Table of Contents

State/Territory Name: Wyoming

State Plan Amendment (SPA) #: WY-09-002

This file contains the following documents in the order listed:

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

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

Center for Medicaid and State Operations, CMSO

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

DEC 22 2009

Re: Wyoming 09-002

Dear Ms. Green:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-002. Effective for services on or after September 1, 2009, this amendment modifies the methodology to Wyoming's inpatient hospital level of care payment 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 (the Act) and the regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment TN 09-002 is approved effective September 1, 2009. The HCFA-179 and the amended plan pages are attached.

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

Sincerely,

Cindy Mann
Director
Center for Medicaid and State Operations

cc: Renee Propps, WY State Medicaid Agency

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: 09-002

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
September 1, 2009

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 U.S.C. §1396a (b) and 45 C.F.R. Part 201, Part 201, Subpart A.

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 -$120,600
b. FFY 2010 -$1,326,347

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A, Part 1, Pages 1-21
Attachment 4.19A, Part1, Addendum 2
Attachment 4.19A, Part 1, Addendum 1
Attachment 4.19A, Part 3, Pages 1-8

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A, Part 1, Pages 1-23A; Attachment 4.19A, Part 1, Pages 24-54; and Attachment 4.19A, Part 1, Addendum 1, Page 12-12A
Attachment 4.19A, Part 1, Addendum 2 (changed page 23 and 23A to Addendum 2 pages 1-2) only Addendum 2 page 1
Attachment 4.19A, Part 1, Addendum 1, Page 54A
Attachment 4.19A, Part 3, Pages 65 -73

10. SUBJECT OF AMENDMENT:
Inpatient Level of Care and general clean up of Attachment 4.19A. There are no changes in the text of Attachment 4.19A, Part 1, Addendum 1 and Attachment 4.19A, Part 3, we are only changing the page numbering in order to make this whole section flow more smoothly. *** Please note that Attachment 4.19A, Part 1, Addendum 2 (previously page 23) has been removed and the content has been moved into 4.19A Part 1.

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: TERI GREEN

14. TITLE: STATE MEDICAID AGENT

15. DATE SUBMITTED: 6/8/2009

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

CC: YVONNE STAYER, MANAGEMENT ASSISTANT
(SAME ADDRESS)

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 12-22-09

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP 1 - 2009

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMSO

23. REMARKS:

LEVEL OF CARE 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, other than specialty services, for individuals admitted on or after its effective date. Inpatient hospital services are also subject to the provisions of Chapters 4, 8, 16, and 26 of the Department's Medicaid Rules, and Attachment 4.19A, Part2, except as otherwise specified in this Attachment.

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

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

Section 3. General Provisions.

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

(b) General methodology.

(i) Level of care. Except as otherwise specified in this Attachment, the Department pays for inpatient hospital services using a prospective per discharge or per diem payment system based on the level of care provided.

(ii) Specialty services. The Department may, from time to time, designate certain services, such as transplant 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 payments. The Department reimburses hospitals that qualify for Qualified Rate Adjustment payments pursuant to 4.19A, Part 1, Addendum 1.

Section 4. Provider Participation.

(a) Payments only to providers. 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 Chapter 4. A provider that wishes to receive Medicaid reimbursement for inpatient hospital services furnished to a recipient must meet the requirements of Chapter 4, Sections 4 through 6, which are incorporated by this reference.

Section 5. Provider Records.

(a) A provider must comply with Chapter 4, 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 of the requirements of this Section shall be given a written notice of deficiency and shall have sixty (60) days after the date of the written notice to correct such deficiency. If, at the end of the sixty (60) days, the Department determines that the deficiency has not been corrected, the Department shall 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 Chapter 4, Section 8, which is incorporated by this reference.

Section 7. **Medicaid Allowable Payment for Inpatient Hospital Services.**

(a) In General. Medicaid reimbursement for inpatient hospital services is based on the level of care provided to each recipient. The payment rate is based on a level of care payment rate as set forth in this Attachment, and payments shall not be cost-settled based on actual costs.

(b) Levels of care. Inpatient hospital services are reimbursed according to the following hierarchy of levels of care:

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

(ii) Maternity - Surgical. Maternity services accompanied by a surgical procedure as designated by the Department.

(iii) Maternity - Medical. Maternity services that do not have surgical procedure codes as designated in paragraph (b) subparagraph (ii).

(iv) Neonatal Intensive Care Unit (NICU). Services provided in two settings: a Level I or II hospital, or a Level III hospital as of the effective date of this Attachment, as confirmed by hospital sources and the American Hospital Association (AHA) Guide, 2009 Edition.

(v) Intensive care unit (ICU)/Coronary care unit (CCU) /Burn services. Inpatient hospital services which are provided to a patient who requires more intensive services than are furnished in a hospital's general medical or surgical unit; expected to require significant time to complete; and accompanied by a high risk of complications.

(vi) Major surgery. Surgical procedures that are mainly performed in a hospital operating room, are expected to require significant time to complete, and which carry an increased risk of complications.

(vii) Psychiatric services. Services furnished to an individual with a psychiatric diagnosis. All psychiatric services must be prior authorized by the Department.

(viii) Newborn nursery. Services provided to newborns who are younger than twenty-nine (29) days old.

(ix) Routine. Covered services other than ancillary care and those services included within any other level of care.

(c) Payment rates for each level of care are determined pursuant to Sections 8 through 11.

(d) The Department shall, from time to time, designate covered services that require prior authorization or admission certification. In designating such services, the Department shall consider the cost of the service, and the availability of lower cost alternatives. The Department shall disseminate a current list of services that require prior authorization or admission certification to providers through Provider Manuals or Provider Bulletins.

(e) The Department shall, from time to time, designate level of care services based on diagnosis or procedure codes, revenue codes, clinical consultation with health care professionals and CMS guidelines. The Department shall disseminate information about level of care assignments to providers through Provider Manuals or Provider Bulletins.

Section 8. Participating Providers.

(a) The base period for the level of care rates is State Fiscal Years 2006 and 2007.

(b) Participating hospitals are all hospitals within Wyoming that are providers, and all out-of-state hospitals that were paid at least four-hundred thousand dollars ($400,000) in the base period. Participating hospitals also include all rehabilitation and psychiatric hospitals that were enrolled in Wyoming Medicaid and received Medicaid funds during the base period.

Section 9. Base Period Allowable Costs.

(a) Base period allowable costs shall be determined from hospitals' as-filed Medicare cost reports for hospital fiscal years ending in state fiscal years 2005 and 2006 and hospitals' Medicaid inpatient claims paid in state fiscal years 2006 and 2007. Medical education costs shall not be allowable.

(b) The Department shall determine base period Medicaid allowable costs for each participating provider as specified in this Section. Base period allowable costs are the sum of routine per diem costs and ancillary services costs.

(c) Base period routine service costs.

(i) Allowable costs for inpatient routine departments shall be extracted from the hospitals' as- filed Medicare base period cost reports.

(ii) Per diem costs derived from (c)(i) shall be applied to Medicaid patient days on each base period claim to determine Medicaid routine base period costs for each claim.

(iii) Medical education costs shall be identified and excluded from routine per diem costs.

(A) Routine medical education costs shall be identified from hospital Medicare cost reports Worksheet B-Part I, Columns 22 and 23 for Medicaid-covered hospital services in cost centers 25 through 36.

(B) Routine patient days shall be identified from Medicare cost reports Worksheet S-3 Part I, Column 6 for Medicaid-covered hospital services in cost centers 1through18 and 26.

(C) Routine medical education costs per day shall be calculated by multiplying the number of patient days associated with each routine revenue code in the base period claims by the associated routine medical education cost per diem.

(D) Base period routine services costs shall be the per diem costs calculated in subparagraph (ii) less the routine medical education costs per day calculated in subparagraph (iii).

(iv) The Medicaid per diem costs determined in subparagraph (iii)(D) shall be inflated forward from the midpoint of the hospital cost reporting period to December 31, 2008 (midpoint of the SFY 2009 rate year) using the CMS-PPS Hospital Market Basket index available as distributed at the Research, Statistics, Data and Systems, Medicare Program Rates and Statistics, Market Basket Data webpage.

(d) Base period ancillary service costs.

(i) Costs and charges for ancillary services shall be extracted from the base period Medicare cost reports, grouped according to the type of service, and the ratio of costs to charges shall be calculated to establish cost-to-charge ratios for each group of services for each provider.

(ii) The cost-to-charge ratios for each group of ancillary services for all providers shall be arrayed, from low to high, and the mean for each group shall be determined.

(iii) The Medicaid allowable base period cost for ancillary services shall be determined as:

(A) The provider's cost-to-charge ratio (CCR) for ancillary services as determined pursuant to paragraph (i); or

(B) If the provider does not have a CCR for a service, base period costs shall be the mean CCR established pursuant to paragraph (ii).

(C) Ancillary costs for each inpatient claim shall be calculated by multiplying the charges associated with each ancillary revenue code in the base period claims data by the associated ancillary CCR.

(iv) Medical education costs shall be identified and excluded from ancillary services costs.

(A) Ancillary medical education costs shall be extracted from hospital base period Medicare cost reports, Worksheet B-Part I, Columns 22 and 23 for Medicaid-covered hospital services in cost centers 37 through 67.

(B) Ancillary charges shall be extracted from Worksheet C-Part I, Column 8 for Medicaid-covered hospital services in cost centers 37 through 67 by ancillary cost center.

(C) Ancillary services CCRs shall be calculated by dividing costs in subparagraph (A) by charges in subparagraph (B) to calculate ancillary CCRs.

(D) Ancillary medical education costs for each inpatient claim shall be calculated by multiplying the charges associated with each ancillary revenue code in the base period claims data by the associated ancillary medical education CCR.

(v) Base period ancillary services costs shall be the base period ancillary services costs determined in paragraph (iii) less the ancillary services medical education costs calculated in paragraph (iv).

(vi) Ancillary service charges for base period claims shall be inflated forward from the date of service to December 31,2008 (midpoint of the SFY 2009 rate year) using the CMS-PPS Hospital Market Basket pursuant to subparagraph c (iv).

(e) Base period capital costs.

(i) Capital-related costs as defined in 42 C.F.R. § 413.130.

(ii) A routine capital cost per diem shall be calculated.

(A) Total capital costs for the base period shall be calculated.

(I) Routine capital costs shall be extracted from the base period Medicare cost reports.

(II) Inpatient routine old capital costs shall be extracted from Worksheet B-Part I, Columns 1 and 2 and inpatient routine new capital costs shall be extracted from Worksheet B-Part I, Columns 3 and 4 for Medicaid-covered hospital services in cost centers 25 through 36.

(B) Patient days shall be extracted from Worksheet S-3 Part I, Column 6 for Medicaid-covered hospital services in cost centers 1 through18 and 26.

(C) Routine capital costs per day shall be calculated by dividing total capital costs in paragraph (A) by patient days in paragraph (B).

(D) Routine capital costs per claim are calculated by multiplying the number of patient days associated with each routine revenue code in the base year claims data by the associated routine capital cost per diem.

(iii) Ancillary services capital costs shall be calculated.

(A) Ancillary capital costs shall be extracted from the base period Medicare cost reports.

(B) Inpatient ancillary old and new capital costs shall be extracted from Worksheet B-Part I, Columns 1 through 4 for Medicaid-covered hospital services in cost centers 37 through 67.

(C) Ancillary total charges shall be extracted from Worksheet C-1, Column 8 for Medicaid-covered hospital services in cost centers 37 through 67.

(D) A ratio of ancillary costs-to-charges shall be calculated by dividing ancillary capital costs in paragraph (B) by the ancillary total charges in paragraph (C).

(E) Ancillary capital costs shall be determined by multiplying the charges associated with each revenue code on the base year claim by the associated ancillary capital cost-to-charge ratio.

(iv) Total capital costs shall be determined by summing routine capital costs and ancillary service capital costs.

(v) Capital costs are not inflated.

Section 10: Determination of Level of Care Costs.

(a) Rehabilitation level of care per diem costs.

(i) The Department shall calculate the cost of each rehabilitation claim for each hospital in the base period claims pursuant to Section 9.

(A) The Department shall identify rehabilitation services claims.

(I) Claims with "zero dollars" in the payment field shall be identified and removed from further calculations in this subsection.

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

(C) A cost per day for each hospital for rehabilitation level of care services shall be calculated.

(I) For each hospital, total costs for rehabilitation services in the base period shall be divided by total days from the base period claims data.

(II) High and low cost Medicaid outlier costs shall be identified for rehabilitation costs per diem. For purposes of this section, the high cost outlier threshold shall be days with allowable costs greater than two standard deviations from the mean per diem cost calculated in paragraph 1. For purposes of this section, low cost outliers shall be discharges with allowable costs less than two standard deviations from the mean.

(ii) The base period allowable Medicaid cost per diem for rehabilitation services for each hospital shall be determined by subtracting outliers as determined in paragraph (II) from costs determined in paragraph (I).

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

(A) The ventilator payment per day shall be calculated 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.

(b) Determination of Level of Care Per Discharge Costs

(i) The Department shall exclude certain base year claims, and the costs and the number of discharges associated with each of those claims, from further consideration in this Section.

(A) Claims with zero dollars ($0.00) in the payment field shall be identified and removed.

(B) Costs associated with less than one day stays shall be identified and removed.

(C) Transfers shall be identified and removed.

(D) Claims from non-participating providers.

(E) Claims from participating providers with fewer than five (5) claims in a level of care.

(ii) Base period claims excluding rehabilitation services will be assigned to a level of care based on designated diagnosis, procedure and revenue codes according to the following hierarchy of levels of care:

(A) Maternity - Surgical;

(B) Maternity - Medical;

(C) Neonatal Intensive Care Unit (NICU) Levels I and II, and NICU Level III services;

(D) Intensive care unit ("ICU")/Cardiac care unit ("CCU") services/Burn Care;

(E) Major surgery;

(F) Psychiatric services;

(G) Newborn nursery;

(H) Routine.

(iii) The Department shall calculate the cost per discharge for maternity/surgical, maternity/medical, NICU Levels I and II, NICU Level III, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine levels of care for each hospital in the base period claims pursuant to Section 9.

(A) The Department shall sum the base period routine cost and the base period ancillary costs for each level of care discharge for each hospital.

(B) The Department shall calculate the number of discharges for each level of care provided by each hospital in the base year adjusted paid claims data.

(C) The Department shall determine a preliminary cost per discharge for each level of care for each hospital by dividing total costs per level of care in the base period as derived in Section 9 by total discharges from the base period claims data.

(D) The Department shall calculate a mean cost per discharge for each level of care by summing each base year participating hospital's costs as calculated in subparagraph (A) and dividing by the number of discharges in subparagraph (B).

(E) High and low cost Medicaid outlier costs shall be identified for each level of care and subtracted from the preliminary costs per discharge calculated in paragraph (C). For purposes of this section, the high cost outliers shall be discharges with allowable costs greater than two standard deviations from the mean per discharge cost. For purposes of this section, low cost outliers shall be discharges with allowable costs less than two standard deviations from the mean.

Section 11: Determination of Level of Care Rates

(a) The level of care payment rate for rehabilitation services shall be comprised of a per diem operating cost payment and a per diem capital cost payment.

(i) The Department shall determine the operating rate per diem for rehabilitation services level of care for each hospital in the base period claims as the average cost per diem for each participating hospital determined in Section 10.

(ii) The Department shall determine the capital per diem for rehabilitation services pursuant to Section 19 paragraph (b).

(b) The Department shall determine an operating rate per discharge for maternity/surgical, maternity/medical, NICU Levels I and II, NICU Level III, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine levels of care.

(i) Only claims from hospitals with five or more discharges in the base period will be considered.

(ii) The Department shall classify hospitals in the base period claims into one of six mutually exclusive peer groups according to the following hierarchy of peer groups. These six peer groups shall be used for the determination of all level of care per discharge rates.

(A) Peer group 1 hospitals are all participating major teaching hospitals as recognized by the Council on Teaching Hospitals.

(B) Peer group 2 hospitals are participating Critical Access Hospitals as defined by CMS in 42 CFR§485.601-645.

(C) Peer group 3 hospitals are participating hospitals with ninety (90) or fewer staffed beds as defined by the American Hospital Association (AHA) Guide, 2009 Edition.

(D) Peer group 4 hospitals are participating hospitals with more than ninety (90) staffed beds as defined by American Hospital Association (AHA) Guide, 2009 Edition.

(E) Peer group 5 hospitals are private, freestanding psychiatric hospitals located in the State of Wyoming that provide services that fall into the psychiatric level of care, for psychiatric services only.

(F) Peer group 6 hospitals are all other hospitals, not included in peer group 5, that provide services that fall into the psychiatric level of care, for psychiatric services only.

(iii) The Department shall calculate a peer group ceiling rate, a not-to-exceed cost amount, for the maternity/surgical, maternity/medical, NICU Levels I and II and NICU Level III, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine levels of care.

(A) For each peer group, and for the maternity/surgical, maternity/medical, NICU Levels I and II and NICU Level III, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine levels of care, a peer group median operating cost per discharge, which is total allowable hospital operating costs excluding capital and medical education costs, divided by the number of Medicaid paid discharges, as determined by arraying the hospital-specific average operating cost per discharge for each hospital as determined pursuant to Section 10 paragraph (b).

(B) The mid-point of the array within each peer group and for maternity/surgical, maternity/medical, NICU Levels I and II, ICU/CCU/Burn, major surgery, newborn nursery and routine levels of care is determined as the peer group median, and a ceiling rate shall be established as one-hundred ten percent (110%) of the median. For NICU Level III discharges from children's hospitals as designated by the National Association of Children's Hospitals, the ceiling shall be determined as one-hundred fifty percent (150%) of the median.

(iv) The Department shall determine each hospital's LOC rate.

(A) The hospital-specific cost per discharge determined in Section 10(b) shall be compared to the peer group ceiling rate as determined in subparagraph (iii).

(B) Each hospital's preliminary level of care rate for maternity/surgical, maternity/medical, NICU, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine levels of care is the lower of its mean cost per discharge as determined in Section 10 subparagraph (b)(iii)(D) and the peer group ceiling rate as determined in subparagraph (ii).

(C) Incentive payment. If the hospital's level of care per discharge rate for maternity/surgical, maternity/medical, NICU Levels I and II, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery or routine levels of care is lower than the peer group ceiling rate, the hospital's preliminary rate for that level of care shall be increased by fifteen percent (15%) of the difference between the peer group ceiling rate and the hospital's per discharge rate.

(c) The final level of care payment shall be:

(i) The amount determined pursuant to Section 11(a) and (b)

(ii) The outlier payment determined pursuant to Section 17;

(iii) The capital payment determined pursuant to Section 19;

Section 12. <u>Reimbursement of Non-participating Hospitals.</u>

(a) The Medicaid payment rate shall be the average per discharge level of care payment for all participating providers, including incentive payments for maternity/surgical, maternity/medical, NICU Levels I and II, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine levels of care. The Medicaid payment rate for the rehabilitation per diem level of care shall be the average payment rate for all participating providers. The Medicaid payment rate for non-participating hospitals shall not include reimbursement for capital costs.

(b) Medicaid payment to a non-participating hospital may not exceed the Medicaid level of care payment rate.

Section 13. Reimbursement of New Hospitals.

(a) The Medicaid payment rate for new hospitals shall be the average level of care payment for all participating providers, including incentive payments.

(b) The Medicaid payment rates for new hospitals shall remain in effect until the level of care system is rebased.

(c) The Medicaid payment rate for new hospitals shall not include reimbursement for capital costs.

Section 14. Reimbursement of Merged Hospitals. The Medicaid allowable hospital-specific level of care payments for a merged hospital shall be:

(a) The level of care payment rates of the surviving hospital;

(b) A capital payment. The capital payment shall be the statewide capital payment per diem or per discharge amount depending upon level of care.

Section 15. 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 28 of this Attachment.

Section 16. Reimbursement for Transfers.

(a) Transferring hospital. A hospital which transfers a patient after admission to another hospital shall receive a per diem payment, not to exceed the level of care payment, for maternity/surgical, maternity/medical, NICU, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine levels of care services.

(i) The transfer policy shall not apply to the rehabilitation services level of care payment.

(ii) Transfers do not include movement of a patient to or from a distinct part hospital unit of the hospital or from one unit to another within a hospital.

(b) Discharging hospital. The hospital which discharges a patient that has been transferred in shall receive a per diem payment, not to exceed the level of care payment for maternity/surgical, maternity/medical, NICU Levels I and II and NICU Level III, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine levels of care, except as provided in subsection (d), unless the admission is a less than one-day stay. Less than one-day stays shall be reimbursed pursuant to Section 18.

(c) Receiving hospital that does not discharge. A hospital which receives a transfer, and then transfers the patient to another hospital, shall receive a per diem payment, not to exceed the level of care payment, for maternity/surgical, maternity/medical, NICU Levels I and II and NICU Level III, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine levels of care.

(d) Outlier payments. A hospital receiving reimbursement pursuant to this Section shall be eligible for an outlier payment pursuant to Section 17.

(e) To calculate the per diem rate for maternity/surgical, maternity/medical, NICU Levels I and II, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine levels of care:

(i) The level of care rate shall be divided by the provider's geometric mean length of stay for that level of care. The geometric mean length of stay indicates the central tendency of the provider's length of stay in the base period.

(ii) For non-participating providers, the statewide per discharge level of care rate shall be divided by the statewide geometric mean length of stay for that level of care.

(f) Capital payments. Payments made pursuant to this Section shall not include a capital payment unless the facility is entitled to a level of care payment.

Section 17. Reimbursement for Outliers.

(a) No outlier payments will be made for the rehabilitation level of care services.

(b) The outlier threshold is two times the level of care payment rate for each level of care.

(c) The Medicaid allowable payment for outliers for maternity/surgical, maternity/medical, NICU Levels I and II and NICU Level III, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine level of care services shall be the applicable level of care payment plus a payment equal to the difference between the hospital's allowable costs for the outlier and the outlier threshold multiplied by seventy-five percent (75%). For purposes of this Section, allowable costs are calculated as the hospital specific cost-to-charge ratio for each level of care, multiplied by the allowable charges submitted on the claim for that level of care. Hospitals with cost-to-charge ratios greater than one (1.0) shall be capped at the statewide cost-to-charge ratio for each level of care.

(i) If a participating hospital does not have a hospital-specific CCR, the peer group CCR shall be used.

(ii) The statewide CCR shall be used for non-participating hospitals.

(d) Submission of claims. Claims for outlier payments shall be submitted in the form specified by the Department in Provider Manuals or Provider Bulletins.

(e) Discharge planning. No hospital shall receive an outlier payment for a patient that is not discharged because of the hospital's failure to conduct appropriate discharge planning.

Section 18. Reimbursement of Less Than One-day Stays.

(a) The Department shall determine a less than one-day stay payment rate for maternity/surgical, maternity/medical, NICU Levels I and II and NICU Level III, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine levels of care for each participating provider. The less than one-day stay policy shall not apply to the rehabilitation services level of care.

(b) The provider's level of care payment for the maternity/surgical, maternity/medical, NICU Levels I and II and NICU Level III, ICU/CCU/Burn, major surgery, newborn nursery and routine levels of care, shall be divided by the provider's geometric mean length of stay for that level of care.

(c) For participating providers with five (5) or fewer claims during the base period, the peer group level of care payment for the maternity/surgical, maternity/medical, NICU Levels I and II and NICU Level III, ICU/CCU/Burn, major surgery, newborn nursery and routine levels of care shall be divided by the peer group geometric mean length of stay to calculate the less than one-day stay payment rate.

(d) For new providers and non-participating providers, payment shall be the statewide level of care payment as described in Sections 12 and 13.

(e) The Medicaid allowable payment for stays of less than one day shall not include outlier reimbursement or capital payment.

Section 19. Reimbursement of Capital Costs.

(a) Capital costs. The Department shall determine a per discharge capital payment rate to be paid for maternity/surgical, maternity/medical, NICU Levels I and II and NICU Level III, ICU/CCU/Burn, major surgery, psychiatric, newborn nursery and routine levels of care.

(i) A capital cost per discharge for each participating hospital shall be calculated by dividing total capital costs calculated pursuant to Section 9 paragraph (e) by total discharges in the base period pursuant to Section 10 paragraph (b) subparagraph (iii)(B).

(ii) The Department shall array the average capital cost per discharge of all participating hospitals and select the median capital cost per discharge for the capital payment rate for all participating hospitals.

(b) The Department shall determine a per diem capital payment rate to be paid for rehabilitation level of care services.

(i) The median capital cost per discharge as calculated in subparagraph (a) shall be divided by the average length of stay of all participating hospitals with rehabilitation services discharges to determine a per diem capital payment.

(ii) The capital payment for rehabilitation level of care shall not exceed the per discharge amount calculated in subparagraph (a).

(c) An adjustment to a provider's capital rate pursuant to subsection (e) shall 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 29 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 20. Inflation Adjustment.

(a) Inflation of base period costs. To establish initial inpatient payment rates, the allowable base period Medicaid per diem costs, as determined pursuant for each level of care pursuant to Section 9, shall be inflated from the mid-point of the base to the midpoint of the rate year.

(b) Inflation of inpatient payment rates. Inpatient payment rates, except the payment for capital costs, shall be inflated from the mid-point of the rate year to the mid-point of the following rate year.

(c) Effective date. New payment rates shall become effective on each July 1.

Section 21. Reimbursement of Swingbed Services. Reimbursement for swingbed services shall be pursuant to Chapter 28.

Section 22. Reimbursement of Readmissions. Medicaid shall not reimburse for a readmission if the readmission is for the continuation of treatment begun in the initial admission and the Department determines that the treatment should have been provided during the initial admission.

Section 23. Third-Party Liability.

(a) Submission of claims. Claims for which third-party liability exists shall be submitted in accordance with 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 24. 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 25. Audits.

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

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

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

(d) Review and payment adjustment of hospital-acquired conditions.

(i) The Department will deny or reduce payment for five (5) hospital-acquired conditions or "Never Events" (object left in after surgery, air embolism, blood incompatibility, pressure ulcer stages III and IV and falls and trauma). Denial or reduction of payment shall be limited to the additional care required by the hospital-acquired condition. Inpatient hospital rates are not applicable for these hospital-acquired conditions. The Department shall review from time to time the list of hospital-acquired conditions and Medicare National Coverage Determinations related to never events, and revise the list as needed. In such an event, the Department shall disseminate to providers, through manuals or bulletins, a current list of hospital-acquired conditions pursuant to this Attachment.

(ii) The Department will review discharges relating to hospital-acquired conditions and make use of the "Present on Admission" indicator to adjust reimbursement accordingly. 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, and detailed at:
http://cms.hhs.gov/Transmittals/downloads/R1240CP.pdf

(iii) The Department will review Medicare National Coverage Determinations related to never events and consider CMS guidance with regard to non-payment of these claims.

(iv) The Department shall not pay the approved inpatient hospital rates, or any other hospital payments including disproportionate share and qualified rate adjustments pursuant to Attachment 4.19A, Parts 1 and 2, for hospital-acquired conditions that are identified as non-payable by Medicare. The Department shall not be liable for payment of any services related to hospital acquired conditions or national coverage determinations that are denied by Medicare and that are on the Wyoming Medicaid hospital acquired conditions list.

(e) Disallowances. If a field audit or desk review discloses non-allowable costs or overpayments, the Department shall recover any overpayments pursuant to Section 28 of this Attachment.

(f) Notice of overpayments. After determining that a provider has received overpayments, the Department shall send written notice to the provider, by certified mail, return receipt requested, stating the amount of the overpayments, the basis for the determination of overpayments and the provider's right to request reconsideration of that determination pursuant to Section 29. The reconsideration shall be limited to whether the Department has complied with the provisions of this Attachment.

(g) Recovery of overpayments. A provider must reimburse the Department for overpayments within thirty days after the provider receives written notice from the Department pursuant to subsection (e), even if the provider has requested reconsideration or an administrative hearing regarding the determination of overpayments. If the provider fails to timely repay overpayments, the Department shall recover the overpayments pursuant to Section 28.

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

Section 26. Rebasing. The Department shall rebase operating costs when the rates determined pursuant to this Attachment no longer meet the requirements of the Social Security Act.

Section 27. Payment of Claims.

(a) Payment of claims shall be pursuant to Chapter 4, Section 11, which is incorporated by this reference.

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

Section 28. Recovery of Overpayments. The Department shall recover overpayments pursuant to Chapter 16, which is incorporated by this reference.

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

Section 30. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, any other agency of the federal, state or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments or take any other final action authorized by this Attachment.

Section 31. Interpretation of Attachment.

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

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

Section 32. Superseding Effect. This Attachment supersedes all prior Attachments or policy statements issued by the Department, including manuals and bulletins, which are inconsistent with this Attachment, except as otherwise specified in this Attachment.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Wyoming

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 costs for the payment period are greater than its projected pre-QRA inpatient Medicaid payments for the same period.

A hospital's calculated Medicaid costs for the payment period are determined by applying the cost-to-charge ratios developed from the hospital's most recently available Medicare cost report to the hospital's billed charges for ancillary services for Medicaid claims paid during the most recently ended State fiscal year (inflated to the midpoint of the payment period) and on the basis of the hospital's routine costs per day developed from the hospital's most recently available cost report (inflated to the midpoint of the payment period). Reimbursable costs are calculated using Medicare payment principles. Billed charges and per diem costs are inflated using the most currently available CMS Prospective Payment System Hospital Input Price Index.

A hospitals projected pre-QRA Medicaid payments for the payment period are the total of Medicaid payments to the hospital for claims paid during the most recently ended State fiscal year, with each payment inflated from its effective period to the midpoint of the payment period using the CMS Prospective Payment System Hospital Input Price Index.

The QRA payment is an annual lump sum supplemental payment equal to a portion of the difference between a qualifying hospital's calculated Medicaid costs for the payment period and its pre-QRA Medicaid payments for the same period, minus amounts payable by other third parties and beneficiaries. Qualified Rate Adjustment payments are made after the qualifying hospital's data for the most recently ended state fiscal year become available. For purposes of the first QRA payments calculated under the provision, the first fiscal year treated as the most recently ended state fiscal year is the July 1, 2003 - June 30, 2004 fiscal year. QRA payments will not be subject to cost settlement. The Medicaid payments and the QRA payments will not exceed Medicare Upper Payment Limits according to 42 CFR, Section 447.272

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Wyoming

The State has in place a public process which complies with the requierments of Section 1902 (a) (13) (A) of the Social Security Act. W.S. § 16-3-103 meets or exceeds these requirements.

STATE: Wyoming

SELECTIVE CONTRACTING OF SERVICES

Section 1. Authority

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

Section 2. Purpose and Applicability.

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

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

Section 3. General Provisions.

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

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

Section 4. Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) For treatment of any diagnosis.

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

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

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

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

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

Section 5. Provider Participation.

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

provider is certified, unless otherwise specified pursuant to Section 9, has signed a provider agreement, is enrolled, and has signed a contract with the Department.

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

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

Section 6. Provider Records.

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

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

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

Section 8. Medicaid allowable payment for specialty services.

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

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

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

Section 9. Contracting process.

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

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

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

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

Section 11. Reimbursement to non-contracting providers.

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

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

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

Section 12. Third party liability.

(a) Submission of claims. Claims for which third party liability exists shall be submitted in accordance with Chapter 4, which is incorporated by this reference.

(b) Medicaid payment. The Medicaid payment for a claim for which third party liability exists shall be the difference between the Medicaid allowable payment and the third party payment. In no case shall the Medicaid payment exceed the payment otherwise allowable pursuant to this Attachment.

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

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

Section 15. Reconsideration.

(a) Request for reconsideration. A provider may request reconsideration of a request to recover excess payments. Such a request must be mailed to the Department, by certified mail,

return receipt requested, within twenty days after the date the provider receives notice pursuant to Section 14. The request must state with specificity the reasons for the request. Failure to provide such a statement shall result in the dismissal of the request with prejudice.

(b) Reconsideration. The Department shall review the matter and send written notice by certified mail, return receipt requested, to the provider of its final decision within forty-five days after receipt of the request for reconsideration or the receipt of any additional information requested pursuant to (c), whichever is later.

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

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

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

(f) Matters not subject to reconsideration.

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

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

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

(h) Administrative hearing. A provider may request an administrative hearing regarding the final agency decision pursuant to Chapter 1 of the Department's Medicaid rules by mailing by certified mail, return receipt requested or personally delivering a request for hearing to the Department within twenty days after the date the provider receives notice of the final agency decision. At the hearing, the burden shall be on the provider to show that the agency's final decision does not comply with this Attachment.

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

Chapter 1.

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

null and void.

Section 16. Interpretation of Attachment.

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

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

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

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

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