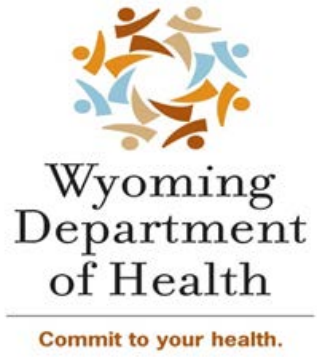

SFY 2019 WYOMING MEDICAID REIMBURSEMENT BENCHMARKING STUDY

Based on Data Ending State Fiscal Year 2019

Wyoming Department of Health

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APPENDICES

Section 1: Introduction

The SFY 2019 Wyoming Medicaid Benchmarking Study is the twelfth published, comprehensive study of reimbursement trends designed to support analysis of Medicaid reimbursement by the Wyoming Department of Health (WDH). This report is a companion document to the *Wyoming Medicaid SFY 2019 Annual Report* to provide information to policymakers as they evaluate reimbursement systems and payment levels and balance the competing demands of Medicaid providers and recipients for limited state resources.

Section 2 of this report reviews payment methodologies and analyzes Wyoming Medicaid reimbursement in comparison to other payers' rates and methodologies for the service areas listed in Figure 1.1. The SFY 2019 Benchmarking Study compares Wyoming Medicaid rates to rates from Medicare, six other state Medicaid programs (Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah) and commercial payers, where available. The methodologies and benchmarks used are detailed in Appendices A-D of this report. Section 2 also describes all Wyoming Medicaid reimbursement and benefit changes that occurred during SFY 2019. As this report focuses on SFY 2019, reimbursement and policy changes due to COVID-19 were not addressed in this report. However, the public health epidemic resulting from COVID-19 will have implications on reimbursement rates and policies in the future, which we briefly discuss in Figures 2.7 and 2.8 of this report.

Figure 1.1: Service Areas Included in the SFY 2019 Benchmarking Study

Service Areas Included in the Benchmarking Study	
Ambulance	Laboratory
Ambulatory Surgery Center (ASC)	Nursing Facilities
Behavioral Health	Program of All-Inclusive Care for the Elderly (PACE)
Dental	Public Health, Federal (Tribal Facilities)
Developmental Center	Physician and Other Practitioner: *includes primary care, physician specialist, and maternity providers*
Durable Medical Equipment, Prosthetic, Orthotic and Supply (DMEPOS)	Prescription Drug
End Stage Renal Disease (ESRD)	Psychiatric Residential Treatment Facility (PRTF)
Federally Qualified Health Center (FQHC)	Rural Health Clinic (RHC)
Home Health	Supplemental Payments
Hospice	Vision- Opthamology
Hospital[1]	Vision- Optician/Optometry
Intermediate Care Facility – Intellectually Disabled (ICF-ID)	Telehealth/Telemedicine

Considerations Regarding Medicaid Reimbursement

In many states, Medicaid rates are generally lower than commercial and Medicare rates. Additionally, Medicaid rates are often held to a different standard. Although comparisons to reimbursement benchmarks are useful to WDH for planning purposes, the Federal requirements for Medicaid rates ultimately govern reimbursement decisions. The Federal requirements allow each state to set its own rates, but states must comply with the provisions of *42 U.S.C. § 1396a(a)(30)(A)*, which 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.*

In addition, it is generally accepted that Medicaid will act as a prudent purchaser of services. As a public program, Medicaid has limited resources with which to provide services and must

[1] Includes inpatient and outpatient hospital services. Inpatient services DRG benchmarking information is included in Appendix B1.

promote responsible use of taxpayer funds. Medicaid, therefore, must make difficult choices regarding provider payment relative to the economic environment of the State and the availability of funding.

Federal regulations (*42 CFR 447.203*) require states to monitor access to services and to determine whether reimbursement is sufficient to assure access, as described in *42 U.S.C. § 1396a(a)(30)(A),* above*.* Under these regulations, states must submit to CMS an "Access Monitoring Review Plan" every three years that assesses access and fee-for-service (FFS) reimbursement levels for five service types: primary care, physician specialist, maternity, behavioral health, and home health. In addition, states must conduct an access evaluation for any future state plan amendment that reduces provider rates or restructures payments in ways that may reduce access to care for any service type. Access evaluations are expected to address the following:

- The extent to which beneficiary needs are being met
- The availability of care through enrolled providers to beneficiaries by provider type and site of service
- Changes in beneficiary utilization of covered services
- The characteristics of the beneficiary population, including considerations for care, service, and payment variations across populations
- Comparison of provider payment levels to other payers, including Medicare and commercial payers

Finally, there are Federal regulations regarding the upper limitations of Medicaid payments for hospital, physician, clinic, prescription drugs and laboratory services with which states must comply. For example:

- For inpatient hospital services, Medicaid payment may not exceed a reasonable estimate of the amount that would be paid under Medicare to a group of facilities within one of the provider grouping categories (state-owned or operated, non-state owned or operated, and private).[2] For outpatient hospital and clinic services, the upper payment limit (UPL) for Medicaid payment may not exceed a reasonable estimate of the amount that would be paid under Medicare. Further, Medicaid payments to a group of facilities within one of the provider grouping categories (state-owned or operated, non-state government owned or operated, and private) may not exceed the upper payment limit.[3,4]
- For Psychiatric Residential Treatment Facilities (PRTFs) and Institutions of Mental Disease (IMDs), Medicaid payment may not exceed the provider's customary charges.[5]

[2] 42 CFR § 447.272
[3] 42 CFR § 447.321
[4] The provider grouping categories are 1) state-owned or operated, 2) non-state owned or operated and 3) privately owned or operated.
[5] 42 CFR § 447.272

- Medicaid payment for clinical diagnostic laboratory services provided by a physician, independent laboratory or hospital may not exceed the Medicare fee schedule.[6]

Considerations Regarding Rate Adjustments

Wyoming Medicaid performs rate updates for most services on an "as needed" basis, although some rate components are updated annually to use new service weights [for example, relative values for outpatient hospital Ambulatory Payment Classifications (APCs) and provider cost-to-charge ratios for the inpatient and outpatient payment systems]. Wyoming Medicaid must take into account State budget targets when performing updates, which can involve maintaining budget neutrality for a particular service area or for the entire Wyoming Medicaid program, or implementing legislatively-mandated budget increases or decreases (service-specific or overall). Updates to one fee schedule may affect multiple service areas [for example, Wyoming Medicaid's Physician and Other Practitioner Resource Based Relative Value Scale (RBRVS) fee schedule applies to nurse practitioners specializing in physical health and behavioral health]. Performing updates in a coordinated, timely fashion minimizes the potential for payment approaches to become out of sync with industry standards and current utilization and expenditure trends.

Comparison to Other States' Medicaid Programs

Comparisons to other states' Medicaid rates can provide Wyoming Medicaid with relevant benchmarks. However, it is important to consider that states have different reimbursement methodologies and coverages so direct rate comparisons may be difficult in some situations. Medicaid rates may be impacted by a state's desire to provide consistent reimbursement between service areas, or impacted by efforts to attract and retain provider types that are especially important to the Medicaid population. Therefore, when looked at in isolation, rate comparisons across states or service areas may not provide an accurate view of a state's underlying policy decisions.

For purposes of this report, WDH compared Wyoming Medicaid rates to Medicaid rates from the surrounding states of Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah. The SFY 2017 benchmarking report included the frontier states of Alaska and North Dakota to gather information about Wyoming's Medicaid payments in comparison to other frontier states. To provide a regional perspective, WDH decided to focus on neighboring states for the SFY 2018 and SFY 2019 benchmarking reports and replaced Medicaid benchmarks for Alaska and North Dakota with Idaho and Nebraska. The methodology for these comparisons is explained in Appendix A and detailed analyses by service area are presented in Appendix B.

Comparison to Medicare

Although there are differences between Medicare and Medicaid in terms of coverage and payment policies, Medicare is an important comparison point for Medicaid. Some Medicaid services are covered only to a limited extent by Medicare. For example, there are several

[6] State Medicaid Manual, Title XIX State Plan Amendments, Part 6 Section 6300.2 "Fee Schedules for Outpatient Clinical Laboratory Tests".

services, including nursing home, that are primarily covered by Medicaid and to a more limited extent (and with different coverage) by Medicare. There are other services, such as dental or vision, that are generally not covered by Medicare. Medicare policy often influences payment policies of other payers, including both commercial and Medicaid payers. In addition, Medicaid and Medicare are both public programs and must provide access to care while appropriately and responsibly spending public funds. However, Congress decides Medicare reimbursement levels, while Medicaid reimbursement methodologies and levels are determined by state legislatures and the agencies that administer the programs.

For services which Medicare bases service reimbursement on a fee schedule, WDH compared Wyoming Medicaid rates for each procedure to the Medicare rates in 2019 fee schedules.[7] Medicare pays for the following services using a fee schedule: ambulance, behavioral health, DMEPOS, hospice, laboratory, physician, and vision services.[8] To the extent that the Medicare rates varied by geographic region, WDH used those rates that are specific to Wyoming.[9] To determine Medicare rates for home health services, WDH calculated average Medicare home health visit rates in Wyoming using the average Wyoming Wage Index Budget Neutrality Factor. To compare Wyoming Medicaid outpatient hospital payments to Medicare, WDH compared Wyoming Medicaid's weighted outpatient conversion factor based on SFY 2019 claims volume (see Figure 2.6) to Medicare's CY 2019 Outpatient Prospective Payment System (OPPS) conversion factor. The methodology for these comparisons is explained in Appendix A, and detailed analyses are presented in Appendix C.

Comparison to Commercial Payers

Another benchmark for consideration is the rates that commercial health plans pay providers in the State. For services that Medicaid reimburses using a fee schedule, WDH compared rates to amounts paid by commercial (i.e., non-government) health plans in Wyoming. We calculated a benchmark by calculating the average amount paid for each service, using the 2018 Truven MarketScan database.[10] The methodology for these comparisons is explained in Appendix A, and detailed analyses by service area are presented in Appendix B.

Medicaid Expansion

Medicaid expansion has continued to gain traction across the United States with 37 states adopting expansions to their Medicaid program as of SFY2019, including several of Wyoming's surrounding states. Colorado chose to adopt Medicaid expansion when first available on January 1, 2014. Since then Idaho, Montana, Nebraska, and Utah have all approved Medicaid expansion. Medicaid expansion was approved via ballot measure by voters in November 2018

[7] Medicare updates rates on a calendar year (CY) basis while Wyoming Medicaid updates rates on a state fiscal year (SFY) basis; therefore, we compared Medicare rates from CY 2019 to Wyoming Medicaid rates from SFY 2019.
[8] FFS Medicare does not normally cover routine vision services, such as eyeglasses and eye exams, but it may cover some vision costs associated with eye problems that result from an illness or injury.
[9] WDH used Wyoming-specific Medicare fee schedules for the following service areas: ambulance, behavioral health, DMEPOS, laboratory, physician, and vision. Medicare does not produce Wyoming-specific fee schedules for ASC or hospice.
[10] Truven MarketScan commercial claims data contains claims from commercial major medical plans, and therefore does not include claims for dental or vision services. For our analysis, we used allowed amounts for services provided by in-network providers. Truven data comprises claims from all of calendar year 2018 (the most recent year of data available).

in Idaho, Nebraska, and Utah. [11] While most states expanded Medicaid in the traditional manner as outlined by the Affordable Care Act, a few states including Montana and Utah expanded Medicaid in an alternative manner (with approval from CMS) through a 1115 waiver.[12] Attempts to expand Medicaid in Wyoming and South Dakota have not had the support of the respective state legislatures.

Trend Towards Value-Based Payments

There is significant movement in the health care industry away from volume-based fee-for-service payment strategies and towards strategies that link payments to quality and outcomes. There are many emerging and evolving payment and service delivery models that provide state Medicaid agencies with the opportunity to move in this direction. For example, add-on care coordination payments, bundled episodes of care, and shared savings arrangements frequently used with accountable care organizations (ACOs). These models require sophisticated analytical and claims processing support and significant collaboration with providers as changes to service delivery systems are often required. WDH currently provides health and utilization management through its WYhealth program and can build upon its experience with WYhealth to look towards value-based payments for opportunities to slow cost growth and improve health outcomes.

Fee-for-Service (FFS) vs Medicaid Managed Care Activities

Another trend seen in the health care industry is the transition from fee-for-service to managed care. In a bid to control rising health care costs, state Medicaid programs have contracted with managed care plans to provide service for their enrollees as well as integrated elements of managed care into their state Medicaid programs. As shown in Figure 1.2, all of Wyoming's six surrounding comparison states have implemented elements of managed care into their Medicaid programs, with actions ranging from assigning enrollees to medical homes to contracting with accountable care organizations. Two of these surrounding states – Nebraska and Utah – have gone one step farther and enrolled over 80 percent of their Medicaid populations in comprehensive managed care plans. In comparison, Wyoming operates primarily on a fee-for-service model and has less than one percent of their total Medicaid population enrolled in any type of Medicaid managed care.[13]

Figure 1.2: Percent of Medicaid Beneficiaries Enrolled in Managed Care[14]

State	Percent of Medicaid Beneficiaries Enrolled in Any Type of Managed Care	Percent of Medicaid Beneficiaries Enrolled in Comprehensive Managed Care
Wyoming[15]	0.6%	0.2%

[11] Medicaid expansion was implemented on the following dates: Montana (1/1/2016), Idaho (1/1/2020), and Utah (1/1/2020).
[12] National Academy for State Health Policy. Where states stand on Medicaid expansion as of March 2020. Available online: https://nashp.org/states-stand-medicaid-expansion-decisions/
[13] CMS defines Comprehensive Managed Care as managed care plans that provide enrollees with comprehensive benefits including acute, primary care, specialty, etc. CMS also classifies PACE programs as comprehensive managed care.
[14] Reported by CMS as of July 2017. See "Medicaid Managed Care Enrollment Report," available online: https://www.medicaid.gov/medicaid/managed-care/enrollment/index.html
[15] Wyoming Medicaid managed care was primarily used for the PACE program. Wyoming has one 1915(b) managed care

State	Percent of Medicaid Beneficiaries Enrolled in Any Type of Managed Care	Percent of Medicaid Beneficiaries Enrolled in Comprehensive Managed Care
Colorado	96.1%	10.2%
Idaho	97.8%	0.8%
Montana	76.0%	0.0%
Nebraska	99.5%	99.5%
South Dakota	74.9%	0.0%
Utah	99.4%	82.8%

The percent of Medicaid spending on managed care varies from state to state, as shown in Figure 1.3. All of Wyoming's surrounding comparison states still use a fee-for-service reimbursement model for some acute and long-term care costs.[16] Nebraska and Utah have the largest spend for managed care at approximately 50 percent of total Medicaid spending. While these states have the majority of their Medicaid population enrolled in managed care, Medicaid beneficiaries with more extensive needs are difficult to serve through managed care due to the specialized services and resources needed to adequately meet their needs. These populations are often served on a fee-for-service model and can help explain the disconnect between Medicaid enrollment in managed care and spending. Colorado and Idaho have almost 100 percent of their Medicaid population enrolled in some type of managed care, but only a small proportion enrolled in comprehensive managed care. As a result, managed care accounts for only 17 percent of spending in Colorado and 10 percent of spending in Idaho. Wyoming, along with Montana and South Dakota, which have the smallest percent of their population enrolled in managed care, spend one percent or less of Medicaid costs on managed care.

Figure 1.3: Medicaid Spending by Service Area[17]

State	Acute Care (FFS)	Long Term Care (FFS)	Managed Care	Payments to Medicare	DSH[18]
Wyoming	48%	49%	1%	2%	<1%
Colorado	59%	20%	17%	2%	2%
Idaho	49%	37%	10%	4%	1%
Montana	72%	24%	1%	3%	0%
Nebraska	6%	42%	48%	3%	2%
South Dakota	55%	40%	<1%	4%	<1%
Utah	24%	30%	44%	2%	1%

Numbers may not sum to 100% due to rounding

waiver that provides wraparound Care Management Entity (CME) benefits for children with serious emotional disorders-statewide, as well as a PACE program that was only available in Laramie County.

[16] Wyoming accounting for the majority of their Medicaid spending through FFS Acute Care and Long-Term Care.

[17] Reported by Kaiser Family Foundation from data based on the Urban Institutes Federal FY 2018 data as reported to CMS as of August 2019. See "Distribution of Medicaid Spending by Service," available online: https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/.

[18] DSH payments are supplementary payments made to hospitals that serve a disproportionate number of low-income patients.

Section 2: Reimbursement Options

Policymakers face difficult decisions about how to most effectively distribute limited state resources. As part of the process, they must evaluate reimbursement systems and payment levels, make recommendations for further analysis, and change and set priorities. The purpose of this section is to provide information and rationale to support WDH's decision-making process regarding reimbursement policies and levels.

Section 2 describes WDH's recommendations regarding Medicaid reimbursement methodologies, payment amounts, and timing and methodology of payment increases. These reimbursement recommendations support WDH's goals of using rational payment methodologies, providing consistency across service areas, and providing fair payments that supports providers' continued participation in Wyoming Medicaid and beneficiaries access to services.

Program Changes During SFY 2019

Wyoming Medicaid made several program changes pertaining to covered services and reimbursement during SFY 2019, which are presented in Figure 2.1.

Figure 2.1: Medicaid Coverage and Reimbursement Changes During SFY 2019

Eligibility Category/ Service Area	Action	Dates of Implementation
Children's Mental Health Waiver	Changed reimbursement for Care Management Entity (CME) to a nonrisk based capitated payment for administrative services and for network providers to a fee for service payments system.	January 1, 2019
Outpatient Prospective Payment System (OPPS)	Recalculated the OPPS conversion factors to: o $42.53 for General Acute Care Hospitals o $88.45 for Children's Hospitals o $105.89 for Critical Access Hospitals o $37.42 for Ambulatory Surgical Centers (ASCs)	January 1, 2019
Hospital Inpatient	Implemented All Patients Refined Diagnosis Related Groups (APR- DRG) implemented May 31, 2019 with an effective date of February 1, 2019. Private hospital UPL program, DSH, QRA remain in place.	February 1, 2019
Non-Physician Fee Schedule	Certified midwives have been approved as Medicaid providers.	July 1, 2019

Wyoming Medicaid Comparisons to Benchmarks

Comparing state Medicaid rates to other benchmarks may be useful in assessing rates, providing consistency between service areas, or in efforts to direct funding to provider types or

service areas to attract or retain provider types that are especially important to the Medicaid population. WDH conducted comparisons to other states' Medicaid rates, Medicare rates and average commercial payments to provide Wyoming Medicaid with relevant benchmarks. WDH calculated Wyoming Medicaid rates in each service area as a percentage of other states' Medicaid rates, Medicare rates, and average commercial payments.[19] Calculating this percentage allows the payment rates in each service area to be compared relative to each other and the percentages can be used as an indicator of consistency. For example, if the Medicaid to Medicare rate ratios are similar for all the service areas, it may suggest that payment is set at a consistent level across service areas. If there are high or low outlier ratios, WDH may wish to further review payment levels for those services.

Figures 2.2 and 2.3 present summaries of Wyoming Medicaid rates by service area to three benchmarks where available: other states' rates, Medicare, and commercial payers.

Figure 2.2 compares Wyoming Medicaid rates to other states, Medicare, and commercial payers, based on services with the highest total paid claims in SFY 2019 within each service area.

Figure 2.2: Comparison of Wyoming Medicaid Rates to Other States, Medicare, and Commercial Payers Using Top Services Based on Utilization[20]

Service Area	Wyoming 2019 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2019 Medicare Rates	Average Commercial Payments (2019)
Ambulance	123%	80%	Data not available[21]
ASC	120%	115%	Data not available[22]
Behavioral Health[23]	98%	86%	Data not available[24]
Dental	123%	Medicare does not cover this service.	79% of estimated costs[25]

[19] The review of rates is limited to the top 20 procedure codes in Wyoming Medicaid claims data for each service area, based on the most frequently utilized codes and the top 20 codes with highest total expenditures during SFY 2019.
[20] For these comparisons, WDH reviewed the top codes for each service area based on paid claims volume in SFY 2019 and compared the 2019 Wyoming Medicaid rates to 2019 Medicare rates and 2019 fee schedules from Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah (if SFY 2019 fee schedules were not available online, WDH used the most recent rates available).
[21] There is little or no Truven MarketScan 2018 data for this service area.
[22] There is little or no Truven MarketScan 2018 data for this service area.
[23] Only CPT codes were included in this analysis because Medicare and other states do not consistently use the H, T, and G codes that Wyoming uses; therefore, no rate comparisons were possible for those codes. According to Appendix B.1, the number of codes for By Utilization is 11 because 11 of the top 20 codes were CPT codes, and the other 9 are H, T, and G codes.
[24] There is little or no Truven MarketScan 2018 data for this service area.
[25] We cannot estimate Wyoming Medicaid dental rates as a percentage of commercial payments because Truven MarketScan data does not include dental claims. Wyoming Medicaid rates as a percentage of commercial costs are based on an analysis using the 2018 ADA Survey of Dental Fees and Expenses in combination with ADA's most recent Survey of Dental Practices (2017). WDH compared Wyoming Medicaid's fees for the top procedure codes to fees from dentists in Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming, and multiplied fees by a dental-specific cost-to-charge ratio to calculate average commercial dental costs for each procedure code.

Figure 2.2: Comparison of Wyoming Medicaid Rates to Other States, Medicare, and Commercial Payers Using Top Services Based on Utilization[20]

Service Area	Wyoming 2019 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2019 Medicare Rates	Average Commercial Payments (2019)
Developmental Center	111%	85%	Data not available [26]
DMEPOS[27]	117%	86%	Data not available[28]
Home Health	89%	54%	128%
Hospice	98%	99%	92%
Hospital – Inpatient	Wyoming Medicaid pays approximately 78.4 percent of inpatient costs.[29]		
Hospital – Outpatient	The weighted average OPPS conversion factor for Wyoming is $57.44. Montana uses a single conversion factor of $56.64 and Utah follows Medicare's. OPPS conversion factor ($78.64 in CY 2018).	72%	Reimbursement methodology does not allow for direct comparisons.
Laboratory	105%	102%	100%
Nursing Facility[30]	105%	Data not available	
Physician and other Practitioner	117%	111%	73%
Primary Care	99%	89%	59%
Physician Specialist	121%	111%	Data not available[31]
Prescription Drugs	Wyoming's dispensing fee: $10.65 Other states' dispensing fees range from $9.31 to $15.11 depending on various factors.[32]	N/A	N/A

[26] While our analysis found that commercial payers reimburse 60 percent of Medicaid, on average, for the types of services provided by Developmental Centers, Developmental Centers do not typically bill commercial insurance. Therefore, there is little or no Truven MarketScan 2018 data available.
[27] The Wyoming 2019 Medicaid rate as a percentage of other states' and Medicare rates for DMEPOS equals the average of the rates for purchasing DMEPOS equipment. There is little to no rental DMEPOS data available for SFY2019.
[28] There is little or no Truven MarketScan 2018 data for this service area.
[29] Inpatient costs are calculated using cost-to-charge ratios from hospitals' Medicare cost reports. See Figure 2.5 for additional explanation.
[30] Wyoming's reimbursement methodology for nursing facilities is cost-based; reimbursement currently covers an estimated 88 percent of nursing facilities' costs when supplemental payments (based on the nursing home assessment program) are included in the cost coverage calculation.
[31] There is little or no Truven MarketScan 2018 data for this service area.
[32] Excluding dispensing fees for drug compounding. See Appendix B.1 for more information about prescription drug

Figure 2.2: Comparison of Wyoming Medicaid Rates to Other States, Medicare, and Commercial Payers Using Top Services Based on Utilization[20]

Service Area	Wyoming 2019 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2019 Medicare Rates	Average Commercial Payments (2019)
Maternity Care[33]	113%	102%	55%
PRTF	98%	Medicare does not cover this service.	Data not available
Vision – Ophthalmology	120%	95%	79%
Vision – Optician and Optometrist	129%	88%	Data not available

Figure 2.3 compares Wyoming Medicaid rates to other states, Medicare, and commercial payers, based on services with the highest total expenditures in SFY 2019 within each service area.

Figure 2.3: Comparison of Wyoming Medicaid Rates to Other States, Medicare, and Commercial Payers Using Top Services Based on Expenditures[34]

Service Area	Wyoming 2019 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2019 Medicare Rates	Average Commercial Rates in Wyoming (2019)
Ambulance	123%	80%	Data not available[35]
ASC	120%	115%	Data not available[36]
Behavioral Health[37]	105%	90%	Data not available[38]
Dental	121%	Medicare does not cover this service.	82% of estimated costs[39]

reimbursement in each state.

[33] Over the past three years, Wyoming Medicaid has historically paid from 102% to 104% more for maternity care services than Medicare.

[34] For these comparisons, WDH reviewed the top codes for each service area based on total expenditures in SFY 2019 and compared the 2019 Wyoming Medicaid rates to 2019 Medicare rates and 2019 fee schedules from Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah (if SFY 2019 fee schedules were not available on the States' websites, we used the most recent rates available).

[35] There is little or no Truven MarketScan 2018 data for this service area.

[36] There is little or no Truven MarketScan 2018 data for this service area.

[37] Only CPT codes were included in this analysis because Medicare and other states do not consistently use the H, T, and G codes that Wyoming uses; therefore, no rate comparisons were possible for those codes.

[38] There is little or no Truven MarketScan 2018 data for this service area.

[39] We cannot estimate Wyoming Medicaid dental rates as a percentage of commercial payments because Truven MarketScan data does not include dental claims. Wyoming Medicaid rates as a percentage of commercial costs are based

Figure 2.3: Comparison of Wyoming Medicaid Rates to Other States, Medicare, and Commercial Payers Using Top Services Based on Expenditures[34]

Service Area	Wyoming 2019 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2019 Medicare Rates	Average Commercial Rates in Wyoming (2019)
Developmental Center	111%	85%	Data not available[40]
DMEPOS[41]	114%	N/A	Data not available[42]
Home Health	89%	54%	128%
Hospice	98%	99%	92%
Hospital – Inpatient	Wyoming's reimbursement of in-state inpatient services covers approximately 78.4 percent of costs .[43]		
Hospital – Outpatient	The weighted average OPPS conversion factor for Wyoming is $57.44. Montana uses a single conversion factor of $50.98 and Utah follows Medicare's OPPS conversion factor ($78.64 in CY 2018).	72%	Reimbursement methodology does not allow for direct comparisons.
Laboratory	105%	102%	100%
Nursing Facility[44]	105%	Data not available	
Physician and other Practitioner	100%	91%	56%
Primary Care	108%	94%	59%
Physician Specialist	108%	93%	54%
Prescription Drugs	Wyoming's dispensing fee: $10.65	N/A	N/A

on an analysis using the 2018 ADA Survey of Dental Fees and Expenses in combination with ADA's most recent Survey of Dental Practices (2017). We compared Wyoming Medicaid's fees for the top procedure codes to fees from dentists in Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming, and multiplied fees by a dental-specific cost-to-charge ratio to calculate average commercial dental costs for each procedure code.

[40] While our analysis found that commercial payers reimburse 60 percent of Medicaid, on average, for the types of services provided by Developmental Centers, Developmental Centers do not typically bill commercial insurance. Therefore, there is little or no Truven MarketScan 2018 data available.

[41] The Wyoming 2019 Medicaid rate as a percentage of other states' and Medicare rates for DMEPOS equals the average of the rates for purchasing DMEPOS equipment. There is little to no rental DMEPOS data available for SFY2019.

[42] There is little or no Truven MarketScan 2018 data for this service area.

[43] Inpatient costs are calculated using cost-to-charge ratios from hospitals' Medicare cost reports. See Figure 2.5 for additional explanation.

[44] Wyoming's reimbursement methodology for nursing facilities is cost-based; reimbursement currently covers an estimated 88 percent of nursing facilities' costs after supplemental payments based on the Nursing Home tax assessment program are made.

Figure 2.3: Comparison of Wyoming Medicaid Rates to Other States, Medicare, and Commercial Payers Using Top Services Based on Expenditures[34]

Service Area	Wyoming 2019 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2019 Medicare Rates	Average Commercial Rates in Wyoming (2019)
	Other states' dispensing fees range from $9.31 to $15.11 depending on various factors.[45]		
Maternity Care[46]	115%	107%	61%
PRTF	98%	N/A[47]	Data not available
Vision – Ophthalmology	119%	108%	77%
Vision – Optician and Optometrist	160%	81%	Data not available

Key findings from these analyses include:

- The Medicaid programs in surrounding states use similar methodologies to Wyoming for most service areas.
- Wyoming Medicaid pays higher rates than Medicaid programs in surrounding states for many service areas but pays slightly lower rates for the other service areas. Additional information about Wyoming's and surrounding states' rates are included in Appendices B1 of this report.
- Based on highest utilized services, Wyoming Medicaid rates as a percentage of the average of other states' rates range from 89 percent for home health services to 129 percent for vision (Optician and Optometrist) services.
- In the benchmarking analysis, Wyoming Medicaid, on average, paid more for physician services included in the Physician and other Practitioner, Physician Specialist, and Maternity Care when looking at the top utilized procedure codes for these service areas. A similar tend occurs with Maternity Care and Vision/Ophthalmology services when looking at the top service expenditures.
- Wyoming Medicaid last updated the relative value units (RVUs) associated with its RBRVS rates in SFY 2010. While Medicare's RBRVS conversion factors and RVUs are updated annually, Wyoming's have been relatively stagnant over the past decade, with minor adjustments, additions and deletions of some procedure codes and a 3.3 percent reduction the Wyoming Medicaid conversion factors in SFY 2017.

[45] Excluding dispensing fees for drug compounding. See Appendix B.1 for more information about prescription drug reimbursement in each state.
[46] Over the past three years, Wyoming Medicaid has historically paid from 106% to 108% more for maternity care services than Medicare.
[47] Medicare does not cover this service.

This differential rate of change has resulted in Wyoming Medicaid using a higher RBRVS conversion factor for Anesthesia and Non-Anesthesia CPT codes than Medicare does. Figure 2.4 below provides a comparison of Wyoming's SFY 2019 and Medicare's 2019 RBRVS Conversion Factors.

Payer	Anesthesia Conversion Factor	Non-Anesthesia Conversion Factor
Medicare	22.11	36.0391
Wyoming Medicaid	26.50	36.86

In addition, while conversion factors for Medicare have changed over the past decade the relative weights that are tied to the Medicare RBRVS system used for physician payments have also been revised multiple times to meet federal policy goals. This has resulted in some CPT codes in the Physician and other Practitioner, Physician Specialist, and Maternity Care categories having Medicare RVUs that are lower than the ones used by Wyoming Medicaid.

- Based on expenditures, Wyoming Medicaid pays lower relative to Medicare for the majority of service areas, excluding ASC, laboratory, maternity care and vision/ophthalmology services which Medicaid pays more than Medicare, on average. Based on expenditures, Wyoming Medicaid rates as a percentage of Medicare's range from 54 percent for home health services to 108 percent for vision/ophthalmology.
- For ASC services, the Wyoming rate as a percent of Medicare is 115 of the Medicare payment rate for ASC services reimbursed via the ASC OPPS fee schedule. Medicare reimburses ASCs using an ASC specific OPPS fee schedule that uses an ASC specific conversion factor and set of OPPS weights. For ASCs reimbursed by Wyoming Medicaid ASCs have a conversion factor equal to 88 percent of the Wyoming General Outpatient Hospital OPPS rate, equal to $37.42 in this analysis, and use the OPPS hospital weights. These weights differ between the two fee schedules causing Wyoming Medicaid's payments to exceed those of Medicare for the benchmarked procedure codes.
- For laboratory services, the overall Wyoming rate as a percent of Medicare, surrounding states and commercial increased. Wyoming's rate as a percent of Medicare increased from 94 percent to 102 percent, as a percent of the surrounding states from 97 percent to 105 percent, and as a percent of commercial rates from 79 percent to 100 percent. Wyoming's increase may be attributed to the fact that the State largely maintained their laboratory fee schedule from SFY 2018 to SFY 2019, while Medicare, Idaho, Montana and Nebraska decreased several of their rates for laboratory services.

We are unable to make comparisons for services for which reimbursement methodologies vary significantly across payers, payment rates are cost-based and vary by provider, or because

comparison rates were not available. Figure 2.4 outlines the services for which we were unable to make comparisons.

Figure 2.4: Explanation of Benchmarking Limitations

Service Area	Benchmarking Limitations
ESRD	Wyoming Medicaid reimburses on a percentage of billed charges basis; therefore, there are no facility-specific Wyoming Medicaid prospective payment rates to use for comparison to Medicare's and other states' prospective payment rates.
FQHC and RHC	Reimbursement for Medicaid services is a provider-specific per-visit rate based on an analysis of allowable costs.
ICF-ID	Per diem rates are not publicly available for Colorado, Idaho, Nebraska, Montana, or South Dakota.
Inpatient hospital	Wyoming reimburses on a LOC per discharge basis unique to the State and causing comparisons to the inpatient reimbursement rates in other states to be inaccurate as other states reimburse differently. For all inpatient claims submitted on or after February 1, 2019 Wyoming will use an APR DRG based per discharge payment methodology. This methodology did not go into effect until February 1, 2019 making benchmarking these services impractical for this analysis. Additional details of state DRG systems is found in Appendix B on page B.1-20.
Outpatient hospital	Comparisons are limited to Medicare and states that also follow the Medicare OPPS system (Montana and Utah).
PACE	Payments to PACE providers are made on a per-member per-month capitated basis. Comparison rates are not publicly available.
Prescription drugs	Variation in reimbursement methodologies do not allow for direct comparisons of drug prices. However, WDH describes the range in dispensing fees in Appendix B.
Supplemental payments	Payments vary according to each state's service delivery system and approve supplemental payment programs and methodologies.
Home and Community Based Services (HCBS) Waivers	Medicare does not cover most HCBS waiver services. Comparisons to surrounding states are limited as waivers vary greatly across states and there are many potential variables in service definition, provider qualifications and reimbursement methodologies between waivers.

Medicare's reimbursement methodologies are detailed in Appendix D and methodologies for the services for which we were unable to make rate comparisons are outlined in Appendix B.1. Rates from Medicare, other states and commercial payers are also detailed for the top procedures in Appendix B.1, when possible.

Hospital Benchmarks

WDH used data from Wyoming Medicaid's SFY 2019 Qualified Rate Adjustment (QRA) payment analysis, in combination with additional data from out-of-state hospitals, to estimate cost coverage for participating inpatient and outpatient hospitals. Figure 2.5 shows the hospital cost benchmarks for Wyoming's in-state providers in SFY 2019, which represent on average how much of hospitals' costs are covered by Medicaid payments. To estimate the costs for Medicaid cost coverage calculations, WDH applied cost-to-charge ratios and per diems from Medicare hospital cost reports to Wyoming Medicaid paid claims data. These estimated costs are considered a reasonable estimate of what Medicare would have paid for the same services. Comparing Wyoming's Medicaid payments to hospitals' Medicare cost is useful as Medicare often serves as a benchmark for assessing the reasonableness of a state's Medicaid payments.

Wyoming Medicaid has two hospital supplemental payment programs that improve the cost coverage for in-state Wyoming providers: the Wyoming QRA and Private Hospital Assessment supplemental payment programs. Figure 2.5 displays the cost coverage for in-state Wyoming hospitals with and without supplemental payments.

Figure 2.5: Hospital Cost Benchmarks

Hospital Payment Type	Cost Coverage Before QRA and Private Hospital Assessment Payments	Cost Coverage Including QRA and Private Hospital Assessment Payments
Inpatient	78.4%	100.0%
Outpatient	45.6%	99.9%

Additional information about Wyoming's and surrounding states' supplemental payment programs and DRG based rates are included in Appendices B and C of this report.

Wyoming APR DRG Transition

On May 20, 2019, CMS approved Wyoming's APR DRG payment methodology, which transitioned payments for inpatient services from the LOC based payment methodology effective February 1, 2020. For the current benchmarking analysis, we have continued the current inpatient benchmarking comparisons as a majority of services included in SFY 2019 QRA analysis were for LOC services. As part of the APR DRG payment transition, WDH and Guidehouse reassessed out-of-state provider participation and cost coverage for Wyoming in-state providers and participating out-of-state providers. For the current benchmarking report, the list of participating out-of-state providers is consistent with the existing LOC payment methodology, which covered a greater portion of the state fiscal year.

Outpatient Services

Wyoming adopted Medicare's relative weights for its outpatient hospital reimbursement but uses state-specific conversion factors.[48] Wyoming Medicaid uses three conversion factors for

[48] At WDH's initial implementation of the OPPS, the Wyoming outpatient hospital conversion factors were a percentage of Medicare's conversion factor. However, beginning in 2010, Wyoming began updating its conversion factors annually to

outpatient hospitals: critical access hospitals (CAH), children's hospitals, and general hospitals compared to Medicare's single conversion factor. As shown in Figure 2.6, the weighted average of the three conversion factors for CY 2019 was $57.44, compared to Medicare's single conversion factor for 2019 of $79.49.[49] We determined that Wyoming Medicaid's rate is approximately 72 percent of Medicare's.

Figure 2.6: Wyoming Outpatient Hospital Conversion Factors for CY 2019

Type	OPPS Conversion Factor	Percent of 2019 Claims	Weighted Average WY Conversion Factor	Conversion Factor and Payment Rates as Percentage of Medicare
Medicare (CY 2019)	**$79.49**	**N/A**	**N/A**	**78%**
WY General Hospital (CY 2019)	$42.53	75.6%	$57.44	N/A
WY CAH (CY 2019)	$105.89	21.1%		
WY Children's Hospital (CY 2019)	$88.45[50]	3.3%		

Considerations Regarding Rate Adjustments

In SFY 2019, Wyoming Medicaid rates for most service areas continued to meet or exceed the Medicaid rates in surrounding states. In comparison to Medicare, however, Wyoming rates are lower for the majority of service areas, as the analyses show in Figures 2.2 and 2.3. For example, on average for the highest utilized services, Wyoming's rates for Ambulance services were 123 percent of surrounding states included in this analysis, while also being equal to only 80 percent of Medicare's rates for these services.

Elsewhere, Wyoming Medicaid addresses the increase in provider costs differently for certain services. For several service areas, including nursing facilities, FQHCs, and RHCs, Wyoming Medicaid updates rates annually using predetermined inflation indices, which are explained in more detail in Appendix E of this report. For other service areas, Medicaid does not have a systematic way to address cost increases on a regular basis and updates them as they are needed.

In addition to considering potential updates to the Wyoming Medicaid fee schedule, there are a number of service areas where adjustments to the underlying reimbursement methodologies may result in better alignment with provider costs or with payments from other payers, such as Medicare.

As WDH considers potential future rate updates, it will consider – among other factors – how the rate changes support Wyoming Medicaid's priorities of encouraging fair reimbursement of

remain budget neutral and no longer correlates them to Medicare's conversion factor updates.

[49] WDH calculated the weighted average WY conversion factor based on the volume of claims in SFY 2019 for each hospital type.

[50] The children's hospital OPPS conversion factor only applies to out-of-state providers as there are no children's hospitals in Wyoming.

service providers and increasing access for beneficiaries. In developing these recommendations, WDH considered expenditures in each service area, current reimbursement methodologies, recent changes, and the results of the Medicaid, Medicare, and commercial rate comparisons outlined in this report.

Based on the analyses presented in this report, WDH recommends evaluating provider rates in several service areas to determine the need for adjustments and has assigned each service area a priority for further evaluation:

- **High priority**: Service areas for which reimbursement methodologies have not been recently updated, that lack a mechanism for systematic updates, have methodologies or levels that are out of line with benchmarks, or where cost data might address payment-related questions. Additionally, high-priority service areas may represent a large portion of Medicaid expenditures, or have high, unexplained growth.
- **Low priority**: Service areas with methodologies that require ongoing monitoring and maintenance and constitute a small proportion of total Medicaid expenditures.

Figures 2.7 and 2.8 describe high and low priority recommendations.

Figure 2.7: Recommendations for Further Evaluation of Reimbursement Rates and Methodologies – High Priority Services

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2019)
High Priorities for Evaluation			
Physician and Other Practitioners	There is no systematic approach to adjusting physician rates in the current RBRVS methodology. Wyoming Medicaid reduced the RBRVS conversation factors in SFY 2017 due to budget cuts, but rates for some services in Wyoming are higher than those of Medicare and surrounding states. Updating Wyoming's RVUs and conversion factors will allow for provider payments to better align with new Medicare payment methodologies while maintaining conversion factors and payments that are lower than those used by Medicare.	WDH is currently considering updating the RBRVS RVUs to the most recently available Medicare RVUs and adjusting conversion factors to maintain a budget neutral system. Wyoming currently has conversion factors for some services than are higher than Medicare's conversion factors and maintains a set of RVUs that no longer reflect some Medicare payment practices. Updating the Wyoming RVUs and conversion factors will continue to ensure that Wyoming's RBRVS payment methodology is compliant with CMS' UPL requirements and that Wyoming continues to receive high value care for professional service payments.	9%
Laboratory	WDH currently pays independent laboratory providers on a fee schedule basis at 90 percent of the 2009 Medicare clinical laboratory fee schedule (CLFS). Effective in 2018, CMS will revise the Medicare payment and coverage	WDH may consider rebasing its laboratory fee schedule for SFY 2021 after CMS updates the CLFS methodology. This will allow WDH to stay current with Medicare's methodology and to maintain Medicaid payments at or below Medicare	<1%

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2019)
	methodologies used to pay laboratory services under the CLFS. As CMS expected overall Medicare payments decreased under the new methodology for CLFS.CMS expects this trend to continue and controlled the rate decrease by capping payment reductions by 10 percent for CLFS tests for the first three years.	payments. The Wyoming rate as a percent of Medicare increased from 94. percent in SFY2018 to 102 percent in SFY2019.	
Supplemental Payment Programs	Wyoming Medicaid currently supports inpatient and outpatient hospital supplemental payment programs. However, Wyoming has additional opportunities to implement, revise, and maximize existing supplemental payment programs or to create new ones to further extend supplemental payments to providers. Additionally, CMS continues to release new rules and guidance on supplemental payment programs that will govern how these programs can be operated.	WDH is pursuing a professional services supplemental payment (PSSP) program for physicians and other professional service providers that will have a retroactive implementation date to July 1, 2019 to draw down additional federal funding for Medicaid providers. WDH should consider implementing other supplemental payment programs or alternative ways to maximize provider assessments from Wyoming providers to allow for additional federal dollars to be injected into the Wyoming Medicaid program without increasing state government spending. The State should also be aware of and prepared to address changes in CMS regulations related to supplemental payments, such as the proposed Medicaid Fiscal Accountability Regulations (MFAR) proposed rule.	Unknown
Nursing Facility	After an increase in expenditures in SFY 2016, nursing facility expenditures have been decreasing while the number of recipients has likewise decreased. The Community Choices Waivers offers an alternative to the nursing home level of care and has seen double digit increases in expenditures and recipients over 5 years.	Expenditures per recipient at a nursing facility are almost twice that of a recipient enrolled in the Community Choices Waiver. WDH might consider studying the reasons behind why individuals might choose nursing facility care over the Community Choices Waiver that would allow them to stay in their community. Such a study could identify strategies for shifting recipients to use HCBS or even the PACE program (for residents of Laramie County), which are both lower cost per recipient programs available to individuals meeting the nursing home level of care.	15%
Ambulatory Surgical Centers	WDH currently reimburses ASCs using the Wyoming OPPS fee schedule and using a similar methodology to that of general acute care hospital outpatient services in the state. Medicare reimburses ASC providers via an	WDH should consider doing a review of all Wyoming ASC payments compared to Medicare ASC weights and status indicators to determine if the Wyoming ASC State Plan Amendment (SPA) should be updated to base Wyoming ASC payments on the Medicare ASC	<1%

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2019)
	ASC specific fee schedule, that uses a separate set of service weights and status indicators that result in Wyoming Medicaid paying more for comparable benchmarked services than Medicare.	OPPS fee schedule instead of the Medicare Hospital OPPS fee schedule. In the most recently completed SFY 2020 clinic UPL, Guidehouse calculated that Wyoming ASCs were being paid more by Medicaid than they were by Medicare for the same set of services. Adjusting the OPPS fee schedule used to calculate ASC rates could prevent future UPL problems for the clinic service category.	
Telemedicine Services	During the SFY 2019 RBRVS analysis, Guidehouse identified that WDH had some key "best practice" policies in place to facilitate telemedicine service utilization. However, Guidehouse also identified certain provider and technology restrictions that may limit telemedicine use compared to other leading telemedicine states. In total, Guidehouse found only 0.35 percent of professional service claims used a telemedicine modifier code for the delivery of a service via telemedicine. However, due to COVID-19 and the resulting public health emergency (PHE), states, including Wyoming, have leveraged telemedicine to accommodate social distancing guidelines. States have loosened restrictions on allowable originating and distant sites, eligible modalities for telemedicine service delivery, eligible telehealth services.	WDH may consider conducting a comparison of Wyoming's telemedicine service policies and those supported by the Health Resource and Service Administration (HRSA), the America Telemedicine Association (ATA), and states similar to Wyoming to determine if the state should make any updates or changes to its telemedicine policies to increase service utilization. In addition, Wyoming can track changes to reimbursement patterns for services provided via telemedicine as a result of the PHE. During COVID-19, Wyoming loosened telemedicine service delivery requirements for FQHCs/RHCs and tribal facilities. The State also allowed for some peer-specialist groups and group therapy services to be delivered via telemedicine.	Unknown

Figure 2.8: Recommendations for Further Evaluation of Reimbursement Rates and Methodologies – Low Priority Services

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2019)
Low Priorities for Evaluation			
Ambulance	Reimbursement is currently set at 75% of Medicare's 2008 ambulance rates; however, WDH payments for certain ambulance codes are significantly higher than the rates of surrounding states. This trend continued in SFY2019 with Wyoming's rates for Ambulance services 123 percent of surrounding states.	WDH may consider an ambulance rate study to determine if the current payment methodology and rates should be updated to more closely match Medicare's current rates or to lower them to more closely align with surrounding states.	<1%
DMEPOS	WDH pays for DMEPOS using multiple methodologies, depending on the procedure code. There is considerable variation when comparing Wyoming's rates to Medicare and other states for both purchasing and renting many types of DMEPOS.	WDH may consider a DMEPOS rate study to more closely align specific rates with Medicare or other states.	2%
Home and Community Based (HCBS) Waiver Services	WDH will be completing a rebase study for their Comprehensive and Supports Waivers (DD waiver services) in SFY 2020 and into 2021. The health emergency of COVID-19 and decreasing Wyoming budget has created an need for WDH to look at their DD waiver services rates and delivery models to look for cost saving opportunities.	WDH may consider the following three opportunities to reduce costs for the DD waiver services: • Increase of telehealth services at a potential reduced rate of in-person services • Implement value-based payments and paying for services based upon outcomes, quality or compliance, instead of the volume of services Wyoming should also explore "agency" and "independent" provider rates, which would differentiate, or tier, the payment rates based upon the provider operations and structure.	27%
Hospital	States are working hard to transition away from paying for quantity, and to paying for quality and value. Alternative payment models (APM) often include pay-for-performance initiatives and require ongoing purchaser oversight. APMs require a shift from monitoring structures and processes to monitoring outcomes – or measuring the value of the purchased services. In other words, APMs force purchasers to become	To continue to improve upon Wyoming's hospital payment reforms, WDH should consider examining the current state of APMs across the country. This would allow Wyoming to identify promising practices that may be transferable. Consideration of claims volume and the rural and frontier nature of the state will be crucial to sort through viable options.	18%

Figure 2.8: Recommendations for Further Evaluation of Reimbursement Rates and Methodologies – Low Priority Services

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2019)
	value generators rather than compliance monitors.		
Maternity	Payment rates for maternity codes are based on RBRVS using 2013 Medicare RVUs. On average, WDH currently pays more than Medicare and comparison states for certain maternity services, but almost half of commercial payment rates.	WDH is currently considering updating the RBRVS RVUs for maternity codes to the most recently available Medicare RVUs and adjusting conversion factors to maintain a budget neutral system. In order to preserve current funding levels for maternity services, these codes would receive a separate conversion factor distinct from those used by other physician and professional services.	Unknown
School-based Services (SBS) Medicaid	The Wyoming Legislature explored implementing an SBS Medicaid Program in Wyoming, which is the only State in the country that does not have an SBS Medicaid Program. The Departments of Education (WDE) and Health (WDH) completed a joint assessment on the costs and revenues of implementing a SBS Medicaid Program during SFY 2020.	WDH should consider implementing an SBS Medicaid Program in Wyoming, as the State would realize an increase in revenue. The assessment of implementing a SBS Medicaid Program projected a net increase in revenue; however, the proposed implementation lacked accountability by the school districts and did not enforce best practices. WDH should revisit the SBS Medicaid Program assessment and how it was proposed to be implemented.	Unknown