CHAPTER 1

Rules and Regulations for Kid Care CHIP ("Children's Health Insurance Program")

General Provisions

Section 1. Authority. This Chapter is promulgated pursuant to the Child Health Insurance Program Act at W.S. § 35-25-108 and the Wyoming Administrative Procedure Act at W.S. § 16-3-102.

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern Kid Care CHIP. This Chapter shall become effective for Kid Care CHIP services provided on or after January 1, 2014.

(b) The requirements of 42 C.F.R. Ch. IV, Subch. D, Pt. 457 and Ch. VII, Subch. XX, Division A and Title XXI of the social Security Act also apply to Kid Care CHIP and are incorporated by this reference as of the effective date of this Chapter, and may be cross-referenced throughout this Chapter where applicable. This incorporation by reference does not include any later amendments or editions of the incorporated matter. The incorporated matter may be viewed at http://www.ecfr.gov/cgi-bin/ECFR and www.ssa.gov, or may be obtained at cost from the Department.

Section 3. General Provisions.

(a) This Chapter is intended to be read in conjunction with the Child Health Insurance Program Act at W.S. §§ 35-25-101 through 35-25-111, 42 U.S.C. § 1397aa through 1397ll, and HHS Regulations at 42 C.F.R. Part 457.

(b) Nothing in this Chapter shall be construed as providing an individual with an entitlement to Kid Care CHIP.

Section 4. Definitions. Except as defined in the Act or as otherwise specified in this section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, health insurance, Medicare, and Medicaid.

For the purposes of all Chapters of Kid Care CHIP Rules, the following shall apply:

(a) "Act" shall mean the "Child Health Insurance Program Act," as enacted by the Wyoming Legislature and codified at W.S. §§ 35-25-101 through 35-25-111.

(b) "Adverse action" shall mean the denial, suspension, or termination of benefits, other than a suspension or termination caused by a suspension of Kid Care CHIP, pursuant to Section 14 or a change in federal or state law, including an amendment

to this Chapter. "Adverse action" does not include the denial of services because they are not covered services or other issues about the scope of covered services.

(c) "Alaska Native" shall mean an Eskimo, Aleut, or other Alaska Native enrolled by the United States Secretary of the Interior.

(d) "Alien" shall mean a person residing in Wyoming who is not a citizen of the United States of America.

(e) "American Indian" shall mean a person who is an enrolled member of a federally recognized Indian tribe, band, or group, or a first or second degree descendent of such person.

(f) "Applicant" shall mean a child on whose behalf an application for coverage by Kid Care CHIP has been submitted, but there has been no final determination of eligibility.

(g) "Application" shall mean the form, specified by the Department, on which an applicant indicates in writing the desire to receive benefits.

(h) "Application date" shall mean the date an application for Kid Care CHIP is noted as received by the Department.

(i) "Basic level of benefits" shall mean the level of benefits established by the Health Benefits Plan Committee pursuant to Chapter 3.

(j) "Benefits" shall mean the health insurance coverage through Kid Care CHIP.

(k) "Benefit year" shall mean January to December of each year, so long as the insured remains eligible.

(l) "Change in circumstances" shall mean a change in an insured's address or health insurance coverage.

(m) "Change report" shall mean a form, as prescribed by the Department, used to report a change in circumstances.

(n) "Chapter 4 of the Medicaid rules" shall mean Chapter 4, Medicaid Administrative Hearings, of the Rules and Regulations for Medicaid.

(o) "Chapter 16 of the Medicaid rules" shall mean Chapter 16, Program Integrity, of the Rules and Regulations for Medicaid.

(p) "Citizen" shall mean an individual, whether adult or child, who is a citizen of the United States of America.

(q) "Centers for Medicare and Medicaid Services (CMS)" shall mean the federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.

(r) "Contested case" as defined in Chapter 1 of the Medicaid rules.

(s) "Cost sharing or co-payment" shall be a charge to an insured for receiving services covered under a health insurance plan.

(t) "Cost-effective" shall mean the cost of providing program benefits does not exceed the average cost of similar programs in similar states, available state funds, or both.

(u) "Covered services" shall mean those health services which are covered by a health insurance plan offered pursuant to Chapter 3. "Covered services" must include the basic level of benefits.

(v) "Crowd out" shall mean the replacement or elimination of private health insurance by benefits offered pursuant to this Chapter.

(w) "Effective date of eligibility" shall mean: the first day of the month following the application date if the application date is on or before the twenty-fifth (25th) day of the month; or the first day of the month after the following month if the application date is after the twenty-fifth (25th) day of the month.

(x) "Eligible" shall mean a person who is approved for Kid Care CHIP.

(y) "Excess payments" shall mean Kid Care CHIP funds received by a participating insurance company to which the company is not entitled for any reason. "Excess payments" includes, but is not limited to:

(i) Overpayments;

(ii) Payments made as a result of system errors;

(iii) Payments for premiums or services furnished to a non-insured;

(iv) Payments for non-covered services furnished to an insured; or

(v) Payments which exceed the contract rate agreed to by the participating insurance company.

(z) "Explanation of benefits form (EOB)" shall mean a form sent by the insurance contractor to the provider and the enrolled child. EOBs provide information, claim payment, and client responsibility.

(aa) "Federal funds" shall mean the Federal funds received by the Department pursuant to 42 U.S.C. § 1397ee to pay for Kid Care CHIP costs.

(bb) "Financially responsible adult" shall mean the person or persons legally responsible to support one or more low income children. "Financially responsible adult" may include a caretaker.

(cc) "Financial records" shall mean all records, in whatever form, used or maintained by a participating insurance company in the conduct of its business affairs and which are necessary to substantiate or understand invoices submitted to the Department.

(dd) "Guardian" shall mean a child's legally appointed conservator or guardian.

(ee) "Health insurance plan" shall mean an individual insurance policy or contract for the purpose of paying for or reimbursing the cost of hospital and medical care. "Health insurance plan" includes private insurance plans.

(ff) "HHS" shall mean the United States Department of Health and Human Services, its agent, designee, or successor.

(gg) "Household" shall mean the person or persons who live together in a residence. A "household" may include one or more families.

(hh) "Illegal alien" shall mean a foreign national who:

(i) Entered the U.S. without inspection or with fraudulent documentation; or

(ii) After entering legally as a nonimmigrant, violated status and remained in the U.S. without permission.

(ii) "Ineligible" shall mean not authorized to be an insured under Kid Care CHIP.

(jj) "Insured" shall mean a low income child who has been determined eligible for Kid Care CHIP.

(kk) "Invoice" shall mean a request by a participating insurance company for payment of Kid Care CHIP funds for insurance premiums.

(ll) "Kid Care CHIP" shall mean the Children's Health Insurance Program established pursuant to the Child Health Insurance Program Act, W.S. § 32-25-101 through 35-25-111.

(mm) "Kid Care CHIP funds" shall mean that combination of Federal funds and State funds which is available to the Department to make payments to participating insurance companies for insurance coverage furnished to eligible children.

(nn) "Kid Care CHIP State Plan" shall mean the state plan prepared by the Department pursuant to 42 U.S.C. § 1397aa(b) and submitted to HHS.

(oo) "Medicaid" shall mean medical assistance and services provided pursuant to Title XIX of the Social Security Act or the Wyoming Medical Assistance and Services Act.

(pp) "Medically necessary" or "medical necessity" shall mean a health service that is required to diagnose, treat, cure, or prevent an illness, injury, or disease which has been diagnosed or is reasonably suspected; to relieve pain; or to improve and preserve health and be essential to life. The service shall be:

(i) Consistent with the diagnoses and treatment of the insured's condition;

(ii) In accordance with the standards of good medical practice among the provider's peer group;

(iii) Required to meet the medical needs of the insured and undertaken for reasons other than the convenience of the insured and the provider; and

(iv) Performed in the most cost effective and appropriate setting required by the insured's condition.

(qq) "Medical records" shall mean all records, in whatever form, in the possession of or subject to the control of a participating insurance company which describes the insured's diagnosis, treatment, or condition.

(rr) "Mid-level practitioner" shall mean a physician's assistant, a certified nurse practitioner, a certified nurse midwife, or any other licensed health care professional authorized to diagnose and treat patients.

(ss) "Month" shall mean a calendar month.

(tt) "Notice of action" shall mean a written notice mailed to an insured which informs the insured of intended action affecting eligibility for benefits. The notice shall include the action to be taken, the effective date of the action, and the legal authority for the action. Notice shall be timely if mailed, by first-class United States mail, ten (10) days before the effective date of the intended action.

(uu) "Orthodontia medical necessity" shall mean medically necessary orthodontic services or cranial facial orthopedic deformities with an evaluation report from an orthodontist.

(vv) "Out of pocket maximum" shall mean the most money in cost sharing that a household will have to pay in a given benefit year. This amount is capped at five percent (5%) of the household's gross annual income. Once the out of pocket maximum has been met, the family will not pay any more cost sharing until the next benefit year begins.

(ww) "Overpayments" shall mean Kid Care CHIP funds received by a participating insurance company as the result of fraud or abuse, as those terms are defined in Chapter 16 of the Medicaid rules.

(xx) "Participating insurance company" shall mean an insurance company which has contracted with the Department to provide health benefits to eligible children.

(yy) "Periodic review" shall mean a review of an insured's eligibility. A "periodic review" shall be conducted every twelve (12) months after the effective date of eligibility.

(zz) "Plan A" shall mean the Kid Care CHIP plan that includes Native American children, Alaskan Native children, and those children whose family income is one hundred percent (100%) or lower of the federal poverty level and who do not qualify for Medicaid because of a failure to meet the 40 quarter rule.

(aaa) "Plan B" shall mean the Kid Care CHIP plan that includes children from one hundred one percent (101%) to one hundred fifty percent (150%) of the federal poverty level.

(bbb) "Plan C" shall mean the Kid Care CHIP plan that includes children from one hundred fifty-one percent (151%) to two hundred percent (200%) of the federal poverty level.

(ccc) "Practitioner" shall mean a physician, nurse practitioner, dentist, optometrist, or any other health care professional acting within the scope of practice.

(ddd) "Pre-existing condition" shall mean an illness, injury, or health condition which exists as of the application date.

(eee) "Premium" shall mean the payment necessary to pay for a health insurance plan provided to an eligible child.

(fff) "Program" shall mean Kid Care CHIP.

(ggg) "Provider" shall mean an individual or entity that has an agreement with a participating insurance company to furnish services to an insured.

(hhh) "Qualified alien" shall mean a lawfully admitted alien who qualifies if the individual:

(i) Is admitted to the United States as a refugee under Section 207 of the Immigration and Naturalization Act (INA);

(ii) Has been granted asylum under Section 208 of the INA;

(iii) Is eligible for deportation, but the deportation is being withheld under Sections 241(b)(3) or 243(h) of the INA;

(iv) Is a lawfully admitted, permanent resident under the INA, and who has lived in the United States for five (5) or more consecutive years;

(v) Is lawfully residing within the State; and

(A) Is a veteran of the United States military service and received an honorable discharge (except such a discharge for alienage);

(B) Is on active duty with the United States military service, other than active duty for training; or

(C) Is the spouse or dependent child of a veteran or active member of the United States military.

(vi) Is a member of another group for which citizenship is met pursuant to the Balanced Budget Act of 1997.

(iii) "Residence" shall mean the place the insured uses as a primary dwelling place and intends to continue to use indefinitely for that purpose.

(jjj) "Resident" shall mean a person who lives in the State of Wyoming and has the intention of residing in the State.

(kkk) "Resource" shall mean real or personal property in which an individual has a legal or equitable interest.

(lll) "Services" shall mean health or medical services, medical supplies, or medical equipment.

(mmm) "State fiscal year" shall mean July first (1st) through June thirtieth (30th) of the following calendar year.

(nnn) "State funds" shall mean the state funds appropriated by the Wyoming Legislature for Kid Care CHIP. "State funds" may include grant funds received by the

Department from a non-governmental source, if such funds are granted to constitute a portion of the State's expenditures for this program.

(ooo) "Termination" shall mean to remove an insured from the program or close the insured's file.

(ppp) "Twelve (12) months of eligibility" shall mean the period of time in which a child is eligible for Kid Care CHIP, unless the child moves out of state, enters an institution, turns nineteen (19), fails quality control, becomes eligible for Medicaid, and/or requests that the policy be closed.

(qqq) "Well-baby or well-child services" shall mean the regular or preventive diagnostic and treatment services necessary to ensure the health of babies and children.

Section 5. Payments Only to Participating Insurance Companies.

(a) Payments for premiums shall be made only to participating insurance companies. No person or entity that furnishes a health insurance plan to an insured shall receive Kid Care CHIP funds unless the health insurance plan is offered by or through a participating insurance company.

(b) Submission of invoices. Any person or entity that submits an invoice for premiums, deductibles, or co-insurance, shall be deemed to have agreed to be bound by these rules.

Section 6. Participating Insurance Company.

(a) No insurance company may participate in Kid Care CHIP, unless it offers a health insurance plan which meets or exceeds the basic level of benefits established pursuant to Chapter 3 Rules and Regulations for Kid Care CHIP and the insurance company has entered into a contract with the Department.

(b) The Department shall notify the participating insurance company of the identity of its participants and shall make premium payments on behalf of those participants directly to the company.

(c) The participating insurance company shall submit invoices to the Department in the manner specified by the Department to request reimbursement for premiums.

(d) When an insured seeks services, the provider must verify the individual's eligibility with the participating insurance company using the procedures established by the company. If a provider fails to verify eligibility, the Department shall not be responsible for paying such services.

Section 7. Payment and Submission of Invoices.

(a) Payment in full of covered services. If the service is a covered service, a participating insurance company may not request, receive, or attempt to collect any payment from the insured or the insured's family for the service, except for co-payments, pursuant to Chapter 4.

(b) Payment for non-covered services. A provider that provides a non-covered service to an insured may seek payment from the insured's parent or guardian, if the provider informed the parent or guardian, in writing, of the insured's potential liability before providing the service, and the parent or guardian agreed in writing to pay for such services before they were furnished.

(c) Submission of invoices.

(i) Invoices shall be submitted to the Department in the manner and form specified by the Department;

(ii) The invoice is considered submitted on the date the invoice is received by the Department.

Section 8. Recovery of Overpayments. The Department may recover overpayments pursuant to Chapter 16 of the Medicaid rules. All references in that Chapter to "Medicaid" shall be replaced with "Kid Care CHIP" for purposes of this Chapter.

Section 9. Reconsideration and Administrative Hearings.

(a) A participating insurance company may request that the Department reconsider a decision to recover overpayments. Such request shall be mailed to the Department by certified mail, return receipt requested, within twenty (20) days of the date of the notice of overpayment. The reconsideration provisions of Chapter 16 of the Medicaid rules, shall govern all aspects of the reconsideration and any administrative hearings shall be governed by Chapter 4 of the Medicaid rules.

(b) Eligibility determinations and redeterminations. An applicant or insured who is denied eligibility or terminated from eligibility may request an administrative hearing pursuant to Chapter 4 of the Medicaid rules. Chapter 4 of the Medicaid rules shall govern administrative hearings involving Kid Care CHIP eligibility issues in all respects, except that a request for hearing on issues involving eligibility for Kid Care CHIP shall be mailed or hand-delivered to the Department within thirty (30) days from the date of the notice of adverse action.

(c) Denial of services or other coverage issues. An insured who is denied services or has any other complaint regarding covered services shall be entitled to review of that decision pursuant to the procedures provided by the participating insurance company. Such action is not adverse action, and the insured shall not be entitled to reconsideration or an administrative hearing regarding such decision pursuant to this

Section or Chapter 4 of the Medicaid rules.

Section 10. Disposition of Recovered Funds. Any and all recovered Kid Care CHIP funds shall be returned to the program and used to provide additional services.

Section 11. Contingent on Funding.

(a) In accordance with Program Expenditure provisions of the Act, payment to participating insurance companies shall be contingent on the availability of Kid Care CHIP funds.

(b) Monitoring and projecting program expenditures. The Department shall:

(i) Monitor program expenditures to ensure that the expenditures do not exceed program funds;

(ii) Make monthly projections of expenditures for the remainder of the biennium based on program expenditures for the most recent six (6) calendar months, trended forward for the remainder of the biennium, and including utilization trends and the estimated amount of unpaid invoices.

(c) Program limitations. If the budget projections prepared pursuant to this Section show that there will or may be insufficient program funds, the Department may declare a partial or total moratorium on new insureds, so that otherwise eligible individuals will not be determined eligible until such time as the Department determines that sufficient program funds are available. Any such moratorium shall be no more restrictive than necessary to bring projected program expenditures into conformance with available program funds. The Department may also consider cost containment actions having no adverse effect on eligibility standards, methods and procedures. As per section 2105(d)(3) of the Social Security Act, as amended by section 2101(b) of the Affordable Care Act, the maintenance of effort (MOE) provision requires maintenance of CHIP eligibility standards, methods and procedures in effect on March 23, 2010, and to continue until a date determined by federal law.

(d) No appeal. A program reduction or termination, or the denial of eligibility because of a moratorium, shall not be adverse actions, and shall not be subject to reconsideration pursuant to this Chapter or an administrative hearing pursuant to Chapter 4 of the Medicaid rules.

Section 12. Financial Audits. The Department may audit a participating insurance company's financial records at any time to determine the accuracy and appropriateness of invoices submitted to the Department. The Department may recover any overpayments pursuant to Section 8.

Section 13. Interpretation of Chapter. The order in which the provisions of

this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision. The text of this Chapter shall control the titles of its various provisions.

Section 14. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals or bulletins, which are inconsistent with this Chapter.

Section 15. Severability. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in effect. If any portion of this Chapter is inconsistent with the provisions required by CMS, as part of the State plan, the State Plan shall control.