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State/Territory Name: Wyoming

State Plan Amendment (SPA) #: WY-17-0003

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
Denver Regional Office
1961 Stout Street, Room 08-148
Denver, CO 80294



REGION VIII - DENVER

October 13, 2017

Teri Green, State Medicaid Agent
Office of Health Care Financing
Wyoming Department of Health
6101 Yellowstone Road, Suite 210
Cheyenne, WY 82009

RE: Wyoming #17-0003

Dear Ms. Green:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 17-0003. This Recovery Audit Contractor (RAC) SPA modifies Section 4.5 to waive certain requirements of Section 1902(a)(42) of the Social Security Act. The State is currently exempt from this program while in procurement status. Wyoming will be in procurement status effective July 1, 2017 through June 30, 2019. Please inform us if a bid is received, and a formal contract has been executed before the end date. The state will need to also subsequently submit an amendment to the state plan to resume the Wyoming Department of Health's program compliance of the Recovery Audit Contract.

Please be informed that this State Plan Amendment was approved today with an effective date of July 1, 2017. We are enclosing the CMS-179 and the amended plan page(s).

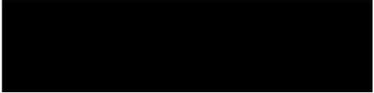
If you have any questions concerning this amendment, please contact Cindy Riddle at (303) 844-7116.

Sincerely,



Richard C. Allen
Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: Thomas Forslund, Director
Sheree Nall
Kristy Wilmarth

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| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | | 1. TRANSMITTAL NUMBER: WY17-0003 | 2. STATE WYOMING |
| | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | | 4. PROPOSED EFFECTIVE DATE 07/01/2017 | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | | | |
| 5. TYPE OF PLAN MATERIAL (<i>Check One</i>): | | | |
| <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT | | | |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>) | | | |
| 6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 455.516 | | 7. FEDERAL BUDGET IMPACT: | |
| | | a. FFY 2017 \$0.00 | |
| | | b. FFY 2018 \$0.00 | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section 4.5b page 36b & 36c | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Section 4.5b page 36b | |
| 10. SUBJECT OF AMENDMENT: Wyoming RAC vendor contract ended 6/30/2016. Wyoming is in need of an extension to the State's requirement to contract with a Medicaid Recovery Audit Contractor while Wyoming attempts to procure a new vendor through the RFP process. | | | |
| 11. GOVERNOR'S REVIEW (<i>Check One</i>): | | | |
| <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT | | <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Delegated to Teri Green, State Medicaid Agent, Division of Healthcare Financing | |
| <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED | | | |
| <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | | 16. RETURN TO: TERI GREEN STATE MEDICAID AGENT OFFICE OF HEALTH CARE FINANCING 6101 YELLOWSTONE ROAD, SUITE 210 CHEYENNE, WY 82002 | |
| 13. TYPED NAME: TERI GREEN | | CC: KRISTY WILMARTH, EXECUTIVE ADMINISTRATIVE ASSISTANT (SAME ADDRESS) | |
| 14. TITLE: STATE MEDICAID AGENT | | | |
| 15. DATE SUBMITTED: 07/20/17 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: July 20, 2017 | | 18. DATE APPROVED: October 13, 2017 | |
| PLAN APPROVED – ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2017 | | 20. SIGNATURE OF REGIONAL OFFICIAL:  | |
| 21. TYPED NAME: Richard C. Allen | | 22. TITLE: ARA, DMCHO | |
| 23. REMARKS: | | | |

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| <p>Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act</p> <p>Section 1902 (a)(42)(B)(ii)(III) of the Act</p> <p>Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act</p> <p>Section 1902(a)(42)(B)(ii)(IV)(bb) of the Act</p> <p>Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act</p> | <p>_____ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.</p> <p>_____ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.</p> <p>_____ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):</p> <p>_____ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).</p> <p>_____ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.</p> <p>_____ The State assures that the recovered amounts will be subject to a State’s quarterly expenditure estimates and funding of the State’s share.</p> <p>_____ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.</p> |
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