Wyoming Medicaid – Provider Network

PROGRAM CORE PURPOSE

Wyoming Medicaid ensures client access to adequate and accessible healthcare provider network through the management of provider enrollment and reimbursement.

OUTCOMES – PROVIDER ENROLLMENT

Performance Metric		SFY 2018 Target	SFY 2019 Target	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Physicians	% of Licensed and Practicing	>99%	>99%	99% + (est.)	99% + (est.)	99% + (est.)	99%+ (est.)	99%+ (est.)
	# In-State	N/A	N/A	1,671	1,800	1,891	1,786	1,915
	# Out-of-State	N/A	N/A	6,552	7,664	7,472	7,133	6,785
Nursing Facilities*	% of In-State	100%	100%	100%	100%	100%	100%	100%
	# In-State	N/A	N/A	39	55	55	57	56
	# Out-of-State	N/A	N/A	15	21	19	20	15
Hospitals**	% of In-State	100%	100%	100%	100%	100%	96.8%	96.7%
	# In-State	N/A	N/A	29	30	31	31	31
	# Out-of-State	N/A	N/A	331	310	270	234	201
Pharmacies	% of In-State	>95%	>95%	86% (est.)	95%*** (est.)	98.5%	100%	100%
	# In-State	N/A	N/A	127	132	131	134	126
	# Out-of-State	N/A	N/A	90	101	93	98	90
Dentists	% of Licensed and Practicing	>85%	>85%	76%	78%	79%	79%	72%
	# In-State	N/A	N/A	300	324	327	346	343
	# Out-of-State	N/A	N/A	137	131	142	143	135

(-) Indicates data not yet available
N/A indicates data not yet available due to the creation of a new metric
* includes swing beds
**31 licensed by OHLS in 2017, 30 participating, 1 not participating. Aspen Mountain Medical Center in Rock Springs is the sole non-participant.
***Metric updated to reflect % enrollment of pharmacies licensed and able to enroll with Medicaid

Outputs and Efficiencies										
Performance Metric		SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	2017 Q1+Q2	2017 Q3+Q4	2018 Q1+Q2	2018 Q3+Q4
Physician rates as a % of the regional average		121%	111%	111%	93%	-	N/A	N/A	N/A	N/A
Nursing facilities % cost coverage with the upper payment limit (UPL)*		87%	83%	91%	91%	89.4%	N/A	N/A	N/A	N/A
Hospital % cost coverage with the qualified rate adjustment (QRA)**	Inpatient	83%	85%	90%	99%	-	N/A	N/A	N/A	N/A
	Outpatient	67%	68%	66%	99%	-	N/A	N/A	N/A	N/A
Dental rates as a % of the estimated provider cost***		96%	88%	90%	91%	-	N/A	N/A	N/A	N/A
% of hospital inpatient days paid by Medicaid		15.89%	13.41%	13.77%	13.93%	-	N/A	N/A	N/A	N/A
Efficiencies										
ALL Claims Processing Time (days)	Service to Bill	26.9	27.4	29.2	33.6	35.7	N/A	N/A	N/A	N/A
	Turnaround Time Receipt to Payment	4.4	4.6	4.2	4.4	3.95	N/A	N/A	N/A	N/A
	Service to Payment	31.3	32	33.3	38	39.6	N/A	N/A	N/A	N/A
% of all claims denied		9.7%	10.6%	12.9 %	13.7%	12.7%	N/A	N/A	N/A	N/A

(-) Indicates data not yet available
N/A indicates data not available on a quarterly basis
* UPL implemented mid-year 2011; data is collected by FFY
** in-state hospitals only
*** Based on the 2016 ADA Survey of Dental Fees and Expenses

Story Behind the Performance

- 42 U.S.C § 1396a(a)(30)(A) – requires states to: "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."
- On an annual basis, Medicaid's actuarial contractor produces a benchmark report, detailing Medicaid's expenditure and reimbursement trends throughout the previous fiscal year. The Department calculates Wyoming Medicaid rates in each service area as a percentage of other states' Medicaid rates, Medicare rates, and cost estimates, as possible.
- While Medicaid strives to meet the direction set forth in 42 U.S.C. § 1396a(a)(30)(A), there are federal regulations regarding the upper payment limitations of Medicaid payments for hospital, physician, prescription drugs and laboratory services. For inpatient hospital services, Medicaid cannot exceed the provider's customary charges (42 CFR 447.271). For hospitals that do not receive DSH supplemental payments, Medicaid payment cannot exceed a reasonable estimate of what Medicare would have paid (42 CFR 447.272). For outpatient hospital and clinic services, Medicaid payment cannot exceed a reasonable estimate of what Medicare would have paid.
- SF89, 2014 – Legislation passed allowing specified licensed mental health professionals to enroll with Medicaid as pay-to provider exclusive of supervisory oversight and to directly bill Medicaid. This change began July 1, 2014. During the 2015 General Session, SEA 21 added in provisionally licensed mental health professionals as a qualified provider type for Medicaid as well beginning July 1, 2015.
- Ambulatory Surgery Center (ASC) payment methodology – was updated in SFY2015 (July 2014).The change converted the current payment structure over to mirror the outpatient prospective payment system (OPPS) currently in place for outpatient hospitals within Medicaid and Medicare.
- 2015 General Legislative Session approved an increase in nursing facility appropriation of $8,414,886. This resulted in the implementation of a new rate model and increased rates effective July 1, 2015. Hospice and swing bed rates, being tied to the state average nursing facility rate, were adjusted accordingly. Methodology caps placed on the Wyoming Retirement Center and the Wyoming Life Resource Center were removed and both state-owned facilities' rates adjust to 100% of reported cost (full cost coverage).
- 2015 General Legislative Session added chiropractic services to Medicaid State Plan. 2016 Budget Session added independently practicing licensed dietitians to Medicaid State Plan.
- Subpart E requirements of the ACA mandate Medicaid enrollment for all ordering (includes prescribing) and rendering providers. This required lower level practitioners who had not previously been Medicaid-enrolled to enroll before March 24, 2015. The ACA also required all providers to re-enroll ensuring appropriate provider screening as detailed in 42 CFR Subpart E.
- Other provider participation initiatives that impacted enrollment, eligibility and claims denial rates in SFY 2016 include 1) Mandatory re-enrollment, 2) ICD-10 implementation on October 1, 2015, 3) Electronic claims mandate implemented July 1, 2015, and 4) Mandatory inclusion of the ordering, referring, prescribing and attending provider on all claim types in preparation for July 1, 2016 when all ordering, referring, prescribing and attending providers MUST be enrolled with Medicaid.
- Starting July 1, 2016, Wyoming Medicaid was required to reduce its General Fund by $54,438,246 for the 17/18 biennium causing reductions in provider rates, coverage and client eligibility. On November 1, 2016, Medicaid implemented a 3.3% reduction to provider fee schedule rates. This included outpatient hospitals and ASC's. Provider participation has been closely monitored through implementation of various policy and rate changes.