

Wyoming Administrative Rules

Health, Department of

Medicaid

Chapter 34: Home & Community Based Waiver Services

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WYOMING MEDICAID RULES

CHAPTER 34

HOME OR COMMUNITY-BASED WAIVER SERVICES

Section 1. Authority

This rule is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. 42-4-101 et seq and the Wyoming Administrative Procedures Act at W. S. 16-3-101 et seq.

Section 2. Purpose and Applicability.

(a) This rule shall apply to and govern the provision of and Medicaid reimbursement for HCBS waiver services.

(b) The Department may issue Provider Manuals, Provider Bulletins, or both, to providers and/or other affected parties to interpret the provisions of this Chapter. Such Provider Manuals and Provider Bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in Provider Manuals or Provider Bulletins shall be subordinate to the provisions of this Chapter.

(c) For each waiver, the Department shall issue Provider Manuals and/or Bulletins which:

(i) Describes the scope of Medicaid reimbursable services under the waiver;

(ii) Identifies the type or types of providers that may furnish such services;

(iii) Details the procedures to be followed in furnishing such services; and

(iv) Describes the methods and standards for obtaining Medicaid reimbursement for services furnished pursuant to that waiver.

Section 3. General Provisions.

(a) Terminology. Except as otherwise specified, the terminology used in this rule is the standard terminology and has the standard meaning used in accounting, health care, Medicaid and Medicare.

(b) HCBS waiver services are those services provided under a waiver from HCFA that are not otherwise available under the Wyoming Medicaid state plan. Such services enable the elderly, disabled, and chronically mentally ill persons, who would otherwise be placed in an institution, to live in the community. Section 1915(c) of the Social Security Act specifies the services that may be included as HCBS waiver services.

Section 4. Definitions.

(a) “Admission certification.” Admission certification as defined by Chapter 8, which definition is incorporated by this reference.

(b) “Administrator.” The administrator of the Division, the administrators agent, designee or successor.

(c) “Chapter I.” Chapter I, Rules for Medicaid Administrative Hearings, of the Wyoming Medicaid rules.

(d) “Chapter 3.” Chapter 3, Provider Participation, of the Wyoming Medicaid Rules.

(e) “Chapter 4.” Chapter 4, Third Party Liability, of the Wyoming Medicaid Rules.

(f) “Chapter 8.” Chapter 8, Inpatient Admission Certification, of the Wyoming Medicaid Rules.

(g) “Chapter 30.” Chapter 30, Level of Care Inpatient Hospital Reimbursement, of the Wyoming Medicaid Rules.

(h) “Chapter 32.” Chapter 32, Disproportionate Share Hospital Reimbursement, of the Wyoming Medicaid Rules.

(i) “Claim.” A request by a provider for Medicaid payment for HCBS waiver services provided to a recipient.

(j) “Covered service.” A health service or supply eligible for Medicaid reimbursement pursuant to the rules and policies of the Department.

(k) “Department.” The Wyoming Department of Health, its agent, designee or successor.

(l) “Division.” The Division of Health Care Financing of the Department, its agent, designee or successor.

(m) “Enrolled.” Enrolled as defined in Chapter 3, which definition is incorporated by this reference.

(n) “Excess payments.” Medicaid funds received by a provider which exceed the Medicaid allowable payment established by the Department.

(o) “HCFA.” The Health Care Financing Administration of the United States Department of Health and Human Services, its agent, designee or successor.

(p) “HHS.” The United States Department of Health and Human Services, its agent, designee or successor.

(q) “Home or community-based waiver services (HCBS).” Services provided under a waiver from HCFA that are not otherwise available under the Wyoming Medicaid state plan. Such services enable the elderly, disabled, and chronically mentally ill persons, who would otherwise be placed in an

institution, to live in the community. Section 1915(c) of the Social Security Act specifies the services that may be included as HCBS waiver services. “HCBS waiver services” includes home and community-based services as specified in the applicable waiver.

(r) “Hospital.” A hospital as defined in Chapter 30, which definition is incorporated by this reference.

(s) “Institution.” A hospital, ICF/MR or nursing facility.

(t) “Intermediate care facility for the mentally retarded (ICF/MR).” An intermediate care facility as defined by 42 U.S.C. 1396(d)(d), which definition is incorporated by this reference.

(u) “Medicaid.” Medical assistance and services provided pursuant to Title XIX of the Social Security Act and the Wyoming Medical Assistance and Services Act.

(v) “Medicaid fee schedule.” The Medicaid fee schedule developed pursuant to Chapter 3.

(w) “Medicaid third party liability cost avoidance waiver.” A waiver from HCFA pursuant to 42 C.F.R. 433.139(e).

(x) “Medical record.” All documents, in whatever form, in the possession of or subject to the control of a provider which describe the recipient’s diagnosis, condition or treatment, including, but not limited to, the plan of care for the recipient.

(y) “Nursing facility.” A nursing facility as defined in 42 U.S.C. 1396r(a), which definition is incorporated by this reference.

(z) “Plan of care.” A written plan of care developed by qualified individuals pursuant to the applicable waiver, and approved by the Division.

(aa) “Prior authorized.” Approval by the Division pursuant to the procedures contained in Chapter 3, which are incorporated by this reference.

(bb) “Qualified individual.” A health care professional or other individual specified in a waiver as qualified.

(cc) “Provider.” A provider as defined by Chapter 3, which definition is incorporated by this reference.

(dd) “Recipient.” A person who has been determined eligible to receive Medicaid.

(ee) “Services.” Health services or supplies.

(ff) “Third party liability.” Third party liability as determined pursuant to Chapter 4, which is incorporated by this reference.

(gg) “Waiver.” A waiver granted by HCFA pursuant to Section 1915(c) of the Social Security

Act (codified at 42 U.S.C. 1396n(c)). HCBS waivers follow federal guidelines and audit procedures.

Section 5. Provider Participation.

(a) Payments only to providers. Except as otherwise specified in this Chapter, no provider that furnishes HCBS waiver services to a recipient shall receive Medicaid funds unless the provider is certified, has signed a provider agreement, is enrolled, and has signed a contract with the Department.

(b) Compliance with Chapter 3. A provider that wishes to receive Medicaid reimbursement for HCBS waiver services furnished to a recipient must meet the requirements of Chapter 3, which are incorporated by this reference.

(c) Qualified provider. A provider or group of providers that contracts to provide HCBS waiver services must meet the criteria that the Department establishes.

Section 6. Provider Records.

(a) A provider must comply with the record-keeping requirements of Chapter 3, which requirements are incorporated by this reference.

(b) Out-of-state records. If a provider maintains financial or medical records in a state other than the state where the provider is located, the provider shall either transfer the records to an in-state location that is suitable for the Department or reimburse the Department for reasonable costs, including travel, lodging and meals, incurred in performing the audit in an out-ofstate location, unless otherwise agreed by the Department.

Section 7. Verification of recipient data. A provider must comply with the verification of recipient data requirements of Chapter 3, which requirements are incorporated by this reference.

Section 8. Eligibility for HCBS waiver services.

(a) Eligibility for HCBS waiver services shall be pursuant to the standards and procedures specified in the applicable waiver.

(b) The provision of HCBS waiver services is contingent upon a recipient's continued Medicaid eligibility.

Section 9. HCBS waiver services.

(a) Plan of care. Except as otherwise specified in the applicable waiver, HCBS waiver services must be provided pursuant to a plan of care.

(b) Medicaid reimbursable services. The services that are Medicaid reimbursable pursuant to this Chapter shall be only those services designated as Medicaid reimbursable in a waiver or waivers, notice of which has been disseminated by the Division through Provider Manuals or Bulletins.

(c) Non-covered services. Those HCBS waiver services for which there is an applicant's/

recipient's failure to:

- (i) Meet the medical necessity of the level of institutional care of each applicable waiver;
- (ii) Meet all the required eligibility factors of each applicable waiver;
- (iii) Comply substantially with the established Plan of Care developed under each applicable waiver.

Section 10. Medicaid allowable payment for HCBS waiver services.

- (a) The Department shall reimburse HCBS waiver services pursuant to the Medicaid fee schedule.
- (b) All-inclusive rate. Providers of HCBS waiver services shall not receive Medicaid reimbursement for furnishing HCBS waiver services in addition to the payment specified in (a), except as provided in Chapter 32.
- (c) HCBS waiver services must be provided pursuant to a plan of care approved under the applicable waiver. Failure to obtain such approval shall result in the denial of Medicaid payment.

Section 11. Third party liability.

- (a) Submission of claims. Claims for which third party liability exists shall be submitted in accordance with Chapter 4, which is incorporated by this reference, except as otherwise provided in a Medicaid third party liability cost avoidance waiver.
- (b) Medicaid payment. The Medicaid payment for a claim for which third party liability exists shall be the difference between the Medicaid allowable payment and the third party payment. In no case shall the Medicaid payment exceed the payment otherwise allowable pursuant to this Chapter.

Section 12. Payment of Claims. Payment of claims shall be pursuant to the provisions of Chapter 3, which provisions are incorporated by this reference.

Section 13. Recovery of excess payments. The Department may recover excess payments pursuant to the recovery provisions of Chapter 3, which are incorporated by this reference.

Section 14. Reconsideration.

- (a) Request for reconsideration. A provider may request reconsideration of a request to recover excess payments. Such a request must be mailed to the Department, by certified mail, return receipt requested, within twenty days after the date the provider receives notice pursuant to Section 13. The request must state with specificity the reasons for the request. Failure to provide such a statement shall result in the dismissal of the request with prejudice.
- (b) Reconsideration. The Department shall review the matter and send written notice by certified mail, return receipt requested, to the provider of its final decision within forty-five days after

receipt of the request for reconsideration or the receipt of any additional information requested pursuant to (c), whichever is later.

(c) Request for additional information. The Department may request additional information from the provider as a part of the reconsideration process. Such a request shall be made in writing by certified mail, return receipt requested. The provider must provide the requested information within the time specified in the request. Failure to provide the requested information shall result in the dismissal of the request with prejudice.

(d) Matters subject to reconsideration. A provider may request reconsideration of a decision to recover excess payments.

(e) Reconsideration shall be limited to whether the Department has complied with the provisions of this Chapter.

(f) Administrative hearing. A provider may request an administrative hearing regarding the final agency decision pursuant to Chapter I of these rules by mailing by certified mail, return receipt requested or personally delivering a request for hearing to the Department within twenty days after the date the provider receives notice of the final agency decision. At the hearing, the burden shall be on the provider to show that the agency's final decision does not comply with this Chapter.

(g) Failure to request reconsideration. A provider which fails to request reconsideration pursuant to this Section may not subsequently request an administrative hearing pursuant to Chapter I.

Section 15. Administrative hearing.

(a) Recipients. A recipient may request an administrative hearing pursuant to Chapter I regarding the following:

- (i) The denial of HCBS waiver services;
- (ii) The denial of the recipient's provider of choice;
- (iii) The denial of a choice between home or communitybased services or institutional services; and
- (iv) Such other matters as are specified in applicable waivers.

(b) Procedures. A request for an administrative hearing must be made in conformance with Chapter I, and the hearing shall be held pursuant to Chapter I.

Section 16. Superseding effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including provider manuals and provider bulletins, which are inconsistent with this Chapter, except as otherwise specified in this Chapter.

Section 17. Severability. If any portion of these rules is found to be invalid or unenforceable, the remainder shall continue in effect.