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State/Territory Name: Wyoming

State Plan Amendment (SPA) #: 19-0014

This file contains the following documents in the order listed:

1) Approval Letter
2) 179
3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

May 20, 2019

Teri Green
State Medicaid Agent
Office of Health Care Financing
6101 Yellowstone Road, Suite 210
Cheyenne, WY 82002

Re: Wyoming 19-0014

Dear Ms. Green:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 19-0014. Effective for services on or after February 1, 2019, this amendment updates the inpatient hospital payment methodology from level of care (LOC) to an All Patient Refined Diagnosis Related Grouping (APR-DRG) methodology.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) ,1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 19-0014 is approved effective February 1, 2019. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at (303) 844-7044.

Sincerely,

[redacted]

Kristin Fan
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: WY19-0014

2. STATE: WYOMING

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
45 CFR Part 201, Subpart A
42 CFR 447.272

7. FEDERAL BUDGET IMPACT:
FFY2019 – $300,000
FFY2020 – $300,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Part I, Pages 1 - 15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Part I, Pages 1-21

10. SUBJECT OF AMENDMENT:
Wyoming is seeking to implement a new reimbursement methodology for inpatient hospital services. Wyoming will be adopting and implementing an APR-DRG methodology, carving out transplant and rehabilitation services.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Delegated to Teri Green, State Medicaid Agent, Division of Healthcare Financing

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: TERI GREEN

14. TITLE: STATE MEDICAID AGENT

15. DATE SUBMITTED: February 21, 2019, Revised 5/17/2019

16. RETURN TO:
TERI GREEN
STATE MEDICAID AGENT
DIVISION OF HEALTHCARE FINANCING
6101 YELLOWSTONE ROAD, SUITE 210
CHEYENNE, WY 82002

CC: CHRIS BASS, MANAGEMENT ASSISTANT
(SAME ADDRESS)

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
MAY 20 2019

19. EFFECTIVE DATE OF APPROVED MATERIAL:
FEB 01 2019

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

REMARKS:

FORM HCFA-179 (07-92)

State: WYOMING

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 4.19A, Part 2, except as otherwise specified in this Attachment.

(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 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 4.19A.

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

(v) Private Hospital Supplemental (PHS) payments. The Department reimburses hospitals that qualify for PHS payments pursuant to 4.19A, 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 State Fiscal Years 2015 – 2017.

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 APR DRG system will use APR DRG version 33 DRGs and relative weights developed by 3M Health Information Systems (3M). 3M updates the APR DRG grouper annually and the Department shall periodically update the version of the APR DRG software that it uses.

(d) The APR DRG payment rate will be calculated as the base rate, multiplied by the APR DRG assigned relative weight and policy adjustor, plus an outlier payment as applicable, plus the prospective flat capital payment rate. Adjustments for patient transfers and one day stays are also made. Components of the APR DRG payment are described in the following sections:

(i) Section 8(e) describes base rate determination

(ii) Section 8(f) describes APR DRG relative weights

(iii) Section 8(g) describes APR DRG policy adjusters

(iv) Section 8(h) describes outlier payments

(v) Section 8(li) describes capital payments

(vi) Section 8(j) describes payments for patient transfers

(vii) Section 8(k) describes payments for one-day stays

(e) Calculation of APR DRG base rate

(i) The base period for development of the Wyoming APR DRG rates is State Fiscal Years 2016 and 2017.

(ii) 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) Hospital-specific base rates for in-state Level II Trauma providers (applies to two facilities)

(B) In-state free-standing psychiatric providers

(C) All other providers

(iii) The Department established base rates so that projected APR DRG payments maintain budget neutrality for claim payments in the base period for participating providers with the exception of in-state free standing psychiatric providers for which the Wyoming legislature has allocated $600,000, on an annual basis, to the base rate to maintain funding at levels prior to APR DRG implementation.

(iv) Only one base rate is available to each provider.

(v) A base rate represents a dollar amount used in the APR DRG calculation and is adjusted by a claim's APR DRG relative weight and relevant policy adjustor.

(vi) The Department will use transitional base rates for the first 12 months after the APR DRG implementation. 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(e)(ii)(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://wymedicaid.portal.conduent.com/fee_schedule.html.

(f) APR DRG relative weights

(i) The Department assigns each claim a relative weight using APR DRG version 33 DRGs and relative weights calculated by 3M. Wyoming will update the APR DRG version and corresponding relative weights on an as-needed basis. The version 33 APR DRG is effective February 1, 2019.

(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) 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.

(g) 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 to the APR DRG relative weight on the claim.

(A) A pediatric policy adjustor of 1.3 will be applied to pediatric claims where a recipient is younger than 19.

(B) A policy adjustor of 1.2 will be applied to Mental Health DRGs (as defined by the 3M APR DRG software).

(C) A policy adjustor of 1.2 will be applied to Substance Abuse DRGs (as defined by the 3M APR DRG software).

(D) A policy adjustor of 1.5 will be applied to Obstetrics DRGs (as defined by the 3M APR DRG software).

(E) A policy adjustor of 1.9 will be applied to Normal Newborn DRGs (as defined by the 3M APR DRG software).

(h) Outlier Payments

(i) The Department will make outlier payments for high cost claims that exceed 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 costs for a claim exceed their 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) Non-participating hospitals are assigned the statewide average cost-to-charge ratio for the outlier calculation.

(D) If the calculated allowable costs less the DRG base payment exceed the provider's cost outlier threshold, an outlier payment will be added to the DRG base payment.

(E) The outlier payment shall be 75 percent of the calculated allowable costs that exceed the provider's cost outlier threshold.

(i) Capital Payments

(i) Wyoming will provide a per discharge capital payment to participating providers.

(ii) Capital payments are set at $277.87 per discharge, as determined during the 2010 level of care rebasing, and will not be inflated.

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

(j) Transfer Payment Adjustments

(i) Transfer payment adjustments are applied to claims for services provided to a patient who is transferred after admission from one acute care hospital to another hospital. 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

(ii) Transfer claims are identified using a distinct list of patient discharge status codes as billed on the UB-04 claim form. The Department lists these codes in related provider policy manuals.

(A) For a provider transferring a Medicaid recipient, the claim payment is calculated as the lesser of the calculated final APR DRG payment or the calculated APR DRG per diem.

(B) Claims from providers transferring and from providers receiving transfers can receive outlier payments

(C) The APR DRG per diem is calculated as follows: *APR DRG Per diem = APR DRG Base Payment /3M national APR DRG Average Length of Stay*

(D) 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.

(E) Transfer status is not considered for certain neonate transfer DRGs. In these cases, the transferring provider will receive the full APR DRG payment instead of a transfer adjusted payment.

(k) Reimbursement of Less Than One-day Stays

(i) The Department will review all inpatient stays lasting less than one day.

(ii) Reimbursement for less than one-day stays will be based on an APR DRG per-diem and does not include outlier reimbursement or capital payments.

(l) Final APR DRG Payment Calculation

(i) The final APR DRG claim payment is as follows:

(ii) Claim Payment = APR DRG Base Payment or (APR DRG Per Diem X actual length of stay) + Outlier Payment (if applicable) + Capital Payment (if applicable)

(iii) 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).

(iv) The Department will use the 3M APR DRG grouper to review for hospital acquired conditions based on present on admission (POA) indicators required for hospitals' submission on all APR DRG claims. 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 will not be allowed to submit interim claims for APR DRG services.

(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 payment rate for new hospitals shall be the APR DRG base payment rate for "other providers" as described in Section 8(e)(ii)(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.

(d) The Medicaid payment rate for new in-state hospitals shall include reimbursement for capital costs.

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. The capital payment shall be the statewide capital payment per diem 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

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.

(b) 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),

(c) 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.

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

(e) 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.

(f) 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.

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.