Wyoming Department of Health

Commit to your health.

SFY 2021 Wyoming Medicaid Reimbursement Benchmarking Study

Based on Data Ending State Fiscal Year 2021

Wyoming Department of Health

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APPENDICES

Section 1: Introduction

The SFY 2021 Wyoming Medicaid Benchmarking Study is the fourteenth 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 2021 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 2021 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 2021. As this report focuses on SFY 2021, only reimbursement and policy changes due to COVID-19 through June 30, 2021, are addressed in this report. Please see the section below on COVID-19 impacts for more information.

Figure 1.1: Service Areas Included in the SFY 2021 Benchmarking Study

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

Considerations Regarding Medicaid Reimbursement

The Federal government allows each state to set its own Medicaid rates based upon program goals and objectives as long as states 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.*

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

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 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.

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 and outpatient hospital services, clinic services, Psychiatric Residential Treatment Facilities (PRTFs), and other qualified practitioners, Medicaid payments may not exceed a reasonable estimate of the amount that would be paid under Medicare to a group of service providers within one of the provider grouping categories (state-owned or operated, non-state owned or operated, and private).[2] For these providers 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 providers grouping categories (state-owned or operated, non-state government owned or operated, and private) may not exceed the upper payment limit.[3,4]
- For PRTFs and Institutions of Mental Disease (IMDs), Medicaid payment may not exceed the provider's customary charges.[2]
- Medicaid payment for clinical diagnostic laboratory services provided by a physician, independent laboratory or hospital may not exceed the Medicare fee schedule.[5]

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 consider 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)[6]. 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 physicians, nurse practitioners, and other physical health and behavioral health providers. Performing updates in a coordinated, timely fashion minimizes the potential for

[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] State Medicaid Manual, Title XIX State Plan Amendments, Part 6 Section 6300.2 "Fee Schedules for Outpatient Clinical Laboratory Tests".
[6] Beginning January 1, 2021, Wyoming Department of Health, Division of Healthcare Financing implemented a 2.5 percent rate reduction across all provider services.

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 useful reference points for evaluating Wyoming's rates and to assure that Wyoming rates are sufficient to enlist enough providers so that care and services are available. 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 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, as Medicare payments rates are generally determined based on the relative, average service cost. Some Medicaid services are covered only to a limited extent by Medicare. For example, there are several services, including nursing home, which 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, which 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 SFY 2021 rates for each procedure to the Medicare rates in 2021 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

[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 2021 to Wyoming Medicaid rates from SFY 2021.
[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.

Neutrality Factor. To compare Wyoming Medicaid outpatient hospital payments to Medicare, WDH compared Wyoming Medicaid's weighted outpatient conversion factor based on SFY 2021 claims volume (see Figure 2.6) to Medicare's CY 2021 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 in the SFY 2021 Benchmarking Report are the rates that commercial health plans (i.e., non-government) pay providers in the State. For services that Medicaid reimburses using a fee schedule, WDH compared rates to amounts paid by commercial health plans in Wyoming. We calculated a benchmark by calculating the average amount paid for each service, using the 2020Truven MarketScan database.[10] The methodology for these comparisons is explained in Appendix A, and detailed analyses by service area are presented in Appendix B

Reimbursement Changes in Response to COVID-19

The COVID-19 public health crisis had notable effects on reimbursement rates and polices in Wyoming, comparison states (Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah), and Medicare throughout SFY 2021. Many of these reimbursement and policy changes were temporary and fluctuated in response to the crisis. For the purpose of consistency, this report captures SFY 2021 rates as they were on June 30, 2021 and does not include any payment modifiers or supplemental payments provided in response to the COVID-19 crisis. We have highlighted changes made to reimbursement rates and policies to demonstrate the impact of the public health crisis throughout the report, as appropriate.

COVID-19 impacted states budgets resulting in Medicaid reimbursement modifications for SFY 2021 for several states. Figure 1.2 highlights Wyoming and comparison state reimbursement changes implemented in SFY 2021 in response to COVID-19:

[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 2020 (the most recent year of data available).

Figure 1.2: State SFY 2021 Reimbursement Changes in Response to COVID-19

Wyoming	Colorado	Idaho	Montana	Nebraska	South Dakota	Utah
• Temporary rate increase for HCBS services continued through September 30, 2020.	• Instituted a rate decrease for: – Hospital Services (Inpatient and Outpatient) – Primary Care – Physical Specialists – Dentists – HCBS • Instituted a rate increase for: – Nursing Facilities • Increased its hospital provider tax and expanded member cost sharing requirements to generate additional revenue[11]	• Instituted a rate decrease for: – Hospital Services (Inpatient and Outpatient) • Expanded member cost sharing requirements[12]	• Instituted a temporary rate increase for: – Primary Care – Physician Specialists – OB/GYNs – Dentists – Nursing Facilities – HCBS • Instituted a rate reduction for: •Inpatient Hospital Services	• Instituted a temporary rate increase for: – Primary Care – Physician Specialists – OB/GYNs – Dentists – Hospital Services (Inpatient and Outpatient) – Nursing Facilities – HCBS	• Instituted a temporary rate increase for: – Primary Care – Physician Specialists – OB/GYNs – Dentists – Hospital Services (Inpatient and Outpatient) – Nursing Facilities – HCBS	No information available

[11] Colorado Department of Health Care Policy and Financing, "*Provider Rates and Fee Schedule*," Available online: https://www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule

[12] Idaho Department of Health and Welfare, "*Idaho Medicaid Providers*," Available online: https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers

In addition to state-specific changes, the federal government also instituted some changes as a result of COVID-19 that impacted rates. At the beginning of the pandemic, the U.S. Department of Health and Human Services issued a COVID-19 Public Health Emergency (PHE) order. The federal PHE order was extended through 2021 and into 2022. The extension of the PHE allows for the continuation of federal healthcare flexibilities including COVID related waivers and relaxed Health Insurance Portability and Accountability Act (HIPAA) requirements. The extension of the federal PHE also extends the CMS Medicaid continuous enrollment requirements and enhanced federal Medicaid match rate (FMAP). In 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act, authorized a 6.2 percent increase in FMAP to help states respond to COVID-19. These funds were made available to states from January 1, 2020 through the quarter in which the PHE period ends[13]. For 2021, the federal government passed the Consolidated Appropriations Act of 2021, which implemented a 3.75 percent increase to the Physician Fee Schedule for all Medicare providers in order to support physicians and other professionals providing care during the public health crisis.[14]

Additional information on the effect of COVID-19 is provided in Appendix B.1.

Medicaid Expansion

Medicaid expansion has continued to gain traction across the United States with 39 states (including the District of Columbia) adopting expansions to their Medicaid program as of SFY 2020, including several states surrounding Wyoming. 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 in Idaho, Nebraska, and Utah. South Dakota will vote on Medicaid expansion via ballot measure in November 2022. 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.[15 & 16]

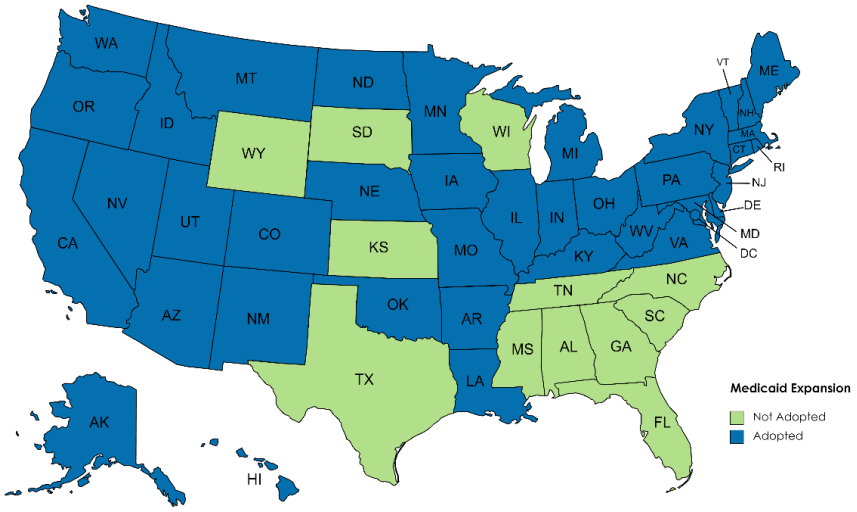
- **Colorado:** The Colorado legislature increased Medicaid eligibility in 2009, before the Affordable Care Act was passed to extend Medicaid coverage to parents and childless adults. As a result, Colorado was able to receive increased federal Medicaid match for the Medicaid expansion population when it was first available on January 1, 2014. [17]
- **Idaho:** Following a Medicaid expansion ballot measure in 2018, Idaho began Medicaid coverage on January 1, 2020 for adults with an annual income up to 138% of the federal poverty level (FPL). The Idaho legislature directed the state to submit several waivers targeted at the expansion population, including work requirements and coverage choice.

[13] https://www.congress.gov/bill/116th-congress/house-bill/748/
[14] https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf
[15] National Academy for State Health Policy. "*Where states stand on Medicaid expansion,"* Available online: https://nashp.org/states-stand-medicaid-expansion-decisions/
[16] KHN, "*South Dakota Votaers Decide Medicaid Expansion*," Available online: https://khn.org/news/article/south-dakota-medicaid-expansion-ballot-initiative/
[17] Colorado Health Institute, "*ACA at 10 Years: Medicaid Expansion in Colorado*," Available online: https://www.coloradohealthinstitute.org/research/aca-ten-years-medicaid-expansion-colorado

The Biden Administration withdrew Medicaid work requirement provisions in February 2021 and the other waiver request remain pending.[18]

- **Montana:** The state submitted a 1115 waiver to CMS in 2015 and began coverage on January 1, 2016 for adults with an annual income up to 138% of the federal poverty level (FPL). Medicaid expansion was initially approved through 2019. Montana submitted a waiver renewal in 2019 for an additional six years, however the 2019 waiver included work requirements as a condition of eligibility. In 2021, Montana was notified by the Biden Administration that the work requirement provision would not be approved. [19]
- **Nebraska:** Following a Medicaid expansion ballot measure in 2018, Nebraska began Medicaid coverage on January 1, 2020. CMS initially approved a waiver to implement a tiered benefit structure that requires members to meet work requirement, however Nebraska withdrew that waiver in 2021, following the Biden Administration's decision to withdrew Medicaid work requirement provisions. Nebraska began offering full benefits to all expansion adults beginning on October 1, 2021.[20]
- **Utah:** Following a Medicaid expansion ballot measure in 2018, Utah began Medicaid coverage on January 1, 2020. At the direction of the Utah state legislature, the state amended their 1115 Primary Care Network Waiver to expand Medicaid eligibility to adults with an annual income up to 138% of the FPL. Utah Medicaid has also requested premiums and surcharges for expansion adults over 100% of the FPL, housing supports and penalties for Medicaid program violations. These items are still pending CMS approval. Utah also requested a work requirement provision for the expansion population, but the Biden Administration withdrew Medicaid work requirement provisions in February 2021. [21]

Figure 1.3: State Medicaid Expansion Under the Affordable Care Act



[18] CMS, "*State Waivers List*," Available online: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html
[19] Montana DPHHS, "*Montana's New Healthcare Option*," Available online: https://dphhs.mt.gov/medicaidexpansion/
[20] Nebraska DHHS, "*Medicaid Expansion in Nebraska*," Available online: https://dhhs.ne.gov/Pages/Medicaid-Expansion.aspx
[21] Utah Department of Health, Medicaid, "*Medicaid Expansion*," Available online: https://medicaid.utah.gov/expansion/

Social Determinants of Health (SDoH)

Social Determinants of Health (SDoH) are "the social factors and physical conditions of the environment in which people are born, live, learn, play, work, and age," and includes factors such as economic stability, education, health and healthcare, neighborhood and environment, and social and community context.[22] While federal Medicaid rules generally prohibit Medicaid programs from paying for non-medical services, in January 2021, CMS released guidance describing opportunities for states to use Medicaid to address SDOH. The opportunities included:

Services and supports that CMS proposed could be covered under Medicaid to address SDoH included: Housing related services and supports (home accessibility modifications, one-time community transition costs, and housing and tenancy supports), non-medical transportation, home-delivered meals, educational services, employment, community integration and social supports, and case management.[23] Several of Wyoming's surrounding states have used these opportunities to implement policies targeted at addressing member's SDoH.

- **State Plan Authority**
    - South Dakota Medicaid leveraged the health home option allowed under optional State Plan Authority to establish health homes to coordinate care for high-cost members with chronic conditions. The goal of the program is to improve members care while reducing utilization of high-cost services. [24]
- **Medicaid Managed Care Flexibility**
    - Colorado's Medicaid Managed Care Contract requires health plans to provide enrollees with referrals to social services, and partner with Community-Based Organizations or social service providers. [25]
    - Nebraska's Medicaid Managed Care contact requires health plans to screen enrollees for social needs, screen enrollees for behavioral health needs or behavioral health risk factors, provide enrollees with referrals to social services and requires health plans to invest in community services. [26]

[22] Office of Disease Prevention and Health Promotion. "*Healthy People: Determinants of Health*," Available online: https://www.healthypeople.gov/2020/about/foundation-health-measures/determinants-of-health
[23] CMS, "*Opportunities in Medicaid and CHIP to Address SDOH*," Available online: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf
[24] South Dakota DSS, "*Introducing Health Homes*," Available online: https://www.nd.gov/dhs/info/pubs/docs/medicaid/presentation-health-home-south-dakota-medicaid.pdf
[25] Kaiser Family Foundation, "*States Reporting SDOH Policies Required in Medicaid MCO*," Available online: https://www.kff.org/other/state-indicator/states-reporting-social-determinant-of-health-related-policies-required-in-medicaid-managed-care-contracts
[26] Kaiser Family Foundation, "*States Reporting SDOH Policies Required in Medicaid MCO*," Available online: https://www.kff.org/other/state-indicator/states-reporting-social-determinant-of-health-related-policies-required-in-medicaid-managed-care-contracts

- **Section 1115 Waivers**
    - Montana Medicaid submitted an 1115 waiver, Healing and Ending Addiction through Recovery and Treatment (HEART) which contains a demonstration to provide tenancy support to certain members.[27]

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.

On September 15, 2020, CMS issued guidance encouraging state Medicaid programs to adopt value-based care strategies and align provider incentives across their programs. The guidance promotes value-based healthcare as a mechanism to allow state Medicaid program to provide efficient, high-quality care while improving health outcomes, addressing Medicaid members social determinants of health, and decreasing disparities across the healthcare system. CMS did not announce any new payment models or funding opportunities but did highlight alternative payment methodologies including payment models built on fee-for-service systems, payments for episodes of care, and payment models for total cost of care accountability. Under fee-for-service payment models the state pays providers on a fee-for-for service basis with shared saving payments (with upside and downside risk) where providers are required to meet quality and performance targets. Under episodes of care payment models the state pays providers under a bundled payment model for a set of services related to a single healthcare event during a defined period of time. Finally, under the total cost of care accountability model providers are held financial responsible for meeting quality and performance measures.[28]

Figure 1.4 highlights comparison states value-based care strategies.

[27] Montana DPHHS, "*HEART Waiver Submission*," Available online: https://dphhs.mt.gov/heartwaiver
[28] CMS, "*Value Based Care Opportunities in Medicaid*," Available online: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf

Figure 1.4: States Value-Based Care Strategies

Wyoming[29]	Colorado[30]	Idaho[31]	Montana[32]	Nebraska[33]	South Dakota[34]	Utah
Wyoming Medicaid does not have a statewide value-based care strategy. In 2015, Wyoming Medicaid implemented a Patient Centered Medical Home (PCMH) that requires providers to commit to implement quality improvement metrics and a patient-centered approach to care. In 2021, approximately 114 providers participated in the PCMH model.	In 2011, Colorado Medicaid implemented an Accountable Care Collaborative (ACC) program that uses accountable care principals to connect Medicaid members to primary care. The program was expanded in 2018, with the creation seven Regional Accountable Entities (REAs) regions. The REAs implemented value-based payment and quality metrics to integrate behavioral health services and primacy care. The state currently contracts with 5	In 2016, Idaho Medicaid launched a Health Connections program which integrated their patient-centered medical home (PCMH) and primary care case management (PCCM) program into one program. In 2017, the State added value-based payments to the program. In 2020, Idaho implemented an updated value-based model which awards payments to primary care providers (PCP) and FQHCs based on cost savings and quality of care	In 1993, Montana Medicaid implemented a primary care case management (PCCM) program. Most Medicaid members are required to participate in the program. Members have a PCP who coordinate most acute, primary, and behavioral health services. The PCCM program which pays a PMPM participation fee and a PMPM fee to support disease management. In 2018, Montana began a 5-year CMS pilot program,	In 2014, Nebraska Medicaid implemented a voluntary, multi-payer PCMH program. Participating managed care entities (MCE) contracted with PCMH clinics to achieve quality measures. In 2017, the state enrolled all Medicaid members in its Medicaid Managed Care program. The MCEs were required to support the PCMH initiative and enter into value-based contracts with providers.	South Dakota does not have a statewide value-based care Medicaid strategy. Since 2013, South Dakota has operated a Medicaid Health Homes model for Medicaid enrollees with complex health care needs. Eligible members have two or more chronic conditions or a sever medical illness or emotional disturbance. Health homes are paid on a Per Member Per Month (PMPM) basis for providing core services.	In 2011, Utah's legislature required the Medicaid agency to implement a value-based reimbursement program. In 2013, the state created four payer-led ACOs that receive monthly risk-adjusted capitated payments for Medicaid members. ACO contracts require providers to achieve a minimum quality performance level.

[29] Wyoming Department of Health, "*Patient Centered Medicaid Home*," Available online: https://health.wyo.gov/healthcarefin/medicaid/pcmh/
[30] Colorado Health Institute, "*The Ways of RAEs*," Available online: https://www.coloradohealthinstitute.org/research/ways-raes
[31]NASHP, "*Idaho Develops a Medicaid Value-Based Model for its FQHCs, Based on Cost and Quality*," Available online: https://www.nashp.org/idaho-develops-a-medicaid-value-based-payment-model-for-its-fqhcs-based-on-cost-and-quality/
[32] Montana DPHHS "*CPC+ Overview*," Available online: https://dphhs.mt.gov/montanahealthcareprograms/cpcplus
[33] State of Nebraska DHHS "*Annual External Quality Review Technical Report*," Available online: https://dhhs.ne.gov/Documents/IPRO%20Report%202020.pdf
[34] Primary Care Collaborative "*South Dakota Health Homes*," Available online: https://www.pcpcc.org/initiative/south-dakota-health-homes

Wyoming[29]	Colorado[30]	Idaho[31]	Montana[32]	Nebraska[33]	South Dakota[34]	Utah
	REAs and Medicaid members are required to access most care through their REA. In each region, the RAEs' are responsible for ensuring Medicaid members have access to primary care and behavioral health services, coordinating members' care and meeting quality metrics. REAs also manage payments for behavioral health services and pay primary care providers bonus payments to encourage value-based care.	metrics. PCPs participate as either accountable primary care organizations or accountable hospital care organizations. Referred to as value care organizations (VOCs) the goal is to contain Medicaid's total cost of care while improving quality. PCPs are paid on a fee-for-for service bases plus a per member per month (PMPM) care management fee and the larger VOCs share in savings or losses generated for Medicaid.	Comprehensive Primary Care Plus (CPC+). An advanced primary care medical home model rewards value and quality through innovative payments that support comprehensive care. The program provides actionable patient-level cost and utilization feedback to providers to guide provider decision making.			

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 1.5 on the next page, 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 70 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.[35]

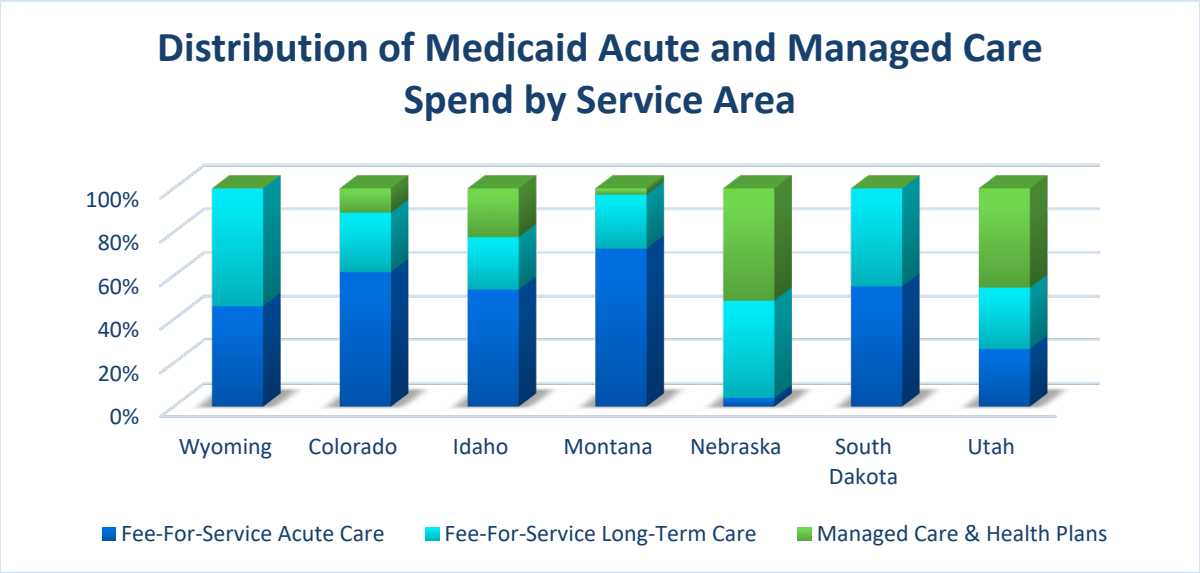
Figure 1.5: Medicaid Managed Care Delivery System and Percent of Medicaid Beneficiaries Enrolled in Managed Care[36]

State	Medicaid Managed Care Delivery System	Percent of Medicaid Beneficiaries Enrolled in Any Type of Managed Care	Percent of Medicaid Beneficiaries Enrolled in Comprehensive Managed Care
Wyoming[37]	No comprehensive Medicaid Managed Care	0.2%	0.2%
Colorado	Medicaid Managed Care Organization and Primary Care Case Management Program	96.0%	9.5%
Idaho	Primary Care Case Management Program	99.2%	4.2%
Montana	Primary Care Case Management Program	81.5%	0.0%
Nebraska	Medicaid Managed Care Organization	99.6%	99.6%
South Dakota	Primary Care Case Management Program	73.9%	0.0%
Utah	Medicaid Managed Care Organization	89.1%	74.3%

[35] 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.
[36] CMS, "*Medicaid Managed Care Enrollment Report*," Available online: https://www.medicaid.gov/medicaid/managed-care/enrollment/index.html
[37] Wyoming Medicaid managed care was primarily used for the PACE program. Wyoming has one 1915(b) managed care 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. Due to State budget cuts, the Wyoming PACE program was defunded Q2 of SFY 2021.

The percent of Medicaid spending on acute and managed care varies from state to state, as shown in Figure 1.6. All of Wyoming's surrounding comparison states still use a fee-for-service reimbursement model for some acute and long-term care costs.[38] Nebraska and Utah have the highest spending for Medicaid managed care services, with managed care expenditures accounting for about 50 percent of each state's total Medicaid spending.

Figure 1.6: Distribution of Medicaid Acute and Managed Care Spend by Service Area



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.

As seen in Figure 1.7, 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 11 percent of spending in Colorado and 25 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 three percent or less of Medicaid costs on managed care.

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

Figure 1.7: Medicaid Spending by Service Area[39]

State	Acute Care (FFS)	Long Term Care (FFS)	Managed Care	Payments to Medicare	DSH[40]
Wyoming	46%	54%	0%	4%	0%
Colorado	61%	27%	11%	2%	2%
Idaho	60%	27%	25%	4%	1%
Montana	76%	26%	3%	3%	0%
Nebraska	4%	45%	52%	3%	2%
South Dakota	54%	44%	0%	4%	0%
Utah	29%	31%	50%	2%	1%

Numbers may not sum to 100% due to rounding

[39] Kaiser Family Foundation, "*Distribution of Medicaid Spending by Service*," Available online: https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/.
[40] 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 distribute limited state resources most effectively. 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 2021

Wyoming Medicaid made several program changes pertaining to covered services and reimbursement during SFY 2021, which are presented in Figure 2.1.

Figure 2.1: Medicaid Coverage and Reimbursement Changes During SFY 2021

Eligibility Category/ Service Area	Action	Dates of Implementation
Coronavirus Related Response: Enhanced FMAP	• Temporary 6.2 percent increase in the federal share of Medicaid spending (FMAP) to help states cover the higher costs of COVID-19. Temporary 6.2 percent increase in FMAP continued through SFY 2021.	January 1, 2020
Waiver – Pregnant by Choice	• Family Planning Waiver approved April 4, 2020 through 12/31/2027. • CMS will reimburse by a PMPM amount that varies depending on calendar year. For SFY 2021 (July 1, 2021 - June 30, 2022), the rate would be $12.10 (7/1/2021-12/31/2021) and $12.65 (1/1/2022- 6/30/2022). Expenses beyond the PMPM would be covered at Wyoming Medicaid's expense.	April 4, 2020
Waiver - Comprehensive and Supports	• Temporary increases in provider rates for some Comprehensive and Supports Waiver services in response to COVID-19 public health emergency were ended on September 30, 2020. Rates reverted to pre-COVID amounts.	September 30, 2020 January 1, 2021

Figure 2.1: Medicaid Coverage and Reimbursement Changes During SFY 2021

Eligibility Category/ Service Area	Action	Dates of Implementation
	• Reimbursement reduced by 2.5% due to Governor's budget cuts	
Ambulance Ambulatory Surgery Center Behavioral Health Developmental Center Dental DMEPOS ESRD Home Health Laboratory Nursing Facility Outpatient Prospective Payment System (OPPS) Psychiatric Residential Treatment Facility Vision	• Reimbursement reduced by 2.5% due to Governor's budget cuts	January 1, 2021
Hospice	• Reimbursement for hospice in nursing homes reduced by 2.5% due to Governor's budget cuts	January 1, 2021
Hospital Inpatient	• Reimbursement reduced by 2.5% due to Governor's budget cuts • All Patients Refined Diagnosis Related Groups (APR- DRG) implemented May 31, 2019 with an effective date of February 1, 2019. Second year of DRG rates implemented February 1, 2020	January 1, 2021
Physicians and Other Practitioners	• Chiropractic services limited to children under EPSDT and members on Medicare. • Threshold limit removed for dietician services • Reimbursement reduced by 2.5% due to Governor's budget cuts	January 1, 2021
Program for All-Inclusive Care of the Elderly (PACE)	• Due to State budget cuts, the Wyoming PACE program was ended effective March 1, 2021.	March 1, 2021

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.[41] 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 2021 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[42]

Service Area	Wyoming 2021 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2021 Medicare Rates	Average Commercial Payments (2021)
Ambulance	116%	78%	Data not available[43]
ASC	112%	100%	Data not available[44]
Behavioral Health[45]	96%	82%	87%
Dental	113%	Medicare does not cover this service.	Data not available[46]
Developmental Center	103%	76%	60%

[41] 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 2021.
[42] For these comparisons, WDH reviewed the top codes for each service area based on paid claims volume in SFY 2021 and compared the 2021 Wyoming Medicaid rates to 2021 Medicare rates and 2021 fee schedules from Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah (if SFY 2021 fee schedules were not available online, WDH used the most recent rates available).
[43] There is little or no Truven MarketScan 2020 data for this service area.
[44] There is little or no Truven MarketScan 2020 data for this service area.
[45] 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.
[46] There is little or no Truven MarketScan 2020 data for this service area.

Figure 2.2: Comparison of Wyoming Medicaid Rates to Other States, Medicare, and Commercial Payers Using Top Services Based on Utilization[42]

Service Area	Wyoming 2021 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2021 Medicare Rates	Average Commercial Payments (2021)
DMEPOS[47]	118%	84%	Data not available[48]
Home Health	85%	49%	86%
Hospice	98%	98%	Data not available[49]
Hospital – Inpatient	Wyoming Medicaid pays approximately 82.1 percent of inpatient costs.[50]		
Hospital – Outpatient	The weighted average OPPS conversion factor for Wyoming is $59.99. Montana uses a single conversion factor of $56.64 and Utah follows a 0.9518 reduction of Medicare's OPPS conversion factor ($82.20 in CY 2021).	72%	Reimbursement methodology does not allow for direct comparisons.
Laboratory	105%	110%	82%
Maternity Care	103%	91%	57%
Nursing Facility[51]	91%	Data not available	
Physician and other Practitioner	103%	89%	53%
Primary Care	110%	95%	64%
Physician Specialist	100%	86%	56%

[47] The Wyoming 2021 Medicaid rate as a percentage of other states and Medicare rates for DMEPOS uses the rates to purchase DMEPOS equipment.
[48] There is little or no Truven MarketScan 2020 data for this service area.
[49] There is little or no Truven MarketScan 2020 data for this service area.
[50] Inpatient costs are calculated using cost-to-charge ratios from hospitals' Medicare cost reports. See Figure 2.5 for additional explanation.
[51] 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.

Figure 2.2: Comparison of Wyoming Medicaid Rates to Other States, Medicare, and Commercial Payers Using Top Services Based on Utilization[42]

Service Area	Wyoming 2021 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2021 Medicare Rates	Average Commercial Payments (2021)
Prescription Drugs	Wyoming's dispensing fee: $10.65 Other states' dispensing fees range from $9.31 to $15.42 depending on various factors.[52]	N/A	Data not available[53]
PRTF	91%	Medicare does not cover this service.	Data not available[54]
Vision – Ophthalmology	111%	92%	65%
Vision – Optician and Optometrist	125%	78%	Data not available[55]

Figure 2.3 compares Wyoming Medicaid rates to other states, Medicare, and commercial payers, based on services with the highest total expenditures in SFY 2021 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[56]

Service Area	Wyoming 2021 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2021 Medicare Rates	Average Commercial Rates in Wyoming (2021)
Ambulance	116%	78%	Data not available[57]

[52] Excluding dispensing fees for drug compounding. See Appendix B.1 for more information about prescription drug reimbursement in each state.
[53] There is little or no Truven MarketScan 2020 data for this service area.
[54] There is little or no Truven MarketScan 2020 data for this service area.
[55] There is little or no Truven MarketScan 2020 data for this service area.
[56] For these comparisons, WDH reviewed the top codes for each service area based on total expenditures in SFY 2021 and compared the 2021 Wyoming Medicaid rates to 2021 Medicare rates and 2021 fee schedules from Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah (if SFY 2021 fee schedules were not available on the States' websites, we used the most recent rates available).
[57] There is little or no Truven MarketScan 2020 data for this service area.

Figure 2.3: Comparison of Wyoming Medicaid Rates to Other States, Medicare, and Commercial Payers Using Top Services Based on Expenditures[56]

Service Area	Wyoming 2021 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2021 Medicare Rates	Average Commercial Rates in Wyoming (2021)
ASC	112%	100%	Data not available[58]
Behavioral Health[45]	94%	84%	84%
Dental	111%	Medicare does not cover this service.	Data not available[59]
Developmental Center	103%	76%	60%
DMEPOS[47]	120%	84%	Data not available[60]
Home Health	85%	49%	86%
Hospice	98%	98%	Data not available[61]
Hospital – Inpatient	Wyoming's reimbursement of in-state inpatient services covers approximately 82.1 percent of costs. [62]		
Hospital – Outpatient	The weighted average OPPS conversion factor for Wyoming is $59.99. Montana uses a single conversion factor of $56.64 and Utah follows a 0.9518 reduction of Medicare's OPPS conversion factor ($82.20 in CY 2021).	72%	Reimbursement methodology does not allow for direct comparisons.
Laboratory	113%	110%	96%
Nursing Facility[51]	91%	Data not available	
Physician and other Practitioner	100%	85%	47%

[58] There is little or no Truven MarketScan 2020 data for this service area.
[59] There is little or no Truven MarketScan 2020 data for this service area.
[60] There is little or no Truven MarketScan 2020 data for this service area.
[61] There is little or no Truven MarketScan 2020 data for this service area.
[62] Inpatient costs are calculated using cost-to-charge ratios from hospitals' Medicare cost reports. See Figure 2.5 for additional explanation.

Figure 2.3: Comparison of Wyoming Medicaid Rates to Other States, Medicare, and Commercial Payers Using Top Services Based on Expenditures[56]

Service Area	Wyoming 2021 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2021 Medicare Rates	Average Commercial Rates in Wyoming (2021)
Primary Care	103%	89%	61%
Physician Specialist	101%	82%	49%
Prescription Drugs	Wyoming's dispensing fee: $10.65 Other states' dispensing fees range from $9.31 to $15.42 depending on various factors.[52]	N/A	Data not available[63]
Maternity Care	104%	92%	58%
PRTF	91%	Medicare does not cover this service.	Data not available[64]
Vision – Ophthalmology	109%	103%	66%
Vision – Optician and Optometrist	124%	78%	Data not available[65]

Key findings from these analyses include:

- The Medicaid programs in surrounding states use similar methodologies to Wyoming for most service areas.
- Even with the 2.5 percent rate reduction across provider services implemented January 1, 2021, Wyoming Medicaid continues to pay higher rates than Medicaid programs in surrounding states for many service areas, including Ambulance, Primary Care, Physician Specialist and Maternity care. However, there are several services areas where Wyoming Medicaid pays lower rates for other service areas, including Behavioral Health, Home Health, Hospice, Nursing Facilities and PRTF. Additional information about Wyoming's and surrounding states' rates are included in Appendix B.1 of this report.

[63] There is little or no Truven MarketScan 2020 data for this service area.
[64] There is little or no Truven MarketScan 2020 data for this service area.
[65] There is little or no Truven MarketScan 2020 data for this service area.

- Based on highest utilized services, Wyoming Medicaid rates as a percentage of the average of other states' rates range from 85 percent for Home Health services to 118 percent for DMEPOS 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 expenditure procedure codes for these service areas compared to surrounding states. A similar tend occurs with Maternity Care and Vision/Ophthalmology services when looking at the top service expenditures.
- The Wyoming Department of Health, Division of Healthcare Financing implemented a 2.5 percent rate reduction during SFY 2021 (began January 1, 2021) to most provider services as a result of the economic impact of falling mineral and extraction related state revenus. This resulted in a decrease in the Wyoming rate as a percent of other state's rates from SFY 2020 to SFY 2021, including a decrease:
    - From 122 percent to 116 percent for Ambulance services. This decrease may be attributed to the fact that Wyoming rate decreased, while Montana, Nebraska, and South Dakota all increased rates in SFY 2021.
    - From 115 percent to 111 percent for Dental services. This decrease may be attributed to the fact that Wyoming decreased rates, while Idaho, Montana, and Nebraska and all increased rates in SFY 2021.
    - From 122 percent to 113 percent for Laboratory services. This decrease may be attributed to the fact that Wyoming decreased rates, while surrounding states largely had to change to rates in SFY 2021.
    - From 114 percent to 109 percent for Maternity services, from 106 percent to 100 percent for Physician and Other services, from 103 percent to 101 percent for Physician Specialist, and from 106 percent to 103 percent for Primary Care services. These decreases may be attributed to the fact that Wyoming decreased rates, while surrounding states increased rates in SFY 2021.
- Rates for Nursing Facility services have been decreasing as compared to other states Medicaid rates. From 105 percent in 2019 to 97 percent in 2020 to 91 percent in 2021. While the average nursing facility rate decreased for Wyoming Medicaid, surrounding states continued to increase their rates.
- Historically, Wyoming Medicaid had higher benchmarked rates compared to Medicare for several services. 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. Comparative analysis between Wyoming Medicaid's RVU-based fee schedule and current Medicare RBRVS was most recently conducted in 2020. Figure 2.4 below provides a comparison of Wyoming's SFY 2020 and Medicare's 2020 RBRVS Conversion Factors.

Payer	Anesthesia Conversion Factor	Non-Anesthesia Conversion Factor
Medicare	22.01	36.0896
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 Vision – Ophthalmology category. For this service area the Wyoming Medicaid reimbursement codes (66984, 66982, 67028, 67228 and 92083) have significantly higher payment rates than Medicare. These codes have higher Medicaid RVUs, accounting for higher Medicaid payment rates.
- Historically this was also seen in the Physician and Other Practitioner, Physician Specialist, and Maternity Care service areas. In addition to the Medicaid RVUs, a sampling bias was affecting these services due to the high number of injection pharmaceuticals and anesthesia services included in the top twenty benchmarked codes for utilization. For SFY 2021, Guidehouse adjusted the sampling methodology to include the top twenty codes excluding injection pharmaceuticals and anesthesia services. For SFY 2021, the Wyoming Medicaid rate as a percent of Medicare for all three service areas was less than 100%.
- Based on expenditures, Wyoming Medicaid pays less than Medicare for the majority of service areas, excluding laboratory and vision/ophthalmology services (where Medicaid pays more than Medicare, on average). Based on expenditures, Wyoming Medicaid's rates as a percentage of Medicare's range from 49 percent for home health services to 110 percent for laboratory services.
- 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 decreased from 118 percent to 110%, as a percent of the surrounding states from 122 percent to 113%, and as a percent of commercial rates from 106 percent to 96%. The decrease may be attributed to the fact that Wyoming Medicaid decreased their laboratory fee schedule from SFY 2020 to SFY 2021, while Medicare, Idaho, Montana, Nebraska, South Dakota, and Utah largely maintained 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 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 surrounding states.
Inpatient hospital	Wyoming reimburses for Medicaid services using on an APR-DRG based payment methodology with base rates, policy adjustors, and cost to charge ratios that are unique to the State. This causes comparisons to the inpatient reimbursement rates in other states to be inaccurate as other states reimburse differently. For the SFY 2021 we have populated information about each comparison state's inpatient payment methodologies and the Wyoming APR-DRG system 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, South Dakota, and Utah).
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 2021 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 2021, 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	82.1%	100.8%
Outpatient	45.0%	98.8%

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, 2019.[66] 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.

Outpatient Services

Wyoming adopted Medicare's relative weights for its outpatient hospital reimbursement but uses state-specific conversion factors.[67] Wyoming Medicaid uses three conversion factors for 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 2021 was $59.99, compared to Medicare's single

[66] During the APR DRG implementation, WDH used an older inpatient hospital grouper version (v33). Since then, 3M has released multiple updated versions (v34 – v39) of the inpatient hospital grouper. WDH may want to consider updating their APR DRG hospital grouper to take into account updates to industry standards and current utilization and expenditure trends.

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

conversion factor for 2021 of $82.80.[68] We determined that Wyoming Medicaid's rate is approximately 72 percent of Medicare's.

Figure 2.6: Wyoming Outpatient Hospital Conversion Factors for CY 2021

Type	OPPS Conversion Factor	Percent of 2021 Claims	Weighted Average WY Conversion Factor	Conversion Factor and Payment Rates as Percentage of Medicare
Medicare (CY 2021)	**$79.49**	**N/A**	**N/A**	**N/A**
WY General Hospital (CY 2021)	$43.81	73.34%	$59.99	72%
WY CAH (CY 2021)	$108.36	22.41%		
WY Children's Hospital (CY 2021)	$84.13[69]	4.24%		

Considerations Regarding Rate Adjustments

In SFY 2021, 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 116 percent of surrounding states included in this analysis, while also being equal to only 78 percent of Medicare's rates for these services.
- Physician and Other Practitioner services were 103 percent of surrounding states included in this analysis, while also being equal to only 89 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

[68] WDH calculated the weighted average WY conversion factor based on the volume of claims in SFY 2021 for each hospital type.
[69] The children's hospital OPPS conversion factor only applies to out-of-state providers as there are no children's hospitals in Wyoming.

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 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 2021)
High Priorities for Evaluation			
Behavioral Health Strategy	Wyoming has conducted several activities related to behavioral health, including a rate study of community mental health centers (CMHCs) and substance abuse treatment centers (SATCs) in SFY 2018. WDH also supports the Care Management Entity (CME) program which targets youth with severe behavioral health challenges.	The recently passed American Rescue Plan Act (ARPA) of 2021 will inject billions more into the healthcare system for behavioral health, including the injection of new payment incentives to meet increasing demand of behavioral health services. Additionally, COVID-19 has introduced new service delivery methods, such as the use of telehealth for group therapies. These emerging	4%

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2021)
		delivery system reforms will push states to evaluate innovative payment methodologies for behavioral health. WDH should conduct additional rate studies for CMHCs and SATCs. WDH should also continue to assess behavioral health services as part of the RBRVS framework.	
Hospital - General	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 value generators rather than compliance monitors.	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.	17%
Hospital Inpatient	Wyoming implemented an All Patients Refined Diagnosis Related Groups (APR- DRG) payment methodology in 2019. During implementation, WDH used an older inpatient hospital grouper version (v33). Since then, 3M has released multiple updated versions (v34 –	WDH may want to consider updating their APR DRG hospital grouper to align with updated best practices. The APR DRG payment methodology classifies patients according to their reason for admission, severity of illness and risk of mortality. WDH is currently operating on an older version of the inpatient hospital grouper	

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2021)
	v39) of the inpatient hospital grouper.	which fails to take into account updates to industry standards and current utilization and expenditure trends.	
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 surrounding states. Updating Wyoming's RVUs and conversion factors will allow for provider payments to better align with new Medicare payment methodologies. For 2021 on average for the highest utilized services, Wyoming's rates for Physician and Other Practitioner services were 103 percent of surrounding states included in this analysis, while also being equal to only 89 percent of Medicare's rates for these services.	WDH may consider updating the RBRVS RVUs to the most recently available Medicare RVUs and adjusting conversion factors to maintain a budget neutral system. Wyoming currently maintains a set of RVUs that no longer reflect some Medicare payment practices – causing certain benchmarked service areas to have higher Wyoming Medicaid reimbursement amounts than Medicare. Updating the Wyoming RVUs and conversion factors will continue to ensure that Wyoming's RBRVS payment methodology is compliant with 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	WDH may consider rebasing its laboratory fee schedule for SFY 2023 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 payments. The	0.1%

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2021)
	coverage 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.	Wyoming rate as a percent of Medicare increased from 102 percent in SFY 2019 to 118 percent in SFY 2020. Budget rate cuts in SFY 2021 helped decrease the Wyoming rate as a percent of Medicare to 110%, but due to current Wyoming methodology the Wyoming rate continues to be higher than the Medicare rate.	
Long Term Care (Nursing Facilities and HCBS Waivers)	The Comprehensive and Supports Waivers (DD waiver services) and the Community Choices Waivers offer individuals the opportunity to receive home- and community-based services. After an increase in expenditures in SFY 2016, nursing facility expenditures have declined, along with the number of recipients. The CCW program offers an alternative to the nursing home level of care and has seen double digit increases in expenditures and recipients over 5 years. Wyoming will want to continually monitor access to, and services delivered by their waiver programs, as they provide a favorable alternative to institutionalized care. WDH completed a rebase study for their Comprehensive and Supports Waivers (DD	For the SFY 2020 benchmarking study, Guidehouse incorporated a review of how neighboring states defined certain services and their corresponding rates. WDH may consider expanding this review to incorporate other services delivered by the DD and CCW waiver programs. The recent rebasing study for CCW added new units of rates for several services, including nursing facilities, case management, and assisted living facilities. These units were added to better reflect how providers are delivering services. For the DD waiver services, WDH may want to explore “agency” and “independent” provider rates, which would differentiate, or tier, the payment rates based upon the provider operations and structure.	Long Term Care % Unknown Total Nursing Facilities and Waiver: 43% • 14% (NF) • 20% (Waiver - Comprehensive) • 6% (Waiver - Community Choices) • 1% (Waiver - Supports)

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2021)
	waiver services) in SFY 2021 and completed a rate rebasing study of the Community Choices Waiver in SFY 2020.As part of this study, Wyoming added additional rates for services, such as separate RN and LPN rates for skilled nursing services. These additions better reflect how services are being delivered for this waiver.	Additionally, as a result of the COVID-19 Public Health Emergency (PHE) and the subsequent tightening of the State budget, WDH may look to other opportunities that will help reduce costs for their waiver programs. These may include: • Increasing use of telehealth services at a potentially reduced rate compared to in-person services. • Implementing value-based payments and paying for services based upon outcomes, quality, or compliance, instead of the volume of services.	
Telemedicine Services	Due to COVID-19 and the resulting 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, and eligible telehealth services. During COVID-19, Wyoming relaxed telemedicine service delivery requirements for FQHCs/RHCs and tribal facilities. The State also allowed for home health providers as well as some peer-specialist groups and group therapy services to	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. WDH may also look to revisit the impact of rates to services, such as home	Unknown

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2021)
	be delivered via telemedicine.	health, as a result of delivery of services via telehealth.	

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

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2020)
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 SFY 2021 with Wyoming's rates for Ambulance services 116 percent of surrounding states.	WDH may consider an ambulance rate study to determine if the current payment methodology and rates should be updated to match Medicare's current rates more closely or to lower them to align with surrounding states more closely.	1%
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 ASC specific fee schedule, which uses a separate set of service weights and status indicators.	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 OPPS fee schedule instead of the Medicare Hospital OPPS fee schedule. In the most recently completed SFY 2020 2022 clinic UPL, Guidehouse calculated that Wyoming ASCs were being reimbursed at a level very near that of Medicare for the same set of services (Medicaid is paying 98% of what Medicare would pay for the same services). Adjusting the	1%

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2021)
		Medicaid OPPS fee schedule used to calculate ASC rates to use Medicare ASC rates instead could prevent future UPL problems for the clinic service category caused by ASCs receiving payments greater than those made by Medicare.	
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 align specific rates more closely with Medicare or other states.	2%
HEDIS Quality Review	Although WDH does not operate a managed care Medicaid program, it uses HEDIS to report key clinical measures for its Total Population Health Management Contract with its fiscal agent. The fiscal agent calculates rates for clinical measures and is expected to achieve performance targets as defined by HEDIS.	WDH should continue to evaluate whether rates submitted by the fiscal agent was in accordance with NCQA and State-specific technical specifications. WDH should look to track rates across years to determine accuracy and alignment with national standards.	N/A
Maternity	Payment rates for maternity codes are based on RBRVS using 2013 Medicare RVUs. On average, WDH currently pays more than comparison states for certain maternity services, but almost half of commercial payment rates.	WDH is 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