SFY 2022 WYOMING MEDICAID REIMBURSEMENT BENCHMARKING STUDY

Based on Data Ending State Fiscal Year 2022

Wyoming Department of Health

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Section 1: Introduction

The SFY 2022 Wyoming Medicaid Benchmarking Study is the fifteenth 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 2022 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 2022 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 2022. As this report focuses on SFY 2022, only reimbursement and policy changes due to COVID-19 through June 30, 2022, 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 2022 Benchmarking Study

Service Areas Included in the Benchmarking Study	
Ambulance	Maternity
Ambulatory Surgery Center (ASC)	Ophthalmology
Behavioral Health	Nursing Facilities
Dental	Physician and Other Practitioner[1]
Developmental Center	Public Health, Federal (Tribal Facilities)
Durable Medical Equipment, Prosthetic, Orthotic and Supply (DMEPOS)[2]	Prescription Drugs
End Stage Renal Disease (ESRD)	Psychiatric Residential Treatment Facility (PRTF)
Federally Qualified Health Center (FQHC)	Rural Health Clinic (RHC)
Home Health	School Based Services
Hospice	Supplemental Payments
Hospital - Inpatient	Vision - Ophthalmology
Hospital - Outpatient	Vision - Optician/Optometry
Intermediate Care Facility – Intellectually Disabled (ICF-ID)	Telehealth/Telemedicine
Laboratory	Waiver Services (HCBS)

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 primary care, physician specialist, and maternity providers.
[2] Includes DMEPOS rentals and purchases.

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 each of the provider grouping categories (state-owned or operated, non-state owned or operated, and private).[3] 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 each of the providers grouping categories (state-owned or operated, non-state government owned or operated, and private) may not exceed the upper payment limit.[4,5]
- For PRTFs and Institutions of Mental Disease (IMDs), Medicaid payment may not exceed the provider's customary charges.[3]
- Medicaid payment for clinical diagnostic laboratory services provided by a physician, independent laboratory or hospital may not exceed the Medicare fee schedule on an individual procedure code level.[6]

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 2022. 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 2022 rates as they were on June 30, 2022, 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.

[3] 42 CFR § 447.272
[4] 42 CFR § 447.321
[5] The provider grouping categories are 1) state-owned or operated, 2) non-state owned or operated and 3) privately owned or operated.
[6] State Medicaid Manual, Title XIX State Plan Amendments, Part 6 Section 6300.2 "Fee Schedules for Outpatient Clinical Laboratory Tests".

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 outpatient and inpatient payment systems. Wyoming Medicaid must also consider State budget targets when performing updates, which can involve maintaining budget neutrality for a particular service area and/or for the entire Wyoming Medicaid program as well as implementing legislatively mandated budget increases or decreases (service-specific or overall)[7]. 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 payment approaches to become disconnected from 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 to ensure that Medicaid beneficiaries have sufficient access to treatment. However, it is important to consider that states have different reimbursement methodologies and coverages so direct rate comparisons may be difficult in certain 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 located 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. 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

[7] Beginning January 1, 2021, Wyoming Department of Health, Division of Healthcare Financing implemented a 2.5 percent rate reduction across all provider services.

methodologies and levels are determined by state legislatures and the agencies that administer the programs.

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.

For services which Medicare bases service reimbursement on a fee schedule, WDH compared Wyoming Medicaid SFY 2022 rates for each procedure to the Medicare rates in 2022 fee schedules.[8] Medicare pays for the following services using a fee schedule: ambulance, behavioral health, DMEPOS, hospice, laboratory, physician, and vision services.[9] To the extent that the Medicare rates varied by geographic region, WDH used those rates that are specific to Wyoming.[10] To determine Medicare rates for home health services, WDH calculated average Medicare home health visit rates in Wyoming using the average Wyoming Wage Index Budget Neutrality Factor. To compare Wyoming Medicaid outpatient hospital payments to Medicare, WDH compared Wyoming Medicaid's weighted outpatient conversion factor based on SFY 2022 claims volume (see Figure 2.6) to Medicare's CY 2022 Outpatient Prospective Payment System (OPPS) conversion factor. The methodology for these comparisons is located in Appendix A, and detailed analyses are presented in Appendix C.

Comparison to Commercial Payers

Another benchmark for consideration in the SFY 2022 Benchmarking Report are the rates that commercial health plans (i.e., non-government) pay providers in the State. While commercial payers are often the "highest" payer, comparing commercial rates offers insights into the commercial market and rates paid by commercial payers. 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 2021Truven MarketScan database.[11] The methodology for these comparisons is located in Appendix A, and detailed analyses by service area are presented in Appendix B.

In addition to state-specific changes, the federal government also instituted some changes because 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 government extended the PHE order through 2022 and into 2023. 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. In 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act,

[8] 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 2022.

[9] 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.

[10] 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.

[11] 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 2021 (the most recent year of data available).

authorized a 6.2 percent increase in the federal Medicaid match rate (FMAP) to help states respond to COVID-19. The federal government made the funds available to states from January 1, 2020, through the quarter in which the PHE period ends.[12] The extension of the federal PHE extended both the FMAP and the CMS Medicaid continuous enrollment requirements into 2023. In 2022, the federal government passed the Consolidated Appropriations Act of 2023 which delinked the continuous enrollment provision from the PHE, ending continuous enrollment on March 31, 2023, and phased down the enhanced FMPA through December 2023.[13]

In 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] This rate increase expired in CY 2022 and as a result lowered the CY 2022 Medicare Physician Fee Schedule (PFS) conversion factor from $34.89 to $33.59. [15]

Following the federal rate increases, numerous states, including those neighboring Wyoming, implemented temporary rate increases for services such as inpatient, outpatient, hospital, and nursing facility services. States implemented these measures to help healthcare providers remain financially solvent amid the pandemic. Although the federal government extended the federal PHE through 2023, individual states including Wyoming and neighboring states terminated their respective states of emergency in 2022. Consequently, depending on the state's PHE termination date many of the rate increases for healthcare providers ended in 2022.

An example of a service increase that has remained past the PHE termination is telehealth. In response to the pandemic, all fifty states and DC expanded Medicaid coverage and/or access of telehealth services to increase health care access and limit patient exposure. Medicaid enrollees' behavioral health continues to be a high utilizer of telehealth services well into SFY 2022. In a recent survey, many states Medicaid agencies report plans to permanently adopt some or all of behavioral health Medicaid telehealth policy expansions. [16]

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, to date forty-one states and the District of Columbia have adopted Medicaid expansion provisions. This includes all of the states surrounding Wyoming. Colorado chose to adopt Medicaid expansion when first available on January 1, 2014. Since then, Idaho, Montana, Nebraska, South Dakota, and Utah have all approved Medicaid expansion. In 2018, voters in Idaho, Nebraska, and Utah approved Medicaid expansion via ballot measure for implementation in 2020. In 2022, South Dakota

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[12] Congress.Gov, "CARES Act." Available online: https://www.congress.gov/bill/116th-congress/house-bill/748/

[13] CMS, "End of the Medicaid Continuous Enrollment Condition Frequently Asked Questions for State Medicaid and CHIP Agencies." Available online: https://www.medicaid.gov/federal-policy-guidance/downloads/caa-2023-unwinding-faqs-05122023.pdf

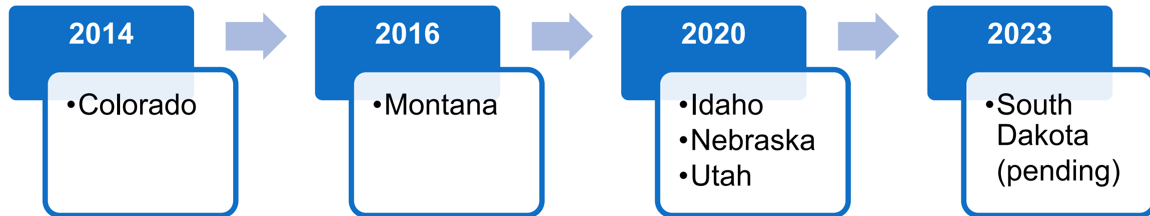
[14] Congress.Gov, "Consolidated Appropriations Act, 2021." Available online: https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf

[15] CMS, "CY2022 Medicare Physician Fee Schedule Final Rule." Available online: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule

[16] KFF, "Telehealth Delivery of Behavioral health Care in Medicaid: Findings from a Survey of State Medicaid programs" Available online: https://www.kff.org/medicaid/issue-brief/telehealth-delivery-of-behavioral-health-care-in-medicaid-findings-from-a-survey-of-state-medicaid-programs/

voters approved Medicaid expansion with an implementation date of July 1, 2023.[17] 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.[18 & 19]

Figure 1.2 Timeline of Surrounding States Medicaid Expansion Coverage



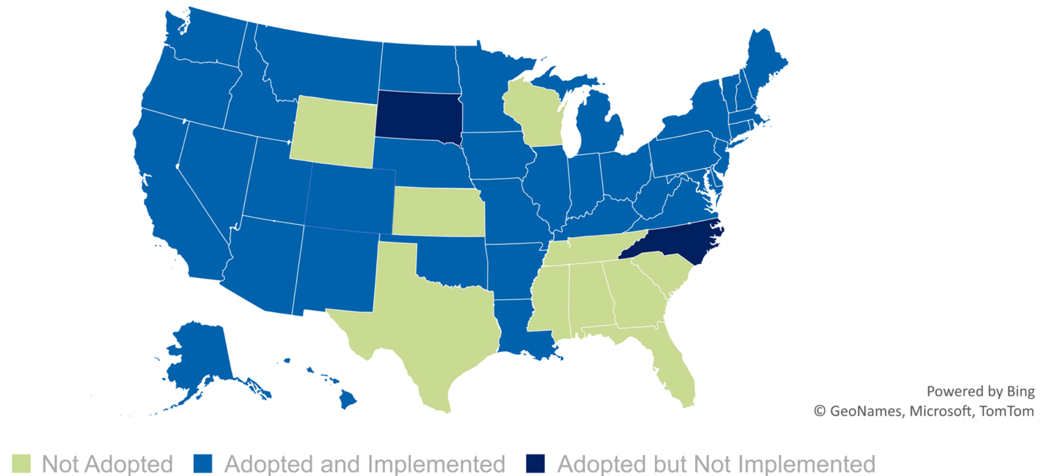
- **Colorado:** The state extended Medicaid coverage to parents of covered Medicaid youth and childless adults in 2009, prior to passage of the Affordable Care Act. As a result, Colorado was eligible for the increased FMAP for the Medicaid expansion population when it was first available on January 1, 2014. [20]
- **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 one hundred thirty eight percent (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. The Biden Administration withdrew Medicaid work requirement provisions in February 2021 and the other waiver request remain pending.[21]
- **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 one hundred thirty eight percent (138%) of the FPL. CMS initially approved the Section 1115 Demonstration for Medicaid expansion through 2019. In 2019, Montana submitted a Section 1115 Demonstration waiver renewal for an additional six years, however the 2019 waiver included work requirements as a condition of eligibility. In 2021, the Biden Administration notified Montana that the work requirement provision would not be approved.[22] Additionally, in December 2021, CMS notified Montana that the premium requirement for the expansion population contained in the Section 1115 Demonstration needed to be phased out by 2022. [23]
- **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

[17] South Dakota Department of Social Services, "*Medicaid Expansion and Unwinding"* https://dss.sd.gov/docs/medicaid/general_info/tribal/2023/01_24_23/Medicaid_Expansion_and_Unwinding.pdf
[18] National Academy for State Health Policy. "*Where states stand on Medicaid expansion,"* Available online: https://nashp.org/states-stand-medicaid-expansion-decisions/
[19]
[20] Colorado Health Institute, "*ACA at 10 Years: Medicaid Expansion in Colorado*," Available online: https://www.coloradohealthinstitute.org/research/aca-ten-years-medicaid-expansion-colorado
[21] CMS, "*State Waivers List*," Available online: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html
[22] Montana DPHHS, "*Montana's New Healthcare Option*," Available online: https://dphhs.mt.gov/medicaidexpansion/
[23] KFF, "Status of State Medicaid Decisions," Available online: Status of State Medicaid Expansion Decisions: Interactive Map | KFF

tiered benefit structure that requires members to meet work requirement, however Nebraska withdrew that waiver in 2021, following the Biden Administration's decision to withdraw Medicaid work requirement provisions. Nebraska began offering full benefits to all expansion adults beginning on October 1, 2021.[24]

- **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 under the age of sixty-five with an annual income up to on one hundred thirty eight percent (138%) of the FPL**.** If available, Utah requires newly eligible adults to enroll in their employer-sponsored health plan and will cover monthly premiums, co-pays, and deductibles**.** [25]
- **South Dakota:** On November 8, 2022, voters approved a ballot measure proposing the inclusion of Medicaid expansion in the South Dakota state constitution. The measure contains language that mandates the implementation of expansion coverage in South Dakota from July 1, 2023. Moreover, the measure prohibits any imposition of additional eligibility or enrollment requirements on the expansion population.[26]

Figure 1.3: State Medicaid Expansion Under the Affordable Care Act



Recent studies have identified the benefits to States that have expanded Medicaid. Areas that have seen improvement include:

- **Benefits for Young Adults:** In states that expanded Medicaid, researchers found that expanded coverage improved care quality, access, and reduced healthcare costs.[27]

[24] Nebraska DHHS, "*Medicaid Expansion in Nebraska*," Available online: https://dhhs.ne.gov/Pages/Medicaid-Expansion.aspx
[25] Utah Department of Health, Medicaid, "*Medicaid Expansion*," Available online: https://medicaid.utah.gov/expansion/
[26] South Dakota DSS, "Medicaid Expansion and Unwinding," Available online: https://dss.sd.gov/docs/medicaid/general_info/tribal/2023/01_24_23/Medicaid_Expansion_and_Unwinding.pdf
[27] National Institute on Minority health and Health Disparities, "Medicaid Expansion Benefits Young Adults," Available online: https://www.nimhd.nih.gov/news-events/research-spotlights/medicaid-expansion-benefits-young-adults.html

- **Increased Financial Outcomes of Providers:** Studies have shown that expanding Medicaid has a positive impact on healthcare providers by increasing financial performance which results in payer mix improvements. Medicaid expansion leads to a lower share of uninsured patients in hospitals and lower overall uncompensated care costs for specific types of hospitals, including rural facilities. This helps to boost revenue and increases stability for providers. [28]
- **Rural Hospitals:** The financial health of rural hospitals and their impact on access to care and local economies has been an ongoing concern for many states. A recent analysis found that rural hospitals in non-expansion states fared worse financially than those in expansion states. The study found that in 2019, the median operating margins of rural hospitals in expansion states were higher than those in non-expansion states (2.0% vs 0.3%). [29]
- **Reduced Postpartum Hospitalizations:** A study based on hospital data collected from 2010 to 2017, has shown Medicaid expansion led to greater coverage for lower income birthing people in preconception and postpartum care. When comparing changes in hospitalizations in states with a Medicaid covered delivery in states with and without Medicaid Expansion; it was found that a seventeen percent (17%) reduction in hospitalizations occurred in the first sixty days postpartum. [30]

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.[31] 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,

[28] Recycle Intelligence, "Medicaid Expansion Helped Improve Provider Financial Performance," Available online: https://revcycleintelligence.com/news/medicaid-expansion-helped-improve-provider-financial-performance

[29] Kaiser Family Foundation, "Rural Hospitals Face Renewed Financial Challenges, Especially in States That Have Not Expanded Medicaid," Available online: https://www.kff.org/health-costs/issue-brief/rural-hospitals-face-renewed-financial-challenges-especially-in-states-that-have-not-expanded-medicaid/

[30] Health Affairs, "*Medicaid Expansion Led to Reductions in Postpartum Hospitalizations*," Available online: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00819?journalCode=hlthaff

[31] 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

home-delivered meals, educational services, employment, community integration and social supports, and case management.[32] 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.[33]
- **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. [34]
  - 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. [35]
- **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.[36]

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

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[32] CMS, "*Opportunities in Medicaid and CHIP to Address SDOH*," Available online: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf
[33] South Dakota DSS, "*Health Home Resource Hub*," Available online: https://dss.sd.gov/medicaid/generalinfo/faq.aspx#healthhomes
[34] 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
[35] 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
[36] Montana DPHHS, "*HEART Waiver Submission*," Available online: https://dphhs.mt.gov/heartwaiver

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.[37]

Medicaid trends in value-based payments are moving towards the integration of physical and behavioral health to reduce costs. By integrating physical and behavioral health services, Medicaid programs can reduce unnecessary utilization of emergency department services and hospitalizations, improve medication adherence and chronic disease management, and better address the complex needs of individuals with co-occurring physical and behavioral health conditions. This, in turn, can lead to cost savings for both Medicaid programs and beneficiaries. This trend is supported by evidence showing that integrated care can improve health outcomes and reduce costs. Strategies for promoting the integration of physical and behavioral health care include payment and delivery system reforms with a focus on developing comprehensive approaches to care coordination, providing financial incentives for evidence-based practices, and using health information technology to facilitate communication and coordination between providers. [38] Below are highlights of each comparison state's value-based care strategies.

- **Wyoming:** Wyoming Medicaid does not have a wide value-based care strategy across its services. 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 2022, approximately 114 providers participated in the PCMH model. [39]

- **Colorado:** 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

[37] CMS, "*Value Based Care Opportunities in Medicaid*," Available online: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf
[38] Medicaid, "Promoting Physical and Behavioral Health Integration in Medicaid Through Section 1115 Demonstrations," Available online: https://www.medicaid.gov/medicaid/downloads/promoting-pbhi.pdf
[39] Wyoming Department of Health, "Patient Centered Medical Home," Available online: https://health.wyo.gov/healthcarefin/medicaid/pcmh/

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 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.
- Colorado seeks to have "fifty percent (50%) of Medicaid payments tied to value-based payment methodologies that move away from fee-for-service payment and towards Alternative Payment Models (APMs) that tie financial rewards to performance measures that achieve shared goals, like improving health, closing disparities, and/or improving health care affordability." Colorado's first APM (APM1) was implemented in 2016, for primary care providers who serve Medicaid Members. Primary care providers were given the opportunity to receive enhanced payment rates if specific quality metrics were met. APM2 went live on July 1, 2021. In APM2, primary care doctors are given the option to receive a percentage of their revenue as a fixed Per Member Per Month payment. This provides stability in revenue and allows for increased investments in improving care. Providers also have the opportunity to share in the savings that result from improved chronic care management by meeting quality thresholds. On November 1, 2020, Colorado's Medicaid program implemented the Maternity Bundled Payment program. Bundled payments involve a "single, comprehensive payment that covers all the services within an episode of care," from prenatal, care, to labor and delivery, and postpartum care. They seek to reduce costs, incentivize doctors with potential savings, and improve maternal outcomes. [40]

- **Idaho:** 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 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 basis plus a per member per month (PMPM) care management fee and the larger VOCs share in savings or losses generated for Medicaid.

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[40] HCPF, "Alternative Payment Models" Available online: https://hcpf.colorado.gov/sites/hcpf/files/Alternative%20Payment%20Model%20Fact%20Sheet.pdf
[41]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/

- **Montana:** 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, 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. Beginning January 1, 2022, CPC+ practices will also be able to participate in Primary Care First (PCF). The PCF Payment Model is a voluntary payment model introduced by the CMS in 2019 to encourage primary care practices to shift to a value-based care approach. The model offers a set of payment options designed to support and reward primary care practices for providing high-quality care to their patients.[43]

- **Nebraska:** 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:** South Dakota does not have a wide 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.

- **Utah:** 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. As of 2021, 13 out of 29 counties in Utah require Medicaid members to enroll in an ACO plan, while the rest are allowed to choose between an ACO and FFS Medicaid.

  Initially, ACOs in Utah were only expected to maintain certain quality standards. However, in 2018, the state changed its approach and began asking ACOs to focus on improving quality by progressively achieving scores that are at or above the national average. This shift in focus has been successful, and Utah's Medicaid ACO program has been able to save the state an average of $15 million each year.

[42] Montana DPHHS "*CPC+ Overview*," Available online: https://dphhs.mt.gov/montanahealthcareprograms/cpcplus
[43] CMS, "Primary Care First Model Options" Available online: https://innovation.cms.gov/innovation-models/primary-care-first-model-options
[44] National Association of ACOs, "Utah," Available online: https://www.naacos.com/medicaid-acos-utah

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, as of CY2020 all of Wyoming's six surrounding comparison states have implemented elements of managed care into their Medicaid programs, with actions ranging from assigning enrollees with medical homes to contracting with accountable care organizations. Two of these surrounding states – Nebraska and Utah – have gone one step farther and enrolled over seventy percent (70%) 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.[45]

Figure 1.5: Medicaid Managed Care Delivery System and Percent of Medicaid Beneficiaries Enrolled in Managed Care[46]

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[47]	No Comprehensive Medicaid Managed Care	0.2%	0.2%
Colorado	Medicaid Managed Care Organization and Primary Care Case Management Program	96.2%	10.2%
Idaho	Primary Care Case Management Program	91.6%	6.8%
Montana	Primary Care Case Management Program	89.1%	0.0%
Nebraska	Medicaid Managed Care Organization	99.5%	99.5%
South Dakota	Primary Care Case Management Program	64.6%	0.0%
Utah	Medicaid Managed Care Organization	94.8%	79.9%

The percentage 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

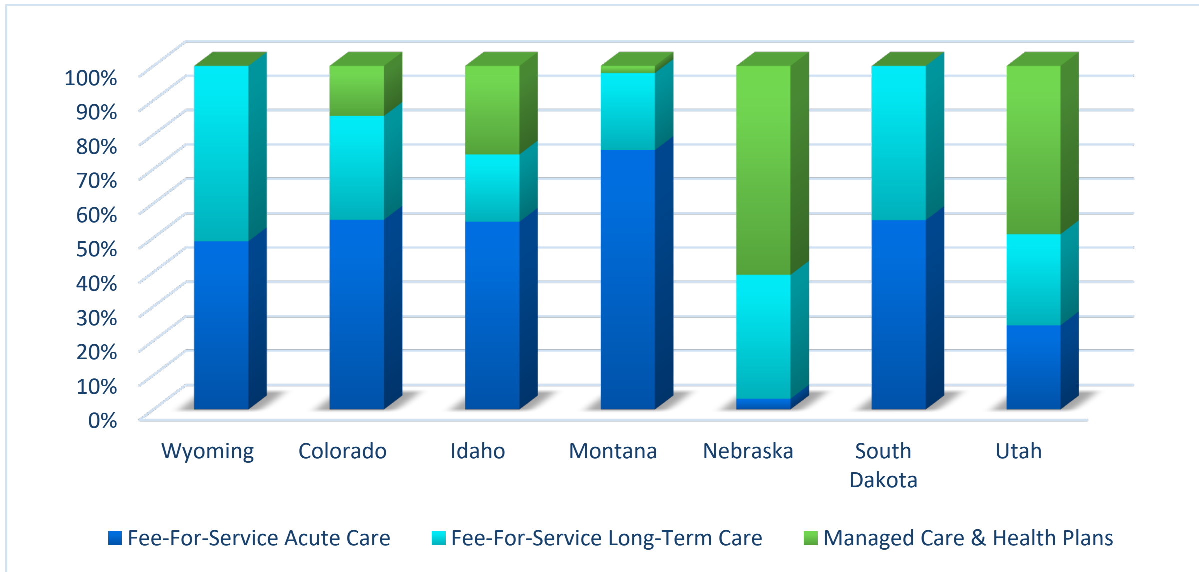
[45] CMS defines Comprehensive Managed Care as managed care plans that provide enrollees with comprehensive benefits including acute, primary care, specialty, etc. CMS also classifies PACE programs as comprehensive managed care.

[46] CMS, "*Medicaid Managed Care Enrollment Report*," Available online: https://www.medicaid.gov/medicaid/managed-care/enrollment/index.html

[47] 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.

reimbursement model for limited acute and long-term care costs.[48] Nebraska and Utah have the highest spending for Medicaid managed care services, with managed care expenditures accounting for about fifty nine percent (59%) percent and forty eight percent (48%) respectively 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 programs 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 over ninety percent (90%) 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 fourteen percent (14%) of spending in Colorado and twenty five percent (25%) of spending in Idaho. Wyoming, along with Montana and South Dakota, which have the smallest percent of their population enrolled in managed care, spend two percent (2%) or less of Medicaid costs on managed care.

[48] 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[49]

State	Acute Care (FFS)	Long Term Care (FFS)	Managed Care	Payments to Medicare	DSH[50]
Wyoming	47%	49%	0%	3%	0%
Colorado	53%	29%	14%	2%	2%
Idaho	53%	19%	25%	3%	1%
Montana	74%	22%	2%	3%	0%
Nebraska	3%	35%	59%	2%	1%
South Dakota	57%	39%	0%	4%	0%
Utah	24%	26%	48%	2%	1%

Numbers may not sum to 100% due to rounding.

[49] Kaiser Family Foundation, "*Distribution of Medicaid Spending by Service*," Available online: https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service//
[50] DSH payments are supplementary payments made to hospitals that serve a disproportionate number of low-income patients.

Section 2: Reimbursement Options

Policymakers face complex decisions about the most effective distribution of limited state resources. As part of their decision-making 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 the 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 support providers' continued participation in the Wyoming Medicaid program and beneficiaries access to services.

Program Changes During SFY 2022

Wyoming Medicaid made several program changes pertaining to covered services and reimbursement during SFY 2022, which are presented in Figure 2.1.

Figure 2.1: Medicaid Coverage and Reimbursement Changes During SFY 2022

Eligibility Category/ Service Area	Action	Dates of Implementation
Care Management Entity (CME)	• Wyoming utilized ARPA funding to provide enhanced care coordination for children and youth with co-occurring issues who are receiving ID/DD waiver waitlist services.	January 1, 2022
Pharmacy Benefit Management Unit (PBMU)	• To receive professional service reimbursement on a postpartum contraceptive implant insertion, providers must bill the procedure separately from the professional global obstetric procedure. • Wyoming implemented a new policy for Speech-Generating Devices.	January 1, 2022
Home and Community-Based Services (HCBS)	• Increased rates for the Community Choices Waiver (CCW) and the Comprehensive and Supports Waiver (DD Waiver). • Implemented a provider attestation process to ensure that providers are applying rate increases to direct support worker compensation.	February 1, 2022

Figure 2.1: Medicaid Coverage and Reimbursement Changes During SFY 2022

Eligibility Category/ Service Area	Action	Dates of Implementation

Medicare Crossover Claims	• On February 4, 2022, criteria for claim submissions changed for Medicare and Medicaid dual eligible members with eligibility beginning November 2021.
	  ○ Medicaid will review chiropractic claims made after June 1, 2021, to ensure appropriateness and documentation requirements are being met.
	  ○ Medicaid will review nursing home claims made after January 1, 2021, for mandatory value and occurrence span codes.
	  ○ Providers need to submit dental prior authorization requests using the WYhealth website.
	• Medicaid updated the system to process Outpatient Hospital/OPPS claims through the 3M grouper and will no longer be a quarter behind.
		February 4, 2022

Federally Qualified Health Center (FQHC) Coverage	• Beginning April 22, 2022, FQHC services are reimbursable for one encounter per day per eligible member unless it is necessary for the member to be seen by different health professional with different specialties or to be seen multiple times per day due to an unrelated diagnosis.	April 22, 2022
Home and Community-Based Services (HCBS)	• Implemented new service plan requirements and processes in response to the Community Choices waiver renewal.	July 1, 2022
Health Management Outcome Improvement (HMOI), Health Management - Utilization Management (HMUM)	• Following the end of the Wyoming's contract with Optum, the new HM/UM vendor, Telligen, went live July 1, 2022.	July 1, 2022

Wyoming Medicaid Comparisons to Benchmarks

Comparing Wyoming 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 with 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.[51] Calculating this percentage allows the comparison of payment rates in each service area relative to each other and these 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 2022 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[52]

Service Area	Wyoming 2022 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2022 Medicare Rates	Average Commercial Payments (2022)
Ambulance	117%	74%	Data not available*
ASC	121%	112%	Data not available*
Behavioral Health[53]	86%	83%	68%
Dental	96%	Medicare does not cover this service.	Data not available*
Developmental Center	97%	78%	55%
DMEPOS[54]	111%	81%	Data not available*
Home Health	83%	48%	127%

[51] 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 2022.
[52] For these comparisons, WDH reviewed the top codes for each service area based on paid claims volume in SFY 2022 and compared the 2022 Wyoming Medicaid rates to 2022 Medicare rates and 2022 fee schedules from Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah (if SFY 2022 fee schedules were not available online, WDH used the most recent rates available).
[53] 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.
* There is little or no Truven MarketScan 2021 data for this service area.
[54] The Wyoming 2022 Medicaid rate as a percentage of other states and Medicare rates for DMEPOS uses the rates to purchase DMEPOS equipment.

Figure 2.2: Comparison of Wyoming Medicaid Rates to Other States, Medicare, and Commercial Payers Using Top Services Based on Utilization[52]

Service Area	Wyoming 2022 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2022 Medicare Rates	Average Commercial Payments (2022)
Hospice	95%	95%	Data not available*
Hospital – Inpatient	Wyoming Medicaid pays approximately 77.0 percent of inpatient costs.[55]		
Hospital – Outpatient	The weighted average OPPS conversion factor for Wyoming is $63.25. Montana uses a single conversion factor of $56.14 and Utah follows a 0.9332 reduction of Medicare's OPPS conversion factor (results in $78.56 in CY 2022).	75%	Different reimbursement methodologies do not allow for direct comparisons.
Laboratory	101%	105%	87%
Maternity Care	105%	101%	59%
Nursing Facility[56]	93%	Data not available	
Physician and other Practitioner	100%	89%	53%
Primary Care	110%	94%	64%
Physician Specialist	96%	86%	47%
Prescription Drugs	Wyoming's dispensing fee: $10.65 Other states' dispensing fees range from $9.31 to	N/A	Data not available*

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

[56] Wyoming's reimbursement methodology for nursing facilities is cost-based; reimbursement currently covers an estimated 83 percent of nursing facilities' costs when supplemental payments (based on the nursing home assessment program) are included in the cost coverage calculation.

* There is little or no Truven MarketScan 2021 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[52]

Service Area	Wyoming 2022 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2022 Medicare Rates	Average Commercial Payments (2022)
	$15.73 depending on various factors.[57]		
PRTF	73%	Medicare does not cover this service.	Data not available*
Vision – Ophthalmology	106%	88%	66%
Vision – Optician and Optometrist	109%	87%	Data not available*

Figure 2.3 compares Wyoming Medicaid rates to other states, Medicare, and commercial payers, based on services with the highest total expenditures in SFY 2022 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[58]

Service Area	Wyoming 2022 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2022 Medicare Rates	Average Commercial Rates in Wyoming (2022)
Ambulance	117%	74%	Data not available. *
ASC	125%	99%	Data not available*
Behavioral Health[53]	87%	90%	68%
Dental	96%	Medicare does not cover this service.	Data not available*

[57] Excluding dispensing fees for drug compounding and hemophilia clotting factor. See Appendix B.1 for more information about prescription drug reimbursement in each state.
[58] For these comparisons, WDH reviewed the top codes for each service area based on total expenditures in SFY 2022 and compared the 2022 Wyoming Medicaid rates to 2021 Medicare rates and 2021 fee schedules from Colorado, Idaho, Montana, Nebraska, South Dakota, and Utah (if SFY 2022 fee schedules were not available on the States' websites, we used the most recent rates available).

Figure 2.3: Comparison of Wyoming Medicaid Rates to Other States, Medicare, and Commercial Payers Using Top Services Based on Expenditures[58]

Service Area	Wyoming 2022 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2022 Medicare Rates	Average Commercial Rates in Wyoming (2022)
Developmental Center	97%	78%	55%
DMEPOS[54]	120%	110%	Data not available*
Home Health	83%	48%	127%
Hospice	95%	95%	Data not available*
Hospital – Inpatient	Wyoming's reimbursement of in-state inpatient services covers approximately 77.0 percent of costs. [59]		
Hospital – Outpatient	The weighted average OPPS conversion factor for Wyoming is $63.25. Montana uses a single conversion factor of $56.14 and Utah follows a 0.9332 reduction of Medicare's OPPS conversion factor (results in $78.56 in CY 2022).	75%	Reimbursement methodology does not allow for direct comparisons.
Laboratory	112%	116%	99%
Maternity Care	105%	101%	59%
Nursing Facility[56]	93%	Data not available*	
Physician and other Practitioner	98%	86%	56%
Primary Care	102%	87%	60%
Physician Specialist	94%	88%	47%
Prescription Drugs	Wyoming's dispensing fee: $10.65	N/A	Data not available*

[59] Inpatient costs are calculated using cost-to-charge ratios from hospitals' Medicare cost reports. See Figure 2.5 for additional explanation.
* There is little or no Truven MarketScan 2021 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[58]

Service Area	Wyoming 2022 Medicaid Rate as a Percent of Benchmarks		
	Other States' Medicaid Rates	2022 Medicare Rates	Average Commercial Rates in Wyoming (2022)
	Other states' dispensing fees range from $9.31 to $15.73 depending on various factors.[57]		
PRTF	73%	Medicare does not cover this service.	Data not available*
Vision – Ophthalmology	113%	107%	69%
Vision – Optician and Optometrist	108%	87%	Data not available*

Key Findings

Key findings from these analyses include:

- The Medicaid programs in surrounding states use similar reimbursement methodologies to Wyoming for most service areas.
- Wyoming Medicaid implemented a two-point five percent (2.5%) rate reduction during SFY 2021 (began January 1, 2021) to most provider services as a result of the Governor's Budget Cuts. Based on expenditures, this generally resulted in a decrease in the Wyoming rate as a percent of other state's rates, an impact that carried from SFY 2021 into SFY 2022, including a decrease from ninety four percent (94%) to eighty seven percent (87%) for Behavioral Health services, from one hundred and eleven percent (111%) to ninety six percent (96%) for Dental services, from one hundred and three percent (103%) to ninety seven percent (97%) for Developmental Center services and from ninety one percent (91%) to seventy three percent (73%) for PRTF services.
- Based on expenditures there are several key services areas where Wyoming Medicaid pays lower rates than Medicaid programs in surrounding states including Behavioral Health, Home Health, Nursing Facilities, Physician Specialist, and PRTF. There are a few service areas where Wyoming Medicaid pays higher rates than Medicaid programs in surrounding states, including Ambulance, ASC, DMEPOS, Laboratory, Vision – Ophthalmology, and Vision – Optician and Optometrist. Trends for select services areas are examined below. Additional information about Wyoming's and surrounding states' rates and trends are included in Appendix B.1 and Appendix I of this report.

Key findings by specific service areas include:

- **Ambulatory Surgery Center**: As shown below in Chart 1 and Table 2.4, Wyoming's ASC rates have been increasing as a percentage of other state's rates. **From SFY 2021 to SFY 2022, Wyoming Medicaid rate increased from one hundred and twelve percent (112%) to one hundred and twenty percent (125%) as a percentage of other states.** Wyoming 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 while Medicare and many other states reimburses ASC providers via an ASC specific fee schedule, which uses a separate set of service weights and status indicators.

Chart 1. Wyoming ASC Rates as a Percentage of Medicare Rates and Other States' Medicaid Rates (Based on Expenditures)

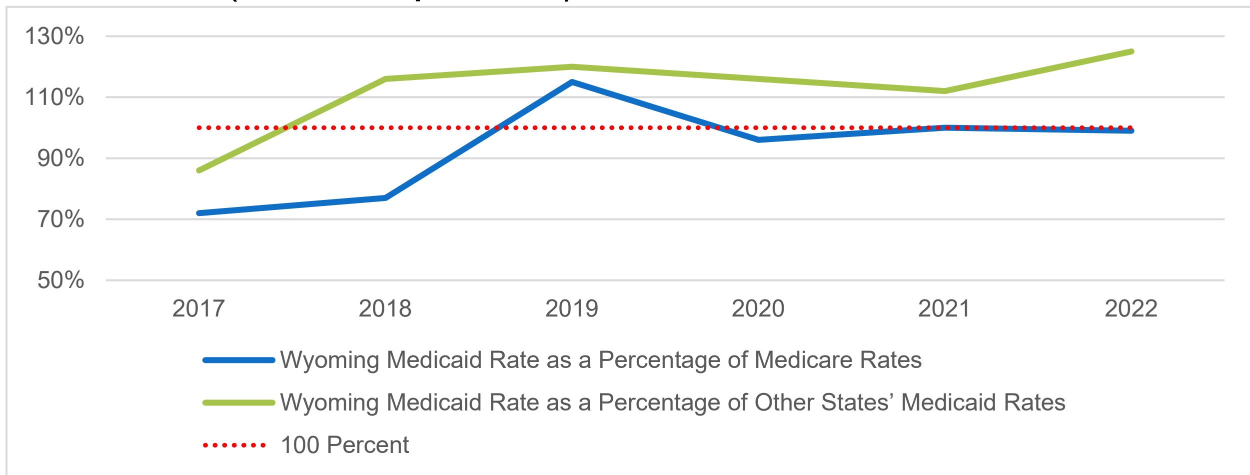


Figure 2.4: Wyoming ASC Rates as a Percentage of Medicare Rates and Other States' Medicaid Rates (Based on Expenditures)

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
WDH Rate as a Percentage of Medicare Rates	72%	77%	115%	96%	100%	99%
WDH Rate as a Percentage of Other States' Medicaid Rates	86%	116%	120%	116%	112%	125%

- **Ambulance:** As shown below in Chart 2 and Table 2.5, for ambulance services **Wyoming Medicaid rates as a percentage of other states Medicaid rates are one hundred and seventeen percent (117%) and seventy four percent (74%) of Medicare rates.** Wyoming Medicaid's ambulance reimbursement rates are based on seventy five percent (75%) of Medicare's 2008 ambulance rates.

Chart 2. Wyoming Ambulance Rates as a Percentage of Medicare Rates and Other States' Medicaid Rates (Based on Expenditures)

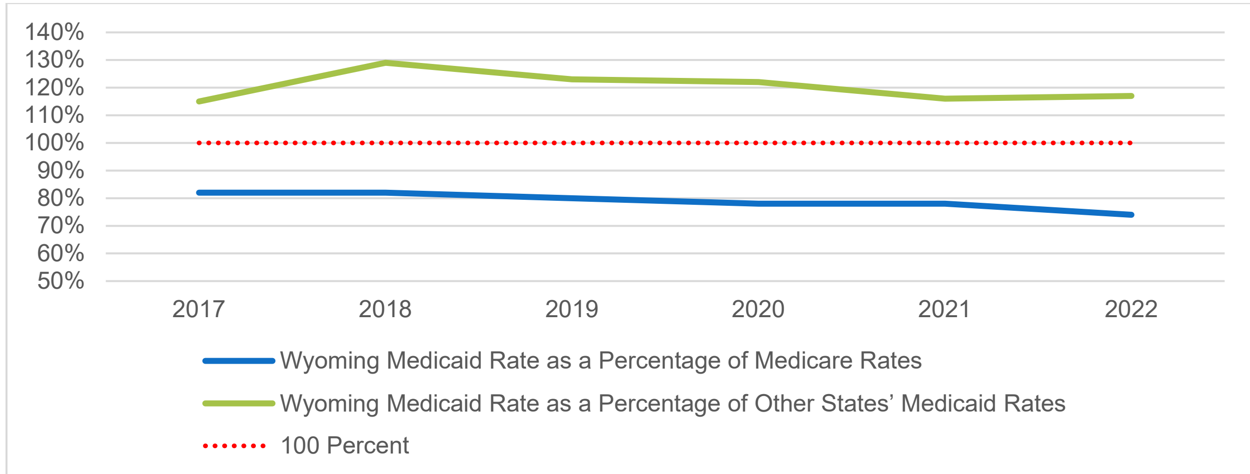


Figure 2.5: Wyoming Ambulance Rates as a Percentage of Medicare Rates and Other States' Medicaid Rates (Based on Expenditures)

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
WDH Rate as a Percentage of Medicare Rates	82%	82%	80%	78%	78%	74%
WDH Rate as a Percentage of Other States' Medicaid Rates	115%	129%	123%	122%	116%	117%

- **Behavioral Health:** As shown below in Chart 3 and Table 2.6, based on expenditures, **Wyoming Medicaid rates for Behavioral Health services have been decreasing as a percentage of Medicare rates and other states rates.** From SFY 2021 to SFY 2022, Wyoming Medicaid rate decreased from ninety four percent (94%) to eighty-seven (87%) as a percentage of other states rates. Surrounding states, including Colorado, Montana, Nebraska, and South Dakota have recently increased rates for Behavioral Health services.

Chart 3. Wyoming Behavioral Health Rates as a Percentage of Medicare Rates and Other States' Medicaid Rates (Based on Expenditures)

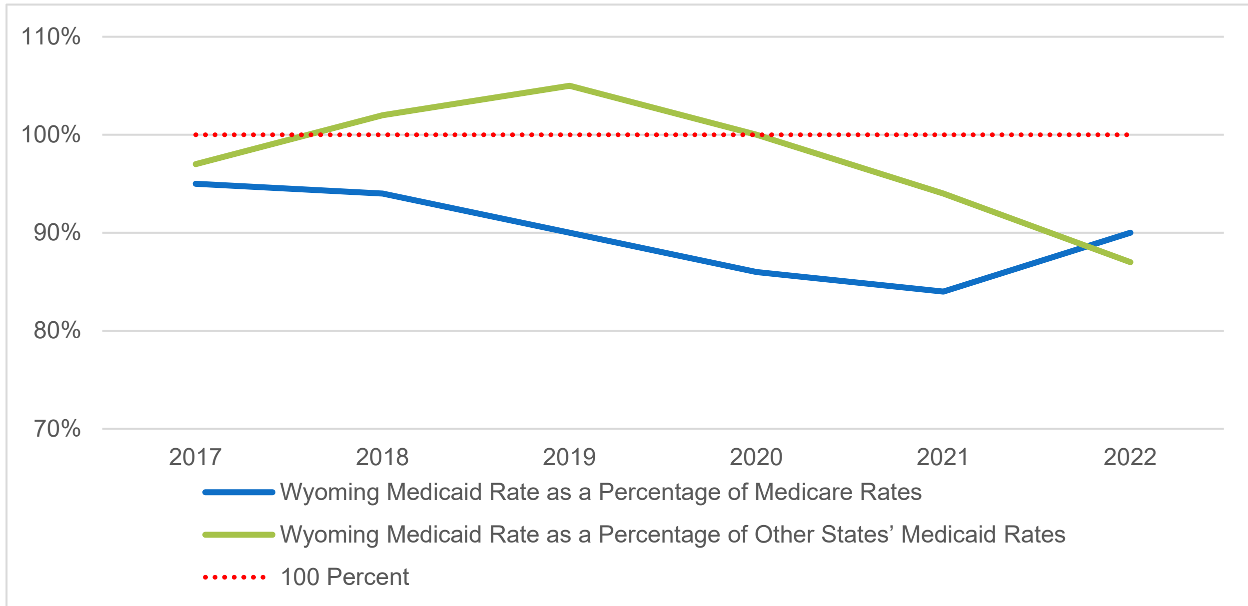


Figure 2.6: Wyoming Behavioral Health Rates as a Percentage of Medicare Rates and Other States' Medicaid Rates (Based on Expenditures)

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
WDH Rate as a Percentage of Medicare Rates	95%	94%	90%	86%	84%	90%
WDH Rate as a Percentage of Other States' Medicaid Rates	97%	102%	105%	100%	94%	87%

- **Hospital:** From SFY 2021 to SFY 2022, Wyoming **Outpatient Hospital** OPPS rate increased, while Montana and Utah experienced reductions in their OPPS rates. **Specifically, Wyoming's Outpatient Hospital weighted average OPPS conversion factor rose from $59.99 in SFY 2021 to $63.25 in SFY 2022.** However, Montana's single conversion factor slightly decreased from $56.64 to $56.14 in SFY 2022, and Utah's OPPS conversion factor fell from $82.20 to $78.56 in SFY 2022.
- **Laboratory Services**: As shown below in Chart 4 and Table 2.7, Wyoming Medicaid rates for Laboratory services have been increasing as a percentage of Medicare rates and other states rates. **From SFY 2021 to SFY 2022, Wyoming Medicaid rate increased from one hundred ten percent (110%) to one hundred and sixteen percent (116%) as a percentage of Medicare's rates.** Wyoming Medicaid reimbursement methodology for independent laboratory services is based on ninety percent (90%) of the 2009 Medicare clinical laboratory fee schedule (CLFS). CMS introduced an updated CLFS methodology in 2018 and has seen a decrease in Medicare rates.

Chart 4. Wyoming Laboratory Rates as a Percentage of Medicare Rates and Other States' Medicaid Rates (Based on Expenditures)

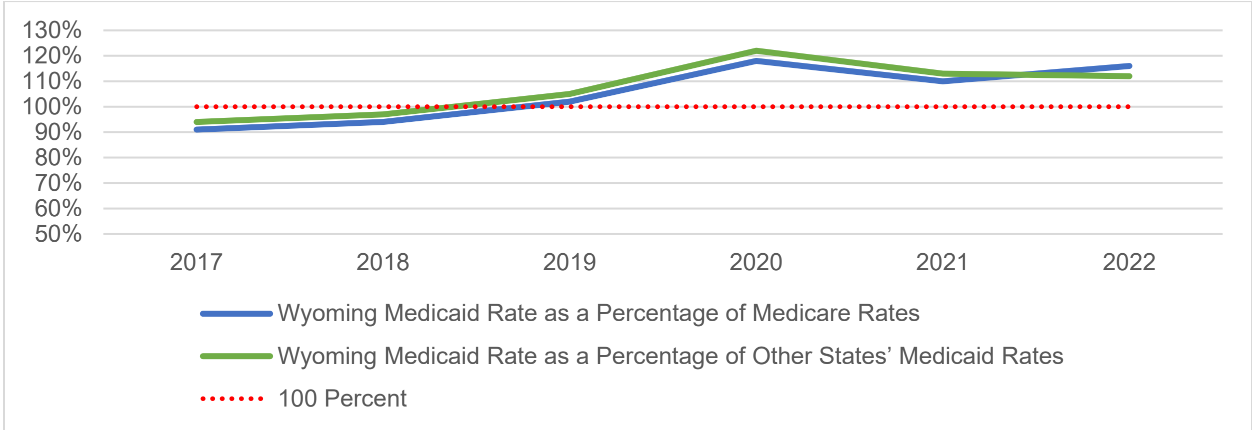


Figure 2.7: Wyoming Laboratory Rates as a Percentage of Medicare Rates and Other States' Medicaid Rates (Based on Expenditures)

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
WDH Rate as a Percentage of Medicare Rates	91%	94%	102%	118%	110%	116%
WDH Rate as a Percentage of Other States' Medicaid Rates	94%	97%	105%	122%	113%	112%

- **Nursing Facility:** Rates for **Nursing Facility services** have been decreasing as compared to other states Medicaid rates, however in SFY 2022 this trend is slowing. **From SFY 2019 to SFY 2022, Wyoming Medicaid rate decreased from one hundred and five percent (105%) to ninety three percent (93%).** There continues to be a large range in average facility rates in surrounding states, going from $181.79 (NE) to $243.79 (CO).
- **Psychiatric Residential Treatment Services (PRTF)**: As shown below in Chart 5 and Table 2.8, Wyoming Medicaid rates for PRTF services have been decreasing as a percentage of other states rates. **From SFY 2021 to SFY 2022, Wyoming Medicaid rate decreased from ninety one percent (91%) to seventy three percent (73%) as a percentage of other states rates.** After decreasing PRTF rates in SFY 2021 by two-point five percent (2.5%) due to the Governor's budget cuts, Wyoming Medicaid increased PRTF rates for SFY 2023 for the first time in 5 years. A comparison with Medicare is not possible, as PRTF services are not covered by Medicare.

Chart 5. Wyoming PRTF Rates as a Percentage of Other States' Medicaid Rates (Based on Expenditures)

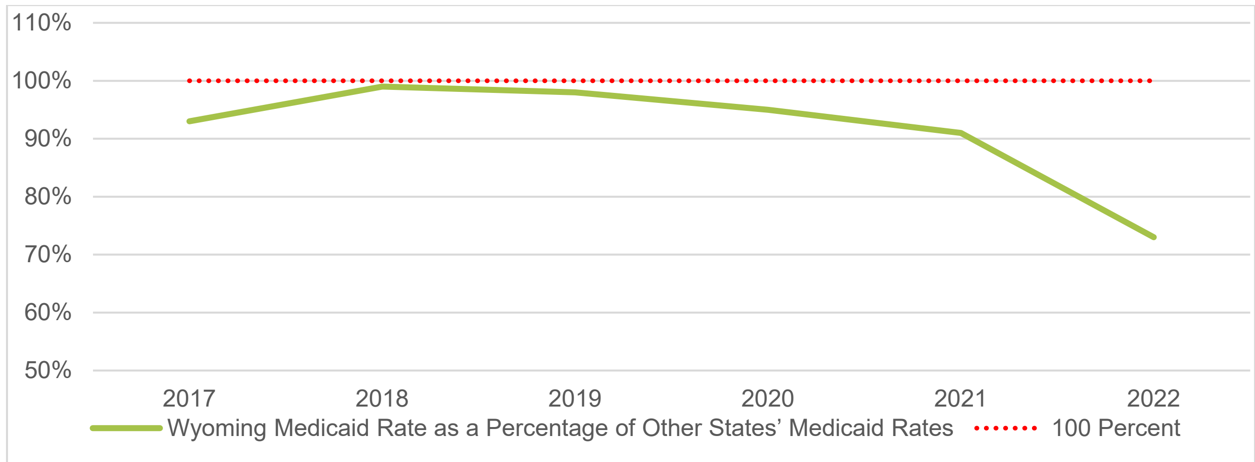


Figure 2.8: Wyoming PRTF Rates as a Percentage of Other States' Medicaid Rates (Based on Expenditures)

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
WDH Rate as a Percentage of Other States' Medicaid Rates	93%	99%	98%	95%	91%	73%

- **Physician Services:** In the prior year's benchmarking analysis, Wyoming Medicaid, on average, paid higher rates for physician services than Medicaid programs in surrounding states. In SFY 2022 this remained true for Maternity Care and Primary Care with both service areas having on average higher rates than surrounding states. However, in SFY 2022 this trend reversed for Physician and Other Practitioner and Physician Specialists with both areas having on average lower rates than surrounding states. As shown below in Chart 6 and Table 2.9, **Wyoming Medicaid rates for Physician and Other Practitioner services decreased from an average of one hundred percent (100%) to ninety-eight percent (98%) of surrounding states rates.** As shown below in Chart 7 and Table 2.10, Wyoming Medicaid rates for Physician Specialist also decreased from an average of one hundred and one percent (101%) to ninety-five percent (94%) of surrounding states rates.

Chart 6. Wyoming Physician and Other Practitioners Rates as a Percentage of Medicare Rates and Other States' Medicaid Rates (Based on Expenditures)

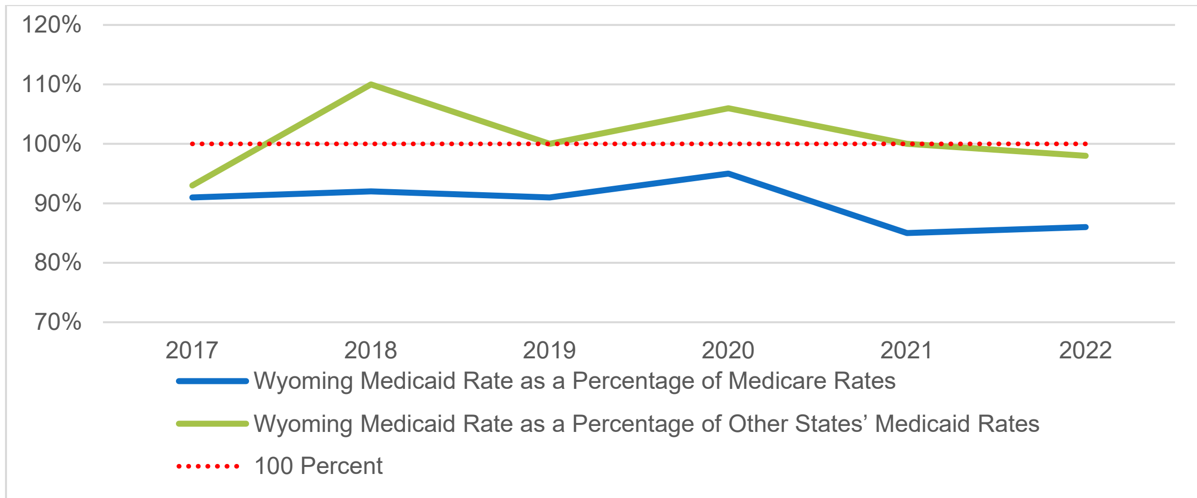


Figure 2.9: Wyoming Physician and Other Practitioners Rates as a Percentage of Medicare Rates and Other States' Medicaid Rates (Based on Expenditures)

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
WDH Rate as a Percentage of Medicare Rates	91%	92%	91%	95%	85%	86%
WDH Rate as a Percentage of Other States' Medicaid Rates	93%	110%	100%	106%	100%	98%

Chart 7. Wyoming Physician Specialists Rates as a Percentage of Medicare Rates and Other States' Medicaid Rates (Based on Expenditures)

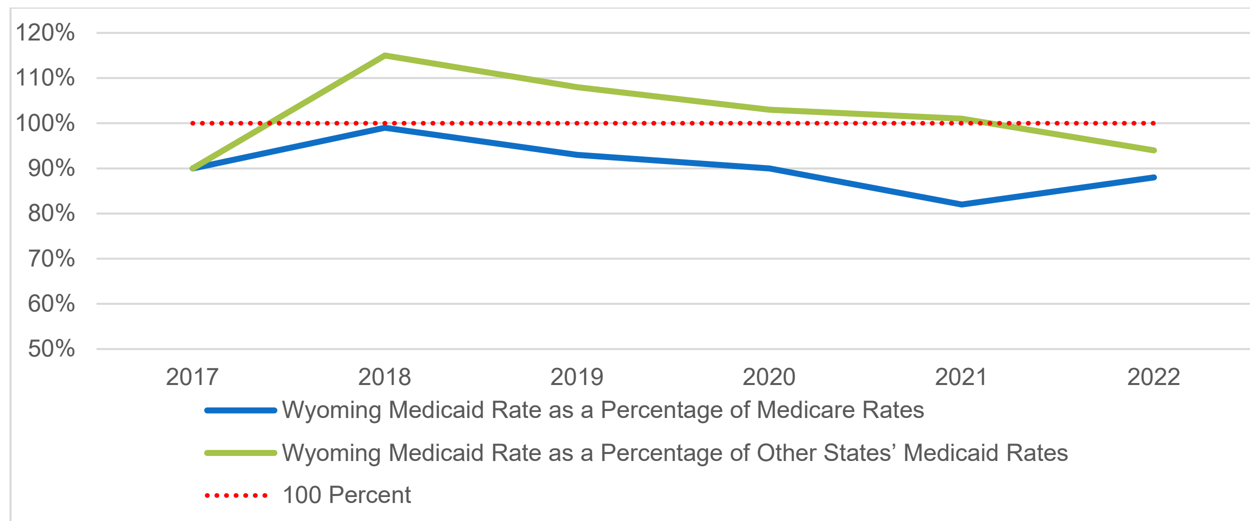


Figure 2.10: Wyoming Physician Specialists Rates as a Percentage of Medicare Rates and Other States' Medicaid Rates (Based on Expenditures)

	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022
WDH Rate as a Percentage of Medicare Rates	90%	100%	93%	90%	82%	88%
WDH Rate as a Percentage of Other States' Medicaid Rates	90%	115%	108%	103%	101%	94%

Hospital Benchmarks

WDH and Guidehouse used data from Wyoming Medicaid's SFY 2022 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 2.12 shows the hospital cost benchmarks for Wyoming's in-state providers in SFY 2022, 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 the amount Medicare would have paid for the same services. Comparing Wyoming's Medicaid payments to hospitals' cost is useful as cost coverage 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 2.11 displays the cost coverage for in-state Wyoming hospitals with and without supplemental payments.

Figure 2.11: Hospital Cost Benchmarks for In-State Hospitals

Hospital Payment Type	Cost Coverage Before QRA and Private Hospital Assessment Payments	Cost Coverage Including QRA and Private Hospital Assessment Payments[60]
Inpatient	74%	103%
Outpatient	42%	106%

[60] Mass adjustments that occurred as a result of transition to a new MMIS vendor significantly impacted SFY 2022 cost coverage. SFY 2023 supplemental payments will be reduced to account for any overpayments that occurred during the SFY 2022 process.

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.

Inpatient Services

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. 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. Wyoming Medicaid is currently in the process of updating its APR-DRG reimbursement system to reflect updated DRG grouper logic and equitable reimbursement for services. Implementation of new payment parameters is expected on October 1, 2023.

Outpatient Services

Wyoming adopted Medicare's relative weights for its outpatient hospital reimbursement but uses state-specific conversion factors.[61] 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 2.12, the weighted average of the three conversion factors for CY 2022 was $63.25, compared to Medicare's single conversion factor for 2021 of $84.18.[62] We determined that Wyoming Medicaid's rate is approximately seventy five percent (75%) of Medicare's.

Figure 2.12: Wyoming Outpatient Hospital Conversion Factors for CY 2021

<table>
<tr><th>Type</th><th>OPPS Conversion Factor</th><th>Percent of 2021 Claims</th><th>Weighted Average WY Conversion Factor</th><th>Conversion Factor and Payment Rates as Percentage of Medicare</th></tr>
<tr><td>Medicare (CY 2021)</td><td>$79.49</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
<tr><td>WY General Hospital (CY 2022)</td><td>$46.88</td><td>73.94%</td><td rowspan="3">$63.25</td><td rowspan="3">75%</td></tr>
<tr><td>WY CAH (CY 2022)</td><td>$112.72</td><td>23.27%</td></tr>
<tr><td>WY Children's Hospital (CY 2022)</td><td>$84.54[63]</td><td>2.79%</td></tr>
</table>

[61] 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.

[62] WDH calculated the weighted average WY conversion factor based on the volume of claims in SFY 2022 for each hospital type.

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

Wyoming Medicaid Rates as a Percentage of Medicare 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. Comparative analysis between Wyoming Medicaid's RVU-based fee schedule and current Medicare RBRVS was most recently conducted in 2020.

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 Wyoming Medicaid reimbursement CPT codes in the Vision – Ophthalmology category (66984, 66982, 92136, 67228 and 92083) to 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. Starting in SFY 2021, WDH and Guidehouse adjusted the sampling methodology to include the top twenty codes excluding injection pharmaceuticals and anesthesia services. For SFY 2022, the Wyoming Medicaid rate as a percentage of Medicare for all three service areas has remained at less than 100 percent.

Based on expenditures, Wyoming Medicaid pays less than Medicare for the majority of service areas, excluding laboratory, DMEPOS, 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 forty eight percent (48%) for Home Health services to one hundred and sixteen percent (116%) for Laboratory services.

Limitations

We are unable to make comparisons for services where reimbursement methodologies vary significantly across payers, payment rates are cost-based and vary by provider, or because comparison rates are not available. Figure 2.13 outlines the services for which we were unable to make comparisons.

While most of Wyoming's Medicaid reimbursement methodologies align with the other Medicaid states within our comparison, there are a few exceptions with coverage:

- Behavioral health – Substance Use Disorder Services: In comparison surrounding Medicaid states Wyoming is the only state that does not cover inpatient detoxification and only Wyoming and Colorado do not cover residential rehabilitation.
- Adult Dental- In Wyoming only preventative and emergency services are covered with no coverage for restorative services for adults. However, five of Wyoming's surrounding states offer limited restorative treatment under their state Medicaid program. Restorative

treatment options are covered with limitations on either service, annual cost, or benefit caps to control costs.

- Telehealth – Post PHE, Wyoming has not re-implemented exceptions for the delivery of telehealth services for FQHC, RHC, or IHS providers. States like Colorado and South Dakota allow for alternatives to two-way audio and video delivery. Alternatives include live chat and telephone delivery in Colorado and audio-only delivery for SUD services in South Dakota.

Figure 2.13: 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 2022 we have populated information about each comparison state's inpatient payment methodologies and the Wyoming APR-DRG system in Appendix B.
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 identified 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 identified for the top procedures in Appendix B.1, when possible.

Considerations Regarding Rate Adjustments

Wyoming Medicaid rates continue to exceed rates in surrounding states in select service areas including Ambulance, ASC, and Laboratory. However, in SFY 2022, we saw a decrease in Wyoming Medicaid rates in service areas that typically meet or exceed rates in surrounding states. Service areas that saw a decrease as a percentage of surrounding states rates include Behavioral Health, Home Health, Nursing Facilities, Physician Specialist, and PRTF. Most notable was a decrease from ninety four percent (94%) to eighty seven percent (87%) for Behavioral Health services and a decrease from one hundred and one percent (101%) to ninety four percent (94%) for Physician Specialists as based on expenditures.

In comparison to Medicare, Wyoming rates are lower for the majority of service areas as required by federal UPL limits to not exceed a reasonable estimate of Medicare payments for the same services. Based on expenditures Wyoming Medicaid's rates as a percentage of Medicare rates were seventy-four (74%) for Ambulance services and eighty-seven percent (87%) for Primary Care services. However, there were several service areas where Wyoming rates exceed Medicare rates. For example, Wyoming Medicaid's rates as a percentage of Medicare rates were one hundred and sixteen percent (116%) for Laboratory services.

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, Wyoming Medicaid does not have a systematic way to address cost increases on a regular basis.

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

As WDH considers future rate updates, it will consider – among other factors – how the rate changes support Wyoming Medicaid's priorities of encouraging fair reimbursement to service providers and while increasing/maintaining access for beneficiaries. In developing these recommendations, WDH considered expenditures in each service area, current reimbursement methodologies 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 deviate from benchmarks, or where cost data might address payment-related questions. Additionally, high-priority service areas that

represent a large portion of Medicaid expenditures, or have high, unexplained growth.

- **Low priority**: Service areas with methodologies with ongoing monitoring and maintenance and constitute a small proportion of total Medicaid expenditures.

Figures 2.14 and 2.15 describe high and low priority recommendations.

Figure 2.14: Recommendations for Further Evaluation of Reimbursement Rates and Methodologies – High Priority Services

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2022)
High 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 2022 with Wyoming's rates for Ambulance services 117 percent of surrounding states.	WDH may consider an ambulance rate study to determine if the current payment methodology and rates should be evaluated to either match Medicare's current rates or to lower them to align with surrounding states more closely.	0.6%
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 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 2021 and 2022 clinic UPL, Guidehouse calculated that Wyoming ASCs were being reimbursed at a level near that of Medicare for the same set of	0.9%

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2022)
		services (Medicaid is paying 98% of what Medicare would pay for the same services). Adjusting the 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.	
Behavioral Health Strategy	WDH does not have a systematic approach to adjusting Wyoming Medicaid behavioral health rates. Currently, Wyoming Medicaid is conducting a rate study of community mental health centers (CMHCs) and substance abuse treatment centers (SATCs). WDH also supports the Care Management Entity (CME) program which targets youth with severe behavioral health challenges.	WDH should consider updating its Behavioral Health fee schedule based on the findings of the ongoing rate study to ensure access to care. Additionally, COVID-19 has introduced new service delivery methods, such as the use of telehealth for group therapies. These emerging delivery system reforms will push states to evaluate innovative payment methodologies for behavioral health.	3.6%
Home Health	Wyoming Medicaid Home Health rates were previously calculated using the average Medicare home health visit rates in Wyoming using the average Wyoming Wage Index Budget Neutrality. However, Wyoming Medicaid rates for home health services are currently well below the average Medicare rates at 48% of Medicare rates. In	WDH should consider reviewing Wyoming Medicaid home health reimbursement rates compared to the average Medicare home health visit rates in Wyoming to determine if home health rates should be rebased. Additionally, home health services are also provided to individuals under the Community Choices Waiver (CCW). WDH could conduct a concurrent review of reimbursement rates for state	0.2%

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2022)
	addition, Wyoming Medicaid rates are 83% of other states Medicaid rates.	plan and CCW home health services to promote rate equity and standardization where appropriate.	
Laboratory	WDH currently pays independent laboratory providers on a fee schedule basis at ninety percent (90%) of the 2009 Medicare clinical laboratory fee schedule (CLFS). CMS introduced an updated CLFS methodology in 2018 and updates the CLFS at least every 3 years. As expected, CMS has seen a decrease in overall Medicare payments under the new CLFS methodology and expects this trend to continue.	WDH should consider rebasing its laboratory fee schedule for SFY 2023 based on CMS updates the CLFS methodology. According to WY State Plan Medicaid payment for clinical diagnostic laboratory services provided by a physician, independent laboratory or hospital may not exceed the Medicare fee schedule. Due to the current Wyoming fee schedule the Wyoming rate continues to be higher than the Medicare rate. An update will allow WDH to stay current with Medicare's methodology and to maintain Medicaid payments at or below Medicare payments in compliance with UPL requirements.	0.2%
Physician and Other Practitioners	There is not a 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	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 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	9.2%

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2022)
	with new Medicare payment methodologies.	that Wyoming's RBRVS payment methodology is compliant while Wyoming Medicaid continues to receive high value care for professional service payments.	

Figure 2.15: Recommendations for Further Evaluation of Reimbursement Rates and Methodologies – Low Priority Services

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2022)
Low Priorities for Evaluation			
Hospital - General	Wyoming Medicaid is currently in the process of updating its APR-DRG reimbursement system to reflect updated DRG grouper logic and equitable reimbursement for services. Implementation of new payment parameters is expected on October 1, 2023. Other payors 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	Updates of the APR-DRG system parameters should be on a more periodic schedule to ensure the adaptation of best practices and an equitable distribution of payments to providers. WDH should also consider examining the current state of APMs across the country. Wyoming Medicaid could 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.	17.9%

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2022)
	generators rather than compliance monitors.		
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 were 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 the 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. 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.	N/A
Prescription Drugs	Prescription drug expenditures have consistently increased year over year. In the past five years prescription drug expenditures have increased 63.62 percent despite a 3.54 percent reduction in recipients.	Consider performing an in-depth cost and trend study on prescription drugs to identify the source driving the trend of increased payments and find possible cost saving solutions. Potential alternatives include modifying WDH's formulary list to favor drugs with a lower cost for a comparable clinical	14.2%

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2022)
		efficacy. The identification of the largest utilized and expenditure drugs may lead to formulary management /utilization management changes and pinpoint areas that require further disease management.	
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 be delivered via telemedicine. Wyoming's post PHE Telehealth policies do not provide exceptions for the delivery of telehealth services by FQHC, RHC, or IHS provider types. Currently, Wyoming telehealth services are reimbursable only if performed in real time, with interactive audio and video via a telecommunications system.	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 due to the PHE. WDH may also look to revisit the impact of rates to services, such as home health, because of delivery of services via telehealth.	N/A

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2022)
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 waiver services) in SFY 2022 and completed a rate rebasing study of the Community Choices Waiver in SFY 2021. 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.	For the SFY 2022 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. As a part of the DD waiver rate study, WDH explored the feasibility of a reimbursement distinction between “agency” and “independent” provider rates. The Wyoming Legislature approved an additional appropriation in its 2023 session to fund enhanced rates for agency providers, reflecting the higher operating costs and resources needed for agency staff retention. 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.	Nursing Facility:12.5% HCBS Waivers: 25.9%

Service Area	Discussion	Recommendation	Percent of Total Expenditures (SFY 2022)
		Implementing value-based payments and paying for services based upon outcomes, quality, or compliance, instead of the volume of services.	