Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: WYOMING

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation	4.2 Hearings for Applicants and Recipients
42 CFR 431.202 AT-79-29 AT-80-34	The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

Revision: HCFA-AT-87-9 (BERC) OMB No.: 0938-0193
AUGUST 1987

State/Territory: WYOMING

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29	Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

Revision:

State/Territory: Wyoming

Citation	**4.4 Medicaid Eligibility Quality Control**	
42 CFR 431 Subparts P & Q **50 FR 21839** **75 FR 48847** **1903(u) of The Act,** **P.L. 99-509 (Section 9407)** **P.L. 107-300** **P.L.111-3**	**(a)**	**A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.** **_X__ Yes.** **___ Not applicable. The State operates An approved MEQC Pilot.**
	(b)	**In accordance with 431.806(c), the State operates a Medicaid quality control claims processing assessment system that meets the requirements of 431.830-431.836.** **___ Yes.** **___ Not applicable. The State has an approved Medicaid Management Information System (MMIS).**
	(c)	**In accordance with 431.806(b), Payment Error Rate Measurement (PERM) is implemented in accordance with 42 CFR Part 431, Subpart Q, in substitution to meet the statutory and regulatory ("traditional") Medicaid Eligibility Quality Control (MEQC) review during the State's PERM cycle year.** **___ Yes.** **_____ Effective for FFY _____** **_____ Effective for FFY _____** **_____ Effective for FFY _____** **___ Not applicable.**

New: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: WYOMING

Citation
Section 1902(a)(64) of the Social Security Act
P.L. 105-33

4.5a Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

State WYOMING

PROPOSED SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

Citation	
Section 1902(a)(42)(B)(i) of the Social Security Act	____ The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.
Section 1902(a)(42)(B)(ii)(I) of the Act	___X_ The State is seeking an exception to establishing such program for the following reasons: *The State Program Integrity Section maintains and operates a dedicated Fraud, Waste, and Abuse technical solution that supports in the identification of fraud, waste and abuse (FWA). The operations and maintenance duties of the corresponding contractor include report generation and data analysis activities. In addition, the technical solution contains a robust suite of data analytics which automatically generate potential leads. These efforts promote efficiency and significantly expand the State's ability to identify potential cases for audit and investigation.* *The State Program Integrity Section also works closely with its assigned Unified Program Integrity Contractor (UPIC). The collaboration with our designated UPIC and the operational processes we've established prove to be effective in the detection of FWA and subsequent completion of audit and investigation activities.* *The State of Wyoming Medicaid program also maintains an active contract with a Utilization Review contractor. This contractor's duties include post payment clinical reviews of paid claims. In collaboration with this contractor the Medicaid program and Program Integrity Section are able to further identify, address, and mitigate FWA.* *Historical efforts have shown that any firm contracted to be the Wyoming Medicaid RAC has the potential to incur significant operational losses under the allowed fee structure and Medicaid RAC regulatory restrictions. It is these challenges and limitations*

Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act	*that have deterred vendors from presenting any interest in bidding on and providing services as a RAC.* *The State's Program Integrity efforts in managing and mitigating FWA are numerous, documented, active, and ongoing. For these reasons, the State is requesting an exception - pursuant to 42 CFR 455.516 - from the requirement to maintain a Recovery Audit Contractor for a period of not more than 2 years from 7/1/2023 (the expiration date of approved SPA WY-21-0008).*
Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act	___ The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute. Place a check mark to provide assurance of the following:
Section 1902 (a)(42)(B)(ii)(III) of the Act	____ The State will make payments to the RAC(s) only from amounts recovered. ____The State will make payments to the RAC(s) on a contingent Basis for collecting overpayments.
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):
Section 1902(a)(42)(B)(ii)(IV(bb) of the Act	____ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.
Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act	_____The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate. _____ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee. ____ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):

	____ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s). ____ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan. _____ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share. ____ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation
42 CFR 431.16
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation
42 CFR 431.18(b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

Revision: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: WYOMING

Citation

42 CFR431.51
AT-78-90
46 FR 48524
48 FR23212
1902 (a) (23) of the Act
P.L. 100-93 (section 8(f))
P.L. 100-203 (Section 4113)

4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual--

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, or

Section 1902(a)(23) of the Social Security Act
P.L. 105-33

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services.

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: WYOMING

Citation

42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is THE DEPARTMENT OF HEALTH

(b) The State authority(ies) responsible for establishing and maintaining standards,other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): DEPARTMENT OF HEALTH.

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: WYOMING

Citation

42 CFR 431.610
AT-78-90
AT-89-34

4.11(d) The DEPARTMENT OF HEALTH _____ (agency), which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

OFFICIAL

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation
42 CFR 431.105(b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

☐ Yes, as listed below:

☒ Not applicable. Similar services are not provided to other types of medical facilities.

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State/Territory: WYOMING

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483 1919 of the Act (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483, Subpart D (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

/X/ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Revision: HCFA-PM-91-9 (MB) OMB No.:
October 1991

State/Territory: WYOMING

Citation
1902(a)(58)
1902(w) 4.13 (e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Health maintenance organizations at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law or court decision exist regarding advance directives.

Revision: HCFA-PM- 91-10 (MB)
DECEMBER 1991

State/Territory: Wyoming

Citation
42 CFR 431.630
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and
1902(d) of the
Act, P.L. 99-509
(Section 9431)

4.14 Utilization/Quality Control

(a) A statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

___ Directly

_X__ By undertaking medical and utilization review requirements through a contract with a utilization and Quality Improvement Organization (QIO) designate under 42 CFR Part 475. The contract with the QIO--

(1) Meets the requirements of §434.6(a);

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to QIO review;

(4) Ensures that QIO review activities are not inconsistent with the QIO review of Medicare services; and

(5) Includes a description of the extent to which QIO determinations are considered conclusive for payment purposes.

___ Quality review requirements described in

section 1902(a)(30)(C) of the Act relating

46 (cont)

to services furnished by HMOs under contract are undertaken through contract with the PRO. designed under 42 CFR Part 462.

1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (section 9431)

___ By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

Revision: HCFA-PM-85-3 (BERC)
May 1985

State/Territory: WYOMING

Citation

42 CFR 456.2
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

_X_ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

___ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

___ All hospitals (other than mental hospitals).

___ Those specified in the waiver.

___ No waivers have been granted.

Revision: HCFA-PM-85-7 (BERC) OMB No.: 0938-0193
July 1985

State/Territory: WYOMING

Citation

42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

_X_ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

___ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

___ All mental hospitals.

___ Those specified in the waiver.

___ No waivers have been granted.

___ Not applicable. Inpatient services in mental hospitals are not provided under this plan.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: Wyoming

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

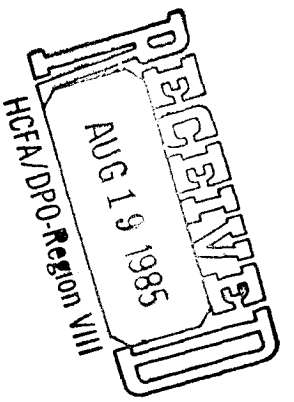
/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

/ / All skilled nursing facilities.

/ / Those specified in the waiver.

/X/ No waivers have been granted.



Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: Wyoming

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 /X/(e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

/X/ Facility-based review.

/ / Direct review by personnel of the medical assistance unit of the State agency.

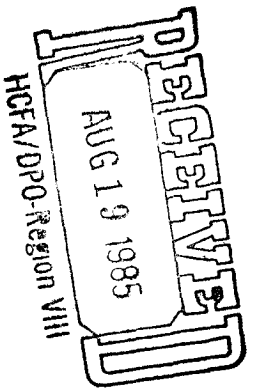
/ / Personnel under contract to the medical assistance unit of the State agency.

/ / Utilization and Quality Control Peer Review Organizations.

/ / Another method as described in ATTACHMENT 4.14-A.

/ / Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/ / Not applicable. Intermediate care facility services are not provided under this plan.



TN No. 85-5
Supersedes
TN No. _____

Approval Date _____ Effective Date 8/1/85

HCFA ID: 0048P/0002P

Revision: HCFA-PM- 91-10 (MB)
DECEMBER 1991

State/Territory: WYOMING

Citation

1902(a)(30) and 1902(d) of the Act, P.L. 99-509 (Section 9431) P.L. 99-203 (section 4113)

4.14 Utilization/Quality Control (Continued)

(f) The Medicaid agency meets the requirements of section 1902(a)(30) of section 1902(a)(30) of the Act for control of the assurance of quality furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

___ A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

___ A private accreditation body.

___ An entity that meets the requirements of the Act, as determined by the Secretary.

The Medicaid agency certifies that the entity in the preceding subcategory under 4.14(f) is not an agency of the State.

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: Wyoming

Citation	4.15 Inspection of Care in Intermediate Care Facilities for the Intellectually Disabled, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals
42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act	_X_ The State has contracted with a Quality Improvement Organization (QIO) to perform inspection of care for: __ ICFs/ID; _X_ Inpatient psychiatric facilities for recipients under age 21; and _X_ Mental Hospitals.
42 CFR Part 456 Subpart A and 1902(a)(30) of the Act	_X_ All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services. ___ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan. ___ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan. __ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation
42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wyoming

Citation (s)
42 CFR 433.36 (c)
1902(a) (18) and
1917(a) and (b) of
The Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

____ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917 (a) of the Act and regulations at 42 CFR 433.36 (c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

_____ The State imposes liens on real property on account of benefits incorrectly paid.

_____ The State imposes TEFRA liens 1917 (a) (1) (B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State Plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

_____ The State imposes liens on both real and personal property of an individual after the individual's death.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wyoming

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

X Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917 (a) (1) (B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

X In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below:

The State recovers for all approved services, for individuals age 55 and over, except for Medicare cost sharing identified at 4.17, (b)(3) Continued.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wyoming

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1,2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: WYOMING

1917(b)(1)(C) (4) _x_ If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6A, Supplement 8C (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

__ The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6A, Supplement 8b.

__ The State adjusts or recovers from the individual's estate on account of all facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

__ The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

__ The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

Revision: HCFA-PM-95-3 (MB
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: WYOMING

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h) - (i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

Revision: HCFA-PM-95-3 (MB
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: WYOMING

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institinalized individual cannot reasonably be expected to be discharged from the medical institution and returen home. The description of the procedures meets the requirements of 42 CFR 443.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 443.36(g).

(3) Defines the following terms:

a. estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), of the State provides a disregard for assets or resources for any individual who received or is enttitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in whcih the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),

b. individual's home,

c. equity interest in the home,

d. residing in the home for at least 1 or 2 years,

e. on a continuous basis,

f. discharge from the medical institution and return home, and

g. lawfully residing.

Revision: HCFA-PM-95-3 (MB
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: WYOMING

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: WYOMING

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

When it has been determined that an institutionalized individual owns or has an equity interest in a home that individual's nursing home records, including all LT101s and screenings, are reviewed by a qualified medical professional and a determination is made as to whether the recipient is reasonably expected to return home. Once it has been determined that the individual is reasonably expected not to return home, notices will be sent to the recipient and the institution. The notices include the definition of a lien and that a lien does not mean that the individual will lose ownership of the home. The notice also includes the steps a recipient must take if they wish to have a fair hearing on the matter and the procedures as specified in Chapter One of Wyoming Administrative Procedures Act.

2. The Following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR 433.36(f):

The Department shall make an estate recovery if the deceased recipient has no son or daughter who has been:

a) Residing in the home continuously for two years or more immediately before the date of the individual's admission to the institution; and

b) Providing care which permitted the individual to reside at home rather than in an institution.

3. The State defines the terms below as follows:

(1) Estate - As defined by W.S. 42-4-206(g)(ii). Any or all real and personal property and other assets in which the individual has any legal title or interest at the time of death, including assets conveyed to surviving individuals.

(2) Individual's home - Any residential property owned solely or jointly by a medicaid recipient.

(3) Equity interest in the home - A recipient's financial interest in any residential property

(4) A sibling of the individual, who has an equity interest in the home and who was residing in the home for a period of at least one (1) year immediately before the death of the individual's admission to the medical institution.

(5) Lawfully residing - A recipient's primary residence. A permanent address or any place of abode that is more than for a limited time, within a township, prior to the recipient's admission to the institution.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: WYOMING

LIENS AND ADJUSTMENTS OR RECOVERIES

4. The State defines undue hardship as follows:

An undue hardship exists if the decedent's home is part of the estate and that home is part of a business, including a working farm or ranch, and recovery of the home would result in the heirs or beneficiaries losing their means of making a living. "Undue hardship" includes any additional definition promulgated by The United States Department of Health and Human Services (HHS) as an administrative regulation. Any part of this definition that is inconsistent with HHS's definition shall become inoperative.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

- Standards and procedures used for undue hardship waiver when it is not cost effective:

  (a) If the Department determines that an estate recovery would be an undue hardship, and when recovery is not cost effective, the Department may waive part or all of the Department's share of the amount which is recoverable pursuant to this Chapter.

  (b) Notice of right to request undue hardship waiver. At the time the Department files an estate claim pursuant to the procedures for recovery from probate and non-probate estate in accordance with Wyoming Administrative Rules, Chapter I, Wyoming State Administrative Procedural Act, and Chapter 35 Medicaid Benefit Recovery, Section 10.

6. The State defines cost-effective as follows: (include methodology/thresholds used to determine cost-effectiveness):

- The determination by the Department that the expected expenses of a recovery, including, but not limited to, administrative costs, attorneys' fees, court costs, costs of litigation, travel costs, expert witness fees and deposition expenses, are less than the expected amount of the recovery.

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

- The Department may seek Medicaid benefit recovery pursuant to the procedures and standards of W.S. 42-4-201 et seq., Wyoming Administrative Rules, Chapter 35, Medicaid Benefit Recovery, Section 8, and applicable federal law.

TL #76-17
Approved 7/1/75

STATE OF WYOMING

EXECUTIVE DEPARTMENT

Executive Order

1976-2

Pursuant to the authority vested in the office of Governor of the State of Wyoming under W.S. 9-160.1 through 9-160.18, I, Ed Herschler, Governor of the State of Wyoming, hereby order:

Section 1. Effective April 20, 1976, through June 30, 1977, the Wyoming Department of Health and Social Services, which includes the Division of Health and Medical Services, the Division of Public Assistance and Social Services, and the Division of Vocational Rehabilitation, shall be the single state agency responsible for the administration or supervision of administration of state plans for those cooperative Federal and State programs set forth in this Order.

Section 2. The Division of Health and Medical Services of the Wyoming Department of Health and Social Services shall administer or supervise the administration of State and Federal programs as follows:

a. Maternal and Child Health and Crippled Children's Services (Title V of the Social Security Act, 42 USC Sec. 701, et seq.).

b. Medical Assistance for the Needy - "Medicaid" (Title XIX of the Social Security Act, 42 USC Sec. 1396 et seq.).

c. Comprehensive Health Planning (Section 314 (a) of Public Health Services Act, 42 USC Sec. 246(a)).

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approved 7/1/75

d. Comprehensive Public Health Services (Including Mental Health) (Section 314(d) of Public Health Service Act, 42 USC Sec. 246(d)).

e. Hospital and Medical Facilities Construction (Section 604 of Public Health Service Act, 42 USC Sec. 291 et seq.).

f. Mental Health and Mental Retardation Construction (P.L. 88-164).

g. Community Mental Health Centers (P.L. 93-63, 42 USC Sec. 2689 et seq.).

h. Developmental Disabilities Services (P.L. 94-103, 42 USC Sec. 6031 et seq.).

i. State Health Planning and Development Function (Section 1523 of P.L. 93-641).

Section 3. The Division of Public Assistance and Social Services of the Wyoming Department of Health and Social Services shall administer or supervise the administration of State and Federal programs as follows:

a. Aid to families with dependent children (Title IV A of the Social Security Act, 42 USC Sec. 601 et seq.).

b. Child Welfare Services (Title IV B of the Social Security Act, 42 USC Sec. 620 et seq.).

c. Child Support and Establishment of Paternity (Title IV D of the Social Security Act, 42 USC Sec. 651 et seq.).

d. Grants to States for Services (Title XX of the Social Security Act, P.L. 93-647, 42 USC Sec. 1397 et seq.).

e. Public Assistance and Social Services Act of the State of Wyoming (W.S. 42-1 et seq.).

Section 4. The Division of Vocational Rehabilitation of the Wyoming Department of Health and Social Services shall

TL # 76-17
approved 7/1/75

administer or supervise the administration of State and Federal programs as follows:

a. Vocational Rehabilitation Services (Rehabilitation Act of 1973, P.L. 93-112, 42 USC Sec. 701 et seq.).

* Note: The statutory references in this Order are not exhaustive. Said references are to include any amendments and other provisions pertinent to the programs enumerated.

Given under my hand and the Executive Seal of the State of Wyoming this 2nd day of April, 1976.

Governor of the State of Wyoming

D-44 ... 416A

STATE OF WYOMING

EXECUTIVE DEPARTMENT

Executive Order

1977- 4

Pursuant to the authority vested in the office of Governor of the State of Wyoming under W.S. 9-160.1 through 9-160.18, and specifically W.S. 9-160.6(a)(ii), I, Ed Herschler, Governor of the State of Wyoming, hereby order:

Section 1. Effective July 1, 1977 through June 30, 1978, the Wyoming Department of Health and Social Services, which includes the Division of Health and Medical Services, the Division of Public Assistance and Social Services, and the Division of Vocational Rehabilitation, shall be the single state agency responsible for the administration or supervision of administration of state plans for those cooperative Federal and State programs set forth in this Order.

Section 2. The Division of Health and Medical Services of the Wyoming Department of Health and Social Services shall administer or supervise the administration of State and Federal programs as follows:

a. Maternal and Child Health and Crippled Children's Services (Title V of the Social Security Act, 42 USC Sec. 701, et seq.).

b. Medical Assistance for the Needy - "Medicaid" (Title XIX of the Social Security Act, 42 USC Sec. 1396 et seq.)

c. Comprehensive Health Planning (Section 314 (a) of Public Health Services Act, 42 USC Sec. 246(a)).

d. Comprehensive Public Health Services (Including Mental Health) (Section 314(d) of Public Health Service Act, 42 USC Sec. 246(d)).

e. Hospital and Medical Facilities Construction (Section 604 of Public Health Service Act, 42 USC Sec. 291 et seq.).

f. Mental Health and Mental Retardation Construction (P.L. 88-164).

g. Community Mental Health Centers (P.L. 93-63, 42 USC Sec. 2689 et seq.).

h. Developmental Disabilities Services (P.L. 94-103, 42 USC Sec. 6031 et seq.).

i. State Health Planning and Development Function (Section 1523 of P.L. 93-641).

Section 3. The Division of Public Assistance and Social Services of the Wyoming Department of Health and Social Services shall administer or supervise the administration of State and Federal programs as follows:

a. Aid to families with dependent children (Title IV A of the Social Security Act, 42 USC Sec. 601 et seq.).

b. Child Welfare Services (Title IV B of the Social Security Act, 42 USC Sec. 620 et seq.).

c. Child Support and Establishment of Paternity (Title IV D of the Social Security Act, 42 USC Sec. 651 et seq.).

d. Grants to States for Services (Title XX of the Social Security Act, P.L. 93-647, 42 USC Sec. 1397 et seq.).

e. Public Assistance and Social Services Act of the State of Wyoming (W.S. 42-1 et seq.).

Section 4. The Division of Vocational Rehabilitation of the Wyoming Department of Health and Social Services shall

administer or supervise the administration of State and Federal programs as follows:

a. Vocational Rehabilitation Services (Rehabilitation Act of 1973, P.L. 93-112, 42 USC Sec. 701 et seq. as amended in P.L. 93-516).

Note: The statutory references in this Order are not exhaustive. Said references are to include any amendments and other provisions pertinent to the programs enumerated.

Given under my hand and the Executive Seal of the State of Wyoming this 21st day of June, 1977.

Governor of the State of Wyoming

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State/Territory: WYOMING

Citation 42 CFR 447.51 through 447.58

4.18 Recipient Cost Sharing and Similar Charges

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

/ / Age 19

/ / Age 20

/X/ Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State/Territory: WYOMING

Citation 4.18(b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

/X/ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a health maintenance organization in which the individual is enrolled.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State/Territory: WYOMING

Citation 4.18(b) (Continued)

42 CFR 447.51 through 447.48

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

/_/ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

/_/ 18 or older

/_/ 19 or older

/_/ 20 or older

/X/ 21 or older

/_/ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

Revision: HCFA-PM-91-1 (BPD) OMB No.: 0938-

State/Territory: WYOMING

Citation
42 CFR 447.51
through 447.58

4.18(b)(3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

/X/ Not applicable. There is no maximum.

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State/Territory: WYOMING

Citation			
1916(c) of the Act	4.18(b)(4)	/ /	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5)	/ /	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
(d) of the Act	4.18(b)(6)	/ /	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State/Territory: WYOMING

Citation

42 CFR 447.51 through 447.58

4.18(c) /_/ Individuals are covered as medically needy under the plan.

(1) /_/ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

/_/ Age 19

/_/ Age 20

/_/ Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

sion: HCFA-PM-91- 1991 (BPD) OMB No.: 0938-

State/Territory: WYOMING

Citation 4.18 (c)(2) (Continued)

42 CFR 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

/_/ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

/_/ Not applicable. No such charges are imposed.

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State/Territory: WYOMING

Citation 4.18(c)(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

/_/ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

/_/ 18 or older

/_/ 19 or older

/_/ 20 or older

/_/ 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State/Territory: WYOMING

Citation 4.18(c)(3) (Continued)

447.51 through 447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

/ / Not applicable. There is no maximum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WYOMING

A The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act

Services And Basis for determination	Type of Charge			
	Deduct	Coins	Copay	Amount
Pharmaceutical Products			X	$0 65 **Generic:** Over 65% of generic medications average reimbursement equals $5 92
			X	$3 65 **Brand:** Average reimbursement equals $234 75
Practitioner Visits – office, home, eye & medical psych-therapy			X	$2 45 Average reimbursement equals $88 99
Outpatient Hospital Visits – non-emergency room visit			X	$3 65 Average reimbursement equals $100 64
Rural Health Clinic & FQHC – per encounter			X	$3 65 Average reimbursement equals $123 00

Copayment amounts were based on the average payment for these services and in accordance with 42 CFR 447.53, 447 54; 447 55 Cost sharing may not be imposed for the services, items, and populations specified at sections 1916(a) (2) and (j) of the Social Security Act and 42 CFR §447 53(b)

Cost sharing will be excluded for items and services furnished directly by the Indian Health Services, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under a purchase order under contract health services as (as described in 42 CFR part 136, subpart C) to an American Indian or Alaska Native, who is enrolled as a member of a Federally – recognized tribe or otherwise meets the definition of an "Indian" at section 4 of the Indian Health Care Improvement Act (25 U S C § 1608) As specified under Section 5006 of ARRA, and defined by 42 CFR 447 50(b) any individual with a verified or pending AI/AN status on their eligibility record or who have an established relationship with one of the following types of facilities (I/T/U's) will be exempted from cost sharing IHS Facility, Tribal Clinic, Urban Indian Organization Facility The State will perform a regular review of Medicaid claims to identify users of the above mentioned facilities and will flag those users as exempt from cost sharing In addition, individuals who have a letter of referral through contract health services will be flagged as exempt from cost sharing This exemption will occur through MMIS editing

Any provider that provides services to a Native American/Alaskan Indian who is exempt from cost sharing will receive full payment

Copayments will be reviewed annually to remain consistent with changes, if any, made by CMS in maximum allowed nominal cost sharing amounts

Co-payment requirements do not apply to.
- Clients under age 21
- Nursing Facility Residents
- Pregnant Women
- Family planning services
- Emergency services
- Hospice services
- Medicare Crossovers
- Inpatient Hospital stays

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Wyoming

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Providers and recipients are notified of copayment requirements through Medicaid bulletins. During claims processing exceptions are identified as follows: age, race, and institutional status from the recipient file; provider taxonomy from the provider file; pregnancy services are indicated on the claims or from the diagnosis file; emergency services from the diagnosis file; family planning services from the procedure/diagnosis/drug file. There are no HMO providers in the state. Hospice services are identified through eligibility lock in status.

E. Cumulative maximums on charges:

X State policy does not provide for cumulative maximums.

___ Cumulative maximums have been established as described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
NOT APPLICABLE				

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

B. The method used to collect cost sharing charges for medically needy individuals:

/ / Providers are responsible for collecting the cost sharing charges from individuals.

/ / The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

NOT APPLICABLE

E. Cumulative maximums on charges:

/ / State policy does not provide for cumulative maximums.

/ / Cumulative maximums have been established as described below:

NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

NOT APPLICABLE

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

NOT APPLICABLE

C. State or local funds under other programs are used to pay for premiums:

/ Yes / No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

NOT APPLICABLE

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

NOT APPLICABLE

C. State or local funds under other programs are used to pay for premiums:

[ ] Yes [ ] No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

A. The State permits hospitals to impose cost sharing for non-emergency services furnished in an emergency department for groups of individuals subject to the following conditions:

- The individual has available and accessible an alternate non-emergency services provider with respect to such services;
- The hospital has performed an appropriate medical screening examination under section 1867 of the Act, and has determined that the individual does not have an emergency medical condition;
- Before providing the non-emergency services, the hospital has informed the individual:
  - that it may require payment of specified cost sharing before the service can be provided;
  - of the name and location of an alternate non-emergency services provider that is available and accessible;
  - of the fact that the alternate provider can provide the services without the imposition of the higher cost sharing amount permitted for the inappropriate use of the emergency room (i.e., a lesser co-payment for the service may be allowed and required under section 1916A(a) of the Act at the alternate non-emergency provider); and
  - it can provide a referral to coordinate treatment.

1. Such cost sharing is limited to the following groups of individuals, and the cost sharing amounts or levels indicated, subject to the statutory conditions and maximums indicated in paragraph 2.

2. The exemptions specified under 42 CR 447.53 for exclusion for cost sharing will continue to be applied: recipients under the age of 21, pregnant women, institutionalized individuals, and family planning are exempt from co-payment. Emergency services as defined in 447.53(b)(4) are also exempt.

Groups of Individuals

3. Cost sharing under paragraph 1 shall be subject to the following limitations and conditions.

   a. For individuals with incomes above 100 percent of the Federal Poverty Level (FPL) but at or below 150 percent, cost sharing cannot exceed twice the nominal cost sharing amount under section 1916 of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

b. Cost sharing can be imposed upon individuals otherwise exempt from alternative cost sharing under section 1916A of the Act, so long as no cost sharing is imposed to receive such care through an outpatient department or alternative health provider, but such cost sharing cannot exceed a nominal amount under section 1916 of the Act.

c. Cost sharing is subject to the aggregate cap of 5 percent of family income per person for premiums and cost sharing under section 1916A of the Act based on a monthly schedule.

d. Cost sharing under this provision is instead of any cost sharing that may be imposed under section 1916A (a) of the Act.

4. Following is a list of hospitals implementing this cost sharing (This list is updated as appropriate):

- Campbell County Memorial Hospital
- Community Hospital
- Converse County Memorial Hospital
- Crook County Medical Services District
- Evanston Regional Hospital
- Hot Springs County Memorial Hospital
- Ivinson Memorial Hospital
- Johnson County Memorial Hospital
- Lander Valley Medical Center
- Memorial Hospital of Carbon County
- Memorial Hospital of Sheridan County
- Memorial Hospital of Sweetwater County
- Niobrara Hospital
- North Big Horn Hospital District
- Platte County Memorial Hospital
- Powell Hospital
- Riverton Memorial Hospital
- South Big Horn Critical Access Hospital
- South Lincoln Hospital District
- St. John's Hospital (aka Teton County Hospital District)
- Star Valley Hospital
- Cheyenne Regional Medical Center Memorial Hospital of Laramie County
- Washakie Memorial Hospital
- Weston County Health Services
- West Park Hospital
- Wyoming Behavioral Institute
- Wyoming Medical Center

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State/Territory: WYOMING

Citation 4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

/X/ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

/ / Inappropriate level of care days are not covered.

Revision: HCFA-PM-93- 6 (MB) OMB No.: 0938-
August 1993

State/Territory: WYOMING

Citation		
42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19(b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m),the Medicaid agency meets the following requirements: (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys). (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
1902(a)(10) and 1902(a)(30) of the Act		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

Revision: HCFA-at-80-38
May 22, 1980

State: WYOMING

Citation

42 CFR 447.40 4.91(c)

4.19(C)
7

[redacted]

Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility

X Yes. The State's policy is described in Attachment 4.19-C.

___ No.

Revision: HCFA-PM-87- 9 (BERC) OMB No.: 0938-0193
AUGUST 1987

State/Territory: WYOMING

Citation 4.19 (d)
42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

/X/ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

/X/ At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/ / Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

/ / At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/ / Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

/ / (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation		
42 CFR 447.45(c) AT-79-50	4.19(e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

A claim is defined as a line item with an associated charge to be adjudicated, except for impatient hospital service for which a claim is defined as a single hospital billing issued for a portion of, or all of, the inpatient hospital stay.

TN No. 87-9
Date Approved 11-23-87
Effective Date 7-1-87
Supersedes Transmittal 77-11

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: WYOMING

Citation		
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State Wyoming

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation		
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

.sion: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State: WYOMING

Citation		
42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: WYOMING

Citation

1903(i)(14) of the Act	4.19(1)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physican to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Revision: HCFA-PM-94-8 (MB)
October 1994

State/Territory: Wyoming

Citation		
4.19 (m)		Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program
1928(c)(2)(C)(ii) of the Act	(i)	A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows:
	(ii)	The State:
		____ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.
		____ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State Law.
		____ sets a payment rate below the level of the regional maximum established by the DHHS Secretary.
		__X__ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.
		The State pays the following rate for the administration of pediatric vaccine: $14.00 per injection or oral feeding for CPT codes 90465 through 90468, $10.00 per injection or oral feeding for CPT codes 90471 through 90474.
		These rates will be adjusted inline with any physician services rate adjustment, subject to the Regional Maxium Cap.
1926 of the Act	(iii)	Medicaid beneficiary access to immunizations is assured through the following methodology:
		__X__ VFC vaccines are provided to 80% of the private providers and 100% of the public providers in the state.
		__X__ All providers have been educated as to VFC requirements, i.e., providers are prohibited from refusing to vaccinate due to the patient's inability to pay an administration fee.
		__X__ In addition, the Immunization program routinely conducts a random survey of providers and the ease of accessing immunization services.

INPATIENT HOSPITAL REIMBURSEMENT

Section 1. Authority.

This Attachment is prepared and submitted to CMS for approval pursuant to 42 U.S.C. §1396a (b) and 45 C.F.R. Part 201, Part 201, Subpart A.

Section 2. Purpose and Applicability.

(a) This Attachment shall apply to and govern Medicaid reimbursement of inpatient hospital services for individuals admitted on or after its effective date. Inpatient hospital services are also subject to the provisions of Wyoming Medicaid Rules Chapters 4, 8, 16, and 26, and Attachment 4.19-A,

(b) The Department may issue Provider Manuals, Provider Bulletins, or both, to interpret the provisions of this Attachment. Such manuals and bulletins shall be consistent with and reflect the policies contained in this Attachment. The provisions contained in manuals or bulletins shall be subordinate to the provisions of this Attachment.

(c) The incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Attachment.

Section 3. General Provisions.

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

(b) General methodology.

(i) Except as otherwise specified in this Attachment, the Department pays for inpatient hospital services using a prospective per discharge system using All Patient Refined Diagnosis Related Groups (APR DRGs) for acute care services, a per diem-based reimbursement method for rehabilitation services, or a percent of billed charges for transplants.

(ii) Specialty services. The Department may, from time to time, designate certain services to be reimbursed based on negotiated rates as specialty services. In such an event, the Department shall disseminate to providers, through Provider Manuals or Provider Bulletins, a current list of which services are reimbursed as specialty services and which are reimbursed pursuant to this Attachment.

(iii) Disproportionate share payments. The Department reimburses disproportionate share hospitals additional annual payments pursuant to Attachment 4.19-A.

(iv) Qualified Rate Adjustment (QRA) payments. The Department reimburses hospitals that qualify for QRA payments pursuant to 4.19-A, Part 1, Addendum 1.

(v) Private Hospital Supplemental (PHS) payments. The Department reimburses hospitals that qualify for PHS payments pursuant to 4.19-A, Addendum 3.

Section 4. Provider Medicaid Certification.

(a) No provider that furnishes inpatient hospital services to a recipient shall receive Medicaid funds unless the provider is certified, has signed a provider agreement and is enrolled in Wyoming Medicaid.

(b) Compliance with Wyoming Medicaid Rule Chapter 3. A provider that wishes to receive Medicaid reimbursement for inpatient hospital services furnished to a recipient must meet the requirements of Wyoming Medicaid Rule Chapter 3, Sections 4 through 6, which are incorporated by this reference.

Section 5. Provider Records.

(a) A provider must comply with Wyoming Medicaid Rule Chapter 3, Section 7, which is incorporated by this reference.

(b) Explanation of records. In the event of a field audit, the provider shall have available at the field audit location one or more knowledgeable persons who can explain to the auditors the provider's financial records, the accounting and control system and cost report preparation, including attachments and allocations.

(c) Failure to maintain records. A provider unable to satisfy all the requirements of this Section shall be given a written notice of deficiency and shall have sixty (60) days after the date of the written notice to correct such deficiency. If, at the end of the sixty (60) days, the Department determines that the deficiency has not been corrected, the Department shall reduce by twenty-five percent (25%) the Medicaid payment due for each of the provider's claims received by the Department on or after the sixtieth day. If at the end of one hundred and twenty days (120) after the mailing of the written notice of deficiency, the Department determines that the deficiency has not been corrected, the Department shall suspend all Medicaid payments to the provider for claims received by the Department on or after such date. The suspension of payments shall continue until the Department determines that adequate records are being maintained. After the deficiency is corrected, the Department shall release any withheld payments, without interest. This remedy shall not affect the Department's right to sanction the provider pursuant to applicable State or Federal rules or laws.

(d) 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-of-state location, unless otherwise agreed by the Department.

Section 6. Verification of Recipient Data. A provider must comply with Wyoming Medicaid Rule Chapter 3, Section 8, which is incorporated by this reference.

Section 7. Wyoming Medicaid Participating Providers. Participating providers are all in-state Wyoming providers and out-of-state providers that are currently enrolled in the Wyoming Medicaid program and received at least eight-hundred thousand ($800,000) in Wyoming Medicaid payments for inpatient services during the most recently available 36-month period based on each claims last date of service. Wyoming Medicaid requires a minimum of six months for billing and claim processing before defining a month as "available" for this determination..

Section 8. Medicaid Allowable Payment for Inpatient Acute Care Hospital Services

(a) Inpatient acute care hospital services will be reimbursed using Wyoming Medicaid's All-Patient Refined Diagnosis Related Groups (APR DRG) reimbursement methodology.

(b) The Wyoming APR DRG reimbursement methodology shall apply to all inpatient stays for Wyoming Medicaid recipients at Wyoming Medicaid enrolled participating and non-participating hospitals except as specified in Subsection (m). This change shall be effective February 1, 2019.

(c) Wyoming's DRG payment method will use APR DRG codes and national relative weights. APR DRG codes and relative weights are updated annually, and the Department shall update the version of the APR DRG codes and relative weights it applies to claims no more than once per year and at least once every three years.

(d) The DRG Allowed Amount will be calculated as DRG Base Payment plus an outlier payment as applicable, plus the prospective flat capital payment rate for dates of service prior to October 1, 2023. On and after October 1, 2023, funds previously reserved for DRG capital add-on payments will be incorporated into the DRG base rate and separate capital payments will not be reimbursed. Adjustments for patient transfers and less than one day stays are also made.

(e) The version of APR DRG code, associated hospital base rate, and associated payment parameters assigned to a claim are determined based on the last date of service on the claim.

(f) Components of the APR DRG payment are described in the following sections:

(i) Section 8(g) describes the calculation of the Final DRG Base Payment including exceptions for transfers and less than one day stays

(ii) Section 8(h) describes base rate determination

(iii) Section 8(i) describes APR DRG relative weights

(iv) Section 8(j) describes APR DRG policy adjusters

(v) Section 8(k) describes outlier payments

(vi) Section 8(l) describes capital payments

(g) Calculation of Final DRG Base Payment

(i) Standard DRG Base Payment will be calculated as hospital base rate multiplied by the APR DRG assigned relative weight and policy adjustor.

(ii) Final DRG Base Payment will equal Standard DRG Base Payment unless the claim qualifies for the Transfer Payment Policy or the claim qualifies the Less-Than-One-Day Stay Payment Policy.

(iii) Transfer Payment Policy

(A) A claim qualifies for the Transfer Payment Policy if the claim is for a patient who is admitted and then transferred to another acute care hospital and is not assigned an APR DRG that includes transfer criteria in its description. Transfer payment adjustments do not apply when a patient is discharged from an acute care hospital to a skilled nursing or rehabilitation facility, or when a patient is moved to or from a distinct part hospital unit of the hospital or from one unit to another within a hospital.

(B) Claims qualifying for the Transfer Payment Policy are identified using a distinct list of patient discharge status codes as billed on the institutional claim form. The Department lists these codes in related provider policy manuals.

(C) Transfer payments do not impact the claim payment for the provider receiving a patient in cases where that provider does not in-turn transfer the patient.

(D) On claims qualifying for the Transfer Payment Policy, the Final DRG Base Payment is calculated as the lesser of the Standard DRG Base Payment and the Transfer DRG Per Diem Base Payment.

(E) The Transfer DRG Per Diem Base Payment is calculated as [(DRG Per Diem) * (Length of Stay + 1)].

(F) The DRG Per Diem is calculated as [(Standard DRG Base Payment) / (National APR DRG Average Length of Stay)].

(G) Claims qualifying for the Transfer Payment Policy are eligible for outlier payments.

(iv) Less-Than-One-Day Stay Payment Policy

(A) An inpatient claim qualifies for the Less-Than-One-Day Stay Payment Policy if the patient was in the hospital for less than 24 hours and the claim is not for one of the following:

- Birth
- Vaginal delivery
- Patients who pass away on their first day in the hospital
- Patients who are transferred to another acute care hospital
- Services assigned a transfer APR DRG

(B) Final DRG Base Payment on claims that qualify for the Less-Than-One-Day Stay Payment Policy will equal a DRG Per Diem amount which will be calculated as [(DRG Base Payment) / (DRG national average Length of Stay)].

(C) Claims that qualify for the Less-Than-One-Day Stay Payment Policy will not be eligible for a DRG outlier payment.

(h) Calculation of hospital DRG base rate

(i) A base rate represents a dollar amount used in the calculation of Medicaid Allowed Amount.

(ii) The base period for development of the Wyoming APR DRG rates contains a minimum of 24 months and a maximum of 36 months of available claims data based on claim last date of service. Wyoming Medicaid requires a minimum of six months for billing and claim processing before defining a month as “available” for this determination..

(iii) Each certified hospital providing inpatient hospital services to Wyoming Medicaid recipients is assigned to one of the following three base rate categories for APR DRG services by the Department.

(A) Critical Access Hospitals (CAHs)

(B) In-state free-standing psychiatric providers

(C) All other providers

(iv) The Department established base rates so that projected APR DRG payments maintain budget neutrality for each base rate category for claim payments between the base period and the new rate period unless otherwise directed by the Wyoming Legislature.

(v) Only one base rate is available to each provider at a given period of time.

(vi) The Department will use transitional base rates for the first 12 months after the APR DRG implementation (from February 1, 2019 through January 31, 2020). During this transition period, provider-specific APR DRG base rates are calculated so that estimated APR DRG inpatient hospital payments in the base period do not increase more than five percent or decrease more than four percent as compared to payments under the pre-DRG model.

(vii) Following the 12-month transition period, providers will receive the base rate from their assigned base rate category.

(viii) During and after the APR DRG transition period non-participating providers will be paid the "all other provider" base rate as specified in Section 8(h)(iii)(C) for APR DRG payment calculations.

(ix) The Department posts base rates for each provider category on the Department website. New rates will be posted with a provider notice sent by the Department when any changes are made to the APR DRG base rates. Base rates effective for dates of service on or after February 1, 2019 will be posted on the Department website at https://www.wyomingmedicaid.com/portal/Diagnosis-Related-Grouping .

(x) Base rates and associated payment parameters are updated each time the Department implements a new version of APR DRGs. A set of base rates apply only for a specific version of APR DRGs.

(i) APR DRG relative weights

(i) The Department assigns each claim a relative weight using the APR DRG version in effect on the claim's last date of service. Wyoming will update the APR DRG version and corresponding relative weights at most once per year and at least once every three years.

(ii) The APR DRG Grouper assigns to each APR DRG a relative weight that reflects the relative resources that are used to deliver the services associated with the assigned APR DRG.

(iii) The Department uses national APR DRG relative weights calculated by the organization that develops and maintains the APR DRG categorization system.

(iv) During the rate modeling for the provider base rates used in the initial year of the APR DRG implementation, the Department applied a documentation and coding improvement (DCI) factor of five percent to the relative weights to account for coding improvements made by providers following the implementation of APR DRGs. Following the first year of implementation, the Department will review coding improvement and may make future DCI adjustments to account for observed changes in provider coding in order to maintain budget neutrality, in aggregate, for inpatient hospital services. Any future adjustments that increase or decrease overall reimbursement for inpatient hospital services will be reflected within the plan language and implemented upon approval by CMS.

(j) APR DRG policy adjustors

(i) One policy or age adjustor can be applied per claim; the adjustment factor with the highest value shall be applied in the calculation of Allowed Amount on the claim.

(A) A pediatric policy adjustor of 1.3 will be applied to pediatric claims where a recipient is younger than 19 years of age on the claim's first date of service.

(B) A policy adjustor of 1.2 will be applied to Mental Health DRGs.

(C) A policy adjustor of 1.2 will be applied to Substance Abuse DRGs.

(D) A policy adjustor of 1.5 will be applied to Obstetrics DRGs.

(E) A policy adjustor of 1.9 will be applied to Normal Newborn DRGs.

(ii) The Department assigns APR DRG codes to the service categories used for policy adjustors based on APR DRG code description and service lines assigned by the organization that develops and maintain APR DRGs.

(k) Outlier Payments

(i) The Department will make outlier payments for high cost claims in which an estimate of hospital financial loss for the stay exceeds a predetermined fixed loss threshold.

(A) The fixed loss threshold is specific to each of the below peer groups. Each peer group's fixed loss threshold is equal to two times the standard deviation of claim cost for all APR DRG base period claims for the following four peer groups: acute care hospitals, critical access hospitals, freestanding psychiatric hospitals, and children's hospitals.

(B) If a provider's cost for a claim minus the DRG base payment exceeds the hospital's assigned fixed loss threshold the provider will receive an outlier payment.

(ii) The outlier payment is calculated as follows:

(A) Identify the cost of each claim by multiplying allowable charges on the claim by a hospital-specific cost-to-charge ratio.

(B) Participating providers are assigned the most recently available provider-specific cost-to-charge ratios developed annually by the Department as part of the QRA supplemental payment program.

(C) For dates of service prior to October 1, 2023, non-participating hospitals are assigned the average cost-to-charge ratio from in-state participating hospitals for the outlier calculation. For dates of discharge on or after October 1, 2023, non-participating hospitals are assigned the average cost-to-charge ratio from out-of-state participating hospitals for the outlier calculation.

(D) Calculate estimated hospital loss as estimated hospital allowable cost minus DRG base payment.

(E) If the estimated hospital loss exceeds the provider's fixed-loss outlier threshold, an outlier payment will be added to the DRG base payment.

(F) The outlier payment shall be 75 percent of the estimated hospital loss.

(l) Capital Payments

(i) For dates of discharge prior to October 1, 2023, Wyoming will provide a per discharge capital payment to participating providers.

(ii) For claim with last date of service between February 1, 2019 and December 31, 2020, capital payments are set at $277.87 per discharge, as determined during the 2010 level of care rebasing, and will not be inflated.

(iii) For dates of service between January 1, 2021 and September 30, 2023, capital payments are set at $270.92 per discharge.

(iv) A description of capital payment calculations is located in Section 13.

(v) Effective October 1, 2023, a separate capital payment will not be applied for claims priced via the APR DRG method. Instead, the funds previously paid via Capital Payments have been incorporated into the determination of DRG base rates and standard DRG payments.

(vi) Final reimbursement amounts will be equal to a claim's allowed amount minus any deductions for recipient cost sharing, patient responsibility, third-party liability or hospital acquired conditions (HACs).

(vii) The Department will use the APR DRG grouper to review for hospital acquired conditions based on present on admission (POA) indicators required for hospitals' submission on all claims to be priced using the APR DRG method. The Department requires hospitals to document a valid Present on Admission (POA) indicator for each inpatient diagnosis, pursuant to CMS regulations in 42 CFR §412. The Department uses POA definitions as outlined by CMS, described in MLN Matters Number 5499. If the presence of a HAC would increase payments, the Department will not provide additional reimbursement for the treatment of the acquired conditions.

(m) Exempted Services and Providers

(i) Wyoming's APR DRG system as implemented on February 1,2019, will not apply to rehabilitation claims which will continue to be reimbursed using a per diem payment as described in Section 9 of this document.

(ii) Eligible transplant services will be reimbursed at a level that covers the provider's eligible costs for the transplant services as calculated using billed charges and the most recently available provider-specific cost-to-charge ratios developed annually by the Department as part of the Department's Medicaid hospital supplemental payment policy calculations.

(n) Interim Claims. Acute care hospitals reimbursed through the APR DRG method will not be allowed to submit interim claims.

(o) Prior Authorization. The Department will still require prior authorization for rehabilitation, psychiatric, transplant, and other services determined by the Department and communicated services through provider manuals or other updates.

Section 9. Payment for Rehabilitation Claims

(a) Rehabilitation services are covered services furnished to an individual with a primary diagnosis for rehabilitation therapy. All rehabilitation services must be prior authorized by the Department.

(b) Payment shall be comprised of a per diem rehabilitation operating cost payment and a per diem capital cost payment, as determined for purposes of the 2010 rehabilitation level of care rebasing.

(i) A description of the capital payment calculation is located in Section 13.

(ii) The Department determined the per diem rehabilitation operating cost payment as the hospital-specific average cost per diem as calculated for purposes of the 2010 rehabilitation level of care rebasing.

(c) The Department calculated the allowable cost of each rehabilitation claim for each participating hospital (as identified for purposes of the 2010 rehabilitation level of care rebasing) using hospitals' as-filed Medicare cost reports for hospital fiscal years ending in state fiscal years 2005 and 2006 and hospitals' inpatient claims paid in state fiscal years 2006 and 2007 (base period). Medical education costs were not considered allowable.

(d) The Department identified base period allowable costs as the sum of routine per diem costs and ancillary service costs.

(iii) Base period allowable costs were inflated forward from the date of service to the midpoint of SFY 2007 using the CMS-PPS Hospital Market Basket.

(iv) The Department determined the number of days of rehabilitation services provided by each hospital from the adjusted base period claims data.

(v) The Department calculated a cost per day for each hospital for rehabilitation services.

A. For each hospital, the Department divided total costs for rehabilitation services in the base period by total days from the base period claims data.

B. High and low-cost Medicaid outlier costs were identified for rehabilitation costs per diem.

C. The Department determined the base period allowable Medicaid cost per diem for rehabilitation services for each hospital by subtracting high and low-cost Medicaid outliers from the costs determined in paragraph (A).

(vi) The Department calculated a ventilator payment per day for qualifying services not to exceed a fixed amount per diem. The ventilator payment was calculated as an incremental cost of rehabilitation services when a patient is receiving ventilator services.

(vii) The Department calculated the ventilator payment per day to reflect the difference in resources used to provide rehabilitation services to patients with more intensive rehabilitation needs, as measured by an examination of prior year's claims, the relative weights for rehabilitation services under the Medicare MS-DRG methodology and research about other states' payment methodologies.

(e) Reimbursement of non-participating hospitals

i. The Medicaid payment rate for the rehabilitation services will be the average payment rate for all participating providers.

ii. The Medicaid payment rate for non-participating hospitals shall not include reimbursement for capital costs.

(f) The Department will accept interim claims for inpatient rehabilitation services.

Section 10. Reimbursement of New Hospitals.

(a) The Medicaid APR DRG base rate for new hospitals shall be the APR DRG base rate for "other providers" as described in Section 8(h)(iii)(C).

(b) The Medicaid rehabilitation payment rate for new hospitals shall be the average rehabilitation per diem payment for all participating providers.

(c) The Medicaid payment rates for new hospitals shall remain in effect until the APR DRG system or the rehabilitation per diem payment is rebased.

Section 11. Reimbursement of Merged Hospitals. The Medicaid allowable APR DRG and rehabilitation payment for a merged hospital shall be:

(a) The APR DRG and rehabilitation payment rates of the surviving hospital;

(b) A capital payment (if applicable):

i. For rehabilitation services, the capital payment shall be the statewide capital payment per diem amount as described in section 13.

ii. For services reimbursed via the APR DRG method and with last date of service prior to October 1, 2023, the capital payment shall be the statewide per-discharge amount as described in section 13.

Section 12. Exempt Hospitals.

(a) Exempt hospitals are defined as State-owned mental health institutes in Wyoming, for which the Department shall reimburse their reasonable costs.

(b) The Department shall reimburse State-owned mental health institutes using an all-inclusive per diem rate determined on an annual basis.

i. Interim rates. At the beginning of each State fiscal year, the Department shall determine an interim rate using the costs reported in the most recent available Medicare cost report. The rate shall be calculated by dividing total allowable costs by total days.

ii. Final rates. Upon receipt of the settled Medicare cost report for the same fiscal period covered by the most recently available cost report in (i), the Department shall calculate the final rates by dividing total allowable costs by total days.

iii. Retroactive adjustment. The final rates shall be established to cover one hundred per cent of the total allowable costs to treat Medicaid clients. If final rates are greater than the interim rates, the Department shall pay each hospital the difference between the final and interim rates. If final rates are less than the interim rates, the Department shall recover any overpayments pursuant to Section 21 of this Attachment.

Section 13. Reimbursement of Capital Costs.

(a) Capital payment for eligible APR DRG services with last date of service prior to October 1, 2023:

i. The Department will use the per discharge capital payment rate determined for non-rehabilitation levels of care during the 2010 level of care rebasing.

ii. The Department calculated the allowable capital cost for each participating hospital using hospitals' as-filed Medicare cost reports for hospital fiscal years ending in state fiscal years 2005 and 2006 and hospitals' inpatient claims paid in state fiscal years 2006 and 2007.

iii. The Department calculated a capital cost per discharge for each participating hospital included in the 2010 level for care rebasing by dividing total capital costs by total discharges based on the data identified in (i).

iv. The Department arrayed the average capital cost per discharge of all participating hospitals and selected the median capital cost per discharge for the capital payment rate for all participating hospitals.

v. Effective January 1, 2021, the Department reduced this payment by 2.5% based on legislative direction.

(b) For eligible APR DRG services with last date of service on or after October 1, 2023, funds previously used for capital payments have been incorporated into DRG payments and no separate capital payment will be assigned.

(c) Capital payment for eligible rehabilitation services –

i. The Department will use the per discharge capital payment rate determined for the rehabilitation level of care during the 2010 level of care rebasing.

ii. The Department identified the per diem capital payment by dividing the median capital cost per discharge as calculated in subparagraph (a) by the average length of stay of all participating hospitals included in the 2010 level of care rebasing with rehabilitation services discharges.

iii. The capital payment amount for rehabilitation services shall not exceed the per discharge amount calculated in subparagraph (a),

(d) An adjustment to a provider's capital rate pursuant to subsection (e) will not result in the redetermination of the statewide average prospective capital rate.

(e) No capital payment shall be made to non-participating providers.

(f) Adjustments to capital rates. A provider may request an adjustment of its capital rate pursuant to Section 22 only to:

i. Compensate for capital expenditures resulting from extraordinary circumstances. Extraordinary circumstances result from a catastrophic occurrence, beyond the control of a hospital, which results in substantially higher costs and which meets the criteria of (A) through (E). An extraordinary circumstance includes, but is not limited to, fire, earthquakes, floods or other natural disasters, and which:

(A) Is a one-time occurrence;

(B) Could not have reasonably been predicted;

(C) Is not insurable;

(D) Is not covered by federal or state disaster relief; and

(E) Is not the result of intentional, reckless or negligent actions or inactions by any director, officer, employee or agent of the provider.

ii. A redetermination pursuant to this subsection will be effective thirty days after the Department issues a notice of rate adjustment.

iii. The statewide base year capital rate will not be adjusted to reflect adjustments to hospital-specific rates pursuant to this subsection.

(g) Capital rates shall not be inflated.

Section 14. Reimbursement of Swingbed Services. Reimbursement for swingbed services shall be pursuant to Wyoming Medicaid Rule Chapter 28.

Section 15. Third-Party Liability.

(a) Submission of claims. Claims for which third-party liability exists shall be submitted in accordance with Wyoming Medicaid Rule Chapter 35.

(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 Attachment.

Section 16. Preparation and Submission of Cost Reports.

(a) Time of submission. Each hospital must submit a complete cost report to the Medicare intermediary in accordance with Medicare requirements.

(b) Preparation of cost reports. Cost reports shall be prepared in conformance with Medicare requirements.

(c) Submission of additional information. The Department may request, in writing, that a hospital submit information to supplement its cost report. The hospital shall submit the requested information within thirty days after the date of the request.

(d) Failure to comply with this Section. The failure of a hospital to comply with the provisions of this Section shall result in the immediate suspension of all Medicaid payments to the hospital and all Medicaid payments under review shall be repaid to the Department within ten days after written request for such payment. The suspension of payments shall continue until the hospital complies with this Section. Upon the Department's receipt of all information required by this Section, payments will be reinstated, without interest. This remedy does not affect the Department's right to withhold payments, terminate provider participation or invoke other remedies permitted by applicable statutes and rules. If the hospital cannot comply with this section because of delay caused by the intermediary, the hospital must submit verification of the delay from the intermediary on or before the designated date. In such a case, the Department shall not withhold payments.

Section 17. Audits.

(a) Field audits. The Department or CMS may perform a field audit of a provider at any time to determine the accuracy and reasonableness of cost reports, the accuracy of cost settlements or whether the hospital has received overpayments.

(b) Desk reviews. The Department or CMS may perform a desk review of a provider at any time to determine the accuracy and reasonableness of cost reports, the accuracy of cost settlements or whether the hospital has received overpayments.

(c) The Department or CMS may perform field audits or desk reviews through employees, agents, or through a third party. Audits shall be performed in accordance with Generally Accepted Auditing Standards (GAAS).

(d) Disallowances. If a field audit or desk review discloses non-allowable costs or overpayments, the Department shall recover any overpayments pursuant to Section 21 of this Attachment.

(e) Notice of overpayments. After determining that a provider has received overpayments, the Department shall send written notice to the provider, by certified mail, return receipt requested, stating the amount of the overpayments, the basis for the determination of overpayments and the provider's right to request reconsideration of that determination pursuant to Section 22. The reconsideration shall be limited to whether the Department has complied with the provisions of this Attachment.

(f) Recovery of overpayments. A provider must reimburse the Department for overpayments within thirty days after the provider receives written notice from the Department pursuant to subsection (e), even if the provider has requested reconsideration or an administrative hearing regarding the determination of overpayments. If the provider fails to timely repay overpayments, the Department shall recover the overpayments pursuant to Section 21.

(g) Reporting audit results. If at any time during a financial audit or a medical audit, the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to HCF's final audit report regarding that provider, shall be referred to the Medicaid Fraud Control Unit of the Wyoming Attorney General's Office.

Section 18. Rebasing. The Department shall rebase rates when the rates determined pursuant to this Attachment no longer meet the requirements of the Social Security Act. The Department has the discretion to update rates based on changes to hospital peer groups, hospital billing practices or changes in hospital operations, or updates in DRG codes.

Section 19. Payment of Claims.

(a) Payment of claims shall be pursuant to Wyoming Medicaid Rule Chapter 3, Section 11, which is incorporated by this reference.

(b) The failure to obtain prior authorization or admission certification shall result in a technical denial.

Section 20. Partial Eligibility

(a) The Department maintains a partial eligibility policy in which providers submit claims only for days the recipient is an eligible Medicaid recipient.

(b) The claim admit date is the actual admit date, and the number of days billed includes only the dates for which the recipient is eligible even if s/he stayed longer.

Section 21. Recovery of Overpayments. The Department shall recover overpayments pursuant to Wyoming Medicaid Rule Chapter 16, which is incorporated by this reference. The Federal share of payments made in excess will be returned to CMS in accordance with 42 CFR Part 433, Subpart F.

Section 22. Reconsideration. A provider may request reconsideration of the decision to recover overpayments pursuant to the provisions of Wyoming Medicaid Rule Chapter 16.

Section 23. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, any other agency of the federal, state or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments or take any other final action authorized by this Attachment.

Section 24. Interpretation of Attachment.

(a) The order in which the provisions of this Attachment appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Attachment shall control the titles of various provisions.

Section 25. Superseding Effect. This Attachment supersedes all prior Attachments or policy statements issued by the Department, including manuals and bulletins, which are inconsistent with this Attachment, except as otherwise specified in this Attachment.

Section 26. Severability. If any portion of this Attachment is found to be invalid or unenforceable, the remainder shall continue in effect.

Inpatient Hospital Medicare Part A Cross Over Reimbursement

1. Medicare Part A Deductible and Coinsurance - Services covered in the Medicaid State Plan.

   Wyoming Medicaid covers the Medicare Part A deductible and coinsurance up to the Medicaid Fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the lesser of:

   - The coinsurance and deductible up to the Medicare Part B deductible and coinsurance billed, OR
   - The Medicaid Fee less any amounts paid by Medicare.

   Exception to method above, if the method described above results in no payment for physician administered pharmaceuticals, then the state will pay at least $0.01 for the physician administered pharmaceutical.

   Medicare cross over claims do not count toward the service cap limits referenced in Section 4 of the Wyoming Medicaid State Plan.

   Wyoming Medicaid covers the Part A deductible and coinsurance for QMB, QMB Plus, and Full Benefit Dual Eligibles who are not eligible as QMBs.

   Medicaid does not cover Medicare Part A deductible and coinsurance for the QI1 or SLMB.

2. Medicare Part A deductible and coinsurance - Medicaid non-covered services.

   For purposes of determining payment for Medicare Part A deductible and coinsurance, Wyoming Medicaid calculates the Medicaid Fee for Medicaid non-covered services using 50 percent of the Medicare allowed amount.

   Wyoming Medicaid covers the Medicare Part A deductible and coinsurance for non-covered services up to the calculated Medicaid Fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the lesser of:

   - The coinsurance and deductible up to the Medicare Part A deductible and coinsurance billed, OR
   - The calculated Medicaid Fee less any amounts paid by Medicare.

   Exception to method above, if the method described above results in a Medicaid payment of $0 and the claim contains lines billed for physician administered pharmaceuticals, the state will authorize payment of $0.01 on the pharmaceutical claim line.

   Medicare cross over claims do not count toward the service cap limits referenced in Section 4 of the Wyoming Medicaid State Plan.

Wyoming Medicaid covers the Medicare Part A and Part B deductible and coinsurance for non-covered Medicaid services only for QMB and QMB plus.

For Full Benefit Dual Eligibles who are not eligible as QMBs, Wyoming Medicaid limits Medicare cost sharing to only those services covered in the Medicaid State Plan.

Wyoming Medicaid does not cover the Medicare Part A or Medicare Part B deductible and coinsurance for QI1 and SLMB.

3. Combined payments shall not exceed the amount Medicaid would have paid had it been the sole payer.

   The financial obligations of Medicaid for services are based upon Medicare' s allowable, not the provider' s charge. Medicaid will not pay any portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid had it been the sole payer. Medicaid shall not pay on the claim if Medicare' s payment is greater than what Medicaid would have paid had Medicaid been the sole payer.

   Exception to method above, if the method described above results in a Medicaid payment of $0 and the claim contains lines billed for physician administered pharmaceuticals, the state will authorize payment of 0. 01 on the pharmaceutical claim line.

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

Wyoming Medicaid meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Wyoming Medicaid will adopt the baseline health care-acquired conditions as described above for inpatient hospital reimbursement:

(i) For any Wyoming Medicaid claims with dates of service after October 1, 2011, Wyoming Medicaid will follow the minimum CMS regulations in 42 CFR §447 and deny payment for all of the health care-acquired conditions identified in 42 CFR §447. Denial of payment shall be limited to the additional care required by the provider preventable condition.

(ii) Wyoming Medicaid will review discharges relating to provider preventable conditions and make use of the "Present on Admission" indicator to identify health care-acquired conditions and deny reimbursement for any service associated with treating the health care-acquired condition. For discharges with a health care-acquired condition, Wyoming Medicaid will request that the hospital resubmit the claim identifying all charges associated with the health care-acquired condition as non-covered. Wyoming Medicaid will determine the total

(iii) payment (discharge payment plus outlier payment) for the covered portion of the claim and compare this payment to prior payment of the claim. If the total payment is less than what was originally paid for the claim, then Wyoming Medicaid will request a refund from the hospital for the difference. Denial of payment shall be limited to the additional care required by the provider preventable condition. Wyoming Medicaid requires hospitals to document a valid Present on Admission (POA) indicator for each inpatient diagnosis, pursuant to CMS regulations in 42 CFR §412. Wyoming Medicaid uses POA definitions as outlined by CMS, described in MLN Matters Number 5499, and detailed at: http://cms.hhs.gov/Transmittals/downloads/R1240CP.pdf

(iv) Wyoming Medicaid shall not pay the approved inpatient hospital rates, or any other hospital payments including disproportionate share and qualified rate adjustments pursuant to Attachment 4.19A, Parts 1 and 2, for provider preventable conditions that are identified as non-payable by CMS. Wyoming Medicaid shall not be liable for payment of any services related to provider preventable conditions that are identified as non-payable by CMS.

(v) Wyoming Medicaid shall review from time to time the list of provider preventable conditions and add to the list in the event that Wyoming Medicaid makes a medical finding using evidence-based guidelines. In such an event, the Department shall disseminate to providers, through manuals or bulletins, a current list of provider preventable conditions pursuant to this Attachment.

In compliance with 42 CFR 447.26(c), Wyoming Medicaid provides:

1) That no reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

2) That reductions in provider payment may be limited to the extent that the following apply:

(i) The identified provider-preventable conditions would otherwise result in an increase in payment.

(ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

3) Assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under Section(s) 4.19(A) :

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Wyoming Medicaid will adopt the baseline for other provider-preventable conditions as described above. The following reimbursement changes will apply:

Payment will be denied for these conditions in any Health Care Setting as identified in Attachments 4.19(A) and any other settings where these events may occur. For any Wyoming Medicaid claims with dates of service after July 1, 2012, Wyoming Medicaid will follow the minimum CMS regulations in 42 CFR §447 and deny payment for all of the OPPCs identified in 42 CFR §447. In the event that individual cases are identified throughout the PPC implementation period, the State will adjust reimbursements according to the methodology above. Denial of payment shall be limited to the additional care required by the provider preventable condition. Wyoming Medicaid shall review from time to time the list of OPPCs and add to the list in the event that Wyoming Medicaid makes a medical finding using evidence-based guidelines. In such an event, the Department shall disseminate to providers, through manuals or bulletins, a current list of provider preventable conditions pursuant to this Attachment.

____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-New. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Qualified Rate Adjustment (QRA) Payments

A hospital located in Wyoming may be eligible for an inpatient Qualified Rate Adjustment (QRA) payment if:

1. It is owned or operated by a non-state governmental entity; and

2. Its calculated inpatient Medicaid Upper Payment Limit (UPL) for the payment period is greater than its total projected pre-QRA inpatient Medicaid claim Allowed Amount for the same period.

The QRA payment is an annual lump sum supplemental payment equal to a portion of the difference between a qualifying hospital's calculated Medicaid Upper Payment Limit (UPL) for the payment period and its pre-QRA Medicaid Allowed Amount for the same period. This difference is referred to as the "UPL gap." If a hospital's UPL gap is negative (that is, total Medicaid inpatient claim Allowed Amount is greater than the hospital's Upper Payment Limit), then their QRA payment will be zero. The sum of the Medicaid claim Allowed Amounts and the QRA payments will not exceed Medicaid Upper Payment Limits for any UPL category as defined in 42 CFR, Section 447.272. If one or more hospitals within a UPL category have claim Allowed Amounts greater than their Upper Payment Limits, then QRA payments are reduced proportionately so that total Medicaid payment for the hospitals in that UPL category does not exceed the UPL for that category. QRA payments will not be subject to cost settlement.

Please see Attachment 4.19-A, Part 1, for a description of the calculation of hospital inpatient Upper Payment Limits.

PRIVATE HOSPITAL SUPPLEMENTAL (PHS) PAYMENT – INPATIENT

I. Subject to the provisions of this section, a privately owned and operated hospital located in Wyoming shall be eligible for a private hospital supplemental payment each quarter (based on a yearly calculation) to compensate such hospitals for the costs of covered hospital inpatient services furnished to Wyoming Medicaid patients.

II. The amount available within the Private Hospital Supplemental Payment pool will equal the aggregate Upper Payment Limit (UPL) gap for privately owned and operated hospitals. The UPL gap is calculated to be the total of the difference between the Allowed Amount that would have been calculated under Medicare payment principles in accordance with 42 CFR 447.272 (Upper Payment Limit) and the Medicaid Allowed Amount calculated for such services by the Medicaid agency.

III. A privately owned and operated hospital may be eligible for a PHS payment if its calculated UPL gap prior to applying supplemental payments is positive (that is, if the UPL is greater than estimated Medicaid Allowed Amount for the payment period). If a hospital's UPL gap is negative, the hospital's PHS payment will be zero.

Private hospital inpatient supplemental payment will be equal to a percentage of each hospital's UPL gap based on each hospital's UPL gap as a proportion of the aggregate UPL gap for all private hospitals. If one or more hospitals within the Private Hospital UPL category have claim Allowed Amounts greater than their Upper Payment Limits, then PHS payments are reduced proportionately so that total Medicaid payment for the hospitals in the Private Hospital UPL category does not exceed the UPL for this category. Please see the table below for an example.

	Inpatient UPL Available for Payment			**Inpatient Supplemental Payments**	
Hospital	**Medicaid Deficit**	**Medicaid Payments Exceeding UPL**	**Amount Available for UPL Payments**	**Inpatient Payment Distribution Percentage**	**Total Inpatient Supplemental Payment**
	A	B	C = B – A	D = C / A	E
Hospital A	100,000	–	100,000		85,000
Hospital B	200,000	–	200,000		170,000
Hospital C	300,000	–	300,000		255,000
Hospital D	400,000	–	400,000		340,000
Hospital E	–	150,000	(150,000)		–
Total	**1,000,000**	**150,000**	**850,000**	**85.00%**	**850,000**

Aggregate payments to private hospitals, including claim payments and all private hospital supplemental payments shall not exceed the Medicaid UPL as defined in 42 CFR 447.272.

IV. Private hospital supplemental payments will be distributed in equal quarterly lump sum payments.

Please see Attachment 4.19-A, Part 1 for a description of the calculation of hospital inpatient Upper Payment Limits and UPL gap.

INPATIENT HOSPITAL UPPER PAYMENT LIMIT CALCULATION

I. Overview of Wyoming Medicaid's Upper Payment Limit Methodology

The following describes the methodology for creating Wyoming Medicaid's hospital inpatient Upper Payment Limit (UPL) demonstration to comply with the Centers for Medicare and Medicaid Services' (CMS') annual UPL demonstration requirements. UPL demonstrations require a comparison of rate-year (a.k.a. "demonstration year") Medicaid payment to an estimate of rate-year Medicare payment for Medicaid reimbursable services provided to Medicaid recipients. The estimate of rate-year Medicare payment is referred to as the Upper Payment Limit or "UPL amount." The Wyoming Department of Health performs a prospective UPL demonstration, using claim data from a base year that aligns with each hospital's most currently available cost report and applies rate-year Medicaid and estimated Medicare pricing to these claims. The UPL test is performed by comparing rate-year Medicaid and estimated Medicare payments by provider class – State-Owned, Non-State Government Owned, and Private. If the Medicaid payments for those services are equal to or less than the reasonable estimate of what would have been paid using Medicare payment principles, the State meets the UPL test.

For hospital inpatient services, the State uses Medicare Inpatient Prospective Payment System (IPPS) grouping and pricing for the UPL amount for hospitals reimbursed by Medicare using the Medicare IPPS. For hospitals not reimbursed by Medicare using the Medicare IPPS (such as Critical Access Hospitals, free-standing psychiatric hospitals, and free-standing rehabilitation specialty hospitals), the State estimates what would have been paid using Medicare payment principles by calculating 100 percent of reasonable costs for non-CAHs and 101 percent of reasonable cost for CAHs. For the inpatient DRG method, Medicare Direct Medical Education payments are retrieved from the hospital cost report and added to the inflated Medicare claim payments to get the UPL amount. For the cost method, the Medicaid portion of hospital Provider Assessment costs are added to inflated claim costs to get the UPL amount.

If Wyoming Medicaid rates have not changed between the base year and the rate year, then the Allowed Amount on the base year claims is used as the Medicaid payment amount for purposes of the UPL demonstration. If the Wyoming Medicaid inpatient rates have increased between base year and the rate year, then estimated hospital cost on each claim is inflated from the mid-point of the base year to the mid-point of the rate year (for DRG outlier calculations) and then the inpatient claims are repriced using the rate year pricing parameters. In addition, the State includes Qualified Rate Adjustment (QRA) supplemental and Private Hospital Supplemental (PHS) payments in the total Medicaid payments for the rate year.

II. Overview of Assignment of Provider Class

The provider classes are: State owned or operated, non-state government owned or operated and privately owned or operated. Wyoming Medicaid uses forms providers submit to request consideration for QRA payment to determine provider ownership. Wyoming has only one State hospital, Wyoming State Hospital, which is an institution for mental disease. This hospital has not provided acute inpatient services to Medicaid recipients, except those who are dually eligible for Medicare and Medicaid. Therefore, this hospital is not included in the UPL calculations. In the UPL demonstration spreadsheets, we group providers appropriate UPL categories based on ownership type.

III. Estimating Hospital Cost on Medicaid Claims

(a) Collect cost report data: Extract total hospital costs, capital costs, medical education costs, ancillary service charges and costs and patient days from the Medicare cost reports, as follows:

i. Worksheet S-3 – patient days. For inpatient, exclude days not directly associated with acute inpatient services such as days from a skilled nursing facility and swing beds.

ii. Worksheet B Part I – operating costs, capital costs and medical education costs for major departmental services. For inpatient, exclude costs not directly associated with acute inpatient services such as costs from a skilled nursing facility and swing beds.

iii. From Worksheet C Part I – Respiratory Therapy/Physical Therapy (RT/PT) adjustments, Reasonable Compensation Equivalent (RCE) disallowances, routine and ancillary department charges and costs for the same departmental services as Worksheet B Part I.

(b) Calculate routine cost per diems for routine cost centers, cost center lines 30 – 43. The cost per diems are calculated for each unique routine hospital cost center.

i. Identify routine services using cost center lines 30 – 43 from the Medicare cost report (Worksheets B and C).

ii. Map the cost center lines to routine hospital cost centers.

iii. Develop cost per diems for inpatient routine services by cost center using the following formula:

$$\text{Routine Cost Per Diem} = \frac{\text{Subtotal costs (Worksheet B, Part I, Column 24) less non-physician anesthetist costs (Worksheet B, Part I, Col 19)}}{\text{Days (Worksheet S-3, Part I, Column 8)}}$$

(c) Calculate cost-to-charge ratios for ancillary services. Ancillary services are those services reported in cost center lines 50 – 97, with some exceptions within that range such as services and

drugs provided in the home. Ancillary cost report lines are mapped to ancillary hospital cost centers, and a cost-to-charge ratio is calculated for each unique hospital cost center.

i. Identify ancillary services using cost center lines 50 – 97 from the Medicare cost report (Worksheets B and C). Exclude those cost centers that do not represent inpatient hospital services, such as the cost center "Federally Qualified Health Center."

ii. Map the cost report lines to ancillary hospital cost centers.

iii. Develop cost-to-charge ratios for inpatient ancillary services by cost center using the following formula for all services except observation beds (cost center 92):

$$\text{Cost-to-Charge Ratio} = \frac{\text{Subtotal costs (Worksheet B, Part I, Column 24) less non-physician anesthetist costs (Worksheet B, Part I, Col 19) plus RT/PT (Worksheet C, Part I, Column 2)}}{\text{Charges (Worksheet C, Part I, Column 8)}}$$

iv. Develop cost-to-charge ratios for inpatient ancillary services for observation beds (cost center 92):

$$\text{Cost-to-Charge Ratio} = \frac{\text{Subtotal costs (Worksheet C, Part I, Column 5) less non-physician anesthetist costs (Worksheet B, Part I, Col 19) less RCE Disallowance (Worksheet C, Part I, Column 4)}}{\text{Charges (Worksheet C, Part I, Column 8)}}$$

v. Determine a provider summary cost-to-charge ratio; use this ratio where a cost center-specific cost-to-charge ratio does not exist for a cost center identified in the provider's claims data (the provider summary cost-to-charge ratio equals the ratio of aggregate ancillary costs to charges).

vi. Capital and non-intern and resident medical education costs, if reported by the provider, are included in the cost per diems and the cost-to-charge ratios.

(d) Estimate reasonable costs for inpatient hospital claim service lines.

i. Identify charges using field "Submitted Charges" on Wyoming Medicaid claim service line data and exclude non-covered charges.

ii. Assign a hospital cost center to each claim line based on revenue code.

iii. For routine (per diem) cost centers, estimate costs by multiplying service line paid units of service by the corresponding provider and cost center-specific cost per diem. Routine (per diem) cost centers are between "30" and "43," inclusive.

iv. For ancillary cost centers, estimate costs by multiplying service line item charges by the corresponding provider and cost center-specific cost-to-charge ratio. Ancillary cost centers

are between "50" and "118," inclusive.

v. Inflate costs from the midpoint of the hospital's cost report period to the midpoint of UPL demonstration year.

(e) Estimate the costs of the Private Hospital Provider Tax for inpatient services. CMS allows the cost of the Medicaid portion of a provider tax to be included in the UPL calculation when using a cost-based methodology. The Private Hospital Provider Tax in Wyoming is assessed at an aggregate level for all inpatient services based on net patient revenues from the Medicare cost report. Because the patient revenues represent those from the entire hospital, we distribute the resulting assessment specifically to Medicaid as well as distribute it between inpatient and outpatient services.

i. Calculate the annual assessment by hospital by multiplying the patient revenues from the cost report, found in Worksheet G-3 Line 3, by the assessment rate.

ii. Calculate the percentage of total assessment payments attributed to inpatient and outpatient services.

iii. Multiply the total assessment amounts by the inpatient and outpatient assessment payment percentages to get separate inpatient and outpatient assessment amounts.

iv. Multiply the resulting annual inpatient assessment amount by the provider's Medicaid Inpatient Utilization Rate (MIUR) to get the provider tax costs applicable to the inpatient Medicaid services.

IV. Calculation of UPL Amount on Medicaid Claims Using Medicare DRG Method

(a) Run claims through Medicare Inpatient Prospective Payment System (IPPS) grouper/pricer software; claims are grouped and priced using the MS-DRG version and pricing parameters applicable for the federal fiscal year which contains the date of discharge on the claim. This is done to allow use of grouping/pricing schedules built into the software.

(b) Calculate Medicare case mix per hospital by computing the average MS-DRG relative weight on the hospital's inpatient claims from the base year.

(c) Separate out components of the Medicare IPPS claim price that are case mix adjusted versus those that are not case mix adjusted.

i. Case mix adjusted components are:

(A) Total Operating Payment

(B) Total Capital Payment

(C) Low Volume Add-On Payment

(D) Hospital Readmission Reduction

(E) HAC Program Reduction

(F) Value Based Adjustment

ii. Non-case mix adjusted components are:

(A) Pass Through Payment

(B) New Technology Payment

(C) Hemophilia Add-On Payment

(D) Clinical Trial Payment

(E) Uncompensated Care Disproportionate Share Hospital Payment

(d) Inflate Medicare IPPS claim payment.

i. Determine inflation factor for the mid-point of the federal fiscal year containing the claim date of discharge (Inflation Factor A)

ii. Determine inflation factor for the mid-point of the federal fiscal year that most overlaps with the UPL demonstration rate year (Inflation Factor B)

iii. Determine Claim Inflation Factor as (Inflation Factor B) / (Inflation Factor A)

iv. Multiply Uninflated Medicare IPPS claim payment by the Claim Inflation Factor

(e) Retrieve supplemental Medicare Direct Medical Education payment for the hospital's cost report. This amount is retrieved from Worksheet E, Part A, Line 52, Column 1.

(f) Sum inflated Medicare IPPS claim payment by provider then add supplemental Medicare Direct Medical Education payment to get the hospital's inpatient UPL amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
WYOMING
REIMBURSEMENT OF DISPROPORTIONATE SHARE HOSPITALS

Section 1 Authority

This Chapter 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) These rules have been adopted to govern disproportionate share payments made on or after its effective date. This Chapter is intended to implement the Department's responsibility to make disproportionate share payments under Section 1923 of the Social Security Act, codified at 42 U.S.C. § 1396r-4. Hospital services are also subject to the provisions of Chapters 4, 8, 9, 30, 31 and 33 of the Department's Medicaid Rules, and Attachment 4.19A, except as otherwise specified in this Attachment.

(b) The Department may issue manuals, bulletins, or both to interpret the provisions of these rules and regulations. Such manuals and bulletins shall be consistent with and reflect the policies contained in these rules and regulations. The provisions contained in manuals or bulletins shall be subordinate to the provisions of these rules and regulations.

(c) The incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of these rules and regulations

Section 3. General Provisions.

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

(b) General methodology. Disproportionate share hospitals receive an annual payment after the year end settlement of the hospital's cost report. The hospital's eligibility for and the amount of any disproportionate share payment shall be determined pursuant to this Chapter

(c) The Department shall calculate disproportionate share payments after the state fiscal year end and make payments prior to the end of that same calendar year.

(d) Disproportionate share payments shall not be redetermined because of changes that result from a reopening, redetermination, administrative hearing, settlement agreement, or other change in a hospital's allowable costs.

Section 4. Disproportionate share payment.

(a) In addition to the payment rates established pursuant to Chapters 30 and 49, a disproportionate share hospital shall be entitled to a disproportionate share payment computed pursuant to this section.

(b) Determination of eligibility for disproportionate share hospital payment. To be eligible for disproportionate share hospital payment a hospital must meet both of the following criteria:

(i) Have a Wyoming Medicaid utilization rate of not less than five percent (5%), defined as the percentage resulting from dividing Medicaid patient days by total patient days, based on the most current available information; and

(ii) Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the Medicaid State Plan. In the case of a hospital located in a rural area (that is, an area located outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budget), the "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(c) Determination of the Medicaid payment deficit.

(i) For each disproportionate share hospital, the Department shall determine total hospital payments for covered services as follows:

(A) Calculate a hospital's inpatient and outpatient Medicaid payments for furnishing covered services during a payment period;

(B) Calculate any amounts payable to the hospital by other third parties and beneficiaries for Medicaid covered services during a payment period;

(C) Calculate all hospital supplemental payments pursuant to Chapter 49.

(D) The results of (A), (B) and (C) shall be summed to determine the total payments for covered services for each hospital.

(ii) For each disproportionate share hospital, the Department shall determine hospital Medicaid costs as follows:

(A) Calculate the hospital-specific ancillary department cost-to-charge ratios using the hospital's most recently available Medicare cost report;

(B) Inflate hospital ancillary billed charges to the midpoint of the payment period using the CMS-PPS Hospital Market Basket index.

(C) Multiply the cost-to-charge ratios by the hospital's inflated billed charges reported on Medicaid claims paid during the most recently ended State fiscal year.

(D) Calculate hospital-specific routine department per diems using the hospital's most recently available Medicare cost report;

(E) Inflate hospital-specific routine department per diems to the midpoint of the payment period using the CMS-PPS Hospital Market Basket Index.

(F) Multiply the inflated routine per diems by the number of days reported on Medicaid claims paid during the most recently ended State fiscal year.

(G) Sum the product determined in (c)(ii)(C) and (c)(ii)(F) to determine a hospital's allowable Medicaid costs for furnishing covered services during the most recently completed payment period.

(iii) For each disproportionate share hospital, the Department shall determine the Medicaid payment deficit as the difference between total payments in (c)(i)(D) and Medicaid costs of services in (c)(ii)(G)

(d) Determination of hospital-specific preliminary disproportionate share hospital payment allocation For each disproportionate share hospital, the Department will calculate a preliminary disproportionate share hospital payment as follows

(i) Calculate the ratio of the hospital's Medicaid payment deficit to the hospital's total payments to determine the hospital-specific Medicaid payment deficit percentage

(ii) Calculate a percentage, to represent each disproportionate share hospital's payment deficit as a percentage of all disproportionate share hospitals' payment deficits, by dividing the hospital-specific Medicaid payment deficit percentage by the sum of all disproportionate share hospitals' Medicaid payment deficit percentages.

(iii) Multiply the percentage obtained in (d)(ii) by Wyoming's federal fiscal year allotment for disproportionate share hospital to determine a hospital's preliminary disproportionate share hospital allocation

(e) Determination of preliminary hospital-specific disproportionate share hospital upper limit. For each disproportionate share hospital, the Department will test hospital-specific disproportionate share hospital payment allocations using the hospital-specific disproportionate share hospital upper limit as follows

(i) Sum total payments from (c)(i)(D) and the initial disproportionate share hospital allocation from (d)(iii) and compare the total to Medicaid costs determined in (c)(ii)(G)

(A) If a disproportionate share hospital's Medicaid costs as calculated in (c)(ii)(G) are greater than the sum of total payments as calculated in (c)(i)(D) and the disproportionate share hospital allocation for the hospital as calculated in (d)(iii), then the hospital has not exceeded the hospital-specific disproportionate share hospital upper limit

(B) If a disproportionate share hospital's Medicaid costs as calculated in (c)(ii)(G) are less than the sum of total payments as calculated in (c)(i)(D) and the disproportionate share hospital allocation for the hospital as calculated in (d)(iii),

share hospital payments up to its hospital-specific disproportionate share hospital upper limit.

(g) In conformity with OBRA '93, the Department will establish disproportionate share payments not greater than each hospital's unreimbursed costs for services rendered to Title XIX patients and uninsured patients. The Department will review cost and payment information annually for each hospital receiving disproportionate share hospital payments to determine conformity with this OBRA '93 requirement. The annual OBRA '93 review will consist of comparing providers' proposed disproportionate share hospital payments to their unreimbursed costs for services rendered to Title XIX patients and uninsured patients If a provider's proposed disproportionate share payments are less than unreimbursed costs, then the provider's disproportionate share payments conform with OBRA '93. If a provider's proposed disproportionate share payments are greater than the provider's unreimbursed costs, the State will reduce the provider's proposed disproportionate share payments to equal the unreimbursed costs The Department will calculate unreimbursed costs by applying provider-specific cost-to-charge ratios to charges for services provided to Title XIX and uninsured patients, and subtracting payments from the costs of those services. For purposes of the cost-to-charge ratio calculation, the Department will use cost and charge data from the same cost reports as those used to calculate the disproportionate share hospital payments.

(h) Disproportionate share payments for hospitals located outside Wyoming

(i) Request. Hospitals certified as disproportionate share hospitals by the Medicaid agency in their home state and meet criteria in subparagraph (b) that wish to be considered for disproportionate share payments, must submit a request for consideration of disproportionate share payments.

(ii) Time and contents of request. A request for disproportionate share payments must be sent to the Department, by certified mail, on or before October 1st of each year. The hospital must submit the correct cost report with the request, if it is available. The hospital must contact the Department before that date to determine which fiscal year's cost report to submit with the request. The failure to timely submit a request, including the correct cost report, if available, shall preclude the hospital from requesting or receiving disproportionate share payment.

(iii) Determination of amount of payment. The amount of the disproportionate share payment shall be that proportion of the amount determined pursuant to subsection (f).

Section 5. Provider Records.

(a) A hospital must comply with Chapter 4, Section 7, which is incorporated by this reference.

(b) Out-of-state records. If a provider maintains financial records or medical records in a state other than Wyoming, 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-of-state location, unless otherwise agreed by the Department.

Section 6. Audits.

(a) The Department may perform audits pursuant to Chapter 30, which is incorporated by this reference.

(b) Reporting audit results. If at anytime during a financial audit or a medical audit, HCF discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to HCF's final audit report regarding that provider, shall be referred to the Medicaid Fraud Unit of the Wyoming Attorney General's Office

(c) The Department shall submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR 455 Subpart D Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments.

a. If based on the audit, the Department determines that there was an overpayment to a provider, the Department immediately shall:

i. Recover the overpayment from the provider pursuant to Section 7.

ii. Redistribute the amount in overpayment to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be distributed pursuant to Section 4 and will be subject to hospital-specific upper payment limits.

Section 7. Recovery of Overpayments. The Department shall recover overpayments pursuant to the provisions of Chapter 16, which are incorporated by this reference.

Section 8. Reconsideration. A provider may request reconsideration of the decision to recover overpayments pursuant to Chapter 16 which is incorporated by this reference

Section 9. Automatic expiration of rule. This Chapter shall automatically expire upon the elimination of Section 1923 of the Social Security Act and/or any other relevant provisions of Federal statutes or regulations.

Section 10. Limitations on DSH payments. Disproportionate share payments shall not exceed the DSH state allotment, except as otherwise required by the Social Security Act. In no event shall the Department be obligated to use State Medicaid funds to pay more than the State Medicaid percentage of DSH payments due a provider.

Section 11. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, any other agency of the federal, state or local government, or a private entity which is capable of performing such

functions, provided that the Department shall retain the authority to impose sanctions, recover excess payments or take any other final action authorized by this Chapter.

Section 12. Interpretation of Chapter.

(a) 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.

(b) The text of this Chapter shall control the titles of various provisions.

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

Section 15. Severability. If any portion of these rules is found to be invalid or unenforceable, the remainder shall continue in effect.

STATE: Wyoming

SELECTIVE CONTRACTING OF SERVICES

Section 1. Authority

This Attachment is prepared and submitted to HCFA for approval pursuant to 42 U.S.C. @ 1396a (b) and 45 C.F.R. Part 201, Subpart A.

Section 2. Purpose and Applicability.

(a) This Attachment shall apply to and govern Medicaid reimbursement of specialty services on or after its effective date.

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

Section 3. General Provisions.

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

(b) General methodology. The Department reimburses providers of specialty services pursuant to contracts with selected providers. Except as otherwise specified by contract, selective services must be provided pursuant to this Attachment.

Section 4. Definitions.

(a) "Admission" or "admitted." The act by which an individual is admitted to a hospital as an inpatient. "Admission" or "admitted" does not include an individual that is transferred from one unit of a hospital to another unit in the hospital or to a distinct part hospital unit.

(b) "Admission certification." The determination of the Division that all or part of a recipient's inpatient hospitalization is or was medically necessary and that Medicaid funds may be used to pay the attending physician, hospital, and other providers of inpatient hospital services for providing medically necessary services, subject to the Department's normal procedures and standards and subject to withdrawal of certification.

(c) "Attachment 4.19A, Part I." Attachment 4.19A, Part 1, Level of Care Inpatient Hospital Reimbursement, of the Wyoming Medicaid State Plan.

(d) "Certified." Approved by the survey agency as in compliance with applicable statutes and rules.

(e) "Chapter I." Chapter 1, Rules for Medicaid Administrative Hearings, of the Wyoming Medicaid rules.

(f) "Chapter 3." Chapter 3, Provider Participation, of the Wyoming Medicaid Rules.

(g) "Chapter 4." Chapter 4, Third Party Liability, of the Wyoming Medicaid Rules.

(h) "Chapter 8." Chapter 8, Inpatient Admission Certification, of the Wyoming Medicaid Rules.

(i) "Chapter 9." Chapter 9, Hospital Services, of the Wyoming Medicaid Rules.

(j) "Claim." A request by a provider for Medicaid payment for covered services provided to a recipient.

(k) "Contract." A written agreement between a provider and the Department in which the provider agrees to provide specialty services pursuant to this Attachment.

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

(m) "Department." The Wyoming Department of Health, its agent, designee or successor.

(n) "Director." The Director of the Department or the Director's designee.

(o) "Division." The Division of Health Care Financing of the Department, its agent, designee or successor.

(p) "Emergency." The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) that referral or transfer of the individual to a contracting provider is impractical, and the absence of immediate medical attention could reasonably be expected to result in:

(i) Placing the patient's health in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part

(q) "Enrolled." A provider that has signed a provider agreement and has been enrolled as a provider with the Division.

(r) "Excess payments." Medicaid funds received by a provider which exceed the Medicaid allowable payment established by the Department.

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

(t) "HHS." The United States Department of Health and Human Services, its agent, designee or successor.

(u) "Hospital." An institution that: (i) is approved to participate as a hospital under Medicare; (ii) is maintained primarily for the treatment and care of patients with disorders other than mental diseases or tuberculosis; (iii) has a provider agreement; (iv) is enrolled in the Medicaid program; and (v) is licensed to operate as a hospital by the State of Wyoming or, if the institution is out-of-state, licensed as a hospital by the state in which the institution is located.

(v) "Inpatient." An "inpatient" as defined by 42 C.F.R. $440.10, which is incorporated by this reference.

(w) "Inpatient hospital service." "Inpatient hospital services" as defined by 42 C.F.R. $ 440.10, which is incorporated by this reference.

(x) "JCAHO." The Joint Commission on Accreditation of Healthcare Organizations.

(y) "Maintenance psychiatric services." Covered extended psychiatric services identified by revenue code 680.

(z) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act and/or the Wyoming Medical Assistance and Services Act. "Medicaid" includes any successor or replacement program created by Congress and/or the Wyoming Legislature.

(aa) "Medical record." All documents, in whatever form, in the possession of or subject to the control of the hospital which describe the recipient's diagnosis, condition or treatment, including, but not limited to, the plan of care for the recipient.

(bb) "Patient." An individual admitted to a hospital or other provider of inpatient hospital services.

(cc) "Physician." A person licensed to practice medicine or osteopathy by the Wyoming State Board of Medical Examiners or a comparable agency in another state, or a person licensed to practice dentistry by the Wyoming Board of Dental Examiners or a comparable agency in another state.

(dd) "Prior authorized." Approval by the Division pursuant to Chapter 3, Section 9, which is incorporated by this reference.

(ee) "Provider." A provider as defined by Chapter 3, Section 3(y), which is incorporated by this reference.

(ff) "Readmission." The act by which an individual is:

(i) Admitted to a provider from which the individual had been discharged;

(ii) On or before the thirty-first day after the previous discharge; and

(iii) For treatment of any diagnosis.

(gg) "Recipient." A person who has been determined eligible for Medicaid.

(hh) "Services." Health services, medical supplies, or equipment.

(ii) "Specialty services." Services identified for selective contracting by the Department and approved by HCFA through appropriate waivers.

(jj) "Survey agency." The Health Facilities Survey, Certification and Licensure Office of the Department, its agent, designee or successor, or a comparable agency in another state.

(kk) "Third party liability." Third party liability as determined pursuant to Chapter 4, which is incorporated by this reference.

Section 5. Provider Participation.

(a) Payments only to providers. Except as otherwise specified in this Attachment, no provider that furnishes specialty services to a recipient shall receive Medicaid funds unless the

provider is certified, unless otherwise specified pursuant to Section 9, 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 specialty services furnished to a recipient must meet the requirements of Chapter 3, Sections 4 through 6, which are incorporated by this reference.

(c) Qualified provider. A provider or group of providers that contracts to provide specialty services must meet the criteria that the Department establishes as part of the selective contracting process.

Section 6. Provider Records.

(a) A provider must comply with Chapter 3, Section 7, which is 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-of-state location, unless otherwise agreed by the Department.

Section 7. Verification of recipient data. A provider must comply with Chapter 3, Section 8, which is incorporated by this reference.

Section 8. Medicaid allowable payment for specialty services.

(a) The Department shall reimburse specialty services through selective contracting with qualified providers. Except as otherwise provided in this Section, only providers that enter a contract with the Department shall be reimbursed for providing specialty services.

(b) All-inclusive rate. Providers of specialty services shall not receive Medicaid reimbursement for furnishing specialty services in addition to the contract rate.

(c) Services that require prior authorization or admission certification. The Division may, as part of the selective contracting process, require prior authorization or admission certification as a prerequisite to Medicaid payment. Failure to obtain prior authorization or admission certification shall result in the denial of Medicaid payment.

Section 9. Contracting process.

(a) Contracting process. The Department shall contract for specialty services as follows:

(i) Identify covered services to be reimbursed as specialty services;
(ii) Identify interested, qualified providers;
(iii) Develop a selective contracting model;
(iv) Solicit proposals using the selective contracting model;
(v) Evaluate proposals and negotiate contracts.

(b) Duration of contracts. Contracts for selective services shall be for twelve months, and may be extended pursuant to the applicable contract.

Section 10. Reimbursement of readmissions. Medicaid shall not reimburse for a readmission if the readmission is for the continuation of treatment begun in the initial admission and the Department determines that the treatment should have been provided during the initial admission.

Section 11. Reimbursement to non-contracting providers.

(a) Medicaid reimbursement for specialty services furnished by non-contracting providers shall be limited to reimbursement for services provided in response to an emergency.

(b) The Medicaid reimbursement rate for specialty services furnished by a non-contracting provider in response to an emergency shall be the average Medicaid rate paid to contracting providers for such services.

(c) Retroactive eligibility. Specialty services furnished by a non-contracting provider to an individual that becomes eligible for Medicaid after the date of admission shall be reimbursed at the average Medicaid rate paid to a contracting provider for the same or similar services.

Section 12. 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.

(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 Attachment.

Section 13. Payment of Claims. Payment of claims shall be pursuant to Chapter 3, Section 11, which is incorporated by this reference.

Section 14. Recovery of excess payments. The Department shall recover excess payments pursuant to Chapter 3, Section 12, which is incorporated by this reference.

Section 15. 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 14. 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 apart 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 Attachment.

(f) Matters not subject to reconsideration.

(i) A provider may not challenge the use or reasonableness of the provisions of this Attachment.

(ii) The Department's refusal to enter into a contract with a provider to furnish specialty services.

(g) Informal resolution. The provider or the Department may request an informal meeting before the final decision on reconsideration to determine whether the matter may be resolved. The substance of the discussions and/or settlement offers made pursuant to an attempt at informal resolution shall not be admissible as part of a subsequent administrative hearing or judicial proceeding.

(h) Administrative hearing. A provider may request an administrative hearing regarding the final agency decision pursuant to Chapter 1 of the Department's Medicaid 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 Attachment.

(i) 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 1.

(j) Confidentiality of settlement agreements. If the Division and a provider enter into a settlement agreement as part of a reconsideration or an administrative hearing, such agreement shall be confidential, except as otherwise required by law. A breach of confidentiality by the provider shall, at the Division's option, result in the settlement agreement becoming

null and void.

Section 16. Interpretation of Attachment.

(a) The order in which the provisions of this Attachment appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Attachment shall control the titles of various provisions.

Section 17. Superseding effect. This Attachment supersedes all prior Attachments or policy statements issued by the Department, including provider manuals and provider bulletins,

which are inconsistent with this Attachment, except as otherwise specified in this Attachment.

Section 18. Severability. If any portion of this Attachment is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

return receipt requested, within twenty days after the date the provider receives notice pursuant to Section 14. 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 apart 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 Attachment.

(f) Matters not subject to reconsideration.

(i) A provider may not challenge the use or reasonableness of the provisions of this Attachment.

(ii) The Department's refusal to enter into a contract with a provider to furnish specialty services.

(g) Informal resolution. The provider or the Department may request an informal meeting before the final decision on reconsideration to determine whether the matter may be resolved. The substance of the discussions and/or settlement offers made pursuant to an attempt at informal resolution shall not be admissible as part of a subsequent administrative hearing or judicial proceeding.

(h) Administrative hearing. A provider may request an administrative hearing regarding the final agency decision pursuant to Chapter 1 of the Department's Medicaid 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 Attachment.

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

Reimbursement of Psychiatric Residential Treatment Facilities For Individuals 21 and Under (PRTF)

Section 1. Authority.

This Attachment is prepared and submitted to CMS for approval pursuant to 42 U.S.C. §1396a (b) and 45 C.F.R. Part 201, Part 201, Subpart A.

Section 2. Purpose and Applicability.

(a) This Attachment shall apply to and govern Medicaid reimbursement of Psychiatric Residential Treatment Facilities (PRTF).

(b) The Department may issue manuals, bulletins, or both, to interpret the provisions of this Attachment. Such manuals and bulletins shall be consistent with and reflect the policies contained in this Attachment. The provisions contained in manuals or bulletins shall be subordinate to the provisions of this Attachment.

(c) The incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Attachment.

Section 3. General Provisions.

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

(b) General methodology.

(i) All-inclusive rate. Payments for services provided in a Psychiatric Residential Treatment Facility (PRTF) will be made using a prospective per diem rate. The rates will be established by the Department of Health based on reasonable, actual costs for services and treatment of residents in the facility. Rates are provider-specific, all-inclusive for room and board and the treatment services specified in the treatment plan. There is no retroactive cost settlement based on actual costs.

(ii) Other medical and ancillary services paid through Medicaid fee schedules. The costs of medical and ancillary services not provided by the PRTF, excluding those services in the treatment plan, shall not be included in the all-inclusive prospective per diem rate, and shall be billed as a

separate service by the provider of those services and Medicaid shall pay for those covered services using the appropriate Medicaid fee schedule.

Section 4: **Determination of PRTF Costs** – This section summarizes the use of reported costs and adjustments to reported costs required to develop the data needed to calculate the room and board and licensed treatment rate components described in Section 5.

(a) Reported costs and days. Reported costs and days data from providers using Medicaid's PRTF cost report.

(i) Room and board costs. Reported on the provider cost report as room and board and non-licensed treatment costs.

(ii) Licensed treatment costs. Reported on the provider cost report as licensed treatment costs. These services are specified in the individual plan of care and include psychiatric and counseling services provided by licensed mental health professionals, and might also include physical, occupational and speech therapies if specified in the individual plan of care.

(iii) Administrative costs. The sum of administrative office employee salaries, contracted administrative office services, total administrative expenses and total liability and other insurance costs reported on provider costs reports.

(iv) Occupied bed days. Reported on the provider cost report as the total number of days beds were occupied during the provider's fiscal year.

(b) Adjustments to reported costs. Reported costs shall be adjusted to standardize data for analysis and remove non-allowable costs.

(i) Adjustment for National School Lunch funding. The revenues associated with the school lunch program shall be subtracted from reported room and board costs if a provider reported such revenue. Excluded National School Lunch costs shall be capped at the lower of food service-related costs or the revenue from the National School Lunch program.

(ii) Adjustment for services paid through a Medicaid fee schedule, as determined through a review of Medicaid paid claims data. Costs of services billed and paid on a fee-for-service basis shall be subtracted from total costs as these are not part of the services paid through the per

diem rate. Medicaid revenue for these payments shall be subtracted from the provider's reported treatment costs, not to exceed the costs reported on the cost report for that service.

(iii) Adjustments for inflation. Reported costs shall be inflated to the midpoint of the SFY of the rate-setting period, for those providers who reported costs for a reporting period different than the period immediately prior to the rate-setting period (i.e., if the current SFY is 2012, providers who submitted cost reports based on Calendar Year 2011 or SFY 2011). Inflation factors shall be determined using publicly available Wyoming-specific data from the National Bureau of Labor Statistics' Quarterly Census of Employment and Wages for Wyoming Nursing and Residential Care.

(c) Administrative costs adjustments.

(i) In-state median licensed treatment administrative costs. The licensed treatment administrative rate for instate PRTFs shall be calculated as the ratio of inflated licensed treatment administrative costs to total inflated costs and arrayed from high to low to determine the median value.

(ii) In-state median room and board administrative costs. The room and board administrative rate for instate PRTFs shall be calculated as the ratio of inflated room and board administrative costs to total inflated costs and arrayed from high to low to determine the median value.

(iii) Adjusted licensed treatment administrative costs. A provider's inflated licensed treatment administrative costs shall be adjusted if a provider's inflated licensed treatment administrative percentage exceeds the benchmark percentage (i.e., the median licensed treatment administrative percentage). The provider's inflated licensed treatment administrative costs shall be capped to equal administrative costs at the benchmark percentage.

(iv) Adjusted room and board administrative costs. A provider's inflated room and board administrative costs shall be adjusted if a provider's inflated room and board administrative percentage exceeds the benchmark percentage (i.e., the median room and board administrative percentage). The provider's inflated room and board administrative costs shall be capped to equal administrative costs at the benchmark percentage.

(d) Adjustments to reported days.

(i) In-state median occupancy level. The occupancy rate for in-state PRTFs shall be calculated as the ratio of reported occupied days to total days and arrayed from high to low to determine the median value. Total days shall be calculated as the number of beds multiplied by the number of days the facility was open.

(ii) Adjusted days. The total number of residential days shall be adjusted to reflect in-state PRTF median occupancy levels. If a provider's occupancy rate was lower than the benchmark occupancy rate (i.e., the median), the residential days shall be recalculated as the number of days that equals the median occupancy rate of in-state PRTF providers.

(e) Final costs and days for rate setting.

(i) Final room and board costs. Final room and board costs shall be calculated by subtracting adjusted room and board administrative costs (Section 4(c)(iii)) from adjusted room and board costs (Section 4(b)).

(ii) Final licensed treatment costs. Final licensed treatment costs shall be calculated by subtracting adjusted licensed treatment administrative costs (Section 4(c)(iv)) from adjusted licensed treatment costs (Section 4(b)).

(iii) Final occupancy days. Final occupancy days shall be determined as reported days for providers with occupancy rates above the instate median occupancy level. For providers below the instate median occupancy level, adjusted days determined in Section 4(d)(ii) shall be used.

(iv) Median room and board per diem cap. Calculate the median room and board per diem cap for instate and out-of-state providers.

(A) In-state median room and board per diem cap. For each in-state provider, the room and board per diem shall be calculated as final room and board costs divided by final occupancy days and arrayed from high to low to determine the median value.

(B) Out-of-state median room and board per diem cap. For each out-of-state provider, the room and board per diem shall be calculated as final room and board costs divided by final occupancy days and arrayed from high to low to determine the median value.

Section 5: **Determination of PRTF Rates**

(a) The PRTF payment rate shall be comprised of a room and board per diem component and a licensed treatment per diem component.

(i) Room and board per diem component. The Department shall determine the room and board per diem component for each PRTF. Each PRTF's room and board per diem calculated in Section 4(e)(iv) is compared to the in-state median room and board cost per day (for instate providers) or the out of state median (for out of state providers); the lower of the provider-specific room and board per diem or median shall be assigned as the final room and board per diem component.

(ii) Licensed treatment per diem component. The Department shall determine the licensed treatment per diem component for each PRTF. The licensed treatment per diem component is provider-specific, and shall be calculated as final licensed treatment costs divided by final occupancy days.

(iii) The Department shall determine the provider-specific, all-inclusive PRTF rate as the sum of the room and board per diem component and the licensed treatment per diem component.

(b) The rate shall not exceed the amount that would have been paid for such services under Medicare principles of reimbursement using publication 15-1.

Section 6. **Preparation and Submission of Cost Reports.**

(a) Time of submission. Each PRTF must submit a complete cost report to the Department or its designee annually by January 15. Providers shall submit cost reports based on their most recently audited financial statements, for the period immediately prior to the rate-setting period. If financial audits are not available for the period immediately prior to the rate-setting period, then the most recently available audited financial statements should be used to complete the cost report. .

(b) Preparation of cost reports. Cost reports shall be prepared in conformance with Medicaid's cost report instructions and allowable cost guidelines.

(c) Requirements of participation. Wyoming Medicaid requires all Wyoming and out-of-state PRTFs enrolled with the Medicaid program to complete a cost report if:

(i) The number of unduplicated clients served in the previous State Fiscal Year (i.e., July 1 to June 30) by the provider was at least five (5) Wyoming Medicaid clients; or

(ii) The total Wyoming Medicaid payments to the provider in the previous State Fiscal Year (i.e., July 1 to June 30) were at least $50,000.

Section 7. **Audits.**

(a) Desk reviews. The Department may perform a desk review of a provider at any time to determine the accuracy and reasonableness of cost reports or whether the PRTF has received overpayments.

(b) Adjustments. If any adjustments are made as a result of a desk audit, the facility will be notified immediately upon determination of the finding and adjustment.

Section 7. **Rebasing**. The Department shall rebase the all-inclusive PRTF per diem periodically using the most recent provider cost report data.

Section 8. **Payment of Claims**. The timing and frequency of payments to PRTF providers is monthly.

Section 9. **Recovery of Overpayments**. The Department shall recover overpayments pursuant to Chapter 16, which is incorporated by this reference.

Section 10. **Reconsideration**. A provider may request reconsideration of the decision to recover overpayments pursuant to the provisions of Chapter 16.

Section 11. **Delegation of Duties**. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, any other agency of the federal, state or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments or take any other final action authorized by this Attachment.

Section 12. **Interpretation of Attachment.**

(a) The order in which the provisions of this Attachment appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Attachment shall control the titles of various provisions.

Section 13. **Superseding Effect**. This Attachment supersedes all prior Attachments or policy statements issued by the Department, including manuals and bulletins, which are inconsistent with this Attachment, except as otherwise specified in this Attachment.

Section 14. **Severability**. If any portion of this Attachment is found to be invalid or unenforceable, the remainder shall continue in effect.

Psychiatric Residential Treatment Facility Supplemental Payment and Upper Payment Limit Calculations

Subject to the provisions of this section and effective for dates of service on or after July 1, 2023 a Psychiatric Residential Treatment Facility (PRTF) located in Wyoming that is owned, operated by, or affiliated with a privately owned and operated hospital also located in Wyoming shall be eligible for a PRTF supplemental payment each quarter (based on a yearly calculation) to compensate such PRTFs for the costs of covered services furnished to Wyoming Medicaid patients.

1. Individual PRTF Upper Payment Limit calculation based on claim payments

Consistent with 42 CFR 447.325, the PRTF Upper Payment Limit (UPL) will be determined for each facility (rather than at the aggregate ownership category level) and will be calculated using customary charges for included services as the estimate for the Medicare Allowed Amount. UPL gap for each facility will be calculated as the total of the difference between the UPL and the Medicaid Allowed Amount calculated for services provided in a PRTF to Medicaid fee-for-service enrollees.

Annual UPL and supplemental payment calculations will be performed in prospective manner using historical claim data from a "base year."
If Wyoming Medicaid PRTF rates have not changed between the base year and the rate year, then the Allowed Amount on the base year claims is used as the Medicaid payment amount for purposes of the UPL demonstration. If the Wyoming Medicaid PRTF rates have increased between base year and the rate year, then the PRTF claims will be repriced using the rate year pricing parameters.

2. Supplemental payment calculation

The amount available within the PRTF Supplemental Payment pool will equal the sum of the UPL gap for each eligible PRTF. An eligible PRTF may qualify for a PRTF supplemental payment if its calculated UPL gap is positive (that is, if the UPL is greater than estimated Medicaid Allowed Amount for the payment period). If a PRTF's UPL gap is negative or zero, the PRTF's supplemental payment will be zero.

Private hospital supplemental payments will be distributed in equal quarterly lump sum amounts based on an annual calculation.

3. Upper Payment Limit Demonstration

For the UPL demonstration, claim and supplemental payments will be summed to determine total Medicaid payment and compared to the UPL separately for each PRTF. Total Medicaid payment will not exceed the UPL amount.

WYOMING OUTPATIENT HOSPITAL REIMBURSEMENT SYSTEM

ATTACHMENT 4.19B

Section 1. Purpose and Applicability.

This Attachment shall apply to and govern the reimbursement of inpatient and outpatient hospital services provided on or after July 1, 1993. Hospital services are also subject to the provisions of Chapters III, VIII and IX of the Wyoming Medicaid rules, except as otherwise specified in this Attachment.

Section 2. General provisions.

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

(b) General methodology. The Department reimburses providers of outpatient hospital services using Medicare's retrospective reasonable cost reimbursement principles, subject to the limits established by Section 1886(b) of the Social Security Act, except as otherwise specified by this Attachment.

Section 3. Definitions.

(a) "Admission." The act by which an individual is admitted to a hospital as an outpatient. "Admission" does not include a new born child or an individual that is transferred from one unit of a hospital to another unit in the hospital or to a distinct part hospital unit.

(b) "Allowable costs." Medicare allowable costs, except as otherwise specified by this Attachment.

(c) "Base year." A hospital's first 12 month cost reporting period ending on or after September 30, 1982 and before September 30, 1983.

(d) "Chapter I." Chapter I, Rules for Medicaid Administrative Hearings, of the Wyoming Medicaid rules.

(e) "Claim." A request by a provider for Medicaid payment for services provided to a recipient.

(f) "Cost report." An itemized statement of a hospital's costs for its most recently completed fiscal year, including an audited or unaudited financial statement, prepared in accordance with GAAP and the instructions of the Department. A cost report must include the information and be prepared in the form specified by the Department and the intermediary, and must be submitted in hardcopy and on computer disc using software designated by the Department. "Cost report" includes any

supplemental request by the Department for additional information relating to the hospital's costs and the hospital's efforts to achieve efficiencies or other cost savings.

(g) "Covered service." A health service or supply eligible for Medicaid reimbursement pursuant to the rules and policies of the Department. "Covered service" does not include nursing facility services.

(h) "Credit balance." Medicaid funds received by a hospital that are owed to the Department for any reason.

(i) "Department." The Wyoming Department of Health, its designee, agent or successor.

(j) "Desk review." A review by the Department of a hospital's cost report to determine: (i) if the cost report has been prepared and submitted in compliance with this Attachment; (ii) that costs have been properly allocated; and (iii) that costs are allowable.

(k) "Director." The Director of the Department or the Director's designee.

(l) "Distinct part hospital unit." A distinct part hospital unit excluded from the Medicare prospective payment system pursuant to 42 C.F.R. 412.20(b)(1), which is incorporated by this reference.

(m) "Division." The Division of Health Care Financing of the Department, its agent, designee or successor.

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

(o) "Extraordinary circumstances." A catastrophic occurrence, beyond the control of a provider, which results in substantially higher costs and which meets the criteria set forth in (i) through (v). "Extraordinary circumstances" include, but are not limited to, labor strikes, fire, earthquakes, floods or similar circumstances which result in substantial cost increases, and which:

(i) Is a one-time occurrence;

(ii) Could not have reasonably been predicted;

(iii) Is not insurable;

(iv) Is not covered by federal or state disaster relief; and

(v) Is not the result of intentional, reckless or negligent actions or inactions by any director, officer, employee or agent of the provider.

(p) "Field audit." An examination, verification and review of a hospital's financial records and any supporting or related documentation conducted by employees, agents or representatives of the Department or HHS.

(q) "Financial records." All records, in whatever form, used or maintained by a hospital in the conduct of its business affairs and which are necessary to substantiate or understand the information contained in the hospital's cost reports.

(r) "Generally accepted accounting principles (GAAP)." Accounting concepts, standards and procedures established by the American Institute of Certified Public Accountants.

(s) "Generally accepted auditing standards (GAAS)." Auditing standards, practices, and procedures established by the American Institute of Certified Public Accountants.

(t) "HCFA." The Health Care Financing Administration of HHS, its agent, designee or successor.

(u) "HHS." The United States Department of Health and Human Services, its agent, designee or successor.

(v) "Hospital." An institution that: (i) is approved to participate as a hospital under Medicare; (ii) is maintained primarily for the treatment and care of patients with disorders other than mental diseases or tuberculosis; (iii) has a provider agreement; (iv) is enrolled in the Medicaid program; and (v) is licensed to operate as a hospital by the State of Wyoming or, if the institution is out-of-state, licensed by the state in which the institution is located.

(w) "Interim rate." The interim reimbursement rate established pursuant to Section 4.

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

(y) "Medical record." All documents, in whatever form, in the possession of or subject to the control of the hospital which describe the recipient's diagnosis, condition or treatment, including, but not limited to, the plan of care for the recipient.

(z) "Medicare." The health insurance program for the aged and disabled established pursuant to Title XVIII of the Social Security Act.

(aa) "Medicare allowable costs." Costs incurred by a hospital which are allowable under Medicare principles of cost reimbursement.

(bb) "Medicare intermediary." The intermediary for Medicare Part A appointed pursuant to 42 U.S.C. § 1395u.

(cc) "Medicare principles of cost reimbursement." The inpatient hospital reimbursement principles established by Medicare as set forth in the Provider Reimbursement Manual and HCFA's instructions for administering the Manual, which are incorporated by reference. The Provider Reimbursement Manual and the HCFA instructions are published by HCFA and are available from that agency. The Provider Reimbursement Manual is also published in the CCH Medicare and Medicaid Guide, beginning at ¶ 7227, and is available from Commerce Clearing House, 4025 West Peterson Avenue, Chicago, Illinois 60646.

(dd) Most recently settled Medicare cost report." A facility's most recent cost report which has been (i) submitted to Medicare, in accordance with Medicare standards and procedures; (ii) cost settled by the Medicare intermediary using Medicare principles of cost reimbursement; and (iii) for which a notice of program reimbursement has been issued. A cost report is considered settled notwithstanding a request to reopen.

(ee) "New hospital." A hospital which has not filed an audited Medicare cost report with the Department.

(ff) "Nonallowable costs." Costs which are not related to covered services. Nonallowable costs include, but are not limited to:

(i) Costs related to other services as described in Section 7; and

(ii) As otherwise specified in this Attachment and the rules of the Department.

(gg) "Notice of Medicaid Program Reimbursement." Written notice from the Department to a hospital, sent by certified mail, which includes, if available, the hospital's Medicaid allowable costs, cost to charge ratio and interim reimbursement rate.

(hh) "Notice of Program Reimbursement." Written notice from the Medicare intermediary to the Department of a hospital's Medicaid allowable costs, cost to charge ratio and interim reimbursement rate.

(ii) "Outpatient." An outpatient as defined by 42 C.F.R. § 440.2(a), which is incorporated by this reference.

(jj) "Outpatient hospital service." "Outpatient hospital services" as defined in 42 C.F.R. § 440.20(a), which is incorporated by this reference.

(kk) "Overpayments." The amount by which the interim rate a hospital received exceeds the final cost-settled amount determined pursuant to Section 6.

(ll) "Provider." A hospital which has a current provider agreement, is licensed to provide services and is enrolled with the Department as a provider.

(mm) "Provider agreement." A written contract between a provider and the Department in which the provider agrees to comply with the provisions of the contract and applicable federal and State statutes and regulations as a prerequisite to receiving Medicaid funds for services provided to recipients.

(nn) "Recipient." A person who has been determined eligible for Medicaid.

(oo) "Reopen." A request by a hospital, the intermediary or the department, pursuant to the procedures and standards established by Medicare, to re-examine or review the correctness of a cost settlement determination or decision made by or on behalf of Medicare.

(pp) "Request for TEFRA target rate adjustment." A request, pursuant to Section 13, for a rate adjustment. "Request for TEFRA target rate adjustment" does not include any request to reopen a provider's cost report or any request for a change in a provider's Medicaid rate based on Medicare principles of cost reimbursement; any such requested change must be handled pursuant to the procedures and standards established by Medicare.

(qq) "TEFRA target rate adjustment." A change in a hospital's Medicaid rate based on extraordinary circumstances or the criteria specified in subsection 13(c), other than a change based on Medicare principles of cost reimbursement.

Section 4. Medicaid allowable payment for outpatient hospital services.

(a) In general. Except as otherwise specified in this Attachment, the Department reimburses hospitals providing outpatient hospital services to recipients using Medicare principles of cost reimbursement. The Medicaid allowable payment shall be the lower of the hospital's usual and customary charges and the allowable payment determined pursuant to this section.

(b) Interim rate. The interim rate for outpatient hospital services shall be the interim rate established for inpatient services reduced by twenty percent.

(c) Negotiated rate. A hospital may negotiate an interim rate which is lower than the interim rate which would otherwise be in effect pursuant to this Section.

(d) New hospitals. A new hospital shall receive an initial rate equal to the lowest rate for outpatient services established for a hospital located in Wyoming pursuant to paragraph (e)(i) until the hospital files its most recently settled Medicare cost report.

(e) Hospitals located in Wyoming.

(i) Interim rate. The Department shall establish an interim rate for outpatient hospital services based on the most recently settled cost report submitted by the hospital to the Medicare intermediary.

(A) Rate effective date. The interim rate shall be effective for all outpatient hospital services provided on or after December 1, 1992;

(B) Rate period. The interim rate shall remain in effect for all outpatient hospital services until redetermined pursuant to this Section;

(C) Except as otherwise specified by this Attachment, the interim rate shall be applied to all claims submitted by the provider.

(ii) Cost settlement. The Department shall cost settle, pursuant to Section 6, Medicaid reimbursement for outpatient hospital services provided during each rate period.

(f) Hospitals located outside Wyoming.

(i) Reimbursement rate. The Department shall determine a reimbursement rate for outpatient hospital services provided by hospitals located outside the State of Wyoming pursuant to paragraphs (ii) and (iii). Such rate shall remain in effect for all outpatient hospital services until redetermined pursuant to this subsection.

(ii) Hospitals which submit cost reports.

(A) Submission and preparation of cost reports. Except as otherwise specified by this subsection, hospitals which submit cost reports shall prepare and submit them pursuant to Section 5.

(B) Time of submission. A hospital shall submit its most recently settled Medicare cost report on or before October 31st of each year.

(I) The cost report must not have been previously submitted or used for a previous rate period, and it must be for a year subsequent to the year reported in the hospital's most recently submitted cost report.

(II) If the hospital cannot submit a cost report which meets the requirements of this subparagraph because of delay caused by the intermediary, the hospital must submit verification of the delay from the intermediary on or before October 31st of the relevant year. If there is a verifiable delay caused by the intermediary, the hospital shall receive a rate equal to the lowest cost to charge ratio established for a hospital located in Wyoming pursuant to paragraph (f)(i) of this Section for the current State of Wyoming fiscal year. The hospital must submit its cost report promptly after it becomes available, and in no event later than 9 months after the October 1st due date. The Department shall determine the hospital's cost to charge ratio and shall adjust the hospital's rate retroactively to the original rate effective date. A hospital which fails to submit a cost report within 9 months after the due date shall receive no retroactive adjustment to its rate.

(C) Determination of reimbursement rate. The Department shall establish a reimbursement rate for each hospital which submits a cost report using Medicare principles of cost reimbursement, as modified by this Attachment, based on the most recently settled Medicare cost report submitted by the hospital to the Department. The reimbursement rate shall be the hospitals' cost to charge ratio for combined inpatient and outpatient services.

(D) Rate effective date. Reimbursement rates for hospitals which submit cost reports shall be effective for services provided on or after July 1, 1992. The rate shall be adjusted each December 1 thereafter, assuming the hospital submits a cost report pursuant to (B).

(E) Duration of reimbursement rate. Rates determined pursuant to this paragraph shall remain in effect for services provided during the twelve months following the rate effective date.

(F) Cost settlement. The Department shall cost settle, pursuant to Section 6, unless the Department determines that it is not cost-effective to do so.

(iii) Hospitals which do not submit cost reports. The reimbursement rate for hospitals which elect not to submit cost reports pursuant to (ii) shall be the lesser of the hospital's submitted charges and the lowest cost to charge ratio established for a hospital located in Wyoming pursuant to paragraph (f)(i) for the current State of Wyoming fiscal year. The rate shall be effective for all services provided on after July 1, 1992. The rate shall be adjusted each December 1 thereafter to correspond

with the then current lowest cost to charge ratio established pursuant to paragrapn (f)(i).

Section 5. Submission and preparation of cost reports.

(a) Time of submission. Each hospital must submit a complete cost report to the Medicare intermediary in accordance with Medicare requirements.

(b) Preparation of cost reports. Each hospital shall prepare its cost report in conformance with Medicare requirements.

(c) Submission of additional information. The Department may request, in writing, that a hospital submit information to supplement its cost report. The hospital shall submit the requested information within thirty days after the date of the request.

(d) Failure to comply with this Section. The failure of a hospital to comply with the provisions of this Section shall result in the immediate suspension of all Medicaid payments to the hospital and all Medicaid payments under review shall be repaid to the Department within ten days after written request for such payment. The suspension of payments shall continue until the hospital complies with this Section. Upon the Department's receipt of all information required by this Section, payments will be reinstated, without interest. This remedy does not affect the Department's right to withhold payments, terminate provider participation or invoke other remedies permitted by applicable statutes and rules.

Section 6. Cost settlement.

(a) Cost settlement methodology. Cost reports shall be cost settled by the Medicare intermediary using Medicare principles of cost reimbursement as modified by this Attachment and using data provided by the Department.

(b) Notice of Medicaid Program Reimbursement. The Department shall, within sixty days after receipt of the Notice of Program Reimbursement, send a Notice of Medicaid Program Reimbursement to the hospital.

(c) Repayment of overpayments. A hospital shall reimburse the Department for overpayments within thirty days after the date of the Notice of Medicaid Program Reimbursement, even if the provider has requested reconsideration or an administrative hearing regarding the determination of overpayments. If a hospital does not timely reimburse the Department, overpayments may be recovered pursuant to Section 11. Notice of overpayments must include the hospital's right to request reconsideration of the cost-settlement pursuant to Section 14. The reconsideration

shall be limited to whether the Department has complied with the provisions of this Attachment.

(e) Payment of underpayments. The Department shall request the issuance of a payment warrant to reimburse the hospital for underpayments within fifteen days after the date of the Notice of Medicaid Program Reimbursement.

Section 7. Medicaid allowable payment for other services.

All costs relating to services provided to recipients which are reimbursed pursuant to a fee schedule or other methodology established by the Department shall be deducted from the hospital's cost report prior to cost settlement.

Section 8. Record retention

(a) Period of retention. A hospital which receives or has received Medicaid funds shall retain financial records for six (6) years following the date of submission of the applicable cost report to the Department. Such records may be maintained in hard-copy, on micro-fiche or micro-film.

(b) Record keeping requirements.

(i) Financial records. A provider must keep financial records in accordance with GAAP and maintain sufficient control and documentation to satisfy the requirements of this Attachment, including accommodating GAAS and reasonable requests by the Department for additional information. The provider must maintain adequate documentation for all line items on the cost report.

(ii) Medical records. A provider must maintain medical records.

(c) Availability of records. A provider shall make financial or medical records available upon request to representatives of the Department or the United States Department of Health and Human Services and pursuant to Chapter XVI, Medicaid Program Integrity.

(d) Refusal to produce records. The refusal of a provider to make financial or medical records available upon request pursuant to this section shall result in the immediate suspension of all Medicaid payments to the provider and all Medicaid payments under review shall be repaid to the Department within ten days after written request for such payment. The suspension of payments shall continue until the requested records are provided.

(e) Explanation of records. In the event of a field audit, the provider shall have available at the field audit location one or more knowledgeable persons who can explain the provider's

financial records, the accounting and control system and cost report preparation, including attachments and allocations, to the auditors.

(f) Failure to maintain records. A provider unable to satisfy one or more of the requirements of this Section shall be given a written notice of deficiency and shall have sixty days after the date of the written notice to correct such deficiency. If, at the end of the sixty days, the Department determines that the deficiency has not been corrected, the Department shall withhold twenty-five percent (25%) of the provider's claims for services provided on or after the sixtieth day. If, at the end of one hundred and twenty days after the mailing of the written notice of deficiency, the Department determines that the deficiency has not been corrected, the Department shall suspend all Medicaid payments for services provided after such date. The suspension of payments shall continue until the the Department determines that adequate records are being maintained. At such time, payments will be reinstated, without interest. This remedy does not affect the Department's right to withhold payments, terminate provider participation or invoke other remedies permitted by applicable statutes and rules.

(g) Out of state records. If a provider maintains financial or medical records out of state, the provider shall either transfer the records to an in-state location that is suitable for the Department to perform the field audit or reimburse the Department for reasonable costs, including travel, lodging and meals, incurred in performing the field audit in an out-of-state location.

Section 9. Audits.

(a) Field audits. The Department or HCFA may perform a field audit of a provider at any time to determine the accuracy and reasonableness of cost reports, the accuracy of cost settlements or whether the hospital has received excess payments.

(b) Desk review. The Department or HCFA may perform a desk review of a provider at any time to determine the accuracy and reasonableness of cost reports, the accuracy of cost settlements or whether the hospital has received excess payments.

(c) The Department or HCFA may perform field audits or desk reviews through employees, agents, or through a third party. Audits shall be performed in accordance with GAAS.

(d) Disallowances. If a field audit or desk review discloses nonallowable costs, overpayments or excess payments, the Department shall adjust the final cost settlement and recover any excess payments pursuant to Section 11.

(e) Notice of excess payments. After determining that a provider has received excess payments, the Department shall send

written notice to the provider, by certified mail, return receipt requested, stating the amount of the excess payments, the basis for the determination of excess payments and the provider's right to request reconsideration of that determination pursuant to Section 14. The reconsideration shall be limited to whether the Department has complied with the provisions of this Attachment.

(f) Recovery of excess payments. A provider must reimburse the Department for excess payments within fifteen days after the provider receives written notice from the Department pursuant to subsection (e), even if the provider has requested reconsideration or an administrative hearing regarding the determination of excess payments. If the provider fails to timely repay excess payments, the Department may recover the excess payments pursuant to Sections 11.

Section 10. Repayment of credit balance.

(a) Quarterly request. The Department shall quarterly request the repayment of any credit balance. Such request shall be made in writing and mailed by certified mail, return receipt requested. The hospital shall repay the credit balance within sixty days after the date of receipt of the request for repayment.

(b) A hospital shall repay any credit balance within sixty days after the date such credit balance is identified by the Department, the hospital or the intermediary.

(c) Lump sum adjustment. If a credit balance identified pursuant to paragraphs (a) or (b) is not timely paid to the Department, the Department may recover the credit balance pursuant to Section 11.

Section 11. Recovery of overpayments, excess payments or credit balance. If a provider does not timely reimburse the Department for overpayments pursuant to subsection 6(d), excess payments pursuant to subsection 9(f), or a credit balance pursuant to Section 10, the Department may recover the overpayments, excess payments or credit balance, even if the provider has appealed the Department's determination, by:

(a) Withholding all or part of Medicaid payments until the overpayments are recovered;

(b) Initiating a civil lawsuit against the provider; or

(c) Any other method of collecting a debt or obligation permitted by law.

Section 12. Request to Reopen.

(a) Medicare standards and procedures. A request to reopen shall be made in the manner specified by Medicare, directed to

the entity specified by Medicare, and shall be disposed of pursuant to the methods and standards specified by Medicare.

(b) Sole remedy. A provider which has an issue which may be resolved through a request to reopen may not request a rate adjustment or reconsideration pursuant to this Attachment or an administrative hearing pursuant to Chapter I.

Section 13. Request for TEFRA target rate adjustment.

(a) Request for TEFRA target rate adjustment. A provider may request a rate adjustment by mailing a written request to the Department by certified mail within sixty days after the date of the Notice of Medicaid Program Reimbursement provided pursuant to subsection 6(c). The request must include the information included in subparagraphs (i) through (iii). A request for rate adjustment shall be dismissed with prejudice if the provider does not comply with the requirements of this subsection.

(i) The nature of the rate adjustment sought;

(ii) The amount of the requested rate adjustment, the methodology used to calculate the requested rate adjustment, the specific calculation for the requested rate adjustment, and documentation which supports the above; and

(iii) The specific reasons, including references to applicable federal and State law, that justify the rate adjustment.

(b) Department's responsibilities.

(i) The Department shall acknowledge, in writing, receipt of the request for rate adjustment within fifteen days after receipt;

(ii) The Department may request, in writing, additional information from the provider. The provider must mail the requested information to the Department, by certified mail, within sixty days after receipt of the request. Failure to timely provide the requested information shall result in the dismissal, with prejudice, of the request for rate adjustment.

(iii) The Department shall review the request for rate adjustment to determine whether the request meets any of the criteria set forth in subsection (c).

(iv) Burden of proof. Except as otherwise provided by this Attachment, the provider requesting a rate adjustment shall bear the burden of proving by a preponderance of the evidence that it is entitled to a rate adjustment.

(v) Notice of final decision. The Department shall send written notice to the provider, by certified mail, of its

final decision within one-hundred eighty days after the receipt of the request for rate adjustment or the receipt of any additional information requested by the Department pursuant to (ii), whichever is later. The provider may request an administrative hearing regarding the decision of the Department pursuant to (g).

(c) Bases for rate adjustment. The Department may grant a request for rate adjustment if the provider demonstrates that:

(i) There has been a significant increase in the acuity of care provided by the hospital since the base year and the failure to make a rate adjustment will result in recipients not having reasonable access to inpatient hospital services of adequate quality;

(ii) Extraordinary circumstances occurring since the base year have caused the provider to incur substantially higher costs;

(iii) There has been an error in the calculation of the provider's TEFRA cost per discharge target amount;

(iv) The provider is rendering atypical services;

(v) The provider is located in an area with a significant change in the Medicaid population during the year;

(vi) The provider is engaged in an approved medical or paramedical education program that has resulted in increased costs;

(vii) For cost reporting periods beginning before October 1982, the provider is rendering more intensive routine care resulting in a shorter length of stay and higher per unit costs than in comparable hospitals;

(viii) Application of the limit would render a hospital insolvent, thereby depriving the community of essential services (the hospital must have exceeded the limit by more than fifteen percent);

(ix) The provider is newly established home health agency (an agency certified for Medicare less than three full years); or

(x) The provider has labor costs that vary by more than ten percent from the labor costs that were used in promulgating the limits.

(d) In determining whether to grant a rate adjustment pursuant to subsection (c), the Department shall consider:

(i) Whether the provider has demonstrated that its unreimbursed costs are caused by factors generally not shared by other Wyoming hospitals;

(ii) Whether the provider has taken every reasonable step to control costs; and

(iii) Whether the provider's costs may be controlled through good management practices or cost containment measures. In determining whether the provider's costs may be so controlled, the Department may consider:

(A) Efforts to reduce or contain employee benefits;

(B) Efforts to consolidate or centralize personnel or departmental functions;

(C) Efforts to review departmental staffing levels and use lesser-skilled employees or reduce full-time equivalent employees, without adversely affecting the quality of patient care;

(D) Efforts to affect physicians' order patterns, e.g., through use of drug formularies, standardizing supplies, and reducing unnecessary tests;

(E) Efforts to reduce reliance on agency or registry personnel;

(F) Efforts to expedite billing;

(G) Use of volunteers and fund-raising;

(H) Efforts to control costs;

(I) Efforts to reduce the incidence of employee injuries;

(K) Efforts to reduce employee turnover;

(L) Efforts to improve efficiency through improved scheduling;

(M) Equipment sharing arrangements; and

(N) The use of information or management systems and procedures.

(e) Calculation of rate adjustment. If the Department determines pursuant to subsection (d) that a hospital is entitled to a rate adjustment for one of the reasons specified in subsection (c), the rate adjustment shall be calculated as follows:

(i) The Department shall recalculate the provider's target amount using the rate year for which the rate adjustment was requested, unless the rate adjustment is based on extraordinary circumstances.

(ii) If the rate adjustment is based on extraordinary circumstances, the Department may increase the per discharge ceiling by the amount necessary to meet the Medicaid share of the net additional allowable costs incurred as a result of the extraordinary circumstances.

(f) Effect of rate adjustments.

(i) Rate adjustments resulting from extraordinary circumstances shall be limited to the fiscal period in question.

(ii) Rate adjustments other than adjustments resulting from extraordinary circumstances shall be limited to the fiscal period in question unless the facility shows, for each succeeding rate period, that the conditions which resulted in the rate adjustment still exist.

(g) 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 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.

(h) Failure to request rate adjustment. A provider which fails to request a rate adjustment pursuant to this section may not subsequently request an administrative hearing pursuant to Chapter I regarding the decision to recover overpayments.

(i) Matters not subject to rate adjustment or reconsideration. The following matters are not subject to a rate adjustment pursuant to this section, reconsideration pursuant to Section 14, or an administrative hearing pursuant to Chapter I:

(i) A recovery of overpayments caused by a change in the reimbursement methodology as the result of a change in state or federal law, including a change in this Attachment; or

(ii) The use or reasonableness of the reimbursement methodology set forth in this Attachment.

Section 14. Reconsideration.

(a) Request for reconsideration. A provider may request that the Department reconsider a decision to recover overpayments pursuant to Section 6 or a decision to recover excess payments pursuant to Section 11. Such request must be mailed to the Department by certified mail within twenty days of the date the facility receives notice pursuant to subsections 6(c) or 11(f).

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. The reconsideration shall be limited to whether the Department has complied with the provisions of this Attachment.

(b) Reconsideration. The Department shall review the decision and send written notice, by certified mail, to the provider of its final decision within forty-five days after receipt of the request for reconsideration. The Department may request additional information from the provider as part of the reconsideration process.

(c) Administrative hearing. A provider may request an administrative hearing regarding the final decision pursuant to Chapter I of these rules by mailing by certified mail or personally delivering a request for hearing to the Department within twenty days of the date the provider receives notice of the final decision.

(d) Failure to request reconsideration. A provider which fails to request reconsideration pursuant to this section may not subsequently request an administrative hearing regarding the decision to recover overpayments pursuant to Chapter I.

(e) A provider may not request reconsideration or an administrative hearing regarding a denial or reduction of payment or recovery of overpayments or excess payments caused by a change in the reimbursement methodology or any change in state or federal law.

Section 15. Severability. If any portion of this Attachment is found to be invalid or unenforceable, the remainder shall continue in effect.

STATE: Wyoming

REIMBURSEMENT OF OUTPATIENT HOSPITAL SERVICES

Section 1. Authority

This Attachment is prepared and submitted to HCFA for approval pursuant to 42 U.S.C. § 42 1396a(b) and 45 C.F.R. Part 201, Subpart A.

Section 2. Purpose and Applicability.

(a) This Attachment shall apply to and govern Medicaid reimbursement of outpatient hospital services furnished to individuals admitted on or after its effective date. Outpatient hospital services are also subject to the provisions of Chapters 3, 9, and 24 of the Wyoming Medicaid rules, except as otherwise specified in this Attachment.

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

Section 3. General Provisions.

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

(b) General methodology. The Department reimburses providers of outpatient hospital services on a fee for service.

Section 4. Definitions.

(a) "Admission" or "admitted." The act by which an individual is admitted to a hospital as an outpatient. "Admission" or "admitted" does not include an individual that is transferred from one unit of a hospital to another unit in the hospital or to a distinct part hospital unit.

(b) "Certified." Approved by the survey agency as in compliance with applicable statutes and rules.

(c) "Chapter 1." Chapter 1, 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 9." Chapter 9, Hospital Services, of the Wyoming Medicaid Rules.

(g) "Chapter 24." Chapter 24, Wyoming Hospital Reimbursement System, of the Wyoming Medicaid Rules.

(h) "Claim." A request by a provider for Medicaid payment for covered services provided to a recipient.

(i) "Covered service." A health service or supply eligible for Medicaid reimbursement pursuant to the Wyoming Medicaid State Plan.

(j) "Department." The Wyoming Department of Health, its agent, designee or successor.

(k) "Director." The Director of the Department or the Director's designee.

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

(m) "Emergency services." Outpatient hospital services designated by the Division based on ICD-9-CM codes and disseminated by Provider Manuals or Provider Bulletins.

(n) "Emergency." The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) that the absence of immediate medical attention could reasonably be expected to result in:

(i) Placing the patient's health in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(o) "Enrolled." Enrolled as defined in Chapter 3, which definition is incorporated by this reference.

(p) "Excess payments." Medicaid funds received by a provider which exceed the Medicaid allowable payment established by the

Department.

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

(r) "HHS." The United States Department of Health and Human Services, its agent, designee or successor.

(s) "Hospital." An institution that: (i) is approved to participate as a hospital under Medicare; (ii) is maintained primarily for the treatment and care of patients with disorders other than mental diseases or tuberculosis; (iii) has a provider agreement; (iv) is enrolled in the Medicaid program; and (v) is licensed to operate as a hospital by the State of Wyoming or, if the institution is out-of-state, licensed as a hospital by the state in which the institution is located.

(t) "ICD-9-CM." The International classification of Diseases, 9th Clinical Modification. The ICD-9-CM is published by HCFA and is available from the United States Government Printing Office, Washington, D.C. 20402.

(u) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act and/or the Wyoming Medical Assistance and Services Act. "Medicaid" includes any successor or replacement program enacted by Congress and/or the Wyoming Legislature.

(v) "Medicaid fee schedule." The Medicaid fee schedule as established pursuant to Chapter 3, as in effect on the effective date of this Attachment, and as modified pursuant to that Chapter.

(w) "Medically necessary" or "medical necessity." 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 must be:

(i) Consistent with the diagnosis and treatment of the recipient'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 recipient and undertaken for reasons other than the convenience of the recipient and the provider; and

(iv) Performed in the least costly setting required by

the recipient's condition.

(x) "Outpatient." An outpatient as defined by 42 C.F.R. § 440.2(a), which is incorporated by this reference.

(y) "Outpatient hospital services." Outpatient hospital services as defined by 42 C.F.R. § 440.20(a), which is incorporated by this reference.

(z) "Patient." An individual admitted to a hospital or other provider of outpatient hospital services.

(aa) "Physician." A person licensed to practice medicine or osteopathy by the Wyoming State Board of Medical Examiners or a comparable agency in another state, or a person licensed to practice dentistry by the Wyoming Board of Dental Examiners or a comparable agency in another state.

(bb) "Prior authorized." Approval by the Division pursuant to Chapter 3, Section 9, which is incorporated by this reference.

(cc) "Provider." A provider as defined by Chapter 3, Section 3(y), which is incorporated by this reference.

(dd) "Readmission." The act by which an individual is:

(i) Admitted to a provider from which the individual had been discharged;

(ii) On or before the thirty-first day after the previous discharge; and

(iii) For treatment of any diagnosis.

(ee) "Recipient." A person who has been determined eligible for Medicaid.

(ff) "Survey agency." The Health Facilities Survey, Certification and Licensure Office of the Department, its agent, designee or successor, or a comparable agency in another state.

(gg) "Third party liability." Third party liability as determined pursuant to Chapter 4, which is incorporated by this reference.

(hh) "Usual and customary charge." A provider's charge to the general public for the same service.

Section 5. Provider Participation.

(a) Payments only to providers. No provider that furnishes outpatient hospital services to a recipient shall receive Medicaid funds unless the provider is certified, has signed a provider agreement and is enrolled.

(b) Compliance with Chapter 3. A provider that wishes to receive Medicaid reimbursement for outpatient hospital services furnished to a recipient must meet the requirements of Chapter 3, Sections 4 through 6, which are incorporated by this reference.

Section 6. Provider Records. A provider must comply with Chapter 3, Section 7, which is incorporated by this reference.

Section 7. Verification of recipient data. A provider must comply with Chapter 3, Section 8, which is incorporated by this reference.

Section 8. Medicaid allowable payment for outpatient hospital services.

(a) Generally. Medicaid allowable payments for outpatient hospital services are made according to one of the following fee schedules depending on the type of service. Facilities receiving payment for outpatient hospital services are provider based according to 42 CFR, Section 413.65. State-developed fee schedule rates for services described in Section 8 are the same for public and private providers. The fee schedule and any periodic adjustments to the fee schedule are published at the State's fiscal agent's website.

(i) Medicaid Ambulatory Payment Classification (APC) fee schedule. The Medicaid APC fee schedule is based on services that are included in Medicare's outpatient prospective payment system as published in the Federal Register Vol. 69, No. 219 (November 15, 2004) and Federal Register Vol. 69, No. 250 (December 30, 2004).

(A) Services included under the APC fee schedule:

a. Significant outpatient procedures, e.g., a procedure or surgery provided to a patient that constitutes the primary reason for the visit to the hospital;

b. Ancillary;

c. Emergency;

d. Observation;

e. Drugs;

f. Laboratory services not included in Medicare's clinical laboratory fee schedule;

g. Durable medical equipment, prosthetics and orthotics;

h. Radiology;

i. Vaccines and immunizations.

(B) Ambulatory Payment Classification relative weights. The State uses Medicare's APC relative weights.

(C) State-specific Medicaid conversion factors. The State uses a Wyoming-specific Medicaid conversion factor for each of the following three hospital groups: children's hospitals, critical access hospitals, and general acute care hospitals as follows:

a. For each group of hospitals, the State divided the estimated costs of APC-based services by the sum of the relative weights for the hospital group.

i. For each hospital, the State calculated estimated costs by dividing SFY 2005 estimated Medicaid costs by SFY 2005 Medicaid billed charges (paid claims).

ii. The State calculated estimated SFY 2005 Medicaid costs by multiplying SFY 2005 billed charges by hospital-specific outpatient hospital cost-to-charge ratios calculated from provider fiscal year end 2004 as-filed cost reports.

b. The State adjusted the conversion factors so that projected payments for all hospitals equaled total payments under the previous outpatient hospital prospective payment system.

c. For each group of hospitals, the State calculated the conversion factor percentage of Medicare's final CY 2006 conversion factor as published in the Federal Register Vol. 70, No. 217 (November 10, 2005). The State divided the Wyoming-specific Medicaid conversion factor by Medicare's final CY 2006 conversion factor:

i. The Wyoming-specific Medicaid conversion factor for children's hospitals is 171% of Medicare's final CY 2006 conversion factor.

ii. The Wyoming-specific Medicaid conversion factor for critical access hospitals is 196% of Medicare's final CY 2006 conversion factor.

iii. The Wyoming-specific Medicaid conversion factor for general acute care hospitals is 75% of Medicare's final CY 2006 conversion factor.

(D) Fee schedule payment calculation. The fee schedule is established by multiplying the state-specific Medicaid conversion factor by the Medicare APC relative weight.

(E) Discounting. Payment amounts will be discounted for services reimbursed using the Medicaid Ambulatory Payment Classification fee schedule when a hospital performs certain procedures.

a. The State will reimburse procedures subject to discounting a percentage of the fee schedule amount.

b. The discount percentage will vary depending if the discounted procedure is a terminated procedure, a reduced services procedure or a procedure otherwise subject to discounting.

(ii) Medicaid physician fee schedule. The Medicaid allowable payment is based on the reported procedure code and is the lesser of charges or the fee schedule amount. The following outpatient hospital services are reimbursed using the physician fee schedule, which is described in additional detail in Attachment 4.19 B, Number 5:

(A) Physical, occupational and speech therapy;

(B) Radiology, including mammography screening and diagnostic mammography;

(C) Vaccines and immunization.

(iii) The Medicaid durable medical equipment, prosthetics and orthotics fee schedule. For those durable medical equipment, prosthetics and orthotics not included in the Wyoming Medicaid APC fee schedule, the Medicaid allowable payment is based on the reported procedure code and is the lesser of charges or the fee schedule amount. The durable medical equipment, prosthetics and orthotics fee schedule is described in additional detail in Attachment 4.19 B, Number 12c.

(iv) The Medicaid laboratory fee schedule. For those laboratory services not included in the Wyoming Medicaid APC fee schedule, the Medicaid allowable payment is based on the reported procedure code and is the lesser of charges or the fee schedule amount. The laboratory fee schedule is described in additional detail in Attachment 4.19 B, Number 3.

(v) Percent of charges. Certain services are reimbursed based on a percent of allowed charges. The Medicaid payments will not exceed Medicare upper payment limits according to 42 CFR, Section 447.321. These services include the following:

(A) Transplants. Reimbursed at 55 percent of billed charges, not to exceed the upper payment limits described in Section 1903(i) of the Social Security Act;

(B) Corneal tissue. Reimbursed using the hospital-specific Medicaid cost-to-charge ratio calculated annually for Wyoming Medicaid's inpatient level of care participating providers. Hospital-specific Medicaid cost-to-charge ratios may not exceed 100 percent. Non-participating hospitals are reimbursed using the average Medicaid cost-to-charge ratio for their provider type (children's hospital, critical access hospital and general acute care hospital);

(C) Medical devices that are paid transitional pass-through payments under Medicare's outpatient prospective payment system according to Social Security Act Section 1833(t) (6). Reimbursed using the hospital-specific Medicaid cost-to-charge ratios used in Section 8(v)(B);

(D) Dental. Reimbursed using the hospital-specific Medicaid cost-to-charge ratios used in Section 8(v)(B).

(b) Upper payment limits. The Medicaid payments will not exceed Medicare upper payment limits according to 42 CFR, Section 447.321. Reimbursement for laboratory services complies with Federal upper limits for laboratory services (1903(i) of the Social Security Act).

(c) Medicaid reimbursement is not available for services that are not medically necessary.

(d) Services that require prior authorization. The Division may, from time to time, designate outpatient hospital services that require prior authorization. In designating such services, the Division shall consider the cost of the service, the potential for over-utilization of the service, and the availability of lower cost alternatives. The Division shall disseminate a current list of services that require prior authorization to providers through Provider Manuals or Provider Bulletins. The failure to obtain prior authorization shall result in denials of Medicaid payment for the service.

(e) Claims for outpatient and inpatient hospital services. A claim seeking reimbursement for outpatient hospital services provided to a recipient within twenty-four hours before the recipient received inpatient hospital services for the same or similar diagnosis shall be denied.

(f) Updates. The APC conversion factors and relative weights is reviewed annually. Considerations for update include adequate provider participation, beneficiary access and the reduction of inequities in the system.

Section 9. 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.

(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 10. Payment of Claims. Payment of claims shall be pursuant to Chapter 3, Section 11, which is incorporated by this reference.

Section 11. Audits.

(a) The Department or Centers for Medicare and Medicaid Services (CMS) may audit a provider at any time to determine whether the hospital has received excess payments.

(b) The Department or CMS may perform audits through employees, agents, or through a third party. Audits shall be performed in accordance with generally accepted auditing standards.

(c) Disallowances. If an audit discloses excess payments, the Department shall recover any excess payments pursuant to Section 12.

(d) Notice of excess payments. After determining that a provider has received excess payments, the Department shall send written notice to the provider, by certified mail, return receipt requested, stating the amount of the excess payments, the basis for the determination of excess payments and the provider's right to request reconsideration of that determination pursuant to Section 13. The reconsideration shall be limited to whether the Department has complied with the provisions of this Chapter.

(e) Recovery of excess payments. A recovery of excess payments from a provider will result in the Department returning the appropriate Federal Financial Participation (FFP) to CMS. A provider must reimburse the Department for excess payments within thirty days after the

provider receives written notice from the Department pursuant to subsection (d), even if the provider has requested reconsideration or an administrative hearing regarding the determination of excess payments. If the provider fails to timely repay excess payments, the Department shall recover the excess payments pursuant to Section 12.

(f) Reporting audit results. If at anytime during a financial audit or a medical audit, the Division discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Division's final audit report regarding that provider, shall be referred to the Medicaid Fraud Control Unit of the Wyoming Attorney General's Office.

Section 12. Recovery of excess payments. The Department shall recover excess payments pursuant to Chapter 3, Section 12, which is incorporated by this reference.

Section 13. 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 11. 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 Attachment.

(f) Informal resolution. The provider or the Department may request an informal meeting before the final decision on reconsideration to determine whether the matter may be resolved. The substance of the discussions and/or settlement offers made pursuant to an attempt at informal resolution shall not be admissible as part of a subsequent administrative hearing or judicial proceeding.

(f) Administrative hearing. A provider may request an administrative hearing regarding the final agency decision pursuant to Chapter 1 of the Department's Medicaid 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 Attachment.

(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 1.

(h) Confidentiality of settlement agreements. If the Division and a provider enter into a settlement agreement as part of a reconsideration or an administrative hearing, such agreement shall be confidential, except as otherwise required by law. A breach of confidentiality by the provider shall, at the Division's option, result in the settlement agreement becoming null and void.

Section 14. Interpretation of Attachment.

(a) The order in which the provisions of this Attachment appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Attachment shall control the titles of various provisions.

Section 15. Superseding effect. This Attachment supersedes all prior Attachments or policy statements issued by the Department, including provider manuals and provider bulletins, which are inconsistent with this Attachment, except as otherwise specified in this Attachment.

Section 16. Severability. If any portion of this Attachment is found to be invalid or unenforceable, the remainder shall continue in effect.

Service 2a.

Outpatient Hospital Services

Qualified Rate Adjustment (QRA) Payments

A hospital located in Wyoming may be eligible for an outpatient Qualified Rate Adjustment (QRA) payment if:

1. It is owned or operated by a non-state governmental entity; and

2. Its calculated outpatient Medicaid costs for the payment period are greater than its projected pre-QRA outpatient Medicaid payments for the same period.

A hospital's calculated Medicaid costs for the payment period are determined by applying the cost-to-charge ratios developed from the hospital's most recently available Medicare cost report to the hospital's billed charges for outpatient services for Medicaid claims paid during the most recently ended State fiscal year (inflated to the midpoint of the payment period). Reimbursable costs are calculated using Medicare payment principles. Billed charges are inflated using the most currently available CMS Prospective Payment System Hospital Input Price Index.

A hospital's projected pre-QRA Medicaid payments for the payment period are the total of Medicaid payments to the hospital for claims paid during the most recently ended State fiscal year.

The QRA payment is an annual lump sum supplemental payment equal to a portion of the difference between a qualifying hospital's calculated Medicaid costs for the payment period and its pre-QRA Medicaid payments for the same period, minus amounts payable by other third parties and beneficiaries. Qualified Rate Adjustment payments are made after the qualifying hospital's data for the most recently ended state fiscal year become available. For purposes of the first QRA payments calculated under this provision, the first fiscal year treated as the most recently ended state fiscal year is the July 1, 2003 – June 30, 2004 fiscal year. QRA payments will not be subject to cost settlement. The Medicaid payments and the QRA payments will not exceed Medicare Upper Payment Limits according to 42 CFR, Section 447.321.

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

Wyoming Medicaid meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under Section(s) 4 19(B)

__X__ Wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, surgical or other invasive procedure performed on the wrong patient

Wyoming Medicaid will adopt the baseline for other provider-preventable conditions as described above The following reimbursement changes will apply

Payment will be denied for these conditions in any Health Care Setting as identified in Attachment 4 19(B) and any other settings where these events may occur For any Wyoming Medicaid claims with dates of service after July 1, 2012, Wyoming Medicaid will follow the minimum CMS regulations in 42 CFR §447 and deny payment for all of the OPPCs identified in 42 CFR §447

In compliance with 42 CFR 447 26(c), Wyoming Medicaid provides

1) That no reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider

2) That reductions in provider payment may be limited to the extent that the following apply

(I) The identified provider-preventable conditions would otherwise result in an increase in payment

(ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions

3) Assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries

In the event that individual cases are identified throughout the PPC implementation period, the State will adjust reimbursements according to the methodology above Denial of payment shall be limited to the additional care required by the provider preventable condition Wyoming Medicaid shall review from time to time the list of OPPCs and add to the list in the event that Wyoming Medicaid makes a medical finding using evidence-based guidelines In such an event, the Department shall disseminate to providers, through manuals or bulletins, a current list of provider preventable conditions pursuant to this Attachment

____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied For example – 4 19(d) nursing facility services, 4 19(b) physician services)* of the plan

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number The valid OMB control number for this information collection is 0938-New The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

PEDIATRIC PRACTITIONER SERVICES

Evaluation and Management

Office or Outpatient or Other Ambulatory Facility (Visit)

New Patient		
* 99201	Physicians typically spend 10 minutes	$ 23.90
* 99202	Physicians typically spend 20 minutes	$ 37.73
* 99203	Physicians typically spend 30 minutes	$ 50.98
* 99204	Physicians typically spend 45 minutes	$ 74.59
* 99205	Physicians typically spend 60 minutes	$ 92.74
Established Patient		
* 99211	Typically 5 minutes are spent supervising or performing these services	$ 12.38
* 99212	Physicians typically spend 10 minutes	$ 20.74
* 99213	Physicians typically spend 15 minutes	$ 28.80
* 99214	Physicians typically spend 25 minutes	$ 43.78
* 99215	Physicians typically spend 40 minutes	$ 67.39

Office or Other Outpatient Consultations

New or Established Patient		
99241	Physicians typically spend 15 minutes	$ 37.15
99242	Physicians typically spend 30 minutes	$ 58.18
99243	Physicians typically spend 40 minutes	$ 75.17
99244	Physicians typically spend 60 minutes	$105.41
99245	Physicians typically spend 80 minutes	$139.97

Confirmatory Consultations

New or Established Patient		
99271	Usually the presenting problem(s) are self limited or minor	$ 34.85
99272	Usually the presenting problem(s) are of low severity	$ 50.40
99273	Usually the presenting problem(s) are of moderate severity	$ 66.82
99274	Usually the presenting problem(s) are moderate to high severity	$ 90.14
99275	Usually the presenting problem(s) are of moderate to high severity	$118.66

Home Services

New Patient		
99341	Usually the presenting problem(s) are of low severity	$ 45.50

99342	Usually the presenting problem(s) are of moderate severity	$ 57.60
99343	Usually the presenting problem(s) are of high severity	$ 74.59

Established Patient

99351	Usually the patient is stable, recovering or improving	$ 35.14
99352	Usually the patient is responding inadequately to therapy or has developed a minor complication	$ 46.37
99353	Usually the patient is unstable or has developed a significant complication or a significant new problem	$ 58.18

Prolonged Services

Prolonged Physician Service with Direct (Face-to-Face) Patient Contact

99354	Prolonged physician serviced in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	$ 60.00
99355	Each additional 30 minutes	$ 30.00

Prolonged Physician Services without Direct (Face-to-Face) Patient Contact

99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	$ 60.00
99359	Each additional 30 minutes	$ 30.00

Preventive Medicine Services

New Patient

* 99381	Initial evaluation and management of a healthy individual requiring a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year)	N/C
* 99382	Early childhood (age 1 through 4 years)	N/C
* 99383	Late childhood (age 5 through 11 years)	N/C
* 99384	Adolescent (age 12 through 17 years)	N/C

Established Patient		
* 99391	Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/ diagnostic procedures; new patient; infant (age under 1 year)	N/C
* 99392	Early childhood (age 1 through 4 years)	N/C
* 99393	Late childhood (age 5 through 11 years)	N/C
* 99394	Adolescent (age 12 through 17 years)	N/C
Local Codes		
New Patient or Established Patient		
* X5501	Physician EPSDT exam	$ 45.00

Counseling and/or Risk Factor Reduction Intervention

New or Established Patient

Preventive Medicine, Individual Counseling		
99401	Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 15 minutes	N/C
99402	Approximately 30 minutes	N/C
99403	Approximately 45 minutes	N/C
99404	Approximately 60 minutes	N/C
Preventive Medicine, Group Counseling		
99411	Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting	N/C
99412	Approximately 60 minutes	N/C
Other Preventive Medicine Services		
99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)	N/C
99429	Unlisted preventive medicine services	N/C

Newborn Care			
	99432	Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s)	$100.00
Immunizations			
	90700	Immunization, active; diphtheria, tetanus toxoids, and accellular pertussis vaccine (DTP)	$ 7.00
*	90701	Immunization, active; diphtheria and tetanus toxoids and pertussis vaccine (DTP)	$ 7.00
	90702	Diphtheria and tetanus toxoids (DT)	$ 7.00
	90703	Tetanus toxoid	$ 13.00
	90704	Mumps virus vaccine, live	$ 7.00
	90705	Measles virus vaccine, live	$ 7.00
	90706	Rubella virus vaccine, live - state supplied	$ 7.00
*	90707	Measles, mumps and rubella virus, live	$ 7.00
	90708	Measles and rubella virus vaccine, live	$ 7.00
	90709	Rubella and mumps virus vaccine, live	$ 17.00
	90710	Measles, mumps, rubella, and varicella vaccine	$ 41.00
	90711	Diphtheria, tetanus, and pertussis (DTP) and injectable poliomyelitis vaccine	$ 50.00
*	90712	Poliovirus vaccine, live, oral (any type(s))	$ 7.00
	90713	Poliomyelitis vaccine - state supplied	$ 7.00
	90714	Typhoid vaccine	BR
	90716	Varicella (chicken pox) vaccine	$ 7.00
	90717	Yellow fever vaccine	BR
*	90718	Tetanus and diphtheria toxoids absorbed	$ 5.00
	90719	Diphtheria toxoid	BR
	90720	Diphtheria, tetanus, and pertussis (DTP) and hemophilus influenza b (HIB) vaccine	$ 7.00
	90721	Diphtheria, tetanus, toxoids, and acellular pertussis vaccine (DTAP) and Hemophilus influenza B(HIB) vaccine	$ 7.00
	90724	Influenza virus vaccine	$ 9.00
	90725	Cholera vaccine	BR
	90726	Rabies vaccine	BR
	90727	Plague vaccine	BR
	90728	BGC vaccine	BR

	90730	Hepatitis A vaccine	$ 13.00
	90732	Pneumococcal vaccine, polyvalent	$ 12.00
	90733	Meningococcal polysaccharide vaccine (any group(s))	$ 20.00
*	90737	Hemophilus influenza B - state supplied	$ 7.00
	90741	Immunization, passive; immune serum globulin, human (ISG)	$ 12.00
	90742	Specific hyperimmune serum globulins (e.g., hepatitis B, measles, pertussis, rabies, Rho(d), tetanus, vaccinia, varicella-zoster)	BR
	90744	Immunization, active, hepatitis B vaccine; new Newborn to 11 years	$ 7.00
	90745	Immunization, active, hepatitis B vaccine; new 11 - 19 years	$ 7.00
	90749	Unlisted immunization procedure	BR
	X5951	HIB conjugate	$ 7.00

OBSTETRICAL PRACTITIONER SERVICES

Maternity Care and Delivery

Incision

59000	Amniocentesis, any method	$ 63.00
59012	Cordocentesis (intrauterine), any method	$ 252.00
59015	Chorionic villus sampling, any method	$ 189.00
59020	Fetal contraction stress test	$ 63.00
59025	Fetal non-stress test	$ 63.00
59030	Fetal scalp blood sampling	$ 63.00
59050	Fetal monitoring during labor by consulting physician with written report (separate procedure); supervision and interpretation	$ 113.40
59051	Interpretation only	$ 88.20

Excision

59100	Hysterotomy, abdominal (e.g., for hydatidiform mole, abortion)	$1008.00
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	$ 882.00
59121	Tubal or ovarian, without abdominal pregnancy	$ 882.00
59130	Abdominal pregnancy	$ 913.50
59135	Interstitial, uterine pregnancy requiring total hysterectomy	$1102.50
59136	Interstitial, uterine pregnancy with partial resection of uterus cervical, with evacuation	$1260.00
59140	Cervical, with evacuation	$ 882.00
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	$ 693.00
59151	With salpingectomy and/or oophorectomy	$1134.00
59160	Curettage, postpartum (separate procedure	$ 264.60

Introduction		
59200	Insertion of cervical dilator	$ 151.20
Repair		
59300	Episiotomy or vaginal repair, by other by other than attending physician	$ 132.30
59320	cerclage or cervix, during pregnancy; vaginal	$ 226.80
59325	Abdominal	$ 378.00
59350	Hysterorrhaphy of ruptured uterus	$ 945.00
Vaginal Delivery, Antepartum or Postpartum Care		
* 59400	Routine obstetric care including antepartum care, vaginal delivery	$1260.00
* 59409	Vaginal delivery only (with or without episiotomy and/or forceps)	$ 787.50
* 59410	Vaginal delivery only (with or without episiotomy and/or forceps) including postpartum care	$ 787.50
* 59412	External cephalic version, with or without tocolysis	$ 220.50
* 59414	Delivery of placenta (separate procedure	$ 157.50
* 59420	Antepartum visit (separate procedure)	$ 42.95
* 59425	Antepartum care only; 4-6 visits	N/C
* 59426	7 or more visits	N/C
* 59430	Postpartum care only (separate procedure)	$ 42.95
* X5901	Initial visit	$ 70.00
Cesarean Delivery		
* 59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	$1575.00
* 59514	Cesarean delivery only	$1102.50
* 59515	Cesarean delivery only including postpartum care	$1102.50
* 59525	Subtotal or total hysterectomy after initial visit cesarean delivery	$ 535.50
Abortion		
59812	Treatment of spontaneous abortion, any trimester, completed surgically	$ 252.00
59820	Treatment of missed abortion, completed surgically; first trimester	$ 283.50

59821	Second trimester	$ 315.00
59830	Treatment of septic abortion, completed	$ 315.00
59840	Induced abortion, by dilation and curettage	$ 283.50
59841	Induced abortion, by dilation and evacuation	$ 283.50
59850	Induced abortion, by one or more intra-amniotic injections	$ 447.30
59851	With dilation and curettage and/or evacuation	$ 567.00
59852	With hysterotomy (failed intra-amniotic injection	$756.00
59855	Induced abortion, by one or more vaginal suppositories (e.g., prostaglandin) with or without cervical dilation (e.g., laminaria)	$ 529.20
59856	With dilation and curettage and/or evacuation	$ 648.90
59857	With hysterotomy (failed medical evaluation)	$ 837.90

Other Procedures

59870	Uterine evacuation and curettage for hydatidiform mole	$ 315.00
59899	Unlisted procedure, maternity care and delivery	BR

STATE: WYOMING

Medicaid reimburses all practitioners using the fees listed in Attachment 4.19-B, Attachment 1, Pages 1-8 regardless of specialty.

Wyoming has no HMO providers.

Incentive payments:

Providers who are certified as disproportionate share providers are allowed a 10% increase in the calculated allowed fee as listed below for the following procedures:

Code	Incentive Payment
99201	$ 26.29
99202	41.51
99203	56.08
99204	82.05
99205	102.02
99211	13.62
99212	22.82
99213	31.68
99214	48.16
99215	74.13
X5901	77.00
59400	1386.00
59409	866.25
59410	866.25
59420	47.25
59430	47.25
59510	1732.50
59514	1212.75
59515	1212.75
59610	1386.00
59612	866.25
59614	866.25
59618	1732.50
59620	1212.75
59622	1212.75
X5501	49.50
X5501 RE	49.50
99431	110.00
99433	33.00

AVERAGE MEDICAID PAYMENT FOR LISTED OBSTETRIC SERVICES

CODE	STATEWIDE	NATRONA COUNTY (CASPER)	LARAMIE COUNTY (CHEYENNE)
59400	$1356.95	$1359.28	$1380.64
59409	801.03	856.58	866.25
59410	823.75	866.25	840.00
59412	220.50	0.00	220.50
59414	157.50	0.00	0.00
59420	49.48	57.34	55.90
59425	0.00	0.00	0.00
59426	0.00	0.00	0.00
59430	43.19	45.56	36.00
59510	1688.81	1677.38	1732.50
59514	1101.42	847.18	1212.75
59515	1144.03	1157.63	0.00
59525	0.00	0.00	0.00

AVERAGE MEDICAID PAYMENT
FOR LISTED OBSTETRIC SERVICES (OB/GYN)

CODE	STATEWIDE	NATRONA COUNTY (CASPER)	LARAMIE COUNTY (CHEYENNE)
59400	$1360.49	$1335.78	$1386.00
59409	796.06	859.69	866.25
59410	820.17	0.00	840.00
59412	220.50	0.00	220.50
59414	157.50	0.00	0.00
59420	46.98	52.18	47.24
59425	0.00	0.00	0.00
59426	0.00	0.00	0.00
59430	43.02	45.00	0.00
59510	1691.06	1641.05	1732.50
59514	1108.00	847.18	1212.75
59515	1137.71	1102.50	0.00
59525	0.00	0.00	0.00

AVERAGE MEDICAID PAYMENT FOR LISTED OBSTETRIC SERVICES (OTHER)

CODE	STATEWIDE	NATRONA COUNTY (CASPER)	LARAMIE COUNTY (CHEYENNE)
59400	$1350.84	$1375.60	$1370.92
59409	822.62	844.17	866.25
59410	830.12	866.25	840.00
59412	0.00	0.00	0.00
59414	157.50	0.00	0.00
59420	54.58	57.89	58.34
59425	0.00	0.00	0.00
59426	0.00	0.00	0.00
59430	43.97	45.90	36.00
59510	1672.53	1716.21	0.00
59514	1051.43	0.00	0.00
59515	1160.87	1212.75	0.00
59525	0.00	0.00	0.00

STATE: WYOMING

AVERAGE MEDICAID PAYMENTS FOR LISTED PEDIATRIC SERVICES

CODE	STATEWIDE	NATRONA COUNTY (CASPER)	LARAMIE COUNTY (CHEYENNE)
90701	$6.46	$6.05	$6.13
90707	6.54	5.91	6.71
90712	5.88	3.85	6.41
90737	6.32	6.01	5.64
90744	0.00	0.00	0.00
90745	0.00	0.00	0.00
99201	24.47	24.82	24.69
99202	38.64	38.76	38.68
99203	51.45	51.25	51.66
99204	69.99	67.39	70.68
99205	83.09	86.20	91.79
99211	12.50	12.06	12.27
99212	21.70	22.28	21.40
99213	30.36	29.75	30.48
99214	44.62	46.34	43.93
99215	64.47	66.21	66.25
99381	0.00	0.00	0.00
99382	0.00	0.00	0.00
99383	0.00	0.00	0.00
99384	0.00	0.00	0.00
99391	0.00	0.00	0.00
99392	0.00	0.00	0.00
99393	0.00	0.00	0.00
99394	0.00	0.00	0.00

AVERAGE MEDICAID PAYMENTS FOR LISTED PEDIATRIC SERVICES (OTHER)

CODE	STATEWIDE	NATRONA COUNTY (CASPER)	LARAMIE COUNTY (CHEYENNE)
90701	$6.19	$5.90	$6.11
90707	6.18	5.39	6.44
90712	5.04	2.41	5.60
90737	6.10	5.73	5.64
90744	0.00	0.00	0.00
90745	0.00	0.00	0.00
99201	24.44	24.82	24.44
99202	38.43	38.79	38.12
99203	51.20	51.26	51.47
99204	71.09	66.78	69.71
99205	82.70	85.92	88.51
99211	12.50	12.00	12.21
99212	21.70	22.39	21.29
99213	29.92	29.83	29.63
99214	43.94	46.25	41.19
99215	62.35	65.16	59.94
99381	0.00	0.00	0.00
99382	0.00	0.00	0.00
99383	0.00	0.00	0.00
99384	0.00	0.00	0.00
99391	0.00	0.00	0.00
99392	0.00	0.00	0.00
99393	0.00	0.00	0.00
99394	0.00	0.00	0.00

AVERAGE MEDICAID PAYMENTS FOR LISTED PEDIATRIC SERVICES (PEDS)

CODE	STATEWIDE	NATRONA COUNTY (CASPER)	LARAMIE COUNTY (CHEYENNE)
90701	$6.89	$6.68	$7.00
90707	6.97	6.93	7.00
90712	6.85	6.95	7.00
90737	6.82	6.74	0.00
90744	0.00	0.00	0.00
90745	0.00	0.00	0.00
99201	25.22	0.00	26.29
99202	39.83	38.15	41.50
99203	52.01	51.19	55.52
99204	66.80	74.39	80.98
99205	84.12	92.74	95.90
99211	12.54	12.65	13.61
99212	21.69	21.13	22.76
99213	30.95	29.54	31.66
99214	46.07	46.60	47.84
99215	68.85	68.06	71.58
99381	0.00	0.00	0.00
99382	0.00	0.00	0.00
99383	0.00	0.00	0.00
99384	0.00	0.00	0.00
99391	0.00	0.00	0.00
99392	0.00	0.00	0.00
99393	0.00	0.00	0.00
99394	0.00	0.00	0.00

STATE: WYOMING

Health Care Financing conducted an annual analysis of all licensed physicians engaged in primary care in Wyoming, by county, to determine their status with regard to participation in the Medicaid program. The definition of primary care for the sake of this analysis included physician specialties of general practice (GP), family practice (FP), obstetrics and gynecology (OG), and pediatrics (PD). There were 291 licensed primary care physicians in Wyoming in March 1997 of which 100% participated in Medicaid during the past year. Participation was defined as having at least one paid claim. These statistics are depicted below.

	Licensed/ Participating					Licensed Non-Participating			
	FP	GP	OG	PD		FP	GP	OG	PD
ALBANY	6	--	3	5		--	--	--	--
BIG HORN	2	2	--	--		--	--	--	--
CAMPBELL	6	2	4	3		--	--	--	--
CARBON	4	3	--	1		--	--	--	--
CONVERSE	1	3	--	--		--	--	--	--
CROOK	0	0	--	--		--	--	--	--
FREMONT	7	4	6	3		--	--	--	--
GOSHEN	4	2	--	--		--	--	--	--
HOT SPRINGS	4	--	--	--		--	--	--	--
JOHNSON	4	--	--	--		--	--	--	--
LARAMIE	47	2	6	9		--	--	--	--
LINCOLN	8	2	--	1		--	--	--	--
NATRONA	43	2	5	6		--	--	--	--
NIOBRARA	--	3	--	--		--	--	--	--
PARK	7	2	2	2		--	--	--	--
PLATTE	1	--	1	--		--	--	--	--
SHERIDAN	5	1	3	4		--	--	--	--
SUBLETTE	3	0	--	--		--	--	--	--
SWEETWATER	9	1	3	3		--	--	--	--
TETON	4	1	4	4		--	--	--	--
UINTA	5	--	2	3		--	--	--	--
WASHAKIE	3	2	--	--		--	--	--	--
WESTON	3	--	--	--		--	--	--	--
TOTALS	176	32	39	44		0	0	0	0

STATE: WYOMING

FAMILY PRACTITIONERS/GENERAL PRACTITIONERS PERFORMING OBSTETRICS

	Licensed		Providing OB			Providing Medicaid OB	
	FP	GP	FP	GP		FP	GP
ALBANY	6	--	4	--		4	--
BIG HORN	2	2	00	1		--	1
CAMPBELL	6	2	4	--		4	--
CARBON	4	3	1	0		1	0
CONVERSE	1	3	1	3		1	3
CROOK	0	0	--	0		--	0
FREMONT	7	4	5	1		5	1
GOSHEN	4	2	3	2		3	2
HOT SPRINGS	4	--	3	--		3	--
JOHNSON	4	--	4	--		4	--
LARAMIE	47	2	27	1		27	1
LINCOLN	8	2	6	2		6	2
NATRONA	43	2	27	1		27	1
NIOBRARA	--	3	--	0		--	0
PARK	7	2	7	1		7	1
PLATTE	1	--	1	--		1	--
SHERIDAN	5	1	--	--		--	--
SUBLETTE	3	0	--	--		--	--
SWEETWATER	9	1	--	1		--	1
TETON	4	1	1	--		1	--
UINTA	5	--	3	--		3	--
WASHAKIE	3	2	2	1		2	1
WESTON	3	--	3	--		3	--
TOTAL	176	32	102	14		102	14

STATE: WYOMING

FAMILY PRACTITIONERS/GENERAL PRACTITIONERS/PEDIATRIC NURSE PRACTITIONERS PROVIDING PEDIATRIC SERVICES

	LICENSED			PROVIDING PED			PROVIDING MEDICAID PED		
	FP	GP	PNP	FP	GP	PNP	FP	GP	PNP
ALBANY	6	--	--	6	--	--	6	--	--
BIG HORN	2	2	--	2	2	--	2	2	--
CAMPBELL	6	2	--	6	2	--	6	2	--
CARBON	4	3	--	4	3	--	4	3	--
CONVERSE	1	3	--	1	3	--	1	3	--
CROOK	0	0	--	0	0	--	0	0	--
FREMONT	7	4	--	7	4	--	7	4	--
GOSHEN	4	2	--	4	2	--	4	2	--
HOT SPRINGS	4	--	--	4	--	--	4	--	--
JOHNSON	4	--	--	4	--	--	4	--	--
LARAMIE	47	2	--	47	2	--	47	2	--
LINCOLN	8	2	--	8	2	--	8	2	--
NATRONA	43	2	--	43	2	--	43	2	--
NIOBRARA	--	3	--	--	3	--	--	3	--
PARK	7	2	--	7	2	--	7	2	--
PLATTE	1	--	--	1	--	--	1	--	--
SHERIDAN	5	1	1	5	1	1	5	1	1
SUBLETTE	3	0	--	3	0	--	3	0	--
SWEETWATER	9	1	--	9	1	--	9	1	--
TETON	4	1	--	4	1	--	4	1	--
UINTA	5	--	--	5	--	--	5	--	--
WASHAKIE	3	2	--	3	2	--	3	2	--
WESTON	3	--	--	3	--	--	3	--	--
TOTAL	176	32	1	176	32	1	176	32	1

STATE: Wyoming

Selective contracting of outpatient services. The Division may identify outpatient services to be reimbursed as speciality services pursuant to Attachment 4.19A, Part 3. In evaluating services for reimbursement as speciality services, the Department shall consider:

(1) The cost of services and the potential savings from selective contracting;

(2) The potential to control over-utilization of services;

(3) Methods of ensuring recipient access to services; and

(4) Methods of ensuring quality.

Selective contracting of outpatient services shall be pursuant to Atachment 4.19A, Part 3.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

2b. RURAL HEALTH CLINIC SERVICES

Payment for Rural Health Clinic (RHC) services conforms to Section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA).

All covered RHC services furnished on or after January 1, 2001 and each succeeding Federal Fiscal Year are reimbursed using a prospective payment system.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse RHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively reimburse RHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

Payment is set prospectively using the RHC's reasonable costs of providing Medicaid-covered services during RHC Fiscal Years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during RHC Fiscal Year 2001.

The baseline per visit rate is determined for each RHC by (1) calculating a per visit rate for RHC Fiscal Year 1999 and RHC Fiscal Year 2000, (2) adding the two rates together, and (3) dividing the sum by two.

Beginning with Federal Fiscal Year 2002 and for each Federal Fiscal Year thereafter, the per visit payment rate is increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the RHC during that RHC Fiscal Year. The RHC is responsible for supplying the needed documentation to the State regarding increases or decreases in the RHC's scope of services.

The Medicaid allowable payment for a provider that qualifies as a Rural Health Clinic (RHC) after September 30, 1999, shall be equal to 100 percent of the reasonable costs used in calculating the rates of RHC's with similar caseloads located in the state during the same facility fiscal year. If there are no RHC's located in Wyoming with a similar caseload, the Department shall calculate the rate for the new RHC based on projected costs after applying tests of reasonableness.

The per visit payment for out-of-state RHC's is the statewide average Medicaid allowable payment in effect in the State as of October 1st of that year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

2c. FEDERALLY QUALIFIED HEALTH CENTER SERVICES

Payment for Federally Qualified Health Center (FQHC) services conforms to Section 702 of the Benefits Improvement and Protection Act of 2000 (BIPA).

All covered FQHC services furnished on or after January 1, 2001 and each succeeding Federal Fiscal Year are reimbursed using a prospective payment system.

Until the State transitions to the prospective payment system on October 1, 2001, the State will reimburse FQHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively reimburse FQHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.

Payment is set prospectively using the FQHC's reasonable costs of providing Medicaid-covered services during FQHC Fiscal Years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during FQHC Fiscal Year 2001.

The baseline per visit rate is determined for each FQHC by (1) calculating a per visit rate for FQHC Fiscal Year 1999 and FQHC Fiscal Year 2000, (2) adding the two rates together, and (3) dividing the sum by two.

Beginning with Federal Fiscal Year 2002 and for each Federal Fiscal Year thereafter, the per visit payment rate is increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the FQHC during that FQHC Fiscal Year. The FQHC is responsible for supplying the needed documentation to the State regarding increases or decreases in the FQHC's scope of services.

The Medicaid allowable payment for a provider that qualifies as a Federally Qualified Health Center (FQHC) after September 30, 1999, shall be equal to 100 percent of the reasonable costs used in calculating the rates of FQHC's with similar caseloads located in the state during the same facility fiscal year. If there are no FQHC's located in Wyoming with a similar caseload, the Department shall calculate the rate for the new FQHC based on projected costs after applying tests of reasonableness.

The per visit payment for out-of-state FQHC's is the statewide average Medicaid allowable payment in effect in the State as of October 1st of that year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

3. OTHER LABORATORY AND X-RAY SERVICES

Laboratory Services

Reimbursement for all outpatient laboratory services is the lessor of charges or the Medicaid fee schedule amount. The fee schedule for laboratory services complies with the Federal upper limits of payments for laboratory services.

X-ray Services

Reimbursement is the lessor of charges or the Physician fee schedule amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

DENTAL SERVICES

Reimbursement is the lesser of charges or the established fee schedule amount. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of dental services and the fee schedule is published on the Medicaid website: https://wymedicaid.portal.conduent.com/

Effective for services provided on or after January 1, 2021, for dental procedures, Wyoming will set a fee at 67.5% of the fee determined by the National Dental Customized Fee Analyzer and fee data from average billed charges of Wyoming dental providers. For procedures that do not have sufficient data to set a fee, reimbursement will be determined by report and reimbursed at 67.5% of billed charge until sufficient data is available to establish an allowable fee. Fees for specific procedures are adjusted and set when a significant number of claims or fees are defined as outliers, or there is a comparable CPT code with a set fee. CPT fees are determined using the Resource-Based Relative Value Scale (RBRVS). This fee will be utilized to price the dental code.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

4.c. FAMILY PLANNING SERVICES AND SUPPLIES

Refer to appropriate services for reimbursement data, i.e., inpatient and outpatient hospital and physician services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

5. PHYSICIAN SERVICES

Reimbursement for physician services is the lesser of charges or the Medicaid fee schedule amount. A maximum allowable fee is established by procedure code regardless of provider location. All public and private providers are reimbursed according to the same fee schedule. Providers may access the fee schedule on the agency website or upon request by calling the fiscal agent.

Physician fees were determined by an RBRVS analysis of customary charges, prevailing charges, and average commercial rates. Charges were inflated to the SFY 2007 rate year using the Medicare Economic Index. The reasonable charge was identified as the lower of the inflated charges or the newly computed rate under each of the three approaches. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. Reimbursement rate for these services, for dates of service on or after July 1st 2010 are on the official Web site of the Department of Health at http://wdh.state.wy.us or http://wyequalitycare.acs-inc.com

New procedures or by report procedures are reimbursed at 70% of billed charges until sufficient data (consultant recommendations or profiling of charges) is available to establish a relative value or allowable fee. Fee for specific procedures are adjusted when a significant number of claims or fees are defined as outliers. The modification may be performed by adjusting the relative value and conversion factor or by establishing a specific fee.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

5.b. MEDICAL AND SURGICAL SERVICES FURNISHED BY A DENTIST

Reimbursement for medical and surgical services furnished by a dentist is the lessor of charges or the Medicaid fee schedule amount.

Reimbursement-Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☐ The rates reflect all Medicare geographic/locality adjustments.

☒ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: Deloitte Fee Schedule Tool , no other changes in rates are anticipated.

Method of Payment

☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☒ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99339, 99340, 99363, 99364, 99368, 99375, 99378, 99386, 99387, 99396, 99397, 99408, 99409, 99411, 99412, 99420, 99444, 99450, 99455, 99456, 99485, 99486, 99487, 99488, 99489, 99495, 99496 and 99499

(Primary Care Services Affected by this Payment Methodology – continued)

☐ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

_____

_____

_____

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☒ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: $11.81.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: _____.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____

_____

_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/14 but not prior to December 31, 2014. All rates are published at http://wyequalitycare.acs-inc.com/index.html.

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/14 but not prior to December 31, 2014. All rates are published at (http://wyequalitycare.acs-inc.com/index.html.

ATTACHMENT 4.19B

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WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

6.b. OPTOMETRISTS

Professional fees are reimbursed at the lessor of charges or the established physicians' fee schedule amount. Materials are reimbursed at the lessor of charges or the Medicaid fee schedule amount.

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POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

6.d. OTHER PRACTITIONERS

Certified Registered Nurse Anesthetist (CRNA)

Reimbursement for CRNA services is the lessor of the charges or the Medicaid fee schedule amount allowed for anesthesia services.

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POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

7. HOME HEALTH SERVICES

Home Health Agency

Reimbursement for home health services other than disposable medical supplies is the lessor of charges or the established fee schedule amount. Disposable medical supplies are reimbursed at charges.

Medical Supplier

For HCPCS codes subject to Section 1903(i)(27) of the Social Security Act:

Reimbursement for DMEPOS is set at the lower of the following, excluding oxygen, oxygen related equipment, and oxygen related supplies:

1. Ninety seven and a half percent (97.5%) of the Medicare DMEPOS fee schedule rate for Wyoming geographic areas, set as of January 1 each year, and updated on an annual basis as needed;
2. The provider's charge; or
3. Actual acquisition cost plus shipping plus a percentage of billed charges.

For HCPCS codes not subject to Section 1903(i)(27) of the Social Security Act, codes for which Medicare does not have an assigned rate, and oxygen, oxygen related equipment, and oxygen related supplies:

Reimbursement for DMEPOS is set at the lower of the following:

1. The Wyoming Medicaid Fee Schedule amount;
2. The provider's charge; or
3. Actual acquisition cost plus shipping plus a percentage of billed charges.

Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of January 1, 2021 and is effective for services provided on or after that date. All rates are published on the Medicaid Web site at https://wymedicaid.portal.conduent.com/fee_schedule.html.

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POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED.

42 CFR 447.321

9. CLINIC SERVICES

a.) Payment for clinic services will not exceed the upper limits of payment specified in 42 CFR 447.321.

b.) Family Planning Clinics - Reimbursement is the lessor of the charges or the fee schedule amount.

c.) End Stage Renal Disease Centers (ESRD) – ESRD clinics will be reimbursed at the lessor of the Medicare rate for services in the state where the facility is located or billed charges.

d.) County Health Departments – Payment is made at the lessor of charges or the established fee schedule amount.

e.) Tribal Health Programs

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of clinic services.

The Agency's fee schedule was last updated January 1, 2014 and is effective for dates of service provided on or after that date. All rates are published on the Medicaid provider website located at: https://wyequalitycare.acs-inc.com/fee_schedule.html.

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POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED.

CLINIC SERVICES (continued)

(e). Payments to Indian Health Services and any 638 tribal health facility that is federally recognized and tribally-operated or operated by the Indian Health Service shall be made according to the following:

Clinic Categories of Service – Payment for multiple encounters on the same date of service will be allowed only if the services are categorically different and/or are provided for distinct and separate diagnoses. Different categories of allowable services shall include but are not limited to practitioner services, mental health services, optometric services, dental services, physical therapy, occupational therapy, and speech therapy. Any services provided outside of the clinic shall be reimbursed according to the fee schedule.

Pharmacy encounters will be paid at the federal OMB clinic encounter rate and will not be limited to a certain number of prescriptions per day.

End Stage Renal Disease (ESRD) clinics will be paid up to one (1) encounter per day if medically necessary.

Nursing Home Reimbursement is located in section 4.19-D of the State Plan.

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POLICY AND METHODS OF ESTABLISHING PAYMENT/PER VISIT RATES FOR INDIAN HEALTH SERVICES

Alternative Payment Methodology for Tribal Facilities Recognized as FQHCs

Under section 1905(I)(2)(B) of the Social Security Act and the Indian Self Determination Act (Public Law 93-638), facilities operated by a Tribe or Tribal organization are, by definition, FQHCs. A Tribal FQHC may bill Wyoming Medicaid for services on a per visit basis whether those services are furnished at the facility, outside the facility, by telehealth (when the practitioner is in the facility and client is off-site) or provided by off-site providers under contract to the Tribal FQHC.

Under the authority of section 1902(bb)(6) of the Social Security Act, Tribal facilities that have chosen to be designated as a Tribal FQHC to be paid using an Alternative Payment Methodology (APM). Tribal FQHCs who agree to receive this APM will receive reimbursement equivalent to the AIR for in-scope FQHC services.

Wyoming Medicaid will establish a Prospective Payment System (PPS) methodology for the Tribal FQHCs so that the agency can determine on an annual basis that the published, all-inclusive rate is higher than the PPS rate. The PPS rate will be established by reference to the PPS rate that is currently paid to non-tribal FQHCs to determine if the all-inclusive rate is higher. Tribal FQHCS are not required to report their costs for the purposes of establishing a PPS rate.

ATTACHMENT 4.19B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

11.a. PHYSICAL THERAPY

Reimbursement is the lessor of charges or the fee schedule amount. Refer to physician services.

TN # 89-09
Supersedes
TN # 88-09

Approval Date 1/31/90 Effective Date 7/1/89

STATE PLAN ATTACHMENT 4.19 B

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

11.B. OCCUPATIONAL THERAPY

Reimbursement is the lessor of charges or the fee schedule amount. The Office of Medicaid utilizes the Resource Based Relative Value Scale (RBRVS) for fee schedule development.

TN: 03-004
Approval: 01/29/04
Effective: 07/01/03
Supersedes: NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

11.c. SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING AND LANGUAGE DISORDERS (PROVIDED BY OR UNDER THE SUPERVISION OF A SPEECH PATHOLOGIST OR AUDIOLOGIST).

Reimbursement is the lessor of charges or the fee schedule amount. Refer to Physician Services.

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

11.d. SPEECH THERAPY

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of speech therapy services. The agency's fee schedule rate for speech therapy services was set as of July 1, 2009 and is effective for services provided on or after that date. All rates are published at wyequalitycare.acs-inc.com.

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

11.d. SPEECH PATHOLOGY

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of speech pathology services. The agency's fee schedule rate for speech therapy services was set as of July 1, 2009 and is effective for services provided on or after that date. All rates are published at wyequalitycare.acs-inc.com.

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State of WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

12.a. PHARMACY PROVIDERS

1. Payment for covered outpatient legend and non-legend drugs dispensed by a retail community pharmacy will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

a) The National Average Drug Acquisition Cost (NADAC) of the drug;
b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%;
c) When neither NADAC nor WAC are available, DHCF shall substitute Average Wholesale Price (AWP)-11%;
d) The Federal Upper Limit (FUL);
e) The State Maximum Allowable Cost (SMAC);
f) The Ingredient Cost submitted;
g) The Gross Amount Due (GAD); or
h) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

Reimbursement for claims that pay at GAD or U&C will not include an additional $10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.

2. Payment for specialty drugs not dispensed by a retail community pharmacy but dispense primarily through the mail will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

a) The National Average Drug Acquisition Cost (NADAC) of the drug;
b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%;
c) When neither NADAC nor WAC are available, DHCF shall substitute Average Wholesale Price (AWP)-11%;
d) The Federal Upper Limit (FUL);
e) The State Maximum Allowable Cost (SMAC);
f) The Ingredient Cost submitted;
g) The Gross Amount Due (GAD); or
h) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

Reimbursement for claims that pay at GAD or U&C will not include an additional $10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.

3. Payment for drugs not dispensed by a retail community pharmacy (i.e., institutional or long-term care facility pharmacies) will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

a) The National Average Drug Acquisition Cost (NADAC) of the drug;
b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%;

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POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

c) When neither NADAC nor WAC are available, DHCF shall substitute Average Wholesale Price (AWP)-11%;
d) The Federal Upper Limit (FUL);
e) The State Maximum Allowable Cost (SMAC);
f) The Ingredient Cost submitted;
g) The Gross Amount Due (GAD); or
h) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

Reimbursement for claims that pay at GAD or U&C will not include an additional $10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.

4. Payment for clotting factor from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence will include the drug ingredient cost plus a $10.65 professional dispensing fee. The drug ingredient cost reimbursement shall be the lowest of:

a) The National Average Drug Acquisition Cost (NADAC) of the drug;
b) When no NADAC is available, DHCF shall substitute Wholesale Acquisition Cost (WAC) + 0%;
c) When neither NADAC nor WAC are available, DHCF shall substitute Average Wholesale Price (AWP)-11%;
d) The Federal Upper Limit (FUL);
e) The State Maximum Allowable Cost (SMAC);
f) The Ingredient Cost submitted;
g) The Gross Amount Due (GAD); or
h) The provider's usual and customary (U&C) charge to the public, as identified by the claim charge.

Reimbursement for claims that pay at GAD or U&C will not include an additional $10.65 dispensing fee as the cost to dispense should be included in the GAD and U&C as submitted on the claim.

5. Entities that purchase products under Section 340B of the Public Health Service Act must request, in writing, to use these drugs for Wyoming Medicaid clients. 340B entities that request and are granted such an arrangement shall bill Medicaid no more than their actual acquisition cost (AAC) for the drug and will be reimbursed no more than the AAC plus a $10.65 dispensing fee. 340B entities that fill Wyoming Medicaid client prescriptions with drugs not purchased under the Section 340B of the Public Health Services Act will be reimbursed in accordance with section 1 of this State Plan Amendment plus the $10.65 professional dispensing fee.

5.1. Drugs acquired through the federal 340B drug price program and dispensed by 340B contract pharmacies are not covered.

6. Facilities purchasing drugs through the Federal Supply Schedule (FSS) or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than 340B drug pricing program will be

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reimbursed no more than the actual acquisition cost for the drug plus a $10.65 professional dispensing fee.

7. Facilities purchasing drugs a Nominal Price (outside of 340B or FSS) will be reimbursed no more than the actual acquisition cost for the drug plus a $10.65 professional dispensing fee. Nominal Price as defined in §447.502 of the Code of Federal Regulation, Part 42 means a price that is less than 10 percent of the average manufacturer price (AMP) in the same quarter for which the AMP is computed.

8. Physician administered drugs (PADs) submitted under the medical benefit will be reimbursed at 100 percent of the Average Sales Price (ASP). PADs without an ASP on the CMS reference file will be reimbursed at an aggregate Wholesale Acquisition Cost (WAC) + 0% for the pertinent HCPCS code. PADs without and ASP or WAC will be reimbursed at an aggregate AWP for the HCPCS code. If it is clearly demonstrated by the provider that reimbursement at the ASP, WAC, or AWP rate will negatively impact a provider's ability to continue service delivery, the DHCF may reimburse for PADs up to 100% of the established Medicare rate for the same PAD. In accordance with section 5 above, covered entities using drugs purchased at the prices authorized under Section 340B of the Public Health Services Act for Medicaid members must bill Medicaid their actual acquisition cost (AAC).

9. Payment to all Indian Health Service, tribal, and urban Indian pharmacies shall be at the All Inclusive Rate (AIR) published annually in the Federal Register. One AIR reimbursement shall be made for each pharmacy claim paid by the Department. The applicable AIR shall be determined by the date of service submitted on the pharmacy claim. Pharmacies reimbursed using the AIR will not be eligible for a dispensing fee.

10. Investigational drugs are not a covered service under the Wyoming Medicaid program.

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STATE: WYOMING

1905(a)(5)(a) Physician Services

Professional Services Supplemental Payments – Non-State Government Owned or Operated Hospitals

Subject to the provisions of this section, effective July 1, 2020 all provider groups owned or operated by licensed non-state government owned or operated (NSGO) hospitals meeting the definition of "health care provider" (pursuant to 42 CFR 433.52) located in Wyoming shall be eligible for a quarterly professional services supplemental payment (PSSP) (based on an annual calculation). The PSSP will be the result of an analysis of the costs of the following covered services furnished to Wyoming Medicaid patients (excludes inpatient and outpatient services):

a) Physician Services, to include Physician Assistants and Nurse Practitioners;
b) Certified Registered Nurse Anesthetists;
c) Certified Nurse Midwives;
d) Services provided by a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor, and Licensed Additions Therapist;
e) Home Health Care Services not otherwise provided as inpatient or outpatient services;
f) Chiropractic Services;
g) Optometric/optician Services;
h) Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services not otherwise provided as inpatient or outpatient services;
i) Psychological Services;
j) Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department; and

In order to qualify to receive supplemental payments, the physician or professional service practitioner must be:

a) Licensed by the State of Wyoming
b) Enrolled as a Wyoming Medicaid provider
c) A provider type that provides the covered services listed above
d) Employed by, or under contract to provide services at or in affiliation with a non-state owned or operated governmental entity and identified by the NSGO entity as a physician or practitioner that is employed by, under contract to provide services at or in affiliation with said entity.

The PSSP amount available for each provider group owned or operated by a NSGO hospital participating in the PSSP program will equal the difference between the Medicaid payment

ceiling that Wyoming commercial payers would pay under average commercial rate (ACR) principles and the amount paid for the same services by the Wyoming Department of Health (the Department). Aggregate payments to provider groups owned or operated by NSGO hospitals shall not exceed the Medicaid upper payment limit (UPL) in accordance with section 1902(a)(30(A) of the Social Security Act. The Department will perform the Medicaid UPL analysis prior to making the supplemental payments.

For services furnished by provider groups owned or operated by a NSGO hospital, the Department will collect from each provider group their current payment arrangement for at least three commercial payers contracted with the provider group. The Department will calculate the ACR by procedure code, modifier, and place of service combination for each provider group that is owned or operated by a NSGO hospital using at least three commercial paid claims sets or fee schedules specific to the provider group. The Department will limit its analysis to covered services within the Medicaid program.

The Department will extract paid claims for the preceding calendar year for provider groups that qualify for inclusion in the PSSP program. The Department will align the provider group's ACR for each procedure code to each Medicaid claim for services furnished by the provider group and calculate the average commercial payments for the claims.

The Department will calculate an aggregate Medicare-to-ACR equivalent ratio (MER), for each NSGO hospital, to create an estimated payment for procedure codes without an ACR. For the provider-specific MER, the Department will divide the estimated average commercial payments for each provider's Medicaid claims by the total estimated Medicare payments for the same set of claims. The Medicare rates will be the most currently available national rates that align with the UPL year. The Department will apply this MER to the current Medicare payment for all included procedure codes found in the claims data to create an estimated Medicaid payment ceiling.

The Department will calculate the PSSP and the UPL demonstration annually using claims data from the most recently completed calendar year. Provider PSSP estimates will be available July 1 of each year.

The Medicare equivalent ratios of the ACR will be re-determined every three years. The Department may add new provider groups owned or operated by NSGO hospitals to the PSSP payment calculations annually.

To have provider groups included in the PSSP program, NSGO hospitals must provide ownership or affiliation attestation documents and the required commercial payer fee schedules or paid claims information for provider groups.

STATE: WYOMING

Professional Services Supplemental Payments – Privately Owned or Operated Hospitals

Subject to the provisions of this section, effective July 1, 2020 all provider groups owned or operated by licensed privately owned or operated (private) hospitals meeting the definition of "health care provider" (pursuant to 42 CFR 433.52) located in Wyoming shall be eligible for a quarterly professional services supplemental payment (PSSP) (based on an annual calculation). The PSSP will be the result of an analysis of the costs of the following covered services furnished to Wyoming Medicaid patients (excludes inpatient and outpatient services):

a) Physician Services, to include Physician Assistants and Nurse Practitioners;
b) Certified Registered Nurse Anesthetists;
c) Certified Nurse Midwives;
d) Services provided by a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor, and Licensed Additions Therapist;
e) Home Health Care Services not otherwise provided as inpatient or outpatient services;
f) Chiropractic Services;
g) Optometric/optician Services;
h) Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services not otherwise provided as inpatient or outpatient services;
i) Psychological Services;
j) Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department; and

In order to qualify to receive supplemental payments, the physician or professional service practitioner must be:

a) Licensed by the State of Wyoming
b) Enrolled as a Wyoming Medicaid provider
c) A provider type that provides the covered services listed above
d) Employed by, or under contract to provide services at or in affiliation with a privately owned or operated governmental entity and identified by the private entity as a physician or practitioner that is employed by, under contract to provide services at or in affiliation with said entity.

The PSSP amount available for each provider group owned or operated by a private hospital participating in the PSSP program will equal the difference between the Medicaid payment ceiling that Wyoming commercial payers would pay under average commercial rate (ACR) principles and the amount paid for the same services by the Wyoming Department of Health (the Department). Aggregate payments to provider groups owned or operated by private hospitals shall not exceed the Medicaid upper payment limit (UPL) in accordance with section 1902(a)(30(A) of the Social Security Act. The Department will perform the Medicaid UPL analysis prior to making the supplemental payments.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

12.c. PROSTHETIC APPLIANCES, ORTHOTICS AND DURABLE MEDICAL EQUIPMENT

Reimbursement for prosthetic appliances, orthotics and durable medical equipment that are not reimbursed using the Wyoming Medicaid Ambulatory Payment Classification (APC) fee schedule which is described in the outpatient hospital reimbursement section of Attachment 4.19B shall be the lower of the fee assigned to the code or reimbursed at invoice cost, plus fifteen percent handling fee, plus shipping costs. The fee schedule for prosthetic appliances, orthotics and durable medical equipment is derived from an historical analysis of providers' charges, while taking into consideration the Medicare fee schedule. Fees were determined to assure access to services and adequate provider participation.

Updates to the schedule may be targeted to specific procedure codes or ranges of procedure codes. Considerations for update are to assure adequate provider participation and to eliminate inequities in the system.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

13d. REHABILITATIVE SERVICES – MENTAL HEALTH & SUBSTANCE ABUSE

Outpatient mental health and substance abuse treatment services are reimbursed on a fee-for-service basis utilizing the American Medical Association's Current Procedural Terminology, HCPCS Level I (CPT) and HCPCS Level II codes. Reimbursement will be the lessor of charges or a percentage of the physician fee schedule amount. All public and private providers are reimbursed according to the same fee schedule. A maximum allowable fee is established by procedure code regardless of provider location.

Providers bill rehabilitation services using either a HCPCS Level I (CPT) or HCPCS Level II code, not both. Physician fees were determined by an RBRVS analysis of customary charges, prevailing charges, and average commercial rates. Charges were inflated to the SFY2007 rate year using the Medicare Economic Index. The reasonable charge was identified as the lower of the inflated charges or the newly computed rate under each of the three approaches. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of mental health and substance abuse illnesses. The agency's fee schedule rate was set as of 1/1/2021 and is effective for services provided on or after that date. All rates are published (https://wymedicaid.portal.conduent.com). The rates for HCPCS Level II codes will be paid at or below 90% of the Medicare fee schedule rates for Wyoming. Rates do not include the cost of room and board and include only Medicaid allowable costs. Payment made by Medicaid will not duplicate payments made to other public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Policy and Methods of Establishing Payment Rate for Each Type of Care Provided.

14 Ambulatory Surgical Center –

(a) Medicaid allowable payments for ambulatory surgical center services are made consistently with outpatient hospital services according to Section 8 of Attachment 4 19B with the following exceptions

(i) State specific Ambulatory Surgical Center Medicaid conversion factor

(ii) Percent of charges. Certain services are reimbursed based on a percent of allowed charges as indicated in the APC fee schedule. These services include corneal tissue medical devices and dental (i e , procedure code 41899)

(b) Updates. The APC conversion factor and relative weights are reviewed annually

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician services

The agency's fee schedule rate was set as of July 1, 2014 and is effective for services provided on or after that date All rates are published at http://wymedicaid.acs-inc com.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

17. NURSE-MIDWIFE SERVICES

Reimbursement will be the lessor of charges or a percentage of the physician fee schedule amount. All public and private providers are reimbursed according to the same fee schedule. A maximum allowable fee is established by procedure code regardless of provider location. Providers may access the fee schedule on the agency website or upon request by calling the fiscal agent.

Physician fees were determined by an RBRVS analysis of customary charges, prevailing charges, and average commercial rates. Charges were inflated to the SFY2007 rate year using the Medicare Economic Index. The reasonable charge was identified as the lower of the inflated charges or the newly computed rate under each of the three approaches. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. Reimbursement rates for these services, for dates of service on or after July 1, 2015 are on the official website of the Department of Health, Medicaid at http://wdh.state.wy.us or http://wyequalitycare.acs-inc.com. Rates will be updated on July 1, 2016 and will be effective for the services provided on or after that date.

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WYOMING

POLICY AND METHODS OF ESTABLISHING A PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

18. REIMBURSEMENT METHODOLOGY FOR HOSPICE CARE

Payment for hospice care is in the same amounts as used under Part A of Title XVIII; except that a separate rate may be paid for hospice care which is furnished to an individual who is a resident of a nursing facility, and who would be eligible under the plan for nursing facility services if he had not elected to receive hospice care, to take into account the room and board furnished by such facility.

The state will pay no less than 95% of the usual per diem rate of the respective nursing facility to the hospice.

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WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

19. Payment is made at the lower of the actual charge or the Medicaid rate on file.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF WYOMING

METHODS AND STANDARDS FOR EXTABLISHING PAYMENT RATES
OTHER TYPES OF SERVICES

Payment for Targeted Case Management (TCM) services provided to persons with a serious and persistent mental illness who are age twenty one (21) and older who have a behavioral health disorder that results in a long-term limitation of the person's capacity to function in activities of daily living and to remain in his/her home community without a range of treatment and other support services will be reimbursed on a fee-for-service basis per unit of service For the purposes of this rule, a unit of service is a period of 15 minutes

The Department will pay the lower of the following for TCM services for this target population

- The provider's actual submitted charge for the services, or
- The Department's fee schedule

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both public and private providers of TCM services. Rates do not include the cost of room and board and include only Medicaid allowable costs.

The agency's fee schedule rates for targeted case management services for adults with severe and persistent mental illness were last updated September 22, 2007 The most recent agency fee schedule rates are effective for services provided on or after September 22, 2007 All rates are published at http.//wyequalitycare acs-inc com/fee_schedule.html.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE/TERRITORY: WYOMING

CASE MANAGEMENT SERVICES

19. Targeted Case Management Service
(Non-Waiver Developmentally Disabled Individuals, All ages)

Payment for case management services under the plan does not duplicate payments made to public agencie or private entities under other program authorities for this same purpose.

All public and private providers that are Medicaid providers and are billing the same codes ar reimbursed with the same rates.

The rates are published on the following website: http://wyequalitycare.acs-inc.com/pub.html

1) A unit for Targeted Case Management is defined as a complete 15 minute unit. A maximum of 3 hours or 120 units will be paid per plan year per client. The service must be prior-authorized an the providers are monitored for appropriate billing accumulation of time.

2) The state agency will assure, through system monitoring, that billed time does not exceed 32 billable units per day by a practitioner to deliver the targeted case management services.

3) As required by regulations, these payments will be subject to utilization review and system editing for efficiency, economy and quality of care.

4) The ISC is required to document the following information for reimbursement of TCM services:
   a. Date of Service
   b. Start time of Service
   c. End time of Service
   d. Total billable units
   e. Type of Service
   f. Description of Service

5) The Medicaid fee schedule does reflect per unit of service, but not the fee, because this service prior authorized. The rate is published in a provider bulletin that is then placed on th http://wyequalitycare.acs-inc.com/pub.html.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF WYOMING

METHODS AND STANDARDS FOR EXTABLISHING PAYMENT RATES
OTHER TYPES OF SERVICES

Payment for Targeted Case Management (TCM) services provided to individuals eligible for Medicaid who are being determined for eligibility for the Wyoming Adult Developmental Disabilities (DD) Waiver the Child DD Waiver Acquired Brain Injury Waiver, Comprehensive Waiver, or Supports Waiver; and to obtain coordination of services while on a wait list for Waiver services will be reimbursed on a fee-for-service basis For the purposes of this rule, a unit of service is a period of 15 minutes

Payment Limitations

1 Cap Up to 120 units may be paid per plan year, per client, per provider

The Department will pay the lower of the following for TCM services for this target population.

- The provider s actual submitted charge for the services, or
- The Department's fee schedule

Except as otherwise noted **in** the plan, state-developed fee schedule rates are the same for both governmental and private providers of TCM services Rates do not include the cost of room and board and include only Medicaid allowable costs

The agency's fee schedule rates for targeted case management services for Medicaid eligible individuals who are being determined for eligibility for the Wyoming Adult Developmental Disabilities (DD) Waiver, the Child DD Waiver, Acquired Brain Injury Waiver, Comprehensive Waiver, or Supports Waiver; and to obtain coordination of services while on a wait list were last updated January 1, 2006 The most recent agency fee schedule rates are effective for services provided on or after January 1, 2006 All rates are published at http://wyequalitycare.acs-inc com/fee_schedule.html.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANC EPROGRAM

STATE OF WYOMING

METHODS AND STANDARDS FOR EXTABLISHING PAYMENT RATES OTHER TYPES OF SERVICES

Payment for targeted case management (TCM) services provided to Medicaid eligible individuals (consumers) who are residing or waiting to be placed, in a Medicaid certified acute care facility or nursing facility and express an interest in returning to the community rather than reside in a facility and qualify based on the targeted case manager's assessment as a good candidate for community living will be reimbursed on a fee-for-service basis per unit of service For the purposes of this rule, a unit of service is a period of 15 minutes

Payment Limitations

1 A maximum of 80 hours or 320 units will be paid per nursing facility episode per client. The providers are monitored for appropriate billing accumulation of time.
2 The State agency will assure, through system monitoring, that billed time does not exceed a maximum of 80 hours or 320 units per nursing facility episode per client.
3 As required by regulations, these payments will be subject to utilization review and system editing for efficiency, economy and quality of care
4 All providers are required to documents the following information for reimbursement of TCM services
    a. Date of Service
    b Place of Services
    c Total billable units
    d. Total charges
    e Type of service
    f. Description of Service

TCM services for clients are reimbursed at the lower of the following
1 Submitted charges, or
2 Fee schedule as determined by the Department of Health

Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of TCM services for clients.

The agency's fee schedule rates for targeted case management services for Medicaid eligible individuals (consumers) who are residing, or waiting to be placed, in a Medicaid certified acute care facility or nursing facility and express an interest in returning to the community rather than reside in a facility were last updated on September 22, 2007 The most recent agency fee schedule rates are effective for services provided on or after September 22, 2007 All rates are published at http://wyequalitycare acs-inc com/fee_schedule.html

5. The Medicaid fee schedule does reflect per unit of service, but not the fee. The rate is published in a provider bulletin that is then place on the http://wyequalitycare.acs-inc.com/

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF WYOMING

METHODS AND STANDARDS FOR EXTABLISHING PAYMENT RATES
OTHER TYPES OF SERVICES

Payment for Targeted Case Management (TCM) services provided to children and youth ages four (4) through twenty-one (21) who meet the definition of having a serious emotional disturbance (per Federal Register, volume 58, no. 96, published May 20, 1993, pgs. 29422 through 29425) will be reimbursed on a fee-for-service basis per unit of service. For the purpose of this rule, a unit of service is a period of 15 minutes.

The Department will pay the lower of the following for TCM services for this target population:

- The provider's actual submitted charge for the services; or
- The Department's fee schedule.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of TCM services provided to children and youth ages four (4) through twenty-one (21) who meet the definition of having a serious emotional disturbance. The agency's fee schedule rate was set as of September 28th, 2018, and is effective for services provided on or after that date. All rates are published on the Medicaid fiscal agent's website at https://wymedicaid.portal.conduent.com/fee_schedule.html. Rates do not include the cost of room and board and include only Medicaid allowable costs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

23. CERTIFIED PEDIATRIC OR FAMILY NURSE PRACTITIONERS' SERVICES

Reimbursement will be the lessor of charges or a percentage of the physician fee schedule amount. All public and private providers are reimbursed according to the same fee schedule. A maximum allowable fee is established by procedure code regardless of provider location. Providers may access the fee schedule on the agency website or upon request by calling the fiscal agent.

Physician fees were determined by an RBRVS analysis of customary charges, prevailing charges, and average commercial rates. Charges were inflated to the SFY2007 rate year using the Medicare Economic Index. The reasonable charge was identified as the lower of the inflated charges or the newly computed rate under each of the three approaches. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers. Reimbursement rates for these services, for dates of service on or after July 1, 2015 are on the official website of the Department of Health, Medicaid at http://wdh.state.wy.us or http://wyequalitycare.acs-inc.com. Rates will be updated on July 1, 2016 and will be effective the services provided on or after that date.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Wyoming

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

24a. Reimbursement for use of a private vehicle shall be at a rate established by the Medicaid agency utilizing a cost/benefit analysis. The rate is published and updated annually. The cost/benefit analysis compares the average cost per gallon of fuel and determines if the current fee is adequate to cover cost of mileage for vehicle traveling 15 miles on one gallon of fuel.

Reimbursement for public carrier and lodging is the lessor of charges or the Medicaid fee schedule amount.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of non-emergency transportation and lodging services. Reimbursement rates for dates of service on or after July 1, 2015 are on the official website of the Department, Medicaid http://wymedicaid.acs-inc.com.

Rates will be updated on 7/1/2016 and will be effective for services provided on or after that date. All rates are published on the Wyoming Medicaid web site (http://wymedicaid.acs-inc.com).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WYOMING

POLICY AND METHODS OF ESTABLISHING PAYMENT RATE FOR EACH TYPE OF CARE PROVIDED

25. TRANSPLANT SERVICES

Reimbursement is the lesser of charges or the fee schedule amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment specified in the chart on page 2 of this supplement. Codes appearing in the chart have the meanings defined below:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters **SP**, following the method described on pages 2, 3, 4 and 5, in items _1, 2, 4 of this attachment.

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses a special rate or method as set out on page 4 in item 3 of this attachment. (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters **MR.**

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in items A and B of this attachment, for those groups and payments listed below and designated with the letters **NR.**

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item _ of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	SP	Deductibles	SP	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance
Other Medicaid Recipients	Part A	SP	Deductibles	SP	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance
Dual Eligible (QMB Plus)	Part A	SP	Deductibles	SP	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance

QT1 or SLMB	Part A	Not Covered	Deductibles
	Part A	Not Covered	Coinsurance
QT1 or SLMB	Part B	Not Covered	Deductibles
	Part B	Not Covered	Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

1. Medicare Part A Deductible and Coinsurance - Services covered in the Medicaid State Plan.

Wyoming Medicaid covers the Medicare Part A deductible and coinsurance up to the Medicaid Fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the lesser of:

- The coinsurance and deductible up to the Medicare Part B deductible and coinsurance billed, OR
- The Medicaid Fee less any amounts paid by Medicare.

Exception to method above, if the method described above results in no payment for physician administered pharmaceuticals, then the state will pay at least $0.01 for the physician administered pharmaceutical.

Medicare cross over claims do not count toward the service cap limits referenced in Section 4 of the Wyoming Medicaid State Plan.

Wyoming Medicaid covers the Part A deductible and coinsurance for QMB, QMB Plus, and Full Benefit Dual Eligibles who are not eligible as QMBs.

Medicaid does not cover Medicare Part A deductible and coinsurance for the QI1 or SLMB.

2. Medicare Part B Deductible and Coinsurance - Services covered in the Medicaid State Plan.

Wyoming Medicaid covers the Medicare Part B deductible and coinsurance up to the Medicaid Fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the lesser of:

- The coinsurance and deductible up to the Medicare Part B deductible and coinsurance billed, OR
- The Medicaid Fee less any amounts paid by Medicare.

Medicare cross over claims do not count toward the service cap limits referenced in Section 4 of the Wyoming Medicaid State Plan.

Exception to method above, if the method described above results in a Medicaid payment of $0 and the claim contains lines billed for physician administered pharmaceuticals, the state will authorize payment of $0.01 on the pharmaceutical claim line.

Wyoming Medicaid covers the Part B deductible and coinsurance for QMB, QMB Plus, and Full Benefit Dual Eligibles who are not eligible as QMBs.

Medicaid does not cover Medicare Part B deductible and coinsurance for the QI1 or SLMB.

3. Medicare Part A & B deductible and coinsurance - Medicaid non-covered services.

For purposes of determining payment for Medicare Part A and Medicare Part B deductible and coinsurance, Wyoming Medicaid calculates the Medicaid Fee for Medicaid non-covered services using 50 percent of the Medicare allowed amount.

Wyoming Medicaid covers the Medicare Part A and Medicare Part B deductible and coinsurance for non-covered services up to the calculated Medicaid Fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the lesser of:

- The coinsurance and deductible up to the Medicare Part A or B deductible and coinsurance billed, OR

- The calculated Medicaid Fee less any amounts paid by Medicare.

Exception to method above, if the method described above results in a Medicaid payment of $0 and the claim contains lines billed for physician administered pharmaceuticals, the state will authorize payment of $0.01 on the pharmaceutical claim line.

Medicare cross over claims do not count toward the service cap limits referenced in Section 4 of the Wyoming Medicaid State Plan.

Wyoming Medicaid covers the Medicare Part A and Part B deductible and coinsurance for non-covered Medicaid services only for QMB and QMB plus.

For Full Benefit Dual Eligibles who are not eligible as QMBs, Wyoming Medicaid limits Medicare cost sharing to only those services covered in the Medicaid State Plan.

Wyoming Medicaid does not cover the Medicare Part A or Medicare Part B deductible and coinsurance for QI1 and SLMB.

4. Combined payments shall not exceed the amount Medicaid would have paid had it been the sole payer.

The financial obligations of Medicaid for services is based upon Medicare's allowable, not the provider's charge. Medicaid will not pay any portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid had it been the sole payer. Medicaid shall not pay on the claim if Medicare's payment is greater than what Medicaid would have paid had Medicaid been the sole payer.

Exception to method above, if the method described above results in a Medicaid payment of $0 and the claim contains lines billed for physician administered pharmaceuticals, the state will authorize payment of $0.01 on the pharmaceutical claim line.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Wyoming

Effective for dates of services on or after October 1, 2016 payments for reserved bed days in long term care facilities will not be made.

Payments for reserved bed days in intermediate care facilities for the intellectually disabled will be made.

a) For periods of hospitalization for acute conditions, up to 15 days per calendar year.
b) Therapeutic home visits are limited to 30 days per calendar year, not exceeding 15 days in duration more than once per month.

Section 1. Authority.

This Chapter 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 Procedure Act at W.S. § 16-3-101, *et seq.*

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to establish methods and standards for Medicaid reimbursement rates for nursing facilities which provide services to clients. It shall apply to and govern all payments of Medicaid funds to facilities for services furnished on or after July 1, 2015.

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

(c) The incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter.

Section 3. Definitions. Except as otherwise specified in the Rules and Regulations for Wyoming Medicaid, Chapter 1, Definitions, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, Medicaid and Medicare.

Section 4. General Provisions.

(a) Cost terms and hierarchy. This rule includes the following cost terms, even though such cost may not be reimbursable because of other provisions of this rule, in the following hierarchy:

(i) General ledger cost. A cost properly recorded on a nursing facility's general ledger in accordance with GAAP. This includes cost incurred at an individual nursing facility as well as central office or pooled cost reasonably allocated to an individual nursing facility;

(ii) Reported cost. General ledger cost properly reported on the cost report. It is composed of allowable cost and non-allowable cost;

(iii) Non-allowable cost. Cost which is not reasonably related to covered services; and

(iv) Allowable cost, as defined in the Rules and Regulations for Wyoming Medicaid, Chapter 1, Definitions.

(b) General methodology.

(i) Costs related to direct patient care are more likely to benefit quality of patient care than indirect costs.

(ii) Costs incurred in the actual delivery of patient care are more likely to contribute to the quality of care offered by a nursing facility than costs incurred at a distance from the delivery of services.

(iii) To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. Providers shall incur costs in such a manner that economical and efficient delivery of quality health care to participants will result.

(iv) Except as otherwise specified in this Chapter, the Department shall determine per diem rates using the methodology set forth in the Medicare Provider Reimbursement Manual ("PRM") and CMS instructions for administering the PRM. The PRM and the CMS instructions are published by CMS and are available from that agency.

Section 5. Submission and Preparation of Cost Reports.

(a) Time of submission. Complete cost reports shall be submitted by the end of the fifth (5th) month following the provider's fiscal period end.

(i) Complete cost report. A cost report shall be deemed complete upon receipt of the completed and certified cost report and the information specified in subsections (c)(iii)(A-K). The per diem rate shall not be computed, however, until the receipt of the information specified in subsections (c)(iii)(A-K). The Department may request additional information, in writing, by certified mail, return receipt requested. Any such information must be submitted, by certified mail, return receipt requested, within thirty (30) days after the date of the request. A cost report may not be amended after submission. The version of the Medicare cost report submitted to Wyoming Medicaid shall agree to the cost report submitted to Medicare.

(ii) Extension. A thirty (30) day extension of the submission date shall be granted by the Department for good cause if requested by a provider, in writing, prior

to the due date. A cost report shall not be deemed past due while an extension term is in effect. Only one (1) request for an extension may be granted for each cost reporting period.

(b) Failure to timely submit cost report. If a cost report, including the information specified in subparagraphs (c)(iii)(A-K) and any information requested pursuant to paragraph (a)(i), is more than ten (10) days past due, the Department shall reduce the per diem rate by twenty-five (25) percent until all missing information is received in writing in the form specified by the Department. If the cost report, including the information specified in subparagraphs (c)(iii)(A-K) is more than sixty (60) days past due, the Department shall suspend all Medicaid payments until all missing information is received in writing in the form specified by the Department. Upon receipt of a complete cost report that has been prepared in accordance with these rules, the penalty will be refunded, without interest. This remedy does not affect the Department's right to withhold per diem payments, terminate provider participation or invoke other remedies permitted by applicable statutes and rules.

(c) Preparation of cost reports.

(i) Cost reporting must be reasonable and consistent within a nursing facility, between Medicaid certified and noncertified parts where such distinction is utilized for cost finding, among multiple facilities under the same ownership or control, and over time.

(ii) Allocation of costs. Costs must be allocated pursuant to the cost report.

(iii) Required information. Authenticated copies of significant agreements and other documentation must be attached to the cost report. This material includes:

(A) Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years, unless previously submitted;

(B) Contracts or agreements with owners or parties related to the provider, unless previously submitted;

(C) Leases regarding real or personal property, unless previously submitted;

(D) Management contracts, unless previously submitted;

(E) Mortgages and loan agreements, unless previously submitted;

(F) Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications;

(G) Audit, review or compilation statements prepared by an independent accountant that includes nursing facility costs or allocation of costs to the nursing facility, including disclosure statements and management letters or SEC Forms 10-K;

(H) Home office cost statement;

(I) Medicare cost report;

(J) Wyoming Financial Report for Long Term Care, a supplemental cost reporting form specific to the Medicaid program; and

(K) Any other document, requested, in writing, by the Department, relating to the provision of services, the submission of claims for reimbursement or a nursing facility's cost reports.

(iv) If any document is not submitted with the cost report, an explanation must be attached to the cost report and subsection (b) shall apply.

(v) Changes in a nursing facility's reporting methods are permissible only when written application is received by the Department prior to the end of the cost report period. The Department shall approve the change if it can reasonably be expected to result in more accurate reporting.

(vi) Fiscal period. A provider shall adopt the same fiscal period for completing the cost report as the nursing facility uses for reporting Medicare costs.

(A) If a provider is not certified by Medicare, the nursing facility's Medicaid cost reporting period shall be the same period the nursing facility uses for federal income tax reporting.

(B) Normally, a fiscal period will be twelve (12) months in length. It may be less than twelve (12) months because of changes in the nursing facility's Medicare cost reporting period. For purposes of nursing facility rate-setting, cost report periods of less than six (6) months will not be used.

(vii) Determination of allowable costs. The Department shall determine a nursing facility's allowable cost within ninety (90) days of the Department's receipt of the nursing facility's cost report and all information required by section 5(c)(iii)(A-K) of this Chapter.

(d) Certification of cost reports.

(i) General requirement. The provider must certify the accuracy and validity of the cost report.

(ii) Who may certify. Certification must be made by a person authorized by the governing body of the nursing facility to make such certification. Proof of such authorization shall be furnished upon request by the Department.

(A) If the provider is a corporation, an officer of the corporation must certify;

(B) If the provider is a general or limited partnership, a general partner must certify;

(C) If the provider is a sole proprietorship or sole owner, the owner must certify;

(D) If the provider is a public nursing facility, the chief administrative officer of the nursing facility must certify; or

(E) If the provider is any other entity, the person certifying must be approved in writing by the Department before the certification.

(iii) Certification statement. The cost report must contain the following certification statement:

> Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.
>
> I hereby certify that I have read the above statement and I have examined the accompanying cost report and supporting schedules prepared by (Provider name and number) _____ for the cost report beginning _____, 20__, and ending _____, 20__, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in

accordance with applicable instructions, except as noted.

Signature	Title	Date

Section 6. Joint Use of Resources.

(a) Multiple business enterprises. If a provider owns, controls or manages multiple business enterprises, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable. If a field audit or desk review establishes that the provider's records do not clearly identify the information required by this rule, none of the commingled cost shall be an allowable cost for purposes of the nursing facility's per diem rate.

(b) Control, ownership or management by third party.

(i) Separate records. When the nursing facility is owned, controlled or managed by a person or entity that owns, controls or manages one (1) or more other nursing facilities, records of central office and other costs incurred outside the nursing facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities.

(ii) Allocation of pooled costs shall be reasonable and conform to GAAP, the provisions of this rule, and the instructions of the Department. Pooled cost is allowable only to the extent that the pooled cost is incurred in providing patient-related services and the provider can demonstrate that pooled cost improves efficiency, economy, or quality of care. All patient-related pooled costs allocated to a nursing facility that meet these requirements shall be reported in the operating cost component.

(iii) Direct patient service costs. Direct patient service costs incurred by multiple nursing facility organizations may be reported in the health care component if the service was rendered to the client at the nursing facility and is separately identified, rather than allocated, in the provider's accounting records. Patient service costs which do not meet these criteria must be reported in the operating cost component.

Section 7. New Facilities and Changes of Ownership Per Diem Rate Determination.

(a) New nursing facilities. A newly constructed facility for a provider that did not previously exist, a newly designated portion of a hospital which has not previously been designated as a facility, or an existing facility which has not previously been

certified. An addition to a certified facility is not a "new facility." An existing provider that constructs a new building to move into is not a "new facility" but the new building may be subject to a re-age adjustment per Section 18.

(i) A new nursing facility rate shall be calculated by rate category as follows:

(A) Health care portion of rate. The new facility will receive the same starting price as all other facilities with a quarterly case mix adjustment using the new provider's case mix scores. If the provider does not have the qualifying case mix data at the time rates are calculated, the health care component will be calculated using the statewide Medicaid average case mix score from the prior quarter.

(B) Capital portion of rate. The new facility will receive a property rental rate based on the age of their building. If the age cannot be determined at the time of rate-setting or if the provider does not supply the appropriate data to calculate the age of the building when requested, the provider will receive a property rental rate based on a 40-year old building. The rate will not be adjusted retrospectively if the provider later supplies the needed documentation. The rate will be adjusted to reflect the revised age at the beginning of the next rate quarter.

(C) Exempt portion of rate. The new facility will receive the exempt portion of their rate using the statewide average calculated in the previous quarter.

(D) Operating portion of rate. The new facility will receive the same fixed price the rest of the state is receiving for that quarter.

(ii) A new nursing facility's rate will be calculated in this manner until the provider has a qualifying cost report on file that has been subjected to audit. At that time, the qualifying cost report will be used to set their rate effective with the July 1 rate cycle in accordance with Section 13(c).

(b) Change of ownership.

(i) A nursing facility which has a change of ownership shall receive a rate calculated as follows:

(A) Health care portion of rate. The new owner will receive the same starting price as all other facilities with a quarterly case mix adjustment using the new owner's case mix scores. If the new owner does not have the qualifying case mix data at the time rates are calculated, the health care component will be calculated using

the prior owner's Medicaid average case mix score from the most recently available quarter.

(B) Capital portion of rate. The new owner shall assume the building age used for the property rental rate from the prior owner and receive a property rental rate in accordance with Section 18.

(C) Exempt portion of rate. The new owner will assume the exempt portion of the per diem rate using the most currently available audited data from the prior owner.

(D) Operating portion of rate. The new owner will receive the same fixed price the rest of the state is receiving.

(ii) The rate will be calculated in this manner until the provider has a qualifying cost report on file that has been subjected to audit. At that time, the qualifying cost report will be used to set their rate effective with the July 1 rate cycle in accordance with Section 13(c).

(ii) Record keeping requirements. The former owner shall be responsible for maintaining all medical and financial records for one (1) year after the date of the change of ownership. If the nursing facility is involved in an audit or administrative or judicial proceedings which require access to such records, the records must be maintained for one (1) year after completion of all proceedings, including any applicable appeal periods.

(c) Other facilities. The per diem rate for facilities other than a new facility or those without a change of ownership shall be established pursuant to the provisions of this Chapter.

(d) Effective dates of per diem rates. Per diem rates are established prospectively and shall remain in effect from the rate effective date until re-determined pursuant to this rule.

Section 8. Medicaid Reimbursement for Reserve Bed Days.

(a) Reserve bed days.

(i) Effective for dates of service on or after October 1, 2016, facilities will not be reimbursed for reserve bed days.

Section 9. Cost and Rate Categories.

(a) General requirements. Costs shall be allocated among the following cost components as specified in this section: (1) health care costs; (2) capital costs; (3) exempt costs; and (4) operating costs. For purposes of this section, "labor costs" includes the cost of employee benefits and taxes. Services and supplies used in providing patient-related services include, but are not limited to, those specified in Attachment A. Reimbursement will be a combination of a cost based system and a fixed price system as described in Section 15.

(b) Health care component. The health care cost component consists of the following costs provided such costs are direct costs of patient-related services actually rendered within the nursing facility. This rate component is subject to a quarterly case mix acuity adjustment.

(i) Medical records;

(ii) Social services;

(iii) Direct nursing health care labor costs for the following:

(A) Registered nurses;

(B) Licensed practical nurses;

(C) Nurse assistants and certified nurse assistants;

(D) Contracted nurses;

(iv) Payroll taxes and employee benefits associated with the wages above.

(c) Capital cost component. The capital cost component consists of the following costs:

(i) Leasehold amortization;

(ii) Rent/lease expense;

(iii) Depreciation; and

(iv) Interest on real estate and personal property.

(d) Exempt cost component. The exempt cost component consists of:

(i) Property taxes. The cost of property taxes on assets used in providing patient care is allowable. Tax penalties, late fees, and income taxes are not allowable;

(ii) Property insurance. The cost of property insurance on assets used in providing patient care is allowable. Malpractice, workmen's compensation, and other employee-related insurances are not considered property insurance;

(iii) Utilities. Heat, electricity, water, sewer, and garbage.

(iv) Nurse aide training. Costs for testing, books, fees, and classes for completing the Nursing CNA exam. Wages and benefits of employees while they are being trained are not considered an exempt cost and will be included in health care costs with other nursing wages. Other training and refresher courses are not includable as exempt and should be reported in health care costs. In-house trainer wages will not be included as exempt and should be included in the health care cost center.

(e) Operating cost component. The operating cost component consists of:

(i) Administrative and general costs, including home office costs and management fees;

(ii) Plant operations;

(iii) Laundry;

(iv) Housekeeping;

(v) Cafeteria;

(vi) Dietary;

(vii) Nurse administration;

(viii) Central services, routine supplies, and non legend drugs;

(ix) Pharmacy consultant;

(x) Activities

(xi) Payroll taxes and employee benefits associated with the wages above.

(xii) Medical director

(xiii) All other allowable costs not mentioned in (b), (c), and (d) in this section.

Section 10. Determination of Capital Cost.

(a) Depreciation.

(i) The depreciation of a tangible asset used to deliver patient-related services is an allowable cost if the asset is:

(A) In use;

(B) Identifiable to patient care;

(C) Available for physical inspection; and

(D) Recorded in the provider's records.

(ii) Basis. The basis used in calculating depreciation shall be the historical cost of the asset, which is the cost incurred by the present owner in acquiring the asset and preparing it for its use. Generally such cost includes costs that are capitalized under GAAP. For example, in addition to the purchase price, historical cost includes architectural fees, consulting fees, and related legal fees.

(iii) Method. Depreciation must be reported on the straight-line method.

(iv) Useful life. Useful life shall be determined in accordance with the most recent edition of Estimated Useful Lives of Depreciable Assets, as published by the American Hospital Association.

(v) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least two (2) years and historical cost of at least the minimum amount utilized by Medicare for cost reporting, which is currently five thousand dollars ($5,000), the cost shall be depreciated over the useful life of the asset.

(vi) Patient-related items that do not qualify for the above definition shall be expenses in the year acquired.

(vii) Donated assets.

(A) Definition. An asset is donated to the extent the provider acquired the asset without paying fair market value in cash, property or services.

(B) Basis. The basis of donated assets, except for donations between providers or from a party related to the provider, is the asset's fair market value, minus the value the provider gave for the asset. If the fair market value of the asset is over two thousand dollars ($2,000.00), the basis shall be the lesser of the appraised value and the fair market value. If the donor is related to the provider, the basis shall be the lesser of the net book value of the donor and fair market value.

(C) Cash donations. Cash donations shall be treated as revenue, and not as an offset to expense accounts.

(b) Permanent Financing Interest. Permanent Financing Interest is financing attendant to the acquisition of patient-related tangible assets.

(i) Allowable cost. Permanent financing interest incurred on patient-related real property, improvements to real property, buildings, building components and equipment is an allowable cost subject to the limitations of this subsection.

(ii) Investment income offset. Interest allowable pursuant to this section must be reduced by investment income pursuant to the PRM.

(iii) Reporting requirements. Interest expense must be supported by a written loan agreement, showing that funds were borrowed, payment of interest and repayment of principal is required, and funds were used to purchase patient-related real property, buildings, building components and equipment. The lender, purpose, principal amount, terms and interest rate must be identifiable in the provider's financial records.

(c) Lease and rental expense.

(i) Allowable cost. Lease or rental expenses incurred on patient-related real property, buildings, building components and equipment are an allowable cost subject to the limitations of this subsection.

(d) Related parties. If a provider rents, leases or purchases patient-related real property, buildings, building components and equipment from a party

related to the provider, the cost should be adjusted to the actual cost incurred by the related party.

(e) Amortization of leasehold improvements.

(i) Allowable cost. Lease or rental expenses incurred on patient-related real property, buildings, building components and equipment are an allowable cost subject to the limitations of this subsection.

(ii) Amortization of leasehold improvements shall be calculated and reported in accordance with GAAP and are a capital cost.

(iii) Amortization of organizational cost shall be reported in the operating cost component.

Section 11. Working Capital Interest.

(a) Working capital interest. Working capital interest is patient-related financing other than permanent financing.

(i) Generally. Interest on working capital loans is an allowable cost only if the loans were costs that must be incurred to provide patient-related services.

(ii) Limitation. Interest on working capital loans may not exceed the actual reported interest less any investment income revenue.

(iii) Reporting. Interest on working capital loans shall be reported as an operating cost.

Section 12. Cost of Services and Supplies not Included in the Per Diem Rate.

(a) Services and supplies which are not included in the per diem rate include, but are not limited to:

(i) Ambulance services;

(ii) Audiology services;

(iii) Barber and beauty shop services other than routine personal hygiene items and services;

(iv) Cigarettes, cigars, pipes and tobacco;

(v) Clothing;

(vi) Cosmetics;

(vii) Dental services (unless under purchase for service contract);

(viii) Dry cleaning;

(ix) Eye examinations and other optical supplies and services;

(x) Hearing aids;

(xi) Hospital services;

(xii) Laboratory services;

(xiii) Orthotic services;

(xiv) Physician services;

(xv) Podiatry services;

(xvi) Prosthetic devices;

(xvii) Ventilators; and

(xviii) Customized wheelchairs that are fitted or fabricated to a specific individual and cannot be used by any other person, and electric wheelchairs, including batteries.

(b) The cost of services and supplies not included in the per diem rate shall be removed from patient-related cost.

(c) Costs not related to patient care are costs that are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary may include, but are not limited to, costs that are not usual, common, and accepted occurrences in the field of the provider's activity.

(d) The method of removal depends on a provider's accounting and

other records. If a provider has adequate segregation in accounting records, such adjustment shall be based on the cost of services or supplies not included in the per diem rate. If a provider does not maintain adequate cost segregation or if such accounts cannot reasonably be subjected to normal audit procedures, then the related revenue shall be used as an adjustment to patient expense, provided the related revenue amount is reasonably equal to or greater than cost. If these conditions are not met, the entire group of aggregated ancillary or other revenue accounts, or aggregated ancillary or other cost accounts, if greater, shall be used as an offset to patient expenses.

Section 13. Rate Period.

(a) Effective date. For nursing facility services provided on or after July 1, 2015, a provider's per diem shall become effective on the rate effective date, which is July 1 of each year, with quarterly acuity case mix adjustments. Per diem rates are established prospectively and shall remain in effect from the rate effective date until re-determined pursuant to this rule.

(b) Effective period of rate. A facility shall be bound by the per diem rate until a new rate is computed pursuant to this rule, unless the rate is changed as the result of a desk review field audit, or legislative budget change.

(c) Applicable cost report data. The data used in establishing the rate calculation effective each July 1 is from the cost reports which ended two (2) calendar years ago (for example, cost reports ending during the period from January 1, 2013 to December 31, 2013, will be used to set rates effective July 1, 2015).

(d) Rates will be adjusted quarterly to reflect case mix acuity adjustments.

(e) Notice of rate. The Department shall notify providers of the per diem rate by certified mail, return receipt requested.

(f) If there is a need to issue an interim rate, the rate will be issued as interim and the rate will later be revised and issued as final. Any amounts paid pursuant to the interim rate which exceed the final rate shall be overpayments and shall be recovered pursuant to Section 31 of this Chapter. If the interim rate is less than the final rate, the Department shall pay the difference to the provider within sixty (60) days.

Section 14. Creation of Database.

(a) Creation of database. Each year the Department shall create a database using the latest complete desk reviewed cost reports for each provider. "Latest

complete" means the cost report used to compute the provider's most recent per diem for the applicable year.

(b) Adjustment of cost reports. Cost reports included in the database shall be adjusted so that transactions with owners or parties related to providers are limited pursuant to this rule.

(c) The database shall separate costs from the reviewed or audited cost report into the categories for (1) health care costs; (2) capital costs; (3) exempt costs; and (4) operating costs as defined in Section 9.

(d) Bed ranges. Providers will be grouped by bed range group. Providers will be grouped into ranges based on the number of licensed beds.

Section 15. Price and Rate Setting – Legislative Appropriation.

(a) Reimbursement will be a combination of a prospective fixed price system and a cost-based system with the health care component subject to an acuity adjustment. The legislature will provide an annual budget each year. The budget will be used to set the cost and price based rates as follows:

(b) Property Price. The first round of legislative allocations will be used to determine the reimbursement necessary to fund the price-based property rental rate system. The property rental rate methodology is defined at Section 18 of this Chapter.

(c) Exempt Cost Per Diem. The second round of allocations will be to determine the reimbursement necessary to fund the exempt cost-based reimbursement category. Exempt costs are defined at Section 9(d) of this Chapter.

(d) Health care and Operating Prices. The balance of the legislative appropriation will be used to fund the prices for the health care and operating categories. The balance of the funding will be allocated between the operating and health care categories based on the statewide total percentage of audited or desk reviewed costs classified to these categories.

(i) The operating price will be the same price reimbursed to all providers, regardless of their cost.

(ii) The health care price will begin with the same price to all providers, regardless of their cost. Each provider's starting price will be further adjusted up or down based on the provider's case mix acuity score for each quarter as is described in Section 16.

(e) Rates will be adjusted quarterly with the only change in the rate being the case mix adjustment to the health care component.

(f) Rates will be further adjusted by bed range group. Each group will receive a percentage adjustment increase or decrease so the resulting cost coverage averages of each group are within + or – 5% of each other.

(g) The state may, due to budget reasons, adjust rates in the last quarter to reflect legislative funding.

Section 16. Health Care Case Mix Acuity Adjustment.

(a) Health care prices will be paid using a starting fixed price that is the same for all facilities. The fixed price will be adjusted for each individual provider on a quarterly basis based on each facility's Medicaid case mix index to reflect the case mix of that facility's Medicaid residents in a certain quarter. The case mix adjustment will be calculated by taking the fixed starting price times each provider's weighted average Medicaid case mix index divided by the statewide average Medicaid case mix index for each quarter.

(b) Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is calculated based on the weighted average assessment for each Medicaid resident in the nursing facility in the prior quarter where an MDS assessment was completed and successfully transmitted to the QIES ASAP system. The CMI is recalculated quarterly and each nursing facility's health care component rate is adjusted accordingly.

(c) Minimum Data Set (MDS). A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The version of the assessment document used for rate setting is version 3.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary.

(d) Case Mix Index (CMI). A numeric score assigned to each nursing facility resident, based on the resident's physical and mental condition that projects the amount of relative resources needed to provide care to the resident.

(i) The department shall employ the Resource Utilization Group IV (RUG IV), 48 Group case mix classification methodology.

(ii) For the 7/1/15 rate quarter, the case mix weight will use the most current MDS assessment for all Medicaid residents as of 04/01/15. Beginning with the 10/01/15 quarter and all subsequent quarters, the case mix weight for each resident of a nursing facility for each prior quarter shall be based on data from MDS assessments completed for the resident and accepted into the QIES ASAP System and weighted by the number of days the resident assessment was in each case mix classification group.

(A) A default case mix group shall be established for cases in which the resident dies or is discharged prior to completion of the resident's initial assessment. The default case mix group and case mix weight for these cases shall be designated by the department.

(B) A default case mix group shall also be established for cases in which there is an untimely assessment for the resident. The default case mix group and case mix weight for these cases shall be designated by the department

(iii) The facility Medicaid case mix average shall be determined by multiplying the case mix weight of each Medicaid resident by the number of days the resident was at each particular case mix classification group, and then averaging.

(A) The payment source for a resident assessment is considered to be Medicaid if the assessment is a non-PPS assessment where MDS item A0700 Medicaid Number is submitted with a valid Medicaid number.

(B) State-Wide Average Medicaid Case Mix Index. The simple average of all nursing facilities Medicaid case mix indexes used in establishing the reimbursement limitation each quarter.

(e) Nursing Facility: MDS Reviews. The following Minimum Data Set (MDS) reviews will be conducted.

(i) Facility Review. Prior to the rate quarter, each facility will be sent a Preliminary report of its resident roster, a listing of residents' assessments, RUG classification, number of days for the RUG classification, case mix index, and payment source. It will be the facility's responsibility to review the roster for accuracy and to submit missing assessments or corrections to the QIES ASAP system prior to the final processing. Once the resident roster has been used for rate setting, it will be considered final.

(ii) Departmental Review. If a departmental review of the MDS data reveals errors that result in an incorrect case mix index, the provider's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and an amount

due to or from the Department will be calculated. This does not include residents who received the default classification due to incomplete or inconsistent MDS data.

Section 17. Determination of Per Diem Rate.

(a) Except as otherwise provided in this Chapter, the Department shall determine per diem rates to be effective for services furnished on or after July 1, 2015, as follows:

(b) Per diem rate. The Department reimburses facilities providing nursing facility services, as defined by 42 U.S.C. 1396d(f), to clients using the per diem rates established pursuant to this Chapter.

(c) Except as otherwise specified in (a), a provider shall receive four (4) rate changes per year on the quarterly rate effective date, unless:

(i) The rate is changed as the result of a desk review or field audit; or

(ii) Changes in federal or state statutes or regulations cause increases in health care costs, as defined in subsection 9(b) of this Chapter, or operating costs, as defined in subsection 9(e) of this Chapter, in which case the Department shall determine whether and how to reimburse for such costs. Any changes pursuant to this paragraph shall be subject to the minimum and maximum budget provided by the legislature.

Section 18. Determination of Property Rental Rate Price.

(a) Property Rental Rate. Nursing facilities will be paid a price-based per diem rate based on the age of each provider's building. The property rental rate is paid in lieu of reimbursement for capital costs defined at Section 9(c). The property rental rate does not reimburse for property taxes and property insurance. Property taxes and property insurance will be reimbursed as an exempt costs as defined at Section 9(d).

(b) The property rental rates for each building age were calculated in 2015. 2015 will serve as the base year for each provider's building age and rental rates effective July 1, 2015 through June 30, 2016. Base year 2015 rental rate per diems by building age are shown in the table below.

Age	Rate	Age	Rate	Age	Rate	Age	Rate
0	15.55	11	14.20	22	12.85	33	11.50
1	15.43	12	14.08	23	12.73	34	11.38
2	15.30	13	13.95	24	12.60	35	11.25
3	15.18	14	13.83	25	12.48	36	11.13
4	15.06	15	13.71	26	12.36	37	11.01
5	14.94	16	13.59	27	12.24	38	10.89
6	14.81	17	13.46	28	12.11	39	10.76
7	14.69	18	13.34	29	11.99	40	10.64
8	14.57	19	13.22	30	11.87	40+	10.64
9	14.45	20	13.10	31	11.74		
10	14.32	21	12.97	32	11.62		

(c) The rates in the table above will be used for rate setting beginning on July 1, 2015. Building ages will all increase by one (1) year every July 1, beginning on July 1, 2016, regardless of the original construction date.

(d) Annual Property Rental Rate Adjustment. Annually on July 1, subject to legislative funding, the prior year rates for each building age will be adjusted up or down by the percentage change published in the Marshall Swift index. The percentage change will be determined using the "Annual Cost Changes" published in the "Current Building Cost Indexes" section of the Marshall Swift Valuation service publication, or its successor. The Annual Cost Changes category used will be for the Western Region, Class D, Nursing Home (convalescent hospital) group. The most recent publication available at the time of rate setting will be used for the annual rate adjustment.

(e) Age of the building. Facilities that existed and participated in Medicaid as of March 2015 were assigned a facility age as of 2015 based on the results of a capital cost survey that was held in 2013 and updated in 2015. The base year ages will not be adjusted due to lack of provider participation or cooperation in the survey.

(f) Buildings with an adjusted age greater than 40 years will be reimbursed as a 40-year old building.

(g) New providers that do not have an existing building age. The age of the building will be determined based on a request for documentation relating to the historical construction date, square footage, and costs of material capital additions.

(i) Adequate documentation will include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices,

building contract, and original notes of indebtedness, total square feet, depreciation schedule, and any other document deemed necessary.

(ii) If adequate information is not submitted by the facility by 30 days prior to the beginning of the next rate quarter to document that the facility, or portion thereof, is newer than forty (40) years, the age will be set at forty (40) years. If adequate documentation is provided later, and if it results in a revised age, the age will be reflected on the first day of the next rate quarter after the documentation is reviewed.

(h) Re-age Adjustment. For rates paid after the July 1, 2015 calendar quarter, the effective age of a facility may be further adjusted when the cost of major repairs, replacement, remodeling, or renovation of a building results in the change in age by at least one (1) year when applied to the formula in Section 18 (h)(iv) of this chapter.

(i) It is the provider's responsibility to notify the Department and document costs, square footage, and any other item needed for the review. The Department may adjust the age after a review of the documented costs and construction is made.

(ii) Re-age adjustments of one (1) year will become effective with the next July 1 rate effective date. Re-age adjustments of two (2) or more years will be effective on the first day of the following rate quarter after the re-age calculation is completed. At no time will the re-age adjustment be made retrospectively or mid-rate quarter.

(iii) Projects will not qualify for a re-age adjustment until all of the costs have been capitalized and the project has been placed into service.

(iv) Re-age adjustment formula. The re-age adjustment is calculated using the following formula: $R = 40 \times E / S \times C$, where

R =	Re-age adjustment.	The reduction of age of the facility in years.
E =	Actual expenses for the construction	Expenses related to capitalized assets for fixed assets including landscaping, sidewalks, egresses, retaining walls, and parking lots. The total costs must have been incurred within twenty-four (24) months of the completion of the construction. For larger construction projects or additions, 36 months may be granted at the State's discretion.
S =	Total square footage in the building	Gross square feet including common area at the end of the construction.
C =	The cost of construction for the building in the year the construction was completed.	Source is from costs published by Marshall & Swift Valuation Service or its successor. Costs reflect current construction costs for average Class D Nursing Home (convalescent hospital) using the most current publication. If the publication is late at the time of rate setting, the prior year amount will be inflated forward using the "Annual Cost Changes" figure identified in Section 18 (d).

(v) If the result of this calculation, "R" is equal to or greater than 1.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero (0).

(vi) Re-age Adjusted Building Age. The beginning age of the building minus the re-age adjustment is defined as the "re-age adjusted building age." This age is used to select the rental rate based on the age of the building.

(i) Funding Limit Property Rental Rate Rebase. If at the time the July 1 rates

are being calculating using the base year property adjusted to the current rate year results in total property reimbursement equating to more than 10% of the total legislative budget, the property rental rates will be rebased to a lower amount as determined by the state to shift those legislative dollars from the property category to the health care and operating rate categories.

Section 19. Wyoming Retirement Center.

The state operated facility will be subject to all rules within this chapter with the exception of the rate and price setting Sections 7, 13(d), 14, 15, 16, 17(c), and 18.

(a) Per diem rates shall be calculated separately from other facilities in this chapter and the Wyoming Retirement Center data will not be included in the database of providers identified in Section 14.

(b) The provider's per diem rate shall be determined utilizing either a desk reviewed or audited cost report. Costs will not be subject to any form of cap or maximum rate.

(i) Effective date. For services effective on or after July 1, 2015, the provider's per diem rate shall become effective on the rate effective date.

(ii) Per diem rates are established prospectively and shall remain in effect from the rate effective date until redetermined pursuant to this rule.

(iii) The most currently reviewed cost report will be used to set the future rate. The same year will not be used twice.

(c) Rates shall be established by inflating the audited or desk reviewed costs from the midpoint of the provider's cost reporting year to the midpoint of the rate year. Inflated costs will be divided by total patient days to arrive at the allowed per diem rate.

(d) "Inflation factor." The inflation factor is the Skilled Nursing Facility (SNF) Market Basket as published quarterly by DRI/Global Resources or its successor.

Section 20. Hold Harmless.

(a) If the provider's July 1, 2015 calculated rate is less than their rate in effect on June 30, 2015, the provider will qualify for a hold harmless rate adjustment as follows:

(b) For the rate quarters effective on July 1, 2015 and October 1, 2015, the provider will continue to receive their rate that was in effect on June 30, 2015.

(c) For the rate quarters effective on January 1, 2016 and April 1, 2016, the provider will receive their rate that is calculated for the rate quarter using the rate methodology effective for that quarter plus 50% of the difference between that rate and their rate that was effective on June 30, 2015.

Section 21. Legislative Appropriations.

(a) If the Wyoming Legislature passes a special appropriation to be used to increase nursing facility reimbursement for any specific purpose defined by the Legislature in such appropriation, this section shall control the allocation of such appropriation among nursing facilities in Wyoming.

(b) The Department shall develop a methodology to allocate the appropriation among nursing facilities in Wyoming.

(i) The Department may consult with representatives of nursing homes, such as representatives of associations which represent nursing homes in Wyoming, about how to allocate the appropriation.

(ii) The Department shall collect the information it deems necessary to allocate the appropriation. The Department shall request information in writing, by certified mail, return receipt requested. Providers shall furnish the requested information in the format and according to the schedule established by the Department. All such information shall be submitted to the Department by certified mail, return receipt requested. Any information provided to the Department shall contain a certification statement substantially in the form specified in subsection 5(d) of this Chapter.

(iii) After collecting information pursuant to subsection (b)(i), the Department shall develop a methodology to distribute the appropriation among nursing facilities in Wyoming. The methodology shall:

(A) Effectuate the legislative purpose of the appropriation in a timely and cost-effective manner;

(B) Benefit Wyoming nursing facilities equitably, such that no nursing facility benefits disproportionately, based on the intent of the appropriation;

(C) Include safeguards to ensure that appropriated funds are

spent for the purposes specified in the appropriation. Such safeguards shall include reporting and documentation requirements for facilities; and

(D) The Department shall disseminate the methodology to facilities through a manual or bulletin.

(c) The department shall follow the existing reimbursement methodology and increase the cost components to reimburse the providers for the legislative appropriation.

Section 22. Reimbursement Rate for Extraordinary Care Clients.

(a) Medicaid reimbursement for services provided to an extraordinary care client may be negotiated for clients who require skilled nursing facility care and require special care as recognized with prior authorization by the Department. Services for these clients shall be the per diem rate calculated in accordance with other sections of this Chapter, plus a negotiated rate to cover the cost of medically necessary services (equipment and staffing) and supplies that are not included in the per diem rate.

(i) The only items that may qualify for an extraordinary rate are as follows:

(A) Tracheostomy

(B) Ventilator

(C) Morbid obesity

(D) Psychiatric care for clients with significant behaviors that cannot otherwise be safely cared for in a standard nursing facility setting without increased staffing or special accommodations. This includes clients with significant physical aggression, delirium and/or psychosis.

(ii) The Department will negotiate with providers on a case-by-case basis to determine the negotiated rate and the billing procedures for extraordinary care clients.

(iii) Prior to such negotiations, the provider shall submit to the Department:

(A) A treatment plan;

(B) A proposed reimbursement rate, including all relevant

financial records and all medical records which document the medical necessity for services provided to an extraordinary care client; and

(C) All other specific documentation required by the Department for processing of the rate request.

(iv) The Department may request, and the provider shall furnish before a negotiated rate is established, additional information to document the medical necessity for services provided to an extraordinary care client.

(v) The negotiated rate shall be the rate determined by the Department based on the negotiations with the provider for medically necessary services.

(vi) The Department shall reevaluate the condition of an extraordinary care client after the first fifteen (15) days after admission, again at (30) days, ninety (90) days thereafter, and then every six (6) months thereafter. The State shall review records on a yearly basis to determine if a renegotiation of the negotiated rate is necessary to reflect changes in the client's condition. Exceptions to the frequency of reporting are at the discretion of the reviewer. It is the provider's responsibility to report any significant changes in care requirements, condition changes, and/or changes in client physical location at any time prior to the established review.

(b) All inclusive. The per diem rate plus the negotiated rate shall be an all inclusive reimbursement rate for all services and supplies furnished by the nursing facility.

(c) Maximum rate. The negotiated rate shall not exceed the actual cost of the services provided to the extraordinary care client.

(d) Until the Department agrees, in writing, to a negotiated rate, reimbursement for services provided to an extraordinary care client shall be limited to the nursing facility's per diem rate.

(e) The nursing facility shall maintain records of the costs it incurs in furnishing services to each extraordinary care client. Costs related to services furnished to extraordinary care clients, other than nursing facility services, are not allowable costs for purposes of determining the nursing facility's per diem rate.

Section 23. Contracted Rate for Distressed Facilities.

(a) The Department may pay a contracted rate to a nursing facility determined by the Department to be in distress. The contracted rate may exceed the nursing facility's

per diem rate as determined pursuant to Section 17 of this Chapter.

(b) The Department shall negotiate and enter into contracts for a temporary contracted rate using the following procedures:

(i) Determine what constitutes a distressed facility, taking into consideration for each nursing facility, the factors specified in (A) and the objectives specified in (B):

(A) Factors:

(I) Financial stability and solvency;

(II) Occupancy (low occupancy as a percentage of capacity or drops quickly);

(III) Whether or not the Department has assumed temporary management of the facility; and

(IV) Geographic location of the facility.

(B) Objectives:

(I) Reduction in the number and frequency of institutionally acquired infections;

(II) Reduction in the number and frequency of adverse resident incidents, such as falls, skin tears, and wandering from the facility.

(III) Reduction in official and unofficial complaints;

(IV) Maintenance of residents' ideal body weight;

(V) Maintenance or improvement of nursing facility survey results;

(VI) Maintenance of ambulatory levels of residents from admission to discharge;

(VII) Increases in the number of discharges to lesser acute settings;

(VIII) Decreases in the incidence of residents' incontinence;
(IX) Maintenance of the provider network in rural or underserved areas; and

(X) Avoidance of client abandonment by the dissolution or insolvency of the incumbent provider.

(ii) Solicit proposals for the temporary rate contracts; and

(iii) Negotiate with providers.

(c) The Department will negotiate with providers determined to be in distress on an individual basis to determine whether a contracted rate is appropriate for that nursing facility, using the Department's distressed facility criteria.

(i) Prior to such negotiations, the provider shall submit to the Department, in the format prescribed by the Department:

(A) A proposed contracted rate; and

(B) Supporting documentation, including:

(I) All relevant financial records and medical records which demonstrate the distressed status of the facility;

(II) A proposed method of monitoring and building overall census, such method to be subject to review and approval by the Department; and

(III) The additional cost the nursing facility will reasonably and necessarily be incurring to maintain required daily operations in compliance with all State and Federal provisions.

(ii) The Department may request, and the provider shall furnish before a contracted rate is established, additional information to document the distressed status and/or added costs.

(iii) The contracted rate shall be the rate agreed upon by the provider and the Department for the maintenance of daily operations focused on client health and safety. The rate shall apply to all Medicaid clients in the nursing facility, unless otherwise agreed by the Department.

(iv) The Department may establish monitoring criteria and procedures to determine whether the facility continues to maintain client health and safety.

(v) If the Department determines that the client's health and safety are not being maintained in accordance with State and Federal standards, the Department shall suspend the nursing facility's temporary rate contract and work with the Office of Healthcare Licensing and Survey to take appropriate action. The contracted temporary rate shall be the rate set for new ownership of a distressed facility pending the return of overall facility census to prior year's operating levels (as documented by the Department) or for up to a maximum of six (6) months. Upon expiration of the temporary contracted rate, the Department may, at its discretion, re-evaluate the continued need for a temporary rate for up to six (6) additional months or terminate the temporary rate contract. Upon final termination, the Department shall reinstate the nursing facility's Medicaid reimbursement rate to the per diem rate established pursuant to Section 17 of this Chapter.

(d) All inclusive. The contracted rate shall be an all inclusive per diem rate for all services and supplies furnished by the nursing facility, except as specified in Section 24 of this Chapter, and/or as otherwise agreed by the Department.

(e) Maximum rate. The negotiated rate shall not exceed the nursing facility's actual costs.

(f) Until the Department agrees, in writing, to a contracted rate, reimbursement for services provided to clients shall be limited to the nursing facility's per diem rate as determined in Section 17 of this Chapter.

(g) The Department's refusal to agree to a contracted rate requested by a provider is not an adverse action for purposes of the Rules and Regulations of Wyoming Medicaid, Chapter 2, State Licensed Shelter Care Eligibility Services.

Section 24. Nursing Care Facility Assessment Act.

(a) Nursing facility adjustment payments to providers based on the upper payment limit calculation.

(i) The Department will make adjustment payments to nursing facilities under the provisions of the Nursing Care Facility Assessment Act, W.S. §§ 42-8-101 through 109.

(A) Adjustment payments will be calculated prospectively on

an annual basis to be effective from October 1 through September 30 of each year. The adjustments will be paid quarterly. New providers opening during that assessment year will not be included in the program until the next assessment year.

(B) The quarterly adjustment payments will be due to the providers not later than thirty (30) days after the end of each calendar quarter.

(C) Change of ownership. If a facility changes ownership, beginning at the start of the calendar quarter following the date of the change of ownership, the new owner will collect the adjustment payment that was calculated using the prior owner's data.

(D) Adjustment payments will be calculated based on Medicaid days paid by the Wyoming medical assistance program.

(I) Wyoming Medicaid days will be collected for the dates of service represented in cost reports ended in the calendar year that precedes the assessment effective each October 1. The Medicaid days will be generated by the Department from their MMIS payment system.

(II) New facilities without a qualifying cost report. For new facilities that opened prior to the October 1 annual calculation that do not have either a full year cost report or a qualifying cost report, as described in Section 5(c) of this Chapter, resident days will be determined using more current information and will be annualized.

(E) State owned facilities will be exempt from this program.

(b) Nursing facility assessment payable to the Department.

(i) The Department will collect an assessment from nursing facilities under the provisions of the Nursing Care Facility Assessment Act, W.S. §§ 42-8-101 through 109.

(A) Assessments will be calculated prospectively on an annual basis to be effective from October 1 through September 30 of each year. The annual assessments will be paid quarterly. New providers opening during that assessment year will not be included in the program until the next assessment year.

(B) The quarterly assessments will be due to the Department no later than forty-five (45) days after the end of each calendar quarter.

(C) Change of ownership. If a facility changes ownership, beginning with the quarter following the date of the change of ownership, the new owner will assume the payment schedule calculated using prior owner's data. If it is not clear to the Department which owner is responsible for the assessment, the owner who received the quarterly adjustment payment will be responsible to pay the Department for the assessment related to that same quarter.

(D) Assessments will be calculated based on a per-resident day basis, exclusive of Medicare resident days.

(I) Resident days will be collected from the Wyoming Nursing Home Reimbursement System, Financial Report for Nursing Homes (cost report) that ended in the calendar year that precedes the assessment effective each October 1. The Department will revise its cost report form to collect the appropriate patient day data. Until the revised cost report forms are in use and have been filed with the Department, the Department will utilize a provider survey to gather the necessary data.

(II) New facilities without a qualifying cost report. If a new facility opened prior to the October 1 annual calculation that does not have either a full year cost report or a qualifying cost report, as described in Section 5(c) of this Chapter, resident days will be determined using more current information and will be annualized.

(E) Assessment expenses shall be reported on the State of Wyoming Financial Report for Nursing Homes annual cost report. Expenses should be reported on schedule B of this same cost report. For providers who do not file Medicare cost report, Assessment expenses shall be reported on line 578 of the State of Wyoming Financial Report for Nursing Homes annual cost report.

(F) State owned facilities will be exempt from this program.

Section 25. Medicaid Allowable Payment for Medicaid Program Services. Any Medicaid program service other than nursing facility services reimbursable within this Chapter shall be reimbursed according to the rules and policies of the Department for that specific program.

Section 26. Billing Requirements.

(a) Submission of claims. A provider seeking Medicaid reimbursement for services provided to a client must submit claims on the forms and in the manner specified by the Department.

WYOMING NURSING HOME REIMBURSEMENT SYSTEM

Addendum 1. Legislative Appropriation- 2000 Session

1. Appropriation for nursing wage increase effective July 1, 2000. The methodology to be used in reimbursing nursing facilities for the nursing wage increase effective July 1, 2000 is as follows:

(i) Prior to July 1, 2000, the Department will send out a survey document to all nursing facility providers requesting information regarding each facility's level of participation in the nursing wage increase.

(A) Facilities will have the opportunity to indicate on the document whether or not they wish to participate in the nursing wage increase.

(B) Facilities electing to participate will be asked to complete a schedule listing each employee receiving the increase, the average hours worked per week, the current wage rate, and the proposed wage rate after the increase.

(ii) Effective July 1, 2000, the allowable nursing wage increase amounts for each nursing facility will be calculated based on the response to the survey document. The nursing wage increase will be limited to the lesser of each facility's proposed increase, $1 per hour, or an allocation of the legislative appropriation.

(A) The per diem nursing wage increase for each facility, subject to the limits above, will be added to the healthcare limit of each facility's rate calculation.
(B) The per diem nursing wage increase for each facility, subject to the limits above, will also be added to the allowable per diem healthcare cost for each facility.
(C) Finally, the per diem nursing wage increase for each facility, subject to the limits above, will be added to the base rate used to establish the minimum and maximum rates in accordance with Section 17 (a).

(iii) In future rate setting periods, the nursing wage increase included in the healthcare component of the rate, as stated in (ii) (A) and (B) above, will be reduced by the portion of the cost report that extends beyond the July 1, 2000 effective date, since the cost report should already reflect these increased costs. The amount added to the base rate as specified under Addendum 1 will remain in the rate setting process until such time as the base rate reflects the cost increase.

(iv) In addition to the initial survey document, an additional schedule will be required with future cost reports ending after July 1, 2000 that will enable the Department to monitor the use of these funds. As stated in Section 21 (c), funds for which the facility cannot provide documentation shall be recovered pursuant to Section 31.

WYOMING NURSING HOME REIMBURSEMENT SYSTEM

Addendum 2. Legislative Appropriation- 2002 Session

1. Appropriation for nursing wage increase effective July 1, 2002. The methodology to be used in reimbursing nursing facilities for the nursing wage increase effective July 1, 2002 is as follows:

(i) Prior to July 1, 2002, the Department will send out a survey document to all nursing facility providers requesting information regarding each facility's level of participation in the nursing wage increase.

(A) Facilities will have the opportunity to indicate whether or not they wish to participate in the nursing wage increase.

(B) Facilities electing to participate will be asked to complete a schedule listing each employee receiving the increase, the average hours worked per week, the current wage rate, and the proposed wage rate after the increase.

(ii) Effective July 1, 2002, the allowable nursing wage increase amounts for each nursing facility will be calculated based on the response to the survey document. The nursing wage increase will be limited to the lesser of each facility's proposed increase or an allocation of the legislative appropriation.

(A) The per diem nursing wage increase for each facility, subject to the limits above, will be added to the healthcare limit of each facility's rate calculation.
(B) The per diem nursing wage increase for each facility, subject to the limits above, will also be added to the allowable per diem healthcare cost for each facility.
(C) Finally, the per diem nursing wage increase for each facility, subject to the limits above, will be added to the base rate used to establish the minimum and maximum rates in accordance with Section 17 (a).

(iii) In future rate setting periods, the nursing wage increase included in the healthcare component of the rate, as stated in (ii) (A) and (B) above, will be reduced by the portion of the cost report that extends beyond the July 1, 2002 effective date, since the cost report should already reflect these increased costs. The amount added to the base rate as specified under Addendum 2 will remain in the rate setting process until such time as the base rate reflects the cost increase.

(iv) In addition to the initial survey document, an additional schedule will be required with future cost reports ending after July 1, 2002 that will enable the Department to monitor the use of these funds. As stated in Section 21 (c), funds for which the facility cannot provide documentation shall be recovered pursuant to Section 31.

SUPPLEMENTAL PAYMENTS

Addendum 3. Supplemental payments for nursing home facilities

Subject to the provisions of this section, eligible providers of Medicaid nursing home facility services shall receive a supplemental payment each quarter (based on a yearly calculation).

The supplemental payments are intended to be used to improve access to health care for Medicaid clients. The payment pool will be based on the aggregate difference in the actual amount paid by the Medicaid program and the amount that would have been paid under Medicare payment principles in accordance with 42 CFR 447.272 of Federal regulations.

The supplemental payments shall not be subject to rules governing payments to nursing home facilities found in Chapter 7 of the Wyoming Medicaid rules. However, they shall not exceed the Medicaid upper payment limits as defined in 42 CFR 447.272. The Medicaid upper payment limit (UPL) analysis will be performed prior to making the supplemental payments.

The computation of the Medicaid UPL will utilize the most recent finalized Medicaid rates effective October first of each year for each nursing facility plus all add-on payments paid during the cost reporting period used to calculate the Medicaid rate for that same rate period. The Medicaid rate plus add-on payments is then subtracted from the average Medicare rate for the same time period, with the result then multiplied by the Medicaid days to arrive at the facility's contribution to the group's aggregate UPL room (over/under the UPL) for each UPL category (e.g., State-owned, non-State owned, private).

Effective for dates of service on or after April 1, 2011, the State will make quarterly supplemental payments for nursing facility services rendered during the quarter (based on a yearly calculation) for each Federal Fiscal year based on a calculation that utilizes Medicaid days for cost reporting periods ended in the previous calendar year that precedes each October 1 rate year. Supplemental payments made to nursing homes that provide nursing facility services to Medicaid clients will be distributed to all nursing facilities, based on Medicaid days for the cost reporting period ended in the previous calendar year, proportionate to the share of total Medicaid days within each provider group, applied to the equal quarterly portion of the payment pool within each UPL category.

2) That reductions in provider payment may be limited to the extent that the following apply:

(i) The identified provider-preventable conditions would otherwise result in an increase in payment.

(ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

3) Assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

In the event that individual cases are identified throughout the PPC implementation period, the State will adjust reimbursements according to the methodology above. Denial of payment shall be limited to the additional care required by the provider preventable condition.

____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-New. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

Wyoming Medicaid meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under Section(s) 4.19(d):

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Wyoming Medicaid will adopt the baseline for other provider-preventable conditions as described above. The following reimbursement changes will apply:

Payment will be denied for these conditions in any Health Care Setting as identified in Attachment 4.19(d) and any other settings where these events may occur. For any Wyoming Medicaid claims with dates of service after July 1, 2012, Wyoming Medicaid will follow the minimum CMS regulations in 42 CFR §447 and deny payment for all of the OPPCs identified in 42 CFR §447. Wyoming Medicaid will retroactively review claims with dates of service on or after July 1, 2012, to identify claims fitting the criteria for PPCs. Wyoming Medicaid will request that providers review claims identified as potential PPCs and provide additional documentation to confirm or deny the claim includes a PPC. For any provider-confirmed PPCs, payment will be adjusted to recoup the payment for the patient day(s) during which the PPC event occurred. Recoupment will be for the amount of the per diem that was in effect for the date(s) of service that the PPC event occurred.

In compliance with 42 CFR 447.26(c), Wyoming Medicaid provides:

1) That no reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(b) Medicaid payment as payment in full. A provider which receives or requests Medicaid payment for services and supplies included in the per diem rate must accept Medicaid payment as payment in full for such services and supplies. A provider may not attempt to collect or retain payment in addition to the per diem rate, except as permitted by 42 C.F.R. § 483.10(c) or other applicable federal law.

Section 27. Change in Provider Status.

(a) Termination of participation. If a provider's participation in the Medicaid program is terminated or suspended for any reason, the provider must submit a cost report for the period ending with the effective date of the termination or suspension if that cost report is needed for rate setting. The cost report is due within forty-five (45) days after the date of termination or suspension, even though the provider's tax period does not end on the date of termination or suspension. The final month's payment due a provider shall be withheld until its cost report is filed and the Department has a reasonable time to perform a desk review and field audit of the cost report and patient funds account.

(b) Change of ownership.

(i) Notice of change of ownership. The parties to a transaction involving a change of ownership must notify the Department, in writing, of the proposed transaction no later than thirty (30) days before the effective date of the change.

(ii) Representation agreement. Upon a change of ownership, all parties to the transaction shall have thirty (30) days after the change to complete and sign a representation statement, in written form specified by the Department, which details the persons or entities which have assumed the assets and liabilities of a nursing facility. If a representation statement is not timely submitted, both the original provider and any subsequent provider shall be jointly and severally responsible for all Medicaid liabilities which exist either before or after the change of ownership.

Section 28. Reimbursement of Out-of-State Providers.

(a) The reimbursement rate for out-of-state facilities providing services to Wyoming clients shall be the lesser of:

(i) The Medicaid reimbursement rate the nursing facility receives for the same or similar services from the Medicaid program in the state where the nursing facility is located;

Nursing Facility Services

Non-State Government Owned Nursing Facility Supplemental Payment Program

A nursing facility located in Wyoming may be eligible for a supplemental payment if:

1) It is owned or operated by a non-state governmental entity; and
2) There are undistributed funds leftover from the Upper Payment Limit (UPL) calculation for non-state governmental entities after all other payments are made.
3) Its Medicare upper payment limit calculation, on an individual provider basis, results in Medicaid payments less than what Medicare would have paid.

The payment is a lump sum supplemental payment based on an annual calculation from the upper payment limit (UPL) analysis conducted for nursing facilities using the annual UPL calculation. The distribution will occur at the end of the UPL year.

The total funds available for this distribution will equal the available UPL gap remaining after UPL distributions are made under the existing authority described on page 31c, Addendum 3 of section 4.19-D. The current UPL does not allow for distributing the entire UPL gap for the NSGO class, the undistributed balance will remain available for this distribution program. The state shall distribute the funds based on the percentage to total of each provider's calculation of the difference between what Medicaid paid and what Medicare would have paid, less the original supplemental UPL payment, as calculated on the annual UPL demonstration. If this calculation results in the provider having a negative UPL gap, that provider will not qualify for a payment. The sum of the Medicaid base payments, and all other supplemental payments will not exceed the Medicare upper payment limit for the non-state governmental total group according to 42 CFR 447.272. Following is an illustration of the methodology:

	UPL Available for Payment			NSGO Supplemental Payment Distribution		
Provider	Medicaid Deficit or (Medicaid Payments Exceeding Costs)	UPL Distribution	Amount Available for NSGO Supplemental Payment Program	Providers Eligible for NSGO Supplemental Payment	% of Total	NSGO Supplemental Payment Distribution
A	B	C	D = B-C	E = If D > 0 then +D	F = E / Total E	G = F * Total D
#1	100,000	10,000	90,000	90,000	10.00%	80,000
#2	200,000	20,000	180,000	180,000	20.00%	160,000
#3	300,000	30,000	270,000	270,000	30.00%	240,000
#4	400,000	40,000	360,000	360,000	40.00%	320,000
#5	(90,000)	10,000	(100,000)	0	0.00%	0
Total	910,000	110,000	800,000	900,000	100.00%	800,000

The timing of the payments will be as follows:

1) Upon program implementation, based on the calculated UPL room for FFY 2016, Wyoming Medicaid will distribute 25% (July 1, 2016 – September 30, 2016) of the total estimated computable amount of $243,940 (or $60,985 to include both state and federal shares) to qualifying providers based on each individual provider's calculated UPL room available.
2) Annually, at the beginning of the FFY UPL year, approximately in October, participation letters will be sent to providers asking for attestation of ownership.
3) At the end of the FFY UPL year, following the attestation period described above, qualifying facilities will receive a payment.

(ii) The average Medicaid day weighted average rate in effect in Wyoming as of the previous July 1; or

(iii) The nursing facility's usual and customary rate.

(b) The average Medicaid day weighted average rate in effect shall be determined by:

(i) Multiplying the number of Medicaid days in each nursing facility by each facility's Medicaid per diem rate;

(ii) Adding the products determined pursuant to (i); and

(iii) Dividing the sum determined pursuant to (ii) by the total number of Medicaid days in the state.

(c) No cost reports. An out-of-state provider need not submit cost reports to the Department.

(d) Billing requirements. An out-of-state provider must submit with each claim a certification of the provider's reimbursement rate under the Medicaid program in the state where the provider is located and the nursing facility's usual and customary charge.

(e) The calculated rate will remain in effect until the following July 1. Out of state providers are not subject to quarterly case mix acuity adjustments.

Section 29. Record Retention.

(a) Providers shall comply with the Provider Records requirements of the Rules and Regulations of Wyoming Medicaid, Chapter 3, Provider Participation.

(b) Explanation of records. In the event of a field audit, the provider shall have available at the field audit location one (1) or more knowledgeable persons who can explain the provider's financial records, the accounting and control system and cost report preparation, including attachments and allocations, to the auditors.

(c) Failure to maintain records. A provider unable to satisfy any of the requirements of this Section shall be given a written notice of deficiency and shall have sixty (60) days after the date of the written notice to correct such deficiency. If, at the

end of the sixty (60) days, the Department determines that the deficiency has not been corrected, the Department shall withhold twenty-five (25) percent of the provider's per diem rate for services provided on or after the sixtieth (60th) day. If, at the end of one hundred and twenty (120) days after the mailing of the written notice of deficiency, the Department determines that the deficiency has not been corrected, the Department shall suspend all Medicaid payments for services provided after such date. Reimbursement shall not be reinstated until the Department determines that adequate records are being maintained. After the deficiency is corrected, the Department shall release any withheld payments.

(d) Out-of-state records. If a provider maintains financial or medical records out of state, the provider shall either transfer the records to an in-state location that is suitable for the Department to perform the field audit or reimburse the Department for reasonable costs, including travel, lodging and meals, incurred in performing the field audit in an out-of-state location.

Section 30. Repayment of Credit Balance.

(a) Report on cost report. A provider shall report a credit balance on the provider's cost report. A credit balance shall be repaid pursuant to subsection (c).

(b) Annual request. The Department may request the repayment of any credit balance annually. Such request shall be made in writing and mailed by certified mail, return receipt requested. The provider shall repay the credit balance within sixty (60) days after the date of receipt of the request for repayment.

(c) A provider shall repay any credit balance within sixty (60) days after the date such credit balance is identified by the Department or the provider.

(d) Lump sum adjustment. If a credit balance identified pursuant to subsections (a) or (b) is not timely paid to the Department, the Department may recover the credit balance pursuant to Section 31 of this Chapter.

Section 31. Audits.

(a) Field audits. The Department or CMS may perform a field audit of a provider at any time to determine the accuracy and reasonableness of cost reports submitted by the provider and/or the validity of rate adjustments made pursuant to a desk review.

(b) Desk review. The Department or CMS may perform a desk review of a provider at any time to determine the accuracy and reasonableness of cost reports

submitted by the provider.

(c) The Department or CMS may perform field audits or desk reviews through employees, agents, or through a third party. Audits shall be performed in accordance with GAAS.

(d) Disallowances.

(i) Nonallowable costs. If a field audit or desk review discloses nonallowable costs or costs for services and supplies not included in the per diem rate, the Department shall adjust the per diem rate retroactively to the beginning of the rate period in question, recover any overpayments pursuant to Section 31 of this Chapter, and adjust the per diem rate for the remainder of the rate period.

(A) Costs which are not reasonably related to services included in the Medicaid per diem rate, or which are against public policy, contractual allowances, courtesy discounts, charity allowances, and similar adjustments or allowances are adjustments to revenue and, therefore, are not included in allowable cost. Nonallowable costs also include, but are not limited to:

(I) Advertising expense (other than help wanted ads and telephone directory expense);

(II) Attorney fees and other costs associated with negotiations, administrative proceedings or litigation involving the Department, except as specified in settlement;

(III) Bad debts;

(IV) Cost arising from joint use of resources (including central office and pooled cost) not reasonably related to patient care;

(V) Capital costs due solely to changes in ownership;

(VI) Costs incurred in transactions with organizations related to the provider by common ownership or control, to the extent that such costs exceed the limits established under 42 C.F.R. § 413.17;

(VII) Costs incurred as a result of enforcement actions taken by the Department pursuant to the Rules and Regulations for Wyoming Medicaid, Chapter 5, Long Term Care Facility Remedies, Terminations, and/or CMS in response to nursing facility deficiencies, including costs of directed in-service training, suspended or

denied per diem payments, reimbursement expenses, transfer costs, and costs relating to state monitoring and/or the appointment of a temporary manager;

(VIII) Costs not reasonably related to patient care;

(IX) The costs associated with ancillary and other services attributable to Medicare Part A or Medicare Part B, including direct and indirect costs;

(1.) Ninety (90) percent of the costs identified pursuant to this paragraph shall be nonallowable costs, and one hundred (100) percent of Medicare bed days shall be removed.

(2.) When determining the capital component for nursing facilities with occupancy below ninety (90) percent Medicare days will be computed to reflect Medicare occupancy.

(X) Costs related to the acquisition, establishment or operation of an in-house pharmacy, other than the reasonable costs of a pharmacy consultant;

(XI) Costs related to extraordinary clients that exceed the per diem rate;

(XII) Costs related to hospice services;

(XIII) Costs (such as legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies) which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any Medicaid payment has been previously made;

(XIV) Federal income and excess profit taxes;

(XV) Fees paid to directors and salaries, wages or fees paid to non-working officers, employees or consultants;

(XVI) Fund-raising expenses;

(XVII) Interest or penalties on federal or state taxes;

(XVIII) Judgments entered against a nursing facility or settlements entered into by a nursing facility arising out of actions or inactions of the

nursing facility's agents or employees, including judgments entered against a nursing facility's agent or employee that a nursing facility pays, or settlements involving the nursing facility's agent or employee that the nursing facility pays;

(XIX) Life insurance premiums for officers and owners and related parties, except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(XX) Meals and lodging provided to guests and employees. If the cost cannot be ascertained, the revenue from meals and lodging furnished to guests and employees shall be offset against the appropriate cost;

(XXI) Prescription drugs;

(XXII) Public relations expenses;

(XXIII) Resident personal purchases;

(XXIV) Return on equity;

(XXV) Self-employment taxes;

(XXVI) Stockholder relations or stock proxy expenses;

(XXVII)Taxes or assessments

(XXVIII) Telephone, television and radio which are located in patient accommodations and which are furnished solely for the personal comfort of patients;

(XXIX) Value of services (imputed or actual) rendered by non-paid workers or volunteers; and

(XXX) Vending machines and related supplies.

(XXXI) Costs of services or supplies provided by a related party are reimbursable at the actual cost incurred by the related party. If the actual cost cannot be determined, the profit percentage from the related party's records will be used to calculate the profit percentage adjustment to the related party cost.

(XXXII) Compensation for services from an owner or a party related to the provider is an allowable cost if such services were:

(1) Actually performed;

(2) Necessary to the delivery of patient-related services; and

(3) The compensation paid was reasonable.

(4) Documentation. A provider must maintain written documentation of the time and work performed, the relationship of the work to patient care, whether such work was performed at the nursing facility or outside the nursing facility, and the compensation paid for such work.

(5) Maximum allowable. Compensation of an owner or party related to the provider is not an allowable cost to the extent it exceeds the median range for comparable services as contained in the most recent survey of administrative salaries paid to persons other than owners of proprietary and nonproprietary providers conducted by the Bureau of Health Insurance and published in the Medicare Provider Reimbursement Manual PRM Part 1, Section 905.2.

(6) Part-time employees. For individuals who work less than a forty (40) hour work week, the maximum allowable amount shall be reduced by the ratio of actual number of hours worked per week to forty (40).

(7) Full-time employees. Individuals who work more than a forty (40) hour work week may have their total salary expenses reviewed for reasonableness. The total salary for that job classification will be compared to industry averages for that position. Any amounts that appear to be excessive as compared to industry averages will be adjusted to a reasonable amount.

(ii) Unsubstantiated cost.

(A) Upon written request by the Department, a provider must substantiate cost or other information reported on the provider's cost report. Substantiation must be provided, in writing, within thirty (30) days after the date of the request.

(B) Any cost which a provider cannot substantiate shall be disallowed.

(C) Substantiation may include, but is not limited to, home office cost statement, resident census, statistical and related information, cost allocations,

account analyses, invoices, stock ownership information, related parties' financial information, or subcontractor's financial information.

(e) Financial or medical records which are not made available at the time of an audit shall not be admissible at an administrative hearing held pursuant to Section 32 of this Chapter unless the nursing facility shows good cause for not making the records available at the time of the audit.

Section 32. Recovery of Overpayments. The Department may recover overpayments pursuant to the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 33. Reconsideration.

(a) A provider may request reconsideration of the decision to recover overpayments pursuant to the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

(b) A provider may request reconsideration of the determination of the provider's per diem rate following the procedures outlined in the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 34. Disposition of Recovered Funds. The Department shall dispose of recovered funds pursuant to the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 35. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, any other agency of the Federal, State or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments or take any other final action authorized by this Chapter.

Section 36. Interpretation of Chapter.

(a) 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.

(b) The text of this Chapter shall control the titles of its various provisions.

Section 37. Superseding Effect. When promulgated, this Chapter supersedes all prior rules or policy statements issued by the Department, including manuals or

bulletins, which are inconsistent with this Chapter.

Section 38. Severability. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.

ATTACHMENT A

ABD Pads
Adhesive Tape
Aerosol, other types
Air Mattresses, Air P.R. Mattresses
Airway-Oral
Alcohol Plaster
Alcohol Sponges
Alternating Pressure Pads
Applicators, Cotton-tipped
Applicators, Swab-eez
Aquamatice K Pads (Water-heated Pad)
Arm slings
Asepto Syringes
Baby Powder
Bandages
Bandages, Elastic or Cohesive
Band-Aids
Basins
Bed Frame Equipment (for certain immobilized bed patients)
Bed Rails
Bedpans, all types
Beds: Manual, Electric and Clinitron
Bedside Tissues
Bibs
Blood Infusion Sets
Bottle, Specimen
Canes, all types
Cannual, Nasal
Catheter Indwelling
Catheter Plugs
Catheter Tray
Catheter (any size)
Colostomy Bags
Combs
Commodes, all types
Composite Pads
Cotton Balls

Crutches, all types
Decubitus Ulcer Pads/Dressings
Denture Cleaner/Soak
Denture Cups
Deodorants
Diapers
Disposal Under pads
Donuts
Douche Bags
Drain Tubing
Drainage Bags
Drainage Sets
Drainage Tubes
Dressing Tray
Dressing, all types
Enema Soap
Enema Supplies
Enema Unit
Equipment and Supplies for Diabetic Blood and Urine Testing
Eye Pads
Feeding Tubes
Fingernail Clipping and Cleaning
Flotation Mattress or Biowave Mattress
Flotation Pads and/or Turning Frames
Foot Cradle, all types
Gastric Feeding Unit, including bags
Gauze Sponges
Gloves, Unsterile and Sterile
Gowns, Hospital
Green Soap
Hair Brushes
Hair Care, Basic
Hand Feeding
Heat Cradle
Heating Pads
Heel Protector
Hot Pack Machine
Hydraulic Patient Lifts
Hypothermia Blanket

Ice Bags
Incontinency Care
Incontinency Pads and Pants
Influenza Vaccine
Infusion Arm Boards
Infusion Pumps, Enteral and Parenteral
Inhalation Therapy Supplies
Irrigation Bulbs
Irrigation Trays
I.V. Needles
I.V. Trays
Jelly, Lubricating
Lines, Extra
Lotion, Soap and Oil
Massages (by nursing facility personnel)
Mattresses, all types
Medical Social Services
Medicine Dropper
Medicine Cups
Nasal Catheter
Nasal Catheter, Insertion and Tube
Nasal Gastric Tubes
Nasal Tube Feeding and Feeding Bags
Nebulizer and Replacement Kit
Needles (various sizes)
Needles: Hypodermic, Scalp and Vein
Nursing Services (all) regardless of level, including the administration of oxygen and restorative nursing care
Nursing Supplies and Dressing
Ostomy Supplies: Adhesive, Applicance, Belts, Face Plates, Flanges, Gaskets, Irrigation Sets, Night Drains, Protective Dressings, Skin Barriers, Tail Closures
Overhead Trapeze Equipment
Over the counter (OTC) drugs, as designated by the Food and Drug Administration
Oxygen, Gaseous and Liquid
Oxygen Concentrators
Oxygen Delivery Systems, Portable or Stationary
Oxygen Mask
Pads
Pitcher

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation
42 CFR 447.25(b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services

☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.

Revision: HCFA-AT-81-34 (BPP) 10-81

State Wyoming

Citation

42 CFR 447.10(c)
AT-78-90
46 FR 42699

4.21 Prohibition Against Reassignment of Provider Claims

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: WYOMING

Citation

4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all requirements of:

(1) 42 CFR 433.138 and 433.139.
(2) 42 CFR 433.145 through 433.148.
(3) 42 CFR 433.151 through 433.154.
(4) Sections 1902(a)(25)(H) and (I) of the Act.

1902(a)(25)(H) and (I) of the Act

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A --

(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii) and (2)(ii)

(2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i) and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i) through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: WYOMING

Citation

42 CFR 433.139 (b)(3)(ii)(A)	X	(c)	Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
		(d)	ATTACHMENT 4.22-B specifies the following:
42 CFR 433.139(b)(3)(ii)(C)		(1)	The method used in determining a provider's compliance with the third §433.139(b)(3)(ii)(C).
42 CFR 433.139(f)(2)		(2)	The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery or reimbursement would not be cost effective.
42 CFR 433.139(f)(3)		(3)	The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20		(e)	The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: Wyoming

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

___ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

___ Other appropriate State agency(s)--

_____

_____

___ Other appropriate agency(s) of another State--

_____

_____

___ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

___ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

_X_ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

1. Frequency of data exchanges (42 CFR 433.138(f)):

   A. SSA Wage, State Wage Information Collection Agencies (SWICA), and Title IV-A: Not utilizing these data sources currently. The Agency has an alternate source of information that furnishes information as timely, complete and useful as these files in determining the legal liability of third parties pursuant to 42 CFR 433.138(d)(2).
   B. Commercial health insurance carriers: Monthly
   C. Workers compensation: Monthly
   D. Motor Vehicle: Monthly
   E. Diagnosis and Trauma Codes: Monthly

2. Timeliness of follow-up (42 CFR 433.138(g)(1)(i) and (g)(2(i)):

   A. SWICA & SSA Wage – 433.138(g)(1)(ii) and IV-A data exchange – 433.168(g)(1(ii)

      The Agency is not utilizing these data sources currently. The Agency has an alternate source of information that furnishes information as timely, complete and useful as these files in determining the legal liability of third parties pursuant to 42 CFR 433.138(d)(2). However, the Agency will begin to perform data matching with SWICA by July 01, 2023. All new clients over the age of 14 will be sent to the Wyoming Department of Workforce Services (DWS) to verify state wage data. If a change in income is disclosed prior to the annual renewal of eligibility, a record will be sent to DWS to confirm income information. For any new and ongoing clients, eligibility records are sent from the Agency to its claims vendor who creates a commercial insurance lead for verification of health insurance coverage by the TPL vendor.

      During the application for and upon annual renewal of Wyoming Medicaid benefits, applicants and clients are asked to provide third party coverage information. This data is transmitted daily from the eligibility system to the claims processing system creating a “TPL Leads” file (Leads File). The Leads File is included in the eligibility extract from the claims processing vendor and transmitted to the TPL vendor. The TPL vendor conducts data matching for all clients included in the eligibility file with private health insurance companies described below. Any confirmed TPL coverage is transmitted from the TPL vendor to the claims processing vendor on a daily basis and loaded into the client’s TPL File. Since the process is conducted daily, it occurs more frequently than the quarterly SWICA and SSA Wage data match. When new health insurance information is verified, it is transmitted daily from the TPL vendor to the claims processing vendor for cost avoidance of claims. This data matching process is not just targeting individuals with income that may have private health insurance, it is

targeting any applicant or client with disclosed private health insurance and any newly eligible clients.

B. Commercial Health Insurance Carriers – 433.138(g)(2)

Health insurers in Wyoming are required by state statute to disclose private health care eligibility for all individuals eligible for and provided medical assistance by the agency, and for the individuals' spouses or dependents. The TPL vendor receives eligibility data for 96% of the Wyoming lives covered by health insurance carriers.

At the time of application for and renewal of Medicaid benefits, applicants are requested to disclose health insurance coverage information. Eligibility workers have 45 days to incorporate eligibility data into the eligibility database and determine financial eligibility. On a daily basis, an eligibility file is transmitted from the eligibility vendor through SFTP and by the system integrator to the claims processing vendor with suspected health insurance coverage information. The claims vendor uses this information to create a Leads File. This leads data is included in an eligibility extract and transmitted daily to the TPL vendor. Through an algorithm and data matching logic, the TPL vendor matches Medicaid eligibility data to eligibility information from private health insurance companies. Any confirmed health insurance coverage is transmitted daily from the TPL vendor to the claims vendor who updates the TPL eligibility file in the claims processing system. Cost avoidance is immediate through electronic edits in the claims processing system.

On a weekly cadence, a paid claims file is transmitted to the TPL vendor, who screens and determines which claims are the responsibility of another health insurance company. Post payment recovery is initiated within 60 days of receipt of the extract. The TPL vendor maintains the TPL recovery records on its database.

C. Workers Compensation – 433.138(g)(2)

No cost avoidance occurs with workers compensation data. On a monthly basis through the system integrator and by Secure File Transfer Protocol (SFTP), a vendor receives two files from Wyoming's Department of Workforce Services, Workers' Compensation Division. The workers claim record file contains active workers compensation payments issued since the last reporting period. The vendor uses this file to perform data matching against the paid claims file to identify overlapping payments made by the Agency and the Department of Workforce Services. The second file is the workers compensation case file. It contains new workers compensation cases in the state of Wyoming since the last reporting period. The vendor uses demographic data from this file to perform a match against the Agency's

The Agency's TPL program is designed to function primarily as a cost avoidance system. This method was chosen as the most efficient and cost effective option. Claims for medical services, unless excluded by federal law, are cost avoided when a third party liability exists within Agency's claims payment system. In certain circumstances, a vendor pursues post payment recovery of claims when confirmed third party coverage is loaded into the member's TPL file after the claims are paid as described in this attachment.

1. Monitoring provider compliance (42 CFR 433.139(b)(ii)(C):

   The State Plan as referenced herein requires providers to bill third parties. When the probable liability of a third party is established, the Agency notifies the provider that the claim was cost avoided due to the existence of TPL. Cost avoided services/claims are identified with Claim Adjustment Reason and Remark Codes, Remittance Advice Remark Codes, and claim error codes transmitted to the provider with non-payment on the provider's remittance advice. Providers are able to access third party coverage information through an online secure web portal. The Agency further certifies that our claims processing system enforces cost avoidance for prenatal services, including labor, delivery, and postpartum care services. The only exceptions to the cost avoidance requirements are as follows:

   A. Under the exemption authority found in 42 CFR 433.139(b) and 42 CFR 433.147(c), children that have been placed in the Wyoming Department of Family Services' custody (DFS) or related entities are excluded from TPL cooperation.

      (i) The Agency will use standard "pay and chase" when processing claims unless it is confirmed that the child's life will be put in jeopardy (e.g. medical support order).

   B. Under the exemption authority found in 42 CFR 433.139(b)(3)(i), the Agency makes payments without regard to potential third party liability for preventative pediatric services, including early and periodic screening, diagnosis and treatment services (EPSDT), unless the state has made a determination related to cost effectiveness and access to care that warrants cost-avoidance for up to 90 days.

      (i) Wyoming will use standard "pay and chase" when processing claims for preventative pediatric services.

   C. Under the exemption authority found in 42 C.F.R. 433.139(b)(3)(ii), the state has flexibility to make payments without regard to potential TPL for up to 100 days for claims related to child support enforcement beneficiaries, In regard to child support services, the Agency chooses to make payment within 30 days as it is cost-effective and necessary for access to care.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

(i) Wyoming will use standard "pay and chase" when processing claims for child support enforcement beneficiaries.

Providers are monitored for compliance with insurance billing requirements through a post payment recovery process by a vendor. The vendor is responsible for identifying claims with potential third party liability where Medicaid has paid primary. The vendor will either directly bill the primary insurance or will perform disallowance by requesting the provider seek payment from the primary insurance and Wyoming's payment will be recouped.

If a provider has billed a third party and has not received payment, the provider will be required to submit a form as proof that they attempted to bill the third party two times within a 90-day period and have not received payment. The provider must have waited 90 days from the date of service and not received payment from the third party before the Agency will pay.

2. Guidelines Used to Determine When to Seek Reimbursement from a Liable Third Party (42 CFR 433.139(f)(2)):

A. Health Insurance

For medical claims that were paid by Wyoming prior to the TPL policy being entered into the claims system, recovery is pursued by a vendor from the provider for amounts greater than $10.00 within eleven months from the date of service. The timeframe is only one year from the date of the service if the provider would need to bill Medicare.

For medical claims that were paid by Wyoming prior to the TPL policy being entered into the member's eligibility file in the claims processing system, recovery is pursued by a vendor from the liable third party payer for amounts greater than $0.01 within a timeframe of twelve months to three years of the claim from date of service.

B. Casualty Threshold

The Agency does not have a threshold amount for casualty insurance claims; however, priority is given to identifying third party liability for those members who have had at least $250.00 in trauma related claims during the month. Those individuals with less than $250.00 in claims are worked as time permits.

C. Casualty Recovery

For casualty recoveries, the agency complies with 42 U.S.C. Section 1396(a)(25)(B) and uses the following factors and guidelines in determining whether to pursue recovery of benefit, after deduction of the agency's proportionate share of attorney's fees and costs, from a liable party.

(i) Ascertain the amount of the Medicaid reimbursement right and the amount of the gross settlement.

(ii) Determine whether the Medicaid right to reimbursement plus attorney's fees and costs will exhaust or exceed the settlement funds.

(iii) If the answer to 2 (ii) is Yes; and if the agency:

(a) Is informed the client will not pursue the claim; or

(b) Cannot handle the case, once it is tendered to the agency by the client or the client's attorney to pursue on behalf of the client; or

(c) Made reasonable effort to ascertain the client's intention regarding the claim, but could not obtain a response; then the agency shall follow procedures stated in (iv).

(iv) The agency shall consider the cost-effectiveness principle in determining the estimated net recovery amount to be pursued, based on the likelihood of collections. Net recovery amount is defined as that amount of recovered dollars to apply to Medicaid costs. In determining the estimated recovery amount, the following factors will be considered:

(a) Settlement as may be affected by insurance coverage or other factors relating to the liable party;

(b) Factual and legal issues of liability as may exist between the client and liable party;

(c) Problems of proof faced in obtaining the award or settlement; and

(d) The estimated attorney's fees and costs required for the agency to pursue the claim.

After considering the above factors, the agency may pursue a lesser recovery amount to the extent that the agency determines it to be cost-effective to do so.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE WYOMING

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

After screening all Medicaid applicants and recipients at intake and re-application process, the State will pay premium, deductibles and co-insurance charges for a Medicaid recipient who has an active insurance policy and is a high cost utilizer of medical services. These cases include but are not limited to:

1. High cost catastrophic illness cases.
2. Temporary disability cases determined by a medical professional; and
3. Cases requiring continuous care for a period of more than six (6) months.

An individual's enrollment in a group health plan is cost effective when the amount paid for premiums and other cost sharing obligations plus the State's administrative cost are less than third party liability payment for the equivalent set of services and amount paid for the same category of service.

Determination is based on the Medicaid recipient's medical needs. After screening all Medicaid applicants and recipients at intake and re-application process, the State will pay premiums, deductibles and co-insurance for a Medicaid recipient who has an active insurance policy and is a high cost utilizer of medical services. These cases include but are not limited to:

1. High cost catastrophic illness cases.
2. Temporary disability cases determined by a medical professional; and
3. Cases requiring continuous care for a period of more than six (6) months.

1. Annual review of cost effectiveness of eligible cases will be obtained by using the actual annual cost to Medicaid for the recipient from MMIS.

2. Compare costs to Medicaid of purchasing insurance (premiums, co-insurance, deductibles, and other cost sharing) to the actual Medicaid costs (obtain from MMIS) for the same recipient.

3. Subtract from the figure derived in step 2 above, the State's administrative cost for processing the health insurance information. (The Administrative cost is periodically readjusted.)

4. A policy is determined to be cost effective if the costs to the State under the group health plan are lower than the cost to the State for these services under Medicaid.

5. If the plan is determined not to be cost effective due to the lack of explanation of benefit submitted by the insurance company, the recipient may submit all historical medical costs as proof to challenge the above format.

6. The State will pay premiums, deductibles, and coinsurance when it is cost-effective to do so.

Revision: HCFA-AT-84-2 (BERC)
01-84

State WYOMING

Citation
42 CFR Part 434.4
48 FR 54013

4.23 Use of Contracts

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

☐ Not applicable. The State has no such contracts.

TN # 85-8
Supersedes
TN # 80-4

Approval Date _____ Effective Date 10-1-85

☆ U.S. GOVERNMENT PRINTING OFFICE: 1984-421-858:1049

Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: WYOMING

Citation	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826		With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. ___ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation
42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of WYOMING

DRUG UTILIZATION REVIEW

Citation(s)	Provision(s)
1927 (g) 42 CFR 456.700	A.1. The Medicaid agency meets the requirements of Section 1927(g)of the Act for a drug use review (DUR) program for outpatient drug claims.
1927 (g)(1)(A)	2. The DUR Program assures that prescriptions for outpaitent drugs are: • Appropriate • Medically necessary • Are not likely to result in adverse medical results
1927(g)(1)(a) 42 CFR 456.705(b) and 456.709(b)	B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as: • Potential and actual adverse drug reactions • Therapeutic appropriateness • Overutilization and underutilization • Appropriate use of generic products • Therapeutic duplication • Drug-disease contraindications • Drug-drug interactions • Incorrect drug dosage or duration of drug treatment • Drug-allergy interactions • Clinical abuse/misuse
1927(g)(1)(B) 42 CFR 456.703 (d) and (f)	C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia: • American Hospital Formulary Service Drug Information • United States Pharmacopeia-Drug Information • American Medicaid Association Drug Evaluation

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of WYOMING

DRUG UTILIZATION REVIEW

Citation(s)	Provision(s)
1927(g)(1)(D) 42 CFR 456.703(b)	D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has nevertheless chosen to include nursing home drugs in: _X_ Prospective DUR _X_ Retrospective DUR
1927(g)(2)(A) 42 CFR 456.705(b)	E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid client.
1927(g)(2)(A)(i) 42 CFR 456.705(b), (1)-(7)	2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to: • Therapeutic duplication • Drug-disease contraindications • Drug-drug interactions • Drug interactions with non-prescription or over-the-counter drugs • Incorrect drug dosage or duration of drug treatment • Drug allergy interactions • Clinical abuse/misuse
1927(g)(A)(ii) 42 CFR 456.705(c) and (d)	3. Prospective DUR includes counseling for Medicaid clients based on standards established by State law and maintenance of patient profiles.
1927(g)(2)(B) 42 CFR 456.709(a)	F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify: • Patterns of fraud and abuse • Gross overuse • Inappropriate or medically unnecessary care among physicians, pharmacists, or Medicaid clients, or associated with specific drugs or groups of drugs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of WYOMING

DRUG UTILIZATION REVIEW PROGRAM

Citation(s)	Provision(s)
1927(g)(2)(C) 42 CFR 456.709(b)	F.2. The DUR program assesses data on drug use against explicit predetermined standards including but no limited to monitoring for: • Therapeutic appropriateness • Overutilization and underutilization • Appropriate use of generic products • Therapeutic duplication • Drug-disease contraindications • Drug-drug interactions • Incorrect drug dosage/duration of drug treatment • Clinical abuse/misuse
1927(g)(2)(D) 42 CFR 456.711	3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.
1927(g)(3)(A) 42 CFR 456.716(a)	G.1. The DUR program has established a State DUR Board either: ___ Directly, or _X_ Under contract with a private organization
1927(g)(3)(B) 42 CFR 456.716 (A) and (B)	2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following: • Clinically appropriate prescribing of covered outpatient drugs • Clinically appropriate dispensing and monitoring of covered outpatient drugs • Drug use review, evaluation and intervention • Medical quality assurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of WYOMING

DRUG UTILIZATION REVIEW PROGRAM

Citation(s)		Provision(s)
1927(g)(3)(C) 42 CFR 456.716(d)		G.3. The activities of the DUR Board include: • Retrospective DUR • Application of Standards as defined in section 1927(g)(2)(C) • Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR
1927(g)(3)(C) 42 CFR 456.711 (a)-(d)		4. The interventions include, in appropriate instances: • Information dissemination • Written, oral and electronic reminders • Face-to-face discussions • Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D) 42 CFR 456.712 (A) and (B)		H. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures and described in the report.
1927(h)(1) 42 CFR 456.722	X	I.1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line: • Real time eligibility verification • Claims data capture • Adjudication of claims • Assistance to pharmacists, etc. applying for and receiving payment
1927(g)(2)(A)(i) 42 CFR 456.705(b)	X	2. Prospective DUR is performed using an electronic point of sale drug claims processing system.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of WYOMING

DRUG UTILIZATION REVIEW PROGRAM

Citation(s)	Provision(s)
1927(j)(2) 42 CFR 456.703(c)	J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.
1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)	K. Claim Review Limitations • Prospective safety edits are in place on opioid prescriptions to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness. • Prospective safety edits are in place for maximum daily morphine milligram equivalents (MME) on opioid prescriptions to limit the daily morphine milligram equivalent covered by the Medicaid program. • Retrospective reviews are conducted on an ongoing basis on opioid prescriptions exceeding these above limitations. • Retrospective reviews are conducted on an ongoing periodic basis on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics. L. Programs to monitor antipsychotic medications to children • Antipsychotic agents are reviewed for appropriateness for all children, including foster children, based on approved indications and clinical guidelines. M. Fraud and abuse identification • The DUR program has established a process that identifies potiential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State Wyoming

Citation
42 CFR 431.115(c)
AT-78-90
AT-79-74

4.27 Disclosure of Survey Information and Provider or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

Revision: HCFA-PM-93-1993 (BPD)
January 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

Citation	4.28 Appeals Process	
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c))	(a)	The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.
	(b)	The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

Revision: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: WYOMING

Citation

1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29	Conflict of Interest Provisions The Medicaid agency meets the requirements of section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33		The Medicaid agency meets the requirements of section 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Wyoming

Citation
42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

/ / The agency, under the authority of State law, imposes broader sanctions.

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: WYOMING

Citation

(b) The Medicaid agency meets the requirements of--

1902(p) of the Act
P.L. 100-93
(secs. 7)

(1) Section 1902(p) of the Act by excluding from participation--

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

(B) Any HMO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that--

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: Wyoming

Citation

1902(a)(39) of the Act
P.L. 100-93
(sec. 8(5))

(2) Section 1902(a)(39) of the Act by--

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of--

1902(a)(41)
of the Act
P.L. 96-272,
(sec. 308(c))

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act
P.L. 100-93
(sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

State/Territory: WYOMING

Citation	Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 10-508, Section 4755(a)(2))	(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(10(B) of the Act	(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: WYOMING

Citation	
455.103 44 FR 41644 1902(a)(38) of the Act P.L. 100-93 (sec. 8(f))	4.31 Disclosure of Information by Providers and Fiscal Agents The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.
435.940 through 435.960 52 FR 5967	4.32 Income and Eligibility Verification System (a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

Income and Eligibility Verification System

The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960 and Section 1137 of the Act.

This Attachment describes in accordance with 42 CFR 435.948(a)(6) the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Wyoming

Citation
1902(a)(48) of the Act, P.L. 99-570 (Section 11005) P.L 100-93 (sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987— 201-818/60437

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wyoming

METHOD FOR ISSUANCE OF MEDICAL ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

The Office of Medicaid's fiscal agent will issue manual coupons upon any homeless client's request.

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: WYOMING

Citation
1137 of
the Act

P.L. 99-603
(sec. 121)

4.34 Systematic Alien Verification for Entitlements

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

/ / The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

/ / The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

/ / Total waiver

/ / Alternative system

/ / Partial implementation

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: WYOMING

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR §488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR §488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

NA The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: WYOMING

Citation

c) Application of Remedies

42 CFR §488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR §488.417(b) §1919(h)(2)(C) of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR §488.414 §1919(h)(2)(D) of the Act.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR §488.408 1919(h)(2)(A) of the Act.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR §488.406(b) §1919(h)(2)(A) of the Act.

(i) The State has established the remedies defined in 42 CFR 488.406(b).

X	(1)	Termination
X	(2)	Temporary Management
X	(3)	Denial of Payment for New Admissions
NO	(4)	Civil Money Penalties
X	(5)	Transfer of Residents; Transfer of Residents with Closure of Facility
X	(6)	State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

Wyoming will implement remedies pursuant to its Administrative Rule, Chapter 5 - Medicaid Long Term Care Facility Remedies/Terminations.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: WYOMING

Citation

42 CFR §488.406(b) §1919(h)(2)(B)(ii) of the Act.

(ii) X The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

No (1) Temporary Management
No (2) Denial of Payment for New Admissions
X (3) Civil Money Penalties
No (4) Transfer of Residents; Transfer of Residents with Closure of Facility
No (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR §488.303(b) 1910(h)(2)(F) of the Act.

(e) No State Incentive Programs

___ (1) Public Recognition
___ (2) Incentive Payments

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

NA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

___ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

_X_ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

ALTERNATIVE REMEDIES FOR WYOMING MEDICAID
STATE PLAN AMENDMENT - ATTACHMENT 4.35-E, Page 1
Wyoming Alternatives to Civil Monetary Penalties

Alternative 1. Denial of the Federal Share of Medicaid Payment for Affected Residents (Category 2)

Definition:

The State Medicaid Agency may withhold the federal share of a facility's established per diem rate for each resident affected by the deficiency(ies).

When will remedy apply:

This is a Wyoming alternative remedy to Civil Money Penalties and may be imposed when category 2 remedies are either required or are an option.

How will the remedy be effective:

The remedy is effective in that it corresponds to the imposition of CMP at the $50-$3000 level. No money withheld under imposition of this remedy will be payable to the provider for any time periods that the provider is not in substantial compliance. The provider may not bill for and receive these payments at a later date. In recommending this remedy, the survey agency will follow the procedures of the State Operations Manual as applicable.

Authorization:

This remedy is included in Chapter 5, Medicaid Long Term Care Facility Remedies/Terminations, of the Wyoming Medicaid Rules.

Alternative 2. Denial of the Federal Share of Medicaid Payment for all Medicaid Residents (Category 3)

Definition:

The State Medicaid Agency may withhold the federal share of a facility's established per diem rate for all Medicaid residents.

When will remedy apply:

This is a Wyoming alternative remedy to Civil Money Penalties and may be imposed when category 3 remedies are either required or are an option.

How will the remedy be effective:

The remedy is effective in that it corresponds to the imposition of CMP at the $3050-$10,000 level. No money withheld under imposition of this remedy will be payable to the provider for any time periods that the provider is not in substantial compliance. The provider may not bill for and receive these payments at a later date. In recommending this remedy, the survey agency will follow the procedures of the State Operations Manual as applicable.

Authorization:

This remedy is included in Chapter 5, Medicaid Long Term Care Facility Remedies/Terminations, of the Wyoming Medicaid Rules.

TRANSMITTAL NO. 95-012
Date Approved 12/12/95
Effective Date 07/01/95
Supersedes Transmittal NEW

Alternative 3. Denial of Fifty Percent (50%) of the State Share of Medicaid Payment for Affected Residents (Category 2)

Definition:

The State Medicaid Agency may withhold, in addition to the federal share, 50% of the state share of the facility's established per diem rate for each resident affected by the deficiency(ies).

When will remedy apply:

This is a Wyoming alternative remedy to Civil Money Penalties and may be imposed in addition to Alternative 1 when category 2 remedies are either required or are an option.

How will the remedy be effective:

The remedy is effective in that it corresponds to the imposition of CMP at the $50-$3000 level. No money withheld under imposition of this remedy will be payable to the provider for any time periods that the provider is not in substantial compliance. The provider may not bill for and receive these payments at a later date. In recommending this remedy, the survey agency will follow the procedures of the State Operations Manual as applicable.

Authorization:

This remedy is included in Chapter 5, Medicaid Long Term Care Facility Remedies/Terminations, of the Wyoming Medicaid Rules.

Alternative 4. Denial of Fifty Percent (50%) of the State Share of Medicaid Payment for all Medicaid Residents (Category 3)

Definition:

The State Medicaid Agency may withhold, in addition to the federal share, 50% of the state share of the facility's established per diem rate for all Medicaid residents.

When will remedy apply:

This is a Wyoming alternative remedy to Civil Money Penalties and may be imposed in addition to Alternative 2 when category 3 remedies are either required or are an option.

How will the remedy be effective:

The remedy is effective in that it corresponds to the imposition of CMP at the $3050-$10,000 level. No money withheld under imposition of this remedy will be payable to the provider for any time periods that the provider is not in substantial compliance. The provider may not bill for and receive these payments at a later date. In recommending this remedy, the survey agency will follow the procedures of the State Operations Manual as applicable.

Authorization:

This remedy is included in Chapter 5, Medicaid Long Term Care Facility Remedies/Terminations, of the Wyoming Medicaid Rules.

TRANSMITTAL NO. 95-012
Date Approved 12/12/95
Effective Date 07/01/95
Supersedes Transmittal NEW

Alternative 5. Resident Reimbursement

Definition:

The State Medicaid Agency shall require the facility to directly reimburse residents for personal funds or property lost at a facility as a result of actions by the facility or by individuals in the employ of the facility.

When will remedy apply:

This remedy is Wyoming alternative remedy to Civil Money Penalties and may be imposed as a category 2 remedies when one or more deficiencies is cited to demonstrate the loss of resident funds or property.

How will the remedy be effective:

The remedy will affect the provider more directly than assessing civil money penalties and using those monies for reimbursement of resident losses. By making direct out-of-pocket payment for these losses, the provider will experience the direct consequences of its actions by its failure to safeguard the funds and property of its residents.

Authorization:

This remedy is included in Chapter 5, Medicaid Long Term Care Facility Remedies/Terminations, of the Wyoming Medicaid Rules.

Alternative 6. Transfer Cost Assessment

Definition:

The State Medicaid Agency shall require the facility to directly assume the full cost of the transfer of residents if transfer or closure with transfer is imposed as a remedy.

When will remedy apply:

This remedy is a Wyoming alternative remedy to Civil Money Penalties and will be imposed as a category 3 remedy when transfer of residents or closure with transfer of residents is imposed as a remedy.

How will the remedy be effective:

The Medicaid agency will bill the provider directly for all costs incurred by the State for the transfer of residents. The remedy will affect the provider more directly than assessing civil money penalties and using those monies to defray the costs of resident transfer. By making direct out-of-pocket payment for transfer costs, the provider will experience the direct results of its actions by its failure to remain in substantial compliance.

Authorization:

This remedy is included in Chapter 5, Medicaid Long Term Care Facility Remedies/Terminations, of the Wyoming Medicaid Rules.

TRANSMITTAL NO. 95-012
Date Approved 12/12/95
Effective Date 07/01/95
Supersedes Transmittal NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

NOT APPLICABLE

Revision: HCFA-PM-91-1991 (BPD) OMB No.: 0938-

State/Territory: WYOMING

Citation	4.36	Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C) and 1902(a)(53) of the Act		The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

Revision: HCFA-PM-91- 10 (BPD)
DECEMBER 1991

State/Territory: WYOMING

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities

(a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.

___ (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).

X (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.

(d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.

___ (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.

___ (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

State/Territory: WYOMING

Citation	
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.
	(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
	(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
	(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
	(k) For program reviews other than the initial review, the State visits the entity providing the program.
	(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

State/Territory: WYOMING

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
		(n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
		(o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
		(p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
	X	(q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.150 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
		(r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

State/Territory: WYOMING

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.

(t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.

(u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.

(v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.

(w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.

X (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).

(y) The State has a standard for successful completion of competency evaluation programs.

State/Territory: WYOMING

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	X	(aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	X	(cc)	The State includes home health aides on the registry.
	___	(dd)	The State contracts the operation of the registry to a non State entity.
	___	(ee)	ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	___	(ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

Revision: HCFA-PM-93-1993 (BPD)
January 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

Citation

Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)); P.L. 101-508 (Sec.4801(b)).

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State Plan" the cost of NF services to individuals who are found not to require NF services.

(e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

Revision: HCFA-PM-93-1993
January 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

4.39 (Continued)

___ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

DEFINITION OF SPECIALIZED SERVICES

Specialized Services: The continuous and aggressive implementation of an individualized Plan of Care that is developed under and supervised by a physician in conjunction with an interdisciplinary team of qualified mental health professionals; prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of severe mental illness, which necessitates supervision by trained mental health personnel; and is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the Specialized Services level of service at the earliest possible time. Specialized Services do not include intermittent or periodic psychiatric services for residents who do not require 24-hour supervision by qualified mental health personnel.

For mental retardation, specialized services means the services specified by the state which, combined with services provided by the nursing facility or other service providers, results in treatment which meets the requirements of 42 CFR 483.440(a)(1).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

CATEGORICAL DETERMINATIONS

Any person with a mental illness or mental retardation who is comatose, ventilator dependent, functions at the brain stem level, or has a diagnosis of Chronic Obstructive Pulmonary Disease, severe Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis, Congestive Heart Failure, primary diagnosis of dementia including Alzheimer's Disease or a related disorder based on DSM Ill-R criteria, or any other diagnosis so determined by HCFA, may be considered appropriate for placement or continued residence in a Medicaid-certified nursing facility without being subject to the Level II process and/or specialized services.

Revision: HCFA-PM-92-3 (HSQB) OMB No.:
April 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

Citation		
Sections 1919(g)(1) thru (2) and 1919 (g)(4) thru (5) of the Act P.L. 100-203 (sec. 4212(a))	4.40	Survey & Certification Process
	(a)	The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-state owned facilities based on the requirements of the section 1919(b), (c) and (d) of the Act, are met.
1919(g)(1) (B) of the Act	(b)	The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.
1919(g)(1) (C) of the Act	(c)	The State provides for a process for the (C) of the receipt and timely review and investigation Act of allegations of neglect and abuse and misappropriation of a resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State's process.
1919(g)(1) (C) of the Act	(d)	The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? Department of Commerce/Board of Nursing
1919(g)(1) (C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility,is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1) (C) of the Act	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

Revision: HCFA-PM-92-3 (HSQB) OMB No.:
April 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

1919(g)(2) (A)(i) of of the Act	(g)	The State has procedures, as provided for at(A)(i) of section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. **Attachment 4.40-C** describes the State's procedures.
1919(g)(2) (A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the qualify of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2) A(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 month.
1919(g)(2) (A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2) (B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later than 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2) (C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol,i.e., survey Act forms,methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

1919(g)(2)(D) of Act	(m)	The State provides for programs to measure and reduce inconsistency in the application survey results among surveyors. **Attachment 4.40-D** describes the State's programs.
1919(g)(2)(E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2)(E)(ii) of the Act	(o)	The State assures that members of a survey do not serve (or have not served within previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2)(E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. **Attachment 4.40-E** describes the State's complaint procedures.
1919(g)(5)(A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies,plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5)(B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or any adverse actions taken against a nursing facility.
1919(g)(5)(C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5)(D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: WYOMING

ELIGIBILITY CONDITIONS AND REQUIREMENTS

SURVEY AND CERTIFICATION EDUCATION PROGRAM

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

- Presentations at Hospital Association Meetings.
- Health Education Development Services continues to perform training and education and needs identification.
- On site technical assistance.
- Survey team recommendations.
- Collaborative training with staff and Title XIX personnel.
- Informational resident council meetings.
- Group residents interviews.
- Individual interviews.
- Exit conferences.
- Telecommunication consultations and referrals.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: WYOMING

ELIGIBILITY CONDITIONS AND REQUIREMENTS

SURVEY AND CERTIFICATION EDUCATION PROGRAM

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

The Administrative Rules and Regulation of the Wyoming State Board of Nursing, pages 43 through 47, inclusive:

Any complaint made against a licensee shall be made in writing and should provide at least the following information: name, address, place of employment and position of the individual believed to have violated the Nursing Practice Act or board rules and regulations;

- A committee of two board members shall review each complaint and, where necessary, direct further investigation.
- Following review and investigation the committee may take any appropriate action, including but not necessarily limited to the following: forward complaint to the board for formal disciplinary proceedings; file a complaint with the board on its own behalf; send a written letter of warning to the individual listed in the complaint; deny issuance or renewal of license; accept the voluntary surrender of a license; recommend terms for a conditional license; close the investigation of any complaint.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: WYOMING

ELIGIBILITY CONDITIONS AND REQUIREMENTS

SURVEY AND CERTIFICATION EDUCATION PROGRAM

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

No notice of any survey is given. Reservations are made at motels under individuals names - no titles given.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: WYOMING

ELIGIBILITY CONDITIONS AND REQUIREMENTS

SURVEY AND CERTIFICATION EDUCATION PROGRAM

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

- All Statements of Deficiencies are reviewed by the same surveyor.
- All training of staff is done by the same individual.
- All staff spend one week in inservice training once per quarter to insure rules and regulation application consistency.
- Review OSCAR data to insure consistency with regulations.
- Provider followup training on deviations noted by survey staff.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: WYOMING

ELIGIBILITY CONDITIONS AND REQUIREMENTS

SURVEY AND CERTIFICATION EDUCATION PROGRAM

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) The facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

The State of Wyoming Medicaid program follows procedures as outlined in "Policy Regarding Complaint Investigation", State of Wyoming, Health Facilities Internal Policy Manual as required by The State of Wyoming Operations Manual.

When a complaint, in writing, is received:

- Assign number and establish complaint file log.
- If complaint involves an accredited hospital - forward the complaint to the regional office for approval to investigate.
- Interview complainant before entering the facility.
- Visit facility to investigate complaint. All complaints surveys are unannounced.

- Write a complete narrative summary on findings.
- Write a letter to the complainant regarding the survey results.

When a complaint, by telephone, is received:
- Interview complainant, ask them to submit the complaint in writing.
- Document fm the phone complaint form.
- Program Manager or Quality Assurance Manager will review Complaint Form to make a decision as what to do concerning the complaint. If phone complaint is not followed up in writing, a phone call will be made to the administrator of the facility asking for information to be submitted.
- Review of the situation will be done at the next onsite investigation
- Acknowledge the complaint in a brief narrative for inclusion in the complaint file

Protect complainants, do not volunteer who they are

Revision: HCFA-PM-92- 2 (HSQB)
MARCH 1992

State/Territory: WYOMING

Citation	4.41 Resident Assessment for Nursing Facilities	
Sections 1919(b)(3) and 1919 (e)(5) of the Act	(a)	The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.
1919(e)(5) (A) of the Act	(b)	The State is using:
	X	the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or
1919(e)(5) (B) of the Act	____	a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

Citation 1902(a)(68) of the Act, P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries.

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining

beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be

protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902 (a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

1902(a)(68) of the Act, P.L. 109-171 (section 6032)

Methodology of Compliance Oversight of the False Claims Act

(1) All entities meeting Section 4.42(a)(1)(A) must be in compliance with section 6032 of the DRA.

(2) INITIAL COMPLAINCE: Within one month of the approval of this State Plan Amendment, an explanation letter and attestation of compliance form will be sent to each entity, as described in Section 4.42(a)(1)(A), requiring attestation of compliance with section 6032 of the DRA. The attestation of compliance will be required from each entity within thirty (30) days of the date of that letter.

(3) ONGOING COMPLIANCE: In the first calendar quarter of every third year after 2007, an explanation letter and attestation of compliance form will be sent to each entity, as described in Section 4.42(a)(1)(A), requiring attestations of compliance with section 6032 of the DRA. The attestation of compliance will be required from each entity by June 30 of that year.

(4) In the first calendar quarter of the two years between every third year, a list of entities will be reviewed to check for any new entities needing attestation of compliance. If there are any new entities, the explanation letter and attestation of compliance will be sent in the year requiring attestation following the deadlines in #3 above.

(5) Actual visual verification of compliance will be performed yearly for these entities that are visited by program integrity personnel and/or provider field representatives of the fiscal agent. At least fifty (50) percent of the entities required to send attestation of compliance will have a visit every year.

(6) If the attestation is not received within the required timeframes or if visual verification can not be obtained then appropriate remedies and sanctions will be imposed according to Chapter 16 of the Wyoming Medicaid Rules, Medicaid Program Integrity, to ensure that the entity is in compliance with section 6032 of the DRA.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

Citation	4.43 Cooperation with Medicaid Integrity Program Efforts.
1902(a)(69) of the Act, P.L. 109-171 (section 6034)	The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WYOMING

Citation	4.44	Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States
1902 (a)(80) of the Act, P.L 111-148 (Section 6505)	X	The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States

TN No. 11-001
Supersedes
TN No. New

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
State: Wyoming

SECTION 4 - GENERAL PROGRAM ADMINISTRATION (Continued)

4.46 Provider Screening and Enrollment

Citation	The State Medicaid Agency gives the following assurances:
1902(a)(77) 1902(a)(39) 1902(kk) P.L. 111-148 and P.L. 111-152	
42 CFR 455 Subpart E	PROVIDER SCREENING __X____Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS __X____Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. __X____Assures that the State Medicaid Agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES ___X___Assures that the State Medicaid Agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT __X_____Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT __X____Assures that the State Medicaid Agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

4.46 Provider Screening and Enrollment

42 CFR 455.420 REACTIVATION OF PROVIDER ENROLLMENT

___X___Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422 APPEAL RIGHTS

___X___Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432 SITE VISITS

__X____Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

42 CFR 455.434 CRIMINAL BACKGROUND CHECKS

__X____Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436 FEDERAL DATABASE CHECKS

__X____Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

4.46 Provider Screening and Enrollment

42 CFR 455.440

NATIONAL PROVIDER IDENTIFIER

___X___Assures that the State Medicaid Agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450

SCREENING LEVELS FOR MEDICAID PROVIDERS

__X____Assures that the State Medicaid Agency complies 1902(a)(77) and 1902(kk) of the Act and with the requirement outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

42 CFR 455.460

APPLICATION FEE

__X____Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(c) of the Act and 42 CFR

42 CFR 455.470

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

___X___Assures that the State Medicaid Agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section (1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries access to medical assistance.

State: WYOMING

4.47 21st Century Cures Act

Requiring Publication of Fee-for-Service Provider Directory

Citation:

Section 5006 of P-L 114-255

X State is in compliance with the requirements of Section 5006 of the 21st Century Cures Act.

☐ State will be in compliance with Section 5006 of the 21st Century Cures Act by_____.

☐ State Plan's managed care coverage exempts this state from the requirements of Section 5006 of the 21st Century Cures Act.

☐ State would potentially need to enact legislation to comply with Section 5006 of the 21st Century Cures Act and will discuss compliance with CMS.