(a) 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 25. 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 28 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 29. 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 28.

(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 26. Rebasing.

(a) The Department shall rebase operating costs when the rates determined pursuant to this Attachment no longer meet the requirements of the Social Security Act.

(b) The Department shall annually update the cost-to-charge ratios for each level of care for purposes of calculating allowable costs per Section 17(c). Rebased cost-to-charge ratios will be calculated using the most recent cost report which occurs after the base period currently in use as defined within this Chapter.

(c) The Department has the discretion to update level of care rates based on changes to hospital peer groups, hospital billing practices or changes in hospital operations.

Section 27. Payment of Claims.

(a) Payment of claims shall be pursuant to Chapter 4, 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 28. Recovery of Overpayments. The Department shall recover overpayments pursuant to Chapter 16, which is incorporated by this reference.

Section 29. Reconsideration. A provider may request reconsideration of the decision to recover overpayments pursuant to the provisions of Chapter 16.

Section 30. 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 31. 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 32. **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 33. **Severability**. If any portion of this Attachment is found to be invalid or unenforceable, the remainder shall continue in effect.

OS Notification

State/Title/Plan Number: **Wyoming 11-006**

Type of Action: **SPA Approval**

Required Date for State Notification: **November 9, 2011**

Fiscal Impact: **FFY 2012 ($3,351,473)**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: Effective October 1, 2011, this inpatient hospital amendment proposes to update the period used in calculating cost-to-charge ratios (CCR) for each level of care for purposes of determining the outlier payment amount. Rebased CCR ratios will be calculated using the most recent cost report and will be updated on an annual basis. This revision is consistent with recommendations made by the OIG in its report titled, "Medicaid Hospital Outlier Follow-Up for Fiscal Years 2004 through 2006."

In April of 2011, the OIG issued a report to CMS after reviewing State practices for capturing and reimbursing outlier payments. In the report, the OIG recommends, and CMS concurs, that CMS should encourage all State agencies that make Medicaid outlier payments to amend their State plans to use the most recent cost-to-charge ratios to calculate Medicaid outlier payments. This amendment complies with the OIG's recommendation.

Wyoming submitted an amendment last year which froze rates across all providers and that freeze remains in effect. Wyoming does not intend to reduce rates at this point. Their intent with this amendment is to allow Wyoming Medicaid to update cost-to-charge ratios for purposes of aligning payments with current provider costs.

The State adequately addressed CMS standard access to care questions. Cost containment

conversations have been held with providers including the discussion of outliers and how to keep them to a standard percentage of total payments. WY has used their research, in part, to determine that updating CCR for purposes of the outlier payment calculation, keeps payment consistent with current costs and is appropriate. WY's reimbursement report estimates Medicaid cost coverage at 89% for participating providers. Discussions were part of each of their hospital quarterly advisory group meetings. The healthcare association was also consulted. Subsequent meetings were held with individual providers groups. As a result, Wyoming has not received any indication of access issues from either providers or eligible individuals.

The State will monitor provider agreement renewals and cancellations, recipient complaints and other qualitative information such as feedback from stakeholders groups. They will continue to consult with their Hospital Advisory Group to assess access to services. If the group advises that there are problems, the State will reassess this policy.

Non-Federal share is derived from General Funds appropriated through the legislature. Public notice/public requirements were met. Tribal consultation requirements were met. The State did not receive any adverse feedback or comments as a result of tribal consult or through public process communication. The responses to the funding questions were deemed appropriate.

Other Considerations: This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

CMS Contact: Christine Storey, (303) 844-7044
National Institutional Reimbursement Team