | $2,246,886 | 2,171 | $1,035 | $98,560 | 166 | $594 |
| PRTF | $3,828,570 | 112 | $34,184 | $188,740 | 9 | $20,971 |
| Public Health or Welfare | $9,335 | 148 | $63 | $2,407 | 47 | $51 |
| Public Health, Federal | $854,292 | 234 | $3,651 | $15,570 | 9 | $1,730 |
| Rural Health Clinic | $150,909 | 349 | $432 | $1,583 | 6 | $264 |
| Vision | $289,337 | 1,084 | $267 | $20,701 | 85 | $244 |
| Total | $19,115,700 | 3,621 | $5,279 | $1,214,600 | 256 | $4,745 |

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

# APPENDIX A: SUPPLEMENTAL TABLES

## SERVICES

Table 62. Behavioral Health Services by Provider Type

| Provider | Services Provided |
|---|---|
| **Behavioral Health Providers** | |
| Mental health and substance abuse treatment professionals through Community Mental Health Centers (CMHCs) and Substance Abuse Treatment Centers (SACs) | • Mental health assessments<br>• Individual group therapy<br>• Rehabilitation services<br>• Peer specialists services<br>• Targeted case management |
| Physicians, including psychiatrists, or other behavioral health practitioners who work under a physician, including:<br><br>- Masters level counselors (e.g. Licensed Addictions Therapists (LATs), Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), or Licensed Clinical Social Workers (LCSWs))<br><br>- Physician Assistants | • Medically necessary psychiatric services |
| Advanced practice mental health nurse practitioners<br><br>Independently practicing clinical psychologists<br><br>Mental health practitioners who work under a clinical psychologist<br><br>Masters level counselors (e.g. Licensed Addictions Therapists (LATs), Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), or Licensed Clinical Social Workers (LCSWs)) | • Behavioral health services |
| **Non-Behavioral Health Providers** | |
| Psychiatric Residential Treatment Facility | • Psychiatric residential treatment for individuals under age 21 |
| Wyoming State Hospital | • Admits patients considered to be a danger to themselves or others pursuant to Wyoming Statue on involuntary hospitalization<br>• Patients who are psychiatrically and medically fragile<br>• Persons whom the legal system placed in the hospital after classifying them as not competent to stand trial or who were found guilty of committing crimes due to mental illness |
| Stand-alone Inpatient Psychiatric Hospital | • Behavioral health services |

Table 63. Waiver Services by Waiver

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

* Service available for Assisted Living recipients only

# BIRTHS

Table 64. Wyoming Medicaid Births[33]

| Calendar Year | Wyoming Births | Medicaid Births | Medicaid % of Total |
|---|---|---|---|
| 2008 | 8,015 | 3,353 | 42% |
| 2009 | 7,841 | 3,401 | 43% |
| 2010 | 7,541 | 3,395 | 45% |
| 2011 | 7,339 | 3,166 | 43% |
| 2012 | 7,576 | 3,071 | 41% |
| 2013 | 7,617 | 3,026 | 40% |
| 2014 | 7,693 | 2,850 | 37% |
| 2015 | 7,715 | 2,757 | 36% |
| 2016 | 7,384 | 2,704 | 37% |
| 2017 | 6,904 | 2,439 | 35% |
| 2018 | 6,549 | 2,206 | 34% |
| 2019 | 6,566 | 2,148 | 33% |

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

# COUNTY DATA

Table 65. County Summary

| County | Enrolled Members[33] | % of Total Enrolled Members | Recipients[34] | % of Total Recipients | Expenditures | % of Total Expenditures |
|---|---|---|---|---|---|---|
| Albany | 3,311 | 4% | 3,050 | 4% | $21,684,714 | 4% |
| Big Horn | 1,983 | 3% | 1,833 | 3% | $13,890,775 | 3% |
| Campbell | 5,626 | 7% | 5,041 | 7% | $31,275,460 | 6% |
| Carbon | 1,801 | 2% | 1,606 | 2% | $7,866,696 | 1% |
| Converse | 1,723 | 2% | 1,559 | 2% | $10,893,185 | 2% |
| Crook | 775 | 1% | 708 | 1% | $3,741,969 | 1% |
| Fremont | 9,173 | 12% | 8,686 | 13% | $97,422,174 | 18% |
| Goshen | 1,672 | 2% | 1,532 | 2% | $13,404,887 | 2% |
| Hot Springs | 724 | 1% | 707 | 1% | $7,530,827 | 1% |
| Johnson | 889 | 1% | 778 | 1% | $5,679,055 | 1% |
| Laramie | 12,909 | 17% | 12,115 | 18% | $93,732,464 | 17% |
| Lincoln | 1,609 | 2% | 1,423 | 2% | $10,238,941 | 2% |
| Natrona | 12,063 | 16% | 11,238 | 16% | $84,535,060 | 16% |
| Niobrara | 289 | 0% | 251 | 0% | $1,826,213 | 0% |
| Other | 1,479 | 2% | 2,181 | 3% | $11,018,247 | 2% |
| Park | 3,412 | 5% | 3,138 | 5% | $22,900,489 | 4% |
| Platte | 1,108 | 1% | 985 | 1% | $6,390,797 | 1% |
| Sheridan | 3,593 | 5% | 3,303 | 5% | $24,488,719 | 5% |
| Sublette | 657 | 1% | 563 | 1% | $3,339,066 | 1% |
| Sweetwater | 5,465 | 7% | 4,929 | 7% | $30,349,337 | 6% |
| Teton | 1,055 | 1% | 935 | 1% | $5,190,315 | 1% |
| Uinta | 3,041 | 4% | 2,803 | 4% | $22,398,432 | 4% |
| Washakie | 1,096 | 1% | 997 | 1% | $7,904,714 | 1% |
| Weston | 770 | 1% | 717 | 1% | $5,566,622 | 1% |
| Overall | 75,360 | | 68,673 | | $543,792,374 | |

[33] Enrollment is based on Complete SFY.

[34] Recipients and Expenditures are based on recipient county of residence on file at the time the claim was processed in the MMIS. As recipients may move between counties, summing the county totals will not match the total recipient count shown. Recipients in "Other" county have moved out of the state prior to their claim being processed.

# PROVIDERS

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

Table 66. Provider Summary by Taxonomy - SFY 2020

| Provider Taxonomy | Providers | Recipients | Expenditures |
|---|---|---|---|
| Advanced Practice Midwife (367A00000X) | 4 | 27 | $27,464 |
| Allergy & Immunology, Allergy (207KA0200X) | 5 | 504 | $210,462 |
| Ambulance (341600000X) | 66 | 3,276 | $2,869,734 |
| Anesthesiology (207L00000X) | 56 | 6,723 | $2,387,211 |
| Audiologist (231H00000X) | 12 | 524 | $344,821 |
| Behavior Analyst (103K00000X) | 7 | 78 | $831,883 |
| Case Management (251B00000X) | 128 | 2,887 | $29,686,195 |
| Chiropractor (111N00000X) | 54 | 1,831 | $368,608 |
| Clinic/Center (261Q00000X) | 12 | 860 | $435,776 |
| Clinic/Center, Ambulatory Family Planning Facility (261QA0005X) | 5 | 198 | $48,668 |
| Clinic/Center, Ambulatory Surgical (261QA1903X) | 27 | 2,216 | $3,170,249 |
| Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X) | 15 | 171 | $1,595,216 |
| Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X) | 16 | 7,422 | $6,554,011 |
| Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X) | 27 | 4,166 | $3,943,838 |
| Clinic/Center, Public Health, Federal (261QP0904X) | 4 | 3,696 | $11,864,895 |
| Clinic/Center, Radiology, Mobile (261QR0208X) | 1 | 1 | $0 |
| Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X) | 1 | 54 | $22,394 |
| Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X) | 33 | 1,270 | $3,065,233 |
| Clinic/Center, Rural Health (261QR1300X) | 31 | 5,562 | $2,377,607 |
| Clinical Medical Laboratory (291U00000X) | 70 | 5,967 | $585,977 |
| Clinical Neuropsychologist (103G00000X) | 4 | 11 | $4,780 |
| Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X) | 10 | 843 | $278,963 |
| Community/Behavioral Health (251S00000X) | 1 | 927 | $3,928,461 |
| Counselor, Addiction (Substance Use Disorder) (101YA0400X) | 3 | 95 | $62,187 |
| Counselor, Professional (101YP2500X) | 155 | 2,412 | $4,184,775 |
| Day Training, Developmentally Disabled Services (251C00000X) | 659 | 2,749 | $114,351,936 |
| Dentist (122300000X) | 31 | 2,838 | $867,521 |
| Dentist, Endodontics (1223E0200X) | 4 | 67 | $52,182 |
| Dentist, General Practice (1223G0001X) | 121 | 10,436 | $3,089,844 |
| Dentist, Oral and Maxillofacial Surgery (1223S0112X) | 11 | 1,111 | $873,145 |
| Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X) | 14 | 277 | $261,832 |
| Dentist, Pediatric Dentistry (1223P0221X) | 33 | 12,111 | $4,749,104 |
| Dermatology (207N00000X) | 16 | 1,835 | $254,356 |
| Dietitian, Registered (133V00000X) | 2 | 5 | $697 |
| Durable Medical Equipment & Medical Supplies (332B00000X) | 202 | 7,204 | $8,174,433 |
| Emergency Medicine (207P00000X) | 29 | 15,935 | $3,400,286 |

| Provider Taxonomy (continued) | Providers | Recipients | Expenditures |
|---|---|---|---|
| Family Medicine (207Q00000X) | 86 | 20,904 | $5,163,045 |
| General Acute Care Hospital (282N00000X) | 103 | 30,689 | $75,855,320 |
| General Acute Care Hospital, Rural (282NR1301X) | 26 | 8,879 | $11,589,064 |
| Hearing Aid Equipment (332S00000X) | 9 | 250 | $775,873 |
| Home Health (251E00000X) | 23 | 239 | $1,004,397 |
| Hospice Care, Community Based (251G00000X) | 13 | 196 | $1,251,068 |
| Intermediate Care Facility, Intellectually Disabled (315P00000X) | 1 | 58 | $16,058,915 |
| Internal Medicine (207R00000X) | 57 | 13,655 | $6,517,068 |
| Internal Medicine, Cardiovascular Disease (207RC0000X) | 20 | 2,246 | $326,970 |
| Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X) | 4 | 163 | $23,002 |
| Internal Medicine, Gastroenterology (207RG0100X) | 6 | 1,164 | $423,968 |
| Internal Medicine, Geriatric Medicine (207RG0300X) | 5 | 196 | $43,886 |
| Internal Medicine, Medical Oncology (207RX0202X) | 4 | 369 | $2,155,922 |
| Internal Medicine, Nephrology (207RN0300X) | 6 | 334 | $73,053 |
| Internal Medicine, Pulmonary Disease (207RP1001X) | 8 | 333 | $91,720 |
| Internal Medicine, Rheumatology (207RR0500X) | 2 | 103 | $8,389 |
| Interpreter (171R00000X) | 2 | 71 | $9,096 |
| Lodging (177F00000X) | 2 | 192 | $108,735 |
| Marriage & Family Therapist (106H00000X) | 10 | 138 | $376,927 |
| Medical Genetics, Clinical Genetics (M.D.) (207SG0201X) | 1 | 18 | $3,083 |
| Medicare Defined Swing Bed Unit (275N00000X) | 12 | 38 | $557,037 |
| Midwife (176B00000X) | 3 | 23 | $14,782 |
| Neurological Surgery (207T00000X) | 9 | 193 | $88,516 |
| Nurse Anesthetist, Certified Registered (367500000X) | 13 | 437 | $86,639 |
| Nurse Practitioner (363L00000X) | 14 | 1,232 | $277,571 |
| Nurse Practitioner, Adult Health (363LA2200X) | 1 | 25 | $2,958 |
| Nurse Practitioner, Family (363LF0000X) | 23 | 1,792 | $338,367 |
| Nurse Practitioner, Pediatrics (363LP0200X) | 3 | 74 | $16,328 |
| Obstetrics & Gynecology (207V00000X) | 27 | 3,066 | $3,657,589 |
| Obstetrics & Gynecology, Gynecology (207VG0400X) | 4 | 196 | $94,634 |
| Obstetrics & Gynecology, Obstetrics (207VX0000X) | 4 | 473 | $474,269 |
| Occupational Therapist (225X00000X) | 14 | 479 | $1,630,049 |
| Ophthalmology (207W00000X) | 32 | 1,767 | $542,002 |
| Optometrist (152W00000X) | 77 | 12,557 | $2,930,037 |
| Orthopaedic Surgery (207X00000X) | 30 | 4,126 | $1,344,579 |
| Otolaryngology (207Y00000X) | 15 | 2,008 | $523,531 |
| Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X) | 14 | 1,749 | $80,615 |
| Pediatrics (208000000X) | 69 | 10,800 | $3,931,381 |
| Pediatrics, Neonatal-Perinatal Medicine (2080N0001X) | 4 | 65 | $283,124 |
| Pharmacy (333600000X) | 205 | 36,994 | $60,432,330 |
| Physical Medicine & Rehabilitation (208100000X) | 14 | 294 | $123,650 |
| Physical Therapist (225100000X) | 66 | 2,891 | $2,316,327 |
| Physician Assistant (363A00000X) | 5 | 165 | $26,466 |

| Provider Taxonomy (continued) | Providers | Recipients | Expenditures |
|---|---|---|---|
| Physician, General Practice (208D00000X) | 61 | 20,122 | $7,102,883 |
| Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X) | 8 | 27 | $16,093 |
| Podiatrist (213E00000X) | 14 | 962 | $42,304 |
| Private Vehicle (347C00000X) | 3 | 41 | $12,973 |
| Program of All-Inclusive Care for the Elderly (PACE) Provider Organization (251T00000X) | 1 | 186 | $3,586,650 |
| Prosthetic/Orthotic Supplier (335E00000X) | 28 | 585 | $540,444 |
| Psychiatric Hospital (283Q00000X) | 4 | 6 | $21,285 |
| Psychiatric Residential Treatment Facility (323P00000X) | 13 | 221 | $7,334,441 |
| Psychiatry & Neurology, Neurology (2084N0400X) | 21 | 1,548 | $331,694 |
| Psychiatry & Neurology, Psychiatry (2084P0800X) | 21 | 881 | $1,570,802 |
| Psychologist, Clinical (103TC0700X) | 59 | 2,493 | $4,442,052 |
| Public Health or Welfare (251K00000X) | 24 | 7,465 | $894,081 |
| Radiology, Diagnostic Radiology (2085R0202X) | 44 | 16,454 | $1,538,606 |
| Rehabilitation Hospital (283X00000X) | 2 | 131 | $408,441 |
| Skilled Nursing Facility (314000000X) | 56 | 2,806 | $88,869,925 |
| Social Worker, Clinical (1041C0700X) | 94 | 2,067 | $2,944,089 |
| Specialist (174400000X) | 4 | 359 | $60,043 |
| Speech-Language Pathologist (235Z00000X) | 10 | 313 | $411,291 |
| Supports Brokerage (251X00000X) | 1 | 435 | $6,172,411 |
| Surgery (208600000X) | 31 | 1,531 | $502,970 |
| Surgery, Pediatric Surgery (2086S0120X) | 5 | 50 | $33,952 |
| Surgery, Vascular Surgery (2086S0129X) | 4 | 51 | $26,205 |
| Taxi (344600000X) | 1 | 179 | $36,725 |
| Technician/Technologist, Optician (156FX1800X) | 6 | 372 | $47,032 |
| Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X) | 2 | 12 | $11,947 |
| Urology (208800000X) | 12 | 1,151 | $235,121 |
| Unclassified | 1 | 20 | $40,885 |
| Total | 3,445 | 68,673 | $543,792,374 |

Table 67. Top 20 Provider Taxonomies by Expenditures

| Provider Taxonomy | Expenditures | Percent of Total Medicaid Expenditures |
|---|---|---|
| Day Training, Developmentally Disabled Services (251C00000X) | $114,351,936 | 21% |
| Skilled Nursing Facility (314000000X) | $88,869,925 | 15% |
| General Acute Care Hospital (282N00000X) | $75,855,320 | 15% |
| Pharmacy (333600000X) | $60,432,330 | 11% |
| Case Management (251B00000X) | $29,686,195 | 5% |
| Intermediate Care Facility, Intellectually Disabled (315P00000X) | $16,058,915 | 2% |
| Clinic/Center, Public Health, Federal (261QP0904X) | $11,864,895 | 2% |
| General Acute Care Hospital, Rural (282NR1301X) | $11,589,064 | 2% |
| Durable Medical Equipment & Medical Supplies (332B00000X) | $8,174,433 | 2% |
| Psychiatric Residential Treatment Facility (323P00000X) | $7,334,441 | 1% |
| Physician, General Practice (208D00000X) | $7,102,883 | 1% |
| Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X) | $6,554,011 | 1% |
| Internal Medicine (207R00000X) | $6,517,068 | 1% |
| Supports Brokerage (251X00000X) | $6,172,411 | 1% |
| Family Medicine (207Q00000X) | $5,163,045 | 1% |
| Dentist, Pediatric Dentistry (1223P0221X) | $4,749,104 | 1% |
| Psychologist, Clinical (103TC0700X) | $4,442,052 | 1% |
| Counselor, Professional (101YP2500X) | $4,184,775 | 1% |
| Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X) | $3,943,838 | 1% |
| Pediatrics (208000000X) | $3,931,381 | 1% |
| Total for Top 20 Providers | $476,978,023 | 88% |

Table 68. Provider Count History by Taxonomy

| Provider Taxonomy | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Advanced Practice Midwife (367A00000X) | 5 | 9 | 7 | 8 | 4 | 4 | -20 |
| Allergy & Immunology, Allergy (207KA0200X) | 10 | 9 | 6 | 5 | 5 | 5 | -50 |
| Ambulance (341600000X) | 72 | 68 | 64 | 63 | 73 | 66 | -8 |
| Anesthesiology (207L00000X) | 81 | 87 | 73 | 78 | 73 | 56 | -31 |
| Audiologist (231H00000X) | 17 | 15 | 14 | 12 | 13 | 12 | -29 |
| Behavior Analyst (103K00000X) | -- | -- | -- | 5 | 3 | 7 | -- |
| Case Management (251B00000X) | 101 | 101 | 115 | 114 | 120 | 128 | 27 |
| Chiropractor (111N00000X) | 13 | 34 | 50 | 52 | 54 | 54 | 315 |
| Clinic/Center (261Q00000X) | 12 | 12 | 14 | 23 | 12 | 12 | 0 |
| Clinic/Center, Ambulatory Family Planning Facility (261QA0005X) | 9 | 9 | 9 | 7 | 7 | 5 | -44 |
| Clinic/Center, Ambulatory Surgical (261QA1903X) | 34 | 33 | 28 | 28 | 31 | 27 | -21 |
| Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X) | 13 | 14 | 15 | 15 | 16 | 15 | 15 |
| Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X) | 10 | 9 | 12 | 11 | 11 | 16 | 60 |

| Provider Taxonomy (continued) | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X) | 27 | 27 | 27 | 26 | 26 | 27 | 0 |
| Clinic/Center, Public Health, Federal (261QP0904X) | 2 | 4 | 4 | 4 | 5 | 4 | 100 |
| Clinic/Center, Radiology, Mobile (261QR0208X) | 1 | 2 | | | | 1 | 0 |
| Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X) | 1 | 1 | 1 | 1 | 1 | 1 | 0 |
| Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X) | 32 | 32 | 31 | 32 | 33 | 33 | 3 |
| Clinic/Center, Rural Health (261QR1300X) | 22 | 23 | 21 | 24 | 32 | 31 | 41 |
| Clinical Medical Laboratory (291U00000X) | 84 | 90 | 85 | 74 | 71 | 70 | -17 |
| Clinical Neuropsychologist (103G00000X) | 2 | 2 | 1 | 4 | 4 | 4 | 100 |
| Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X) | 9 | 12 | 14 | 12 | 9 | 10 | 11 |
| Community/Behavioral Health (251S00000X) | -- | 1 | 1 | 1 | 1 | 1 | -- |
| Counselor, Addiction (Substance Use Disorder) (101YA0400X) | 2 | 4 | 4 | 3 | 3 | 3 | 50 |
| Counselor, Professional (101YP2500X) | 64 | 97 | 123 | 138 | 145 | 155 | 142 |
| Day Training, Developmentally Disabled Services (251C00000X) | 665 | 614 | 629 | 649 | 656 | 659 | -1 |
| Dentist (122300000X) | 35 | 28 | 29 | 27 | 29 | 31 | -11 |
| Dentist, Endodontics (1223E0200X) | 5 | 5 | 3 | 3 | 2 | 4 | -20 |
| Dentist, General Practice (1223G0001X) | 154 | 149 | 137 | 130 | 129 | 121 | -21 |
| Dentist, Oral and Maxillofacial Surgery (1223S0112X) | 17 | 14 | 16 | 11 | 13 | 11 | -35 |
| Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X) | 14 | 16 | 17 | 15 | 17 | 14 | 0 |
| Dentist, Pediatric Dentistry (1223P0221X) | 33 | 34 | 32 | 34 | 32 | 33 | 0 |
| Dentist, Periodontics (1223P0300X) | 1 | 1 | -- | -- | -- | -- | -100 |
| Dermatology (207N00000X) | 17 | 15 | 13 | 15 | 17 | 16 | -6 |
| Dietitian, Registered (133V00000X) | -- | -- | 1 | 2 | 2 | 2 | -- |
| Durable Medical Equipment & Medical Supplies (332B00000X) | 255 | 246 | 234 | 231 | 222 | 202 | -21 |
| Emergency Medicine (207P00000X) | 38 | 39 | 36 | 32 | 32 | 29 | -24 |
| Family Medicine (207Q00000X) | 99 | 88 | 86 | 84 | 93 | 86 | -13 |
| General Acute Care Hospital (282N00000X) | 193 | 190 | 114 | 114 | 112 | 103 | -47 |
| General Acute Care Hospital, Rural (282NR1301X) | 36 | 42 | 36 | 30 | 27 | 26 | -28 |
| Hearing Aid Equipment (332S00000X) | 16 | 12 | 11 | 9 | 8 | 9 | -44 |
| Home Health (251E00000X) | 33 | 30 | 29 | 25 | 23 | 23 | -30 |
| Hospice Care, Community Based (251G00000X) | 14 | 11 | 12 | 13 | 12 | 13 | -7 |
| Intermediate Care Facility, Intellectually Disabled (315P00000X) | 1 | 1 | 1 | 1 | 1 | 1 | 0 |
| Internal Medicine (207R00000X) | 60 | 68 | 55 | 57 | 60 | 57 | -5 |

| Provider Taxonomy (continued) | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Internal Medicine, Cardiovascular Disease (207RC0000X) | 17 | 26 | 17 | 18 | 19 | 20 | 18 |
| Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X) | 7 | 8 | 4 | 4 | 4 | 4 | -43 |
| Internal Medicine, Gastroenterology (207RG0100X) | 6 | 9 | 4 | 6 | 6 | 6 | 0 |
| Internal Medicine, Geriatric Medicine (207RG0300X) | 2 | 2 | 4 | 4 | 5 | 5 | 150 |
| Internal Medicine, Medical Oncology (207RX0202X) | 12 | 11 | 7 | 6 | 4 | 4 | -67 |
| Internal Medicine, Nephrology (207RN0300X) | 9 | 9 | 6 | 6 | 7 | 6 | -33 |
| Internal Medicine, Pulmonary Disease (207RP1001X) | 13 | 12 | 11 | 9 | 10 | 8 | -38 |
| Internal Medicine, Rheumatology (207RR0500X) | 4 | 4 | 2 | 2 | 2 | 2 | -50 |
| Interpreter (171R00000X) | 1 | 1 | 1 | 2 | 3 | 2 | 100 |
| Lodging (177F00000X) | -- | -- | 2 | 3 | 2 | 2 | -- |
| Marriage & Family Therapist (106H00000X) | 8 | 10 | 15 | 13 | 15 | 10 | 25 |
| Medical Genetics, Clinical Genetics (M.D.) (207SG0201X) | -- | -- | 1 | 1 | 1 | 1 | -- |
| Medicare Defined Swing Bed Unit (275N00000X) | 9 | 10 | 11 | 15 | 11 | 12 | 33 |
| Midwife (176B00000X) | -- | -- | -- | -- | -- | 3 | -- |
| Neurological Surgery (207T00000X) | 14 | 16 | 12 | 10 | 10 | 9 | -36 |
| Nurse Anesthetist, Certified Registered (367500000X) | 23 | 21 | 16 | 13 | 14 | 13 | -43 |
| Nurse Practitioner (363L00000X) | 10 | 10 | 9 | 9 | 14 | 14 | 40 |
| Nurse Practitioner, Adult Health (363LA2200X) | 1 | 1 | 1 | 1 | 1 | 1 | 0 |
| Nurse Practitioner, Family (363LF0000X) | 17 | 16 | 15 | 12 | 16 | 23 | 35 |
| Nurse Practitioner, Obstetrics & Gynecology (363LX0001X) | 2 | 1 | -- | -- | -- | -- | -100 |
| Nurse Practitioner, Pediatrics (363LP0200X) | 1 | 2 | 2 | 2 | 2 | 3 | 200 |
| Obstetrics & Gynecology (207V00000X) | 48 | 48 | 40 | 33 | 28 | 27 | -44 |
| Obstetrics & Gynecology, Gynecology (207VG0400X) | 5 | 6 | 5 | 5 | 3 | 4 | -20 |
| Obstetrics & Gynecology, Obstetrics (207VX0000X) | 2 | 5 | 5 | 5 | 5 | 4 | 100 |
| Occupational Therapist (225X00000X) | 18 | 20 | 21 | 20 | 17 | 14 | -22 |
| Ophthalmology (207W00000X) | 36 | 34 | 25 | 30 | 32 | 32 | -11 |
| Optometrist (152W00000X) | 102 | 98 | 93 | 89 | 80 | 77 | -25 |
| Orthopaedic Surgery (207X00000X) | 35 | 37 | 36 | 34 | 32 | 30 | -14 |
| Otolaryngology (207Y00000X) | 26 | 27 | 24 | 19 | 18 | 15 | -42 |
| Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X) | 22 | 22 | 19 | 17 | 16 | 14 | -36 |
| Pediatrics (208000000X) | 72 | 73 | 97 | 76 | 67 | 69 | -4 |
| Pediatrics, Neonatal-Perinatal Medicine (2080N0001X) | 8 | 6 | 5 | 5 | 3 | 4 | -50 |
| Pharmacy (333600000X) | 206 | 207 | 205 | 208 | 206 | 205 | 0 |

| Provider Taxonomy (continued) | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Physical Medicine & Rehabilitation (208100000X) | 14 | 17 | 14 | 12 | 15 | 14 | 0 |
| Physical Therapist (225100000X) | 61 | 60 | 63 | 62 | 67 | 66 | 8 |
| Physician Assistant (363A00000X) | 1 | 1 | 1 | 1 | 3 | 5 | 400 |
| Physician, General Practice (208D00000X) | 74 | 81 | 67 | 62 | 58 | 61 | -18 |
| Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X) | 15 | 10 | 11 | 11 | 7 | 8 | -47 |
| Podiatrist (213E00000X) | 17 | 16 | 13 | 11 | 15 | 14 | -18 |
| Private Vehicle (347C00000X) | -- | -- | 4 | 4 | 6 | 3 | -- |
| Program of All-Inclusive Care for the Elderly (PACE) Provider Organization (251T00000X) | 1 | 1 | 1 | 1 | 1 | 1 | 0 |
| Prosthetic/Orthotic Supplier (335E00000X) | 31 | 27 | 26 | 31 | 28 | 28 | -10 |
| Psychiatric Hospital (283Q00000X) | 4 | 2 | 3 | 3 | 3 | 4 | 0 |
| Psychiatric Residential Treatment Facility (323P00000X) | 20 | 17 | 14 | 13 | 16 | 13 | -35 |
| Psychiatry & Neurology, Neurology (2084N0400X) | 27 | 26 | 20 | 19 | 22 | 21 | -22 |
| Psychiatry & Neurology, Psychiatry (2084P0800X) | 35 | 32 | 31 | 26 | 25 | 21 | -40 |
| Psychologist, Clinical (103TC0700X) | 122 | 96 | 76 | 69 | 60 | 59 | -52 |
| Public Health or Welfare (251K00000X) | 24 | 24 | 24 | 24 | 24 | 24 | 0 |
| Radiology, Diagnostic Radiology (2085R0202X) | 49 | 45 | 46 | 49 | 46 | 44 | -10 |
| Rehabilitation Hospital (283X00000X) | 4 | 3 | 2 | 3 | 3 | 2 | -50 |
| Residential Treatment Facility, Emotionally Disturbed Children (322D00000X) | 1 | 3 | -- | -- | -- | -- | -100 |
| Skilled Nursing Facility (314000000X) | 51 | 53 | 53 | 52 | 56 | 56 | 10 |
| Social Worker, Clinical (1041C0700X) | 43 | 60 | 74 | 77 | 84 | 94 | 119 |
| Specialist (174400000X) | -- | -- | -- | 7 | 7 | 4 | -- |
| Speech-Language Pathologist (235Z00000X) | 13 | 10 | 9 | 9 | 10 | 10 | -23 |
| Supports Brokerage (251X00000X) | 1 | 1 | 2 | 1 | 1 | 1 | 0 |
| Surgery (208600000X) | 38 | 43 | 33 | 30 | 30 | 31 | -18 |
| Surgery, Pediatric Surgery (2086S0120X) | 2 | 3 | 5 | 2 | 2 | 5 | 150 |
| Surgery, Vascular Surgery (2086S0129X) | 5 | 6 | 4 | 4 | 5 | 4 | -20 |
| Taxi (344600000X) | -- | -- | 1 | 1 | 1 | 1 | -- |
| Technician, Pathology, Phlebotomy (246RP1900X) | 1 | 1 | -- | -- | -- | -- | -100 |
| Technician/Technologist, Optician (156FX1800X) | 11 | 9 | 6 | 6 | 6 | 6 | -45 |
| Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X) | 4 | 5 | 3 | 2 | 2 | 2 | -50 |
| Urology (208800000X) | 18 | 17 | 16 | 13 | 13 | 12 | -33 |
| Unclassified | 1 | 2 | 1 | 1 | 1 | 1 | 0 |
| Total | 3,733 | 3,721 | 3,548 | 3,505 | 3,509 | 3,445 | -8 |

Table 69. Provider Expenditures History by Taxonomy

| Eligibility Category | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Advanced Practice Midwife (367A00000X) | $19,041 | $51,381 | $89,855 | $64,608 | $31,747 | $27,464 | 44 |
| Allergy & Immunology, Allergy (207KA0200X) | $473,744 | $444,553 | $372,655 | $396,665 | $282,684 | $210,462 | -56 |
| Ambulance (341600000X) | $4,352,067 | $3,571,623 | $3,847,375 | $2,381,969 | $3,543,958 | $2,869,734 | -34 |
| Anesthesiology (207L00000X) | $2,519,148 | $2,568,307 | $2,697,539 | $2,488,633 | $2,449,632 | $2,387,211 | -5 |
| Audiologist (231H00000X) | $134,326 | $123,718 | $158,494 | $229,847 | $141,981 | $344,821 | 157 |
| Behavior Analyst (103K00000X) | -- | -- | -- | $167,595 | $533,209 | $831,883 | -- |
| Case Management (251B00000X) | $16,927,792 | $20,056,038 | $21,007,543 | $27,226,271 | $29,146,077 | $29,686,195 | 75 |
| Chiropractor (111N00000X) | $6,347 | $99,664 | $280,207 | $347,441 | $406,862 | $368,608 | 5,707 |
| Clinic/Center (261Q00000X) | $1,339,630 | $1,361,953 | $1,327,800 | $972,701 | $815,334 | $435,776 | -67 |
| Clinic/Center, Ambulatory Family Planning Facility (261QA0005X) | $69,754 | $55,497 | $62,853 | $51,449 | $51,977 | $48,668 | -30 |
| Clinic/Center, Ambulatory Surgical (261QA1903X) | $6,090,776 | $5,953,159 | $4,095,973 | $3,881,705 | $3,555,184 | $3,170,249 | -48 |
| Clinic/Center, End-Stage Renal Disease (ESRD) Treatment (261QE0700X) | $1,099,569 | $948,612 | $1,267,034 | $1,012,427 | $1,063,315 | $1,595,216 | 45 |
| Clinic/Center, Federally Qualified Health Center (FQHC) (261QF0400X) | $3,259,793 | $3,689,548 | $5,725,094 | $11,418,874 | $5,776,571 | $6,554,011 | 101 |
| Clinic/Center, Mental Health (Including Community Mental Health Center) (261QM0801X) | $8,668,925 | $7,930,515 | $7,681,061 | $6,188,978 | $5,378,811 | $3,943,838 | -55 |
| Clinic/Center, Public Health, Federal (261QP0904X) | $8,761,358 | $8,479,944 | $8,718,888 | $19,625,445 | $12,488,676 | $11,864,895 | 35 |
| Clinic/Center, Radiology, Mobile (261QR0208X) | $52 | $7 | | | | $0 | -100 |
| Clinic/Center, Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF) (261QR0401X) | $154,682 | $146,226 | $84,406 | $29,156 | $26,024 | $22,394 | -86 |
| Clinic/Center, Rehabilitation, Substance Use Disorder (261QR0405X) | $4,793,708 | $3,895,890 | $2,997,914 | $2,939,968 | $2,793,311 | $3,065,233 | -36 |
| Clinic/Center, Rural Health (261QR1300X) | $1,668,167 | $1,413,842 | $1,540,607 | $1,894,505 | $2,283,377 | $2,377,607 | 43 |
| Clinical Medical Laboratory (291U00000X) | $1,516,042 | $1,536,310 | $844,218 | $1,020,356 | $719,701 | $585,977 | -61 |
| Clinical Neuropsychologist (103G00000X) | $2,071 | $642 | $6,824 | $24,628 | $25,943 | $4,780 | 131 |
| Clinical Nurse Specialist, Psychiatric/Mental Health (364SP0808X) | $319,007 | $286,789 | $335,697 | $363,266 | $326,066 | $278,963 | -13 |
| Community/Behavioral Health (251S00000X) | -- | $5,021,978 | $7,135,148 | $7,599,455 | $3,290,255 | $3,928,461 | -- |
| Counselor, Addiction (Substance Use Disorder) (101YA0400X) | $10,121 | $112,463 | $235,019 | $207,018 | $210,373 | $62,187 | 514 |
| Counselor, Professional (101YP2500X) | $2,338,814 | $3,676,332 | $5,605,555 | $5,024,798 | $4,176,857 | $4,184,775 | 79 |

| Eligibility Category (Continued) | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Day Training, Developmentally Disabled Services (251C00000X) | $94,141,526 | $93,766,911 | $95,950,535 | $100,791,096 | $113,656,959 | $114,351,936 | 21 |
| Dentist (122300000X) | $1,345,202 | $1,445,036 | $1,468,732 | $1,051,336 | $962,164 | $867,521 | -36 |
| Dentist, Endodontics (1223E0200X) | $125,417 | $51,569 | $43,105 | $52,582 | $49,611 | $52,182 | -58 |
| Dentist, General Practice (1223G0001X) | $6,400,779 | $7,171,071 | $6,085,423 | $4,331,962 | $3,985,182 | $3,089,844 | -52 |
| Dentist, Oral and Maxillofacial Surgery (1223S0112X) | $1,045,169 | $1,225,956 | $1,132,105 | $1,106,227 | $879,442 | $873,145 | -16 |
| Dentist, Orthodontics and Dentofacial Orthopedics (1223X0400X) | $406,253 | $547,443 | $543,829 | $368,831 | $420,012 | $261,832 | -36 |
| Dentist, Pediatric Dentistry (1223P0221X) | $5,148,703 | $5,008,474 | $4,894,424 | $4,936,642 | $5,007,670 | $4,749,104 | -8 |
| Dentist, Periodontics (1223P0300X) | $2,341 | $480 | -- | -- | -- | -- | -100 |
| Dermatology (207N00000X) | $276,343 | $253,755 | $272,569 | $300,262 | $271,678 | $254,356 | -8 |
| Dietitian, Registered (133V00000X) | -- | -- | $391 | $1,803 | $617 | $697 | -- |
| Durable Medical Equipment & Medical Supplies (332B00000X) | $6,970,432 | $6,610,828 | $7,360,167 | $6,944,732 | $7,850,643 | $8,174,433 | 17 |
| Emergency Medicine (207P00000X) | $3,862,924 | $3,198,766 | $4,130,517 | $4,026,740 | $3,855,001 | $3,400,286 | -12 |
| Family Medicine (207Q00000X) | $5,824,202 | $6,384,974 | $6,805,220 | $6,424,856 | $5,746,636 | $5,163,045 | -11 |
| General Acute Care Hospital (282N00000X) | $86,971,143 | $91,167,750 | $83,353,763 | $84,380,731 | $84,697,383 | $75,855,320 | -13 |
| General Acute Care Hospital, Rural (282NR1301X) | $16,389,825 | $15,380,672 | $14,474,403 | $11,942,563 | $12,195,829 | $11,589,064 | -29 |
| Hearing Aid Equipment (332S00000X) | $940,058 | $790,555 | $912,176 | $831,358 | $567,915 | $775,873 | -17 |
| Home Health (251E00000X) | $4,618,885 | $9,467,835 | $9,596,803 | $4,012,083 | $570,570 | $1,004,397 | -78 |
| Hospice Care, Community Based (251G00000X) | $1,157,101 | $1,014,959 | $1,316,838 | $1,394,149 | $1,190,302 | $1,251,068 | 8 |
| Intermediate Care Facility, Intellectually Disabled (315P00000X) | $18,091,427 | $18,193,221 | $19,204,867 | $13,999,444 | $12,901,888 | $16,058,915 | -11 |
| Internal Medicine (207R00000X) | $4,966,149 | $6,899,612 | $7,938,991 | $7,076,336 | $7,075,072 | $6,517,068 | 31 |
| Internal Medicine, Cardiovascular Disease (207RC0000X) | $437,224 | $388,767 | $419,095 | $291,341 | $302,157 | $326,970 | -25 |
| Internal Medicine, Endocrinology, Diabetes & Metabolism (207RE0101X) | $37,657 | $19,270 | $22,999 | $18,807 | $21,509 | $23,002 | -39 |
| Internal Medicine, Gastroenterology (207RG0100X) | $377,353 | $442,390 | $495,528 | $550,096 | $479,940 | $423,968 | 12 |
| Internal Medicine, Geriatric Medicine (207RG0300X) | $17,669 | $20,590 | $27,816 | $12,796 | $43,908 | $43,886 | 148 |
| Internal Medicine, Medical Oncology (207RX0202X) | $2,493,943 | $1,632,500 | $2,469,020 | $2,756,577 | $1,914,670 | $2,155,922 | -14 |
| Internal Medicine, Nephrology (207RN0300X) | $54,404 | $51,808 | $26,828 | $37,495 | $64,890 | $73,053 | 34 |
| Internal Medicine, Pulmonary Disease (207RP1001X) | $83,584 | $77,414 | $147,096 | $102,784 | $121,574 | $91,720 | 10 |
| Internal Medicine, Rheumatology (207RR0500X) | $49,969 | $15,778 | $18,310 | $13,849 | $13,841 | $8,389 | -83 |

| Eligibility Category (Continued) | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Interpreter (171R00000X) | $56,339 | $47,205 | $32,056 | $22,119 | $5,799 | $9,096 | -84 |
| Lodging (177F00000X) | -- | -- | $53,950 | $85,915 | $127,715 | $108,735 | -- |
| Marriage & Family Therapist (106H00000X) | $161,044 | $280,470 | $298,392 | $510,758 | $391,014 | $376,927 | 134 |
| Medical Genetics, Clinical Genetics (M.D.) (207SG0201X) | -- | -- | $2,583 | $6,455 | $3,266 | $3,083 | -- |
| Medicare Defined Swing Bed Unit (275N00000X) | $833,841 | $775,338 | $462,413 | $620,073 | $479,918 | $557,037 | -33 |
| Midwife (176B00000X) | -- | -- | -- | -- | -- | $14,782 | -- |
| Neurological Surgery (207T00000X) | $955,405 | $536,628 | $251,854 | $69,210 | $75,191 | $88,516 | -91 |
| Nurse Anesthetist, Certified Registered (367500000X) | $227,083 | $189,955 | $73,627 | $65,899 | $78,819 | $86,639 | -62 |
| Nurse Practitioner (363L00000X) | $336,154 | $336,366 | $297,224 | $142,851 | $200,823 | $277,571 | -17 |
| Nurse Practitioner, Adult Health (363LA2200X) | $1,791 | $1,789 | $7 | $2,582 | $2,284 | $2,958 | 65 |
| Nurse Practitioner, Family (363LF0000X) | $368,970 | $311,405 | $268,262 | $246,169 | $251,881 | $338,367 | -8 |
| Nurse Practitioner, Obstetrics & Gynecology (363LX0001X) | $6,019 | $7,023 | -- | -- | -- | -- | -100 |
| Nurse Practitioner, Pediatrics (363LP0200X) | $10,995 | $12,213 | $20,832 | $20,745 | $15,922 | $16,328 | 49 |
| Obstetrics & Gynecology (207V00000X) | $6,832,110 | $5,733,312 | $4,887,444 | $4,563,484 | $3,814,652 | $3,657,589 | -46 |
| Obstetrics & Gynecology, Gynecology (207VG0400X) | $11,932 | $80,997 | $164,003 | $134,985 | $93,676 | $94,634 | 693 |
| Obstetrics & Gynecology, Obstetrics (207VX0000X) | $10,974 | $417,994 | $655,371 | $534,587 | $503,347 | $474,269 | 4,222 |
| Occupational Therapist (225X00000X) | $2,260,765 | $3,053,289 | $3,199,864 | $2,904,323 | $1,884,711 | $1,630,049 | -28 |
| Ophthalmology (207W00000X) | $690,214 | $606,722 | $604,685 | $584,656 | $574,291 | $542,002 | -21 |
| Optometrist (152W00000X) | $3,521,016 | $3,571,953 | $3,782,521 | $3,656,808 | $3,409,020 | $2,930,037 | -17 |
| Orthopaedic Surgery (207X00000X) | $1,422,229 | $1,404,323 | $1,628,003 | $1,534,594 | $1,222,153 | $1,344,579 | -5 |
| Otolaryngology (207Y00000X) | $957,868 | $895,930 | $917,671 | $795,300 | $679,438 | $523,531 | -45 |
| Pathology, Clinical Pathology/Laboratory Medicine (207ZP0105X) | $170,879 | $164,404 | $145,815 | $142,709 | $83,620 | $80,615 | -53 |
| Pediatrics (208000000X) | $5,662,679 | $5,455,184 | $5,310,575 | $4,878,853 | $4,681,066 | $3,931,381 | -31 |
| Pediatrics, Neonatal-Perinatal Medicine (2080N0001X) | $452,942 | $248,989 | $227,825 | $295,963 | $208,703 | $283,124 | -37 |
| Pharmacy (333600000X) | $47,785,528 | $48,325,155 | $50,007,275 | $57,006,524 | $61,385,109 | $60,432,330 | 26 |
| Physical Medicine & Rehabilitation (208100000X) | $191,749 | $128,026 | $111,247 | $119,039 | $137,136 | $123,650 | -36 |
| Physical Therapist (225100000X) | $2,917,423 | $3,382,286 | $3,286,973 | $2,653,095 | $2,491,622 | $2,316,327 | -21 |
| Physician Assistant (363A00000X) | $589 | $577 | $86 | $4,294 | $21,168 | $26,466 | 4,397 |
| Physician, General Practice (208D00000X) | $10,113,348 | $7,598,341 | $7,254,319 | $7,406,209 | $7,372,159 | $7,102,883 | -30 |
| Plastic Surgery, Plastic Surgery Within the Head and Neck (2082S0099X) | $116,240 | $90,174 | $85,222 | $22,339 | $22,049 | $16,093 | -86 |

| Eligibility Category (Continued) | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | 5 Year % Change |
|---|---|---|---|---|---|---|---|
| Podiatrist (213E00000X) | $78,388 | $79,404 | $72,405 | $58,482 | $47,751 | $42,304 | -46 |
| Private Vehicle (347C00000X) | -- | -- | $7,329 | $11,145 | $18,455 | $12,973 | -- |
| Program of All-Inclusive Care for the Elderly (PACE) Provider Organization (251T00000X) | $2,242,570 | $2,934,877 | $3,520,283 | $3,471,255 | $3,693,978 | $3,586,650 | 60 |
| Prosthetic/Orthotic Supplier (335E00000X) | $720,162 | $798,679 | $757,241 | $615,641 | $598,186 | $540,444 | -25 |
| Psychiatric Hospital (283Q00000X) | $275,227 | $127,648 | $75,848 | $200,677 | $122,776 | $21,285 | -92 |
| Psychiatric Residential Treatment Facility (323P00000X) | $13,575,847 | $11,797,657 | $12,121,830 | $12,537,788 | $10,391,372 | $7,334,441 | -46 |
| Psychiatry & Neurology, Neurology (2084N0400X) | $1,354,679 | $959,006 | $805,683 | $611,258 | $458,404 | $331,694 | -76 |
| Psychiatry & Neurology, Psychiatry (2084P0800X) | $2,650,594 | $2,705,413 | $2,552,807 | $2,270,198 | $1,813,284 | $1,570,802 | -41 |
| Psychologist, Clinical (103TC0700X) | $14,027,227 | $13,790,956 | $7,869,869 | $5,398,489 | $5,023,024 | $4,442,052 | -68 |
| Public Health or Welfare (251K00000X) | $1,009,814 | $1,072,715 | $912,444 | $881,179 | $917,179 | $894,081 | -11 |
| Radiology, Diagnostic Radiology (2085R0202X) | $2,218,816 | $2,018,120 | $1,821,704 | $1,794,304 | $1,677,907 | $1,538,606 | -31 |
| Rehabilitation Hospital (283X00000X) | $887,751 | $1,016,080 | $563,688 | $562,051 | $619,218 | $408,441 | -54 |
| Residential Treatment Facility, Emotionally Disturbed Children (322D00000X) | $35,712 | $237,904 | -- | -- | -- | -- | -100 |
| Skilled Nursing Facility (314000000X) | $69,520,419 | $81,670,473 | $86,538,699 | $86,684,517 | $83,960,515 | $88,869,925 | 28 |
| Social Worker, Clinical (1041C0700X) | $907,851 | $2,284,684 | $3,213,974 | $3,274,619 | $2,962,987 | $2,944,089 | 224 |
| Specialist (174400000X) | -- | -- | -- | $61,574 | $58,231 | $60,043 | -- |
| Speech-Language Pathologist (235Z00000X) | $745,421 | $714,369 | $688,314 | $407,957 | $242,416 | $411,291 | -45 |
| Supports Brokerage (251X00000X) | $2,707,383 | $4,434,368 | $3,975,987 | $4,570,890 | $5,530,177 | $6,172,411 | 128 |
| Surgery (208600000X) | $635,372 | $713,150 | $740,929 | $621,880 | $648,362 | $502,970 | -21 |
| Surgery, Pediatric Surgery (2086S0120X) | $80,089 | $57,200 | $76,375 | $32,996 | $30,182 | $33,952 | -58 |
| Surgery, Vascular Surgery (2086S0129X) | $18,527 | $32,393 | $6,400 | $23,257 | $14,387 | $26,205 | 41 |
| Taxi (344600000X) | -- | -- | $16,674 | $33,435 | $45,135 | $36,725 | -- |
| Technician, Pathology, Phlebotomy (246RP1900X) | $1,920 | $575 | -- | -- | -- | -- | -100 |
| Technician/Technologist, Optician (156FX1800X) | $74,200 | $80,235 | $68,054 | $56,048 | $57,048 | $47,032 | -37 |
| Thoracic Surgery (Cardiothoracic Vascular Surgery) (208G00000X) | $31,776 | $34,078 | $20,262 | $14,046 | $27,538 | $11,947 | -62 |
| Urology (208800000X) | $740,261 | $441,176 | $295,664 | $303,965 | $268,132 | $235,121 | -68 |
| Unclassified | $154,857 | $272,555 | $292,866 | $635,221 | $224,355 | $40,885 | -74 |
| Total | $527,531,608 | $554,583,138 | $556,274,739 | $567,478,640 | $554,032,539 | $543,792,374 | 3 |

# APPENDIX B: REIMBURSEMENT METHODOLOGY

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

Table 70. Reimbursement Methodology and History by Service Area

## Ambulance

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Fixed fee schedule for transport
Mileage and disposable supplies reimbursed separately
Separate fee schedules for: Basic life support (ground), Advanced life support (ground), Additional advanced life support (ground), Air ambulance

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | No change | No change | No change | No change |

Wyoming State Rule Chapter 15; Chapter 3

## Ambulatory Surgery Center

Based on Medicaid's Outpatient Prospective Payment System (OPPS). Uses Medicare's relative weights and the Wyoming Medicaid payment method for each service (OPPS status indicator) for each procedure code. Medicaid adopted Medicare's OPPS status indicators for most services, with some adjustments for Medicaid policies.

Services are paid based on one of the following (by status indicator): 1) Ambulatory Payment Classification (APC) fee schedule, 2) separate Medicaid fee schedule, or 3) percentage of charges.

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| Adopted new OPPS-based methodology to better align reimbursement with those services provided in other outpatient settings | No change | Adjusted conversion factors effective calendar year 2017 | No change | No change | No change |

43 CFR 447.321 SPA 4.19B

## Behavioral Health

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Separate fee schedules based on the type of provider

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | Reimbursement rate reduced by 3.3% | No change | Psychologists paid 100% of fee schedule. APRN paid 90% of fee schedule (eff. 1/1/2018) | No change |

State plan 4.19B

## Care Management Entity

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Reimbursement based on procedure code fee schedule

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| N/A | Beginning of service | No change | No change | Payment is made to the CME under a non-risk capitated payment methodology for administrative services. Payment is made to the CME network providers based on a procedure code fee schedule after prior authorization from the CME. | No change |

42 CFR 438.6; Annual actuarial analysis with review and approval by CMS for each SFY.

## Clinic/Center

Lower of the Medicaid fee schedule or the provider's usual and customary charge

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | Changed from billing as single entity to billing as a group with treating providers effective for dates of service as of 6/1/17. Also became part of the Cap Limit process, effective the same date. | No change | No change | No change |

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

## Dental

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Adult optional dental services added (effective July 1, 2006)

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | Per Governor's budget cuts, adult dental coverage reduced to preventive and emergency services only. | No change | No change | No change |

Wyoming State Plan Attachment 4.19B

## Durable Medical Equipment, Prosthetics, Orthotics and Supplies

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

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | No change | Codes impacted by the 21st Century CURES Act are set at 100% of the lowest Medicare rate. Codes not impacted by the 21st Century CURES Act, no change | No change | No change |

Wyoming State Rule Chapter 11; Chapter 3; Wyoming State Plan Attachment 4.19B-12c

## End Stage Renal Disease

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Dialysis services reimbursed at a percentage of billed charges

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| Dialysis services reimbursed at 9% of billed charges (Effective January 1, 2014) | No change | No change | No change | No change | No change |

42 CFR Part 413 Subpart H; State Plan 4.19B

## Federally Qualified Health Centers

Prospective per encounter payment system as required by the Benefits Improvement and Protection Act (BIPA) of 2000.
Based on 100% of a facility's average costs during SFYs 1999 and 2000.
Rates increase annually for inflation based on Medicare Economic Index (MEI) charges

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| Rates increased 0.8% based on MEI | Rates increased 1.1% based on MEI | Rates increased 1.2% based on MEI | Rates increased 1.01% based on MEI | Rates increased 1.015% based on MEI | Rates increased 1.9% based on MEI |

42 CFR 405 Subchapter B; 405.2400-405.2472 Subpart X; 405.2400-405.2417; 405.2430-405.2452; 405.2460-405.2472; Chapter 37 Rule

## Home Health

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Per visit rates based on Medicare's fee schedule

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | Prior authorization required starting dates of service 3/1/17 and newer | No change | No change | Prior authorization suspended in March 2020. |

42 CFR 484 Subpart E

## Hospice

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

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| Rates adjusted per Medicare adjustments | Rates adjusted per Medicare adjustments | Rates adjusted per Medicare adjustments | Rates adjusted per Medicare adjustments | Rates adjusted per Medicare adjustments | Rates adjusted per Medicare adjustments |

42 CFR 418; Wyoming State Statute 42-4-103(a)(xxv)

## Hospital Inpatient

Level of Care (LOC) rate per discharge
Per diem rates for rehabilitation with a ventilator and separate rate without a ventilator
Transplant services are reimbursed at 55% of billed charges
Specialty services not otherwise obtainable in Wyoming negotiated through letters of agreement

Additional payments:
Inpatient hospitals that serve a disproportionate share of low-income individuals receive disproportionate share hospital (DSH) payments
Qualified Rate Adjustment (QRA) program provides supplemental payments to non-state governmental hospital

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | No change to LOC reimbursement; private hospital UPL implemented | No change | DRG implemented 5/31/19 with an effective date 2/1/19. Private hospital UPL program, DSH, QRA still in place. Rehab claims will be paid outside of DRG | Second year of DRG rates implemented February 1, 2020 |

CFR 447 Subpart C Payment; State Plan 4.19B

## Hospital Outpatient

Outpatient prospective payment system (OPPS) based on Medicare's Ambulatory Payment Classifications (APC) system
Three conversion factors based on hospital type: General acute; Critical access; Children's
Separate fee schedules for: Select DME; Select vaccines, therapies immunizations, radiology, mammography screening and diagnostic mammographies; Laboratory; Corneal tissue, dental and bone marrow transplant services, new medical devices

Additional payments:
Qualified Rate Adjustment (QRA) program provides supplemental payments to non-state governmental hospital

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| Adjusted conversion factors to support budget neutrality in the aggregate (effective calendar year 2014): General acute $45.45 Critical access $118.86 Children's $100.05 | Adjusted conversion factors to support budget neutrality in the aggregate (effective calendar year 2015): General acute $42.34 Critical access $111.93 Children's $92.71 | Adjusted conversion factors due to budget cuts (effective calendar year 2017): General acute $37.94 Critical access $98.80 Children's $76.34 ASCs $33.39 | Adjusted conversion factors due to budget cuts (effective calendar year 2018): General acute $39.70 Critical access $104.27 Children's $83.92 ASCs $34.94 | Adjusted conversion factors (effective calendar year 2019): General acute $42.53 Critical access $105.89 Children's $88.45 ASCs $37.42 | Adjusted conversion factors (effective calendar year 2020): General acute: $45.79 Critical access: $109.66 Children's: $83.59 ASCs: $40.30 |
| No change for QRA | No change for QRA | No change for QRA | No change for QRA | No change for QRA | |

CFR 447.321; CFR 447.325; Chapter 33 Rule

## Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)

Full cost reimbursement method based on previous year cost reports.

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | Removed link with Nursing Home rates. Rates now updated annually with full cost coverage. | No change | No change | No change | No change |

Wyoming State Rule Chapter 20

## Laboratory

Lower of the Medicaid fee schedule or the provider's usual and customary charge

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | No change | No change | No change | No change |

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

## Nursing Facility

Prospective per diem rate with rate components for capital cost, operational cost and direct care costs
Additional reimbursement on a monthly basis for extraordinary needs determined on a per case basis

Additional payments:
Provider Assessment and Upper Payment Limit (UPL) Payment provides supplemental payments (effective April 1, 2011)
Nursing Facility Gap Payment Program approved in SFY 2017 as a supplemental payment program

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| Rate updates effective SFY16 pending SPA approval- based on approved NH Rate Reimbursement update | No change | Nursing Facility Gap Payment Program approved in SFY 2017; no change to rate methodology | No change | No change | No change |

W.S. 42-4-104 (c ); State Plan- 4.19D; Chapter 7 Rule

## Physicians and Other Practitioners

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Resource-Based Relative Value Scale (RBRVS) reimbursement methodology based on Medicare's RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rates.

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | Adjusted conversion factor on November 1, 2016 to reflect a 3.3% reduction on all RBRVS codes | No change | No change | No change |

State Plan Amendment 3.1 and 4.19B

## Prescription Drugs

New rate structure implemented on April 1, 2017, pays lower of:
1) The National Average Drug Acquisition Cost (NADAC)
2) When no NADAC is available, DHCF substitutes Wholesale Acquisition Cost (WAC) into logic
3) State Maximum Allowable Cost (SMAC)
4) Federal Upper Limit (FUL)
5) Ingredient Cost Submitted
6) Gross Amount Due (GAD)
7) Provider's usual and customary (U&C) charge to the public

Reimbursement for claims that pay at GAD or U&C will not include a dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim. Dispensing fee is $10.65 per claim

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| PDL expanded to 123 specific drug classes | No change | Reimbursement structure changed on April 1, 2017 to be in compliance with the Final Covered Outpatient Drug Rule. | No change | No change | No change |

State Plan Amendment, Attachment 4.19B, Section 12.a., pages 1-3; Wyoming Medicaid Rules, Chapter 10, Pharmaceutical Services, Section 16 (Medicaid Allowable Payment)

## Program for All-Inclusive Care of the Elderly (PACE)

Reimbursement made on a per diem rate, based on an all-inclusive payment methodology
Per diem rates are based on the participant's functional assessment

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | Rate increased | Rate decreased | Rate decreased for Medicaid-only; increased for dual-Medicare/Medicaid | Rates increased for Medicaid-only; decreased for dual-Medicare/Medicaid | Rate decreased |

State Plan Amendment 3.1-A

## Psychiatric Residential Treatment Facility

Per diem rate. The rate includes room and board, treatment services specified in the treatment plan, and may include an add-on rate for medical services.

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | No change | No change | No change | No change |

W.S. 42-4-103 (a)(xvi); 42 CFR Part 483 Subpart G; 42 CFR Part 441 Subpart D; State Plan- Attachment 4.19A, pg. 1; Attachment 3.1A, pg. 7; Chapter 40 Rule

## Public Health or Welfare

Lower of the Medicaid fee schedule or the provider's usual and customary charge

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | Adjusted conversion factor on November 1, 2016 to reflect 3.3% reduction on all RBRVS codes | No change | No change | No change |

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

## Public Health, Federal

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

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | No change | No change | IHS encounter increases every year based on OMB calculations | |

Public Health Service Act, Sections 321(a) and 322(b); Public Law 83-568; Indian Health Care Improvement Act

## Rural Health Center

Prospective per encounter payment system as required by the Benefits Improvement and Protection Act (BIPA) of 2000
Based on 100% of a facility's average costs during SFYs 1999 and 2000
Rates increased annually for inflation based on Medicare Economic Index (MEI)

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| Rates increased 0.8% based on MEI | Rates increased 1.1% based on MEI | Rates increased 1.2% based on MEI | Rates increased 1.01% based on MEI | Rates increased 1.015% based on MEI | Rates increased by 1.9% based on MEI |

42 CFR 405 Subchapter B; 405.2400-405.2472 Subpart X; 405.2400-405.2417; 405.2430-405.2452; 405.2460-405.2472; Chapter 37 Rule

## Vision

Lower of the Medicaid fee schedule or the provider's usual and customary charge. The most recent update was in SFY 2006 when the rate for standard frames was increased.
Ophthalmologists and optometrists are reimbursed under the Resource-Based Relative Value Scale (RBRVS) reimbursement methodology based on Medicare's RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rates.
Optician reimbursement based on a procedure code fee schedule

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | No change | No change | No change | No change |

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

## Waivers - Comprehensive and Supports

Implemented in SFY 2014 with reimbursment based on the cost based reimbursement methodology implemented in SFY 2009, but with the reductions made in SFY 2011 and SFY 2014 applied. The Individualized Budget Amount (IBA) is based on the historical plan of care units multiplied by the respective service rate less one-time costs, such as assessments, specialized equipment or home modifications. Reimbursement for specific residential and day habilitation services is made on a per diem basis and varies by provider and consumer. Consumers negotiate rates based on their budget amount. For extraordinary care needs, the Extraordinary Care Committee (ECC) reviews the full service and support structure of a participant, including non-waiver services and supports, to determine the appropriate service(s) and funding to meet the participant's assessed needs. The ECC will also review requests for IBA adjustments due to a change in client needs or emergencies.

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| Waivers implemented with reimbursement based on SFY 2009 methodology with SFY '11 and '14 reductions included | No change | 3.3% across-the-board rate increase and 3.3% increase to each IBA to be implemented 1/1/17 | February 1, 2017, implemented 3.3% rate increase applied retroactively back to July 1, 2016. | Rate increase of 4.2% for all services | In response to the COVID-19 public health emergency, provider rates for some Comprehensive Waiver Services were increased by 12.5%, beginning March 1, 2020. The temporary increase ends September 1, 2020. Services receiving the increase were as follows: Adult Day, Child Habilitation, Community Living, Community Support, Companion, Crisis Intervention, Homemaker, Individual Habilitation Training, Personal Care, Respite, Skilled Nursing, Special Family Habilitation Home. and Supported Employment.<br><br>Additionally, self-directed budgets were increased by 12.5% for the month of June 2020. |

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

## Waiver - Children's Mental Health

Lower of the Medicaid fee schedule or the provider's usual and customary charge
Reimbursement based on procedure code fee schedule

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | Care Management Entity began serving youth July 1, 2015 | CMS approved SFY 2017 rates, and SFY2017 claims were adjusted | CMS approved SFY 2018 rates, and SFY2018 claims were adjusted | Changed to non-risk based capitated payment to the CME for administrative services and fee for service payments to the network providers. | No change |

42 CFR 438.6; Annual actuarial analysis with review and approval by CMS for each SFY.

## Waiver - Community Choices

Long-Term Care services are paid lower of the Medicaid fee schedule or the provider's usual and customary (U&C) charge with reimbursement limited to a monthly or yearly cap per person, according to their established care plan.
For Assisted Living services, reimbursement made on a per diem rate, based on an all-inclusive payment methodology. Per diem ratesare based on the participant's functional assessment. Per diem rate includes required personal care, 24-hour supervision and medication assistance up to a monthly or yearly cap. Case management services are reimbursed a separate rate. Participants pay their own room and board.

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | 12% increase per rate rebasing project, effective March 1, 2016. | No change | No change | No change | Rates for select direct care services increased in response to COVID-19 public health emergency. |

Waiver agreement

## Waiver - Pregnant by Choice

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

| SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 |
|---|---|---|---|---|---|
| No change | No change | No change | No change | Extension application submitted to CMS | No change |

11-W-00238/8

# APPENDIX C: ELIGIBILITY REQUIREMENTS & BENEFITS

Table 71. Income Limits by Eligibility Category

| Eligibility Category | CY 2018-2019 |
|---|---|
| Children 0-5 | 154% FPL, no resource limits |
| Children 6-18 | 133% FPL, no resource limits |
| Former Foster Care Children, age 19 to 26 | Eligible, no resource limits |
| Family Care Adults | Values in Table 74, no resource limits |
| Pregnant Women | 154% FPL, no resource limits |
| ABD Waivers and institutions | Less than or equal to 300% SSI |
| ABD with Eligibility Determined by Social Security Administration | 100% SSI |
| Qualified Medicare Beneficiary | 100% FPL |
| Specified Low-Income Medicare Beneficiary | Less than or equal to 120% FPL |
| Qualified Individual | 121 to 135% FPL |
| Breast & Cervical Cancer | Less than or equal to 250% FPL |
| Tuberculosis | 100% SSI |
| Employed individuals with disabilities | Less than or equal to 300% SSI |
| Non-Citizens with Medical Emergencies | Depends on eligibility group qualified under |

Table 72. Monthly Income Standard Values by Family Size

| Income Standard | Income Limit | CY 2019 | | | | CY 2020 | | | |
|---|---|---|---|---|---|---|---|---|---|
| Family Size | | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| Family Care Adults | | $529 | $737 | $873 | $999 | $529 | $737 | $873 | $999 |
| Federal Poverty Level (FPL) | 100% | $1,041 | $1,410 | $1,778 | $2,146 | $1,063 | $1,437 | $1,810 | $2,183 |
| | 133% | $1,385 | $1,875 | $2,365 | $2,854 | $1,414 | $1,911 | $2,407 | $2,904 |
| | 154% | $1,603 | $2,171 | $2,738 | $3,305 | $1,637 | $2,213 | $2,787 | $3,362 |
| Supplementary Security Income (SSI) | 100% | $771 | $1,157 | -- | -- | $783 | $1,175 | -- | -- |
| | 300% | $2,313 | $3,471 | -- | -- | $2,349 | $3,525 | -- | -- |

Table 73. Eligibility Requirements

| Category Group | Eligibility Category | Benefits | Eligibility Requirement | Countable Income | Income Level | Resource Limits |
|---|---|---|---|---|---|---|
| Children | Newborn | Full Medicaid Coverage | Newborns up to age one, with Medicaid eligible mothers | N/A; eligibility determined by mother's Medicaid eligibility | | |
| | Children Age 0-5 | Full Medicaid Coverage | Under age six | Countable family income | Less than or equal to 154 percent of FPL | |
| | Children Age 6-18 | Full Medicaid Coverage | Under age 19 | Countable family income | Less than or equal to 133 percent of FPL | |
| | Foster Care | Full Medicaid Coverage | Under age 21, in DFS custody | Requirements vary by type of foster care coverage | | |
| | Subsidized Adoption | Full Medicaid Coverage | Under age 18; under age 21 for children with special needs | Requirements vary by type of subsidized adoption | | |
| Pregnant Women | Pregnant Women | Full Medicaid Coverage | Pregnant | Countable family income | Less than or equal to 154 percent of FPL | |
| | Presumptive Eligibility for Pregnant Women | Outpatient services for a limited time | Pregnant | Countable family income | Less than or equal to 154 percent of FPL | |
| Family Care | Family Care | Full Medicaid Coverage | Adult with eligible child under age 19 living in the household | Countable family income | Less than or equal to Family Care Income Standard | |
| | Family Care 4 and 12 month (extended medical) | Full Medicaid Coverage | Adult with eligible child under age 19 living in the household; Family unit must have received family care benefits for at least three of the previous 6 months | Countable family income | Exceeds the family care income standard due to increased income due to increased employment, increased earnings, parent returning to work, or child support | |
| | Aging-Out Foster Care Program | Full Medicaid Coverage | Under age 26 | Requirements vary by the type of foster care coverage | | |

| Category Group | Eligibility Category | Benefits | Eligibility Requirement | Countable Income | Income Level | Resource Limits |
|---|---|---|---|---|---|---|
| Aged, Blind, or Disabled (ABD) | ABD Individuals in Institutions | Full Medicaid Coverage | Age 65 or older; or blind by SSI standards; or disabled by SSI standards; and in an institutional setting, such as nursing home, IMD, hospice care, inpatient hospital, or ICF-IID | Countable personal income | Less than or equal to 300 percent of the SSI payment standard for a single individual | yes |
| | Categories with eligibility determined by Social Security Administration (SSA) | Full Medicaid Coverage | SSI eligibility | Countable personal and spousal income | Eligibility determined by SSA; automatically eligible for Medicaid Monthly SSI Payment Standard | yes |
| | SSI related categories with eligibility determined by WDH | Full Medicaid Coverage | Lost SSI due to increase or receipt of Social Security benefits; disregard increase or SSA benefit amount | Countable personal income | Countable income less than or equal to Monthly SSI Payment Standard | yes |
| Medicare Savings Program | Qualified Medicare Beneficiary (QMB) | • Medicaid covers Medicare Part A/B premiums<br>• CMS assists with Medicare Part D premiums<br>• Medical deductible and coinsurance payments | Entitled to Medicare Part A or Part B | Countable personal and spousal income | Less than or equal to 100 percent of FPL | yes |
| | Specified Low-Income Medicare Beneficiary (SLMB) | Medicaid pays Medicare Part B premiums | Entitled to Medicare Part B | Countable personal and spousal income | Between 101 and 120 percent of FPL | yes |
| | Qualified Individuals (QI | Medicaid pays Medicare Part B premiums (100% federal funds) | Entitled to Medicare Part B | Countable personal and spousal income | Between 121 and 135 percent of FPL | yes |
| Special Groups | Breast and Cervical Cancer | Full Medicaid Coverage | Between age 18 and 65 (if over 65, must not be eligibile for Medicare Part B); meet Preventative Health and Safety Division criteria; no insurance coverage paying for cancer screening or treatment (including Medicaid and Medicare Part B) | Countable personal income | Less than or equal to 250 percent of FPL | |
| | Tuberculosis | Partial benefits related to tuberculosis | Verification of tuberculosis | Countable personal income | SSI Payment Standard | yes |

| Category Group | Eligibility Category | Benefits | Eligibility Requirement | Countable Income | Income Level | Resource Limits |
|---|---|---|---|---|---|---|
| Medicaid Buy-In | Employed Individuals with Disabilities | Full Medicaid benefics after payment of premium (7.5 percent of gross monthly income) | Between age 16 and 64; disabled; employed | Countable personal and spousal income | Unearned income less than or equal to 300 percent of the SSI standard for a single individual, no limit on earned income | |
| Non-Citizens | Non-Citizens with Medical Emergencies | Benefits limited to services provided from the time treatment was given for a condition until that same condition is no longer considered an emergency | Illegal immigrants or qualified immigrants who do not meet citizenship criteria | Meets applicable eligibility requirements under an existing eligibility group | | |

# APPENDIX D: GLOSSARY & ACRONYMS

## GLOSSARY

**Acquired Brain Injury (ABI) –** Damage to the brain that occurs after birth and is not related to a congenital or degenerative disorder.

**Affordable Care Act (ACA) –** The Patient Protection and Affordable Care Act as well as the Healthcare and Education Reconciliation Act was signed into law in March 2010. These laws are collectively known as the Affordable Care Act legislation and represent a significant overhaul to the healthcare system.

**Ambulatory Surgical Center (ASC) –** A free-standing facility, other than a physician's office or a hospital, where surgical and diagnostic services are provided on an ambulatory basis. The facility operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours.

**Ambulatory Payment Classifications (APC) –** A group to which an outpatient service is assigned in Medicare's prospective payment system for outpatient hospital services. The healthcare common procedure coding system, including certain current procedural terminology codes and descriptors are used to identify and group the services within each APC group. Services within an APC group are comparable clinically and with respect to resource use. A payment rate is established for each APC group.

**American Recovery and Reinvestment Act of 2009 (ARRA) –** Legislation signed into law in February 2009 in response to the economic crisis. The Act specified funding for a wide range of federal programs, including certain benefits under Medicaid.

**Average Wholesale Price (AWP) –** The published price for drug products charged by wholesalers to pharmacies.

**Basic Life Support –** A level of medical care, usually provided by emergency medical service professionals, provided to patients of life-threatening illnesses or injuries until they can be given full medical care. Basic life support consists of essential non-invasive life-saving procedures including CPR, bleeding control, splinting broken bones, artificial ventilation, and basic airway management.

**Benefits Improvement and Protection Act of 2000 (BIPA) –** Legislation signed into law in December 2000 that affects several aspects of Medicare and Medicaid.

**Centers for Medicare and Medicaid Services (CMS) –** The government agency within the Department of Health and Human Services that administers the Medicare program, and works with states to administer Medicaid. In addition to Medicare and Medicaid, CMS oversees the Children's Health Insurance Program.

**Children's Health Insurance Program (CHIP) –** A federal-state partnership program to provide free or low-cost health insurance for uninsured children under age 19. The CHIP is intended for uninsured children whose families earn too much to qualify for Medicaid, but not enough to get private coverage.

**Cognos –** The reporting tool used to extract data from the Medicaid Management Information System (MMIS).

**Commission on Accreditation of Rehabilitation Facilities (CARF) –** An organization that accredits rehabilitation facilities.

**Community Mental Health Center (CMHC) –** A community based healthcare facility that provides comprehensive mental health services to individuals residing or employed in the facility service area.

**Comprehensive Outpatient Rehabilitation Facility (CORF) –** A facility that provides coordinated, comprehensive outpatient rehabilitation services under the supervision of a physician. At minimum, a CORF must provide physician supervision and physical therapy and social or psychological services to be certified as a CORF.

**Co-payment –** A fixed amount of money paid by the enrolled member at the time of service.
Council on Accreditation – An organization that accredits healthcare organizations.

**Crossover Claim –** Services for Medicaid and Medicare dual individuals in which Medicare is the primary payer and forwards the claim to Medicaid for additional payments.

**Current Procedural Terminology (CPT) –** A code set developed by the American Medical Association for standardizing the terminology and coding used to report medical procedures and services. CPT codes are Level I of the HCPCS code set.

**Deficit Reduction Act of 2005 (DRA) –** Legislation signed into law in February 2006 that affects several aspects of Medicare and Medicaid.

**Department of Health and Human Services (HHS) –** The United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

**Disproportionate Share Hospital (DSH) –** Hospitals that serve a significantly disproportionate number of low-income individuals. Eligible hospitals can receive an adjustment payment under Medicaid.

**Drug Utilization Review (DUR) –** A review utilization of outpatient prescription drugs to determine if recipients are receiving appropriate, medically necessary medications which are not likely to result in adverse effects.

**Durable Medical Equipment (DME), Prosthetics, Orthotics and Supplies –** Medical equipment and other supplies that are intended to reduce an individual's physical disability and restore the individual to his or her functional level.

**Dual Individual –** For the purposes of this Report, an individual enrolled in Medicare and Medicaid who is eligible to receive Medicaid services.

**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) –** The comprehensive and preventive child health component of Medicaid for individuals under age 21. Medicaid's EPSDT services are operated under the Health Check program. All medically necessary diagnostic and treatment services within the federal definition of Medicaid medical assistance must be covered, regardless of whether or not such services are otherwise covered under the state Medicaid plan for adults ages 21 and older.

**Eligibility –** Criteria that establish an individual as qualified to enroll in Medicaid. The federal government establishes minimum eligibility standards and requires states to cover certain population groups. States have the flexibility to cover other population groups within federal guidelines.

**Enrollment –** A unique count of members enrolled in Medicaid. Enrollment may be reported at a point in time (e.g., as of June 30) or over a time frame (e.g., SFY 2015).

**End Stage Renal Disease (ESRD) –** The complete, or almost complete, failure of the kidneys to function. The only treatments for ESRD are dialysis or kidney transplantation.

**Estimated Acquisition Cost (EAC) –** The estimated cost to the pharmacy of acquiring a prescription drug. Federal regulations require that each State's reimbursement for Medicaid prescription drugs not exceed the lower of (1) its estimated acquisition cost plus a dispensing fee, or (2) the provider's usual and customary charge to the public for the drug.

**Expenditure –** Funds or money spent to liquidate an expense regardless of when the service was provided or the expense was incurred.

**Explanation of Benefits (EOB) –** An itemized statement of services from an insurance company detailing what services were paid for on the behalf of an individual. The EOB informs an individual what portion of a claim was paid to the healthcare provider and what portion of the payment, if any, the individual is responsible for.

**Federal Fiscal Year (FFY) –** The 12 month accounting period, for which the federal government plans its budget, usually running from October 1 through September 30. The FFY is named for the end date of the year (e.g., FFY 2009 ends on September 30 2009).

**Federal Medical Assistance Percentage (FMAP) –** The percentage rates used to determine the federal matching funds allocated to the Medicaid program. The FMAP is the portion of the Medicaid program that is paid by the federal government.

**Federal Poverty Level (FPL) –** The amount of income determined by the Department of Health and Human Services that is needed to provide a minimum for living necessities.

**Federally Qualified Health Center (FQHC) –** A designated health center in a medically under-served area that is eligible to receive cost-based Medicare and Medicaid reimbursement.

**Federal Upper Limit (FUL) –** The maximum price pharmacies receive as reimbursement for providing multiple-source generic prescription drugs. The FUL is established by the Centers for Medicare and Medicaid Services in order to achieve savings by taking advantage of current market pricing. Not all drugs have FULs and states may establish reimbursement limits for non-FUL drugs using other pricing methodologies.

**Fee Schedule –** A complete listing of fees used by health plans to pay medical care professionals.

**Healthcare Common Procedure Coding System (HCPCS) –** A standardized coding system used to report procedures, specific items, equipment, supplies, and services provided in the delivery of healthcare. There are two principal subsystems, Level I and Level II. Level I codes are comprised of CPT codes which are identified by five numeric digits. Level II codes are used primarily to identify equipment, supplies and services not included in the CPT code set. Level II codes are alphanumeric codes.

**Home and Community Based Services (HCBS) –** Care provided in the home and community to individuals eligible for Medicaid. The HCBS programs help the elderly and disabled, intellectually disabled, developmentally disabled and certain other disabled adults.

**HCBS Acquired Brain Injury (ABI) Waiver –** A HCBS waiver developed to assist adults from ages 21 to 65 with acquired brain injuries to receive training and support that will allow them to remain in their home communities and avoid institutionalization. Being replaced by the Comprehensive and Supports Waiver starting in SFY 2016.

**HCBS Assisted Living Facility (ALF) Waiver** – A HCBS waiver that allows participants ages 19 and older who require services equivalent to a nursing facility level of care to receive services in an ALF. This waiver closed in SFY 2017, with service now provided under the Community Choices Waiver.

**HCBS Adult Developmental Disabilities (DD) Waiver** – A HCBS waiver developed to assist adults with developmental disabilities to receive training and support that will allow them to remain in their home communities and avoid institutionalization. Replaced by the Comprehensive and Supports Waiver starting in April 2014.

**HCBS Child Developmental Disabilities (DD) Waiver –** A HCBS waiver developed to assist children under age 21 with developmental disabilities to receive training and support that will allow them to remain in their home communities and avoid institutionalization. Replaced by the Comprehensive and Supports Waiver starting in April 2014.

**HCBS Children's Mental Health (CMH) Waiver –** A HCBS waiver developed to allow youth with serious emotional disturbances who need mental health treatment to remain in their home communities.

**HCBS Community Choices (CC) Waiver –** A HCBS waiver allowing participants age 19 and older who require services equivalent to a nursing facility level of care to receive services in an assisted living facility or in their home.

**HCBS Comprehensive Waiver –** A HCBS waiver developed to replace the former DD waivers for with people with a developmental disability.

**HCBS Long-Term Care (LTC) Waiver** – A HCBS waiver that provides in-home services to participants ages 19 and older who require services equivalent to a nursing facility level of care. Replaced by the Community Choices Waiver in SFY 2017.

**HCBS Supports Waiver** - A HCBS waiver developed to replace the former DD waivers for with people with a developmental disability. Provides more flexible service than the Comprehensive Waiver, but with a lower cap on benefits.

**Health Professional Shortage Area (HPSA) –** A geographic, demographic or institutional designation by the Health Resources and Services Administration as having shortages of primary medical care, dental or mental health providers.

**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) –** A facility that primarily provides comprehensive and individualized healthcare and rehabilitation services above the level of custodial care to intellectually disabled individuals but does not provide the level of care available in a hospital or skilled nursing facility.

**Individualized Budget Amount (IBA) –** In the developmental disability and acquired brain injury waiver programs, the amount of funding allocated to each participant based on individual characteristics and his or her service utilization.

**Joint Commission –** An organization that accredits healthcare organizations.

**Level of Care (LOC) –** Medicaid's prospective payment system for inpatient hospital services. Medicaid reimburses an amount per discharge. Each discharge is classified into a LOC based on the diagnosis, procedure, or revenue codes that hospitals report on the

inpatient claim.

**Medicaid –** A joint federal-state program authorized by Title XIX of the Social Security Act that provides medical coverage for certain low-income and other categorically related individuals who meet eligibility requirements. A portion of the Medicaid program is funded by the federal government using the Federal Medical Assistance Percentage.

**Medicaid Management Information System (MMIS) –** An integrated group of procedures and computer processing operations (subsystems) that supports the Medicaid program operations. The functional areas of the MMIS include recipients, providers, claims processing, reference files, surveillance and utilization review, management and administration reporting, and third party liability. The MMIS is certified by the Centers for Medicare and Medicaid Services.

**Medicare –** A federal program, authorized by Title XVIII of the Social Security Act, that provides medical coverage for individuals age 65 or older, individuals under age 65 with certain disabilities, and individuals of all ages with end stage renal disease.

**Medicare Economic Index (MEI) –** An index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule. Medicaid uses the index as an update factor for FQHC and RHC reimbursement rates.

**Member –** An individual enrolled in Medicaid and eligible to receive services.

**Modified Adjusted Gross Income (MAGI) —** A new income methodology implemented in SFY 2013.

**Per Member per Month –** The monthly average cost for each enrolled member.

**Pharmacy Benefit Management (or Manager) (PBM) –** Third party administrator of prescription drug programs.

**Preferred Drug List (PDL) –** A list of clinically sound and cost effective prescription drugs covered by Medicaid that do not require prior authorization.

**Pregnant by Choice Waiver –** A Section 1115 waiver that provides family planning services and birth control options to women who have received Medicaid benefits under the Pregnant Women program and who would otherwise lose Medicaid eligibility 60 days after giving birth.

**Prescription Drug Assistance Program (PDAP) –** A state-funded program administered by the Healthcare Financing Division providing up to three prescriptions per month to Wyoming residents with income at or below 100 percent of the FPL.

**Prior Authorization (PA) –** The requirement of a prescriber to obtain permission to prescribe a medication prior to prescribing it. In the context of a PBM plan, a program that requires physicians to obtain certification of medical necessity prior to drug dispensing.

**Procedure Code –** A HCPCS Level I or Level II code used to report the delivery of healthcare for reimbursement purposes.

**Psychiatric Residential Treatment Facility (PRTF) –** A facility that provides services to individuals who require extended care beyond acute psychiatric stabilization or extended psychiatric services. These services address long-standing behavioral disturbances, which are not usually responsive to shorter-term care.

**Qualified Rate Adjustment (QRA) –** Medicaid's annual lump sum supplemental payment equal to a portion of the difference between a qualifying hospital's Medicaid allowable costs for the payment period and its pre-QRA Medicaid payments for the same period, minus amounts payable by other third parties and beneficiaries. The QRA payments are only available to in-state hospitals for inpatient and outpatient services.

**Recipient –** For the purposes of this Report, an individual enrolled in Medicaid who received Medicaid services.

**Resource Based Relative Value Scale (RBRVS) –** Established as part of the Omnibus Reconciliation Act of 1989, Medicare's payment principles for physician services were adjusted by establishing an RBRVS fee schedule. This payment methodology has three components: a relative value for each procedure, a geographic adjustment factor and a conversion factor. Procedures are assigned a relative value which is adjusted by geographic region. This value is then multiplied by a conversion factor to determine the amount of payment.

**Rural Health Clinic (RHC) –** A designated health clinic in a medically under-served area that is non-urbanized as defined by the U.S. Bureau of Census and that is eligible to receive cost-based Medicare and Medicaid reimbursement.

**Section 1115 Waiver –** An experimental, pilot or demonstration project authorized by Section 1115 of the Social Security Act. Section 1115 projects allow states the flexibility to test new or existing approaches to financing and delivering the Medicaid program.
**Social Security Act –** The legislation, signed in 1965 that authorized Medicare under Title XVIII, and Medicaid under Title XIX.

**State Fiscal Year (SFY) –** The 12 month accounting period for which the state plans its budget, usually running from July 1 through June 30. The SFY is named for the end date of the year (e.g., SFY 2009 ends on June 30 2009).

**State Funds –** For the purposes of this Report, funds that do not receive any Medicaid Federal Medical Assistance Percentage.

**State Maximum Allowable Cost (SMAC) –** The maximum price pharmacies receive as reimbursement for equivalent groups of multiple-source generic prescription drugs. Medicaid may include more drugs than what are covered under the federal upper limit program as well as set reimbursement rates that are lower than federal upper limit rates.

**Supplemental Security Income (SSI) –** A federal income supplement program administered by the Social Security Administration. It is designed to assist the aged, blind, or disabled individuals who have little or no income and provides cash to meet basic needs for food, clothing and shelter.

**Third Party Liability (TPL) –** The legal obligation of a third party to pay part or all of the expenditures for medical assistance under Medicaid.

**Usual and Customary Charge –** The fee that is most consistently charged by a healthcare provider for a particular procedure. The actual price that pharmacies charge cash-paying customers for prescription drugs.
Table 77, below, provides the parameters used for extracting data for each service area included in this report.

# ACRONYMS

Table 74. Acronyms

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

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

# APPENDIX E: DATA METHODOLOGY

## ENROLLMENT

- A member is any individual enrolled in Medicaid, identified by a Medicaid ID number
- Enrollment is a distinct count of Medicaid members based on ID number
- Members are enrolled in an eligibility program code, which define the eligibility categories
- See tables for the eligibility category breakdown by program codes
- Monthly average of enrollment is calculated using the distinct count of members as of the last day of each month
- Total SFY enrollment is a distinct count of all members enrolled at any time during the SFY, regardless of the duration of their enrollment span

## RECIPIENTS

- A recipient is any enrolled member who has received services and had a Medicaid claim processed and paid during the SFY
- Since the distinct count of recipients is based on claims paid during the SFY, this count may exceed enrollment as some recipients may not have maintained enrollment in the SFY in which their claim paid

## EXPENDITURES

- Expenditures represent claim payments made to providers during the SFY.
- For this report, expenditures includes all paid claims, including those that were adjusted and re-adjusted during the SFY.
- Third-party payments, co-payments, DSH payments, and history-only adjustments are excluded from totals, as are premium and cost-sharing assistance for Medicare individuals

## PER MEMBER PER MONTH

- The Per Member Per Month (PMPM) represents the monthly average cost for each enrolled member.
- The calculation is equal to expenditures divided by member months in which expenditures are based on original and final adjusted claims by first service dates and member months is the sum of the number of months individuals are enrolled in Medicaid.
- The PMPM value in this report is a preliminary value only.
- The final SFY 2020 PMPM value will be available in the separate Wyoming Medicaid Per Member Per Month report.

## SERVICES

- Most service areas are defined using pay-to provider taxonomy codes on claims paid during the SFY. See table 77 for the parameters used for each service and special population in this report.
- Other services may use claim types or the recipient's eligibility program code in addition to the pay-to-provider tax code.

Table 75. Medicaid Chart A Eligibility Program Codes

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

| Eligibility Category (Continued) | Program Codes | |
|---|---|---|
| Aged, Blind, Disabled Intellectual/ Developmental Disabilities and Acquired Brain Injury (continued) | W18 | SSI Support ABI Waiver Adult > 21 |
| | W19 | SSI Support ABI Waiver Aged > 65 |
| | W20 | 300% Support ABI Waiver Adult > 21 |
| | W21 | 300% Support ABI Waiver Aged > 65 |
| Aged, Blind, Disabled Institution | S14 | Institutional (Hosp) Aged - Inactive |
| | S15 | Inpatient Hospital 300% Cap > 65 |
| | S34 | Inatitutional (Hosp) Disabled - Inactive |
| | S35 | Inpatient Hospital 300% Cap < 65 |
| | S13 | Inpat-Psych > 65 |
| Aged, Blind, Disabled Long-Term Care | R01 | Asst Living Fac Wvr SSI < 65 |
| | R02 | Asst Living Fac Wvr 300% < 65 |
| | R03 | Asst Living Fac Wvr SSI > 65 |
| | R04 | Asst Living Fac Wvr 300% > 65 |
| | S50 | Hospice Care > 65 |
| | S51 | Hospice Care < 65 |
| | N98 | WLTC Temp Services |
| | S24 | LTC Waiver SSI > 65 |
| | S25 | LTC Waiver 300% Cap > 65 |
| | S46 | LTC Waiver SSI < 65 |
| | S47 | LTC Waiver 300% Cap < 65 |
| | N97 | NH Temp Services |
| | S01 | NH-SSI & Ssa Blend >65 |
| | S02 | NH-SSI & Ssa Blend <65 |
| | S10 | Nursing Home SSI >65 |
| | S11 | Nursing Home 300% Cap >65 |
| | S17 | Retro Medicaid-"Pr" Aged (inactive) |
| | S18 | Retro Medicaid-"Rm" Aged (inactive) |
| | S30 | Retro Medicaid-"Pr" Disabled (inactive) |
| | S32 | Nursing Home SSI <65 |
| | S33 | Nursing Home 300% Cap <65 |
| | S54 | Medicaid Only-No Rm & Brd >65 |
| | S55 | Medicaid Only-No Rm & Brd <65 |
| | S90 | Retro Medicaid-"Rm" Disabled |
| | P11 | PACE < 65 |
| | P12 | PCMR < 65 |
| | P13 | PACE SSI Disabled < 65 |
| | P14 | PACE Mcare SSI Disabled < 65 |
| | P15 | PACE NF < 65 |
| | P16 | PACE NF SSI Disabled < 65 |
| | P17 | PACE NF Mcare Disabled < 65 |
| | P18 | PACE NF Mcare SSI Disable < 65 |
| | P21 | PACE > 65 |
| | P22 | PCMR > 65 |

| Eligibility Category (Continued) | Program Codes | |
|---|---|---|
| Aged, Blind, Disabled Long-Term Care (continued) | P23 | PACE SSI Aged > 65 |
| | P24 | PACE Mcare SSI Aged > 65 |
| | P25 | PACE NF > 65 |
| | P26 | PACE NF SSI Aged > 65 |
| | P27 | PACE NF Mcare Aged > 65 |
| | P28 | PACE NF Mcare SSI Aged > 65 |
| Aged, Blind, Disabled SSI & SSI Related | S12 | SSI Eligible >65 |
| | S20 | Blind SSI - Receiving Payment |
| | S21 | Blind SSI - Not Receiving Pymt |
| | S31 | SSI Eligible <65 |
| | S36 | Disabled Adult Child (DAC) |
| | S37 | Goldberg-Kelly |
| | S39 | 1619 Disabled |
| | S40 | Aptd Essent. Person Med Only -I |
| | S48 | Zebley >21 |
| | S49 | Zebley <21 |
| | S92 | Widow-Widowers SDX |
| | S98 | Pseudo SSI Aged (inactive) |
| | S99 | Pseudo SSI Disabled (inactive) |
| | S09 | SSI-Disabled Child Definition |
| | S16 | Pickle >65 |
| | S38 | Pickle <65 |
| | S42 | Widow-Widowers |
| | S43 | Qual Disabled Working Ind |
| Adults | A01 | Family Care Past 5yr Limit >21 (inactive) |
| | A03 | Family Care >21 |
| | A68 | 12 Mo Extended Med >21 |
| | A69 | 2nd-6mos. Trans Mcaid Adult (inactive) |
| | A75 | Institutional (AFDC) Adult (inactive) |
| | A77 | AFDC-Up Unemployed Parent Ad (inactive) |
| | A79 | Retro Medicaid-"Rm" Adult (inactive) |
| | M11 | Family MAGI PE >21 |
| | A80 | Refugee Adult (inactive) |
| | A82 | Alien: 245 (IRCA) Adult (inactive) |
| | A83 | Alien: 210 (IRCA) Adult (inactive) |
| | A70 | AFDC Medicaid - Adult (inactive) |
| | A76 | 4 Mo Extended Med >21 |
| | A78 | Retro Medicaid-"Pr" Adult (inactive) |
| | M04 | Family MAGI >21 |
| | M08 | Former Foster Youth > 21 |
| | M18 | Former Foster Youth PE > 21 |
| | M01 | Adult MAGI > 21 |
| | M13 | Adult MAGI PE > 21 |

| Eligibility Category (Continued) | Program Codes | |
|---|---|---|
| Children | A02 | Family Care Past 5yr Limit <21 |
| | A04 | Family Care <21 |
| | A50 | AFDC Medicaid (inactive) |
| | A54 | 2nd-6mos. Trans Mcaid Child (inactive) |
| | A56 | Alien: 245 (IRCA) Child (inactive) |
| | A57 | Baby <1 Yr, Mother SSI Elig (inactive) |
| | A59 | Retro Medicaid-"Pr" Child (inactive) |
| | A60 | 4 Mo Extended Med <21 |
| | A61 | Institutional (AF-IV-E) (inactive) |
| | A62 | Retro Medicaid-"Rm" Child (inactive) |
| | A63 | Refugee Child (inactive) |
| | A64 | Alien: 245 (IRCA) Child (inactive) |
| | A58 | Child 6 Through 18 Yrs |
| | A65 | AFDC-Up Unemployed Parent Ch (inactive) |
| | A67 | 12 Mo Extended Med <21 |
| | A87 | 16+ Not In School AF HH (inactive) |
| | K03 | Kidcare to Child Magi |
| | M02 | Adult MAGI <21 |
| | M03 | Child MAGI |
| | M05 | Family MAGI <21 |
| | M10 | Children's PE |
| | M12 | Family MAGI PE <21 |
| | M14 | Adult MAGI PE <21 |
| | S62 | Continuous SSI Eligible <19 |
| | A55 | Child 0 Through 5 Yrs |
| | S65 | Cont Childrns Ment Health Wvr < 19 |
| | S95 | Childrens Ment Hlth Wvr SSI < 21 |
| | S96 | Childrens Ment Hlth Wvr 300% <21 |
| | A51 | IV-E Foster Care |
| | A52 | IV-E Adoption |
| | A85 | Foster Care Title 19 |
| | A86 | Subsidized Adoption Title 19 |
| | A88 | Aging Out Foster Care |
| | A97 | Foster Care 0 Through 5 |
| | A98 | Foster Care 6 Through 18 |
| | M09 | Former Foster Youth <21 |
| | M17 | Former Foster Youth PE <21 |
| | S63 | Continuous Foster Care <19 |
| | A53 | Newborn |

| Eligibility Category (Continued) | Program Codes | |
|---|---|---|
| Medicare Savings Programs | Q17 | QMB > 65 |
| | Q41 | QMB < 65 |
| | Q66 | QMB Dual with Full Medicaid |
| | Q94 | SLMB 2 > 65 |
| | Q95 | SLMB 2 < 65 |
| | Q96 | SLMB 1 > 65 |
| | Q97 | SLMB 1 < 65 |
| | Q67 | SLMB Dual with Full Medicaid |
| | Q98 | Part B-Partial Aged (Inactive) |
| | Q99 | Part B-Partial Disabled (Inactive) |
| Non-Citizens with Medical Emergencies | A81 | Emergency Svc < 21 |
| | A84 | Emergency Svc > 21 |
| Pregnant Women | A71 | Pregnant Woman < 21 |
| | A72 | Pregnant Woman > 21 |
| | A73 | Qualified Pregnant Woman > 21 |
| | A74 | Qualified Pregnant Woman < 21 |
| | M06 | Pregnancy MAGI > 21 |
| | M07 | Pregnancy MAGI < 21 |
| | A19 | Presumptive Eligibility |
| Special Groups | B03 | Breast & Cervical > 21 |
| | B04 | Breast & Cervical < 21 |
| | M15 | Breast & Cervical PE > 21 |
| | M16 | Breast & Cervical PE < 21 |
| | S52 | Tuberculosis (Tb) > 65 |
| | S53 | Tuberculosis (Tb) < 65 |
| | A20 | Pregnant By Choice |
| Screenings & Gross Adjustments | N96 | Disability Determination Only |
| | N99 | LTC Screening Only |
| | W99 | Single Day Waiver Assessment |
| | S97 | CASII Screening Only |
| | ZZZ | Other |
| | P07 | CHIPRA CME |

**Table 76. Medicaid Chart B Eligibility Program Codes**

| Eligibility Category | Program Codes | |
|---|---|---|
| State Funded Foster Care | A95 | Pending Foster Care |
| | A96 | Basic Foster Care |
| | A99 | Institutional Foster Care |
| Project Out | P05 | Project Out Transitional Coverage |

# DATA PARAMETERS

As stated in the previous section, Expenditures are calculated using all Medicaid Chart A recipient program codes and all claim adjustments except history-only adjustments. Counts exclude several program codes and only include original and final claims.

Table 77. Data Parameters by Service Area

| Service Area | Pay-to-Provider Taxonomy | | Other Parameters |
|---|---|---|---|
| Ambulance - Total | 341600000X | Ambulance | n/a |
| Ambulance - Air | 341600000X | Ambulance | Procedure Codes: A0030, A0430, A0431, A0435, A0436, A0382, A0398, A0422, A0433, A0434, A0998 |
| Ambulance - Ground | 341600000X | Ambulance | Procedure Codes: A0221, A0360, A0362, A0368, A0370, A0380, A0390, A0425, A0426, A0427, A0428, A0429, A0382, A0398, A0422, A0433, A0434, A0998 |
| Ambulatory Surgery Center | 261QA1903X | Ambulatory Surgery Center | n/a |
| Behavorial Health | 101Y00000X<br>101YA0400X<br>101YP2500X<br>103G00000X<br>103K00000X<br>103TC0700X<br>1041C0700X<br>106E00000X<br>106H00000X<br>106S00000X<br>163W00000X<br>164W00000X<br>171M00000X<br><br>172V00000X<br>2084P0800X<br>261QM0801X<br><br>261QR0405X<br>364SP0808X | Professional Counselor; Certified Mental Health Worker<br>Addictions Therapist/Practitioner<br>Professional Counselor<br>Neuropsychologist<br>Behavior Analyst<br>Clinical Pscyhologist<br>Social Worker<br>Assistant Behavior Analyst<br>Marriage and Family Therapist<br>Behavior Technician<br>RN<br>LPN<br>Case Worker<br>Community Health Worker; Peer Specialist; Certified<br>Addictions Practitioner Asisstant<br>Psychiatrist<br>Mental Health - including Community Mental Health Center<br>Rehabilitation, Substance Use Disorder<br>NP, APN Psychiatric/Mental Health | n/a |
| Behavioral Health services provided by Non BH providers | EXCLUDE Behavioral Health Provider taxonomies and 261QP0904X: Public Health, Federal | | Procedure Codes: G9012, T1007, T1012, T1017, T2011, 90785, 90791, 90792, H0001-H2037, 90801-90899, 96101-96125<br>99201 and 99360 when paired with 90833, 90836, 90838, or 90785 on same claim with same treating provider<br><br>Claim Types: EXCLUDE W (waiver) |
| Care Management Entity | 251S00000X | CHPR CME | n/a |

| Service Area (Continued) | Pay-to-Provider Taxonomy | | Other Parameters |
|---|---|---|---|
| Clinic/Center | 261Q00000X | Clinic/Center | n/a |
| Dental | 122300000X<br>1223D0001X<br>1223E0200X<br>1223G0001X<br>1223P0221X<br>1223P0300X<br>1223S0112X<br>1223X0400X | Dentist<br>Dental Public Health<br>Endodontics<br>General Practice Dentist<br>Pedodontics<br>Periodontics<br>Surgery, Oral and Maxillofacial<br>Orthodontics | n/a |
| Durable Medical Equipment, Prosthetics, Orthotics, and Supplies | 332B00000X<br>332S00000X<br>335E00000X | DME<br>Hearing Aid Equipment<br>POS | n/a |
| Durable Medical Equipment Only | 332B00000X<br>332S00000X | DME<br>Hearing Aid Equipment | n/a |
| Prosthetics, Orthotics, and Supplies Only | 335E00000X | POS | n/a |
| End-Stage Renal Disease | 261QE0700X | End-Stage Renal Disease | n/a |
| Federally Qualified Health Center | 261QF0400X | Federally Qualified Health Center | n/a |
| Home Health | 251E00000X | Home Health | n/a |
| Hospice | 251G00000X | Hospice Care, Community Based | n/a |
| Hospital Total | 261QR0400X<br>282N00000X<br>282NR1301X<br>283Q00000X<br>283X00000X | Rehabilitation<br>General Acute Care Hospital<br>General Acute Care Hospital - Rural<br>Psychiatric Hospital<br>Rehabilitation Hospital | n/a |
| Hospital Inpatient | 282N00000X<br>282NR1301X<br>283Q00000X<br>283X00000X | General Acute Care Hospital<br>General Acute Care Hospital - Rural<br>Psychiatric Hospital<br>Rehabilitation Hospital | Claim Type:<br>I, X |
| Hospital Outpatient | 261QR0400X<br>282N00000X<br>282NR1301X<br>283X00000X | Rehabilitation<br>General Acute Care Hospital<br>General Acute Care Hospital - Rural<br>Rehabilitation Hospital | Claim Type:<br>O, V |
| Hospital Emergency Room | All Taxonomies | | Procedure Codes:<br>99281 thru 99285<br>OR<br>Place of Service: 23 AND Procedure Codes in Emergency Department Procedure Code Value Set (2020 HEDIS)<br>OR<br>Revenue Code:<br>0450 through 0459<br><br>Counts: Claim Type O<br>Expenditures: Header level amounts for all events that have both Medical and Outpatient claim (i.e. no associated inpatient admission) |
| International Care Facility for Individuals with Intellectual Disabilities | 315P00000X | Intermediate Care Facility, Intellectual Disability | n/a |
| Laboratory | 291U00000X | Clinical Medical Laboratory | n/a |

| Service Area (Continued) | Pay-to-Provider Taxonomy | | Other Parameters |
|---|---|---|---|
| Nursing Facility | 275N00000X<br>314000000X | Medicare Defined Swing Bed<br>Skilled Nursing Facility | n/a |
| Program for All-Inclusive Care of Elderly (PACE) | 251T00000X | PACE Organization | n/a |
| Physician and Other Practitioner Total | All Taxonomies starting with '20' EXCLUDING<br>2084P0800X<br><br>363A00000X<br>225X00000X<br>225100000X<br>213E00000X<br>363L00000X<br>363LA2200X<br>363LF0000X<br>363LG0600X<br>363LX0001X<br>363LP0200X<br>367A00000X<br>367500000X<br>231H00000X<br>235Z00000X | <br>Psychiatrists<br><br>Physician Assistant<br>Occupational Therapist<br>Physical Therapist<br>Podiatrist<br>Nurse Practitioner<br><br><br><br><br><br>Nurse Midwife<br>Nurse Anesthetist<br>Audiologist<br>Speech-Language Pathologist | n/a |
| Physician | All Taxonomies starting with '20' EXCLUDING<br>2084P0800X<br><br>363A00000X | <br>Psychiatrists<br><br>Physician Assistant | n/a |
| Other Practitioner | 225X00000X<br>225100000X<br>213E00000X<br>363L00000X<br>363LA2200X<br>363LF0000X<br>363LG0600X<br>363LX0001X<br>363LP0200X<br>367A00000X<br>367500000X<br>231H00000X<br>235Z00000X | Occupational Therapist<br>Physical Therapist<br>Podiatrist<br>Nurse Practitioner<br><br><br><br><br><br>Nurse Midwife<br>Nurse Anesthetist<br>Audiologist<br>Speech-Language Pathologist | n/a |
| Prescription Drug | 333600000X | Pharmacy | Claim Type: P |
| Psychiatric Residential Treatment Facility | 323P00000X | Psychiatric Residential Treatment Facility | Claim Types: I, X |
| Public Health, Federal | 261QP0904X | Public Health, Federal | n/a |
| Public Health or Welfare | 251K00000X | Public Health or Welfare | n/a |
| Rural Health Clinic | 261QR1300X | Rural Health Clinic | n/a |
| Vision | 152W00000X<br>156FX1800X | Optometrist<br>Optician | n/a |

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

| Service Area (Continued) | Pay-to-Provider Taxonomy | | Other Parameters |
|---|---|---|---|
| Waiver - Child with ID/DD Non-Waiver Services | All Taxonomies | | EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X<br><br>Recipient Program Codes: S58, S93, S94, S64 |
| Waiver - Children's Mental Health Waiver Only | 251B00000X | Case Management | Claim Type: W, G<br><br>Recipient Program Codes: S95, S96, S65 |
| Waiver - Children's Mental Health Non-Waiver Services | All Taxonomies | | EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X<br><br>Recipient Program Codes: S95, S96, S65 |
| Waiver Comprehensive Waiver Only | 251C00000X<br>251X00000X | Day Training, DD<br>PACE PPL | Claim Type: W, G<br><br>Recipient Program Codes: W03, W04, W08, W09, W10, W14, W15, W16, W22, W23, W24, W25, W26 |
| Waiver Comprehensive Non-Waiver Services | All Taxonomies | | EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X<br><br>Recipient Program Codes: W03, W04, W08, W09, W10, W14, W15, W16, W22, W23, W24, W25, W26 |
| Waiver - Community Choices Waiver Only | 251B00000X | Case Management | Claim Type: W, G<br><br>Recipient Program Codes: S24, S25, S46, S47, N98, R01, R02, R03, R04 |
| Waiver - Community Choices Non-Waiver Services | All Taxonomies | | EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251B00000X<br><br>Recipient Program Codes: S24, S25, S46, S47, N98, R01, R02, R03, R04 |
| Waiver - Pregnant by Choice | All Taxonomies | | Recipient Program Code: A20 |
| Waiver - Supports Waiver Only | 251C00000X<br>251X00000X | Day Training, DD<br>PACE PPL | Claim Type: W, G<br><br>Recipient Program Codes: W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21 |
| Waiver - Supports Non-Waiver Services | All Taxonomies | | EXCLUDE Claim Types W, G for Pay to Provider Taxonomies: 251C00000X, 251X00000X<br><br>Recipient Program Codes: W01, W02, W05, W06, W07, W11, W12, W13, W17, W18, W19, W20, W21 |

Table 78. Data Parameters for Subprogram and Special Populations

| Subprogram / Special Population | Parameters |
|---|---|
| Crossover Claims | Claim Type: B, V, X |
| Foster Care - Medicaid | Recipient Program Codes: A51, A52, A85, A86, A88, A97, A98, S63 |
| Foster Care - State Funded | Recipient Program Codes: A95, A96, A99 |
| Project Out | Procedure Codes S5165, T2038, T1017, S9986 and Pay to Provider Taxonomy 251B00000X |