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State/Territory Name: Wyoming

State Plan Amendment (SPA) #: 23-0014

This file contains the following documents in the order listed:

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

Financial Management Group

December 19, 2023

Lee Grossman
State Medicaid Agent
Division of Healthcare Financing
Wyoming Department of Health
122 W. 25th Street, 4 West
Cheyenne, WY 82002

Re: Wyoming 23-0014

Dear Lee Grossman:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 23-0014. Effective for dates of services on or after July 1, 2023, this amendment updates the Diagnostic Related Group (DRG) payment methodology, calculation description for Qualified Rate Adjustment (QRA) and private hospital supplemental payment provides, documents the calculation methodology for the upper payment limit (UPL), and provides for supplemental payments for in-state, private Psychiatric Residential Treatment Providers.

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 23-0014 is approved effective July 1, 2023. The CMS-179 and the amended plan pages are attached.

If you have any questions, please contact Christine Storey at Christine.storey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: WY 23—0014

2. STATE: Wyoming

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 07/01/2023

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

42 CFR, Section 447.272

7. FEDERAL BUDGET IMPACT

a. FFY 2024 $ 10,850,000
b. FFY 2025 $ 10,850,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Amendment 4.19.A:
1. 4.19-A, Part 1, Pages 1-15 (IP Hosp Reimb)
2. 4.19-A, Part 1, Pages 16-17 (NEW – IP Hosp Medicare Part A Cross Over)
3. 4.19-A, Part 1, Page 26 (IP QRA)
4. 4.19-A, Part 1, Page 27-28 (PHS IP)
5. 4.19-A, Part 1, Page 29-33 (NEW - IP UPL Calc)
6. 4.19-A, Part 2, Page 2 (DSH)
7. 4.19-A, Part 4, Page 8-9 (PRTF Supp)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Amendment 4.19-A:
1. 4.19-A, Part 1, Pages 1-15, Supersedes WY19-0014 (IP Hosp Reimb)
2. 4.19-A, Part 1 – NEW pages (IP Hosp Medicare Part A Cross Over)
3. 4.19-A, Part 1, Addendum 1, Supersedes WY09-002 (IP QRA)
4. 4.19-A, Part 1, Addendum 3, Supersedes WY16-008 (PHS IP)
5. 4.19-A, Part 1 - NEW pages (IP UPL Calc))
6. 4.19-A, Part 2, Page 2, Supersedes WY08-006 (DSH)
7. 4.19-A, Part 4, NEW pages (PRTF Supp)

10. SUBJECT OF AMENDMENT

Updates to the Diagnosis Related Group (DRG) payment methodology for hospital inpatient services.
Documentation of the calculation methodology for calculating Medicaid reimbursement on hospital inpatient Medicare Crossover claims.
Updates to the calculation description for the hospital inpatient Qualified Rate Adjustment (QRA) and Private Hospital Supplemental (PHS) Payment Programs.
Documentation of the current calculation methodology for the hospital inpatient Upper Payment Limit.
Small wording change for Disproportionate Share Hospitals (DSH) section.
Add supplemental payments for in state Psychiatric Residential Treatment Facility providers that are privately owned.

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 Lee Grossman, State Medicaid Agent, Division of Healthcare Financing

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME: Lee Grossman

14. TITLE: State Medicaid Agent

15. DATE SUBMITTED: 09/29/2023

16. RETURN TO

Lee Grossman, MPA
State Medicaid Agent
Division of Healthcare Financing
Wyoming Department of Health
122 W 25th St, 4 West
Cheyenne, WY 82002

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2023

18. DATE APPROVED: December 19, 2023

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2023

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME: Rory Howe

22. TITLE: Director, Financial Management Group

23. REMARKS: State authorized pen and ink revision to block 10.

Instructions on Back

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.

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.

(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;

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.