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State/Territory Name: Wyoming

State Plan Amendment (SPA) #: WY-14-013

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region VIII

September 17, 2014

Teri Green, State Medicaid Agent
Wyoming Division of Health Care Financing
401 Hathaway Building
Cheyenne, WY 82002

RE: Wyoming #14-013

Dear Ms. Green:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 14-013. This SPA concerns the implementation of a Primary Care Medical Home through a voluntary PCCM authority to allow for Wyoming Medicaid to pay the PCCM entities a Per Member/Per Month case management fee for managing the health care needs in a primary care medical home setting and for reporting quality measures to the State, in addition to payments made on a FFS basis.

Please be informed that this State Plan Amendment was approved September 16, 2014 with an effective date of October 1, 2014. We are enclosing the CMS-179 and the amended plan page(s).

If you have any questions concerning this amendment, please contact Cindy Riddle at (303) 844-7116.

Sincerely,

/s/

Mary Marchioni
Acting Associate Regional Administrator
Division for Medicaid & Children's Health Operations

CC: Chris Bass
Lee Clabots, Deputy Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 14-013

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
October 1, 2014

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 447.205

7. FEDERAL BUDGET IMPACT:
Savings expected to offset costs in year one. In following years, savings projected.

$0 in SFY 2015, SFY 2016 (-$494,657 total, -$247,657 Federal funds only), SFY 2017 (-$565,922, -$282,961 Federal Funds Only), Savings projected to continue to continue to increase SFY 2018 and beyond.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1 F pages 1-~~16~~ 13

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Implementation of a Primary Care Medical Homes through a voluntary Primary Care Case Management authority to allow for the Wyoming Medicaid will pay the Primary Care Case Management entities a Per Member Per Month (PMPM) case management fee for managing the healthcare needs in a primary care medical home setting, and for reporting quality measures to the State, in addition to payments made on a fee-for-service basis.

Enrollment of Medicaid recipients in PCCMs will be on a voluntary, statewide basis based on their free choice of provider. No limitations will be placed on the Medicaid recipient free choice of participating Medicaid provider. By choosing a provider that is enrolled as a PCCM, the client voluntarily enrolls in the program. If the provider is participating in the PCCM program, the client's claim history will indicate whether they have chosen a primary care provider or whether they use multiple providers.

Providers participating in the PCCM program agree to comply with an additional set of requirements to receive the PMPM payment through the execution of a separate annual attestation with the State of Wyoming. These include an additional enrollment/application procedure, utilizing a continuity of care document during office visits, extended office hours, after hours availability, and entering clinical quality measures information into the State Level Registry at a practice level. (Annual attestation attached).

In the current phase of the program, there will be one PMPM payment level for participation. In future years, Wyoming Medicaid will explore moving to three levels of payment to recognize participation, continuous improvement, and meeting or exceeding benchmarks for clinical quality measures

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME: TERI GREEN

14. TITLE: STATE MEDICAID AGENT

15. DATE SUBMITTED: 07-22-14

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

CC: CHRIS BASS, MANAGEMENT ASSISTANT
(SAME ADDRESS)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **7/22/14**	18. DATE APPROVED: **9/16/14**
19. EFFECTIVE DATE OF APPROVED MATERIAL: **10/01/14**	20. SIGNATURE OF REGIONAL OFFICIAL: **/s/**
21. TYPED NAME: **Mary Marchioni**	22. TITLE: **Acting ARA, DMCHO**

REMARKS:

State:

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Wyoming enrolls Medicaid beneficiaries on a voluntary basis into primary care case managers (PCCMs) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on state wideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may not be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
__X_ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

__X_ i. fee for service;
____ ii. capitation;
__X_ iii. a case management fee; for the PCCM
____ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____ vi. other. (Please provide a description below).

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

Citation	Condition or Requirement
	If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ____ii. Incentives will be based upon specific activities and targets. ____iii. Incentives will be based upon a fixed period of time. ____iv. Incentives will not be renewed automatically. ____v. Incentives will be made available to both public and private PCCMs. ____vi. Incentives will not be conditioned on intergovernmental transfer agreements. __X_vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. The State has in place a public process which complies with the requirements of Section 1902(a)(1 3)(A) of the Social Security Act. Public notice will be published on the Wyoming Department of Health website which is available to the public on an ongoing basis. In addition ongoing public input is solicited through various provider advisory committees including the Physician Advisory Group. Tribal notification is provided through e-mail to designated tribal leadership and the Indian Health Service.

Citation	Condition or Requirement
1932(a)(1)(A)	5. The state plan program will___/will not_X__ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary__X___ enrollment will be implemented in the following county/area(s): i. county/counties (mandatory) _____ ii. county/counties (voluntary)____ALL_____ iii. area/areas (mandatory)_____ iv. area/areas (voluntary)_____ALL_____
	C. State Assurances and Compliance with the Statute and Regulations. If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. NA__The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. _X__The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. NA__The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met. No limitations will be placed on the recipient freedom of choice of providers.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. X__The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. X___The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. NA__The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. X__The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8. X___The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. Eligible groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. Enrollment is voluntary for all persons and groups into PCCMs. No persons will be enrolled on a mandatory basis
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. X___ (for PCCM only) Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. Clients voluntarily enroll by utilizing the fee for service provider of their choice. The client's history will indicate whether they have chosen a primary care provider.

Citation	Condition or Requirement
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. X___ (for PCCM only) Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. X___(for PCCM only) Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. X___(for PCCM only) Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. X___(for PCCM only) Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. X___(for PCCM only)Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. X___(for PCCM only) Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V.

Enrollment in the Maternal and Child Health Children's Special Health Program.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
_X__iii. both

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. _X__ i. yes ____ ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: i. Children under 19 years of age who are eligible for SSI under title XVI; Not applicable to voluntary PCCM program ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; Not applicable to voluntary PCCM program iii. Children under 19 years of age who are in foster care or other out-of-home placement; Not applicable to voluntary PCCM program iv. Children under 19 years of age who are receiving foster care or adoption assistance. Not applicable to voluntary PCCM program
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. Not applicable to voluntary PCCM program

Citation	Condition or Requirement

1932(a)(2)
42 FR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care:

i. Recipients who are also eligible for Medicare

Not applicable to voluntary PCCM program

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Not applicable to voluntary PCCM program

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

Not applicable to voluntary PCCM program

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

All groups described as eligible in Section 2.2 of Wyoming's approved State Medicaid Plan will be permitted to enroll on a voluntary basis into the PCCM program. Wyoming Medicaid will not make PMPM payments for Medicare buy-in individuals (QMB, SLMB), non-full Medicaid individuals (Breast and Cervical Cancer program, Tuberculosis program) or emergency service groups (non-citizens).

Citation	Condition or Requirement

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

For the PCCM program:

Wyoming Medicaid will not disrupt or interfere with the existing provider-recipient relationship.

There is no default enrollment process, but there will be a look-back at paid claims for the past 12 months for the PCCM for selected Evaluation and Management and Preventive Visit codes for Established Patients. If the client is currently Medicaid enrolled, the PCCM with all of the selected Evaluation and Management and Preventive Visit codes visits with a specific client will receive the attribution and the PMPM payment for that client for the month. If Wyoming Medicaid is billed a PMPM for the same month by multiple providers and the client used services at multiple PCCMs, the client will be attributed to neither PCCM resulting in denial of both PMPM provider claims for the month. The attribution will be re-assessed on a monthly basis for a rolling twelve months (i.e. each month, the oldest month will be dropped and the newest month added).

Citation	Condition or Requirement

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

For the PCCM program:
Any willing provider that meets the enrollment criteria may enroll.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2).

For the PCCM program:
Any willing provider that meets the enrollment criteria may enroll.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

The PCCM program is voluntary and therefore does not utilize a default enrollment process.

Items 3.i-3vi below do not apply to the enhanced PCCM program.

i. The state will____/will not_X___ use a lock-in for managed care managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be_____N/A_____.

Citation	Condition or Requirement
	iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* Not applicable
	iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)* Not applicable
	v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)* Not applicable
	vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)* Not applicable

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. ___The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

   _X_ This provision is not applicable to this 1932 State Plan Amendment.

2. ____The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

   _X_ This provision is not applicable to this 1932 State Plan Amendment.

3. ____The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   _X__This provision is not applicable to this 1932 State Plan Amendment.

4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   X___ This provision is not applicable to this 1932 State Plan Amendment.

5. ____The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   X___ (for the PCCM program only) This provision is not applicable to this 1932 State Plan Amendment.

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will___/will not _X__ use lock-in for managed care.

2. The lock-in will apply for _N/A___ months (up to 12 months).

3. Place a check mark to affirm state compliance.

____The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

X__ Not Applicable

4. Describe any additional circumstances of "cause" for disenrollment (if any).

None

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

X___The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

For the PCCM program:
No services are excluded for the PCCM program.

Citation	Condition or Requirement

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_____/will not __X___ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option.

   For the PCCM program:
   There is no limit on enrollees. There is no limit on providers meeting qualification to enroll. Wyoming uses a non-competitive contracting and enrollment process soliciting applications from interested Family/General Practice, Internal Medicine, and Pediatric providers in all areas of the state.

4. X___ The selective contracting provision in not applicable to this state plan.