

# Wyoming

**Total Medicaid Enrollment:** 81,600 (FY 2006)

Source: <http://www.statehealthfacts.org>

**Total Population:** 532,668(2008)

Source: Population Division, U.S. Census Bureau

<http://quickfacts.census.gov/qfd/states/56000.html>

For Wyoming specific information, visit Wyoming's Medicaid Website:

<http://wdh.state.wy.us/>.

## Medicaid Eligibility

Maximum Income Limits for Populations Applying for Medicaid as a Percentage of Federal Poverty Guidelines, 2009	
Population Segment	%
Infants (Ages 0 – 1)	133
Children (Ages 1 – 5)	133
Children (Ages 6 – 19)	100
Working Parents <sup>1, 2</sup>	54
Non-Working Parents <sup>1, 2</sup>	40
Pregnant Women	133
Aged and Disabled (OBRA '86), 2001 <sup>3</sup>	NA
Supplemental Security Income, 2000	74
Medicaid expansion group (1115 waiver):	NA

Source: [www.statehealthfacts.org](http://www.statehealthfacts.org)

## Children's Health Insurance Program (CHIP)

CHIP coverage applies to uninsured children with incomes that are too high to qualify for Medicaid but are less than or equal to the maximum CHIP income limits.

**Total CHIP Enrollment:** 8,976 (FY 2008)

Source: <http://www.statehealthfacts.org>

Structure of CHIP As of April 1, 2009		
Separate State Program	Medicaid Expansion	Combination Program
X		

Source: Centers for Medicare and Medicaid Services

<http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/CHIPStatePlanActivityMap.pdf>

<b>Maximum Income Limits for Children's Separate CHIP Program as a Percentage of Federal Poverty Guidelines, 2009</b>	
<b>Population Segment</b>	<b>%</b>
Income Eligibility – Separate CHIP Program	200

Source: [www.statehealthfacts.org](http://www.statehealthfacts.org)

### *Services Covered*

For information about the services covered by Medicaid, visit the Kaiser Family Foundation's Medicaid Benefits Online Database: [www.kff.org/medicaid/benefits](http://www.kff.org/medicaid/benefits).

### *Delivery System Description*

<b>Medicaid Enrollment by Delivery System Type, as of June 30, 2006</b>		
<b>Delivery System</b>	<b>#</b>	<b>%</b>
Fee-for-Service	62,660	100
Managed Care	0	0
<b>Total</b>	<b>62,660</b>	<b>100</b>

Source: [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04\\_MdManCrEnrllRep.asp](http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp)

<b>Medicaid Enrollment by Managed Care Program Type, as of June 30, 2006</b>	
<b>Managed Care Program</b>	<b>#</b>
Commercial MCO <sup>4</sup>	0
Medicaid-only MCO <sup>5</sup>	0
Health Insuring Organization <sup>6</sup>	0
Primary Care Case Management <sup>7</sup>	0
Prepaid Inpatient Health Plan <sup>8</sup>	0
Prepaid Ambulatory Health Plan <sup>9</sup>	0
PACE <sup>10</sup>	0
Other <sup>11</sup>	0

Source: [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04\\_MdManCrEnrllRep.asp](http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp)

Notes: Individuals can fall within more than one type of managed care program type.

### *Federal Matching Rate (FMAP)*

<b>FMAP<sup>12</sup> for Medicaid and Multiplier<sup>13</sup> FY 2009</b>
56.20%

Source: [www.statehealthfacts.org](http://www.statehealthfacts.org)

## Rural Information

The information below defines “Urban” as residing in a metropolitan county and “Rural” as residing in a non-metropolitan county.

<b>Age</b>	<b>Urban % on Medicaid</b>	<b>Rural % on Medicaid</b>
0 – 18	22.2	22.3
19 – 64	5.1	5.3
65 and Over	3.7	3.0

Source: Current Population Survey, 2006 - 2007

County level data is not available on Wyoming’s website.

## Critical Access Hospital Payment under Medicaid

<b>Care</b>	<b>Payment Type</b>
Inpatient	No special reimbursement
Outpatient	No special reimbursement

Source: Renee Probst, Wyoming Hospital Association, 2009.

<sup>1</sup> Parents’ eligibility levels are based upon the income threshold applied to a working parent in a family of three.

<sup>2</sup> In Wyoming, the earning disregard is based on marital status and whether one or both parents are employed. The figures in this table represent the income thresholds for families with unmarried parents with one earner.

<sup>3</sup> This Section 209b states exercise an option that allows states to use their 1972 financial and non-financial standards instead of the federal SSI standards to determine eligibility for the disabled. If a state uses its more restrictive 1972 financial eligibility standards, it must also allow disabled individuals to “spend down” into Medicaid eligibility by deducting incurred medical expenses from income.

<sup>4</sup> A commercial managed care organization (MCO) provides comprehensive services to Medicaid and commercial and/or Medicare populations.

<sup>5</sup> A Medicaid MCO provides comprehensive services to only Medicaid beneficiaries, not to commercial or Medicare populations.

<sup>6</sup> CMS defines a Health Insuring Organization (HIO) as “a managed care entity which, by law, is exempt from certain rules governing MCO program operation such as the requirement for beneficiaries to have a choice of at least two managed care entities in mandatory programs.”

<sup>7</sup> CMS defines a Primary Care Case Management (PCCM) provider as: “a provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants who contracts directly with the State to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category also includes those PIHPs that contract with the State as “primary care case managers.”

<sup>8</sup> CMS defines a Prepaid Inpatient Health Plan (PIHP) as a plan that “provides less than comprehensive services on an at-risk or other than state plan reimbursement basis; and provides, arranges for, or otherwise

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have responsibility for provision of any inpatient hospital institutional services.” States can offer PIHPs for medical services, mental health, substance abuse disorders, or long-term care services.

<sup>9</sup> CMS defines a Prepaid Ambulatory Health Plans (PAHP) as a plan that “provides less than comprehensive services on an at-risk or other than state plan reimbursement basis; and does not provide, arrange for, or otherwise have responsibility for provision of any inpatient hospital or institutional services.” States may offer PAHPs for medical services, mental health, substance abuse disorders, dental, transportation or disease management.

<sup>10</sup> CMS defines the Program for All-inclusive Care for the Elderly (PACE) as a “program that provides prepaid, capitated comprehensive, health care services to the frail elderly.”

<sup>11</sup> CMS categorizes managed care organizations as “other” if it is “not considered a PCCM, PIHP, PAHP, Commercial MCO, Medicaid-only MCO, HIO or PACE.”

<sup>12</sup> The Federal Medical Assistance Percentage (FMAP) is computed from a formula that takes into account the average per capita income for each State relative to the national average. By law, the FMAP cannot be less than 50%.

<sup>13</sup> The multiplier is based on the FMAP. For every dollar the state spends on Medicaid, the federal government matches at a rate that varies year to year.