# Appendix F: Wyoming Medicaid Rate History

Table F.1 details changes to Wyoming Medicaid rates for the service areas used in the benchmarking study. Inflation updates indicated in the *SFY 2018 and Previous* column of the table are not indicated as a change for the SFY 2019 through SFY 2022 columns of the table, unless it is an inflation update based on the Medicare Economic Index (MEI).

**Table F.1: Changes to Wyoming Service Area Medicaid Rates[10]**

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| Ambulance | • In SFY 2010, Rates adjusted to 75% of Medicare's 2008 ambulance rates<br>• Lower of the Medicaid fee schedule or the provider's usual and customary charges<br>• Fixed fee schedule amount for transport<br>• Mileage and disposable supplies billed separately<br>• Separate fee schedules for basic life support (ground); advanced life support (ground); additional advanced life support (ground) and air ambulance<br>• Rates adjusted to 90% of Medicare's 2007 ambulance rates<br>• Ground mileage rate increased 125% from $2.50 to $5.63 per mile<br>• Fixed wing air mileage rate decreased to $10.12 per mile and base rate increased 325% to $3,303.63<br>• Rotary wing air mileage rate increased to $26.95 per mile and base rate increased 627% from $528.34 to $3,840.96 | No change | No change | Reimbursement reduced by 2.5% due to Governor's budget cuts | No change |

[10] Service areas updates obtained from Wyoming Medicaid Annual Report.

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| Ambulatory Surgery Centers (ASCs)[11] | • Lower of the Medicaid fee schedule or the provider's usual and customary charges<br>• Rates based on eight ASC payment groups established by Medicare. The groups are all inclusive bundled payment per procedure code<br>• Rates are 90% of Medicare's 2007 ASC rates<br>• Ninth payment group added for services that are not paid through the other eight groups<br>• Group Y (ninth group) reimbursed at 70% of billed charges<br>• Adopted new OPPS-based methodology to better align reimbursement with those services provided in other outpatient settings<br>• Adjusted conversion factors effective calendar year 2017<br>• In SFY 2018, ASC OPPS rate: $34.94 | ASC OPPS rate: $37.42 | ASC OPPS rate: $40.30 | Reimbursement reduced by 2.5% due to Governor's budget cuts | No change |
| Behavioral Health | • In SFY 2010, CPT code rates decreased to 90% of Medicare's rates (effective November 1, 2009)<br>• Lower of the Medicaid fee schedule or the provider's usual and customary charges<br>• Separate fee schedules based on the type of provider<br>• Legislated and funded rate increase of 24% from $70 per hour to $87 per hour<br>• State portion of the increase effective July 1, 2007 and federal portion effective September, 2007<br>• In SFY 2017 reimbursement rate reduced by 3.3%<br>• In SFY 2018, Psychologists paid 100% of fee schedule and APRN paid 90% of fee schedule as of 1/1/18 | No change | No change | Reimbursement reduced by 2.5% due to Governor's budget cuts | No change |

[11] On July 1, 2014 (SFY 2015), Wyoming Medicaid implemented a new reimbursement methodology for ASC services based on Medicare's ASC reimbursement system.

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| Care Management Entity | • Lower of the Medicaid fee schedule or the provider's usual and customary charges<br>• Adopted risk-based capitated payment in SFY 2016<br>• In SFY 2018, rates were adjusted SFY 2017 and 2018 Care Management Entity (CME) premium payment claims to the approved CMS rate for risk-based capitated payments | Administrative services payments to CME are made under a non-risk capitated payment methodology<br>CME network providers payments require CME prior authorization and use the procedure code fee schedule | No change | Beginning 10/01/2020, the CME sends a 278 transaction to Conduent. Conduent uses the 278 file to issue PA numbers for services provided by the CME network providers who utilize the PA's to bill the Medicaid fiscal agent directly. Magellan continues to send an 837P to Conduent for the PMPM payments but doesn't submit FFS claims on behalf of the CME network providers since the change on 10/01/2020. | Rate increase of 2.5% effective 1/1/2022. |
| Clinic/Center | • Lower of the Medicaid fee schedule or the provider's usual and customary charges<br>• SFY 2017 Changed from billing as single entity to billing as a group with treating providers effective for dates of service as of 6/1/17. Became part of the Cap Limit process. | No change | No change | Reimbursement reduced by 2.5% due to Governor's budget cuts | No change |
| Dental | • Lower of the Medicaid fee schedule or the provider's usual and customary charges<br>• Adult optional dental services added (effective July 1, 2006)<br>• SFY 2017 Adult dental coverage reduced to preventive and emergency services only | No change | No change | Reimbursement reduced by 2.5% due to Governor's budget cuts | No change |

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| Durable Medical Equipment, Prosthetics and Orthotics | • In SFY 2009, Rates increased to 90% of Medicare's rates (effective January 1, 2009)<br>• Lower of the Medicaid fee schedule, or the provider's usual and customary charges for each HCPCS code. Medicaid uses Medicare's fee schedule, which is updated annually for inflation based on the consumer price index. For procedure codes not on Medicare's list, Medicaid considers other states' rates.<br>• Certain DME, e.g., customized wheelchairs, is manually priced based on the manufacturer's invoice price, plus a 15 percent add-on, plus shipping and handling<br>• Delivery of DME more than 50 miles roundtrip is reimbursed per mile | Codes impacted by the 21st Century CURES Act are set at 100% of the lowest Medicare rate<br>No change for codes not impacted by the 21st Century CURES Act | No change | Reimbursement reduced by 2.5% due to Governor's budget cuts | Codes impacted by the 21st Century CURES Act are set at 97.5% of the lowest Medicare rate. Codes not impacted by the 21st Century CURES Act, no change |
| End Stage Renal Disease Services | • Lower of the Medicaid fee schedule or the provider's usual and customary charges<br>• Dialysis services reimbursed at a percentage of billed charges<br>• Dialysis services reimbursed at 70% of billed charges (effective September 1, 2008)<br>• Dialysis services reimbursed at 17% of billed charges (effective January 1, 2012)<br>• Dialysis services reimbursed at 12% of billed charges (effective January 1, 2013)<br>• Dialysis services reimbursed at 9% of billed charges (effective January 1, 2014) | No change | No change | Reimbursement reduced by 2.5% due to Governor's budget cuts | No change |

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| Federally Qualified Health Centers | • Prospective per visit payment system implemented on January 1, 2001 as required by the Benefits Improvement and Protection Act (BIPA) of 2000<br>○ Based on 100%of a facility's average costs during SFYs 1999 and 2000. Rates updated annually for inflation based on the Medicare Economic Index (MEI)<br>○ Rates increased 0.6% based on MEI<br>• In SFY 2013, rates increased 0.8% based on MEI<br>• In SFY 2014, rates increased 0.8% based on MEI<br>• In SFY 2015, rates increased 0.8% based on MEI<br>• In SFY 2016, rates increased 1.1% based on MEI<br>• In SFY 2017, rates increased 1.2% based on MEI<br>• In SFY 2018, rates increased 1.01% based on MEI | Rates increased 1.015% based on MEI | Rates increased 1.9% based on MEI | Rates increased 1.4% based on MEI | Rates increased 2.1% based on MEI |
| Home Health | • Lower of the Medicaid fee schedule or the provider's usual and customary charges<br>• Per visit rates based on Medicare's fee schedule<br>• Prior authorization required starting March 2017 | No change | Prior Authorization suspended in March 2020 | Reimbursement reduced by 2.5% due to Governor's budget cuts | No change |
| Hospice | • In SFY 2011, rates increased 2.6%<br>• Fees based on Medicare rates. Medicare pays a per-diem rate based on level of care and updates fees annually based on inflation<br>• For nursing facilities that provide hospice services, payment is 95% of the facility's Medicaid per diem rate and is made to the hospice in lieu of the nursing facility reimbursement<br>• Rates increase annually based on Medicare's inflation increases<br>• In SFY 2013, rates increased 0.6% based on MEI<br>• In SFY 2019, rates were adjusted per Medicare's adjustments | Rates adjusted per Medicare's adjustments | Rates adjusted per Medicare's adjustments | Reimbursement reduced by 2.5% for hospice in nursing homes due to Governor's budget cuts | Rates adjusted per Medicare's adjustments; NH hospice was increased by 5% for part of SFY 2022 |

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| Inpatient Hospital | • Rebased the LOC system using more recent cost and claims data to better categorize services. New rates effective September 1, 2009<br>• In SFY 2010, approved budget reduction of $5.8 million over two years based on Governor's recommendations<br>• Based on a budget footnote for SFY 2010, the Governor's office authorized an increase to The Children's Hospital rates after the required reductions, resulting in an increase of $1 million over a two-year period<br>• Prospective level of care (LOC) rate per discharge implemented on July 1, 1994 and rebased in 1998. Services paid outside of the LOC system are:<br>  ○ Transplant services are paid at 55 percent of billed charges<br>• Hospitals that serve a disproportionate share of low-income patients receive disproportionate share hospital (DSH) payments<br>• Per diem rates are for rehabilitation with a ventilator and separate rate without a ventilator<br>• Specialty services not otherwise obtainable in Wyoming negotiated through letters of agreement<br>• LOC rates updated annually for inflation using the Medicare inpatient prospective payment (PPS) inflation rates<br>• Qualified Rate Adjustment (QRA) program implemented on July 4, 2004 to provide supplemental payments to non-state governmental hospital<br>• In SFY 2009, LOC rates updated for inflation<br>• In SFY 2017, No change to LOC reimbursement. Private hospital UPL implemented | DRG implemented 5/31/19 with an effective date of 2/1/19<br>Private hospital UPL program, DSH, and QRA remain in place<br>Rehab claims paid outside of the DRG | Second year of DRG rates implemented on February 1, 2020 | Reimbursement reduced by 2.5% due to Governor's budget cuts | No changes |
| Intermediate Care Facility for people with Intellectual Disabilities (ICD-ID) | • Full cost reimbursement method based on previous year cost reports<br>• Removed link with Nursing Home rates. Rates now updated annually with full cost coverage | No change | No change | No change | No change |

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| Laboratory | • Lower of the Medicaid fee schedule or the provider's usual and customary charges<br>• In SFY 2009, Rates increased to 90% of Medicare's rates<br>• Twelve laboratory procedure codes' rates adjusted to 80% of SFY 2007 average billed charges | No change | No change | Reimbursement reduced by 2.5% due to Governor's budget cuts | No change |
| Nursing Facility[12] | • In SFY 2011, Rates were updated based on analysis of Medicaid cost reports<br>• Prospective per diem rate with rate components for capital cost, operational cost, and direct care costs<br>• Additional reimbursement monthly for extraordinary needs determined on a per case basis<br>• Rate updates in SFY 2016 based on approved NF reimbursement update.<br>• Additional payments:<br>  • Provider Assessment and Upper Payment Limit (UPL) Payment provides supplemental payments (effective April 1, 2011)<br>  • Implemented Provider Assessment and Upper Payment Limit (UPL) Payment after Legislative and federal approval. First payment in SFY 2012.<br>• Nursing Facility Gap Payment Program approved in SFY 2017; no change to rate methodology | No change | No change | Reimbursement reduced by 2.5% due to Governor's budget cuts | Rates were increased by 5% July,1 2021 through June 30, 2022. |

[12] On July 1, 2015 (SFY 2016), Wyoming Medicaid implemented an acuity-based reimbursement methodology for nursing facility services.

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|---|---|---|---|---|---|
| Outpatient Hospital | • Outpatient prospective payment system (OPPS) based on Medicare's Ambulatory Payment Classifications (APC) system<br>• Separate fee schedules for:<br>  ○ Select DME<br>  ○ Select vaccines, therapies immunizations, radiology, mammography screening and diagnostic mammography<br>  ○ Laboratory<br>  ○ Corneal tissue, dental and bone marrow transplant services, new medical devices<br>• QRA program provides supplemental payments to non-state governmental hospital<br>• SFY 2012 adjusted conversion factors:<br>  ○ General acute: $50.99<br>  ○ Critical access: $129.74<br>  ○ Children's: $109.95<br>• SFY 2013 adjusted conversion factors:<br>  ○ General acute: $48.19<br>  ○ Critical access: $126.82<br>  ○ Children's: $105.50<br>  ○ No change to QRA<br>• SFY 2014 adjusted conversion factors:<br>  ○ General acute: $45.45<br>  ○ Critical access: $118.86<br>  ○ Children's: $100.05<br>  ○ No change to QRA<br>• SFY 2015 adjusted conversion factors:<br>  ○ General acute: $42.34<br>  ○ Critical access: $111.93<br>  ○ Children's: $92.71<br>  ○ No change to QRA<br>• SFY 2016 adjusted conversion factors: Adjusted conversion factors due to budget cuts<br>  ○ General acute $39.41<br>  ○ Critical access $102.53<br>  ○ Children's $85.41<br>  ○ No change to QRA | • Adjusted conversion factors (effective calendar year 2019):<br>  ○ General acute $42.53<br>  ○ Critical access $105.89<br>  ○ Children's $88.45<br>  ○ ASCs $37.42<br>• No change for QRA | • Adjusted conversion factors (effective calendar year 2020):<br>  ○ General acute $45.79<br>  ○ Critical access $109.66<br>  ○ Children's $83.59<br>  ○ ASCs $40.30<br>• No change for QRA | Reimbursement reduced by 2.5% due to Governor's budget cuts | • Adjusted conversion factors (effective calendar year 2022):<br>  ○ General acute $46.88<br>  ○ Critical access $112.72<br>  ○ Children's $84.54<br>  ○ ASCs $41.25<br>• No change for QRA |

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| | • SFY 2017 adjusted conversion factors due to budget cuts<br>o General acute $37.94<br>o Critical access $98.80<br>o Children's $76.34<br>o ASCs $33.39<br>o No change to QRA<br>• SFY 2018 adjusted conversion factors due to budget cuts (effective calendar year 2018):<br>o General acute $39.70<br>o Critical access $104.27<br>o Children's $83.92<br>o ASCs $34.94<br>o No change to QRA | | | | |
| Physicians/ Practitioners[13] | • Adopted Medicare's 2009 RVUs (effective August 1, 2009)<br>• Adjusted the conversion factors for physician services (effective August 1, 2009)<br>• Reimbursement budget reduced by $4.8 million<br>• Resource-Based Relative Value Scale (RBRVS) reimbursement methodology based on Medicare's RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rates.<br>• Beginning January 1, 2013, the Affordable Care Act (ACA) mandated increased primary care service payment by State Agencies of at least the Medicare rates in effect in CY 2009 for CY 2013 and 2014<br>• Beginning August 1, 2013, transitioned OB services to RBRVS reimbursement methodology using Calendar Year 2013 RVUs<br>• Adjusted conversion factor on November 1, 2016 to reflect a 3.3% reduction on all RBRVS codes | No change | No change | Reimbursement reduced by 2.5% due to Governor's budget cuts<br>Chiropractic services limited to children under EPSDT and members on Medicare.<br>Threshold limit for dietician services removed. | No change |

[13] The ACA Primary Care Service Payments ended December 31, 2014 (SFY 2015).

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| Prescription Drugs | • In SFY 2011, Prescription Drug List prescription drug list (PDL) expanded to 80 specific drug classes<br>• Lower of the estimated acquisition cost (EAC) of the ingredients plus the dispensing fee and the provider's usual and customary charge<br>  ○ The EAC is the Average Wholesale Price (AWP) minus 11%<br>  ○ The AWP is determined by pricing information supplied by drug manufacturers, distributors and suppliers and is updated monthly. Some drugs are priced by the State Maximum Allowable Cost (SMAC)<br>• Dispensing fee is $5.00 per claim<br>• In SFY 2009, Preferred Drug List (PDL) expanded to 21 specific drug classes<br>• SFY 2011 - PDL expanded to 80 specific drug classes<br>• SFY 2012 - PDL expanded to 109 specific drug classes<br>• SFY 2013 - PDL expanded to 108 specific drug classes<br>• SFY 2014 – PDL expanded to 119 specific drug classes<br>• SFY 2015 – PDL expanded to 123 specific drug classes<br>• Reimbursement structure changed on April 1, 2017 to comply with the Final Covered Outpatient Drug Rule | No change | No change | No change | No change |
| PRTFs | • Rates increased based on analysis of Medicaid cost reports<br>• Per diem rate. The rate includes room and board, treatment services specified in the treatment plan, and may include an add-on rate for medical services<br>• SFY 2014 – Rates adjusted December 1, 2014 based on analysis of Medicaid cost reports | No change | No change | Reimbursement reduced by 2.5% due to Governor's budget cuts | No change |

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| RHCs | • In SFY 2011, Rates increased 0.4% based on MEI<br>• Prospective per encounter payment system as required by the Benefits Improvement and Protection Act (BIPA) of 2000<br>  ○ Based on 100% of a facility's average costs during SFYs 1999 and 2000<br>• Rates increased annually for inflation based on Medicare Economic Index (MEI)<br>• SFY 2014 – rates increased 0.8% based on MEI<br>• SFY 2015 – rates increased 0.8% based on MEI<br>• SFY 2016 - rates increased 1.1% based on MEI<br>• SFY 2017 – rates increased 1.2% based on MEI<br>• SFY 2018 - rates increased 1.01% based on MEI | Rates increased 1.015% based on MEI | Rates increased 1.9% based on MEI | Rates increased 1.4% based on MEI | Rates increased 2.1% based on MEI |
| Vision | • Lower of the Medicaid fee schedule or the provider's usual and customary charge<br>• Ophthalmologists and optometrists are reimbursed under the Resource-Based Relative Value Scale (RBRVS) reimbursement methodology based on Medicare's RBRVS methodology. The methodology utilizes Relative Value Units (RVUs) and a conversion factor to determine rates<br>• Optician reimbursement based on a procedure code fee schedule | No change | No change | Reimbursement reduced by 2.5% due to Governor's budget cuts | No change |

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| Waiver Services – Comprehensive, Supports and Acquired Brain Injury (ABI) Waivers | • A 6% restoration of the SFY 2010 10% rate reduction (or 96% of the SFY 2009 rates) was implemented<br>• Cost-based reimbursement methodology, implemented in SFY 2009<br>  ○ The Individualized Budget Amount (IBA) is based on the historical plan of care units multiplied by the respective service rate less one-time costs, such as assessments, specialized equipment, or home modifications<br>  ○ Prior to cost-based reimbursement, individualized budget amount determined by the "DOORS" funding model, which estimates individual expenditures based on specific customer characteristics<br>• Reimbursement for specific residential and day habilitation services is made on a per diem basis and varies by provider and consumer<br>• Consumers negotiate rates based on their budget amount<br>• Rates were reduced by 1% at the beginning of FY 14 as required by the legislature to reach a 4% overall budget reduction for the waivers<br>• Participants from ABI waivers will transition to either the Comprehensive or Supports Waiver between January 1st and March 31st of 2017. On March 31st, 2017, ending the ABI waivers<br>• Implemented 3.3% rate increase on February 1, 2017, applied retroactively back to July 1, 2016; Adult and Children ID/DD Waivers closed | No change | Rate increase 4.2% for all services[14] | Temporary provider rate increase of 12.5% for some waiver services in response to the COVID-19 public health emergency (March 1 - September 1, 2020) | Temporary provider rate increase (February 1, 2022 – March 1, 2024). Rate increases are financed through American Rescue Plan Act of 2021 (ARPA), funding and providers must apply the entire rate increases to direct support worker compensation. |

[14] The Acquired Brain Injury Waiver was closed in April 2018, with enrolled members being transitioned into the Comprehensive and Supports Waivers.

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| Waiver Services – Children's Mental Health Waiver | • In SFY 2010, Rates were adjusted to reflect budget neutrality<br>• Lower of the Medicaid fee schedule or the provider's usual and customary charge<br>• Reimbursement based on procedure code fee schedule<br>• July 1, 2015: Care Management Entity began serving youth<br>• In SFY 2018, working with CMS for approval of SFY 2017 rates | Adjusted SFY 2017 and 2018 Care Management Entity (CME) premium payment claims to the approved CMS rate for risk-based capitated payments | Administrative services payments to CME made under a non-risk capitated payment methodology<br>CME network providers payments require prior authorization from CME. Payments based on procedure code fee schedule | No change | No change |
| Waiver Services – Community Choices [formerly: Long-Term Care and Assisted Living Facility (ALF) Waivers] | • Lower of the Medicaid fee schedule or the provider's usual and customary charge<br>• Reimbursement limited to a monthly or yearly cap per person, according to the established care plan<br>• Rates increased for ALF Waiver<br>• ALF Waiver: 12% increase per rate rebasing project, effective March 1, 2016<br>• LTC Waiver: 8% increase per rate rebasing project, effective March 1, 2016<br>• ALF Waiver closed in SFY 2017, with service provided under the Community Choices Waiver | No change | No change | Rate increase for select direct care services in response to the COVID-19 public health emergency | Provider rate increase implemented July 1, 2021. As required by ARPA, case management and assisted living facility rates were retroactively adjusted to ensure rates were not less than the rates that were effective as of April 1, 2021. |

| Service Area | SFY 2018 and Previous | SFY 2019 | SFY 2020 | SFY 2021 | SFY 2022 |
|---|---|---|---|---|---|
| Waiver Services - Family Planning Waiver - Pregnant by Choice Program | • The waiver was implemented in SFY 2009<br>• Multiple reimbursement methodologies and fee schedules based on the service areas detailed in this table<br>• Extended to 12/31/2019 | Extension application submitted to CMS | Extended to 12/31/2027 | Family Planning Waiver approved 4/7/2020 to cover FPW services through 12/31/2027.<br><br>CMS reimbursing by a PMPM amount. For CY 2021 the PMPM rate is $12.10. For CY 2022 the PMPM rate is $12.65.<br><br>Any expenses beyond the PMPM are covered by Wyoming Medicaid. | No change |